Quality strategy for NHS-funded care in England – technical annex

Core quality metrics: trend, variation and inequality data
Generated: 09 July 2026

How to use this pack

Purpose and conventions

This technical annex accompanies the Quality strategy for NHS-funded care in England and presents the latest available data for each of the strategy's quality metrics. It provides a comprehensive baseline picture of quality in England.

Structure

The annex is organised around three quality domains:
1. Effectiveness: improving health outcomes, reducing premature mortality, and increasing years lived in good health
2. Safety: ensuring safe care and reducing avoidable harm across all settings
3. Experience of care: ensuring people have a positive experience of NHS services

Within each domain, metrics span three tiers:
• Tier 1 Outcomes: the population-level results the strategy aims to shift. These are slow-moving (annual or 3-yearly) and represent the ultimate measures of success.
• Tier 2 Drivers: the clinical and system levers that influence outcomes. Movement here provides early evidence that interventions are working.
• Tier 3 Process metrics: fast-moving operational signals that show whether care processes are functioning effectively.

Each metric begins with a summary page explaining why it matters for the strategy, followed by one chart per page. Each page shows the metric's domain, tier and direction of improvement. Some metrics will be relevant to more than one domain.

Data views

For each metric we show, where data are available, an England-level trend over time, variation across NHS Regions (or Cancer Alliances for cancer metrics) and health inequalities data on the deprivation gradient.

Notes

• Missing data views are noted on each page.
• Time periods vary by publication schedule.
• All figures are from published national sources, cited on each page.

About the trend charts

How to read statistical process control (SPC) and non-SPC trends

Trend charts in this pack use statistical process control (SPC), specifically individuals and moving range (XmR) charts, where there are enough data points. SPC distinguishes ordinary variation from special-cause signals worth investigating.

With SPC (10 or more data points)

Each chart shows four series:
• Data line: the metric's observed values (NHS Blue or Orange).
• Mean: the average across all points (dark grey solid line).
• Upper control limit (UCL) and lower control limit (LCL): the limits at 3 standard deviations above and below the mean (red dashed lines). Points outside these limits are unlikely to be ordinary variation.
• Special-cause markers: orange dots highlight points outside the control limits.

Without SPC (fewer than 10 data points, annual data)

Where the published time series is too short for reliable control limits or has annual data, the chart shows either a simple trend or the mean, UCL and LCL without SPC markers. Examples in this pack include the inequality gap metrics and several newly-published indicators.

Charts split by sex

Some metrics are published with separate male and female series. Where SPC applies, male and female SPC charts are shown on separate pages. Where SPC does not apply, both series share a single chart.

What to look for

• A point above the UCL or below the LCL is a special-cause signal.
• A run of six or more consecutive points on one side of the mean is also a signal.
• Points within the control limits represent ordinary variation, not necessarily a meaningful change in the system.

Accessibility

How to request this document in another format

This document is designed to be accessible when exported to PDF. Every chart includes alternative text describing what it shows, and the commentary page for each metric describes the key messages in plain text.

If you use assistive technology and need a version of this document in a more accessible format, such as large print or an accessible PDF, please email england.da-qis-analysis@nhs.net. Tell us the format you need and which document you are asking about.

Charts in this annex use statistical process control where there are enough data points. The page "About the trend charts" explains how to read them. Each metric also has a commentary page stating the latest value, the trend and any inequality findings, so the information in every chart is also available as text.

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Effectiveness

This section covers the effectiveness of healthcare in England: whether the system is improving health outcomes, reducing premature mortality, and increasing years lived in good health.

Metrics span population health outcomes (life expectancy, avoidable mortality), major clinical pathways (cardiovascular disease, cancer, respiratory disease, mental health, diabetes, dementia), and prevention (smoking, obesity, vaccination).

Each metric is tagged with its tier: Tier 1 outcomes show the population-level results; Tier 2 drivers show whether the clinical levers are moving; Tier 3 process metrics provide fast-moving signals.

Life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live if current age-specific mortality rates carried on (Office for National Statistics (ONS) national life tables via Office for Health Improvement and Disparities (OHID) Fingertips, single-year).

Why it matters for the strategy

• Life expectancy at birth is a key summary measure of population health and the headline figure used in international comparison. It underpins the strategy's overarching ambition of improving healthy life expectancy and reducing inequalities
• The latest figure for England (2025) is 83.8 (F), 80.0 (M) Years.
• The picture is improving: 1.5y above 2020 (79.5) and 0.1y above the 2019 peak (79.9). F 83.8 – 1.3y above 2020 (82.5) and 0.2y above the 2019 peak (83.6), a new post-pandemic high. Pre-2010 rate of increase has not resumed.
• Performance varies across NHS Regions (2024 data): the best-performing area was South East for males (80.9 years) and London for females (85.0 years); the lowest was North West (78.4 M / 82.2 F Years).
• The deprivation gap (2021 to 2023) is 10.4 years for males (72.8 most deprived to 83.2 least deprived) and 8.2 Years for females (78.0 to 86.2).

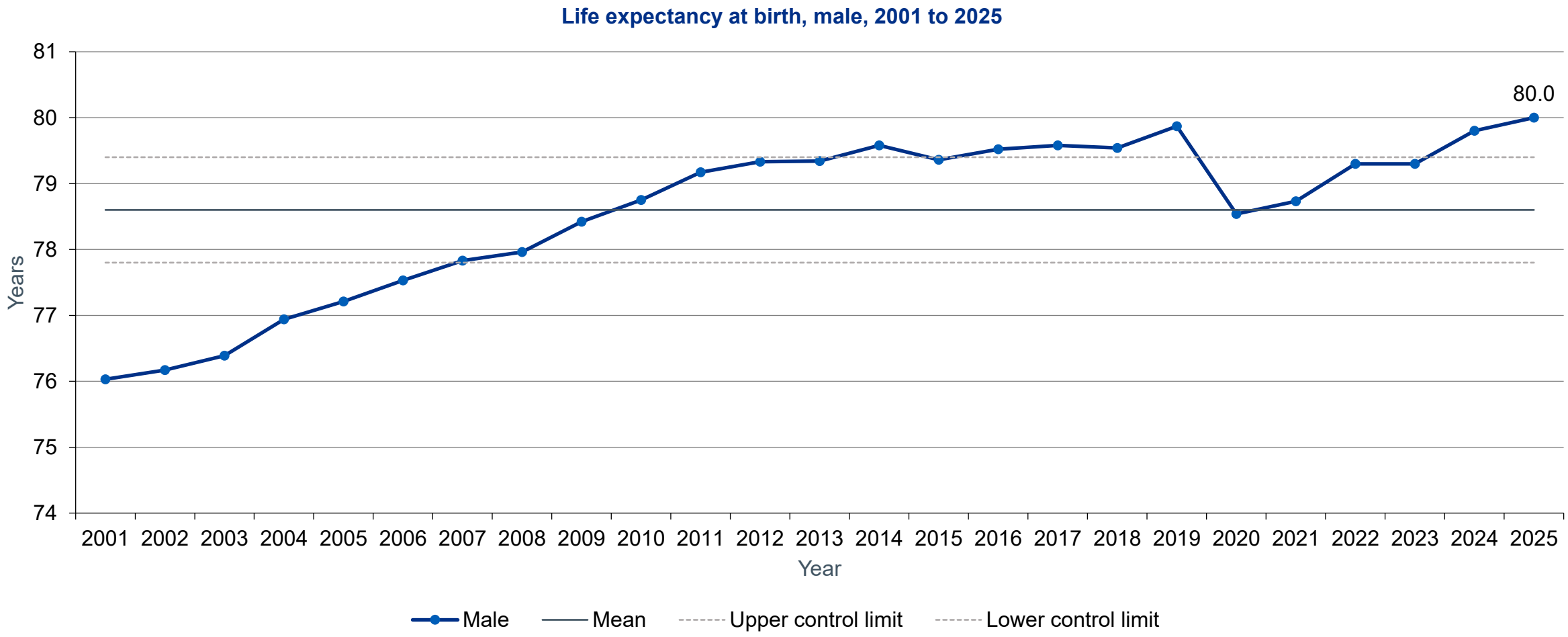
Source: ONS life tables, OHID Fingertips indicator 90366. Trend and NHS region values: single-year estimates. Deprivation deciles: 2021 to 2023 three-year pooled (single-year Index of Multiple Deprivation (IMD) breakdown not published).

Life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live if current age-specific mortality rates carried on (ONS national life tables via OHID Fingertips, single-year).

Figure 1.1: Life expectancy at birth: England trend (male)



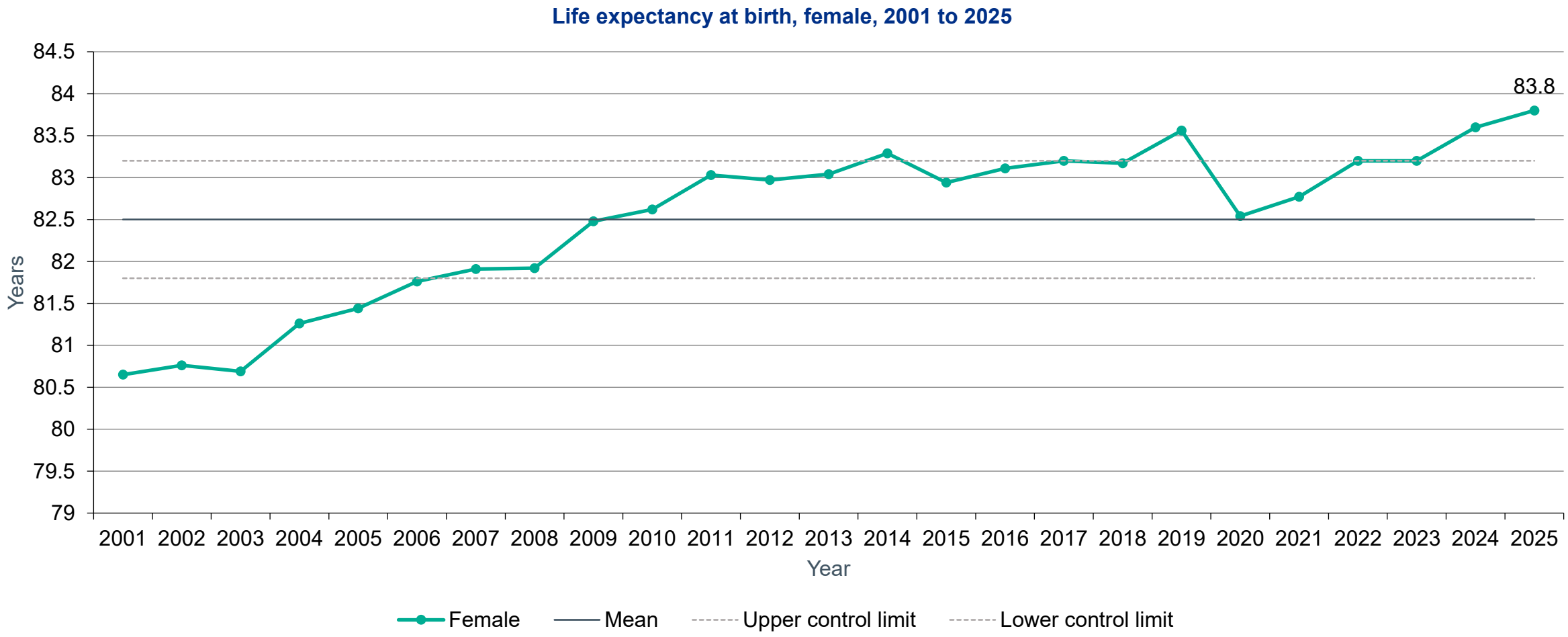
Source: ONS life tables, OHID Fingertips indicator 90366. Trend and NHS region values: single-year estimates. Deprivation deciles: 2021 to 2023 three-year pooled (single-year IMD breakdown not published).

Life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live if current age-specific mortality rates carried on (ONS national life tables via OHID Fingertips, single-year).

Figure 1.2: Life expectancy at birth: England trend (female)



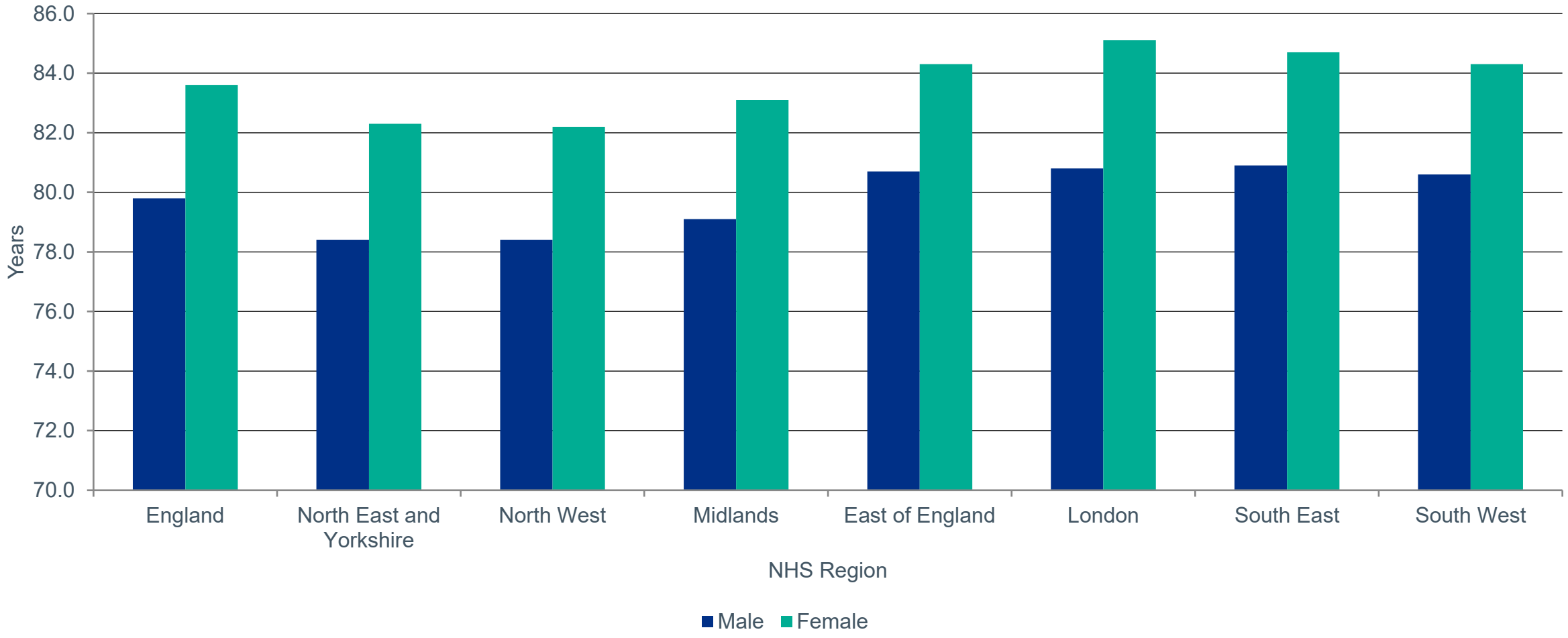
Source: ONS life tables, OHID Fingertips indicator 90366. Trend and NHS region values: single-year estimates. Deprivation deciles: 2021 to 2023 three-year pooled (single-year IMD breakdown not published).

Life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live if current age-specific mortality rates carried on (ONS national life tables via OHID Fingertips, single-year).

Figure 1.3: Life expectancy at birth by NHS Region, 2024 (latest)



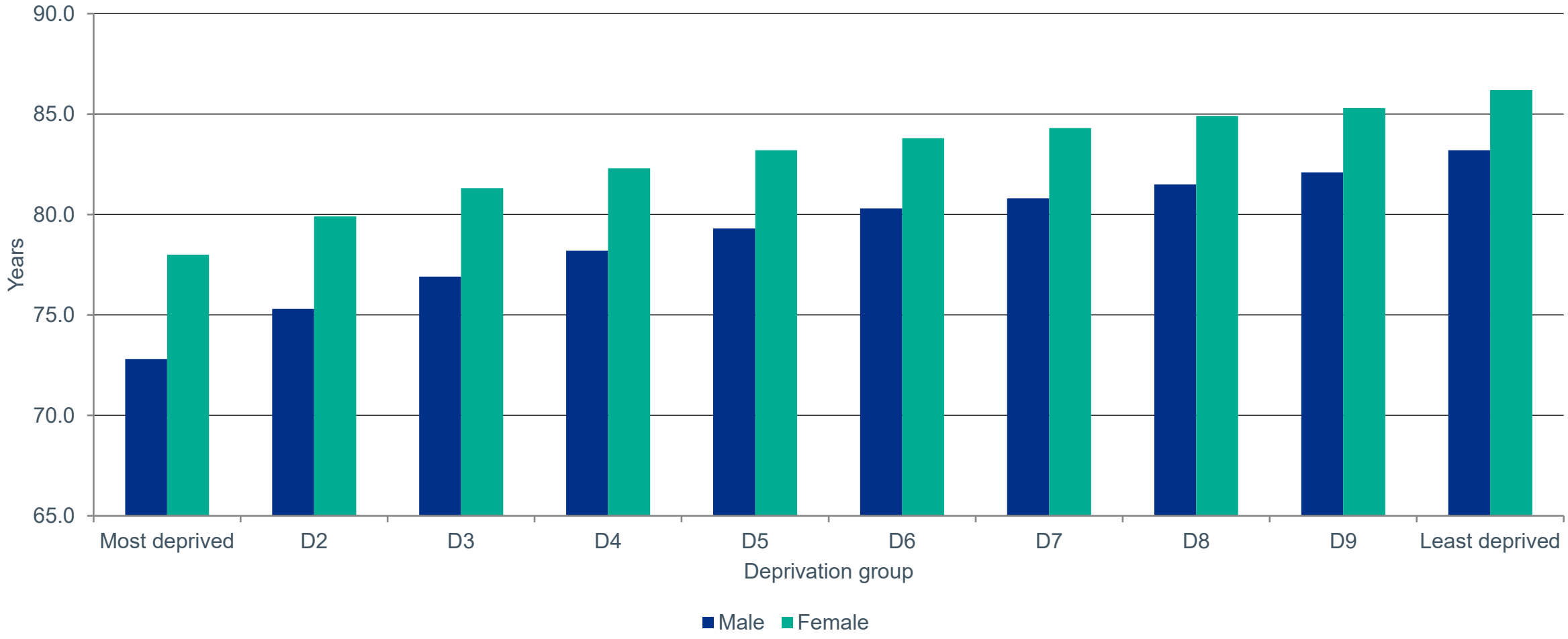
Source: ONS life tables, OHID Fingertips indicator 90366. Trend and NHS region values: single-year estimates. Deprivation deciles: 2021 to 2023 three-year pooled (single-year IMD breakdown not published).

Life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live if current age-specific mortality rates carried on (ONS national life tables via OHID Fingertips, single-year).

Figure 1.4: Life expectancy at birth by deprivation group (IMD decile), 2021 to 2023 (latest)



Source: ONS life tables, OHID Fingertips indicator 90366. Trend and NHS region values: single-year estimates. Deprivation deciles: 2021 to 2023 three-year pooled (single-year IMD breakdown not published).

Healthy life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live in self-assessed good health, combining mortality data with Annual Population Survey self-reported health (Office for National Statistics (ONS) Health State Life Expectancies).

Why it matters for the strategy

• Healthy life expectancy at birth is a key measure of population health, folding length and quality of life into one figure that distinguishes extra years lived in good health from extra years lived with illness and disability.
• The latest figure for England (2022 to 2024) is 61.3 (F), 60.9 (M) Years.
• This is getting worse: Down 2.2y (M) and 2.7y (F) from the 2018 to 2020 reference: M 63.1 to 60.9, F 64.0 to 61.3. Latest period 2022 to 2024. Down 0.6y (M) and 0.6y (F) on 2021 to 2023. Deprivation chart uses 2020 to 2022 (latest available by Index of Multiple Deprivation (IMD) decile).
• The deprivation gap (2020 to 2022) is 19.0 years for males (51.1 most deprived to 70.1 least deprived) and 19.6 years for females (50.5 to 70.2).
• Healthy life expectancy (HLE) responds to decades of investment in prevention, treatment and the wider determinants of health; meaningful change takes many years. This metric is the strategy's most prominent measure of declining health and is named directly in the overarching ambition to improve healthy life expectancy and reduce inequalities.

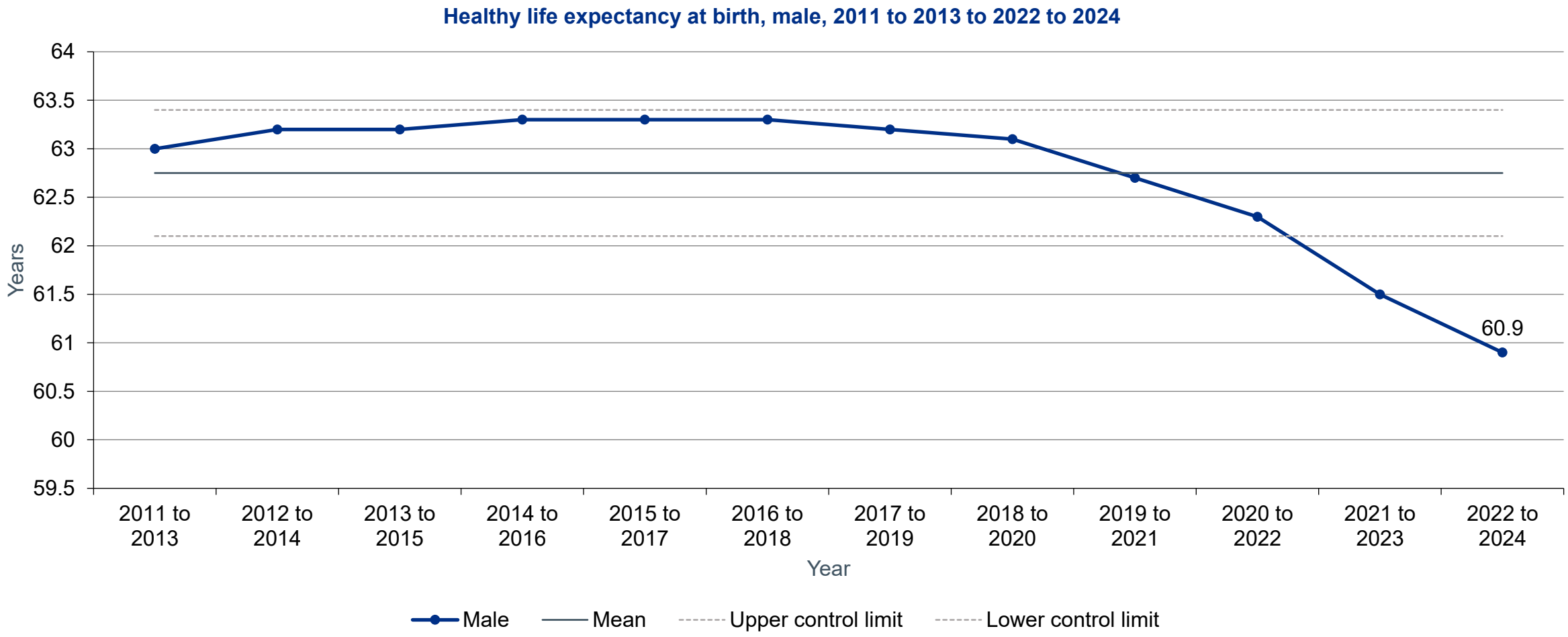
Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

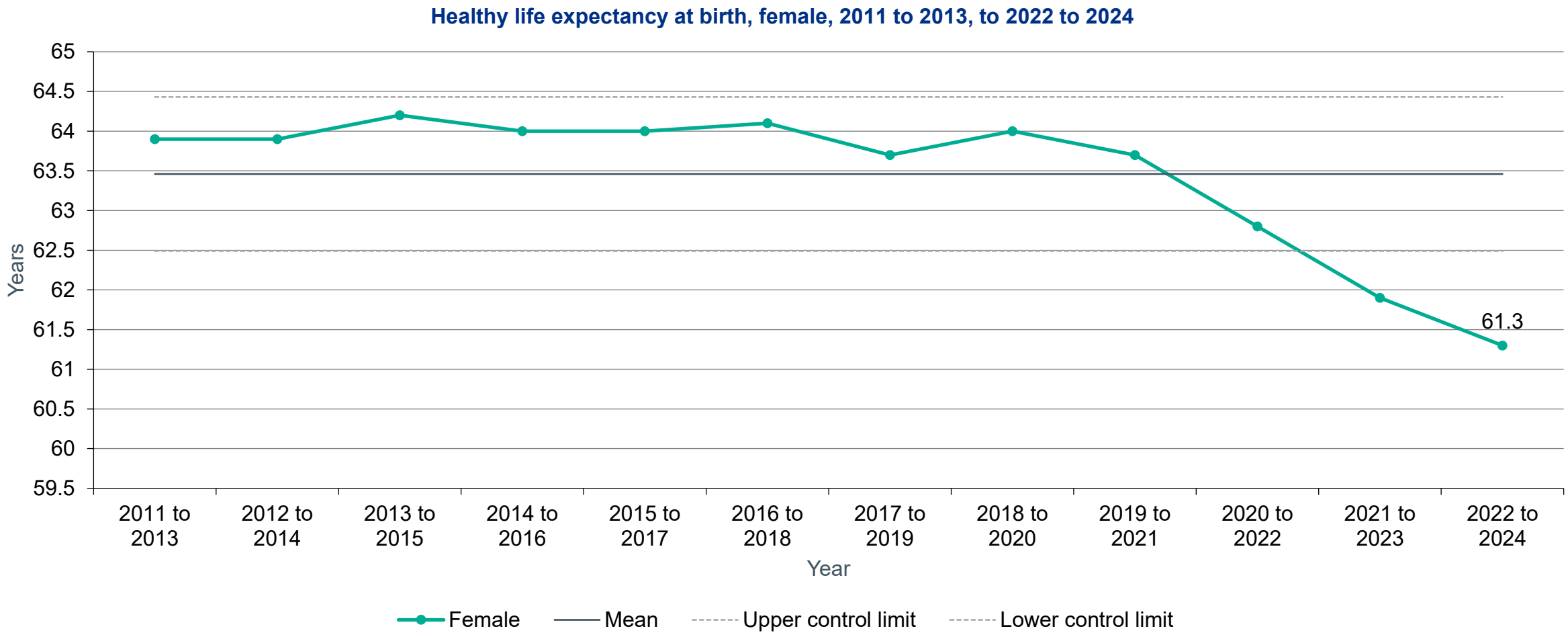
Average years a newborn would live in self-assessed good health, combining mortality data with Annual Population Survey self-reported health (ONS Health State Life Expectancies).

Figure 1.5: Healthy life expectancy at birth: England trend (male)



Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.6: Healthy life expectancy at birth: England trend (female)



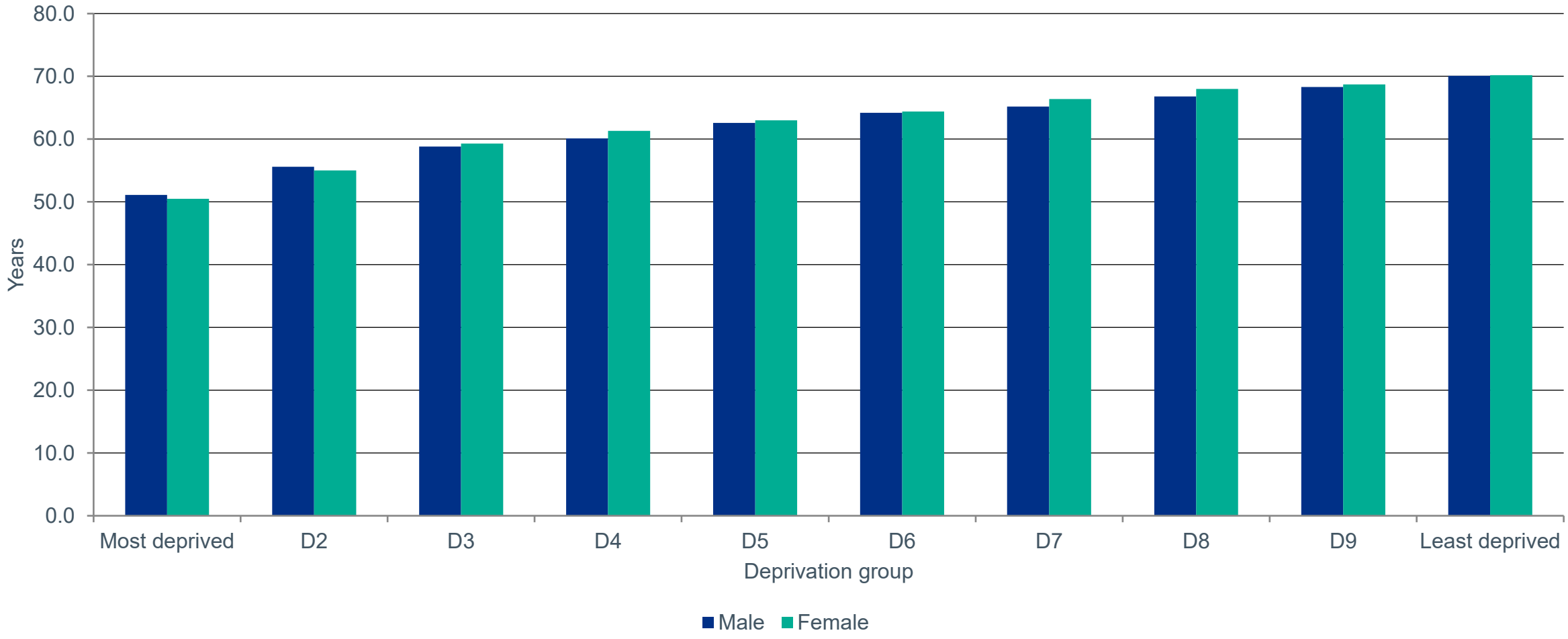
Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy at birth

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Average years a newborn would live in self-assessed good health, combining mortality data with Annual Population Survey self-reported health (ONS Health State Life Expectancies).

Figure 1.7: Healthy life expectancy at birth by deprivation group (IMD decile), 2020 to 2022 (latest)



Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy at 65

Effectiveness | Tier 1: Outcome | ↑ Higher is better

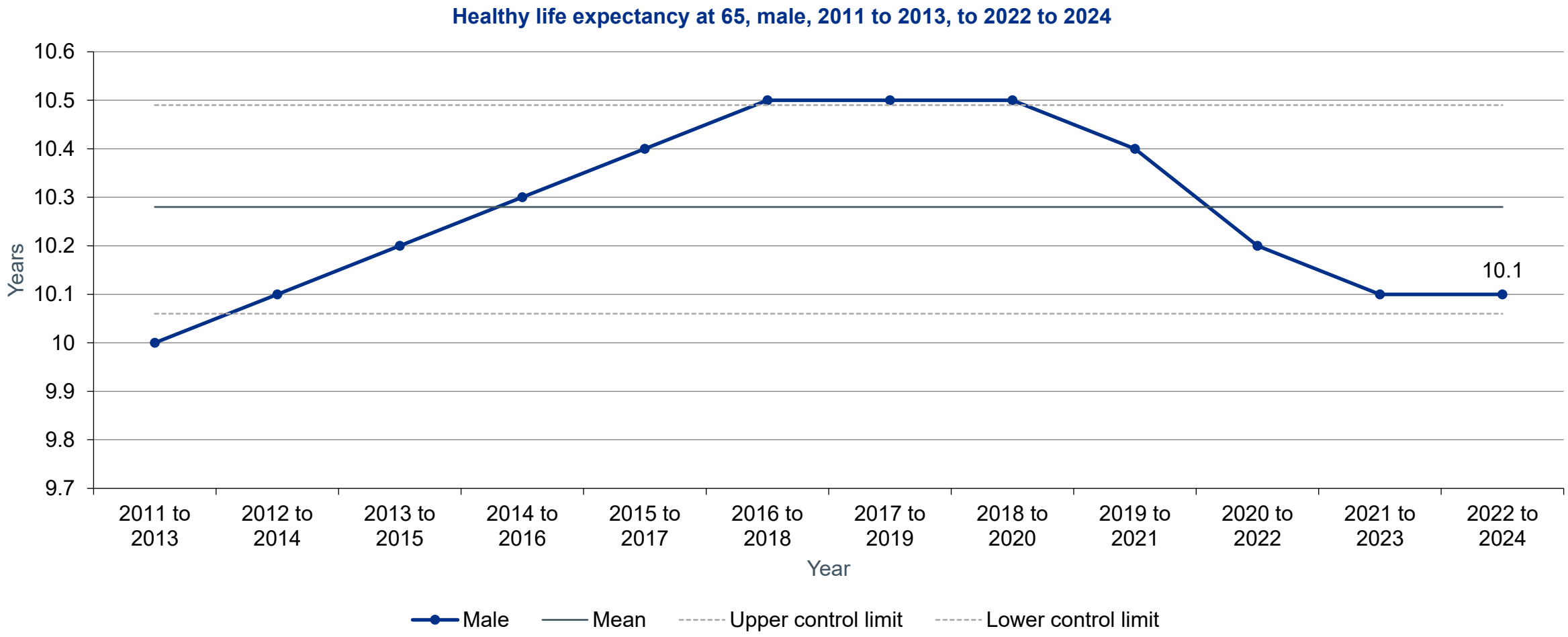
Healthy life expectancy at age 65 for England, estimating the average number of remaining years a 65-year-old would live in self-assessed good health (Office for National Statistics (ONS) Health State Life Expectancies).

Why it matters for the strategy

• Healthy life expectancy at 65 shows how many years of good health older people can expect, directly informing the sustainability of health and social care services and the lived experience of ageing. Older-people population health signal: a sub-indicator of healthy life expectancy (HLE) at birth that anchors the strategy's Effectiveness ambition and action on long-term conditions including musculoskeletal (MSK), dementia and common mental disorders, which dominate years lived in ill health for older adults.
• The latest figure for England (2022 to 2024) is 11.1 (F), 10.1 (M) Years.
• This is getting worse: M stable at 10.1 (2021 to 2023, to 2022 to 2024) but declined by 0.4y from 2018 to 2020 peak (10.5); F declined from 11.2 to 11.1. Female is 0.6y below 2018 to 2020 peak (11.7).
• The deprivation gap (2020 to 2022) is 7.7 years for males (5.7 most deprived to 13.4 least deprived) and 7.8 Years for females (6.6 to 14.2).

Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026). Trend and regional values 2022 to 2024; deprivation deciles 2020 to 2022 three-year pooled (Fingertips 93... | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.8: Healthy life expectancy at 65: England trend (male)



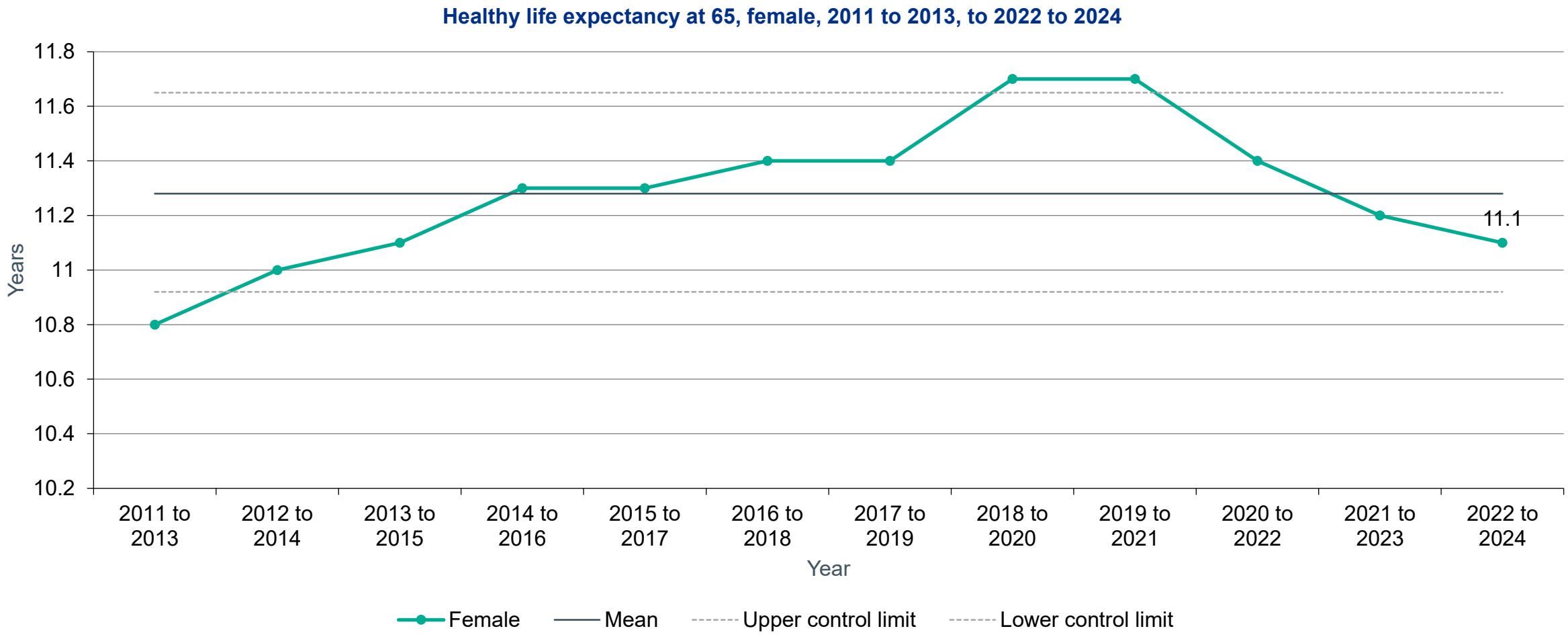
Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026). Trend and regional values 2022 to 2024; deprivation deciles 2020 to 2022 three-year pooled (Fingertips 93... | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy at 65

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Healthy life expectancy at age 65 for England, estimating the average number of remaining years a 65-year-old would live in self-assessed good health (ONS Health State Life Expectancies).

Figure 1.9: Healthy life expectancy at 65: England trend (female)



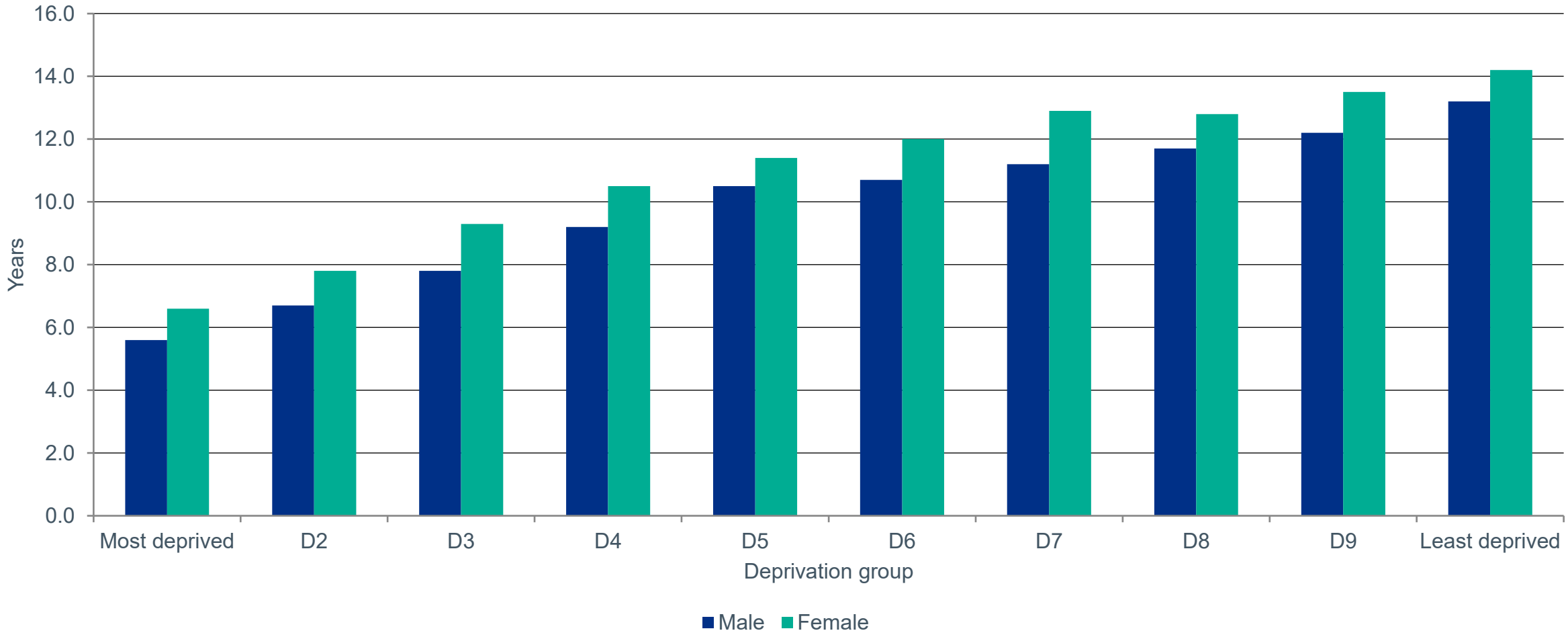
Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026). Trend and regional values 2022 to 2024; deprivation deciles 2020 to 2022 three-year pooled (Fingertips 93... | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy at 65

Effectiveness | Tier 1: Outcome | ↑ Higher is better

Healthy life expectancy at age 65 for England, estimating the average number of remaining years a 65-year-old would live in self-assessed good health (ONS Health State Life Expectancies).

Figure 1.10: Healthy life expectancy at 65 by deprivation group (Index of Multiple Deprivation (IMD) decile), 2022 to 2024 (latest)



Source: ONS, Health state life expectancies, UK: between 2011 to 2013 and 2022 to 2024 (19 Feb 2026). Trend and regional values 2022 to 2024; deprivation deciles 2020 to 2022 three-year pooled (Fingertips 93... | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Healthy life expectancy inequality gap

Effectiveness | Tier 1: Outcome | ↓ Lower is better

The inequality gap in healthy life expectancy at birth between the most and least deprived areas of England, measured as the Slope Index of Inequality across Index of Multiple Deprivation (IMD) deciles (Office for National Statistics (ONS) Health State Life Expectancies by deprivation).

Why it matters for the strategy

• The HLE inequality gap measures the difference in healthy life expectancy between the most and least deprived areas. Narrowing it is a core objective of the strategy
• The latest figure for England (2022 to 2024) is 20.1 (F), 19.3 (M) Years.
• This is getting worse: Slope Index of Inequality widening: M=19.3, F=20.1 years (2022 to 2024), up from M=18.6, F=19.2 in 2017 to 2019. England national figure only - SII is not published by region, sub-decile, or ethnicity in any current ONS / Fingertips release.
• Inequalities dimension of the HLE outcome and the central rationale for the Core20PLUS5 framework. Driven by the same conditions that shape overall HLE (cardiovascular disease (CVD), cancer, respiratory, common mental disorders) but heavily concentrated by deprivation, ethnicity and geography.

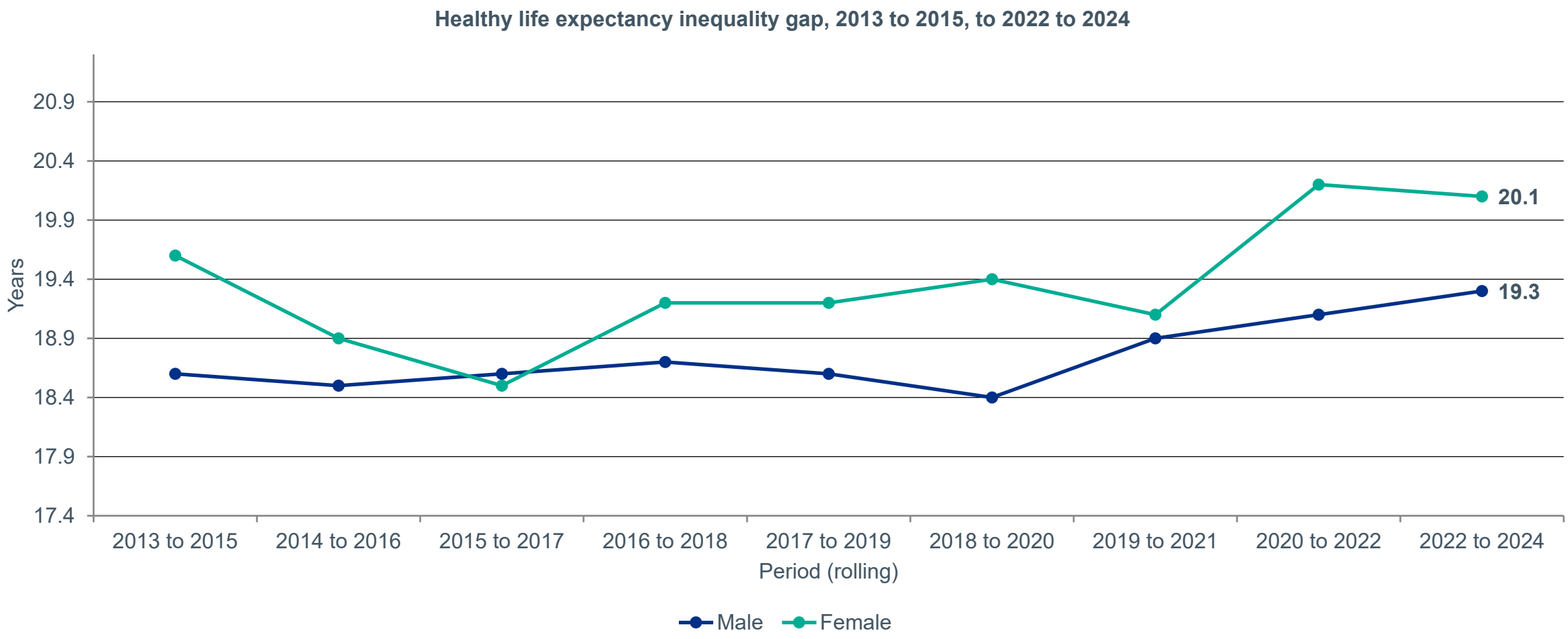
Source: ONS healthy life expectancy (HLE) by national area deprivation (15 Apr 2026). England slope index of inequality (SII) across IMD deciles. England-only - the SII is not published by region or ethnic group

Healthy life expectancy inequality gap

Effectiveness | Tier 1: Outcome | ↓ Lower is better

The inequality gap in healthy life expectancy at birth between the most and least deprived areas of England, measured as the Slope Index of Inequality across IMD deciles (ONS Health State Life Expectancies by deprivation).

Figure 1.11: Healthy life expectancy inequality gap: England trend (male)



Source: ONS HLE by national area deprivation (15 Apr 2026). England SII across IMD deciles. England-only - the SII is not published by region or ethnic group

Life expectancy inequality gap

Effectiveness | Tier 1: Outcome | ↓ Lower is better

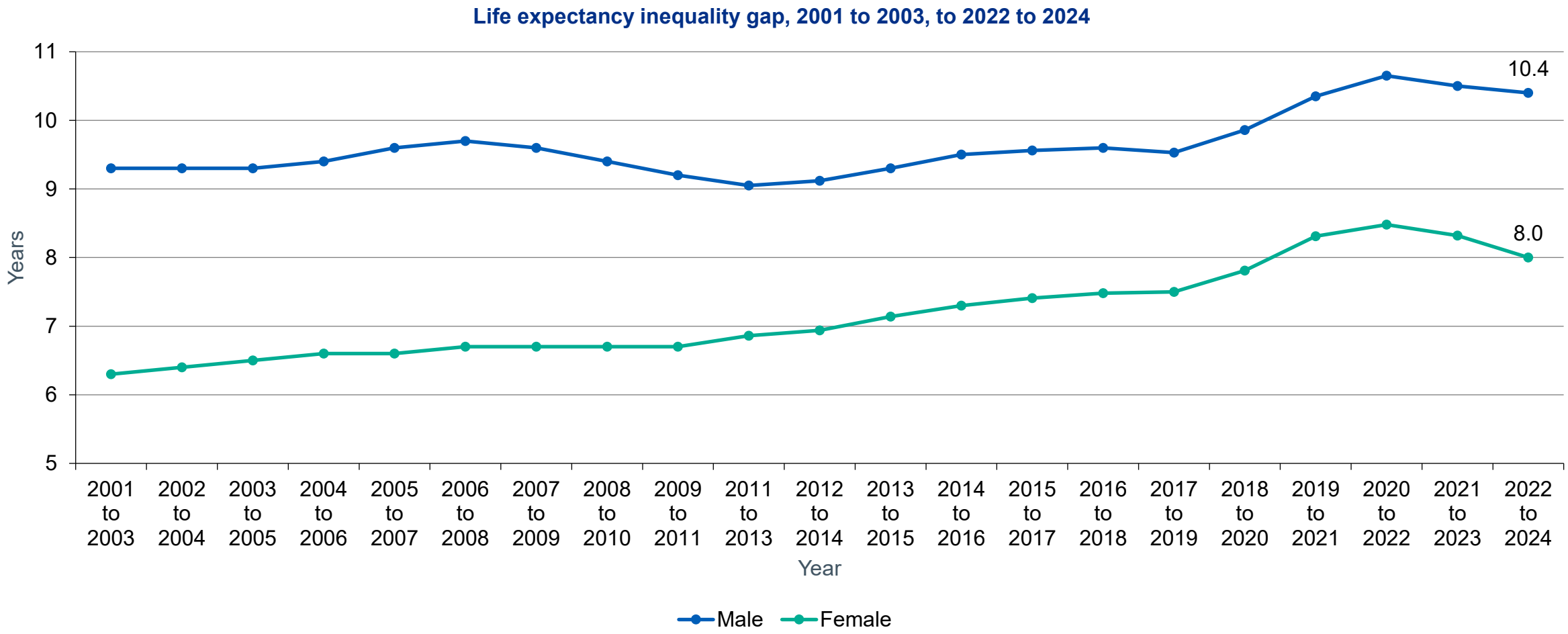
The inequality gap in life expectancy at birth between the most and least deprived areas of England, measured as the Slope Index of Inequality across Index of Multiple Deprivation (IMD) deciles (Office for National Statistics (ONS) life expectancy by local areas).

Why it matters for the strategy

• The Slope Index of Inequality (SII) summarises the gradient in life expectancy at birth across England's IMD deciles into a single national measure - the headline inequality outcome that the strategy is committed to narrowing.
• The latest figure for England (2022 to 2024) is 8.0 (F), 10.4 (M) Years.
• The picture is mixed: Female SII reduced by 0.5y vs 2020-22 (8.5); male reduced by 0.3y vs 2020 to 2022. Both still above 2017 to 2019 pre-pandemic (M=9.5, F=7.5) - England's gap remains historically wide.
• Sits under the strategy's Core20PLUS5 commitment and the overarching ambition of reducing healthcare inequalities. Narrowing the SII requires sustained action on prevention, primary-care equity and Modern Service Framework delivery in the most deprived populations.

Source: ONS healthy life expectancy (HLE) by national area deprivation (15 Apr 2026). England slope index of inequality (SII) for life expectancy (LE) at birth across IMD deciles. England-only - the SII is not published by region or ethnic group |

Figure 1.12: Life expectancy inequality gap: England trend (male)



Source: ONS HLE by national area deprivation (15 Apr 2026). England SII for LE at birth across IMD deciles. England-only - the SII is not published by region or ethnic group |

Under-75 mortality rate (all causes)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from all causes for people aged under 75 in England, expressed per 100,000 population (Office for National Statistics (ONS) death registrations, confirmed by Office for Health Improvement and Disparities (OHID) Fingertips indicator 108).

Why it matters for the strategy

• Captures deaths under 75 potentially avoidable through prevention, earlier diagnosis and effective treatment, and is the primary outcome against which the quality of the health system is judged internationally.
• The latest figure for England (2025) is 394.6 per 100,000 – male, and 251.5 per 100,000, female.
• The picture is mixed: Increased for both Male and Female between 2018 and 2021 before recovering post-pandemic to around 2018 lowest rate, M declined by 43.3 per 100,000 from 2021 (437.9) to 2025 (394.6), F declined by 25.7 per 100.000 from 2021 (277.2) to 2025 (251.5)
• Performance varies across NHS Regions (2024 data): the best-performing area was South East for males (356.6 per 100,000) and London for females (220.6 per 100,000); the worst was North West (470.3 M / 308.1 F per 100,000).
• The deprivation gap (2024) is 241.2 per 100,000 for males (553.4 most deprived to 312.2 least deprived) and 151.0 per 100,000 for females (347.3 to 196.3).
• Concentrated in the same four condition groups the strategy targets - cardiovascular disease (CVD), cancer, respiratory and severe mental illness - and responds to Tier 2 drivers (case-finding, treated-to-target, secondary prevention) over a 3 to 5 year lag.

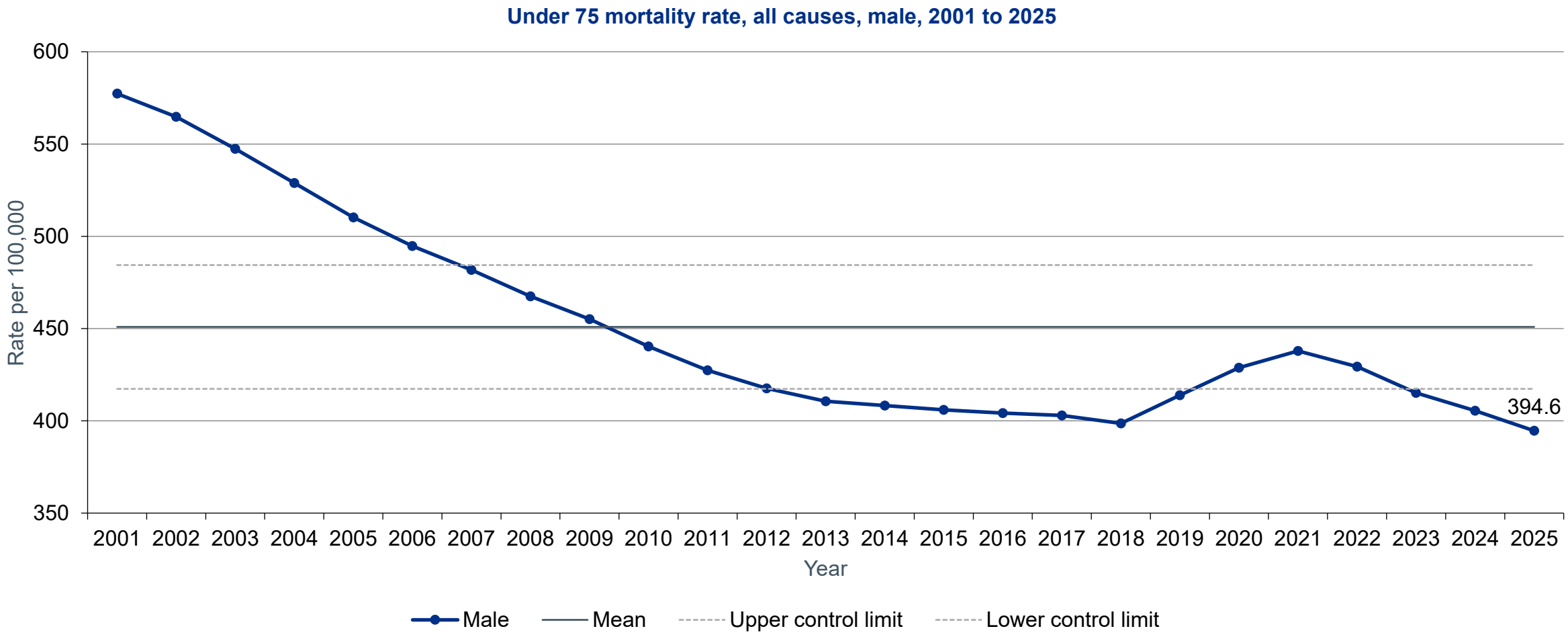
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025)

Under-75 mortality rate (all causes)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from all causes for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 108).

Figure 1.13: Under-75 mortality rate (all causes): England trend (male)



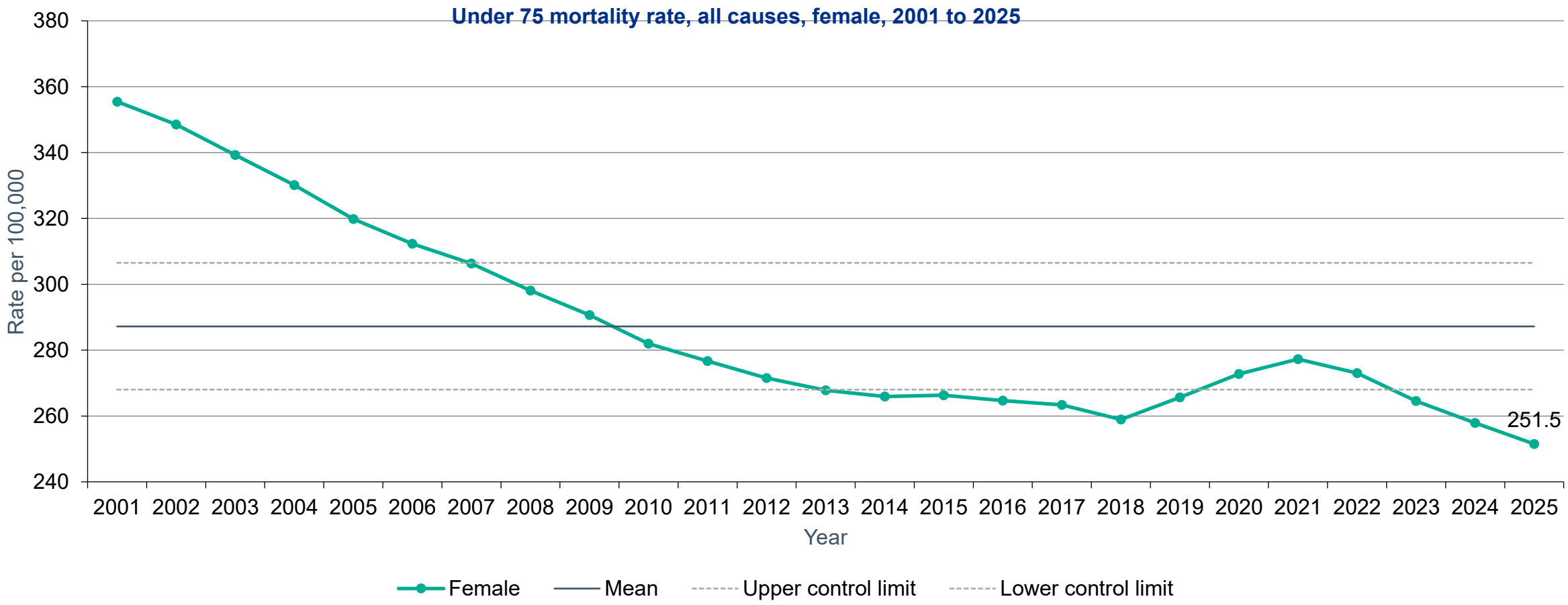
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025)

Under-75 mortality rate (all causes)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from all causes for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 108).

Figure 1.14: Under-75 mortality rate (all causes): England trend (female)



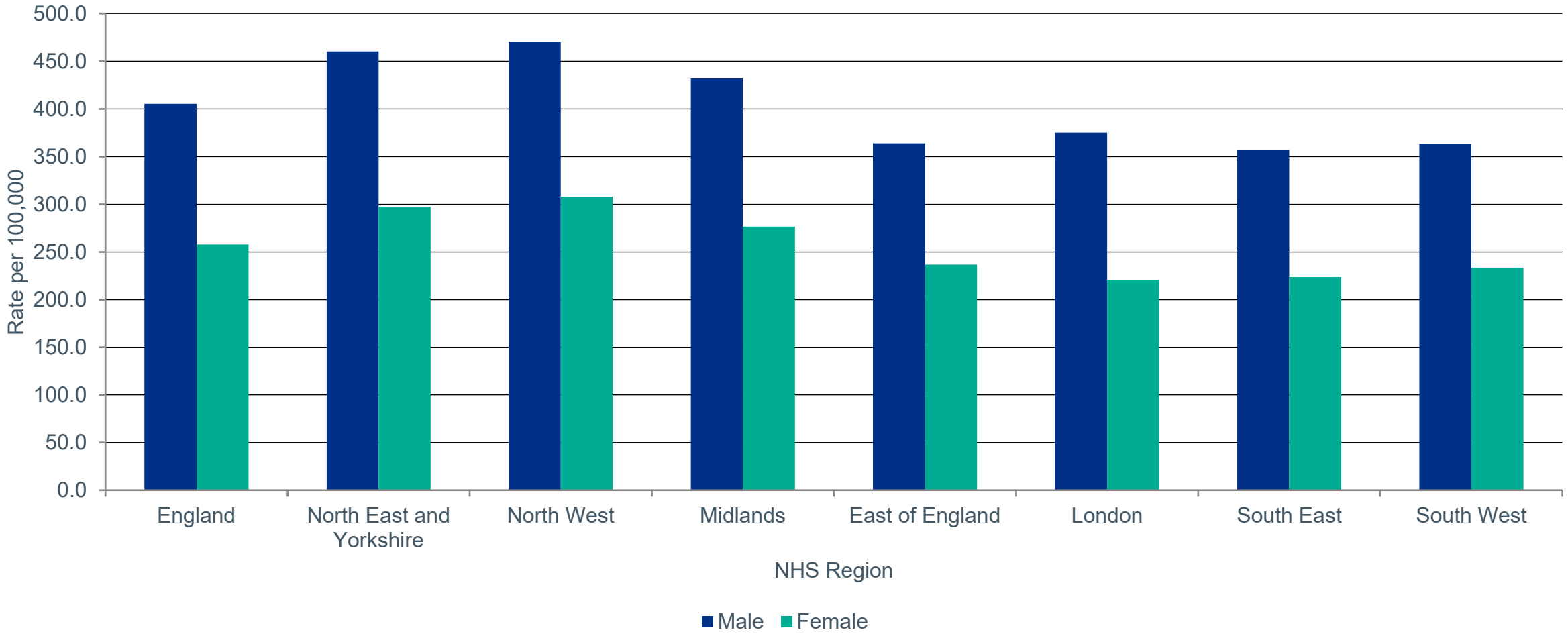
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025)

Under-75 mortality rate (all causes)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from all causes for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 108).

Figure 1.15: Under-75 mortality rate (all causes) by NHS Region, 2024 (latest)



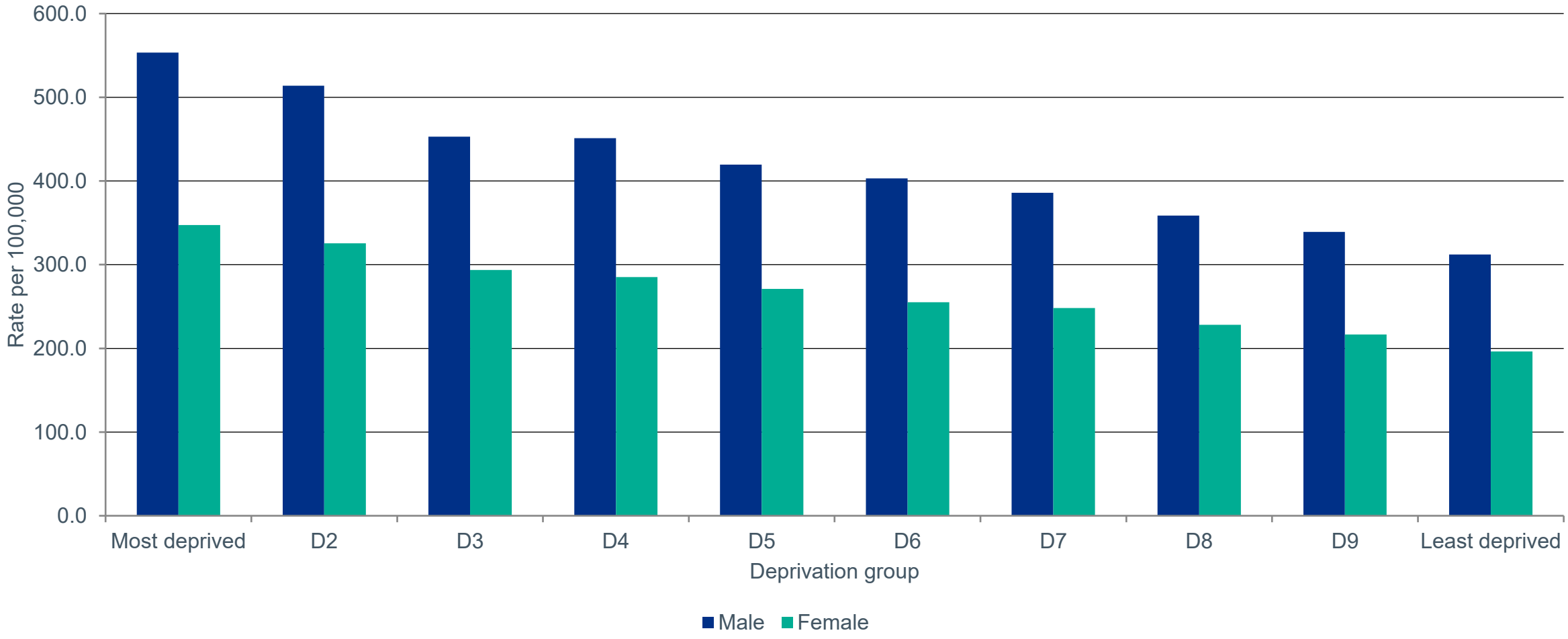
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025)

Under-75 mortality rate (all causes)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from all causes for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 108).

Figure 1.16: Under-75 mortality rate (all causes) by deprivation group (Index of Multiple Deprivation (IMD) decile), 2024 (latest)



Source: ONS, Death registrations summary tables - England and Wales (Oct 2025)

Avoidable mortality (under 75)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

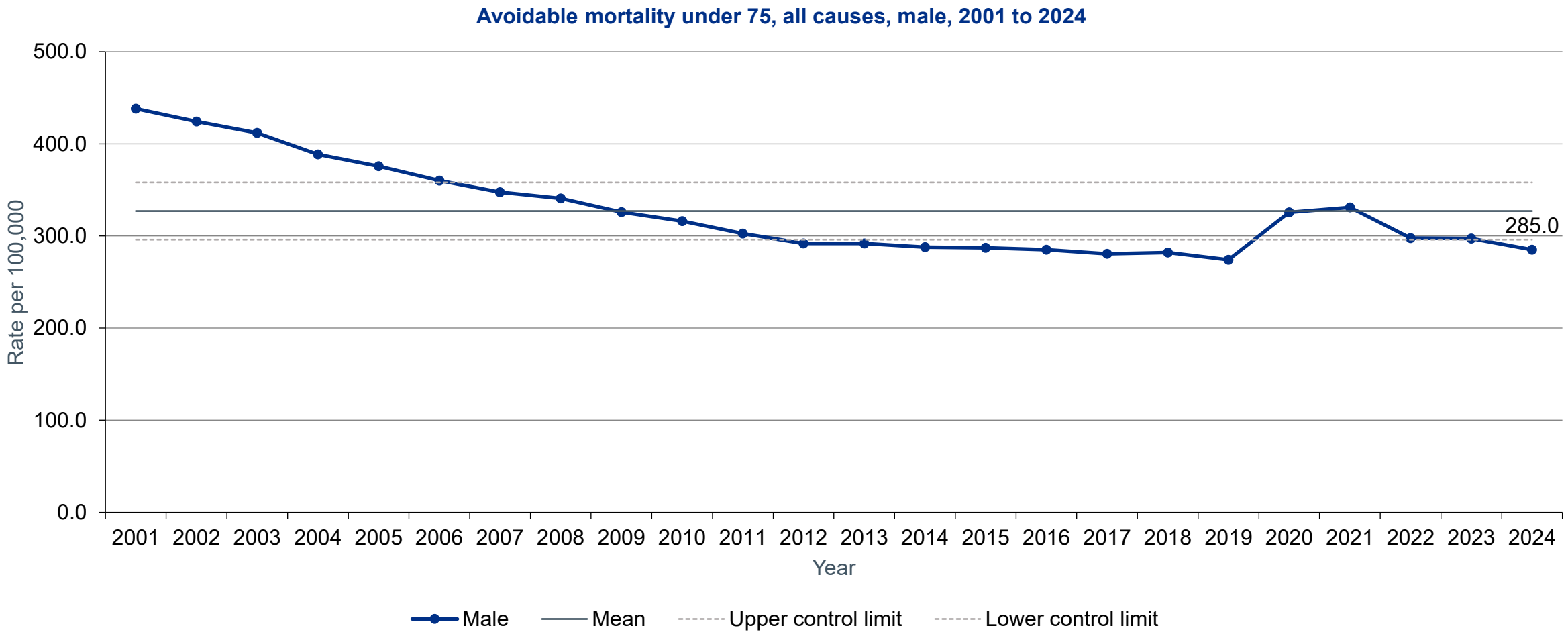
Age-standardised rate of avoidable mortality (preventable plus treatable causes) in people aged under 75 in England, expressed per 100,000 population

Why it matters for the strategy

• Quantifies deaths under 75 that could have been prevented (through public health) or treated (through timely healthcare) - the most direct measure of where the health system is failing to save lives.
• The latest figure for England (2024) is 285.0 per 100,000 for Male and 173.6 per 100,000 for Female.
• The picture is mixed: Has improved since 2001 and the 2021 peak but remains around 10 per 100,000 higher than in 2019 for both Male and Female. • Performance varies across NHS Regions (2024 data): the best-performing area was South East for males (242.6 per 100,000) and for females (148.1 per 100,000); the worst was North East (345.5 M / 218.9 F per 100,000).
• The deprivation gap (2024) is 136.4 per 100,000 for males (276.5 most deprived to 140.1 least deprived) and 78.7 per 100,000 for females (149.3 to 70.6).
• Drives the deprivation gradient in life expectancy: avoidable mortality is roughly twice as high in the most deprived decile as in the least. The strategy frames closing this gap as the central operational test of effectiveness, anchored in the 25% reduction ambition for premature heart disease and stroke mortality.

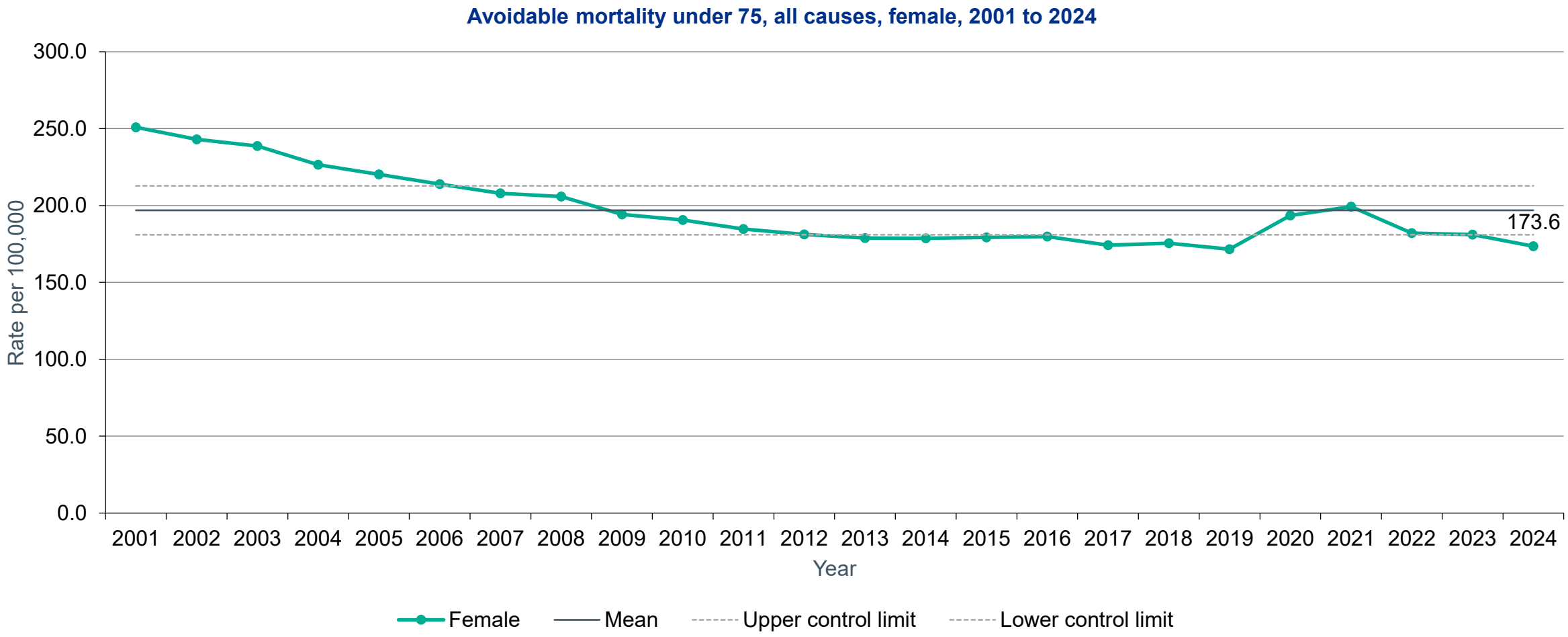
Source: Office for Health Improvement and Disparities (OHID) Fingertips indicator 93721, Avoidable mortality (persons, under 75, 2024)

Figure 1.17: Avoidable mortality (under 75): England trend (male)



Source: OHID Fingertips indicator 93721, Avoidable mortality (persons, under 75, 2024)

Figure 1.18: Avoidable mortality (under 75): England trend (female)



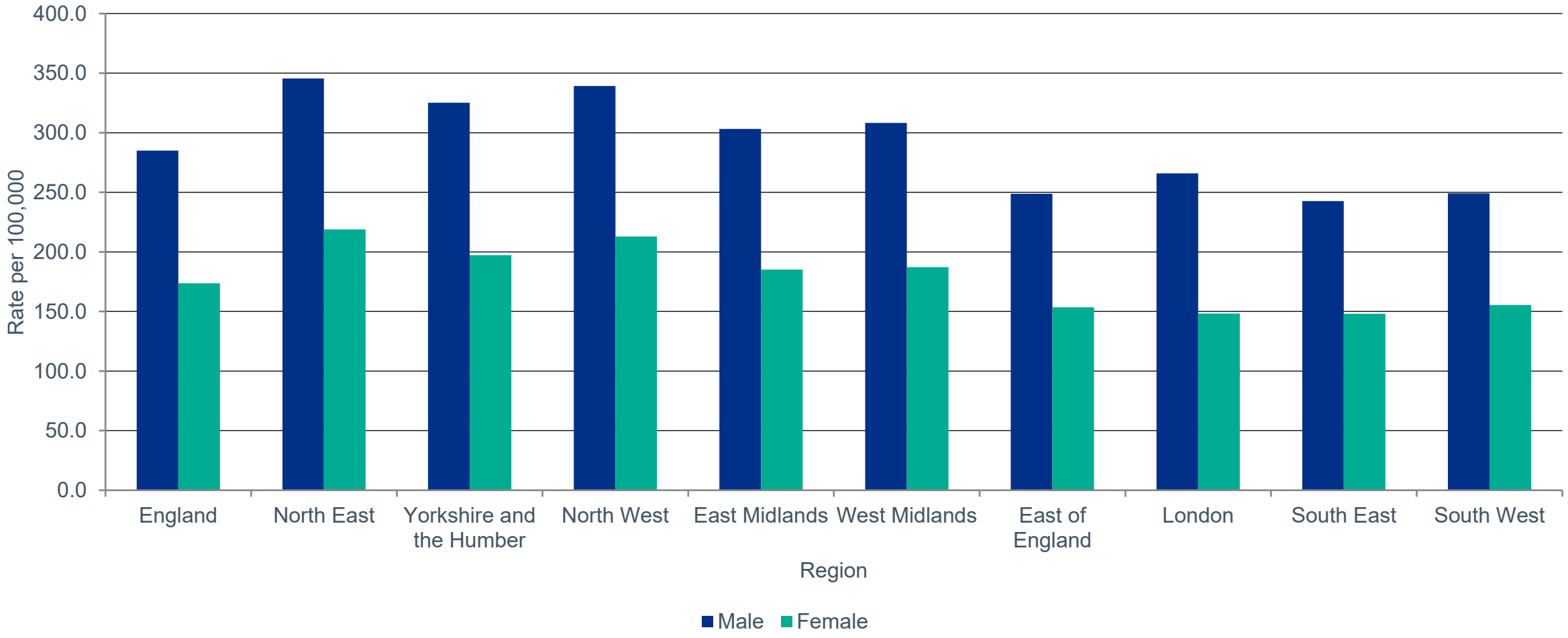
Source: OHID Fingertips indicator 93721, Avoidable mortality (persons, under 75, 2024)

Avoidable mortality (under 75)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

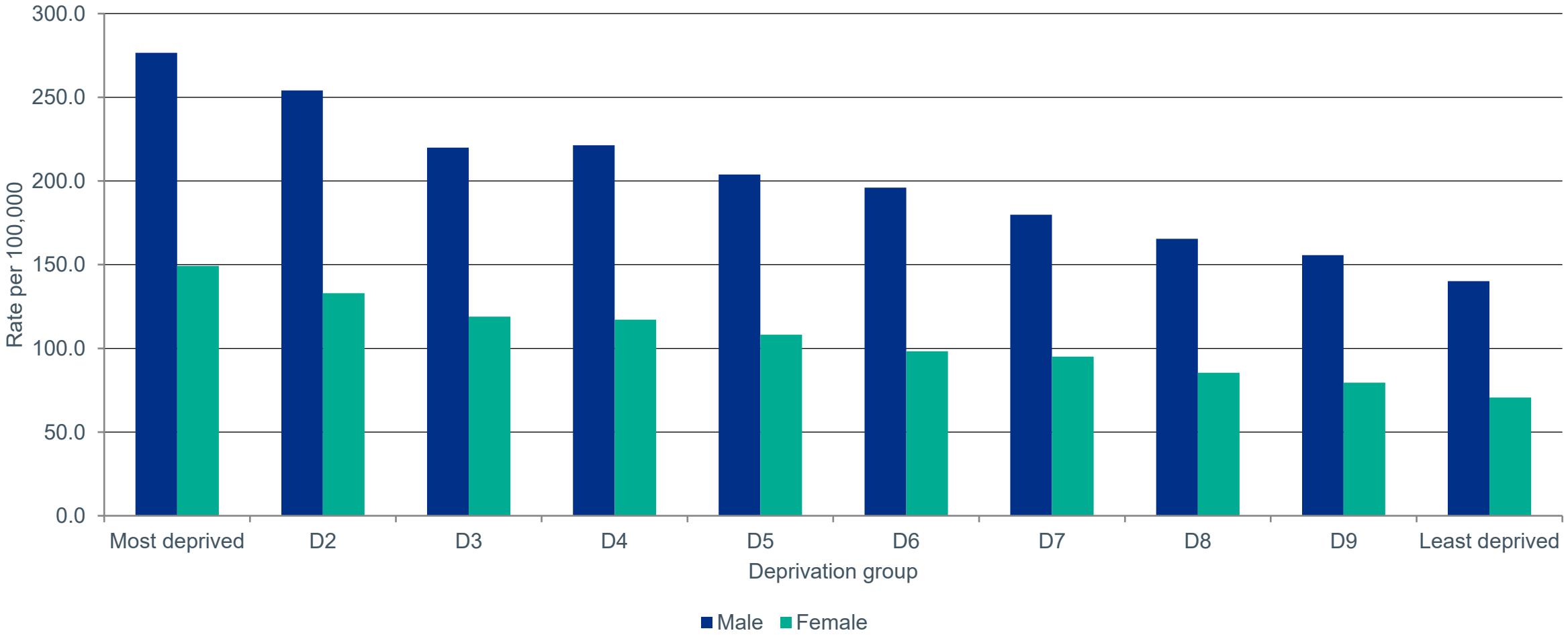
Age-standardised rate of avoidable mortality (preventable plus treatable causes) in people aged under 75 in England, expressed per 100,000 population

Figure 1.19: Avoidable mortality (under 75) by Region - 2024



Source: OHID Fingertips indicator 93721, Avoidable mortality (persons, under 75, 2024)

Figure 1.20: Avoidable mortality (under 75) by deprivation group (Index of Multiple Deprivation (IMD) decile), 2024



Source: OHID Fingertips indicator 93721, Avoidable mortality (persons, under 75, 2024)

Self-reported health

Effectiveness | Tier 1: Outcome | ↑ Higher is better

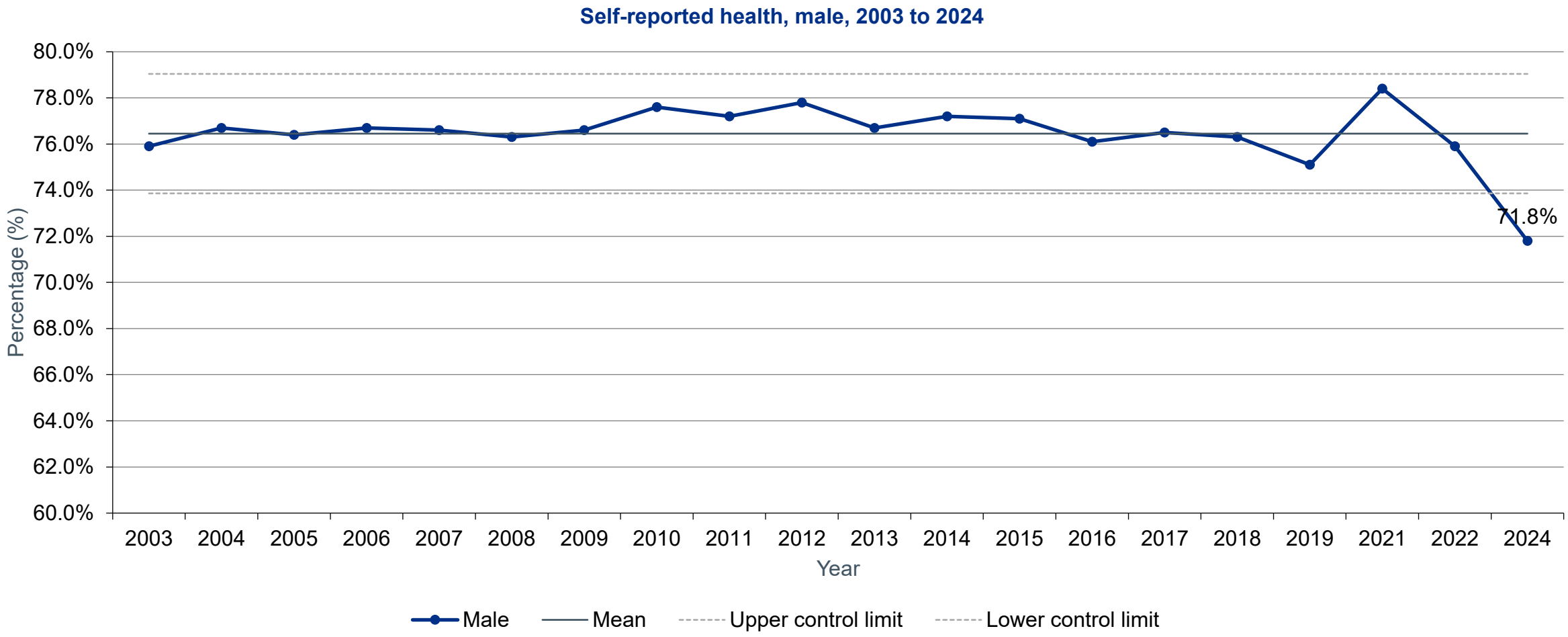
Proportion of adults in England reporting their general health as very good or good, based on clinical interview responses in the Health Survey for England.

Why it matters for the strategy

• Captures the lived experience of population health and is a leading indicator of future healthcare demand and linked to prevalence of conditions that drive Healthy Life Expectancy. The proportion of adults reporting very good or good health is now at its lowest level since the Health Survey for England (HSE) series began in 1993.
• The latest figure for England (2024) is 72.0%.
• This is getting worse: Male declined to 71.8% in 2024 from the 78.4% peak in 2021; Female to 72.1% from the 76.2% in 2021 - both sexes now at multi-year lows for adults reporting very good or good health (HSE).
• Lived-experience signal that runs about 1 to 3 years ahead of measured Healthy Life Expectancy. A sub-indicator of healthy life expectancy (HLE) at birth, anchored in the strategy's Effectiveness ambition to improve healthy years lived and reduce inequalities.

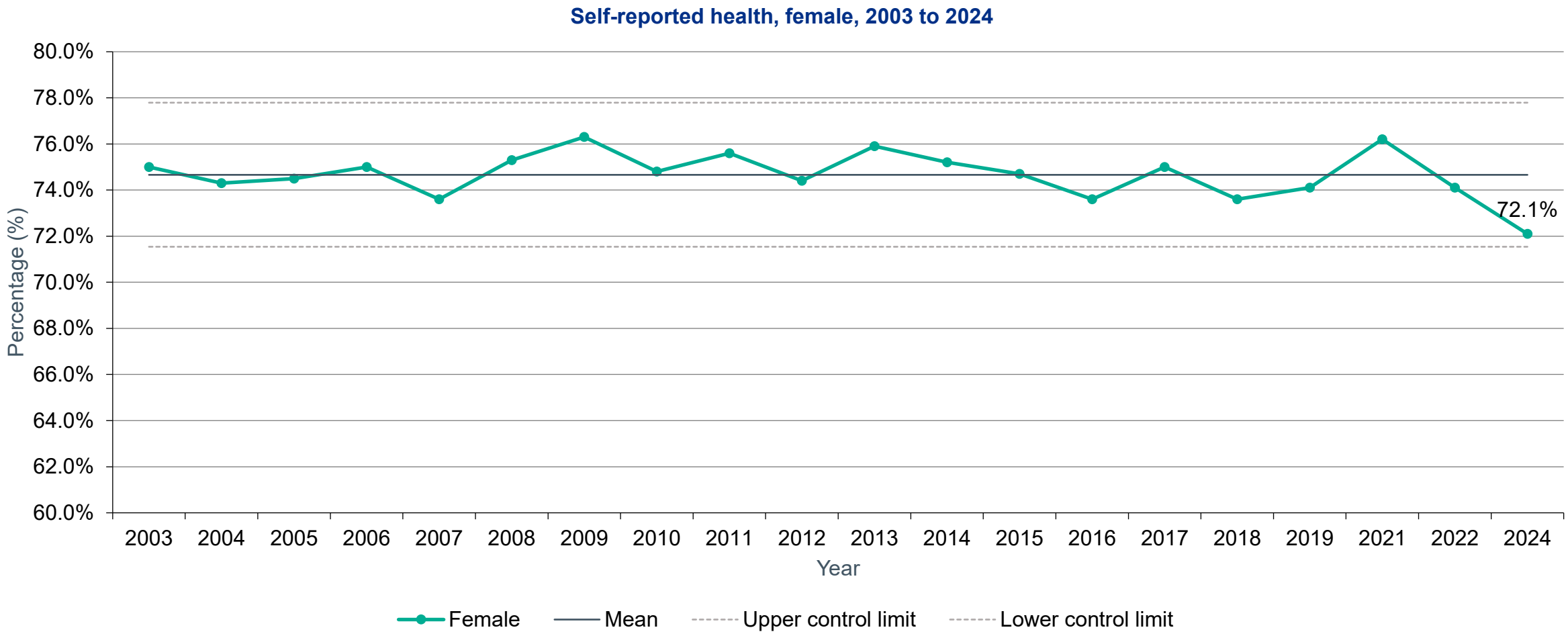
Source: NHS Digital, Health Survey for England 2024 (Jan 2026)

Figure 1.21: Self-reported health: England trend (male)



Source: NHS Digital, Health Survey for England 2024 (Jan 2026)

Figure 1.22: Self-reported health: England trend (female)



Source: NHS Digital, Health Survey for England 2024 (Jan 2026)

Unmet healthcare need

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of GP patients who reported that their needs were not at all met during their last appointment, used as a proxy for unmet healthcare need (GP Patient Survey, Q31).

Why it matters for the strategy

• Used as a proxy for unmet healthcare need: the proportion of GP patients who say their needs were 'not at all' met at their last appointment. The only England-wide unmet-need indicator available since EU-SILC was discontinued.
• The latest figure for England (2025) is 10.1%.
• This has remained unchanged: the same as in 2024. The 2024 GP Patient Survey (GPPS) redesign means pre-2024 figures are not directly comparable, so only two reference periods are currently available.
• Performance varies across NHS Regions (2025 data): the best-performing area (South West) had a rate of 8.8%, while the worst (London) had 11.5%.
• Inequalities-of-access signal underpinning the strategy's access and equity commitments. NHS Region variation is published; deprivation/Index of Multiple Deprivation (IMD) breakdown is not currently published for GPPS Q31.

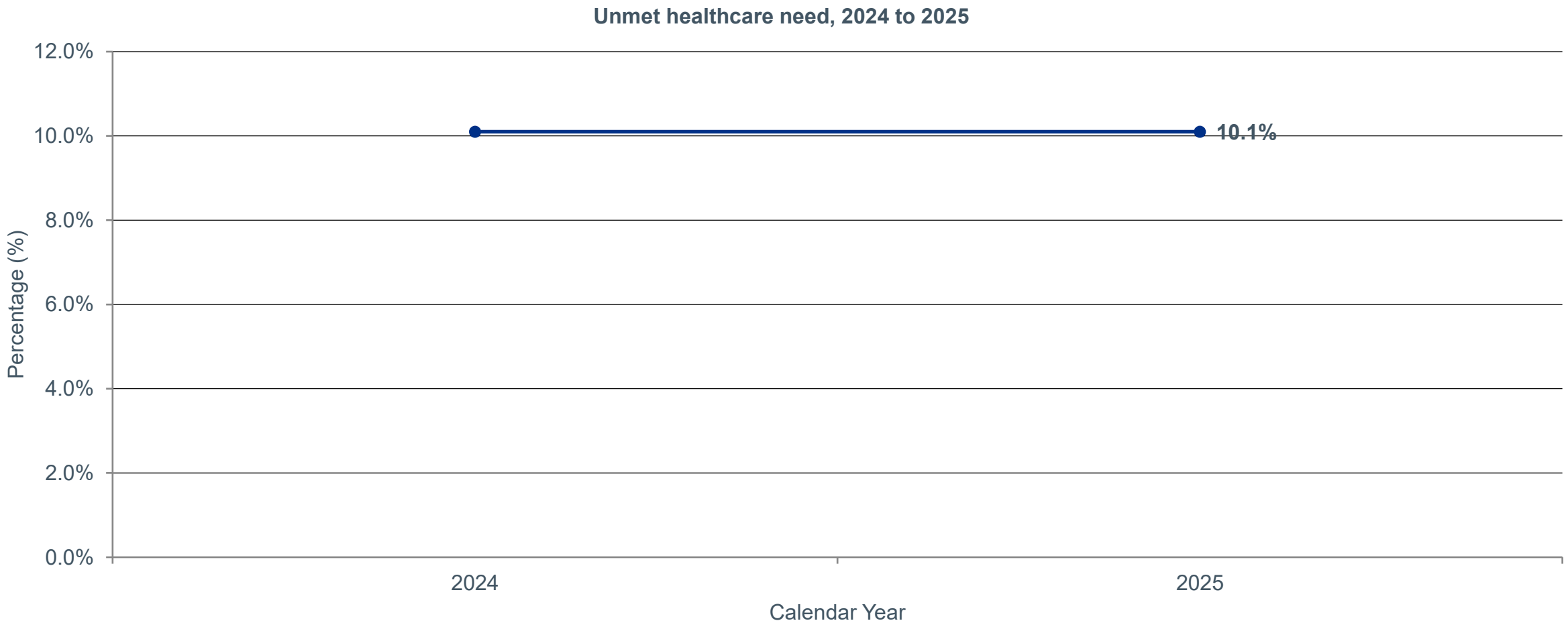
Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q31

Unmet healthcare need

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of GP patients who reported that their needs were not at all met during their last appointment, used as a proxy for unmet healthcare need (GP Patient Survey, Q31).

Figure 1.23: Unmet healthcare need: England trend



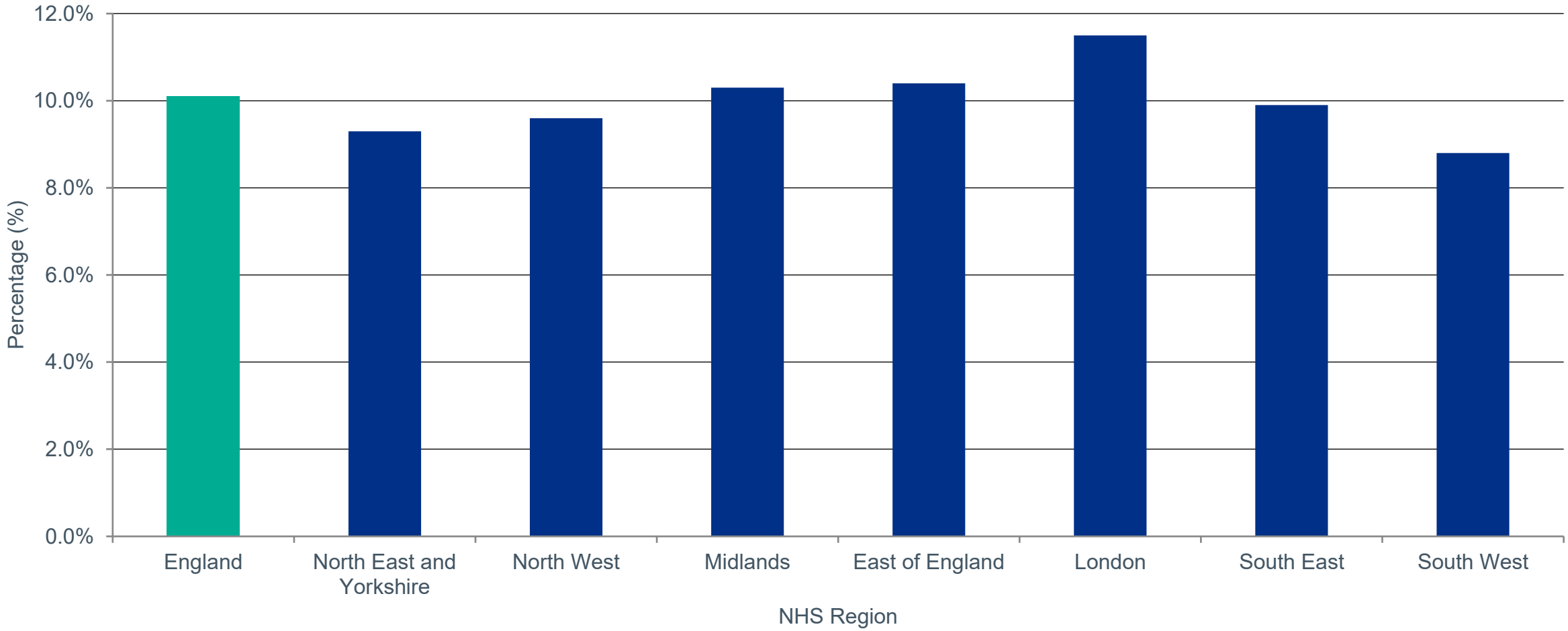
Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q31

Unmet healthcare need

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of GP patients who reported that their needs were not at all met during their last appointment, used as a proxy for unmet healthcare need (GP Patient Survey, Q31).

Figure 1.24: Unmet healthcare need by NHS Region, 2025



Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q31

Standardised years of life lost - avoidable causes

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Standardised Years of Life Lost (SYLL) from avoidable causes per 100,000 population, by sex (Office for National Statistics (ONS) Avoidable mortality dataset). Converts mortality into a life-years measure that captures the cost of premature death better than counts alone.

Why it matters for the strategy

• Standardised Years of Life Lost from avoidable causes. Translates avoidable mortality into the years of life that were cut short, weighted by how young those deaths were - a more sensitive measure of where the system can save the most life-years with focus on the conditions where the system can act earliest.
• The latest figure for England (2024) is 4386.0 (F), 6673.7 (M) SYLL per 100,000.
• The picture is mixed: down from the 2021 peak (M 7535.9, F 4927.5) but still higher than the 2019 lows (M 6350.7, F 4290.4). 2024: Male 6673.7, Female 4386.0 SYLL per 100,000 - the 2010 to 2019 improvement trajectory has not resumed.

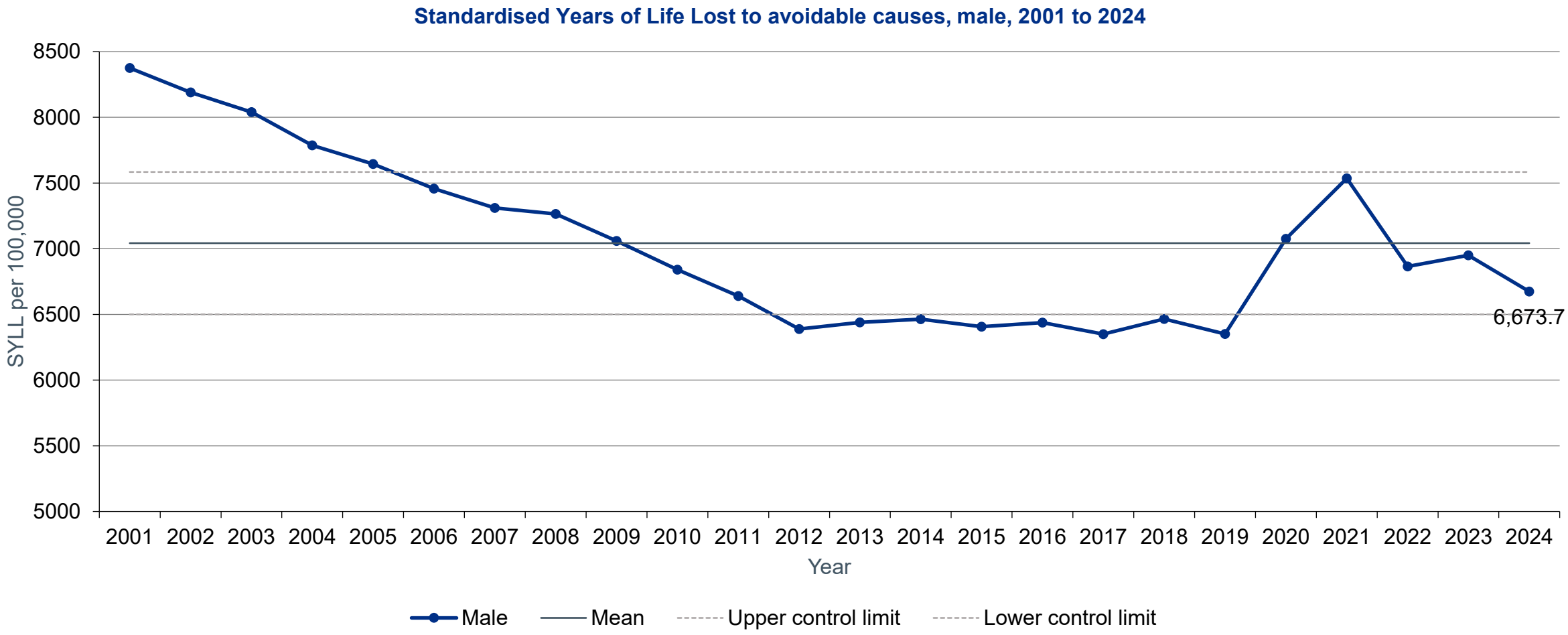
Source: ONS Avoidable mortality dataset 2024, Table 7 (released 24 Feb 2026). England Avoidable All-causes SYLL by sex, 2001 to 2024

Standardised years of life lost - avoidable causes

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Standardised Years of Life Lost (SYLL) from avoidable causes per 100,000 population, by sex (ONS Avoidable mortality dataset). Converts mortality into a life-years measure that captures the cost of premature death better than counts alone.

Figure 1.25: Standardised years of life lost - avoidable causes: England trend (male)



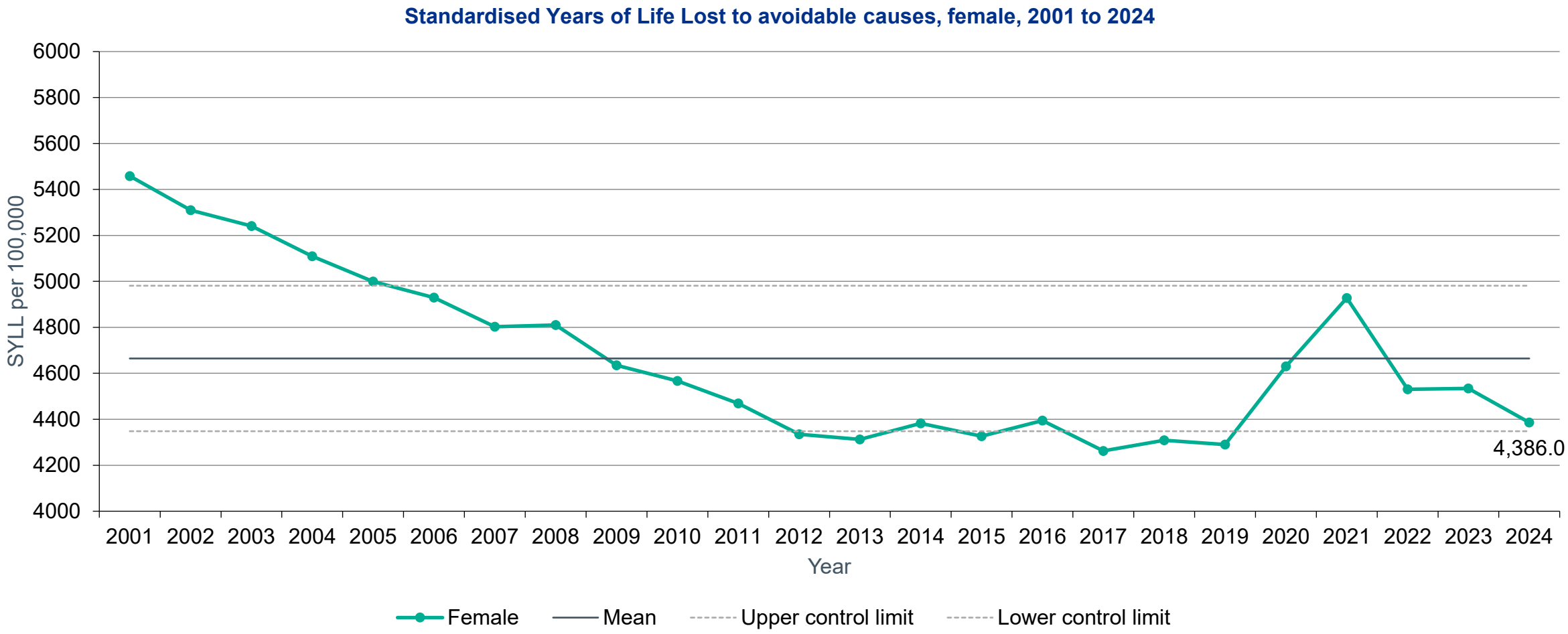
Source: ONS Avoidable mortality dataset 2024, Table 7 (released 24 Feb 2026). England Avoidable All-causes SYLL by sex, 2001 to 2024

Standardised years of life lost - avoidable causes

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Standardised Years of Life Lost (SYLL) from avoidable causes per 100,000 population, by sex (ONS Avoidable mortality dataset). Converts mortality into a life-years measure that captures the cost of premature death better than counts alone.

Figure 1.26: Standardised years of life lost - avoidable causes: England trend (female)



Source: ONS Avoidable mortality dataset 2024, Table 7 (released 24 Feb 2026). England Avoidable All-causes SYLL by sex, 2001 to 2024

Under-75 liver disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality from liver disease, under 75.

Why it matters for the strategy

• Under-75 liver disease mortality has risen around 10% over the past decade and, of the four leading causes of premature death, has shown the steepest sustained rise. Alcohol-related harm is the dominant driver and the deprivation gradient is steep - most deprived areas see roughly twice the rate of the least.
• The latest figure for England (2025) is 19.4 per 100,000.
• The picture is mixed: up 0.9 per 100,000 between 2018 (18.5) and 2025 (19.4) but down 2.5 since 2023.
• Performance varies across NHS Regions (2024 data): the best-performing area (South East) had a rate of 16.8 per 100,000, while the worst (North West) had 25.7 per 100,000.
• People in the most deprived areas have a rate of 28.4 per 100,000, compared with 14.5 in the least deprived - a gap of 13.9 per 100,000.

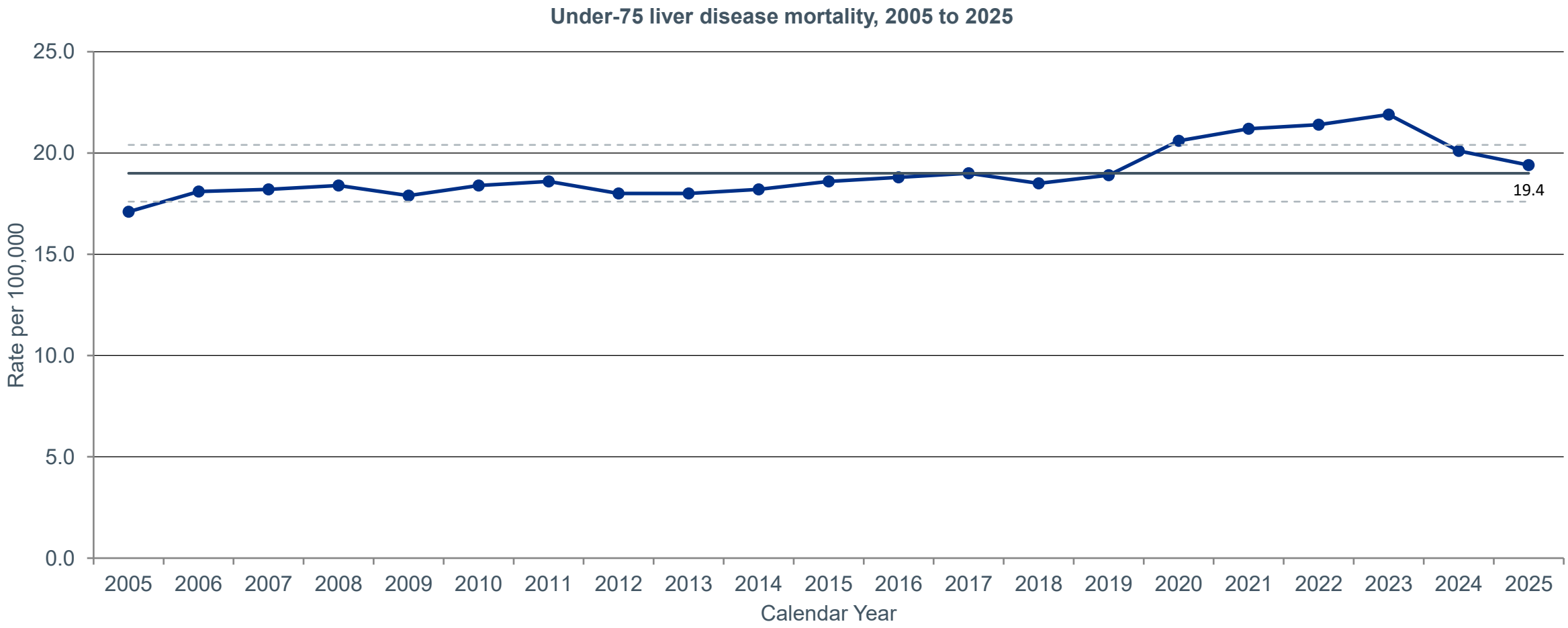
Source: Office for National Statistics (ONS) mortality data, Office for Health Improvement and Disparities (OHID) Fingertips indicator 40601, Under 75 mortality from liver disease

Under-75 liver disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality from liver disease, under 75.

Figure 1.27: Under-75 liver disease mortality: England trend



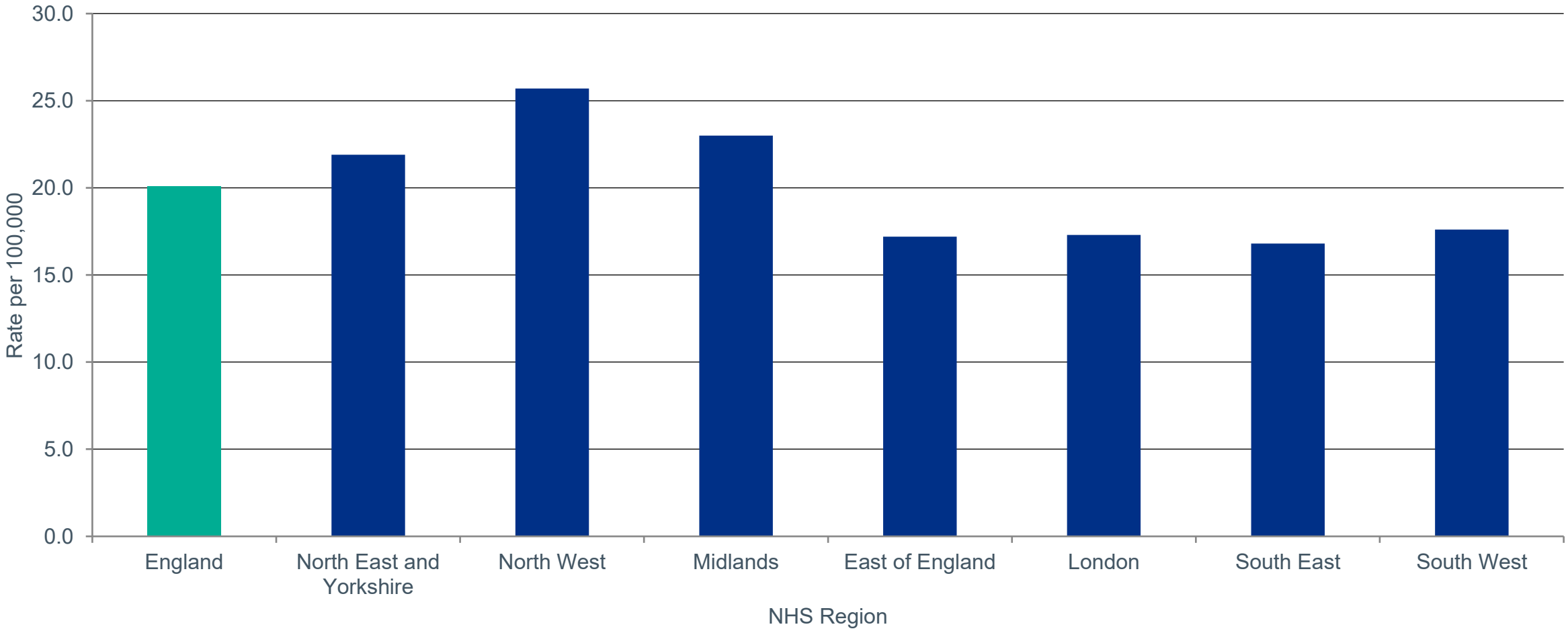
Source: ONS mortality data, OHID Fingertips indicator 40601, Under 75 mortality from liver disease

Under-75 liver disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

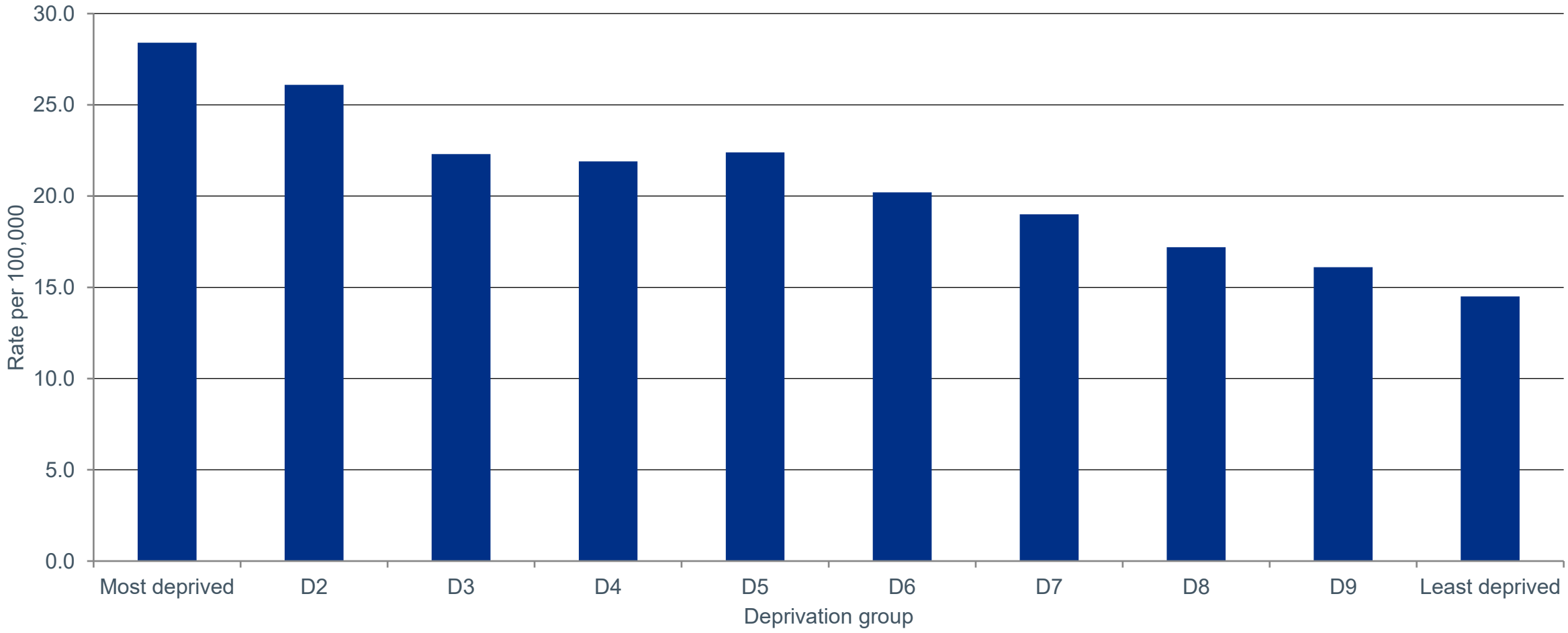
Age-standardised mortality from liver disease, under 75.

Figure 1.28: Under-75 liver disease mortality by NHS Region, 2024 (latest)



Source: ONS mortality data, OHID Fingertips indicator 40601, Under 75 mortality from liver disease

Figure 1.29: Under-75 liver disease mortality by deprivation (IMD) decile - 2024 latest)



Source: ONS mortality data, OHID Fingertips indicator 40601, Under 75 mortality from liver disease

Under-75 cardiovascular disease (CVD) mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

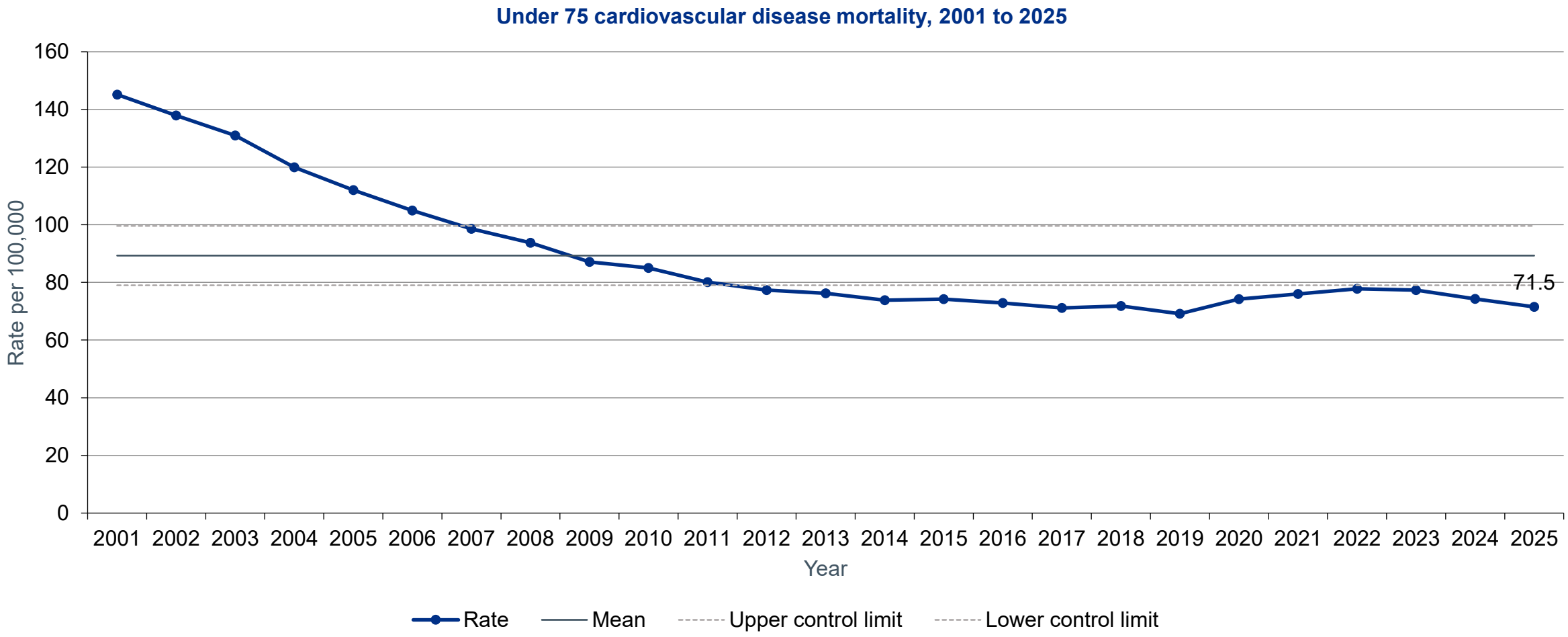
Age-standardised mortality rate from cardiovascular disease for people aged under 75 in England, expressed per 100,000 population

Why it matters for the strategy

• Cardiovascular disease is a leading preventable cause of premature death and a direct driver of the headline u75 mortality rate. The first Modern Service Framework (spring 2026) and the Government's 25% reduction ambition make this a key effectiveness outcome in the strategy.
• The latest figure for England (2025) is 71.5 per 100,000.
• This has remained broadly stable since 2017:, 71.5 per 100,000 2025 compared to 71.1 in 2017
• Performance varies across NHS Regions (2024 data): the best-performing area (South East) achieved 87.6 (M) / 37.0 (F) per 100,000, while the worst (North West) achieved 125.4 (M) / 57.7 (F) per 100,000.
• The deprivation gap (2024) is 75.0 per 100,000 for males (150.1 most deprived to 75.1 least deprived) and 35.2 per 100,000 for females (65.8 to 30.6).
• CVD is the largest single contributor to the deprivation gap (about 26% of the male slope index of inequality (SII)) - the male inequality (75 per 100,000) is more than twice the female gap (35 per 100,000).
• Up to 70% of CVD is preventable - driven by hypertension, lipids, smoking, obesity and physical inactivity, all named in the strategy and addressed by the CVD Modern Service Framework (MSF).

Source: Office for National Statistics (ONS) mortality data, Office for Health Improvement and Disparities (OHID) Fingertips indicator [40401]

Figure 1.30: Under-75 CVD mortality: England trend



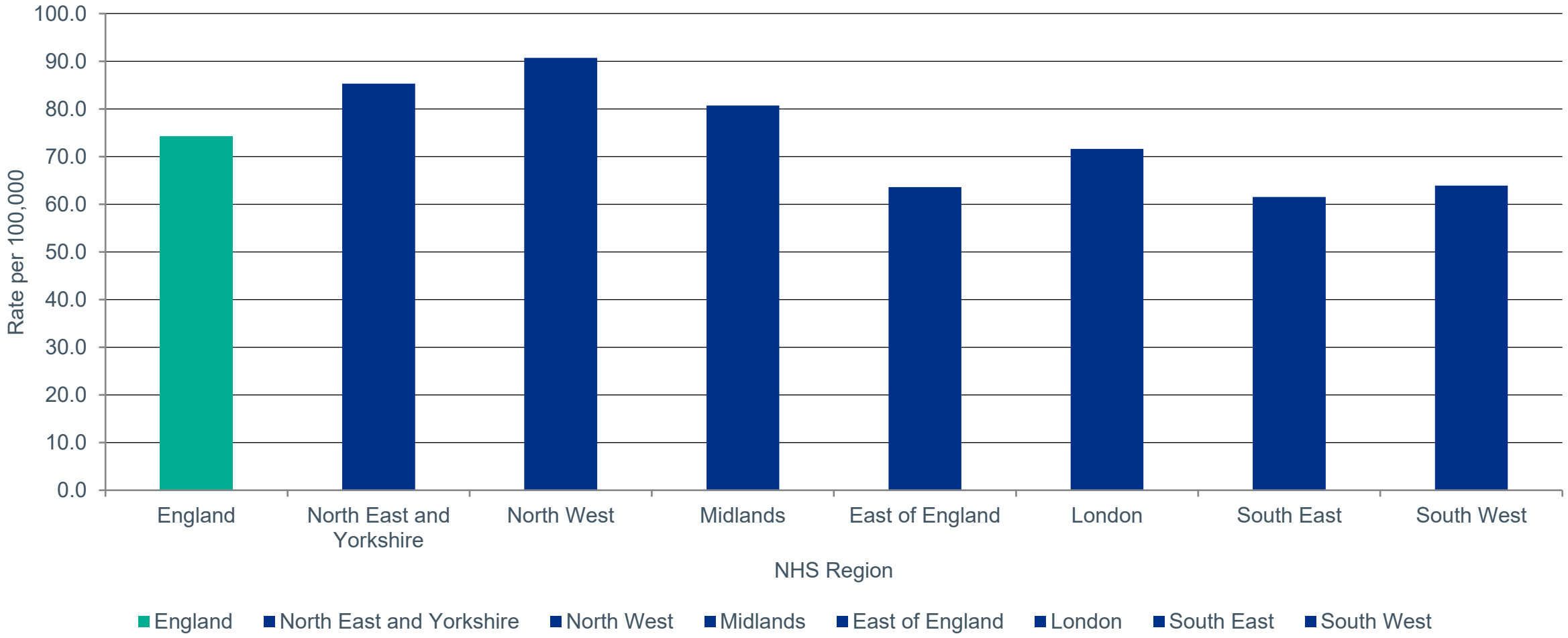
Source: ONS mortality data, OHID Fingertips indicator [40401]

Under-75 CVD mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cardiovascular disease for people aged under 75 in England, expressed per 100,000 population

Figure 1.31: Under-75 CVD mortality by NHS Region, 2024 (latest)



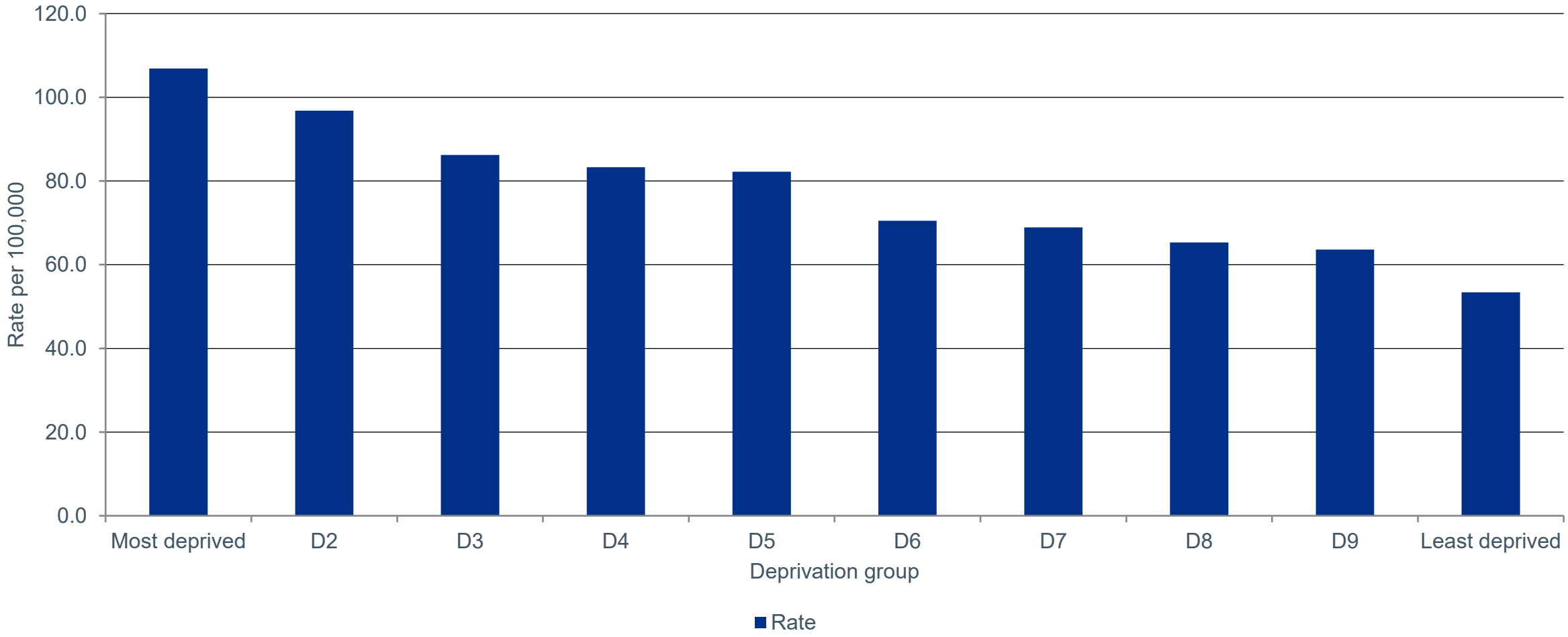
Source: ONS mortality data, OHID Fingertips indicator [40401]

Under-75 CVD mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cardiovascular disease for people aged under 75 in England, expressed per 100,000 population

Figure 1.32: Under-75 CVD mortality by deprivation group (Index of Multiple Deprivation (IMD) decile), 2024 (latest)



Source: ONS mortality data, OHID Fingertips indicator [40401]

Hypertension: undiagnosed gap

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults with high blood pressure who remain undiagnosed, based on clinical blood pressure measurements in the Health Survey for England.

Why it matters for the strategy

- Finding and treating people with hypertension is one of the highest-impact interventions for preventing heart attacks, strokes and premature cardiovascular disease (CVD) death - the named clinical driver for U75_CVD and a CVD Modern Service Framework (MSF) priority (spring 2026).
- The latest figure for England (2024) is 27.8%.
- The picture is mixed: Down 6% on 2022 (33.8%) but 4.7% higher than 2017 low (23.1%).
- Performance varies across NHS Regions (2024 data): the best-performing area (North West) had a rate of 22.9%, while the worst (South East) had 36.4%.

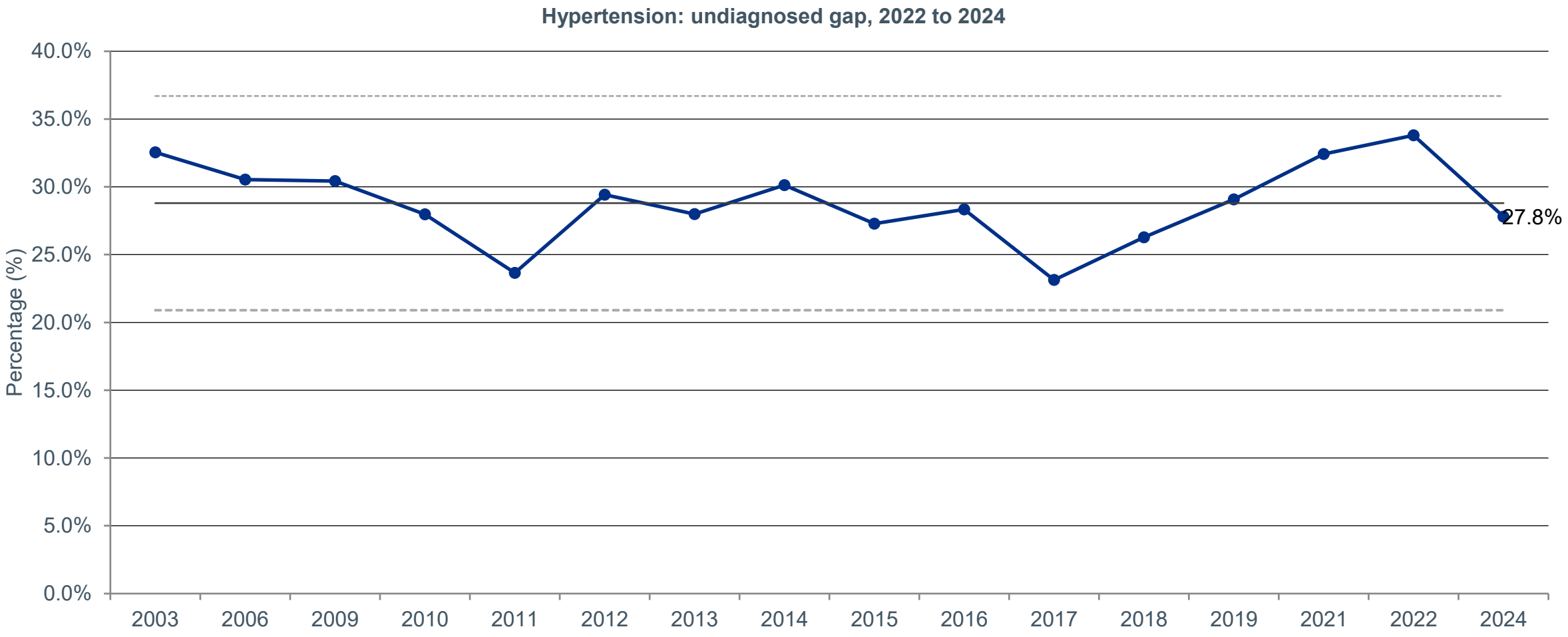
Source: Health Survey for England (HSE) 2024 Table 11 HSE 2022 baseline; pre-2022 used a different methodology. British Medical Journal (BMJ) Medicine 2025 (doi:10.1136/bmjmed-2025-001556, PMC12666190...

Hypertension: undiagnosed gap

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults with high blood pressure who remain undiagnosed, based on clinical blood pressure measurements in the Health Survey for England.

Figure 1.33: Hypertension: undiagnosed gap: England trend



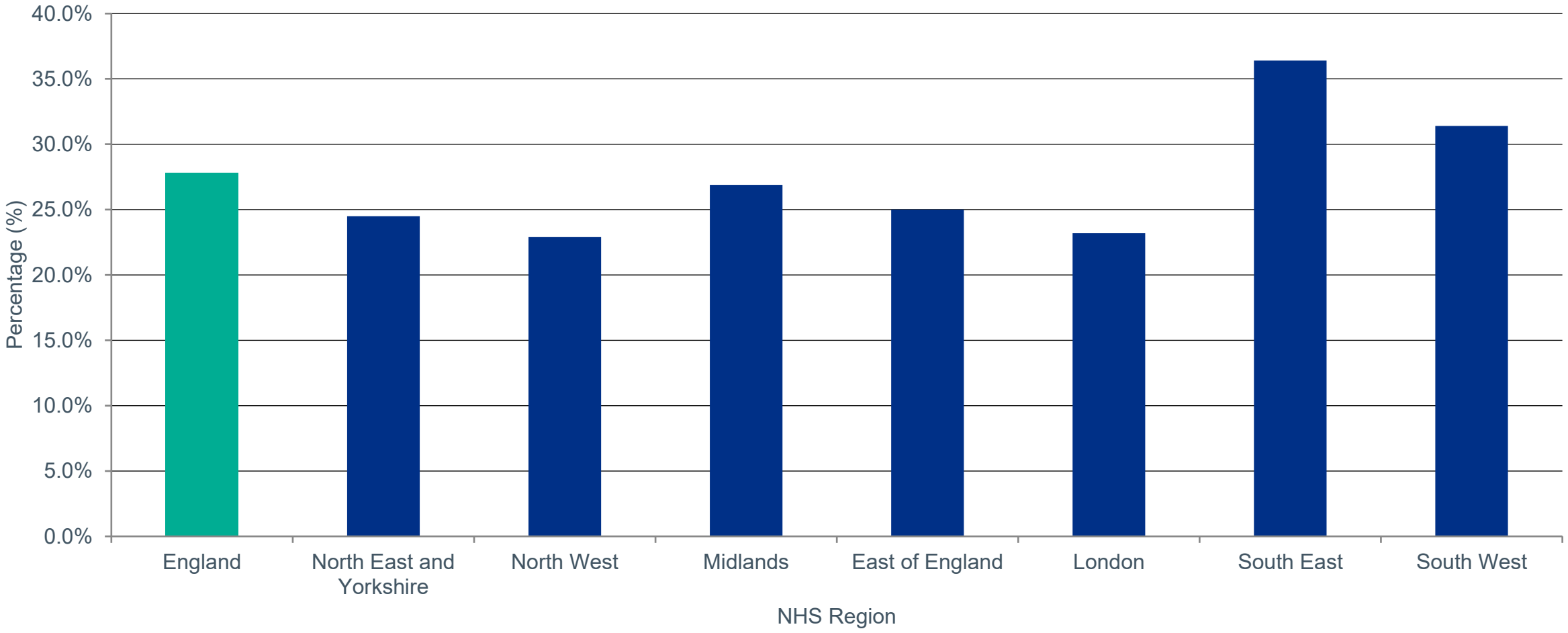
Source: HSE 2024 Table 11 HSE 2022 baseline; pre-2022 used a different methodology. BMJ Medicine 2025 (doi:10.1136/bmjmed-2025-001556, PMC12666190...

Hypertension: undiagnosed gap

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults with high blood pressure who remain undiagnosed, based on clinical blood pressure measurements in the Health Survey for England.

Figure 1.34: Hypertension: undiagnosed gap by NHS Region



Source: HSE 2024 Table 11 HSE 2022 baseline; pre-2022 used a different methodology. BMJ Medicine 2025 (doi:10.1136/bmjmed-2025-001556, PMC12666190...

Hypertension: treated to target

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the hypertension register whose blood pressure is treated to the recommended clinical threshold, from the CVDPREVENT national audit programme.

Why it matters for the strategy

• Identifying hypertension is important , but in addition the undiagnosed gap only translates into health gain if those found are then treated to target. The clinical driver step between case-finding and cardiovascular disease (CVD) outcomes, and a named CVDPREVENT priority for the CVD Modern Service Framework (MSF).
• The latest figure for England (to Dec 2025) is 69.5%.
• This is getting better: up 2.7% between Q2 April 2024 to March 2025 (66.8%) and Q3 April 2025 to March 2026 (69.5%)
• Performance varies across NHS Regions: the best-performing area (North East and Yorkshire) achieved 71.7%, while the lowest (South East) achieved 67.8%.
• People in the least deprived areas achieve 71.3%, compared with 67.2 in the most deprived - a gap of 4.1%.

