

# Performance Tracker 2022/23

Spring update



Nick Davies | Stuart Hoddinott | Matthew Fright  
Philip Nye | Paul Shepley | Gil Richards

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## About Performance Tracker

*Performance Tracker* is an ongoing analysis of the performance of public services. This eighth edition brings together more than 250 indicators to analyse how the pandemic has affected spending, staff and performance in nine public services. Produced in partnership by the Institute for Government and the Chartered Institute of Public Finance and Accountancy (CIPFA), the analysis examines the problems faced by public services and whether they have sufficient funding or staff to return performance to pre-pandemic levels by 2025.

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# Summary

**This is the second edition of *Performance Tracker* that the Institute for Government and CIPFA have published this financial year, in response to a fast-changing and crisis-driven period in public services and the new government's decision to deliver a budget in March.**

Since our October publication, we have a new prime minister – the third in a year – and widespread strikes have engulfed the country. Rishi Sunak's government has made substantial changes to the spending plans set out in the 2021 spending review but the fragility of public services has remained and winter in the NHS has been as bad as feared. Despite the 'twindemic' of flu and Covid hitting hospitals and general practice as predicted, too little was done to prepare, in large part due to the political instability and administrative paralysis caused by the defenestration of two prime ministers over the summer and autumn.

These winter pressures have combined with long-standing problems in adult social care, hospitals and primary care and resulted in the worst NHS crisis in a generation. The elective waiting list stands at more than 7 million and bed occupancy is above 95%. Waits at A&E and for ambulances meaningfully improved in January, having reached record levels in December, but are still substantially worse than pre-pandemic. Failures in the health and care system are estimated to be contributing to hundreds of preventable deaths a week.

The situation in other services – while not quite as extreme – remains very concerning. Increasing numbers of recorded crimes go unsolved and a series of high-profile police scandals involving the Met and other forces have further damaged trust in the police and raised serious questions about the quality of leadership in the service. The case backlog in the crown court is at record levels and, when adjusting for complexity of cases, is more than twice as large as before the pandemic. The lack of progress in addressing court backlogs has meant that prisoner numbers are lower than the Ministry of Justice anticipated they would be. Despite this, some prisons still have insufficient capacity to safely offer even pre-pandemic standards of rehabilitative activity, and the government has been forced to make emergency use of 400 police cells.

In schools, the National Tutoring Programme is now reaching large numbers of pupils. However, evidence on its effectiveness is limited, and the overall pandemic catch-up programme is worth just a third of what the government's own education recovery commissioner thought would be necessary to allow schools to make up for lost learning. Many children also continue to be let down by social care services, and the government's response to an independent review has been criticised by the author

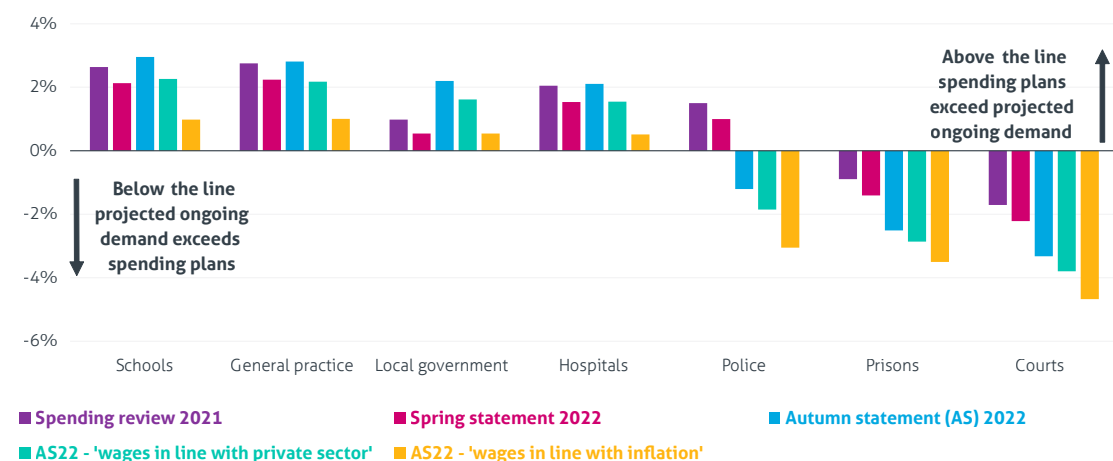
of that review for being slow and lacking in ambition. The situation is particularly shocking for unaccompanied asylum-seeking children, hundreds of whom have gone missing from the Home Office’s care.<sup>1</sup>

The Sunak government will need to grapple with these issues and more in the run-up to the next election. Public concern about health care is particularly high at the moment<sup>2</sup> and Sunak identified tackling NHS waiting lists as one of his top five priorities in a speech in January 2023.<sup>3</sup> The analysis in this report outlines the scale of the challenge in nine public services – general practice, hospitals, adult social care, children’s social care, neighbourhood services, schools, police, criminal courts and prisons. To date, the new government’s decisions have done little to shift the dial and it will need to do much better if it wishes to campaign on its public services track record.

### The autumn statement has eased some pressures, but services still do not have sufficient funding to return to pre-pandemic performance levels

On 17 November, the government published an autumn statement. This was in effect a mini-spending review, making some substantial changes to public sector spending plans for the remaining two years of the current spending review period and beyond. As covered in detail in previous Institute for Government and CIPFA work,<sup>4</sup> the overall settlement for day-to-day departmental spending across the current spending review period (2022/23 to 2024/25), was broadly as generous as when originally announced in October 2021, with additional cash in the autumn statement offsetting higher than anticipated inflation.

Figure 0.1 Average annual increases in spending between 2021/22 and 2024/25 relative to demand under different inflation scenarios



Source: Institute for Government analysis of HM Treasury, spending review 2021, spring statement 2022 and autumn statement 2022, supported by CIPFA. Notes: 'Wages in line with private sector' assumes increases in line with Bank of England average earnings from 2022/23 onwards. 'Wages in line with inflation' assumes increases in line with OBR CPI from 2022/23 onwards. Full details on data sources are provided in the Methodology chapter.

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The NHS, adult social care and schools were the big winners from this, with each receiving meaningful funding increases. As a result, hospitals, general practice, schools and local government services should, assuming no change to productivity, now have enough money to meet inflationary pressures and ongoing demographic demand over the spending review period. However, it does not provide the level of funding required for major improvements to performance. First, because spending settlements are front-loaded, with big increases this year (2022/23) but little increase in the following two years. Despite this front-loading, the NHS in particular has not been able to convert additional funding and staff into increased activity, suggesting a fall in productivity. As such, in practice, the additional funding will not be enough to cover backdated inflation-level wage increases for 2022. Second, without further funding injections, an increased share of budgets will need to be spent on higher pay awards if they are used to bring strikes to an end. Third, performance in some services has got substantially worse over the last three years and reversing that will require considerable effort. As such, performance in these services is unlikely to return to pre-pandemic levels before the next election. This means that hospital waiting times and lists will remain above where they were in 2019, pupils will not catch up on lost learning, and the social care provider market will not be put on a sustainable long-term financial footing.

The situation in prisons and courts is arguably worse. With no additional funding announced in the autumn statement, progress in addressing the crown court backlog will be slow and the prison service will find it very difficult to safely house the expected increase in prisoner numbers.

Given the certainty of continued poor service-related performance and the prospect of ongoing industrial unrest across the public sector, it is unclear whether the government will find existing funding levels to be politically sustainable in the run-up to the next election. The situation will be even harder for whoever forms the next government. If the autumn statement's spending plans for 2025/26 onwards were replicated at a spending review in 2025, it would be less generous than every spending review announcement since 2002 except 2010 and 2015, with the latter proving undeliverable due to poor performance.

### **The government's strikes strategy has exacerbated existing staffing problems**

Problems with the recruitment, retention and morale of staff are central to the poor performance of public services. The situation is particularly acute in adult social care, with 50,000 staff leaving the workforce in 2021/22. In the NHS, almost 10% of its roles were vacant at the end of September 2022: the worst gap on record. In schools, teacher training numbers are at crisis levels. There are fewer than three postgraduate trainee teachers for every five the government thinks are needed to staff secondary schools. And the situation is much worse for some subjects, with less than one physics trainee for every five required. In criminal courts, the deal to end the barristers' strikes should prevent the situation from worsening, but there are still too few barristers to make much progress on the crown court backlog. Sickness and other absences have also remained high in many services, reducing staffing levels and increasing the pressure on other workers, who are already at heightened risk of burnout.

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We warned in the autumn that substantially below-inflation pay offers would exacerbate these staffing problems. Since then, there have been widespread strikes across the public sector. Of the services covered in this report, schools and the NHS, particularly hospitals, have been worst affected. Members of the largest education union, the National Education Union, have begun strike action and two other teaching unions are planning to re-ballot their members after failing to meet turnout thresholds on a first attempt. In the NHS, nurses and ambulance workers have been striking since December and will be joined shortly on the picket lines by junior doctors.

Rather than seeking to quickly resolve these disputes, the government had, until late February, refused to meaningfully discuss pay and introduced the Strikes (Minimum Service Levels) Bill. This will allow ministers to set legally binding minimum service levels in health, education and other services, and enable employers to name which members of staff have to work to meet these service levels. In theory, the bill should make it cheaper for the government to resolve disputes, as it will limit the impact of strikes and therefore weaken the negotiating position of unions.

However, this strategy has and will continue to be damaging for the performance of public services and in many cases exacerbate the problems driving staffing crises. In the short term, it has extended the length and breadth of industrial disputes and the disruption caused. Strikes by junior doctors, ambulance staff and teachers could have been avoided had the government been more willing to discuss pay. It is notable that the government was able to end strikes by criminal barristers by eventually offering an improved pay deal and that nurses paused strike action when, again in late February, the government offered pay talks. In the medium term, the government's actions have undermined trust in the pay review bodies.<sup>5</sup> With many unions now refusing to participate in this process, there is a greater likelihood that future pay decisions will also lead to strike action. In the long term, limiting the ability of staff to strike and paying them less than they think they are worth will exacerbate the already serious recruitment and retention problems facing public services.

There are no easy options for the government. Refusing to raise pay offers will make it much harder for it to address backlogs and other public service performance issues. Raising pay but asking services to fund this from existing budgets will likely necessitate painful cuts as there is little meaningful fat to trim elsewhere. Similarly, increasing public service budgets to accommodate higher pay would require increasing taxes, higher borrowing or cuts to other public spending, none of which will be pain free.

Returning services to pre-pandemic performance levels, never mind those of 2010, is a daunting task. There is precedent for such an improvement, though: New Labour turned around a comparably bad NHS in the 2000s. But this required sustained investment, rather than short-term funding in responses to crises, and a strong focus on reform. Similar efforts are likely to be required now.

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# 1. General practice

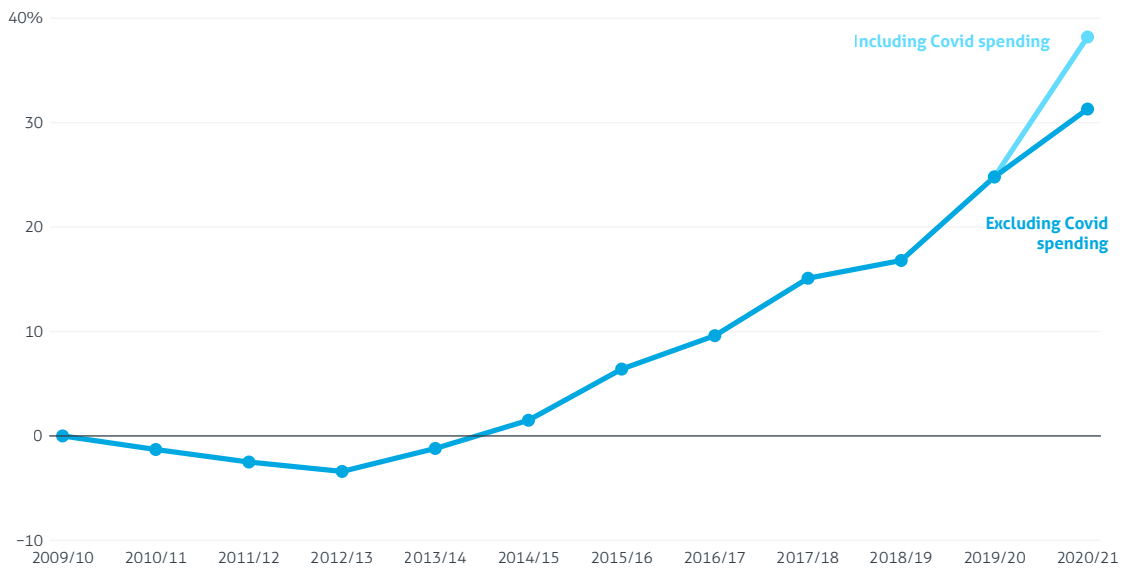
The pandemic affected general practice in different ways as it progressed. In the early stages, GP teams conducted far fewer appointments as patients followed advice from the government to stay away from the service unless in need of emergency care. Then, during the rollout of the Covid vaccine, they played a key role delivering doses in their communities. Now, three years after the pandemic began, general practice is attempting to cope with a huge surge in demand, as many of those who stayed away come forward for care. The level of pressure on an already overstretched workforce is immense: GPs delivered more appointments in 2021/22 than in any year on record.

Despite this increased activity, there is evidence that many people have tried but failed to book an appointment,<sup>1</sup> contributing to increasing public dissatisfaction with the service. Those appointments that did take place were delivered in different ways, with a large proportion being carried out over the telephone. The outcomes of appointments also changed: referrals from general practice to secondary care dropped during 2019/20 (before the pandemic) and remained below pre-pandemic levels in 2020/21 and 2021/22. Despite a recruitment drive that has increased the number of GPs in training contracts and led to a large and rapid expansion of the wider primary care workforce, the combination of growing demand, additional responsibilities and new ways of working is worsening stress and burnout, in turn contributing to a deteriorating retention of GPs in primary care.



## Covid costs have driven high spending in general practice

Figure 1.1 Change in total spending on general practice since 2009/10 (real terms)



Source: Institute for Government analysis of NHS Digital, 'Investment in General Practice, 2009/10 to 2013/14', NHS Digital, 'Investment in General Practice, 2011/12 to 2015/16' and NHS England, 'Investment in General Practice, 2016/17 to 2020/21', supported by CIPFA. Notes: Figures cover both current and capital spending.

Spending on general practice in 2020/21 was 35.5% higher in real terms including Covid costs, and 31.7% higher in real terms excluding Covid costs, than in 2009/10.<sup>2</sup> The increase in spending in 2019/20 and 2020/21 followed the launch of the NHS Long Term Plan, in January 2019, which aimed to increase spending on general practice and community health services by at least £4.5 billion by 2023/24<sup>3</sup> – a target that NHS England is currently on track to meet, even when excluding additional Covid spending.

NHS England spent £704.8 million on Covid measures in primary care in 2020/21.<sup>4</sup> Of this, £333.8m related to the Covid vaccination programme, where GP teams carried out a greater proportion of vaccinations than forecast and more affordably than dedicated vaccination centres – the average cost for each dose was £24 and £34 respectively.<sup>5</sup> The remaining £371m included funding for measures such as opening on bank holidays, personal protective equipment (PPE) provision and an enhanced flu vaccination scheme.<sup>6</sup> It is currently unclear how much NHS England will need to continue spending over the coming years to deal with ongoing Covid pressures in general practice.

### Spending on staffing has also driven increased expenditure

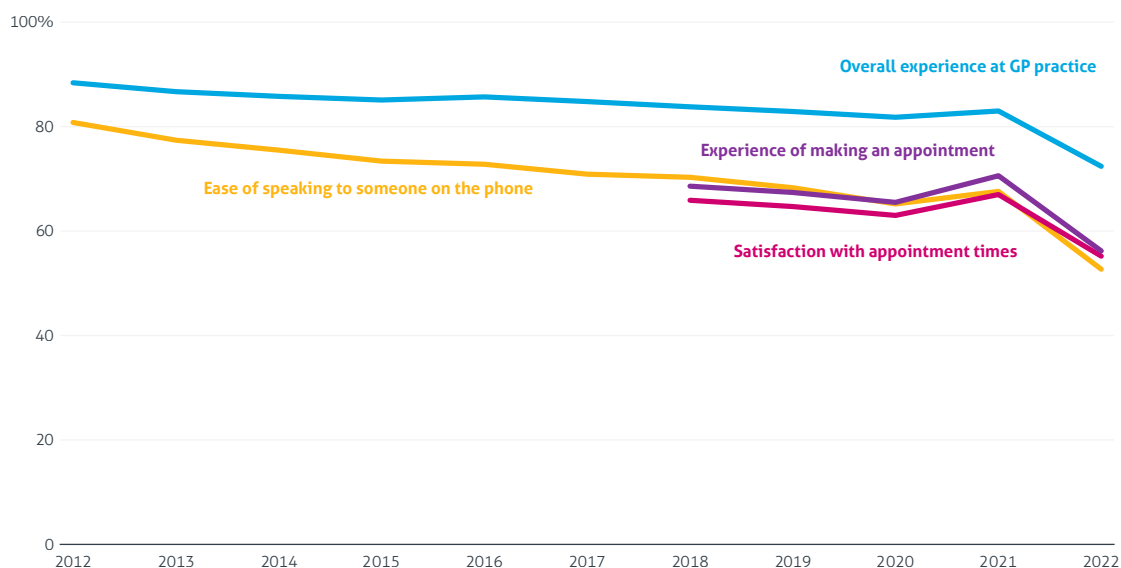
Spending on primary care organisations – a category that includes recruitment, retention, locum payments and seniority payments in general practice<sup>7</sup> – increased 21.7% a year in real terms on average from 2018/19 (the last year before the NHS Long Term Plan came into effect) to 2020/21.<sup>8</sup> This was partly to support the government's ambition to have a further 26,000 primary care staff by March 2024<sup>9</sup> and 6,000 more GPs,<sup>10</sup> which would represent a 17.4% increase in the total number of GPs, compared with March 2019.<sup>11</sup>

## Demand for general practice is reportedly high, but difficult to quantify

Demographic changes continue to push up demand for primary care. The population in England grew by 0.4% between 2019 and 2021, with the population aged 65-plus growing by 1.1%.<sup>12</sup> Adjusted for age- and sex-based factors, demand for GP services is estimated to have risen 0.6% in 2022 compared with 2021, due to purely demographic factors.<sup>13</sup>

However, this projection is unlikely to represent true levels of demand since the pandemic. Interviewees and anecdotal reports indicate that primary care is facing more demand than ever, although this is difficult to quantify. NHS England records the numbers of appointments that GPs and other primary care staff carry out, but not how many people try but fail to book an appointment.

Figure 1.2 **Patients' experiences of general practice, 2012–22**



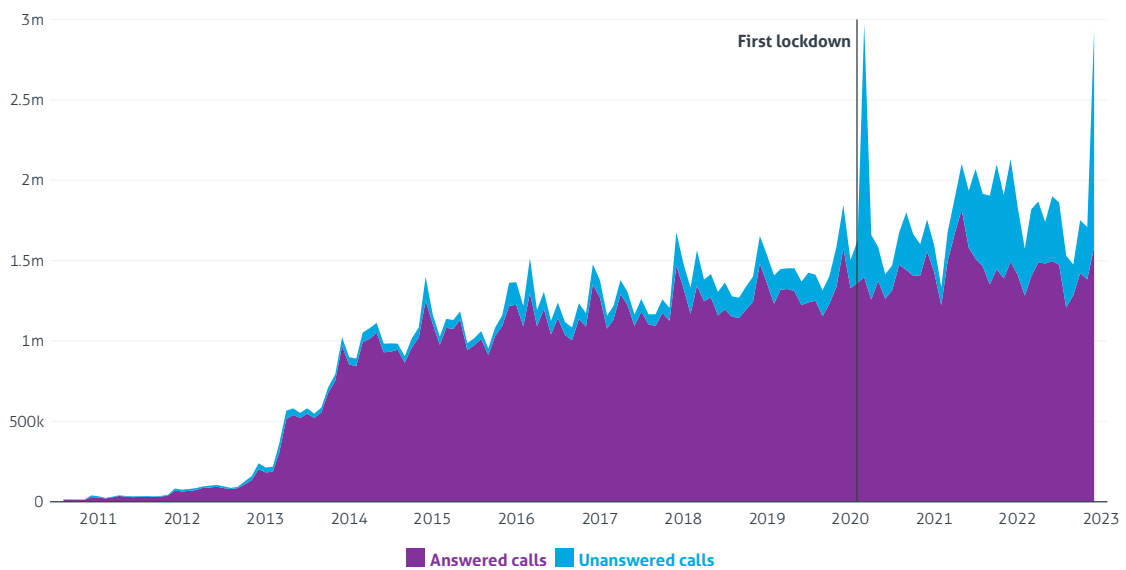
Source: Institute for Government analysis of NHS, 'GP Patient Survey 2022', questions 1, 6, 21 and 32, supported by CIPFA. Notes: Each time series starts from the first year the question was asked.

However, surveys of patients registered with a GP practice indicate that unmet demand is substantial and has increased. In the annual GP Patient Survey, only 56.2% rated their experience of making an appointment as good or better in 2022, down from more than 70% in 2021. And among those who avoided making a GP appointment in 2022, 26.5% did so because they found it too difficult, up from 11.1% in 2021.<sup>14</sup>

The survey indicates that, overall, satisfaction with the service that general practice teams are providing is down: only 72.4% described their experience as 'good' or 'very good' in 2022, down from 83% a year earlier. Patients' inability to make appointments, due to excessive demand, appears to be a major driver of this.

In September the government, then headed by Liz Truss, announced an ambition for every patient to see a GP within 14 days.<sup>15</sup> The Sunak government re-committed to this ambition in the autumn statement at the same time as providing the NHS with a further £3.3bn funding per year for 2023/24 and 2024/25<sup>16</sup> – though general practice will receive only a portion of this increase. It is, however, unclear what impact that money will have on helping primary care achieve the government’s three manifesto promises that relate to the service: 50 million more appointments, recruiting an additional 26,000 direct patient care staff, and hiring 6,000 more GPs. The government has admitted that the latter of these is unachievable,<sup>17</sup> which casts doubt on the likelihood of meeting its stated goal in the autumn statement of improving appointment access.

Figure 1.3 **Calls to the NHS 111 service, August 2010 to December 2022**

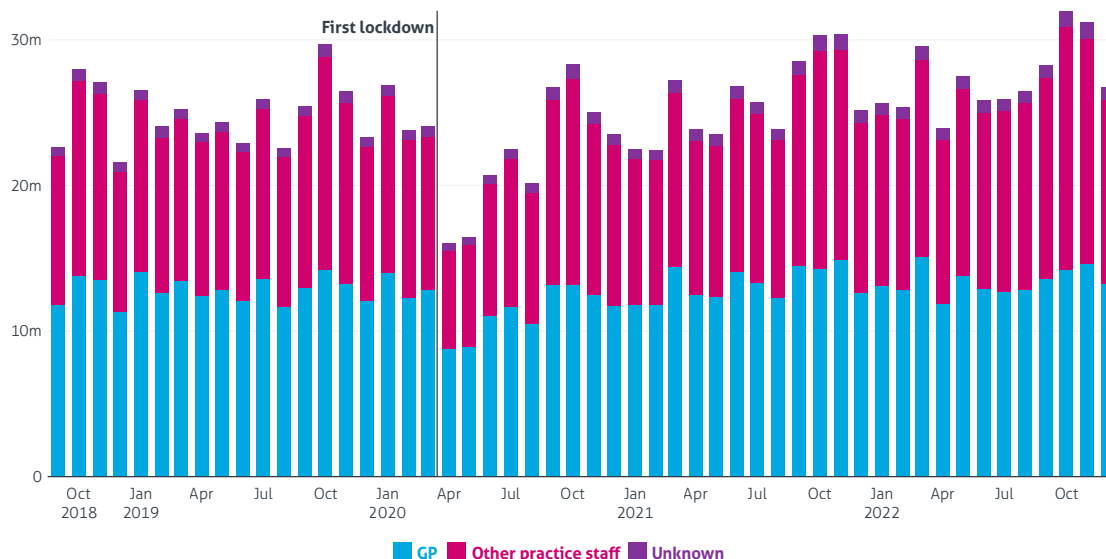


Source: Institute for Government analysis of NHS England, 'NHS 111 Minimum Data Set', March 2021 and NHS England, 'Integrated Urgent Care Aggregate Data Collection (IUCADC including NHS 111) Statistics, Apr 2021 – Dec 2022', supported by CIPFA. Notes: The 111 service was first piloted in 2011.

Another proxy for health demand – and, by extension, demand for GP services – is the number of calls made to the NHS 111 service. The number of calls that the service *received* fell in 2022 compared to 2021, from 22.6 million to 22 million – a 2.5% decline, though there was a large spike in December, with the second highest ever level of received calls.<sup>18</sup> Despite this lower call volume, the proportion of calls that the service *answered* fell from 79.2% in 2021 to 76.9% in 2022 – though if December is excluded from the analysis, the number of answered calls was higher than in 2021, at 80.5%.

## GP teams carried out more appointments in 2022 than before the pandemic, but it is unclear whether they saw more patients

Figure 1.4 Appointments in general practice by provider, September 2018 to December 2022



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, December 2022', supported by CIPFA. Notes: Data was first published in 2018/19.

After a decline in 2020, the number of general practice appointments delivered in 2022 rose above the amount carried out in 2019. This was true for both GP appointments (which rose from 155.1 million in 2019 to 160.9 million in 2022, a 3.7% uplift) and appointments with other practice staff, such as practice nurses, physiotherapists or counsellors (which increased from 136.8 million in 2019 to 157 million in 2022, a 14.8% rise).

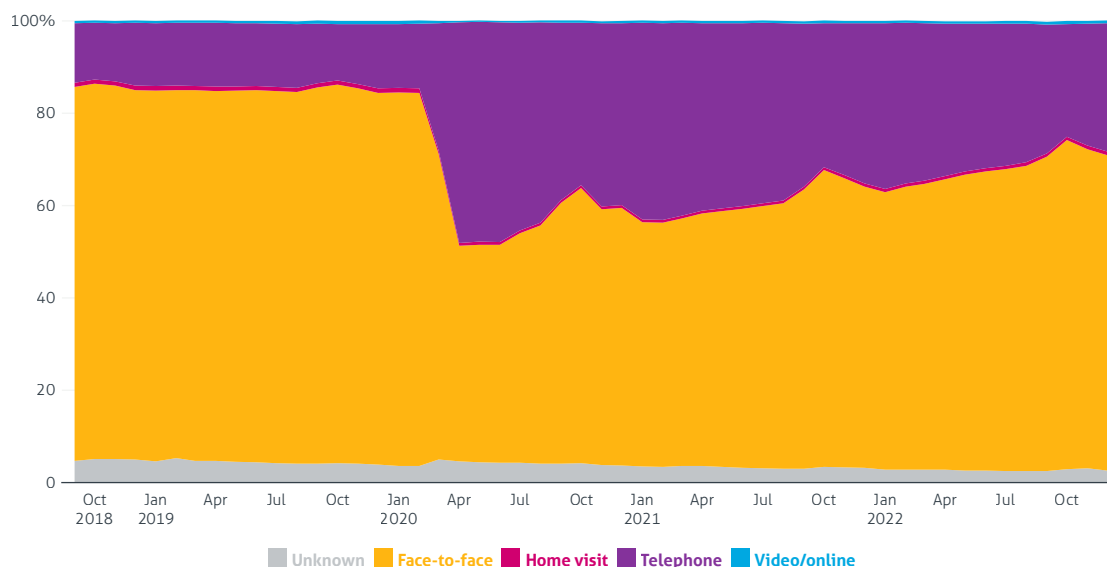
While the number of appointments increased in 2021/22, this data is not comparable to previous years. With a 'telephone-first approach', GP teams can end up conducting two shorter appointments for some patients – an initial telephone appointment followed by a face-to-face appointment – which would previously have been recorded as one longer appointment. It is therefore difficult to tell whether GP teams are actually seeing more patients, or just recording more appointments because patients require both telephone and in-person appointments to resolve their health problem.

Appointments are also not the only component of GP workloads – just under 60% of GPs' time is spent on direct patient care,<sup>19</sup> meaning that 40% of GP activity is not observed by looking at appointment data.

## General practice

# GPs continue to deliver appointments differently

Figure 1.5 GP appointments by mode of delivery, September 2018 to December 2022



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, December 2022', supported by CIPFA. Notes: Data was first published in 2018/19.

The way that appointments are delivered has also changed. In the year to February 2020, telephone appointments accounted for only 13.5% of all consultations. In April 2020, this increased to 47.8%. Since then, the proportion of telephone appointments has been steadily falling and in December 2022, GP teams conducted 27.8% of appointments by telephone. This trend has persisted despite the NHS issuing guidance in May 2021 that all GP practices should offer patients face-to-face appointments and that patient preferences for face-to-face should be respected. The move during the pandemic to an 'online triage' model may also partly explain the trend.<sup>20</sup> Having completed an online triage form, GPs often follow up with a telephone appointment, which might then lead to a face-to-face appointment.<sup>21</sup>

The continuation of this mode of appointment delivery may also be because patients often prefer it. Telephone appointments eliminate the need for people to attend and wait in a GP surgery, saving them time and money. This can translate into higher patient satisfaction: one survey showed that 58% of patients either agreed or strongly agreed that telephone appointments were a convenient way of receiving care,<sup>22</sup> while another survey showed that 56% of respondents rated telephone appointments as more convenient than face-to-face ones.<sup>23</sup>

But there are disadvantages for patients with an increased proportion of remote appointments. There is a risk that it exacerbates existing inequalities<sup>24</sup> among vulnerable and elderly patients.<sup>25</sup> There is also concern that remote appointments lead to worse clinical outcomes for patients,<sup>26</sup> although more work needs to be done to understand their effect on outcomes.

## The benefits to general practice of increased numbers of remote appointments are mixed

The benefits of remote appointments for clinicians are more ambiguous than they are for patients. Some clinicians like working remotely and, during the pandemic, appreciated that they were able to work with a lower risk of catching Covid.<sup>27</sup>

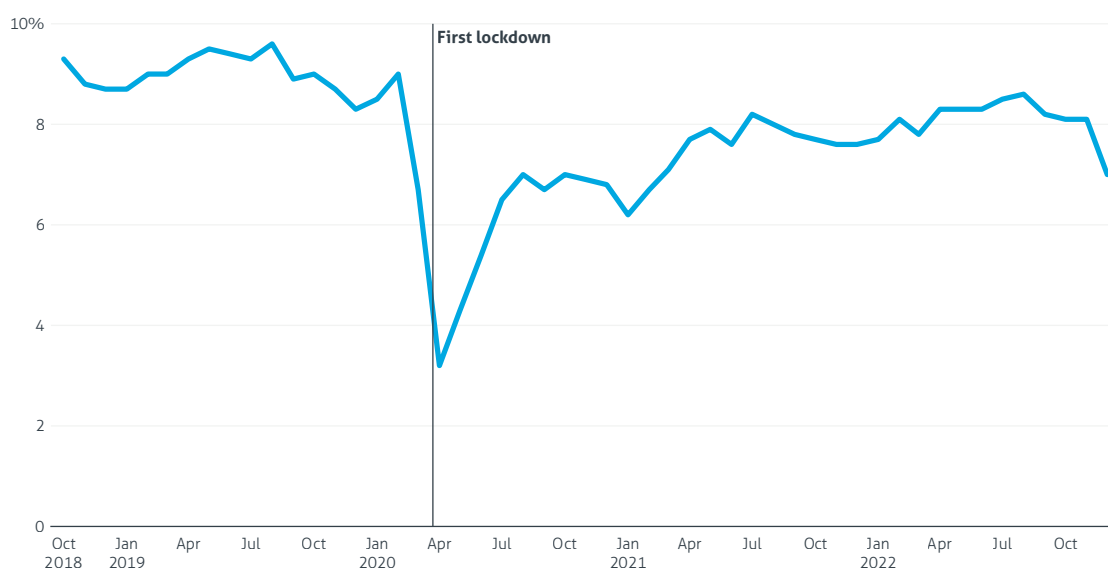
Telephone appointments were found to be effective for “a considerable part of patient workload”,<sup>28</sup> in particular simpler, single-issue problems.<sup>29</sup> But for more complex or uncertain cases, patients are asked to attend a face-to-face appointment for further examination.

There are also clinical risks associated with remote consultations, if not implemented correctly. For example, GP teams reported issues such as a loss of visual information, a loss of information from a physical examination<sup>30</sup> and a reduced incidence of patients raising ‘door knob’ concerns as they left their appointment.<sup>31</sup>

Telephone consultations also contributed to GPs’ stress, for a number of reasons.<sup>32</sup> First, GPs often found it difficult to extract a full history from patients remotely, which reduced their confidence in their diagnoses.<sup>33</sup> Second, if working from home, they lost the ability to consult with colleagues in the way they would have done if they had been in the GP surgery.<sup>34</sup> Third, they often found telephone and video calls more tiring than face-to-face appointments<sup>35</sup> and that telephone appointments often increased the amount of time they spent working.<sup>36</sup> Finally, GPs felt that remote appointments were more transactional, which in turn lowered their job satisfaction.<sup>37</sup>

## Referrals to secondary care dropped after the onset of the pandemic and have remained low

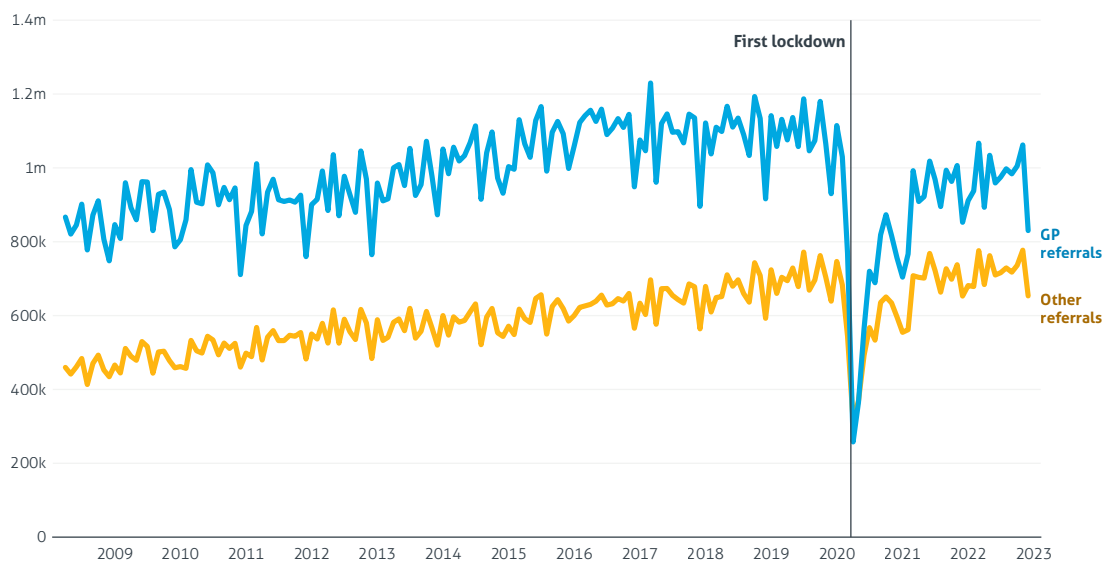
Figure 1.6 **GP appointments resulting in a specific and acute referral, October 2018 to December 2022**



Source: Institute for Government analysis of NHS England, ‘Appointments in General Practice, December 2022’ and NHS England, ‘Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, December 2022’, supported by CIPFA. Notes: Appointments are attended GP appointments. Data was first published in 2018/19.

Whether or not GP teams are working more or seeing more patients, the data shows that they are less likely to refer patients to hospital. The proportion of GP appointments that have resulted in a specific and acute referral has dropped over the course of the pandemic. But we are not seeing referral rates return to pre-pandemic levels. Between October 2018 (when the appointment time series began) and February 2020, 9% of GP appointments resulted in a referral. This fell to 6.2% between March 2020 and February 2021. From March 2021 to March 2022, the rate increased to only 7.7%, despite the expectation that more patients would require referral to secondary care – having been unable to access care during the pandemic.<sup>38</sup> The rate has continued to increase, rising to 8.1% in 2022, though this is still below pre-pandemic levels.

Figure 1.7 **Specific and acute referrals to NHS secondary care by source per month, April 2009 to December 2022**

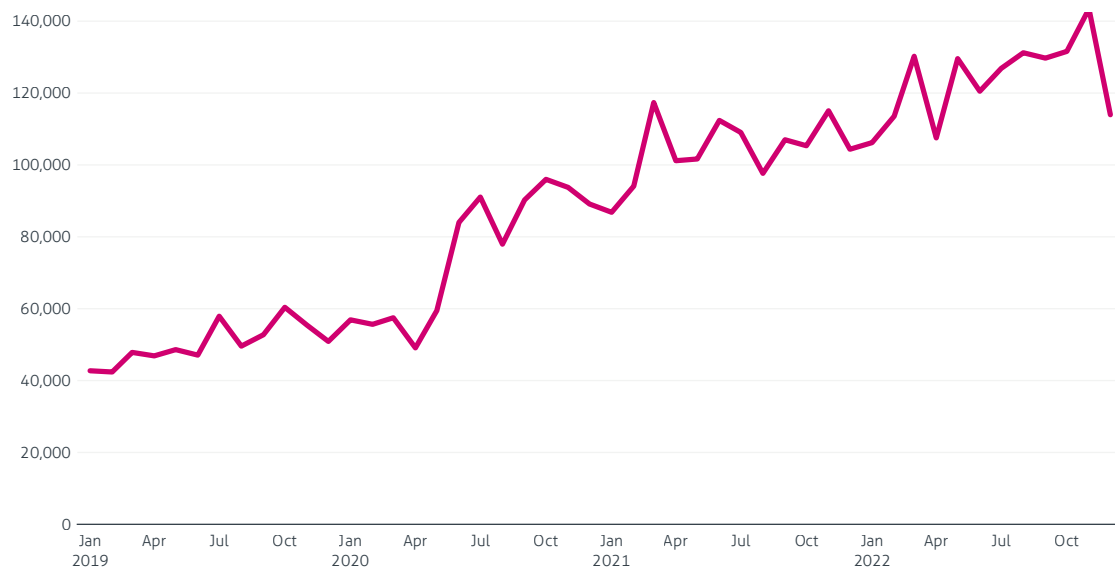


Source: Institute for Government analysis of NHS England, 'Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, December 2022', supported by CIPFA.

The lower rate of referral has translated into fewer absolute referrals, despite more appointments taking place. The number of specific and acute referrals – from both GPs and other sources – was 20.3 million in 2022, down from 21.5 million in 2019 – a fall of 5.8%. This is despite a drop in referrals to 15 million in 2020/21, which could have indicated pent-up demand for referrals to secondary care.

There are multiple reasons for this decrease. First, there was a slight downward trend in referral rates before the pandemic, which, if continued, could explain some of the observed decline, although this was not a long-running trend and there was no particular reason to expect it to continue. Second, there are claims that hospitals are blocking referrals,<sup>39,40</sup> although this should not affect the overall number of referrals, as we observe referrals when a GP refers a patient, whether or not there is then a follow-up appointment.<sup>41</sup> Third, it may be that, before making a referral, GPs are following up initial telephone appointments with face-to-face consultations, meaning more appointments taking place for each referral, on average.

Figure 1.8 **GPs' requests for advice and guidance using the NHS e-Referral Service, January 2019 to December 2022**



Source: Institute for Government analysis of NHS England, 'Monthly Outpatient Referrals Data, Outpatient Referrals Time-series, December 2022', supported by CIPFA. Notes: 'Advice and Guidance' (A&G) was introduced in 2019.

Fourth, and arguably most importantly, is new encouragement from NHS England for GPs to consult their secondary care colleagues in advance about whether a referral is the best course of action. This mechanism is known as 'Advice and Guidance' (A&G). NHS England has introduced a target for GPs to register 16 specialist advice requests, including A&G, for every 100 first outpatient appointments, by March 2023.<sup>42</sup> The National Audit Office reports that GPs are already exceeding this target, seeking A&G for 22 of 100 first outpatient appointments between April and June 2022.<sup>43</sup>

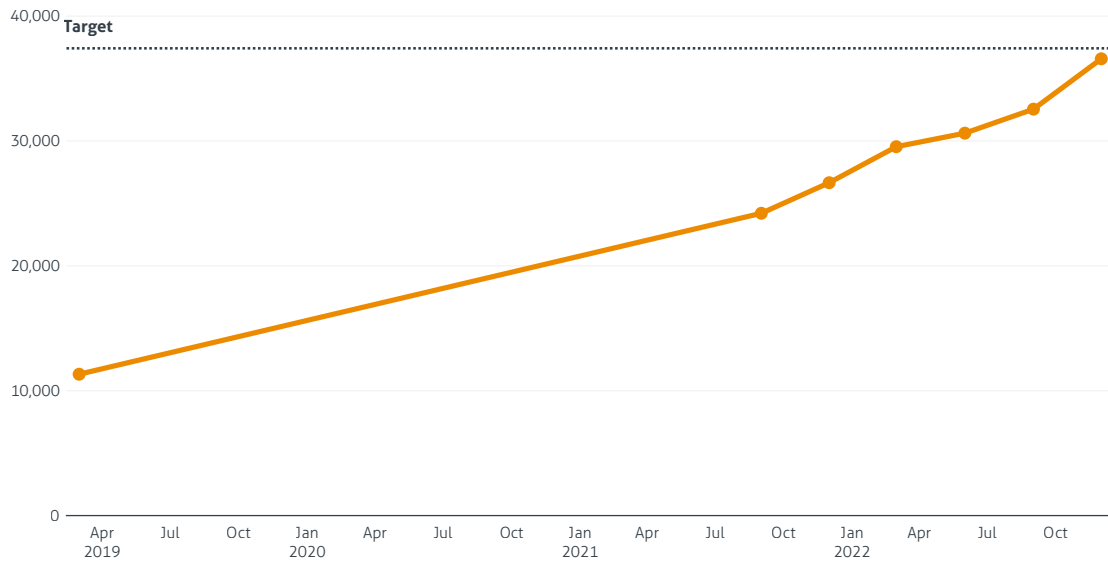
There are advantages and disadvantages to the increased use of A&G. It can help speed up treatment and enable patients to receive the care they need closer to home. NHS England also claims that the 1.6 million A&G requests in 2020/21 resulted in 1 million fewer "unnecessary face-to-face outpatient attendances",<sup>44</sup> thus helping to ease the pressure on secondary care. In contrast, some argue that mandated A&G ignores GPs' better judgment<sup>45</sup> and increases the risk that patients who A&G screens out return to primary care, increasing demand for that service.<sup>46</sup>

## The wider primary care workforce is growing, in line with government targets

In 2019, the NHS announced its ambition to recruit an extra 20,000 direct patient care (DPC) staff – in particular, clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics<sup>47</sup> – by March 2024.<sup>48</sup> The Conservative Party then added to this goal in its 2019 election manifesto,<sup>49</sup> bringing the total target to 26,000 additional DPC staff. The aim of this recruitment drive is to reduce some of the burden on GPs and thereby support the broader target of delivering 50 million more general practice appointments by 2024.<sup>50</sup> The NHS is now supporting primary care networks to recruit these staff by reimbursing them for any staff hired in addition to the baseline that was set in March 2019 under the Additional Roles Reimbursement Scheme (ARRS).



Figure 1.9 DPC staff employed in primary care networks, March 2019 to December 2022



Source: Institute for Government analysis of NHS Digital, 'Primary Care Workforce Quarterly Update, 31 December 2022', supported by CIPFA. Notes: Quarterly data between March 2019 and September 2021 was not published.

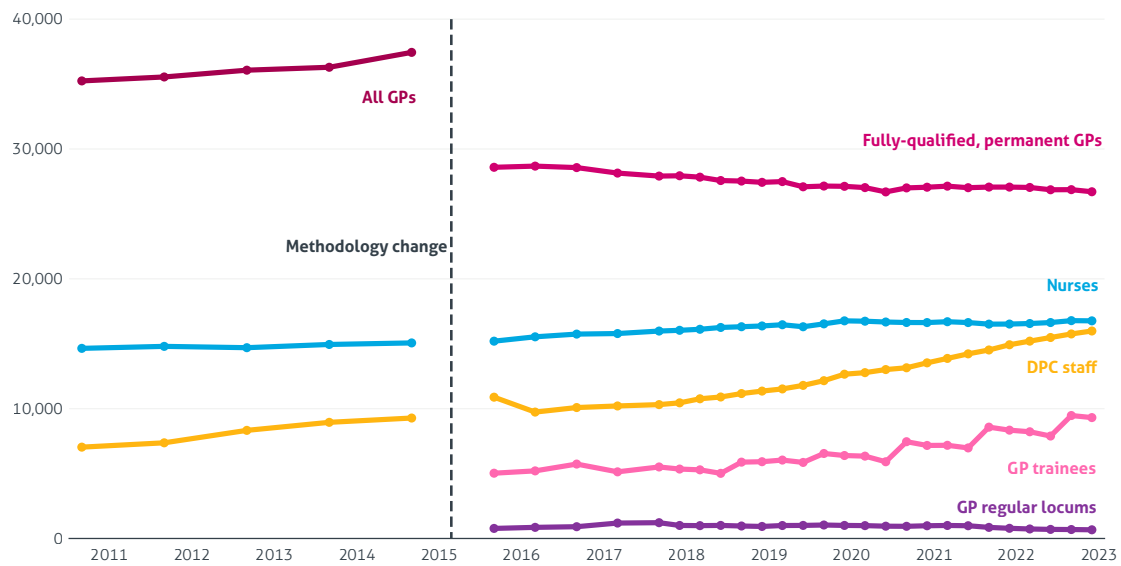
The NHS only began releasing regular quarterly data updates on the number of staff employed under the ARRS in September 2021. From that time series, the total number of DPC staff increased from 11,321 in March 2019 to 36,583 in December 2022. This is an increase of 25,262 staff – a 223.1% rise in just under four years. This leaves the government with only a further 738 DPC staff to recruit before March 2024 to hit their target of an increase of 26,000, effectively guaranteeing that they have fulfilled that manifesto promise.

But there are a number of concerns about the implementation of this recruitment drive. First, it is not clear that primary care networks (PCNs) – still relatively new themselves – have a clear vision for these new employees, meaning that PCNs might not be utilising new staff members effectively.<sup>51</sup> Second, the expansion of the primary care workforce may be putting additional pressure on GPs. Some GPs report that DPC staff take on the easy cases, leaving GPs with the more complex casework. In addition, GPs are required to take on a greater supervisory role as they manage a larger team.<sup>52</sup>

It is also not clear what additional activity these staff members are carrying out. Appointments that they conduct are not currently captured separately\* in general practice appointment data and the NHS does not release any other data relating to these appointments. There are now more DPC staff than GPs working in primary care and it should therefore be a priority for NHS England to show their impact on the service.

\* The general practice appointment data does not provide separate figures for appointments carried out by all DPC staff in PCNs and there is no public data on other primary care activity they undertake.

Figure 1.10 **General practice primary care workforce by role, full-time equivalent, September 2010 to December 2022**



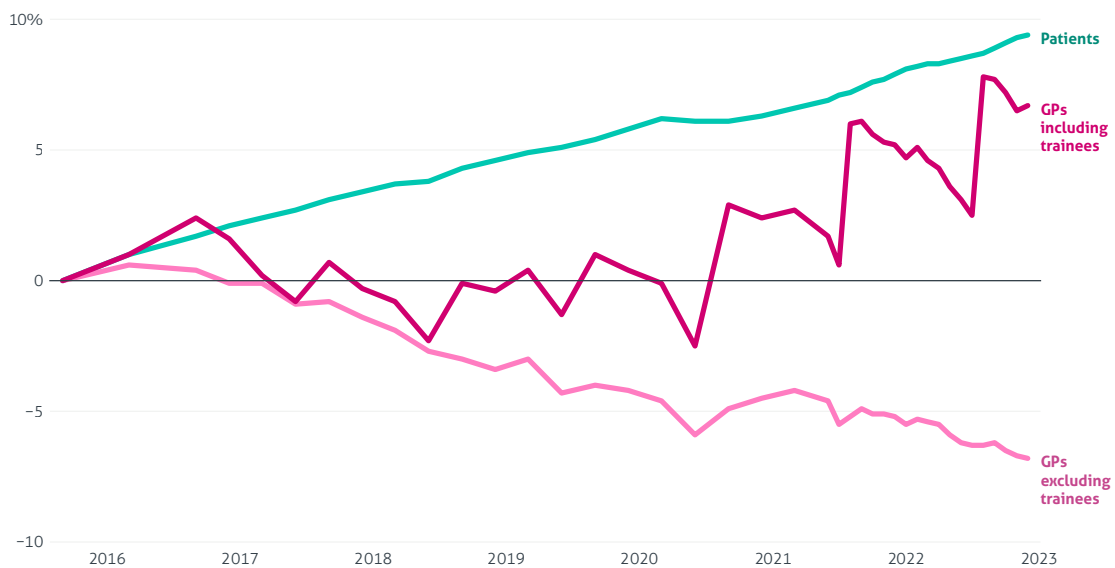
Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – December 2022' and NHS Digital, 'General and Personal Medical Services, England, 2004–14, as at 30 September', supported by CIPFA. Notes: There is a break in the dataset between 2014/15 and 2015/16 due to a change in methodology. Following that change, it is possible to split out trainee and locum GPs from fully qualified, permanent GPs, which is why there is a large drop in the number of GPs between 2014 and 2015. The number of direct patient care (DPC) staff in this chart is not directly comparable with the number of DPC staff in the chart titled 'DPC staff employed in primary care networks, March 2019 to March 2024' (Figure 1.9). This is because the former includes only those DPC staff who work in GP practices, while the latter includes DPC staff employed across wider primary care networks.

