Fixing public services

Priorities for the new Labour government

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About this report

This report looks at the most pressing issues facing the new Labour government in four key public services – the NHS, local government, schools and the criminal justice system – and the common problems that cut across them. It also analyses the implications of sticking with current spending plans, and makes recommendations for how the government can improve performance.

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Over the last 14 years, Conservative-led governments oversaw the hollowing out of public services. The effects of this, in particular the deep budget cuts to some services in the first half of the last decade, have been felt across the nation – and will continue to be felt for some time to come.

Reductions to already low capital budgets have left staff working in cramped, poorly maintained buildings, with outdated IT and without access to the modern equipment available to their counterparts in other countries. Pay freezes, below-inflation pay rises and declining working conditions have resulted in endemic problems with recruitment and retention, with staff leaving in their droves. It should not be surprising, then, that 2022 and 2023 saw the most widespread public sector strikes in a generation.

Serial crises have forced governments into repeated cycles of emergency cash injections and policy interventions that have secured poor value for money and made it extremely hard for those on the front line to plan beyond the next year.

The pandemic was naturally hugely disruptive but exacerbated rather than started the problems public services currently face, and almost across the board – the sole exception being schools – the services on which the public relies are performing worse in 2024 than they were in 2010. For some, like prisons, immediate action is required to prevent a full-scale collapse.

This report sets out the most pressing problems facing the new government, in four key areas – health and social care, local government, criminal justice and schools – and the cross-cutting issues that compound them.

It also offers a warning to the new administration. Labour is right to point out how dire its inheritance on public services is. At the same time, the spending plans laid out in its manifesto are the tightest since 2015 and imply real-terms *cuts* to some of the already worst-performing services. The hard truth for Labour is that sticking to the status quo means most services are likely to be performing worse at the next election in 2028/29 than at the last election in 2019.

Box 1 **Headline findings**

The NHS

1. Hospital productivity is poor. Since 2019, funding has increased by 12% and the number of doctors and nurses by more than 20%, but the number of completed elective cases has increased by only 2% and outpatient appointments by 8%.

2. The *NHS Long Term Workforce Plan*, launched in 2023, will be expensive and extremely difficult to deliver. Spending will need to rise by 3.6% a year, more than double the average annual increase between 2009/10 and 2019/20.

3. Health services are too concentrated in hospitals – as is spending. In 2022/23, £89.5 billion was spent on hospitals, 63% more than on adult social care, mental health trusts, GP services, community trusts and public health combined.

4. The NHS needs more GPs – but since 2015 the number of fully qualified full-time equivalent GPs has declined by 5%, while the number of GP partners fell by 26%.

Local government

1. Local government finances are unsustainable. Since 2018, eight councils have issued section 114 notices, effectively declaring 'bankruptcy', some more than once. This happened just twice in the preceding 30 years.

2. Rising acute pressures – particularly in adult and children's social care, homelessness services and special educational needs and disabilities (SEND) provision – has forced spending cuts on other services. Total local authority spending on neighbourhood services like libraries and youth clubs fell by almost a third (-31.9%) between 2009/10 and 2022/23.

3. The children's social care market is broken. Private providers, which account for three quarters of residential care places, are making consistent profit margins of more than 20%, while children are increasingly being placed in homes outside their local area.

4. Adult social care is much harder to access than it used to be, but fewer people who request care are receiving it than previously: between 2015/16 and 2022/23, the number of people receiving long-term care fell by 4%, despite requests going up by 10%.

Schools

- Since the pandemic, primary school attainment has fallen and disadvantage gaps at KS2 and KS4 have grown to levels not seen in over a decade.

- Many children with SEND are not receiving the support they should (despite ballooning costs for local authorities). Two thirds of local authorities have cumulative schools budget deficits, largely due to the cost of meeting their statutory duties to those with SEND.

- Secondary schools are in a teacher recruitment crisis. The total number of postgraduate entrants into training fell below 22,000 in 2023–24, compared with 29,000 in 2019–20, the last pre-pandemic year, and is just 62% of the annual overall target.

- School buildings are in poor condition due to years of underfunding. Repairs and improvements of £11.4bn would be needed to return all elements of the school estate to a good condition.

Criminal justice

- The police are not resolving most crimes and have lost the confidence of the public. Less than 10% of victim-based offences in 2023 resulted in either a charge, out-of-court disposal or a diversionary resolution.

- Criminal courts cannot keep pace with demand and are becoming increasingly inefficient. As a result, the case backlogs in magistrates' and crown courts are growing, with the latter at its highest level ever at 67,573 cases, more than three quarters higher (78%) than on the eve of the pandemic.

- Prisons are facing a major capacity crisis and the situation is set to get worse. Some 4,400 additional prison places are due to be built by December 2025, but the population is projected to increase by 12,000 by then.

- The probation service is overstretched and cannot adequately manage caseloads or risk. The workforce is increasingly short of the required staff level, with a 25% vacancy rate in Q4 2023, compared to 10% in Q4 2020.

Cross-cutting challenges

- Policy and funding are short term and inconsistent. For example, since 2018, government policing 'priorities' have included serious violence, rape, acquisitive crime, knife crime, violence against women and girls, anti-social behaviour and shoplifting.
- Staff retention is poor, there are key skills gaps and many staff are inexperienced. In 2022/23, around a third (36%) of police officers and over half (51%) of prison officers had less than five years' experience, compared to 14% and 15% respectively in 2015/16.
- There is consistent under-investment in capital. Between 1970 and 2020 there were only two years (2007 and 2009) in which the UK exceeded the OECD average for capital investment in health.
- Acute demand is rising as preventative work has been cut. Drivers of acute demand include cuts to the welfare system, the cost of living crisis, and insecure and increasingly expensive housing.

The inheritance means sticking with current spending plans is likely to be untenable

That inheritance is a poisoned chalice. The public is tired of poorly performing services and want a government that can deliver improvement. But that will be difficult to achieve if Labour sticks to the spending plans laid out in its manifesto, which would see day-to-day departmental spending increasing by 1.2% per year in real terms between 2025/26 and 2028/29. Taking account of commitments on the NHS, schools, defence, aid and childcare, other services – including police, criminal courts, prisons, probation, adult and children's social care – will face average annual real-terms funding cuts of 2.4% over that period. These spending plans would be less generous than any of the five spending reviews undertaken by the Blair and Brown governments between 1998 and 2007, and the tightest since 2015.

Capital spending plans are equally tight, implying cuts of 1.7% per year. Without sufficient capital investment all services will struggle with productivity issues over this parliament.

Even in the services whose budgets are assumed to be protected (general practice, hospitals and schools) there are serious challenges, which mean that additional spending may, absent reform, not deliver meaningful performance improvements. As a result, our analysis suggests that most services are likely to be performing worse at the next election in 2028/29 than at the last election in 2019. Service quality and access in local government and particularly the criminal justice system would continue on a downward trajectory between now and then.

The new government is likely to find it impossible to weather the political storm of the worse performance that current spending plans imply. Even in 2023/24, when budgets were relatively generous, the Sunak government found it necessary to provide extra funding to key public services such as the NHS and local authorities.

The above assumes that performance is directly correlated with spending. The reality is more complex. Performance can improve even if spending does not grow faster than demand, as was the case in schools during the 2010s. Equally, performance can stagnate, even as funding grows substantially, as has happened in hospitals since 2019. The missing ingredient is productivity. The new government needs a strategy for improving this, whether or not it sticks to existing spending plans. In the absence of this, existing trends are likely to continue, with tight spending leading to unacceptably poor performance.

Meaningful improvements can be made to public service performance

The new government should implement a bold programme of public service reform, with the objective of improving the long-term productivity of services. At the heart of this should be a greater focus on outcomes, rather than inputs; on prevention, rather than acute provision; on capital, rather than day-to-day spending; on front-line innovation, rather than top-down command and control; and on the contribution of staff to performance, rather than their cost to the exchequer.

Key parts of this reform programme can be delivered without spending more and, over the long term, would deliver substantially improved public service performance at existing levels of spending. But if the government wishes to see better access to higher quality services more quickly then, at least in the short term, it will need to spend more.

The government must spend money more effectively

Focus on a small set of priorities

The government should **set out its priorities** at the beginning of the parliament. These priorities should be incorporated into the government's budgeting and performance framework, with oversight by the prime minister and senior ministers. Within departments, ministers' time should be focused on priority areas. Ministers should also reflect priorities in the performance measures that front-line services have to report against, scrapping existing targets that are no longer a priority.

Adjust the spending framework

Focus more on prevention. How, and where, spending is allocated influences public service performance. The government should embed its priorities into the spending framework. For example, given its various commitments to shift spending towards preventative interventions, it should identify and protect preventative spending, publish a prevention strategy and properly fund evaluations of spending as part of its first multi-year spending review.

Improve capital spending. The government should also aim to improve investments in public service buildings and equipment by, for example, setting longer term capital budgets and rebalancing accounting officer responsibilities so that they are also scrutinised for underspends and how well they maintain their assets, not just overspends.

Set longer term budgets. Greater certainty is crucial for services. The government should allocate longer term settlements to arm's length bodies and delivery bodies, with fewer ring-fences around small pots of money. The government should also redesign financial incentives in public services so they align with its priorities. For example, it will be hard to shift NHS funding towards prevention while such a high proportion of it is allocated based on a 'payment by results' formula that encourages more acute activity in hospitals.

Make changes to regulations, tax or other policies to reduce demand

The government can influence the demand for public services, and spending, through changes to tax, regulation and other policy. It could, for example, more heavily regulate advertising or increase taxation for tobacco products or food and drink that contribute to obesity – both factors that worsen population health and ultimately require more spending on acute health care. Likewise, it could make changes to sentencing policy to reduce the number of people who are sent to already overcrowded prisons. Not all of these examples will be in line with the political positioning of the government. But whatever the political views of ministers, there will be some options that are aligned with the wider priorities of the government.

Such decisions may come at political cost, though these concerns are often overstated, but political capital is more abundant than money immediately after this election.

Improve the relationship with public sector staff

Pay is the primary driver of staff dissatisfaction, but there are other causes of poor retention that the government could address for relatively low cost. It should take a more collaborative approach to pay disputes; seek to reduce high workloads by more carefully considering the impact of reporting, training and other requirements on staff capacity; improve the quality of service leadership; and support flexible working arrangements where possible.

Where should the government prioritise additional investment?

Improving services quickly is likely to require additional spending, at least in the short term, but this will involve trade-offs. Government can either spend less on other areas, increase taxes or borrow more. Any additional funding for public services will be hard earned and must be used as effectively as possible. We therefore make recommendations on where extra money is likely to lead to meaningful performance improvements.

Investment in prevention and capital would be the best way to improve long-term performance

When budgets have been tight, governments since 2010 have tended to cut preventative and capital spending in favour of day-to-day spending. That decision has contributed to poor service performance and reversing it should be a priority for additional funding.

Investing in a wide portfolio of preventative interventions – for example, raising benefits, targeting public health, and youth services – would likely reduce the amount and intensity of acute demand over the coming years. Similarly, public services will be more productive if staff are able to work in modern buildings with access to suitable equipment. Within capital budgets, the next spending review must ensure sufficient funding is devoted to maintaining existing equipment and buildings to an adequate standard, rather than neglecting this in favour of more glamorous new buildings.

Resolve pay disputes and prioritise spending on back-office staff

Pay has fallen in real terms since 2010, due to a combination of governments' decisions to hold down wages and the unexpected surge in inflation in 2022: public service pay is now at a record low relative to the private sector. Industrial action is the most obvious way that staff express dissatisfaction with pay. But arguably just as impactful – though less visible – is the slow attrition of staff from services as they seek higher pay elsewhere.

To ensure that the services covered in this report work well, the government should prioritise pay and conditions for GPs, social and care workers and criminal barristers. In all four cases, poor rates of pay make it very difficult to retain experienced staff and to recruit new staff from the UK. The shortage of these staff often increases demand in other, more acute and expensive parts of the system.

The government should also prioritise additional spending on recruitment and retention of management and support staff in hospital trusts, integrated care boards, local authorities and the police. While these staff have often been treated as an unnecessary overhead and a waste of limited funds, their work is vital to enabling those on the front line to do their jobs well.

The problems facing public services, built up over the past decade and a half, are well known. Addressing them, while also getting the public finances back on to a sustainable path, will be hard. But there are various ways the new government can start to make progress. With a substantial parliamentary majority and a fresh mandate, Labour has an opportunity do what governments of the last 14 years have repeatedly failed to do: make sensible decisions that may not be immediately popular but that benefit services and citizens over the long term and which will allow them to credibly claim they have left public services in a better state than they found them.

This will not be easy – but will not get any easier as the parliament progresses. With political bravery, vision and a will to lead, these changes could make a real difference to the lives of millions.

The NHS


SO MANY
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1. The NHS

The NHS is broken. That is no longer just the opinion of think tanks, the press and the public, but is now official government policy.[1] Wes Streeting, the new Labour health and social care secretary, is largely correct. Problems in the NHS are well documented and extensive. There is almost no part of the service that is performing better now than it was on the eve of the pandemic. The previous government launched a spate of recovery plans for the service, including one for elective care, one for urgent and emergency care and one for primary care. But despite those plans, improvements have been marginal.

"Building an NHS fit for the future" is one of the new government's five missions.[2] And Labour has made a range of commitments on the NHS that mean that spending is likely to increase. In its election manifesto, it committed to delivering the *NHS Long Term Workforce Plan*.[3] Separately, it has made clear that it is aiming to return to target on elective and A&E care by the end of this parliament.[4] While delivering these ambitions is likely to require more spending, Labour will need to wrestle with the fact that recent spending increases in hospitals have not generated commensurate performance improvements.

This chapter lays out four of the biggest challenges facing the NHS across general practice, hospitals and community care:

- hospitals have a productivity problem
- delivering the planned workforce will be extremely difficult
- health and care services are too hospital-centred
- the number of fully qualified GPs and GP partners has fallen since 2019.

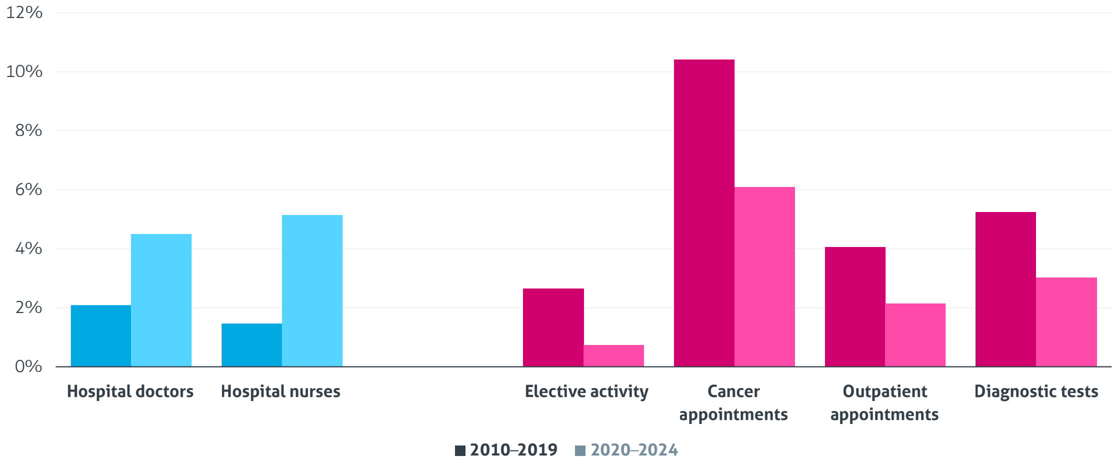
The chapter also touches on areas such as adult social care and public health, as these are both affected by and affect performance in the NHS.

Hospitals have a productivity problem

More money for hospitals is not translating into improved performance

Despite a substantial increase in hospital funding and staffing since 2019, the NHS has failed to deliver a commensurate increase in activity. The government spent 11.9% more on hospitals' day-to-day spending in real terms in 2022/23 than it did in 2019/20. That extra funding has translated into more staff. There were 20.1% more doctors and 23.2% more nurses working in hospitals in March 2024 than in December 2019.

Figure 1.1 **Average annual change in hospital staffing and activity, 2010–24**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, doctors by grade and specialty', NHS Digital, 'NHS workforce statistics, staff group, care setting and level' ('Nurses and midwives' table), NHS England, 'Referral to treatment waiting times' ('Full time series' table), NHS England, 'Cancer waiting times' ('Monthly referrals seen' table), NHS England, 'Monthly diagnostic waiting times and activity' ('Total activity' table) and NHS Digital, 'Monthly hospital episode statistics for admitted patient care and outpatients', March 2024.

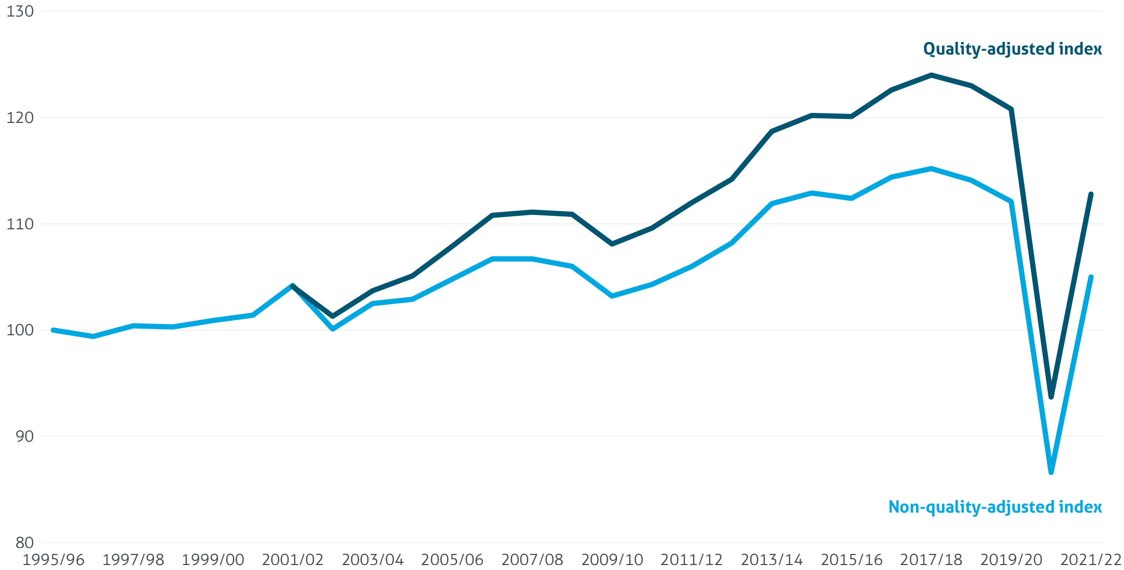
Despite staffing levels increasing more quickly than they did in the 2010s, rates of activity have grown more slowly on average than they did during that decade. Cancer appointments have grown the fastest of the four areas of activity that we looked at, by an average of 6.1% a year since 2020. But that lags far behind the 10.6% a year increases that hospitals achieved between 2010 and 2019.* Although cancer appointments are growing the fastest out of the activity types that we looked at, they comprise a relatively small proportion of total hospital activity. By far the biggest component is outpatient appointments, which have risen by an average of 2.1% a year since 2020, compared with 4.1% in the 2010s. Growth in diagnostic tests has also been slower than might have been expected (3.0% since 2020, versus 5.2% in the 2010s), although the worst-performing area is elective activity, which has been growing by an average of 0.7% a year since 2020 – an outcome that is contributing to the stubbornly high elective waiting list.

There has also been a smaller improvement in urgent and emergency care than might be expected given additional staff. There have been record waits in A&E departments in recent years. More than 1.5 million people waited more than 12 hours in A&E** in 2023/24 (9.7% of those who attended A&E), up from 477,000 in 2019 (2.9% of attendees). The last time the NHS met its target for no more than four-hour waits in A&E was in July 2015. Ambulance performance has improved from the record worst during the winter of 2022/23, but response times are still well above target: in 2023/24, the mean response time for category 2 ambulance incidents*** was 36:23 minutes, down from 50:00 in 2022/23 but still more than double the target of 18:00.

* We used this period as the comparator because it was unaffected by the pandemic.
** This is type-1, or major, A&E units.
*** This includes suspected stroke victims and people with chest pains.

Poor productivity is the result of decisions that governments have taken over decades, but particularly since 2010. The coalition and then Conservative governments chose to hold down inputs – capital spending, wages and staff numbers – into the service.[5] This made measured health productivity[*] in the UK grow quickly throughout the 2010s: quality-adjusted productivity grew at a rate of 1.1% a year between 2010/11 and 2019/20, compared with 0.5% a year between 2001/02 and 2009/10.

Figure 1.2 **Health care productivity, 1996/97–2021/22**



Source: Institute for Government analysis of ONS, 'Public service productivity, healthcare', 2022. Notes: This is an index, where 1996/97=100. The ONS only produced a quality-adjusted index from 2002 onwards.

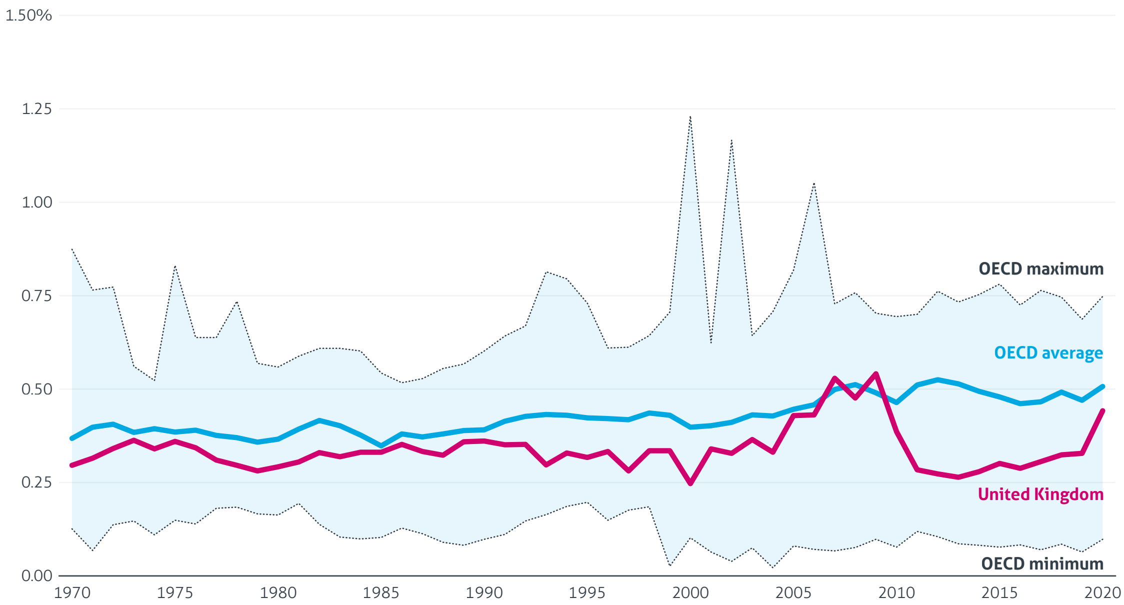
But those 'productivity improvements' stored up issues for the future – a legacy that the current NHS is now reaping, as we describe below. Covid caused a large and sudden drop in health productivity as much NHS activity ground to a halt. But even since Covid restrictions were lifted, productivity has not returned to pre-pandemic levels: in 2021/22, it was still 6.6% below 2019/20 levels and only 2.9% above 2010/11 levels.

Hospitals are falling apart and staff do not have enough equipment

For decades, governments have under-invested in health capital compared with similar countries. But investment fell further in the 2010s, as the then government cut capital budgets and allowed an NHS under strain to shift funding from its capital budget to its day-to-day budget. Capital spending has increased since 2020, but so far this has not been enough to overcome the cumulative under-investment of earlier years.

* The Office for National Statistics (ONS) describes productivity as "a measure of the amount of service provided… for the quantity of inputs used". See ONS, '8. Glossary', 2024, retrieved 4 July 2024, www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/articles/publicservicesproductivityestimateshealthcare/financialyearending2022#glossary

Figure 1.3 **Gross capital formation in health care as a percentage of GDP, by OECD country, 1970–2020**



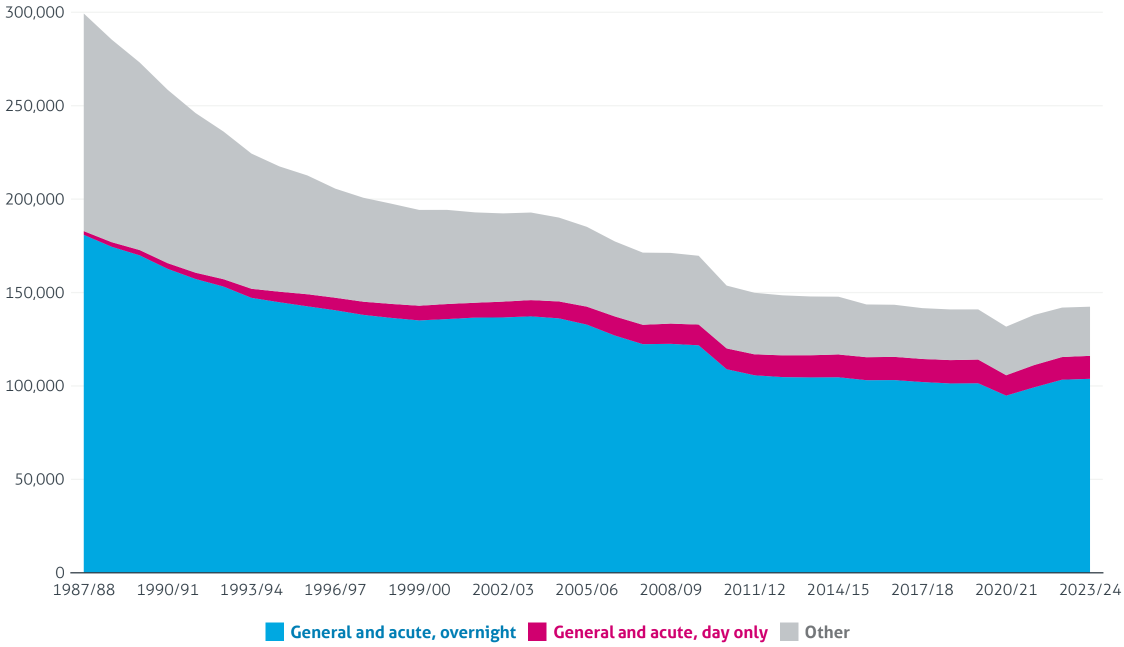
Source: Institute for Government analysis of OECD, 'Gross fixed capital formation in the health care system', 2022 and OECD, 'Gross Domestic Product (GDP)', 2022. Notes: The average is weighted by the size of the country's GDP. When a country has no data for a particular year, it is excluded from the analysis. 2020 is the last year for which the UK has data. Adapted from Health Foundation analysis.

The results have been disastrous. Hospitals are falling apart, with one hospital alone suffering from at least 40 leaks of raw sewage in recent years.[6] There is not enough diagnostic equipment for staff to carry out timely tests. IT systems are outdated and fragmented, making it difficult to communicate across the system. And IT hardware is not much better; computers work sporadically and slowly. These factors all make it much harder for hospital staff to work effectively.[7]

Hospitals do not have enough beds

A long-term decline in the number of hospital beds has hindered patient flow. Between 1987/88 and 2023/24, the NHS cut hospital beds by more than half (-52.5%). Some of this was for good reason. The NHS started treating more people out of hospital and, as treatments improved, people needed to stay in hospital for less time, reducing the need for beds. But there is evidence that this has now gone too far. The strategy of cutting bed numbers in pursuit of increased efficiency has been shown to be vulnerable to increases in length of stay, as has happened in the years since the pandemic. This has resulted in the NHS having to raise admission thresholds, thus admitting fewer people into hospital.[8]

Figure 1.4 **NHS beds, 1987/88–2023/24**



Source: Institute for Government analysis of NHS England, 'Bed availability and occupancy data' ('Open overnight' and 'Open day only' tables), March 2024. Notes: The chart shows 'available' beds in NHS hospitals. 'Other beds' is comprised of learning disability, maternity and mental illness beds.

The resulting lack of beds means that there is consistently high bed occupancy.* There is no month since September 2020 in which the average national bed occupancy in hospitals** was below 85% – the level that the Royal College of Emergency Medicine deems to be "safe".[9] This has ramifications for many elements of hospital performance. It is harder to admit people from A&E departments. And hospitals are forced to cancel elective procedures that require an admission. In short, patients are not able to flow through the system.

Hospitals are badly under-managed

Effective management is vital if the NHS hopes to make the most of its expensive and extensive workforce. Despite that, the number of managers per NHS worker has fallen since 2010. In March 2024, 2.96% of the NHS workforce were managers, down from 3.75% in September 2009 – a decline of more than a fifth (21.0%). By comparison, across the entire UK economy, approximately 11% of staff work in management roles,[10] although a good proportion of management work in hospitals is (and should be) carried out by doctors and nurses.

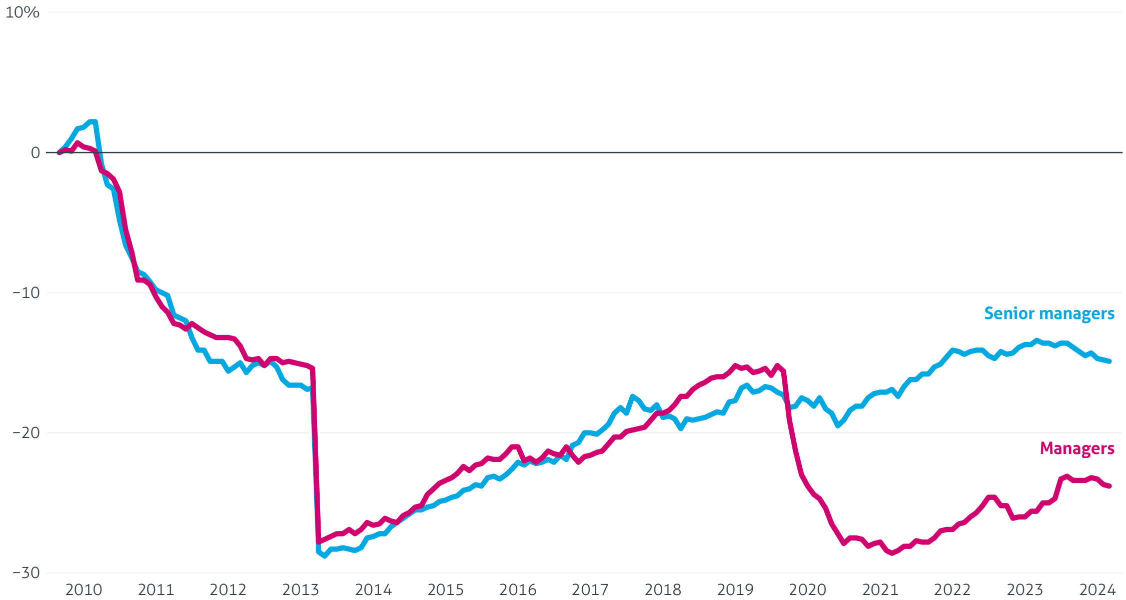
Management spending is also lower versus other countries. The UK spent 1.9% of its health spending on administration in 2021, below countries such as Ireland, the Netherlands, Germany and France, which spent 2.2%, 3.7%, 4.4% and 5.5% respectively.[11] But there are also comparison issues here, as the type of funding model that each country employs affects administration costs.[12]

* This does not necessarily mean that the NHS has to increase the number of beds in hospital. It could also try to treat more people in other settings such as community care, or through improved prevention.

** With a type 1 (major) A&E unit.

More management is not always a good thing. After a certain point, the benefits of additional managers will start to decline. But work carried out by academics at the University of Leeds found that the ratio of managers to staff in hospitals in England was below the optimal level (1.8% versus 3%).[13]

Figure 1.5 **Change in NHS managers per staff member since September 2009**



Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, England and organisation' (Table '1. England'), March 2024. Notes: Both managers and total NHS staff numbers are in terms of FTE staff.

This lack of management capacity makes it difficult to use scarce NHS resources effectively. Operating theatres may be under-used, rotas may be poorly designed and administrative work that is not done may fall to front-line staff.

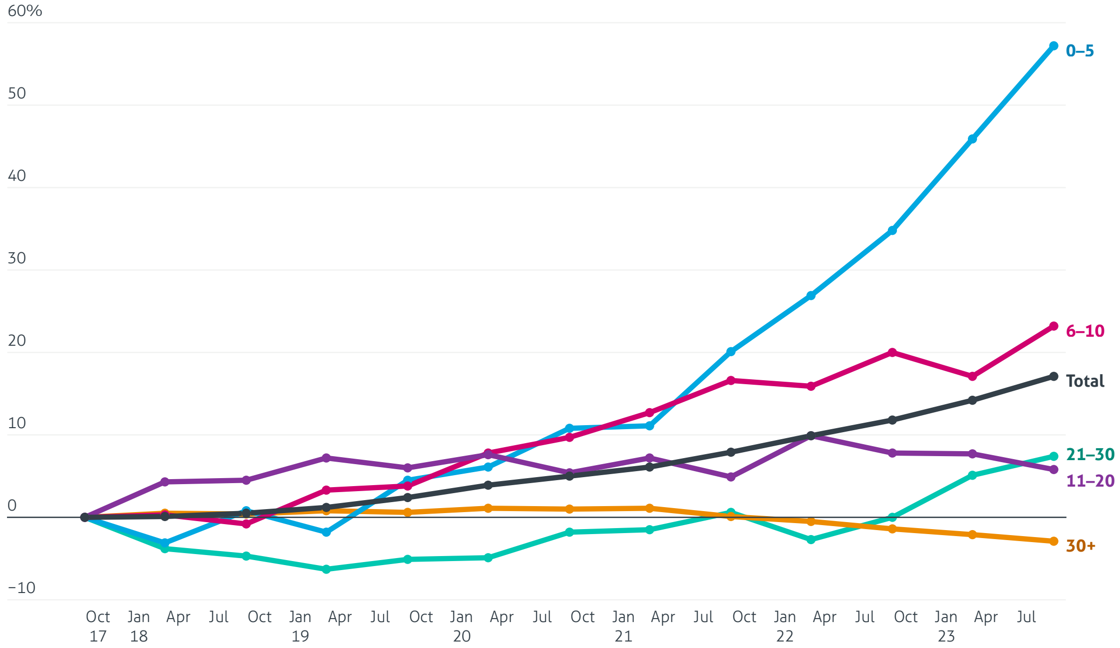
The *NHS Long Term Workforce Plan*[14] lays out specific targets for doctors, nurses and allied health professionals,[*] but there are no ambitions for management or administrative staff. While easier to train than clinical staff, it is short-sighted to assume that there will be a reliable supply of well-trained managers. Without commensurate planning and hiring of that portion of the workforce, the new government risks not achieving as much from the expanded clinical workforce as it might otherwise.