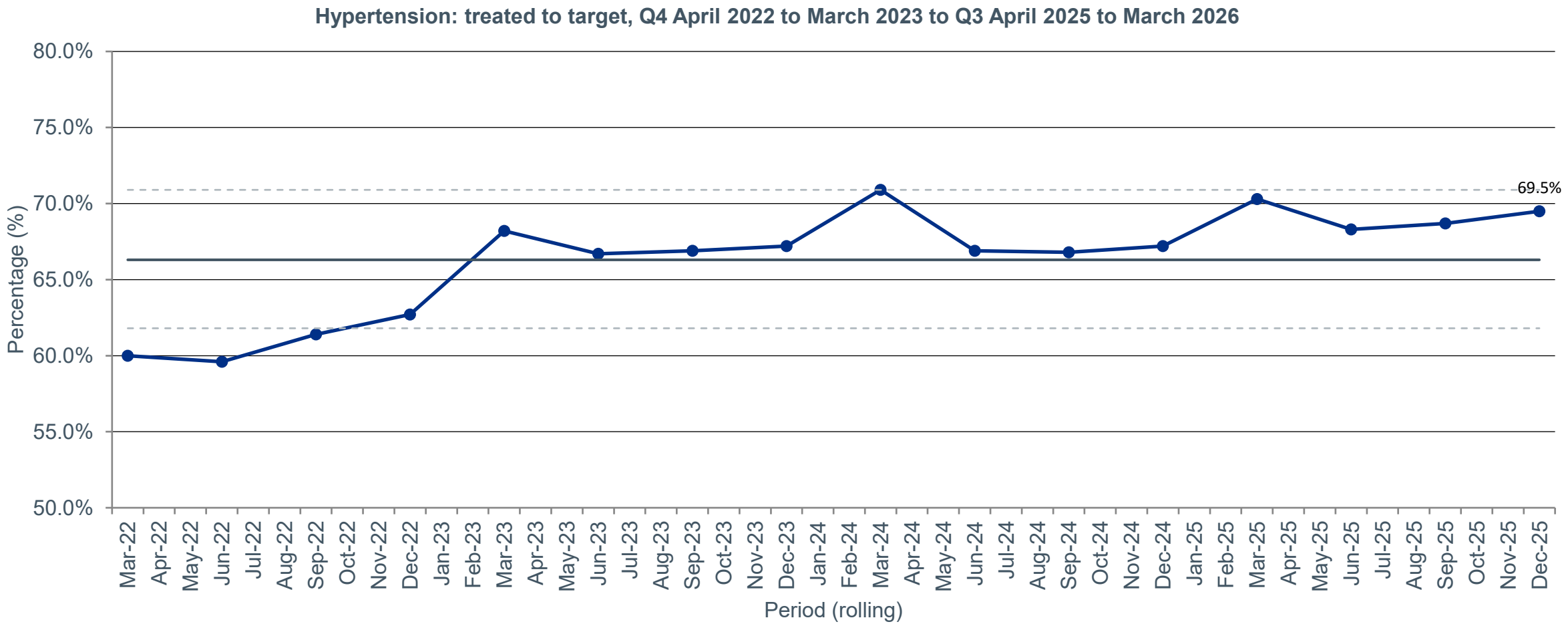
Source: CVDPREVENT indicator CVDP007HYP. Proportion of registered hypertension patients treated to blood pressure (BP) threshold (under-80s <=140/90; 80+ <=150/90). Quarterly rolling-year snapshots.

Hypertension: treated to target

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the hypertension register whose blood pressure is treated to the recommended clinical threshold, from the CVDPREVENT national audit programme.

Figure 1.35: Hypertension: treated to target: England trend



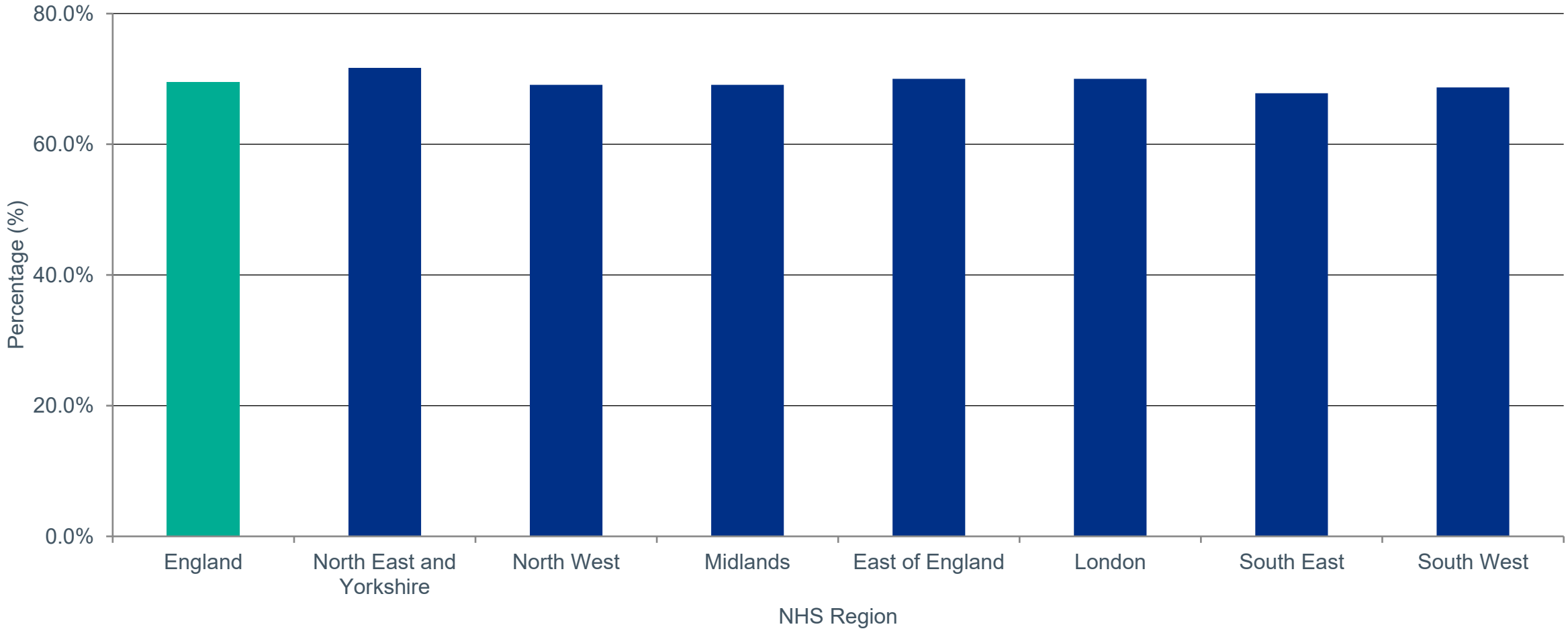
Source: CVDPREVENT indicator CVDP007HYP. Proportion of registered hypertension patients treated to BP threshold (under-80s <=140/90; 80+ <=150/90). Quarterly rolling-year snapshots.

Hypertension: treated to target

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the hypertension register whose blood pressure is treated to the recommended clinical threshold, from the CVDPREVENT national audit programme.

Figure 1.36: Hypertension: treated to target by NHS Region, Q3 April 2025 to March 2026



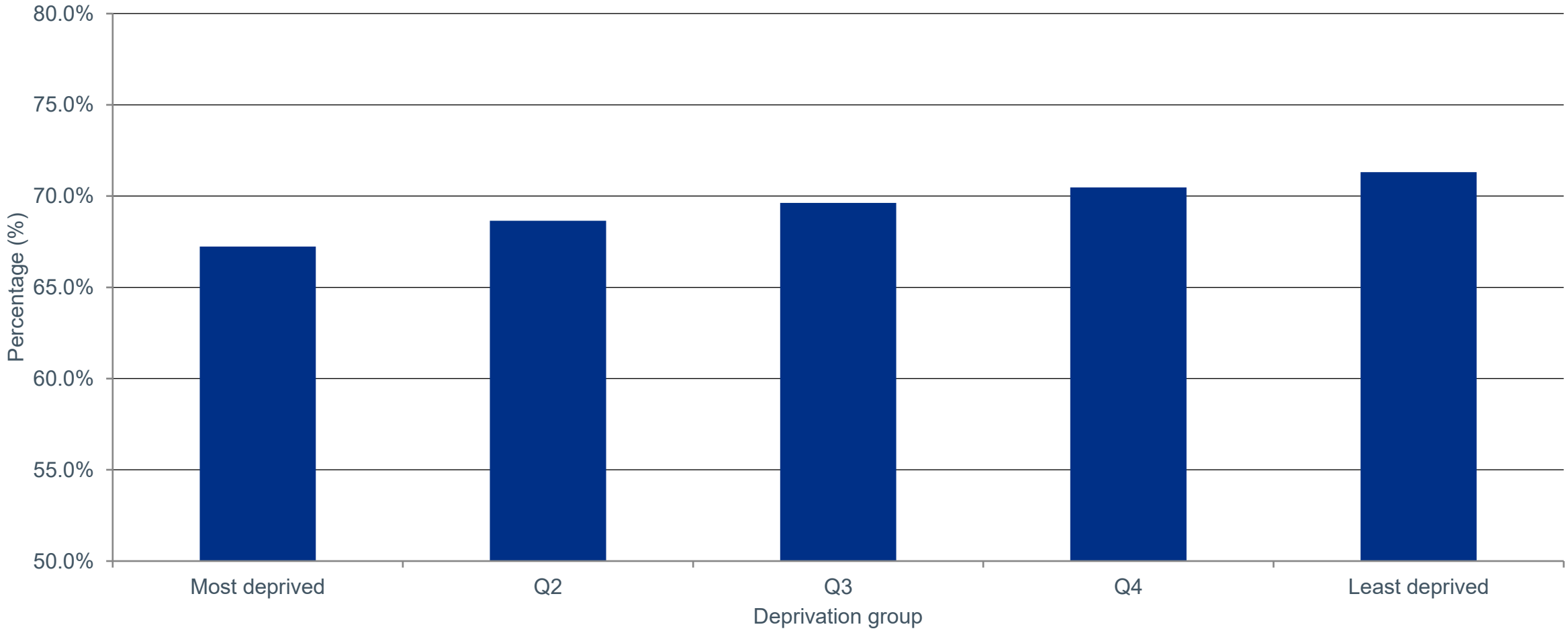
Source: CVDPREVENT indicator CVDP007HYP. Proportion of registered hypertension patients treated to BP threshold (under-80s <=140/90; 80+ <=150/90). Quarterly rolling-year snapshots.

Hypertension: treated to target

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the hypertension register whose blood pressure is treated to the recommended clinical threshold, from the CVDPREVENT national audit programme.

Figure 1.37: Hypertension: treated to target by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: CVDPREVENT indicator CVDP007HYP. Proportion of registered hypertension patients treated to BP threshold (under-80s <=140/90; 80+ <=150/90). Quarterly rolling-year snapshots.

Cardiovascular disease (CVD) secondary prevention

Effectiveness | Tier 2: Driver | ↑ Higher is better

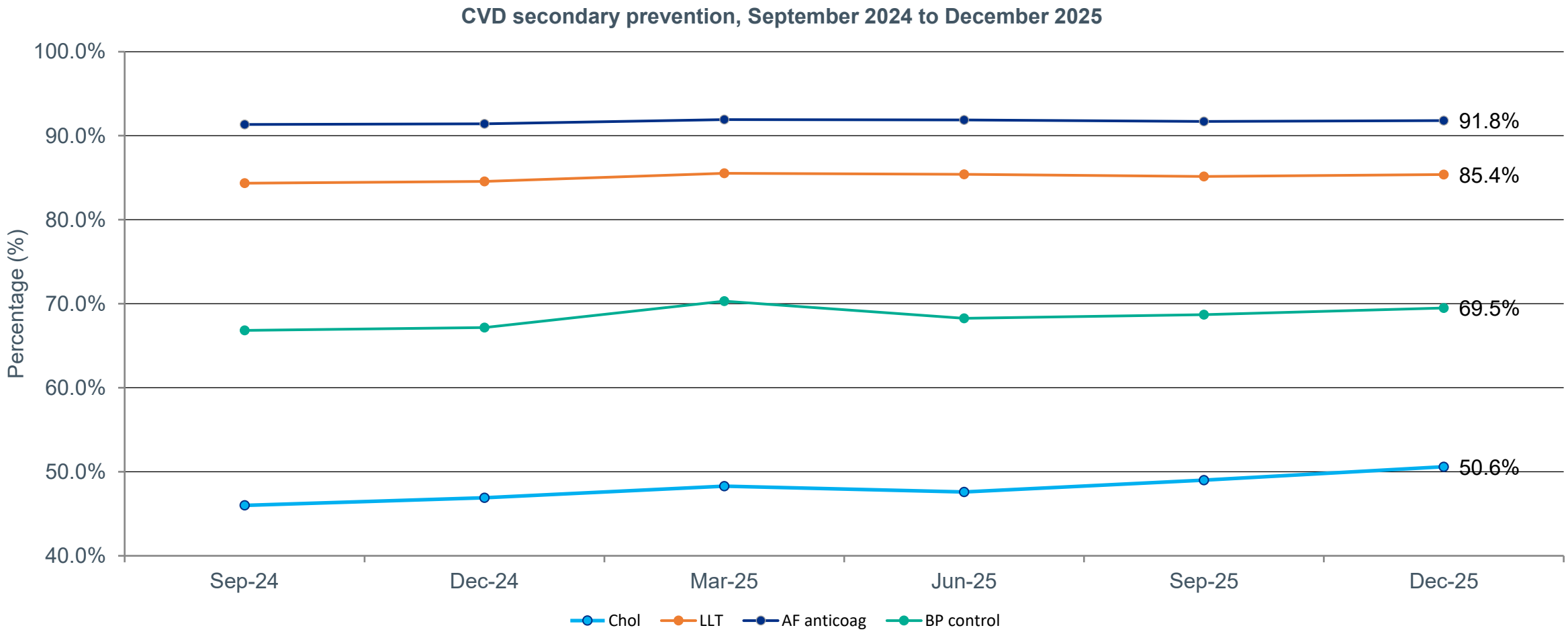
Composite of secondary prevention measures for patients with established cardiovascular disease, cholesterol treated to target, lipid-lowering therapy treatment rate, atrial fibrillation (AF) anticoagulation rate, and blood pressure control, from the CVDPREVENT national audit.

Why it matters for the strategy

• The secondary-prevention bundle (Lipid Lowering Therapy, Atrial Fibrillation anticoagulation, blood pressure control, cholesterol treated to target) is the single largest modifiable lever for U75 CVD mortality and a CVD Modern Service Framework (MSF) priority.
• The latest figure for England (To Dec 2025) is LLT 85.4%, AF anticoag 91.8%, blood pressure control 69.5%, cholesterol treated to target 50.6%.
• This is getting better for blood pressure control (up 2.7% from Sep-24 to Dec-25) and cholesterol treatment (up 4.6% from Sep-24 to Dec-25). The trend is broadly stable for lipid lowering therapy and AF anticoagulation
• Cholesterol target achievement is the weakest link: 50.6% England average, with 1.43M CVD patients on LLT but not at target (low-density lipoprotein (LDL) <=2.0 / non-high-density lipoprotein (HDL) <=2.6). Closing this gap is the largest secondary-prevention opportunity.
People in the most deprived areas receive lower levels of intervention for blood pressure control (67.2%) compared to the least deprived (71.3%) a gap of 4.1%, and for cholesterol treated to target, 49.1% in the most deprived compared to 52.0% in the least deprived, a gap of 2.9%.

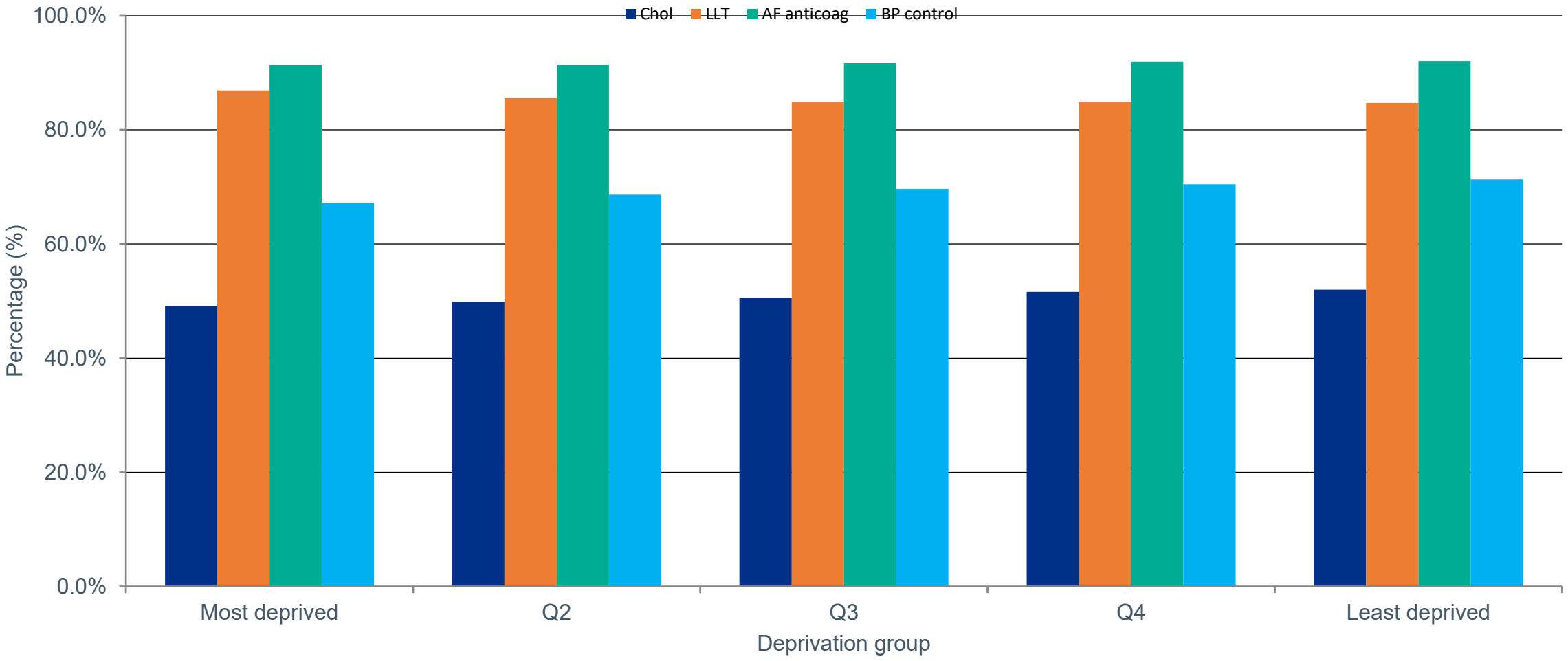
Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by Index of Multiple Deprivation (IMD)). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Figure 1.38: CVD secondary prevention: England trend



Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by IMD). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Figure 1.39: CVD secondary prevention by deprivation group (IMD quintile), December 2025



Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by IMD). Other components in narrative: CVDP002AF, CVDP002CHD, C...

NHS Health Check: uptake among eligible population

Effectiveness | Tier 2: Driver | ↑ Higher is better

Cumulative proportion of the eligible population aged 40 to 74 who received an NHS Health Check within the rolling 5-year programme cycle, from local authority returns via Office for Health Improvement and Disparities (OHID) Fingertips indicator 91112.

Why it matters for the strategy

• The NHS Health Check programme identifies adults aged 40 to 74 at risk of cardiovascular disease (CVD), type 2 diabetes, kidney disease and dementia. Uptake is the gating measure for the upstream interventions named in the CVD Modern Service Framework (MSF) and strategy Prevention pathway - check coverage caps the reach of every downstream lever.
• The latest figure for England is 34.4% (Q3 April 2025 to March 2026)
• This metric represents cumulative coverage within the last five years.
• Performance varies across NHS regions: the best-performing area (London) has achieved 45.1%, while the lowest (South West) achieved 25.9%, a 19.2% gap.
• People in the least deprived areas achieve 29.2%, compared with 35.0 in the most deprived - a gap of 5.8%.
• There is no simple relationship between deprivation decile and delivery of health checks.

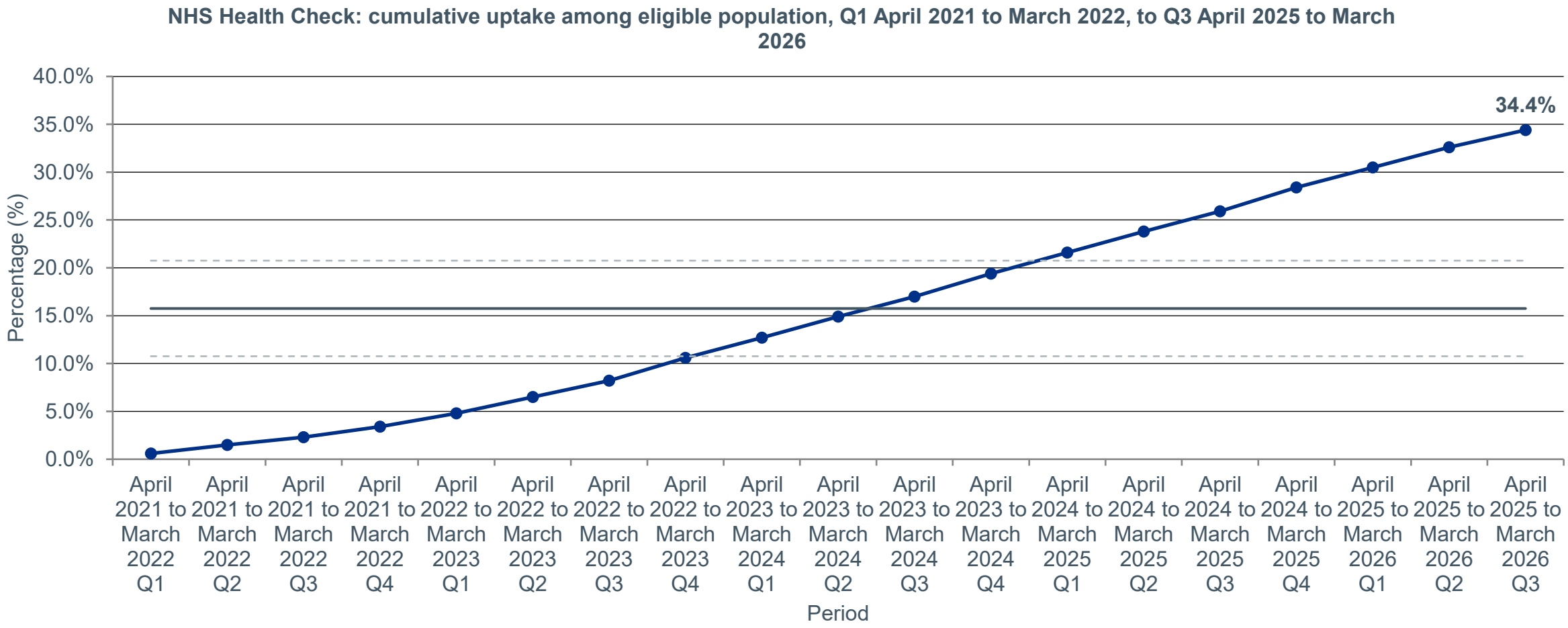
Source: NHS Health Check programme OHID Fingertips indicator [91112]

NHS Health Check: uptake among eligible population

Effectiveness | Tier 2: Driver | ↑ Higher is better

Cumulative proportion of the eligible population aged 40 to 74 who received an NHS Health Check within the rolling 5-year programme cycle, from local authority returns via OHID Fingertips indicator 91112.

Figure 1.40: NHS Health Check: uptake among eligible population: England trend



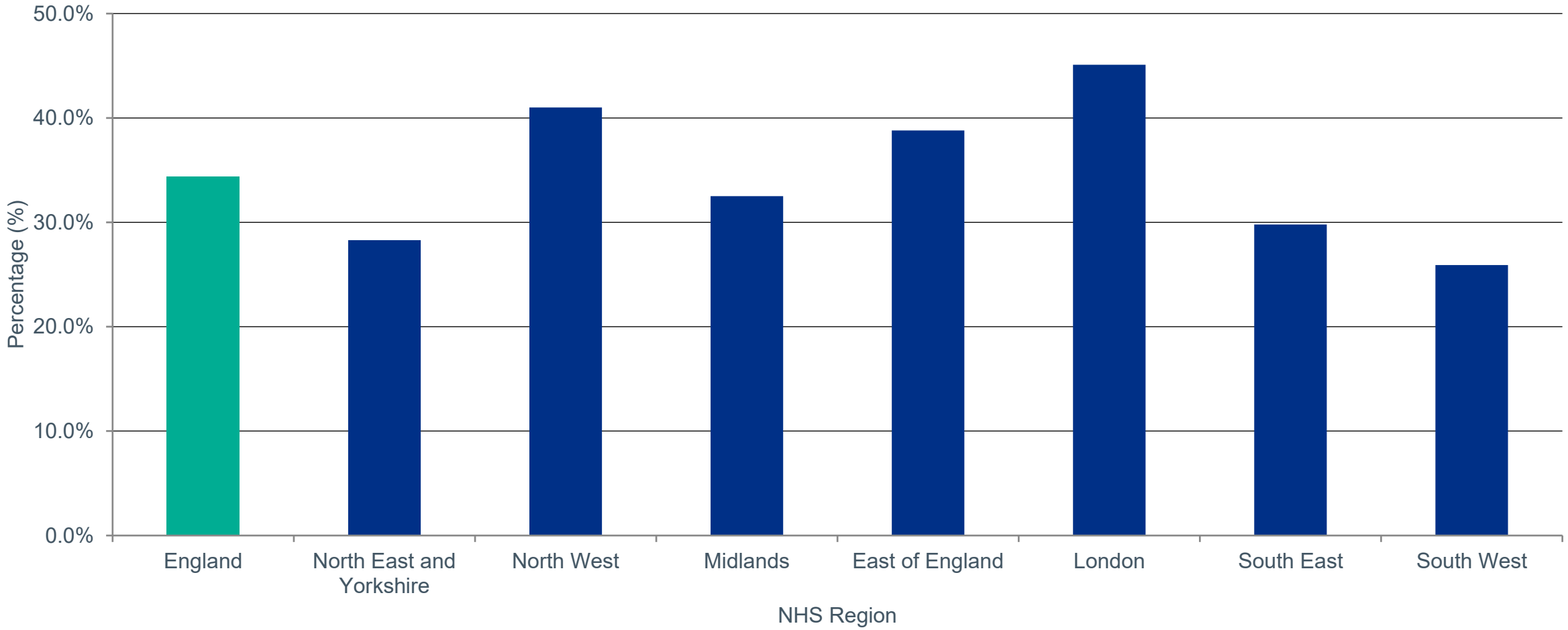
Source: NHS Health Check programme OHID Fingertips indicator [91112]

NHS Health Check: uptake among eligible population

Effectiveness | Tier 2: Driver | ↑ Higher is better

Cumulative proportion of the eligible population aged 40 to 74 who received an NHS Health Check within the rolling 5-year programme cycle, from local authority returns via OHID Fingertips indicator 91112.

Figure 1.41: NHS Health Check: uptake among eligible population by NHS Region



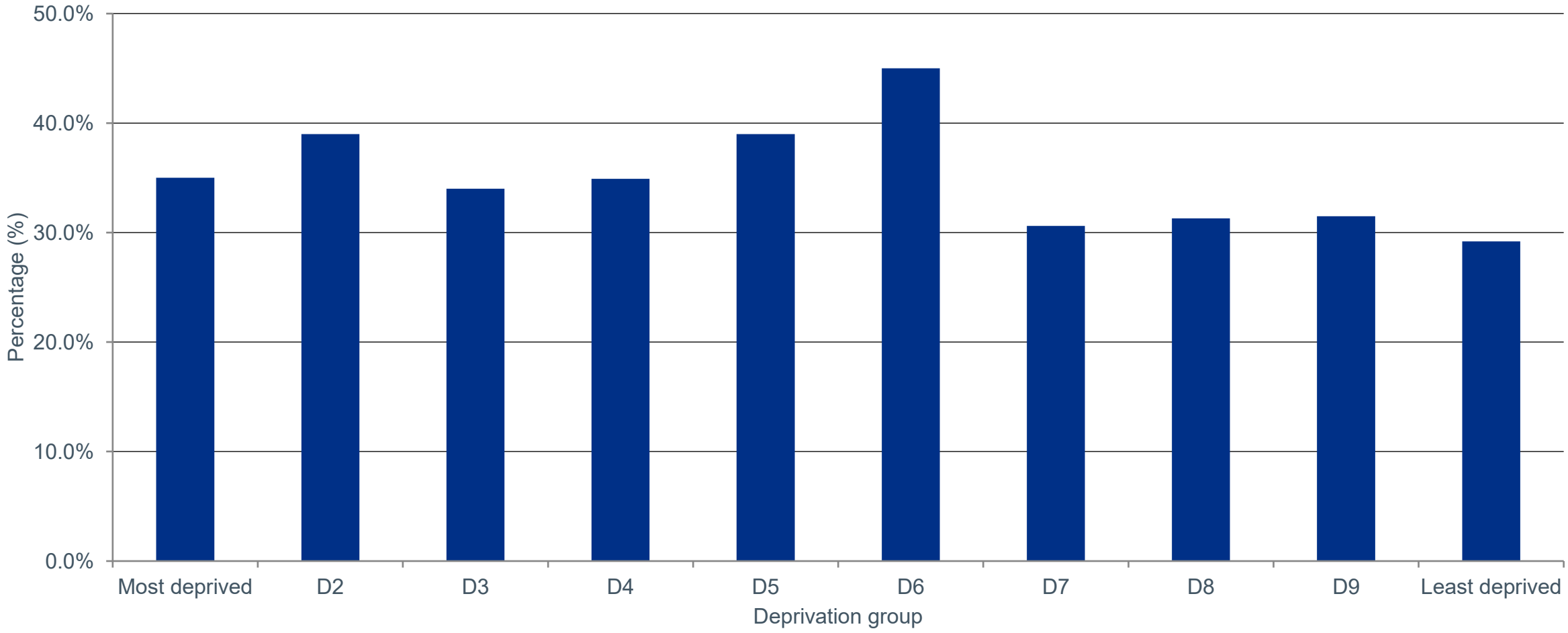
Source: NHS Health Check programme OHID Fingertips indicator [91112]

NHS Health Check: uptake among eligible population

Effectiveness | Tier 2: Driver | ↑ Higher is better

Cumulative proportion of the eligible population aged 40 to 74 who received an NHS Health Check within the rolling 5-year programme cycle, from local authority returns via OHID Fingertips indicator 91112.

Figure 1.42: NHS Health Check: uptake among eligible population by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: NHS Health Check programme OHID Fingertips indicator [91112]

Chronic kidney disease prevalence

Effectiveness | Tier 2: Driver

Quality and Outcomes Framework (QOF)-recorded prevalence of chronic kidney disease among adults aged 18 and over in England, reflecting the proportion of the GP-registered population on the chronic kidney disease (CKD) register (Office for Health Improvement and Disparities (OHID) Fingertips indicator 258).

Why it matters for the strategy

• We track CKD prevalence because chronic kidney disease affects ~6-7% of adults but over 30% remain undiagnosed. Improved case finding enables early intervention with blood pressure (BP) control and SGLT2 inhibitors to slow progression and prevent dialysis.
• The latest figure for England (2024-25) is 4.6%.
• The trend requires careful interpretation as changes can be both positive and negative in relation to actual prevalence vs better case finding
• The prevalence varies across NHS Regions (April 2024 to March 2025 data): from 3.2% in London to 5.4% in the Midlands
• Prevalence also varies across deprivation deciles, from 3.8% (decile 4) to 5.4% (decile 7) There is no simple relationship between deprivation decile and CKD prevalence.

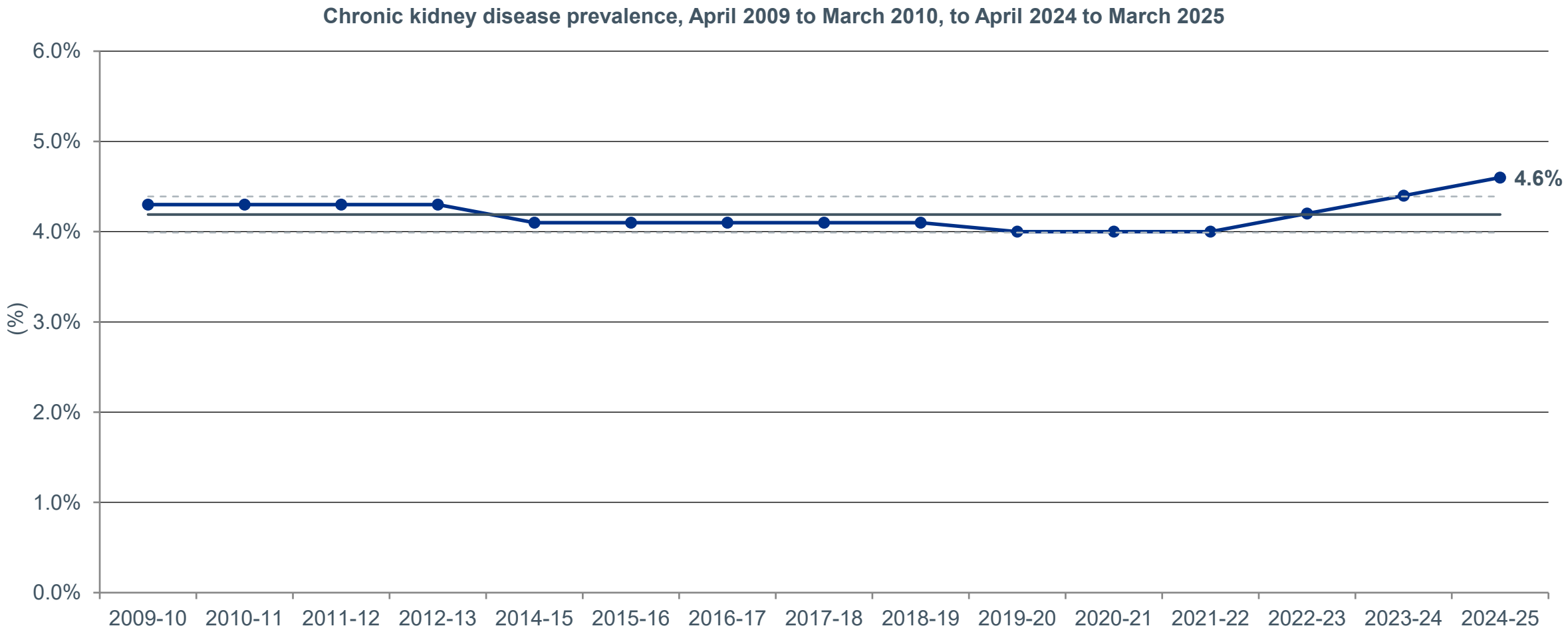
Source: NHS England, Quality and Outcomes Framework, OHID Fingertips indicator 258

Chronic kidney disease prevalence

Effectiveness | Tier 2: Driver

QOF-recorded prevalence of chronic kidney disease among adults aged 18 and over in England, reflecting the proportion of the GP-registered population on the CKD register (OHID Fingertips indicator 258).

Figure 1.43: Chronic kidney disease prevalence: England trend



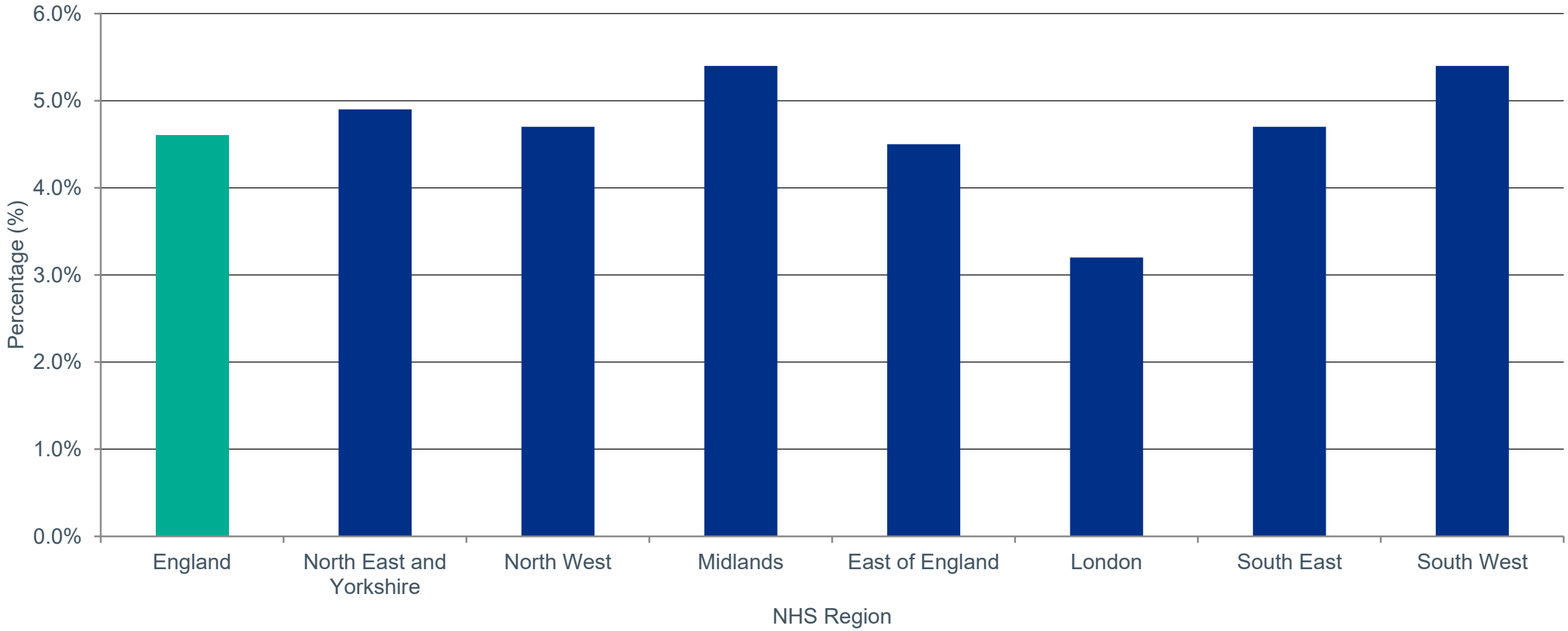
Source: NHS England, Quality and Outcomes Framework, OHID Fingertips indicator 258 Note: no data point is published for April 2013 to March 2014; the chart shows the years for which data is available.

Chronic kidney disease prevalence

Effectiveness | Tier 2: Driver

QOF-recorded prevalence of chronic kidney disease among adults aged 18 and over in England, reflecting the proportion of the GP-registered population on the CKD register (OHID Fingertips indicator 258).

Figure 1.44: Chronic kidney disease prevalence by NHS Region, April 2024 to March 2025



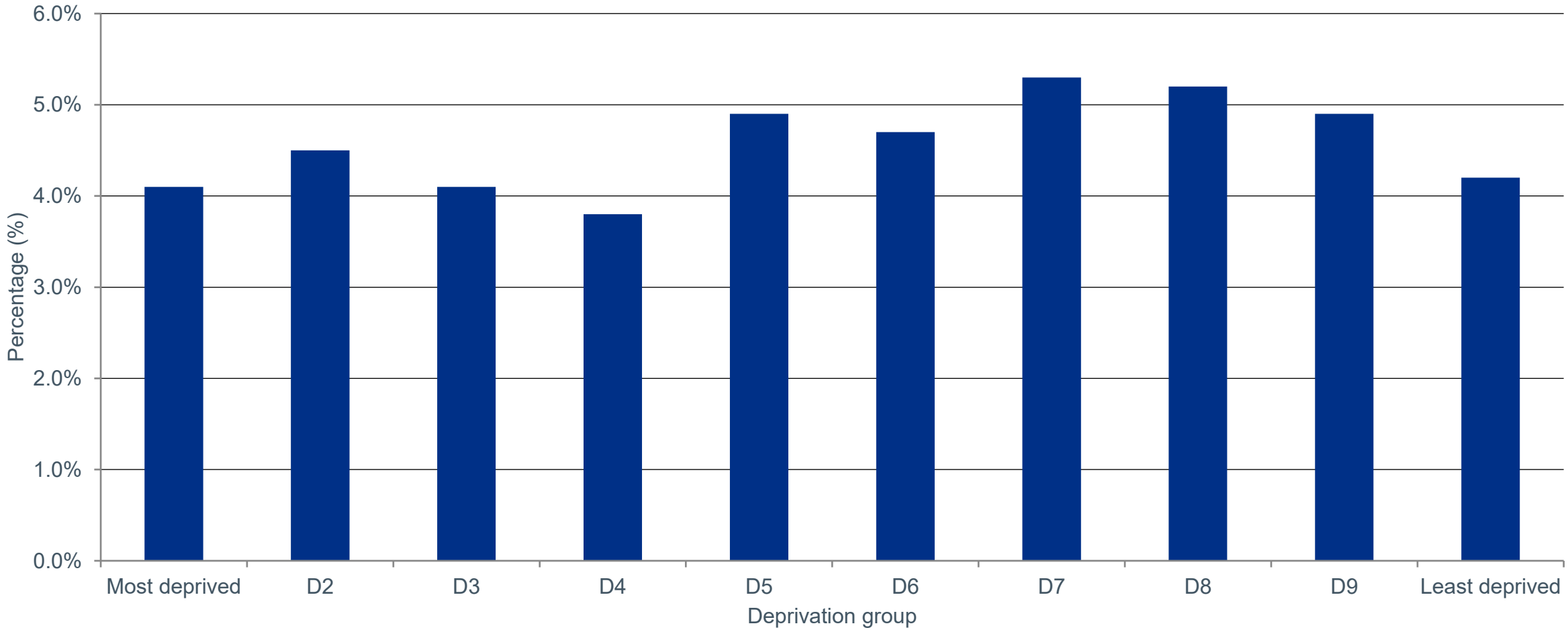
Source: NHS England, Quality and Outcomes Framework, OHID Fingertips indicator 258

Chronic kidney disease prevalence

Effectiveness | Tier 2: Driver

QOF-recorded prevalence of chronic kidney disease among adults aged 18 and over in England, reflecting the proportion of the GP-registered population on the CKD register (OHID Fingertips indicator 258).

Figure 1.45: Chronic kidney disease prevalence by deprivation group (Index of Multiple Deprivation (IMD) decile), April 2024 to March 2025



Source: NHS England, Quality and Outcomes Framework, OHID Fingertips indicator 258

Cardiac rehabilitation completion rate

Effectiveness | Tier 2: Driver | ↑ Higher is better

Percentage completing cardiac rehabilitation.

Why it matters for the strategy

• This metric reflects the extent to which patients receive effective care after a cardiac event, leading to better outcomes, reducing avoidable readmissions and reduce premature mortality.
• The latest figure for England (2024) is 81.3%
• Trend: This is broadly stable, increasing 1.3% between 2023 (80.0%) and 2024 (81.3%)

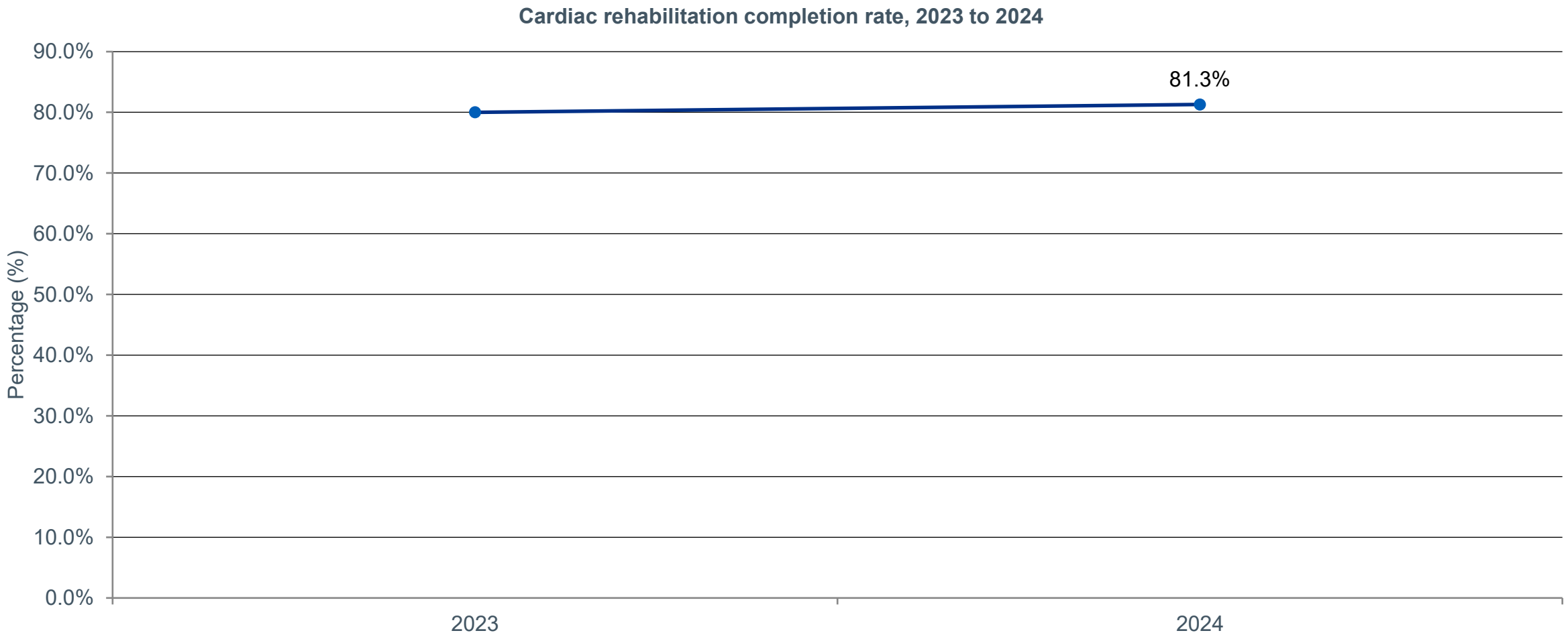
Source: National Audit of Cardiac Rehabilitation

Cardiac rehabilitation completion rate

Effectiveness | Tier 2: Driver | ↑ Higher is better

Percentage completing cardiac rehabilitation.

Figure 1.46: Cardiac rehabilitation completion rate: England trend



Source: National Audit of Cardiac Rehabilitation

Stroke care, median time from symptom onset to hospital arrival and % access to stroke unit within 4 hours of clock start on hospital arrival

Effectiveness | Tier 3: Signal | For median time ↓ Lower is better; For access to stroke unit ↑ Higher is better

Median time from stroke onset to hyper-acute stroke unit.

Why it matters for the strategy

• These metrics indicates how quickly people get specialist treatment for stroke where every minute of delay worsens neurological outcomes and appropriate specialist treatment improves outcomes, recovery and reducing mortality from cerebrovascular disease.
• The latest figure for England (Dec-25) is median time of 268 minutes from symptom onset to hospital arrival, and 50.3% arriving on the stroke unit within 4 hours.
• Trend: This is getting better for access to stroke unit increasing by 7.2% between Feb-25 (43.1%) and Dec-25 (50.3%). The trend overall is broadly stable for median time from symptom onset to hospital arrival, although this has increased by 28 minutes between Mar-25 (240 minutes) and Dec-25 (268 minutes)
• Companion to cardiovascular disease (CVD) mortality outcome and rehab-related drivers.

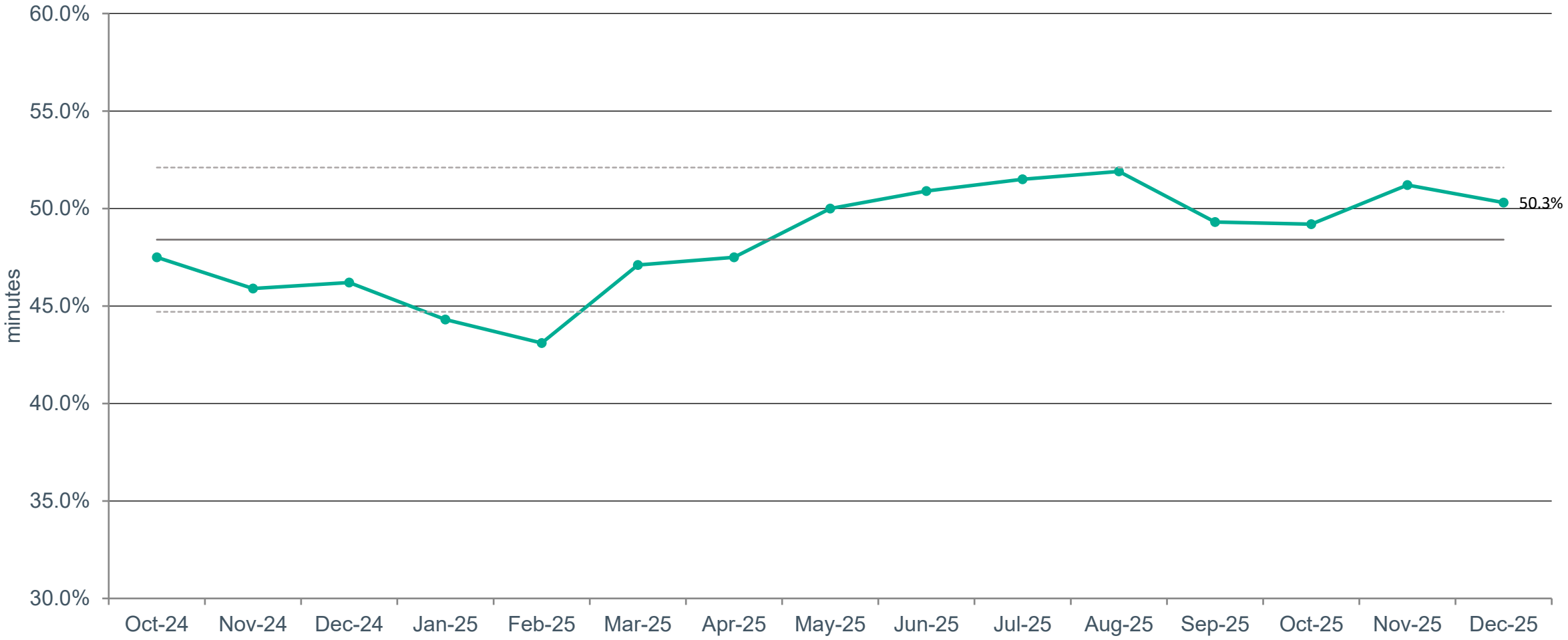
Source: Stroke Sentinel National Audit Programme (SSNAP)

Stroke care, median time from symptom onset to hospital arrival and % access to stroke unit within 4 hours of clock start on hospital arrival

Effectiveness | Tier 3: Signal | For median time ↓ Lower is better; For access to stroke unit ↑ Higher is better

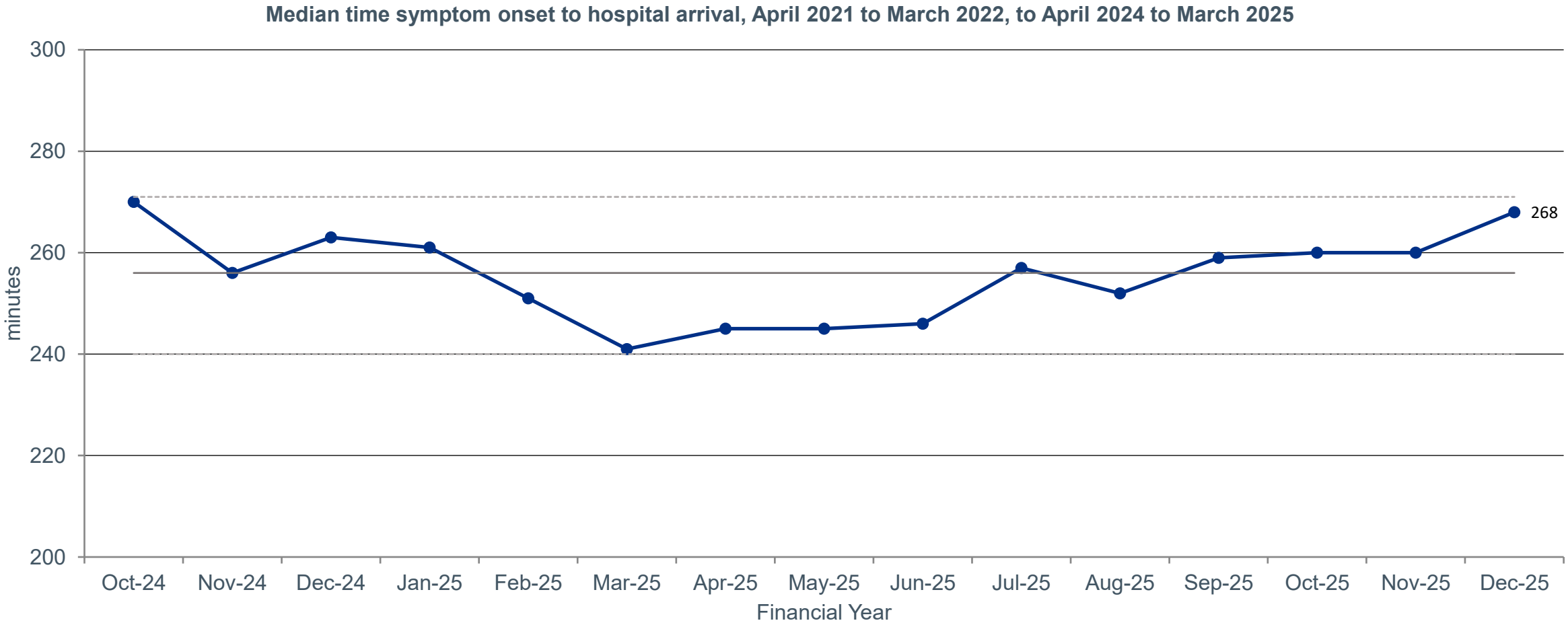
Median time from stroke onset to hyper-acute stroke unit.

Figure 1.47: Percentage with access to stroke unit within 4 hours of clock start on hospital arrival



Source: Stroke Sentinel National Audit Programme (SSNAP)

Figure 1.48: Stroke care, median time from symptom onset to hospital arrival and % access to stroke unit within 4 hours of clock start on hospital arrival: England trend



Source: Stroke Sentinel National Audit Programme (SSNAP)

Door-to-Balloon, median time (minutes) for higher-risk STEMI patients

Effectiveness | Tier 2: Driver | ↓ Lower is better

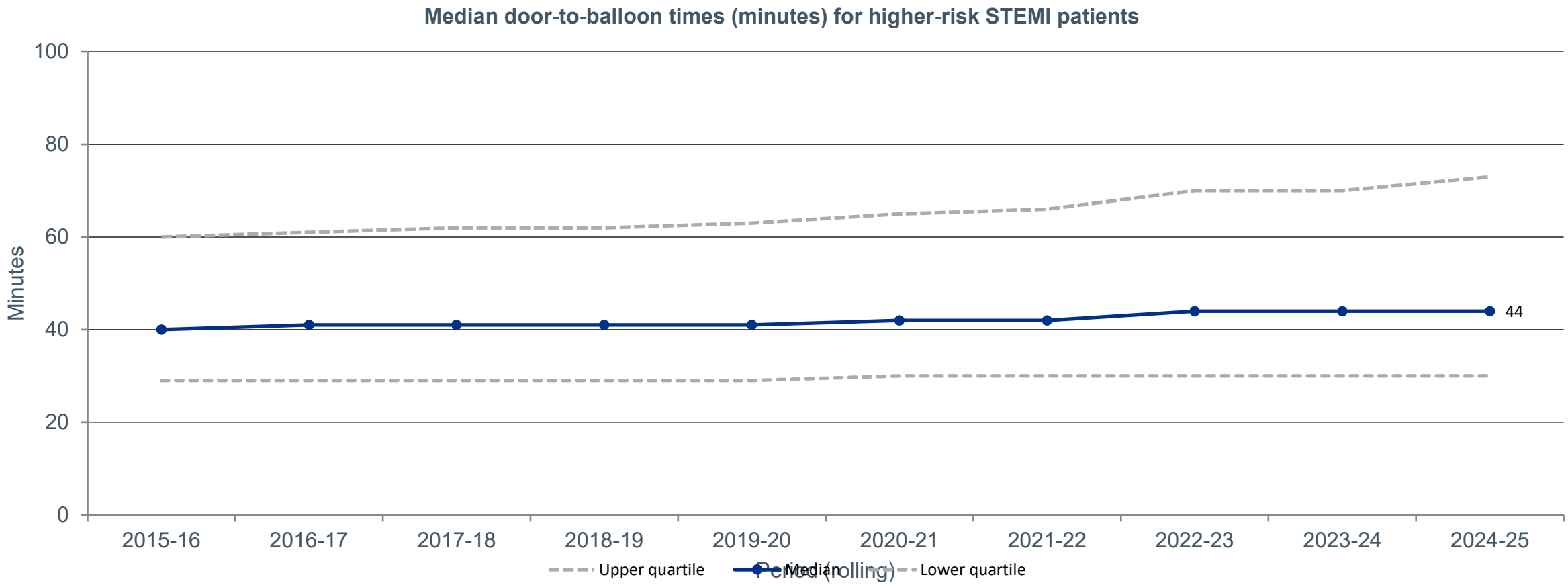
Median door-to-balloon time in minutes from arrival at hospital to reopening of artery using reperfusion primary PCI therapy for higher-risk STEMI patients

Why it matters for the strategy

• Door-to-balloon time for high-risk STEMI patients is a key measure of acute sector effectiveness related to a major cause of premature death and key contributor to life expectancy and healthy life expectancy.
• The latest figure for England is 44 minutes in April 2024 to March 2025.
• This is getting worse: increasing steadily by four minutes from April 2015 to March 2016 (40) to April 2024 to March 2025 (44).

Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by Index of Multiple Deprivation (IMD)). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Figure 1.49: Door-to-Balloon, median time (minutes) for higher-risk STEMI patients: England trend



Source:Myocardial Ischaemia National Audit Project (MINAP)/National Cardiac Audit Programme – 2024-25 Annual Report

Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by IMD). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Under-75 cancer mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cancer for people aged under 75 in England, expressed per 100,000 population (Office for National Statistics (ONS) death registrations, confirmed by Office for Health Improvement and Disparities (OHID) Fingertips indicator 40501).

Why it matters for the strategy

- Under-75 cancer mortality is a key cause of premature death and contributor to life expectancy
- This is getting better, decreasing by 57.4 per 100,000 between 2001 (172.0) and 2025 (114.6)
- Performance varies across NHS Regions (2024 data): the best-performing area was London (105.4 per 100,000); the worst was North East and Yorkshire (128.0 per 100,000).
- The deprivation gap (2024) is 48.3 per 100,000 for males (162.2 most deprived to 113.8 least deprived) and 37.8 per 100,000 for females (126.6 to 88.9).
- The National Cancer Plan does not contain an explicit commitment to reducing under 75 cancer mortality, though some of the activities within it may contribute, such as expansion of cancer screening. The 2026 National Cancer Plan commits to 75% 5-year survival by 2035 supported by earlier diagnosis and more consistent access to high quality care

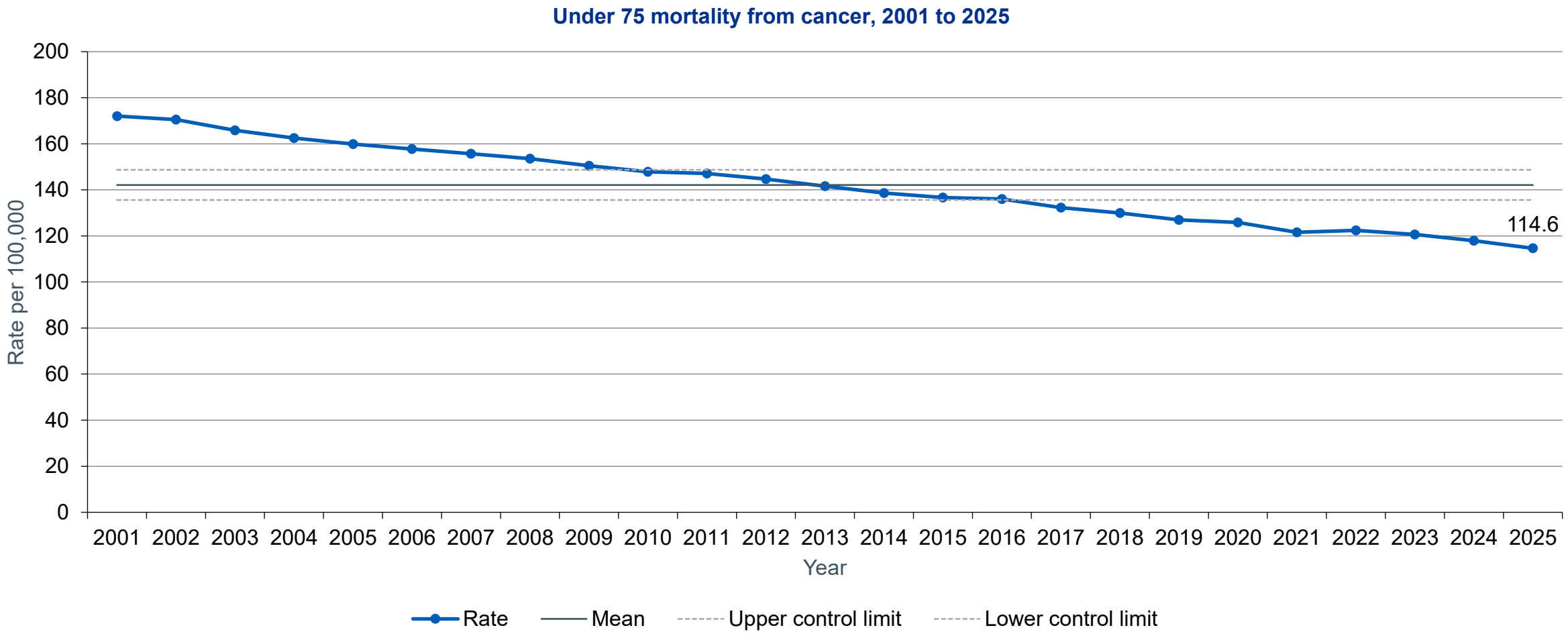
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025) |

Under-75 cancer mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cancer for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 40501).

Figure 1.50: Under-75 cancer mortality: England trend



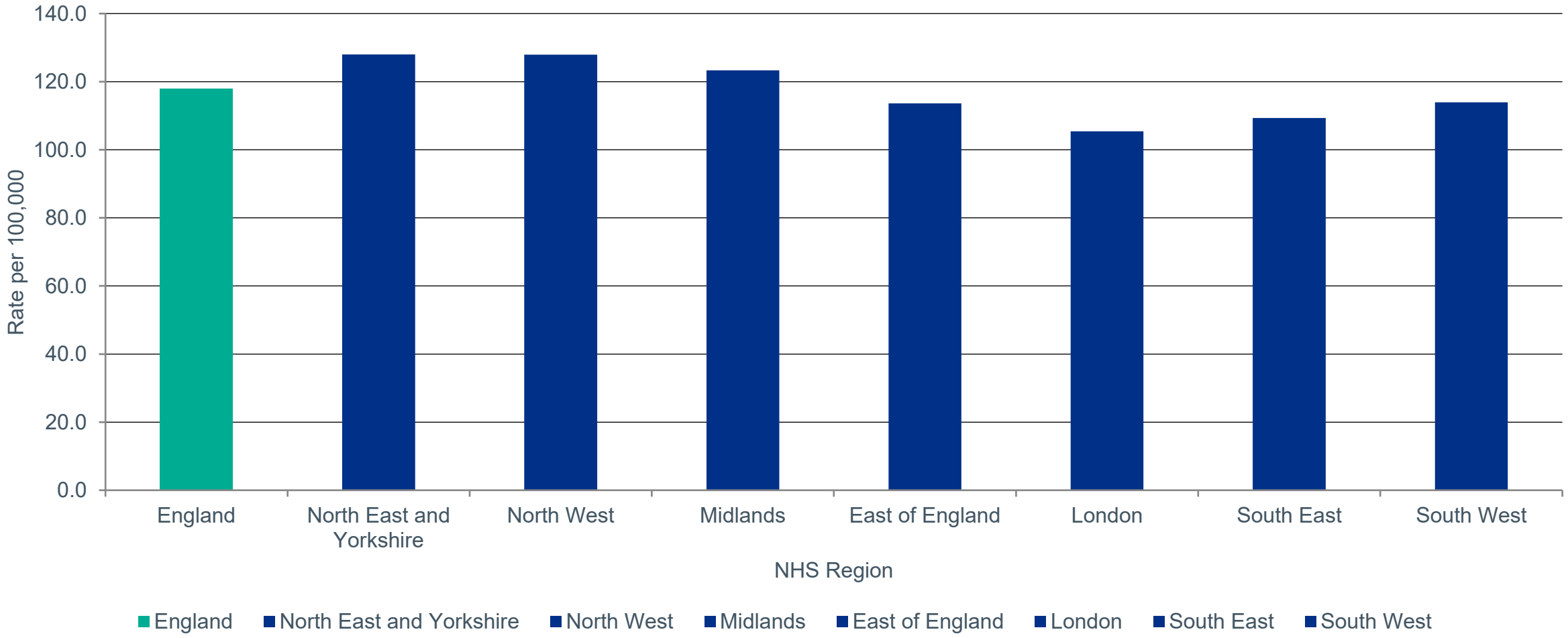
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025) |

Under-75 cancer mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cancer for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 40501).

Figure 1.51: Under-75 cancer mortality by NHS Region, 2024 (latest)



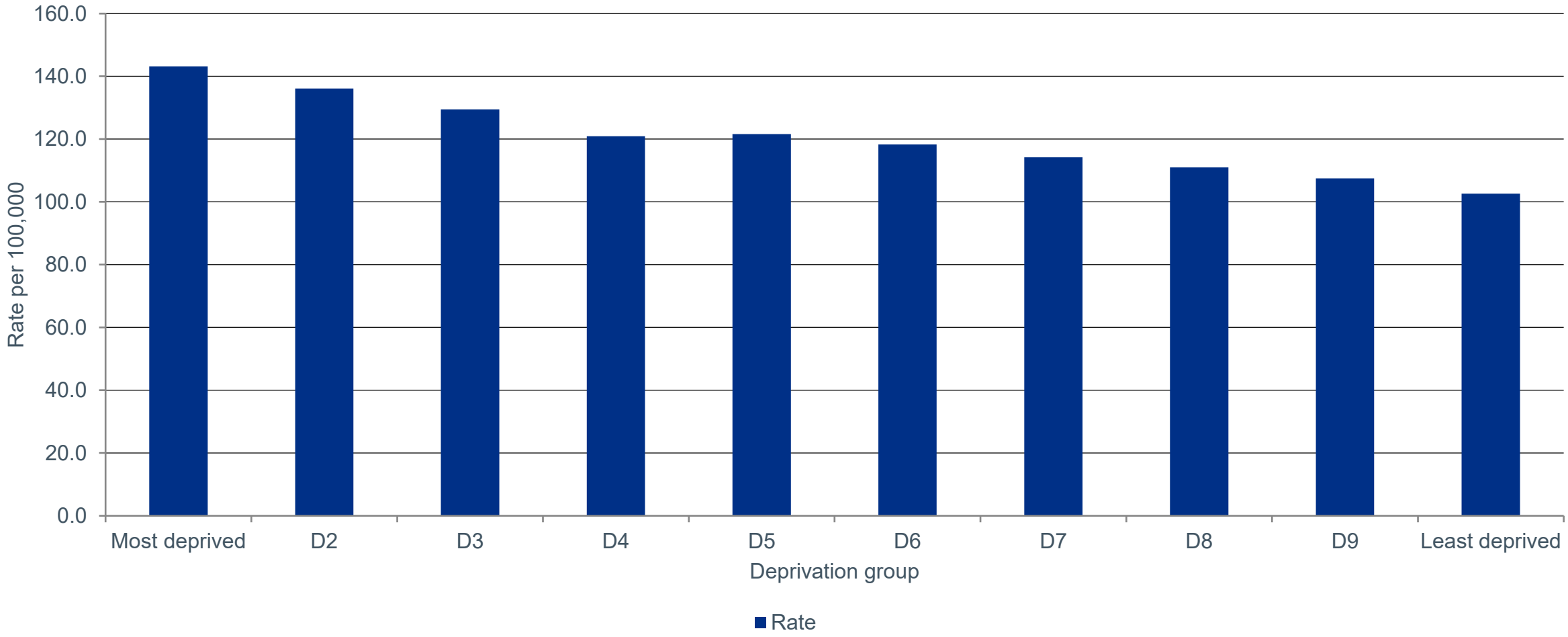
Source: ONS, Death registrations summary tables - England and Wales (Oct 2025) |

Under-75 cancer mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from cancer for people aged under 75 in England, expressed per 100,000 population (ONS death registrations, confirmed by OHID Fingertips indicator 40501).

Figure 1.52: Under-75 cancer mortality by deprivation group (Index of Multiple Deprivation (IMD) decile), 2024 (latest)



Source: ONS, Death registrations summary tables - England and Wales (Oct 2025) |

Cancer 5-year net survival

Effectiveness | Tier 1: Outcome | ↑ Higher is better

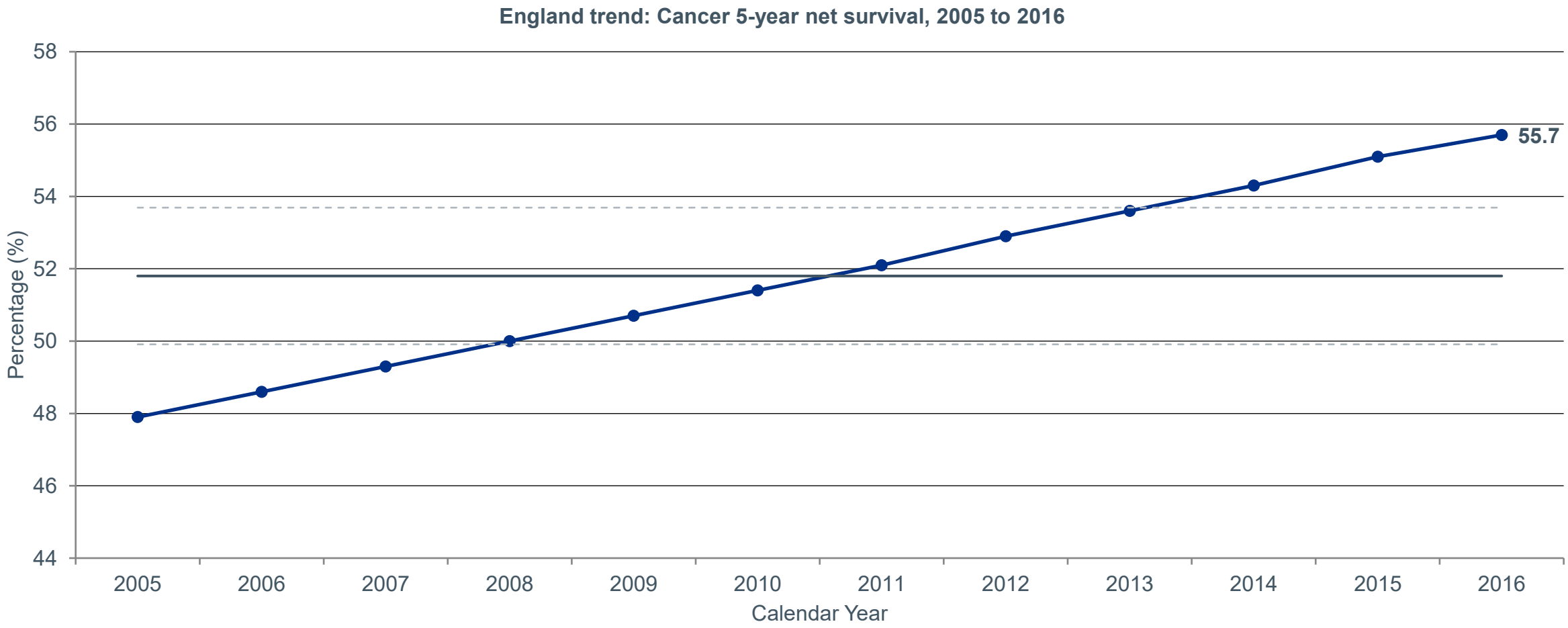
Five-year net survival for all cancers combined in adults aged 15 to 99 diagnosed in England, from the NHS Digital Cancer Survival Index.

Why it matters for the strategy

• It is a key measure of cancer outcome and in line with the ambitions of the National Cancer Plan to improve 5 year survival to 75% by 2035. reflecting the combined impact of early diagnosis, treatment quality and follow-up care.
• The latest figure for England (2016) is 55.7%.
• This is getting better: Steady improvement from 47.9% (2005 cohort) to 55.7% (2016 cohort).
• Performance varies across Cancer Alliances: the best-performing area (N Central London) achieved 57.8%, while the lowest (North East London) achieved 53.2%.
• England trails several international comparators (CONCORD-3): we lose ground on stage-shift and on ~~time-~~access to-treatment for the most complex cancers.
• Survival varies sharply by site (testicular >95%, pancreatic <10%) and by deprivation (10pp gap by quintile for several cancers).
• 5-year survival is the slowest-moving of the cancer outcomes; achieving the 2035 ambition requires consistent gains on early diagnosis and consistent access to high quality treatment

Source: NHS Digital, Index of Cancer Survival in England: adults diagnosed 2005 to 2020 (Apr 2023). Cancer Plan ambition: 75% five-year survival by 2035 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.53: Cancer 5-year net survival: England trend



Source: NHS Digital, Index of Cancer Survival in England: adults diagnosed 2005 to 2020 (Apr 2023). Cancer Plan ambition: 75% five-year survival by 2035 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Early cancer diagnosis (stage 1 to 2)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of cancers diagnosed at stage 1 or stage 2 in England, based on 12-month rolling data from the National Disease Registration Service (NDRS) Rapid Cancer Registration Dataset, as a proportion of all staged cancers.

Why it matters for the strategy

• Stage at diagnosis is the strongest predictor of cancer survival. Monitoring progress on early cancer diagnosis will give a strong indication of progress against the National Cancer Plan's survival ambition. The survival ambition is premised on achieving at least a 20 percentage point increase in early diagnosis above the 2019 level (approx. 55%), by 2035.
• The latest figure for England (January 2026) (12m rolling)) is 59.2%.
• This is getting better: increasing by 2.0% from Apr-24 (57.2%) to Jan-26 (59.2%)
• Performance varies across Cancer Alliances: the best-performing area (N Central London) achieved 63.1%, while the lowest (Lancs and S Cumbria) achieved 54.9% (RCRD (rapid registration)).
• People in the least deprived areas achieve 61.9%, compared with 55.4% in the most deprived - a gap of 6.5%.
• Steep deprivation and ethnicity gradient: emergency presentations (where stage is much later) cluster in the most deprived quintile and in some Asian and Black communities.
• The 2026 National Cancer Plan commits to expanded screening, developing and delivering more proactive approaches to case finding, and supporting faster referral; the lung cancer screening rollout is the largest near-term move.

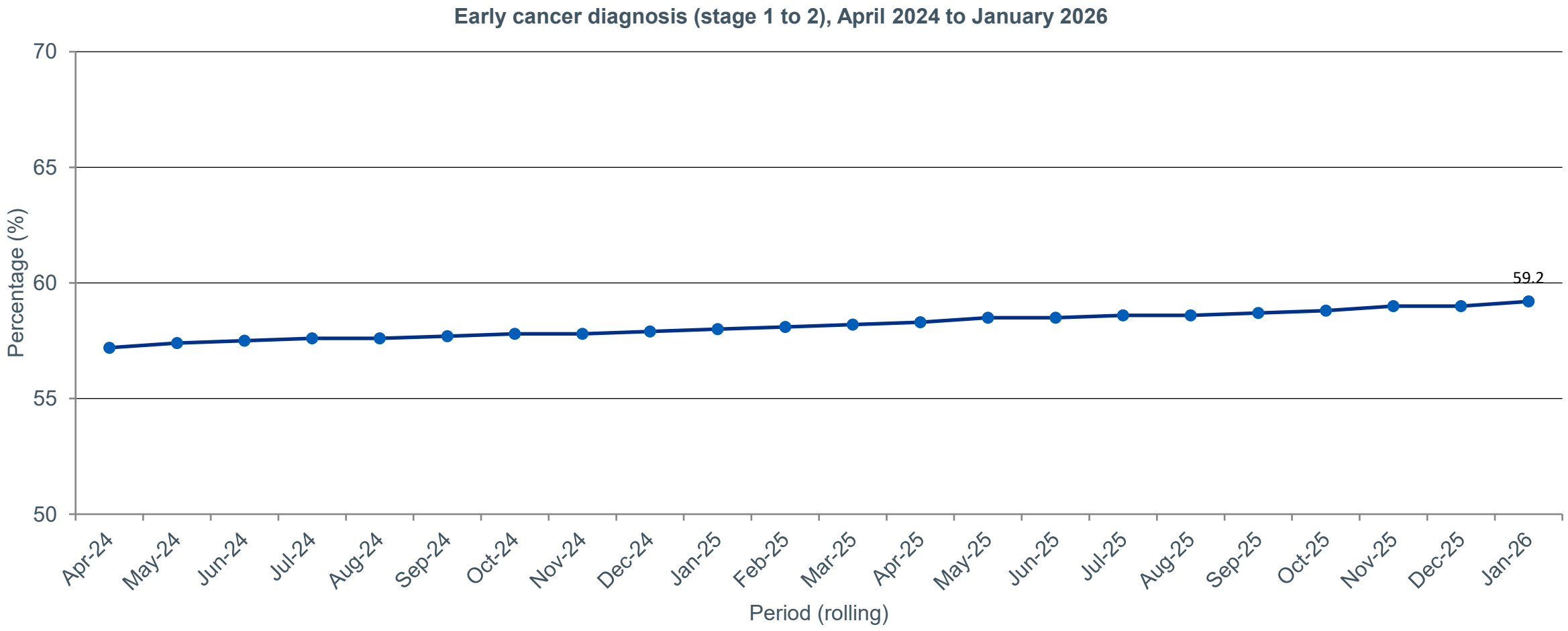
Source: NDRS Rapid Cancer Registration Dataset (rapid cancer registration dataset (RCRD)), 12-month rolling to Sep 2025. integrated care board (ICB) variation from RCRD All Geographies. Deprivation quintiles from RCRD.

Early cancer diagnosis (stage 1 to 2)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of cancers diagnosed at stage 1 or stage 2 in England, based on 12-month rolling data from the NDRS Rapid Cancer Registration Dataset, as a proportion of all staged cancers.

Figure 1.54: Early cancer diagnosis (stage 1 to 2): England trend



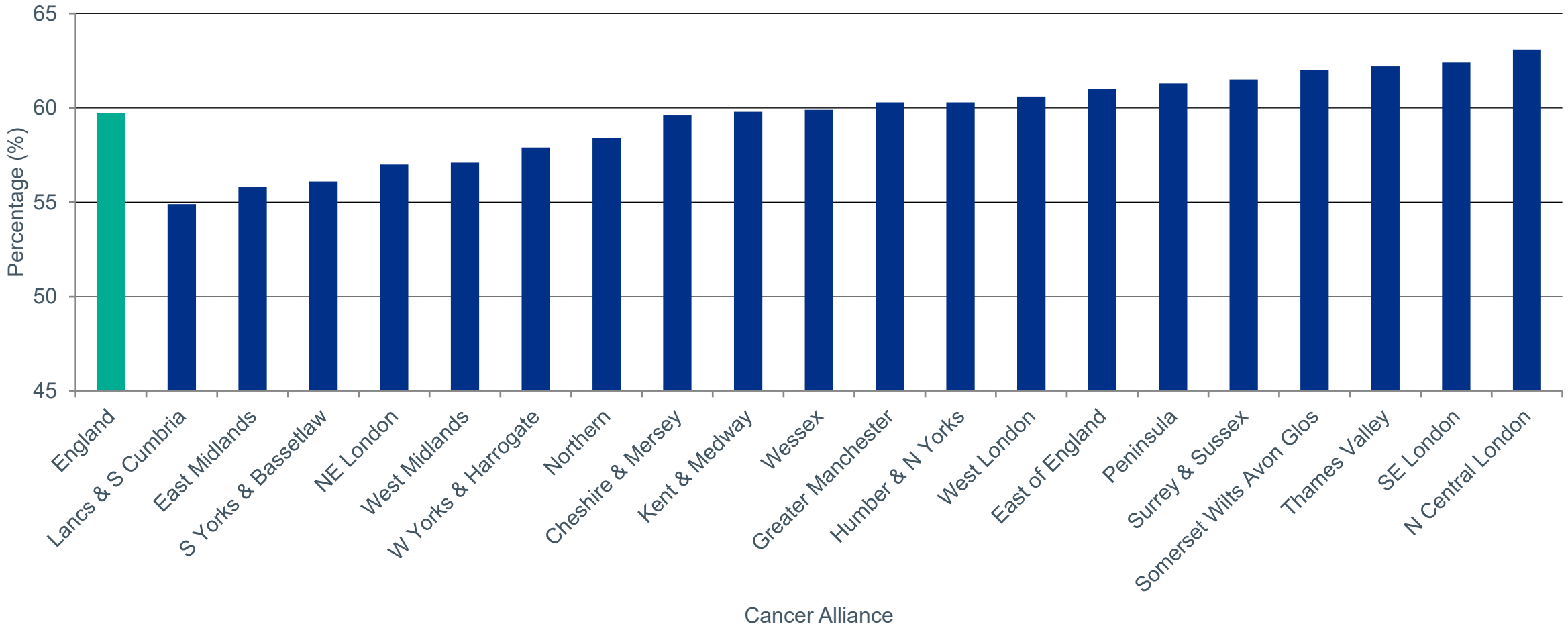
Source: NDRS Rapid Cancer Registration Dataset (RCRD), 12-month rolling to Sep 2025. ICB variation from RCRD All Geographies. Deprivation quintiles from RCRD.

Early cancer diagnosis (stage 1 to 2)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of cancers diagnosed at stage 1 or stage 2 in England, based on 12-month rolling data from the NDRS Rapid Cancer Registration Dataset, as a proportion of all staged cancers.

Figure 1.55: Early cancer diagnosis (stage 1 to 2) by Cancer Alliance



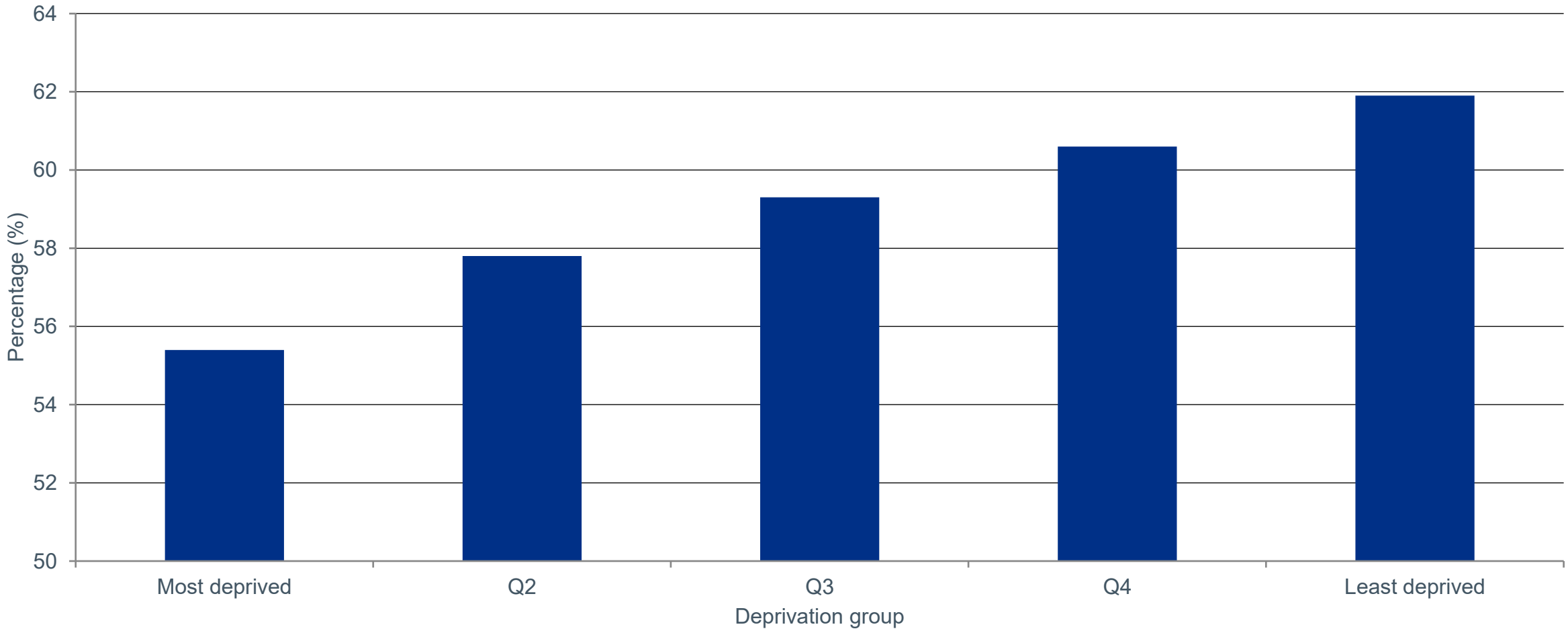
Source: NDRS Rapid Cancer Registration Dataset (RCRD), 12-month rolling to Sep 2025. ICB variation from RCRD All Geographies. Deprivation quintiles from RCRD.

Early cancer diagnosis (stage 1 to 2)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of cancers diagnosed at stage 1 or stage 2 in England, based on 12-month rolling data from the NDRS Rapid Cancer Registration Dataset, as a proportion of all staged cancers.

Figure 1.56: Early cancer diagnosis (stage 1 to 2) by deprivation group (Index of Multiple Deprivation (IMD) quintile) – January 2026



Source: NDRS Rapid Cancer Registration Dataset (RCRD), 12-month rolling to Sep 2025. ICB variation from RCRD All Geographies. Deprivation quintiles from RCRD.

Cancer: emergency presentations (percentage of all cancers)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of all staged cancer diagnoses that were made via an emergency presentation route, from the National Disease Registration Service Route to Diagnosis dataset.

Why it matters for the strategy

• Cancers diagnosed via emergency routes have significantly worse outcomes than cancers diagnosed with managed routes (only 29.7% at stage 1 to 2 vs 59.4% overall). The National Cancer Plan speaks to reducing the proportion of cancers diagnosed in an emergency setting, as a check that progress is being made in the diagnosis of blood, brain and some other rarer cancers which are not conventionally staged. Actions to support earlier diagnosis of cancer are expected to positively impact on levels of emergency presentation assuming that there is good access to primary care services and patients do not turn to emergency provision when other routes would have been suitable.

• The latest figure for England is 18.4% (2022 Q2)

• This has remained broadly stable since 2020 Q3 Emergency presentations but decreasing by 1.5% from 19.9% to 18.4% in 2022 Q2

.

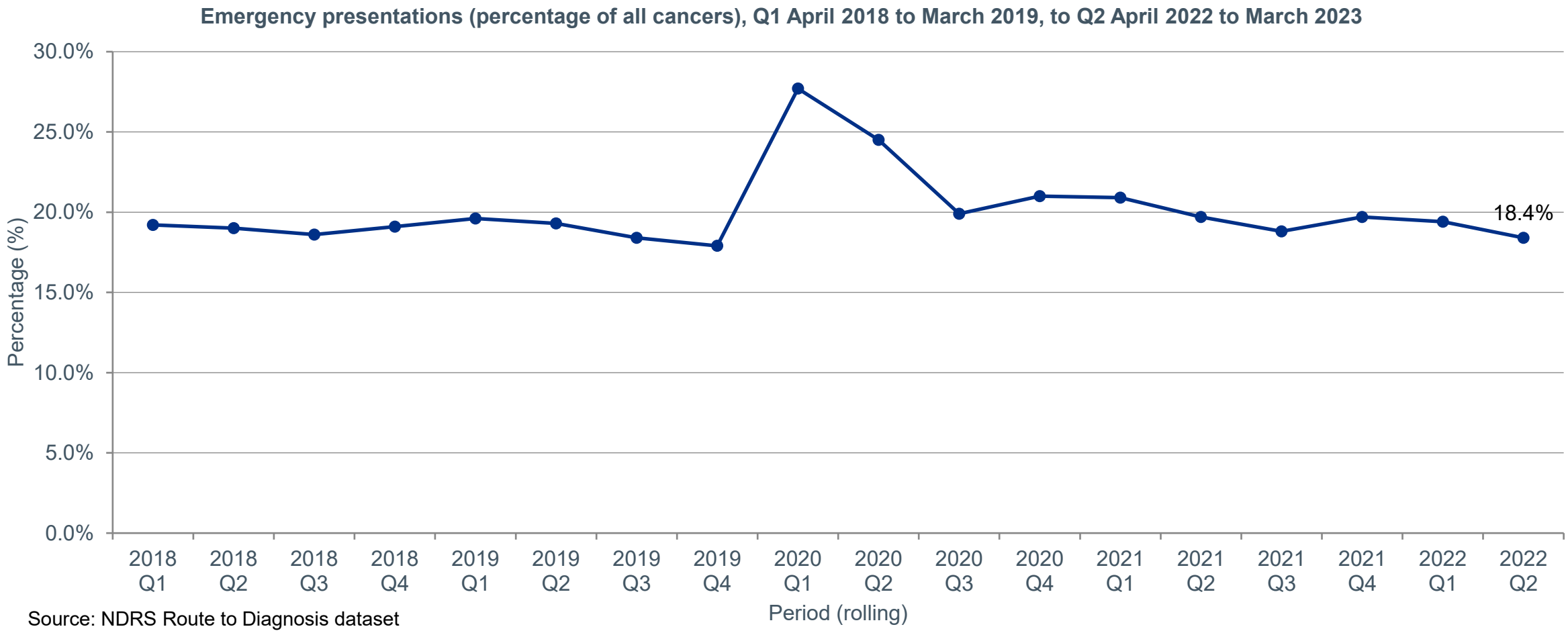
Source: National Disease Registration Service (NDRS) rapid cancer registration dataset (RCRD) Route to Diagnosis dashboard (staged-only denominator), 12-month rolling to Jul 2025

Cancer: emergency presentations (percentage of all cancers)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of all staged cancer diagnoses that were made via an emergency presentation route, from the National Disease Registration Service Route to Diagnosis dataset.

Figure 1.57: Cancer: emergency presentations (percentage of all cancers): England trend



Source: NDRS Route to Diagnosis dataset

Source: NDRS RCRD Route to Diagnosis dashboard (staged-only denominator), 12-month rolling to Jul 2025

Route to cancer diagnosis: percentage via emergency presentation (NDRS) by deprivation

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

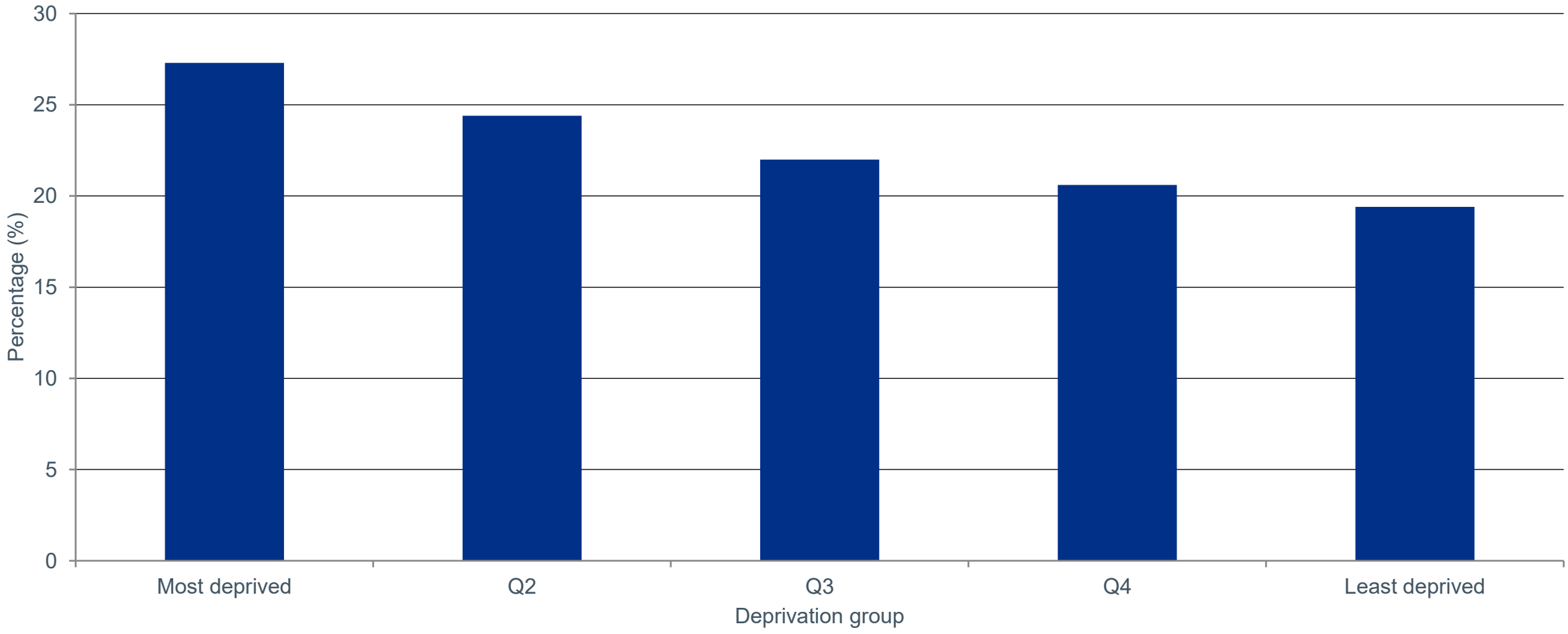
NDRS Routes to Diagnosis: percentage of all malignant cancer diagnoses presenting via emergency route , broken down by deprivation. Full multi-route breakdown also available (screening, GP referral, urgent suspected cancer (USC), inpatient elective, DCO).

Why it matters for the strategy

• Cancers diagnosed via emergency routes have significantly worse outcomes than cancers diagnosed with managed routes (only 29.7% at stage 1 to 2 vs 59.4% overall). The National Cancer Plan speaks to reducing the proportion of cancers diagnosed in an emergency setting, as a check that progress is being made in the diagnosis of blood, brain and some other rarer cancers which are not conventionally staged. Actions to support earlier diagnosis of cancer are expected to positively impact on levels of emergency presentation assuming that there is good access to primary care services and patients do not turn to emergency provision when other routes would have been suitable.
• This data source allows a breakdown by deprivation
• People in the most deprived areas have a rate of 27.3%, compared with 19.4 in the least deprived - a gap of 7.9%.
•

Source: NDRS Routes to Diagnosis 2006 to 2020 (England, all malignant neoplasms, emergency route) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.58: Route to cancer diagnosis: percentage via emergency presentation (NDRS) by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: NDRS Routes to Diagnosis 2006 to 2020 (England, all malignant neoplasms, emergency route) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer Faster Diagnosis Standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of patients referred urgently for suspected cancer who received a diagnosis or ruling-out of cancer within 28 days, from the Cancer Waiting Times national time series.

Why it matters for the strategy

• We track the Faster Diagnosis Standard because it is the operational measure of whether patients with an urgent referral for suspected cancer receive a timely diagnosis. The operational standard for faster diagnosis standard (FDS) is 80% from 31.3.26 and was previously 75%,
• The latest figure for England (March 2026) is 79.4%.
• This is impacted by seasonality during the winter months, but has remained broadly stable with the rate very similar to the same period in the previous year (79.0 in Mar-25 vs 79.4 in Mar-26) Winter seasonal dip: 77.4% (Dec 2025) to 72.8% (Jan 2026).
• The standard for FDS is now 80%.
• The 2026 National Cancer Plan commits to meeting the three cancer waiting-time standards (FDS, 31-day, 62-day) by March 2029.

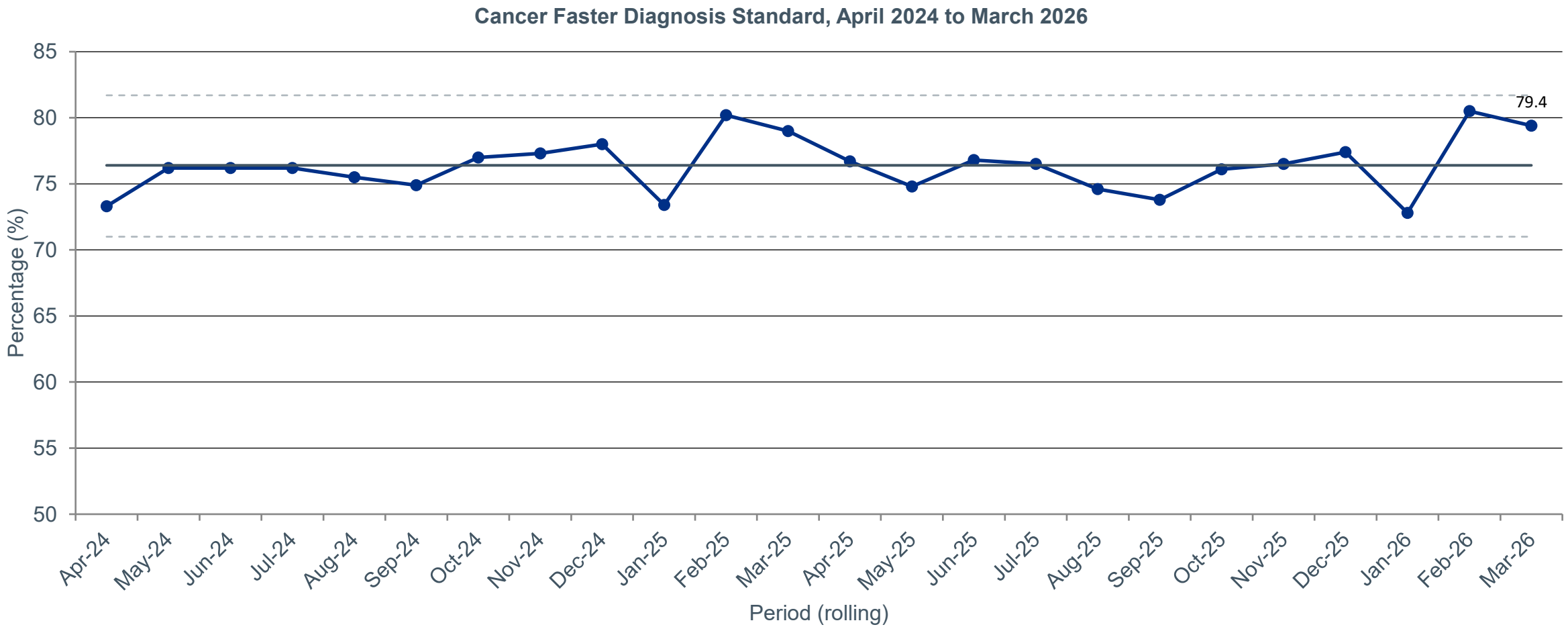
Source: NHS England, Cancer waiting times Mar 2026 (May 2026). cancer waiting times (CWT)-cancer registration system (CRS) National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer Faster Diagnosis Standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of patients referred urgently for suspected cancer who received a diagnosis or ruling-out of cancer within 28 days, from the Cancer Waiting Times national time series.

Figure 1.59: Cancer Faster Diagnosis Standard: England trend



Source: NHS England, Cancer waiting times Mar 2026 (May 2026). CWT-CRS National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer: 31-day treatment standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of cancer patients who received their ~~first~~ treatment within 31 days of the decision to treat, across all cancer types, from the Cancer Waiting Times national time series.

Why it matters for the strategy

• We track the 31-day treatment standard because it measures whether patients receive their ~~first~~ cancer treatment within 31 days of the decision to treat. The National Cancer Plan commits to all three cancer waiting time standards (faster diagnosis standard (FDS), 31-day, 62-day) by March 2029.
• The latest figure for England (March 2026) is 92.8%
• This has remained broadly stable: around 90-93% since Apr 2022. Winter seasonal dip to 89.8% (Jan 2026) from 92.5% (Dec 2025). Consistently below the 96% operational standard.

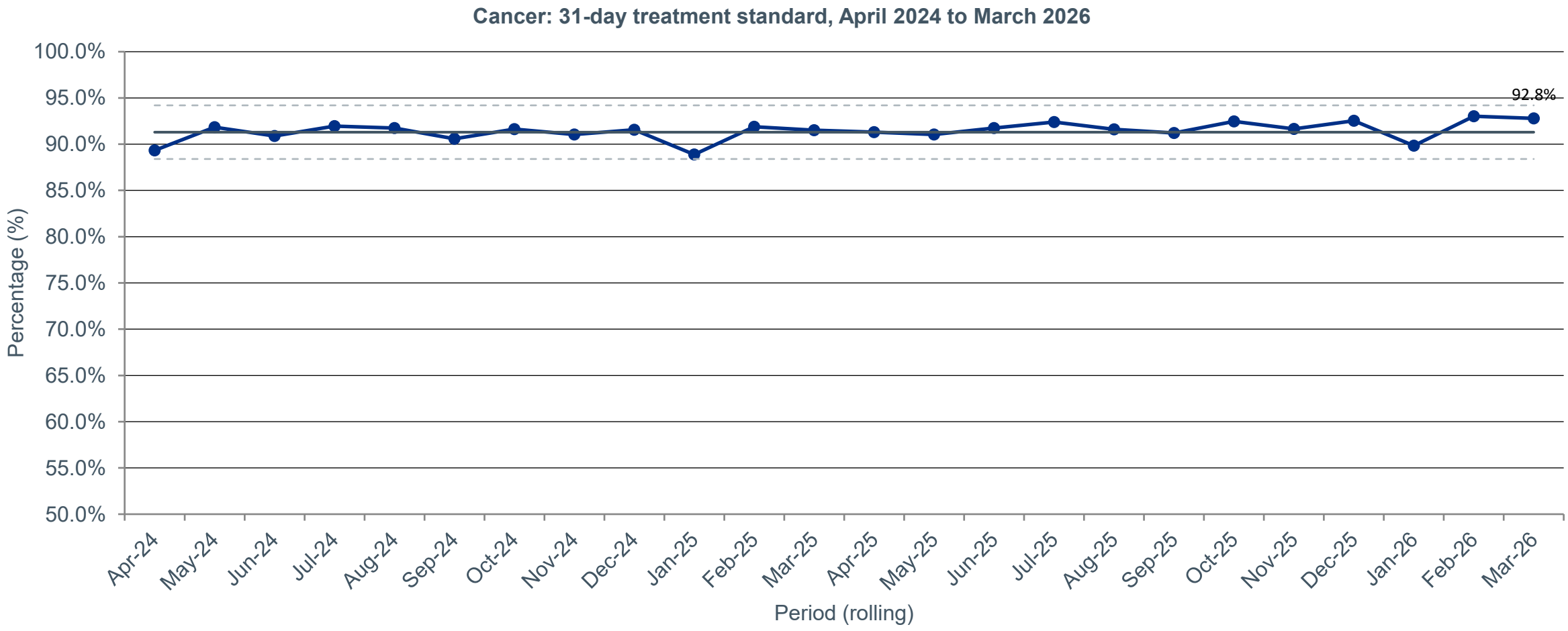
Source: NHS England, Cancer waiting times Mar 2026 (May 2026). cancer waiting times (CWT)-cancer registration system (CRS) National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer: 31-day treatment standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of cancer patients who received their ~~first~~ treatment within 31 days of the decision to treat, across all cancer types, from the Cancer Waiting Times national time series.

Figure 1.60: Cancer: 31-day treatment standard: England trend



Source: NHS England, Cancer waiting times Mar 2026 (May 2026). CWT-CRS National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer: 62-day referral to treatment standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of cancer patients who received their first treatment within 62 days of referral, across all cancer types, from the Cancer Waiting Times national time series.

Why it matters for the strategy

• We track the 62-day referral to treatment standard because it measures whether patients receive their first cancer treatment within 62 days of referral. Performance is currently well below the 85% standard and is a key focus of the National Cancer Plan
• The latest figure for England (March 2026) is 72.8%.
• The picture is broadly stable, fluctuating between 71.4% and 72.8% in the 12 months to Mar-26 : Gradual improvement from 67.0% (April 2024), but with winter seasonal dip in April 2025 to March 2026, recovering to 72.9% (March 2026). Still well below the 85% operational standard.

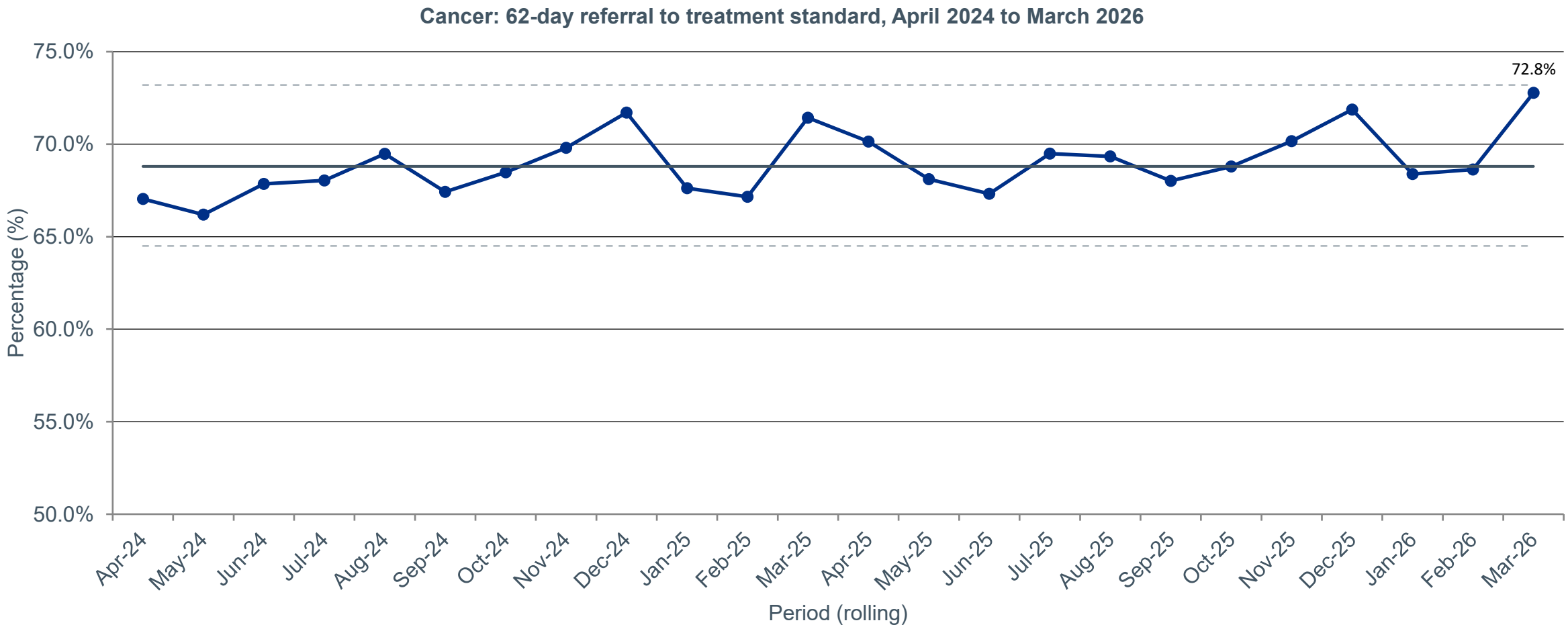
Source: NHS England, Cancer waiting times Mar 2026 (May 2026). cancer waiting times (CWT)-cancer registration system (CRS) National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer: 62-day referral to treatment standard

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of cancer patients who received their first treatment within 62 days of referral, across all cancer types, from the Cancer Waiting Times national time series.

Figure 1.61: Cancer: 62-day referral to treatment standard: England trend



Source: NHS England, Cancer waiting times Mar 2026 (May 2026). CWT-CRS National Time Series + System Level Performance | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cancer outcomes, 30-day mortality post-Systematic Anti-Cancer Therapy

Effectiveness | Tier 2: Driver | ↓ Lower is better

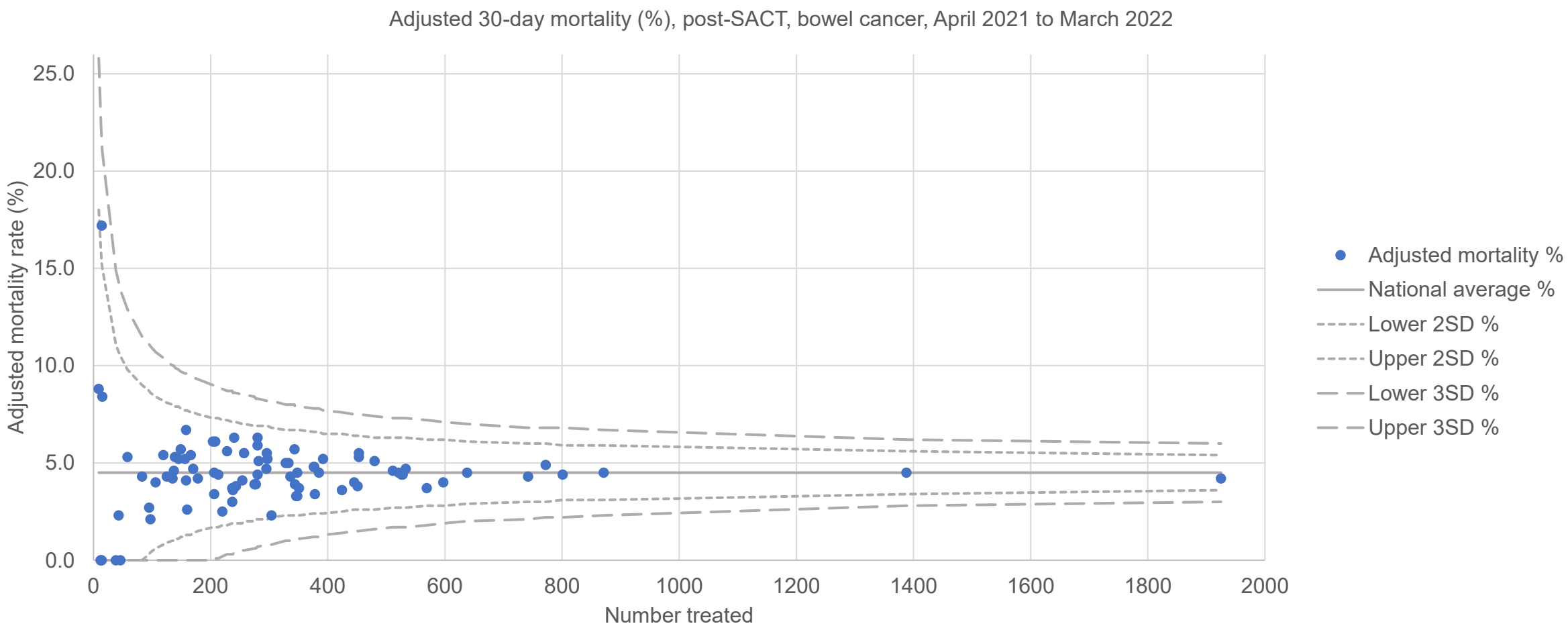
Case mix adjusted 30-day mortality following Systematic Anti-Cancer Therapy for bowel, prostate and breast cancer.

Why it matters for the strategy

• Key outcome measure for cancer treatment. We track 30-day mortality post-systemic anti-cancer therapy because it can provide a sensitive and standardised indicator of treatment-related harm and early outcomes that can improve the effectiveness of cancer care.
• Provider-level variation in adjusted 30-day mortality following Systemic Anti-Cancer Therapy for bowel cancer in 2021-22 shows that most providers are clustering around the national average (4.5%) and within expected control limits. There is only a small number of low-volume providers showing greater variability and a few potential outliers warranting further review.
• Provider-level variation in adjusted 30-day mortality following Systemic Anti-Cancer Therapy for prostate cancer in 2021 shows that many providers are clustering around the national average (4.2%) and within statistical control limits. There is evidence that mortality is generally decreasing and variation narrowing at higher treatment volumes, indicating no widespread outliers but some variability among lower-volume providers.
• Provider-level variation in adjusted 30-day mortality following Systemic Anti-Cancer Therapy for breast cancer in 2021 shows that mortality rates are generally low and that many providers are clustering around the national average (2%) and falling within expected control limits. The plot might suggest tighter clustering at higher treatment volumes and no strong evidence of systematic outliers.

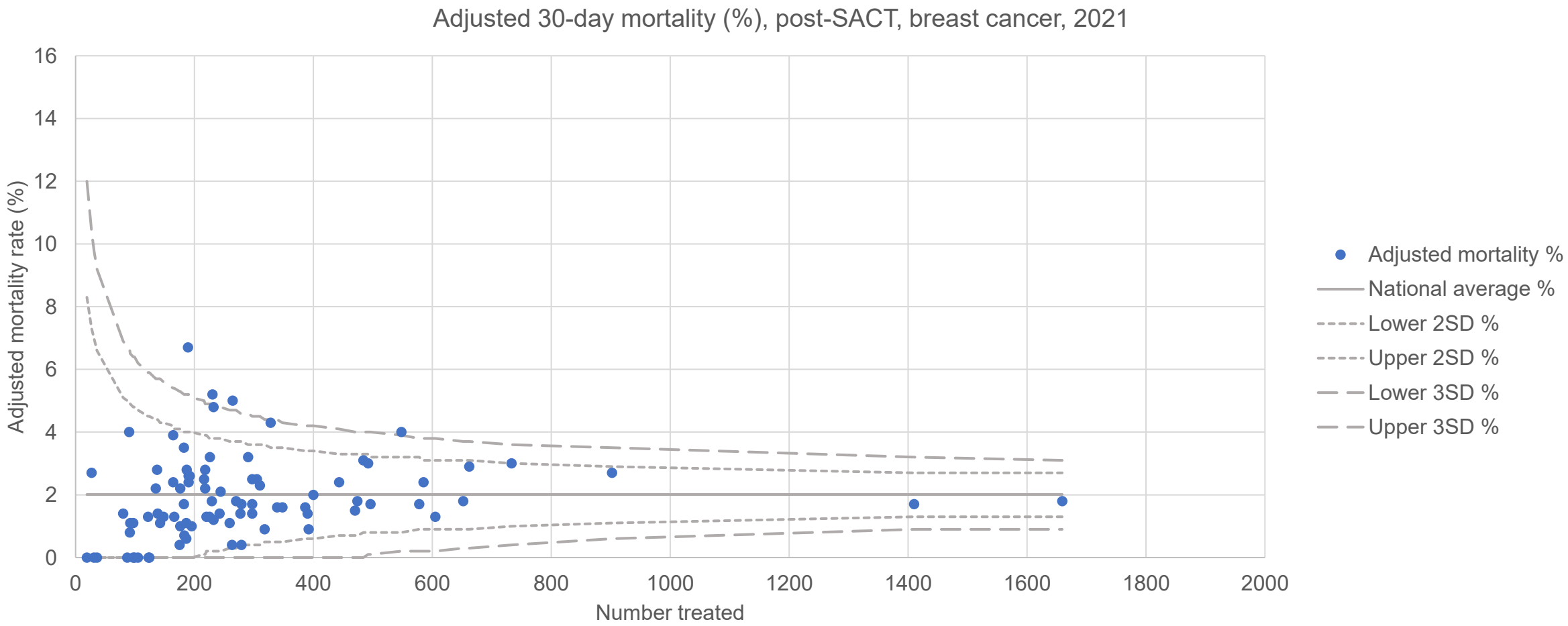
Source: National Disease Registration Service, Systematic Anti-Cancer Therapy

Figure 1.62: Cancer outcomes, 30-day mortality post-Systematic Anti-Cancer Therapy: England trend



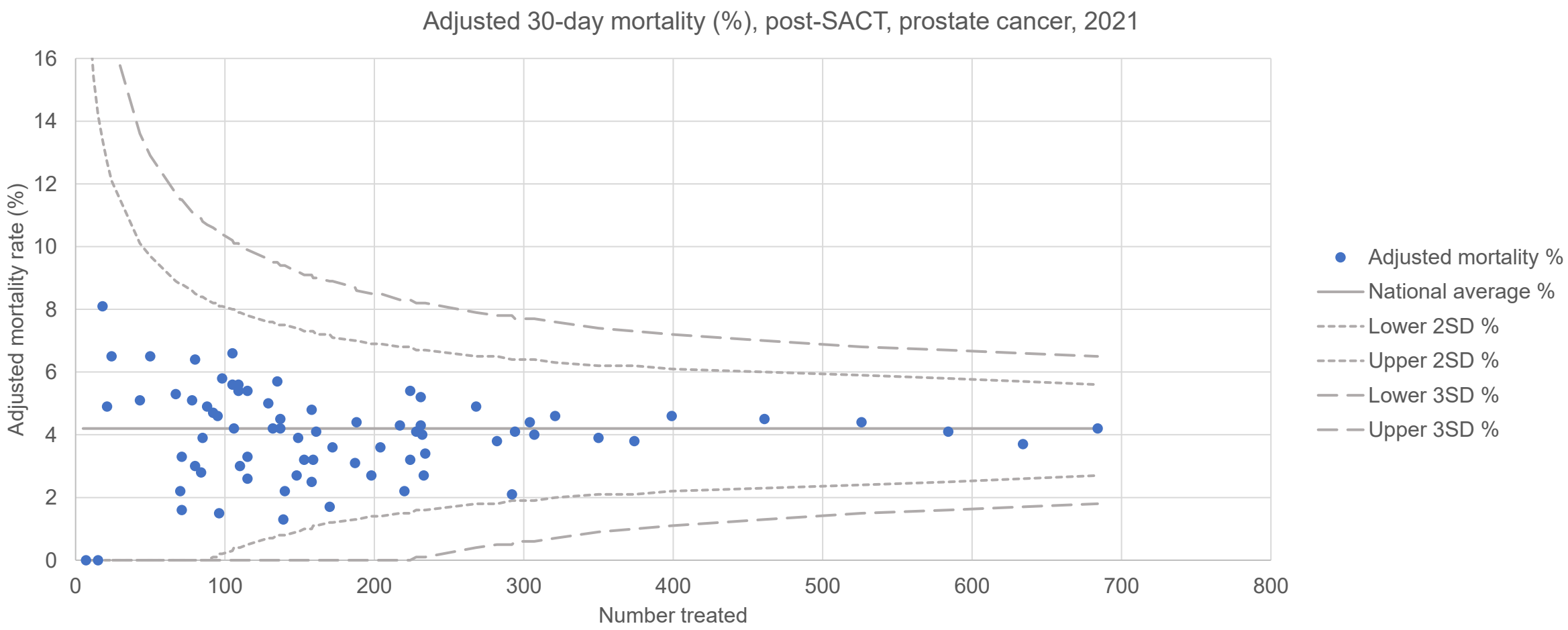
Source: National Disease Registration Service, Systematic Anti-Cancer Therapy

Figure 1.63: Cancer outcomes, 30-day mortality post-Systematic Anti-Cancer Therapy: England trend



Source: National Disease Registration Service, Systematic Anti-Cancer Therapy

Figure 1.64: Cancer outcomes, 30-day mortality post-Systematic Anti-Cancer Therapy: England trend



Source: National Disease Registration Service, Systematic Anti-Cancer Therapy

Cancer screening coverage

Effectiveness | Tier 2: Driver | ↑ Higher is better

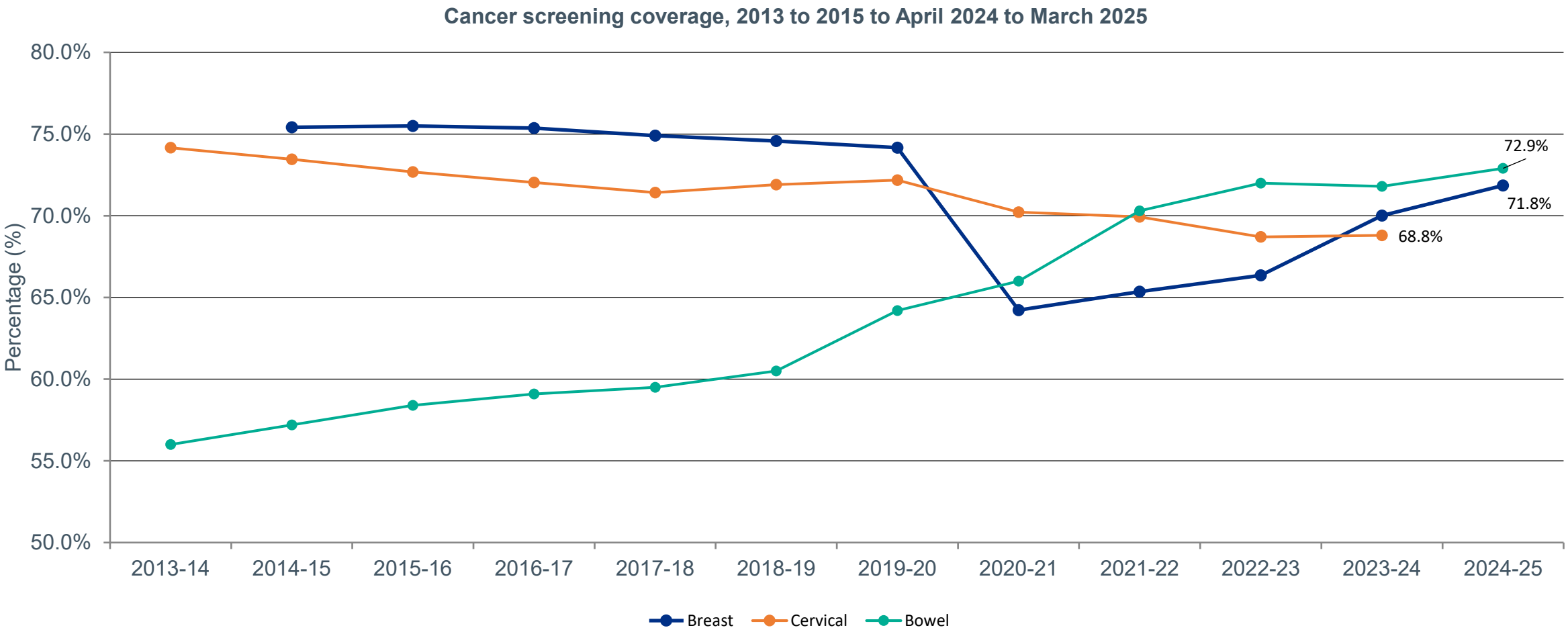
Coverage of the three national cancer screening programmes in England: breast (aged 50 to 70), bowel (aged 60 to 74), and cervical (aged 25 to 64), from Office for Health Improvement and Disparities (OHID) Fingertips screening indicators.

Why it matters for the strategy

• Fully rolled out NHS screening programmes (breast, cervical, bowel) are associated with higher proportions of early cancer diagnosis compared to other routes to cancer diagnosis. Variation in coverage by deprivation is associated with variation in early cancer diagnosis rates.
• The latest figure for England (April 2024 to March 2025) is 71.8% for breast (April 2024 to March 2025), 72.9% for Bowel (April 2024 to March 2025) and 68.8% for Cervical (April 2023 to March 2024).
• This is getting better for Breast up 7.6% from April 2020 to March 2021 (64.2%), and for bowel up 16.9% from April 2013 to March 2014 (56.0%) but getting worse for Cervical, down 5.4% from April 2013 to March 2014 (74.2%).
• Cancer screening coverage (bowel/breast/cervical) is below World Health Organization (WHO) and NHS targets for all three programmes, with bowel screening the greatest gap (around 70% vs 80% target).
• The 2026 National Cancer Plan commits to expanded screening, including the lung cancer screening programme rollout, as a key near-term lever on early diagnosis.

Source: National Cancer Screening Programmes

Figure 1.65: Cancer screening coverage: England trend



Source: National Cancer Screening Programmes

Diagnostic test waits >6 weeks

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Patients waiting 6+ weeks for a diagnostic test.

Why it matters for the strategy

- Diagnostics are a key rate-limiting step for both cancer (Faster Diagnosis Standard and 62d standard) and non-cancer diagnosis pathways
- The latest figure for England is 21.2% (Mar-26)
- Trend: This is broadly stable, unchanged between Mar-25 and Mar-26
- At regional level, the proportion waiting over 6 weeks ranges from the highest in East of England (29.8%) to the lowest in North West (12.7%) a gap of 17.1%
- Tier 3 signal - fast-moving operational indicator

.

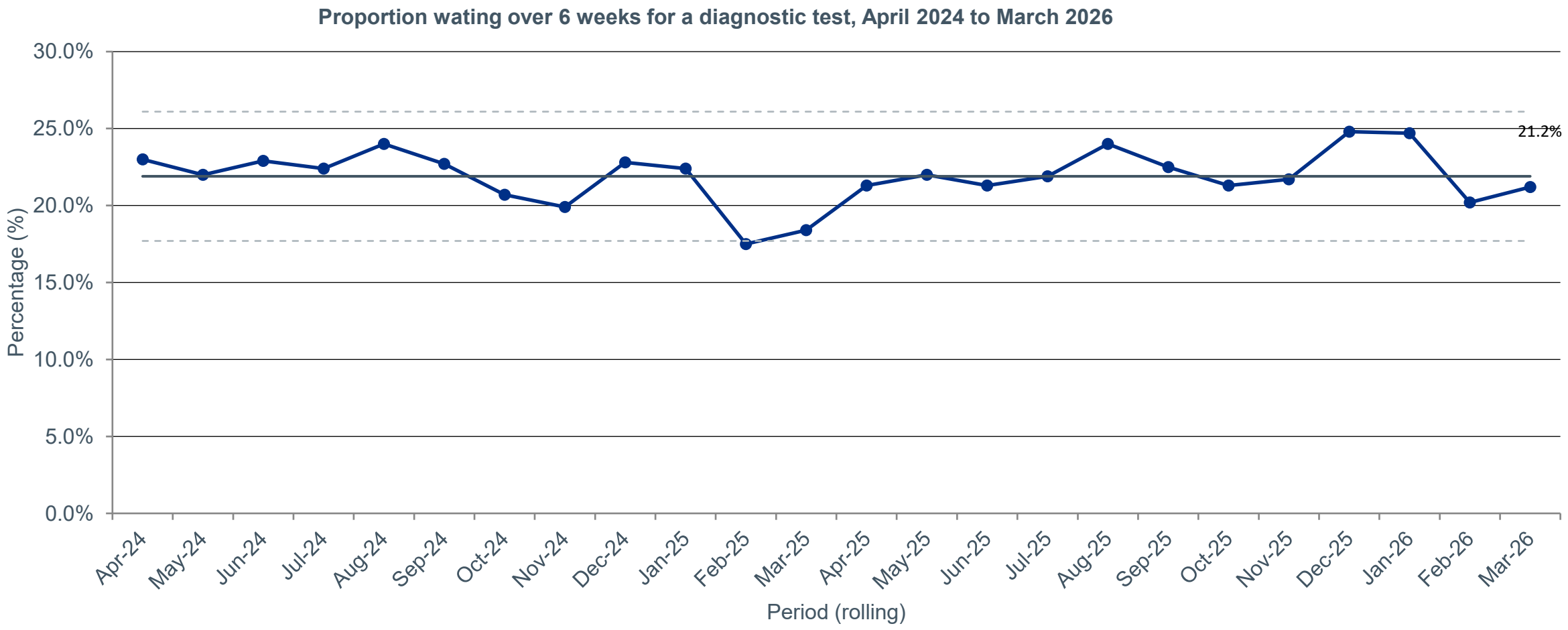
Source: NHS England, Diagnostic waiting times | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Diagnostic test waits >6 weeks

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Patients waiting 6+ weeks for a diagnostic test.

Figure 1.66: Diagnostic test waits >6 weeks: England trend



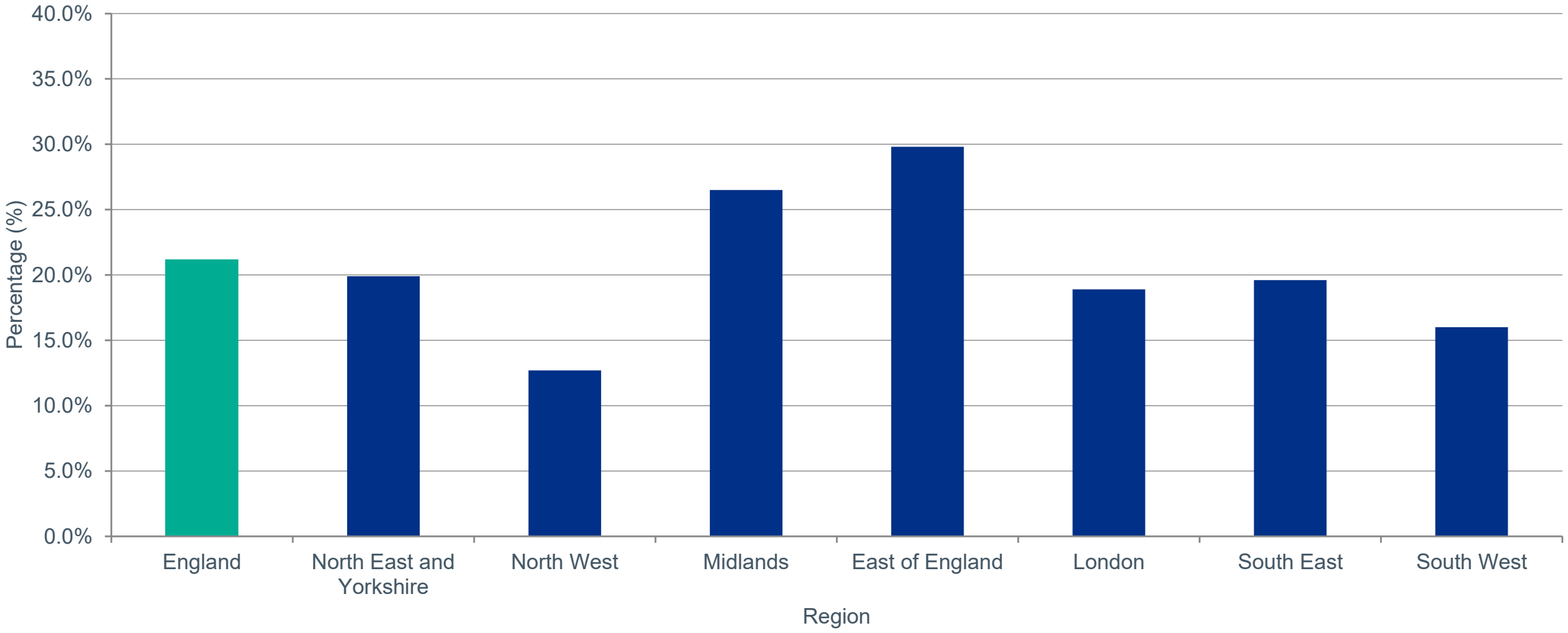
Source: NHS England, Diagnostic waiting times | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Diagnostic test waits >6 weeks

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Patients waiting 6+ weeks for a diagnostic test.

Figure 1.67: Proportion waiting over 6 weeks for a diagnostic test, NHS Region, March 2026



Source: NHS England, Diagnostic waiting times | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Under-75 respiratory disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from respiratory disease in people aged under 75 in England, from Office for National Statistics (ONS) death registrations via Office for Health Improvement and Disparities (OHID) Fingertips indicator 40701.

Why it matters for the strategy

- This is a key measure of premature mortality and contributor to life expectancy
- The latest figure for England (2025) is 31.5 per 100,000.
- This has remained broadly stable comparted to pre-pandemic 33.4 in 2019, compared to 31.5 in 2025
- Performance varies across NHS Regions (2024 data): the best-performing area (London) had a rate of 25.4 per 100,000, while the worst (North West) had 45.1 per 100,000.
- People in the most deprived areas have a rate of 54.8 per 100,000, compared with 21.1 in the least deprived - a gap of 33.7 per 100,000.
- Under-75 respiratory disease mortality has plateaued well above the 2019 best, driven by chronic obstructive pulmonary disease (COPD) and chronic respiratory disease in the most deprived communities.
- Respiratory is the third leading cause of premature death - concentrated by deprivation, smoking history, air quality and damp housing.
- Variation by integrated care board (ICB) is steep: emergency COPD admissions show a 2.9-fold deprivation gradient (most vs least deprived), tracking through to mortality.
- strategy lever: the long-term-conditions chapter and prevention enabler, with pulmonary rehabilitation referral and completion as the named clinical lever.

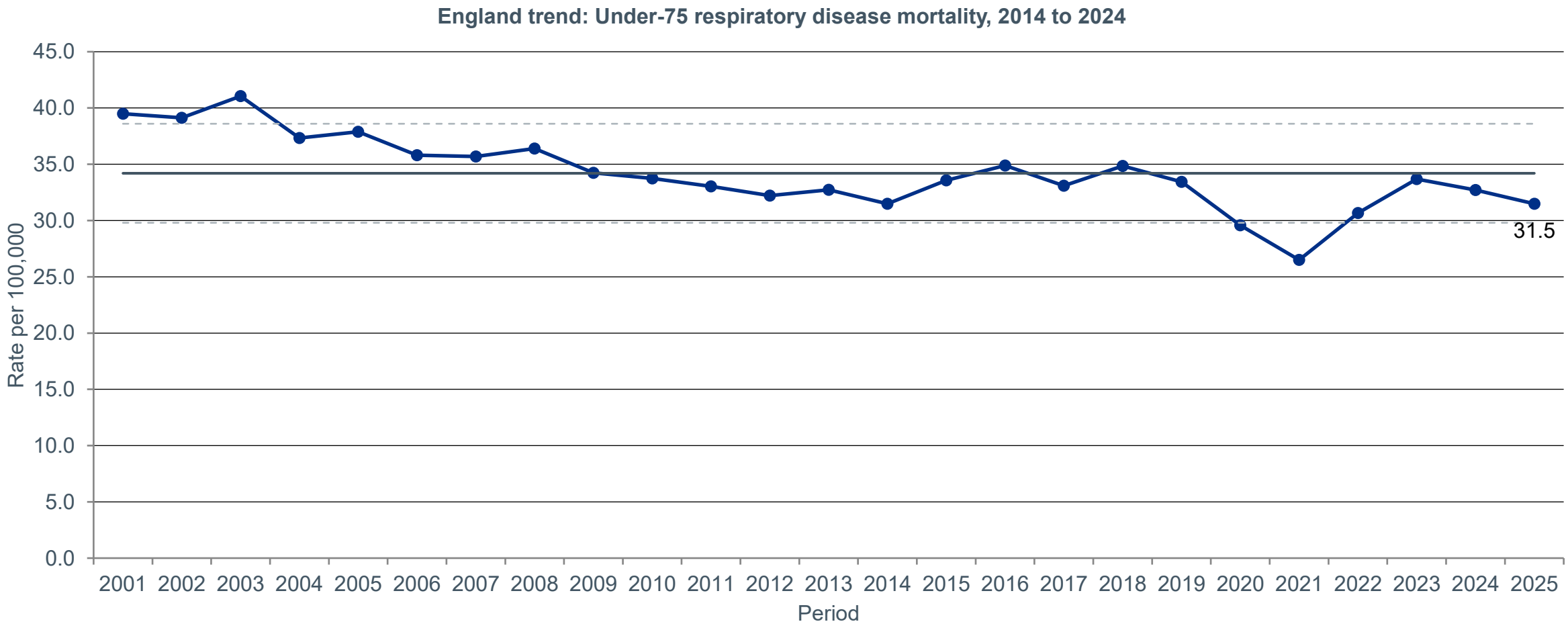
Source: ONS mortality data, OHID Fingertips [40701]

Under-75 respiratory disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from respiratory disease in people aged under 75 in England, from ONS death registrations via OHID Fingertips indicator 40701.

Figure 1.68: Under-75 respiratory disease mortality: England trend



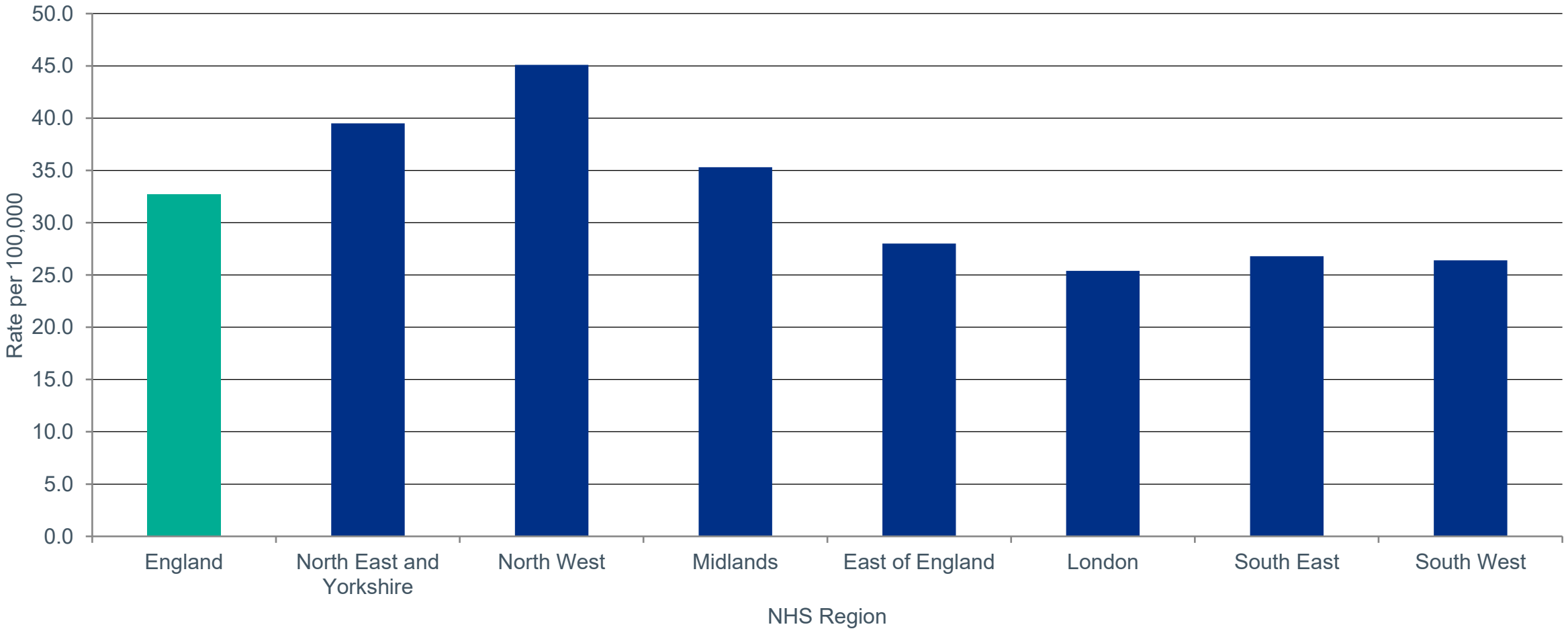
Source: ONS mortality data, OHID Fingertips [40701]

Under-75 respiratory disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from respiratory disease in people aged under 75 in England, from ONS death registrations via OHID Fingertips indicator 40701.