### The number of GPs has grown, but not by enough to meet demand

The total number of GPs – fully qualified, permanent GPs and GP trainees – increased by 2,504 between December 2019 and December 2022, from 33,513 to 36,017. This increase, however, hides variation in the split of trainee GPs and fully qualified, permanent GPs. The latter group saw a decline of 418 between December 2019 and December 2022 – a 1.5% fall to 26,706.<sup>53</sup> Boris Johnson made GP recruitment one of his core election commitments, promising to increase the number of GPs by 6,000 between March 2019 and March 2024.<sup>54</sup> Of these 6,000, half were intended to be fully qualified, permanent GPs and half trainees.<sup>55</sup> Given the decline in fully qualified, permanent GPs outlined above, the government is not on track to hit its target by 2024.<sup>56</sup>

Despite declining numbers of fully qualified, permanent GPs, GP recruitment continues to improve, with 9,311 GP trainees in December 2022 – an increase of 2,922 (45.7%) compared to December 2019.<sup>57</sup> This is the second year in a row when the number of new GP trainees has exceeded 4,000, and the fifth year in a row that Health Education England has surpassed its targets for GP trainees.<sup>58</sup>

Figure 1.11 **Change in GP numbers and patients registered with GP practices since December 2015**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables September 2015 – December 2022', supported by CIPFA. Notes: Data was first published in 2015/16. "All GPs" refers to fully qualified, permanent GPs, GP trainees, and GP regular locums.

Despite better recruitment, the number of GPs is not keeping pace with the number of patients registered with practices. Including GP trainees, the number of GPs rose 6.7% between September 2015 and December 2022, compared to 9.4% for the number of patients. If trainees are excluded, however, the picture is considerably worse. The number of fully qualified, permanent GPs declined 6.8% in that time, meaning that there are now 2,273 patients for every fully qualified, permanent GP, compared to 1,938 in 2015 – a 13.3% increase.<sup>59</sup>

This increase in patient numbers also does not take into account the changing demographics of the population – patients are now, on average, older than in 2015 and often, therefore, in more need of care. There are also increasing rates of people living with multiple long-term conditions, both in the 65-plus and working-age populations. One study estimates that the proportion of people over the age of 65 with more than one condition could rise from 54% in 2015 to 68% in 2035.<sup>60</sup> Among working-age adults, 34% now have chronic health conditions at ages 46–48.<sup>61</sup> This in turn drives higher demand for primary care services.<sup>62</sup>

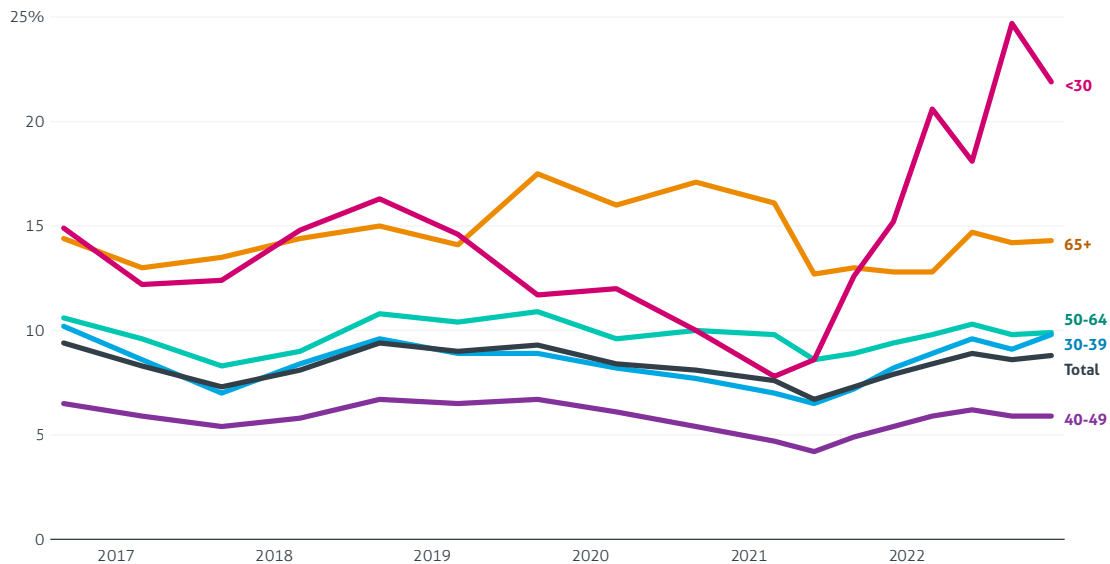
## GP trends are worsening the mismatch in supply and demand

Workforce trends that are seeing more GPs working part-time or leaving the service are exacerbating the problem of demand for general practice services outstripping the supply of GPs. By December 2022, 77% of GPs worked fewer than 37.5 hours a week, compared with 66.7% in September 2015.<sup>63</sup>

But headline figures in relation to the increasing number of part-time GPs hide a more complex picture. Part-time GPs often work up to or more than the 37.5 hours required of their FTE colleagues, while FTE GPs can work 50 hours a week or more.<sup>64</sup> This is partly because working hours are measured by how many 'sessions' a GP carries out a day – a crude measure that takes into account only the time that GPs spend with patients. In reality, GPs must finish administrative work after the end of a session.<sup>65</sup>

The higher workloads discussed above are contributing to GP stress and worsening retention in primary care. When polled, GPs identified increased workloads and increased demand from patients as the two factors that most contribute to greater levels of stress, and they rated 'hours of work' as the category with the lowest overall satisfaction.<sup>66</sup>

Figure 1.12 **GPs leaving the NHS by age group, full-time equivalent, September 2016 to December 2022**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, GP Joiners and Leavers 2015 – December 2022', supported by CIPFA. Notes: The figures relate to fully qualified GPs who left the NHS in the 12 months up to the relevant date. Data was first published in 2016/17.

After an improvement during the pandemic that saw a low of only 6.7% of GPs leaving the service in the 12 months to June 2021, retention has gradually worsened again, reaching 8.8% in the 12 months to December 2022.<sup>67</sup> It should also be noted that because this is a 12-month rolling average, the measure does not fully capture any recent large changes in the number of GPs leaving the service. Concerningly, the age group with the largest increase since the pandemic in the proportion leaving the workforce is the under-30s, where 21.9% of the workforce left the service in the 12 months to December 2022. While this is an improvement on the level of September 2022, this is still worrying for the future GP workforce. If the under-30 cohort leaves in large numbers, then there will be fewer GPs in the future to staff the service. This increase in the youngest GPs leaving the service could also explain at least in part why higher GP trainee numbers are not translating into more fully qualified, permanent GPs.

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## 2. Hospitals

By any reasonable measure, hospitals are in crisis. The proportion of people waiting more than four hours at A&E was higher in 2022 than any year since records began, the mean response times for ambulances attending category 2 calls (which includes strokes and chest pain) was over an hour and a half in December 2022, the waiting list for elective care stands at over 7 million, and the number of outpatient appointments has still not returned to pre-pandemic levels.

The pandemic forced the NHS in England to suspend much of its normal hospital work and encourage people to actively stay away from hospitals except in an emergency. Beds that would have been used for routine activity were repurposed for Covid patients as hospitals struggled to meet the demands of each successive wave. As a result, the number of outpatient appointments, diagnostic tests and elective procedures all declined sharply in 2020/21.

This winter is proving to be a difficult one for the NHS, as we predicted in last autumn's *Performance Tracker 2022*. The yearly peak in demand – which has in effect become an 'annual winter crisis' – coincides with an ongoing and worsening staffing crisis with almost one in 10 NHS roles vacant at the end of September 2022<sup>1</sup> and a range of industrial action across nursing, ambulance workers and, most recently, junior doctors.<sup>2</sup> Covid has also not gone away and continues to divert NHS resources away from regular activity. In addition, this flu season is proving to be a particularly bad one, with over 6,000 people in hospital with flu at the beginning of January 2023.<sup>3</sup>

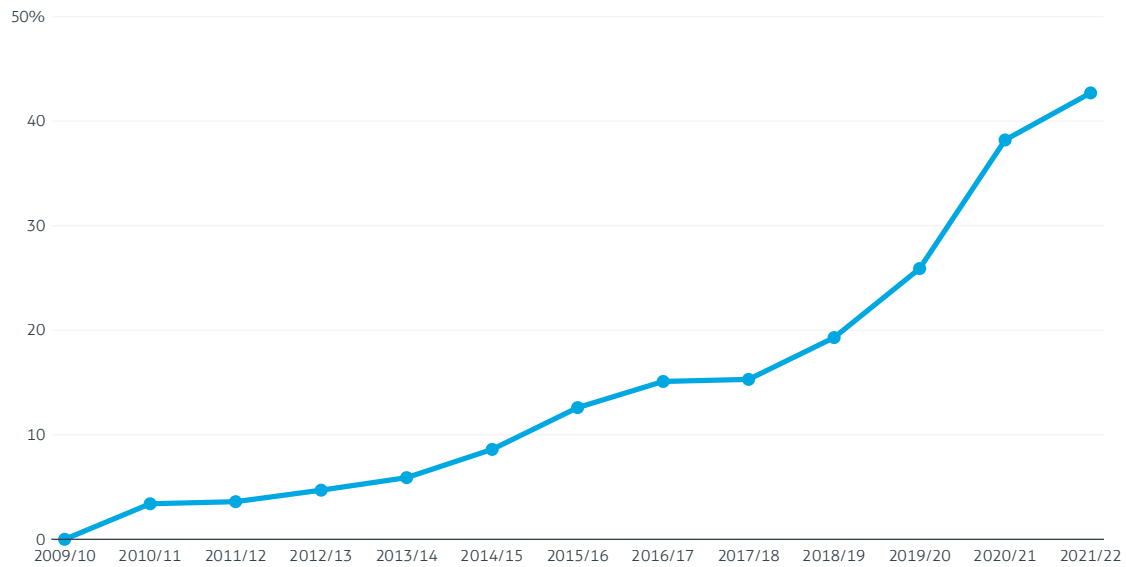
The NHS attempted to return to normal operations in 2021/22 and has become better at ramping up and down its Covid capacity as required. But it is still struggling with the effects of the pandemic, which continue to reduce hospital productivity.<sup>4</sup> However, factors outside of Covid – namely pre-pandemic trends of insufficient bed numbers, an overstretched workforce, increasing numbers of workforce vacancies and delays in discharging patients – all continue to contribute to the immense pressure that hospitals are under.

The current crisis in the NHS was not inevitable. Instead, it has been driven by more than a decade of relative underinvestment in the service, which has led to too few, burnt-out staff working with too little, faulty, or out-of-date equipment in buildings that are often unsuitable for a modern health service. The level of investment in the NHS is ultimately a political decision, meaning the government cannot lay the blame for the critical state of the service on the pandemic or striking staff, though these have exacerbated underlying problems.

This chapter discusses NHS acute, ambulance and specialist trusts in England, which provide specific short-term treatments, including diagnostic services, outpatient treatment and services, emergency treatments – such as ambulances and A&E – and surgeries. As data relating solely to acute and specialist trusts is not always available, in some places we analyse corresponding data for all NHS trusts.

## Spending has increased 13.4% since 2019/20, but much of this was Covid-related

Figure 2.1 Change in spending on NHS providers in England since 2009/10 (real terms)



Source: Institute for Government analysis of DHSC, 'Annual accounts, departmental group detail – expenditure (NHS providers), 2021/22', supported by CIPFA.

Spending on NHS providers – which includes NHS acute trusts, ambulance, community and mental health services – increased by 13.4% in real terms between 2019/20 and 2021/22. After the biggest single-year spending increase since 2009/10 in 2020/21, spending grew a further 3.3% in 2021/22. This brings the total increase in spending since 2009/10 up to 42.7% in real terms. However, 2020/21 and 2021/22 were also the first two years of the pandemic and it should be expected that the NHS would increase spending to match the increased pressure imposed on hospitals.

Unfortunately, it is not possible to determine how much of the spending in hospitals in those years was Covid-specific, but overall spending should either fall or grow less slowly in the coming years as Covid spending is rolled back,<sup>5</sup> though it is likely that there will be continuing Covid-related spending in the medium to long term.

Another key area where spending increased was on staffing, which rose 11.4% between 2019/20 and 2021/22. This increase was driven by a mixture of higher spending on recruitment in line with ambitions in the NHS Long Term Plan (LTP)<sup>6</sup> and emergency spending on staffing due to Covid.

The increase in spending on hospitals since 2019/20 comes in the wake of a period of historically low spending increases for the service. Spending on hospitals increased by 1.6% per year in real terms between 2009/10 and 2014/15 – compared to an average of 6.3% per year in the decade to 2009/10.<sup>7</sup>

## Hospitals will continue to incur Covid costs

Hospitals face continuing spending pressures from preventing the spread of Covid and responding to outbreaks of different variants. The National Audit Office (NAO) estimates that the government spent £89bn between March 2020 and June 2022 to support health and social care services through the pandemic.<sup>8</sup> Estimating future cost, though, is more difficult. It is unclear how frequently Covid waves will occur and also difficult to accurately differentiate Covid costs from business-as-usual costs.<sup>9</sup> Despite relative normality returning for the rest of the country, the average number of beds occupied by Covid patients per day\* was almost a fifth (19.4%) higher in 2022 than in 2021 – at 9,179 in 2022 compared to 7,691 in 2021.<sup>10</sup>

In addition, the emergence of new variants might require the reintroduction of 'mass vaccination and testing'<sup>11</sup> measures that would entail an expansion of NHS spending. There are, however, reasons to believe that the emergence of another variant would not require the same extent of funding as previous variants. According to interviewees, the NHS has become more efficient at responding to Covid, taking less time – and therefore spending less money – to increase Covid capacity. Despite this, a joint report by NHS Confederation and NHS Providers, which uses survey data from 54% of NHS providers, estimates that the NHS will need to spend an additional £4–5bn per year on Covid-related costs "for some years to come".<sup>12</sup>

The continuing high number of people in hospital with Covid also has implications for other areas of hospital performance. For instance, more people occupying beds with Covid makes it harder to admit urgent and emergency patients or conduct admitted elective activity.

## Hospitals found some efficiencies during the pandemic

The pandemic encouraged the NHS to develop new ways of working. Some proved to be effective and could lead to longer-term – though not transformative – savings across the NHS. These innovations can be grouped into three categories.

First, more efficient use of existing resources. For example, hospitals expanded the use of 'mutual aid' – the sharing of resources such as vaccines<sup>13</sup> and staff between different NHS providers – to reduce wastage and improve productivity.

Second, measures designed to keep people away from hospitals. Examples include the use of virtual wards<sup>14,15</sup> (in which hospital staff remotely monitor patients who stay in their own homes), increasing the number of virtual outpatient appointments<sup>16</sup> and carrying out acute services in the community.<sup>17,18</sup> There were 53 virtual wards providing 2,500 'virtual beds' in February 2022<sup>19</sup> and approximately 7,000 such beds by December 2022<sup>20</sup> – an increase of 180%. The NHS has an ambition to increase this capacity to "40–50 virtual beds per 100,000 population"<sup>21</sup> by the end of December 2023. This would equate to approximately 23,000–28,000 virtual beds<sup>22</sup> – or around a quarter of the currently available general and acute beds.

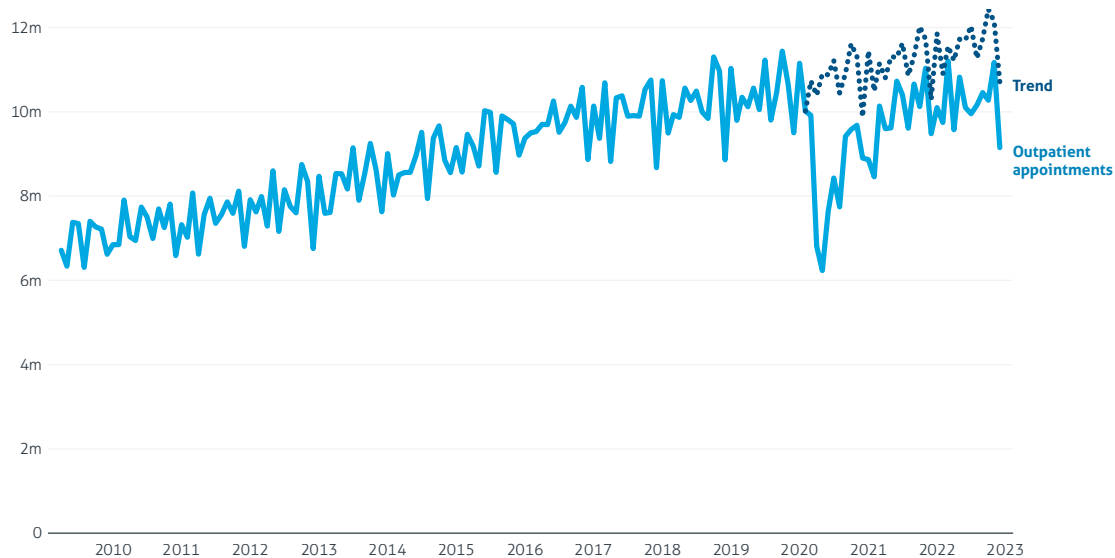
\* This includes 'primary and secondary Covid patients': those admitted for Covid and those admitted for something else but whose stay was prolonged due to their catching Covid in hospital respectively.

Virtual wards are still, however, a relatively new innovation and there is not enough evidence to evaluate their effectiveness.<sup>23</sup> In addition, while not physically being in a hospital, staff still need to monitor the status of patients in virtual beds,<sup>24</sup> which may prove difficult given current staffing issues (more on which below). Work by Nuffield Trust points out that virtual beds still require staff to interact with patients, and that those staff also often require additional training.<sup>25</sup>

Finally, hospitals have attempted to reduce unnecessary activity. One lever for this is the introduction of 'patient initiated follow-up' (PIFU),<sup>26</sup> which places the onus on patients to arrange follow-up appointments only when they think they are necessary. This has the potential to free up capacity in the NHS; follow-up appointments accounted for 67.8%, 69.7% and 68.5% of attended outpatient appointments in 2019/20,<sup>27</sup> 2020/21<sup>28</sup> and 2021/22 respectively. The NHS hopes that its target of "moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023"<sup>29</sup> will help it to achieve its wider target of reducing outpatient follow-up appointments by 25% by March 2023.<sup>30</sup> There remain questions about this approach, however. The evidence that PIFU reduces unnecessary appointments remains mixed and there are some concerns that it could contribute to health inequalities.<sup>31,32</sup>

## Hospital activity has not returned to pre-pandemic trend

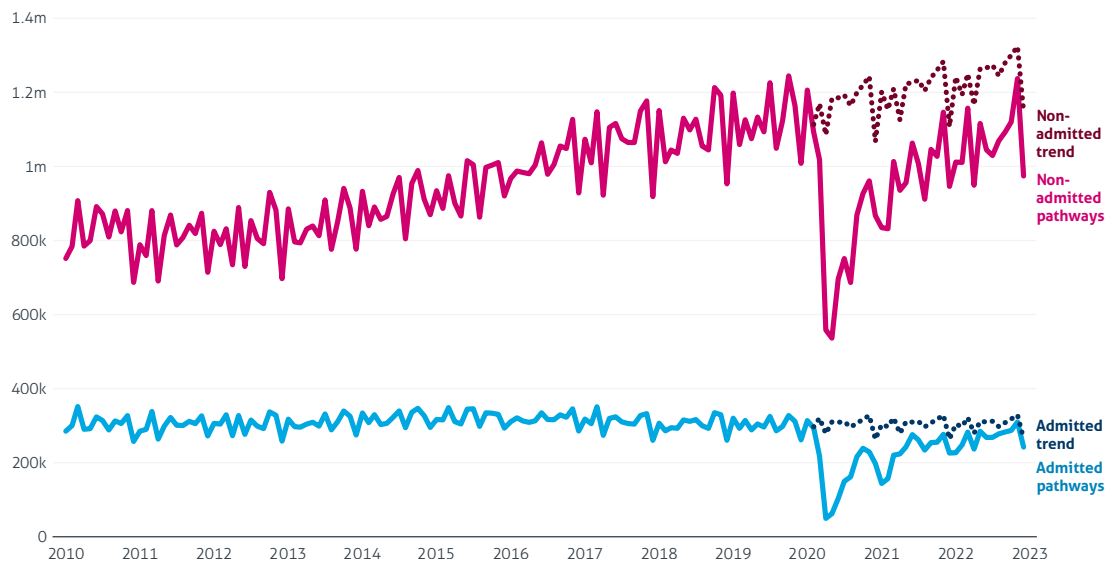
Figure 2.2 **Outpatient activity in hospitals, actual and trend in the absence of Covid, January 2010 to December 2022**



Source: Institute for Government analysis of NHS Digital, 'Monthly Hospital Episodes Statistics: Monthly outpatient activity', December 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

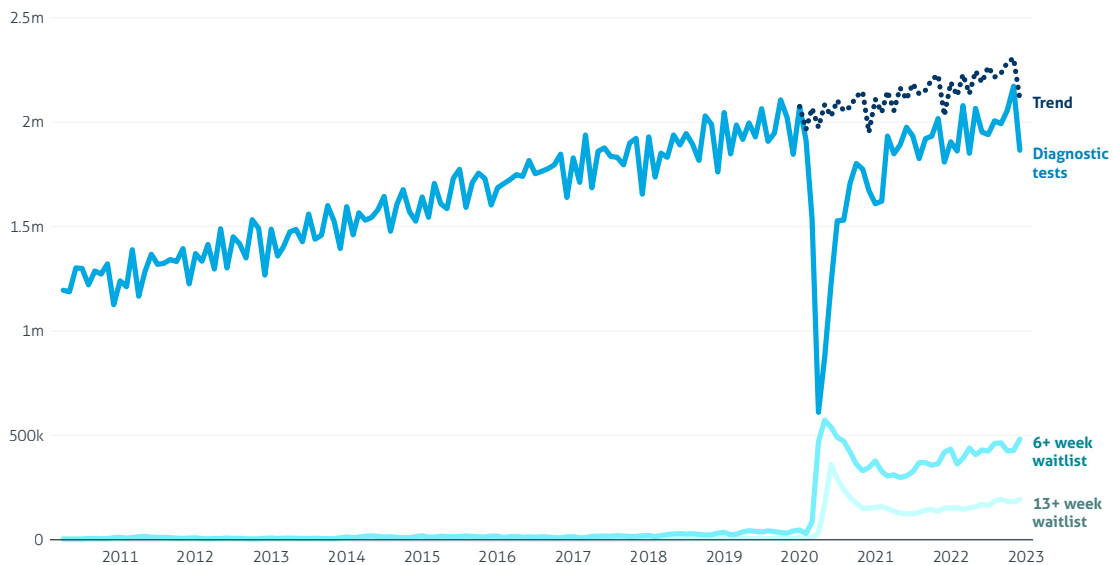


Figure 2.3 **Elective activity by type of pathway, actual and trend in the absence of Covid, January 2010 to December 2022**



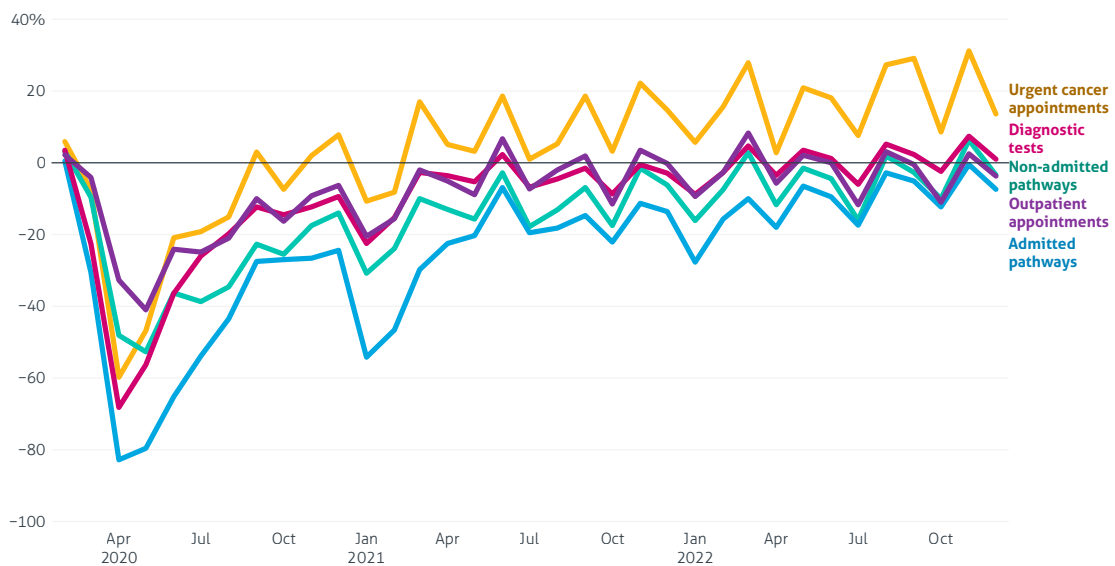
Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times', December 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Figure 2.4 **Monthly diagnostic tests, actual and trend in the absence of Covid, and waiting lists for diagnostic tests, April 2010 to December 2022**



Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity', ('Total Activity' table), ('6+ week waits' table), ('13+ week waits' table), December 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Figure 2.5 **Hospital activity compared to last pre-pandemic month, February 2020 to December 2022**



Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity' ('Total Activity' table), December 2022; NHS England, 'Referral to treatment waiting times', December 2022; NHS Digital, 'Monthly Hospital Episodes Statistics for Admitted Patient Care and Outpatients' 2009/10–2022/23; and NHS England, 'Cancer waiting times' ('Monthly data – Two week wait from GP urgent' table), December 2022; supported by CIPFA.

Hospital activity dipped during the pandemic and has not returned to trend levels. This is despite the government spending more on the service, including employing 9.4% and 13.8% more doctors and nurses respectively between August 2019 and August 2022. The NHS conducted 23.7 million diagnostic tests (including tests carried out in non-hospital settings) in 2022 compared to 21.5 million in 2019 – a 10.3% increase. This comes after the NHS opened 91 community diagnostic centres (CDCs),<sup>33</sup> remote locations designed to boost the number of tests carried out. The government claims that the previously opened 91 CDCs delivered 2.4 million tests between July 2021 and December 2022,<sup>34</sup> which means that CDCs could be accounting for the majority of the 2.2 million increase in diagnostic tests between 2019 and 2022.

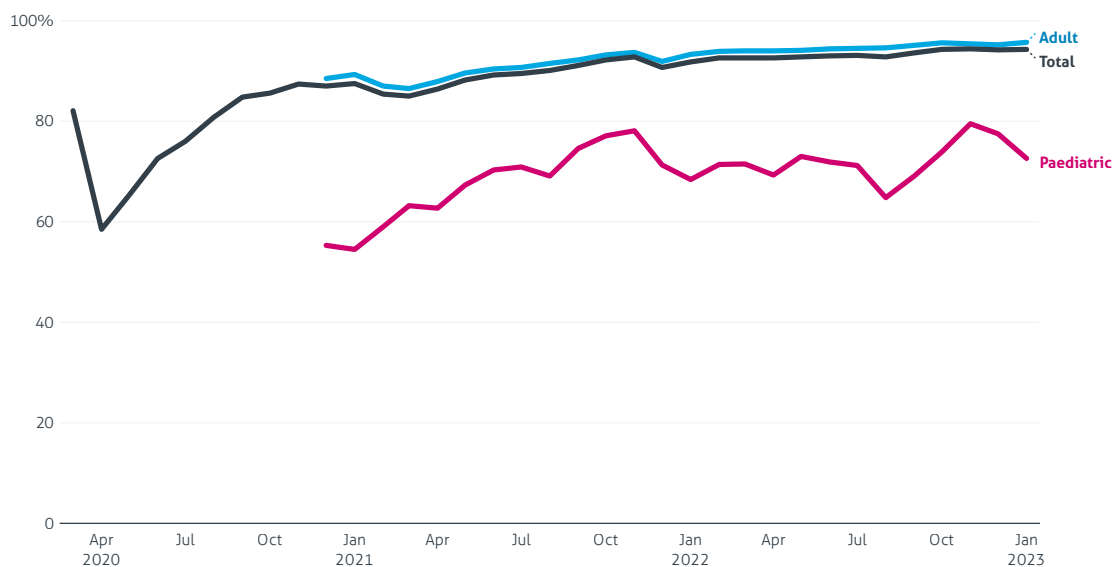
Other areas of hospital activity, however, continue to operate below pre-pandemic levels. Hospitals carried out 125 million outpatient appointments in 2019. This fell to 122.7 million in 2022 – a 1.8% decline. Concerningly for the NHS's ability to clear the elective backlog, the number of elective procedures fell from 17.1 million in 2019 to 16 million in 2022, a fall of 6.4%.

This decline in output despite higher inputs indicates that the NHS is now less productive than it was before the pandemic, as other commentators have noted.<sup>35</sup> The reasons for this are complex and multifaceted and will therefore require further research to determine, but likely include: an historic underinvestment in capital, staffing issues (for example, poor retention of more experienced staff, or burnout or low morale among staff from working in unacceptable conditions, among others), under-management of the service, and the shock from Covid to a system that was designed to operate with little spare capacity. These trends and others are explored in more detail below.

## High bed occupancy is limiting NHS capacity

Patients are staying in beds longer than needed.<sup>36</sup> On average between 29 November 2021 and 12 February 2023 (the time period covered by the Daily SitRep data),<sup>37</sup> 21,728 patients per day no longer met the criteria to reside in hospital.\* On average over half (58.3%, 12,672) of this number remained in hospital at the end of the day. With approximately 100,000 general & acute (G&A) beds available across the NHS at the end of January 2023, this means that 12.6% of G&A bed capacity on an average day was occupied by patients who were eligible for discharge.

Figure 2.6 **General and acute bed occupancy, March 2020 to January 2023**



Source: Institute for Government analysis of NHS England, 'Critical care and general & acute beds – urgent and emergency care daily situation reports' ('Time series type 1 acute trusts' table), January 2023, supported by CIPFA. Notes: A split between adult and paediatric general and acute beds was not available before December 2020.

The data for patients who no longer meet the criteria to reside, but whose length of stay is greater than 21 days, is worse. Between 14 November 2022 and 12 February 2023 (the time period for which this data is available), there was an average of 7,436 patients at the beginning of each day who had been in hospital for 21 days or more and were eligible for discharge. Of these the vast majority (6,613 patients, 88.9%) continued to occupy a bed at the end of the day, mostly due to a lack of appropriate support for discharge. Beyond the unnecessary occupancy of limited bed capacity, delayed discharge also uses up clinical resource, as staff have to care for patients who remain in hospital, diverting attention away from those more in need of care.

After a decline at the beginning of the pandemic, occupancy of general and acute (G&A) beds has increased steadily and has been above 90% every month since August 2021, reaching a high of 94.4% in November 2022.<sup>38</sup> The situation is worse for adult G&A beds, where occupancy reached 95.7% in January 2023 – the most recent month for which we have data. This high occupancy is concerning for the performance of hospitals because, as noted, it makes it difficult to admit patients for urgent and emergency care and carry out planned elective care.

\* While a useful tool for understanding the problem of high bed occupancy in hospitals, there are problems with this dataset. For more, see [www.lgcplus.com/services/health-and-care/simon-white-we-must-challenge-the-myths-of-delayed-discharge-in-order-to-improve-04-01-2023](http://www.lgcplus.com/services/health-and-care/simon-white-we-must-challenge-the-myths-of-delayed-discharge-in-order-to-improve-04-01-2023)

Unfortunately, following the suspension of the Delayed Transfer of Care dataset in February 2020, there is no longer official data on the cause of these delayed discharges.<sup>39</sup> But interviews point to several reasons. First, limited staffing, both among social workers in local authorities who carry out assessments for care<sup>40</sup> and in care workers, reduces the supply of care into which hospitals can discharge patients.

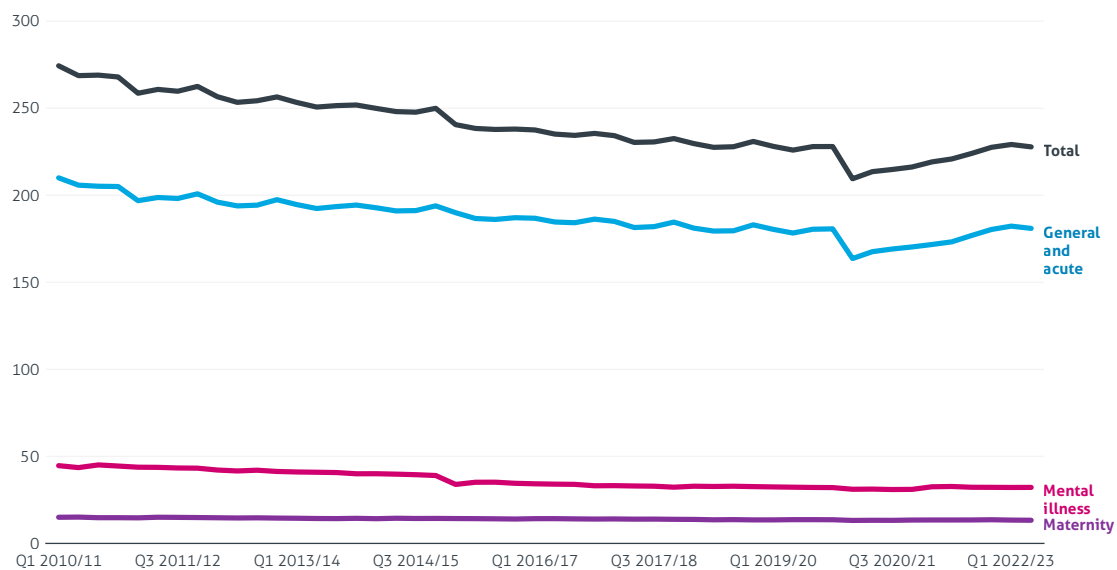
Second, there is a lack of available NHS community care that is preventing hospitals from discharging patients in a timely manner, increasing the reliance on social care<sup>41</sup> – a service that is contending with its own workforce crisis.<sup>42</sup> This was likely worsened at the beginning of 2022 by the redeployment of community care staff to the vaccination programme.<sup>43</sup>

Third, the NHS itself can cause delays due to a lack of intermediate care – for example, reablement and rehabilitation services – needed to facilitate a patient’s discharge from hospital.<sup>44</sup> A Freedom of Information request carried out by Nuffield Trust confirms this view. Its research showed that in April 2022 almost two fifths (39%) of delayed discharges were due to patients awaiting either a permanent bed in a nursing or care home, or care in their own home.<sup>45</sup>

The government seems to have recognised the importance of improving discharge from hospitals. In September 2022, Liz Truss’s government announced a £500m Adult Social Care Discharge Fund, with the aim of making it easier for hospitals to discharge patients into social care,<sup>46</sup> though it is not clear how much of that is new money. Rishi Sunak and Jeremy Hunt’s autumn statement went further still, providing an additional £2.3bn and £3.6bn for adult social care in 2023/24 and 2024/25 respectively, with the explicit goal that £500m of that should be used to improve discharge out of hospitals.<sup>47</sup> The crisis in the winter of 2022/23 precipitated a further round of emergency funding, with the health secretary announcing an additional £250m as part of a ‘winter pressures and discharge’ fund.<sup>48</sup> While this funding is welcome, its short-term and haphazard nature makes it very difficult for the service to effectively plan and spend the money.

While bed occupancy increased after an initial dip during the pandemic, the shortage of beds predates Covid. The number of overnight general and acute beds per 100,000 people has declined steadily since 2010/11, from a high of 210 beds per 100,000 people in the first quarter of 2010/11 to 181 by the second quarter of 2022/23 – a decline of 13.8%. It should be noted that this is a trend that predates 2010, with the number of G&A beds falling since the 1980s partly due to improved treatments that reduced length of stay and a shift to treating more people in the community.<sup>49</sup> But despite that longer term trend, there is evidence that in the 10 years before 2020 bed numbers were cut too far; bed occupancy was above 95% in one in six trusts by 2015<sup>50</sup> – well above the recommended safe level of 85%<sup>51</sup> – and the UK had the sixth lowest number of beds per capita compared to the 37 OECD countries by 2019<sup>52</sup> – 2.4 beds per 1,000 people compared to the EU OECD average of 5.<sup>53</sup>

Figure 2.7 **Overnight hospital beds per 100,000 people, split by type, April 2010 to September 2022**

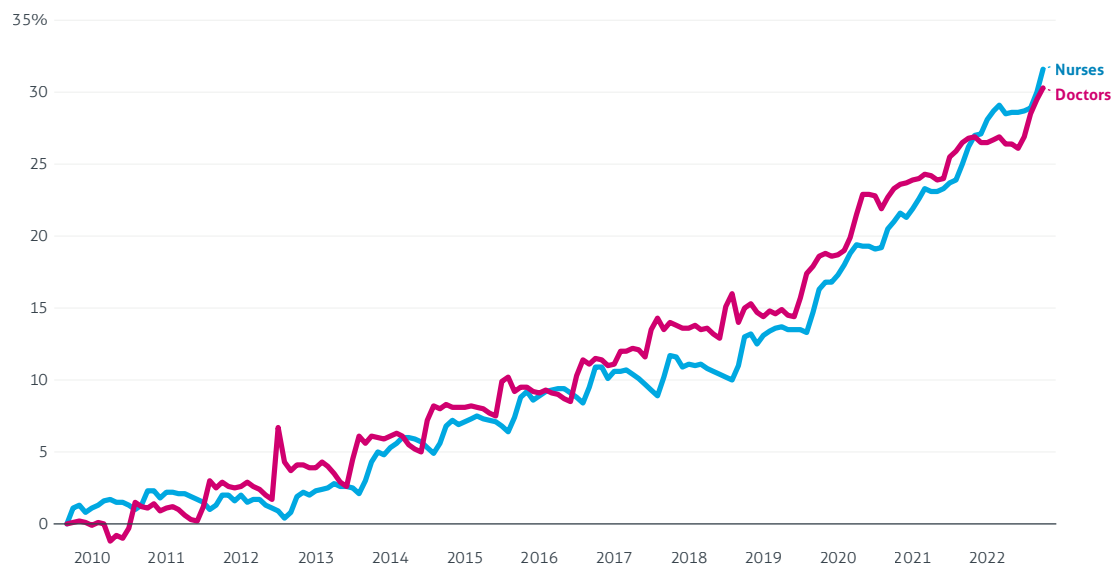


Source: Institute for Government analysis of NHS England, 'Bed availability and occupancy data – overnight' ('Average daily available and occupied bed time series – open overnight' table), Q2 2022/23; ONS, 'Mid-year population estimates' ('MYE1 population estimates: summary for the UK, mid-2020' table), 2021; supported by CIPFA. Notes: Time series does not start in 2009/10 because data was only released for the first time in 2010/11. See Methodology for full details.

Fewer open beds mean that the NHS is less well equipped to deal with urgent and emergency demand, elective activity and Covid surges. This worsens hospital performance in these areas, as explored below. However, increasing bed capacity by itself – as outlined in the operational resilience plan for the winter of 2021/22<sup>54</sup> – is not sufficient to improve NHS performance; without extra staff to work on those beds, there is a risk of overburdening current staff.

## Staff numbers are increasing, but poor retention is hampering performance

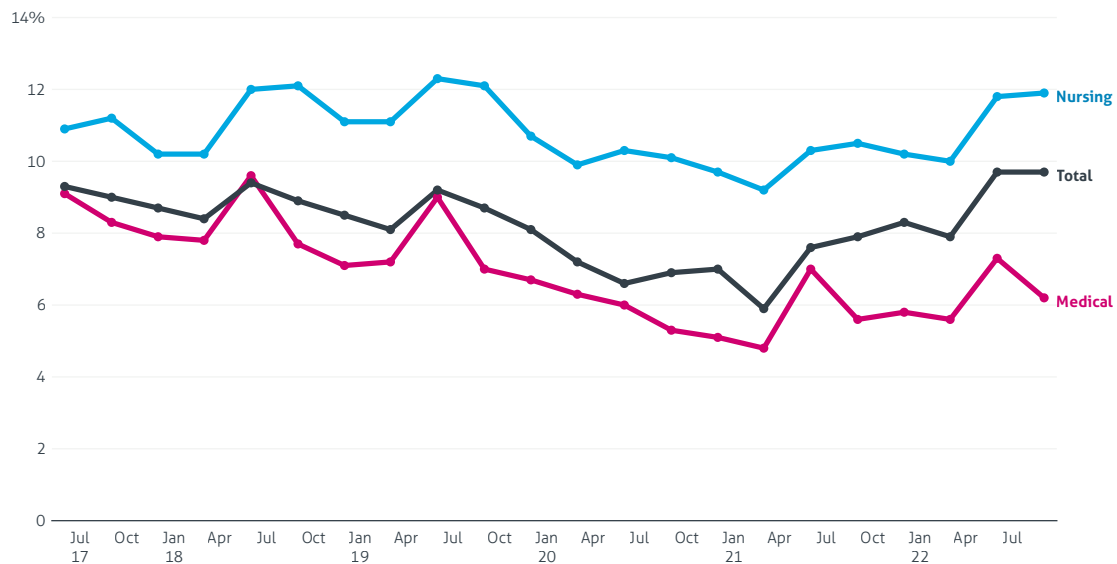
Figure 2.8 **Change in doctor and nurse numbers since 2009**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, Doctors by grade and specialty', October 2022 and 'NHS workforce statistics, Staff group, care setting and level' ('Nurses and Midwives' table), October 2022, supported by CIPFA. Notes: See Methodology for full details.

The number of nurses and doctors continued to increase over 2022, by 4.2% and 2.8% respectively, between October 2021 and October 2022. Since 2019/20, the number of nurses and doctors has increased by 4.2% and 3.4% per year respectively. This compares to a rate of 1.3% and 1.5% respectively between January 2010 and January 2019. This follows the launch of the LTP<sup>55</sup> in that year, which included ambitions to increase the number of nurses and doctors<sup>56</sup> through improved recruitment and retention.

Figure 2.9 **Vacancy rates by type of role, June 2017 to September 2022**



Source: Institute for Government analysis of NHS Digital, 'NHS vacancy statistics England' ('Total 2018 onwards' table), ('Nursing 2018 onwards' table) and ('Medical 2018 onwards' table), September 2022, supported by CIPFA. Notes: Time series does not start in 2009/10 because data was not available until June 2017.

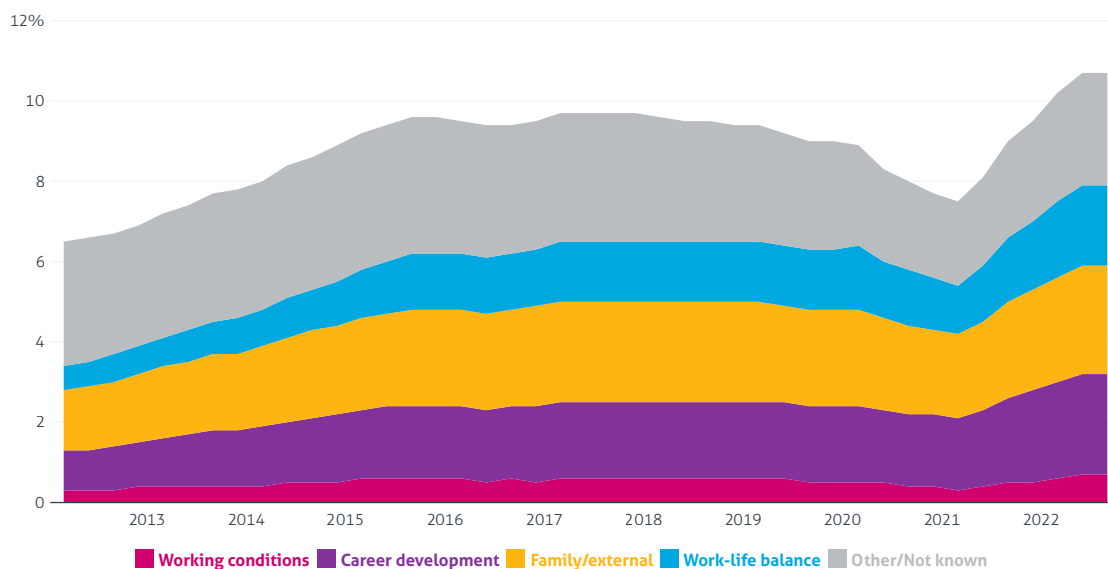
After a decline in vacancies during the first year of the pandemic,<sup>\*</sup> the proportion of unfilled roles in the NHS workforce has increased. In the quarter to the end of September 2022, nursing and total vacancies in NHS providers rose to 11.9% and 9.7% respectively, though medical vacancies dipped to 6.2%. This total figure is the highest level of vacancies since at least June 2017, when the time series started.

However, these rates hide variation between specialities. For example, in February 2022 the Royal College of Anaesthetists estimated that there was a shortfall of 1,400 anaesthetists across the NHS<sup>57</sup> – representing an 8.7% vacancy rate, well above the 5.6% given for 'medical roles' in that quarter (ending March). This is concerning for hospital productivity; anaesthetists are vital for carrying out operations and the same report puts the number of missed operations due to lack of anaesthetists at 1 million per year.<sup>58</sup>

\* We use NHSE vacancy data for our analysis. This shows the difference between 'funded establishment posts' and those filled by substantive staff. This does not show which posts are filled by temporary workforce. While we believe this is the best measure of vacancies in the service, it should be noted that there could be differences in how those reporting the data understand the requirements.

Nursing vacancies are the highest among staff groups, despite increasing numbers of nurses across the service. After dipping before and during the early stages of the pandemic, vacancy rates rose above 10% in 2021/22, reaching a high of 11.9% in September 2022. Overall, the Health and Social Care Committee estimates that there is currently a shortage 50,000 nurses and midwives in England; its figure for doctors is 12,000.<sup>59</sup>

Figure 2.10 **Voluntary resignations by reason, March 2012 to September 2022**

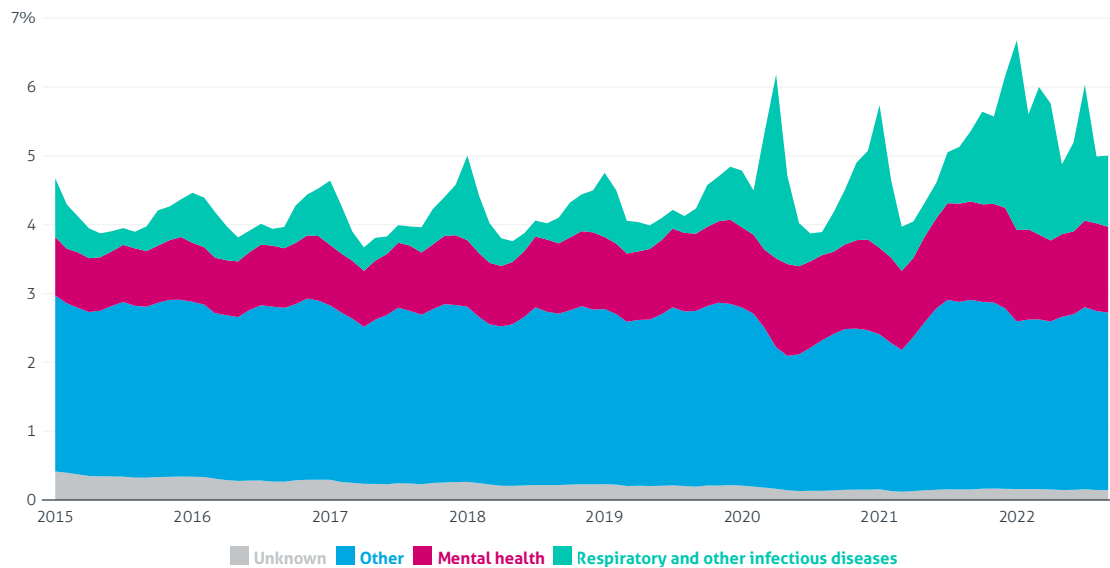


Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – reasons for leaving' ('Reasons for leaving' table), September 2022, supported by CIPFA. Notes: Time series does not start in 2009/10 because data is not available before 2011/12. This is a 12-month rolling average to smooth out seasonal variation. See Methodology for full details.

Persistently high NHS vacancy rates are in part due to record levels of voluntary resignations. These grew to 148,640 in the year ending September 2022, up from 118,781 and 102,654 for the periods ending September 2021 and September 2020 respectively – increases of 25.1% and 44.8% respectively. Of these, the proportion of leavers citing 'work-life balance' as the reason for leaving has increased to its highest ever level, at close to a fifth (18.9%) of total voluntary resignations. It is also likely that as staff work under more stressful conditions this winter, we will see an increase in voluntary resignations for this reason.

Elsewhere, the number of people resigning because they have been offered a better reward package (captured in the 'working conditions' category of our chart) saw the largest increase with 76.3% more people leaving in the 12 months to September 2022 than in the year before – though this still only accounted for roughly one quarter of the number of people who resigned for work-life balance reasons.