Staff are less experienced than they were before the pandemic

There was a large movement of staff out of the NHS after the worst of the pandemic in 2021. Staff left for a number of reasons, including burnout from high workloads during the pandemic and dissatisfaction with pay. The NHS workforce has also rapidly expanded in recent years. The result is that staff are less experienced on average than before. For example, the number of nurses on the Nursing and Midwifery Council's (NMC) register with fewer than five years' experience grew by 57.2% between September 2017 and September 2023, while the number of nurses with more than 30 years' experience fell by 2.9% over the same period. All else being equal, less experienced staff will be less effective in their roles.

* Allied health professionals are NHS staff who provide a range of services such as physiotherapy, pharmacy, osteopathy and podiatry.

Figure 1.6 **Change in registered nurses since September 2017, by number of years since registration**



Source: Institute for Government, Public First and Health Foundation analysis of Nursing and Midwifery Council, 'Permanent register tables' ('Time' table), March 2023. Notes: Figures are only available from September 2017.

The problem is not contained to hospitals

Productivity issues are most visible in hospitals (largely because hospitals are the part of the health and care system for which there is the best data) but both the causes and the effects of these issues are visible across the wider health and care system.

One of the most high-profile examples of this is in social care. A key determinant of patient flow – and therefore performance – is the ability of hospitals to discharge patients in a timely manner. But hospitals have difficulty discharging people who no longer need to be in hospital. Throughout April 2024, approximately 12,750 patients a day remained in hospital despite no longer meeting the criteria to reside.[15] Given there were 100,902 general and acute beds available in hospitals in that month,[16] it means that roughly one in eight beds were occupied by people who did not need to be in hospital. This partly reflects problems inside hospitals, but is also indicative of a lack of capacity in other services, particularly social care. The Nuffield Trust estimates that 43% of those delayed more than seven days and 47% of those delayed more than 21 days are waiting for social care.[17] Conversely, delays in discharges increase the risk that people lose their mobility, necessitating additional support from social care and other services.

Delivering the planned workforce will be extremely difficult

The proposed expansion in training places is incredibly ambitious

Parliament, think tanks and bodies such as the National Audit Office spent years calling for a thorough and extensive workforce plan for the NHS. The Sunak government finally delivered that plan in June 2023 with the *NHS Long Term Workforce Plan* (LTWP).[18]

The vision laid out in that document is ambitious and welcome. By 2031/32, its aims include:

- doubling the number of medical school training places
- increasing the number of GP training places by 50%
- increasing adult nursing training places by 92%.[19]

Labour has committed to delivering the LTWP but doing so will require expanding the number of training places in universities and the number of educators in services. Work from the Health Foundation estimates that those training for clinical roles will account for approximately 16% of all first-year student enrolments in 2031/32, up from 11% in 2022/23.[20] In other words, one out of every six students in the UK will be studying to enter a clinical role.

The Sunak government committed £2.4 billion of funding between 2024/25 and 2028/29 to expand university training places.[21] But that money is being put into a higher education system that is under immense financial pressure, with many universities warning that they may have to close or substantially pare back the services and courses that they offer.[22]

There will also need to be an increase in clinical placements – a challenge that the LTWP itself acknowledges.[23] The LTWP's proposal for addressing this ("We will work with stakeholders… to ensure clinical placements are designed into health and care services, and placement providers know what core standards they need to meet"[24]) is incredibly vague and does little to reassure that there is a clear plan for how the government can achieve this target.

More training places requires more permanent, qualified staff to train incoming staff. These staff (referred to from here on as 'educators') are already under substantial pressure. In its 2023 survey of educators and trainees, the General Medical Council (GMC) found that less than half of educators (46%) can devote the full amount of time that they are supposed to to training due to competing pressures.[25] The NHS released a strategy for increasing the size of the educator workforce,[26] but is yet to publish the implementation plan for that strategy.[27] Concerns about growing the educator workforce seem particularly pertinent in general practice, where there are fewer fully qualified GPs working in the service than in 2019.

Implementing the NHS Long Term Workforce Plan (LTWP) will be expensive

Aside from the practical implementation challenges, implementing the LTWP will be expensive and have implications for the new government's wider taxation and spending plans. The Institute for Fiscal Studies estimates that the government will need to increase NHS spending by 3.6% a year in real terms to meet the ambitions of the LTWP.[28] While this is below the average increases in government health spending of 4.3% a year between 1949/50 and 2009/10, it is well above the 1.7% a year average between 2009/10 and 2019/20. This amount also understates the spending that would be needed to deliver the LTWP as it only includes staffing costs, whereas the LTWP modelling assumes sustained capital investment in technology and the estate.[29] Funding the LTWP will likely require difficult trade-offs, either in terms of more taxation or borrowing, or else cuts to other public services.

The NHS has become reliant on international recruitment

The LTWP states that nearly a quarter of staff are currently recruited internationally and that the goal is to reduce that number to "around 9–10.5% of our workforce" in 15 years' time.[30]

But recent trends have gone in the opposite direction. Since the middle of the pandemic, the NHS and the adult social care sector have increasingly relied on recruitment from outside the UK to fill workforce vacancies. The number of joiners to the NHS's doctor and nursing workforce from outside the UK rose by 43.9% and 71.9% respectively between March 2020 and December 2023. In comparison, the number of joiners from the UK was relatively flat in the same period. That trend has been even more stark in the GP workforce. The proportion of GP trainees that are from the UK fell from 70.7% in September 2015 to 49.6% in April 2024. A similar dynamic has taken place in the social care workforce.

There was a large exodus of staff from both the NHS and adult social care workforces from June 2021 onwards. A record 10.8% of NHS staff voluntarily resigned in the 12 months to June 2022, more than 10% higher than the pre-pandemic record of 9.7%.[31] That was for a number of short- and long-term reasons such as dissatisfaction with pay, more attractive pay in competing sectors and pandemic burnout. This led to a large number of vacancies and services subsequently turning to international recruitment as a way to grow their workforces.

But relying on international recruits has generated a political backlash. After record-high net migration numbers, the Sunak government tightened visa rules for health and care workers at the end of 2023.[32] That decision could jeopardise the ability of both the NHS and the adult social care sector to find enough staff. Even if the new government can expand training places in line with ambitions in the LTWP, it will need to find a way to balance the immediate needs of the workforce against political pressure to reduce net migration. This is particularly true if there is not a reversal in the poor staff retention record of recent years.

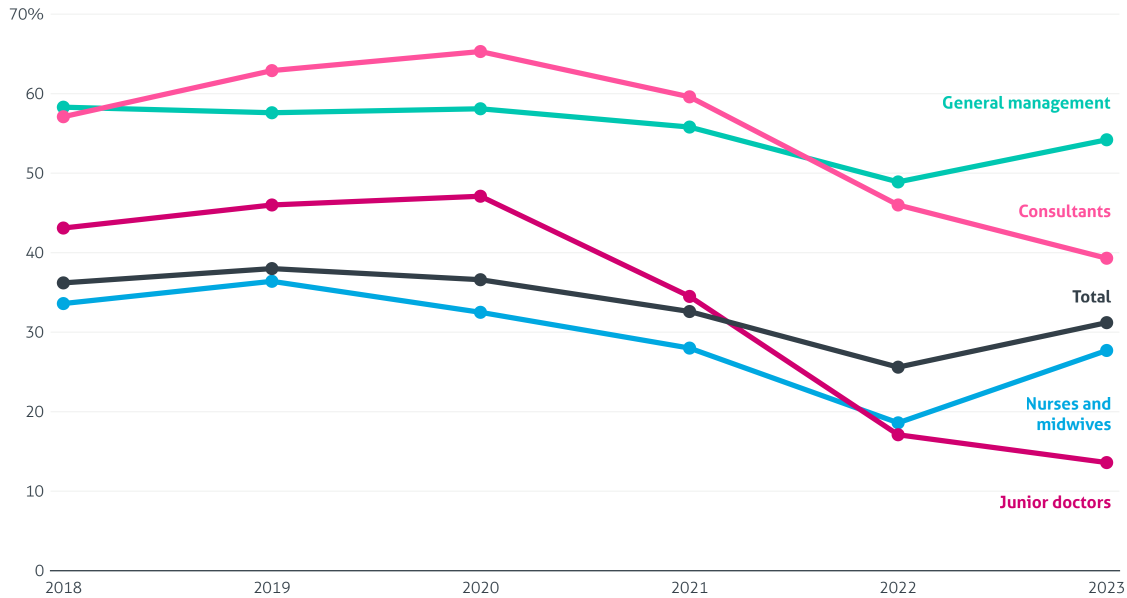
There is a risk of further industrial action

Delivering the LTWP also relies on retaining and getting the most out of the existing workforce. The last parliament saw the worst period of industrial relations in the NHS's history. Nurses, ambulance workers, consultants and junior doctors have all walked out of hospitals at various points since 2022.

The Sunak government resolved all but the junior doctors' dispute. But industrial relations are still poor across the service. The British Medical Association (BMA) – the union that represents most doctors – is balloting GP partners on industrial action.[33] And the Royal College of Nursing (RCN) – the union that represents a large proportion of the nursing workforce – has threatened renewed strike action in 2024.[34]

The key driver of industrial disputes (and wider retention problems) is dissatisfaction with pay. Satisfaction with pay remains below pre-pandemic levels across the entire health service, but has fallen furthest among doctors: only 13.6% of junior doctors were satisfied with pay in 2023, down from 46% in 2020.

Figure 1.7 **Satisfaction with pay, by NHS staff group, 2018–23**



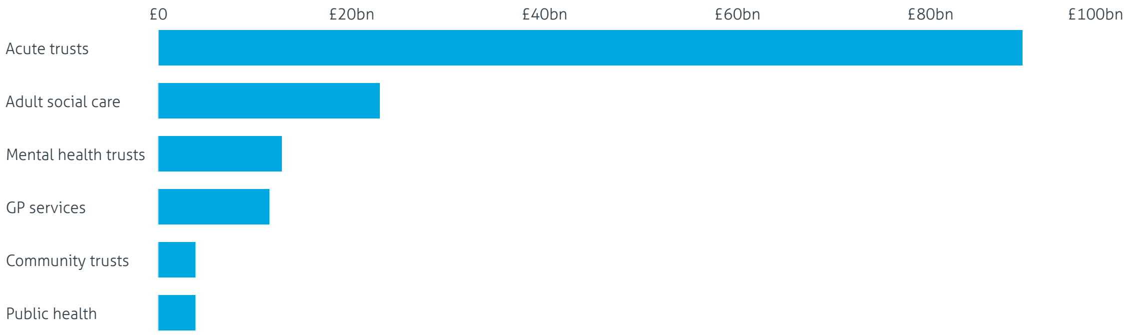
Source: Institute for Government analysis of NHS England, 'Staff Survey' (Q4c: How satisfied are you with your level of pay?), 2023. Notes: The percentages show those who responded 'satisfied' and 'very satisfied'.

The upcoming reports by pay review bodies and the government's response to these could trigger further industrial action. These would lead to the cancellation or rescheduling of elective procedures and absorb limited management capacity in trusts, distracting from some of the productivity-enhancing improvements that those managers could be working on. It could also potentially further reduce staff goodwill and discretionary effort – a factor that interviewees claimed is contributing to lower hospital productivity.[35]

Health and care services are too hospital-centred

Hospitals have long been the centrepiece of the NHS. They receive more funding and attention than any other part of the health and care system. To an extent, this is understandable. Equipping, staffing and operating a modern hospital is an intensely complex and expensive endeavour and it is where the NHS delivers some of the most visible and easily understood health care. And ambulance delays and A&E waits make for more dramatic news stories than the quiet and largely unseen – although invaluable – work of staff such as health visitors and district nurses.

Figure 1.8 **Public spending on the health and social care system, by sector, 2022/23**



Source: Institute for Government analysis of NHS England, 'Annual report and accounts', 2022/23, NHS England, 'Consolidated NHS provider accounts' ('Analysis by type of trust' table), DLUHC, 'Local authority revenue outturns: RO3', 2022/23 and NHS Digital, 'Adult Social Care Activity and Finance Report, England 2022-23' ('Appendix B, Table 5').

Too often, there has been a tendency to wait for people's health to deteriorate before then treating them in hospital. This is an expensive way to run a health and care system. This information is not unknown to the NHS: the King's Fund estimates that governments have been attempting to shift care away from hospitals and to better integrate disparate parts of the health and care system since 1974.[36] New Labour attempted it with the establishment of primary care trusts in 2000.[37] More recently, the 2019 *NHS Long Term Plan* made "boost[ing] 'out-of-hospital' care, and finally dissolv[ing] the historic divide between primary and community health services" one of the key priorities of its "new service model for the 21st century".[38]

The NHS and government have not made the most of integrated care systems

One of the key innovations in the last parliament was the NHS-wide introduction of integrated care systems (ICSs) under the Health and Care Act 2022. ICSs are intended to join up health and care services at a local level, and shift the focus of the NHS away from output metrics and towards health outcomes such as population health and health inequalities.[39] This work is led by integrated care boards (ICBs) at a local level, through which the majority of NHS funding flows.

The theory behind the introduction of these systems is sound, but implementation has thus far fallen short. The Conservative government put ICBs on a statutory footing in July 2022 and then decided to cut their management budgets by 30% in March 2023.[40] This meant that ICB leaders then spent the following months cutting programmes and staff that they had only recently launched or hired.

ICBs have also often been pulled into firefighting in the acute hospital sector. This is partly because of the context of the past few years. NHS strikes started five months after the establishment of ICBs in December 2022 and improvements in hospital performance have been anaemic since the end of the pandemic, absorbing press and ministerial attention. As a result, ICBs have been under pressure from ministers and NHS England to focus on hospital performance. As the old adage goes, what you measure matters and there is far more data about what is happening in hospitals.[41]

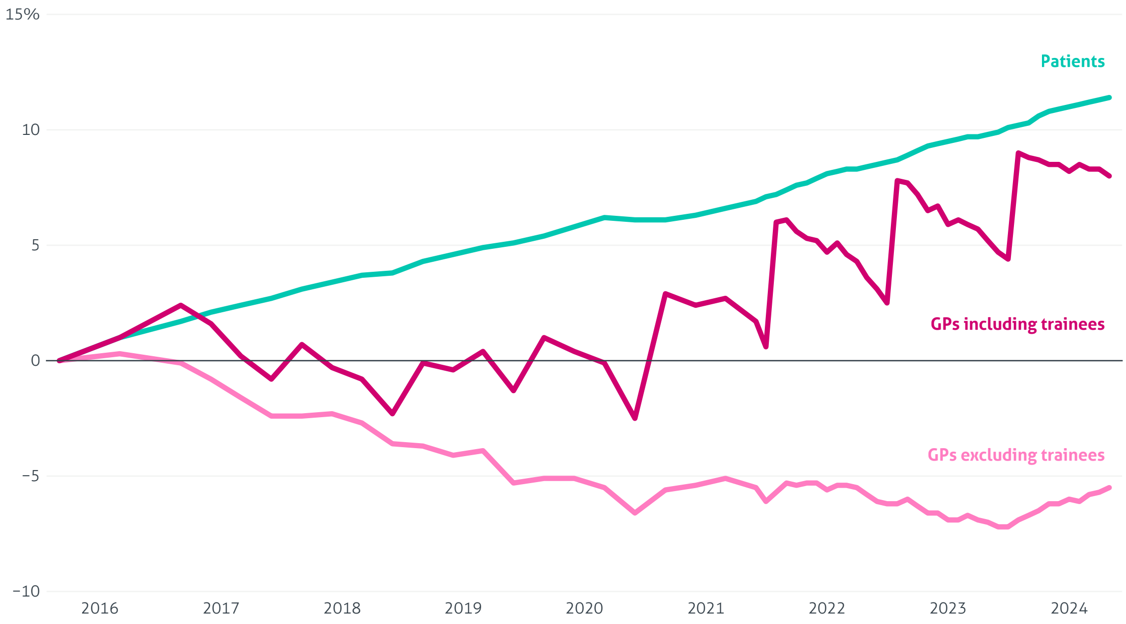
Acute hospital trusts have a disproportionately strong voice in ICBs. They have by far the biggest budgets and the most staff. Funding flows – for example, payment by results, wherein NHS England pays hospitals for carrying out more elective activity – also incentivise more activity in hospitals.[42] As a result, ICBs have often focused on issues in hospitals at the expense of reforms to the wider health and care system.

The number of fully qualified GPs and GP partners has fallen since 2019

The number of fully qualified GPs has declined most in the most deprived parts of England

There has been a steady attrition of fully qualified GPs from the general practice workforce in recent years. Between September 2015 and May 2024, the number of fully qualified full-time equivalent (FTE) GPs declined by 1,570 or 5.5%. While there was an increase of 477 fully qualified GPs between July 2023 and May 2024, this still leaves the total much lower than in 2016. During the same period, the number of patients in general practice grew by 11.3%. There are now 2,350 patients for every GP in England, up from 1,990 in September 2015 – an increase of 18.0%.

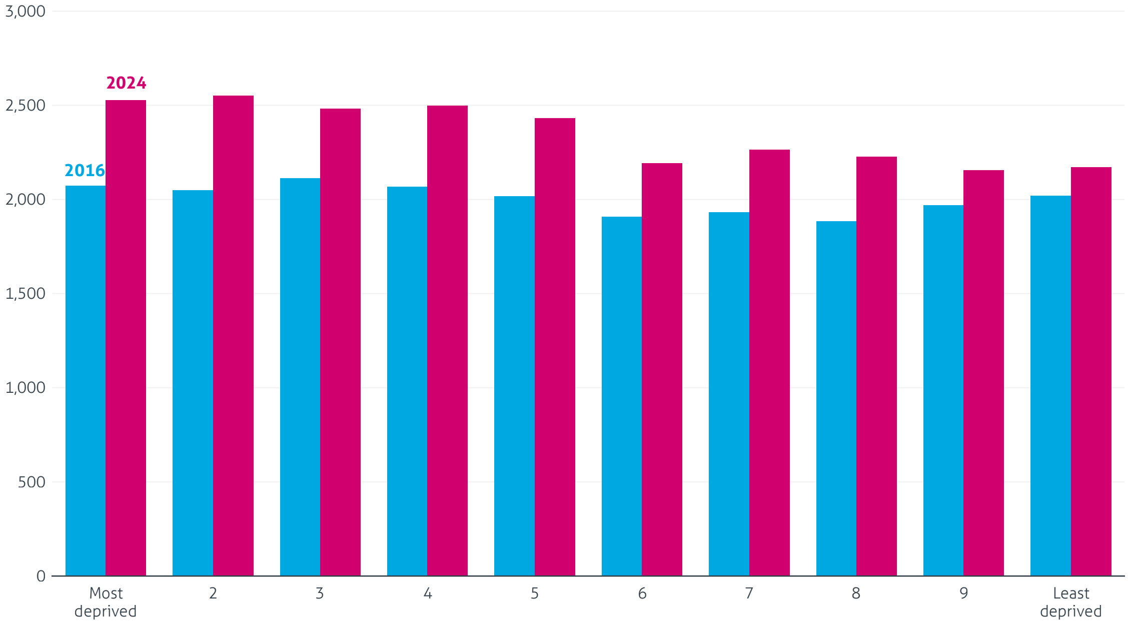
Figure 1.9 **Change in number of GPs and patients registered with GP practices since September 2015**



Source: Institute for Government analysis of NHS Digital, 'General practice workforce, England, bulletin tables September 2015 – April 2024'. Notes: Data was first published in 2015/16. 'GPs' refers to the number of fully qualified, permanent GPs. Staffing numbers are expressed in terms of FTEs.

That change has not happened equally across England. The ratio of patients to GPs has increased far more quickly in the most deprived parts of the country as both the numbers of GPs working in those areas has declined and the number of patients has grown. In March 2024, in the most deprived decile of the country there were 16.3% more patients for every GP compared with the least deprived parts of the country – 2,526 compared with 2,172.

Figure 1.10 **Patients per GP, by decile of deprivation, 2016 and 2024**



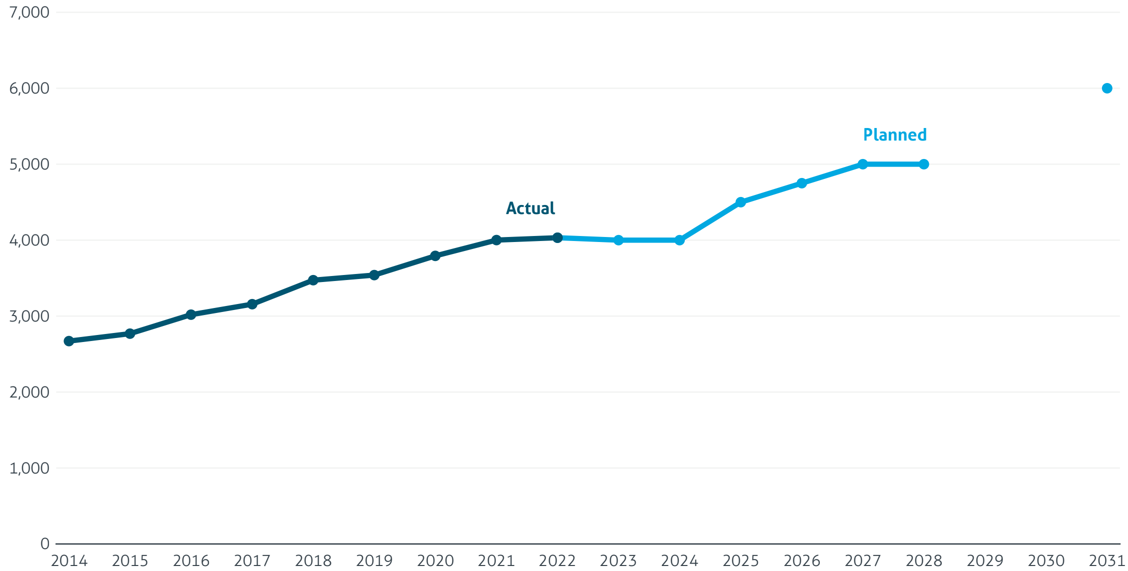
Source: Institute for Government analysis of NHS Digital, 'Patients registered at a GP practice', March 2024, NHS Digital, 'General practice – practice level staffing', March 2024 and DLUHC, 'English indices of deprivation', 2019. Notes: This analysis is carried out at the lower-layer super output area level. The month of analysis is March in both years. Staffing numbers are expressed in terms of FTEs.

This trend poses a substantial threat to the effectiveness of general practice and any government's ambitions to improve access to primary care, reduce health inequalities and make a shift towards a more preventative model of health care.

Higher numbers of GP trainees are not translating into fully qualified GPs

The NHS has focused on improving the supply of GP trainees. It has been incredibly effective at doing this: the number of GP trainees increased from 2,671 in 2014 to 4,032 in 2022 – an increase of 51%. The LTWP lays out an ambition to further increase this to 6,000 by 2031.

Figure 1.11 **Number of GP trainees, actual and planned, 2014–31**



Source: Institute for Government analysis of Health Education England, 'GP trainee recruitment data', 2022 and NHS England, 'NHS Long Term Workforce Plan', 2023.

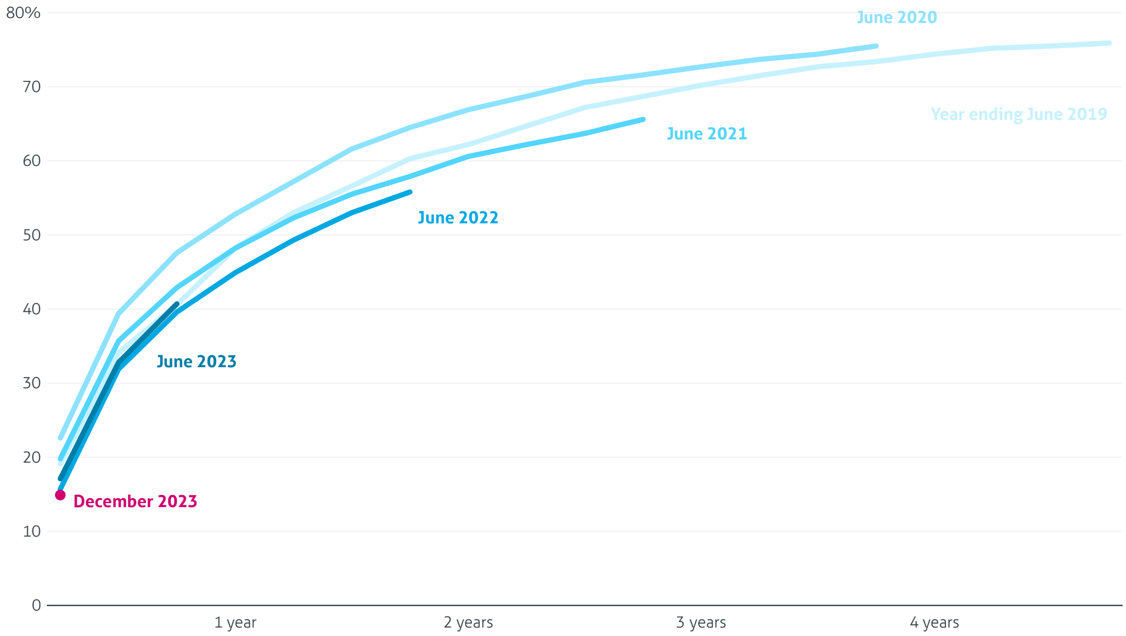
But rapidly rising numbers of GP trainees are not translating into the necessary fully qualified GP workforce. Between September 2015 and September 2022, 27,784 GP trainees started training placements.[43] While not all trainees who start their training finish it, a good proportion will and they will then be eligible to work as fully qualified GPs. Despite that, the number of GPs fell from 28,590 in September 2015 to 27,020 in May 2024 – a decline of 1,570 or 5.5%. Some GPs have retired at the end of their careers or otherwise left the service, but others have not taken their place.

There are several reasons for this. Interviewees reported that trainees are often put off working in the service by high workloads. This is supported by General Medical Council (GMC) polling, which shows trainee burnout increasing consistently between 2020 and 2023.[44]

Paradoxically, there are reports of very few available jobs for salaried GPs, despite high demand for their services.[45] It seems that this is due to a lack of core funding (which has risen less quickly than inflation since 2019) – the pot of money that GP partners use to pay for the majority of practice staff salaries – and the previous government's decision to prohibit GPs from using funding from the Additional Roles Reimbursement Scheme (ARRS) to hire GPs. And the situation is not expected to improve, with the LTWP assuming, bizarrely, no growth in fully qualified GPs over the course of this parliament.[46]

Some of this is also due to a growing lag between GPs finishing training and joining the fully qualified workforce. Only 44.9% of those trainees who completed training in the year ending June 2022 had joined the workforce after a year, compared with 48.2% of those finishing training in the year ending June 2019.

Figure 1.12 **Proportion of GP trainees entering the fully qualified workforce, by year in which they completed training, 2019–23**

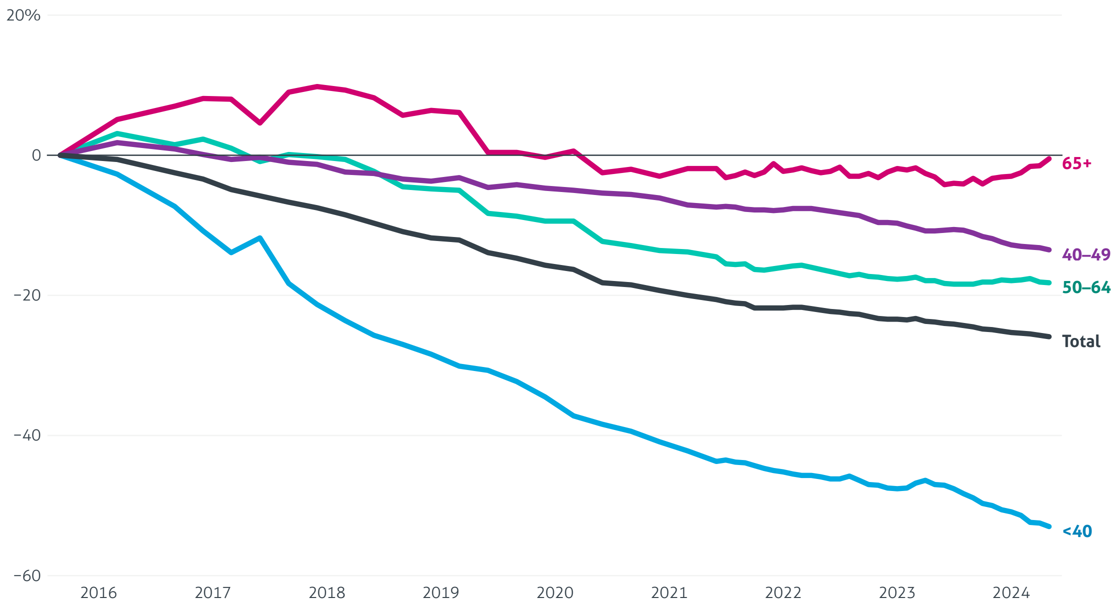


Source: Institute for Government analysis of NHS Digital, 'Tracking GPs in training into fully qualified general practice roles' (Table '1. All GPs'), March 2024. Notes: Each series shows the GPs who finished their training programme in the previous 12 months, with the exception of December 2023, which shows the previous six months.

There is a crisis in the GP partner workforce

Hidden beneath the headline figures of declining numbers of fully qualified GPs is a greater crisis in the GP partner workforce.* While the number of fully qualified GPs declined by 5.5% between September 2015 and May 2024, the GP partner workforce declined even more precipitously, by 25.9%.

Figure 1.13 **Change in GP partner numbers since September 2015, by age band**



Source: Institute for Government analysis of NHS Digital, 'General practice workforce, England, bulletin tables December 2015 – May 2024' (Table '2a'). Notes: All staff numbers are in terms of FTE.

* The GP workforce is split into GP partners, who are effectively independent contractors who own and operate practices, and salaried GPs, who practices employ to deliver GP services.

The issue is most severe among younger GP partners. The number of GP partners under the age of 40 more than halved (-53.0%) between September 2015 and May 2024, falling from 4,152 to 1,949. In comparison, the number of salaried GPs under the age of 40 rose from 3,793 to 5,090 in the same time period, an increase of 34.2%.

Partnership is often unattractive because it requires substantial up-front investment of personal money, particularly into the premises.[47] The unlimited liability model of many partnerships means that GP partners can often find themselves personally responsible for paying off practice liabilities in the event they want to wind up the partnership.[48] Partnership is also incredibly inflexible. Once a GP enters a partnership, they are generally tied to a location for a number of years, if not decades. Finally, being a GP partner is much harder in a context of constrained spending increases. They have to manage tight budgets that, since 2019 at least, have not kept pace with inflation.

For a service where delivery relies on GPs taking on partnership, this should sound serious alarm bells about the sustainability of the current model.

Pressure on GPs is rising and funding is not keeping pace

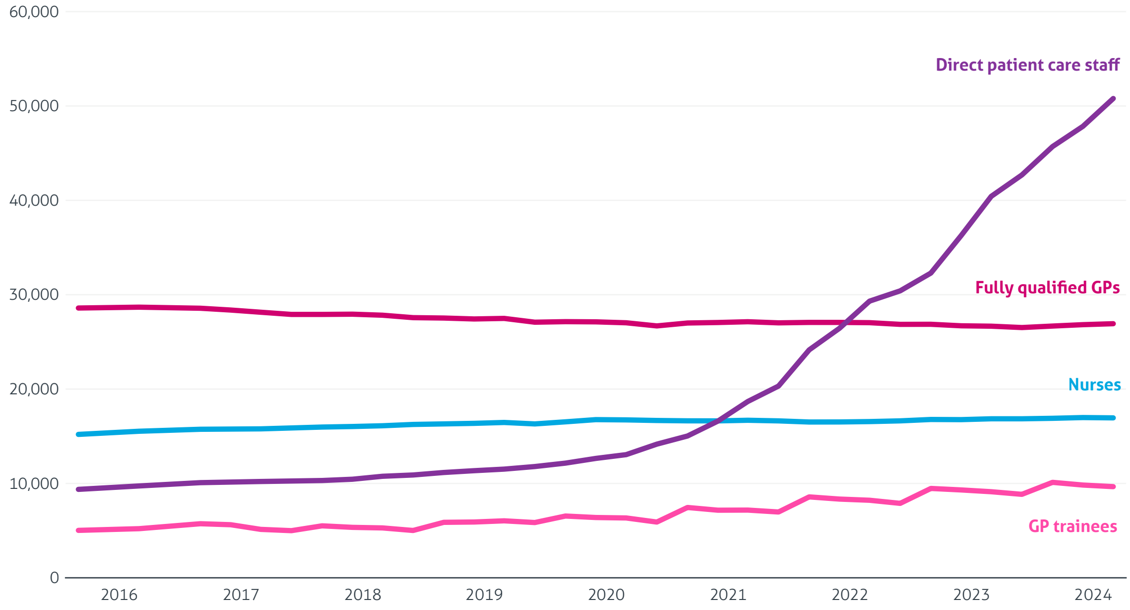
This workforce crisis is happening for a few reasons. GP workloads have arguably never been higher. GPs delivered a record 161.9 million appointments in 2023/24, up from 154.1 million in 2019/20 – an increase of 5.0%. This is a remarkable achievement given the fall in the number of fully qualified GPs in that time. But it likely comes at a cost. In the most recent GP Worklife Survey (conducted in 2021), GPs reported that increasing workloads were the most significant stressor in their jobs.[49] This is understandable: they were rapidly changing ways of working and attempting to handle the needs of a population during a global pandemic. It is likely that workloads have risen further since 2021. And there is arguably an invisible backlog of unmet need that general practice is attempting to manage. NHS England's decision to manage demand off the elective waiting list through the increased use of diversionary measures such as advice and guidance has exacerbated this.[*] In its assessment of advice and guidance, the National Audit Office (NAO) argues that "it is unclear whether GPs will be able to manage the additional workload that might result".[50]

Another source of dissatisfaction – particularly among GP partners – is that the Conservative government did not adjust the 2019 GP contract enough (which ran between 2019/20 and 2023/24) to account for the full range of new responsibilities during and after the pandemic and the rising costs that were a result of the bout of inflation that gripped the country from 2022.[51]

[*] Under advice and guidance, GPs discuss with colleagues in hospitals whether or not they need to refer someone for more specialist care. The stated aim of this is to ensure that patients' care is managed in the most appropriate setting.