Figure 1.69: Under-75 respiratory disease mortality by NHS Region, 2024 (latest)



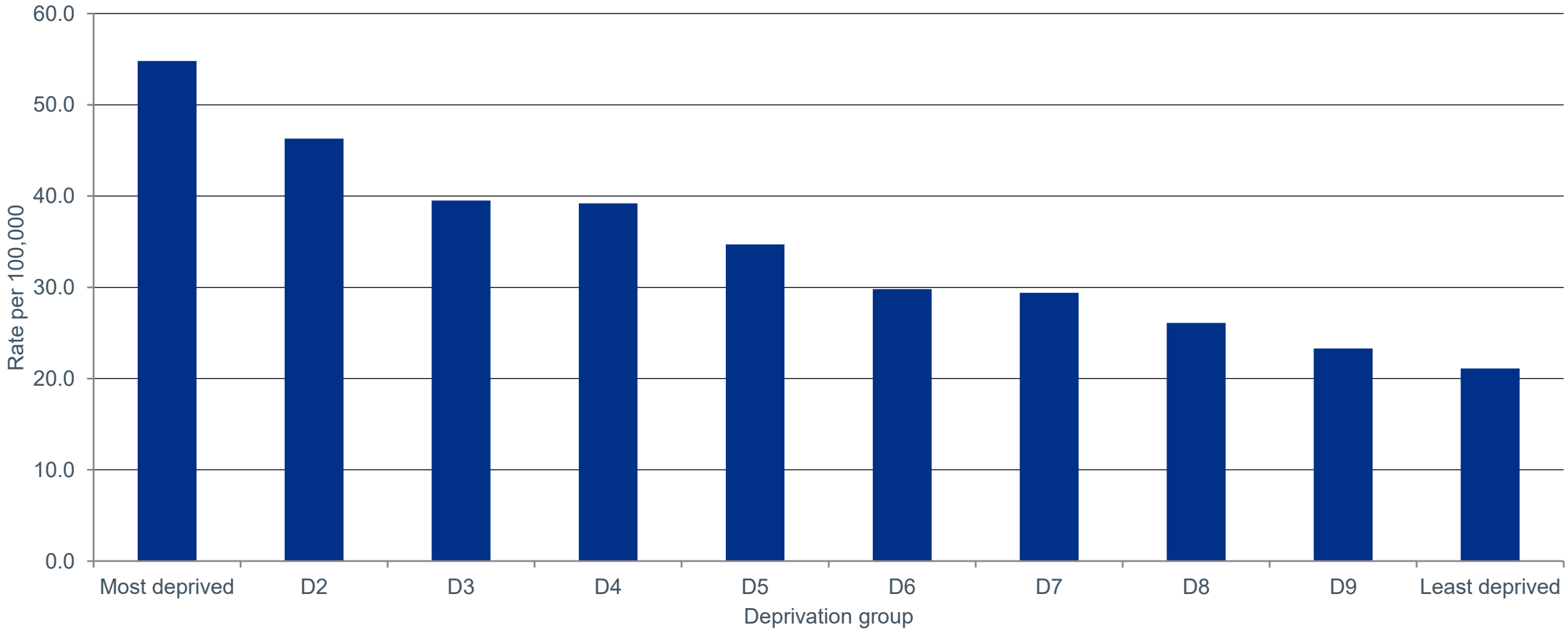
Source: ONS mortality data, OHID Fingertips [40701]

Under-75 respiratory disease mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Age-standardised mortality rate from respiratory disease in people aged under 75 in England, from ONS death registrations via OHID Fingertips indicator 40701.

Figure 1.70: Under-75 respiratory disease mortality by deprivation group (Index of Multiple Deprivation (IMD) decile), 2024 (latest)



Source: ONS mortality data, OHID Fingertips [40701]

Chronic obstructive pulmonary disease (COPD) emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for COPD in adults aged 35 and over in England, expressed per 100,000 population (Office for Health Improvement and Disparities (OHID) Fingertips indicator 92302).

Why it matters for the strategy

• A key metric relating to upstream management (smoking cessation, medication adherence, pulmonary rehabilitation) and are a major driver of premature respiratory mortality.
• The latest figure for England (2023-24) is 357 per 100,000.
• This picture is mixed: Reduced from ~418 to ~228 per 100,000 during pandemic but increasing since to 357 in April 2023 to March 2024.
• Performance varies across NHS Regions: the best-performing area (South East) had a rate of 229.3 per 100,000, while the worst (North East and Yorkshire) had 400.2 per 100,000.
• People in the most deprived areas have a rate of 632.5 per 100,000, compared with 218.7 in the least deprived - a gap of 413.8 per 100,000.

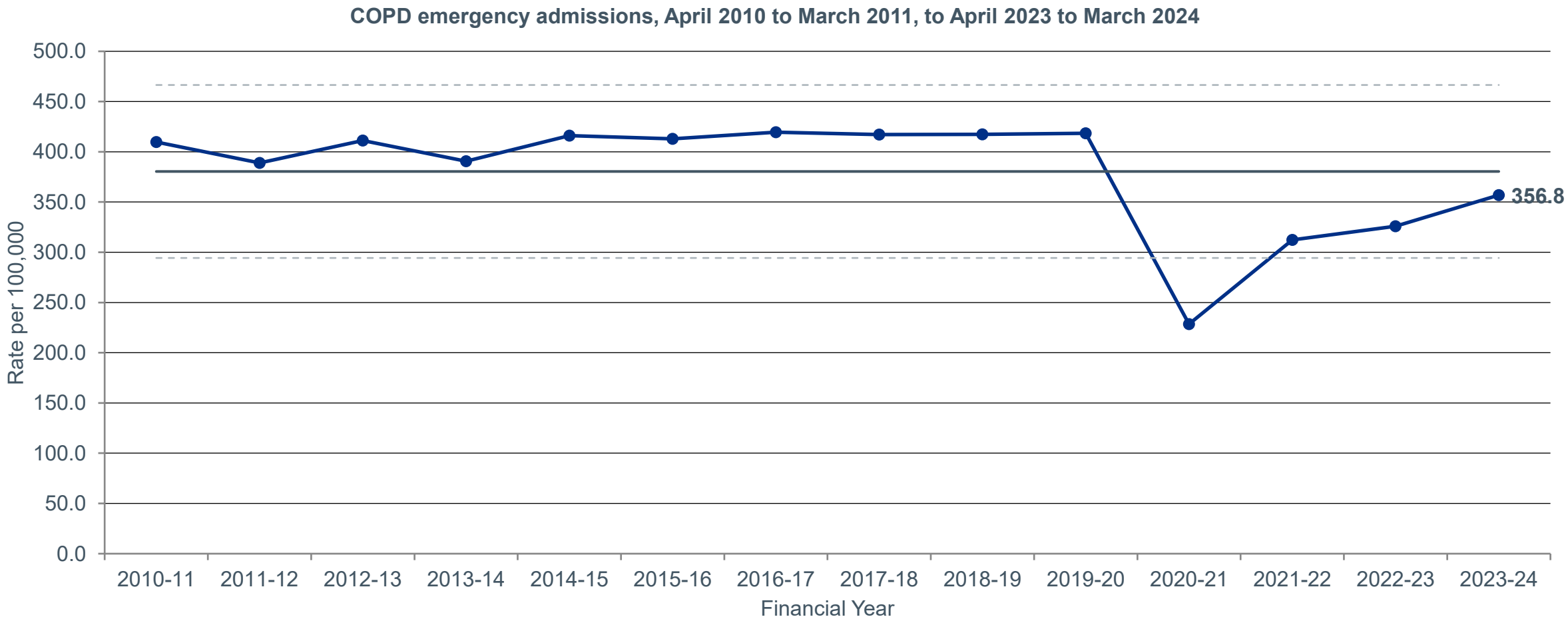
Source: NHS England Hospital Episode Statistics, Office for National Statistics (ONS) population data OHID Fingertips indicator 92302, COPD emergency admissions aged 35+

COPD emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for COPD in adults aged 35 and over in England, expressed per 100,000 population (OHID Fingertips indicator 92302).

Figure 1.71: COPD emergency admissions: England trend



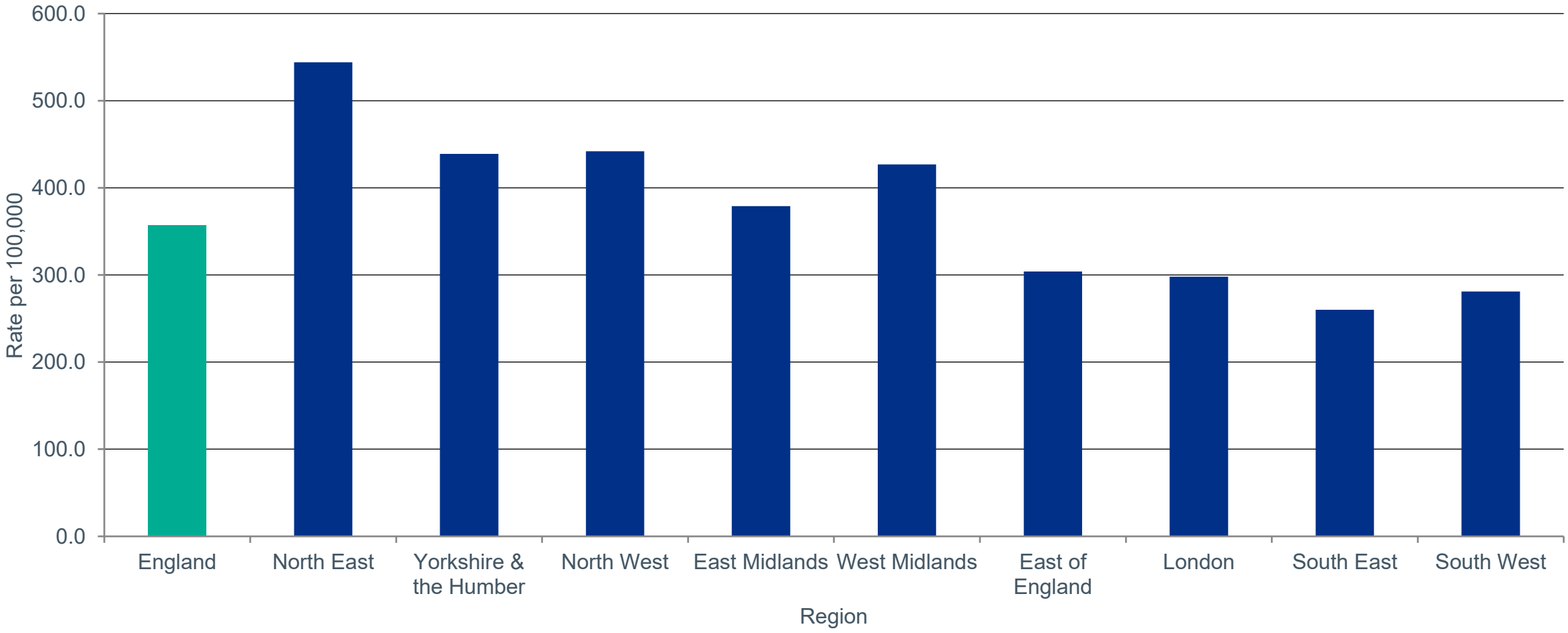
Source: NHS England Hospital Episode Statistics, ONS population data OHID Fingertips indicator 92302, COPD emergency admissions aged 35+

COPD emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for COPD in adults aged 35 and over in England, expressed per 100,000 population (OHID Fingertips indicator 92302).

Figure 1.72: COPD emergency admissions by Region, April 2023 to March 2024



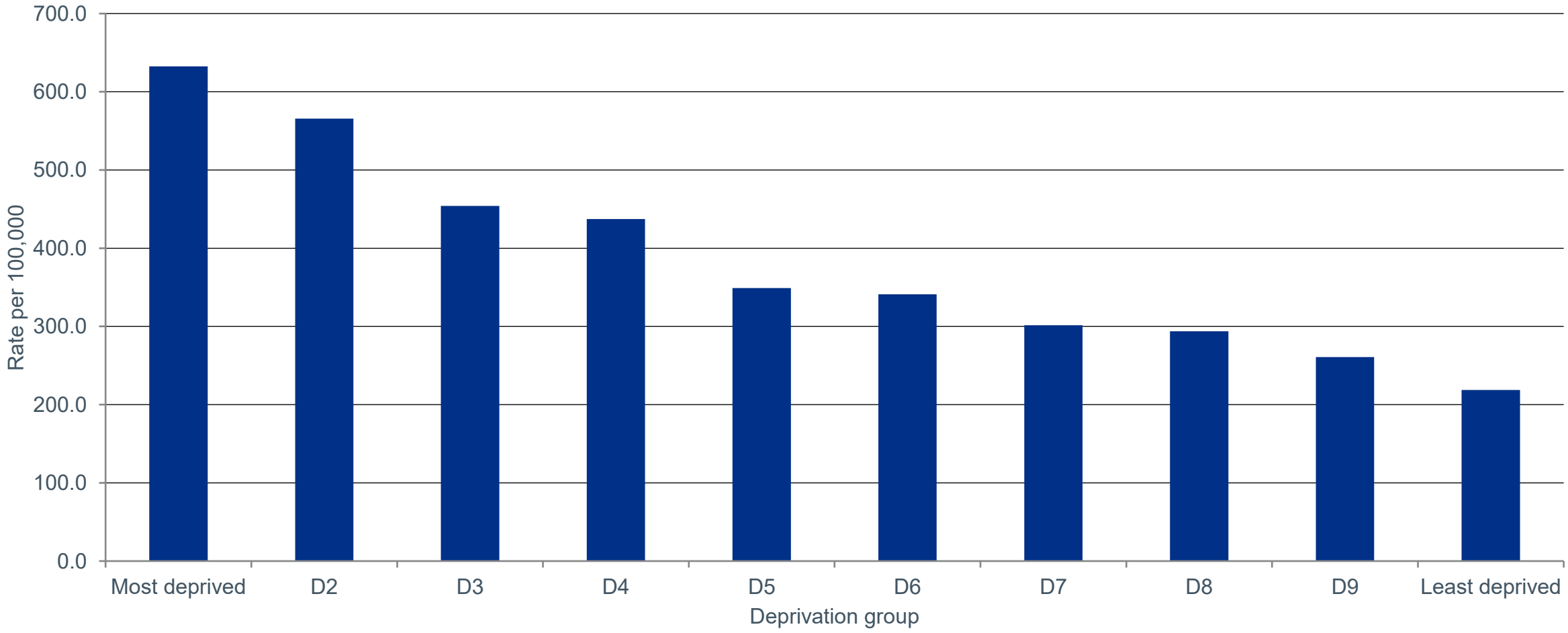
Source: NHS England Hospital Episode Statistics, ONS population data OHID Fingertips indicator 92302, COPD emergency admissions aged 35+

COPD emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for COPD in adults aged 35 and over in England, expressed per 100,000 population (OHID Fingertips indicator 92302).

Figure 1.73: COPD emergency admissions by deprivation group (Index of Multiple Deprivation (IMD) decile) – April 2023 to March 2024



Source: NHS England Hospital Episode Statistics, ONS population data OHID Fingertips indicator 92302, COPD emergency admissions aged 35+

Flu vaccination uptake (65+)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of adults aged 65 and over in England who received a seasonal influenza vaccination, from Office for Health Improvement and Disparities (OHID) Fingertips indicator 30314.

Why it matters for the strategy

• We track flu vaccination uptake in over-65s because it is a key measure of preventive care delivery in primary care, and sustained high uptake prevents thousands of hospital admissions and deaths each winter.
• The latest figure for England (2024-25) is 74.9%.
• The picture is mixed: 74.9% flu vaccination uptake in 65+ (2024-25, flu only). Down from 82.4% pandemic peak (2021-22) but up from 72.4% pre-pandemic (2019-20). Below 75% World Health Organization (WHO) target.
• Performance varies across NHS Regions: the best-performing area (South West) achieved 79.4%, while the lowest (London) achieved 62.1%.
• People in the least deprived areas achieve 78.3%, compared with 68.0 in the most deprived - a gap of 10.3%.

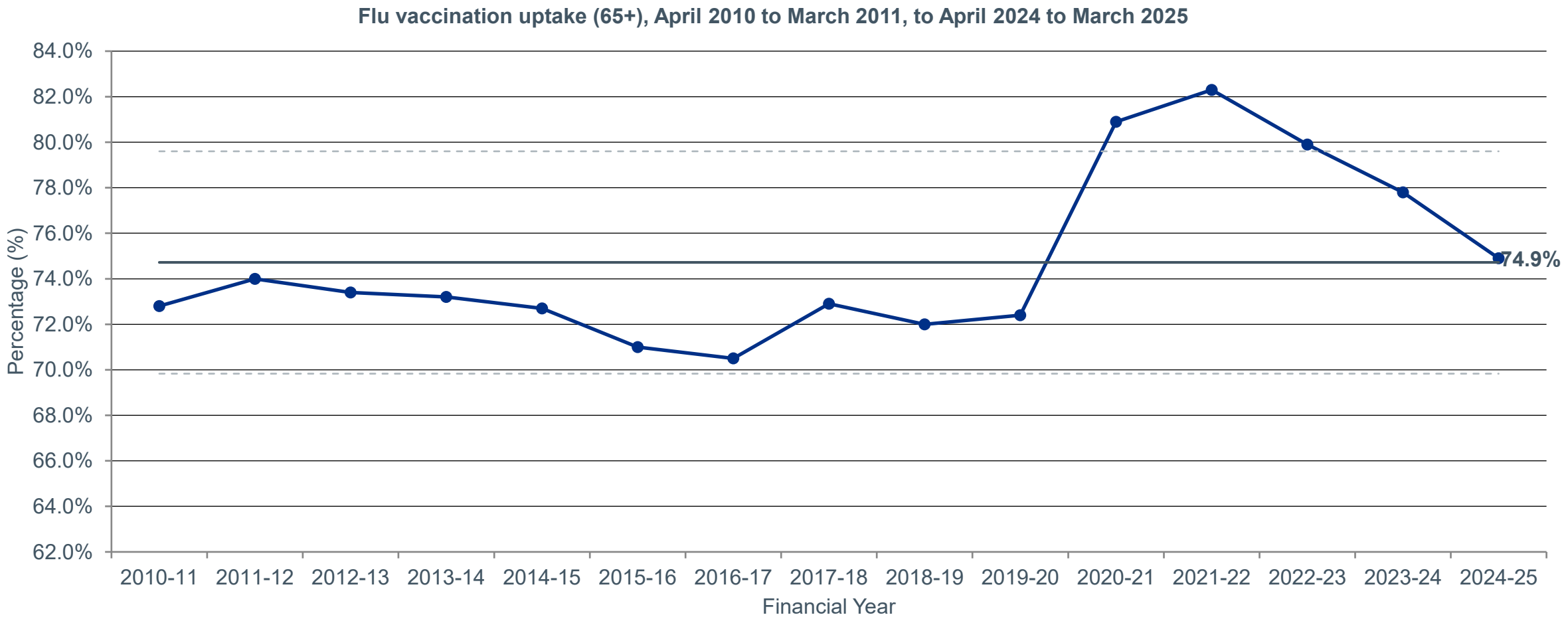
Source: NHS England, OHID Fingertips indicator 30314, Flu vaccination coverage aged 65+

Flu vaccination uptake (65+)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of adults aged 65 and over in England who received a seasonal influenza vaccination, from OHID Fingertips indicator 30314.

Figure 1.74: Flu vaccination uptake (65+): England trend



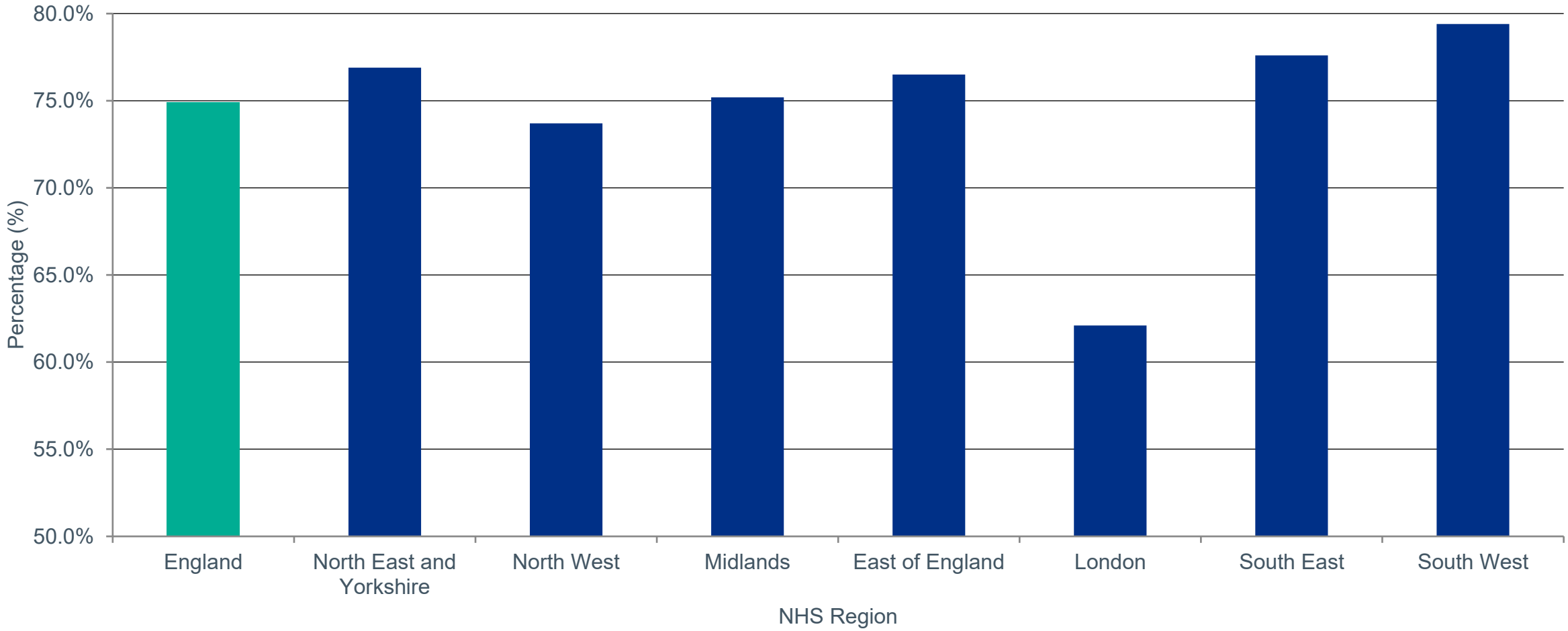
Source: NHS England, OHID Fingertips indicator 30314, Flu vaccination coverage aged 65+

Flu vaccination uptake (65+)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of adults aged 65 and over in England who received a seasonal influenza vaccination, from OHID Fingertips indicator 30314.

Figure 1.75: Flu vaccination uptake (65+) by NHS Region, April 2024 to March 2025



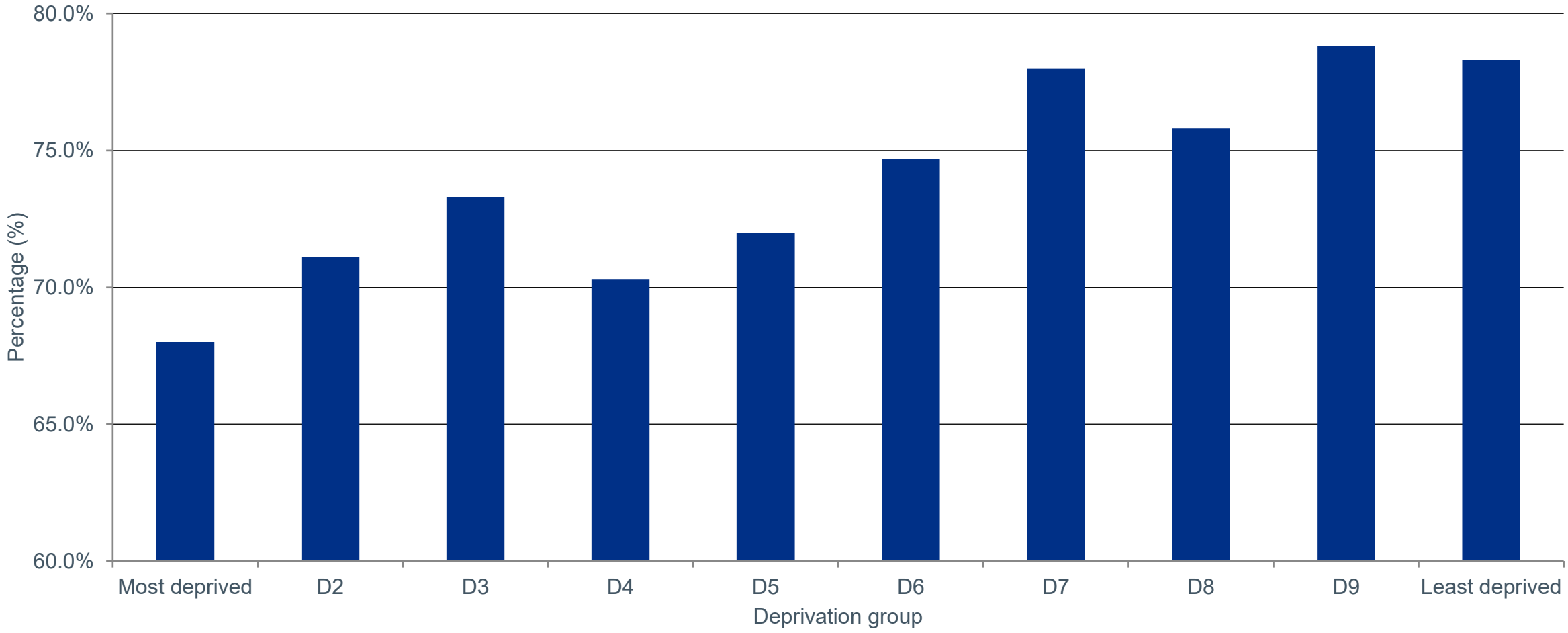
Source: NHS England, OHID Fingertips indicator 30314, Flu vaccination coverage aged 65+

Flu vaccination uptake (65+)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of adults aged 65 and over in England who received a seasonal influenza vaccination, from OHID Fingertips indicator 30314.

Figure 1.76: Flu vaccination uptake (65+) by deprivation group (Index of Multiple Deprivation (IMD) decile) – April 2024 to March 2025



Source: NHS England, OHID Fingertips indicator 30314, Flu vaccination coverage aged 65+

Pulmonary rehabilitation

Effectiveness | Tier 2: Driver | ↑ Higher is better

Referral rate of eligible chronic obstructive pulmonary disease (COPD) patients to pulmonary rehabilitation (Quality and Outcomes Framework (QOF) COPD014) and completion rate among enrolled patients (National Respiratory Audit Programme).

Why it matters for the strategy

• It is the most cost-effective intervention for COPD (National Institute for Health and Care Excellence (NICE) NG115), reducing emergency admissions by 25-40%, yet only 22.5% of eligible patients are actually referred (QOF 2024-25), and only 40% of those referred start within 90 days (NRAP target: 70%). The current trend is deteriorating, with completion and referral rates falling.
• The latest figure for England (2024-25) is 22.5%
• This is getting worse decreasing by 5.7% from April 2023 to March 2024 (28.2%) to April 2024 to March 2025 (22.5%)
• Performance varies across NHS Regions: the best-performing area (London) achieved 34.0%, while the lowest (North East and Yorkshire) achieved 18.1%.
• Referral and completion rates remain low against audit benchmarks (NRAP).
• Cost-effective COPD intervention signal. strategy effectiveness pathway.
• Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

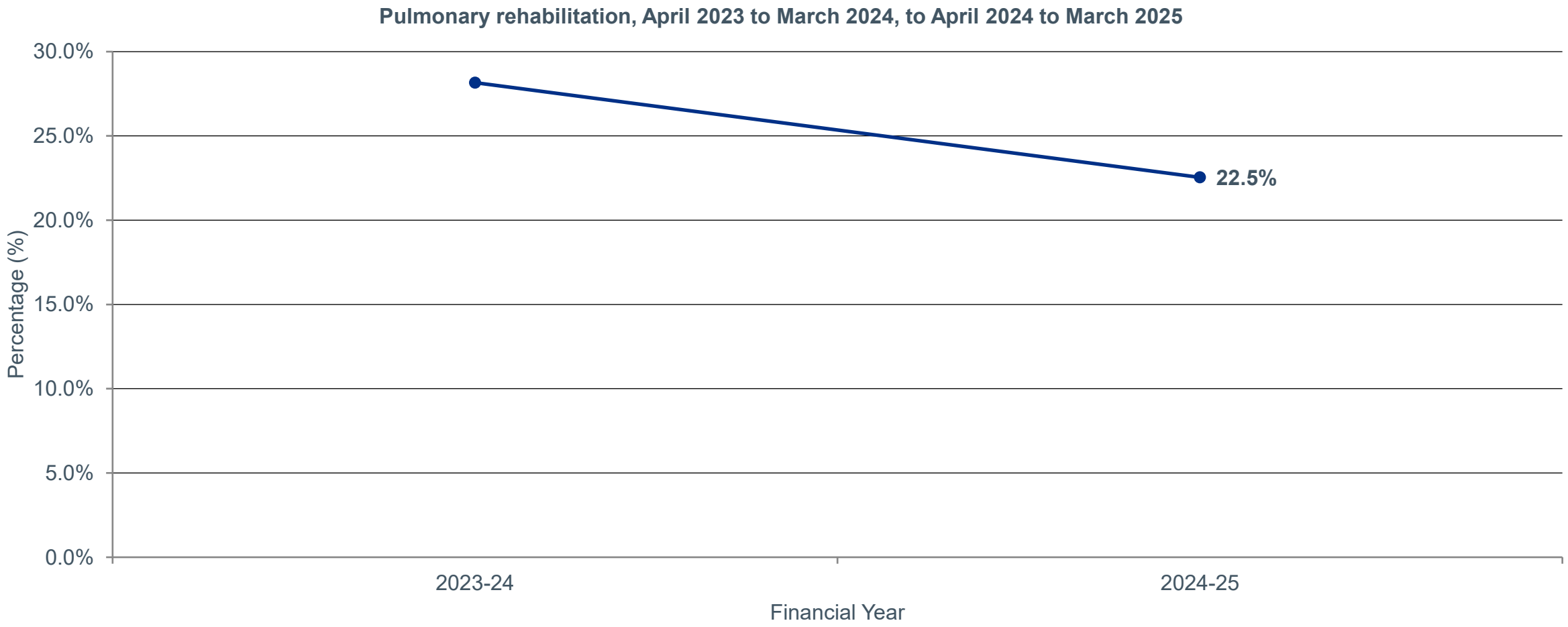
Source: Referral: NHS Digital, QOF April 2024 to March 2025, COPD014 indicator (published 28 Aug 2025). Completion/timeliness: National Respiratory Audit Programme (NRAP) 'Catching our breath' April 2023 to March 2024 (Royal College of Physicians (RCP), Jun 2025)

Pulmonary rehabilitation

Effectiveness | Tier 2: Driver | ↑ Higher is better

Referral rate of eligible COPD patients to pulmonary rehabilitation (QOF COPD014) and completion rate among enrolled patients (National Respiratory Audit Programme).

Figure 1.77: Pulmonary rehabilitation: England trend



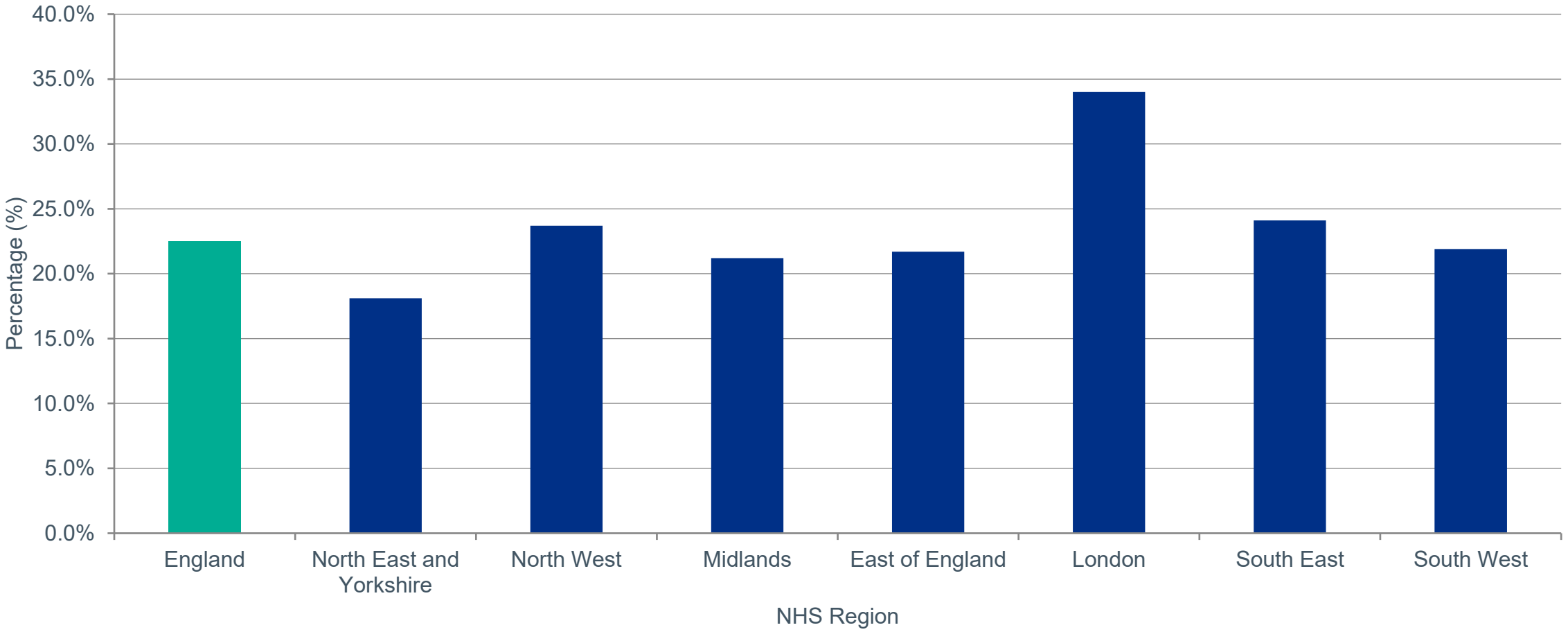
Source: Referral: NHS Digital, QOF April 2024 to March 2025, COPD014 indicator (published 28 Aug 2025). Completion/timeliness: NRAP 'Catching our breath' April 2023 to March 2024 (RCP, Jun 2025)

Pulmonary rehabilitation

Effectiveness | Tier 2: Driver | ↑ Higher is better

Referral rate of eligible COPD patients to pulmonary rehabilitation (QOF COPD014) and completion rate among enrolled patients (National Respiratory Audit Programme).

Figure 1.78: Pulmonary rehabilitation by NHS Region, April 2024 to March 2025



Source: Referral: NHS Digital, QOF April 2024 to March 2025, COPD014 indicator (published 28 Aug 2025). Completion/timeliness: NRAP 'Catching our breath' April 2023 to March 2024 (RCP, Jun 2025)

Asthma emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for asthma in adults aged 19 and over in England, expressed per 100,000 population (Office for Health Improvement and Disparities (OHID) Fingertips indicator 93573).

Why it matters for the strategy

• They complement chronic obstructive pulmonary disease (COPD) data to give a full picture of chronic respiratory disease burden, and well-managed asthma should not require emergency hospital attendance.
• The latest figure for England (2024-25) is 79.5 per 100,000.
• The picture is mixed: down 16.4 per 100,000 on April 2019 to March 2020 peak (95.9) but 35.5 per 100,000 higher than in April 2020 to March 2021(44.4). Complements COPD_EMERG_ADM (357 per 100,000, 35+) to give full picture of chronic respiratory disease burden.
• Performance varies across NHS Regions: the best-performing area (East of England) had a rate of 64.9 per 100,000, while the worst (Midlands) had 107.9 per 100,000.
• This is getting worse - having decreased at the start of the pandemic in April 2020 to March 2021, asthma emergency admissions in adults 19+ rose by 40 per 100,000 from 2020-21 (44.4) to April 2023 to March 2024 (84.5).
• Chronic respiratory burden signal. Sub-indicator of under-75 respiratory mortality in Core.
• Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

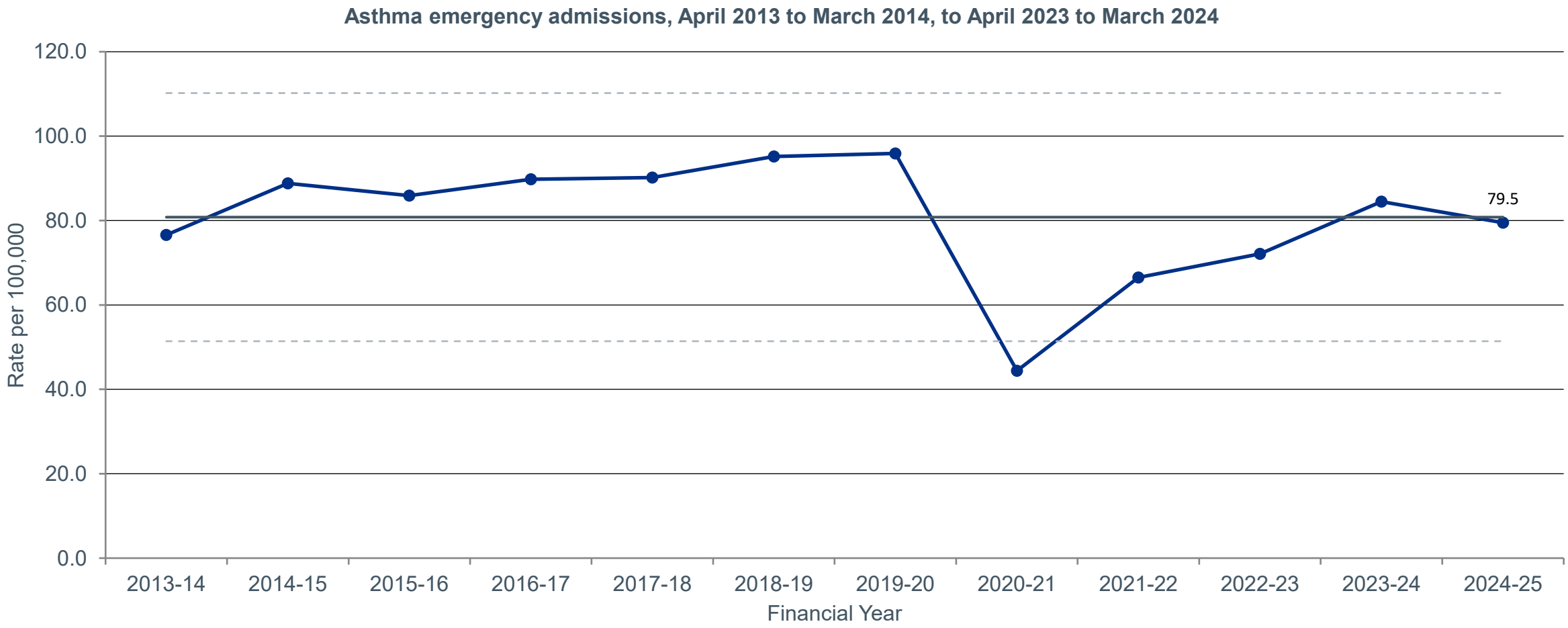
Source: OHID Fingertips indicator 93573, Emergency hospital admissions for asthma, adults aged 19+

Asthma emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for asthma in adults aged 19 and over in England, expressed per 100,000 population (OHID Fingertips indicator 93573).

Figure 1.79: Asthma emergency admissions: England trend



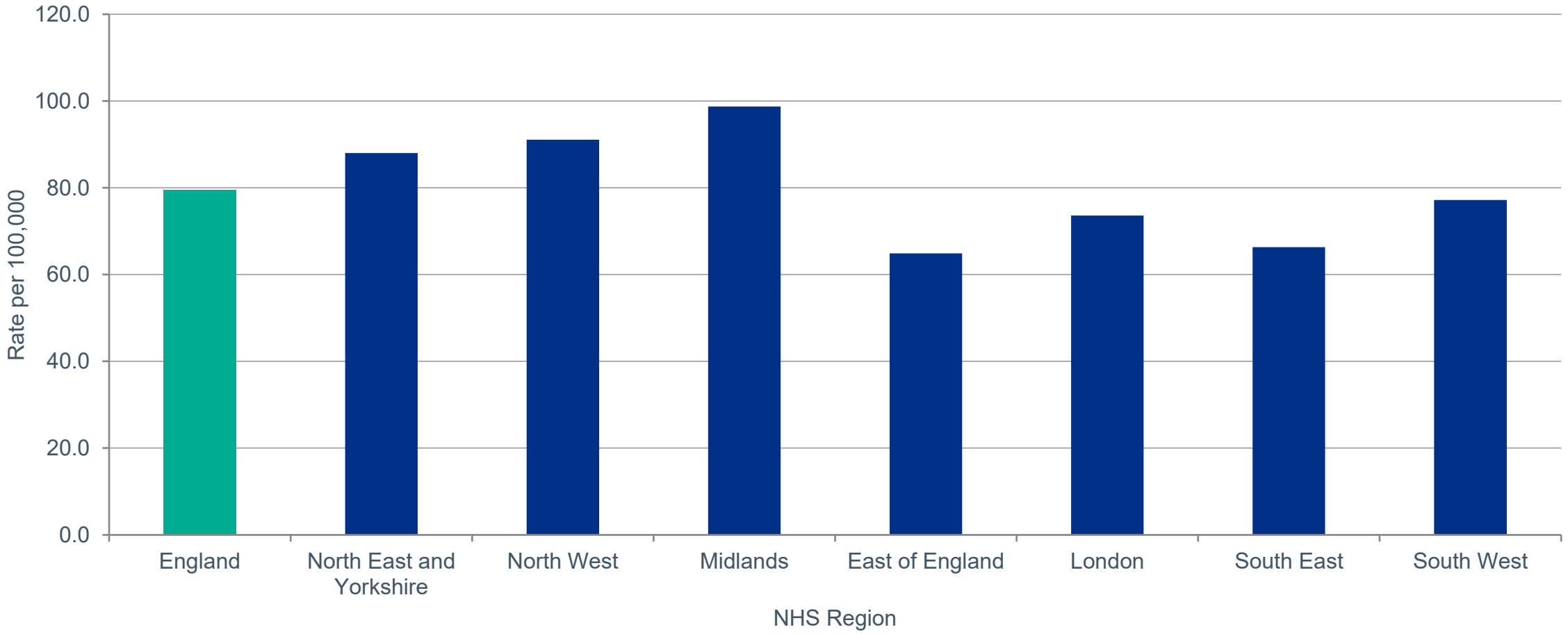
Source: OHID Fingertips indicator 93573, Emergency hospital admissions for asthma, adults aged 19+

Asthma emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for asthma in adults aged 19 and over in England, expressed per 100,000 population (OHID Fingertips indicator 93573).

Figure 1.80: Asthma emergency admissions by NHS Region, April 2024 to March 2025



Source: OHID Fingertips indicator 93573, Emergency hospital admissions for asthma, adults aged 19+

Pneumococcal vaccination (65+)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults aged 65 and over in England who received the pneumococcal polysaccharide vaccine, from the UK Health Security Agency (UKHSA) annual coverage report.

Why it matters for the strategy

• We track pneumococcal vaccination because pneumococcal disease is a significant and preventable cause of respiratory infection in older adults, and vaccine uptake is a marker of the effectiveness of preventive care delivery in primary care.
• The latest figure for England (April 2024 to March 2025) is 73.6%.
• This is getting better: 73.6% pneumococcal (PPV23) vaccine uptake in adults aged 65+ in April 2024 to March 2025 (UKHSA). Below 75% World Health Organization (WHO) target. Below flu vaccine uptake (74.9%). PCV20 replacing PPV23 from April 2025 to March 2026.
• Performance varies across NHS Regions: the best-performing area (North East and Yorkshire) achieved 75.0%, while the lowest (London) achieved 67.7%.- a gap of 7.3%
• People in the least deprived areas achieve 75.2%, compared with 70.4 in the most deprived - a gap of 4.8%.

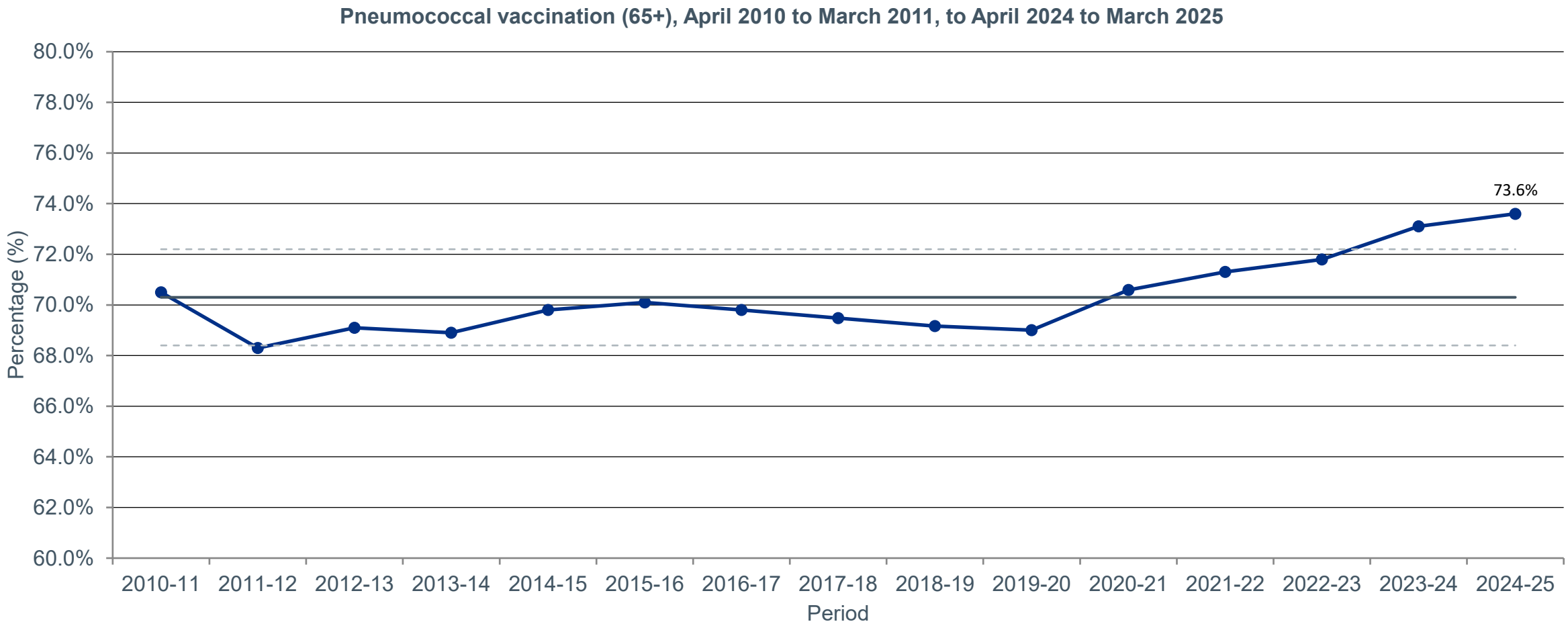
Source: UKHSA, Pneumococcal Polysaccharide Vaccine (PPV) Coverage Report, England

Pneumococcal vaccination (65+)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults aged 65 and over in England who received the pneumococcal polysaccharide vaccine, from the UKHSA annual coverage report.

Figure 1.81: Pneumococcal vaccination (65+): England trend



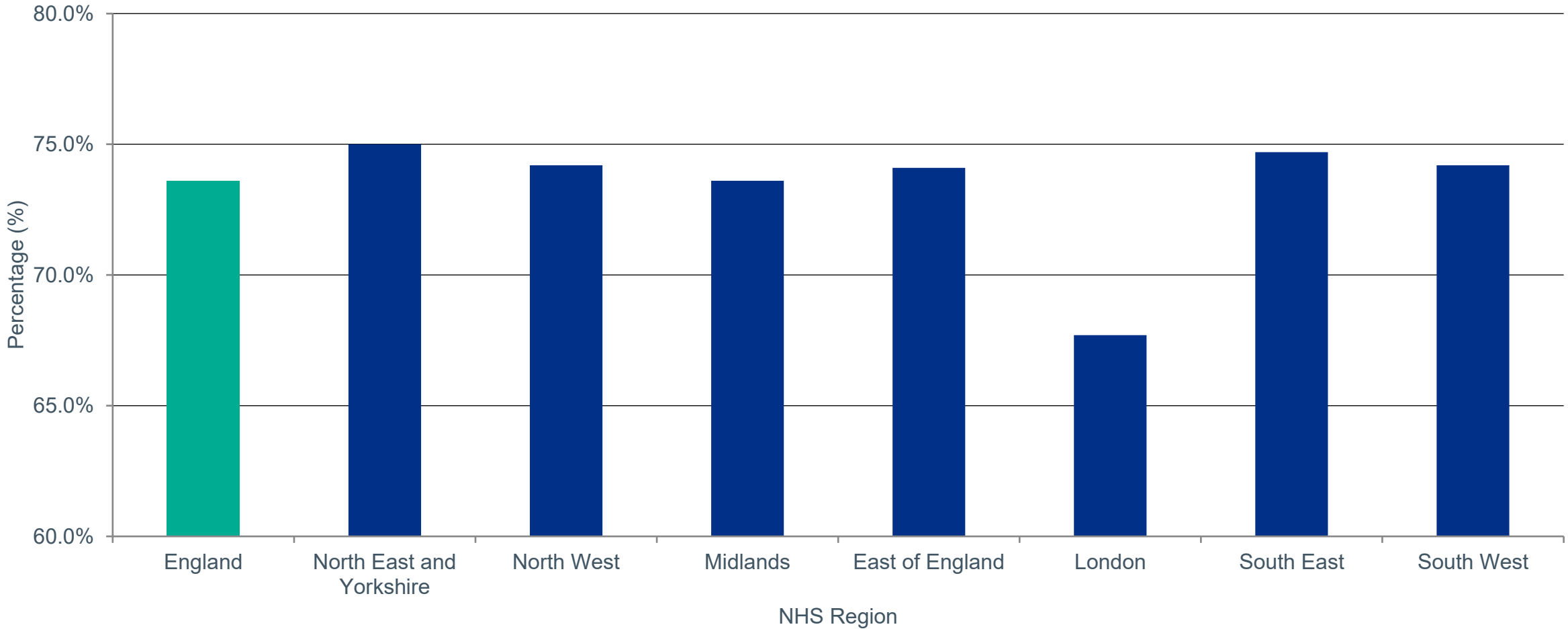
Source: UKHSA, Pneumococcal Polysaccharide Vaccine (PPV) Coverage Report, England

Pneumococcal vaccination (65+)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults aged 65 and over in England who received the pneumococcal polysaccharide vaccine, from the UKHSA annual coverage report.

Figure 1.82: Pneumococcal vaccination (65+) by NHS Region, April 2024 to March 2025



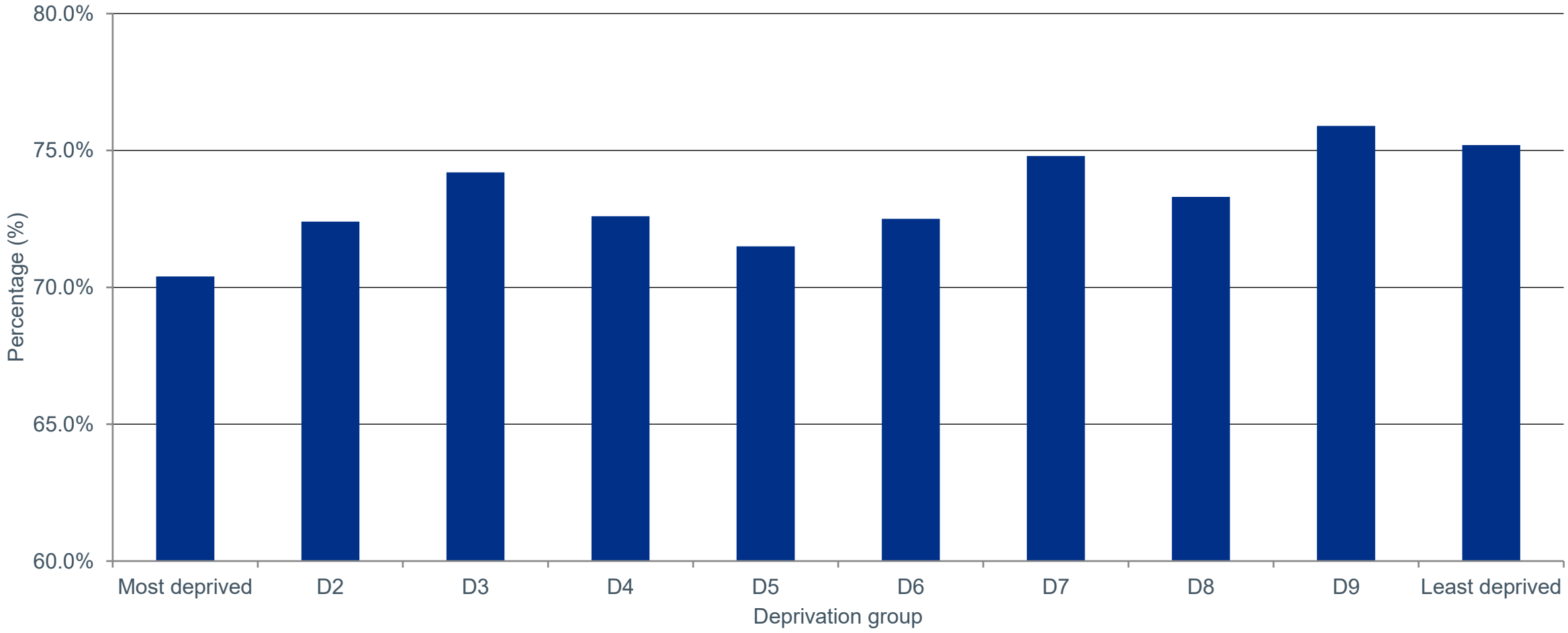
Source: UKHSA, Pneumococcal Polysaccharide Vaccine (PPV) Coverage Report, England

Pneumococcal vaccination (65+)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults aged 65 and over in England who received the pneumococcal polysaccharide vaccine, from the UKHSA annual coverage report.

Figure 1.83: Pneumococcal vaccination (65+) by deprivation group (Index of Multiple Deprivation (IMD) quintile) – April 2024 to March 2025



Source: UKHSA, Pneumococcal Polysaccharide Vaccine (PPV) Coverage Report, England

Severe mental illness (SMI) excess mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

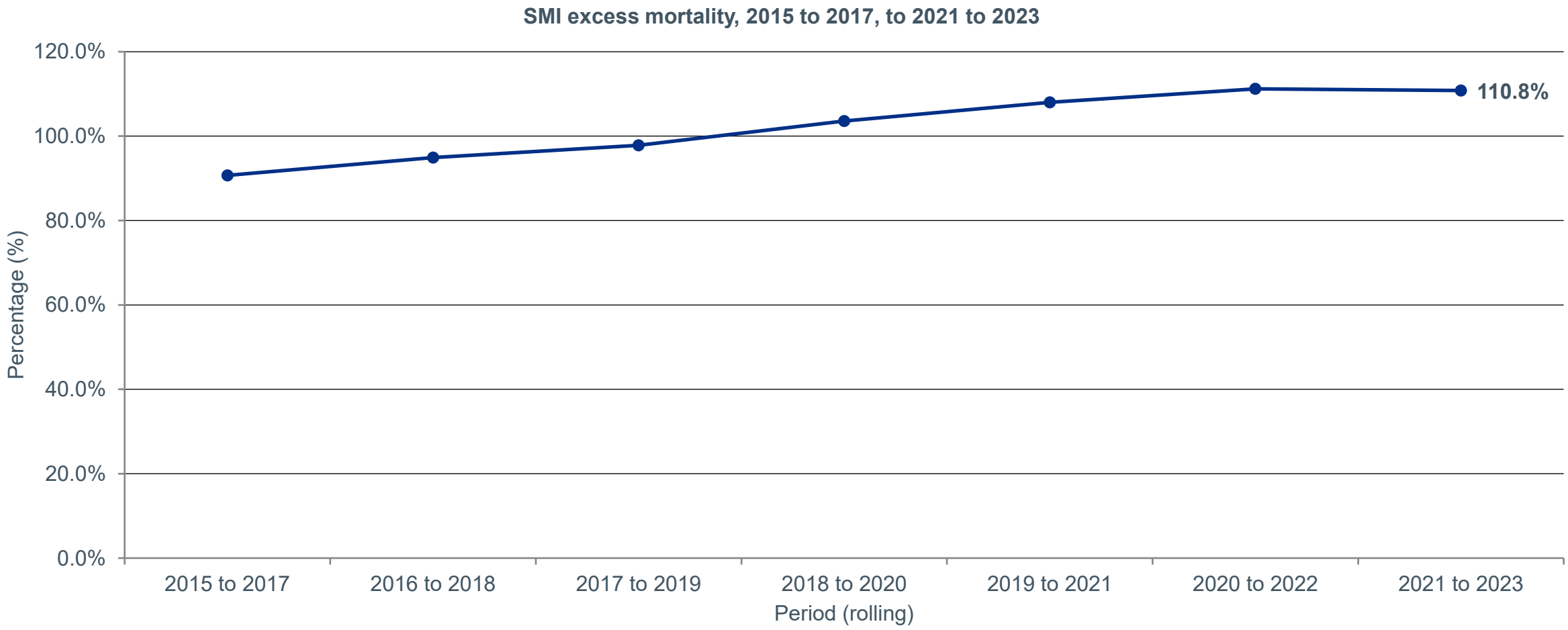
Excess under-75 mortality among people with severe mental illness compared to the general population, expressed as a percentage ratio

Why it matters for the strategy

• We track excess mortality in severe mental illness because people with SMI die on average 15 to 20 years earlier than the general population, and closing this gap requires both better physical health checks and integrated care. The current trend is deteriorating, with the excess mortality ratio significantly above 2017 to 2019 levels.
• The latest figure for England (2021 to 2023) is 110.8%.
• This is getting worse: increasing by 20.1% from 2015 to 2017 (90.7%) to 2021 to 2023 (110.8%)
• It varies by region, with the worst excess rate in North West (152.6%) and the lowest in South West (89.0%) – a gap of 63.6%
• Closing the gap needs both better physical health checks and properly integrated care.
• Named strategy mental health priority. Represents the largest single mortality inequality in the NHS.

Source: Office for Health Improvement and Disparities (OHID), Fingertips indicator 93581 (2021 to 2023)

Figure 1.84: SMI excess mortality: England trend



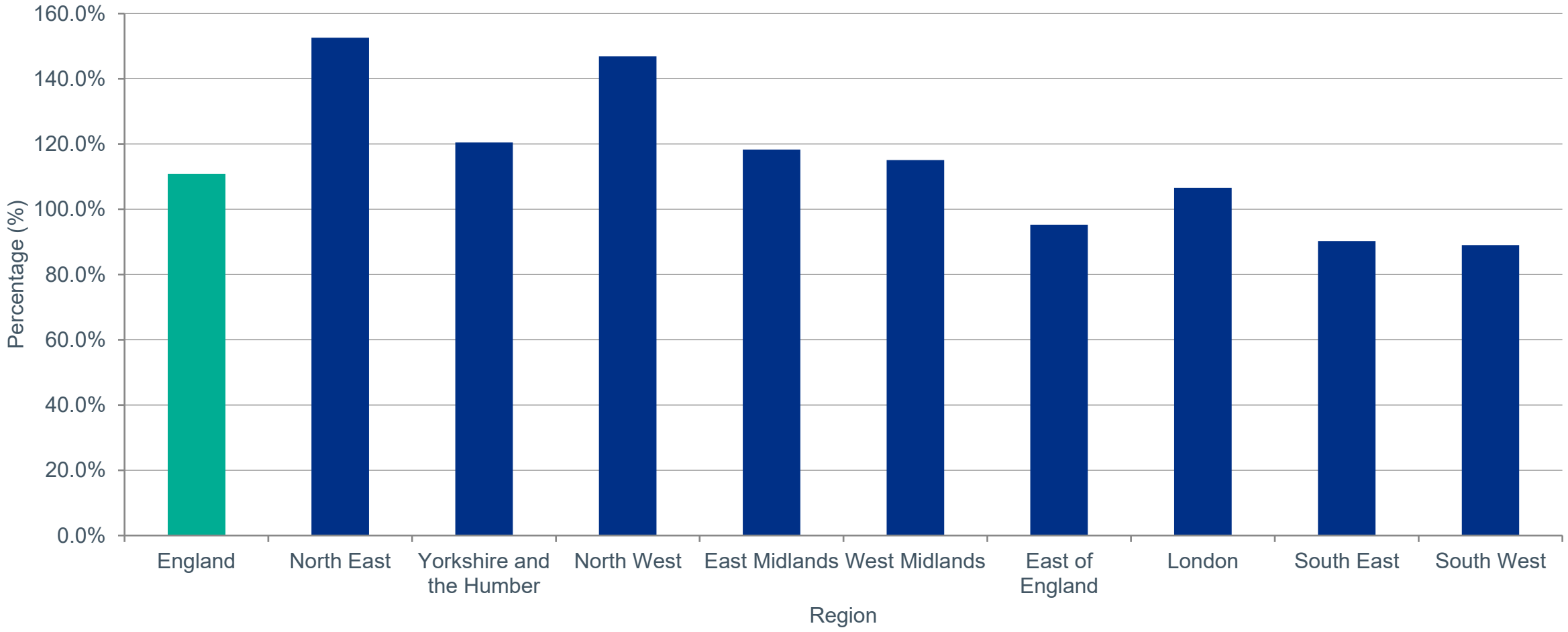
Source: OHID, Fingertips indicator 93581 (2021 to 2023)

SMI excess mortality

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Excess under-75 mortality among people with severe mental illness compared to the general population, expressed as a percentage ratio

Figure 1.85: SMI excess mortality by Region, April 2024 to March 2025



Source: OHID, Fingertips indicator 93581 (2021 to 2023)

NHS Talking Therapies recovery rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Recovery rate for NHS Talking Therapies (formerly Improving Access to Psychological Therapies (IAPT)), measuring the proportion of patients who moved to recovery among those completing a course of treatment for common mental health conditions (NHS England quarterly statistics).

Why it matters for the strategy

• We track NHS Talking Therapies recovery rate because common mental disorders (anxiety and depression) are the largest contributor to years lived with disability, and the recovery rate of the national programme is the primary outcome measure for whether psychological treatment is effective at population scale. The current trend is deteriorating, with recovery rates declining from their peak.
• The latest figure for England (Mar-26) is 48.4% %.
• This is broadly stable: fluctuating at around an average of 47% in the last two years.
• Performance varies across NHS Regions: the best-performing area (South West) achieved 51%, while the lowest (North West) achieved 45% .
• The recovery rate of NHS Talking Therapies is the primary population-scale measure of whether psychological treatment is working.
• The named strategy outcome for the IAPT programme.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

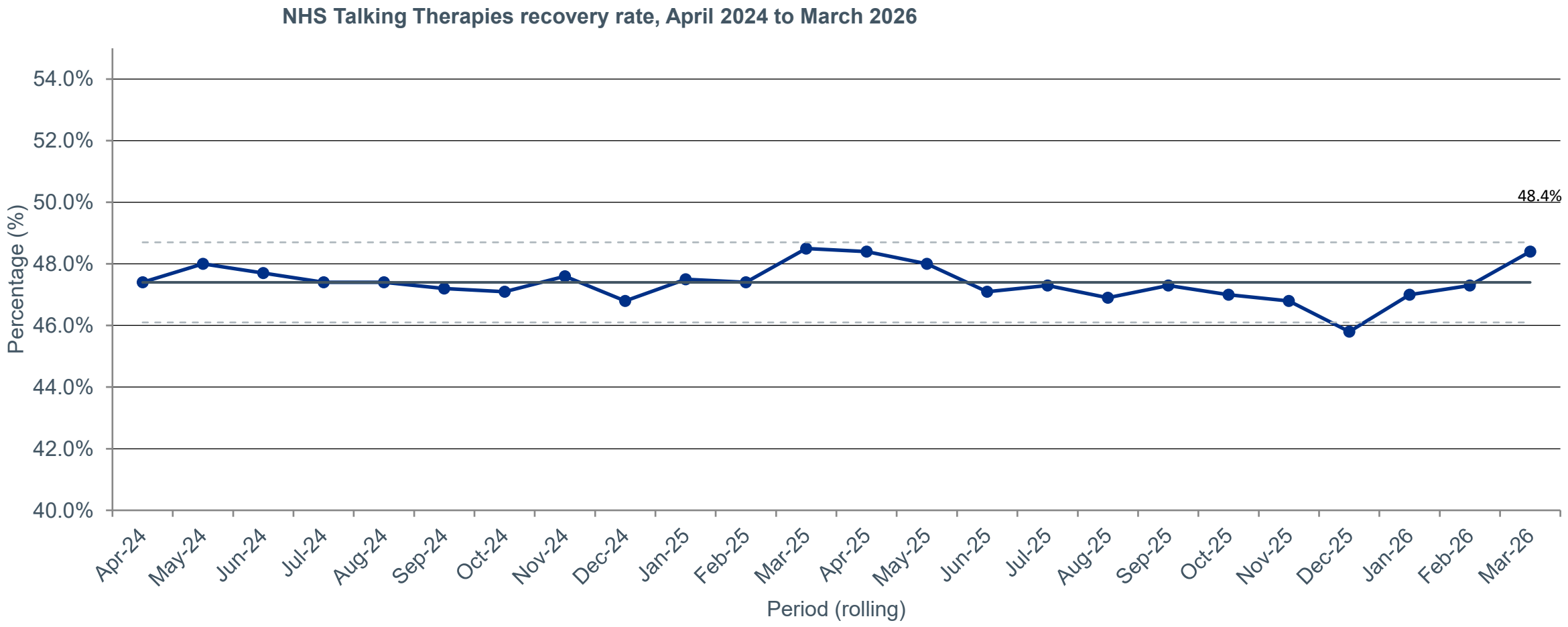
Source: NHS England Digital, NHS Talking Therapies for Anxiety and Depression, Monthly Statistics Dec 2024-Dec 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

NHS Talking Therapies recovery rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Recovery rate for NHS Talking Therapies (formerly IAPT), measuring the proportion of patients who moved to recovery among those completing a course of treatment for common mental health conditions (NHS England quarterly statistics).

Figure 1.86: NHS Talking Therapies recovery rate: England trend



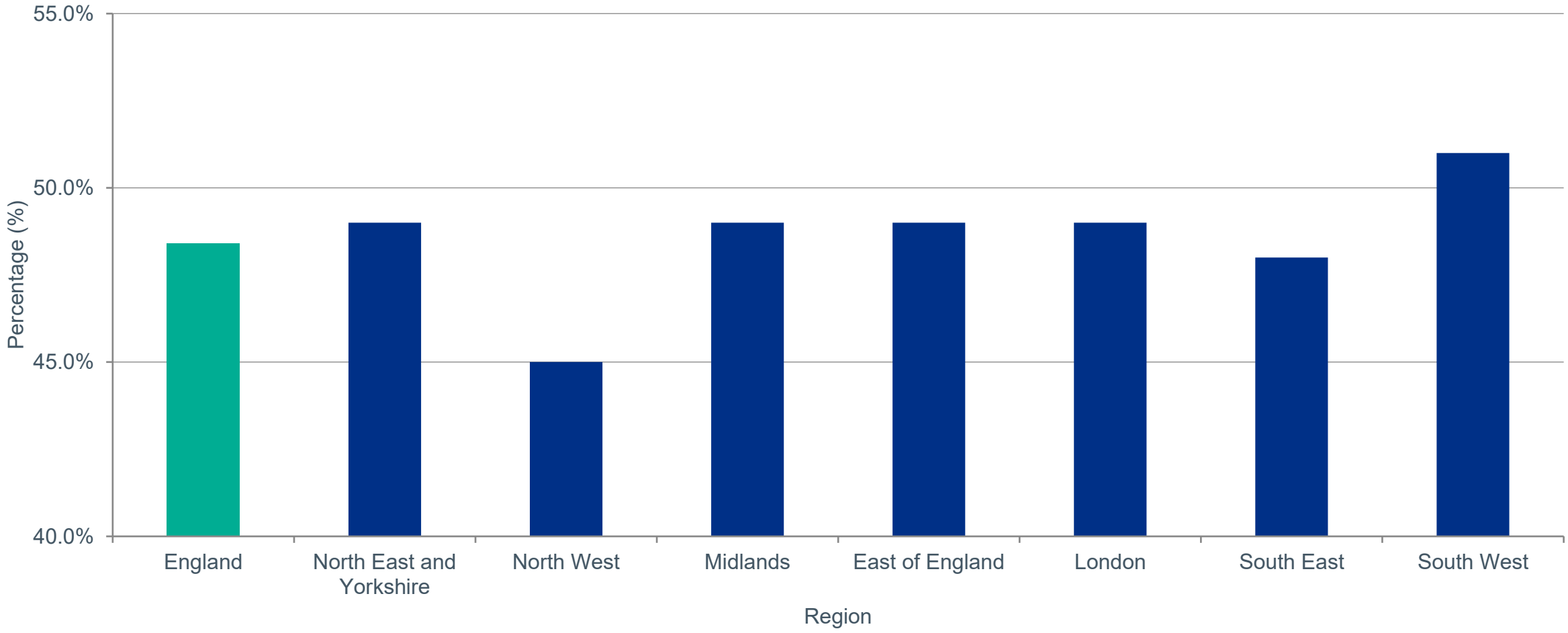
Source: NHS England Digital, NHS Talking Therapies for Anxiety and Depression, Monthly Statistics Dec 2024-Dec 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

NHS Talking Therapies recovery rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Recovery rate for NHS Talking Therapies (formerly IAPT), measuring the proportion of patients who moved to recovery among those completing a course of treatment for common mental health conditions (NHS England quarterly statistics).

Figure 1.87: NHS Talking Therapies by NHS Region, March 2026



Source: NHS England Digital, NHS Talking Therapies for Anxiety and Depression, Monthly Statistics Dec 2024-Dec 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Severe mental illness (SMI) physical health checks

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people on the GP severe mental illness register who received a complete physical health check covering all six components (blood pressure, body mass index (BMI), blood glucose, blood lipids, alcohol, and smoking status), from NHS England quarterly publication.

Why it matters for the strategy

• We track SMI physical health checks because people with severe mental illness die 15 to 20 years earlier than the general population, and comprehensive annual health checks (blood pressure (BP), BMI, glucose, lipids, alcohol, smoking) are the principal mechanism for detecting and managing the physical health conditions that drive this excess mortality.
• The latest figure for England (Q4 April 2025 to March 2026) is 65.2%.
• The picture is mixed: 65.2% of people on GP SMI register received a complete physical health check (all 6 components: BP, BMI, blood glucose, blood lipids, alcohol, smoking) in Q4 April 2025 to March 2026 down 1.3% compared to the same period the previous year, but 8.2% higher than the lowest value (57.0%; Q2 April 2024 to March 2025)
• Performance varies across NHS Regions in Q4 April 2025 to March 2026: the best-performing area (London) achieved 70.5%, while the lowest (South East) achieved 60.0% - a gap of 10.5%.
• There is not a simple linear relationship across deprivation deciles, although the highest deprivation group had the lowest uptake (63.6%) with the highest uptake 66.2% (6th decile) – a gap of 2.6%

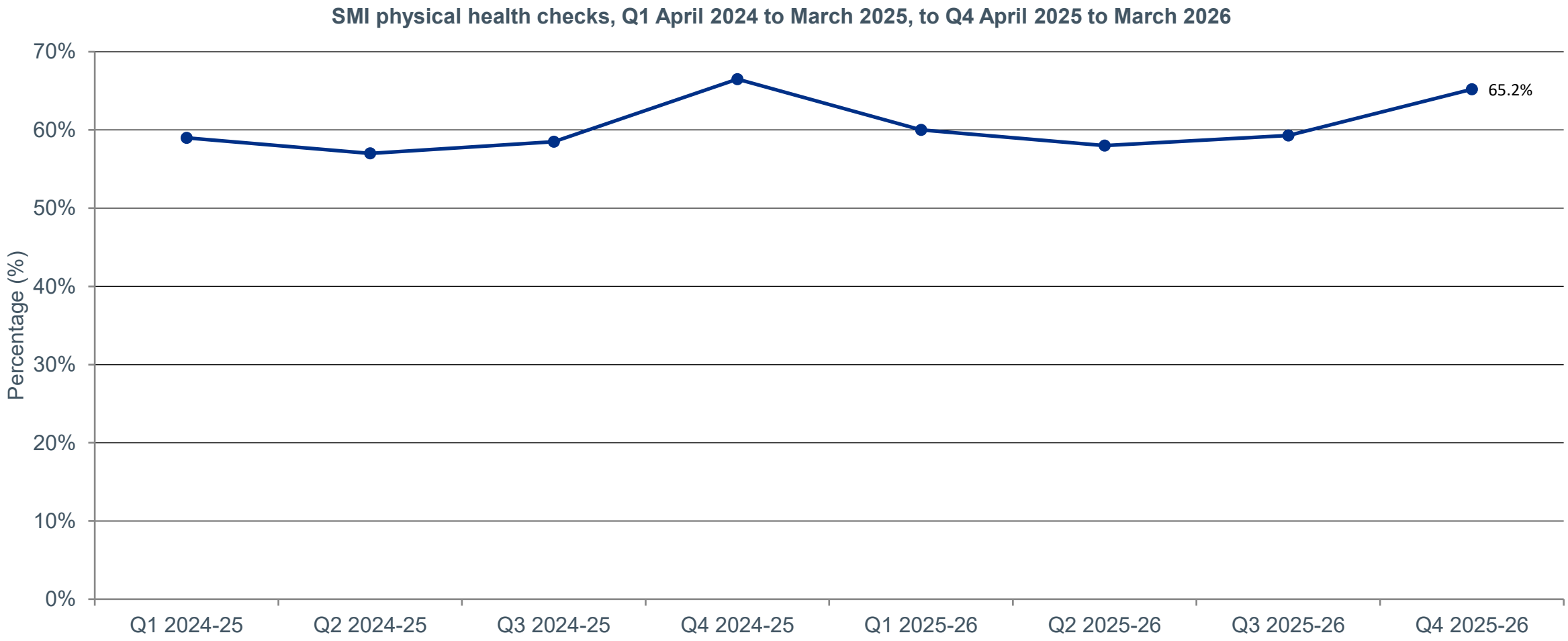
Source: NHS England, Physical Health Checks for People with Severe Mental Illness

SMI physical health checks

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people on the GP severe mental illness register who received a complete physical health check covering all six components (blood pressure, BMI, blood glucose, blood lipids, alcohol, and smoking status), from NHS England quarterly publication.

Figure 1.88: SMI physical health checks: England trend



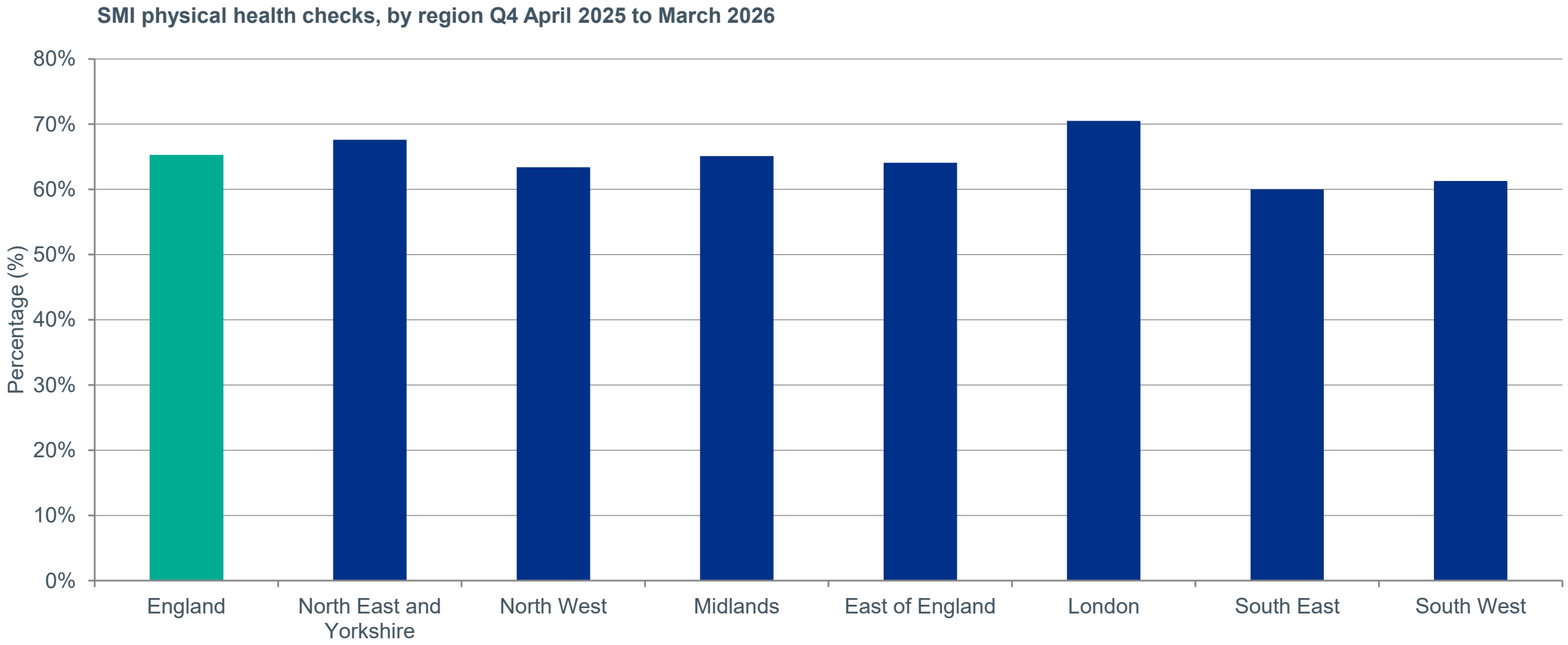
Source: NHS England, Physical Health Checks for People with Severe Mental Illness

SMI physical health checks

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people on the GP severe mental illness register who received a complete physical health check covering all six components (blood pressure, BMI, blood glucose, blood lipids, alcohol, and smoking status), from NHS England quarterly publication.

Figure 1.89: SMI physical health checks by NHS Region



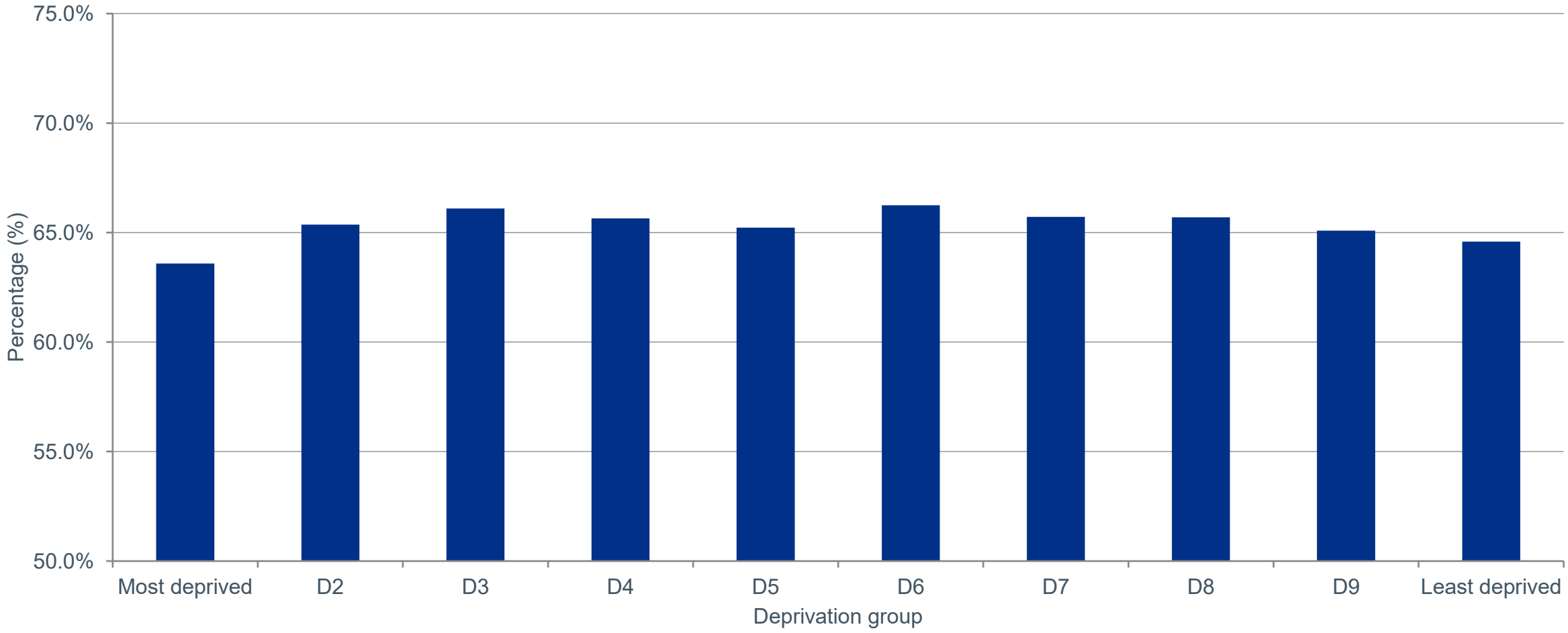
Source: NHS England, Physical Health Checks for People with Severe Mental Illness

SMI physical health checks

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people on the GP severe mental illness register who received a complete physical health check covering all six components (blood pressure, BMI, blood glucose, blood lipids, alcohol, and smoking status), from NHS England quarterly publication.

Figure 1.90: SMI physical health checks, Index of Multiple Deprivation Q4 April 2025 to March 2026



Source: NHS England, Physical Health Checks for People with Severe Mental Illness

Antidepressant prescribing

Effectiveness | Tier 3: Process indicator

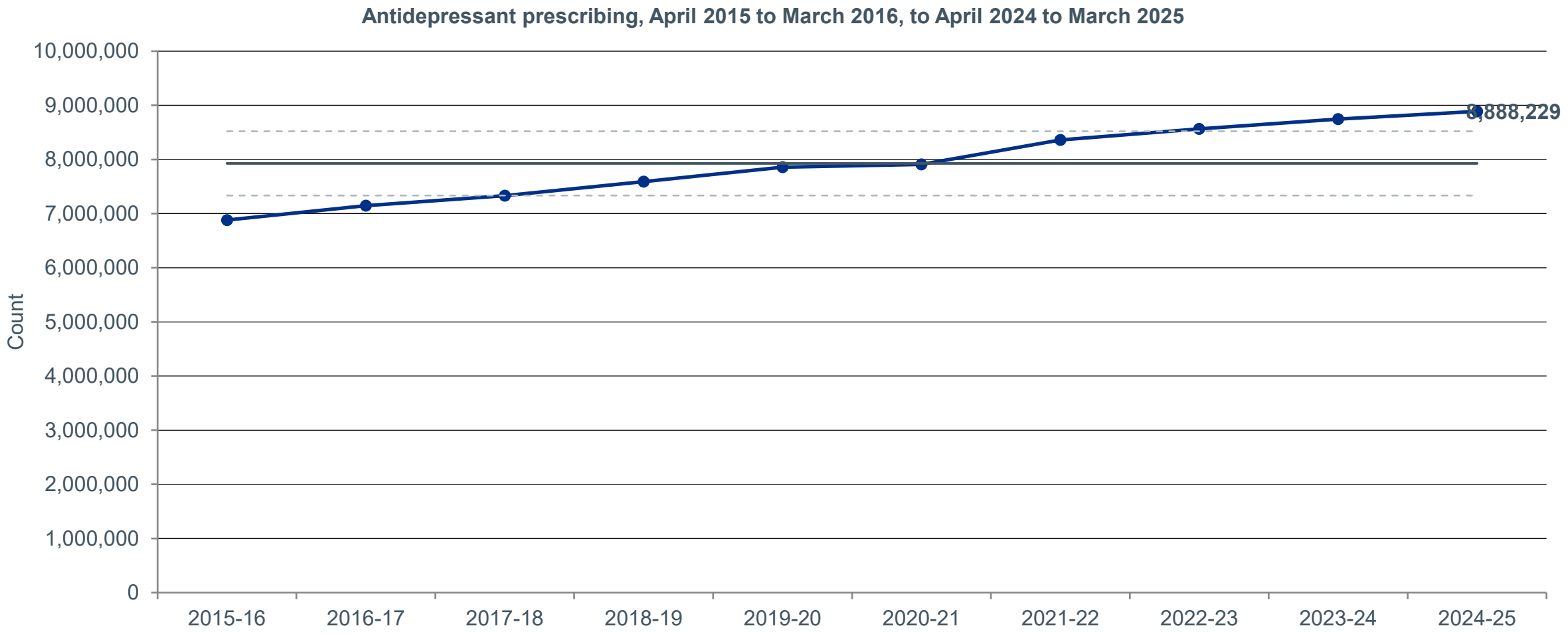
Number of identified patients receiving antidepressant prescriptions in primary care in England, from the NHS Business Services Authority (NHSBSA) Medicines Used in Mental Health annual publication.

Why it matters for the strategy

- We track antidepressant prescribing because it is a key Tier 3 care pathway indicator for common mental disorders, reflecting both access to treatment and potential over-reliance on pharmacological approaches over talking therapies.
- The latest figure for England (April 2024 to March 2025) is 8.89M.identified patients.
- This has increased steadily : by 2.00M between April 2015 to March 2016 (6.89M) to April 2024 to March 2025 (8.89M with 79.2M items dispensed).
- Operational signal that moves before the underlying driver - early warning for changes in the wider pathway.
- Common mental disorders treatment signal. Companion to talking therapies recovery in Core.

Source: NHSBSA, Medicines Used in Mental Health, England April 2024 to March 2025 (published Nov 2025).

Figure 1.91: Antidepressant prescribing: England trend



Source: NHSBSA, Medicines Used in Mental Health, England April 2024 to March 2025 (published Nov 2025).

Dementia prescribing

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Number of identified patients receiving cholinesterase inhibitors or memantine prescriptions for dementia in England, from the NHS Business Services Authority (NHSBSA) Medicines Used in Mental Health annual publication.

Why it matters for the strategy

• We track dementia prescribing because medication (cholinesterase inhibitors and memantine) can slow cognitive decline and improve quality of life, and prescribing rates relative to diagnosis rates reveal whether diagnosed patients are receiving recommended treatment.
• The latest figure for England (2024-25) is 325,803 identified patients.
• This is increasing,:by around 92 thousand identified patients prescribed drugs for dementia between April 2015 to March 2016 (234K) and April 2024 to March 2025 (326K)
• Comparing prescribing rates against diagnosis rates provides an indication of whether the people who have been diagnosed are actually getting recommended treatment.

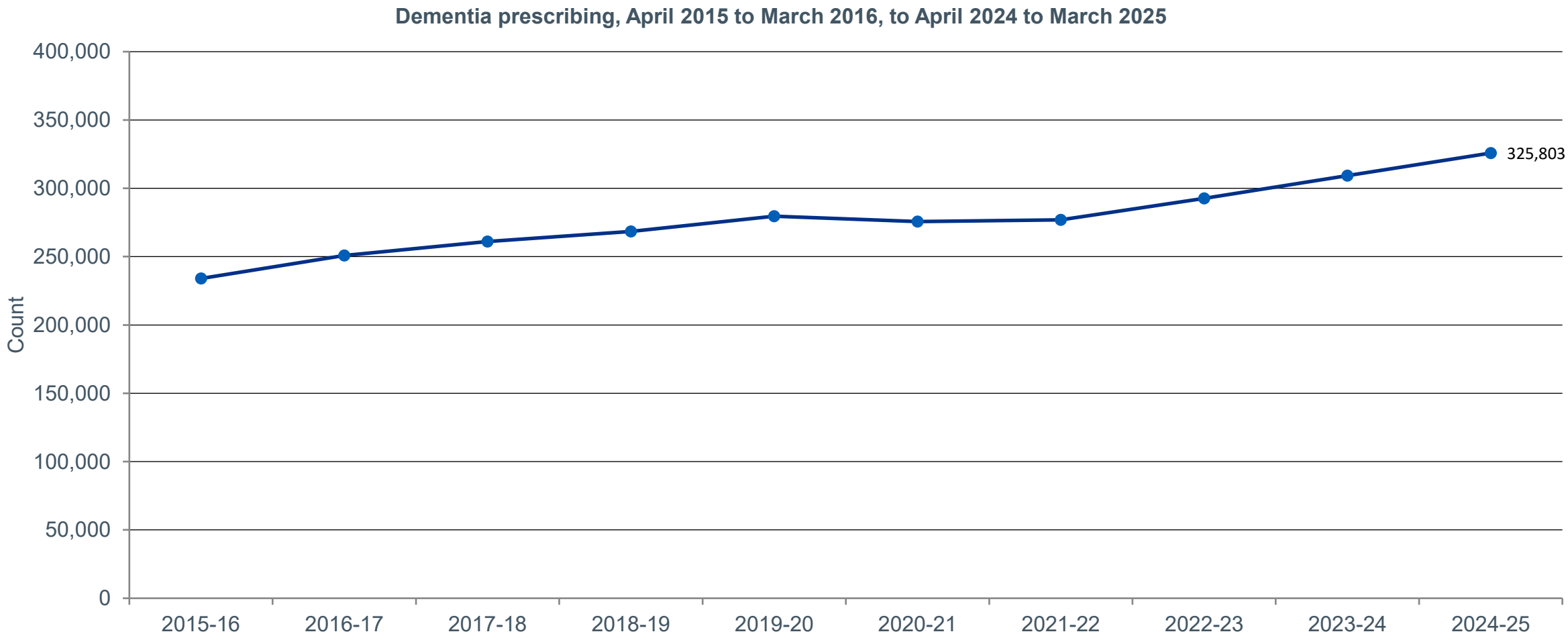
Source: NHSBSA, Medicines Used in Mental Health, England April 2024 to March 2025 (dementia drugs chapter, published Nov 2025)

Dementia prescribing

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Number of identified patients receiving cholinesterase inhibitors or memantine prescriptions for dementia in England, from the NHSBSA Medicines Used in Mental Health annual publication.

Figure 1.92: Dementia prescribing: England trend



Source: NHSBSA, Medicines Used in Mental Health, England April 2024 to March 2025 (dementia drugs chapter, published Nov 2025)

Dementia diagnosis rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Estimated dementia diagnosis rate in England, representing the proportion of people estimated to have dementia who have a formal diagnosis recorded in primary care (Office for Health Improvement and Disparities (OHID) Fingertips indicator 92949).

Why it matters for the strategy

• We track dementia diagnosis rates because timely diagnosis is the gateway to care planning, support services, and medication that can slow decline -- without diagnosis, people with dementia cannot access what they need.
• The latest figure for England (2025) is 65.6%.
• This picture is mixed but is now getting better:The rate decreased from 68.7% in 2019 to 61.6% in 2021 before increasing steadily to 65.6% in 2025
• Performance varies across NHS Regions (2025 data): the best-performing area (North West) achieved 70.1%, while the lowest (Midlands NHS.) achieved 61.0%.
• Without a diagnosis, people with dementia cannot access any of it.
• Named strategy priority. A third of people with dementia remain undiagnosed.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

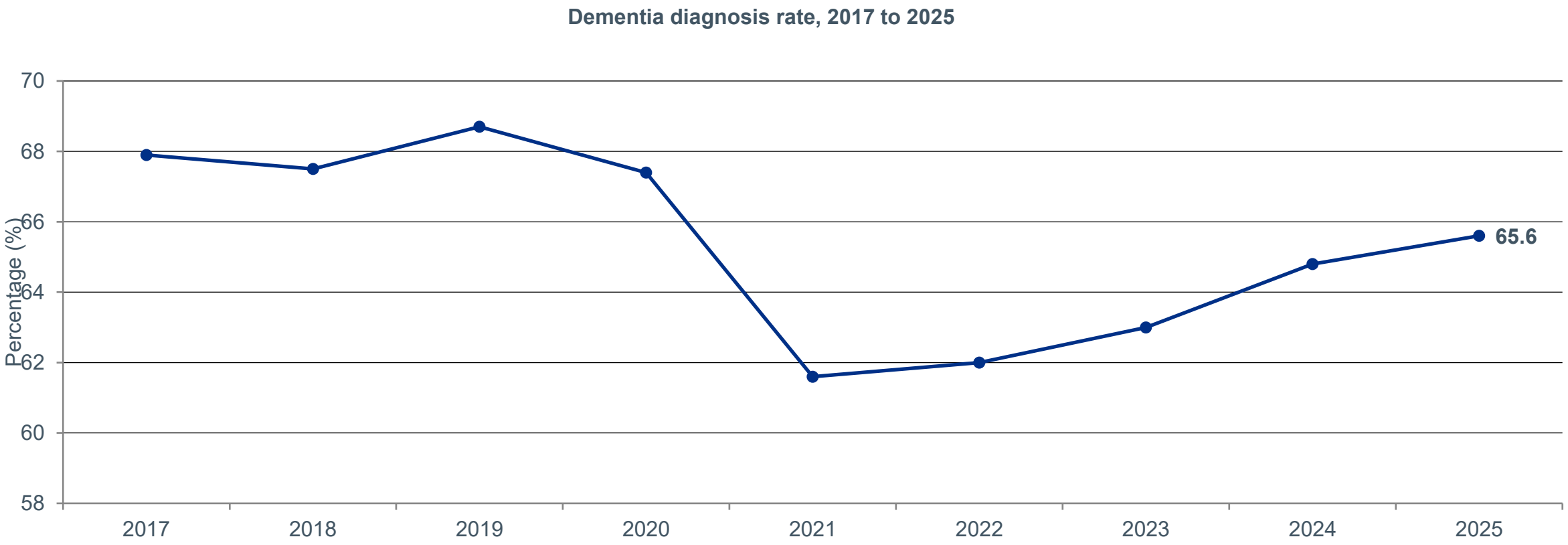
Source: OHID Fingertips indicator 92949, estimated dementia diagnosis rate

Dementia diagnosis rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Estimated dementia diagnosis rate in England, representing the proportion of people estimated to have dementia who have a formal diagnosis recorded in primary care (OHID Fingertips indicator 92949).

Figure 1.93: Dementia diagnosis rate: England trend



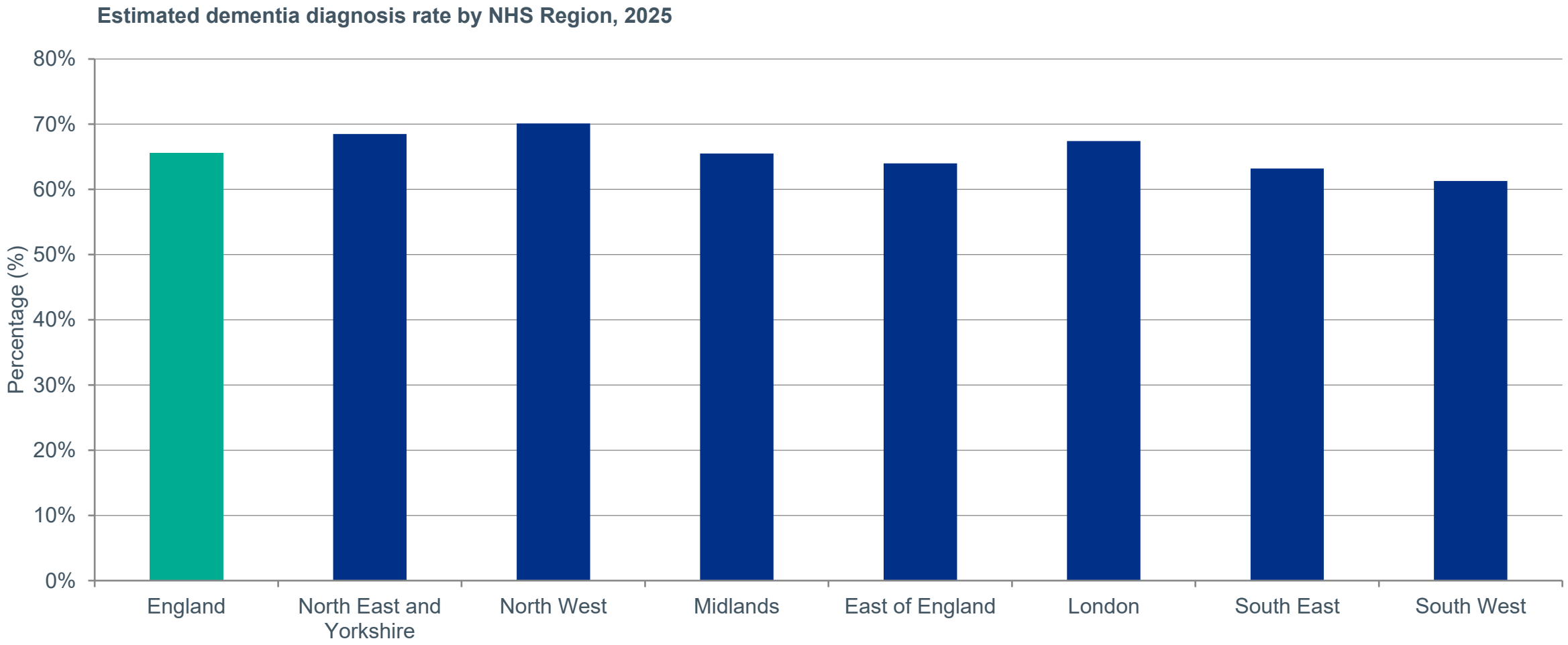
Source: OHID Fingertips indicator 92949, estimated dementia diagnosis rate

Dementia diagnosis rate

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Estimated dementia diagnosis rate in England, representing the proportion of people estimated to have dementia who have a formal diagnosis recorded in primary care (OHID Fingertips indicator 92949).

Figure 1.94: Dementia diagnosis rate by NHS Region



Source: OHID Fingertips indicator 92949, estimated dementia diagnosis rate

Dementia emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for people aged 65 and over with dementia in England, expressed per 100,000 population

Why it matters for the strategy

• We track dementia emergency admissions because they indicate failure to provide adequate community support, and emergency hospital stays are associated with poorer outcomes for people living with dementia. The current trend is worsening, with emergency admission rates increasing.
• The latest figure for England (April 2019 to March 2020) is 3517.3 per 100,000.
• This is getting worse, increasing from 3,365 (April 2016 to March 2017) to 3,517 (April 2019 to March 2020). Only 4 annual data points available. Data stops at April 2019 to March 2020 (pre-pandemic).
• Operational signal that moves before the underlying driver - early warning for changes in the wider pathway.

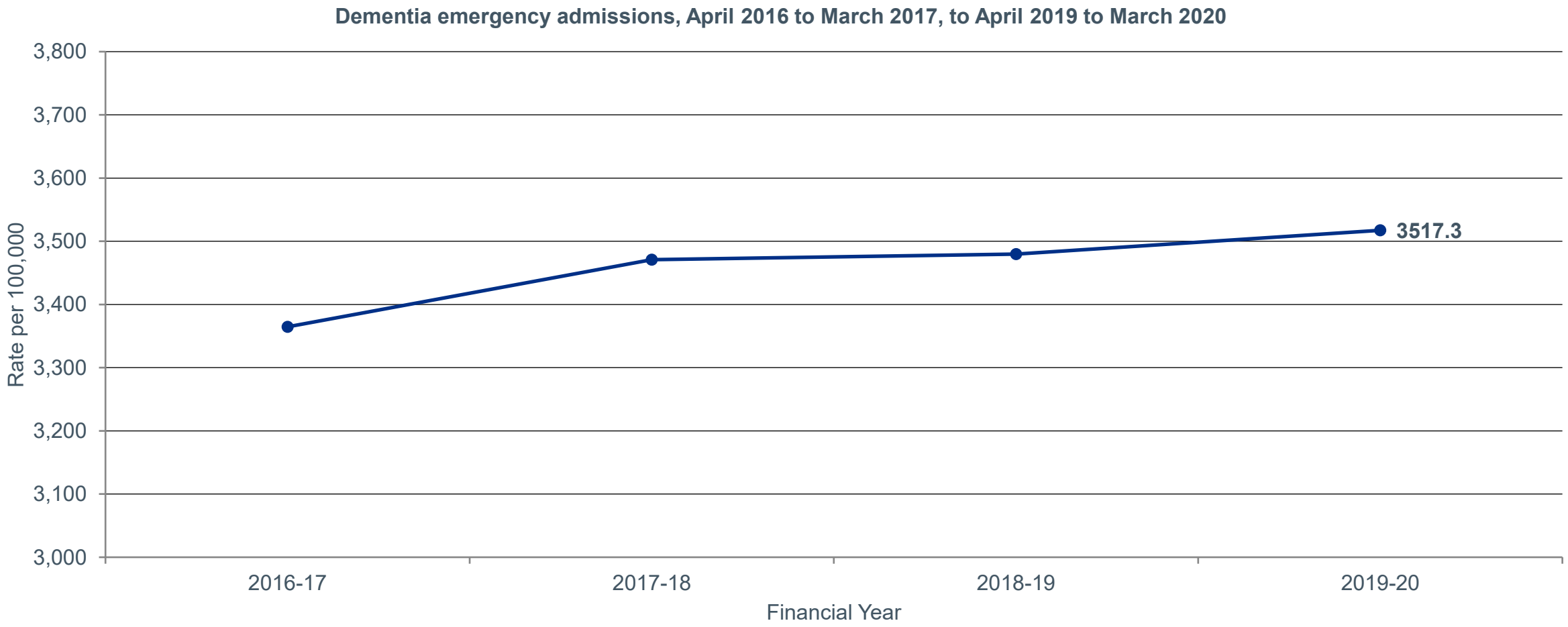
Source: Office for Health Improvement and Disparities (OHID) Fingertips indicator 91281, Dementia directly standardised rate (DSR) emergency admissions (65+), April 2016 to March 2017, to April 2019 to March 2020

Dementia emergency admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for people aged 65 and over with dementia in England, expressed per 100,000 population

Figure 1.95: Dementia emergency admissions: England trend



Source: OHID Fingertips indicator 91281, Dementia DSR emergency admissions (65+), April 2016 to March 2017, to April 2019 to March 2020

Dementia care plan review (Quality and Outcomes Framework (QOF) DEM004)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the GP dementia register whose care plan has been reviewed in the last 12 months, from QOF indicator DEM004 via Office for Health Improvement and Disparities (OHID) Fingertips indicator 91215.

Why it matters for the strategy

• We track dementia care plan reviews because a regularly reviewed, person-centred care plan is the foundation of good dementia care, linking diagnosis to coordinated support that prevents crises and unplanned hospital admissions.
• The latest figure for England (April 2024 to March 2025) is 76.0%.
• The picture is mixed: 76.0% of dementia patients had care plan reviewed in last 12 months in April 2024 to March 2025, down 1.9% compared to April 2013 to March 2014 but recovered from significant drop during the pandemic (78% to 40% in April 2020 to March 2021) followed by recovery.
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (North West) achieved 77.7%, while the lowest (Midlands NHS.) achieved 39.1%.
• The review measure links diagnosis to the coordinated support that prevents crises and unplanned hospital admissions.
• Person-centred care signal. Sub-indicator of dementia diagnosis

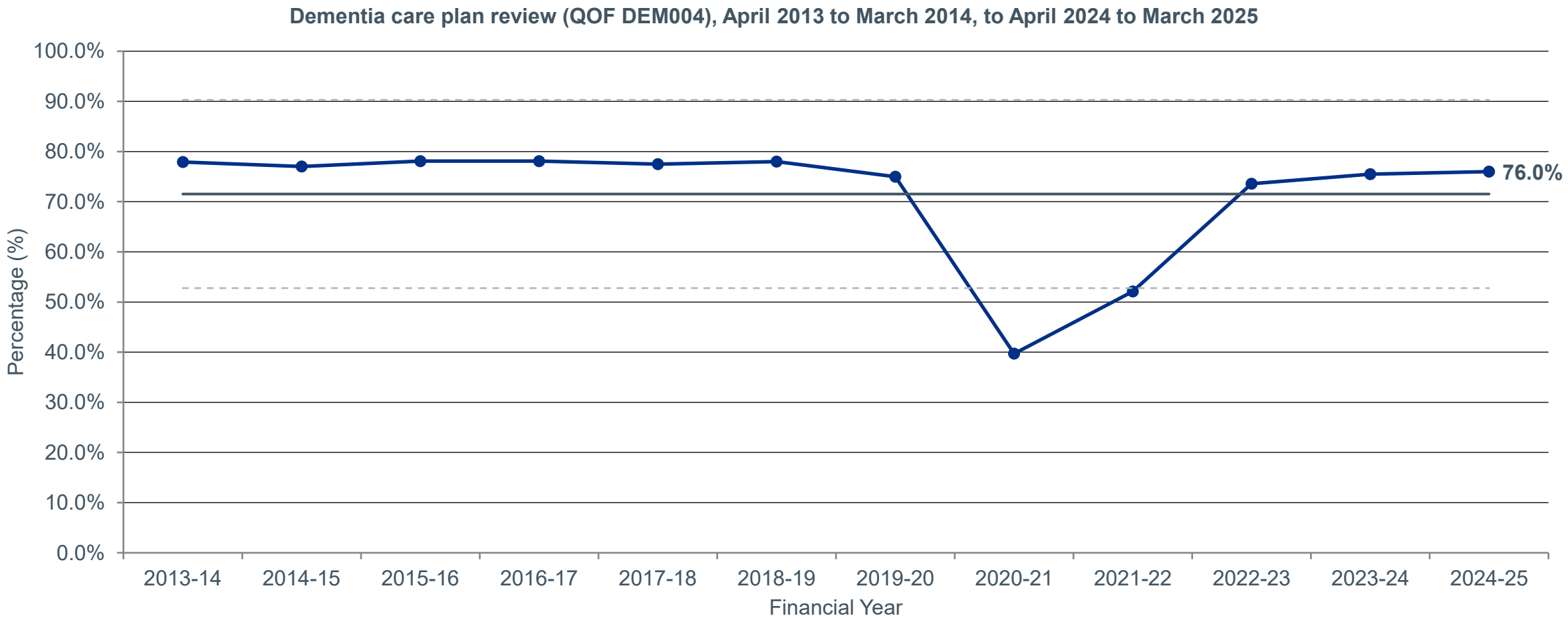
Source: OHID Fingertips indicator 91215 (QOF DEM004: dementia care plan reviewed in last 12 months) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Dementia care plan review (QOF DEM004)

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of patients on the GP dementia register whose care plan has been reviewed in the last 12 months, from QOF indicator DEM004 via OHID Fingertips indicator 91215.

Figure 1.96: Dementia care plan review (QOF DEM004): England trend



Source: OHID Fingertips indicator 91215 (QOF DEM004: dementia care plan reviewed in last 12 months) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Learning disability, health checks

Effectiveness | Tier 2: Driver | ↑ Higher is better

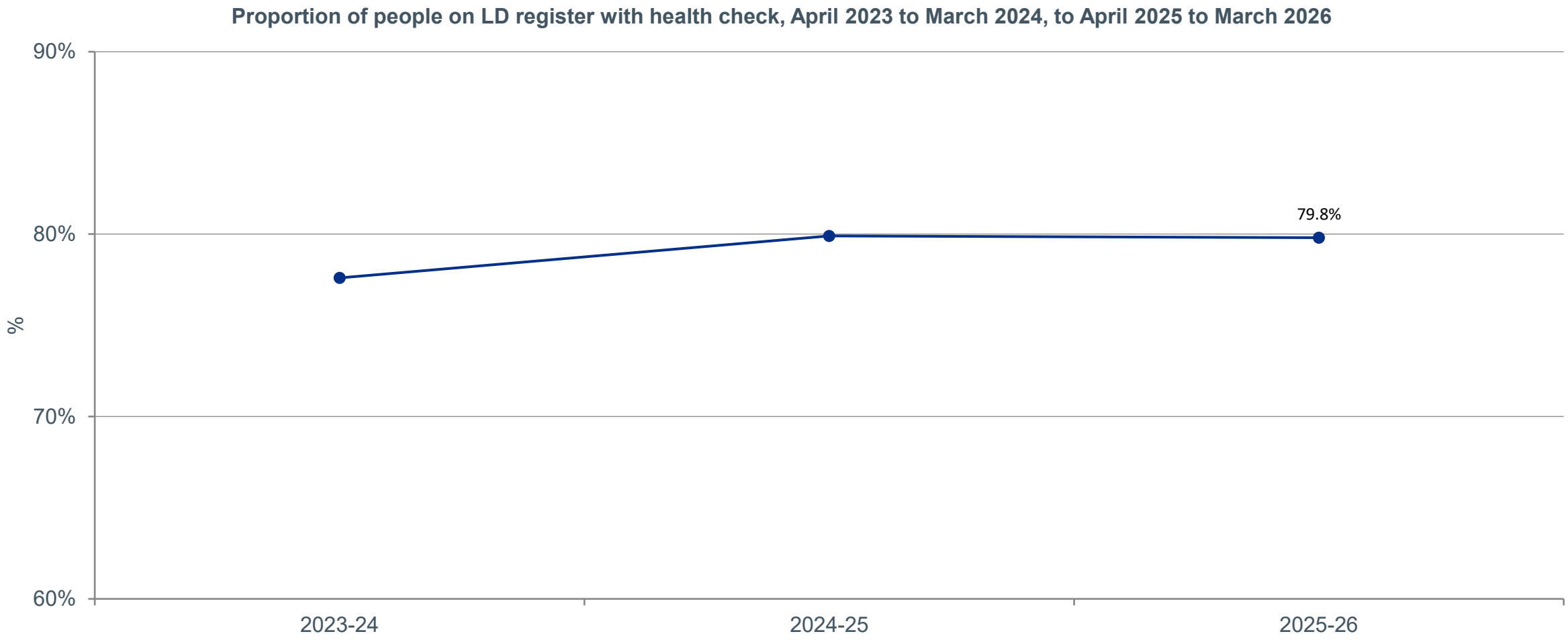
Proportion of those on the learning disability register aged 14+ who had a health check in the year

Why it matters for the strategy

• Health outcomes for people with a learning disability are significantly worse than for the general population, and ensuring that they receive a health check and have a health action plan put in place are key contributors to improving health outcomes.
• The latest data for England is 79.8% in April 2025 to March 2026.
• Trend: this has been stable through April 2024 to March 2025 and April 2025 to March 2026, and up 2.2% since April 2023 to March 2024 (77.6%)b
• There is variation at regional level, from 83.8% in the highest performing region (London) to 76.4% in the lowest (South West), a gap of 7.4%

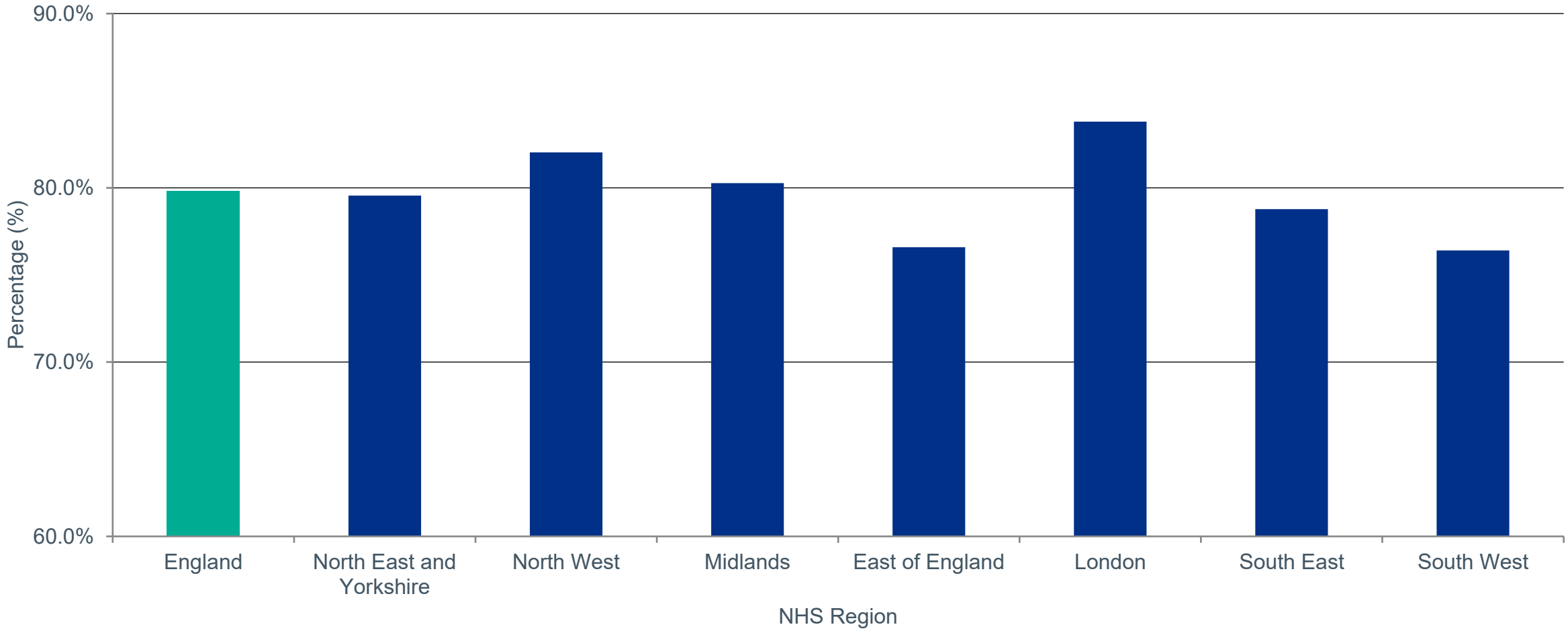
Source: NHS Digital, Learning Disabilities Health Check Scheme

Figure 1.97: Learning disability, health checks: England trend



Source: NHS Digital, Learning Disabilities Health Check Scheme

Figure 1.98: Proportion on LD register with health check, NHS Region, April 2025 to March 2026



Source: NHS Digital, Learning Disabilities Health Check Scheme

Learning disability, health action plan

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of those on the learning disability register aged 14+ who had a health action plan completed in the year

Why it matters for the strategy

• Health outcomes for people with a learning disability are significantly worse than for the general population and ensuring that they receive a health check and have a health action plan put in place are key contributors to improving health outcomes.
• The latest data for England is 77.9% in April 2025 to March 2026.
• Trend: this has been stable through April 2024 to March 2025 and April 2025 to March 2026, and up 2.9% since April 2023 to March 2024 (75.0%).
• There is variation at regional level, from 82.3% in the highest performing region (London) to 74.5% in the lowest (South West), a gap of 7.8%.

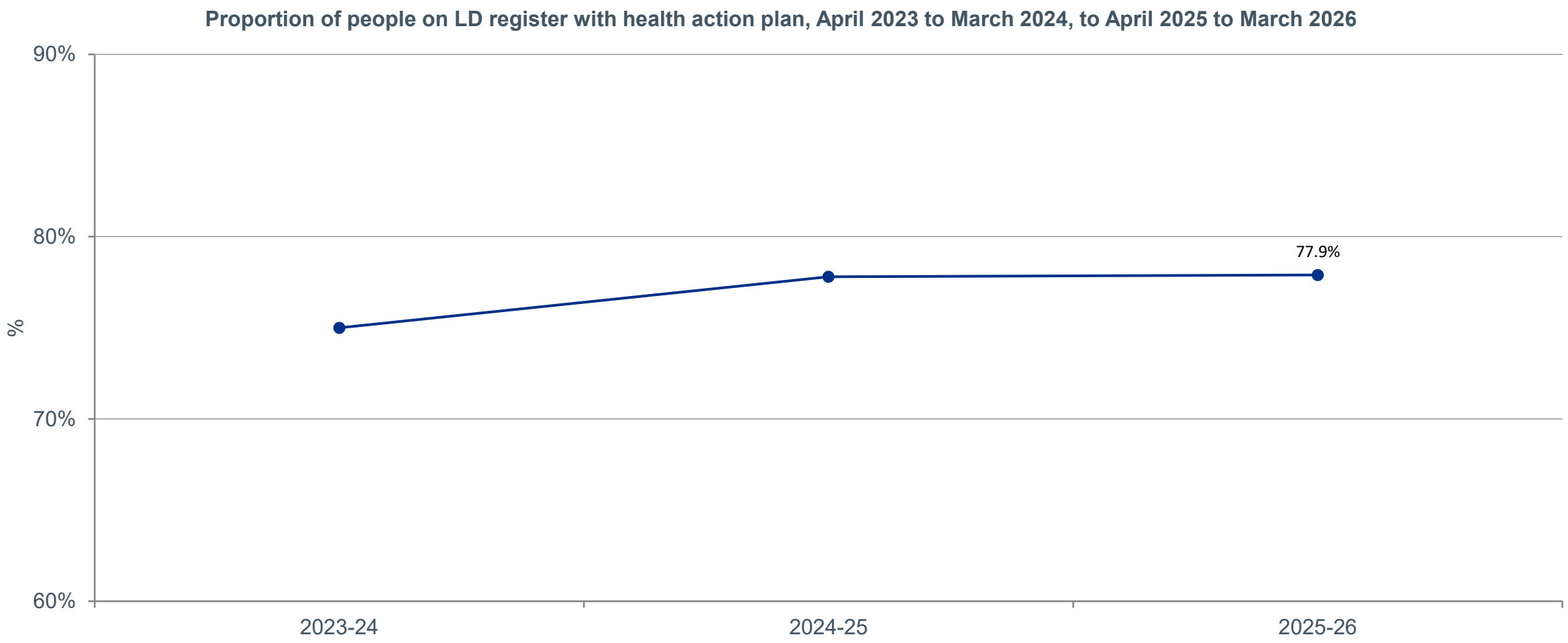
Source: NHS Digital, Learning Disabilities Health Check Scheme.

Learning disability, health action plan

Effectiveness | Tier 2: Driver | ↑ Higher is better

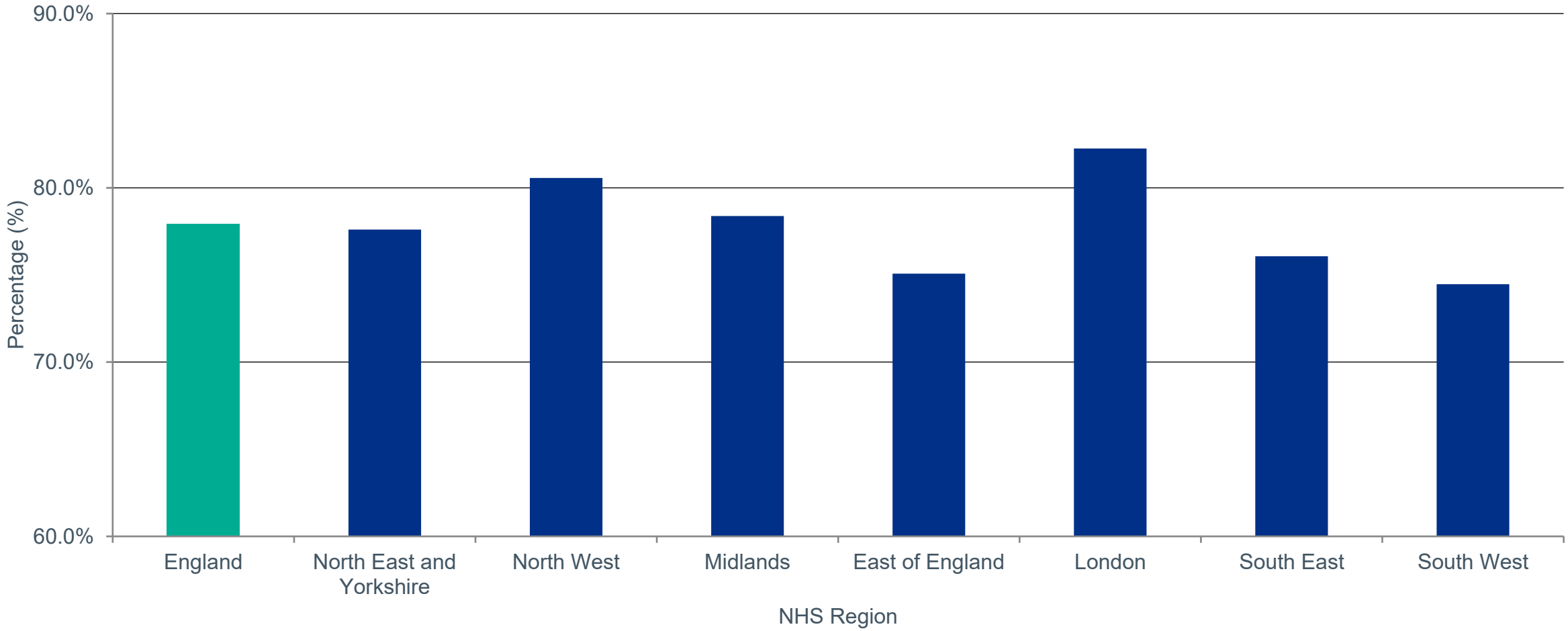
Proportion of those on the learning disability register aged 14+ who had a health action plan completed in the year

Figure 1.99: Learning disability, health action plan: England trend



Source: NHS Digital, Learning Disabilities Health Check Scheme.

Figure 1.100: Proportion on LD register with health action plan, NHS Region, April 2025 to March 2026



Source: NHS Digital, Learning Disabilities Health Check Scheme.

Learning disability and autism, adult inpatient admission rate

Effectiveness | Tier 3: Process | ↓ Lower is better

12-month admission rate for adults with a learning disability and autistic adults into mental health inpatient care per 1,000,000 population

Why it matters for the strategy

- This metric relates to reducing the reliance on mental health inpatient care for people with a learning disability and autistic people.
- The latest data for England is 34 per million for the 12-month period to April 2026.
- Trend: this is the first available datapoint.
- There is variation at regional level, from the highest rate of 50 per million (East of England) to 22 per million (North West) more than two-fold variation.

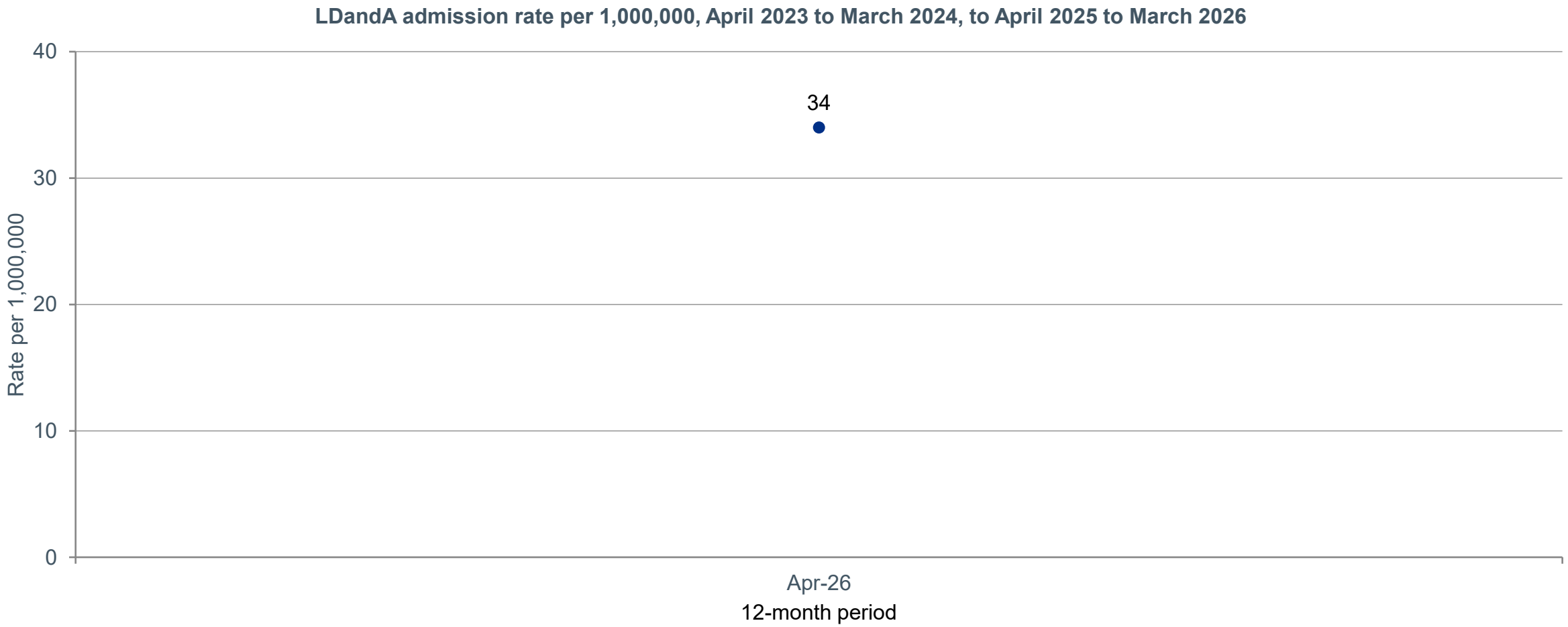
Source: NHS Digital, Assuring Transformation dataset.

Learning disability and autism, adult inpatient admission rate

Effectiveness | Tier 3: Process | ↓ Lower is better

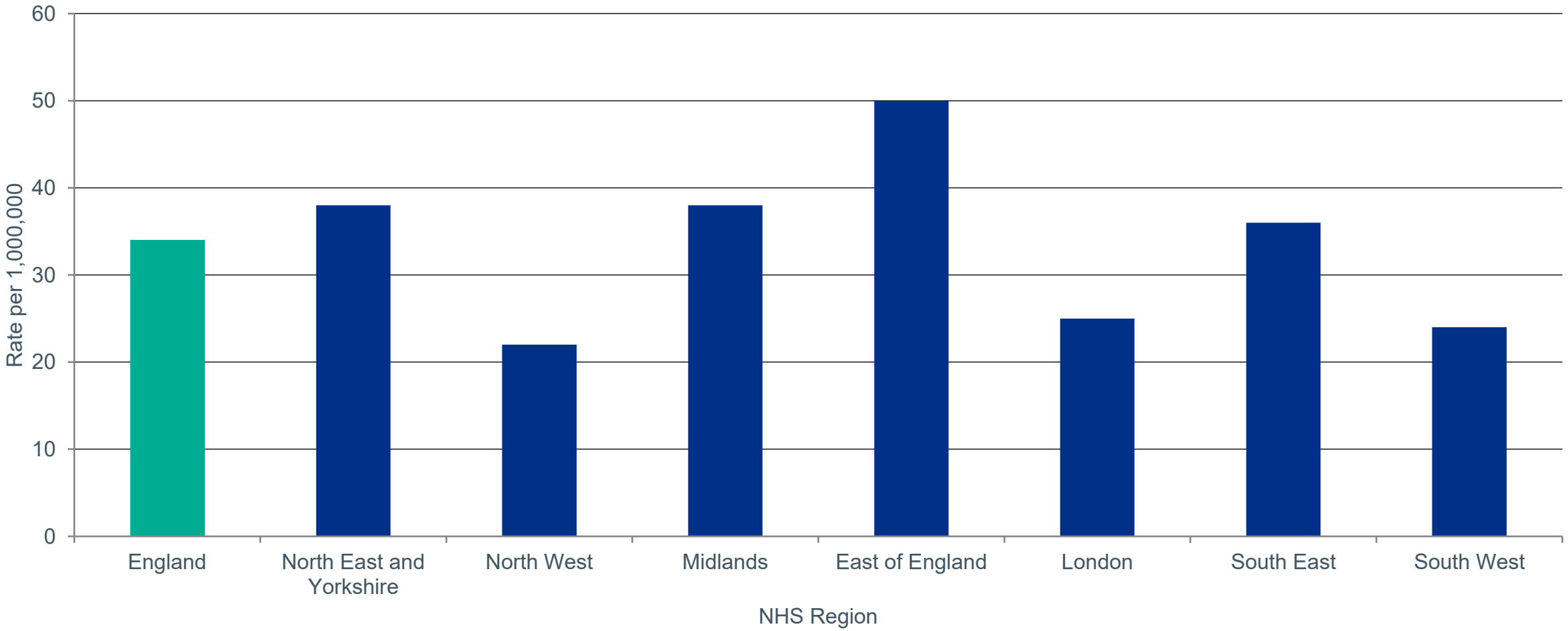
12-month admission rate for adults with a learning disability and autistic adults into mental health inpatient care per 1,000,000 population

Figure 1.101: Learning disability and autism, adult inpatient admission rate: England trend



Source: NHS Digital, Assuring Transformation dataset.

Figure 1.102: Proportion on LD register with health action plan, NHS Region, April 2025 to March 2026



Source: NHS Digital, Assuring Transformation dataset.

Learning disability and autism, length of stay

Effectiveness | Tier 3: Process | ↓ Lower is better

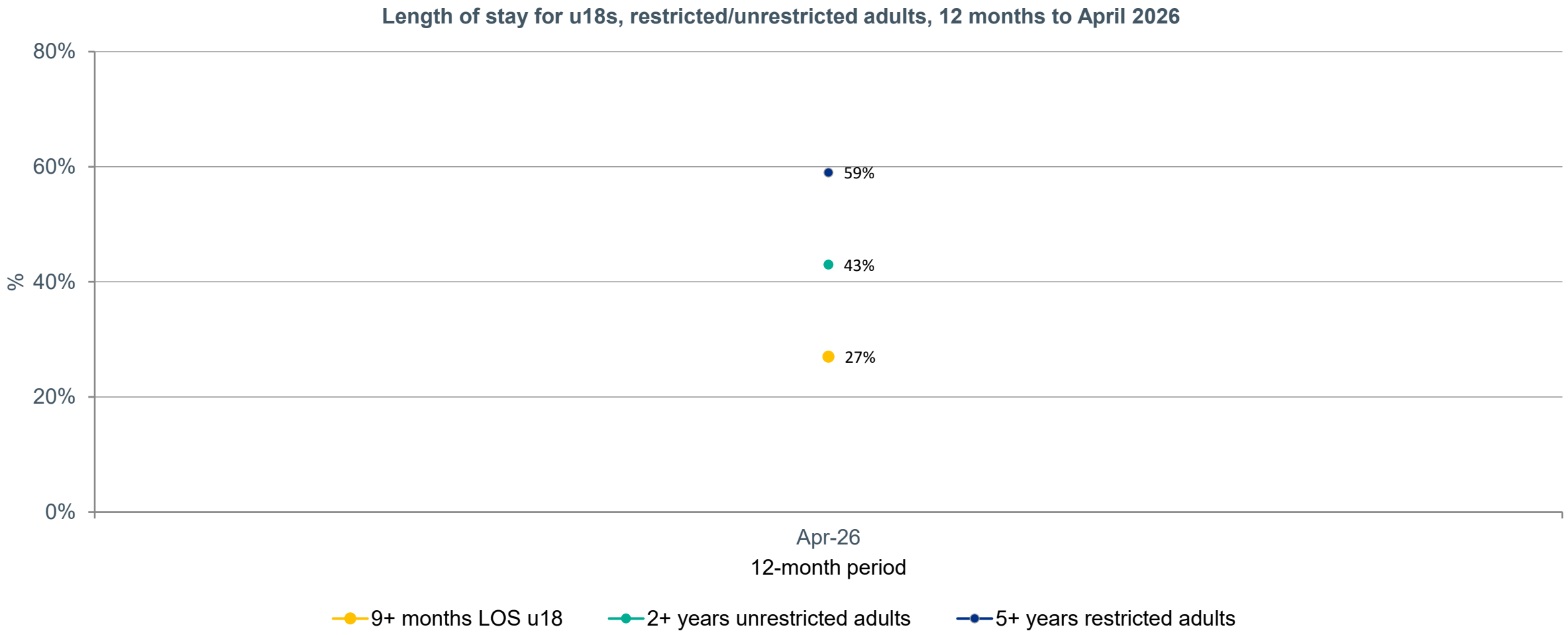
Proportion of LDandA patients with long lengths of stay; 9+ months for under 18s, 2+ years for unrestricted adults, 5+ years for restricted adults

Why it matters for the strategy

- This metric relates to reducing the reliance on mental health inpatient care for people with a learning disability and autistic people by reducing long lengths of stay.
- The latest data for England 27% for 9+ months length of stay for under-18s, 43% for 2+ years for unrestricted adults and 59% for 5+ years for restricted adults.
- Trend: this is the first available datapoint.
- There is variation at regional level, from a highest proportion for under 18s of 32% (South West) to 18% (London), a gap of 14%, for unrestricted adults ranging from 51% (North West) to 26% (East of England) an two-fold variation, and for restricted adults from 75% (North West) to 46% (South East), a gap of 29%.

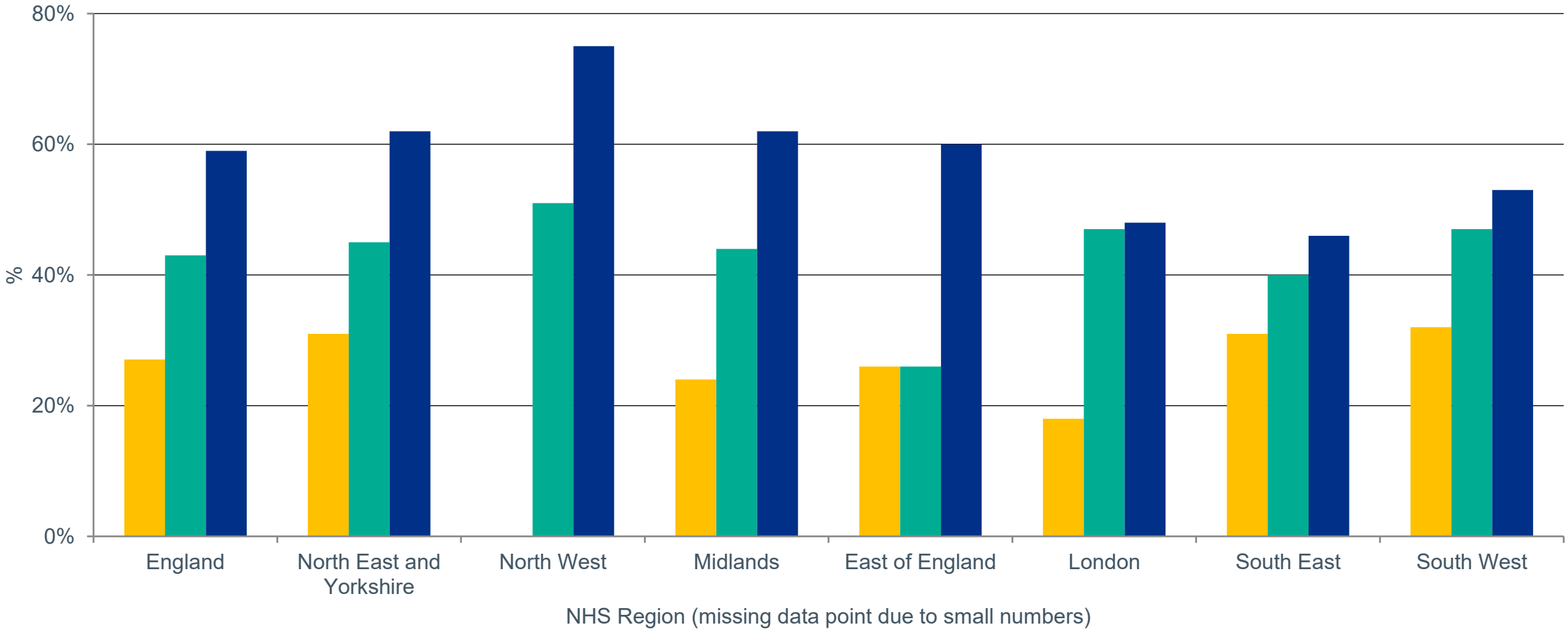
Source: NHS Digital, Assuring Transformation dataset.