Figure 2.11 Staff absence by reason, January 2015 to September 2022



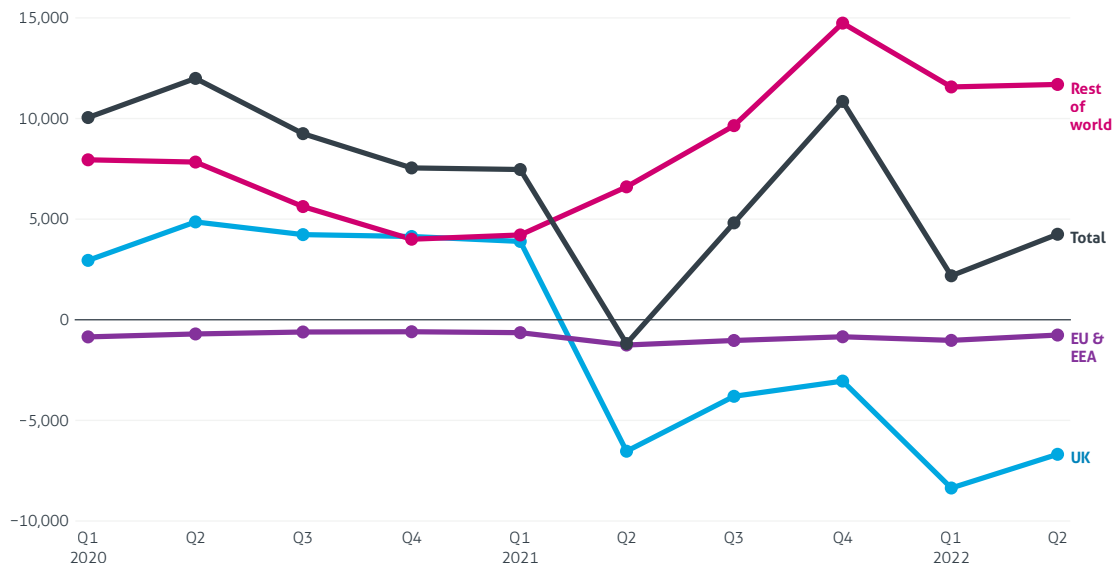
Source: Institute for Government analysis of NHS Digital, 'NHS sickness absence rates' ('Table 2: Count'), September 2022, supported by CIPFA. Notes: Time series does not start in 2009/10 because no data was available until 2015. See Methodology for full details.

Worsening retention reflects the pressure that many staff experienced during and after the pandemic. The proportion of available FTE days lost to mental health reasons rose 22.3% in the first six months of 2022/23, compared to the same time in 2019/20 – 1.31% in the former compared to 1.07% in the latter. One interviewee described the mental health crisis in hospitals as a “vicious cycle”, wherein staff resign due to stress and burnout, which in turn applies more pressure to remaining staff.<sup>60</sup> The NHS also continues to experience a high number of staff absences due to cold, cough, flu, chest and respiratory problems, and infectious diseases, showing the ongoing effect of Covid on the hospital workforce. This is likely to have worsened during the winter, as the flu season has been particularly bad.<sup>61</sup>

The NHS is filling staffing gaps with agency staff and overseas recruitment, but both solutions come with problems. Agency staff are likely to be more inefficient as they work in unfamiliar teams, areas and roles,<sup>62</sup> and also cost more per shift than regular staff.<sup>63</sup> The NHS is trying to reduce the amount spent on agency staff.<sup>64</sup> Reliance on agency staff also risks cannibalising the workforce of other hospitals, shifting staffing problems to another part of the NHS.<sup>65</sup>



Figure 2.12 **Rolling 12-month average of net nurse and health visitor joiners and leavers, by nationality, Q1 2020 to Q2 2022**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics – turnover tables' ('Leavers, age & nationality' table) and ('Joiners, age & nationality' table), September 2022, supported by CIPFA.

Since April 2021, more British nurses have left the NHS than have joined. In their place, the NHS hired more nurses than ever from outside the UK and the EU/EEA. Recruitment costs of foreign nurses are generally lower than those trained in the UK,<sup>66</sup> but the government has no control over the number of nurses trained abroad and is likely to face greater competition for those nurses in the future as more OECD countries' nursing workforces are increasingly staffed by foreign nurses.<sup>67</sup>

Uncompetitive pay in the NHS is also worsening retention. This has been exacerbated by two key factors. First, the UK's tighter post-pandemic labour market has caused employers in competing sectors – such as retail and hospitality – to offer better pay deals, including welcome bonuses and higher hourly wages in an attempt to attract in-demand employees.<sup>68</sup> Second, high and rising inflation is eroding the real value of employees' pay.

In July 2022, the government accepted the NHS Pay Review Body's recommendation for a pay uplift in full,<sup>69</sup> which will increase the NHS' wage bill "by almost 5% in 2022/23", with the highest uplifts going to the bottom of the wage distribution.<sup>70</sup> The pay increase, however, is unfunded by central government, meaning that the money will have to come out of the existing NHS settlement. The DHSC claims that this could cost the NHS an extra £900m for every additional 1% pay increase.<sup>71</sup>

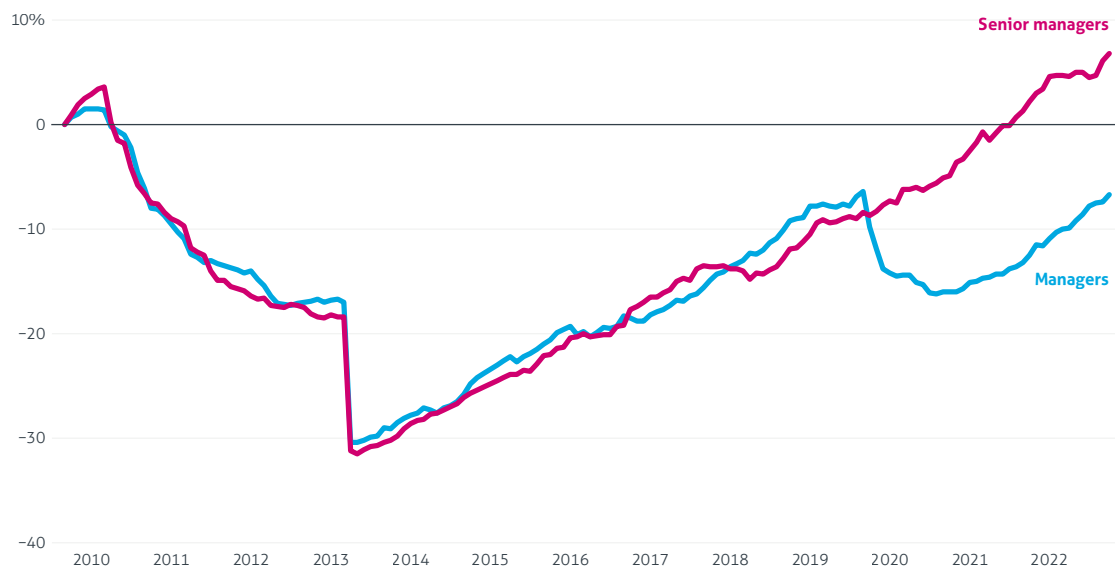
Many NHS staff do not think this uplift is sufficient given the rising cost of living that has driven real salaries down, with nurses' and consultants' salaries both forecast to fall by more than 10% in real terms compared to 2010/11 by the end of 2022/23.<sup>72</sup> This was one factor that led to a number of staff groups voting to go on strike, most notably ambulance workers,<sup>73</sup> junior doctors,<sup>74</sup> and nurses – the first time the Royal College of Nursing (RCN) has voted to go on strike.<sup>75</sup> At the time of writing, there has been no resolution to this dispute, though nurses have paused strikes for pay talks) and ongoing industrial action will make it harder for hospitals to clear backlogs and meet ongoing demand for urgent and emergency care.

## The NHS is undermanaged

Despite hiring 30.3% more doctors and 31.6% more nurses between September 2009 and October 2022, the number of managers employed by the NHS has not kept pace. In the same time, the NHS hired only 6.8% more senior managers and now employs 6.7% fewer managers than at the beginning of the time period.<sup>76</sup> The sharpest decline in the number of NHS managers occurred in 2013, in the wake of the coalition government's Lansley reforms, which aimed to direct more funding towards "front-line care", in part by cutting management costs.<sup>77</sup> This seems to be an attitude that the current government maintains, with the health secretary declaring in September 2022 that "too much management can be a distraction to the front line".<sup>78</sup>

The dismissive attitude to management in the NHS extends downwards into the service itself; the Messenger review found that "management lacks the status enjoyed by the established professions in health and social care" and also that managers do not receive the training and support needed to maximise their efficacy.<sup>79</sup>

Figure 2.13 **Change in the number of managers employed in the NHS, September 2009 to October 2022**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, Staff group, care setting and level' ('HCHS staff (excl Drs)' table), October 2022, supported by CIPFA.

It could, however, be argued that the decline in the number of managers since 2009 was because the service was overmanaged before then. But when comparing NHS management to a range of benchmarks, it is clear that the service is remarkably understaffed with managers. Approximately 2% of the NHS workforce are managers,<sup>80</sup> compared to 10.8% in the UK workforce.<sup>81</sup> The level of management in the NHS is also not typical of other health services: the average proportion of health care spending in OECD countries dedicated to administration was 3.1% in 2014, compared to 1.5% in the UK.<sup>82</sup>

Managers help to improve the NHS's productivity in several ways. First, they play a co-ordination role, directing front-line staff and resources to where they are most needed.<sup>83</sup> Second, they often take on administrative work, relieving front-line staff of those tasks, thereby allowing them to spend more time with patients.<sup>84</sup> Third, they are able to take a system-wide view – be that across a single hospital, an integrated care system or the entire service – to identify inefficiencies and implement productivity-enhancing reform.<sup>85</sup>

These are not abstract benefits but rather directly contribute to improved outcomes in the NHS. Research shows that up to a certain point – when approximately 3% of hospital staff are managers, whereas current levels sit at around 1.8%<sup>86</sup> – more managers resulted in higher patient satisfaction scores, improved efficiency and a reduction in infection rates.<sup>87</sup>

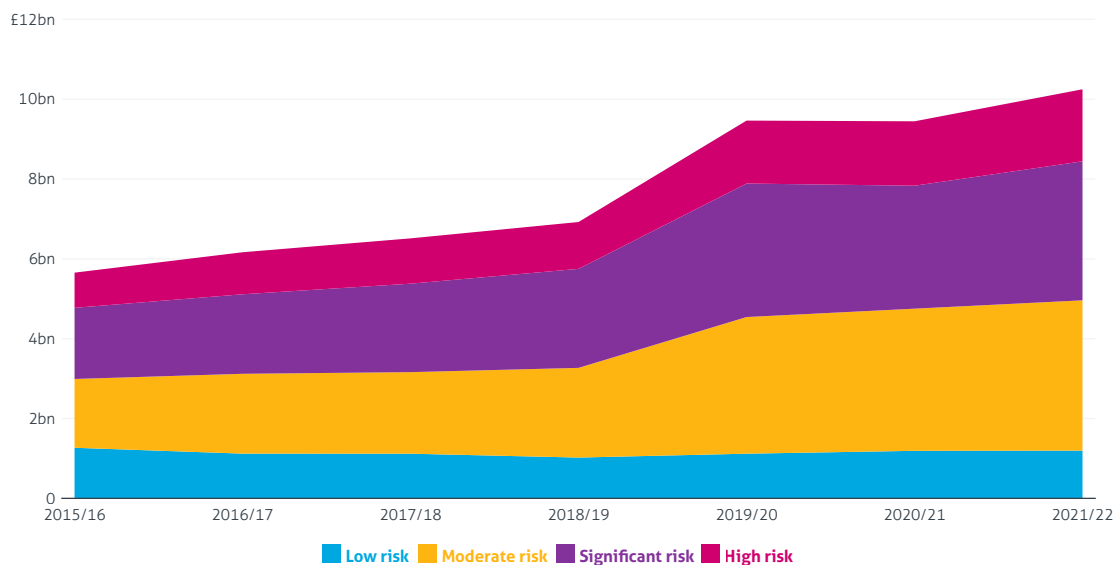
At a time when hospitals beds are scarce, more staff than ever are absent and vacancy rates are soaring, the role of managers has arguably never been more important. As an example of this, managers in Maidstone and Tunbridge Wells Trust created a 'Care co-ordination centre', which was better able to track available beds than clinical staff in the hospital. The result was a halving of bed turnaround times as the hospital admitted patients more quickly.<sup>88</sup> The NHS has also opened more than 40 'traffic control centres' across England, designed to allow better monitoring of activity and planning of resource use.<sup>89</sup>

## The NHS has underinvested in capital

The amount that the NHS spends on capital investment has long been below that of other OECD countries. Since 2000, the NHS exceeded the OECD average for amount spent on capital formation in only three years, from 2007–2009.<sup>90</sup> Capital spending declined further in the years after 2010/11, with the average amount spent in the years until 2019/20 being 4.7% below the 2010/11 total. This was due to a combination of lower capital budgets, underspends on that budget (which amounted to £2.8bn, or 5.1% of budgeted capital spending), and transfers from the capital budget to day-to-day spending to cover gaps in that area of spending (which totalled £4.3bn, or 7.8% of budgeted capital spending).

The capital budget is spent on a range of assets such as the NHS estate, diagnostic equipment, IT infrastructure, and research and development.<sup>91</sup> The effects of underinvesting in these important areas can be seen in a range of indicators: the UK has the fifth lowest number of CT and PET scanners and MRI units per capita compared to the 37 OECD countries – 16.5 per million people, compared to the OECD average of 44.8.<sup>92</sup> As another indication of underinvestment in capital, the estates maintenance backlog is now at its highest ever level – £10.2bn, an increase of 81.2% since 2015/16 and 5.5% since 2020/21 in real terms.

Figure 2.14 **Cost to eradicate NHS hospital estate maintenance backlog, split by severity 2015/16– 2021/22 (real terms)**



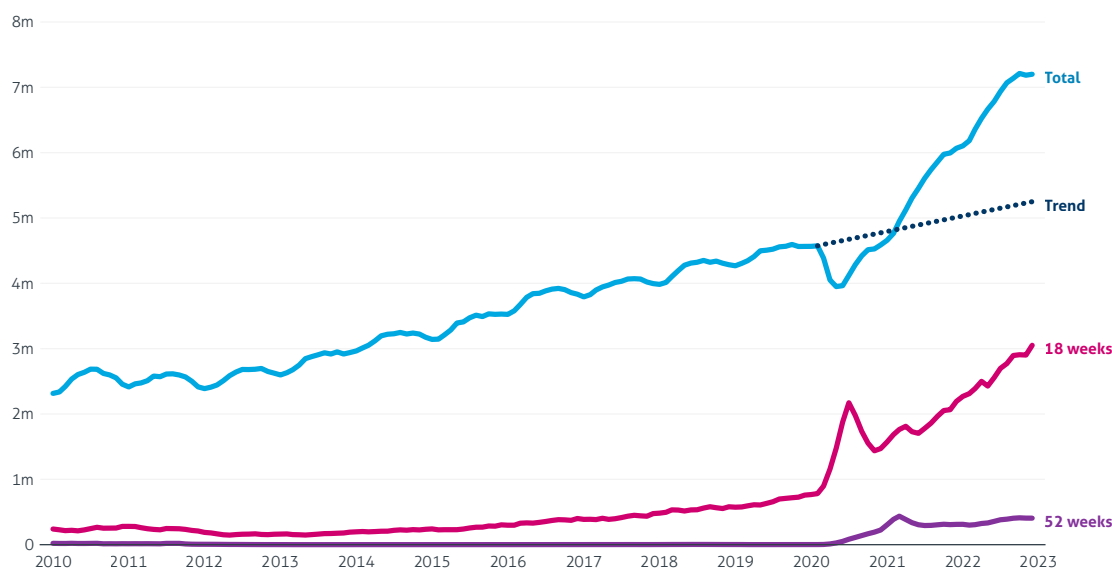
Source: Institute for Government analysis of NHS England, 'Estates return information collection' ('Table 10: Quality of buildings'), 2021/22, supported by CIPFA. Notes: Data is not available before 2015/16.

Though difficult to draw direct causal links, it is likely that underinvesting in capital harms NHS productivity. For example, fewer diagnostic machines limits the service's ability to carry out diagnostic tests – one of the key bottlenecks to reducing the elective waiting list<sup>93</sup> and increasing the number of early cancer diagnoses.<sup>94</sup> A poorly maintained estate means that staff may not be able to use faulty diagnostic equipment or a section of the hospital where the roof is at risk of collapse.<sup>95</sup> Problems like these could be part of the reason why NHS activity has not yet returned to pre-pandemic levels.

In its 2019 manifesto, the Conservative Party committed to building 40 new hospitals by 2030,<sup>96</sup> thus providing hope that there would be a reversal in the trend of low capital spending. This commitment became the New Hospitals Programme, which came with a promise of £3.7bn of funding.<sup>97</sup> Since the launch of that programme, however, there has been little progress made against the target. The two hospitals that the government claims have been completed under the programme – the Northern Centre for Cancer Care<sup>98</sup> and the Royal Liverpool Hospital<sup>99</sup> – were both started before its 2019 announcement.<sup>100,101</sup> Even among the remaining projects, it seems that there were never 40 projects to begin with, they are not all hospitals, and they are not all new.<sup>102</sup>

## The elective backlog has grown, but is smaller than expected

Figure 2.15 **Elective waiting list length, total and by length of wait, January 2010 to December 2022**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), December 2022, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

By December 2022, the elective backlog had grown to 7.2 million incomplete pathways,<sup>\*</sup> its second highest level ever, behind only October 2022. People are also waiting longer for procedures. The proportion of the waiting list seen within 18 weeks of referral from a GP fell to 57.6%, its lowest level outside of the first months of the pandemic and far below the NHS's target of 92%.<sup>103</sup> There are more people waiting longer, with 406,035 pathways waiting longer than 52 weeks at the end of December – a substantial increase from the 1,845 waiting that long in February 2020. But while Covid worsened wait times for elective procedures, it is not the root cause for them increasing. The last time that the NHS met the 18-week target was in February 2016. This is due to a combination of rising demand for services and underinvestment in the beds and staff that would have been needed to meet that demand.<sup>104</sup>

Despite the record size of the waiting list, there is evidence that more people than are currently on waiting lists should have come forward for care. In December 2021, the Institute for Fiscal Studies (IFS) estimated that 7.6 million fewer people than expected joined a waiting list for hospital care during the pandemic.<sup>105</sup>

There are several possible explanations for this. First is a change in patient behaviour.<sup>106</sup> While the NHS might have wanted to encourage people to come forward for care after the initial Covid wave,<sup>107</sup> government messaging – for example, 'Stay at home. Protect the NHS. Save lives' – portrayed the NHS as under immense pressure.<sup>108</sup> This might have led to fewer people coming forward for care. This messaging has since stopped, but the public still see stories in the media about the pressure the service is under, which might discourage them from coming forward.

\* A pathway is a course of treatment that starts from the time a patient is referred and stops when it is either deemed that they do not need treatment, when they receive treatment, or if they do not respond to attempts to contact them. We refer to the size of the elective waiting list in terms of 'pathways' rather than 'people' because one person could simultaneously be on the waiting list for multiple pathways.

Second, and most importantly, there are now higher barriers to care at each stage of the referral process than before the pandemic. Our 'General practice' chapter outlines the unprecedented demand for primary care services, which means that it is now more difficult to book a GP appointment than it was before the pandemic. The rate at which GPs refer patients through to secondary care has also dropped, in line with guidance from NHS England.<sup>109</sup> Interviewees told us that, once referred, hospitals are now more likely to reject referrals they do not believe need treatment.<sup>110,111</sup>

The results of limiting access to the elective waiting list are mixed. On one hand, keeping people who do not need care away from an already overstretched system helps hospitals, freeing up capacity to meet emergency and Covid demand. The conditions that would have previously led to admission on to the waiting list, however, do not go away. Instead, patients seek care elsewhere, mainly in primary or social care.<sup>112</sup> So while this protects hospitals it places a greater burden on services struggling with demand pressures and creates a 'hidden backlog' of care, while keeping the elective waiting list artificially low. This is despite a supposed increased focus on improving health outcomes through early intervention and prevention.<sup>113</sup> There is also the risk that the longer would-be patients stay away the worse their condition becomes – meaning that when they do present, treatment is more complex and expensive.

### **The NHS came close to meeting the first of its backlog recovery targets**

NHS England launched its Covid backlog recovery plan in February 2022.<sup>114</sup> This plan includes measures such as the separation of elective from urgent activity to prevent surges in demand reducing elective activity, investing in community diagnostic centres and surgical hubs, increasing bed capacity, moving patients between trusts, and use of the independent sector, among others.

The elective backlog recovery plan also lays out the NHS's timetable for reducing the waiting list:

- Eliminate waits of more than two years by July 2022
- Eliminate waits of more than 18 months by April 2023
- Eliminate waits of more than one year by March 2025.

According to NHS England, it nearly met the first – and most achievable – of these targets. By the end of July, 2,885 people who had been on the elective waiting list for more than two years were still awaiting treatment, down from 23,778 in January of the same year.<sup>115</sup> There are, however, some caveats that NHS England make to this outcome: of those 2,885 remaining on the waiting list, 1,579 opted to defer treatment and 1,030 were "very complex cases".<sup>116</sup>

The other targets will prove even harder to meet. There are far more people waiting 18 months or a year – and the NHS will not know who is in the latter group until April 2024.<sup>117</sup> This means it does not yet know the types of procedures that will be needed to meet the target, making it harder to plan resource use.

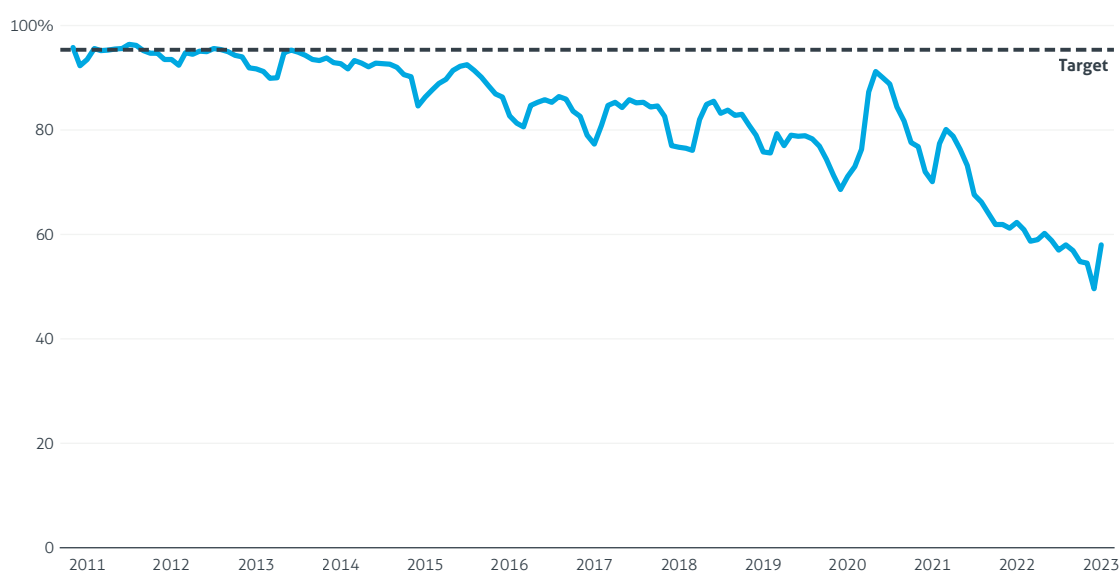
In an attempt to meet the second of these targets, NHS England ordered all trusts to book those waiting more than 18 months at the beginning of January 2023.<sup>118</sup> While understandable, this does show the risk of using these targets as performance metrics; the NHS is incentivised to prioritise patients on the basis of time spent on the waiting list as opposed to clinical need.

It is not clear the planned measures to clear the backlog will work, as they are highly contingent on the extent to which Covid continues to impact the NHS.<sup>119</sup> The NHS estimates that it needs to operate at 130% of pre-pandemic activity levels by 2024/25 to clear the elective backlog,<sup>120</sup> but in 2022 it was not yet running at 100% of 2019 activity, with completed pathways (admitted and non-admitted) at only 93.6% of the amount carried out in that year.

There has been some improvement since then – November 2022 saw the highest level of elective activity since the start of the pandemic, with 1.5 million completed admitted and non-admitted pathways. This is 4.8% higher than the amount carried out in November 2019, and the fourth highest level since records began. The results for December, however, show that the winter crisis in urgent and emergency care and ongoing industrial action will make it hard for the service to maintain November's level of activity; the NHS completed 21.4% fewer elective pathways in December compared to November, a level that was also 4.2% lower than December 2019.

## Performance of emergency and acute services is the worst on record

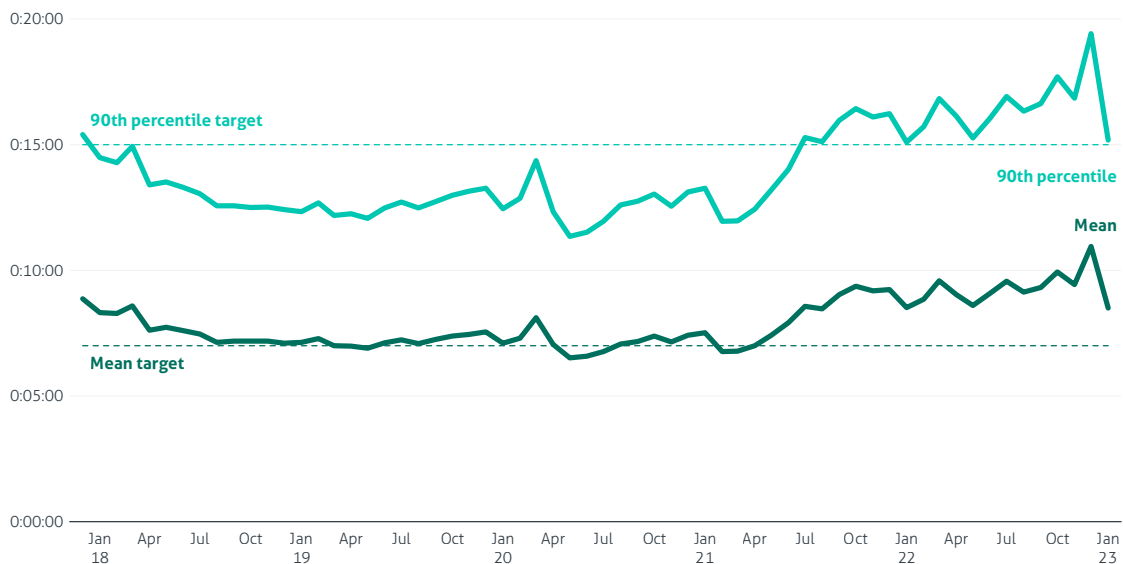
Figure 2.16 **A&E attendances seen within four hours, November 2010 to January 2023**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions' ('Performance' table), January 2023, supported by CIPFA. Notes: These are waiting times for type 1 A&E departments.

After a slight improvement in A&E wait times during the pandemic (mostly because fewer people attended emergency departments), only 58% of people attending type 1 A&Es were seen within four hours in January 2023, against a target of 95%. This follows the worst performance on record in December 2022, which saw only 49.6% treated within four hours. The same decline in performance is evident in the ambulance service, where response times reached their highest recorded level in December 2022, before falling back to lower – though still relatively high – levels in January 2023. In December 2022, the mean response time for category 1 ambulance incidents – the most urgent category – rose to 10 minutes 57 seconds, the worst on record, before falling to 8 minutes 30 seconds in January 2023. The decline in performance is even worse for category 2 call-outs, which includes conditions such as strokes,<sup>121</sup> where the mean response time rose from 22 minutes 33 seconds in July 2018 to 1 hour 32 minutes and 54 seconds in December 2022, before improving to 32 minutes and 6 seconds in January 2023.

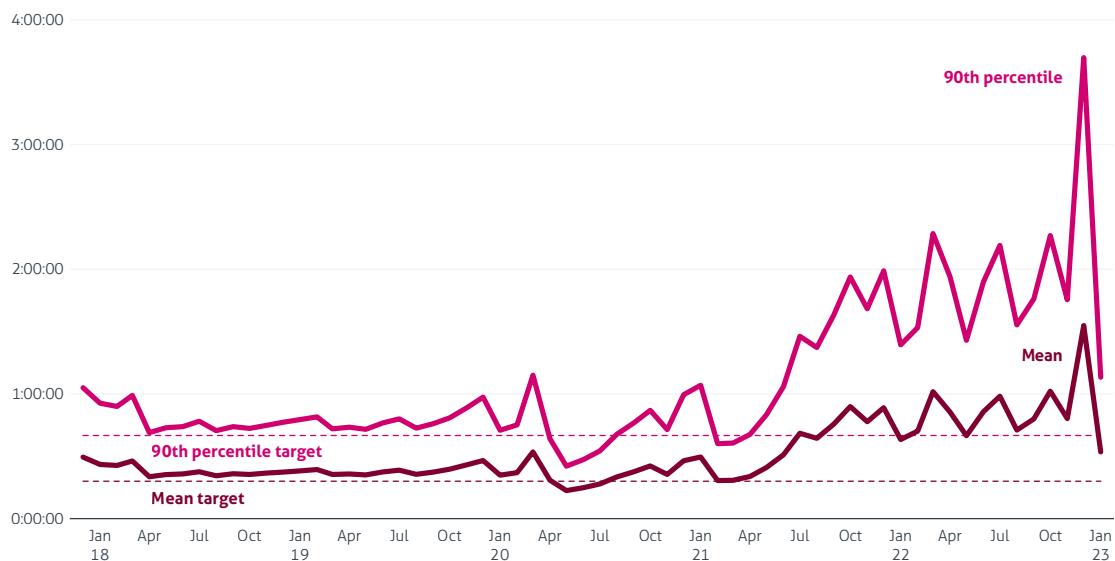
Figure 2.17 **Response times in minutes for category 1 ambulance incidents, December 2017 to January 2023**



Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators time series' ('Response times' table), January 2023, supported by CIPFA. Notes: 90th percentile indicates that 90% of response times were faster than this, and 10% were slower. Category 1 responses are for the most severe calls that include a life-threatening condition, such as cardiac or respiratory arrest. Time series does not start in 2009/10 because data was not available before 2017.



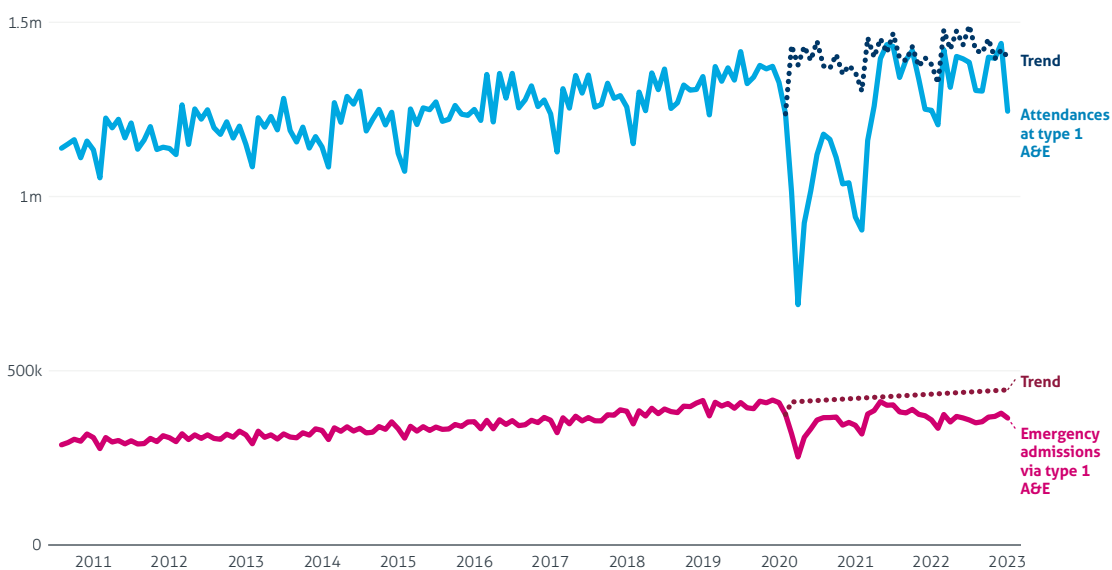
Figure 2.18 **Response times in minutes for category 2 ambulance incidents, December 2017 to August 2022**



Source: Institute for Government analysis of NHS England, 'Ambulance quality indicators' ('Response times' table), January 2023, supported by CIPFA. Notes: 90th percentile indicates that 90% of response times were faster than this, and 10% were slower. Category 2 responses are for serious conditions, such as a stroke or chest pain which may require urgent transport. Time series does not start in 2009/10 because data was not available before 2017.

Worsening performance in urgent and emergency care cannot be attributed to a post-pandemic surge in demand for this service. There were only 0.2% more attendances at type 1 A&Es in 2022 compared to 2019 – 16.21 million compared to 16.18 million, a decline of 0.5%. This compares to an annual increase of 1.3% between 2011/12 and 2019/20. The difference is even more stark for A&E admissions. There were 4.8 million admissions in 2019, compared to 4.3 million in 2022, a decline of 10.2%.

Figure 2.19 **Attendances and admissions in type 1 A&Es, August 2010 to January 2023**



Source: Institute for Government analysis of NHS England, 'A&E attendances and emergency admissions' ('Activity' table), January 2023, supported by CIPFA. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

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Rather than increased demand, the major problems with urgent and emergency care relate to capacity elsewhere in hospital. Most importantly, poor patient flow through hospitals has a knock-on effect on the performance of urgent and emergency care.<sup>122</sup> When staff eventually see people, they find it difficult to admit patients due to the lack of unoccupied beds in hospitals, as noted above. This has resulted in 2022 having the lowest percentage of A&E attendances resulting in admissions since 2013 – 26.7%, compared to 29.9% in 2018 and 29.8% 2019. This difficulty in admitting patients pushes up the amount of time that people wait in A&Es.

This also explains much of the delay in ambulance response times; ambulances cannot hand over patients for admission into hospitals because of a lack of available beds. This has resulted in the highest proportion of ambulance arrivals resulting in delayed handovers (more than 30 minutes) on record.<sup>123</sup> This in turn prevents ambulances from responding to new calls, thereby increasing response times.

All of this is compounded by the staffing issues, both related and unrelated to Covid, that A&E departments are still experiencing.<sup>124</sup>

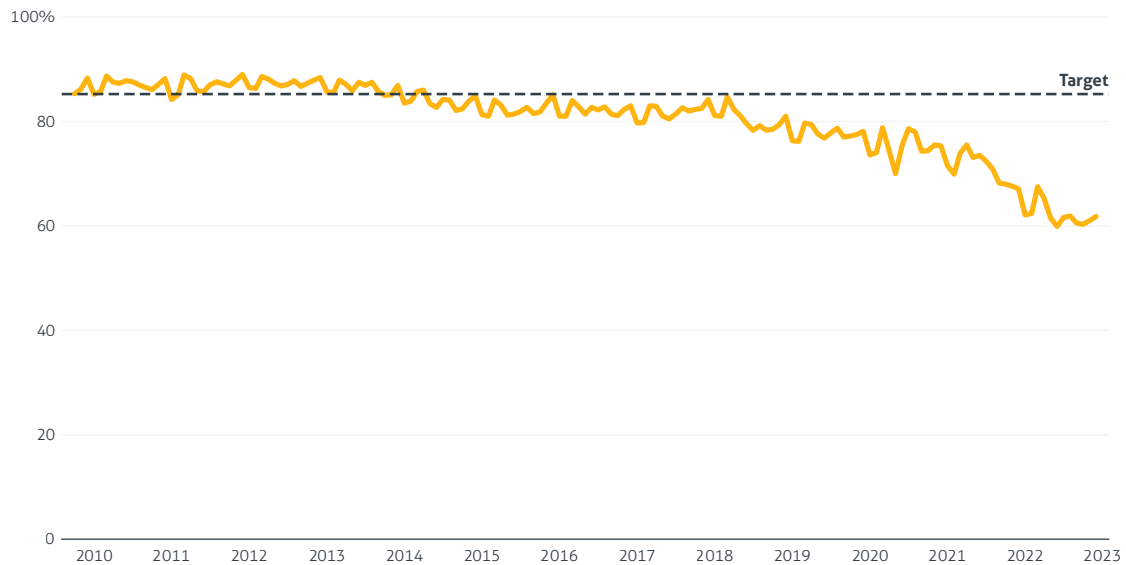
Declining performance in emergency care is extremely serious. Beyond the worsening experience for attendees, there is evidence that those who wait more than five hours are more likely to die within 30 days of attending A&E.<sup>125</sup>

The NHS has recognised these issues and used the 2023/24 operational and planning guidance to outline targets for the coming year. The NHS is now aiming for improved performance such that 76% of A&E patients are seen within four hours by March 2024, that category 2 ambulance response times average 30 minutes across 2023/24, and that G&A bed occupancy is reduced to 92%.<sup>126</sup>

While it is good that the NHS is targeting these improvements, it is striking how poor performance would still be if the NHS achieves these objectives. Improving the number of people waiting less than four hours to 78% would only return performance to 2019 levels, themselves some of the worst on record. The same is true for category 2 ambulance response times: a mean response time of 30 minutes would be two thirds longer than the current target of 18 minutes and would be higher than any month on record before March 2020. These targets in many ways show the long road that lies ahead for improvement in hospital performance.

## More people are waiting longer for cancer treatment

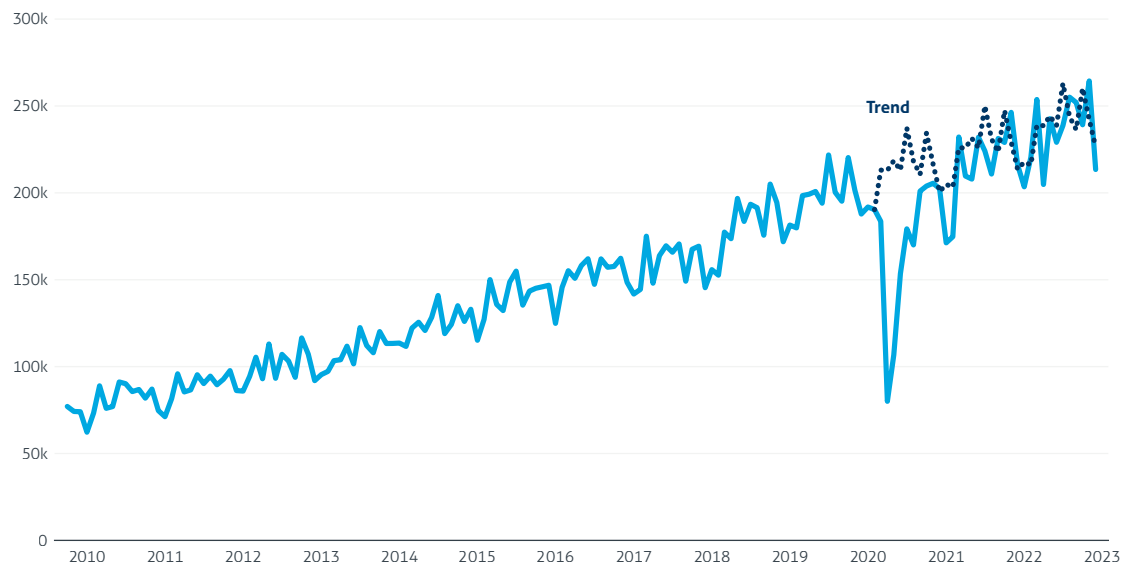
Figure 2.20 **Patients starting treatment within two months of an urgent cancer referral, October 2009 to December 2022**



Source: Institute for Government analysis of NHS England, 'Cancer waiting times' ('Monthly data – Two month wait from GP urgent referral to a first treatment' table), December 2022, supported by CIPFA.

The proportion of patients on a cancer referral pathway starting treatment within the targeted 62 days declined again in 2022 – from 70.9% in 2021 to 62.1%. As with other aspects of hospital performance, increasing cancer wait times predate the pandemic: the last month that the NHS exceeded the 85% target was December 2015.

Figure 2.21 **Urgent cancer appointments, October 2009 to December 2022**



Source: Institute for Government analysis of NHS England, 'Cancer waiting times' ('Monthly data – Two week wait from GP urgent' table), December 2022, supported by CIPFA. Notes: the 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

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Despite worsening wait times for treatment following a cancer referral, the NHS has run a successful campaign to encourage people to come forward for cancer care.<sup>127</sup> After a drop in the number of cancer referrals in 2020/21 – down to 2.1 million from 2.4 million in 2019/20 – GPs made 2.8 million urgent referrals in 2022.<sup>128</sup> This compares to an average of 2.7 million urgent referrals per year in 2021 and 2022, and is 13.5% higher than in 2019, implying that a good number of the people who did not come forward for care in the early months of the pandemic did so at a later date, and potentially due to the NHS's awareness campaign. Despite this excellent recovery, the proportion of patients seen by a consultant within the targeted two weeks from an urgent referral fell in 2022 to 78.2%, down from 84.4% in 2021 and 91% in 2019. It is also substantially below the NHS's operational target of 93%.

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## 3. Adult social care

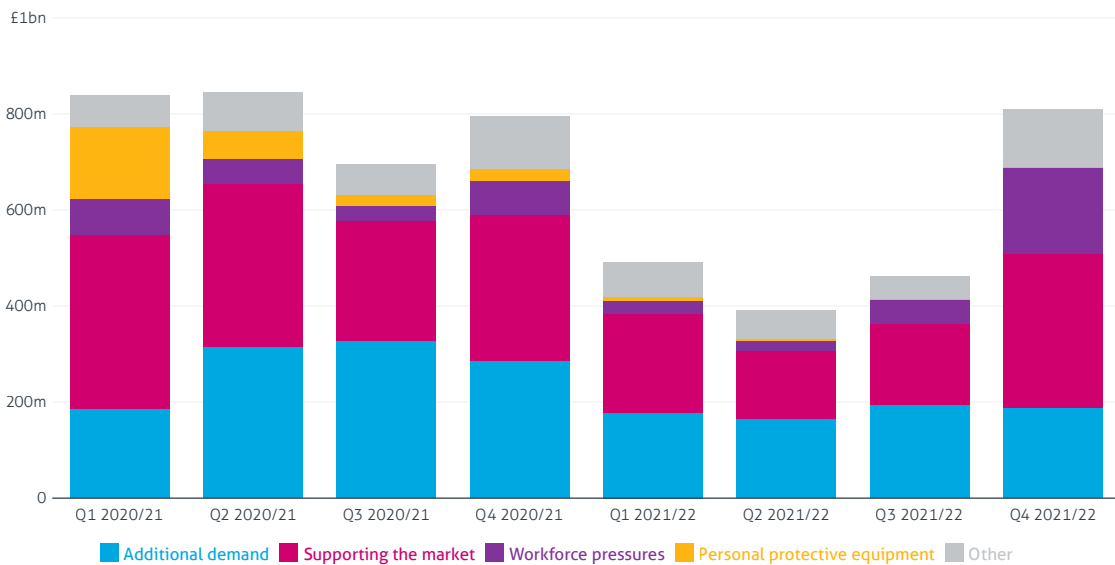
Covid has hit adult social care services hard. In 2020/21, some 39,000 people in residential and nursing homes died from the virus,<sup>1</sup> discouraging older people from coming forward for care.<sup>2</sup> By the end of 2020/21, both the number of people in long-term nursing and residential care and the number of requests for this care had declined. Some of that demand has now come back, with a year-on-year increase in both the number of people requesting care and the number of people awaiting assessment for care.

At the same time, the workforce crisis that briefly eased during the first year of the pandemic is now worse than ever, with 50,000 fewer posts in the social care workforce filled in March 2022 than at the same point the year before,<sup>3</sup> and the highest vacancy rate on record. This has severe implications for providers' ability to operate effectively. Many directors of adult social services report providers going out of business or handing contracts back, unable to provide enough care to meet demand. This has ripple effects across public services, particularly hospitals and general practice.

The cost of care is also rising, with providers facing a range of inflationary pressures. In response, the government announced a substantial uplift in funding in the November 2022 autumn statement. A portion of that funding, however, came at the expense of implementation of reforms to adult social care charging. This not only breaks one of the Conservative Party's key manifesto promises,<sup>4</sup> but also leaves unresolved a policy issue that dates back at least 25 years<sup>5</sup> and means that one in seven people still face 'catastrophic' care costs of over £100,000.<sup>6</sup> The government has also provided two tranches of additional funding to speed up discharge of patients from hospitals to social care settings.

## Covid-related spending on adult social care totalled £5.3bn over the first two years of the pandemic

Figure 3.1 Pandemic-related local authority spending on adult social care, 2020/21–2021/22



Source: Institute for Government analysis of DLUHC, 'Local authority COVID-19 financial impact monitoring information, rounds 1–20', supported by CIPFA.

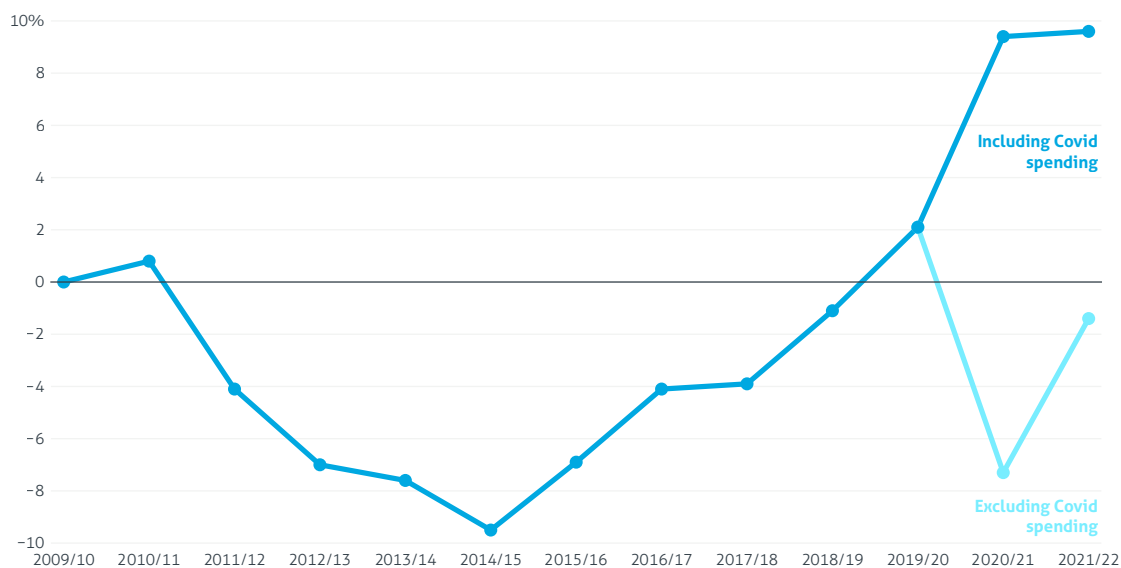
Local authority Covid-related spending on adult social care amounted to £5.3 billion over 2020/21 and 2021/22, with spending falling from £3.2bn in 2020/21 to £2.2bn in 2021/22. Spending on workforce pressures was the only category to increase over the same period, rising from £231.6 million to £282m, an increase that reflects worsening workforce retention in the second year of the pandemic, discussed further below. This money was spent on a range of initiatives such as supporting payments to increase hours worked, local recruitment initiatives and the hiring of local authority social services staff.<sup>7</sup>

Spending on 'supporting the market' – money to prevent providers going out of business – made up the largest proportion of spending in both years, at 39.5% and 39% respectively. The Care Quality Commission (CQC) found that this funding largely achieved its intended purpose, with fewer-than-expected providers closing or handing contracts back.<sup>8</sup> But it also found that some providers benefited more than others from emergency funding, with home care providers in particular seeing "stable or improved profit margins over the course of 2020/21".<sup>9</sup> The end of this funding in March 2022 raises questions about market sustainability, as discussed below.

Grants from central government mostly funded the additional spending. This money was provided as a mixture of un-ringfenced grants that could be spent at the discretion of local authorities and grants intended for specific purposes.<sup>10</sup> For adult social care, the latter category included grants such as the adult social care Infection Control Fund (worth £2.1bn over 2020/21 and 2021/22<sup>11,12</sup>), the Workforce Capacity Fund for adult social care (£120m) in 2020/21<sup>13</sup> and the Workforce Recruitment and Retention Fund for adult social care (£462m) in 2021/22.<sup>14</sup>

## Central government support drove spending increases during the pandemic

Figure 3.2 Change in spending on adult social care since 2009/10 (real terms)



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity and Finance Report, England 2021-22', Appendix B, Table 5, supported by CIPFA.

The amount the government spent on adult social care increased by 7.4% in real terms between 2019/20 and 2021/22 (and by 9.6% between 2009/10 and 2021/22). The majority of this increase came from additional local authority spending on adult social care, financed mostly by central government grants that were designed to support both social care users and providers during the pandemic.<sup>15</sup> This additional spending amounted to £3.2bn of the £20.7bn spent on adult social care in 2020/21 and £2.2bn of the £21.4bn spent in 2021/22. This means that across the first two years of the pandemic 12.8% of spending was on emergency Covid measures.

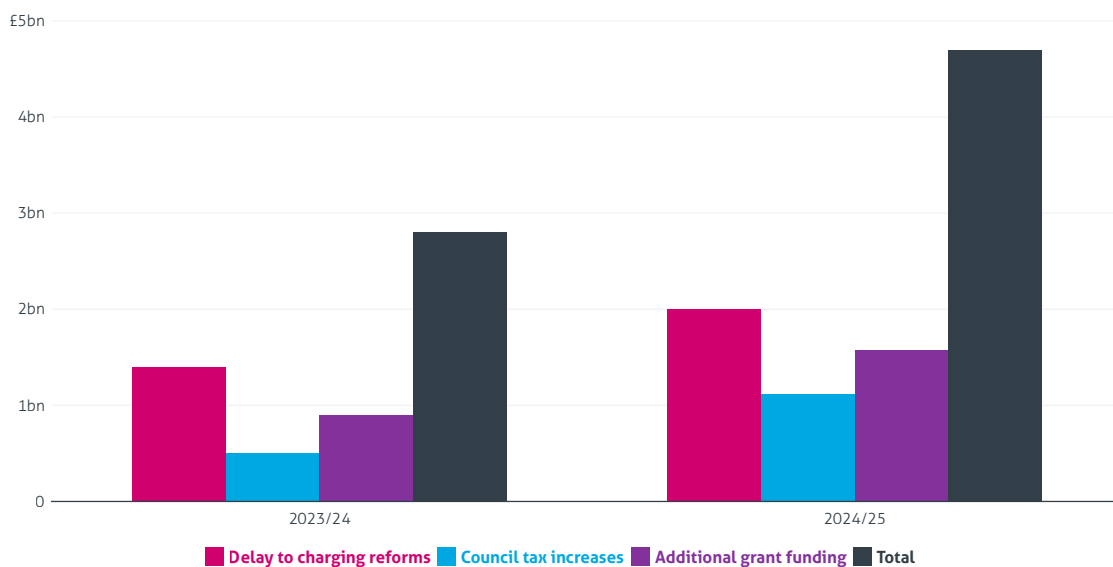
Excluding the amount spent on Covid, it would appear that spending on adult social care would have fallen during the first two years of the pandemic. This is, however, not quite the case. It is likely that some spending would have been incurred in the absence of Covid, but which was classified as Covid spending because of difficulties distinguishing between 'business as usual' and Covid expenditure. It is also likely that some activity that would have continued in the absence of Covid could not go ahead due to the pandemic. This is potentially observable in the lower number of people in long-term care, as discussed below.