One area of funding that has exceeded inflation is the ARRS pot of money. The ARRS has funded an enormous increase in the number of what are known as 'direct patient care' (DPC) staff.* Between March 2019 and March 2024, the number of DPC staff working in primary care grew from 11,519 to 50,794 – an increase of 39,275, or 341%. The number of DPC staff is now almost double (1.89 times) the fully qualified GP workforce, having started the last parliament at approximately 40%.

Figure 1.14 **NHS primary care staff, by staff group, September 2015 to March 2024**



Source: Institute for Government analysis of NHS Digital, 'General practice workforce, England, bulletin tables December 2015 – March 2024' (Table '1a'), NHS Digital, 'Primary care network workforce March 2019 – June 2021' (Table 1a) and NHS Digital, 'Primary care workforce quarterly update' (Table '1b'), March 2024. Notes: For more information on how DPC staff are calculated, please refer to the Methodology. All staff numbers are in terms of FTE.

The addition of ARRS staff was intended to improve access to care and to reduce pressure on GPs. For example, pharmacists can now prescribe some things like the oral contraceptive pill and take patients' blood pressure.[52] While this is likely to have increased the number of people seen in general practice, there is also evidence that it has worsened GP workloads. ARRS staff are doing a lot of the low-complexity work that GPs previously did. But high levels of demand for GP services mean that the appointment slots that were previously taken up by less complex patients are immediately filled with more complex patients. GPs are then required to treat as many complex patients in the same amount of time while also managing many of these new staff.[53]

The new government must make stemming the steady drip of fully qualified GPs from the service a priority. This is particularly true for GP partners, on whom the current model of general practice relies.

* This includes staff groups such as pharmacists, care co-ordinators and social prescribing link workers.

Local government

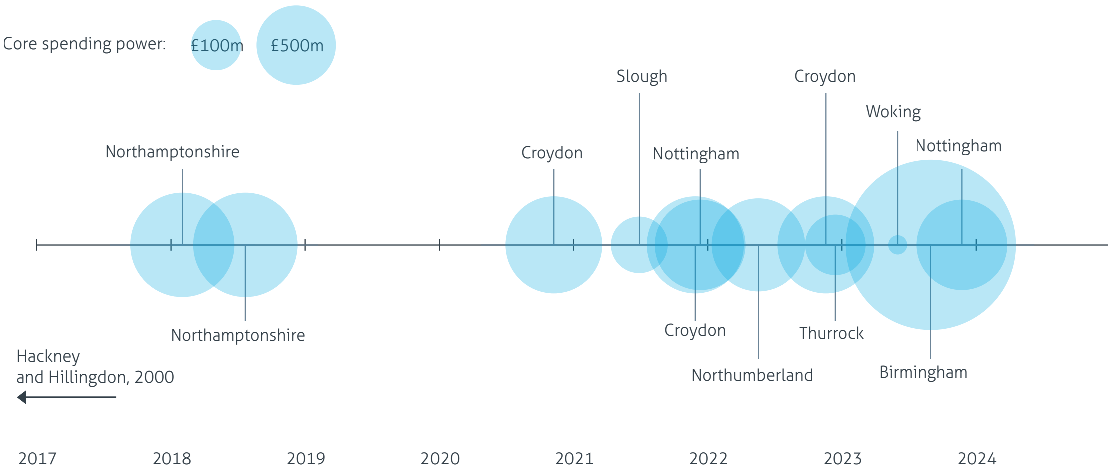
2. Local government

Local government bore a disproportionate share of spending cuts in the 2010s. Local government is one of the few areas of public services where spending remains lower in real terms in 2024/25 than it was in 2010/11. This has had widespread and profound consequences for the quality and accessibility of local authority services,[1] leaving residents across England struggling to access – or receiving poor-quality service from – adult and children's social care, local road maintenance, libraries, planning departments, recycling and homelessness services, among others.

Local government finances are unsustainable

Pressure on local government finances has never been higher. Since 2018, eight local authorities have issued a total of 12 section 114 notices (section 114 notices are colloquially known as 'bankruptcy' notices) compared with two in the preceding 30 years.[2]

Figure 2.1 **Section 114 notices, 2017 to June 2024 (2024/25 prices)**



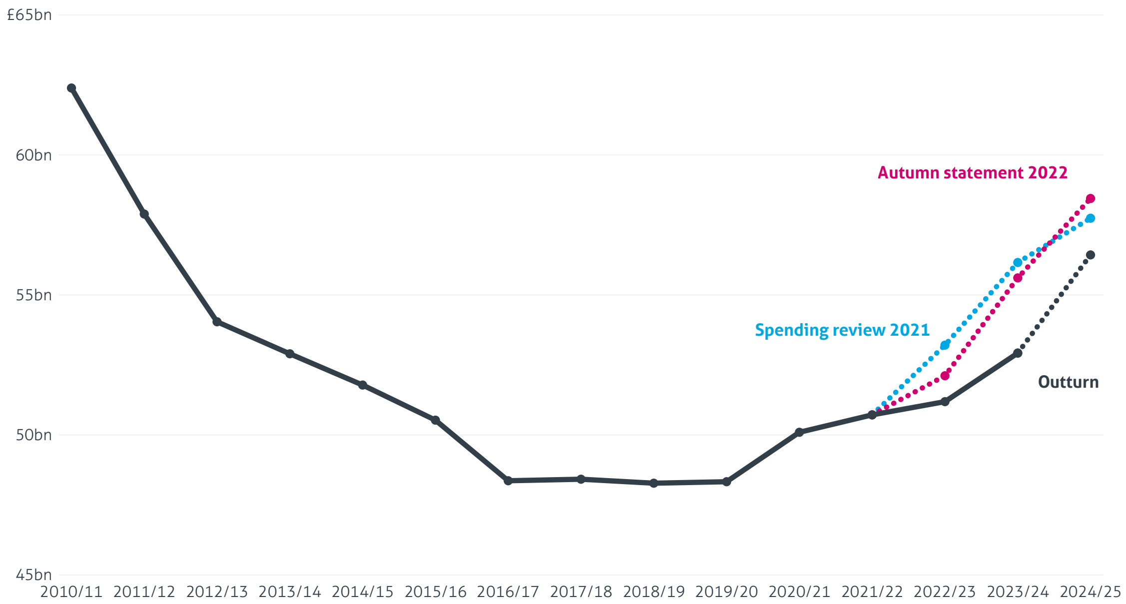
Source: Institute for Government analysis of various sources including local authority press releases and media reports. Notes: Section 114 notices for Nottingham (the first time) and Northumberland were issued as a result of unlawful spending, as opposed to being unable to balance their budget.

Michael Gove, former Conservative secretary of state for levelling up, housing and communities, claimed that this spate of section 114 notices was due to local authorities' financial mismanagement, but this is not the whole story.[3] The failure of high-profile investments has often been the proximate cause of a number of these section 114 notices, but it was cuts to grant funding that both incentivised local authorities to take greater risk in the search for alternative sources of income and made local authorities less resilient to financial shocks. For mismanagement to have been the entire cause of the uptick in section 114 notices, it would have to have been the case that the quality of management in local authorities declined precipitously throughout the 2010s, and just so happened to coincide with a period of historically deep cuts to councils' grant funding and rising acute pressures.

Local authorities are worse off now than in 2010

Instead, local authority financial fragility is the result of government policy since 2010. The coalition government chose to make substantial cuts to local authority grant funding from 2010 onwards. Some of these cuts were offset by rising council tax from the middle of the 2010s. But by 2019/20, local authority core spending power* (CSP) was almost a quarter (-22.5%) lower in real terms than it had been in 2010/11.

Figure 2.2 **Local authority core spending power, actual and forecast, by fiscal event, 2010/11–2024/25 (2021/22 prices)**



Source: Institute for Government analysis of DLUHC, 'Core spending power supporting information', 2010/11–2024/25 and HM Treasury, 'Autumn statement documents', 2022. Notes: CSP before 2015/16 is calculated by applying the annual change in revenue spending power to the following year's CSP total to create a time series. Dotted lines show the anticipated path of spending at different points in time.

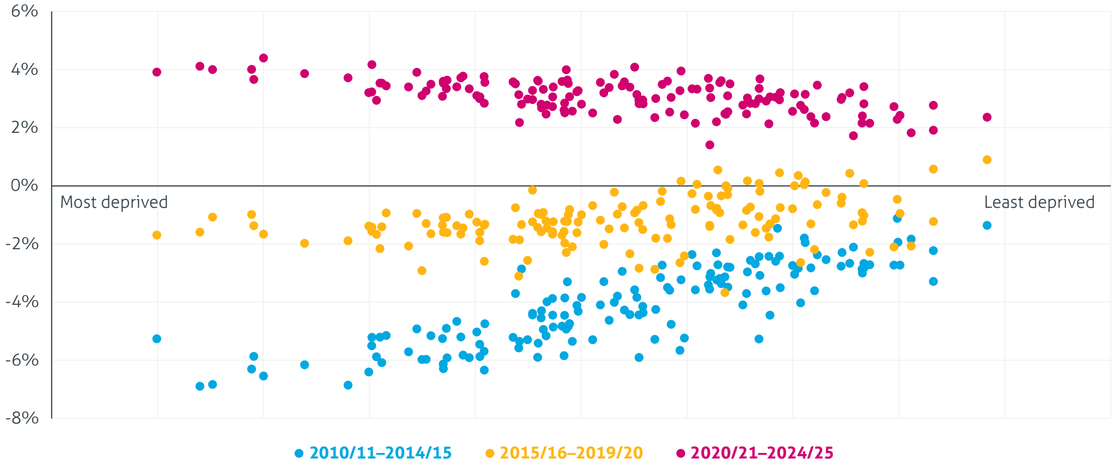
Since 2019/20, the government has increased central government grant funding in response to rising pressures. Both the 2021 spending review and the 2022 autumn statement made more money available for local authorities in cash terms, the latter primarily through additional funding for adult social care. But that additional funding has been consistently eroded by higher-than-expected inflation. The result is that in 2024/25, CSP is still approximately 10% lower than in 2010/11 in real terms. Local authority budgets would need to increase by £7.1 billion to bring funding back to the level it was at in 2010/11, through either central government top-ups or higher council tax income.

* Core spending power is a measure of the amount of money available to local authorities to fund service delivery. It is a combination of council tax, central government grants, retained business rates and some smaller income streams such as planning application and parking fees.

Cuts have fallen hardest on the most deprived parts of England

While CSP has fallen, on average, across England, cuts were not distributed equally. Because of the way the coalition government chose to cut grant funding in 2010, local authorities in the most deprived parts of the country, which were more dependent on central government grants, ended up with lower CSP than councils in less deprived areas. Likewise, when central government chose to allow councils to raise funding through council tax increases, less deprived authorities benefited more because a greater proportion of their funding comes from council tax income.

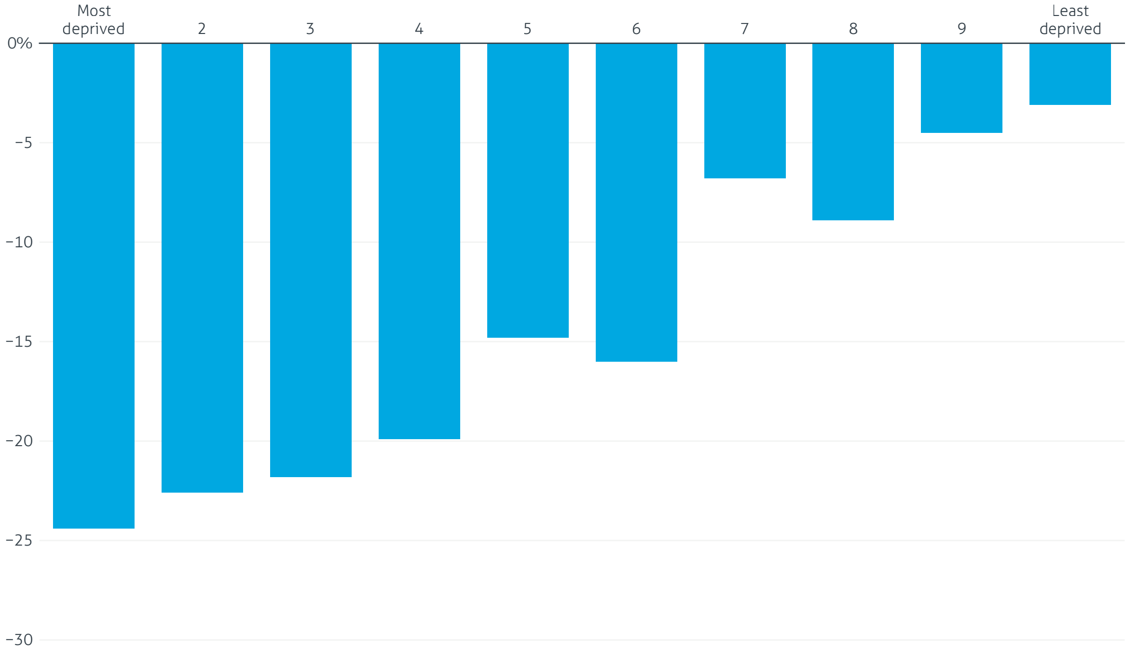
Figure 2.3 **Annual real-terms change in local authority spending power, by deprivation and time period**



Source: Institute for Government analysis of DLUHC, 'Core spending power supporting information', 2010/11–2024/25 and DLUHC, 'English indices of deprivation. File 10: local authority district summaries', 2019. Notes: 'Local authorities' in this instance are upper- and single-tier local authorities. 'Spending power' refers to revenue spending power between 2010/11 and 2014/15 and refers to CSP from 2015/16 onwards. Local authorities that unitarised during this period are excluded. This analysis also excludes the City of London. To align this chart with others in this chapter, we have reversed the order of the average Index of Multiple Deprivation (IMD) score.

While this has been partially redressed in recent years, the most deprived local authorities are still substantially worse off compared with 2010/11 than their better-off counterparts. In 2024/25, local authorities in the most deprived decile of the country had seen their CSP fall by 24.4% on average in real terms, compared with 3.1% in the least deprived decile of local authorities.

Figure 2.4 **Change in local authority spending power, by decile of deprivation, between 2010/11 and 2024/25**



Institute for Government analysis of DLUHC, 'Core spending power supporting information', 2010/11–2024/25 and DLUHC, 'English indices of deprivation. File 10: local authority district summaries', 2019. Notes: 'Local authorities' in this instance are upper- and single-tier local authorities. 'Spending power' refers to revenue spending power in 2010/11 and 2014/15 and refers to CSP in 2024/25. Local authorities that changed their boundaries or unitarised during this period are excluded. This analysis also excludes the City of London.

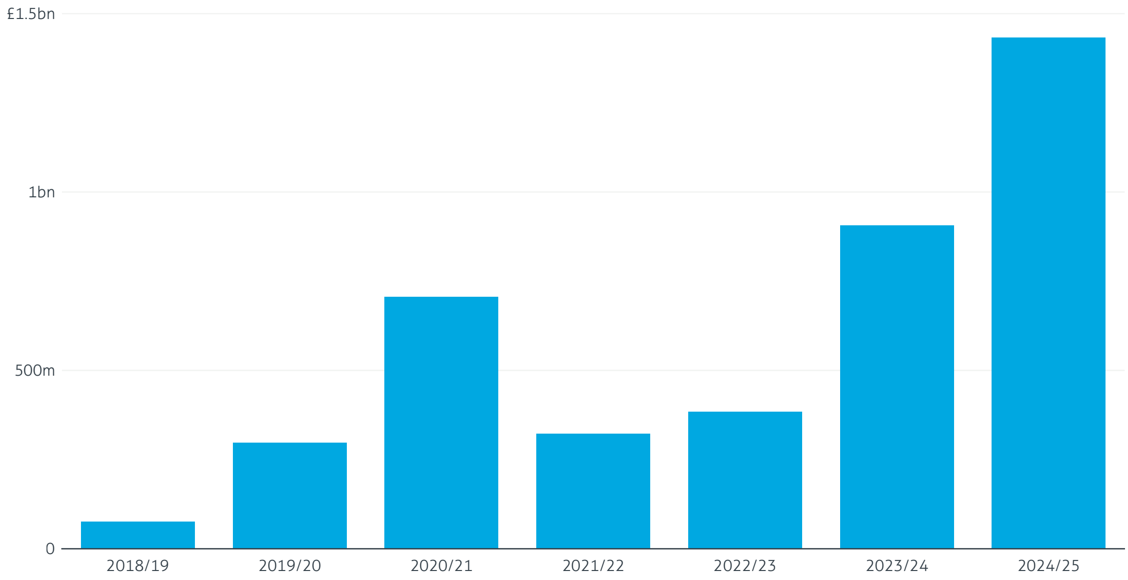
This is likely to also have been exacerbated by the fact that the funding formula – which the government uses to determine some of the distribution of grant funding to local authorities – is now very out of date. The formula was introduced in the 2000s and the government last updated it in 2013/14.[4] As a result, grant allocations do not account for the way that demographics and deprivation have changed in the intervening two decades.

From 2016 onwards, Conservative governments promised to update the funding formula in a process called the 'fair funding review'. This was supposed to more closely link funding with spending need, based on factors such as population, levels of deprivation and the rurality of local authorities. Despite that promise, implementation was repeatedly delayed, most recently in October 2022, when the Truss government announced that it would not be brought into force until 2025/26 at the earliest.[5] It is vital that the new government updates the funding formula to better reflect need.

Covering shortfalls in day-to-day spending with capital budgets is unsustainable

In response to the crisis in local government finance, the Sunak administration expanded the use of 'exceptional financial support' (EFS). This mostly took the form of providing local authorities with 'capitalisation directions', in other words allowing local authorities to use their capital resources for day-to-day spending.[6] The government has so far granted 16 single-tier local authorities – more than 10% of the total – and two district authorities exceptional financial support worth £1.4bn in 2024/25, up from £61.7m in 2018/19. Given CSP in 2024/25 is set at £64.7bn, this represents 2.2% of local authority budgets for this financial year.

Figure 2.5 **Exceptional financial support granted to local authorities, 2018/19–2024/25 (2024/25 prices)**



Source: Institute for Government analysis of DLUHC, 'Exceptional financial support for local authorities', 2024/25.
Notes: With the exception of *£3.7m* in 2020/21, all financial support in this chart was provided in the form of capitalisation directions.

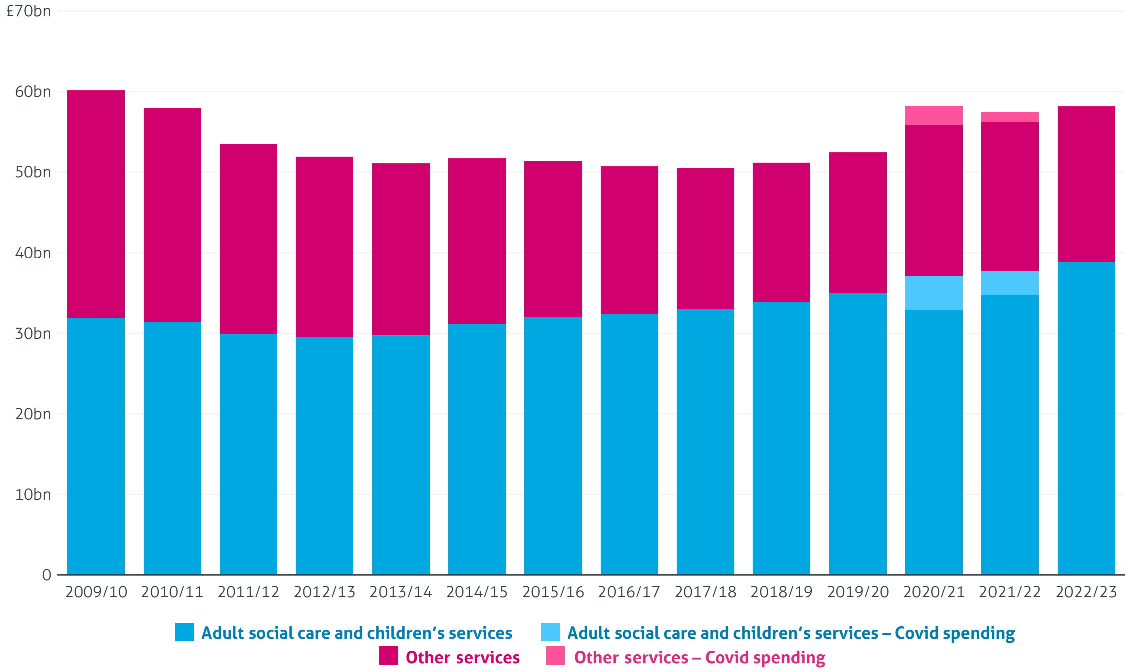
But this method of supporting local authorities relies on councils using often one-off capital budgets to fund day-to-day spending. This is a completely unsustainable approach to funding services that are driven by demand, which is only set to increase in the coming years.

Acute pressures force councils to cut spending on other services

Demand for acute, statutory services is outpacing funding

At the same time as central government cut grant funding for local government, demand for acute statutory services – in particular adult and children's social care, homelessness services and special educational needs and disabilities (SEND) provision – continued to grow. As a result, local authorities have spent an increasingly large proportion of their budgets on those services. In 2009/10, spending on adult and children's social care accounted for approximately half (53%) of total local authority spending. By 2022/23, this was two thirds (66.9%).

Figure 2.6 **Spending by local authorities in England, by type, 2009/10–2022/23 (2024/25 prices)**



Source: Institute for Government analysis of DLUHC, 'Local authority revenue outturns', 2009/10–2022/23 and DLUHC, 'Local authority COVID-19 financial impact monitoring information round 20', March 2020–March 2022. Notes: Excludes spending on education services, police and public health.

Several factors are driving the increase in spending. First, the population is both growing and becoming increasingly old. Between 2010 and 2022, the population in England grew by 8.5% while the number of people aged over 65 (who are more likely to draw on adult social care) grew by 24.1%. Second, there are also increasing levels of disability among working-age adults (those aged between 18 and 64),[7] many of whom will need adult social care. Even though spending on adult social care has increased since 2009/10, it has not kept pace with demand, and many local authorities have increasingly rationed care.[8]

Third, child poverty has increased over the past decade. There was a record high of 4.4 million children living in poverty[*] in 2022/23, up from 3.6 million in 2011/12 – an increase of 20.6%.[9] That is concerning on its own, but it also puts further pressure on local authorities' children's social care budgets.

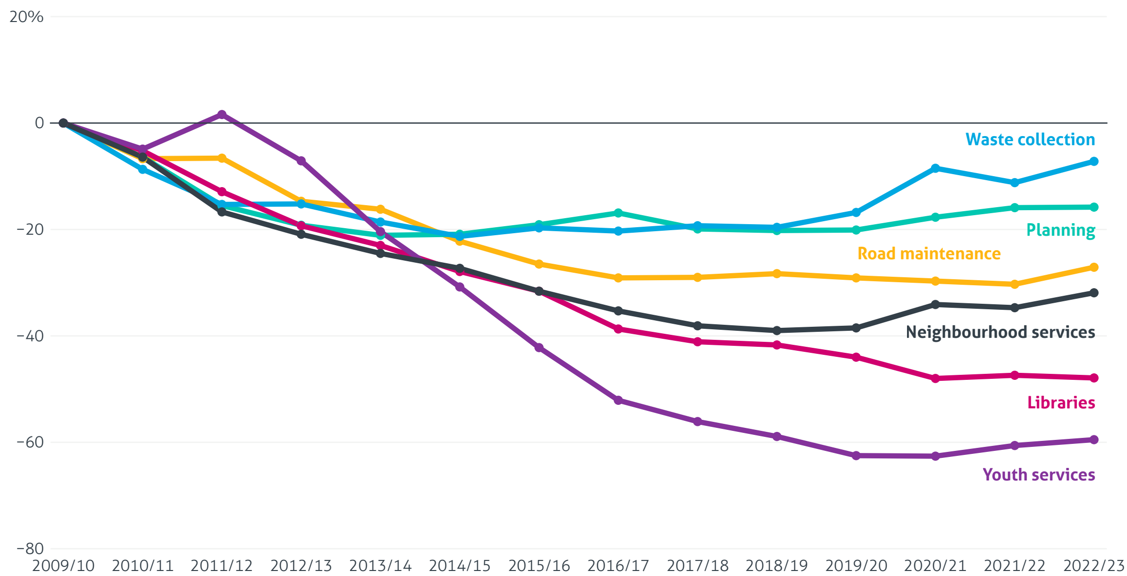
Finally, local authorities also report increasing demand for homelessness and SEND services,[**] which is pushing them closer to the brink of having to issue a section 114 notice.

* After housing costs.
** For more on this, please refer to the Schools chapter.

Spending on acute services is squeezing out spending elsewhere

The increasing demand for social care spending has crowded out spending on other local authority-provided services (which we refer to collectively as 'neighbourhood services'). Local authorities now spend much less on neighbourhood services such as libraries and services for young people. While the magnitude of the drop is smaller than for other services, they also spend less on waste collection, road maintenance and planning services now than in 2009/10. Overall, local authorities spent almost a third (-31.9%) less on neighbourhood services in 2022/23 than in 2009/10.

Figure 2.7 **Change in spending on neighbourhood services, by service, since 2009/10 (real terms)**

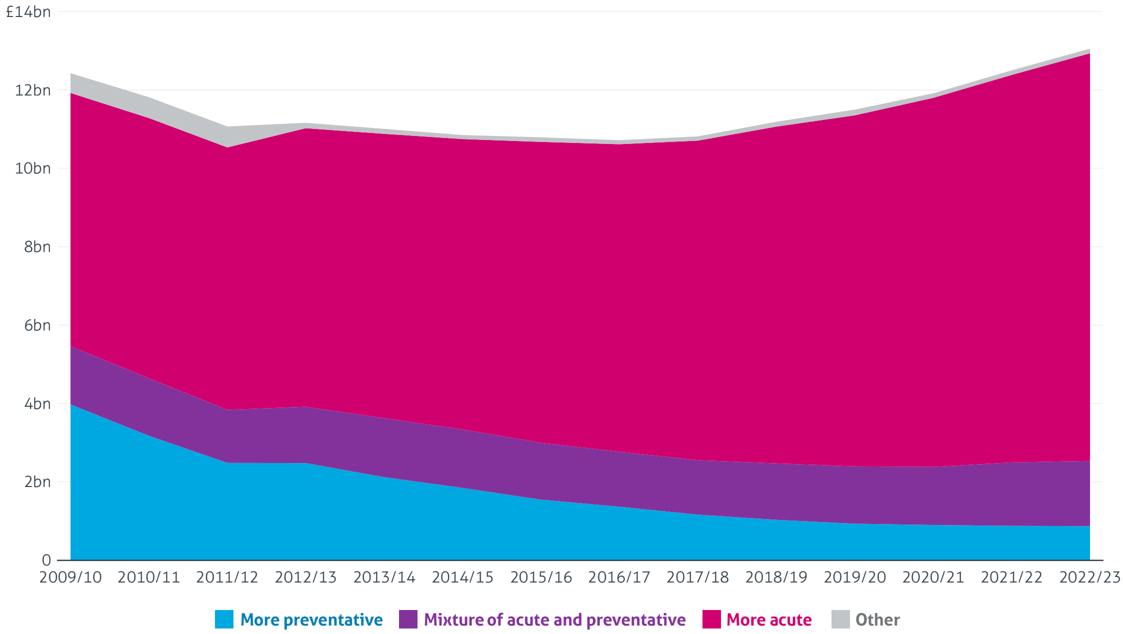


Source: Institute for Government analysis of DLUHC, 'Local authority revenue outturns', 2009/10–2022/23 and DfE, 'Section 251 returns', 2009/10–2022/23. Notes: This chart shows the change in total spending on these services.

Interviewees in local authorities reported to us that they feel like all their attention and funding are consumed by firefighting acute demand. One interviewee described their situation as being akin to an adult social care factory, which was focused on providing care packages at the expense of almost everything else.

Caught between rising acute demands and intense budgetary pressures, local authorities have often cut discretionary, preventative services. In interviews, local authorities reported that cutting preventative services leads to rising demand for more acute – and more expensive – services in the future. It also leads to more acute demands in other parts of the public sector, such as the NHS. That creates a vicious cycle: cuts to grant funding mean that local authorities cut preventative services, which raises demand for acute services in the future, which then necessitates further cuts to preventative services. This represents poor value for money for the government.

Figure 2.8 **Local authority spending on children's services, by type of service, 2009/10–2022/23 (2024/25 prices)**



Source: Institute for Government analysis of DfE, 'Local authority and school finance', 2009/10–2022/23. Notes: We classify 'children's centres and children under 5' and 'services for young people' as more preventative services; 'family support services' and 'youth justice' as a mixture of acute and preventative services; and 'safeguarding children' and 'looked-after children' as more acute.

For example, local authorities cut spending on Sure Start children's centres – which offer early years education and childcare support for children and families[10] – by 77.4% in real terms between 2009/10 and 2022/23.[11] That led to the closure of 730 Sure Start centres between 2010 and 2023 (a drop of 20.3%) and a paring back of services in the remaining centres,[12] despite excellent evidence that Sure Start reduces demand for more acute services and improves children's long-term health and educational outcomes.[13]

The children's social care market is broken

Private providers are making excessively high profits from rising demand for children's social care

There has been a steady rise in the number of children looked after by local authorities since 2010, increasing demand for residential care. But as both local authorities and the voluntary sector have reduced their residential provision over the past few decades,[14] councils have increasingly turned to private providers to meet this demand. The Competition and Markets Authority (CMA) found in a 2022 report that 76% of residential care placements in England were with private providers.[15]

While there is little evidence that private provision is of lower quality than local authority provision, it is providing extremely poor value for money, putting strain on council budgets. The CMA has issued strong criticisms of the largest private providers of residential and foster care, stating that they are making significantly higher profits than would be expected under competitive market conditions, with private children's home operators making consistent profit margins of more than 20%.[16] One council has reported that it was obliged by a lack of alternative placement options to rely on private providers and make cuts to other children's services as a consequence of rising fees.[17]

The 2022 Independent Review of Children's Social Care, led by Josh MacAlister, who has just been elected as a Labour MP, also highlights the risks associated with dependence on private sector providers of residential care. The review notes that, when "a majority of homes [are] owned by a few very large providers... many children are at risk of being affected by [a] Southern Cross type collapse".[*,18]

Lack of capacity in residential care is driving a rise in out-of-area placements

Local authorities are required under the Children Act 1989 to provide placements near a child's home and within local authority areas "as is reasonably practicable".[19] It is sometimes necessary to place children in homes outside their local authority area due to safeguarding issues; for example, if there are concerns about local criminal or sexual exploitation.[20] But an increasing number of out-of-area placements are due to a lack of available capacity in local children's homes.[21]

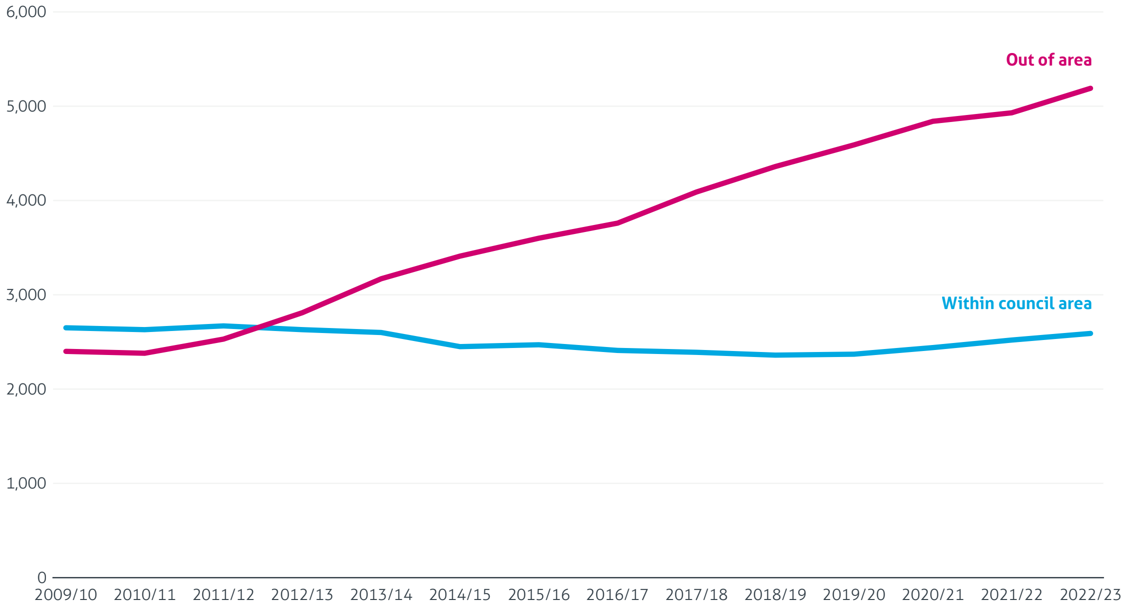
The mismatch between the regional supply of homes and demand is a particular problem in London, which accounts for 11% of children in children's homes but just 7% of places.[22] The average distance between a child's home address and their placement was 60 miles in 2018,[23] up from 52 miles in 2014.[**,24]

Since 2009/10, the number of placements within a local authority's area has remained comparatively stable. In contrast, the number of out-of-area placements increased by 116% between 2009/10 and 2022/23, meaning that by 2022/23 two thirds of all placements in children's homes were out of area.