Figure 1.103: Learning disability and autism, length of stay: England trend



Source: NHS Digital, Assuring Transformation dataset.

Figure 1.104: Length of stay for under-18s, restricted/unrestricted adults, NHS Region, 12 months to April 2026



Source: NHS Digital, Assuring Transformation dataset.

Musculoskeletal (MSK) patient-reported outcomes

Effectiveness | Tier 2: Driver | ↑ Higher is better

Average health gain reported by patients before and after hip or knee replacement surgery, measured using the EQ-5D index and Oxford Hip/Knee Scores, from NHS Digital Patient Reported Outcome Measures.

Why it matters for the strategy

• We track MSK PROMs because patient-reported outcome measures for hip and knee replacement are the most robust available signal of whether the NHS is improving health-related quality of life for people with long-term MSK conditions, and MSK has the largest impact on Healthy Life Expectancy
• The latest figure for England (April 2023 to March 2024) is 0.46 health gain for hip and 0.32 health gain for knee.
• The picture is mixed: Hip health gain has increased by around 0.02 from April 2014 to March 2015 (0.44) to April 2023 to March 2024 (0.46) but is lower than the April 2020 to March 2021 peak (0.47). Knee health gain is the same in April 2023 to March 2024 as in April 2014 to March 2015 (0.32), but lower than the April 2019 to March 2020 peak (0.34).
• Clinical driver that translates into population outcomes within 1 to 3 years when delivered at scale.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

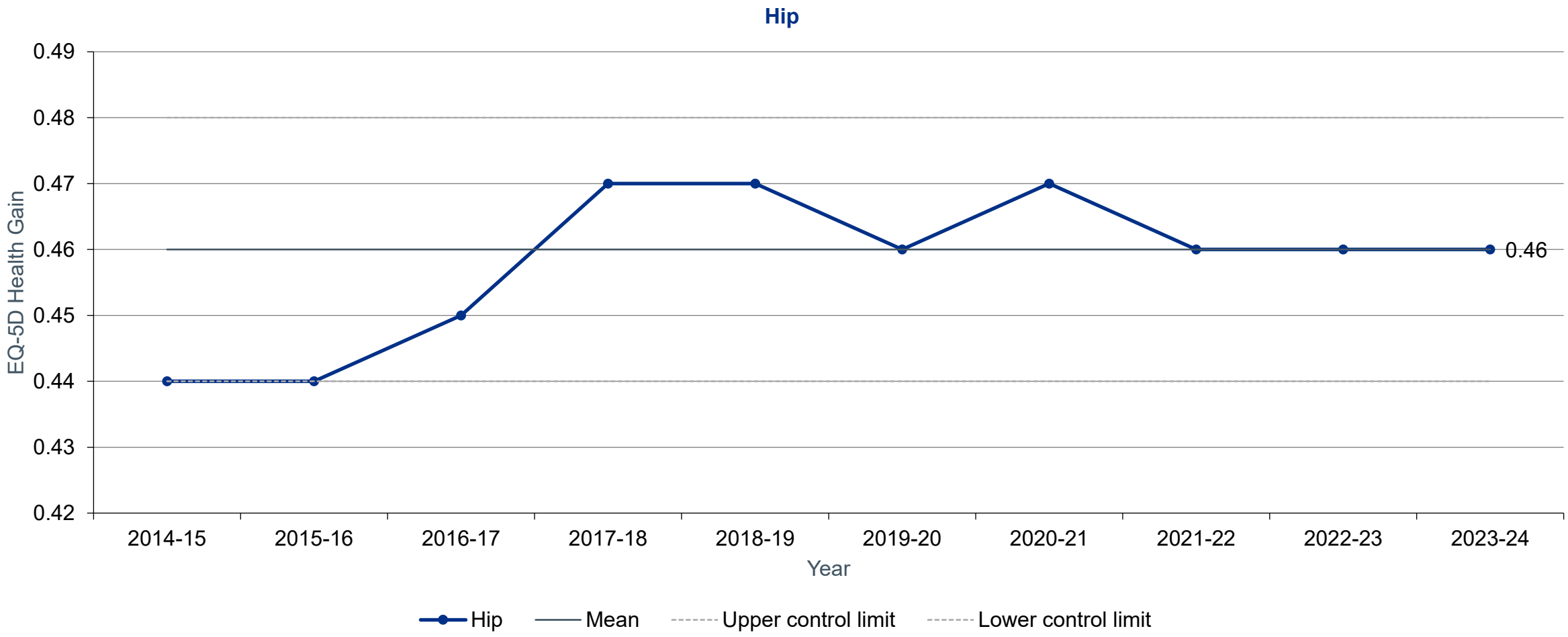
Source: NHS Digital, Finalised Patient Reported Outcome Measures (PROMs) in England, Final April 2023 to March 2024 data (Feb 2025)

MSK patient-reported outcomes

Effectiveness | Tier 2: Driver | ↑ Higher is better

Average health gain reported by patients before and after hip or knee replacement surgery, measured using the EQ-5D index and Oxford Hip/Knee Scores, from NHS Digital Patient Reported Outcome Measures.

Figure 1.105: MSK patient-reported outcomes: England trend



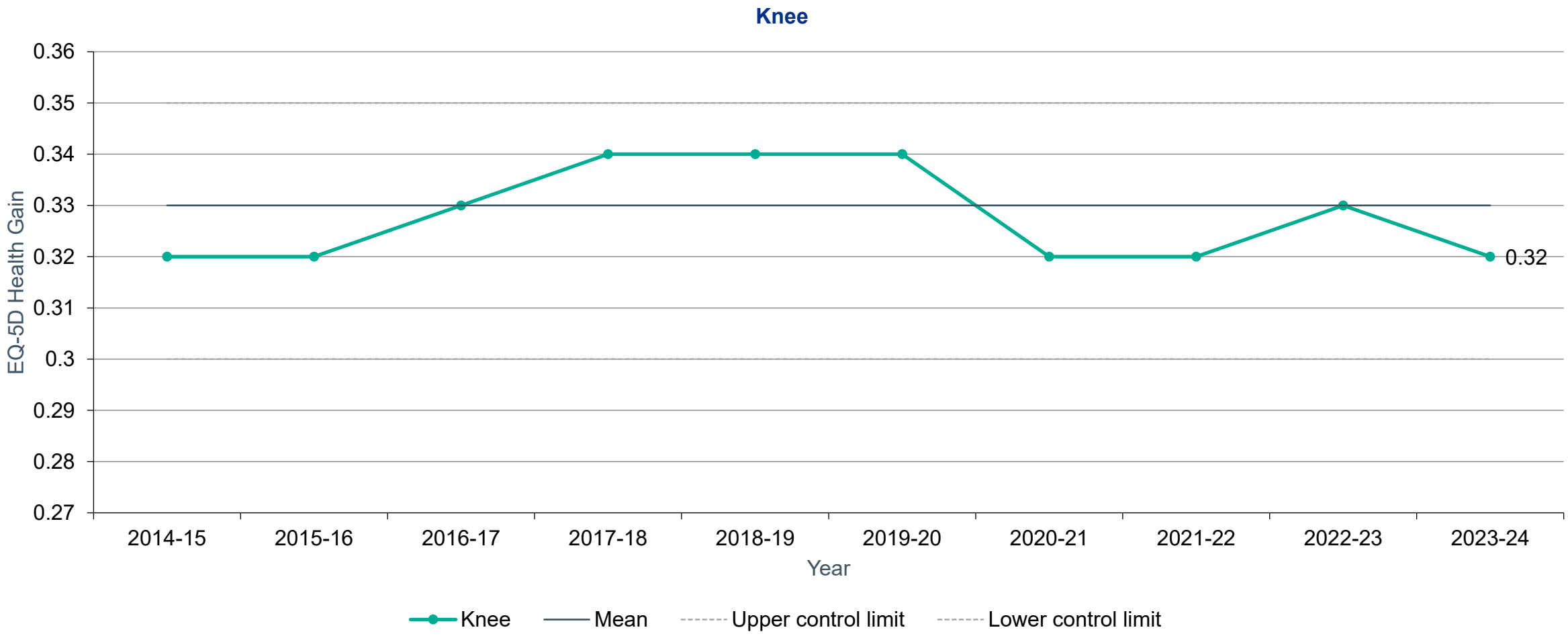
Source: NHS Digital, Finalised Patient Reported Outcome Measures (PROMs) in England, Final April 2023 to March 2024 data (Feb 2025)

MSK patient-reported outcomes

Effectiveness | Tier 2: Driver | ↑ Higher is better

Average health gain reported by patients before and after hip or knee replacement surgery, measured using the EQ-5D index and Oxford Hip/Knee Scores, from NHS Digital Patient Reported Outcome Measures.

Figure 1.106: MSK patient-reported outcomes: England trend



Source: NHS Digital, Finalised Patient Reported Outcome Measures (PROMs) in England, Final April 2023 to March 2024 data (Feb 2025)

Diabetes: all 8 care processes

Effectiveness | Tier 2: Driver | ↑ Higher is better

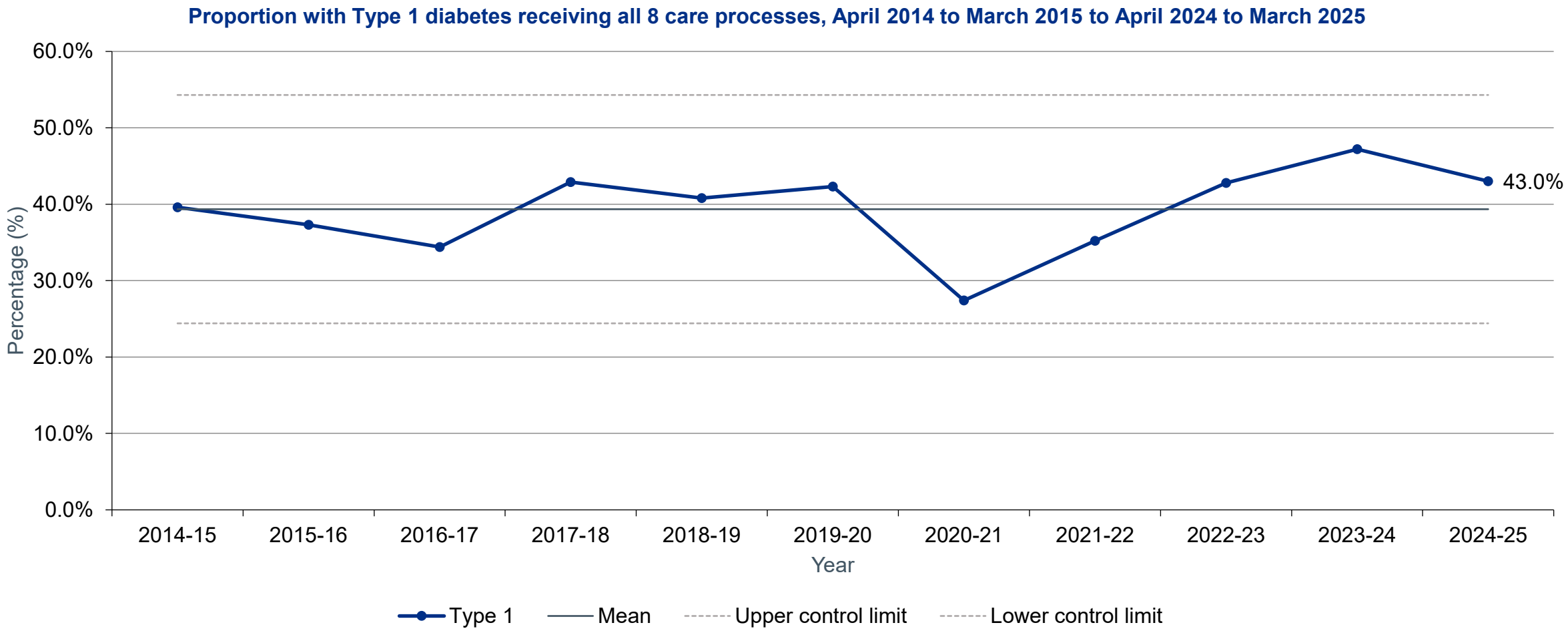
Proportion of people with Type 1 and Type 2 diabetes who received all eight National Institute for Health and Care Excellence (NICE)-recommended care processes in the audit year, from the National Diabetes Audit annual report.

Why it matters for the strategy

• We track the diabetes 8 care processes because they represent the minimum standard of annual care for people with diabetes. Completion of all 8 processes (HbA1c, blood pressure (BP), cholesterol, eye screening, foot check, body mass index (BMI), urine albumin, smoking status) prevents complications that drive emergency admissions, amputations and premature death. The current trend is static, with the April 2024 to March 2025 decline partly attributable to audit window changes.
• The latest figure for England (April 2024 to March 2025) is 43.0 (T1), 58.2 (T2) %.
• This has remained broadly stable: T1 43.0% and T2 58.2% (all persons) in April 2024 to March 2025, down from 47.2%/62.4% in April 2023 to March 2024. Decline of 4.2pp in both types is largely attributable to the audit window change from 15 months to 12 months, reducing opportunity for care process completion.
• Completing all 8 (HbA1c, BP, cholesterol, eye screening, foot check, BMI, urine albumin, smoking status) prevents the complications that drive emergency admissions, amputations and premature death.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: NHS Digital, National Diabetes Audit April 2024 to March 2025 Report 1

Figure 1.107: Diabetes: all 8 care processes: England trend



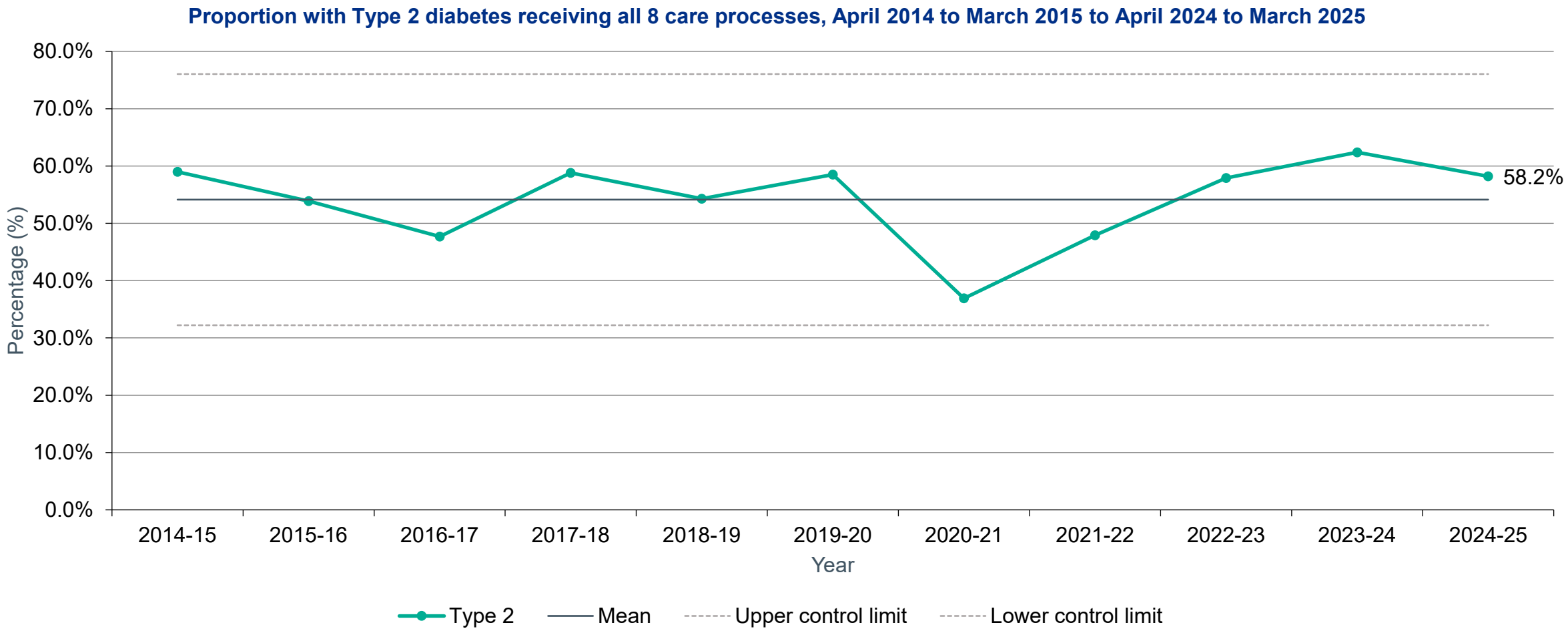
Source: NHS Digital, National Diabetes Audit April 2024 to March 2025 Report 1

Diabetes: all 8 care processes

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people with Type 1 and Type 2 diabetes who received all eight NICE-recommended care processes in the audit year, from the National Diabetes Audit annual report.

Figure 1.108: Diabetes: all 8 care processes: England trend



Source: NHS Digital, National Diabetes Audit April 2024 to March 2025 Report 1

Diabetes: HbA1c target achievement

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people with Type 1 and Type 2 diabetes achieving the National Institute for Health and Care Excellence (NICE)-recommended HbA1c target of 58 mmol/mol or below, from the National Diabetes Audit.

Why it matters for the strategy

• We track HbA1c target achievement because it is the primary treatment outcome for diabetes, distinct from care process completion (DIABETES_8CP). Achieving glycaemic control prevents microvascular complications (retinopathy, nephropathy, neuropathy) and reduces macrovascular risk.
• The latest figure for England (April 2024 to March 2025) is 41.5 (T1), 64.7 (T2) %.
• This is getting better: T1: 41.5% achieving HbA1c <=58 mmol/mol, T2: 64.7%. Broadly stable over the long term, recovering from the dip in April 2020 to March 2021 (T1 down to ~35%, T2 to ~59%). Up from 39.8%/64.2% in April 2023 to March 2024. 3 Treatment Targets (HbA1c+blood pressure (BP)+cholesterol): T1 30.7%, T2 45.2%.
• Performance varies across NHS Regions: the best-performing area (London) achieved 45.4%, while the lowest (North East and Yorkshire) achieved 39.1% (Type 1).
• Reaching glycaemic targets prevents microvascular complications (retinopathy, nephropathy, neuropathy) and reduces macrovascular risk.
• Treatment-outcome signal for the strategy's diabetes pathway. Companion to diabetes 8CP in Core.
• Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

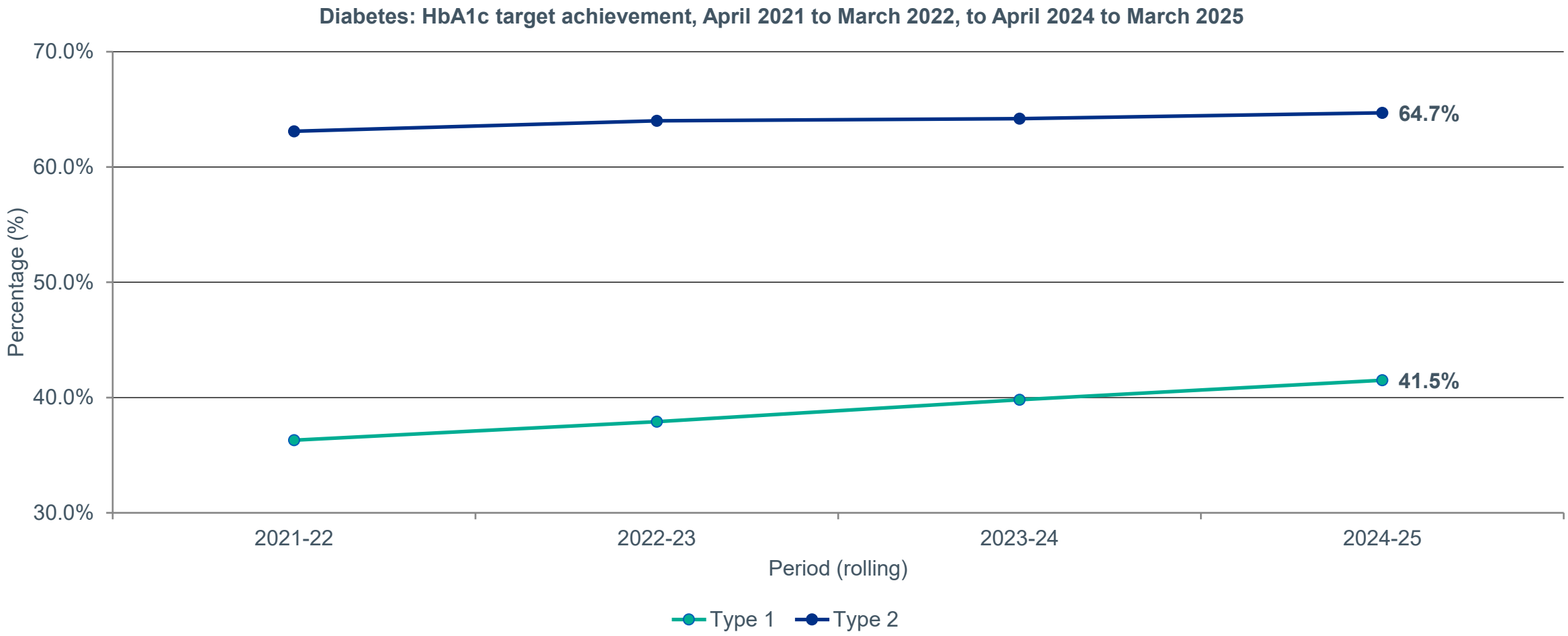
Source: NHS Digital, National Diabetes Audit April 2024 to March 2025 Report 1

Diabetes: HbA1c target achievement

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people with Type 1 and Type 2 diabetes achieving the NICE-recommended HbA1c target of 58 mmol/mol or below, from the National Diabetes Audit.

Figure 1.109: Diabetes: HbA1c target achievement: England trend



Source: NHS Digital, National Diabetes Audit April 2024 to March 2025 Report 1

Diabetes lower-limb amputations (major)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Rate of major lower-limb amputations among people on the diabetes register, expressed per 1,000 diabetes register population, from the National Diabetes Audit Complications dashboard.

Why it matters for the strategy

• We track diabetes-related major amputations because they represent the most severe consequence of poor foot care and glycaemic control, and are largely preventable through systematic screening and multi-disciplinary foot teams.
• The latest figure for England (2022) is 1.4 (T1), 0.7 (T2) per 1,000 diabetes register.
• The picture is mixed, with type 1 fluctuating and 0.3 per 1,000 lower in 2023 compared to 2009 (1.7). Type 2 is 0.1 lower than in 2009 (0.8) but increased for the first time in 2023 compared to previous years.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

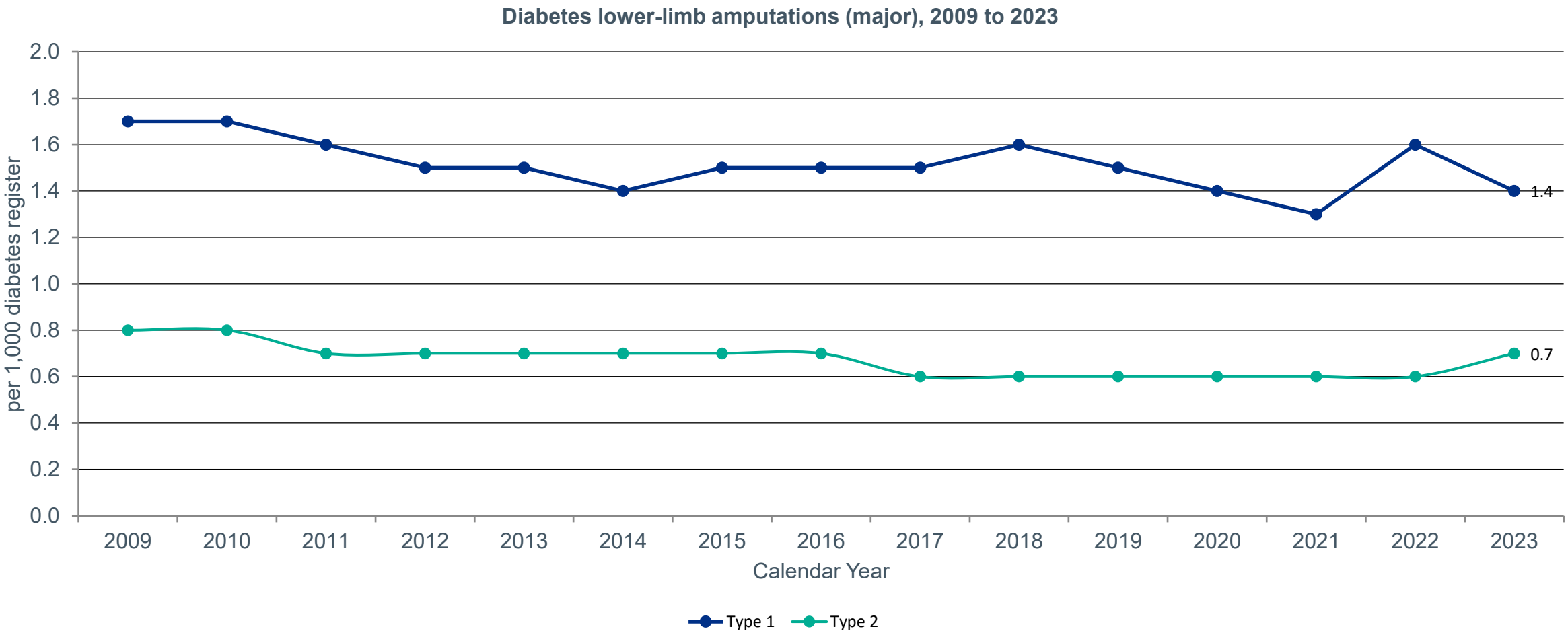
Source: National Diabetes Audit complications dashboard (major lower-limb amputation procedures for people with diabetes, 17+)

Diabetes lower-limb amputations (major)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Rate of major lower-limb amputations among people on the diabetes register, expressed per 1,000 diabetes register population, from the National Diabetes Audit Complications dashboard.

Figure 1.110: Diabetes lower-limb amputations (major): England trend



Source: National Diabetes Audit complications dashboard (major lower-limb amputation procedures for people with diabetes, 17+)

Diabetic eye screening uptake

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people with diabetes who attended their diabetic eye screening appointment, from the Diabetic Eye Screening Programme via Office for Health Improvement and Disparities (OHID) Fingertips indicator 92318.

Why it matters for the strategy

• We track diabetic retinopathy screening because it is the most established diabetes complication screening programme, and uptake reflects both the effectiveness of the screening system and patients' engagement with long-term condition management.
• The latest figure for England (April 2023 to March 2024) is 80.8%.
• The picture is mixed: 80.8% uptake of diabetic eye screening in April 2023 to March 2024, increase from 67.9% in April 2020 to March 2021 but down from 82.6% pre-pandemic (2018-19). Recovery continuing post-COVID, now above 80% national standard.
• Established complication-screening signal. Sub-indicator of diabetes 8CP in Core.

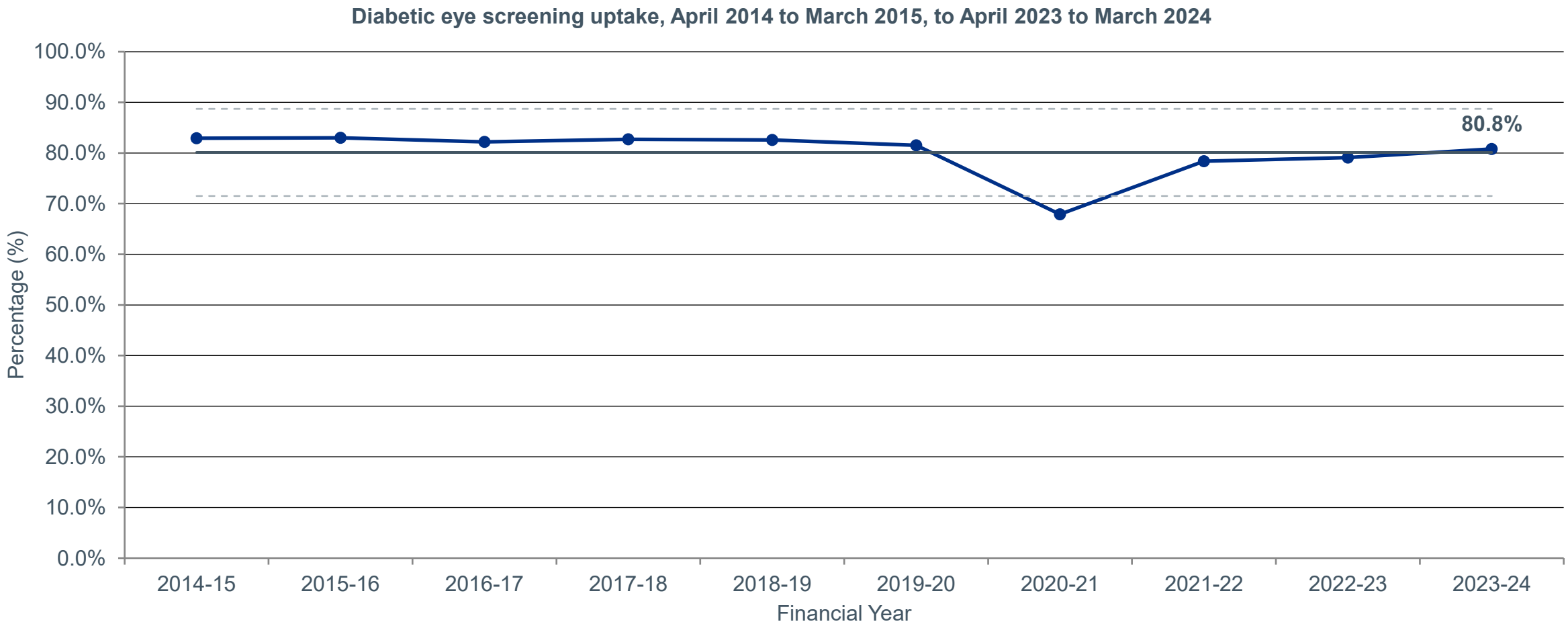
Source: NHS Diabetic Eye Screening Programme (DESP), annual data April 2022 to March 2023 (GOV.UK). Also reported in National Diabetes Audit (NDA) Report 1 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Diabetic eye screening uptake

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of people with diabetes who attended their diabetic eye screening appointment, from the Diabetic Eye Screening Programme via OHID Fingertips indicator 92318.

Figure 1.111: Diabetic eye screening uptake: England trend



Source: NHS Diabetic Eye Screening Programme (DESP), annual data April 2022 to March 2023 (GOV.UK). Also reported in NDA Report 1 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Quality and Outcomes Framework (QOF) overall achievement rate

Effectiveness | Tier 2: Driver | ↑ Higher is better

Overall QOF achievement rate.

Why it matters for the strategy

- The latest figure for England (April 2024 to March 2025) is 93.8%.
- Trend: 93.8% (April 2024 to March 2025). The picture is mixed - QOF overall achievement is up 3.4 percentage points from April 2022 to March 2023 (90.4%) to April 2024 to March 2025 (93.8%), but 3.1% down on April 2011 to March 2012 (96.9%)
- A pragmatic single number that signals how consistently evidence-based chronic disease care is being delivered at scale.

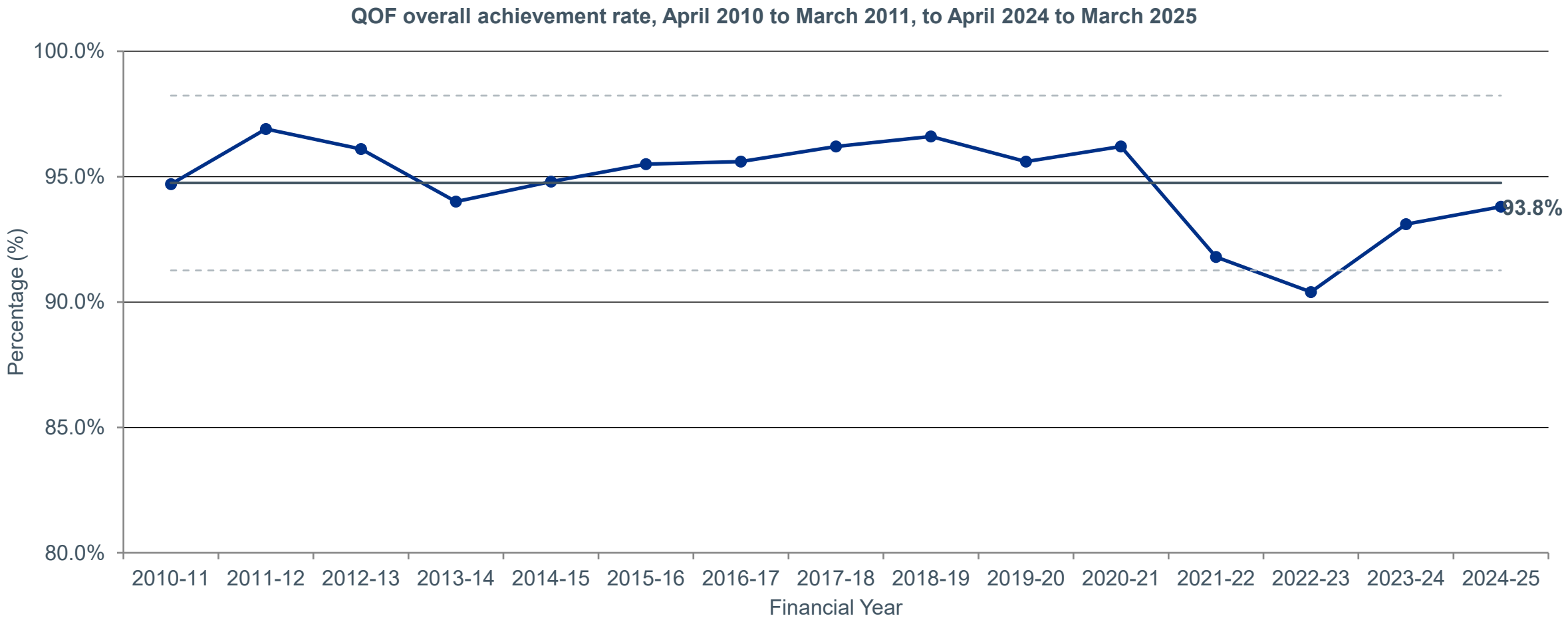
Source: Office for Health Improvement and Disparities (OHID) Fingertips [295] - QOF | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

QOF overall achievement rate

Effectiveness | Tier 2: Driver | ↑ Higher is better

Overall QOF achievement rate.

Figure 1.112: QOF overall achievement rate: England trend



Source: OHID Fingertips [295] - QOF | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Alcohol and drug-related deaths

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised mortality rates for alcohol-specific deaths and drug misuse deaths in England, expressed per 100,000 population (Office for Health Improvement and Disparities (OHID) Fingertips indicators 91380 and 92432).

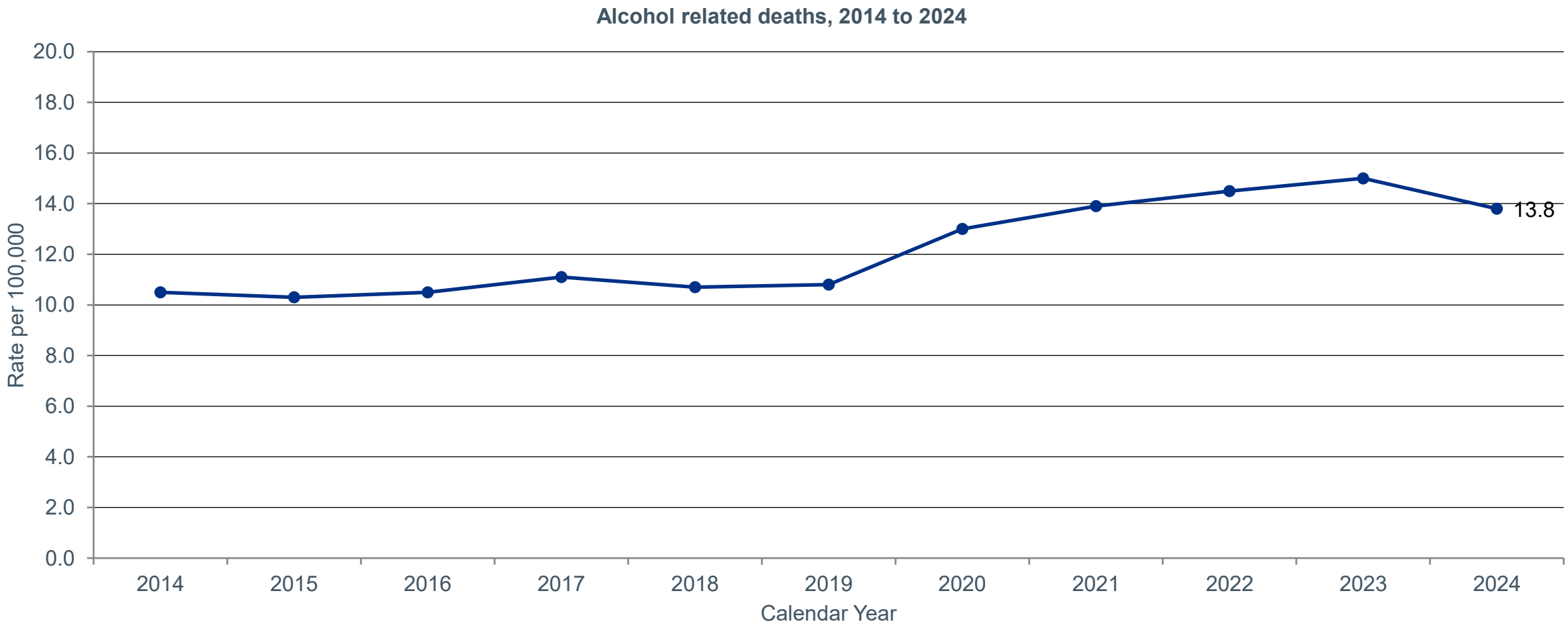
Why it matters for the strategy

• We track alcohol-specific and drug-related mortality because these deaths have risen significantly (alcohol mortality up 28% and drug deaths up 14% since 2019), are heavily concentrated in the most deprived communities, and are a major driver of the widening life expectancy gap. This is a long-term outcome; addiction treatment and prevention take years to affect mortality rates.
• The latest figure for England (2024) is 13.8 per 100,000.
• This is getting worse: Alcohol-specific mortality 13.8 per 100,000 (2024), up 3.0 per 100,000 from 2019 (10.8). Drug misuse deaths 5.9 per 100,000 (2022 to 2024), up 1.6 per 100,000 from 2014 to 2016 (4.3).
• People in the most deprived areas have a rate of 19.5 alcohol related deaths per 100,000, around double that in the least deprived areas (9.5). For drug-related deaths, the rate varies from 9.0 per 100,000 in the most deprived areas to 3.4 per 100,000 in least deprived areas
• Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

Source: OHID Fingertips indicator 91380 (alcohol-specific mortality, 2024) and indicator 92432 (drug misuse deaths, 2022 to 2024). NHS regional variation: 5 regions from Fingertips E40 area type

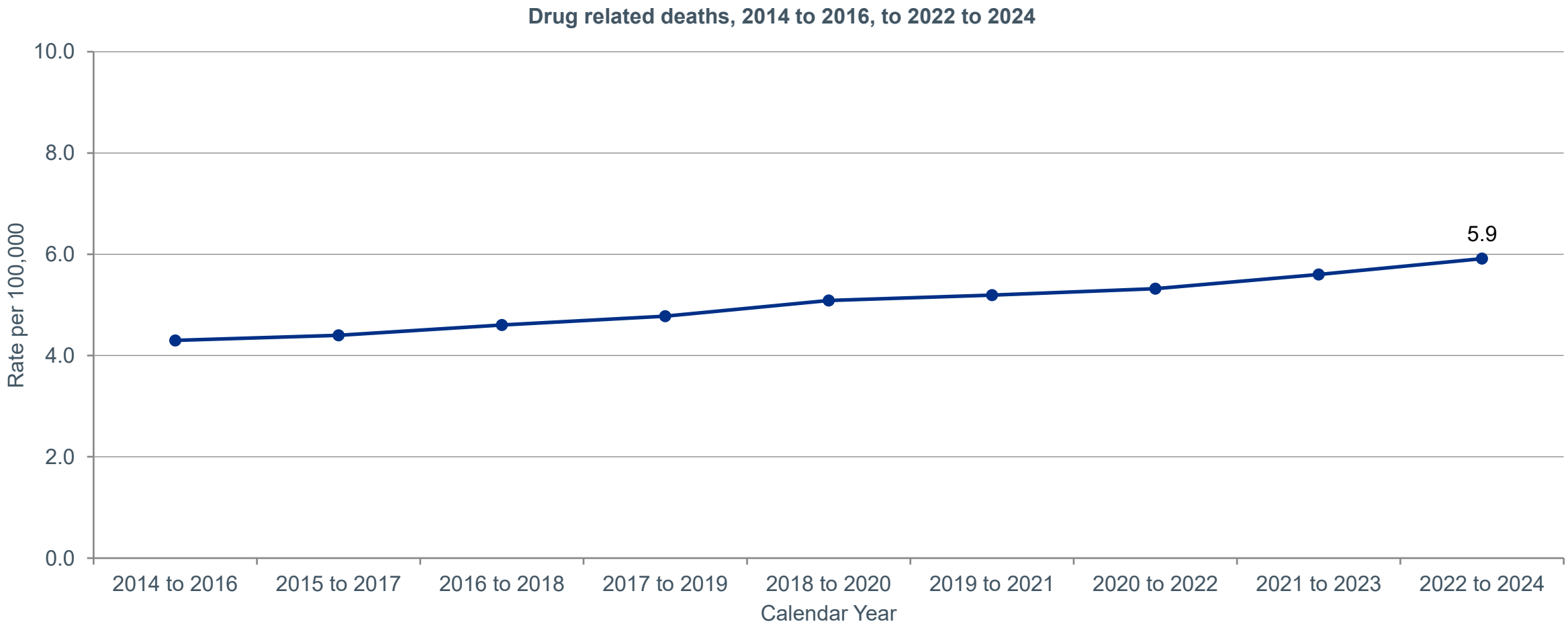
Age-standardised mortality rates for alcohol-specific deaths and drug misuse deaths in England, expressed per 100,000 population (OHID Fingertips indicators 91380 and 92432).

Figure 1.113: Alcohol and drug-related deaths: England trend



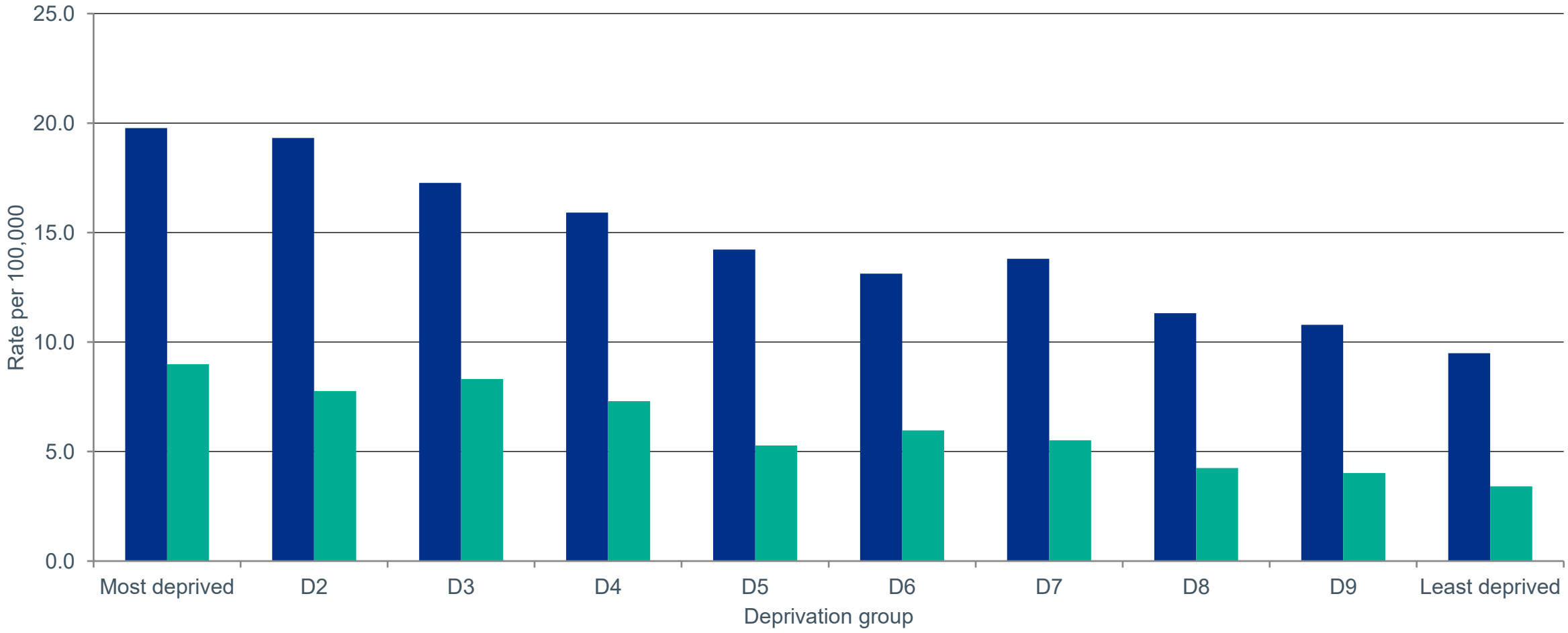
Source: OHID Fingertips indicator 91380 (alcohol-specific mortality, 2024) and indicator 92432 (drug misuse deaths, 2022 to 2024). NHS regional variation: 5 regions from Fingertips E40 area type

Figure 1.114: Alcohol and drug-related deaths: England trend



Source: OHID Fingertips indicator 91380 (alcohol-specific mortality, 2024) and indicator 92432 (drug misuse deaths, 2022 to 2024). NHS regional variation: 5 regions from Fingertips E40 area type

Figure 1.115: Alcohol and drug deaths by deprivation group (2024 Index of Multiple Deprivation (IMD) decile)



Source: OHID Fingertips indicator 91380 (alcohol-specific mortality, 2024) and indicator 92432 (drug misuse deaths, 2022 to 2024). NHS regional variation: 5 regions from Fingertips E40 area type

Smoking prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England who currently smoke, based on clinical interview and cotinine validation in the Health Survey for England.

Why it matters for the strategy

• We track smoking prevalence because tobacco remains the single largest modifiable risk factor for premature death, health inequality, and years of life lived in poor health. Reducing prevalence is the highest-impact prevention lever for healthy life expectancy (HLE) and life expectancy (LE). Population prevalence is a long-term outcome; a 1pp/year decline is typical.
• The latest figure for England (2024) is 11.3%.
• This is getting better: Year on year decreases - down 12% from 2004 (23.3%) to 2024 (11.3%).
• Performance varies across NHS Regions: the lowest recorded prevalence was 9.9% (South East) had a rate of 9.9%, while the highest recorded was 11.6% (North East and Yorkshire, and Midlands)
• People in the most deprived areas have a rate of 17.5%, compared with 7.2% in the least deprived - a gap of 10.3%.

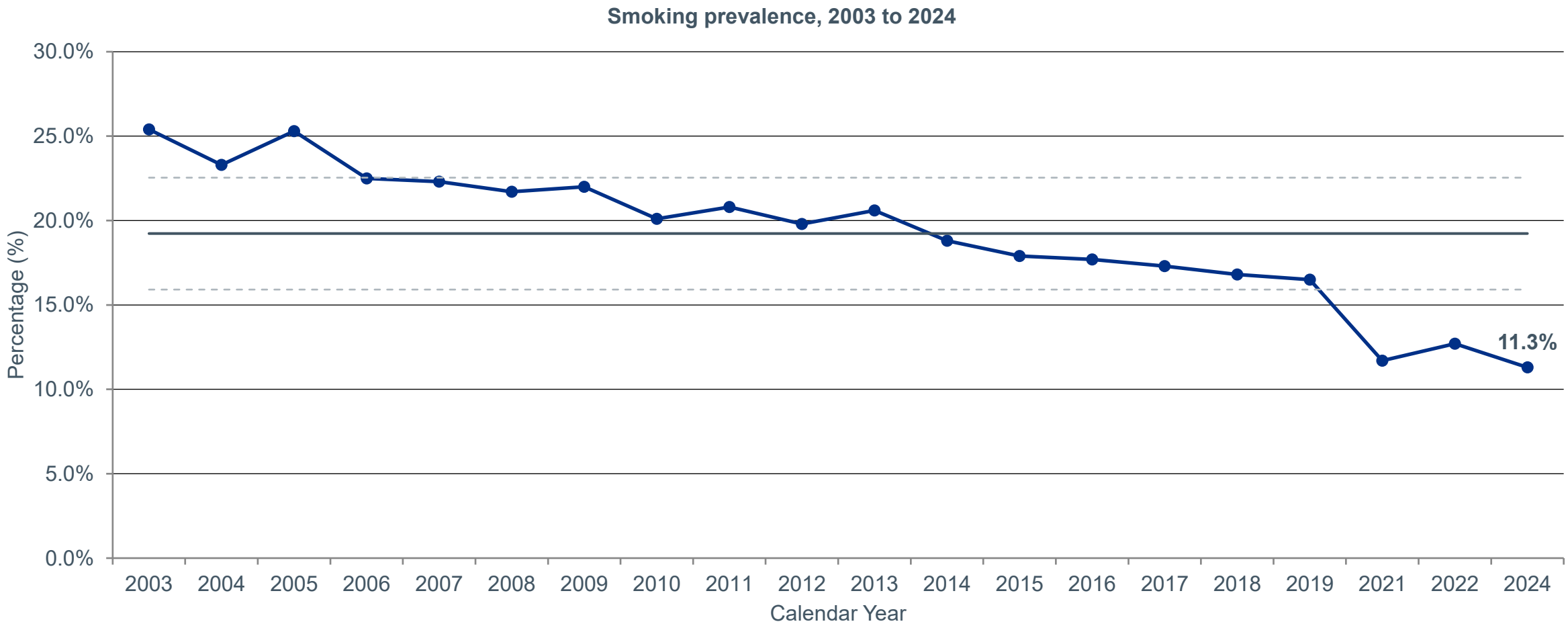
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Smoking prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England who currently smoke, based on clinical interview and cotinine validation in the Health Survey for England.

Figure 1.116: Smoking prevalence: England trend



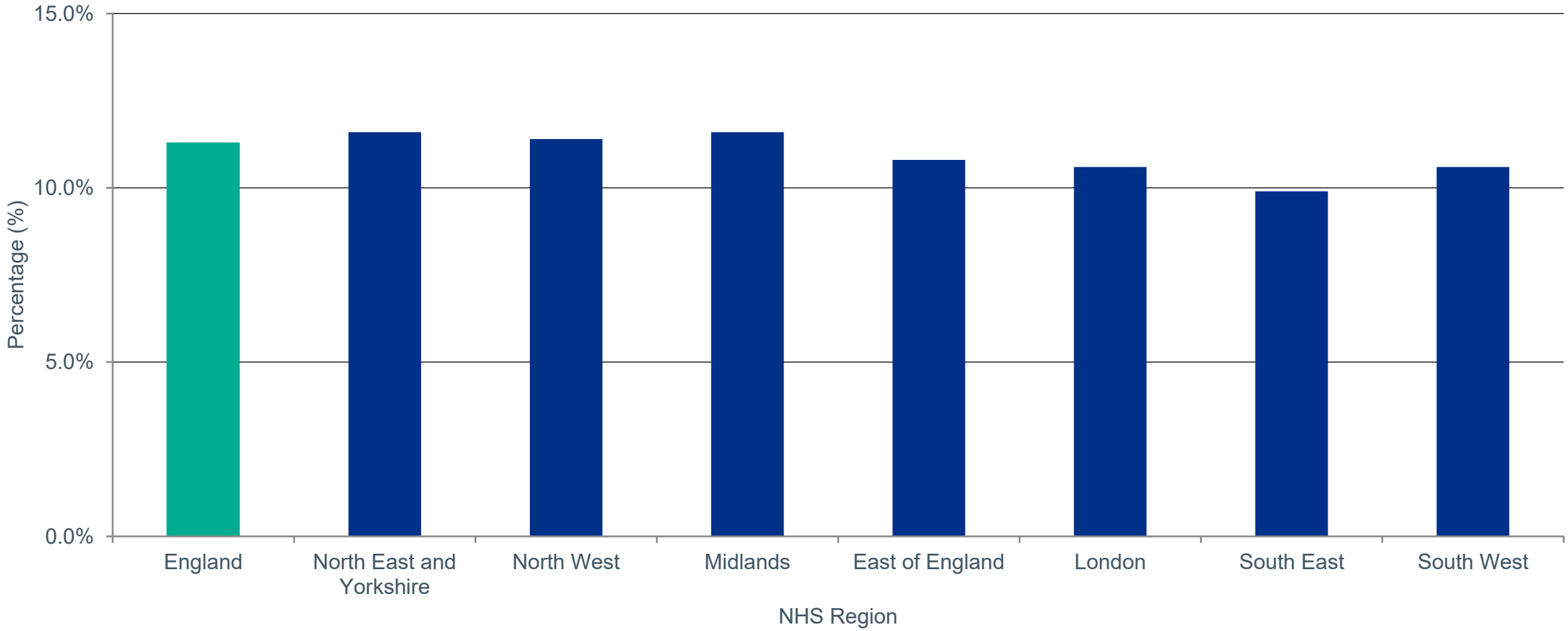
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Smoking prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England who currently smoke, based on clinical interview and cotinine validation in the Health Survey for England.

Figure 1.117: Smoking prevalence by NHS Region



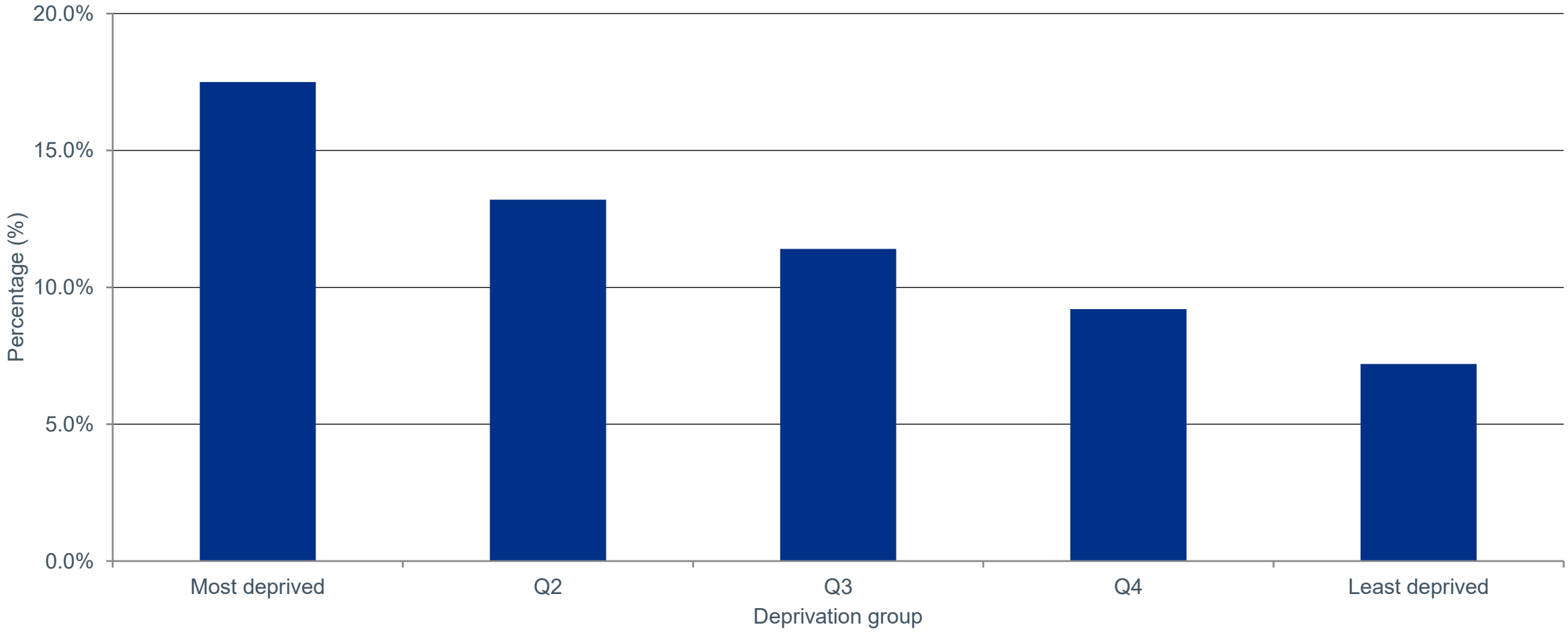
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Smoking prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England who currently smoke, based on clinical interview and cotinine validation in the Health Survey for England.

Figure 1.118: Smoking prevalence by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Obesity prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England classified as obese (body mass index (BMI) 30 or above), based on clinical measurements in the Health Survey for England.

Why it matters for the strategy

• We track obesity prevalence because excess weight is the second largest modifiable risk factor for premature mortality and a major driver of type 2 diabetes, cardiovascular disease (CVD), cancer, and musculoskeletal (MSK) disease, all of which degrade healthy life expectancy. Population obesity is a long-term outcome; it is extremely resistant to intervention and takes decades to shift at scale.
• The latest figure for England (2024) is 29.9%.
• This is getting worse, increasing by around 7% from 2009 (23.0%) to 2024 (29.9%).
• Performance varies across NHS Regions: the best-performing area (London) had a rate of 21.1%, while the worst (North East and Yorkshire) had 34.7%.
• People in the most deprived areas have a rate of 37.8%, compared with 25.3 in the least deprived - a gap of 12.5%.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

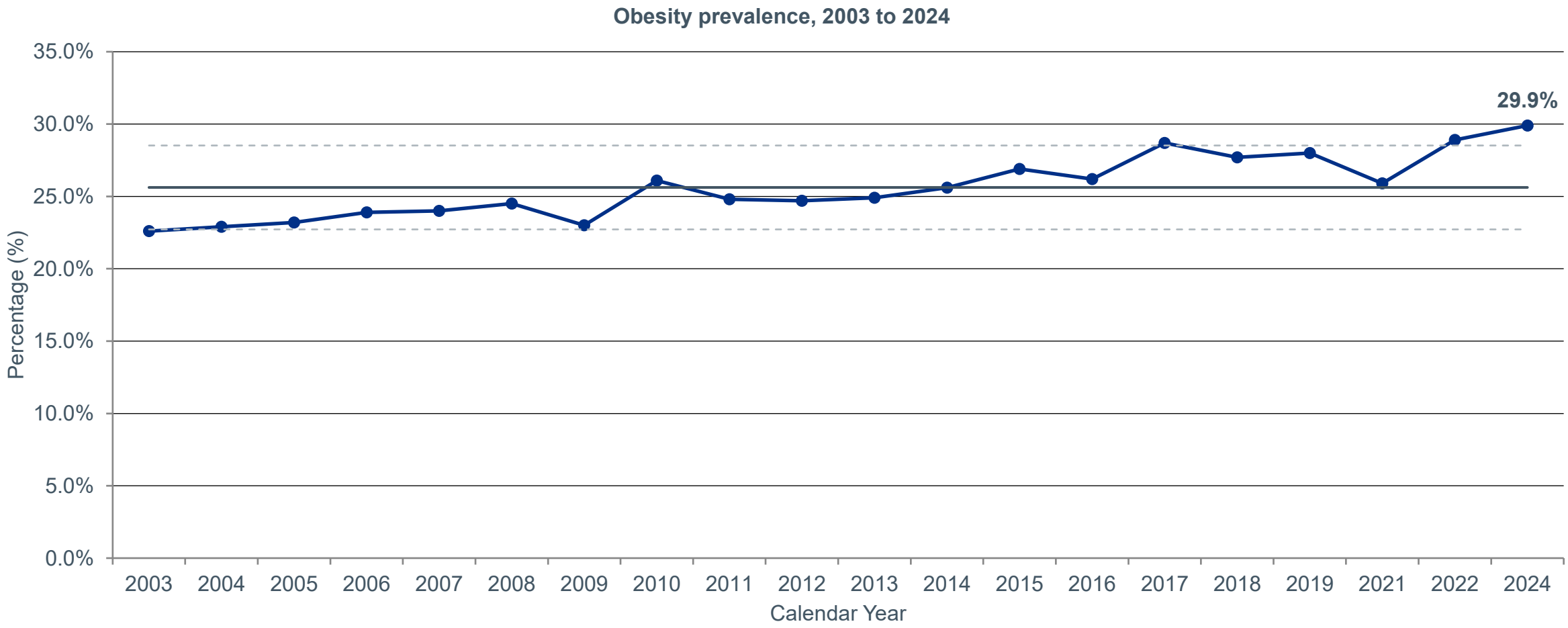
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Obesity prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England classified as obese (BMI 30 or above), based on clinical measurements in the Health Survey for England.

Figure 1.119: Obesity prevalence: England trend



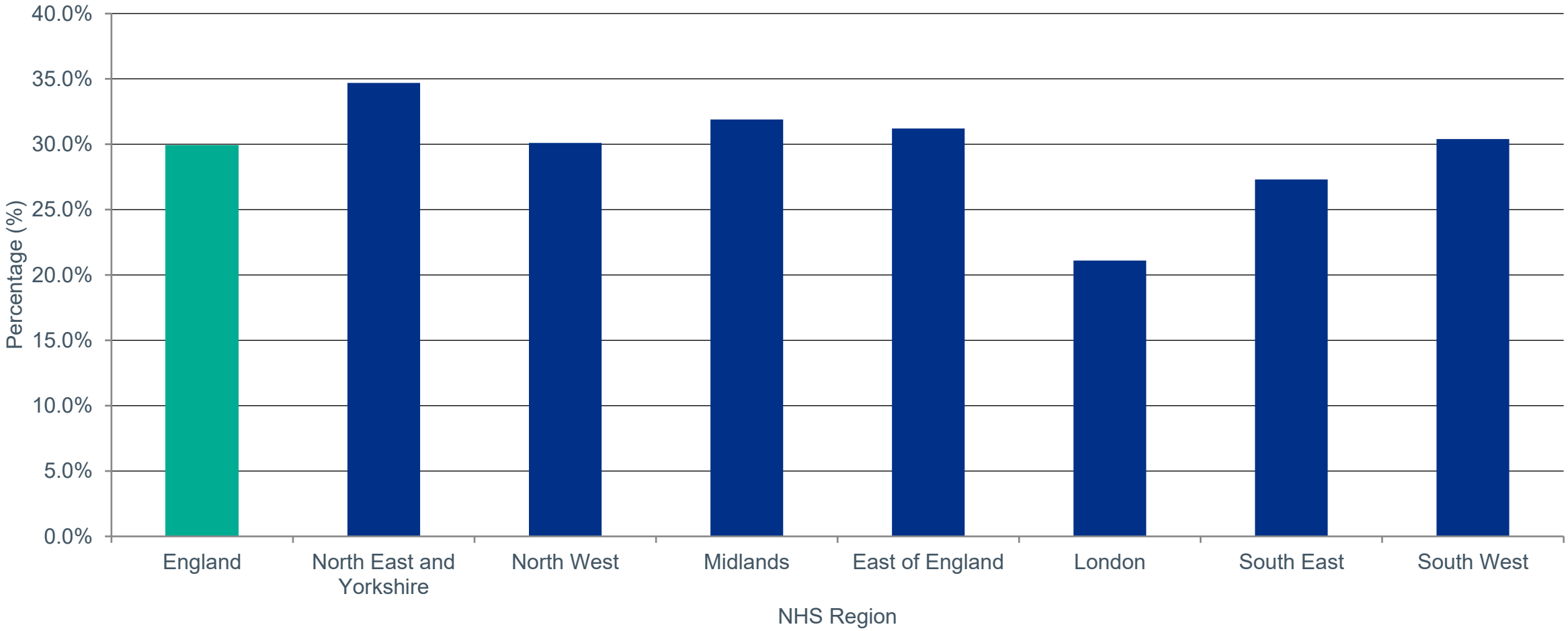
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Obesity prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England classified as obese (BMI 30 or above), based on clinical measurements in the Health Survey for England.

Figure 1.120: Obesity prevalence by NHS Region



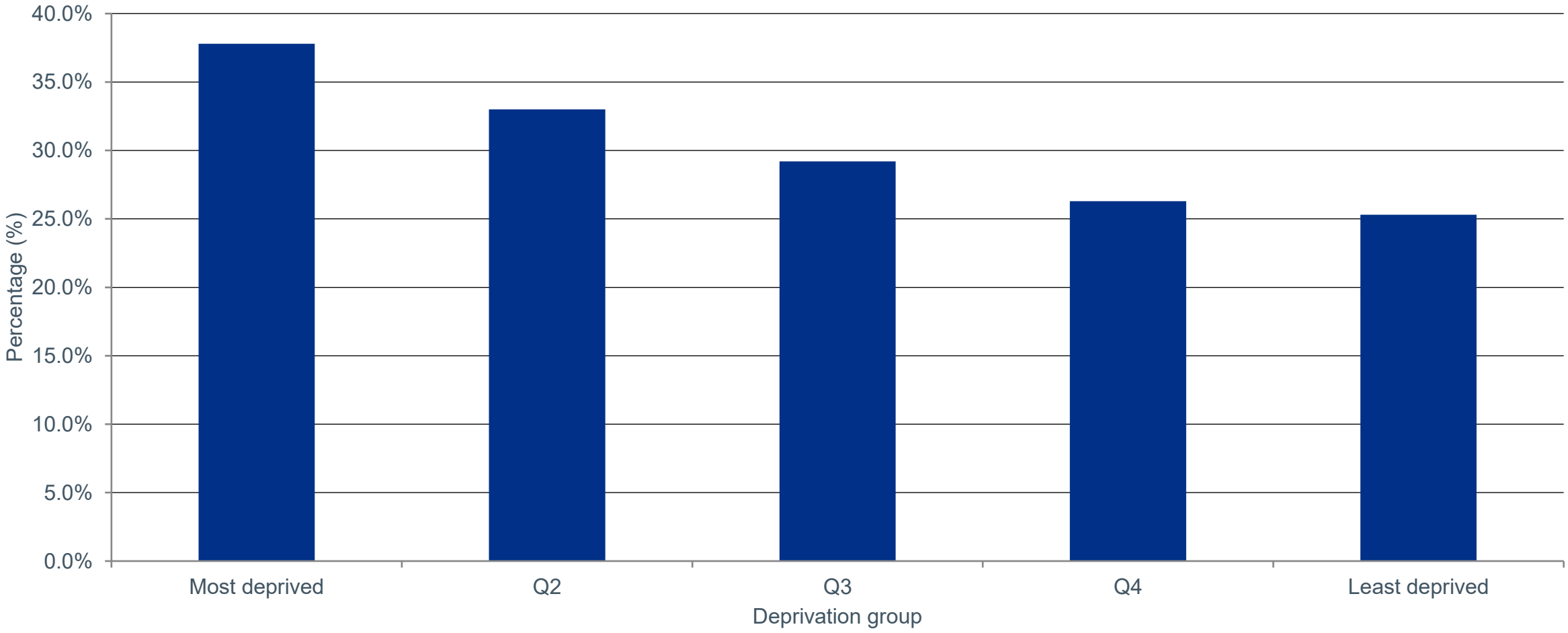
Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Obesity prevalence

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of adults in England classified as obese (BMI 30 or above), based on clinical measurements in the Health Survey for England.

Figure 1.121: Obesity prevalence by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: NHS Digital, Health Survey for England 2024 (Jan 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Childhood obesity (Year 6)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of children in Year 6 (age 10 to 11) classified as obese in England, from the National Child Measurement Programme via Office for Health Improvement and Disparities (OHID) Fingertips indicator 90323.

Why it matters for the strategy

• We track childhood obesity because obese children are five times more likely to become obese adults, embedding future demand for diabetes, cardiovascular disease (CVD), and musculoskeletal (MSK) services; Year 6 prevalence is the most robust population-level measure. The current trend is deteriorating, with Year 6 obesity prevalence rising.
• The latest figure for England (April 2024 to March 2025) is 22.2%.
• This is getting worse: 22.2% of Year 6 children (age 10 to 11) classified as obese in April 2024 to March 2025 (133,553 children). Up 1.2pp from pre-pandemic April 2019 to March 2020 (21.0%).
• Performance varies across Regions (April 2024 to March 2025 data): the best-performing area (South East) had a rate of 19.2%, while the worst (North East) had 25.0% - a gap of 5.8%
• People in the most deprived areas have a rate of 29.3%, compared with 13.5 in the least deprived - a gap of 15.8%.
• strategy Prevention priority. National Child Measurement Programme.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

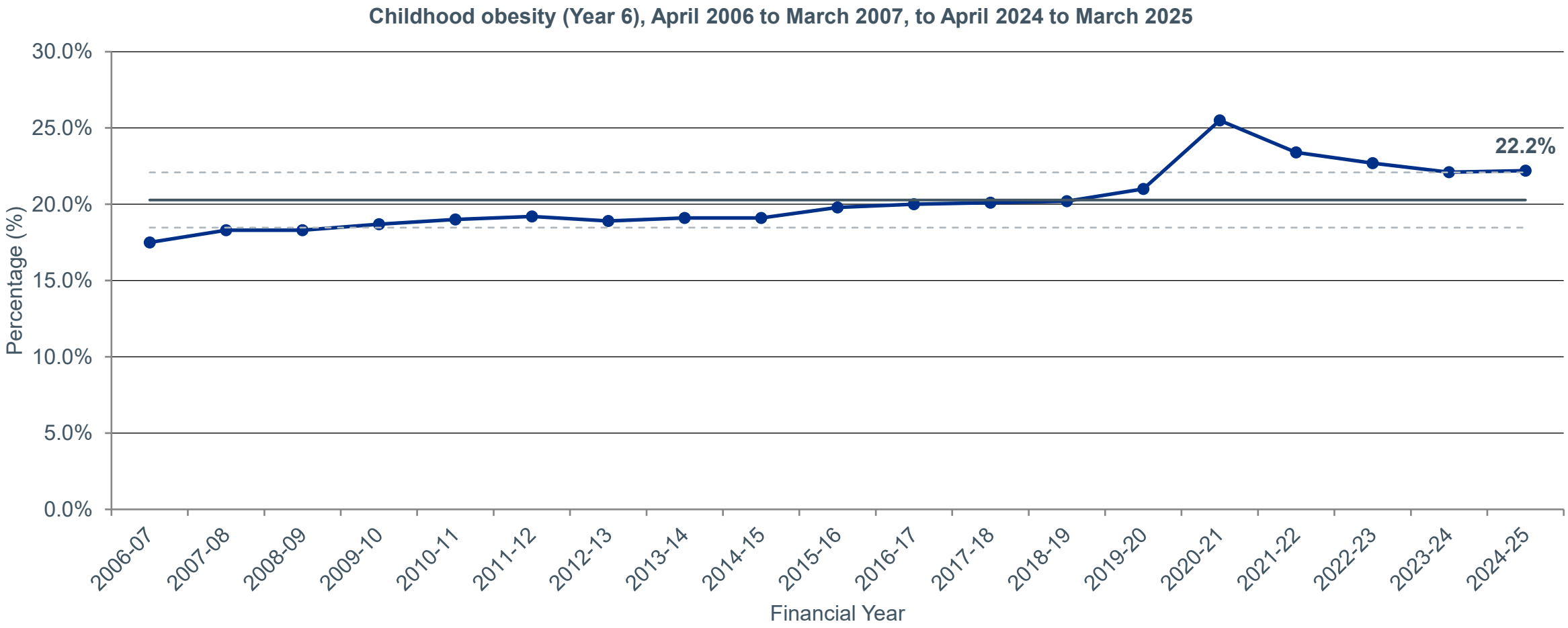
Source: OHID Fingertips indicator 90323, National Child Measurement Programme (NCMP) Year 6 obesity prevalence (April 2024 to March 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Childhood obesity (Year 6)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of children in Year 6 (age 10 to 11) classified as obese in England, from the National Child Measurement Programme via OHID Fingertips indicator 90323.

Figure 1.122: Childhood obesity (Year 6): England trend



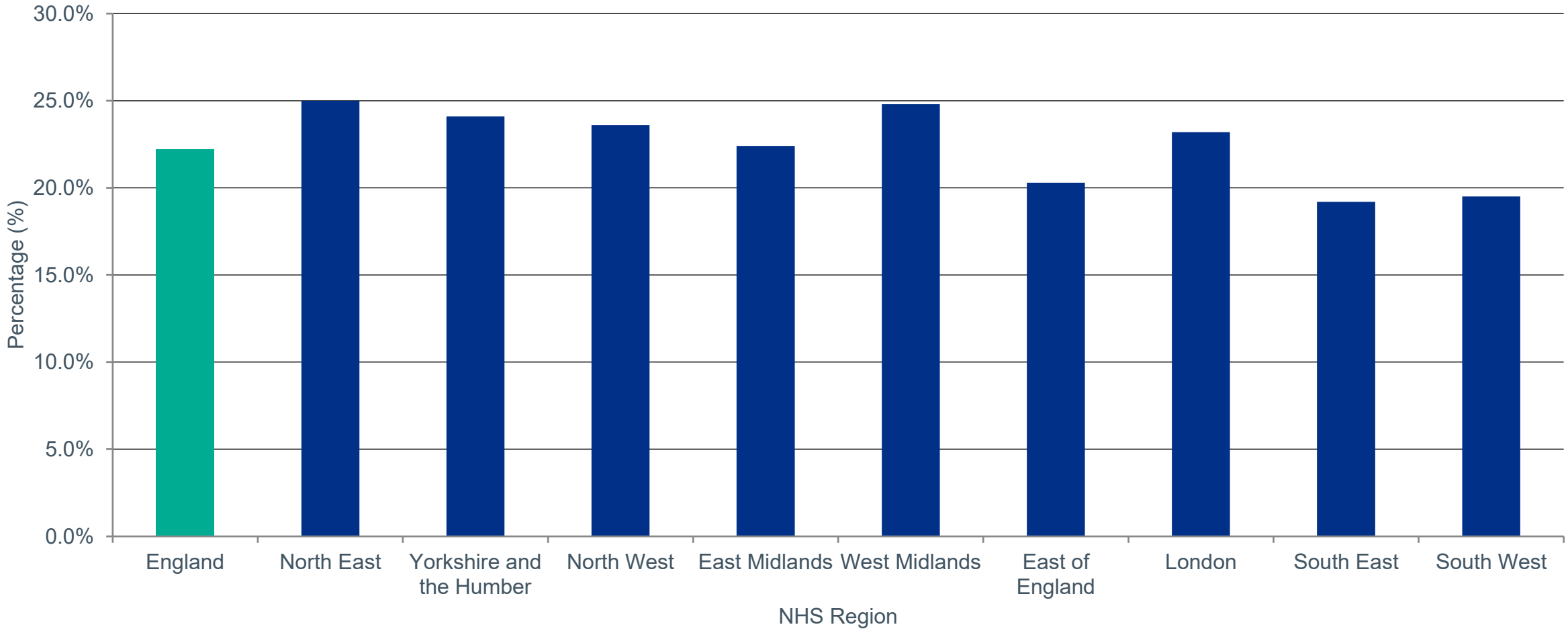
Source: OHID Fingertips indicator 90323, NCMP Year 6 obesity prevalence (April 2024 to March 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Childhood obesity (Year 6)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of children in Year 6 (age 10 to 11) classified as obese in England, from the National Child Measurement Programme via OHID Fingertips indicator 90323.

Figure 1.123: Childhood obesity (Year 6) by Region, April 2024 to March 2025



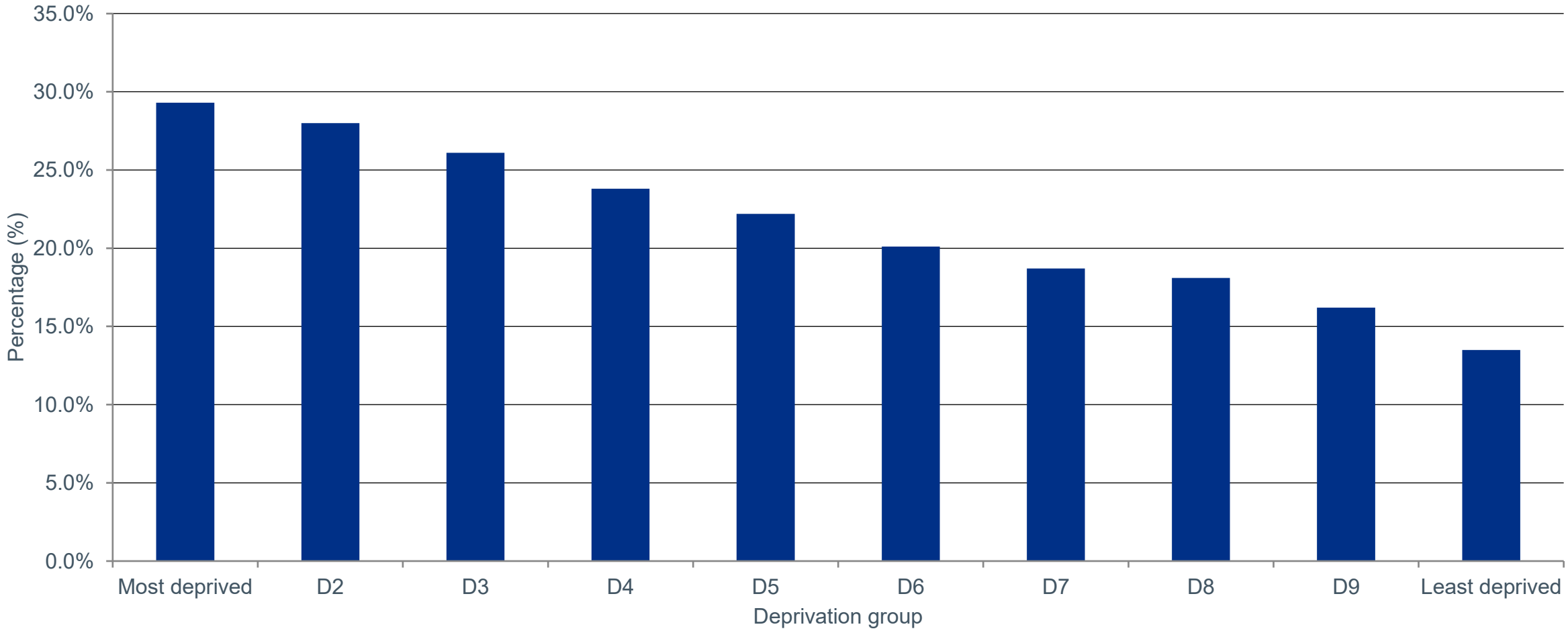
Source: OHID Fingertips indicator 90323, NCMP Year 6 obesity prevalence (April 2024 to March 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Childhood obesity (Year 6)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of children in Year 6 (age 10 to 11) classified as obese in England, from the National Child Measurement Programme via OHID Fingertips indicator 90323.

Figure 1.124: Childhood obesity (Year 6) by deprivation group (Index of Multiple Deprivation (IMD) decile) – April 2024 to March 2025



Source: OHID Fingertips indicator 90323, NCMP Year 6 obesity prevalence (April 2024 to March 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Childhood vaccination: diphtheria, tetanus and pertussis (DTaP)/inactivated polio vaccine (IPV)/Haemophilus influenzae type b (Hib)/hepatitis B (HepB) at 2 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of children receiving routine vaccinations by the target age in England, including DTaP/IPV/Hib/HepB at 2 years and measles, mumps and rubella (MMR) at 2 and 5 years, from the UK Health Security Agency (UKHSA) Cover of Vaccination Evaluated Rapidly (COVER) programme via Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• We track childhood vaccination coverage because it is the single most cost-effective public health intervention, and falling coverage risks outbreaks of preventable diseases that disproportionately affect deprived communities. The current trend is getting worse, with coverage falling below herd immunity thresholds.
• The latest figure for England (April 2024 to March 2025) is 92.5%.
• Trend: 92.5% DTaP/IPV/Hib/HepB coverage at 2 years in April 2024 to March 2025 (Fingertips 30304). Below 95% World Health Organization (WHO) target. MMR dose 1 at 2yr: 88.9% (30309). MMR two-dose coverage at 5 years only 83.7% (30311) and declining. integrated care board (ICB) variation significant. 15-year trend available (April 2010 to March 2011, to April 2024 to March 2025). Note: trend charts show DTaP only; MMR figures are quoted here for context.
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (South West) achieved 94.9%, while the lowest (London) achieved 87.1% (DTaP/IPV/Hib/HepB at 2yr).
• People in the least deprived areas achieve 87.9%, compared with 79.0% in the most deprived - a gap of 8.9%.
• Falling coverage, particularly for MMR, opens the door to outbreaks of preventable diseases that fall hardest on deprived communities.
• strategy Prevention priority. Population protection driver.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

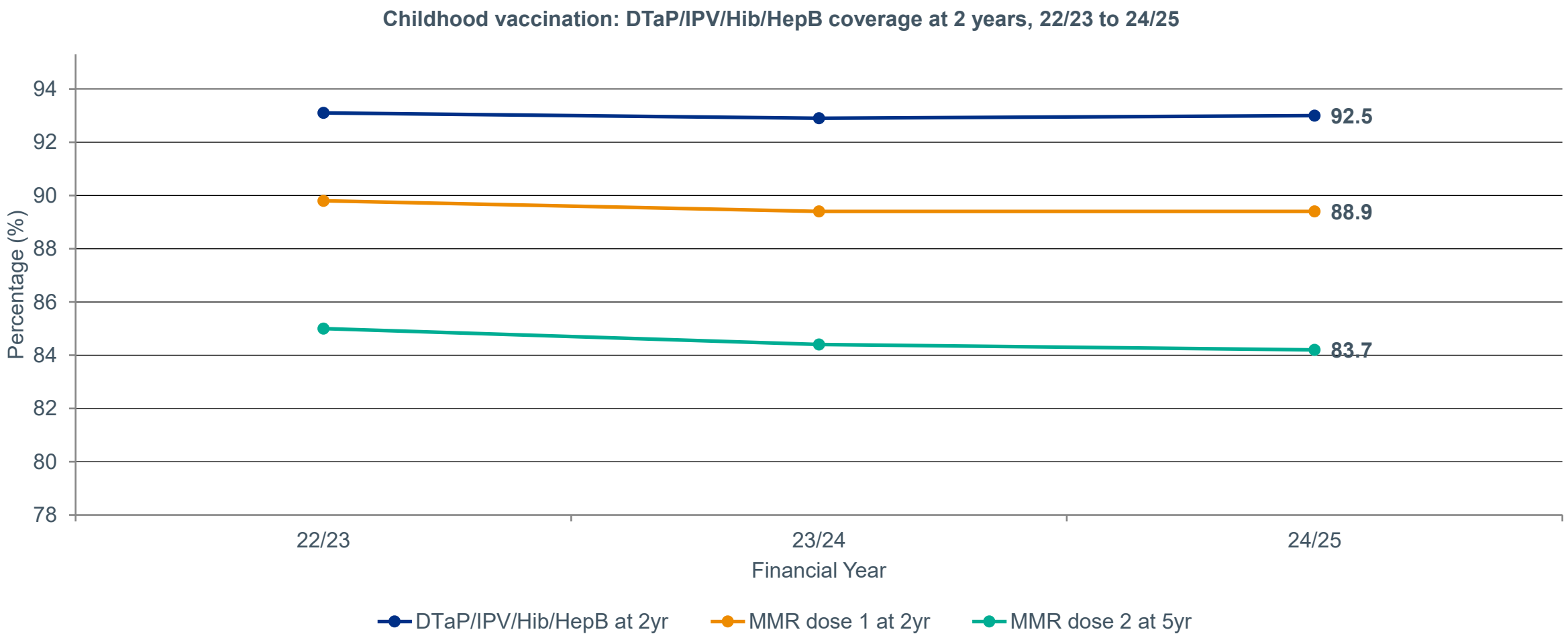
Source: OHID Fingertips indicators 30304 (DTaP/IPV/Hib/HepB 2yr), 30309 (MMR1 2yr), 30311 (MMR2 5yr). UKHSA COVER programme

Childhood vaccination: DTaP/IPV/Hib/HepB at 2 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of children receiving routine vaccinations by the target age in England, including DTaP/IPV/Hib/HepB at 2 years and MMR at 2 and 5 years, from the UKHSA COVER programme via OHID Fingertips.

Figure 1.125: Childhood vaccination: DTaP/IPV/Hib/HepB at 2 years: England trend



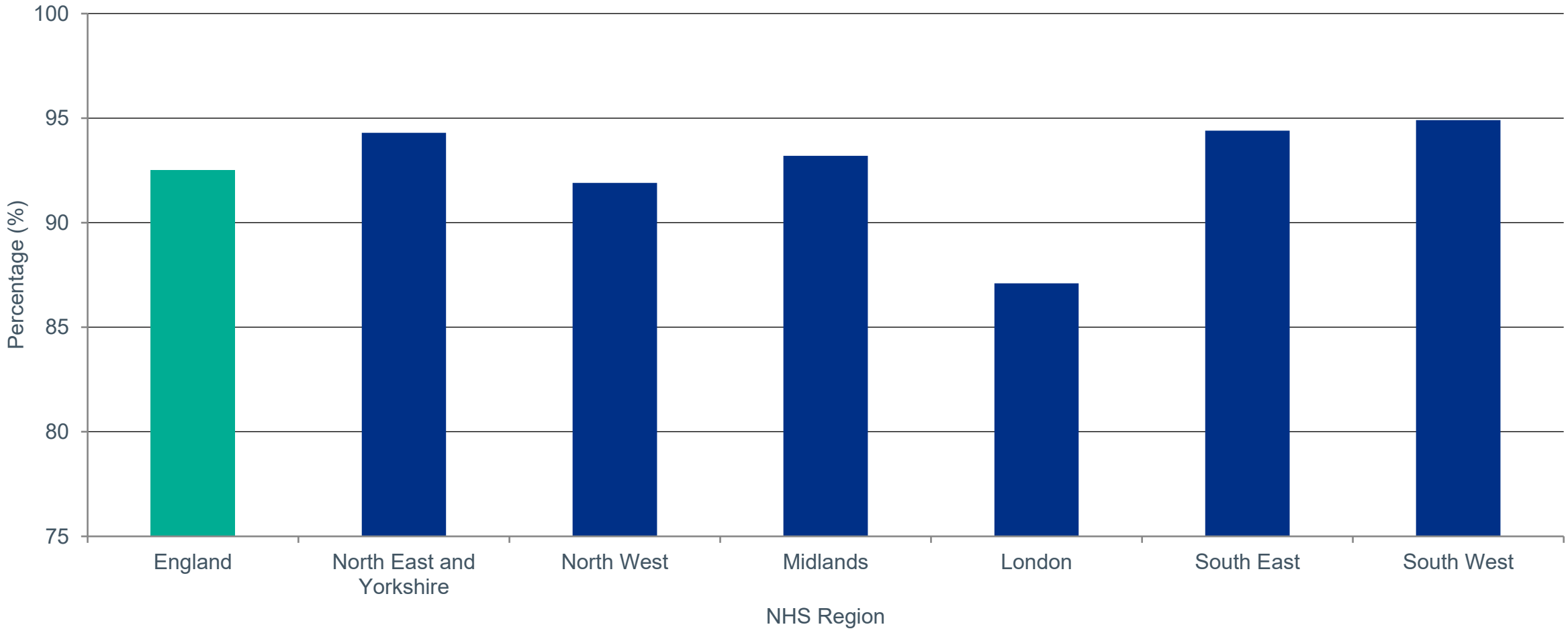
Source: OHID Fingertips indicators 30304 (DTaP/IPV/Hib/HepB 2yr), 30309 (MMR1 2yr), 30311 (MMR2 5yr). UKHSA COVER programme

Childhood vaccination: DTaP/IPV/Hib/HepB at 2 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of children receiving routine vaccinations by the target age in England, including DTaP/IPV/Hib/HepB at 2 years and MMR at 2 and 5 years, from the UKHSA COVER programme via OHID Fingertips.

Figure 1.126: Childhood vaccination: DTaP/IPV/Hib/HepB coverage at 2 years by NHS Region



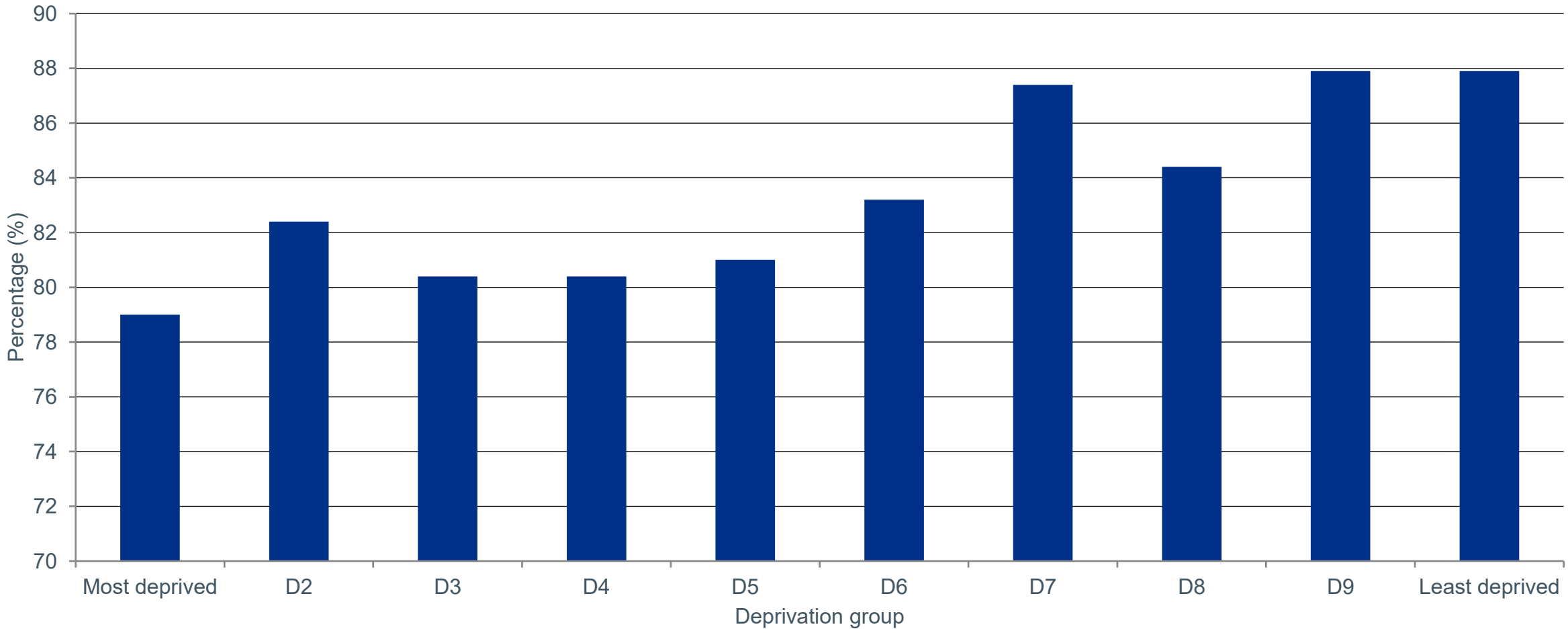
Source: OHID Fingertips indicators 30304 (DTaP/IPV/Hib/HepB 2yr), 30309 (MMR1 2yr), 30311 (MMR2 5yr). UKHSA COVER programme

Childhood vaccination: DTaP/IPV/Hib/HepB at 2 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of children receiving routine vaccinations by the target age in England, including DTaP/IPV/Hib/HepB at 2 years and MMR at 2 and 5 years, from the UKHSA COVER programme via OHID Fingertips.

Figure 1.127: Childhood vaccination: DTaP/IPV/Hib/HepB coverage at 2 years by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: OHID Fingertips indicators 30304 (DTaP/IPV/Hib/HepB 2yr), 30309 (MMR1 2yr), 30311 (MMR2 5yr). UKHSA COVER programme

Human papillomavirus (HPV) vaccination coverage: one dose at 12 to 13 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

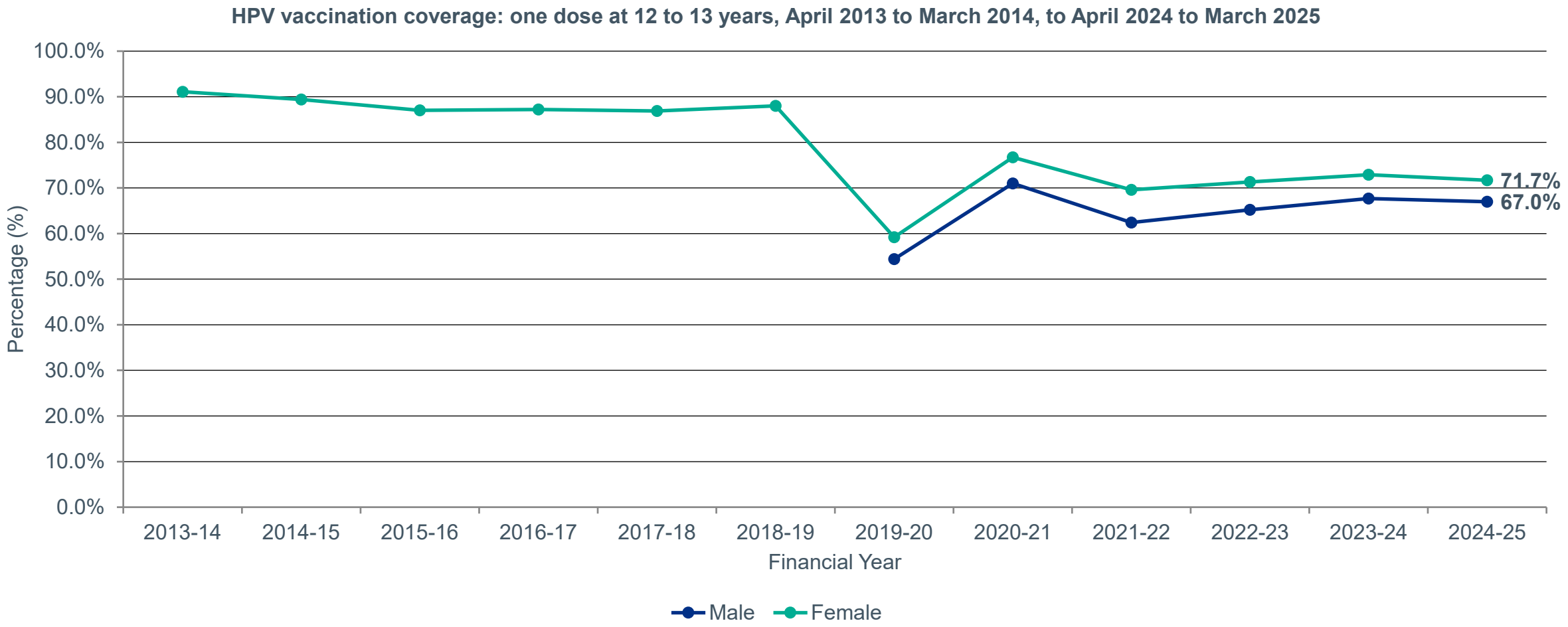
Proportion of 12 to 13 year olds in England who received one dose of HPV vaccine, from the UK Health Security Agency (UKHSA) annual HPV coverage report and Office for Health Improvement and Disparities (OHID) Fingertips indicator 92319.

Why it matters for the strategy

• We track HPV vaccination coverage because it directly prevents cervical cancer and other HPV-related cancers, with the World Health Organization (WHO) targeting 90% coverage by 2030 to accelerate elimination of cervical cancer as a public health problem. The current trend is getting worse, with coverage declining from previous levels.
• The latest figure for England (April 2024 to March 2025) is 71.7%.for Males and 67.0% for Females
• Trend: Both well below 90% WHO target. Sustained decline since April 2020 to March 2021, continuing from April 2023 to March 2024 (F 72.9%, M 67.7%). Programme moved from 2-dose to 1-dose from Sep 2023. Coverage fell sharply during COVID (Female from 88% to 59%) with incomplete recovery. Males included from April 2019 to March 2020.
• Performance varies across NHS Regions (April 2024 to March 2025): the best-performing area (East of England) achieved 73.1% (M) / 76.7% (F), while the lowest (London) achieved 59.7% (M) / 63.8% (F)
• The deprivation gap (April 2023 to March 2024) is 22.2% for males (54.5% most deprived to 76.7% least deprived) and 20.3% for females (60.8% to 81.1%).
• WHO has set elimination of cervical cancer as a public health problem as a long-term ambition, with high coverage as a key enabler.
• Cancer-prevention vaccination signal. strategy prevention pathway and Cancer Plan.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: OHID Fingertips indicator 92319 (HPV vaccination coverage, one dose, 12 to 13 year olds)

Figure 1.128: HPV vaccination coverage: one dose at 12 to 13 years: England trend (male)



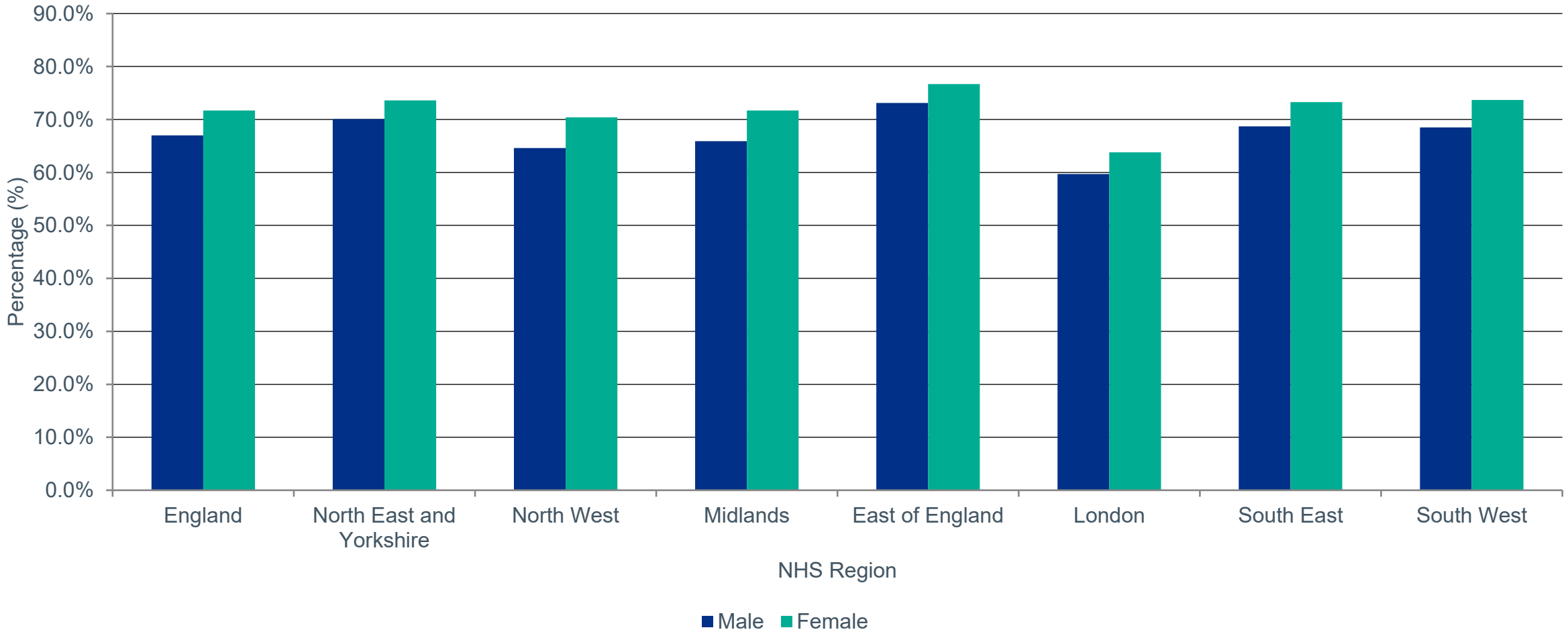
Source: OHID Fingertips indicator 92319 (HPV vaccination coverage, one dose, 12 to 13 year olds)

HPV vaccination coverage: one dose at 12 to 13 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of 12 to 13 year olds in England who received one dose of HPV vaccine, from the UKHSA annual HPV coverage report and OHID Fingertips indicator 92319.

Figure 1.129: HPV vaccination coverage: one dose at 12 to 13 years by NHS Region, April 2024 to March 2025



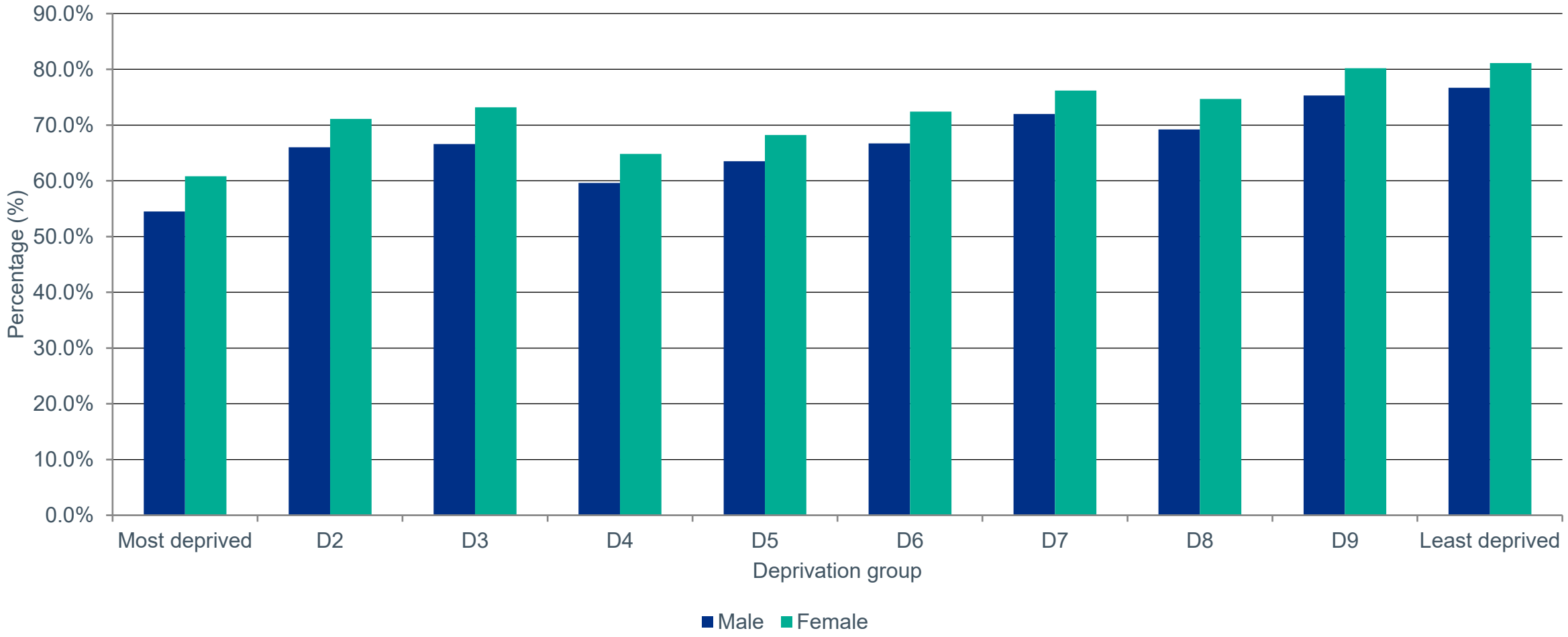
Source: OHID Fingertips indicator 92319 (HPV vaccination coverage, one dose, 12 to 13 year olds)

HPV vaccination coverage: one dose at 12 to 13 years

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of 12 to 13 year olds in England who received one dose of HPV vaccine, from the UKHSA annual HPV coverage report and OHID Fingertips indicator 92319.

Figure 1.130: HPV vaccination coverage: one dose at 12 to 13 years by deprivation group (Index of Multiple Deprivation (IMD) decile) – April 2024 to March 2025



Source: OHID Fingertips indicator 92319 (HPV vaccination coverage, one dose, 12 to 13 year olds)

Pertussis vaccination in pregnancy

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of pregnant women in England who received the pertussis (whooping cough) vaccination during pregnancy, from UK Health Security Agency (UKHSA) ImmForm prenatal vaccine coverage data.

Why it matters for the strategy

• We track pertussis vaccination in pregnancy because maternal vaccination is the primary intervention to protect newborns before their own vaccination course begins, and coverage has significant deprivation and ethnicity gradients.
• The latest figure for England (Dec 2025) is 75.1%.
• This is getting better: Steady improvement, increasing by 16.2% from Apr-24 (58.9%) to 75.1% (Dec 2025), driven by whooping cough outbreak response. Still below 90% UKHSA target and pre-pandemic peak (~75-80%).
• Performance varies across NHS Regions: the best-performing area (South West) achieved 80.6%, while the lowest (London) achieved 65.1%.
• People in the least deprived areas achieve 80.4%, compared with 61.8 in the most deprived - a gap of 18.6%.
• Maternal vaccination signal. strategy maternity and prevention pathways.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

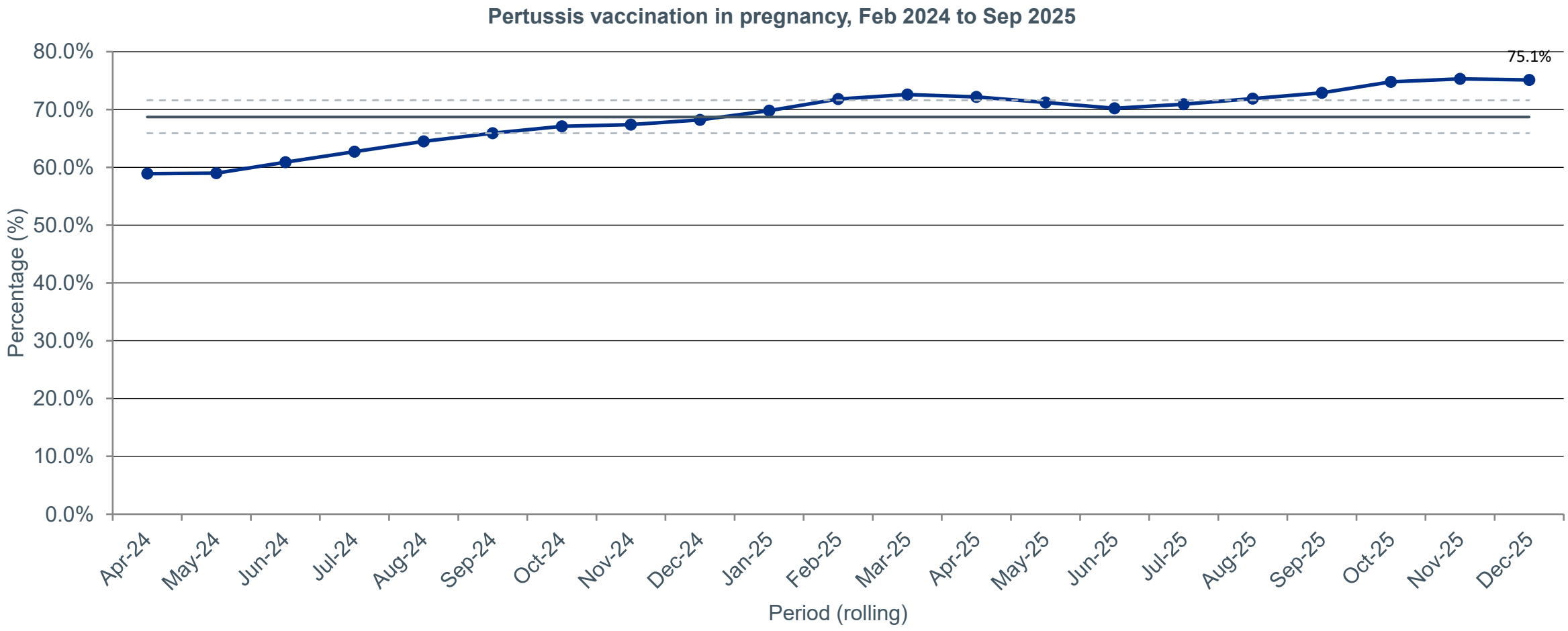
Source: UKHSA ImmForm, Prenatal pertussis vaccination coverage (monthly, Apr 2016-Sep 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Pertussis vaccination in pregnancy

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of pregnant women in England who received the pertussis (whooping cough) vaccination during pregnancy, from UKHSA ImmForm prenatal vaccine coverage data.

Figure 1.131: Pertussis vaccination in pregnancy: England trend



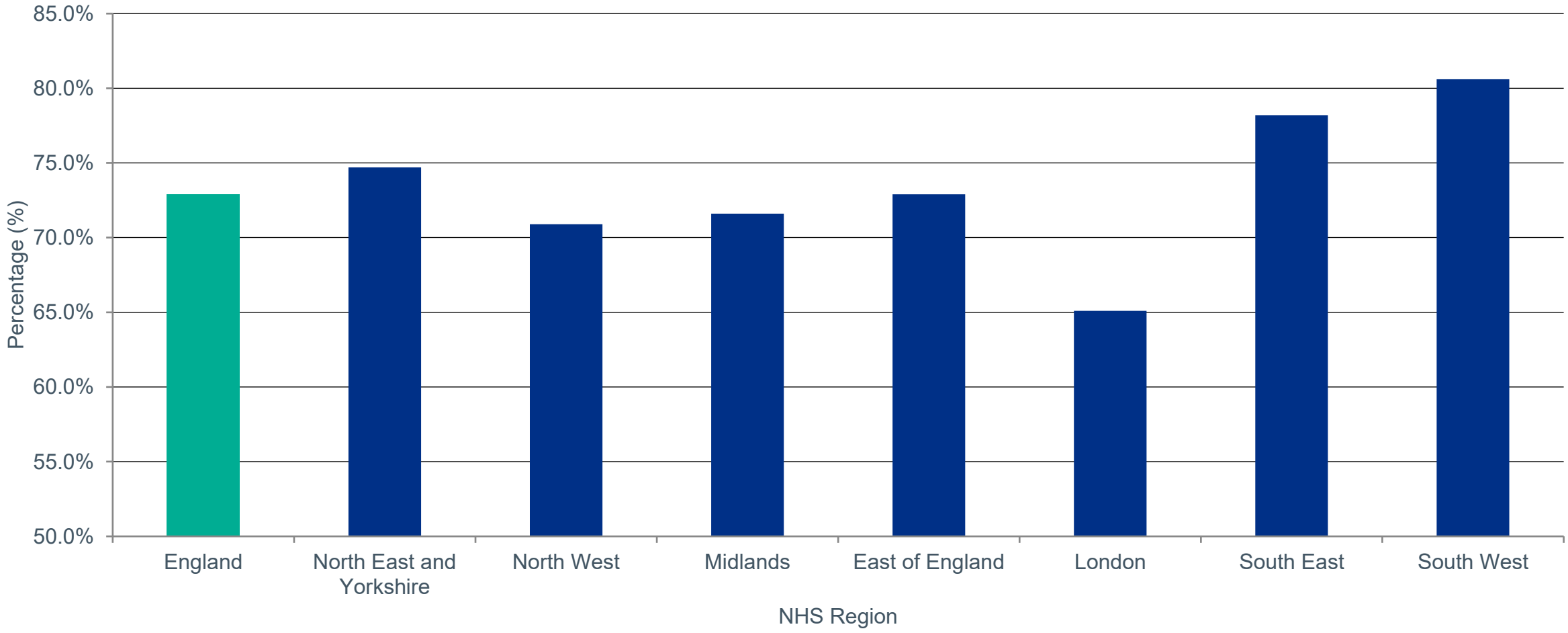
Source: UKHSA ImmForm, Prenatal pertussis vaccination coverage (monthly, Apr 2016-Sep 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Pertussis vaccination in pregnancy

Effectiveness | Tier 2: Driver | ↑ Higher is better

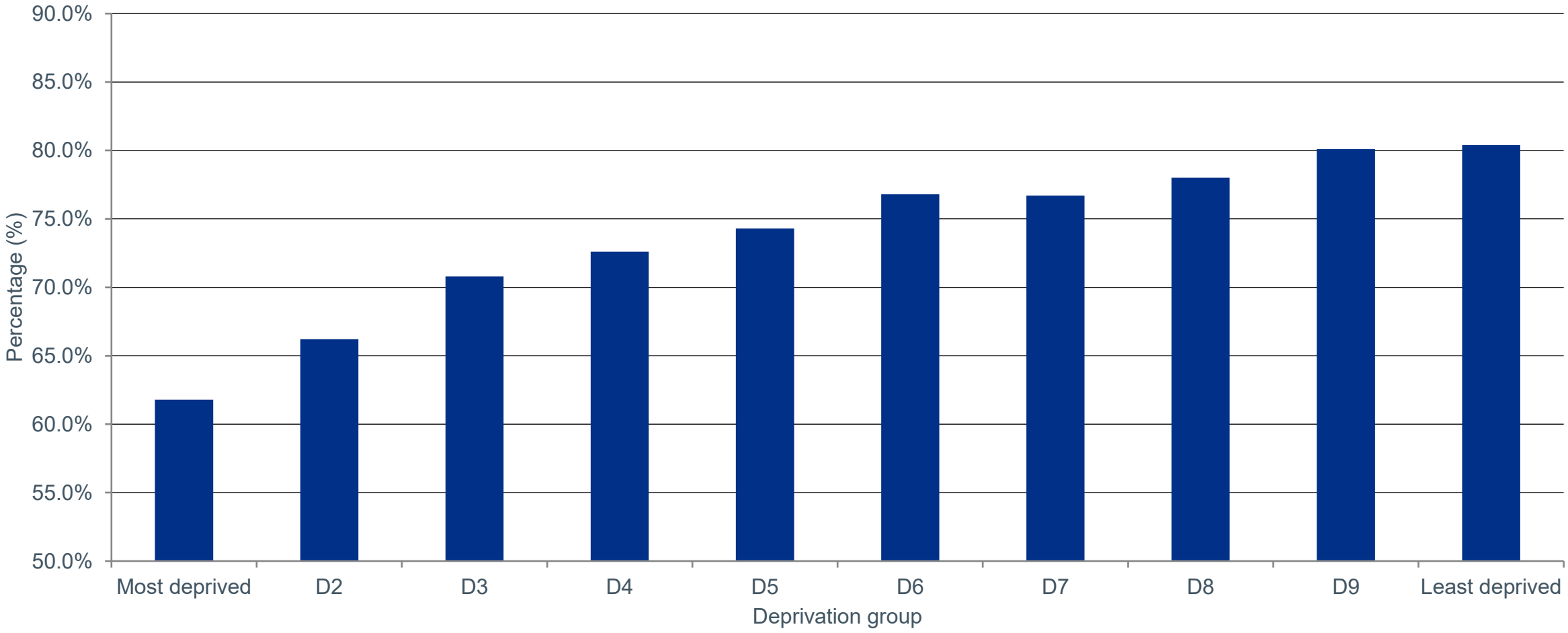
Proportion of pregnant women in England who received the pertussis (whooping cough) vaccination during pregnancy, from UKHSA ImmForm prenatal vaccine coverage data.

Figure 1.132: Pertussis vaccination in pregnancy by NHS Region



Source: UKHSA ImmForm, Prenatal pertussis vaccination coverage (monthly, Apr 2016-Sep 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.133: Pertussis vaccination in pregnancy by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: UKHSA ImmForm, Prenatal pertussis vaccination coverage (monthly, Apr 2016-Sep 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Pertussis incidence rate

Effectiveness | Tier 2: Driver | ↓ Lower is better

Confirmed pertussis (whooping cough) incidence rate in England, expressed per 100,000 population, from UK Health Security Agency (UKHSA) surveillance data and Office for Health Improvement and Disparities (OHID) Fingertips indicator 93515.

Why it matters for the strategy

• We track pertussis incidence because whooping cough outbreaks cause significant morbidity in infants and unvaccinated individuals, and the epidemic cycle reflects gaps in maternal pertussis vaccination coverage. The current trend is deteriorating, with a 2024 outbreak reflecting vaccination gaps.
• The latest figure for England (2024) is 25.8 per 100,000.
• This is getting worse: 25.8 per 100k in 2024 (UKHSA, 14,894 confirmed cases). Worst outbreak in over a decade, being more than 2012 peak (17.5/100k). Epidemic cyclicity (peaks every 3 to 5 years). COVID suppression 2020 to 2022 (near zero). 2025 Q1: 335 cases, outbreak waning.
• There is no simple gradient by deprivation, with the highest rate (30.6 per 100,000) in the 6th most deprived decile and the lowest rate (18.4 per 100,000) in the 2nd most deprived decile
• The epidemic cycle is a related signal of maternal pertussis vaccination coverage.

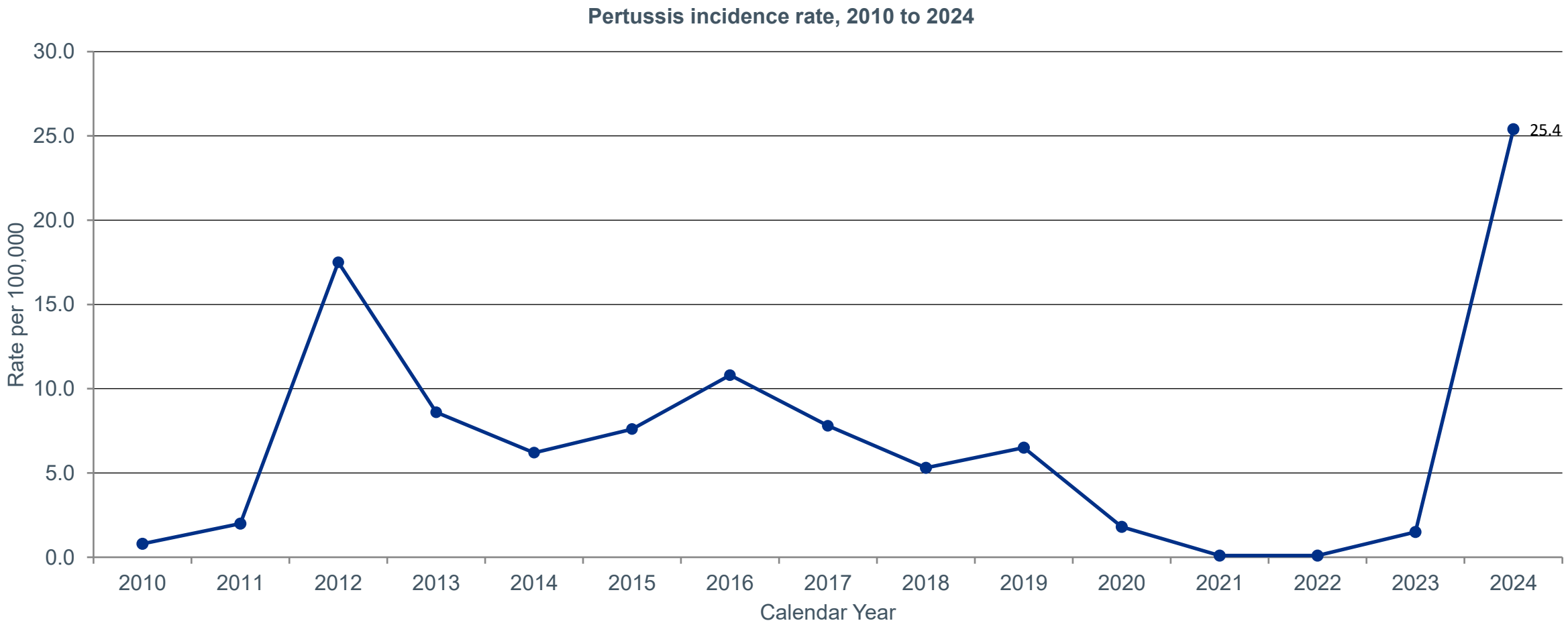
Source: OHID Fingertips indicator 93515, UKHSA pertussis surveillance (2023) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Pertussis incidence rate

Effectiveness | Tier 2: Driver | ↓ Lower is better

Confirmed pertussis (whooping cough) incidence rate in England, expressed per 100,000 population, from UKHSA surveillance data and OHID Fingertips indicator 93515.

Figure 1.134: Pertussis incidence rate: England trend



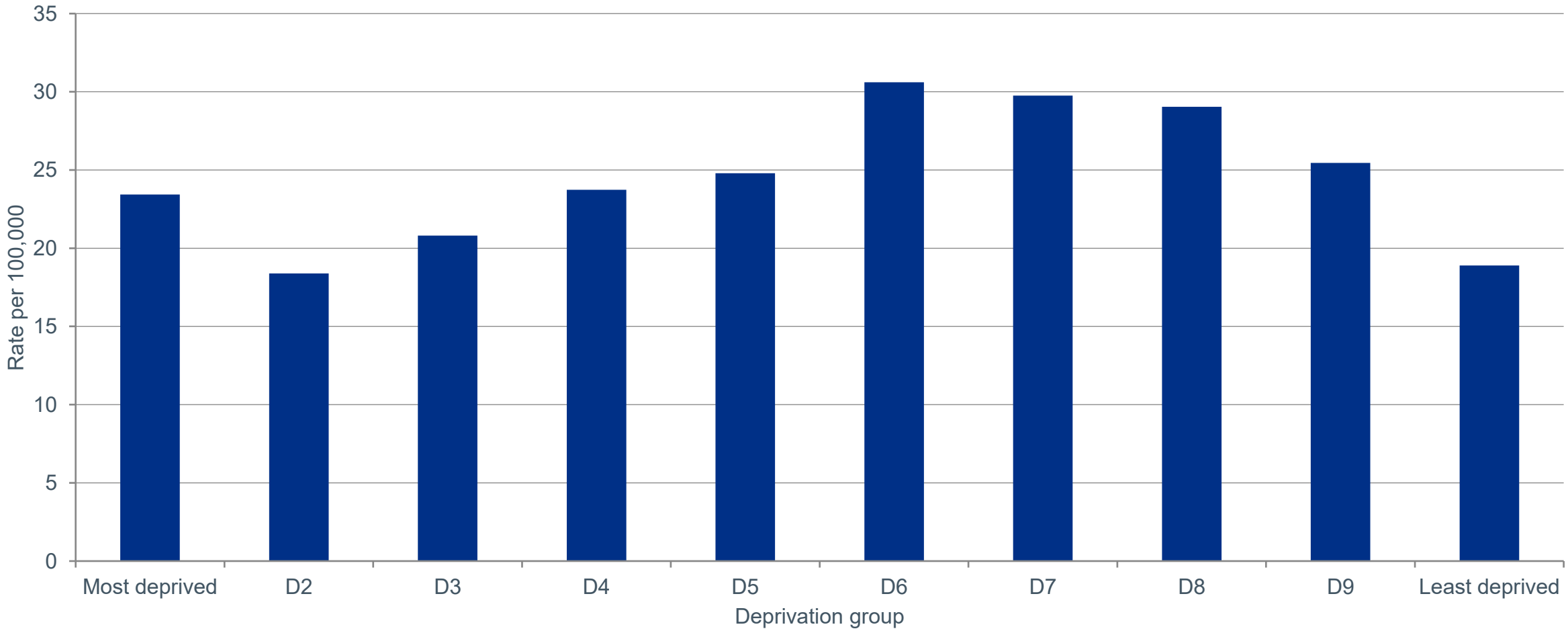
Source: OHID Fingertips indicator 93515, UKHSA pertussis surveillance (2023) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Pertussis incidence rate

Effectiveness | Tier 2: Driver | ↓ Lower is better

Confirmed pertussis (whooping cough) incidence rate in England, expressed per 100,000 population, from UKHSA surveillance data and OHID Fingertips indicator 93515.

Figure 1.135: Pertussis incidence rate, by Index of Multiple Deprivation - 2024



Source: OHID Fingertips indicator 93515, UKHSA pertussis surveillance (2023) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Physical activity prevalence

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults in England meeting the Chief Medical Officer guideline of at least 150 minutes of moderate-intensity physical activity per week, from the Sport England Active Lives Adult Survey.

Why it matters for the strategy

• We track physical activity prevalence because inactivity is a major modifiable risk factor for cardiovascular disease (CVD), cancer, diabetes, and poor mental health, and the deprivation gradient in activity levels directly drives health inequalities.
• The latest figure for England (Nov 2024-Nov 2025) is 64.6%.
• This is getting better: increasing by 3.2% from April 2020 to March 2021 (61.4%) to April 2024 to March 2025 (64.6%
• Performance varies across NHS Regions (April 2023 to March 2024 data): the best-performing area (South West) achieved 68.8%, while the lowest (Midlands) achieved 61.6%.
• People in the least deprived areas achieve 69.8%, compared with 56.7% in the most deprived - a gap of 13.1%.
• Modifiable health-inequalities driver. strategy prevention pathway

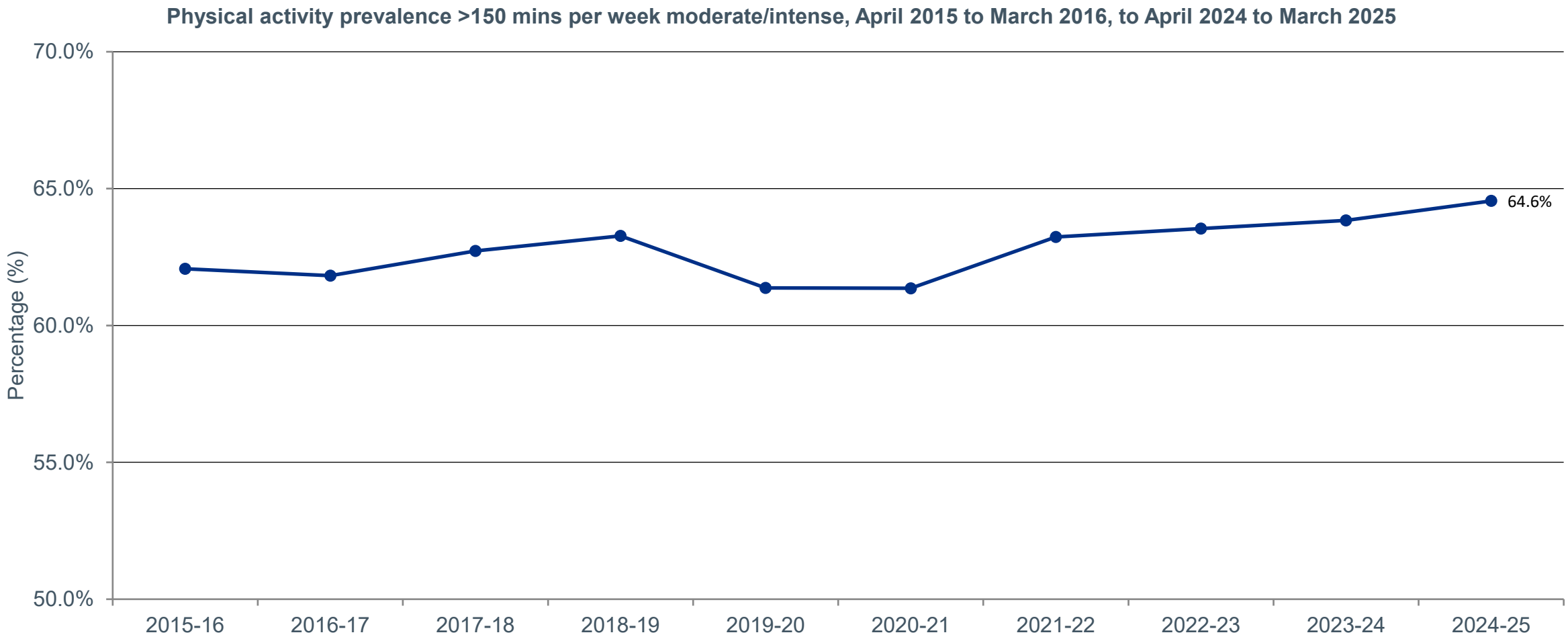
Source: Sport England, Active Lives Adult Survey November April 2023 to March 2024 (published Apr 2025)

Physical activity prevalence

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults in England meeting the Chief Medical Officer guideline of at least 150 minutes of moderate-intensity physical activity per week, from the Sport England Active Lives Adult Survey.

Figure 1.136: Physical activity prevalence: England trend



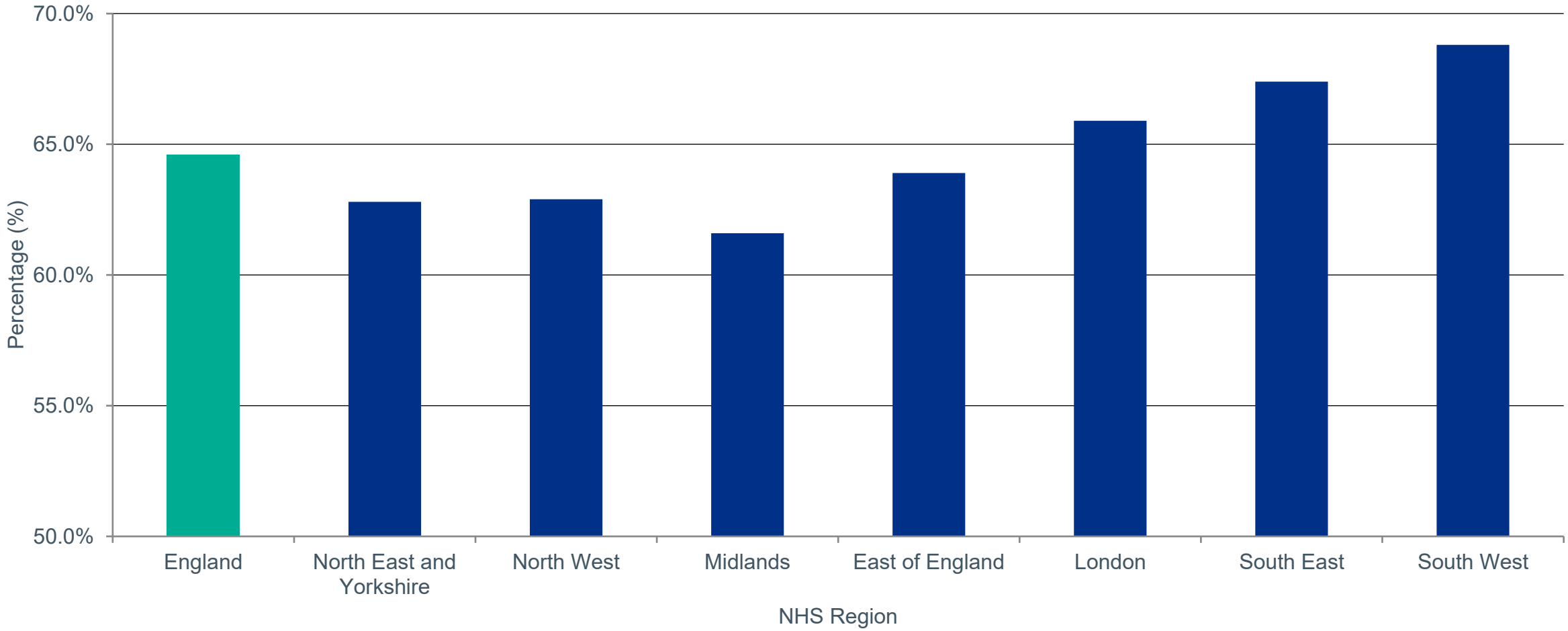
Source: Sport England, Active Lives Adult Survey November April 2023 to March 2024 (published Apr 2025)

Physical activity prevalence

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults in England meeting the Chief Medical Officer guideline of at least 150 minutes of moderate-intensity physical activity per week, from the Sport England Active Lives Adult Survey.

Figure 1.137: Physical activity prevalence by NHS Region, April 2024 to March 2025



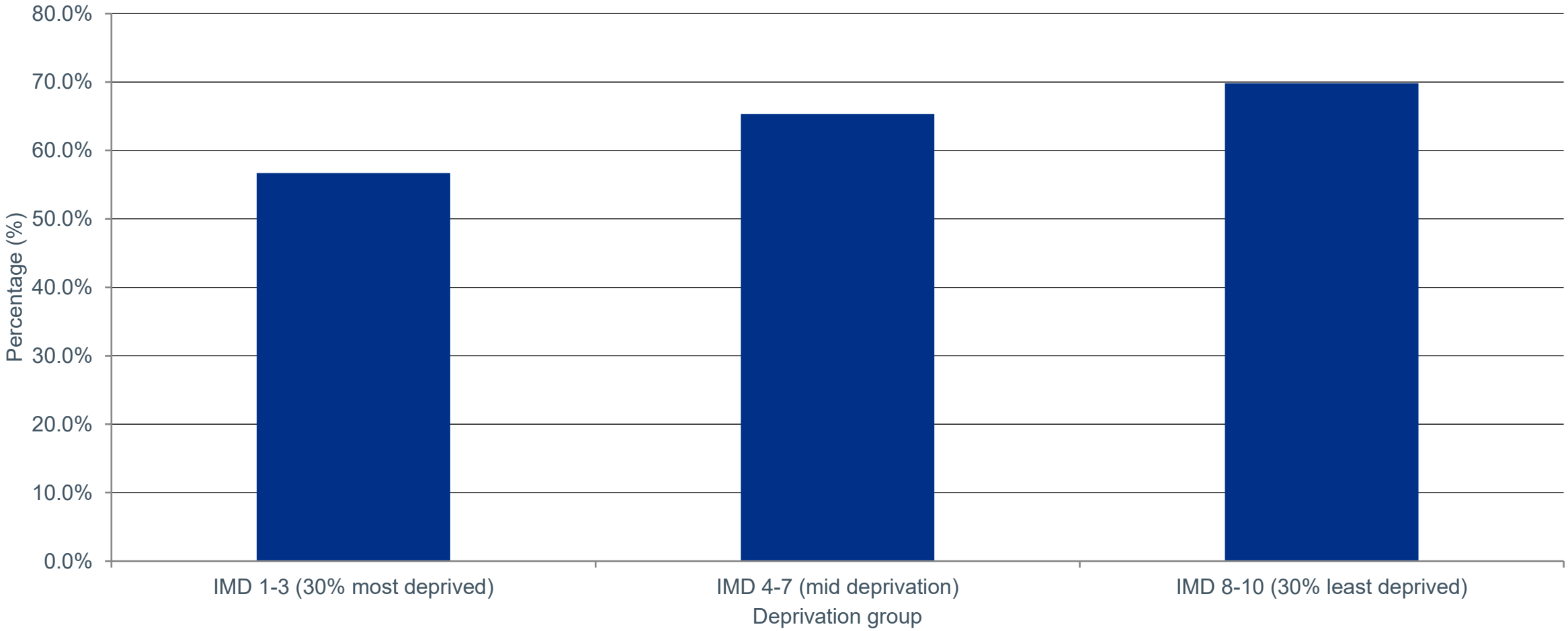
Source: Sport England, Active Lives Adult Survey November April 2023 to March 2024 (published Apr 2025)

Physical activity prevalence

Effectiveness | Tier 2: Driver | ↑ Higher is better

Proportion of adults in England meeting the Chief Medical Officer guideline of at least 150 minutes of moderate-intensity physical activity per week, from the Sport England Active Lives Adult Survey.