Throughout the winter of 2022/23, adult social care has been the focus of much media and policy attention. However, this has largely been related to the role that the service plays in preventing discharge of patients from hospital – an area identified as a key contributor to the ongoing crisis in secondary care (see the 'Hospitals' chapter of this report for more detail). To that end, the government announced £500m of funding to improve discharge from hospitals as part of the Adult Social Care Discharge Fund in September 2022,<sup>16</sup> and a further £200m in January 2023 to "buy thousands of extra beds in care homes and other settings to help discharge more patients who are fit to leave hospitals".<sup>17</sup>

This funding will no doubt be welcomed by local authorities, the NHS, and financially stretched providers, but it is problematic for a number of reasons. First, this funding is unlikely to have the desired effect of rapidly increasing social care provision, and in turn freeing up space in hospitals. Much of the money has taken longer than expected to reach providers, with the government only disbursing the first tranche of the Adult Social Care Discharge Fund in December 2022 – three months after it was announced.<sup>18</sup> Once it has been disbursed, it will then take time to reach providers, partly because of high reporting requirements imposed by the government.<sup>19</sup> Providers then cannot simply tap into a reservoir of ready provision, but instead have to attempt to recruit new staff, invest in capacity, and work with local authorities and the NHS to actually place people in care. Second, and relatedly, this sort of short-term, emergency funding makes it difficult for providers to plan and invest over a longer time period. Third, government will likely pay more than if it had increased funding more predictably and over a longer period of time.<sup>20</sup> Fourth, people might be placed in care that is inappropriate for their needs as they are rushed out of hospitals.<sup>21</sup>

In the absence of any further intervention from the government, spending might have fallen back towards pre-pandemic levels in 2023/24 and beyond. But it looks like the trend of increasing spending on the service will continue, as the government used the autumn statement in November 2022 to increase funding for adult social care in 2023/24 and 2024/25. It did this through a mixture of new grant funding, increasing the amount that local authorities could raise each year through council tax, and reallocating the funding that had been earmarked for charging reform by delaying implementation until October 2025 at the earliest.<sup>22</sup> Importantly, the government is providing more funding to the least deprived councils, helping to redress the disproportionate cuts they suffered in the 2010s.<sup>23</sup>

Figure 3.3 **Increase in funding for adult social care from the 2022 autumn statement, by source**



Source: Institute for Government analysis of HM Treasury, 'Autumn statement 2022', supported by CIPFA.



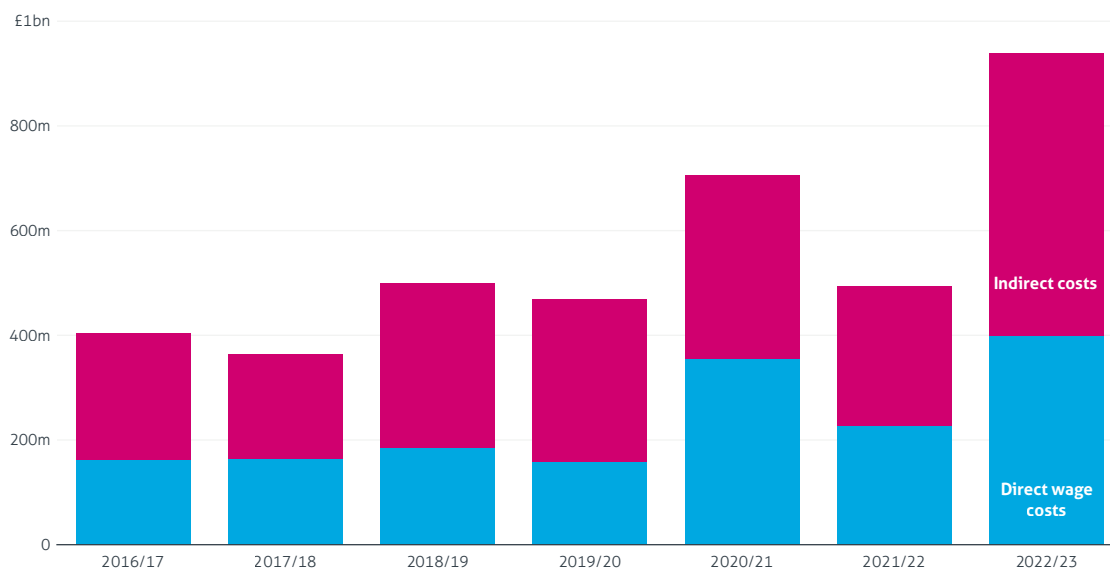
In total, the autumn statement provided local authorities with an additional £2.8bn in 2023/24 and £4.7bn in 2024/25. This would represent a 13% and 21.5% uplift in real terms compared to spending on the service in 2019/20. It should be noted, though, that this includes £0.5bn and £1.1bn in 2023/24 and 2024/25 respectively coming from council tax rises. These amounts represent the total that authorities *could* raise if 95% of authorities exercised their full precepts in both years. It is not, however, clear that all authorities will do so. Raising council tax means asking residents to pay more, something councils may be reluctant to do during a cost of living crisis. As a comparison, only 45% of authorities used their full precept in 2021/22.<sup>24</sup> According to reports only approximately seven in ten authorities have decided to exercise the full precept in 2023/24.<sup>25</sup> Nonetheless, this is a substantial uplift in spending on the service.

### Additional funding will help meet rising costs

The additional funding could hardly be more timely as the sector faces a range of cost pressures. While Covid is not as burdensome as during the first two years of the pandemic, there is still a need for increased infection prevention and control, although it is difficult to estimate how much this costs providers.<sup>26,27</sup>

The national living wage (NLW) rose 6.6% in April 2022 and will rise a further 9.7% in April 2023.<sup>28</sup> Other, non-NLW, wages will also need to rise to improve the recruitment and retention of staff in a tight labour market.<sup>29</sup> Aside from wages, providers and local authorities now need to spend more to meet rising inflation and costs, such as fuel – be that for travelling between clients<sup>30</sup> or for heating care homes – and food.<sup>31,32</sup>

Figure 3.4 **Cost to local authorities of changes in the national living wage, 2016/17–2022/23 (real terms)**



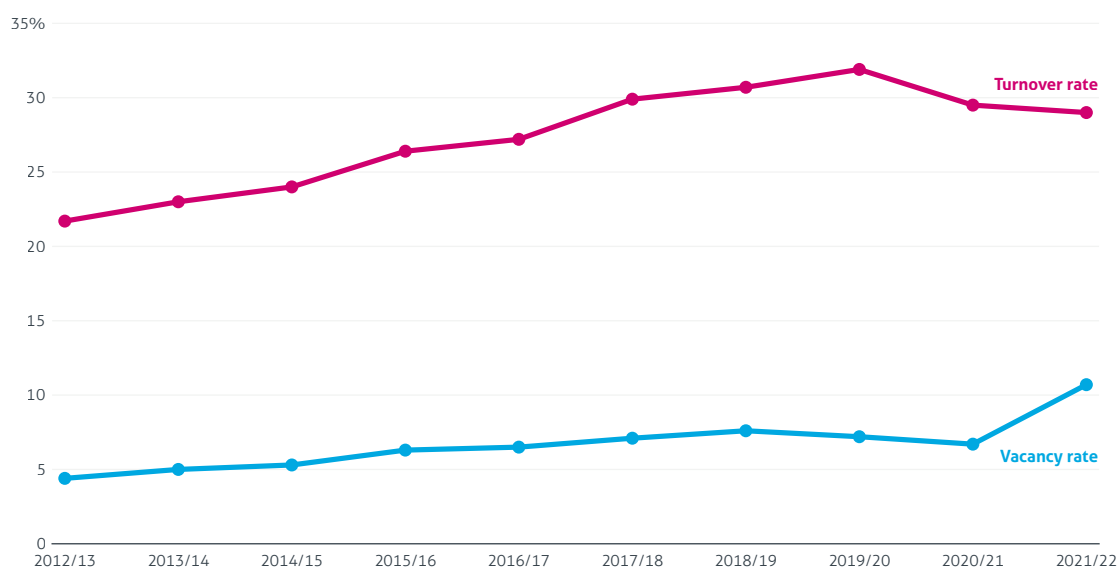
Source: Institute for Government analysis of ADASS, 'Spring budget survey 2022', supported by CIPFA. Notes: 2016/17 was the first year in which ADASS published this estimate.

Before the autumn statement, local authorities also faced the prospect of implementing reforms to social care charging in October of this year. The government decided to delay implementation until at least October 2025, following a campaign by local authorities and representative bodies like the County Council Network, who argued that councils would not be able to effectively implement reforms for a number of reasons. First, they claimed that the current level of funding was insufficient to make the changes.<sup>33</sup> Second, they estimate that authorities would need to hire an additional 4,300 social workers – an increase of approximately a quarter compared to current levels – to carry out 200,000 additional assessments per year arising from the reforms.<sup>34</sup> While it is probably true that the amount of money that central government had earmarked for the reforms was not enough, it is questionable whether delaying the reforms until the next parliament was the most appropriate response. The cap on personal care costs would have protected some of the most vulnerable people from catastrophic care costs and meant a fairer means test for others attempting to access the service.<sup>35</sup> Delaying these reforms means that recommendations that the Dilnot commission first made in 2011 may not be implemented until 2025 at the earliest.<sup>36</sup>

It is yet to be seen what this additional funding will mean for providers. Before the autumn statement, providers were feeling the dual effects of increasing cost pressures and reduced support from central government (among other factors): 64% of councils reported that providers in their area had closed, ceased trading, or handed back contracts in the four months to November 2022.<sup>37</sup> This compared to 67% in the six months to March 2022, and 25% in the six months to March 2020.<sup>38</sup> Local authorities are likely to use much of the additional funding from central government to support the social care market.

### Care worker vacancies fell during the first year of the pandemic, but are now on the rise

Figure 3.5 Vacancy and turnover rates for the adult social care workforce, 2012/13–2021/22



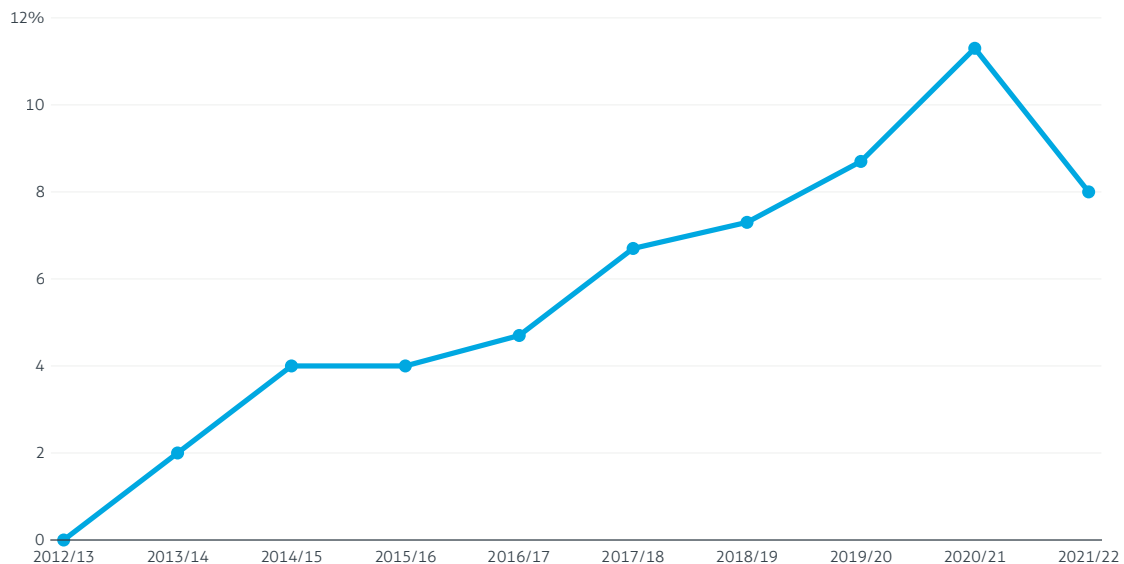
Source: Institute for Government analysis of Skills for Care, 'State of the workforce', 2020/21 and Skills for Care, 'Size and structure of the workforce', 2021/22, supported by CIPFA. Notes: 2012/13 was the first year in which Skills for Care published this data.

During the first year of the pandemic, both the turnover rate and the vacancy rate among social care workers fell, following patterns seen across other public services. But this trend reversed from April 2021 onwards,<sup>39</sup> with the annual vacancy rate reaching 10.7% in 2021/22<sup>40</sup> – the highest level it has been since the beginning of the Skills for Care time series in 2012/13. There is little sign of this trend reversing; Skills for Care reports that the vacancy rate was 10.8% in December 2022, the most recent month that it has reported.<sup>41</sup>

## There were 50,000 fewer filled posts in the social care workforce in March 2022 compared with March 2021

The rise in the vacancy rate was the result of people leaving the adult social care workforce. The number of filled posts in the social care workforce decreased by 50,000 between March 2021 and March 2022, from 1.67 million to 1.62 million.<sup>42</sup> This included 35,000 fewer carers.\* This reduction of the workforce has severe implications for the functioning of the service. Having fewer carers restricts the supply of social care, which in turn makes it harder to place people in care.

Figure 3.6 **Change in the size of the adult social care workforce since 2012/13**



Source: Institute for Government analysis of Skills for Care, 'State of the workforce, 2021/22', supported by CIPFA.  
Notes: The time series does not start in 2009/10 because Skills for Care revised its methodology for measuring the adult social care workforce in 2020/21 and only revised data from 2012/13 onwards.

A range of factors is driving the exodus of the adult social care workforce. First, care workers were under immense pressure during the first two years of the pandemic and many suffered burnout due to "chronic stress",<sup>43</sup> causing them to leave for less-intense jobs. Second, approximately 7% of the adult social care workforce comes from the EU,<sup>44</sup> but Brexit has made it harder for EU citizens to work in the UK.<sup>45</sup> Third, social care offers few opportunities for training or progression<sup>46</sup> – factors which encourage people to stay in the sector<sup>47</sup> – in comparison with other careers. Fourth, the government mandated vaccination against Covid for all care home workers from November 2021.<sup>48</sup> Unwillingness to be vaccinated was the second most cited reason among care home staff for leaving the workforce in December 2021.<sup>49</sup> Finally,

\* By carer we mean care workers and senior care workers, but do not include personal assistants, who are hired by people given personal budgets to pay for their own care.

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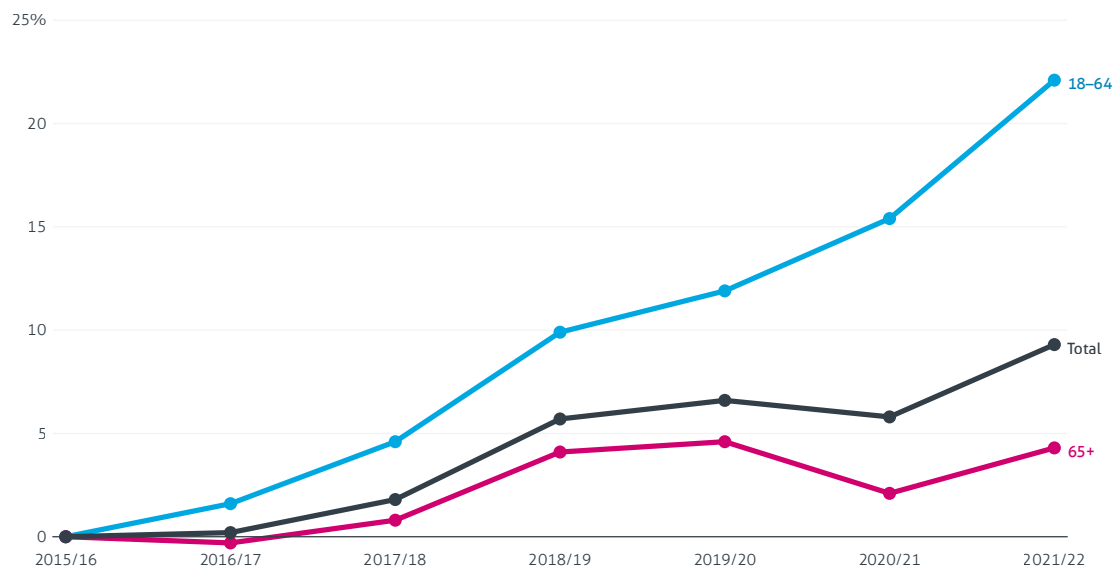
carers are paid poorly compared with workers in other sectors. For example, in 2020/21, the median sales and retail assistant earned 14p more per hour on average than the median care worker.<sup>50</sup> Median pay for care workers in the independent sector fell in real terms between March 2021 to March 2022, from £9.65 per hour to £9.50 per hour.<sup>51</sup> Adult social care also competes for workers with the NHS,<sup>52</sup> which often pays health care assistants and porters more than care workers.<sup>53</sup> The cost of living crisis is likely to be exacerbating this issue. Nine in ten councils report an increase in the number of people leaving the social care workforce due to the rising cost of working in the sector. In particular, they cite higher fuel costs deterring workers from remaining in the home care sector.<sup>54</sup>

The government has recognised at least some of the difficulties in the adult social care workforce and has taken steps to try to improve the situation. It has added care workers, care assistants and home care workers to the shortage occupation list (SOL)<sup>55</sup> – a measure designed to make it easier to recruit in-demand workers from outside the UK.<sup>56</sup> Skills for Care estimates that following the addition to the SOL, the proportion of new starters in the social care workforce arriving from outside the country increased from 4% in 2021 to 11% in 2022, though this could partly be because the number of new starters has fallen compared to 2021. The government also introduced the Workforce Development Fund during the pandemic to promote continuing professional development for care staff.<sup>57</sup> This was extended into 2022/23, with £500m of funding behind it.<sup>58</sup>

This workforce crisis comes in the wake of repeated calls for the government to design and implement a long-term workforce strategy.<sup>59,60,61</sup> The Department of Health and Social Care committed to producing a workforce strategy in 2018, after recommendations from the National Audit Office<sup>62</sup> and the House of Commons Committee of Public Accounts,<sup>63</sup> but failed to do so.<sup>64</sup> This means there has been no update to the workforce strategy since 2009.<sup>65</sup> During the legislative process for the Health and Care Act 2022, the government rejected an amendment that would have required it to commit to regular forecasts.<sup>66,67</sup> The government announced in the autumn statement that it would publish a workforce plan for NHS in 2023,<sup>68</sup> but declined to carry out the same exercise for adult social care.

## After falling during the first year of the pandemic, requests for care increased in 2021/22

Figure 3.7 Change in requests for support from new clients since 2015/16, by age group



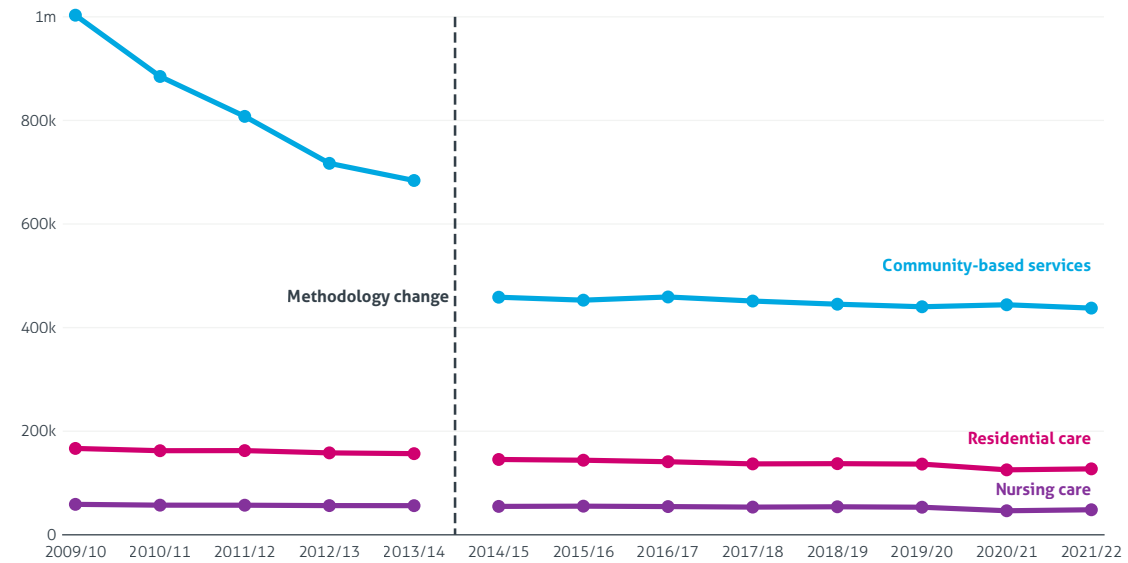
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2021/22, supported by CIPFA. Notes: 2015/16 was the first year that NHS Digital published this information.

After a decline in requests for care among the 65-plus population in 2020/21, numbers returned to pre-pandemic levels, with 1.37 million requests in both 2019/20 and 2021/22. It might have been expected that the fall in requests in 2020/21 would have created pent-up demand and led to a larger increase in 2021/22. But it is worth remembering that the pandemic continued in 2021/22 and many of the factors that kept people away from care in 2020/21 – the risk of contracting Covid from a carer<sup>69</sup> or in a care setting<sup>70</sup> and potentially increasing amounts of unpaid care<sup>71</sup> – are likely to have held true in the second year of the pandemic, thus depressing demand for local authority-provided care.

In contrast, the number of working-age adults (aged 18–64) requesting care increased in 2021/22, to 611,505 from 577,765 in 2020/21 – a 5.8% rise. From our interviews, it is unclear what drove this increase, but adult social care directors are increasingly concerned about the financial pressure that rising demand for social care from working-age adults will have on spending, due to this group often having more complex and longer-term requirements than the older population (aged 65-plus).<sup>72</sup>

## The number of people in long-term care declined in the second year of the pandemic

Figure 3.8 People in care 2009/10–2021/22, by setting



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2021/22, supported by CIPFA. Notes: These data refer to the number of people in long-term care at the end of the year.

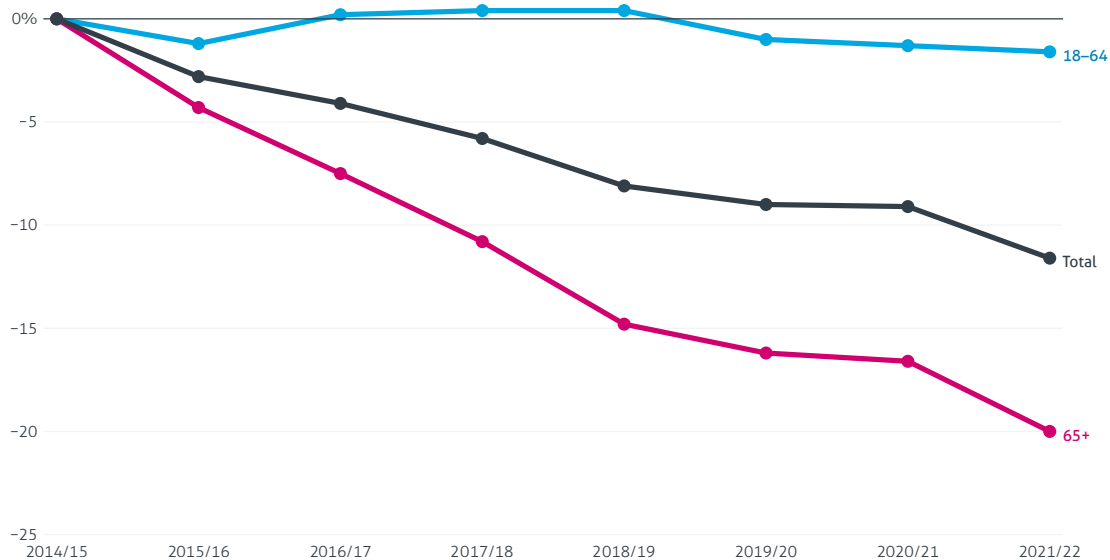
The number of people in long-term care at the end of the year fell for at least the 12th year in a row in 2021/22, from 616,180 in 2020/21 to 613,510, a 0.4% decline. This fall was not evenly split by care setting. The number of people in community-based care decreased by 1.5%, while the number of people in nursing and residential care rose by 4.2% and 1.5% respectively.

High Covid mortality in nursing and residential homes had the dual effect of reducing the number of people in care and in all likelihood discouraging people from seeking care in those settings in 2020/21. In 2021/22 there was a slight increase in the number of people receiving long-term care in nursing and residential settings – 175,675 compared to 171,855 in 2020/21 – but this amount is still lower than we might expect, given pent-up demand that could have built up while people stayed away during 2020/21. Despite this increase, the number of people receiving care in residential and nursing settings is also still below where it might have been if the pandemic had not hit. The annual decline in people cared for in those settings was 1.7% per year on average between 2009/10 and 2019/20, while the number declined 3.8% per year on average between 2019/20 and 2021/22. This shift away from these settings is due to a combination of government policy – which aims to increase the number of people cared for at home<sup>73</sup> – and an increase in personal preference for home care among older people.<sup>74</sup>

## The proportion of people in long-term care continued to fall during the pandemic

The proportion of the population aged 65-plus in local authority-funded long-term care fell in 2021/22, from 5,271 people per 100,000 population to 5,054 – a 4.1% year-on-year fall and a 20.1% decrease since 2014/15.

Figure 3.9 **Change in people accessing long-term support during the year since 2014/15, by age band**



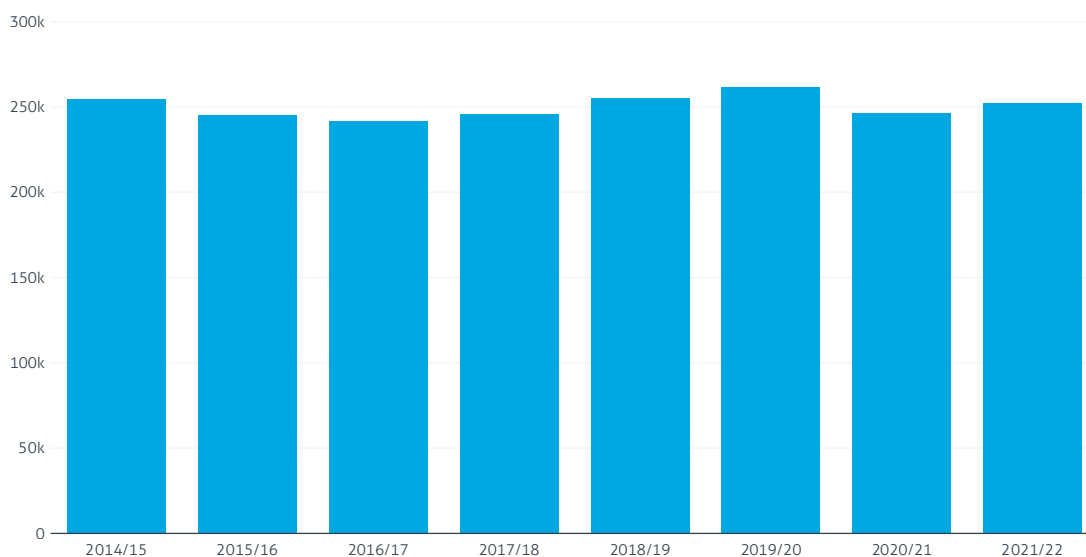
Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21 and ONS, 'Mid-year population estimates', 2021, supported by CIPFA. Notes: 2015/16 was the first year in which NHS Digital published this information. This refers to people accessing care during the year and is weighted by the number of people in each age band.

There are a number of explanations for this longer-term shift. First, today, people aged over 65 generally have less need for social care than people of the same age 15 years ago.<sup>75</sup> Second, cuts in central government grants since 2009/10 have forced local authorities to make tough decisions<sup>76</sup> and have resulted in many choosing to ration care, which is easier to do for those aged over 65 than for working-age adults, whose needs tend to be greater.<sup>77</sup> Third, because the means test for publicly funded care has been frozen in cash terms, a smaller proportion of people are eligible for it.<sup>78</sup> Finally, local authorities moved away from being 'care-package factories' that offer social care as the first option,<sup>79</sup> to making greater use of 'asset-based' models – such as the 'three conversations' model<sup>80</sup> – which aim to integrate people into communities by making use of any skills and connections they have. The aim of this approach is to allow people to live fulfilled, independent lives without relying on long-term social care.<sup>81</sup>

But asset-based approaches may not be fulfilling their purpose, for a couple of reasons. First, it could be that local authorities use these approaches as a means of saving money, in the process pushing caring responsibilities on to families, neighbours and the voluntary sector.<sup>82</sup> Second, there is little evidence about whether these approaches deliver better or worse outcomes.

## The number of completed short-term care packages remain below pre-pandemic levels

Figure 3.10 Number of completed short-term care packages to maximise independence, 2014/15–2020/21



Source: Institute for Government analysis of NHS Digital, 'Adult Social Care Activity', 2020/21, supported by CIPFA. Notes: 2015/16 was the first year in which NHS Digital published this information.

The number of completed short-term care packages to maximise independence (among both new and existing clients) rose slightly from 246,600 in 2020/21 to 252,145 in 2021/22, a 2.2% increase. This is still, however, below the pre-pandemic amount of 261,605 packages delivered in 2019/20. The reasons for this decline are likely to be similar to those for long-term care packages: people could have avoided care where possible due to Covid. Another reason may be that it was easier at the height of the pandemic to discharge people from hospital into nursing or residential care, rather than into short-term settings, which can require more specialised care.<sup>85</sup> There is also evidence of staff shortages during the pandemic leading to reablement staff – who usually assist people coming out of hospital to regain the skills that will allow them to live independently – working in residential homes, therefore making it harder for local authorities to place clients in short-term care.<sup>84</sup>

It is also worth noting that if local authorities were pursuing an asset-based approach with the aim of facilitating independent living rather than reducing the amount of budget dedicated to adult social care, then we would expect to see increasing levels of short-term care packages to maximise independence. This outcome is not evident from the data.

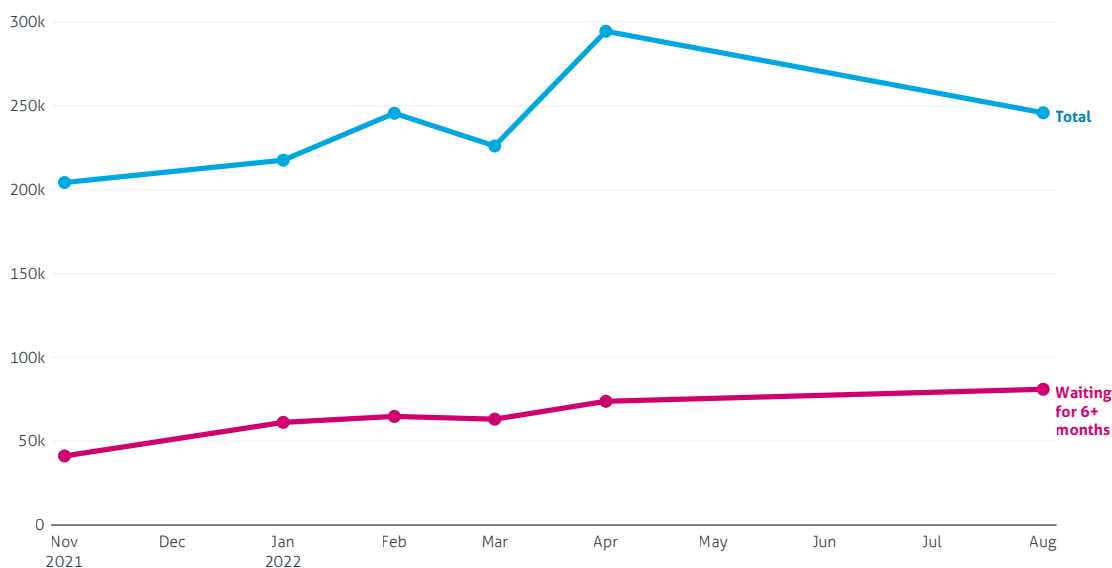


## There are signs of a backlog in social care demand

The decline in activity in adult social care could mean that there is pent-up demand for care. There is some indication of this already: the Association of Directors of Adult Social Services (ADASS) estimates that as of August 2022, 245,821 people were awaiting assessment for care,<sup>85</sup> up from 204,241 in November 2021,<sup>86</sup> but down from the peak of 294,449 in April 2022. Among those people waiting, an increasing proportion are waiting longer. Of the 245,821 people awaiting assessment in August 2022, 80,967 of those had been waiting for more than six months.<sup>87</sup> At 32.9%, that was the highest proportion since ADASS began collecting this data. Part of the reason for this delay in receiving assessments is that the number of social workers – local authority employees who carry out social care assessments, alongside other responsibilities – declined from 17,500 in 2020 to 17,300 in 2021.<sup>88</sup> While not a large drop (only 1.1%), this does mean that fewer workers are now carrying out a greater volume of work, leading to a bottleneck before people even reach care.

When a social worker assesses a client as being in need of adult social care, often there is no care available for them, due to the workforce crisis<sup>89</sup> and cost pressures described above.<sup>90</sup> This means that people who need care may go without<sup>91</sup> or seek care elsewhere, not least from unpaid carers.<sup>92</sup>

Figure 3.11 **People awaiting assessments for adult social care, November 2021 to August 2022**



Source: Institute for Government analysis of ADASS, 'Autumn survey report 2022', supported by CIPFA. Notes: Comparable data is not available before November 2021.

The reduction in the number of people in care aged 65 and over, up to 2019/20, despite an increase in the number of requests for care, means it is likely there was substantial unmet demand even before the pandemic. Unmet demand for social care may increase pressures in primary, community and secondary care,<sup>93,94</sup> although evidence for this is mixed.<sup>95</sup> It should also be noted that causality between the health and social care systems flows both ways; during the worst of the pandemic, hospitals often discharged patients too early, meaning that they had a higher need for care, putting even more pressure on adult social care.<sup>96</sup>

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## 4. Children's social care

The pandemic made it more difficult for local authorities to ensure children's safety, exacerbating existing long-term problems facing the sector. During the height of the crisis, limited spare capacity in the residential sector fed into higher costs as authorities sought out accommodation. The number of children in care remained at an all-time high as fewer children could be safely discharged – this is despite referrals to social services falling dramatically, principally during lockdowns.

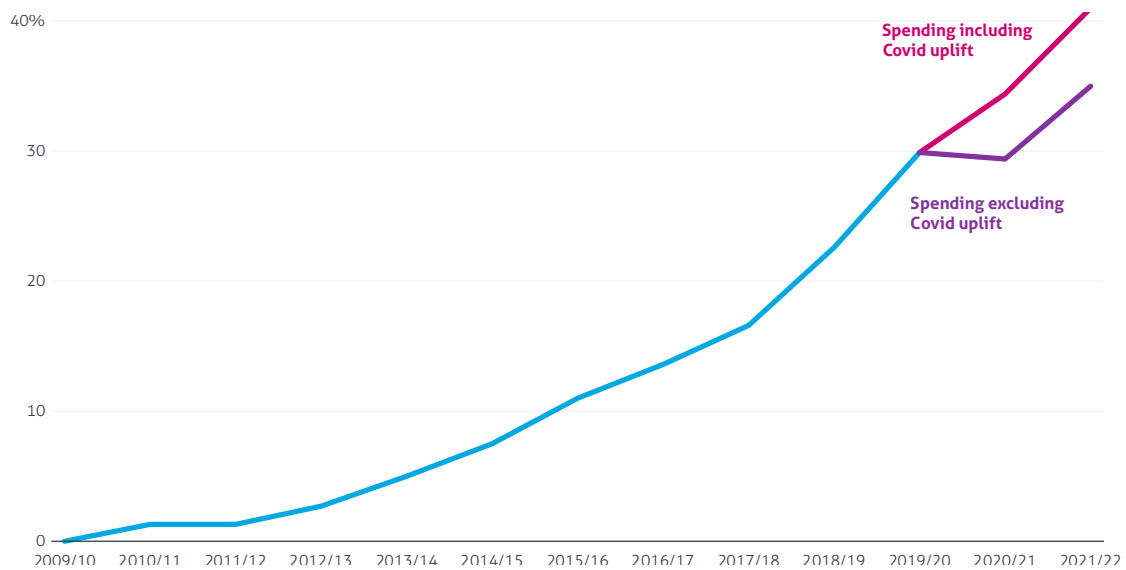
Since the reopening of schools, referrals have returned to pre-pandemic levels. Yet it is still too early to know whether 'missing' lockdown cases will show up or the extent of additional harm suffered by children during this time, though there have been some notably tragic cases. Following several highly critical reviews calling for radical overhauls of the children's social care system, the government launched a long-term plan for the sector, which has been criticised for the scale and speed of response. The children's social care workforce will be critical to the delivery of any reforms but the sector is struggling with chronic shortfalls leading to a reliance on costly agency staff.

This chapter examines children's social care in England. These services are provided by upper tier local authorities, which are legally obliged to provide support for disabled children, to protect children from harm, and to take responsibility for 'looked-after children', including through foster and residential care placements.

### **Spending on children's social care is increasing pressure on local authority budgets**

Local authorities spent £11.1 billion on children's social care in 2021/22, a 41% rise in real terms compared to 2009/10.<sup>1</sup> By comparison, the children's population grew by less than 10% over the same period. The sustained increase in children's social care spending continues to squeeze other areas of local government spending.<sup>2</sup>

Figure 4.1 **Change in local authority spending on children’s social care in England since 2009/10 (real terms)**



Source: Institute for Government analysis of DfE, 'LA and school expenditure' ('S251 Outturn – Children and Young People's Services' table), 2009/10–2021/22; DLUHC, 'Local authority revenue expenditure and financing'; supported by CIPFA. Notes: Details on spend net of Covid can be found in the Methodology chapter.

Spending has also prioritised children’s social care at the expense of other services for children. Spending on safeguarding children and young people’s services increased by 27%, and on looked-after children\* by 49%, between 2009/10 and 2021/22.<sup>3</sup> Over the same period spending on services for young people was cut by 61% – Sure Start children’s centres and other spend on children under five fell by 74%.<sup>4</sup>

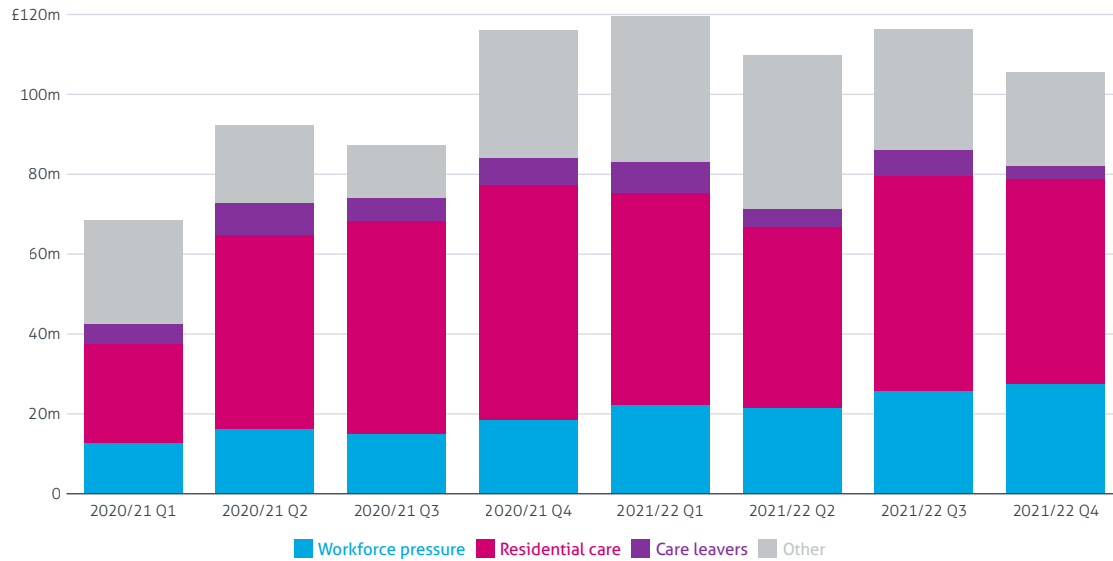
The government-commissioned independent review of children’s social care has called for a roughly £2bn (20% in cash terms) uplift to children’s social care spending over the next five years.<sup>5</sup> It also called for a rebalancing of priorities away from crisis interventions towards earlier stage interventions with an annual amount of £1bn ringfenced for family help.<sup>6</sup>

### Local authorities faced additional pandemic-related children’s social care spend, particularly on residential care

During the 2020/21 and 2021/22 financial years, local authorities spent £820.6 million on pandemic-related social care costs.<sup>7</sup> Almost half (48%) of these extra costs in 2021/22 were accounted for by the higher cost of residential care placements for children.<sup>8</sup> The cost of these placements rose sharply during the pandemic due to infection control measures and higher residential staffing costs.<sup>9,10</sup> Almost a fifth (19%) of the additional pandemic-related costs – totalling £159.5m during 2020/21 and 2021/22 – came from workforce pressures as local authorities and providers faced higher unit costs from agency staff.<sup>11</sup> Local authorities were given support to meet these and other costs through non-ringfenced grants from central government, though the degree to which Covid-specific funding helped to offset regular children’s social care costs is difficult to assess.<sup>12</sup>

\* A child who has been in the care of their local authority for more than 24 hours is known as a looked-after child. Looked-after children are also often referred to as children in care.

Figure 4.2 Additional pandemic related children's social care spending, 2020/21–2021/22



Source: Institute for Government analysis of DLUHC, 'Local authority COVID-19 financial impact monitoring information', rounds 1-20, supported by CIPFA. See Methodology for full details.

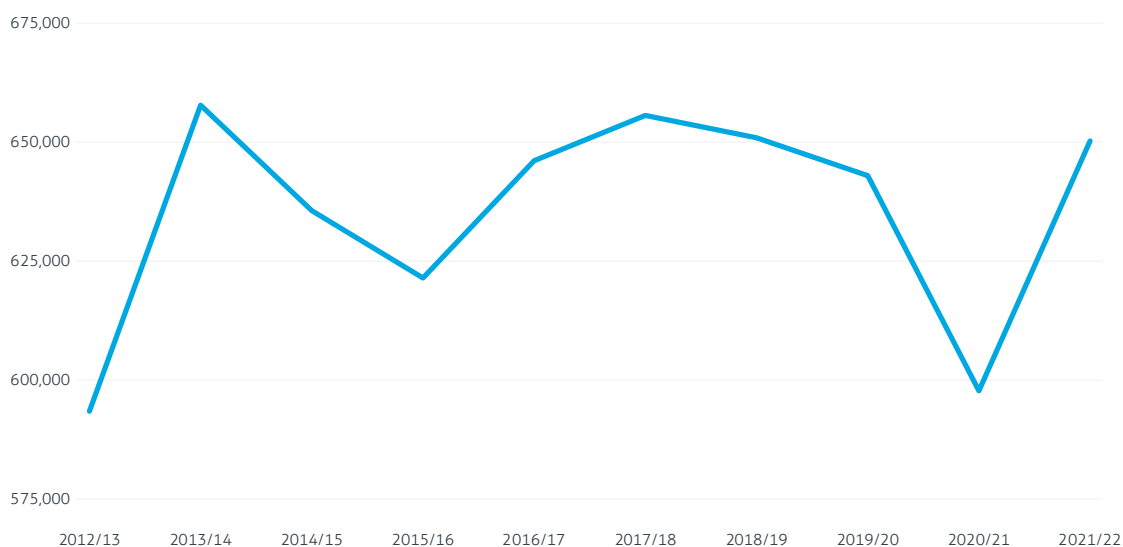
Additionally, the demand for children's residential places has increased following the 2021 ban on the use of unregulated accommodation,<sup>13</sup> though the practice still continues in some cases.<sup>14</sup> Overall, despite the number of children's homes increasing by 378 to 2,970 between August 2020 and 2022,<sup>15</sup> this was likely to have been outstripped by demand.<sup>16</sup> Furthermore, national increases can mask local shortfalls, including in the quantity and quality of secure homes, and, in placements for children with complex or challenging needs.<sup>17,18</sup> These problems predate the pandemic. For example, in 2022 Ofsted analysis showed that as of March 2020 only 5% of homes stated that they could accommodate complex health needs.<sup>19</sup>

Higher profits by private residential providers have added to costs facing local authorities, with 83% of all provision in the independent sector.<sup>20</sup> This trend was also identified in a recent report by the Competition and Markets Authority, which found private providers were making higher profits through higher prices and provision which did not always meet the needs of children.<sup>21</sup>

## The number of children being referred to children's services has returned to pre-pandemic levels

Referrals to children's social care have returned to pre-pandemic levels, rising by approximately 52,500 in 2021/22 (8.8%) compared to 2020/21.<sup>22</sup>

Figure 4.3 Referrals to children's social care, 2012/13–2021/22



Source: Institute for Government analysis of ONS, 'Characteristics of children in need' (Table C1), 2022, supported by CIPFA. Notes: Following a methodology change in 2018 and revisions to earlier data, comparable figures are not available before 2012/13. If a child has more than one referral in a year, then each referral is counted.

Part of the reason for the increase in referral numbers is that as lockdown restrictions were reduced, potentially vulnerable children had greater contact with public services. Schools are the second highest source of referrals to social care and between 2020/21 and 2021/22 schools referred 59% more cases – reversing the large 30.6% fall in referrals seen between 2019/20 and 2020/21.<sup>23,24</sup>

While referrals are now 1.1% higher than 2019/20 levels, it is unclear whether missing referrals during the pandemic will lead to higher referrals at a later date.<sup>25</sup> Some local authorities responding to a survey by the Department for Education (DfE) reported that, continuing the pre-pandemic trend, the nature of cases coming forward appears to be more complex, which may add pressures to the system.<sup>26</sup> A 2022 British Association of Social Workers survey of members also raised concerns that cost of living pressure could lead to unmanageable caseloads.<sup>27</sup>

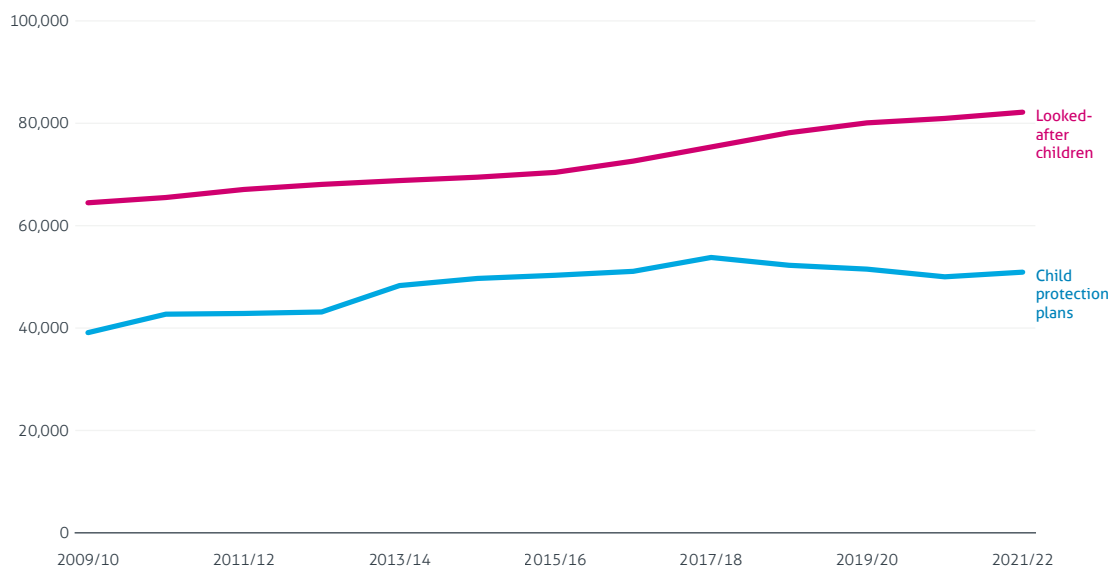
## The number of children on child protection plans remains high despite falling slightly during the pandemic

The number of child protection plans (CPPs)\* rose in 2021/22 for the first time in four years and now stands at around 51,000.<sup>28</sup> While this is up 1.8% against 2020/21, figures remain low and are down 1.1% from 2020 and at their second lowest level since 2015.<sup>29,30</sup> The number, however, remains significantly higher than the approximately 39,000 plans in place in 2009/10.<sup>31</sup>

\* After a referral, a child may be assessed under section 47 of the Children Act 1989 to be judged at a reasonable risk of harm. If that happens, a child protection plan is agreed, which commits a local authority to support the child; this plan may cover their care while the child lives with their family or, for example, while they are in residential care.

It is too early to say whether this increase is part of a broader trend. Ofsted analysis suggests that the increase may be partially linked to continued social worker hesitancy to reduce the level of support to children in the context of a new post-lockdown environment.<sup>32</sup>

Figure 4.4 **Looked-after children and child protection plans, 2009/10–2021/22**



Source: Institute for Government analysis of DfE, 'Characteristics of children in need' ('D4 Child Protection Plans at 31 March by category of abuse and local authority, England 2013 to 2021' table) and 'Children looked-after in England including adoption', 2009/10–2020/21 ('CLA numbers and rates per 10,000 children aged under 18 years – LA' table), supported by CIPFA.