* Before 2011, Southern Cross was the largest private provider of care homes in the UK, with a 9% market share. Its collapse that year because of high debt affected 31,000 residents and increased scrutiny of the risks from large social care providers' failure. For further details, see Public Accounts Committee, '1 The oversight of care markets', (no date) retrieved 3 July 2024, https://publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1530/153005.htm

** This is the most recent data release, which was not affected by Covid. Restrictions during the pandemic led to children's homes accepting fewer out-of-area placements, thus reducing the average distance from the capital. For further details, see Association of Directors of Children's Services, *Safeguarding Pressures Phase 7*, 2021, p. 53, www.adcs.org.uk/wp-content/uploads/2024/05/ADCS_Safeguarding_Pressures_Phase7_FINAL.pdf

Figure 2.9 **Number of placements in children's homes, by location, 2009/10–2022/23**



Source: Institute for Government analysis of DfE, 'Children looked after in England including adoptions', 2009/10–2022/23 (Table A2: CLA on 31 March by placement and CLA on 31 March by characteristics). Notes: Numbers of placements are as at 31 March rather than new placements during the year. 'Out of area' includes both out of council area and distant placements outside adjourning council boundaries. Data excludes placements in unregulated children's homes.

In 2019, the children's commissioner noted that 52% of children in out-of-area placements experienced placement instability, where they experienced at least two changes within two years, compared with 23% of children looked after within their local authority area, negatively affecting their wellbeing.[25]

High-cost care placements are putting further pressures on councils

In addition to growing numbers of residential care placements, children's needs are becoming more complex, with an increasing number of cases involving multiple risk factors to children's physical and mental wellbeing.[26,27] Declining capacity in secure children's homes and inpatient mental health services, which provide specialist support for children with the most complex needs, has led to local authorities spending more on high-cost placements, putting them under further financial strain.[28]

A Local Government Association (LGA) survey found that the number of placements costing more than £10,000 a week rose from 120 in 2018/19 to 1,510 in 2022/23 – a 1,250% increase, compared with a 22.5% rise for all placements. The LGA reports the median weekly cost of local authorities' most expensive care placements as £16,450 and noted substantial variation, with one council spending £63,000 a week on a single placement.[29]

In 2018/19, a quarter of local authorities reported having at least one high-cost placement; this surged to 91% in 2022/23. Almost all councils (98%) stated that a lack of appropriate local placements forced councils to turn to private providers, and more than 90% also cited children's challenging behaviour or complex mental health needs as reasons for resorting to high-cost placements[30] – a factor that interviewees said had worsened since the pandemic.

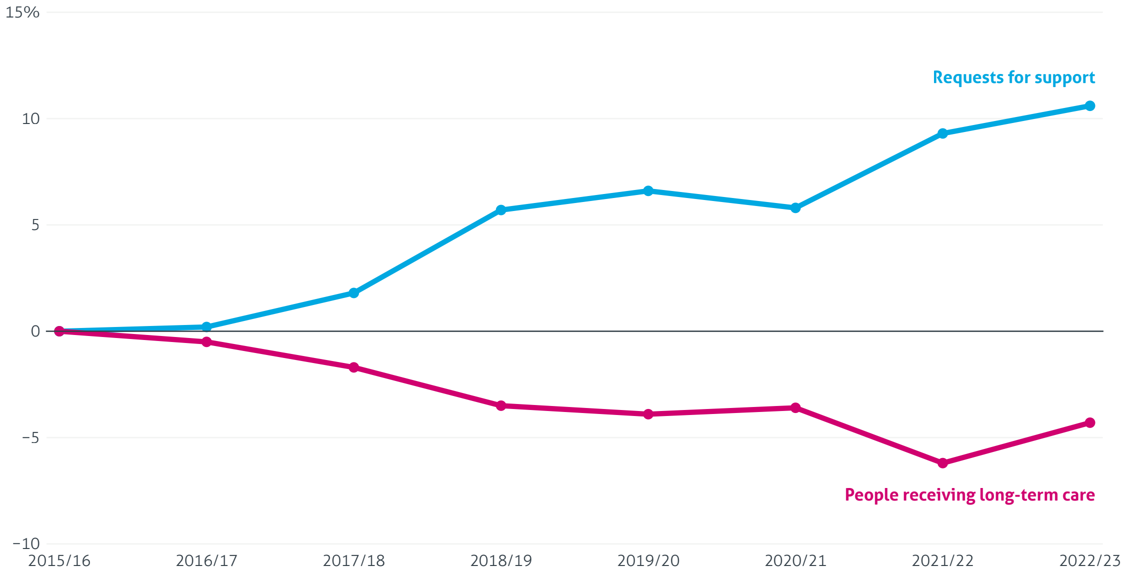
Children's social care is now a leading driver of overspending by councils: a study found that it was responsible for half of the £640m overspend forecast by local authorities in 2023/24.[31]

It is much harder to access adult social care

Despite more requests for support, fewer people can access care due to rationing

Funding for adult social care has increased in recent years and, since 2019/20, has exceeded real-terms spending in 2009/10. Despite that additional funding, there is strong evidence that funding is not keeping pace with demand. Costs in the sector are rising fast, not least due to rapid recent increases in the national living wage.[32]

Figure 2.10 **Change in requests for support and people receiving long-term care since 2015/16**



Source: Institute for Government analysis of NHS Digital, 'Adult social care activity' (Tables 8 and 34), 2022/23.
Notes: 'People receiving long-term care' refers to the total number of people receiving care throughout the year.

Insufficient funding has meant that, since 2015/16 (the earliest year for which we have data), there has been a gradual decline in the number of people receiving publicly funded adult social care, even though the number of people requesting support has increased. By 2022/23, there were 4.3% fewer people receiving long-term care while the number of people requesting support had risen by 10.6%. People are also waiting longer to access care. The Association of Directors of Adult Social Services (ADASS) reports that there were approximately 250,000 people awaiting an assessment for adult social care in August 2023, up from 204,000 in November 2021.[33] There was a greater proportional increase in the number of people waiting more than six months for an assessment, from 41,000 in November 2021 to 85,000 in August 2023.[34]

The nature of the problem varies in different parts of the population. In 2022/23, the number of people receiving long-term care was 10% lower among the over-65 population than in 2015/16, while the number of requests for support in this age group grew by 6.1% in that period. In contrast, requests for support from the working-age population grew by 22.2% between 2015/16 and 2022/23, while the number accessing long-term care grew by only 2.1%.

The growing gap between the number of people asking for care and those receiving it is due to rationing. To be eligible for publicly provided adult social care, people have to meet both a means test and a needs test. Rationing has occurred in a couple of ways. First, the means test for adult social care has remained frozen in cash terms since 2010/11, meaning that as people's wages and incomes have risen with inflation, fewer people are now eligible for publicly funded social care. People may still have requested support from their local authority, unaware that they would not meet the means test, but they would now find themselves ineligible.

Second, while difficult to prove, interviewees agreed that local authorities have also effectively raised the needs threshold for care. This is because the judgment about the need for any individual to receive care rests with local authorities. This means that someone who might have met the needs test in 2010 no longer does so in 2024.

There are alternative possible explanations for the decline in the number of people receiving publicly funded care, such as that local authorities are increasingly relying on a 'strengths-based' approach to adult social care – in which people are empowered to live in and contribute to their communities, rather than relying on long-term support.[35] But this explanation is not supported by a change in indicators that would provide evidence that local authorities are pursuing this approach. There has, for example, been little change in the number of people able to access short-term care to maximise independence, and there has been a decline in the amount of support provided to unpaid carers.[36]

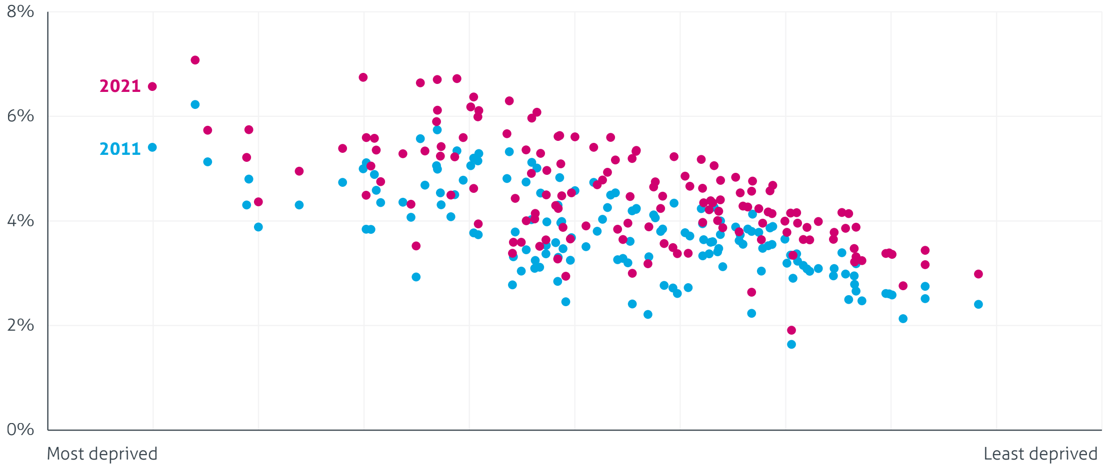
This is not to say that local authorities are acting maliciously. No local authority wants to resort to rationing. But they are caught in an invidious and unenviable position between the needs of their residents, their legal obligation to provide an effective service, and cuts to their funding that prevent them from doing so.

Rising unmet need has wide-ranging implications

It is easy when discussing adult social care to talk in abstract terms about the change in the number of people receiving care and impersonal, technocratic concerns such as frozen thresholds in the means test. But a lack of support can have deep and material impacts on people's lives. It means someone may struggle to feed, wash and clothe themselves. Or that they are denied help with their mobility, and their condition then rapidly deteriorates. Unmet need contributes to greater suffering and immiseration.

Just because people cannot access publicly funded care, it does not mean that their need for care goes away; rather, the burden of care just shifts elsewhere. Often that burden is carried by friends and family, who step in to help their loved one. According to the census, the number of people providing more than 20 hours a week of unpaid care (as it is impersonally known in policy circles) rose from 2.0 million in 2011 to 2.4 million in 2021. As a proportion of the population, it rose from 3.7% to 4.4% over this period.

Figure 2.11 **Proportion of the adult population providing 20+ hours a week of unpaid care, by local authority deprivation, 2011 and 2021**



Source: Institute for Government analysis of ONS, 'Census – provision of unpaid care', 2021 and DLUHC, 'English indices of multiple deprivation', 2019. Notes: The x-axis orders local authorities from the most deprived to the least deprived by average Index of Multiple Deprivation score.

This trend has not happened equally across England: the more deprived the area, the more likely it is that someone will have to provide more than 20 hours of unpaid care a week, and this gap widened between 2011 and 2021. In Blackpool, the most deprived upper-tier local authority in 2019, 6.6% of the population provided more than 20 hours of unpaid care a week, compared with 2.8% in Richmond-upon-Thames, the fourth least deprived local authority in 2019. This inequality is likely both because there is higher demand for adult social care among the most deprived parts of the population and because local authorities in deprived areas have also had their funding cut the most since 2010, as previously discussed. Residents in the least deprived parts of the country are also more likely to be able to pay for their own care, meaning that they rely less on unpaid care from relatives and friends.

One of the government's policies for increasing funding for adult social care is the 'adult social care precept' – a percentage-point amount that local authorities may raise council tax by to fund their spending on the sector. But this approach exacerbates inequality of provision. As already discussed, the least deprived authorities receive a greater proportion of their funding from council tax. This means that for every 1 percentage-point increase in council tax, they raise more money than their more deprived counterparts.

A failure to provide adequate social care also affects other public services. Approximately 45% of the people who remain in hospital after being eligible for discharge are there because there is not enough capacity in adult social care.[37] A lack of adequate care also increases the likelihood that someone will attend A&E[38] and need admission to hospital,[39] as well as increases their need for GP appointments.[40] Therefore, putting aside the improvements in people's quality of life that would come from increased access to adult social care, it would also help to reduce demand for more acute and expensive services.

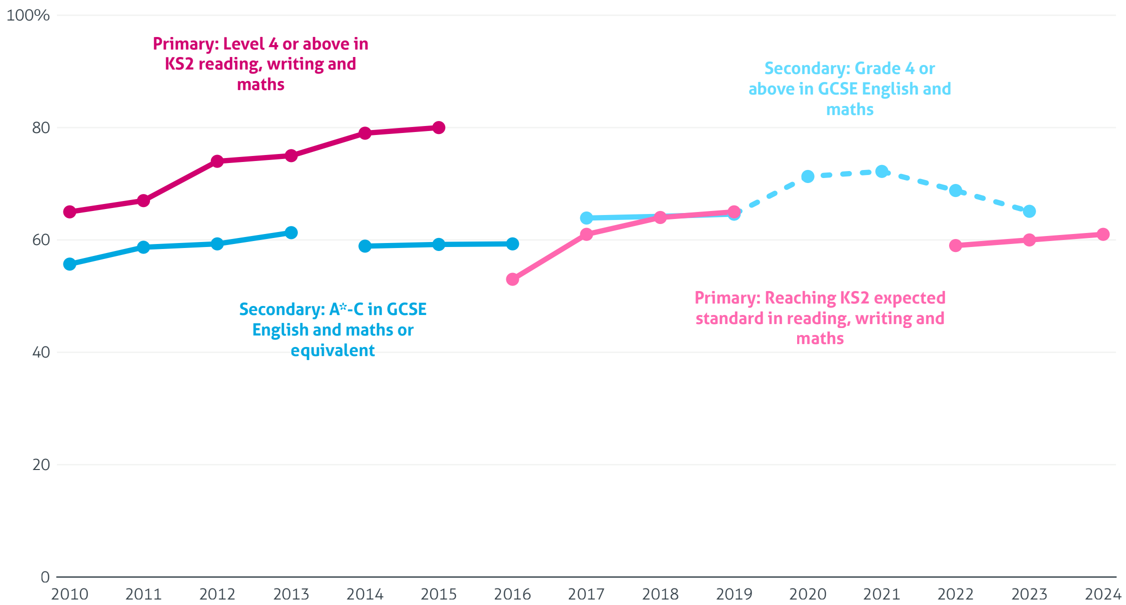
Schools

3. Schools

Primary school attainment has fallen and educational disparities have increased

Primary school attainment is below pre-pandemic levels

Figure 3.1 **Attainment at the end of primary and secondary school, 2010–24**



Source: Institute for Government analysis of Department for Education, key stage 2 statistics, 2010–24 and DfE, GCSE and equivalent results (national tables), 2010–23. Notes: All figures include those not in mainstream education. KS2 assessments did not take place in 2020 and 2021. GCSE results were awarded based on centre/teacher assessment rather than external assessment in 2020 and 2021, while in 2022 they were set between pre-pandemic 2019 levels and 2021 levels, and in 2023 they were allowed to return to pre-pandemic levels, with some grading protections in place. See the Methodology for a description of earlier changes.

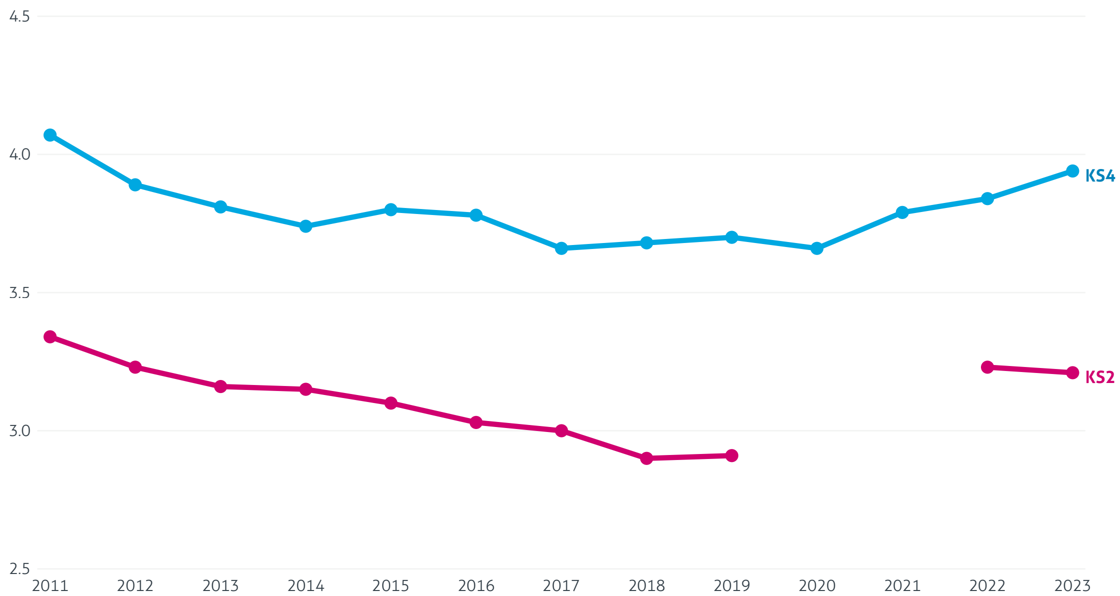
Primary school attainment has improved slowly since external assessments restarted after the disruption of the Covid pandemic, but remains below pre-pandemic levels. Between 2010 and the onset of the pandemic there was a trend of increasing performance at key stage 2 (KS2), covering pupils at the end of primary school, with 65% of pupils meeting the expected standard in reading, writing and maths in 2019. KS2 assessments resumed in 2022 after cancellations in 2020 and 2021, and in the same year the Conservative government set an ambitious target for 90% of pupils to meet the expected standard in the three subjects by 2030.[1] Since the pandemic, results have increased from 59% of pupils reaching the expected standard in 2022 to 61% in 2024.

GCSE assessments continued throughout the pandemic, but exams were replaced by teacher grading of pupils' performance in 2020 and 2021. External assessment resumed in 2022 and 2023, but with some grading protections in place so that results did not drop below 2019 levels. While, therefore, some caution should be exercised in directly comparing pre- and post-pandemic performance, the share of students achieving grade 4 or above in maths and English in 2023 was similar to that in 2019.*

Disadvantage gaps have grown substantially

At both KS2 and KS4, the gap in attainment between disadvantaged pupils and their non-disadvantaged peers has returned to levels not seen in more than 10 years. The primary school (KS2) attainment gap had narrowed nearly every year in the lead-up to the pandemic. Now, even with a slight reduction between 2022 and 2023, it is at its widest point since 2012.[2] The secondary school (KS4) attainment gap meanwhile broadly narrowed between 2011 and 2017 before plateauing. It then increased during the pandemic and has continued to increase since external exams resumed.[3]

Figure 3.2 **KS2 and KS4 disadvantage gap index, 2011–23**



Source: Institute for Government analysis of DfE, 'Key stage 2 attainment, academic year 2022/23: Disadvantage gap index at key stage 2, 2011 to 2023' and DfE, 'Key stage 4 performance, academic year 2022/23' (Table 7).
Notes: No figures are available for 2010. In addition, figures are not available for KS2 in 2020 and 2021 as assessments were cancelled.

The widening disadvantage gap partly reflects that schooling for more affluent pupils was less disrupted during the pandemic due to better access to remote learning technology and resources.[4] But it may also stem from changes to the allocation of school funding made from 2018/19. While funding allocations remained progressive,

* Additional evidence on secondary school attainment presents a mixed picture. The National Reference Test found little statistically significant change in overall English and maths attainment between 2017 and 2023. For further details see National Foundation for Educational Research, *National Reference Test Results Digest 2023*, 2023, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1180184/NRT_Results_Digest_2023.pdf. But the 2022 Programme for International Student Assessment (PISA) revealed a decline in 15-year-olds' maths and reading scores from 2018, although England's scores remained above the OECD average in these subjects. For further details, see Department for Education, *PISA 2022: National report for England*, 2023, https://assets.publishing.service.gov.uk/media/656dc3321104cf0013fa742f/PISA_2022_England_National_Report.pdf

ensuring that schools serving more deprived communities receive more per head, the Education Policy Institute, in its analysis of changes up to 2021/22, concluded that "the link between funding and pupil need is being weakened", on average benefiting schools in more affluent areas.[5] (From 2023/24, the DfE increased disadvantage-related funding in the main schools funding grant, which is likely to have started to reverse this trend.[6])

Catch-up measures have had limited effect

The decline in KS2 attainment and the widening of the disadvantage gap have come despite catch-up efforts from the government. The Conservative government committed £3.5 billion for catch-up measures in schools between 2020–21 and 2023–24 to reduce the gap, of which the three largest components were a 'recovery premium', the National Tutoring Programme (NTP) and a 'catch-up premium'. While the recovery and catch-up premiums were paid directly to schools on a per-pupil basis, the NTP was designed to subsidise academic support to pupils who had fallen behind their peers.[7]

The NTP has run between November 2020 and the end of the 2023–24 academic year. By January 2024, the NTP had delivered 5.3 million courses,[8] against an initial target of 6 million over the life of the programme.[9] While this means the overall target is likely to be achieved, the Department for Education (DfE) has clawed back £248 million of unused allocations from 2021–22[10] and 2022–23,[11] around a quarter of the NTP's total £1.1bn funding, diverting the 2022–23 allocations towards teacher pay awards.

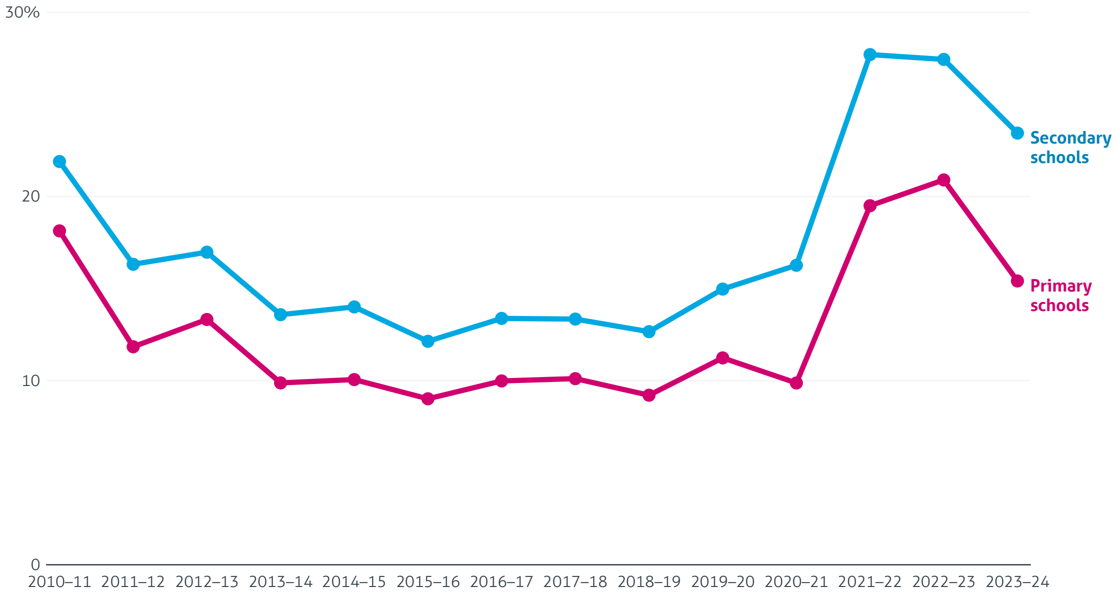
There is some evidence that the NTP has boosted attainment, with an evaluation of the programme's second year finding that taking part in the main strand of the NTP was associated with small improvements in KS2 and KS4 maths outcomes, and some limited evidence that it was associated with improvements in English outcomes.[12] Separately, in research visits to 63 schools between September 2021 and July 2022, Ofsted found strong tutoring quality in more than half of the schools visited, but found that many were not adequately assessing tutoring's impact on pupils' attainment.[13]

Questions have been raised over prioritisation under the NTP. Ofsted found that the resumption of external exams from 2022 led some schools to focus tutoring resources on KS4 pupils near key GCSE grade boundaries, despite identifying younger pupils as being in greatest need of catch-up support.[14] In a report published in February 2023, the National Audit Office, meanwhile, noted that there was limited evidence on how schools were using NTP funding and the extent to which this was targeted at disadvantaged pupils.[15]

High pupil absence rates have hampered efforts to boost attainment

Hampering efforts to make up for lost learning, pupil absence rates have been very high since the reopening of schools. Persistent absence, defined as pupils missing at least 10% of school sessions, sharply increased after the pandemic and has remained at elevated levels. In autumn term 2023, 15% of primary pupils were persistently absent, up from 11% in autumn 2019. In secondary schools, the figures were 23% and 15% respectively.[16]

Figure 3.3 **Pupil persistent absence rates, autumn term, 2010–11 to 2023–24**



Source: Institute for Government analysis of DfE, 'Pupil absence in schools in England', autumn term 2009–23.
Notes: A pupil is persistently absent if they miss 10% or more of possible school sessions across a term. Figures shown are for a single term, to remove seasonal effects.

Several factors have been identified as contributing to the rise in persistent absence, including poorer mental wellbeing among pupils[17] and shifts in parental attitudes regarding regular school attendance.[18]

Efforts to reverse the fall in KS2 results and the widening KS2 and KS4 disadvantage gaps will therefore require a full-spectrum response from the new education secretary, encompassing action on schools funding, catch-up, mental health support, attendance and more.

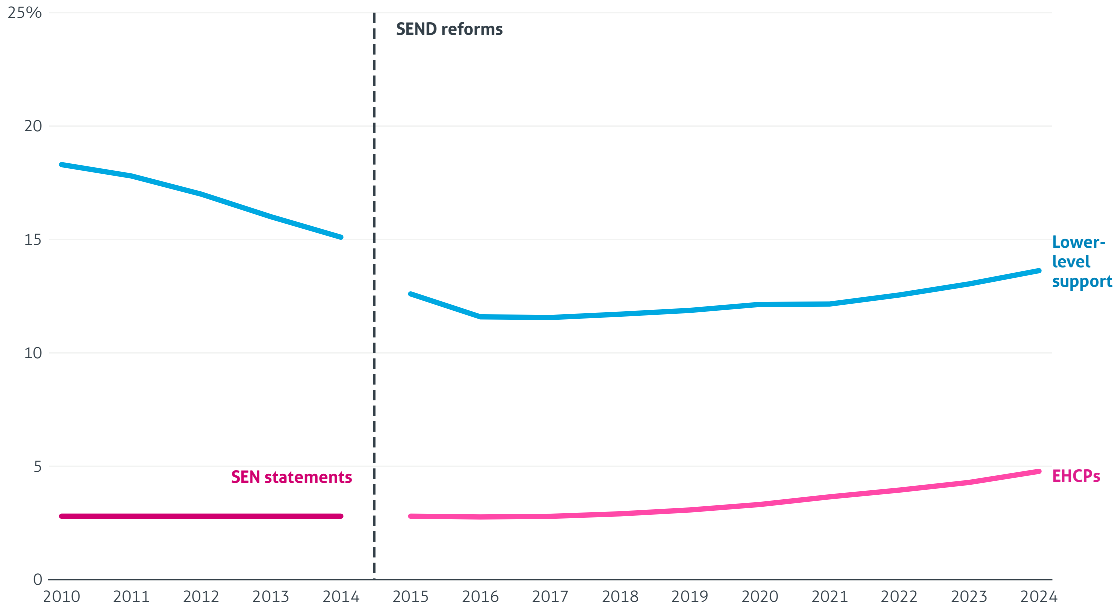
SEND spending threatens the financial sustainability of councils but many children are not receiving the support they need

The number of children with special educational needs and disabilities is increasing sharply

The number of children with special educational needs and disabilities (SEND) is rising and they are becoming a growing share of the overall pupil population. The number of pupils with education, health and care plans (EHCPs), which provide a detailed plan of support for children with higher needs, has continued to increase. Since their introduction in 2014,* the number of pupils with EHCPs has risen from 240,000 (2.8% of all pupils) to 434,000 (4.8% of all pupils) in 2024 – an increase of 85%. The proportion of pupils receiving wider SEND support without an EHCP has also been rising steadily since 2017, representing 13.6% of all pupils in 2024.

* EHCPs replaced statements of special educational needs (SEN) and were phased in over several years. Numbers for 2014 are for SEN statements.

Figure 3.4 **Pupils receiving special educational needs and disabilities support, 2010–24**

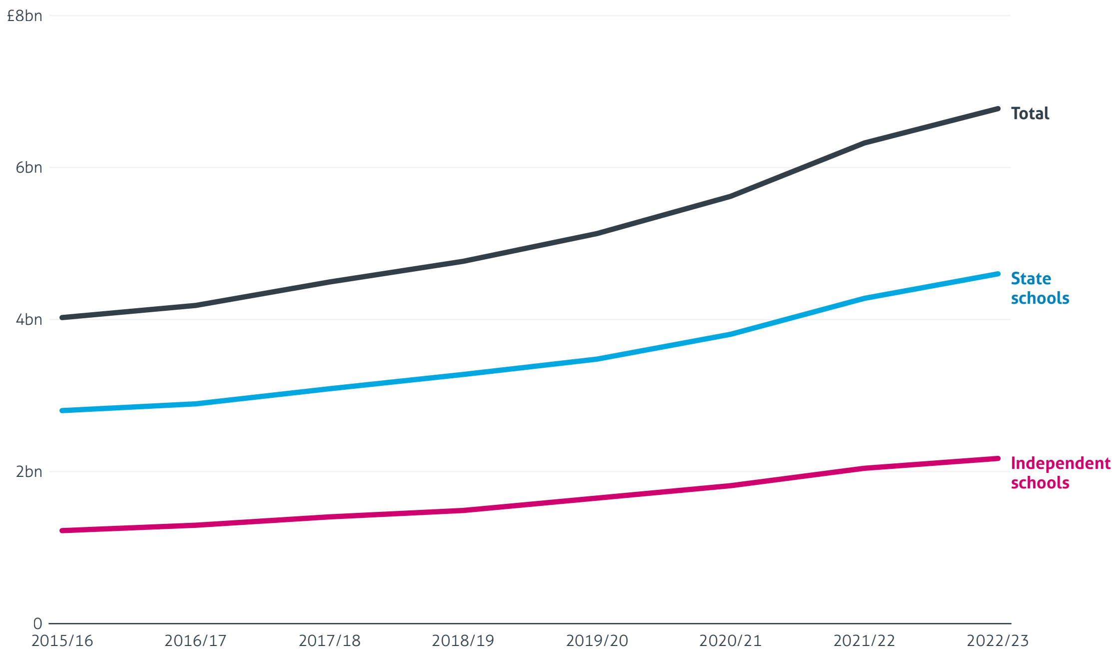


Source: Institute for Government analysis of DfE, 'Special educational needs in England', academic years 2009–10 to 2023–24. Notes: Support for children with SEND was reformed in 2014, with two lower levels of support – 'school action' and 'school action plus' – replaced by 'SEN support', and EHCPs replacing SEN statements. The transition from SEN statements to EHCPs then occurred between 2014 and 2018.

Local authorities are buckling under the soaring cost of SEND and some are limiting provision

While schools cover the initial costs of support for each pupil with SEND, local authorities are responsible for covering additional costs to enable a pupil or student with high needs to take part in education and learning. The total value of this 'top-up' funding by local authorities has risen in real terms by 68% since 2015/16.[19] Growing numbers of pupils with SEND are being placed in independent special schools, where the costs are particularly high. While top-up SEND spending on state schools has risen by 64% since 2015/16, the increase over the period for independent schools is 78%.

Figure 3.5 **SEND top-up funding provided to schools by local authorities, by provision type, 2015/16–2022/23 (2024/25 prices)**



Source: Institute for Government analysis of DfE, 'LA and school expenditure: total gross expenditure (£ million) by local authorities on top up funding, financial years 2015–16 to 2022–23'. Notes: 'Top-up funding' is provided above the core high-needs place funding that a school receives to enable a pupil with SEND to take part in education. 'State schools' consist of maintained schools, academies, free schools and colleges. 'Independent schools' also include non-maintained schools. Includes post-16 educational settings. Figures are for gross expenditure.

SEND has consequently become one of the leading drivers of financial pressures for local authorities. Two thirds of local authorities have deficits on the part of their budgets reserved for schools spending, largely due to the cost of meeting their statutory duties to those with SEND. Across these local authorities, the cumulative deficit totalled £1.6bn as of March 2023.[20] Since 2020, the government has allowed local authorities to hold schools budget deficits off their balance sheets under a special allowance. But this provision is due to expire in March 2026, and one council has warned that it will have to issue a section 114 notice[*] as soon as December 2024 if this statutory override is not extended.[21]

To limit escalating costs, local authorities are delaying appropriate provision for children or withholding it.[22] Growing disagreements over SEND provision (and in particular over EHCPs) have led more parents to take legal action against their local authority. HM Courts and Tribunals Service tribunals registered 14,000 SEND appeals in the 2022–23 school year, of which 86% were connected to councils' refusal to issue an EHCP or disputes over the plans' contents.[23] Of the 8,000 cases decided by tribunals in 2022–23, just 2% ruled against the family.[24]

* This is a report from the council's finance officer that they believe that the authority is about to incur expenditure that is unlawful according to the Local Government Finance Act 1988. This is usually because they expect their expenditure to exceed their income for a particular financial year.

In March 2023, the Conservative government published a SEND and alternative provision (AP) improvement plan, outlining steps to improve experiences of the SEND system, standardise SEND provision nationally and make mainstream education more inclusive.[25] It remains too early to observe whether these will succeed in reducing disagreements between parents and local authorities or in relieving financial pressures, if the new government continues with them.