Figure 1.138: Physical activity prevalence by deprivation group (Index of Multiple Deprivation (IMD) decile) – April 2024 to March 2025



Source: Sport England, Active Lives Adult Survey November April 2023 to March 2024 (published Apr 2025)

Bowel screening uptake by deprivation quintile

Effectiveness | Tier 2: Driver | ↑ Higher is better

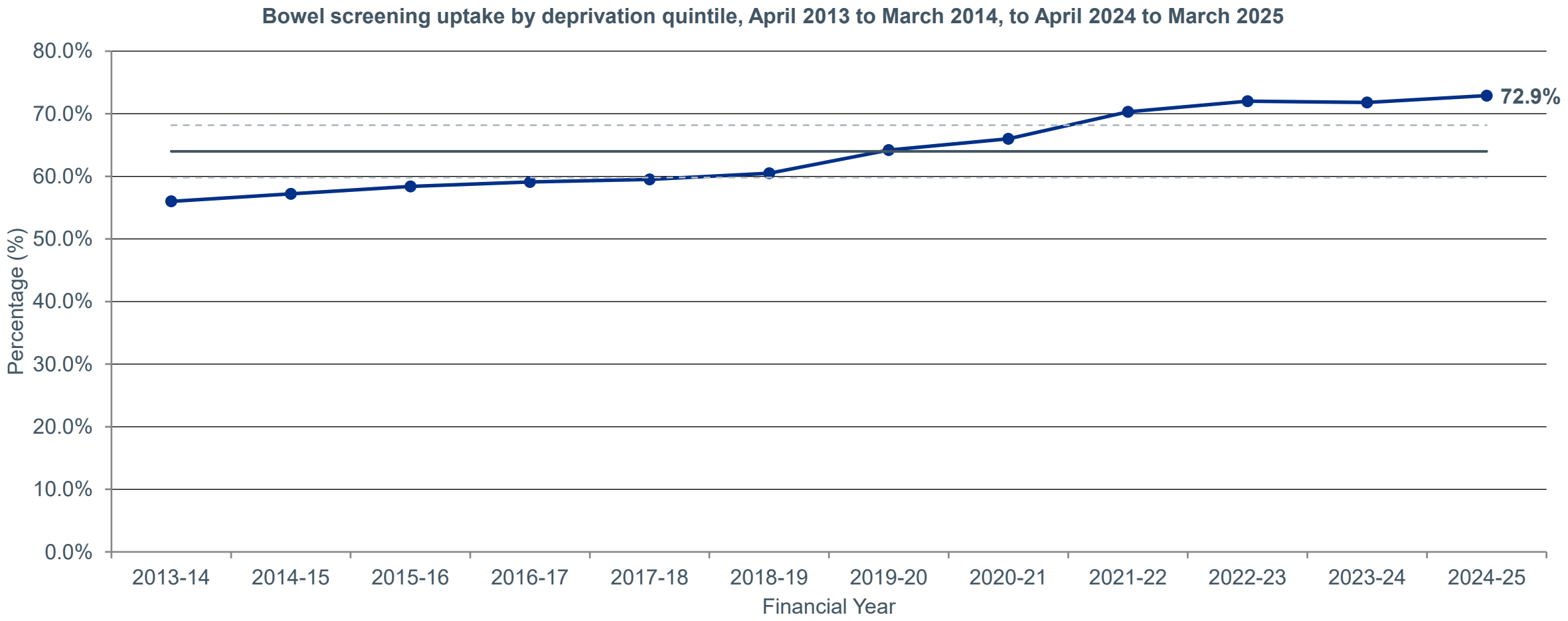
Bowel screening uptake by deprivation quintile.

Why it matters for the strategy

- The latest figure for England (April 2024 to March 2025) is 72.9%.
- Trend: This is getting better, increasing by around 17% from April 2013 to March 2014 (56.0%) to April 2024 to March 2025 (72.9%)
- Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (South West) achieved 76.6%, while the lowest (London) achieved 65.2%.
- Screening is the primary mechanism for early-stage diagnosis, which the strategy identifies as the key lever for cancer survival.
- Screening-inequality signal. Sub-indicator of cancer screening coverage in Core; strategy inequalities priority.
- Tier 3 signal - fast-moving operational indicator suitable for SPC surveillance.

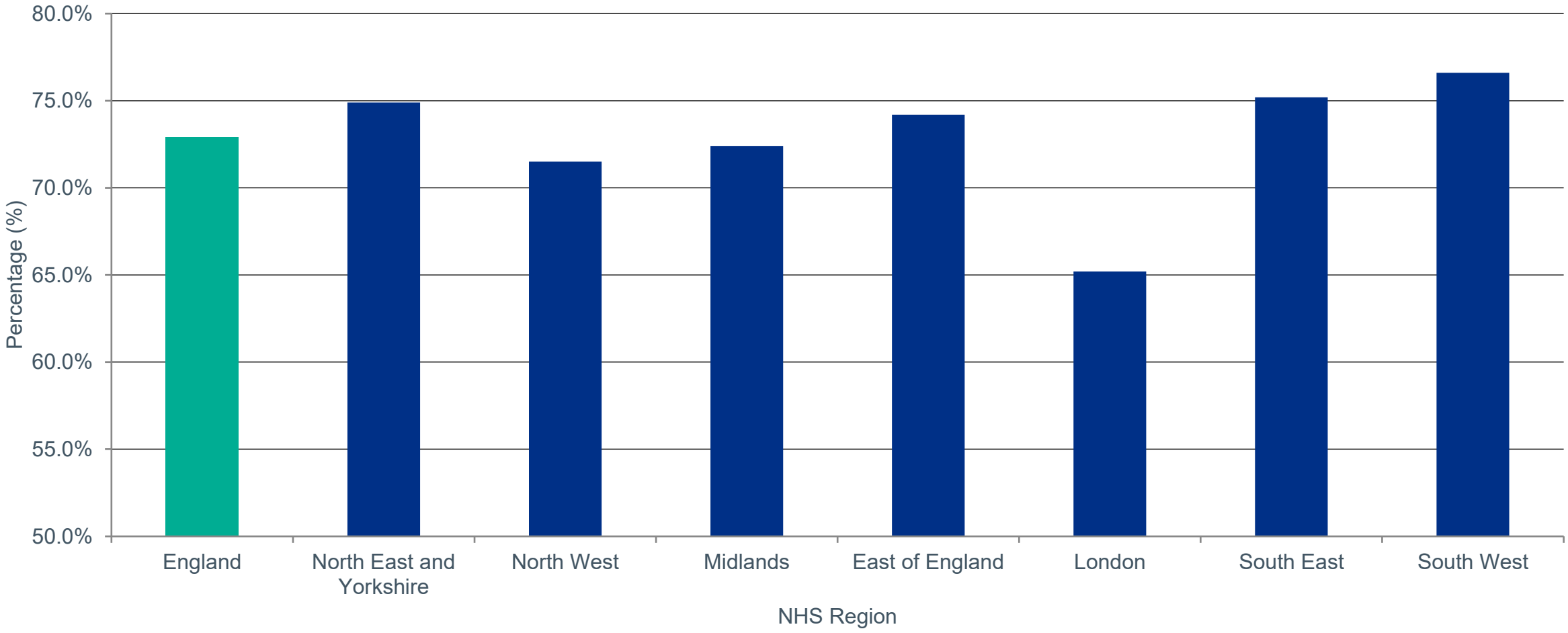
Source: Office for Health Improvement and Disparities (OHID) Fingertips [92600] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.139: Bowel screening uptake by deprivation quintile: England trend



Source: OHID Fingertips [92600] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.140: Bowel screening uptake by deprivation quintile by NHS Region



Source: OHID Fingertips [92600] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Emergency admissions children and young people (CYP) lower respiratory tract infections

Effectiveness | Tier 2: Driver | ↓ Lower is better

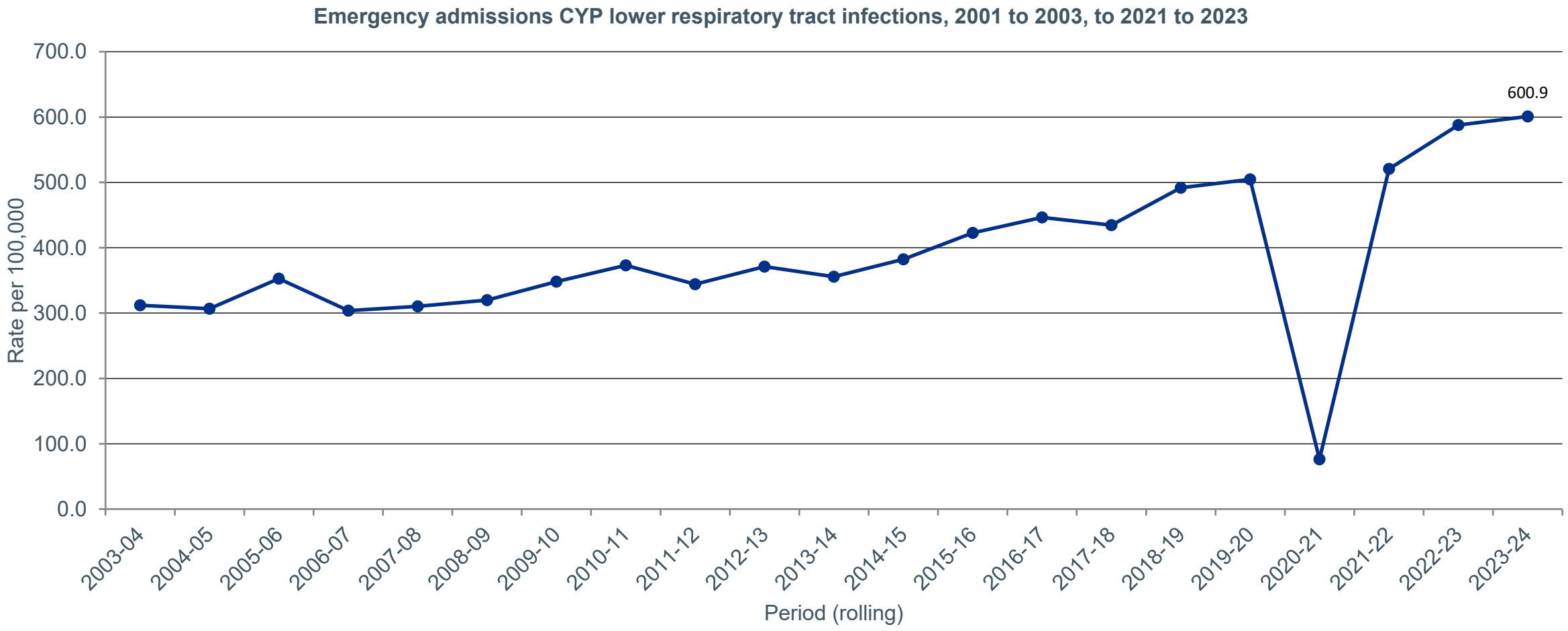
Emergency admissions for CYP lower respiratory infections.

Why it matters for the strategy

• This is among the leading causes of hospital admission in young children, and largely preventable through vaccination, smoke-free environments and early primary-care intervention.
• The latest figure for England (2023 - 24) is 600.9 per 100,000.
• Trend: This is getting worse, with the rate per 100,000 almost doubling between April 2003 to March 2004 (311.9) and April 2023 to March 2024 (600.9), with the exception of a significant dip during the pandemic, before pre-pandemic trend continued.

Source: Office for Health Improvement and Disparities (OHID) Fingertips [92901] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 1.141: Emergency admissions CYP lower respiratory tract infections: England trend



Source: OHID Fingertips [92901] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Measles measles, mumps and rubella (MMR)/MMRV vaccination: 2 doses by age 5

Effectiveness | Tier 2: Driver | ↑ Higher is better

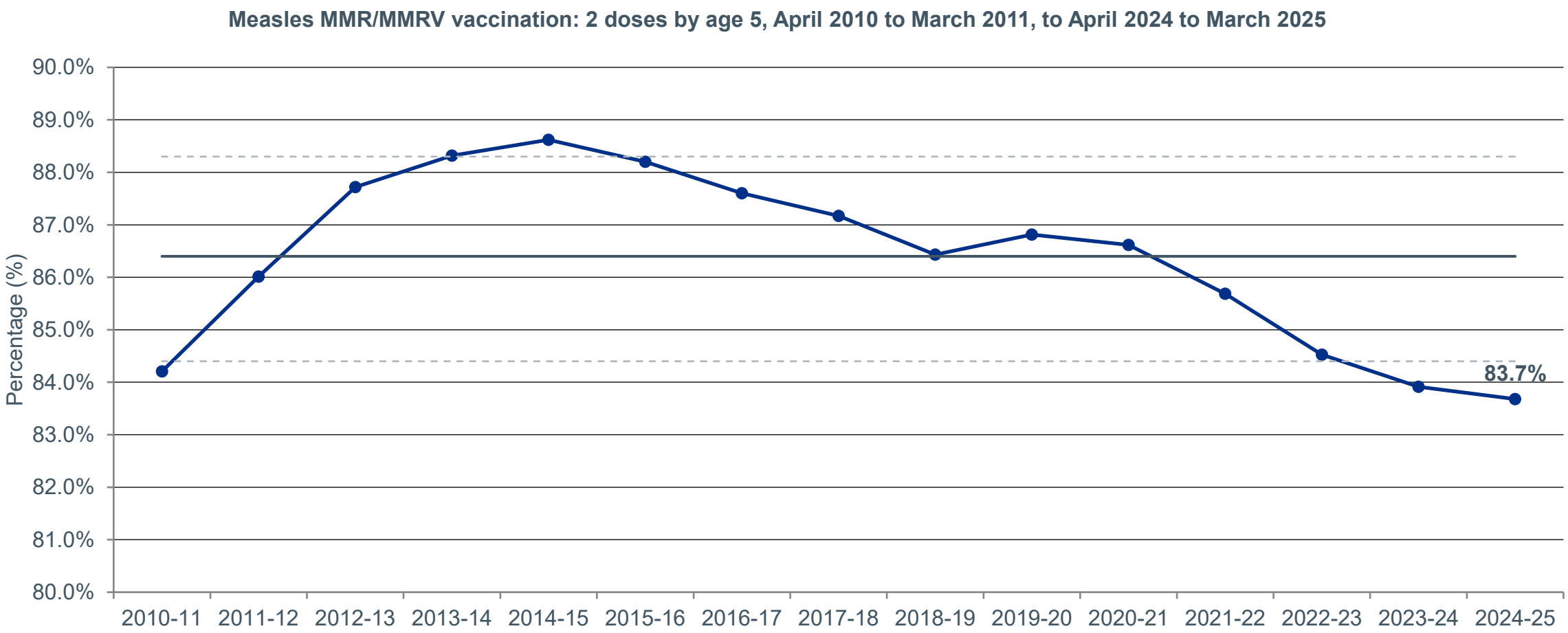
The proportion receiving 2 doses of Measles MMR/MMRV vaccination by age 5

Why it matters for the strategy

• This metric relates to a key line of defence against the resurgence of childhood viruses.
• The latest figure for England (April 2024 to March 2025) is 83.7%.
• Trend: This is getting worse, decreasing by 3.8% from April 2013 to March 2014 (92.7%) to April 2024 to March 2025 (88.9%)
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (South West) achieved 92.5%, while the lowest (London) achieved 80.8%.
• People in the least deprived areas achieve 92.0%, compared with 84.3 in the most deprived - a gap of 7.7%.

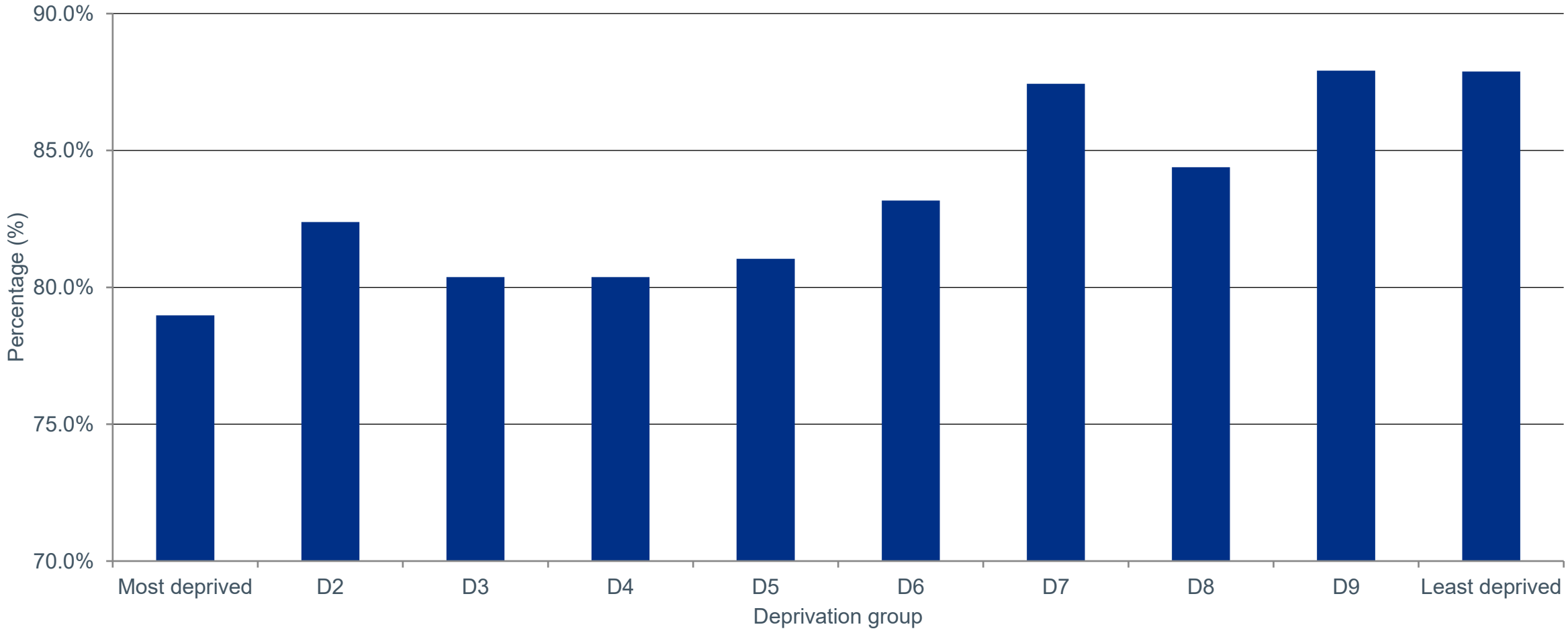
Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly (COVER) programme, Office for Health Improvement and Disparities (OHID) Fingertips [30311] .

Figure 1.142: Measles MMR/MMRV vaccination: 2 doses by age 5: England trend



Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly (COVER) programme, OHID Fingertips [30311] .

Figure 1.143: MMR vaccination: 2 doses by age 5 by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: UK Health Security Agency, Coverage of Vaccinations Evaluated Rapidly (COVER) programme, OHID Fingertips [30311] .

Hip fracture 30-day mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Percentage of patients who died within 30 days of admission to A&E, from the National Hip Fracture Database (NHFD).

Why it matters for the strategy

• Older people are more vulnerable to falls and hip fractures, and these have a significant impact on quality of life and impact both life expectancy and healthy life expectancy
• The latest figure for England (Q3 2025) is 5.0%.
• This is getting better: reducing by 2.0% from Q4 2021 (7.0%) to Q3 2025 (5.0%)
• Clinical driver that translates into population outcomes within 1 to 3 years when delivered at scale.
• A strategy safety 'giant'. Also a marker of acute care effectiveness for the over-65s.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

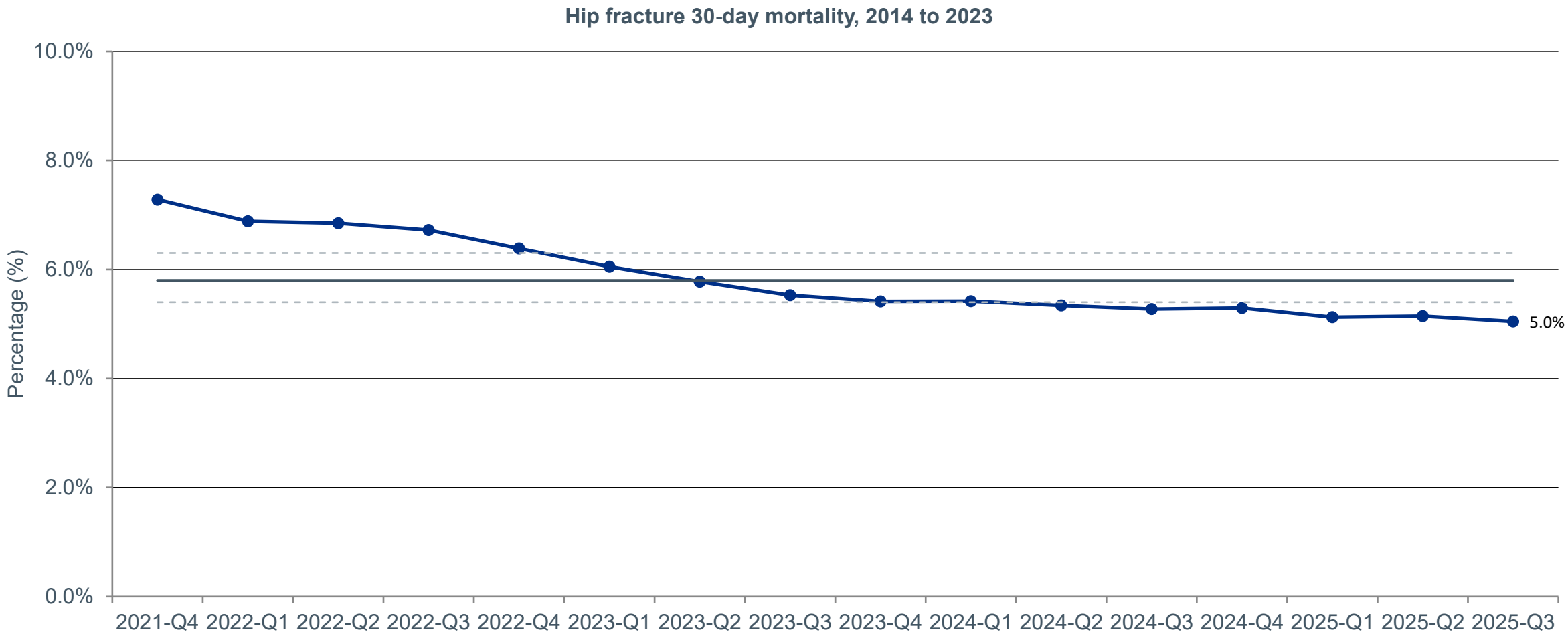
Source: National Hip Fracture Database (NHFD) Annual Reports | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Hip fracture 30-day mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Percentage of patients who died within 30 days of admission to A&E, from the National Hip Fracture Database (NHFD).

Figure 1.144: Hip fracture 30-day mortality: England trend



Source: National Hip Fracture Database (NHFD) Annual Reports | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Emergency laparotomy 30-day risk-adjusted mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Risk-adjusted 30-day mortality rate for patients undergoing emergency laparotomy in NHS hospitals, from the National Emergency Laparotomy Audit (NELA).

Why it matters for the strategy

• Emergency laparotomy is an important but high-risk surgical procedure and this metric is an outcome measure linked to how well-manged patients are through the laparotomy pathway, including appropriate risk assessment, sepsis management and multidisciplinary care
• The latest figure for England (April 2023 to March 2024) is 8.1%.
• This is getting better: 8.1% risk-adjusted 30-day mortality (April 2023 to March 2024, NELA Year 10). Lowest in 10 years of audit. Down from 11.7% (Year 1, April 2013 to March 2014). ~1,150 fewer deaths/year.
• Clinical driver that translates into population outcomes within 1 to 3 years when delivered at scale.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

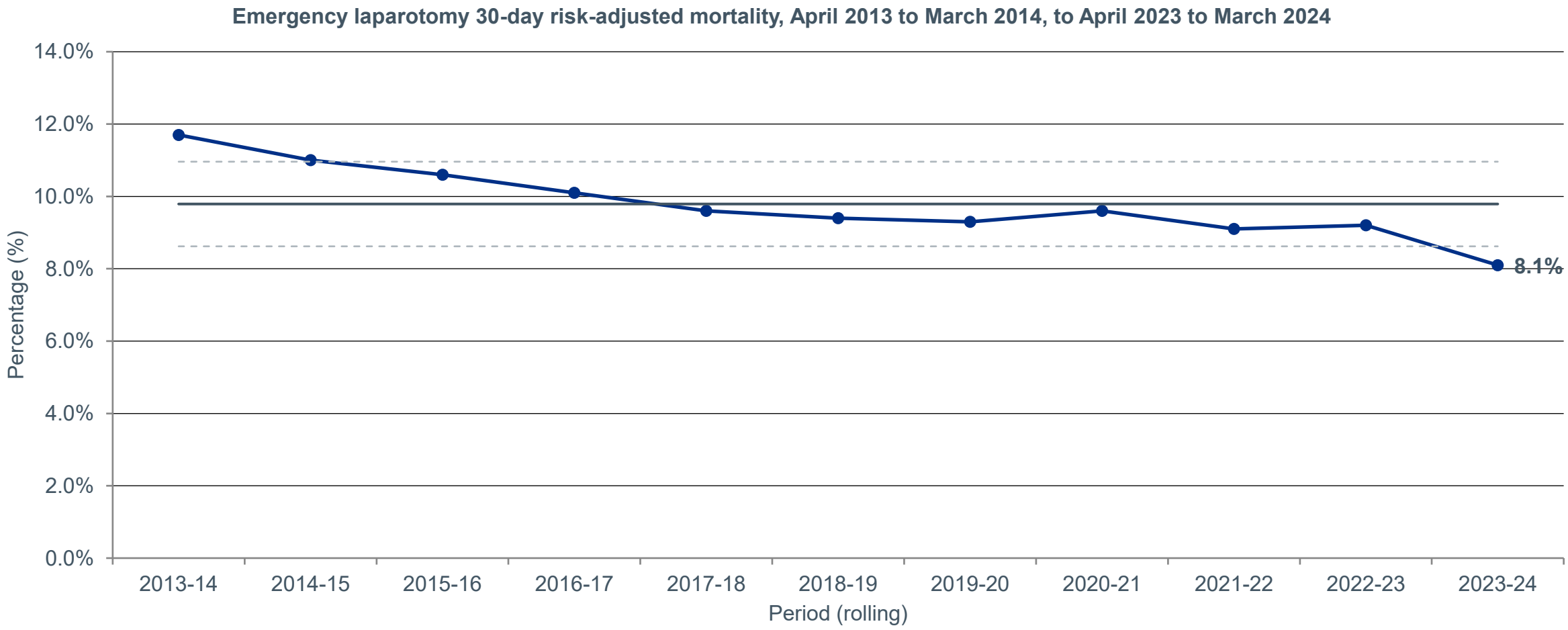
Source: National Emergency Laparotomy Audit (NELA), Healthcare Quality Improvement Partnership (HQIP)

Emergency laparotomy 30-day risk-adjusted mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Risk-adjusted 30-day mortality rate for patients undergoing emergency laparotomy in NHS hospitals, from the National Emergency Laparotomy Audit (NELA).

Figure 1.145: Emergency laparotomy 30-day risk-adjusted mortality: England trend



Source: National Emergency Laparotomy Audit (NELA), HQIP

Measles confirmed cases

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Laboratory-confirmed measles cases in England.

Why it matters for the strategy

• We track measles cases because they are a direct indicator of vaccination programme effectiveness. The 2024 outbreak (2,926 cases) demonstrated the consequences of accumulated susceptibility from declining measles, mumps and rubella (MMR) uptake.
• The latest figure for England (2025) is 4.9 per 100,000
• This is getting worse increasing from 0.04 per 100,000 in 2021 to 4.9 per 100,000 in 2024
• The recent outbreak demonstrated the consequences of accumulated susceptibility from declining MMR uptake.
• Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

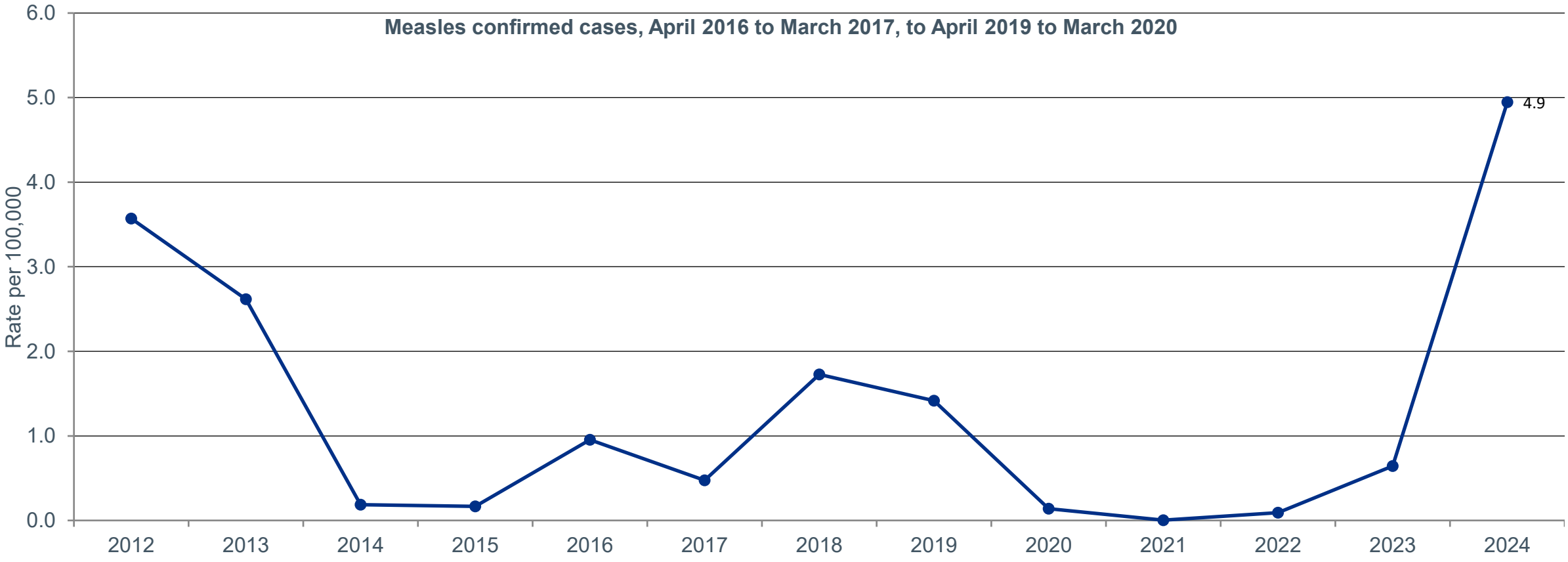
Source: UK Health Security Agency (UKHSA), Measles in England surveillance data (weekly)

Measles confirmed cases

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Laboratory-confirmed measles cases in England.

Figure 1.146: Measles confirmed cases: England trend



Source: UKHSA, Measles in England surveillance data (weekly)

Respiratory syncytial virus (RSV) hospital admissions

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Hospital admissions for RSV among children aged 0, 4 (UK Health Security Agency (UKHSA) surveillance).

Why it matters for the strategy

• We track RSV admissions because respiratory syncytial virus causes significant hospital burden in infants and older adults, and new vaccines and monoclonal antibodies offer transformative prevention potential.
• The latest figure for England (w/e 30/03/2026) is 2.8 per 100,000.
• The trend follows a seasonal pattern, with the peak rate per 100,000 slightly lower in April 2025 to March 2026 (42.7) than in April 2024 to March 2025 (46.2)
• Vaccine and monoclonal antibody impact signal. strategy prevention pathway.

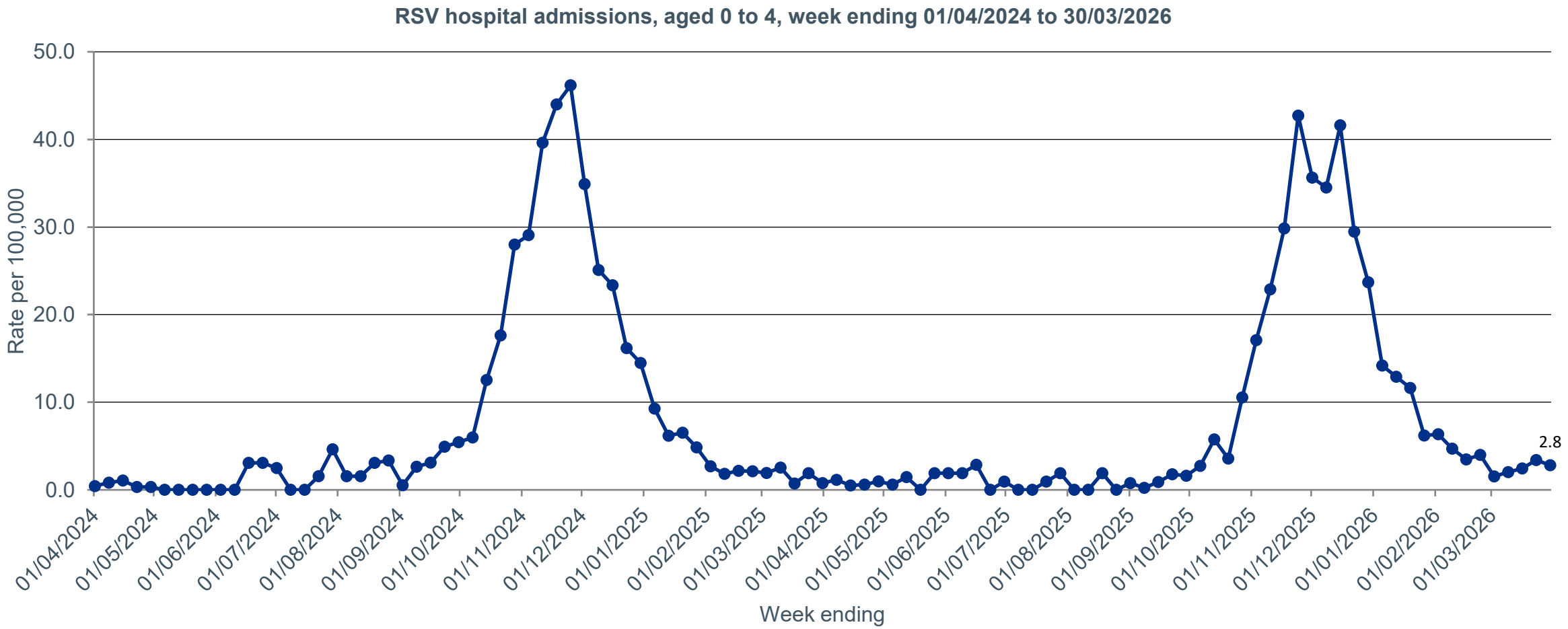
Source: UKHSA Dashboard, RSV healthcare admission rate (weekly)

RSV hospital admissions

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Hospital admissions for RSV among children aged 0, 4 (UKHSA surveillance).

Figure 1.147: RSV hospital admissions: England trend



Source: UKHSA Dashboard, RSV healthcare admission rate (weekly)

Hospital mortality (SHMI)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Summary Hospital-level Mortality Indicator for England, the ratio of observed to expected in-hospital deaths plus deaths within 30 days of discharge, from NHS Digital SHMI publication.

Why it matters for the strategy

• We track the Summary Hospital-level Mortality Indicator because it is the established national tool for monitoring whether the number of deaths associated with hospitalisation is within the expected range, prompting investigation where it is not. This metric shows the proportion of trusts in the ‘higher than expected’ category.
• The latest figure for England (12m to Dec 2025) is 7.6% of trusts in the ‘higher than expected’ category
• The picture is mixed, up from 5.9% for the 12m ending Jan-25, but down from 11.9% in the 12m ending Jun-24
• Trusts above the range are flagged for investigation.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

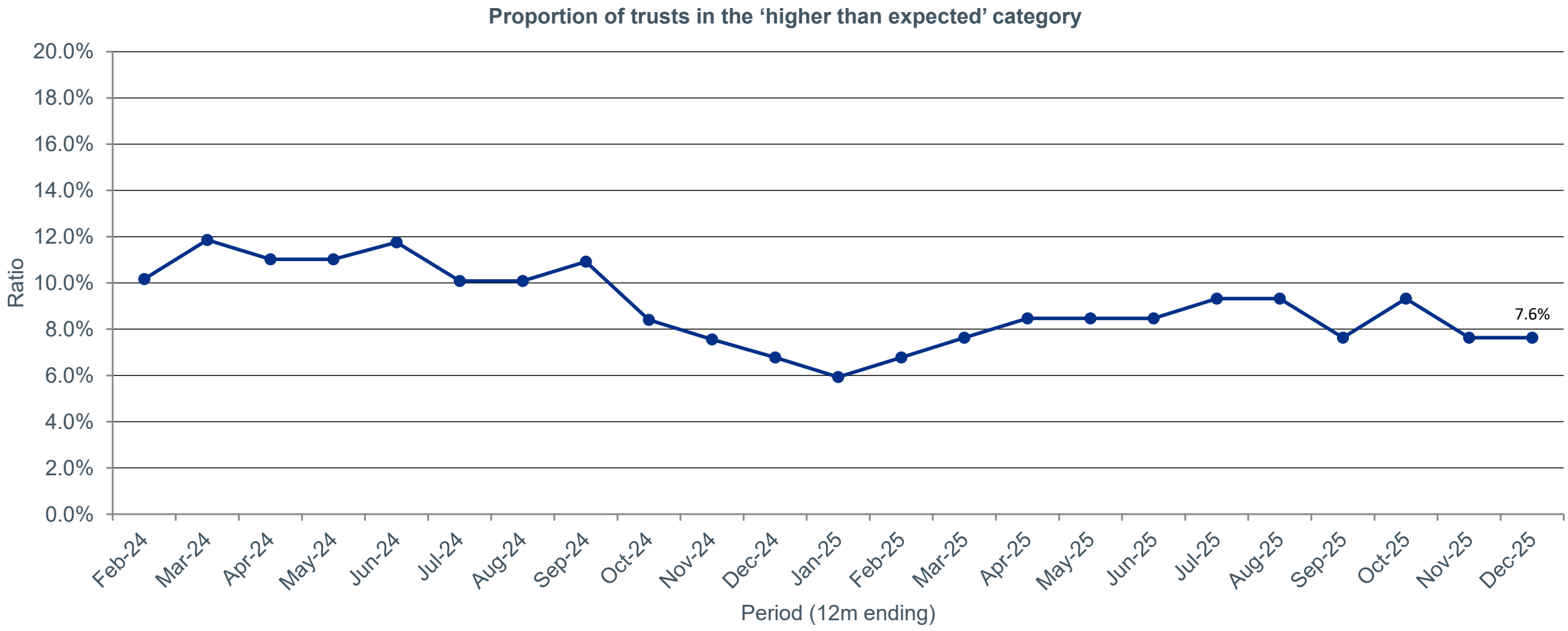
Source: NHS Digital, SHMI data Oct 2024-Sep 2025 (Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Hospital mortality (SHMI)

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Summary Hospital-level Mortality Indicator for England, the ratio of observed to expected in-hospital deaths plus deaths within 30 days of discharge, from NHS Digital SHMI publication.

Figure 1.148: Hospital mortality (SHMI): England trend



Source: NHS Digital, SHMI data Oct 2024-Sep 2025 (Feb 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Risk-adjusted acute hospital mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Risk-adjusted acute hospital mortality, observed/expected percentage of complete eligible admissions that died before ultimate discharge from acute hospital/calculated as the mean predicted rate of death

Why it matters for the strategy

- Key measure of the effectiveness of acute and critical care, assessing whether patient outcomes are in line with what would be expected given case mix and clinical risk.
- The latest position is that observed mortality was 17.6% in April 2023 to March 2024, 1% higher than expected mortality.
- This is similar to April 2021 to March 2022 and April 2022 to March 2023 though in both those years, observed was slightly lower than expected.

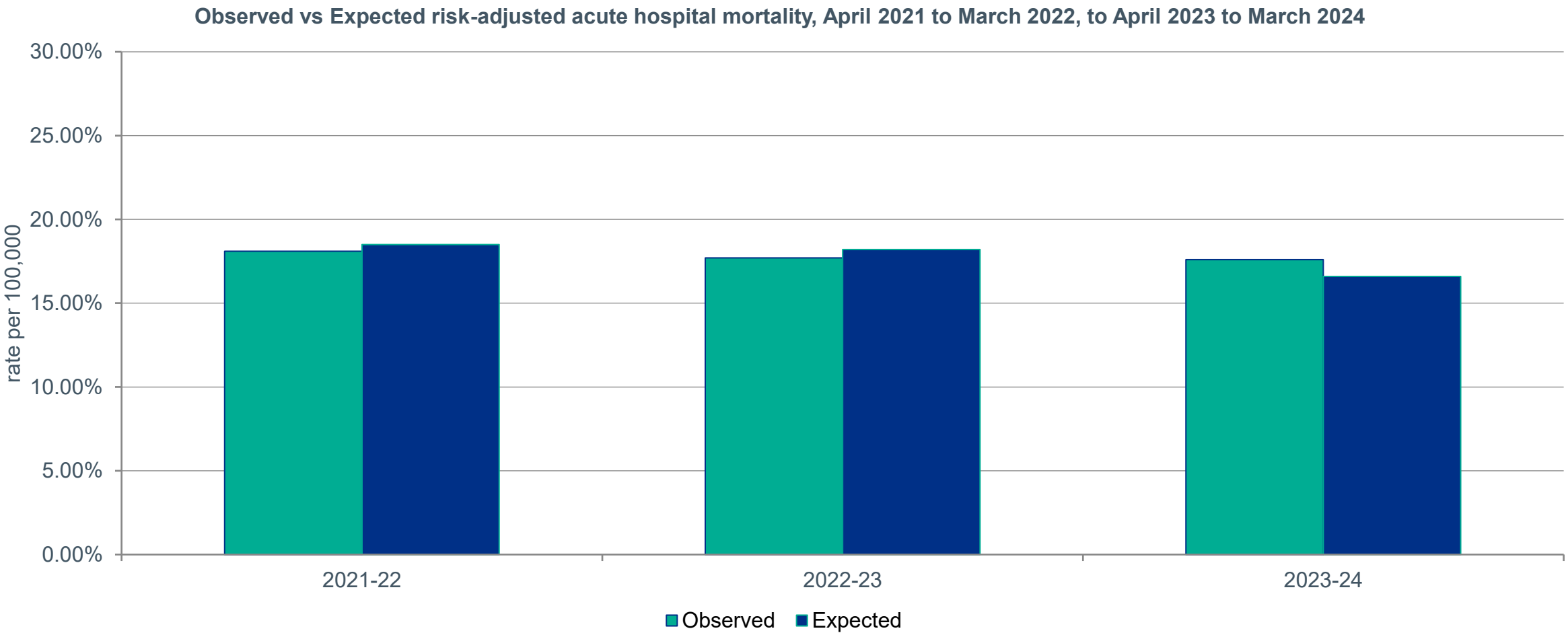
Source: Intensive Care National Audit and Research Centre (ICNARC) – Casemix Programme

Risk-adjusted acute hospital mortality

Effectiveness | Tier 2: Driver | ↓ Lower is better

Risk-adjusted acute hospital mortality, observed/expected percentage of complete eligible admissions that died before ultimate discharge from acute hospital/calculated as the mean predicted rate of death

Figure 1.149: Risk-adjusted acute hospital mortality: England trend



Source: Intensive Care National Audit and Research Centre (ICNARC) – Casemix Programme

Emergency admissions for acute coronary syndrome (ACS) conditions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for ambulatory care sensitive conditions in England, covering 19 chronic conditions that should be manageable in primary care, expressed per 100,000 population (NHS Outcomes Framework (NHSOF) indicator 3a).

Why it matters for the strategy

• We track emergency admissions for ambulatory care sensitive conditions because these represent admissions that could have been avoided through effective primary care and community management. A rising ambulatory care sensitive condition (ACSC) rate signals gaps in out-of-hospital care. The current trend is deteriorating, with rates rising post-pandemic.
• The latest figure for England (2023-24) is 1264.9 per 100,000.
• This is getting worse: 1,264.9 per 100k in 2023-24 (NHSOF 3a). 21-year trend from 839.7 (2003/-4). COVID trough 849.9 (April 2020 to March 2021). Post-pandemic rebound continuing.
• Performance varies across NHS Regions (2023-24 data): the best-performing area (London) had a rate of 818.4 per 100,000, while the worst (North East and Yorkshire) had 1682.2 per 100,000.
• A rising ACSC rate is a direct signal of gaps in out-of-hospital care.
• Ambulatory care sensitive admissions - a classical proxy for primary/community care effectiveness.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

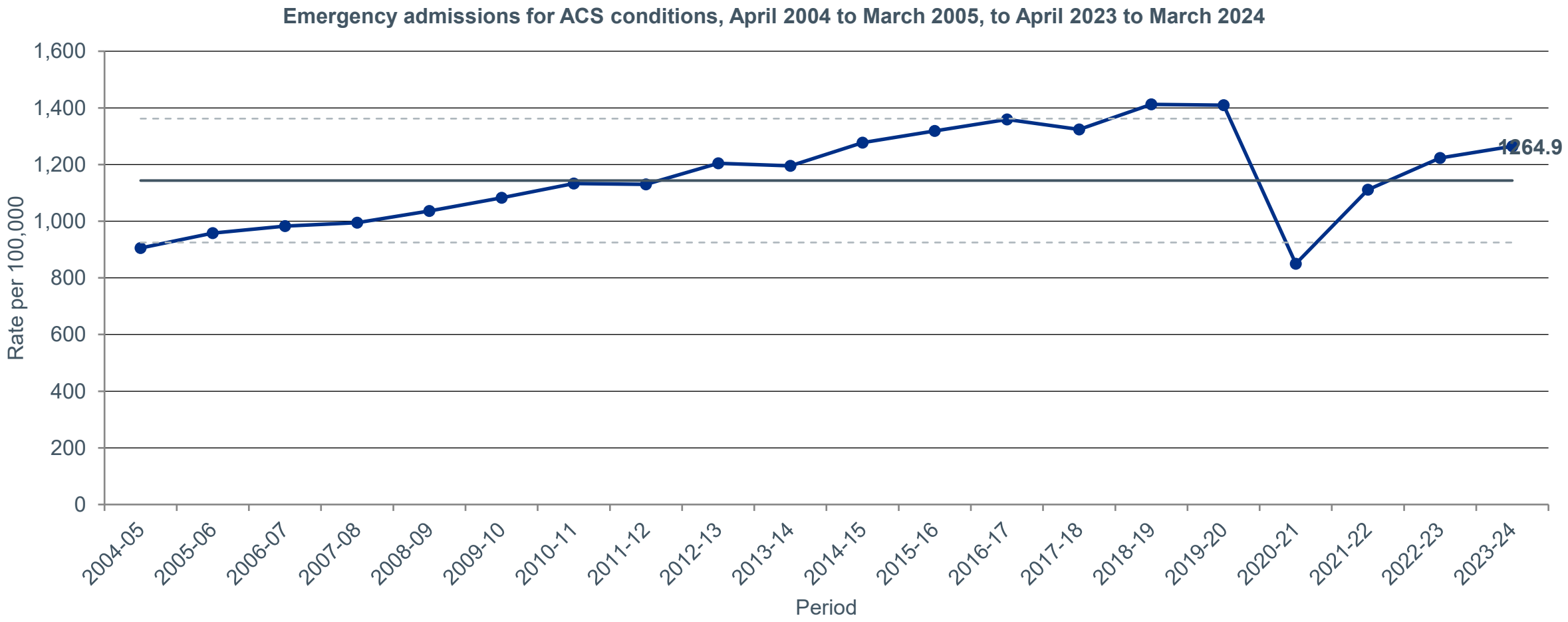
Source: NHS Digital, NHS Outcomes Framework indicator 3a (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Emergency admissions for ACS conditions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of emergency hospital admissions for ambulatory care sensitive conditions in England, covering 19 chronic conditions that should be manageable in primary care, expressed per 100,000 population (NHSOF indicator 3a).

Figure 1.150: Emergency admissions for ACS conditions: England trend



Source: NHS Digital, NHS Outcomes Framework indicator 3a (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Under-19 acute coronary syndrome (ACS) admissions (asthma/diabetes/epilepsy)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of unplanned hospital admissions for asthma, diabetes, and epilepsy in children and young people under 19 in England, expressed per 100,000 population (NHS Outcomes Framework (NHSOF) indicator 2.3.ii).

Why it matters for the strategy

• We track under-19 ACS admissions for asthma, diabetes and epilepsy because hospitalisations for these conditions in children are largely avoidable with good ambulatory care, self-management education and timely specialist review.
• The latest figure for England (April 2023 to March 2024) is 257.0 per 100,000.
• The picture is mixed: rate per 100,000 decreasing from 345.9 (2003-04) to 257.0 in April 2023 to March 2024 but has not improved since April 2021 to March 2022 (248.9) following the dip during the pandemic
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

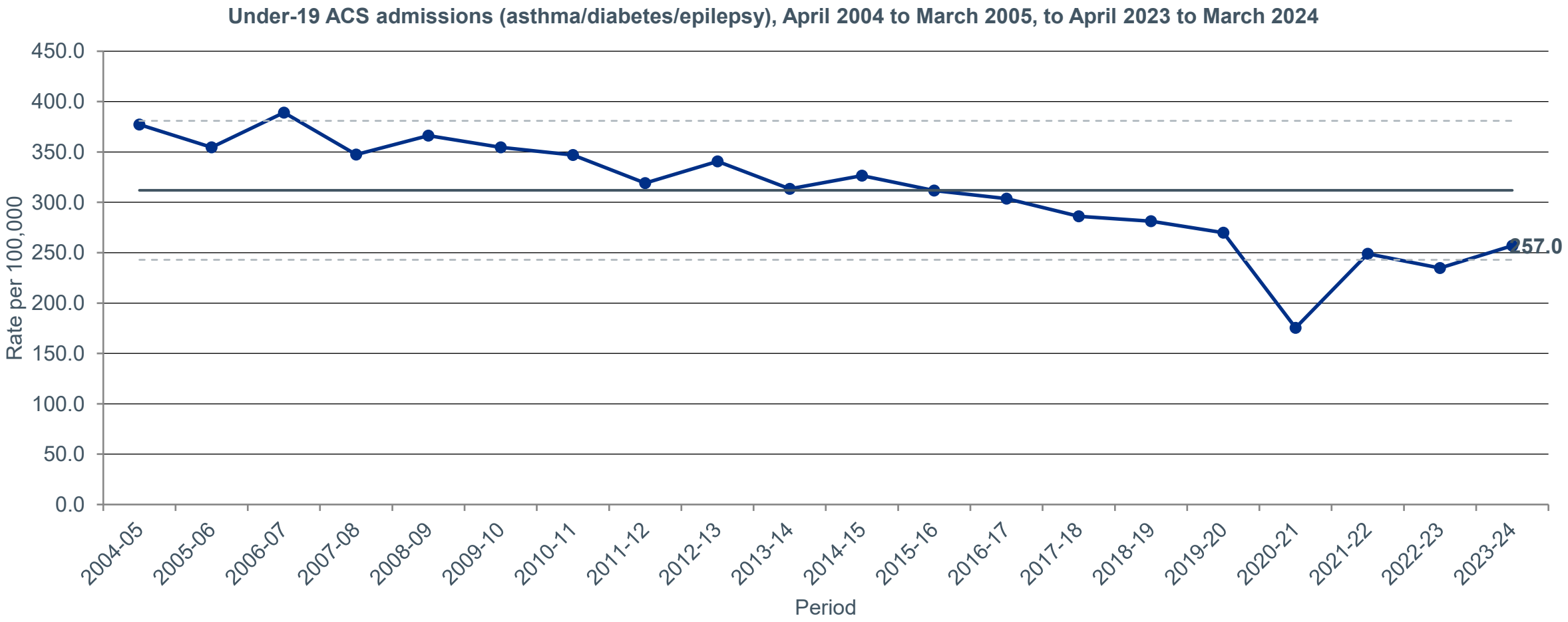
Source: NHS Digital, NHS Outcomes Framework indicator 2.3.ii (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Under-19 ACS admissions (asthma/diabetes/epilepsy)

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of unplanned hospital admissions for asthma, diabetes, and epilepsy in children and young people under 19 in England, expressed per 100,000 population (NHSOF indicator 2.3.ii).

Figure 1.151: Under-19 ACS admissions (asthma/diabetes/epilepsy): England trend



Source: NHS Digital, NHS Outcomes Framework indicator 2.3.ii (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Chronic acute coronary syndrome (ACS) condition admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of unplanned hospital admissions for chronic ambulatory care sensitive conditions in England, expressed per 100,000 population (NHS Outcomes Framework (NHSOF) indicator 2.3.i).

Why it matters for the strategy

• We track unplanned hospitalisations for chronic ACS conditions because these are a subset of ambulatory care sensitive condition (ACSC) admissions specifically for conditions manageable in primary care (diabetes, chronic obstructive pulmonary disease (COPD), asthma, epilepsy, heart failure), and the rate reflects the effectiveness of chronic disease management in primary and community care
• The latest figure for England (2023-24) is 841.8 per 100,000.
• The picture is mixed – the current rate of 841.8 per 100,000 in 2023-24 is below the pre-pandemic rate of 862.1 (2019-20) but has increased by ~180 per 100,000 since dip during the pandemic.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

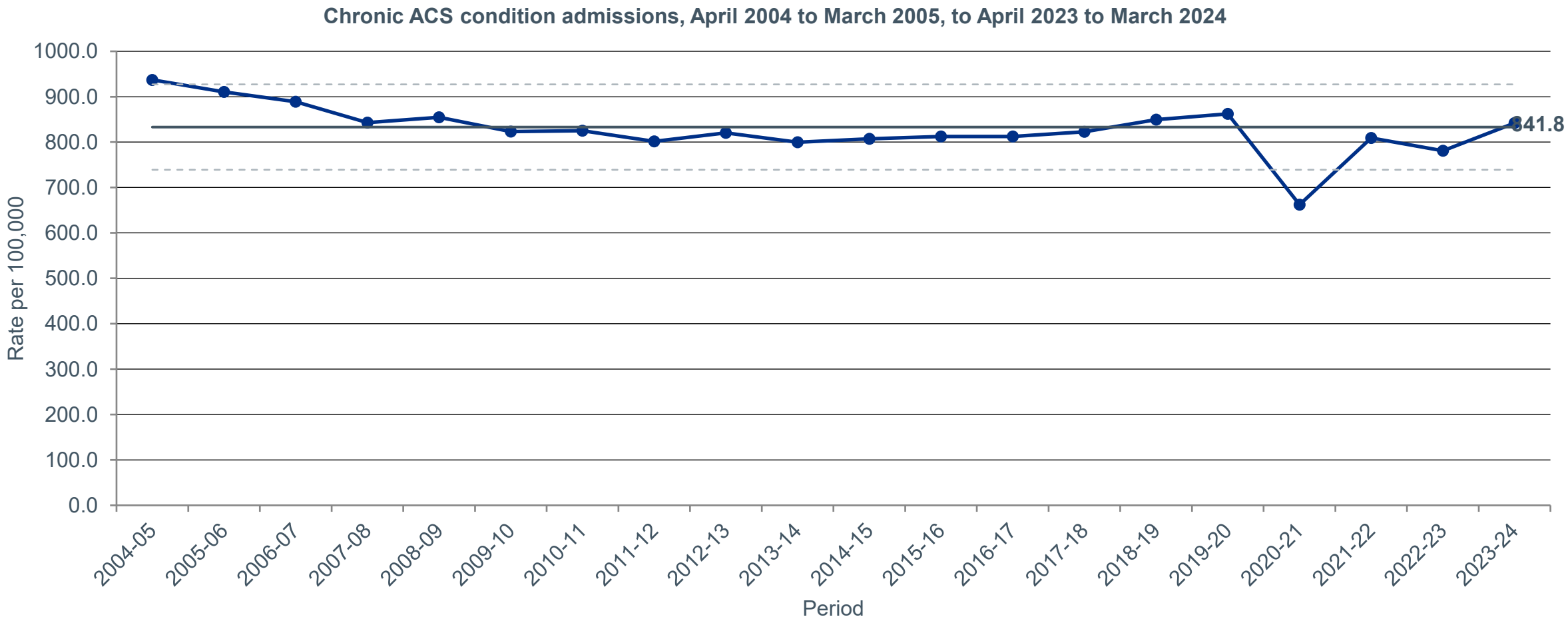
Source: NHS Digital, NHS Outcomes Framework indicator 2.3.i (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Chronic ACS condition admissions

Effectiveness | Tier 2: Driver | ↓ Lower is better

Age-standardised rate of unplanned hospital admissions for chronic ambulatory care sensitive conditions in England, expressed per 100,000 population (NHSOF indicator 2.3.i).

Figure 1.152: Chronic ACS condition admissions: England trend



Source: NHS Digital, NHS Outcomes Framework indicator 2.3.i (Feb 2025) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Emergency readmissions within 30 days

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of patients discharged from hospital in England who had an emergency readmission within 30 days, from Office for Health Improvement and Disparities (OHID) Fingertips indicator 41101.

Why it matters for the strategy

- We track 30-day emergency readmissions because they are indicator of problems with discharge planning, care transitions and post-discharge community support.
- The latest figure for England (April 2024 to March 2025) is 14.7%.
- Trend: This is getting worse: increasing by 2.1% since April 2014 to March 2015
- Performance varies across NHS Regions (2024-25 data): the best-performing area (East of England) had a rate of 13.9%, while the worst (South West) had 16.2%.
- People in the most deprived areas have a rate of 15.4%, compared with 14.0 in the least deprived - a gap of 1.4%.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

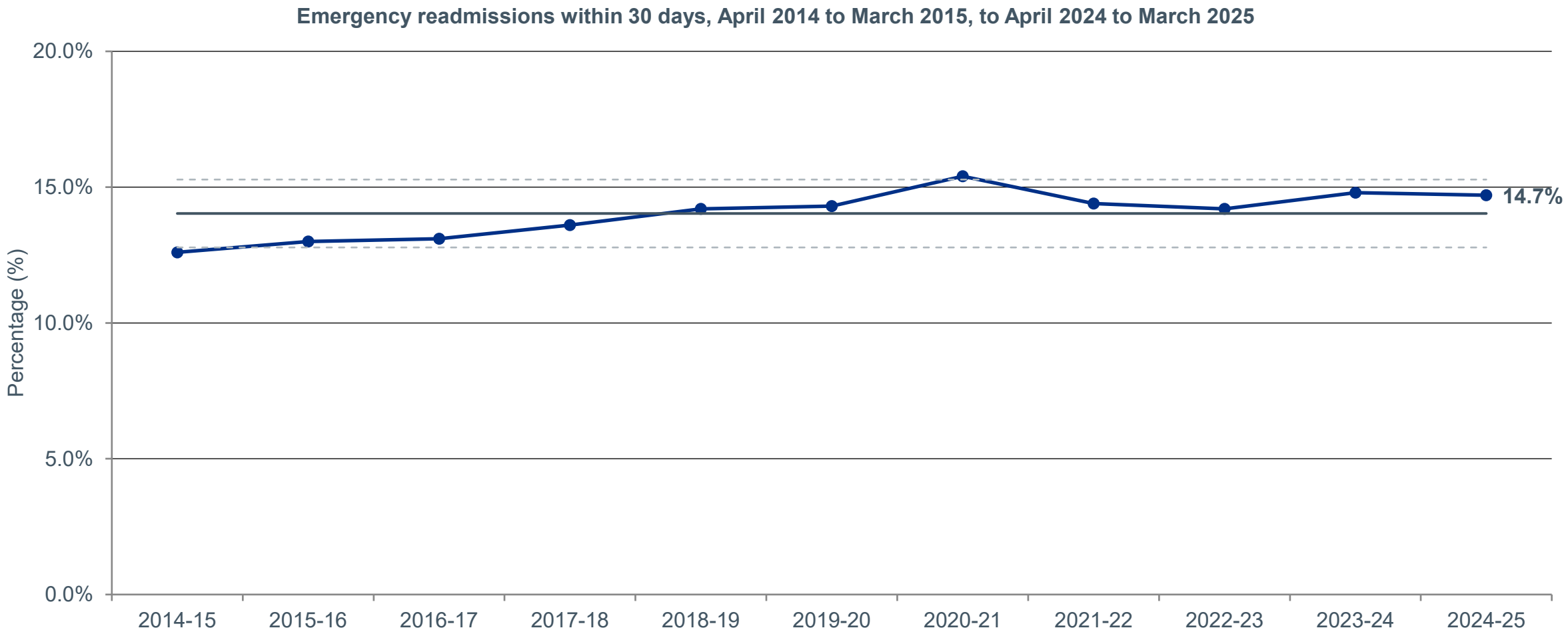
Source: OHID Fingertips indicator 41101

Emergency readmissions within 30 days

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of patients discharged from hospital in England who had an emergency readmission within 30 days, from OHID Fingertips indicator 41101.

Figure 1.153: Emergency readmissions within 30 days: England trend



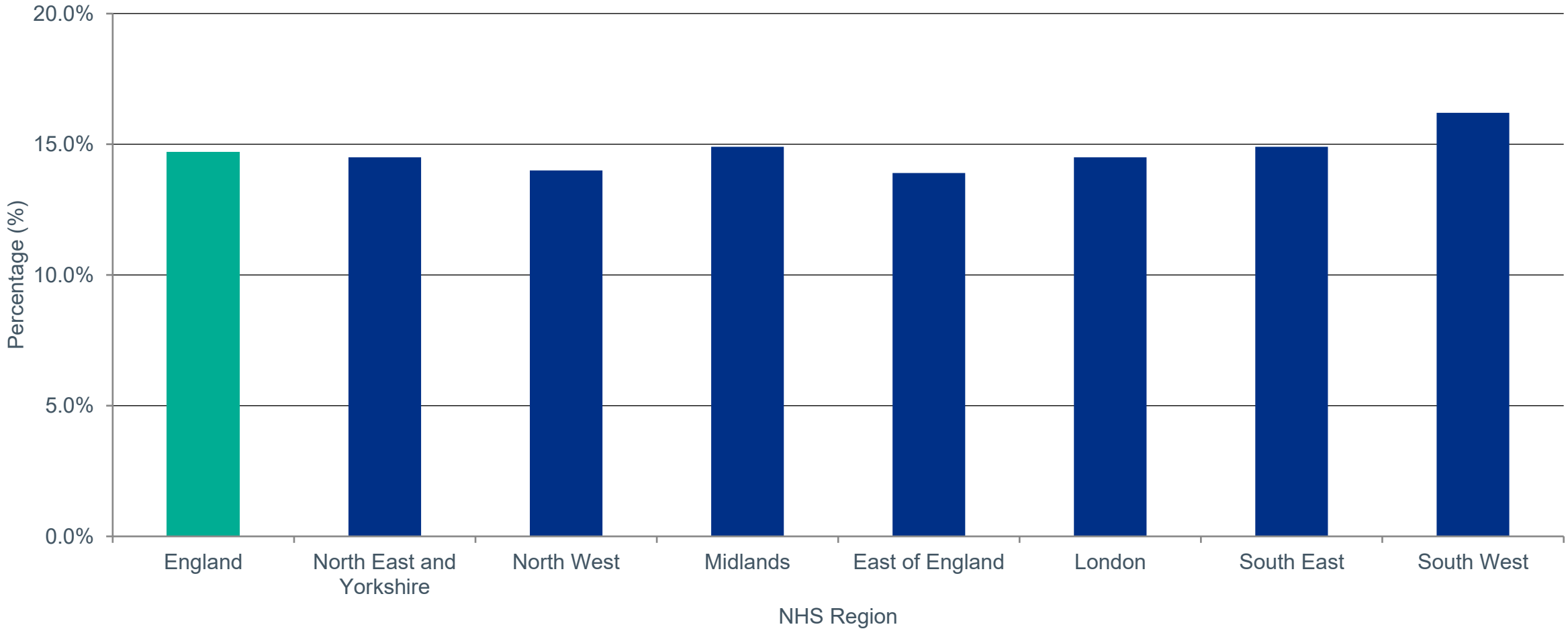
Source: OHID Fingertips indicator 41101

Emergency readmissions within 30 days

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of patients discharged from hospital in England who had an emergency readmission within 30 days, from OHID Fingertips indicator 41101.

Figure 1.154: Emergency readmissions within 30 days by NHS Region - April 2024 to March 2025



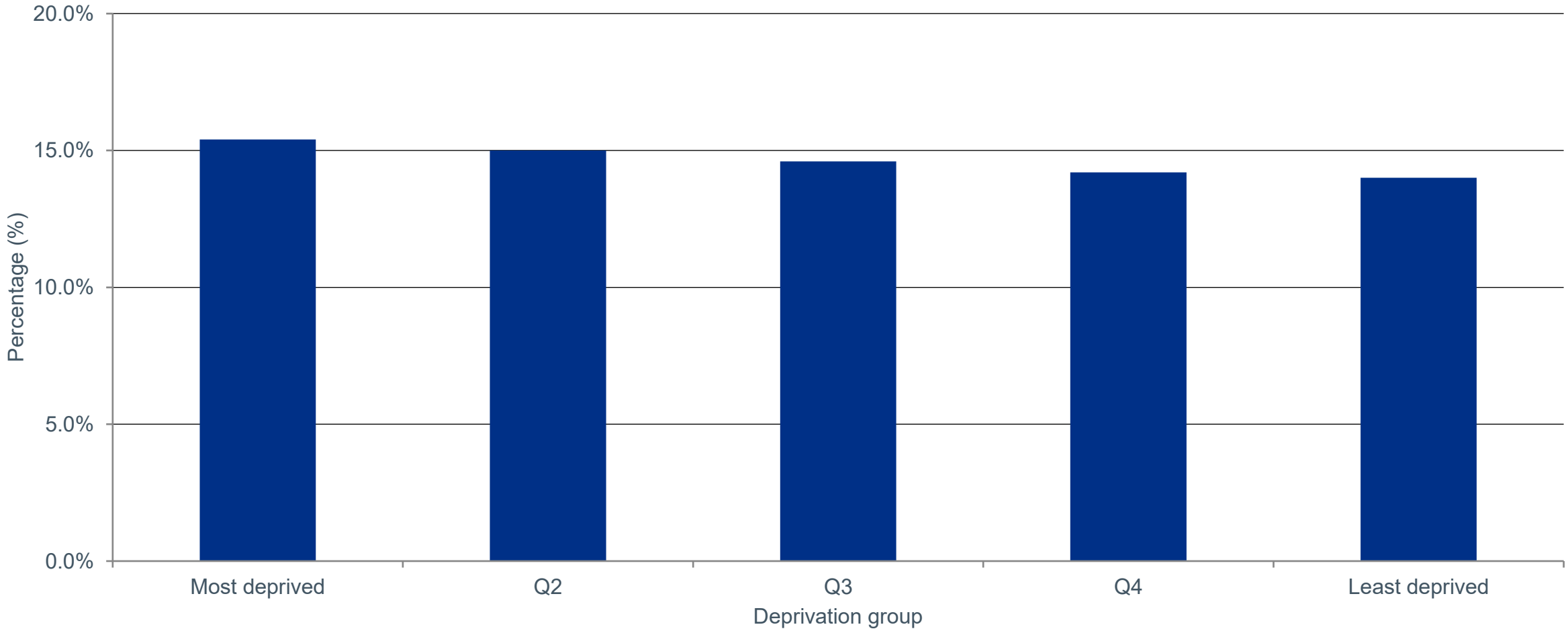
Source: OHID Fingertips indicator 41101

Emergency readmissions within 30 days

Effectiveness | Tier 2: Driver | ↓ Lower is better

Proportion of patients discharged from hospital in England who had an emergency readmission within 30 days, from OHID Fingertips indicator 41101.

Figure 1.155: Emergency readmissions within 30 days by deprivation group (Index of Multiple Deprivation (IMD) quintile), 2024=25



Source: OHID Fingertips indicator 41101

Elective waiting times (18 weeks)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of patients on incomplete referral-to-treatment pathways in England who have been waiting 18 weeks or less, from NHS England monthly referral to treatment (RTT) statistics.

Why it matters for the strategy

• We track elective waiting times because, while the list has fallen from its 7.77M peak (Sep 2023) to 7.23M, this remains the largest sustained backlog in NHS history, with significant consequences for patient outcomes and experience
• The latest figure for England (March 2026) is 65.3%.
• This is getting better: increasing by 7.1% between August 2024 (58.2%) and Mar-25 (65.3%)
• Tier 3 signal - fast-moving operational indicator suitable for SPC surveillance.

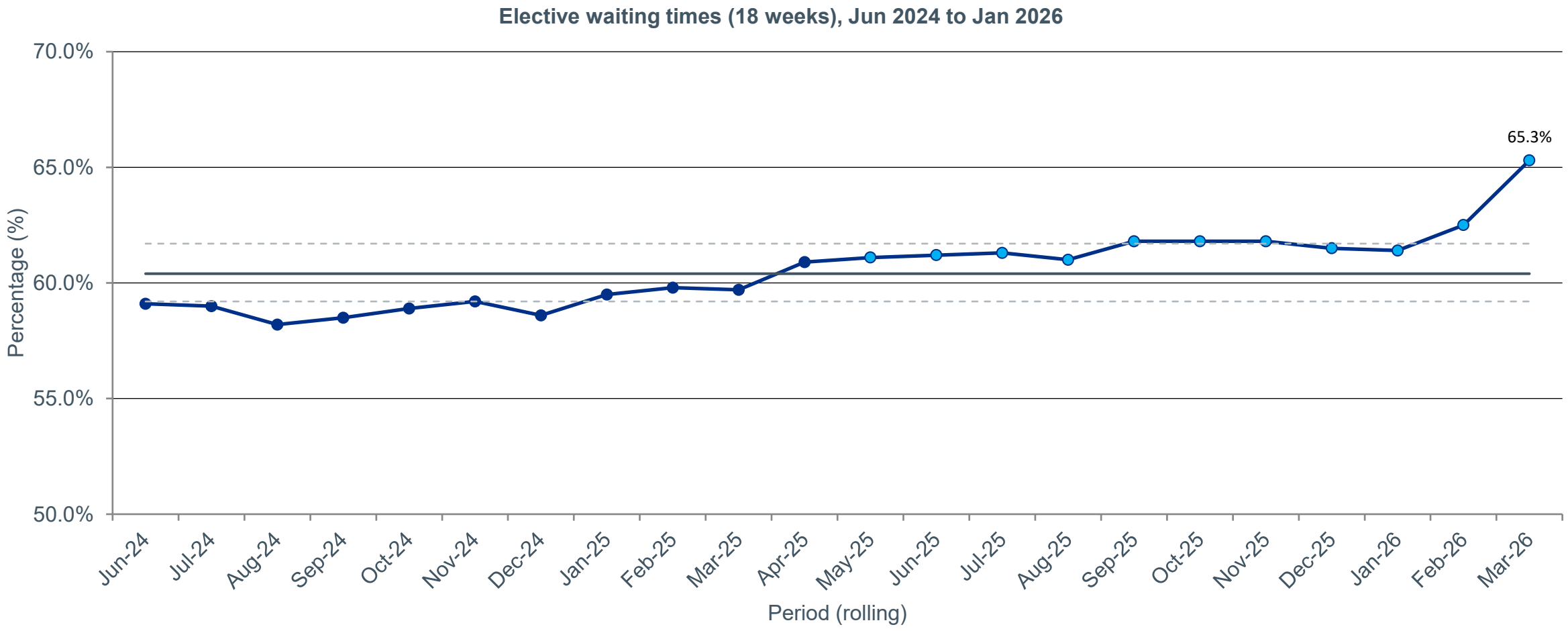
Source: NHS England, Referral to Treatment (RTT) waiting times statistics, January 2026 (published Mar 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Elective waiting times (18 weeks)

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Proportion of patients on incomplete referral-to-treatment pathways in England who have been waiting 18 weeks or less, from NHS England monthly RTT statistics.

Figure 1.156: Elective waiting times (18 weeks): England trend



Source: NHS England, Referral to Treatment (RTT) waiting times statistics, January 2026 (published Mar 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Ambulance Category 2 mean response time

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Mean response time for Cat 2 ambulance calls.

Why it matters for the strategy

• Category 2 ambulance mean response time is the headline operational signal for urgent pre-hospital care, covering conditions including stroke and heart attack where each minute of delay worsens outcomes.
• The latest figure for England is 24m 27s in Apr-26.
• Trend: This is getting better, reducing by 3m 5s from Apr-25 (27m 32s)
.

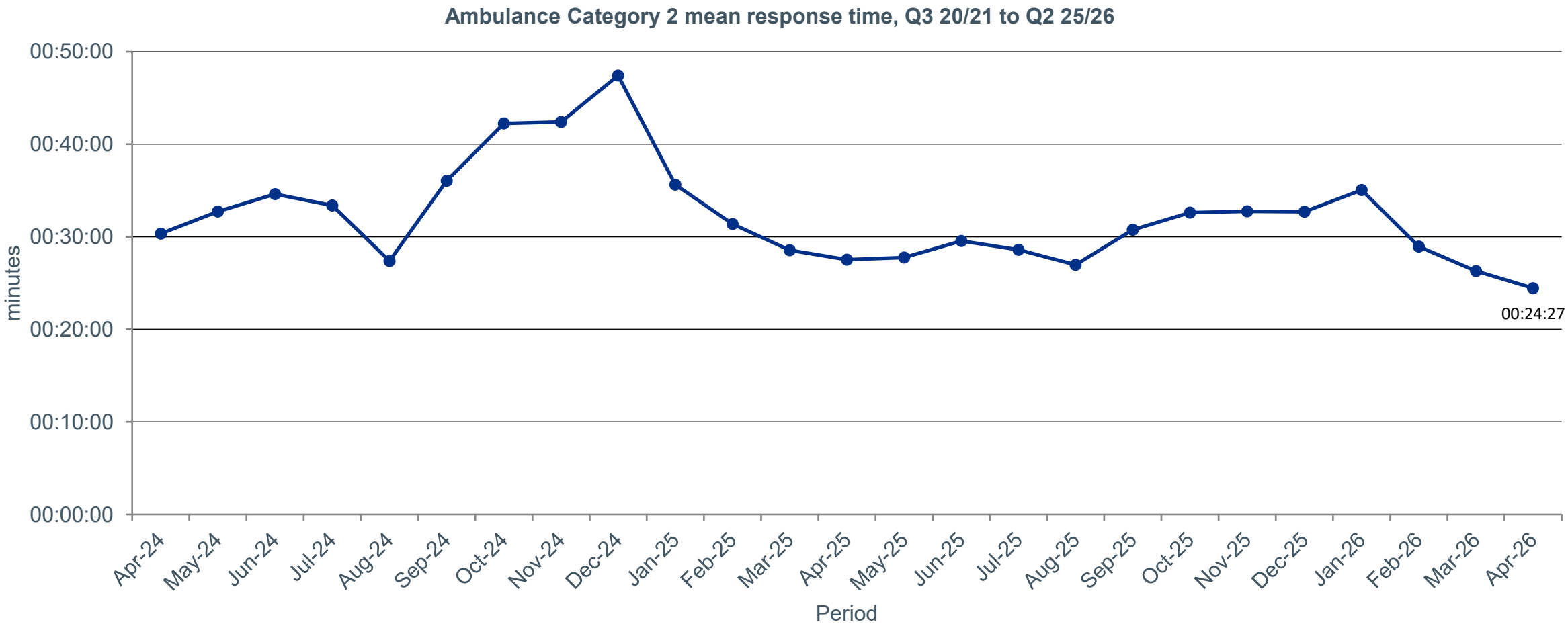
Source: Office for Health Improvement and Disparities (OHID) Fingertips [93824] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Ambulance Category 2 mean response time

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Mean response time for Cat 2 ambulance calls.

Figure 1.157: Ambulance Category 2 mean response time: England trend



Source: OHID Fingertips [93824] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Community services 52+ week waits

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Number waiting 52+ weeks for community services.

Why it matters for the strategy

- The latest figure for England is 89,630 for Mar-26
- Trend: This is getting worse, increasing by around 52,000 from Feb-24 (37,620) to Mar-26 (89,630).
- Included as the community-equivalent of the acute referral to treatment (RTT) long-waits measure.
- Tier 3 signal - fast-moving operational indicator suitable for SPC surveillance.

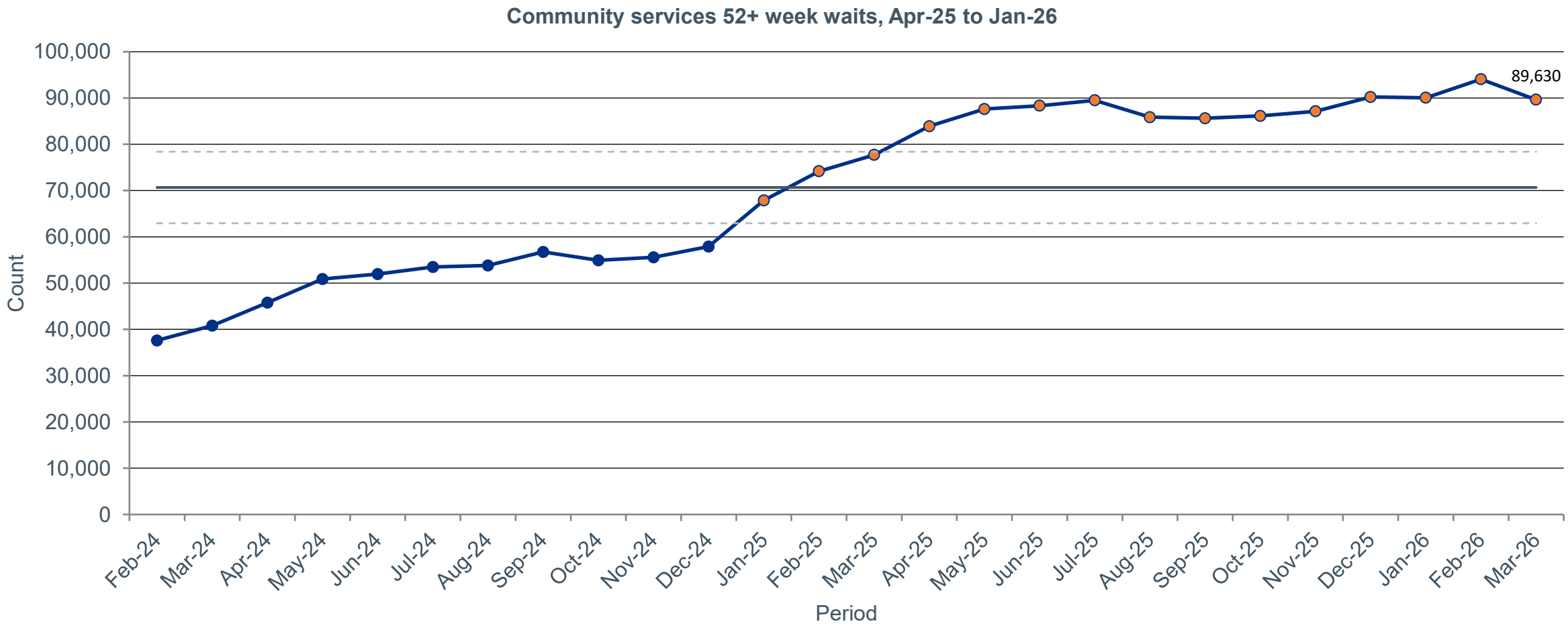
Source: Community Health Services (CHS) SitRep, NHS England (Mar 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Community services 52+ week waits

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Number waiting 52+ weeks for community services.

Figure 1.158: Community services 52+ week waits: England trend



Source: Community Health Services (CHS) SitRep, NHS England (Mar 2026) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

65+ at home 91 days after reablement

Effectiveness | Tier 2: Driver | ↑ Higher is better

Percentage still at home 91 days after reablement.

Why it matters for the strategy

- The latest figure for England (April 2024 to March 2025) is 60.7%.
- Only one data point currently as this metric is using a new methodology based on client-linked data from April 2024 to March 2025.
- Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (South East) achieved 66.0%, while the lowest (East of England) achieved 57.7%.
- The accepted national indicator of whether short-term rehabilitation has supported sustained independence, and a downstream effectiveness signal for discharge-to-assess and transfer-of-care pathways.
- Discharge-to-assess effectiveness signal. Aligns with the strategy's transitions-of-care commitment.

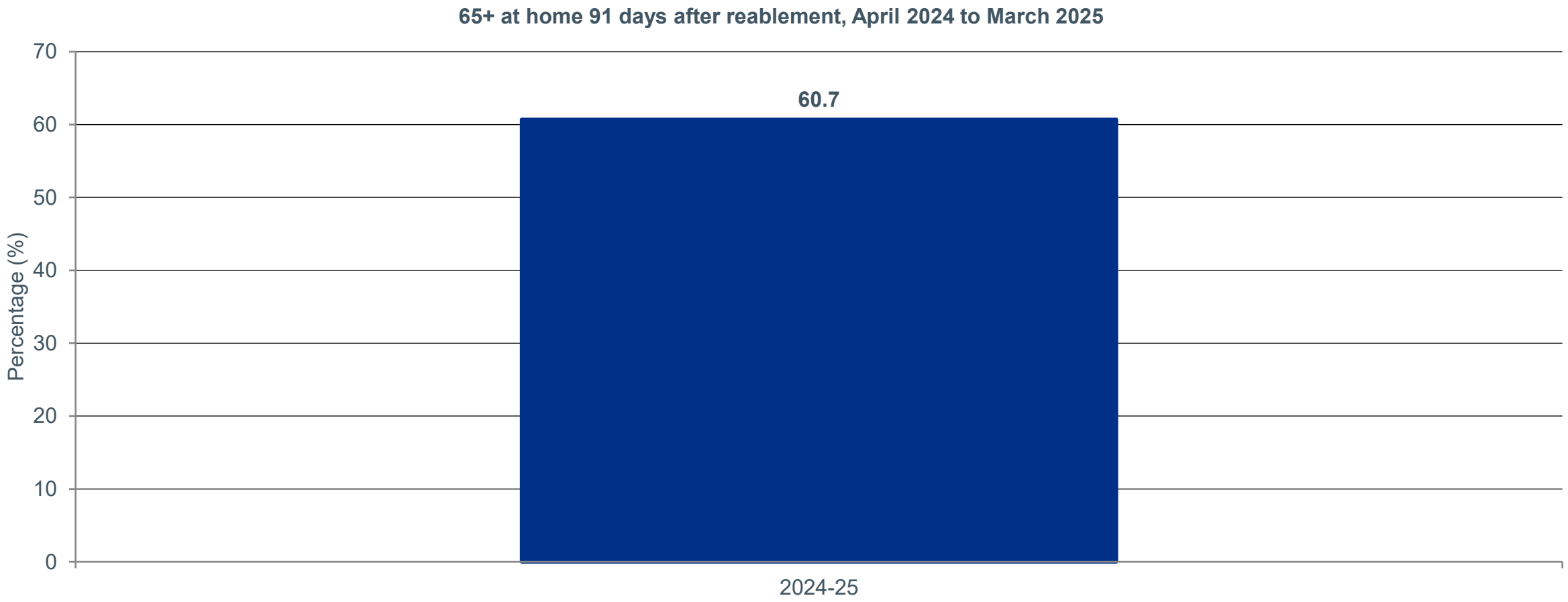
Source: Adult Social Care Outcomes Framework (ASCOF) 2d(1), Department of Health and Social Care (DHSC) (Jan 2026). New chronic liver disease (CLD) methodology from April 2024 to March 2025.

65+ at home 91 days after reablement

Effectiveness | Tier 2: Driver | ↑ Higher is better

Percentage still at home 91 days after reablement.

Figure 1.159: 65+ at home 91 days after reablement: England trend



Source: ASCOF 2d(1), DHSC (Jan 2026). New CLD methodology from April 2024 to March 2025.

Referral to treatment (RTT) patients waiting 52+ weeks

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Patients on incomplete RTT pathways waiting 52+ weeks.

Why it matters for the strategy

- Long waits are a key cause of deconditioning, mental health deterioration and worsening outcomes
- The latest figure for England (Mar 2026) is 92,609
- This is getting better, reducing by around 210 thousand waiting 52+ weeks from June 2024 (302,693) to Mar 2026 (92,609).
- Tier 3 signal - fast-moving operational indicator suitable for SPC surveillance.

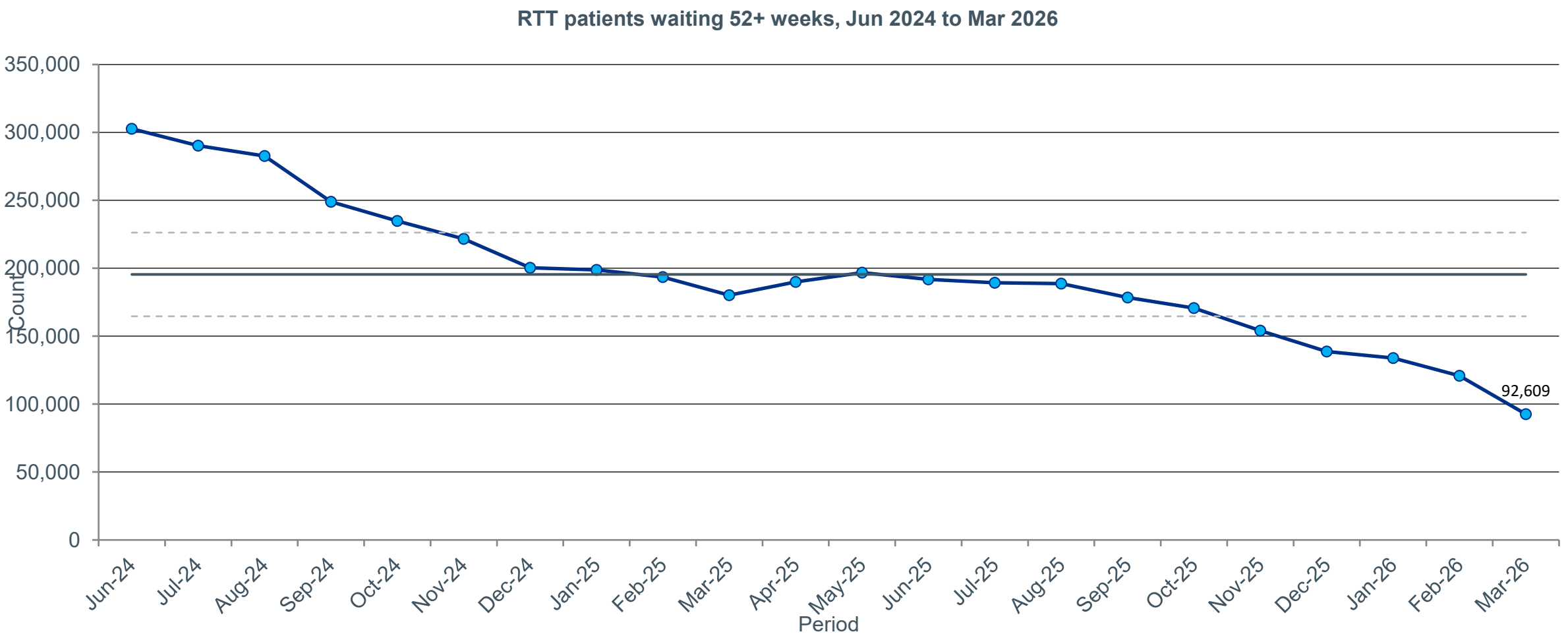
Source: NHS England RTT waiting times (monthly) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

RTT patients waiting 52+ weeks

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Patients on incomplete RTT pathways waiting 52+ weeks.

Figure 1.160: RTT patients waiting 52+ weeks: England trend



Source: NHS England RTT waiting times (monthly) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Surgical cancellations on day of/after admission

Effectiveness | Tier 2: Driver | ↓ Lower is better

Operations cancelled on day of or after admission.

Why it matters for the strategy

- The latest figure for England (Q3 April 2025 to March 2026) is 21,456
- This is broadly stable with a seasonal pattern - surgical cancellations on day of/after admission decreased by around 1,200 in the 12 months from Q3 April 2024 to March 2025 (22,681) and Q3 April 2025 to March 2026 (21,456).
- A direct patient-harm and patient-experience indicator, and a sensitive signal of bed, workforce or theatre pressure.
- Aligns with the strategy's safety and access priorities.
- Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

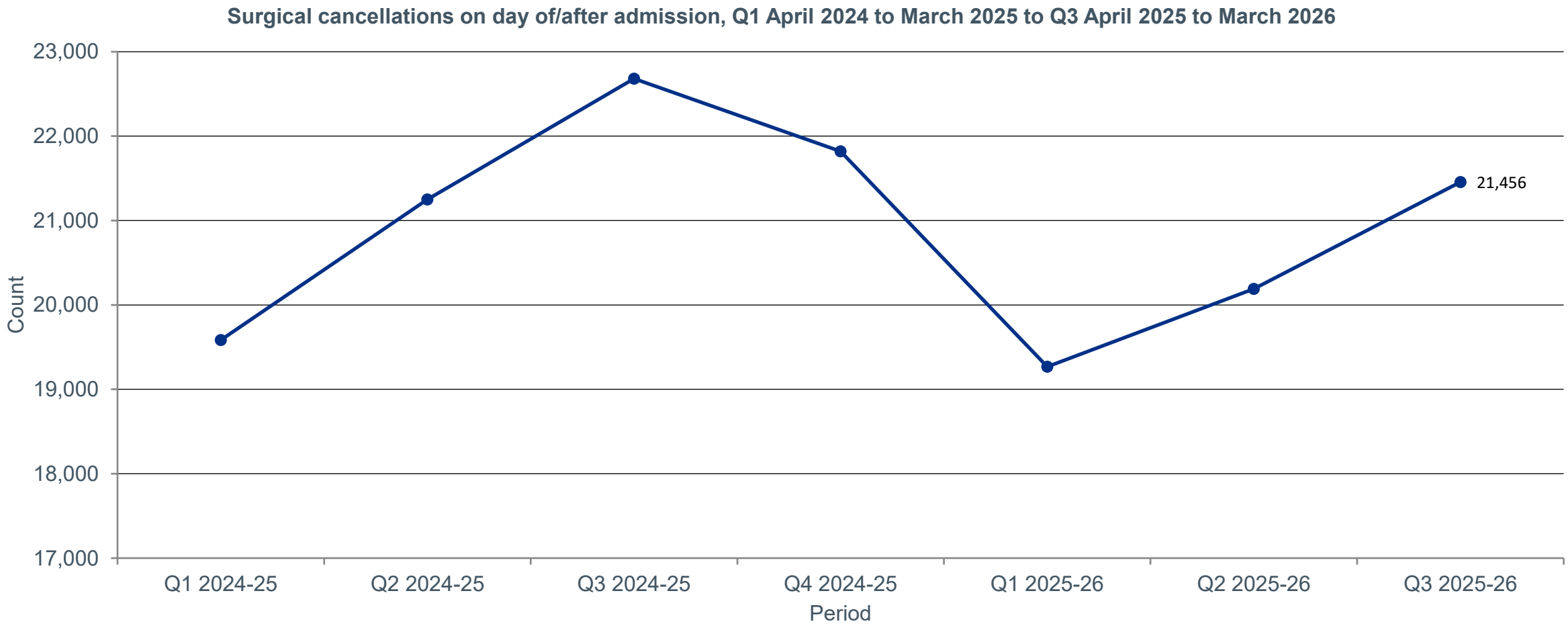
Source: NHS England Cancelled Elective Operations (quarterly)

Surgical cancellations on day of/after admission

Effectiveness | Tier 2: Driver | ↓ Lower is better

Operations cancelled on day of or after admission.

Figure 1.161: Surgical cancellations on day of/after admission: England trend



Source: NHS England Cancelled Elective Operations (quarterly)

Outpatient – Did Not Attend

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Proportion of outpatient appointments where the patient did not attend

Why it matters for the strategy

- Outpatient ‘Did Not Attend’s lengthen waits and waste system capacity
- The latest figure for England (March 2026) is 5.6%
- This has remained broadly similar since April 2024 but has increased by 0.3% since then

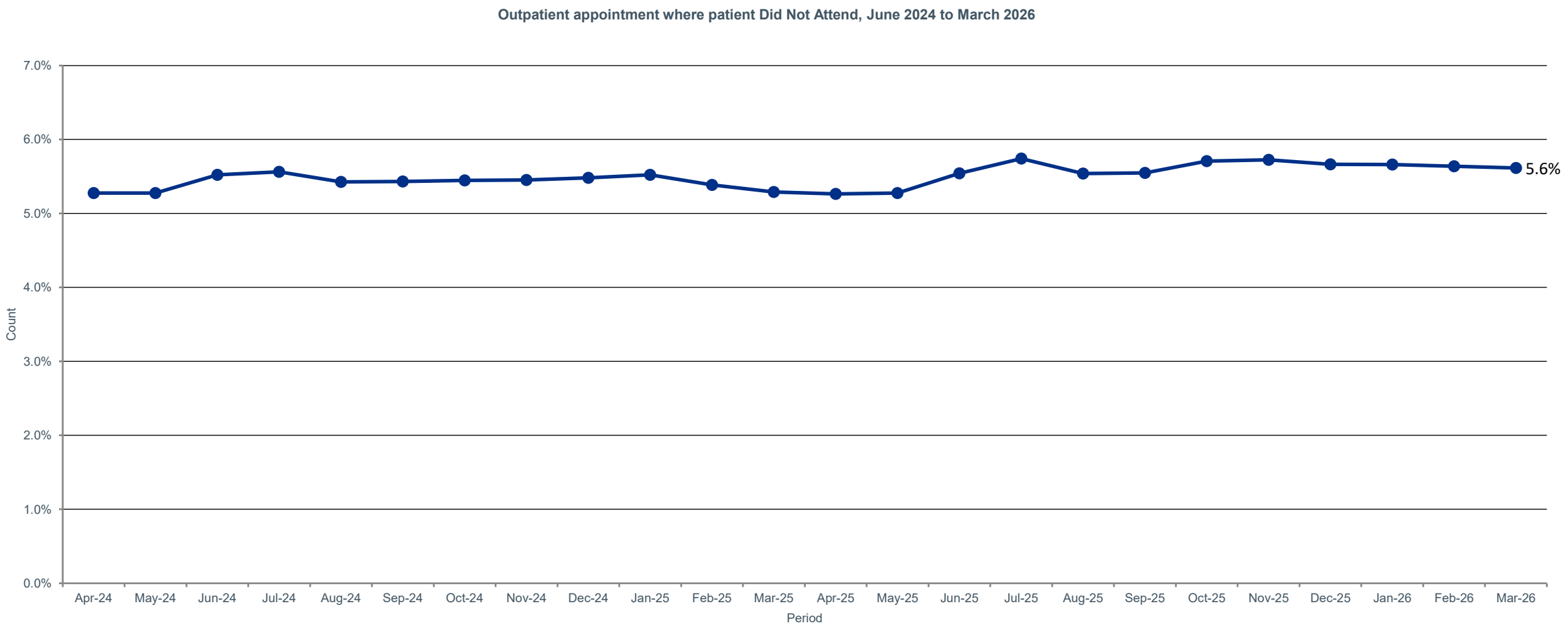
Source: NHS Hospital Episode Statistics, Admitted Patient Care and Outpatients

Outpatient – Did Not Attend

Effectiveness | Tier 3: Process indicator | ↓ Lower is better

Proportion of outpatient appointments where the patient did not attend

Figure 1.162: Outpatient – Did Not Attend: England trend



Source: NHS Hospital Episode Statistics, Admitted Patient Care and Outpatients

Percentage of urgent community referrals seen within 2 hours

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Percentage of 2-hour urgent community response (UCR) referrals seen within 2 hours.

Why it matters for the strategy

- The latest figure for England (March 2026 (provisional)) is 85.4%.
- Trend: This is broadly stable, varying between 84.1% and 85.4% at points between April 2025 and March 2026
- Performance varies across NHS Regions (February 2026 (provisional*) data): the best-performing area (North West) achieved 88.0%, while the lowest (East of England) achieved 81.7%.
- When it fails, demand pushes back into A&E and ambulance services, against the strategy's community-first emphasis.
- Operational measure for the strategy's community-first emphasis and the Neighbourhood Health model.
- Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

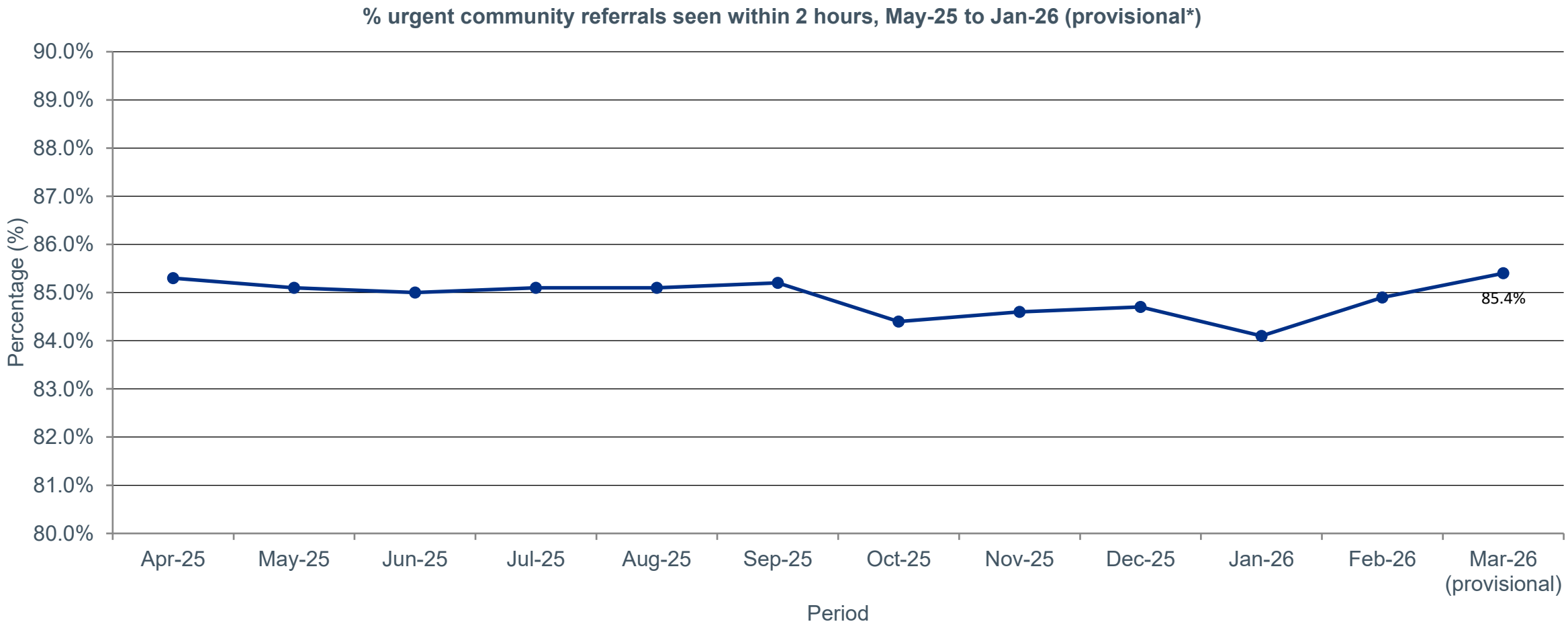
Source: NHS England 2-hour Urgent Community Response (monthly)

Percentage of urgent community referrals seen within 2 hours

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Percentage of 2-hour UCR referrals seen within 2 hours.

Figure 1.163: Percentage of urgent community referrals seen within 2 hours: England trend



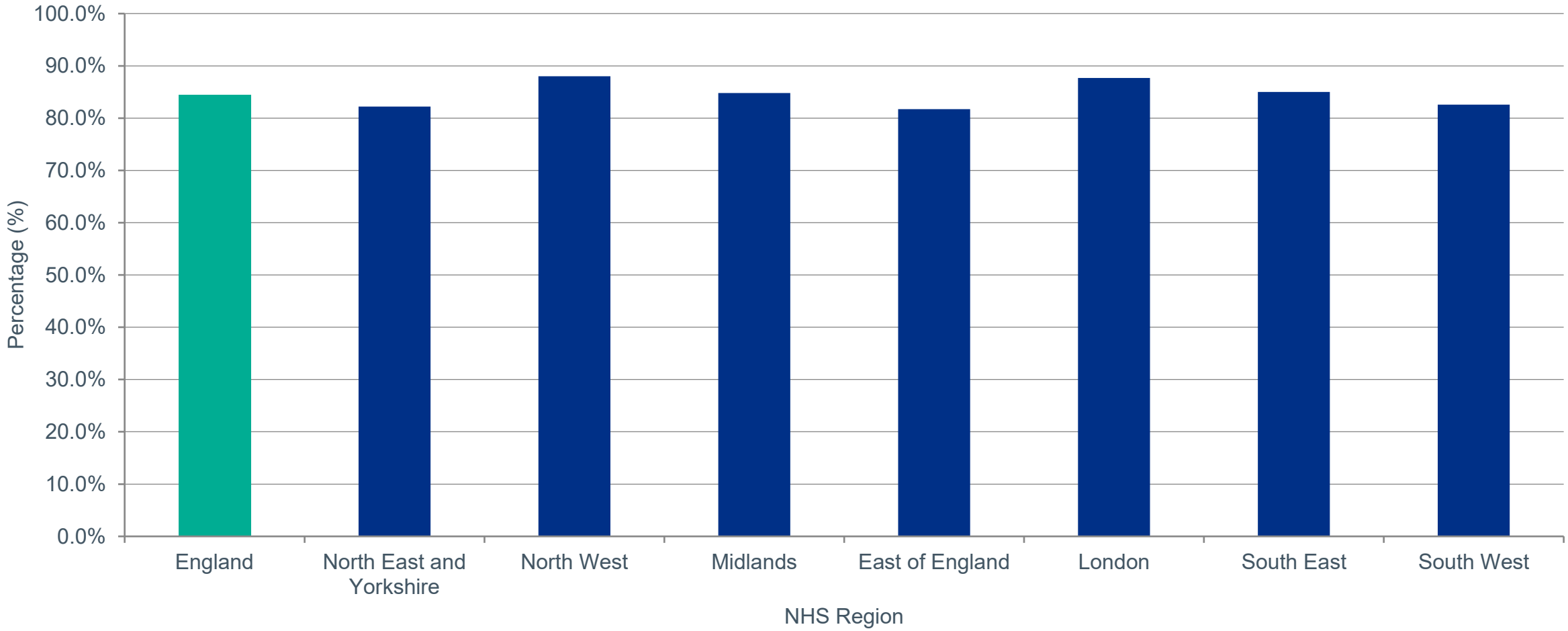
Source: NHS England 2-hour Urgent Community Response (monthly)

Percentage of urgent community referrals seen within 2 hours

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Percentage of 2-hour UCR referrals seen within 2 hours.

Figure 1.164: Percentage of urgent community referrals seen within 2 hours by NHS Region



Source: NHS England 2-hour Urgent Community Response (monthly)

Referrals to community services

Effectiveness | Tier 3: Process indicator | ↑ Higher is better

Volume of all urgent community response contacts.

Why it matters for the strategy

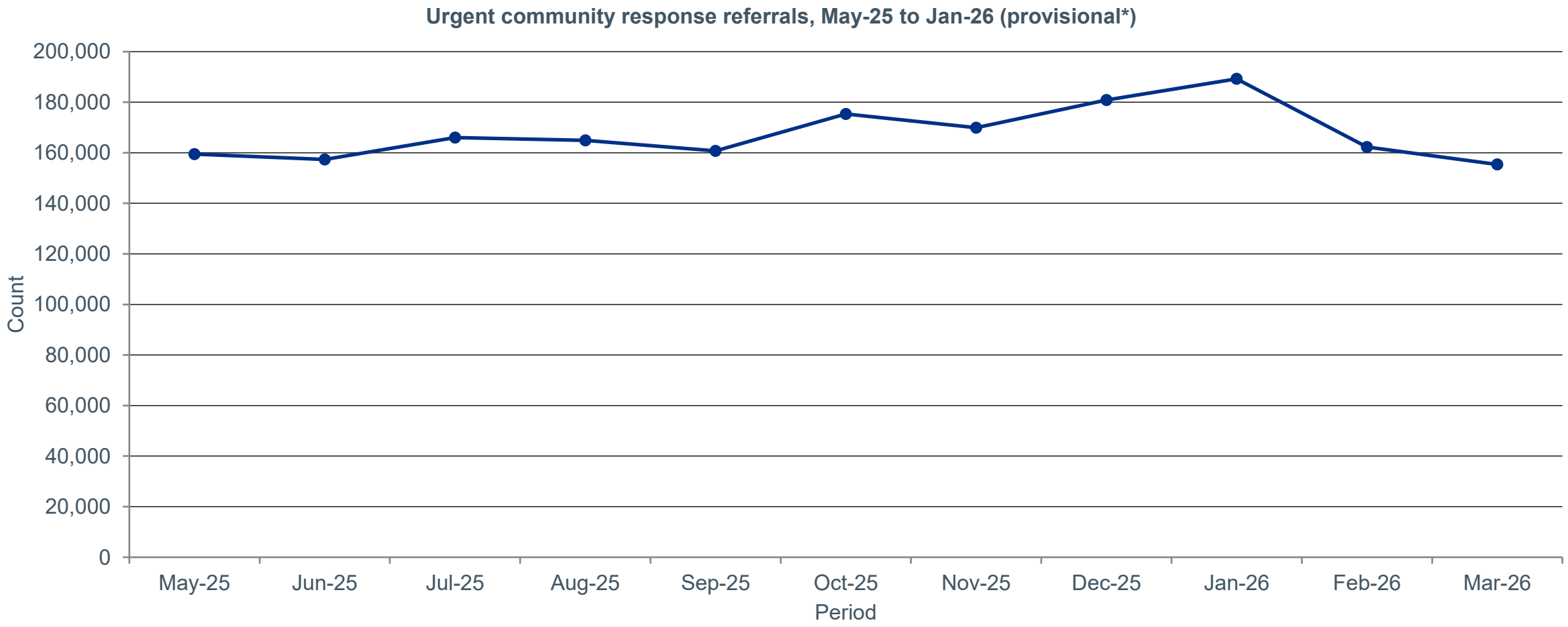
- The latest figure for England (Feb-26) is 162,300
- Trend: This is broadly stable, at around 155 to 160 thousand between Apr-25 and Mar-26, though down from a peak of around 189,000 in Jan-26
- Acts as both the denominator for urgent community response (UCR) performance measures and a direct read on community-service capacity in use.
- Capacity signal for the strategy's shift from acute to community settings.
- Tier 3 signal - fast-moving operational indicator suitable for statistical process control (SPC) surveillance.

Source: NHS England 2-hour Urgent Community Response (monthly)

Referrals to community services

Effectiveness | Tier 3: Process indicator | ↑ Higher is better
Volume of all urgent community response contacts.

Figure 1.165: Referrals to community services: England trend



Source: NHS England 2-hour Urgent Community Response (monthly)

Under-18 mortality rate

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Deaths 1-17 per 100,000 population. Annual National Child Mortality Database (NCMD) (from CDOPs) and Office for National Statistics (ONS).

Why it matters for the strategy

- The latest figure for England (2022 to 2024) is 9.19 per 100,000.
- Trend: 9.19 per 100,000 (2022 to 2024).
- People in the most deprived areas have a rate of 14.9 per 100,000, compared with 9.2 in the least deprived - a gap of 5.7 per 100,000.
- The picture is mixed - under-18 mortality fell by around 9 per 100,000 between April 2003 to March 2005 (16.9) and 2011 to 2013 (8.1) before rising to 9.2 in 2022 to 2024.
- Children and young people (CYP) health is a priority pathway in the strategy, with a Modern Service Framework in development.
- strategy CYP priority. Includes avoidable, preventable and early-life deaths.
- Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

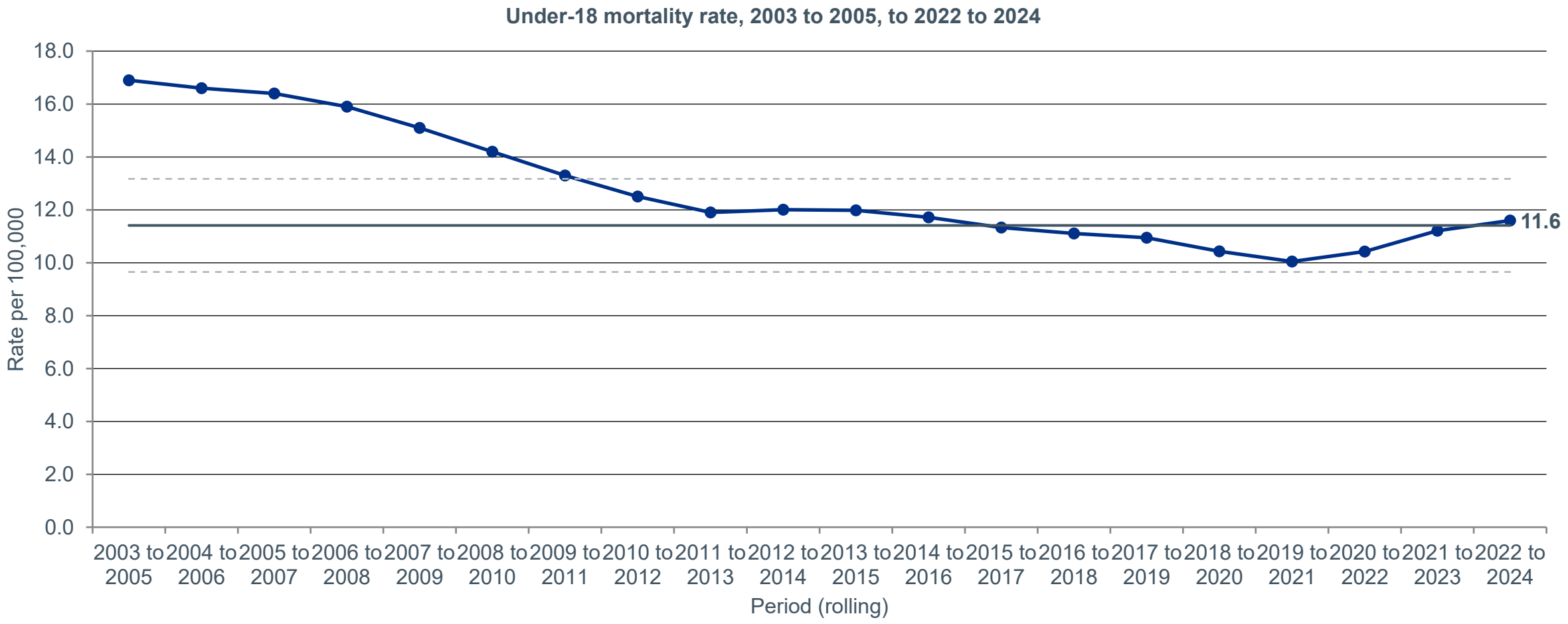
Source: Office for Health Improvement and Disparities (OHID) Fingertips [90801] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Under-18 mortality rate

Effectiveness | Tier 1: Outcome | ↓ Lower is better

Deaths 1-17 per 100,000 population. Annual NCMD (from CDOPs) and ONS.

Figure 1.166: Under-18 mortality rate: England trend



Source: OHID Fingertips [90801] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Cause contribution to under-75 mortality

Effectiveness | Tier 2: Driver

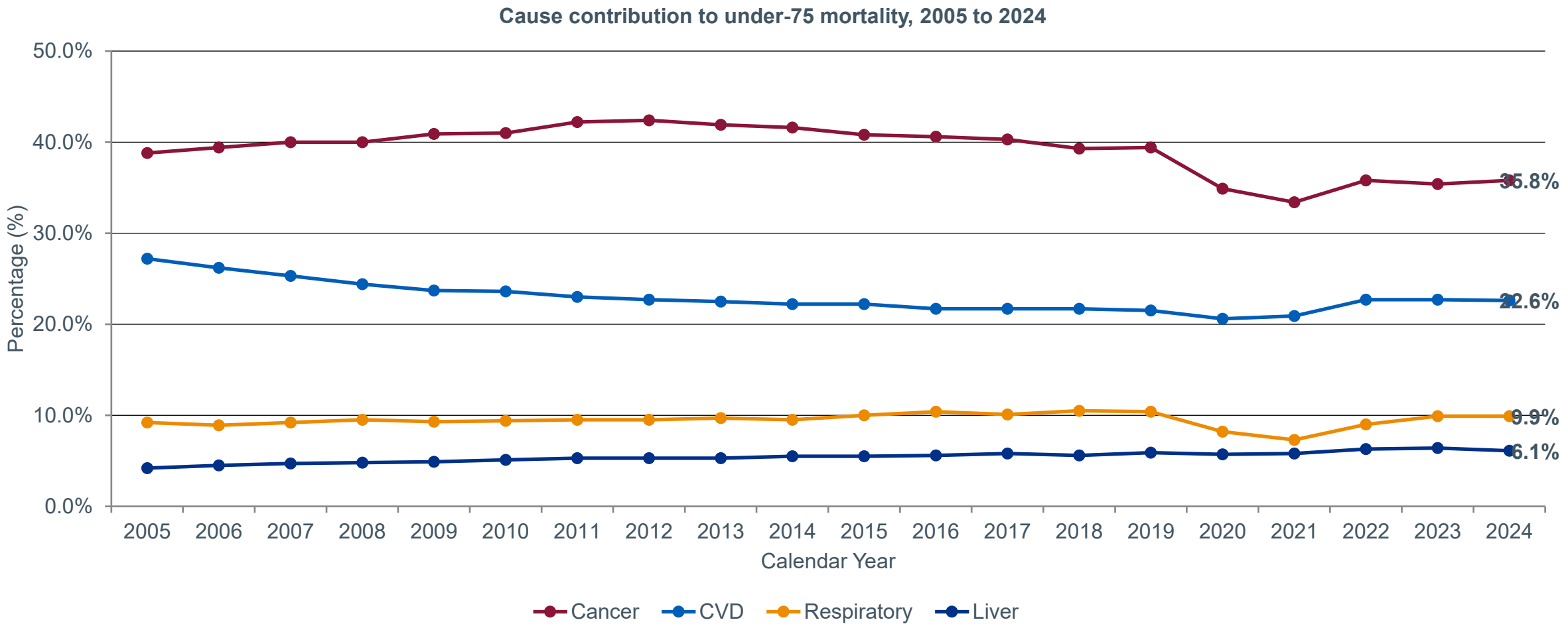
Proportional breakdown of under-75 mortality in England by major cause group (cancer, cardiovascular disease (CVD), respiratory, liver disease), derived from Office for Health Improvement and Disparities (OHID) Fingertips cause-specific mortality indicators.

Why it matters for the strategy

• We track the proportional contribution of different causes to premature mortality because understanding the relative weight of CVD, cancer, respiratory, and liver disease deaths informs where the greatest gains from prevention and treatment improvement can be made.
• The latest figure for England (2024) is 74.4%.
• The picture is mixed: Proportional breakdown of under-75 mortality by cause (2024, Fingertips). Cancer 35.8% (largest cause, declining from 42% peak 2012). CVD 22.6% (declining from 27% in 2005). Respiratory 9.9% (stable ~10%). Liver 6.1% (rising from 4.2% in 2005, the only worsening cause). COVID effect visible: April 2020 to March 2021 4-cause sum dropped to 67-69% as COVID deaths inflated total denominator.
• Strategic-targeting signal for the strategy's effectiveness pathways. Companion to premature mortality in Core.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: OHID Fingertips: indicator 108 (all-cause U75, 329.4/100k), 40401 (CVD, 74.3), 40501 (cancer, 117.9), 40701 (respiratory, 32.7), 40601 (liver, 20.1). All 2024, persons. NOTE: 40601=liver, 4...

Figure 1.167: Cause contribution to under-75 mortality: England trend



Source: OHID Fingertips: indicator 108 (all-cause U75, 329.4/100k), 40401 (CVD, 74.3), 40501 (cancer, 117.9), 40701 (respiratory, 32.7), 40601 (liver, 20.1). All 2024, persons. NOTE: 40601=liver, 4...

Safety

This section covers patient safety, one of the three core domains of quality: whether the NHS is keeping people safe from avoidable harm during their care.

Metrics span healthcare-associated infections, physical harm in hospital (falls, venous thromboembolism (VTE)), maternity and neonatal safety, and safety culture.

Healthcare-associated infection (HCAI): E.coli

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia), expressed per 100,000 population using the Trust Counting methodology from Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• We track healthcare-associated infections because they are a direct measure of the safety of care delivered in hospitals and community settings. Rising rates of C.difficile and MRSA since the pandemic indicate that earlier gains in infection prevention have been reversed. The current trend is deteriorating, with C.difficile and MRSA rates rising since April 2020 to March 2021.
• The latest figure for England (April 2024 to March 2025) is E.coli 76.6 per 100,000.
• This is getting worse: E.coli up 17% since April 2020 to March 2021.
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (London) had a rate of 65.4 per 100,000, while the worst (North East and Yorkshire) had 92.5 per 100,000.
• People in the most deprived areas have a rate of 110.4 per 100,000, compared with 56.4 in the least deprived - a gap of 54.0 per 100,000.
• HCAI is the most direct read on whether basic infection-prevention discipline is holding, across both hospital and community-onset cases.
• Antimicrobial stewardship sits alongside as a Tier 2 lever.
• The strategy treats hospital-acquired infection as a safety priority the system must drive down.

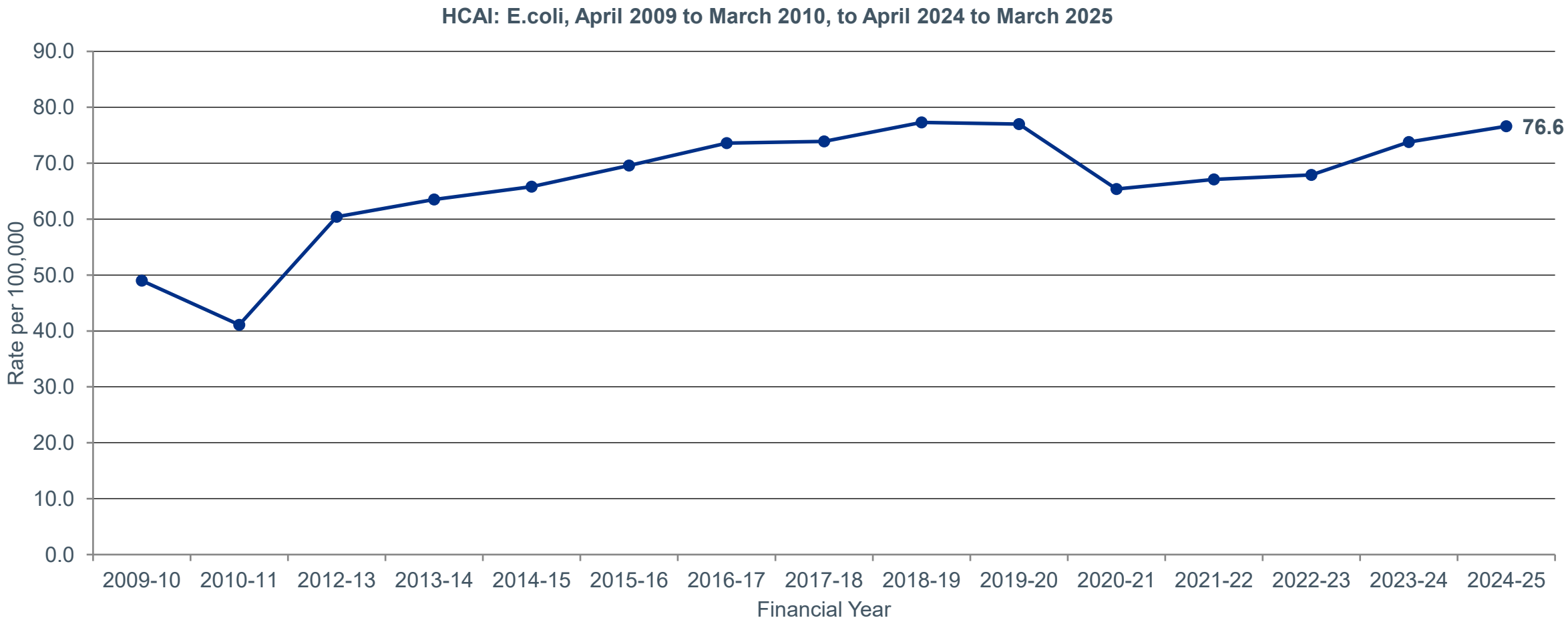
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: E.coli (indicator 91909). Trust Counting = hospital-onset healthcare-associated (HOHA)+community-onset healthcare-associated (COHA).

HCAI: E.coli

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.1: HCAI: E.coli: England trend



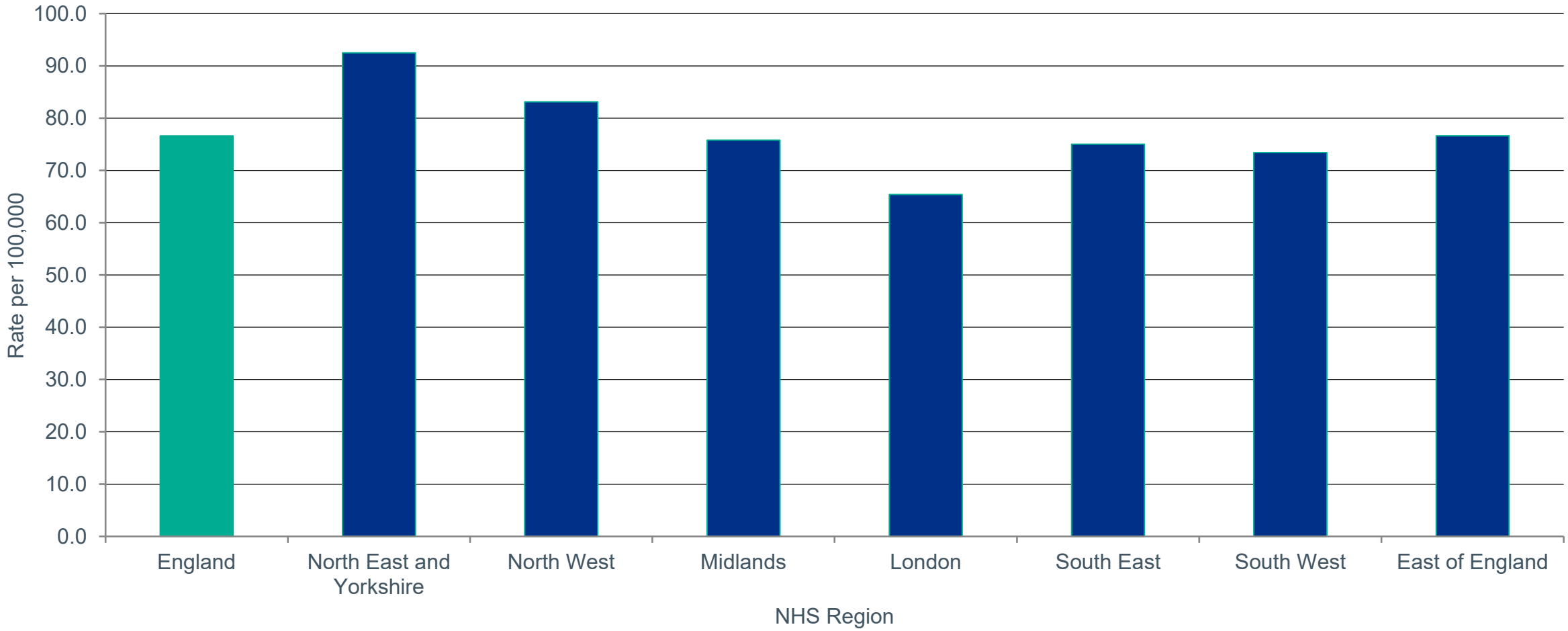
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: E.coli (indicator 91909). Trust Counting = HOHA+COHA.
Note: no data point is published for April 2011 to March 2012; the chart shows the years for which data is available.

HCAI: E.coli

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.2: HCAI: E.coli by NHS Region



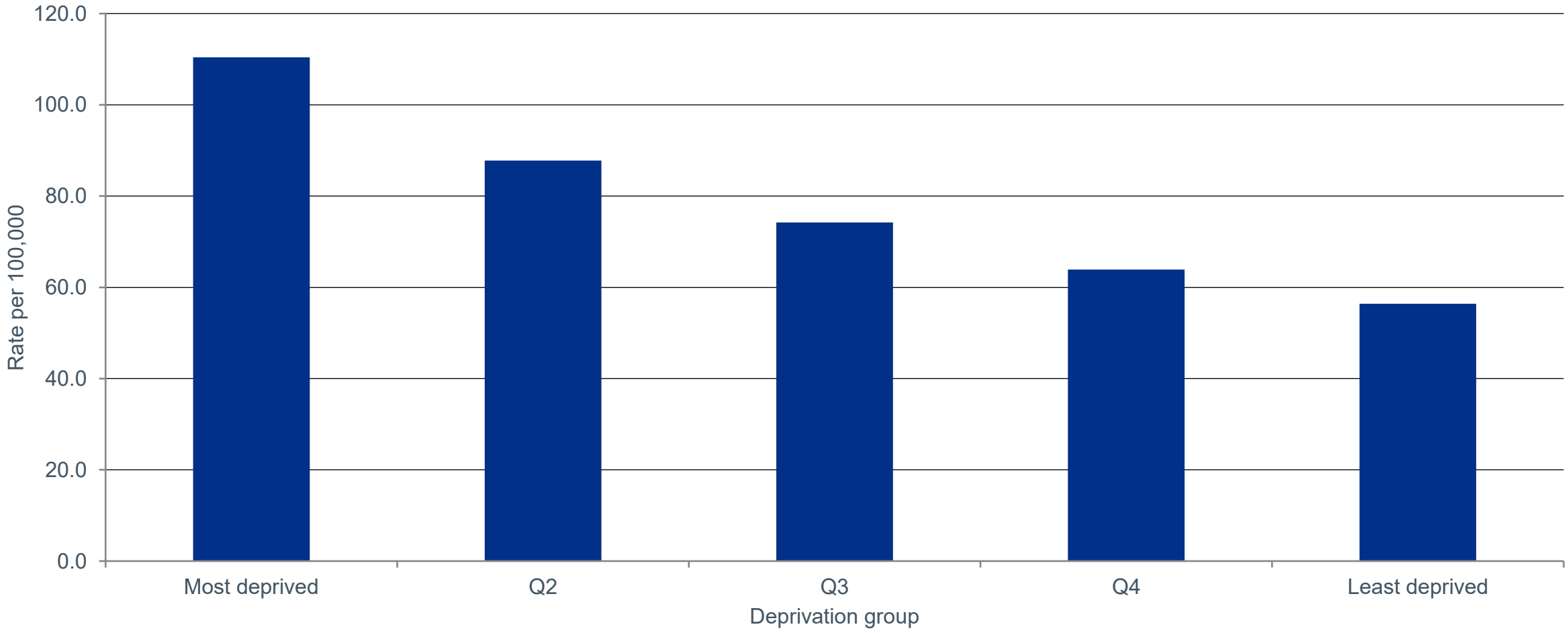
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: E.coli (indicator 91909). Trust Counting = HOHA+COHA.

HCAI: E.coli

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.3: HCAI: E.coli by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: E.coli (indicator 91909). Trust Counting = HOHA+COHA.

Healthcare-associated infection (HCAI): C.difficile

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia), expressed per 100,000 population using the Trust Counting methodology from Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• We track healthcare-associated infections because they are a direct measure of the safety of care delivered in hospitals and community settings. Rising rates of C.difficile and MRSA since the pandemic indicate that earlier gains in infection prevention have been reversed. The current trend is deteriorating, with C.difficile and MRSA rates rising since April 2020 to March 2021.
• The latest figure for England (April 2024 to March 2025) is C.diff 33.3 per 100,000.
• This is getting worse: C.diff up 50% since April 2020 to March 2021.
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (London) had a rate of 18.8 per 100,000, while the worst (North West) had 46.5 per 100,000.
• People in the most deprived areas have a rate of 47.4 per 100,000, compared with 26.6 in the least deprived - a gap of 20.8 per 100,000.
• HCAI is the most direct read on whether basic infection-prevention discipline is holding, across both hospital and community-onset cases.
• Antimicrobial stewardship sits alongside as a Tier 2 lever.
• The strategy treats hospital-acquired infection as a safety priority the system must drive down.

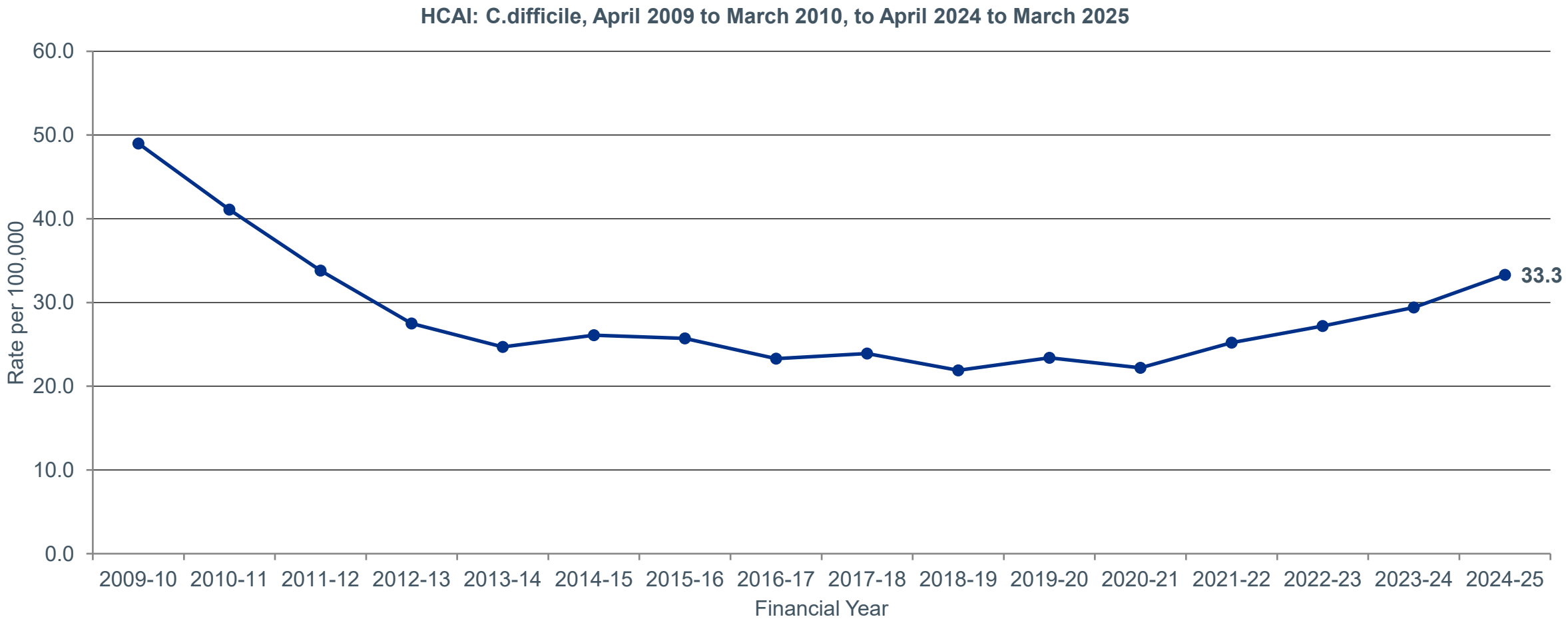
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: C.difficile (indicator 91902). Trust Counting = hospital-onset healthcare-associated (HOHA)+community-onset healthcare-associated (COHA).

HCAI: C.difficile

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.4: HCAI: C.difficile: England trend



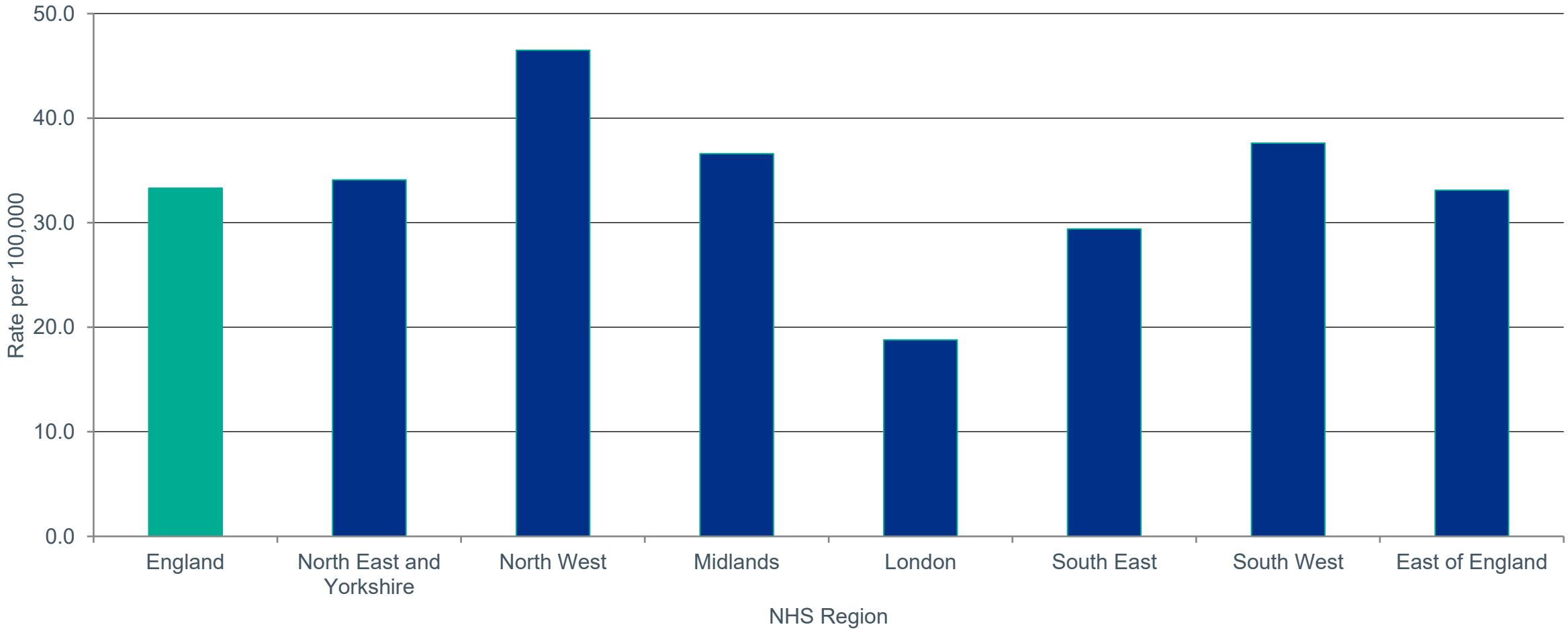
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: C.difficile (indicator 91902). Trust Counting = HOHA+COHA.

