Independent Investigation of the National Health Service in England: Technical Annex

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Notes on international comparisons

Comparator countries

International peers included here are a subset of 38 OECD countries to arrive at a more comparable country set to the UK in terms of size of economy, constitutional and cultural closeness. The categories of countries are the EU15 Western European countries (excluding smaller or city states), Nordics and Anglosphere.

19 peer countries are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, and the United States.

Further sub-groups are defined as follows, with no overlap between groups:

- Other predominantly English-speaking countries: Australia, Canada, Ireland, New Zealand and United States
- Nordics: Denmark, Finland, Iceland, Norway and Sweden
- Other EU15 Western European countries: Austria, Belgium, France, Germany, Greece, Italy, Netherlands, Portugal and Spain

Averages

All averages are simple, unweighted averages unless otherwise specified.

Timeseries generally include all possible data (not just complete timeseries).

Calendar versus financial year

All international data is presented in calendar years, unless otherwise specified.

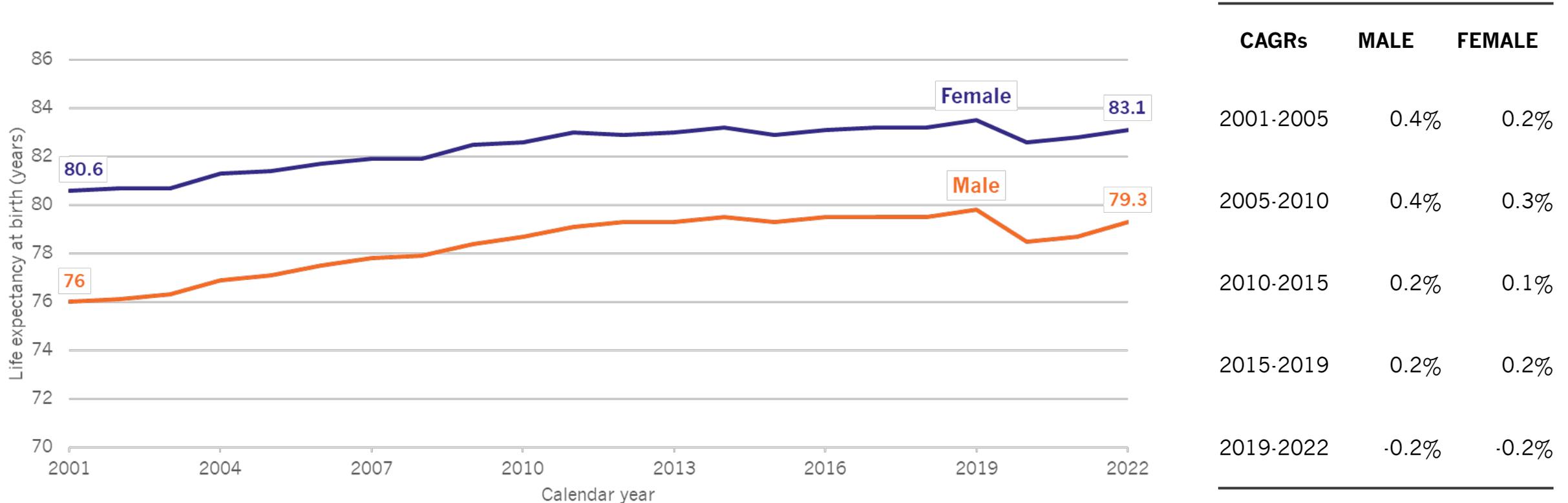This means compound annual growth rates etc are estimated based on calendar, not financial, years.

Missing data

Where data is missing for a country or time period this is specified in the chart notes.

I. The Health of the Nation

1. Life expectancy at birth in England

Figure I.1: Life expectancy at birth in England, 2001 to 2022

CAGRs	MALE	FEMALE
2001-2005	0.4%	0.2%
2005-2010	0.4%	0.3%
2010-2015	0.2%	0.1%
2015-2019	0.2%	0.2%
2019-2022	-0.2%	-0.2%

Source: Office for National Statistics (2024), Single year life tables: England edition 2022. Accessed at: Single year life tables, UK and constituent countries - Office for National Statistics

2. Trends in healthy life expectancy

Figure I.2: Trends in Healthy Life Expectancy at birth in England, between 2001-2003 and 2020-2022
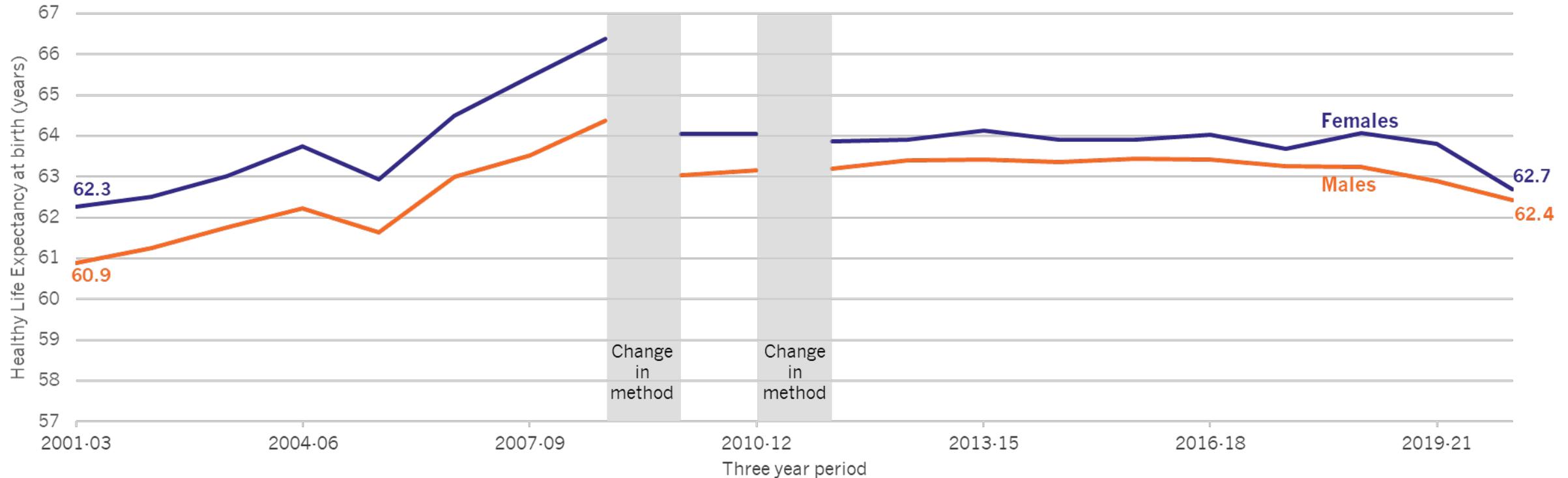

Notes: Due to changes in methodology, data from 2001-03 to 2008-10, 2009-11 to 2010-12, and 2011-13 to 2020-22 are not directly comparable with each other. Healthy life expectancy is an estimate of life spent in good or very good health.

Source: Office for National Statistics (ONS), Health state life expectancies, England: 2009 – 2012 and 2020 – 2022. Available at: Health state life expectancies in England, Northern Ireland and Wales · Office for National Statistics (ons.gov.uk); ONS, Health Expectancies in the United Kingdom: 2000–02 to 2009–11. Available at: Health Expectancies in the United Kingdom, Great Britain, England, Wales, Scotland & Northern Ireland

3. International comparisons of avoidable mortality – preventable causes

Figure I.3: Mortality from preventable causes, 2022 (or nearest year)
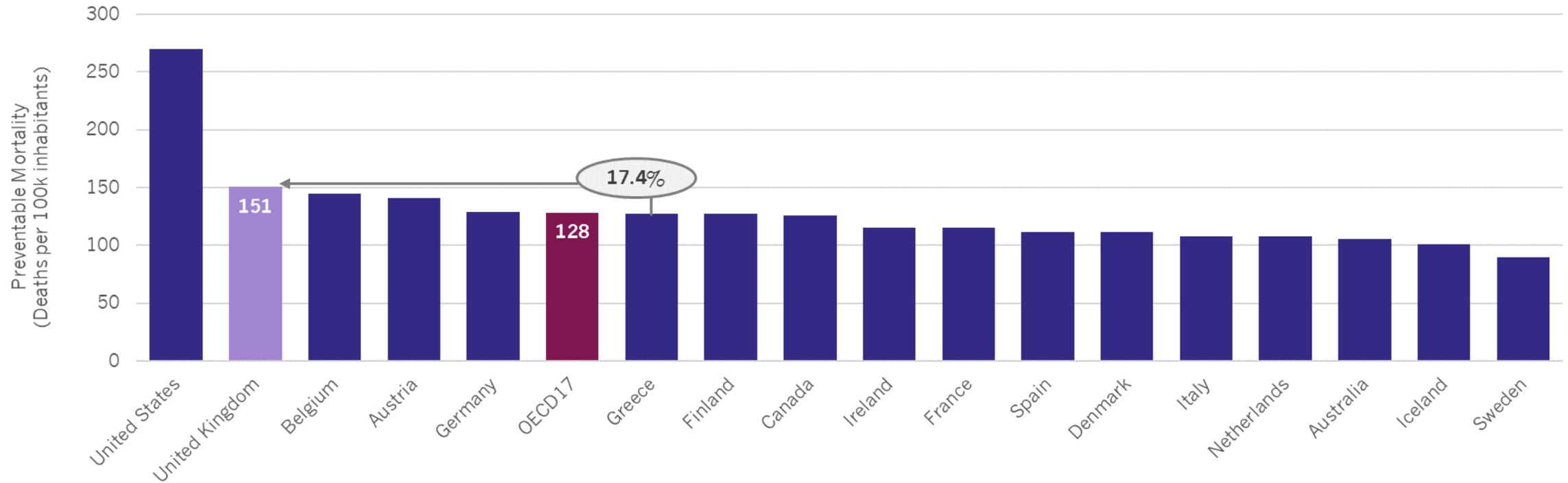
Notes: No data for New Zealand, Norway and Portugal. Data for Austria, Denmark, Finland, Spain and United States from 2021. Data for Belgium, France, Germany, Greece, Ireland, Italy and UK from 2020.

Source: Organisation for Economic Co-operation and Development (OECD) (accessed 14/08/24)

4. International comparisons of avoidable mortality – treatable causes

Figure I.4: Mortality from treatable causes, 2022 (or nearest year)
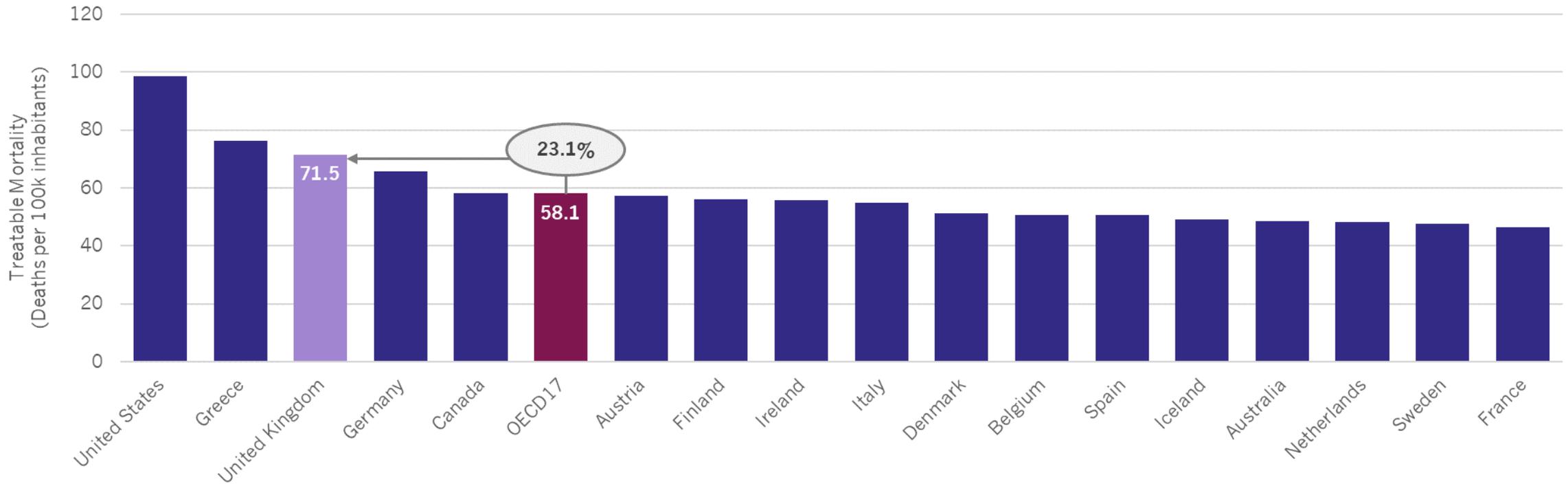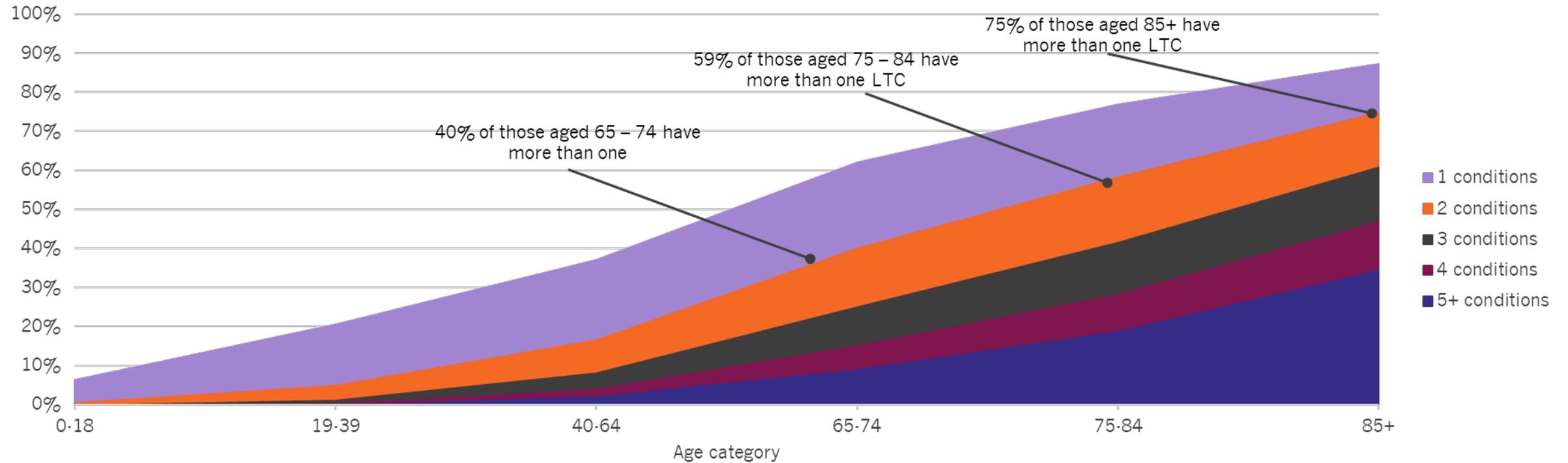

Notes: No data for New Zealand, Norway and Portugal. Data for Austria, Denmark, Finland, Spain and United States from 2021. Data for Belgium, France, Germany, Greece, Ireland, Italy and UK from 2020.

Source: Organisation for Economic Co-operation and Development (OECD) (accessed 14/08/24)
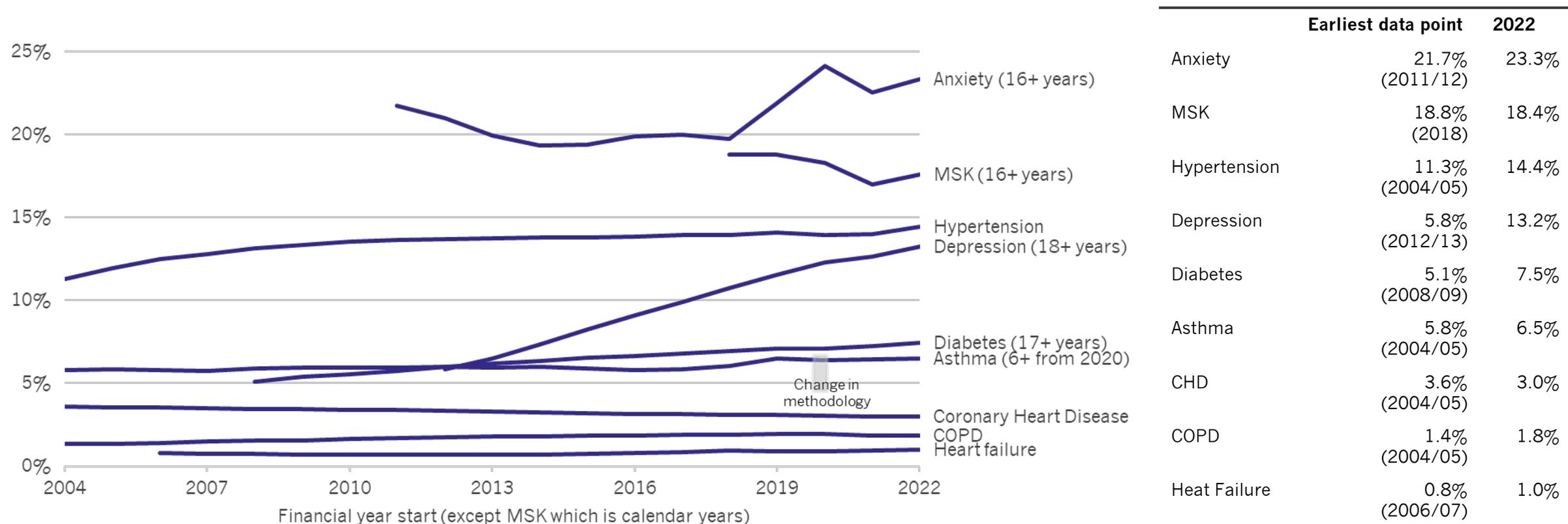
5. Prevalence of long-term conditions by age band

Figure I.5: Share of patients with no, one, or multiple long-term conditions by age

75% of those aged 85+ have more than one LTC

59% of those aged 75 – 84 have more than one LTC

40% of those aged 65 – 74 have more than one

Legend:
- 1 conditions
- 2 conditions
- 3 conditions
- 4 conditions
- 5+ conditions

X-axis: Age category (0-18, 19-39, 40-64, 65-74, 75-84, 85+)

Source: NHS England, National segmentation dataset (v4.0_20230331)

6. Disease prevalence since 2004

Figure I.6: Recorded prevalence of health conditions by year (financial or calendar) for all ages (except where indicated) in England, 2004 and 2022

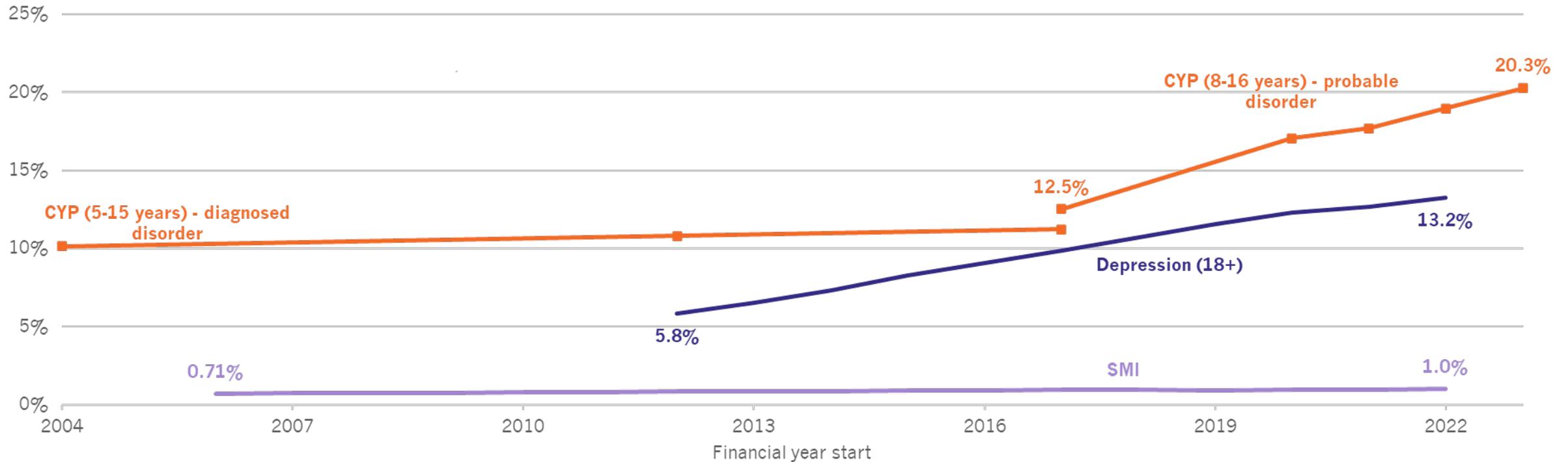|	Earliest data point	2022
Anxiety	21.7% (2011/12)	23.3%
MSK	18.8% (2018)	18.4%
Hypertension	11.3% (2004/05)	14.4%
Depression	5.8% (2012/13)	13.2%
Diabetes	5.1% (2008/09)	7.5%
Asthma	5.8% (2004/05)	6.5%
CHD	3.6% (2004/05)	3.0%
COPD	1.4% (2004/05)	1.8%
Heat Failure	0.8% (2006/07)	1.0%

Notes: Musculoskeletal Disorders (MSK) is reported in calendar years, and all other metrics are reported in financial years. Prior to 2020/21, asthma data was measured for all ages but is now measured using 6+ registers. Data for anxiety and MSK are self-reported measures rather than medically reported diagnoses; self-reported wellbeing = people 16 years or older with a high anxiety score; self-reported musculoskeletal problem = people aged 16 or older who reported "arthritis or ongoing problem with back or joints".
Source: Hypertension, depression, diabetes, asthma, Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD), heart failure – NHS England (2023), Quality and Outcomes Framework (QOF), 2022-23,. Anxiety – ONS (2023), Annual Population Survey: annual personal well-being estimates; MSK – NHS England (2024), GP Patient Survey. All data is available at: Fingertips | Department of Health and Social Care (phe.org.uk)

7. Mental health prevalence is rising for adults and children

Figure I.7: Mental health prevalence in England, 2004 to 2023

CYP (8-16 years) - probable disorder — 20.3%

CYP (5-15 years) - diagnosed disorder

12.5%

Depression (18+) — 13.2%
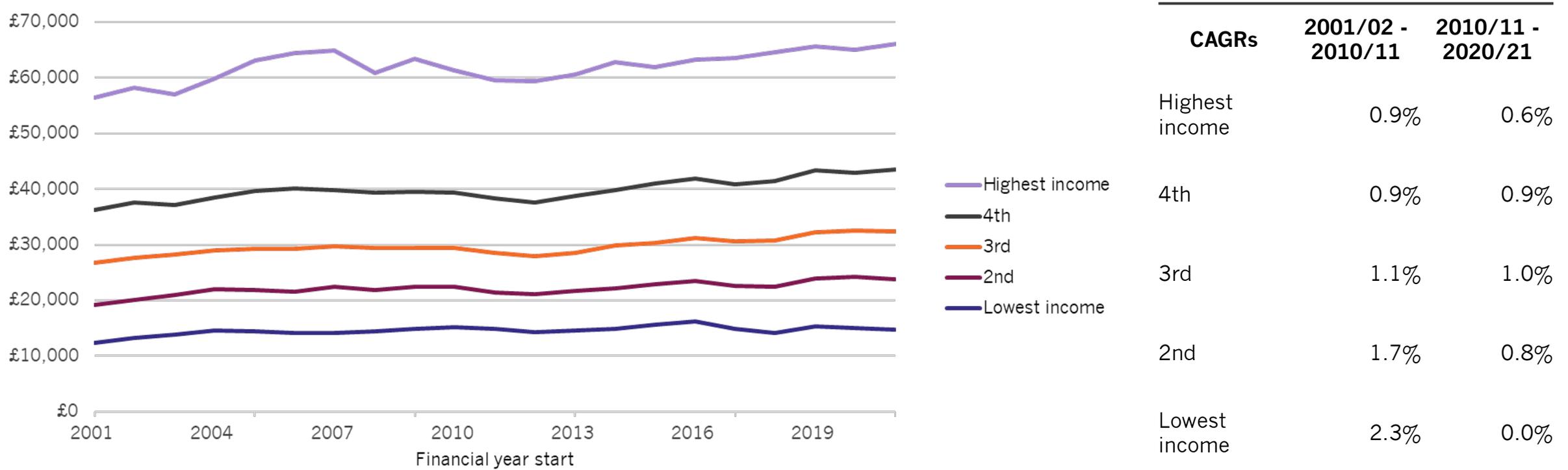
5.8%

0.71%

SMI — 1.0%

Financial year start

Notes: Depression and severe mental illness (SMI) prevalence based on recording on GP registers (QOF). In 2017, the children and young peoples (CYP) data had a methodological change; CYP (8-16 years) is based on probable disorder (SDQ), and data points available for 2017, 2020, 2021, 2022, and 2023 only; CYP (5-15 years) is based on diagnosed disorder (DAWBA), and data points available for 1999, 2004, 2017 only. CYP survey years are indicated by markers on the chart.

Source: NHS England (2023), Quality and Outcomes Framework (QOF) 2022/23, Accessed via Fingertips; CYP 8-16, probable disorder – NHS England (2023), Mental Health of Children and Young People in England, 2023; CYP 5-14, diagnosed disorder – NHS England (2018), Mental Health of Children and Young People in England, 2017 [PAS]

8. Real household income by income quintile 2001-2020

Figure I.8: Median equivalised disposable household income of individuals by income quintile UK (2021/22 prices), 2001 to 2020


CAGRs	2001/02 - 2010/11	2010/11 - 2020/21
Highest income	0.9%	0.6%
4th	0.9%	0.9%
3rd	1.1%	1.0%
2nd	1.7%	0.8%
Lowest income	2.3%	0.0%

Notes: Disposable income is equivalent to gross income less direct taxes (for example, income tax and employee national insurance contributions) and council tax or Northern Ireland rates. Equivalised to allow comparisons across households with different compositions (for example, comparing a single-person household with a household containing a family of four).

Source: Office for National Statistics (2023), The effects of taxes and benefits on household income, disposable income estimate. Available at: The effects of taxes and benefits on household income, disposable income estimate - Office for National Statistics (ons.gov.uk)

9. Poverty and deep poverty rates and children living in poverty and deep poverty

Figure I.9: Poverty rates, 2001 to 2021
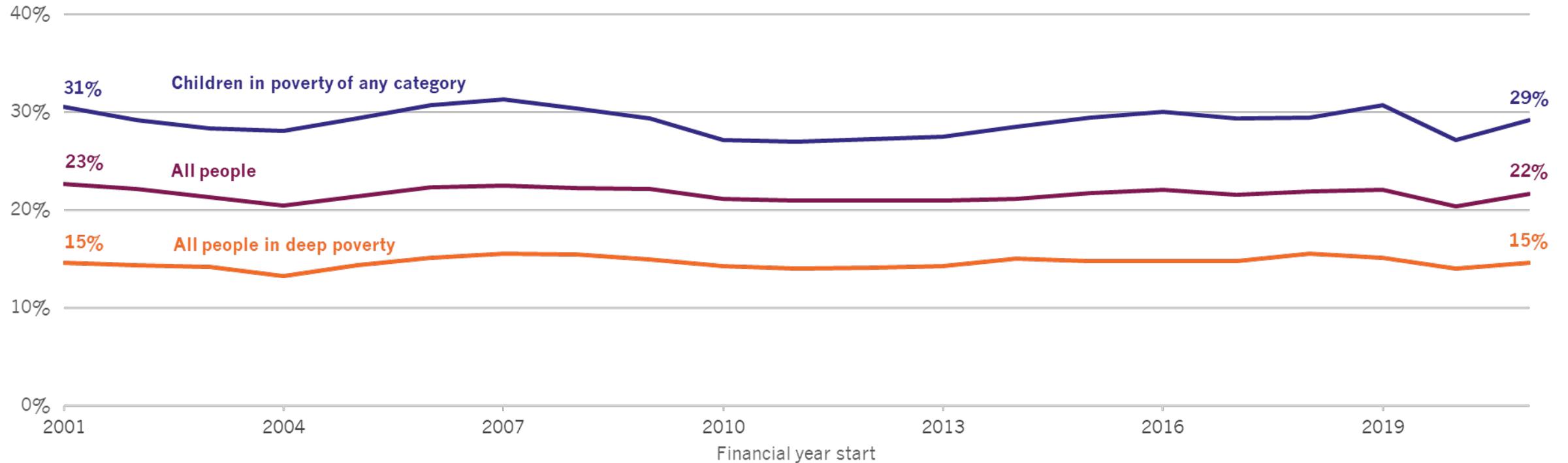
Notes: Children refers to people aged 0-19. Poverty refers to those with an equivalised AHC (after housing costs) household income less than 60% of median AHC income. Deep poverty refers to less than 50% of median AHC income, and very deep poverty refers to less than 40% of median AHC income.

Source: Joseph Rowntree Foundation, UK Poverty 2024

10. Food insecurity in the UK measured by emergency food supply distribution

Figure I.10: Number of emergency food supply parcel distributed by the Trussell Trust, 2017/18 to 2023/24
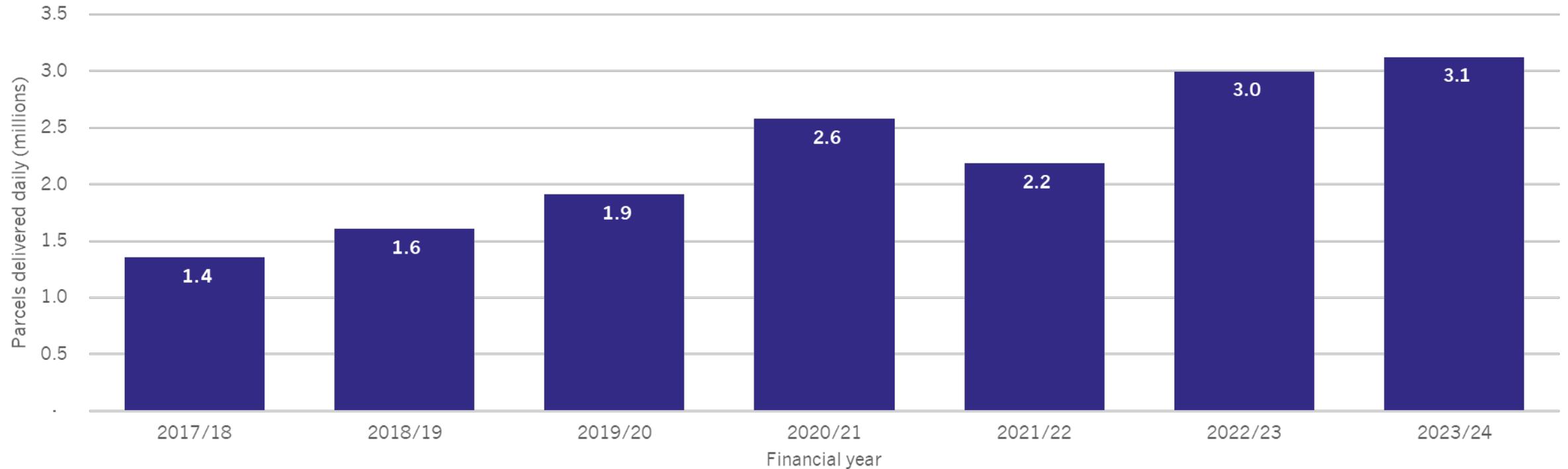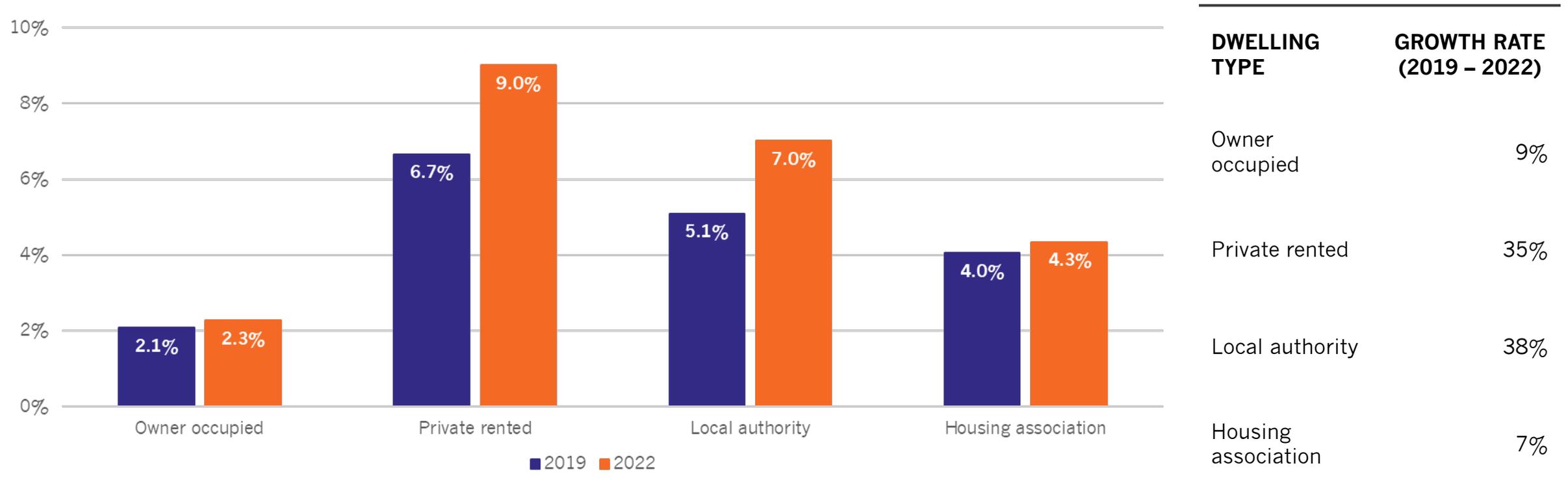

Notes: The Trussell Trust are the largest food bank in the UK (according to this report, their market share is approximately 60% of the UK market). According to the Office for National Statistics OPN survey in Winter 2023 around 1 in 25 adults (4%) said that they had run out of food and could not afford to buy more in the past two weeks, similar to late autumn and winter 2022 (5%). Analysis by the Food foundation suggests that after a sharp rise during 2020, food insecurity peaked in October 2022.

Source: Trussell Trust (2024), End of year statistics. Available at: End of Year Stats - The Trussell Trust

# 11. Housing quality: damp problems by sector, 2019 and 2022

Figure I.11: Dwellings with any damp problems, England, 2019 and 2022

DWELLING TYPE	GROWTH RATE (2019 – 2022)
Owner occupied	9%
Private rented	35%
Local authority	38%
Housing association	7%

Notes: A home is considered to have damp or a problem with damp if the surveyor records damp which is significant enough to be taken into consideration when making their Housing Health and Safety Rating System assessments.

Source: Department for Levelling Up, Housing & Communities (2023), English Housing Survey Headline Report, 2022-23

12. Physical inactivity among adults and children

Figure I.12: Percentage of adults and children who are physically inactive (less than 30 moderate intensity equivalent (MIE) minutes physical activity per week), 2015-16 to 2022-23
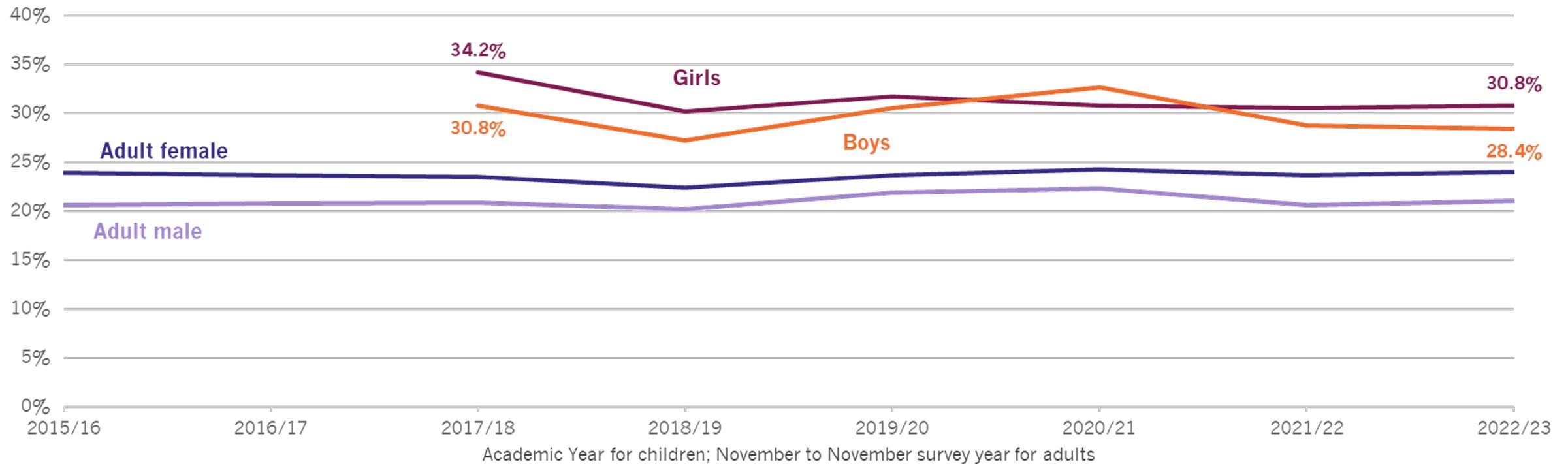
Notes: Children are defined as ages 5 to 16, and data is only available from financial year 2017/18 onwards. The definition of physical inactivity for children is 'less than 30 minutes moderate physical activity per day' whereas the definition for adults is 'less than 30 minutes moderate physical activity per week', and so data between adults and children are not directly comparable. Adults are classed as 'physically inactive', and children are classed as 'less active.

Source: Adult physical inactivity – Office for Health Improvement and Disparities (OHID) analysis of Sport England, Active Lives Survey; Financial Years 2017/18 to 2022/23 Office for Health Improvement and Disparities (OHID) analysis of the Sport England, Active Lives Survey

13. Children's use of social media and depression

Figure 1.13A: Mean (geometric) depressive symptom scores by social media use, 2016
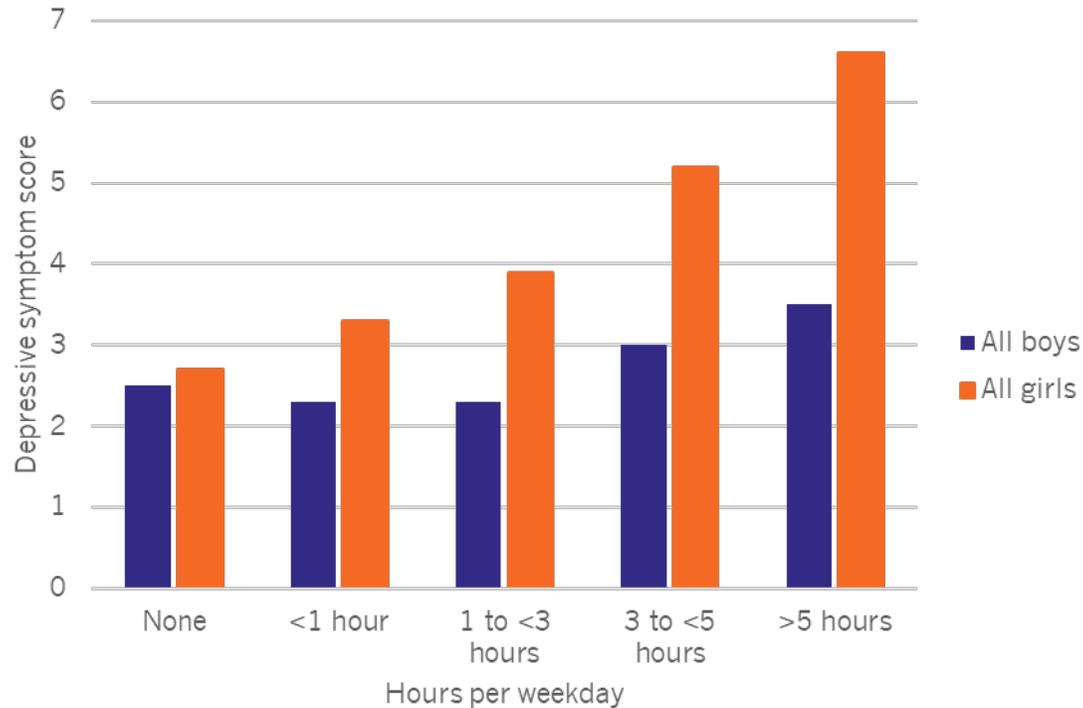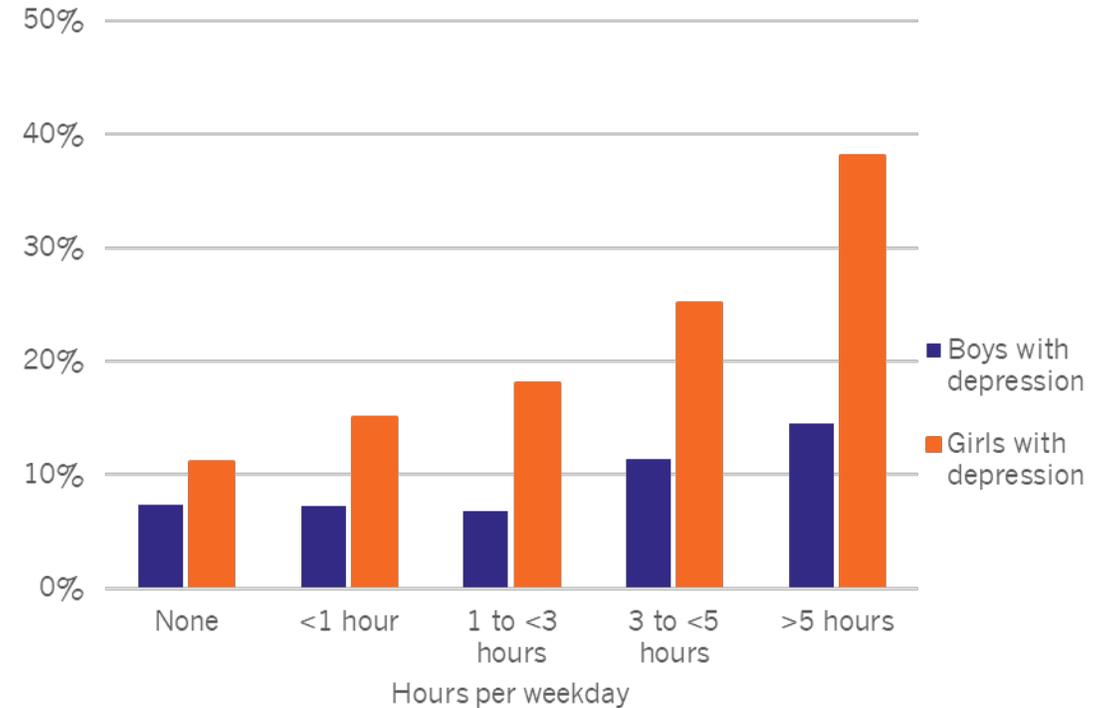

Figure 1.13B: Proportion of adolescents with clinically relevant symptoms by social media use, 2016
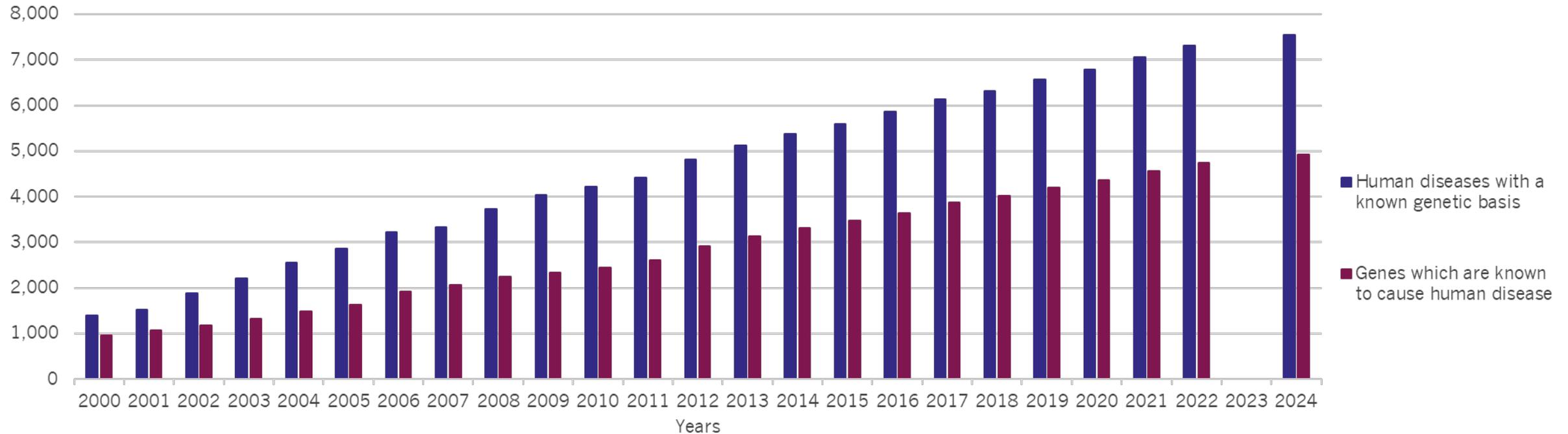

Notes: Data collected in 2016. Participants were aged 14 years old. Data is from self-reported social media use and depressive symptom questionnaires.

Source: Kelly, Y., Zilanawala, A., Booker, C., Sacker, A., (2019), Social Media Use and Adolescent Mental Health: Findings From the UK Millennium Cohort Study

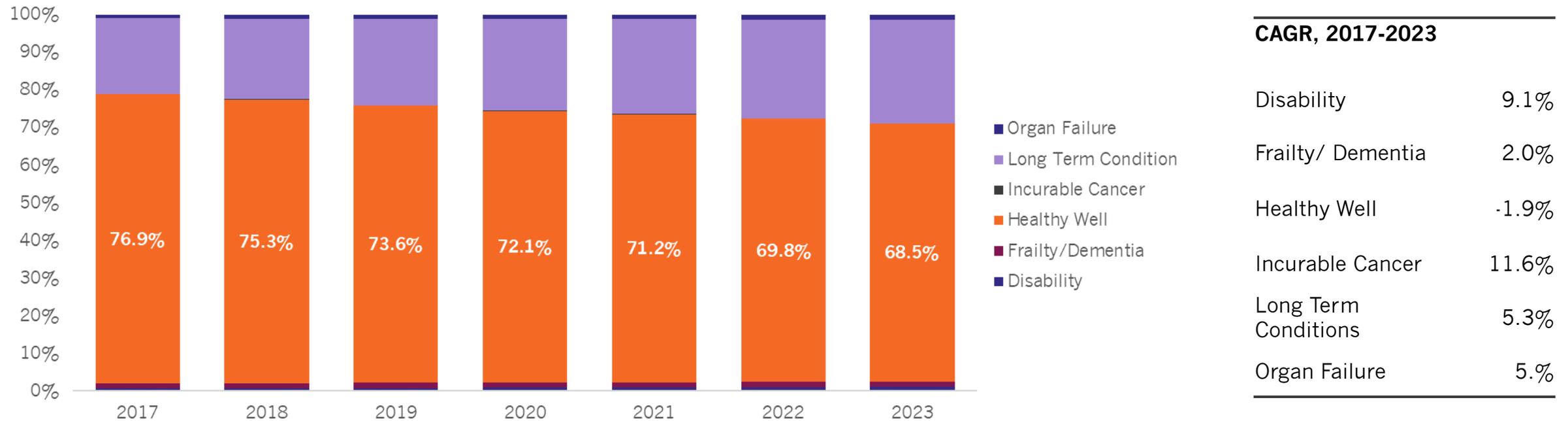# 14. Number of human diseases with a known genetic basis and genes known to cause human disease

Figure I.14: Growth of Gene-Phenotype Relationships

15. Complexity of needs

Figure I.15: Relative proportions of each population segment, 2017-2023

Legend:
- Organ Failure
- Long Term Condition
- Incurable Cancer
- Healthy Well
- Frailty/Dementia
- Disability

Healthy Well percentages by year:
- 2017: 76.9%
- 2018: 75.3%
- 2019: 73.6%
- 2020: 72.1%
- 2021: 71.2%
- 2022: 69.8%
- 2023: 68.5%

CAGR, 2017-2023

Disability	9.1%
Frailty/ Dementia	2.0%
Healthy Well	-1.9%
Incurable Cancer	11.6%
Long Term Conditions	5.3%
Organ Failure	5.%

Notes: Most recent data included (2023)

Source: NHS (2023) Population and person insight database. Available at: https://apps.model.nhs.uk/report/PaPi

# 16. Changes in NHS activity over time

Figure I.16: Changes in NHS activity over time, 2018/19 to 2023/24, indexed to 2018/19
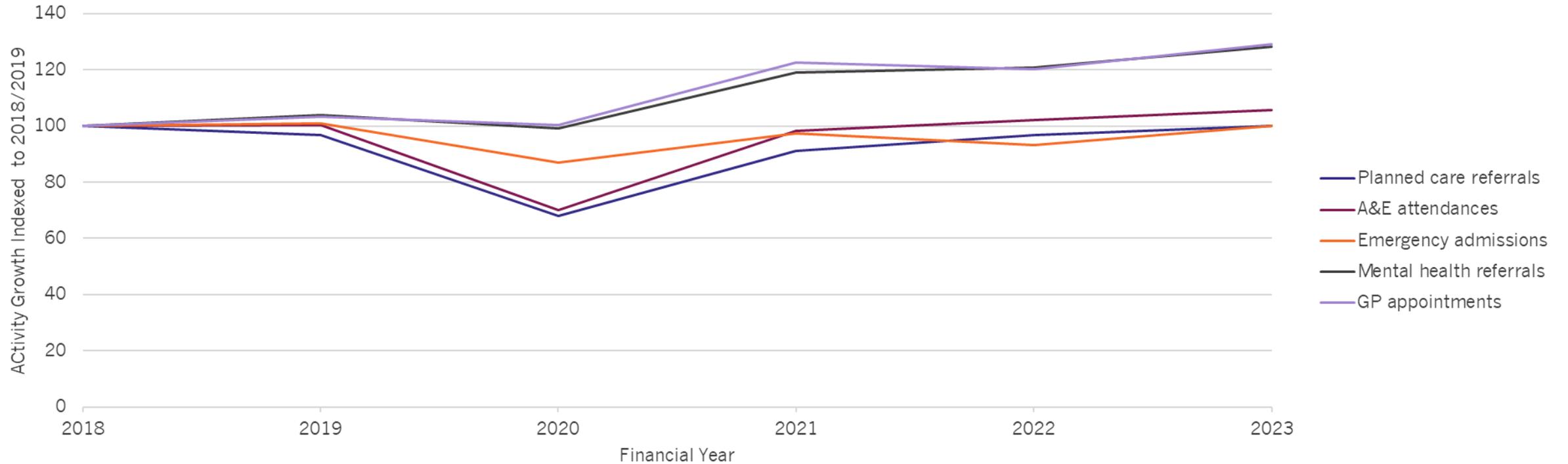
Source: NHS England, Referral to treatment official statistics; NHS England, A&E attendances and emergency admissions official statistics; NHS England, MHSDS and NHS talking therapies official statistics; NHS England, Appointments in general practice official statistics

17. Access to local authority supported adult social care

Figure I.17: Changes to requests for support and user of long-term and short-term care to maximise independence support arranged or provided by local authorities in England, 2015-16 to 2022-23
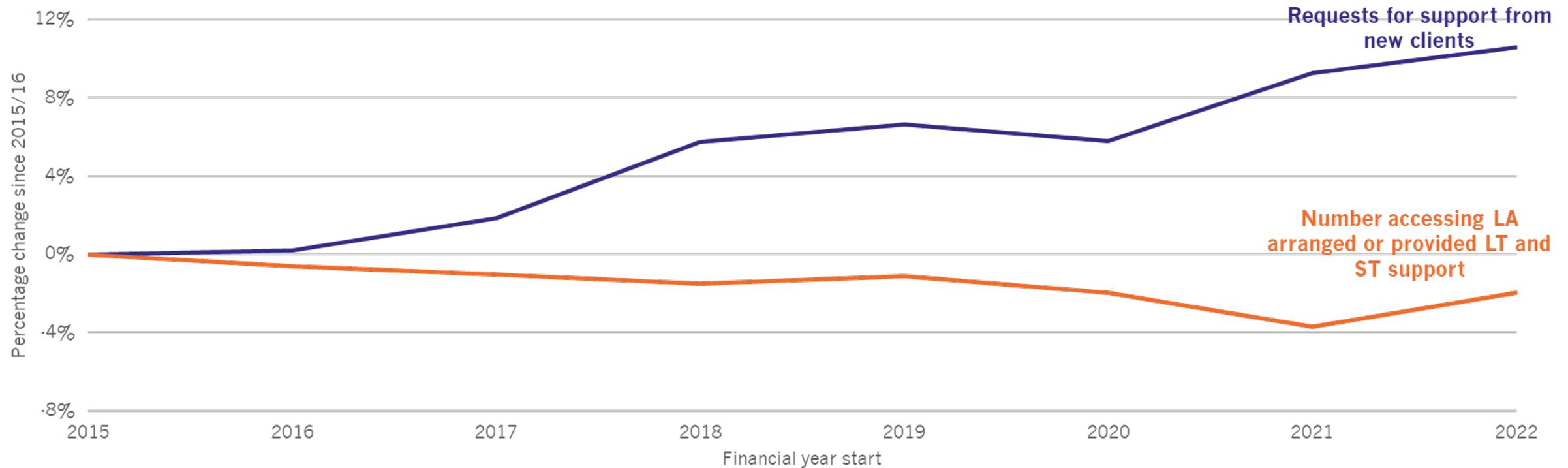

Notes: Not all adults are eligible for LA-funded adult social care. Eligibility is determined by needs and means testing. There is limited data on self-funders. According to data from SALT, the number of requests for care have increased by 11% since 2015-16. The number of adults receiving LA-supported care has decreased by 2% over the same period. There will be double counting of care users who accessed both short-term and long-term care in a given year. LT and ST are abbreviations for long term and short term.

Source: NHSE SALT, Reproduced from the King's Fund

II. Access to NHS services

1.1 NHS performance against Constitutional Standards

Figure II.1.1: NHS constitutional targets and whether they are being met
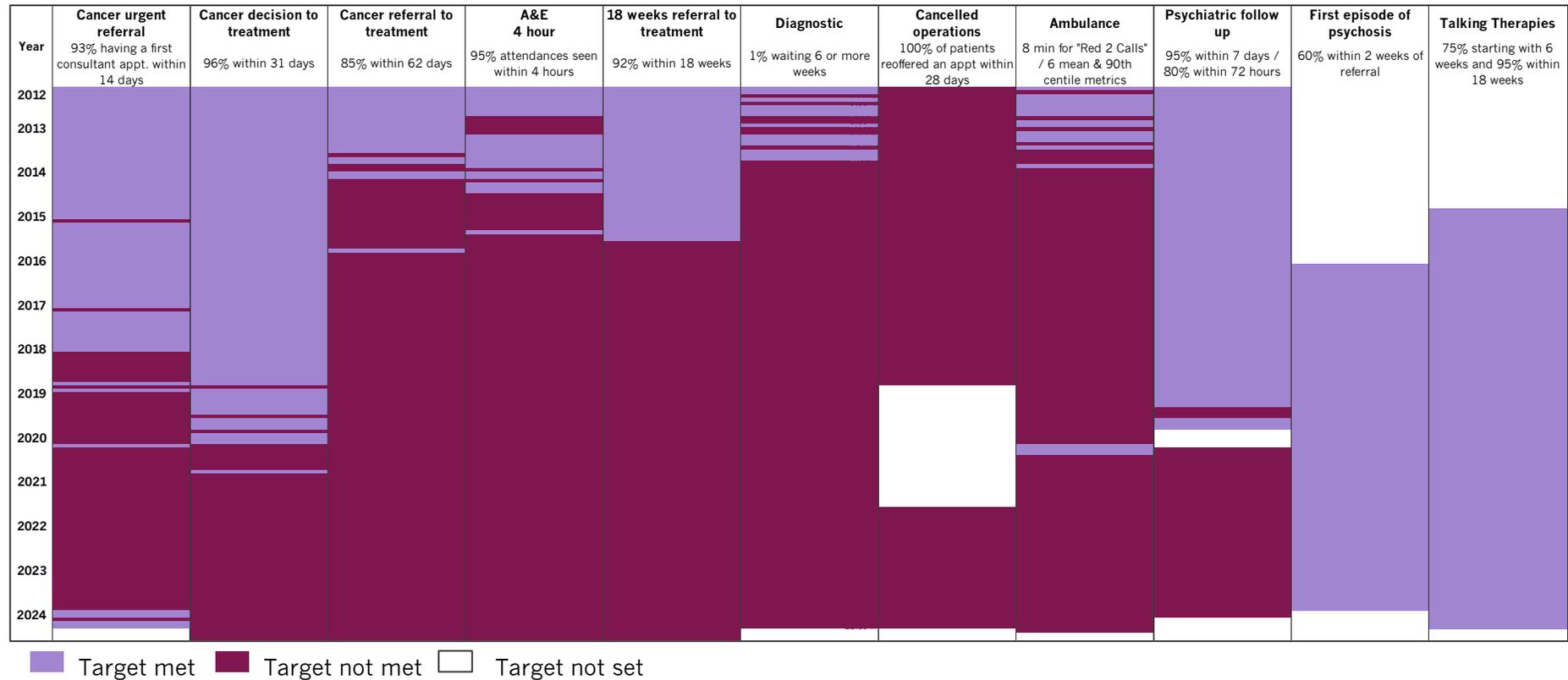
Notes: Cancer urgent referral – the 93% within 14 days standard was stood down in September 2023. This then uses the faster diagnosis standard (75% of urgent referrals being told where the patient has cancer within 28 days) which came into effect in October 2022. Targets are measured on a monthly basis (psychiatric follow up was measured quarterly until December 2019).
Source: NHS England. Available at https://www.england.nhs.uk/statistics/statistical-work-areas, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics, https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports . Credit given to Nuffield Health for original visualisation.

2.1 Performance of NHS 111: total call volume and split by speed of answer or abandoned

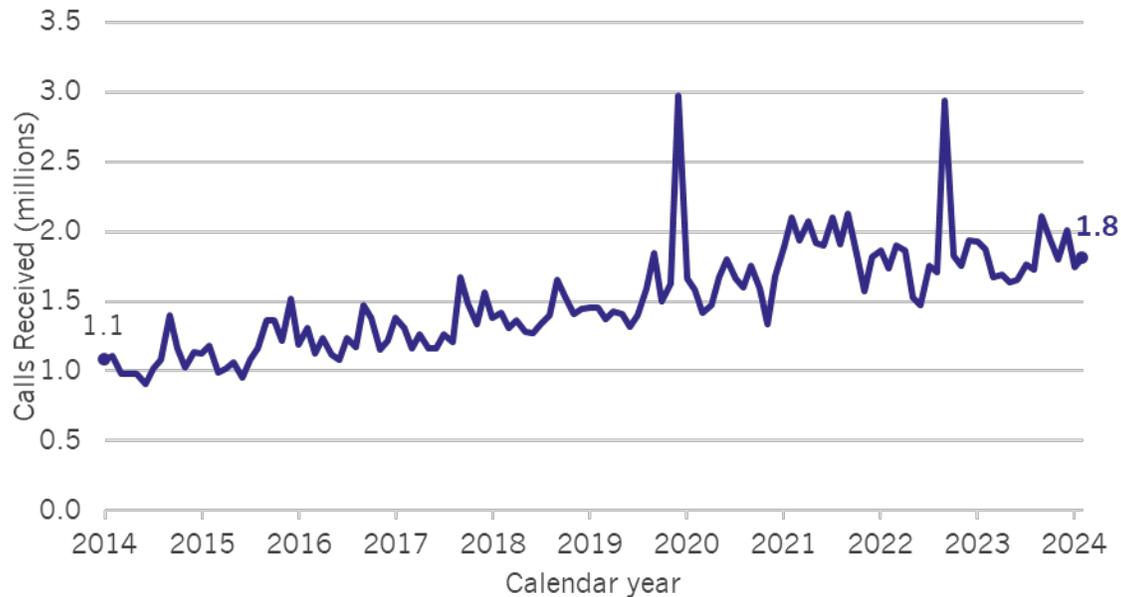**Figure II.2.1A: NHS 111 Calls Received (numbers)**

Figure II.2.1B: Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds (percentage)

Notes: calls abandoned after at least 30 seconds changed definition in April·21 when collection went from 111MDS to 111IUCADC.

In the MDS, calls·abandoned were counted over 30 seconds after being queued for an advisor (the 30 seconds should account for IVR (Interactive Voice Response) · which may or may not take 30 seconds); in the ADC calls abandoned are counted from the moment the call is queued to skillset after IVR.

Denominator for NHS 111 handling of incoming calls = sum of calls answered in 60 seconds, calls answered after 60 seconds and calls abandoned after at least 30 seconds

Source: NHS England. NHS 111 MDS times series Available: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/07/20210708-NHS-111-MDS-time-series-to-March-2021.xlsx; IUC ADC https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/

2.2 NHS 111 call handling

**Figure II.2.2: NHS 111 dispositions, average across last financial year April 2023 – March 2024**
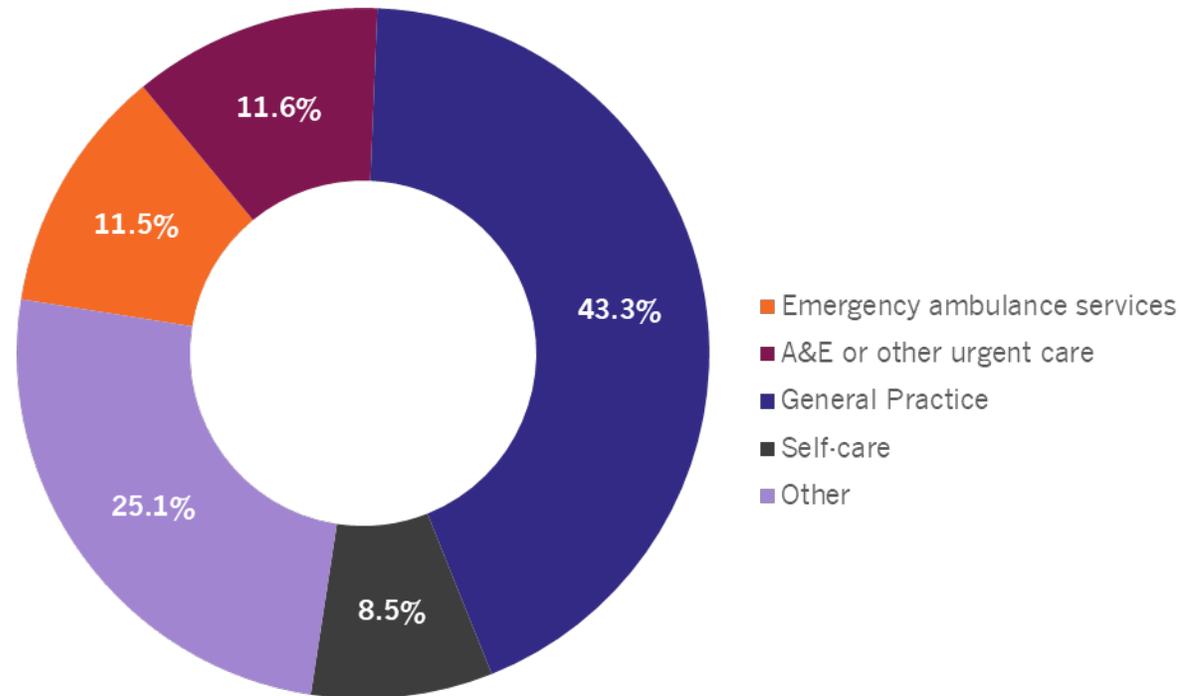
Notes: NHS 111 call handlers give recommendations (technically termed as "dispositions") to the caller based on what would be most appropriate for them to do next for their health needs. A&E or other urgent care – comprises callers recommended to attend an Emergency Treatment Centre (ETC) or recommended to attend Same Day Emergency Care (SDEC). General Practice – comprises callers recommended contact or speak to primary care services (bookable and non-bookable dispositions). Other – comprises IUCADC data items recommended contact or speak to dental practitioner, contact or speak to pharmacist, repeat prescription medication, contact or speak to other service and recommended other outcome

Source: NHS England, 111 MDS and IUC ADC: Available: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/07/20210708-NHS-111-MDS-time-series-to-March-2021.xlsx. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/10/IUCADC_Data_KPI_Combined_Time_Series-March-2023_REVISED.xlsx
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/07/IUCADC_Data_KPI_Combined_Time_Series-to-May-2024.xlsx

2.3 NHS app registrations and monthly usage

Figure II.2.3: NHS App – Proportion of 18+ Population using NHS App on a monthly basis
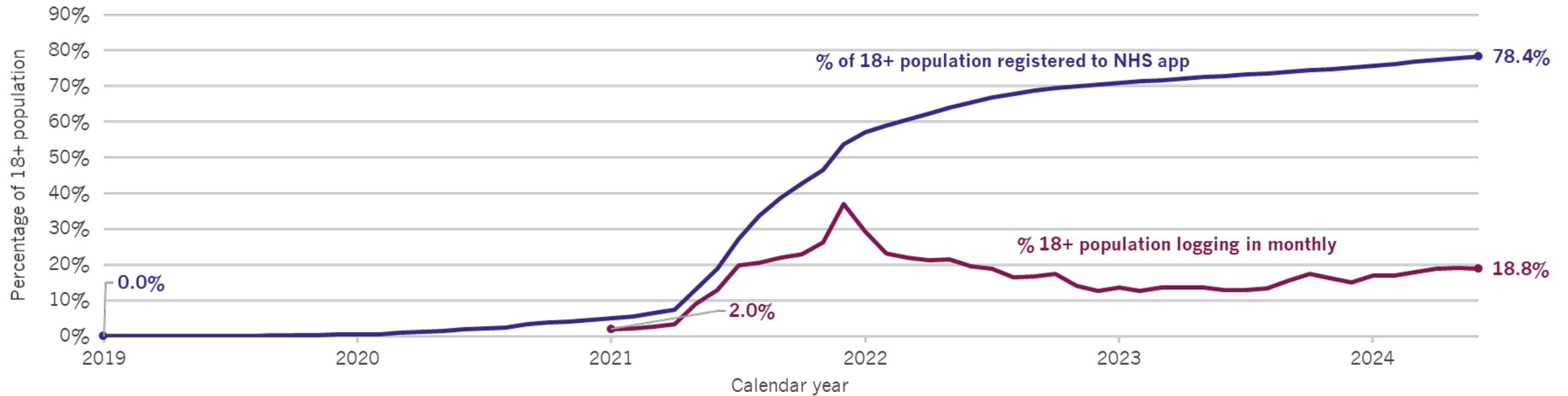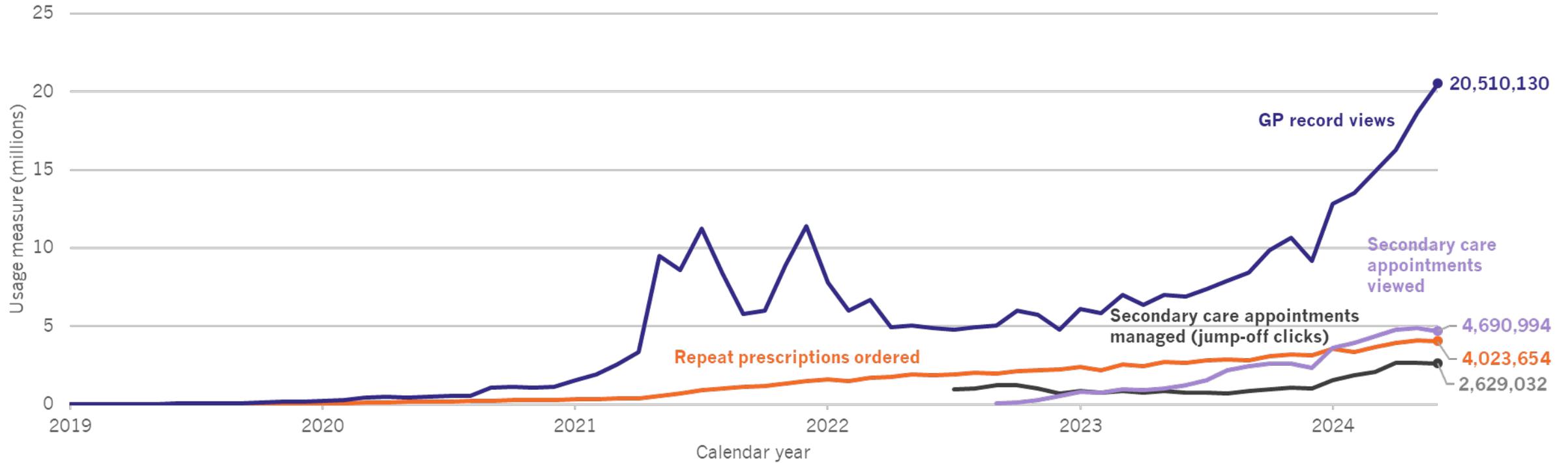

Notes: Denominator from Office for National Statistics 2021 Census – England 18+ Population

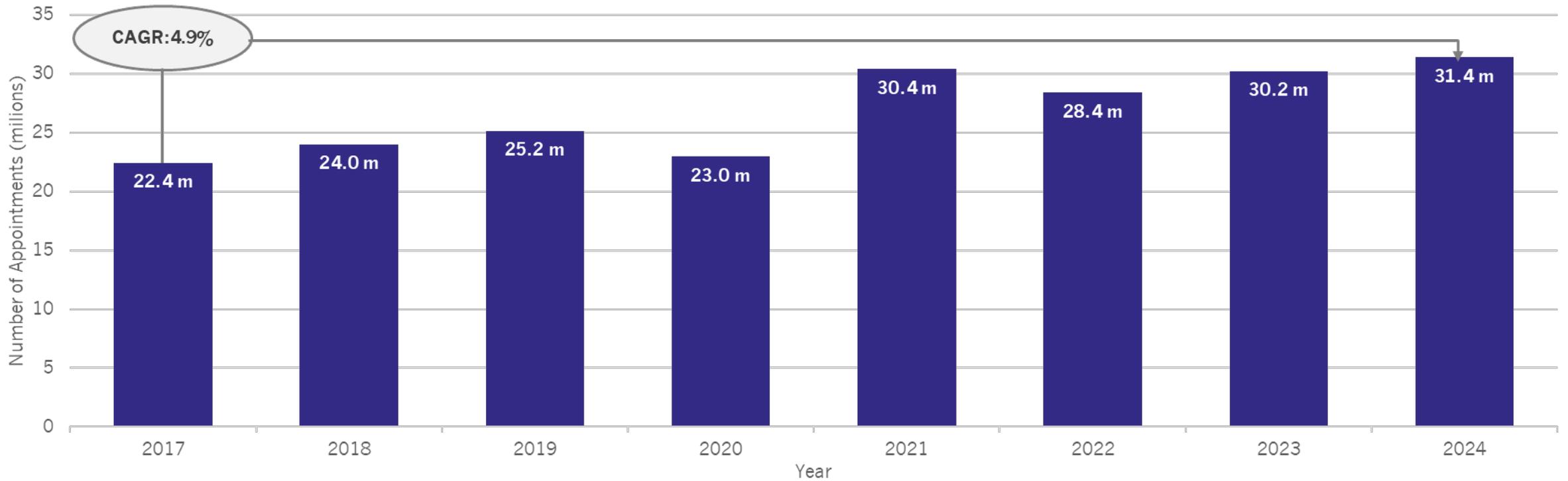Source: NHS England, NHS App Dashboard

2.4 Use of the NHS app

Figure II.2.4: NHS App usage by type (2019-2024)

Source: NHS England, NHS App Dashboard.

3.1 Monthly GP appointment volumes

**Figure II.3.1: Monthly GP appointments delivered from Nov-2017 to June 2024**

Notes: Chart shows the total number of GP appointments per month from Jan 2018 to June 2024, with the CAGR overlaid. Includes all appointments delivered in general practice, including covid vaccines and PCN appointments.

2017/18 only includes date from January to March 2018 and 2024/25 only includes data from April to June 2024. To avoid skewing the CAGR calculation these are excluded from the CAGR calculation.

Source: Appointments in General Practice Official Statistics Available: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

3.2 Patient reported waiting times for GP appointments

**Figure II.3.2: Patient-reported waiting times for GP appointments**
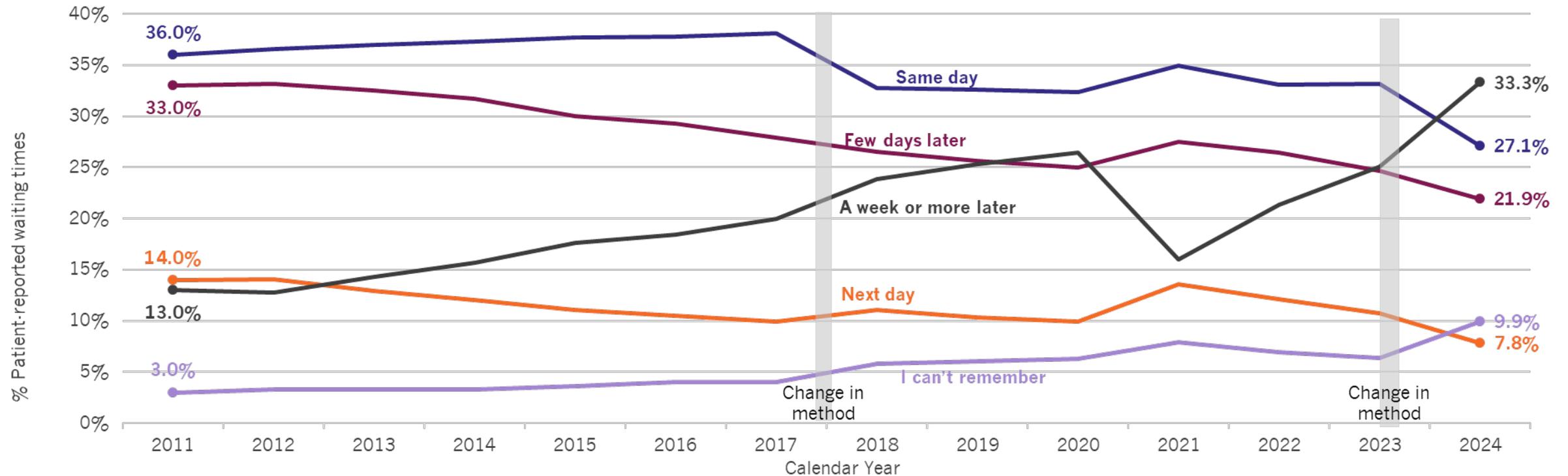
Notes: This chart shows % how long after patients first contacted their GP practices did the appointment take place. Also, breaks have been added before 2024 as 2024 data cannot be compared directly with previous years. In addition, data between 2011 and 2017 cannot be compared directly. Data Source: GP Patient Survey (2011-2024)

Source: GP Patient Survey (2011 – 2024) Available at: https://www.gp-patient.co.uk/surveysandreports

3.3 Patient-reported GP access and GP satisfaction

Figure II.3.3: Question asked: 'From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of the parts of the NHS runs nowadays: Local doctors or GPs
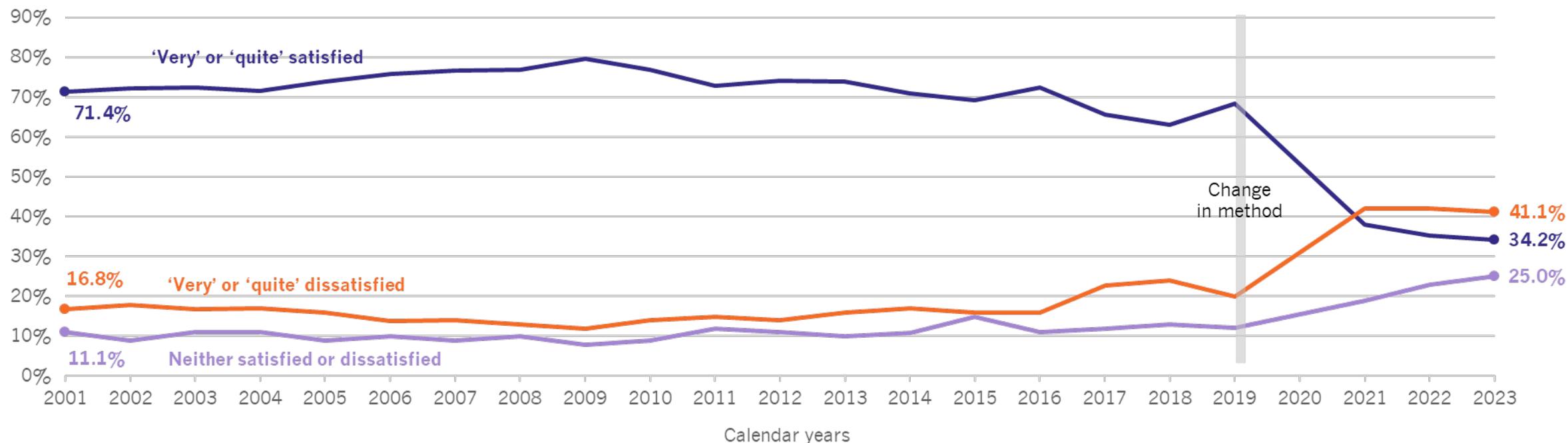

Notes: Reproduced from the King's Fund and Nuffield Trust analysis of Nat Cen's BSA survey data. 2023 sample size 1,206. This questions was not asked in 2020. 'Don't know' and 'Refusal' responses are not shown as consistently selected by less than1% respondents (2023 = 0.3). Data has been carefully weighted to minimise differences due to the change in methodology between 2021 and previous years

Source: Kings Fund, *Public satisfaction with the NHS and social care in 2023*. Available: Public Satisfaction With The NHS And Social Care In 2023 | BSA | The King's Fund (kingsfund.org.uk)

3.4 GP appointments per GP

Figure II.3.4: All appointments per WTE GP and Appointments delivered by GPs only per WTE GP (Nov-2017 to June 2024)
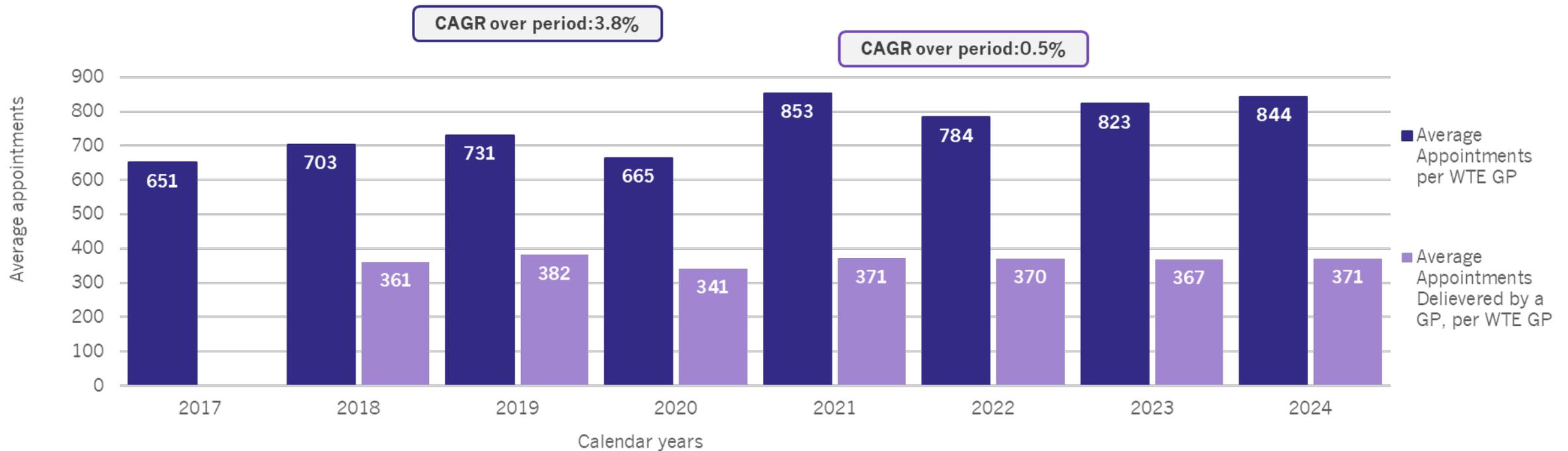

Notes: This chart shows both all appointments per WTE GP (some of which are delivered by other practice staff) & the Appointments delivered by GP's only per WTE GP. Figures represent fully qualified GPs. Workforce data was quarterly prior to June 2021, this means we have used the quarterly figures for months where data was missing. Please note that the figures presented are annual averages.

Source: Appointments in General Practice & General Practice Workforce Official Statistics. Available: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice, https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
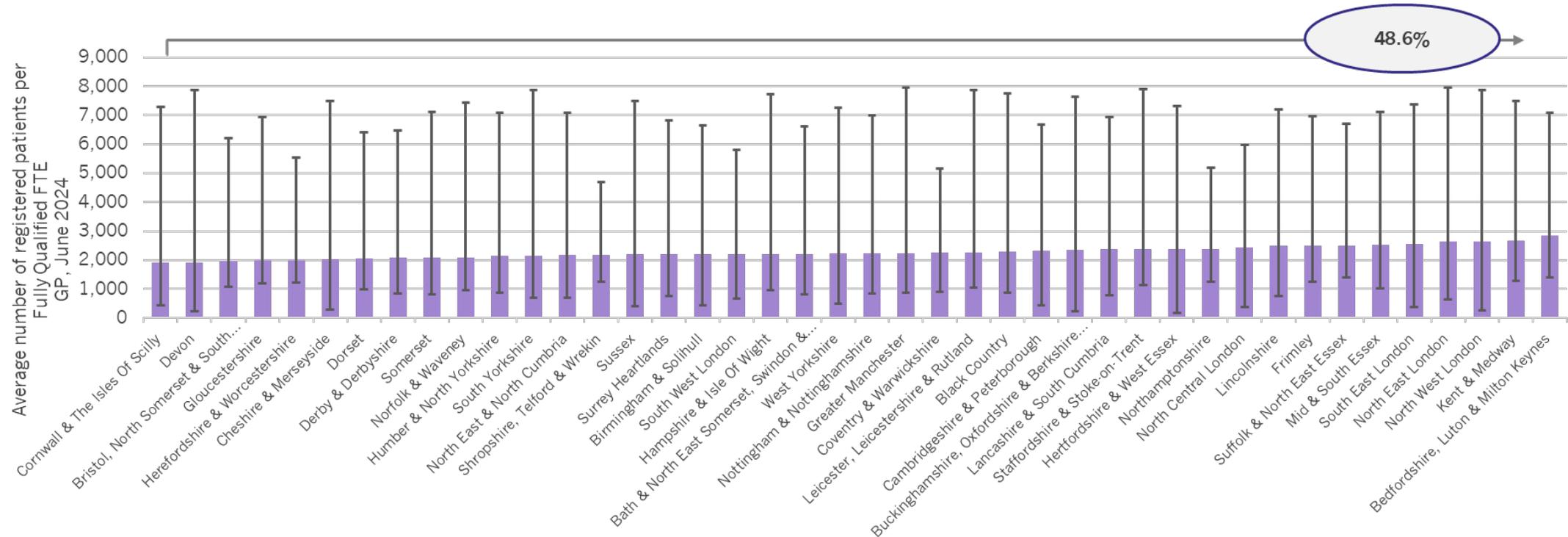
3.5 Patients per GP over time

Figure II.3.5: Average number of Patients Per fully qualified GP 2015/16 to 2023/24
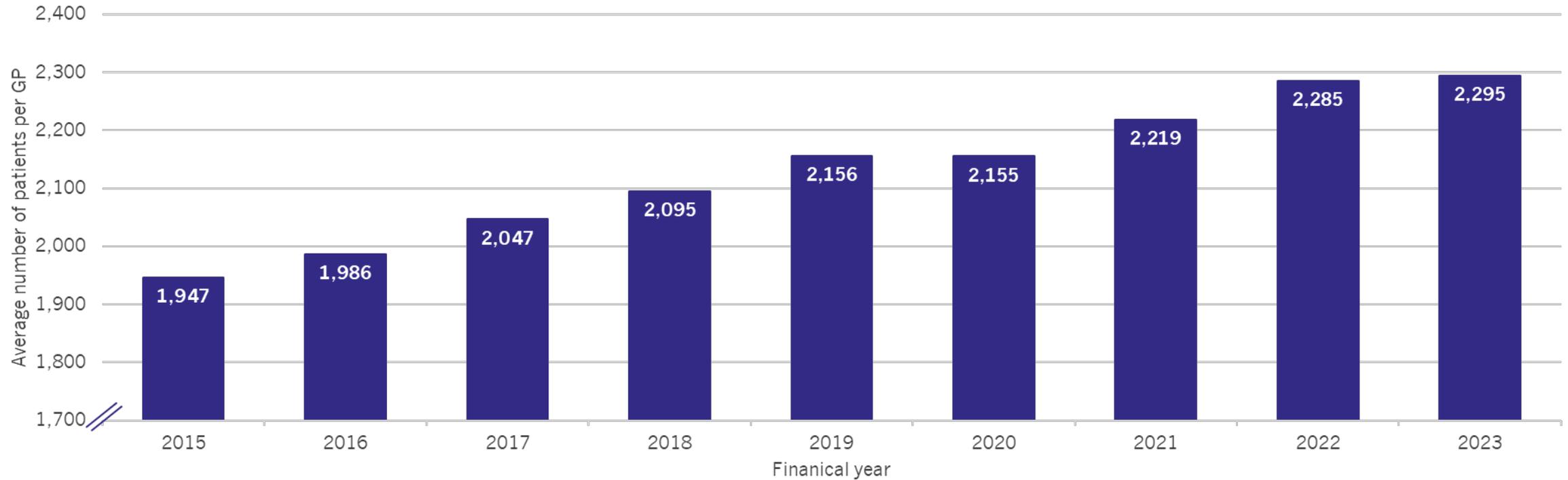
3.6 Variation in number of patients per GP

Figure II.3.6: Average number of registered patients per full-time equivalent GP in each ICB, June 2024

Notes: All figures calculated from the practice-level CSV in the Official Statistics https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2024. Lines represent the GP practices with the minimum and maximum registered patients per FTE GP within each ICB. Records are excluded as follows: Ten records where the total patient count at the practice <100, 28 records where the patient count = 0, 80 records where the reported count of full-time equivalent (FTE) GPs = 0.

Source: All figures calculated from the practice-level CSV in the Official Statistics https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/30-june-2024

3.7 Association between number of registered patients per fully qualified GP and patient reported satisfaction

Figure II.3.7: Reported patient satisfaction by average numbers of registered patients per GP, June 2024


Notes: Patient satisfaction taken from most recent GPPS, Ten records where the total patient count at the practice <100, 28 records where the patient count = 0, 80 records where the reported count of FTE GPs = 0, 595 records where the average number of registered patients per FTE GP is >4,000; this is generally due to very low numbers of recorded FTE GPs rather than a large patient list size and includes 191 records where the FTE GP count is <1

Source: Average number of registered patients per full-time equivalent (FTE) GP calculated from the practice-level CSV in the Official Statistics https://digital.nhs.uk/data-and-ation/publications/statistical/general-and-personal-medical-services/30-june-2024.

3.8 Waiting times for urgent treatment centres and walk-in centres

Figure II.3.8: Total time in department from arrival to admission, transfer or discharge, UTCs and WICs
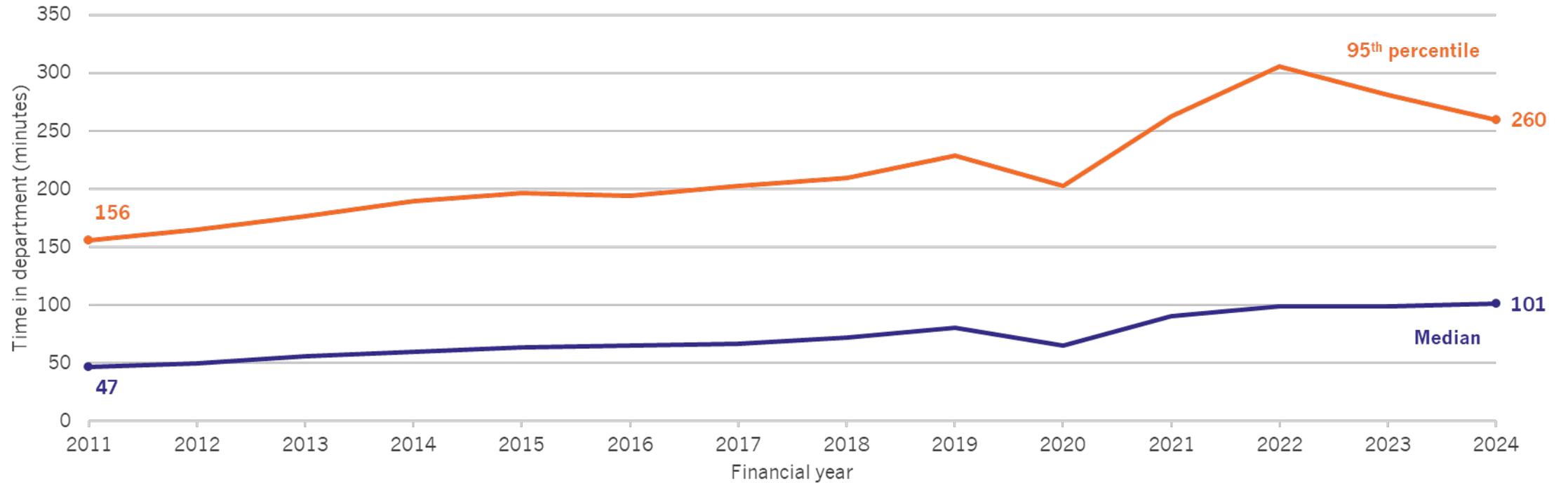

Notes: Data quality and coverage issues between 2008/09 and 2010/11. Data from type 3 and type 4 emergency departments. Type 3 departments are designated Urgent Treatment Centres (UTCs) whereas Type 4 departments are other non UTC facilities that continue to operate as minor injury units, urgent care centres, walk-in centres etc. Excludes planned follow ups and attendances in department over 1 day (due to suspected data quality). Also excludes streamed activity.

Source: NHS England, A&E CDS and ECDS

4.1 General dental practices availability to NHS patients

Figure II.4.1: Percentage of general dental practices currently accepting new NHS patients for routine appointments
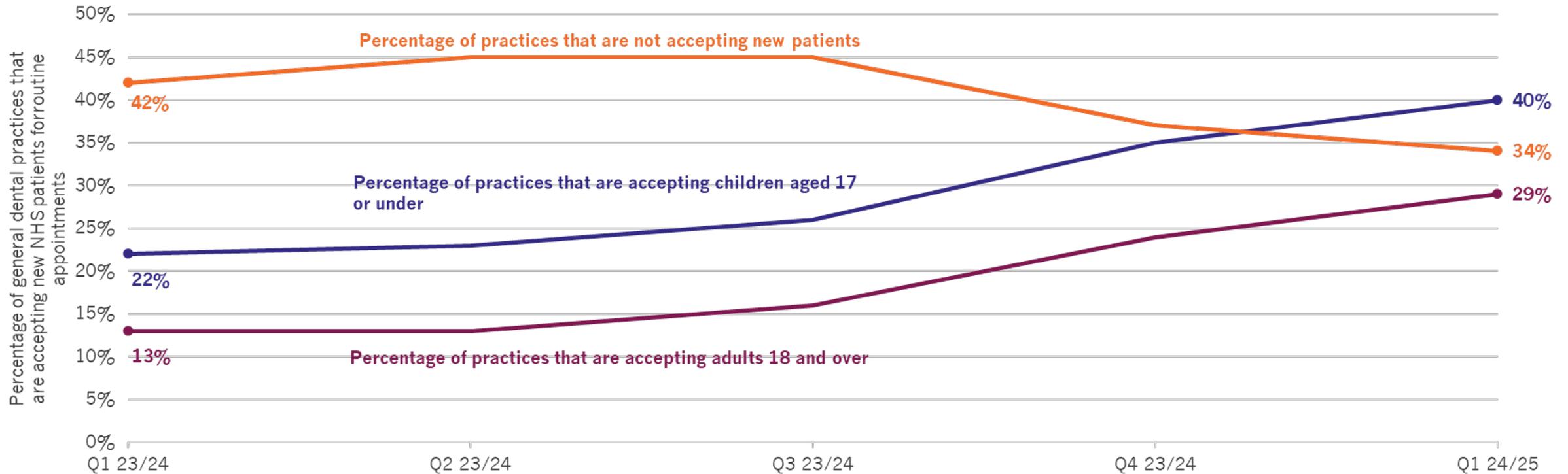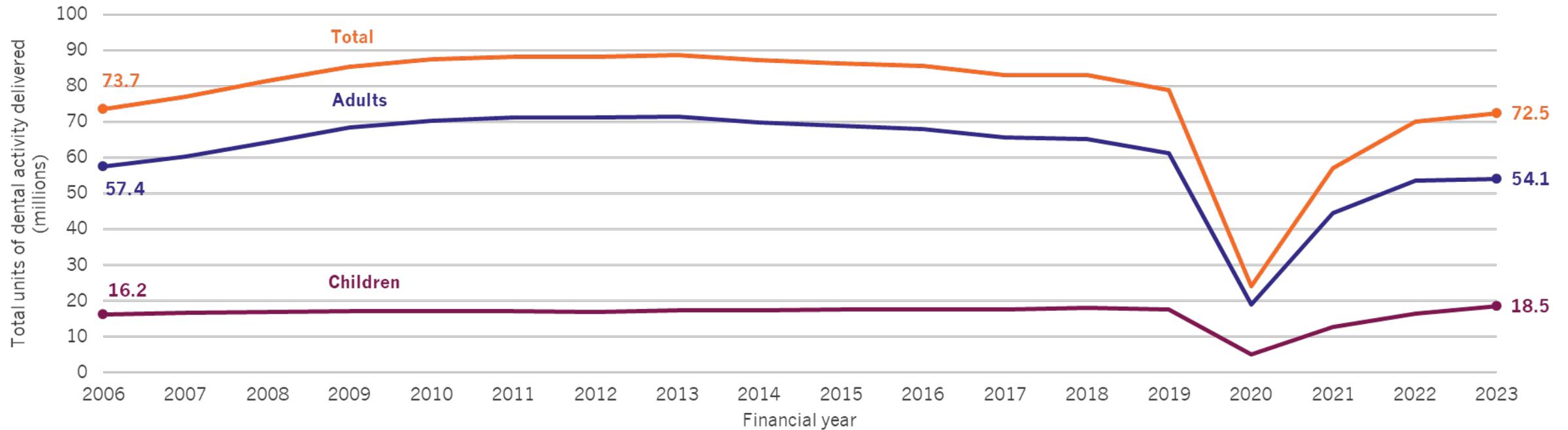

Notes: Data is based on confirmations through NHS Profile Manager that practices are, or are not, accepting new patients. Percentages do not add to 100 due to not all practices updating their profile.

Source: NHS profile manager
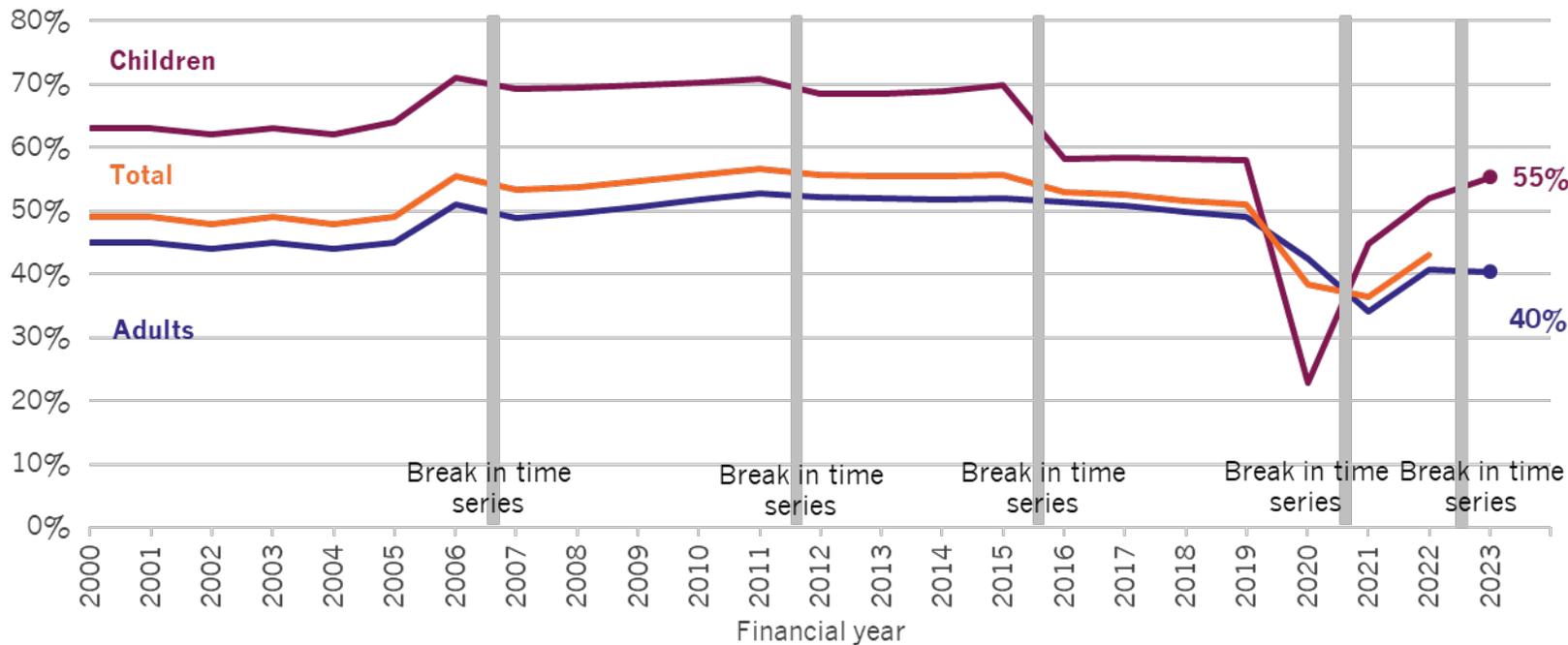
4.2 Units of Dental Activity

Figure II.4.2: Total units of dental activity (millions)

4.3. Proportion of adults and children registered with an NHS dentist

Figure II.4.3: Percentage of the population registered with an NHS dentist and percentage of the population, that has an NHS dentists 2006/07 onwards


Year	CAGR		
	Children	Adults	Total
2000/01-2005/06	0.32%	0.00%	0.00%
2005/06-2010/11	1.90%	2.85%	2.60%
2010/11 - 2015/16	-0.14%	0.04%	0.00%
2015/16 – 2019/20	-4.52%	-1.38%	-2.18%
2019/22 – 2022/23	-3.57%	-6.06%	-5.46%

Notes: Percentage of the population registered with an NHS dentist 2000/01 to 2005/06. Percentage of the population, adults and children, seen by an NHS dentists in the previous 24 months 2006/07 to 2015/16. Percentage of the adults seen by an NHS dentist in the previous 24 months and children in the previous 12 months 2016/17 to 2022/23. Totals for all years are weighted averages of adult and child percentages.

Source: NHS dental statistics. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics; https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202324

4.4 NHS Dentist availability to patients

Figure II.4.4: NHS Dentists per 100,000 people, by sub-ICB, 2023/24

Number of NHS dentists per 100,000 people

- ≥ 60.00
- ≥ 54.26, < 60.0
- ≥ 54.00, < 54.26
- ≥ 46.00, < 54.00
- ≤ 46.00
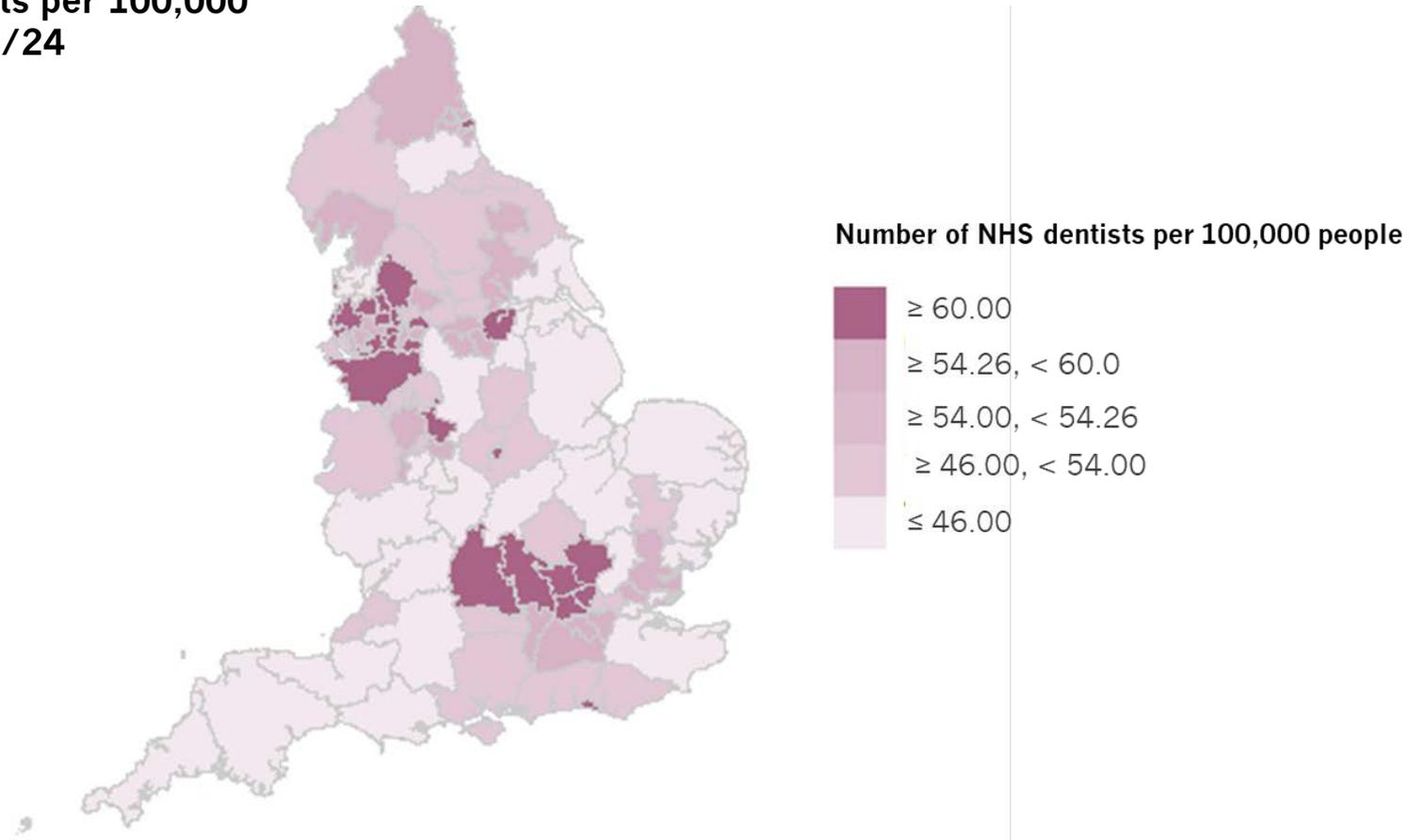
Notes: Data used is for 2023/24, this is provisional data based on the latest available mid-year population figures. Dentists are defined as performers with NHS activity done within the financial year, these figures therefore show that a dentist performed some NHS dentistry but doesn't include the quantity performed.

Source: Reproduced and updated from a Nuffield Trust publication, based on NHS Dentistry Statistics

5.1 Number of pharmacies in England

Figure II.5.1: Number of pharmacies in England from 2015 to 2022
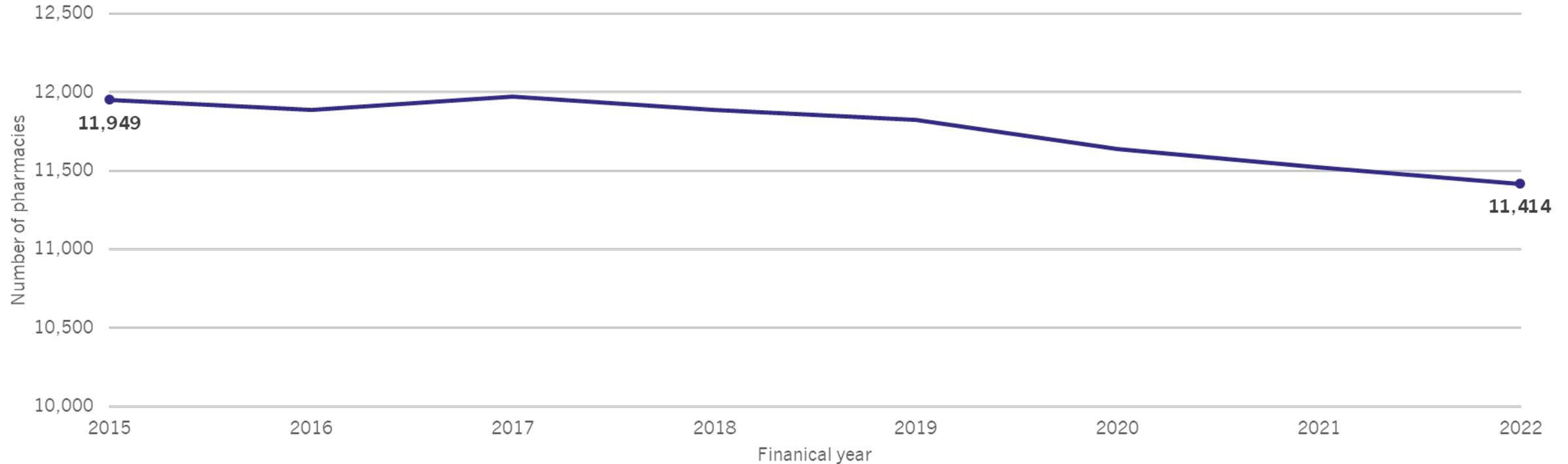
Notes: The figures shown in this release by NHSBSA are based on contractors that have been active at any point in the given year. This has been done to provide consistency with other figures given in the publication that do not exclude contractors that have closed during the year, and to more accurately reflect the level of activities carried out by contractors during a year. Previous releases of these statistics by NHS Digital counted active contractors as those open at 31 March of the given year. This change avoids the exclusion of contractors that have opened and closed in the same financial year.

Source: NHS Business Services Authority, General Pharmaceutical Services in England. Available: General Pharmaceutical Services in England 2015/16 - 2022/23 | NHSBSA

5.2 Walking distance to pharmacies

**Figure II.5.2: Walking distance to a pharmacy for all populations in England (as of 31 December 2023)**

Walking Distance to pharmacy (miles)	Population in Distance Band	Total Population in area	Population in Distance Band (%)
0 to 0.5	31,377,401	56,488,181	55.5
0.5 to 1	16,794,304	56,488,181	29.7
1 to 1.5	3,102,978	56,488,181	5.5
1.5 to 2	1,171,904	56,488,181	2.1
>2	4,041,594	56,488,181	7.2

Notes: This shows the walking distance to a pharmacy for all populations in England. Access on average remains reasonable across England with 85.2% of patients living within a 1 mile walk of a pharmacy. As the crow flies, 93.2% of patients living in areas of highest deprivation live within 1 mile of a pharmacy compared to 71.2% in areas of the lowest deprivation, reinforcing the pharmacy inverse care law.

Source: South, Central and West Commissioning Support Unit (SCW CSU) and Department of Health and Social Care (DHSC) Analysis of postcode-level walking distance to the closest pharmacy GI3229 DHSC Postcode to Pharmacy data download (arcgis.com)

5.3 Community pharmacy funding

Figure II.5.3: Community Pharmacy Contractual Framework (CPCF) total contract sum
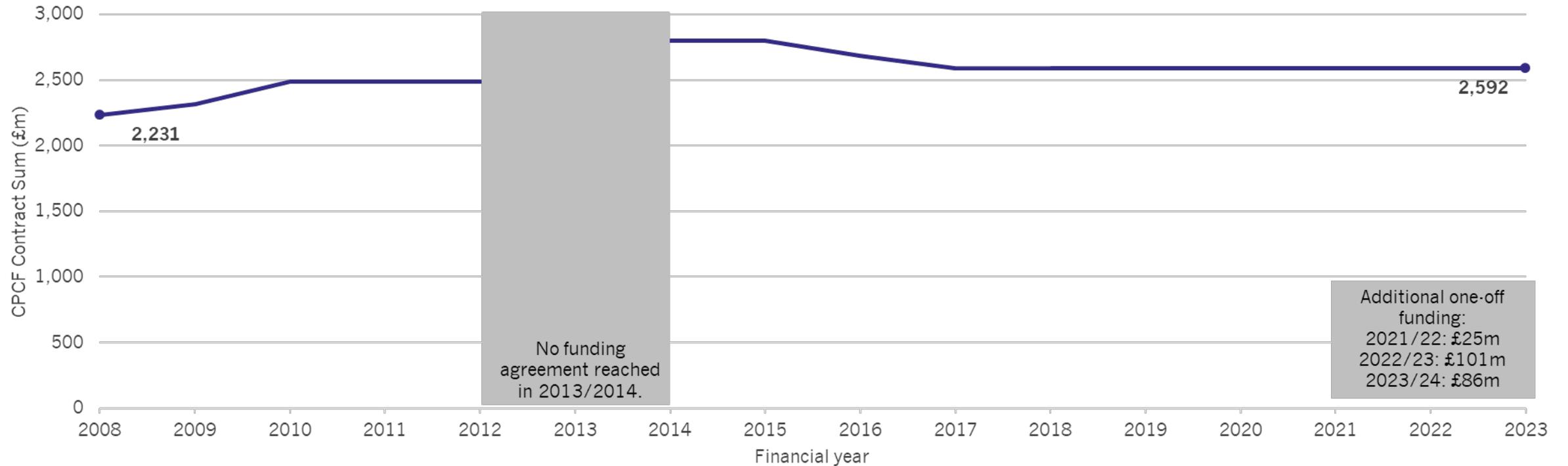

Notes: This shows the Community Pharmacy Contractual Framework (CPCF) total contract sum from 2008/09 to 2023/24. Over the same period, pharmacies dispensed more medicines and introduced a range of clinical services (such as the New Medicines Service, the Blood Pressure Check Service, the Pharmacy Contraception Service, the Community Pharmacist Consultation Service for minor illness and urgent medicines supply.)

Source: Community Pharmacy England (CPE) and Department for Health and Social Care (DHSC); https://cpe.org.uk/funding-and-reimbursement/pharmacy-funding/historical-funding-arrangements/2016/2017; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf; https://assets.publishing.service.gov.uk/media/5d359f2e40f0b604de59fd82/cpcf-2019-to-2024.pdf

6.1 Number of new referrals to mental health services

Figure II.6.1: New referrals Mental Health, Learning Disability and Autism and Dementia Services (18 years+), England
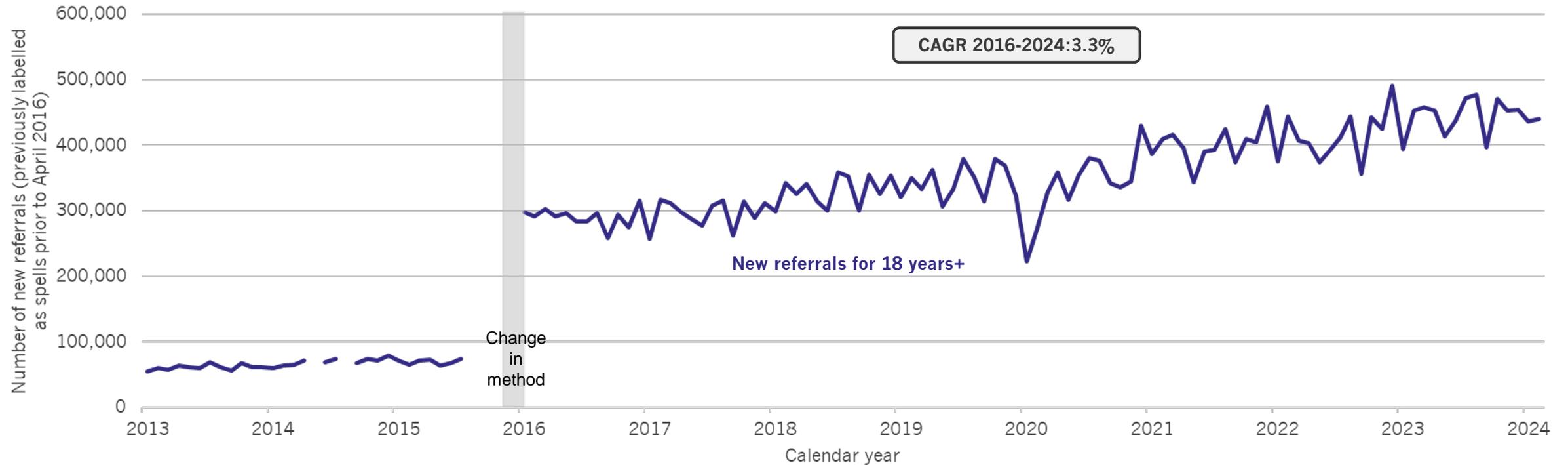

Notes: Data relating to secondary mental health services has been collected via the Mental Health Services Dataset (MHSDS) since January 2016. Prior to this, data was collected via the Mental Health Minimum Dataset (MHMDS) or the Mental Health Learning Disabilities Dataset (MHLDDS). The scope of these collections was different to that of MHSDS, specifically around the inclusion of LDA in MHLDDS and then the inclusion of Children from MHSDS onwards. In addition, prior to 2016, the dataset measured spells rather than referrals.

Source: NHS England, *Mental Health Services Dataset , Mental Health Minimum Dataset, Mental Health Learning Disabilities Dataset.*

6.2 Number of new referrals to mental health services (under 18)

Figure II.6.2: New referrals for people aged 0 to 17 at the time of referral to Mental Health, Learning Disability and Autism and Dementia Services, England
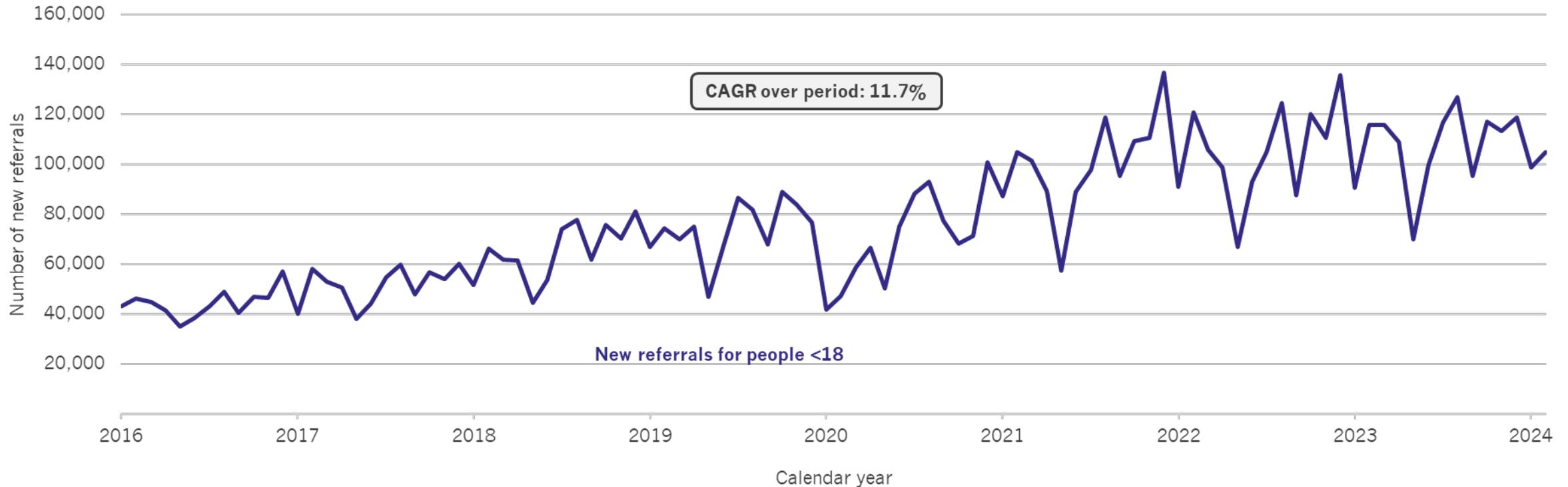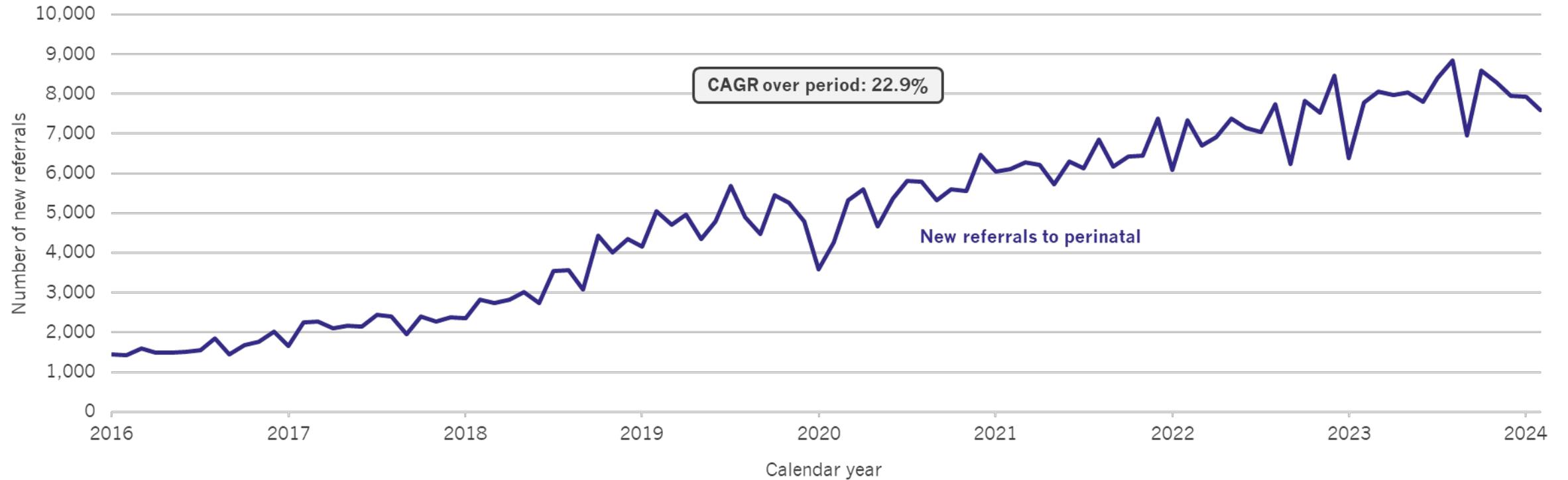

Notes: Prior to 2016/17 CYP were not recorded on a national dataset.

Source: NHS England. Mental Health Services Dataset.

# 6.3 Number of new referrals to perinatal mental health services

Figure II.6.3: New referrals to perinatal services (includes Specialist perinatal services and maternal mental health services)

CAGR over period: 22.9%

New referrals to perinatal

Source: NHS England, Mental Health Services Dataset.