## There has been a small increase in the number of children cared for by local authorities

Social workers now support a slightly higher number of looked-after-children.\* As of March 2022, there were approximately 82,000 looked-after children, which was up 1.5% on the previous year and an increase of 2.7% compared to March 2020.<sup>33</sup> This continues a longer-term rise seen over the past decade.<sup>34</sup> This is largely due to fewer children leaving care before the age of 18.<sup>\*\*</sup><sup>35</sup>

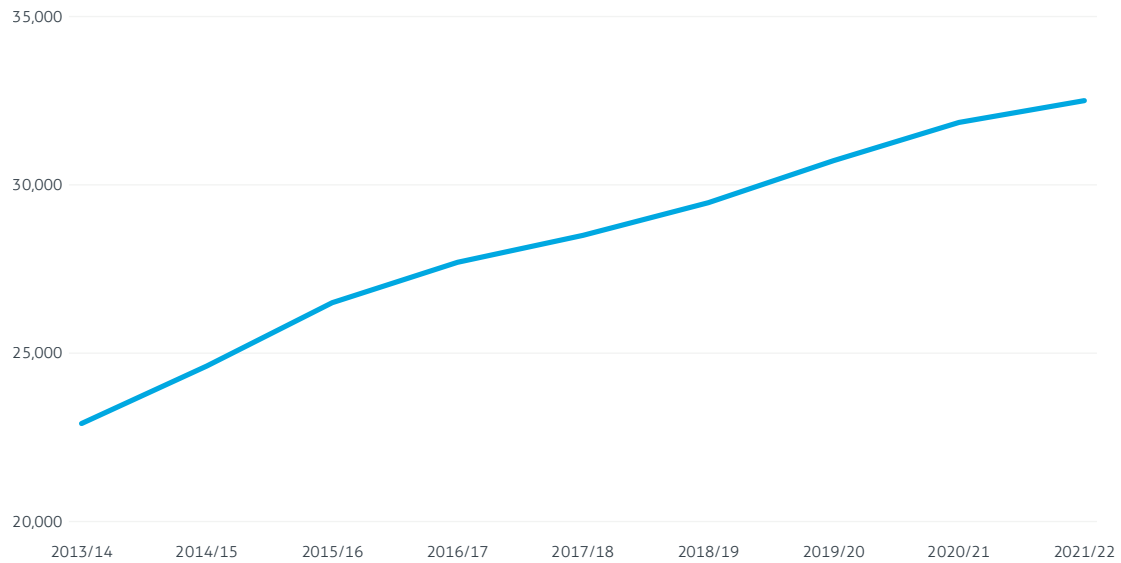
## Social worker staffing levels continue to rise alongside sustained levels of vacancies

The number of children's and family social workers continued to grow with a 2% increase in 2021/22 but the proportion of vacancies remained steady.<sup>36</sup> Despite this, a considerable majority of local authorities (83%) when surveyed said that they are struggling to recruit children's social care staff.<sup>37</sup>

\* A child who has been in the care of a local authority for more than 24 hours. Generally these children are accommodated in children's homes, residential settings like secure units, or with foster parents.

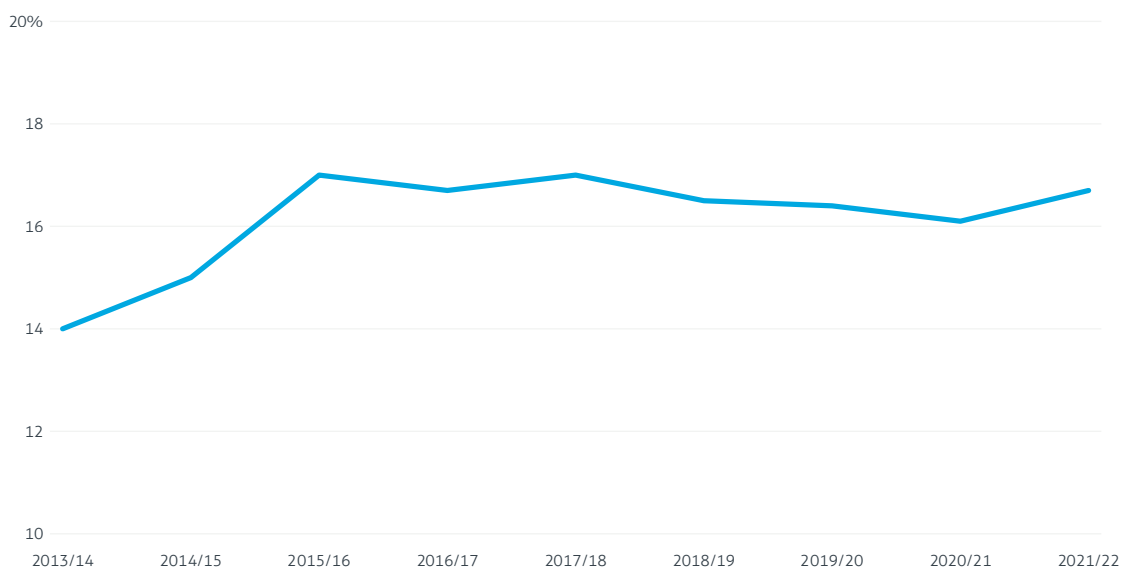
\*\* It remains unclear what is the key driver of this trend. Multiple explanations have been outlined in DfE, 'Drivers of activity in children's social care' research report, May 2022, accessed September 2022, pp. 7–8, 18–24, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1080111/Drivers\\_of\\_Activity\\_in\\_Children\\_s\\_Social\\_Care.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080111/Drivers_of_Activity_in_Children_s_Social_Care.pdf)

Figure 4.5 **Children’s social workers, full-time equivalent, 2013/14–2021/22**



Source: Institute for Government analysis of DfE, 'Children’s social work workforce' ('Caseloads, absence, vacancies, turnover and agency workers' table), reporting year 2021, supported by CIPFA. Notes: Following a methodology change comparable figures are not available before 2013/14. Figures are as at 30 September of the relevant year.

Figure 4.6 **Social worker vacancies, 2013/14–2021/22**

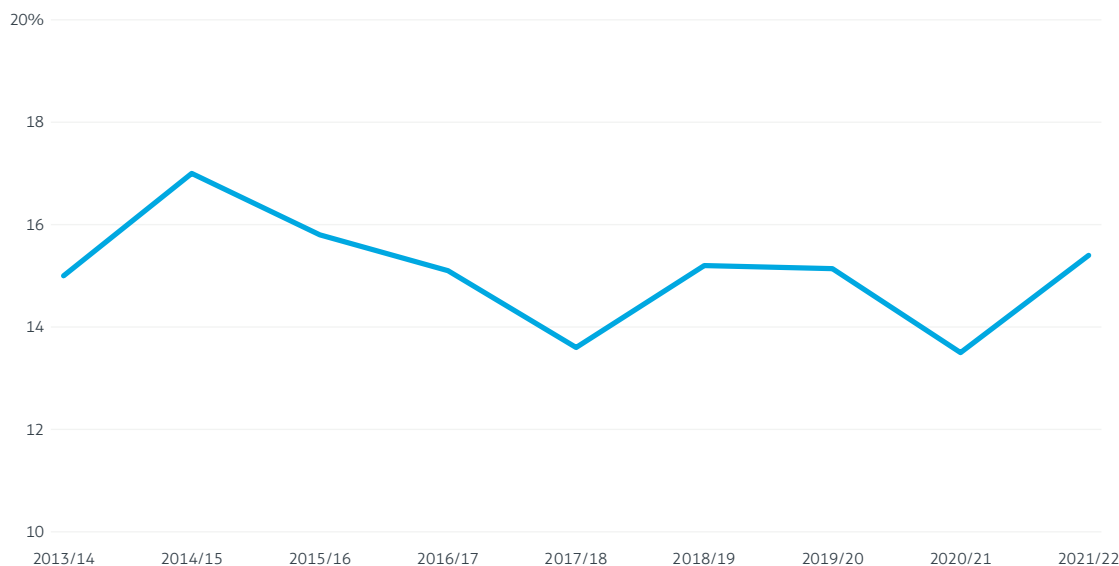


Source: Institute for Government analysis of DfE, 'Social work workforce statistics' ('Caseloads, absence, vacancies, turnover and agency workers' table), reporting year 2021, supported by CIPFA. Notes: Following a methodology change comparable figures are not available before 2013/14. Vacancy numbers are as at 30 September of the relevant year.

As of 2021/22, staff with less than five years’ experience make up 60% of the labour force.<sup>38</sup> While there has been some improvement in the proportion of staff with two to five years’ experience, rising from 27% in 2020/21 to 29% in 2021/22, a relatively high proportion of staff (31%) have under two. This could affect the quality of children’s social care services. As the independent review of children’s social care highlighted in May 2022, social work requires experienced, knowledgeable and skilled workers to make difficult and sensitive decisions.<sup>39</sup> Yet the review noted that social work is often carried out by relatively inexperienced and early career staff who lack the supervision and support to develop skills.<sup>40</sup>

Staff undertook similar volumes of work in 2021 to 2020. However, the average caseload of each social worker remained higher than in 2015, with 16.3 cases per social worker in 2021 compared to 15 in 2015.<sup>41</sup> The 2021 British Association of Social Workers annual survey found increasing workloads were affecting staff wellbeing.<sup>42</sup>

Figure 4.7 **Social worker turnover, 2013/14–2021/22**



Source: Institute for Government analysis of DfE, 'Social work workforce statistics' ('Caseloads, vacancies, turnover and agency workers' table), reporting year 2021, supported by CIPFA. Notes: Following a methodology change comparable figures are not available before 2013/14. Turnover is calculated by dividing the number of leavers during the year by the number of staff on 30 September.

Increasing workload pressures linked to Covid may have contributed to the increase in turnover rate seen in 2021/22, when almost 5,000 (FTE) social work staff left their job, equating to 15.4% of the total workforce.<sup>43</sup> Now, 72% of local authorities report difficulties retaining social workers.<sup>44</sup> Responses to a DfE survey of social workers show high caseloads are an important reason for workers wanting to leave the profession alongside complaints about the culture of local authority social work.<sup>45</sup>

A sustained turnover rate greater than 15% of the workforce since 2013/14 ultimately costs more for local authorities either directly through recruitment costs and higher wages to attract staff or indirectly through higher costs from private providers to fill staffing gaps.<sup>46</sup> Analysis from the Association of Directors of Children's Services (ADCS) shows the percentage of agency workers employed in the workforce increased from 15.6% in June 2021 to 16.7% in June 2022 nationally, but with some local authorities highly dependent on agency workers.<sup>47</sup> ADCS analysis also shows a marked increase in the hiring of agency staff on a team rather than individual basis, which gives local authorities less flexibility and further raises costs.<sup>48</sup> Combined, these factors have led to council spending on agency workers increasing by 38% over five years.<sup>49</sup> The impact of problems recruiting and retaining care staff and foster carers was also cited as a problem for social care quality in the recent Competition and Markets Authority investigation.<sup>50</sup>



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## Social work practices changed during the height of the pandemic but have largely returned to normal

In autumn 2021, we reported that the pandemic had led to increased use of remote working tools while face-to-face contact was restricted. In general, regular face-to-face services resumed as restrictions were lifted, though some local authorities continued to use new technologies like WhatsApp to stay in contact with children.<sup>51</sup> Some councils also prepared contingency plans for how to best prioritise work in response to the Omicron wave in December 2021.<sup>52</sup>

## Many local authorities need to improve the quality of children's social care

The lifting of Covid protection measures saw the return to regular Ofsted inspections from 12 April 2021 (for part of the year), which meant a snapshot of service performance can be provided for some local authorities as they exited the pandemic. Of the 23 inspection reports published for 2021/22 over half were judged as outstanding or good (57%). Ten of the authorities improved their judgment, while four declined and seven stayed at the same grade.<sup>\*,53</sup> As of December 2022, 84 authorities are rated good or outstanding (55%), 49 are rated as requiring improvement (32%) and 17 rated as inadequate (11%) – though many of these ratings are based on assessments that predate the pandemic.<sup>\*\*,54</sup>

The independent review of children's social care has called for a radical change in services to make them more responsive, respectful and effective.<sup>55</sup> This includes changes to working practices and processes, as well as reform of the children's social care market.<sup>56</sup> Echoing similar calls from the children's commissioner,<sup>57</sup> it also called for children's voices to be better heard when decisions are made on their care packages.<sup>58</sup> Local authorities would need more funding to enact all these recommendations. The government launched its response in February 2023, outlining ambitions for change in the sector and opening several consultations.<sup>59</sup> While broadly welcomed by the sector,<sup>60</sup> it has been criticised for the scale and pace of change,<sup>61</sup> and for providing only 20% of the funding called for by the independent review.<sup>62</sup>

## The number of registered serious incidents has reversed from its mid-pandemic high

Local authorities monitor and notify Ofsted when a child who was known to be at risk has later died or come to harm using serious incident notifications. In 2021/22 there were fewer than 450 of these, compared to more than 500 in 2020/21.<sup>63</sup> However, it is too early to judge whether the decline in 2021/22 reflects a permanent reduction in comparison to the first year of the pandemic or whether the number will rise again in future years.<sup>64</sup>

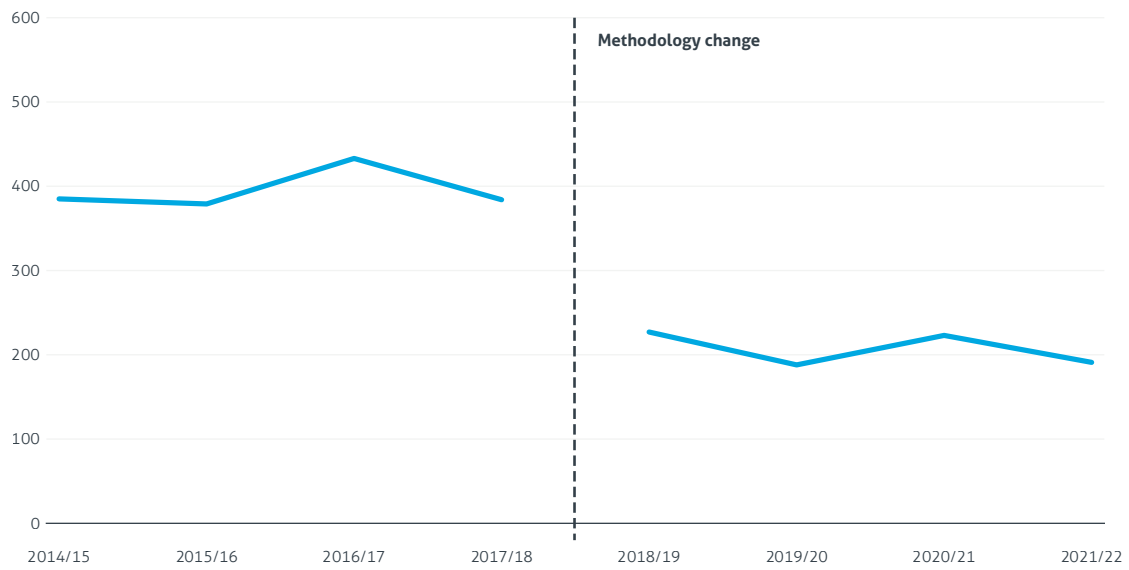
Following the tragic deaths of Arthur Labinjo-Hughes and Star Hobson a national inquiry recommended the need for dedicated multi-agency teams for every local area.<sup>65,66</sup> If implemented, this might help to reduce the number of these incidents.

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\* A further two authorities were assessed for the first time.

\*\* A further two authorities have yet to be assessed.

Figure 4.8 **Serious incident notifications, 2014/15–2021/22**



Source: Institute for Government analysis of DfE, 'Serious incident notifications' ('All year totals' table) 2021/22, supported by CIPFA. Notes: Data was available from 2014/15 onwards. The notification criteria for local authorities to report serious incidents changed in July 2018.

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## 5. Neighbourhood services

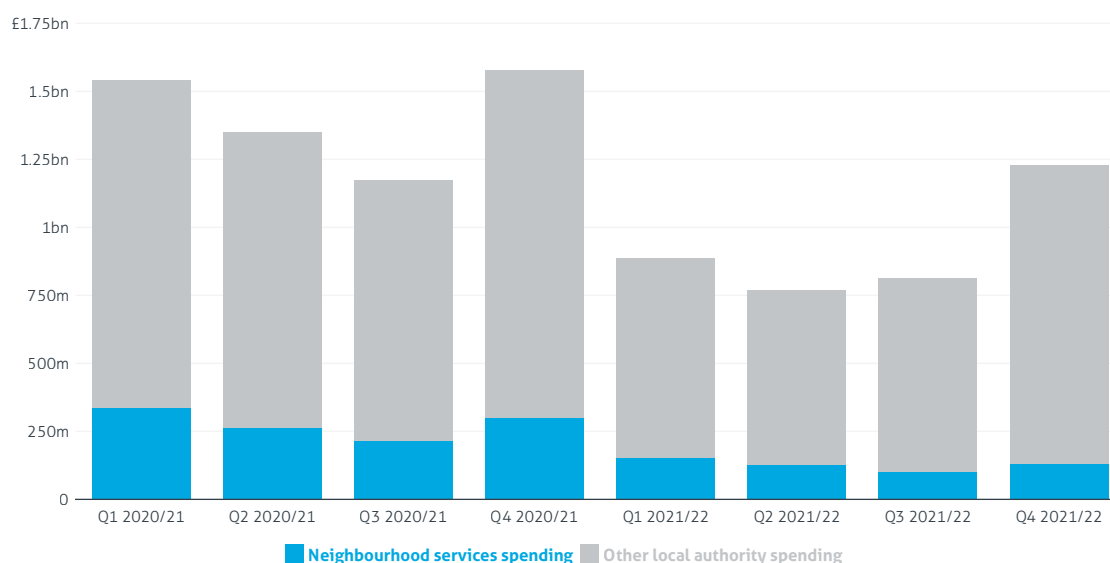
Local authorities were increasingly stretched even before the pandemic began. The previous decade had seen successive central governments cut their grant funding, while demand for adult and children's social care – among other statutory duties such as homelessness services – continued to rise. These pressures forced councils to make tough decisions about which services they should prioritise and – more commonly – which they should scale back.<sup>1</sup> Neighbourhood services – food safety, health and safety, trading standards, libraries, planning, road maintenance, and waste collection and disposal – consequently entered the pandemic with radically reduced or changed amenities.

The effects of Covid restrictions on demand for neighbourhood services varied widely. Some – such as food safety, health and safety, and trading standards, which we refer to collectively as regulatory services – had to cease almost all activity due to social distancing rules and redeployment of staff to support authorities' Covid response. Others – for example, libraries – continued to operate, though using novel or previously under-utilised means. Others still, such as waste collection and planning, saw increased demand.

Looking ahead, neighbourhood services face several problems – and have some opportunities. There are backlogs in some services – such as planning and regulatory services – and others will now capitalise on Covid-era innovations to expand service provision. The cost of living crisis will also threaten the financial sustainability of local authorities; councils are already reporting worsening recruitment and retention of staff as they struggle to compete with the wages offered by private sector employers.<sup>2</sup>

## Local authorities spent £4.9bn on emergency Covid support in 2021/22

Figure 5.1 **Additional Covid spending on neighbourhood services and other local authority-provided services, Q1 2020/21 to Q4 2021/22**



Source: Institute for Government analysis of DLUHC, 'Local authority Covid-19 financial impact monitoring information', rounds 1–20, 'Expenditure due to COVID-19 by service line (£ millions)' (Table 3), supported by CIPFA. Notes: Other local authority spending excludes spending on public health, education services, police, fire and rescue services and foregone savings. See Methodology for full details.

Local authorities spent £3.7 billion on Covid support in 2021/22, down from £5.6bn in 2020/21.<sup>3</sup> This money was spent on a range of local authority-supplied services, such as adult and children's social care, neighbourhood services, housing and central services.\* In addition, local authorities lost income as receipts from business rates, council tax, sales, fees and charges fell. This lost income totalled £1.2bn in 2021/22, down from £5.1bn in 2020/21.<sup>4</sup>

Of the £9.3bn spent by local authorities on emergency support across the two years of the pandemic, £1.6bn was spent on neighbourhood services, with £1.1bn spent in 2020/21 and £512 million in 2021/22.

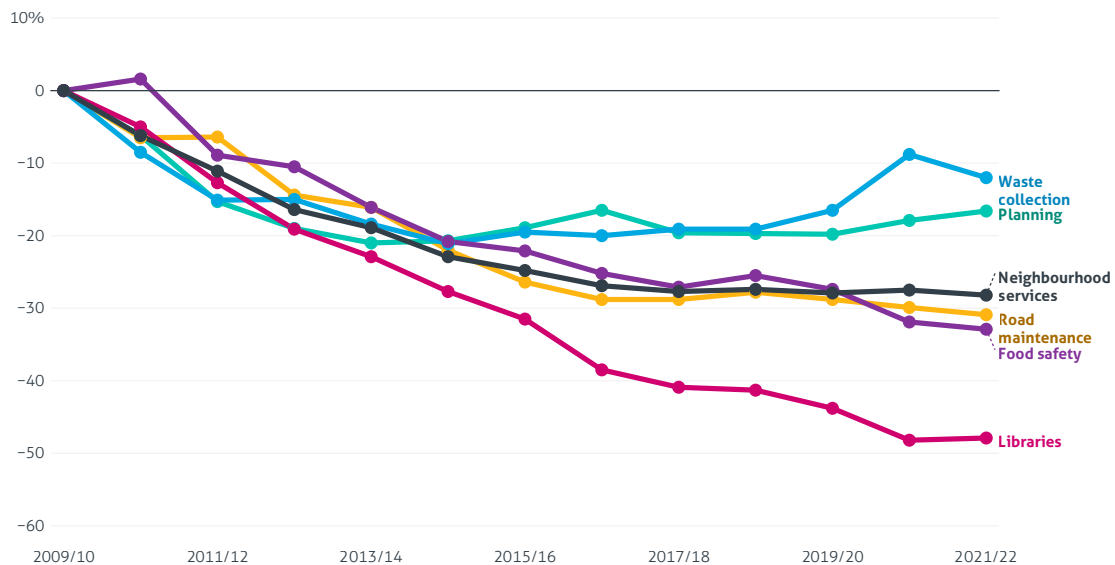
In response to the pandemic, central government provided local authorities with emergency funding that was intended to cover their increased costs and lost income.<sup>5</sup> This support from central to local government totalled £15.2bn across 2020/21 and 2021/22,\*\* with £9.4bn disbursed in 2020/21 and £5.8bn in 2021/22.<sup>6</sup> Some of this funding was earmarked for specific purposes – for example, the Welcome Back Fund allocated £56m for reopening high streets in 2021/22<sup>7</sup> – while central government provided £6.2bn of un-ringfenced funding across the two years, with £1.6bn falling in 2021/22.<sup>8</sup>

\* This excludes spending on education services, public health, and police, fire and rescue services to make these amounts comparable with other spending amounts in this chapter, where we also exclude these same items.

\*\* It should be noted that the amount of funding that central government provided to local authorities does not match the amount that local authorities spent. This is because local authorities also have income from locally raised revenues – council tax, business rates and other income – as well as grants from central government that they would have received in the absence of the pandemic. Any additional money that was left over after emergency Covid spending would also have then been put into reserves, as discussed later in the chapter.

## Spending on neighbourhood services plateaued, but with variation between services

Figure 5.2 Change in local authority spending on neighbourhood services in England since 2009/10 (real terms)



Source: Institute for Government analysis of DLUHC, 'Revenue outturn highways and transport services' and 'Revenue outturn cultural, environmental, regulatory and planning services', 2021/22, supported by CIPFA.

Overall spending on neighbourhood services fell slightly by 1% in real terms between 2020/21 and 2021/22. This continues the trend of relatively flat spending changes since 2017/18. However, spending on neighbourhood services was 28.2% lower in real terms than 2009/10.

The relatively small spending decrease in the last year hides variation between services. The service with the greatest annual decline was waste services, where funding fell by 3.4% in real terms – though spending is still 5.4% higher than pre-pandemic levels, a reflection of the increased volume of activity seen during the pandemic. Waste collection is the service that has seen spending cut least since 2009/10, at only 12% in real terms.

Like waste collection, planning work continued throughout the pandemic with social distancing less of a concern. Indeed, planning spending in 2021/22 is 4% higher in real terms than 2019/20 spending, and saw in-year increases in spending in both 2020/21 and 2021/22.

Other spending areas have yet to fully return to pre-pandemic spending levels. Spending on road maintenance and food safety have fallen for two successive years. And while spending on library services, trading standards, and health and safety increased in 2021/22 these relatively small increases failed to offset the fall in spending seen in 2020/21. With the exception of road maintenance, these are all services that saw declines in activity during the pandemic as a result of social distancing requirements.<sup>9</sup>

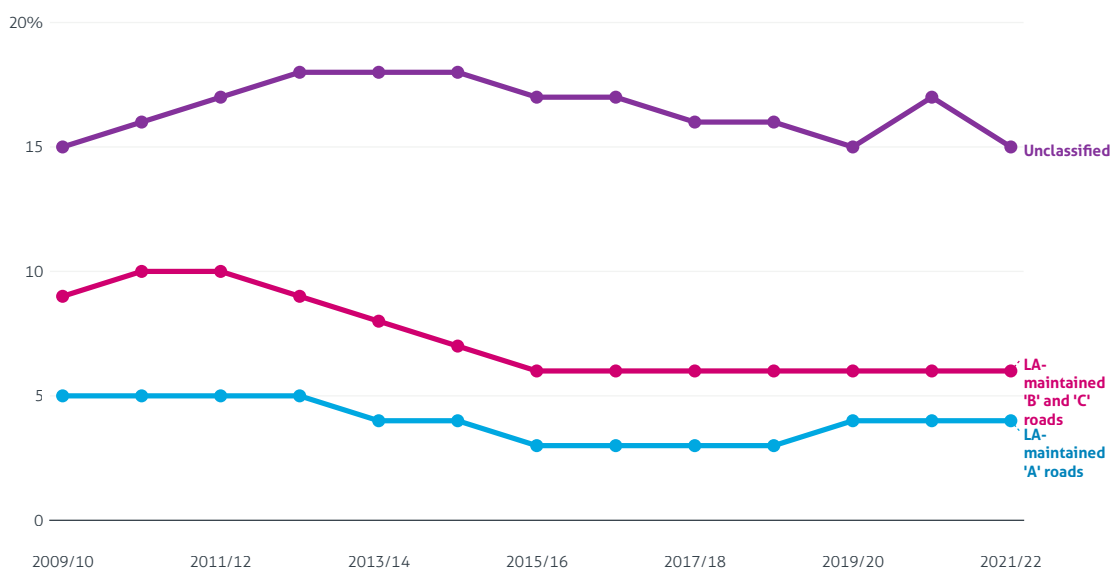
The post-2010 decline in neighbourhood services spending was driven in large part by substantial reductions in grant funding from central government.<sup>10</sup> In response, several councils took advantage of rules allowing them to borrow to invest in commercial properties, in the hope that this would provide a new income stream.<sup>11</sup> In 2022/23, both Croydon and Thurrock issued Section 114 notices – in effect, declaring themselves bankrupt<sup>12</sup> – after large losses on such investments. In Croydon’s case this was the third Section 114 notice in two years. Since 2020/21, eight Section 114 notices have been issued,<sup>13</sup> mostly by councils that have made risky commercial investments.

### Neighbourhood service delivery changed during the pandemic

The pandemic forced local authorities to deliver neighbourhood services differently. Social distancing requirements made it difficult for many services to operate as normal, with some moving their delivery online. In those services that ran a reduced service, local authorities redeployed many of the staff to Covid enforcement roles.<sup>14</sup>

Libraries responded to the pandemic by making many of their services virtual and also expanded the range of services they provided.<sup>15</sup> In addition to the more typical library duties, library staff also supported the community through programmes such as ‘Keep in touch’ (KIT), in which library staff telephoned vulnerable people in the local community to help combat loneliness.<sup>16</sup>

Figure 5.3 Roads in need of maintenance by type, 2009/10–2021/21

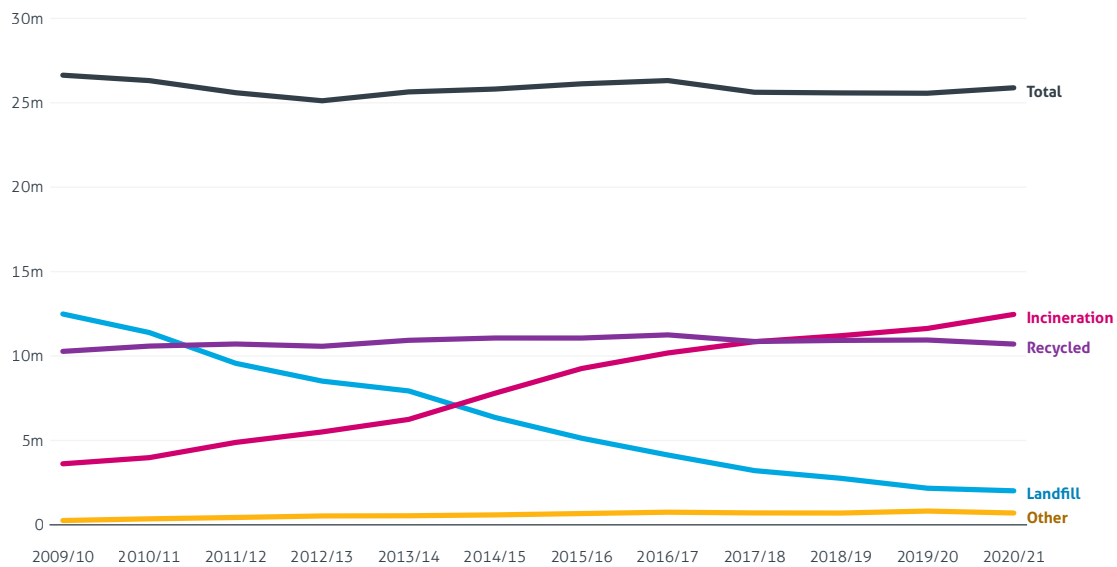


Source: Institute for Government analysis of DfT, ‘Local authority managed classified/unclassified roads where maintenance should be considered’ (‘RDC0120’ and ‘RDC0130’ tables), 2021/22, supported by CIPFA.

With quieter roads and an outdoors working environment, some local authorities reported increasing road maintenance activity during the pandemic,<sup>17</sup> though this did not result in an improvement in the proportion of local authority-maintained roads recorded as in need of maintenance.

There was increased demand for waste collection during the pandemic. The kilograms of waste collected per person from homes increased from 392 in 2019/20 to 406 in 2020/21<sup>18</sup> – a 3.6% rise – as more people stayed at home.<sup>19</sup> How that waste was disposed of also changed. The proportion of household waste that was sent for recycling declined from 42.8% in 2019/20 to 41.4% in 2020/21 – the lowest level since 2011/12. The year 2020/21 was also the fourth in a row when incineration exceeded recycling as the most used method of waste disposal; 48.1% of waste being incinerated. This result also meant that the government missed its target to recycle 50% of household waste by 2020.<sup>20</sup>

Figure 5.4 **Tonnes of waste disposed of by local authorities, by method, 2009/10–2020/21**



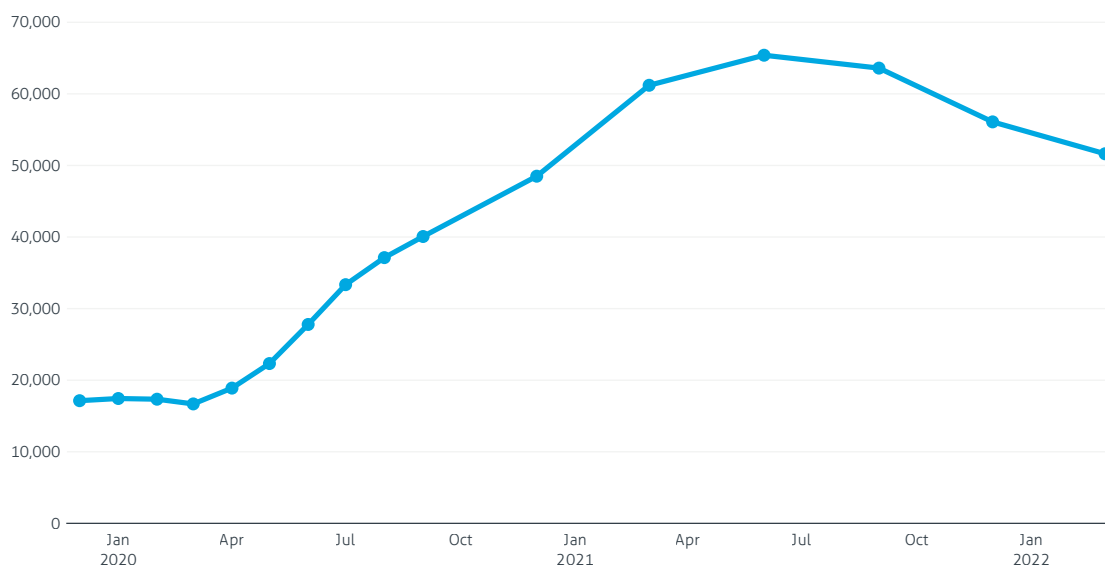
Source: Institute for Government analysis of Defra, 'ENV18: Local authority collected waste generation from April 2000 to March 2021 (England and regions) and local authority data April 2020 to March 2021' (Table 1a), supported by CIPFA.

This reduction in the recycling rate occurred for a number of reasons. First, the amount of household waste increased during this time as more people stayed at home during lockdown, stretching recycling resources. It is notable that although the recycling rate declined year-on-year, local authorities recycled slightly more household waste in 2020/21 compared to 2019/20 – 10,077 compared to 10,057 thousand tonnes. Second, local authorities suspended some services during the pandemic. In particular, councils closed household waste and recycling centres (HWRCs) between April and June 2020 – service points that normally make a large contribution to household waste recycling – and reopened them with some restrictions to maintain social distancing. Local authorities also chose to prioritise other services when the pandemic hit, and as a result paused the collection of low-priority garden waste from households.<sup>21</sup> One of the Department for Environment, Food and Rural Affairs' hypotheses for why the proportion of recycling fell is that residents put (heavy) garden waste into residual bins following the suspension of garden waste services, increasing the tonnage of residual waste and consequently decreasing the proportion of recycled waste.<sup>22</sup>

## Lockdowns caused backlogs in some neighbourhood services

Social distancing requirements, a reduced workload as pubs and restaurants closed, and the need to enforce Covid regulations<sup>23</sup> meant that local authorities stopped normal patterns of compliance work in areas such as food safety, health and safety, and trading standards.

Figure 5.5 **Businesses awaiting a food inspection, December 2019 to March 2022**



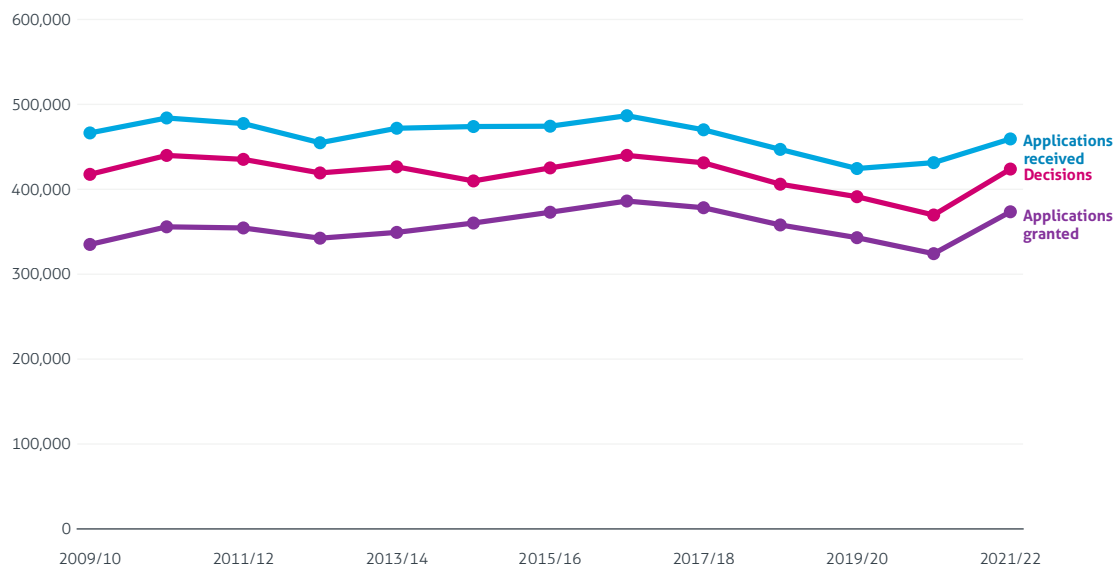
Source: Institute for Government analysis of FSA, Performance and Resources reports, June 2022, supported by CIPFA. Notes: Data moved from being reported monthly to quarterly after September 2020.

This reduction in activity created a backlog of food safety inspection, though local authorities are making progress reducing this. The Food Standards Authority (FSA) reports that the number of food businesses awaiting inspection in England at the end of March 2022 was 51,633,<sup>24</sup> down from a high of 65,400 at the end of June 2021<sup>25</sup> – a 21.1% reduction in nine months – though this is still 201.2% higher than the 17,343 businesses awaiting inspection in February 2020.<sup>26</sup> Local authorities are making this progress by following the FSA's Covid recovery plan, which recommends prioritising high-risk and non-compliant establishments while implementing an "intelligence-based" approach for low-risk establishments – in other words, not conducting unnecessary inspections of compliant establishments.<sup>27</sup> A return to normal staffing patterns after Covid has also helped this. In March 2021, only 43.4% of food hygiene and food standards staff were available to carry out food controls. This increased to 82.4% by October 2021 and 88.7% by March 2022.<sup>28</sup>

Trading standards has not accumulated a backlog in activity in the same way that food work has, as it does not involve the same levels of programmed inspections, but it is still under pressure. The Chartered Trading Standards Institute has warned of a possible boom in fraud as criminals take advantage of consumers struggling with the cost of living crisis and an understaffed trading standards workforce.<sup>29</sup>



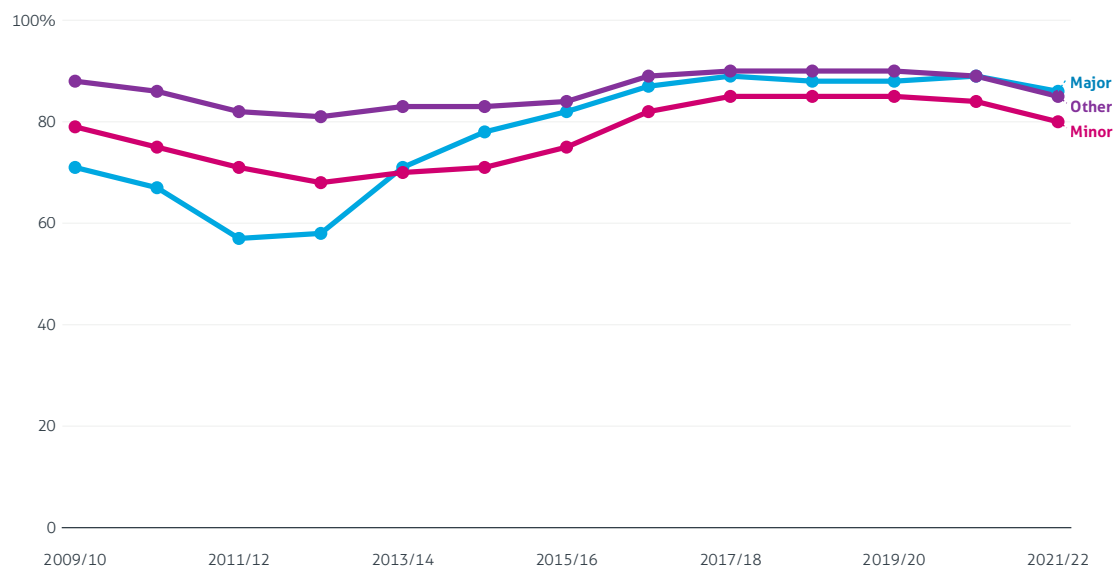
Figure 5.6 **Planning applications received by local authorities, decisions made and applications granted, 2009/10–2021/22**



Source: Institute for Government analysis of DLUHC, 'District planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England' ('Table P120'), 2021/22, supported by CIPFA.

Planning departments are also struggling with their own backlog. The number of planning applications received increased for the second year in a row in 2021/22, up to 459,331 from 431,396 in 2020/21 – a 6.5% year-on-year increase and the highest number of applications since 2017/18. There were a number of reasons for this increase. First, people spent more time at home during lockdown and wanted to improve their properties.<sup>30</sup> Second, in the absence of other usual spending on things such as going out, travel or holidays, households had more disposable income, which they chose to spend on home improvement.<sup>31</sup> Potential demand during 2021/22 may indeed be higher than this as staffing and materials shortages delay some projects.<sup>32</sup>

Figure 5.7 **Planning applications decided within agreed time limit, by type, 2009/10–2021/22**



Source: Institute for Government analysis of DLUHC, 'District planning authorities – planning applications received, decided, granted, performance agreements and speed of decisions, England' ('Table P120'), 2021/22, supported by CIPFA. Notes: Major decisions have a standard target of 13 weeks and minor decisions have a target of eight weeks.

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Rising applications requires an increase in the number of responses. The number of decisions increased faster than applications between 2020/21 and 2021/22, rising 14.6% from 369,718 to 423,831. The speed of responding to applications, however, fell in 2021/22 across all three types of planning applications. The proportion of major, minor and other applications that local authorities decided within the agreed time limit fell by 3, 5 and 4 percentage points respectively. This decline is driven by a few factors. First, there is a lack of resource within local authorities<sup>33</sup> that predates the pandemic.<sup>34</sup> Cuts to local authority budgets since 2010 have resulted in fewer planning officers, who are now struggling to deal with the Covid-induced backlog. Second, retention of planning officers has worsened over the pandemic as they have faced high workloads and the difficulties of remote working, further slowing response times.<sup>35</sup> Third, local authorities have increasingly prioritised major planning applications – for which they are able to charge a larger fee – as they have been forced to supplement cut budgets with locally raised revenue.<sup>36</sup>

### **Local authorities are struggling with recruitment and retention**

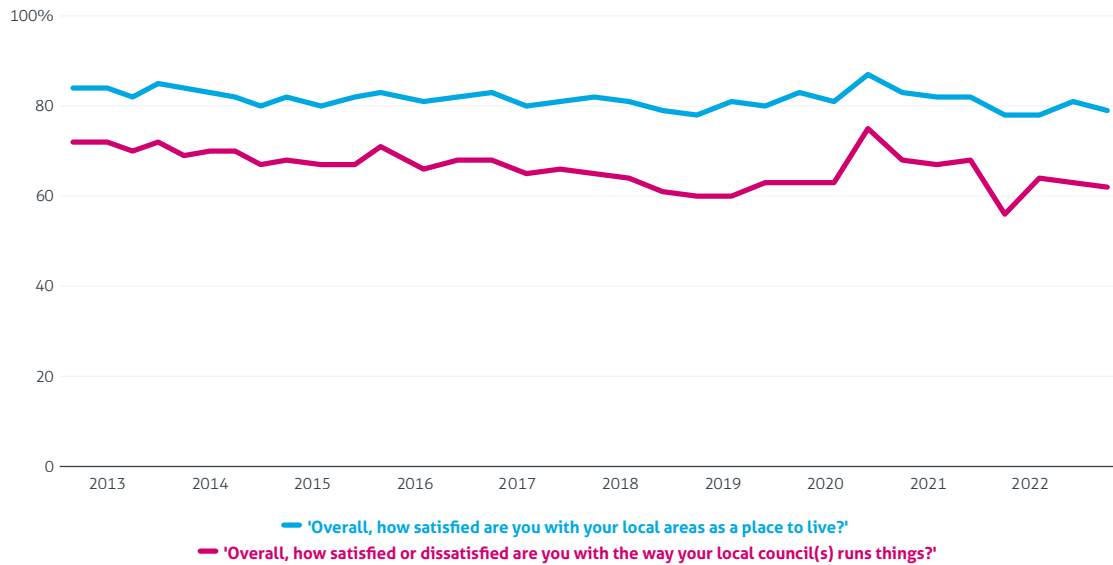
As with many other public services, local authorities are finding it difficult to meet staffing requirements in a tight labour market. In a survey conducted by the Local Government Association (LGA), 94% of councils reported experiencing recruitment and retention difficulties, with 58% struggling to recruit planning officers and 53% having problems finding legal professionals.<sup>37</sup>

Local authorities are struggling to compete with private sector pay and are losing staff because of it.<sup>38</sup> One interviewee from a local authority told us that an employee in their IT department left the organisation for a private sector role where they were paid more than double their local authority salary, with the benefit of working completely remotely.<sup>39</sup> The same interviewee told us that their local authority was struggling to recruit lawyers, accountants and other professionals who all found more competitive pay in the private sector.<sup>40</sup>

Local authorities are using workforce practices from the pandemic to help alleviate some of these pressures. At the height of the pandemic, local authorities deployed staff from areas with workforce capacity to others that needed support.<sup>41,42</sup> One interviewee told us that their council developed a platform for recording workforce capacity and facilitating the movement of staff from one area of the council to another during the pandemic, which they continue to use to ease some of the worst of the workforce crisis.<sup>43</sup>

## Satisfaction with councils remains similar to pre-pandemic levels

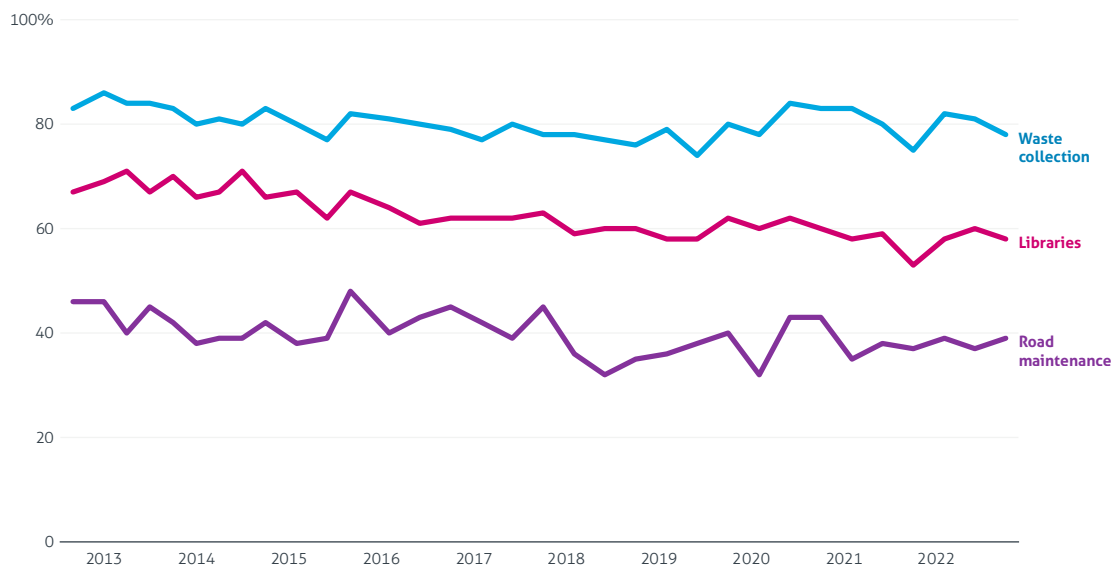
Figure 5.8 Public satisfaction with local area and local council, September 2012 to October 2022



Source: Institute for Government analysis of LGA, 'Polling on resident satisfaction with councils: Round 33 – October 2022' ('Figure 1' and 'Figure 2'), supported by CIPFA. Notes: Time series does not start in 2009/10 because polling was not carried out until 2012.

After a slight dip in the third quarter of 2021, 62% of residents were either very or fairly satisfied with their local council in October 2022, close to figures three years earlier.<sup>44</sup> Likewise, public satisfaction with their local area was at 79% in October 2022, compared to 80% in June 2019.<sup>45</sup>

Figure 5.9 Public satisfaction with neighbourhood services, September 2012 to October 2022



Source: Institute for Government analysis of LGA, 'Polling on resident satisfaction with councils: Round 33 – June 2022' ('Figure 12'), supported by CIPFA. Notes: Time series does not start in 2009/10 because polling was not carried out until 2012.

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Roughly the same trend occurred for road maintenance. In October 2019, 40% of residents were either very or fairly satisfied with the service. This then fell only slightly to 39% in October 2022. In the other two services for which there is data – waste collection and libraries – satisfaction fell more sharply from 80% to 78% and from 62% to 58% in that same period, but in both cases, these are comparable to earlier scores from 2019.<sup>46</sup>

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## 6. Schools

The closure of schools during the pandemic was one of the starkest examples of public service disruption wrought by Covid, with in-person teaching not offered for most pupils for more than a quarter of the 2019–20 and 2020–21 academic years combined.<sup>\*,1</sup> Schools are now attempting to make up for the learning lost during this time.

But while the schools system has received relatively generous increases in recent government spending settlements, schools are having to cope with a range of extra demands on them, teacher training numbers are at crisis levels and strike action over pay is disrupting learning.

This chapter focuses on mainstream, state-funded schools in England serving pupils aged 5–16. It covers both local authority-maintained schools and academies but, unless otherwise stated, excludes special schools, alternative provision (schooling for those who cannot receive their education in mainstream schools, for example because of exclusion), early-years and post-16 education.