HCAI: C.difficile

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.5: HCAI: C.difficile by NHS Region



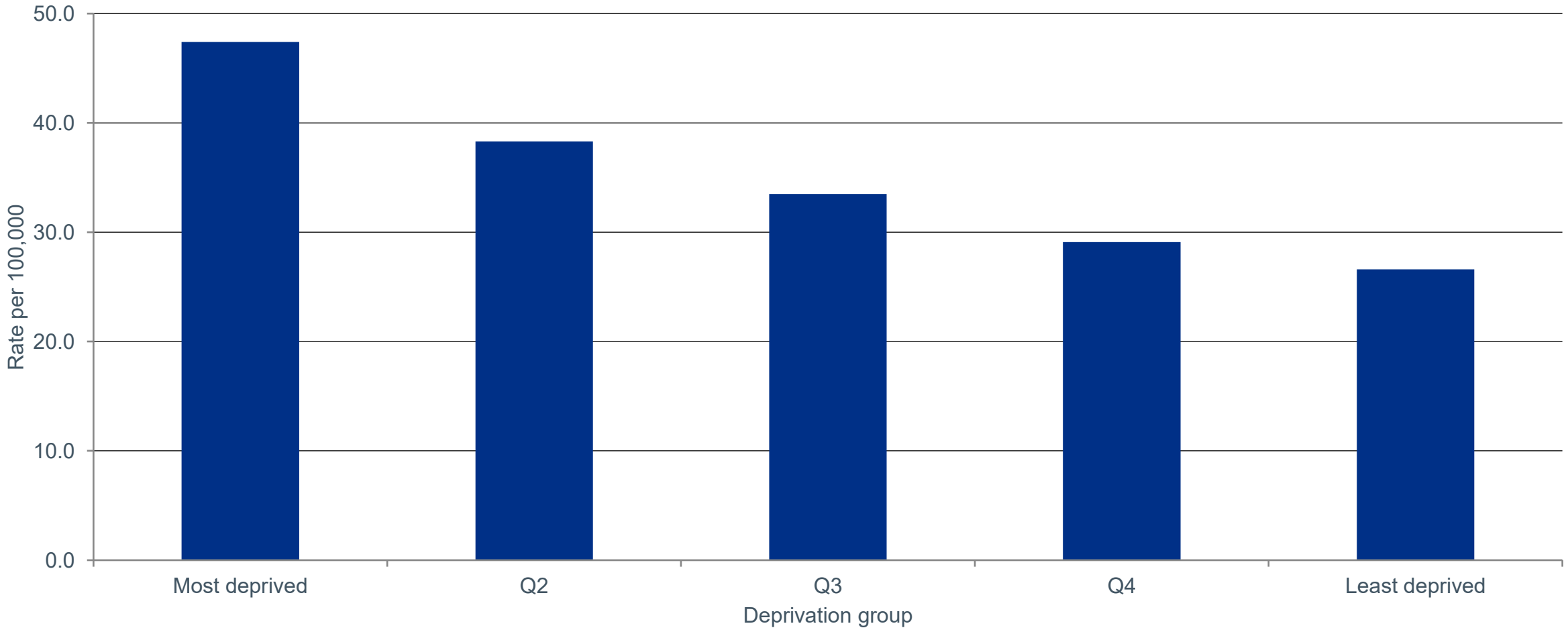
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: C.difficile (indicator 91902). Trust Counting = HOHA+COHA.

HCAI: C.difficile

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.6: HCAI: C.difficile by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: C.difficile (indicator 91902). Trust Counting = HOHA+COHA.

Healthcare-associated infection (HCAI): methicillin-resistant Staphylococcus aureus (MRSA)

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• We track healthcare-associated infections because they are a direct measure of the safety of care delivered in hospitals and community settings. Rising rates of C.difficile and MRSA since the pandemic indicate that earlier gains in infection prevention have been reversed. The current trend is deteriorating, with C.difficile and MRSA rates rising since April 2020 to March 2021.
• The latest figure for England (April 2024 to March 2025) is MRSA 1.9 per 100,000.
• This is getting worse: MRSA up 51% since April 2020 to March 2021.
• Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (Midlands) had a rate of 1.5 per 100,000, while the worst (London) had 2.4 per 100,000.
• People in the most deprived areas have a rate of 2.9 per 100,000, compared with 1.0 in the least deprived - a gap of 1.9 per 100,000.
• HCAI is the most direct read on whether basic infection-prevention discipline is holding, across both hospital and community-onset cases.
• Antimicrobial stewardship sits alongside as a Tier 2 lever.
• The strategy treats hospital-acquired infection as a safety priority the system must drive down.

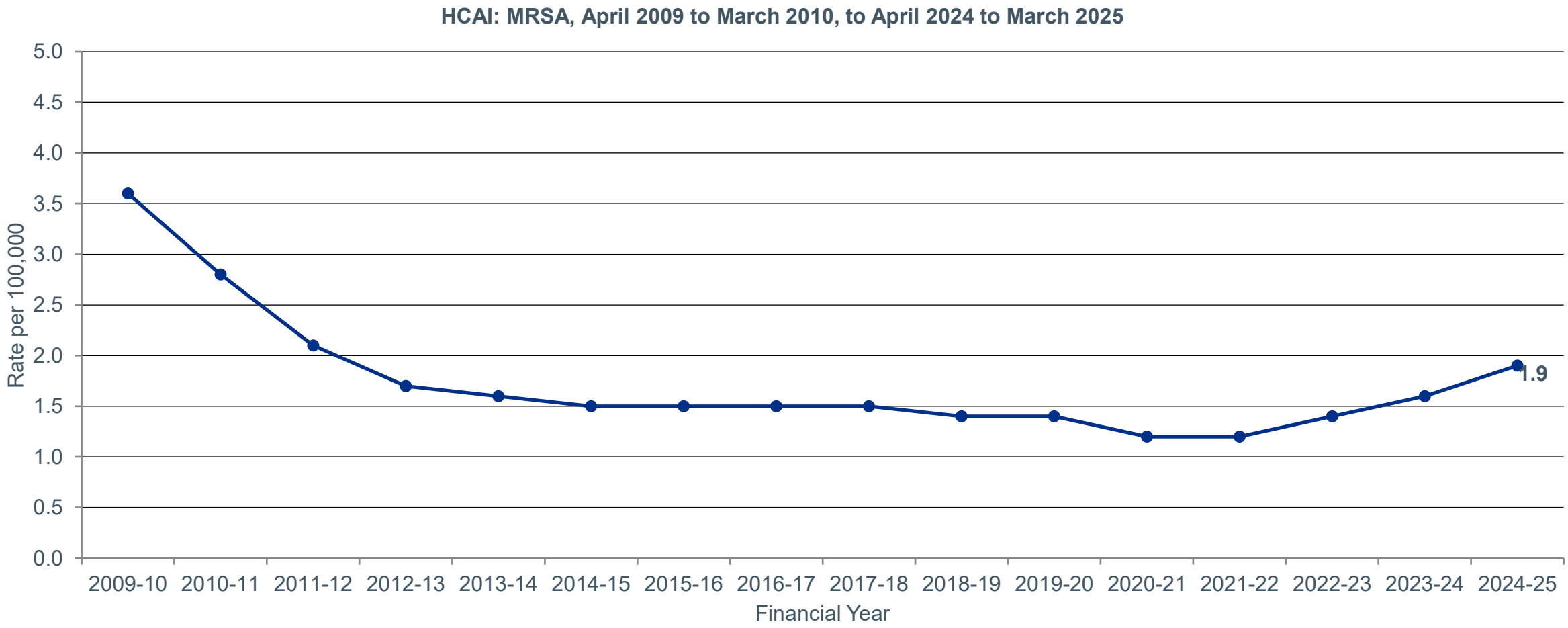
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: MRSA (indicator 91913). Trust Counting = hospital-onset healthcare-associated (HOHA)+community-onset healthcare-associated (COHA).

HCAI: MRSA

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.7: HCAI: MRSA: England trend



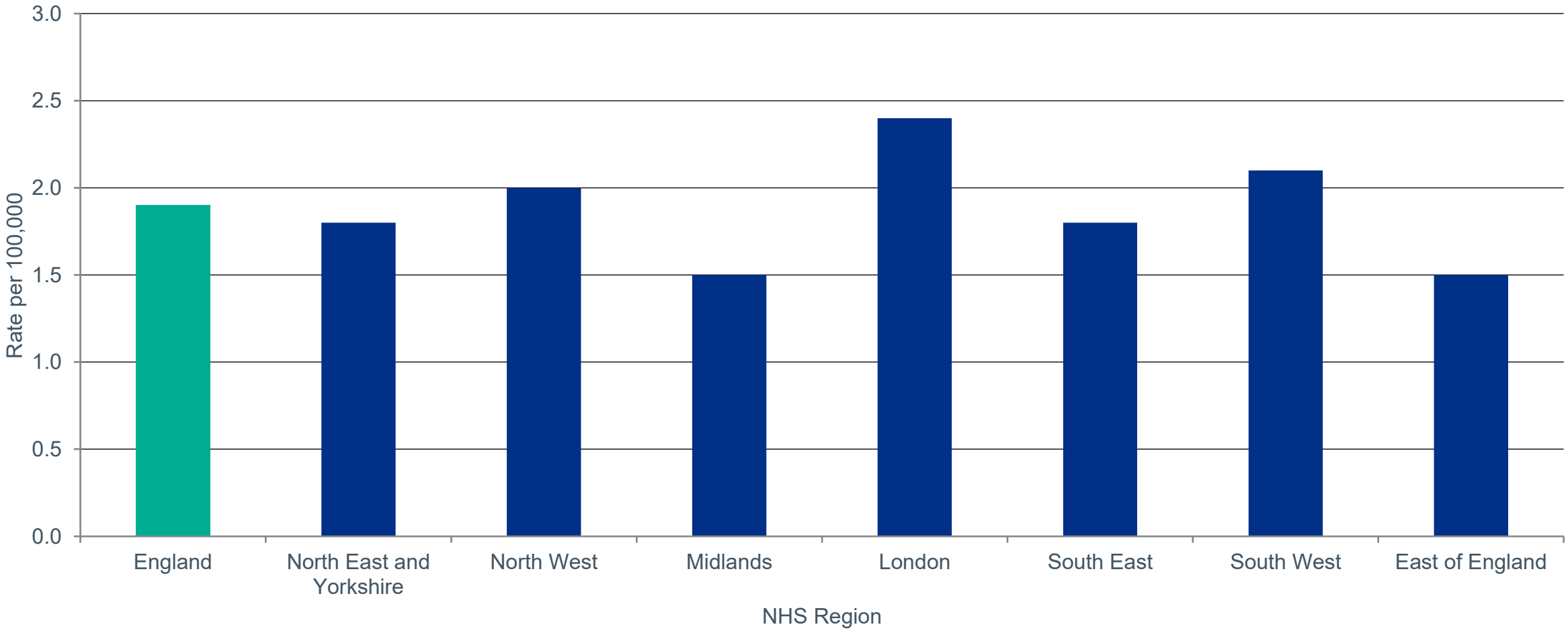
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: MRSA (indicator 91913). Trust Counting = HOHA+COHA.

HCAI: MRSA

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.8: HCAI: MRSA by NHS Region



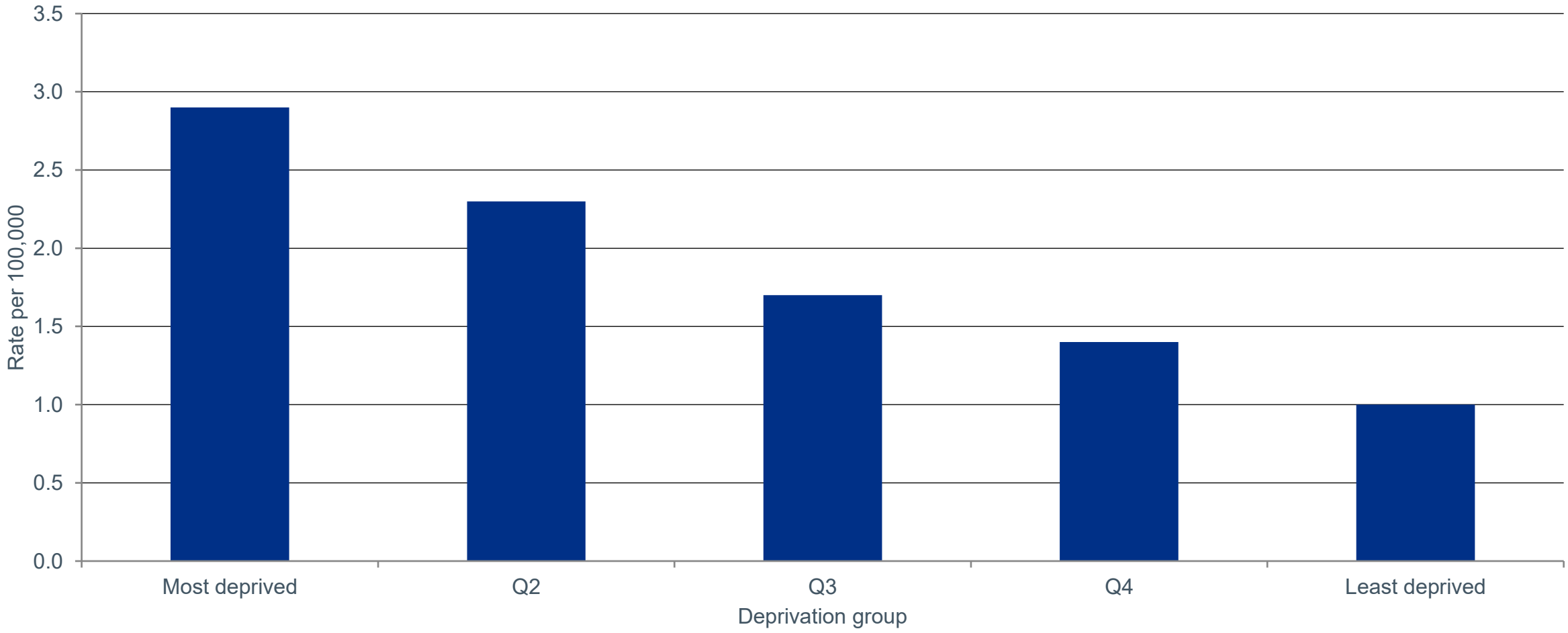
Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: MRSA (indicator 91913). Trust Counting = HOHA+COHA.

HCAI: MRSA

Safety | Tier 2: Driver | ↓ Lower is better

Rates of the three headline healthcare-associated infections in England (E. coli bloodstream infections, C. difficile, and MRSA bacteraemia), expressed per 100,000 population using the Trust Counting methodology from OHID Fingertips.

Figure 2.9: HCAI: MRSA by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: OHID Fingertips, HCAI Trust Counting Methodology by Financial Year April 2024 to March 2025: MRSA (indicator 91913). Trust Counting = HOHA+COHA.

Inpatient falls (NHFD)

Safety | Tier 2: Driver | ↓ Lower is better

percentage of hip fracture patients whose hip fracture was sustained as an inpatient, from the National Hip Fracture Database (NHFD chart PS4). Per senior responsible officer (SRO) decision 16/04/26: replaced previous 'emergency admissions for falls 65+' measure (Fingertips 22401, which combined community+inpatient falls).

Why it matters for the strategy

• We track falls with harm because inpatient falls are frequently reported patient safety incident causing moderate or severe harm and reducing them is a precondition for bringing down the headline avoidable harm rate.
• The latest figure for England (Feb 2026) is 2.7%.
• The picture is mixed: 2.7% of hip fracture patients sustained their fracture as an inpatient (Feb 2026). Trend: declined from 2.6% in October 2025 to 2% in December 2025 but keeps increasing since then.
• Inpatient falls (NHFD chart PS4) remain frequently reported patient safety incident causing moderate or severe harm.
• Falls with harm in the inpatient setting is the named lever - distinct from community falls - and a precondition for bringing the headline avoidable harm rate down.
• Concentrated in older patients, particularly those with delirium, polypharmacy and frailty; reductions are driven by environmental, pharmacy and observation interventions.
• Listed in the strategy as one of the persistent patient-safety giants; the inpatient-falls metric replaced the legacy generic incident-reporting measure in the Core Metric Set.

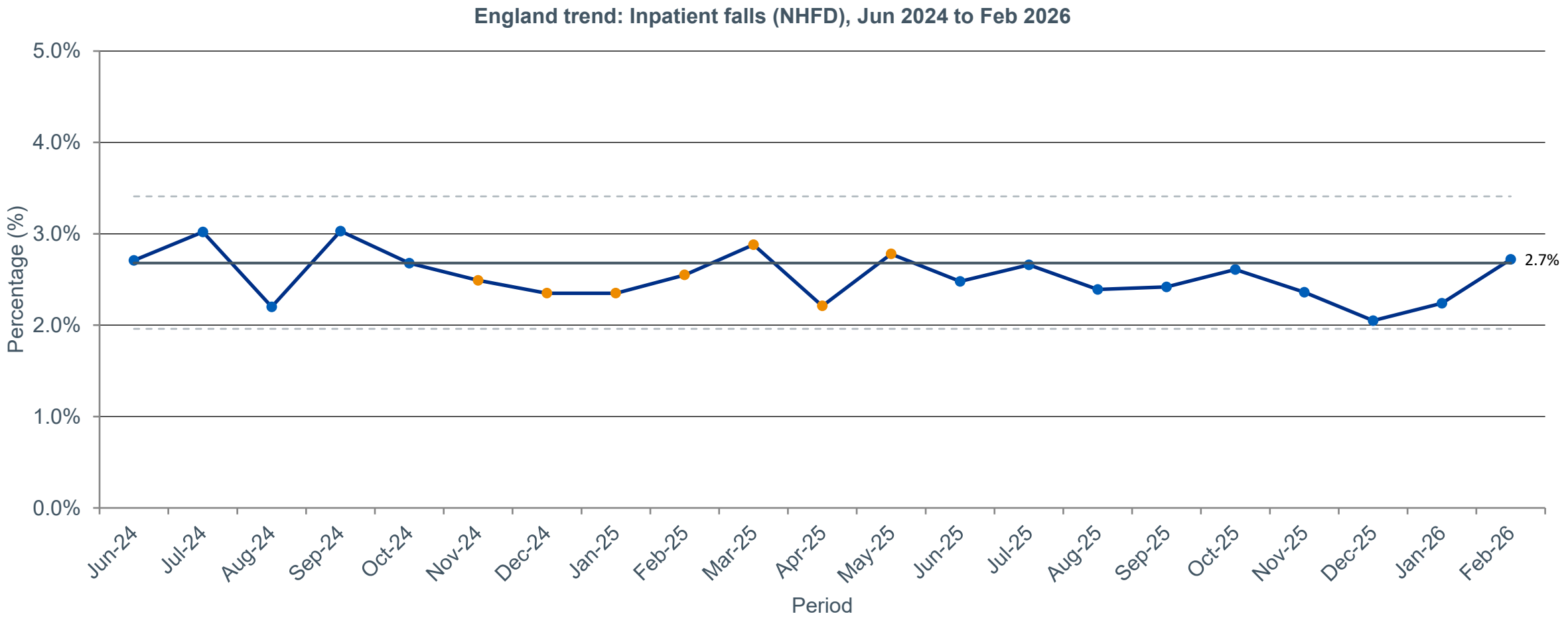
Source: NHFD chart PS4 (Patient Safety), Royal College of Physicians Falls and Fragility Fracture Audit Programme (FFFAP). percentage of hip fracture patients whose fracture was sustained as an inpatient. Apr 2011 - Jan 2026. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Inpatient falls (NHFD)

Safety | Tier 2: Driver | ↓ Lower is better

percentage of hip fracture patients whose hip fracture was sustained as an inpatient, from the National Hip Fracture Database (NHFD chart PS4). Per SRO decision 16/04/26: replaced previous 'emergency admissions for falls 65+' measure (Fingertips 22401, which combined community+inpatient falls).

Figure 2.10: Inpatient falls (NHFD): England trend



Source: NHFD chart PS4 (Patient Safety), Royal College of Physicians FFFAP. percentage of hip fracture patients whose fracture was sustained as an inpatient. Apr 2011 - Jan 2026. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Venous thromboembolism (VTE) deaths within 90 days

Safety | Tier 2: Driver | ↓ Lower is better

Rate of deaths from venous thromboembolism within 90 days of hospital discharge in England, expressed per 100,000 hospital admissions (NHS Outcomes Framework indicator 5.1).

Why it matters for the strategy

• We track VTE deaths because venous thromboembolism after hospital admission is a largely preventable cause of death, and consistent prophylaxis is a well-evidenced intervention that directly reduces avoidable harm.
• The latest figure for England (April 2023 to March 2024) is 61.2 per 100,000 admissions.
• This is getting better: Rate of 61.2 per 100,000 in April 2023 to March 2024 (9,171 deaths / 14,987,267 admissions), down from 74.1 (April 2022 to March 2023) and 103.6 pandemic peak (April 2020 to March 2021). Now near pre-pandemic level of 59.8 (April 2018 to March 2019).
• Venous thromboembolism deaths within 90 days of admission ran at 61.2 per 100,000 in April 2023 to March 2024 - back at pre-pandemic levels but still a largely preventable cause of death.
• VTE is named in the strategy alongside hip fracture and pressure ulcers as one of the persistent safety issues the NHS has not solved despite decades of guidance.
• Consistent risk assessment and prophylaxis closes most of the gap.
• The refreshed NHS Patient Safety strategy, will set the next phase of action.

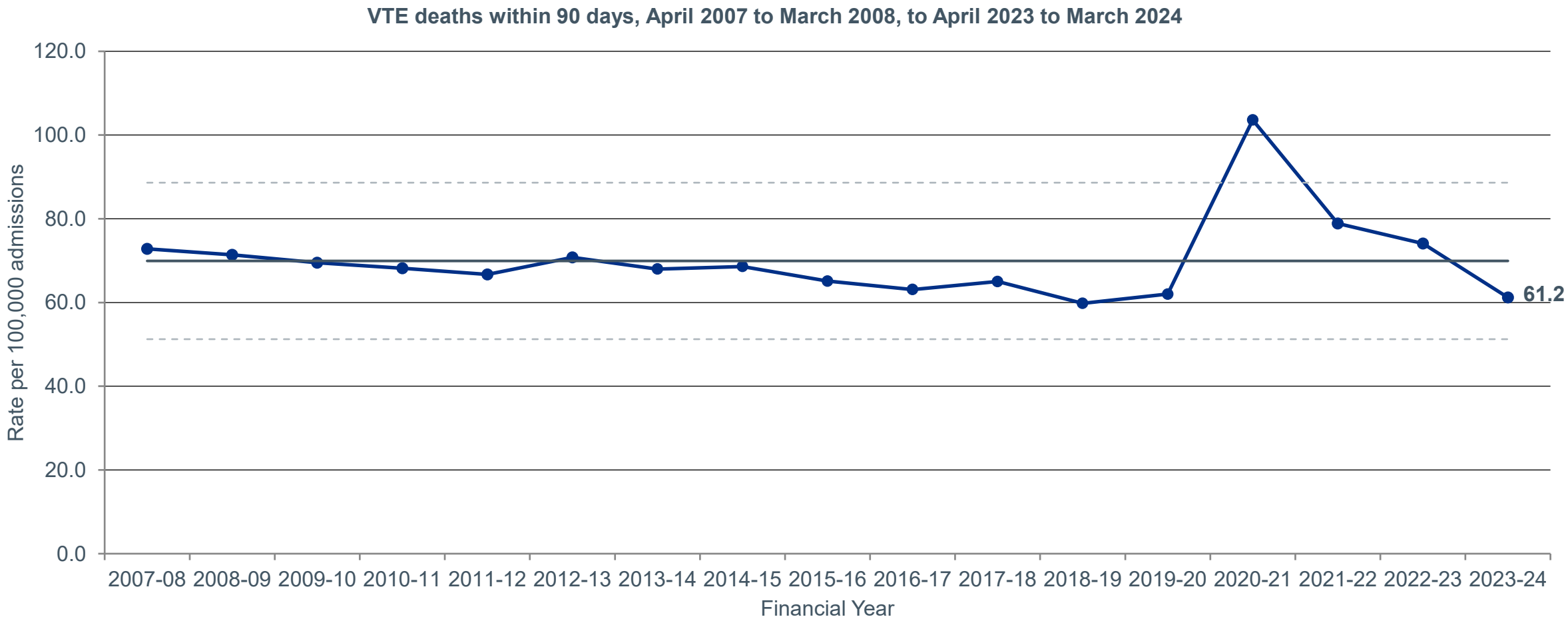
Source: NHS Digital, NHS Outcomes Framework indicator 5.1 (April 2023 to March 2024, Feb 2025 release) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

VTE deaths within 90 days

Safety | Tier 2: Driver | ↓ Lower is better

Rate of deaths from venous thromboembolism within 90 days of hospital discharge in England, expressed per 100,000 hospital admissions (NHS Outcomes Framework indicator 5.1).

Figure 2.11: VTE deaths within 90 days: England trend



Source: NHS Digital, NHS Outcomes Framework indicator 5.1 (April 2023 to March 2024, Feb 2025 release) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Inpatient suicides (number)

Safety | Tier 2: Driver | ↓ Lower is better

Number of deaths by suicide of inpatients in mental health and general hospital settings in the UK, from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).

Why it matters for the strategy

- The latest figure for England (2023) is 66.
- This is getting better: 66 inpatient suicides (2023), down from 120 in 2013. 11 years of trend data from NCISH Annual Report 2026.
- Inpatient suicides remain a safety failure; the latest NCISH report records 66 inpatient suicides in UK mental health services in 2023.
- The post-discharge week and the days following ward leave are the highest-risk windows; 72h follow-up after discharge is the most direct upstream lever.
- Concentrated by ward type (acute adult, paediatric intensive care unit (PICU)) and by service-design factors (observation, ligature anchors, transitions of care).
- strategy mental health commitment names inpatient suicides and 72h follow-up as the linked outcome or driver pair for safer transitions of care.

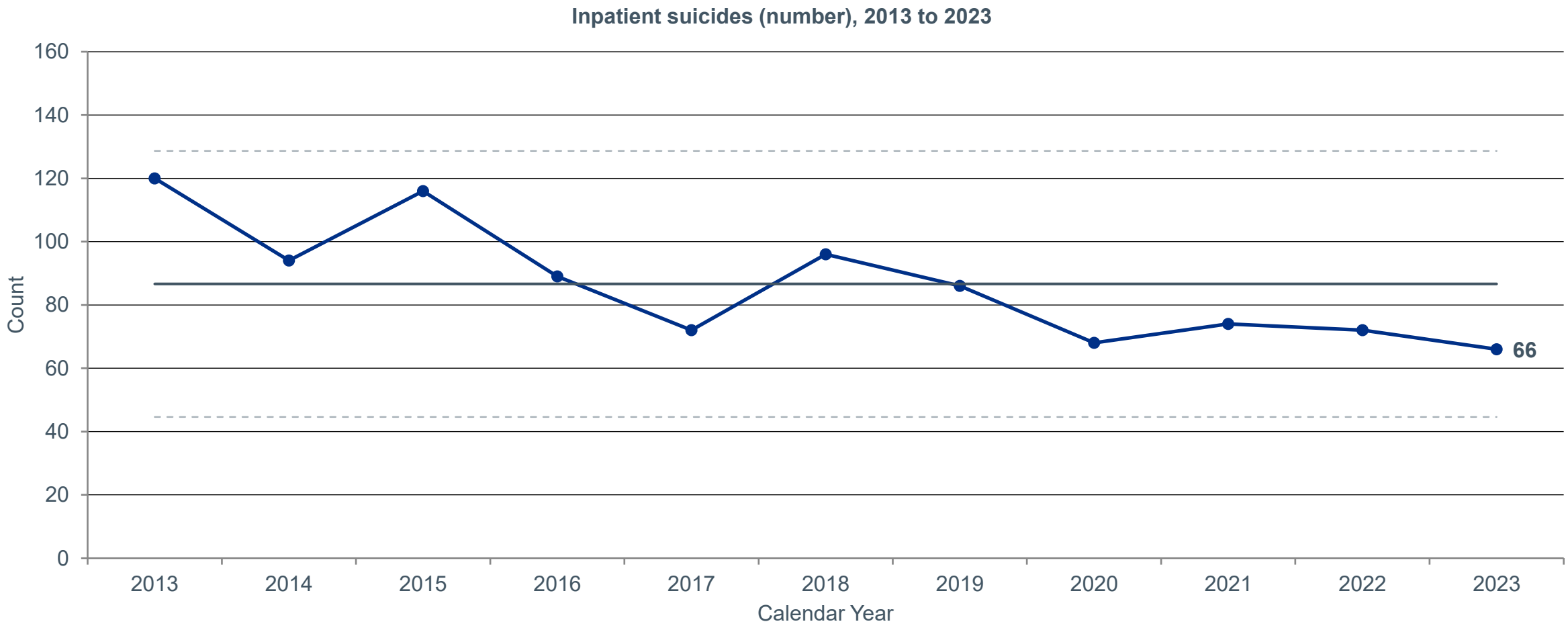
Source: NCISH Annual Report 2026, Figure 11 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Inpatient suicides (number)

Safety | Tier 2: Driver | ↓ Lower is better

Number of deaths by suicide of inpatients in mental health and general hospital settings in the UK, from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).

Figure 2.12: Inpatient suicides (number): England trend



Source: NCISH Annual Report 2026, Figure 11 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

72h follow-up after mental health inpatient discharge

Safety | Tier 3: Process indicator | ↑ Higher is better

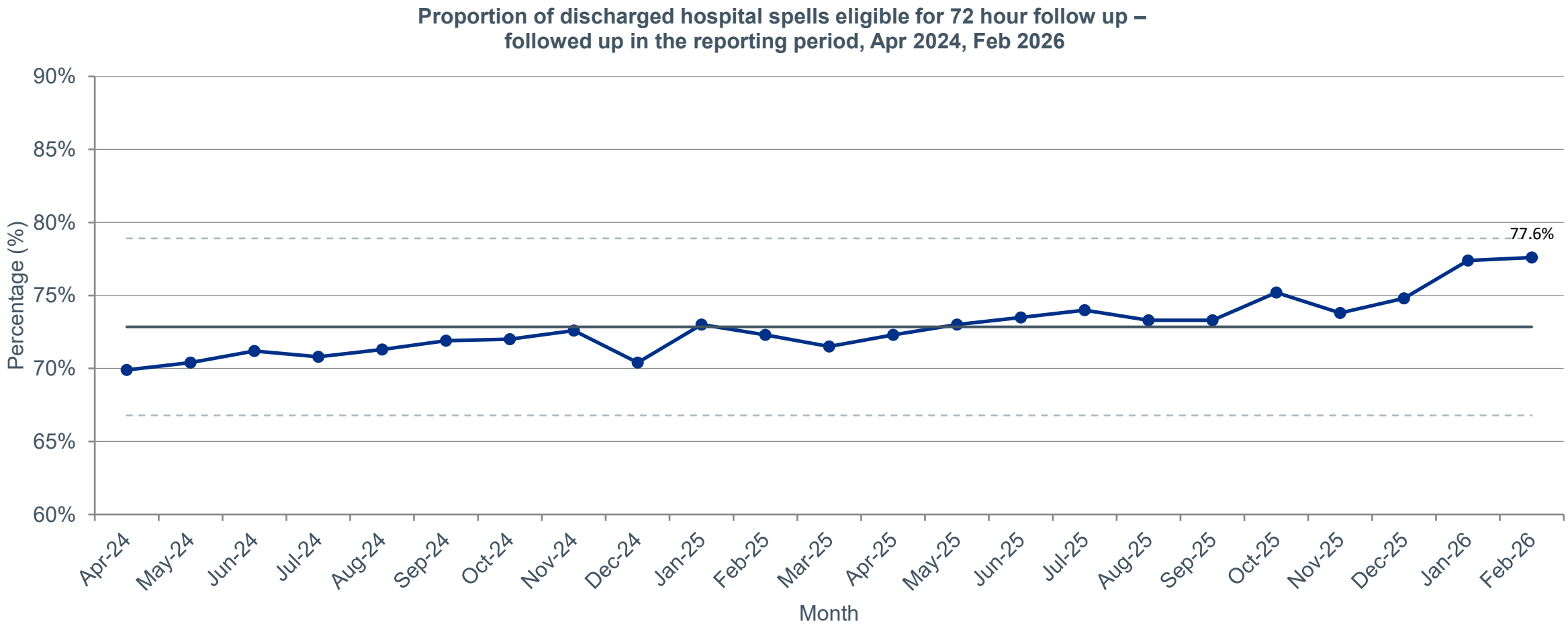
Proportion of discharged hospital spells eligible for 72 hour follow up - followed up within the reporting period, NHS Digital, Mental Health Services Monthly Statistics.

Why it matters for the strategy

- The latest figure for England (Feb 2026) is 77.6%.
- Trend: increased from 69.9% (Apr 2024) to 77.6% (Feb 2026).
- Performance varies across NHS Regions (Feb 2026 data): the best-performing area (North East and Yorkshire) achieved 82%, while the lowest (South East) achieved 74%.
- Performance on 72-hour follow-up after discharge on Mental Health (mental health) inpatients is below the 80% safety-net threshold and Amber on the Quality Insights Pack.
- 72h follow-up is the named transitions-of-care safety signal in mental health - the post-discharge week carries the highest suicide risk of the year.
- Variation by trust is large and tied to discharge-day-of-week patterns, especially Friday afternoons; staffing and crisis-pathway capacity are the limiting factors.

Source: NHS Digital, Mental Health Services Monthly Statistics | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.13: 72h follow-up after mental health inpatient discharge: England trend



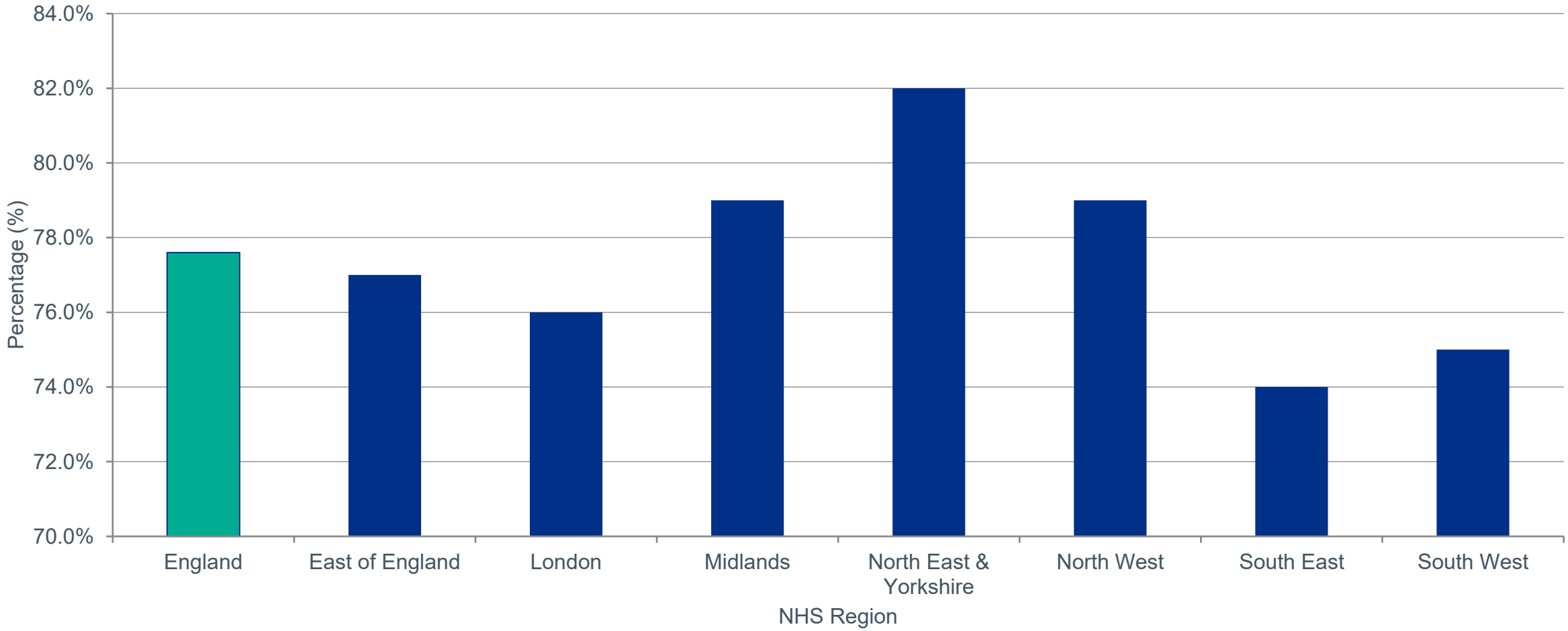
Source: NHS Digital, Mental Health Services Monthly Statistics | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

72h follow-up after mental health inpatient discharge

Safety | Tier 3: Process indicator | ↑ Higher is better

Proportion of discharged hospital spells eligible for 72 hour follow up - followed up within the reporting period, NHS Digital, Mental Health Services Monthly Statistics.

Figure 2.14: Proportion of discharged hospital spells eligible for 72 hour follow up by NHS Region



Source: NHS Digital, Mental Health Services Monthly Statistics | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Inappropriate adult out of area placements for mental health inpatients

Safety | Tier 3: Process indicator | ↓ Lower is better

Proportion of Inappropriate OAPs bed days in Adult Acute beds in the period, NHS Digital, Mental Health Services Monthly Statistics.

Why it matters for the strategy

- The latest figure for England (Feb 2026) is 2.6%.
- Trend: decreased from 3% (Apr 2024) to 2.6% (Feb 2026).
- Performance varies across NHS Regions (April 2024 to March 2025 data): the best-performing area (East of England and South East) achieved 4%, while the lowest (North East and Yorkshire and North West) achieved 1%.
- OAPs separate patients from family and care teams, with measurable impacts on recovery and length of stay.
- Mental health-safety pathway signal. strategy mental health priority and family-involvement commitment.

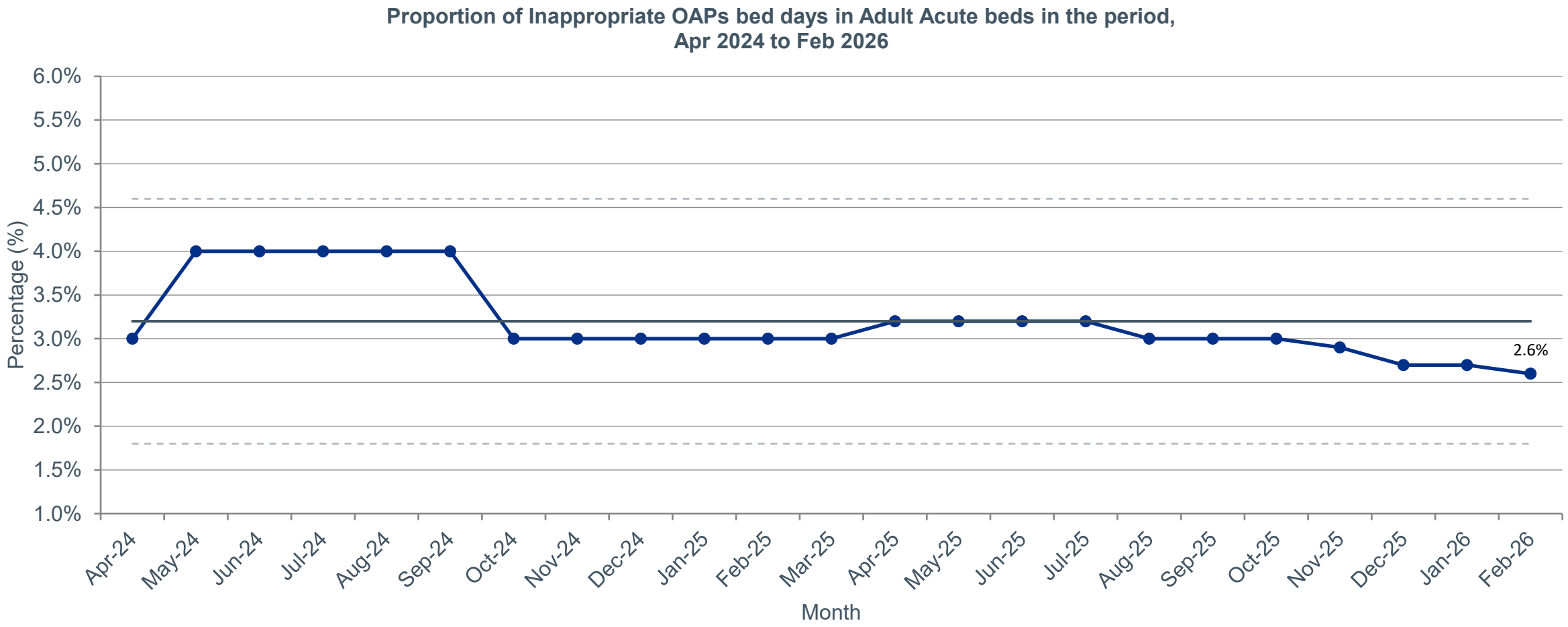
Source: NHS Digital, Mental Health Services Monthly Statistics | statistical process control (SPC): Grey line = mean. Grey dashed = control limits (±3σ). Orange dots = special cause variation.

Inappropriate adult out of area placements for mental health inpatients

Safety | Tier 3: Process indicator | ↓ Lower is better

Proportion of Inappropriate OAPs bed days in Adult Acute beds in the period, NHS Digital, Mental Health Services Monthly Statistics.

Figure 2.15: Inappropriate adult out of area placements for mental health inpatients: England trend



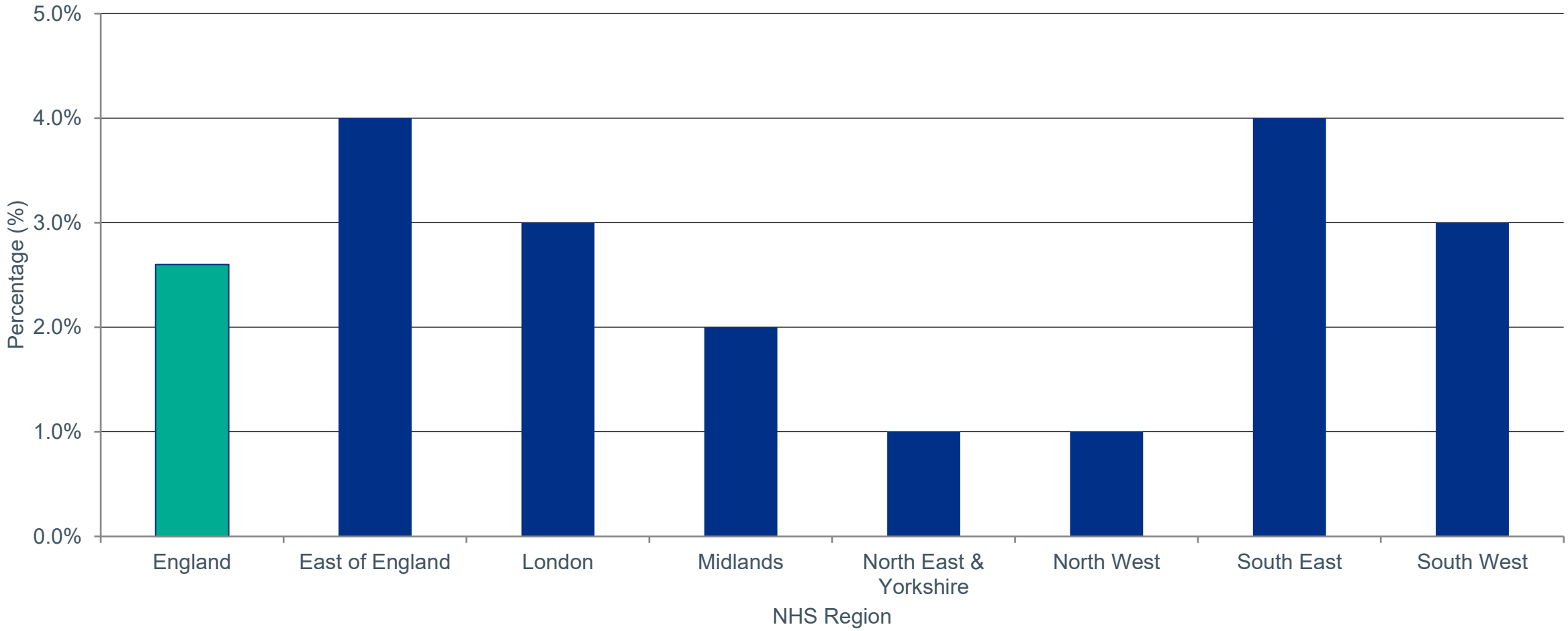
Source: NHS Digital, Mental Health Services Monthly Statistics | SPC: Grey line = mean. Grey dashed = control limits (±3σ). Orange dots = special cause variation.

Inappropriate adult out of area placements for mental health inpatients

Safety | Tier 3: Process indicator | ↓ Lower is better

Proportion of Inappropriate OAPs bed days in Adult Acute beds in the period, NHS Digital, Mental Health Services Monthly Statistics.

Figure 2.16: Proportion of Inappropriate OAPs bed days in Adult Acute beds by NHS Region



Source: NHS Digital, Mental Health Services Monthly Statistics | SPC: Grey line = mean. Grey dashed = control limits (±3σ). Orange dots = special cause variation.

Safety culture: raising concerns

Safety | Tier 2: Driver | ↑ Higher is better

Score on the PP3_2 Raising Concerns sub-score from the NHS Staff Survey, a composite of four questions measuring whether staff feel safe to speak up about patient safety and other concerns, on a 0 to 10 scale.

Why it matters for the strategy

• We track safety culture because staff confidence in raising concerns is the foundation of a safe healthcare system; the PP3_2 composite sub-score (Q20a, Q20b, Q25e, Q25f) captures both willingness to speak up and confidence that concerns will be addressed; the persistent gap between these components (Q20a 71.5% vs Q25f 49.5%) indicates systemic barriers to learning from safety events. The current trend is deteriorating, with the PP3_2 raising concerns score at a five-year low.
• The latest figure for England (2025) is 6.4 score (out of 10).
• This remains almost stable: PP3_2 Raising Concerns sub-score: 6.5 (2021), 6.4 (2022), 6.5 (2023), 6.5 (2024), 6.4 (2025). Five-year low. All four component questions declined in 2025.
• Performance varies across NHS Regions: the best-performing area (London) achieved 6.5 score (out of 10), while the lowest (East of England) achieved 6.1 score (out of 10).
• This remains stable - staff confidence in raising concerns (NSS PP3_2 composite, 6.45 / 10 in 2024) is at a five-year low - the persistent gap between willingness to speak up and confidence concerns are addressed signals systemic learning failures.
• Safety culture is the foundation under every other safety metric: venous thromboembolism (VTE) prophylaxis, sepsis recognition and healthcare-associated infection (HCAI) control all degrade when staff do not speak up.
• The strategy explicitly names 'culture, leadership and listening' as enablers and ties Quality Management Systems to confidence in raising concerns.

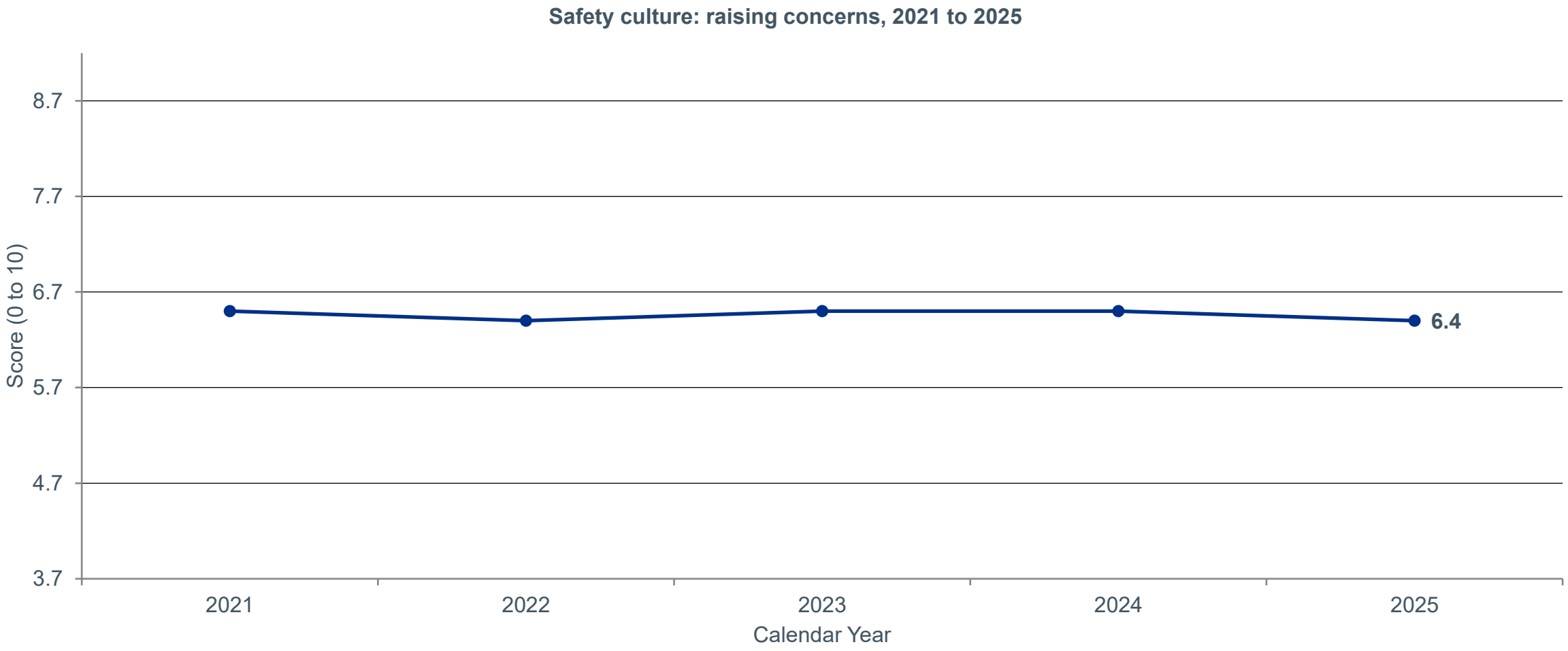
Source: NHS England, NHS Staff Survey 2024, PP3_2 'Raising concerns' sub-score (composite of Q20a, Q20b, Q25e, Q25f), published Mar 2025

Safety culture: raising concerns

Safety | Tier 2: Driver | ↑ Higher is better

Score on the PP3_2 Raising Concerns sub-score from the NHS Staff Survey, a composite of four questions measuring whether staff feel safe to speak up about patient safety and other concerns, on a 0 to 10 scale.

Figure 2.17: Safety culture: raising concerns: England trend



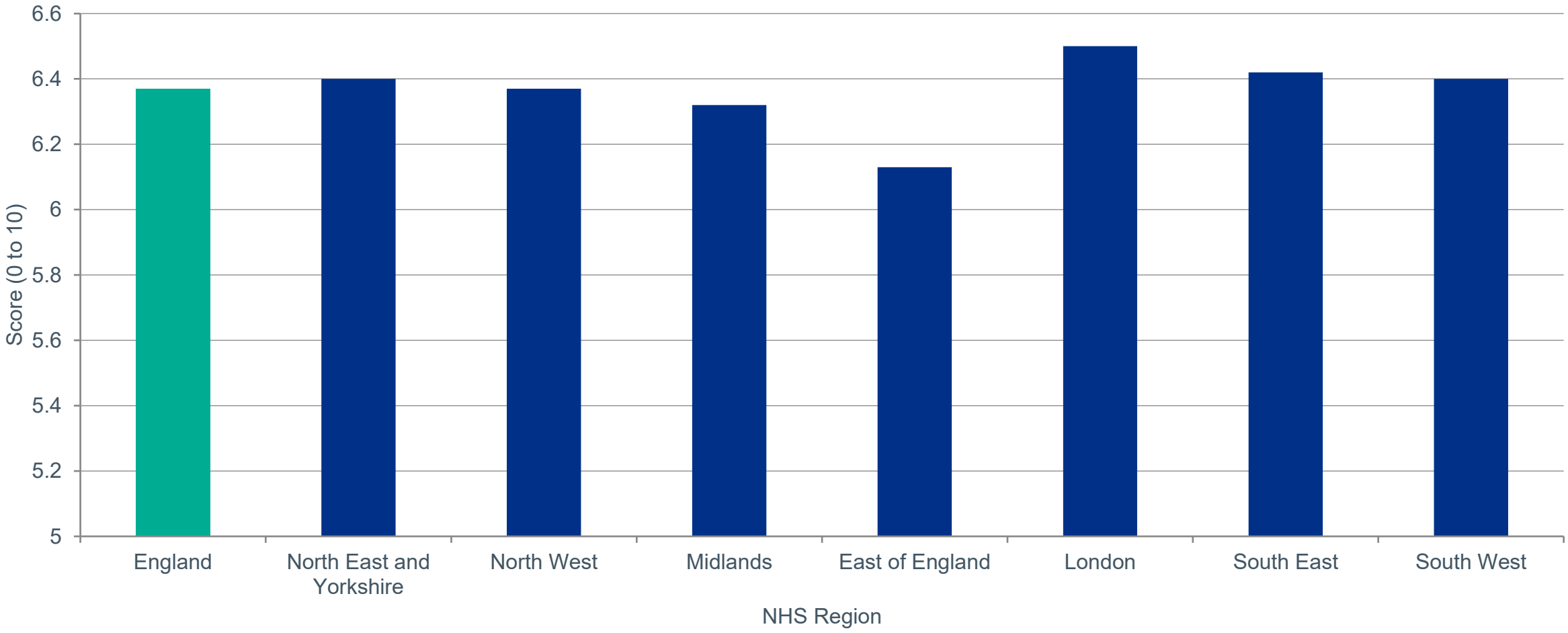
Source: NHS England, NHS Staff Survey 2024, PP3_2 'Raising concerns' sub-score (composite of Q20a, Q20b, Q25e, Q25f), published Mar 2025

Safety culture: raising concerns

Safety | Tier 2: Driver | ↑ Higher is better

Score on the PP3_2 Raising Concerns sub-score from the NHS Staff Survey, a composite of four questions measuring whether staff feel safe to speak up about patient safety and other concerns, on a 0 to 10 scale.

Figure 2.18: Safety culture: raising concerns by NHS Region



Source: NHS England, NHS Staff Survey 2024, PP3_2 'Raising concerns' sub-score (composite of Q20a, Q20b, Q25e, Q25f), published Mar 2025

Antibiotic prescribing (children)

Safety | Tier 3: Process indicator | ↓ Lower is better

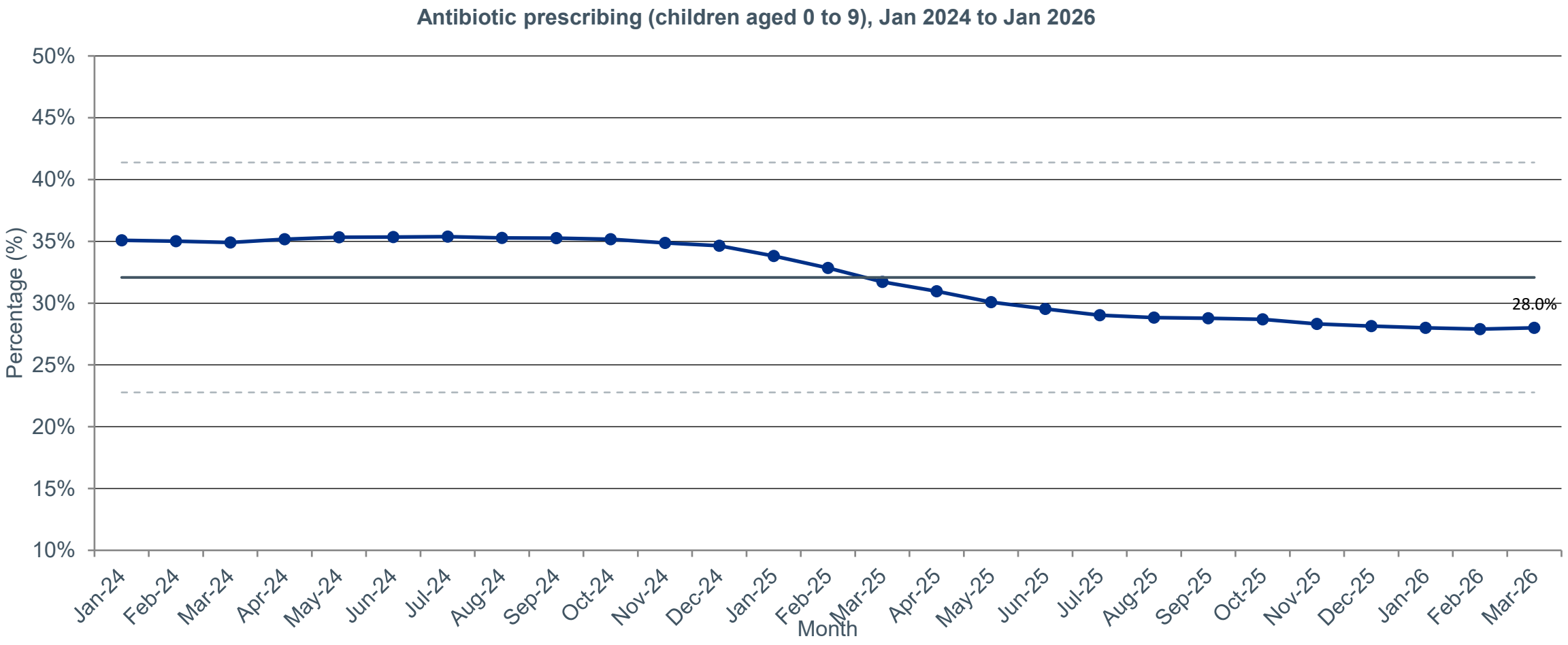
Percentage of children aged 0 to 9 years prescribed antibiotics in primary care, PrescQIPP C.I.C., NHS Oversight Framework 2025 to 2026.

Why it matters for the strategy

• We track antibiotic prescribing in children because inappropriate antibiotic use drives antimicrobial resistance, one of the greatest long-term threats to global health, and children are the age group most commonly prescribed antibiotics.
• The latest figure for England (Feb 2026) is 28%.
• This declined from 35.3% (Sep 2024) to 28% (Feb 2026).
• Performance varies across NHS Regions (Feb 2026 data): the best-performing area (East of England) achieved 31.5%, while the lowest (South West) achieved 22.2%.
• Children are an age group commonly prescribed antibiotics, which makes paediatric prescribing a direct lever.

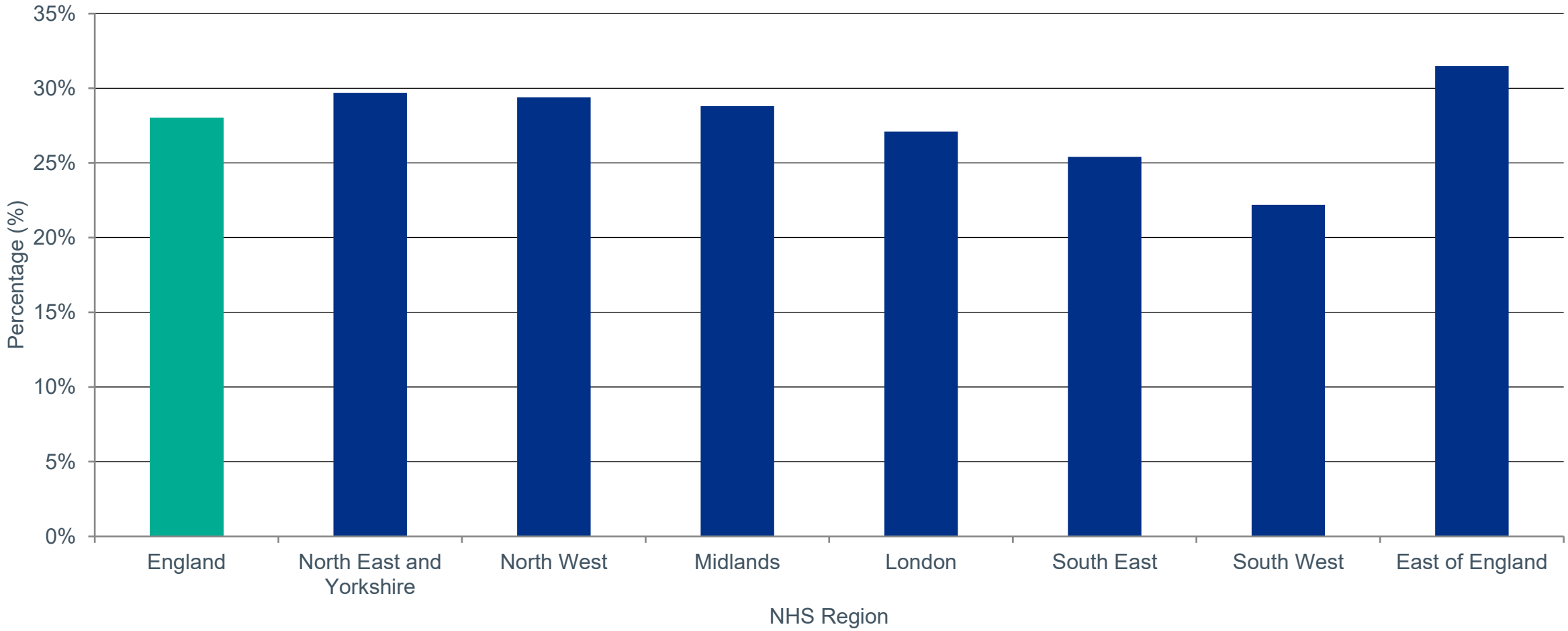
Source: PrescQIPP C.I.C., NHS Oversight Framework 2025 to 2026 - integrated care board (ICB) performance dashboard: Children prescribed antibiotics in primary care | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.19: Antibiotic prescribing (children): England trend



Source: PrescQIPP C.I.C., NHS Oversight Framework 2025 to 2026 - ICB performance dashboard: Children prescribed antibiotics in primary care | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.20: Antibiotic prescribing (children aged 0 to 9) by NHS Region



Source: PrescQIPP C.I.C., NHS Oversight Framework 2025 to 2026 - ICB performance dashboard: Children prescribed antibiotics in primary care | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Perinatal mortality rate

Safety | Tier 1: Outcome | ↓ Lower is better

Extended perinatal mortality rate in England, comprising stillbirths from 24 weeks gestation plus neonatal deaths up to 28 days, expressed per 1,000 total births, from the MBRRACE-UK Perinatal Mortality Surveillance Report.

Why it matters for the strategy

• We track perinatal mortality because it is a critical safety and effectiveness outcome for maternity services, reflecting the quality of antenatal, intrapartum and neonatal care.
• The latest figure for England (2023) is 4.9 per 1,000.
• This is getting better: Improving from 6.09 (2013) to 4.88 (2023). COVID dip to 4.79 (2020) then returned to 5.12 (2021) before resuming decline.
• Improving from 6.1 (2013) to 4.9 (2023).
• Note (O'Rourke, April 2026): several maternity and neonatal reports (MBRRACE, National Maternity and Perinatal Audit (NMPA), Maternity Taskforce) are due to publish in summer 2026; figures and narrative across the Maternity and Neonatal section may need refreshing once these land.
• Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

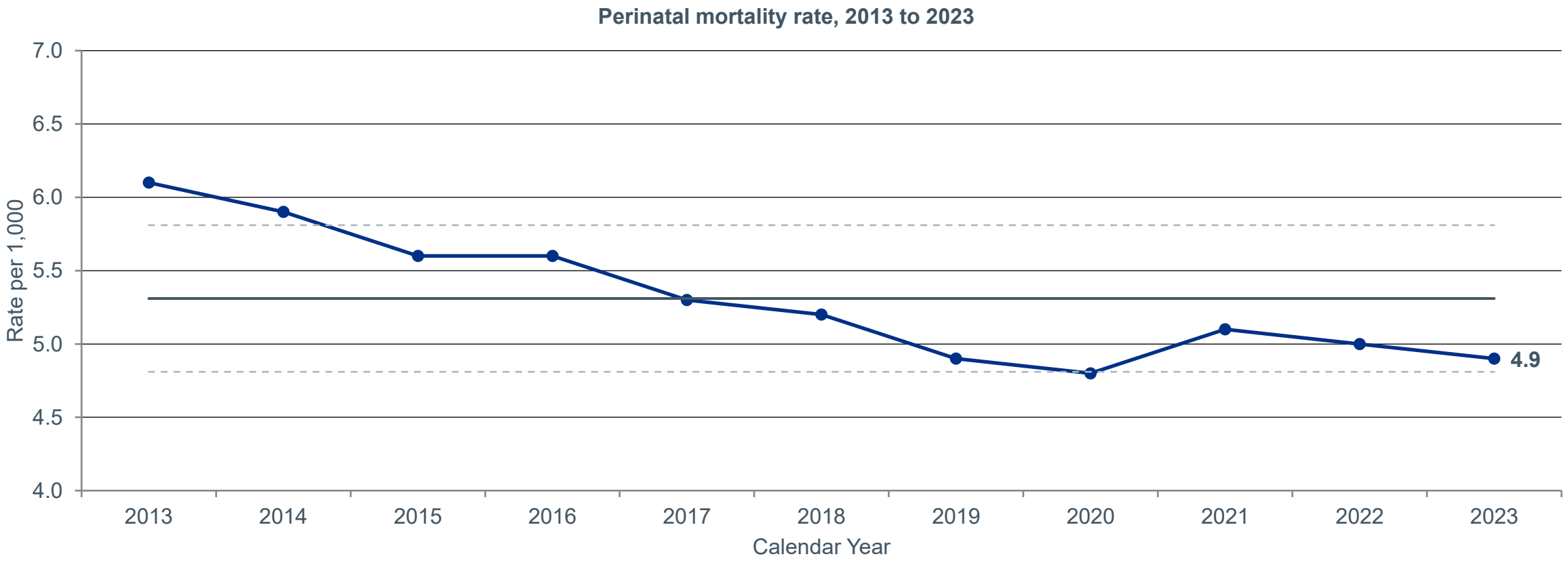
Source: Office for National Statistics (ONS)/MBRRACE-UK, Perinatal Mortality Surveillance Report (2024); | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Perinatal mortality rate

Safety | Tier 1: Outcome | ↓ Lower is better

Extended perinatal mortality rate in England, comprising stillbirths from 24 weeks gestation plus neonatal deaths up to 28 days, expressed per 1,000 total births, from the MBRRACE-UK Perinatal Mortality Surveillance Report.

Figure 2.21: Perinatal mortality rate: England trend



Source: ONS/MBRRACE-UK, Perinatal Mortality Surveillance Report (2024); | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternal mortality rate

Safety | Tier 1: Outcome | ↓ Lower is better

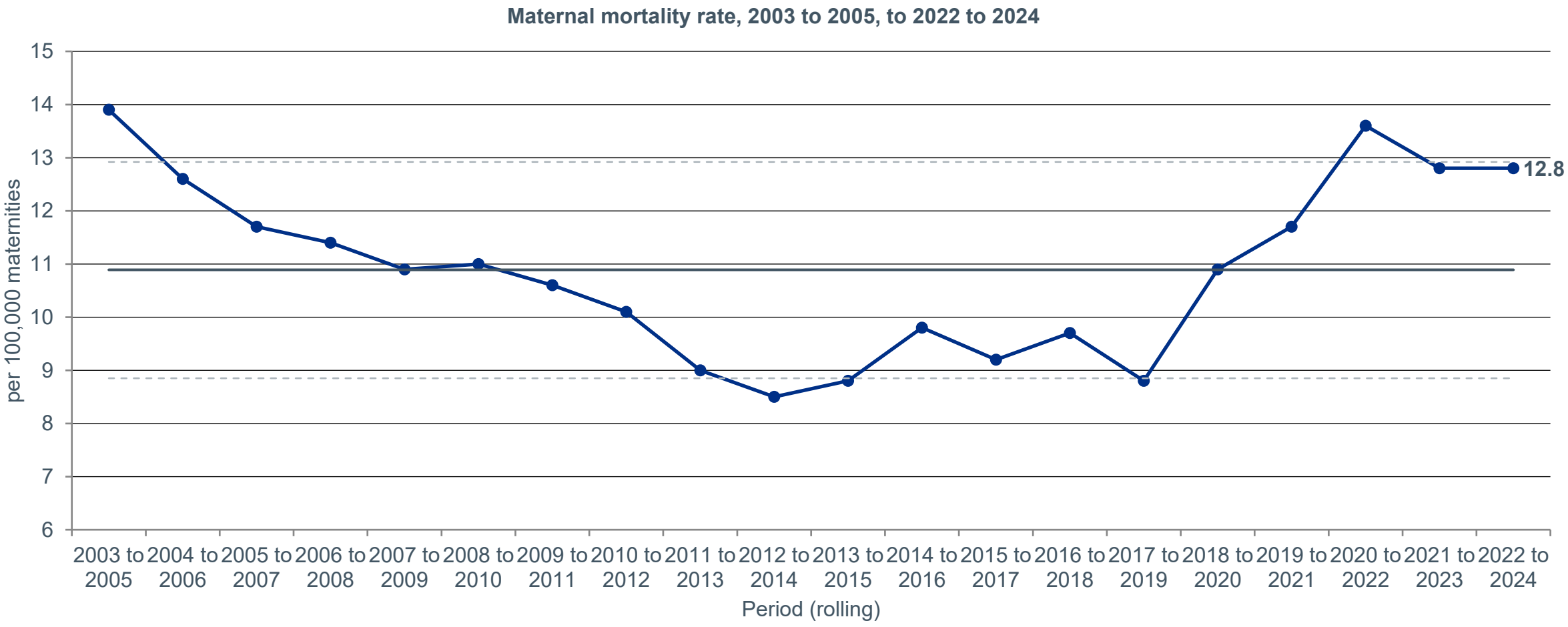
Maternal mortality rate (direct and indirect deaths during or within 42 days of pregnancy) across the UK, expressed per 100,000 maternities, from the MBRRACE-UK Confidential Enquiry.

Why it matters for the strategy

• We track maternal mortality because it is a severe adverse outcome of pregnancy and childbirth. The UK rate has been rising since 2012 to 2014, and most direct maternal deaths have elements of care that could have made a difference.
• The latest figure for England (2022 to 2024) is 12.8 per 100,000 maternities.
• This is getting worse: 12.8 per 100k maternities in 2022 to 2024 (UK-wide, 252 deaths / ~2.0M maternities). Worsening trend from 8.5 (2012 to 2014) to 12.8 per 100,000 maternities (2022 to 2024). Direct deaths 5.7, indirect deaths 7.06.
• People in the most deprived areas have a rate of 19.3 per 100,000 maternities, compared with 10.2 in the least deprived - a gap of 9.1 per 100,000 maternities.
• The trend has been rising over the past decade, and most direct maternal deaths involve care elements that could have made a difference.
• One of the three core maternity safety outcomes.
• Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

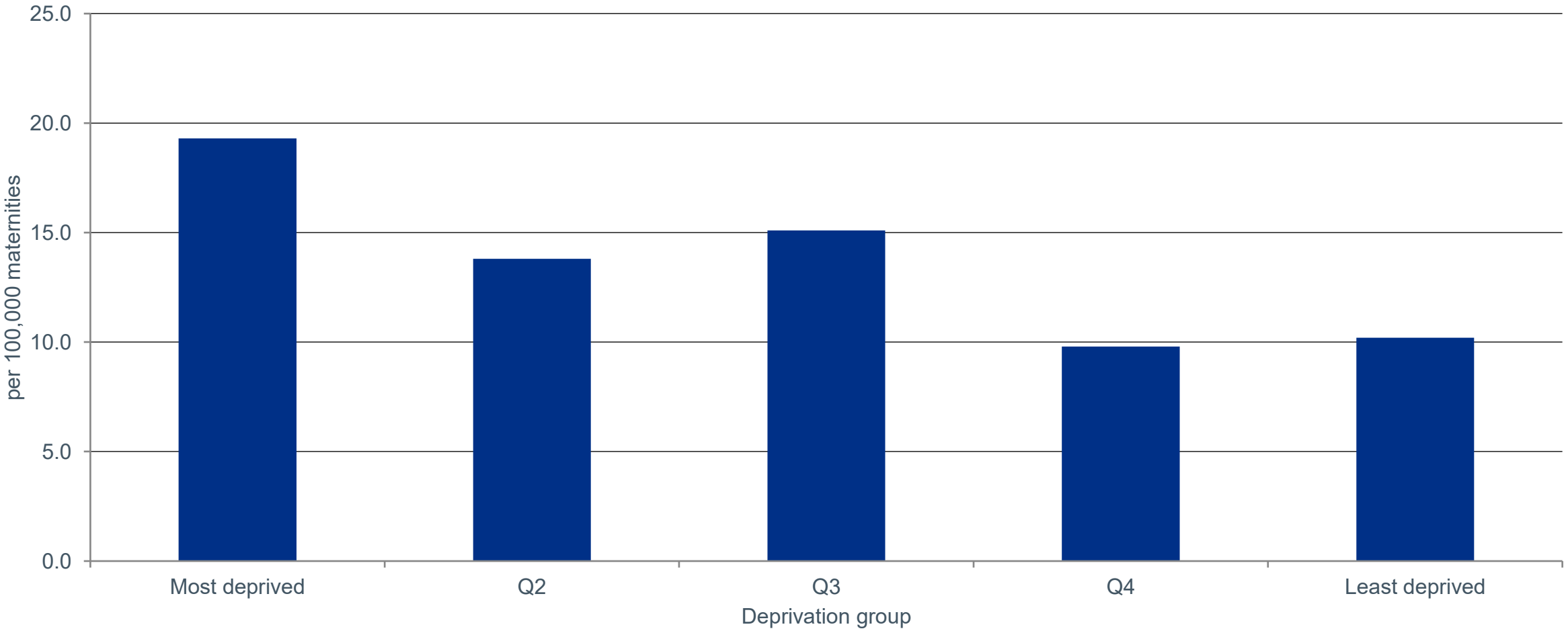
Source: MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), Saving Lives reports | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.22: Maternal mortality rate: England trend



Source: MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), Saving Lives reports | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.23: Maternal mortality rate by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), Saving Lives reports | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternal mortality rate by cause

Effectiveness | Tier 2: Driver | ↓ Lower is better

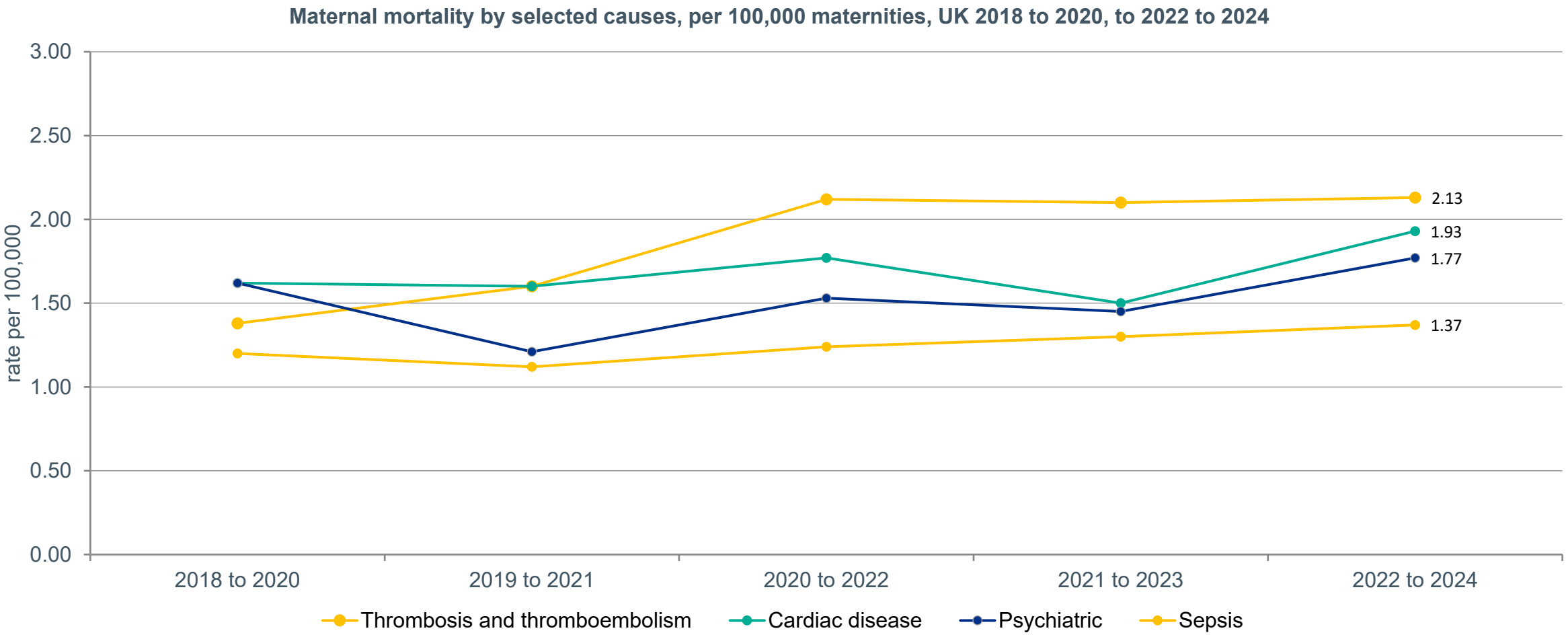
Maternal mortality by cause, per 100,000 maternities

Why it matters for the strategy

• Key outcome metric providing deeper insight into the cause of maternity mortality. We track maternal mortality because it is a severe adverse outcome of pregnancy and childbirth.
• The latest data for England (2022 to 2024) is 2.13 per 100,000 for thrombosis and thromboembolism, 1.93 per 100,000 for cardiac disease, 1.77 per 100,000 for psychiatric causes, and 1.37 per 100,000 for sepsis.
• This is getting worse for all 4 causes of maternal mortality in 2022 to 2024 compared to 2018 to 2020; from 1.38 (2018 to 2020) to 2.13 (2022 to 2024) per 100,000 for thrombosis and thromboembolism, from 1.62 (2018 to 2020) to 1.93 (2022 to 2024) per 100,000 for cardiac disease, from 1.62 (2018 to 2020) to 1.77 (2022 to 2024) per 100,000 for psychiatric causes, and from 1.2 (2018 to 2020) to 1.37 (2022 to 2024) per 100,000 for sepsis.
• Thrombosis and thromboembolism is the leading cause of direct maternal deaths happening in 2022 to 2024 (2.13 per 100,000). Psychiatric and pregnancy-related sepsis were the next most frequent direct causes of maternal deaths in 2022 to 2024 (0.91 and 0.81 per 100,000 respectively). Deaths due to indirect causes comprised just over half (55%) of direct and indirect maternal deaths in the UK in 2022 to 2024. Cardiac disease and neurological were the leading causes of indirect maternal death in 2022 to 2024, each with a maternal mortality rate of 1.93 and 1.47 per 100,000 maternities respectively.

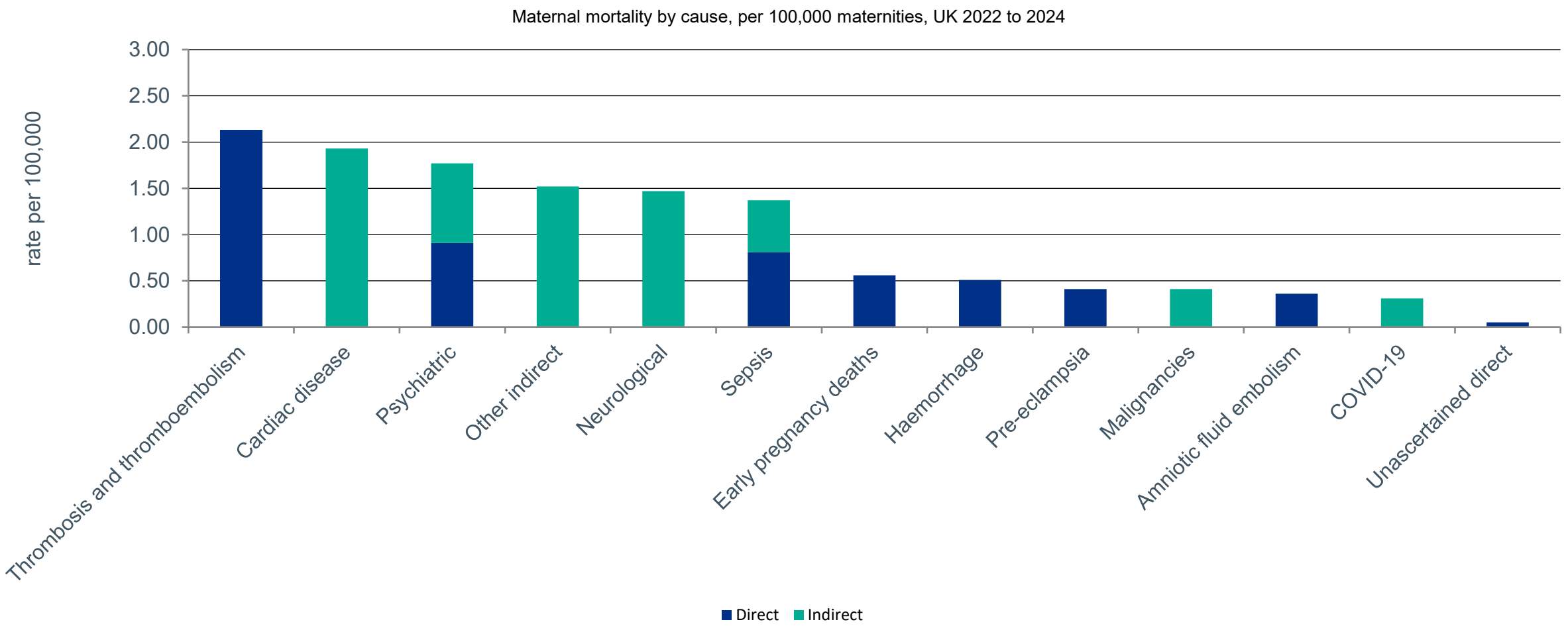
Source: MBRRACE-UK UK Maternal Report 2025

Figure 2.24: Maternal mortality rate by cause: England trend



Source: MBRRACE-UK UK Maternal Report 2025

Figure 2.25: Maternal mortality rate by cause: England trend



Source: MBRRACE-UK UK Maternal Report 2025

Maternity continuity of carer

Safety | Tier 2: Driver | ↑ Higher is better

Proportion of women recorded as having continuity of carer at 28 weeks of pregnancy in England, from the Maternity Services Data Set.

Why it matters for the strategy

• We track maternity continuity of carer because women who experience continuity report better experience and have improved outcomes; reducing variation by deprivation addresses maternity inequality.
• The latest figure for England (January 2026) is 19.2%.
• This shows a mixed picture: Increasing from 16.5% (Apr 2024) to 18% (Dec 2024) and then varied to reach 17.3% (Oct 2025) but increased since then to 19.2% (Jan 2026).
• Performance varies across NHS Regions: the best-performing area (London) achieved 27.1%, while the lowest (East of England) achieved 3.8%.
• People in the least deprived areas achieve 19.1%, compared with 20.7 in the most deprived - a gap of 1.6%.
• A named strategy driver for improving maternity safety and experience.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

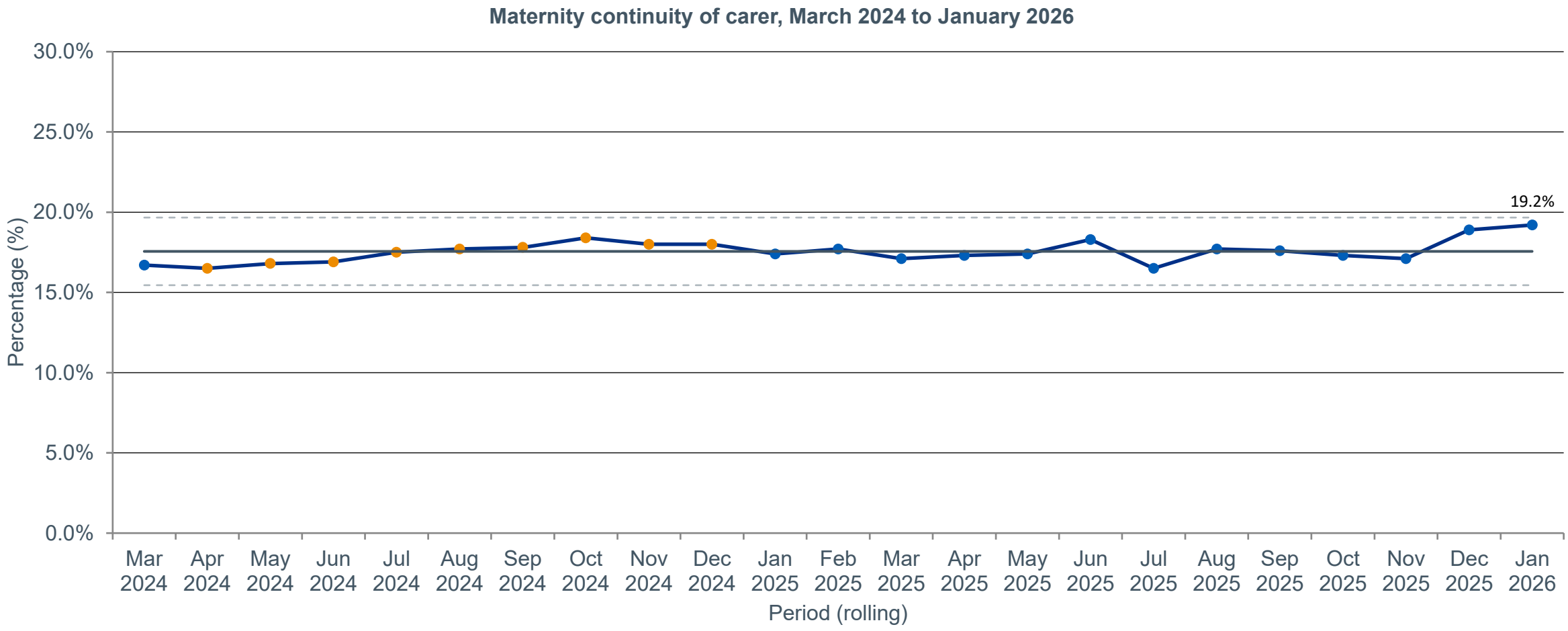
Source: NHS Digital, Maternity Services Data Set (MSDS) April 2024 to March 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternity continuity of carer

Safety | Tier 2: Driver | ↑ Higher is better

Proportion of women recorded as having continuity of carer at 28 weeks of pregnancy in England, from the Maternity Services Data Set.

Figure 2.26: Maternity continuity of carer: England trend



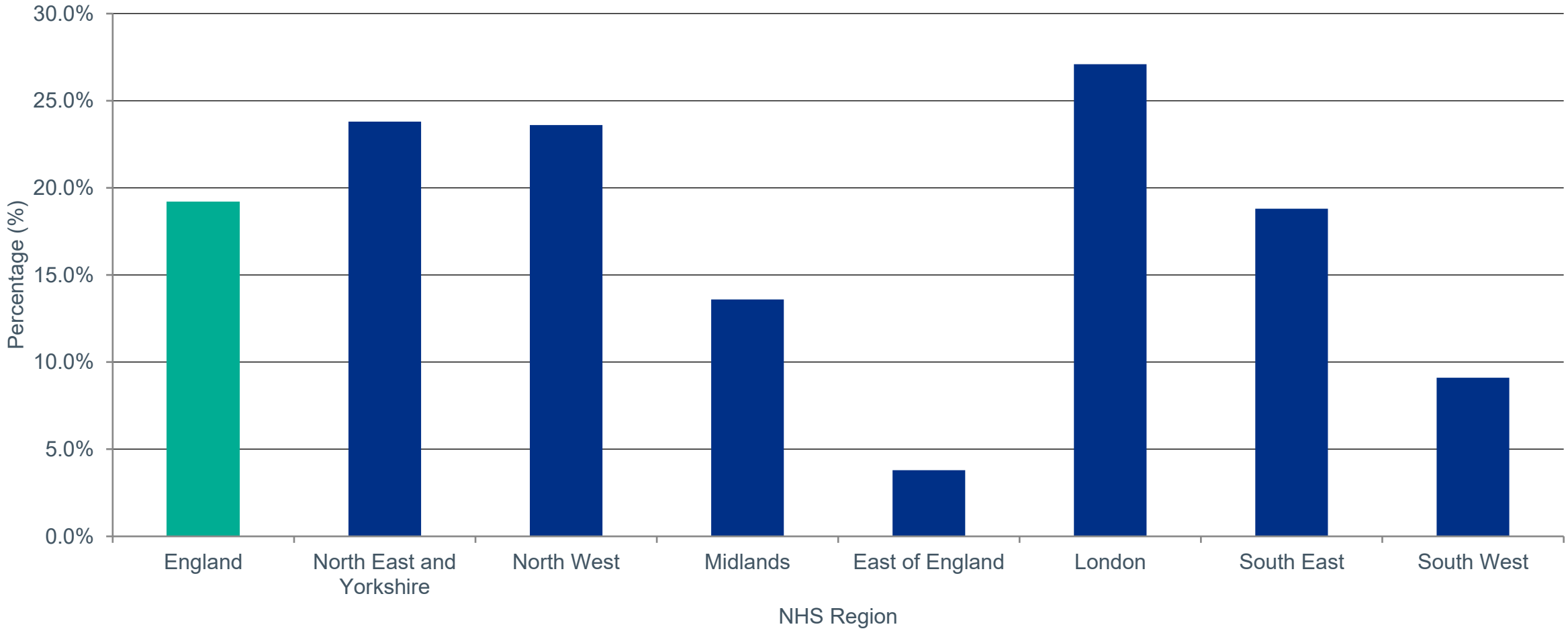
Source: NHS Digital, Maternity Services Data Set (MSDS) April 2024 to March 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternity continuity of carer

Safety | Tier 2: Driver | ↑ Higher is better

Proportion of women recorded as having continuity of carer at 28 weeks of pregnancy in England, from the Maternity Services Data Set.

Figure 2.27: Maternity continuity of carer by NHS Region



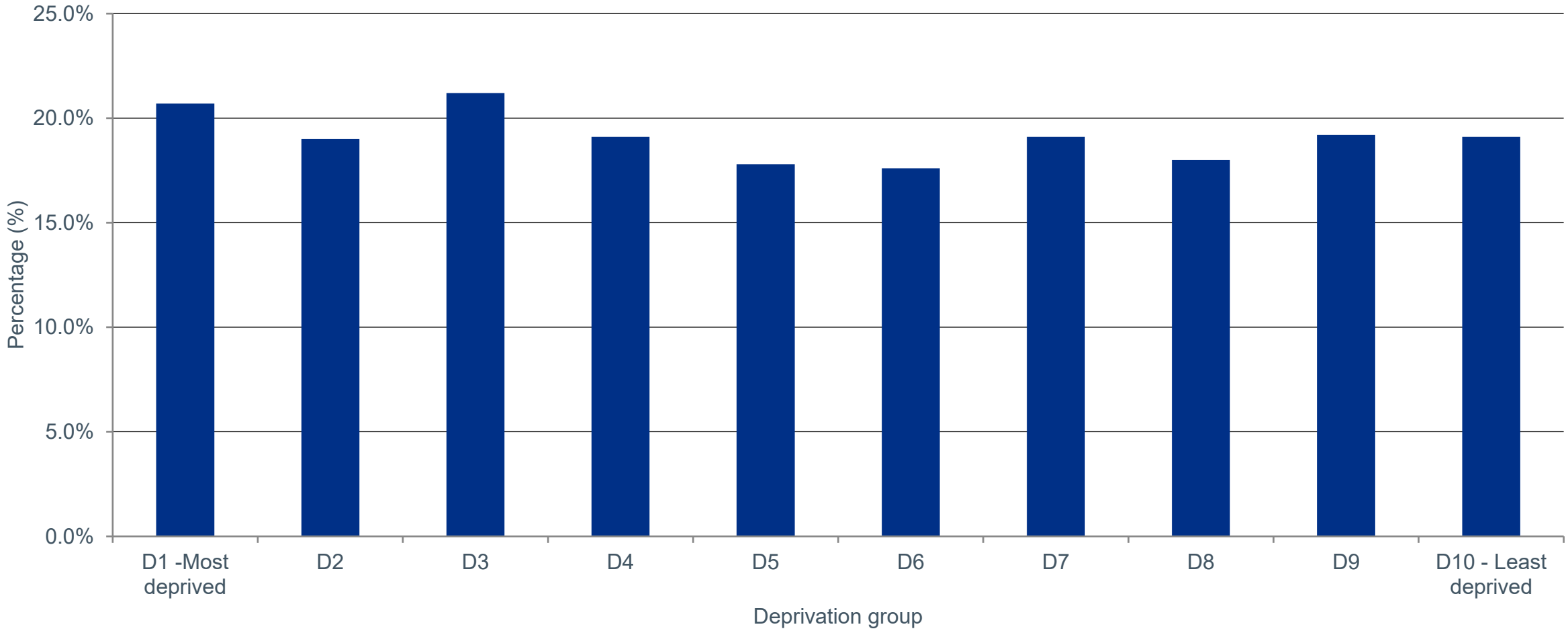
Source: NHS Digital, Maternity Services Data Set (MSDS) April 2024 to March 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternity continuity of carer

Safety | Tier 2: Driver | ↑ Higher is better

Proportion of women recorded as having continuity of carer at 28 weeks of pregnancy in England, from the Maternity Services Data Set.

Figure 2.28: Maternity continuity of carer by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: NHS Digital, Maternity Services Data Set (MSDS) April 2024 to March 2025 | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Antenatal management of pre-existing conditions in pregnancy - diabetes

Effectiveness | Tier 2: Driver | ↑ Higher is better

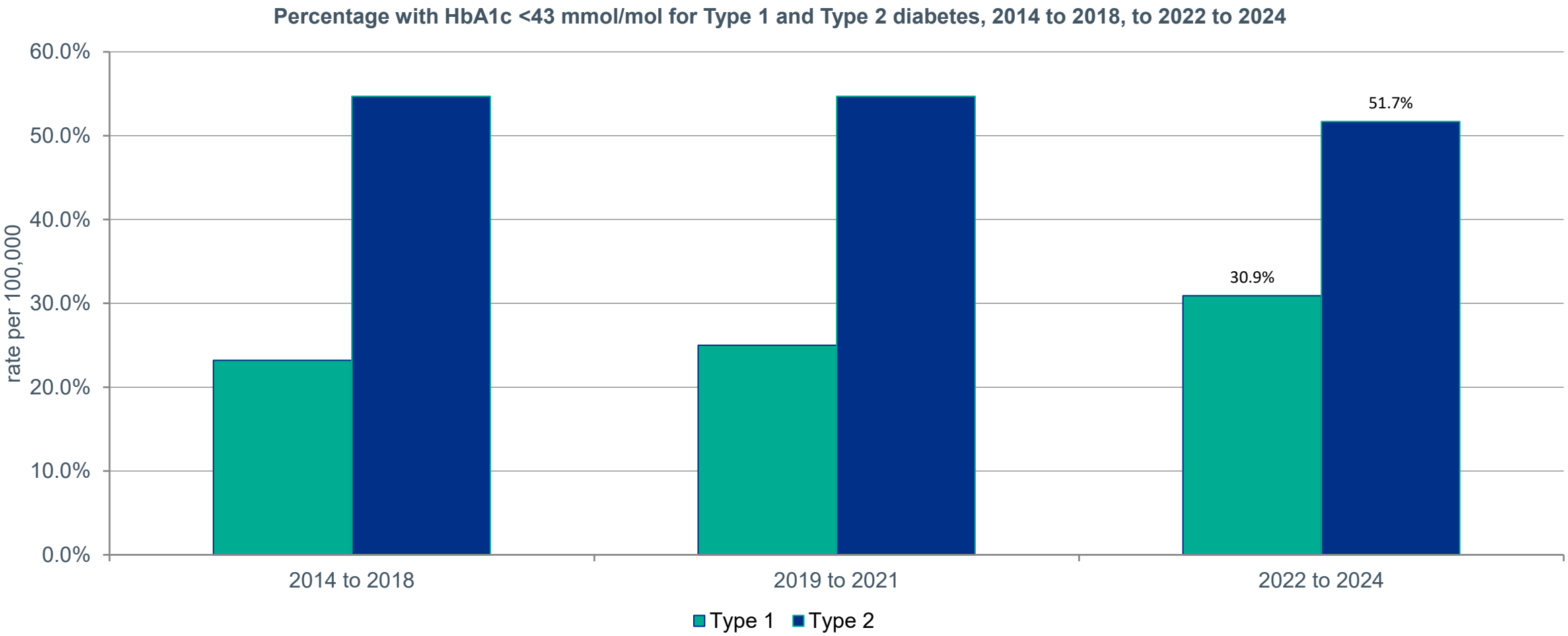
Percentage of pregnancies with HbA1c <43 mmol/mol in late pregnancy by diabetes type

Why it matters for the strategy

• The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address three key questions around whether women with diabetes adequately prepared for pregnancy, whether appropriate steps were taken during pregnancy to minimise adverse outcomes to the mother and whether adverse neonatal outcomes were minimised
• The latest value for England is 30.9% for Type 1 and 51.7% for Type 2
• This is getting better for Type 1 diabetes, increasing by 7.7% from 2014 to 2018 (23.2%) to 2022 to 2024 (30.9%), but getting worse for Type 2, decreasing by 3% from 2014 to 2018 (54.7%) to 2022 to 2024 (51.7%)

Source: National Pregnancy in Diabetes Audit

Figure 2.29: Antenatal management of pre-existing conditions in pregnancy - diabetes: England trend



Source: National Pregnancy in Diabetes Audit

Severe perineal tear rate (3rd/4th degree)

Safety | Tier 3: Process indicator | ↓ Lower is better

Rate of severe (3rd and 4th degree) perineal tears during vaginal birth in England, from the Maternity Services Data Set (MSDS).

Why it matters for the strategy

- The latest figure for England (3 months to Dec 2025) is 2.9 per 10,000.
- This has remained broadly stable: Severe perineal tear rate 2.9 per 10,000 (3 months to Dec 2025).
- A leading cause of maternal morbidity and lifelong incontinence.
- National audit standard, moves with unit-level practice. Core maternity safety signal.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

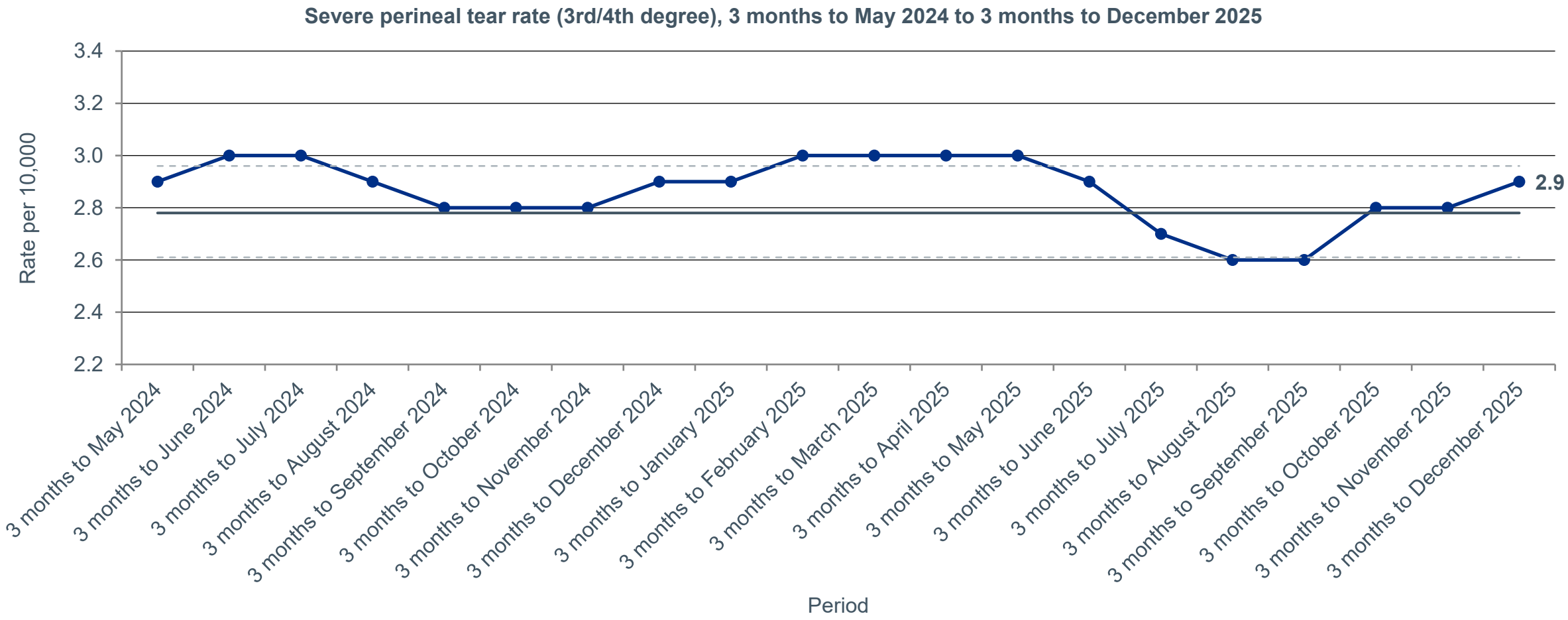
Source: MSDS Monthly Statistics aggregated measures (NHS Digital). Rolling 3-month periods. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Severe perineal tear rate (3rd/4th degree)

Safety | Tier 3: Process indicator | ↓ Lower is better

Rate of severe (3rd and 4th degree) perineal tears during vaginal birth in England, from the Maternity Services Data Set (MSDS).

Figure 2.30: Severe perineal tear rate (3rd/4th degree): England trend



Source: MSDS Monthly Statistics aggregated measures (NHS Digital). Rolling 3-month periods. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Post-partum haemorrhage rate (>=1500ml)

Safety | Tier 3: Process indicator | ↓ Lower is better

Rate of post-partum haemorrhage of 1500ml or more during birth in England, from the Maternity Services Data Set (MSDS).

Why it matters for the strategy

- The latest figure for England (Q3 2025) is 3.2 per 10,000.
- This has remained broadly stable: postpartum haemorrhage (PPH) rate (>=1500ml) 3.2 per 10,000 (3 months to Nov 2025).
- Operational signal that moves before the underlying driver - early warning for changes in the wider pathway.
- National maternity audit standard. Monthly/quarterly visibility of maternity safety.

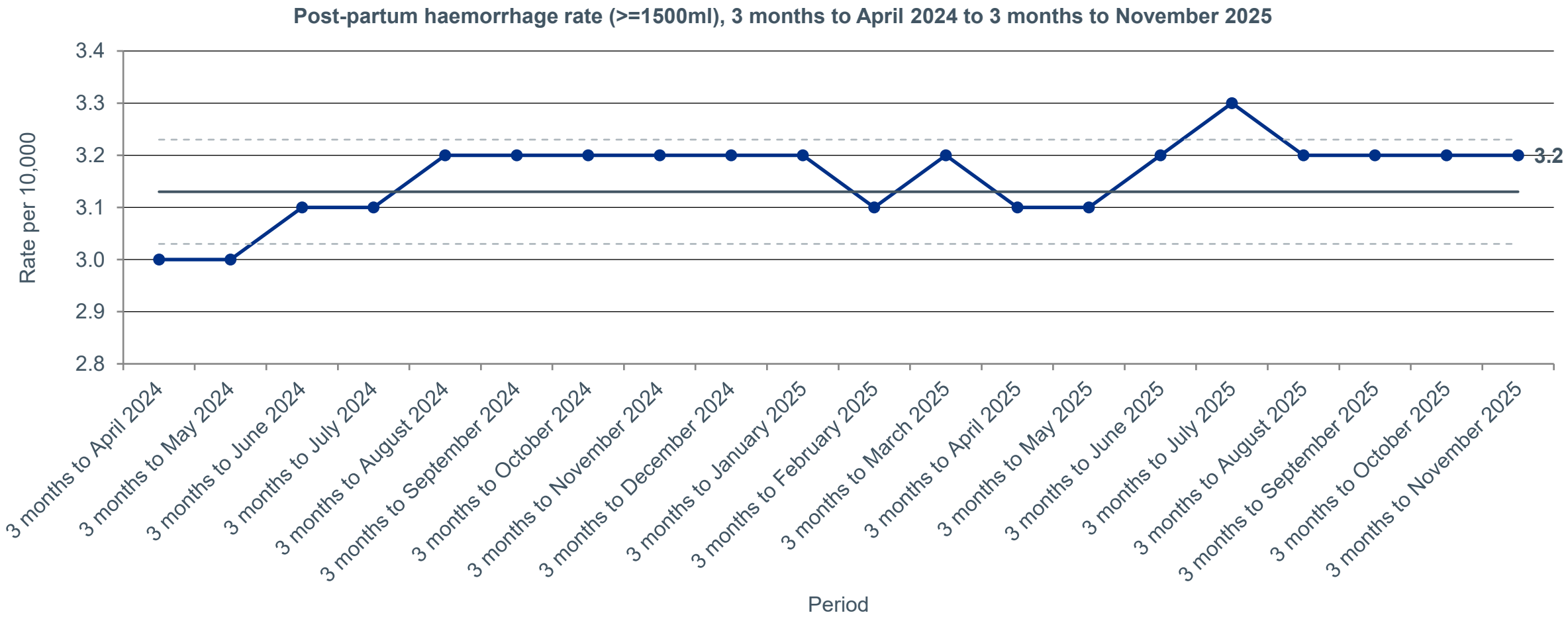
Source: MSDS Monthly Statistics aggregated measures (NHS Digital). Rolling 3-month periods. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Post-partum haemorrhage rate (>=1500ml)

Safety | Tier 3: Process indicator | ↓ Lower is better

Rate of post-partum haemorrhage of 1500ml or more during birth in England, from the Maternity Services Data Set (MSDS).

Figure 2.31: Post-partum haemorrhage rate (>=1500ml): England trend



Source: MSDS Monthly Statistics aggregated measures (NHS Digital). Rolling 3-month periods. | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Neonatal mortality rate

Safety | Tier 1: Outcome | ↓ Lower is better

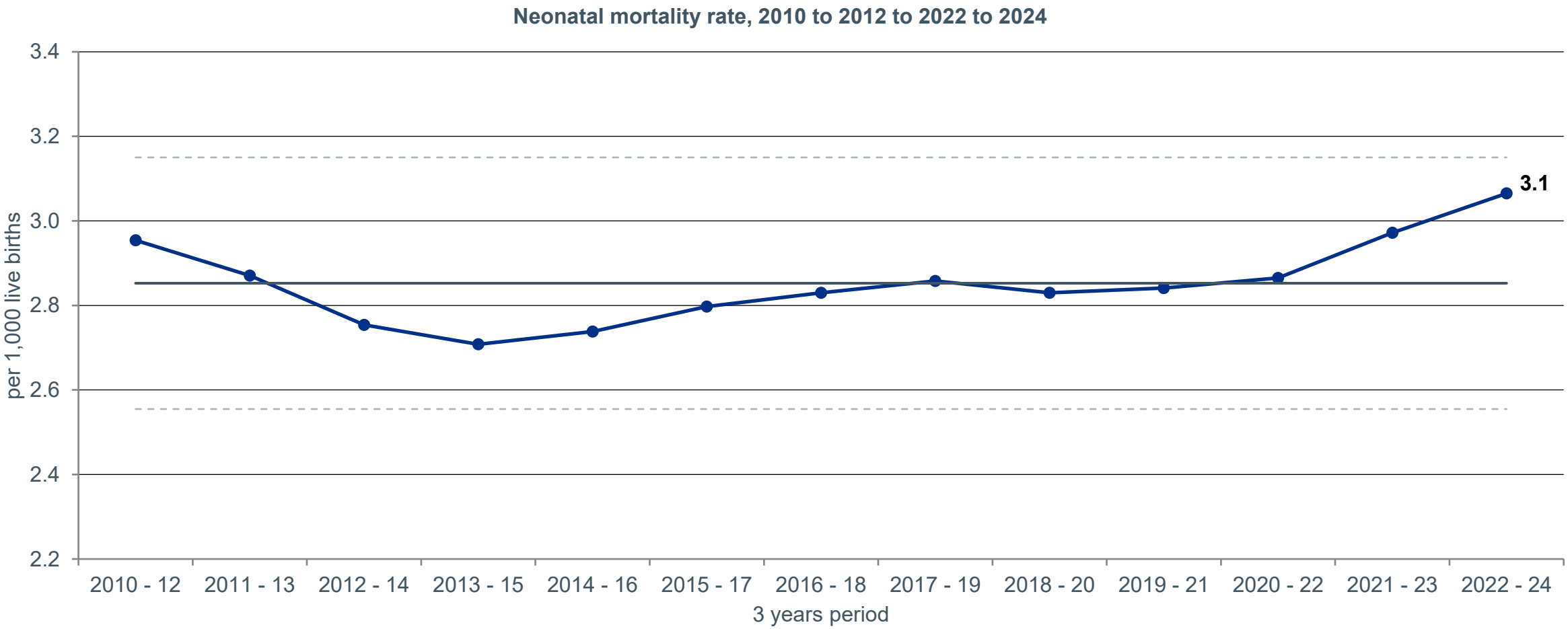
Neonatal death rate by ethnicity, deprivation and gestational age.

Why it matters for the strategy

• The latest figure for England (2022 to 2024) is 3.1 per 1,000 live births.
• Trend shows an increase over the last 10 years: from 2.7 (2013 to 2015) to 3.1 (2022 to 2024) per 1,000 live births .
• Performance varies across NHS Regions (2022 to 2024 data): the best-performing area (South West) had a rate of 2.15 per 1,000 live births, while the worst (Midlands) had 4.3 per 1,000 live births.
• People in the most deprived areas have a rate of 4.9 per 1,000 live births, compared with 2.1 in the least deprived - a gap of 2.7 per 1,000 live births.
• Maternity and neonatal outcomes are a priority safety domain in the strategy.
• Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

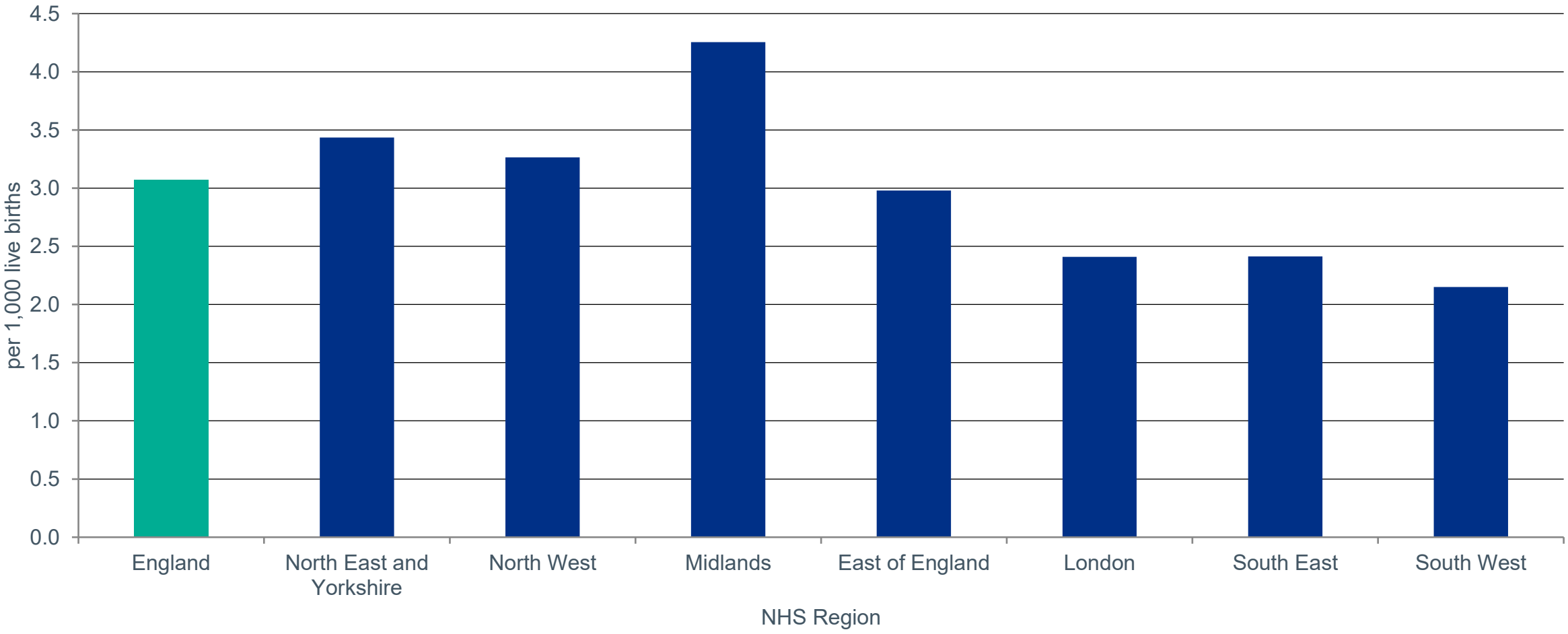
Source: Office for Health Improvement and Disparities (OHID) Fingertips [92705] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.32: Neonatal mortality rate: England trend



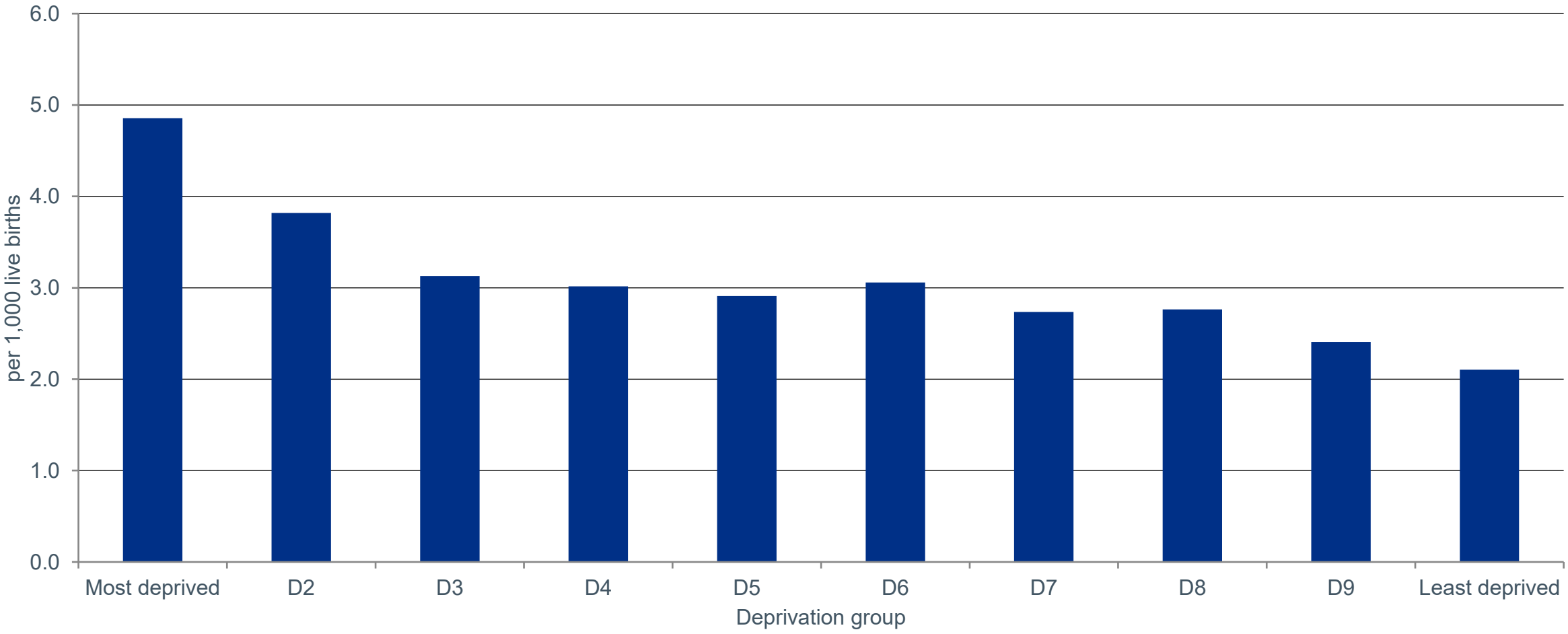
Source: OHID Fingertips [92705] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.33: Neonatal mortality rate by NHS Region



Source: OHID Fingertips [92705] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.34: Neonatal mortality rate by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: OHID Fingertips [92705] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Neonatal mortality rate by cause

Effectiveness | Tier 2: Driver | ↓ Lower is better

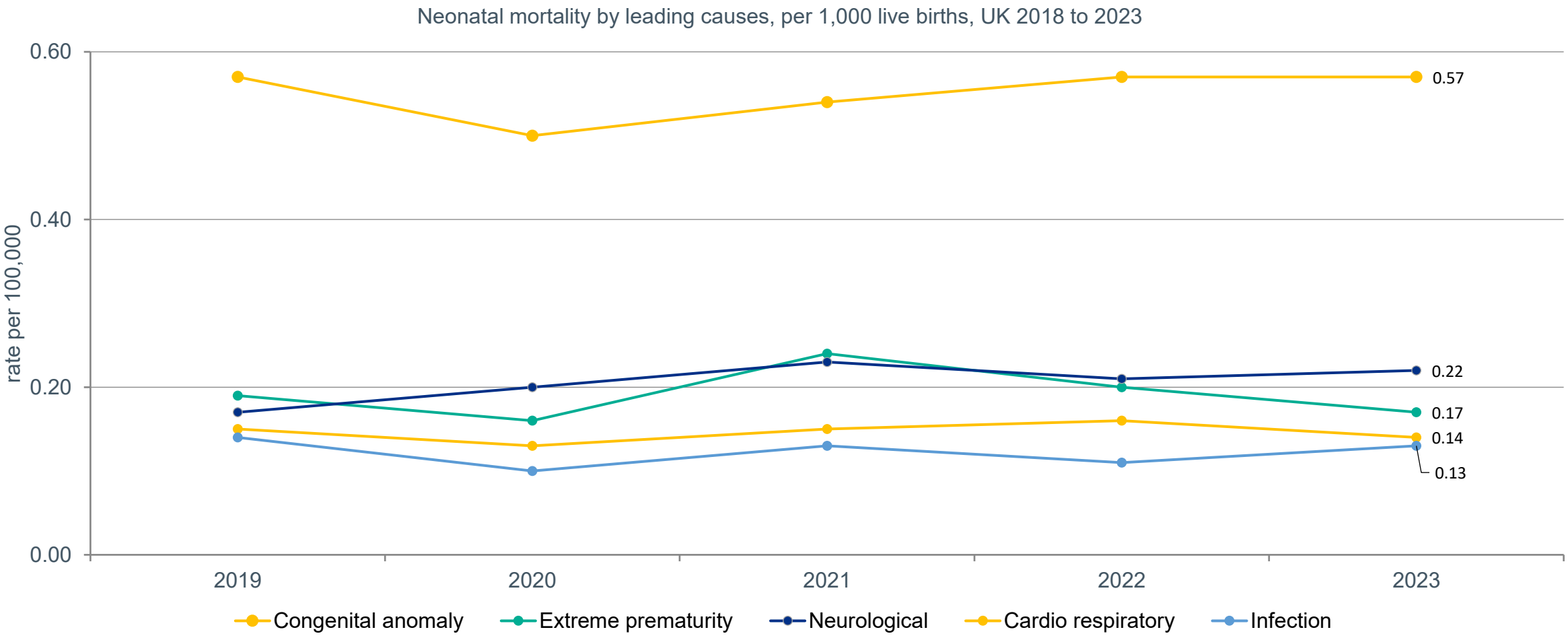
Neonatal mortality by leading causes, per 1,000 live births

Why it matters for the strategy

• Key outcome metric providing deeper insight into the cause of neonatal mortality. We track neonatal mortality because it is a severe adverse outcome of pregnancy and childbirth.
• The latest data for England (2023) is 0.57 per 100,000 for congenital anomaly, 0.22 per 100,000 for neurological causes, 0.17 per 100,000 for extreme prematurity, 0.14 per 100,000 for cardio-respiratory causes and 0.13 per 100,000 for infection.
• This remains almost stable for congenital anomaly, extreme prematurity, cardio-respiratory causes and infection and getting worse for neurological causes of neonatal mortality in 2023 compared to 2019; 0.57 (in 2019 and 2023) per 100,000 for neurological causes, from 0.15 (2019) to 0.22 (2023) per 100,000 for neurological causes, 0.17 (in 2019 and 2023) per 100,000 for extreme prematurity, 0.14 (in 2019 and 2023) per 100,000 for cardio-respiratory causes, and from 0.14 (2019) to 0.13 (2023) per 100,000 for infection.
• Congenital anomaly is the leading cause of direct maternal deaths happening in 2023 (0.57 per 100,000), neurological is the second leading cause (0.22 per 100,000), then extreme prematurity (0.17 per 100,000), cardio-respiratory (0.14 per 100,000) and last is infection (0.13 per 100,000 for infection).

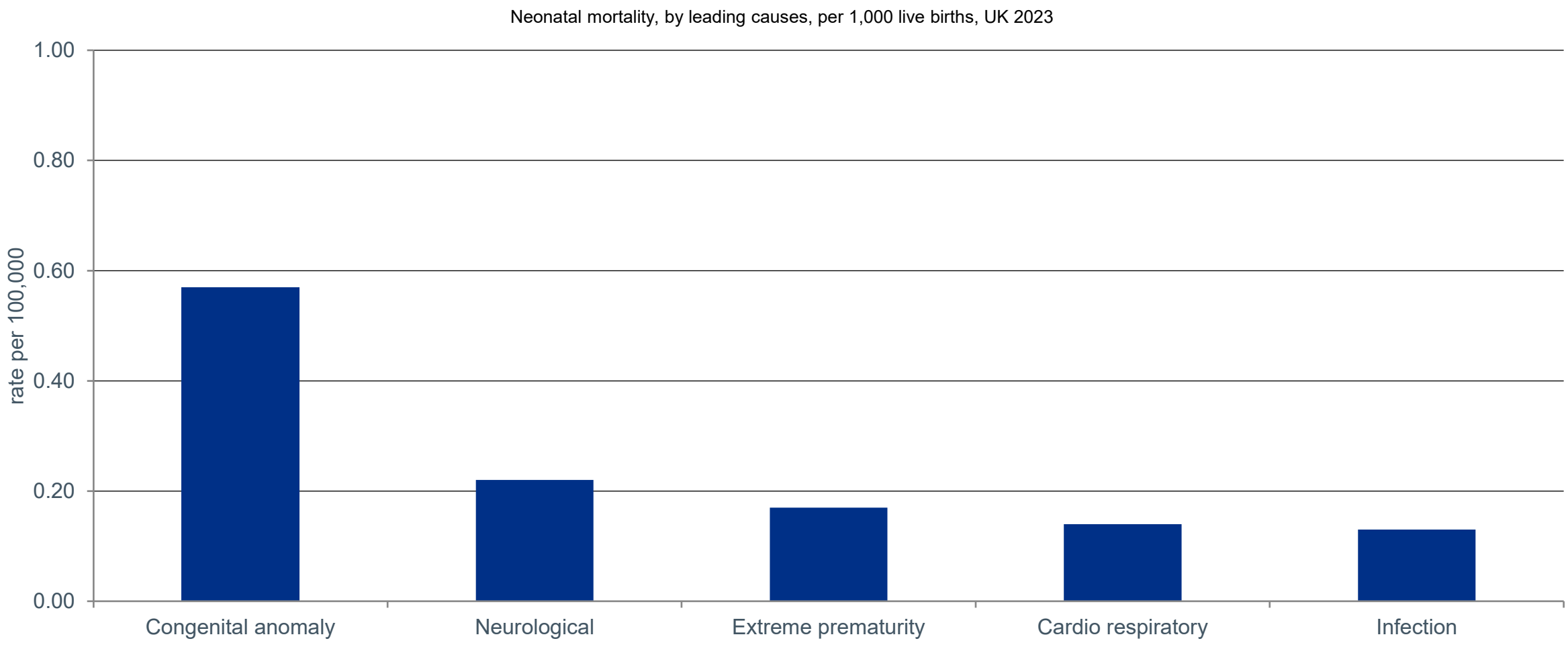
Source: MBRRACE-UK State of the Nation Report 2025

Figure 2.35: Neonatal mortality rate by cause: England trend



Source: MBRRACE-UK State of the Nation Report 2025

Figure 2.36: Neonatal mortality rate by cause: England trend



Source: MBRRACE-UK State of the Nation Report 2025

Stillbirth rate

Safety | Tier 1: Outcome | ↓ Lower is better

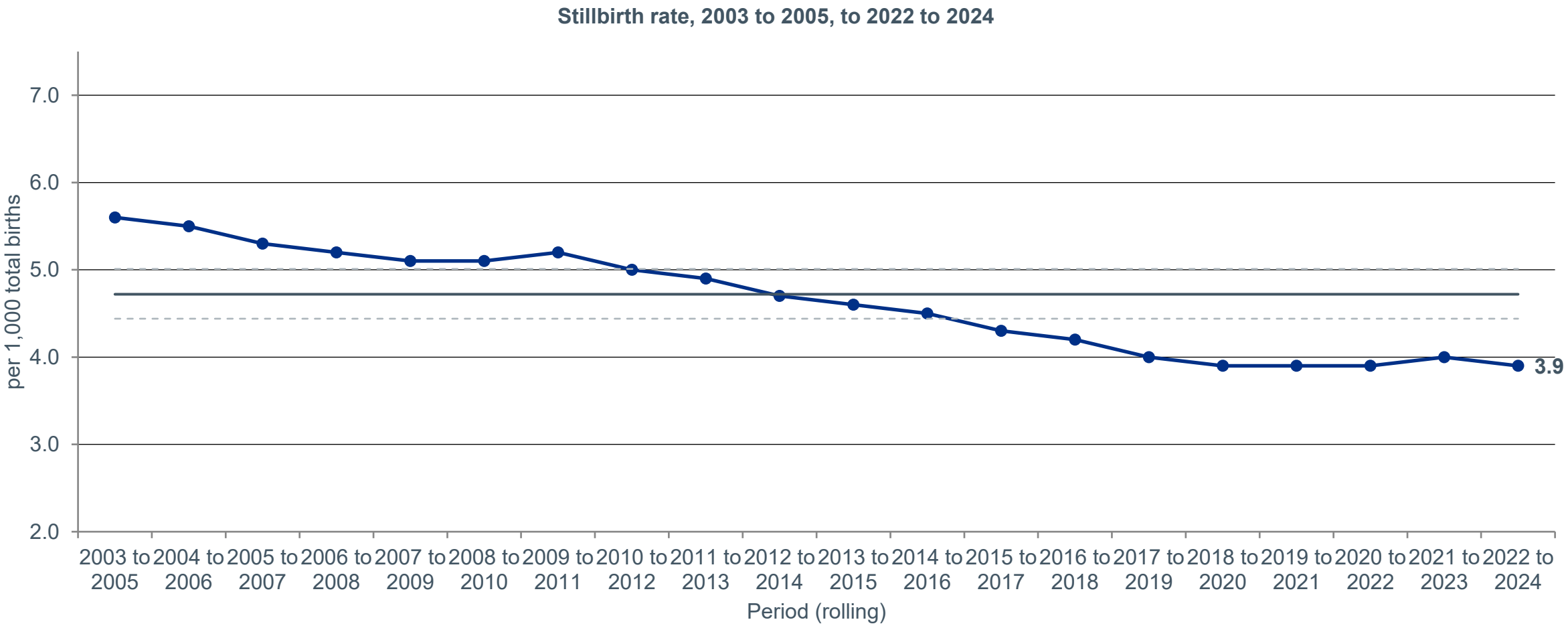
Stillbirth rate by ethnicity and deprivation.

Why it matters for the strategy

- The latest figure for England (2022 to 2024) is 3.9 per 1,000 total births.
- Decreasing trend: 5.6 (2003 to 2005) to 4.6 (2013, 15) to latest 3.9 per 1,000 total births (2022 to 2024).
- Performance varies across NHS Regions (2022 to 2024 data): the best-performing area (South West) had a rate of 3.1 per 1,000 total births, while the worst (Midlands) had 4.3 per 1,000 total births.
- People in the most deprived areas have a rate of 5.1 per 1,000 total births, compared with 3.2 in the least deprived - a gap of 1.9 per 1,000 total births.
- Maternity-safety inequality signal. strategy-aligned indicator for the Three Year Delivery Plan.
- Tier 1 outcome - moves slowly; multi-year baseline needed to read change against the strategy's ambition.

Source: Office for Health Improvement and Disparities (OHID) Fingertips [92530] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.37: Stillbirth rate: England trend

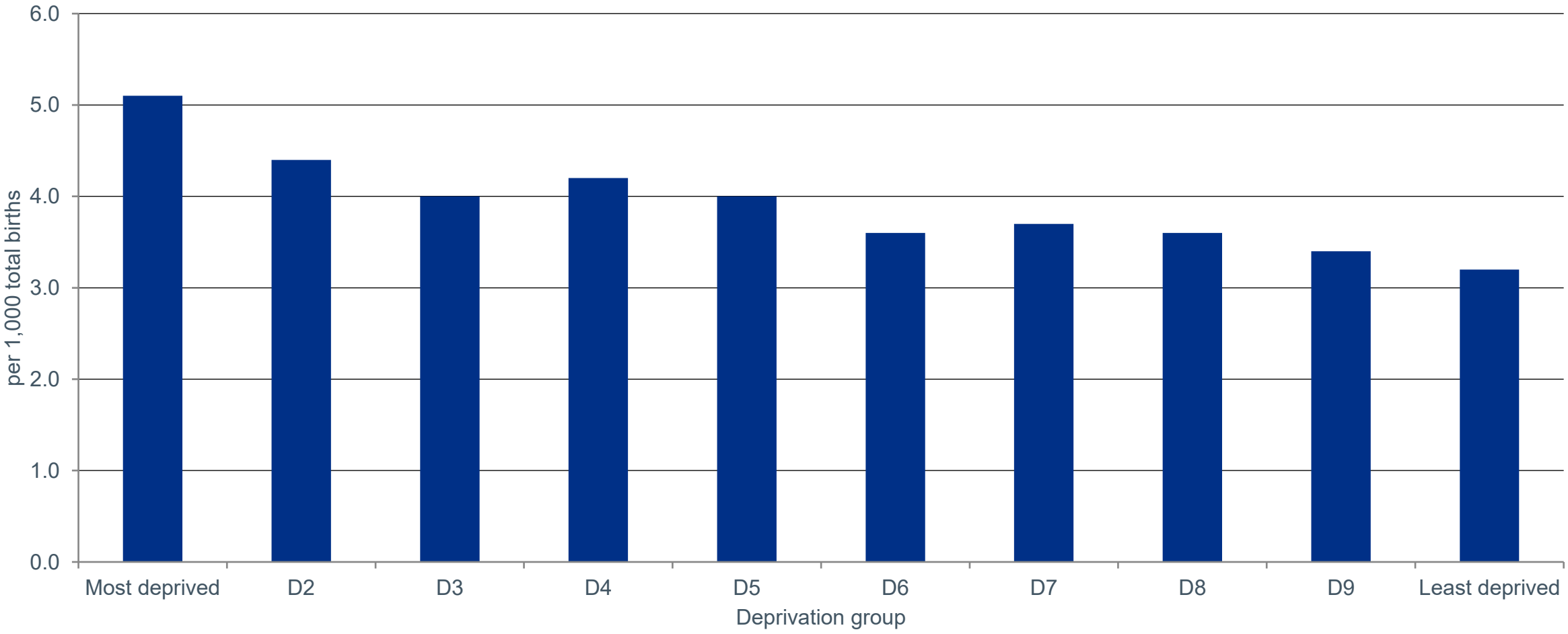


Source: OHID Fingertips [92530] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.38: Stillbirth rate by NHS Region

Source: OHID Fingertips [92530] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 2.39: Stillbirth rate by deprivation group (Index of Multiple Deprivation (IMD) decile)



Source: OHID Fingertips [92530] | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Babies with an APGAR score between 0 and 6

Effectiveness | Tier 2: Driver | ↓ Lower is better
Rate per 1,000 births of babies with an APGAR score between 0 and 6.

Why it matters for the strategy

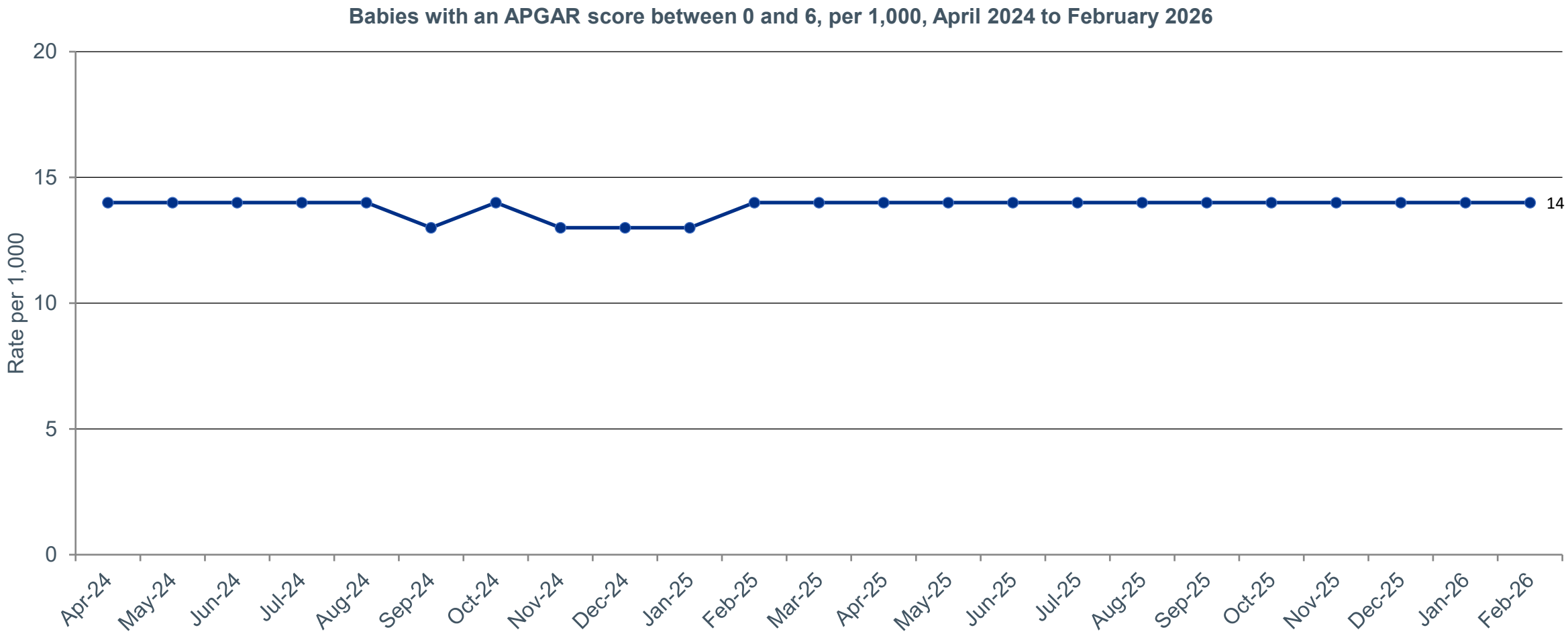
• This is a sensitive indicator of intrapartum care quality, reflecting factors such as timely recognition of fetal distress, effectiveness of labour management, and the safety of delivery practices.
• The latest position is 14 per 1,000.
• This has remained broadly stable since Apr-24
• Tier 2 Driver of improved neonatal and perinatal outcomes

Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by Index of Multiple Deprivation (IMD)). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Babies with an APGAR score between 0 and 6

Effectiveness | Tier 2: Driver | ↓ Lower is better
Rate per 1,000 births of babies with an APGAR score between 0 and 6.

Figure 2.40: Babies with an APGAR score between 0 and 6: England trend



Source: CVDPREVENT national primary care audit, To Sep 2025. Trend = CVDP009CHOL (LLT). Inequality = CVDP012CHOL (cholesterol target by IMD). Other components in narrative: CVDP002AF, CVDP002CHD, C...

Experience of care

This section covers people's experience of NHS care: whether patients feel involved in decisions, supported to manage their health, and treated with dignity and respect.

Metrics are drawn from national patient surveys (GP Patient Survey, Care Quality Commission (CQC) Adult Inpatient Survey, Community Mental Health Survey, Maternity Survey, Cancer Patient Experience Survey) and the NHS Staff Survey.

Experience metrics are grouped by care setting (GP, inpatient, mental health, maternity, cancer) and by the workforce conditions that enable good experience.

Public satisfaction with the NHS

Experience of care | Tier 1: Outcome | ↑ Higher is better

Proportion of the British public who report being satisfied with the NHS overall, from the British Social Attitudes survey conducted annually by NatCen Social Research.