6.4 People in contact with mental health services

Figure II.6.4: Number of people in contact with services in England, 2003-04 to 2022-23
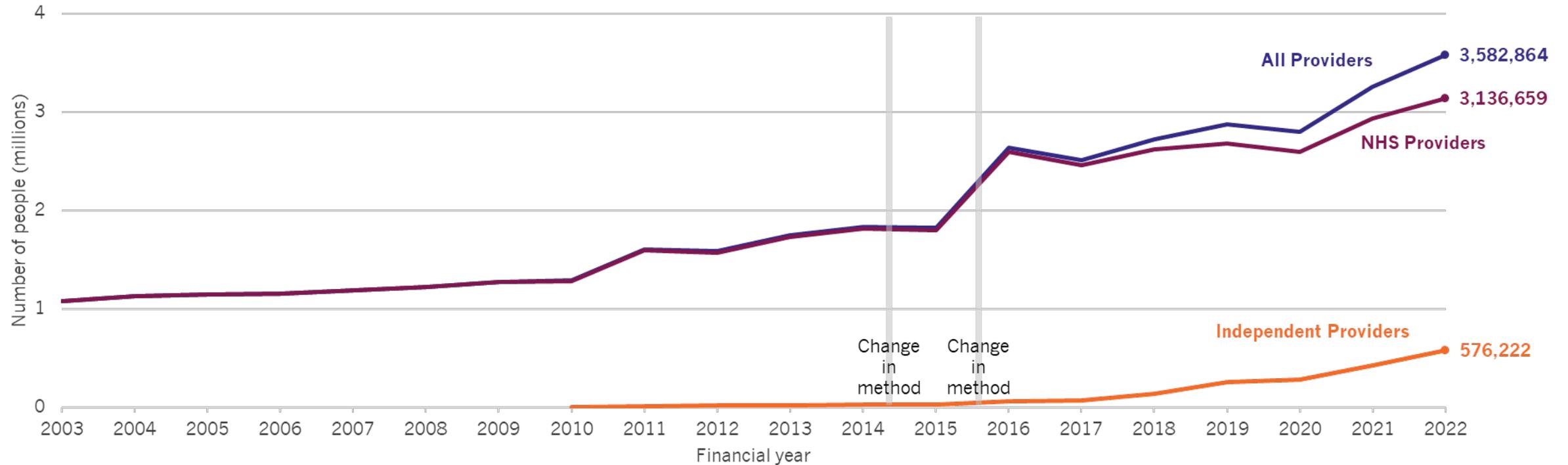

Notes: Includes learning disability services, autism services and dementia services. However, this is a recognised underestimate of all activity that takes place due to the complex nature of the Mental Health service provision (some mental health activity not captured such as crisis houses, 111 #MH options responses and indirect support, and inconsistent data quality and coverage). Data prior to 2014-15 didn't include children or learning disabilities and autism services. Data for 2014-15 and 2015-16 included learning disabilities and autism services but still excluded children. Data for 2016-17 includes all secondary mental health services

Source: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin

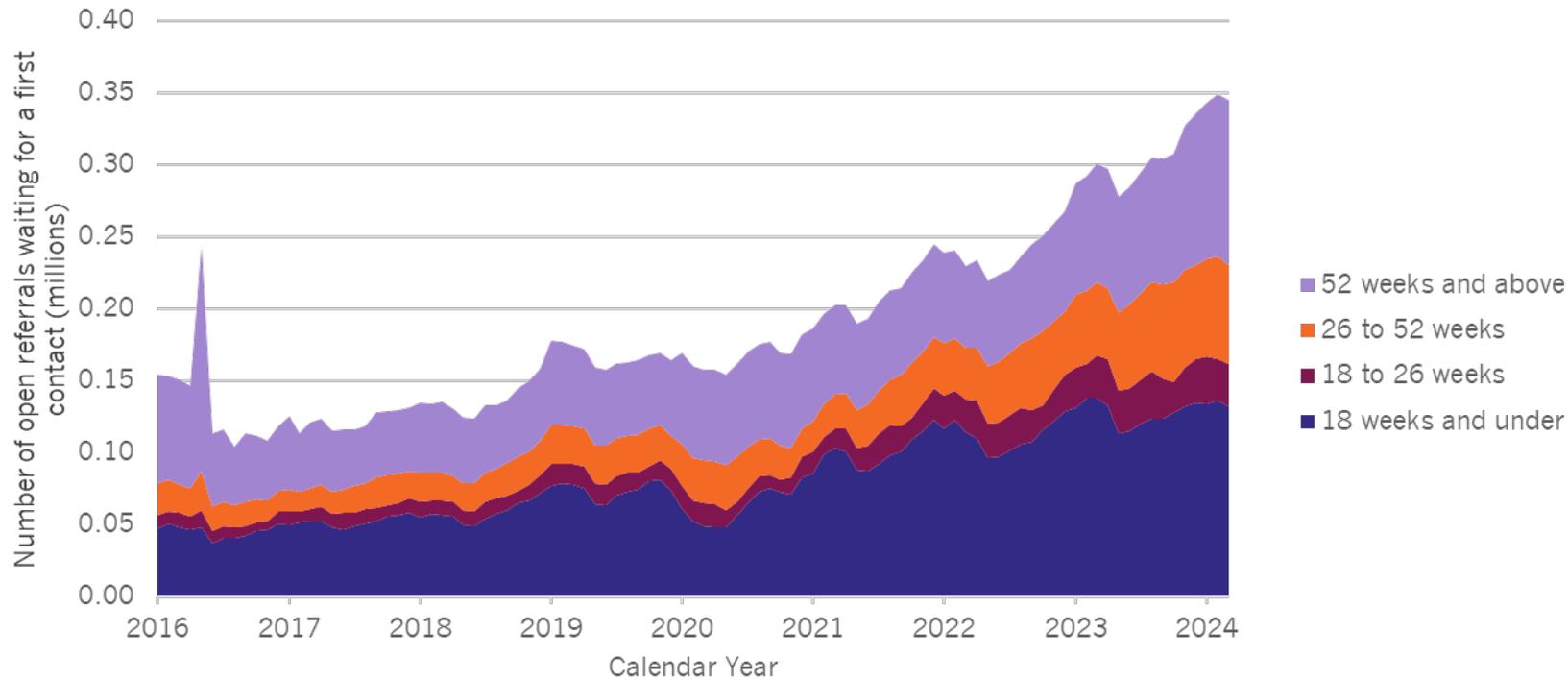# 6.5 Size of waiting lists for mental health by weeks waiting (all)

Figure II.6.5: Number of Open Referrals for people of all ages at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact
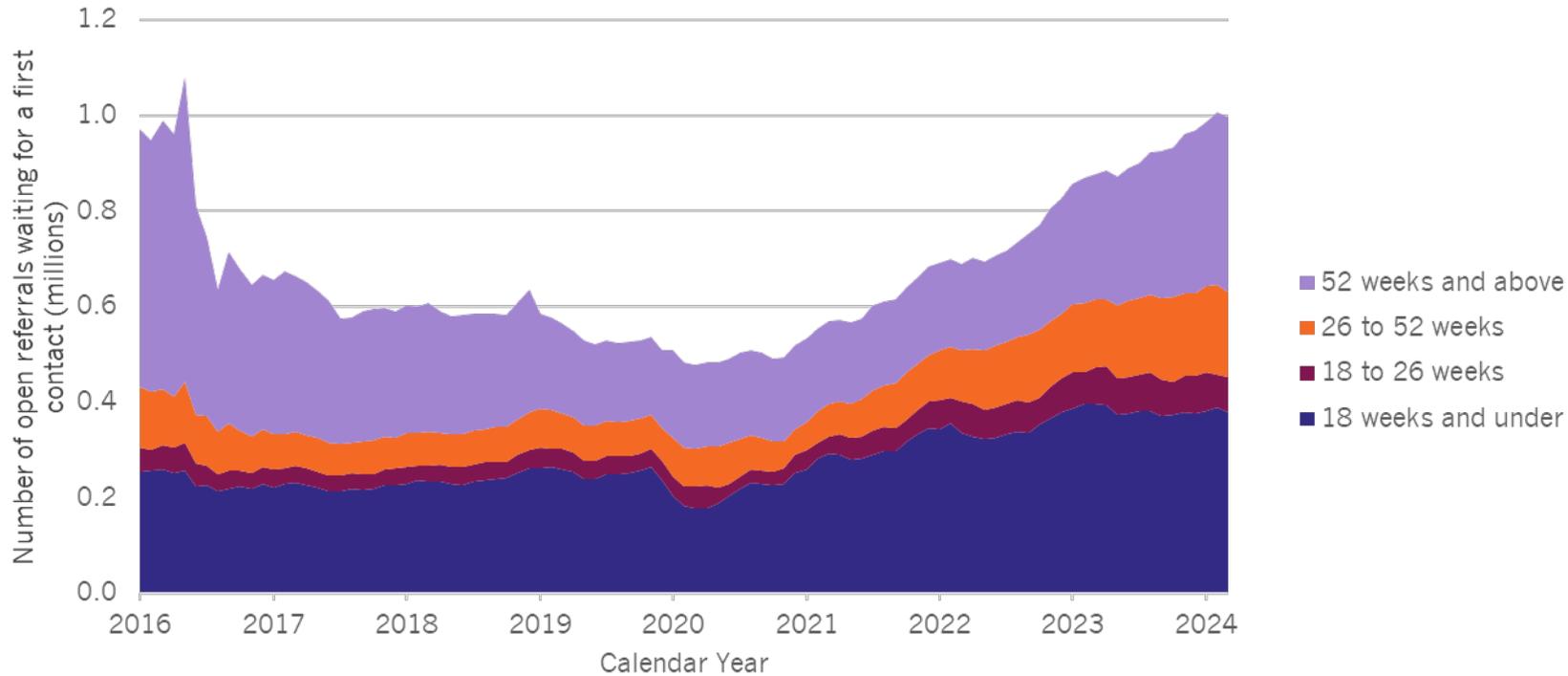
Waiting Time	Volume (Apr 24)
18 Weeks and Under	381,933
18 to 26 Weeks	79,362
26 Weeks to 52 Weeks	180,805
52 Weeks and Above	344,514

Source: NHS England. *Mental Health Services Dataset.*

6.6 Size of waiting lists for mental health services by weeks waiting (Under 18)
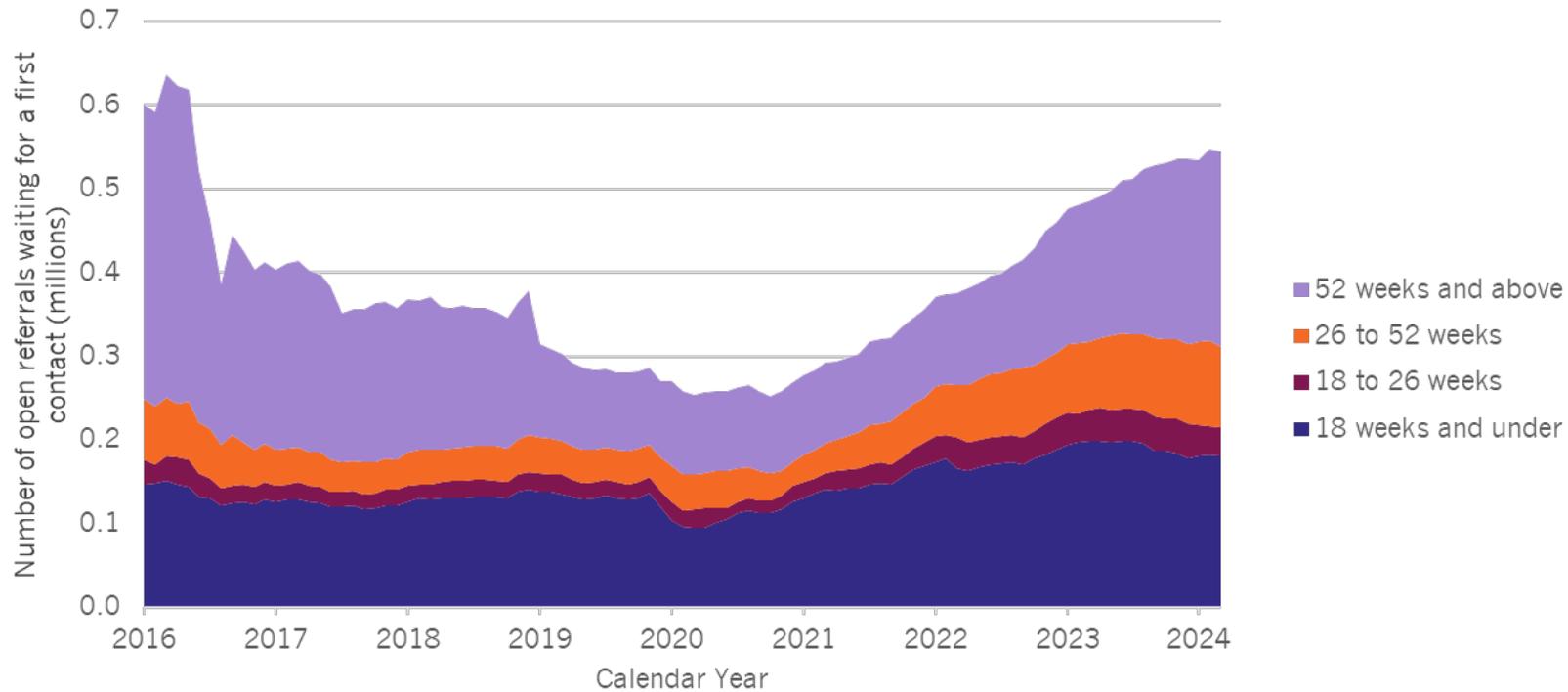
Figure II.6.6: Number of Open Referrals for people aged 0 to 17 at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact

Waiting Time	Volume (Apr 24)
18 Weeks and Under	133,327
18 to 26 Weeks	33,094
26 Weeks to 52 Weeks	68,354
52 Weeks and Above	108,635

Source: NHS England. *Mental Health Services Dataset.*

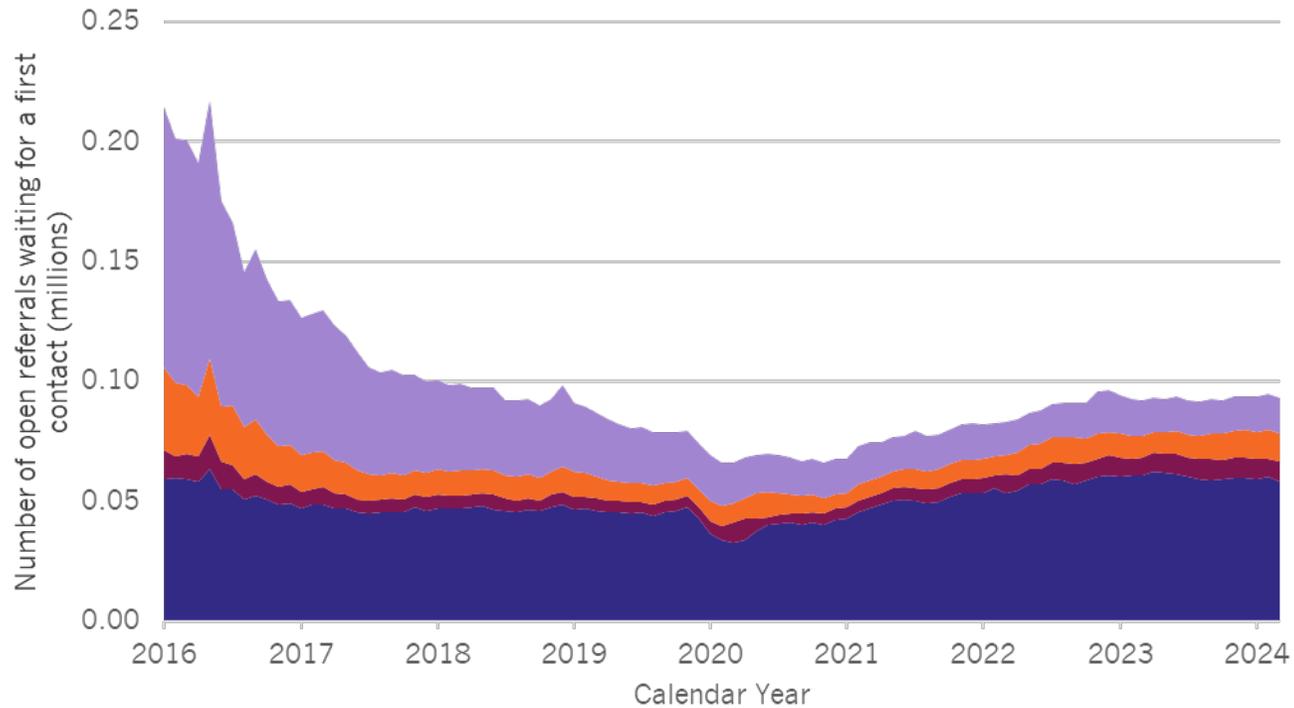# 6.7 Size of waiting lists for mental health by weeks waiting (18-64)

Figure II.6.7: Number of Open Referrals for people aged 18 to 64 at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact

Waiting Time	Volume (Apr 24)
18 Weeks and Under	180,576
18 to 26 Weeks	36,806
26 Weeks to 52 Weeks	99,070
52 Weeks and Above	217,974

Source: NHS England. *Mental Health Services Dataset*

# 6.8 Size of waiting lists for mental health by weeks waiting (65+)

Figure II.6.8: Number of Open Referrals for people aged 65 and over at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact

Waiting Time	Volume (Apr 24)
18 Weeks and Under	59,394
18 to 26 Weeks	8,276
26 Weeks to 52 Weeks	11,294
52 Weeks and Above	14,603

Source: NHS England. *Mental Health Services Dataset.*

6.9 Size of waiting lists for mental health by weeks waiting (CORE20 Aged 18+)

Figure II.6.9: Number of Open Referrals for people classed as CORE20 aged 18 and over at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for contact
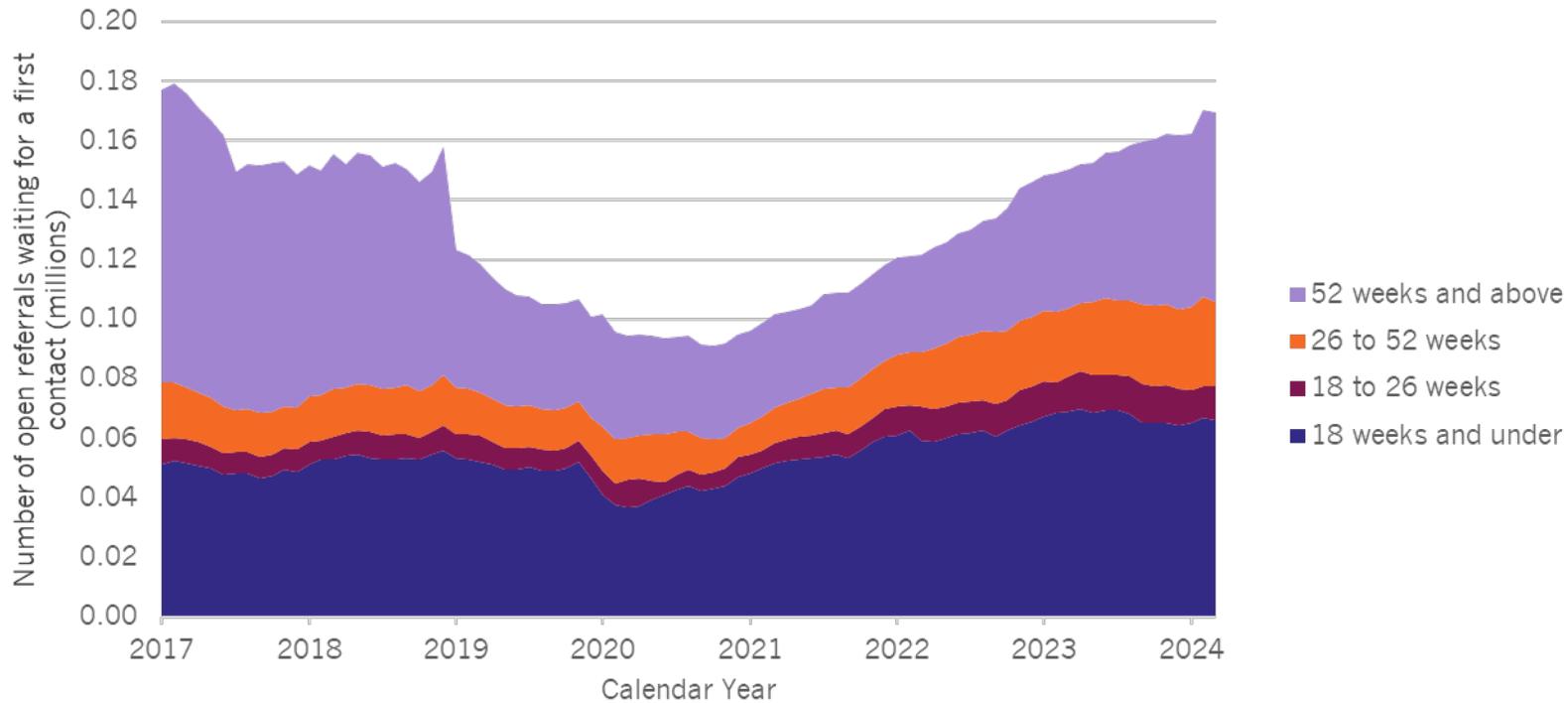
Waiting Time	Volume (Apr 24)
18 Weeks and Under	65,059
18 to 26 Weeks	11,119
26 Weeks to 52 Weeks	27,776
52 Weeks and Above	58,443

Source: NHS England. *Mental Health Services Dataset*

6.10 Patients on waiting lists for adult ADHD assessments and number in 2023

Figure II.6.10: Implied clearance time for adult ADHD assessments based on activity and wait list size (based on 44 providers, in England, Wales and Scotland)
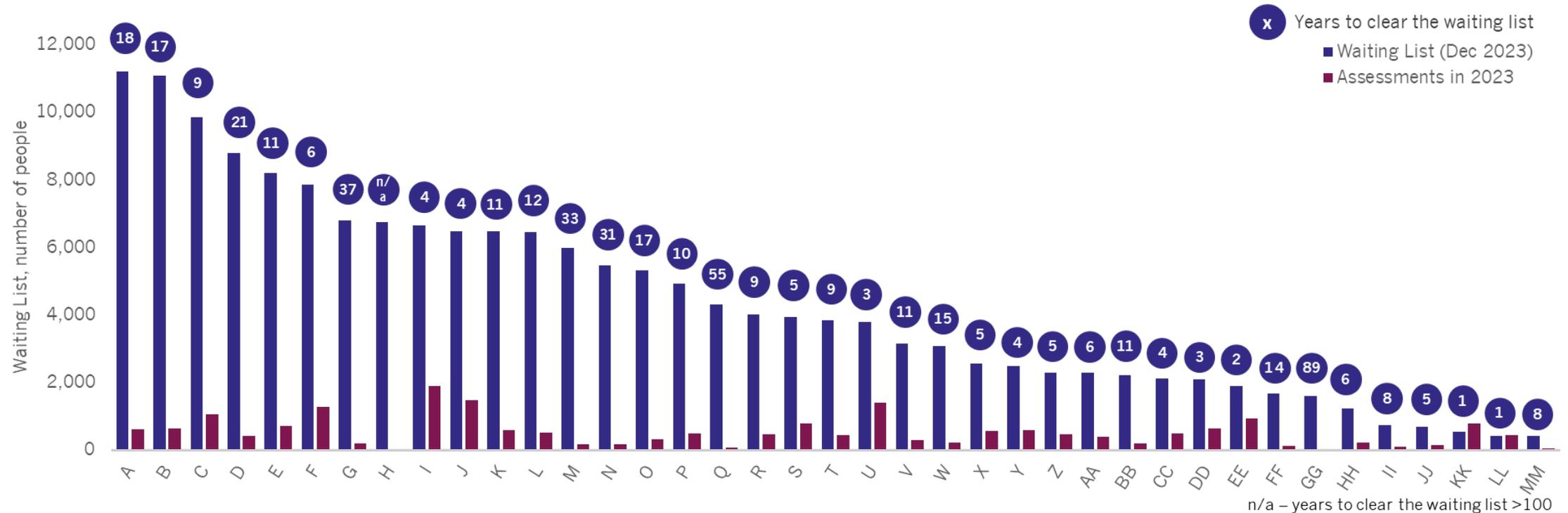

Notes: x-axis represents 44 anonymised providers in England. This data should be treated with caution – there is no official list of NHS adult ADHD service providers in England. This is based on data returned from an FOI sent by the BBC from 44 providers and of those providers 5 are not in England. Inconsistencies are expected in the methodology used in measuring actual or estimated waiting times.

Source: Carnall Farrar analysis of BBC Freedom of Information data https://www.bbc.co.uk/news/articles/c0dm20k491wo (accessed September 2024)

6.11 Neurodevelopmental conditions (excluding Autism) referrals since 2018

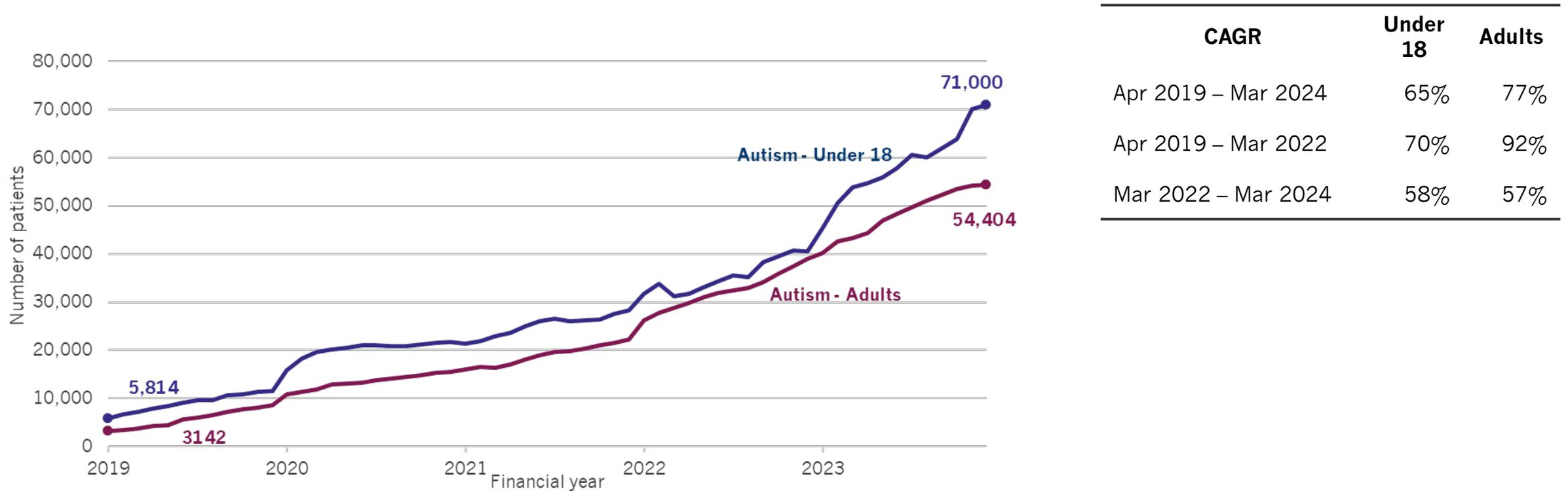**Figure II.6.11: Reported (known) case load without appointment over time**
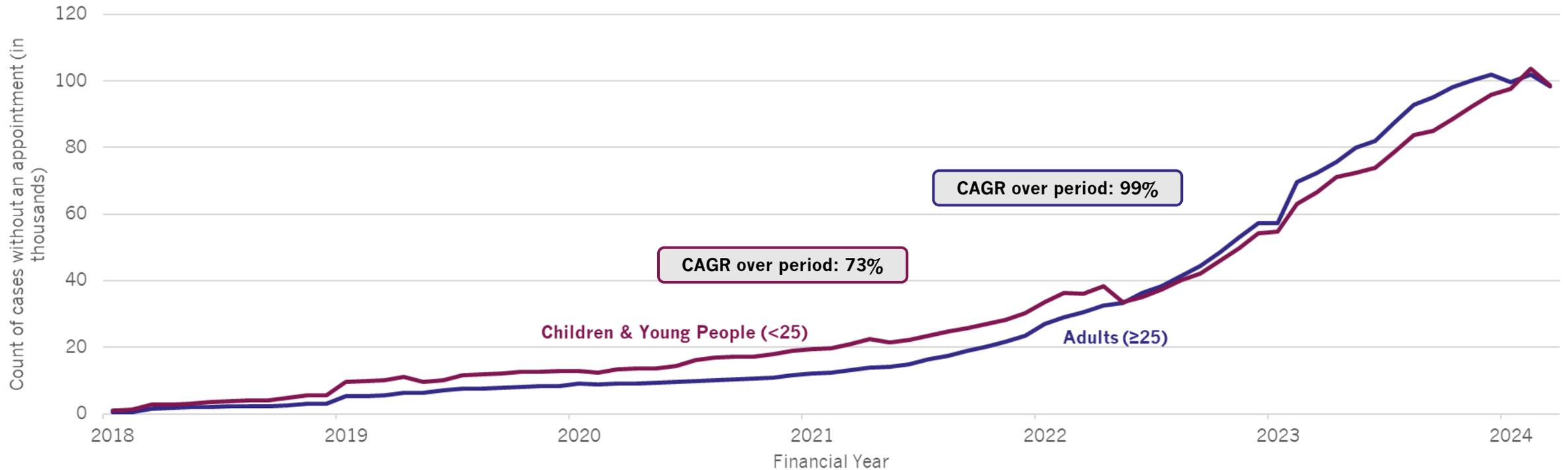
Notes: Referrals without an outpatient appointment for Neurodevelopmental Conditions excluding Autism (including ADHD, dyslexia, dyspraxia and Tourette's) for any providers submitting data since 2017 (Source: MHSDS data). The vast majority will be for ADHD. Data is not included from community health services, so this likely understates the true numbers of waiting referrals for ADHD.

Source: NHS England, Mental Health Services Data Set

6.12 Waiting times for autism assessment for adults and children and young people

Figure II.6.12: Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, April 2019 to March 2024


CAGR	Under 18	Adults
Apr 2019 – Mar 2024	65%	77%
Apr 2019 – Mar 2022	70%	92%
Mar 2022 – Mar 2024	58%	57%

Notes: Only children and young people referred to CAMHS services are in scope of the MHSDS and included in the autism data. Referrals and diagnoses of autism in child development services, which comprise the majority of autism referrals for young children in the UK, are out of scope of the MHSDS and excluded in these statistics. NHS England does not have a full list of in-scope providers of autism diagnostic services, and it is therefore very likely that some providers of autism services may not be submitting autism data to MHSDS even though they are providing these services.

Source: NHS England, Mental Health Services Data Set. Available: https://digital.nhs.uk/data-and-information/publications/statistical/autism-statistics

6.13 Waiting list for talking therapies

Figure II.6.13: Monthly average number of referrals yet to have a first treatment at the end of reporting month (by year)
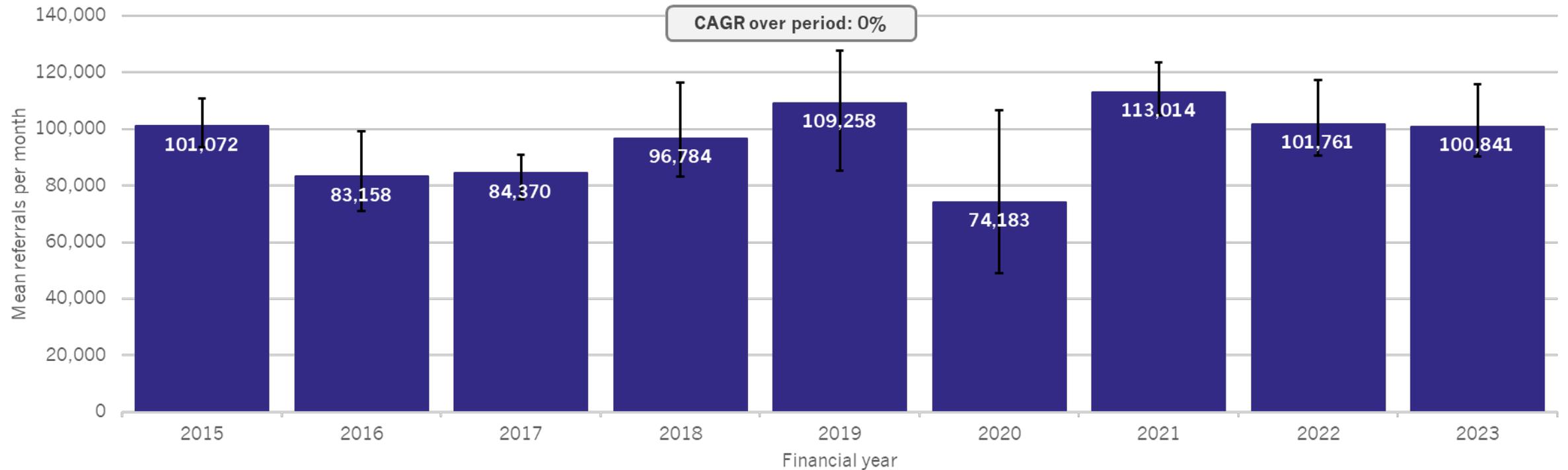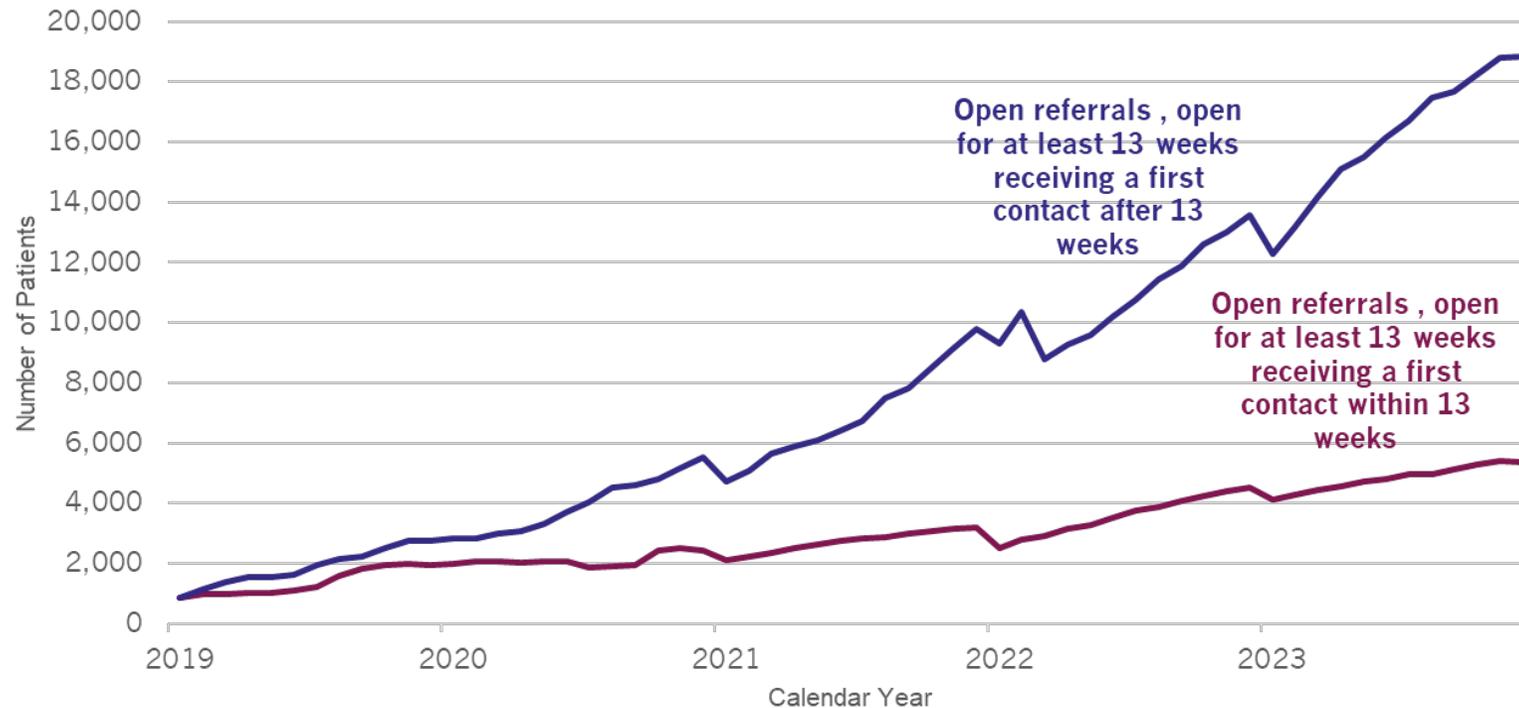

Notes: Bars indicate maximum and minimum monthly referrals in that financial year

6.14 Waiting times for autism assessment for children and young people: patients with a first contact

Figure II.6.14: Number of under 18s with a referral for suspected autism, open for at least 13 weeks, with a first contact, April 2019 to March 2024

| GAGR	Open referrals receiving a first contact within 13 weeks	Open referrals receiving a first contact after 13 weeks
2019/20 – 2023/24	59%	117%

Notes: Only children and young people referred to CAMHS services are in scope of the MHSDS and included in the autism data. Referrals and diagnoses of autism in child development services, which comprise the majority of autism referrals for young children in the UK, are out of scope of the MHSDS and excluded in these statistics.

NHS England does not have a full list of in·scope providers of autism diagnostic services, and it is therefore likely that some providers of autism services may not be submitting autism data to MHSDS even though they are providing these services.

Source: NHS England, Mental Health Services Data Set

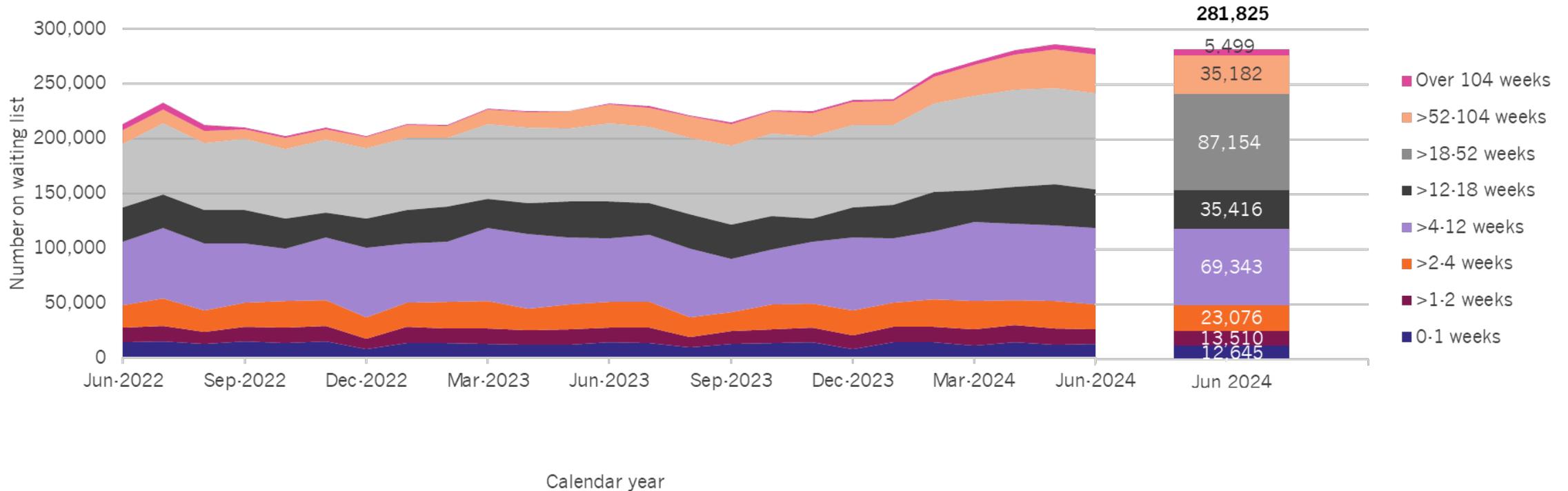# 7.1 Size of community health services waiting list, by weeks waiting (all)

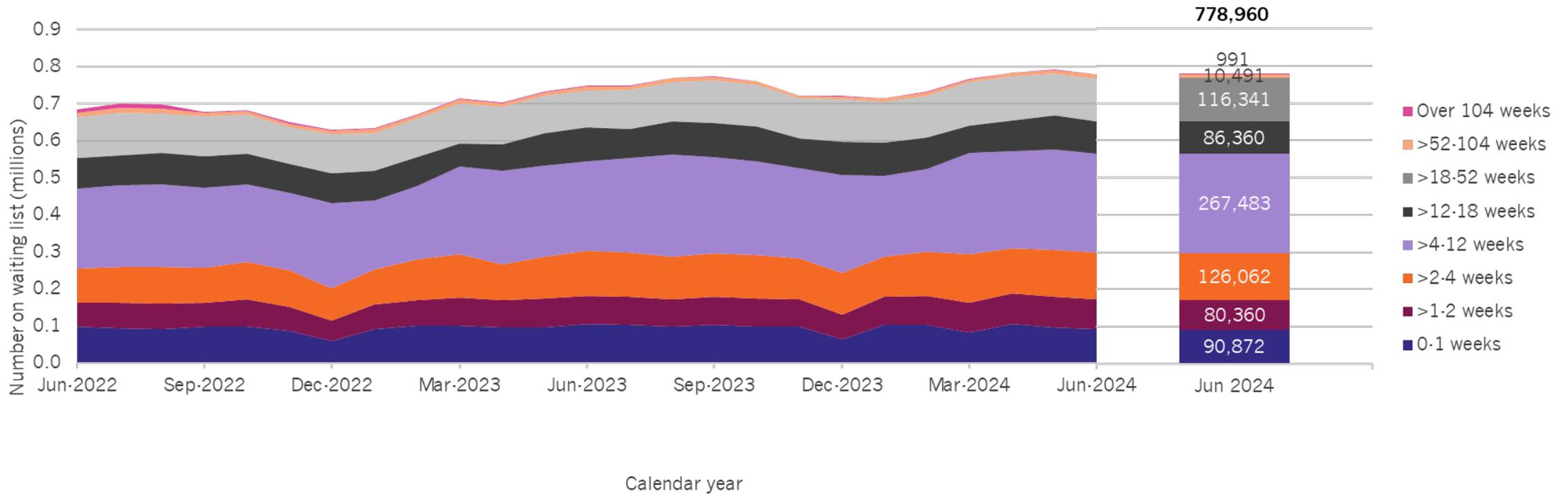**Figure II.7.1: Total community health services waits by waiting times, Jun 2022- June 2024**
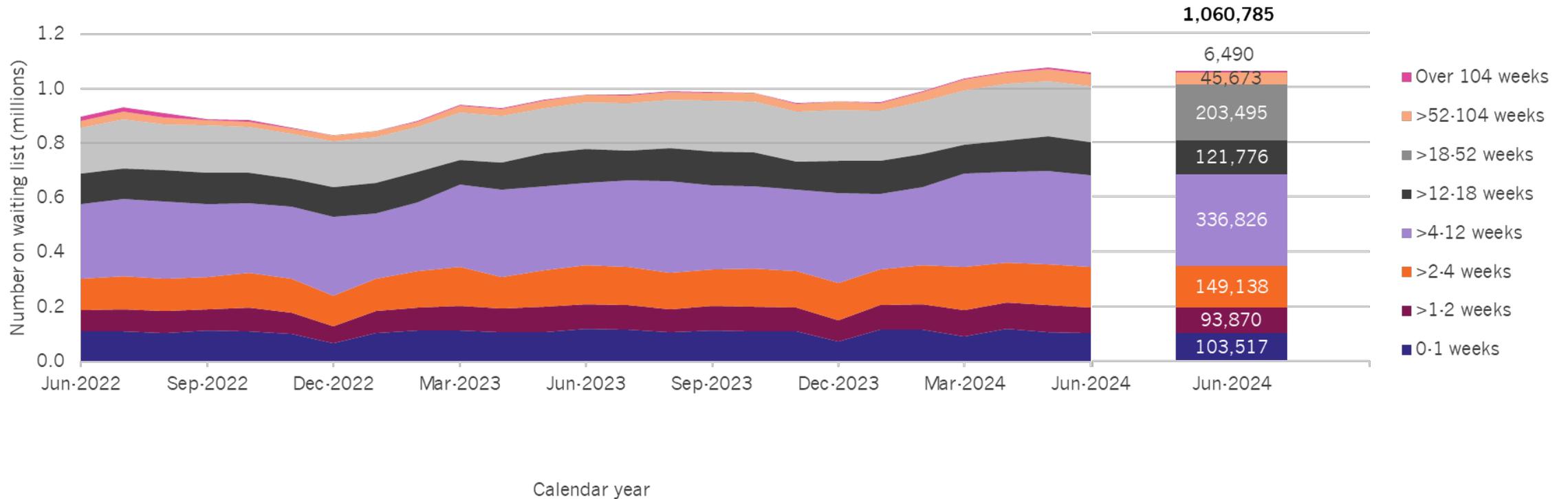
Source: Community health service waiting lists. Available: Statistics » Community Health Services Waiting Lists (england.nhs.uk)

7.2 Size of community health services waiting list, by weeks waiting (children and young people)

Figure II.7.2: Total CYP community health services waits by waiting times, Jun 2022 - June 2024

Source: Community health service waiting lists. Available: Statistics » Community Health Services Waiting Lists (england.nhs.uk)

7.3 Size of community health services waiting list, by weeks waiting (all adults)
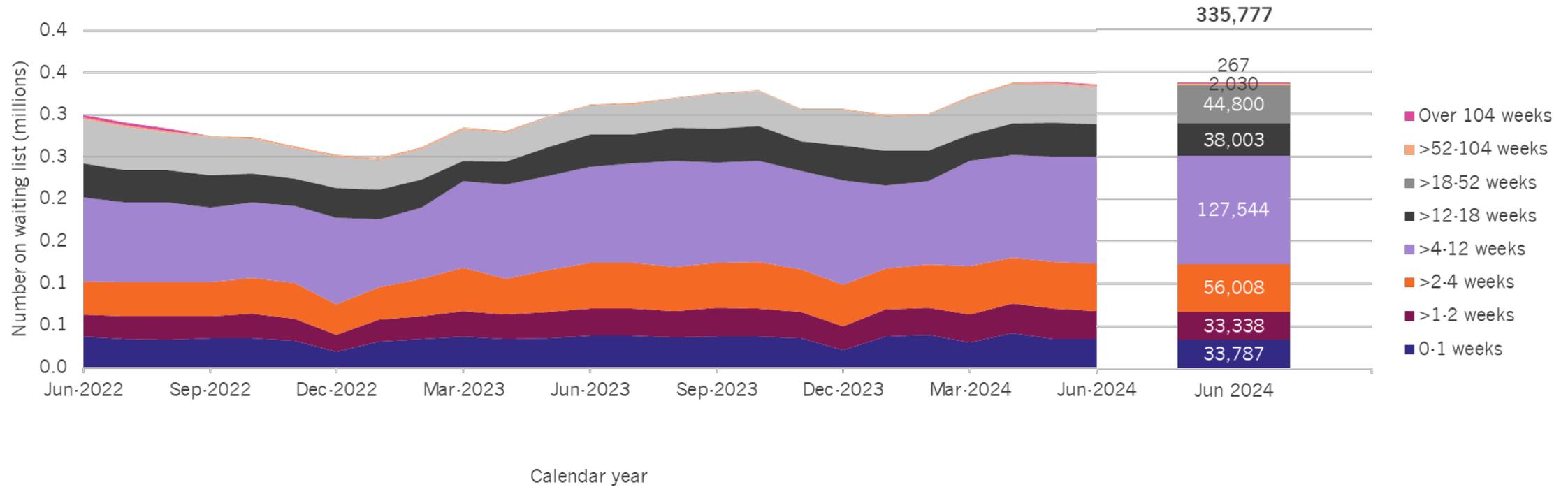
Figure II.7.3: Total adult community health services waits by waiting times, Jun 2022 - June 2024

Source: Community health service waiting lists. Available: Statistics » Community Health Services Waiting Lists (england.nhs.uk)

7.4 Size of waiting lists for MSK services by weeks waiting (working age adults)

Figure II.7.4: Total Adult Musculoskeletal services waits by waiting times, Jun 2022 - June 2024

Source: Community health service waiting lists. Available: Statistics » Community Health Services Waiting Lists (england.nhs.uk)

8.1 Patient satisfaction with accident and emergency services

Figure II.8.1: Public satisfaction with NHS Accident and Emergency Services, 2001-2023
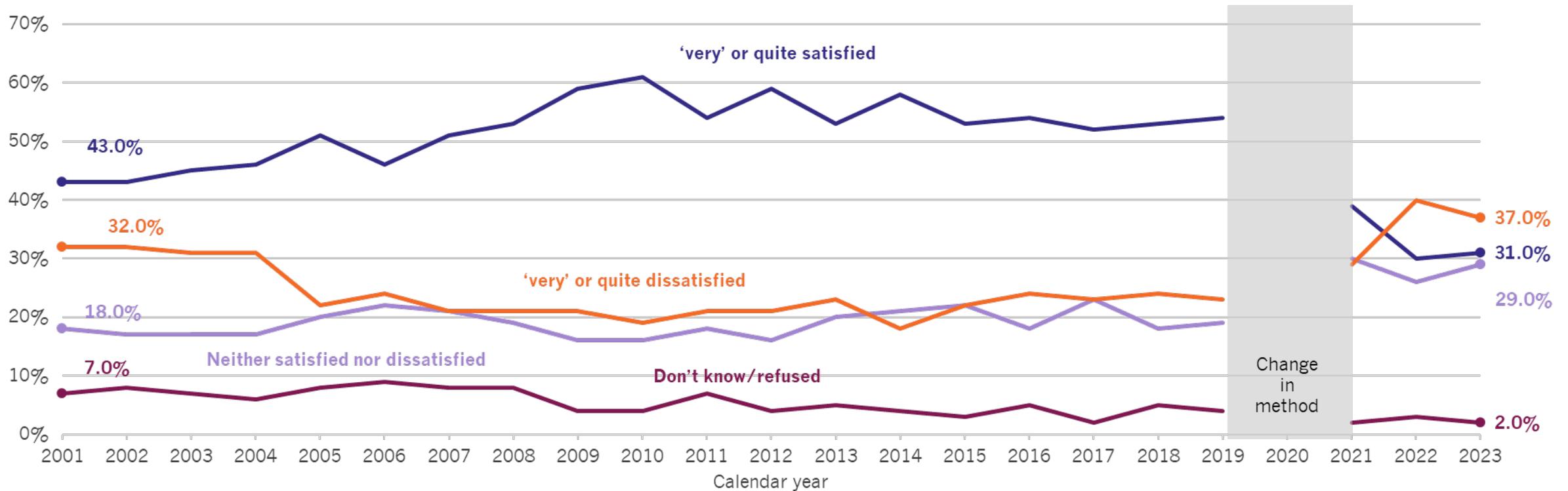

Notes: Question asked: ''From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays. Accident and emergency departments?'. This question was not asked in 2020. Data has been weighted to minimize differences due to the change in methodology between 2021 and previous years.

Source: The King's Fund and Nuffield Trust analysis of NatCen's BSA survey data: available at
https://assets.kingsfund.org.uk/f/256914/x/48c40ea52b/public_satisfaction_nhs_social_care_2023_bsa_2024.pdf#page=4

# 8.2 Ambulance response times by category

Figure II.8.2: Category 1 to 4 ambulance response times, England
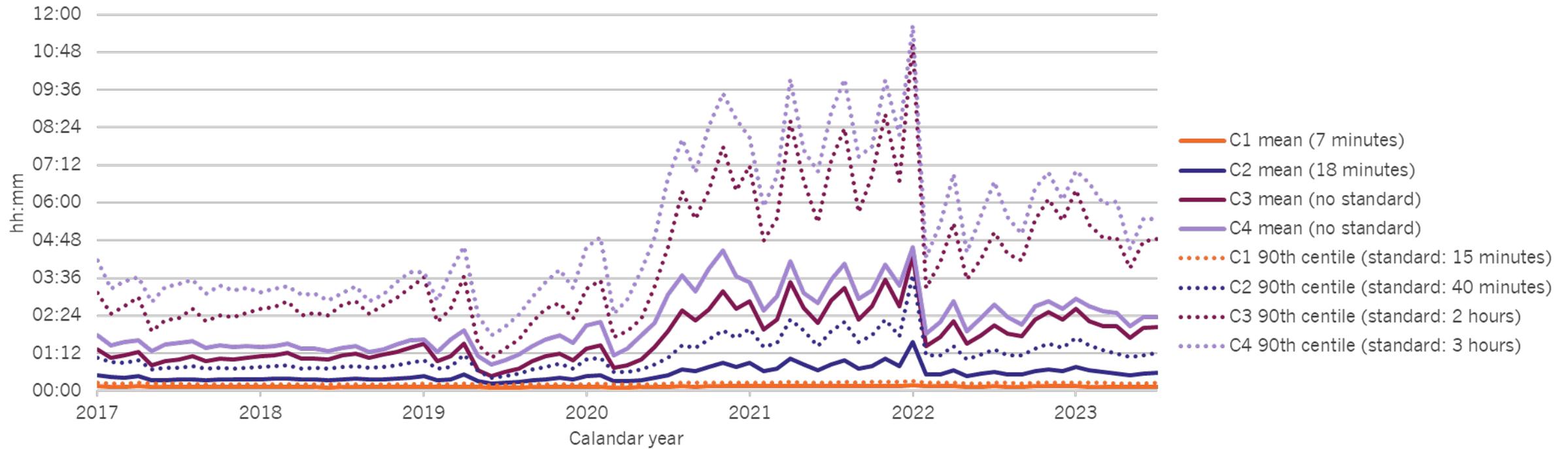
Source: NHS England Ambulance Quality Indicators. Available: www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators
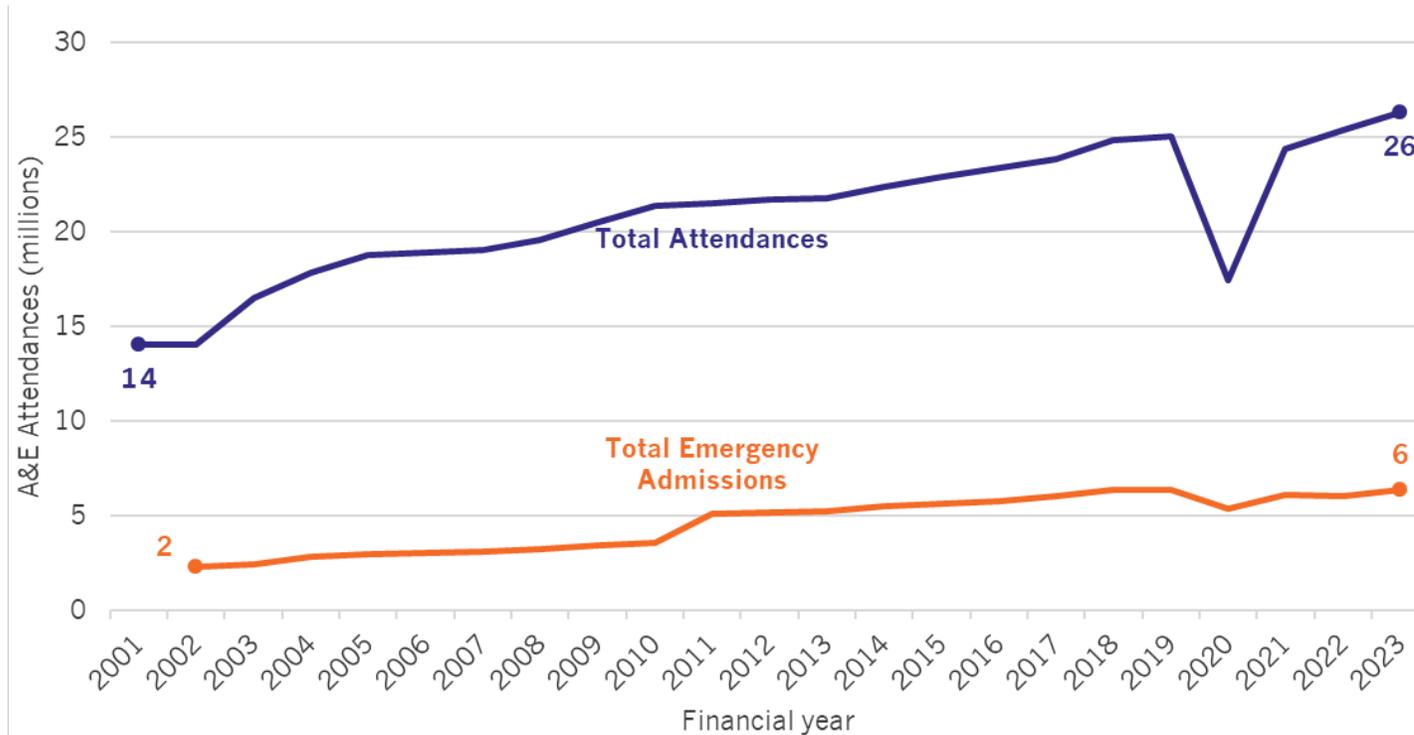
8.3 Demand for emergency care

Figure II.8.3: Accident and Emergency Attendances and Admissions via Emergency Department per 1,000 population since 2010
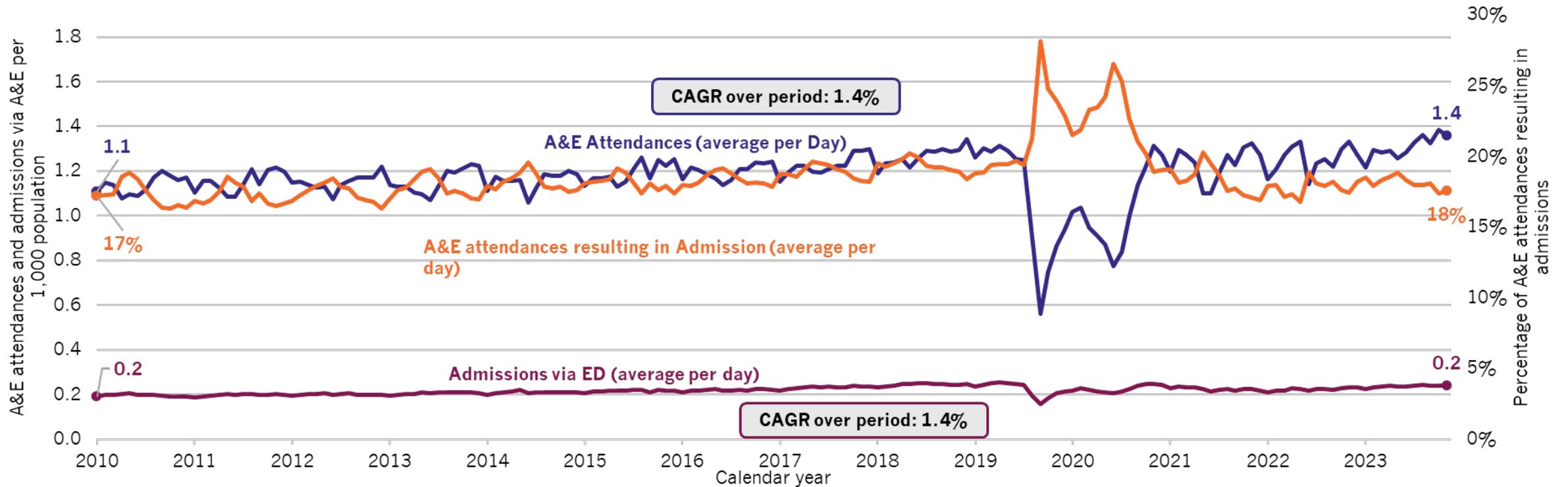
8.4 Activity in emergency departments

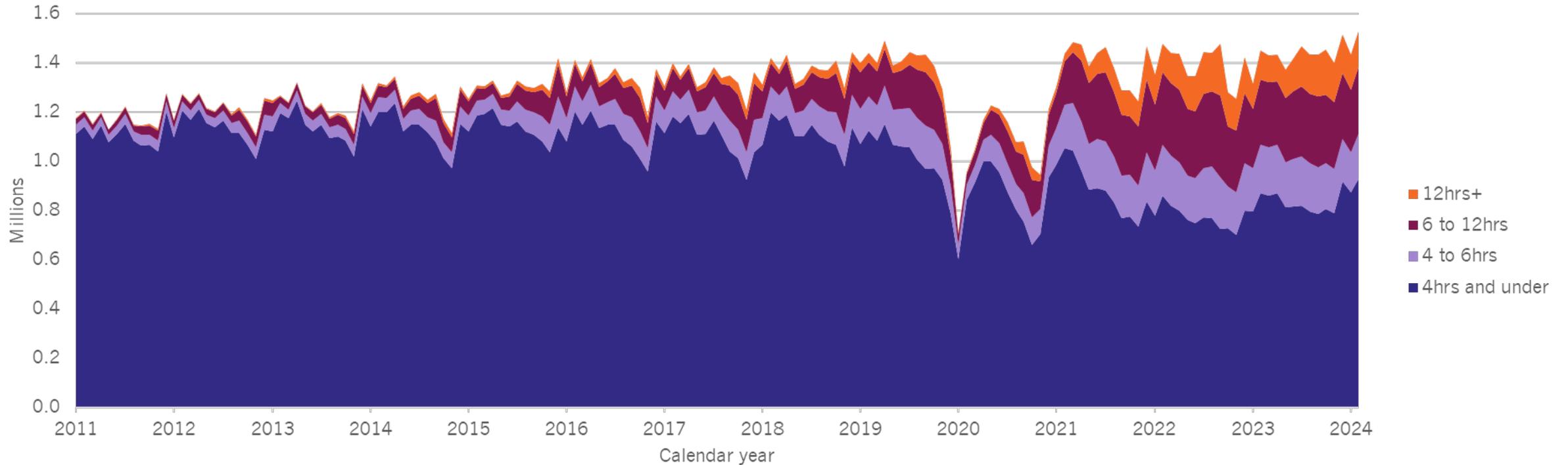**Figure II.8.4: Total Accident & Emergency Attendances and Emergency Admissions (per annum)**

CAGR	Attendances	Total Emergency Admissions
2001 - 2005	7.5%	8.9%
2005 - 2010	2.7%	3.8%
2010 – 2015	1.4%	9.7%
2015 – 2019	2.2%	3.2%
2019 – 2021	-1.3%	-2.3%
2022 - 2023	3.8%	4.8%

Notes: *CAGR for total emergency admissions under 2001-2005 based on data for the period 2002/3 to 2005/6No data for period 2001/2002 Admissions via a type 2 or type 3 emergency department collected from 2004/05, and admissions not via the emergency department collected from 2011/12 onwards. Urgent care activity was impacted by the Covid-19 pandemic. In 2020/21, A&E attendances and total emergency admissions fell by 30.3% and 16.4% respectively from the previous year. Data from 2011/12 to 2015/16 Q1 is based on an aggregate of weekly data so annual figures are considered estimates. Emergency admissions data available from 2002/03. Admissions via a type 2 or type 3 emergency department collected from 2004/05, and admissions not via the emergency department collected from 2011/12 onwards.
Source: KH09 data used for 2001/02, QMAE data used from 2002/03 to 2010/11, WSitAE data used from 2011/12 to June 2015, and MSitAE used from July 2015 onwards.

8.5 Accident & Emergency attendances by duration of waits

Figure II.8.5: Total A&E attendances by duration of waiting time (monthly)
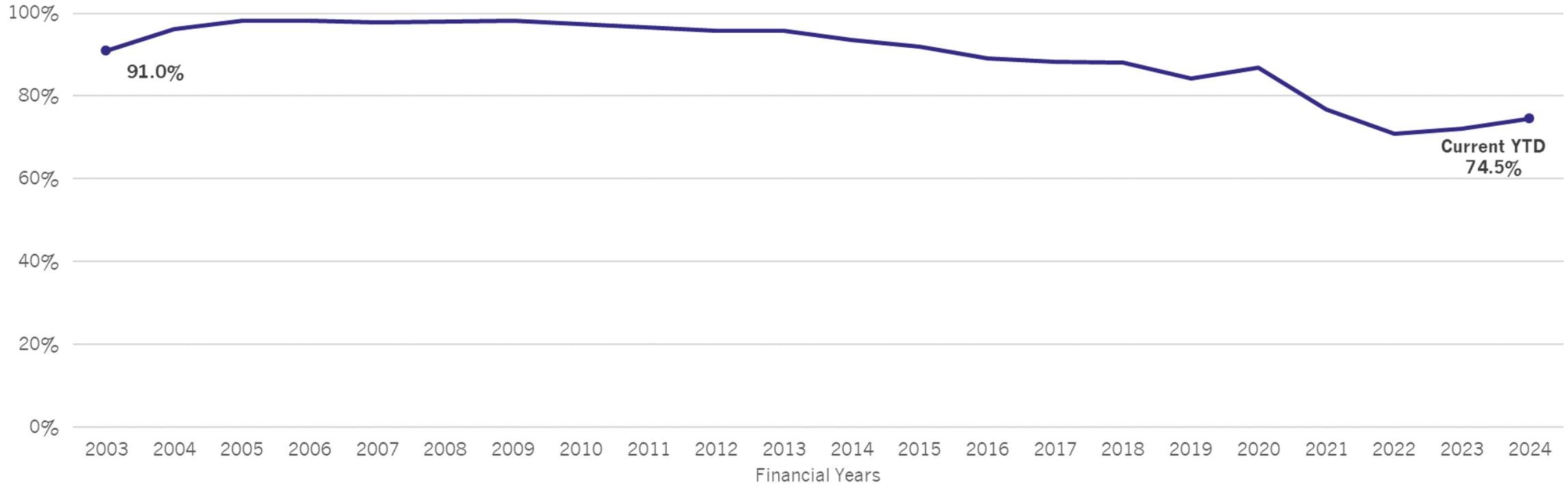

Notes: Data from type 1 and type 2 emergency departments.

Source: NHS England, A&E CDS and ECDS

8.6 All Types Accident & Emergency 4 Hour Performance

Figure II.8.6: Percentage of attendances admitted, transferred or discharged within 4 hours of arrival at A&E
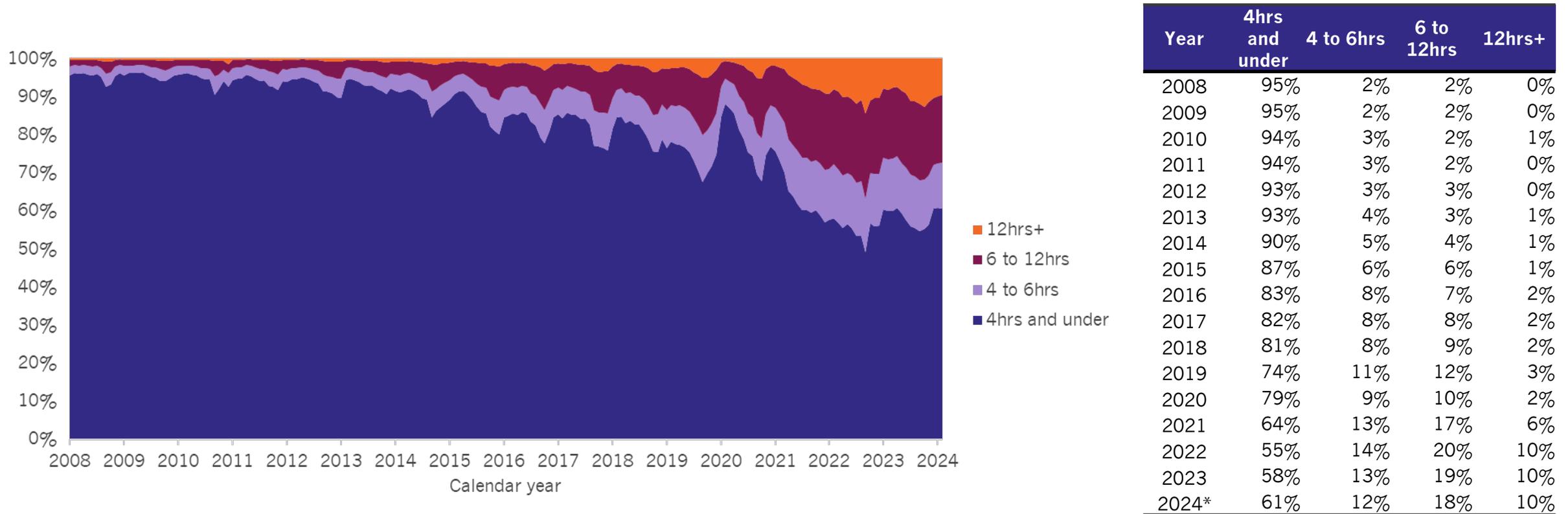

Notes: The UEC Clinical Review of Standards commenced in May 2019 and ended in May 2023. During this time the 14 Acute Trusts participating in the UEC CRS programme were not required to submit performance data to NHS England. Care should be taken when comparing performance during this period to other years as the national figures are not comparable. QMAE data is used from 2002-03 to 2010-11. WSitAE data is used from 2011-12 to June 2015. MSitAE data is used from July 2015 onwards. Yearly figures from 2011-12 to Quarter 1 2015/16 are based on weekly data and therefore considered estimates. Please note that 2024/25 is a current year to date figure for the period April 2024 to July 2024.

Source: *NHS England* Monthly A&E Attendances and Emergency Admissions Monthly Return Available: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

# 8.7 Proportion of A&E attendances by duration of waits

Figure II.8.7: Percentage of Type 1 and Type 2 A&E attendances by duration of waiting time

Year	4hrs and under	4 to 6hrs	6 to 12hrs	12hrs+
2008	95%	2%	2%	0%
2009	95%	2%	2%	0%
2010	94%	3%	2%	1%
2011	94%	3%	2%	0%
2012	93%	3%	3%	0%
2013	93%	4%	3%	1%
2014	90%	5%	4%	1%
2015	87%	6%	6%	1%
2016	83%	8%	7%	2%
2017	82%	8%	8%	2%
2018	81%	8%	9%	2%
2019	74%	11%	12%	3%
2020	79%	9%	10%	2%
2021	64%	13%	17%	6%
2022	55%	14%	20%	10%
2023	58%	13%	19%	10%
2024*	61%	12%	18%	10%

Notes: 2024 is year to date data (indicated by * in the summary table). A&E CDS has data quality and coverage issues between 2008 and 2010, however, the distribution is comparable to later years. Covers Type 1 and Type 2 Emergency Departments only.

Source: NHS England, A&E CDS and ECDS

8.8 A&E waiting times (infants 0-2 years)

Figure II.8.8: A&E Waiting Times - Infants 0 to 2 years old (April 2008 to June 2024)
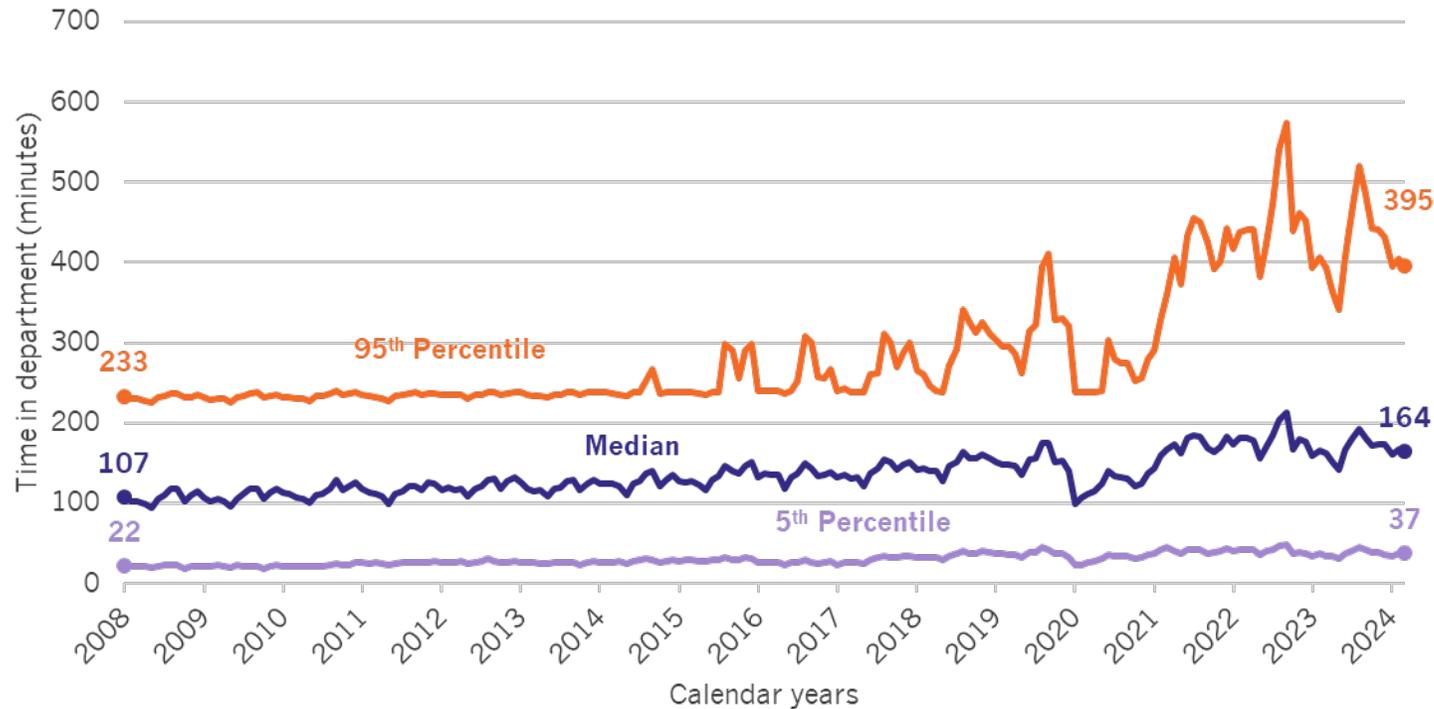
CAGR	5th percentile	Median	95th Percentile
2008-2011	5.7%	2.4%	0.3%
2011-2015	3.6%	3.6%	1.0%
2015-2019	6.1%	3.5%	7.9%
2019-2021	3.9%	5.0%	10.3%
2021-2023	-3.7%	-0.3%	3.5%

Total number of children waiting 2023/2024	
> 4 hours	245,375
> 6 hours	102,664

Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 5 days (suspected data quality issue). Also excludes streamed activity.

Source: NHS England, A&E CDS and ECDS

8.9 A&E waiting times (children 3-17 years)

Figure II.8.9: A&E Waiting Times – Children 3 to 17 years old (April 2008 to June 2024)
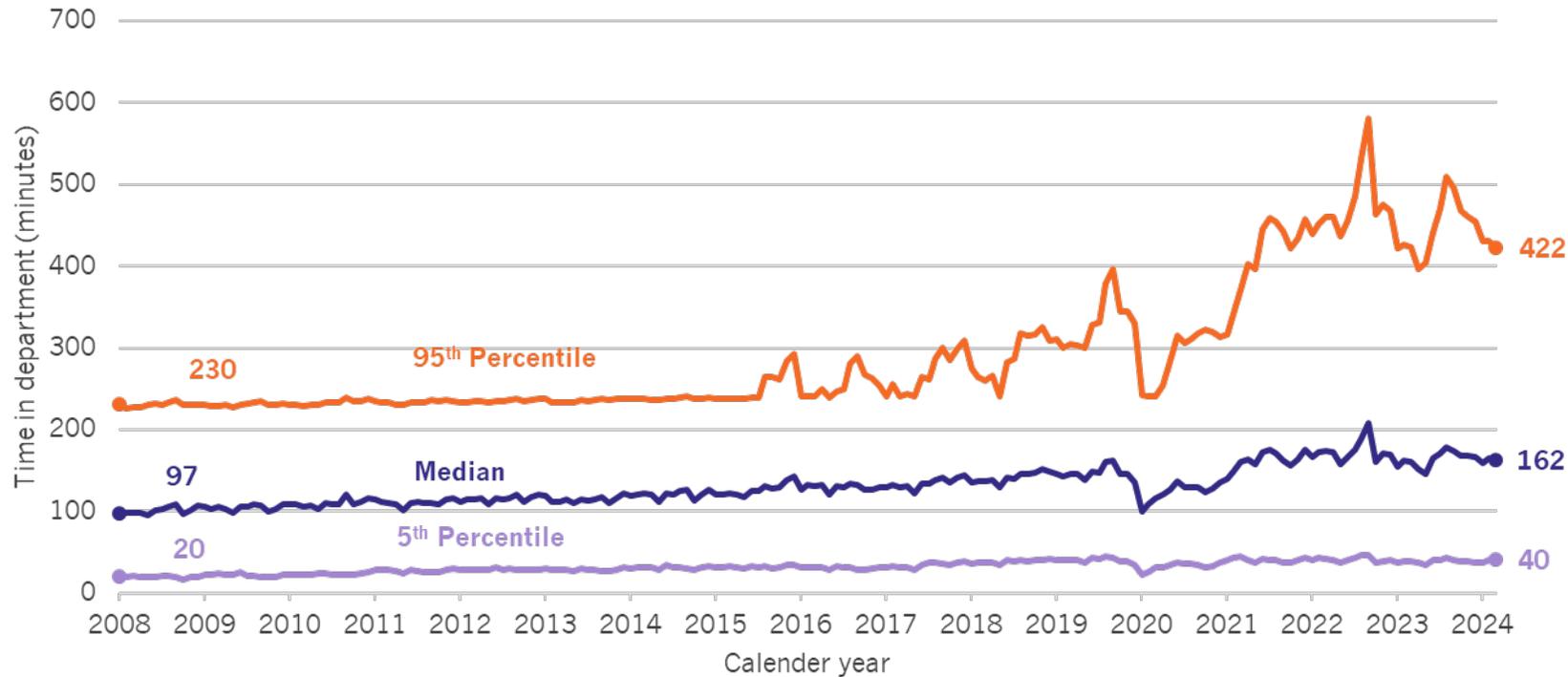
CAGR	5th percentile	Median	95th Percentile
2008-2011	10.5%	2.9%	0.3%
2011-2015	4.3%	3.4%	0.6%
2015-2019	6.4%	3.7%	8.5%
2019-2021	0.0%	5.0%	11.8%
2021-2023	-2.5%	0.6%	4.0%

Total number of children waiting 2023/2024

>4 hours	499,779
> 6 hours	224,150

Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 5 days (suspected data quality issue). Also excludes streamed activity.

Source: NHS England A&E CDS and ECDS

8.10 A&E waiting times (adults 18-64 years)

Figure II.8.10: A&E waiting times – Adults 18 to 64 years old (April 2008 to June 2024)
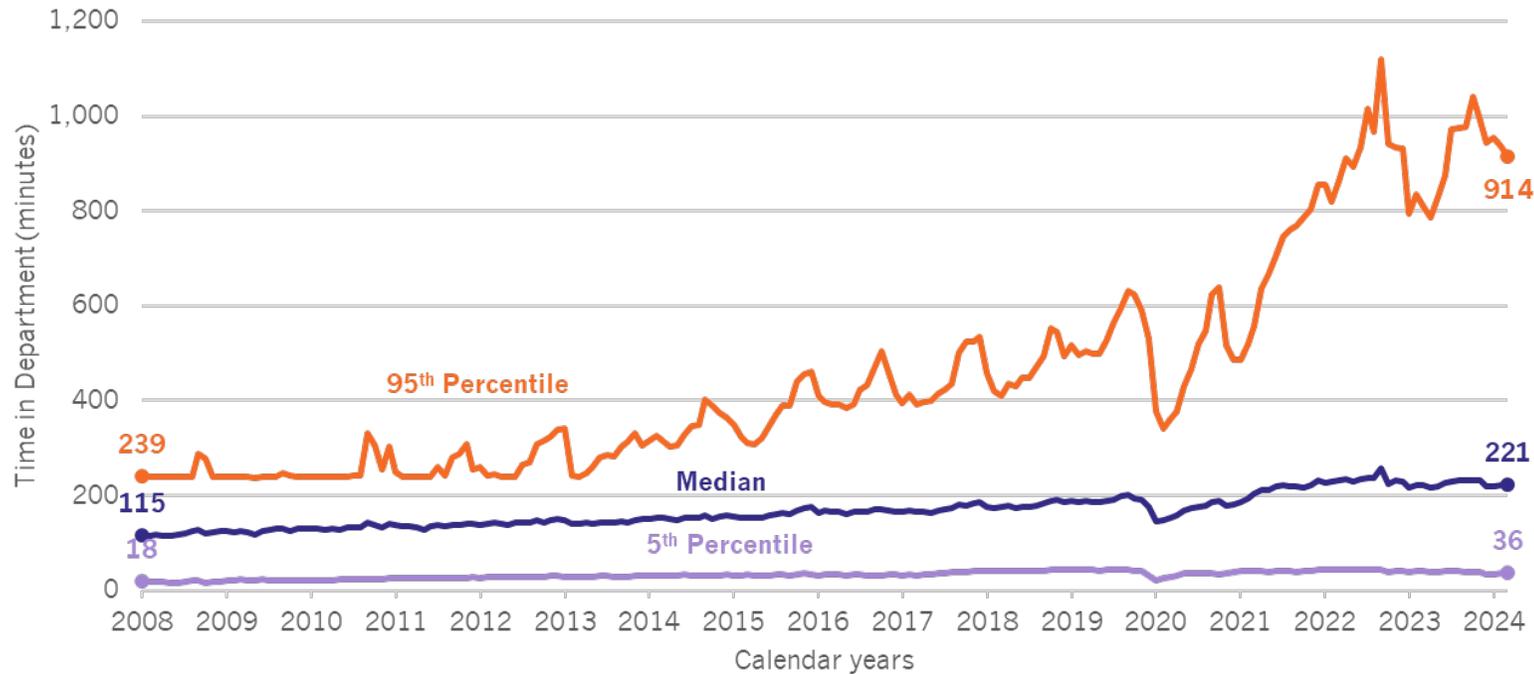
CAGR	5th percentile	Median	95th Percentile
2008-2011	11.0%	4.0%	1.6%
2011-2015	5.3%	4.1%	10.6%
2015-2019	7.0%	4.4%	9.8%
2019-2021	-1.2%	5.6%	12.5%
2021-2023	-2.5%	3.0%	14.0%

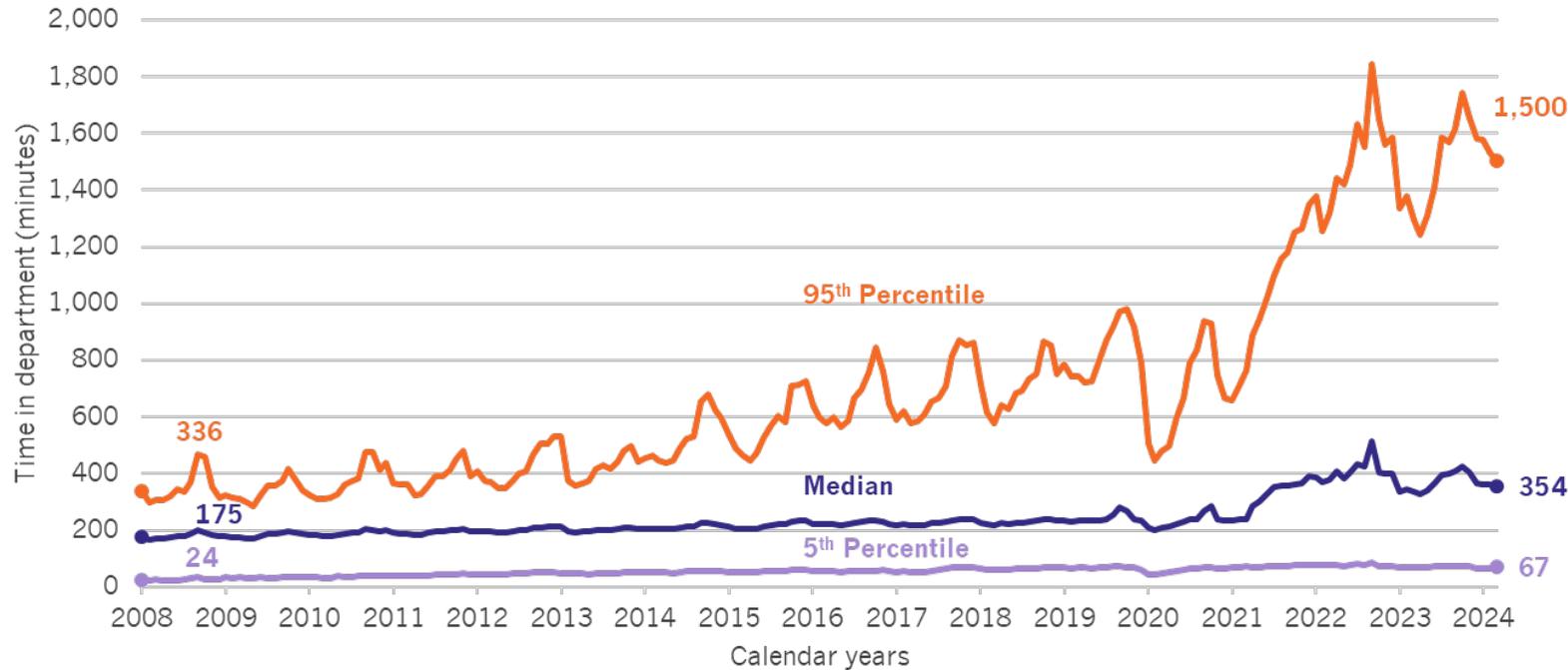| Total number of adults waiting 2023/2024	
>4 hours	3,412,611
> 6 hours	2,240,697

Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 5 days (suspected data quality issue). Also excludes streamed activity.

Source: NHS England A&E CDS and ECDS

8.11 A&E waiting times (adults 65 years and older)

Figure II.8.11: A&E waiting times – Adults 65 years and older (April 2008 to June 2024)

CAGR	5th percentile	Median	95th Percentile
2008-2011	15.9%	1.8%	1.5%
2011-2015	6.5%	3.0%	10.9%
2015-2019	5.9%	2.2%	9.6%
2019-2021	2.9%	14.2%	11.8%
2021-2023	-1.4%	9.1%	18.8%

Total number of adults 65+ waiting 2023/2024	
> 4 hours	2,702,866
> 6 hours	2,104,839

Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 5 days (suspected data quality issue). Also excludes streamed activity.

Source: NHS England, A&E CDS and ECDS

8.12 A&E waiting times (CORE20 and rest of population)

Figure II.8.12: A&E Waiting Times - Index of Multiple Deprivation Core20 vs Other (April 2008 to June 2024)
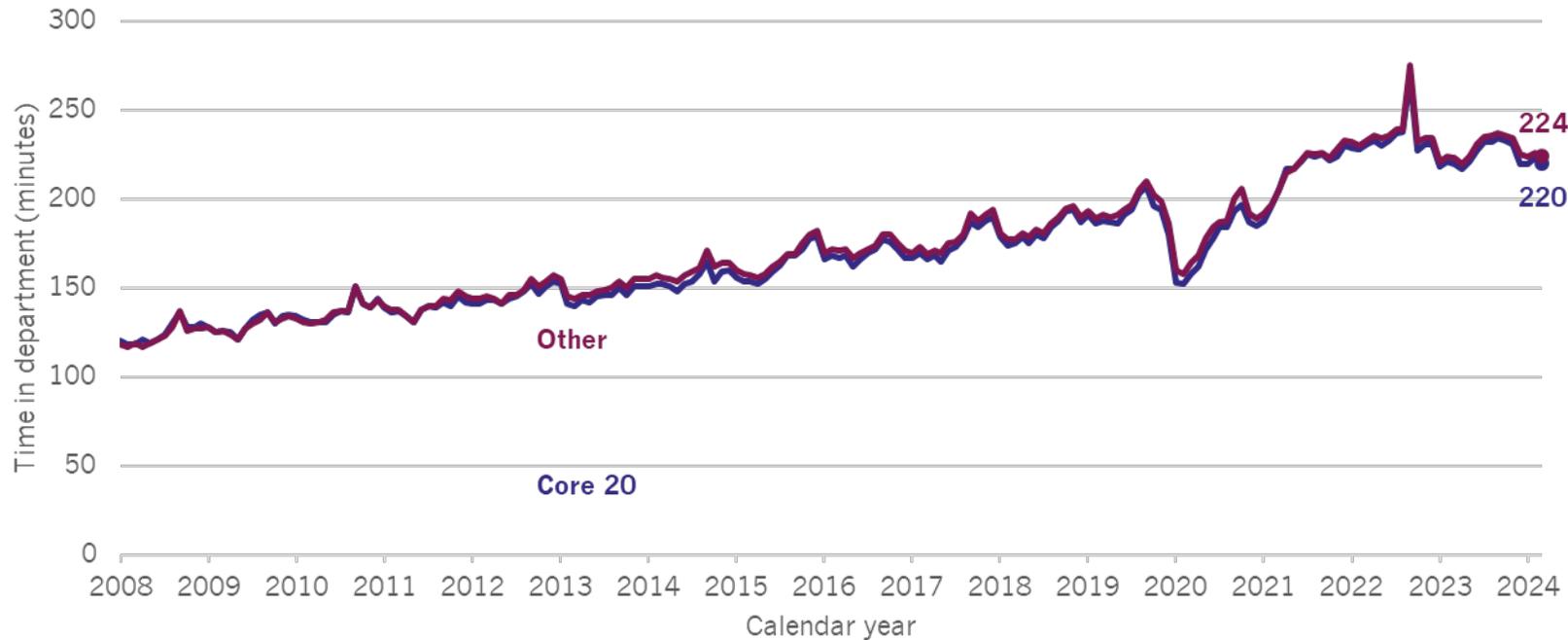
CAGR	Core 20	Not Core 20
2011 - 2015	2.9%	3.4%
2015 - 2019	5.2%	4.8%
2019 - 2021	-0.5%	-0.2%
2021 - 2023	7.7%	7.3%

Total no. waiting 2023/2024	Core 20	Not Core 20
> 4 hours	1,749.195	5,111,436
> 6 hours	1,180,983	3,491,367

Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 5 days (suspected data quality issue). Also excludes streamed activity. Data for period April 2008 to June 2024. CAGRs calculated from April of each year shown.

Source: NHS England A&E CDS and ECDS.

8.13 A&E waiting times (mental health flag vs rest of population)

Figure II.8.13: Emergency Department Waiting Times - Attendances with a Mental Health Flag vs no Mental Health Flag (April 2019 to May 2024)
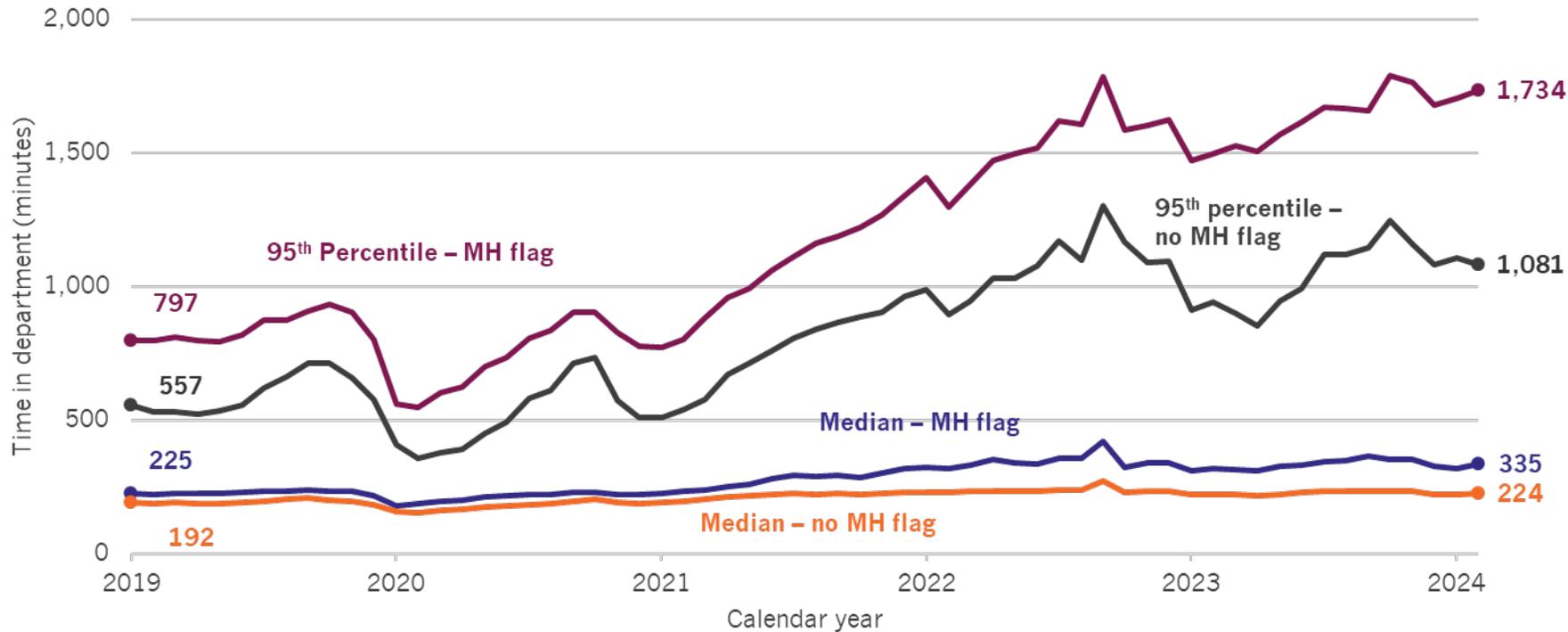

CAGRs		
Mental Health flag	**5th Percentile**	**Median**
2019 - 2021	4.2%	6.3%
2021 - 2023	2.6%	13.4%
No Mental Health flag	**5th Percentile**	**Median**
2019 - 2021	0.0%	5.3%
2021 - 2023	-2.2%	2.8%

Total no. waiting with a mental health flag (2023/2024)	
> 4 hours	250,741
> 6 hours	189,490
> 12 hours	83,580
> 24 hours	26,656

Notes: We currently use a proxy measure in ECDS (Emergency Care Data Set) for identifying mental health related attendances at A&E. Mental health attendances are identified from records where the coded chief complaint (reason for attending A&E) included self-harm, depressive feelings, hallucinations/delusions, or where the coded injury intent was self inflicted injury, or where the primary diagnosis was related to, but not limited to, eating disorder, depressive disorder, psychotic disorder, schizophrenia, anxiety disorder etc.

Source: NHS England A&E CDS and ECDS

8.14 A&E waiting times – 12+ hour waits

**Figure II.8.14: ICB A&E waiting times, 12+ hour waits from time of arrival**
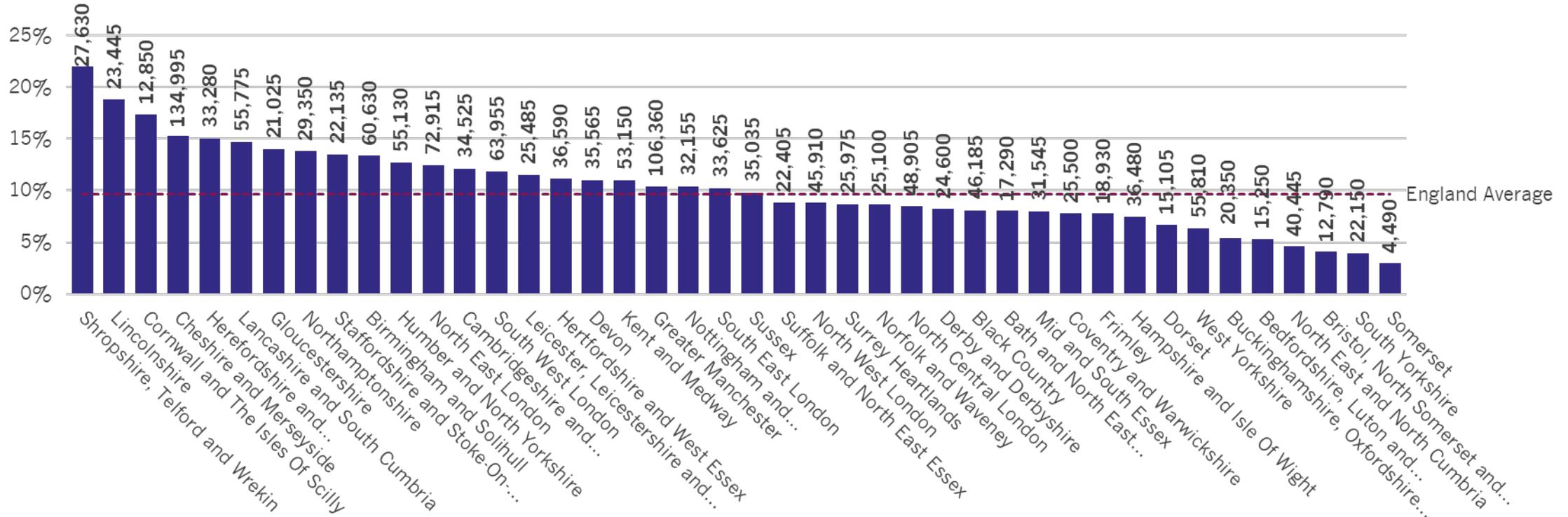
Notes: Data is for type 1 and type 2 attendances only and is only published for trusts that met the required data quality requirements each month. All data is rounded to the nearest 5 attendances. For each month in 2023-24, 90% or more of the providers met the data quality requirements to be included in the data. The numbers above the bars represent A&E Attendances >12hrs From Arrival

Source: Emergency Care Data Set (ECDS) Available: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2023-24/

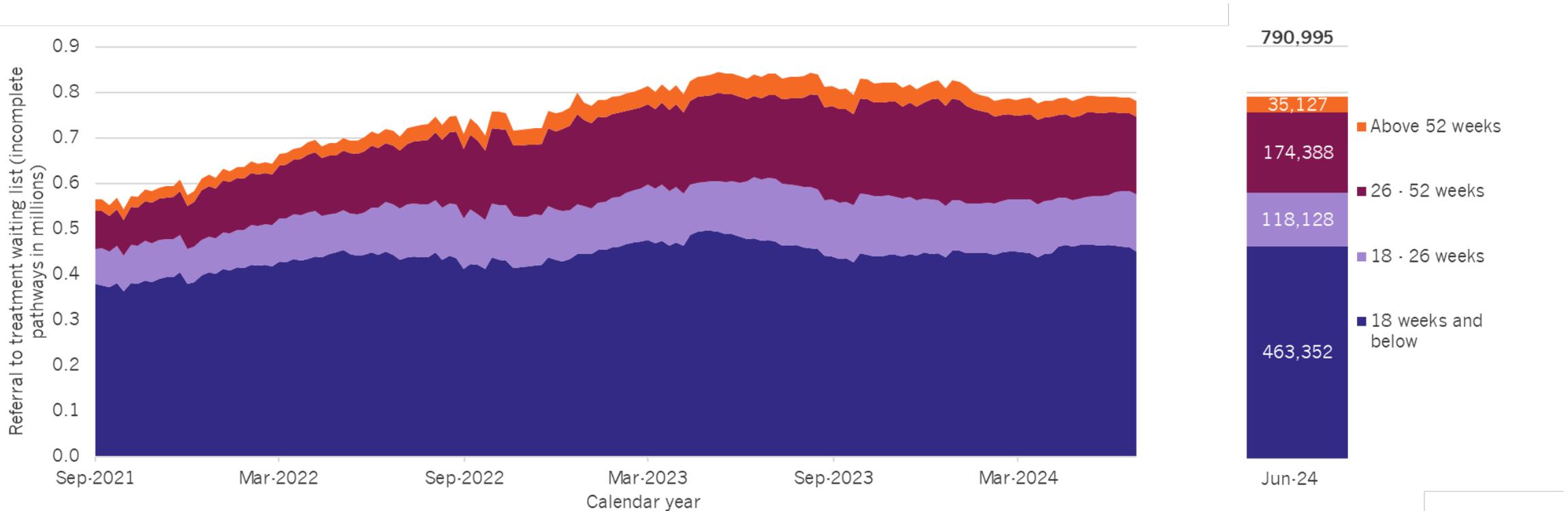# 8.15 Size of waiting lists by weeks waiting (all)

Figure II.8.15: Referral to treatment waiting list over time by weeks waiting
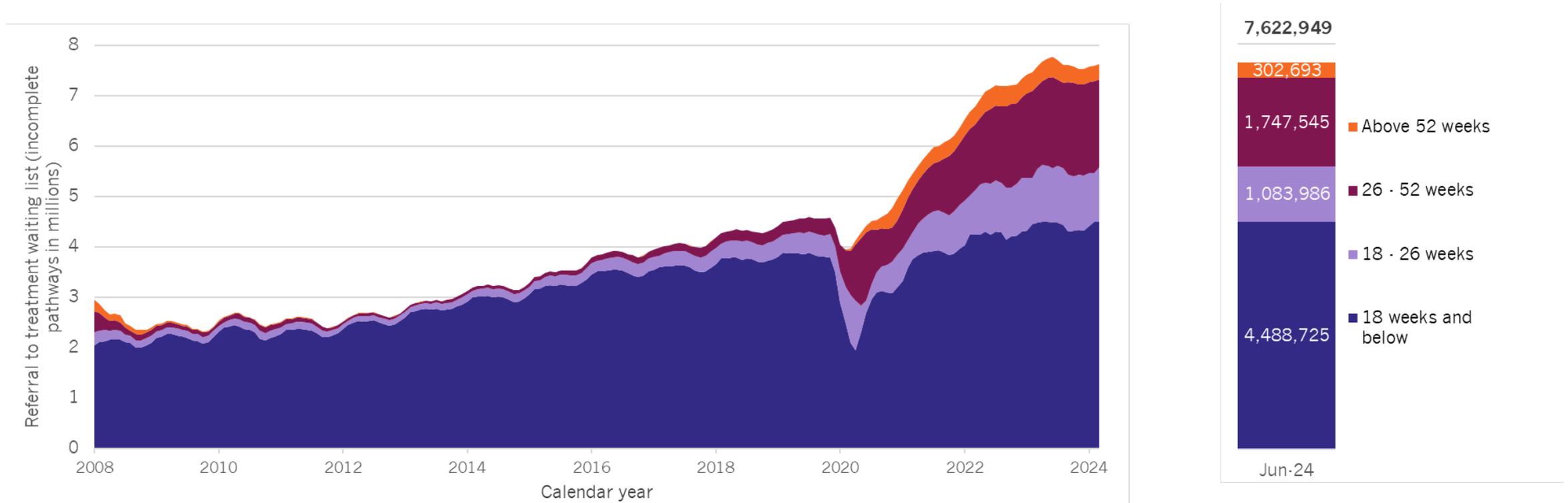
Source: Monthly referral to treatment official statistics Available: Statistics » Referral to Treatment (RTT) Waiting Times (england.nhs.uk)

| 75

8.16 Size of waiting list by weeks waiting (children and young people)

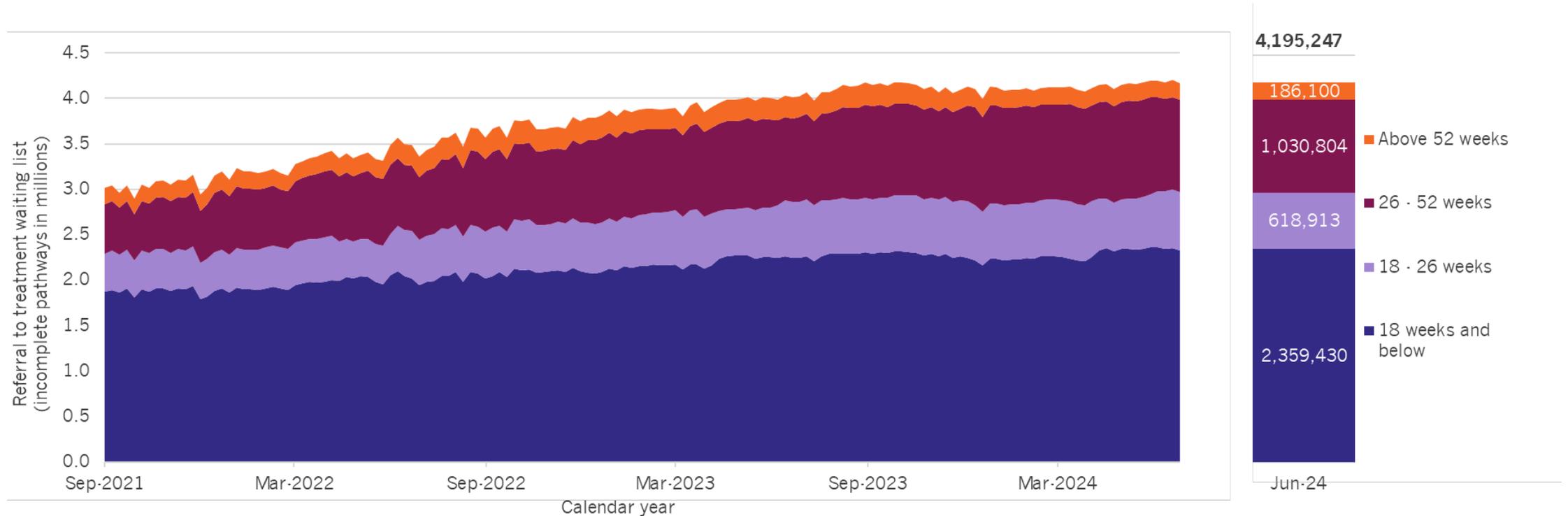**Figure II.8.16: Referral to treatment waiting list for children and young people (0-17) over time by weeks waiting**
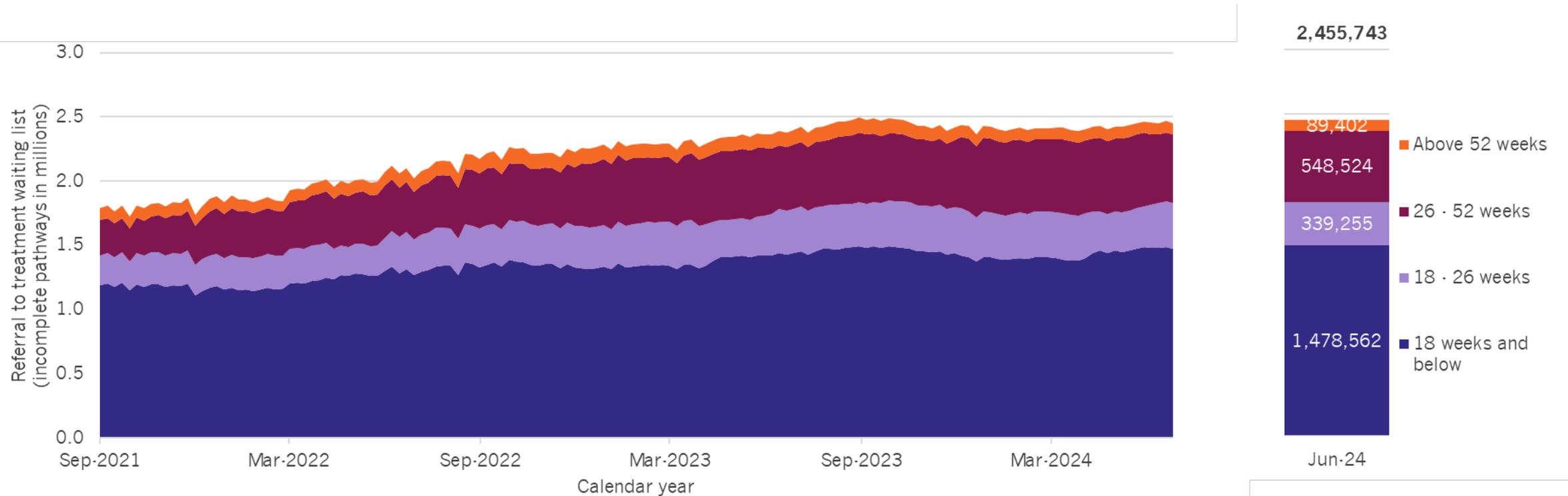

Notes: This is weekly management information that is subject to less validation than the monthly official statistics. There may be issues regarding the quality and completeness of the recorded data. No adjustments or estimations have been made for missing data submissions.

Source Waiting List Minimum Dataset (WLMDS) Available at Statistics » Waiting List Minimum Data Set (WLMDS) Information (england.nhs.uk))

8.17 Size of waiting lists by weeks waiting (working age adults)

Figure II.8.17: Referral to treatment waiting list for working age adults (18 to 64) over time by weeks waiting
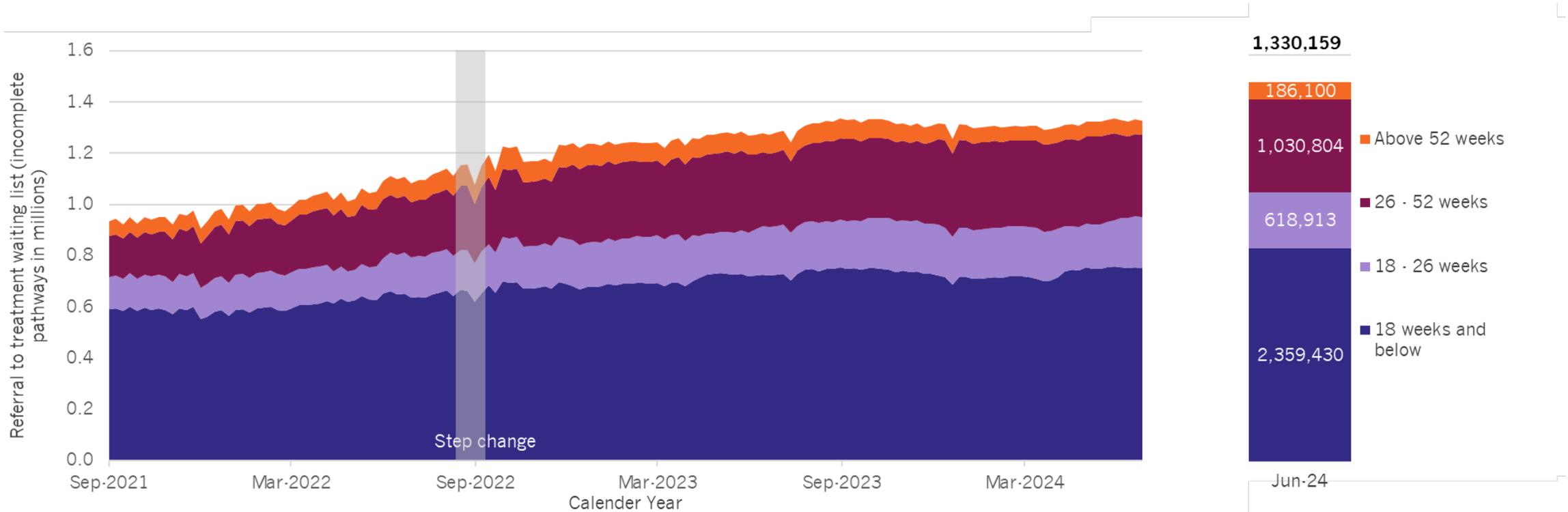

Notes: This is weekly management information that is subject to less validation than the monthly official statistics. There may be issues regarding the quality and completeness of the recorded data. No adjustments or estimations have been made for missing data submissions.

Source: Waiting List Minimum Dataset (WLMDS)) Available at Statistics » Waiting List Minimum Data Set (WLMDS) Information (england.nhs.uk)

8.18 Size of waiting lists by weeks waiting (older adults)

Figure II.8.18: Referral to treatment waiting list for older adults (65+) over time by weeks waiting

Notes: This is weekly management information that is subject to less validation than the monthly official statistics. There may be issues regarding the quality and completeness of the recorded data. No adjustments or estimations have been made for missing data submissions.

Source: Waiting List Minimum Dataset (WLMDS) Available at Statistics » Waiting List Minimum Data Set (WLMDS) Information (england.nhs.uk)

8.19 Size of waiting lists by weeks waiting (CORE20)

Figure II.8.19: Referral to treatment waiting list for adults (18+) and CORE20 over time by weeks waiting


Notes: Step changes around October 2022 caused by improvements in data coverage from around 6% to 2% unknown IMD
This is weekly management information that is subject to less validation than the monthly official statistics. There may be issues regarding the quality and completeness of the recorded data. No adjustments or estimations have been made for missing data submissions

Source: Waiting List Minimum Dataset (WLMDS) Available: Statistics » Waiting List Minimum Data Set (WLMDS) Information (england.nhs.uk)

8.20 Duration of waiting times for elective activity

Figure II.8.20: Referral to treatment median and 92nd percentile waiting time
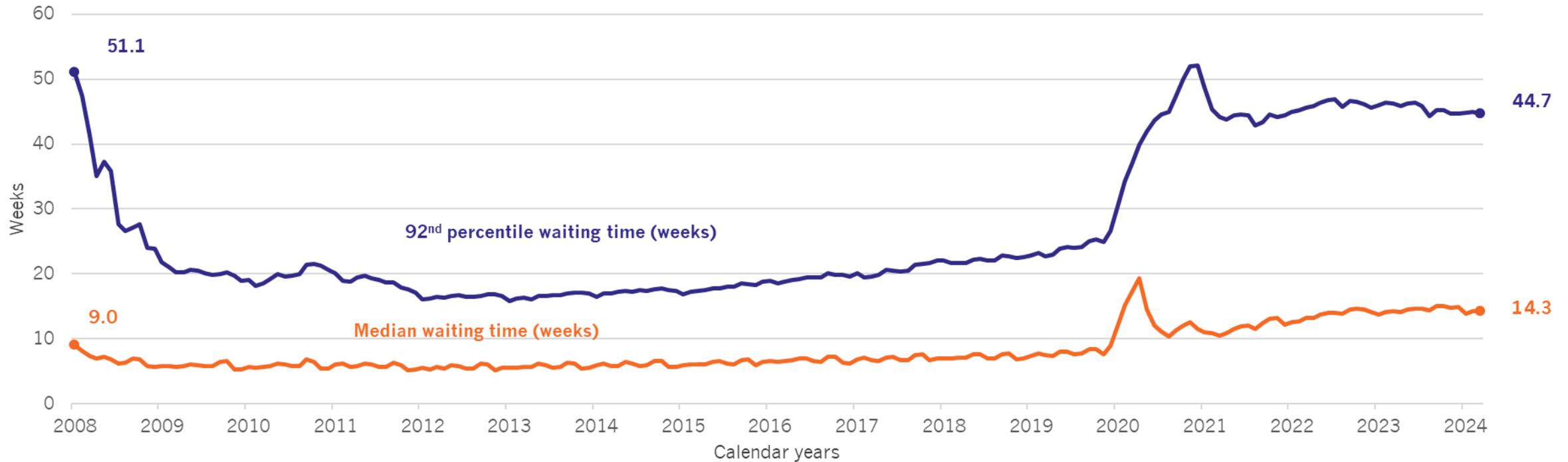
8.21 Elective inpatient spells for CYP and adults

Figure II.8.21A: Elective inpatient spells compared to 2019/20 baseline for CYP and adults
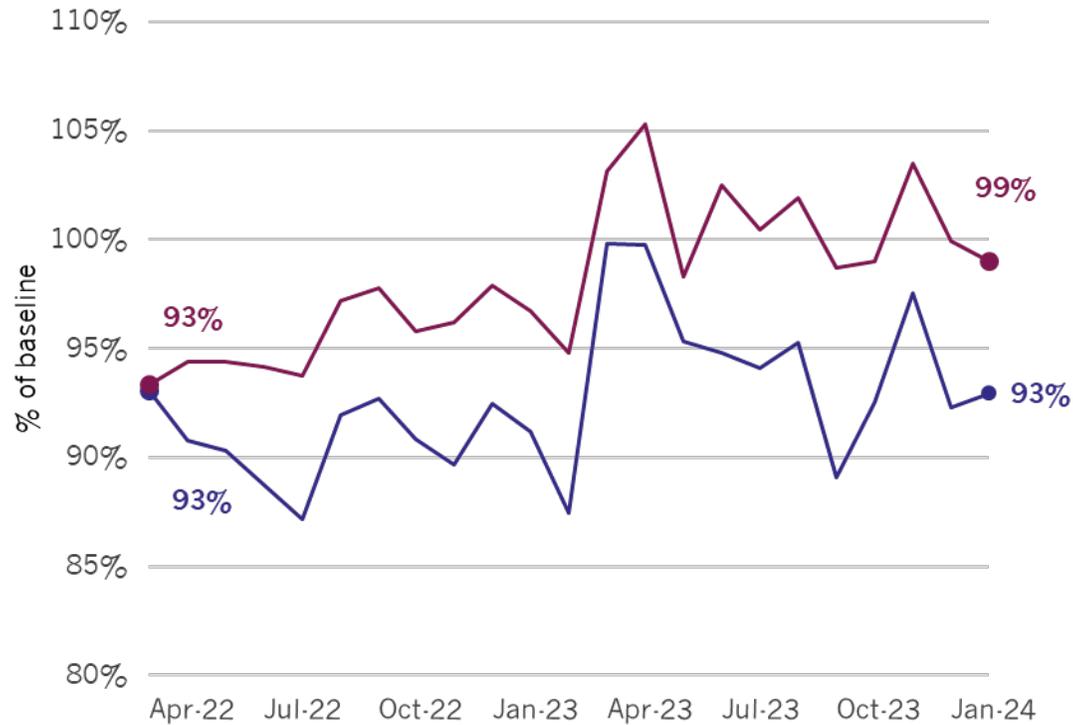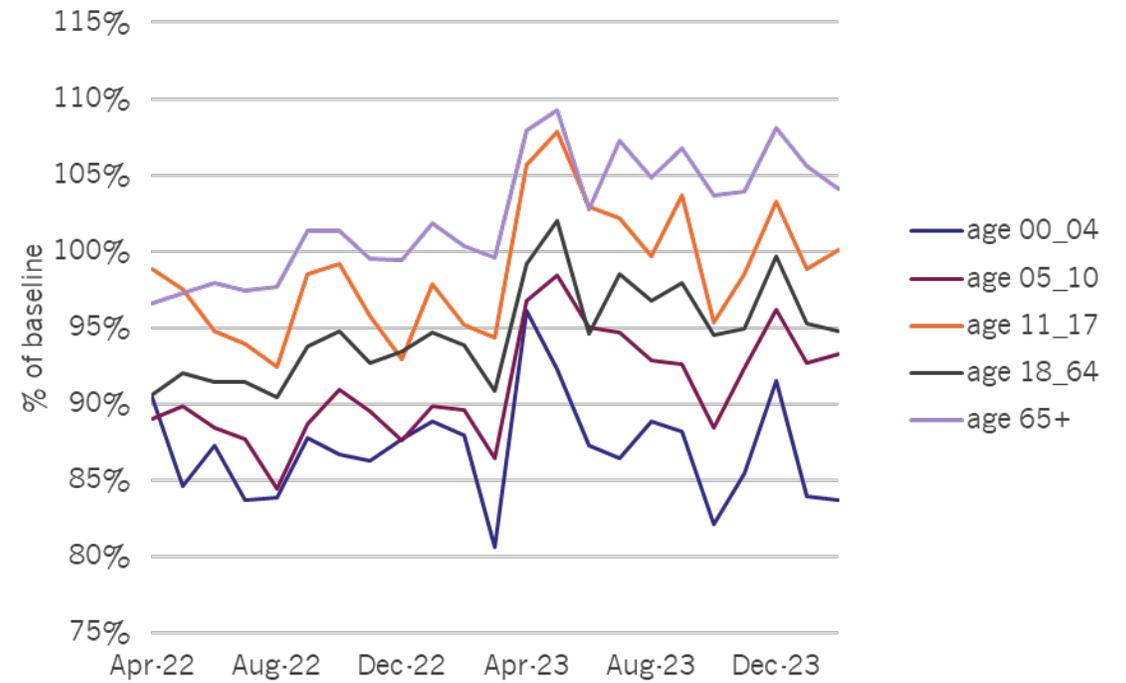
Figure II.8.21B: Elective inpatient spells compared to 2019/20 baseline by age


Notes: The baseline used is March 2019 to February 2020. Activity is calculated per working day. Does not take account of differential population growth between the age groups, which may account for some of the differential in recovery rates

Source: NHS England (2024) Unpublished from the Admitted Patient Care CDS via the SUS+ Service

8.22 Duration of waits for diagnostics

**Figure II.8.22: Diagnostic waiting times – median and 95th percentile waiting**
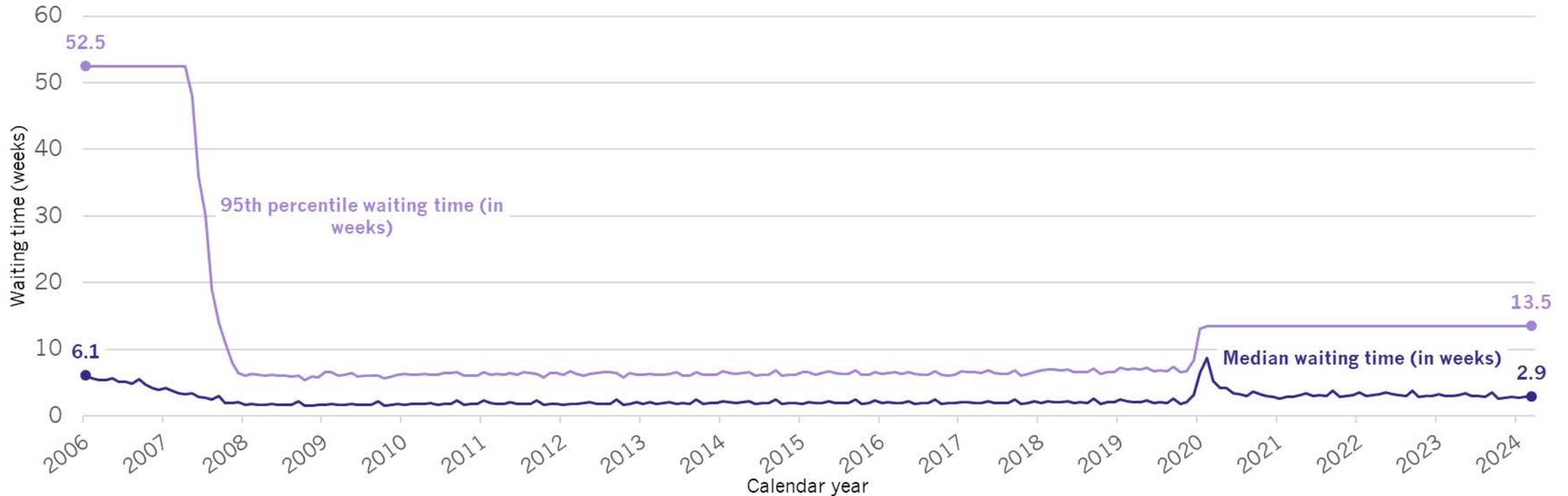
Notes: Where the 95th percentile falls in the highest waiting time band: 52+ weeks up to March 2009 and 13+ weeks thereafter, the value has been shown as 52.5 and 13.5 weeks respectively.