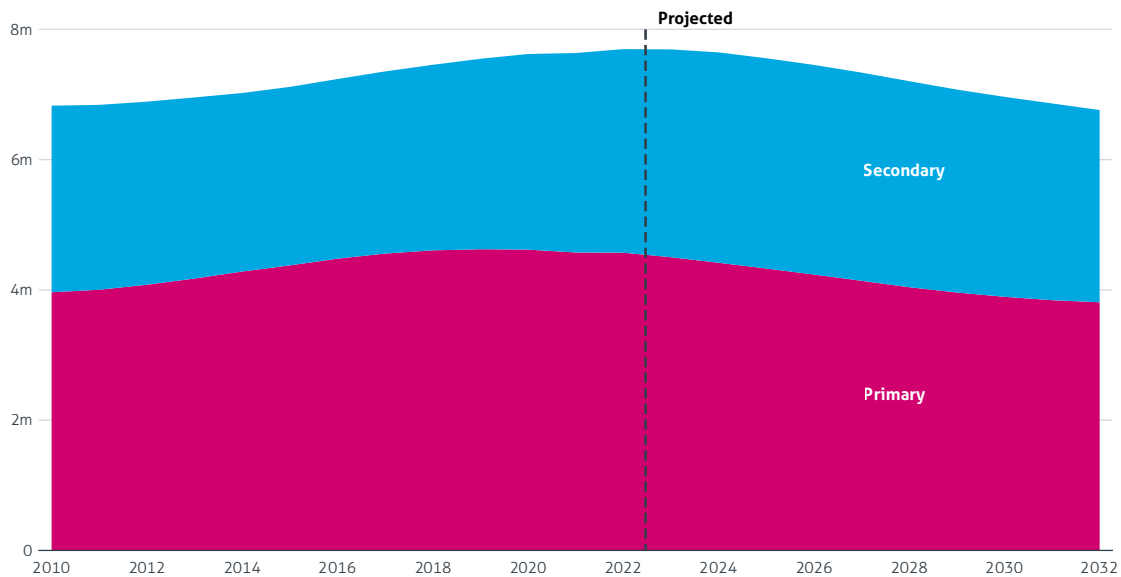
### **Demands on schools have increased**

Pupil numbers have been increasing overall in recent years, with a small decline in the number of primary school pupils being more than offset by an increase in secondary school pupil numbers. The government forecasts that pupil numbers peaked in 2022 and will decline for the next decade.<sup>2</sup>

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\* This chapter refers to both academic school years and financial years. We refer to school years as 20XX–YY, and financial years as 20XX/YY.

Figure 6.1 Pupils in state-funded schools, actual and projected, 2010–2032



Source: Institute for Government analysis of DfE, 'National pupil projections: July 2022', supported by CIPFA. Notes: Figures are as at January of the given year.

Other demands on schools have also increased. There has been a huge rise in the number of children who require a higher level of special educational needs and disabilities (SEND) support. Since 2016, the number of pupils with an education, health and care plan, which sets out specific support a child requires, has increased from 237,000 to 356,000. Around half of these pupils are in state-funded mainstream primary and secondary schools.<sup>3</sup>

Many schools are also finding that they are having to do more than in 2010/11 to make up for reduced local authority services and stretched children and young people's mental health services.<sup>4</sup> Reporting suggests most local authorities that previously offered educational psychologists to schools for free now charge for the service.<sup>5</sup> And in a pre-pandemic survey by the National Foundation for Educational Research, more than half of secondary school leaders said that their school had contracted external specialists to deliver mental health and wellbeing services.<sup>6</sup>

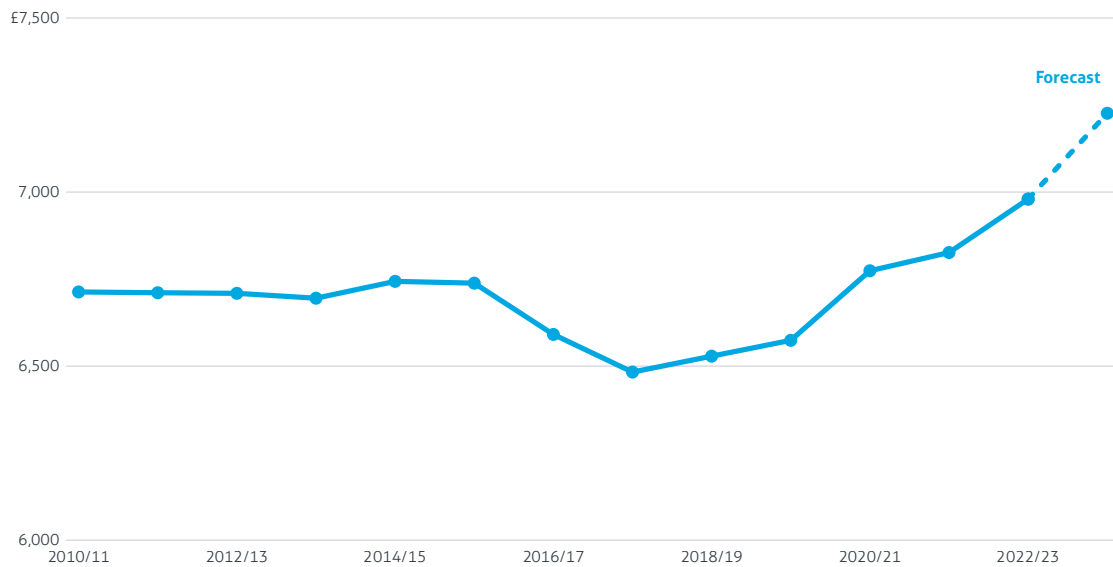
### Overall per-pupil funding has increased but funding reforms saw real-terms cuts for some schools in deprived areas

In the 2022 autumn statement the schools budget received a generous settlement, with £2.3 billion of extra funding in both 2023/24 and 2024/25.<sup>7</sup> This follows additional money being made available in the 2019 spending round and the 2021 spending review.<sup>8,9</sup> While high inflation has eroded some of these earlier funding increases, they were great enough to mean that per-pupil funding has been above 2010/11 levels since 2020/21, with funding forecast to reach its highest level yet, of £6,892 per pupil, in 2023/24.<sup>\*,10</sup>

\* These figures cover both mainstream and non-mainstream schools, and exclude specific Covid funding.

It should be noted that, including school sixth-forms (outside of the scope of this chapter, but where there were greater funding cuts in the years after 2010 than in 5–16 education) and accounting only for general, economy-wide inflation, the Institute for Fiscal Studies forecasts that school spending per pupil will return to 2010/11 levels only in 2024/25.<sup>11</sup>

Figure 6.2 **Per-pupil funding for state-funded schools, 2010/11–2023/24 (2022/23 prices)**



Source: Institute for Government analysis of DfE, 'School funding statistics: Financial year 2022–23', supported by CIPFA. Notes: Comparable figures are available only from 2010/11. Figures cover major revenue funding streams, but exclude some smaller elements of revenue funding and specific Covid-19 funding. Figures cover both mainstream and non-mainstream schools. See Methodology for details of how figures have been put into 2022/23 terms.

While per-pupil funding has increased on average, the experience of individual schools varies. The government introduced a national funding formula in 2018/19 to address discrepancies in funding that schools in different parts of the country received.<sup>12</sup>

Schools serving more deprived communities still get more funding than those in less deprived ones. But analysis by the National Audit Office found that between 2017/18 and 2020/21 most London boroughs saw real-terms decreases in per-pupil funding, as did cities with relatively high levels of deprivation such as Nottingham and Birmingham. Conversely, local authorities with lower levels of deprivation in the South West, the East Midlands and the South East received real-terms increases. The main reasons for this were that the national funding formula newly took into account changes in the relative deprivation of places such as London and included minimum per-pupil funding that benefited some parts of the country more than others.<sup>13</sup>

\* The national funding formula currently operates in a form in which funding allocations set by the Department for Education can be revised at local authority level. Implementation of a 'direct' national funding formula, without substantial local adjustment, may not be complete until 2027/28. (Department for Education, *Implementing the Direct National Funding Formula*, government consultation, 7 June 2022, p. 7, [https://consult.education.gov.uk/funding-policy-unit/implementing-the-direct-national-funding-formula/supporting\\_documents/Implementing%20the%20direct%20national%20funding%20formula%20%20government%20consultation.pdf](https://consult.education.gov.uk/funding-policy-unit/implementing-the-direct-national-funding-formula/supporting_documents/Implementing%20the%20direct%20national%20funding%20formula%20%20government%20consultation.pdf))

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## Higher schools spending reflects increased costs

In 2021/22, £56.8bn was spent on the schools system, including non-mainstream schools, early-years and post-16 – up from £55.4bn the previous year.<sup>14</sup>

Increased spending by schools reflects extra costs. One area where spending has increased considerably in recent years is high needs – support for SEND pupils, as well as spending on alternative provision. As noted above, there has been a big increase in the number of children with education, health and care plans. Since 2017/18, the earliest year for which comparable figures exist, high needs funding has increased by 41.8%, from £5.3bn to £7.6bn.<sup>15,16,17,18</sup> (For comparison, general funding to schools through the national funding formula has increased by only 17.8% over the same period.) In early 2022 the government published a SEND green paper that aimed to standardise SEND provision nationally and improve early intervention. If implemented, the proposals may have the effect of controlling SEND costs to some extent – but the government is likely to face opposition from parents given they would also reduce their freedom in picking a school for their child.<sup>19,20</sup> The government is expected to announce its plans for SEND reform by the end of February 2023.

Staff costs, which account for around 80% of school spending, have also been subject to several exceptional increases in recent years.<sup>21</sup> The employers' contribution rate for teacher pensions increased from 14.1% to 16.4% in April 2015, then to 23.6% in September 2019.<sup>22,23</sup> Teacher pay increases from September 2022, discussed further below, were expected to average 5.4%, according to Institute for Fiscal Studies calculations.<sup>24</sup>

## The financial position of schools improved in the first year of the pandemic

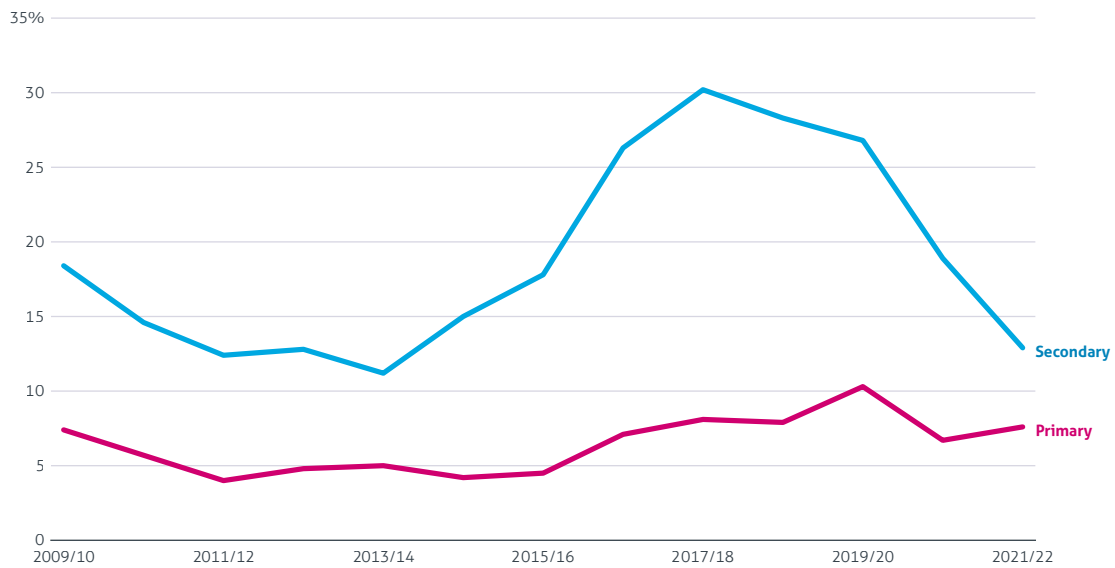
Despite the additional demands noted above, in 2021/22 the percentage of local authority-maintained schools with cumulative negative reserves – a proxy for financial distress\* – was lower than it has been for most of the last half-decade.<sup>25,26,27,28,29,30,31</sup> Reserves improved notably between 2019/20 and 2020/21, which the Department for Education put down to the pandemic, with schools spending less on supply teachers, learning resources and exam fees among other areas.<sup>32</sup> Things improved further for secondary schools in 2021/22, though secondary figures are based on far fewer schools than those for primaries so are more susceptible to larger changes. The Department for Education also says that it has been encouraging local authorities to deal with schools that have large deficits, many of which were secondary schools.<sup>33</sup>

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\* Reserves show the cumulative financial position of schools. If schools record in-year deficits this can ultimately lead to them building up negative reserves – in this situation, local authority-maintained schools are reliant on their local authority supplying additional funding. Academy trusts are reliant on support from the Education and Skills Funding Agency.



Figure 6.3 **Local authority-maintained schools with negative financial reserves, 2009/10–2021/22**



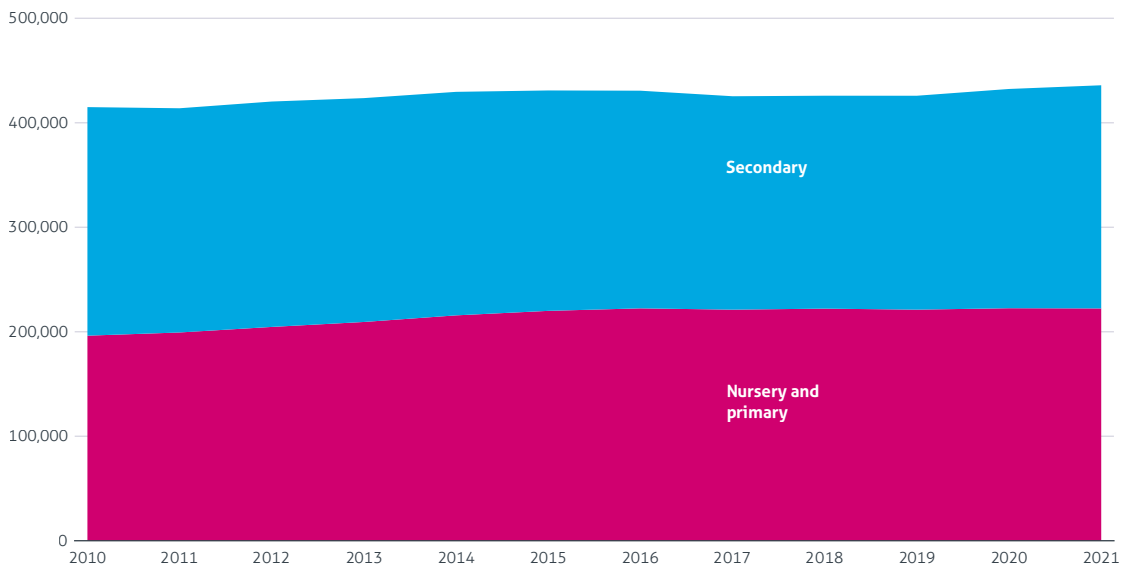
Source: Institute for Government analysis of DfE, 'LA and school expenditure' ('LA maintained schools, revenue reserves' table), 2010–2022, supported by CIPFA. Notes: Figures relate to revenue (day-to-day) spending.

The share of academy trusts with cumulative negative reserves, including those covering non-mainstream schools, also decreased between 2018–19 and 2020–21, from 6% to 2.6%.<sup>34,35</sup>

## Teacher numbers have grown in recent years

Overall teacher numbers have been increasing since 2018. Nursery and primary teacher numbers have been broadly stable, but secondary full-time equivalent employee numbers have increased by 4.8% over that period.<sup>36</sup>

Figure 6.4 **Teachers in state-funded schools, full-time equivalent, 2010–2021**

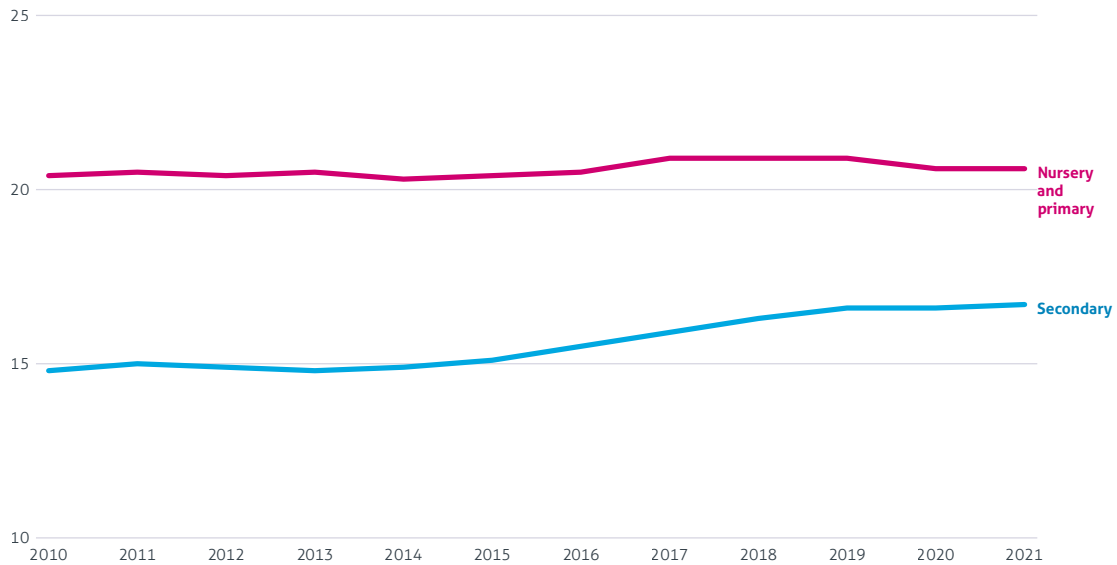


Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting year 2021' ('Teacher and support staff full-time equivalent and headcount numbers' table), supported by CIPFA. Notes: Figures are as of November in the relevant year and include both qualified and unqualified teachers.

\* Academy trusts' financial years are aligned to the academic year, unlike those of local authority-maintained schools.

With the number of younger children decreasing, nursery and primary pupil–teacher ratios have fallen since 2019, while the increase in secondary teacher numbers has been enough to keep secondary pupil–teacher ratios broadly stable, despite a growing number of secondary school pupils.<sup>37</sup>

Figure 6.5 Pupils per teacher in state-funded schools, 2010–2021

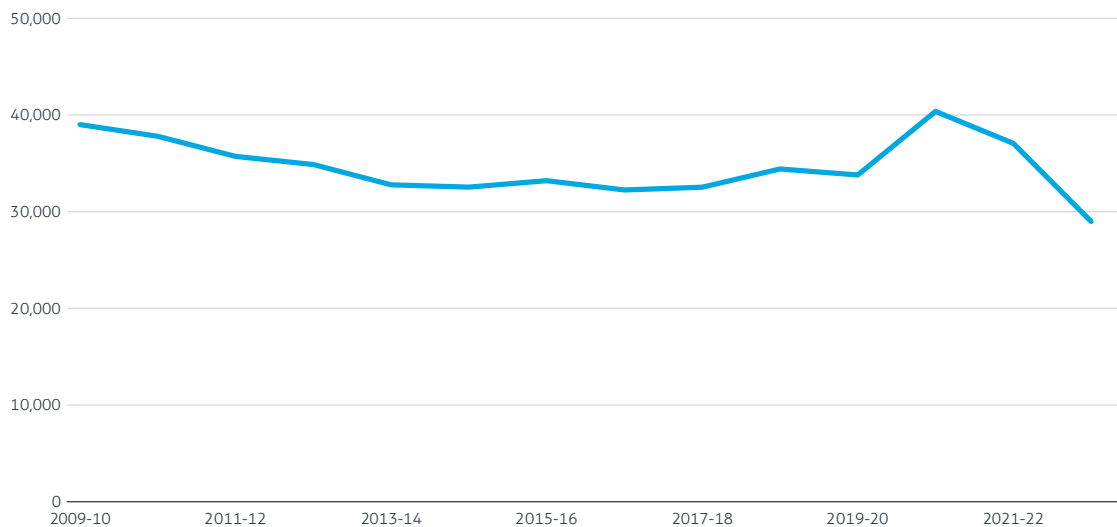


Source: Institute for Government analysis of DfE, 'School workforce in England: Reporting year 2021' ('Pupil to teacher ratios' table), supported by CIPFA. Notes: Ratios are based on teacher numbers in November of the stated year and pupil numbers in the following January. Figures include both qualified and unqualified teachers.

## Teacher training numbers are at crisis levels

As has been observed at other times of economic instability, teacher recruitment was boosted by the pandemic, with more than 40,000 new entrants to initial teacher training in 2020–21 – the highest level since at least 2009–10.<sup>38</sup> Trainee numbers have dropped back starkly since then, however – coming in at only 29,000 in 2022–23.

Figure 6.6 Entrants to initial teacher training, 2009–10 to 2022–23

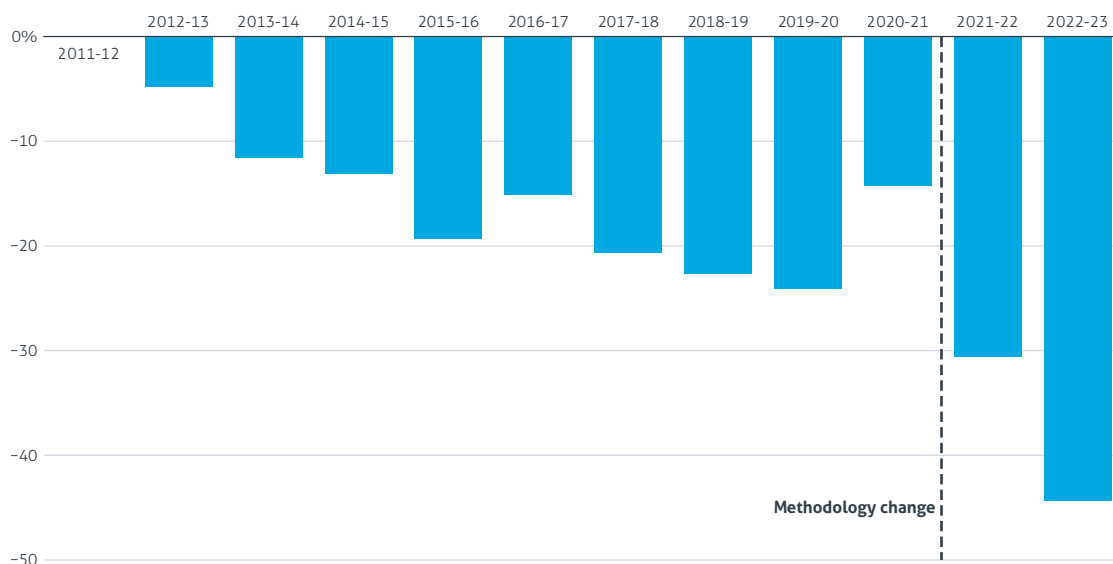


Source: Institute for Government analysis of DfE, 'Initial Teacher Training Census: Academic Year 2022/23' ('ITT new entrants by subject and training route' table), supported by CIPFA.

The picture in individual subjects is even less encouraging. The government sets annual, subject-by-subject initial teacher training recruitment targets, covering postgraduate training, and in many subjects shortages are both severe and persistent.

What we refer to as the ‘underlying shortfall’ in initial teacher training for secondary teachers – the cumulative shortfall across individual subjects, ignoring over-recruitment in other subjects – fell in 2020–21. But it rose again in the two subsequent years, hitting 44.4% in 2022–23 – that is, a shortfall of more than two-fifths versus targets. A change in how the Department for Education calculates subject targets may have contributed to this. The new methodology is, however, intended to give a more accurate picture of whether enough teachers are being trained to meet demand.<sup>39</sup> The performance in some individual subjects is even worse – the target for physics was missed by 83% in 2022–23.

Figure 6.7 **Underlying shortfall in postgraduate initial teacher training recruitment for secondary school teachers, 2011–12 to 2022–23**



Source: Institute for Government analysis of DfE, initial teacher training census ('ITT new entrants and targets by subject time series' table), 2015/16–2022/23, supported by CIPFA. Notes: Underlying shortfall is calculated as the cumulative shortfall across individual subjects, ignoring over-recruitment in other subjects. Comparable figures are not available for 2009–10 and 2010–11. There was no shortfall in 2011–12. Since 2021–22 DfE has taken under-recruitment in the preceding two years into account in setting subject targets.

### Retention rates improved before the pandemic but this is unlikely to persist

Retention rates for teachers in the first two years of their career increased slightly immediately before the pandemic – for those who qualified in 2016, 77.6% were still in teaching in 2018; for those who qualified a year later, 78.3% were in teaching in 2019.<sup>40</sup> This increased further during the pandemic – the two-year retention rate was 82.7% for those qualifying in 2019, the latest cohort for which data is available.

Pay is one factor that affects recruitment and retention, and the government also increased teacher salaries in September 2022 following a one-year pay freeze. This included an increase of 8.9% for the lowest paid qualified teachers as part of plans to reach £30,000 starting salaries for all qualified teachers from September 2023 – one

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year later than initially planned.<sup>41,42,43</sup> But while better pay for those on the lowest salaries may have some effect on retention, it seems highly unlikely that the boost to retention rates during the pandemic will persist.

Overall, teacher pay was expected to increase by an average of 5.4% from September 2022, according to Institute for Fiscal Studies calculations, an increase which schools are required to cover from the funding allocated to them in the 2021 spending review.<sup>44</sup> Members of the National Education Union – the largest education union – have begun strike action over pay, with individual schools affected on four days.<sup>45</sup> Ballots held by NASUWT and headteachers’ union the NAHT failed to meet the required turnout threshold, with both planning to re-ballot their members.<sup>46,47</sup>

## **Pupils have missed large amounts of education, with primary results falling**

Headteachers should prioritise vulnerable pupils, the children of key workers and those in exam years where they do not have enough staff to open fully on strike days, according to newly updated Department for Education guidance.<sup>48</sup> They should also consider providing remote education to those unable to attend in person, the guidance says.

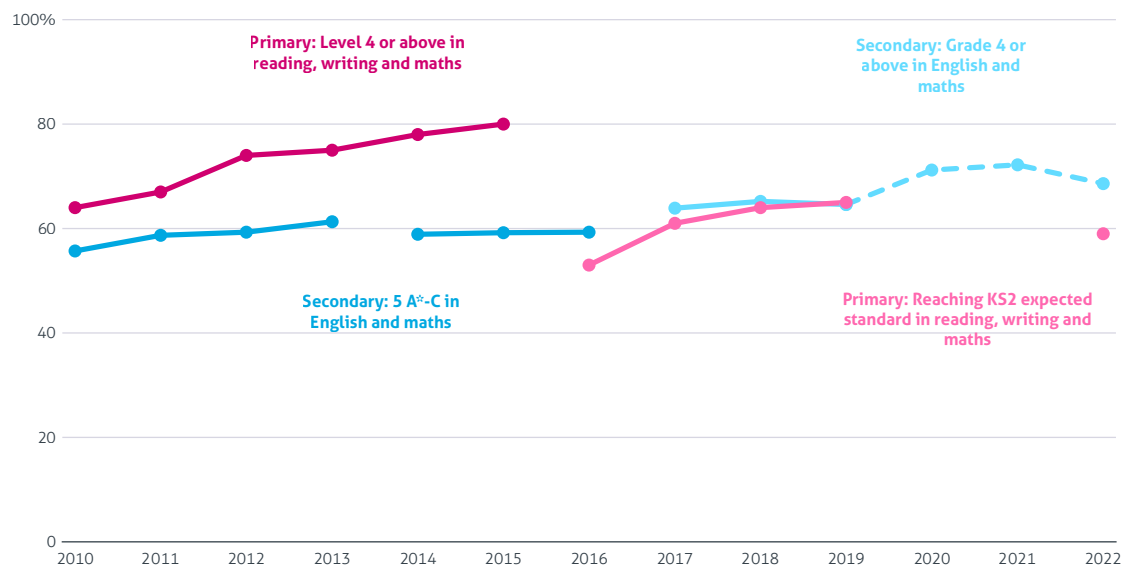
This builds upon steps taken at the height of the Covid pandemic, when in-person teaching was interrupted by national lockdowns over the course of two academic years, with high pupil absence at other times.<sup>49</sup>

Multiple studies have found that as a result of this disruption pupils lost learning during 2019–20 and 2020–21, with disadvantaged pupils particularly badly affected.<sup>50</sup> Available evidence, which has tended to focus on primary school pupils, generally shows that there had been some recovery by summer 2021, but that on average pupils were still behind where previous cohorts had been.

The government cancelled Key Stage 2 assessments, covering pupils at the end of primary school, in 2020 and 2021. Pupils were assessed in 2022, however, with results showing a fall in the percentage of pupils meeting the expected standard in reading, writing and maths from 65% in 2019 to 59% in 2022.<sup>51</sup> Under the two forms of Key Stage 2 assessment that have been in place since 2010, this is the first time that attainment has fallen. This was driven by steep falls in maths and writing attainment, while attainment in reading increased slightly. One hypothesis of researchers is that reading skills were easier for parents to sustain during periods of school closure.<sup>52</sup>

GCSEs and other external assessments were also cancelled for secondary pupils in 2020 and 2021 – with a major backlash in 2020 against plans to use an algorithm to set grades. Grades were set instead by schools and regulators in 2020, and schools in 2021, and were considerably higher than those in previous years.<sup>53</sup> GCSE exams took place in 2022, with results set between pre-pandemic, 2019 levels and 2021 levels.<sup>54</sup> GCSE results are therefore of little value when trying to assess the performance of pupils in recent years. Alternative evidence – the National Reference Test, taken by a sample of pupils at the end of secondary school – found a statistically significant fall in maths attainment from shortly before the pandemic hit in 2020 to 2022, but no statistically significant fall in English language.<sup>55</sup>

Figure 6.8 **Attainment at the end of primary and secondary school in state-funded schools, 2010–2022**



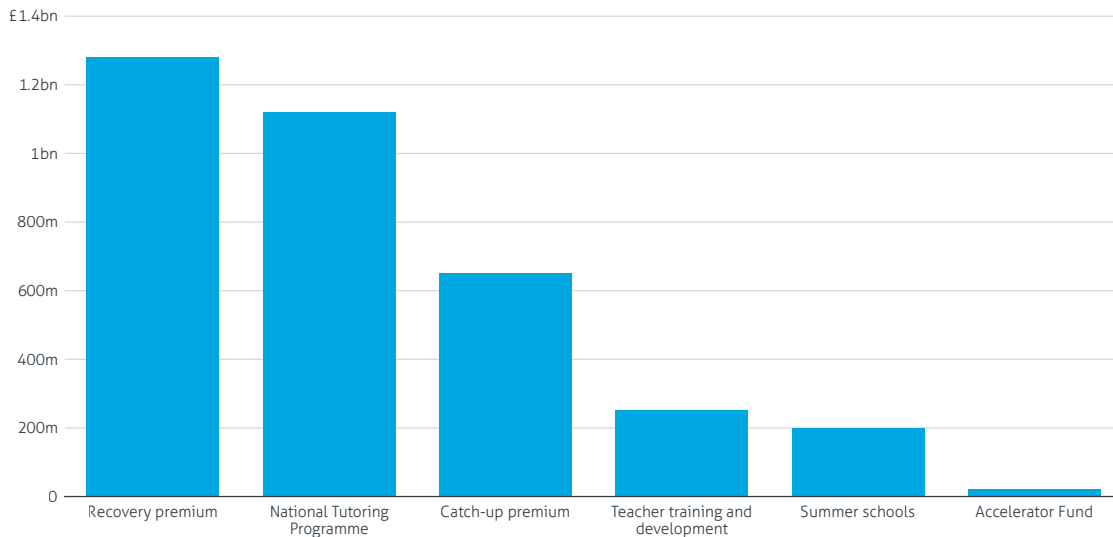
Source: Institute for Government analysis of DfE, Key Stage 2 statistics, 2010–2022; DfE, GCSE and equivalent results (national tables), 2010–2022; supported by CIPFA. Notes: Primary school assessments were reformed between 2015 and 2016. Between 2013 and 2014 a number of changes were made to secondary qualifications. Reformed English and maths GCSEs were awarded for the first time in 2017. In 2020 and 2021, KS2 tests did not take place and GCSE results were awarded on the basis of centre-/teacher-assessment rather than external assessment. Results include those not in mainstream education.

On another measure of school performance, 90% of primary schools and 81% of secondary schools had good or outstanding inspection ratings as of December 2022.<sup>56</sup> This is higher than was the case pre-pandemic, though fewer schools hold an outstanding rating. This follows the removal of an exemption from inspection for schools holding the highest rating in 2020, with most of these schools dropping to a good rating when inspected.

### The National Tutoring Programme is reaching large numbers of pupils but evidence on its effectiveness is limited

Since June 2020 the government has committed £4.9bn for educational catch-up, allocated between the 2020–21 and 2023–24 school years.<sup>57</sup> This is significantly less than the roughly £15bn recommended in 2021 by the government’s education recovery commissioner,<sup>58</sup> and as such is likely to be insufficient to allow schools to fully make up for lost learning. Of the £4.9bn, £3.5bn relates to schools, with the rest relating to early years and 16–19 education. The National Audit Office has estimated that, up to the end of the 2021/22 financial year, there had been a 14% underspend on the available schools funding.<sup>59</sup>

Figure 6.9 Education catch-up funding committed to schools, 2020–21 to 2023–24

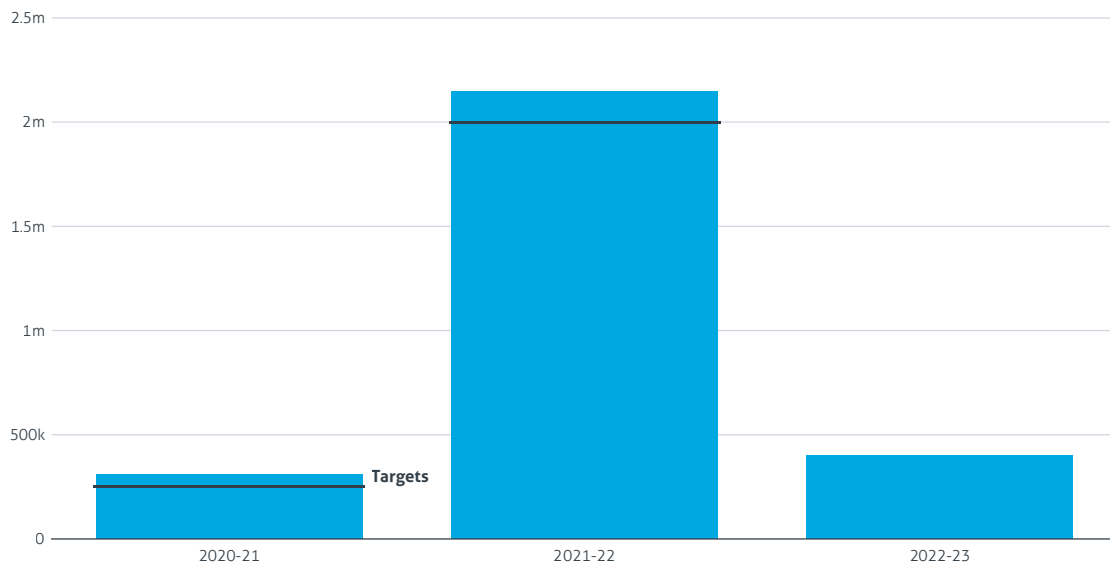


Source: Institute for Government analysis of NAO, 'Education recovery in schools in England' (Figure 1), February 2023, supported by CIPFA. Notes: Catch-up premium and recovery premium are two types of funding supplied to schools with limited conditions attached. The Accelerator Fund is intended to scale up evidence-based literacy and numeracy interventions. Some Covid-19 support isn't included e.g. funding for digital devices.

Two of the main components of this support – catch-up premium and recovery premium – have provided schools with funding for general use, with limited conditions attached.<sup>60,61</sup> The other main component, and the more innovative, is the government's £1.1bn National Tutoring Programme, launched in November 2020.<sup>62</sup>

The government has an overall target of 6 million courses being taken under the National Tutoring Programme by 2024.<sup>63</sup> It does not publish figures on course completions, but an estimated 2.9 million courses had been started as of 6 October 2022, while individual targets for 2020–21 and 2021–22 were reached if estimated starts are again compared to course targets.<sup>64,65,66</sup> No specific target has been published for the 2022–23 academic year, but 0.4 million courses had been started in that year as of 6 October 2022.

Figure 6.10 **Estimated National Tutoring Programme course starts 2020–21 to 2022–23 (as at 6 October 2022)**



Source: Institute for Government analysis of DfE, 'National Tutoring Programme: Academic Year 2022/23', December 2022; targets come from government and NTP announcements; supported by CIPFA. Notes: The 2020–21 target relates to pupils taking a course and the 2021–22 target relates to courses delivered, while performance in both years is shown in terms of course starts. No target has been published for 2022–23, but an overall target of 6 million courses by 2024 exists.

Of the programme's three strands, one in which schools are able to source their own tutors has proved by far the most popular. (In March 2022, recruiting firm Randstad was axed from the contract for future academic years, owing to poor take-up of the two strands it was responsible for.<sup>67</sup>)

An independent evaluation of the second year of the National Tutoring Programme found that 63% of school leaders and teachers who had experienced the programme were satisfied with it, based on a self-selecting sample.<sup>68</sup>

A review was also completed by Ofsted, the schools regulator, based on visits to a sample of 63 schools during the scheme's second year.<sup>69</sup> In more than half the schools, tutoring was judged to be strong, with tutoring in some of the other schools visited having strong features – though in 10 of the schools tutoring was "haphazard and poorly planned". Ofsted also noted that schools generally had not yet developed efficient means of assessing the impact of the tutoring.

# 7. Police

Police work has broadly returned to pre-pandemic patterns, with less focus on non-crime activity such as antisocial behaviour, though this still takes up more police time than a decade ago. Total crime is at historically low levels but the picture over the past year is less clear due to recent methodology changes within police forces.

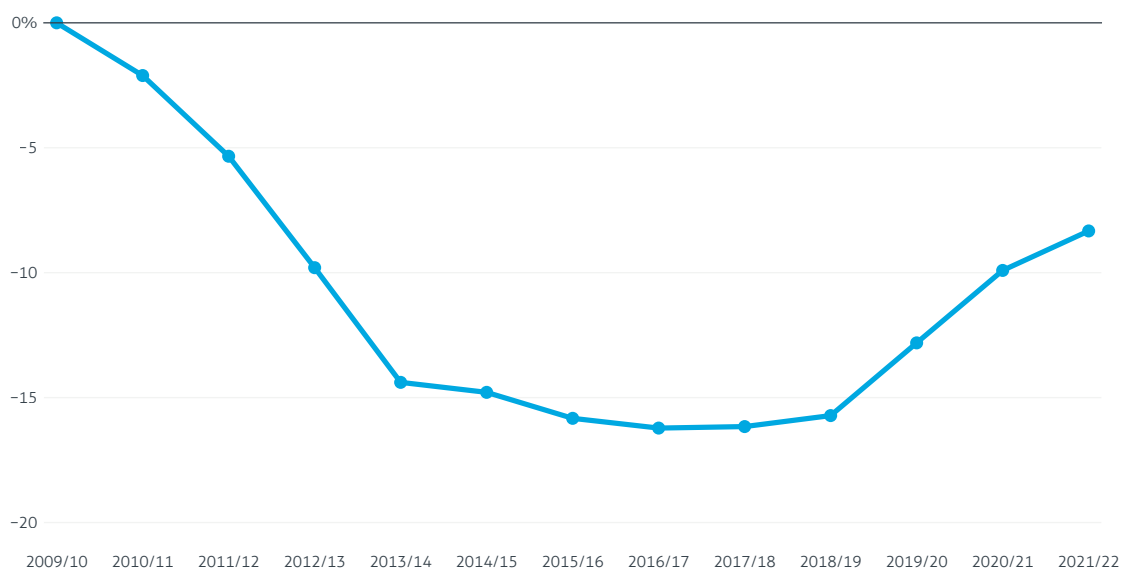
Forces have come under heavy criticism after several scandals, most recently over the convicted sex offender and former police officer David Carrick, which have exposed severe flaws in forces' vetting and misconduct procedures. These have contributed to falling public confidence in the police in recent years.

Forces must continue integrating large numbers of newly recruited officers, the result of the Johnson government's 2019 recruitment drive to add 20,000 officers by March 2023, while managing shortfalls that remain in some localities and key areas such as fraud and investigations. The increase in officer numbers has not yet boosted the proportion of recorded crimes being charged, however, which is at its lowest ever level.

This chapter covers the 43 police forces in England and Wales, as the Home Office is responsible for policing in both nations.

## Police spending has risen in recent years but is still lower than in 2009/10

Figure 7.1 Change in real-terms spending since 2009/10



Source: Institute for Government analysis of DLUHC, 'Local authority revenue expenditure and financing in England: 2021 to 2022 individual local authority data – outturn', R06; StatsWales, 'Revenue outturn expenditure summary', 2009/10–2021/22; supported by CIPFA.



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Most of the funding for policing in England and Wales comes from central government grants, with around a third coming from local taxation through a council tax levy known as the 'police precept'. In 2021/22, £15.75 billion was spent on policing in England and Wales; this was 1.8% more in real terms than in 2020/21.<sup>1</sup>

A large part of this increase came from the government drive to recruit more officers, which increased spending by £700 million in 2020/21,<sup>2</sup> with a further £400m allocated for 2021/22.<sup>3</sup> The government also set aside an additional £58m to support Covid-related costs including overtime, bringing the total additional funding available to the police for Covid to £200m since the start of the pandemic.<sup>4</sup>

### **Policing responsibilities have returned to pre-pandemic patterns**

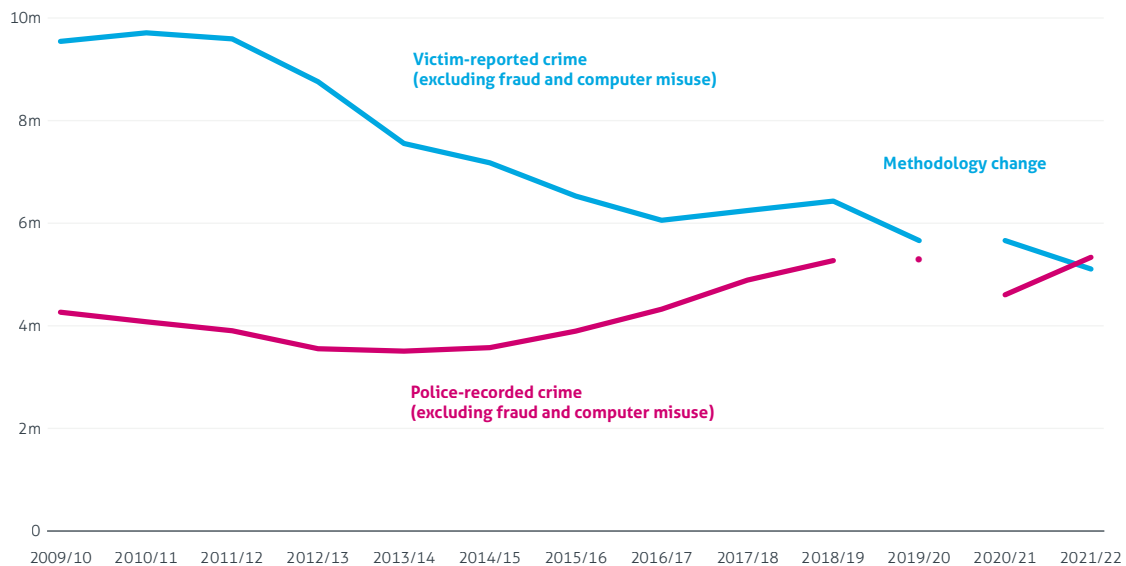
The nature of police work changed during the height of the pandemic, especially during lockdowns. First, there was a dramatic fall in traditional 'volume crimes' such as theft and burglary. Second, police increasingly focused on non-crime activities such as antisocial behaviour and mental health-related incidents, acting as 'the service of last resort' as other front-line services withdrew.<sup>5</sup>

However, neither of these trends was new. For example, while there was a 13.4% fall in recorded incidents of burglary between 2013/14 and 2019/20, there was a 65% increase in the number of missing persons incidents recorded by the police over the same period.<sup>6</sup> But both were accelerated in the first year of the pandemic.

More recently, there is evidence that demands on the police have returned to pre-pandemic levels. Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) noted in May 2022 that while "demand on policing... continues to shift and change, inspectors generally find that practice is back to normal".<sup>7</sup>

## Total crime is at historically low levels but the picture over the past year is unclear

Figure 7.2 Incidents of crime excluding fraud and computer misuse, 2009/10–2021/22



Source: Institute for Government analysis of ONS, 'Crime in England and Wales: Appendix tables' ('Tables A1 and A2'); and ONS, 'Recorded crime data at Police Force Area level', 2009/10–2021/22, supported by CIPFA. Notes: Police-recorded crime figures exclude those from the Greater Manchester police force 2019/20, as following the implementation of a new IT system in July 2019, the force was unable to supply data for the period July 2019 to March 2020. The change in victim-reported crime measurement is detailed in the Methodology chapter.

There are two ways of measuring crime: how many crimes the police record (police-recorded crime) and how many crimes a representative sample of the population report in the Crime Survey for England and Wales (CSEW; victim-reported crime). Fraud data, which was only recently incorporated into the CSEW, is discussed separately below.

The CSEW is a household-based victimisation survey that includes crimes that are not reported to the police and as such is a better indicator of longer-term trends for the crimes it covers.<sup>8</sup> Because of a methodology change the data for 2020/21 and 2021/22 is, however, not directly comparable to pre-pandemic figures. The police-recorded crime figures cover a broader range of crimes, in addition to victim-based crimes, but are heavily influenced by changes in police crime recording practices.<sup>9</sup>

The CSEW shows a sustained long-term decline in crime over the past decade and in the last year. In 2021/22, there were 5,107,000 crimes (excluding fraud), an almost 10% fall on the year before.<sup>10</sup> This was driven by a 12% decline in theft offences over the period. Recent data covering the year to September 2022 shows a 22% decline in these crime types compared to the last comparable pre-pandemic year.<sup>11</sup>

In contrast, after declining during the first year of the pandemic, police-recorded crime (again excluding fraud) rose in 2021/22, with 5,335,806 crimes, 7% more than in 2019/20.<sup>12</sup> We cannot say for certain which data source better reflects crime trends over the past year but it is likely that overall crime (excluding fraud) has fallen

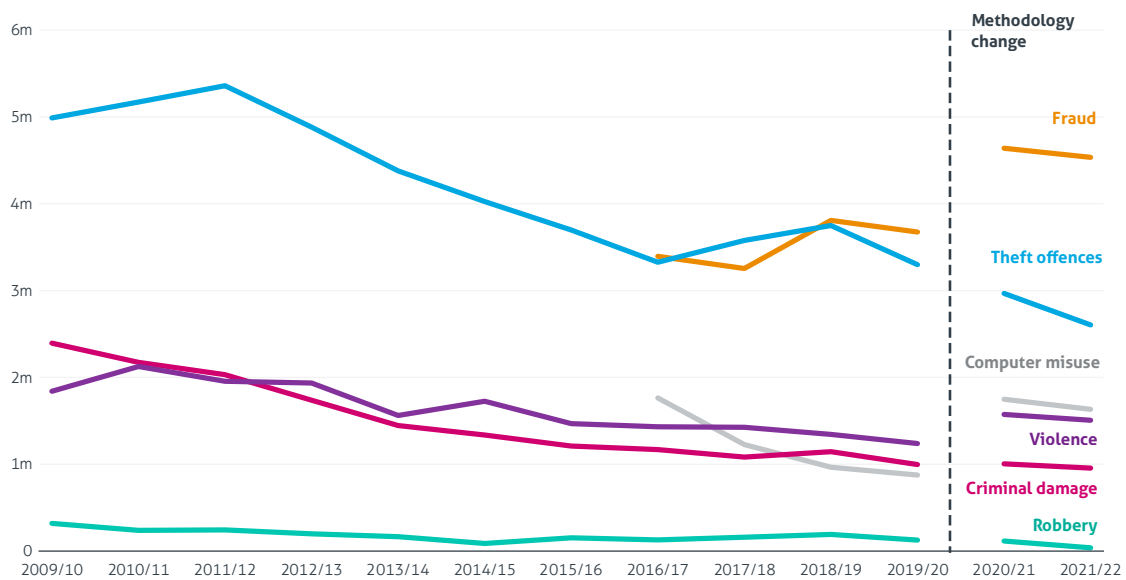
and that the rise in police-recorded crime is largely due to improvements to police recording practices, particularly of crimes reported by professional third parties such as social services.<sup>13</sup>

## Incidents of fraud remain high but fell slightly in 2021/22

Digital technology has transformed the nature of crime. Many crimes have shifted online and are carried out by criminals overseas that are difficult for police forces to reach.<sup>14</sup>

The CSEW started reporting on fraud during 2015/16 and since then levels of fraud and online crimes remain high.<sup>15</sup> The survey identified approximately 4.5 million victim-reported fraud crimes in 2021/22, though this was 100,000 fewer than 2020/21.<sup>16</sup>

Figure 7.3 **Victim-reported crime by type, 2009/10–2021/22**

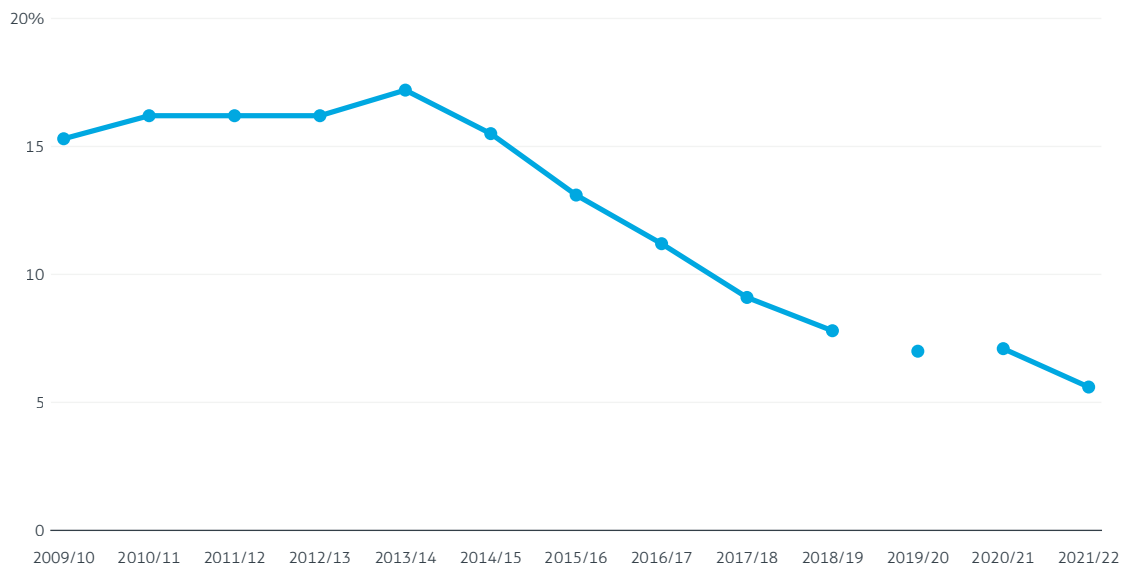


Source: Institute for Government analysis of ONS, 'Crime in England and Wales: Appendix tables' ('Tables A1 and A2'), 2009/10–2021/22, supported by CIPFA. Notes: The Crime Survey for England and Wales has recorded fraud victimisation only since October 2015. The change in victim-reported crime measurement is detailed in the Methodology chapter.