Why it matters for the strategy

• We track public satisfaction with the NHS because it captures the public's overall assessment of the health service, reflecting access, quality and confidence. At 21% in 2024, it is at the lowest level since the BSA survey began. The current trend has started improving, rising from 21% (2024) to 26% (2025), though still far below pre-pandemic levels.
• The latest figure for England (2025) is 26%.
• This is getting better: 26% satisfied in 2025 (up 5pp from record low of 21% in 2024). First increase since 2019. Satisfaction fell from 49% (2006) to 60% (2019) and then decreased. Still far below pre-pandemic. 65+ most satisfied (35%); under-35s least (20%). Access remains dominant concern.
• BSA satisfaction is the headline Tier 1 Experience outcome and one of the most-watched indicators of public trust in the system.
• Dissatisfaction is driven primarily by access, waiting and communication rather than clinical concerns - the issues that the strategy's experience commitments target.
• The BSA methodology uses random probability sampling to select British households to take part. The questions on health measure and track public views about health and care; it is not necessarily the case that all respondents will have recent and direct experience of NHS care when answering the questions.

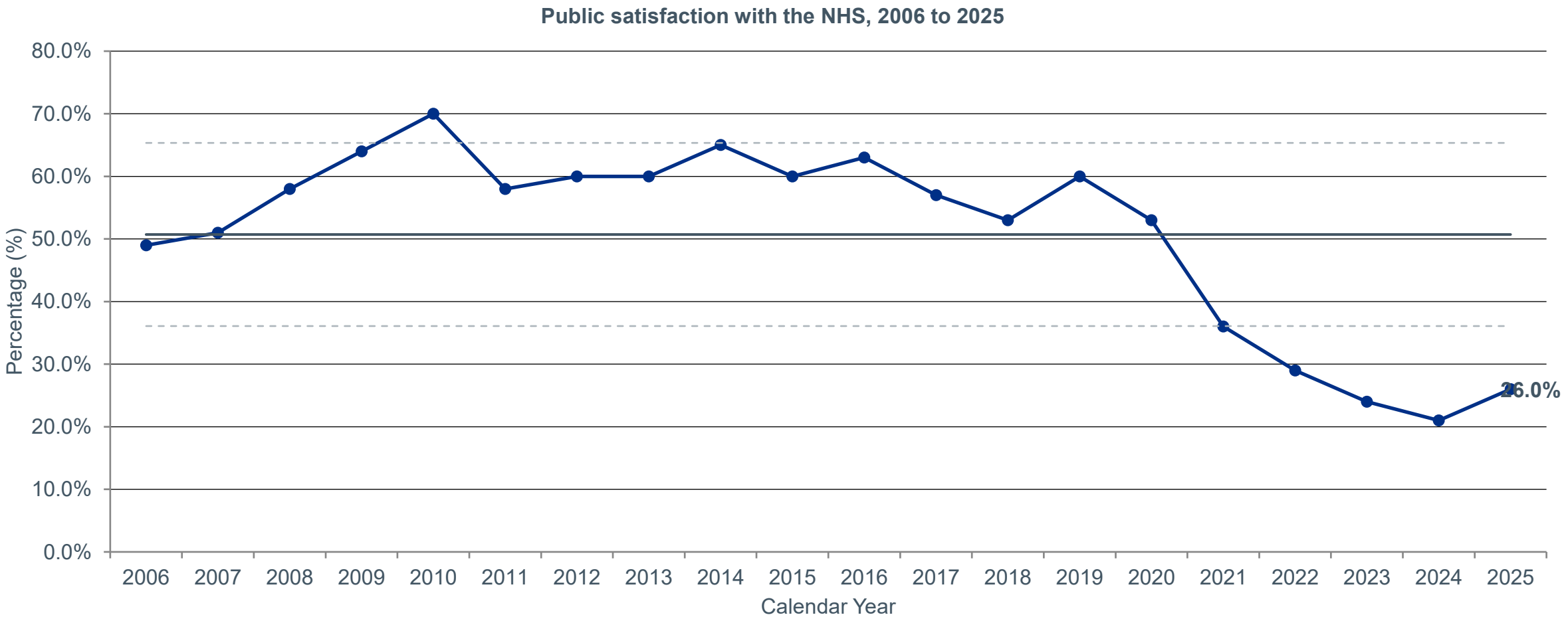
Source: NatCen/King's Fund, British Social Attitudes Survey 2025 (published 30 Mar 2026). NB: Business Services Authority (BSA) uses random probability sampling; respondents may not have recent direct experience of NHS care | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Public satisfaction with the NHS

Experience of care | Tier 1: Outcome | ↑ Higher is better

Proportion of the British public who report being satisfied with the NHS overall, from the British Social Attitudes survey conducted annually by NatCen Social Research.

Figure 3.1: Public satisfaction with the NHS: England trend



Source: NatCen/King's Fund, British Social Attitudes Survey 2025 (published 30 Mar 2026). NB: BSA uses random probability sampling; respondents may not have recent direct experience of NHS care | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Shared decision-making

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported being 'definitely' involved in decisions about their care and treatment (GP Patient Survey, Q29).

Why it matters for the strategy

• We track shared decision making because involving patients in decisions about their care is a core NHS commitment and a determinant of treatment adherence, patient satisfaction and health outcomes.
• The latest figure for England (2025) is 91.2% (including responses 'Yes, definitely' and 'Yes, to some extent' .
• This is getting better: 61.6% said 'Yes, definitely' in 2025 (up from 60.9% in 2024) and further 29.6% said 'Yes, to some extent' (compared to 30% in 2024).
• Only 2 trend points: GP Patient Survey (GPPS) substantially redesigned in 2024, pre-2024 data not directly comparable.
• Only 61.6% of GP patients say they were 'definitely' involved in decisions about their care, with 8.8% saying they were not involved at all (GPPS 2025). The regional chart shows the wider 'Yes' and 'Yes to some extent' combined response.
• Involvement is one of the strongest predictors of treatment adherence, satisfaction and downstream outcomes - and is named in the strategy's Experience Excellence Framework as one of its five pillars.

Source: NHS England, GP Patient Survey 2025 (Jul 2025)

Shared decision-making

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported being 'definitely' involved in decisions about their care and treatment (GP Patient Survey, Q29).

Figure 3.2: Shared decision-making: England trend

Source: NHS England, GP Patient Survey 2025 (Jul 2025)

Self-care support from local services

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported 'definitely' feeling supported by local services and organisations to manage their health (GP Patient Survey, Q43).

Why it matters for the strategy

• We track self-care support because empowering patients to manage their own conditions reduces unplanned care demand and improves quality of life, yet only 31.2% say they are 'definitely' supported by local services.
• The latest figure for England (2025) is 68.6% (including responses 'Yes, definitely' and 'Yes, to some extent'.
• This is getting better: 31.2% said 'Yes, definitely' in 2025, a slight increase from 30.7% in 2024 (+0.5pp). A further 37.4% said 'Yes, to some extent'. 31.4% said No.
• Only 2 trend points: GP Patient Survey (GPPS) substantially redesigned in 2024, pre-2024 data not directly comparable.
• Many patients still report that they are not 'definitely' supported by local services.
• strategy Experience priority. Drives the NHS Long Term Plan personalised care ambition.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

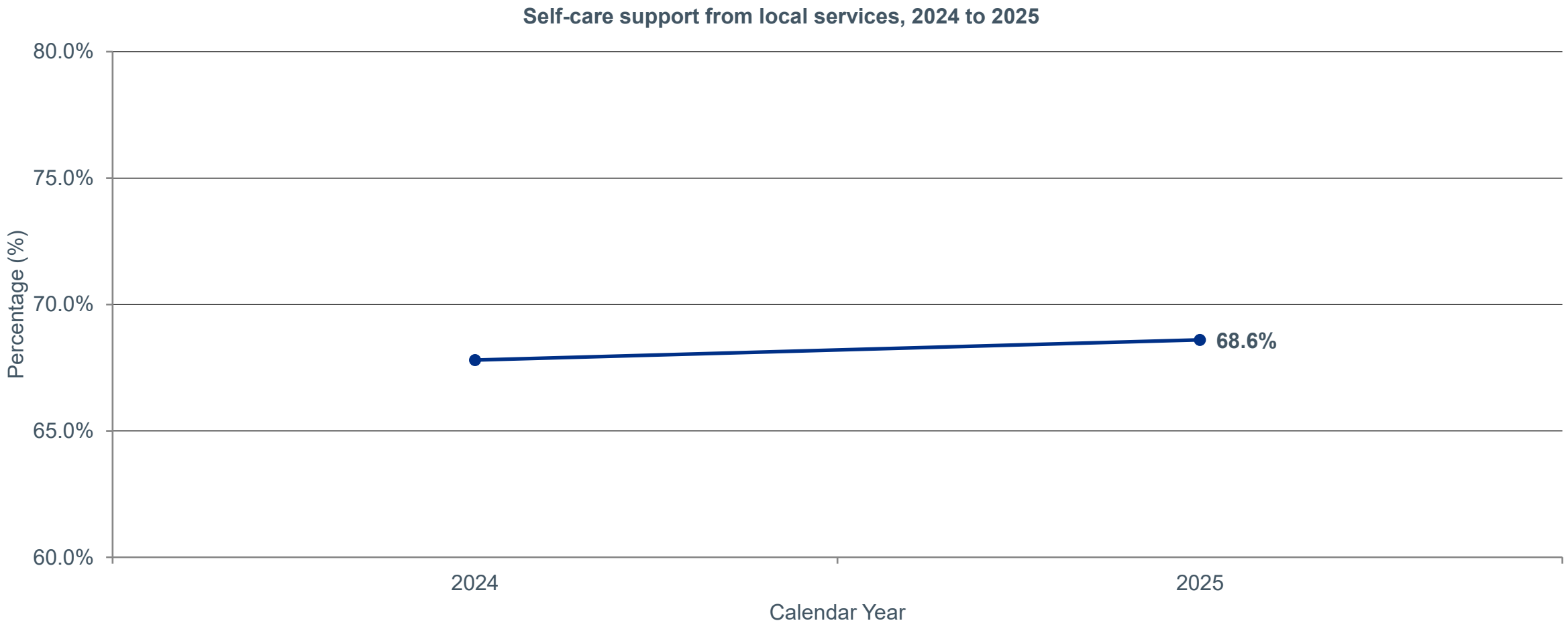
Source: NHS England, GP Patient Survey 2025 (Jul 2025)

Self-care support from local services

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported 'definitely' feeling supported by local services and organisations to manage their health (GP Patient Survey, Q43).

Figure 3.3: Self-care support from local services: England trend



Source: NHS England, GP Patient Survey 2025 (Jul 2025)

GP experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of respondents who described their overall experience of their GP practice as good (very good or fairly good), from the GP Patient Survey (Q32).

Why it matters for the strategy

• We track overall GP experience because general practice is the front door to the NHS and the primary care setting where most patient interactions happen. While 75.4% describe their experience as good (up from 73.9%), significant variation carries on between practices and populations.
• The latest figure for England (2025) is 75.4% (including responses “very good” and “fairly good”)
• This is getting better: 75.4% describe GP experience as good in 2025 (43.9% very good + 31.5% fairly good), up from 73.9% in 2024 (+1.5pp).
• Only 2 trend points: GP Patient Survey (GPPS) substantially redesigned in 2024, pre-2024 data not directly comparable.
• GPPS headline. Tracks access, communication, trust.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

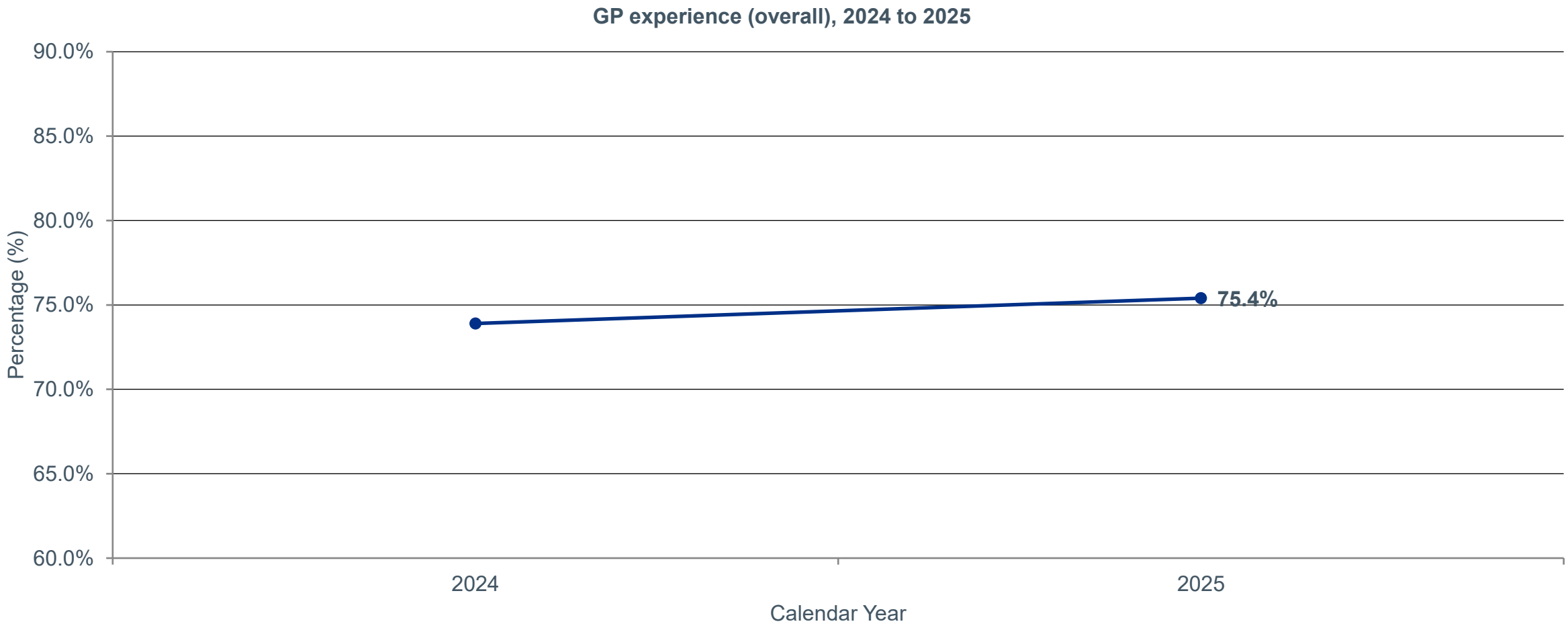
Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q32

GP experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of respondents who described their overall experience of their GP practice as good (very good or fairly good), from the GP Patient Survey (Q32).

Figure 3.4: GP experience (overall): England trend



Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q32

GP appointment access

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who rated their overall experience of contacting their practice as good (very good or fairly good), from the GP Patient Survey (Q16).

Why it matters for the strategy

• We track GP appointment access because contacting a GP practice remains the most common concern raised by patients. GP Patient Survey (GPPS) data shows 69.6% report a good experience contacting their practice (2025, up from 67.3%), indicating that access, while improving, remains a priority.
• The latest figure for England (2025) is 69.6%. Only 2 trend points: GPPS redesigned in 2024, pre-2024 data not directly comparable.
• This is getting better: 69.6% report good experience contacting GP practice in 2025 (Q16), up from 67.3% in 2024 (+2.3pp). Q16 components: easy to get through (phone/online), offered appointment that worked, appointment available when needed.
• The trend in reported experience of contact is gradually improving, but it is still a priority.
• One of strategy and 10YHP access priority.

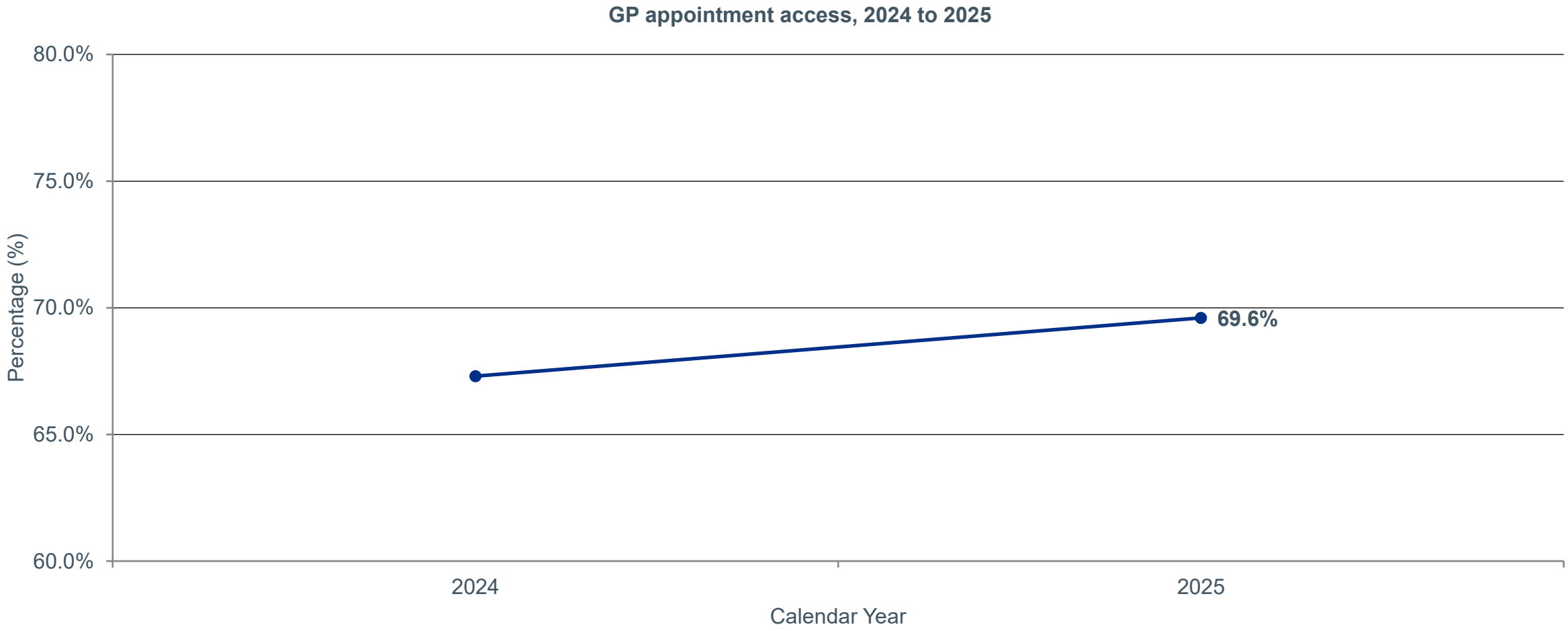
Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q16

GP appointment access

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who rated their overall experience of contacting their practice as good (very good or fairly good), from the GP Patient Survey (Q16).

Figure 3.5: GP appointment access: England trend



Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q16

GP access: easy to contact by phone

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to contact their practice by telephone (GP Patient Survey, Q1).

Why it matters for the strategy

• We track phone access to GP practices because difficulty contacting the practice is the most common complaint in primary care, with only 52.9% finding it easy by phone.
• The latest figure for England (2025) is 52.9%.
• This is getting better: 52.9% in 2025, up from 49.7% in 2024 (+3.2pp).
• Only 2 trend points: Q1 redesigned in 2024.
• One of strategy's access priority. Primary-care access signal.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

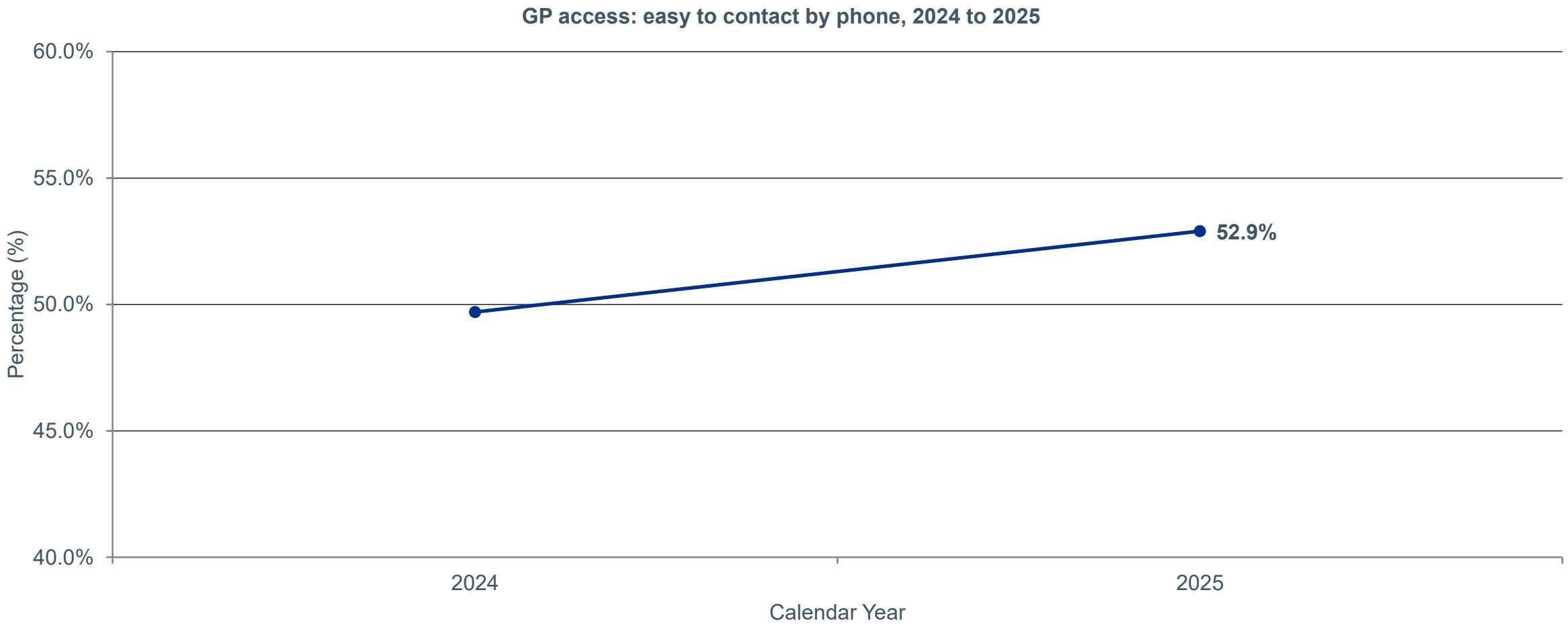
Source: GP Patient Survey (GPPS) 2025, Q1 ease of contacting practice by phone

GP access: easy to contact by phone

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to contact their practice by telephone (GP Patient Survey, Q1).

Figure 3.6: GP access: easy to contact by phone: England trend



Source: GPPS 2025, Q1 ease of contacting practice by phone

GP access: easy via website

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to contact their practice via its website (GP Patient Survey, Q2).

Why it matters for the strategy

• We track website access to GP practices because digital channels should complement phone access, yet only 51.2% find it easy, indicating the digital front door is not yet working.
• The latest figure for England (2025) is 51.2%.
• This is getting better: 51.2% in 2025, up from 47.9% in 2024 (+3.3pp).
• Only 2 trend points: Q2 redesigned in 2024.
• Digital front-door signal. Companion to GP phone access in Core; supports the Technology enabler.

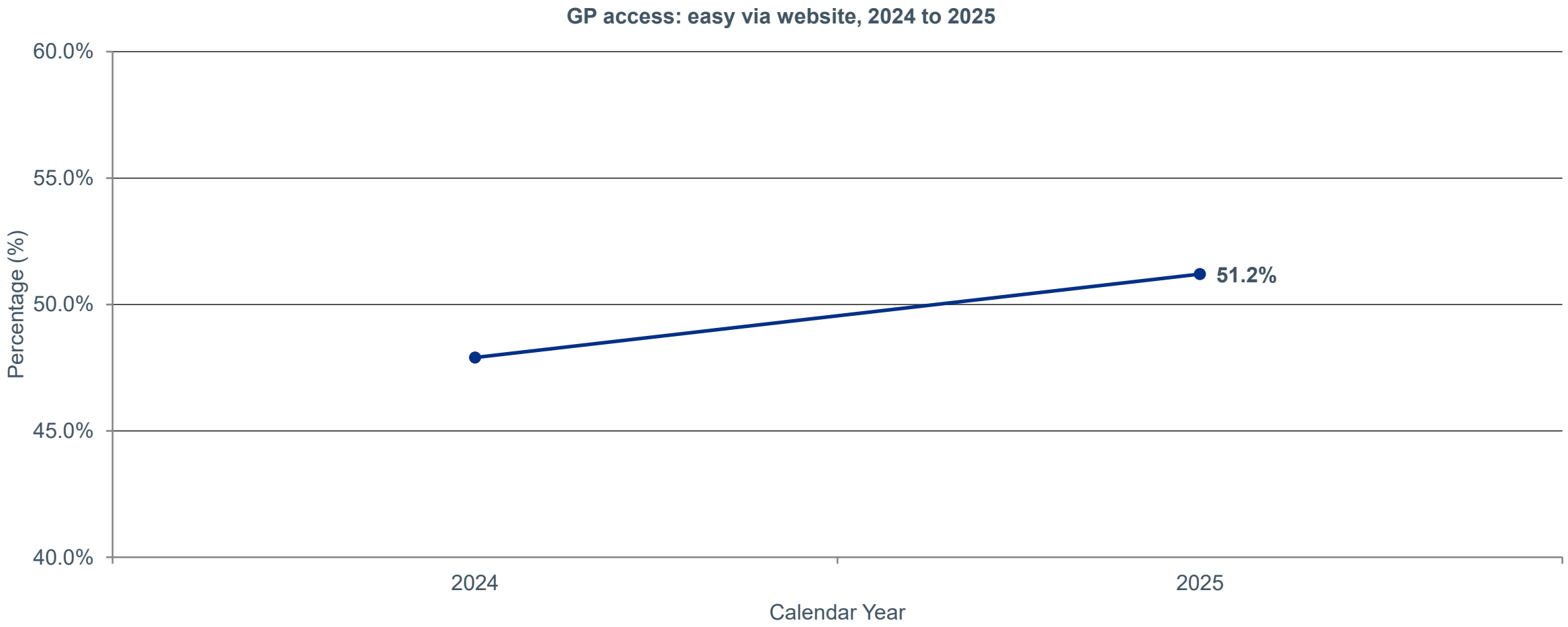
Source: GP Patient Survey (GPPS) 2025, Q2 ease of contacting practice via website

GP access: easy via website

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to contact their practice via its website (GP Patient Survey, Q2).

Figure 3.7: GP access: easy via website: England trend



Source: GPPS 2025, Q2 ease of contacting practice via website

GP access: easy via NHS App

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to use the NHS App to access GP services (GP Patient Survey, Q3).

Why it matters for the strategy

• We track NHS App access because the App is the national digital channel for primary care, yet only 49% find it easy to use, limiting its role in reducing phone demand.
• The latest figure for England (2025) is 49%.
• This is getting better: 49% in 2025, up from 44.8% in 2024 (+4.2pp).
• Only 2 trend points: Q3 redesigned in 2024. Note: 57.6% of respondents have not tried the NHS App.
• Operational signal that moves before the underlying driver - early warning for changes in the wider pathway.
• strategy digital-channel signal. Companion to GP phone access in Core; supports the Technology enabler.

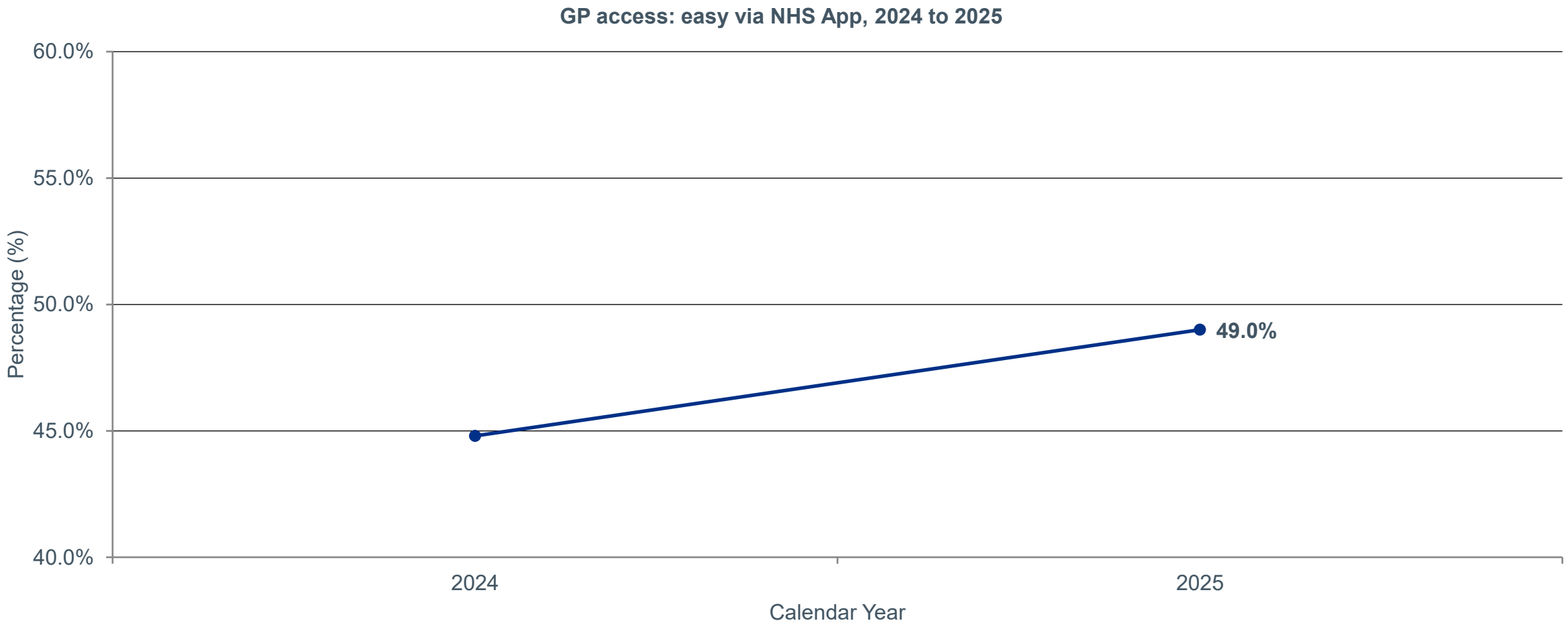
Source: GP Patient Survey (GPPS) 2025, Q3 ease of using NHS App

GP access: easy via NHS App

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who found it easy to use the NHS App to access GP services (GP Patient Survey, Q3).

Figure 3.8: GP access: easy via NHS App: England trend



Source: GPPS 2025, Q3 ease of using NHS App

GP: confidence in healthcare professional

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who reported 'definitely' having confidence and trust in the healthcare professional they saw or spoke to (GP Patient Survey, Q28).

Why it matters for the strategy

• We track patient confidence in healthcare professionals because it is a core component of the therapeutic relationship. Only 63.6% say 'yes, definitely', revealing significant improvement opportunity masked when aggregated with 'to some extent' responses. The current trend is static, with the headline figure unchanged between 2024 and 2025.
• The latest figure for England (2025) is 63.6% responded 'Yes, definitely' and 28.9% responded 'Yes, to some extent.
• This has remained broadly stable: 63.6% said 'Yes, definitely' in 2025 (up from 63.4% in 2024). A further 28.9% said 'Yes, to some extent' in both years.
• Only 2 trend points: GPPS redesigned in 2024, pre-2024 data not directly comparable.
• Therapeutic-relationship signal. Sub-indicator of overall GP experience.

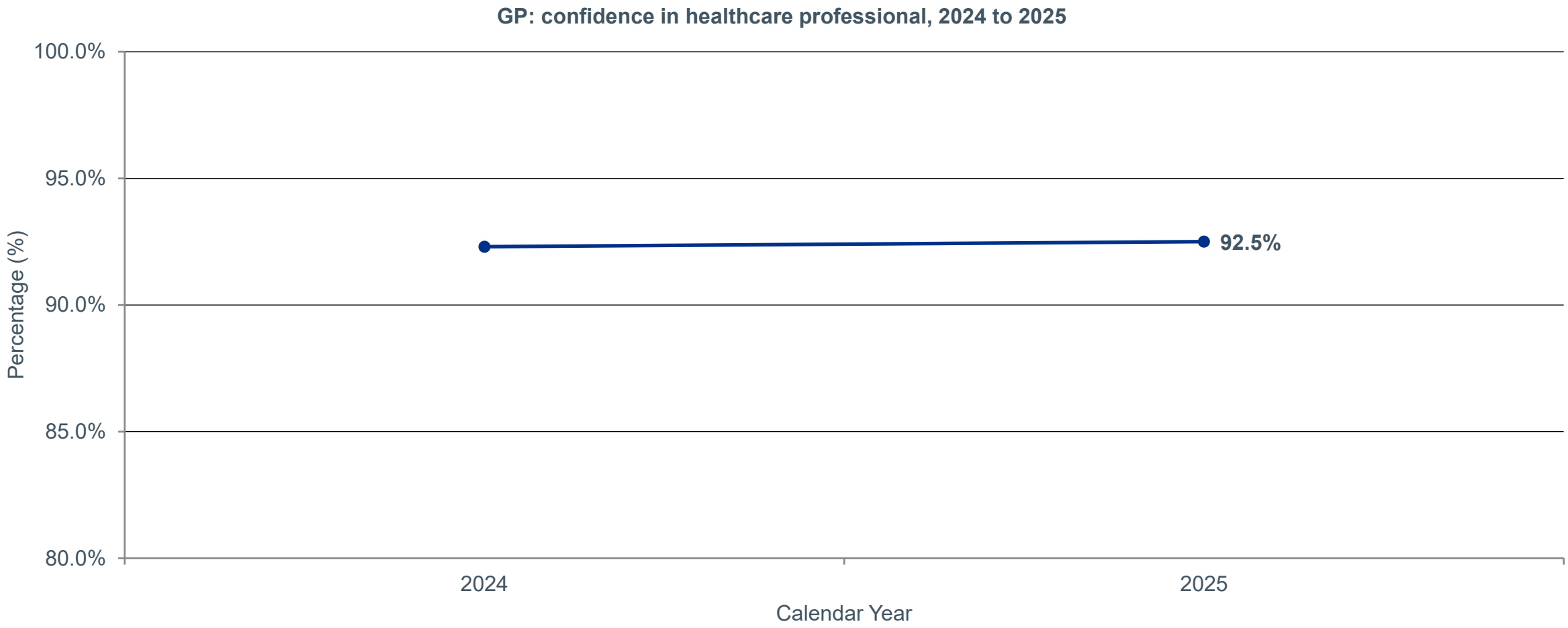
Source: GP Patient Survey (GPPS) 2025, Q28 confidence in healthcare professional

GP: confidence in healthcare professional

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who reported 'definitely' having confidence and trust in the healthcare professional they saw or spoke to (GP Patient Survey, Q28).

Figure 3.9: GP: confidence in healthcare professional: England trend



Source: GPPS 2025, Q28 confidence in healthcare professional

GP practice: conversation about managing condition (Q44)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients with a long-term condition who reported having had a conversation with a healthcare professional about how to manage their condition (GP Patient Survey, Q44).

Why it matters for the strategy

- We track whether patients have a conversation with their GP about managing their condition because this is the starting point for supported self-management, and only 42.4% report having this conversation.
- The latest figure for England (2025) is 42.4%.
- This has remained broadly stable: 41.5% (2024), 42.4% (2025).
- Only 2 trend points: Q44 redesigned in 2024.

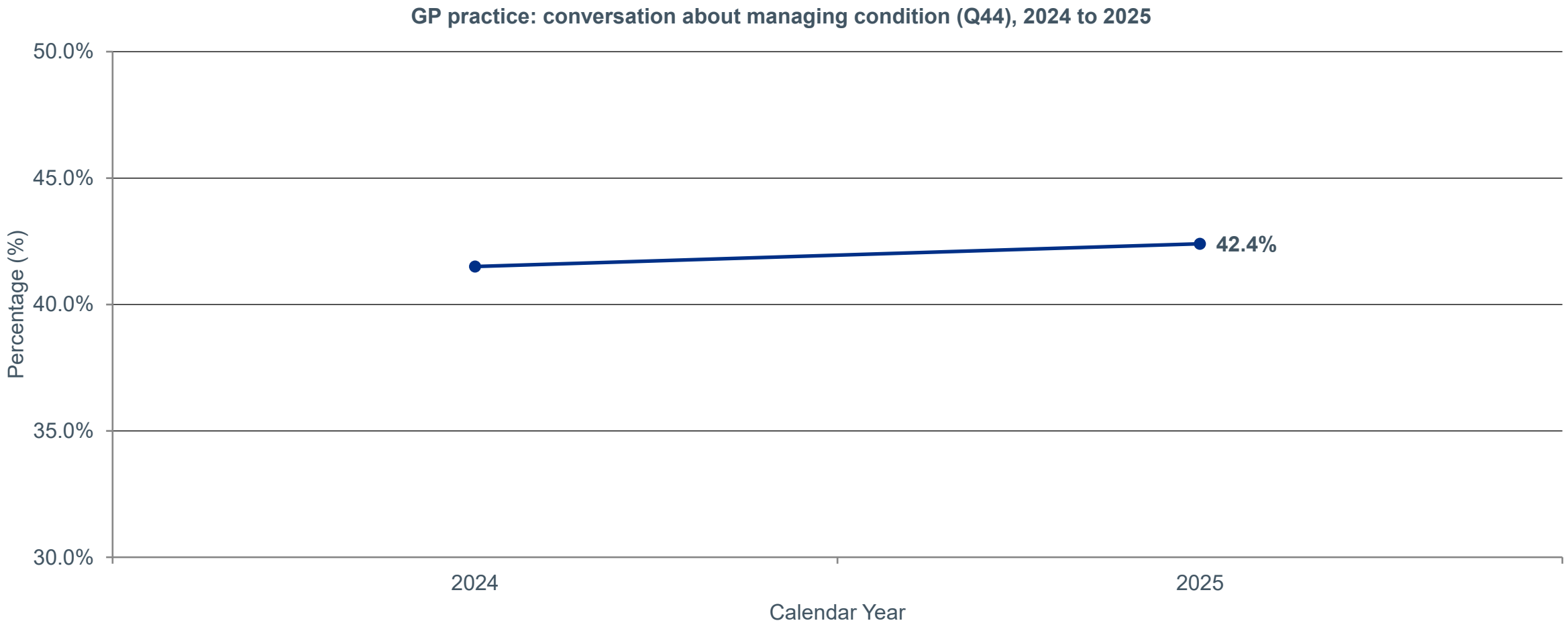
Source: GP Patient Survey 2025, Q44 conversation about managing condition

GP practice: conversation about managing condition (Q44)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients with a long-term condition who reported having had a conversation with a healthcare professional about how to manage their condition (GP Patient Survey, Q44).

Figure 3.10: GP practice: conversation about managing condition (Q44): England trend



Source: GP Patient Survey 2025, Q44 conversation about managing condition

GP: confident managing own health

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who reported feeling very confident in managing their own health (GP Patient Survey, Q42).

Why it matters for the strategy

• We track self-management confidence because empowering patients to manage their own health reduces demand on services and improves outcomes for long-term conditions.
• The latest figure for England (2025) is 77.9%.
• This has remained broadly stable: 24.9% said 'Very confident' in 2025 (down from 25.2% in 2024, -0.3pp). Within survey margin of error. A further 53.0% said 'Fairly confident' in both years.
• Only 2 trend points: GPPS redesigned in 2024, pre-2024 data not directly comparable.
• Self-management confidence signal. Sub-indicator of self-care support.

Source: GP Patient Survey (GPPS) 2025, Q42 self-management confidence

GP: confident managing own health

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of GP patients who reported feeling very confident in managing their own health (GP Patient Survey, Q42).

Figure 3.11: GP: confident managing own health: England trend

Source: GPPS 2025, Q42 self-management confidence

GP continuity of care

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported always or almost always being able to see or speak to their preferred healthcare professional (GP Patient Survey, Q7).

Why it matters for the strategy

• We track GP continuity because patients who can see their preferred GP report better experience and better management of long-term conditions; variation by integrated care board (ICB) reflects access inequalities.
• The latest figure for England (2025) is 40%.
• Trend: 40% always/almost always see preferred HCP in 2025 (up from 39.7% in 2024).
• Only 2 trend points: GPPS redesigned in 2024, pre-2024 data not directly comparable.
• Primary-care lever that the strategy and 10YHP both emphasise.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: GP Patient Survey (GPPS) 2025, Q7

GP continuity of care

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported always or almost always being able to see or speak to their preferred healthcare professional (GP Patient Survey, Q7).

Figure 3.12: GP continuity of care: England trend

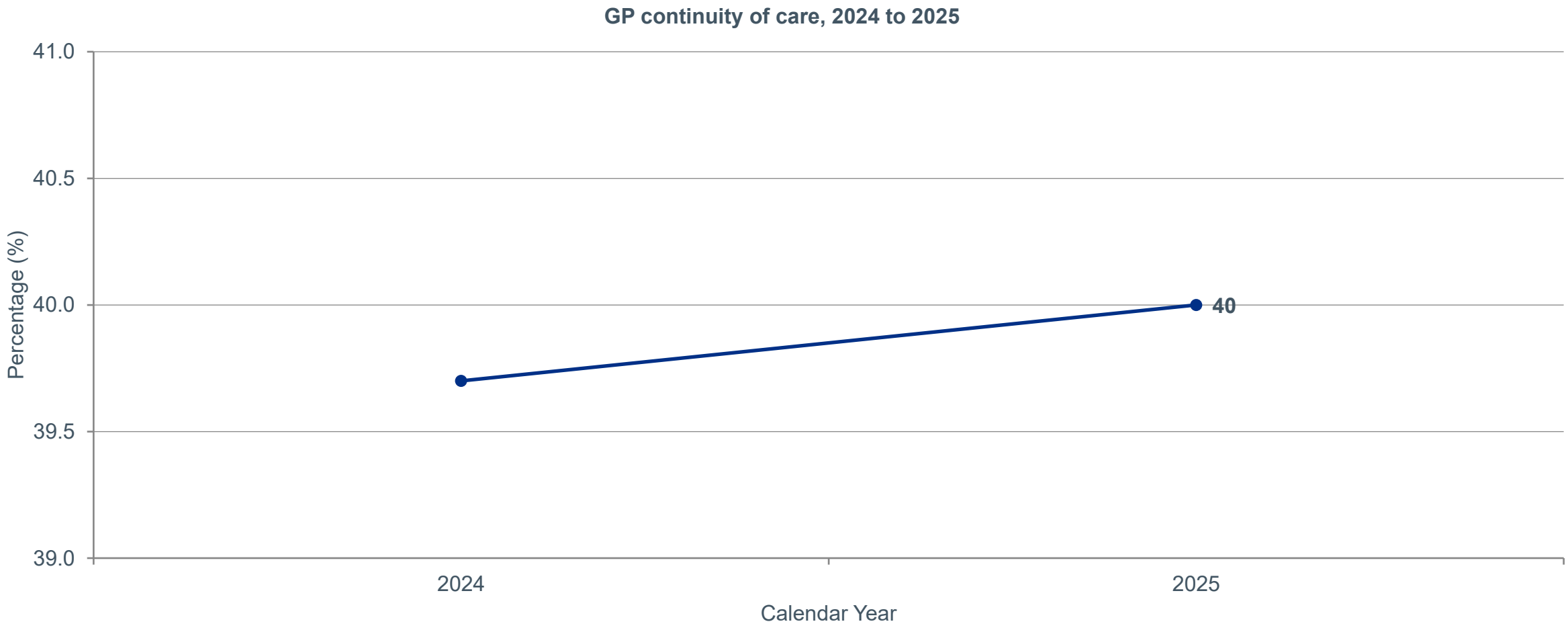
Source: GPPS 2025, Q7

GP continuity of care

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients who reported always or almost always being able to see or speak to their preferred healthcare professional (GP Patient Survey, Q7).

Figure 3.13: GP continuity of care: England trend



Source: GPPS 2025, Q7

Long-term condition care planning

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients with long-term conditions who have an agreed care plan, derived from the GP Patient Survey (Q44 conversation rate multiplied by Q45 plan agreement rate).

Why it matters for the strategy

• We track care planning for long-term conditions because fewer than 1 in 5 long-term condition (LTC) patients have an agreed care plan, yet 93% of those who do find it helpful. Care planning improves experience, confidence and self-management, and reduces hospital costs by £1,000-£2,000 per patient per year.
• The latest figure for England (2025) is 19%.
• This is getting better: 19% of LTC patients have an agreed care plan in 2025 (derived: 42.4% had conversation × 44.9% agreed plan). Slight increase from 18.6% in 2024 (+0.4pp). 93.4% of those with a plan find it helpful.
• Only 2 trend points: GP Patient Survey (GPPS) redesigned in 2024, pre-2024 data not directly comparable.
• Coverage of agreed care plans across the LTC population remains low.
• strategy Experience priority. Direct personalisation measure.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q44/Q45/Q46

Long-term condition care planning

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of GP patients with long-term conditions who have an agreed care plan, derived from the GP Patient Survey (Q44 conversation rate multiplied by Q45 plan agreement rate).

Figure 3.14: Long-term condition care planning: England trend

Source: NHS England, GP Patient Survey 2025 (Jul 2025), Q44/Q45/Q46

Dental services experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better

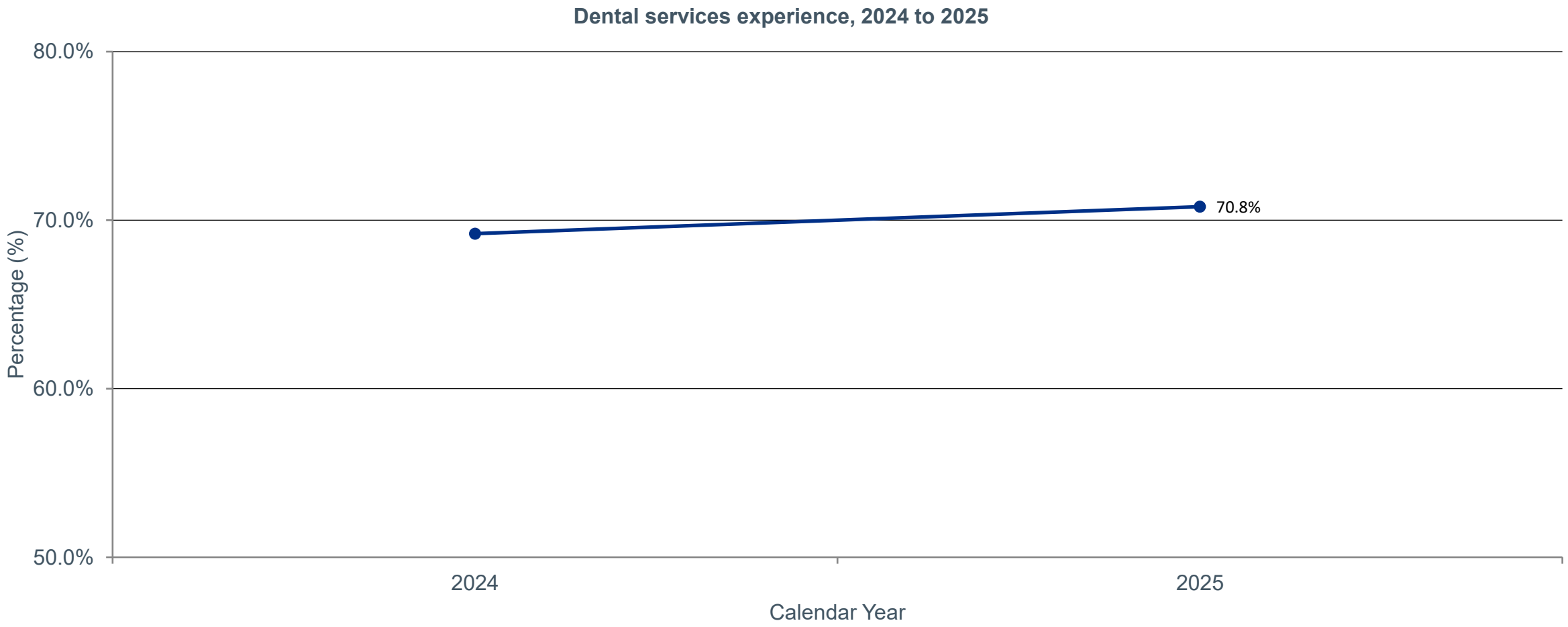
Patient experience of NHS dental services (GP Patient Survey (GPPS) dentalserviceoverall, % good/very good).

Why it matters for the strategy

- The latest figure for England (2025) is 70.8%.
- This is slight increase from 69.2% (in 2024) to 70.8% (in 2025).
- Access to NHS dentistry has deteriorated, with downstream effects on A&E attendance for dental pain and paediatric admissions for decay.
- strategy primary-care access pathway. Downstream effects on A&E and paediatric admissions.

Source: GP Patient Survey 2025 (dentalserviceoverall)

Figure 3.15: Dental services experience: England trend



Source: GP Patient Survey 2025 (dentalserviceoverall)

Inpatient experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall rating of inpatient care on a 0 to 10 scale, from the Care Quality Commission (CQC) Adult Inpatient Survey (Q48), reported as a weighted mean score across NHS trusts in England.

Why it matters for the strategy

- We track overall inpatient experience because hospital stays are the most resource-intensive patient interaction. Positive responses (9 to 10 / 10) fell from 56% (2020) to 50% (2022) before partially recovering to 52% (2024).
- The latest figure for England (2024) is 52%.
- The picture is mixed: Declining from 56% (2020) to 50% (2022) before partially recovering to 52% (2024).
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

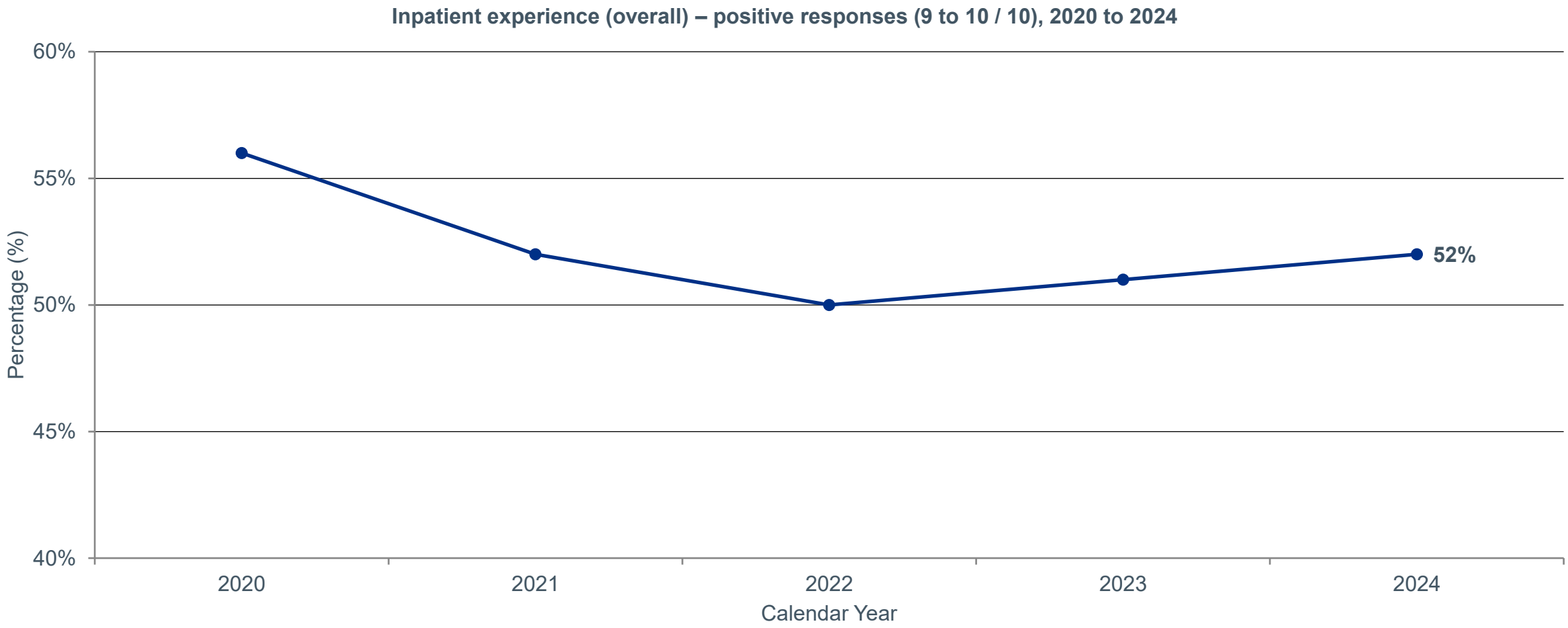
Source: CQC Adult Inpatient Survey 2024, Q48 overall experience

Inpatient experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall rating of inpatient care on a 0 to 10 scale, from the CQC Adult Inpatient Survey (Q48), reported as a weighted mean score across NHS trusts in England.

Figure 3.16: Inpatient experience (overall): England trend



Source: CQC Adult Inpatient Survey 2024, Q48 overall experience

Inpatient: confidence in doctors

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported always having confidence and trust in the doctors treating them (Care Quality Commission (CQC) Adult Inpatient Survey, Q18).

Why it matters for the strategy

- We track confidence in doctors because a declining 5-year trend (84.0% to 80.1%) indicates growing challenges with the doctor-patient relationship in hospitals. The current trend is deteriorating, with confidence in hospital doctors declining.
- The latest figure for England (2024) is 80.1%.
- This is getting worse: Declining: 84.0% (2020), 81.4% (2021), 81.0% (2022), 80.2% (2023), 80.1% (2024).
- A multi-year decline points to growing pressure on the doctor-patient relationship in hospitals.
- Therapeutic-relationship signal. Sub-indicator of overall inpatient experience.

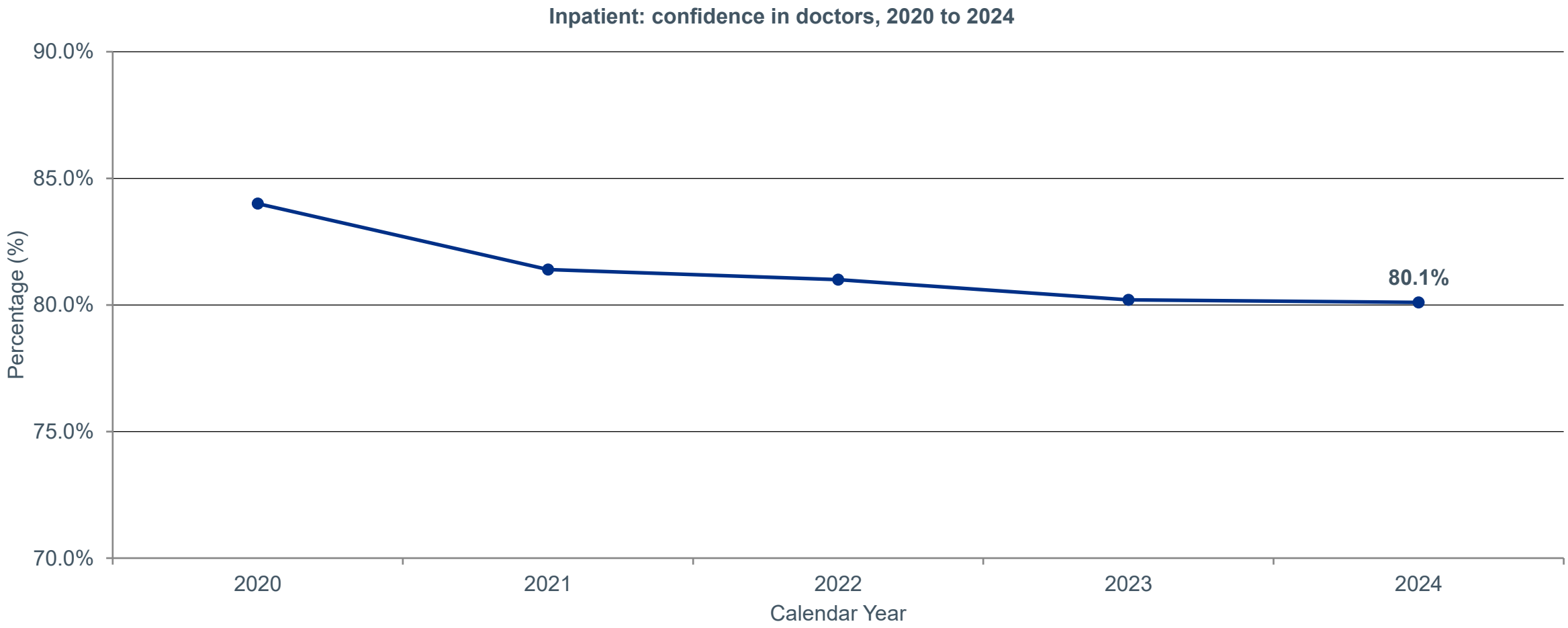
Source: CQC Adult Inpatient Survey 2024, Q18 confidence in doctors

Inpatient: confidence in doctors

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported always having confidence and trust in the doctors treating them (CQC Adult Inpatient Survey, Q18).

Figure 3.17: Inpatient: confidence in doctors: England trend



Source: CQC Adult Inpatient Survey 2024, Q18 confidence in doctors

Inpatient: confidence in nurses

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported always having confidence and trust in the nurses treating them (Care Quality Commission (CQC) Adult Inpatient Survey, Q21).

Why it matters for the strategy

• We track confidence in nurses because the 4pp decline from pre-pandemic levels reflects workforce pressures affecting the quality of nursing care. The current trend is deteriorating, with confidence in hospital nurses declining.
• The latest figure for England (2024) is 78.3%.
• This is getting worse: Declining: 82.7% (2020), 79.4% (2021), 78.8% (2022), 77.8% (2023), 78.3% (2024).
• Operational signal that moves before the underlying driver - early warning for changes in the wider pathway.
• Workforce-pressure signal in nursing. Sub-indicator of overall inpatient experience.

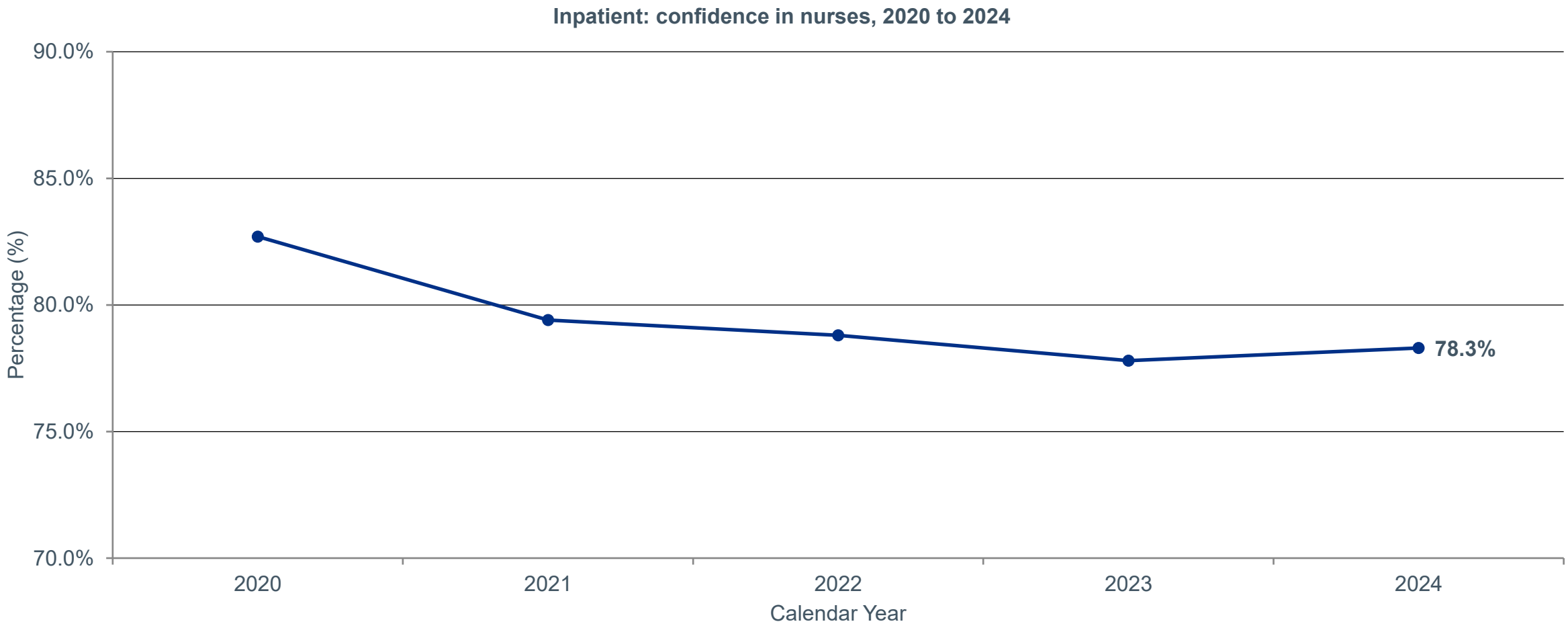
Source: CQC Adult Inpatient Survey 2024, Q21 confidence in nurses

Inpatient: confidence in nurses

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported always having confidence and trust in the nurses treating them (CQC Adult Inpatient Survey, Q21).

Figure 3.18: Inpatient: confidence in nurses: England trend



Source: CQC Adult Inpatient Survey 2024, Q21 confidence in nurses

Inpatient: involved in care decisions

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported being involved a great deal in decisions about their care and treatment (Care Quality Commission (CQC) Adult Inpatient Survey, Q25).

Why it matters for the strategy

- We track involvement in care decisions because shared decision-making is a core NHS commitment, yet only 36.8% say they were involved 'a great deal'.
- The latest figure for England (2024) is 36.8%.
- The picture is mixed: Declined from 37.5% (2020), 35.3% (2021), 33.8% (2022) and then increased to 34.7% (2023), 36.8% (2024).
- A direct shared-decision-making indicator named explicitly in the strategy.
- Shared-decision-making signal named in the strategy. Sub-indicator of overall inpatient experience.

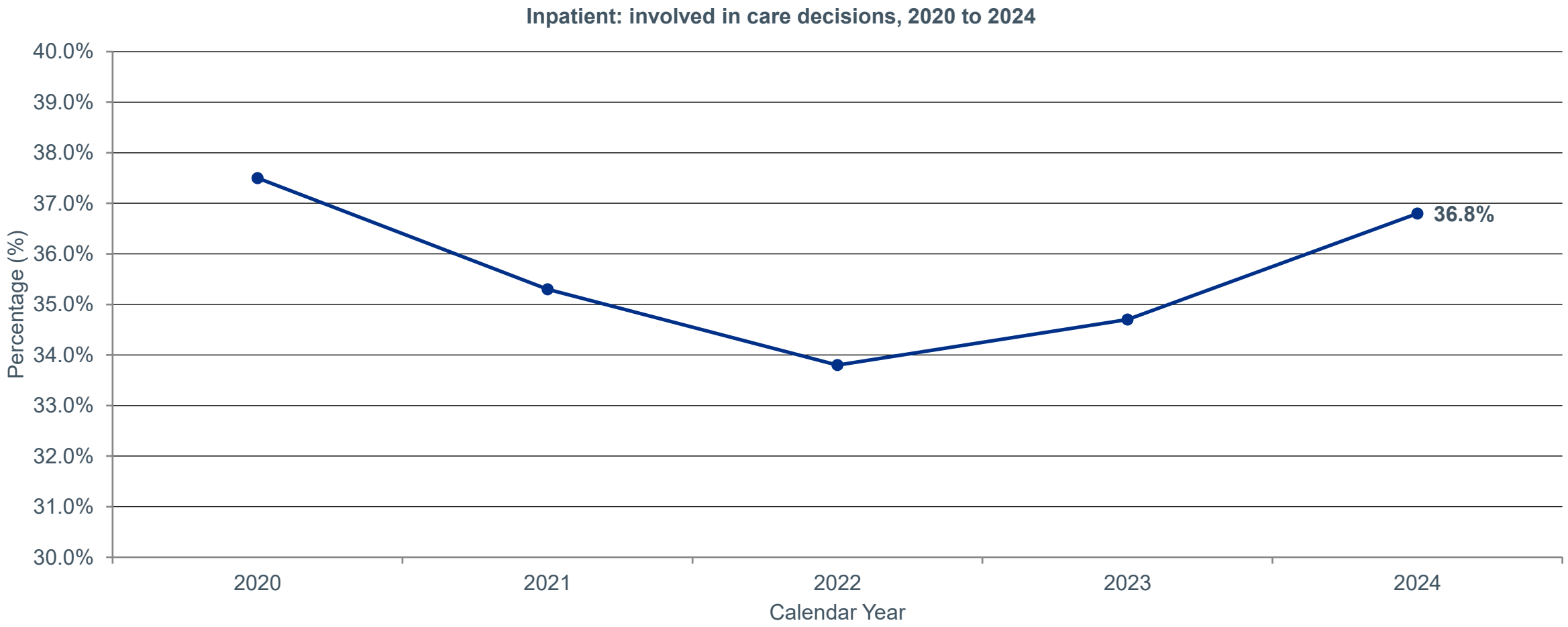
Source: CQC Adult Inpatient Survey 2024, Q25 involved in decisions

Inpatient: involved in care decisions

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported being involved a great deal in decisions about their care and treatment (CQC Adult Inpatient Survey, Q25).

Figure 3.19: Inpatient: involved in care decisions: England trend



Source: CQC Adult Inpatient Survey 2024, Q25 involved in decisions

Inpatient: family in discharge planning

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported that their family or someone close to them was involved a great deal in decisions about their discharge (Care Quality Commission (CQC) Adult Inpatient Survey, Q36).

Why it matters for the strategy

- We track family involvement in discharge because poor discharge planning is the leading cause of readmissions, and only 28.9% say family was involved 'a great deal'.
- The latest figure for England (2024) is 28.9%.
- The picture is mixed: 28.4% (2022), 27.2% (2023), 28.9% (2024).
- Poor discharge planning is a leading cause of readmissions, and reported family involvement remains low.
- Discharge-planning signal. Sub-indicator of overall inpatient experience.

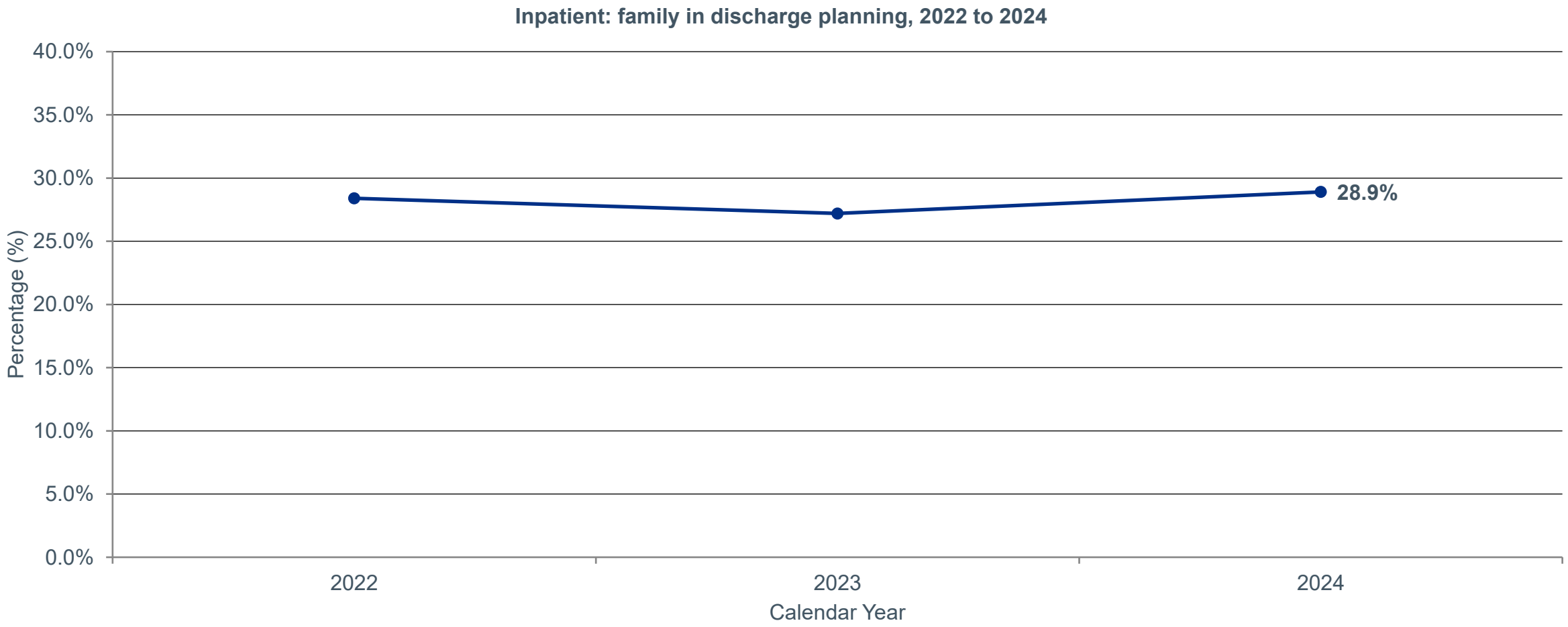
Source: CQC Adult Inpatient Survey 2024, Q36 family in discharge

Inpatient: family in discharge planning

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported that their family or someone close to them was involved a great deal in decisions about their discharge (CQC Adult Inpatient Survey, Q36).

Figure 3.20: Inpatient: family in discharge planning: England trend



Source: CQC Adult Inpatient Survey 2024, Q36 family in discharge

Inpatient: post-discharge information

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of hospital inpatients who reported being given written or printed information about what they should or should not do after leaving hospital (Care Quality Commission (CQC) Adult Inpatient Survey, Q39).

Why it matters for the strategy

• We track post-discharge information because 22.8% of patients are not given information about what to do after leaving hospital, contributing to readmissions and poor recovery.
• The latest figure for England (2024) is 77.2%.
• The picture is mixed: 70.3% (2020), 78.4% (2021), 77.6% (2022), 75.6% (2023), 77.2% (2024).
• Inpatients reporting they were 'definitely' given enough information at discharge has stalled at sub-60% in the CQC Adult Inpatient Survey.
• Discharge information is one of the strongest predictors of unplanned re-attendance and post-discharge harm.
• The strategy's transitions-of-care commitment names communication at discharge as one of priorities for the Experience Excellence Framework.
• Tier 3 sub-indicator of overall inpatient experience; surfaces in the Insights Pack only when the headline rating moves.

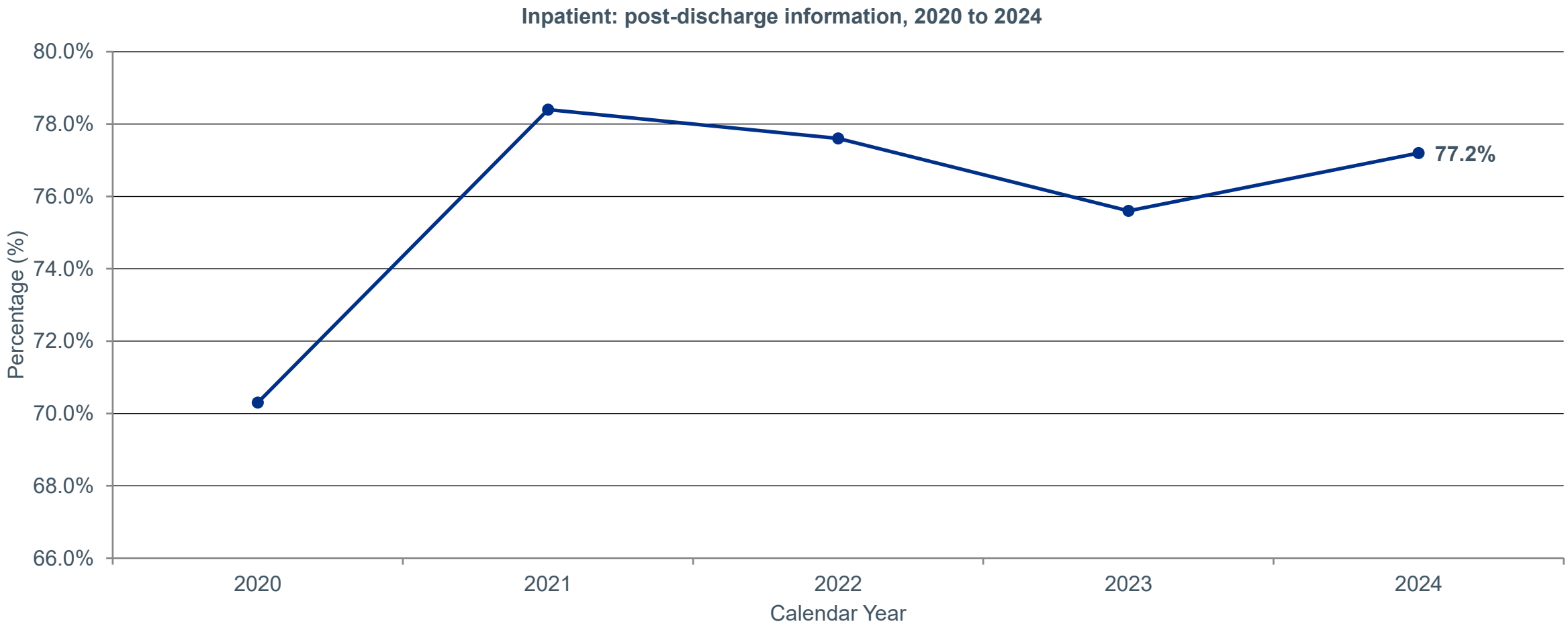
Source: CQC Adult Inpatient Survey 2024, Q39 post-discharge info

Inpatient: post-discharge information

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of hospital inpatients who reported being given written or printed information about what they should or should not do after leaving hospital (CQC Adult Inpatient Survey, Q39).

Figure 3.21: Inpatient: post-discharge information: England trend



Source: CQC Adult Inpatient Survey 2024, Q39 post-discharge info

Inpatient: discussion of further care needs

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported that hospital staff discussed with them whether they may need any further health or social care services after leaving hospital (Care Quality Commission (CQC) Adult Inpatient Survey, Q44, Yes).

Why it matters for the strategy

• Whether the conversation about onward health and social care needs actually happened during the inpatient stay. Sits between 'information given' (Q39) and 'support received' (Q45) on the CQC Adult Inpatient Survey - a key signal for whether discharge planning is happening at the right point.
• The latest figure for England (2024) is 78.5%.
• The picture is mixed: 81.4% (2020), 78.6% (2021), 78.8% (2022), 76.7% (2023), 78.5% (2024). Significant improvement vs 2023; significantly below 2020 baseline.
• The conversation about onward care needs is a key discharge metric. strategy Experience domain, sub-indicator of inpatient experience.

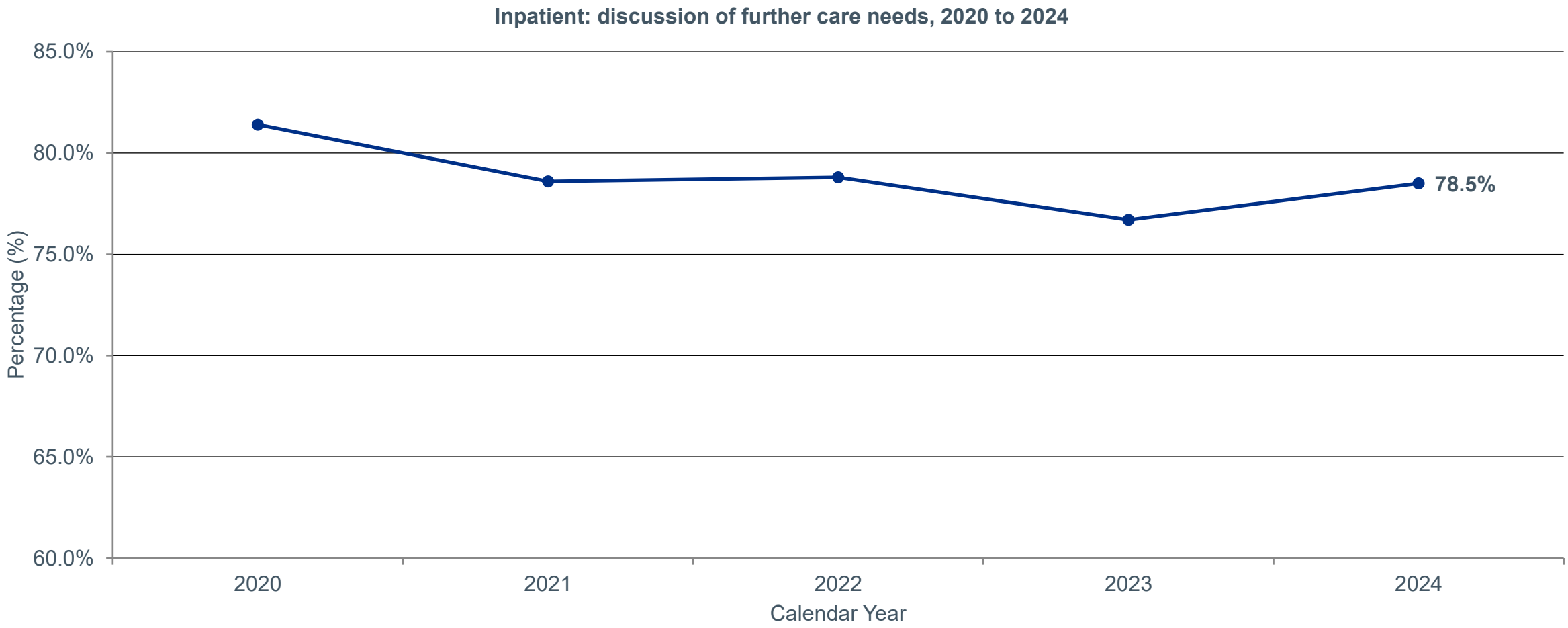
Source: CQC Adult Inpatient Survey 2024, Q44 (Yes). 5-year national trend.

Inpatient: discussion of further care needs

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported that hospital staff discussed with them whether they may need any further health or social care services after leaving hospital (CQC Adult Inpatient Survey, Q44, Yes).

Figure 3.22: Inpatient: discussion of further care needs: England trend



Source: CQC Adult Inpatient Survey 2024, Q44 (Yes). 5-year national trend.

Inpatient: knew what happens next

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported 'definitely' knowing what would happen next with their care after leaving hospital (Care Quality Commission (CQC) Adult Inpatient Survey, Q42).

Why it matters for the strategy

- We track whether patients know what happens next because 54% do not 'definitely' know, indicating a breakdown in care continuity at the most vulnerable transition point.
- The latest figure for England (2024) is 46%.
- The picture is mixed: 46.2% (2020), 45.0% (2021), 44.8% (2022), 44.4% (2023), 46% (2024).
- A meaningful share do not 'definitely' know, pointing to a breakdown in care continuity at one of the most vulnerable transition points.
- Care-continuity signal at a vulnerable transition point. Sub-indicator of overall inpatient experience.

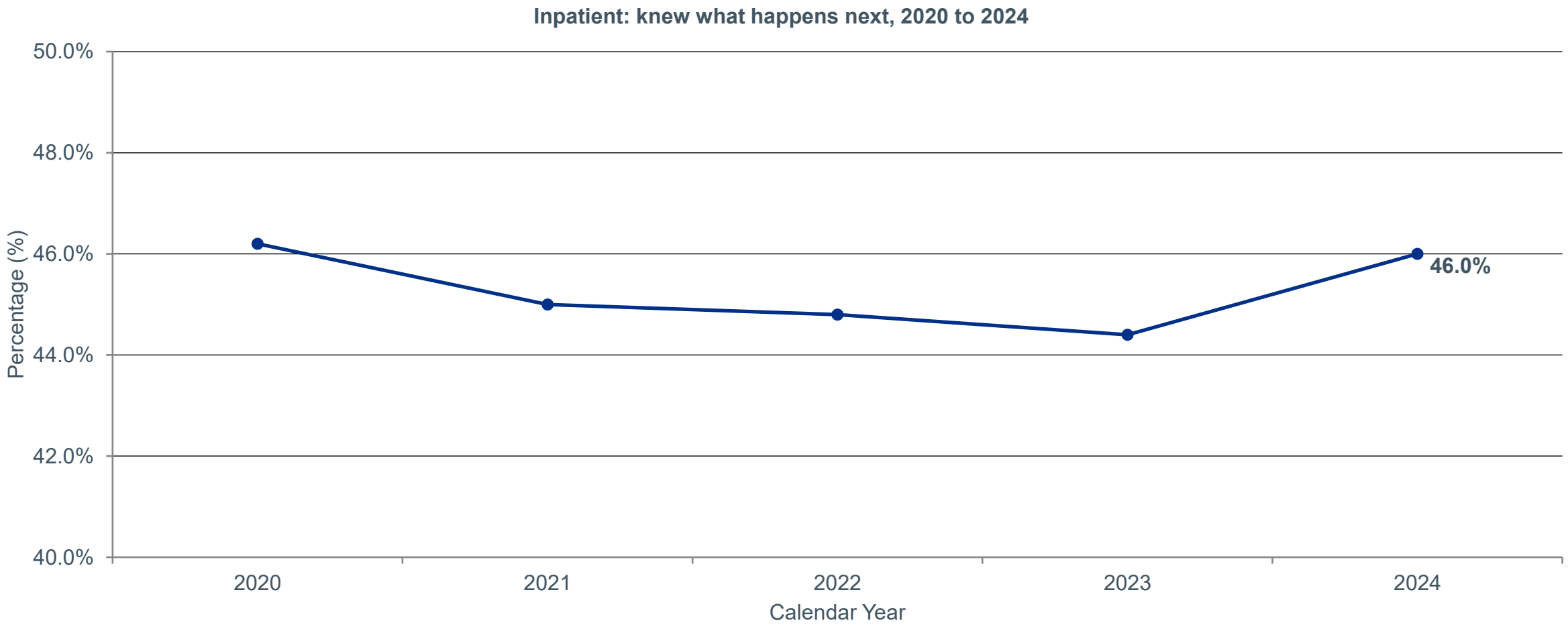
Source: CQC Adult Inpatient Survey 2024, Q42 knew next steps

Inpatient: knew what happens next

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported 'definitely' knowing what would happen next with their care after leaving hospital (CQC Adult Inpatient Survey, Q42).

Figure 3.23: Inpatient: knew what happens next: England trend



Source: CQC Adult Inpatient Survey 2024, Q42 knew next steps

Inpatient: told who to contact

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported being told who to contact if they were worried about their condition or treatment after leaving hospital (Care Quality Commission (CQC) Adult Inpatient Survey, Q43).

Why it matters for the strategy

- We track whether patients are told who to contact because 26.3% are not, leaving them without a safety net during post-discharge recovery.
- The latest figure for England (2024) is 73.7%.
- This has a mixed picture: Declined from 76.2% (2020) to 72.4% (2022), partial recovery to 73.7% (2024). Still 2.5pp below pre-pandemic level.
- A specific safety-relevant discharge indicator: patients without a named contact disproportionately present to A&E for concerns that primary care could have handled.
- Safety-relevant discharge signal. Sub-indicator of overall inpatient experience.

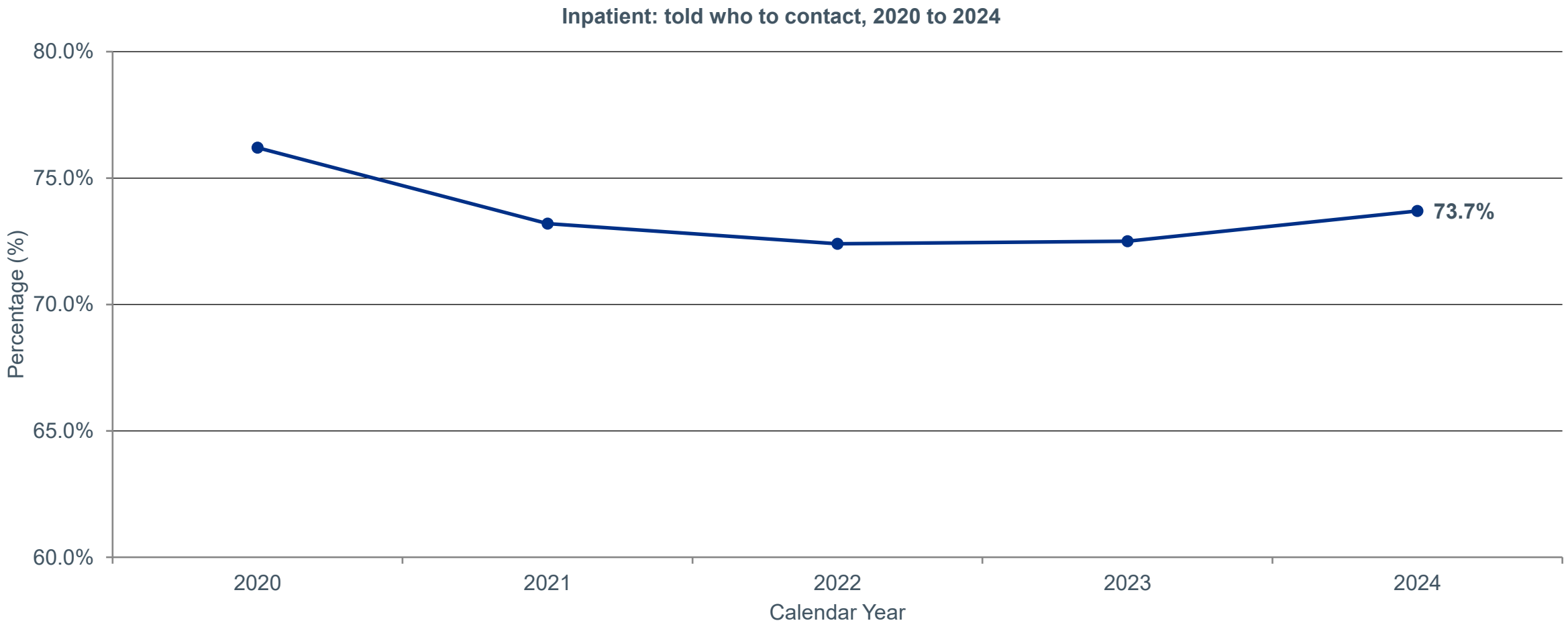
Source: CQC Adult Inpatient Survey 2024, Q43 told who to contact

Inpatient: told who to contact

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of hospital inpatients who reported being told who to contact if they were worried about their condition or treatment after leaving hospital (CQC Adult Inpatient Survey, Q43).

Figure 3.24: Inpatient: told who to contact: England trend



Source: CQC Adult Inpatient Survey 2024, Q43 told who to contact

Inpatient: treated with dignity and respect

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Care Quality Commission (CQC) Inpatient Survey Q47: treated with respect and dignity (% yes always).

Why it matters for the strategy

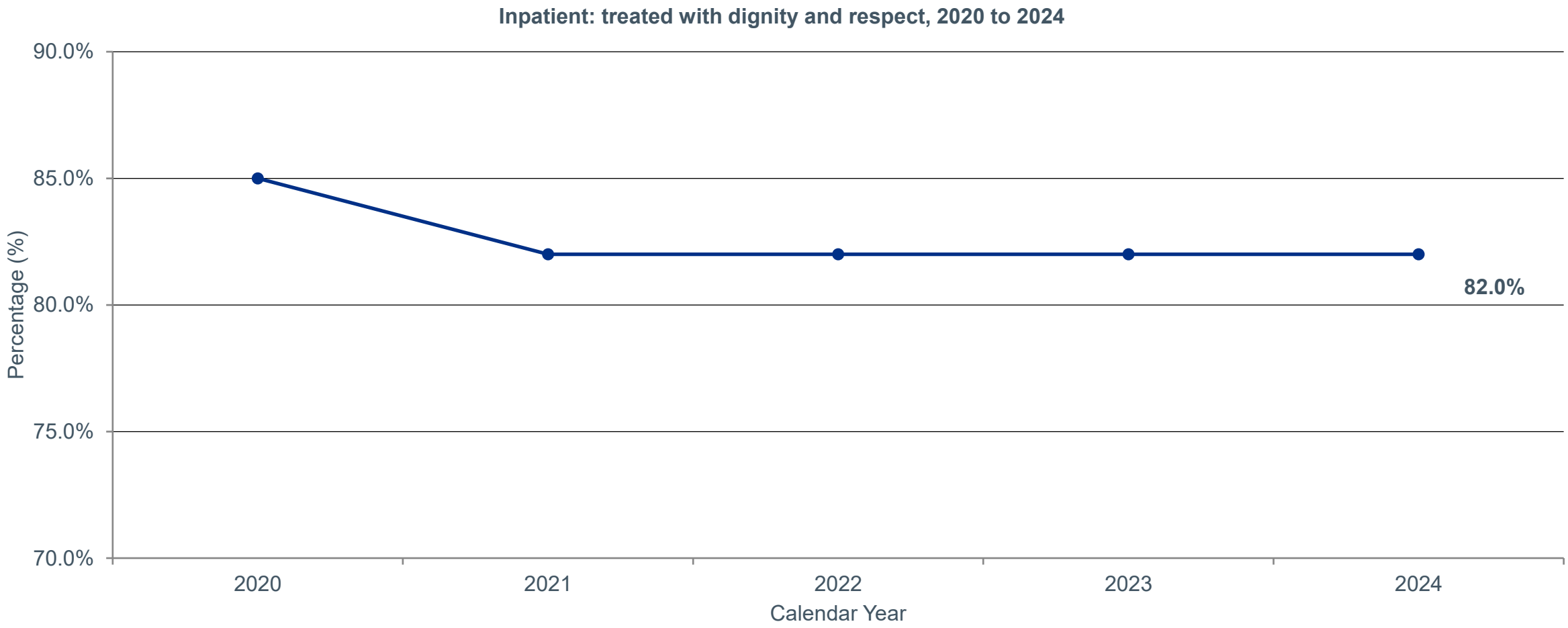
- The latest figure for England (2024) is 82%.
- This is getting worse: 82% treated with dignity and respect (2024 national) compared to 85% (2020 national) but stable over the last 3 years.
- The strategy names dignity as foundational to the experience domain, under Pillar 1 of the NHS Experience Excellence Framework.
- Dignity and respect is the foundational pathway-level driver of overall inpatient experience.
- Tier 3 signal - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: CQC Adult Inpatient Survey (Q47)

Inpatient: treated with dignity and respect

Experience of care | Tier 3: Process indicator | ↑ Higher is better
CQC Inpatient Survey Q47: treated with respect and dignity (% yes always).

Figure 3.25: Inpatient: treated with dignity and respect: England trend



Source: CQC Adult Inpatient Survey (Q47)

Urgent and emergency care: overall experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better

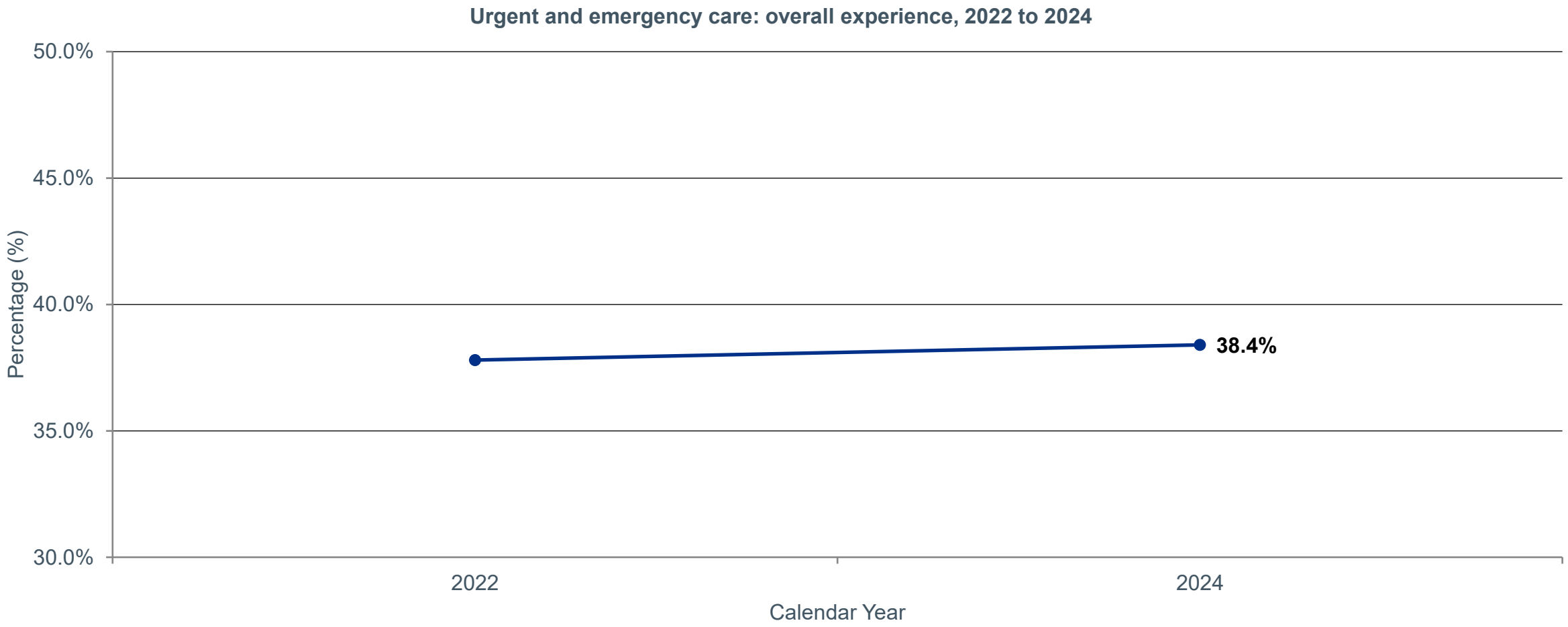
Proportion of patients rating their overall A&E experience as 9 or 10 out of 10, from the Care Quality Commission (CQC) Urgent and Emergency Care Survey.

Why it matters for the strategy

- The latest figure for England (2024) is 38.4%.
- This is increasing: 37.8% in 2022 to 38.4% in 2024.
- Clinical driver that translates into population outcomes within 1 to 3 years when delivered at scale.
- CQC A&E survey headline. Named strategy experience area.
- Tier 3 signal - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: CQC Urgent and Emergency Care Survey 2024, Type 1

Figure 3.26: Urgent and emergency care: overall experience: England trend



Source: CQC Urgent and Emergency Care Survey 2024, Type 1

A&E: confidence in doctors (Care Quality Commission (CQC) urgent and emergency care (UEC) Q21)

Experience of care | Tier 3: Process indicator | ↑ Higher is better
CQC UEC Survey Q21: confidence in doctors or nurses (% Yes definitely).

Why it matters for the strategy

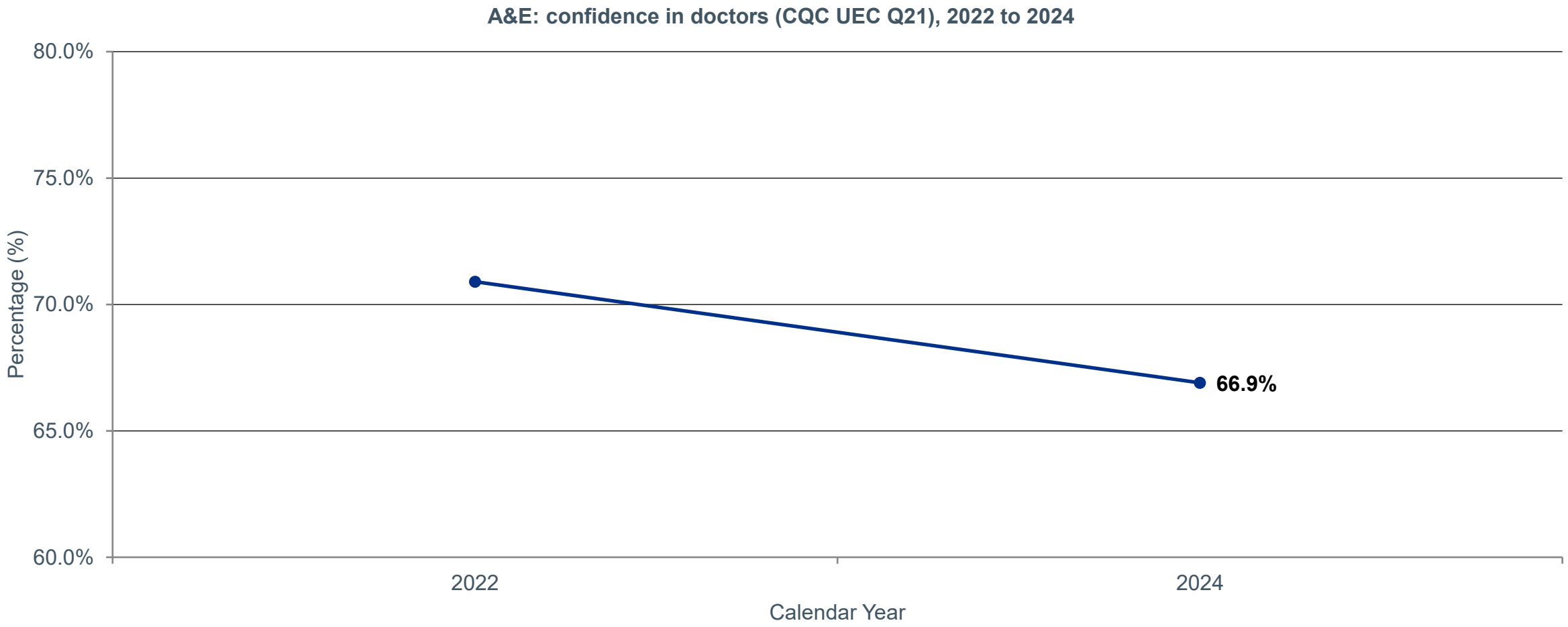
• The latest figure for England (2024) is 66.9%.
• This is getting worse: 70.9% in 2022 to 66.9% in 2024 (Q21 'yes definitely').
• Confidence in clinicians is the core measure of therapeutic relationship in unscheduled care; low values correlate with repeat A&E attendance and patients holding off seeking help in later episodes.
• Tier 3 strategic signal (strategy watchlist) - therapeutic-relationship signal in unscheduled care.
• Sub-indicator of A&E experience within the Urgent & Emergency Care priority.

Source: CQC Urgent and Emergency Care Survey 2024 – Type 1 (Q21 confidence in doctors)

A&E: confidence in doctors (CQC UEC Q21)

Experience of care | Tier 3: Process indicator | ↑ Higher is better
CQC UEC Survey Q21: confidence in doctors or nurses (% Yes definitely).

Figure 3.27: A&E: confidence in doctors (CQC UEC Q21): England trend



Source: CQC Urgent and Emergency Care Survey 2024 – Type 1 (Q21 confidence in doctors)

Children and young people (CYP) inpatient experience (overall)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Care Quality Commission (CQC) CYP Survey: % felt that children were well looked after in hospital, overall (Question P70)

Why it matters for the strategy

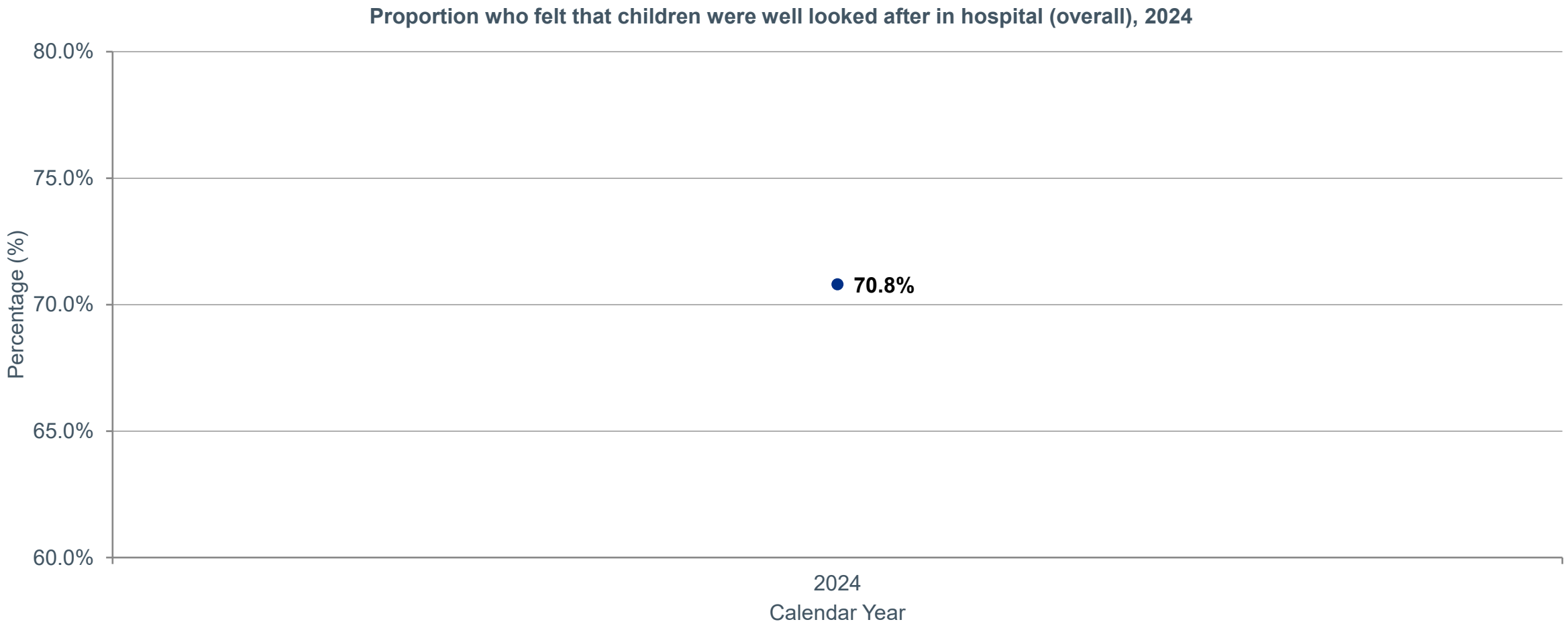
- The latest figure for England (2024) is 70.8%.
- One data point available only 70.8% in 2024 (% Very well, ages 8 to 15).
- A summary of how well NHS inpatient services are caring for this population, taken from parents or carers.
- Tier 3 strategic signal (strategy watchlist) - strategy headline CYP inpatient experience signal.

Source: CQC Children and Young People's Patient Experience Survey 2024 (P70)

Figure 3.28: CYP inpatient experience (overall): England trend

Source: CQC Children and Young People's Patient Experience Survey 2024 (P70)

Figure 3.29: CYP inpatient experience (overall): England trend



Source: CQC Children and Young People's Patient Experience Survey 2024 (P70)

Children and young people (CYP) inpatient: felt listened to by staff

Experience of care | Tier 3: Process indicator | ↑ Higher is better

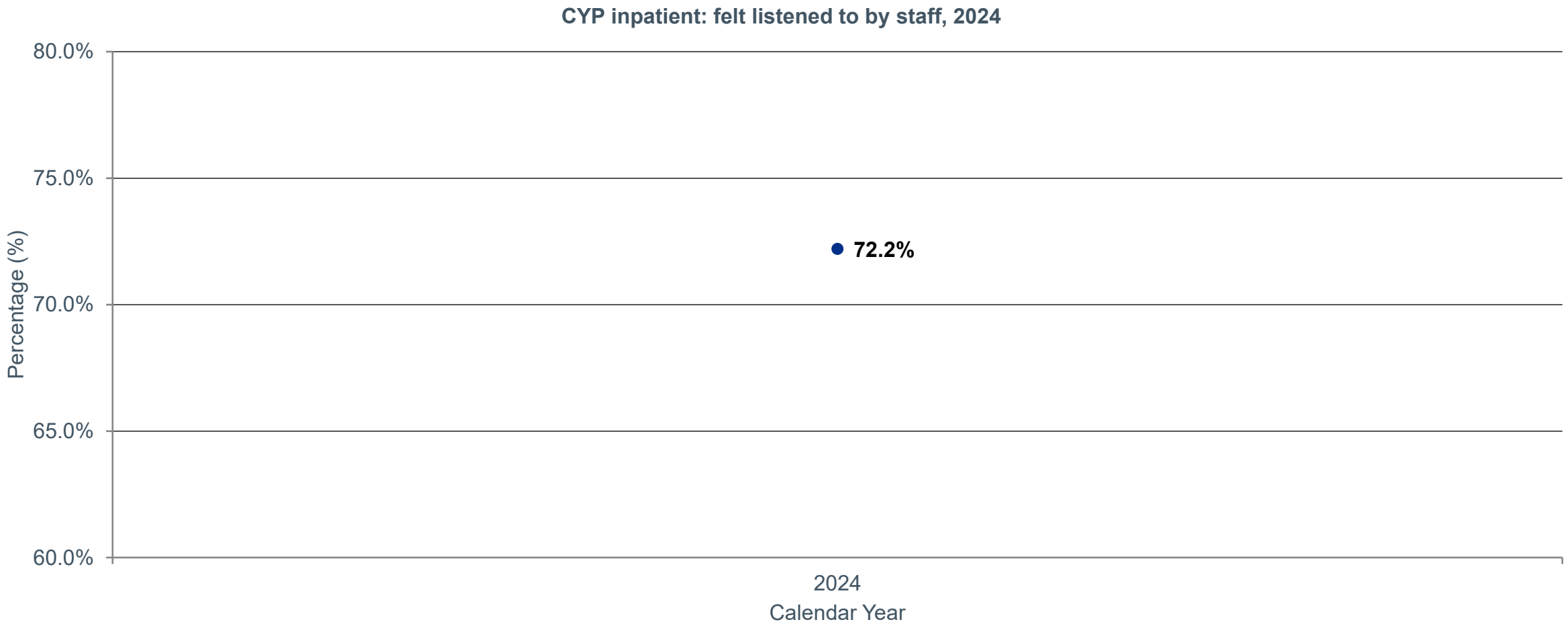
Care Quality Commission (CQC) CYP Survey: percentage of CYP saying staff 'always' listened to them. (Question c15)

Why it matters for the strategy

- The latest figure for England (2024) is 72.2%.
- Only one data point 72.2% in 2024 (% yes always).
- A practical signal of whether the inpatient pathway treats children as participants in their own care.
- Tier 3 strategic signal (strategy watchlist) - CYP advocacy and respect indicator. Sub-indicator of CYP inpatient experience.

Source: CQC Children and Young People's Patient Experience Survey 2024 (Question c15)

Figure 3.30: CYP inpatient: felt listened to by staff: England trend



Source: CQC Children and Young People's Patient Experience Survey 2024 (Question c15)

Children and young people (CYP): concerns taken seriously

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Care Quality Commission (CQC) CYP Survey: people looking after child listened (X43).

Why it matters for the strategy

- We track whether concerns about children's care are taken seriously because 10% of parents who raised concerns did not feel they were 'definitely' taken seriously.
- The latest figure for England (2024) is 90% - 62% responded ‘yes, definitely’ and 28% ‘yes, to some extent’.
- 2024 data only (first year of redesigned survey).
- A meaningful share of parents who raised concerns did not feel they were 'definitely' taken seriously, which is a fundamental signal in the CYP survey.
- Sub-indicator of CYP inpatient experience.

Source: CQC CYP Inpatient/Day Case Survey 2024, P53 concerns taken seriously

Figure 3.31: CYP: concerns taken seriously: England trend

Source: CQC CYP Inpatient/Day Case Survey 2024, P53 concerns taken seriously

Cancer patient experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall rating of cancer care on a 0 to 10 scale, from the Care Quality Commission (CQC) Cancer Patient Experience Survey (Q59), reported as an unadjusted national average score.

Why it matters for the strategy

- We track experience of cancer diagnosis, treatment and care because it provides insight into how people feel about their care around the end of their treatment.
- The latest figure for England (2024) is 8.94 Score /10.
- This has increased from 8.88 to 8.94 between 2022 and 2024
- People in the least deprived areas achieve a similar score to those in the least deprived areas.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

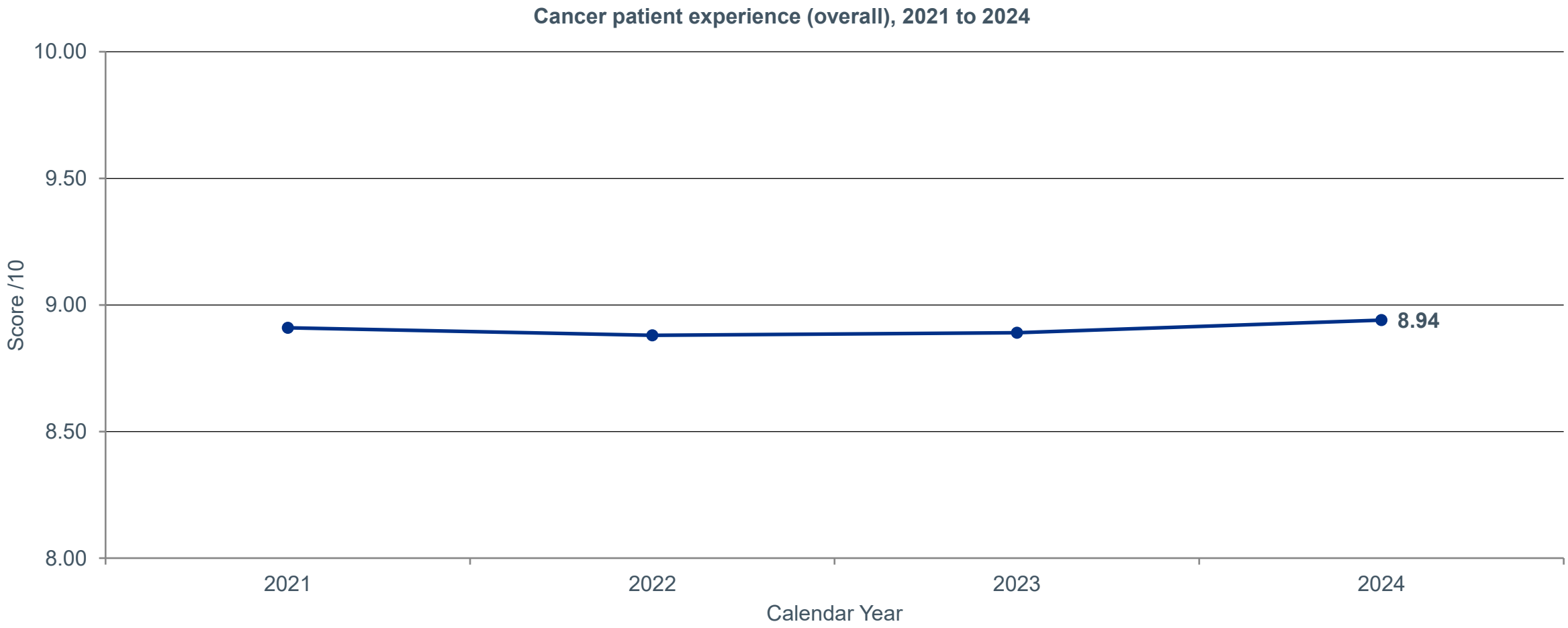
Source: CQC National Cancer Patient Experience Survey 2024, Q59 overall rating

Cancer patient experience (overall)

Experience of care | Tier 2: Driver | ↑ Higher is better

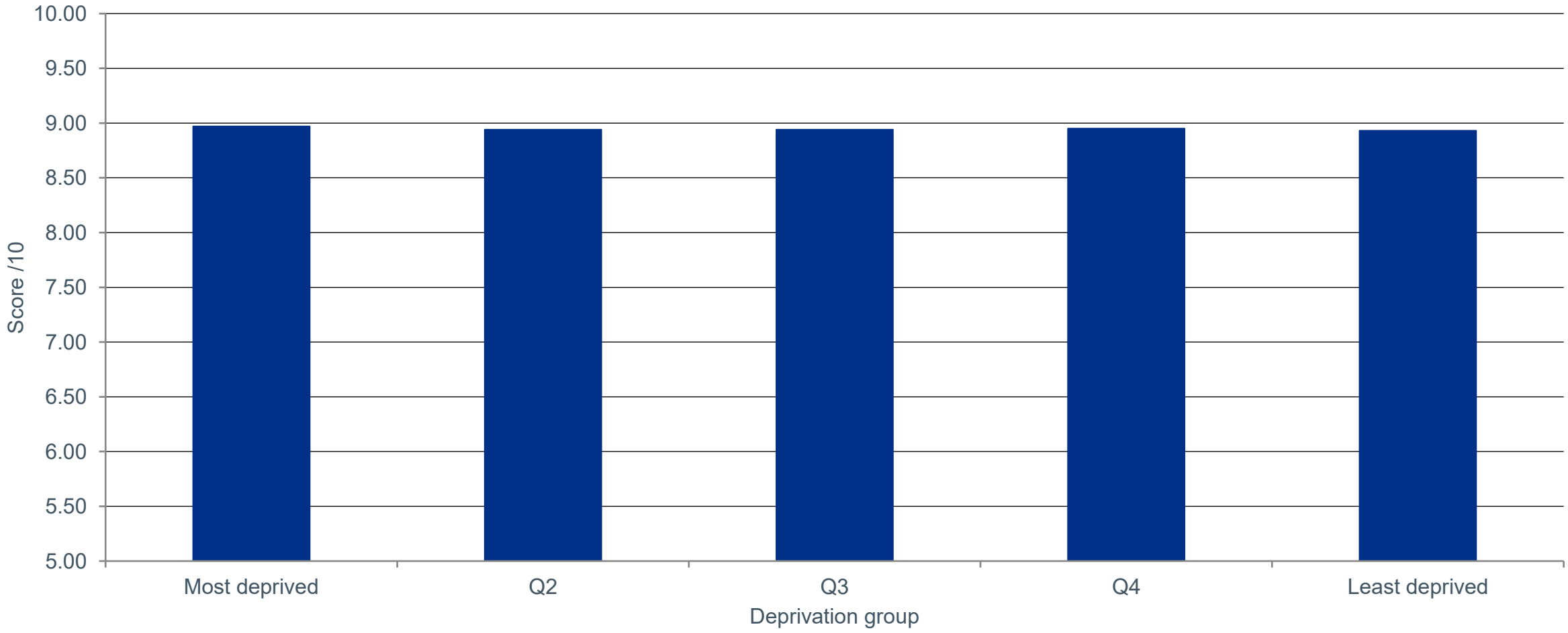
Overall rating of cancer care on a 0 to 10 scale, from the CQC Cancer Patient Experience Survey (Q59), reported as an unadjusted national average score.

Figure 3.32: Cancer patient experience (overall): England trend



Source: CQC National Cancer Patient Experience Survey 2024, Q59 overall rating

Figure 3.33: Cancer patient experience (overall) by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: CQC National Cancer Patient Experience Survey 2024, Q59 overall rating

Children and young people (CYP) inpatient cancer experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better

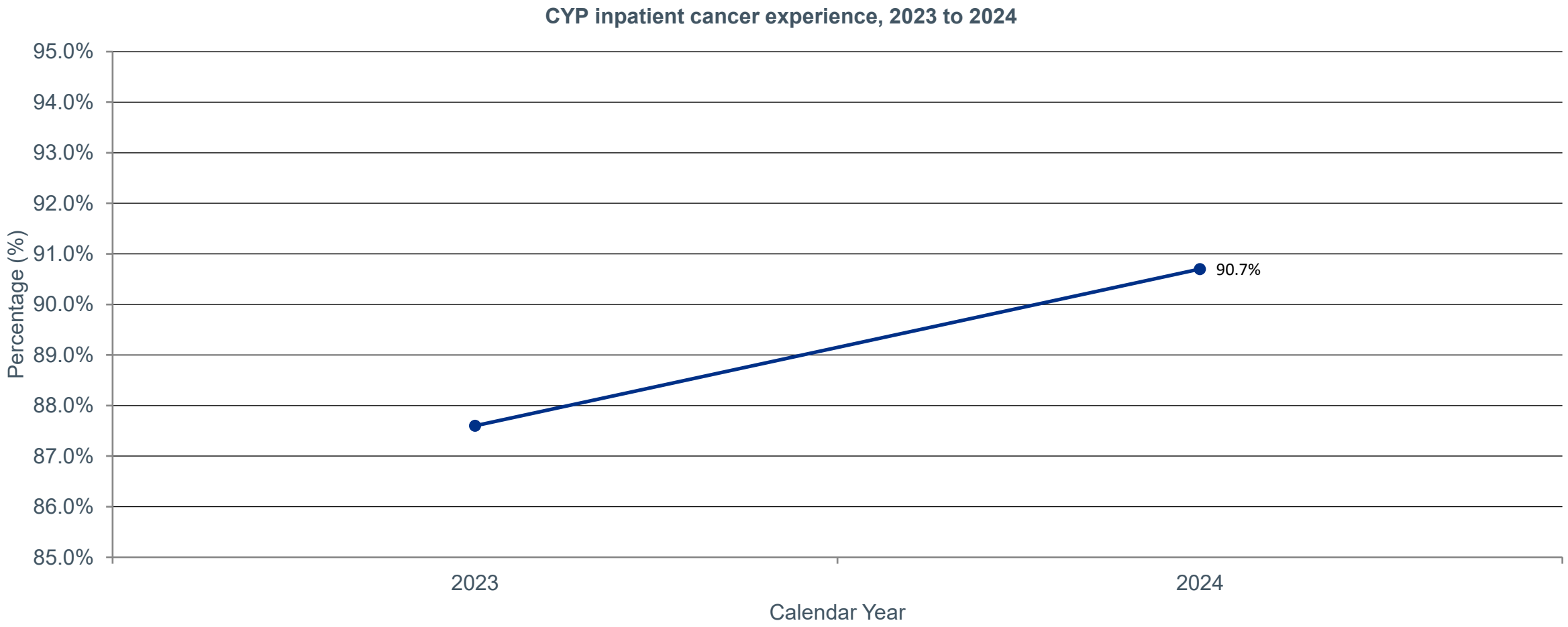
Children's cancer patient experience.

Why it matters for the strategy

- The latest figure for England (2024) is 90.7%
- This has slightly increased: 87.6% (2023) to 90.7% (2024).
- CYP cancer pathways have different survivorship, family-involvement and long-term psychological needs from adult pathways.
- strategy CYP priority pathway. CYP Modern Service Framework (MSF) in development.

Source: Under 16 Cancer Patient Experience Survey 2024, Question X59

Figure 3.34: CYP inpatient cancer experience: England trend



Source: Under 16 Cancer Patient Experience Survey 2024, Question X59

Cancer: told in a sensitive way (Cancer Patient Experience Survey (CPES) Q13)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q13: percentage of patients definitely told sensitively that they had cancer (England average score, unadjusted).

Why it matters for the strategy

• Being told sensitively about having cancer is proven to be a key driver of overall good experience of cancer care
• The latest figure for England (2024) is 75%.
• This is getting better: 75% in 2024 (definitely told sensitively). Trend: 73.5% (2021) to 73.5% (2022) to 74.4% (2023) to 75% (2024). Significant change overall (CPES marker).
• 75% of cancer patients said they were definitely told sensitively that they had cancer in the 2024 CPES, up from 73.5% in 2021.
• How a cancer diagnosis is delivered shapes the entire experience that follows; failure here can leave patients without trust at the start of treatment. Being told sensitively is a key driver of overall good experience of care.
• Tier 3 strategic signal (strategy watchlist) - sub-indicator of overall cancer experience.

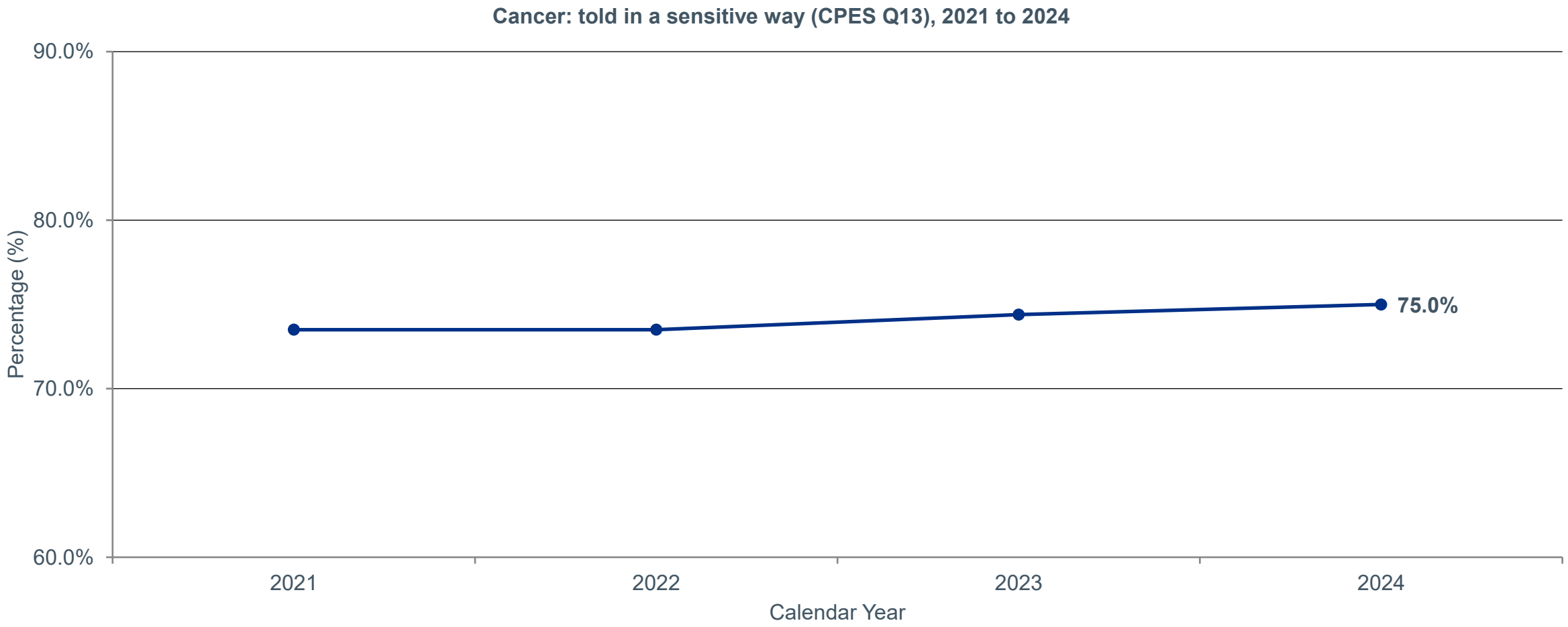
Source: Care Quality Commission (CQC) National Cancer Patient Experience Survey 2024, Q13 told in a sensitive way

Cancer: told in a sensitive way (CPES Q13)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q13: percentage of patients definitely told sensitively that they had cancer (England average score, unadjusted).

Figure 3.35: Cancer: told in a sensitive way (CPES Q13): England trend



Source: CQC National Cancer Patient Experience Survey 2024, Q13 told in a sensitive way

Cancer: contacting main contact (Cancer Patient Experience Survey (CPES) Q18)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q18: percentage of patients found it very or quite easy to contact their main contact person

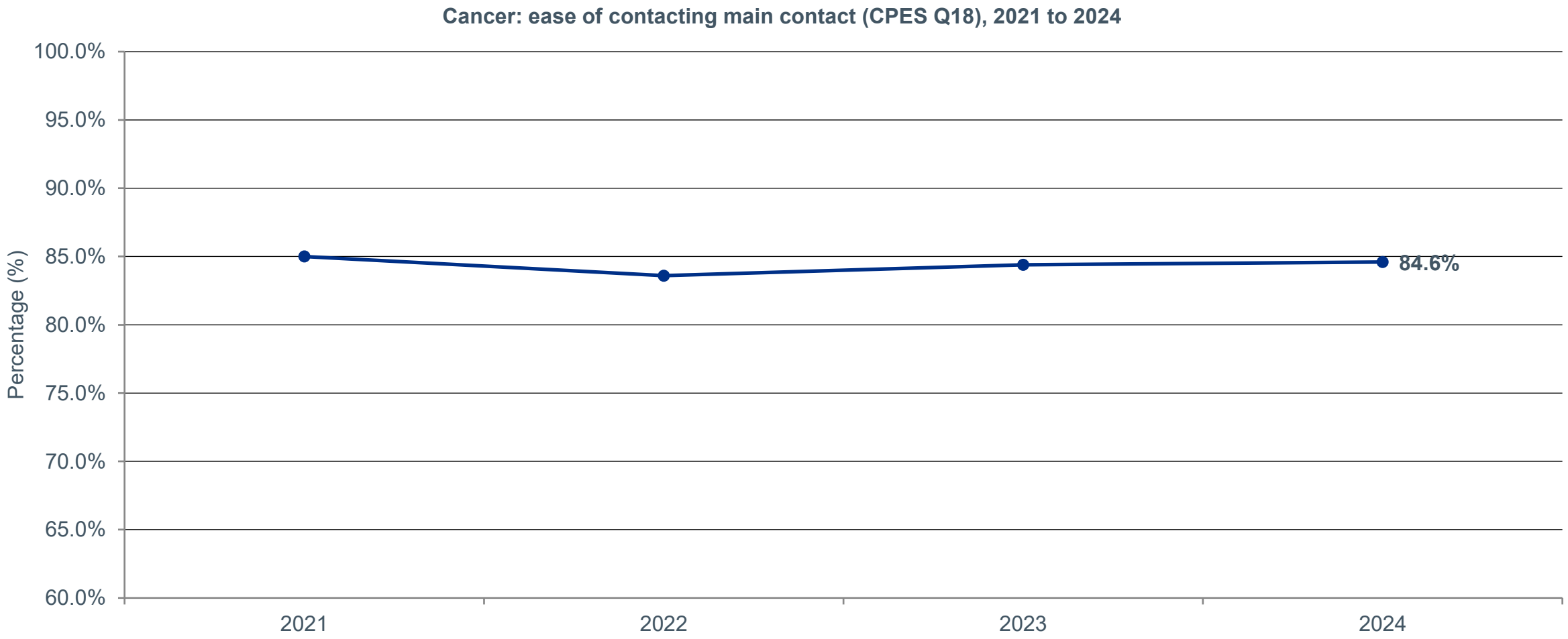
Why it matters for the strategy

- The latest figure for England (2024) is 84.6%.
- This has not changed significantly since 2021
- National Cancer Plan 2026 commits to access to a clinical nurse specialist (CNS) or other ~~worker~~ named lead to support them through diagnosis and treatment. Being able to access this person easily will feed into experience of care.
- Although the reported score is 84.6% , only 47.3% found it 'very easy' and 37.3% found it 'quite easy' so there is room for improvement to achieve more 'very easy' responses.

- Tier 3 strategic signal (strategy watchlist) - sub-indicator of overall cancer experience.

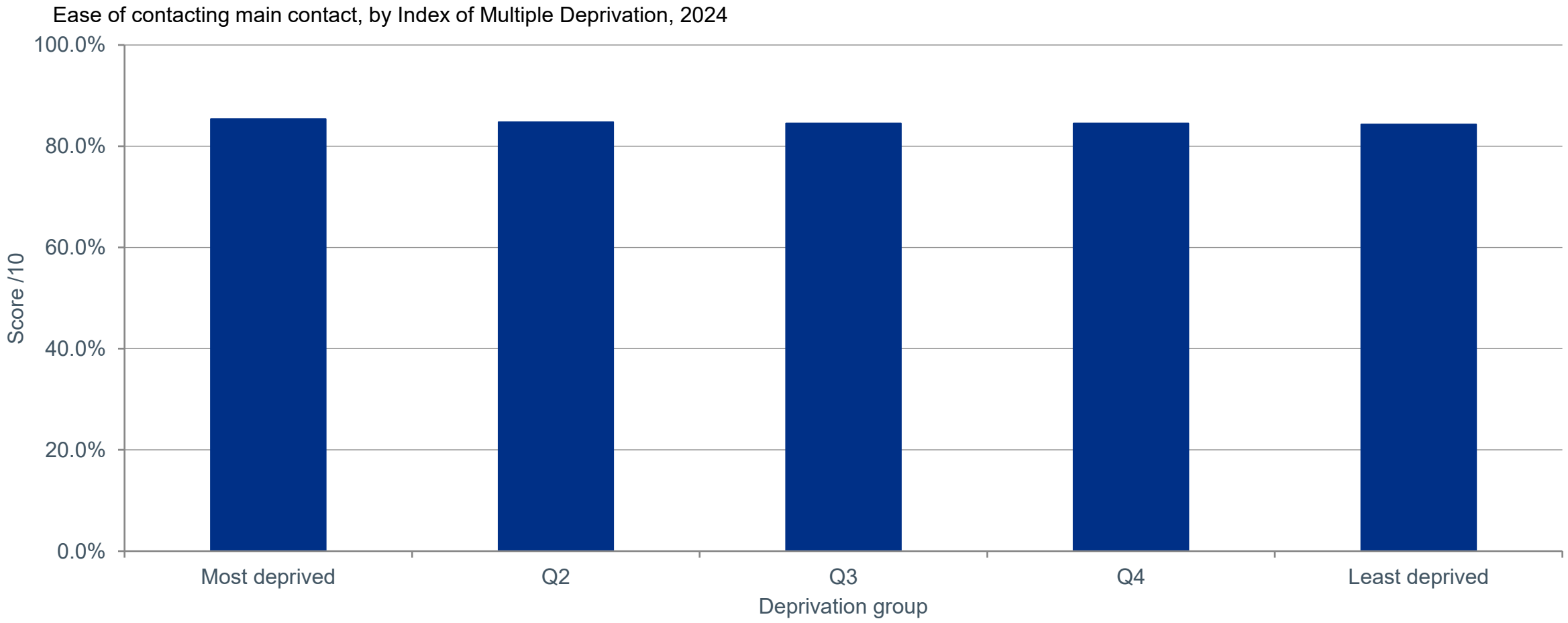
Source: Care Quality Commission (CQC) National Cancer Patient Experience Survey 2024,

Figure 3.36: Cancer: contacting main contact (CPES Q18): England trend



Source: CQC National Cancer Patient Experience Survey 2024,

Figure 3.37: Cancer: contacting main contact (CPES Q18) by deprivation group



Source: CQC National Cancer Patient Experience Survey 2024,

Cancer: family given info to care at home (Cancer Patient Experience Survey (CPES) Q49)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q49: percentage of care teams giving family or someone close all the information needed to care for the patient at home.

Why it matters for the strategy

The latest figure for England is 63.0%.

This is getting better: 63.0% had all the information needed in 2024. Trend: 55.4% (2021) to 57.9% (2022) to 61.6% (2023) to 63.0% (2024) which is a statistically significant increase over this time period.

In both the patient's early recovery phase and longer-term, family members are very important to their health and wellbeing, and to ensure action is taken when there are urgent and serious concerns.

17.6% said 'some information' was provided and 19.3% answered 'no' indicating no information was given.

Tier 3 strategic signal (strategy watchlist) - sub-indicator of overall cancer experience

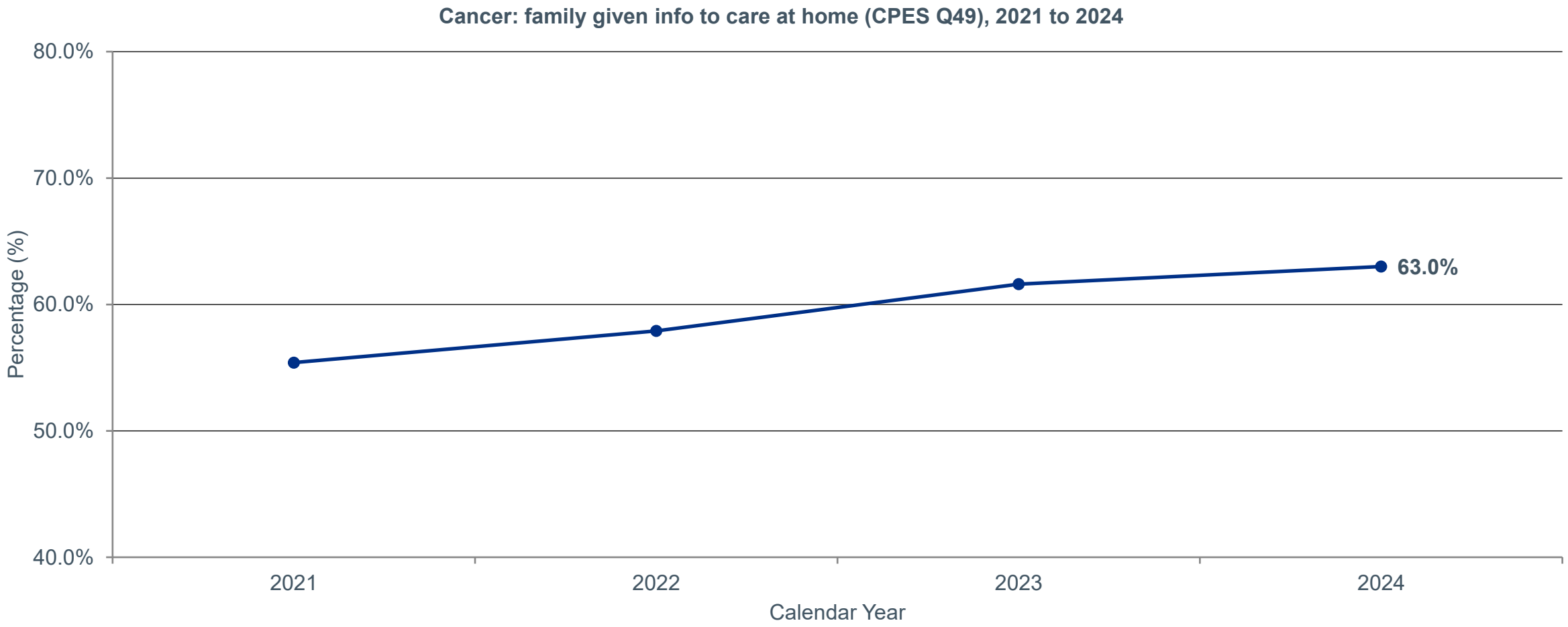
Source: Care Quality Commission (CQC) National Cancer Patient Experience Survey 2024, Q49 family info to care at home

Cancer: family given info to care at home (CPES Q49)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q49: percentage of care teams giving family or someone close all the information needed to care for the patient at home.

Figure 3.38: Cancer: family given info to care at home (CPES Q49): England trend



Source: CQC National Cancer Patient Experience Survey 2024, Q49 family info to care at home

Cancer: emotional support after treatment (Cancer Patient Experience Survey (CPES) Q53)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q53: percentage of patients who definitely could get enough emotional support at home from community or voluntary services after treatment.

Why it matters for the strategy

- The latest figure for England is 33.5%.
- This is getting better but from a low base.
- Trend: 31.9% (2021) to 31.3% (2022) to 32.3% (2023) to 33.5% (2024) which is a statistically significant increase from 2021 to 2024.
- Cancer patients leaving hospital/specialist care can report feeling as if they've 'fallen off a cliff' with no access to the right kind of support for their emotional and mental health issues. Access to local community or voluntary support services that are culturally sensitive supports care and is in line with the shift towards Neighbourhood Health.
- Tier 3 strategic signal (strategy watchlist) - sub-indicator of overall cancer experience

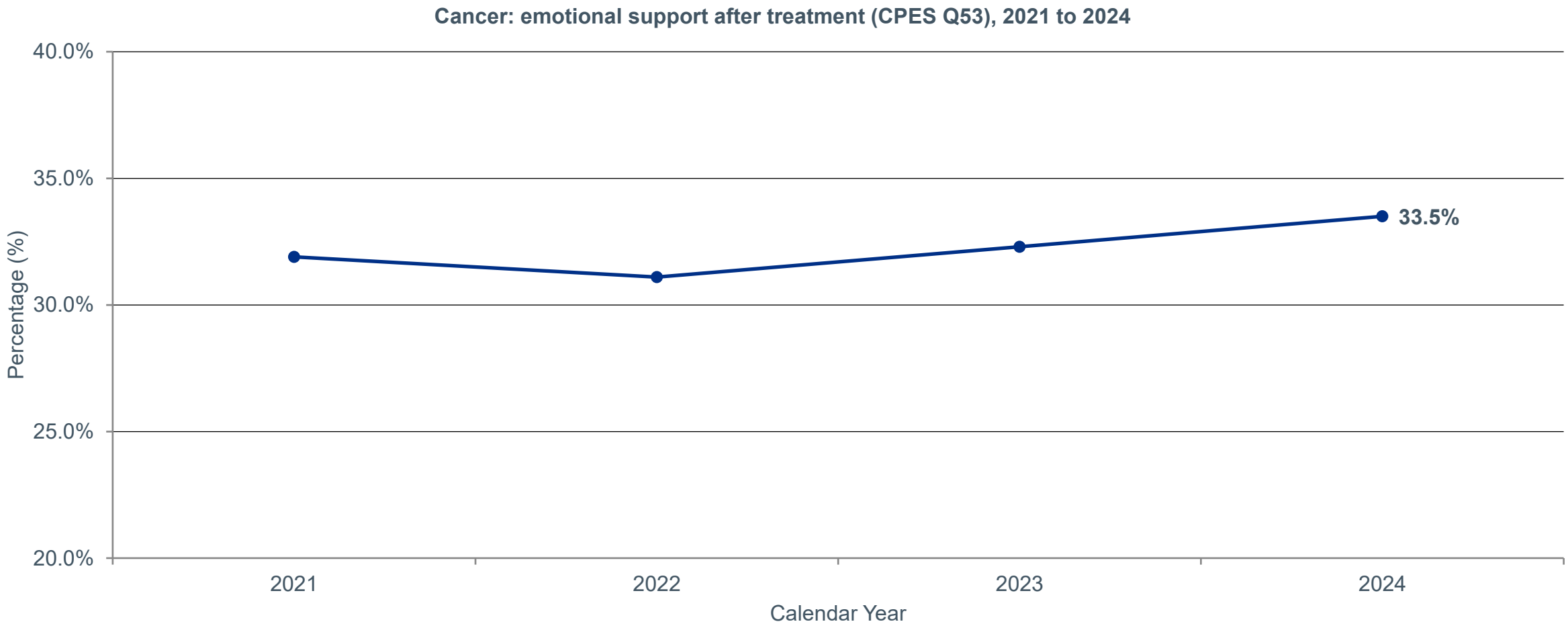
Source: Care Quality Commission (CQC) National Cancer Patient Experience Survey 2024, Q53 emotional support after treatment

Cancer: emotional support after treatment (CPES Q53)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q53: percentage of patients who definitely could get enough emotional support at home from community or voluntary services after treatment.