Source: *NHS England*. Monthly Diagnostic Waiting times and Activity. Available: Statistics » Monthly Diagnostic Waiting Times and Activity (england.nhs.uk)

III. Quality of care

1.1 Adult smoking rates

Figure III.1.1: Percentage of adult smokers (aged 18 and over) in England, 2001 to 2022

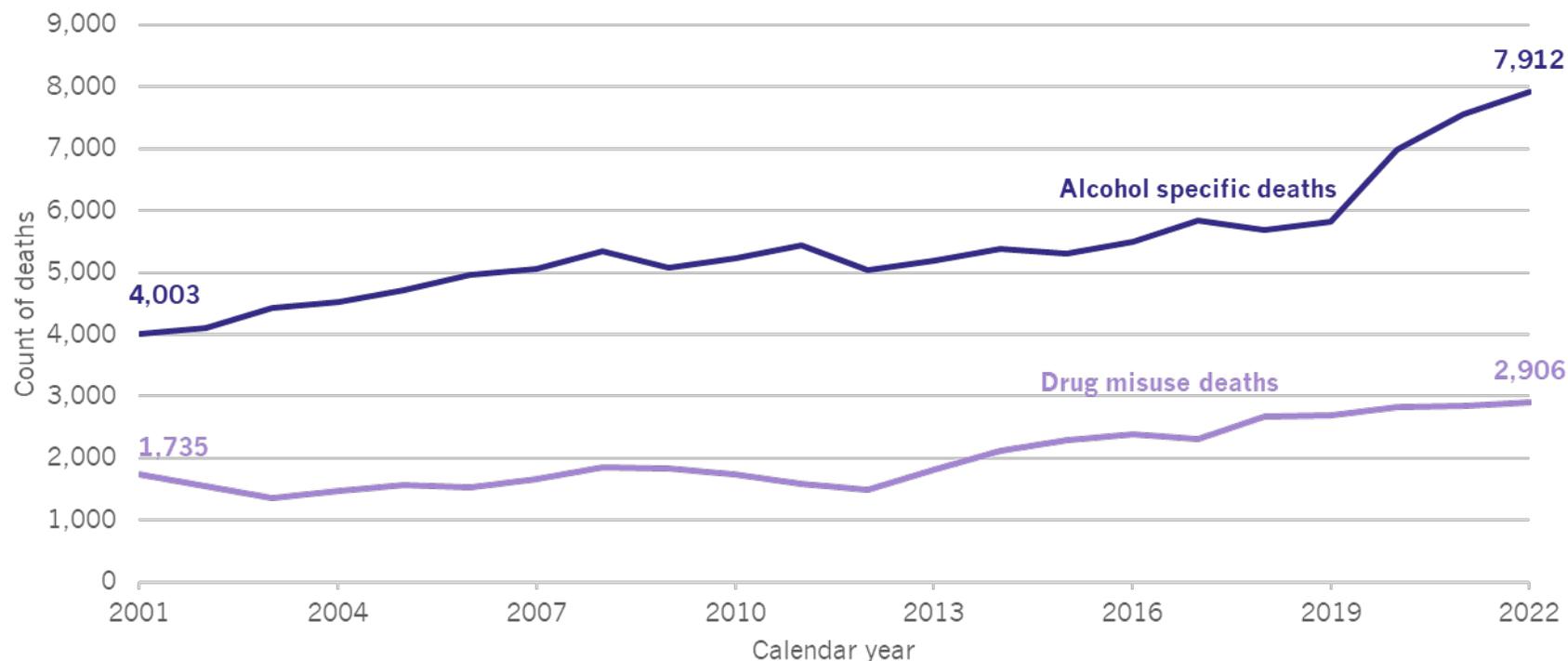| TIME PERIOD	CAGR
2001-2005	0.0%
2005-2010	-4.4%
2010-2015	-3.3%
2015-2019	-4.8%
2019-2022	-3.0%
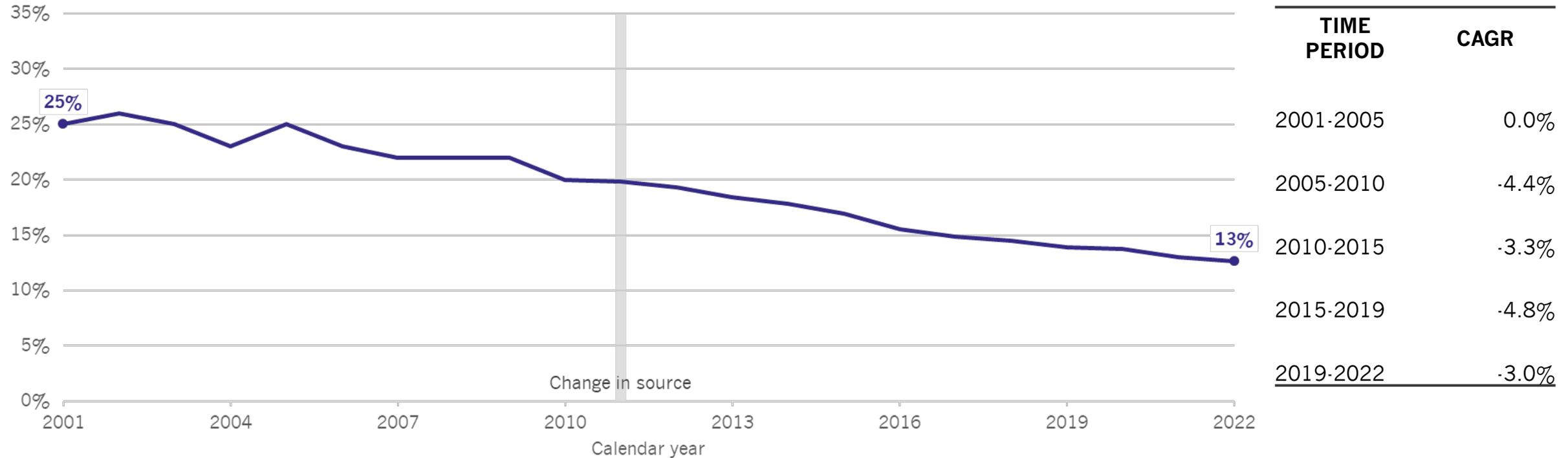
Notes: Due to changes in methodology, data from 2001 to 2010 are not directly comparable to data post-2011.

Source: 2011 to 2022 Annual Population Survey Adult smoking trend chart, 2001 to 2010 Health Survey for England, 2021: Data tables - NHS England Digital

1.2 Deaths from alcohol and drug misuse

Figure III.1.2: Drug misuse deaths and alcohol specific deaths in England 2001 to 2022

Time period	Alcohol specific deaths CAGR	Drug misuse deaths CAGR
2001-2019	2.1%	2.5%
2019-2022	10.8%	2.7%

Notes: Deaths related to drug poisoning by local authority England and Wales, 1993 to 2022

Source: Alcohol specific deaths · Office for National Statistics (2024), Alcohol-specific deaths in England and Wales by local authority. Available at: Alcohol-specific deaths in England and Wales by local authority · Office for National Statistics (ons.gov.uk); Drug misuse deaths – Office for National Statistics (2023), Deaths related to drug poisoning by local authority, England and Wales. Available at: Deaths related to drug poisoning by local authority, England and Wales · Office for National Statistics (ons.gov.uk)

1.3. Alcohol-related deaths and affordability of alcohol

Figure III.1.3A: Age-standardised alcohol-specific mortality rate per 100,000 in the United Kingdom, 2001 to 2022
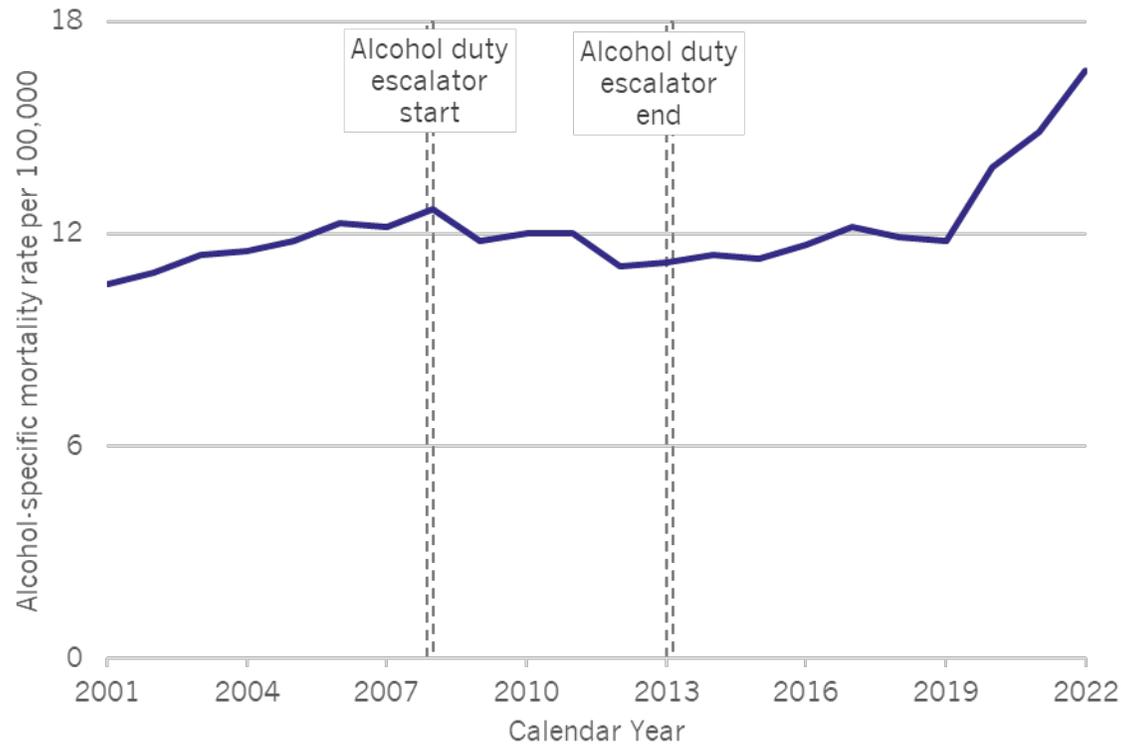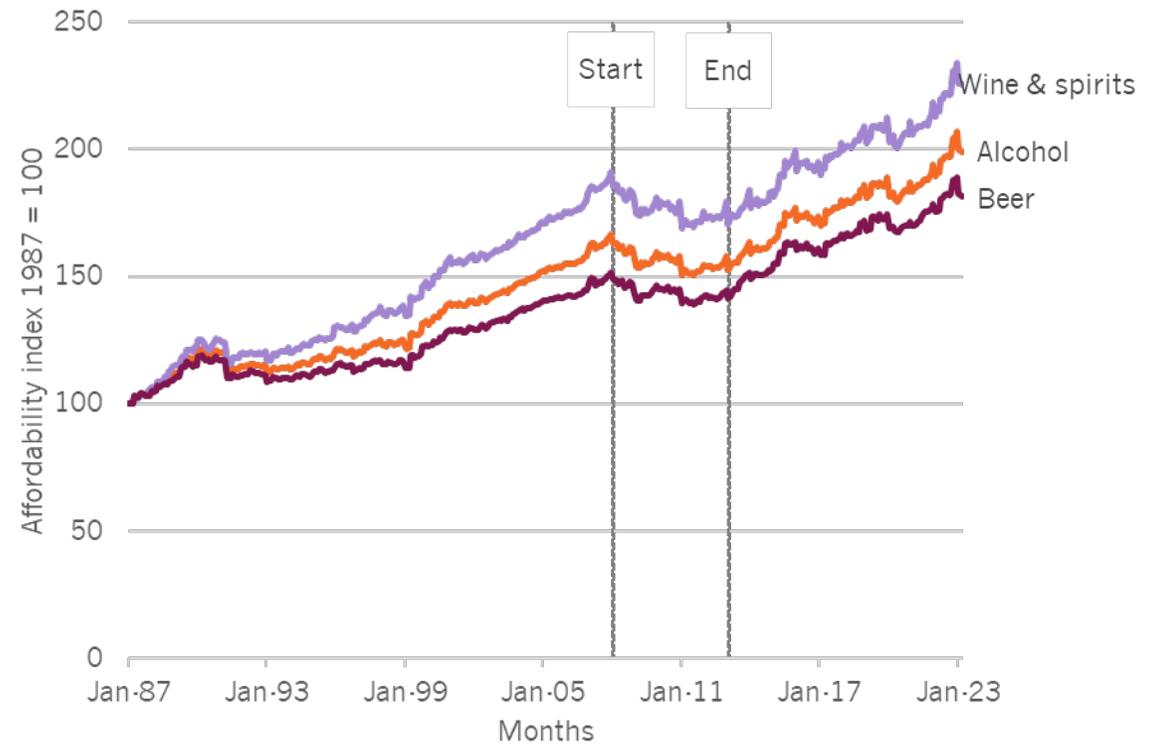

Figure III.1.3B: Alcohol affordability in the United Kingdom, January 1987 to March 2023


Notes: The alcohol duty escalator started in 2008 and ended in 2013. This is indicated on the alcohol affordability chart by "Start" and "End".

Source: Office for National Statistics (ONS), Alcohol·specific deaths in the UK: registered in 2022 (2024); Alcohol affordability: ONS, Consumer price inflation time series & Households: Real disposable Income per head; NHS (2024) Statistics on Public Health, England 2023 Part 4: Affordability and expenditure · NHS England Digital; ONS, Consumer price inflation time series Consumer price inflation time series · Office for National Statistics

1.4 Obesity and physical inactivity

Figure III.1.4: Percentage of adults living with obesity and percentage of adults who are physically inactive (less than 30 moderate intensity equivalent (MIE) minutes physical activity per week)
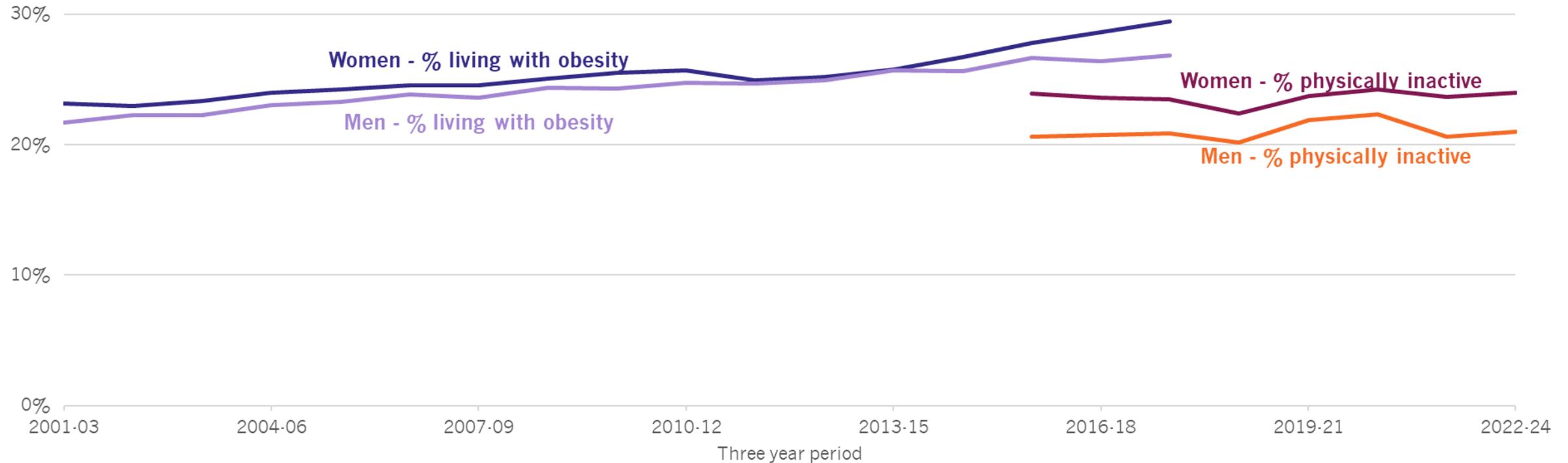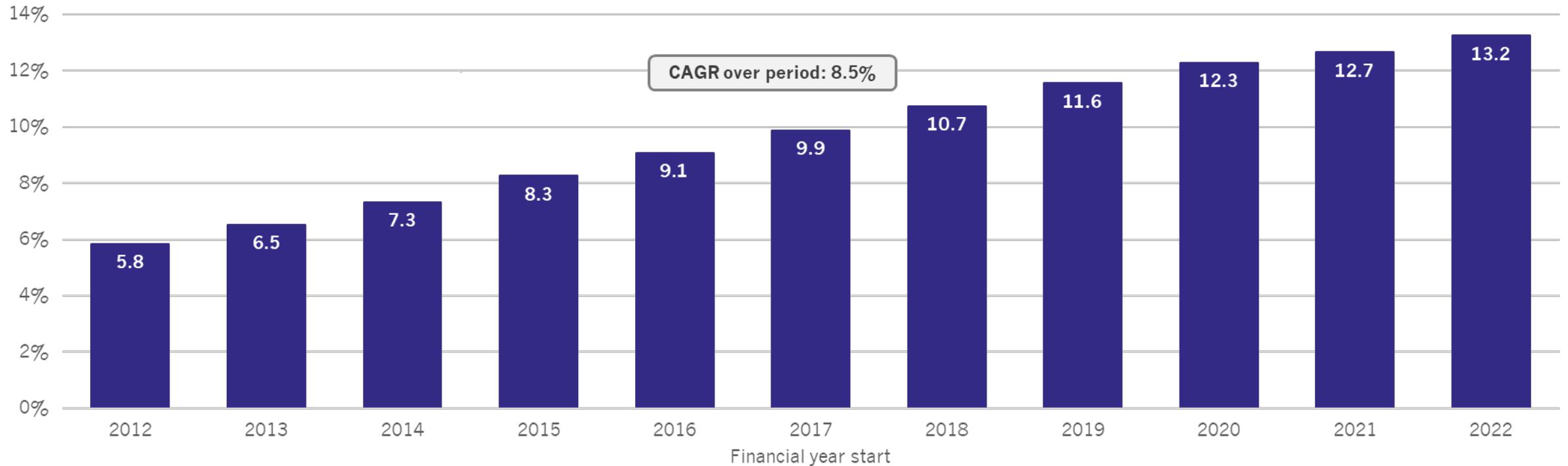

Notes: Obesity prevalence uses 3 years combined survey data and physical inactivity data uses single survey year data (November to November). Single year (November to November) data points align with the starting year of combined years. For example, data for 2015/16 is at axis point 2015-2017.

Source: Obesity prevalence is OHID analysis of NHS England (2023) Health Survey for England, Available at: Health Survey for England - NHS England Digital . Physically inactive data is OHID analysis of Sport England (2024), Active Lives Survey, Available at: Active Lives | Sport England

1.5 Depression diagnoses, 18+ (QOF)

Figure III.1.5: The percentage of patients on the GP practice disease register with a depression diagnosis (aged 18 and over), England, 2012 to 2022

CAGR over period: 8.5%

| Year	Value
2012	5.8
2013	6.5
2014	7.3
2015	8.3
2016	9.1
2017	9.9
2018	10.7
2019	11.6
2020	12.3
2021	12.7
2022	13.2

Financial year start

Note: QOF is a measure of depression diagnosis which is influenced by a range of factors.

Source: NHS England, Quality and Outcomes Framework (QOF) (2022/23). Available at: Fingertips | Department of Health and Social Care (phe.org.uk)

1.6 Public Health Grant in real terms per capita

Figure III.1.6: Value of the Public Health Grant, substance misuse, and smoking funding per capita (real prices), 2015/16 to 2024/25
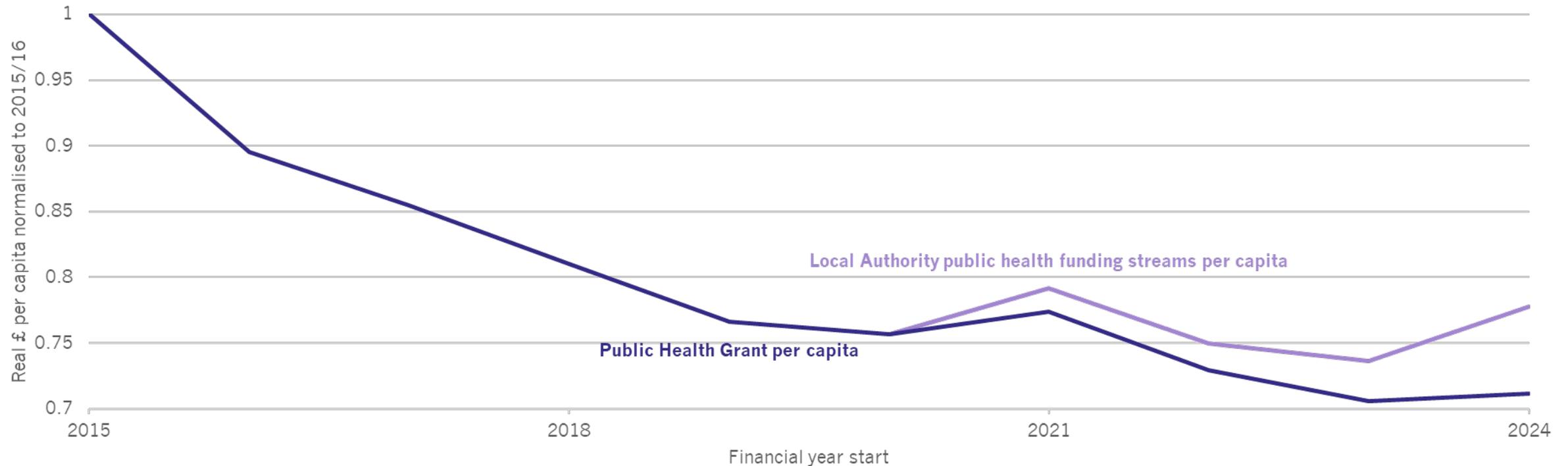

Notes: Additional funding streams are the Drugs Strategy funding and additional funding for local Stop Smoking Services. The 2015/16 Public Health Grant allocation has been adjusted to reflect a full year of 0·5s funding and includes the £200m that was cut mid-year. Local authorities received additional funding for Start for Life services which is not included in these figures.

Source: Reproduced Health Foundation chart, which uses DHSC, Public Health Grant Allocations to Local Authorities in England, various; Office for National Statistics, GDP deflator · Budget, June 2024, OHID, Additional drug and alcohol treatment funding allocations, November 2023; DHSC, Local stop smoking services and support, November 2023

1.7 People in treatment for substance misuse or alcohol dependence

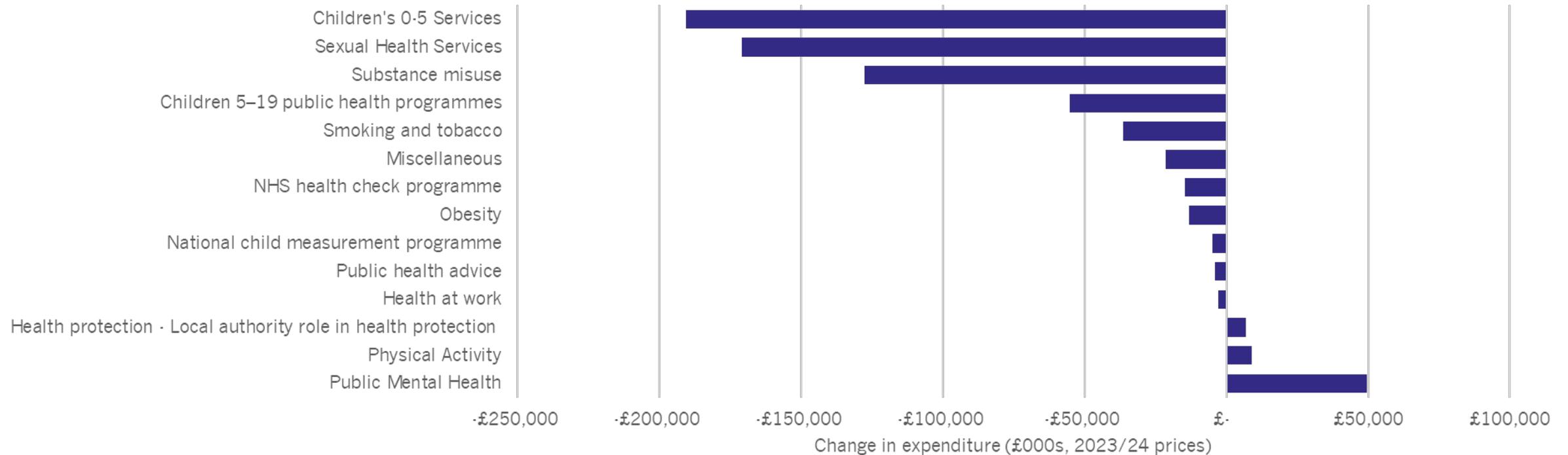**Figure III.1.7: Number of people in treatment by substance group, England, 2005-2006 to 2022-2023**
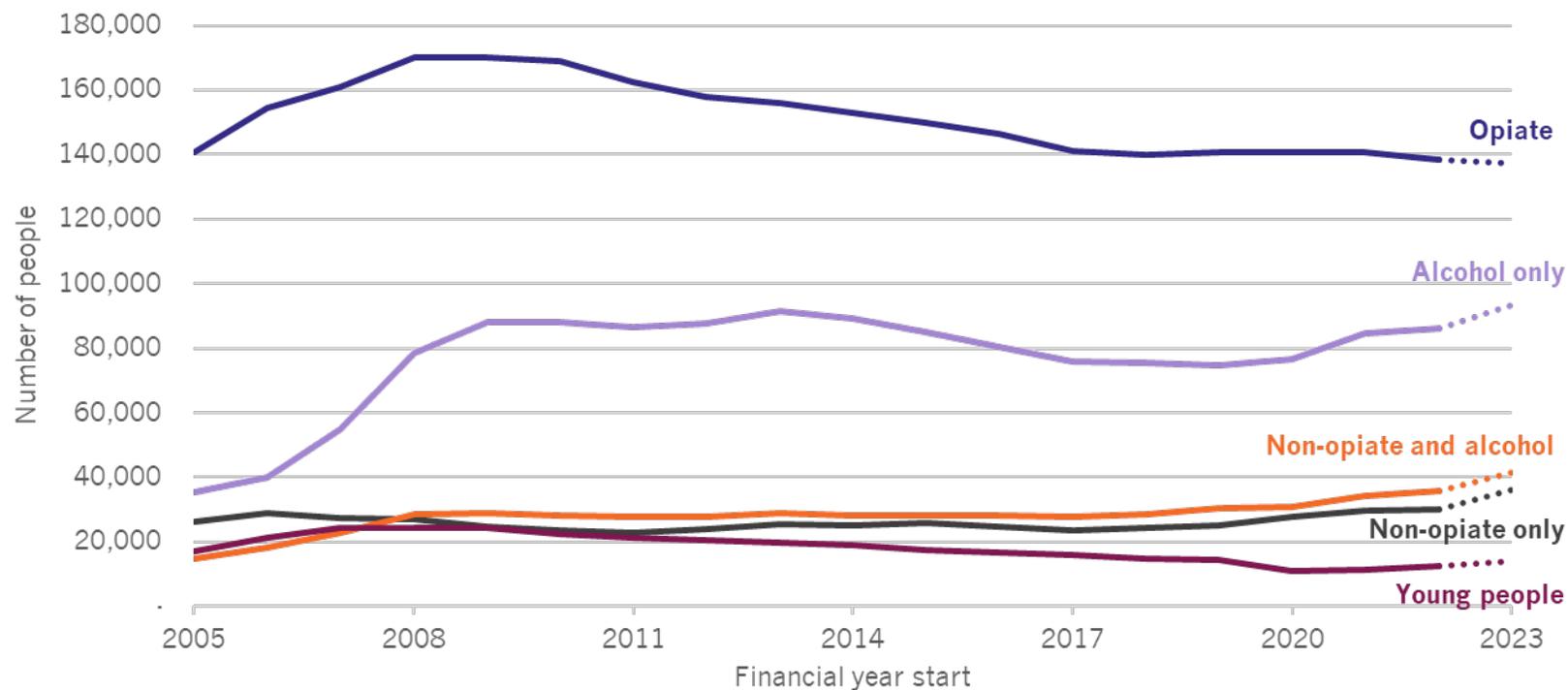
Time period	Opiate	Non opiate	Non opiate and Alcohol	Alcohol only	Young people
			Compound annual growth rate		
2005-2010	3.8%	-2.1%	13.9%	20.1%	5.7%
2011-2015	-2.4%	1.8%	0.0%	-0.7%	-4.9%
2016-2019	-1.6%	-0.6%	1.8%	-3.2%	-5.0%
2020-2021	0.0%	8.3%	6.6%	6.5%	-11.0%
2022-2023	-1.1%	10.6%	10.0%	5.0%	11.2%
Whole period	-0.1%	1.8%	5.9%	5.6%	-1.1%

Notes: Data for 2023 is provisional, indicated by dotted lines on the chart.

Source: OHID, Adult substance misuse treatment statistics 2022 to 2023. Available at: Adult substance misuse treatment statistics 2022 to 2023: report - GOV.UK (www.gov.uk); OHID (2024) Young people's substance misuse treatment statistics 2022 to 2023. Available at: Young people's substance misuse treatment statistics 2022 to 2023: report - GOV.UK (www.gov.uk); OHID, NDTMS community adult treatment performance reports. Available at: NDTMS - Monthly - Adults. OHID, NDTMS, community young people treatment performance reports. Available at: https://www.ndtms.net/Monthly/YoungPeople

1.8 Reductions in public health expenditure by element of provision

Figure III.1.8: Change in reported local authority spend on public health services from 2016/17 to 2022/23, 2023/24 prices

Children's 0-5 Services
Sexual Health Services
Substance misuse
Children 5–19 public health programmes
Smoking and tobacco
Miscellaneous
NHS health check programme
Obesity
National child measurement programme
Public health advice
Health at work
Health protection · Local authority role in health protection
Physical Activity
Public Mental Health

-£250,000   -£200,000   -£150,000   -£100,000   -£50,000   £-   £50,000   £100,000
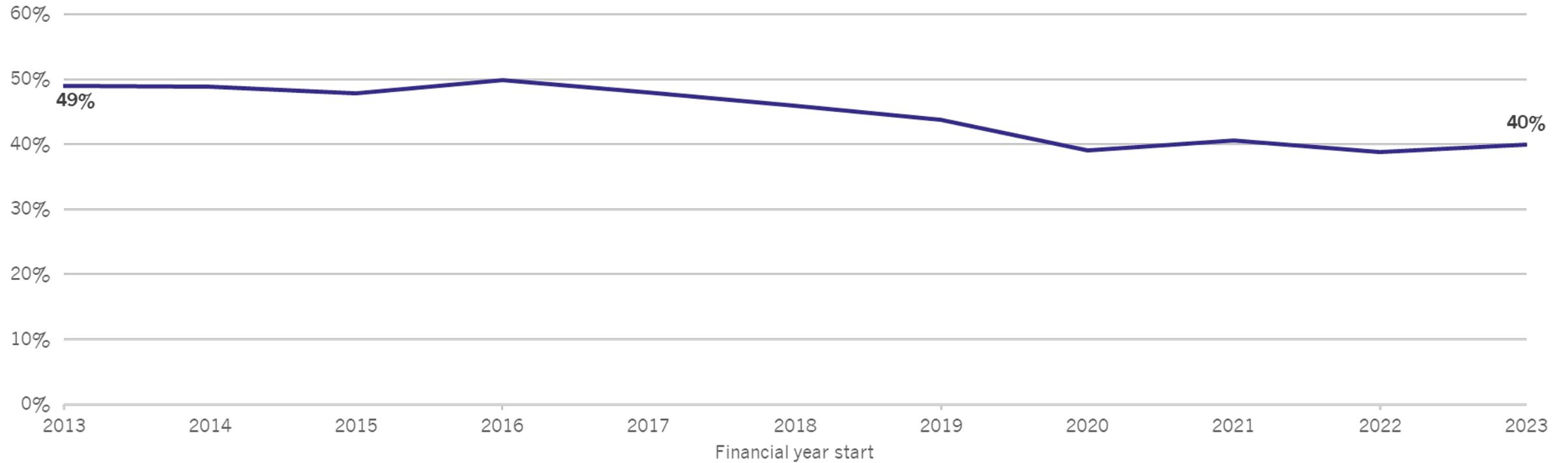
Change in expenditure (£000s, 2023/24 prices)

Notes: 2016/17 marks the first year of the current reporting categories for Local Authority public health spending, with the latest available data being for 2022/23.

1.9 Uptake of the NHS health check

Figure III.1.9: Percentage of people invited for an NHS Health Check taking one up, 2013 to 2023

Source: OHID, based on NHS Health Check Programme data. Available at: Fingertips | Department of Health and Social Care (phe.org.uk)

# 1.10 Screening coverage – cancer screening programmes

Figure III.1.10: National Cancer Screening Programmes Coverage (%), 2001 to 2022
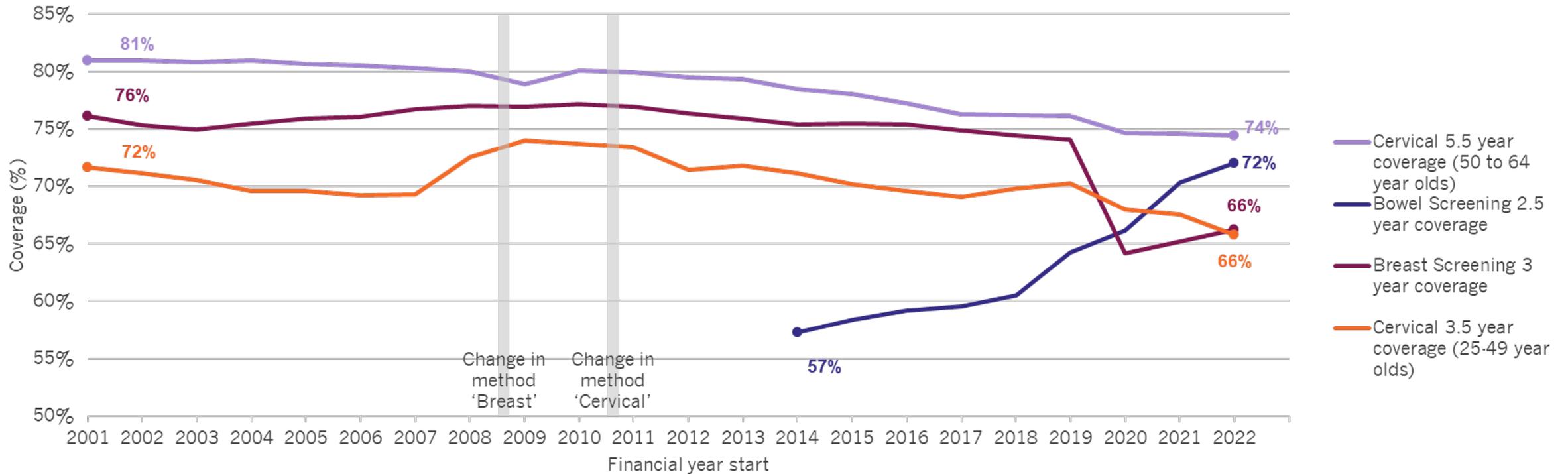
Notes: The standard age cohort for breast screening changed from 2009/10 from 53-64 to 53-70. The definition for measuring coverage in cervical screening changed in 2010/11. Bowel screening was not fully rolled out to the full standard age group until 2011, meaning coverage could not be reported on until 2014/15. Coverage for cancer screening programmes is calculated as a percentage of all those eligible on the 31 March each year.
Source: Public Health Outcomes Framework. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data; NHS Breast Screening Programme Annual Report. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme; NHS Cervical Screening Programme Annual Report. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-annual

1.11 Screening coverage – other adult screening programmes

Figure III.1.11: National Adult Screening Programmes coverage & uptake (%), 2014 to 2022
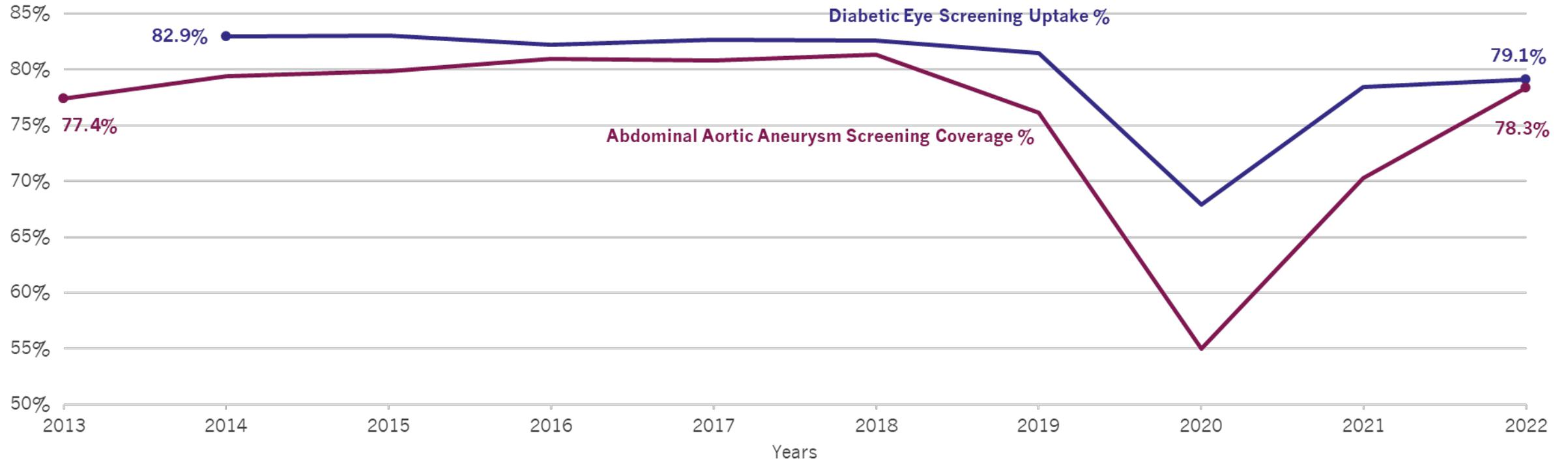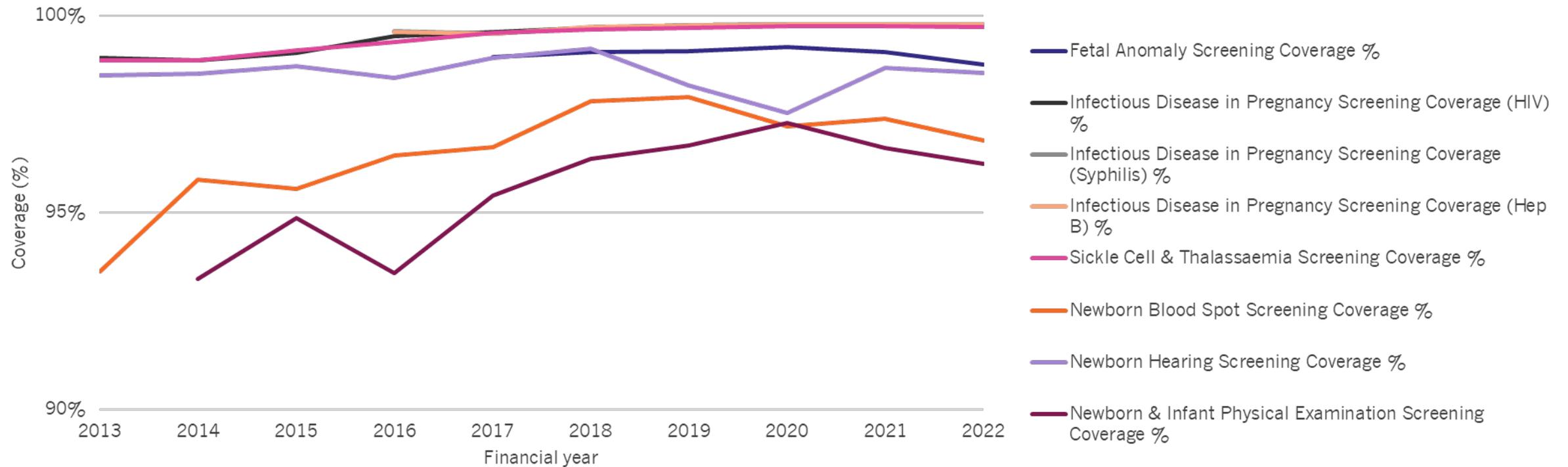

Notes: 2013/14 was the first full year when abdominal aortic aneurism (AAA) screening was available throughout England. A new national pathway for diabetic eye screening was introduced in 2013/14 but not fully rolled out until 2014/15. To date, the diabetic eye screening programme uses uptake (rather than coverage) to monitor participation

Source: Department of Health and Social Care, Fingertips. Public Health Outcomes Framework. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data

1.12 Screening coverage – maternity and newborn screening programmes

Figure III.1.12: National Antenatal & Newborn Screening Programmes Coverage (%), 2013 to 2022


Notes: 2013/14 was the first full year when consolidated national coverage measurement took place across antenatal and newborn screening programmes in England. Measurement and reporting of coverage of foetal anomaly screening commenced in 2017/18. The coverage standard for Hepatitis B screening in pregnancy was introduced in 2016/17. Full rollout of the newborn and infant physical examination IT system (NIPE SMaRT) was not concluded until 2016. Data prior to this date has been collected manually

Source: *Public Health Outcomes Framework*. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data

2.1 Rates of onset of labour by induction, spontaneous and caesarean

Figure III.2.1: Rates of onset of labour by induction, spontaneous and caesarean section as a percentage of all deliveries of known onset method, 2001 to 2022
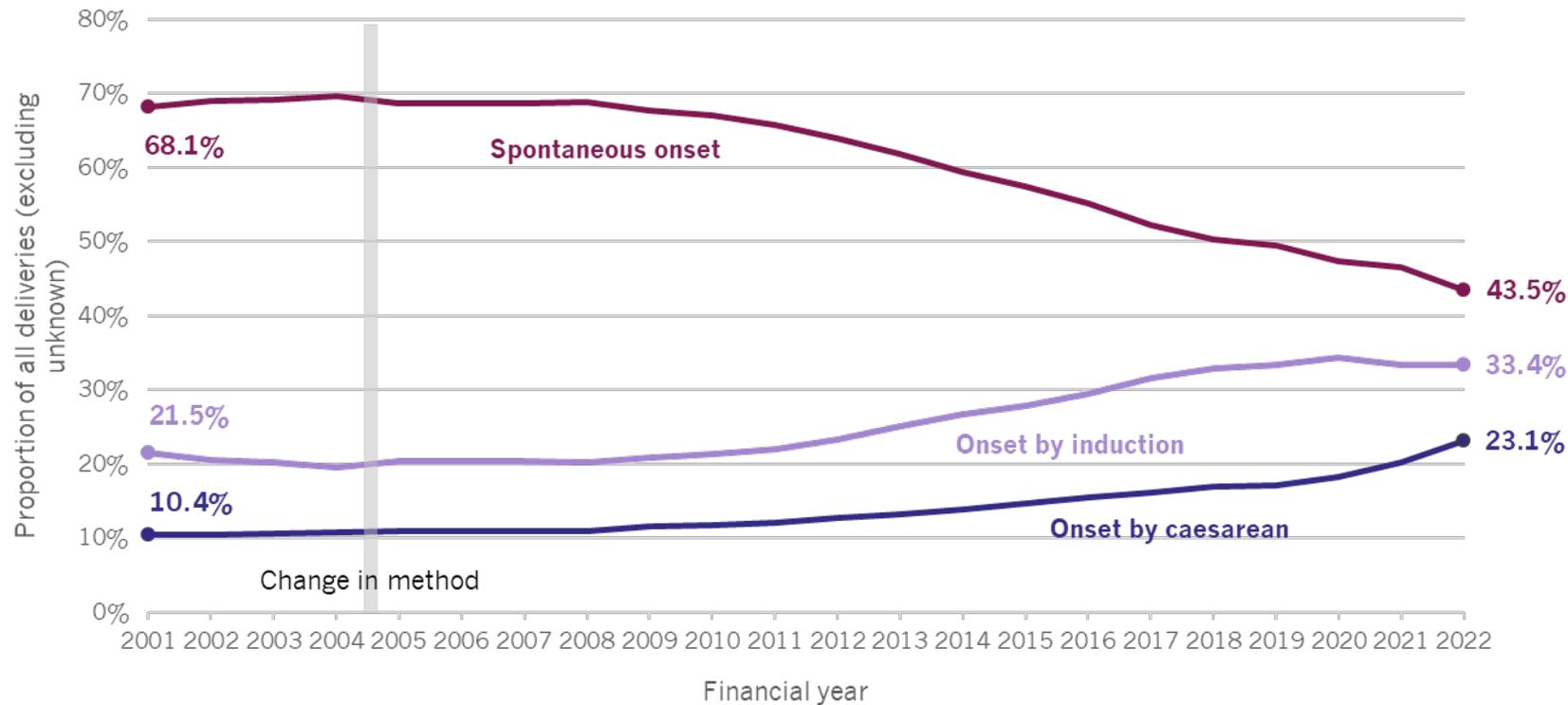

Type	Compound adjusted growth rate
	2005 - 2022
Spontaneous	-2.7%
Induction	2.9%
Caesarean	4.6%

Notes: Data is for financial years with the first year of the financial year presented on the chart x-axis. Data from 2006-07 are not comparable with previous years due to changes in methodology. 2005-06 figures have been reproduced for comparison purposes. Induction includes medical induction, surgical induction and combined methods.
Compound Annual Growth Rates for 2005-06 to 2022-23 are presented alongside trends in light blue bubbles.

Source: *NHS England. Annual Maternity Statistics (Hospital Episode Statistics)*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/

2.2 Maternal BMI at first antenatal appointment

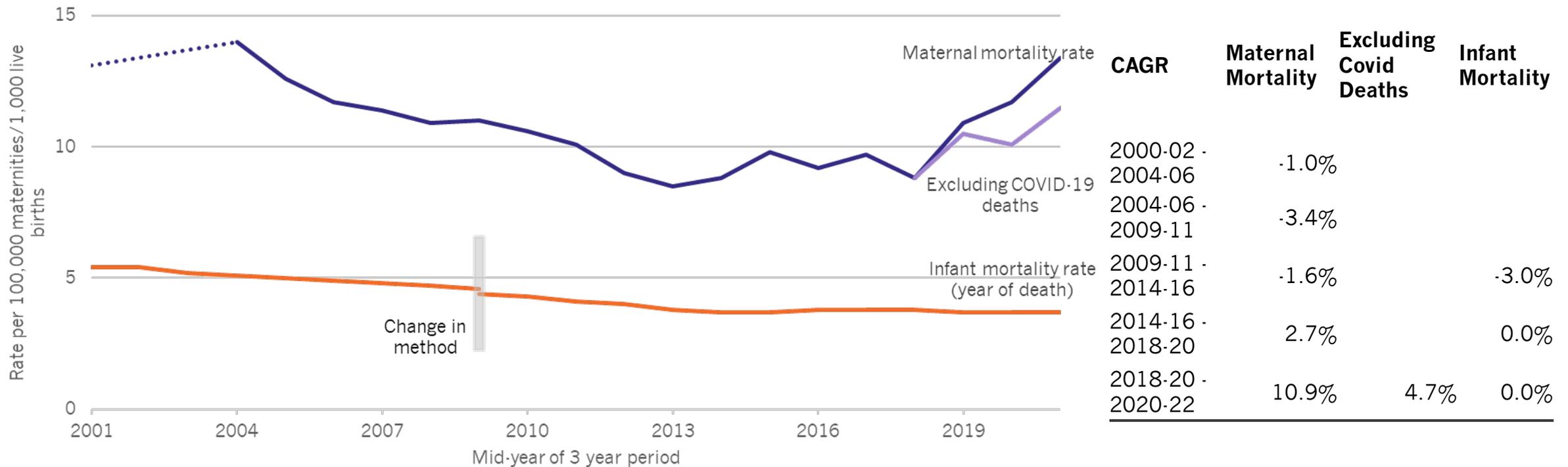**Figure III.2.2: Maternal BMI at first antenatal (booking) appointment**
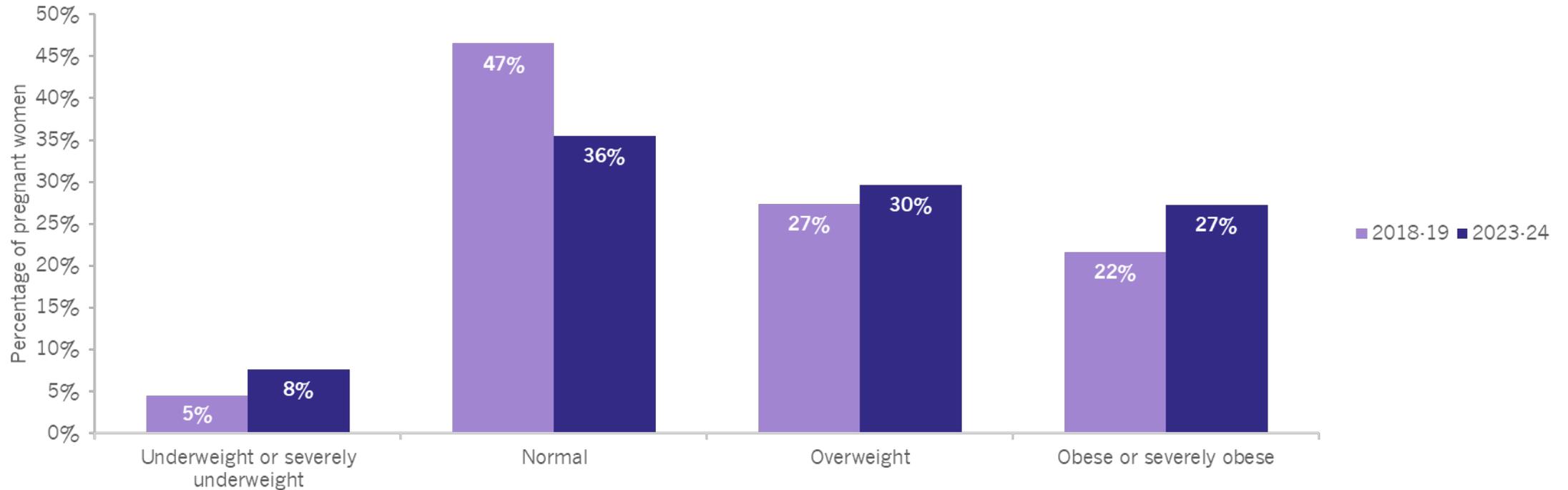
Notes: Pregnant women with normal BMI fell from 46.5% in 2018-19 to 35.5% in 2023-24, when over a quarter of women were obese or severely obese. BMI is as measured at the first antenatal (booking) appointment

Source: NHS England. NHS Maternity Services Monthly Statistics. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics

2.3 Maternal and infant mortality

Figure III.2.3: Maternal mortality rate per 100,000 maternities in the United Kingdom, and infant mortality per 1,000 live births in England, 2000-02 to 2020-22

| CAGR	Maternal Mortality	Excluding Covid Deaths	Infant Mortality
2000-02 - 2004-06	-1.0%		
2004-06 - 2009-11	-3.4%		
2009-11 - 2014-16	-1.6%		-3.0%
2014-16 - 2018-20	2.7%		0.0%
2018-20 - 2020-22	10.9%	4.7%	0.0%

Notes: Prior to 2009, 'year of registration' rather than 'year of death' was used for infant mortality data. Dotted lines represent data missing in the years 2002 and 2003.

Source: University of Oxford, MBRRACE-UK Maternal mortality 2020-2022. Available at: Maternal mortality 2020-2022 | MBRRACE-UK | NPEU (ox.ac.uk); Office for National Statistics (2022), Child and infant mortality in England and Wales. Available at: Child and infant mortality in England and Wales - Office for National Statistics (ons.gov.uk); Office for National Statistics (2023) Deaths registered in England and Wales: 2022. Available at: Deaths registered in England and Wales - Office for National Statistics (ons.gov.uk)

2.4 Rates of stillbirth, neonatal mortality, preterm birth and serious brain injury occurring during or soon after birth

Figure III.2.4: Rates of stillbirth, neonatal mortality, preterm birth and serious brain injury occurring during or soon after birth
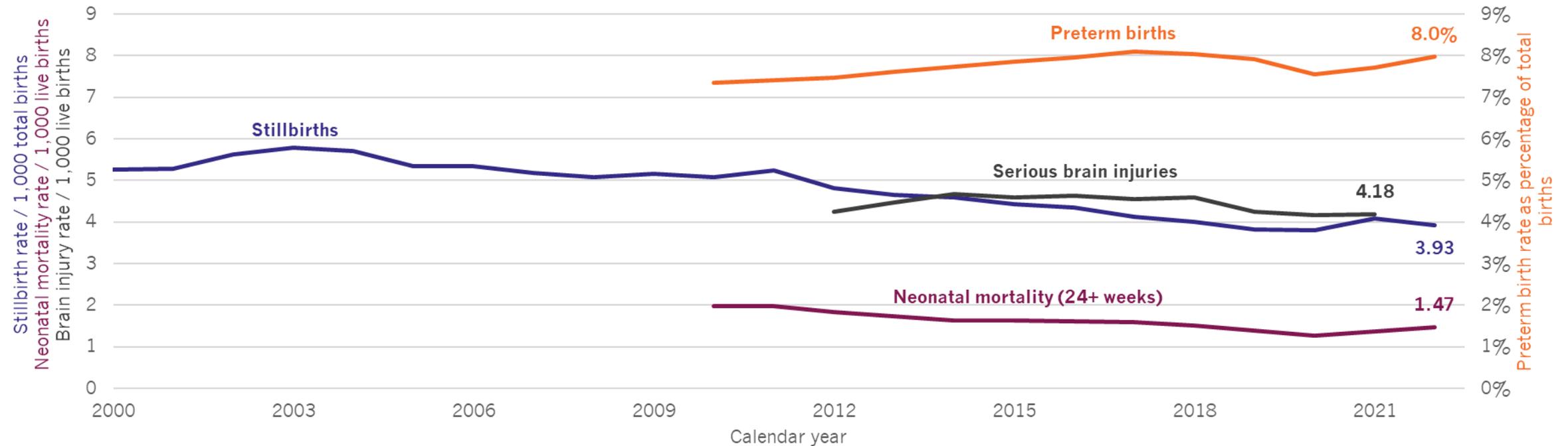

Notes: Preterm birth rate is the number of live births and stillbirths at between 24^{+0} and 36^{+6} weeks gestation as a proportion of all live births and stillbirths of known gestation.

Source: Office for National Statistics, Child and Infant Mortality Statistics; Office for National Statistics Birth Characteristics; Imperial College London, Neonatal Data Analysis Unit

2.5. Rates of perineal tears

Figure III.2.5: Percentage of deliveries in English NHS hospitals with a perineal laceration, 2006-07 to 2022-23
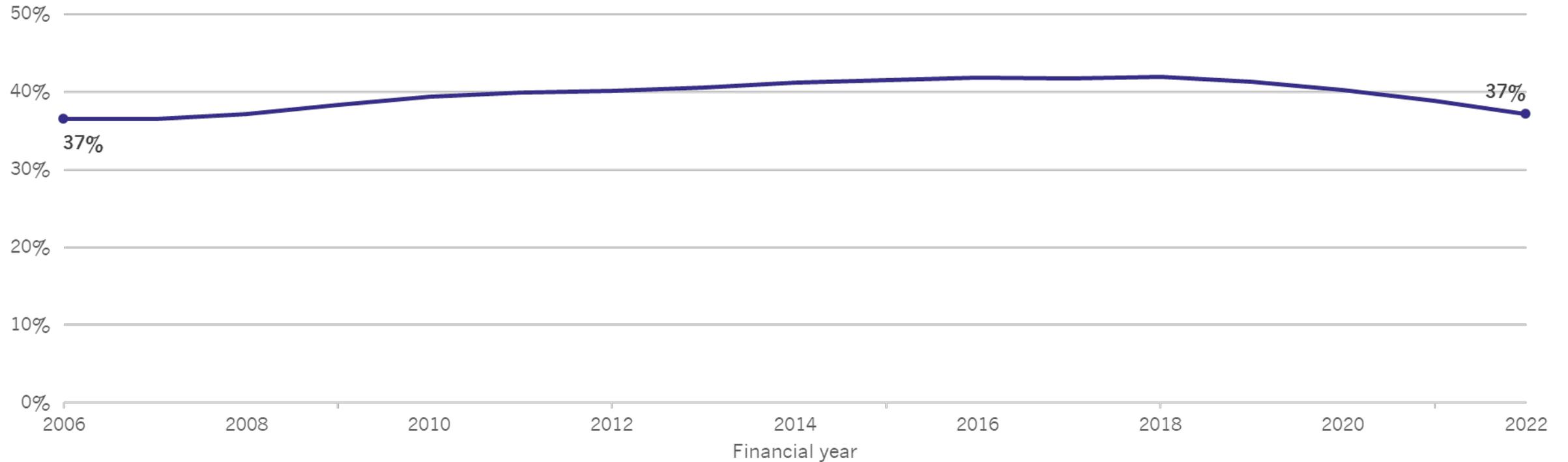
Source: *NHS Maternity Statistics*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics

2.6 Babies born with low and very low birth weights over time

Figure III.2.6: Babies born with low or very low birth weight in England, 2001 to 2022
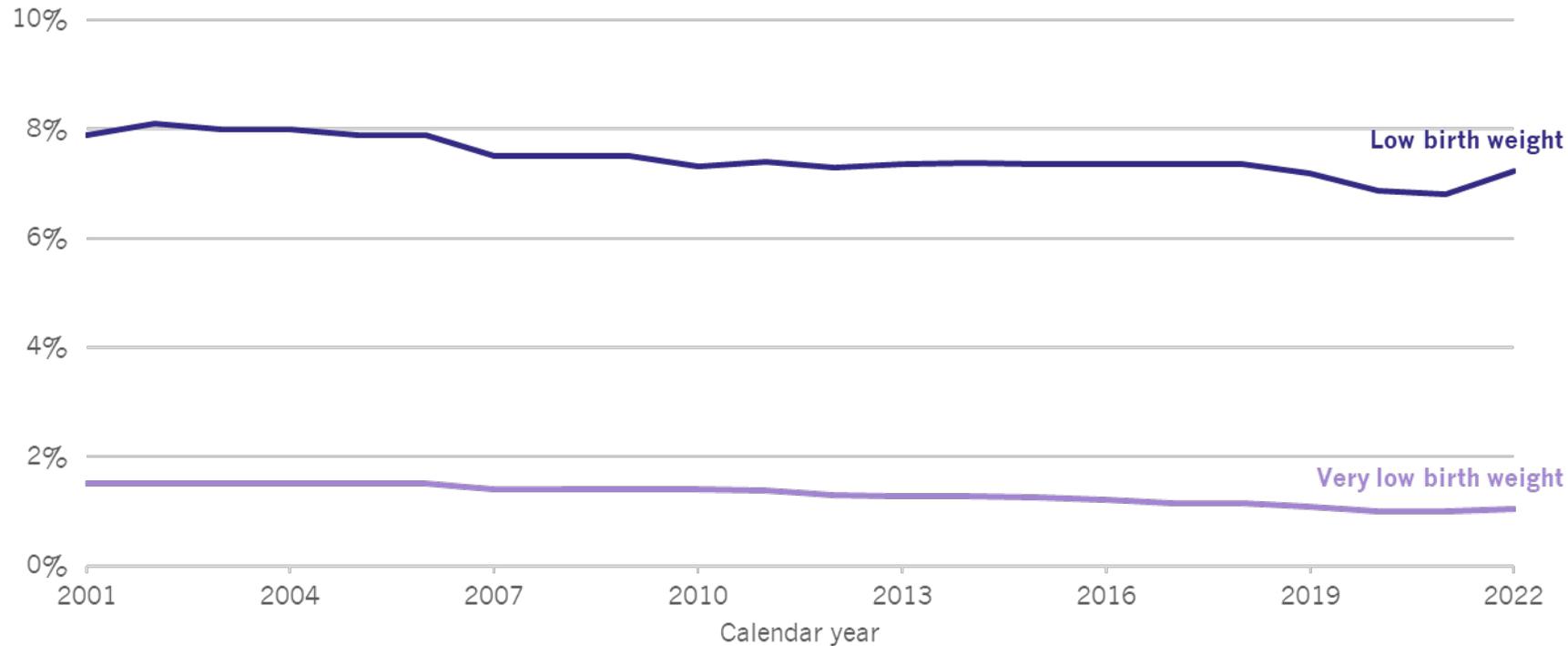
CAGRs	LOW BIRTH RATE	VERY LOW BIRTH RATE
2001-2005	0.0%	0.0%
2005-2010	-1.5%	-1.2%
2010-2015	0.1%	-2.3%
2015-2019	-0.6%	-3.8%
2019-2022	0.2%	-1.1%

Note: Low birth weight is < 2,500g, Very low birth weight is < 1,500g

Source: Office for National Statistics (2024), Births in England and Wales: 2022 (refreshed populations). Available at: [Births in England and Wales - Office for National Statistics (ons.gov.uk)](https://ons.gov.uk)

2.7 Inequalities in maternity outcomes

Figure III.2.7: Relative risk of adverse outcomes by ethnicity and deprivation, 2022

|		Maternal mortality (2020-22)	Stillbirths (2022)	Neonatal mortality (all births, 2022)	Brain injuries (2021)	Live preterm birth (England and Wales, 2022)
Ethnicity	White (ref.)	1.00	1.00	1.00	1.00	1.00
	Asian	1.67	1.35	1.88	1.19	1.04
	Black	2.81	1.9	2.39	1.4	1.08
	Mixed/multiple	1.35	1.16	1.22	0.45	0.97
	Other	0.70	1.26	1.17	1.00	1.02
Deprivation	1 - most deprived	2.25	1.35	2.36	1.44	-
	2	1.35	1.18	1.82	1.21	-
	3	1.67	1.12	1.44	1.1	-
	4	0.96	0.89	1.43	1.09	-
	5 - least deprived (ref.)	1.00	1.00	1.00	1.00	-

Higher relative risk
Similar risk
Lower relative risk

Notes: For data on maternal mortality, Chinese women are included in the 'Other' ethnic group. For other metrics, Chinese babies are included in the 'Asian' ethnic group. The white and least deprived groups are the reference groups for the calculation of the relative risk of all other groups.

Source: Office for National Statistics Child and Infant Mortality Statistics; Office for National Statistics Birth Characteristics; Neonatal Data Analysis Unit, Imperial College London; MBRRACE-UK, University of Oxford, Maternal Mortality 2020-22.

2.8 Inequalities in stillbirth and neonatal mortality rate and preterm birth rate by deprivation and ethnicity

Figure III.2.8: Relative risks of stillbirth and neonatal mortality, and preterm birth in England and Wales
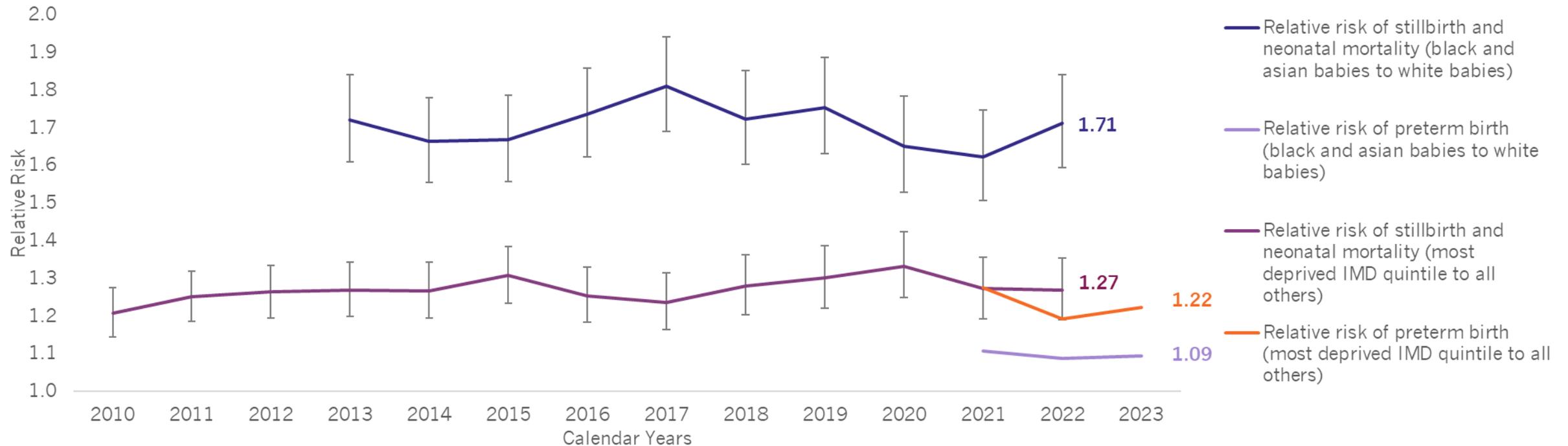

Notes: Rates presented for Black and Asian babies compared to White babies; and for babies born in the most deprived areas compared to babies born in other areas (95% confidence intervals included to aid interpretation). Data is presented for all years available from source data set. A relative risk of 1.71 indicates the likelihood of the adverse event is 71% greater in the higher risk group. A relative risk of 1 would indicate equality between groups. Stillbirth and neonatal mortality rate is measured as the number of stillbirths and neonatal deaths per 1000 births (at all gestational ages). Preterm birth rate is measured as the number of births before 37 weeks gestation as a percentage of all births (over 24 weeks gestation)

Source: Office for National Statistics, Child and Infant Mortality Statistics (May 2024)

2.9 Inequalities in maternal mortality rates by ethnicity

Figure III.2.9: Maternal mortality rates per 100,000 maternities in England for Black, Asian and White women for available years (95% confidence intervals included to aid interpretation)
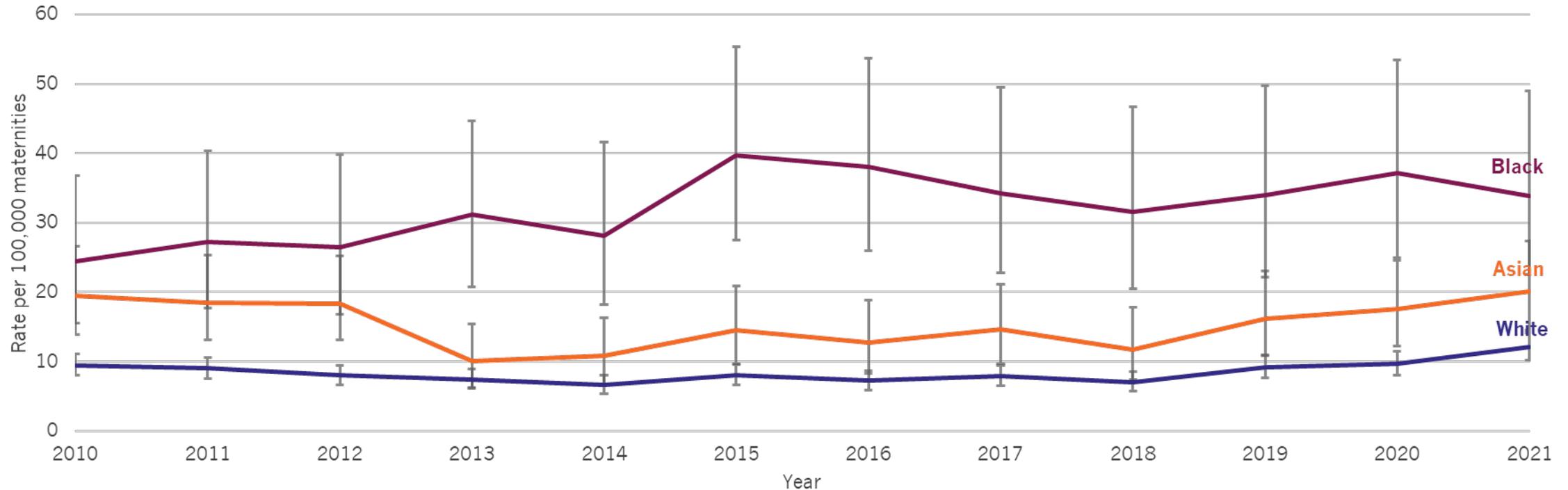

Notes: In 2020-2022, the relative risk of maternal mortality was 2.8 time as high for black women than white women and 1.7 times as high for Asian women than white women. Maternal mortality rates are reported for rolling triennia. The mid-year of the triennia is shown in the x-axis of the chart.

Source: *MBRRACE-UK Maternal mortality 2020-2022* Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2020-2022

2.10 Deliveries per midwife

Figure III.2.10: Deliveries per midwife in England, 2001 to 2022
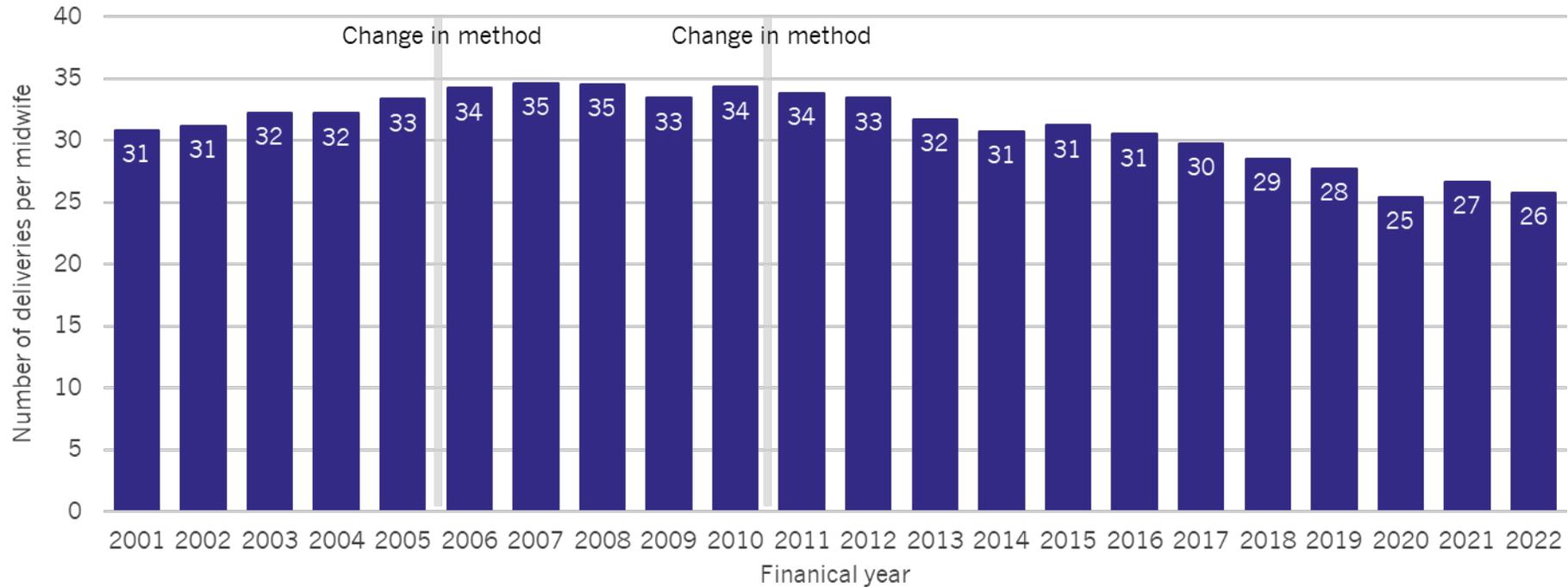
| TIME PERIOD	CAGR
2001-02 to 2022-23	-0.8%
2010-11 to 2020-23	-2.4%

Notes: Data is included for all full financial years available from both source data sets. Data for the number of midwives relates to the number of Full Time Equivalent midwives as of September of each year (excluding those on maternity leave). Data is for financial years with the first year of the financial year presented on the chart x-axis

Source: *Deliveries per year - Annual Maternity Statistics (Hospital Episode Statistics).* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2022-23
Number of FTE Midwives - NHS Workforce Statistics. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

2.11 Maternity services reporting suspension of units, services or admissions in July 2024

**Figure III.2.11: Percentage of maternity services reporting suspension of units and services by region**
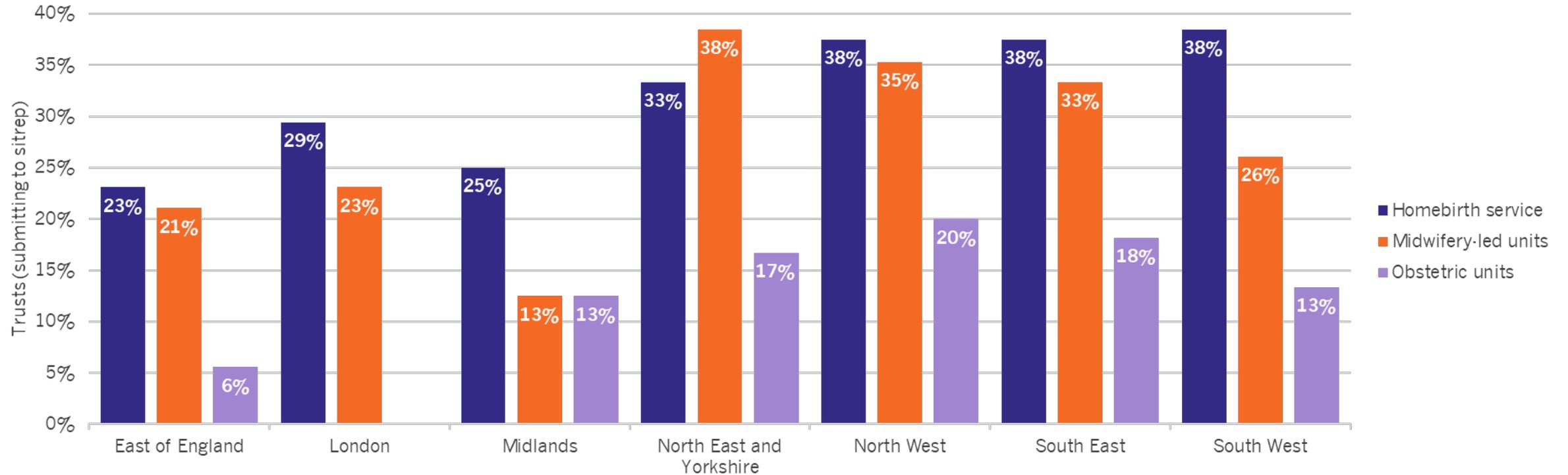
Notes: Latest period 1st – 14th July 2024. Percentages of home birth service suspensions reported are based on 113 trusts that submitted to the SitRep for the specified data period, out of 120 trusts with maternity services. Percentages of unit closures are based on the total number of units in the submitting trusts.

Source: *NHS England National Maternity and Neonatal Situation Report.*

2.12 Numbers of maternity outpatient attendances and number of maternity outpatient attendances per delivery

Figure III.2.12. Number of maternity outpatient attendances and number of maternity outpatient attendances per delivery
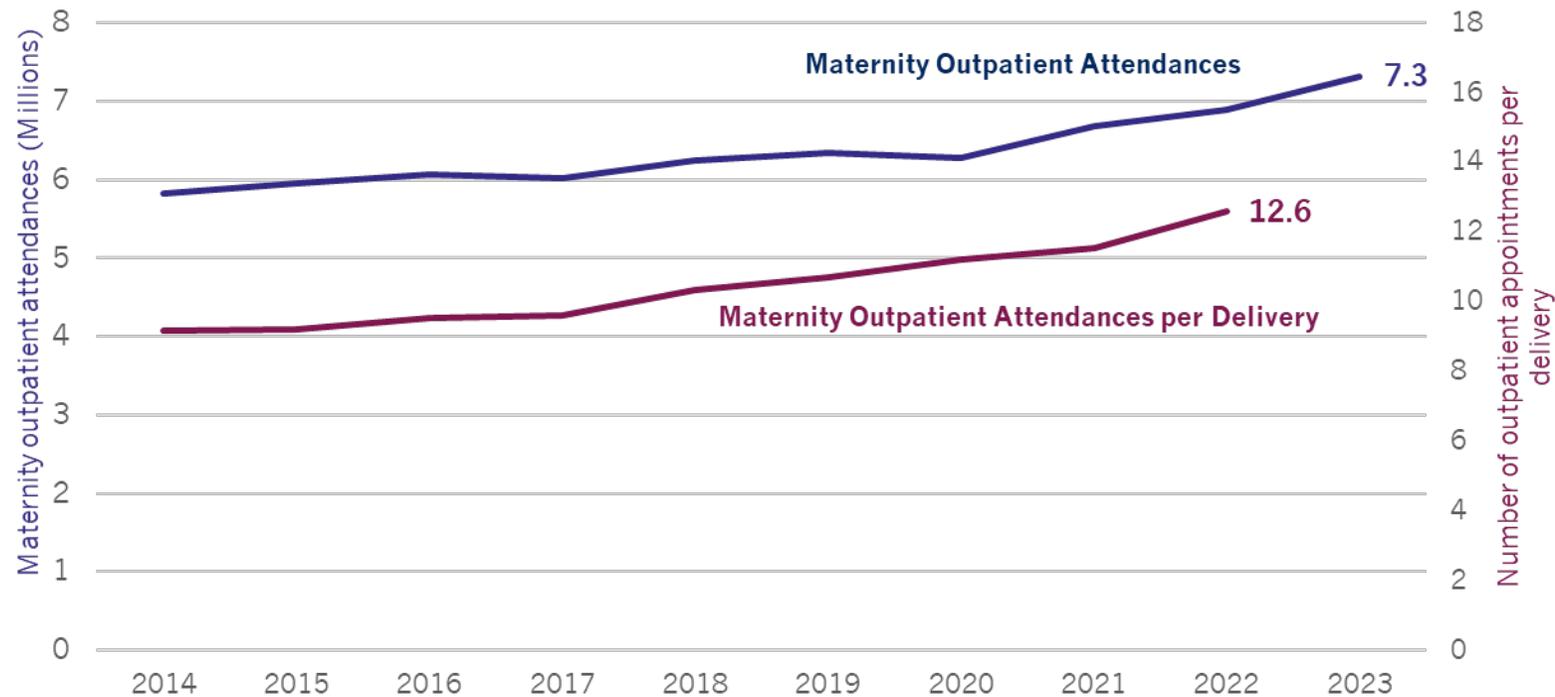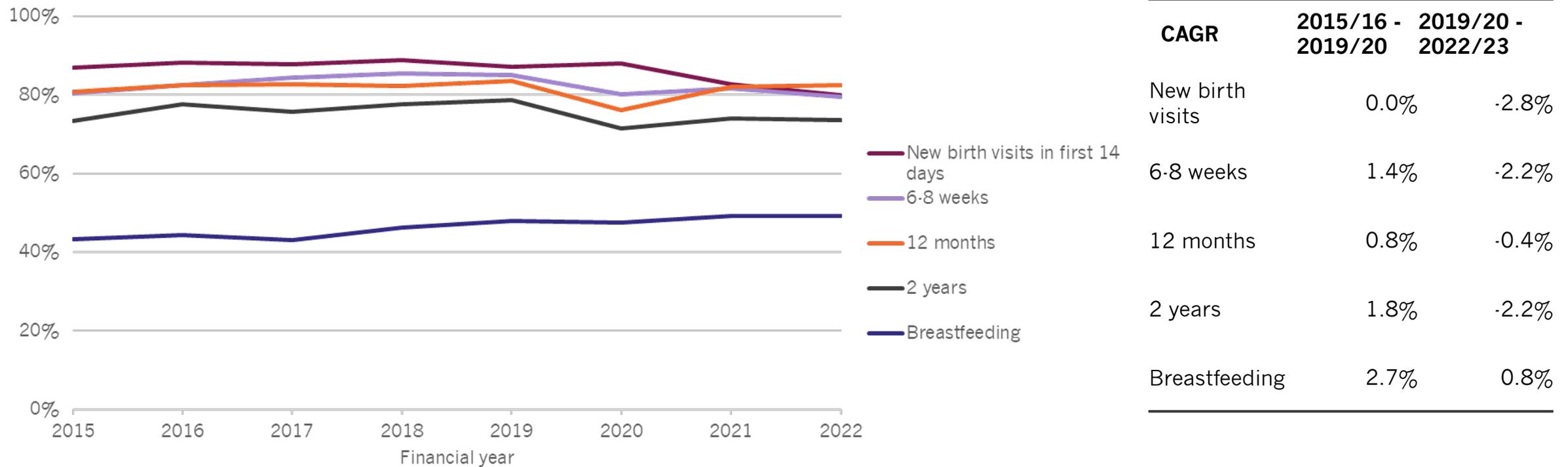

CAGRs	Compound Annual Growth Rate
Attendances (2014-15 to 2023-24)	2.6%
Attendances per delivery (2014-15 to 2022-23)	4.1%

Notes: Data is presented for all years available from source data set
Data is for financial years with the first year of the financial year presented on the chart x-axis
Maternity outpatient attendances including first and follow-up consultant led and non-consultant led attendances

Source: NHS Secondary Use Service data (SUS)

2.13 Universal health visiting reviews and breastfeeding prevalence at 6-8 weeks over time

Figure III.2.13: Universal health visitor reviews and breastfeeding prevalence at 6-8 weeks, 2015/16 to 2021/22


CAGR	2015/16 - 2019/20	2019/20 - 2022/23
New birth visits	0.0%	-2.8%
6-8 weeks	1.4%	-2.2%
12 months	0.8%	-0.4%
2 years	1.8%	-2.2%
Breastfeeding	2.7%	0.8%

Notes: Breastfeeding data at 6 to 8 weeks is only available for 77 local authorities, as 72 have inadequate data quality for a figure to be published. Data is only provided for new birth visits within 14 days. Coverage of new birth visits within 30 days is approximately 98%.

Source: Health Visiting – 2015/16 to 2016/17, Health visitor service delivery metrics, Public Health England. 2017/18 to 2021/22, Child and Maternal Health Profile, Office of Health Improvement and Disparities; Breastfeeding – 2015/16 to 2016/17, Breastfeeding at 6 to 8 weeks after birth, Public Health England. 2017/18 to 2021/22, Child and Maternal Health Profile, Office of Health Improvement and Disparities.

2.14 Women's reported perinatal experience

Figure III.2.14: Experiences of women and other pregnant people who had a live birth
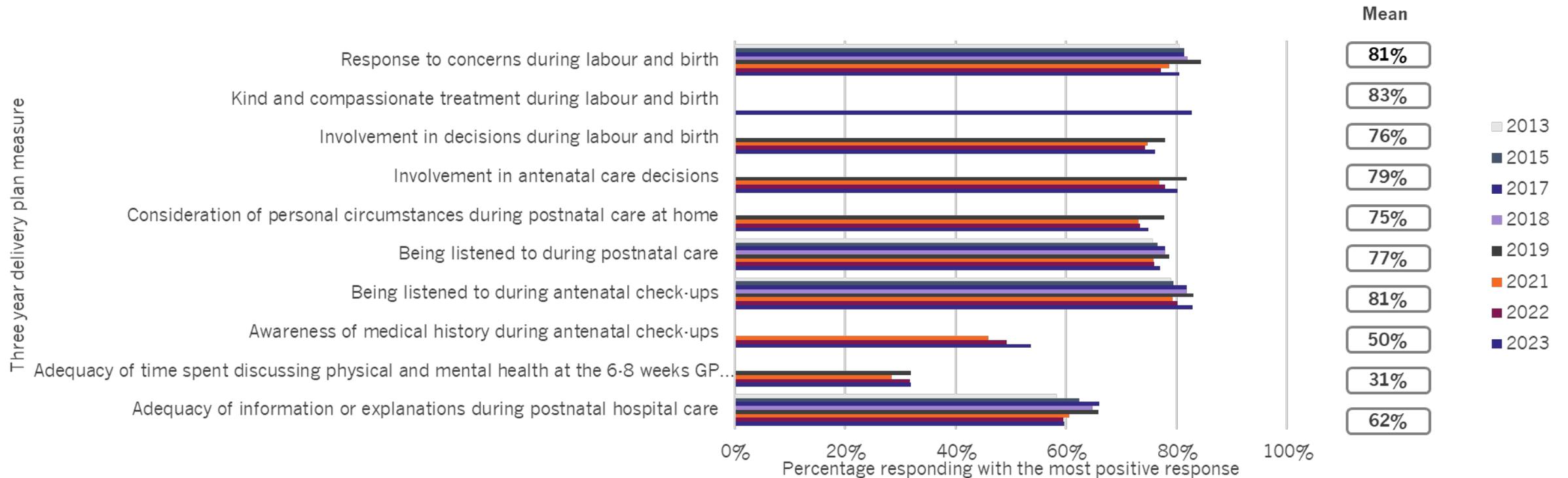

Notes: NHS England's Maternity and Neonatal Programme (MNP) use the results of eleven questions in the National Maternity Survey to track progress against key deliverables in the Three-Year delivery Plan for Maternity and Neonatal Services. The questions focus on women being listened to and involved in decisions about their care, which were key themes identified in the Ockenden and East Kent reports. The NHS Patient Survey Programme is delivered by the CQC on behalf of NHS England and the Department of Health and Social Care and conducted every two years from 2013 to 2017, then annually with the exception of 2020.

Source: *CQC National Survey Programme - Maternity Survey*. Available at: https://www.cqc.org.uk/publications/surveys/maternity-survey

3.1 Childhood obesity prevalence

Figure III.3.1: Percentage of children in Reception year (aged 4 to 5 years) and children in Year 6 (aged 10 to 11 years) living with obesity in England, academic year 2006/07 to 2022/23
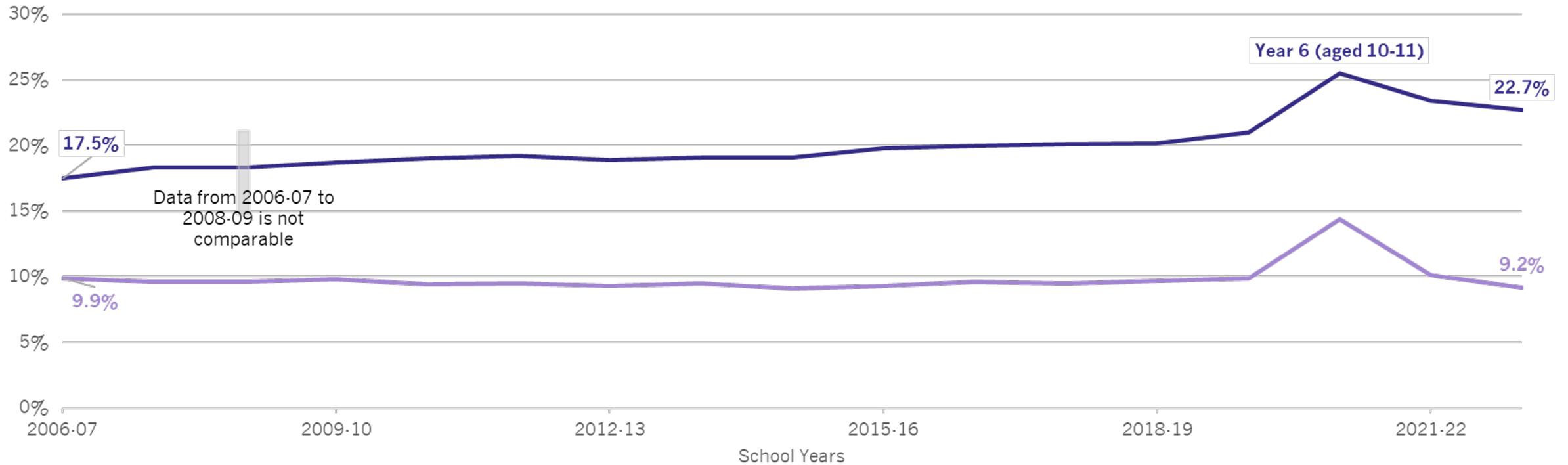
Notes: Comparisons are not possible with the first years (2006/2007 to 2008/2009) of the National Child Measurement Programme (NCMP) for children in year 6 as low participation levels led to underestimation of obesity prevalence.

Source: NHS England (2023), National Child Measurement Programme (NCMP). Available at: National Child Measurement Programme (NCMP), NHS England, 2023; Charts produced by OHID

3.2 Childhood obesity prevalence by deprivation decile

Figure III.3.2A: Percentage of children in Reception year (aged 4 to 5 years) living with obesity by IMD 2019 deprivation decile in England, 2022/23
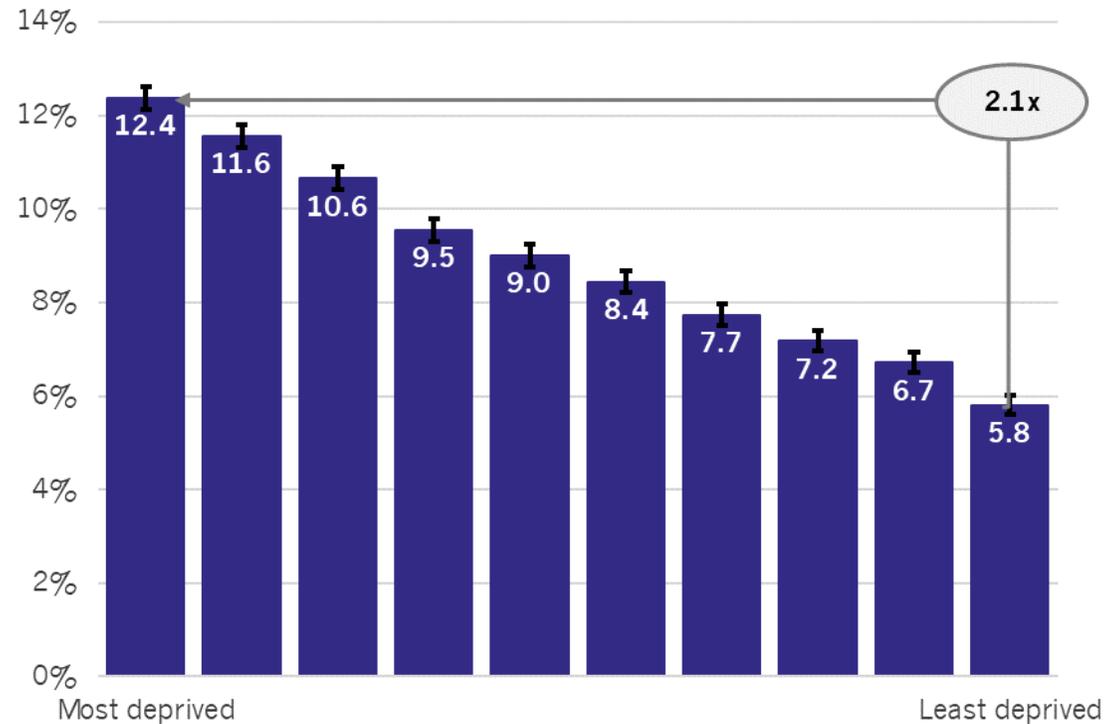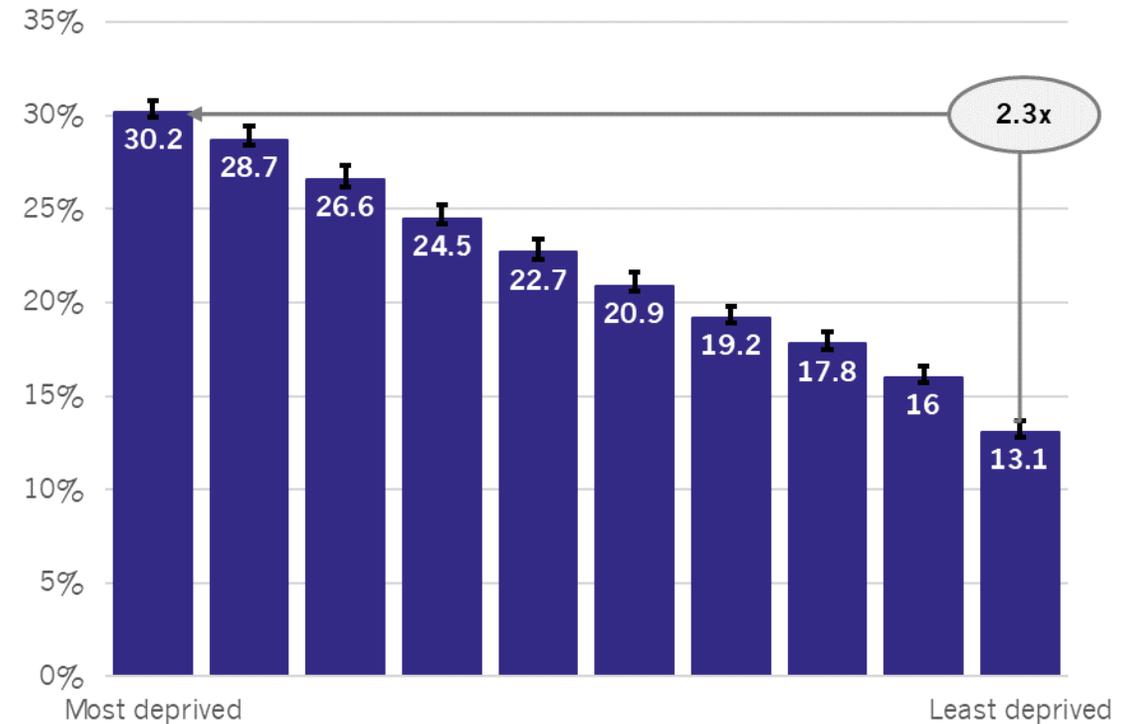

Figure III.3.2B: Percentage of children in Year 6 (aged 10 to 11 years) living with obesity by IMD 2019 deprivation decile in England, 2022/23

Source: NHS England (2023), National Child Measurement Programme (NCMP). Available at: National Child Measurement Programme (NCMP), NHS England, 2023; Charts produced by OHID

3.3 Physical activity (averaging 60 minutes of activity per day) amongst 5 to 16 year olds

Figure III.3.3: Percentage of physically active children and young people in England, 2017/18 to 2022/23 (aged 5 to 16 years)
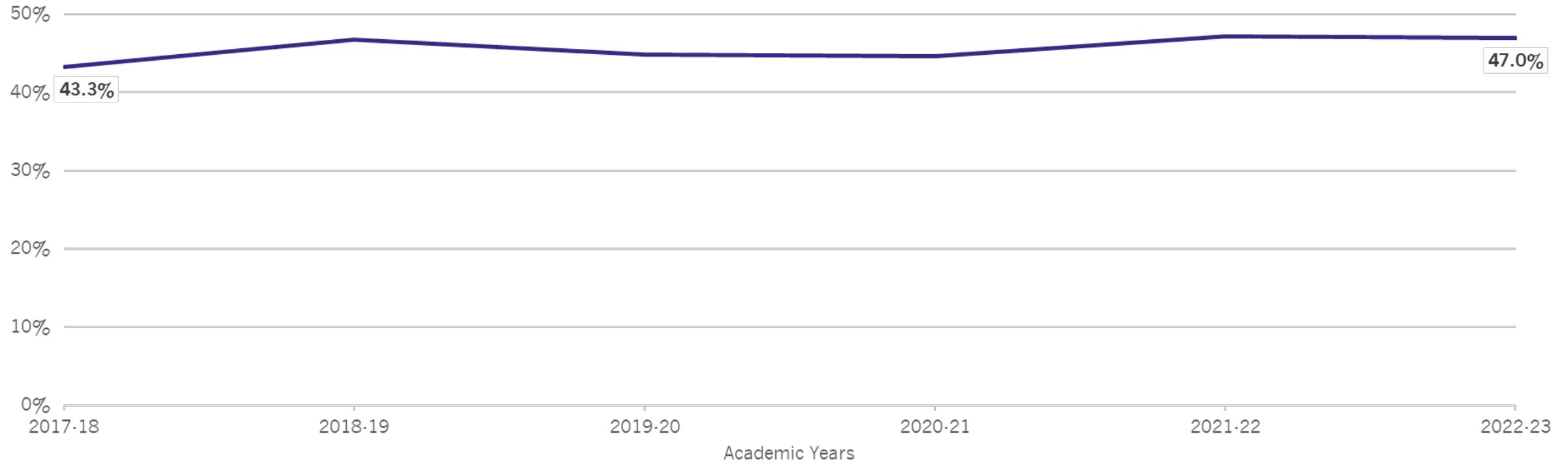
Source: Academic Years 2017/18 to 2022/23 (age 5 to 16 years) OHID analysis of the Active Lives Survey, physical activity trend chart

3.4 Smoking and vaping prevalence among children

Figure III.3.4: Percentage of secondary school pupils who smoke and percentage who use e-cigarettes in England, 2001 to 2021
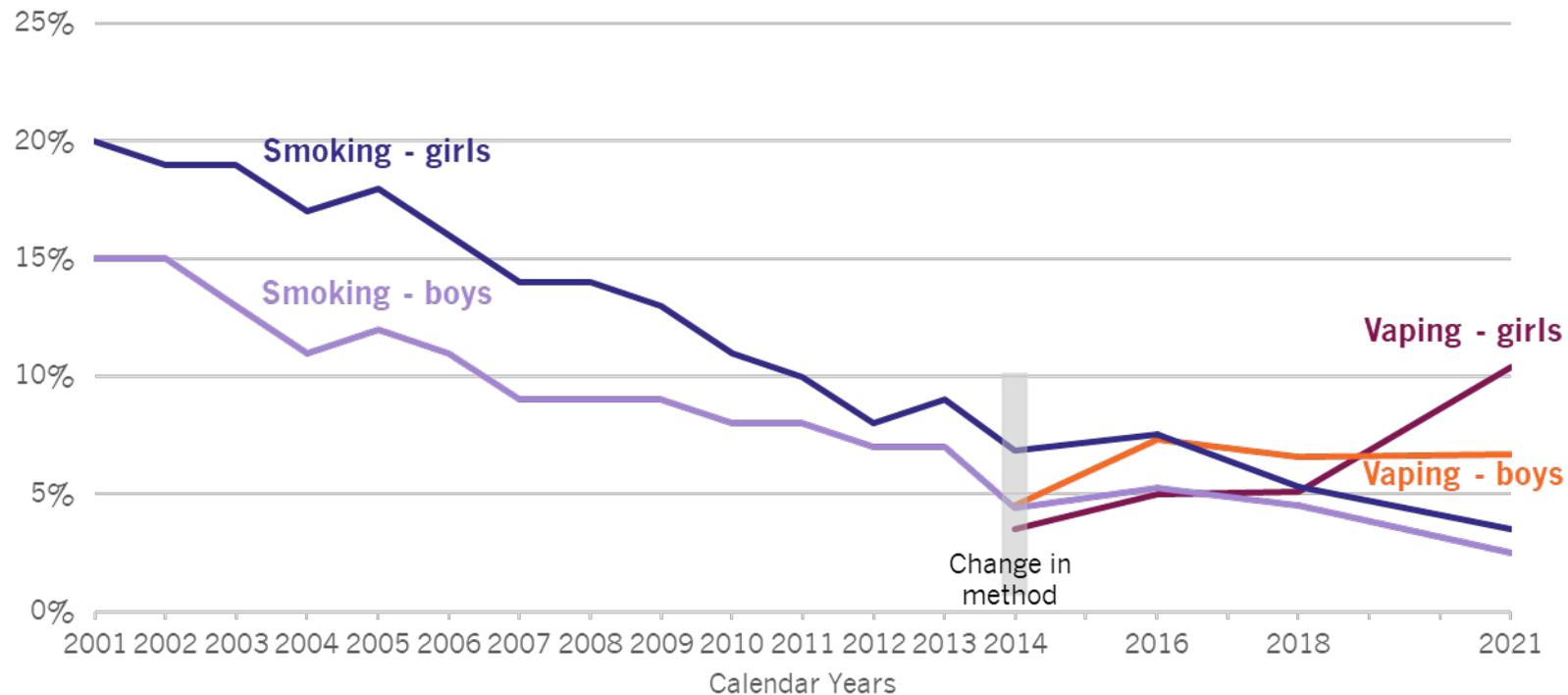

CAGRs	SMOKING		VAPING	
	BOYS	GIRLS	BOYS	GIRLS
2001-2005	-5.4%	-2.6%		
2005-2010	-7.8%	-9.4%		
2010-2014	-13.8%	-11.2%		
2014-2018	0.5%	-6.0%	9.8%	9.7%
2018-2021	-18.1%	-12.9%	0.5%	26.9%

Notes: Surveys have not been conducted annually since 2014, this is reflected in the labels on the x-axis, corresponding to the survey dates.

Source: NHS Digital (2022), Data for children in school years 7 to 11. Available at: Smoking, Drinking and Drug Use among Young People in England, 2021

3.5 Proportion of school pupils with education, health and care plans

Figure III.3.5: Percentage of all Pupils with EHCP by Primary Need for year 2015 to 2023.
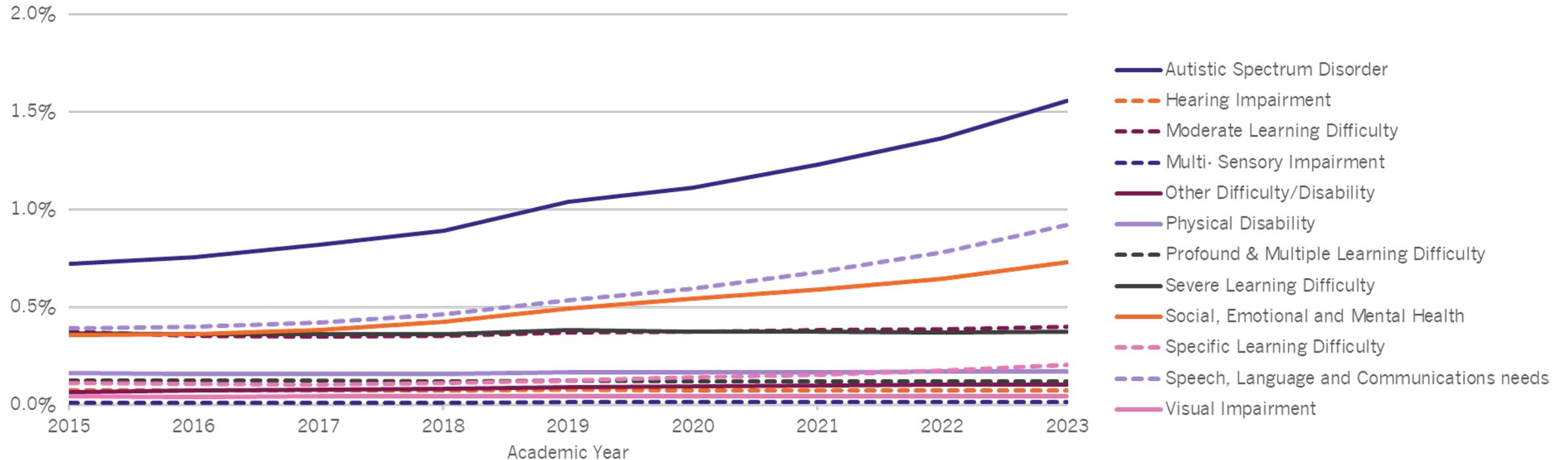

Notes: This includes state-funded nursery, primary, secondary and special schools, non-maintained special schools and state-funded alternative provision schools. Does not include independent schools.

Source: Department for Education (2024), Special Educational Needs. Available at: Special educational needs in England, Academic year

3.6 Proportion of school pupils with social, emotional and mental health needs

Figure III.3.6: Percentage of school pupils who have educational support for social, emotional and mental health needs (school age)

CAGR over period: 5.3%

2.30%

3.30%

School Years
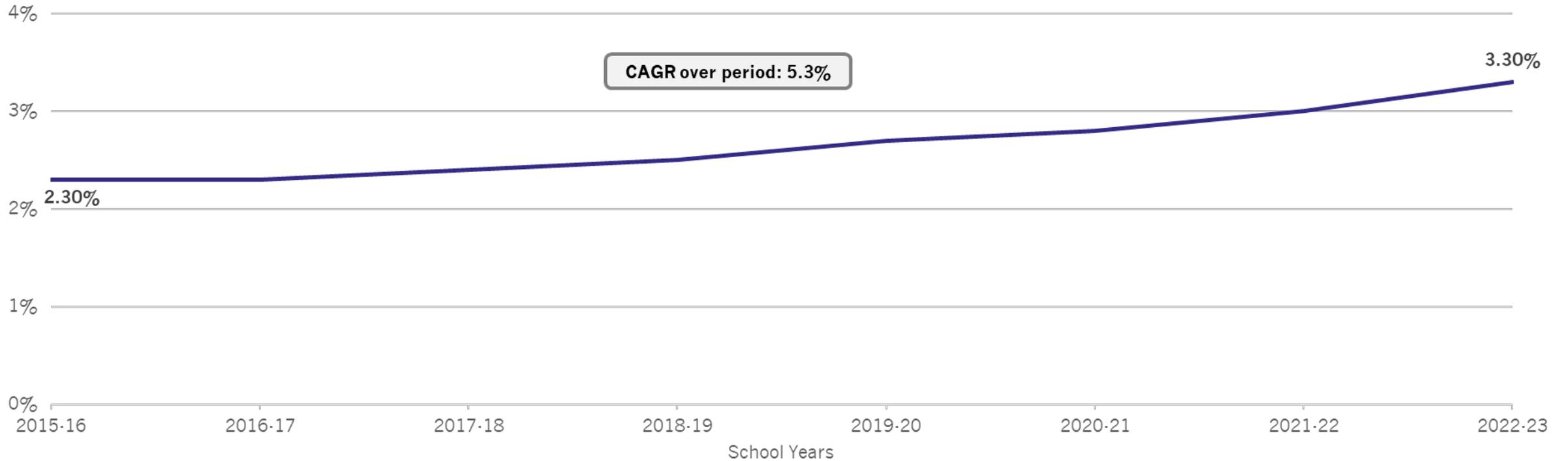
Notes: This data shows the percentage of pupils in schools who have been formally identified in schools as having Special Educational Needs (i.e. requiring/eligible for additional in school support) and whose primary type of need is recorded as social, emotional and/or mental health. Schools have different practices for recording pupils as SEN and for which type of need is recorded as primary, and many pupils also have multiple needs.

Source: Department for Education, Special Educational Needs, Accessed via: Children and Young People's Mental Health and Wellbeing | Fingertips

# 3.7 Childhood vaccination coverage

Figure III.3.7A: Vaccine coverage of children aged 24 months with the MMR vaccine (dose 1) and aged 5 years with the MMR (dose 1 and dose 2) and diphtheria vaccines, in England
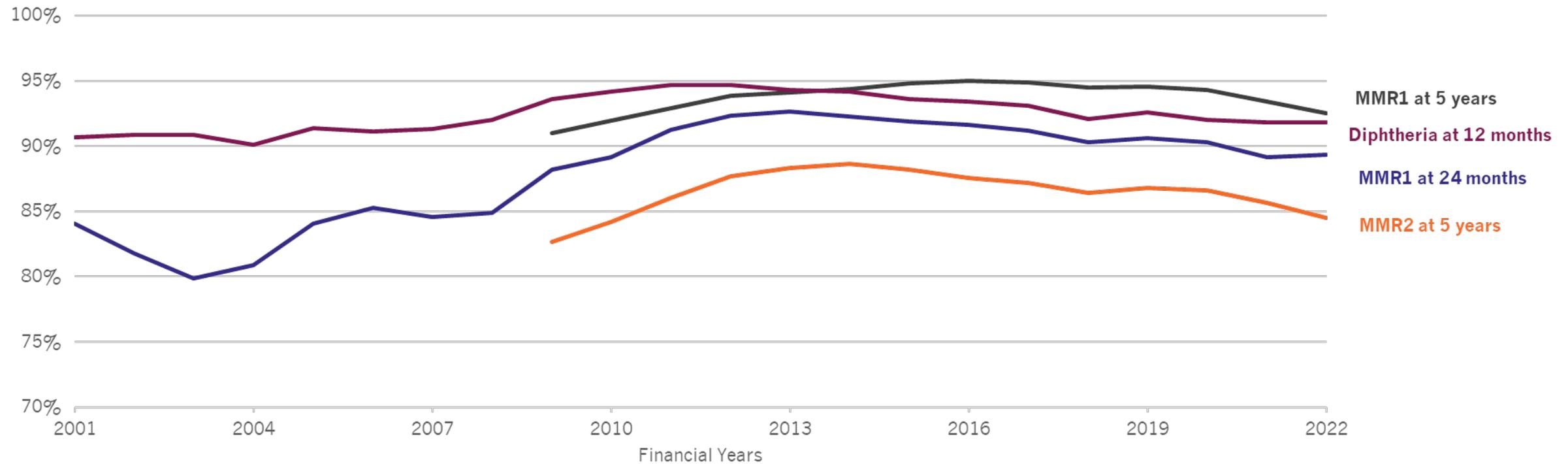
Source: NHSE (2023), Childhood Vaccination Coverage Statistics, England. Available at: Childhood Vaccination Coverage Statistics · NHS England Digital

3.7b Childhood vaccination coverage: CAGR tables

Figure III.3.7B: Vaccine coverage of children aged 24 months with the MMR vaccine (dose 1) and aged 5 years with the MMR (dose 1 and dose 2) and diphtheria vaccines, in England, CAGRs

CAGR	Diphtheria at 5 years	MMR1 at 24 months
2001/02 - 2005/06	0.2%	0.0%
2005/06 - 2010/11	0.8%	1.5%
2010/11 - 2015/16	-0.1%	0.5%
2015/16 - 2019/20	-0.3%	-0.4%
2019/20 - 2022/23	-0.3%	-0.5%

CAGR	MMR1 at 5 years	MMR2 at 5 years
2009/10 - 2010/11	1.0%	1.8%
2010/11 - 2015/16	0.5%	0.8%
2015/16 - 2019/20	-0.1%	-0.4%
2019/20 - 2022/23	-0.7%	-0.9%

3.8 Children having 1+ emergency admissions to hospital per 10,000 children by local authority

Figure III.3.8: Average number of non-elective spells per day for children aged 0 to 17 years expressed as a rate per 10,000 children.


YEAR	CAGR
2010/11 - 2015/16	1.0%
2015/16 - 2019/20	1.5%
2019/20 - 2021/22	-5.0%
2021/22 – 2023/24	-1.8%
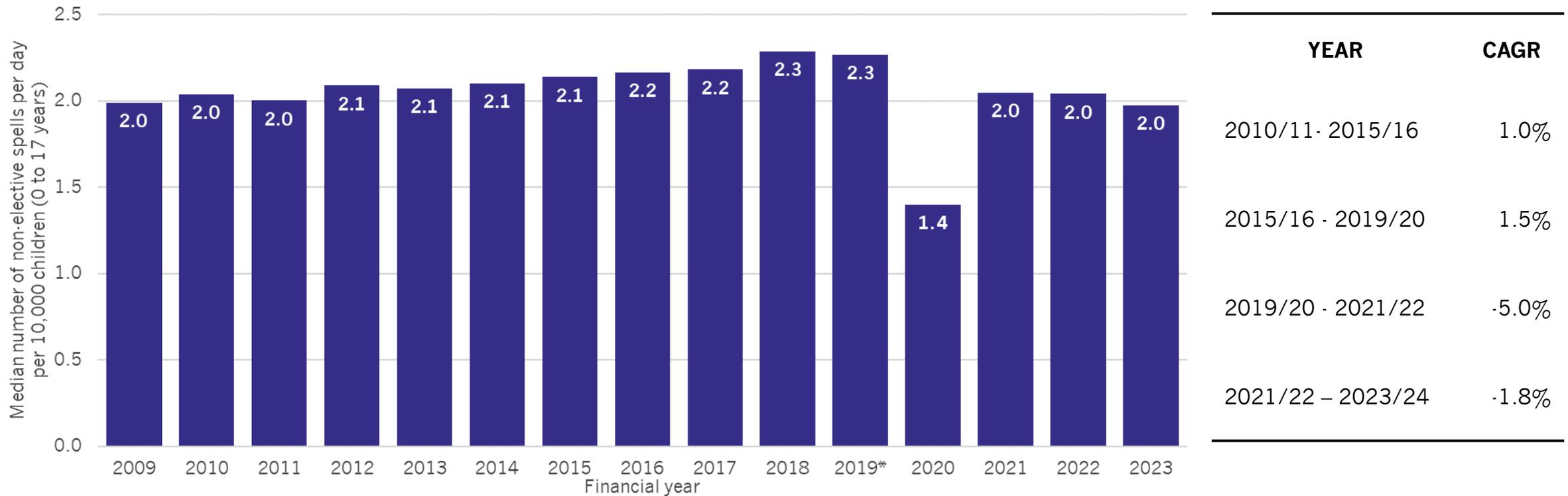
Notes: Using Office for National Statistics mid-year estimates by upper tier local authority. *Mar-19 to Feb-20 figure to avoid impact of the COVID-19 pandemic

Source: Data are unpublished and are based on APC CDS data sourced from the SUS+ Service

3.9 Parents' satisfaction with paediatric services and young people's satisfaction with services

Figure III.3.9: Children and Young People Overall Experience
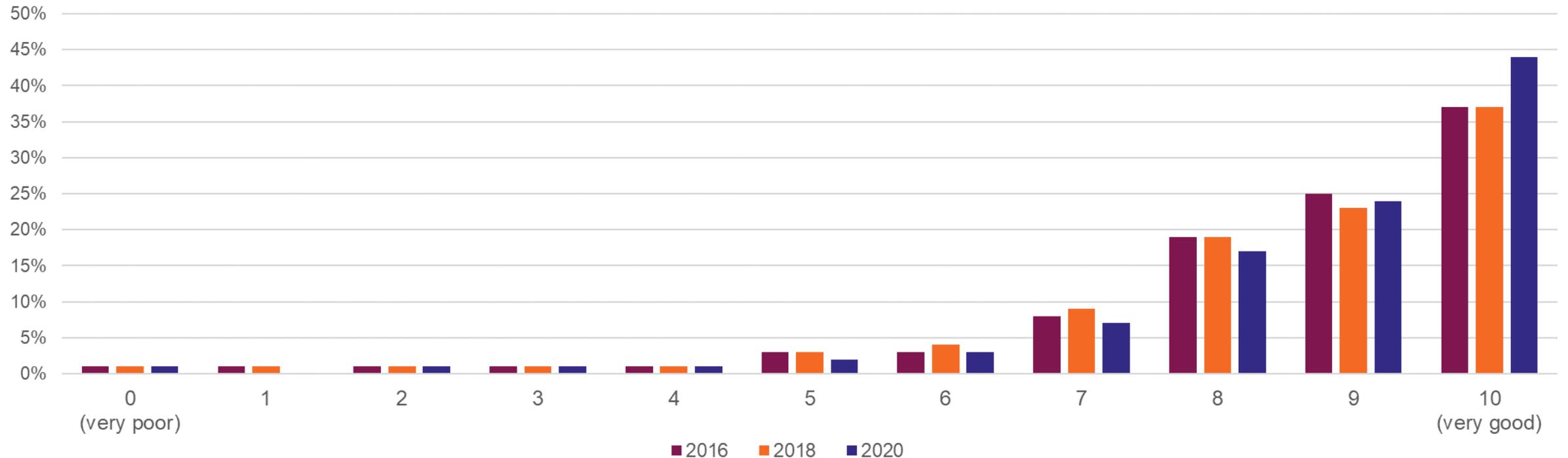

Notes: Parents asked to rate their child's overall experience from 0 ("I felt my child had a very poor experience") to 10 ("I felt my child had a very good experience"). Total respones: 2016 = 33,647, 2018 = 32,184, 2020 = 26,515.

Source: Care Quality Commission. Children and young people's experience survey for patients aged 0 to 15 years with a hospital admission. Available: https://www.cqc.org.uk/publications/surveys/children-young-peoples-survey-2020

4.1 Referrals for outpatient appointments by source of referral

Figure III.4.1: Referrals for outpatients by source of referral

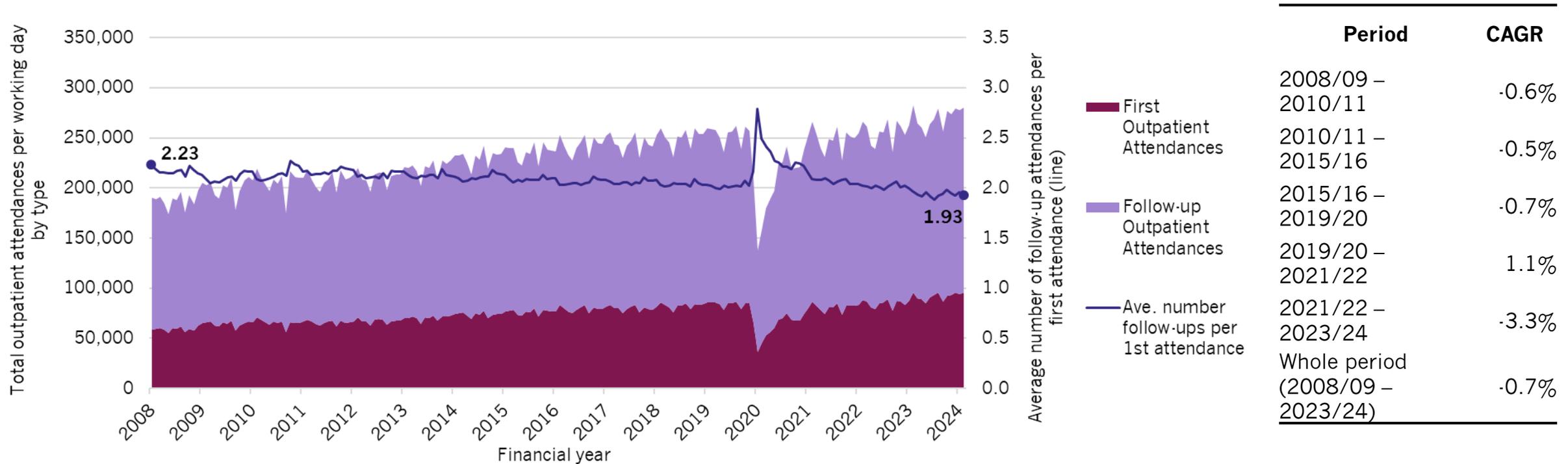| YEAR	CAGR
2008-2011	3.7%
2011-2015	4.2%
2015-2019	1.2%
2019-2021	-6.8%
2021-2023	4.3%
2008-2023	2.3%
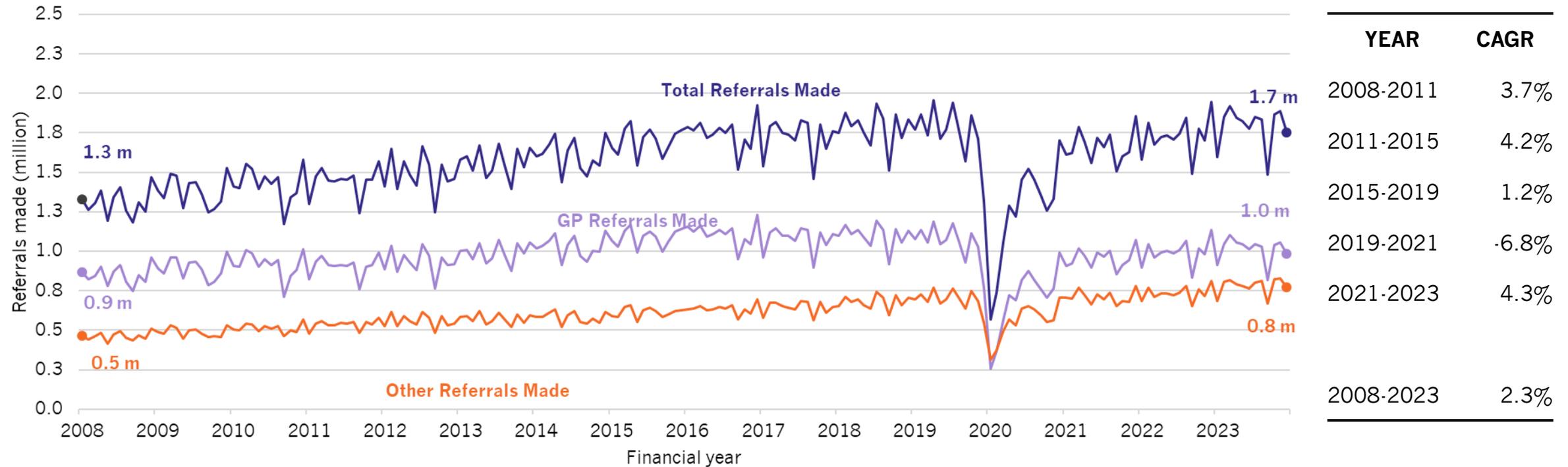
Notes: The labels show the working day adjusted compound annual growth rate over those financial years; March 2020 data point excluded from 2019/20 so as not to bias the comparison.

Source: NHS England (2024) Monthly Referral Return official statistics. Available at: Statistics » Monthly Outpatient Referrals Data (england.nhs.uk)

4.2 Average number of follow-up outpatient attendances per first attendance

Figure III.4.2: Monthly numbers of outpatient attendances per working day for NHS commissioned consultant-led attendances for specific acute treatment functions.

Period	CAGR
2008/09 – 2010/11	-0.6%
2010/11 – 2015/16	-0.5%
2015/16 – 2019/20	-0.7%
2019/20 – 2021/22	1.1%
2021/22 – 2023/24	-3.3%
Whole period (2008/09 – 2023/24)	-0.7%

Notes: The labels show the working day adjusted compound annual growth rates. FY2019/20 are based on the 12 months to Feb-2020 to avoid distortion due to the start of the COVID-19 pandemic.

Source: NHS England (2024) Unpublished from the Outpatient CDS via the SUS+ Service.

Figure III.4.3: Variation in elective overnight average length of stay by treatment function

Key:

Highest ALOS

Lowest ALOS

Year	General Surgery	Urology	Vascular surgery	Trauma & Orthopaedics	ENT	Ophthalmology	Oral Surgery	Maxillo-facial surgery	Neurosurgery	Plastic Surgery	Cardiothoracic Surgery	Paediatric ear nose and throat	Paediatric maxillo-facial surgery	General Medicine	Gastroenterology	Cardiology	Dermatology	Thoracic Medicine	Neurology	Rheumatology	Geriatric Medicine	Gynaecology	Other Medicine	Other Surgery	Other Specialty
FY2009	4.0	3.0	4.9	4.3	1.6	1.6	2.9	3.0	5.0	3.4	8.2	1.5	1.9	5.2	3.1	2.4	9.5	4.7	7.8	6.8	14.5	2.8	5.7	4.5	3.8
FY2010	3.9	2.8	4.8	4.1	1.6	1.6	3.0	3.0	4.7	3.4	8.1	1.3	1.3	5.0	3.5	2.3	7.7	4.6	7.0	6.3	13.5	2.6	5.5	4.3	3.5
FY2011	3.8	2.8	4.8	3.9	1.7	1.7	2.7	3.0	4.5	3.4	7.8	1.4	1.3	5.0	3.4	2.4	8.1	4.0	6.4	6.2	16.3	2.4	5.8	4.2	3.3
FY2012	3.8	2.7	4.8	3.9	1.7	1.7	2.6	3.0	4.3	3.3	7.9	1.3	1.4	5.2	3.3	2.3	7.4	3.8	6.4	5.7	16.6	2.3	5.9	4.3	3.3
FY2013	3.7	2.6	4.8	3.8	1.7	1.5	2.7	2.9	4.2	3.3	7.8	1.4	1.5	5.7	3.4	2.3	6.7	3.9	6.6	5.7	15.1	2.2	6.0	4.3	3.4
FY2014	3.6	2.6	4.9	3.7	1.8	1.7	2.6	3.2	4.6	3.3	7.6	1.4	1.5	5.7	3.5	2.3	5.5	3.9	7.1	6.0	12.8	2.1	6.3	4.4	3.3
FY2015	3.7	2.5	4.9	3.6	1.9	1.7	2.8	3.1	5.0	3.5	7.4	1.4	1.6	5.8	3.7	2.3	5.4	3.9	7.1	8.4	11.6	2.1	6.3	4.3	3.1
FY2016	3.6	2.4	4.8	3.6	1.9	1.9	2.7	3.0	4.9	3.4	7.4	1.4	1.3	5.1	3.4	2.4	5.5	3.9	7.0	10.0	10.9	2.0	6.4	4.3	3.0
FY2017	3.6	2.4	4.7	3.5	1.9	1.9	3.1	3.3	4.8	3.4	7.3	1.5	1.2	4.5	3.7	2.5	5.6	3.9	6.9	7.3	10.8	2.1	6.6	4.5	3.2
FY2018	3.6	2.3	4.8	3.4	2.0	1.7	2.7	3.2	4.5	3.6	7.1	1.4	1.4	4.7	3.5	2.6	5.6	3.8	7.4	5.4	11.8	2.0	6.1	4.4	3.2
FY2019	3.7	2.3	4.8	3.3	2.1	1.9	2.9	3.3	4.8	3.6	7.2	1.6	1.4	4.2	4.2	2.8	8.3	4.1	7.3	6.1	11.9	2.0	6.2	4.5	3.2
FY2020	3.7	2.3	4.8	3.0	2.5	1.9	3.6	4.7	5.0	3.4	7.1	1.6	1.5	4.4	3.7	2.8	6.4	4.2	8.0	5.3	10.3	2.0	6.7	4.5	3.2
FY2021	3.6	2.3	4.9	3.0	2.3	2.2	3.4	3.7	5.0	3.1	7.1	1.6	1.6	4.1	3.7	3.0	13.0	4.3	7.3	5.6	9.8	1.9	6.4	4.4	3.9
FY2022	3.7	2.3	5.1	3.1	2.3	2.2	3.5	3.8	5.1	3.2	7.1	1.6	1.7	4.8	4.0	3.3	4.2	5.4	7.1	6.9	11.0	2.0	6.5	4.4	3.9
FY2023	3.6	2.3	5.1	2.8	2.3	2.0	3.3	3.9	4.8	3.4	7.1	1.8	1.7	5.0	4.3	3.6	6.0	5.8	7.7	7.0	10.7	1.9	6.4	4.5	3.4

Notes: Covers the main treatment functions reported separately as part of the RTT standard. The table presents average length of stay in days where the colouring is specific to each treatment function and demonstrates how ALOS for each treatment function has changed through time. Changes to day surgeries and outpatient procedures may have impacted on length of stay over time.

Source: NHS England (2024) Unpublished from the Admitted Patient Care CDS via the SUS+ Service.

4.4 Emergency readmissions to hospital within 30 days of discharge

Figure III.4.4: Emergency readmissions to hospital within 30 days of discharge, by age group, 2002/03 – 2022/23
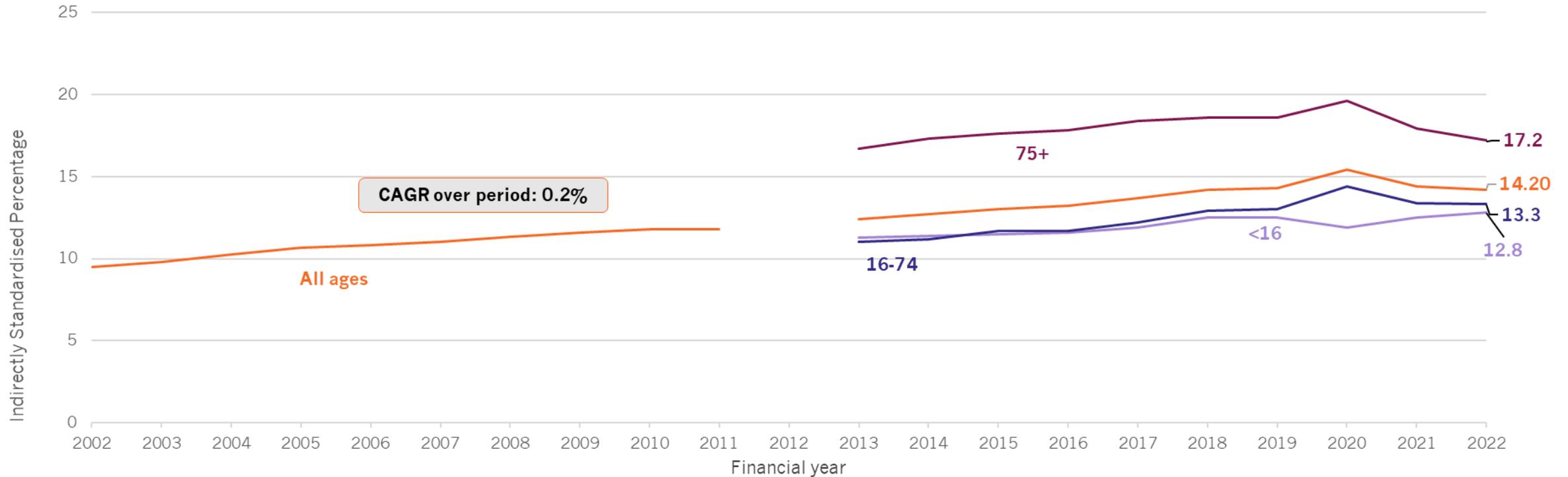

Notes: The labels show the compound annual growth rates (percentage point growth). Age breakdowns for years prior to 2013/14 are not available. No value was calculated for 2012/13 due to the reorganisation of the NHS and this also represents a change in the underlying methodology.

Source: NHS England (2002/03 to 2011/12) NHS Outcomes Framework. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework
NHS England (2013/14 to 2022/23) Compendium Readmissions. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/compendium-emergency-readmissions

4.5 Number of virtual wards beds

Figure III.4.5: Number of patients who can be managed simultaneously on virtual wards
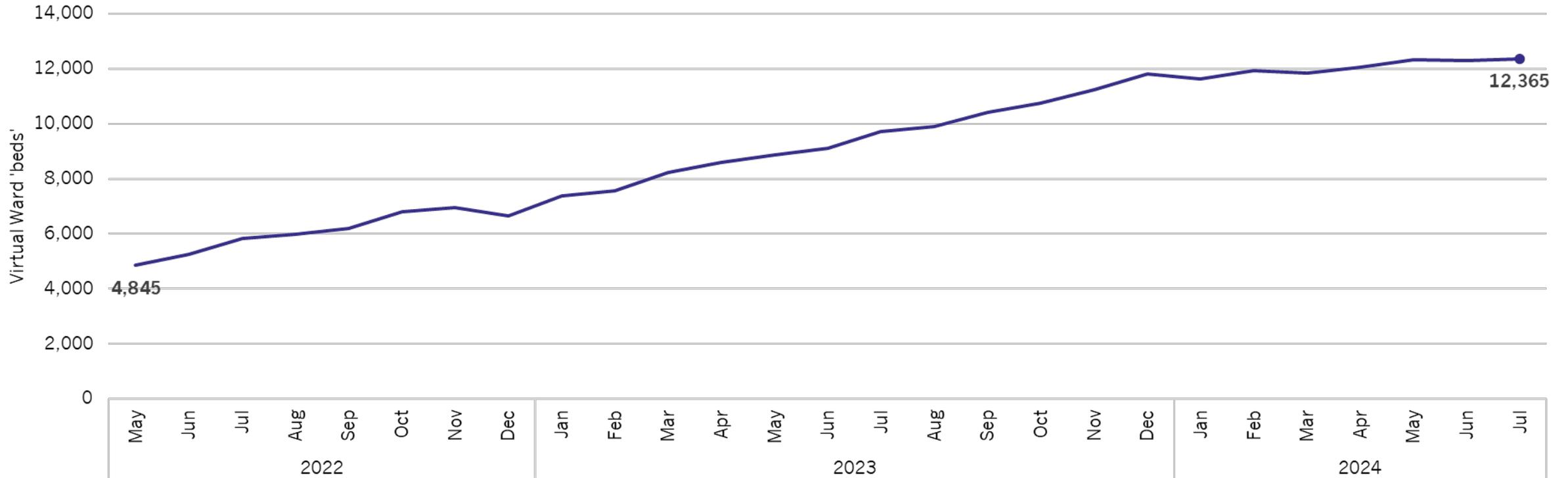
4.6 Impact on referrals of pre-referral specialist advice to GPs

Figure III.4.6: Estimated impact of pre-referral specialist advice on the GP referral rate for consultant-led treatment per appointment
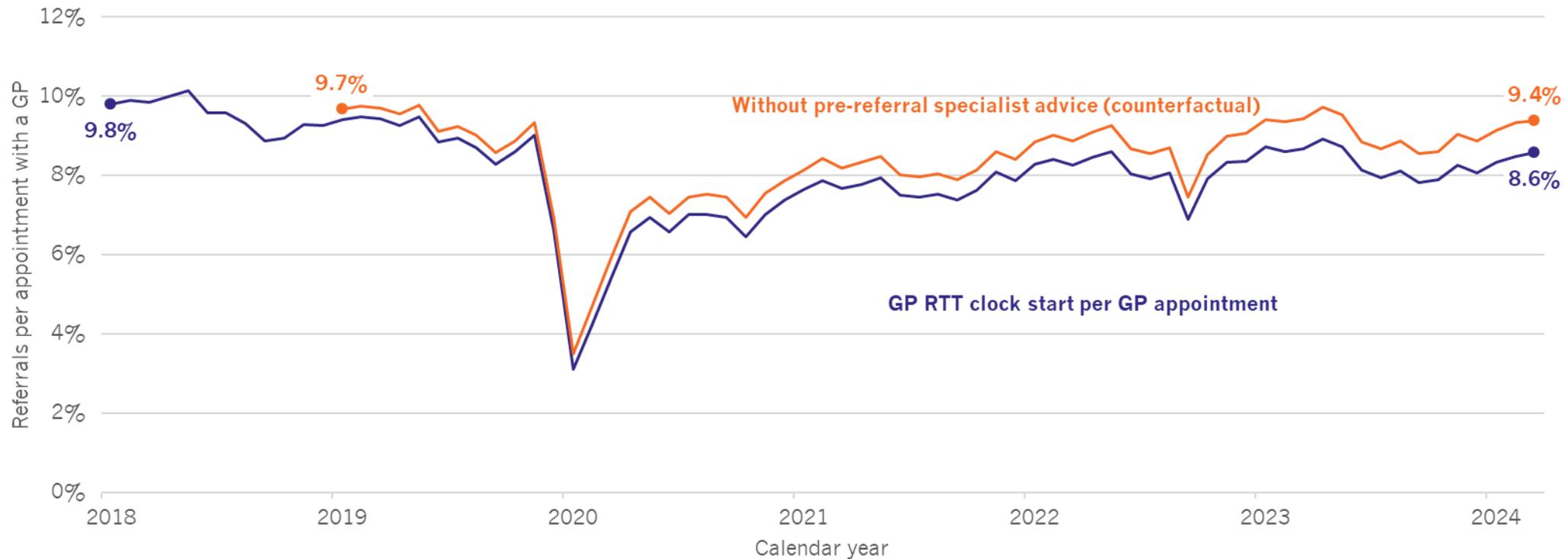
Source: Referral to treatment official statistics; Appointments in general practice official statistics; Monthly Referral Return official statistics; analysis of unpublished management information Waiting List Minimum Dataset (WLMDS); Elective Recovery Outpatients Collection (EROC) for specialist advice activity; and analysis of electronic referral system data (eRS) to estimate the advice & guidance national series prior to EROC commencing

4.7 Daily volumes of referrals and referrals diverted through use of specialist advice

Figure III.4.7: Referrals for consultant-led treatment (clock starts) compared to growth in referrals diverted through use of specialist advice
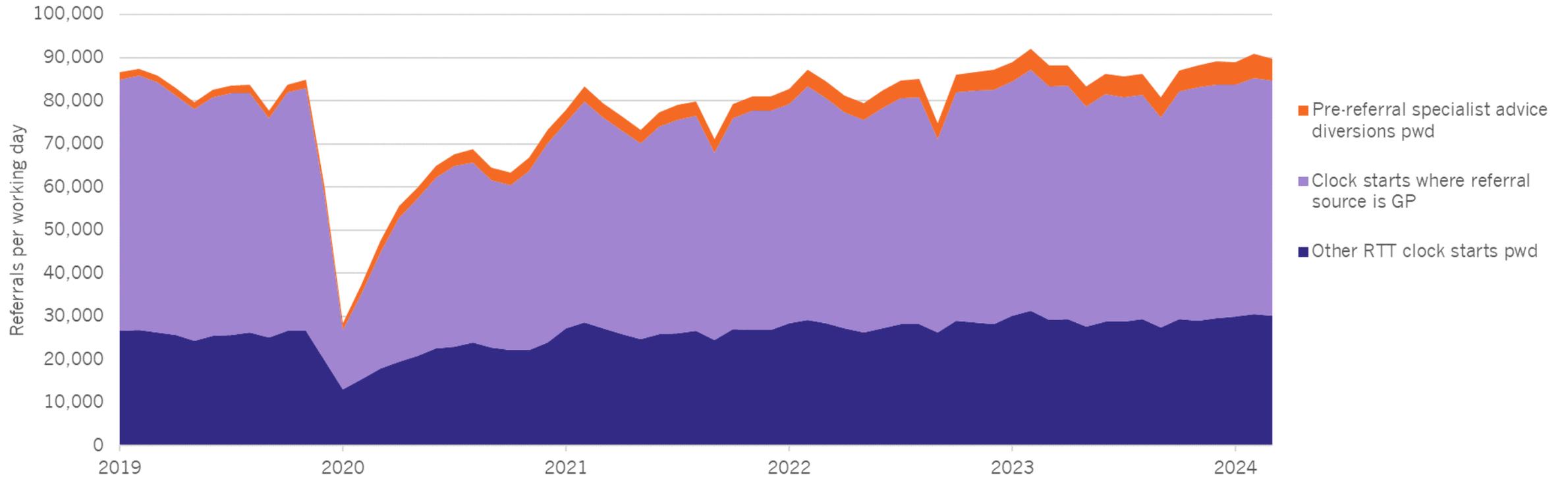
Source: Referral to treatment official statistics; Monthly Referral Return official statistics; analysis of unpublished management information Waiting List Minimum Dataset (WLMDS); Elective Recovery Outpatients Collection (EROC) for specialist advice activity; and analysis of electronic referral system data (eRS) to estimate the advice & guidance national series prior to EROC commencing

4.8 Safety incidents reporting culture performance

Figure III.4.8: All incidents reported to the NRLS, by quarter, from Oct 2003 – Jun 2021
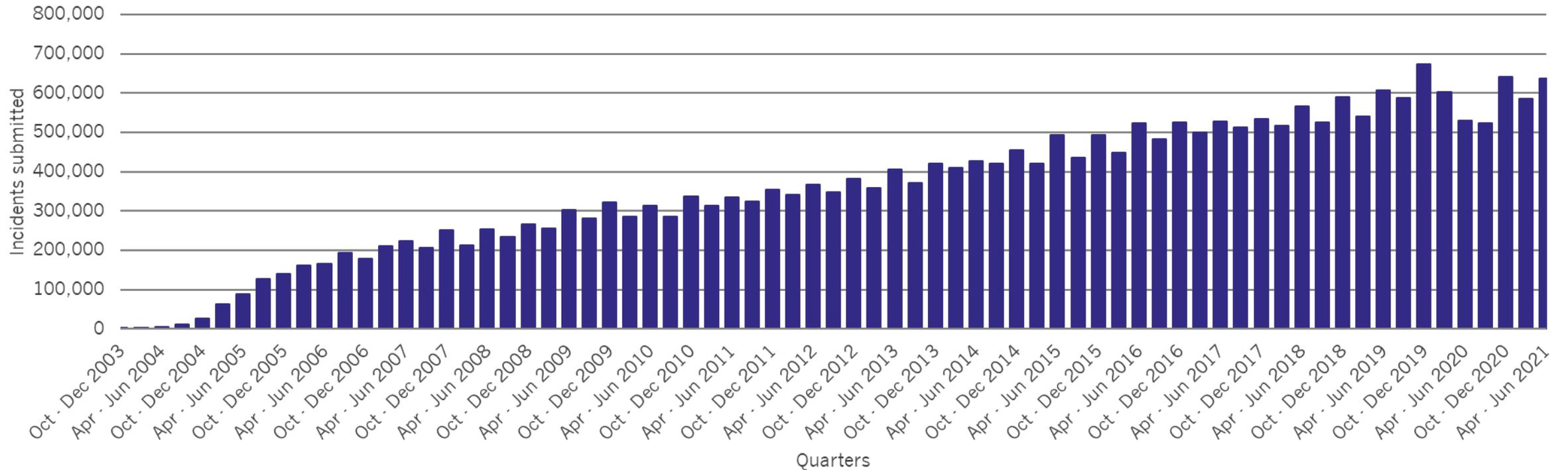
Notes: Patient Safety Incident recording has increased steadily from the creation of patient safety incident recording systems in the early 2000s, to around 2.4 million incident records being made in the NHS each year now. The vast majority of incidents are recorded as causing no harm (c. 70%) or low harm (c. 26%), with c.3% causing moderate harm, 0.3% severe harm and 0.2% death.

Source: NHS England National Reporting and Learning System. Available: NHS England » National Reporting and Learning System (NRLS) monthly report England

4.9 Rates of harm-free care during NHS Safety Thermometer initiative

Figure III.4.9: Proportion of patients surveyed with none of four recorded harms (January 2013 - March 2017) with mean over each financial year (pressure ulcers, falls, UTIs in patients with a catheter, VTEs)
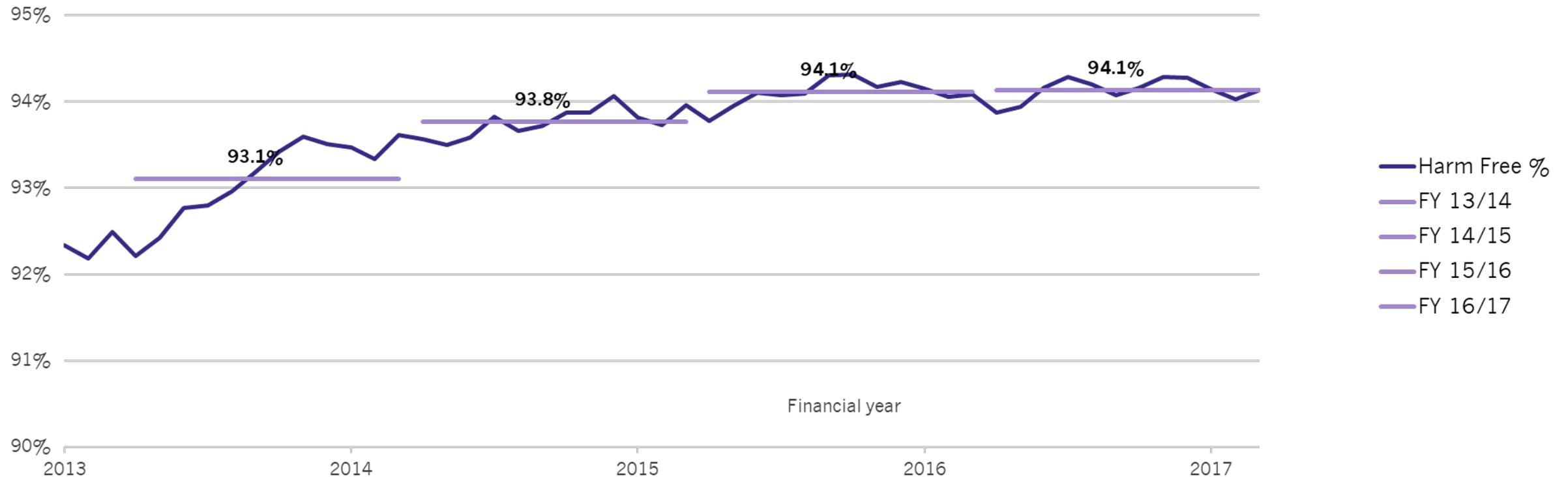
Notes: Data from January 2013 to January 2014 were taken from the January 2013 to January 2014 NHS Safety Thermometer report. Data following this were taking from the latest possible report. i.e. March 2017 was taken from the March 2016 to March 2017 report, February 2017 was taken from the February 2016 to February 2017 report. The NHS Safety Thermometer initiative ran from 2010 to 2020. It collected point prevalence data on the proportion of patients on one day a month in some settings thought to have; a pressure ulcer; had a fall resulting in harm in the previous 72 hours; were being treated for a UTI with an indwelling catheter; and were being treated for VTE. It was intended to support local improvement work but there were growing concerns over time about its validity and particularly its use at national level.

Source: NHS England National Reporting and Learning System. Available: NHS England » National Reporting and Learning System (NRLS) monthly report England

4.10 Number of surgical never events by type

Figure III.4.10: Number of surgical category never events by type (annual), April 2014 – March 2023
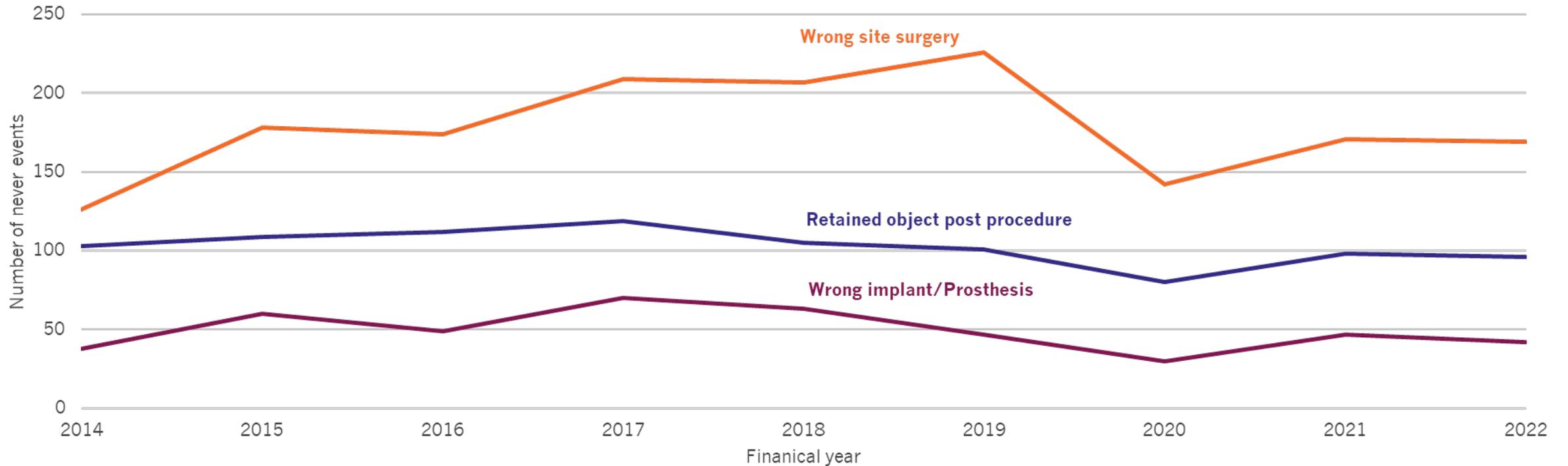
Source: NHS England National Reporting and Learning System. Available: NHS England » National Reporting and Learning System (NRLS) monthly report England

4.11 Rates of healthcare acquired infections

Figure III.4.11: Total count of infection cases over time
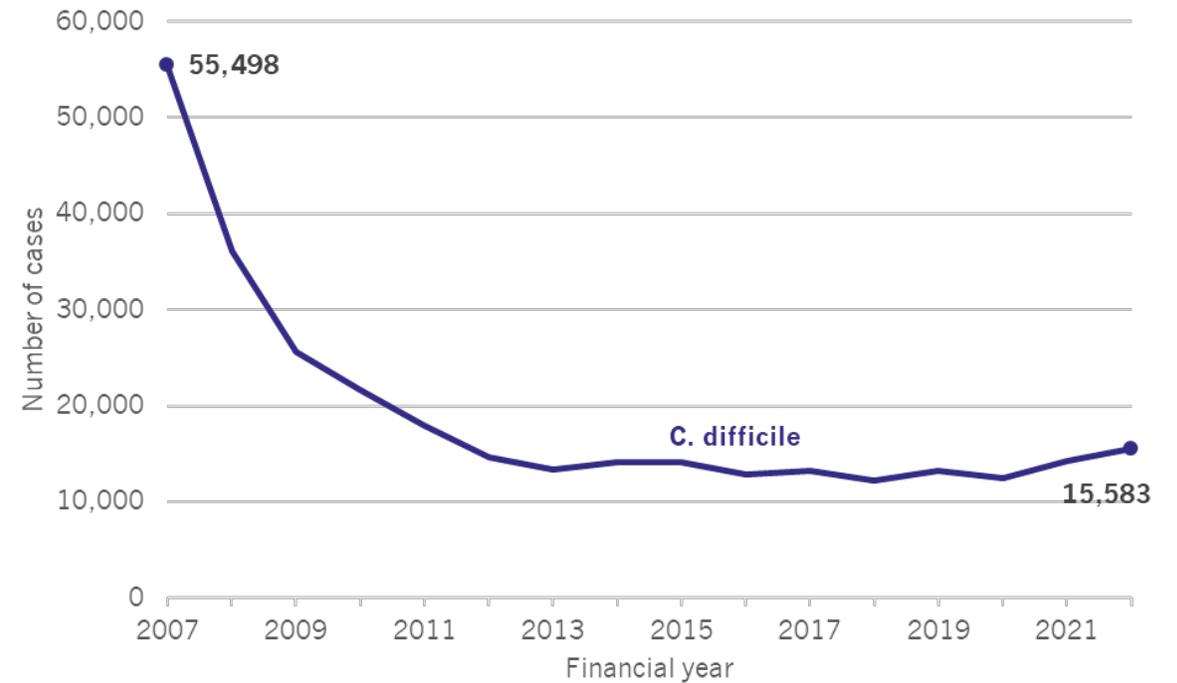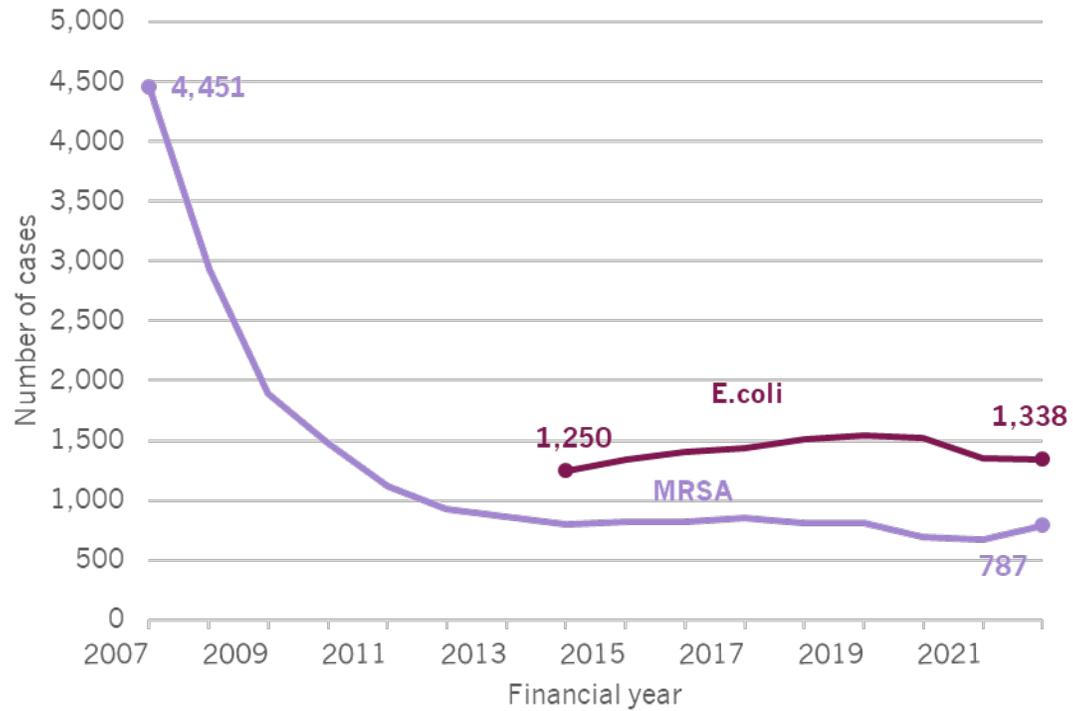
Source: NHS England National Reporting and Learning System. Available: NHS England » National Reporting and Learning System (NRLS) monthly report England

4.12 Deaths from blood clot (VTE) related events within 90 days post discharge

Figure III.4.12: Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital (2007-2022)
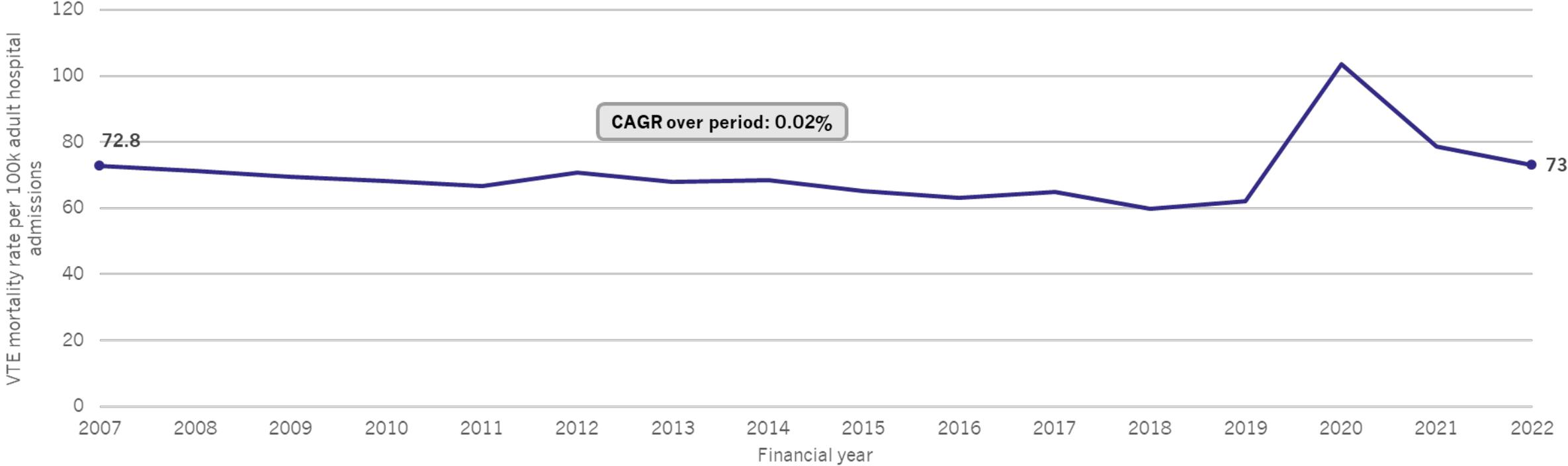
Notes: CAGR for financial years 2007/2008 to 2022/2023

Source: NHS England Digital Available: 5.1 Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital · NHS England Digital

5.1 Proportion of population with anxiety/depression entering NHS talking therapies

Figure III.5.1: Percentage of estimated population (18+) with anxiety/depression accessing NHS Talking Therapies over time
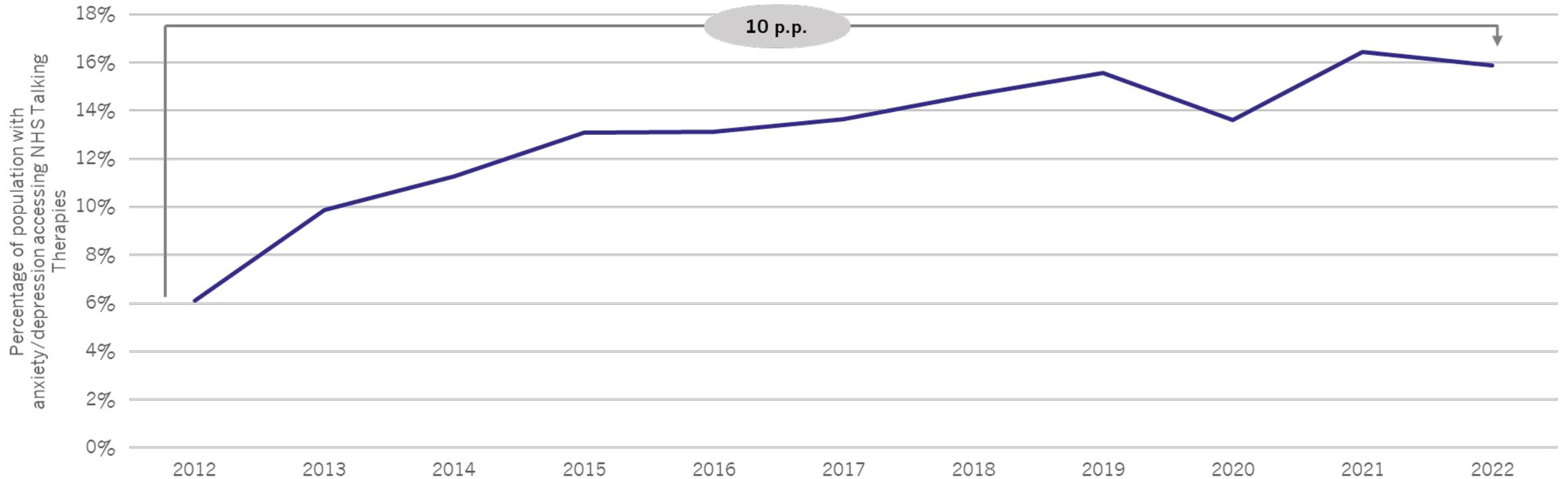
Notes: IAPT access figures & Office for National Statistics population figures relate to adults only (18+). Caveat: Prevalence data for Anxiety and Depression estimated in 2014 on population age 16+

Source: NHS England (2023) NHS Talking Therapies, for anxiety and depression, Annual reports (for access figures). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2022-23 and NHS Digital (2016) Adult Psychiatric Morbidity Survey. Available at: Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS England Digital

5.2 Recovery rate in NHS Talking Therapies

Figure III.5.2: Percentage of referrals that finished a course of treatment (end date in the year and a minimum of two attended treatment appointments during the referral) where the service user has moved to recovery over time
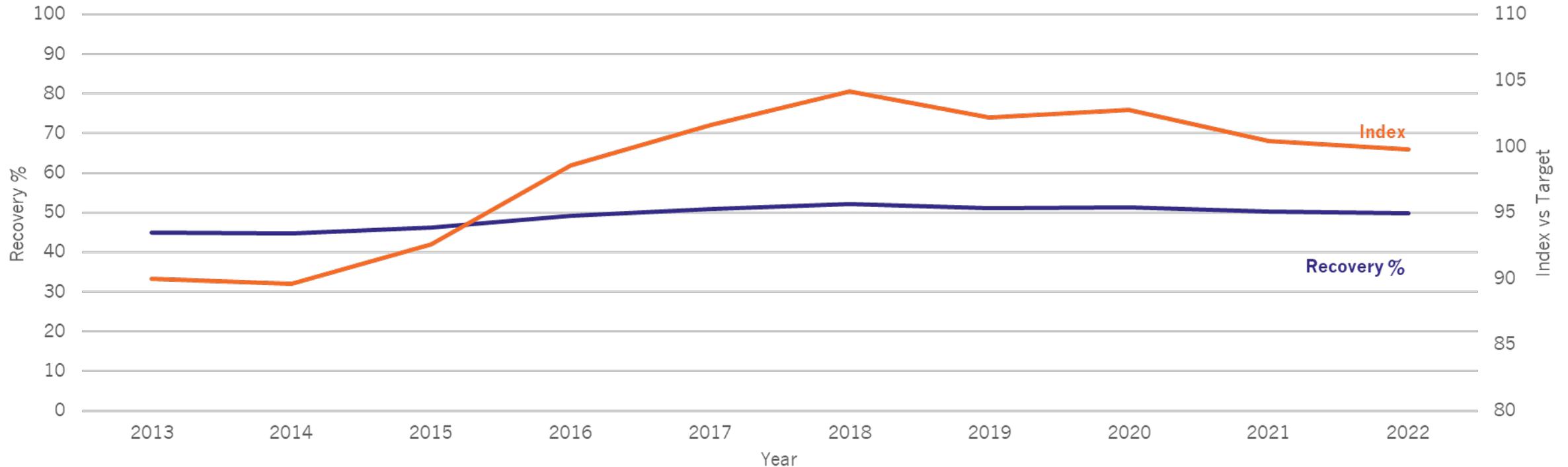
Notes: Index is based on government target of 50% of patients achieving recovery. Historically the target set by government has been that 50% of eligible referrals to NHS Talking Therapies services should move to recovery. In 2024/25 (which isn't included in the data) the targets have changed to focus on Reliable Recovery (48%) and Reliable Improvement (67%).

Source: NHS England (2023) NHS Talking Therapies, for anxiety and depression, Annual reports. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2022-23

5.3 Estimated number of patients prescribed medication for ADHD

Figure III.5.3: The estimated number of patients being prescribed medication for ADHD, 2004-2023

Time periods	CAGR - Estimated number of patients
2004 - 2009	11.9%
2009 – 2015	8.1%
2015 – 2019	7.8%
2019 – 2021	8.5%
2021 – 2023	17.9%
Whole period	10.1%
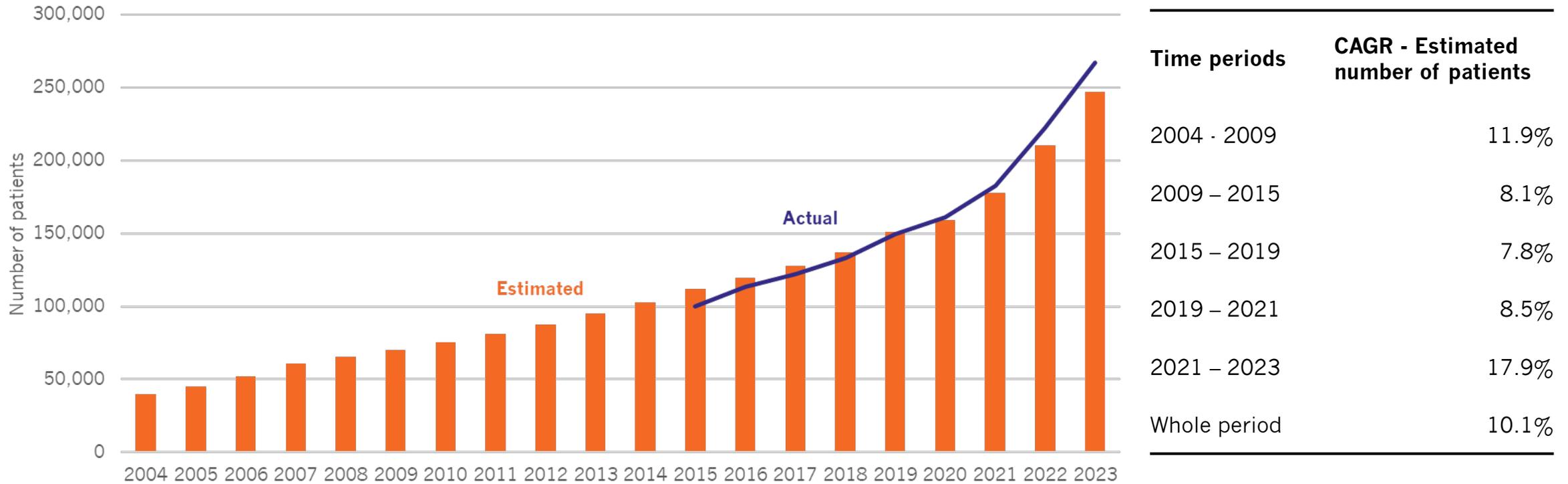
Notes: CAGR time periods are calendar years. No data available for complete years before 2004 or after 2023. This includes all prescriptions dispensed in the community in England. Data for the actual number of patients on these prescriptions are only available from 2015. To get data on a consistent basis across the full time series, the number of patients is estimated by inferring from the number of dispensed prescription items. Conversion method: Patient numbers are estimated by dividing total prescription items per year by 11.5 which is the average number of items per patient, per year, observed in the nine years for which there is data on number of patients (2015 to 2023).

Source: NHS BSA (2023) Prescription Cost Analysis – England. Available at: Prescription Cost Analysis · England | NHSBSA

5.4 Restrictive interventions in mental health inpatient settings by age group

Figure III.5.4: Number of restrictive intervention types per 1,000 occupied bed days (Sep 2020 - Mar 2024)

Age groups	CAGR
Under 18	79%
18-24	16%
25-34	14%
25-44	13%
45-54	-13%
55-64	5%
65 or over	12%
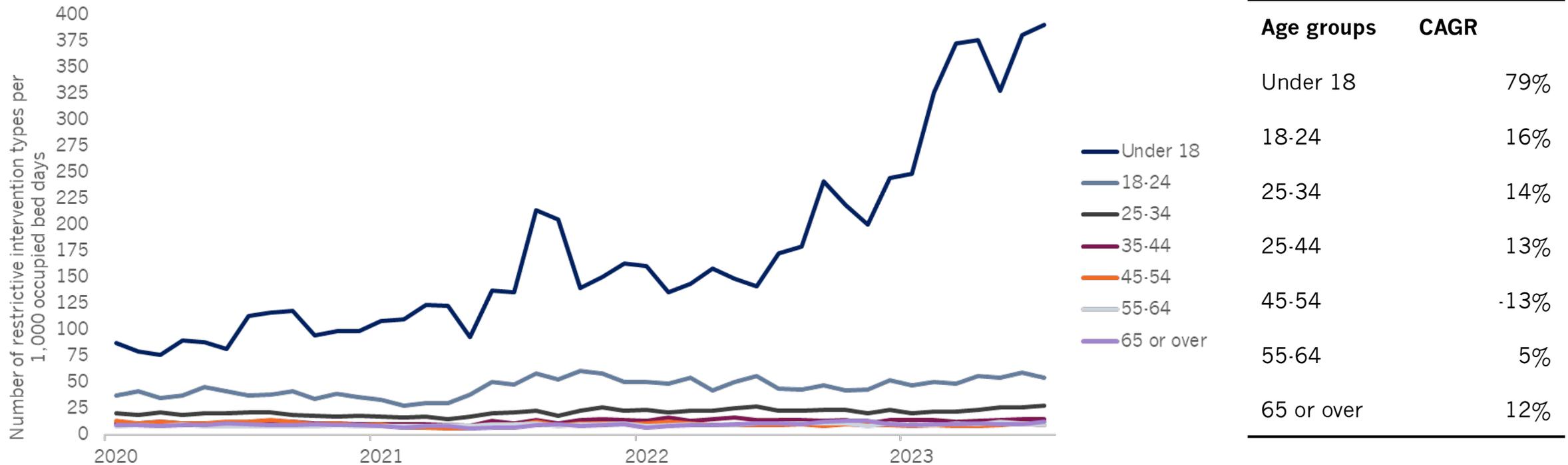
Notes: The timeseries trends will be impacted by data quality improvements and new submitters of data being onboarded over the reported time frame

5.5 Numbers of inpatient mental health suicides and rate per occupied bed days

Figure III.5.5: Number of Inpatient suicides and rate per 100,000 bed days

Age groups	CAGR
Number of inpatient suicides	-5.3%
Rate of inpatient suicides	-3.8%

5.6 Active inappropriate out of area placements

Figure III.5.6: Number of active inappropriate out of area placements during the year
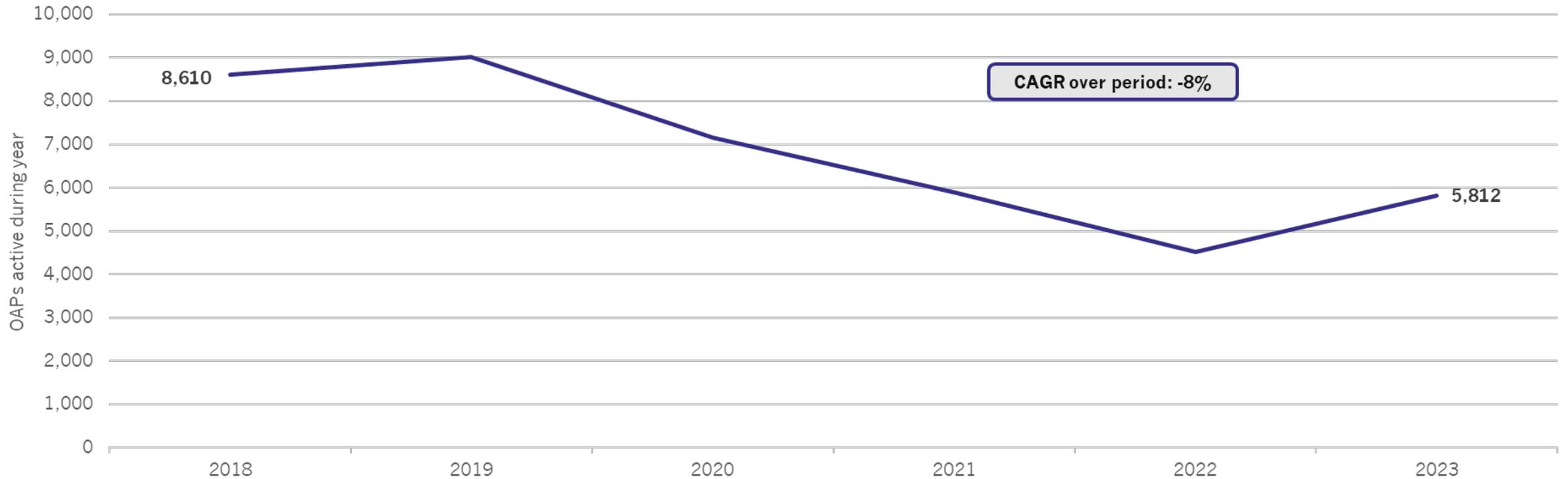
Notes: Data is sourced from the Clinical Audit Platform (CAP) collection, not the Mental Health Services Dataset (MHSDS). Data for 2023-24 was the last period that the CAP collection covered. From 2024 onwards, MHSDS became the official source of OAPs reporting.

Source: NHS England (2023) OAPS publication. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services

5.7 Excess mortality in adults with serious mental illness

Figure III.5.7: Excess Under 75 mortality rates in adults with serious mental illness, 2015-17 to 2020-22, England
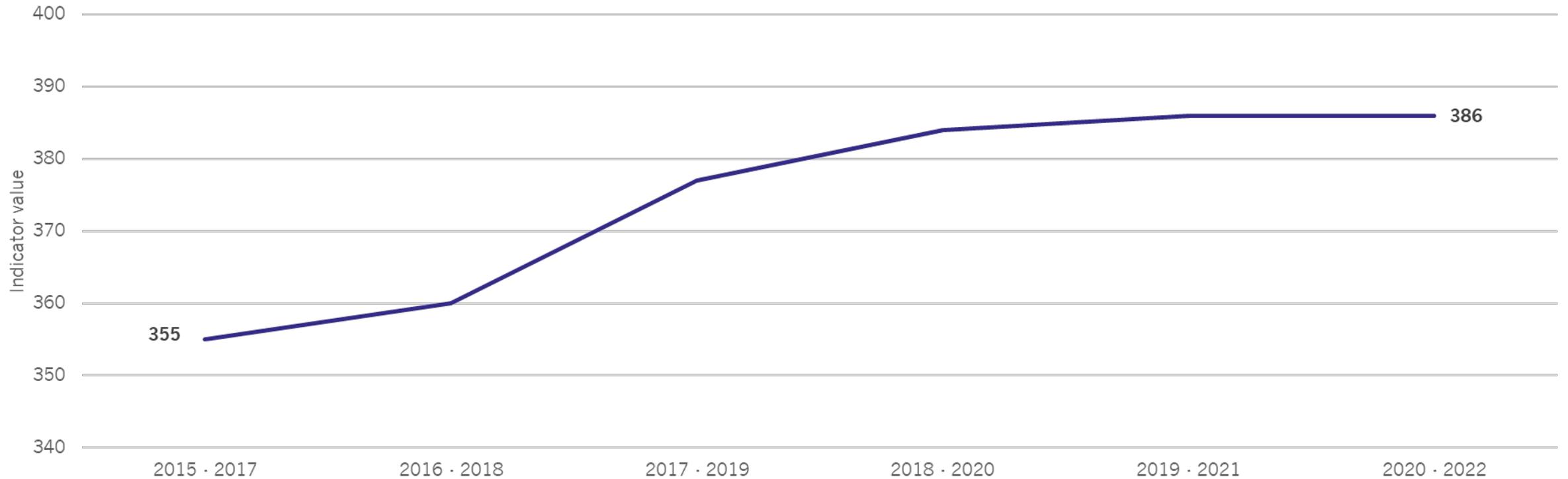
Notes: Data for 2015-17 included data from MHLDDS for 2015. Data for 2016 onwards is sourced from MHSDS. The indicator value is a measure of the extent to which adults with a serious mental illness (SMI) die younger than adults without a serious mental illness. The indicator value is expressed as a percentage so for 2020-22, a person with SMI is around 3.8x (indicator value of 386) more likely to die younger.

Source: NHS England (2022) Excess under 75 mortality rates in adults with serious mental illness. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/excess-under-75-mortality-rates-in-adults-with-serious-mental-illness

6.1 Daily count of Covid-19 patients in hospital

Figure III.6.1: Daily count of confirmed COVID-19 patients in hospital at 8am, England, August 2020 to June 2024
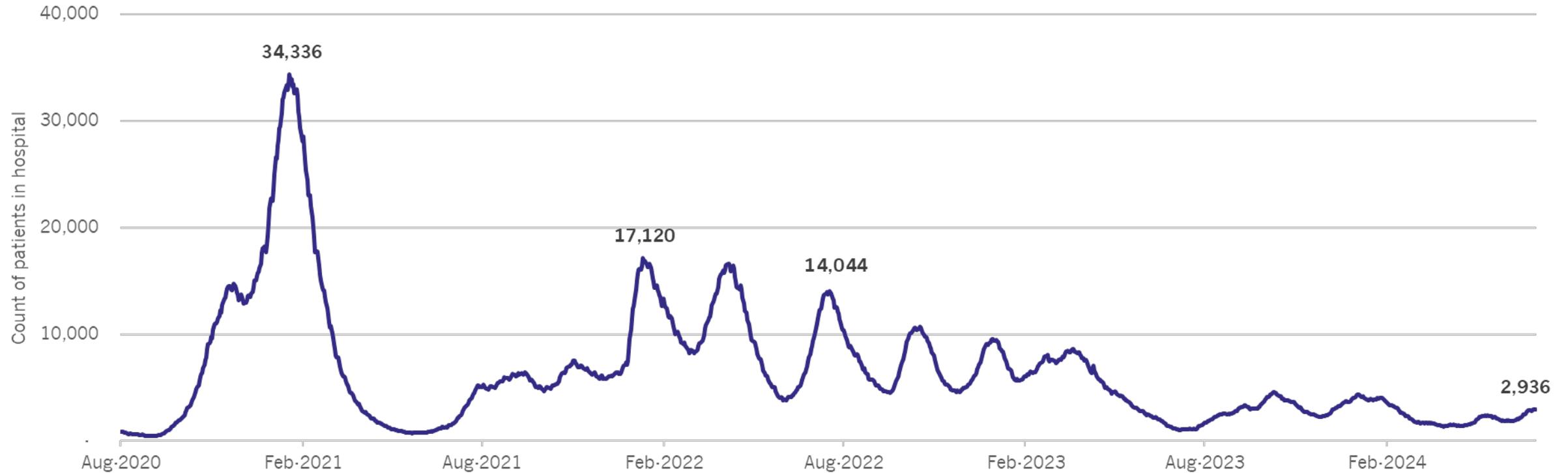
Source: UK Health Security Agency (2024). Available at: UKHSA Data Dashboard

6.2 Daily count of Covid-19 patients in hospital (2024)

Figure III.6.2: Daily count of confirmed COVID-19 patients in hospital at 8am, England, December 2023 to June 2024
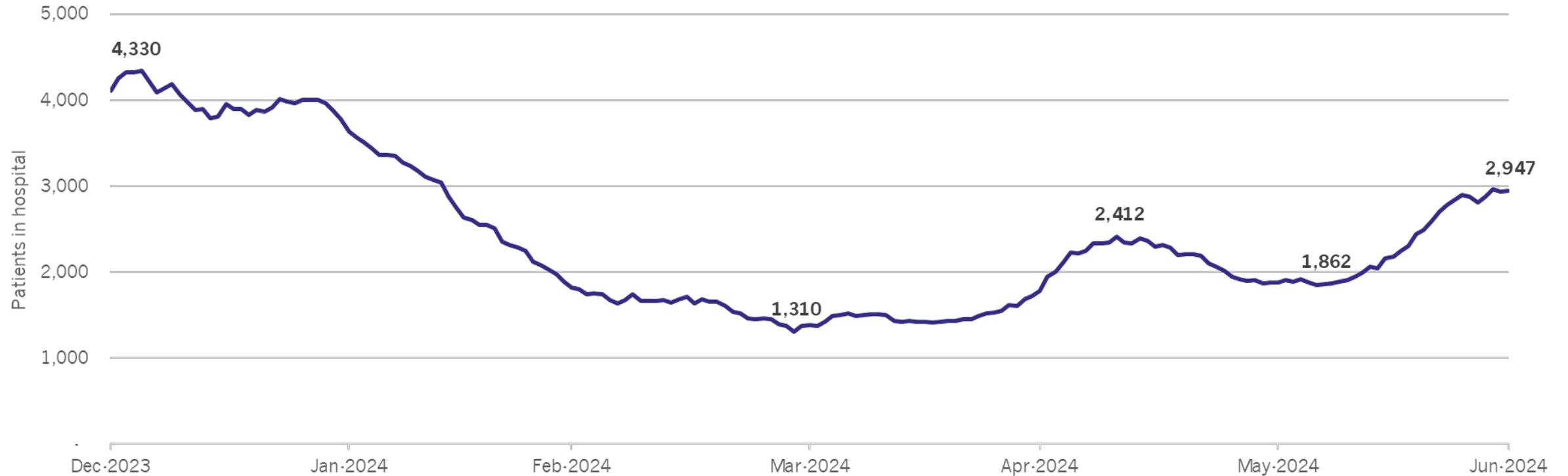
Source: UK Health Security Agency (2024). Available at: UKHSA Data Dashboard

6.3 Uptake of autumn and spring Covid-19 vaccinations

Figure III.6.3: Uptake for Covid-19 Vaccination Campaigns in those aged 75+, England
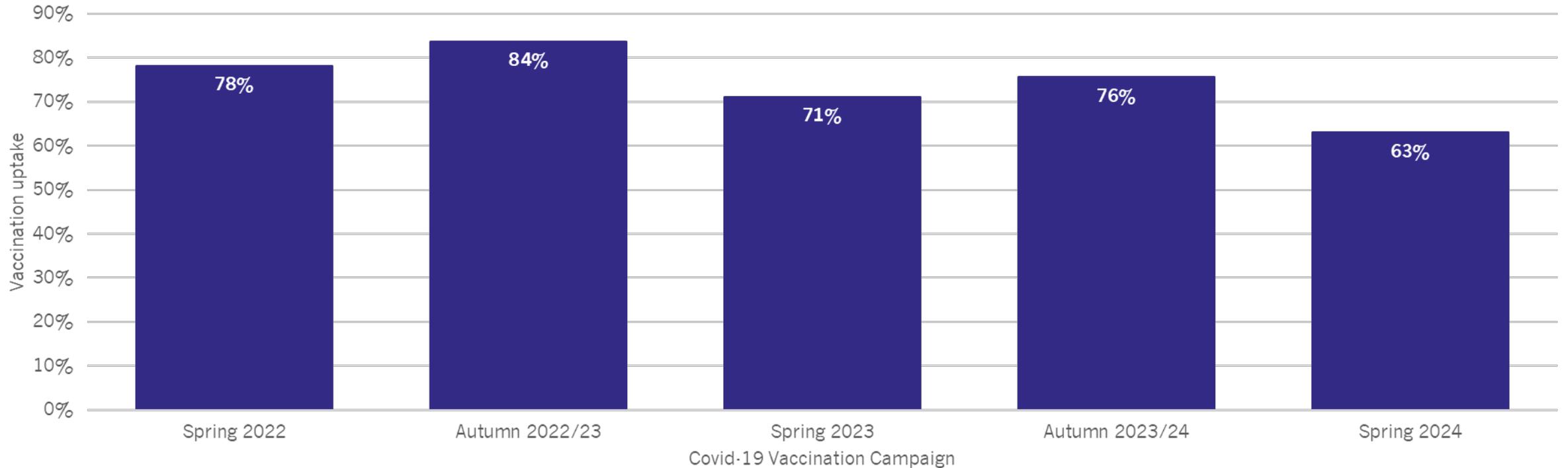
Notes: Figures were calculated by summing the number of vaccines administered to the 75+ age groups and dividing by the sum of the cohorts.

Source: UKHSA, Weekly National Influenza and Covid-19 Reports 2022-2024. Available at: Weekly national flu reports - GOV.UK (www.gov.uk)

6.4 Seasonal flu vaccination uptake (65+ years and <65 at risk)

Figure III.6.4: Uptake for Seasonal Flu Vaccinations in those aged over 65 and those at risk (aged 6 months to under 65 years), England, 2001 to 2023

CAGR	Age 65+	At risk
2001/02 - 2005/06	2.8%	
2005/06 - 2010/11	-0.7%	1.0%
2010/11 - 2015/16	-0.5%	-2.2%
2015/16 - 2019/20	0.5%	-0.1%
2019/20 - 2023/24	1.4%	-1.6%
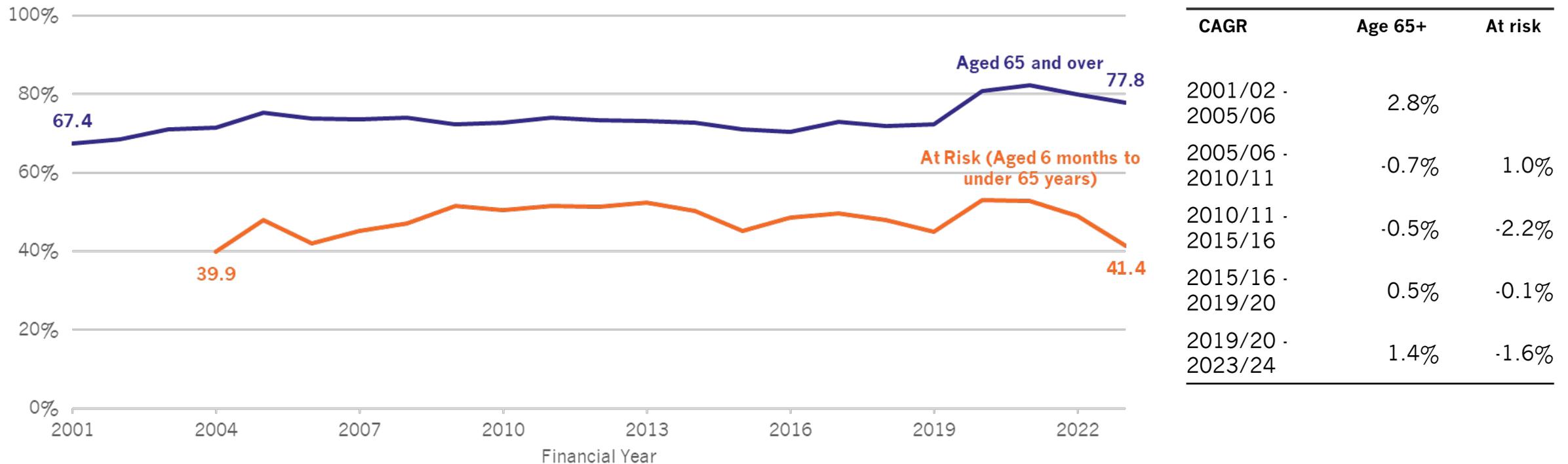
Source: Public Health England (up to 2009/10), Fingertips Public Health Profiles, 23 May 2024 (2010/11 to 2022/23), UKHSA (2023/24)

6.5 Confirmed cases of measles

Figure III.6.5: Confirmed cases of measles in England, 2001 to 2024

Period	CAGR
2001 - 2005	3%
2005 - 2010	37%
2010 - 2015	-24%
2015 - 2019	72%
2019 - 2022	-59%
2022 - 2024	516%
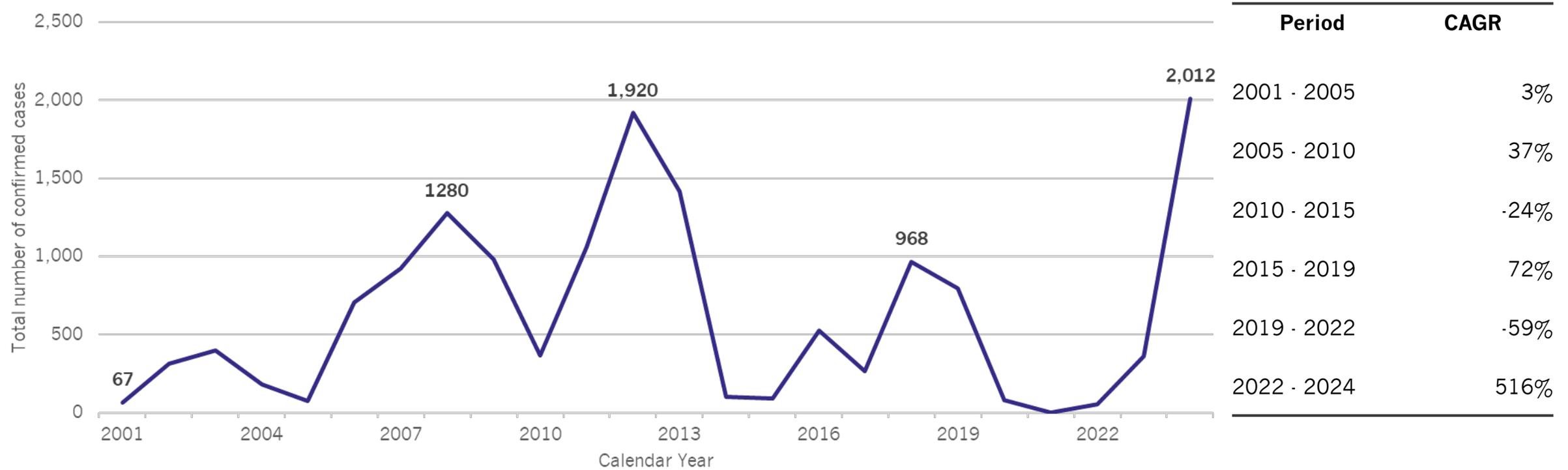
Sources: Cases data 2001 – 2022; UKHSA, Nov 2023; Cases data 2023; UKHSA, July 2024; Cases data 2024; UKHSA Data Dashboard, July 2024

6.6 Laboratory-confirmed cases of Pertussis

Figure III.6.6: Laboratory Confirmed Cases of Pertussis (whooping cough), England, 2001 to 2024
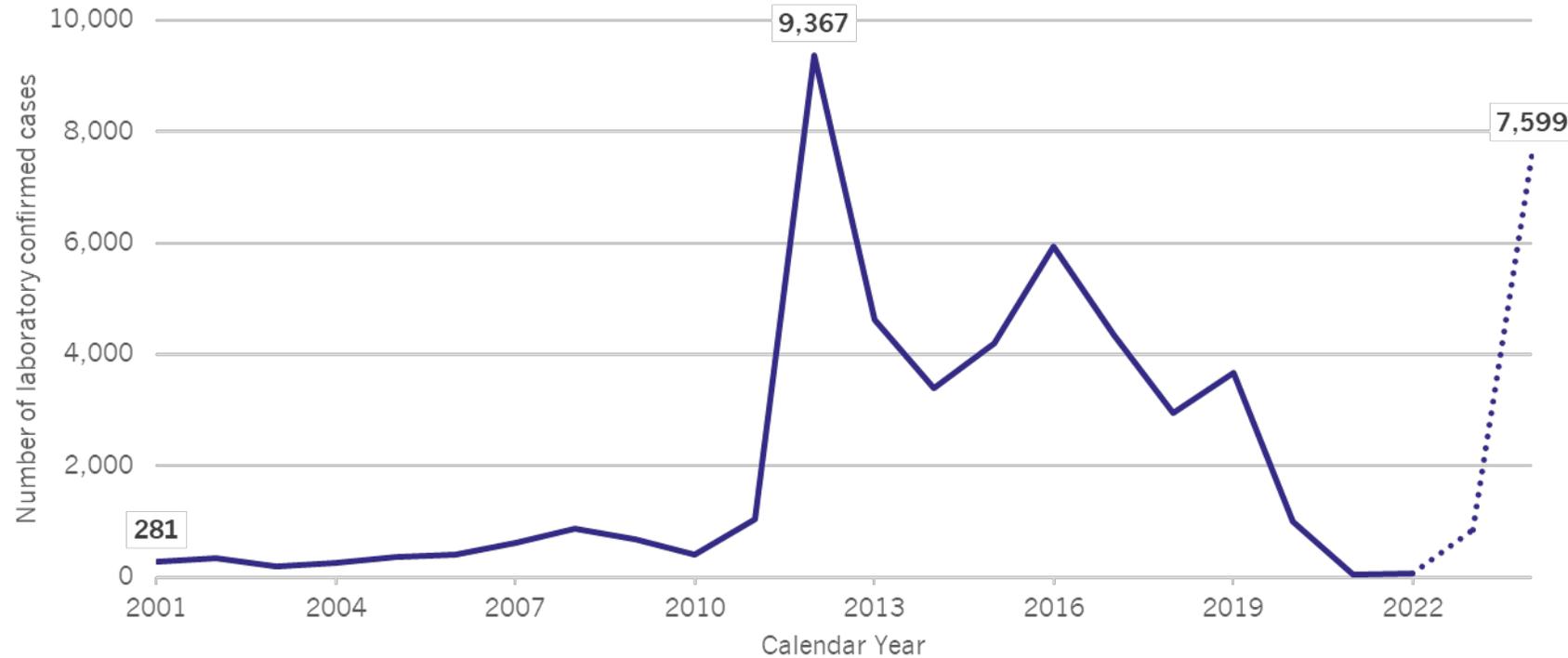
Period	CAGR
2001 - 2005	7%
2005 - 2010	2%
2010 - 2015	59%
2015 - 2019	-3%
2019 - 2022	-74%
2022 - 2024	957%

Notes: Data for 2023 and 2024 are provisional, this is shown by dotted lines.

Source: UK Health Security Agency (2024). Pertussis: guidance, data and analysis. Available at: UKHSA Pertussis Epidemiology, July 2024

6.7 Total number of newly diagnosed sexually-transmitted infections

Figure III.6.7: Total number of new STI diagnoses reported in England, 2004 to 2023
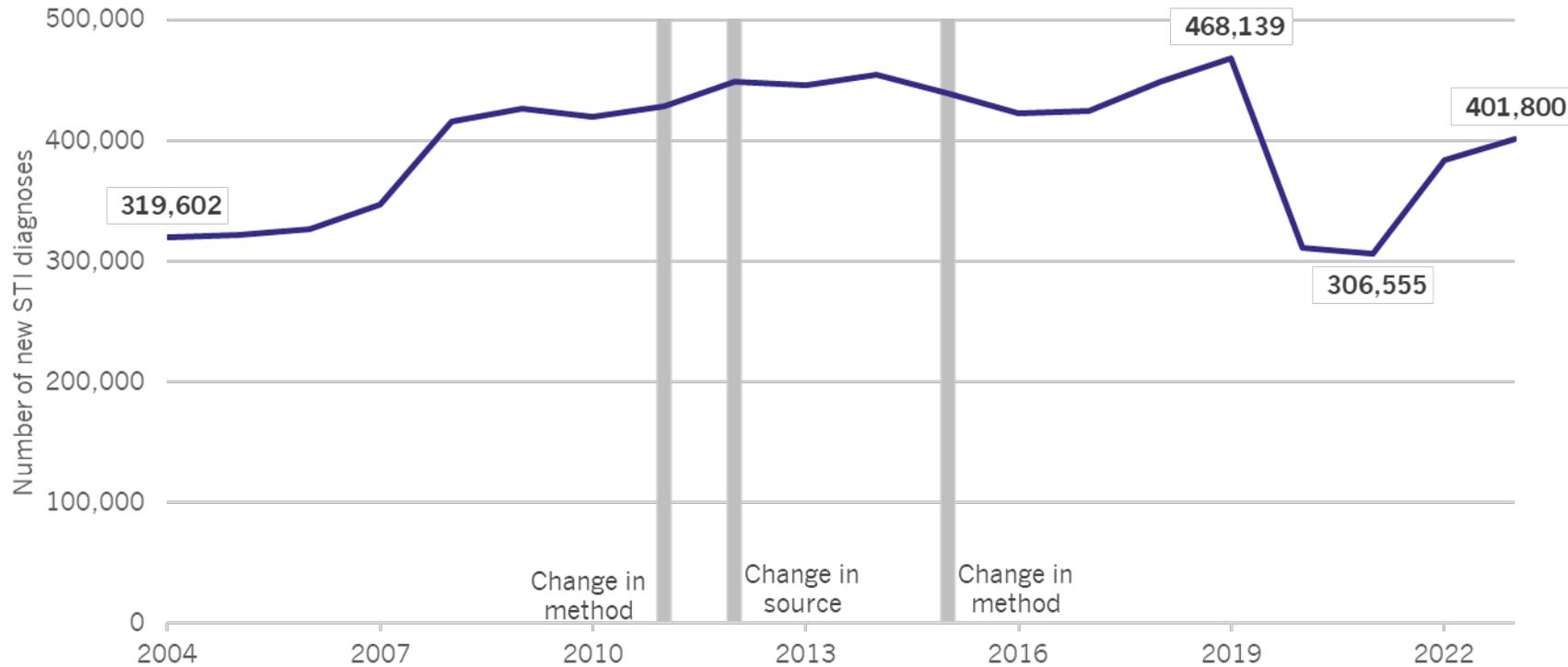
Period	CAGR
2004-2010	4.7%
2012-2014	0.7%
2015-2019	1.6%
2019-2023	-3.7%

Notes: Changes in methodology mean that the series cannot be compared across the full time period.

Source: UK Health Security Agency (2024), National STI surveillance data 2023 (2014-2023). Available at: Sexually transmitted infections (STIs): annual data - GOV.UK (www.gov.uk);
Public Health England, STI diagnoses & rates in England (2004 – 2013)

6.8 Prevalence and treatment rates for Hepatitis C

Figure III.6.8A: HCV modelled prevalence versus number of treatments initiated (cumulative) over time
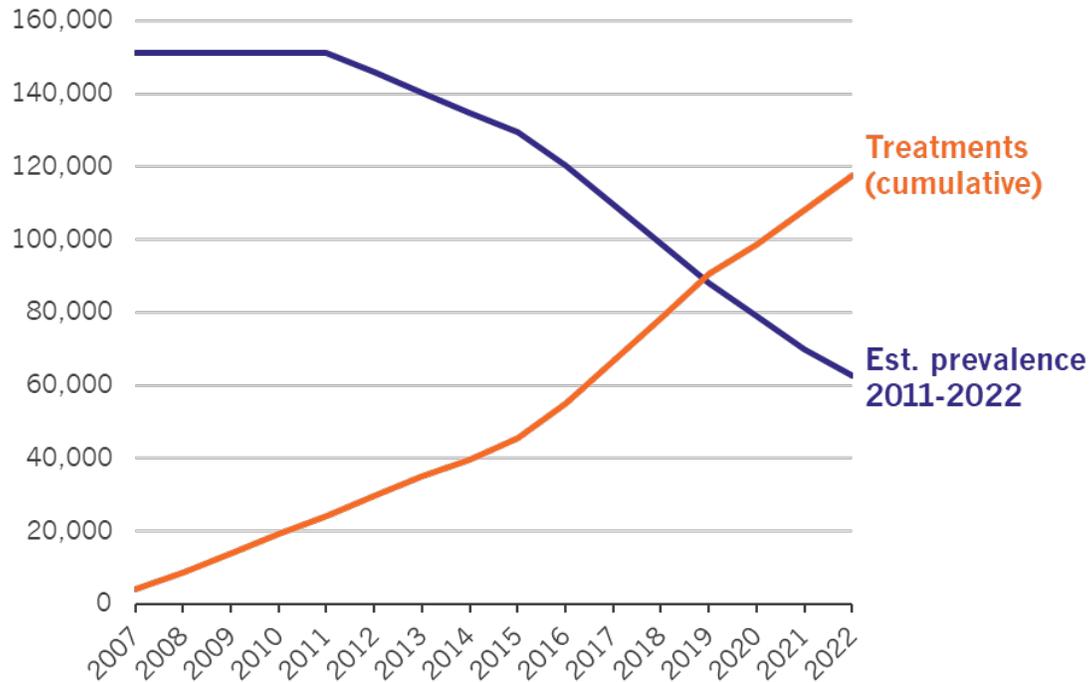
Figure III.6.8B: Number of death registrations for HCV related Hepatocellular Carcinoma (HCC) and/or End Stage Liver Disease (ESLD)
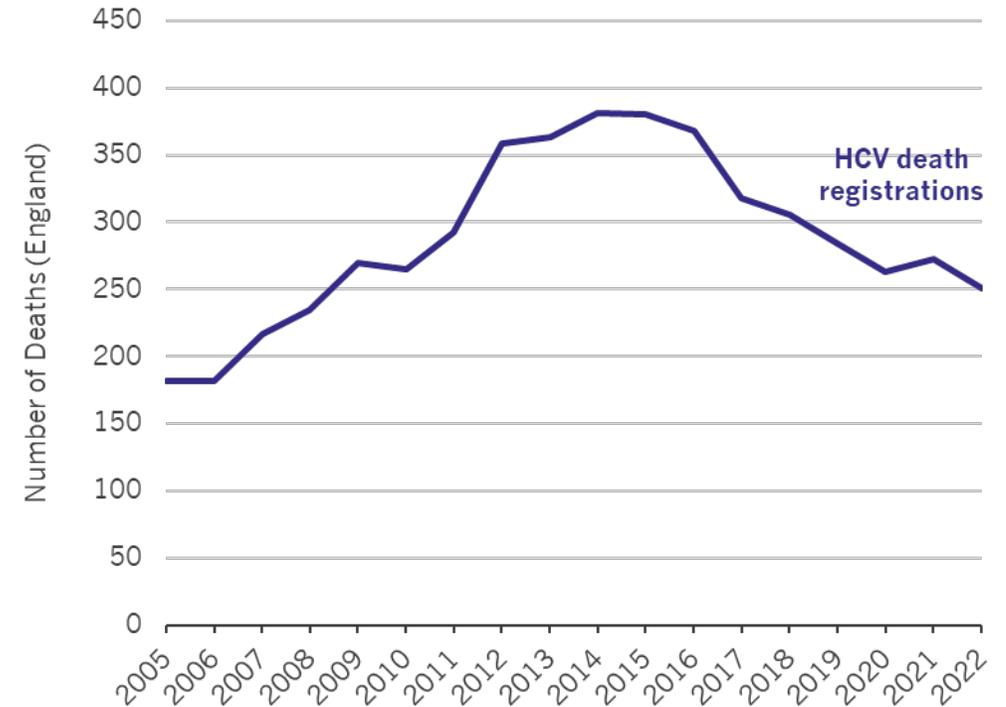
Notes: RHS: Graph reflecting a fall from the peak of 381 death registrations attributable to HCV in 2014, falling to 251 in 2022 (a 34% reduction), primarily driven by a decrease in HCV-related ESLD, which fell by 45.4% during this period.

Source: *UKHSA*. Hepatitis C virus (HCV) monitoring metrics headline data tables, data to end of 2022. Available: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fmedia%2F65e9c58962ff48001a87b370%2FHCV-in-England-2023-data-tables.ods&wdOrigin=BROWSELINK

6.9 Treatments for HCV by index of multiple deprivation decile

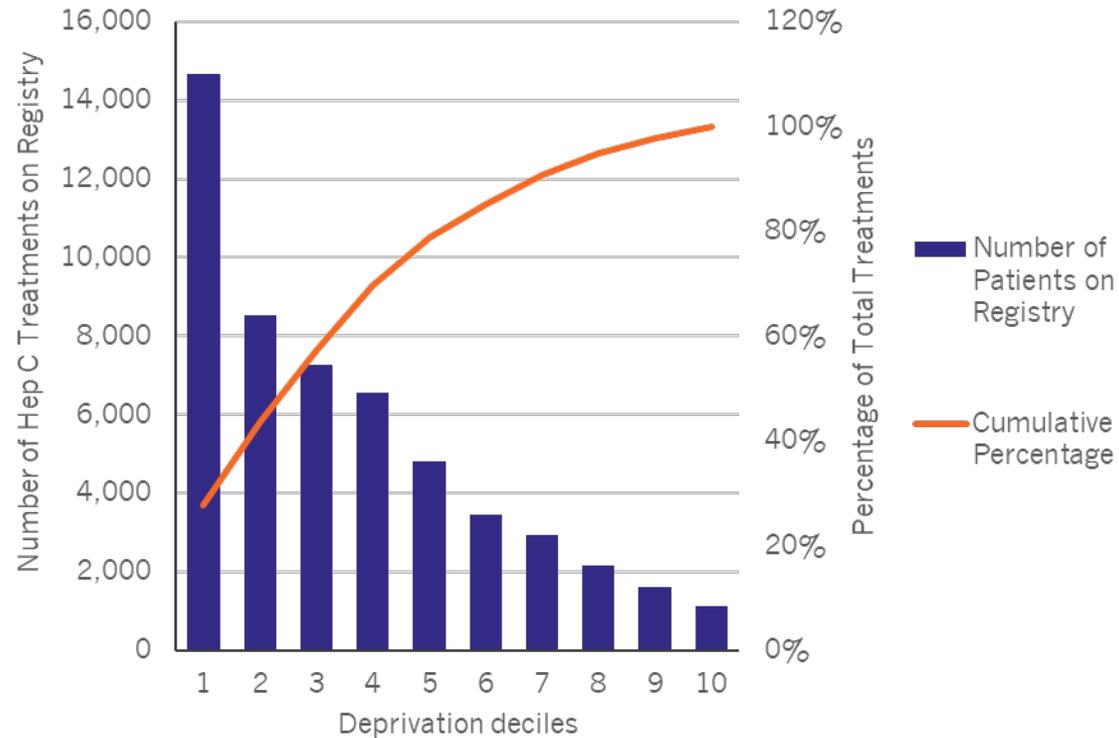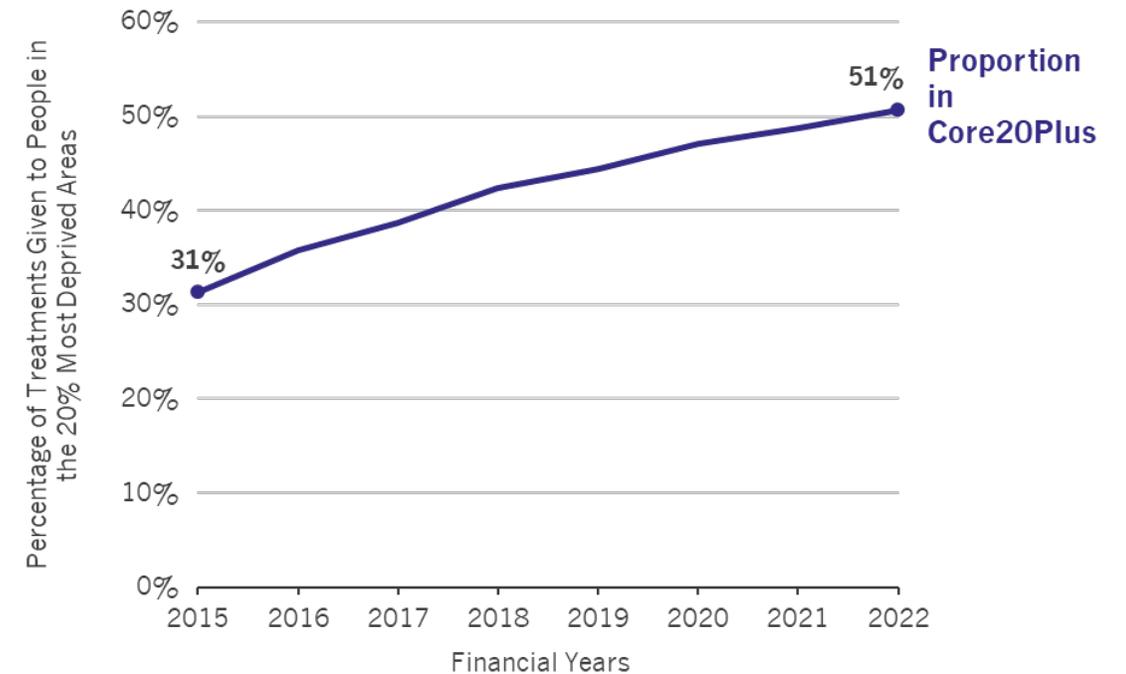**Figure III.6.9A: Deprivation deciles of patients who have received HCV treatment**

Figure III.6.9B: Percentage of those treated with HCV in the most deprived 20% of the population of England (Core20Plus), over time


Notes: Decile 1 represents the most deprived 10% (or decile) of small areas in England, and Decile 10 represents the least deprived 10%.

Source: *UKHSA*. Hepatitis C virus (HCV) monitoring metrics headline data tables, data to end of 2022. Available: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fmedia%2F65e9c58962ff48001a87b370%2FHCV-in-England-2023-data-tables.ods&wdOrigin=BROWSELINK

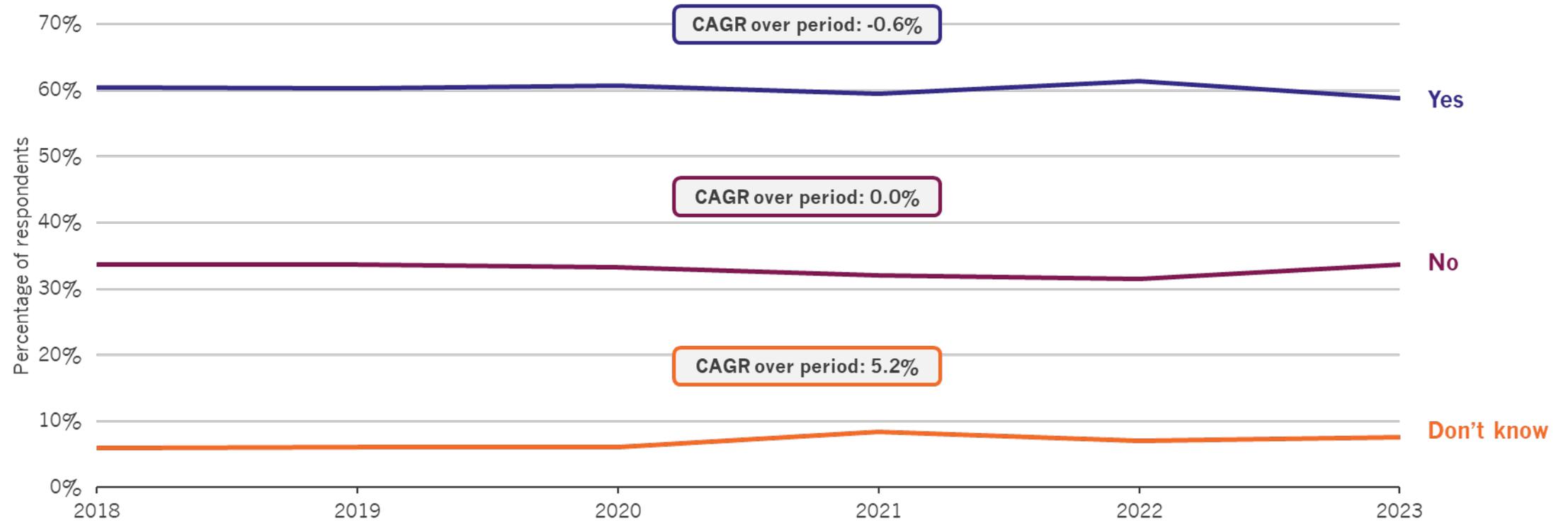# 7.1 Prevalence of multiple long-term conditions

Figure III.7.1: Multiple Long-Term Conditions (MLTCs) by select count of conditions, England, 2017 to 2022, percent
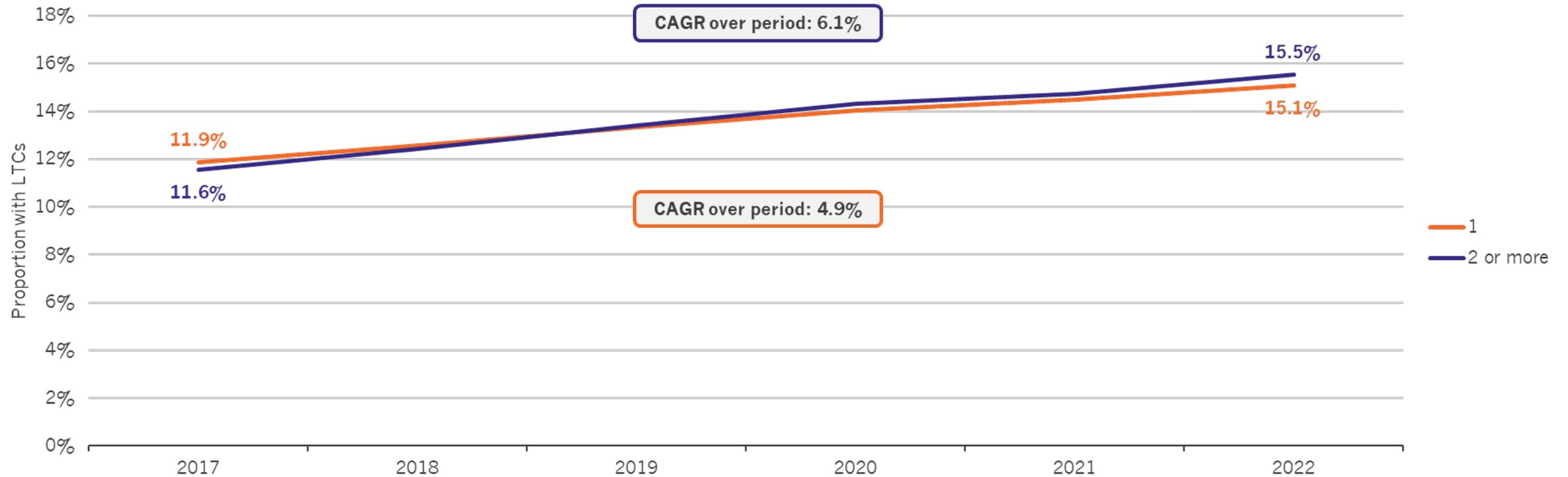
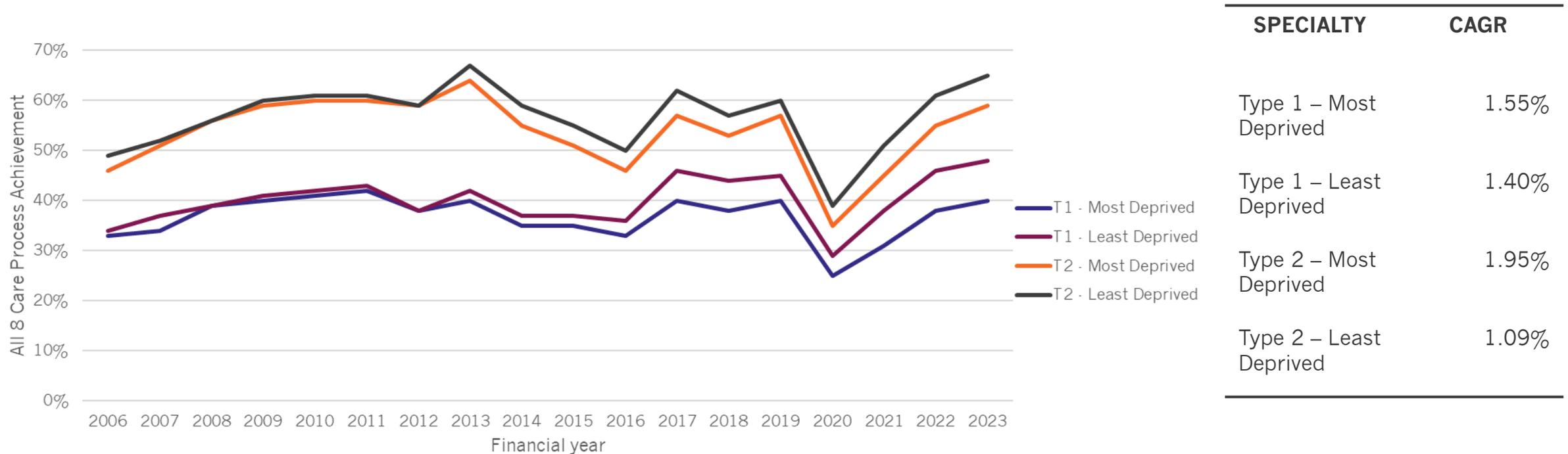# 7.2 Care plan coverage for people with long-term conditions

Figure III.7.2: GP Patient Survey results on 'Agree plan with healthcare professional to manage conditions or illness'

Source. *NHS England*. GP patient survey data. Available: https://gp-patient.co.uk/surveysandreports

7.3 Delivery of all 8 care processes for people with diabetes

Figure III.7.3: Percentage of patients with all 8 Care Process achieved, by diabetes type and deprivation quintile (most and least deprived)


SPECIALTY	CAGR
Type 1 – Most Deprived	1.55%
Type 1 – Least Deprived	1.40%
Type 2 – Most Deprived	1.95%
Type 2 – Least Deprived	1.09%

Notes: Data from 2006/07 through to 2022/23 contains data collected from specialist services and GP. Data from 2023/24 contains data from GP only.
People with Type 1 and type 2 diabetes in the most deprived IMD are less likely to receive all 8 care processes than people in the least deprived IMD. The gap has grown since 2012/13.

Source: NHS England. *National Diabetes Audit Programme – Core dataset.*

7.4 COPD Patients Enrolled To and Completing Pulmonary Rehab

Figure III.7.4: National view of the percentage of patients completing PR each year. A patient has completed PR after they were enrolled and a discharge assessment was performed
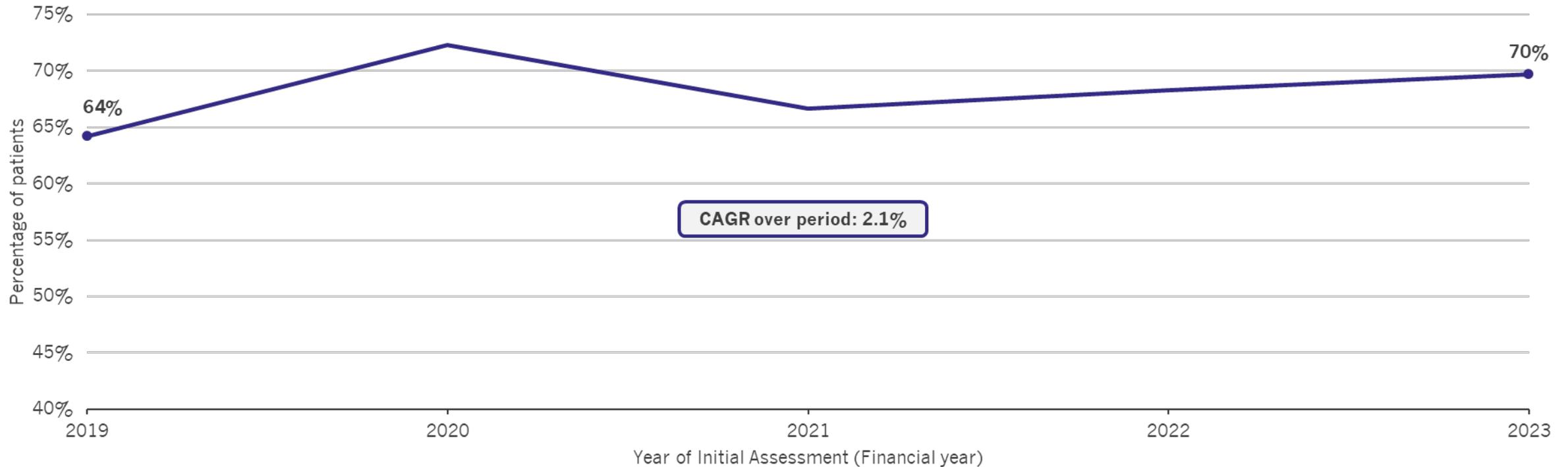

Notes: National completion figures for 23/24 are now complete up to March 2024.

Source: Royal College of Physicians. *National Respiratory Audit Programme (NRAP).* Available: https://www.nrap.org.uk/

7.5 COPD Patients Enrolled To and Completing Pulmonary Rehab By IMD

Figure III.7.5: National completion rates for each year split by IMD.

| Deprivation Decile	CAGR
Least Deprived (IMD 10)	1.5%
Median	1.9%
Most Deprived (IMD 1)	3.6%
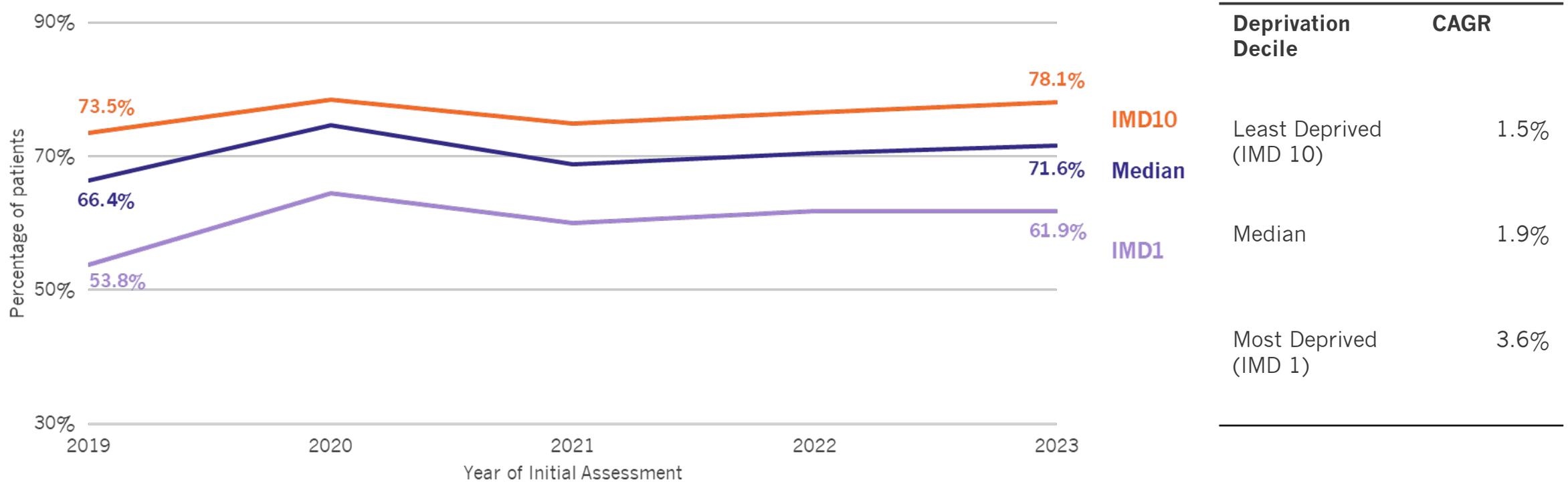
Notes: IMD 1 represents patients from the most deprived areas (CORE20+5), with IMD 10 representing patients from the least deprived areas. The chart also shows the median across all IMD deciles for each year.

Source: *Royal College of Physicians,* National Respiratory Audit Programme (NRAP). Available: https://www.nrap.org.uk/

7.6 Risk reduction for patients enrolled in NHS Diabetes Prevention Programme (DPP)

Figure III.7.6: Incidence of type 2 diabetes between April 2018 and March 2023 for individuals referred to the NHS DPP
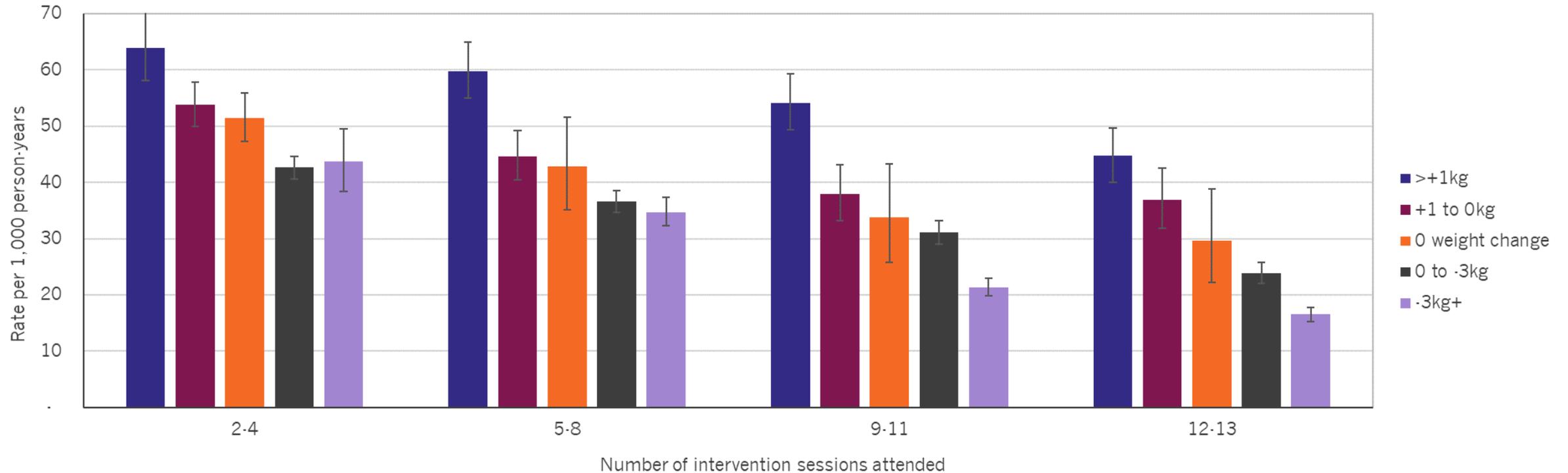
Source: *NHS England*. Diabetes Prevention Programme data.

8.1 Same Day Emergency Care – Non-elective zero-day length of stay

Figure III.8.1: SDEC - All types, Medicine, Surgery and Paediatrics (% of all non-elective attendances)

| Specialty	CAGR
Medicine	3.2%
Surgery	4.6%
Paediatrics	0.1%
(Overall)	2.0%
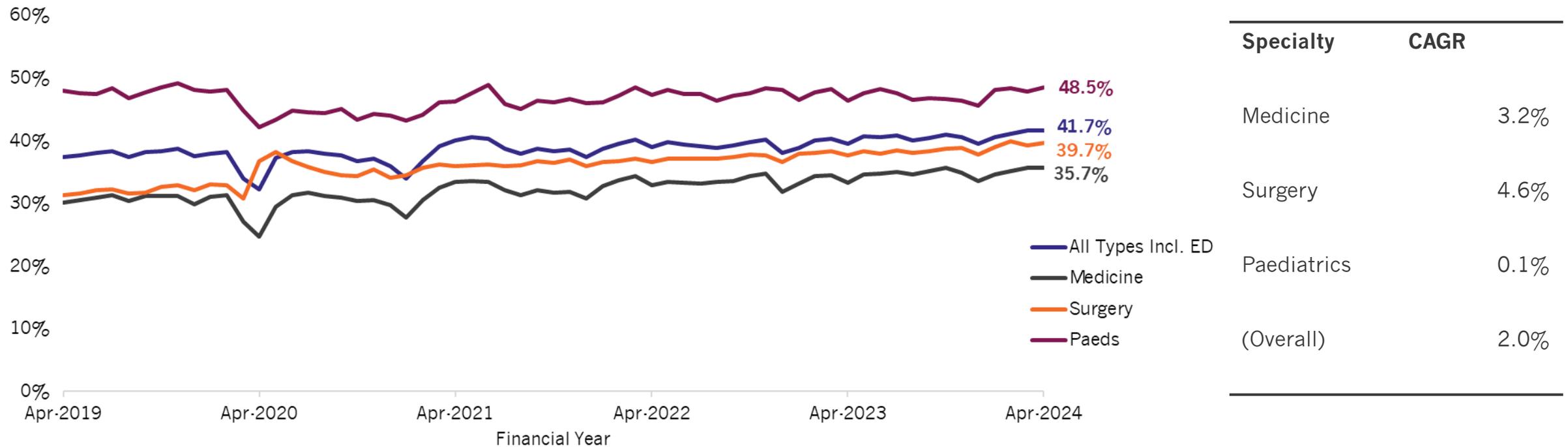
Notes: SDEC dataset recorded from 2019.

Sources: NHS England (2024) *SDEC Evaluation Tool using zero-day length of stay (0LOS) non-elective episodes in Admitted Patient Care (APC) CDS*

8.2 Call-to-balloon time for higher-risk STEMI heart attacks

Figure III.8.2: Call-To-Balloon times (minutes) for higher-risk STEMI heart attack patients England, Wales and Northern Ireland
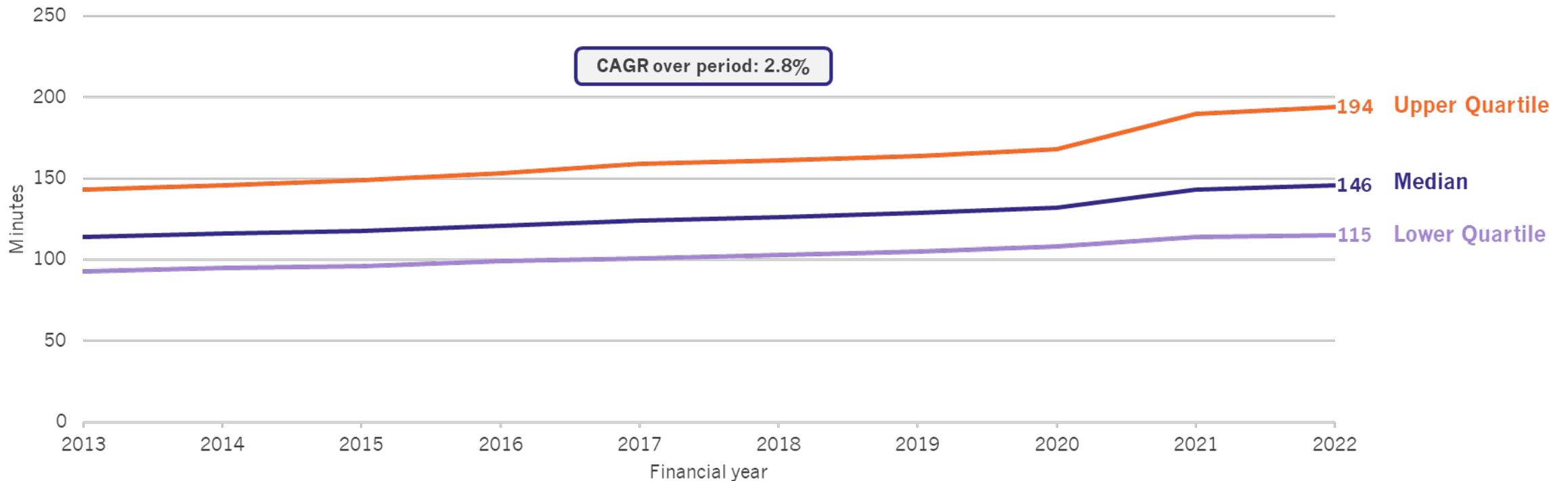

Notes: As in previous years, this mostly resulted from lengthening CTD times, representing the time taken between a call for help, the arrival of the ambulance and the transfer to a hospital able to perform a PPCI. The median CTD time is now 28 minutes longer than in 2013/14, a rise of 42%. The impact is greatest on the 25% of patients experiencing the longest delays, for whom the CTD time was 130 minutes or more.

Source: National Institute for Cardiovascular Outcomes Research (NICOR). Myocardial Ischaemia National Audit Project (MINAP) – Heart Attack. Available:
https://www.nicor.org.uk/interactive-reports/myocardial-ischaemia-national-audit-project-minap-heart-attack

8.3 Variation in call-to-balloon times between ICBs

Figure III.8.3: Median CTB times (minutes) based on hospital location by ICB (2022/23)
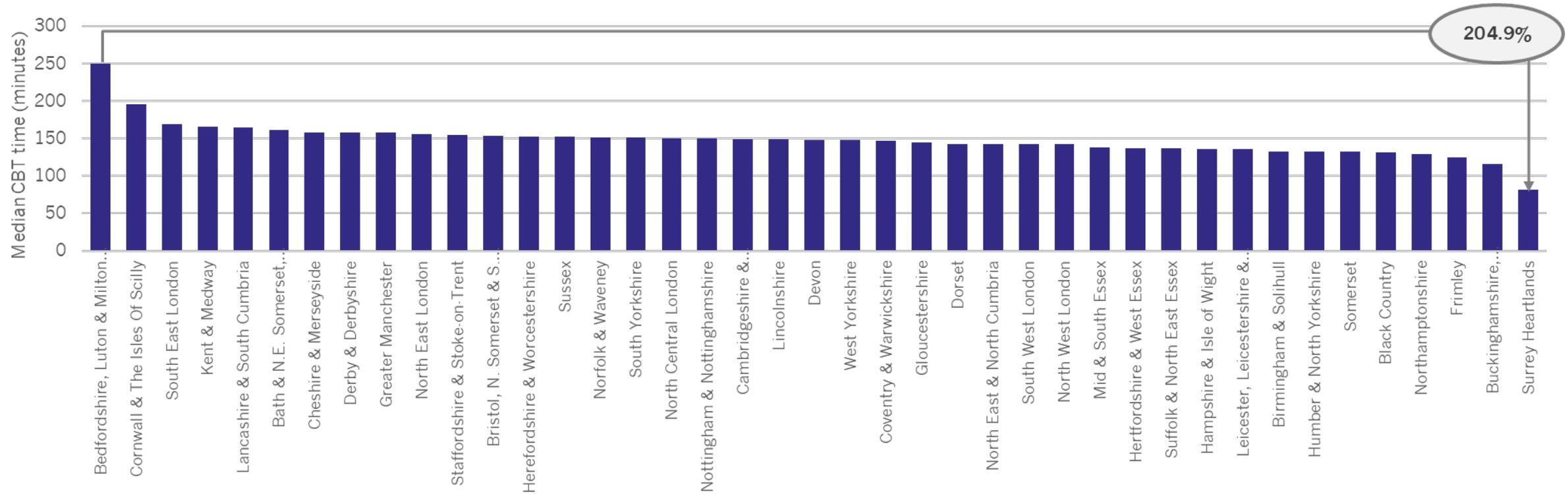

Notes: Bubble represents delta between highest and lowest values. The median DTB time in 2022/23 was up three minutes from five years before. Again, the biggest problem is with the 25% of cases who experience the longest delays, where delays of 71 minutes or more occur. A new, more stringent target has been set to treat at least 70% of higher-risk STEMI patients within 60 minutes of arrival time at hospital. In 2022/23, most hospitals (45 in total) did not meet this target.

Source: National Institute for Cardiovascular Outcomes Research (NICOR). Myocardial Ischaemia National Audit Project (MINAP) – Heart Attack. Available: https://www.nicor.org.uk/interactive-reports/myocardial-ischaemia-national-audit-project-minap-heart-attack

8.4 Median time from symptom onset to arrival at a stroke unit

Figure III.8.4: Median time from onset of symptoms to arrival at a stroke unit
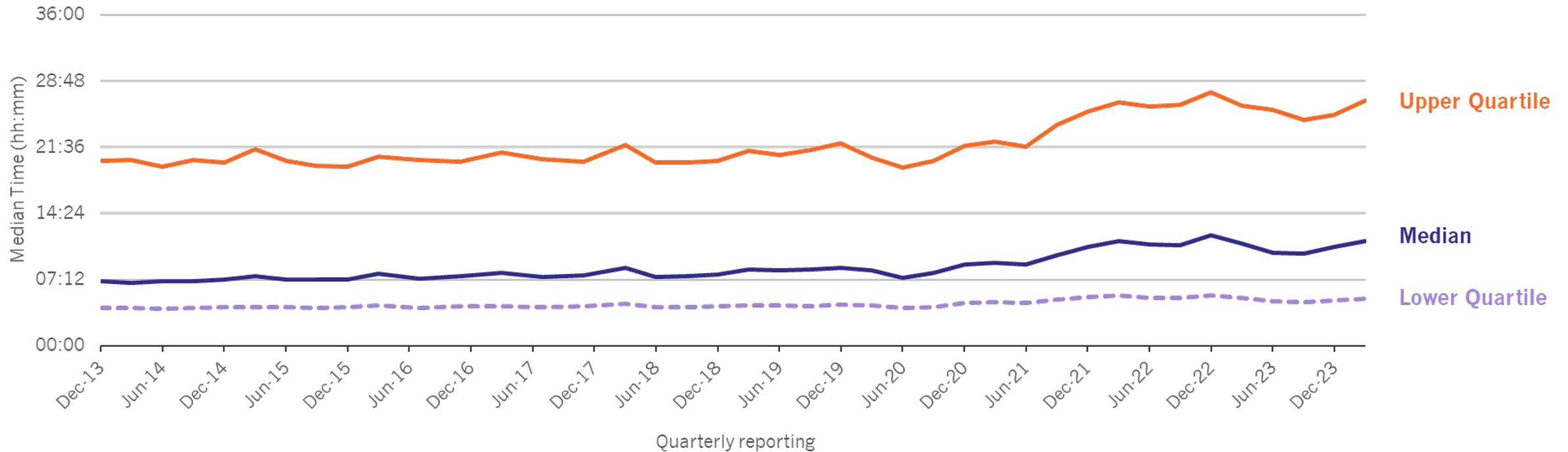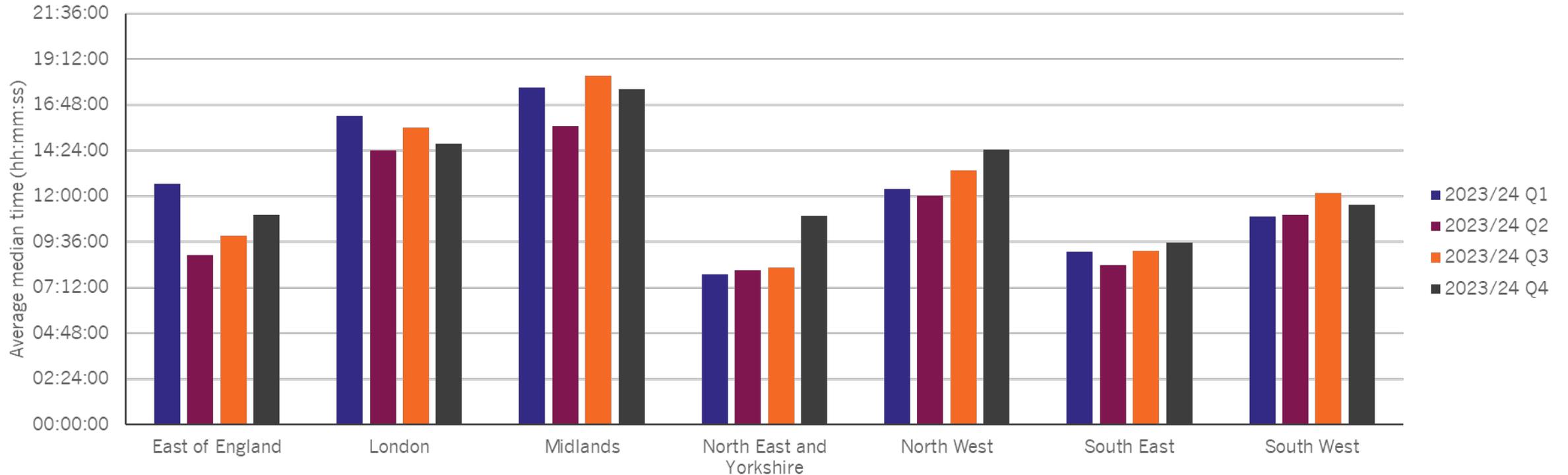

Notes: The causes of the increase are multifactorial and include delays in recognising stroke symptoms at the outset, ambulance capacity to attend, transfer to acute stroke centres and delays within A&E departments, and access to stroke units.

Source: *King's College London*. Sentinel Stroke National Audit Programme (SSNAP) data. Available: https://www.strokeaudit.org/Audits/Clinical-audit-information/About.aspx

8.5 Regional variation in median time from symptom onset to arrival at a stroke unit

Figure III.8.5: Quarterly (average) median time from symptom onset to arrival at stroke unit, 2023/24 Q1-Q4

Notes: The causes of the increase are multifactorial and include delays in recognising stroke symptoms at the outset, ambulance capacity to attend, transfer to acute stroke centres and delays within A&E departments, and access to stroke units.

8.6 Proportion of patients receiving CT or MRI brain scan < 1 hour of hospital arrival for stroke by ICB

Figure III.8.6: Percentage of patients scanned within one hour of arrival, by ICB (England) / LHB (Wales) 2023/24
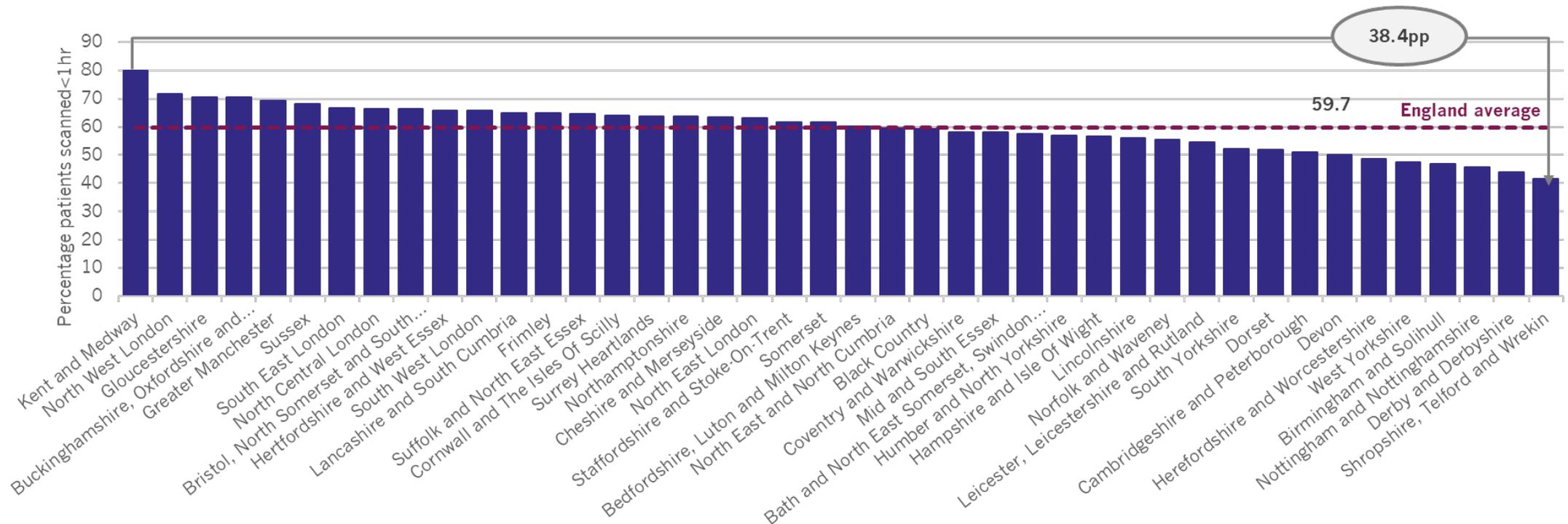

Notes: Bubble represents delta between highest and lowest values. There is 38.4 percentage point difference between the best and worst performing ICB/LHB.

Source: *King's College London*. Sentinel Stroke National Audit Programme (SSNAP) data. Available: https://www.strokeaudit.org/Audits/Clinical-audit-information/About.aspx

8.7 30-day mortality for stroke survivors

Figure III.8.7: England -- Annual Stroke 30 days crude mortality rate (%)
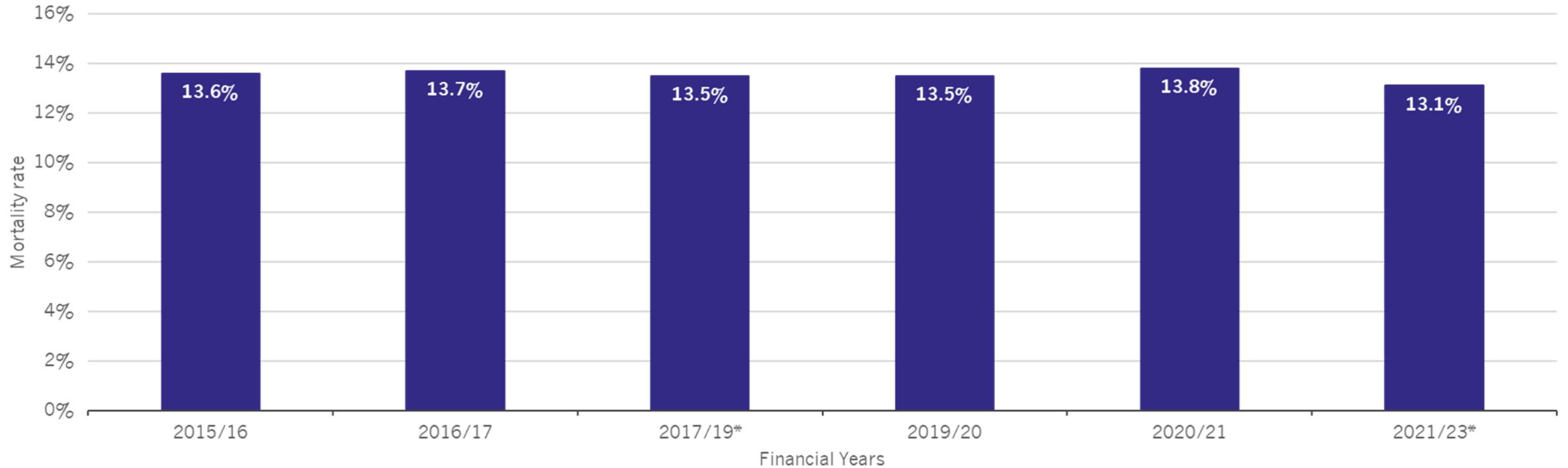

Notes: 2017/19 and 2021/23 are a two-year data collection. 30-day mortality for stroke survivors has decreased to pre-pandemic levels. The reduction in mortality is multifactorial and corresponds to improved access to re-canulisation therapy, management of intracerebral haemorrhage and multi-disciplinary stroke unit care including rehabilitation.
*SSNAP data for 2017-19 and 2021-23 reported over 24-month period.

Source: *King's College London*. Sentinel Stroke National Audit Programme (SSNAP) data. Available: https://www.strokeaudit.org/Results2/Clinical-audit/National-Results.aspx

9.1 Dementia prevalence

**Figure III.9.1: Estimated prevalence of dementia per 1000 population, 2021**
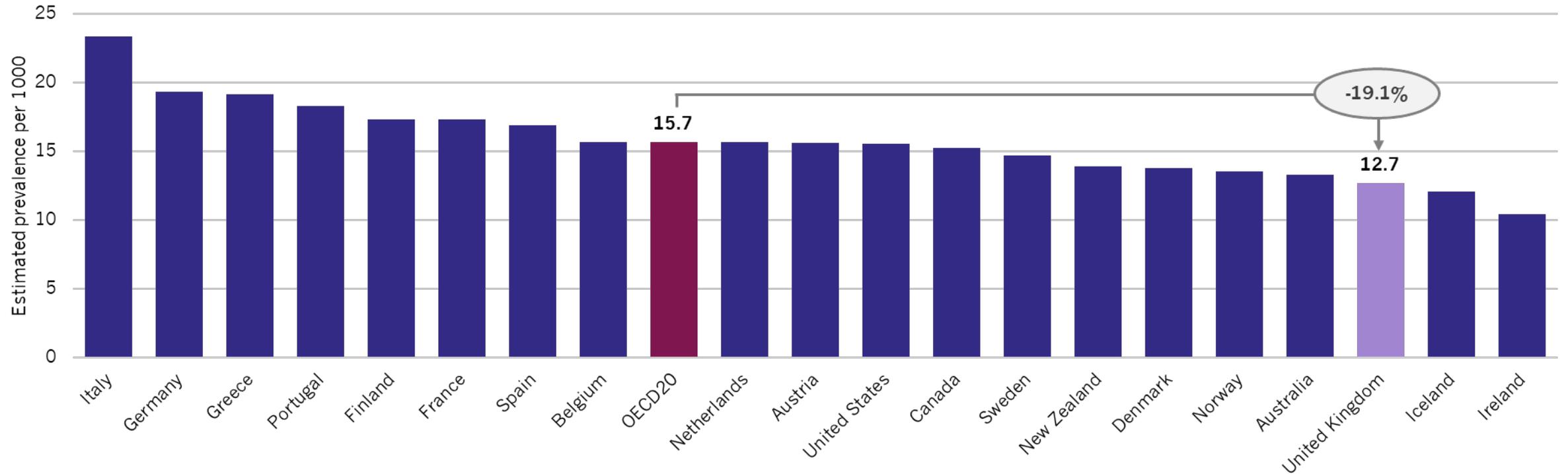
Notes: All data is available for the countries shown above for 2021, unlike other international comparisons within this pack.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

9.2 Mortality rates from dementia

Figure III.9.2: Dementia deaths per 100,000 patients (standardised rates)
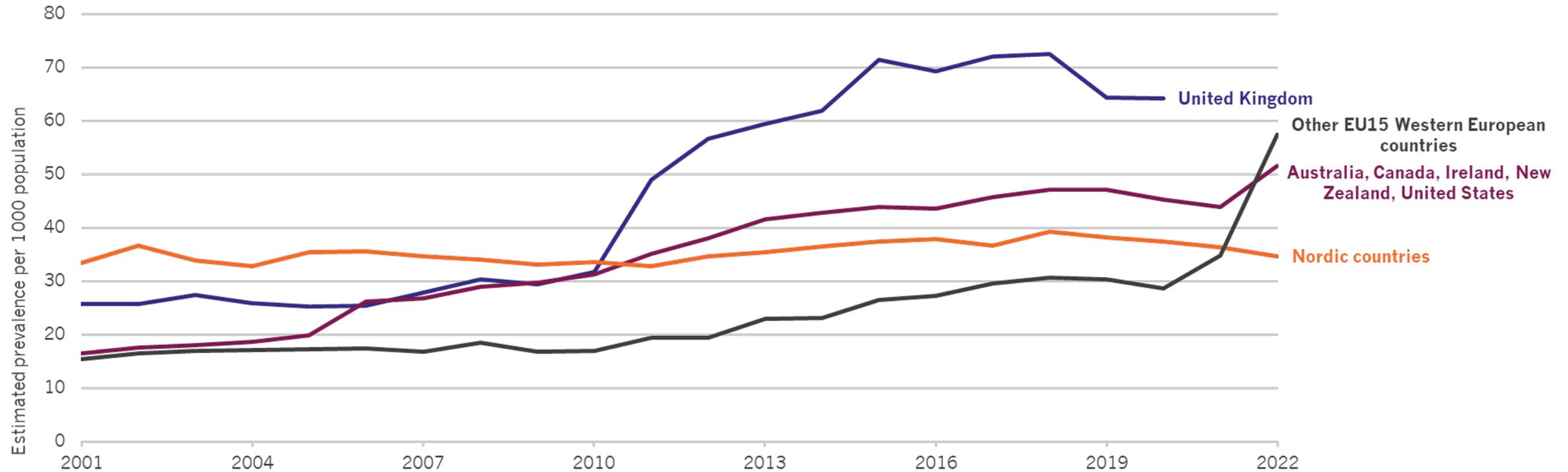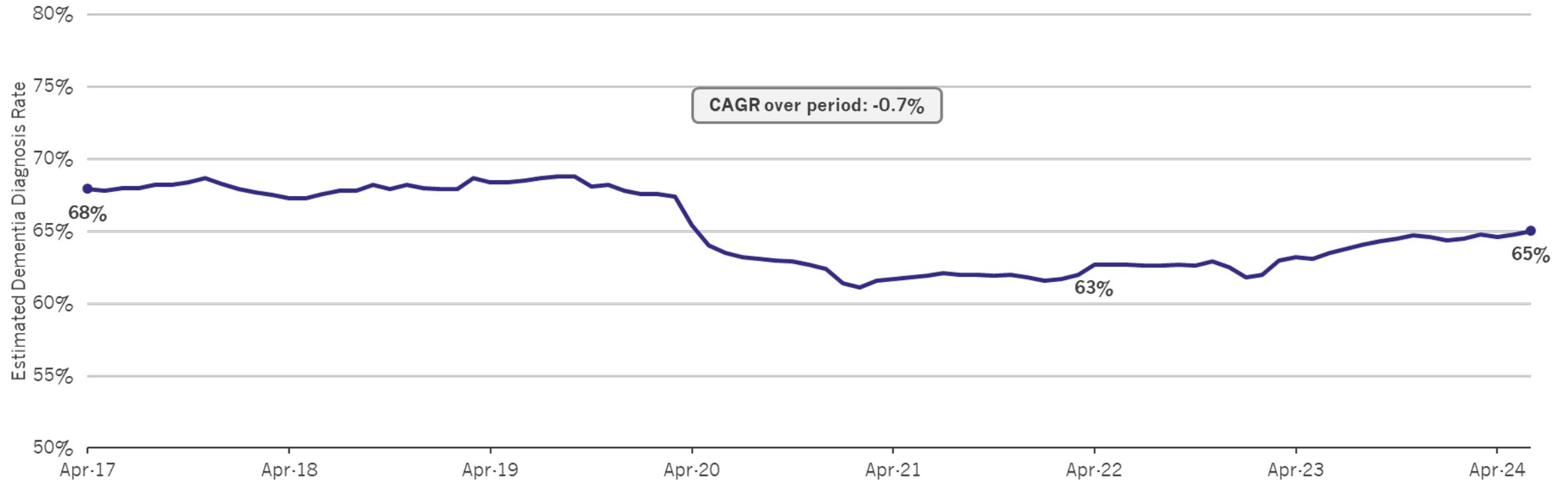

Notes: No 2023 data available for Ireland, the United States or New Zealand. 2023 data for 'Other EU15' countries includes data for the Netherlands only.

Source: OECD

9.3 Dementia diagnosis rate

**Figure III.9.3: Estimated Dementia Diagnosis Rate over time**

Notes: Time series showing estimated dementia diagnosis rates. Updated: August 2024

9.4 People with dementia with a care plan produced or reviewed within the last 12 months

Figure III.9.4: Proportion of patients with a dementia diagnosis who have a care plan, or have had a care plan review in the previous 12 months, over time
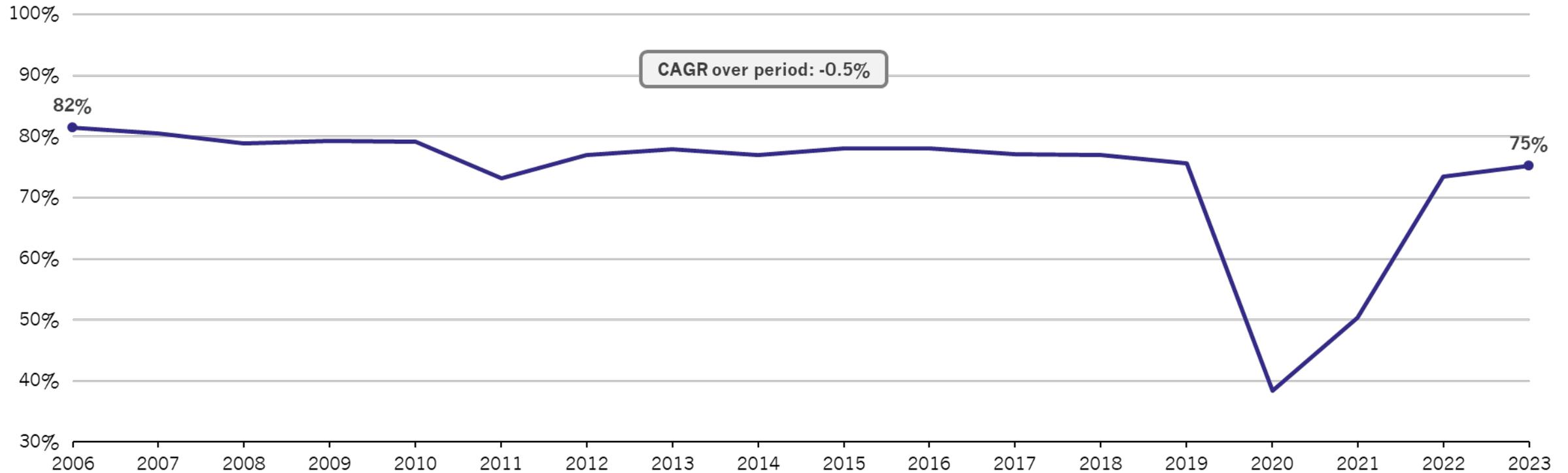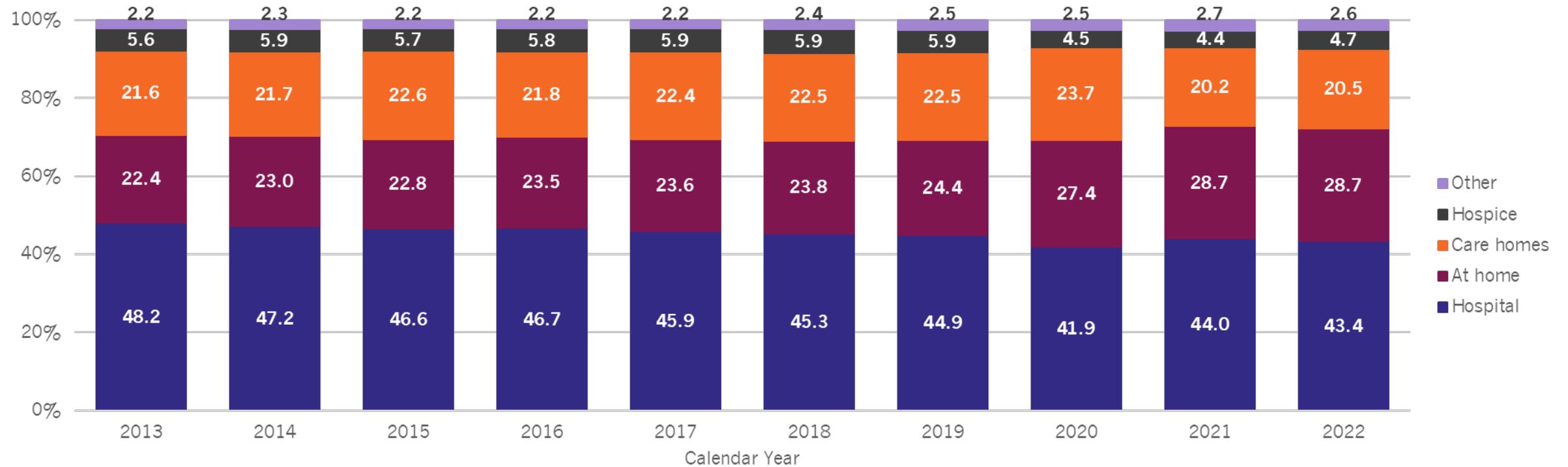

Notes: Time series showing proportion of patients who have had a care plan or care plan review. Updated: August 2024.

10.1 Proportion of people dying each year by place of death

Figure III.10.1: Proportion of people dying each year by place of death, England, 2013 to 2022

Source: Office for National Statistics, Annual mortality extract (produced for OHID). Available at: Palliative and end of life care profiles

10.2 International comparisons of people dying in hospital as a proportion of all deaths

Figure III.10.2: Proportion of deaths in acute inpatient care as a percentage of all deaths, 2014 to 2022 (or nearest year)
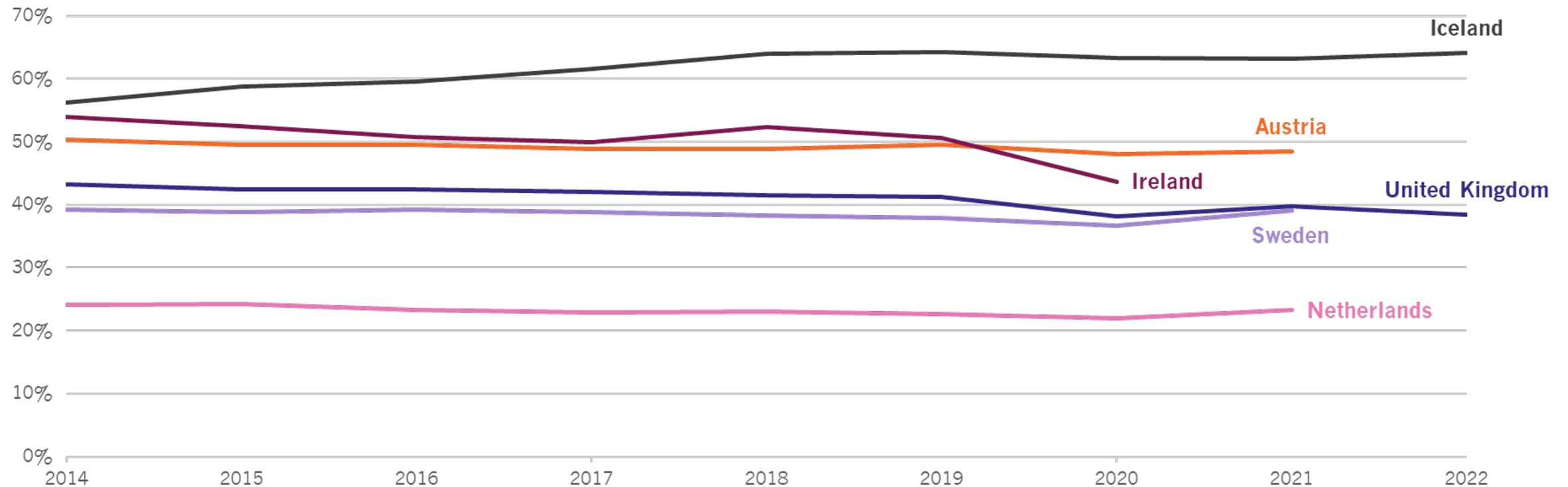
Notes: Data starts at 2014 as this is the point from which data is available for the UK. No data was available for Australia, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Portugal or United States. Data for Canada, New Zealand, Norway and Spain was partially available but was excluded due to not having sufficient data for the purpose of the analysis.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

10.3 Age-sex standardised admissions to hospital in the last 12 months of life by deprivation decile

Figure III.10.3: Sub-ICB age-sex standardised rates of 1+ day non-elective spells in the last year of life, shaded by proportion of population living in more deprived areas

	Overnight non-elective spells in last year of life	Av. 21/22 & 22/23 (Financial Years)
Min (5%)		641,264
Median		815,347
Max (95%)		1,055,511
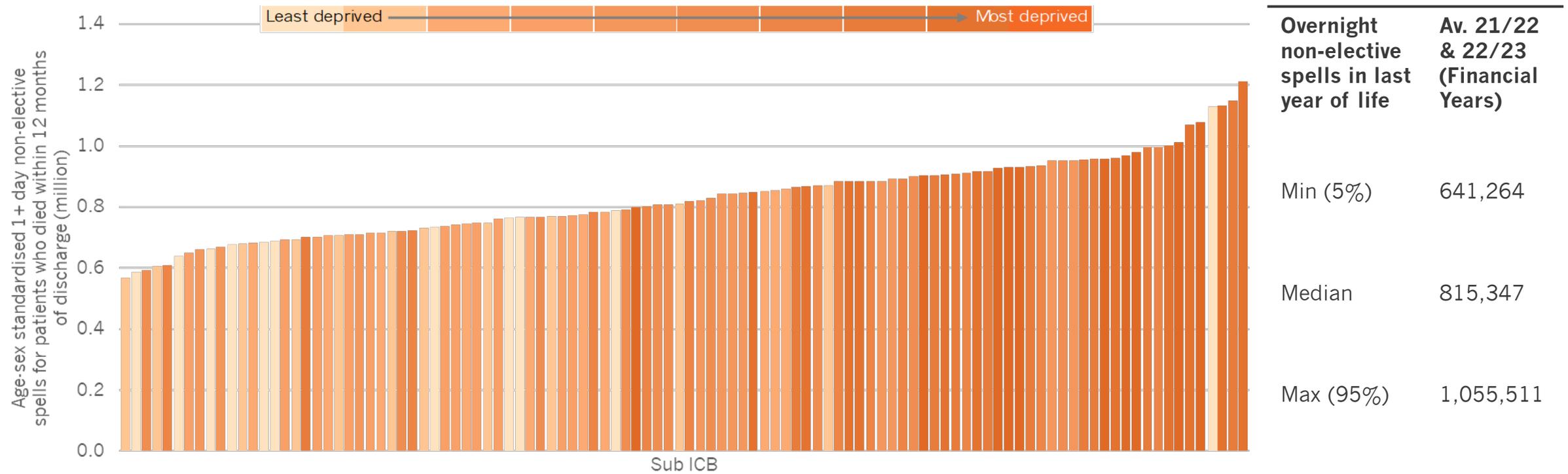
Notes: Deprivation decile (darker = more deprived). Data represent 1+ day non-elective spells per year for patients who died within 12 months of discharge (averaged across financial years 2021/22 and 2022/23). Darker bars indicate a relatively higher level of deprivation in the sub-ICB. To allow for meaningful comparison across sub-ICBs, rates of activity have been age sex standardised by applying five-year age sex bands to the English population. ICB data available.

Source: *NHS England and Office for National Statistics (ONS)*. Data from Admitted Patient Care Commissioning Datasets via and Secondary Uses Service+, linked to mortality records from the Office for National Statistics.

10.4 Recording of end-of-life preferences on GP systems

Figure III.10.4: Percentage of patients in need of palliative care/support, as recorded on practice disease registers, irrespective of age (England)
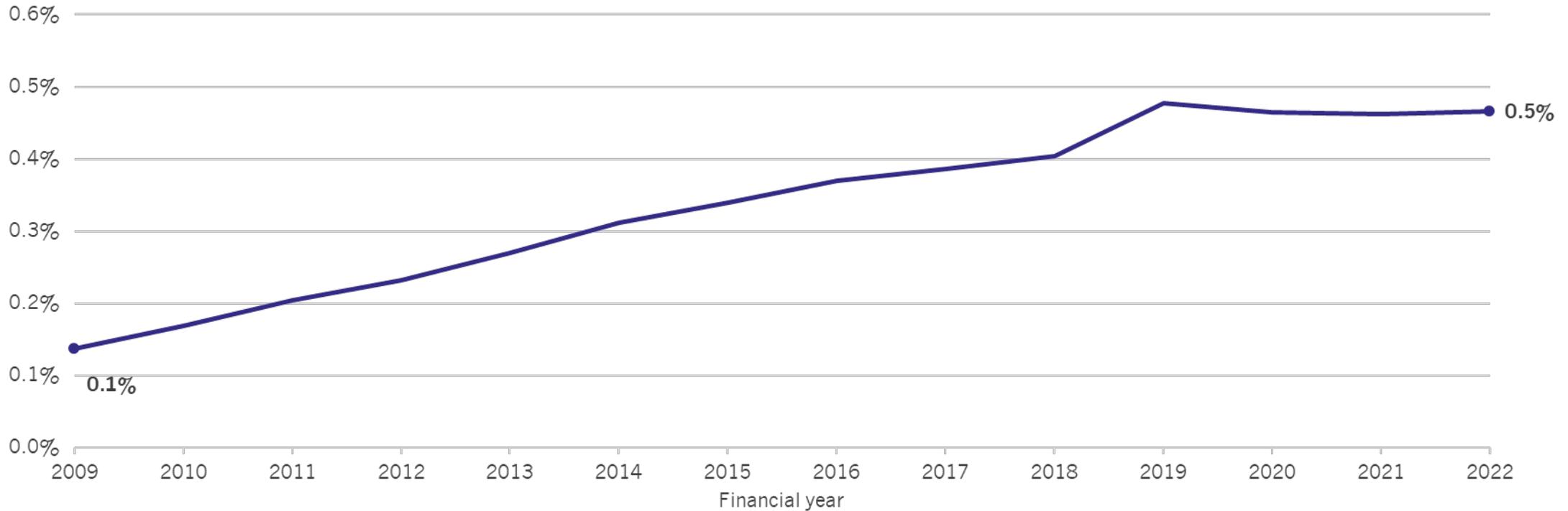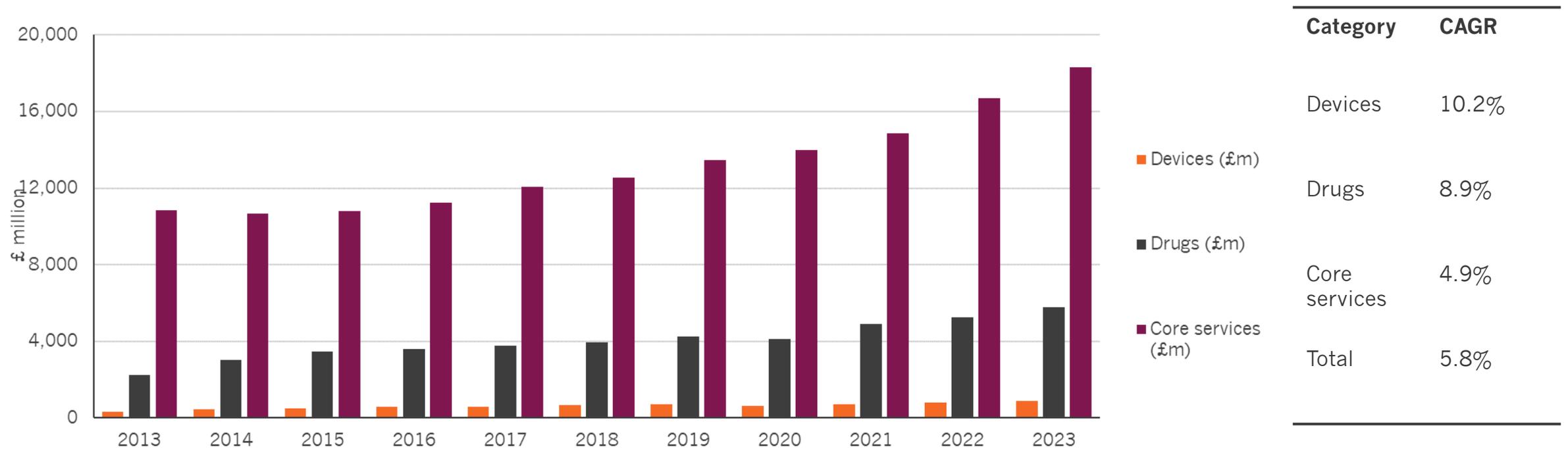
11.1 NHS spend on nationally commissioned (specialised) services

Figure III.11.1: Specialised services expenditure, financial years 2013-2024.

Category	CAGR
Devices	10.2%
Drugs	8.9%
Core services	4.9%
Total	5.8%

Notes: Recent years have seen significantly higher than average cost uplifts driven by pay deals. For example, if pay above 2% is stripped out for the years 21/22, 22/23 and 23/24 this would reduce spend by approximately £201m, £294m, and £433m respectively. Core services relates to spend on services that is not the cost of tariff excluded high-cost drugs and devices.

Source: NHS England analysis of locally reported data held by regional commissioning and national team.

11.2 Growth in rare and inherited disease genomic testing (Non-WGS and WGS) and associated turnaround times

Figure III.11.2: Total number of genomic tests in England done by the NHS GMS for patients with rare and inherited disease (WGS and Non-WGS activity) vs % of those tests delivered within the standard turnaround time
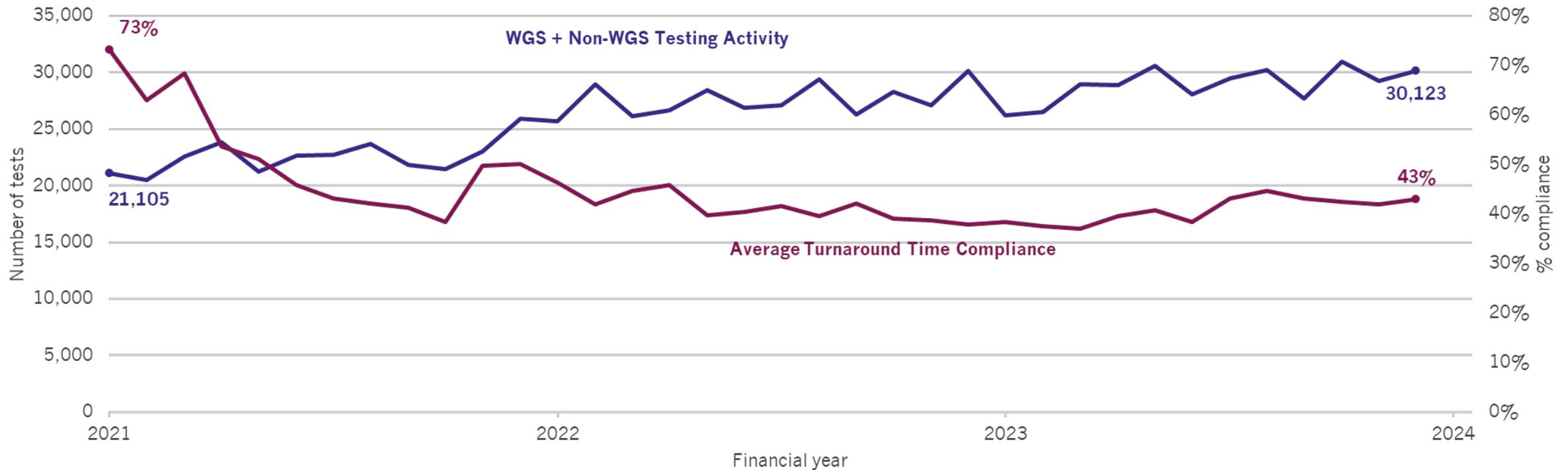
Notes: Non-WGS is non-whole genome sequencing. WGS is whole genome sequencing.

Source: *NHS England*. Genomics PLCM submissions and Genomics England data packs. TATs unpublished.

11.3 NHS delivery of whole genome sequencing for rare diseases

Figure III.11.3: National Rare and Inherited Disease genomic testing activity for Whole Genome Sequencing (WGS) and average rare disease turnaround time compliance
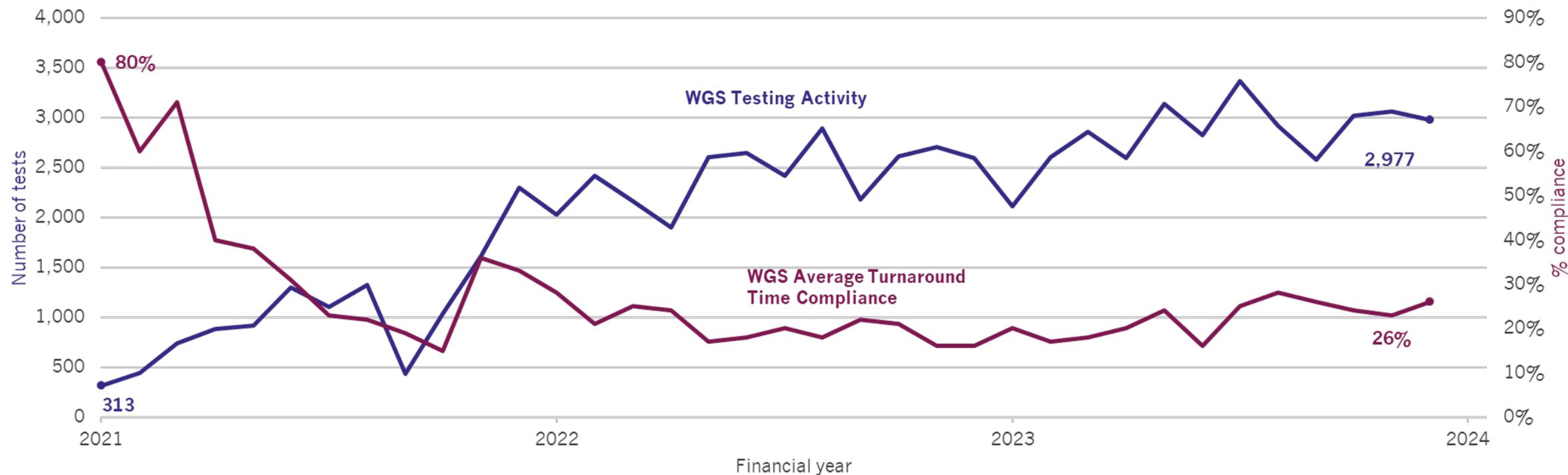
Note: WGS is whole genome sequencing

Source: *NHS England*. Genomics PLCM submissions and Genomics England data packs. TATs unpublished.

11.4 Recommended medicines split by local or specialised commissioning

Figure III.11.4: Number of medicines, with a positive recommendation, commissioned by local commissioners or central specialised commissioning
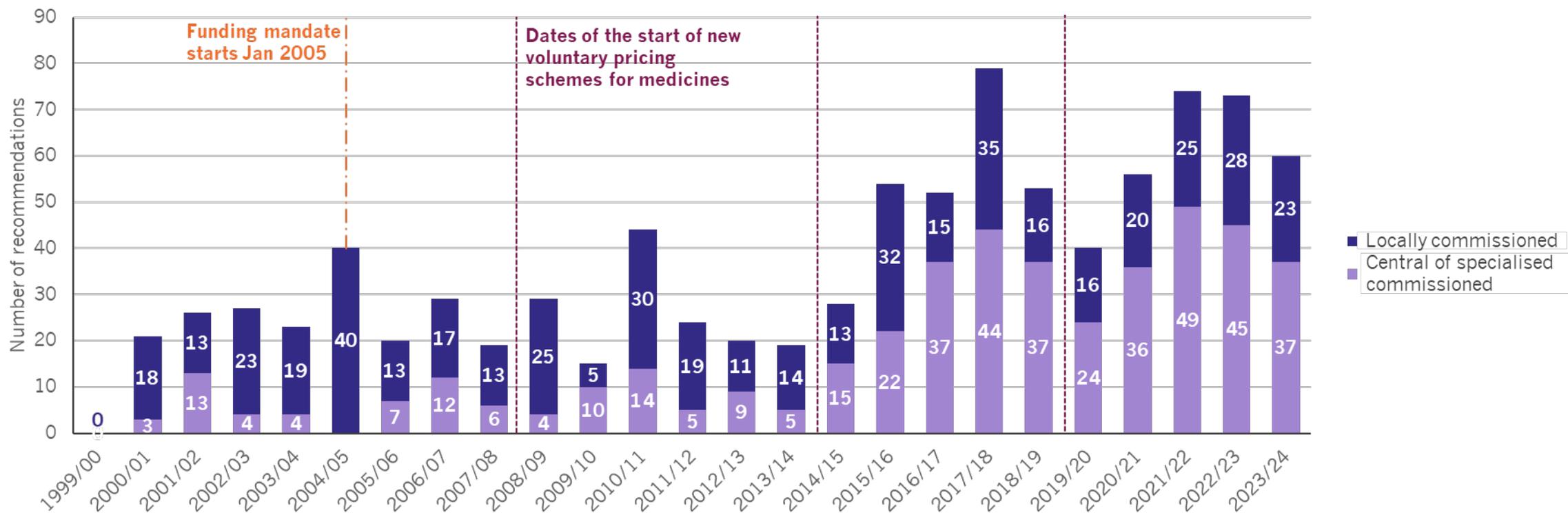
Notes: Locally commissioned = primary care trusts (PCTs), clinical commissioning groups (CCGs) or integrated care boards (ICBs). Central or specialised commissioned = NHS England from 2013/14 onwards

Source: *NICE*. Internal administrative data.

12.1 Cancer incidence over time

Figure III.12.1: Incidence trends for all cancers combined excluding non-melanoma skin cancer (ICD-10 C00-C97 excl. C44), England, persons, 2001-2019
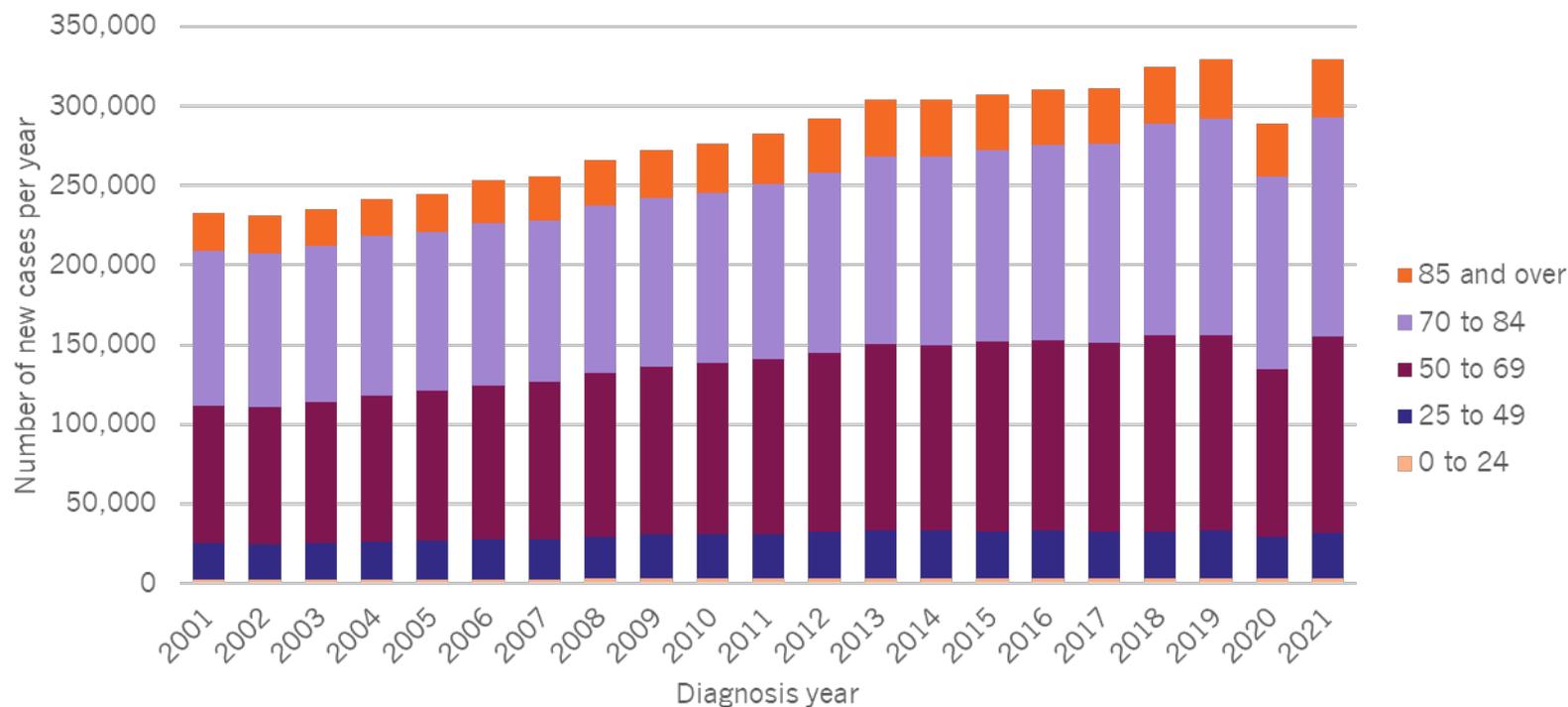
CAGRS	NUMBER OF CASES, %	AGE-STANDARDISED RATES, %
2001-05	1.20%	0.30%
2005-10	2.50%	1.10%
2010-15	2.10%	0.50%
2015-19	1.70%	0.10%
2019-21	0.10%	
2001-21	1.70%	

Notes: Annual avg. absolute increase of new cancer cases in England over the period 2001-2019 was 5,333. The increased number of cancer cases per year is due partly to the growing and ageing population.

Source: NDRS/NHSE. Cancer Registration Statistics. Available: https://www.cancerdata.nhs.uk/incidence_and_mortality and Cancer Registration Statistics, England, 2021 - Full release - NHS England Digital

12.2 Cancer survival rates (all cancers)

Figure III.12.2: Index of cancer survival by calendar year of diagnosis in England, Persons aged 15 to 99 years, diagnoses 2005 to 2020
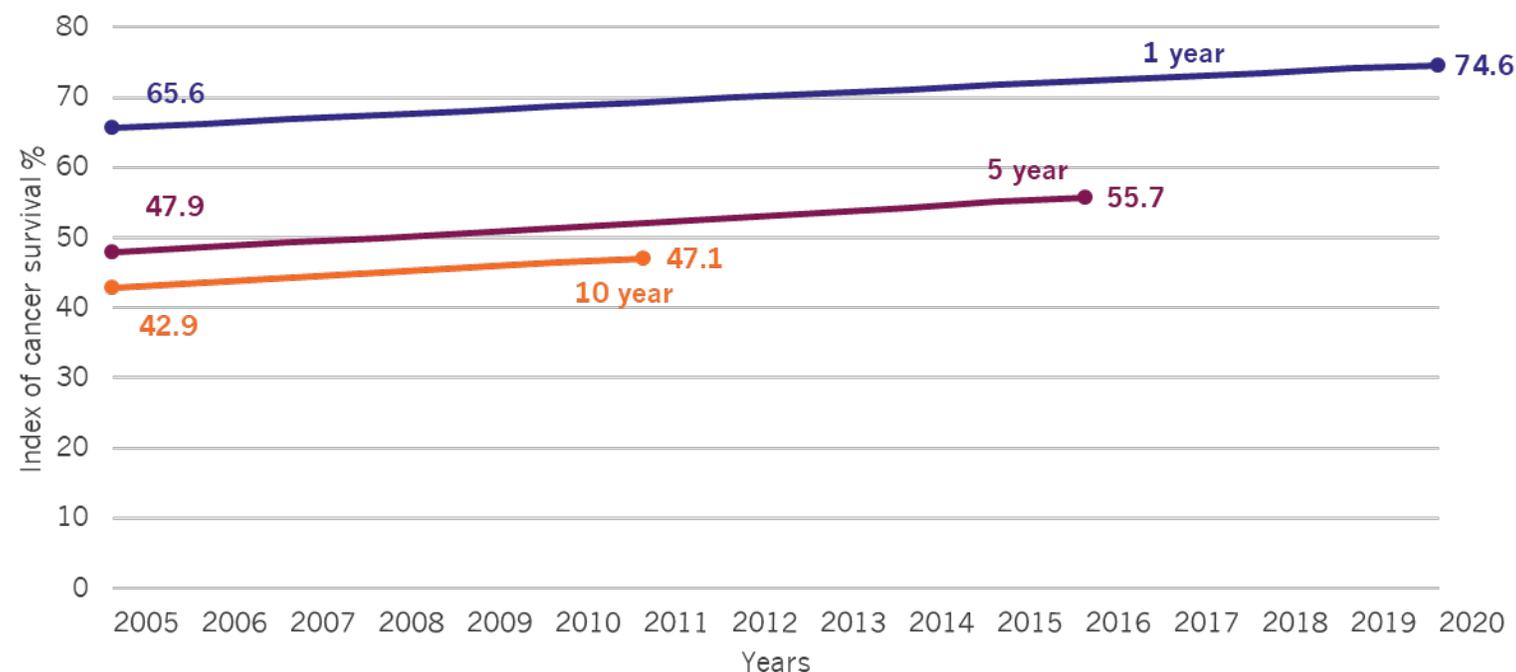
	CAGR 1yr survival	CAGR 5yr survival	CAGR 10yr survival
2005 - 2020	0.90%	NA	NA
2005 - 2008	1.00%	1.40%	1.60%
2009 - 2011	0.90%	1.40%	1.50%
2012 - 2016	0.80%	1.30%	NA
2017 - 2020	0.80%	NA	NA

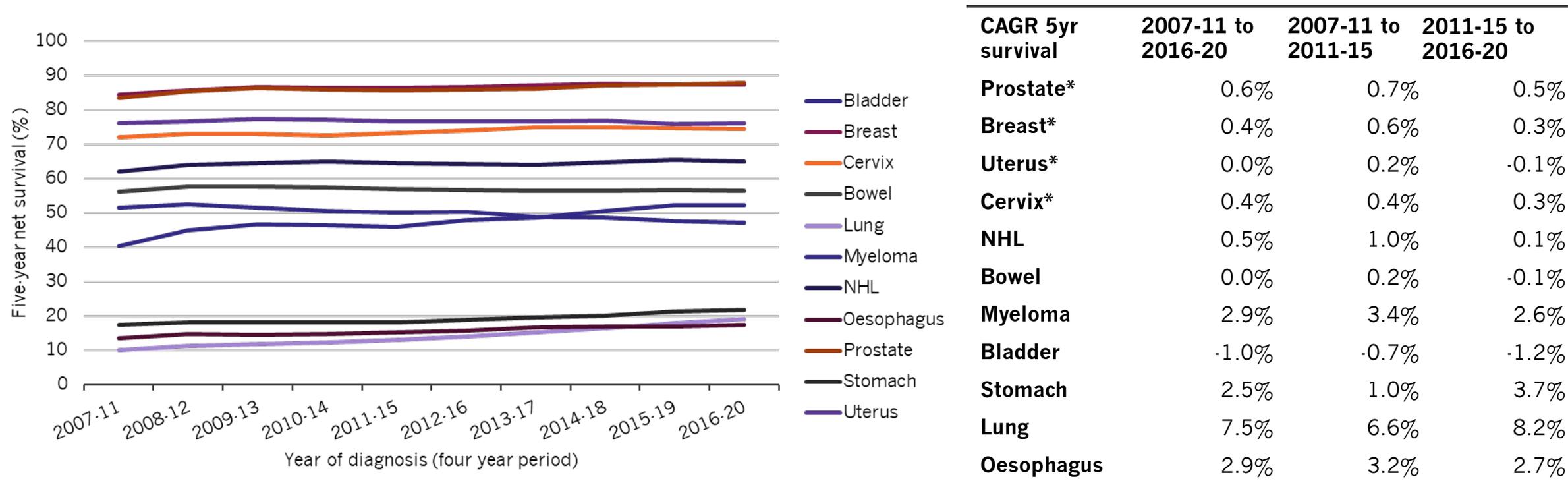Notes: Dataset recorded until 2020. This is a survival index whereby the case mix is held constant, so it does not reflect changing incidence. The index of cancer survival has improved over the time period, with a 0.9% CAGR for 1-year survival (2005 to 2020). Greater improvements were seen for 5-year and 10-year index of cancer survival. The index of cancer survival provides a convenient, single number that summarises the overall pattern of net cancer survival (excluding non-melanoma skin cancer and prostate cancer). It combines net survival estimates for breast cancer (women only), colorectal (bowel) cancer, lung cancer and other cancers. The index of cancer survival can be compared over time because it is adjusted for any changes in the profile of cancer patients by age, gender or type of cancer.
Source: Source: *NDRS/NHSE*. Cancer survival: Index for sub-Integrated Care Boards, 2005 to 2020. Available: https://digital.nhs.uk/data-and-information/publications/statistical/cancer-survival-in-england/index-for-sub-integrated-care-boards-2005-to-2020 Credit given to Cancer Research UK for original visualisation.

12.3 Cancer survival rates by cancer site

Figure III.12.3: Five-year net survival, selected cancer sites, England, Persons, diagnoses 2007-11 to 2016-20

| CAGR 5yr survival	2007-11 to 2016-20	2007-11 to 2011-15	2011-15 to 2016-20
Prostate*	0.6%	0.7%	0.5%
Breast*	0.4%	0.6%	0.3%
Uterus*	0.0%	0.2%	-0.1%
Cervix*	0.4%	0.4%	0.3%
NHL	0.5%	1.0%	0.1%
Bowel	0.0%	0.2%	-0.1%
Myeloma	2.9%	3.4%	2.6%
Bladder	-1.0%	-0.7%	-1.2%
Stomach	2.5%	1.0%	3.7%
Lung	7.5%	6.6%	8.2%
Oesophagus	2.9%	3.2%	2.7%

Notes: Survival for many cancer sites has improved between 2007-11 and 2016-20 (CAGRs 0.4% to 7.5%, however the pace of change was generally slower in the late 2010s compared with the early 2010s. For some sites, survival has fallen or remained unchanged over the period. Dataset recorded from 2007 until 2020. Asterisked sites are sex-specific. These figures are not comparable with the all cancers combined survival index, due to method differences.

Source: *NDRS/NHSE*. Cancer Survival in England, cancers diagnosed 2016 to 2020, followed up to 2021. https://digital.nhs.uk/data-and-information/publications/statistical/cancer-survival-in-england/cancers-diagnosed-2016-to-2020-followed-up-to-2021

12.4 International comparisons of cancer mortality

Figure III.12.4: Standardised rate of malignant neoplasms deaths per 100,000 patients, 2001 to 2022 (or nearest year)
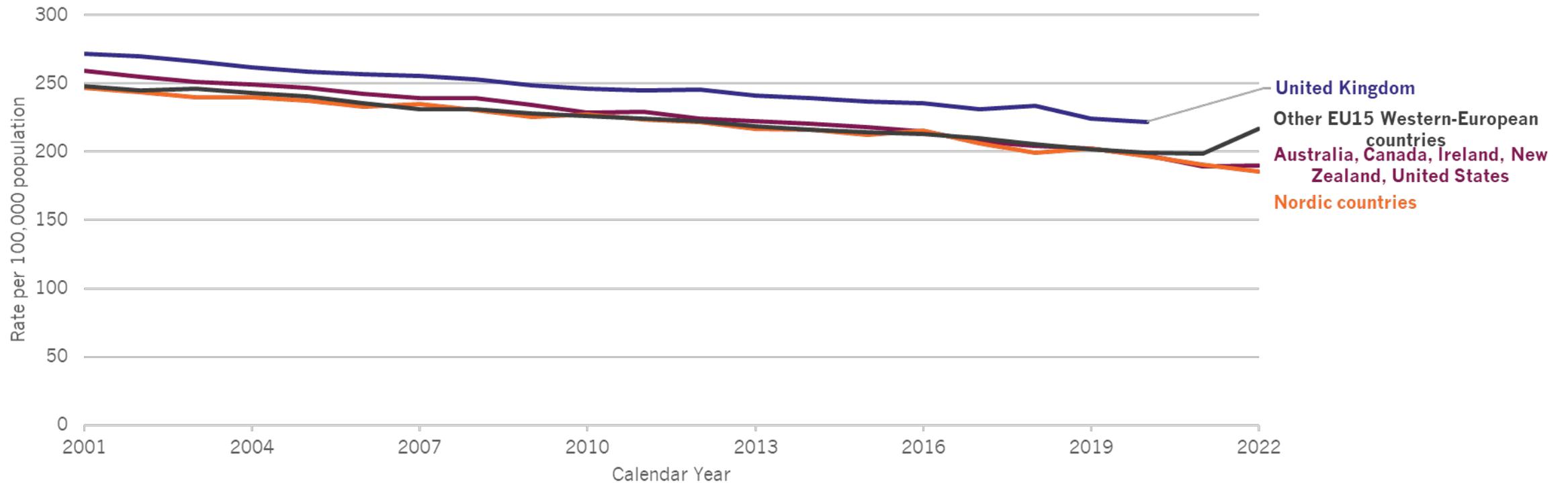

Notes: By country group, 2001-2022. For 2022, only Australia, Canada, Netherlands, Sweden had data. Excluding 2022, New Zealand, Norway and Portugal had more than one missing year of data.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

# 12.5 International comparisons of cancer survival

Figure III.12.5: % age-standardised five-year net cancer survival, 15 years and above, 2000 to 2014
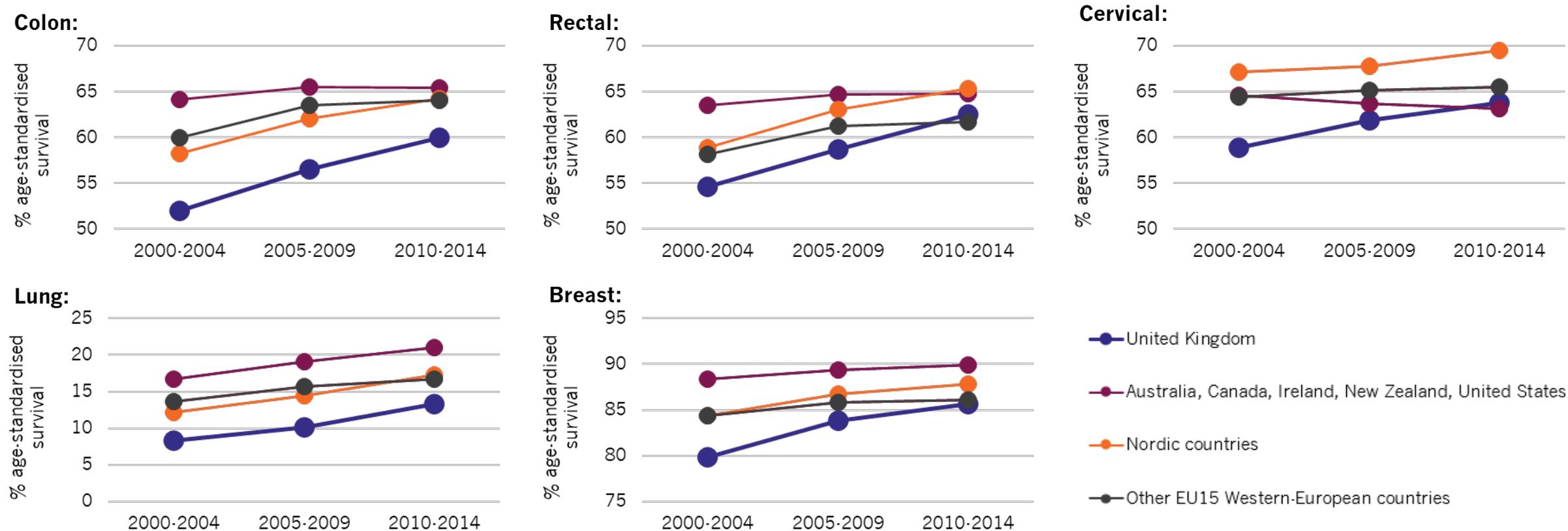
Notes: No data available for Greece. Note that the y-axis range changes between charts.

Source: OECD

12.6 Cancer routes to diagnosis over time

Figure III.12.6: Proportion of Cancer Cases by Route to Diagnosis Over Time: All Cancers Combined
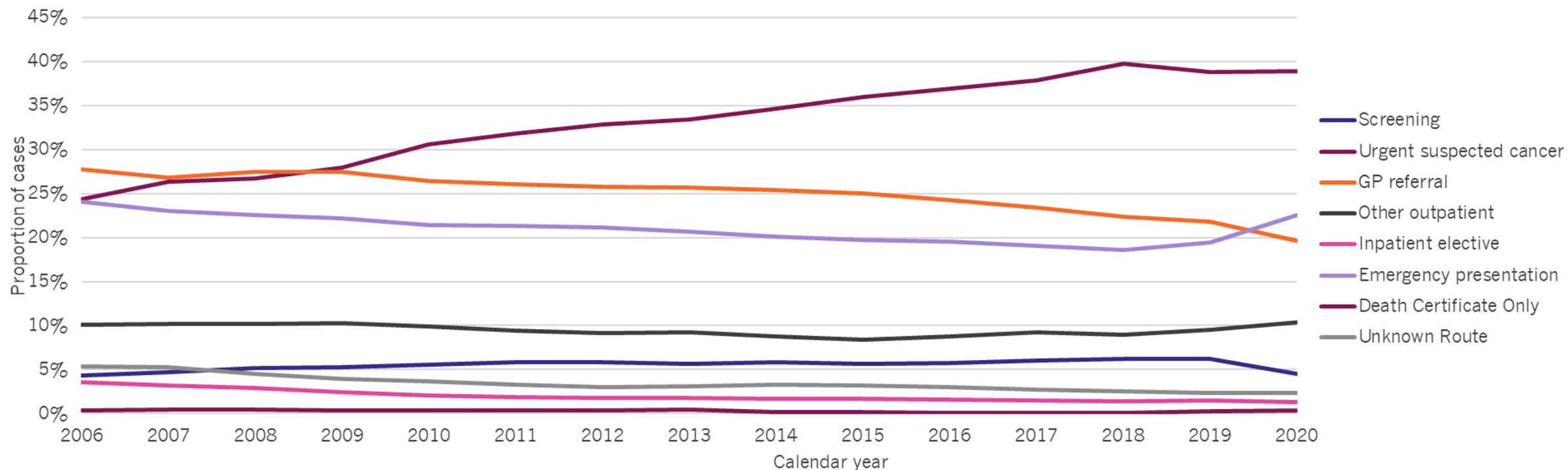

Notes: The data does not currently go beyond 2020. Information provided for the "screen detected" Route is known to be of variable data quality and completeness.
Over time the bowel screening programme has been rolled out with extensions to its age range. Policy around urgent suspected referral of cancers has also changed greatly, and a drive towards early diagnosis is also present during the time period. 2020 is heavily impacted by the COVID-19 pandemic, particularly as the number of cancers diagnosed dropped substantially, so the 2020 proportions shown in the figures are based on a reduced denominator during that period.

Source: *NHS England*. National Cancer Registration Service (NDRS), Routes to Diagnosis. Available: https://nhsd-ndrs.shinyapps.io/routes_to_diagnosis/

12.7 Cancer routes to diagnosis by deprivation

Figure III.12.7: Routes to Diagnosis by deprivation quintile, (2020)
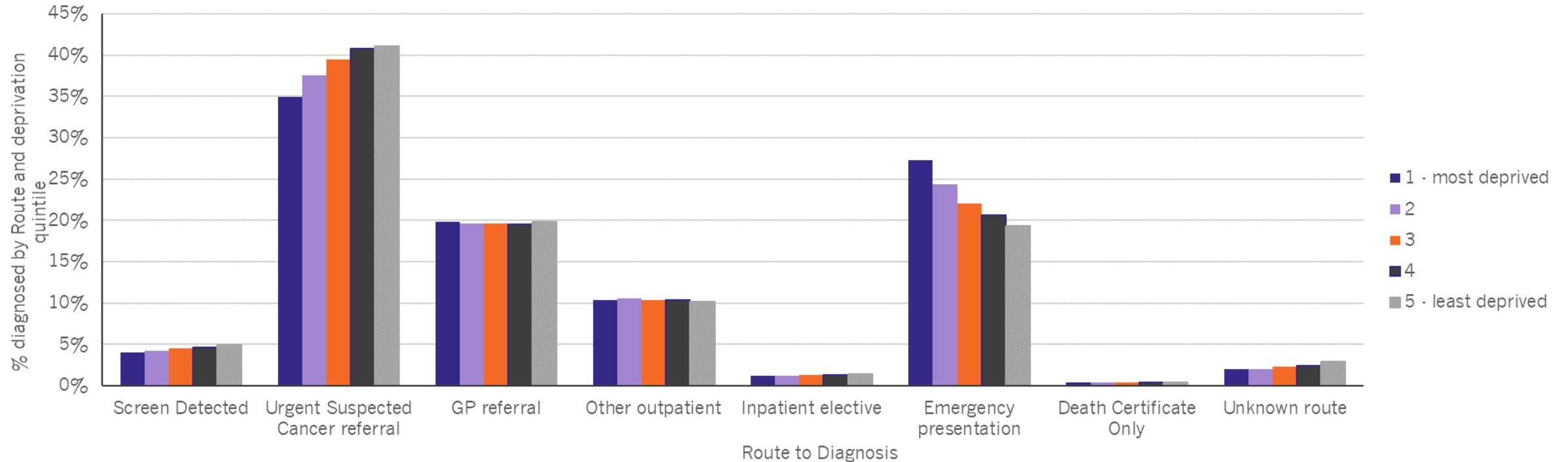
Notes: Covers all malignant cancers (excl. non-malignant melanoma), England, 2020. 2020 is heavily impacted by the COVID-19 pandemic, particularly as the number of cancers diagnosed dropped substantially, so the 2020 proportions shown in the figures are based on a reduced denominator during that period.

Source: *NHS England*. National Cancer Registration Service (NDRS), Routes to Diagnosis.
Available: https://nhsd-ndrs.shinyapps.io/routes_to_diagnosis/

12.8 Cancer diagnoses at stage 1 and 2

Figure III.12.8: Percentage of cancers diagnosed at early stage (stage 1 and 2) by diagnosis year
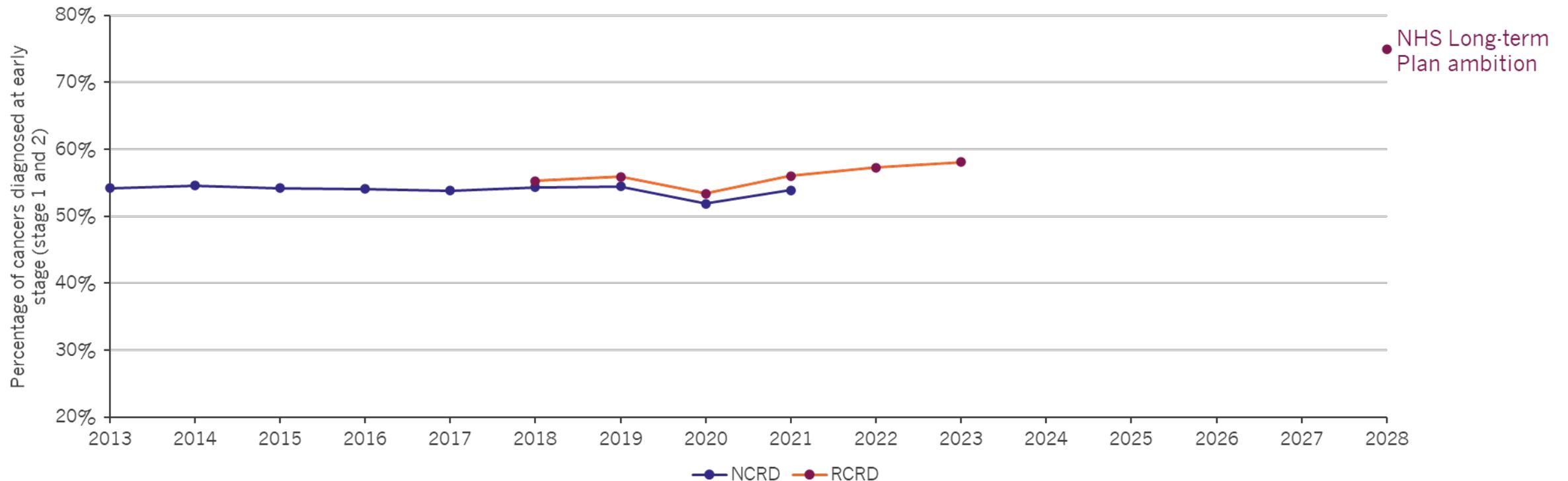
Notes: denominator all cancers in persons with a valid stage; national cancer registration data (NCRD) and rapid cancer registration dataset (RCRD)

Sources: NDRS/NHSE NCRD: Case-mix adjusted percentage of cancers diagnosed at stages 1 and 2 by sub-ICB in England, 2021; available at: https://digital.nhs.uk/data-and-information/publications/statistical/case-mix-adjusted-percentage-of-cancers-diagnosed-at-stages-1-and-2-in-england/2021
RCRD: Rapid Cancer Registration data dashboard (Version used: release 40, CAS2406); available at: https://nhsd-ndrs.shinyapps.io/rcr_covid19/

12.9 Cancer diagnosis in stage 1 or 2 by tumour type

Figure III.12.9A: Percentage of breast cancers (ICD10 C50) in females (NCRD) or persons (RCRD) diagnosed at early stage (stage 1 and 2) by diagnosis year.
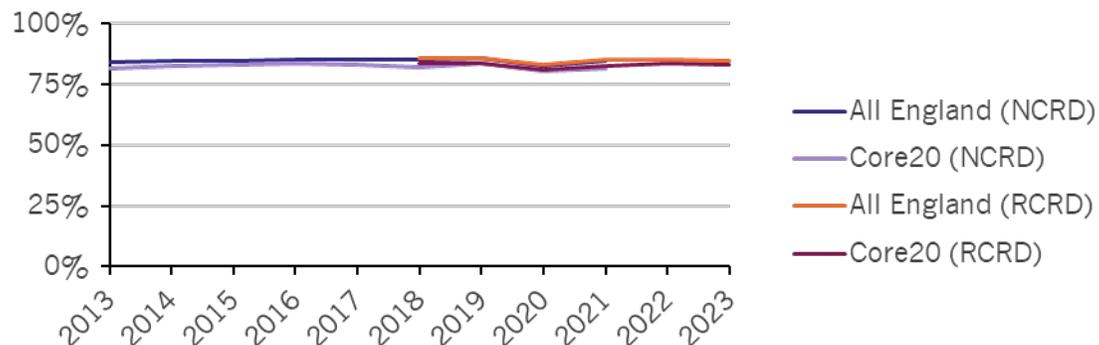

Figure III.12.9B: Percentage of lung cancers (ICD10 C33-C34) diagnosed at early stage (stage 1 and 2) by diagnosis year
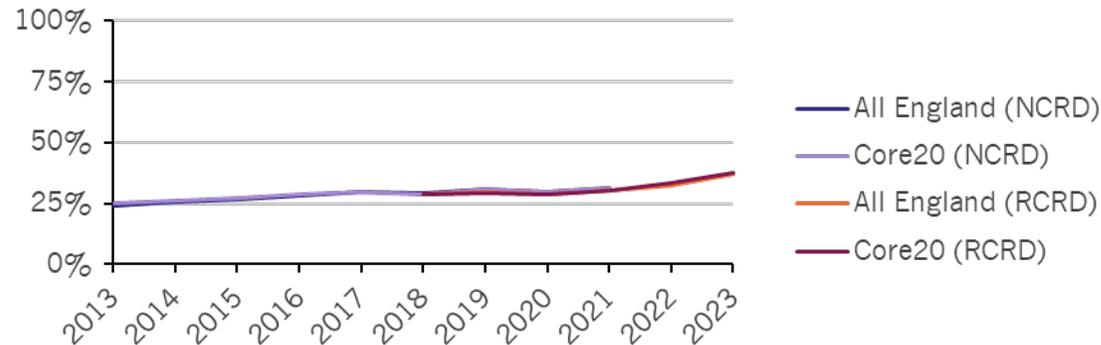
Figure III.12.9C: Percentage of colon (NCRD, ICD10 C18)/ colorectal cancers (RCRD, ICD10 C18-C20) diagnosed at early stage (stage 1 and 2) by diagnosis year

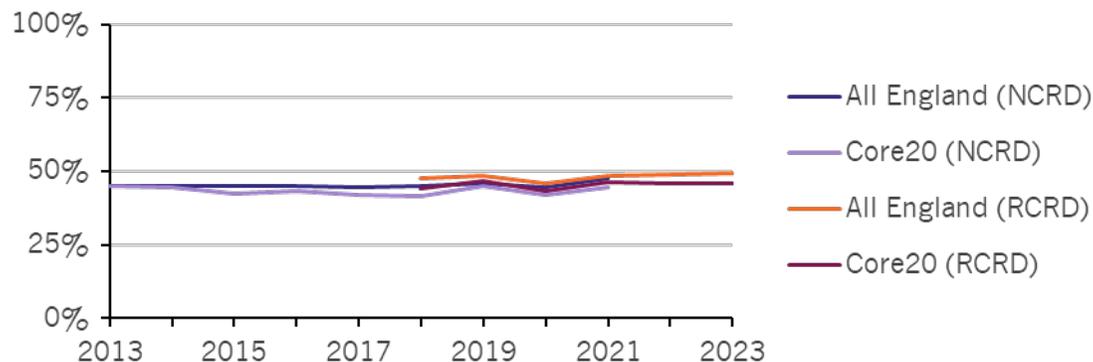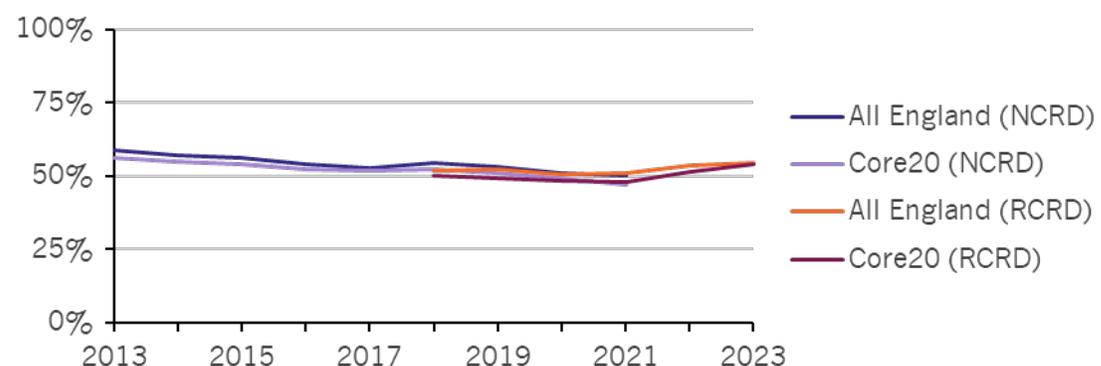**Figure III.12.9D: Percentage of prostate cancers (ICD10 C61) in males diagnosed at early stage (stage 1 and 2) by diagnosis year**


Notes: Denominators are all cancers with a valid stage: for breast, all cancers in females/persons with a valid stage; for prostate, all cancers in males with a valid stage.

12.10 Early diagnosis of lung cancer by indices of multiple deprivation quintile

Figure III.12.10: Rolling 12-month average early diagnosis proportion for lung cancer by Indices of Multiple Deprivation (IMD) quintile, taken from the Rapid Cancer Registration Dataset, up to March 2024 (most recent data)
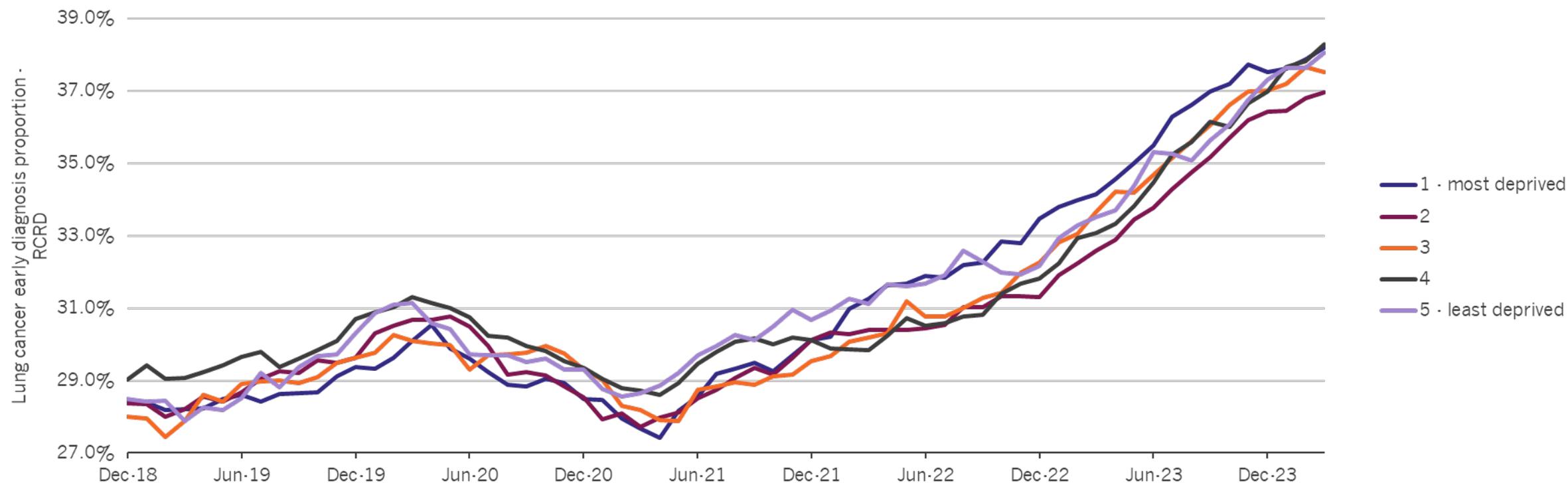
Notes: Whilst the lung cancer early diagnosis proportion has increased for all quintiles, it has risen most in the most deprived quintile. Compared to the pre-pandemic baseline (Mar-19 to Feb-20), the lung cancer early diagnosis proportion in the most deprived quintile has increased 8.6 percentage point up to most recent data (Apr-23 to Mar-24). In the other four quintiles, the difference ranged from 6.4 to 7.3. The most deprived quintile has moved from having the lowest early-stage proportion pre-pandemic to being one of the highest post-pandemic: 38.2% in the most deprived quintile in the most recent 12 months (Apr-23 to Mar-24), compared to between 37.0% and 38.3% in the other four quintiles.

Source: *NHS England*. Rapid Cancer Registration Dataset. Available: https://digital.nhs.uk/ndrs/data/data-sets/rcrd

12.11 Number of lung cancers diagnosed through the Targeted Lung Health Check (TLHC) Programme

Figure III.12.11: The number of Lung Cancers Diagnosed each month through the TLHC Programme April 2019 – May 2024 (TLHC Management Information Return)

Notes: 4,342 total lung cancers have been diagnosed through the TLHC programme from April 2019 to May 2024. 76.7% of these have been diagnosed at early stage (denominator the sum of all stageable cancers). The number of lung cancers diagnosed through the TLHC programme has been increasing over time, as the programme coverage continues to expand around the country.

Source: *NHS England*

12.12 Rollout of teledermatology to Urgent Suspected Skin Cancer pathways

Figure III.12.12: Urgent Suspected Skin Cancer Referrals managed through Teledermatology by Region over time
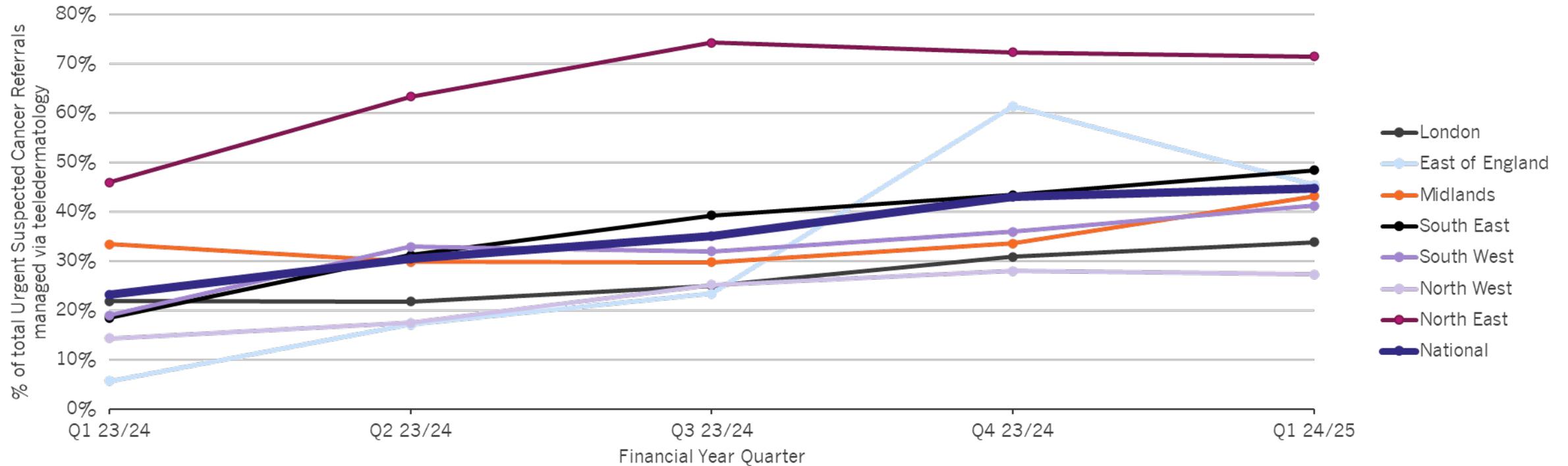
Source: *NHS England*. NHS Cancer Programme, Cancer Alliance Quarterly Assurance Returns.

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12.13 Faecal immunochemical test (FIT) triage in primary care and low value colonoscopy rates

Figure III.12.13A: The proportion of LGI urgent suspected cancer referrals accompanied by a FIT
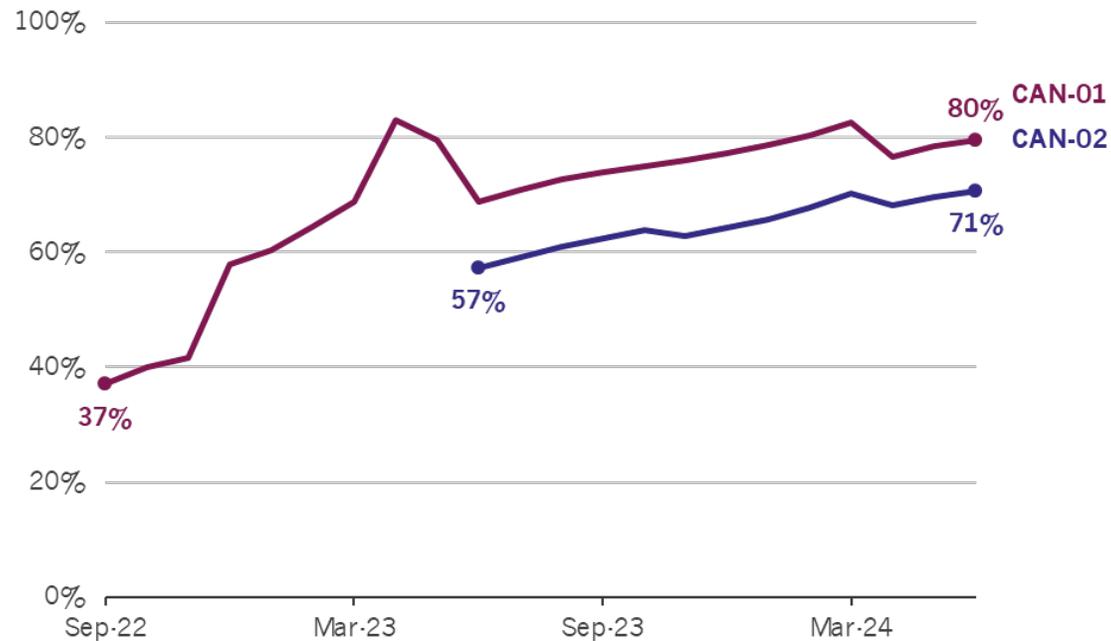
Figure III.12.13B: The percentage of Urgent Suspected Cancer colonoscopies performed on those with a FIT negative result (<10ug/gm)
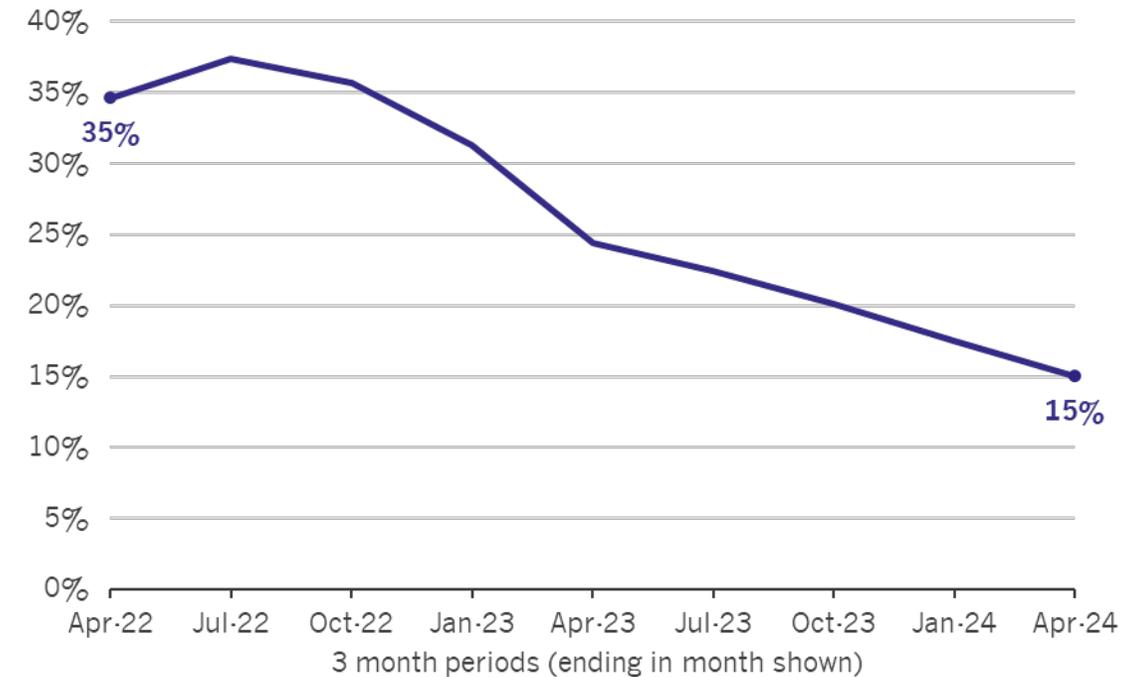
Notes: CAN-01: the proportion of LGI urgent suspected cancer referrals accompanied by a FIT result in the 21 days prior to referral or 14 days post-referral. CAN-02: the proportion of LGI urgent suspected cancer referrals accompanied by a FIT result in the 21 days prior to referral. It should be noted that PCNs are required to sign-up to the incentive at the beginning of each financial year, therefore Q1 data is incomplete – focus should instead be placed on trends seen in Q2-Q4.

Sources: Left chart: *NHS England*. Network Contract Directed Enhanced Service (DES). Available: https://digital.nhs.uk/data-and-information/publications/statistical/mi-network-contract-des; Right chart: *NHS England*. Cancer Alliance Delivery Plan Template

12.14 Impact of Faecal immunochemical test (FIT) rollout on Urgent Suspected Cancer lower GI referrals

Figure III.12.14: (Bar) Change in the number of breaches this year vs the equivalent number of breaches (Line) Urgent Suspected Lower Gastrointestinal Cancer Faster Diagnosis Standard growth in working day adjusted activity this year vs the same month last year.
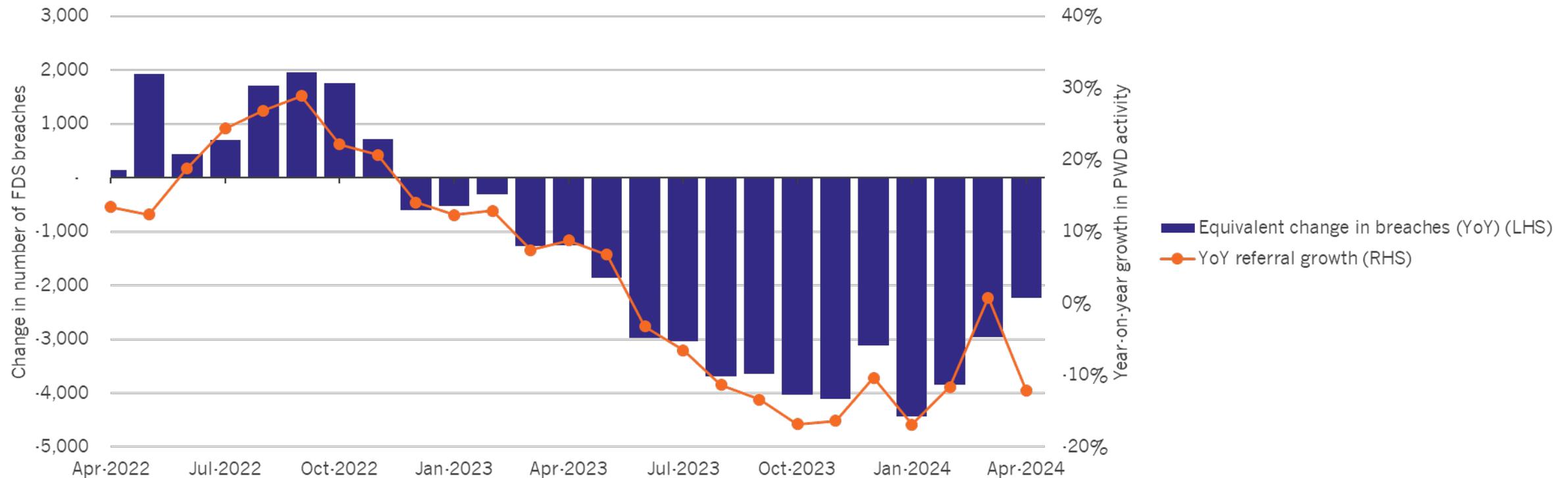
Notes: Reduction in per working day activity compared to the same month in the previous year since Jun-23 (avg. -10.7%) which is expected to be driven by FIT use in the pathway. Mar-24 was the only outlier (0.8% growth) which may be explained by Easter falling differently across years. The equivalent change in Faster Diagnosis Standard breaches since Dec-22 are negative indicating improved performance as more patients are told their outcome within target on the previous year (e.g., 59.4% in Apr-24; 53.3% in Apr-23). Strong correlation (R2 = .89) suggests demand reduction, expected to be driven by FIT, is key to improved FDS performance within this tumour group.

Source: *NHS England*. Cancer Waiting Times data. Available: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

12.15 Growth of cancer genomic test activity (including whole genome sequencing) and associated turnaround times

Figure III.12.15: Total number of genomic tests in England done by the NHS GMS for patients with cancer (WGS and Non-WGS activity) vs % of those tests delivered within the standard turnaround time
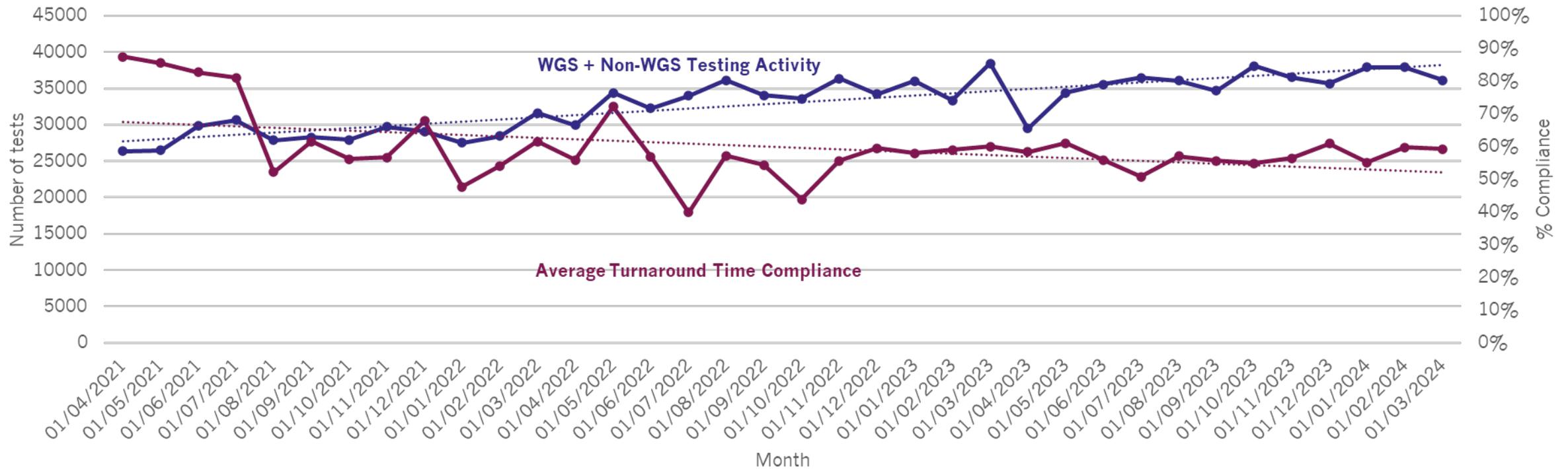
Notes: Non-WGS is non-whole genome sequencing and WGS is whole genome sequencing

Source: *NHS England*. Genomics PLCM submissions and Genomics England data packs. TATs unpublished.

12.16 Cancer waiting times: 62-day standard – urgent suspected cancer

Figure III.12.16: Number of patients receiving a first definitive treatment for cancer and proportion treated within 62 days, England (USCR routes only)
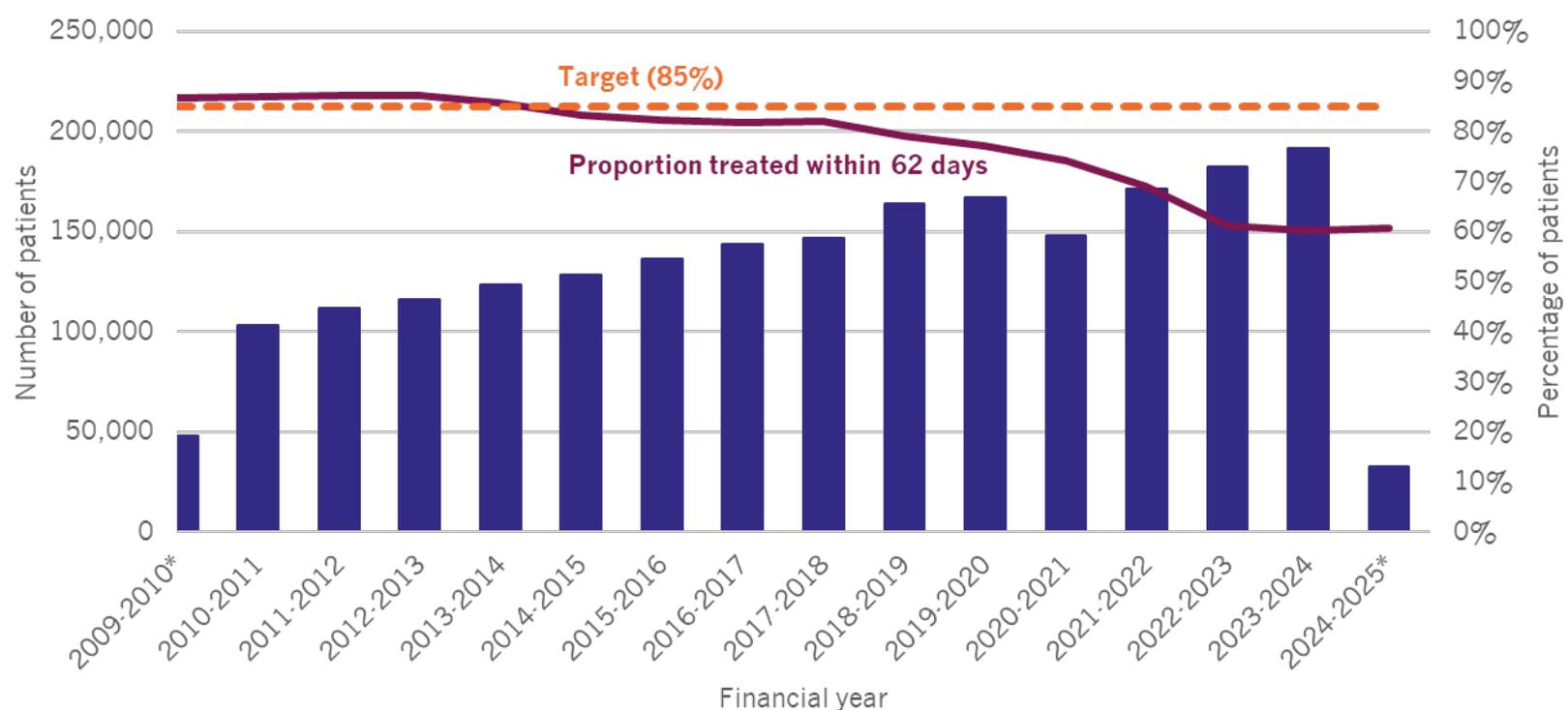
Period	62-day Urgent suspected cancer CAGR	
	Treatments	**Performance**
2011/12-2016/17	4.97%	-1.26%
2016/17-2020/21	0.94%	-2.39%
2020/21-2022/23	11.37%	-9.31%
2022/23-2023/24	5.41%	-1.39%
2010/11-2023/24	4.94%	-2.78%

Notes: *non-complete FY
In May 2024, the 62-day combined target (85%) was not met (65.8%) – the 62 day urgent suspected cancer standard was last met in December 2015. If the combined standard was met in May 2024, around 5,200 additional patients would have been treated on time

Source: *NHS England. Statistics » Cancer Waiting Times (england.nhs.uk)*

12.17 Radiotherapy waiting times

Figure III.12.17: % of patients waiting longer than 31 days for radical radiotherapy in England
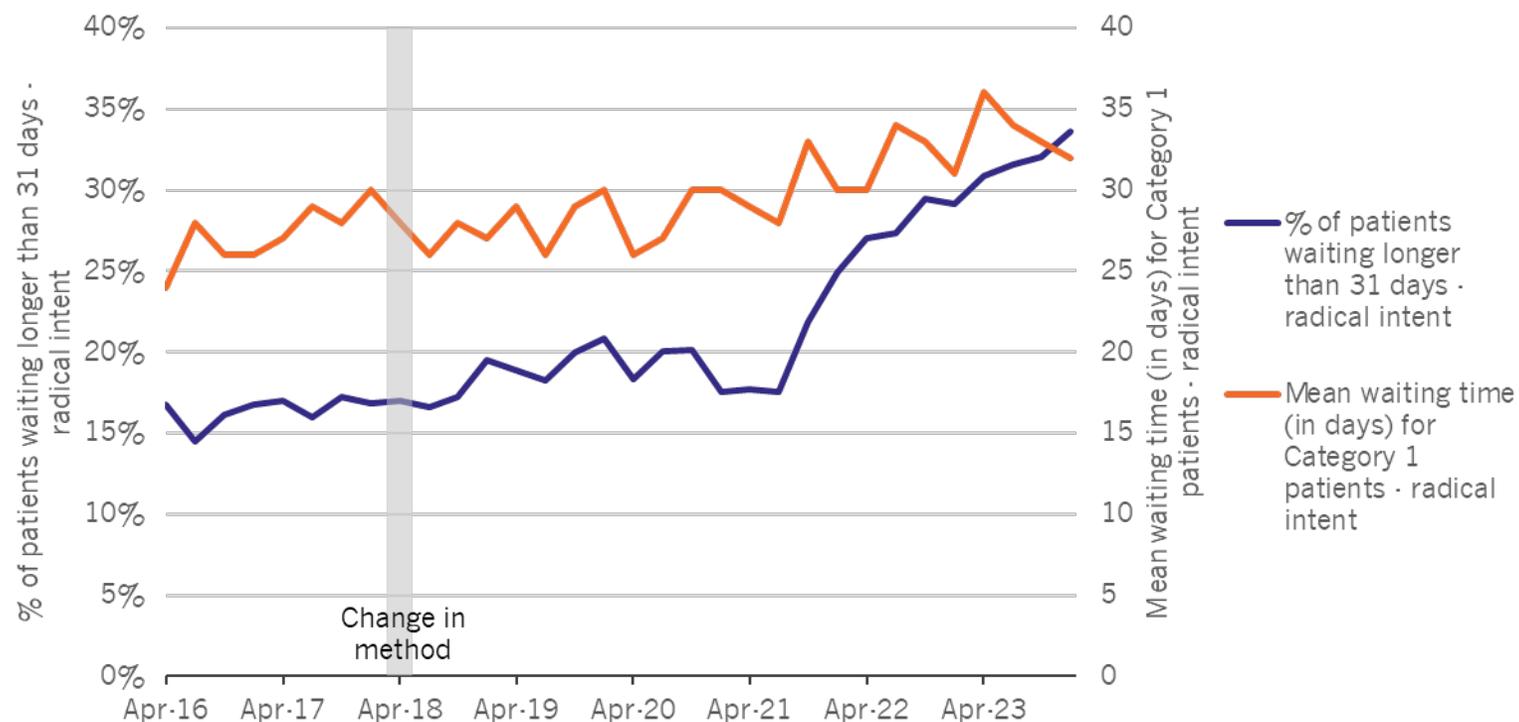
Metric	Time Period	CAGR
% of patients waiting longer than 31 days - radical intent	2016 - 2019	4.2%
	2019 - 2021	-3.3%
	2021 - 2023	20.4%
	Whole period	9.1%
Mean waiting time (in days) for Category 1 patients - radical intent	2016 - 2019	6.5%
	2019 - 2021	0.0%
	2021 - 2023	7.5%
	Whole period	6.0%

Source: NHS England. *Radiotherapy Data Set (RTDS)*. Available: https://digital.nhs.uk/ndrs/data/data-sets/rtds

12.18 Time from approval to adoption for alpelisib & fulvestrant

Figure III.12.18: Time from alpelisib & fulvestrant being approved by NICE to first use by trust
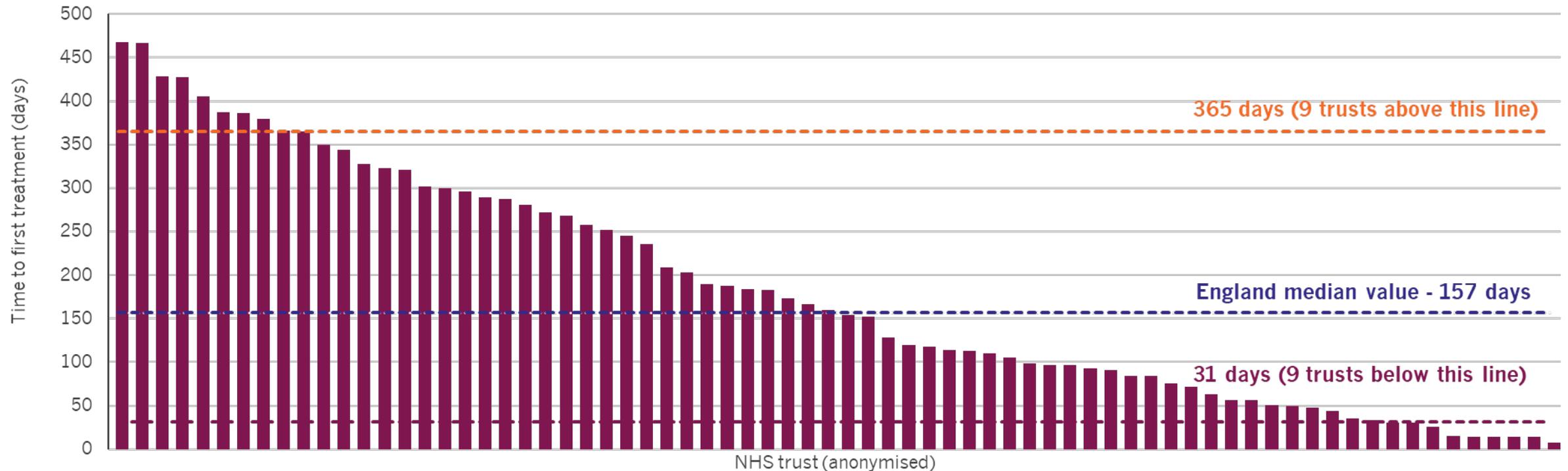
Notes: Full details of anonymised trusts are available. Alpelisib plus fulvestrant is recommended as an option for treating hormone receptor-positive, HER2-negative, PIK3CA-mutated, locally advanced or metastatic breast cancer in adults only if their cancer has progressed after a CDK4/6 inhibitor plus an aromatase inhibitor.

Source: NHS. Time to first treatment – Cancer stats. Available: https://cancerstats.ndrs.nhs.uk/sact/ttft

12.19 Patient satisfaction with cancer care

Figure III.12.19A: Patient experience score by age group
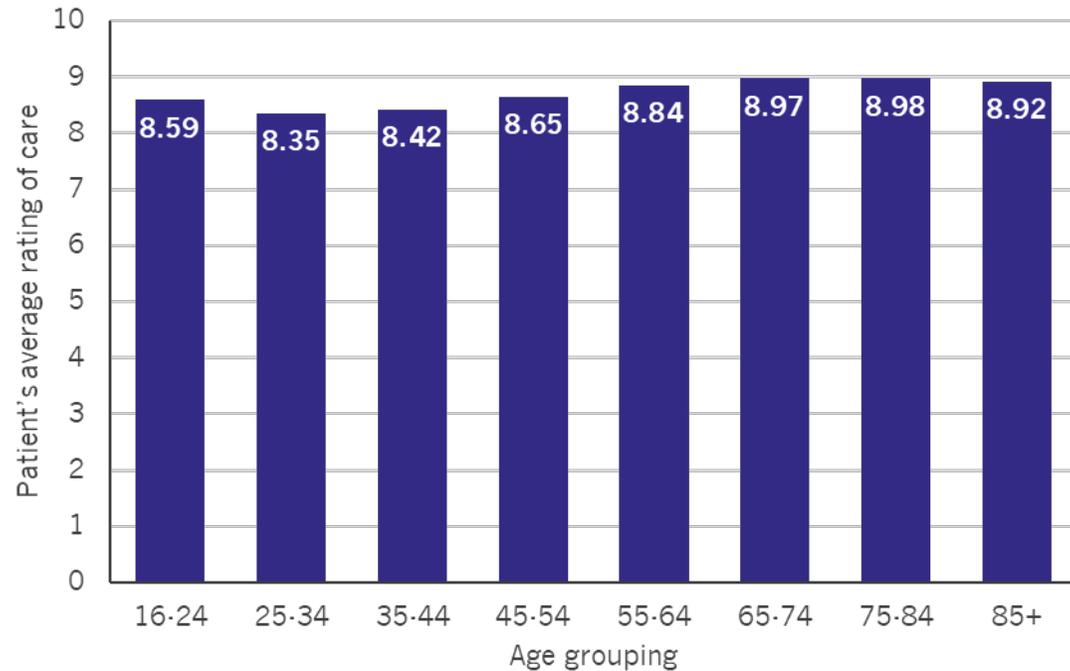
Figure III.12.19B: Patient experience score by deprivation level
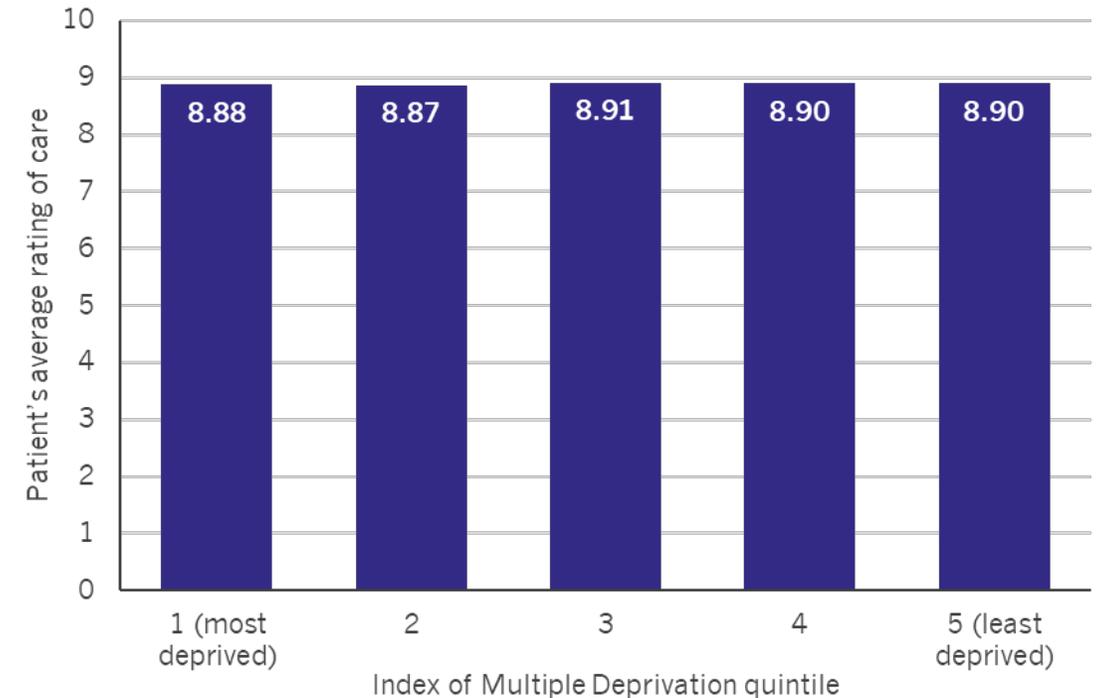
Notes: Scores for age groups 65-74 (8.97) and 75-84 (8.98) are statistically significantly higher than the national average, all other age groups scored statistically significantly lower than the national average (with the exception of 85+ which is not significantly different).

No significant difference is present between the most and least deprived groups. *Indices of Multiple Deprivation (IMD) classifies geographic areas into five quintiles based on relative disadvantage. Patient postcode from sample data is used to map to the Indices of Multiple Deprivation (IMD). Patients with a non-England postcode have been excluded.

Source: *NHS*. National Cancer Patient Experience Survey 2023. https://www.ncpes.co.uk/latest-national-results/

13.1 Mortality rates from all circulatory disease

Figure III.13.1: Under 75 mortality rate from all circulatory diseases, persons, England, 2001 to 2022
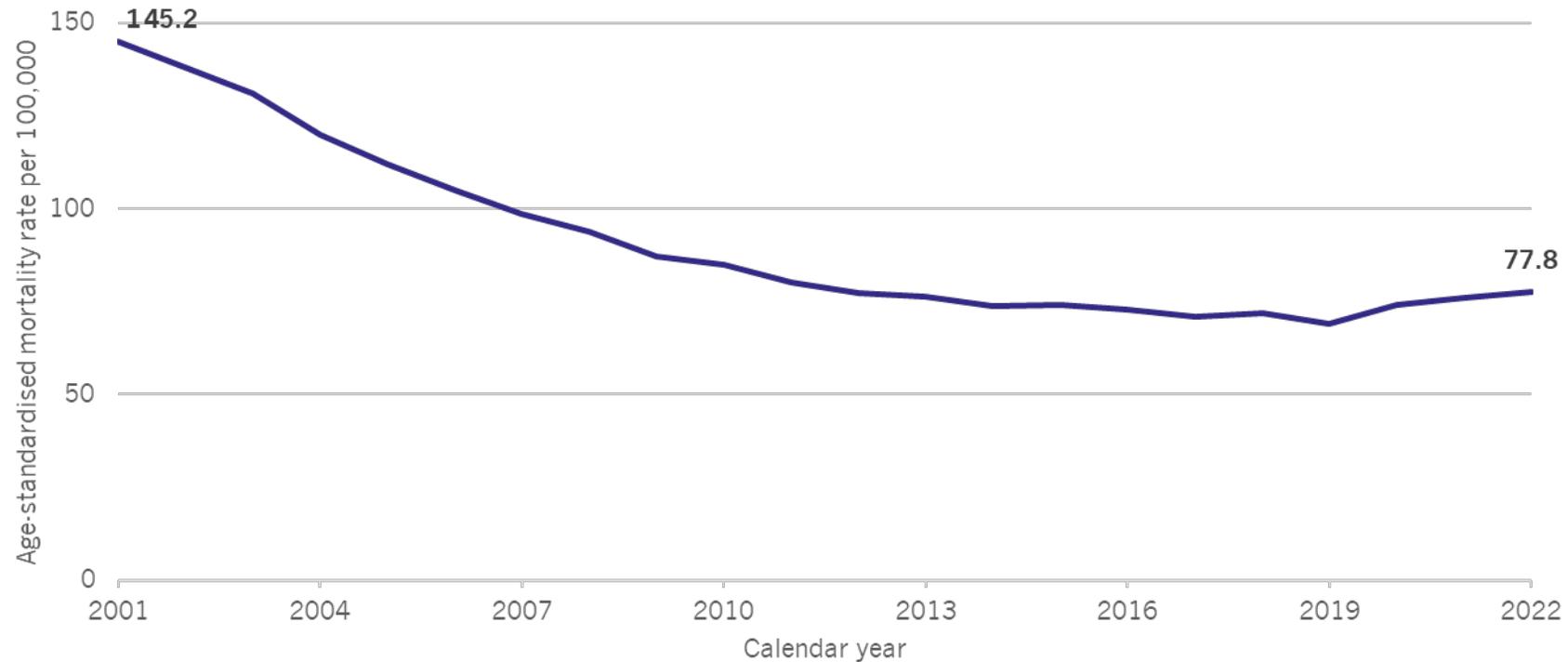
PERIOD	CAGR
2001-2005	-6.3%
2005-2010	-5.4%
2010-2015	-2.7%
2015-2019	-1.7%
2019-2022	4.0%

Source: OHID, based on annual mortality extracts and mid-year population estimates data from Office for National Statistics, Available at: Fingertips | Department of Health and Social Care (phe.org.uk)

13.2 Under 75 mortality rate from circulatory diseases

Figure III.13.2: Under 75 mortality rate from circulatory diseases, England, 2001 to 2022

a) Male

b) Female

13.2b Under 75 mortality rate from circulatory diseases

Figure III.13.2B: Under 75 mortality rate from circulatory diseases CAGRs for males and females, England, time periods between 2001 and 2022

CAGR	MALES			FEMALES		
	All circulatory diseases	Ischaemic heart disease	Stroke	All circulatory diseases	Ischaemic heart disease	Stroke
2001-2005	-6.2%	-7.0%	-6.7%	-6.6%	-8.6%	-6.0%
2005-2010	-5.2%	-6.2%	-5.4%	-5.9%	-7.5%	-6.5%
2010-2015	-3.1%	-3.9%	-3.4%	-1.8%	-3.6%	-1.9%
2015-2019	-1.5%	-1.8%	-1.4%	-2.3%	-2.8%	-3.6%
2019-2022	4.2%	4.7%	0.6%	3.6%	4.5%	2.5%

13.3 International comparisons of 30-day mortality for AMI

Figure III.13.3: 30-day mortality for Acute Myocardial Infarction (age-sex standardised rates per 100 patients aged 45 and over)
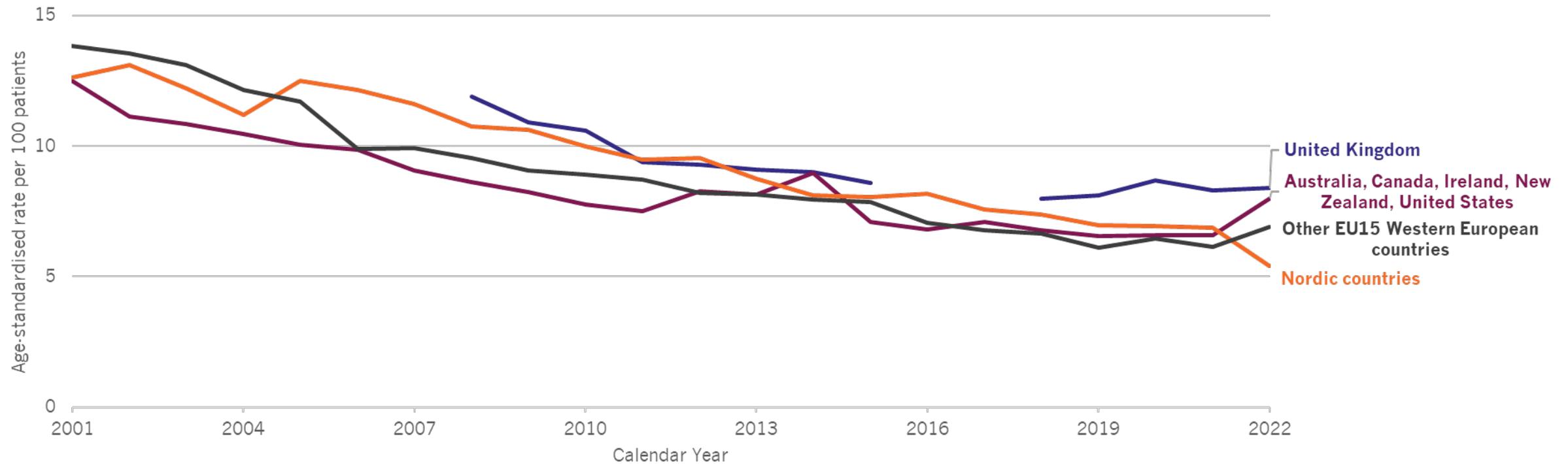
Notes: 2022 data only available for Finland (Nordic countries) Austria, and Portugal (Other EU15 Western European countries, and New Zealand.
Time series data not available for Belgium, Germany and Greece (Other EU15 Western European countries), Australia, and Ireland.
Data for the United Kingdom is unavailable prior to 2008, and between 2016-17.

Source: Organisation for Economic Co-operation and Development (OECD) (Accessed on 14/08/2024)

13.4 Premature (<75 years) deaths from heart disease by deprivation

Figure III.13.4: Under 75 mortality rate from ischaemic heart disease, persons, England, 2022

13.5 International comparisons of 30-day mortality for stroke

Figure III.13.5A: Ischaemic stroke 30-day mortality (age-sex standardised rates per 100 patients aged 45 and over)

Figure III.13.5B: Haemorrhagic stroke 30-day mortality (age-sex standardised rates per 100 patients aged 45 and over), 2001 to 2022

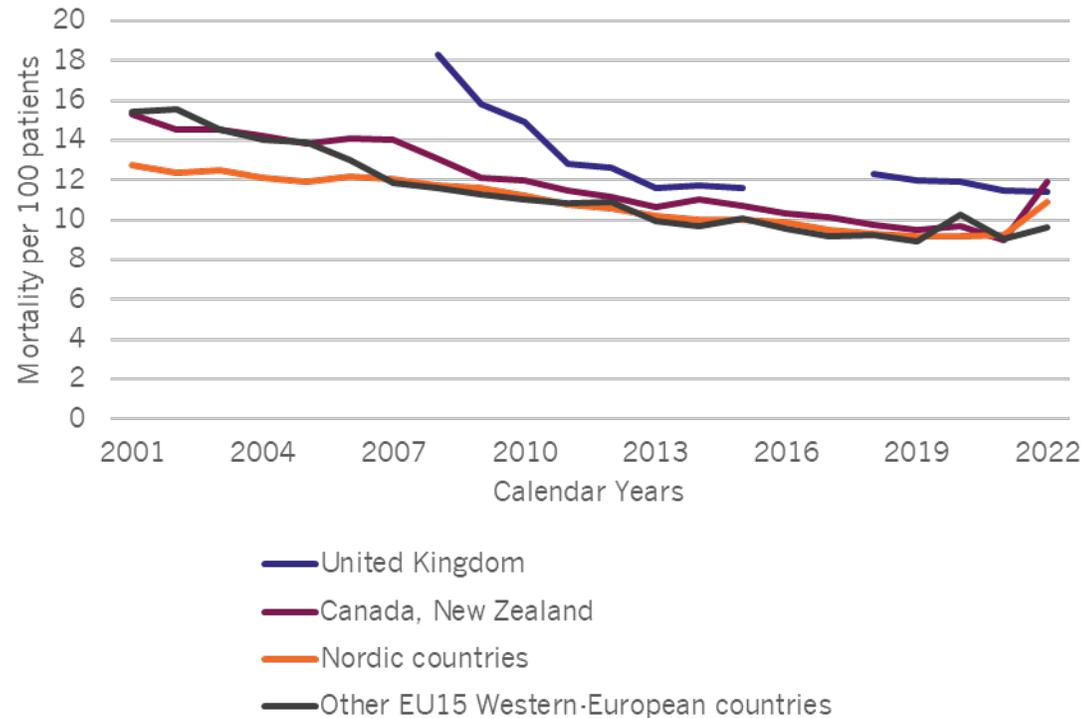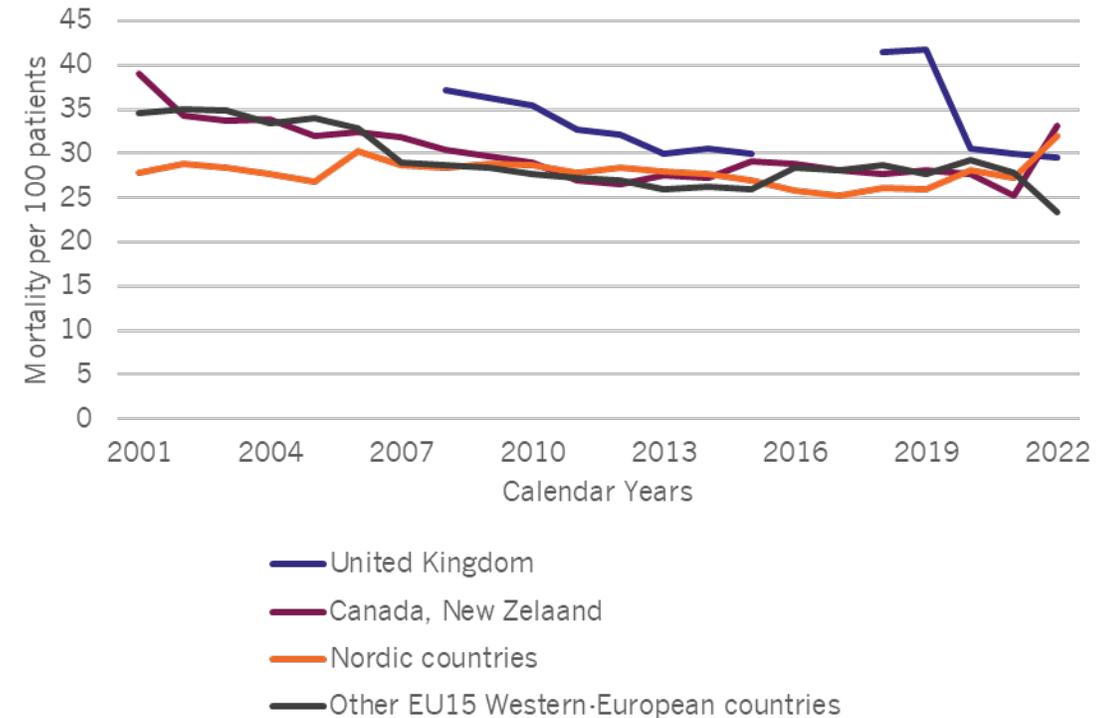
Notes: Thirty-day mortality after admission to hospital for ischaemic stroke is based on linked data, 2011, 2019 and 2021 (or nearest year)

Source: OECD, (Accessed on 14/08/24)

13.6 Uptake of cardiac rehabilitation among eligible acute coronary syndrome patients

Figure III.13.6: Number of patients uptake/access of cardiac rehabilitation among eligible Acute Coronary Syndrome (ACS) patients
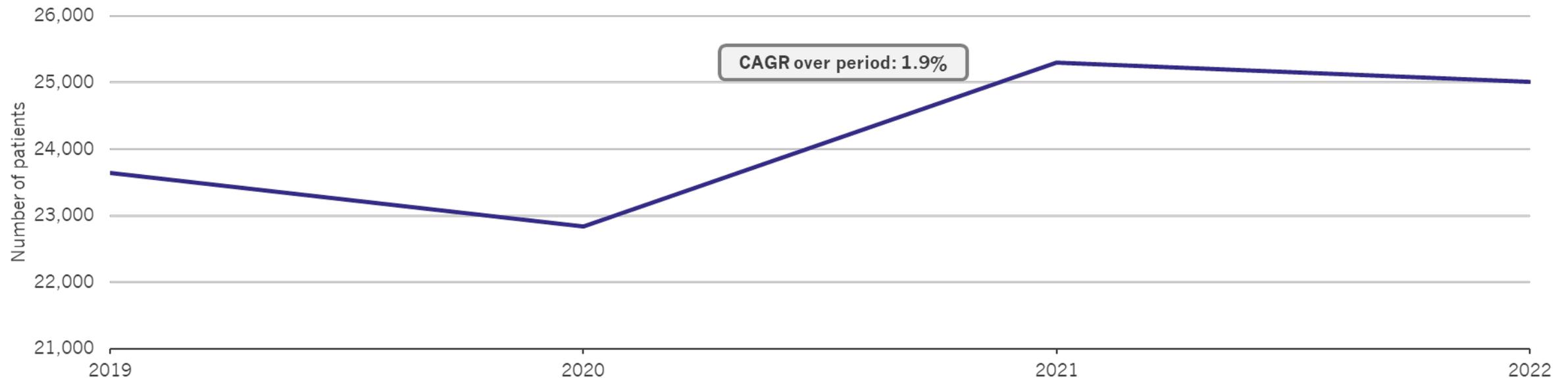
Notes: This is an initial output using the new methodology for identifying eligible patients post heart attack from 2019/20 hence the trend data starts from 2019/20. Previous years data before 2019/20 will not be comparable as we would not be looking at the same population (denominator). Also note the data is incomplete due to suppression. Work is ongoing to improve the data quality used for tracking Cardiac Rehabilitation access rate. Previous approach used NACR as pseudo-eligible which was very different and is no longer being used. Data for the Eligible and Starting number are from two sources, as such no linkage is presently performed. There is data lag in entry of SUS and NACR, thus caution should be taken including data from 6-9 months from the running of the data

For patients who have experienced myocardial infraction (MI) and/or coronary revascularisation, attending and completing the exercise-based component of a Cardiac Rehabilitation is associated with: an absolute risk **reduction in cardiovascular mortality from 10.4% to 7.6%** when compared to those who do not receive CR; a **significant reduction in acute hospital admissions (reduced from 30.7% to 26.1%** NNT 22) which is a key determinant of the intervention's overall cost=efficacy

Source: NHS England, Secondary Uses Service (SUS)+. Available: https://digital.nhs.uk/services/secondary-uses-service-sus

13.7 Variation in uptake of cardiac rehabilitation among eligible acute coronary syndrome patients across ICBs

Figure III.13.7: Percentage uptake/access of cardiac rehabilitation among eligible Acute Coronary Syndrome (ACS) patients (2023/24 Q1) by ICB

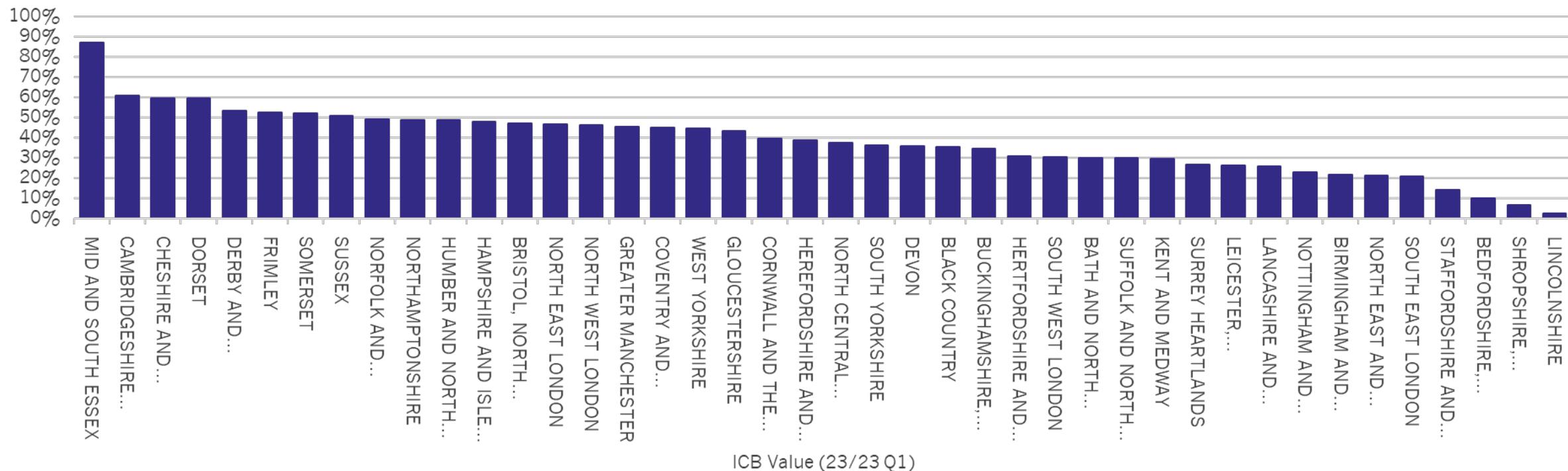Notes: There is significant variation in uptake of cardiac rehabilitation across ICBs. The average across ICBs is 38.4% against an NHS LTP target of 85% of patients accessing cardiac rehab following heart attack by 2029. Previous approach used NACR as pseudo-eligible which was very different and is no longer being used. Data for the Eligible and Starting number are from two sources, as such no linkage is presently performed. There is data lag in entry of SUS and NACR, thus caution should be taken including data from 6-9 months from the running of the data

Source: NHS England. *Secondary Uses Service (SUS)+ data*. Available: https://digital.nhs.uk/services/secondary-uses-service-sus. National Audit of Cardiac Rehabilitation

13.8 Proportion of people at high risk of cardiovascular disease treated with lipid lowering therapies

Figure III.13.8: LLT primary prevention: CVDP003CHOL % of patient aged 18 and over with a QRISK score of 20% or more, on lipid lowering therapy
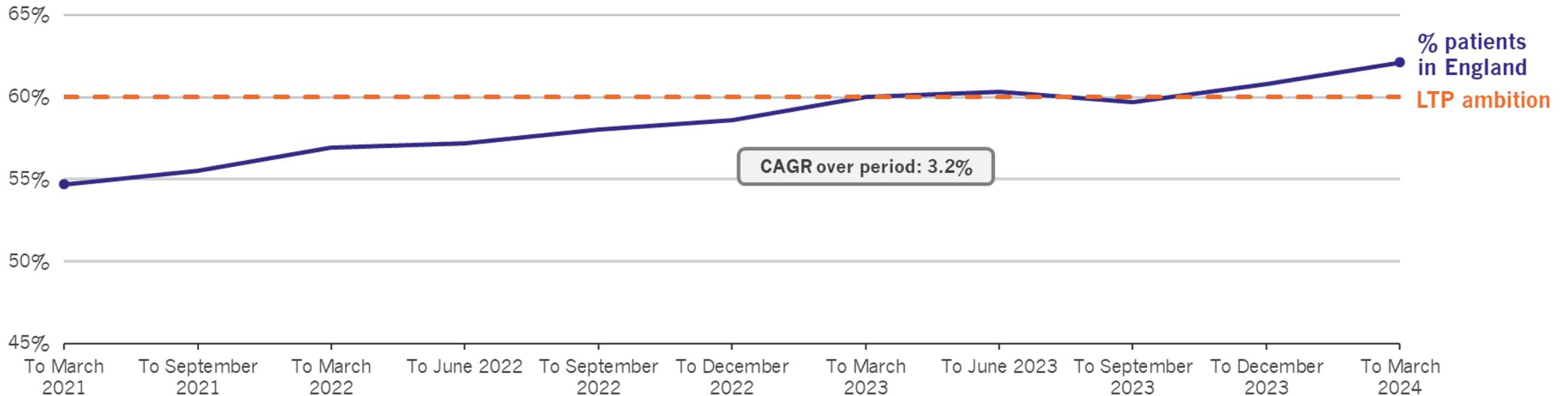
Notes: Cholesterol – Primary prevention: More people (proportion) at high risk of CVD have been treated with lipid lowering therapies since March 2021.

13.9 Proportion of people with cardiovascular disease treated with lipid lowering therapies

Figure III.13.9: Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy
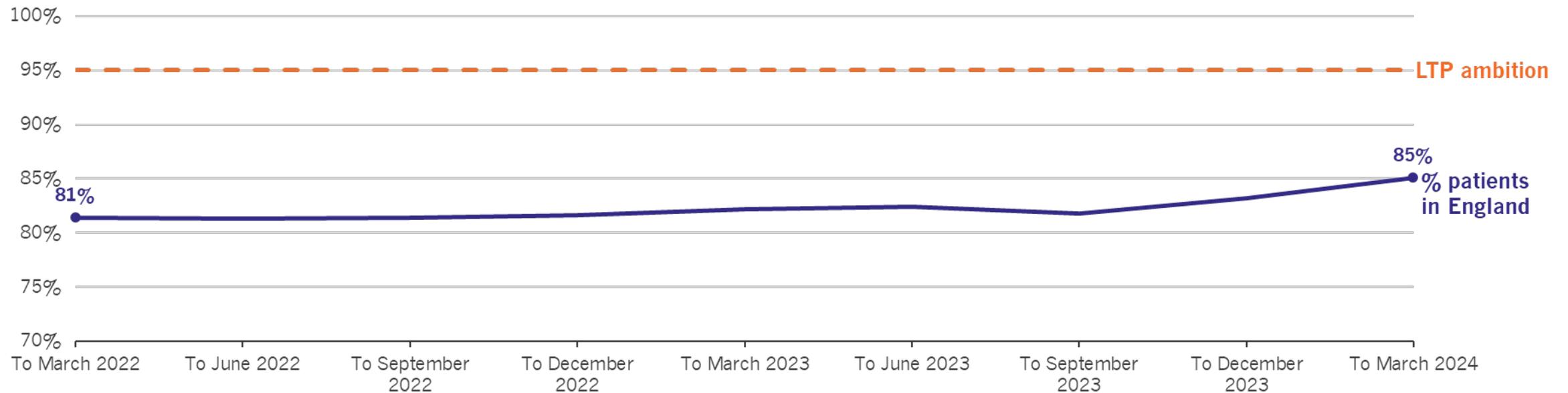
14.1 International comparison of suicide rates

Figure III.14.1: Age-standardised suicide rates per 100,000 population, 2001 to 2019
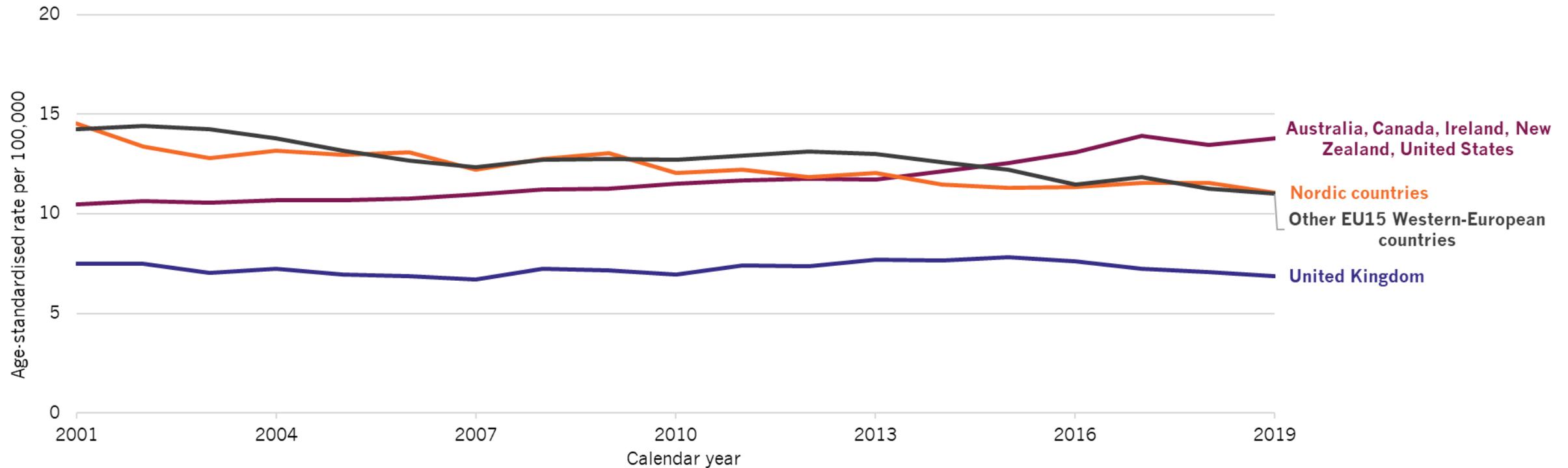
Notes: Recording of suicide rates varies across countries due to several factors, including who is responsible for completing the death certificate, whether a forensic investigation is carried out, the provisions for confidentiality of the cause of death, and how a person's intention of killing themselves is ascertained.

Source: WHO: Available at: https://www.who.int/data/gho/data/themes/mental-health/suicide-rates

14.2 Suicide rate by year, sex, and age group for England

Figure III.14.2: Age-standardised suicide rate for males and females by age group, England, 2001 to 2022
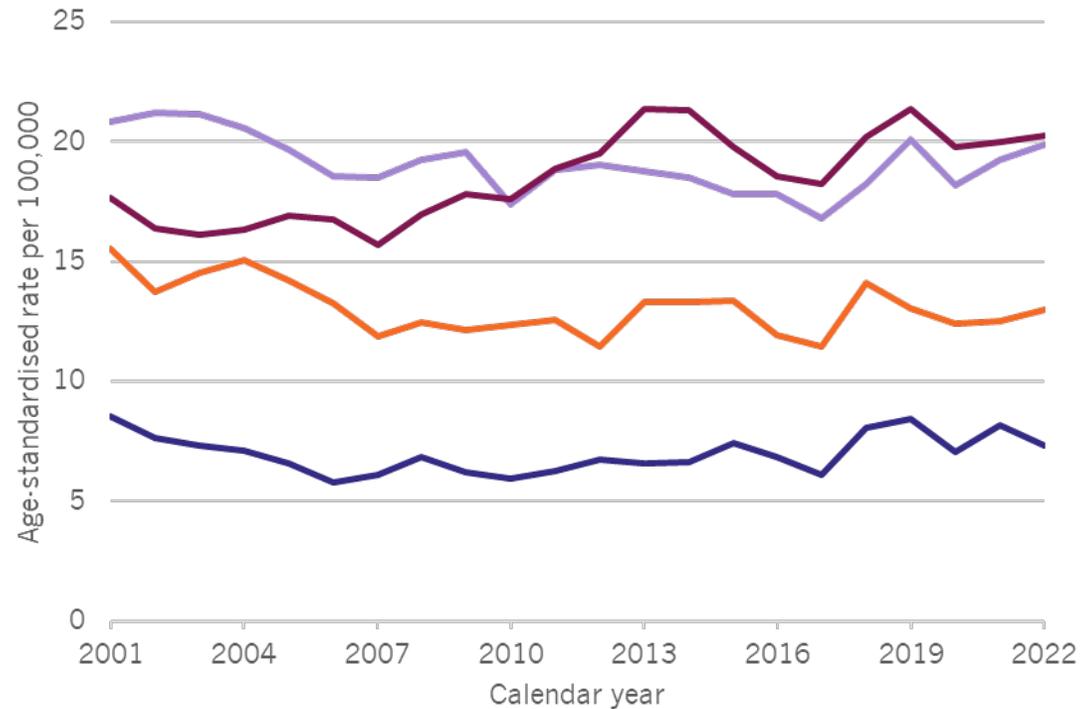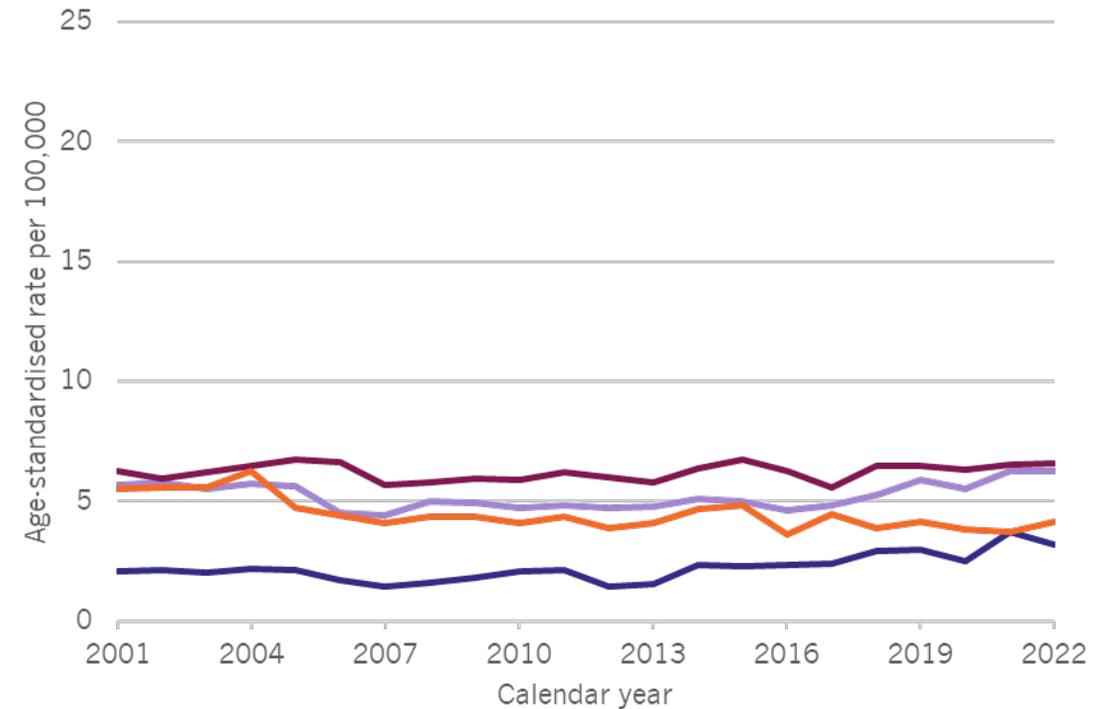
Notes: For the period 2001-2006 there was a discrepancy in the numbers of suicides published online from Office for National Statistics and those extracted from OHID database. After consultation with Office for National Statistics, data extracted for persons aged 15 years and above excludes ICD10 code Y33.9 where the coroner's verdict was pending for the years 2001-2006. The difference in numbers is now less than 15.

Source: Office for National Statistics (2023), Deaths registered in England and Wales, 2022. Available at: Suicides in England and Wales

14.3 Suicide rate amongst adolescents aged 15-19

Figure III.14.3: Suicide rate among adolescents aged 15-19, 2019
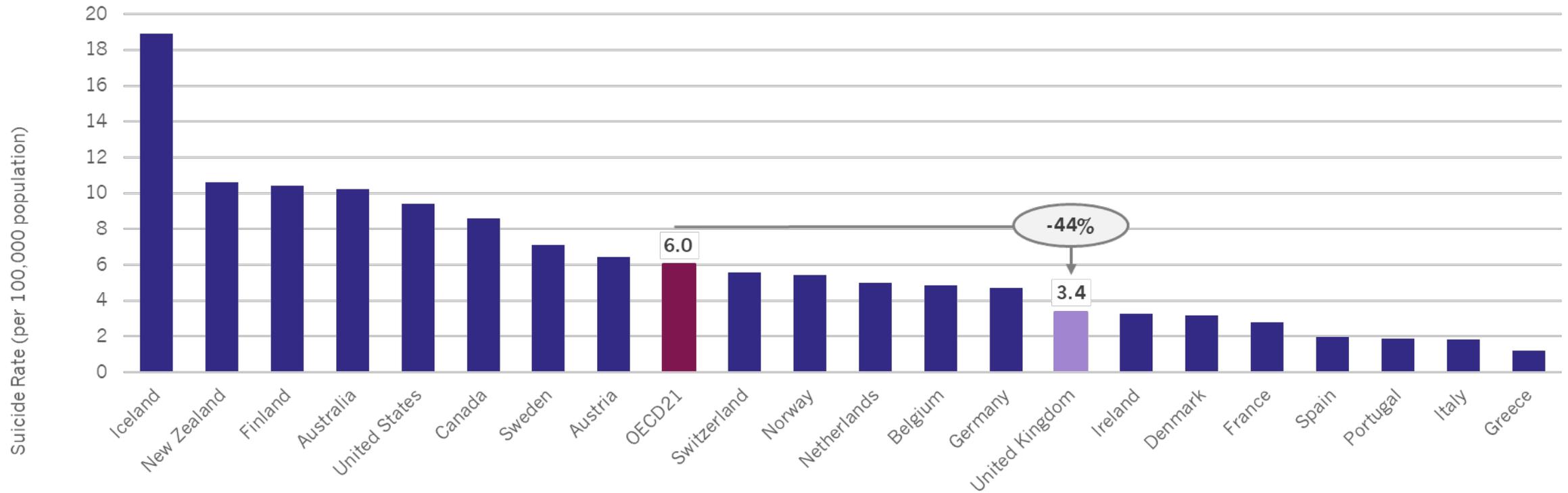
Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

14.4 Suicide rate by year, sex, and age group for England

Figure III.14.4: CAGR change in suicide rates for males and females by age group, England, 2001 to 2022

	10 to 24 years		25 to 44 years		45 to 44 years		65 years and over	
	Males	Females	Males	Females	Males	Females	Males	Females
2001-2005	-6.4%	0.9%	-1.5%	-0.1%	-1.1%	1.9%	-2.1%	-3.6%
2005-2010	-2.0%	-0.7%	-2.4%	-3.5%	0.8%	-2.7%	-2.8%	-2.8%
2010-2015	4.6%	1.9%	0.5%	1.2%	2.3%	2.8%	1.5%	3.4%
2015-2019	3.2%	6.9%	3.1%	4.2%	2.0%	-1.1%	-0.6%	-3.9%
2019-2022	-4.7%	2.6%	-0.4%	2.0%	-1.8%	0.5%	-0.1%	0.0%

Source: Office for National Statistics (2023), Deaths registered in England and Wales: 2022. Available at: Suicides in England and Wales - Office for National Statistics (ons.gov.uk)

14.5 Number of suicides by mental health condition

Figure III.14.5: Number of mental health patient suicides by main mental health condition
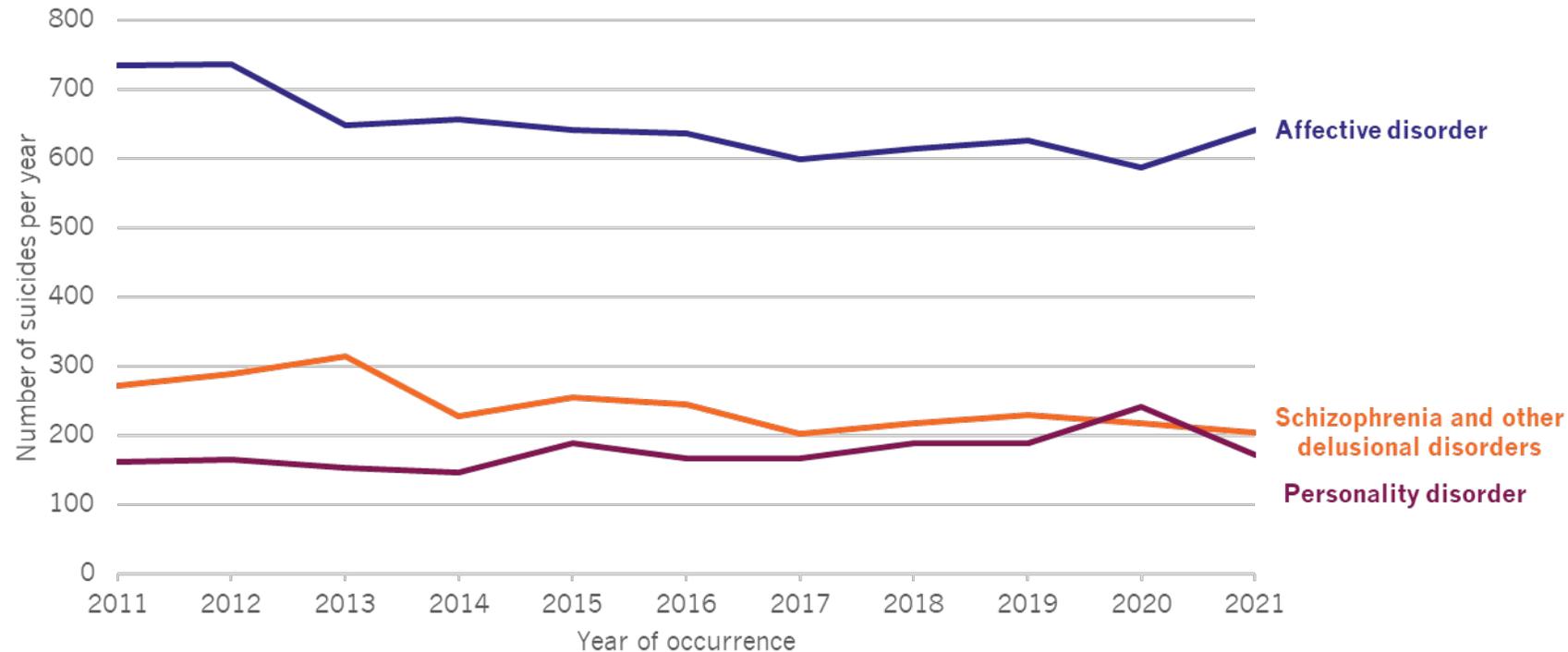
CAGR	2011 - 2021
Affective disorder	-1.36%
Schizophrenia and other delusional disorders	-2.84%
Personality disorder	0.60%

Source: National Confidential Inquiry into Suicide and Safety in Mental Health (2024), Annual report 2024: UK patient and general population data 2011-2021. Available at: NCISH | Annual report 2024: UK patient and general population data 2011-2021 (manchester.ac.uk)

15.1 International comparison of clinical negligence costs

Figure III.15.1: International comparison of cost per capita for clinical negligence by scheme type.
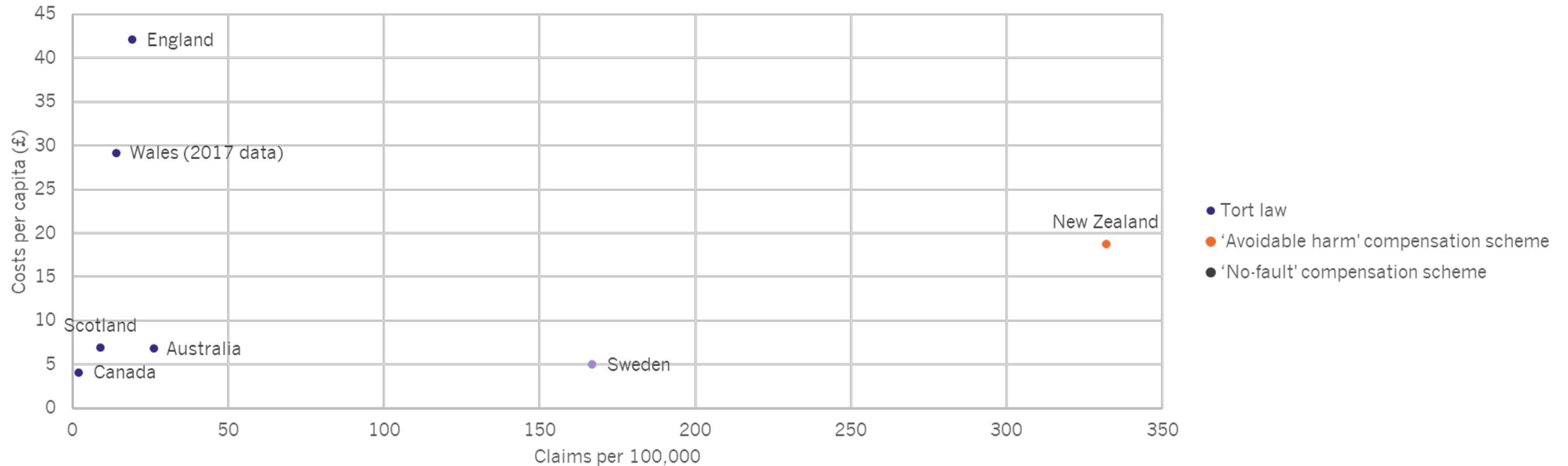
Notes: When considering international comparisons for clin neg costs it is important to note that lower costs do not necessarily equate to a safer healthcare system. Different countries include different components in their compensation, for example in Sweden care costs are not part of compensation, whereas they are likely to make a high proportion of high value claims in the UK. Other countries have different legal systems or administrative systems for claims which can affect costs. This goes beyond the healthcare system to the wider approach to compensation for negligence in society more generally.

Source: NHS litigation reform (parliament.uk)

15.2 Number of clinical negligence claims by clinical specialty

Figure III.15.2: Number of settled clinical negligence claims each year in clinical specialties with the highest total claims costs
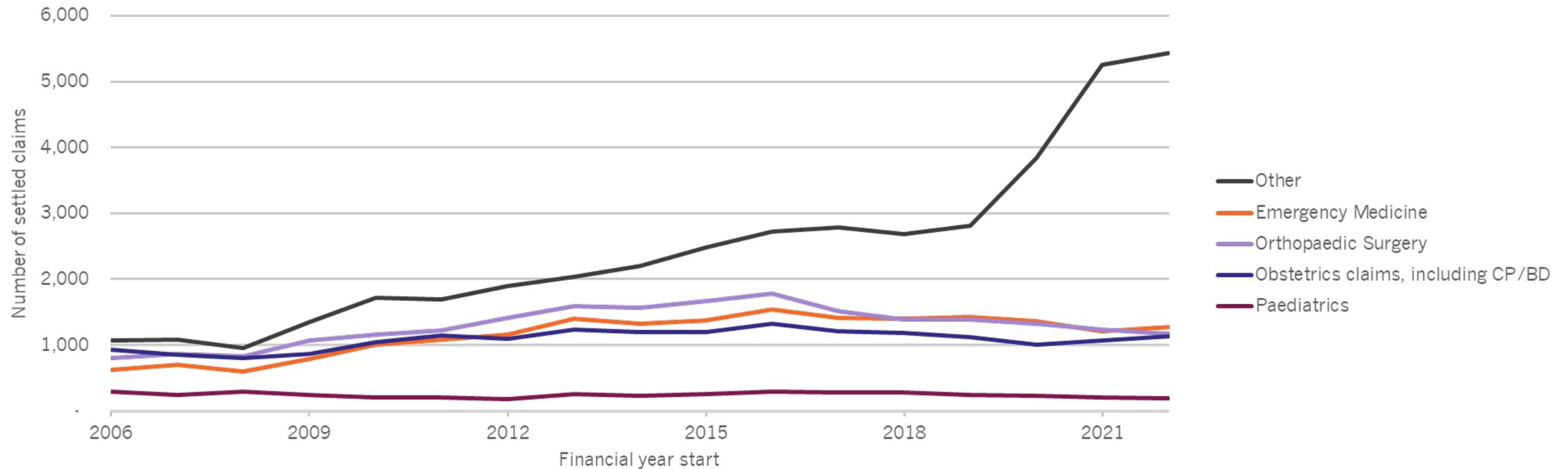
Notes: "Other" claims refers to claims outside of clinical specialties, such as Covid-19 related claims. "Other" claims also includes the state GP schemes for clinical negligence which were introduced in 2019/20. CP/BD – Cerebral Palsy/brain damage claims

Source: NHS Resolution (2023), Annual Statistics (including Factsheet 5). Available at: Annual statistics (including Factsheet 5) - NHS Resolution

15.3 Clinical negligence costs by clinical specialty

Figure III.15.3: Cost of clinical negligence claims settled each year in clinical specialties with the highest costs of claims
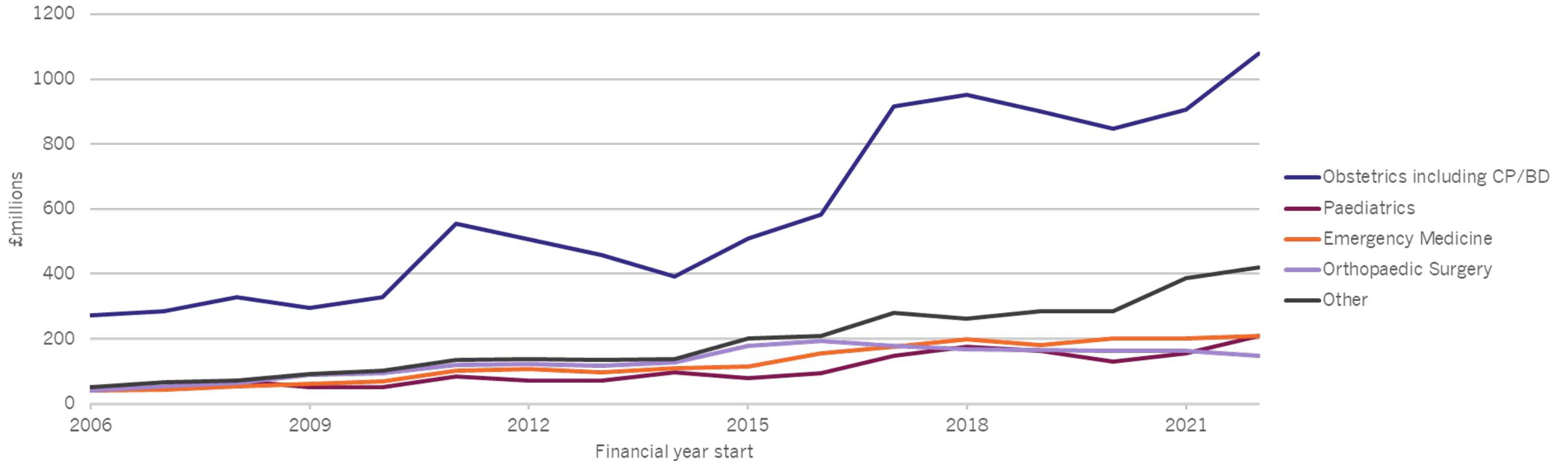
Notes: "Other" claims refers to claims outside of clinical specialties, such as Covid-19 related claims. "Other" claims also includes the state GP schemes for clinical negligence which were introduced in 2019/20. CP/BD = Cerebral Palsy/brain damage claims

Source: NHS Resolution (2023), Annual Statistics (including Factsheet 5). Available at: Annual statistics (including Factsheet 5) - NHS Resolution

15.4 Clinical negligence costs by damages value

Figure III.15.4: Clinical negligence claims costs for all clinical claims settled each year by damages value
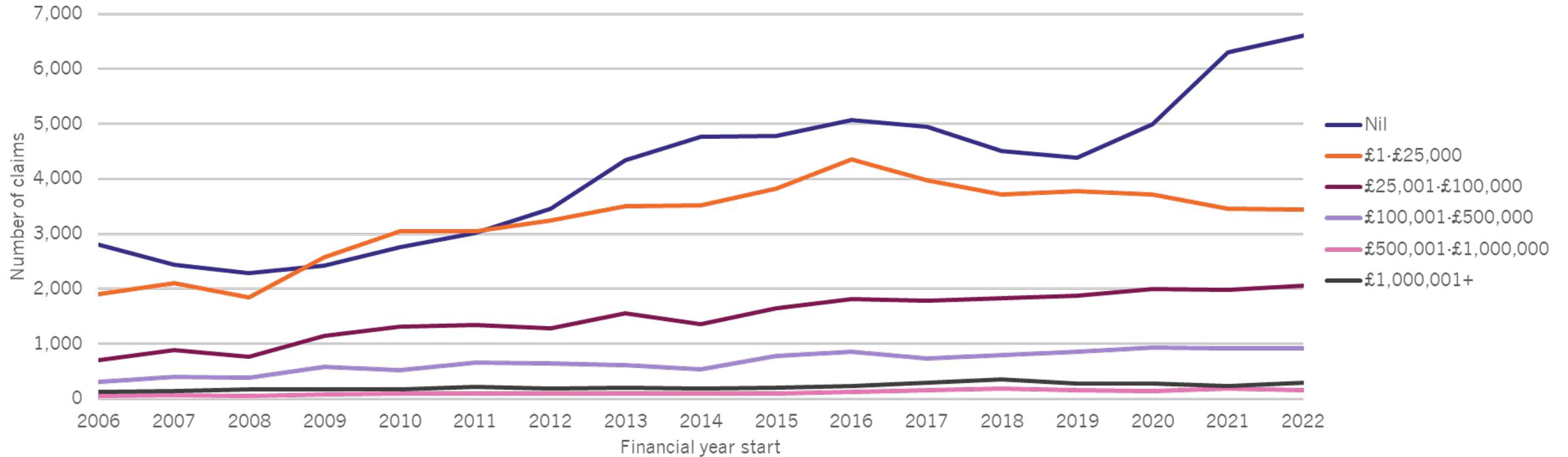
Source: NHS Resolution (2023), Annual Statistics (including Factsheet 5). Available at: Annual statistics (including Factsheet 5) - NHS Resolution

IV. Health and prosperity

1. Economically inactive people by main reason

Figure IV.1: Percentage and CAGR of people who are economically inactive by main reason, 16 to 64, UK, 2001 to 2024

	2001/02-2005/06	2006/07-2010/11	2011/12-2015/16	2016/17-2019/20	2020/21-2021/22	2022/23-2024/25
Student	3.4%	3.7%	0.9%	-0.9%	2.9%	1.6%
Looking after family/ home	-0.7%	-1.7%	0.5%	-4.3%	-3.1%	-3.0%
Long-term sick	-1.5%	-1.5%	0.2%	1.8%	3.5%	6.3%
Retired	0.1%	1.0%	-5.1%	1.2%	0.5%	-7.9%
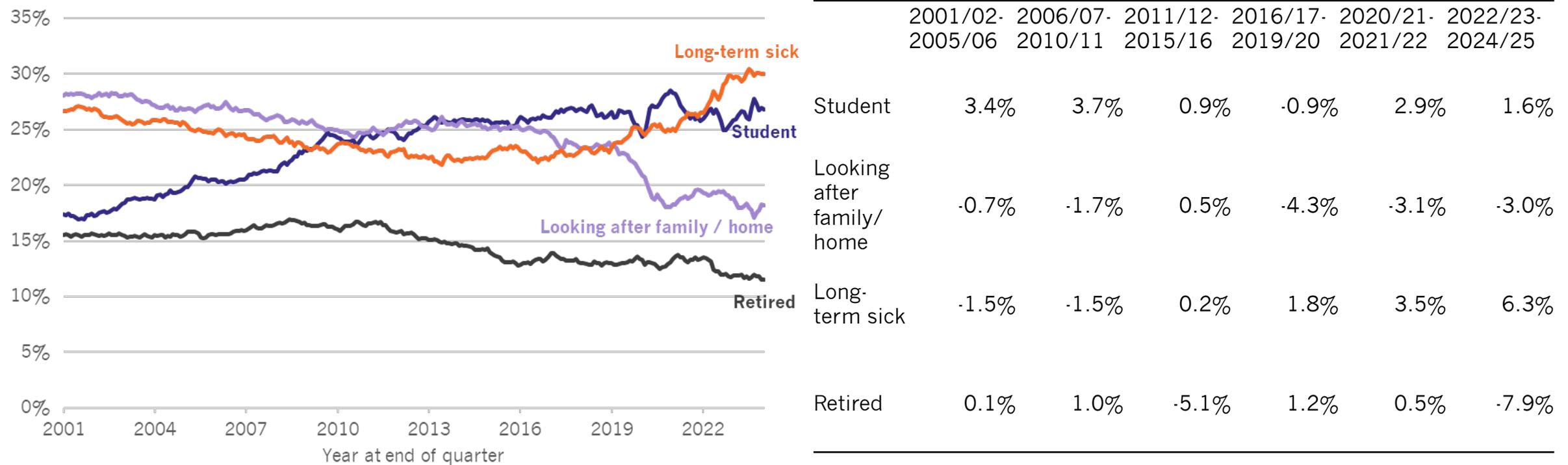
Notes: Data from July to September 2022 onwards has been reweighted to incorporate the latest estimates of the size and composition of the UK population. Therefore, data prior to and from July to September 2022 are not directly comparable. Reweighting does not address the volatility seen in recent periods and caution should be used when interpreting short term changes.

Source: Office for National Statistics (2024), Economic Inactivity by reason (seasonally adjusted). Available at: Office for National Statistics, Economic inactivity by reason, seasonally adjusted

2. Economically inactive people due to long-term sickness, by main reason

Figure IV.2: Change in the number of people aged 16-64 in the UK who are economically inactive due to long-term sickness by age and main or secondary health condition, 2015 to 2019 and 2019 to 2023

CAGRs	2015-2019	2019-2023
Musculoskeletal condition, Total	-3.5%	6.3%
16 to 34	-9.7%	16.4%
35 to 49	-5.6%	4.0%
50 to 64	-1.7%	5.7%
Mental health condition, Total	0.7%	7.5%
16 to 34	2.3%	12.0%
35 to 49	-2.3%	4.9%
50 to 64	1.8%	6.9%
Other health problem or disability, Total	-1.4%	6.8%
16 to 34	-0.6%	12.5%
35 to 49	-3.2%	4.3%
50 to 64	-0.8%	6.0%
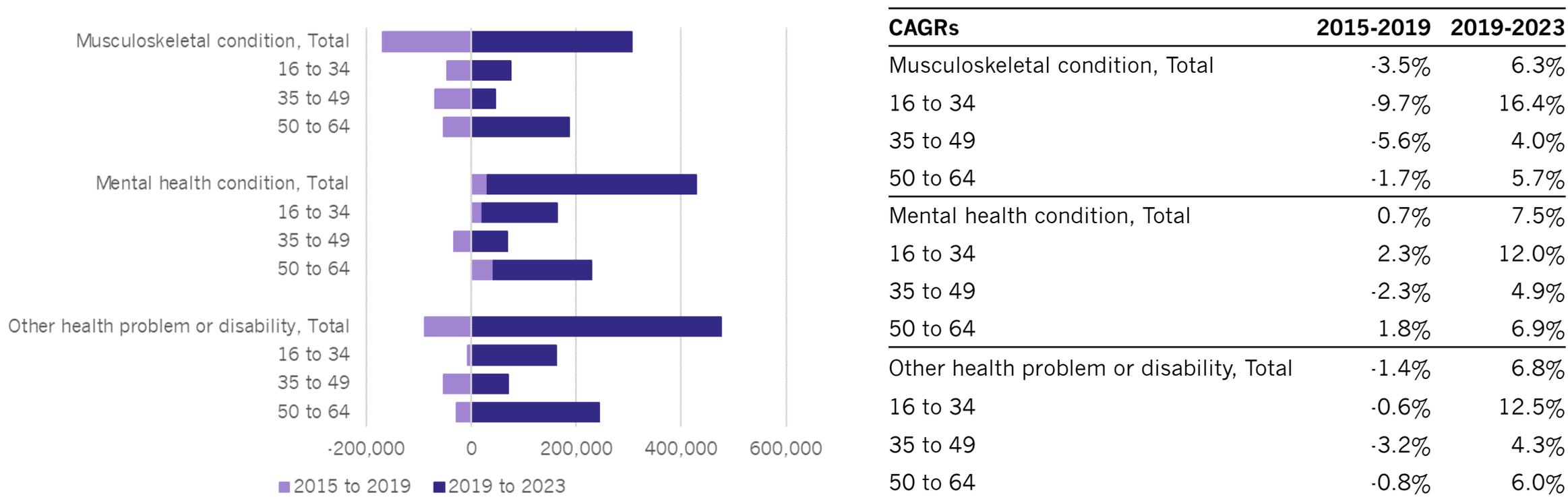
Notes: The long-term health condition reported may not be the reason, or the only reason, for a person being in or out of work. There are other factors such as skills, qualifications, caring responsibilities and the availability of suitable jobs that may also play a role. Data has not been reweighted using the latest population estimates.

Source: Department for Work and Pensions (2023), The employment of disabled people 2023. Available at: The employment of disabled people 2023,

3. Recruitment to clinical research studies

Figure IV.3: Number of participants recruited into studies in the UK held on the National Institute for Health and Care Research (NIHR) Clinical Research Network's Central Portfolio Management System (CPMS), 2014/15 to 2023/24
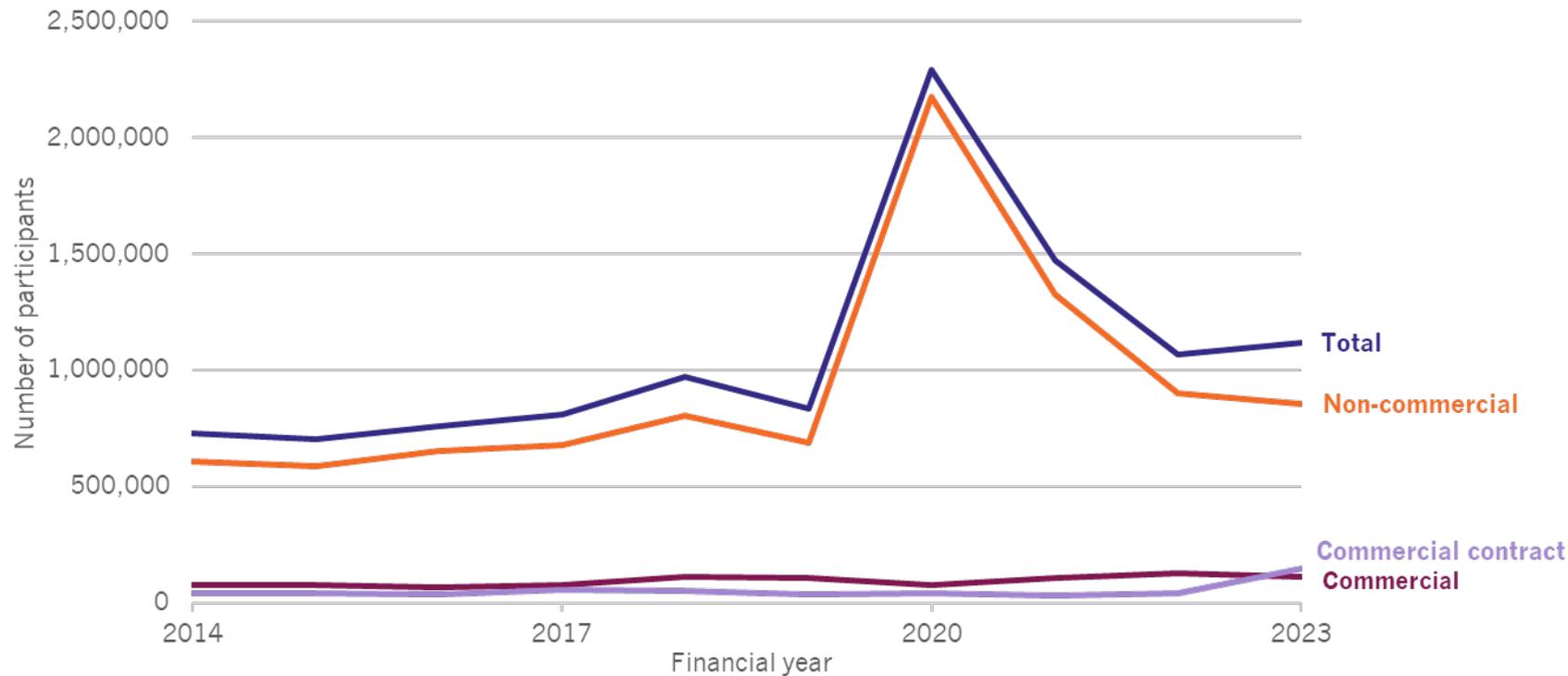
CAGR	2014/15 - 2023/24
Commercial	4%
Commercial contract	15%
Non-commercial	4%
Total	5%

Notes: The data is not exclusive to NHS sites only and includes recruitment to non-NHS sites. The data does not show recruitment to the whole clinical research system, just recruitment to studies on the CRN's CPMS. Pre-COVID baseline taken from an average of 2019 data. It is not clear what the coverage of DA led studies included in the data is.

Source: National Institute for Health and Care Research, June 2024

4. International comparison of proportion of clinical research studies

Figure IV.4: Proportion of total clinical trials in selected countries, 2012 to 2022
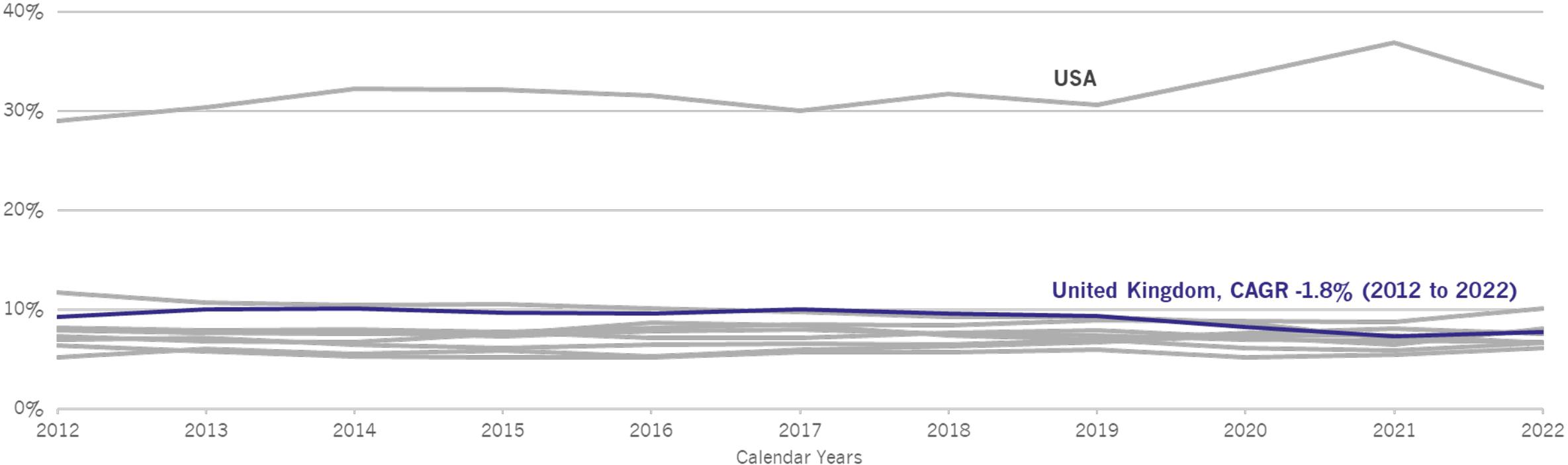
Notes: In addition to the United Kingdom and USA which are labelled, data for Germany, France, Italy, Spain, Poland, Canada, Australia and Japan are also included on this chart.

Source: ABPI, sourced from Clarivate

5. International comparison of access to medicines

Figure IV.5: Rate of availability (2019 – 2022)
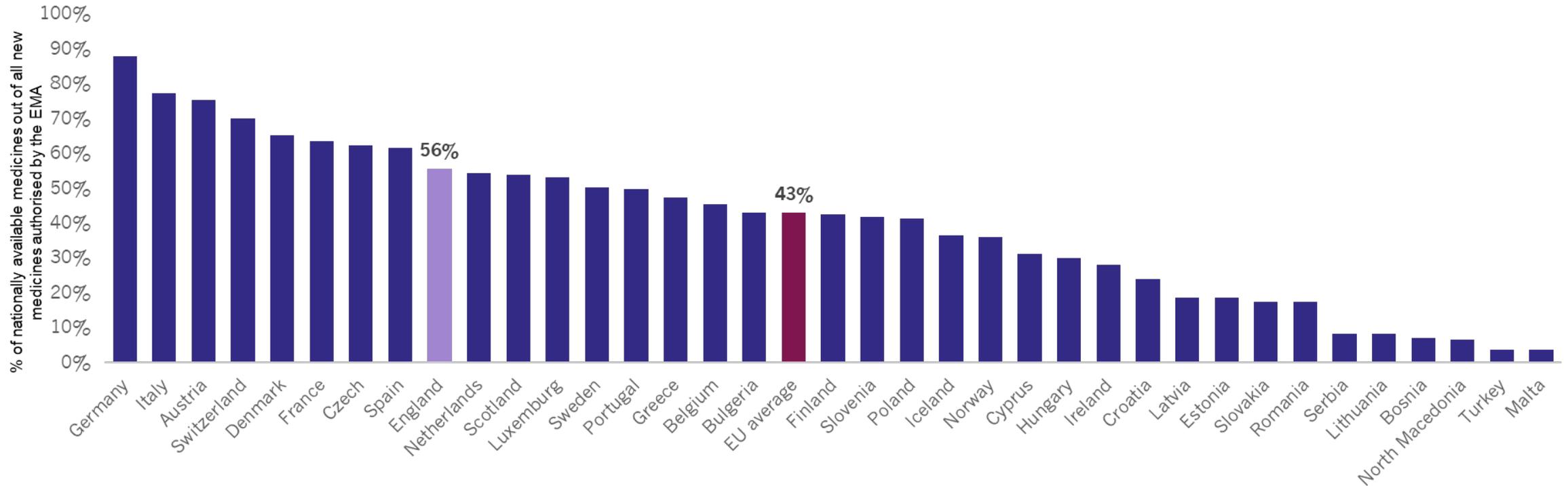
Notes: Rate of availability is the ratio of the number of products available to patients in each country divided by the number of EU approvals (167). In most countries availability equates to granting of access to the reimbursement list – for England a positive recommendation by NICE is used. As of July 2024 England is 7th in Europe at 63% availability. This adjustment takes account of 8 NICE recommendations subsequent to EFPIA data capture and of 4 other commissioned medicines which were not recorded by EFPIA.

Source: *European Federation of Pharmaceutical Industries and Associations*. W.A.I.T report 2024. Available: https://efpia.eu/news-events/the-efpia-view/efpia-news/new-data-from-efpia-reveals-multiple-factors-leading-to-unequal-access-to-medicines-for-patients-across-europe/

6. Number of technology appraisals split by recommendation

Figure IV.6: Total number of technology appraisals split by recommended or not recommended per year for pharmaceutical products per year 1999/00 to 2023/24
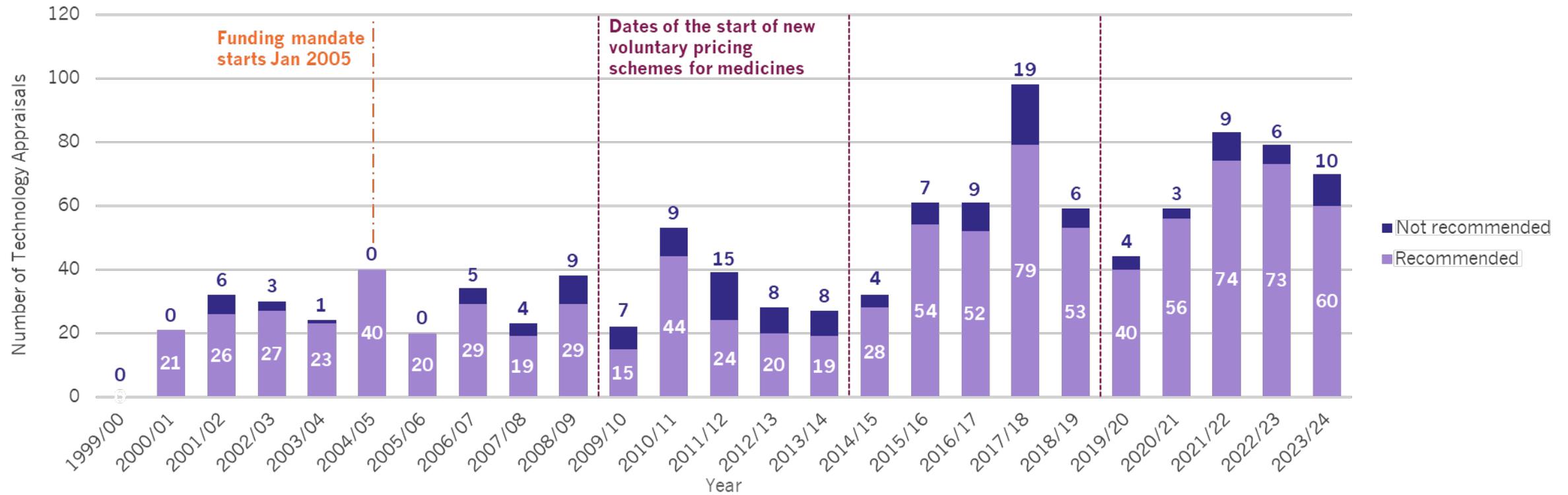
Notes: Since 1999/00 NICE has published the outcomes of 1098 appraisals. Of these 86% have a positive recommendation and 14% were not recommended.

Source: *NICE*. Internal administrative data.

7. Technology appraisals split by cancer and non-cancer

Figure IV.7: Split (cancer / non cancer) of technology appraisals with positive recommendations per year for pharmaceutical products per year 1999/00 to 2023/24
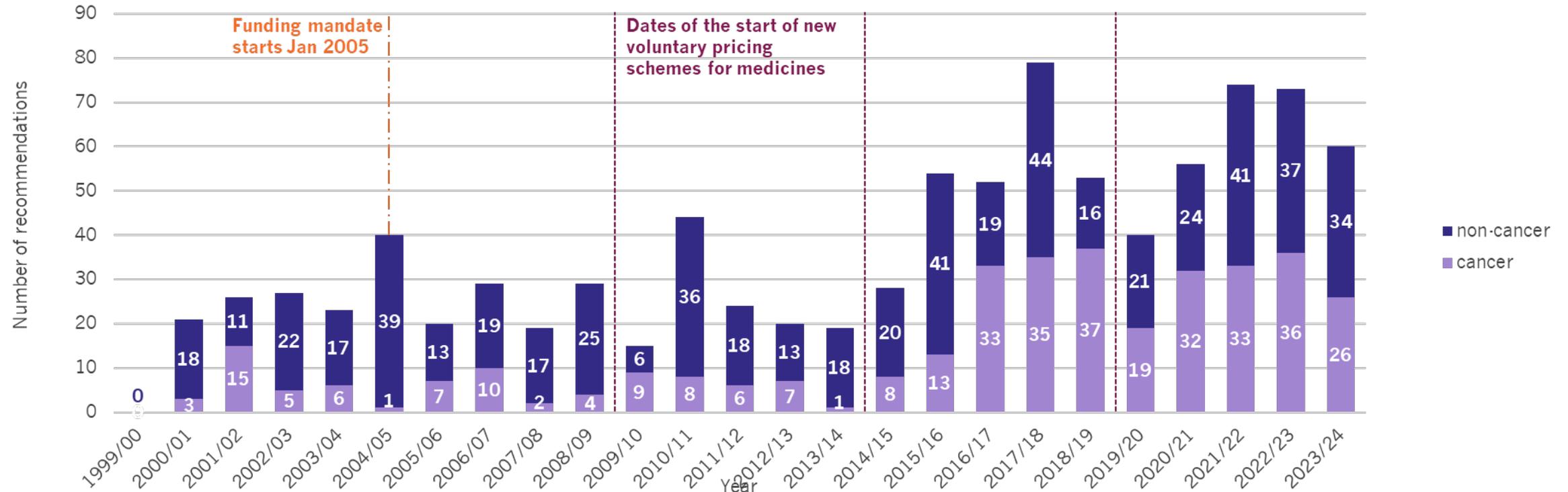
Notes: Cancer medicines make up a high proportion of the products assessed by NICE (356 out of 925). From 2016/17 onwards the number of TAs for cancers medicines has to risen to over 30 per year on average – many of which relate to the cancer Drugs fund (CDF)

Source: *NICE. Internal administrative data.*

8. Notifications of medicine supply issues and discontinuations

Figure IV.8. Notifications of medicine supply issues and discontinuations, October 2020 to December 2023
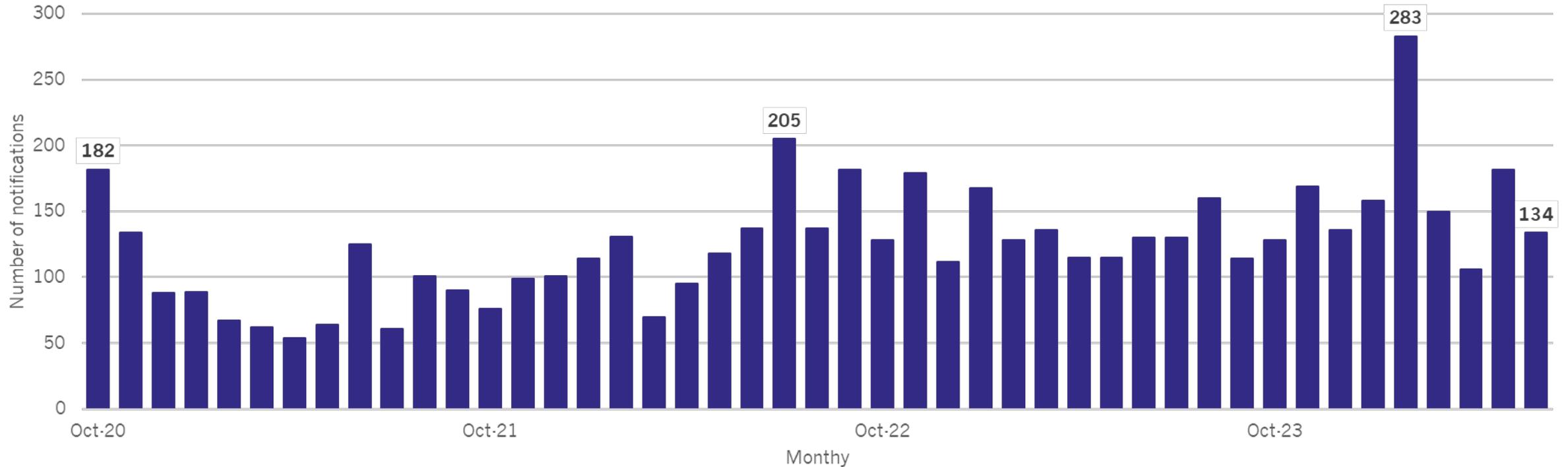
Notes: The Discontinuations and Shortages Portal (DaSH) was introduced in October 2020 to record the number of potential UK medicine supply issue notifications on the date they were added to DaSH. Notifications are reported at an individual medicine level by the Market Authorisation Holder. Awareness of the portal has increased over the years and reporting behaviour varies by Market Authorisation Holder, meaning that underreporting and overreporting will exist in the data. Not all supply issue notifications will result in an actual medicine shortage or cause impact to patients. Market authorisation holders can notify DaSH multiple times if the situation doesn't improve, therefore there may be multiple notifications for 1 product supply issue. The number of notifications can fluctuate month to month and be driven by acute events.

Source: Discontinuations and Shortages Portal (DaSH) notifications

V. Funding, investment and technology

1.1 Real terms spending on the NHS in England adjusted for population size and demographic profile

Figure V.1.1: Real Terms spending on the NHS in England adjusted for population size and demographic profile
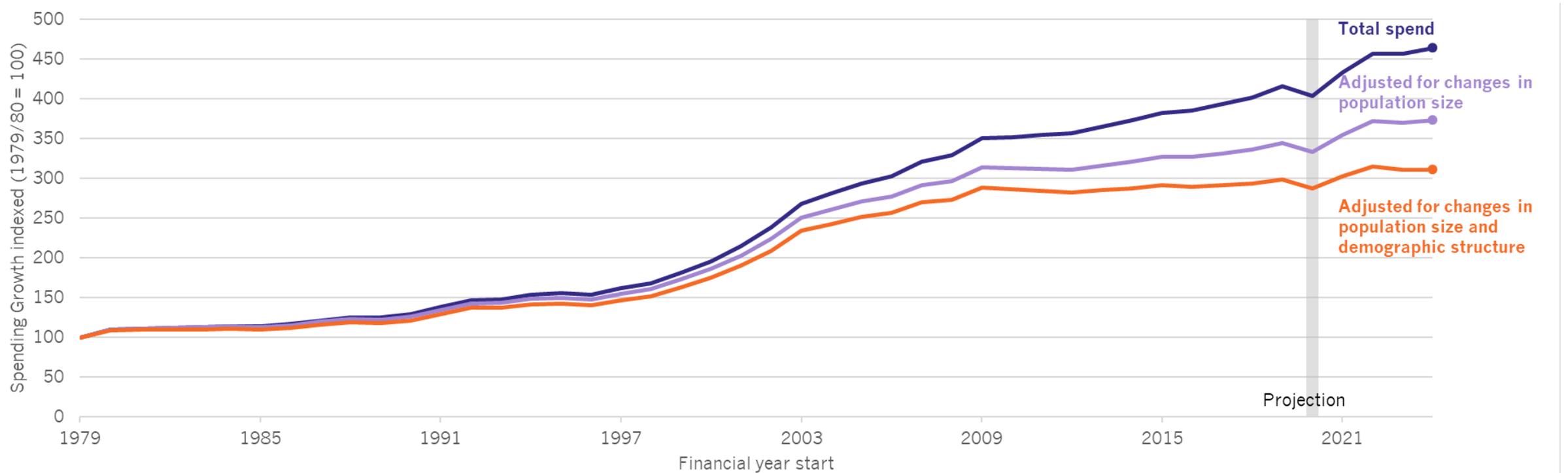
Notes: Figures exclude Covid special measures spending. Last four years use estimates of GDP deflators. Financial years shown.

Sources: Nuffield Trust analysis of GOV.UK and House of Commons Library data. Department of Health and Social Care spending: Total and adjusted for population size and demographic structure (2021/22 prices). Change of method represents planned spend (not published outturn figures).
https://www.nuffieldtrust.org.uk/news-item/the-past-present-and-future-of-government-spending-on-the-nhs

1.2 Real terms revenue expenditure on the NHS in England

Figure V.1.2: Resource DEL (exc. depreciation) NHS England – real terms (£m), 2013/14 to 2024/25
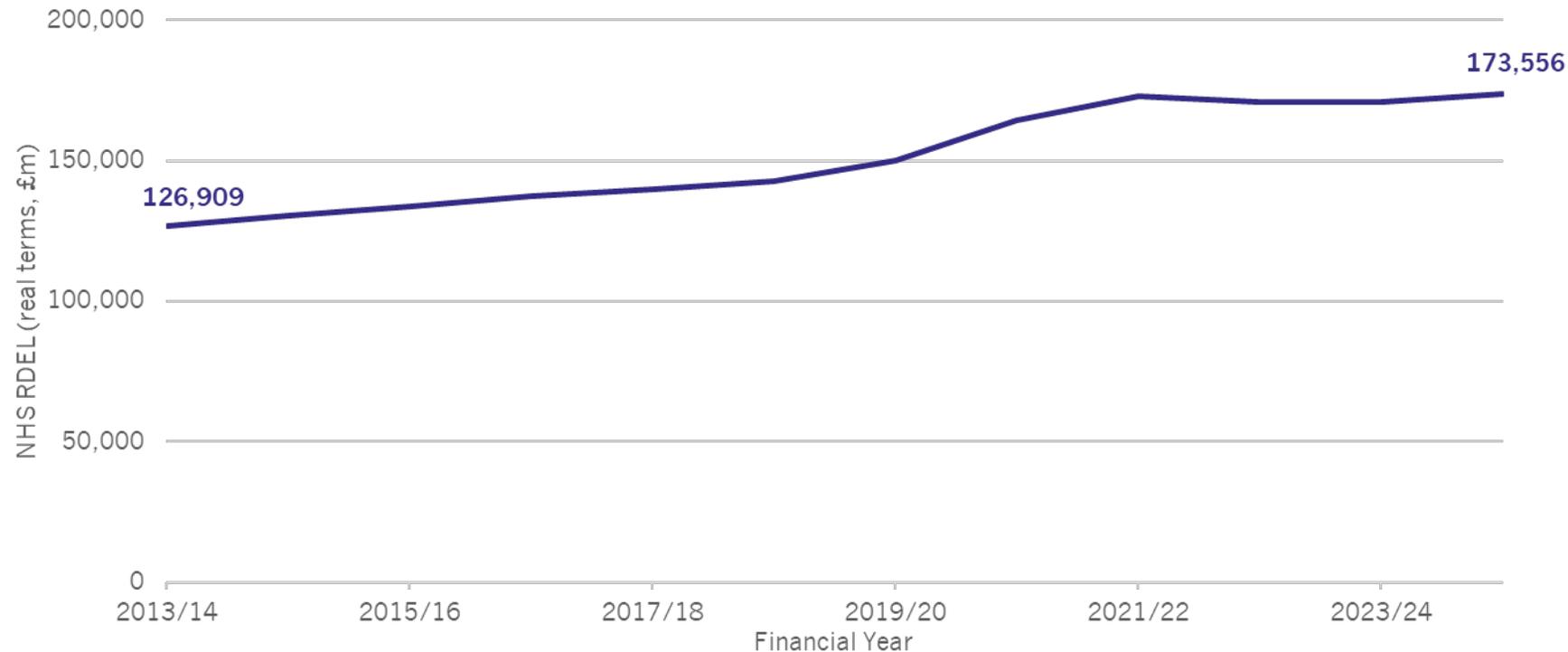
Period	CAGR
2013/14 – 2016/17	2.72%
2016/17 – 2019/20	2.92%
2019/20 – 2024/25	2.97%
Whole period 2010/11 – 2024/25	2.89%

Notes: Figures in this timeseries reflect the NHS England RDEL spending outturn but adjusted for NHS Providers' spending that scores outside of the Resource DEL, excluding depreciation control limit. Planned expenditure for 2024/25 excludes c.£2bn for the change in NHS Pensions valuations for setting employer contributions in unfunded public sector pension schemes. Previous years' spending outturn figures have also been adjusted to reflect spending in entities that were merged with NHS England during 2022-23 and from 2023-24, to allow for consistency across all years.

Source: HM Treasury Public Expenditure Statistical Analyses https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa

1.3 Total government spending on health per person

Figure V.1.3: Total government spend on health per person, 2001 to 2022
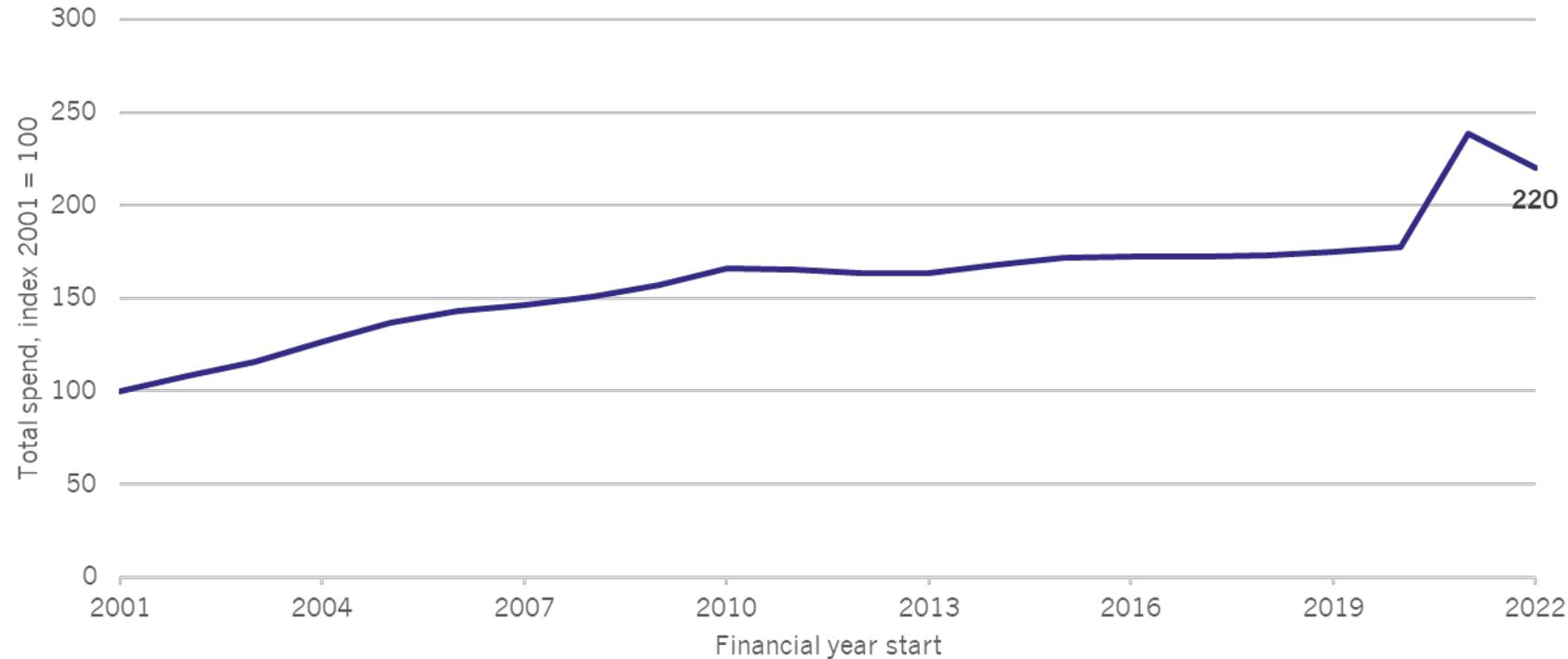
	Growth rate
2001/02 to 2010/11	5.8%
2010/11 to 2018/19	0.5%
2018/19 to 2022/23	6.2%

Notes: Most recent data is 2022/23

Source: HM Treasury (2024), Public Expenditure Statistical Analyses (PESA). Available at: HMT Public Expenditure Statistical Analyses (PESA) - GOV.UK (www.gov.uk)

1.4 International comparisons of health expenditure as a percentage of GDP

Figure V.1.4: Health expenditure as a percentage of GDP
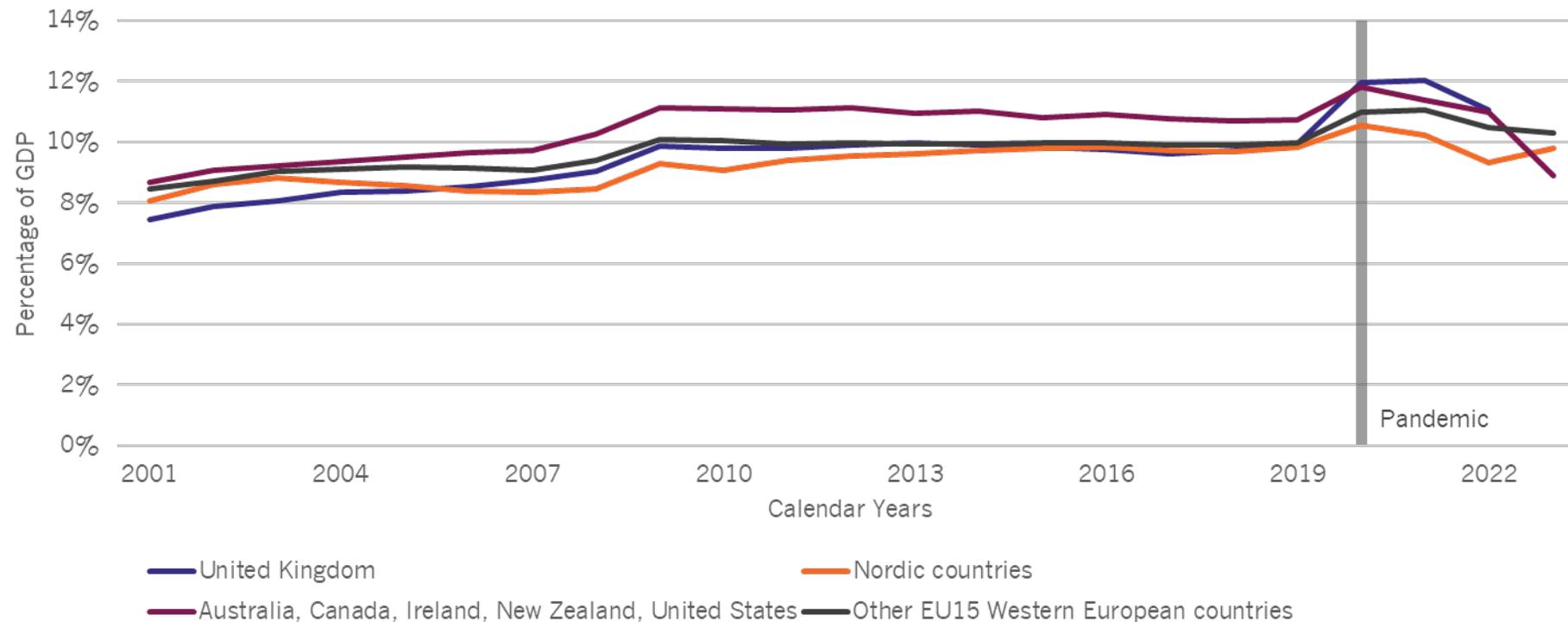
AREA	2022 VALUES
United Kingdom	11.1%
Nordic countries	9.3%
Australia, Canada, Ireland, New Zealand, United States	11.0%
Other EU15 Western European countries	10.5%

Notes: 'Other EU15 Western European countries' includes Austria, Belgium, France, Germany, Greece, Italy, Netherlands, Portugal and Spain.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

1.5 Total NHS surplus/deficit by year excluding central adjustments

Figure V.1.5: Total NHS surplus / deficit as % of non-ringfenced RDEL funding
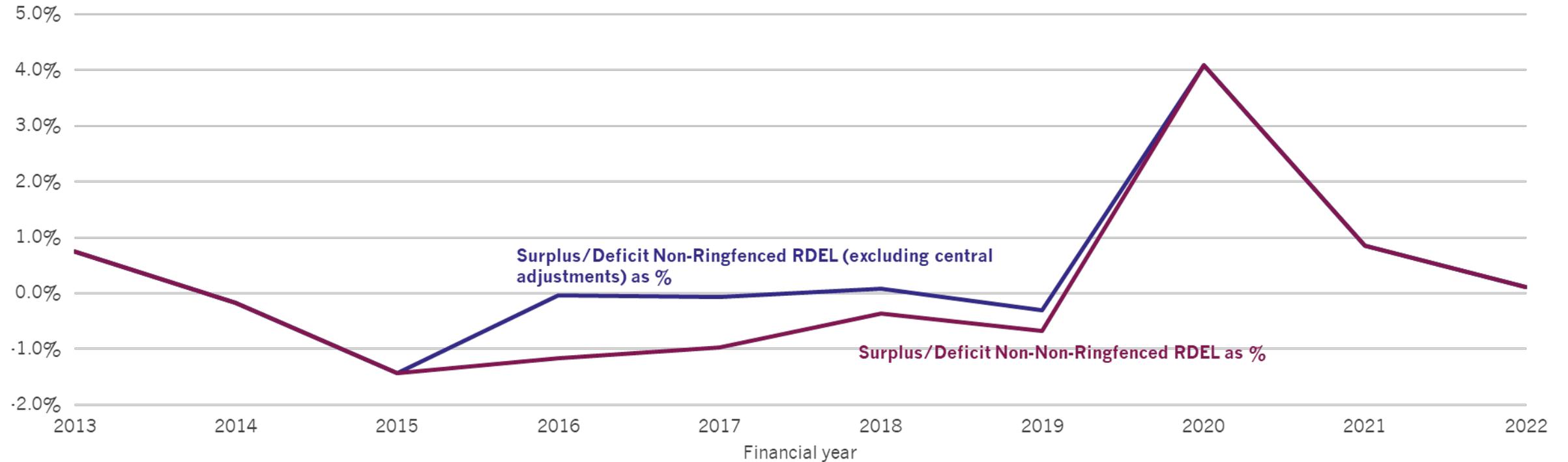
Notes: Dataset recorded from 2013/14 financial year; Figures presented do not take account for any changes in financial regime; and Central adjustments relating to capital to switches are those specified in the HSC estates memoranda as being explicitly undertaken to reallocate resource to manage deficits.

Source: Department of Health and Social Care and NHS England . *DHSC accounts and NHS England accounts.*

2.1 International comparison of health expenditure per capita

Figure V.2.1: Health expenditure per capita, PPP converted, constant 2020 prices
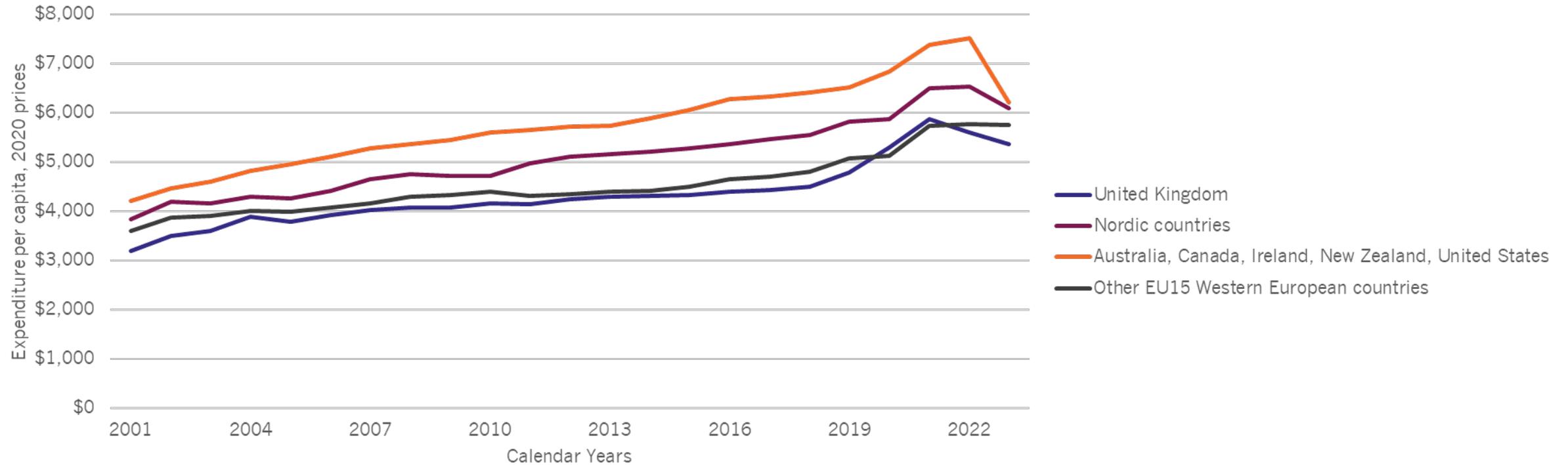
Notes: Data converted from Organisation for Economic Co-operation and Development statistics to constant 2020 prices using the HMT GDP deflators.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/2024); HM Treasury GDP deflators at market prices, and money GDP

2.2 International comparison of capital expenditure

Figure V.2.2: Capital spend in healthcare as % GDP
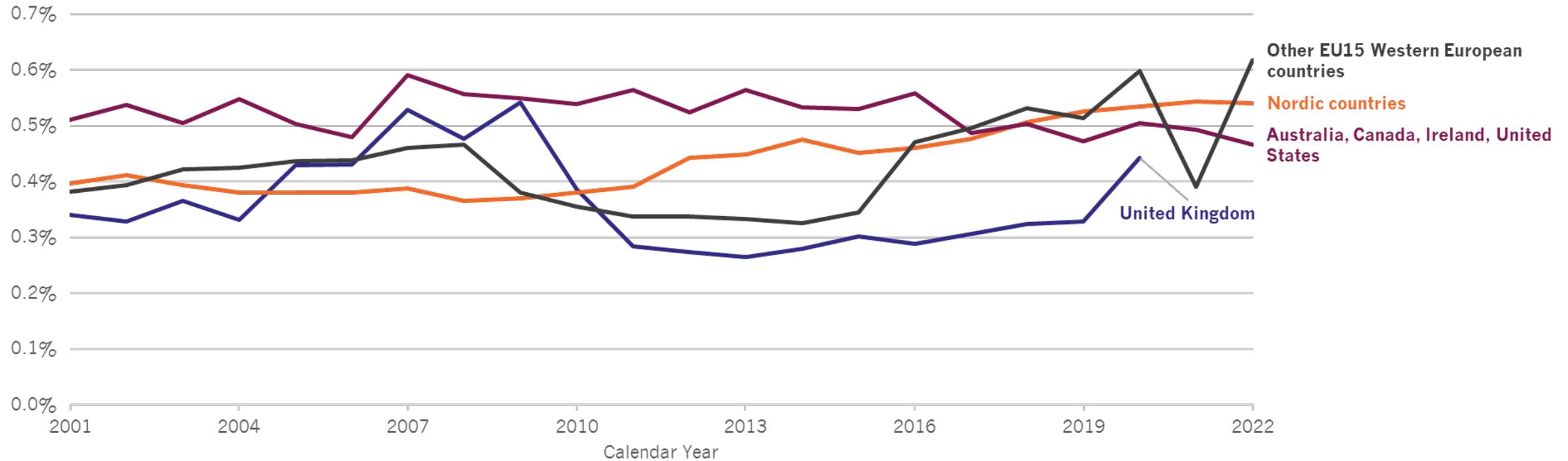
Notes: No data available for Belgium, Germany, Italy, Netherlands and New Zealand. Limited data for France, Greece and Portugal. 2022 data is only available for Denmark (Nordic countries), Austria (Other EU15 Western European countries), and Canada; 2021 data is unavailable for Finland (Nordic countries) and Australia, and the only available data for Other EU15 Western European countries is Greece, Austria and Spain. Capital spending data across countries relates to 'gross fixed capital formation' – that is, the purchase of assets (for example, buildings and scanners) minus the sale of assets in that year. Research and development spending may be counted if it involves the purchase or sale of an asset or leads to intellectual property. Private Finance Initiatives and all other private capital spending in health care may be included.
Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

2.3 NHS capital spending split by capital delegated expenditure limit and real outturn

Figure V.2.3: Real NHS CDEL outturn 2022/23 Base Year (£ millions), including capital value of PFI/PF2

Legend:
- Capital / Revenue Switches
- PFI/PF2
- NHS CDEL Outturn
- Real CDEL budget

	CAGR
2000-2010	10.3%
2010-2020	-2.5%
2020-2022	11.1%

Notes: PFI/PF2 refers to capital value. Real CDEL budget is for NHS and DHSC.

Source: Department of Health and Social Care and NHS England. NHS England analysis of published DHSC annual accounts and Published Supplementary estimates.

2.4 NHS capital spending per person

Figure V.2.4: Total NHS spend per person – revenue and capital, 2001/02 to 2024/25
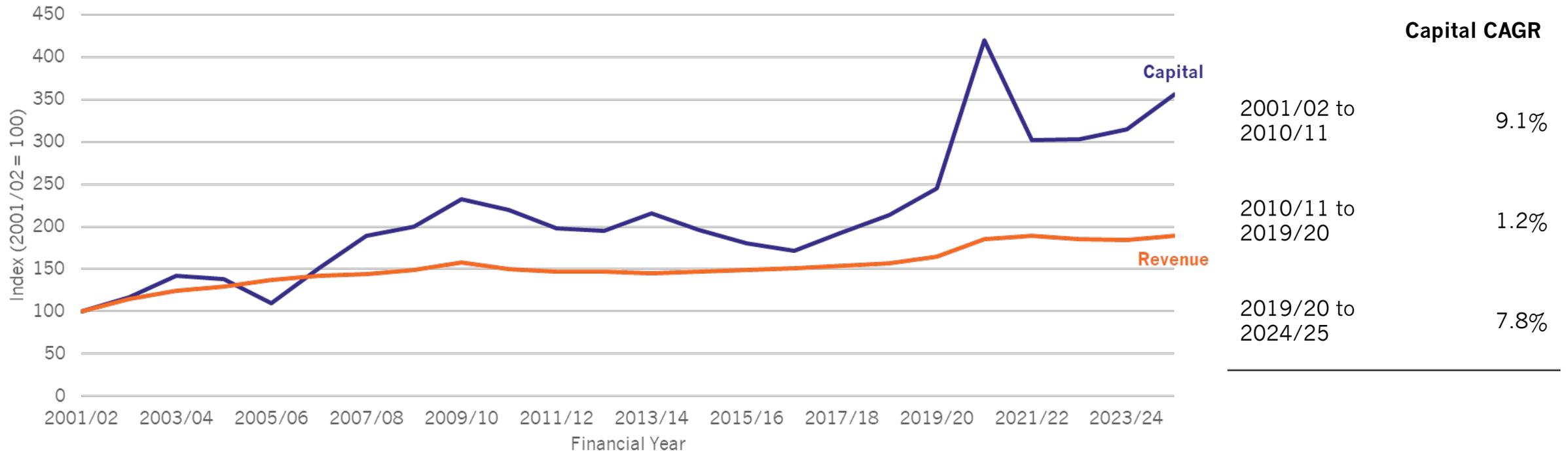
Notes: Capital and revenue time series represent CDEL and RDEL actual expenditure per person (planned expenditure for 2024/25). Capital series excludes PFI. Time series reflects Dates on the x-axis represent Financial Years. Data is indexed to 2001 = 100.

Source: HMT Public Expenditure Statistical Analyses (PESA), mid-year population estimates ONS.

2.5 Cumulative capital gap versus peers

Figure V.2.5: Cumulative capital gap UK vs peers, £ millions, constant 2020 prices
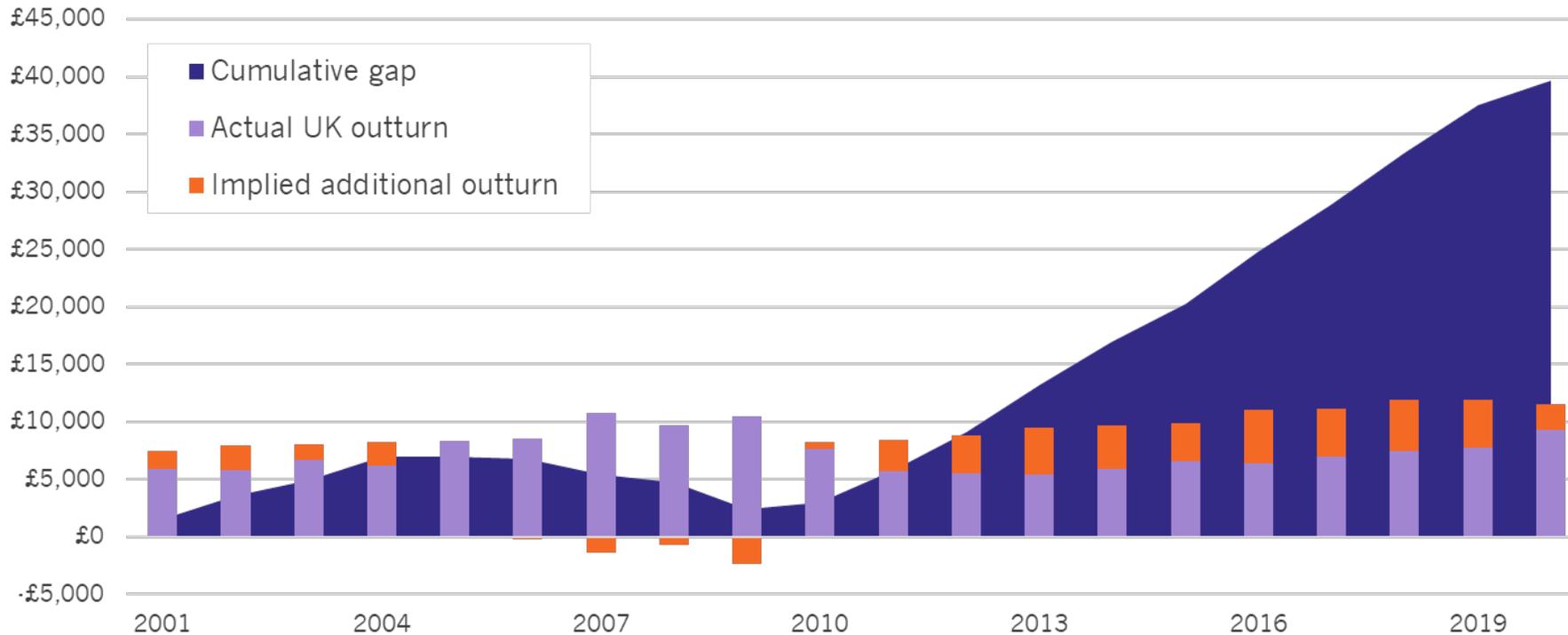
Cumulative capital gap for peer groups, £ millions, constant 2020 prices

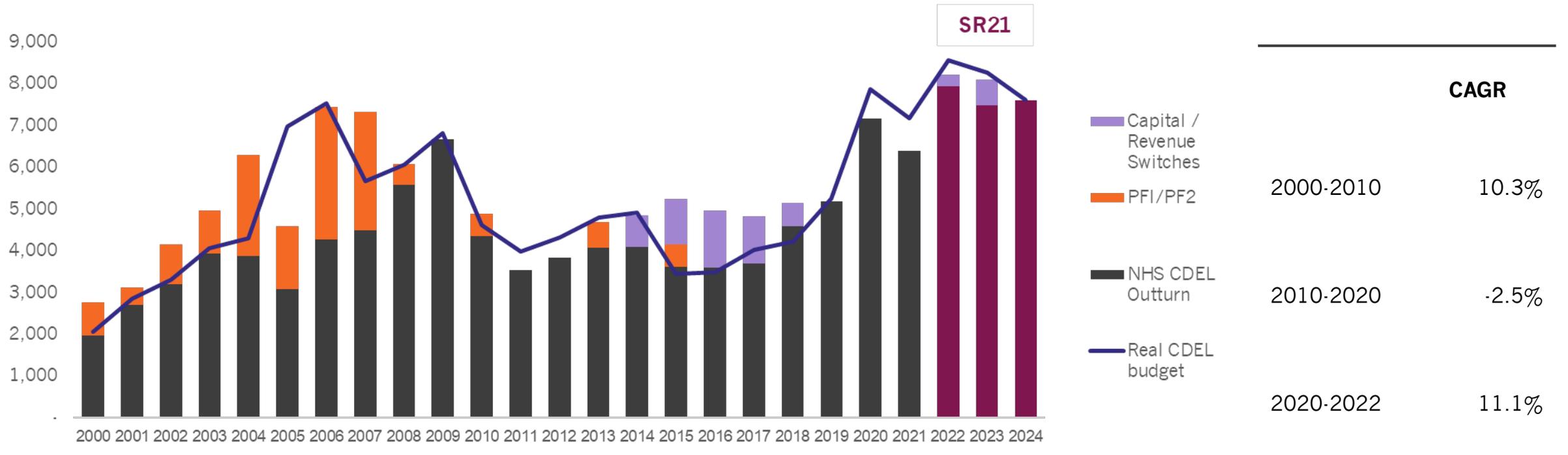|	2001-2010	2011-2020
Australia, Canada, Ireland, United States	£21,867	£46,397
Nordic countries	-£6,605	£35,478
Other EU15 Western European countries	-£379	£26,644
Average (all peers)	£3,030	£36,646

Notes: No data available for Belgium, Germany, Italy, Netherlands and New Zealand. Limited data for France, Greece and Portugal. Converted to constant 2020 prices using HM Treasury GDP deflator (June 2024).

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

2.6 Capital underspends and capital to revenue transfers

Figure V.2.6: Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)
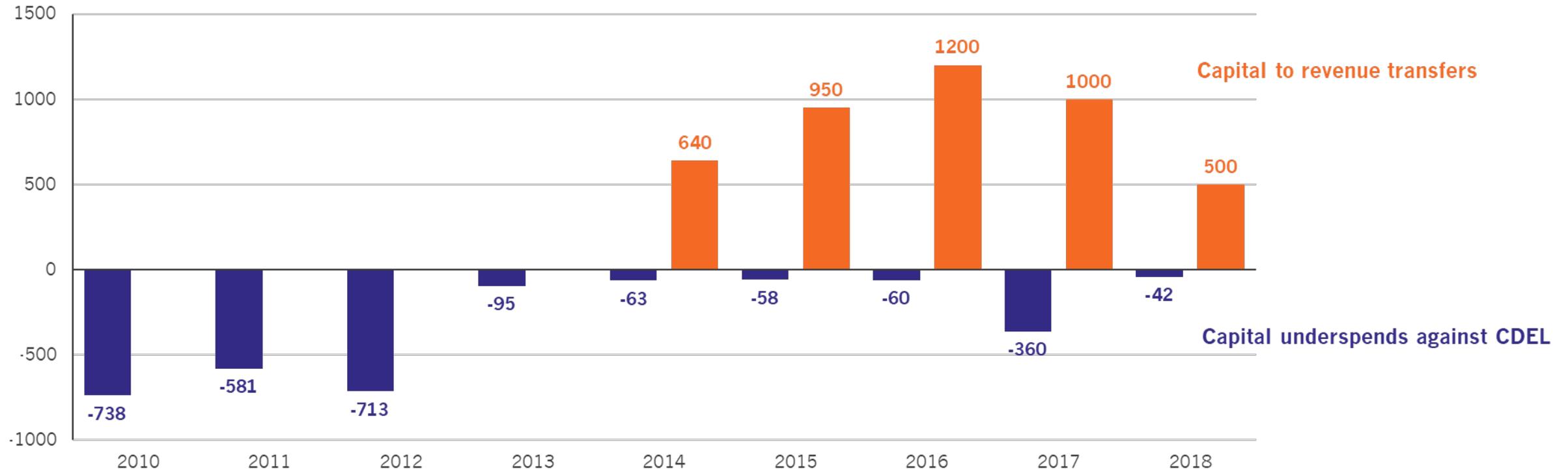
Notes: Underspend relates to the 'after the transfer' position.

Source: Department of Health and Social Care and NHS England. NHS England analysis of published DHSC annual accounts and Published Supplementary estimates.

2.7 Capital intensity measured as ratio total capital to total revenue

Figure V.2.7: Capital intensity (%) measured as ratio total capital to total revenue (£m)

Time period	Average multiple
Period 1 (2001/02-2005/06)	3.6%
Period 2 (2006/07-2010/11)	3.8%
Period 3 (2011/12-2015/16)	3.7%
Period 4 (2016/17-2019/20)	3.5%
Period 5 (2020/21-2021/22)	3.7%
Period 6 (2022/23-2024/25)	3.8%
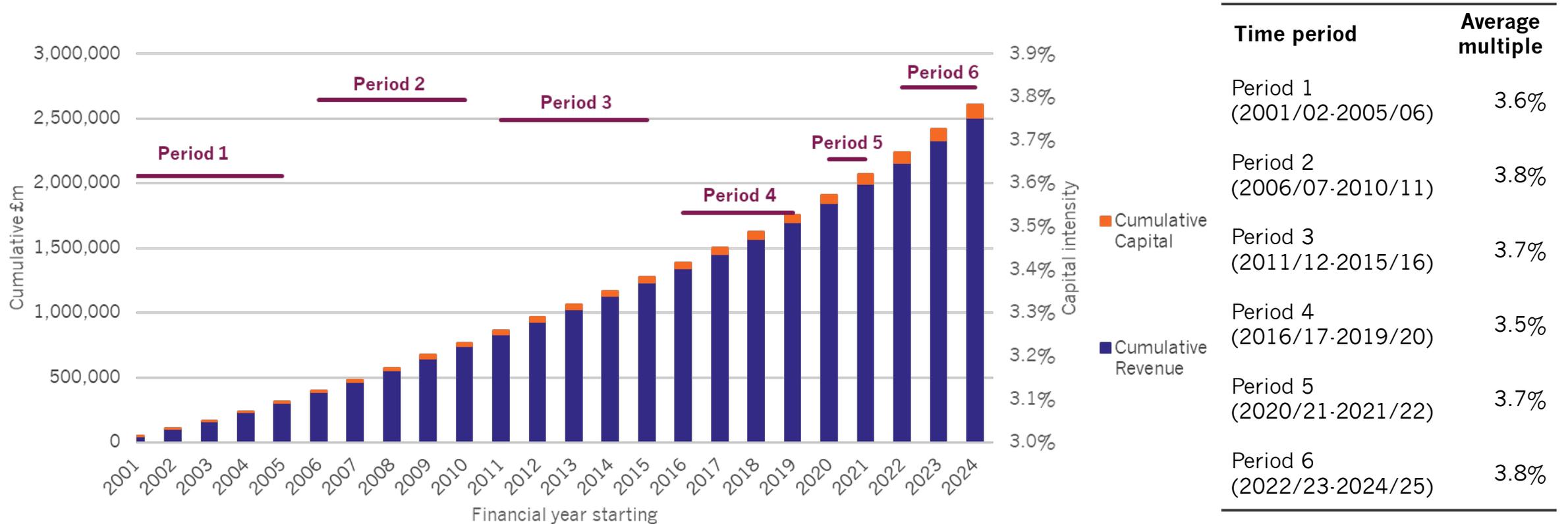
Notes: Capital intensity is measured as the proportion of cumulative NHS capital compared to cumulative NHS overall funding (capital plus revenue). The average capital intensity over different time periods is the average of this measure. Horizontal lines on the chart represent the average multiple for each time period given (%, RHS).

Source: Department of Health and Social Care and NHS England. NHS England analysis of published DHSC annual accounts and Published Supplementary estimates.

2.8 NHS capital spend split by care setting

Figure V.2.8: CDEL by Care Setting %
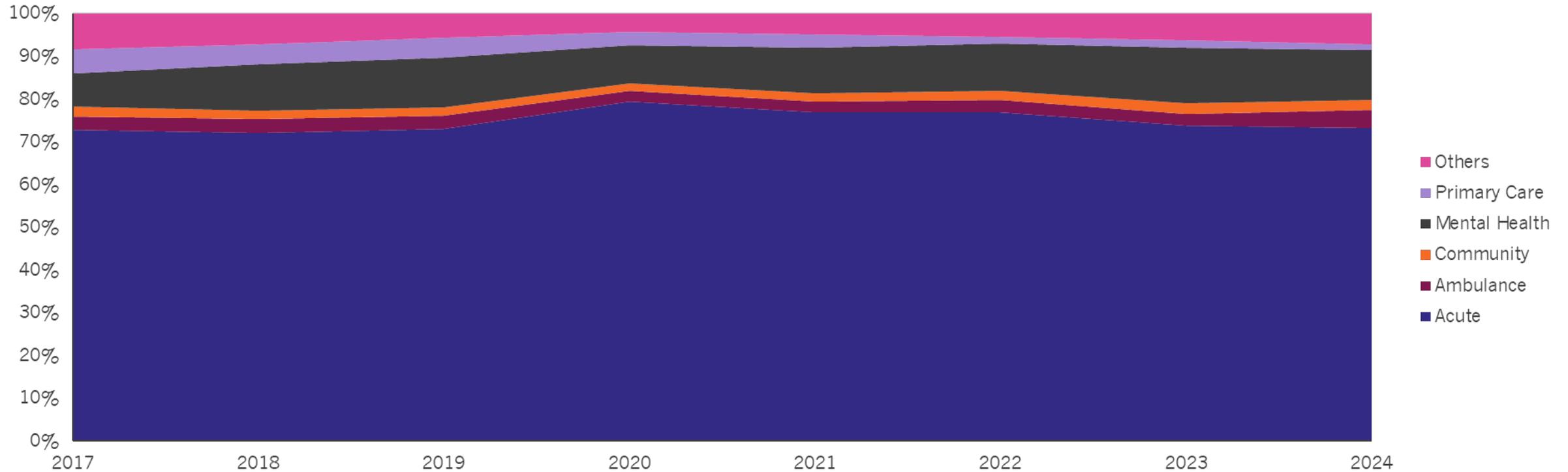
Notes: The capital data held and used to support this analysis only goes back as far as, and includes, 2017/18. Before this date, capital information was collated separately by the NHS Trust Development Authority (NHS Trusts), Monitor (Foundation Trusts), and NHS England (commissioners) and reported to DHSC by these organisations. In respect of providers, the data collected by NHS TDA and Monitor required different data points which were collected and monitored. This means capital spend analysis and comparison before this date is not possible.

Source: NHS England. Unpublished NHSE Capital and Cash team analysis of CDEL data.

2.9 Assets to revenue by acute provider trust 2023/24

Figure V.2.9: Assets to revenue by acute provider trust 2023/24
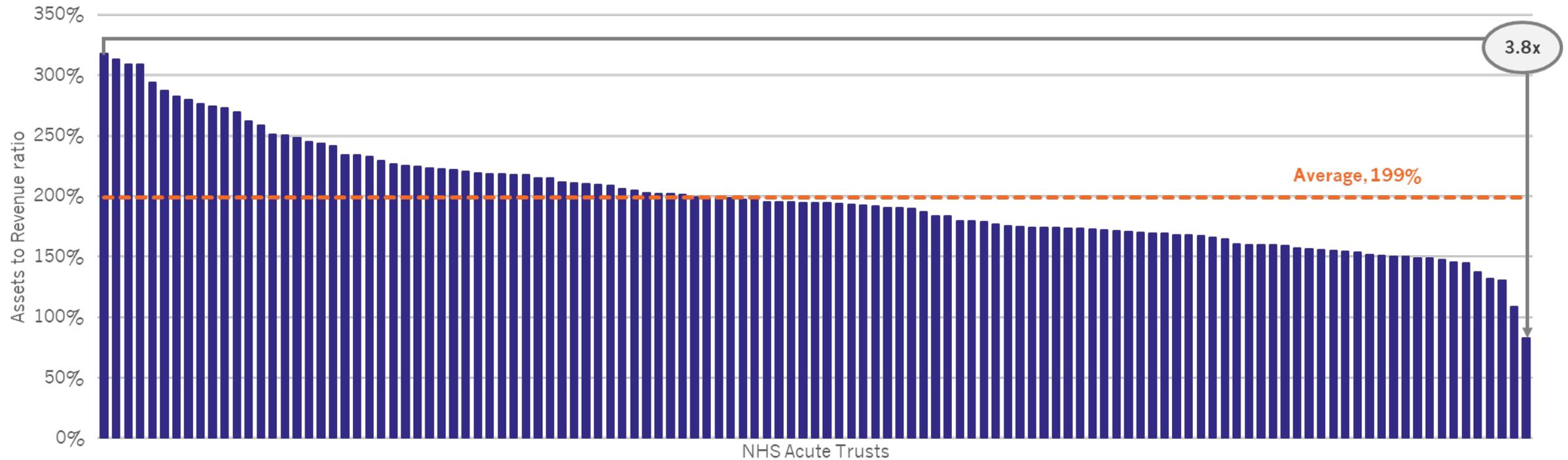
Notes: Bubble represents the multiple between the highest and lowest trust values.

Source: NHS England. Unpublished NHSE Capital and Cash team analysis of provider data.

2.10 Assets to revenue by all non-acute trusts 2023/24

Figure V.2.10: Assets to revenue by all (excluding acute) trusts 2023/24
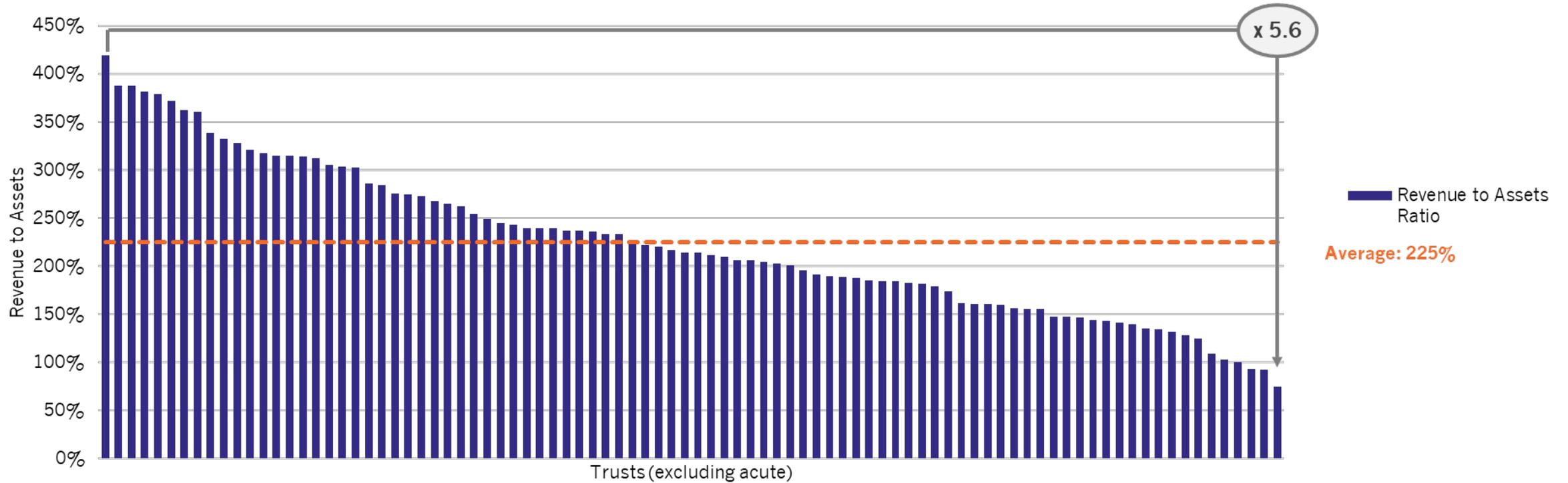
Notes: Bubble represents the multiple between the highest and lowest trust values.

Source: NHS England. Unpublished NHSE Capital and Cash team analysis of provider data.

2.11 Age profile of the secondary care estate

Figure V.2.11: Age profile of the secondary care estate as at March 23

2.12 Age profile of the primary care estate

Figure V.2.12: Age profile of the primary care estate as at June 2024
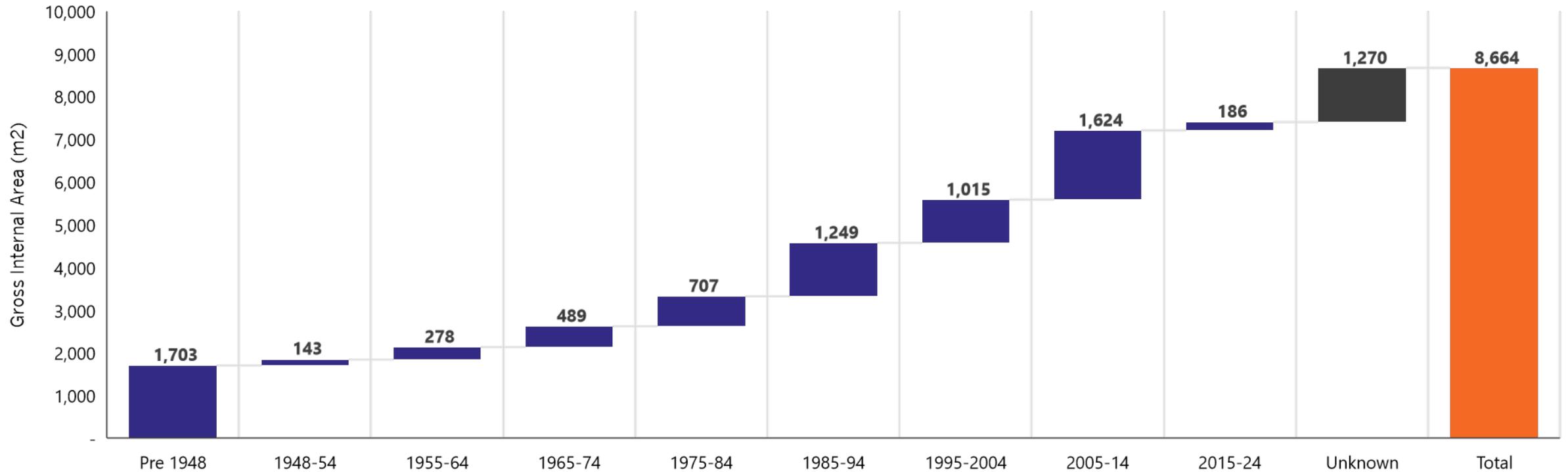
Source: NHS England. Primary Care Data Gathering Collection (PCDG), which is available via SHAPE Atlas

2.13 Backlog maintenance by risk category

Figure V.2.13: Backlog Maintenance - Actual
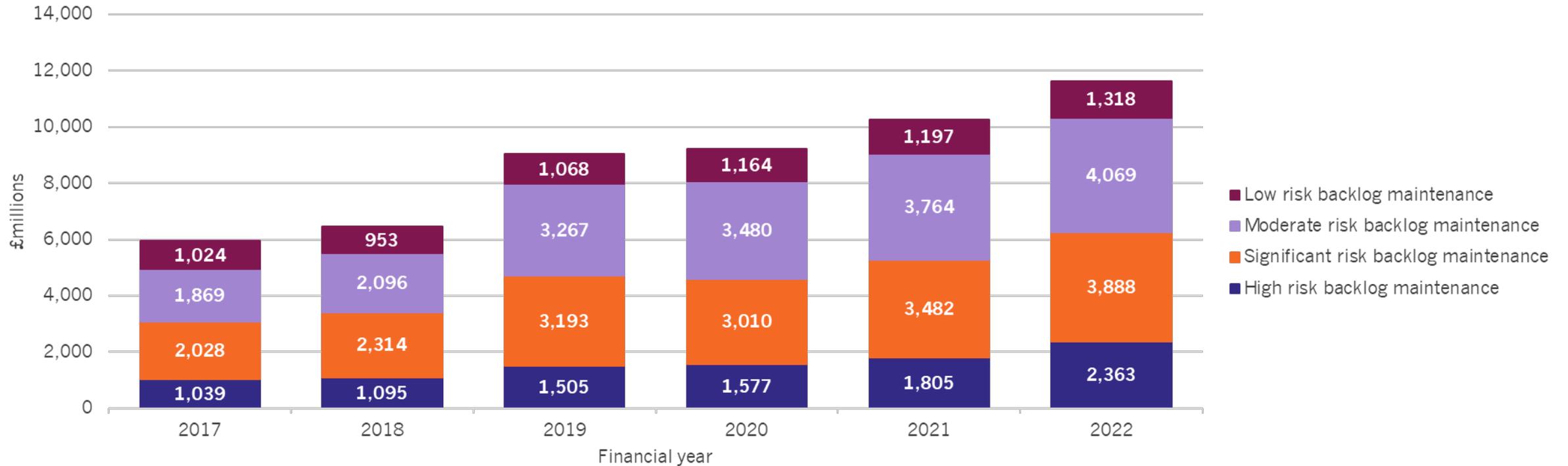
Source: NHS England. Estates Returns Information Collection. Available: https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection.

2.14 Clinical incidents caused by estates and facilities failures

Figure V2.14: Number of clinical incidents caused by estates and facilities (E&F) failures, recorded in the ERIC data set, over time

2.15 Numbers of NHS beds

Figure V.2.15: G&A bed availability over time

Time period	CAGR
2001 – 2010	-2.5%
2010 – 2019	-0.8%
2019 - 2021	-1.1%
2021 - 2023	2.6%
Whole period	-1.2%
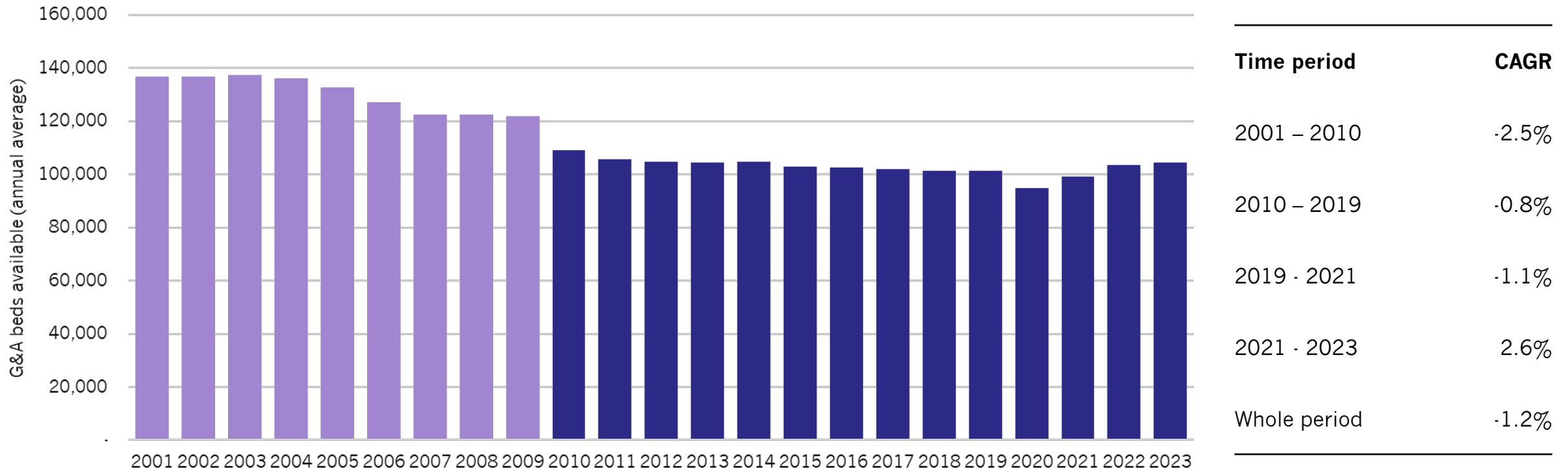
Notes: Data for G&A beds available is for financial years. This data changed definitions in 2010-11 moving from wards to consultant led main specialty. A growth rate across the full period would be misleading to report due to changes to the collection so two have been displayed below.

Source: NHS England. Bed Availability and Occupancy – KH03 data. Available: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-availability-and-occupancy-kh03/

2.16 International comparison of bed numbers

Figure V.2.16: Hospital beds per 1,000 inhabitants, 2001 to 2022 (or nearest year)
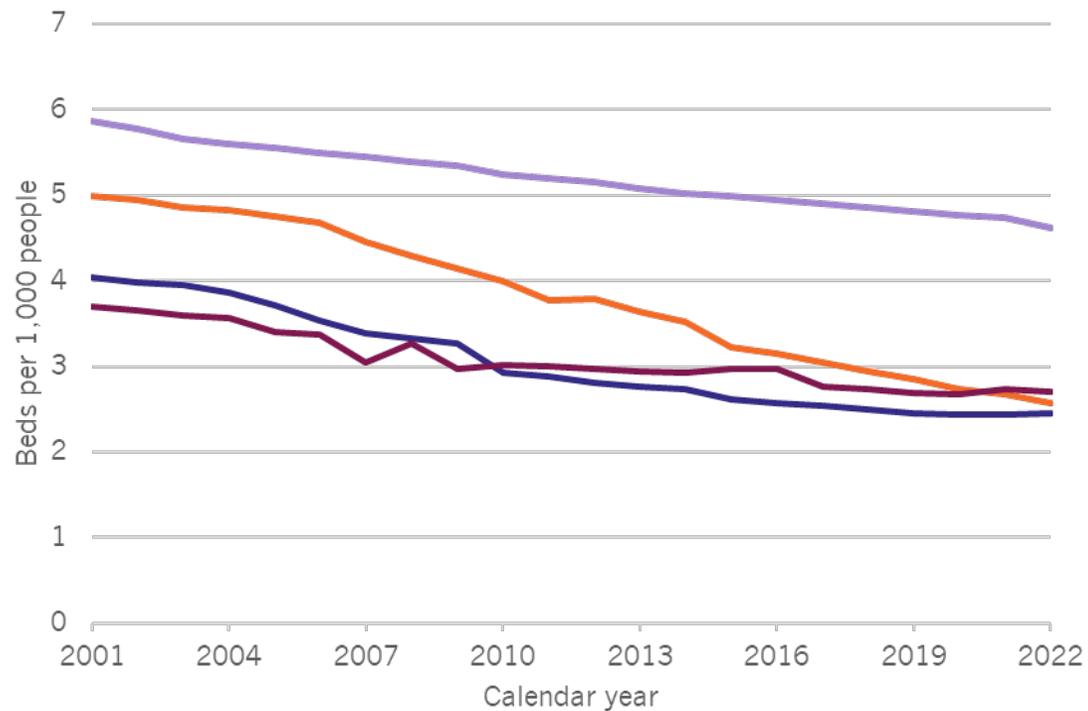
CAGR	2001 - 2005	2005 - 2010	2010 - 2015	2015 - 2019	2019 - 2022
United Kingdom	-2.0%	-4.7%	-2.3%	-1.6%	0.0%
Nordic countries	-1.2%	-3.4%	-4.2%	-3.0%	-3.4%
Australia, Canada, Ireland, New Zealand, United States	-2.1%	-2.4%	-0.3%	-2.5%	0.1%
Other EU15 Western European countries	-1.3%	-1.2%	-0.9%	-1.0%	-1.3%

Notes: 2022 data for Nordic countries is only available for Norway, Sweden and Denmark, excluding Finland and Iceland; 2021 data for Nordic countries excludes Iceland; The latest data available for Australia is 2016.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

3.1 International comparison of number of diagnostic scanners

Figure V.3.1: Number of CT, MRI and PET scanners per million inhabitants, 2023 (or nearest year)
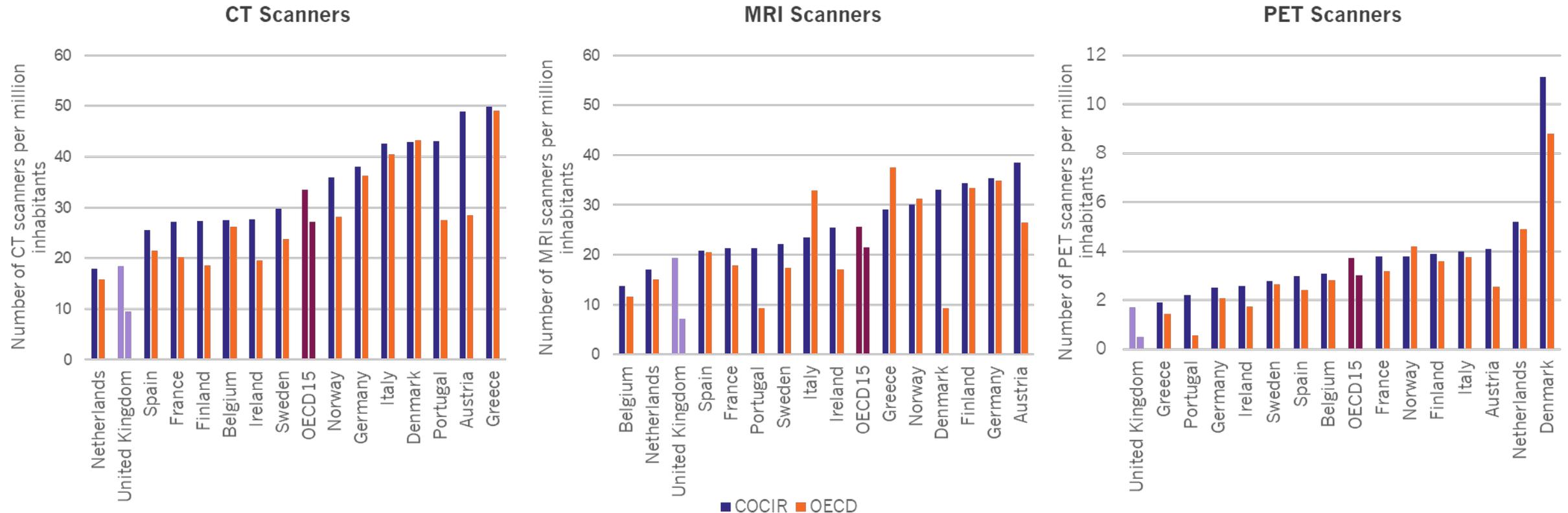
Notes: These figures exclude scanners associated with ambulatory providers (practices of GPs and specialists, dental practices, ambulatory health care centres, and providers of home health care services). This must be taken into consideration when comparing against the charts which cover both hospital and ambulatory providers. COCIR data was taken from the COCIR 2023 Medical Imaging Equipment Age Profile & Density publication. Data for PET scanners in Germany was not available on the Organisation for Economic Co-operation and Development Data Explorer, therefore the figure was taken from Health at a Glance 2023.

Source: Reproduced from Nuffield Trust, using data from Organisation for Economic Co-operation and Development (accessed 15/08/24) and COCIR. These are highlighted in the legends.

3.2 NHS capital budget split by setting and by investment type

Figure V.3.2: CDEL Outturn By Care Setting and Investment Type (£000)
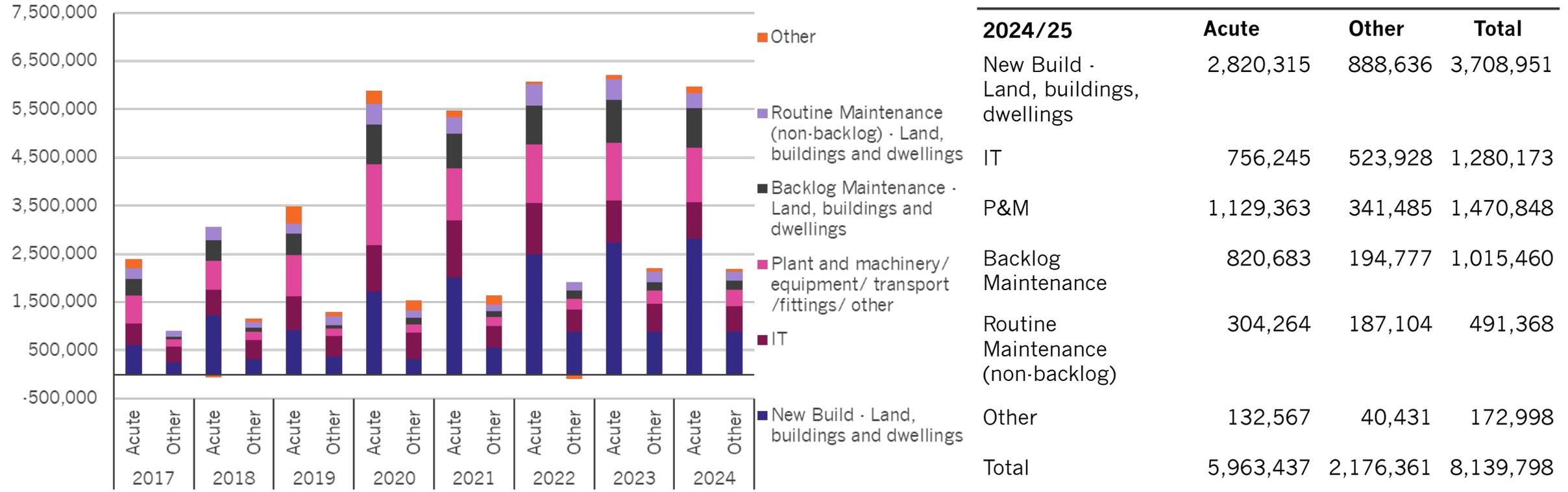
2024/25	Acute	Other	Total
New Build - Land, buildings, dwellings	2,820,315	888,636	3,708,951
IT	756,245	523,928	1,280,173
P&M	1,129,363	341,485	1,470,848
Backlog Maintenance	820,683	194,777	1,015,460
Routine Maintenance (non-backlog)	304,264	187,104	491,368
Other	132,567	40,431	172,998
Total	5,963,437	2,176,361	8,139,798

Notes: The capital data held and used to support this analysis only goes back as far as, and includes, 2017/18. Before this date, capital information was collated separately by the NHS Trust Development Authority (NHS Trusts), Monitor (Foundation Trusts), and NHS England (commissioners) and reported to DHSC by these organisations. In respect of providers, the data collected by NHS TDA and Monitor required different data points which were collected and monitored. This means capital spend analysis and comparison before this date is not possible.

Source: NHS England. Unpublished NHSE Capital and Cash team analysis of CDEL data.

3.3 Capital funding for technology & data

Figure V.3.3: Central CDEL spend on Technology & Data by spend type £'m
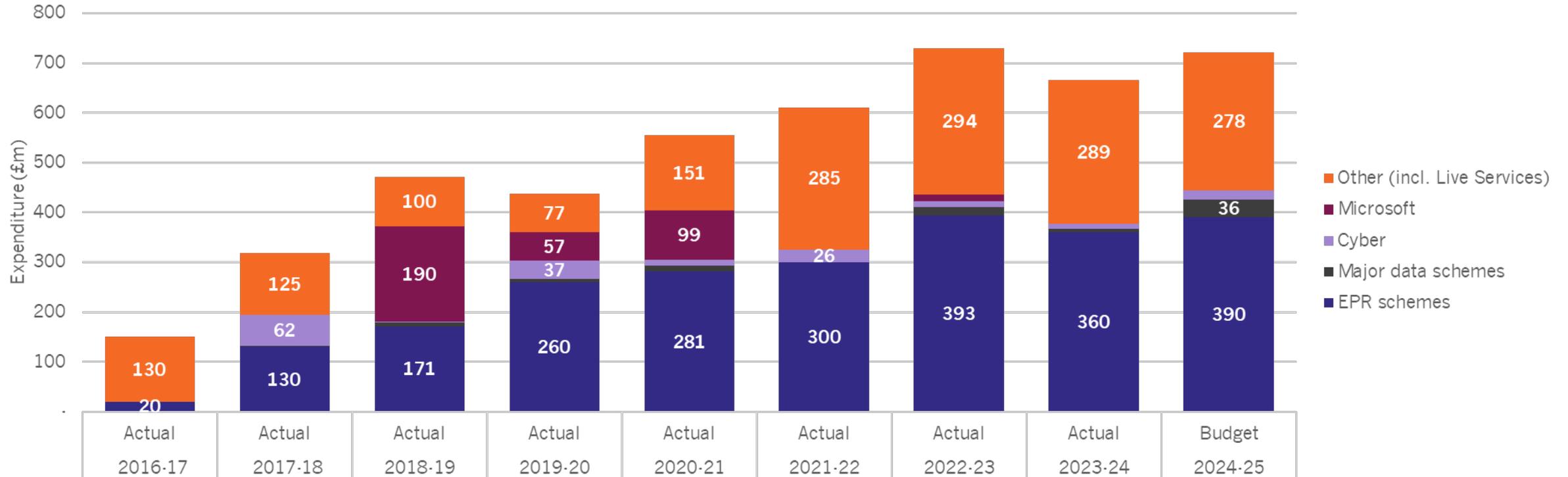
Notes: Central spend is across NHS England, DHSC and former NHS Digital. Other includes spend on our Live Services and various other Transform programmes, including The App, Screening, NHS.UK, Primary Care and many others; none are individually material enough to include as separate lines. Microsoft figures are from the purchase of Windows 10/ N365 licences post-Wannacry. Post 22/23, these have been recorded as Revenue and not Capital

Source: NHS England

3.4 IT capital investment per clinical FTE by NHS provider type

Figure V.3.4: IT capital investment per clinical FTE by NHS provider type (cash terms), England
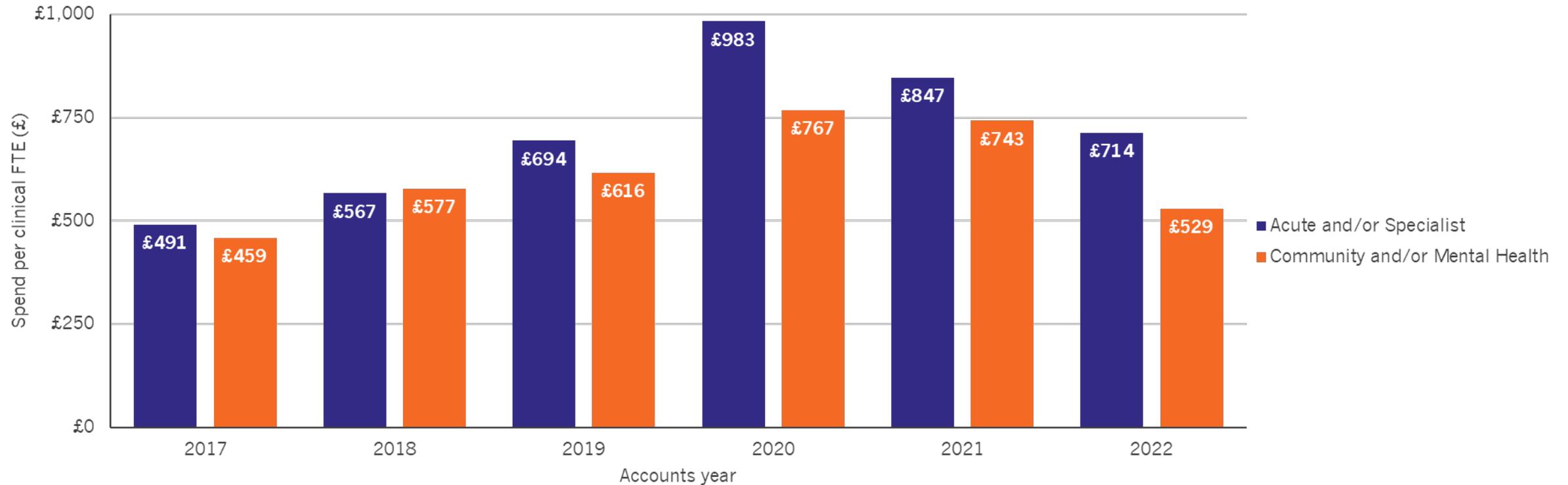
3.5 Digital maturity assessment of secondary care providers

Figure V.3.5: DMA secondary care provider scores (out of 5), 2024

Legend:
- Each dot represents one **provider**
- Average maturity score across **secondary care providers** in region
- Average maturity score across all **secondary care providers** in England
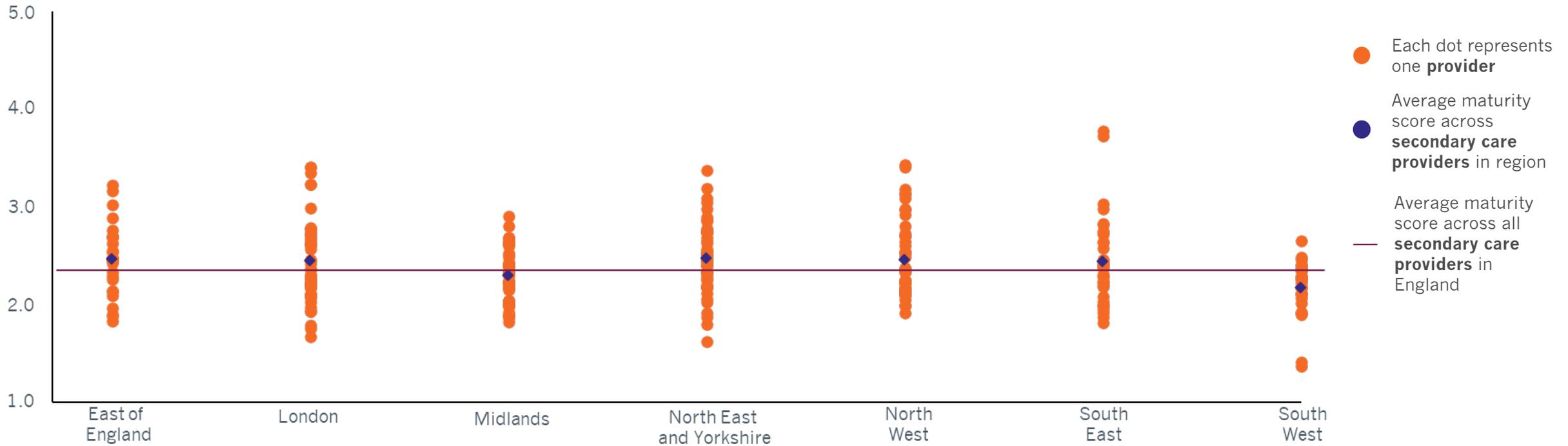
Notes: For 2024, digital maturity hovers between 2.4-2.6 on average, with significant variability across dimensions and care settings. The DMA scores are based on 1 to 5 rating. They are a volumetric capture against maturity questions. The more aspects/questions that are attained contribute to a higher score

Source: *NHS England*. 2024 Digital Maturity Assessment.

VI. The impact of the Covid-19 pandemic

1. Number of excess deaths in England during the pandemic years

Figure VI.1: Number of excess deaths in England (Office for National Statistics new method), 2020 to 2023
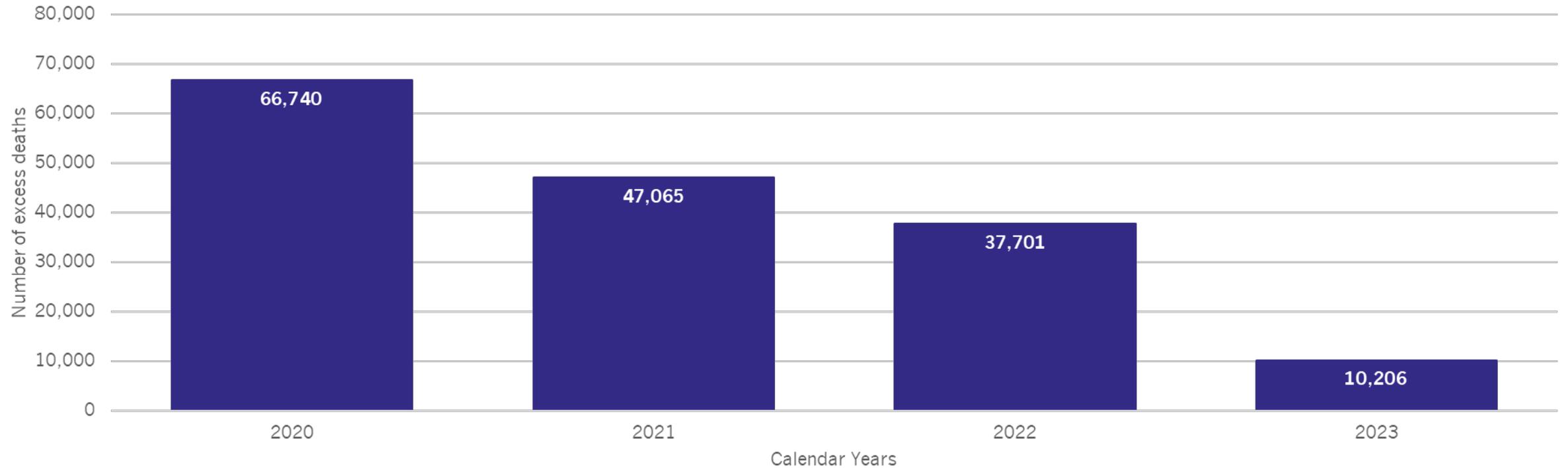
Notes: These excess deaths estimates include the impact of Covid-19

Source: Office for National Statistics (2024), Annual estimates of excess deaths from the current and new methods by UK country: 2011 to 2023. Available at: Estimating excess deaths in the UK, methodology changes

2. International comparison of excess mortality during the pandemic

Figure VI.2: Cumulative excess mortality, relative to the 2015 to 2019 average mortality rate, week ending 3 January 2020 to week ending 1 July 2022
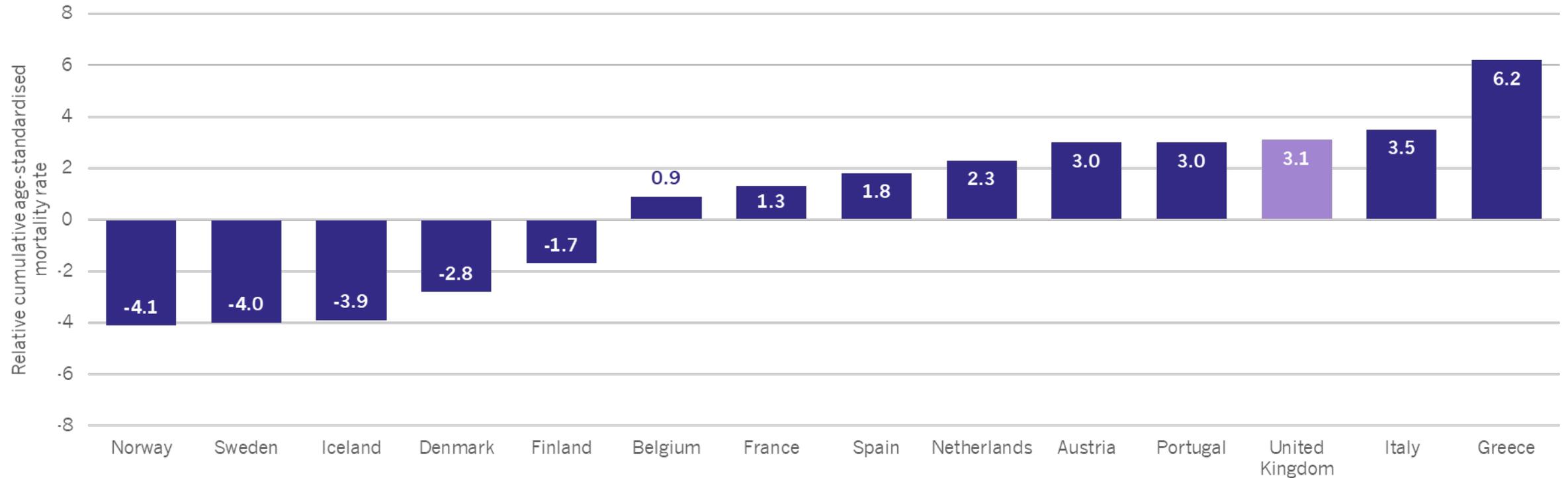
Notes: This is a selection of countries from the ONS publication consistent with other international comparisons used in this technical annex.

Sources: Office for National Statistics, Comparisons of all-cause mortality between European countries and regions, 2022. Available at: Comparisons of all-cause mortality between European countries and regions. Data for the United Kingdom is from Office for National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency. Data for other European countries is from Eurostat · Eurostat

3. International comparison of health system capacity going into the Covid-19 pandemic

Figure VI.3: International comparison of health system capacity going into the Covid-19 pandemic

	Practising physicians per 1,000, 2019	Practising nurses per 1,000, 2019	Hospital beds per 1,000, 2019	Occupancy rate of curative (acute) care beds, 2019	Total health spending, US dollars per capita, 2019	Average length of stay in hospital, 2019	Capital expenditure on health as share of GDP, average over 2015–19
UK	**3.0**	**8.2**	**2.5**	**89.1**	**4,268.7**	**6.7**	**0.4**
Australia	3.8	12.2			5,545.9	5.3	0.8
Austria	5.3	10.4	7.2	73.0	5,263.0	8.3	0.9
Belgium	3.4	11.6	5.6	72.5	5,049.6	6.0	1.0
Canada	2.7	10.0	2.5	91.6	5,116.0	7.6	0.5
Denmark	4.3	10.1	2.6		6,059.0		0.8
Finland	3.6	13.5	3.4		4,460.0	7.7	0.7
France	3.2	8.8	5.8	75.9	4,504.5	8.8	0.6
Germany	4.4	11.8	7.9	78.9	5,487.0	8.8	1.1
Ireland	3.3	13.4	2.9	89.9	5,462.7	5.9	0.4
Israel	3.3	5.1	3.0	91.6	3,354.0	6.7	0.6
Italy	4.1	6.2	3.2	78.1	2,911.0	8.0	0.4
Netherlands	3.8	10.8	3.0	63.7	5,341.0	4.4	0.9
Portugal	5.3	7.0	3.5	82.0	2,222.0	8.0	0.7
Spain	4.4	5.9	3.0	75.9	2,716.8	8.1	0.6
Sweden	4.3	10.9	2.1		5,653.0	5.6	0.6

Bottom third

Middle third

Top third

Notes: Portugal data for physicians is those licensed to practice, so this is likely an overestimate. Portugal and Ireland data for nurses is those professionally active, so this may also be an overestimate. Finland data for average length of stay in hospital is from 2018. There are gaps in the table where there is no data or no recent enough data.

Sources: This table is reproduced from the Nuffield Trust (2022), Health system recovery from Covid-19: International lessons for the NHS (Nuffield Trust) report and has been updated with more recent data from Organisation for Economic Co-operation and Development and World Bank (Accessed on 22/08/24)

4. Changes in consultation rate by age and physical or mental health long-term condition status during the Covid-19 pandemic

Figure VI.4: Percentage change in consultation rate in 2020 compared to 2019, by number of pre-existing conditions and age
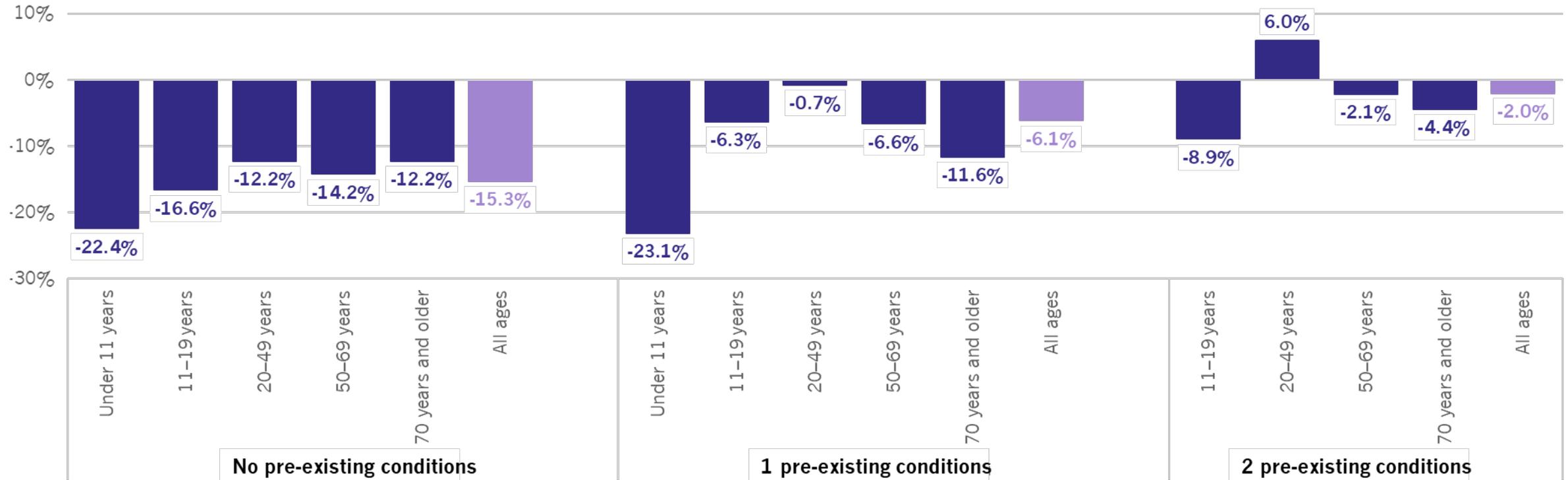
Notes: Data is unavailable for under 11-year-olds with two or more pre-existing conditions.

5. Percentage of patients reporting not having seen a doctor in the last 12 months

Figure VI.5: Percentage of patients aged 65+ reporting not seeing a doctor in the last 12 months, excluding any time they were hospitalised, 2017 and 2021
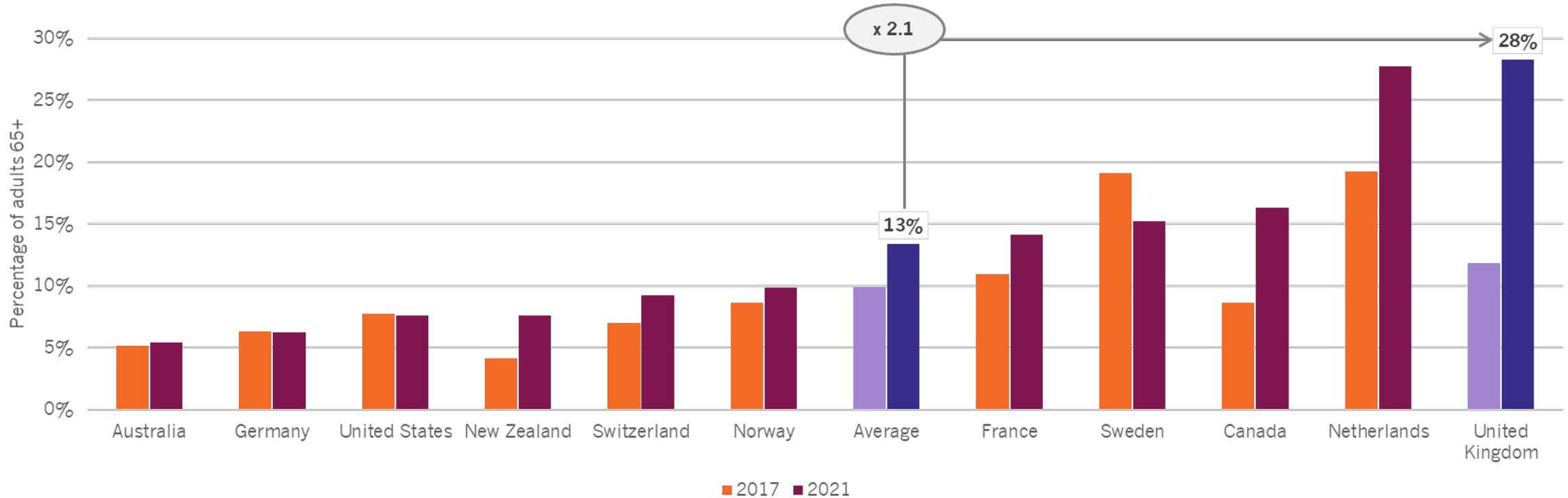
Notes: Responses to question: 'Not counting any time you may have been hospitalised, how many different doctors have you seen in the past 12 months?' Results from Sweden are not directly comparable with the UK's results. Self-reported from 1,876 UK residents aged 65+ and does not count time spent in A&E. This can include an in-person appointment or an appointment over the telephone or through video.

Source: Commonwealth Fund International Health Policy Surveys

6. Changes in hip and knee replacement surgeries from 2019 to 2020

Figure VI.6A: Hip replacement, percentage change between 2019 and 2020
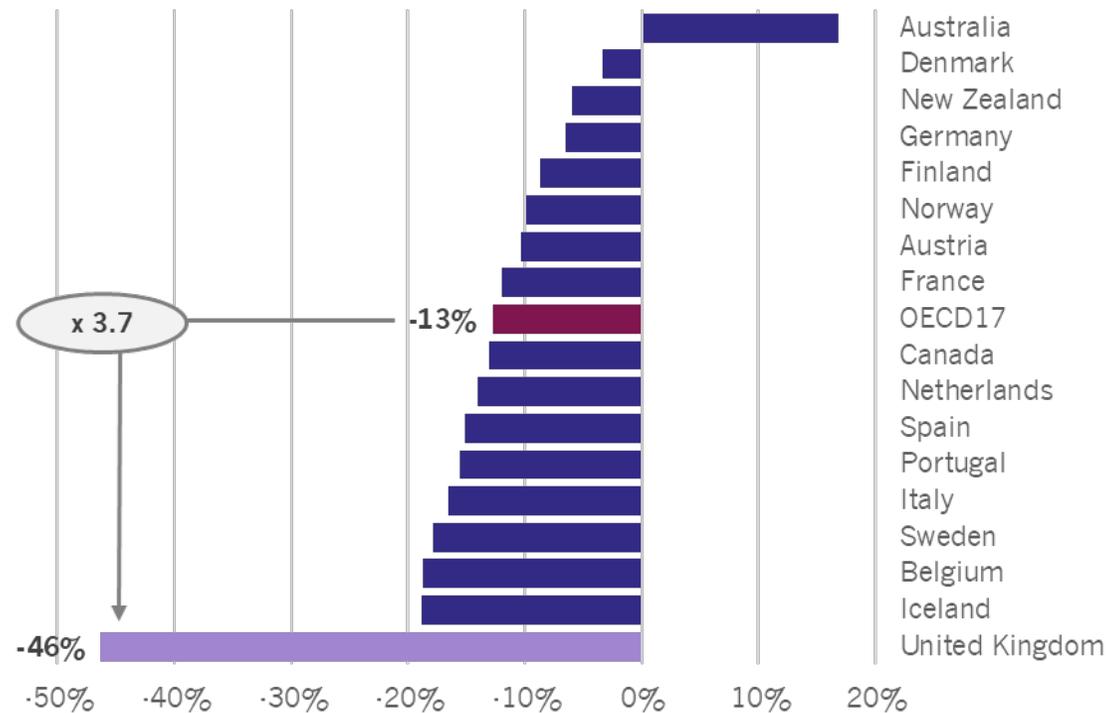
Figure VI.6B: Knee replacement, percentage change between 2019 and 2020

Notes: No data available for Greece or United States. Data for Ireland not included due to a change in data collection from 2020 to include procedures carried out in acute private hospitals.
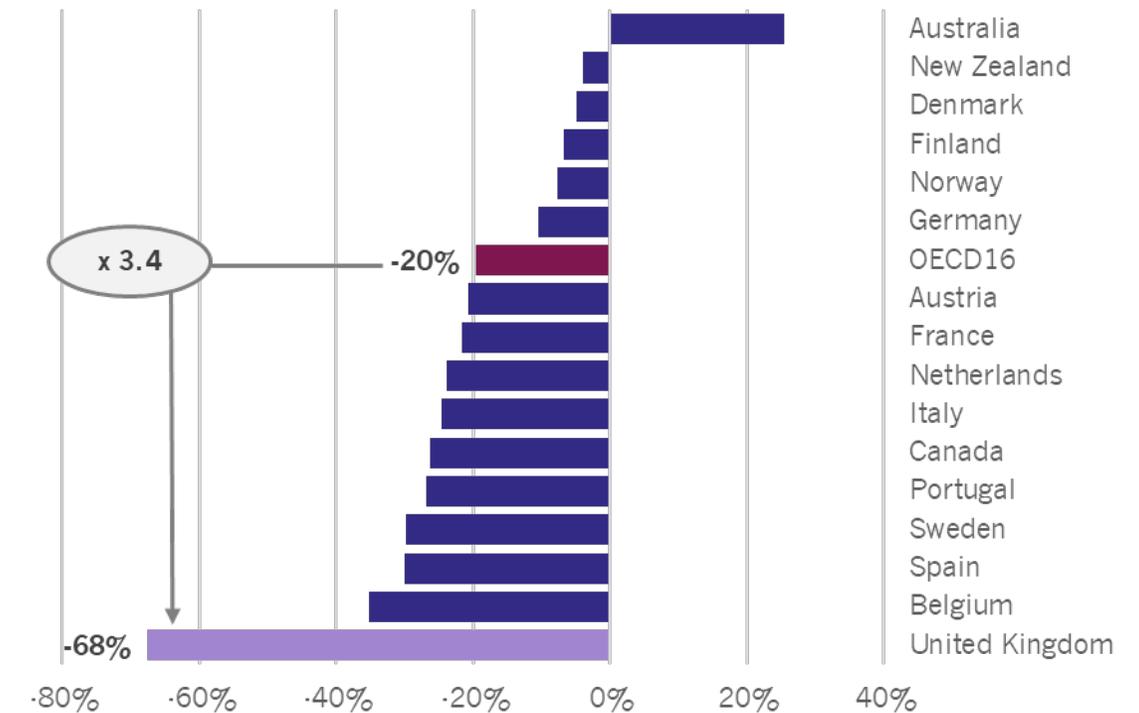
Notes: No data available for Greece, Iceland or United States. Data for Ireland not included due to a change in data collection from 2020 to include procedures carried out in acute private hospitals.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

7. Changes in cataract surgeries and mastectomy surgeries from 2019 to 2020

Figure VI.7A: Cataract replacement, percentage change between 2019 and 2020
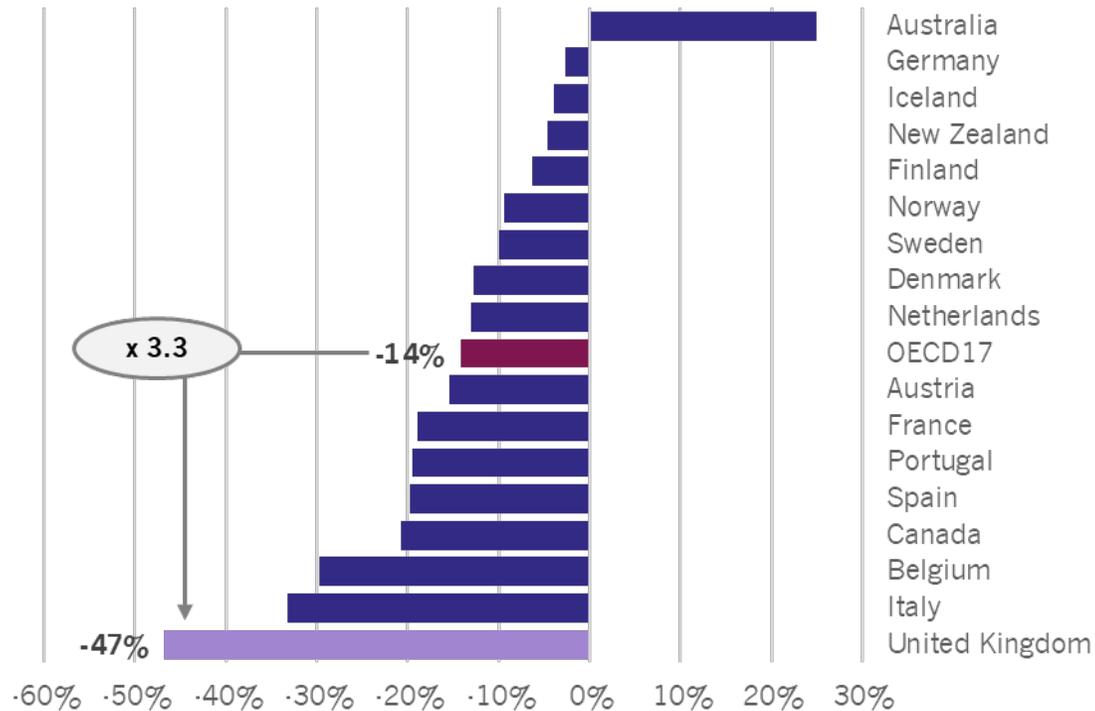
Figure VI.7B: Mastectomy, percentage change between 2019 and 2020
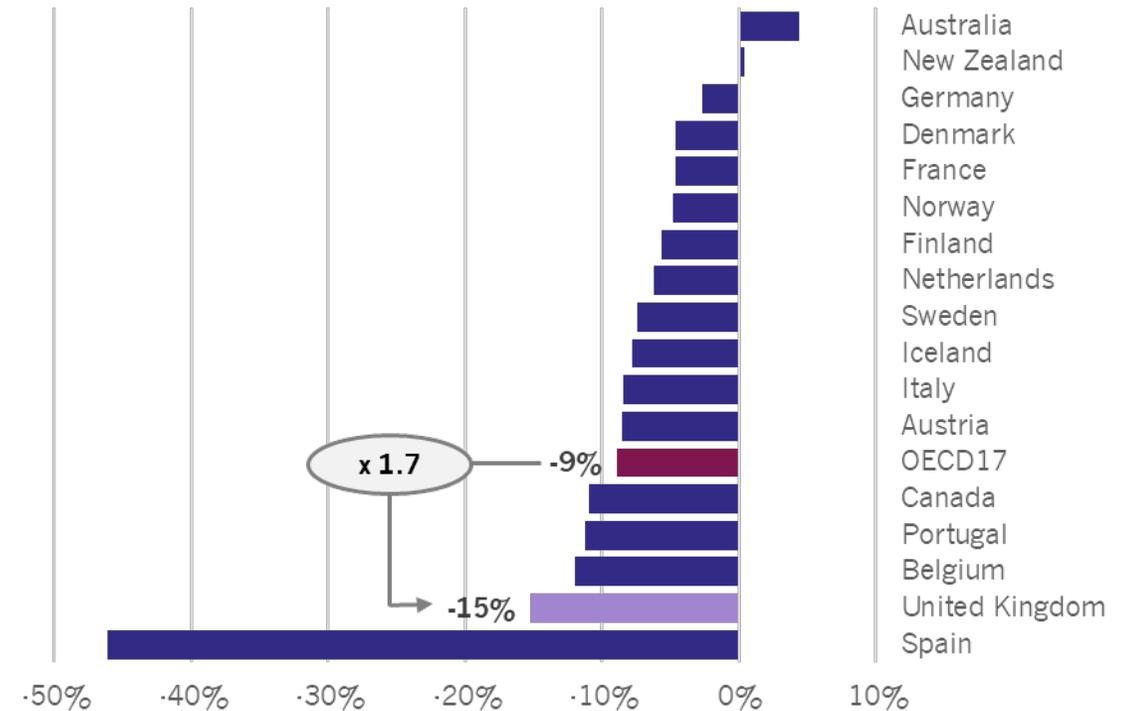
Notes: No data available for Greece or United States. Data for Ireland not included due to a change in data collection from 2020 to include procedures carried out in acute private hospitals.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

8. Changes in hospital discharges between 2019 and 2020

Figure VI.8: Change in hospital discharge rate per 100,000 population, percentage change between 2019 and 2020

Change in hospital discharge rate between 2019 and 2020
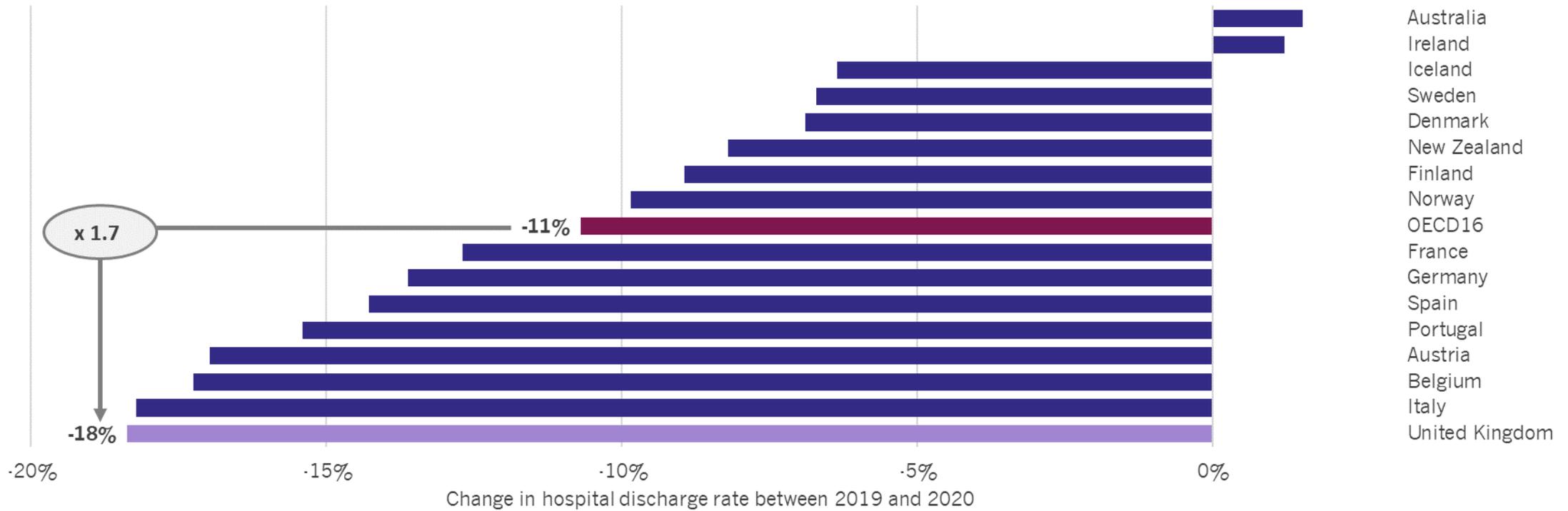
Notes: No data is available for Canada, United States, Greece or Netherlands.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

VII. Staff Engagement

1. Staff satisfaction

Figure VII.1: Staff satisfaction
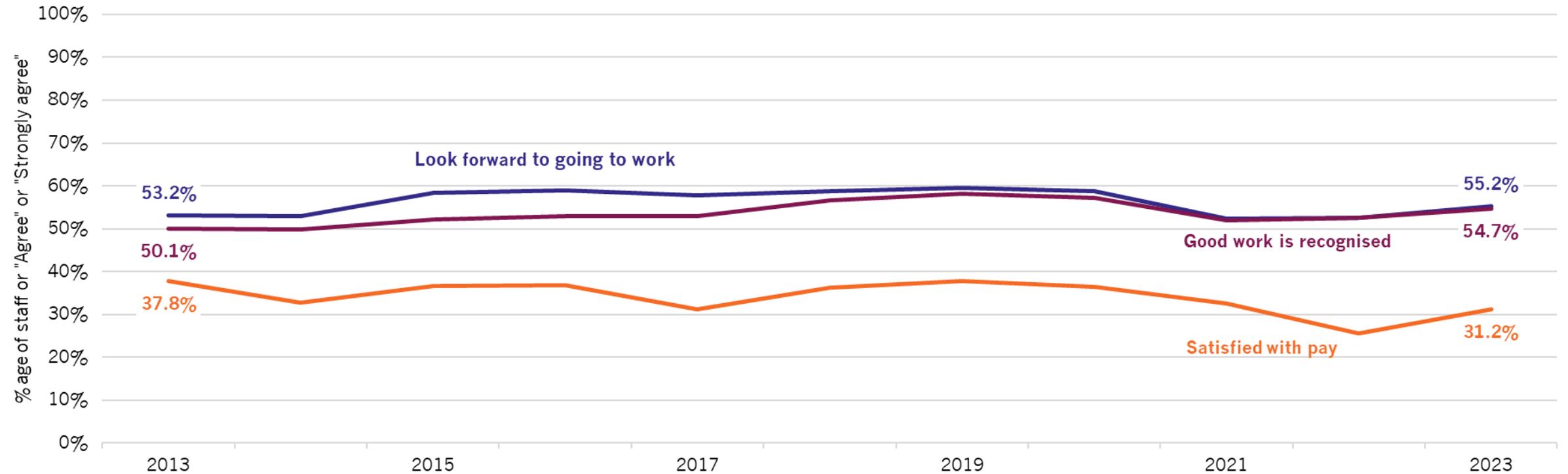
Notes: For the "Look forward to going to work" and "Good work is recognised" questions, the percentage shows those who responded "agree" or "strongly agree". For the "Satisfied with pay" question, the percentage shows those who responded "satisfied" or "very satisfied".

Source: Source: NHS England, NHS Staff Survey Data, Available: https://www.nhsstaffsurveys.com/results/

2. Staff recommending their organisation as a place to work and staff recommending their organisation as a place to receive care

Figure VII.2: Recommend as place to work or receive care, 2013 to 2023
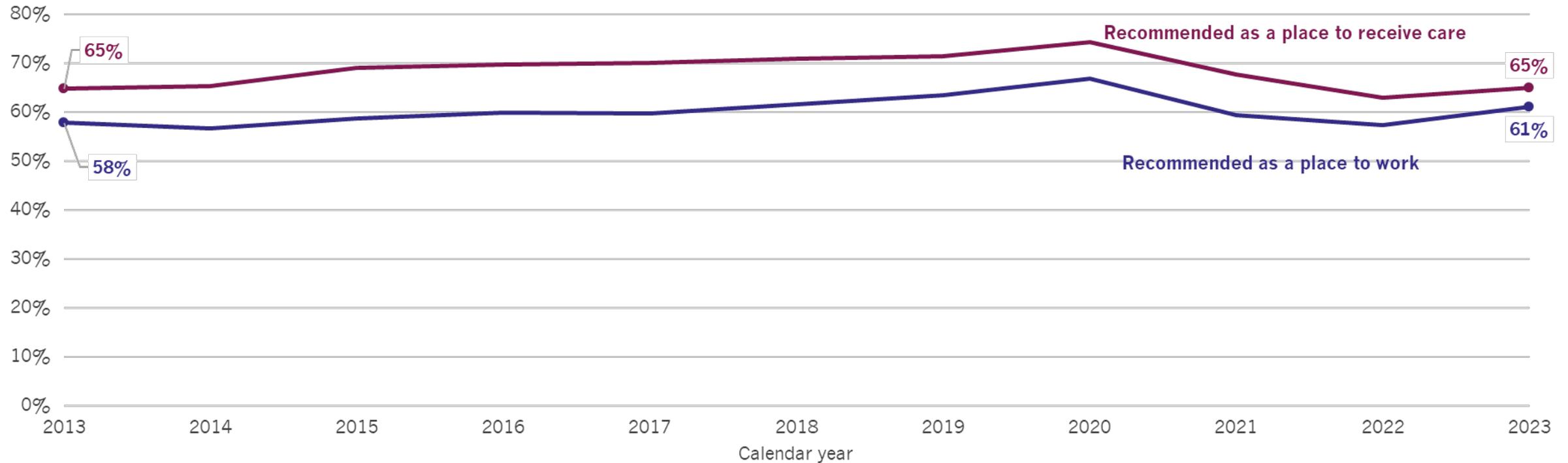
Notes: For the above questions, the percentage shows those who responded "agree" or "strongly agree".

Source: NHS England, NHS Staff Survey Data, Available: https://www.nhsstaffsurveys.com/results/

3. Changes in discretionary effort by role

Figure VII.3: Percentage change in unpaid hours, over and above contracted hours, by occupation group, between 2019 - 2023
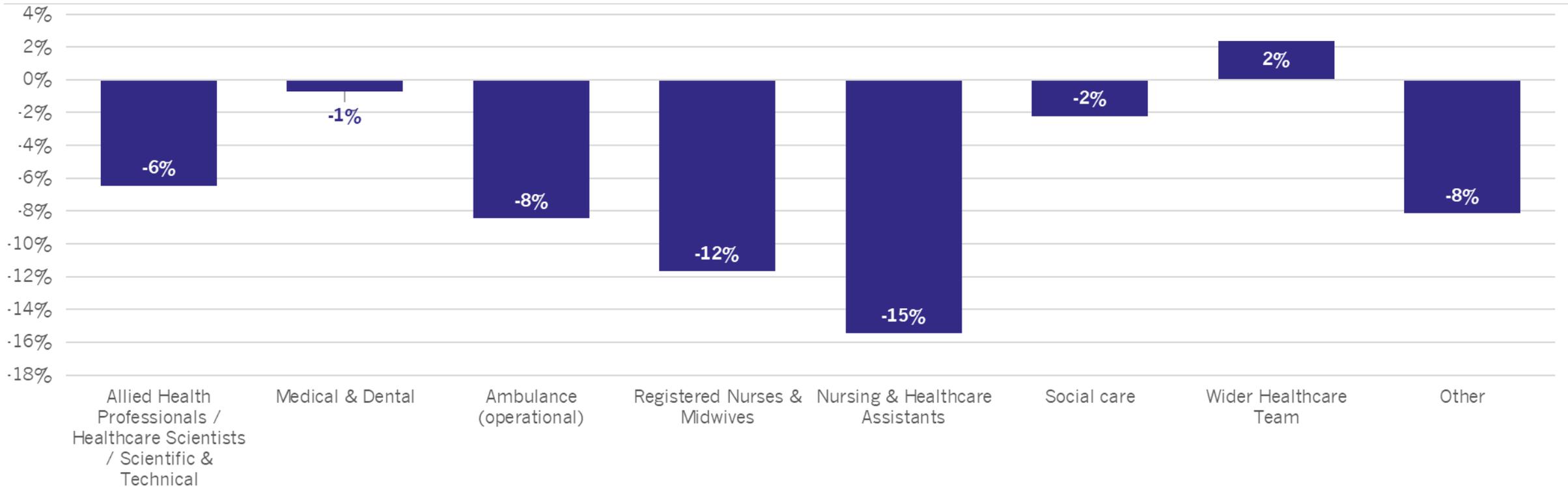
4. Changes in average days lost to sickness per FTE pre and post pandemic

Figure VII.4: Total days lost per year to sickness absence by staff group, 2016 to 2019 and 2023 to 2024
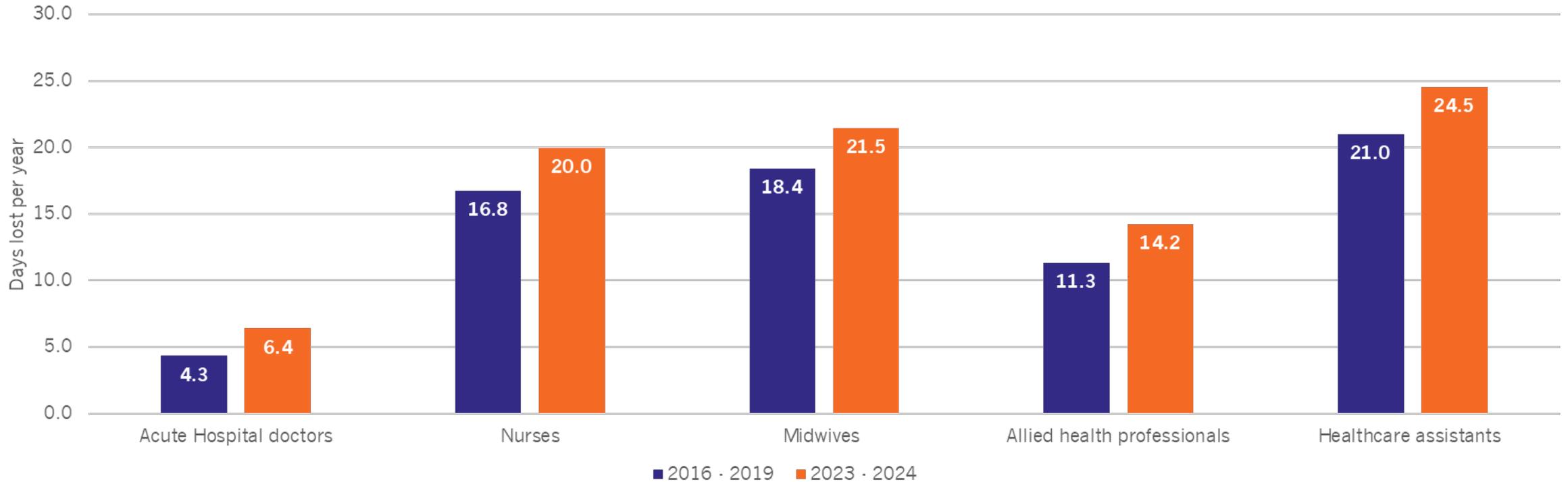
Notes: The above graph shows the total days lost due to sickness during the year. To convert monthly days lost to total annual days lost, we multiplied monthly days lost by 12.

Source: NHS England, Electronic Staff Record

5. Reasons for sickness absence, average number of sick days per month 2019/20 and 2023/24

Figure VII.5: Reasons for sickness absence, average number of sick days per month 2019/20 and 2023/24
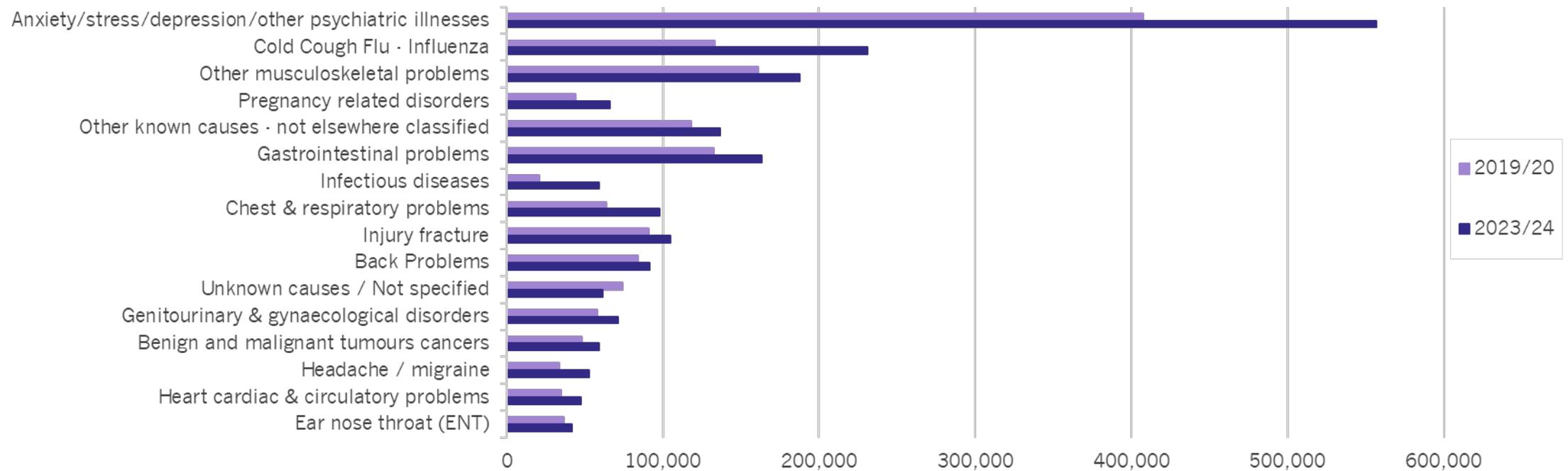
Notes: Between 2019 and 2022, the sickness absence rate in the NHS grew by 29%, In total across 2022, some 27 million days were lost to sickness absence, equivalent to 74,500 full-time staff, including some 20,400 nurses and 2,900 doctors. Reasons relating to cough, cold, and fu, infectious disease, and chest and respiratory problems are likely to capture Covid-10 absences (amongst other reasons) in 2022

Source: NHS England, NHS Digital, NHS Sickness Absence Rates · NHS England Digital Original visualisation credit to Nuffield Trust

6. NHS practitioner health registrations by year

Figure VII.6: NHS Practitioner Health registrations by year
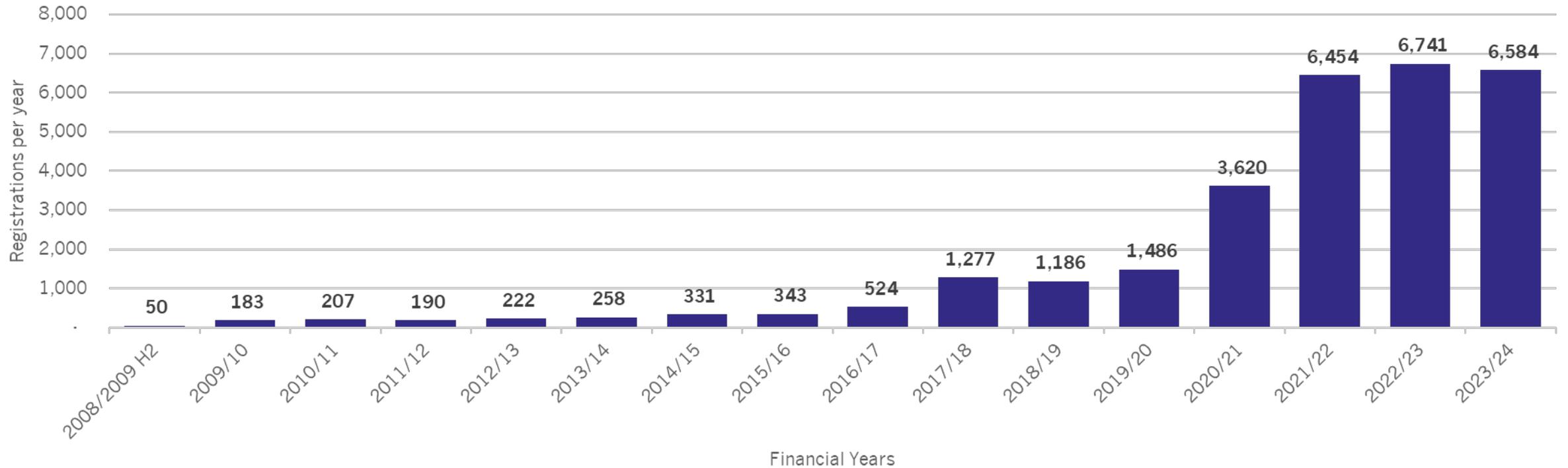
Source: NHS (2024), Fifteen Years of NHS Practitioner Health. Available at: NHS Practitioner Health

7. NHS practitioner health proportion of registration diagnosed with anxiety and/or depression

Figure VII.7A: GAD7 scores assessing severity of generalised anxiety disorder
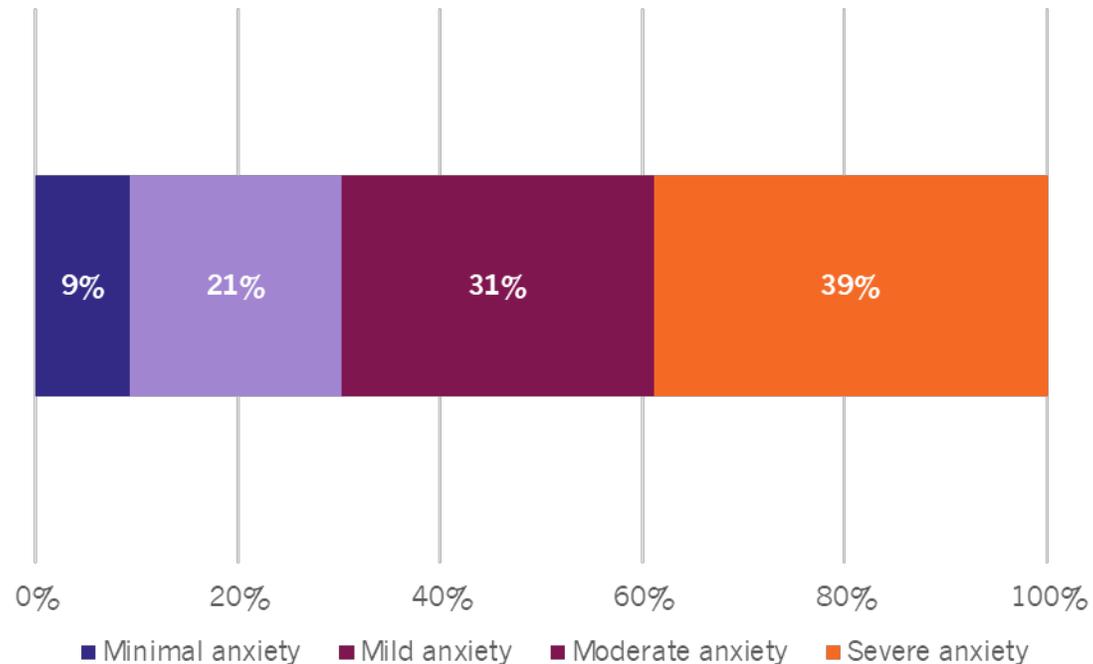
Figure VII.7B: PHQ9 scores – assessing severity of depression.
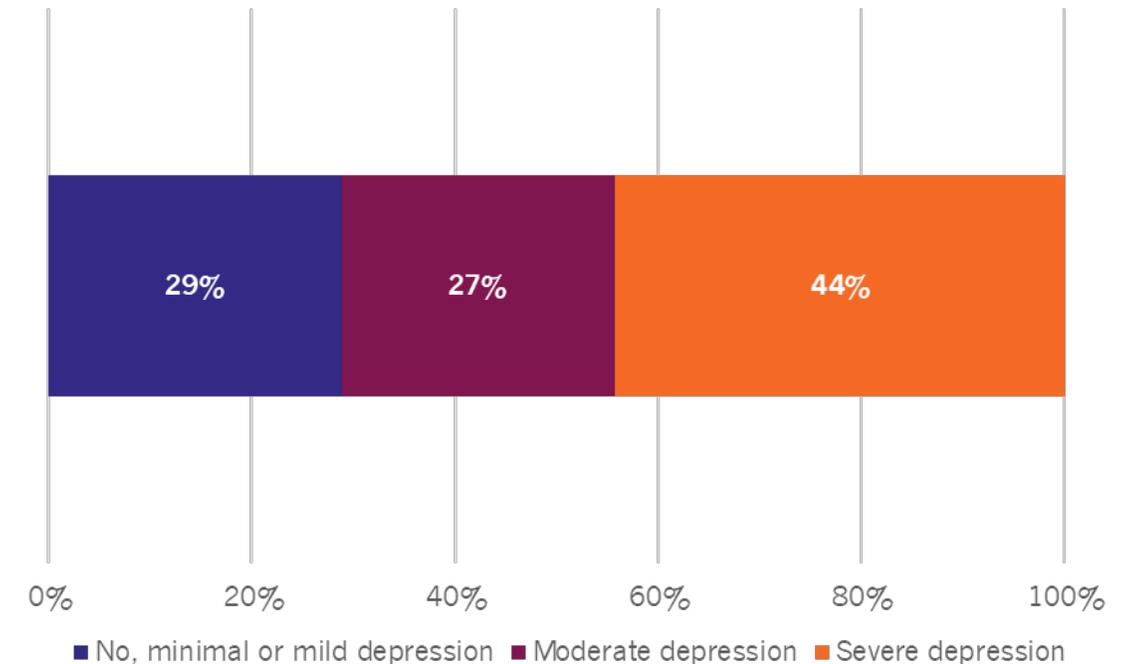
Notes: The generalised anxiety disorder questionnaire (GAD-7) assesses the severity of generalised anxiety disorder. The Patient Health Questionnaire (PHQ-9) assesses the severity of depression.

Source: NHS (2024), Fifteen Years of NHS Practitioner Health. Available at: NHS Practitioner Health

8. NHS Staff staying in post over the previous 12 months by staff group

Figure VII.8: NHS staff staying in post over the previous 12 months, by staff group, Sep 2010 to Mar 2024

	CAGR
Doctors	0.06%
Nurses and health visitors	-0.07%
Total	-0.02%
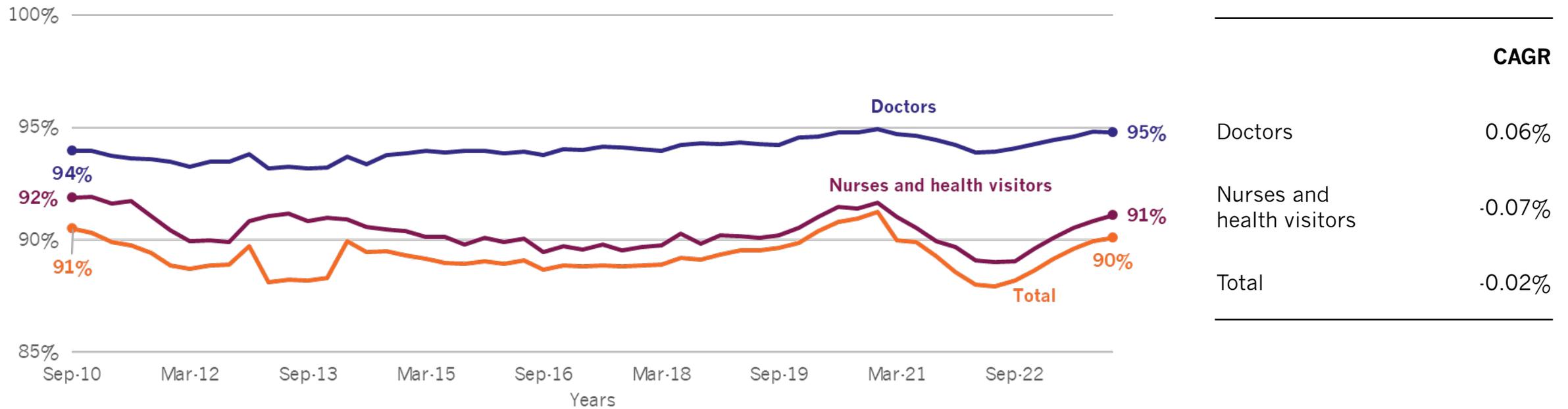
Notes: The % of staff staying in post (or "stability index") is calculated by dividing the number of leaver FTE in a rolling 12-month period by the average staff in post FTE at the start and end of the period, subtracted from 1. "Doctors" refer to all doctors working in Hospital and Community Healthcare Services (HCHS) but excluding those in training.

Source: NHS HCHS staff in NHS Trusts and core orgs March 2024 · Turnover tables https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

9. NHS Staff with bank contracts

Figure VII.9: Staff on Bank April 2016-May 2024
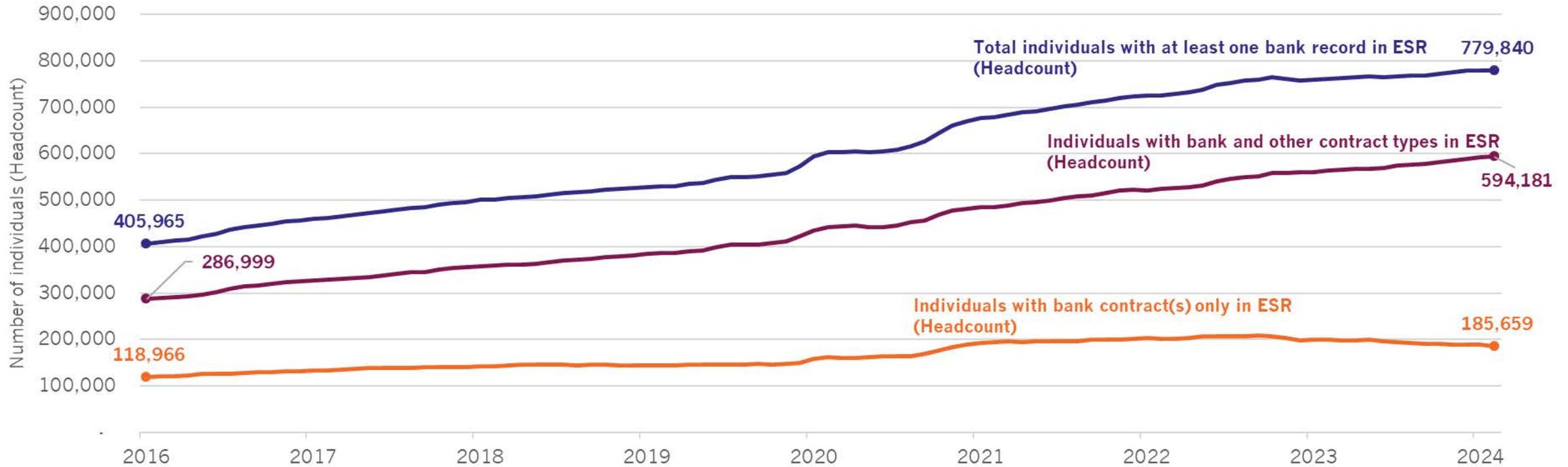
Notes: The latest data available is for the month of May 2024 and is readily available within NHS England systems from April 2016 onwards.

Source: *NHS England*, Electronic Staff Record

10. Total numbers of bank and agency shifts over time

Figure VII.10: Bank and Agency Shifts from April 2017 to May 2024
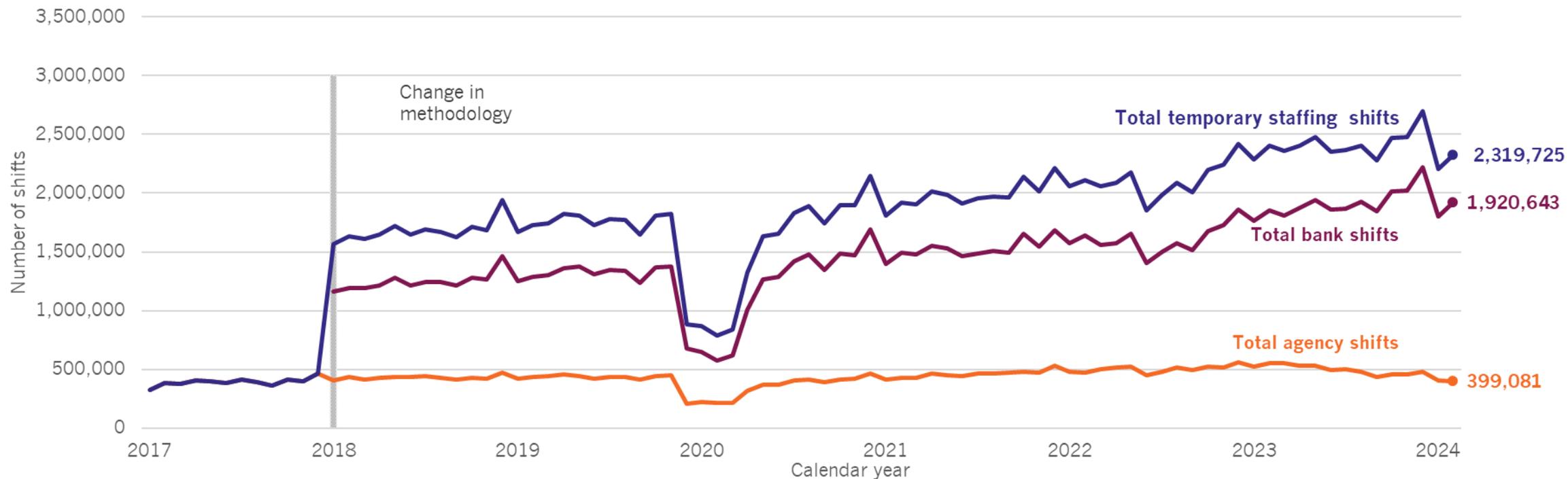
Notes: bank data only available from April 2018 onwards, agency data from April 2017 onwards. Between the period March 2020 and July 2020, the submission process for bank and agency usage was relaxed to reduce burden on trusts at this time. Data drawn exclusively for this period shows a marked decrease in shift numbers across these five months and will not accurately reflect usage at this time.

Source: *NHS England*, Electronic Staff Record

11. Total annual spending on agency staff for acute trusts

Figure VII.11: Agency Expenditure for Acute Trusts, by financial year

Average yearly spend 2017/18 – 2018/19: £1,885m

2019/20 – 2023/24 average yearly spend: £2,061m
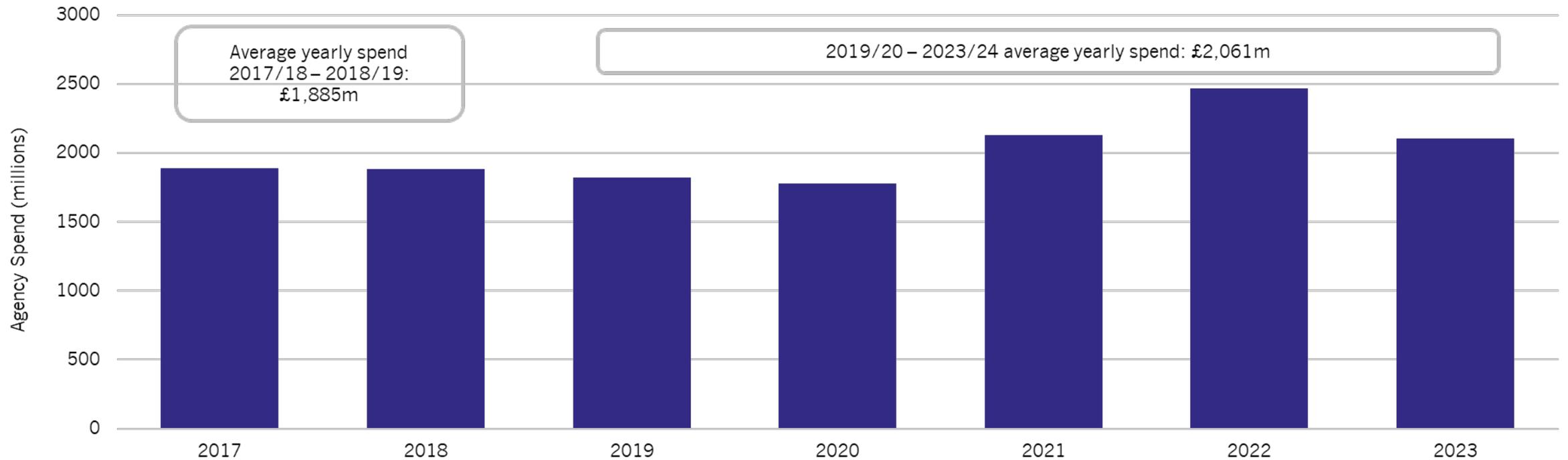
Source: NHS England. NHS England analysis of provider monthly financial submission.

VIII. Where and how the money is spent

1.1 NHS resources by setting

Figure VIII.1.1: Estimation of NHS group spend by healthcare service

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Other	3%	3%	2%	3%	3%	3%	3%	3%	4%	2%	2%	6%	7%	7%	8%	8%	8%	8%	10%	8%
Community health services	7%	7%	7%	8%	9%	9%	9%	10%	10%	9%	9%	9%	9%	10%	8%	8%	8%	8%	8%	7%
Mental Health Services	13%	13%	13%	13%	13%	14%	14%	13%	10%	9%	10%	9%	9%	9%	8%	9%	9%	9%	9%	9%
Primary Care Services	27%	29%	29%	28%	28%	27%	26%	25%	24%	24%	24%	22%	21%	21%	20%	19%	19%	18%	18%	18%
Acute Services	49%	48%	49%	48%	47%	48%	48%	50%	53%	55%	56%	54%	54%	54%	56%	56%	56%	57%	56%	58%

Notes: There are two natural breaks in the data due to changes in methodology, with new methods being introduced in 2010/11 and 2013/14, and so the data should be strictly considered as three separate timeseries.

Source: Department of Health and Social Care and NHS England. Bespoke analysis of published data from of NHS Summarised Accounts, DH/DHSC Annual Reports and Accounts, NHS National Cost Collection.

1.2 Average NHS spend per NHS provider

Figure VIII.1.2: Average NHS spend per NHS provider (cash terms)
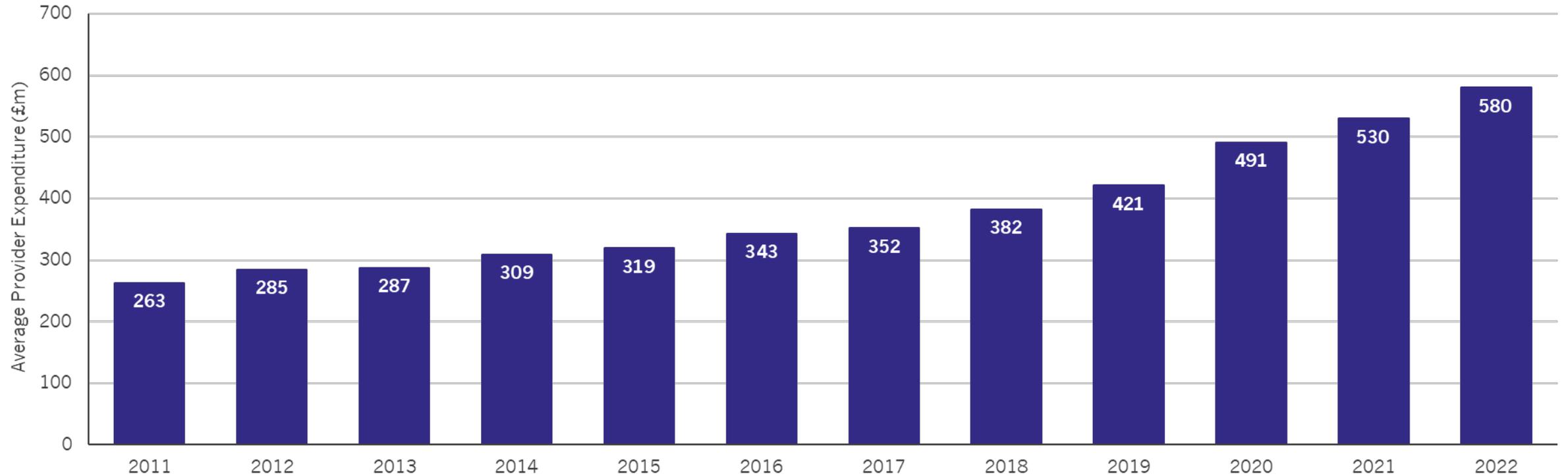
Notes: DH/DHSC data on gross expenditure used to calculate average NHS spend per provider.

Source: *Department of Health and Social Care and NHS England*. NHSE analysis of published data from DH/DHSC Annual Reports and Accounts.

1.3 Care integration

Figure VIII.1.3: Google Trends for 'NHS integrated care' compared patient responses to ''How often does your regular doctor or someone in your doctor's practice help coordinate or arrange the care you receive from other doctors and places?'' (% of respondents 'always' and 'often')
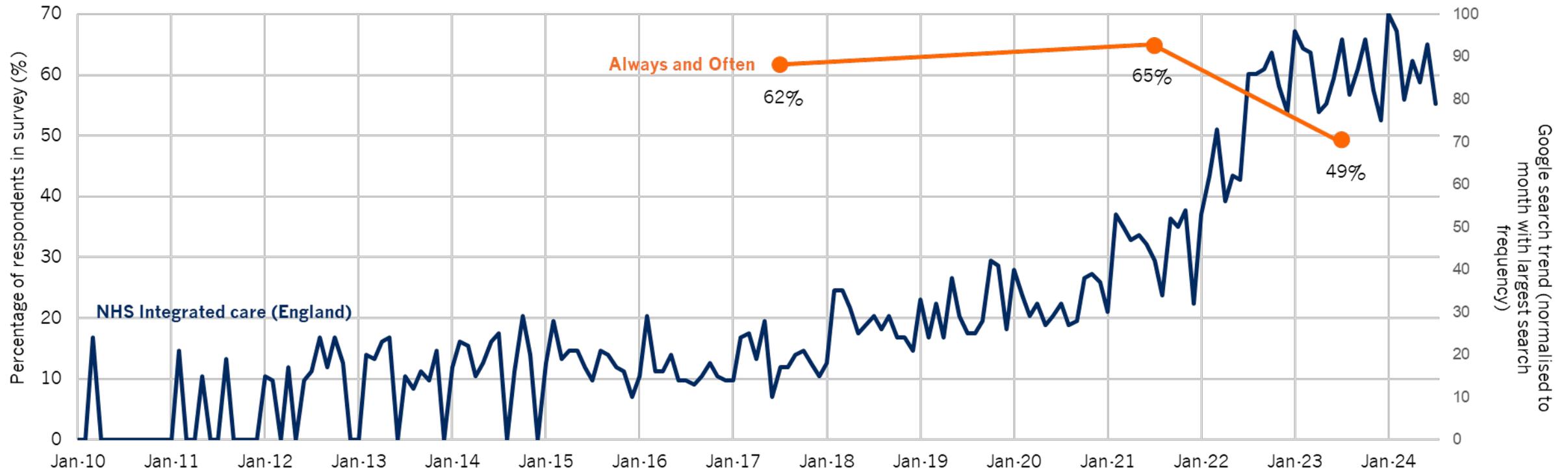
Notes: Commonwealth Fund Survey: Sample sizes: 753 (2017), 1,876 (2021), 3,361 (2023). Results were weighted.

2.1 Overall NHS workforce over time

Figure VIII.2.1: Hospital and Community Health Services (HCHS) staff by staff group, in NHS Trusts and other core organisations, March 2010 to 2024
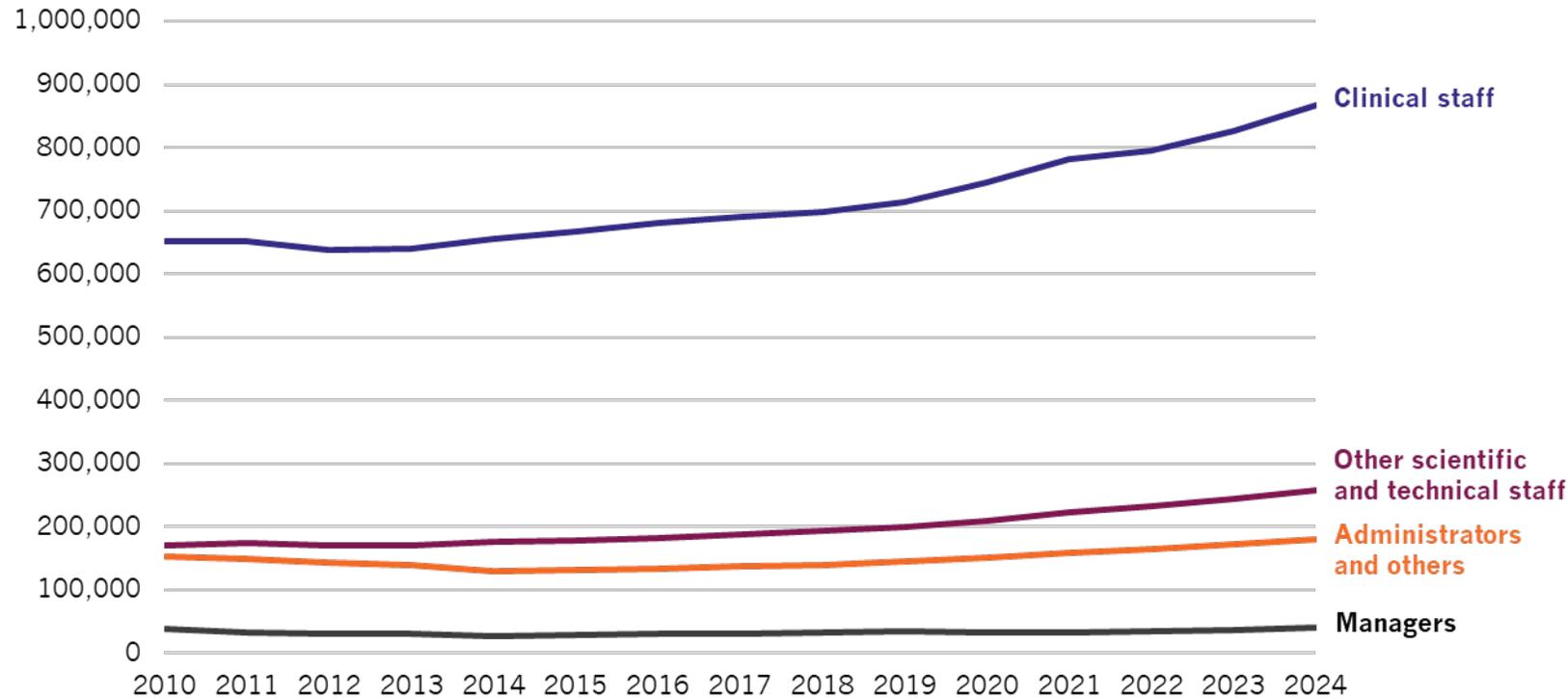
CAGRs	2010-2016	2016-2020	2020-2022	2022-2024
Clinical staff	0.7%	2.3%	3.3%	4.5%
Other scientific or technical staff	1.2%	3.5%	5.3%	5.3%
Administrators and others	-2.4%	3.3%	3.9%	4.8%
Managers	-4.0%	2.4%	3.6%	5.8%

Notes: Data from March in each year (every year 2010-2024).

Source: NHS England. *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics*. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2.2 Overall NHS clinical workforce over time

Figure VIII.2.2: Hospital and Community Health Services (HCHS) professionally qualified clinical staff by staff group, in NHS Trusts and other core organisations in England, March 2010 to 2024
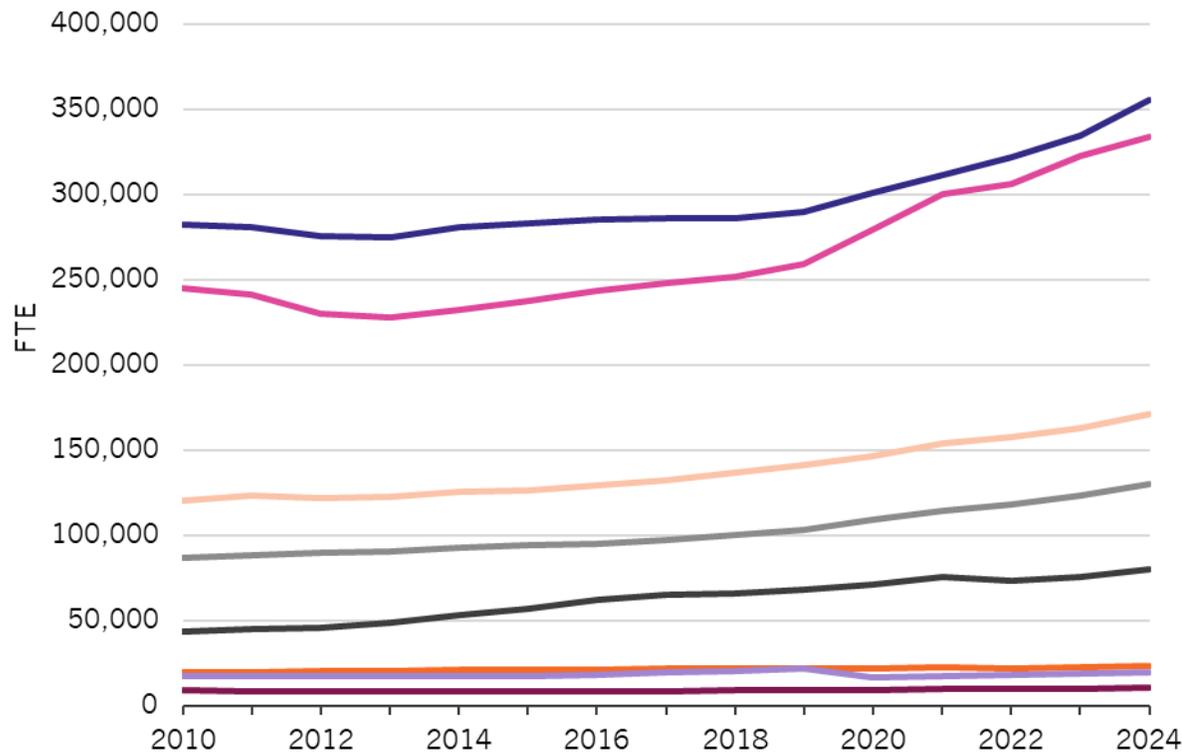
CAGRs	2010 - 2016	2016 - 2020	2020 - 2022	2022 - 2024
Nurses & health visitors	0.2%	1.3%	3.5%	5.1%
Support to clinical staff (excl. HCAs)	-0.1%	3.5%	4.7%	4.5%
Scientific, therapeutic & technical staff	1.2%	3.2%	3.8%	4.2%
HCHS doctors (excl. MH doctors)	1.6%	3.4%	4.2%	4.7%
Healthcare Assistants	6.1%	3.5%	1.5%	4.4%
Midwives	1.7%	0.8%	-0.2%	3.7%
Ambulance staff	0.8%	-2.2%	3.7%	5.3%
Mental Health doctors	-0.4%	1.7%	3.4%	4.8%

Notes: Data from March in each year (every year 2010-2024).

*Ambulance Staff reclassified April 2019

2.3 Total factor productivity for the NHS in England and the whole UK economy

Figure VIII.2.3: Total factor productivity level for the NHS in England, wider public sector in England and the whole UK economy

CAGRs	NHS	Wider public	Whole economy
1997-2000	0.3%	-0.9%	2.1%
2000-2005	1.3%	-1.3%	1.8%
2056-2010	0.3%	-1.3%	-0.1%
2010-2015	1.8%	0.7%	0.2%
2015-2019	0.1%	1.4%	0.2%
2019-2021	-3.4%	-3.9%	0.8%
1997-2021	0.5%	-0.6%	0.8%
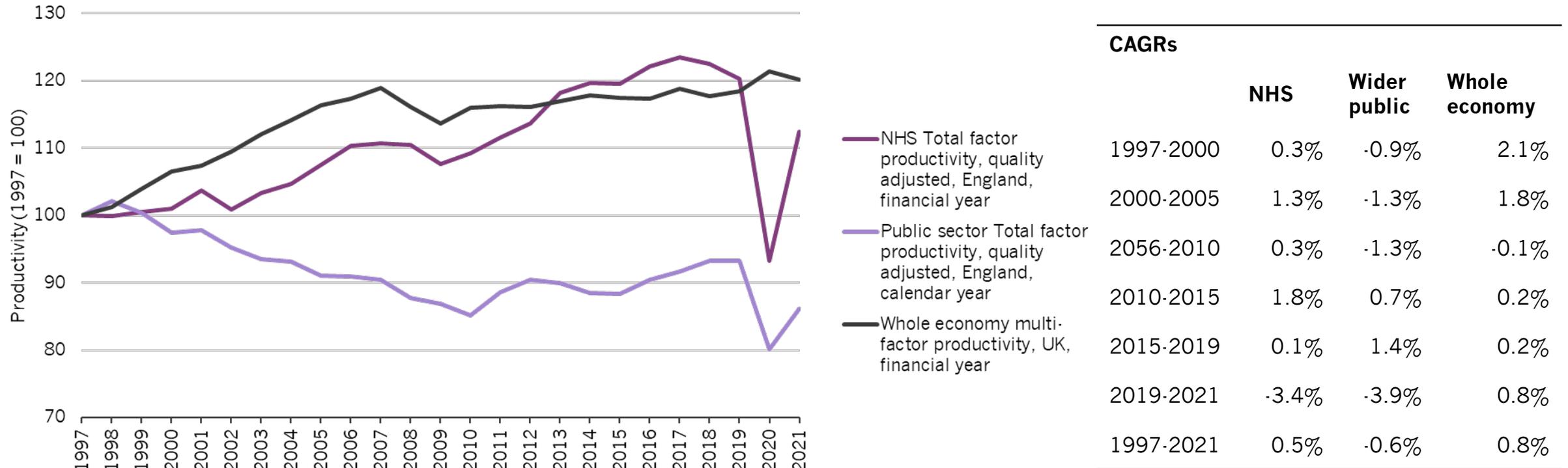
Notes: Data is provided by financial year for some data (see chart), all presented here as calendar years for simplicity

Source; NHS: Office for National Statistics (March 2024) Available at:
https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/datasets/publicserviceproductivityestimateshealthcareengland. Wider public sector: Office for National Statistics (March 2024) Available at:
https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/datasets/publicserviceproductivityestimatestotalpublicservice (excludes sectors for which inputs = outputs). Whole economy: Office for National Statistics (March 2024) Available at:
https://www.ons.gov.uk/economy/economicoutputandproductivity/productivitymeasures/datasets/growthaccountingquarterlyuk

2.4 Total factor productivity for the NHS in England

Figure VIII.2.4: Total factor productivity level for the NHS in England
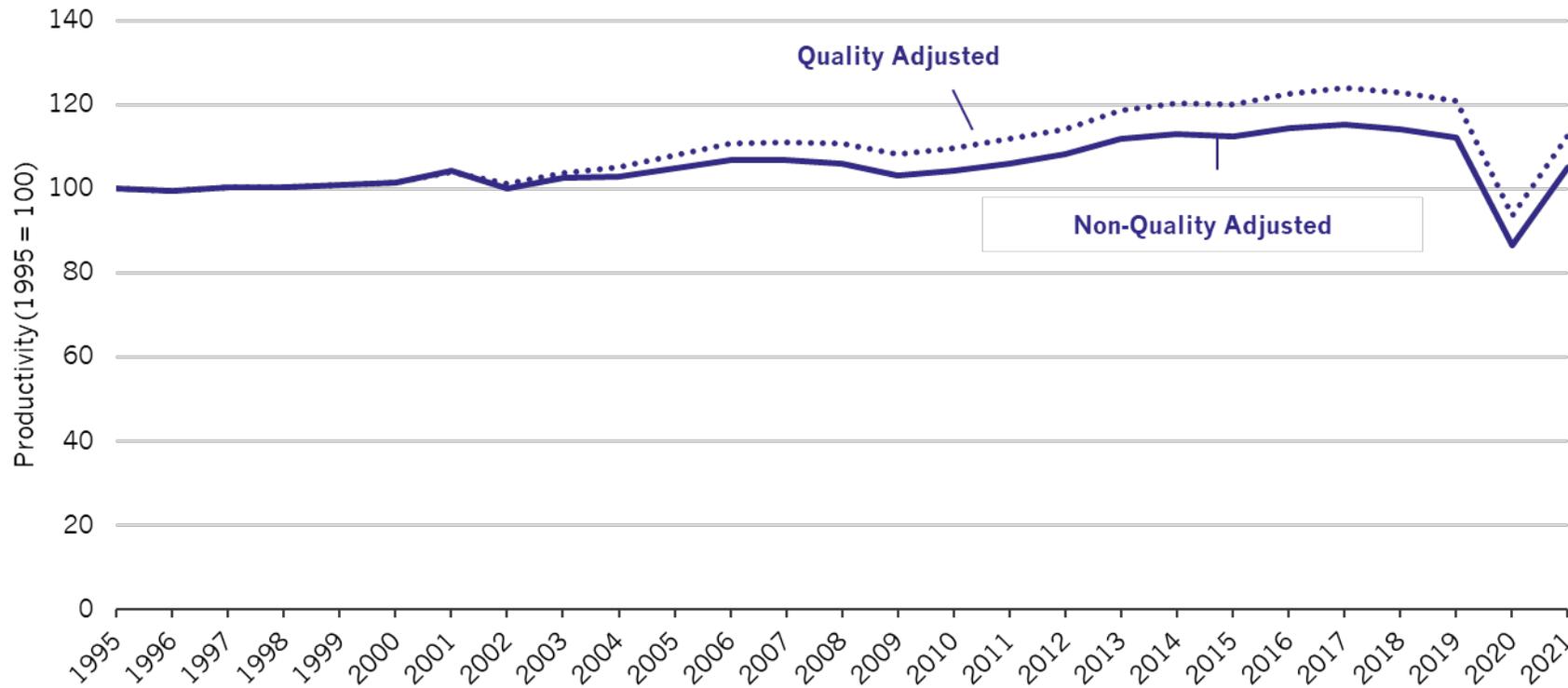
CAGRs		
	Quality Adjusted	**Non-Quality Adjusted**
1995-2000	0.3%	0.3%
2000-2005	1.3%	0.7%
2056-2010	0.3%	-0.1%
2010-2015	1.8%	1.5%
2015-2019	0.1%	-0.1%
2019-2021	-3.4%	-3.2%
Whole period	0.5%	0.2%

Notes: data is provided by financial year, presented here as calendar years for simplicity. Activity coding changes occur regularly, which can have a substantial impact on output counts.

Source: Office for National Statistics (March 2024), Available at:
https://www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/datasets/publicserviceproductivityestimateshealthcareengland

3.1 International comparison of GPs per 1,000 population

Figure VIII.3.1: Number of GPs per 1000 population, 2023 (or nearest year)
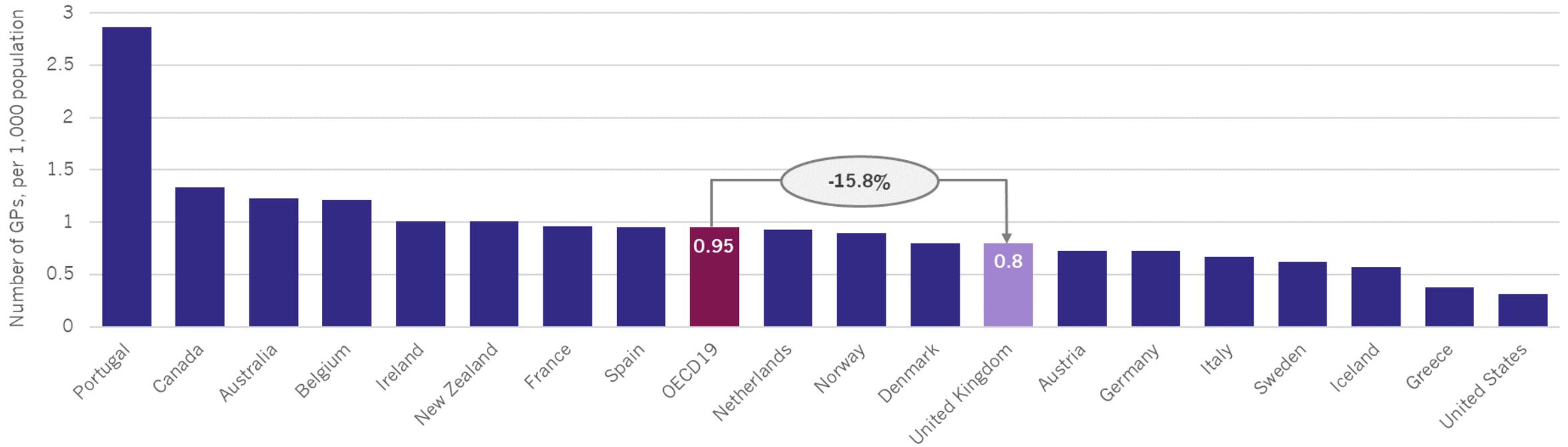
Note: Data for Sweden and Denmark is from 2021, Iceland, Austria, UK, Norway, New Zealand and Ireland is from 2023, and all other countries is from 2022.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

3.2 Number of full-time equivalent GPs per 100,000 registered patients

Figure VIII.3.2: Number of GPs FTE per 100,000 registered patients, by GP type – March 2016 to March 2024

	March 2016-2020	March 2020-2022	March 2022-2024	March 2016-2024
All GPs	-2.5%	-1.0%	-1.8%	-1.9%
GP Partners	-5.4%	-4.2%	-3.7%	-4.7%
Salaried GPs	3.9%	5.3%	2.0%	3.8%
GP Trainees	3.8%	12.7%	7.0%	6.7%
Locum GPs	7.3%	0.1%	-6.9%	1.8%

Notes: Comparable information with the requested GP role breakdowns is not available prior to September 2015. To align with secondary care charts and requested time periods, data presented from March 2016 to March 2024. The analysis covers all GP partners, salaried GPs and locum GPs working in General Practice. GP locum figures represent 'Regular' locums up to September 2017, with 'Ad-hoc' locum FTE also included from December 2017. 'Regular' locums are defined as GPs based in a practice to cover long-term absences such as maternity leave or a vacancy, or they may cover one or more ses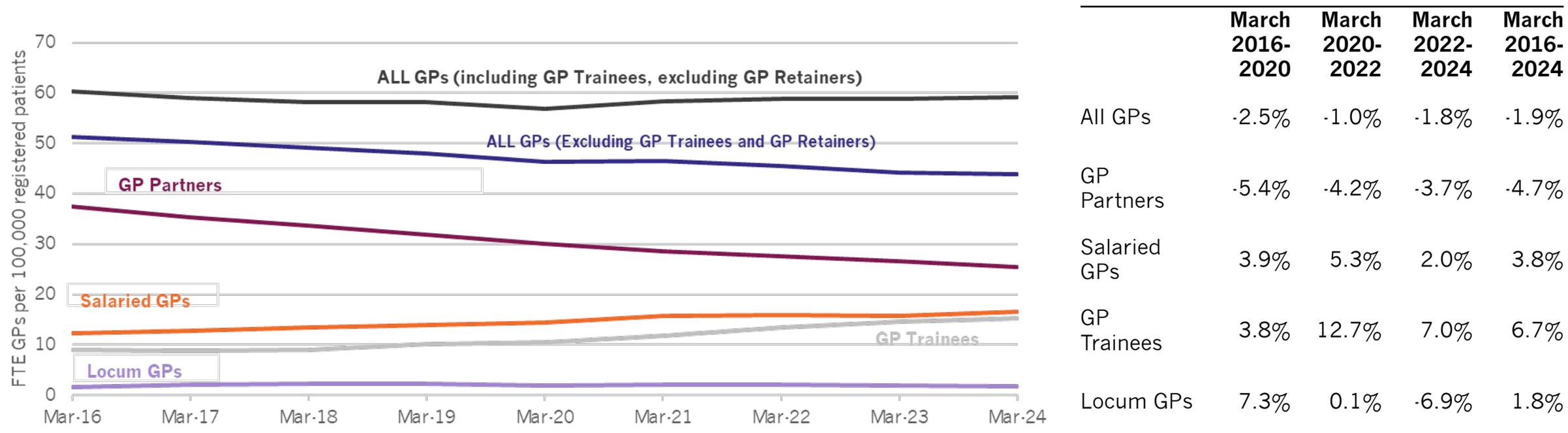sions on a planned or regular basis. Since the autumn of 2017, data has been collected about 'ad-hoc' locum GPs. These are locum or sessional GPs who typically work briefly at practices to cover for short-term or unexpected absences. Data are available monthly from July 21 but March of each year is shown. GPs working in Primary Care Networks are not included, nor are GP retainers employed by practices. Data relates to the last day of the applicable month.

Source: NHS England (2024) General Practice Workforce series. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services

3.3 Drivers of primary care drug spend

Figure VIII.3.3: Drugs spend in primary care with aggregate drivers of price, volume and product mix, expressed as an index with base = Q1 2015/16

Spend is net of commercially negotiated central rebates but gross of rebates from branded medicines affordability mechanisms.

Indices

- **Price Index**: a measure of the change in prices paid for prescriptions, holding constant any change in the medicines prescribed

- **Volume Index:** a measure of the change in overall prescription volumes, unweighted by prices so it captures the pure effect of underlying shifts in prescription volumes

- **Product Mix**: a measure of the change in the average unit cost, with prices and overall volumes held constant. It captures the impact from a shift in the composition of the products prescribed. An increase in the product mix shows that the composition of products prescribed is shifting, on average, to more costly ones.

Notes: Actual values are excluded due to potential commercial confidentiality considerations. Spend = Actual Cost - Commercially negotiated central rebates. Central rebates: data collected by NHS England and available publicly in aggregate in: Prescribing Costs in Hospitals and Community; Volumes = Prescription Items; Price index calculated by NHS BSA for NHS England and not publicly available; Product mix calculated by NHS England based on spend, volume and price indexes. Data only available from 2015/16.

Source: NHS BSA (2024) *NHS BSA epact2* for all data except central rebates which is provided by NHSE Finance. Available at: https://www.nhsbsa.nhs.uk/access-our-data-products/epact2

4.1 International comparison of nurses and midwives working outside hospitals

Figure VIII.4.1: Practicing nurses and midwives per 1,000 inhabitants outside of hospital, 2023 (or nearest year)
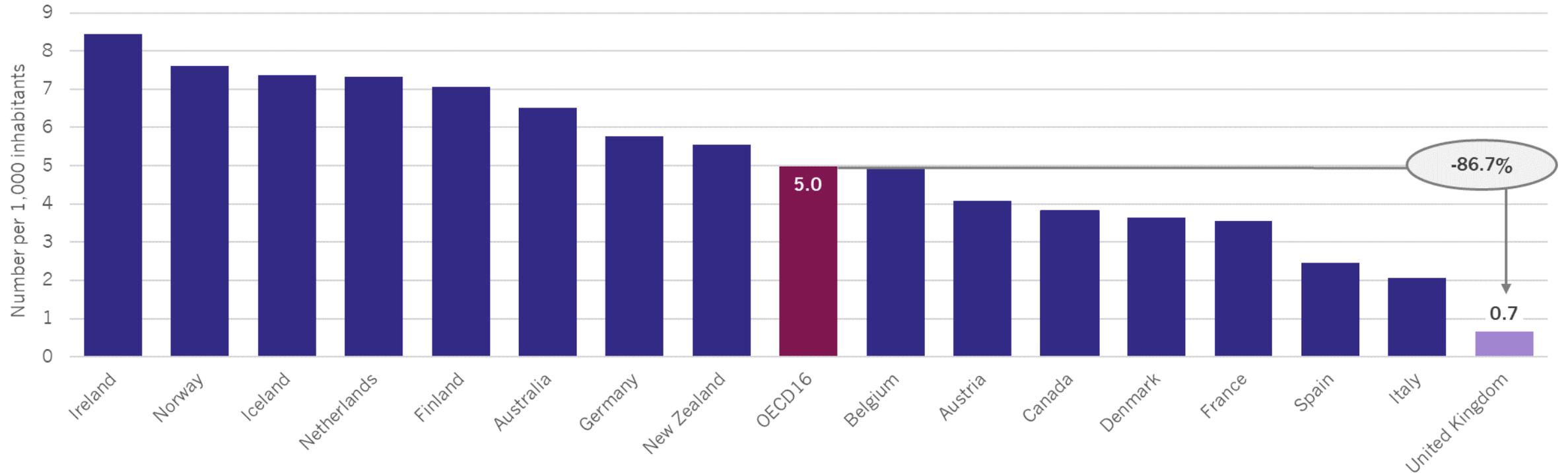
Notes: These figures were calculated by subtracting hospital nurses and midwifes per 1000 from total nurses and midwifes per 1000 inhabitants. Data not available for Greece, Sweden & United States. Belgium data is 2018; Iceland data is 2020; Finland data is 2021; Ireland, New Zealand, UK and Norway data is 2023; Remaining countries' data is 2022. UK data follows a different definition to that of other countries.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

4.2 Changes in the community services workforce

Figure VIII.4.2: Percentage change in FTE for Community staff, by staff group - March 2017 to March 2024
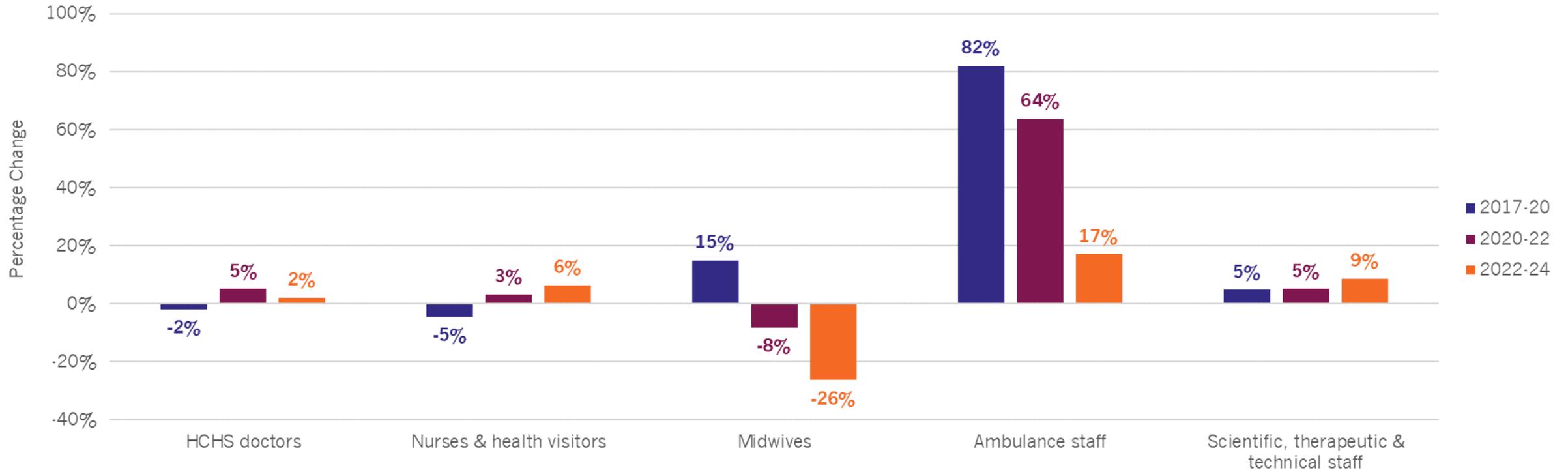
Notes: Recoding may impact staff numbers; Further information on these changes can be found in version 16.1 of the NHS Occupation Code Manual: NHS Occupation Codes. Staff group classifications: Consultant includes HCHS Doctors with a Grade of Consultant; Junior doctors includes HCHS Doctors with a Grade in: Core Training, Foundation Doctor Year 1, Foundation Doctor Year 1, Specialty Registrar; Staff Grade doctors includes HCHS Doctors with a Grade in: Associate Specialist, Hospital Practitioner / Clinical Assistant, Other and Local HCHS Doctor Grades, Specialty Doctor, Staff Grade; Nurses & health visitors includes the Nurse & health visitor staff group; Midwives includes the Midwives staff group; Ambulance staff includes those with a staff group of Ambulance staff; Scientific, therapeutic & technical staff includes those with a staff group of Scientific, therapeutic & technical staff

Source: NHS England (2024) *Electronic Staff Record.*

4.3 Community nurses in post

Figure VIII.4.3: Community Nurses (FTE) over time (April 2016 – May 2024)
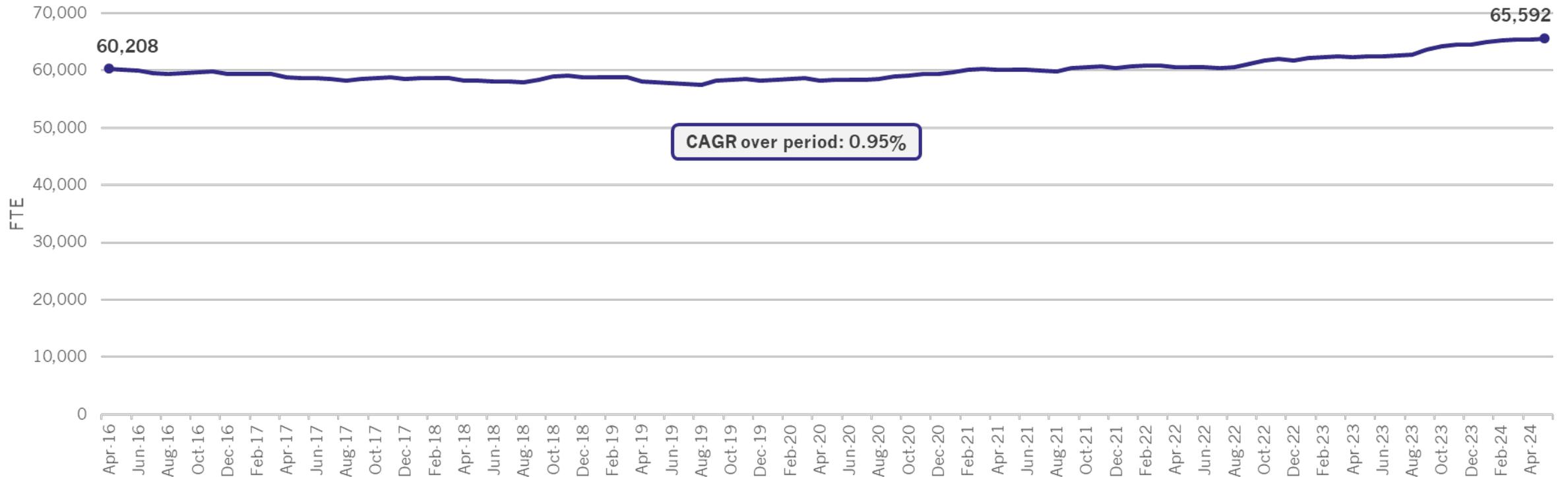
Notes: Community Nurses are defined using a different definition than published data. It uses a combination of occupation code, job role, and area of work in line with the definition used In LTWP

Source: NHS England (2024) *Electronic Staff Record.*

4.4 District nurses in post

Figure VIII.4.4: District Nurses (FTE) over time (April 2016 – May 2024)

CAGR over period: -0.8%
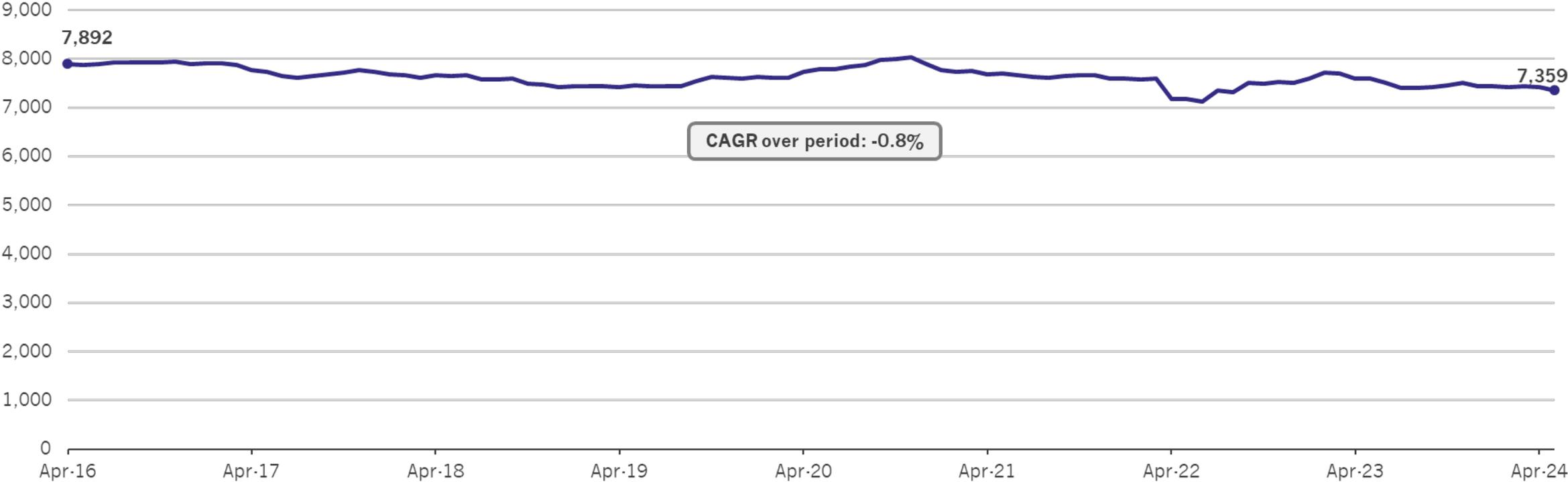
Source: NHS England (2024) *Electronic Staff Record.*

4.5 Change in the numbers of nurses by setting and by region

Figure VIII.4.5: Change in the number of nurses in hospital, community and general practice settings, December 2019 – September 2023
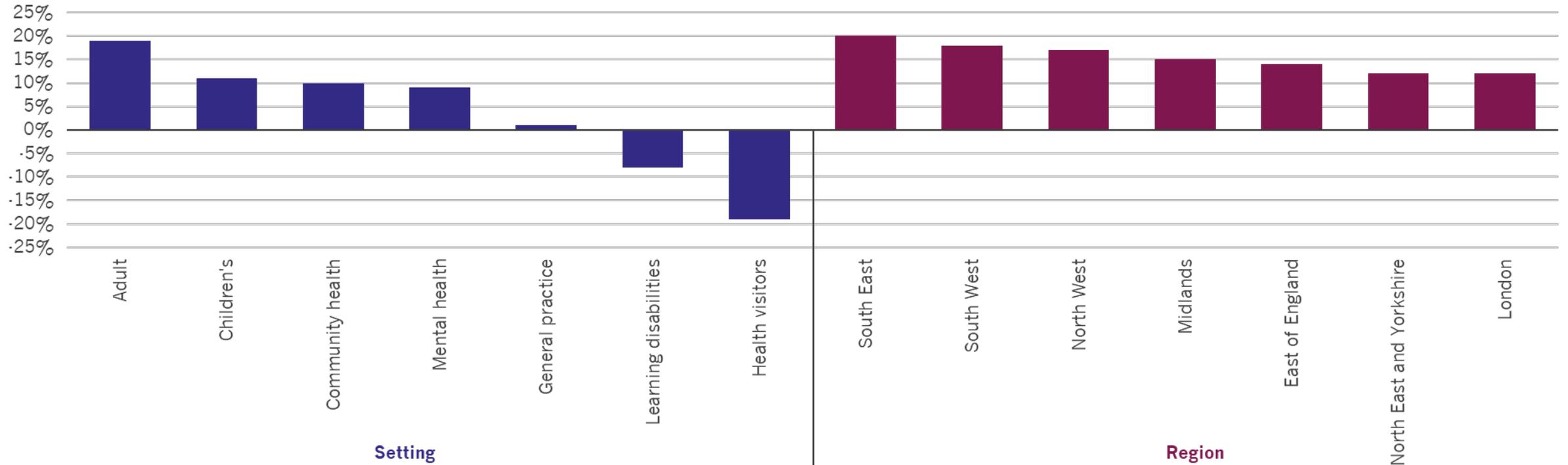
Notes: Regional differences exclude health visitors.

Source: Nuffield Trust. *What health and care need from the next government. NHS staffing*. Available: https://www.nuffieldtrust.org.uk/sites/default/files/2024-06/Nuffield%20Trust%20-%20General%20election%20-%20workforce%20test_WEB.pdf
Based on Nuffield Trust analysis of NHS Digital data. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

5.1 Changes in the mental health workforce

Figure VIII.5.1: Percentage change in FTE for Mental Health staff, by staff group - March 2010 to March 2024
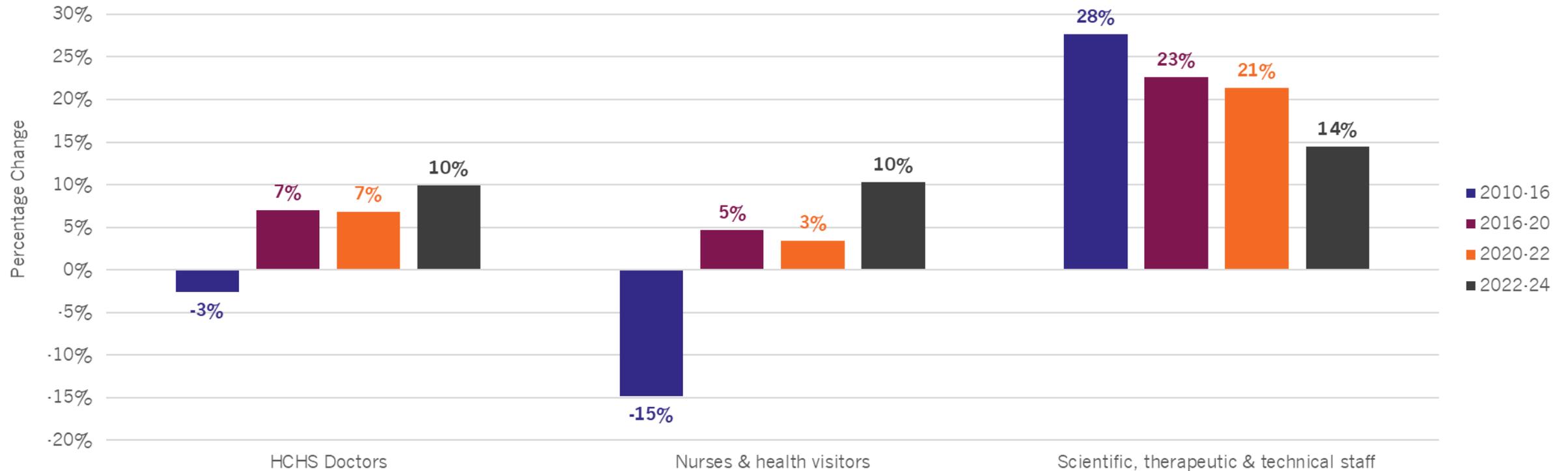
Notes: Recoding may impact staff numbers; Further information on these changes can be found in version 16.1 of the NHS Occupation Code Manual. Staff group classifications: Consultant includes HCHS Doctors with a Grade of Consultant; Junior doctors includes HCHS Doctors with: Core Training, Foundation Doctor Yr 1, Foundation Doctor Yr 1, Specialty Registrar; Staff Grade doctors includes HCHS Doctors with: Associate Specialist, Hospital Practitioner / Clinical Assistant, Other and Local HCHS Doctor Grades, Specialty Doctor

Source: NHS England (2024) NHS Hospital & Community Health Service (HCHS) monthly workforce statistics. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

5.2 Mental health needs vs mental health nurses

Figure VIII.5.2: Prevalence of mental disorders by age group – England vs Mental Health Nurses
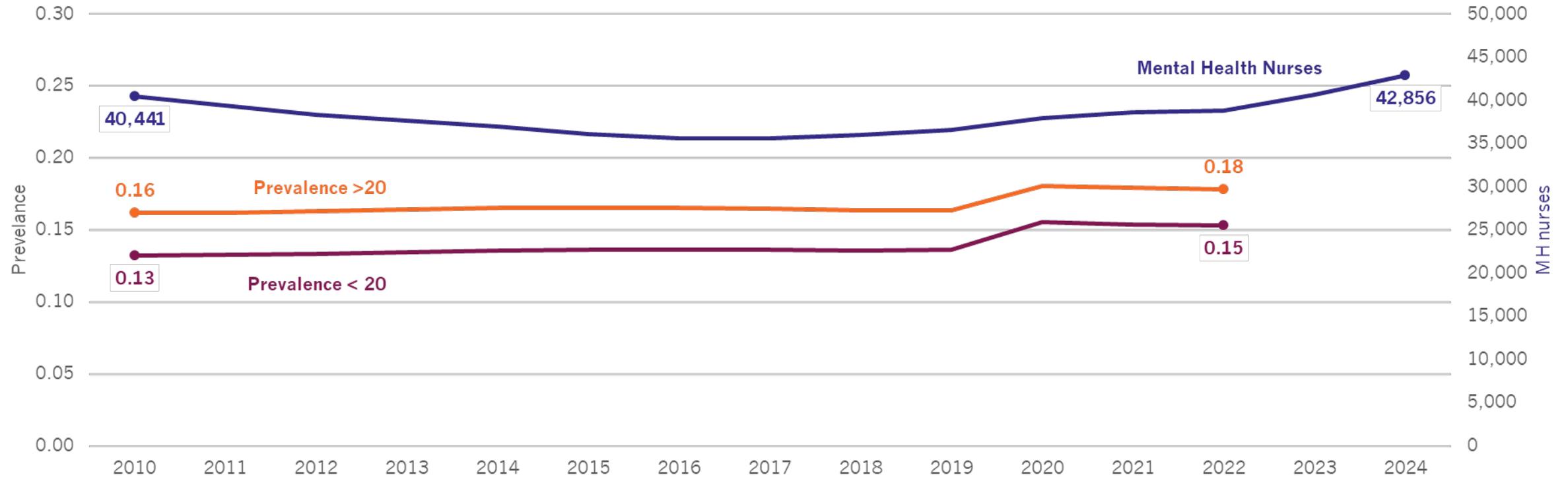
Notes: Data is NHS Hospital & Community Health Service (HCHS) data only as the data source is the NHS Electronic Staff Record (ESR) - GPs, GP Practice staff and other primary care providers and not included on the ESR system.

Source: IHME (2022) *Prevalence, Global Burden of Disease Study*. Available at: https://www.healthdata.org/research-analysis/gbd-data
NHS England (June 2024), *NHS Workforce Statistics – March 2024*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

5.3 Changes in mental health nursing staff and learning disabilities staff between 2010 and 2023

Figure VIII.5.3A: NHS Hospital & Community Health Service (HCHS) Mental Health Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region

Figure VIII.5.3.B: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region

Notes: Data sets recorded from 2010.

Source: NHS England (June 2024), *NHS Workforce Statistics – March 2024*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

5.4 Overall mental health workforce

Figure VIII.5.4: NHS Hospital & Community Health Service (HCHS) Mental Health Workforce staff in post (FTE) changes April 2010 to March 2024
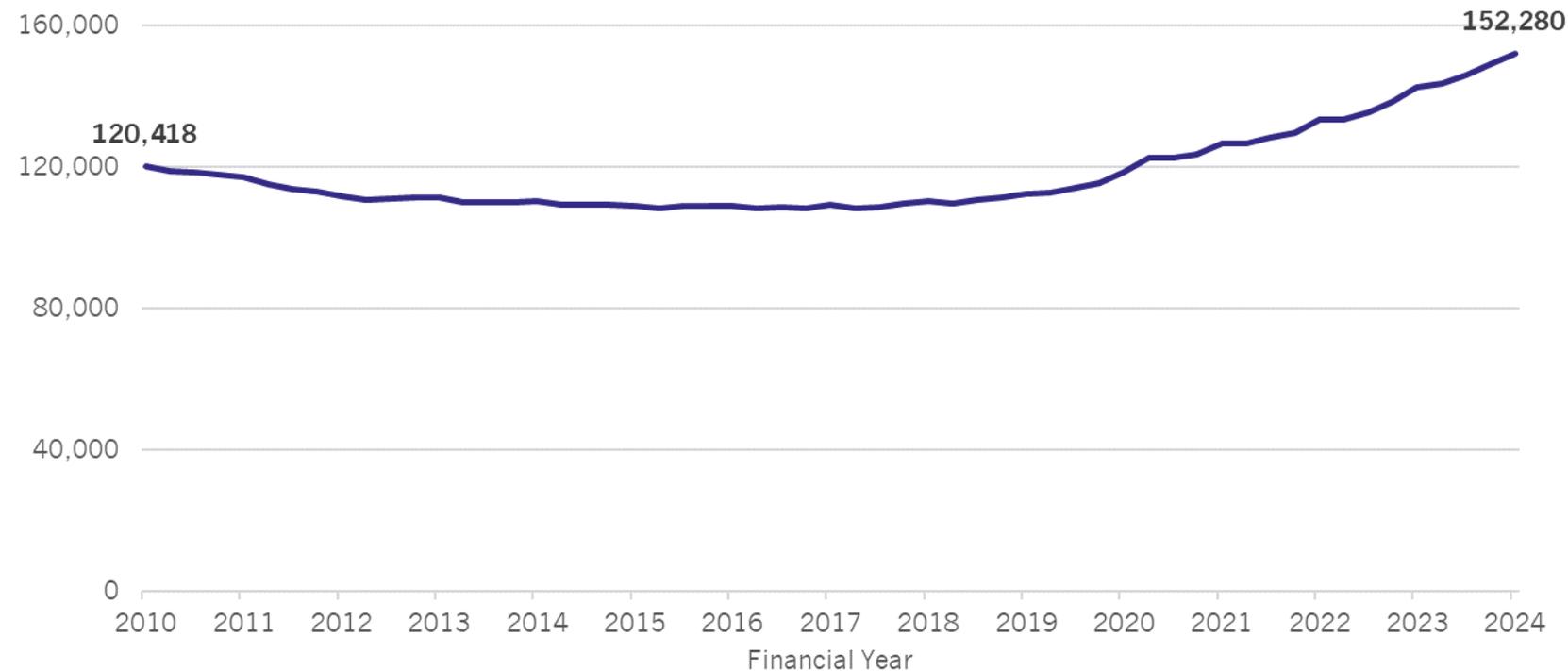
Time period	CAGR
March 2010 – March 2014	-2.2%
March 2014 – March 2019	0.4%
March 2019 – March 2021	6.2%
March 2021 – March 2024	6.3%
Whole period	1.7%

Note: Graph shows financial years. Data set recorded from 2010.

Source: NHS England (March 2024) *HCHS Mental Health Workforce in NHS Trusts and core orgs*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

5.5 Mental health nursing workforce
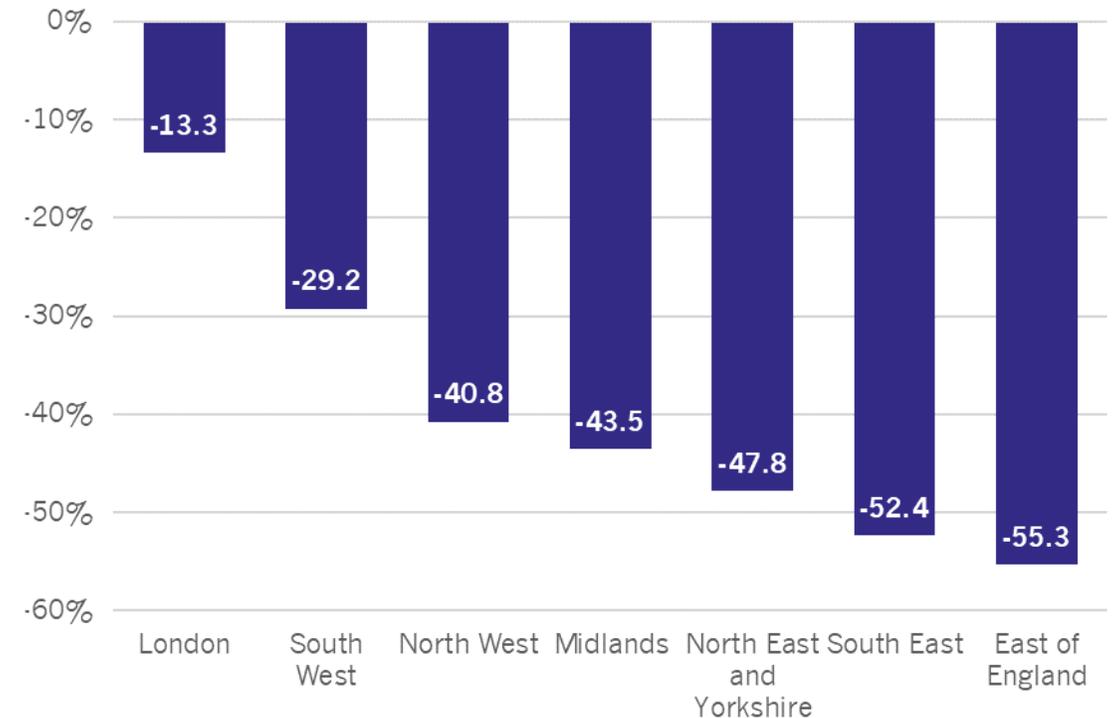
Figure VIII.5.5: NHS Hospital & Community Health Service (HCHS) Mental Health Nursing staff in post (FTE) changes April 2010 to April 2024
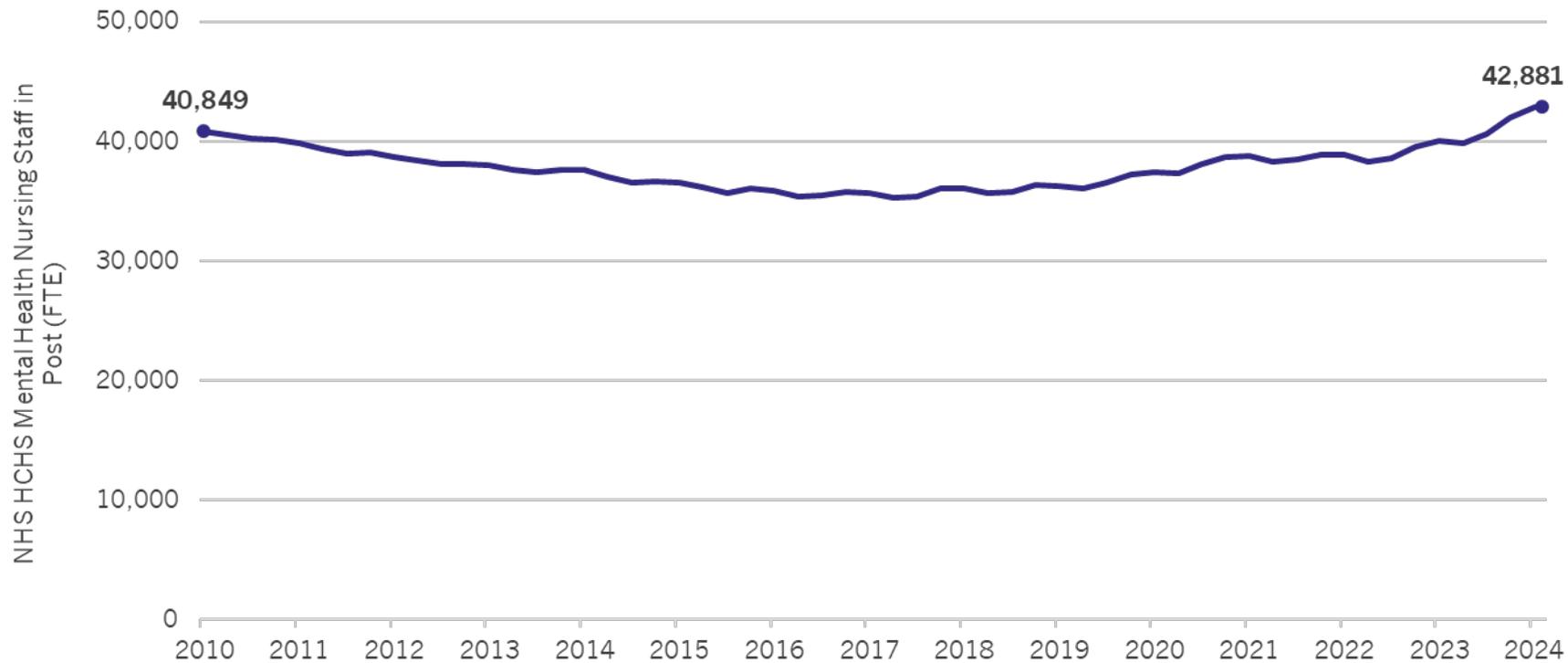
Time period	CAGR
March 2010 – March 2014	-2.1%
March 2014 – March 2019	-0.7%
March 2019 – March 2021	3.4%
March 2021 – March 2024	3.4%
Whole period	0.3%

Note: Graph shows financial years

Source: NHS England. *NHS Workforce Statistics*. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/april-2024

5.6 Learning disabilities nursing workforce

Figure VIII.5.6: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) changes end of Mar 2010 to end of Mar 2024

Time period	CAGR
March 2010 – March 2014	-7.7%
March 2014 – March 2019	-4.0%
March 2019 – March 2021	-0.5%
March 2021 – March 2024	-1.5%
Whole period	-4.0%

Notes: Data set recorded from 2010. Graph shows financial years

5.7 Mental health medical workforce

Figure VIII.5.7: NHS Hospital & Community Health Service (HCHS) Psychiatry Group Doctors (all grades) staff in post (FTE) changes April 2010 to April 2024

Note: Graph shows financial years.

5.8 Mental Illness and Learning Disability bed availability

Figure VIII.5.8: Mental illness and learning disability beds available

CAGR	MENTAL ILLNESS	LEARNING DISABILITY
2001 – 2010	-3.7%	-10.1%
2010 – 2019	-2.8%	-8.9%
2019 – 2021	0.5%	-7.9%
2021 – 2023	-1.3%	-3.3%
Whole period	-2.7%	-8.8%
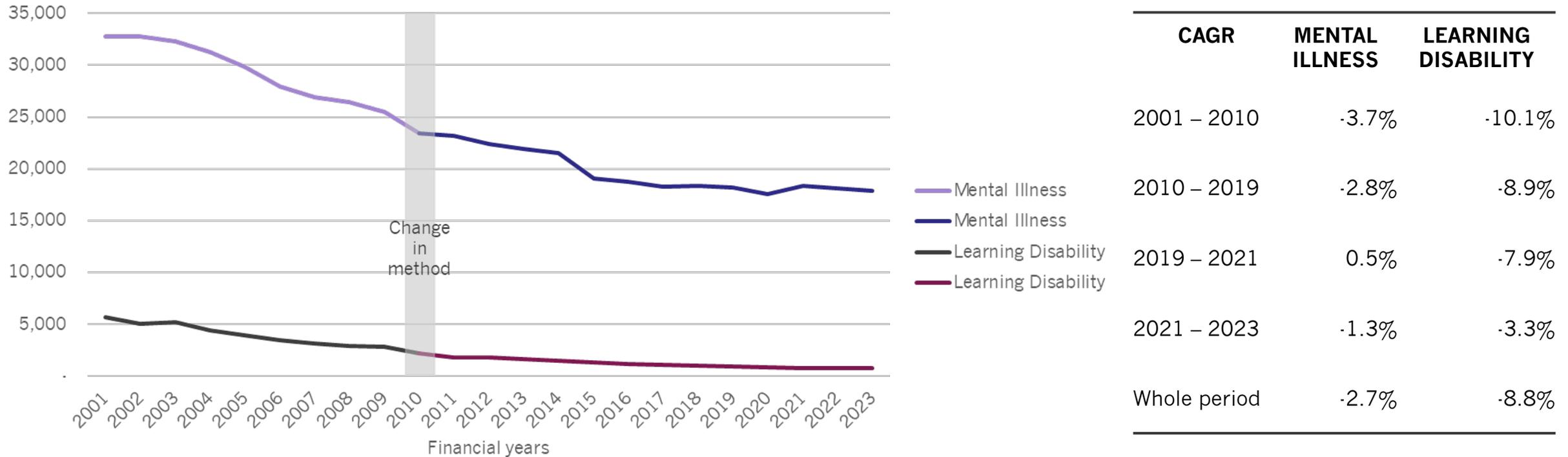
Notes: Data for bed availability is for financial years. Prior to 2010-11 the KH03 was an annual return collecting beds by ward classification. It also included data on Residential Care beds. From 2010-11 the KH03 became a quarterly return collecting beds that are consultant led by consultant main speciality, as wards and main specialties are not directly comparable, we introduced a break in the timeseries to signify the change in the data collection methodology. A growth rate across the full period would be misleading to report due to changes to the collection so two have been displayed below.

Source: Bed Availability and Occupancy (KH03) https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

6.1 International comparison of all healthcare workers employed in hospitals

Figure VIII.6.1: All healthcare workers employed in hospitals per 1,000 inhabitants, 2022 (or nearest year)
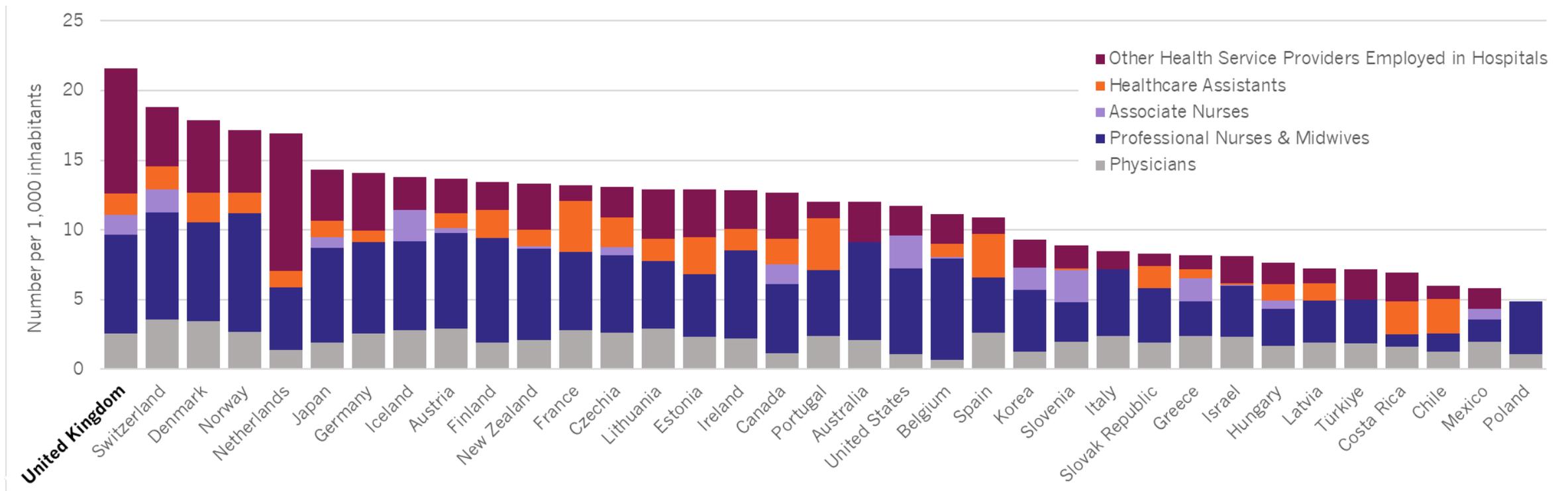
Notes: Data was not available for Sweden or Luxembourg. Number of FTE workers were used for Australia, Japan and Slovak Republic, resulting in an underestimation. New Zealand and the United Kingdom only report data on employment in public hospitals, resulting in an underestimation. UK data is also defined differently to other countries. Directly comparing nurse types should be taken with caution due to variances in the categorisation of nursing staff

Source: Organisation for Economic Co-operation and Development (Accessed 14/08/24)

6.2 International comparison of doctors, nurses and midwives employed in hospital

Figure VIII.6.2: Doctors, nurses and midwives employed in hospitals per 1,000 inhabitants, 2022 (or nearest year)
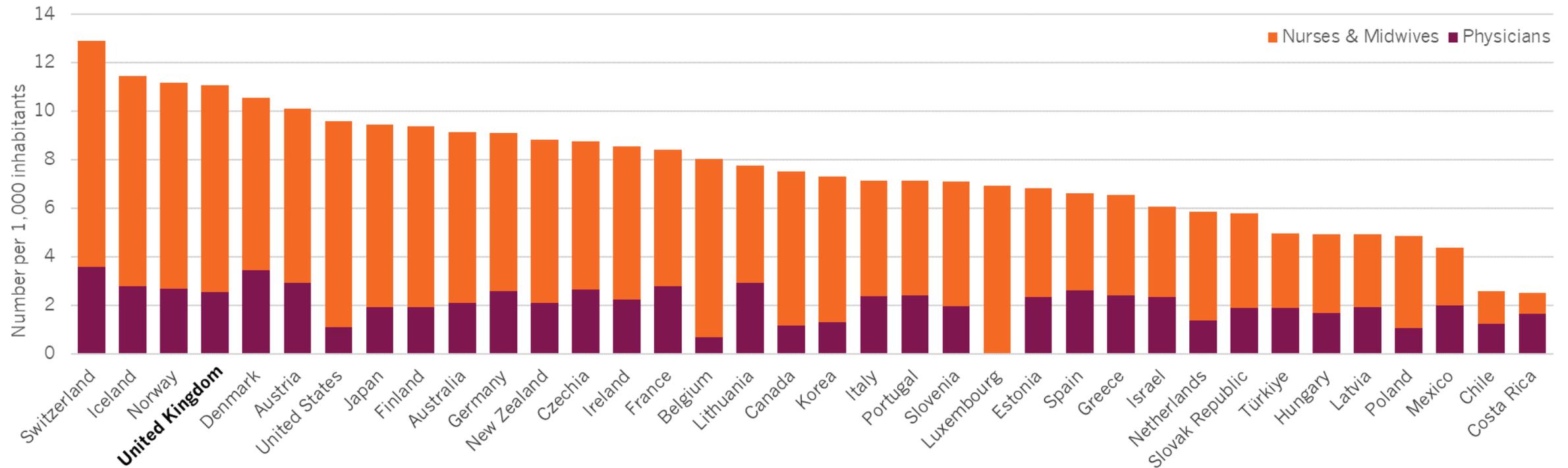
Notes: Number of FTE workers were used for Australia, Japan and Slovak Republic, resulting in an underestimation. Professional nurses and midwives are combined in hospital headcounts

Source: Organisation for Economic Co-operation and Development (Accessed 14/08/24)

6.3 International comparison of specialist doctors

Figure VIII.6.3: Specialist medical practitioners per 1,000 population, 2023 (or nearest year)
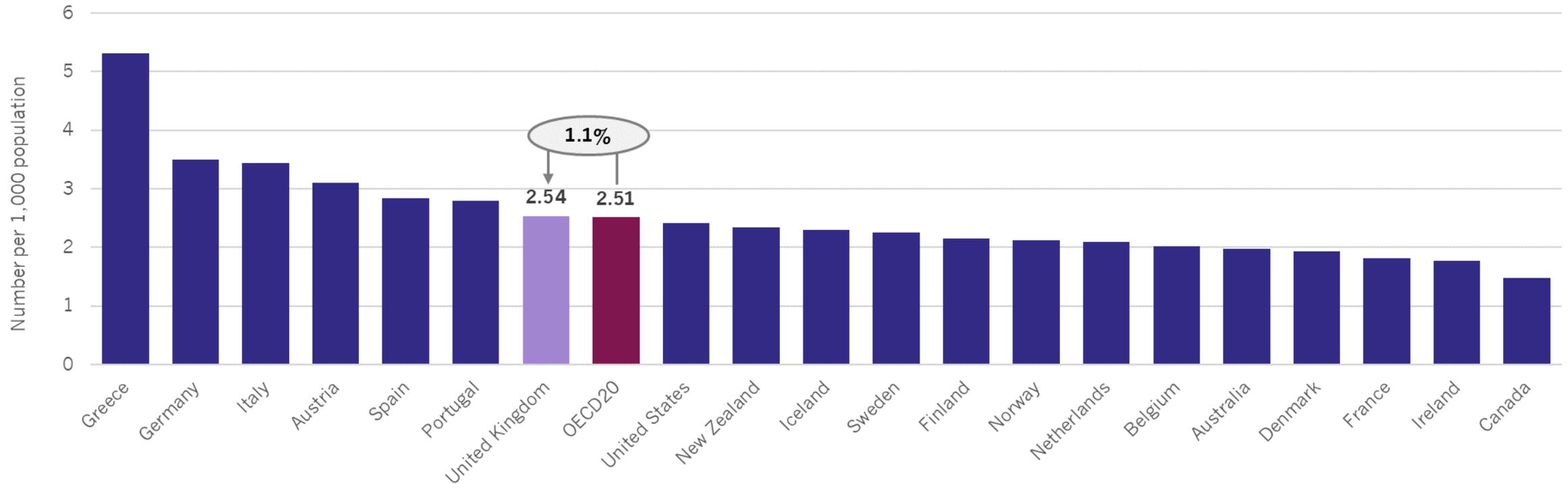
Notes: Data from Finland, Sweden & Denmark is 2021; Data for Austria, UK, New Zealand, Iceland, Ireland & Norway is 2023; Data for remaining countries is 2022.
Specialist doctors are defined as having been qualified 12 years with at least six years' specialty experience. Not all countries are able to report all their physicians in the two broad categories of specialists and generalists. This may be because specialty-specific data is not available for doctors in training or for those working in private practice.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

6.4 International comparison of nurses and midwives working in hospitals

Figure VIII.6.4: Nurses and midwives in hospitals per 1,000 inhabitants, 2023 (or nearest year)
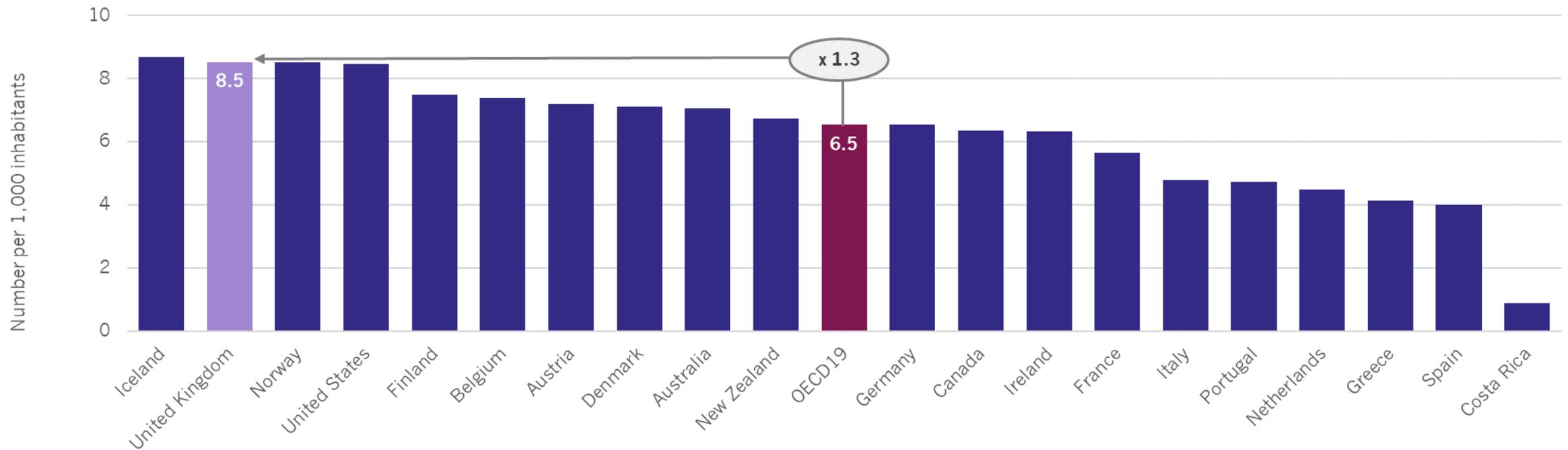
Notes: Data not available for Sweden. Belgium data is 2018; Iceland data is 2020; Finland data is 2021; Ireland, New Zealand, UK and Norway data is 2023; Remaining countries' data is 2022.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24)

6.5 Changes in the hospital workforce

Figure VIII.6.5: Percentage change in FTE for Hospital staff, by staff group - March 2010 to March 2024
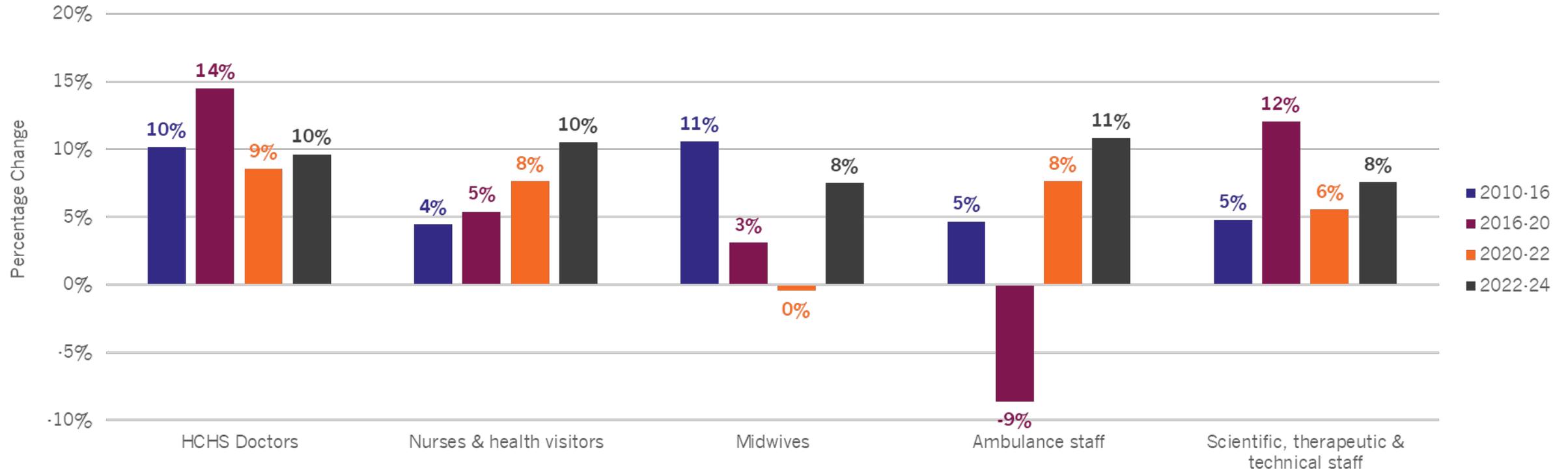
Notes: From April 2019 the Ambulance Staff matrix of the NHS Occupation Code manual has undergone a significant change to identify staff in greater detail especially by Care Setting, which could impact staff numbers. Further information on these changes can be found in version 16.1 of the NHS Occupation Code Manual. Staff group classifications: Consultant includes HCHS Doctors with a Grade of Consultant; Junior doctors includes HCHS Doctors with: Core Training, Foundation Doctor Year 1, Foundation Doctor Year 1, Specialty Registrar; Staff Grade doctors includes HCHS Doctors with: Associate Specialist, Hospital Practitioner / Clinical Assistant, Other and Local HCHS Doctor Grades, Specialty Doctor, Staff Grade

Source: NHS England (March 2024) *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics*, NHS England. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

6.6 Doctors and nurses per G&A available bed

Figure VIII.6.6: Number of acute doctors and nurses per G&A available bed
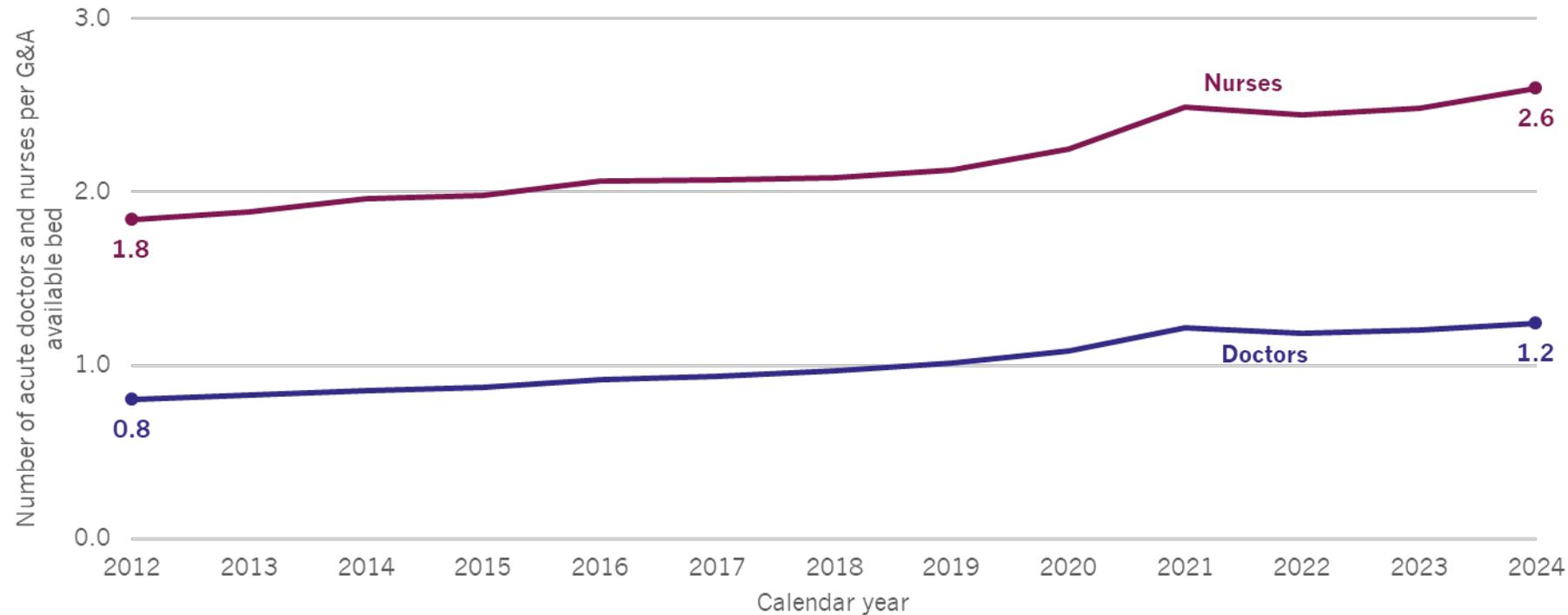
Years	Doctors	Nurses
2012-2015	2.8%	2.5%
2015-2019	3.9%	1.8%
2019-2021	9.4%	8.1%
2021-2024	0.8%	1.5%
2012-2024	3.7%	2.9%

Note: data is provided as at March, presented here as calendar years for simplicity. The estimate of staff working in acute settings will not be exact. Staff provide a range of different care and do so in different ways. For example, increased management of patients in ED to avoid admission may inflate the number of doctors and nurses per available bed.

Source: NHS England (2024) ESR extract, Number of nurses and doctors providing acute care. NHS England (2024) Available general and acute beds, KH03 data collection. Available at:
https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-availability-and-occupancy-kh03/

6.7 Growth in acute hospital workforce 2019/20 – 2023/24

Figure VIII.6.7: Acute substantive staff WTEs (000s) change 2019/20 – 2023/24
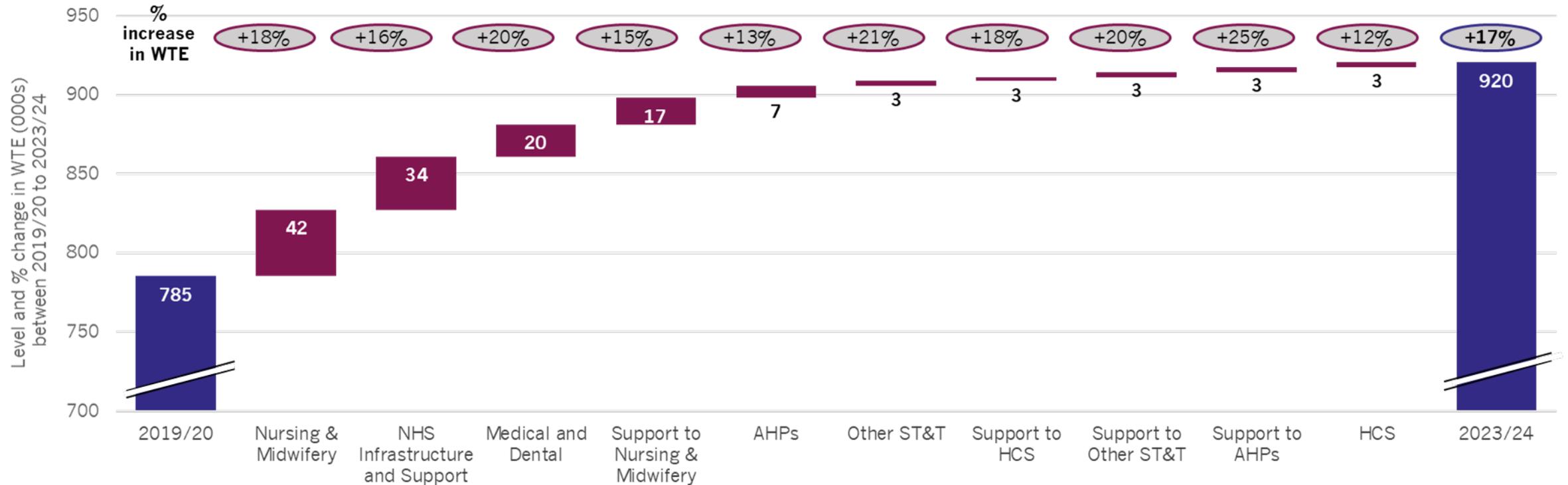
Notes: 2019/20 figures are based the 12 months ending 29th February 2020 to avoid the impact of the COVID-19 pandemic. Acute trusts (n=123) in England used in this sample. Substantive staff WTE only showed in this chart.

Source: *NHS England* (2024) *ESR Extract, substantive staff WTE*.

6.8 Total factor productivity of acute NHS provider trusts

Figure VIII.6.8: Total factor productivity level of acute NHS providers, compared to all NHS
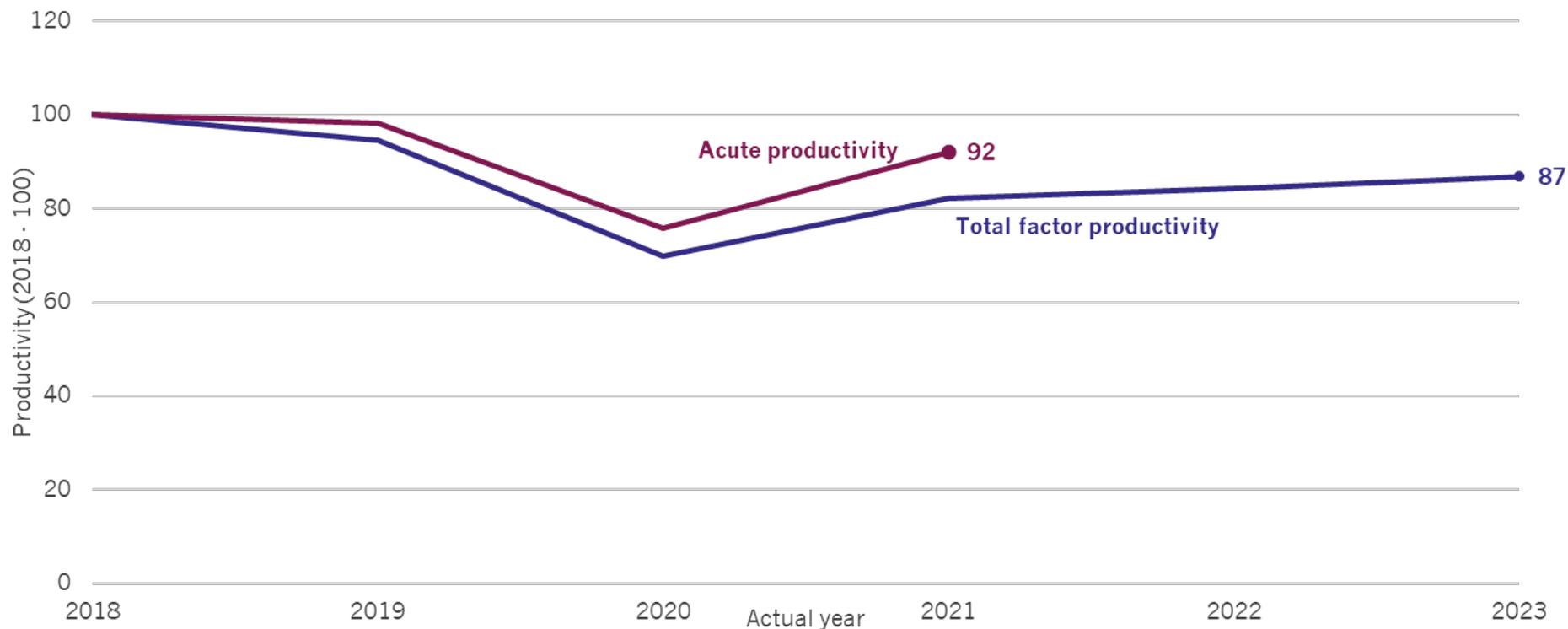
Growth rates

	Acute	NHS
2018	-	-
2019	-5.5%	-1.8%
2020	-27.0%	-22.8%
2021	+17.0%	+21.3%
2022	+1.7%	N/A
2023	+2.0%	N/A

Notes: Data is only available for the acute sector, not other sectors. The Office for National Statistics only provide national level estimates, not sector level. As set out earlier, national estimates are only available up to 2021/22. Whole NHS total factor productivity, non-quality-adjusted source: Office for National Statistics. Data is provided by financial year, presented here as calendar years for simplicity

Source: *Public service productivity, healthcare, England - Office for National Statistics (ons.gov.uk)*

6.9 Acute productivity gap between 2019/20 and 2023/24

Figure VIII.6.9: Quantifiable drivers of acute productivity gap, April-Feb 19/20FY vs 23/24 M11
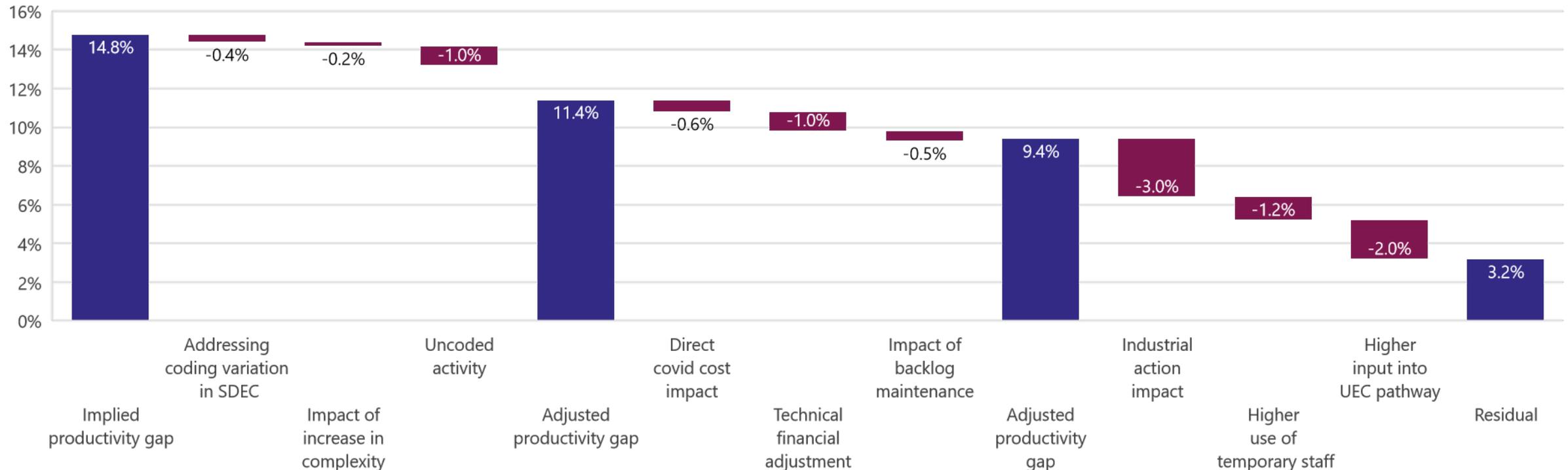
Notes: (1) Implied productivity gap reflects complexity, estimated impact of standardised reporting of SDEC activities. (2) Technical financial adjustments relate to cost that are not associated with patient care such as CNST (clinical negligence), Education and Training, high cost drugs etc. (3) Backlog maintenance impact is estimated by extrapolating an in-depth case study in one trust of annual loss of capacity and downtime related to backlog maintenance issues, (4) Higher input into UEC pathway includes impact of delayed discharge and higher clinical and non-clinical input required to care for people on UEC pathway due to capacity constraint..

Source: Internal NHS England analysis.

6.10 Changes in staff per bed and activity per staff member 2001/02 – 2023/24

Figure VIII.6.10: Staff per bed, activity per bed and activity per staff ratios, 2000/01 – 2023/24
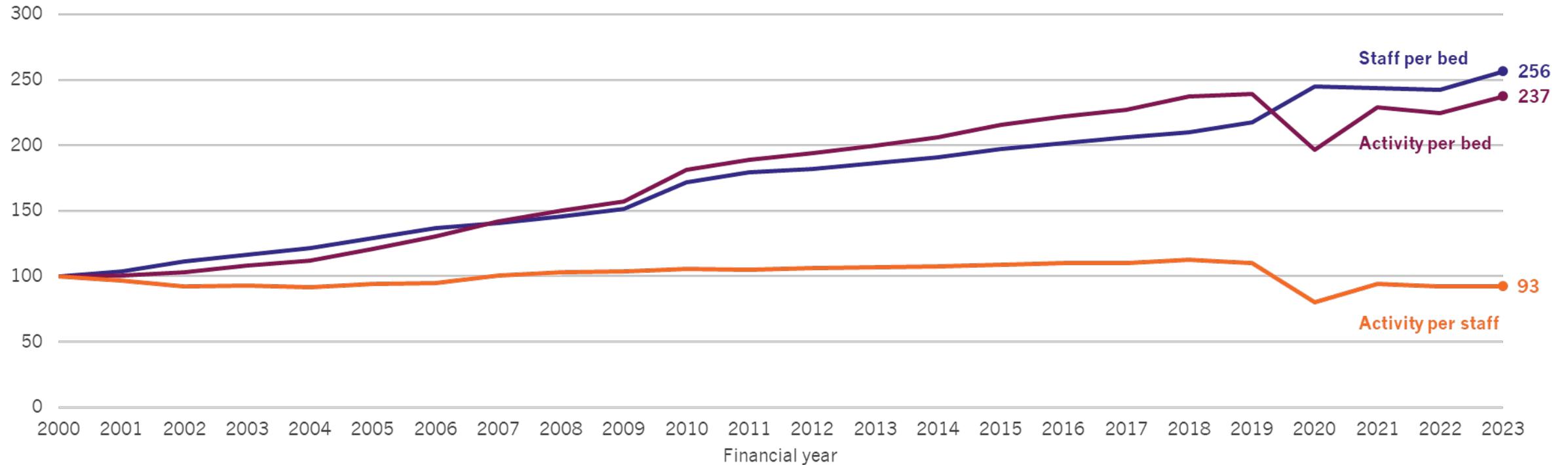
Notes: Staff per bed: Doctors and nurses; Available overnight G&A beds; Activity per available bed: HES total G&A FCEs (NEL and EL); Available overnight G&A beds; Activity per staff: Doctors and nurses; HES total G&A FCEs (NEL and EL)

Source: NHSE Workforce statistics; Department of Health form KH03, average number of available beds by sector; HES

6.11 Clinical workforce productivity metrics

Figure VIII.6.11A: Clinical WTEs per G&A bed
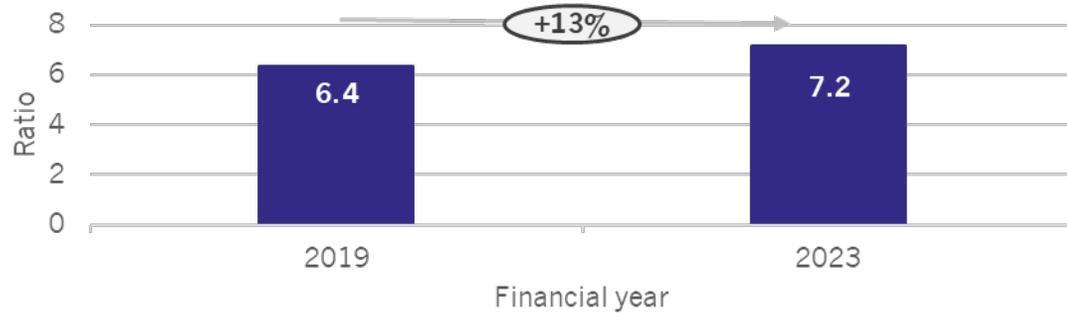
Figure VIII.6.11B: Non-admitted emergency activity (per calendar day) per medical emergency medicine WTE.
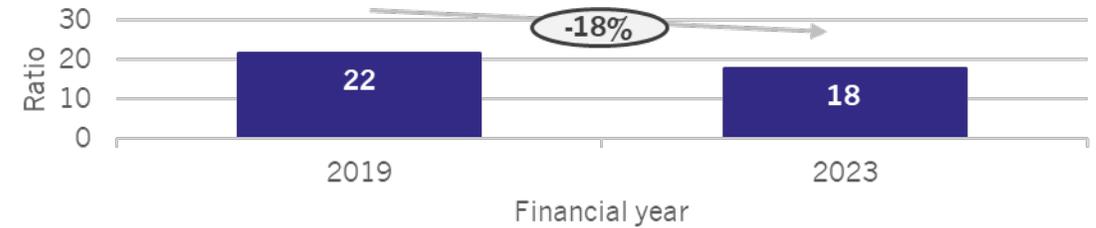
Figure VIII.6.11C: Outpatient attendances (price-weighted, per working day) per consultant WTE
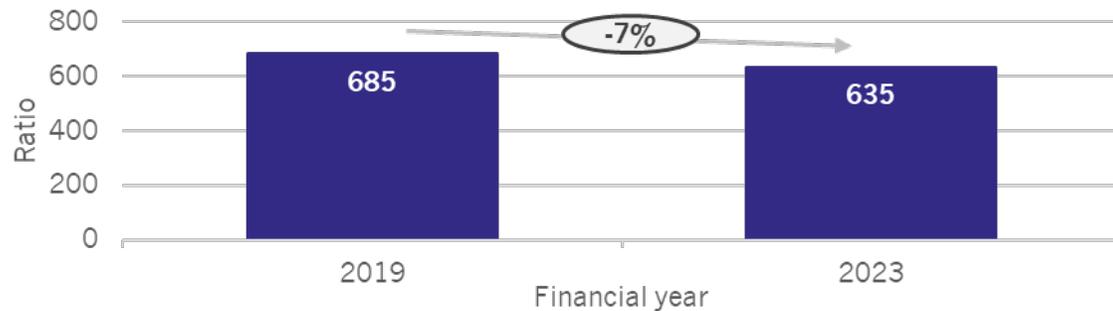
Figure VIII.6.11D: Surgical specialty spells per medical WTE in surgical specialties
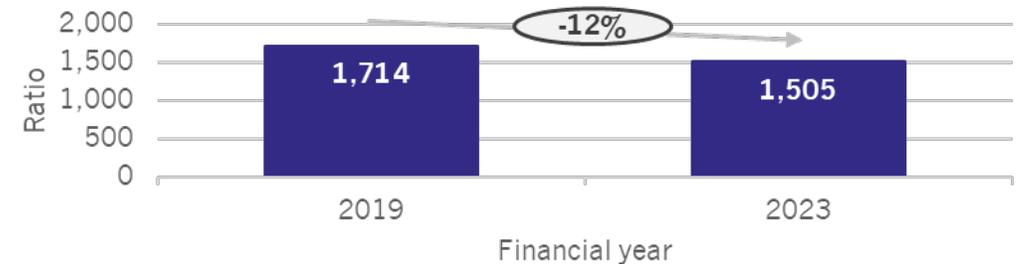
Notes: 19/20 figures end 29th Feb to avoid impact of covid. All figures for acute providers based on NHS planning definitions. A&E and OP attendances adjusted for calendar day and working day respectively. Surgical spells include elective (working day adjusted) and nonelective (calendar day adjusted) cases and have been identified using 'surgical' Health Care Resource Groups based on the FY23/24 HRG Payment Grouper. Occupied Overnight G&A beds in 19/20 and 22/23. Surgical specialty data price weighted at 5-character HRG level. When price weighted at the 4-character HRG level, the productivity fall is slightly larger at -13%. Activity is not adjusted for complexity, i.e. treated as equally weighted units / not complexity adjusted (for OP does not take into account OP procedures with a different weighting). "Surgical specialities" mapped to surgical HRGs.

Source: NHS England (2024) SUS, *statistics*. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024.

6.12 Size of the queue in A&E departments

Figure VIII.6.12: Average number of patients arrived but not admitted, transferred or discharged per A&E Trust, A&E CDS & ECDS
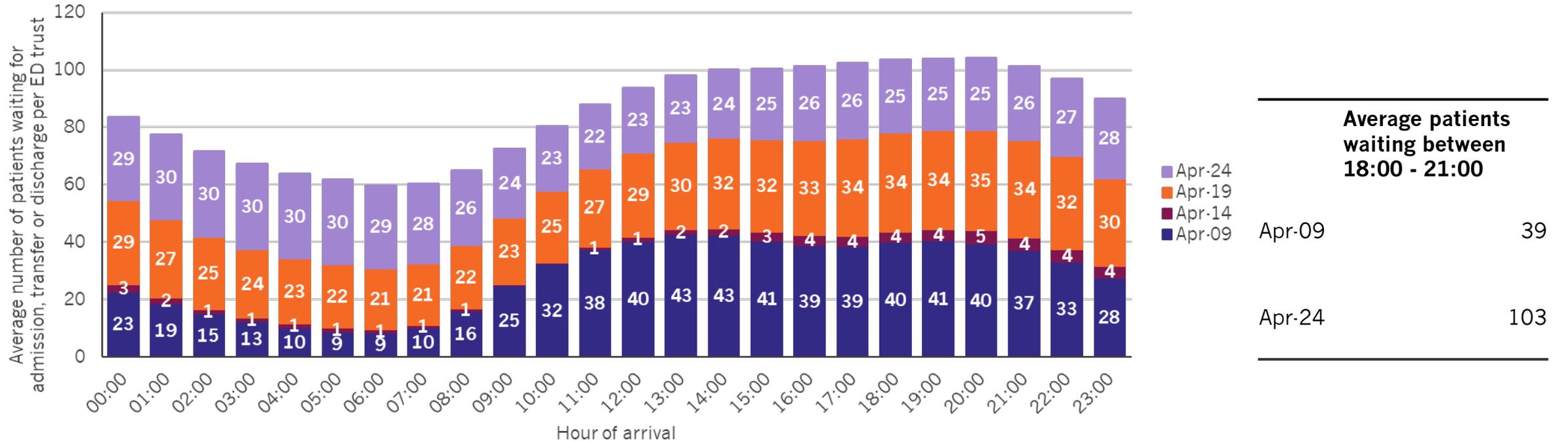
Notes: Data from type 1 and type 2 emergency departments. Excludes planned follow ups and attendances in department over 1 day (suspected data quality issue). Also excludes streamed activity.

Source: NHS England. *Accident & Emergency Commissioning Data Sets (A&E CDS) and Emergency Care Data Set (ECDS).*

6.13 Working days lost to ambulance handover delays

Figure VIII.6.13: Working days lost per day due to ambulance handover delays, England (assumes 7.5 hours lost is equivalent to a working day lost for two staff)
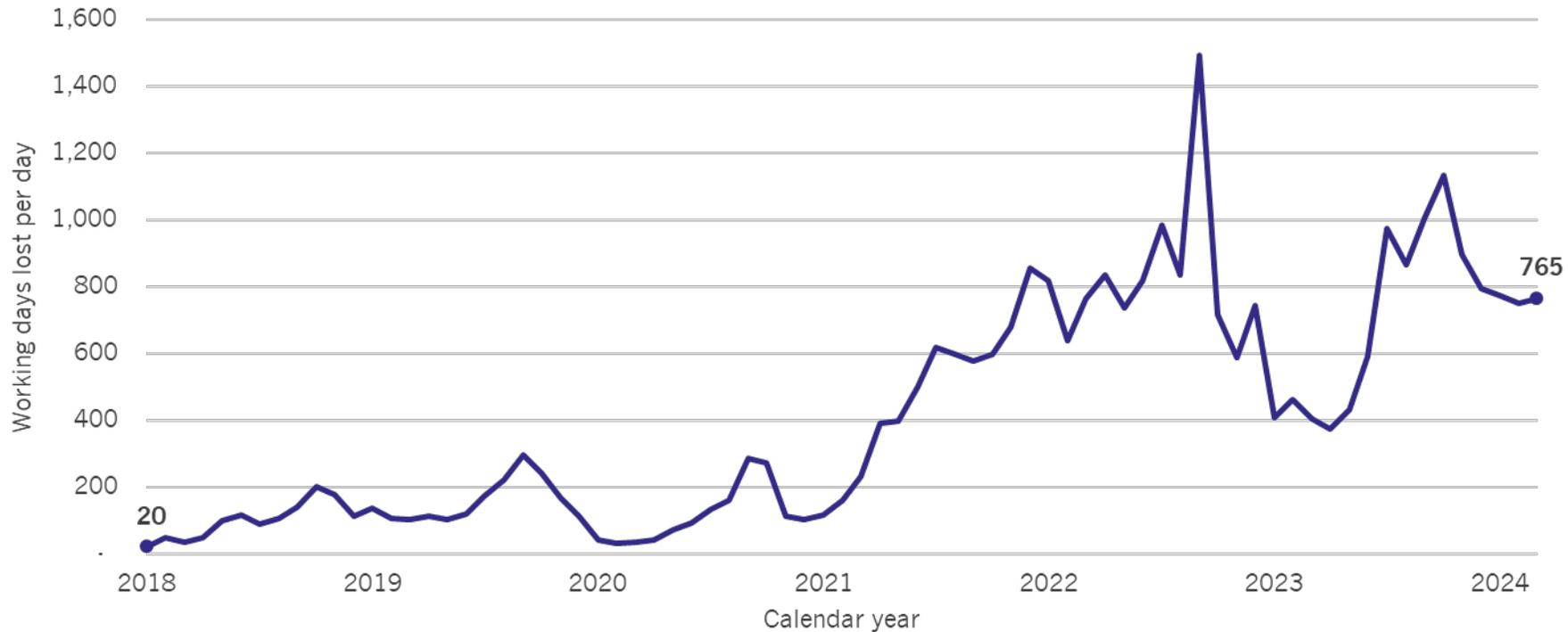
Period	CAGR
April 2018 – April 2021	79.7%
April 2021 – April 2024	87.4%
Whole Period April 2018 – April 2024	83.5%

Notes: Time lost to handover delays excludes first 30 minutes of each handover. 2024 YTD (Jan to Jun) 853 working days lost per day. 2024 -25 YTD (April to Jun) 763 working days lost per day.

Source: From 1 October 2023 NHS Ambulance Quality Indicators Available: Statistics » Ambulance Quality Indicators (england.nhs.uk)
Before 1 October 2023: Daily Ambulance Collection, unpublished except 14th November 2022 to 2 April 2023, some non-ED handovers are not available

6.14 Bed occupancy over time

Figure VIII.6.14: General and Acute (G&A) bed occupancy over time
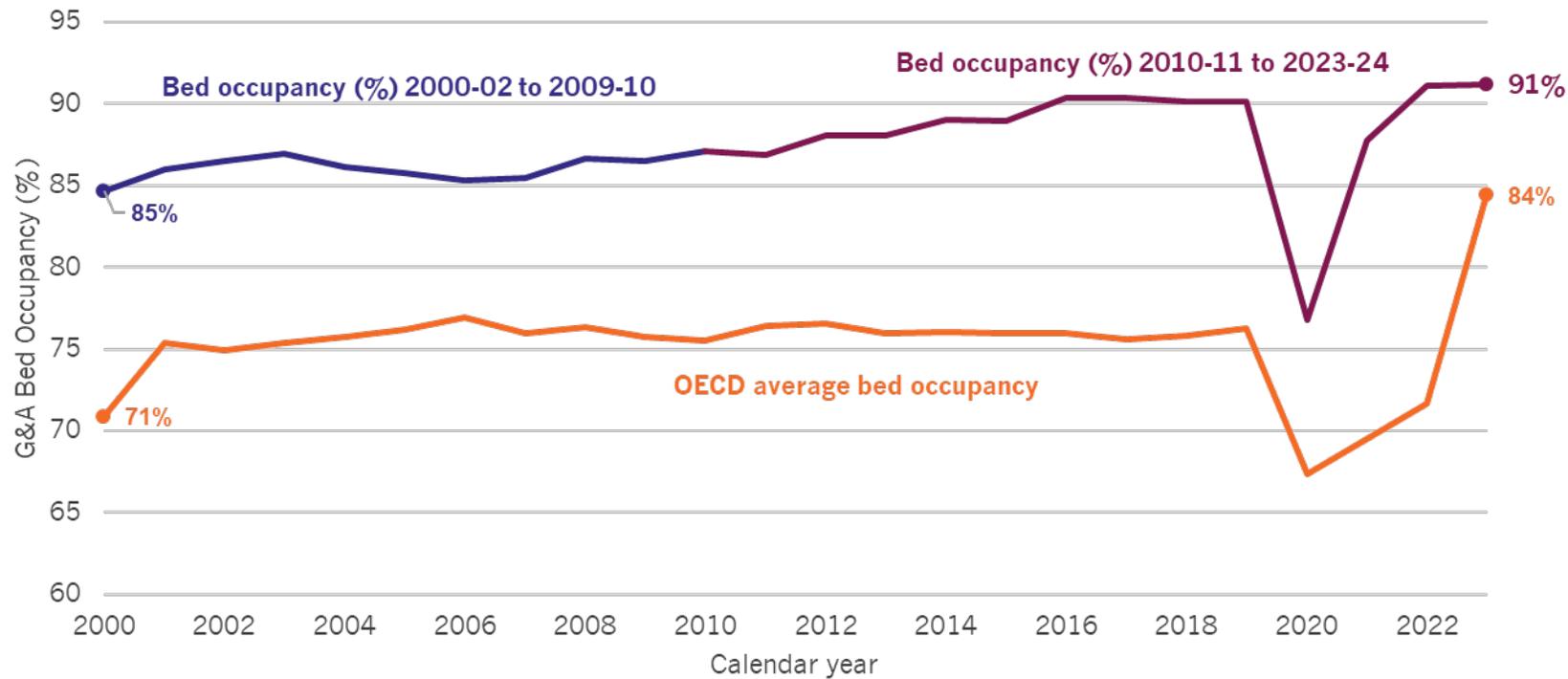
CAGRs	NHS	OECD
2000-2008	0.3%	0.8%
2008-2015	0.4%	0.9%
2015-2019	0.3%	-0.1%
2019-2021	-1.4%	0.1%
2021-2023	1.9%	-4.5%
Whole period 2000-2023	0.3%	10.2%

Source: NHS England, Bed availability and occupancy rates, Available: Statistics » Bed Availability and Occupancy (england.nhs.uk); Organisation for Economic Co-operation and Development, Available: https://data-explorer.oecd.org/

6.15 International comparisons of bed occupancy

Figure VIII.6.15: Occupancy rate of curative (acute) care beds, 2022 (or nearest year)
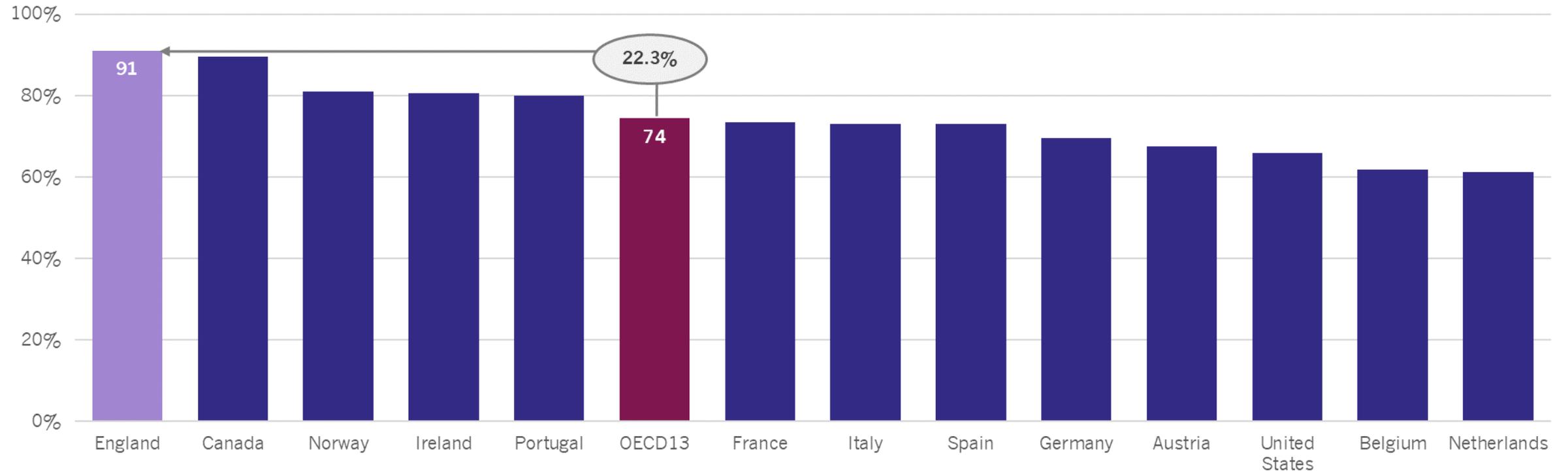
Notes: No data available for Australia, Iceland and New Zealand. Denmark, Finland, Greece and Denmark excluded as latest data is on or before 2017. Data for Netherlands is 2021. Data for England is taken from NHS statistics, using the average General and Acute bed occupancy across 2022/23 to produce an estimate.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/24); NHS England, Bed Availability and Occupancy – KH03 (England only)

6.16 Drivers of secondary care drug spend

Figure VIII.6.16: Drugs spend in secondary care with aggregate drivers of price, volume and product mix, expressed as an index with base = Q1 2015/16
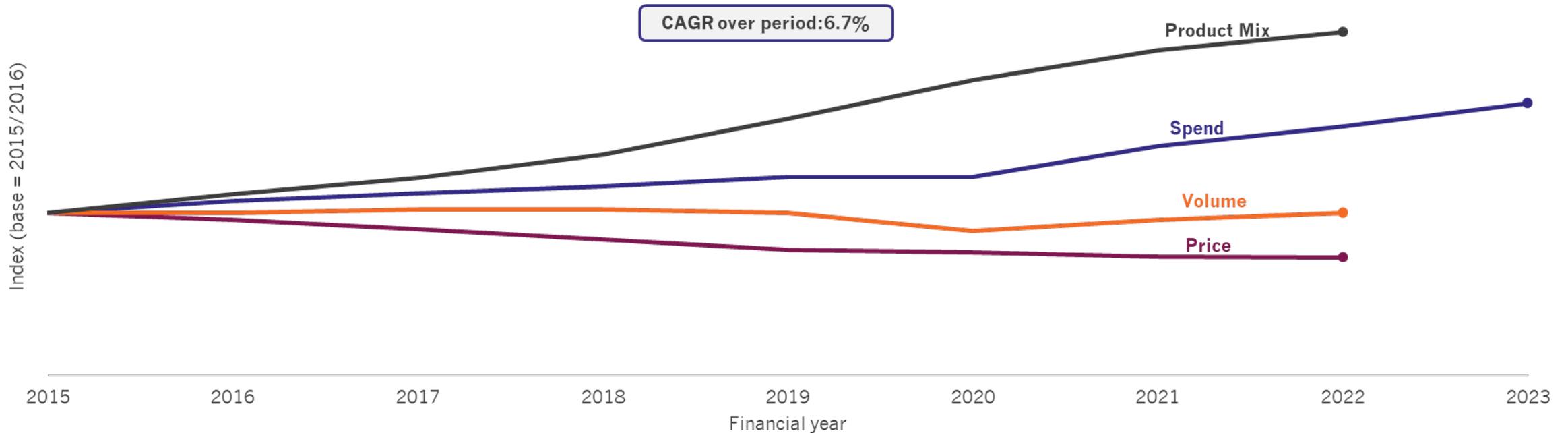
Notes: Actual values are excluded due to potential commercial confidentiality considerations. Spend is net of commercially negotiated central rebates but gross of rebates from branded medicines affordability mechanisms. Indices:Price index: a measure of the change in prices paid for prescriptions, holding constant any change in the medicines prescribed; Volume index: a measure of the change in overall prescription volumes, unweighted by prices so it captures the pure effect of underlying shifts in prescription volumes; Product mix: a measure of the change in the average unit cost, with prices and overall volumes held constant. It captures the impact from a shift in the composition of the products prescribed. An increase in the product mix shows that the composition of products prescribed is shifting, on average, to more costly ones.

Source: *NHS Business Services Authority* (2016/17 to 2022/23) Available: https://www.nhsbsa.nhs.uk/statistical-collections/prescribing-costs-hospitals-and-community-england

6.17 Reasons for delayed discharges from acute hospitals

Figure VIII.6.17: Primary delay reasons for acute patients with 14+ Length of Stay
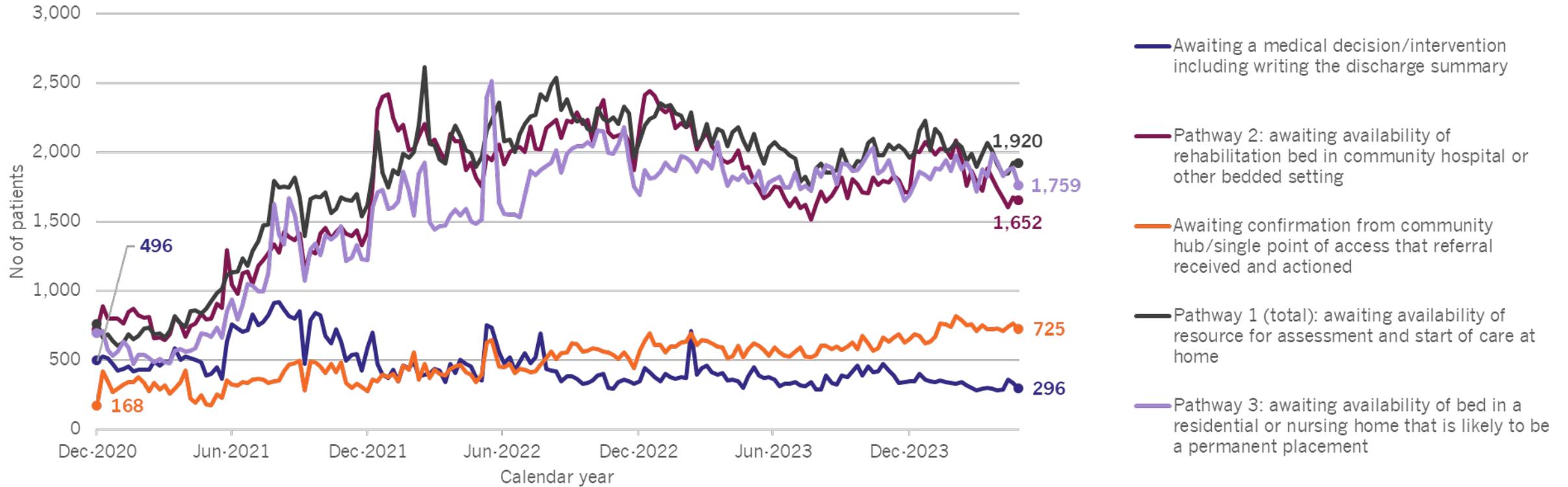
Source: NHS England, Acute discharge sitrep Available: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays-acute-data/

6.18 Delayed discharges over time and equivalent number of NHS beds

Figure VIII.6.18: Beds occupied by people who no longer meet the criteria to reside, April 2021 to June 2024

IX. NHS Structures and Systems

1.1 NHS organisations created or existing during time periods

Figure IX.1.1: Number of NHS Bodies existing and created across time periods
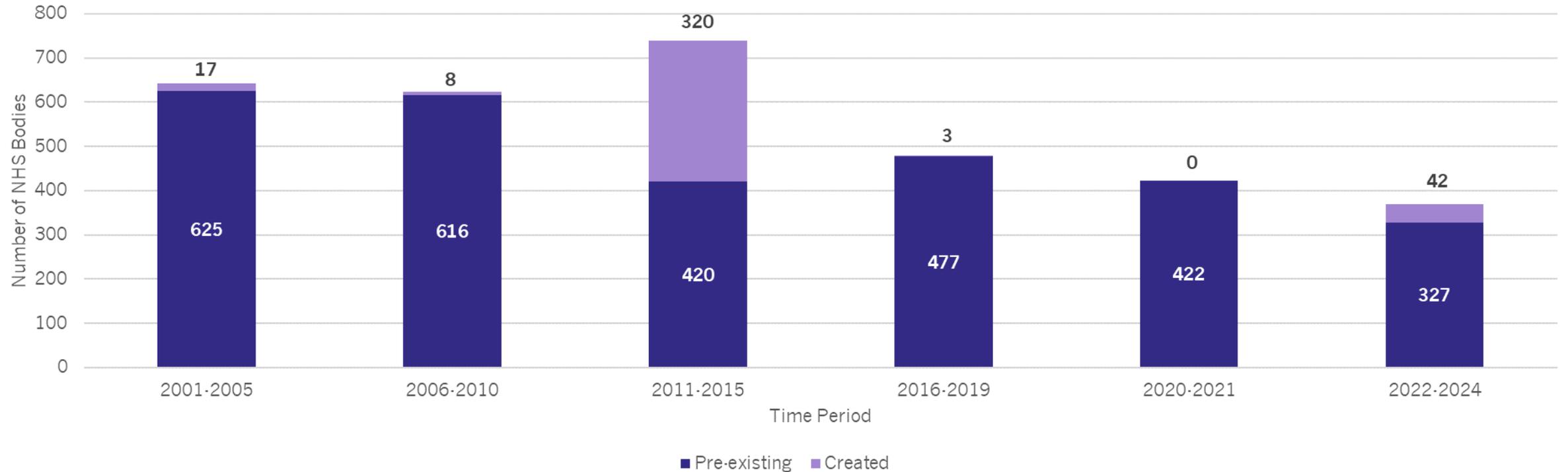
Notes: 2001-2005 period data starts in 2003, 2022-2024 period ends in 2023

Sources: Department of Health and Social Care and NHS England. NHS England analysis of published data from of NAO Reports, Government Resources and Accounts, DH/DHSC Annual Reports and Accounts.

1.2 Cumulative number of NHS bodies created and abolished

Figure IX.1.2: Cumulative Number of NHS Bodies Created and Abolished in 2002-2010 and 2011-2022
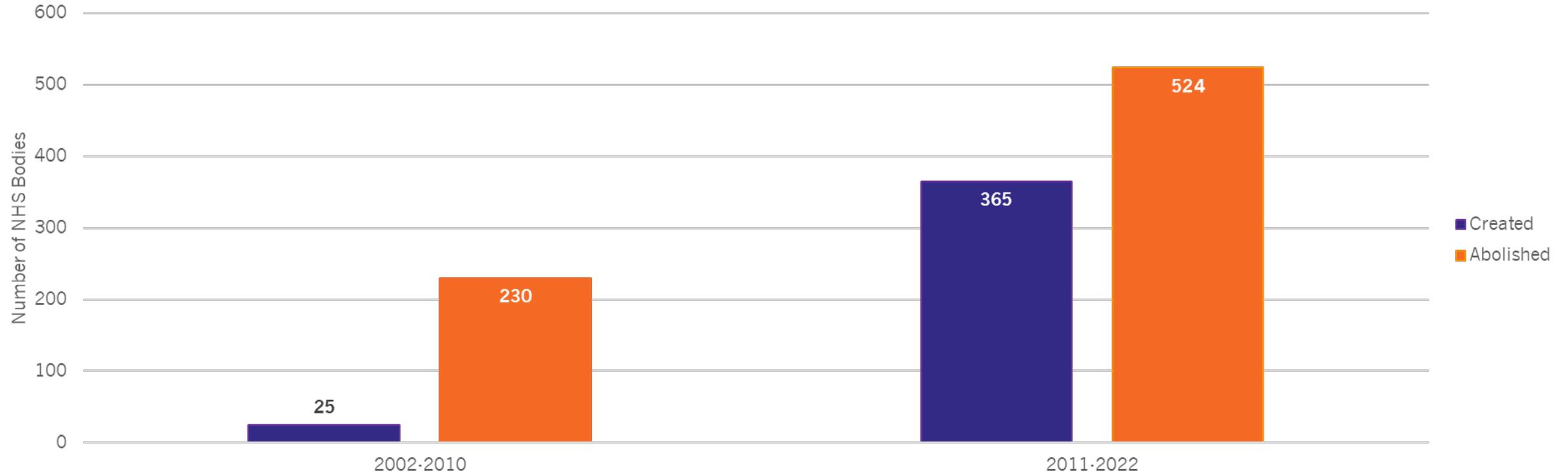
Notes: 2002 is not shown as it is considered the starting point where change is measured from

Sources: Department of Health and Social Care and NHS England. NHS England analysis of published data from of NAO Reports, Government Resources and Accounts, DH/DHSC Annual Reports and Accounts.

1.3 Ratio of NHS provider trusts to all other NHS statutory bodies

Figure IX.1.3: Number of NHS bodies (2002-2022)
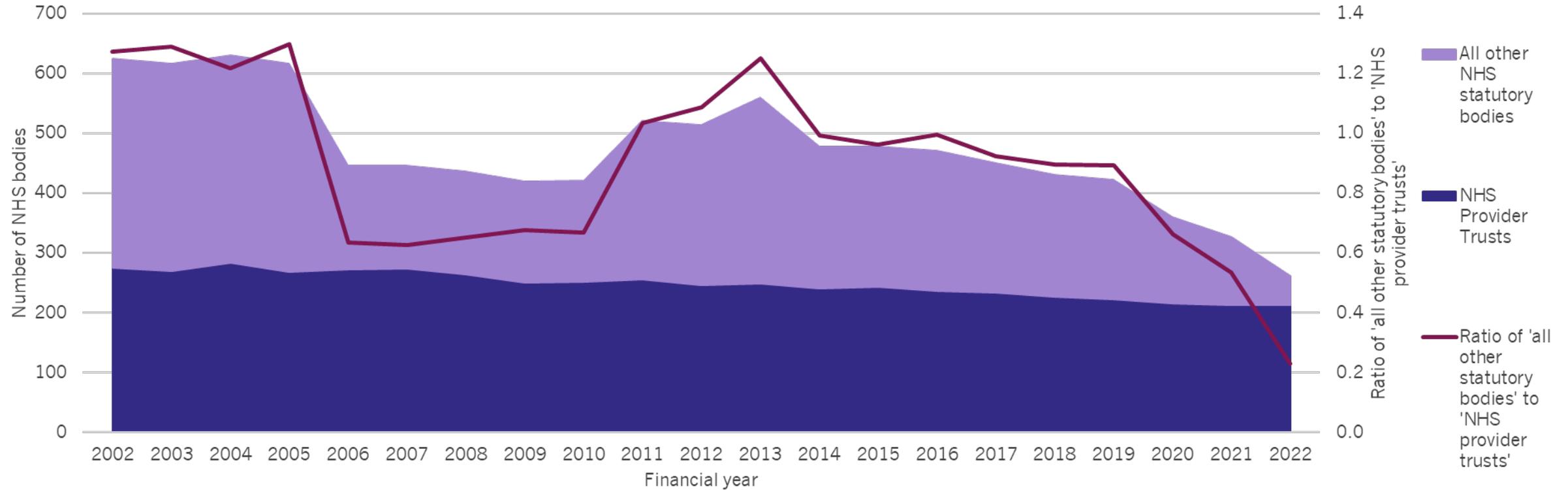
Notes: Year listed is the first year of the financial year

Source: Department of Health, Department of Health and Social Care & National Audit Office annual reports/end of year accounts.

1.4 Number of managers and senior managers moving within the NHS and leaving the NHS (turnover)

Figure IX.1.4: Turnover of managers and senior managers: ratio of leavers to joiners, September 2010 to March 2024

CAGRs	2010-2024
Managers	-5.94%
Senior Managers	-4.97%
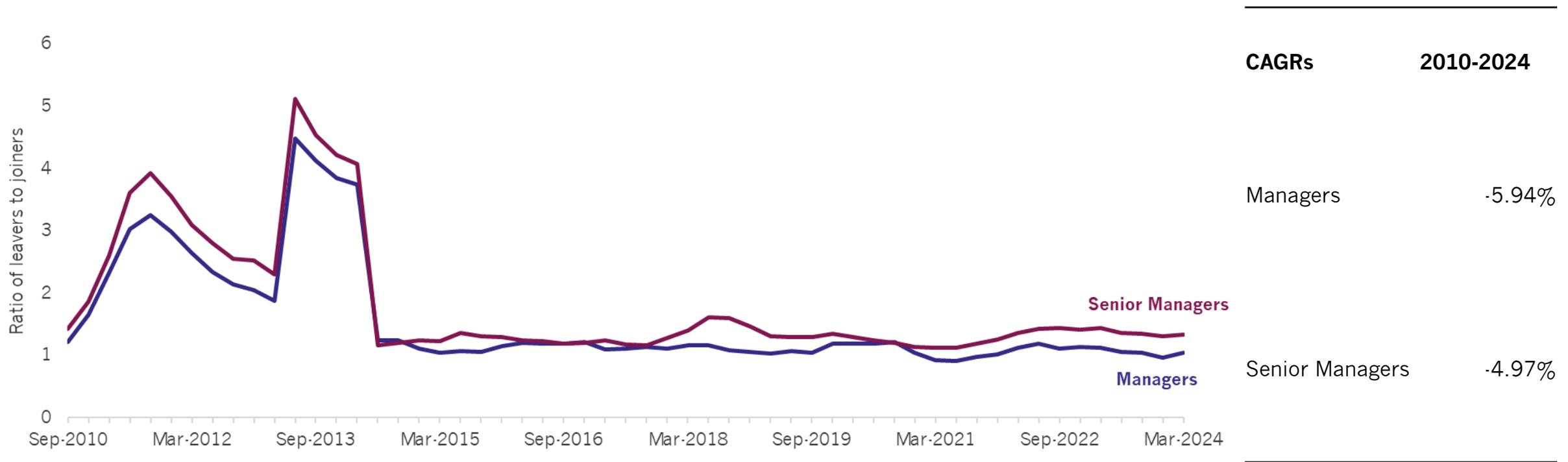
Notes: Published statistics used, which cover turnover of staff which includes people leaving individual organisations. This may be to go to other organisations within the NHS or leaving the NHS entirely however within the publication all are referred to as "Leavers"

Source: NHS England. NHS Hospital and Community Health Services (HCHS) staff in NHS Trusts and other core organisations in England - Turnover tables. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

2.1 International comparisons of admin costs as a percentage of health spending

Figure IX.2.1: Administration and overall governance spend as a percentage of total health expenditure, 2023 (or nearest year)
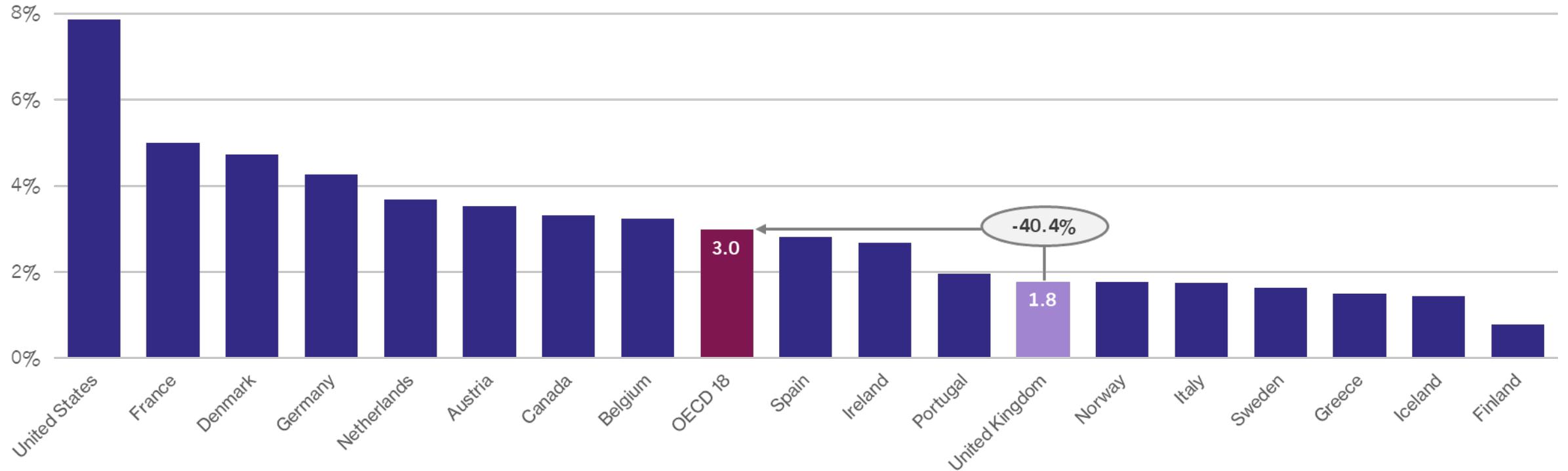
Notes: The United States, France, Germany, Netherlands, Austria, Belgium, Spain, Portugal, United Kingdom, Norway, Sweden, Greece, and Finland use 2022 data. Data for Denmark, Canada, Ireland, Italy and Iceland is from 2023.

Source: Organisation for Economic Co-operation and Development (accessed 14/08/2024)

2.2 Managers and senior managers as a proportion of total NHS staff

Figure IX.2.2: Managers and senior managers as a % of total staff, Sept 2009 to Mar 2024
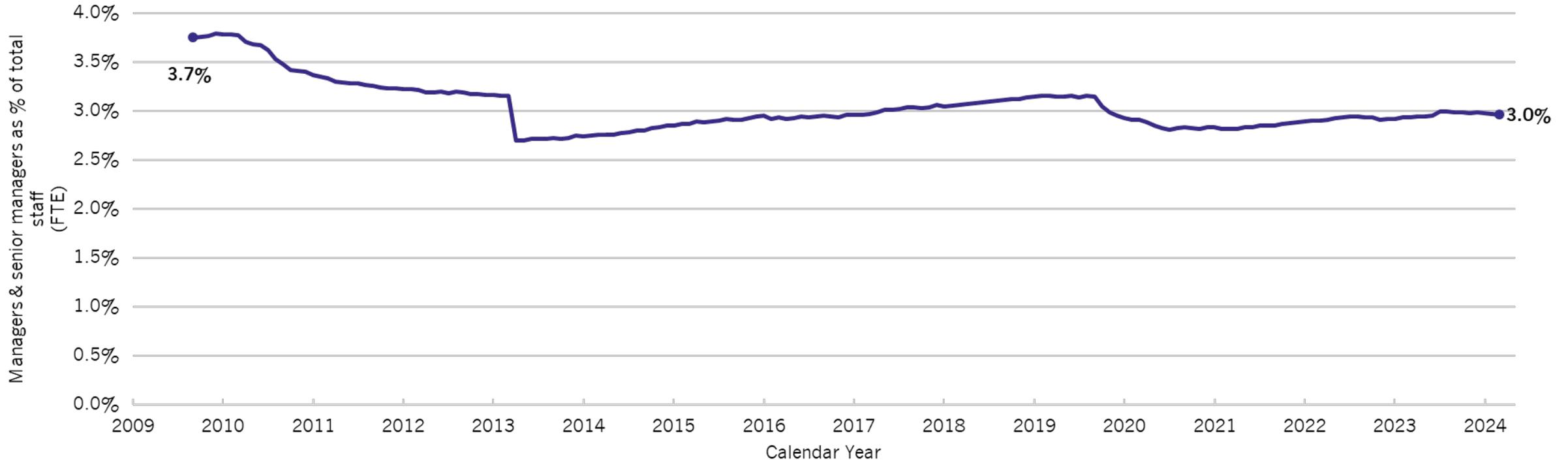
Notes: Please note: Data not available prior to September 2009. Latest data available – March 2024

Source: NHS England (2024) *Workforce statistics.* Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2024

2.3 Changes in managers per NHS employee since 2009

Figure IX.2.3: Change in managers per NHS employee since September 2009
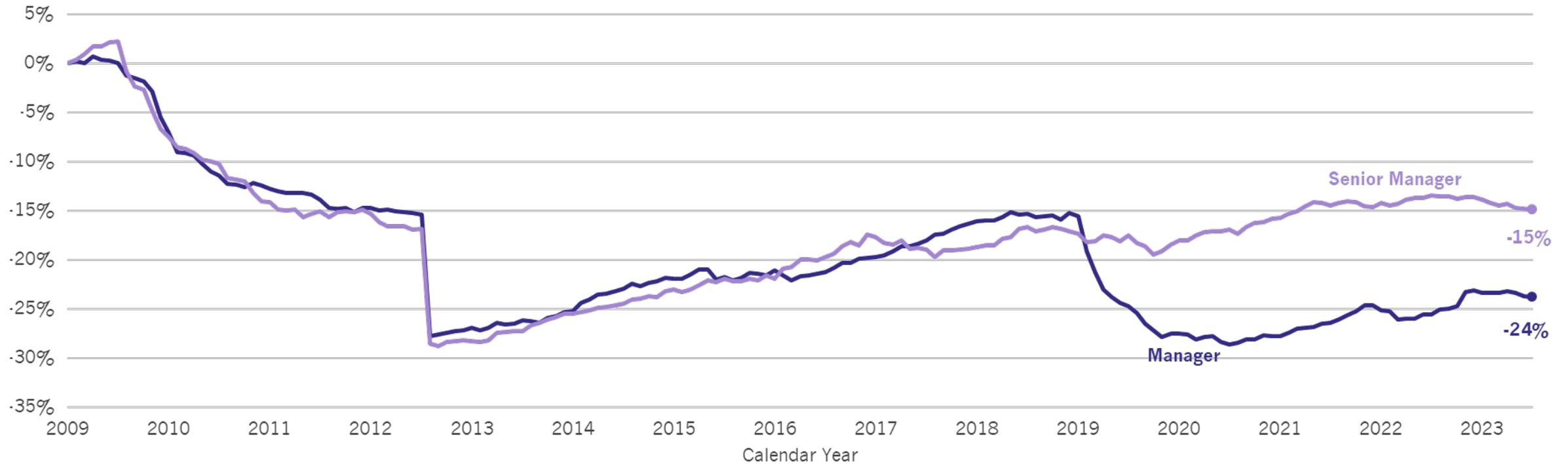
Notes: Staff numbers are in terms of FTE.

Source: NHS England. *NHS Workforce Statistics, April 2024*. Available: NHS Workforce Statistics, April 2024 England and Organisation.xlsx (live.com)

3.1 NHS staff working in NHS Support Organisations and Central Bodies in England

Figure IX.3.1: Full Time Equivalent (FTE) staff in NHS Support Organisations and Central Bodies March 2024
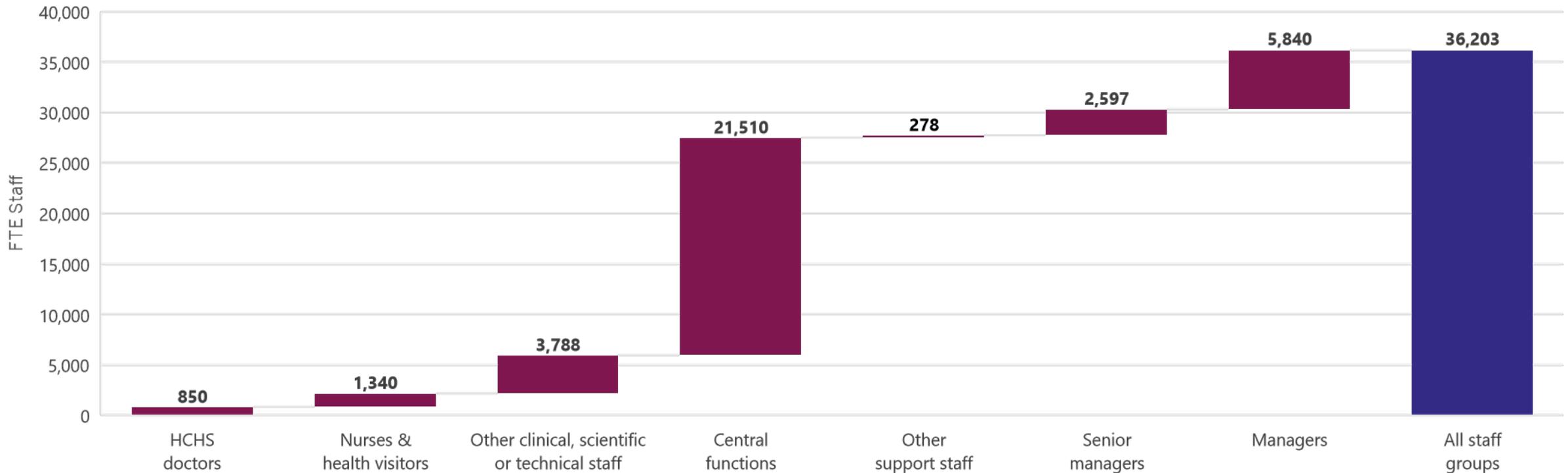
Notes: Organisations included: Health Research Authority; Health Services Safety Investigations Body; National Institute for Health and Care Excellence; NHS Arden and Greater East Midlands Commissioning Support Unit; NHS Blood and Transplant; NHS Business Services Authority; NHS Counter Fraud Authority; NHS England; NHS Midlands and Lancashire Commissioning Support Unit; NHS North of England Commissioning Support Unit; NHS Professionals Ltd; NHS Resolution; NHS South, Central and West Commissioning Support Unit; Non Geographic Central Staff. Other clinical, scientific or technical staff includes the following staff groups; Midwives, Ambulance staff, Scientific, therapeutic & technical staff, Support to doctors, nurses & midwives, Support to ambulance staff and Support to ST&T staff

3.2 Number of NHS staff employed in non-clinical roles

Figure IX.3.2: Full Time Equivalent (FTE) NHS infrastructure support staff by staff group, in NHS Trusts and other core organisations, March 2010 to 2024
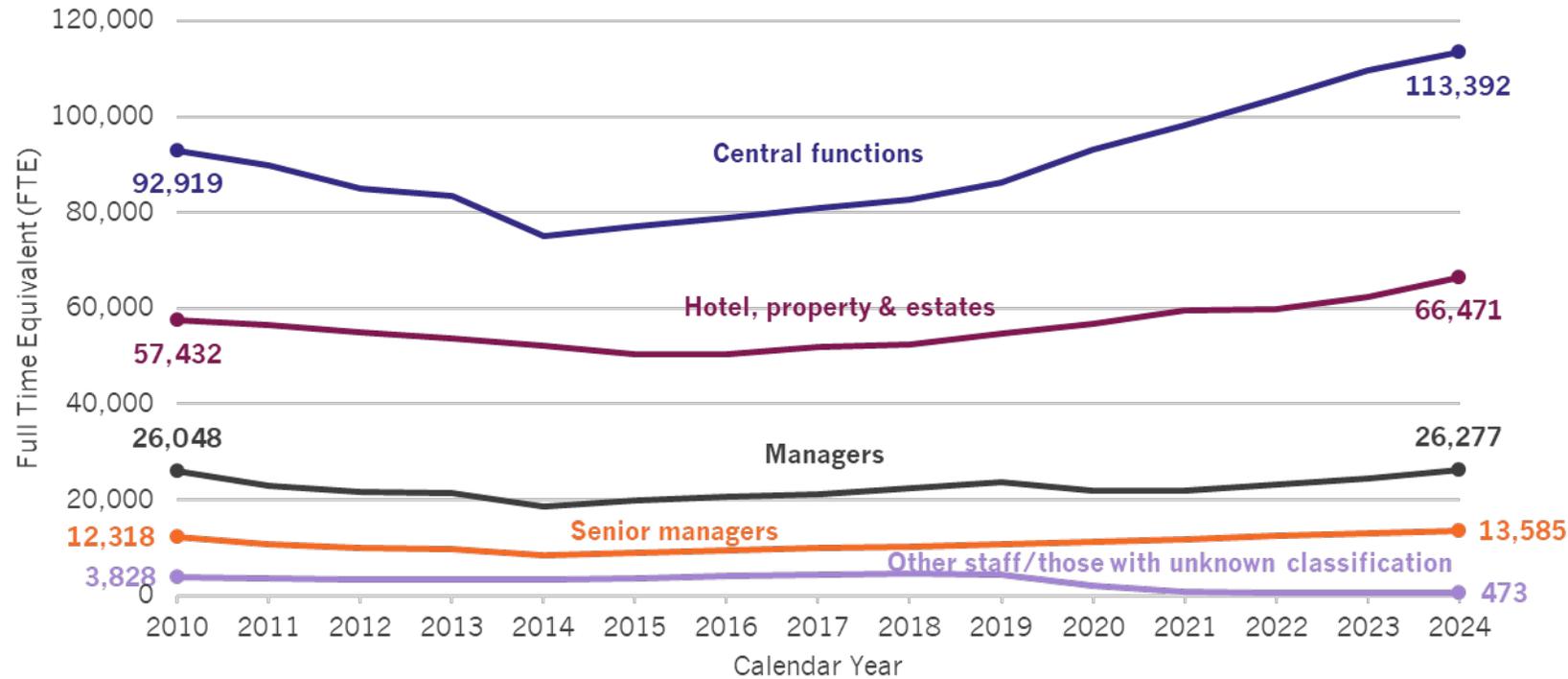
CAGR	2010-2016	2016-2020	2020-2022	2022-2024
Central functions	-2.7%	4.2%	5.7%	4.5%
Hotel, property & estates	-2.1%	2.3%	3.3%	4.5%
Managers	-3.8%	1.7%	2.6%	6.6%
Senior managers	-4.2%	4.1%	5.7%	4.4%

3.3 Changes in the NHS infrastructure support workforce

Figure IX.3.3: Percentage change in FTE of NHS infrastructure support staff, in NHS Trust and other core organisations, March 2010 to March 2024

Source: NHS England. NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Staff in NHS Trusts and other core organisations. Available:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

3.4 Clinically qualified staff (FTE) working in NHS Support Organisations and Central Bodies

Figure IX.3.4: The number of clinically qualified staff working in NHS support organisations and central bodies (March 2024)
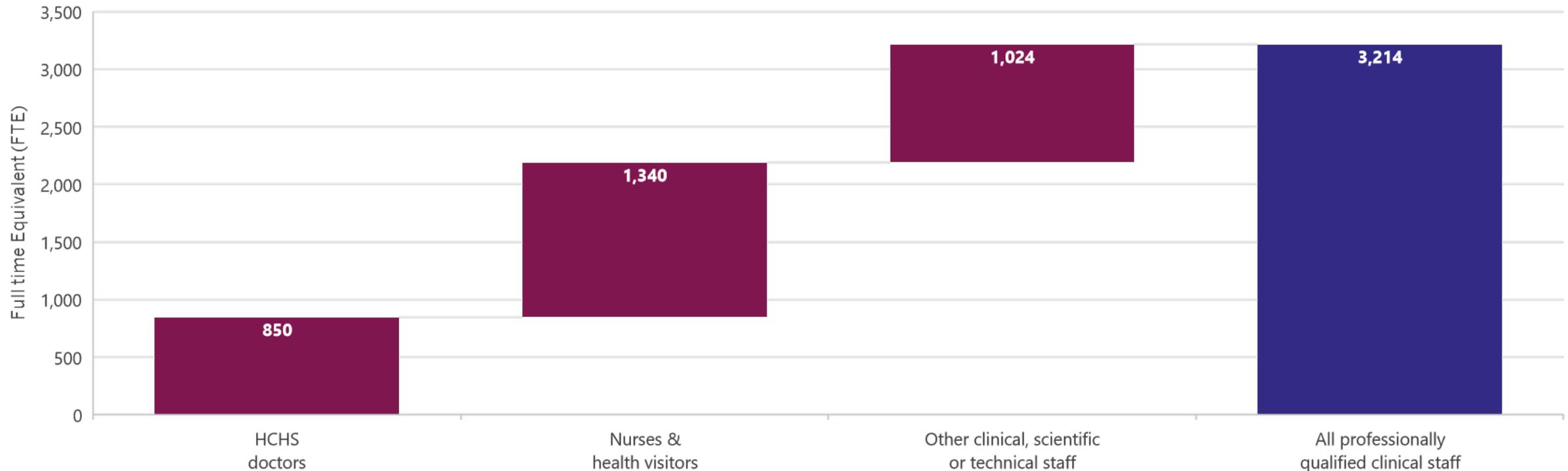
Notes: *Other clinical, scientific or technical staff includes the following staff groups; Midwives, Ambulance staff and Scientific, therapeutic & technical staff.

3.5 Employment in NHS England and other national entities relating to the NHS

Figure IX.3.5: NHS England* and DHSC headcount
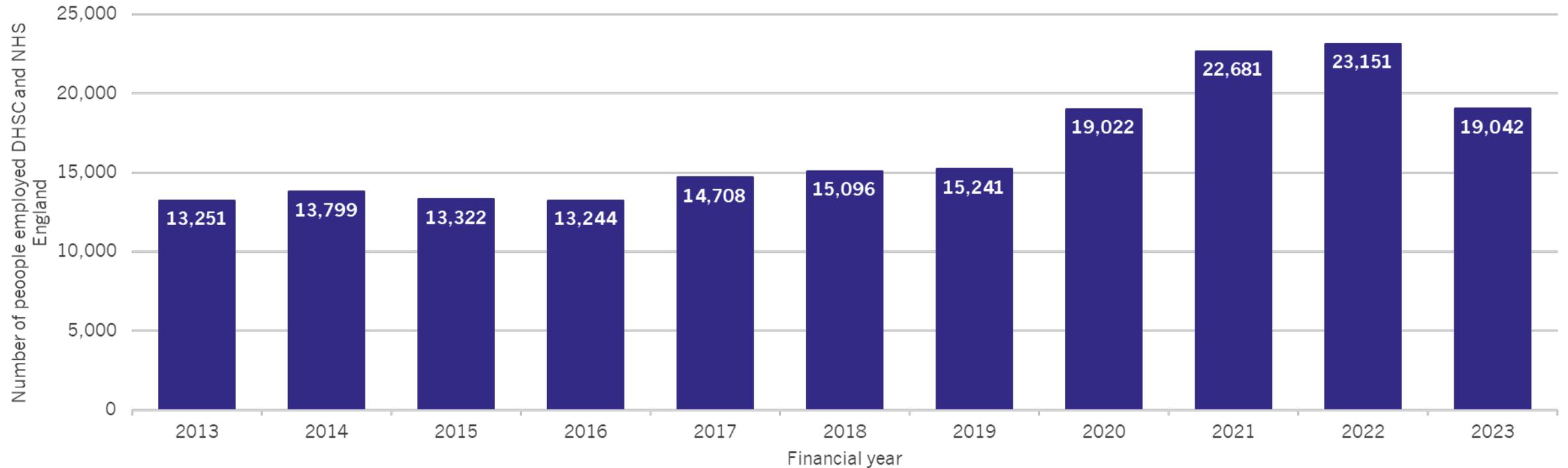
Notes: 2023/24 DHSC figure has been taken from January 2024 WMI data due to more current data not being published.

Source: *NHS England*. NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Staff in NHS Trusts and other core organisations. Available:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

3.6. National NHS organisations created and abolished since 2010

Figure IX.3.6: NHS organisations created and abolished from 2010 including headcount

2012: 32

NHS Appointments Commission

2013: 188

NHS Institute for Innovation and Improvement

2016: 569**

Monitor — Making the health sector work for patients

2021: 7388*

Public Health England

2022: 3862

NHS Digital

2012: 174

NHS National Patient Safety Agency

2013: 1233*

NHS Connecting for Health

2016: 326**

tda Trust Development Authority — Quality. Delivery. Sustainability.

2022: 861* ***

NHSx

2013: 160

NHS National Treatment Agency for Substance Misuse

2014: 1433

NHS Direct

2022: 1488**

NHS Improvement

2022: 3105

NHS Health Education England

Notes: *These may not be technically considered National NHS organisations and are included for visibility. **Monitor & TDA operationally merged into NHS Improvement in 2016 but continued to be separate legal entities until the NHS commissioning board legally merged with NHSD, HEE, Monitor and TDA into NHS England in the Health and Care Act 2022.
***Source: internal NHSE figures
Source: *NHS England*, Internal and Available: www.england.nhs.uk/wp-content/uploads/2023/07/monitor-annual-report-and-accounts-2022-23.pdf,
assets.publishing.service.gov.uk/media/5a80011240f0b62302690efb/NTDA_annualreport2016_WEB.pdf ,
assets.publishing.service.gov.uk/media/5a7d587840f0b60a7f1a9f44/HC_402_NHS_Direct_print.pdf , assets.publishing.service.gov.uk/media/5a7c8d5ee5274a0bb7cb7cc9/0079.pdf,
assets.publishing.service.gov.uk/media/5a7ba38ced915d4147621ad2/NPSA-Annual-Report-and-Accounts-2011-12-020812.pdf

3.7 Employment in NHS England and the Department of Health and Social Care

Figure IX.3.7: Employment in the NHS England, DHSC and NHS Provider Trusts, 2013/14 to 2023/24

Payroll Period	NHS England Total	DHSC Total	NHS England & DHSC Total	NHS Provider Trust	Headcount per trust
2013/14	11,331	1,920	13,251	249	53.2
2014/15	11,771	2,028	13,799	240	57.5
2015/16	11,321	2,001	13,322	243	54.8
2016/17	11,889	1,355	13,244	236	56.1
2017/18	13,189	1,519	14,708	234	62.9
2018/19	13,474	1,622	15,096	227	66.5
2019/20	13,471	1,770	15,241	223	68.3
2020/21	15,492	3,530	19,022	216	88.1
2021/22	18,606	4,075	22,681	213	106.5
2022/23	19,481	3,670	23,151	212	109.2
2023/24	15,857	3,185	19,042	212	89.8
CAGR (%)	27.5%	2.3%	15.1%		21.1%

Notes: Data in the table is from March of each year represented. 2023/24 Provider Figures have been projected based on 2022/23. For 2023/24, NHS England includes data from NHS England, NHS Digital, Health Education England, Monitor, Trust Development Authority.

Source: NHS England. *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Staff in NHS Trusts and other core organisations*. Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

3.8 The number of staff in NHS statutory bodies with 'regulatory' type functions

Figure IX.3.8: The full-time equivalent number of staff in NHS statutory bodies with 'regulatory' type functions, and the ratio of staff to provider trusts, 2003 to 2024

Statutory bodies in scope:
NHS Resolution
National Institute for Health and Clinical Excellence
National Patient Safety Agency
NHS Counter Fraud Authority
Appointments Commission
Health Development Agency
NHS Information Authority
NHS Litigation Authority
National Treatment Agency
Prescription Pricing Authority
Family Health Services Appeal Authority
Dental Practice Board
Human Fertilisation and Embryology Authority
Health Research Authority
Human Tissue Authority
Care Quality Commission
Medicines and Healthcare products Regulatory Agency
Health Services Safety Investigations Body

Notes: The exact number of staff in each statutory organisation that have are involved in regulatory functions is unknown. Not all bodies listed are in scope across the whole time series. Some organisations were formed recently, some have been abolished, and some have changed names and/or function.

Source: NHS England (Electronic Staff Record and Workforce Census), DHSC Arm's Length Body Oversights Team, Annual reports and Accounts

3.9 NHS England functions and scale
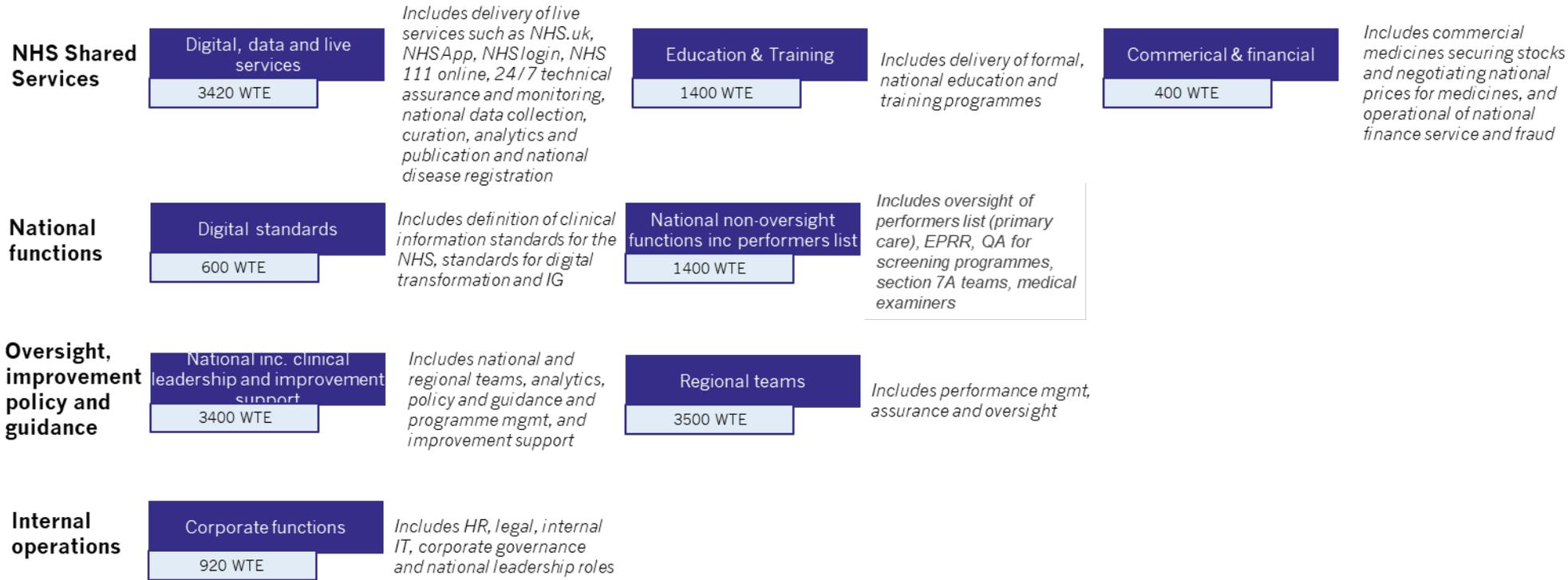
Figure IX.3.9: NHS England functions and associated FTE

NHS Shared Services		
Digital, data and live services — 3420 WTE	Education & Training — 1400 WTE	Commerical & financial — 400 WTE

Digital, data and live services: *Includes delivery of live services such as NHS.uk, NHS App, NHS login, NHS 111 online, 24/7 technical assurance and monitoring, national data collection, curation, analytics and publication and national disease registration*

Education & Training: *Includes delivery of formal, national education and training programmes*

Commerical & financial: *Includes commercial medicines securing stocks and negotiating national prices for medicines, and operational of national finance service and fraud*

National functions	
Digital standards — 600 WTE	National non-oversight functions inc performers list — 1400 WTE

Digital standards: *Includes definition of clinical information standards for the NHS, standards for digital transformation and IG*

National non-oversight functions inc performers list: *Includes oversight of performers list (primary care), EPRR, QA for screening programmes, section 7A teams, medical examiners*

Oversight, improvement policy and guidance	
National inc. clinical leadership and improvement support — 3400 WTE	Regional teams — 3500 WTE

National inc. clinical leadership and improvement support: *Includes national and regional teams, analytics, policy and guidance and programme mgmt, and improvement support*

Regional teams: *Includes performance mgmt, assurance and oversight*

Internal operations
Corporate functions — 920 WTE

Corporate functions: *Includes HR, legal, internal IT, corporate governance and national leadership roles*

Notes: Following the merger of NHS Improvement, TDA, NHS England, HEE and NHS Digital, the new NHS England brings together c 15,000 people across four broad categories of function. These are:

NHS shared services – national services required for the NHS to function e.g. digital services like the NHS Spine, national statistics publications, Information Governance, financial accounting system and fraud, medicines purchasing, national procurements and frameworks, delivery of education and training.

National functions – functions that need to happen once within the service e.g. EPRR, clinical information and IG standards etc.
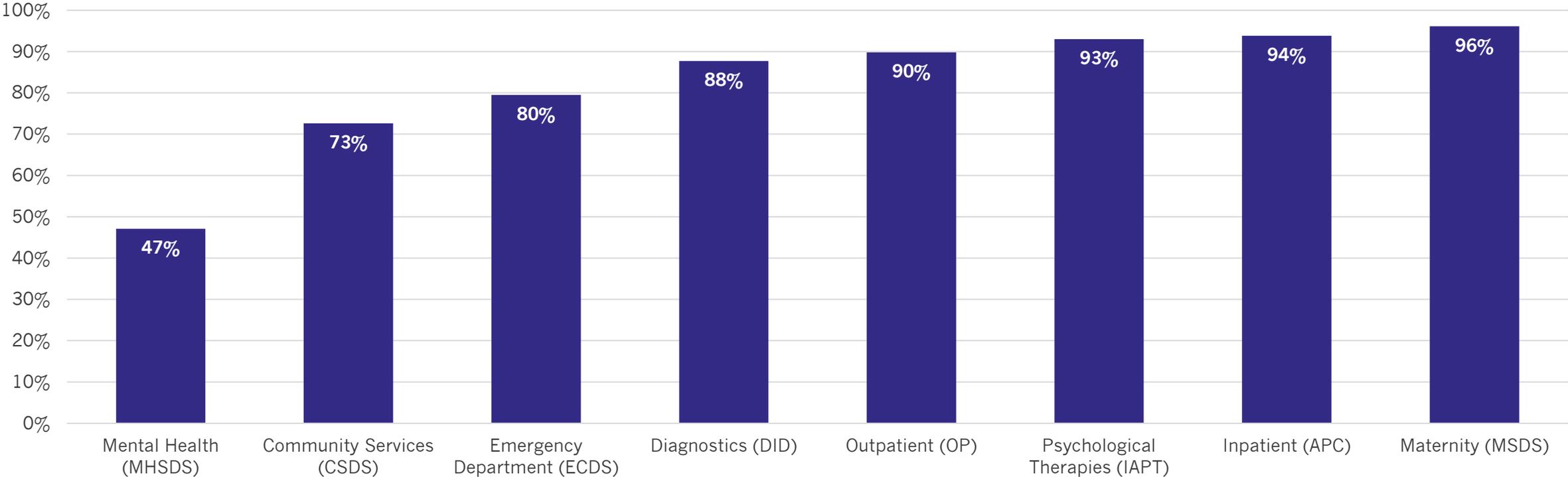
Oversight, improvement, policy and guidance – including clinical advisors, national policy and guidance, clinical regional oversight and infrastructure.

Internal operational functions – required to run an organisation e.g. internal IT, HR, legal, internal comms, financial accounting, board governance etc.

Source: NHS England (Electronic Staff Record)

4.1 Completeness of datasets

Figure IX.4.1: Data Quality Maturity Index, March 2024

Source: NHS England. *Data Quality Maturity Index reports*. Available: https:digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality

4.2. NHS Planning, Commissioning and Improvement Data Sharing Agreements

Figure IX.4.2: Number of new NHS Planning/Commissioning/Improvement Agreements signed, by month, Jan 2019 to July 2024
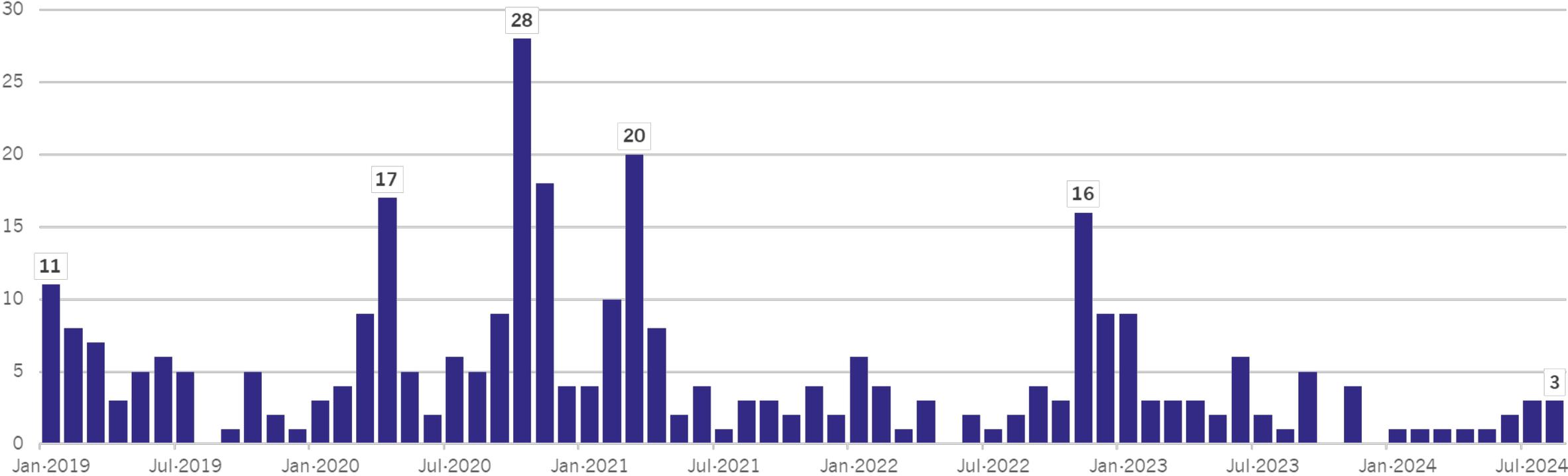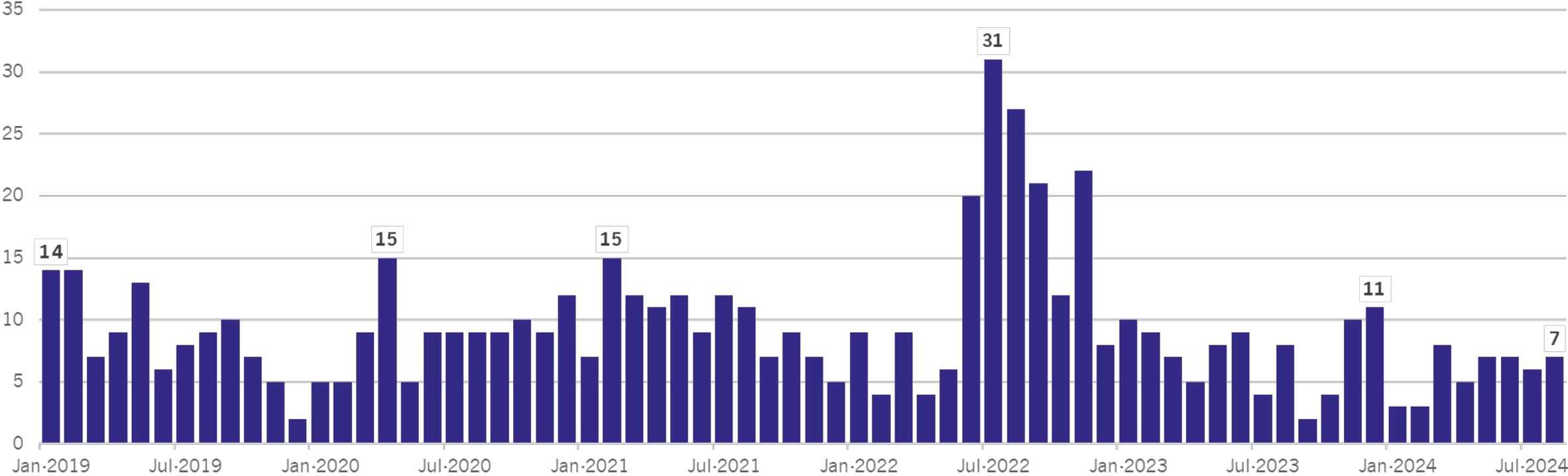

Notes: Number of new data sharing agreements signed each month for NHS planning, commissioning and improvement purposes (including Local Authority Public Health teams or where the data is required to deliver the organisation's statutory function) by NHS England's Data Access Request Service, 01 Jan 2019 to 22 Aug 2024. that for planning/commissioning data sharing there is a decline in new application volumes from 2022 but this is because we moved from having agreements with just over 100 CCGs to 42 ICBs.

Source: NHS England, DARS CRM

4.3 NHS Data Sharing for Research

**Figure IX.4.3: Number of new research agreements signed, by month, Jan 2019 to Jul 2024**

Notes: Number of new data sharing agreements signed each month by NHS England's Data Access Request Service where the application purpose is specified as research, 01 Jan 2019 to 22 Aug 2024. Research data sharing agreements are in response to external demand, which fluctuates depending on academic/principal investigator activity among other reasons.

Source: NHS England, DARS CRM

4.4 Combined surplus/deficit of trusts in England between 2010/11 and 2022/23

Figure IX.4.4: Combined surplus/deficit of trusts in England between 2010/11 and 2022/23
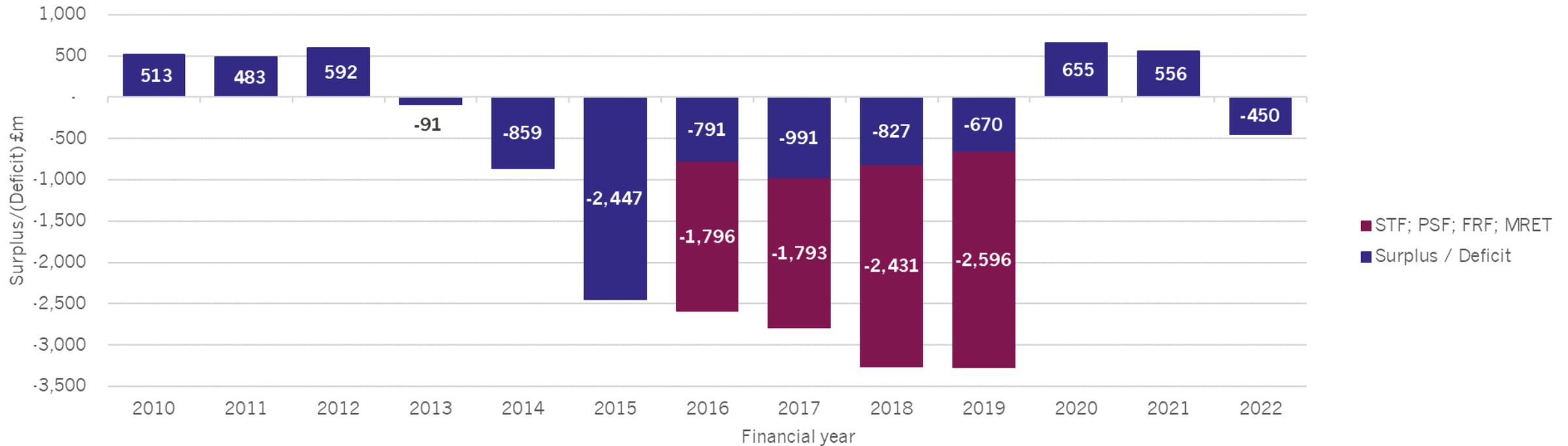

Notes: STF = Sustainability and Transformation Fund; PSF = Provider Sustainability Fund; FRF = Financial Recovery Fund; MRET = Marginal Rate Emergency Tariff

Source: Nation Audit Office (NAO) 2010/11 - 2018/19 - NAO report, 2019/20-2022/23. Available: https://www.nao.org.uk/wp-content/uploads/2020/02/Review-of-capital-expenditure-in-the-NHS.pdf; DHSC Annual reports and accounts: 2022 to 2023. Available: https://www.gov.uk/government/publications/dhsc-annual-report-and-accounts-2022-to-2023; NHSI Consolidated NHS provider accounts 2019-20. Available: https://www.england.nhs.uk/wp-content/uploads/2021/01/consolidated-nhs-provider-accounts-19-20.pdf

4.5 Numbers of NHS organisations authorised as Foundation Trusts for the first time

Figure IX.4.5: Numbers of NHS organisations authorised as Foundation Trusts for the first time
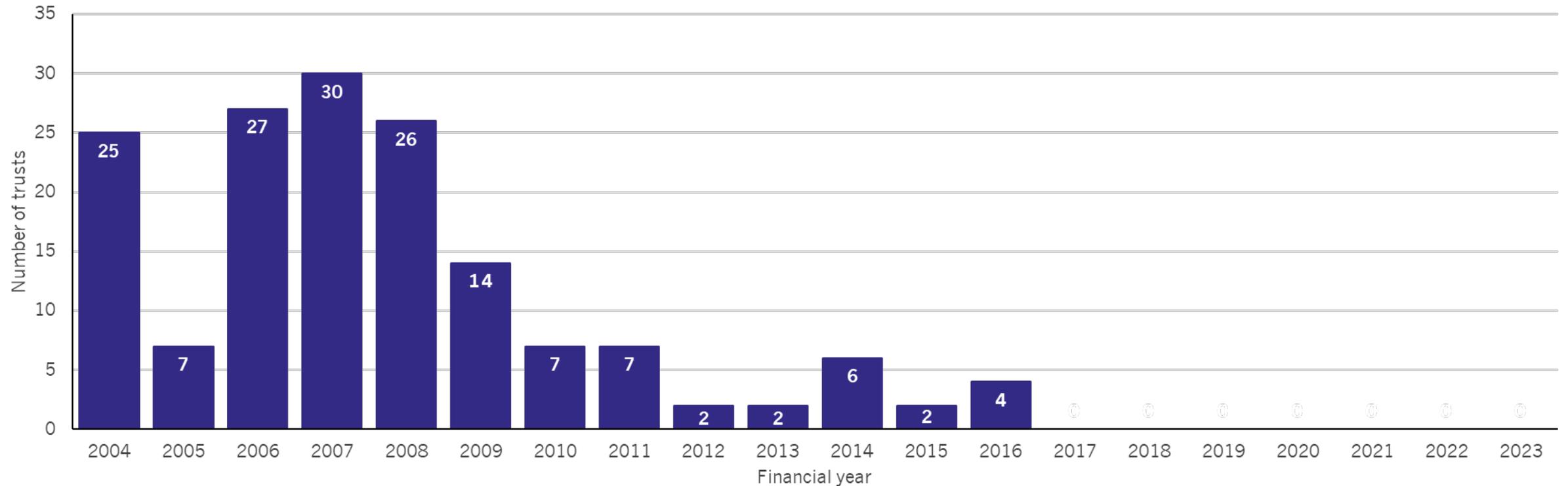
Notes: In 2016, the assessment process for NHS Trusts to become Foundation Trusts (FTs) was paused under government policy. As a result, any new FTs created from 2017 onwards are the result of mergers of existing FTs with other FTs or NHS trusts.

Source: NHS England, Internal data but held in public domain (in Monitor and NHSE annual reports/end of year accounts).