Despite the high levels of fraud and other online crimes, the Police Foundation has criticised the scale of police response, noting from the estimated 4.6 million fraud cases in 2020/21 there were only 4,853 charges or summons over the same period.<sup>17</sup> They also highlighted the digital skills gap in many police forces including areas such as digital forensics and data analysts.<sup>18</sup>

## Charge rates have fallen further

Figure 7.4 Crimes recorded by the police that result in charges, 2009/10–2021/22



Source: Institute for Government analysis of Home Office, 'Crime outcomes in England and Wales' ('Table 2.2'), 2009/10–2021/22, supported by CIPFA. Notes: 2019/20 figures exclude Greater Manchester police force data, as following the implementation of a new IT system in July 2019, the force was unable to supply data for the period July 2019 to March 2020.

Excluding fraud, the proportion of recorded crimes that result in charges rose slightly in 2020/21 but fell to a new low of 6% in 2021/22, continuing the decline since 2014/15.<sup>19</sup> This trend has partly been driven by the increase in volume of crimes recorded (as above), but also the continued fall in the absolute number of charges. These have continually fallen since 2014/15 and fell 12.7% between 2020/21 and 2021/22 (from 417,751 to 364,799).<sup>20</sup> In a highly critical report, HMICFRS attributed low charge rates for burglary, robbery and theft to prioritisation, a lack of capacity, poor digital forensic capability and insufficient supervision.<sup>21</sup>

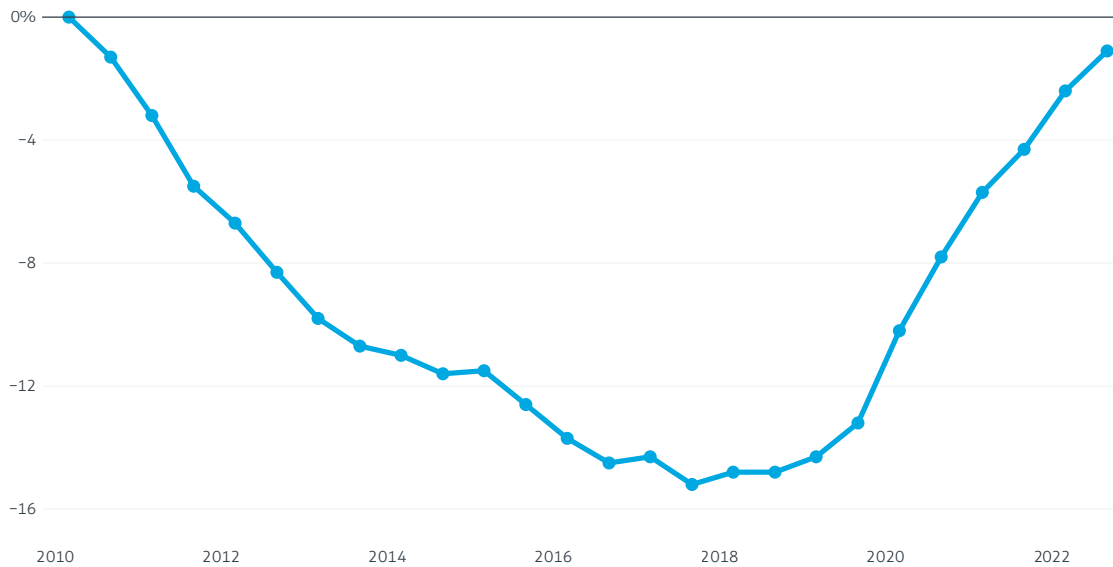
Charging rates have fallen particularly sharply for some types of crime. For example, between 2014/15 and 2021/22 the charge rate for sexual offences, including rape, fell from 11.3% to just 2.9%.<sup>22</sup> The government's end-to-end review of rape in England and Wales described this as "totally unacceptable", and attributed it to complex factors such as increasing levels of digital data requested from victims, a national shortage of detectives and delays in investigative processes.<sup>23</sup> It also called for significantly greater levels of support to victims.<sup>24</sup>

Charging rates for sexual offences increased marginally in the first six months of 2022/23. This may be due to increased attention to sexual offences and efforts (e.g. Operation Soteria<sup>25</sup>) to increase police effectiveness on this crime type. However, we will not know this increase will be sustained until more data is released.

## The number of officers has increased but the government is not on track for its recruitment target

As of September 2022, there were 142,145 full-time officers, 1.1% fewer than March 2010.<sup>26</sup> This is still a sharp increase from the mid-to-late 2010s, after which point the government committed in 2019 to a net increase of 20,000 officers by 2023.

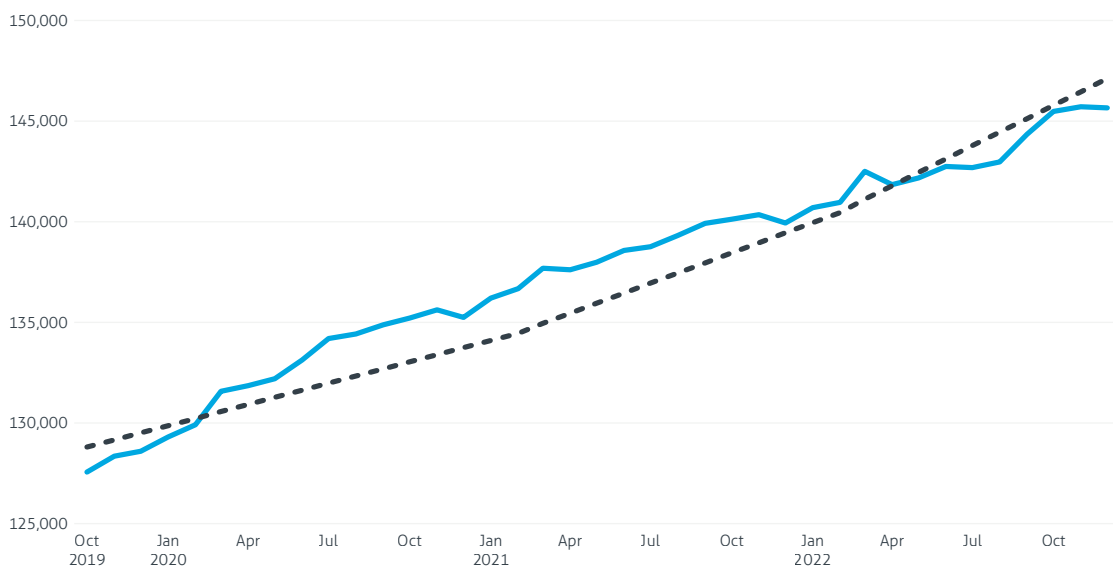
Figure 7.5 Change in police officer numbers since 2010



Source: Institute for Government analysis of Home Office, 'Police workforce, England and Wales: 30 September 2022: data tables' ('Table 1'), supported by CIPFA.

By December 2022 the 'police uplift programme' launched in July 2019 had recruited 16,753 new officers.<sup>27</sup> The National Audit Office reports that £3.6bn will be spent on the programme by March 2023, covering recruitment, training, equipment, and the programme team.<sup>28</sup>

Figure 7.6 Police officer headcount, October 2019 to December 2022



Source: Institute for Government analysis of Home Office, 'Police officer uplift' ('Table U1'), October 2019–December 2022, supported by CIPFA. Notes: Figures are shown from the beginning of the police uplift programme and includes both police officers recruited through the police uplift programme and those recruited through other streams. The analysis spreads each annual target over the 12 months of the year.

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The programme started to fall below its target in May 2022. Recent data shows that to recruit the additional 20,000 officers by the end of 2022/23, the government will need to increase officer headcount by over 1,000 per month between January and March 2023. This is something the programme has rarely achieved, and there is a serious risk that the government will miss its target. A Public Accounts Committee report noted the more difficult labour market conditions facing the programme, with many vacancies across the economy and some recruits deterred by declining confidence in policing.<sup>29</sup> An increase in officers leaving forces (discussed below) will make this situation yet more difficult.

### **Constabularies still lack key skills and a representative workforce**

A National Audit Office review found that the need to maintain officer numbers may undermine workforce modernisation, as it gives chief constables less flexibility in how they use their resources, limiting, for example, their ability to deploy civilian staff who may have specialist skills.<sup>30</sup> This may exacerbate shortfalls in specialist policing areas such as intelligence and investigations.<sup>31</sup> The Police Foundation identified a shortfall of 6,851 accredited investigation detectives in 2021 with only 76% of accredited posts filled (though when trainees are factored in, this rises to 93%).<sup>32</sup> In the short term this affects workloads and timeliness, and leads to de-prioritisation of some crime types such as burglary, assault and theft.<sup>33</sup> According to a recent HMICFRS report, many forces do not have appropriate numbers of staff trained with the forensic skills necessary to handle the increasing prevalence of digital evidence in criminal investigations.<sup>34</sup>

Increasing police numbers has not adequately addressed the under-representation of minority ethnic groups in the police force noted by the Home Affairs Committee in 2021.<sup>35</sup> The programme has not included targets for ethnic minority recruitment, while efforts to promote workforce diversity are made difficult by the pace of the recruitment drive.<sup>36</sup> By the end of December 2022, just 1.6% of all new officers recruited since April 2020 were Black<sup>37</sup> – approximately half the size of the Black population in England and Wales.<sup>38</sup> It also does not suggest police forces have been particularly successful in attempts to bring this rate up as the existing proportion of Black officers nationally stands at 1.3%, unchanged from September.<sup>39</sup>

### **Police retention worsened in 2021/22 amid high levels of dissatisfaction with pay**

Throughout the pandemic, the police faced difficult working conditions that may have impacted wellbeing. The Police Foundation has highlighted harder work with longer shifts and unique challenges – such as members of the public threatening to infect officers with Covid – as factors adding to police stress.<sup>40</sup> Despite this, police turnover stabilised during 2020/21.<sup>41</sup> However, this trend reversed in 2021/22 with a 35% increase in officers leaving the force. The total number of officers leaving was higher than in 2019/20, though below the high of 2018/19.<sup>42</sup>

In the medium term, there may be further retention problems. Some 86% of respondents to the Police Federation's December 2022 pay and morale survey reported high levels of pay dissatisfaction, up from 69% in 2020.<sup>43</sup> Over the same period, the proportion of respondents believing they are not fairly paid considering

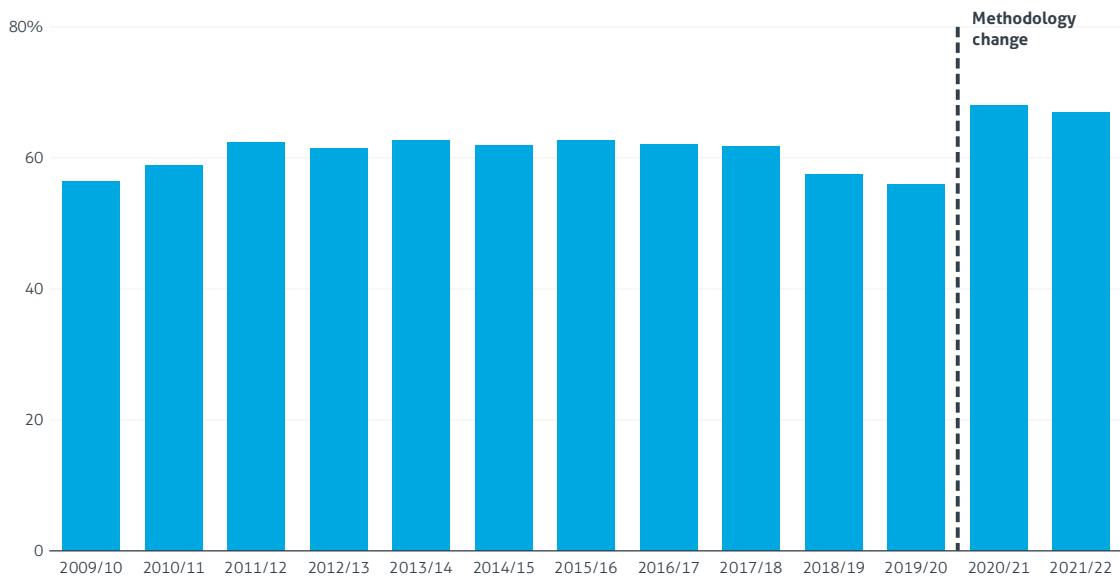
the stress of policing has risen from 86% to 94%.<sup>44</sup> Police forces have little financial headroom as the police uplift programme is only financed by central government for the first three years, after which costs fall to forces.<sup>45</sup>

## There is declining public confidence in policing

A range of survey evidence suggests that public confidence in and satisfaction with the police has fallen over recent years.

Most respondents to the CSEW report their local police are doing a good or excellent job. However, the number doing so declined from 63% in 2015/16 to 56% in 2019/20. A change to telephone-based interviews make recent years non-comparable, but they too show a decline between 2020/21 and 2021/22.

Figure 7.7 **Public perception that local police are doing a good or excellent job, 2009/10–2021/22**



Source: Institute for Government analysis of ONS, 'Crime in England and Wales: Annual supplementary tables' ('Table 2'), 2015/16–2019/20; ONS, 'Crime in England and Wales: coronavirus (COVID-19) and crime tables' ('Table 5'), year ending March 2022, supported by CIPFA. Notes: Full details of the methodology change are explained in the Methodology chapter.

Similarly, data from YouGov asking about policing in general indicates a marked loss of confidence. Averaging figures over a 12-month period in a survey carried out between March 2022 and February 2023, 50% of respondents said they either had not very much or no confidence at all in the police to deal with crime, compared to 45% a year earlier.<sup>46</sup> Similarly, in a different survey, averaged figures over the same period show 52% of respondents felt the police were doing a good job compared to 60% a year earlier.<sup>47</sup>

This deterioration in attitudes to policing is likely to be linked to several high-profile policing scandals. The case of David Carrick, recently found guilty of 49 offences (including rape) committed over a long career as an officer in the Metropolitan Police, has reopened questions over forces' ability to identify and appropriately vet poor officers (including those who have historically come to police attention). This comes after HMICFRS placed the Metropolitan Police under special measures in July 2022

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after “substantial and persistent” concerns arose over the poor handling of the Stephen Port case, the murder of Sarah Everard, the strip search of three children including Child Q, and unprofessional behaviour at Charing Cross Police Station.<sup>48</sup> Reports that the Metropolitan Police is investigating domestic and sexual abuse claims implicating a further 800 officers are likely to worsen public confidence.<sup>49</sup>

Trust among minority groups is even lower. A YouGov poll in October 2021 identified that only 44% of minority ethnic Britons trust the police, down from 52% in October 2020.<sup>50</sup> This finding matters given continued disproportionate use of stop and search powers which, HMICFRS notes, causes suspicion among communities that they are being unfairly targeted.<sup>51</sup> HMICFRS identified using 2019/20 data that Black people were about 5.7 times more likely to have force used on them than their white counterparts.



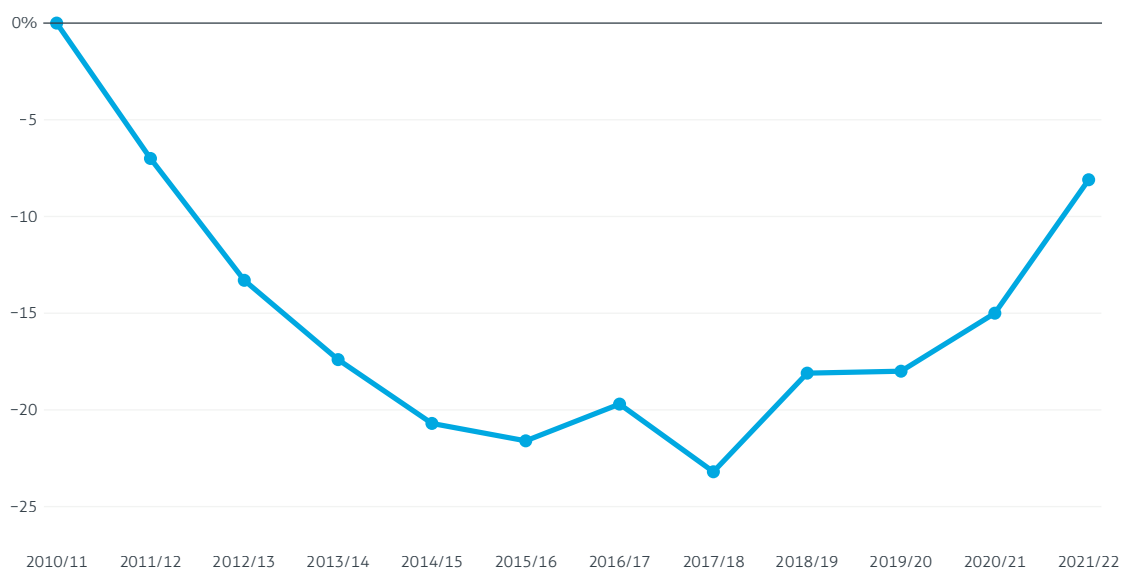
## 8. Criminal courts

In the first half of 2022/23, the barristers' strike significantly worsened the capacity of criminal courts to process cases and further contributed to an already record-breaking backlog of cases in the crown court. Even before the strikes, criminal courts were still not operating as efficiently as before the pandemic. While the number of cases processed recovered quickly during the pandemic, shortages of judges and barristers will likely continue to restrict how quickly the courts in England and Wales can tackle the backlog, which will remain far above pre-Covid levels for several years.

### Spending on courts increased in response to coronavirus but remains low in historical terms

During 2020/21 and 2021/22, Her Majesty's Courts and Tribunal Service (HMCTS), which is responsible for civil courts and tribunals as well as the criminal courts, received additional funding to help adjust its working during the pandemic and address its consequences. In 2021/22, additional funding for cleaning, temporary courts and extra technology came to £78 million.<sup>1</sup> Covid-related funding accounted for around 3% of HMCTS's £2.4 billion budget in 2021/22.\* Spending was 19.5% higher than the low point of 2017/18, but still 8.1% below the 2010/11 budget in real terms despite a record backlog and a need to process more cases.

Figure 8.1 **Change in HMCTS spending since 2010/11 (real terms)**



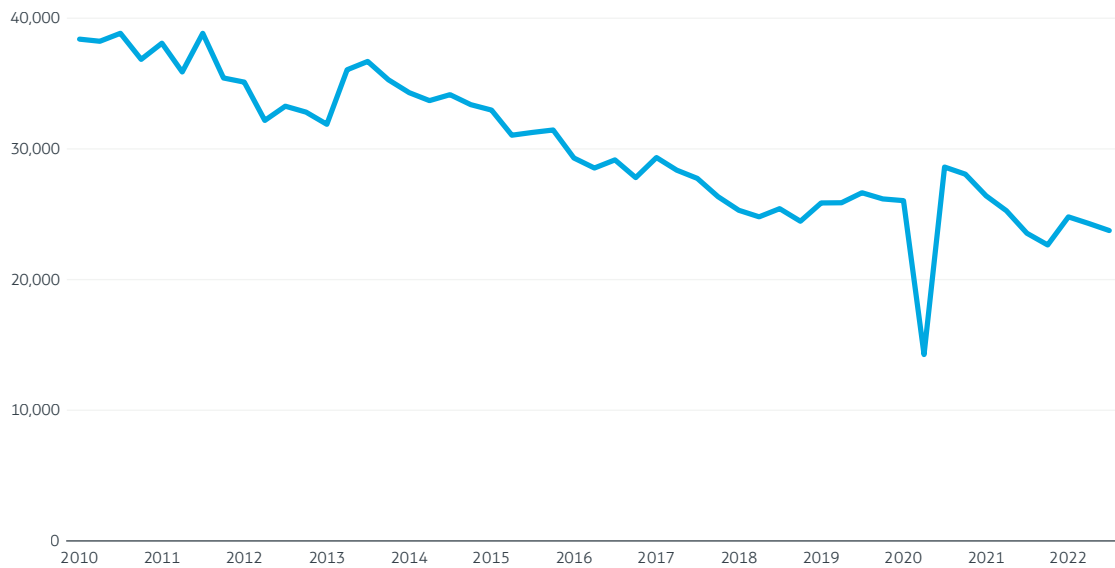
Source: Institute for Government analysis of various HMCTS annual reports and accounts, supported by CIPFA.  
Notes: 2010/11 is the first full year after HMCTS was formed.

\* HMCTS also receives some fee income for civil court and tribunal cases, but not for criminal cases. Around three fifths of the £2.4bn was spent on criminal courts.

## The number of cases criminal courts had to deal with fell during the pandemic and has not yet fully recovered

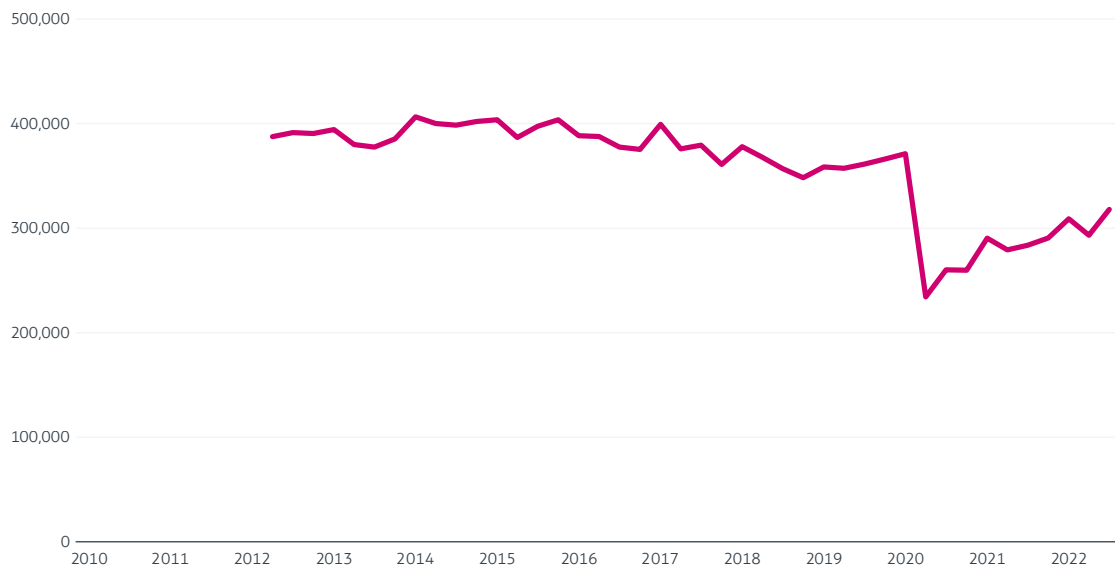
Demand in the criminal courts is best measured by the number of new cases entering the court system. All criminal cases first enter the magistrates' courts. Most stay there with only the most serious cases being passed on to the crown court.

Figure 8.2 Cases received by the crown court, Q1 2010 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics (quarterly): July to September 2014' ('Table C1') and 'Criminal court statistics, July-September 2022' ('Table C1'), supported by CIPFA.

Figure 8.3 Cases received by magistrates' courts, Q2 2012 to Q3 2022



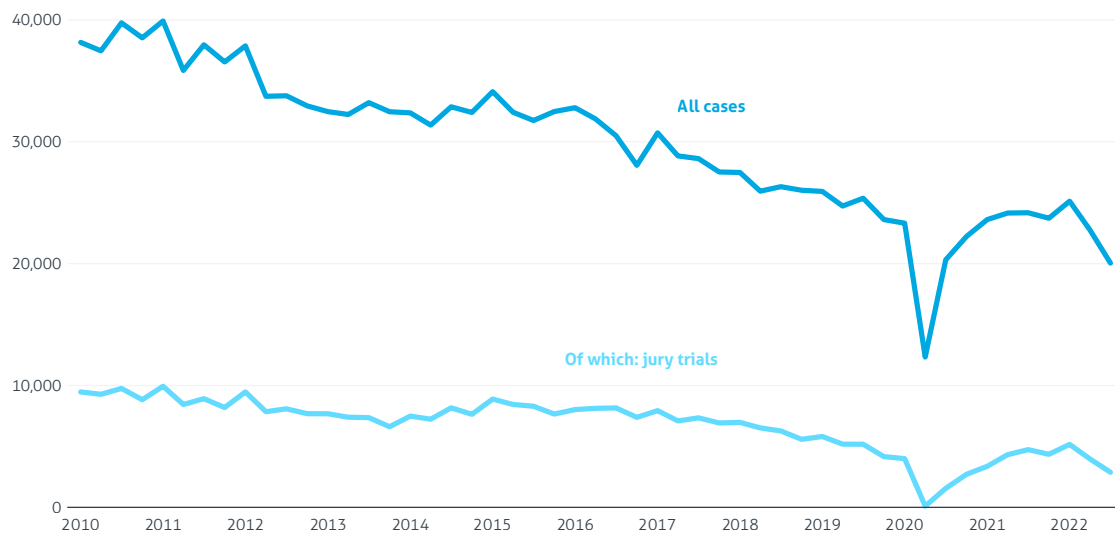
Source: Institute for Government analysis of MoJ, 'Criminal court statistics, July-September 2022' ('Table M1'), supported by CIPFA.

The number of cases entering the court system has been declining since 2014/15 but fell sharply during the pandemic. The decline since the mid-2010s has been attributed to a combination of falling police resources (the number of police fell by 20,000 between 2010 and 2018) and the growing volume and complexity of digital evidence,

which mean investigations take longer to conduct.<sup>2</sup> Lower case receipts during the pandemic can be explained by changing crime patterns and police activity, outlined in the Police chapter. Despite official government projections of growing demand on criminal courts after the pandemic,<sup>3</sup> largely due to increasing police officer numbers, this has not yet materialised and demand remains far below mid-2010s levels.

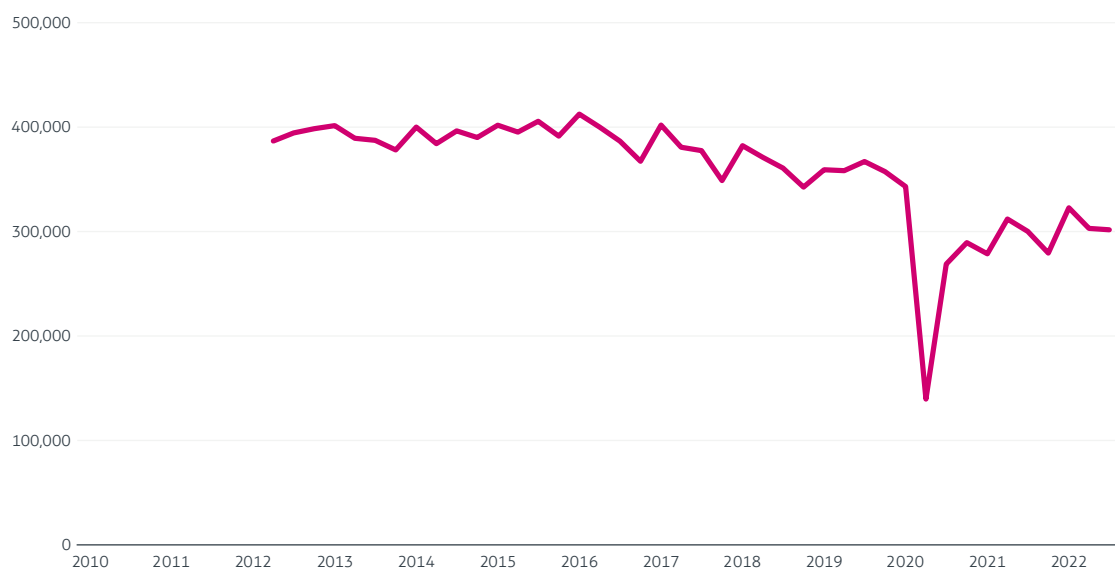
## But the courts' capacity to process cases fell by more and remains below the required level to keep pace with future demand

Figure 8.4 Cases processed by the crown court, Q1 2010 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics (quarterly): July to September 2014' ('Table C1') and 'Criminal court statistics July–September 2022' (Table C1'), supported by CIPFA. Notes: Quarterly data is only available from 2010/11. Most cases in the crown court do not require a jury trial, either because the defendant pleads guilty or because it is a sentencing or appeal decision from the magistrates' court. This chart shows the total number of cases disposed and the number that are jury trials.

Figure 8.5 Cases processed by magistrates' courts, Q2 2012 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics July–September 2022' ('Table M1'), supported by CIPFA. Notes: Quarterly data is only available from 2012/13.

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In both the magistrates' and crown courts, the number of cases completed fell dramatically in 2020 owing to the pandemic. Initially hearings could not be held in person and while some cases could be heard online, jury trials in particular needed to take place in person. Social distancing restrictions limited the use of courtrooms for most of 2021/22<sup>4</sup> and the number of cases – and jury trials – processed by the crown court in particular did not match up to the government's recovery plan, disposing of fewer cases than in 2019/20.<sup>5</sup>

While the crown courts began processing cases at the pre-pandemic level in early 2021, progress stalled significantly due to the barristers' strike in the first half of 2022/23. And although the magistrates' courts, being less reliant on barristers, continued gradually increasing the number of cases it processed, progress may be being hampered by the intermittent strikes in progress since October among court associates and legal advisers over the rollout of the Common Platform.<sup>6</sup>

### Courts were less efficient in 2021/22 than before the pandemic

The failure of criminal courts to process more cases in 2021/22 does not reflect a lack of spending or resources but instead a less efficient system.

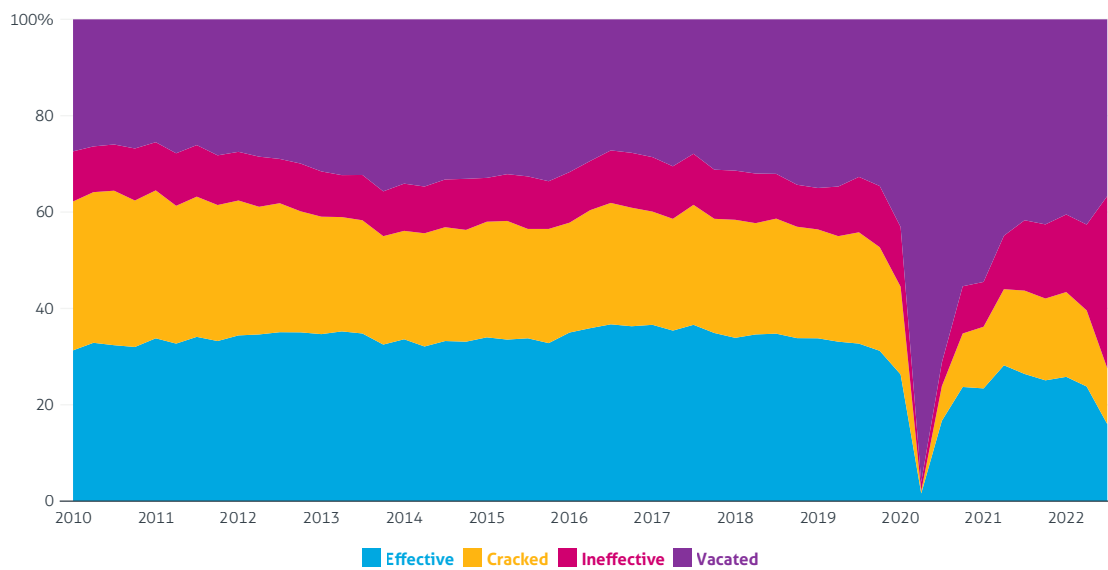
Cases that are listed for trial can have four outcomes, as laid out by HMCTS: they can be **effective**, meaning the trial occurs as planned; **cracked**, meaning the trial need not happen but this is only decided on the day; **vacated**, meaning the trial is delayed but ahead of time so another trial can be listed in its place; or **ineffective**, meaning the trial does not happen on the day and needs to be rearranged.

During 2020/21, a much higher share of cases than usual were vacated due to the impact of coronavirus restrictions. However, in 2021/22 and the first half of 2022/23, while the vacation rate has been higher than usual, a higher share of trials have also been ineffective – the worst outcome – than before coronavirus in both magistrates' and crown courts. In 2021/22, the single biggest contributor to this was 'defendant illness or other unavailability': almost 5,000 cases across both courts were ineffective for this reason in 2021/22, compared with fewer than 2,000 in 2019.<sup>7</sup>

More recently, the barristers' strike prevented many cases being processed. In the first half of 2022/23, the share of ineffective cases in the crown court rose to 36% (by far the highest level since at least 2009), contributing to declines in the share of vacated, effective and cracked cases. The number of ineffective cases caused by defence advocates failing to attend, for example, was 3,058. That is higher than all of the ineffective cases caused by the same reason for the preceding eight financial years combined.<sup>8</sup> However, recent data also suggests levels of defendant illness (as a contributor to ineffective trials) have declined to pre-pandemic levels. Based on this and the end of the barristers' strike, we would expect rates of ineffectiveness to trend back to pre-pandemic levels (assuming workforce problems do not worsen – see below).<sup>9</sup> If this happens, it still means we can expect a high quarterly ineffectiveness rate of 10%.

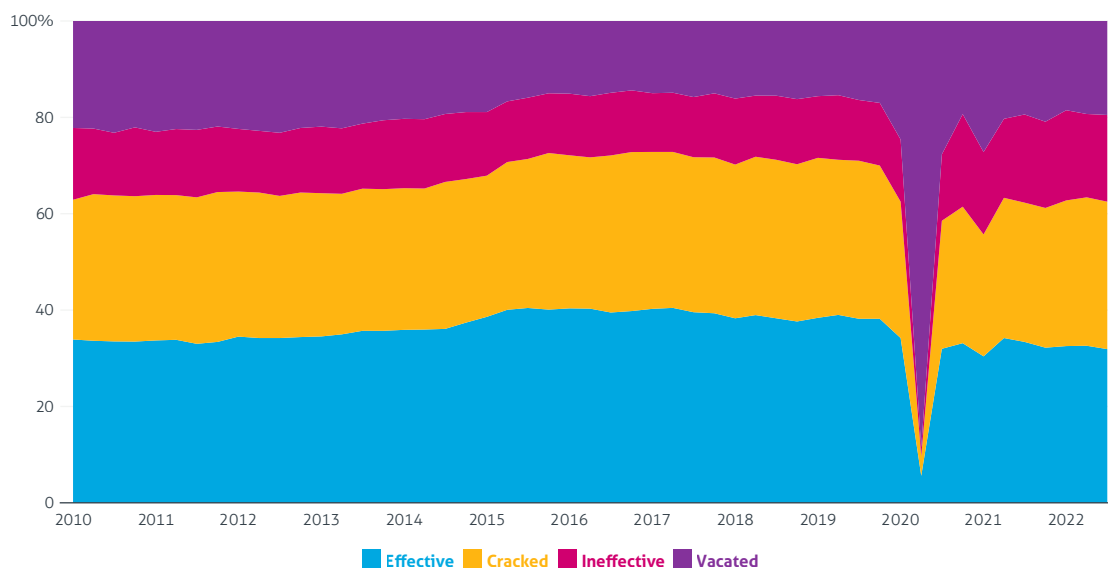
When trials are ineffective or cracked, it means that court time cannot be used effectively because it will often not be possible to find another trial to fill the slot. In the crown court, the number of measured sitting days – that is, the number of days a judge sat to hear cases – was 100,000 in 2021. This was much higher than the reduced 69,000 in 2020 and similar to the 102,000 in 2018.<sup>10</sup> However, the total amount of time spent hearing cases in 2021 was only 292,000 hours (or 2.9 hours per sitting day), compared with 359,000 hours (or 3.6 hours per sitting day) in 2018, showing that the courts have made less use of the available court time.<sup>11</sup> We understand this is in part due to Covid restrictions, which increased the downtime between hearings due to social distancing and additional cleaning.

Figure 8.6 Trial effectiveness in the crown court, Q1 2010 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics July–September 2022' ('Table M2'), supported by CIPFA.

Figure 8.7 Trial effectiveness in magistrates' courts, Q1 2010 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics July–September' ('Table M2'), supported by CIPFA.

Criminal courts

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During the pandemic, courts made widespread use of remote hearings – video and audio technology – to avoid in-person interactions. These have continued beyond formal pandemic restrictions, but mostly for short routine hearings rather than substantive ones.<sup>12</sup> Short, routine hearings account for a relatively small share of court time and so there is a limit to how much of an efficiency gain this new technology can provide. In any case, the consensus among interviewees and a survey of magistrates is that remote hearings do not help courts run more efficiently,<sup>13</sup> although they can provide a benefit to solicitors and barristers who would otherwise need to travel to attend short hearings. No data has been published by HMCTS on the prevalence of remote hearings since May 2021,<sup>14</sup> although interviewees told us that they are used much more readily by some judges and in some jurisdictions than others.

## **Adjusting for complexity, the backlog is twice as large as before Covid and falling slowly**

The big fall in the number of cases processed during 2020 – a fall in capacity that outweighed the smaller fall in demand – led to a big increase in the number of cases in the system waiting to be dealt with.

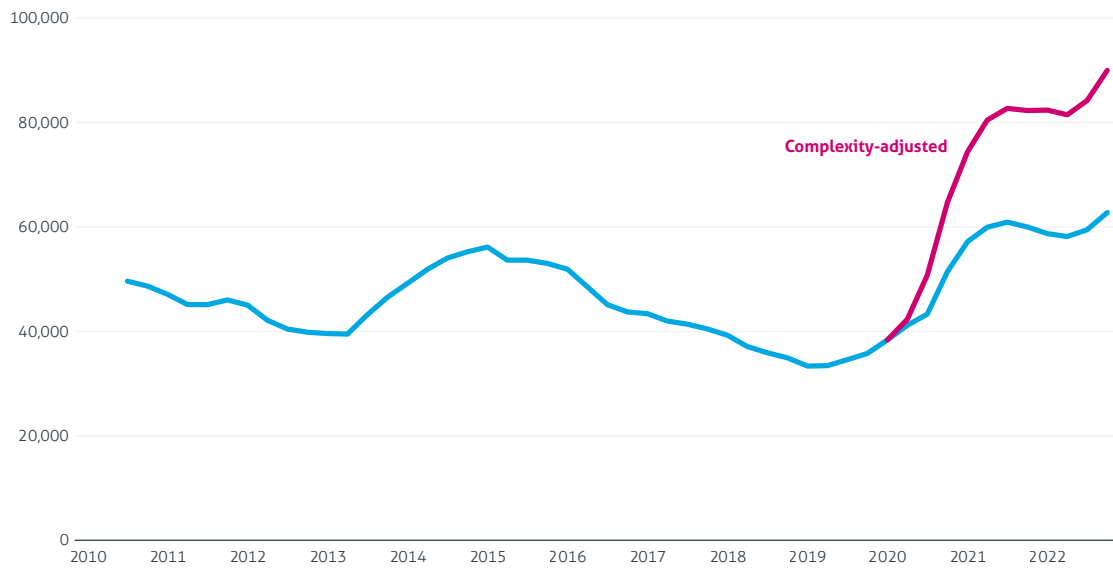
In the magistrates' courts, the backlog initially increased substantially, but a combination of lower demand (including fewer motoring and other less serious offences, which account for over three quarters of the caseload), use of remote hearings and no jury trials being required meant that the backlog quickly began to fall from Q3 2020.

The situation in the crown court is much more difficult. Capacity fell much further during the pandemic because jury trials could not be held at all in Q2 2020 and were affected by social distancing requirements thereafter. The backlog increased from below 40,000 in January 2020 to 61,000 cases in June 2021, before falling by 2,500 cases over the next three quarters. However, it subsequently rose over summer 2022, reaching 62,800 in September as an initial no-returns policy followed by the full defence barristers' strike hampered courts' ability to process cases.

The government's official plan is to reduce the backlog to 53,000 cases by March 2025,<sup>15</sup> which would mean cases remaining far above the pre-crisis level for a long time. If courts are able to start processing cases at the rate they were over the year preceding industrial action, they will miss this target by 2,900 cases. If demand increases as expected on top of this, the gap will be even larger. This stands in stark contrast to the progress of the Scottish Courts and Tribunals Service, which anticipates it can eliminate its high and sheriff court backlogs by March 2026.<sup>16</sup>

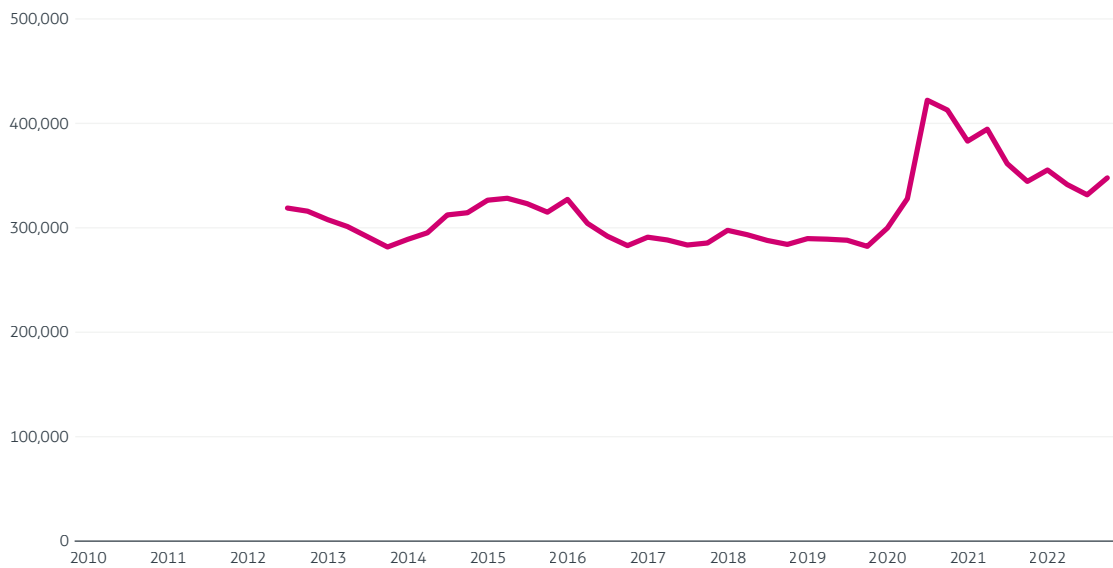
The headline backlog figure also understates the scale of the problem. The cases that could not be heard during the pandemic were disproportionately jury trials. These account for a minority of cases but most court time as they take much longer than other cases. Adjusting the backlog to account for this additional complexity, the 'true' backlog is more than twice as large as before the pandemic.

Figure 8.8 **Backlog of cases in the crown court, Q2 2010 to Q3 2022**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics July–September 2022' ('Table C1'), supported by CIPFA. Notes: Complexity-adjusted backlog accounts for the greater share of cases awaiting jury trial in the backlog, as modelled by the Institute for Government. See Methodology for full details.

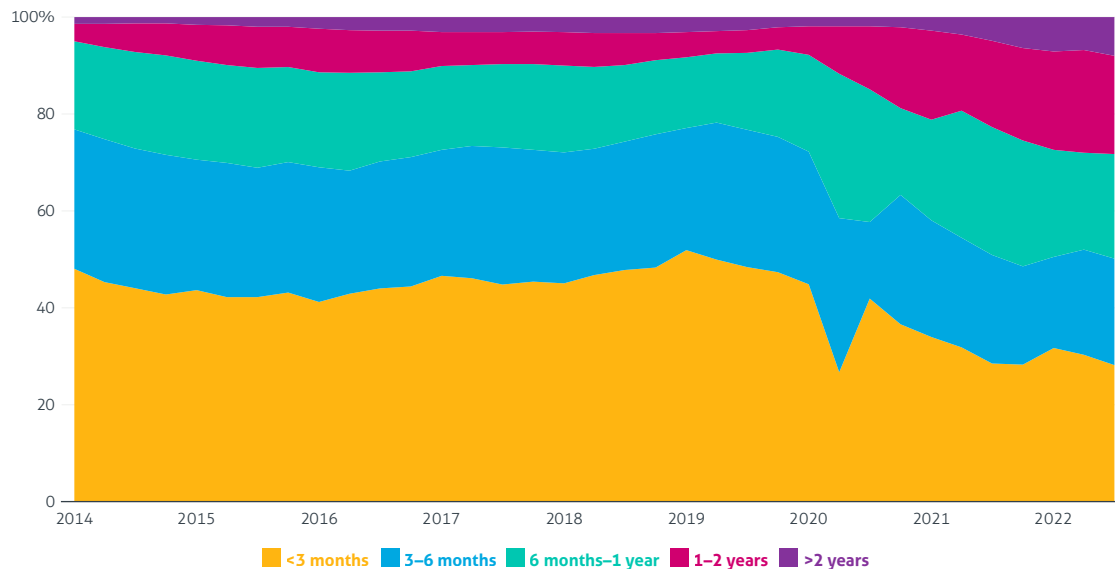
Figure 8.9 **Backlog of cases in magistrates' courts, Q2 2012 to Q3 2022**



Source: Institute for Government analysis MoJ, 'Criminal court statistics July–September 2022' ('Table M1'), supported by CIPFA

## As a result, victims are waiting longer for justice than at any time on record

Figure 8.10 Waiting times for cases in the crown court backlog, Q1 2014 to Q3 2022



Source: Institute for Government analysis of MoJ, 'Criminal court statistics July–September 2022' ('Table O3'), supported by CIPFA.

A big backlog matters because it means people have to wait longer to have their cases heard. By 30 September 2022, 28% of cases yet to be completed had been in the system for more than a year, compared with less than 10% before the pandemic.

Long waiting times can undermine justice. It can affect the recollections of witnesses and defendants, and may mean that defendants do not want to fight a case that could last for years. The number of defendants held in prison on remand while they await trial (if they are not granted bail) has risen since Covid. It is possible these people will be found not guilty after a long stint behind bars, or even plead guilty (even if they are innocent) if serving a sentence is quicker than waiting on remand.

### Shortages of judges and barristers limit how quickly the courts can reduce the backlog, exacerbated by industrial action

Despite the impact of backlogs on the operation of criminal courts, the government is expecting to reduce the backlog only slowly over the next few years. This is not because of a lack of money – the government provided funding for 'unlimited sitting days' in 2021/22, which has been continued into 2022/23. Instead, the constraint on the number of cases the courts can process is the availability of judges and barristers.