Figure 3.39: Cancer: emotional support after treatment (CPES Q53): England trend



Source: CQC National Cancer Patient Experience Survey 2024, Q53 emotional support after treatment

Cancer: info about recurrence/spread (Cancer Patient Experience Survey (CPES) Q55)

Experience of care | Tier 3: Process indicator | ↑ Higher is better

CPES 2024 Q55: percentage of patients given enough information about the possibility and signs of cancer coming back or spreading.

Why it matters for the strategy

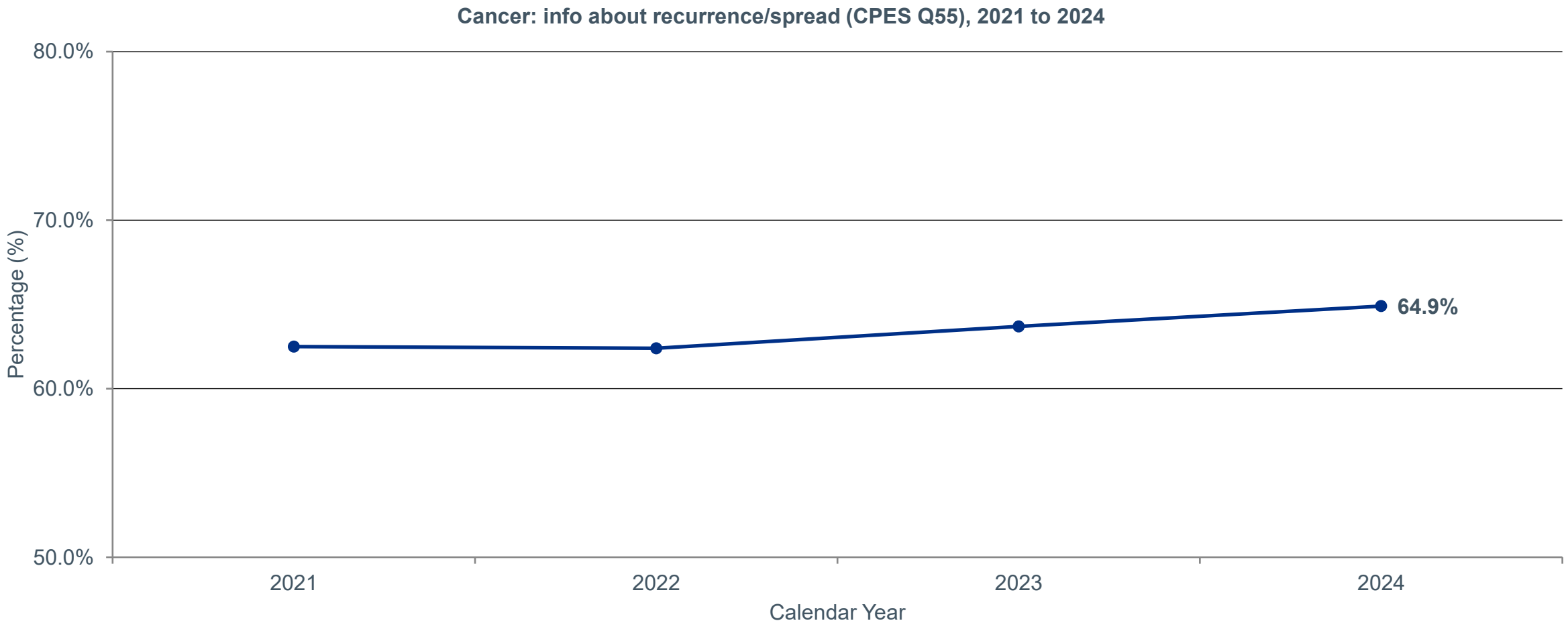
- The latest figure for England is 64.9%.
- This is getting better: 64.9% of people said they were given enough information about the possibility and signs of cancer coming back or spreading in 2024.
- Trend: 62.5% (2021) to 62.4% (2022) to 63.7% (2023) to 64.9% (2024) which is a statistically significant increase from 2021 to 2024.
- The National Cancer Plan 2026 commits to all patients having an End of Treatment Summary. This document must include information on the possibility of, and the signs and symptoms or cancer coming back or spreading. This helps to ensure people and their GPs know when and how to contact cancer services and get quick access back in if there are any concerns. This is particularly important for people on self-managed follow up.

18.0% said they had 'some information' and 17.1% answered 'no' and thought they should have had this information, reinforcing room for improvement

- Tier 3 strategic signal (strategy watchlist) - sub-indicator of overall cancer experience

Source: Care Quality Commission (CQC) National Cancer Patient Experience Survey 2024, Q55 info about recurrence

Figure 3.40: Cancer: info about recurrence/spread (CPES Q55): England trend



Source: CQC National Cancer Patient Experience Survey 2024, Q55 info about recurrence

Mental health service experience

Experience of care | Tier 2: Driver | ↑ Higher is better

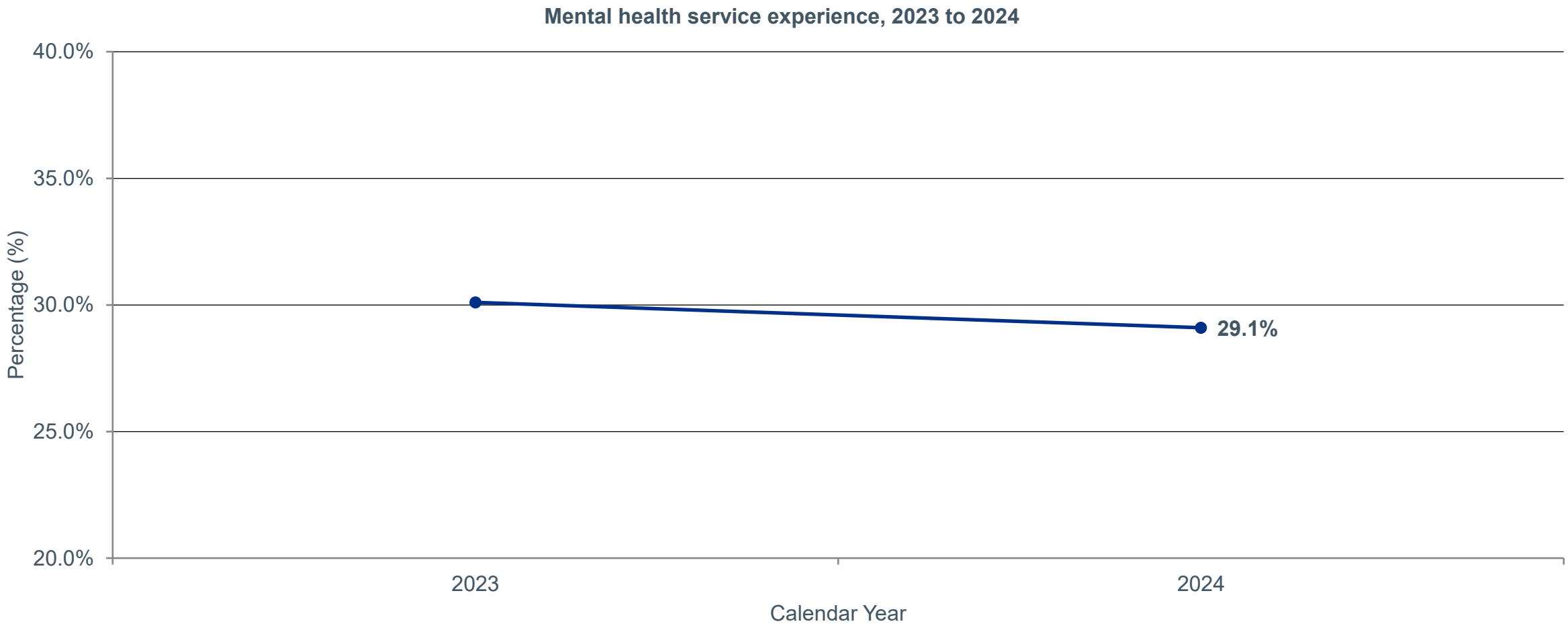
Proportion of community mental health service users who reported 'definitely' feeling in control of their care, from the Care Quality Commission (CQC) Community Mental Health Survey (Q19).

Why it matters for the strategy

• We track community mental health experience because only 29.1% of people feel definitely in control of their care and 38% lack a care plan. Mental health services have historically had weaker experience measurement than acute services, despite being a major service area.
• The latest figure for England (2024) is 29.1%.
• Only 2 trend points: community mental health survey (CMHS) redesigned in 2023, pre-2023 data not directly comparable. This is not collected in 2025 survey.
• This has slightly decreased: 30.1% (2023) to 29.1% (2024).
• Experience measurement in mental health has historically been weaker than in acute services, despite mental health being a major service area.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: CQC, Community Mental Health Survey 2024 (Apr 2025)

Figure 3.41: Mental health service experience: England trend



Source: CQC, Community Mental Health Survey 2024 (Apr 2025)

Mental health: family involvement

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported that their family or someone close to them was 'definitely' involved in their care as much as they wanted (Care Quality Commission (CQC) Community Mental Health Survey, Q33).

Why it matters for the strategy

- We track family involvement in mental health because carers and families play a vital role in recovery, yet only 48% feel 'definitely' involved.
- The latest figure for England (2025) is 48%.
- This has remained broadly stable for two years 45% (2023), 45% (2024) and then increased 48% (2025).
- Only 3 trend points: community mental health survey (CMHS) redesigned in 2023, pre-2023 data not directly comparable.
- Carers and families are central to recovery, and reported family involvement remains low.
- Carer-centred recovery signal. strategy Mental Health experience priority.

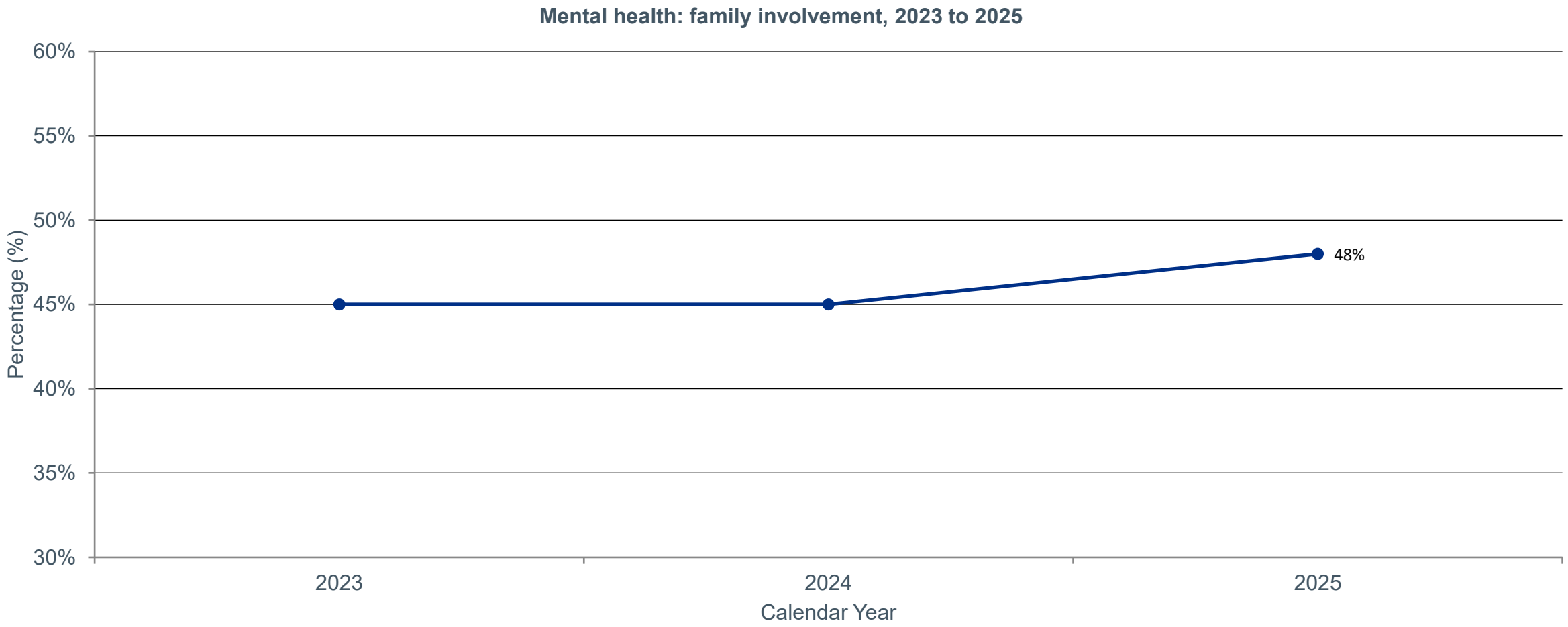
Source: CQC Community Mental Health Survey 2024, Q33 family involved

Mental health: family involvement

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported that their family or someone close to them was 'definitely' involved in their care as much as they wanted (CQC Community Mental Health Survey, Q33).

Figure 3.42: Mental health: family involvement: England trend



Source: CQC Community Mental Health Survey 2024, Q33 family involved

Mental health: supported decisions

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported that the NHS mental health team 'definitely' helped them with decisions about their care (Care Quality Commission (CQC) Community Mental Health Survey, Q18).

Why it matters for the strategy

• We track supported decision-making in mental health because only 46% feel 'definitely' supported, indicating that shared decision-making is not yet embedded in community mental health.
• The latest figure for England (2025) is 46%.
• This has remained stable for two years 42% (2023), 41% (2024) and then increased to 46% (2025).
• Only 2 trend points: community mental health survey (CMHS) redesigned in 2023, pre-2023 data not directly comparable.
• Reported support remains low, indicating that shared decision-making is not yet embedded in community mental health.
• Shared-decision-making in mental health signal. strategy core experience priority.

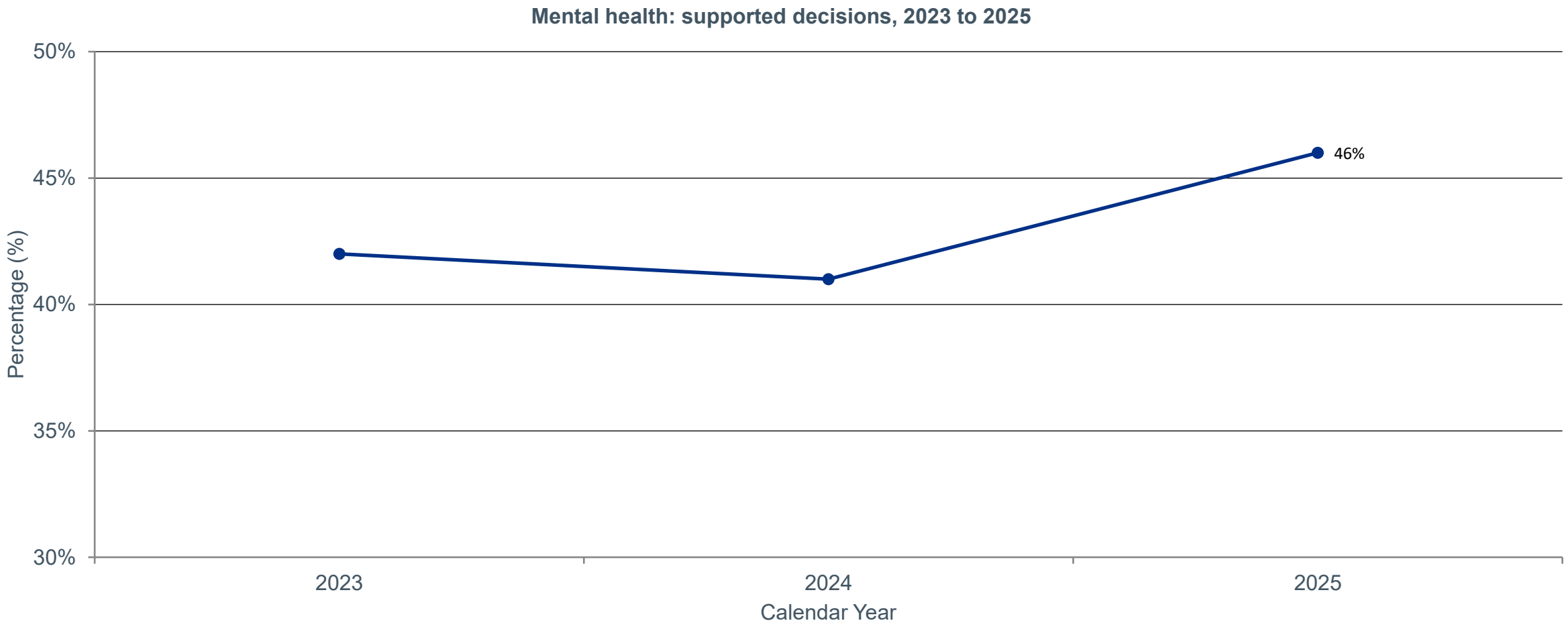
Source: CQC Community Mental Health Survey 2024, Q18 supported decisions

Mental health: supported decisions

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported that the NHS mental health team 'definitely' helped them with decisions about their care (CQC Community Mental Health Survey, Q18).

Figure 3.43: Mental health: supported decisions: England trend



Source: CQC Community Mental Health Survey 2024, Q18 supported decisions

Mental health: crisis contact known

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported knowing who to contact out of office hours within the NHS if they had a crisis (Care Quality Commission (CQC) Community Mental Health Survey, Q26).

Why it matters for the strategy

• We track crisis contact knowledge because, despite improvement from 78% (2024) to 83% (2025), still do not know who to contact in a crisis - a fundamental safety requirement.
• The latest figure for England (2025) is 83%.
• This is getting better: from 78% (2023 and 2024) to 83% (2025). Only 2 trend points: community mental health survey (CMHS) redesigned in 2023, pre-2023 data not directly comparable.
• A meaningful share of community mental health users do not know who to contact in a crisis, which is a fundamental safety requirement.
• Fundamental mental health safety signal. strategy mental health crisis-pathway commitment.

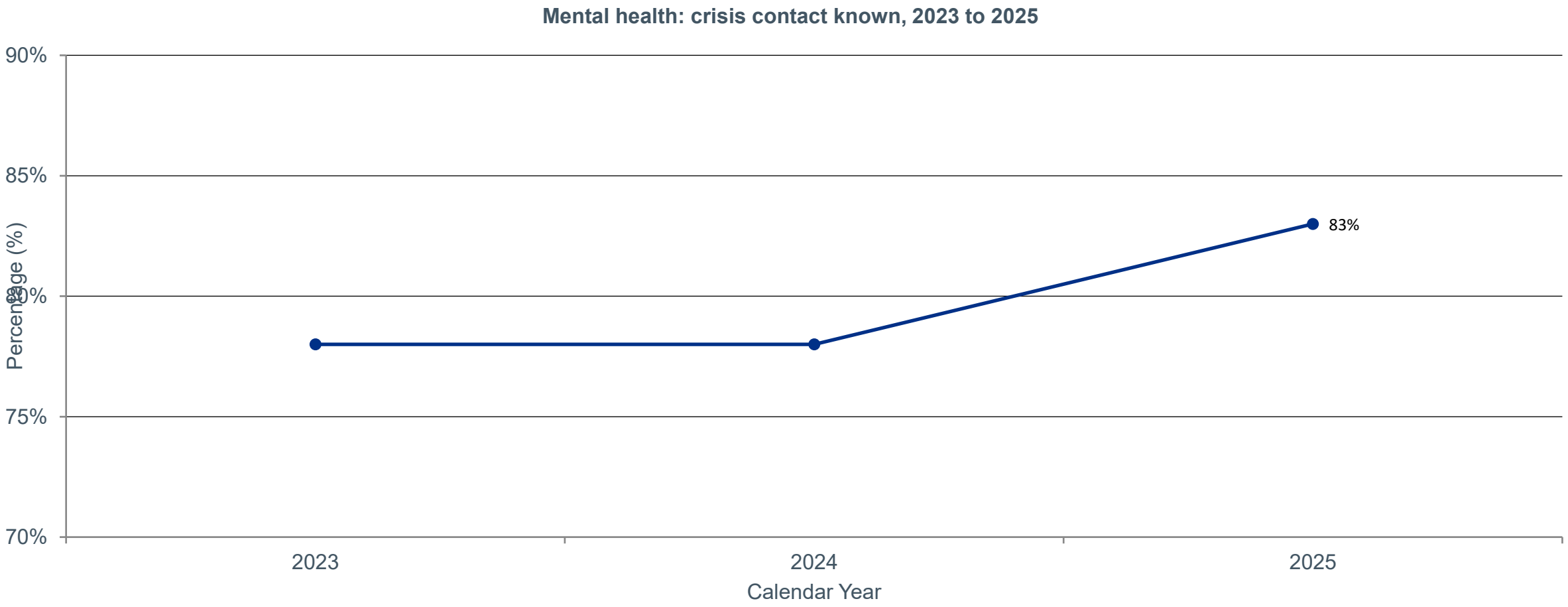
Source: CQC Community Mental Health Survey 2024, Q26 crisis contact

Mental health: crisis contact known

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of community mental health service users who reported knowing who to contact out of office hours within the NHS if they had a crisis (CQC Community Mental Health Survey, Q26).

Figure 3.44: Mental health: crisis contact known: England trend



Source: CQC Community Mental Health Survey 2024, Q26 crisis contact

Mental health: involved in care plan

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Care Quality Commission (CQC) community mental health survey (CMHS) Q15: percentage of service users who have a care plan.

Why it matters for the strategy

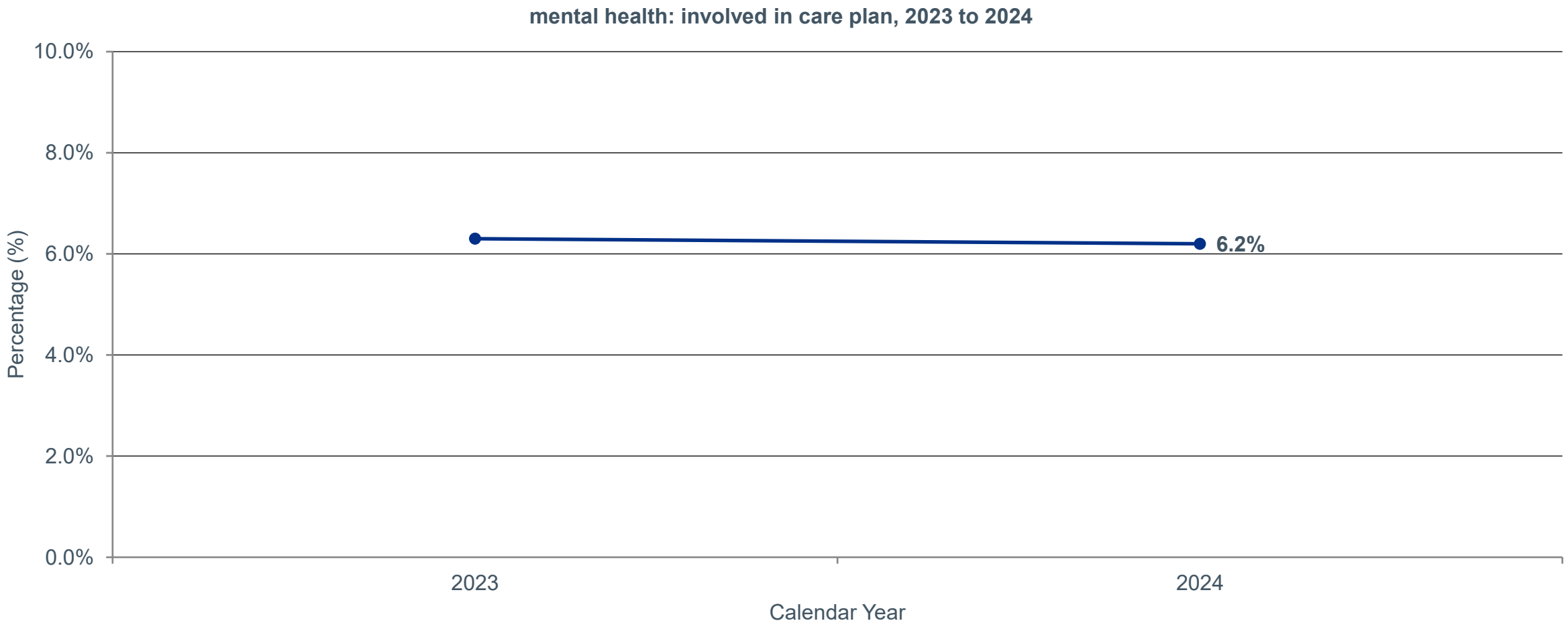
- The latest figure for England (2024) is 6.2%.
- This has remained broadly stable: 6.2% (2024). This is not collected in 2025 survey.
- strategy Mental Health and personalised care is a planning priority.

Source: CQC Community Mental Health Survey 2024

Mental health: involved in care plan

Experience of care | Tier 3: Process indicator | ↑ Higher is better
CQC CMHS Q15: percentage of service users who have a care plan.

Figure 3.45: Mental health: involved in care plan: England trend



Source: CQC Community Mental Health Survey 2024

Maternity: confidence in staff

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported 'definitely' having confidence and trust in the staff caring for them during labour and birth (Care Quality Commission (CQC) Maternity Survey, C18).

Why it matters for the strategy

• We track confidence in labour staff because, while partially recovering from 77.6% (2022) to 78.2% (2025), the rate remains 5.3pp below the 83.5% pre-pandemic level (2019), and 'No' responses have doubled. The current trend is deteriorating, with confidence not yet recovering to pre-pandemic levels.
• The latest figure for England (2025) is 78.2%.
• This is getting worse: 77.8% (2013), 83.5% (2019 peak), 77.6% (2022), 78.2% (2025).
• A core indicator in the CQC Maternity Survey and a direct measure of therapeutic relationship quality during labour.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

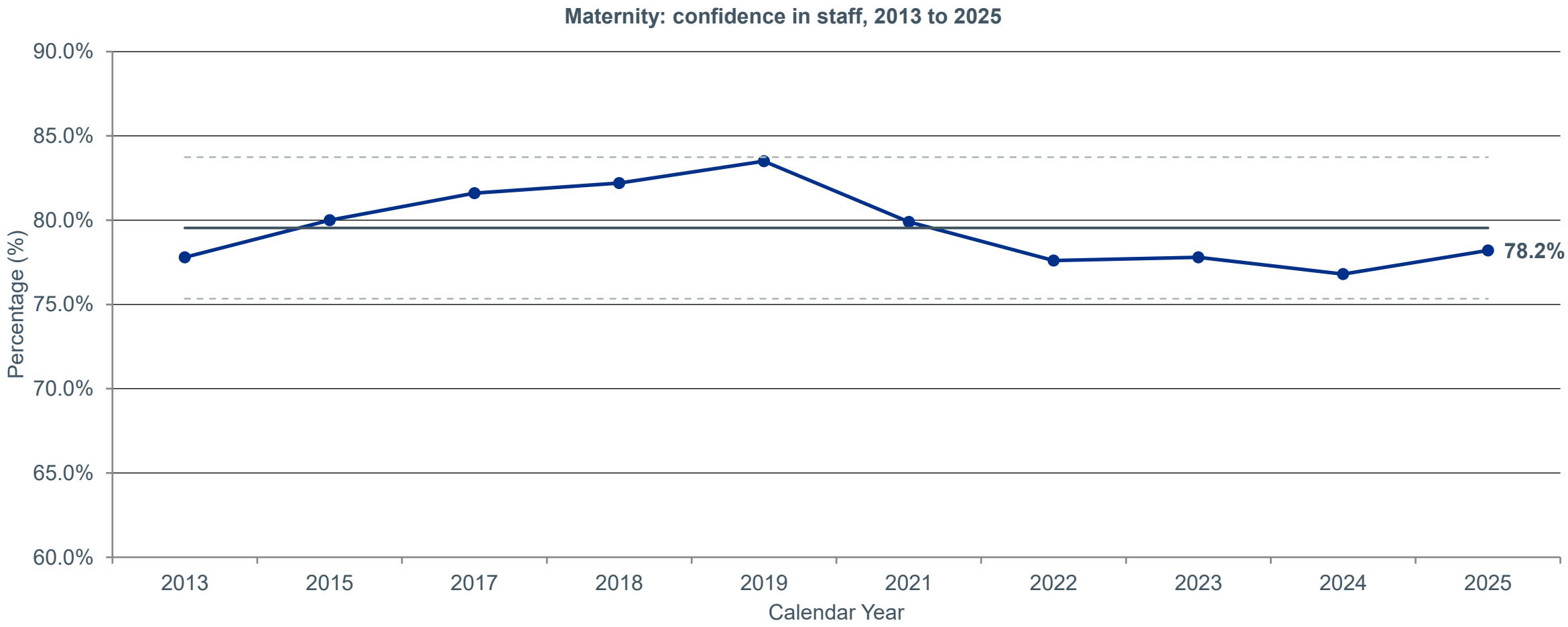
Source: CQC Maternity Survey 2025, C18 confidence in staff during labour | statistical process control (SPC): Grey line = mean. Grey dashed = control limits (±3σ). Orange dots = special cause variation.

Maternity: confidence in staff

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported 'definitely' having confidence and trust in the staff caring for them during labour and birth (CQC Maternity Survey, C18).

Figure 3.46: Maternity: confidence in staff: England trend



Source: CQC Maternity Survey 2025, C18 confidence in staff during labour | SPC: Grey line = mean. Grey dashed = control limits (±3σ).
Orange dots = special cause variation.

Maternity: midwives or doctor aware of medical history

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported midwives or doctor always being aware of medical history (Care Quality Commission (CQC) Maternity Survey, C20).

Why it matters for the strategy

- We track this metric as awareness of medical history is in essential part of ensuring that appropriate care is given during pregnancy, to improve maternal and neonatal outcomes
- The latest figure for England (2025) is 64.9%.
- The picture is getting better, increasing by 4.6% from 2022 (60.3%) to 2025 (64.9%)

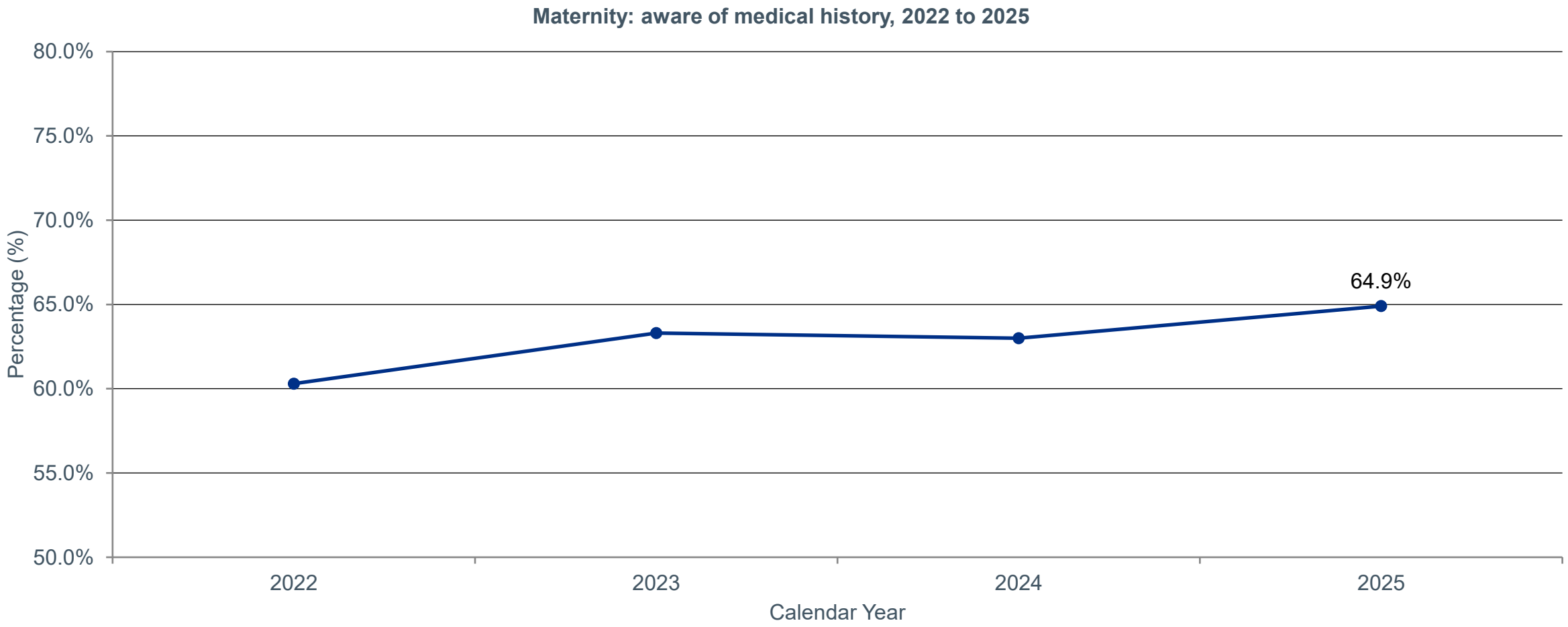
Source: CQC Maternity Survey 2025, C20 aware of medical history

Maternity: midwives or doctor aware of medical history

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported midwives or doctor always being aware of medical history (CQC Maternity Survey, C20).

Figure 3.47: Maternity: midwives or doctor aware of medical history: England trend



Source: CQC Maternity Survey 2025, C20 aware of medical history

Maternity: involved in decisions

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported always being involved enough in decisions about their care during labour and birth (Care Quality Commission (CQC) Maternity Survey, C16).

Why it matters for the strategy

- We track involvement in labour decisions because 23.1% of women are not 'always' involved, and the gap to the 2019 level has not closed.
- The latest figure for England (2025) is 76.9%.
- The picture is mixed: 77.9% (2019), 74.3% (2022), 76.9% (2025).
- Shared decision-making in maternity is a core strategy priority, and a known driver of traumatic birth experience when it fails.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

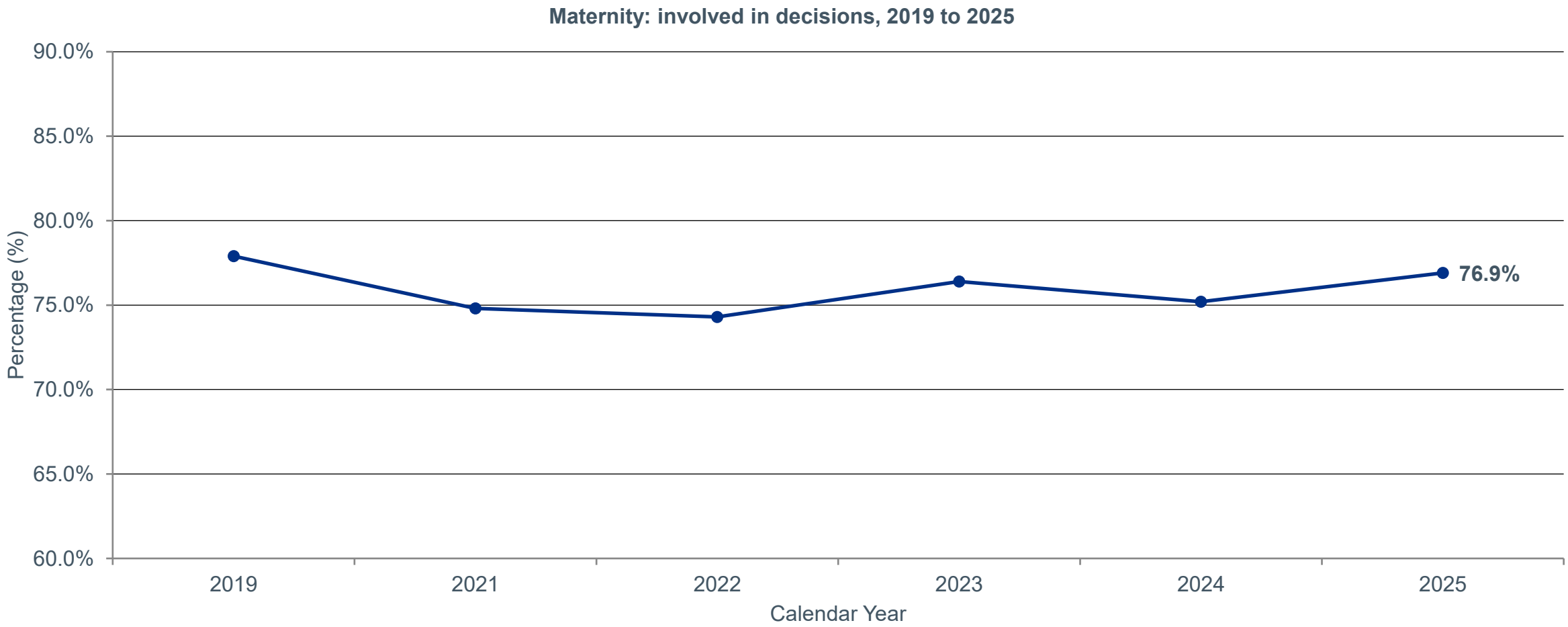
Source: CQC Maternity Survey 2025, C16 involved in decisions during labour

Maternity: involved in decisions

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who reported always being involved enough in decisions about their care during labour and birth (CQC Maternity Survey, C16).

Figure 3.48: Maternity: involved in decisions: England trend



Source: CQC Maternity Survey 2025, C16 involved in decisions during labour

Maternity: concerns taken seriously

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who raised a concern during labour and birth and reported that their concerns were taken seriously (Care Quality Commission (CQC) Maternity Survey, C12).

Why it matters for the strategy

- We track whether concerns are taken seriously during labour because this is a fundamental measure of respectful maternity care, and the 2.8pp gap from 2019 (84.4%) to 2025 (81.6%) has not fully recovered.
- The latest figure for England (2025) is 81.6%.
- The picture is mixed: 84.4% (2019 peak), 77.2% (2022), 81.6% (2025).
- Respectful maternity care signal. Sub-indicator of confidence in labour staff.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

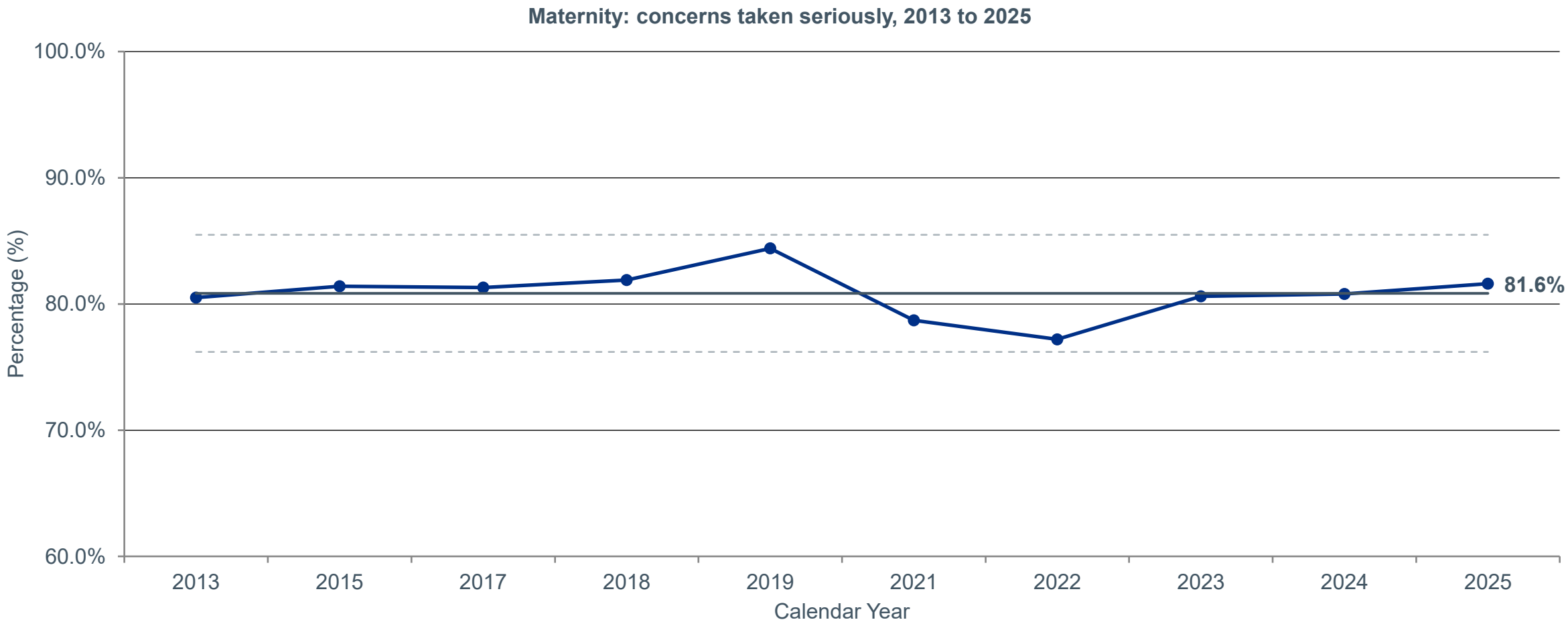
Source: CQC Maternity Survey 2025, C12 concerns taken seriously | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternity: concerns taken seriously

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of women who raised a concern during labour and birth and reported that their concerns were taken seriously (CQC Maternity Survey, C12).

Figure 3.49: Maternity: concerns taken seriously: England trend



Source: CQC Maternity Survey 2025, C12 concerns taken seriously | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Maternity: postnatal experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Care Quality Commission (CQC) Maternity Survey g1: involved in decisions about postnatal care (% yes always).

Why it matters for the strategy

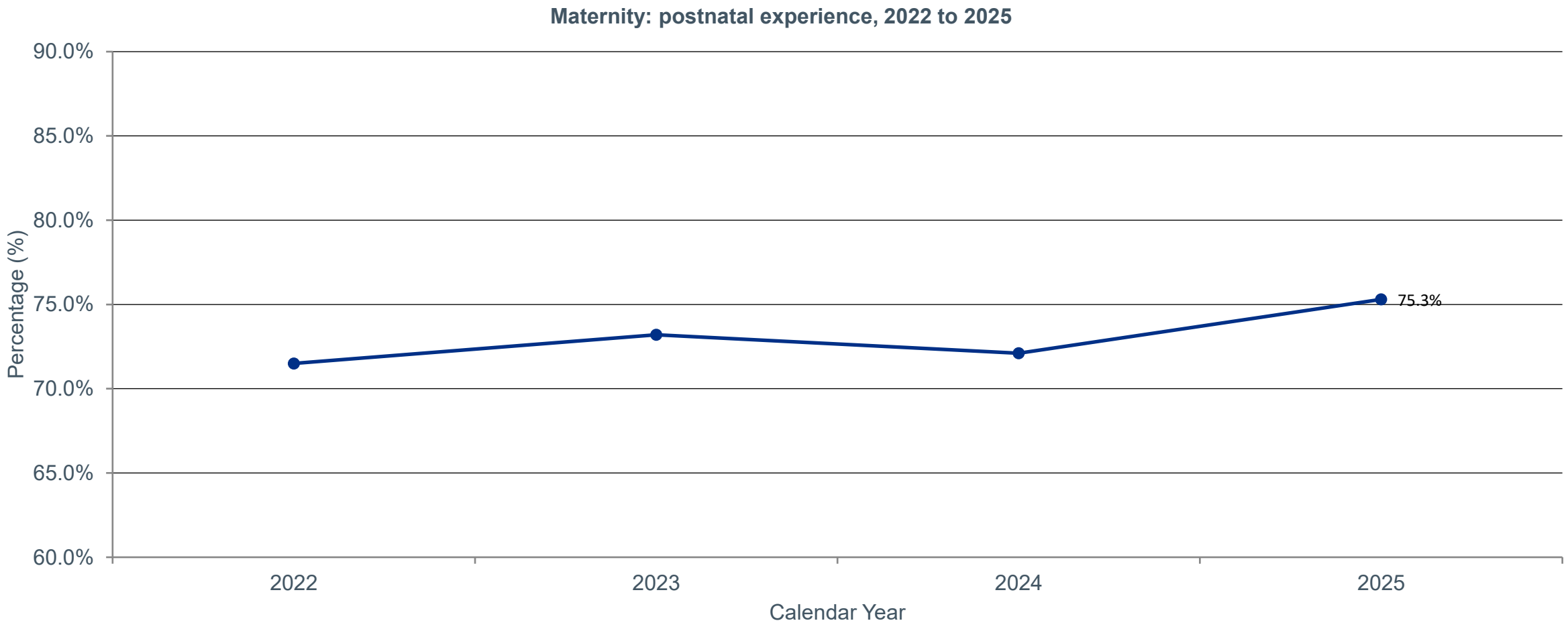
- The latest figure for England (2024) is 75.3%.
- The picture is mixed: 71.5% (2022), 73.2% (2023), 72.1% (2024), and improved to 75.3% (2025). Postnatal experience remains the lowest-scoring section of the maternity pathway.
- Postnatal care is the lowest-scoring part of the maternity pathway in successive CQC surveys and is the area the Maternity Taskforce identifies as needing most improvement.
- Maternity Taskforce priority pathway. Sub-indicator of confidence in labour staff.

Source: CQC Maternity Survey (g1)

Maternity: postnatal experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better
CQC Maternity Survey g1: involved in decisions about postnatal care (% yes always).

Figure 3.50: Maternity: postnatal experience: England trend



Source: CQC Maternity Survey (g1)

NHS written complaints

Experience of care | Tier 2: Driver | ↓ Lower is better

Total volume of formal written complaints received by NHS organisations in England, from NHS Digital KO41a annual returns.

Why it matters for the strategy

• We track NHS written complaints because they provide a structured signal of where care falls below expectations, and trends in complaint volumes and themes reveal systemic issues that survey data alone may not capture. The current trend is deteriorating, with complaint volumes rising year on year.
• The latest figure for England (April 2024 to March 2025) is 256,777 written complaints.
• This is getting worse: Written complaints was more than 256,000 in April 2024 to March 2025 (>5% increase on prior year). Complaint volumes have increased by approximately 50K over the past decade, reflecting a sustained upward trend. Communications, patient care, and appointments are top complaint categories.
• Volume and theme trends reveal systemic issues that survey data alone can miss.
• strategy Experience priority - written complaints are a direct read on dissatisfaction the surveys miss, with consistent year-on-year growth in volume.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

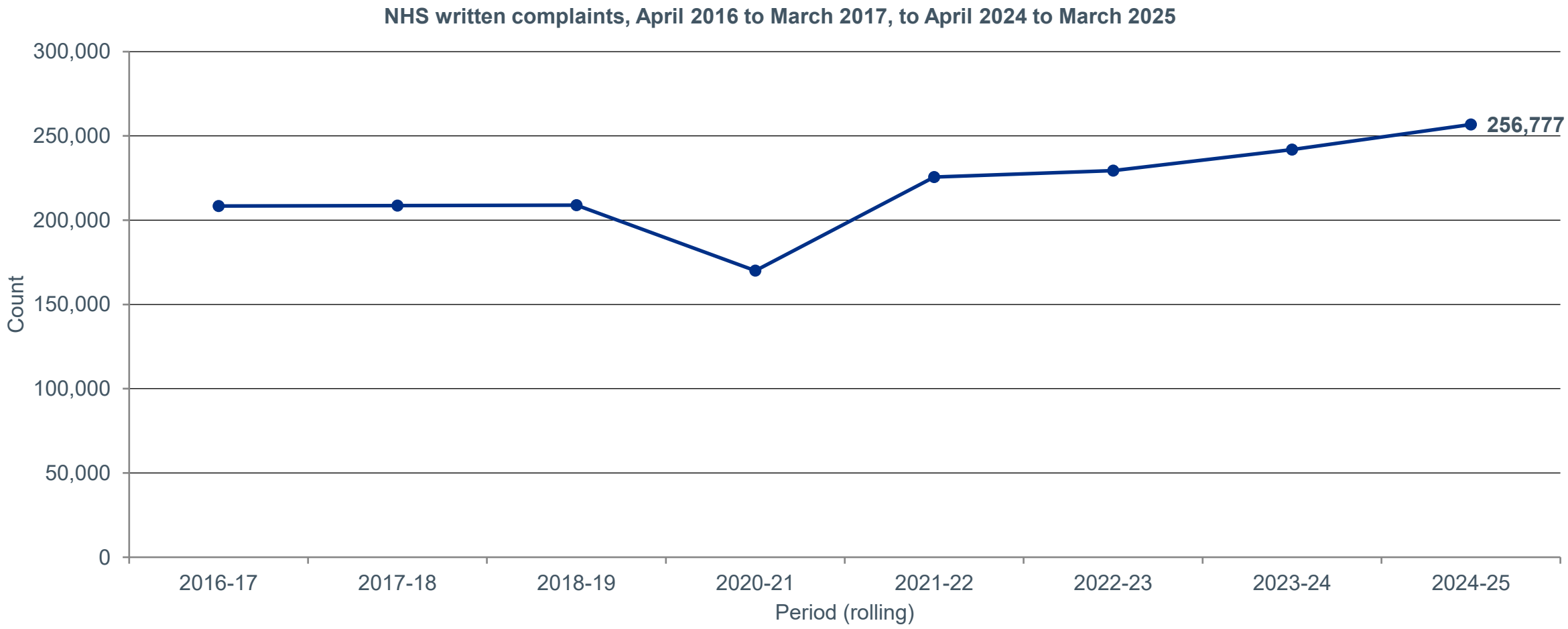
Source: NHS Digital, Data on Written Complaints in the NHS April 2024 to March 2025 (KO41a) (Oct 2025)

NHS written complaints

Experience of care | Tier 2: Driver | ↓ Lower is better

Total volume of formal written complaints received by NHS organisations in England, from NHS Digital KO41a annual returns.

Figure 3.51: NHS written complaints: England trend



Source: NHS Digital, Data on Written Complaints in the NHS April 2024 to March 2025 (KO41a) (Oct 2025)

Deaths in hospital

Experience of care | Tier 2: Driver | ↑ Higher is better

Percentage of deaths that happen in hospital, from Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• We track end of life care because dying in a place aligned to preference is a strong marker of person-centred care, and dying in hospital tends to indicate potential failures in end of care planning and taking that preference into account.
• The latest figure for England (2024) is 42.3%.
• This is getting better: 42.3% of deaths in hospital, down from 44.4% in 2021 and 46.6% in 2015. Also, down from 44.4% in 2019 pre-pandemic.
• Performance varies across NHS Regions (2024 data): the highest percentage of deaths in hospitals happened in London (47.9%) and the lowest in South East (37.5%).
• People in the most deprived areas have a percentage of 46.2%, compared with 39.1%in the least deprived - a gap of 7.1%.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

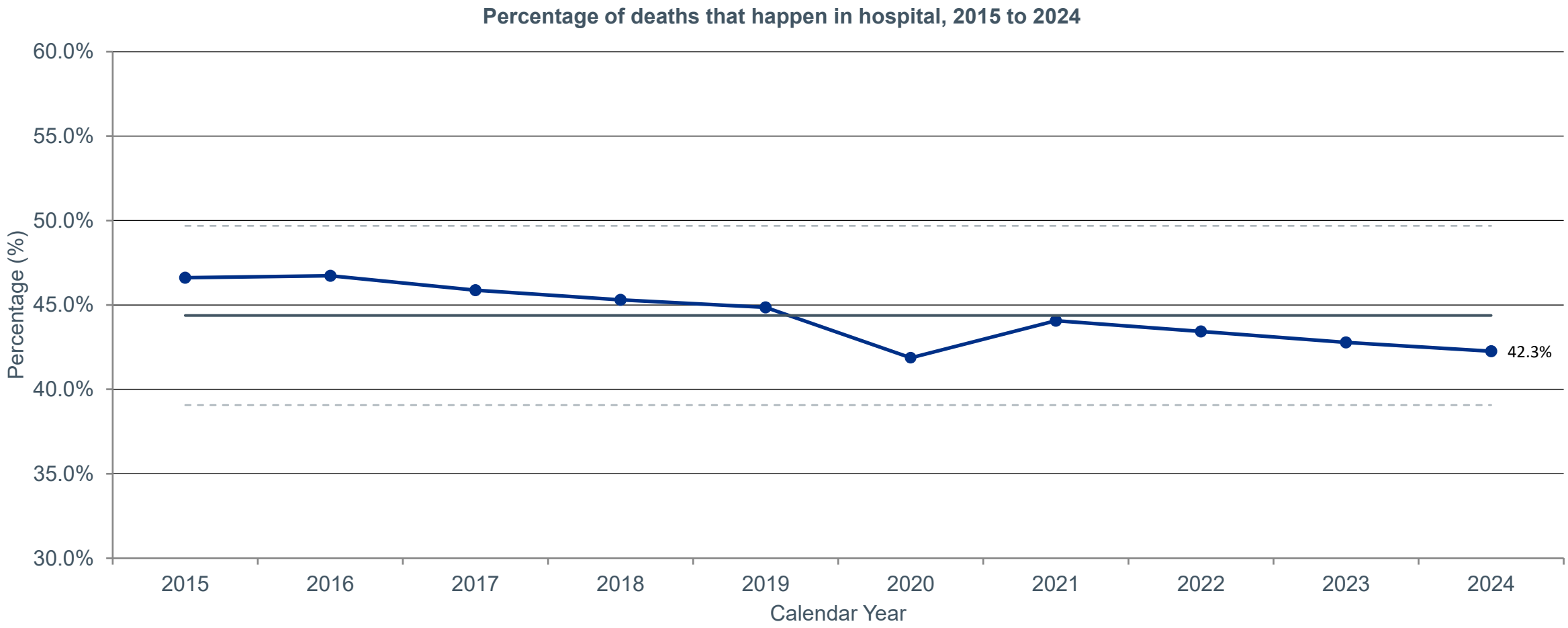
Source: OHID Fingertips (indicators 93474, 2024 data) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Deaths in hospital

Experience of care | Tier 2: Driver | ↑ Higher is better

Percentage of deaths that happen in hospital, from OHID Fingertips.

Figure 3.52: Deaths in hospital: England trend



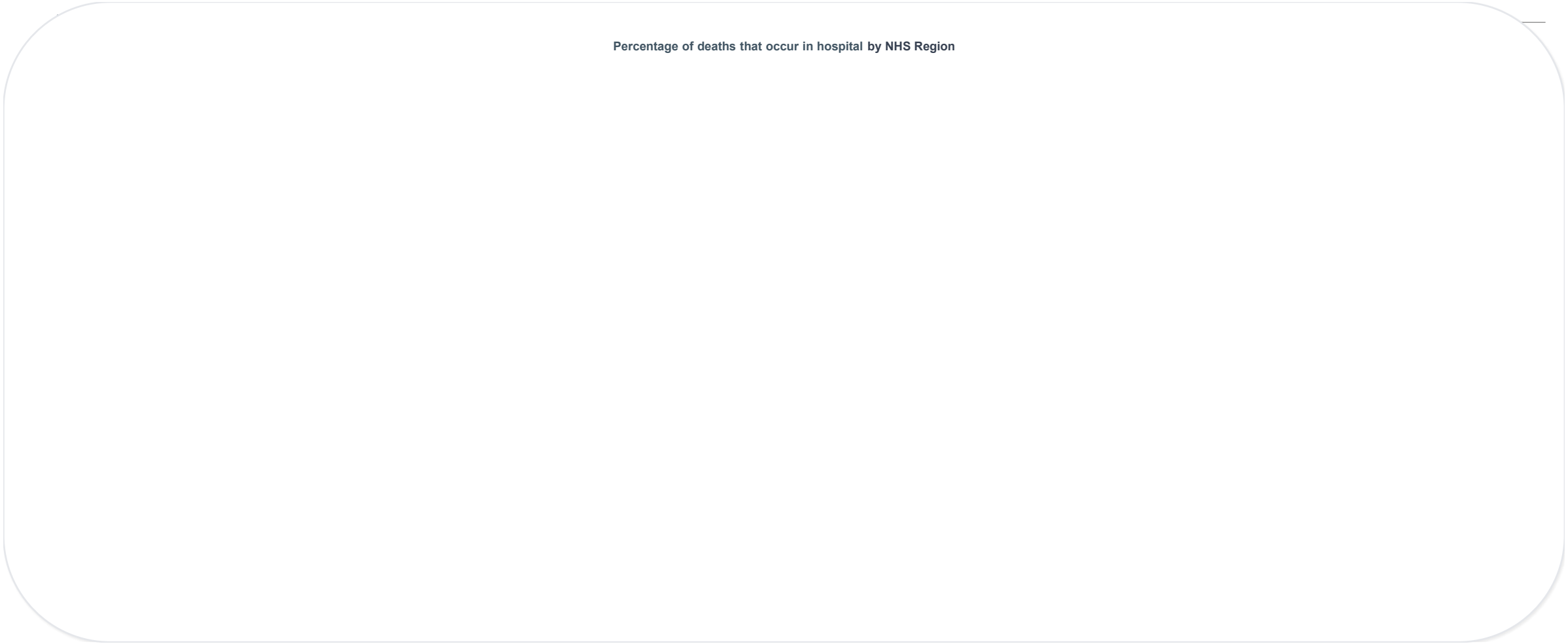
Source: OHID Fingertips (indicators 93474, 2024 data) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Deaths in hospital

Experience of care | Tier 2: Driver | ↑ Higher is better

Percentage of deaths that happen in hospital, from OHID Fingertips.

Figure 3.53: Deaths in hospital by NHS Region



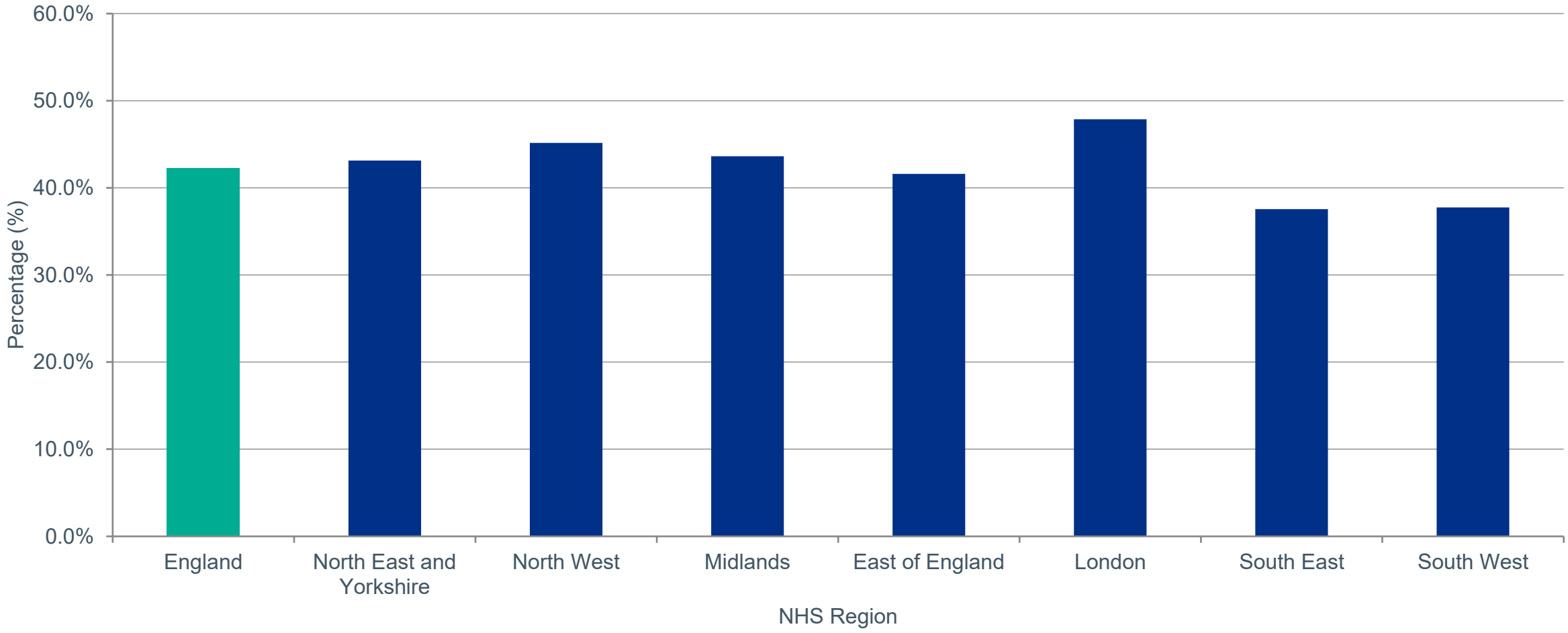
Source: OHID Fingertips (indicators 93474, 2024 data) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Deaths in hospital

Experience of care | Tier 2: Driver | ↑ Higher is better

Percentage of deaths that happen in hospital, from OHID Fingertips.

Figure 3.54: Deaths in hospital by NHS Region



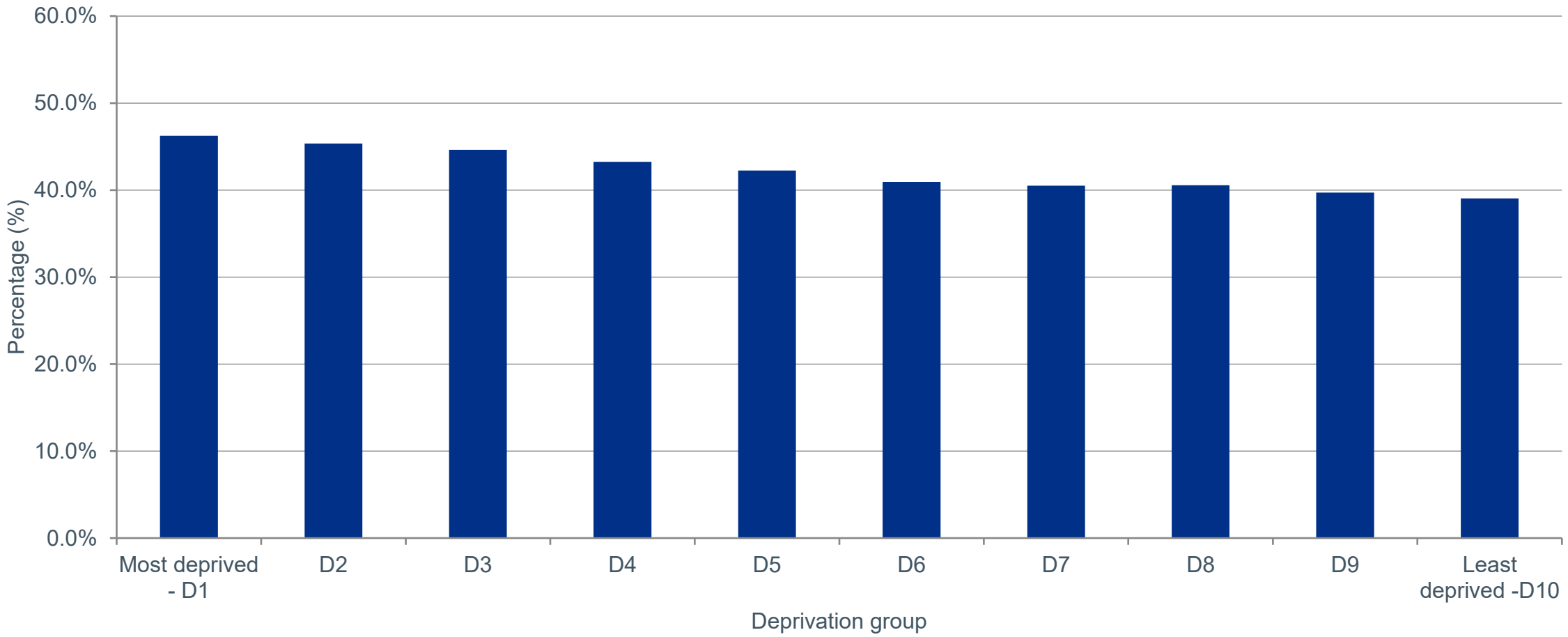
Source: OHID Fingertips (indicators 93474, 2024 data) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Deaths in hospital

Experience of care | Tier 2: Driver | ↑ Higher is better

Percentage of deaths that happen in hospital, from OHID Fingertips.

Figure 3.55: Percentage of deaths that happen in hospital by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: OHID Fingertips (indicators 93474, 2024 data) | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Emergency admissions in the last 90 days of life

Experience of care | Tier 3: Process indicator | ↓ Lower is better

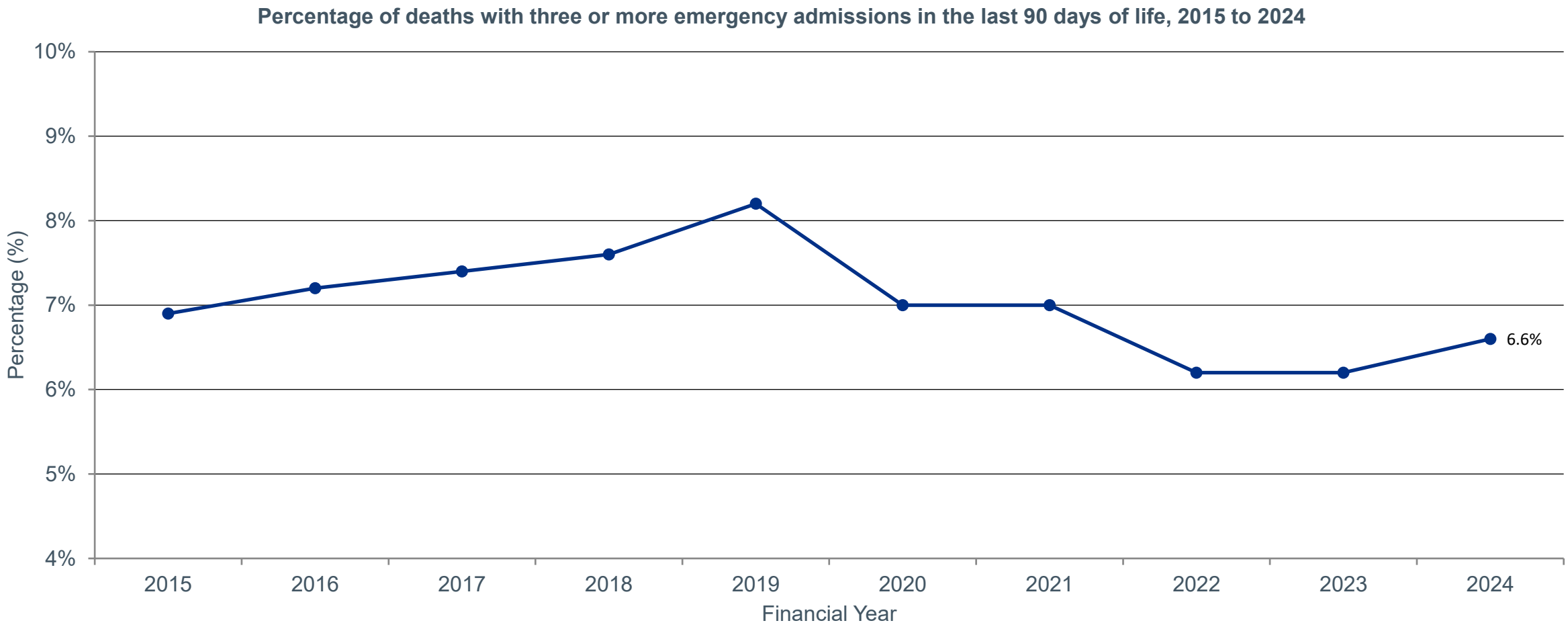
Percentage of deaths with three or more emergency admissions in the last 90 days of life, Office for Health Improvement and Disparities (OHID) Fingertips.

Why it matters for the strategy

• An indicator that shows how end-of-life pathways are functioning. High rates point to avoidable acute admissions that could have been managed in community or hospice settings, against the strategy's community-first emphasis.
• The latest figure for England (2024) is 6.6%.
• The picture is mixed - but the trend is upward over recent years; from 6.2% in 2022 to 6.6% in 2024.
• Performance varies across NHS Regions (2024 data): the best-performing area (North West) had a percentage of 6% deaths within 3 or more emergency admissions in the last 90 days of life, while the worst (Midlands) had 7.6%.
• People in the most deprived areas have a percentage of 7.4%, compared with 6.3% in the least deprived - a gap of 1.1%.
• The established system indicator that end-of-life pathways are functioning.
• Community signal for the strategy's end-of-life pathway.

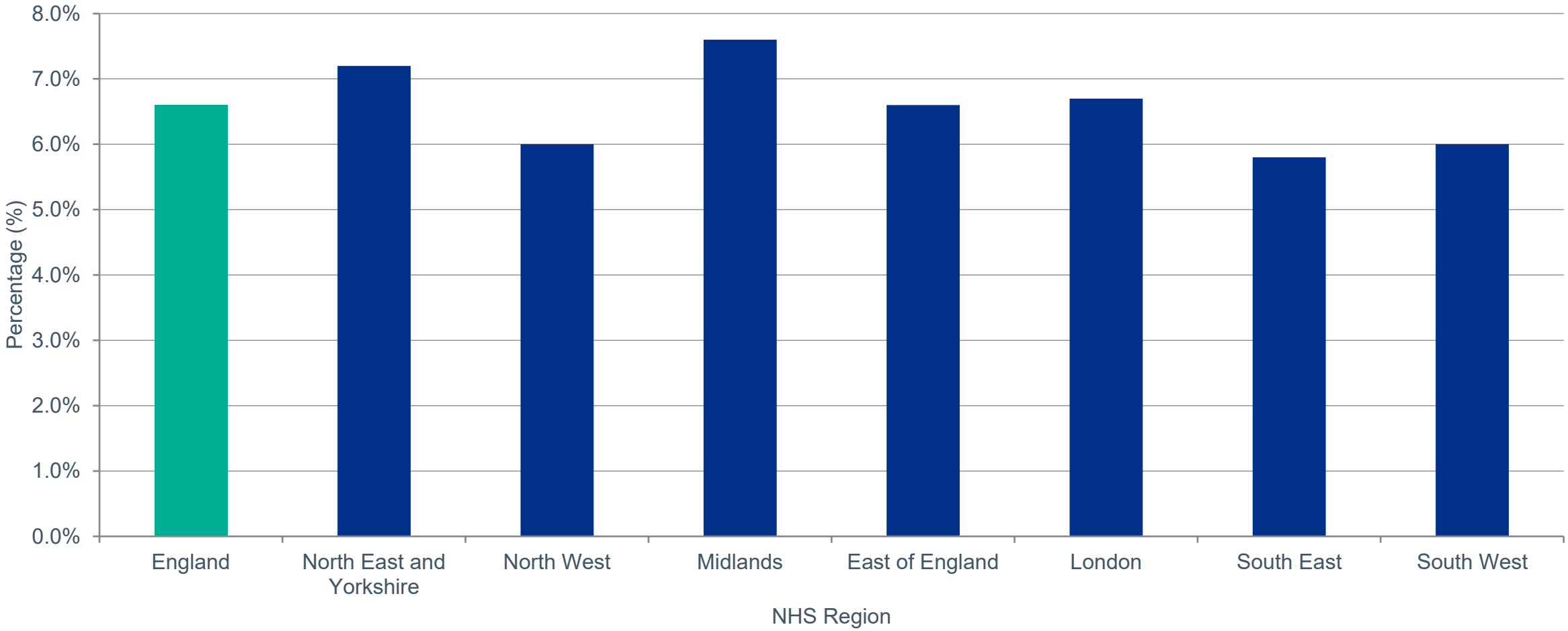
Source: OHID Fingertips [93613]

Figure 3.56: Emergency admissions in the last 90 days of life: England trend



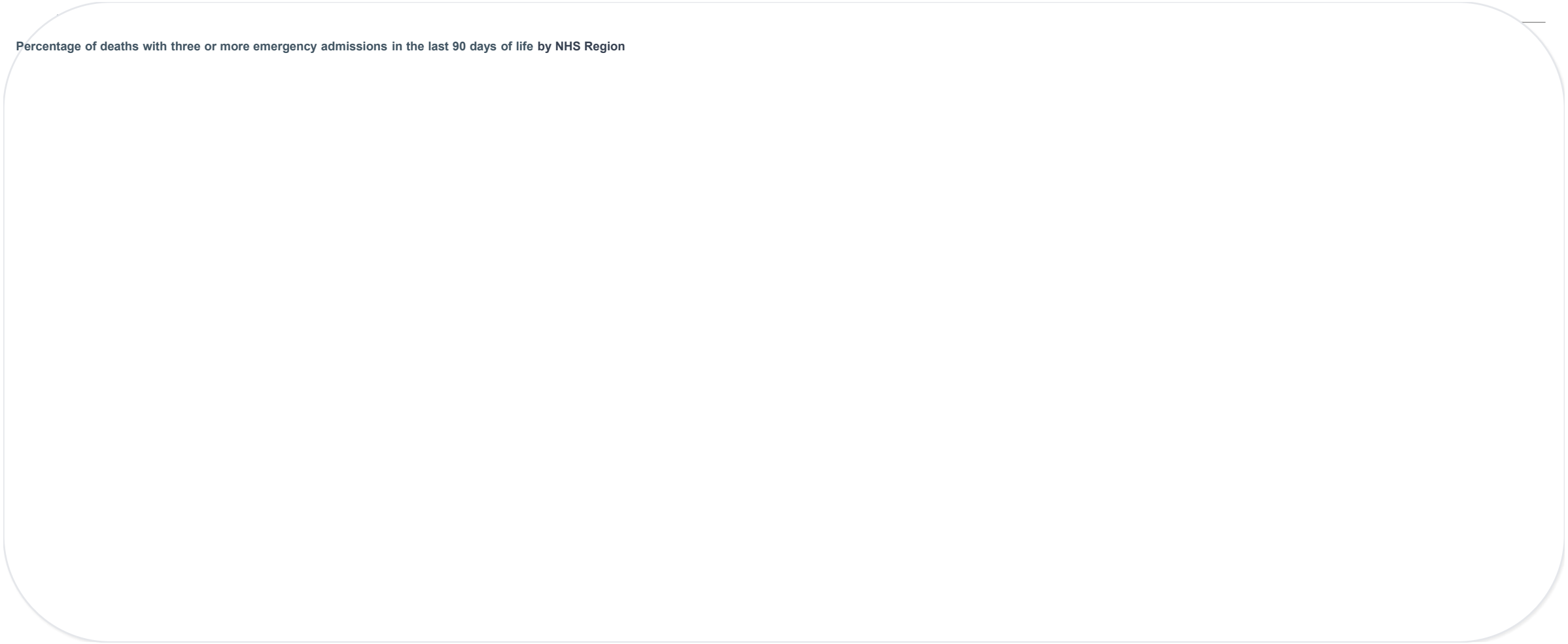
Source: OHID Fingertips [93613]

Figure 3.57: Emergency admissions in the last 90 days of life by NHS Region



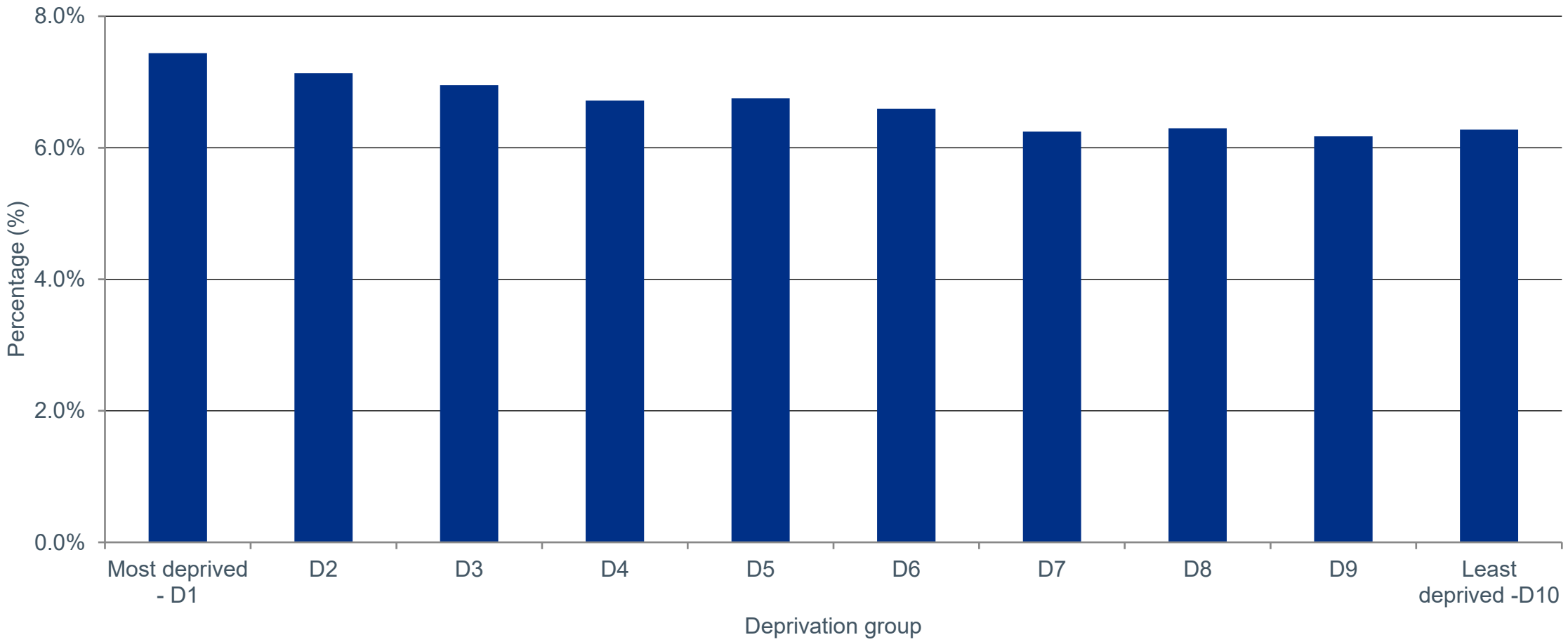
Source: OHID Fingertips [93613]

Figure 3.58: Emergency admissions in the last 90 days of life by NHS Region



Source: OHID Fingertips [93613]

Figure 3.59: Percentage of deaths with three or more emergency admissions in the last 90 days of life by deprivation group (Index of Multiple Deprivation (IMD) quintile)



Source: OHID Fingertips [93613]

Pharmacy services experience

Experience of care | Tier 3: Process indicator | ↑ Higher is better

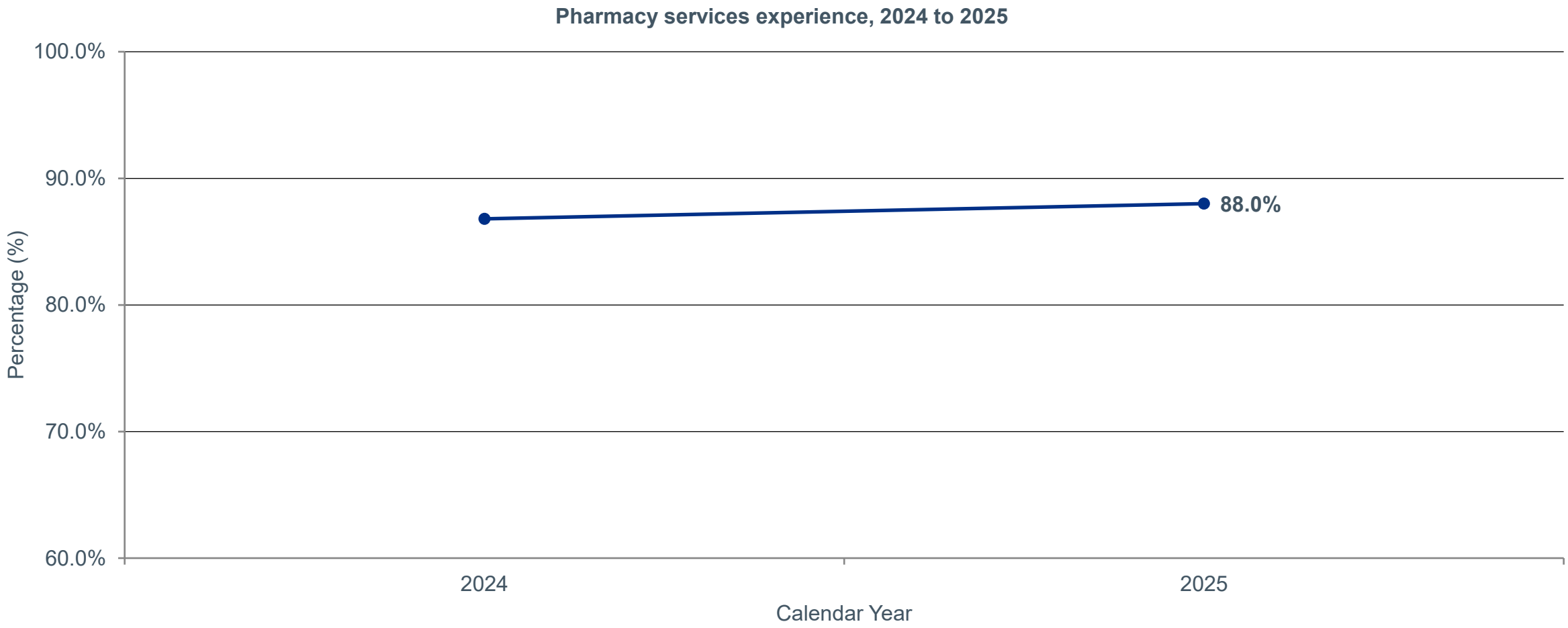
Patient experience of pharmacy services (GP Patient Survey (GPPS) pharmacyoverall, % good/very good).

Why it matters for the strategy

- The latest figure for England (2025) is 88%.
- This has remained broadly stable: 88% (2025), 86.8% (2024.
- Pharmacy access and Pharmacy First are expanding parts of the primary-care offer, and experience is the direct signal of whether the shift is delivering quality as well as volume.
- Pharmacy First and primary-care expansion signal.

Source: GP Patient Survey 2025 (pharmacyoverall)

Figure 3.60: Pharmacy services experience: England trend



Source: GP Patient Survey 2025 (pharmacyoverall)

Staff engagement score

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall staff engagement score from the annual NHS Staff Survey, a composite of motivation, involvement, and advocacy sub-scores on a 0 to 10 scale.

Why it matters for the strategy

- We track staff engagement because engaged staff deliver better care, have lower turnover and sickness rates, and their experience directly predicts patient experience and outcomes. At 6.8 in 2025, engagement is below the pandemic position of 6.8 (2022).
- This remained almost stable in last 5 years, 6.8 in 2025 but below pre-pandemic position of 7.1 (2020). All three components declined: Motivation 6.9, Involvement 6.8, Advocacy 6.6. Historical: 7.1 (2020), 6.8 (2021), 6.8 (2022), 6.9 (2023), 6.8 (2024).
- Performance varies across NHS Regions: the best-performing area (London) achieved 7.0 score (out of 10), while the lowest (East of England) achieved 6.6 score (out of 10).
- 10-Year Workforce Plan headline. Drives retention and patient experience.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

Source: NHS England, NHS Staff Survey 2025

Staff engagement score

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall staff engagement score from the annual NHS Staff Survey, a composite of motivation, involvement, and advocacy sub-scores on a 0 to 10 scale.

Figure 3.61: Staff engagement score: England trend

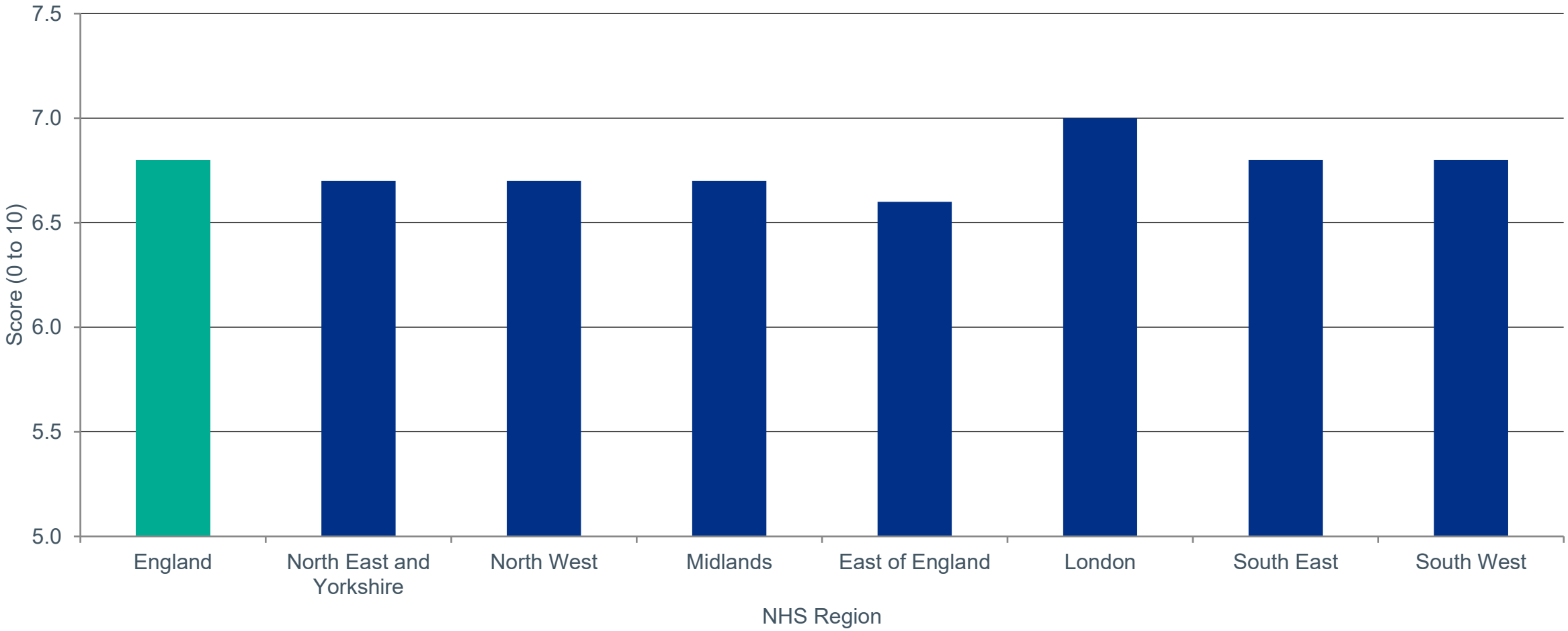
Source: NHS England, NHS Staff Survey 2025

Staff engagement score

Experience of care | Tier 2: Driver | ↑ Higher is better

Overall staff engagement score from the annual NHS Staff Survey, a composite of motivation, involvement, and advocacy sub-scores on a 0 to 10 scale.

Figure 3.62: Staff engagement score by NHS Region



Source: NHS England, NHS Staff Survey 2025

Staff safe and healthy (PP4 sub-score)

Experience of care | Tier 2: Driver | ↑ Higher is better

Score on the PP4 'We are safe and healthy' People Promise element from the annual NHS Staff Survey, measuring staff perceptions of workplace health, safety, and wellbeing, on a 0 to 10 scale.

Why it matters for the strategy

- The latest figure for England (2025) is 6.1 score (out of 10).
- This has remained broadly stable: PP4 stable: 6.14 (2024) to 6.15 (2025). Only 2 data points available (PP4 score was introduced in 2021).
- Clinical driver that translates into population outcomes within 1 to 3 years when delivered at scale.
- Staff wellbeing indicator is leadership enabler.
- Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

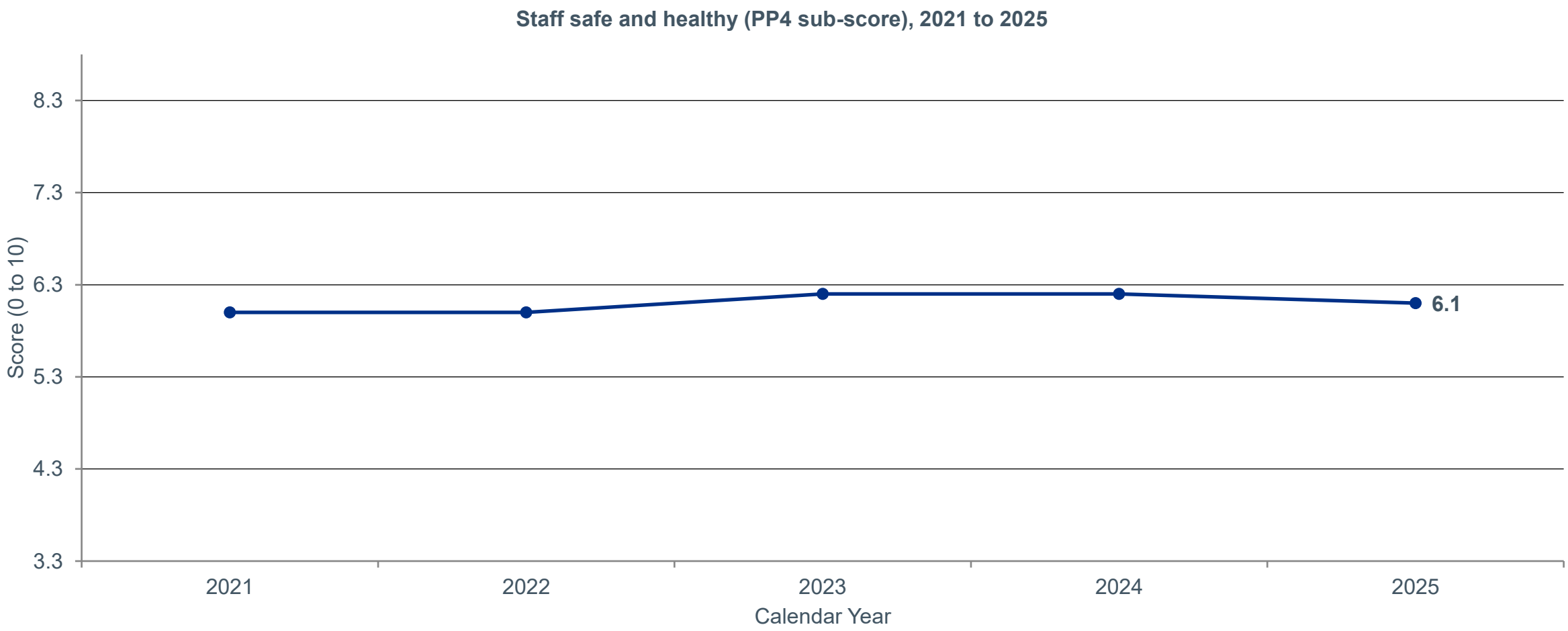
Source: NHS Staff Survey (nhsstaffsurveys.com) PP4 composite

Staff safe and healthy (PP4 sub-score)

Experience of care | Tier 2: Driver | ↑ Higher is better

Score on the PP4 'We are safe and healthy' People Promise element from the annual NHS Staff Survey, measuring staff perceptions of workplace health, safety, and wellbeing, on a 0 to 10 scale.

Figure 3.63: Staff safe and healthy (PP4 sub-score): England trend



Source: NHS Staff Survey (nhsstaffsurveys.com) PP4 composite

Staff: feel safe to speak up about concerns (Q25e)

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of NHS staff who agreed they feel safe to speak up about anything that concerns them at work (NHS Staff Survey, Q25e).

Why it matters for the strategy

• We track whether staff feel safe to speak up about concerns because a culture of psychological safety is a foundation of patient safety. At 60.3% in 2025, this is a five-year low, down from 62.4% in 2023. Almost 40% of NHS staff do not feel safe to speak up. The current trend is deteriorating, with almost 40% of staff not feeling safe to speak up.
• The latest figure for England (2025) is 60.3%.
• This is getting worse: 66.2% (2020), 62.1% (2021), 61.5% (2022), 62.4% (2023), 61.8% (2024). Dropped to 60.3% in 2025 -- five-year low.
• Performance varies across NHS Regions: the best-performing area (South West) achieved 62.7%, while the lowest (East of England) achieved 56.4%.
• Named Freedom to Speak Up indicator. Safety culture signal.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

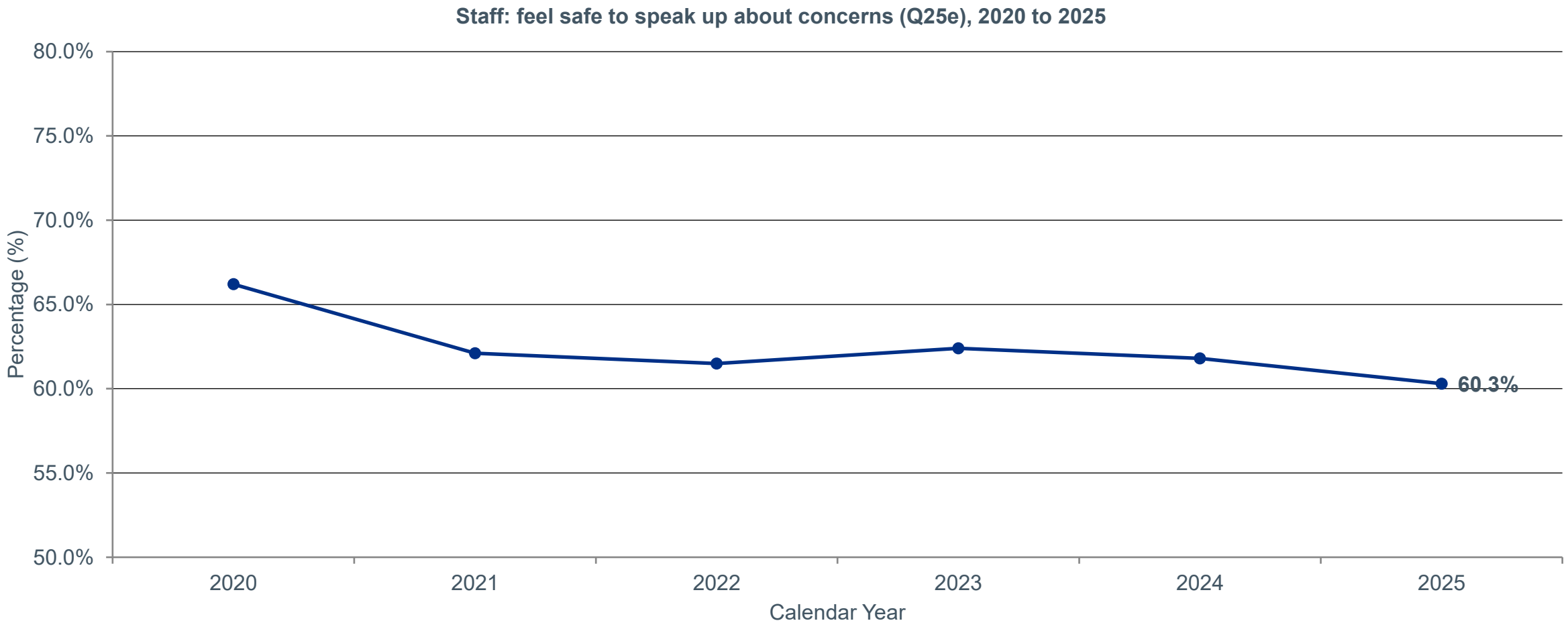
Source: NHS Staff Survey 2025, Q25e feel safe to speak up about anything that concerns them

Staff: feel safe to speak up about concerns (Q25e)

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of NHS staff who agreed they feel safe to speak up about anything that concerns them at work (NHS Staff Survey, Q25e).

Figure 3.64: Staff: feel safe to speak up about concerns (Q25e): England trend



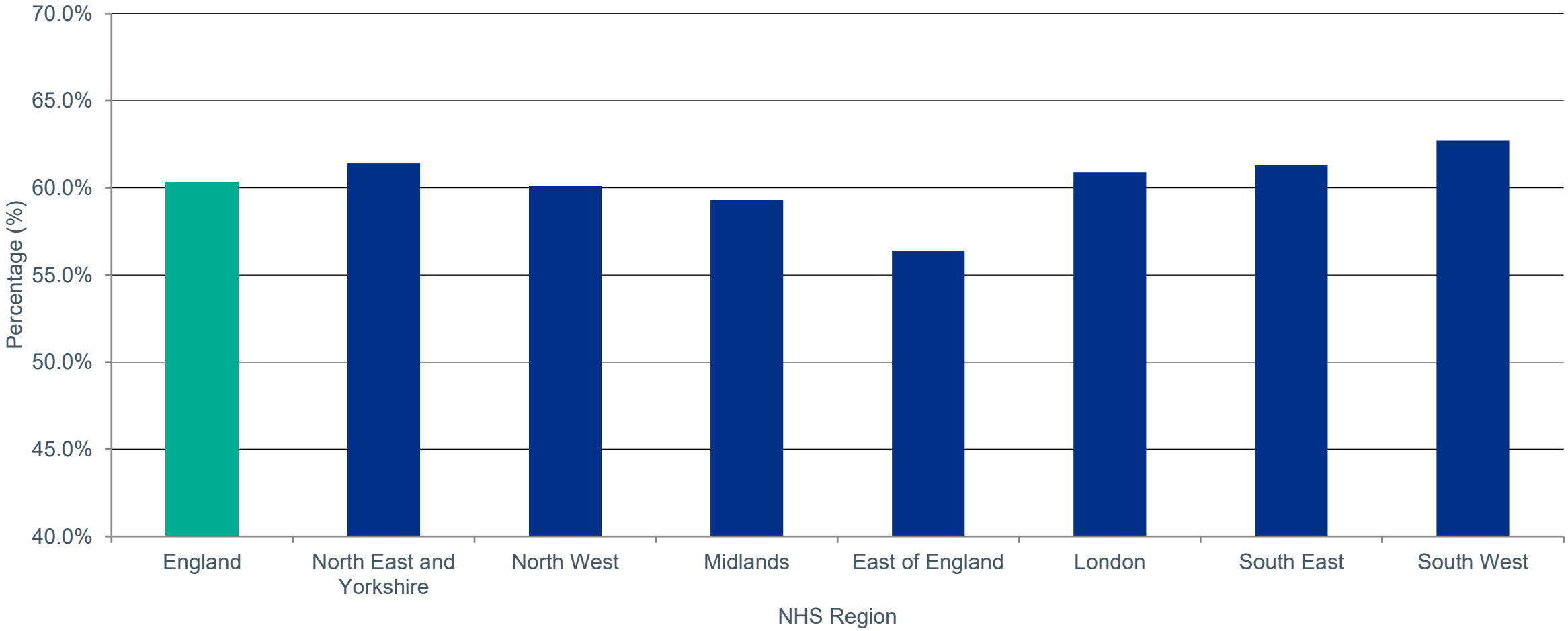
Source: NHS Staff Survey 2025, Q25e feel safe to speak up about anything that concerns them

Staff: feel safe to speak up about concerns (Q25e)

Experience of care | Tier 2: Driver | ↑ Higher is better

Proportion of NHS staff who agreed they feel safe to speak up about anything that concerns them at work (NHS Staff Survey, Q25e).

Figure 3.65: Staff: feel safe to speak up about concerns (Q25e) by NHS Region



Source: NHS Staff Survey 2025, Q25e feel safe to speak up about anything that concerns them

Staff: organisation acts on patient concerns

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed that their organisation acts on concerns raised by patients and service users (NHS Staff Survey, Q25b).

Why it matters for the strategy

• We track whether staff believe their organisation acts on patient concerns because the 6.2pp decline from pre-pandemic levels (75.4% to 69.2%) indicates a widening gap between policy and staff perception. The current trend is deteriorating, with staff confidence in organisational patient safety declining.
• The latest figure for England (2025) is 69.2%.
• This is getting worse: 75.4% (2020), 72.0% (2021), 69.1% (2022), 70.5% (2023), 70.9% (2024). Dropped to 69.2% in 2025.
• Performance varies across NHS Regions: the best-performing area (London) achieved 75.1%, while the lowest (East of England) achieved 64.2%.
• The strategy identifies 'speaking up without fear of inappropriate blame' as a core cultural principle, and names Freedom to Speak Up as a structural safeguard.
• Freedom to Speak Up signal. Sub-indicator of safety culture.

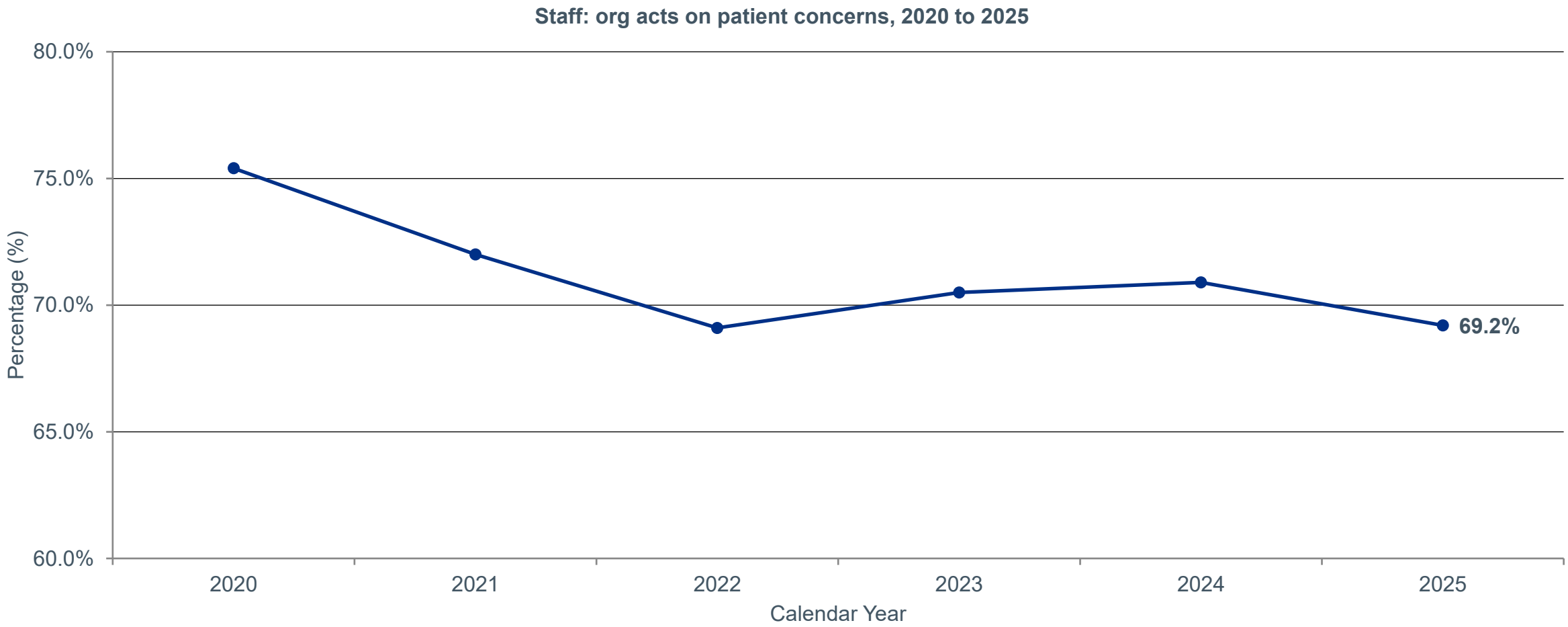
Source: NHS Staff Survey 2025, Q25b organisation acts on patient concerns

Staff: organisation acts on patient concerns

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed that their organisation acts on concerns raised by patients and service users (NHS Staff Survey, Q25b).

Figure 3.66: Staff: organisation acts on patient concerns: England trend



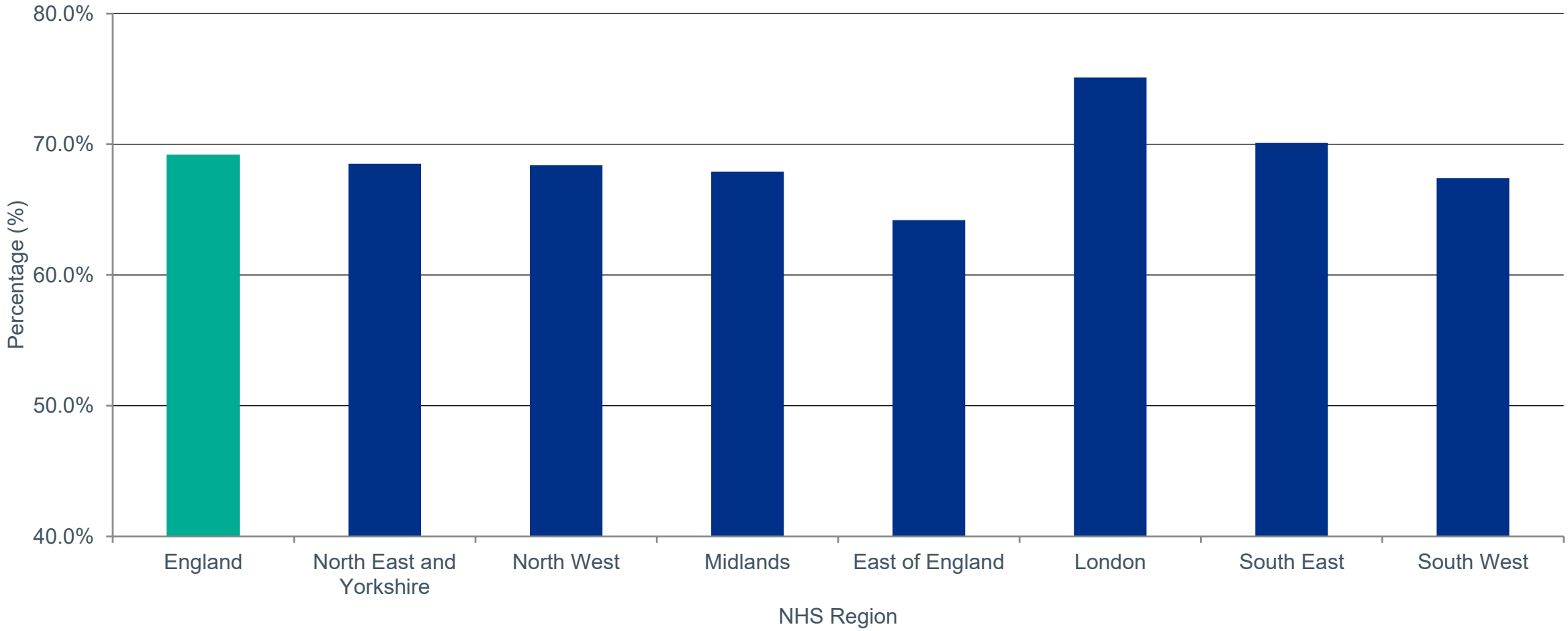
Source: NHS Staff Survey 2025, Q25b organisation acts on patient concerns

Staff: organisation acts on patient concerns

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed that their organisation acts on concerns raised by patients and service users (NHS Staff Survey, Q25b).

Figure 3.67: Staff: organisation acts on patient concerns by NHS Region



Source: NHS Staff Survey 2025, Q25b organisation acts on patient concerns

Staff: able to make improvements

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed they are able to make suggestions to improve the work of their team or department (NHS Staff Survey, Q3f).

Why it matters for the strategy

• We track whether staff feel able to make improvements because empowered staff are the mechanism through which quality improvement happens, and 45.8% feel unable. The 2025 figure of 54.2% is below the 2020 level (56.0%). The current trend is deteriorating, with the 2025 figure below the 2020 baseline.
• The latest figure for England (2025) is 54.2%.
• This is getting worse: 56.0% (2020), 53.1% (2021), 54.3% (2022), 55.9% (2023), 55.2% (2024). Dropped to 54.2% in 2025.
• Performance varies across NHS Regions: the best-performing area (London) achieved 58.4%, while the lowest (East of England) achieved 51.3%.
• Quality-improvement empowerment signal. strategy quality management system (QMS) and leadership enabler.

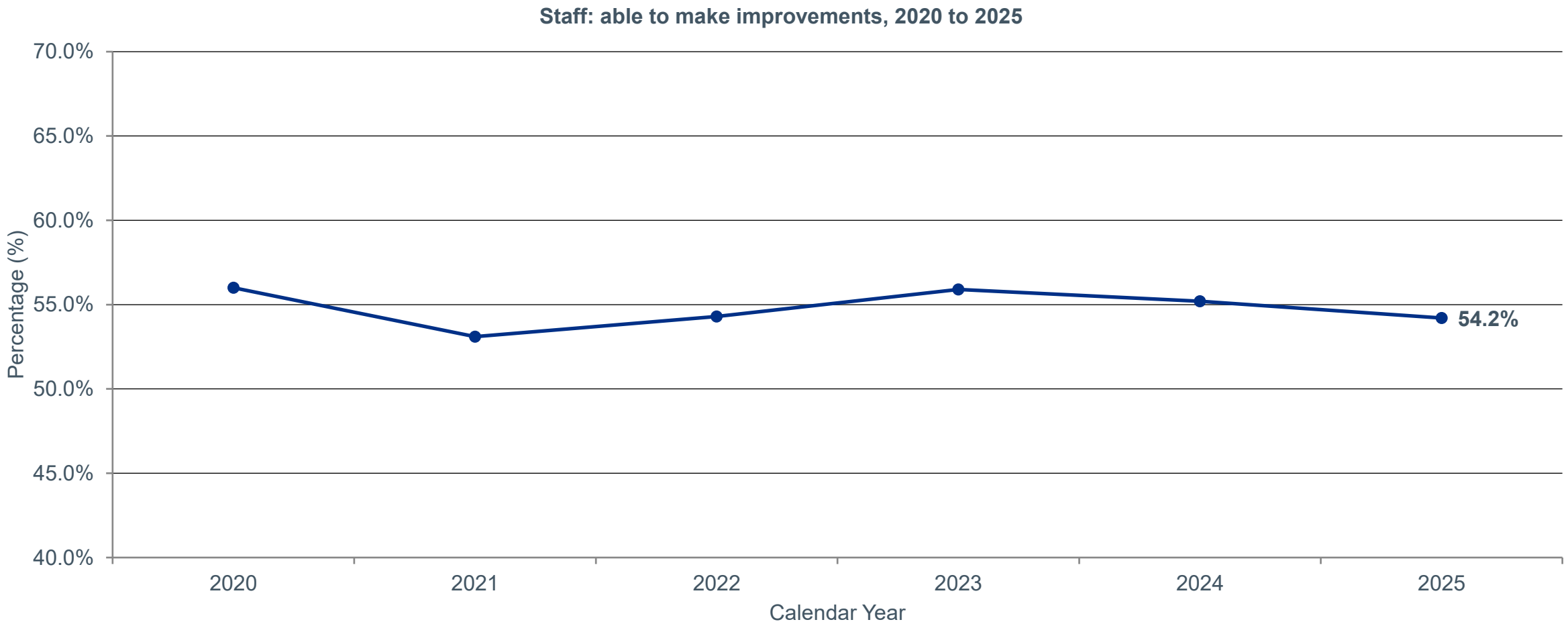
Source: NHS Staff Survey 2025, Q3f (Q4d in 2020) able to make improvements

Staff: able to make improvements

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed they are able to make suggestions to improve the work of their team or department (NHS Staff Survey, Q3f).

Figure 3.68: Staff: able to make improvements: England trend



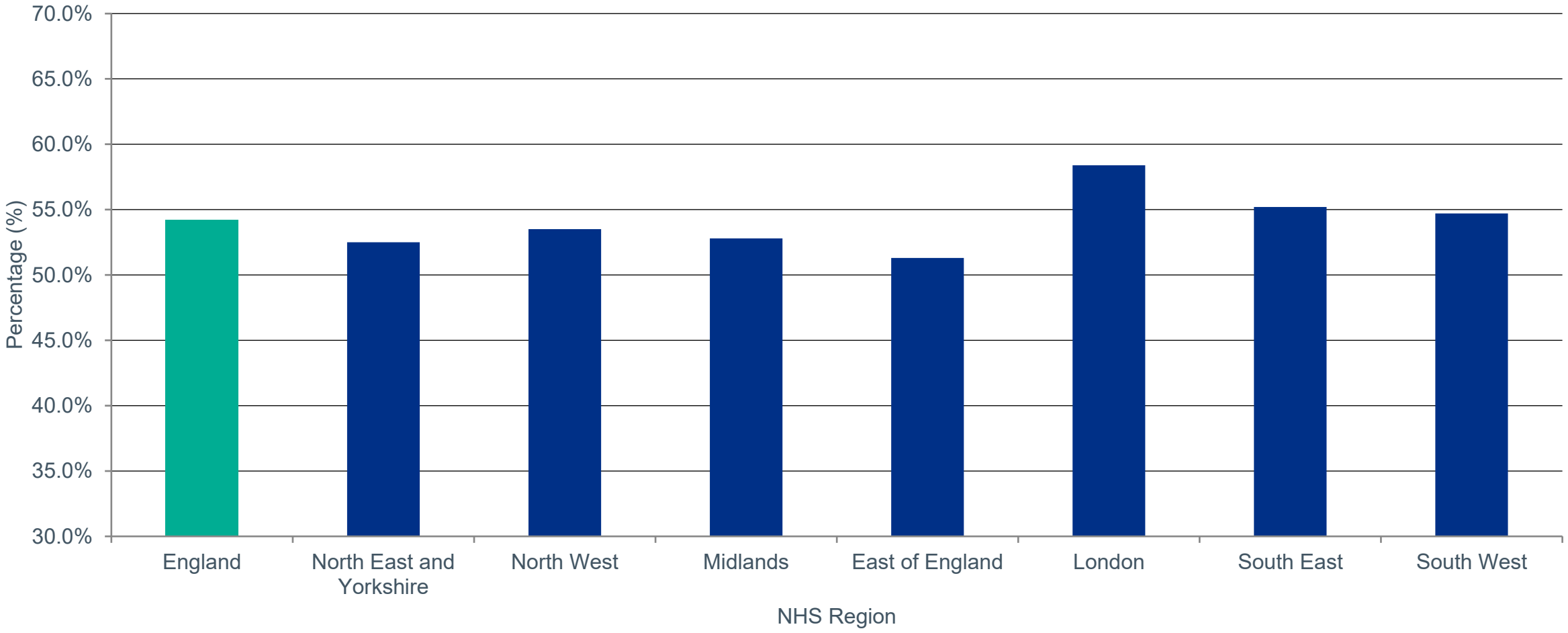
Source: NHS Staff Survey 2025, Q3f (Q4d in 2020) able to make improvements

Staff: able to make improvements

Experience of care | Tier 3: Process indicator | ↑ Higher is better

Proportion of NHS staff who agreed they are able to make suggestions to improve the work of their team or department (NHS Staff Survey, Q3f).

Figure 3.69: Staff: able to make improvements by NHS Region



Source: NHS Staff Survey 2025, Q3f (Q4d in 2020) able to make improvements

NHS sickness absence rate

Experience of care | Tier 3: Process indicator | ↓ Lower is better

NHS sickness absence rate in England, measured as the percentage of full-time equivalent (FTE) days lost to sickness absence across all NHS trusts, from NHS Digital monthly sickness absence statistics.

Why it matters for the strategy

• We track workforce sickness absence because sustained high absence erodes the capacity and morale of clinical teams and is both a consequence and a predictor of poor staff engagement. The current trend is deteriorating, with absence rates remaining elevated post-pandemic.
• The latest figure for England (Feb 2026) is 5.4%.
• This is getting worse: increased from 4.8% (Apr 2024) to 5.7% (Jan 2026).
• Mental health-related absence is the largest category (>25% of days lost).
• Performance varies across NHS Regions: the best-performing area (London) had a rate of 4.9%, while the worst (North West) had 6.1%.
• This is a workforce wellbeing signal.

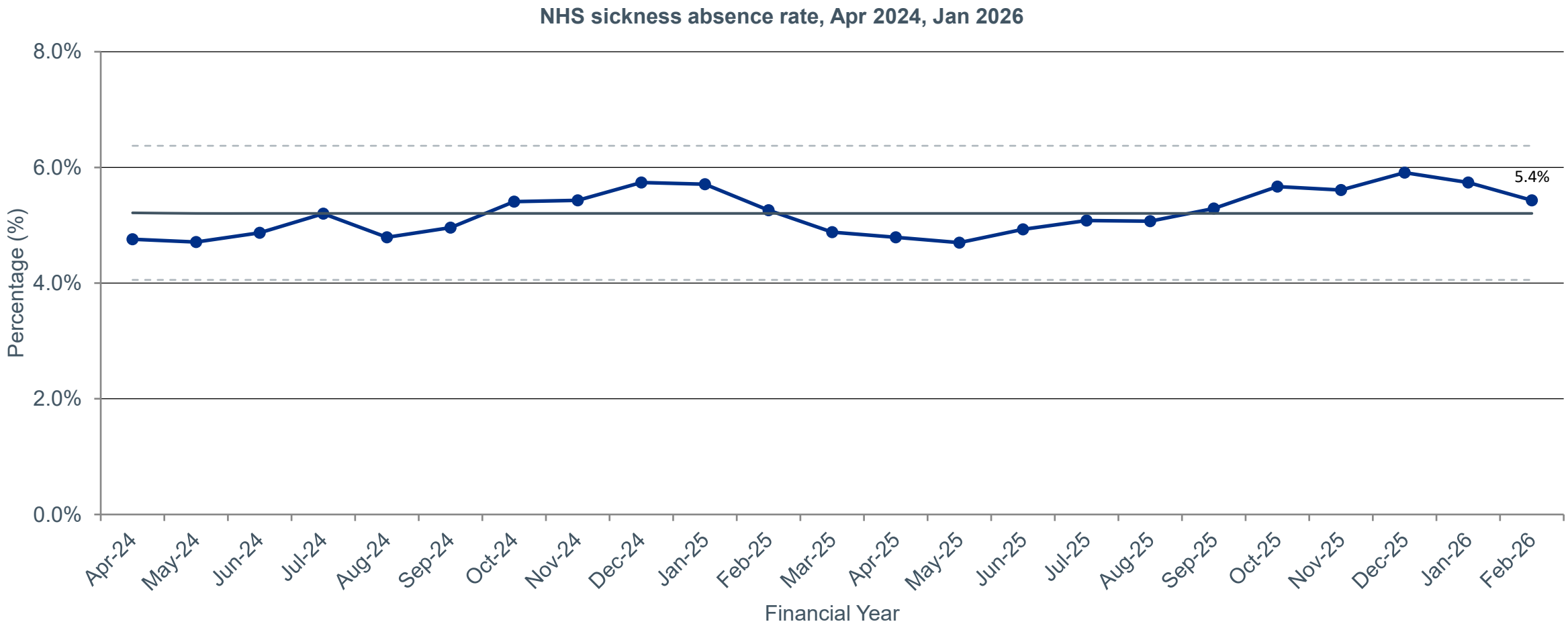
Source: NHS Digital, NHS Sickness Absence Rates | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

NHS sickness absence rate

Experience of care | Tier 3: Process indicator | ↓ Lower is better

NHS sickness absence rate in England, measured as the percentage of FTE days lost to sickness absence across all NHS trusts, from NHS Digital monthly sickness absence statistics.

Figure 3.70: NHS sickness absence rate: England trend



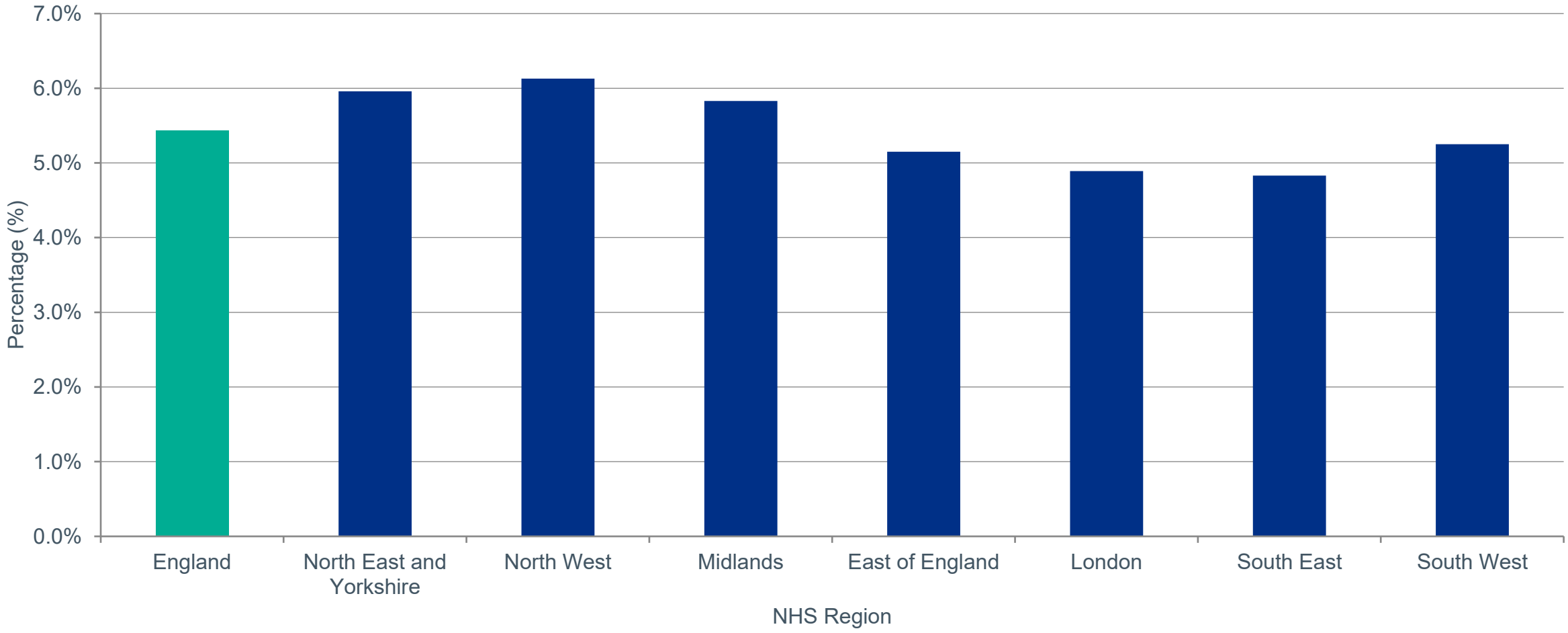
Source: NHS Digital, NHS Sickness Absence Rates | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

NHS sickness absence rate

Experience of care | Tier 3: Process indicator | ↓ Lower is better

NHS sickness absence rate in England, measured as the percentage of FTE days lost to sickness absence across all NHS trusts, from NHS Digital monthly sickness absence statistics.

Figure 3.71: NHS sickness absence rate by NHS Region



Source: NHS Digital, NHS Sickness Absence Rates | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

NHS workforce vacancy rate

Experience of care | Tier 2: Driver | ↓ Lower is better

NHS workforce vacancy rate in England, measured as the proportion of funded full-time equivalent (FTE) posts that are unfilled, from NHS Digital Vacancy Statistics (experimental statistics).

Why it matters for the strategy

• We track NHS vacancy rates because, despite improvement from April 2023 to March 2024 to April 2025 to March 2026, workforce gaps remain a constraint on service delivery, and the pattern of vacancies by staff group and region reveals where capacity is most limited.
• The latest figure for England (December 2025) is 6.5%.
• This is getting better: 6.5% vacancy rate in Q4 April 2025 to March 2026, down from 8.9% peak in Q1 April 2023 to March 2024.
• Performance varies across NHS Regions: the best-performing area (North East and Yorkshire) had a rate of 5.3%, while the worst (London and Midlands) had 7.1% each.
• The pattern by staff group and region is what shows where capacity is most limited.
• 10-Year Workforce Plan outcome. Directly affects access and experience.
• Tier 2 driver - the modifiable lever the strategy expects to move within the Modern Service Framework or pathway redesign window.

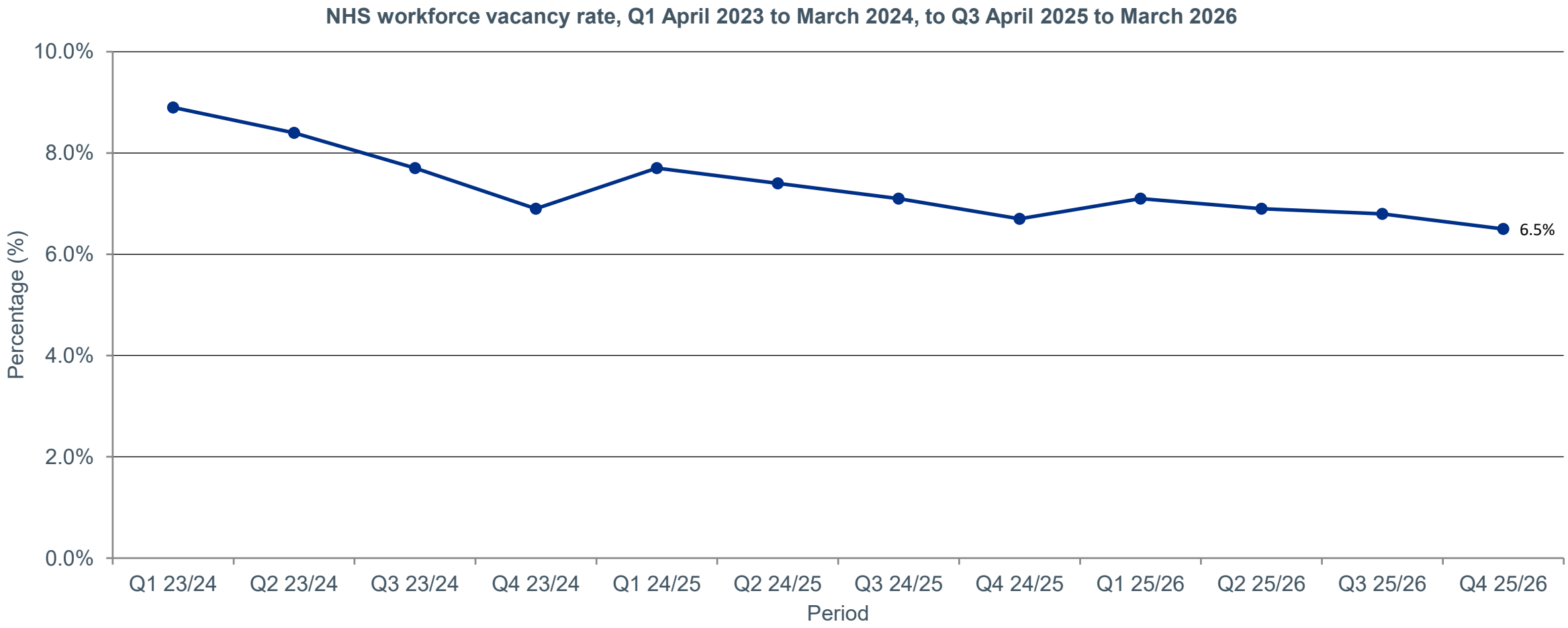
Source: NHS Digital, NHS Vacancy Statistics, December 2025 (published Feb 2026). Experimental Statistics

NHS workforce vacancy rate

Experience of care | Tier 2: Driver | ↓ Lower is better

NHS workforce vacancy rate in England, measured as the proportion of funded FTE posts that are unfilled, from NHS Digital Vacancy Statistics (experimental statistics).

Figure 3.72: NHS workforce vacancy rate: England trend



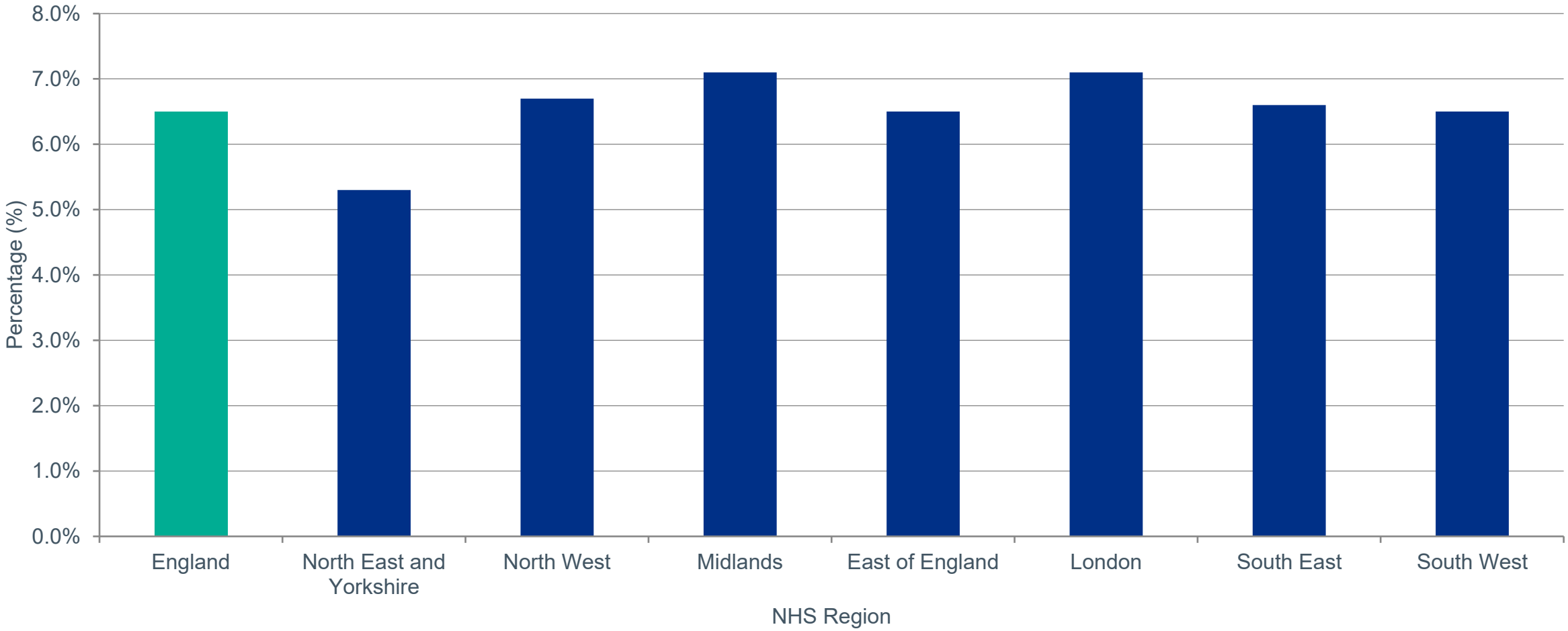
Source: NHS Digital, NHS Vacancy Statistics, December 2025 (published Feb 2026). Experimental Statistics

NHS workforce vacancy rate

Experience of care | Tier 2: Driver | ↓ Lower is better

NHS workforce vacancy rate in England, measured as the proportion of funded FTE posts that are unfilled, from NHS Digital Vacancy Statistics (experimental statistics).

Figure 3.73: NHS workforce vacancy rate by NHS Region



Source: NHS Digital, NHS Vacancy Statistics, December 2025 (published Feb 2026). Experimental Statistics

GP leaver rate

Experience of care | Tier 3: Process indicator | ↓ Lower is better

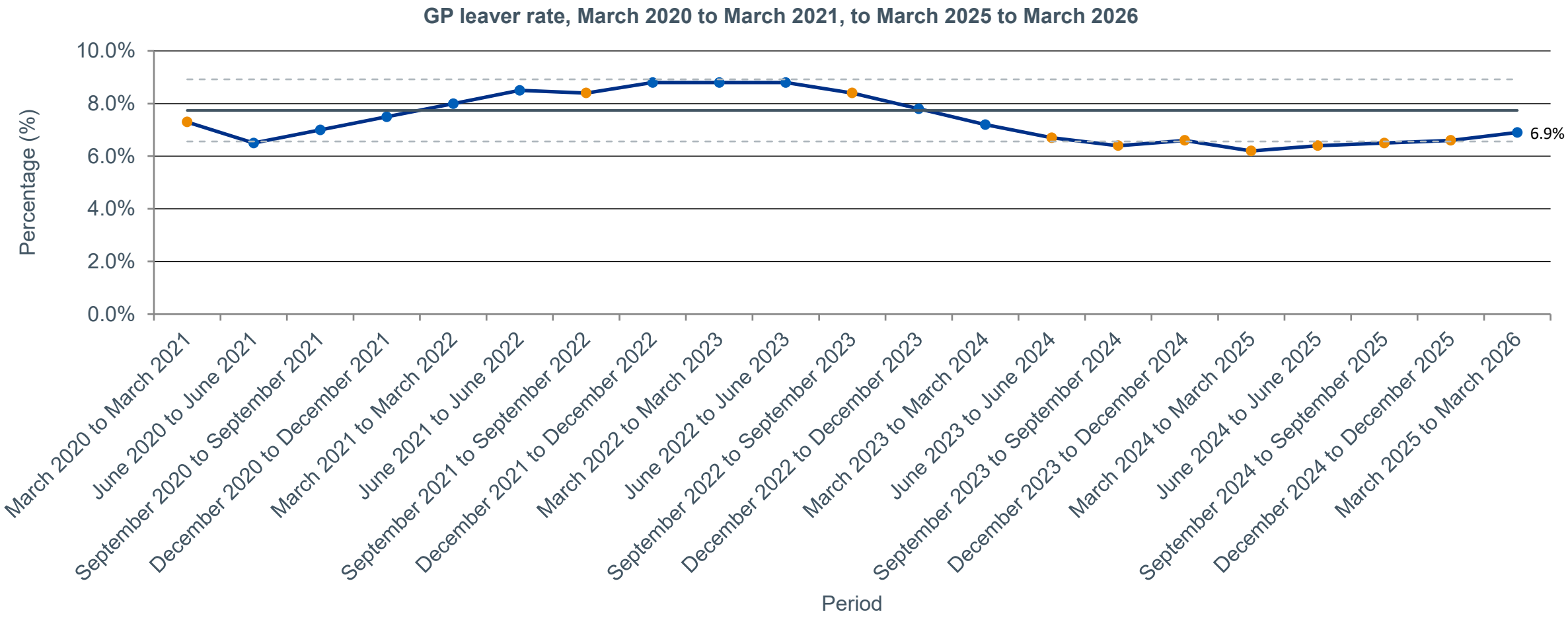
Rate of GPs leaving the profession (annual rolling).

Why it matters for the strategy

• The latest figure for England (March 2025 to March 2026) is 6.9%.
• This is a mixed picture, with a decrease in March 2025 to March 2026 compared to pandemic March 2020 to March 2021.
• A sensitive indicator of primary-care workforce sustainability, and the strategy explicitly ties workforce capacity to delivery, particularly for long-term conditions and prevention.
• Primary-care workforce sustainability signal. 10-Year Workforce Plan commitment.

Source: NHS Digital GP Workforce, Joiners and Leavers | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.

Figure 3.74: GP leaver rate: England trend



Source: NHS Digital GP Workforce, Joiners and Leavers | Statistical process control (SPC) chart: grey line shows the mean, grey dashed lines show control limits (3 standard deviations above and below the mean), orange dots show special cause variation.