The DfE is also operating a 'safety valve' scheme, under which local authorities receive funding to clear their deficits in return for taking action to reduce future SEND spending; for example, by making less use of independent provision. To date, 38 councils have entered safety-valve agreements with the DfE.[26]

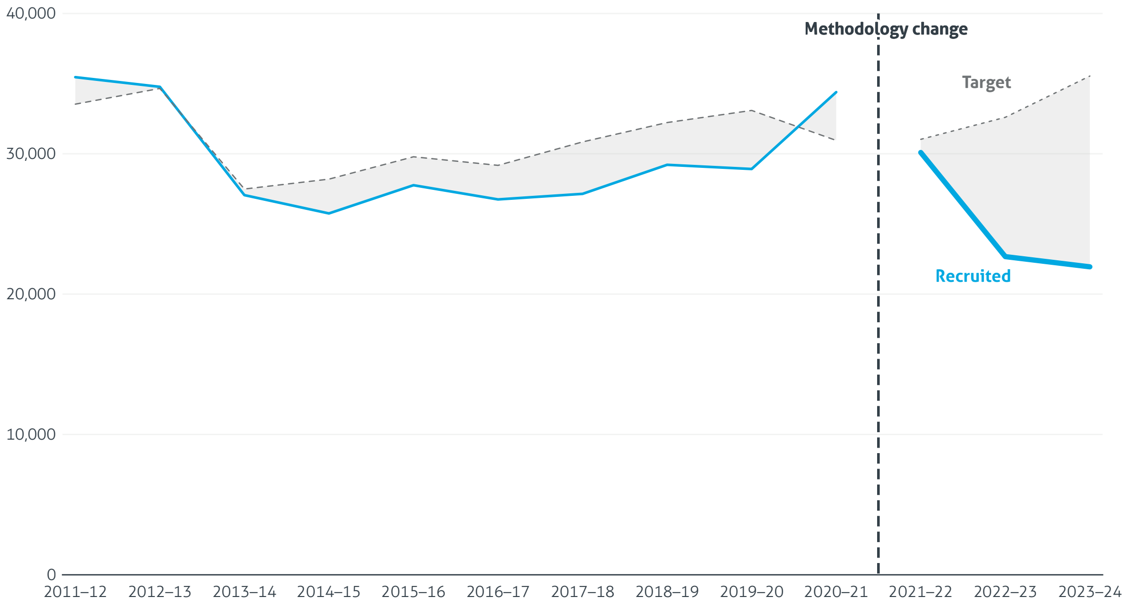
The safety-valve programme is controversial, with reports of local authorities attempting to limit EHCP numbers.[27] Moreover, several councils taking part in the programme are reported to remain at risk of being unable to produce balanced budgets, despite the extra funding from the DfE.[28] This makes this one of the most urgent, and thorniest, problems in the new secretary of state's in-tray.

Secondary school teacher recruitment is in crisis

Teacher training targets are being missed by a large margin

The number of full-time equivalent teachers increased slightly in 2023 to 468,700, a record high. Despite this, initial teacher training recruitment is at crisis point. The total number of postgraduate entrants into training fell below 22,000 in 2023–24, compared with 29,000 in 2019–20, the last pre-pandemic year, and is just 62% of the annual overall target.[29]

Figure 3.6 **Postgraduate initial teacher training recruitment, 2011–12 to 2023–24**



Source: Institute for Government analysis of DfE, 'Initial teacher training census' ('ITT new entrants and targets by subject time series' table), 2015/16–2023/24. Notes: Comparable figures are not available for 2009–10 and 2010–11. Since 2021–22, the DfE has taken under-recruitment in the preceding two years into account in setting subject targets.

The situation is especially concerning at secondary level. Entrants into postgraduate secondary training dropped below 50% of the target for the 2023–24 school year. There is considerable variation between subject areas: physics is one of the worst performing, with just 17% of the target met, while recruitment for maths, another STEM* subject, is 63% of the target.[30] To incentivise recruitment, from September 2024, chemistry, computing, maths and physics teachers working in high-disadvantage schools will receive an additional £6,000 payment in each of the first five years of their career.[**,31]

Teachers' pay is substantially lower in real terms than in 2010

Several factors influence entry rates into teaching, including flexibility of working hours, perceptions of workload and pupil behaviour, and a competitive salary.[32] Of these, salaries are the one over which the government has the most direct control, and where it could start to make changes most quickly.[33]

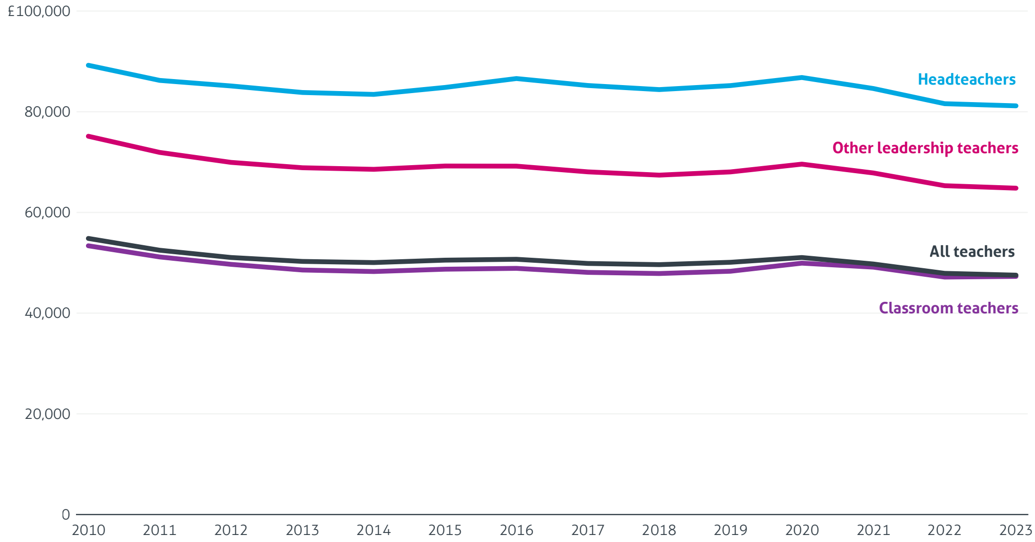
Staffing costs form the largest component of school spending, at around 80% of the total.[34] After a one-year freeze in 2021–22, teachers received a 5% pay increase in 2022–23 (with a higher award for early-career teachers) and a 6.5% pay increase in 2023–24. The 2023–24 pay award came after eight days of strike action by members of the National Education Union, with other teaching unions also balloting their members on strike action.[35]

Despite these two pay awards being more generous than those for staff in some other public services, the real-terms value of teacher pay has fallen, with median teacher salaries in 2023 13.3% below 2010 levels. Pay freezes in 2011–12 and 2012–13, consecutive below-inflation increases until 2017–18 and elevated inflation from 2021 all contributed to this decline between 2010 and 2023. Teachers in leadership roles except headteachers had the greatest real-terms fall at 13.7%, while pay for classroom teachers fell by 11.4% and pay for headteachers fell by 9.0%.[36]

* Science, technology, engineering and maths.

** Primary school recruitment has improved, with entrants hitting 96% of the 2023–24 target. This has been aided by the target being lower than in previous years, as the number of primary school pupils decreases.

Figure 3.7 **Median teacher pay by role, 2010–23 (2024 prices)**



Source: Institute for Government analysis of DfE, 'Median teacher pay using teacher pension scheme data, academic year 2023/24' and OBR, 'Economic and fiscal outlook March 2024 – detailed forecast tables' (Table 1.7). Notes: Figures cover all teachers including those in non-mainstream schools, early-years and post-16 education. Figures are as at December of the given year.

The pay award for the 2024–25 academic year has not yet been finalised, with a decision due to be made by the new government. The previous government had called for a "more sustainable" pay increase in its evidence submission to the School Teachers' Review Body; while it did not specify a figure, it is likely to be lower than unions' demands.[37]

In its submission, the NAHT union advocated an increase "in double digits" to exceed the increase of 7.3% in the Consumer Price Index (CPI) during 2023 and to begin to restore real-terms pay to 2010 levels.[38] Other teaching unions also raised restoration of pay to this level.[39,40] The unions also expect pay awards to be fully funded – that is, not coming out of schools' existing budgets (set in 2021 based on pay awards of around 3% a year). This gives two possible grounds on which the unions may find the eventual pay award unacceptable.

School buildings are in poor condition due to years of underfunding

The RAAC crisis is only one indictment of the condition of many school buildings

The DfE ordered 104 schools in England to close just before the start of the 2023 autumn term after discovering reinforced autoclaved aerated concrete (RAAC) on their premises.[41] Approximately 100,000 students were affected by school closures, with contingency measures ranging from a delayed start to the term,[42] lessons taking place in temporary classrooms[43] or marquees,[44] and virtual learning.[45]

By February 2024, the DfE had identified RAAC in 234 educational settings, of which 119 schools will require extensive refurbishment or rebuilding to remove the faulty concrete.[46] These schools subsequently received funding under the Schools Rebuilding Programme, while the DfE provided individual grants to the remainder to cover removal costs.[47]

Independently of RAAC, concerns have been raised about the condition of the school estate, including mould and cold classrooms.[48,49] The DfE has acknowledged the detrimental impact that poor conditions can have on pupil outcomes.[50]

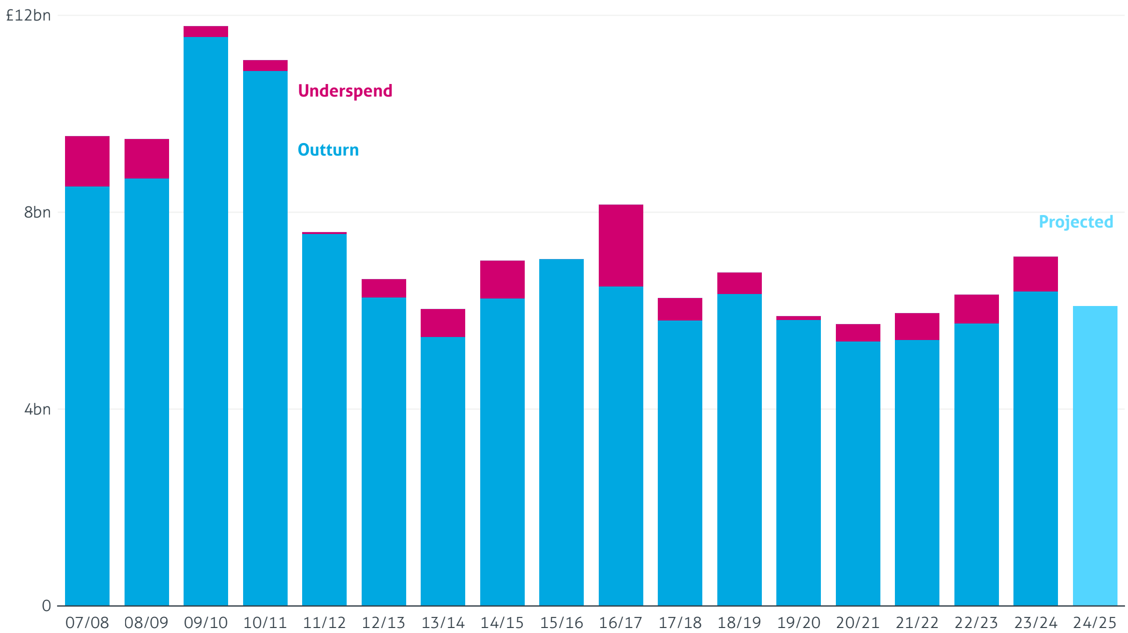
Capital funding has been less than required

Insufficient capital funding has contributed to a deterioration of the school estate. DfE capital spending was cut sharply in real terms in the 2010s and remains substantially below the level in 2007/08. Since 2012, the first year for which data is available, the UK has consistently spent a lower proportion of gross domestic product (GDP) on capital for education than other OECD countries.[51]

On the latest figures available, repairs and improvements of £11.4bn would be needed to return all elements of the school estate to a good condition. But the true figure is likely to be considerably higher, given this finding was based on a data collection exercise carried out between 2017 and 2019, and therefore does not reflect the recent identification of widespread RAAC problems.[52]

As part of the 2020 spending review process, the DfE calculated that it would require £5.3bn in annual funding for school maintenance and repairs plus rebuilding or refurbishment of the most high-risk school buildings, but received an average of just £3.1bn annually from the Treasury for this for each of 2021/22 and 2022/23.[*,53]

Figure 3.8 **Department for Education capital spending, actual and forecast, 2007/08–2024/25 (2024/25 prices)**



Source: Institute for Government analysis of HM Treasury, *Public Expenditure Statistical Analyses* [PESA] (Tables 1.6, 1.8, 1.10, 3.2, 3.3 and 3.7), 2019–23 and HM Treasury, *Spring Budget 2024* (Table 2.2). Notes: Not all DfE capital spend relates to schools. Figures have been adjusted to account for machinery-of-government changes. In 2015/16, the DfE had a capital overspend of £147m. The underspend in 2023/24 is the difference between the planned capital budgets recorded in PESA 2023 and the Spring Budget 2024.

* Comparable figures for 2023/24 and subsequent years – focusing solely on the school estate – are not in the public domain.

In 2020, the DfE launched the School Rebuilding Programme, intended to replace "poor-condition and ageing school buildings" over a 10-year period, with 513 projects announced by February 2024.[54]

But if the decline in the school estate is to be reversed, capital spending will need to be considerably greater than the £6bn that the DfE has planned for 2024/25. Insufficient capital funding – covering both maintenance and rebuilds – is likely to lead to further structural deterioration, a worsening learning environment and possible safety issues at schools.

Criminal justice system

4. Criminal justice system

The criminal justice system is failing to cope with demand. In the police service, capacity and experience that were lost during the 2010s have been partially rebuilt, and some first steps to do the same have been made in the criminal courts. But this is a slow process that requires sustained investment.

Repeated restructures and staff cuts in probation from the late 2000s to mid-2010s[1] have left the service with high caseloads, few experienced practitioners and struggling either to meet offenders' needs or to manage risk. In prisons, policy changes and challenges in courts and probation have led to a spiralling population, which the estate can no longer accommodate, requiring emergency measures. Worse, any substantial improvement in performance for policing or the courts would only deepen the crisis for prisons.[*]

The police are not resolving crimes and have lost the confidence of the public

Police effectiveness has fallen over the past decade

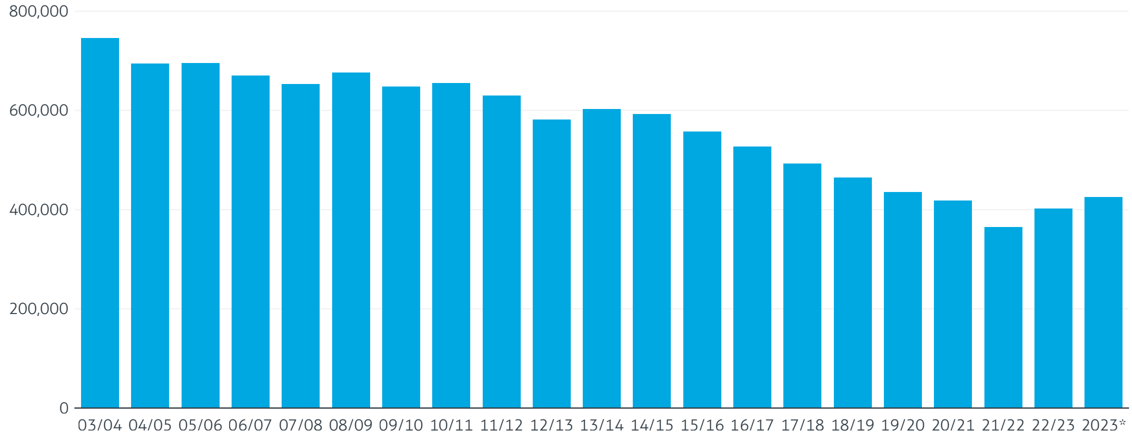
Only a small proportion of crimes recorded by the police result in a positive outcome – a charge, an out-of-court disposal or a diversionary resolution. Before a slight rise in 2023, both the total number of positive outcomes and the rate of reported crimes solved had fallen for a decade. The police inspectorate, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), has criticised police forces for the low proportion of crimes that they are solving and for their decisions to close investigations without exhausting available lines of enquiry.[2] Less than 10% of victim-based offences in 2023 resulted in a successful outcome – down from 20% in 2015.[3]

Cuts to officer and staff numbers during the 2010s were key drivers of these problems. From 2009/10 to 2017/18, police officer numbers fell from 144,000 to 122,000, with knock-on effects on crimes solved. But since 2014/15, the number of charges per officer has also been falling. This is due partly to the increasingly complex and serious crime mix recorded by police from 2014, and partly to falling officer productivity due to key skills shortages, including around digital forensics.

Since 2019, productivity has been further reduced by the police uplift programme. While the uplift programme successfully increased officer numbers, which reached 147,000 in 2022/23, it takes time for new officers to become effective, and training and overseeing new recruits has imposed a significant burden on more experienced officers. As new officers become more experienced, we would expect productivity to increase – and recent improvements in solve rates suggest this is occurring. The number of charges has risen substantially in the past two years, up 18% from 2021 to 2023, and is now close to 2019/20 levels – although still well below 2010 levels. Retaining these officers will be crucial to maintaining productivity.

* This chapter covers England and Wales, which have a shared policing and legal system.

Figure 4.1 **Charges recorded by police forces, 2003/04–2023**



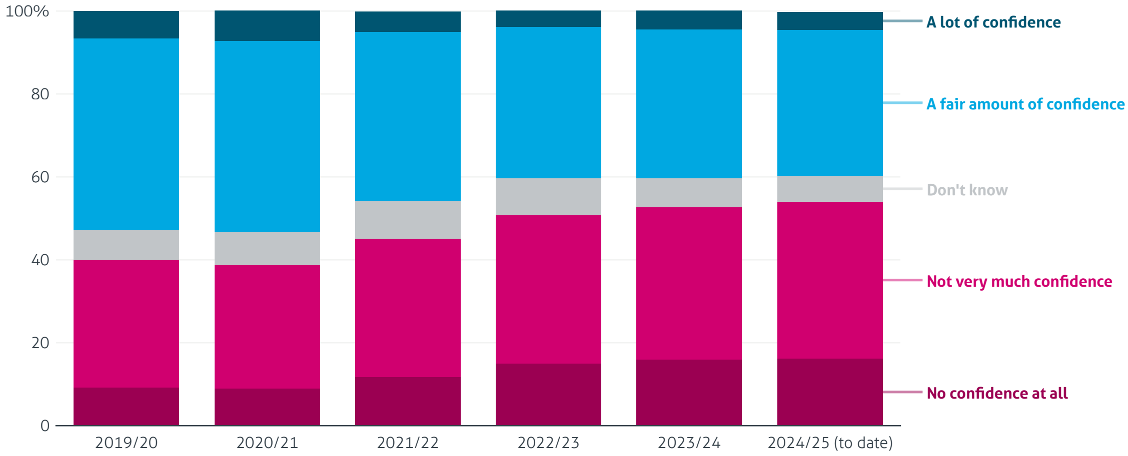
Source: Institute for Government analysis of Home Office, 'Crime outcomes in England and Wales' (Table B2), 2022/23 and Home Office, 'Police recorded crime and outcomes open data tables', 2018/19–2022/23. Notes: *Value for 2023 is for 12 months ending December 2023; all other figures are for 12 months ending in March for 2009/10–2022/23. Includes all charges/summonses. Some data is missing for Greater Manchester Police for 2019/20 and Devon and Cornwall Police for 2022/23 and 2023. We have imputed missing figures for these years; see Methodology for more detail.

Poor performance has contributed to falling public confidence and trust in the police

Positive outcomes are important for public trust and confidence, which have fallen to new lows in recent years.[4] The problem is particularly acute for some forces, such as the Metropolitan Police, but has been felt across England and Wales. Trust and confidence are related, but distinct: confidence is about effectiveness and how well the public think the police are performing their role, while trust is about fairness, equal treatment and upholding standards.[5]

Confidence tends to correspond closely to crime attendance or response rates, positive outcome rates and police visibility. Declining officer numbers, charge rates and police visibility since 2010 have caused confidence to drop, as people have lost faith in the police's ability to investigate and deter crime. In July 2024, YouGov found only 40% of people had at least a 'fair amount of confidence' in the police to deal with crime in their local area – and 16% had no confidence at all.[6] As recently as 2020/21, these figures were 53% and 9% respectively. Similarly, in 2023, less than half of people thought their local police were doing a good or excellent job (49%), compared with 56% in 2019/20.[7] This continuing fall in public confidence shows that recent increases in police officer numbers and a slight rise in the charge rate have not yet translated into improved public confidence.

Figure 4.2 **Public confidence in the police to tackle crime in their local area, 2019/20–2024/25**



Source: Institute for Government analysis of YouGov, 'How much confidence Brits have in police to deal with crime', retrieved 8 July 2024. Notes: Financial year figures are based on average of all polls run in that year. 2024/25 value includes monthly polls from April to July 2024.

Trust is more closely related to views on fairness and trustworthiness than effectiveness.[8] This has been profoundly damaged by a series of major scandals, hitting the Metropolitan Police hardest but also affecting several other forces. In 2023, an Ipsos poll found less than half of people would describe their local police as trustworthy (48%), down from 56% in 2022.[9] Trust varies significantly across groups: nationally, people from minority ethnic groups are less likely than others to trust the police, and in London, women have less trust in the police than men (the reverse is true elsewhere).[10]

These declines in trust and confidence have serious implications for policing. The police are reliant on positive community relationships, intelligence and co-operation for the reporting and investigation of crime.[11] Certain offence types, such as sexual offences, domestic abuse and all forms of exploitation, are likely to be particularly affected. Low levels of trust and confidence may therefore pose a challenge for the new government's mission to halve violence against women and girls within 10 years.

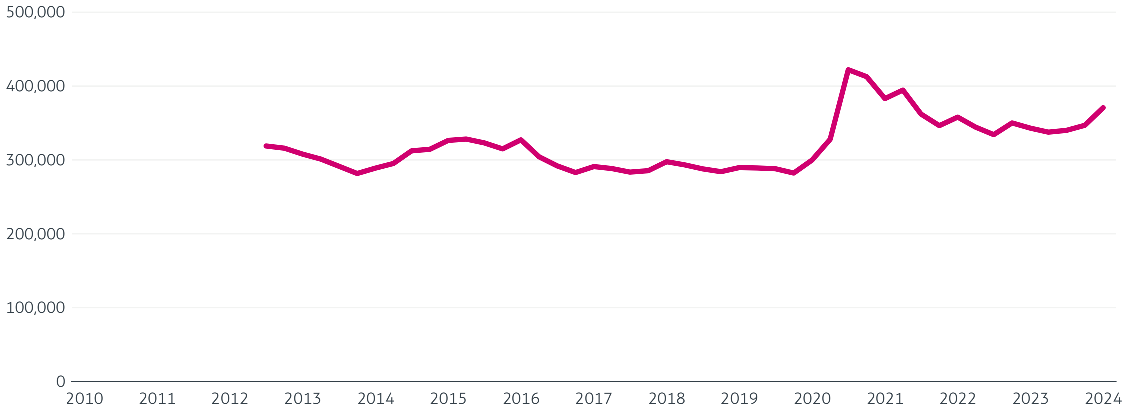
Workforce shortages and growing inefficiency mean criminal courts still cannot meet demand, despite rising capacity

Backlogs in criminal courts are growing

On 26 June 2024, the Ministry of Justice announced a potential data quality issue affecting criminal court statistics.[12] The scale of this issue is currently unknown. Findings should therefore be interpreted with caution and numbers may be subject to change.

Backlogs in magistrates and crown courts are large and growing, with courts operating less efficiently and failing to keep pace with demand. After initially good progress in clearing outstanding cases that built up during the pandemic, the backlog in magistrates' courts began rising again in the second half of 2023. The sharp uptick at the end of that year suggests this may be driven by hearing delays due to the lack of space in prisons, which is unlikely to be resolved soon.

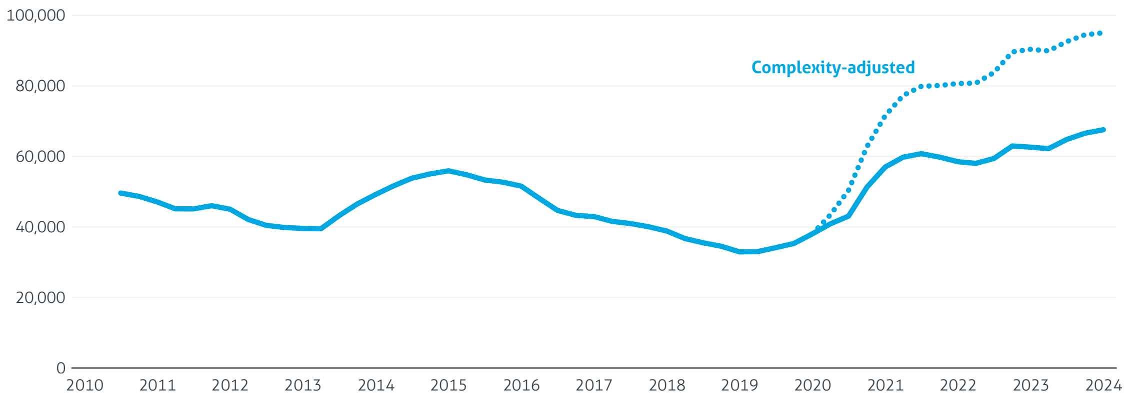
Figure 4.3 **Outstanding cases in magistrates' courts, Q2 2012 to Q4 2023**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, October–December 2023' (Table M1). Notes: Quarterly data is only available from 2012/13. On 26 June 2024, the Ministry of Justice announced a potential data quality issue affecting criminal court statistics. The scale of this issue is currently unknown. Findings should therefore be interpreted with caution and numbers may be subject to change.

The situation is much worse in the crown court, where the case backlog is now at its highest level ever, at 67,573 cases, more than three quarters (78%) higher than on the eve of the pandemic. When taking into account the greater complexity of cases in the backlog, it is equivalent to around 95,000 cases – roughly equal to the total number of cases dealt with in the crown court in 2023.

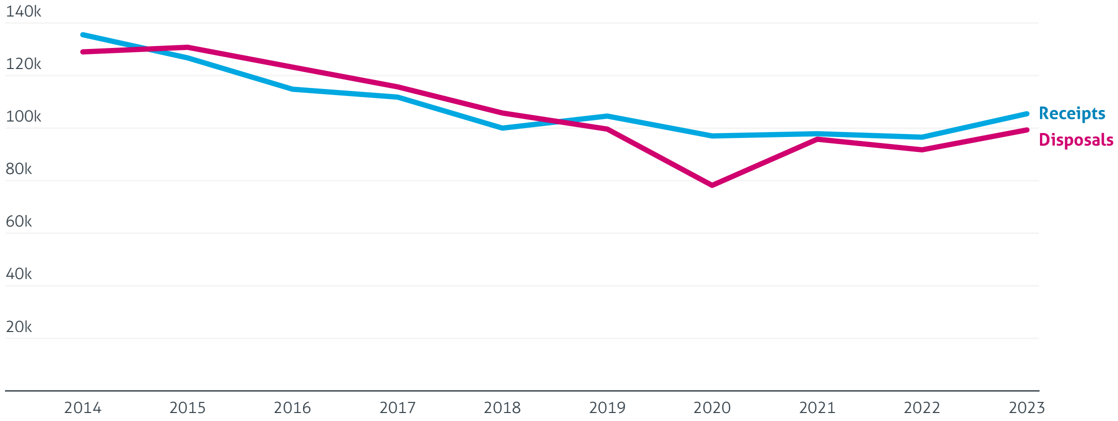
Figure 4.4 **Outstanding cases in the crown court, Q2 2010 to Q4 2023**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics, October to December 2023' (Table C1). Notes: The complexity-adjusted backlog is based on Institute for Government modelling and accounts for the greater share of cases awaiting jury trial in the backlog. For further details, see the Methodology. On 26 June 2024, the Ministry of Justice announced a potential data quality issue affecting criminal court statistics. The scale of this issue is currently unknown. Findings should therefore be interpreted with caution and numbers may be subject to change.

The growing backlog is not principally due to rising demand. While crown court case receipts have now returned to 2019 levels, they fell more than 25% from 2010 to 2019. The reason the backlog has grown is because processing capacity in the crown court has fallen.

Figure 4.5 **Crown court receipts and disposals**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics quarterly, October to December 2023'. On 26 June 2024, the Ministry of Justice announced a potential data quality issue affecting criminal court statistics. The scale of this issue is currently unknown. Findings should therefore be interpreted with caution and numbers may be subject to change.

Capacity has declined for several reasons. During the 2010s, police officer numbers and charges fell substantially, requiring less capacity in the courts. The number of sitting days was reduced, magistrate and judge numbers fell and courtrooms were closed. Criminal legal aid funding was also cut sharply, leading many barristers and solicitors to move away from criminal practice.[13] The number of barristers receiving at least 80% of their income from criminal work fell 6% from 2017 to 2021.[14] These changes meant that the backlog in both courts had already begun to grow in 2019, and when the pandemic hit, the system came under immense pressure. The 2022 barristers' strike in response to pay recommendations not being fully implemented exacerbated this, but even once the strike and pandemic were no longer delaying cases, quarterly receipts have continued to outpace disposals.

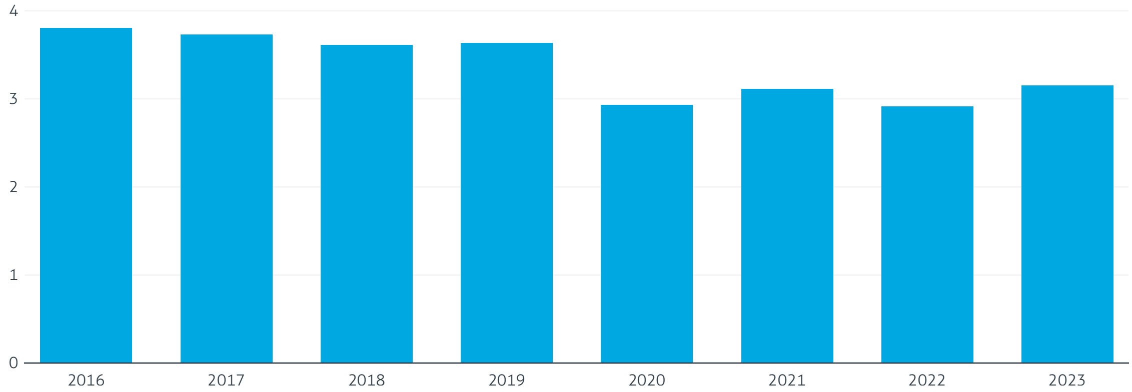
The courts system is running less efficiently than before the pandemic

From 2021, Conservative governments attempted to ramp up capacity again, with some success. Removing the cap on the number of sitting days funded and successfully recruiting new judges[15] have led to a large increase in sitting days, which are now at their highest level since 2016 and 23% higher than in 2019.[16] Several nightingale courts, introduced during the pandemic, continue to provide additional physical court capacity. However, it is proving harder to replace lost legal advocates, particularly for certain serious offence types such as rape and serious sexual assault.[17] Rate increases for legal aid work in 2022 and 2023 fell far short of cuts over previous years,[18] and pay remains low relative to other areas of legal practice.[19]

There are not enough lawyers to meet demand and this means the court system runs less efficiently. In 2023, 5% of all scheduled trials in the crown court were rescheduled on the day due to the unavailability of legal professionals (1,436 trials in total).[20] That compares to 0.3% (71 trials total) in 2019.[21] The total proportion of ineffective trials – trials rearranged on the day they were due to take place – has gone up sharply and now makes up more than a quarter of all crown court trials (27%), up from 16% in 2019. The ineffective rate has also risen in the magistrates' courts and is now at its highest level since 2005 (22%). Ineffective trials waste time and make courts less productive.

The number of hours spent in hearings per sitting day is a good measure of court productivity. In the crown court, this was 3.15 hours in 2023; while a slight rise on 2022, this was still lower than any year before the pandemic. The practical impact of this is that the 23% increase in sitting days since 2019 only translates to a 7% increase in hours spent in hearings.

Figure 4.6 **Crown court hearing hours per sitting day, 2016–23**



Source: Institute for Government analysis of MoJ, 'Criminal court statistics quarterly, October to December 2023' and HMCTS, 'HMCTS management information – March 2024','Ad-hoc management information release on Crown Court sitting days'. Notes: Total annual hearing hours are calculated by multiplying average hearing time in hours per case by the total number of cases disposed. On 26 June 2024, the MoJ announced a potential data quality issue affecting criminal court statistics. The scale of this issue is currently unknown. Findings should therefore be interpreted with caution and numbers may be subject to change.

Backlogs are causing substantial delays, worsening the quality of justice

The size of the backlog means cases are waiting months or years to be heard. Trials being rearranged worsens this, because limited advocate and judge availability makes it extremely difficult to reschedule them. Such delays have serious consequences. They create long periods of uncertainty for victims, defendants and their families, preventing them from moving on after an offence. Victims are more likely to withdraw from the process the longer cases are delayed, particularly for serious or sensitive offences. In the last quarter of 2023, victim withdrawal was responsible for 19% of non-convictions post-charge in rape cases and 48% of domestic abuse-flagged cases.[22] Some defendants face years on remand without having been convicted of any crime;[23] more than a third (38%) of defendants held on remand will later be acquitted or given a non-custodial sentence.[24]

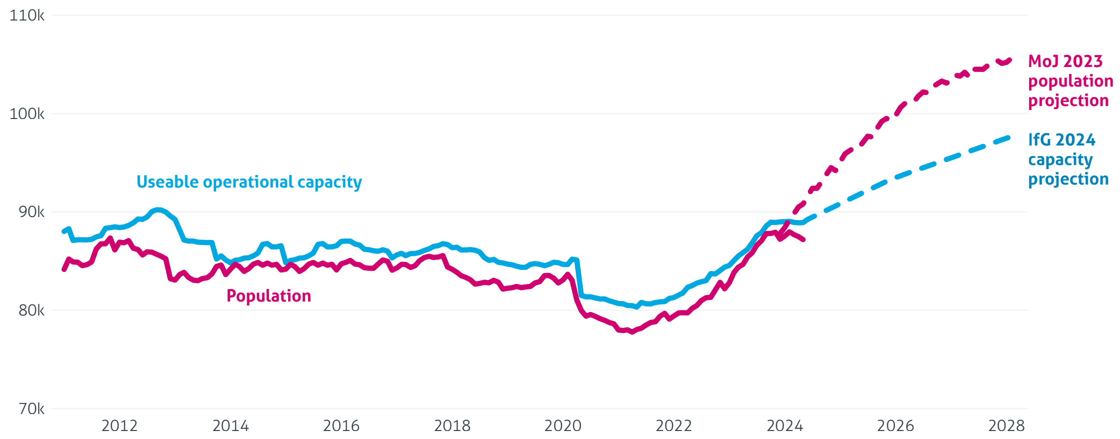
There are also negative effects for the broader criminal justice system. Very long delays undermine public trust in the system and may increase reoffending.[25] The large remand population – currently 19% of all prisoners – places heightened pressure on the prison system.[26] Delays can also be self-defeating: the recent rise in defendants failing to attend their court hearings may be due in part to long waiting periods between being instructed to appear in court and the actual hearing date. This results in wasted time for the court and additional burdens on the police in locating and remanding defendants to custody.

Prisons could exceed safe capacity within weeks

Prisons are full and the situation is set to get much worse

The prison system has a severe capacity crisis. Prison expansion efforts have failed to keep pace with growing demand, especially in the male estate, and the Sunak government implemented a range of emergency measures to stay within useable capacity.

Figure 4.7 **Prison population and useable operational capacity, actual and projected, 2011–28**



Source: Institute for Government analysis of MoJ, 'Prison population figures', 2011–24 and MoJ, 'Prison population projections, 2023–28'. Notes: Actual and projected population figures are based on month-end figures. The capacity projection assumes 10,000 new spaces are delivered by December 2025 and 20,000 by December 2030, no additional spaces are lost and the current operating margin of 1,350.

Following an initial drop during the pandemic, since early 2021 the number of prisoners has been climbing sharply. This rise is a combination of the long-term trend for longer sentences, as well as dramatically larger remand and recall populations,[*] up 84% and 72% respectively since 2018/19. These, in turn, reflect challenges elsewhere in the system: the large court backlog and struggling probation service, as well as legislative changes increasing the use of probation supervision.

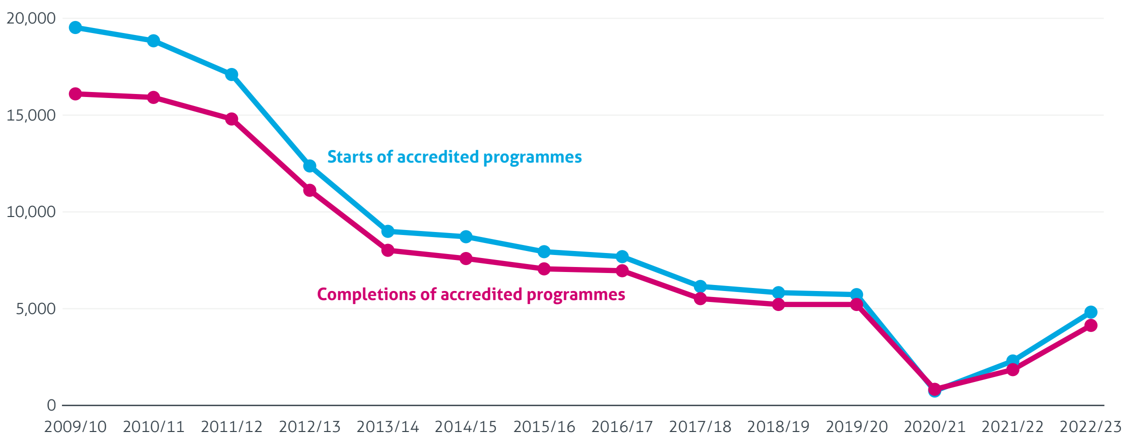
Efforts to increase capacity to keep up with this rising demand have fallen short. In 2021, the Johnson government pledged to build 20,000 new prison places by the mid-2020s. So far, about 5,600 have been delivered, and a further 4,400 are expected by December 2025.[27] This falls far short of the projected prison population, which is estimated to increase by 12,000 by then. Planning appeals and construction difficulties have been the major reason for these delays, and have dogged successive governments' attempts to increase capacity. A lack of capital investment has also hindered efforts, with more than 2,700 (gross) spaces lost to dilapidation since 2019.[28] The capacity crunch exacerbates this, as non-essential maintenance has been paused to maximise capacity.

[*] People on remand are awaiting trial or sentencing. The recall population refers to those who have been recalled to prison for a breach of their licence conditions, after having been released on parole.

Staff levels also contribute to capacity constraints. The staffing situation in prisons has improved substantially, with joiners up and leavers down in the past year. At a national level, the prison estate is now fully staffed for the first time in years. But the total number of operational officers is still below the 2009/10 figure, despite a larger prison population and a more serious mix of offenders. Recruitment has been patchy across the country, leaving some prisons still seriously understaffed and reliant on short-term deployments of staff from other prisons. More staff would be required to increase capacity swiftly; for instance, through rapid deployment cells – Portakabin-style modular cells that are quick to set up. Staff are also less experienced than they were. More than half of officers have less than five years' experience, compared with just 22% in 2010, while the number with more than 10 years' experience has fallen sharply. New recruits are also increasingly young, in their teens and early 20s, which has raised concerns about potential criminal exploitation of staff by prisoners.[29]

Overcrowding makes it harder to maintain a functioning regime inside prisons, and often hinders access to purposeful activity such as work and education. While the number of accredited programmes started and completed by prisoners has risen since last year, both remain lower than before the pandemic. This comes on top of a dramatic decline before the pandemic. Reduced access to education can itself exacerbate capacity pressures if prisoners are unable to complete the courses they need to improve their chances of parole.

Figure 4.8 **Starts and completions of accredited programmes, 2009/10–2022/23**

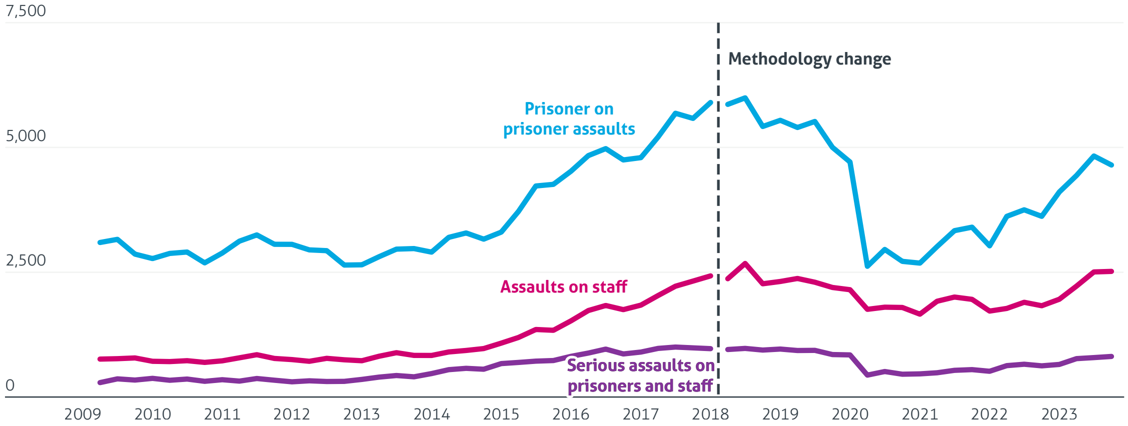


Source: Institute for Government analysis of MoJ, 'Prison Education and Accredited Programme Statistics 2022 to 2023'.

Overcrowding also lowers morale for both prisoners and staff and makes outbreaks of violence and unrest more likely. Assaults on prisoners, although still below their pre-pandemic peak, have risen sharply since 2021, while assaults on staff have returned to around peak levels. The degree of overcrowding, narrow operating margin[*] and lack of flexibility in moving prisoners also increase the risk of a major riot, as the recent disorder at HMP Parc in Wales suggests.

* The operating margin – the difference between the maximum operational capacity and the useable operational capacity required to place prisoners in the right cells according to sex, security category and other factors – has been reduced, from 2,000 before the pandemic to just 1,350 now. See MoJ, 'Prison population figures: 2020' and 'Prison population figures: 2024'.

Figure 4.9 **Prison assaults, Q2 2009 to Q4 2023**



Source: Institute for Government analysis of MoJ, 'Safety in custody statistics' (Table 7), Q2 2009 to Q4 2023. Notes: Figures from Q2 2018 onwards exclude incidents occurring within the youth estate.

Further emergency measures to reduce the prison population will be necessary but come with major drawbacks

In response to the crisis in prisons, the Sunak government introduced several emergency measures, including releasing prisoners up to 70 days early, delaying hearings in the magistrates' courts and using police cells as overflow prison capacity. Prison overcrowding has also influenced sentencing decisions,[30] and the National Police Chiefs' Council advised police forces to consider reducing arrests due to pressure on prison capacity.[31] So far, the impact of these emergency measures has been insufficient. Further crisis measures are likely to be necessary over the summer.[32]

However, these measures have serious downsides. They all impair fair and equitable justice, and risk undermining public confidence in the justice system. If prison capacity influences the length and type of sentence, people do not receive equivalent sentences for equivalent crimes. Early release has been implemented very rapidly, which has negatively affected preparation for release.[33] Prisoners are more likely to be released without accommodation and with limited support, often leading to rapid reoffending and recall to prison.[34] And victims who are entitled to be notified of an offender's release – mostly domestic abuse victims – may be informed after the fact or not at all.[35]

There are also public protection risks. Early release decisions are made centrally by His Majesty's Prison and Probation Service (HMPPS), according to set criteria. Neither prison governors nor probation practitioners have a veto if they believe a prisoner poses an unacceptable risk if released, although they can raise an objection.[36] Equally, delaying remand hearings means defendants will be released on police bail, due to time limits on police custody.[37] There is a lack of transparency as to what risk assessment processes are governing these decisions, or who is accountable for them.

The prison crisis is the most immediate criminal justice challenge facing the new government, and it requires swift and decisive action to remedy it, even if none of the options is palatable. While short-term measures will be necessary to mitigate the immediate crisis, it has been driven by long-term policy trends, which the government will also need to address if it is to get away from stop-gap measures and find a sustainable solution.

The probation service is overstretched and cannot adequately manage caseloads or risk

The vacancy rate is rising and staff lack experience

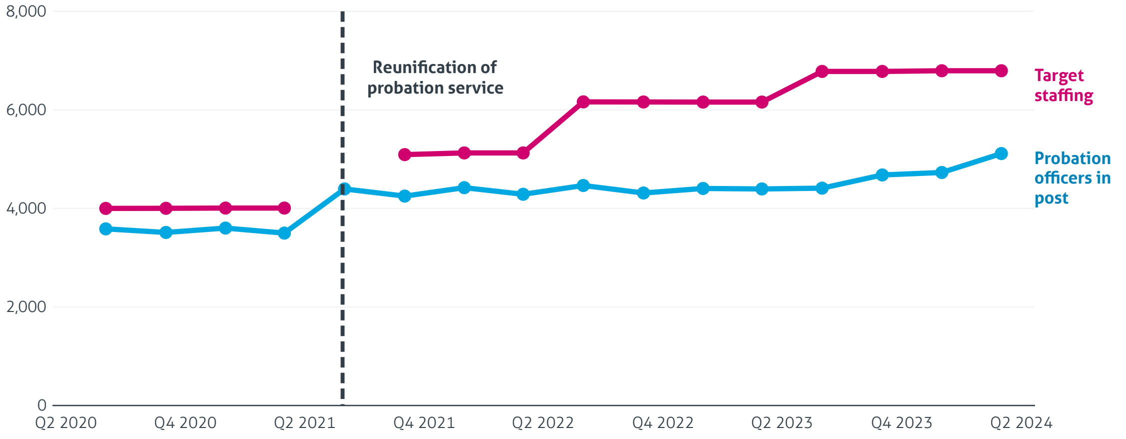
Probation is often the forgotten service within the criminal justice system, but it plays a vital role in resettling and rehabilitating offenders, supporting court decision making and contributing to public protection. However, it is currently facing a range of deep-seated challenges, including unmanageable caseloads, high vacancy rates and inadequate risk assessment processes. The service currently lacks a clear sense of its purpose and role within the justice system, exacerbated by repeated restructuring and changes in focus within the past 10 years and an inexperienced workforce that is struggling to cope.

Probation performance has been poor for some time. In 2014/15, the coalition government replaced the 31 regional probation trusts with a partially outsourced system, divided into private sector-led community rehabilitation companies (CRCs) to oversee low- to medium-risk offenders and the National Probation Service, which supervised high-risk offenders. Poor performance in many CRCs, much of which stemmed from a poor initial contracting process, led the service to be reunified under public sector management in 2021, run nationally within HMPPS.[38] But performance has worsened since reunification. When CRC caseloads and staff were brought into the national service, it became clear there was a severe staffing shortfall and particularly a lack of qualified probation officers, with CRCs instead relying heavily on unqualified probation services officers.[*]

Recruitment of trainee probation officers has boosted numbers in post in recent years, but dropout rates are high and rising. Among those who started their training course in 2020/21 or 2021/22, around 20% of trainees did not complete the course. This compares to 13% for the 2017/18 class. The leaving rate for qualified probation officers has also risen, hitting 8% in March 2024 compared with 5% in March 2018.[39] The combination of high workloads and responsibility with low pay is a driver of poor retention; probation officers in 2022/23 earned 22% less on average in real terms than in 2010/11, and less than either prison or police rank-and-file officers.[40]

* Probation services officers and probation officers are collectively referred to as probation practitioners. Trainees work as probation services officers during their training, so some probation services officers are working towards their professional probation officer qualification.

Figure 4.10 **Probation officers in post and target staffing level, Q2 2020 to Q1 2024**



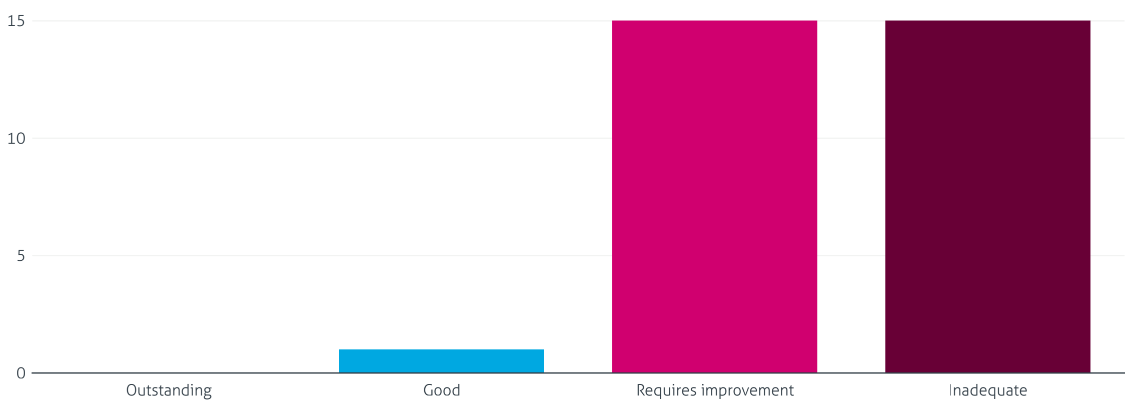
Source: Institute for Government analysis of MoJ, 'HM Prison and Probation Service workforce quarterly March 2024', 'Annex – Prison and Probation Officer Recruitment'. Notes: There was no target staffing figure produced for Q2 2021 due to the reunification of the service. Changes to target staffing levels from 2022/23 reflect the move towards the new target operating model for probation.

The increase in staff numbers needed to improve performance since reunification means the workforce is increasingly short of the required staffing level, with a 25% vacancy rate in Q4 2023, compared with 10% in Q4 2020. There is still a lack of experienced staff, with only 10% of probation officers having spent 10 years or more in probation (compared with 25% in prisons). Caseloads have reduced since reunification, but remain very high, particularly for junior probation services officers: 53% are holding more than 50 cases (down from 72% within CRCs).[41]

Probation performance is declining

The high vacancy rate and large caseloads result in poor-quality supervision. In 2022/23, His Majesty's Inspectorate of Probation (HMIP) rated nearly half of the 31 probation delivery units as 'inadequate', while only one was 'good' and none was 'outstanding'.[42] This reflects failures across probation activities, from supporting offenders to desist from offending to adequately assessing risk of harm. HMIP highlighted that performance across all categories of need had deteriorated since reunification. The most successfully met need was around accommodation, but this was still only delivered to a high enough standard in 43% of cases.

Figure 4.11 **Inspectorate ratings of probation delivery units, 2022/23**



Source: Institute for Government analysis of HM Inspectorate of Probation, 'Annual Report 2022/2023'.

This poor performance has knock-on effects on the rest of the criminal justice system. Probation supervises community sentences for adults, and these have declined sharply, falling from 12% of all sentences passed in 2012 to 6% in 2023. This has been attributed in large part to judges and magistrates losing confidence in the quality of supervision and support from probation.[43]

The growing number of recalls to custody for people on probation suggests that probation is struggling to work effectively with offenders or manage risk in the community. Recalls have risen 26% since 2021 – even though the number of people on post-release supervision has fallen 5% over the same period. We do not know what proportion of people on post-release supervision have been recalled because this data is not published, but the ratio of recalls to parolees is now almost 1:2, up from around 3:10 in 2016.

If rising recalls represented a genuine increase in risk levels or poor rehabilitation, this would not be a bad thing. But the bulk of this increase comes from those serving short sentences, rather than more serious offenders, and most recalls do not involve a charge for a further offence: only 27% in 2023. These suggest that high recalls may be a product of probation's failure to meet the needs of those on licence, as well as changing probation practice. HMIP's annual report highlighted that non-compliance with licence conditions in the cohort it reviewed was driven chiefly by homelessness and/or substance misuse, often arising from prison leavers not being able to access appropriate support in the community.[44]

High caseloads mean practitioners do not have time to develop meaningful relationships with those they supervise – possibly only having 10 minutes a week for each of their cases[45] – so they may be more willing to recall them to prison. HMIP has been highly critical of case supervision and risk assessment processes in the probation service, with just three out of the 31 probation delivery units managing adequate risk assessment in at least half their cases.[46] Without the capacity or experience to assess risk appropriately, and with ineffective management supervision, many probation practitioners appear to be taking a very risk-averse approach, using relatively minor breaches as a reason for recall. High-profile failures of probation supervision, such as Jordan McSweeney's murder of Zara Aleena in 2022, encourage this approach.[47]

However, heavy reliance on the use of recall has serious downsides. It disrupts accommodation, employment and family relationships for those recalled to prison, leads to poorer relationships between probation practitioners and those they supervise[48,49] and places a heavy demand on prison capacity – 14% of current prisoners are there on recall post-release. It is also unlikely to reduce reoffending, as short recall periods of 14 or 28 days offer no opportunity for rehabilitative activities in prison and only result in more acute needs when the person is re-released.

High recall rates lay bare a cultural struggle at the heart of probation: What is the purpose of the service? Is it principally to provide support and rehabilitation, or punishment and risk management? The original role of the probation officer was to 'advise, assist and befriend', but policy changes since the 1990s have increased the focus on public protection and risk management.[50] Repeated restructures and changes in practice have muddled the clarity of purpose and identity of probation as a service,[51] particularly the recent integration of probation and the prison system as one service in HMPPS, run nationally with limited local connections. HMIP emphasises the importance of strong supportive relationships between practitioners and those under supervision to effective rehabilitation.[52]

But these have increasingly been lost under high caseloads and a more punitive approach, which damages trust and discourages honesty from those being supervised. Improving performance in probation is likely to require not only addressing high vacancy rates and staff inexperience, but also setting out clearly the role and purpose of the service.

Cross-cutting problems

Cross-cutting problems

Policy and funding are short term and inconsistent

Funding for front-line services is short term

Almost all front-line services, like local authorities, receive single-year financial settlements. This is despite their sponsor departments being given multi-year settlements, at spending reviews, to allow them to plan their spending over a longer time period. On top of this, providers are given limited guarantees on what funding they will receive in future years, which means that budgets for the services they oversee can only be set for a year. Even in neighbourhood services and policing, where councils and police and crime commissioners have some of their own revenue-raising powers through council tax and the policing precept, the amount they can increase these annually is limited by central government, reducing certainty about future budgets.

In recent years, governments have repeatedly found it necessary to top up single-year budgets in response to poor performance. In hospitals and adult social care, repeated emergency cash injections have proved necessary to manage predictable (and in reality, annual) winter crises. Likewise, the Sunak government expanded the use of 'exceptional financial support', allowing 18 local authorities to use their capital resources to cover shortfalls in day-to-day spending in 2024/25.

These short-term budgets make it harder for services to plan or work efficiently. In particular, they restrict investment in long-term preventative programmes, which often need sustained delivery and funding to be effective.

Policy making is inconsistent and rarely considers the wider system

There is similarly a lack of long-term thinking behind many policy decisions. Integrated care boards (ICBs) provide a particularly damning example: the government put ICBs on a statutory footing in July 2022 only to slash their management budgets by 30% less than a year later. As a result, ICB leaders found themselves having to cut programmes they had just launched rather than focusing on the substantive work of improving performance in their areas.

Changes in the political and economic outlook result in programmes and reforms being scrapped or focus shifting, exacerbated by high levels of churn among ministers and officials. Incoming ministers also often layer new priorities on top of old ones, leading to a proliferation of poorly aligned targets.

All this creates confusion for the front line. In policing, since 2018 key priorities have included serious violence,[1] rape,[2] serious acquisitive crime,[3,4] knife crime,[5] violence against women and girls,[6] anti-social behaviour[7] and shoplifting.[8] Health has similarly had a proliferation of recovery plans, without clear prioritisation among them.

Policy makers also rarely take a system-wide approach to policy. For example, the 20,000 police officer 'uplift' launched in 2019 was expected to result in increased charges and prosecutions over time, but there was no accompanying move to expand capacity in the rest of the criminal justice system (at least until after the backlog in criminal courts ballooned to dramatic levels during the pandemic). Sentencing policy is another, connected example. The court backlog and declining probation performance have amplified pressure on prisons, but governments have continued to increase sentence lengths, with obvious knock-on effects for the prison population.

Services have high leaving rates, inexperienced staff and key skills gaps

Workforce challenges are universal across the public services we cover. Some have large staff shortages; in particular, adult social care and probation. Others are missing staff in key roles, whether that is detectives in the police, legal advocates in the criminal courts, managers in the NHS or teachers of subjects such as physics and maths in schools. These gaps harm both performance and productivity.

In health and adult social care, services are increasingly reliant on immigration to fill workforce gaps. There can be benefits to bringing in international recruits, who may provide new perspectives and ideas, but there are also drawbacks – perhaps most importantly, political. Labour committed in its manifesto to reduce net migration,[9] meaning there is a risk that this recruitment channel could be squeezed or cut off by the new government, possibly at short notice.

Retention problems and inexperience harm productivity

Staff inexperience and poor retention pose big problems across services. Some turnover helps the workforce stay dynamic and can bring in new skills, but high turnover as seen in recent years is a drag on performance, leading to lost expertise and institutional memory, and increasing the burden on other staff to train up new entrants. High leaving rates can also drive high vacancy rates, because of the time it takes to replace staff.

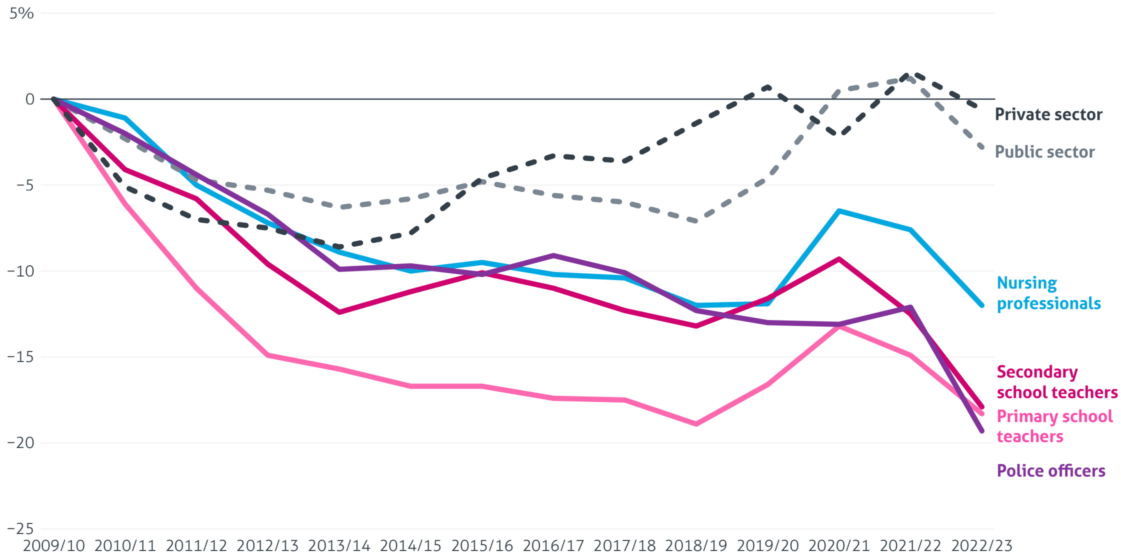
After a temporary reduction in leavers during the first year of the pandemic, many services saw leaving rates rise again from around 2021/22. This has since settled, but leaving rates remain high in many services: 8% of probation officers and 12.8% of operational band 3–5 prison officers left the service in 2023/24, and 15.9% of children and families social workers left in the 12 months to September 2023. The situation is arguably most severe in adult social care, where more than a third of care workers (35.6%) left the service in 2022/23.

Inexperienced staff tend to be less effective and can also be a short-term drain on the productivity of experienced colleagues.[10] In 2022/23, around a third of police officers (36%)[11] and over half (51%)[12] of prison officers had less than five years' experience. This is a substantial change since 2015/16, when the figures were 14%[13] and 15% respectively. Likewise, in September 2023, almost three in every 10 nurses (27%) had less than five years' experience, up from two in 10 in September 2017.

The root causes vary somewhat across services: police and prisons saw large-scale redundancies during the 2010s; both have had major recruitment drives in recent years to expand their workforces, as did hospitals; and all services have had high levels of turnover. The lack of experienced staff results in limited support and mentorship for new hires, meaning it can take longer for them to gain skills and become more productive and making them less likely to remain in the service long term, exacerbating retention problems. The requirement to train new staff – either formally or informally – also means that experienced staff spend less time on their own work and are therefore less productive.

Pay is a key driver of both recruitment and retention problems.[14] Over the long term, pay for public service workers has dropped both in real terms and relative to the private sector, while high inflation in recent years has further eroded the value of settlements agreed in recent pay deals. Perceived low pay damages morale and staff goodwill, which is very low in many services, and has driven broad industrial action. Adult social care, children's social care and prisons all have limited pay progression, which discourages workers from staying long term and building up experience.

Figure 5.1 **Real-terms change in earnings of selected public sector professionals since 2009/10**



Source: Institute for Government analysis of ONS, 'Earnings and hours worked, occupation by four-digit SOC' ('ASHE' series table 14), November 2023, and ONS, 'Earnings and hours worked, all employees' ('ASHE' series table 13), November 2023. Notes: Gross median earnings used. Figures have been deflated using OBR CPI. Figures for "primary school teachers" include nursery staff up to 2020/21. "Nursing professionals" figures use data from "nursing professionals" for 2020/21-2021/22, "nursing and midwifery professionals" for 2010/11-2019/20 and "health associate professionals" for 2009/10. "Police officers" figures include all officers ranked sergeant and below.

Poor working conditions and low morale also harm retention. Workloads in these services have always been high, but seem to have increased following the pandemic, and are commonly cited by staff as their main reason for wanting to leave their job. Working patterns can also be unsociable and inflexible, particularly in the NHS, police and prisons, and this contrasts sharply with changing societal norms around flexible working arrangements in other sectors. Staff morale and goodwill is declining, and this is exacerbated by incidents of poor leadership, bullying and discrimination – 28% of

NHS staff and 12% of teachers reported experiencing bullying or harassment in the last 12 months. All together, these factors make it increasingly hard for public service employers to compete for and retain staff.

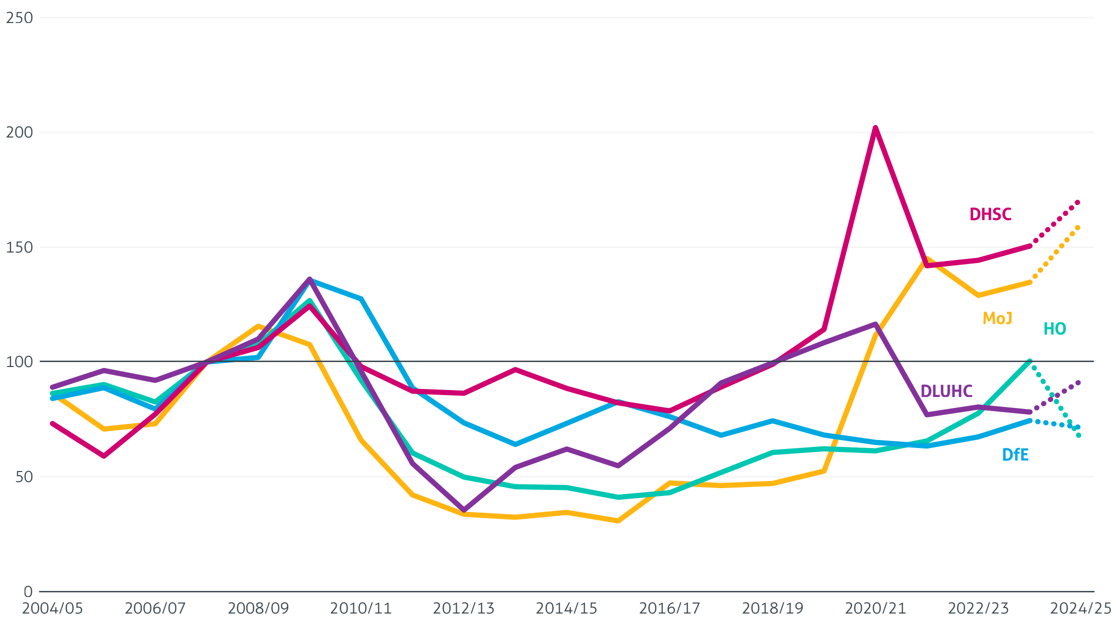
Under-investment in capital

Governments have under-invested in public service capital for decades

Capital investment in equipment and in the public sector estate* is crucial if public services are to run effectively and reliably. Governments have long under-invested in these, however: between 1970 and 2010 there were only two years (2007 and 2009) that the UK exceeded the OECD average for capital investment in health.

Even by that low standard, governments of the 2010s consistently deprioritised capital spending. As part of its austerity programme, the coalition government cut capital budgets substantially across all the departments that we look at. Cuts were deepest in the Ministry of Justice, where capital spending was on average only 43.3% of its 2007/08 level between 2010/11 and 2019/20. Between 2011/12 and 2018/19, not one of the departments we examine exceeded its 2007/08 total for capital spending. Capital budgets in DHSC and MoJ have increased substantially in recent years, but it will take time to address historic underinvestment.

Figure 5.2 **Capital spending index, public service departments, 2004/05–2024/25 (real terms, 2007/08 = 100)**



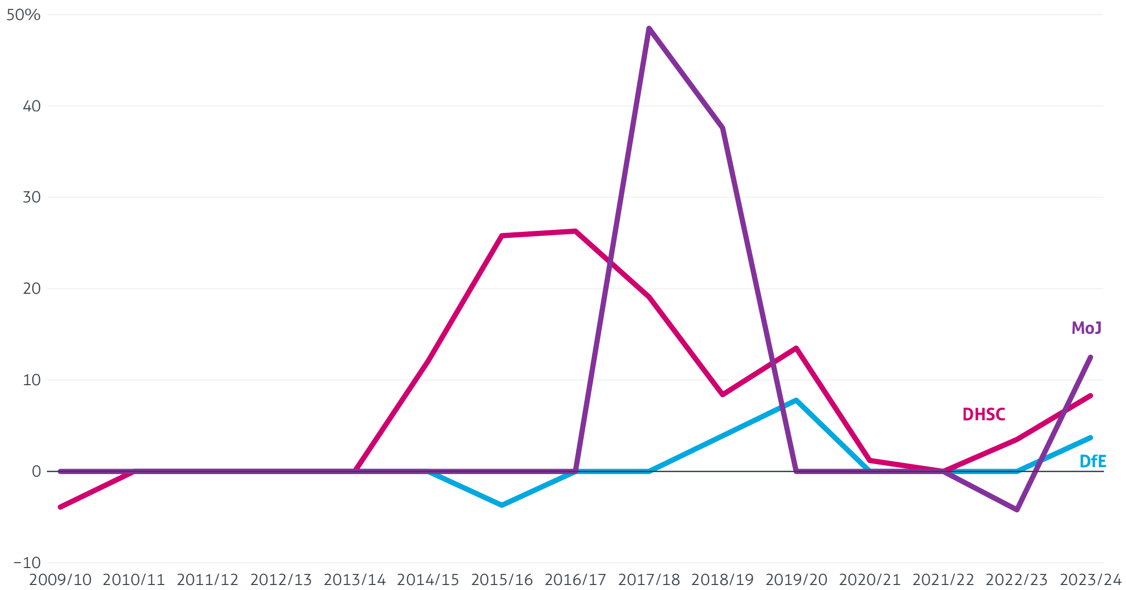
Source: Institute for Government analysis of HMT, Public Expenditure Statistical Analyses, 2009–2023 and HMT, 'Spring Budget 2024', ('Table 2.2: Capital Departmental Expenditure Limits (DEL)'. Notes: 'DLUHC' refers to DLUHC community capital spending, and excludes DLUHC spending on housing services.

* Capital spending funds the construction of new buildings, the maintenance of existing ones, the purchase of equipment and investment in IT services, among other things.

Services have used capital to plug day-to-day deficits

Not only did the government provide insufficient capital funding to services throughout the 2010s, it also granted them permission to shift funding from what capital budgets they did receive to their resource (or day-to-day) budgets. Nowhere was this more apparent than in DHSC (whose budget is almost entirely spent on the NHS), where the government reallocated £5.6 billion worth of capital budgets between 2013/14 and 2017/18. Despite claiming that this practice had ended, the government then allowed the NHS to reallocate a further £500 million from its capital budget in November 2023.[15]

Figure 5.3 **CDEL to RDEL transfers, % of department CDEL, 2009/10–2023/24**



Source: Institute for Government analysis of DHSC, 'Annual accounts', 2022/23 and HM Treasury, 'Comprehensive spending review', 2021. Notes: 'RDEL' refers to resource spending – planned money that the department spends on day-to-day activities.

However, perhaps paradoxically, many services also consistently underspend their capital budgets. For example, between 2010/11 and 2022/23, DHSC underspent 7.9% of its CDEL (capital) budget, DfE 4.9% and MoJ 6.8%.[16] Such underspends are largely due to service leaders' caution, because departments are heavily punished for overspending their budgets – the incentives not to underspend are much weaker.

The government allocates CDEL in a variety of ways, including multi-year settlements for some major projects, but too often uses single-year capital budgets, with a substantial amount of volatility year to year. This makes it hard for services to plan their spending effectively. With single-year, unpredictable capital settlements, services cannot commit to more than 12 months' worth of spending, creating a cliff edge at the end of the financial year. This creates uncertainty for services and suppliers, in response to which suppliers often charge more. There is commonly also a 'hockey stick' effect with spending where services rush to spend capital budgets at the end of the year before they lose them. This can represent poor value for money.

The estate is crumbling and staff lack equipment

Under-investment means that the public sector estate is now crumbling across many public services. There is a record maintenance backlog in hospitals, with some trusts forced to close wards and operating theatres due to things such as sewage leaks and collapsing ceilings.[17] The government has failed to expand prison capacity in line with demand and the estate that does exist is often not fit for purpose: less than a quarter of prison officers believe their working conditions are adequate[18] and more than 2,700 (gross) prison spaces have been lost to dilapidation since 2019.[19] Days before the start of the school year in 2023, the government was forced to close more than 100 schools found to be at risk of imminent collapse because they were built using RAAC.[*,20]

Some of the estate is more straightforwardly unsuited to a modern state. Almost a quarter of the general practice estate was built before the NHS was established in 1948, and much of it is cramped and ill-equipped to meet the needs of a modern health system.[21]

Staff in public services are often forced to work with either insufficient or worn-out equipment and IT systems. UK hospitals have less than half the number of CT scanners per head of population compared to the OECD average (10.0 per million people vs 20.1).[22] IT systems are out of date and often cannot communicate between different parts of the NHS – in June, IT failures in the NHS in Cornwall[23] brought the system to a grinding halt, with staff forced to reschedule appointments. In the courts, poor quality IT and Wi-Fi continue to interfere with remote hearings; despite significant improvements in the last few years, 35% of barristers still said they experienced technical problems with video platforms in 2023.[24]

These factors make public services far less effective and reduce the value for money from investing in additional staff. Nowhere is this more evident than in hospitals, where performance remains stubbornly poor despite large recent increases in the number of doctors and nurses.[25] However well trained and motivated staff are, they will find it much harder to do their jobs well if they are operating out of leaking buildings, working on computers that take 20 minutes to turn on, and without access to the latest equipment.

Increasing acute demand

Rising acute demand is overwhelming some services

While spending has increased in recent years for several services, there is good evidence that for the most part it has not kept pace with demand.

In local authorities, demand is rising fastest for children's residential care, homelessness services, special educational needs and disabilities (SEND) services and for adult social care for working-age adults. As discussed in the local government chapter, those pressures are due to a mixture of factors including: increasing prevalence of disability among working-age adults; more mental health and developmental issues among children; rising levels of child poverty; insecure and increasingly expensive housing; and cuts to preventative services, among others.

* Reinforced autoclaved aerated concrete.

Recently expanded police forces are starting to charge more people, meaning that more cases will need to be heard in criminal courts, where there is already a record backlog. This will in turn put additional pressure on a prison system which – due to lengthier sentences, a growing remand population and extremely high levels of recall to custody among parolees – is already at capacity.[26] Attempts to deal with the crisis in prisons are likely to result in further demand being shifted on to probation, which is already struggling to cope.

GPs and other practice staff are delivering more appointments than ever, but despite that patient satisfaction with the service and with appointment times continues to decline. In 2023, only 52.8% of patients were satisfied with the appointment times available to them, down from 65.9% in 2018, suggesting substantial unmet need.

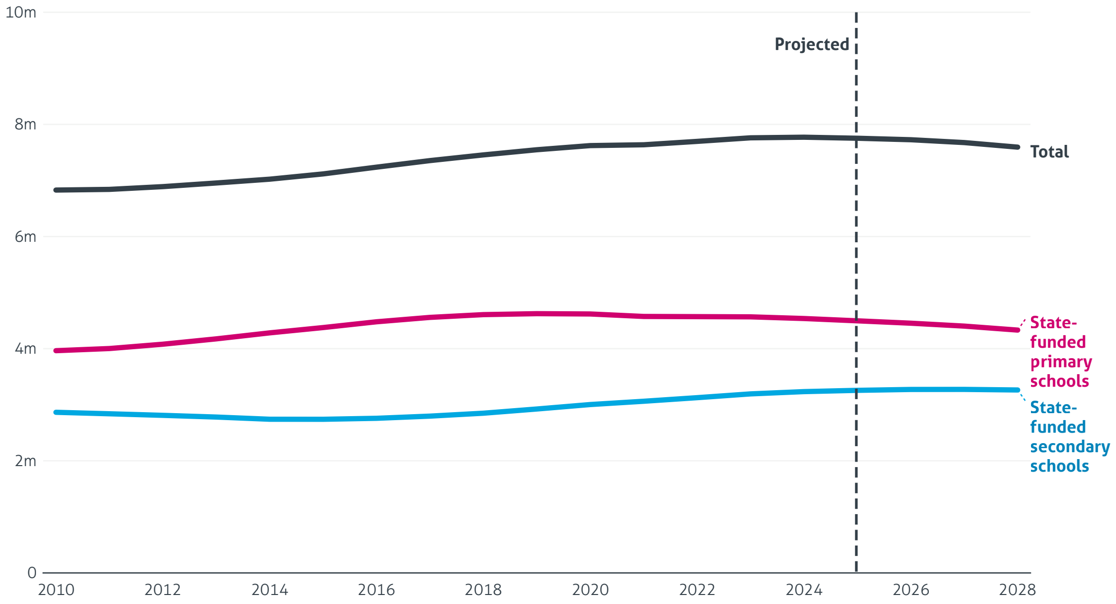
An ageing and increasingly ill population requires more adult social care. Despite that, the trend since at least 2015/16 is that fewer and fewer people are receiving publicly funded care. That leads to poor outcomes for individuals who are thus not supported to live as independently as they might otherwise. But it also puts pressure on other parts of the health and care system. People who cannot access care may present more frequently to their GP or to A&E, and their condition may deteriorate further, requiring more expensive and intensive care in the future. These pressures also go beyond the health and care system, with local authorities cutting other services (including leisure and cultural services, as well as preventative services) in response to the funding needs of the rising demand for care.

Demand is less of a problem in hospitals and schools

Unlike in other parts of the health and care system, the story in hospitals since the pandemic has been a surprising *lack* of demand. Two of the prime indicators of hospital demand – A&E attendances and additions to the elective waiting list – are only slightly above pre-pandemic levels and behind where we would expect them to be if they had grown in line with pre-pandemic trends. Although there appear to be fewer people than expected coming forward for hospital care, there is evidence that those who do present have more complex needs. A study of A&E attendees carried out by NHS England (NHSE) found that only 4% were presenting with low acuity compared to NHSE's expectation, based on national and international experience, that it would be somewhere between 20% and 40%.[27]

The number of pupils in schools is set to decline over the next decade as lower birth rates translate into lower pupil enrolments. By 2028, there will be approximately 206,000 fewer children in state-funded primary schools and only 29,000 more children in state-funded secondary schools compared to 2024 – a decline of 4.5% and a rise of 0.9% respectively.

Figure 5.4 **Pupils, 2010–2032**



Source: Institute for Government analysis of DfE, 'National pupil projections: Reporting year 2023'. Notes: Figures are as at January of the given year. Primary pupil numbers are higher than secondary pupil numbers as primary school covers more years of compulsory education. Primary pupil numbers also include pupils in nurseries at state primary schools.

As the government plans to hold per-pupil spending flat in real terms, declining pupil numbers will provide some helpful additional headroom for other spending. However, most costs will not decrease in a straight line with pupil numbers, and realising the majority of savings will require staffing cuts or schools closures. In short, schools will struggle if the government sees this as cash that can be easily reallocated elsewhere.

Cuts to preventative services have contributed to rising acute demand

Across a range of services including the NHS, children's services, housing services, adult social care, and the criminal justice system, governments of the past 14 years have prioritised spending on acute services at the expense of more preventative services.

In a fiscal environment with falling budgets – as was the case in the 2010s – services have an incentive to prioritise the more immediate pressures of acute demand: these are the most visible to voters and are least easily cut. Protecting the spend on ambulances, for instance, seems more important than protecting the spending on vaccination and other public health programmes. There are also more statutory duties, particularly on local government, to meet acute needs, necessitating cuts elsewhere.

But it was also the way that the government carried out austerity that incentivised cuts to prevention. The government generally 'salami-sliced' services' budgets while requiring them to deliver the same quality of service and relying on 'efficiency savings' to make up the difference. While some services did find efficiencies in the early years of the 2010s, those were quickly exhausted and services were then forced to start paring back discretionary spending. This was generally on more preventative services.

Many factors have driven an increase in demand for services since 2010. Cuts to the welfare system, compounded since 2022 by the cost of living crisis, have contributed to higher rates of poverty. Insecure and increasingly expensive housing has contributed to a spike in homelessness and likely worsened people's health. While difficult to prove directly, cuts to preventative services have also likely increased demand for more expensive acute services.[28]

The status quo and recommendations

Sticking with the status quo: implications of current spending plans

Spending from April 2025 is planned to grow more slowly than under Johnson, Brown or Blair

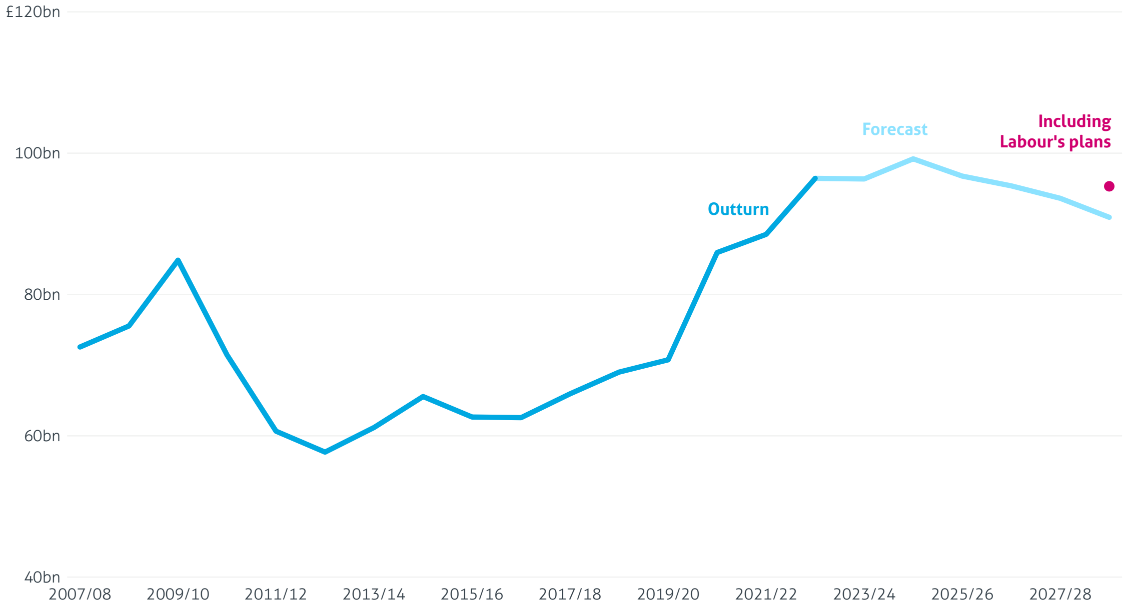
Current spending plans – those set out by the Sunak government plus additional spending commitments included in the Labour manifesto – indicate that day-to-day departmental spending is set to increase by 1.2% per year in real terms between 2025/26 and 2028/29. However, Labour has also said it would stick to other spending commitments inherited from the previous government – namely, implementing the *NHS Long Term Workforce Plan*, increasing aid and defence spending in line with GDP and expanding childcare provision.* Taking those into account, this implies annual real-terms spending cuts of 2.4% to unprotected areas of day-to-day public spending.

Under existing spending plans, capital budgets will be flat in cash terms. This implies real-terms cuts of 1.7% per year, although it is unclear how this will translate to public service capital budgets, which account for only 20–25% of total capital spending.

And this limited capital pot will be in much demand – not least from the wealth fund, R&D and net zero transition. If the 1.7% real-terms cut is applied to public services, capital budgets in the Department of Health and Social Care and the Ministry of Justice will still be higher than at any point during the 2010s. However, both departments still have an effective 'backlog' in capital spending that is required to make up for the under-investment in that decade. In the Home Office, DLUHC and DfE, there would be a continuation of the low levels of investment seen in the 2010s. Without sufficient capital investment all services will struggle with productivity issues over this parliament (discussed in more detail below).

* We also assume it will keep per-pupil schools spending flat in real terms, but spend extra on commitments made in the 2024 Labour manifesto.

Figure 6.1 **Government capital spending, outturn and forecast, 2007/08–2028/29 (2024/25 prices)**

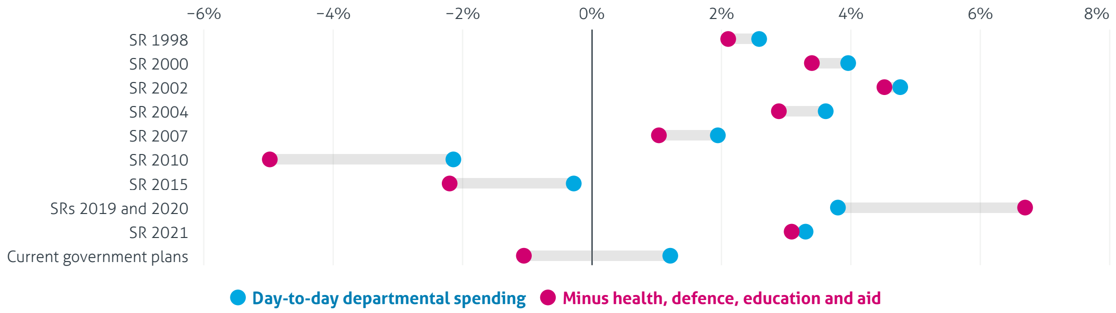


Source: Institute for Government analysis of Office for Budget Responsibility, 'Economic and fiscal outlook - detailed forecast tables: expenditure' (table '4.3: Consistent historical RDEL and CDEL series'), March 2024 and Labour Party manifesto 2024 ('Green prosperity plan' table). Notes: "Including Labour's plans" puts the £4.7bn annual increase in spending from the Green Prosperity plan into 2024/25 prices and adds this to the forecast total for CDEL in 2028/29.

If the government sticks to these spending plans at the next spending review, then it will be the tightest for day-to-day spending since 2015. It would also be tighter than any of the five spending reviews undertaken by the Blair and Brown governments between 1998 and 2007 – including the 1998 spending review in which Labour pointedly stuck to the tight spending plans inherited from the Major government, at least for the first year.

Given the various commitments Labour has made to improve public services, it is highly unlikely that the new government will be able to stick to these plans. The 2015 spending review proved undeliverable, with the May government repeatedly providing emergency funding top-ups over the following years in response to poor performance. Even in 2023/24, when budgets were relatively generous, the Sunak government found it necessary to provide extra funding to key public services such as the NHS and local authorities.[1]

Figure 6.2 **Average annual real-terms change in spending planned at successive multi-year fiscal events, 2002-2023**

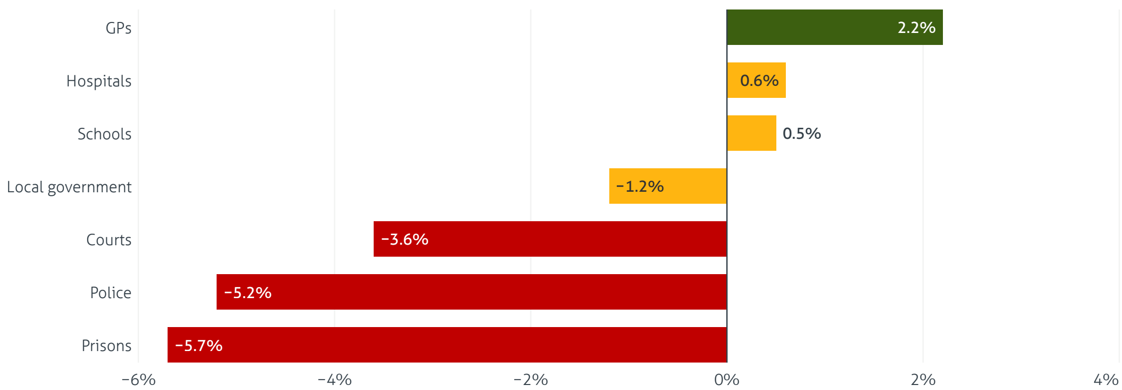


Source: Institute for Government analysis of successive HM Treasury multi-year spending review documents. Notes: The change in 'Day-to-day minus health, defence, education and aid' between 2024/25 and 2028/29 is a different measure to the changes in unprotected spending in the same period discussed elsewhere in this document to make the data comparable across many spending reviews. These spending plans include costings from the 2024 Labour Party manifesto.

Under current spending plans most services are likely to be performing worse by the time of the next election than in 2019

Implementing current spending plans would mean most services are likely still be performing worse in 2028/29, at the end of the new parliament, than before the pandemic and 2019 general election. Service quality and access in local government and the criminal justice system, in particular, are expected to be on a continued downward trajectory between now and then.

Figure 6.3 **Average annual real-terms change in spending between 2024/25 and 2028/29 under current government plans, relative to demand**



Source: Institute for Government analysis of HM Treasury, Spring budget 2024 (Table 2.1: Resource departmental expenditure limits (DEL) excluding depreciation) and Cabinet Office, 'Defending Britain' (Table 'Annex – Spending detail'), April 2024 and demand assumptions come from a range of sources. Notes: Local government covers neighbourhood services, children's social care and adult social care. This chart uses the 2024 spring budget as the baseline and adjusts for the government's subsequent defence spending announcement in April 2024 and Labour's manifesto commitments in June 2024. For information about demand assumptions please see the Methodology.

Increasing spending in line with the NHS Long Term Workforce Plan would likely lead to a small improvement in performance

It has been calculated that delivering the *NHS Long Term Workforce Plan* will require spending growth of 3.6% per year. This would see NHS funding grow more quickly than demand is projected to. However, The Health Foundation has calculated that the NHS would need annual funding increases of 4.5% between 2024/25 and 2029/30 to see "sustained improvement", while 3.1% increases will be needed just "to keep the NHS going with minimal change".[2] As such, increasing spending by 3.6% would be likely to lead to a notable but small improvement in NHS performance.

Delivering all NHS targets in this parliament will be difficult

Under current spending plans, Labour will struggle to deliver its commitment to return to meeting the elective, A&E, cancer and ambulance waiting time targets.[3] The last time any government met the first three of these was in February 2016, July 2015, and December 2015 respectively.

In elective care, the target that 92% of people should wait no longer than 18 weeks from referral to treatment was last met when the waiting list was around 3.5 million,[4] compared to 7.6 million in April 2024 and 4.6 million in February 2020. However, modelling work undertaken by the IFS suggests that, even in its optimistic scenario, the elective waiting list could still be higher at the next election than it was on the eve of the pandemic. In its pessimistic scenario, the waiting list would still be over 7.5 million in December 2027.[5] It will be challenging to meet the 18-week waiting time target while waiting lists are so long, though not impossible.

Some analysts do believe it is possible for Labour to return to the elective target by the end of the parliament.[6] The difficulty for the government is that hospital targets are often interdependent; elective and emergency care can compete for the same bed space, meaning that improving performance in elective care may come at the expense of A&E and ambulance performance. Recommitting to hitting these targets also implies continuing with health policies that prioritise hospital care. However, the government has also committed to shifting more care out of hospitals and improving prevention. These moves are welcome, but will be harder to do if ICBs are focused primarily on hospital targets.

Current plans will not lead to a step change in general practice performance

In general practice, the *Long Term Workforce Plan* assumes no growth in the number of fully qualified GPs during this parliament, with the GP workforce instead largely boosted by higher numbers of trainees.[7] While this may help to marginally improve performance, it is unlikely to deliver a step change in patient access and satisfaction. And performance could decline without efforts to reduce GP workloads, improve the estate and make better use of the expanded direct patient care workforce.

It is unclear what impact maintaining per-pupil funding at current levels in real terms would have on performance

School costs are expected to grow more quickly than inflation,[8] so a flat settlement may make it difficult to maintain the current level of service – though there were meaningful improvements in attainment relative both to previous years and other countries during the 2010s despite per-pupil funding cuts. Complicating the picture further, the impact of pandemic-era disruption on primary school performance is likely to reduce over the course of this parliament as pupils move through the school system. However, for secondary schools, pupil attainment is at risk from teacher recruitment problems.

Councils would have little choice but to further cut preventative services and ration acute services

For local government, the current spending plans imply a continuation of the key trends since 2010. Reduced funding from central government will be offset, at least partially, by increases to council tax. Local authorities will also need to manage increasing demand for acute services like homelessness and adult social care, and above-inflation cost pressures in some areas such as children's residential care and National Living Wage in adult social care. As a result, most will be forced to further cut universal services like libraries and youth clubs, and increase rationing of acute services.

It may also require increased intervention from central government in the form of capitalisation directions – that is, to allow local authorities to use their capital resources to cover shortfalls in day-to-day spending. The challenges are likely to be greatest in more deprived areas, which have greater underlying demand for public services and less ability to raise funds locally.

Performance in courts and prisons would decline dramatically

The situation, if left unchanged, would be most dramatic in the criminal justice system. While the Labour manifesto pledged to increase the number of neighbourhood police officers by 13,000, under current spending plans it would in fact probably be necessary to cut some of the additional officers recruited since 2019. Either way, the implied cuts to spending in courts and prisons would likely prove untenable.

The growth in magistrates' and crown court case backlogs, the latter of which is already at a record level, is likely to accelerate, lengthening the already long waits for victims and defendants. Lives would be put on hold for years, with even more cases collapsing as memories fade or victims withdraw. In prisons, it would be impossible to accommodate, never mind to rehabilitate, additional prisoners. The government would have no choice but to release large numbers of them or allow an increasing number of those sentenced to avoid incarceration. As a result, public confidence in the system is likely to fall and reoffending is likely to increase.

Pay dissatisfaction, and disputes, would be hard to resolve

Across all these services, under current spending plans it would be very difficult to address the real-terms reduction in the value of staff pay since 2010. Even in the NHS, the best funded of these services, 3.6% per-year real-terms funding increases would only be enough to ensure that wages grow in-line with economy-wide wages.[9] The NHS would not become more attractive, in relative terms, compared to jobs in the private sector, meaning that problems with recruitment, retention and industrial disputes are likely to persist. In most other services, the situation would probably get worse.

Performance and productivity

The above analysis assumes that performance is directly correlated with spending. But, of course, the reality is more complex than that. There is huge variation in performance between different service providers within any given public service, even once different levels of spending and demand are accounted for. And it is perfectly possible for performance to improve even if spending does not grow faster than demand. For example, Wigan Council has increased healthy life expectancy and improved the quality of social care services, while also making savings.[10] Equally, performance can stagnate, even as funding grows substantially – as has happened in hospitals since 2019.

The missing ingredient is productivity. Whether or not the new government sticks to existing spending plans, what it will need is a strategy for improving productivity.

Recommendations

The new government should implement a bold programme of public service reform, with the objective of improving the long-term productivity of services. At the heart of this should be a greater focus on outcomes, rather than inputs; on prevention, rather than acute provision; on capital, rather than day-to-day, spending; on front-line innovation, rather than top-down command and control; and on the contribution of staff to performance, rather than their cost to the exchequer.

Much of this can be delivered without spending more. The government could do this by better prioritisation, by embedding prevention and improvements to investment in the spending framework, by changing policy to address acute demand, and by taking a more collaborative approach to industrial relations. If begun immediately, these changes will start to bear fruit by the end of this parliament. Over the long term, they would deliver substantially improved public service performance at existing levels of spending.

However, if the government wishes to see higher quality services more quickly it will, at least in the short term, need to spend more. We recommend focusing any additional spending on prevention and capital projects, as well as on key staff groups such as GPs, criminal barristers, social workers, and those in management and support roles.

How can the new government spend money more effectively?

Focus on a small number of priorities

This report has identified the biggest problems facing the new government, but the true list of issues that ministers must address is virtually unending. For every meeting that they take or briefing they read, there will be 10 others vying for their attention. It can be easy to be overwhelmed but unless ministers set clear objectives, they will achieve little. As noted by former cabinet minister Kenneth Clarke: "You have got to move on from being slightly shocked and overwhelmed by events to actually being in charge and having some idea of where, at least, you are trying to go and what you are trying to do."[1]

Prioritisation is particularly important when funding is tight. Sticking with the status quo will mean rapidly declining performance in some services, and limited improvement in others. If the new government wishes to enter the next election with tangible public service achievements, it must focus ministerial attention on priority areas. In turn, that could lead to prioritising funding for some things at the expense of others (and it could mean cutting them altogether to ensure sufficient funding for remaining responsibilities). But these are exactly the trade-offs that ministers are appointed to resolve.

Prioritisation should start immediately and at the top. Our Commission on the Centre of Government recommended the government agrees and publishes a 'priorities for government' at the beginning of the parliament as part of the King's Speech. These priorities should be incorporated into the government's budgeting and performance framework, with oversight by the prime minister and senior ministers.[2]

Prioritisation within departments is just as important. Critically, ministers must retain focus. David Laws said: "You need not only to identify priorities, but then follow through on them and structure your day and your week and your month around that."[3]

Ministers should also reflect priorities in the performance measures that front-line services have to report against. Targets, though not without their downsides, can be an effective way for raising minimum service standards. For example, there is good evidence that targets to reduce A&E and elective waiting times contributed to substantial improvements in performance under the Blair government.[4] But the proliferation of NHS targets in recent years means there is little clarity about what those on the front line should prioritise.[5] Former health secretary Patricia Hewitt, in her review of integrated care systems, argued that the government should "significantly reduce the number of national targets, with certainly no more than 10 national priorities".[6]

That is good advice for all new ministers and we recommend that ministers remove targets that do not reflect the priorities of the government. This will not be politically easy. Existing targets were implemented for a reason and new ministers will be tempted to layer new targets on top of existing ones to avoid upsetting relevant interest groups. But the reality is, the more targets there are, the less weight each one carries. Unless the new suite of targets is small and coherent, public services will not respond in the way ministers intend. For example, the government may want to consider whether the high-profile hospital performance targets on A&E, elective and cancer waiting times reflect its stated objective to make the NHS more local and preventative. This will be complex and the government should consider the options carefully, but it must start the process immediately.

The good news is that Whitehall and the wider public sector are responsive to ministerial direction. Ministers can hope to make meaningful improvements to public services. But to do so, they must focus on a small number of priorities within each service.

- **Use the King's Speech to set strategic priorities for the new government**
- **Focus ministerial time on a small number of priorities**
- **Scrap targets that no longer reflect the government's priorities.**

Make changes to the spending framework to provide front-line services with more autonomy and to embed prevention and improvements to capital spending

The new government may not wish to spend more, but it can improve outcomes by spending more effectively, through changes to the spending review process, spending management, and how departments spend their allocations.

It is expected that the new government will hold a one-year spending review this year to determine budget allocations for 2025/26, with a multi-year spending review being presented next year, which will cover 2026/27–2028/29. If the government wishes to make improvements to public services, then it should base these spending decisions on clear priorities. The government has already started to lay these out, but greater clarity is needed soon.

Whichever outcomes the government chooses to prioritise, it must address rising acute demand and the poor state of buildings and equipment. To that end, we recommend embedding prevention and improvements in capital spending into these spending review processes.[*] For the former, and as set out in previous Institute work, this should involve agreeing a definition of preventative spending, ring-fencing this, publishing a cross-government prevention strategy and funding thorough evaluations of preventative spending as part of the government's first multi-year spending review.[7]

For capital spending, the multi-year spending review should provide five years of spending settlements at least. The Treasury should also establish more, large capital spending programmes – for example, to build hospitals and prisons – setting even longer term base levels of investment for these. The government should also aim to make the spending mix more capital-intensive over time.[8]

Better spending management can also improve how money is spent. For example, previous Institute work on capital spending[9] has recommended amending the *Managing Public Money* guidance to provide a stronger incentives to maintain existing assets, giving major capital programmes a separate line in spending documents to provide greater clarity and certainty about these budgets, and rebalancing accounting officer responsibilities so that they are also scrutinised for underspends, not just overspends.

Finally, there is much that the government could do to improve how departments allocate spending to their ALBs and delivery bodies. The objective should be to provide front-line public service providers with greater certainty and flexibility so that they can make more strategic investments to deliver the government's top priorities, as well as local ones, based on their understanding of needs in their area. There are already good examples of front-line services delivering performance improvements at little or no cost – see the Institute for Government and the Productivity Institute's Productivity Pitches event series[10,11] – but many more would be able to do so with greater freedom to innovate (as well as support to increase front-line management capacity, which is discussed below).

* It will not be possible to fully do this in a one-year spending round taking place this year, but the government should try to make as much progress as possible in the short time available.

The best way of empowering the front line would be to provide longer term funding settlements, particularly for capital, and reducing the huge number of ring-fences around small pots of money, but putting a single broad ring-fence around areas of spending that local areas can use for preventative services. The government should also redesign financial incentives in public services so they align with its priorities. For example, it will be hard to shift NHS funding towards prevention while such a high proportion of it is allocated on a 'payment by results' formula that encourages more acute activity in hospitals.

Some of these changes will take a year or more to fully implement, but work on all of them should begin in the next six months to deliver improvement by the end of this parliament.

- **Agree a definition of preventative spending, ring-fence this, publish a cross-government prevention strategy and fund thorough evaluations of preventative spending**

- **Provide five-year capital budgets and make the spending mix more capital-intensive over time**

- **Provide front-line services with longer term funding settlements and reduce the number of ring-fences around small funding pots.**

Make changes to regulations, tax or other policies to reduce demand as part of a prevention strategy

High levels of demand for acute services place a major strain on public finances, which could be reduced by preventing acute problems materialising in the first place. Debate on prevention often focuses on specific government programmes – such as Sure Start – and the up-front costs of setting up and running these. These types of preventative programmes have a critical role to play and, as discussed below, there is a good case for providing them with additional funding. But these are not the only policies that affect acute demand for services. The new government should consider the tax, regulatory and other changes that it can make.

For example, research suggests that smokers need social care earlier and are more likely to be admitted to hospital.[12] As a result, it has been estimated that smoking has a net cost to the UK's public finances of £13.5bn a year, including more than £3.5bn in costs for the NHS and local authorities.[13] The Khan Review[14] made a number of recommendations to reduce smoking that would cost little or even raise money. These included raising the minimum age for purchasing tobacco, promoting vaping, introducing a tobacco licence for retailers, increasing taxation on tobacco, and ensuring health care professionals talk to people about smoking cessation every time they come into contact with health services.

Likewise, the UK has the third highest level of obesity in Europe, with rapid increases in recent years. It is estimated that the NHS spends around £6.5bn a year on obesity-related care, with the total annual cost of obesity to society thought to be 1–2% of

GDP.[15] The 'sugar tax' was introduced in 2016 and has been effective in reducing the volume of sugar sold[16] but government proposals to implement regulations restricting advertising and promotion of food that is high in fat, salt and sugar have been delayed or dropped.[17] Implementing some of these measures, alongside other activities like education and awareness raising, would likely reduce future obesity-related demand for public services.

Chris Whitty, the chief medical officer for England, has also used his annual reports to address the impact of alcohol[18] and pollution[19] on public service demand and the regulatory, tax and other policy changes that could be used to reduce these.

In some cases, there is an even more direct link between policy and demand for acute services. Perhaps most notably, the record size of the prison population is in large part driven by reforms to lengthen sentences and increase the proportion of sentences spent in custody. While longer sentences provide greater punishment, there is little evidence that they reduce crime.[20] Whatever the politics involved, reversing some of these changes would certainly be much cheaper than building, maintaining and staffing the many thousands of new prison places needed to meet demand. And in any case, in the short term, the new government has little choice but to reduce the prison population – by, for instance, lowering the automatic release point for most offenders, introducing a 'queuing system' for immediate custodial sentences, or allowing sentences of up to three years to be suspended.[21]

Not all of the examples provided in this section will be in line with the political positioning of the government. But whatever the political views of ministers, there will be some options that are aligned with the wider priorities of the government.

While these tax, regulatory and policy changes are cheap, they may not be politically cost-free. Past efforts have been stymied by fears of being seen as 'nanny statist' or 'soft on crime'. Those fears are not unfounded, but are often overstated. And while political capital is always in short supply, immediately following the election it is more abundant than money. We therefore recommend that the new government incorporates regulatory, tax and other policy changes into a wider prevention strategy, developed as part of its first spending review.

- **Publish a prevention strategy that includes regulatory, tax and other policy changes to reduce acute demand.**

Improve the relationship with public sector staff

Workforce problems have been a major contributor to poor public service performance in recent years. It is much harder to deliver high-quality services when staff are unhappy or inexperienced, when turnover and vacancies are so high, and when large numbers of people go on strike. Pay is, of course, a big driver of all these issues, but there is also much that could be done to address them at little or no cost.

First, the new government should seek to improve the relationship between government, unions and staff. Workforce disputes are inevitable, but the Sunak government's combative approach to strikes likely extended their duration. Its refusal to negotiate for months, misrepresentation of the role of pay review bodies, and introduction of the Strikes (Minimum Service Levels) Act all made reaching agreements harder.[22] More broadly, such a confrontational approach can make staff feel less valued and appreciated, with many, particularly in health and care services, finding it galling given the conditions they worked in during the pandemic. Taking a more collaborative approach and making better use of pay review bodies[23] should be a priority for the new government.

Second, the government should take steps to better manage the workloads of public service staff. High workloads are cited by many staff as a reason for leaving their roles. While workloads are primarily driven by the number of staff relative to demand, bureaucratic requirements can also be unnecessarily time-consuming. The government should therefore carefully consider the impact of reporting, training and other requirements on staff capacity. Departments should also provide front-line services with practical resources on how to reduce workloads.[24]

Third, the government should seek to improve the quality of public service leadership and recruitment, another important factor in staff satisfaction and retention. Deeply ingrained cultural problems are hard to address, but the government can remove barriers to effective leadership such as perverse incentives to prioritise personal objectives over organisational performance, short-termism, hierarchical structures and unwillingness to embrace different approaches, viewpoints and backgrounds.[25]

Finally, the government should, where possible, support flexible working initiatives. Flexi-working arrangements are now a key consideration for many staff. While some public service roles, particularly those on the front line, are necessarily less flexible than desk-based jobs, there is often more that can be done. For example, there is evidence that allowing nurses to self-roster reduces turnover.[26]

- **Take a more collaborative approach to industrial disputes and make better use of pay review bodies**

- **Carefully consider the impact of reporting, training and other requirements on staff capacity**

- **Improve the quality of public service leadership and recruitment**

- **Support flexible working initiatives.**

Where should the government prioritise any additional investment?

Spending more on some services or areas will require trade-offs. Government can either spend less on other areas, increase taxes or borrow more. None would be easy and would entail political and other costs, particularly given Labour was vague about its spending plans and ruled out raising some key taxes during the election campaign – a commitment Keir Starmer repeated in his first press conference as prime minister.

This means any additional funding for public services will be hard earned and must be used as effectively as possible. We therefore make recommendations on where extra money is likely to lead to the most meaningful performance improvements.

Focus investment on prevention and capital

The benefits of spending on capital projects and prevention accrue over many years, potentially decades. Similarly, the impact of cuts to these areas is not always felt immediately. As a result, and particularly since 2010, politicians have found it easier to cut and to raid capital and prevention budgets to make more money available for acute day-to-day spending. The new government should resist this temptation, and will likely deliver greater improvements in public service performance over the course of this parliament by spending any additional funding on preventative programmes and capital projects.[27]

On prevention, there is good evidence that spending on a wide range of preventative services and programmes – including benefits, Sure Start centres, public health and youth work – can improve people's outcomes and, in time, reduce acute demand for public services.[28] If the government is going to increase spending on preventative programmes, then it should do so in a balanced portfolio of interventions, setting out as part of the spending review process how these will contribute to meeting the government's priorities.[29] While it is inevitable that some will be less impactful than others, the aggregate impact is more likely to be positive than spending further money on acute interventions. To that end, it is welcome that Wes Streeting, the new health and social care secretary, has committed to increasing the share of NHS funding going to out-of-hospital services such as a primary and community care.[30]

Within capital budgets, spending is currently biased towards politically attractive new projects.[31] But the poor state of the existing public sector estate is a major drag on service productivity and performance. The government should therefore focus any additional capital spending on maintenance.

Spending now on capital and prevention should make services less expensive to deliver in the future than they might otherwise be, either by improving their productivity or reducing acute demand. As such, there is a case for making an up-front investment funded by temporarily raising taxes or borrowing, on the expectation that this will be paid for by lower spending in coming years. 'Double-running'* would allow

* Increasing investment in prevention and capital alongside continued funding for acute services..

for a quicker and more sizeable initial investment, and thus a more rapid improvement in service performance. Though, given the timeframes involved for some capital investments and the realisation of prevention benefits, it may be necessary to do so for most of this parliament.

- **Focus new funding on capital and prevention projects**
- **Focus capital spending on maintenance**
- **Consider 'double-running' – increasing funding for prevention and capital, while maintaining spending on acute services – to kick-start the recovery across public services.**

Resolve pay disputes and prioritise spending on back-office staff

Workforce problems are an important driver of poor public service performance, and pay is the single biggest factor contributing to these. The fall in the value of public sector pay since 2010 – both relative to the price level and relative to pay in the private sector – exacerbated by high levels of inflation in recent years, led to the most widespread public sector strikes in more than a quarter of a century.[32] Poor pay makes it harder to recruit new staff and retain existing ones, with staff across public services reporting low and falling levels of satisfaction with their pay. If the government wishes to improve public service performance, it will have little choice but to spend more on pay to address these issues.

The most high-profile ongoing industrial dispute is by junior doctors, who undertook their latest strike in the week before the election. However, while other staffing groups such as teachers, nurses and consultant doctors accepted improved government pay offers over the past year, dissatisfaction with pay remains. For example, teachers backed further strike action in an indicative ballot conducted by the NEU earlier this year.[33] New recommendations by pay review bodies, which are due to be published shortly, and the government's response to these, could well be the trigger for further waves of industrial action. A change of tone will help to resolve disputes, but will likely need to be backed up with money very quickly.

For other staff groups, the main risk is not that they join the picket line, but that they walk away from the profession altogether. To ensure that the services covered in this report work well, the government should prioritise additional spending on improved pay for GPs, social workers and criminal barristers. In all three cases, poor pay makes it very difficult to retain experienced staff and to recruit new staff from the UK, with staffing gaps often then increasing demand in other, more acute and expensive parts of the system. Shortfalls in general practice and adult social care have been papered over in recent years by recruiting large numbers of people from other countries, but given global competition for these staff and the politics of immigration, there is no guarantee that this approach will continue to be viable. Either way, the new government should ensure that its immigration policies and public service staffing policies are consistent with one another.

In some cases, the priority for additional spending should be lower profile staffing groups that are nonetheless critical to public service productivity. Management and support staff enable those on the front line to do their jobs well, but are often treated as an unnecessary overhead and a waste of limited funds. Indeed, in the election campaign the Conservatives pledged to cut 5,500 NHS managers to fund spending elsewhere in the NHS.[34] But all the evidence suggests that the NHS is under-managed, and the shortage of managers is a key reason why the substantial increase in hospital doctors and nurses has not led to a commensurate increase in hospital activity.[35] Boosting management and analytical capacity in hospital trusts and ICBs (rather than in DHSC or NHS England) would be far more impactful and cheaper than further increasing the number of doctors and nurses.

The government bemoans poor management in local authorities while ignoring the fact that cuts to grant funding mean that local authorities are forced to cut back on staff such as accountants and analysts who would improve the effectiveness of spending. It is a similar story in the police, where the focus in recent years on increasing the number of officers, while maintaining tight budgets, has created perverse incentives for forces to cut the number of PCSOs and staff, filling their roles with more expensive officers.[36] It would be more cost effective to allow the number of officers to fall slightly and to recruit more staff and PCSOs instead.

- **Back up a less combative approach to industrial relations with pay awards, working with pay review bodies and unions to reach settlements that will retain and recruit staff**

- **Prioritise additional spending on improved pay for GPs, social workers and criminal barristers**

- **Don't just focus on the front line: managers and analysts will help make spending more effective, particularly in the NHS and local authorities.**

Methodology

General

Public services spending, including estimates of the total spend on public services

To estimate the real cost of public spending, we deflate government spending figures using the GDP deflators published by the Office for Budget Responsibility (OBR) in the *Economic and Fiscal Outlook* from March 2024.[1] 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 the entire report to 2024/25 prices. There are some instances throughout where we put spending into prices from a year other than 2024/25. Where this is the case, we explain our reasoning below.

In cases where we calculate real-terms changes in figures that relate to individuals – for example, wages or the adult social care means test – we use the consumer price index (CPI) rather than the GDP deflator. The CPI that we use also comes from the OBR's *Economic and Fiscal Outlook* from March 2024.

Change in demand for public services (used most prominently in Figure 6.3)

General practice

To project likely growth in demand for general practice, we use analysis from The Health Foundation. Its main published analysis for ongoing health demand, published in May 2024, includes an estimate for how much demand for general practice will increase due to increasing size and morbidity of the population.[2]

To ensure comparability with the demand projections shown for other services (for which we do not include service-specific cost pressures or possible productivity gains), we only factor in increases in demand, rather than additional assumptions around changes to pay, productivity or to the health care model.

Hospitals

To project likely growth in demand in hospitals, we again draw on analysis from The Health Foundation. Its analysis provides an estimate of the rate of growth in activity, adjusted for morbidity, needed to meet growing demand for acute care, while maintaining its scope and quality. We assume that demand for acute and specialist trusts (our focus in this chapter) changes in the same way as The Health Foundation's projection of demand for acute care.

To ensure comparability with the demand projections we show for other services – where we do not include service-specific cost pressures or possible productivity gains – we only factor in increases in demand. This means that we use their "minimal change" scenario[3] which assumes that activity in hospitals will grow more quickly than demographic and morbidity pressures, reflecting the trend between 2010/11 and 2018/19.

The Health Foundation kindly provided us with a breakdown of its model to allow us to derive an overall estimate of acute care, based on a weighted average of elective, emergency, A&E and outpatient activities.

Adult social care

For adult social care, we take the projected increase in demand from The Health Foundation's REAL Centre, published in October 2021. This model incorporates several factors, including increases in pay and projected changes in productivity. We take only the increase in demand projected in the model, as the outlook for pay has changed since it was published.

Children's social care

To estimate demand for this service, we split it into two component parts, weighted by the amount that local authorities spent on those services in 2022/23. The two halves of that spending are on "looked after children" and "other" spending, which includes "safeguarding children and young people's services", "family support services" and "other" spending.

We assume that demand for looked after children will increase in line with the number of section 47 referrals that local authorities receive. We project this by calculating the average annual growth rate of section 47 referrals between 2015/16 and 2022/23. We start in 2015/16 because there has been a significant and sustained increase in the rate of section 47 referrals since that year that would not be captured by starting earlier.

We assume that demand for other parts of children's social care spending increases in line with assessments under section 17 of the Children Act 1989. Similarly, we use the period of 2015/16 to 2022/23 as the years to calculate the average annual growth rate.

Table 8.1 **Projected growth rates for children's social care**

Spending category	Gross spending 2022/23 (£bn)	Growth rate assumption	Projected growth 2022/23 to 2028/29
Looked after children	£7.0bn	Increases in line with the growth rate of section 47 referrals between 2015/16 and 2022/23	25.8%
Other – safeguarding children and young people's services, family support services and 'other'	£5.0bn	Increases in line with the growth rate of section 17 assessments between 2015/16 and 2022/23	12.5%

We then create a demand index starting in 2022/23, weighting the two parts of the index by spending on those areas in 2022/23. We increase the index by the average annual increase of section 47 referrals and section 17 assessments every year until 2028/29.

Neighbourhood services

We assume that demand for neighbourhood services increases in line with population growth in England.

Schools

To project how much schools would have to spend to meet increased demand, we separate primary and secondary schools because:

- on average, the government spends slightly more on each secondary school pupil than on each primary school pupil
- the DfE projects that the number of primary school pupils will fall over the period 2019/20–2024/25 while the number of secondary school pupils will increase.

As 2020/21 was an unusual year, we base our projections on spending in 2019/20 (see Table 8.2). We multiply the 2019/20 level of spending per pupil in primary and secondary schools by expected growth in pupil numbers between 2019/20 and 2028/29 and add together the implied figures for spending on primary and secondary schools. We assume that the costs of the inputs used in providing school services rise in line with economy-wide inflation.

Table 8.2 **Projected growth rates for schools**

Service category	Gross spending in 2019/20 (£bn)	Growth rate assumption	Projected growth 2022/23 to 2028/29
Primary schools	£19.8bn	The number of pupils grows in line with DfE projections for the number of primary school children	-10.5%
Secondary schools	£18.5bn	The number of pupils grows in line with DfE projections for the number of secondary school children	-1.5%

Police

To project police demand, we divide demand on the police into the following categories:

- reactive demand, subdivided into: reactive crime demand and reactive non-crime demand
- protective demand, such as intelligence-gathering and safeguarding
- internal demand, including HR, training and professional standards.

We then calculate likely trends in each of these separately to project overall demand.

We calculate the proportion of current demand made up by each of category based on the number of FTE officers, staff and police community support officers (PCSOs) within each function, drawn from Home Office police workforce data. We weight the number of FTE roles according to the mean salary of these groups, to account for police officers being more expensive on average than staff or PCSOs. Mean salary data comes from the Annual Survey of Hours and Earnings, Table 13.7, for officers and PCSOs, and the *Police Staff Council Earnings Survey 2023* for police staff.

Some functions within reactive demand deal exclusively with crime (e.g. investigations) but it is not possible to separate local policing and dealing with the public into crime and non-crime. We assume that reactive demand is two-thirds due to crime and one third due to non-crime, based on existing estimates of police demand and the greater time involved in responding to crime than non-crime incidents. Other estimates of police demand suggest all non-crime demand, including protective and internal demand, accounts for 21– 35% of demand.[4,5]

Reactive demand (crime and non-crime)	Protective demand	Internal demand
• Local policing (including neighbourhood and response) • Dealing with the public • Criminal justice arrangements (such as custody, court preparation etc.) • Roads • Operational support (e.g. firearms units, dog support) • Investigations • Investigative support (e.g. forensics) • National policing (e.g. counter-terrorism	• Intelligence • Public protection (e.g. protecting vulnerable people, managing serious repeat offenders via multi-agency public protection arrangements (MAPPA)	• Support functions, including training, HR processes, professional standards
75% of total demand (crime 50%, non-crime 25%)	12% of total demand	13% of total demand

Internal demand we assume will remain flat, based on maintaining the current workforce. Non-crime reactive demand and protective demand we project will grow in line with the population in England and Wales. We model reactive crime demand based on the trend in police recorded crime since 2018/19, adjusted for the growing complexity of the crime mix and investigations. We do this by generating a 'complexity score' for each offence group, based on the median length of time between an offence being reported and an outcome recorded for that offence type, relative to that for all offences. We based these complexity scores on data across 2022 and 2023.

We then multiplied the number of offences for each offence group each year by the relevant complexity score to calculate the complexity-adjusted trend in police recorded crime. Finally, we applied a 0.5% annual increase in reactive crime demand to account for the increasing volume of digital evidence.[6] This is likely to be an underestimate of the impact of increasing complexity and growing volumes of evidence, given the large increase in recent years in the time it takes for the police to record an outcome once an offence has been reported. However, it is not possible to determine how much of this is due to increasing complexity as opposed to reduced police productivity.

Demand type	Proportion of total demand	Method of projecting change	Projected growth 2022/23 to 2028/29
Reactive crime demand	50%	Trend in complexity-adjusted crime from 2018/19 to 2028/29, plus 0.5% yearly increase for growing digital evidence	37.9%
Reactive non-crime demand	25%	In line with population for England and Wales	5.6%
Protective demand	12%	In line with population for England and Wales	5.6%
Internal demand	13%	In line with workforce growth	0%
Total demand	**100%**	**-**	**21%**

Criminal courts

We project demand for the crown and magistrates' courts separately.

For the crown court, we calculate demand as the number of cases received each year, weighted by the average hearing time for cases completed in each year. We do this separately for cases that are 'for trial' and other cases (such as appeals and sentencing). We assume that: (i) longer hearing times are a result of cases being more complex, rather than inefficient use of hearing time; and (ii) the average hearing time for cases received would have been the same as the average hearing time of the ones disposed of, within case type (cases for trial and others), in the year in question.

For magistrates' courts, where the data we have is less detailed, we measure demand simply as the number of cases received each year.

We weight magistrates' and crown court demand to come to an overall measure of court demand. We do this using two components. First, we use the number of sitting days in the crown court and magistrates' courts in 2018. Second, we use the average costs per sitting day in the crown court and magistrates' courts, which the National Audit Office reported in 2016, as these are the latest available figures. This implies that 61% of court demand comes from the crown court and around 39% comes from the magistrates' courts. We then project demand forward separately for the crown and magistrates' courts.

The main driver of our projection of court demand is the increase in police officers; the government met its commitment to increase officer numbers by 20,000 on top of 2018/19 figures by April 2023. We assume that an increase in the number of officers means the police can charge more cases, because as it stands the number of charges is only a small fraction of total crimes reported. The number of charges per police officer has fallen steadily for several years.

We assume that once officers are embedded the number of charges per officer will return to and stay at 2019/20 levels. However, we assume that there is a lag of three years between recruitment and a return to 2019/20 levels of charges, as this is the time it has taken between the start of the uplift programme and an increase in that indicator. We therefore project that charges per officer will return to 2019/20 levels in 2026/27, increasing uniformly between 2022/23 and 2026/27.

In the magistrates' courts, we assume that the least serious 'summary' cases are unaffected by the number of police officer charges as some of these are brought by non-police organisations and they are simple, routine offences. With all other cases, in both the crown and magistrates' courts, increases occur in line with the lag described above.

Prisons

To project demand for prisons, we use the Ministry of Justice's (MoJ) central estimate for prisoner numbers over the five years from 2023 to 2028, which was published in November 2023.

This projection incorporates the recruitment of the additional 20,000 police officers and the estimated impact of other policies, including new offences and changes in agreed sentencing, such as the Police, Crime, Sentencing and Courts Act and the Release of Prisoners Order 2020. It does not account for emergency early release measures or changes to the point of automatic release being considered to ease the emergency capacity crisis. These measures reflect insufficient supply rather than lower demand.

1. The NHS

Hospital productivity (Figure 1.1)

Hospital doctors includes all NHS Hospitals and Community Health Service (HCHS) doctors from the NHS England 'organisation' dataset. Hospital nurses includes adults and children's nurses.

Elective activity is a combination of admitted and non-admitted completed pathways from the 'referral to treatment' dataset. Outpatient appointments are total appointments from the 'hospital episodes statistics' dataset. Diagnostic tests come from the activity table in the 'DM01' dataset. Cancer appointments are urgent suspected cancer referrals seen at a first outpatient attendance from 'cancer waiting times' datasets.

The time series for both staffing and activity levels start in January 2010. The time series for activity levels (elective activity, outpatient appointments, cancer appointments and diagnostic tests) end in April 2024. The time series for staff ends in March 2024. Both of these are the most recent months for which there is data.

For staff, the annualised growth rate is taken by calculating a compounded monthly growth rate between January 2010 and December 2019 and January 2020 and March 2024, then converting those numbers into compounded annual growth rates.

For activity levels, we first create a time series of the average level of activity in the previous 12 months. We do this to avoid variation that comes from using any individual month, where activity may be temporarily lower or higher than is typical for unobservable reasons. Thus the first data point in this time series is the average activity in the previous 12 months in December 2010. We then calculate a compounded monthly growth rate between that point and December 2019 and between January 2020 and April 2024. We then convert those into a compounded annual growth rate.

Gross capital formation in health care as a percentage of GDP, by OECD country (Figure 1.3)

The weighted OECD average is calculated by first calculating the total spent on gross capital formation in every year by multiplying the percentage given in the dataset by the GDP number for the relevant year. This is then summed and divided by the sum of GDP for every country that has a data point in that year. Any country that does not have a data point in a given year is excluded from the analysis for that year.

Change in the number of managers per FTE NHS staff member (Figure 1.5)

We calculated the number of senior managers and managers per NHS staff on an FTE basis for every month of this time series. We then calculated how this changed over the course of the time series.

Patient to GP ratio by decile of deprivation (Figure 1.10)

For this we use a snapshot of the number of patients and the number of fully qualified, permanent GPs in March 2016 and March 2024, to account for any seasonality in either number. To find how many GPs and patients there are in each decile of deprivation, we use the practice postcode to place a practice into a Lower layer Super Output Area (LSOA). We then use the English indices of multiple deprivation at a LSOA level to assign a decile of deprivation to each practice. From there it is possible to sum both the patients and the number of fully qualified permanent GPs and then divide the former by the latter to come to a patient–GP ratio for each decile of deprivation.

Proportion of GP trainees entering the fully qualified workforce (Figure 1.12)

To calculate the annual proportions, we sum the number of trainees that entered the workforce in each of the preceding four quarters. We then sum the total number of trainees that finished training in those four quarters and use that as the denominator in the calculation. For example, for the June 2022 cohort, we include those who finished training in September 2021, December 2021, March 2022 and June 2022. This removes any seasonal variation there might be in the rate at which trainees join the workforce.

Staff working in primary care, by staff group (Figure 1.14)

All staff are shown in terms of FTEs.

Data for the full-qualified GPs, nurses, and GP trainees comes directly from the NHS Digital GP workforce bulletin tables. This therefore only captures those GPs that work in general practice rather than the wider primary care workforce. We discussed this approach with experts on primary care data and they agreed that given how few additional GPs worked outside general practice, this was an acceptable approach.

For the direct patient care (DPC) staff, three approaches were used for different time periods:

- Between September 2015 and December 2018, the DPC staff shown on the chart are taken directly from the GP workforce bulletin tables. Given that primary care networks did not exist at this time, this measure should capture all the DPC staff working in primary care.
- Between March 2019 and June 2021, the DPC staff are a combination of the GP workforce bulletin tables DPC staff and those from the primary care network workforce bulletin tables.
- From September 2021 onwards, the DPC staff comes from the primary care workforce – nurses, DPC and admin/non-clinical staff dataset.

2. Local government

Local authority core spending power, actual and forecast, by fiscal event (Figure 2.2)

For the years 2015/16 onwards, this chart shows local authorities' core spending power (CSP). This measure did not exist before 2015/16, when the government instead measured local authorities revenue spending power (RSP). To create a comparable CSP for the years before 2015/16, we apply the annual percentage growth in RSP to the first year of the CSP metric until we have an artificial CSP total for 2010/11.

For the outturn line between the years 2015/16 and 2024/25, the totals come from the final local government finance settlement 2024/25, put into 2021/22 prices using the spring budget 2024 deflator.

The "Spending review 2021" and "Autumn statement 2022" lines take the CSP settlements outlined in those fiscal events and put them in 2021/22 prices using the GDP deflators that were used in each respective fiscal event.

We keep this chart in 2021/22 prices so that the anticipated path of CSP growth for the spending review period can be compared to the actual growth of CSP in that time.

Annual real terms change in local authority spending power, by deprivation and time period (Figure 2.3)

The earliest time period (2010/11–2014/15) shows the change in RSP ordered by deprivation.

The later two time periods (2015/16–2019/20 and 2020/21–2024/25) show the change in CSP, ordered by level of deprivation.

Change in local authority spending power, by decile of deprivation (Figure 2.4)

As with the CSP timeline in Figure 2.2, we constructed a consistent CSP time series for each upper- and single-tier local authority between 2010/11 and 2024/25. We then used the 2019 English index of multiple deprivation (IMD) to assign a deprivation score to each local authority.

We excluded those local authorities that were either abolished or created during this period and then grouped local authorities into deciles of deprivation, summed their CSP in 2010/11 and 2024/25 and then calculated the percentage change.

Spending by local authorities in England, by type (Figure 2.6)

We take total expenditure from the revenue summary for each type of local authority (shire districts, shire counties, unitary authorities, metropolitan districts, London boroughs, and others). We then deduct spending on schools, public health (because local authorities only had responsibility for this from 2013/14 onwards), fire and rescue services, and police services.

We then split out adult and children's social care and add in local authorities' spending for the better care fund to create a total amount that local authorities spend on social care.

For the years in which there was Covid spending (2020/21 and 2021/22), we calculate the total spent on social care and neighbourhood services from the Covid-19 financial impact monitoring returns and subtract that from the spending for each category in the revenue outturns to avoid double counting spending.

3. Schools

Attainment at the end of primary and secondary school, 2010–23 (Figure 3.1)

All figures include pupils not in mainstream education.

Primary (KS2) assessments were reformed between 2015 and 2016 and did not take place in 2020 and 2021.

Between 2013 and 2014 a number of changes occurred to secondary qualifications. In 2017 reformed English and maths GCSEs were awarded for the first time. In 2020 and 2021 GCSE results were awarded by centre- or teacher-based assessments rather than external exams. In 2022 GCSE results were set between pre-pandemic (2019) levels and 2021 levels. In 2023 results were allowed to return to pre-pandemic levels with some grade protections in place.

SEND top-up funding provided to schools by local authorities, by provision type, 2015/16–2022/23 (Figure 3.5)

Figures have been deflated using the smoothed deflator described at the start of the Methodology.

Median teacher pay by role, 2010–23 (Figure 3.7)

We take teacher pay from estimates of median full-time equivalent pay using teacher pension scheme data, which retroactively includes backdated pay awards.

Figures have been deflated using CPI figures from the spring budget, as described at the start of the Methodology.

4. The criminal justice system

On 26 June 2024, the Ministry of Justice announced a potential data quality issue affecting criminal court statistics.[7] The scale of this issue is currently unknown. Findings drawing on criminal court statistics should therefore be interpreted with caution and numbers may be subject to change.

Charges/summonses recorded by police forces (Figure 4.1)

All figures in this chart are for a 12-month period. Values for 2009/10–2022/23 are for 12 months ending in March and the value for 2023 is 12 months ending December. This means there is a three-month (one quarter) overlap between the 2022/23 figure and the 2023 figure. Greater Manchester only supplied data for Q1 2019/20 and Devon and Cornwall Police only supplied data for Q1 and Q2 2022/23 and not at all in 2023. To represent the national trend as accurately as possible, we have imputed missing figures for these quarters based on their average share of national charges in other years. For Devon and Cornwall, the average share was calculated based on data from 2014/15 to 2021/22, as values were similar throughout the period. For Greater Manchester, the average share was calculated based on figures from 2016/17 to 2020/21, excluding 2019/20 when data is missing. This is because of changing trends in the proportion of charges GM is responsible for, driven partly by an increased emphasis on charging over other outcomes in recent years.

Data for this chart is drawn from two different sources. Values for 2003/04 to 2013/14 are headline national figures from Home Office, 'Crime outcomes in England and Wales' (Table B2), 2022/23. Values from 2014/15 to 2022/23 and for calendar year 2023 are from Home Office, 'Police recorded crime and outcomes open data tables', 2018/19–2022/23. Totals may vary slightly across different data sources.

Outstanding cases in the crown court (Figure 4.4)

The latest official statistics for the backlog in the criminal courts are taken from the Criminal Court Statistics Quarterly up to December 2023. Jury trials were disproportionately likely to be delayed during the pandemic, so outstanding cases (cases in the 'backlog') are more likely to require jury trials than the average case. Jury trials are more complex and require much more hearing time in courts, so adjusting for this allows us to better compare the current backlog with pre-pandemic levels.

The number of outstanding cases (the 'backlog') is the cumulative difference between cases entering the court system (receipts) and cases completed ('disposed') each quarter. We adjust for the greater complexity of the backlog in several stages:

- We calculate a pre-pandemic baseline for the proportion of case receipts that result in a jury trial by dividing the number of trials by the total number of disposals. This is based on data from Q2 2019 to Q4 2019 and we include both effective trials (those that go ahead as planned and result in a verdict) and cracked trials (those that are cancelled on the day of the listing and not rescheduled; for example, because of a late guilty plea or discontinued prosecution).

- We assume that the proportion of cases coming into the crown court that end up as jury trials is the same as before the pandemic and use this to estimate the number of jury trial receipts. We then subtract the number of jury trial disposals to estimate the number of outstanding jury trials. We use the same process to calculate outstanding non-jury trial cases, by subtracting other disposals from estimated non-jury trial receipts.

- We calculate a complexity value for jury trial cases by dividing [trial cases share of total hearing time] by [trial cases share of total cases]. We multiply the number of outstanding cases by this complexity value. We repeat this process for non-jury trial cases, calculating a separate complexity value by dividing [non-jury trial cases share of total hearing time] by [non-jury trial cases share of total cases] and multiplying it by the number of outstanding non-jury trial cases. We then add them together for a total complexity-adjusted increase in the backlog.

- Even before the pandemic, outstanding cases were more complex than the average of all cases processed. We adjust for this to make our backlog consistent with the pre-Covid backlog. We calculate a complexity value for pre-pandemic backlog cases by dividing [average hearing time of pre-pandemic backlog case mix] by [average hearing time of all pre-pandemic cases]. We multiply this by the complexity-adjusted increase in the backlog for a comparable complexity-adjusted backlog figure.

Crown court hearing hours per sitting day (Figure 4.6)

We calculated total annual hearing hours by multiplying [average hearing time in hours per case] by [total number of cases disposed]. We then divided this by the total number of sitting days to calculate hearing hours per sitting day.

Prison population and useable operational capacity, actual and projected (Figure 4.7)

We use month-end figures for both actual and projected population and actual useable operational capacity. Operational capacity is the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime. Useable operational capacity is the operational capacity minus an 'operating margin' that reflects the constraints imposed by the need to appropriately accommodate different classes of prisoner (for example, by sex, age, conviction status, single cell risk assessment, geographic distribution and security category). In any given monthly data release, either the total operational capacity or useable capacity is given, along with the operating margin in the notes. In cases where the total operational capacity is published, the useable figure is calculated by subtracting the operating margin from the total.

The population projection is the Ministry of Justice's (MoJ) central estimate for prisoner numbers over the five years from 2022 to 2027, which was published in February 2023. This projection incorporates the recruitment of the additional 20,000 police officers and the estimated impact of other policies, including new offences and changes in agreed sentencing, such as the Police, Crime, Sentencing and Courts Act and the Release of Prisoners Order 2020. It does not account for emergency early release measures or changes to the point of automatic release being considered to ease the emergency capacity crisis. These measures reflect insufficient supply rather than lower demand.

We divide the capacity projection into two phases, first from June 2024 to December 2025 and second from January 2026 to December 2030. The Labour Party confirmed its commitment to delivering the planned 20,000 new prison spaces during the 2024 election,[8] so we assume these will be delivered on the same schedule planned by the Sunak government. The Sunak government stated it had delivered 5,600 new spaces of the planned 20,000 by October 2023, and would have delivered 10,000 (that is, 4,400 further spaces) by the end of 2025.[9]

Useable operational capacity has remained flat from October 2023 to May 2024, so we assume the remaining 4,400 spaces will be delivered between June 2024 and December 2025. Without more specific information on when additional spaces will become operational, we assume that they will be delivered at a consistent rate from June 2024 until December 2025. We recognise that this is unlikely to reflect actual delivery patterns, but it provides a rough indication of how capacity is likely to grow. The date at which the remaining 10,000 places will become operational is unknown, but is likely to take at least until December 2030, so again we assume they will be delivered at a consistent rate from January 2026 to December 2030. We do not have data on the number or rate of cells becoming unusable, so have assumed that all cells currently in use remain in use throughout the forecast period. As such, this should be viewed as a maximum capacity projection rather than a central scenario.

5. Cross-cutting problems

Change in median gross earnings of selected public sector professionals since 2009/10 (Figure 5.2)

The ONS has changed how it classified professions twice since 2009/10. To ensure consistency we cross-referenced codes against volumes of employees to check similar numbers of staff were being assessed. The most affected data series was nursing professionals, for which we used data for health associate professionals for 2009/10, nursing and midwifery professionals for 2010/11–2019/20 and nursing professionals for 2020/21–2021/22. Additionally, figures for primary education teaching professionals include nursery staff up to 2020/21.

Figures were deflated using the consumer price index as published by the OBR.

Capital spending index, public service departments (Figure 5.3)

The primary problem in the creation of this chart is change in departmental structures and responsibilities. To circumvent this issue, we create a retrospective time series, using the most recent outturn as the baseline for the years 2018/19 to 2024/25 (the years for which there is data in the PESA tables). We then input the PESA results for previous years. We transform the last outturn year (2018/19) by the change in spending for the previous PESA outturn. We then replicate this method for all departments and for all years going back to 2004/05.

For 2023/24 and 2024/25 numbers, we use the forecast from the March 2024 spring budget. We call the 2023/24 numbers outturn rather than forecast because the budget was close enough to the end of the financial year that we believe that there will be very little change between that number and the outturn.

CDEL to RDEL transfers, % of department CDEL (Figure 5.4)

We find both the CDEL to RDEL and the RDEL to CDEL transfers in either HMT PESA tables, or in House of Commons Library revised government spending plans.[10] From there, we create a percentage by dividing that number by the total CDEL budget in a given year.

6. Implications of sticking with the status quo

Government capital spending, outturn and forecast (Figure 6.1)

The outturn and forecast lines for this chart show numbers that come from the Office for Budget Responsibility's March 2024 Economic and Fiscal outlook. It shows total government CDEL to 2028/29.

The dot "Including Labour's spending plans" shows the total after accounting for the increase that comes from the Green prosperity plan in their manifesto.[11]

Average annual real-terms change in spending planned at successive multi-year fiscal events (Figure 6.2)

We first increased total RDEL across government by 1% in real terms for each year between 2024/25 and 2028/29, as laid out in the March 2024 spring budget. From that we subtracted protected spending.

For this chart, protected spending is spending on health, defence, education and foreign aid. To calculate health spending, we increased spending for the NHS (in this case, general practice and hospitals) by 3.6% in real terms for each year of this future spending review as this is the amount that the Institute for Fiscal Studies (IFS) estimates that it would require to meet the commitments laid out in the NHS Long Term Workforce Plan.[12] For foreign aid, we increased the budgets of the Foreign, Commonwealth and Development Office (FCDO) by the real-terms GDP forecast from annex A of the OBR's March 2024 *Economic and Fiscal Outlook*. For defence, we assume that the Labour government will remain committed to the previous government's ambition to increase defence spending to 2.5% of GDP by 2030.[13] Finally, for education we keep spending flat in real terms per pupil.

Please note, that the definition of unprotected spending in this chart differs from the measure used in the one below, where we also exclude spending on childcare and assume that per-pupil spending on schools is held flat in real terms. We do this to make the unprotected spending in this Figure 5.2 comparable across different spending reviews.

Average annual real-terms change in spending between 2024/25 and 2028/29 under current government plans, relative to demand (Figure 6.3)

As noted, we use a slightly different unprotected spending definition for this chart than for Figure 6.2. We include childcare spending and schools spending (held flat in real terms on a per-pupil basis) in protected spending.

We then include analysis of Labour's commitments in its manifesto.[14] We do not think that all of the spending that it has committed to will be in addition to the baseline RDEL commitments. Table 8.3 gives details of the Labour spending commitments as outlined in its manifesto and whether or not we believe that they are additional to the baseline or included in it.

Table 8.3 **Labour manifesto spending commitments**

Commitment	Cost in 2028/29 (£m)	Additional to baseline?	Service
40,000 more NHS appointments per week	1,010	No	NHS
Double the number of scanners	250	No	NHS
Dentistry package	125	No	NHS
Free breakfast clubs	315	Yes	Schools
Investment in HMRC	855	Yes	Unprotected
6,500 new teachers	450	Yes	Schools
Increased teacher and headteacher training	270	Yes	Schools
Delivering work experience and careers advice	85	Yes	Schools
Early language development	5	Yes	Schools
Ofsted reform	45	Yes	Schools
3,000+ new nurseries	35	Yes	Childcare
Mental health support for schools	175	Yes	Schools
Young future hubs	95	Yes	Unprotected
8,500 new mental health staff	410	No	NHS
Legal aid for victims of disasters	30	Yes	Unprotected
Waive visa costs	10	Yes	Unprotected
Appoint 300 planning officers	20	Yes	Unprotected
Barnett consequentials	650		
Total	**4,835**		

After adding the spending from the Labour manifesto that we assumed was truly additional, we assumed that all unprotected departments would change in line with the change in unprotected RDEL. From there, we offset the spending increases by demand for each service as has already been described at the beginning of this Methodology section.

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