The number of judges (who oversee all crown court cases) has been relatively stable over the past eight years, but the government is trying to recruit more to enable more cases to be heard. However, in the latest round of recruitment only 52 of 63 vacancies were filled and the Public Accounts Committee does not believe the government's plan to recruit 78 in the next round is credible.<sup>17</sup>



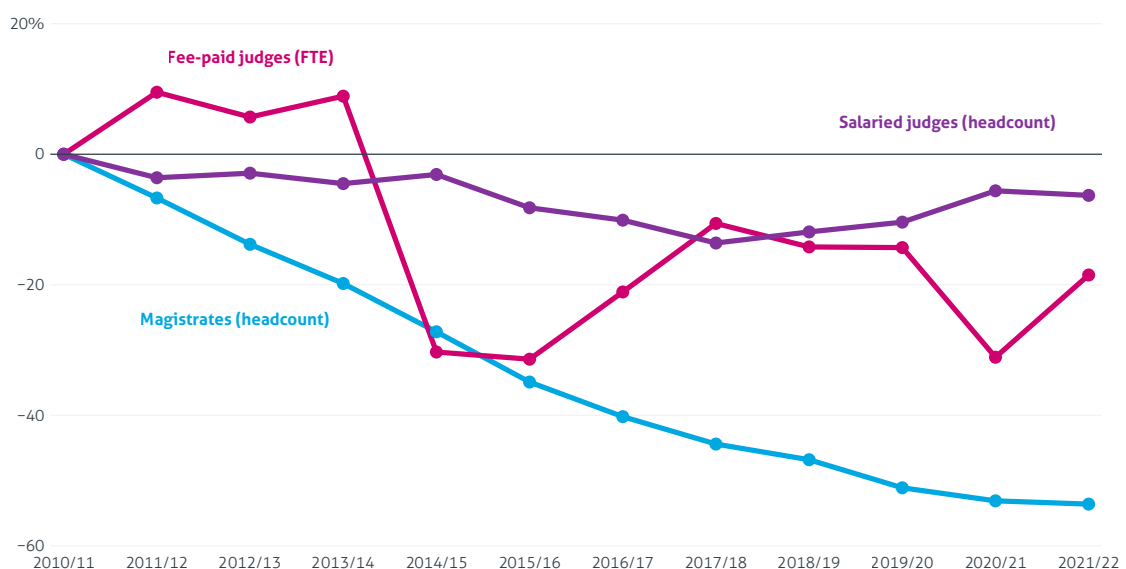
Crown court judges will mostly be recruited from the existing pool of criminal barristers. But this poses a problem, because there is also a shortage there. The number of barristers fell further during the pandemic as defence barristers in particular diversified their portfolios to maintain their income.<sup>18</sup> The rates paid to barristers for criminal cases through legal aid have fallen substantially in real terms since 2010. Combined with lower activity in the courts, this has made criminal defence work poorly paid compared with other legal work, especially early in careers. Spending on criminal legal aid was 41% lower in real terms in 2021/22 than in 2011/12.<sup>19</sup>

The Criminal Legal Aid Review reported in 2021 and, among other recommendations, advised rates should be increased by 15%.<sup>20</sup> The government initially acceded to this for new cases (not the significant number in the backlog), before extending the 15% rise to the majority of cases in backlog in response to industrial action by defence barristers between April and October 2022.<sup>21</sup>

Barrister strikes were disruptive while they lasted, so it was important for the sustainability of the courts system that the government was able to agree a deal. The backlog rose between March and September 2022 to 62,766, which in turn pushed the adjusted backlog to a record high of 89,996. A Freedom of Information release from the Ministry of Justice shows that on average fewer than 300 trials were completed per week between April and July 2022, down from an average of more than 350 in 2021/22.<sup>22</sup>

However, while defence barristers have gone back to work, shortages of this group are likely to continue to limit how quickly the government can process cases to reduce the backlog. Indeed, the director of public prosecutions recently highlighted a lack of prosecution barristers and the size of the backlog as key contributors to delays that cause some victims to withdraw their cases.<sup>23</sup>

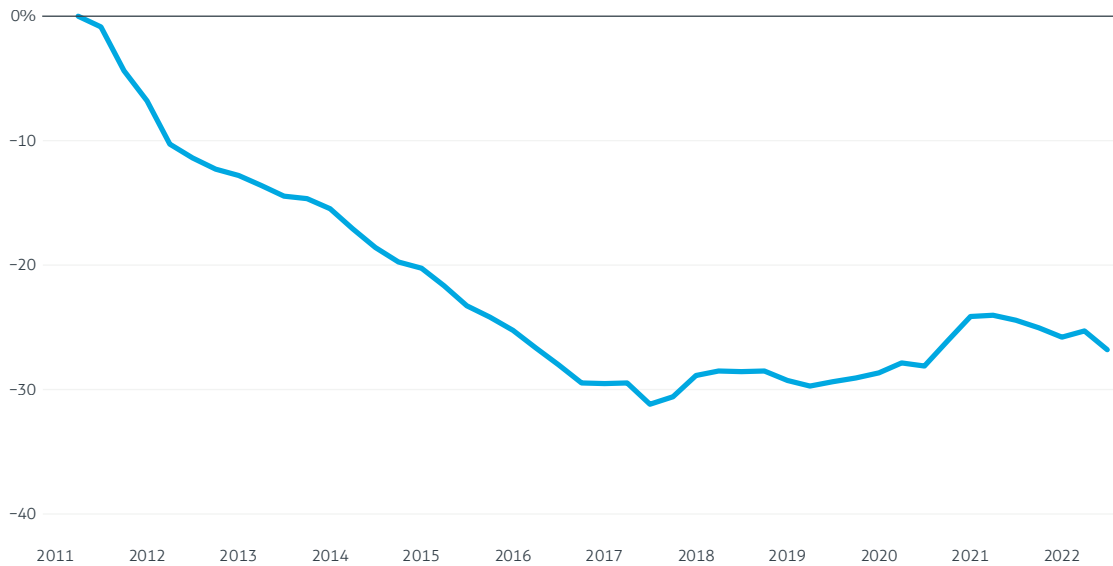
Figure 8.11 Change in the number of judges and magistrates since 2010/11



Source: Institute for Government analysis of HMCTS, 'Annual Report and Accounts 2021–22', supported by CIPFA.

The other relevant workforces for the criminal courts are magistrates and HMCTS staff. Magistrates are volunteers and their numbers have fallen by more than 50% since 2010. Nonetheless, this is not currently a major constraint on how many cases can be processed. Magistrates have managed with reduced numbers by sitting as a panel of two rather than the usual three. HMCTS staff numbers have increased since 2017, and despite a much smaller workforce than 2010 the department believes the workforce is big enough.<sup>24</sup>

Figure 8.12 **Change in the number of HMCTS staff since Q2 2011**



Source: Institute for Government analysis of ONS, 'Public Sector Employment, September 2022', supported by CIPFA.

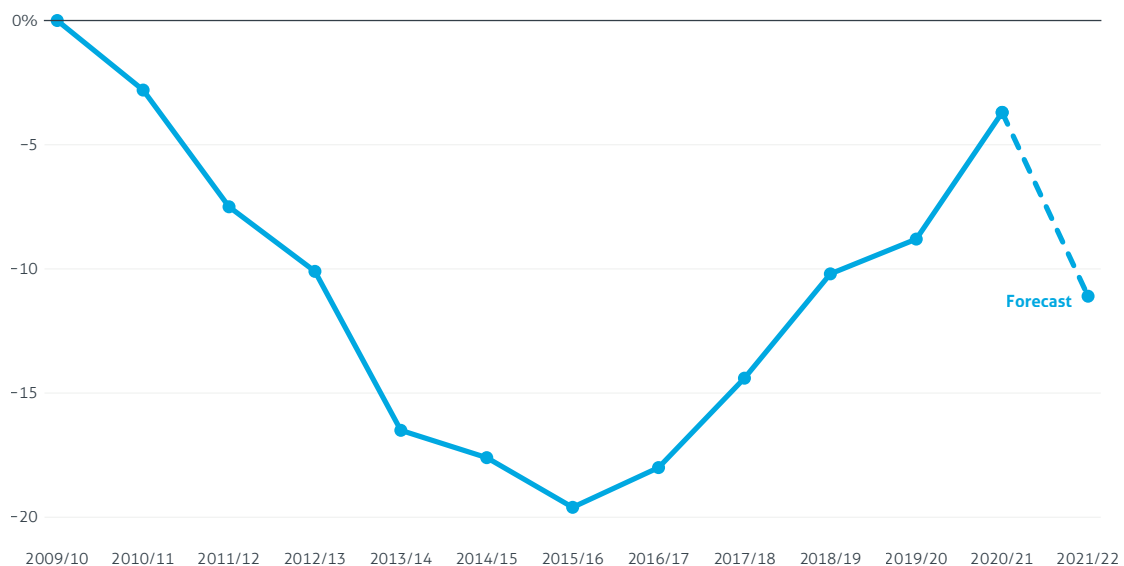
# 9. Prisons

Prisons were placed in stringent lockdown regimes throughout the pandemic, with many restrictions still in place. This successfully limited the spread of Covid and the number of prisoner deaths, but led to several harmful consequences. Long periods spent in cells, delays for routine health appointments and severely reduced access to education, training and work have all harmed prisoners' wellbeing and prospects. And though prison governors have, since May 2022, been able to lift Covid restrictions, poor leadership and workforce shortages mean some prisoners are still being kept locked in their cells for most of the day.

This chapter considers the 119 publicly and privately run prisons in England and Wales. Her Majesty's Prison and Probation Service (HMPPS), an executive agency within the Ministry of Justice, runs 105 of these, while Serco, G4S and Sodexo run the remaining 14.

## Spending on prisons fell in 2021/22

Figure 9.1 Change in spending on prisons since 2009/10 (real terms)



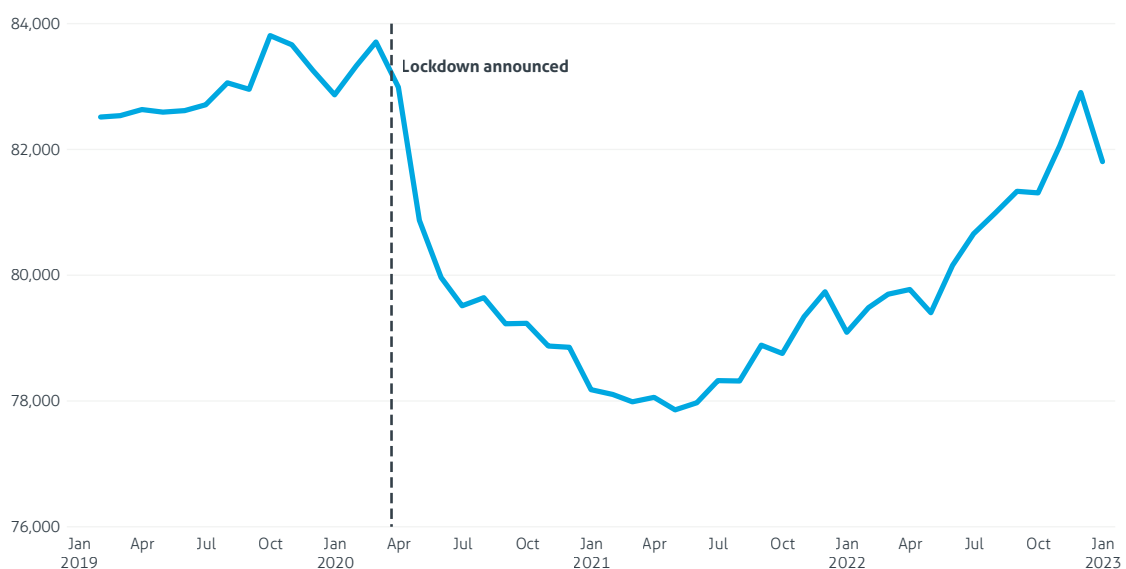
Source: Institute for Government analysis of MoJ, 'Costs per prison place and prisoner by individual prison', 2009/10-2020/21; HM Treasury, 'Central Government Supply Estimates 2021-22: Supplementary Estimates'; supported by CIPFA. See Methodology for how the 2021/22 spending figure was estimated.

Spending on prisons had been increasing since 2015/16 and this trend continued in the first year of the pandemic, when a number of Treasury-approved schemes were implemented to ensure the continued supply of staff and to minimise the risk of unrest. Day-to-day spending rose 5.6% in 2020/21, but was expected to fall by around 8% in real terms in 2021/22 as Covid support measures come to an end.<sup>\*1</sup>

Investments have been made in the prison estate during the pandemic. In 2020/21, HMPPS bought and installed 1,150 temporary accommodation units to make it easier to spread out and isolate prisoners.<sup>2</sup> It has also expanded the availability of video and telephone facilities. Video-calling between prisoners and their friends and family was first introduced in March 2020 and all prisons had this capability by the end of the year. Between March 2020 and August 2022, in-cell telephones were installed in 31 establishments, leaving 12 closed prisons<sup>3</sup> and 12 open prisons<sup>4</sup> still to have these installed.

## The number of prisoners fell 6% during the pandemic but rose in the first nine months of 2022/23

Figure 9.2 Number of prisoners, January 2019 to December 2022



Source: Institute for Government analysis of MoJ, 'Offender management statistics quarterly' ('Table 1.1'), Prison population, 31 January 2019 to 31 December 2022, supported by CIPFA.

The prison population fell substantially at the start of the pandemic and by 6% between March 2020 and July 2021, reducing the total number by nearly 5,000. This was largely due to fewer people being sent to prison as a result of the initial closure of courts and subsequent social distancing requirements, which reduced the number of cases heard. The population remained below 80,000 for all of 2021/22 but had risen above this in this financial year, reaching 82,905 on 30 November 2022 but falling back to 81,806 a month later.<sup>5</sup>

\* Spending figures for 2021/22 had not been released at time of publication.

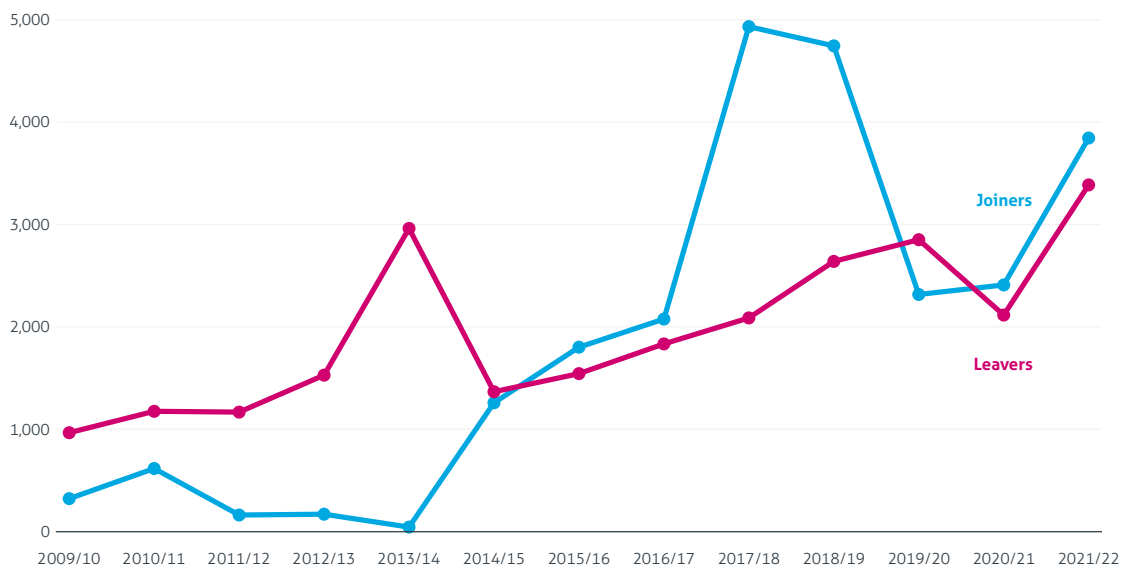
The Ministry of Justice projects that the prison population will grow dramatically over the coming years, up to 97,500 in 2025,<sup>6</sup> primarily as a consequence of the government’s policy to increase the number of police officers by 20,000. However, as of July 2022, the prison population was almost 4,000 lower<sup>7</sup> than the government anticipated when these projections were published in September 2021, again due to delays in the courts.

Despite being lower than anticipated, there is insufficient capacity in adult male prisons and the government found it necessary to request the temporary use of up to 400 police cells on 30 November 2022.<sup>8</sup>

### Staff numbers rose due to higher recruitment – but retention worsened

The number of prison officers increased slightly during 2021/22, having remained flat during the first 12 months of the pandemic. But retention worsened substantially, with 3,387 officers leaving in 2021/22, compared to 2,116 in 2020/21. This was more than offset by the recruitment of 3,845 staff, an increase of 1,435 compared to the year before.<sup>9</sup> Interviewees noted the success of recruitment campaigns but added that it was increasingly hard to retain staff due to better pay and conditions elsewhere, including other parts of the public sector, particularly the police.

Figure 9.3 **Band 3–5 prison officer joiners and leavers, 2009/10–2021/22**



Source: Institute for Government analysis of HMPPS, ‘Workforce statistics bulletin’ (‘Tables 8a and 8c’), 2009/10–2021/22, supported by CIPFA.

### The workforce is insufficient to safely lift restrictions in all prisons

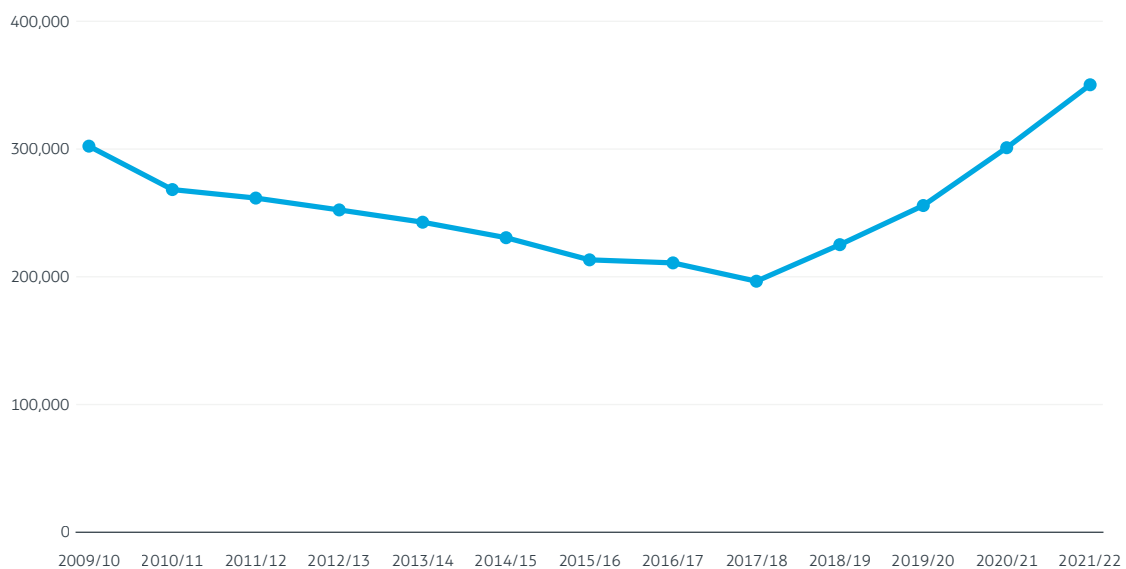
Lockdown regimes were eased from summer 2021 but prisons were required by MoJ to reimplement Covid measures in January 2022 to contain the Omicron wave. Since 9 May 2022, prison governors have freedom to lift all restrictions.

However, prison regimes vary substantially across the country, even between prisons of the same category.<sup>10</sup> HM Inspectorate of Prisons (HMIP) found that “many prisoners were still locked up for almost 22 hours a day”, even as restrictions in prisons were

lifted, citing a lack of ambition from some prison governors.<sup>11</sup> We were told by interviewees that some prisons still do not have enough staff to safely return prisons to pre-pandemic regimes and that in some only half of a prison wing were allowed out of their cells at any one time.

The situation has been exacerbated by high levels of staff sickness. In 2021/22, more than 350,000 days were lost to sickness, 21% higher than in 2020/21 and 43% more than 2019/20. Covid-related absences still accounted for more than 20% of the total in 2021/22, with a further 10% due to other respiratory illnesses.<sup>12</sup>

Figure 9.4 **Band 3–5 prison officer sick days, 2009/10–2021/22**



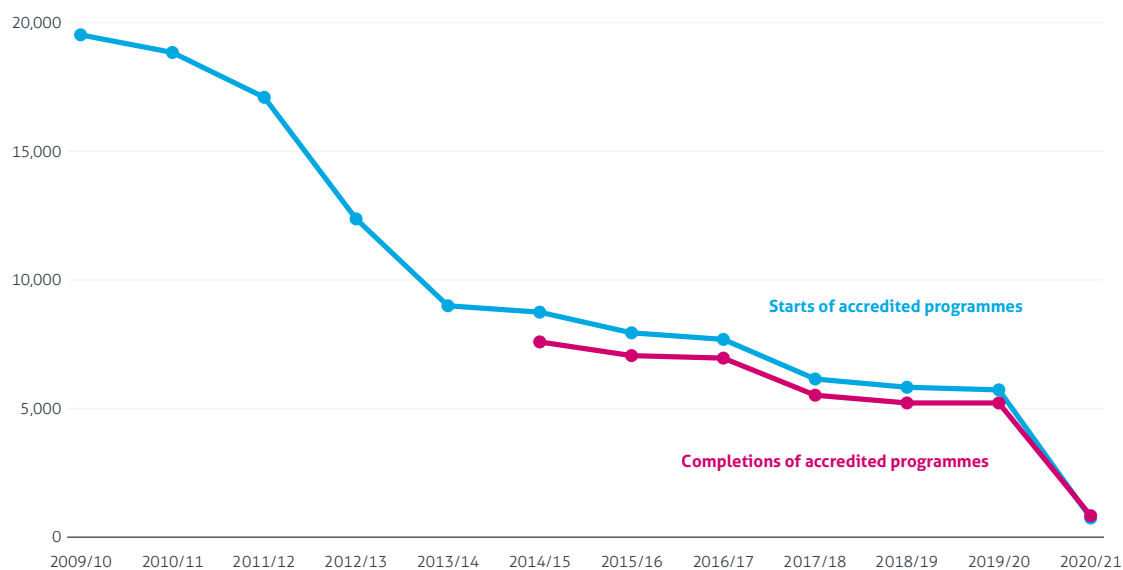
Source: Institute for Government analysis of HMPPS, 'Workforce statistics bulletin' ('Table 20'), 2009/10–2021/22, supported by CIPFA.

As a consequence of the high staff turnover noted above, the prison workforce is also relatively inexperienced, with more than a quarter of prison officers having been in post for less than two years.<sup>13</sup> Newer staff are less likely to have the trust of prisoners or the interpersonal skills that more seasoned officers have, and will tend to be less effective at de-escalating potentially violent situations – something that also has implications for how safely prisons can accommodate the expected rise in the prisoner population.

### **Continued lockdowns in prisons have reduced access to purposeful activities**

Enhanced lockdown regimes in prisons meant that fewer prisoners have been able to access purposeful activities. Inspections by HMIP and Ofsted found that education was badly disrupted with, for example, reading mentors unable to leave their cells to provide sessions for fellow prisoners.<sup>14</sup>

Figure 9.5 **Starts and completions of accredited programmes, 2009/10–2020/21**



Source: Institute for Government analysis of HMPPS, 'Offender Equalities Annual Report' ('Tables 5.2 and 5.9'), 2009/10–2020/21, supported by CIPFA. Notes: These are evidence-based treatment programmes covering domestic violence, extremism, general offending, sexual offending, substance misuse, and violence.

There was a big reduction in both starts and completions of accredited programmes in 2020/21. Just 744 accredited programmes were started, down from 5,726 in 2019/20, a fall of 87%,<sup>15</sup> with completions following a similar trajectory. Interviewees told us that the prison education service has also found it difficult to recruit and retain staff.

Prisoners have also been able to work less during the pandemic. The average number of active prisoners\* fell by 45% between 2020 and 2021. Work increased substantially in 2022, but there were still 2% fewer active prisoners per month than in 2020.<sup>16</sup>

As the access to traditional purposeful activity was limited due to Covid restrictions, prisoners have been given in-cell activity packs and some elements of education courses have been made available to be completed from a cell. However, HMIP's annual report is highly critical of the slow pace at which face-to-face purposeful activity has resumed, blaming a lack of ambition from some governors and the prison service, as well as the reluctance of some providers to come back into prisons.<sup>17</sup>

## **Violence has increased as prison lockdown regimes have been eased**

Violence in prisons rose substantially after 2014/15 but had started to fall before the onset of the pandemic, thanks to a wide-ranging safety programme.<sup>18</sup>

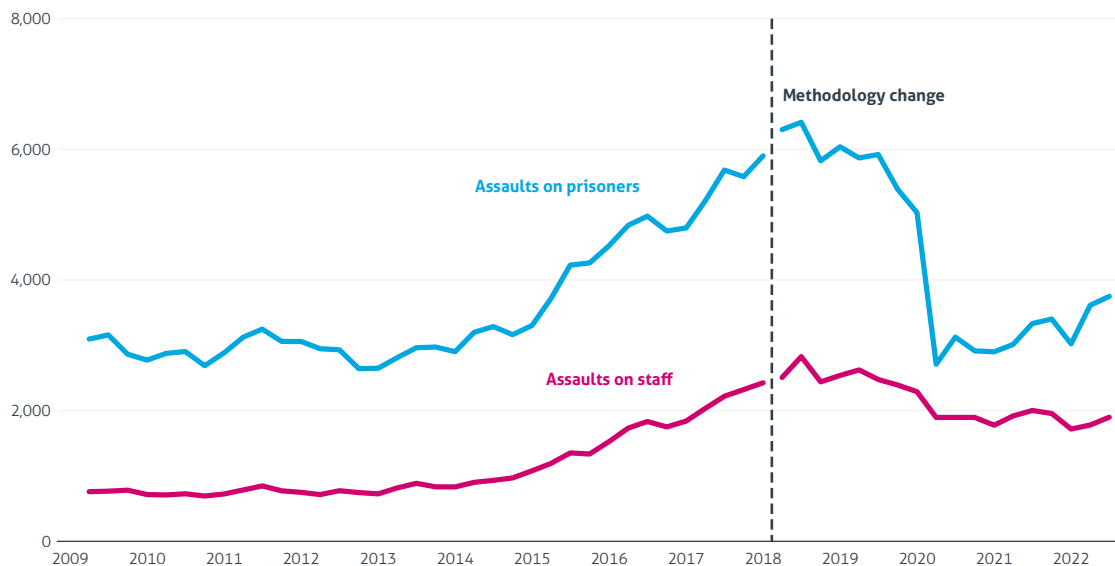
It then fell dramatically following the introduction of lockdown regimes at the start of the pandemic – unsurprisingly, with prisoners separated for long periods. But incidents of assault rose again as prisons lifted restrictions and face-to-face contact

\* The number of prisoners who received a salary.

between prisoners, and between prisoners and staff, increased. This situation was probably exacerbated by the noted inexperience of staff, as well as other factors such as “paying off of debts” and frustration at prolonged restrictions.<sup>19</sup>

The rate of prisoner-on-prisoner assaults per 1,000 prisoners increased by 16% in 2021/22. However, the rate remains substantially below pre-pandemic levels. The rate of assaults on staff has followed a similar pattern, increasing by 9% in 2021/22.

Figure 9.6 **Prison assaults, Q2 2009–Q3 2022**



Source: Institute for Government analysis of MoJ, ‘Safety in custody statistics’ (‘Table 7’), Q2 2009–Q3 2022, supported by CIPFA. Notes: Figures from Q2 2018 onwards exclude incidents occurring within the youth estate.

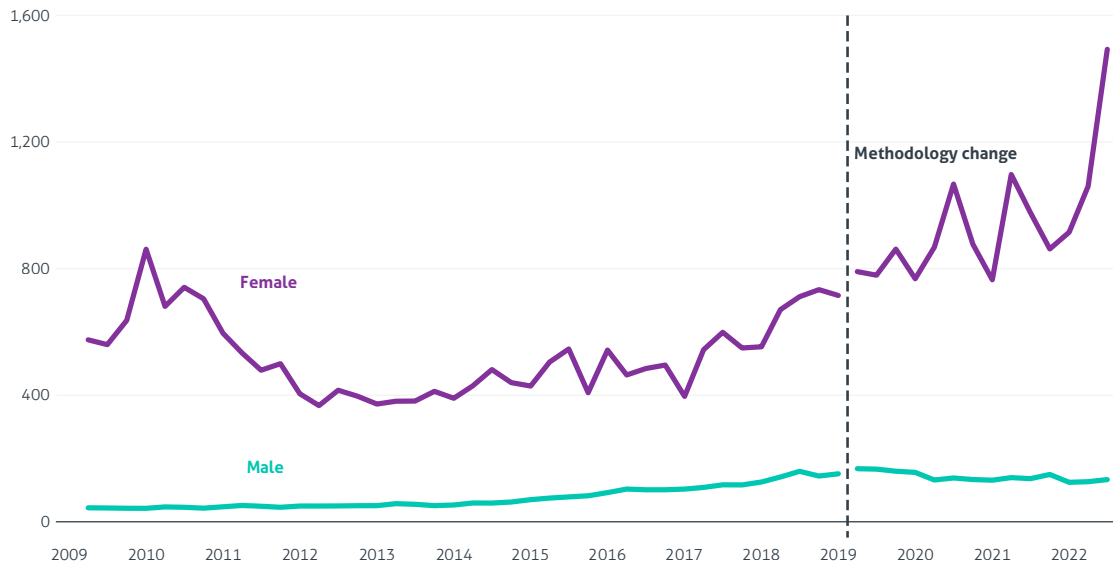
## Self-harm has fallen in men’s prisons but increased in women’s prisons

Self-harm has always been more prevalent in female prisons\* but the trends have diverged during the pandemic. The rate of self-harm incidents per 1,000 prisoners in male establishments fell by 11% between 2020/21 and 2021/22. The rate rose by 8% in 2021/22 but remained below pre-pandemic levels.

\* Self-harm in the women’s estate is characterised by a small number of women who self-harm multiple times. More than a third of female prisoners self-harm, compared to 15% of male prisoners.



Figure 9.7 **Self-harm rates per 1,000 prisoners, Q2 2009–Q3 2022**



Source: Institute for Government analysis of MoJ, 'Safety in custody statistics' ('Table 6'), Q2 2009–Q3 2022, supported by CIPFA. Notes: Figures from Q2 2019 onwards exclude incidents occurring within the youth estate.

In female prisons, self-harm incidents per 1,000 prisoners grew by 12% in 2020/21, by a further 7% in 2021/22, and by an unprecedented 63% in the first half of 2022/23. The average of almost 11 incidents of self-harm per individual in 2021/22 is the highest on record – and 17% higher than the pre-pandemic rate.<sup>20</sup>

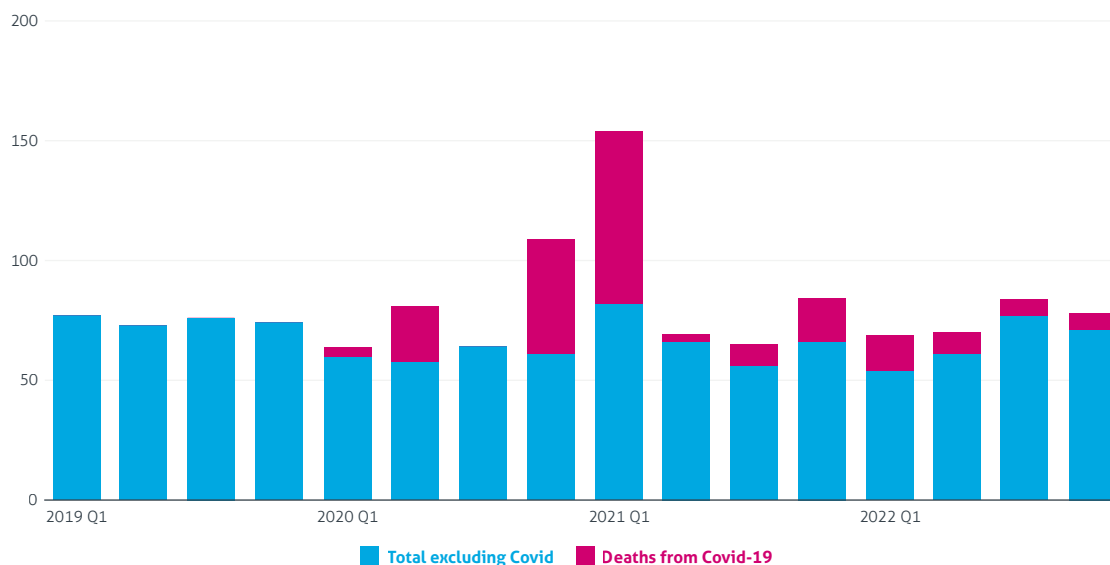
It is unclear what has caused the divergence but HMIP noted in its 2020/21 annual report that: "Women's lack of contact with the outside world had led to extreme frustration and many had not seen their children for many months, leaving them feeling lonely and anxious."<sup>21</sup>

To address the problem the government works with the Samaritans, and has implemented a new case management approach and training package for staff.<sup>22</sup>

### **Prisons experienced fewer Covid deaths in 2021/22 than in the first year of the pandemic**

In March 2020, Public Health England predicted that as many as 2,700 prisoners could die from Covid.<sup>23</sup> However, highly restrictive lockdown regimes within prisons meant that the prison service limited the spread of Covid. There were 215 Covid-related deaths from the start of the pandemic up to the end of December 2022. These peaked over the winter of 2020/21 but have been substantially lower in subsequent waves following the rollout of vaccinations.

Figure 9.8 **Deaths in prison, Q1 2019–Q4 2022**



Source: Institute for Government analysis of HMPPS, 'Covid-19 statistics' ('Table 1'), March 2020–December 2022; MoJ, 'Safety in custody statistics' ('Table 5'), Q1 2019–Q4 2022; supported by CIPFA.

## Backlogs have grown and prisoners are waiting longer to access services

There is limited publicly available data on backlogs in prisons. However, according to the MoJ, there are backlogs across its services, including staff training, staff annual leave, offender management assessments, offending behaviour programmes and access to health services.<sup>24</sup> Another interviewee told us that some prisons are keeping prisoners in their cell for even longer than usual one day a week to enable staff to undertake essential training.<sup>25</sup>

As a result of backlogs and staff shortages, prisoners are waiting a long time to access a wide range of routine services. Recent inspection reports found prisoners waiting several days before they could call their family after arrival,<sup>26</sup> four weeks for GP appointments,<sup>27</sup> over 26 weeks to see an optician,<sup>28</sup> and “unacceptable” waits for refunds from prison shops.<sup>29</sup> Worryingly, in one establishment, vulnerable prisoners waited several weeks for a bed on a specialist wing and only 19% of prisoners said that emergency cell bells were answered within five minutes.<sup>30</sup>

The prison maintenance backlog for the highest priority capital works has also grown from £900 million in 2019/20 to £1.3 billion in 2021/22. These are projects needed to address “significant health & safety and fire safety risks, and/or critical risk to capacity”.<sup>31</sup>

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# Methodology

## Public services spending

To estimate the real cost of public spending, we deflate government spending figures using the GDP deflators published in the November 2022 autumn statement, available at [www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-november-2022-autumn-statement](http://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-november-2022-autumn-statement). To better reflect the underlying inflation conditions present in 2020/21, we estimate our own figures by generating a mid-point that averages across values from 2019/20 and 2021/22. We deflate spending figures in our financial analysis across all Performance Tracker chapters.

## Average annual increases in spending between 2021/22 and 2024/25 relative to demand under different inflation scenarios (Figure 0.1)

For the nine services we cover in this report, we project how much money the public sector would have to spend to meet demand. To estimate the cost of doing this, we project growth in underlying demand for each service as described in the Methodology chapter of *Performance Tracker 2022*.

For each service we also project how spending is likely to evolve over the course of the spending review (up to 2024/25). The 2021 spending review did not provide budgets for particular public services, only government departments (with the exception of schools and the NHS, which have their own budget lines).

For each service, we take the most relevant department's settlement, implicitly assuming that all spending within those budgets will increase at the same rate. This means that we assume that spending on GPs and hospitals will increase in line with NHS spending, spending on courts and prisons will increase in line with MoJ spending, spending on the police will increase in line with Home Office spending, and schools' spending will increase in line with the specific school funding line in the spending review. For the three local government services (adult social care, children's social care and neighbourhood services), we take the government's projections for local authority spending power, which incorporate changes to grants and assumed increases in local taxes (council tax and business rates).

To compare the generosity of the cash-terms settlements set out in the 2021 spending review over time, we deflate these numbers using three iterations of the GDP deflator, a measure of economy-wide inflation that is widely used – including by the government – to assess the real-terms generosity of public service spending plans. We take the GDP deflator from the October 2021 spending review itself and then the GDP deflator at the spring statement in March 2022. Both of these come from the Office for Budget Responsibility (OBR).

The third column in the series looks at the effects on spending envelopes of the autumn statement from November 2022. That fiscal event provided some services – the NHS, schools, and adult social care – with additional funding for the remainder of the spending review period. This new funding total was then deflated using the deflator provided by the OBR to accompany the autumn statement.

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The final two columns of this chart look at the effect on the spending envelopes from the autumn statement under different wage scenarios. The fourth bar assumes that public sector wages will grow in line with private sector wages, thus reducing the amount that services can spend on other areas. The estimate for private sector wage growth comes from the Bank of England's February 2023 monetary policy report. The final column assumes that public services' wages will grow in line with inflation – in this case measured using CPI.

To capture demands on local authorities as a whole, we combine the increases in demand for neighbourhood services, children's social care and adult social care, weighting the projected increases by the 2021/22 spending on each service.

## **1. General practice**

### **Spending in general practice (Figure 1.1)**

Spending on GP services comes from the 'Investment in General Practice in England, 2016/17 to 2020/21' dataset.<sup>1</sup> For 2020/21, this dataset splits out the amount that the NHS provided GPs for spending on Covid-related activity. This information allows us to plot a separate data point for Covid spending in 2020/21.

### **Appointments in general practice (Figures 1.4 and 1.5)**

The NHS changed how it collects information on the number and type of appointments in primary care in October 2018. There is an overall time series going back to November 2017, but granular daily counts of appointments are only available from December 2018. There is, however, a consistent time series of the number of referrals that GPs have made that is available back to 2008.

### **Referrals (Figures 1.6 and 1.7)**

We start the referral rate time series from the point when there is consistent appointments data, as specified above. For the referral rate, we calculate the proportion of attended appointments that GPs conducted that resulted in a specific and acute GP referral. To calculate the number of attended GP appointments, we take the total number of attended appointments across all of general practice in a given month (as outlined in the 'Appointments in General Practice' dataset) and multiply that by the percentage of appointments that GPs carried out (using the SDS Role Group categorisation, rather than HCP categorisation). This step requires us to assume that the attendance rate of GP appointments is the same as the attendance rate of all primary care appointments, an assumption that is unlikely to be met in any month but which will be close enough to make this analysis meaningful. For the monthly number of referrals, we use the 'GP Referrals Made (Specific Acute)' data from the Monthly Referral Return dataset.<sup>2</sup>

### **Number of direct patient care staff employed in primary care (Figure 1.9)**

For the projected number of direct patient care (DPC) staff, we calculate the number of DPC staff that the NHS has added to the service per quarter since March 2019. We then extrapolate that forward to come to a total number of DPC employees if recruitment continues at its current pace.

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## Size of job groups within the primary care workforce (FTE) (Figure 1.10)

The number of GPs used in this chart is the 'All regular GPs (excludes locums)' line from the GP Workforce Bulletin tables. This is a combination of 'All qualified permanent GPs' and 'GPs in training grades' from the same dataset.

## Percentage change in the number of patients registered with GP practices and the number of GPs, since September 2015 (Figure 1.11)

As with Figure 1.10, the change in the number of GPs refers to the percentage change in the number of 'All regular GPs (excludes locums)'. The change in the number of patients comes from the 'Total number of patients' line in Table 5 of the GP Workforce Bulletin tables. The starting date for both of these time series is September 2015 because this is when the time series starts in that dataset.

## 2. Hospitals

### Beds per head (Figure 2.7)

For this chart, we take the total number of general and acute overnight beds from NHS England's 'Bed availability and occupancy' dataset and divide this number by the number of people in England in the relevant year from the Office for National Statistics (ONS) 'Mid-year population estimate' dataset.

### Staffing (Figure 2.8)

Nursing numbers include adult and children's nurses who work in hospitals, but do not include community nurses from the 'NHS workforce statistics' dataset.

Doctor numbers are taken from the 'NHS workforce statistics, doctors by grade and speciality' dataset. The total number of doctors includes consultants, associate specialists, specialty doctors, staff grade doctors, specialty registrars, F1 and F2 doctors and hospital practitioners/clinical assistants.

### Voluntary resignations (Figure 2.10)

For this chart, we group some of the voluntary resignation categories from the 'NHS workforce, reasons for leaving' dataset to make the chart easier to read. The groupings are as follows:

- Work–life balance: this includes just the 'work–life balance' category from the original dataset, as this is the category that we want to highlight.
- Working conditions: this includes the 'better reward package' and 'incompatible working relationships' categories.
- Career development: this includes the 'lack of opportunities', 'promotion' and 'to undertake further education and training' categories.
- Family/external: this includes the 'adult dependants', 'child dependant', 'health' and 'relocation' categories.
- Other/not known: this includes only the 'other/not known' category.

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To calculate the proportion of the workforce that left in the previous 12 months, we first calculated the total voluntary resignations for a given year. This is the sum of the total number of people resigning in the previous four quarters. That amount is then divided by the average NHS headcount across the same 12-month period. The NHS headcount total comes from the monthly 'NHS workforce statistics' dataset, and can be found in the tab called '1. England'.

For example, for the final datapoint in this chart, 10.8% of the workforce voluntarily resigned in the 12 months to September 2022. The number of voluntary resignations is calculated by summing the last two quarters of 2021/22 (35,057 and 36,263) and the first two quarters of 2022/23 (34,909 and 42,411) for a total of 148,640. The average headcount in the NHS in the 12 months to September 2022 was 1,373,904. The proportion of voluntary resignations was therefore 10.8%.

### **Staff absences (Figure 2.11)**

NHS England has 25 categories for staff absences, but no specific number for absences due to Covid. We produced an upper-bound estimate for this number by combining the total number of absences listed under S13 Cold cough flu – influenza, S15 Chest & respiratory problems and S27 Infectious diseases. But in practice this will have caught a proportion of non-Covid absences. Our upper-bound estimate of mental health absences uses the numbers reported under S10 Anxiety/stress/depression/other psychiatric illnesses. We cannot preclude the possibility that some staff absences for either Covid or mental health were reported under S98 Other known causes – not elsewhere classified, or S99 Unknown causes / not specified, but for the sake of simplicity we disregarded this.

In all cases we calculate the number of full-time equivalent (FTE) days lost to sickness in a given month for each category as a share of the total FTE days available, and present this percentage as the sickness absence rate.

## **3. Adult social care**

### **Covid-related spending on adult social care in 2020/21 and 2021/22 (Figure 3.1)**

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. But Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely not to be completely accurate, as September actuals might have differed from the September forecast. But they are close enough for the imputation to be useful.

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It should be noted that it was impossible to impute separate totals for July and August 2021 and November and December 2021 because the survey data was released too infrequently. Instead, we calculate a total for the two months. This should not be a problem as, in both cases, the months fall in the same quarter (Q2 2021/22 and Q3 2021/22 respectively) and therefore are shown in aggregate on the chart.

### **Change in spending on adult social care in England since 2009/10 (real terms) (Figure 3.2)**

We calculate the spending – excluding Covid support – data points on the chart by subtracting the additional local authority spending on adult social care (as laid out in Figure 3.1) from the total adult social care spending as outlined in Table 5 of Appendix B of the 'Adult social care activity and finance report, England – 2021–22' (ASCAFR) dataset. We use this time series rather than the spend on adult social care as outlined in the local authority revenue outturn dataset because it captures a wider range of spending on the service than just local authority related spending.

### **Change in clients per head accessing long-term support during the year since 2014/15, by age band (Figure 3.9)**

This is calculated as the number of people accessing long-term care during the year – from SALT table 36, in ASCAFR – divided by the number of people in the country in that year, as laid out in the ONS's 'Mid-year population estimate'.

## **4. Children's social care**

### **Change in local authority spending on children's social care in England since 2009/10 (real terms) (Figure 4.1)**

We calculate the spending – excluding Covid support – data points on the chart by subtracting the additional local authority spending on children's social care (as laid out in Figure 4.2) from the total children's social care spending as outlined in the DfE's 'Local authority and school expenditure 2021 to 2022' dataset. We use this time series rather than the spending on children's social care as outlined in the local authority revenue outturn dataset because it captures a wider range of spending on the service than just local authority related spending.

### **Additional pandemic-related children's social care spending, 2020/21–2021/22 (Figure 4.2)**

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. But Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely not to be completely accurate, as September actuals might have differed from the September forecast, but they are close enough for the imputation to be useful.

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## **5. Neighbourhood services**

### **Additional Covid spending on neighbourhood services and other local authority-provided services, Q1 2020/21 to Q4 2021/22 (Figure 5.1)**

This information comes from the 'Covid-19 financial impact monitoring information' dataset, released in 20 rounds by DLUHC. Quarterly totals are calculated by summing monthly totals where this is relevant. Spending details for some months are not available in the dataset and in these instances we impute those monthly amounts through comparisons between year-to-date (YTD) amounts in different releases. For example, Round 17 does not include a monthly amount for October 2021, and only shows the financial YTD total for April to October 2021. However, Round 16 includes YTD data to the end of August 2021 and forecasts spend for September 2021. Combining the August YTD actuals with the September forecast means that we could create a YTD September total, which, when subtracted from the YTD October actuals, would give an estimate for the spending in October 2021. This means that the monthly totals are likely not to be completely accurate, as September actuals might have differed from the September forecast, but they are close enough for the imputation to be useful.

It should be noted that it was impossible to impute separate totals for July and August 2021 and November and December 2021 because the survey data was released too infrequently. Instead, we calculate a total for the two months. This should not be a problem as, in both cases, the months fall in the same quarter (Q2 2021/22 and Q3 2021/22 respectively) and therefore are shown in aggregate on the chart.

Neighbourhood services spending here includes all emergency spending on: cultural and related services; housing, environment and regulatory; and planning and development. 'Other local authority spending' is the remainder of local authority emergency Covid support, excluding spending on public health, local authority education support services, 'other – costs associated with foregone savings/delayed projects' and police, fire and rescue services. We exclude these items to make the totals in this chart comparable with other spending amounts in the chapter, where we also exclude public health, education and police, fire and rescue services. We exclude public health because this only became a local authority responsibility in 2013/14 while our time series for neighbourhood services spending extends to 2009/10, meaning that this spending would be incomparable with other spending amounts in the chapter. We exclude education and fire, police, and rescue services because local authorities do not have any control over the level of spending on these services.



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## 7. Police

### Change in gross police spending since 2009/10 (real terms) (Figure 7.1)

Police spending figures for 2020/21 and 2021/22 are generated by combining DLUHC 'Local authority revenue expenditure and financing England: 2021 to 2022 individual local authority data – outturn', 'Revenue outturn central, protective and other services' RO6 tables for England<sup>3</sup> and StatsWales, 'Revenue outturn expenditure summary, by service' figures for Wales.<sup>4</sup>

### Victim-reported crime methodology change (Figures 7.2 and 7.3)

The Crime Survey in England and Wales (CSEW) suspended face-to-face interviews on 17 March 2020 due to the pandemic. From the year ending June 2020, data tables include data from the Telephone-operated Crime Survey in England and Wales (TCSEW). These do not include crimes experienced by children aged 10 to 15 years. Further details are outlined in ONS, 'User guide to crime statistics for England and Wales: measuring crime during the coronavirus (COVID-19) pandemic', 21 July 2022, retrieved 7 October 2022, [www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales/measuringcrimeduringthecoronaviruscovid19pandemic](http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales/measuringcrimeduringthecoronaviruscovid19pandemic)

### Public perception that local police are doing a good or excellent job, 2009/10–2021/22 (Figure 7.7)

Supplementary tables were not published as part of the CSEW in 2020/21 or 2021/22, as the new telephone survey limited time and questionnaire length. As a result, not all of the usual questions were asked of all participants. Data for a similar question, on rating the local police, is available for each quarter, however. The 2022 figure represents the average of responses from each quarter.

## 8. Criminal courts

### Backlog calculations (Figure 8.8)

The latest official statistics for the backlog in the criminal courts are taken from the Quarterly Criminal Court Statistics up to September 2022. We calculate a backlog adjusted for complexity in three stages:

- We calculate the number of jury and non-jury disposals that are missing by assuming that the share of cases coming into the crown court since March 2020 that end up as jury trials is the same as pre-Covid. The 'missing' cases are then the gap between those assumed to be entering the courts system and those that are completed each quarter.
- We treat jury trials and other cases separately. We multiply the 'missing' number of both by [share of total hearing time]/[share of total cases] to get a complexity-weighted increase in the backlog.
- An 'ordinary' backlog is more complex than the average of cases processed (specifically, more cases that will end up as a jury trial), so to adjust this number to be consistent with the pre-Covid backlog we multiply it by [average hearing time of backlog case mix]/[average hearing time of all cases].

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## 9. Prisons

### Change in spending on prisons since 2009/10 (real terms)

To project spending in 2021/22, for which the official total is not yet published, we update the 2020/21 spending figure in line with the increase in HMPPS spending between 2020/21 and 2021/22 published in the supplementary estimates laid before parliament in February 2022.<sup>5</sup>

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# About the authors

## Nick Davies

Nick is the programme director leading the Institute's work on public services, outsourcing and infrastructure. Before joining the Institute, Nick was public services manager at the National Council for Voluntary Organisations. He has also worked at Children England, London Youth and as a parliamentary researcher for an MP.

## Matthew Fright

Matthew is a senior researcher working in the public services team. He joined the Institute in June 2022 from a secondment to the Public Administration and Constitutional Affairs Committee at the House of Commons. Before joining the Institute, Matthew worked at the National Audit Office scrutinising the value for money of government programmes.

## Stuart Hoddinott

Stuart is a researcher in the public services team. He has worked on health and social care policy as well as local government finances and services. Before joining the institute Stuart completed an MSc in public policy and previously worked as a management accountant.

## Philip Nye

Philip is a data scientist at the Institute, working across the organisation. He codes predominantly in SQL and Python, and has a keen interest in data visualisation. Previously, he spent around six years at research organisation FFT Education Datalab, and earlier in his career spent time at the National Audit Office and the Department for Business, Innovation and Skills, as it then was.

## Paul Shepley

Paul is a data scientist at the Institute, working across the Institute's programme areas on large-scale data projects and modelling. His work also extends into the use of data in governance and data and privacy legislation. Before joining the Institute, Paul was a lecturer in geotechnical engineering in the Civil and Structural Engineering Department at the University of Sheffield.

## Gil Richards

Gil is a research assistant who joined the Institute in 2022, working on this year's *Performance Tracker* as part of the public services team.

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## Acknowledgements

This project was undertaken in partnership between the Institute for Government and the Chartered Institute of Public Finance and Accountancy (CIPFA). Thanks to Mark Davey, Tim Fenton and Loic Beuzit for their support and in particular to Jeff Matsu, Ellie Roy, Milan Palmer, Joanne Pitt and Andrew Burns for their comments.

We also would like to thank our colleagues at the Institute for Government – particularly Will Driscoll, Melissa Ittoo, Sam Macrory, Tom Pope and Emma Norris – and David Edwards for their help in producing this report.

This work could not have been completed without the contributions of many experts who graciously gave up their time to review and comment on our findings. All views expressed, together with responsibility for any errors or omissions, are those of the authors.

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**Institute for Government**  
**2 Carlton Gardens, London SW1Y 5AA**  
**United Kingdom**

**+44 (0) 20 7747 0400**

**[enquiries@instituteformgovernment.org.uk](mailto:enquiries@instituteformgovernment.org.uk)**

**February 2023**

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The Institute for Government is a registered charity in England and Wales (No.1123926) with cross-party governance. Our main funder is the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts.