

*LCP on point* 

# *Going swimmingly or treading water: Is the Elective Recovery Plan bringing down NHS waiting lists?*

March 2023





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## Executive Summary

In 2021, we revealed that the total NHS waiting list was not just the 5.8 million that the official figures showed, but also included an estimated 7.8 million people who were yet to come forward for care – the so-called hidden need that had arisen due to various Covid-19-related reasons. We also demonstrated that the problem was not equally distributed across England.

As the impacts of the Covid-19 pandemic on health-seeking behaviour recede, attempts to bring down the record-breaking numbers of people waiting for treatment have been ramping up. The NHS Elective Recovery Plan (ERP), launched in February 2022, is intended to make a major contribution to reducing waiting lists. It is now time to assess if the ERP is already making a difference, and how this may play out in the future. Our key findings include:

- If the NHS and ERP achieve their targets, the official waiting list is expected to peak in March 2023, when there will be roughly 7.3 million patient pathways waiting for elective care, or one patient pathway for every eight people in England.
- However, if only 2/3 of the capacity uplift is achieved, the waiting list will peak at 7.9 million people in July 2023, and leave an additional two million waiting for NHS elective treatment by the end of 2025.
- These numbers may be underestimated given that there remains hidden need accrued during the Covid-19 pandemic. However, we are yet to see a sudden increase in those with hidden need coming forward for care.
- Combining waiting list figures with hidden need shows us that a much greater proportion of the population may have unmet health needs than official statistics indicate. If we are at the peak of total unmet health need for elective care (13.1 million people on the official waiting list and hidden need combined), that means 1 patient pathway for every 4 people in England needs care, adding extreme short-term pressure on the NHS.
- Our previous projections of the waiting list compared with actual waiting list data in 2022 differed by only 1.4%, indicating their robustness.
- There is some good news for the NHS – over the course of 2022 the longest waiting times, those waiting over two years, in most regions and specialities have been coming down – but so far, this represents only the low-hanging fruit.
- Despite progress, the waiting list is still increasing overall and geographical and speciality specific problems remain. For gynaecological care there is an 18-fold difference between the Integrated Care Systems (ICSs) with the greatest and smallest waiting lists after adjusting by population.



- Unmet need is not only a personal problem for those who should be seeking treatment, it is also a political problem. Constituencies won by the Conservatives from Labour in the 2019 general election are concentrated in the North West and Midlands where unmet need is far above that of the national average.
- The ERP is ambitious in its targets for increasing NHS treatment capacity. By projecting a range of scenarios, we show how waiting lists and unmet need will be impacted over the coming years if those targets are not achieved.

Our report highlights that waiting lists still show geographical and clinical inequalities. Whilst the ERP is a national strategy, policymakers and healthcare leaders must stay true to their commitment to 'level-up every area'. They must recognise inequities both regionally and clinically across waiting lists, and target resources and support more equitably or risk exacerbating inequalities further.



## Key terms & NHS structure

- **ERP:** [Elective Recovery Plan](#)
- **Hidden need:** The cumulative reduction in RTTs during the pandemic relative to the referral rates seen in the year prior to the pandemic. These are people that are in need of care but have not yet come forward to receive care.
- **ICB: Integrated Care Boards** are part of each ICS and hold the responsibility for planning NHS services that were previously held by Clinical Commissioning Groups until July 2022.
- **ICS: Integrated Care Systems** bring together health care organisations across England to deliver care locally. There are 42 ICSs in total.
- **PREMS: Patient Reported Experience Measures**
- **RTTs:** Referrals to treatment, occur when a person seeking care enters the NHS (most often through primary care) and is referred to another part of the healthcare system. One person can have multiple RTTs for different health needs.
- **Sub-ICB: Sub-integrated care boards** have replaced the 106 Clinical Commissioning Groups. Sub-ICBs have less of a functional role yet retain some usefulness in providing a more granular breakdown of ICSs.
- **Unmet need:** The sum of the waiting list (the known need) and the hidden need at a given point in time.
- **Waiting list** and **Total incomplete pathways** are the number of patients who have been referred for treatment and are waiting to start treatment at the end of any given month. These terms are used interchangeably in this report; however, it should be noted that one patient can have multiple incomplete pathways at any given point in time.



# 01 Introduction

Elective waiting lists have risen to record numbers since the pandemic. Our [2021 report](#) highlighted a total of **5.8 million** people on the waiting list and a further **7.8 million** people with potential hidden health needs as at September 2021. This increase in waiting lists is a persistent, indirect effect of the pandemic.

Covid-19 cases and deaths have declined in England since January 2022, falling from 178,000 daily cases and 202 daily deaths, to 2,800 daily cases and less than 40 daily deaths in November 2022<sup>1</sup>. However, waiting lists have continued to increase. As the direct impact of the pandemic lessens, government focus has been to limit the indirect impacts felt from the disruption and delays to treatment during the pandemic.

Tackling the elective backlog has consistently remained a key issue for policy makers, despite significant changes in government leadership and NHS structure over the past year. During her appointment as Health Secretary from September-October 2022, Therese Coffey outlined four priority 'ABCD' areas: Ambulances, Backlogs, Care, and Doctors and Dentistry. The incumbent Health Secretary, Steve Barclay, has suggested that cutting ambulance waiting times and reducing delayed discharge, thus freeing up NHS beds, should be key priorities.<sup>2</sup>

In February 2022 the Government launched the Elective Recovery Plan (ERP), which aimed to address the backlog by introducing 100 diagnostic centres and additional surgical hubs to help clear high volume routine surgeries. Through these interventions, the ERP aimed to increase elective capacity by 30% by 2024/25 compared to pre-pandemic levels.

In our 2021 report, we projected the waiting list to 2025 under a number of scenarios to determine how those on the waiting list and those still to come forward ('hidden need') may change over time depending on how a 30% uplift in capacity was managed. We concluded that those on the waiting list plus hidden need could peak at 15.5 million in 2023 without the implementation of the ERP, 2.5 million more people than estimates by the Department of Health and Social Care, assuming all hidden need patients are referred to the waiting list.

In this report we set out:

- how the national waiting list has changed over the year and the impact of the ERP;
- inequalities in the waiting list by speciality and geography and how the ERP has thus far impacted regions differently; and
- our projections past and future - how our previous projections compared to 2022's waiting list and what our projections are to 2027 in light of over a years' worth of new data being available.

<sup>1</sup> [Cases and deaths in England | Coronavirus in the UK \(data.gov.uk\)](#)

<sup>2</sup> [Urgent and Emergency Care - Hansard - UK Parliament](#)



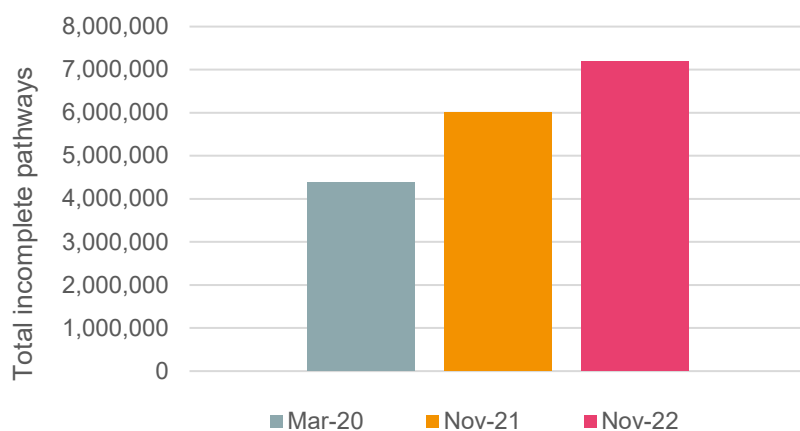
## 02 The elective recovery plan shows reasons for optimism, but the largest challenges still lay ahead

### Number of people needing treatment continues to increase

NHS elective waiting lists have continued to increase since 2021, with largely consistent increases month on month (only October and November 2022 showed decreases from the previous month). In November 2022, there were 7,185,000<sup>3</sup> <sup>4</sup> people waiting for elective care (Figure 1), compared to 5,995,000 in November 2021, thus the waiting list had increased by 20% since November 2021, compared to the previous change from 2020 to 2021 of 32%.

Throughout this report we refer to the number of ‘people’ waiting for care; however, this is more accurately described as the total number of incomplete pathways. These terms are used interchangeably here but a key nuance is that one person can have multiple simultaneous incomplete pathways. Recently, the NHS has begun to publish national level estimates of waiting lists including ‘missing data’, using estimates for NHS organisations that did not submit data for a given month. Our national figures include these estimates, but as these are not available at provider, commissioner, or speciality level, all other figures do not include the missing data estimates.

Figure 1. Total number of incomplete pathways on the waiting list for NHS elective care for all specialities in March 2020, November 2021 and November 2022.



<sup>3</sup> Figures account for non-reported data through NHS estimates and therefore are higher than the aggregate reported for sub-ICBs, regions and ICSSs.

<sup>4</sup> All data is sourced from [NHS Consultant-led Referral to Treatment Waiting Times Data](#)



The true number of patients requiring care may be even higher. Hidden need, a key focus of our previous waiting list report, concerns those who may not have joined the elective waiting list during the pandemic, either through fear of contracting Covid-19 and delaying seeking healthcare or due to challenges in securing appointments to enable the onward referral.

Whilst the 'known' waiting list has increased at a steady rate over the past year, we estimate that there has been a decrease in the stock of hidden need. With new referrals to treatment levelling off at rates comparable to, if slightly below, pre-pandemic levels, we have assumed that, since May 2022, all new patients needing care are now coming forward for treatment, i.e. there is no further new hidden need. The estimated decrease in hidden need is due to existing patients with hidden need starting to come forward for treatment, as well as natural attrition factors such as death, recovery or seeking private care.

We have made two updates to our calculation of both historical and projected hidden need since our previous report:

1. We have tapered the amount of new monthly hidden need from October 2021 to zero in May 2022, to reflect new RTTs levelling out close to pre-pandemic levels during this period.
2. We have assumed 50% of the hidden need will leave the hidden need state without seeking NHS treatment. This reflects that many patients with hidden need may no longer need care, have sought care elsewhere or have died. This also reflects the fact that we have not observed any early signs of the large increase in new RTTs compared to pre-pandemic levels that would have been expected if 100% of those with hidden need were to return to seek NHS care.

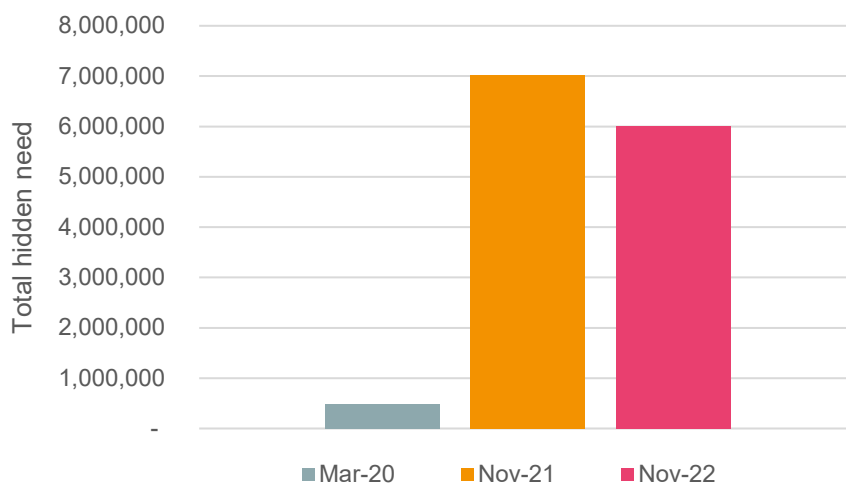
These updates are described in more detail in the Appendix.

Under our updated methodology, in November 2022 there were an estimated 6.0 million people with hidden need (Figure 2), compared with 7.0 million in November 2021 – a fall of 15%. This contrasts with a 32% increase in hidden need from November 2020 to November 2021 and reflects existing patients with hidden need who are likely starting to come forward for treatment.





Figure 2. Estimated total hidden need for all specialities in March 2020, November 2021 and November 2022.



### Has the ERP impacted the waiting list so far?

The ongoing backlog and increasing number of people waiting has, more than ever, underlined the importance of delivering the ERP as it was proposed in February 2022. A year later, there is opportunity to assess how well the ERP has been implemented thus far. The measure of success can be looked at through three different lenses:

- how many people are on the waiting list;
- how many people have been waiting against targets at key dates outlined in the ERP:
  - eliminating 2 year waits by July 2022
  - eliminating waits over 18 months by April 2023
  - eliminating waits over 65 weeks by March 2024
  - reducing waits over 1 year
  - reducing waits over 18 weeks; and
- what patient reported experience measures (PREMs) have been like whilst on the waiting list.

Data for the first two measures of success are published by the NHS, however data for PREMs specifically relating to NHS waiting lists are less readily available for analysis.

The large increase in the number of people waiting for elective care might initially suggest that the ERP is yet to take effect; however, a more granular look at waiting times shows some movement in the right direction. The ERP specified a logical focus on clearing those who have been waiting the longest first, i.e. those who have been waiting more than two years; the aim was to eliminate two-year waits (barring where the patient has chosen to wait) by July 2022.

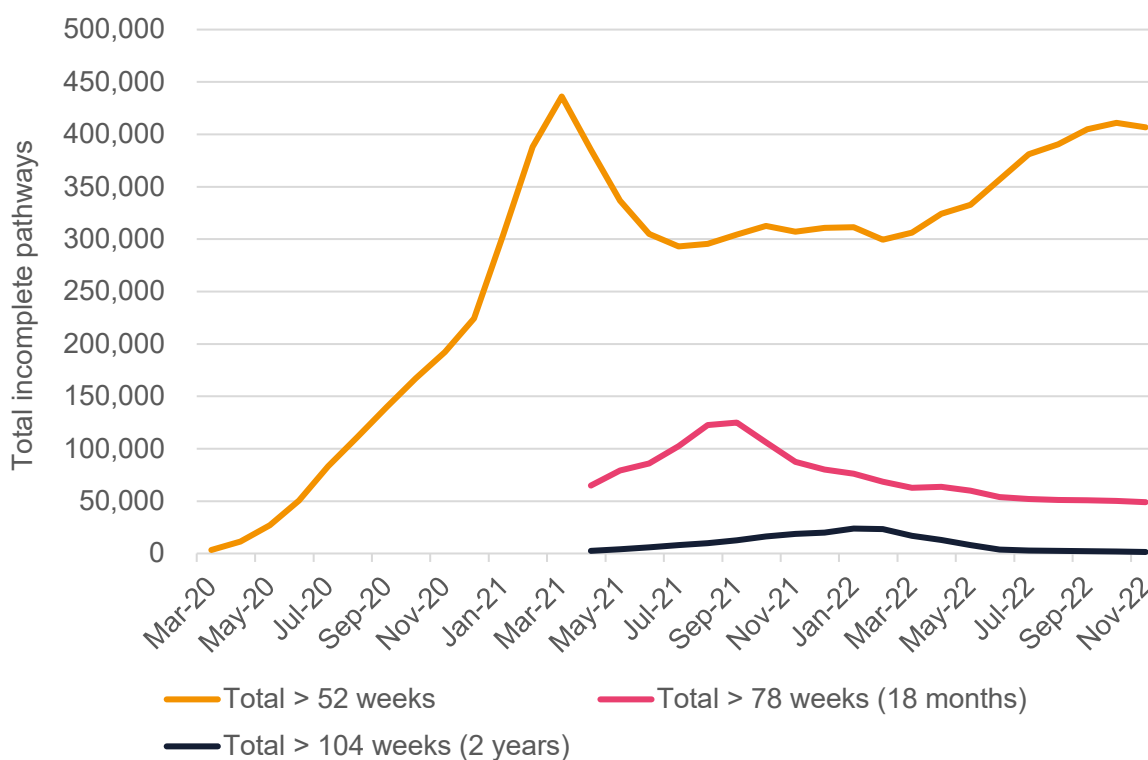
The number of people waiting two years for elective care peaked at 24,000 in January 2022 (Figure 3), following a steady increase from April 2021 (42 per 100,000 people). Since this peak and the publication of the ERP, there has been a sharp decrease and then plateau during the summer of 2022, with only 1,300 (2 per 100,000 people) waiting two years for elective care in November 2022.



Many of those still waiting longer than two years are concentrated around the South West, with the region responsible for 40% of patients nationally in November 2022. A closer look within the South West reveals that two ICBs in particular, NHS Devon and NHS Cornwall and Isles of Scilly, account for the vast majority (91%) of waits longer than two years in the region. Yet even for these ICSs, the numbers waiting longer than two years for elective care have been dropping over the course of 2022, pointing to progress.

Elsewhere in the country waits longer than two years have been completely or nearly eliminated. In the South East, the region with the lowest number of patients waiting longer than two years for treatment (accounting for 3% nationally in November 2022), there are three sub-ICB areas (NHS Frimley, NHS Hampshire, Southampton and Isle of Wight, and NHS Berkshire West) with no patients waiting over two years in November 2022. This has been a clear win for the NHS and the ERP and has been the result of efficient planning and use of capacity.

Figure 3. Total incomplete pathways more than 52, 78 and 104 weeks in England for All specialties from March 2020 – November 2022. Note that NHS only started publishing 78 week and 104 week wait data from April 2021.



The next steps will be to progressively cascade down the waiting time targets, with efforts now being focused on clearing people who have been waiting over 18 months for elective care (pink line in Figure 3). There already appears to be progress towards this next milestone. Since the launch of the ERP, the number of people waiting more than 18 months has decreased by 29%, from 65,000 in February 2022 to 49,000 in November 2022. While this demonstrates progress, there is more still to be done over the coming months if the ERP target of the NHS eliminating 18-month waits by April 2023<sup>5</sup> is to be achieved.

<sup>5</sup> [NHS England » NHS publishes electives recovery plan to boost capacity and give power to patients](#)



Reducing the waiting list for those waiting over a year is likely to take longer. Currently 407,000 people, or 5.7% of the waiting list have been waiting more than a year. Reducing this figure will require a large step change in approach to make similar gains as for those waiting longer. Since the launch of the ERP the number of people waiting more than one year (Figure 3) has increased 36% from 299,000 to 407,000. More recently this number has begun to decrease, which may reflect the impact of the ERP, but it remains to be seen if this is to continue.

The final milestone, those waiting longer than 18 weeks for elective care, is significant as it is mandated that this should be the maximum waiting time for non-urgent, consultant-led treatments. The 18-week wait time target has become further out of reach for many patients over the previous year. There has been a 26% increase in the number of people waiting longer than 18 weeks for elective care since the launch of the ERP, from 2,312,000 in February 2022 to 2,902,000 in November 2022. Whilst the ERP currently focuses on those waiting longest in the 1-year, 18-month and 2-year categories, we may not be able to appraise how the ERP has affected the NHS' ultimate aim of reducing waiting times to 18 weeks until 2025.



## 03 *Inequalities in the waiting list persist*

Our previous report and analysis conducted with the Royal College of Obstetricians and Gynaecologists (RCOG) highlighted the widespread inequalities in waiting list numbers by speciality and geographically. We have quantified these inequalities in 2022 and reviewed how the ERP has impacted areas differently.

### **Speciality focus: Inequalities in Orthopaedic and Gynaecology waiting lists**

We have focused on orthopaedics and gynaecology because:

- orthopaedics has consistently had the greatest number of people on the waiting list; and
- gynaecology has had the greatest percentage increase in its waiting list since the beginning of the pandemic, with clear impacts on gender equality. Furthermore, the Government has highlighted the need for a focus on gynaecological healthcare in its Women's Health Strategy for England published in August 2022.<sup>6</sup>

### **Orthopaedics**

Whilst waiting for care, orthopaedic patients can experience severe pain, and lose mobility, independence and ability to work. The [British Orthopaedic Association has welcomed](#) the addition of surgical hubs in the ERP, which will help to increase capacity for orthopaedic operations. Orthopaedics is the clinical speciality with the largest population-adjusted waiting lists, with 1,386 per 100,000 people in November 2022, an increase of 60% since March 2020, highlighting it as a speciality requiring specific resource allocation.

In November 2022, 7.4% of those waiting for orthopaedic care had been doing so for more than 52 weeks, although this figure has halved from its peak in March 2021. Despite improvements over the previous year in those waiting longer than 52 weeks for care, 7.5% of those currently waiting for orthopaedic care translates to over 59,000 patients.

The median waiting time for orthopaedic care has been relatively stable, fluctuating roughly between 15 and 16 weeks for care over the course of 2022. This is down from peaks in median waiting times of 24 weeks in August 2020 and 18 weeks in March 2021.

When looking at waiting lists by ICB area, there was a 13-fold difference between the ICB areas with the greatest and lowest waiting lists per 100,000 (NHS Shropshire, Telford and Wrekin with 2,629 per 100,000, and NHS Frimley with 199 per 100,000).

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<sup>6</sup> [Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](#)



## Gynaecology

We helped to highlight how gynaecological waiting lists have been disproportionately affected by the Covid-19 pandemic when providing analysis for the RCOG [waiting list report](#) published in April 2022. In early 2023, updated analysis shows that gynaecological care remains disproportionately affected – with clear implications for gender inequality on NHS waiting lists.

As of November 2022, gynaecological waiting lists have increased from 489 per 100,000 people across England in March 2020 to 963 per 100,000, representing a near 100% increase since the beginning of Covid-19. Not only are more patients waiting for gynaecological care, but they are also waiting longer. The median time waiting whilst on the list for gynaecological care was 15.4 weeks by November 2022, an increase from 8.7 weeks in March 2020, at the beginning of the pandemic.

When looking at waiting lists by ICB area, there is an 18-fold difference between the ICB area with the greatest and lowest waiting lists per 100,000 (NHS Greater Manchester with 1,471 per 100,000, and NHS Frimley with 81 per 100,000).

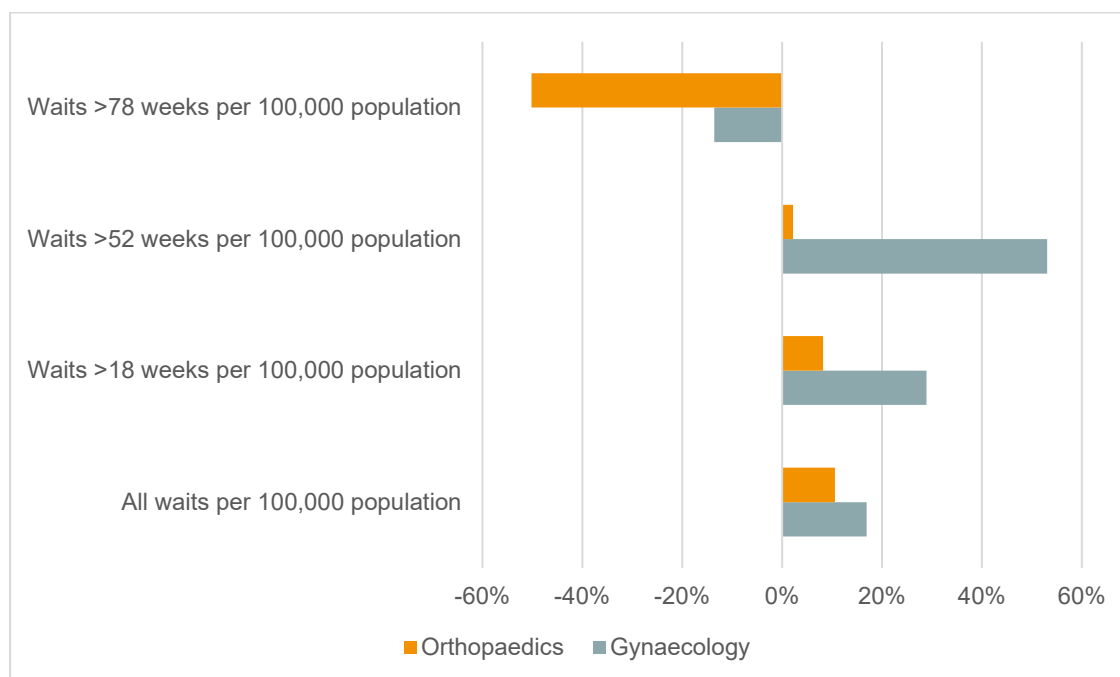
### Speciality focus: Has the ERP impacted specialities equally?

Both orthopaedics and gynaecology have observed a decrease in the number of people waiting more than 18 months per 100,000. However, both specialities have observed an increase in the number of people waiting more than 52 weeks, 18 weeks and in total per 100,000.

Figure 4 may indicate that the ERP has been particularly well implemented in orthopaedics when compared to gynaecology. Orthopaedics has not only observed greater relative improvements in those waiting longer for care than gynaecology (waiting >78 weeks), but it has also seen a lower relative increase in shorter waiting time targets (1 year and 18 weeks). Gynaecology has seen a pronounced increase in those waiting longer than 1 year for elective care, with a 53% increase after adjusting for population since implementation of the ERP. Going forward, resource allocation should be focused on unmet need to allow equity within the waiting list. Our analysis shows there is still much to do to realise aspirations set out in the ERP, yet these need to balance other strategic aims that aim to reduce inequalities, such as those set out in the Women's Health Strategy.



Figure 4. The percentage change in the number of incomplete pathways per 100,000 by weeks waiting between February 2022 and November 2022. Note that >104 weeks wait data is not available by speciality



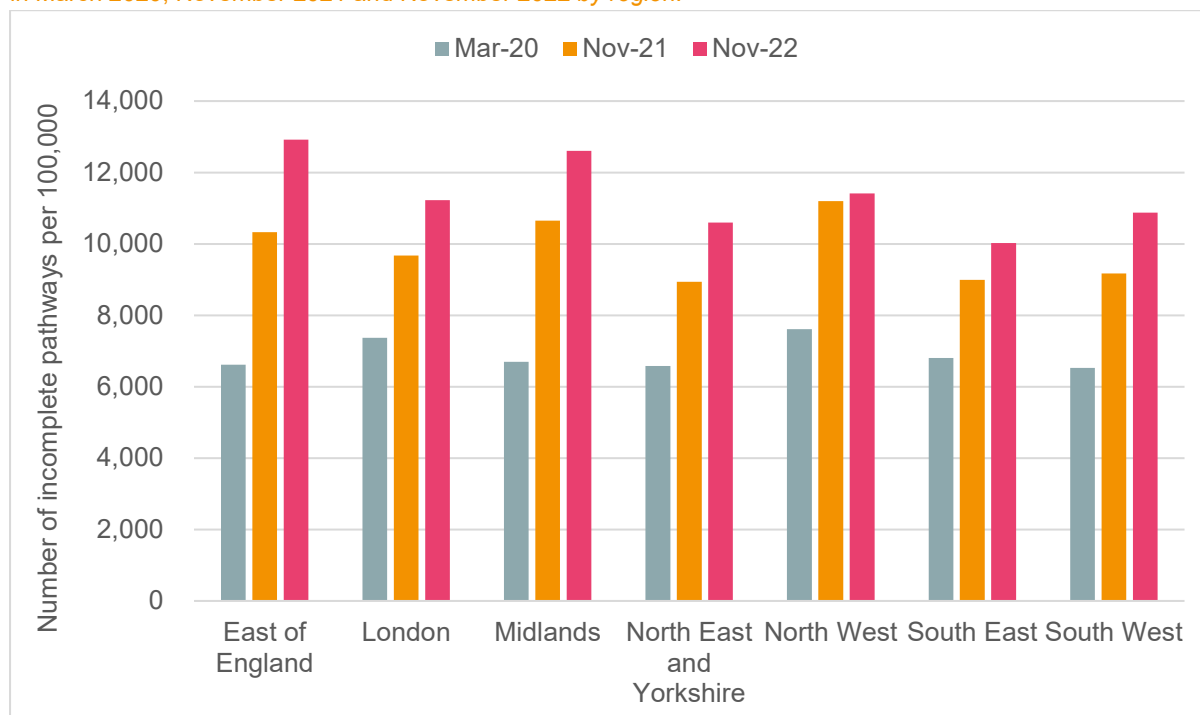
### Regional focus: Regional inequalities have widened over the year

In November 2021, the regions with the most and fewest people on the waiting list after adjusting for population size were the North West (11,199 per 100,000 people) and the North East (8,941 per 100,000 people). Thus there were over 25% more people on the waiting list in the most affected region than the least affected.

One year on, rather than bridging the gap, geographical inequalities in waiting lists appear to be more pronounced. In November 2022, the most and least affected regions were the East of England (12,918 per 100,000 people) and the South East (10,022 per 100,000 people), giving a 29% difference in the number of people waiting in the most and least affected region.



Figure 5. Total number of *incomplete pathways per 100,000* on the waiting list for NHS elective care for all specialities in March 2020, November 2021 and November 2022 by region.



One driver of this inequality may be to what extent referrals to the independent service sector are being utilised. In January 2022 [it was announced](#) that the NHS had struck a deal with the independent services (IS) sector as part of the national Covid-19 response. A three-month agreement was made with multiple independent service providers to provide surge capacity in the event of an Omicron strain outbreak.

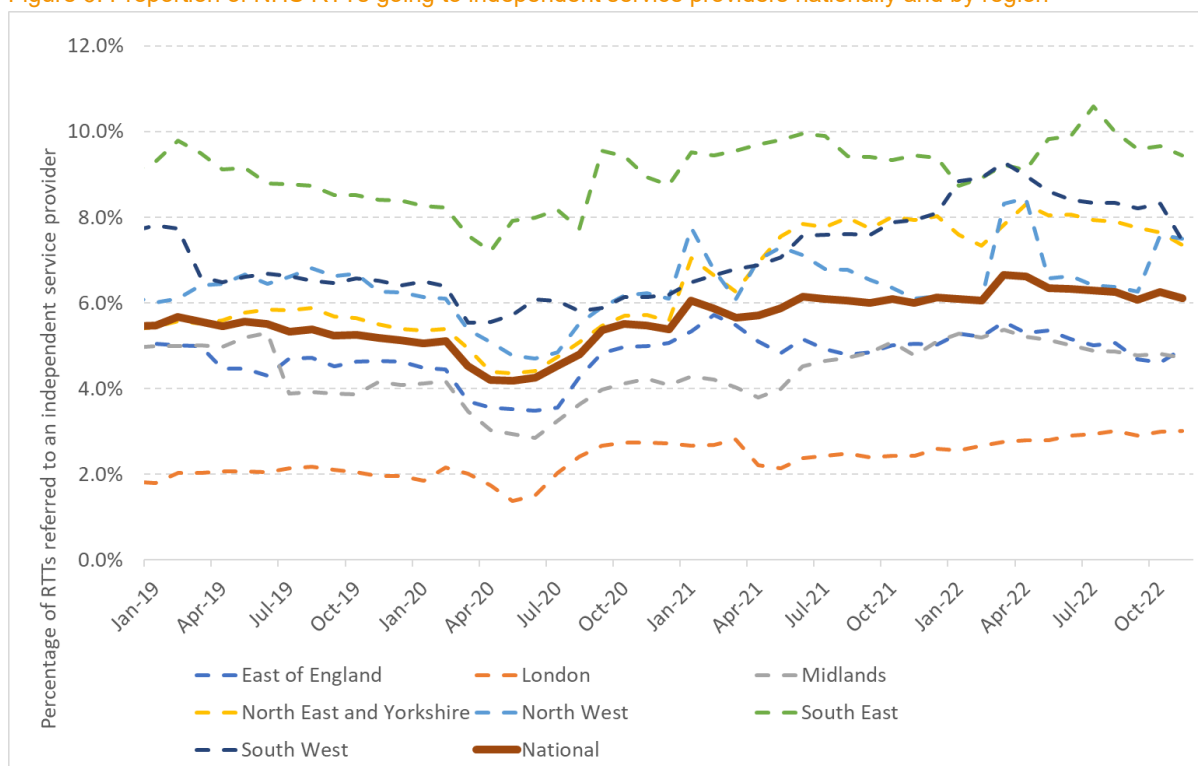
Following the January 2022 IS sector deal, there was a notable increase in use of independent service providers nationally from February 2022 (see Figure 6). Most regions experienced an increase, with this being particularly acute in the North West, before dropping off.

Both the South East and South West, regions with lower than national average population adjusted waiting lists, observed more NHS referrals to the IS sector than other regions over the course of 2022.

The IS sector has played an important part in providing surge capacity for Covid-19 related referrals. However, the NHS should be aware of the additional costs to regions where referral to the IS sector is higher in the future.



Figure 6. Proportion of NHS RTTs going to independent service providers nationally and by region



### Regional focus: How the ERP has been rolled out regionally

The effect of the ERP on long waits varies by region (Figure 7). All regions have had substantial reductions in the number of people per 100,000 waiting longer than two years for all specialities since the implementation of the ERP. The reduction in two-year waits in the South West since February 2022 is notably smaller than the other regions, falling by 79% compared to at least 94% for all other regions.

There is wider regional disparity in the differences for those waiting more than 18 months for elective care, although all regions have seen a reduction. The Midlands has thus far only experienced a 20% reduction in those waiting over 18 months for care since the implementation of the ERP, by contrast the South East and London have experienced 51% and 49% reductions, respectively.

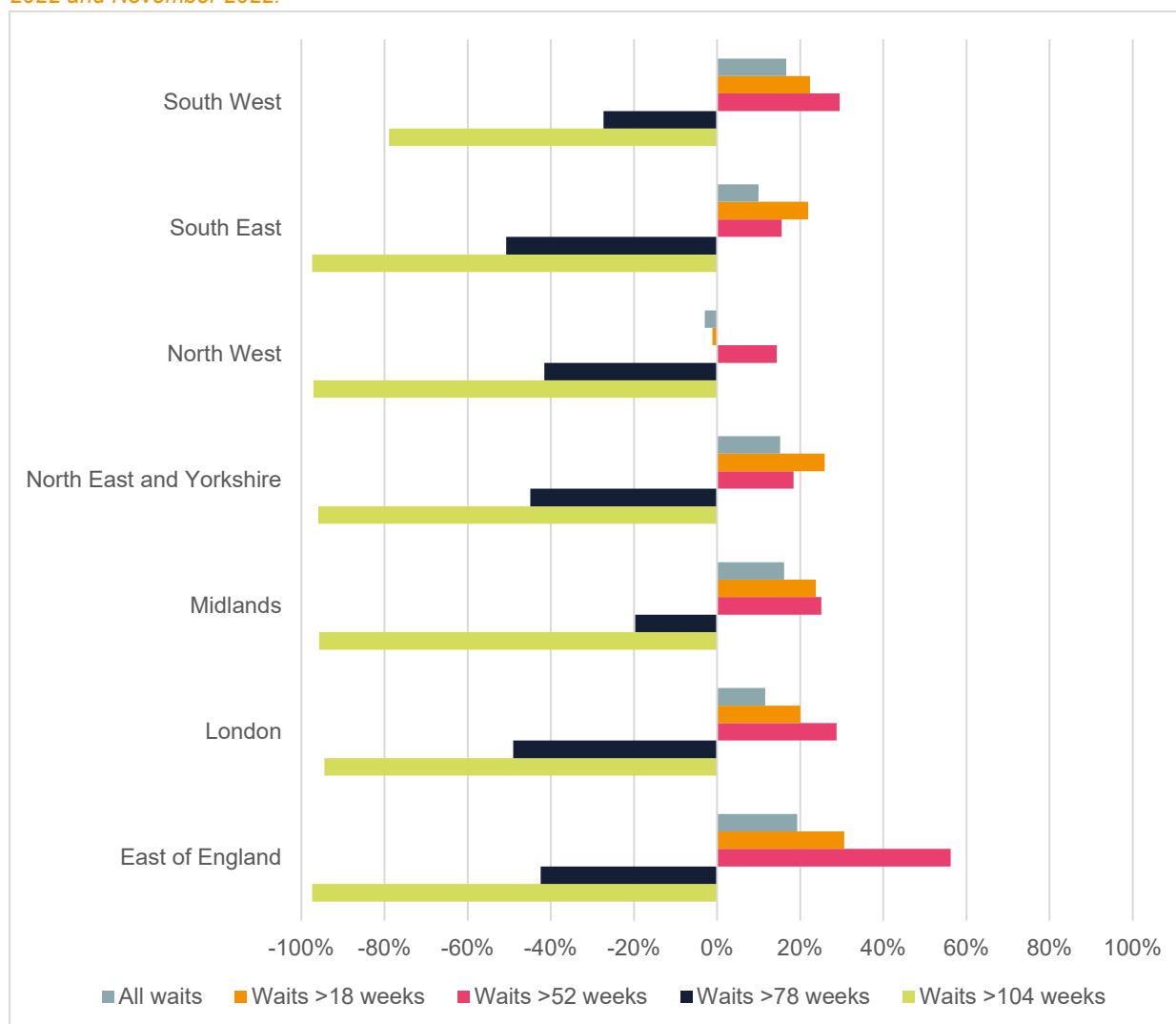
For waits longer than one year, all seven regions in England have experienced increasing number of patients after adjusting for population size. However, the East of England has had the largest increase since February 2022, at 56% compared to only 14% in the North West. Figure 7 appears to show that the ERP is affecting the North West favourably when compared to other regions (e.g. it is the only region with reduced number of overall incomplete pathways), however, it should be noted that Manchester University NHS Foundation Trust did not report waiting list data for October and November 2022, therefore likely underestimating the waiting list metrics in the North West for those months.





Regional disparities should be considered when allocating resources over the coming years to prevent widening inequalities. Whilst each ICS or locality within the different regions has its own health context and needs of its own population, sharing of best practices with other ICS or localities should be incentivised.

Figure 7. The percentage change in the population adjusted total number of incomplete pathways and the number of incomplete pathways waiting more than 18, 52, 78 and 104 weeks for all specialities by region between February 2022 and November 2022.



### Constituency focus: Unmet need is above national average in concentrated marginal constituencies in the ‘red wall’

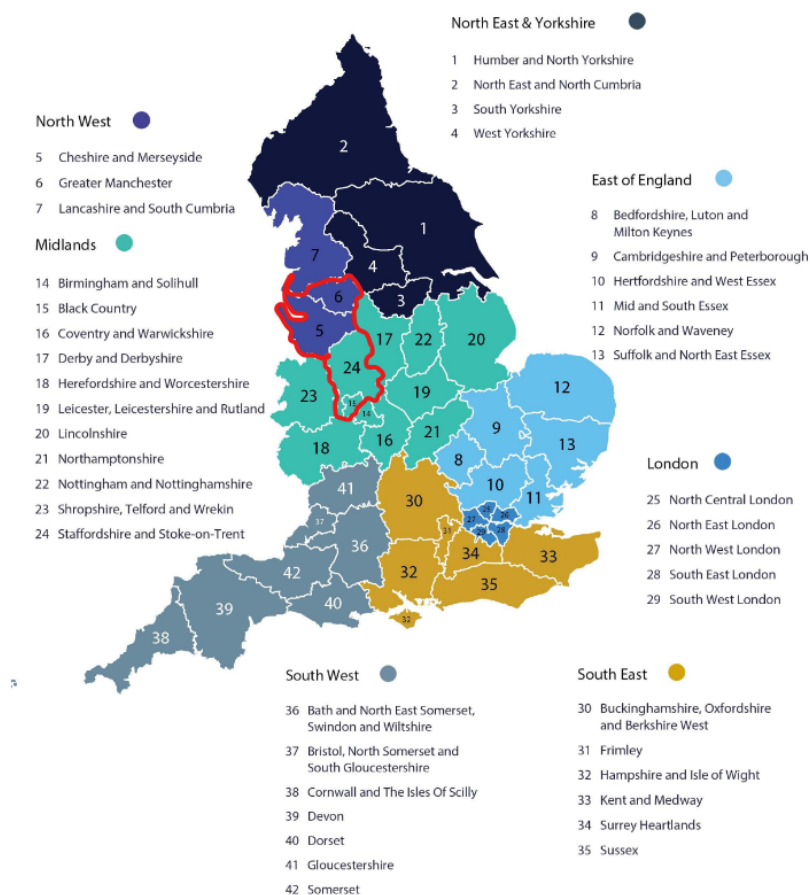
NHS pressures, and elective backlogs in particular, are likely to be a significant political issue in the run-up to the next general election, which is due no later than January 2025. On 4 January 2023, Rishi Sunak announced cutting NHS waiting lists and speeding up care for patients as one of his five pledges to deliver “peace of mind” to the public.<sup>7</sup> Meanwhile,

<sup>7</sup> [Rishi Sunak's five promises analysed - BBC News](#)

Labour’s shadow health secretary, Wes Streeting, has stated that he would be prepared to use private sector capacity to bring down NHS waiting lists.<sup>8</sup>

A significant driver of the large Conservative majority at the 2019 general election was the party’s ability to win ‘red wall’ constituencies in the Midlands and Northern England, which had historically supported the Labour Party. The Conservatives currently hold slender majorities in some of these constituencies, which is likely to make them key battleground seats at the next election. Of the ICBs with the most unmet need (the waitlist in addition to the hidden need) per 100,000 in November 2022, four out of the top six are clustered together across the North West and Midlands (see Figure 8). These ICBs are NHS Black Country (rank = 2nd most unmet need per 100,000), NHS Cheshire and Merseyside (rank = 4th), NHS Staffordshire and Stoke-on-Trent (rank = 5) and NHS Greater Manchester (rank = 6th).

Figure 8. Map of ICBs across England<sup>9</sup>. The ICB cluster highlighted in red makes up four out of the top 6 ICBs with unmet need per 100,000 people as of November 2022



Of the 42 English seats that the Conservatives won from Labour in the 2019 general election, 12 of these (29%) are found within the North-West/Midlands cluster with high amounts of hidden need (Table 1). These constituencies could prove to be pivotal in the upcoming general election given that most of these constituencies have had a historical preference for Labour and have seen a disproportionate amount of unmet health needs, above the national average, accrue during the most recent Conservative tenure.

<sup>8</sup> [Labour would use private providers to cut NHS waiting lists, says Streeting - BBC News](#)

<sup>9</sup> Map sourced from [Integrated care systems \(ICS\) | NHS Confederation](#)



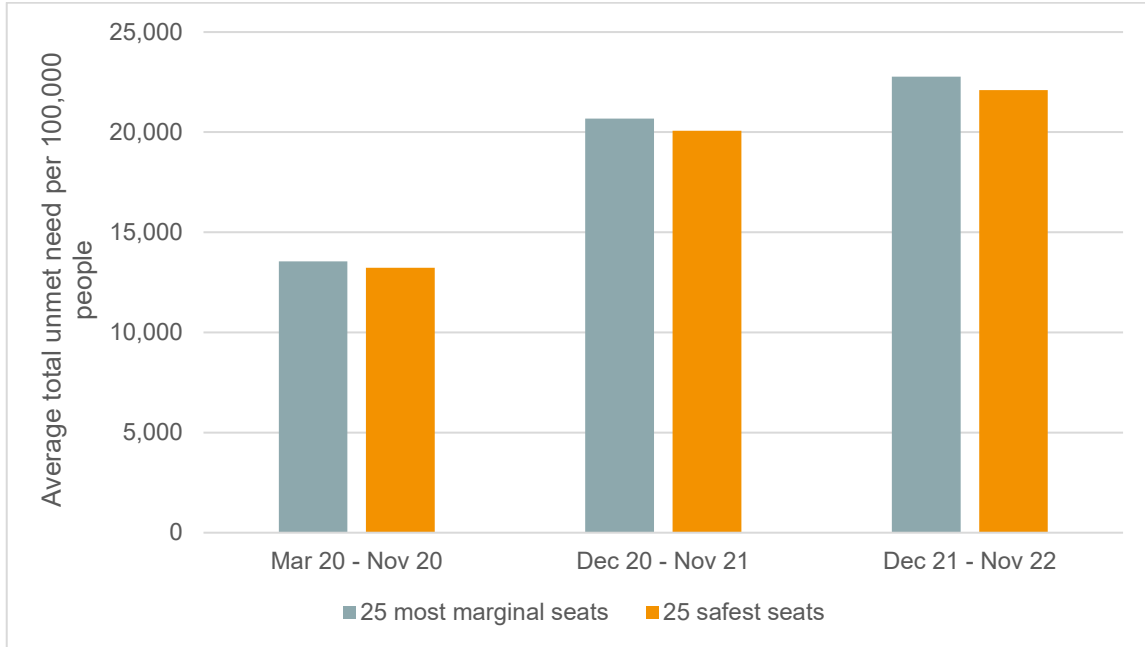
Table 1. Constituencies won by the Conservatives from Labour in the 2019 general election in England that lie within the North West/Midlands ICB cluster with high estimated unmet need per 100,000

Constituency	Majority (%)	Sub-ICB code (and name of former CCG)	ICB	Estimated unmet need per 100,000 people in sub-ICB at 30 November 2022 (England average = 23,328)
Bury North	0.22%	00V (NHS Bury)	NHS Greater Manchester	25,937
Bury South	0.80%	00V (NHS Bury)	NHS Greater Manchester	25,937
Bolton North East	0.86%	00T (NHS Bolton)	NHS Greater Manchester	25,718
Heywood and Middleton	1.40%	01D (NHS Heywood, Middleton and Rochdale)	NHS Greater Manchester	29,111
Warrington South	3.24%	02E (NHS Warrington)	NHS Cheshire and Merseyside	21,454
Wolverhampton South West	4.04%	D2P2L (NHS Black Country and West Birmingham)	NHS Black Country	25,148
West Bromwich East	4.42%	D2P2L (NHS Black Country and West Birmingham)	NHS Black Country	25,148
Wolverhampton North East	11.90%	D2P2L (NHS Black Country and West Birmingham)	NHS Black Country	25,148
Stoke-On-Trent North	15.66%	05W (NHS Stoke-on-Trent)	NHS Staffordshire and Stoke-on-Trent	23,436
Crewe and Nantwich	15.74%	27D (NHS Cheshire)	NHS Cheshire and Merseyside	28,348
Newcastle-Under-Lyme	16.64%	05G (NHS North Staffordshire)	NHS Staffordshire and Stoke-on-Trent	24,250
Dudley North	31.44%	D2P2L (NHS Black Country and West Birmingham)	NHS Black Country	25,148

More broadly, a comparison of the 25 most marginal Conservative seats against the 25 safest Conservative seats at the 2019 general election shows relatively higher per-capita estimated unmet need in the marginal seats since mid-2020 (see Figure 9). Over the previous year (from December 2021 to November 2022) the average unmet need was 22,772 per 100,000 in the 25 most marginal seats, compared with 22,094 per 100,000 in the safest seats.



Figure 9: The population adjusted total unmet need in the 25 most marginal Conservative seats and the 25 safest Conservative seats at the 2019 general election from March 2020 – November 2022. Note that Manchester University NHS Foundation Trust did not submit waitlist data from October 2022 to November 2022 reducing the average total unmet need average for the 25 most marginal seats for the respective period.





## 04 Projections

### How did our national models play out compared to reality?

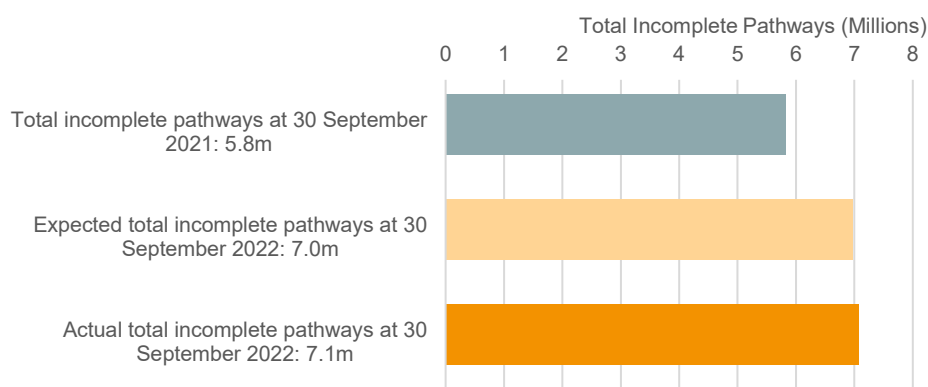
We previously projected NHS waiting lists for four separate scenarios. These were:

1. Base case – no ERP is implemented to clear the waiting list backlog.
2. Symmetric uplift in capacity (30% increase) across inpatient and outpatient services from May 2022.
3. Symmetric uplift in capacity (30% increase) that reaches pre-Covid-19 capacity levels immediately.
4. Asymmetric uplift whereby outpatient capacity is increased faster than inpatient capacity (overall capacity increase 30%).

One year on from our 2021 report, we have assessed how our waiting list estimates compare to what we have observed over the last 12 months. For consistency, our analysis here compares the national estimates without the data that the NHS now publishes (including estimates for providers who did not submit monthly waitlist data) but which was previously missing. Last year, our symmetric uplift scenario showed the total waiting list for elective care increasing from 5.8 million in September 2021 to a projected figure of 7.0 million in September 2022 (Figure 9).

Waiting list data released by the NHS over the previous year gives an actual figure of 7.1 million waiting for elective care in September 2022 (Figure 9), 1.4% above our projected value of 7.0 million.

Figure 9. Expected waiting lists from last year's projection in September 2021 compared to actual NHS waiting list data for September 2022



The largest difference between our projections and observed waiting list total was that the number of patients leaving the waiting list without receiving treatment was 570,000 lower than we projected – whether due to death, recovery or seeking private healthcare. This could reflect fewer people seeking private care once on the waiting list, or it could be that some patients



decided to go private before joining the waiting list due to the backlog (i.e. those with hidden need seeking private care). A key issue with exit rates from the waiting list is that it is unknown how many people report that they no longer need care (for any reason) and when they do so. If some patients do not inform the NHS that they no longer need care, it is possible that the exit rate is being underestimated.

The other greatest absolute differences were 300,000 (2.5%) more outpatient admissions and 230,000 (1.2%) fewer RTTs than projected. However, both acted to reduce the size of the waiting list, largely cancelling out the overestimation of the number of exits. Accounting for all contributing factors, the observed difference between the actual and our projected waiting list values was 100,000 (1.4%). Including the estimated missing data increased the waiting list by 70,000 patients, however this was not impactful after rounding.

### Projection scenarios for 2023

In this report we have expanded the projection analysis to explore the three key drivers of the waiting list:

- the number of patients exiting the waiting list without receiving NHS care;
- the increase in NHS capacity that the ERP achieves; and
- the amount of hidden need coming forward for care.

We have focused on exploring these factors with particular respect to the symmetric uplift scenario included in the 2021 report. Symmetric refers to a proportionate increase in both inpatient and outpatient completed pathways. We have also included an asymmetric uplift scenario (where outpatient completed pathways are completed at a quicker rate than inpatient) and a Private care scenario, where it is assumed that there is an increase in those with hidden need choosing private care rather than NHS care (see Appendix for further detail). The projected scenarios are set out below.

1. Base case – no ERP is implemented to clear the waiting list backlog.
2. Symmetric uplift in capacity (linear increase to 30% by April 2025) across inpatient and outpatient services.
3. Symmetric uplift in capacity (staggered increase to 21% by April 2025) across inpatient and outpatient services and new RTTs reduce by 8% by April 2025.
4. Symmetric uplift in capacity (staggered increase to 21% by April 2025) across inpatient and outpatient services and new RTTs stay at pre-Covid 19 levels.
5. Symmetric uplift in capacity (linear increase to 30% by April 2025) across inpatient and outpatient services and exit rates continue at current low rates of 3.0% from the waiting list.
6. Asymmetric uplift whereby outpatient capacity is increased faster than inpatient capacity (overall capacity increases linearly to 30% by April 2025).
7. Private care scenario where more people with hidden need seek private care instead of seeking NHS care (linear capacity increase to 30% by April 2025).

In all scenarios, we now assume that 50% of the hidden need state does not come forward for care over the course of the projection period (see Appendix for further detail on this



assumption). Additionally, for all scenarios except Scenario 5, we apply an exit rate that tapers up to average pre-Covid-19 levels (6.3%) from current rates (3.0%). All scenarios now include NHS national estimates that include missing data for new RTTs, completed pathways and incomplete pathways.

Scenarios 2 and 3 explore what could happen if NHS England (NHSE) achieves its target of a 30% increase in elective capacity compared to pre-Covid-19 levels. Scenario 2 projects waiting lists if the 30% increase in capacity is achieved by increasing the number of completed pathways alone, whilst Scenario 3 takes a more nuanced approach, where the increase in capacity is achieved by a 21% increase in completed pathways and a planned reduction of 8% of RTTs through to advice and guidance. Scenario 4 looks at what happens if only a 21% increase in completed pathways is achieved but the reduction in new RTTs is not achieved.

The assumptions for Scenarios 3 and 4 are as outlined in the National Audit Office report: *Managing NHS backlogs and waiting times in England*.<sup>10</sup> Detail on the planned staggered increase in capacity and reduced RTTs is shown in the Appendix.

### Projections to 2027: Reaching the uplift target is pivotal to success of ERP

Similarly to last year, we project that, without targeted intervention to increase treatment capacity above pre-Covid-19 levels (Scenario 1), the waiting list will continue to rise throughout 2023 and peak at 8.4 million patients in February 2024 (Figure 10), which would equate to roughly one patient pathway waiting for care for every seven people in England. The waiting list would then gradually reduce towards 2027, reaching 5.2 million patients by November 2027. This would remain 0.6 million more than in November 2019, when there were 4.6 million on the waiting list.

It should be noted that the waiting list approaches very low numbers or even 0 from the end of 2025 for some of the scenarios where the ERP is modelled. Whilst it is unrealistic that these figures would be achieved in reality due to practical constraints, they demonstrate how rapidly NHS waiting lists could be cleared if the ERP achieves and sustains its ambitious target of a 30% increase in NHS capacity compared to pre-Covid-19 levels. For the symmetric uplift scenario, with a 30% increase in capacity through completed pathways (Scenario 2), the waiting list peaks in June 2023 at 7.7 million people. By October 2025, six months after the ERP achieves its final uplift in capacity, the waiting list would stand at 2.2 million. By comparison, if the roughly 30% increase in capacity is partly achieved by avoiding new RTTs, as planned by NHSE (Scenario 3), then we would expect the waitlist to peak in April 2023 at 7.3 million and fall to 1.5 million by October 2025.

Yet the reality remains there is little evidence to suggest that the NHS will be able to achieve its planned 30% increase in capacity by 2025. At the end of 2022 monthly inpatient capacity was 3% less than pre-Covid levels whilst outpatient capacity was only 2% more than pre-Covid levels. The prospect of increasing demand for the NHS due to a cost-of-living crisis and workforce strikes only make this ambition more likely to be out of reach for a strained health care system. Scenario 4, which explores a 21% increase in capacity without a reduction in new RTTs, projects that the waiting list will peak in July 2023 at 7.9 million. The rate at which people continue to be cleared from the waiting list is slower than for scenarios 2 and 3, such that six months after the ERP intends to achieve its uplift in capacity (October 2025), there would be 3.5

<sup>10</sup> [Managing NHS backlogs and waiting times in England \(nao.org.uk\)](https://nao.org.uk/publications/managing-nhs-backlogs-and-waiting-times-in-england)

million people on the waiting list. This is 1.3 million and 2 million more than on the waiting list at October 2025 than for scenarios 2 and 3, respectively.

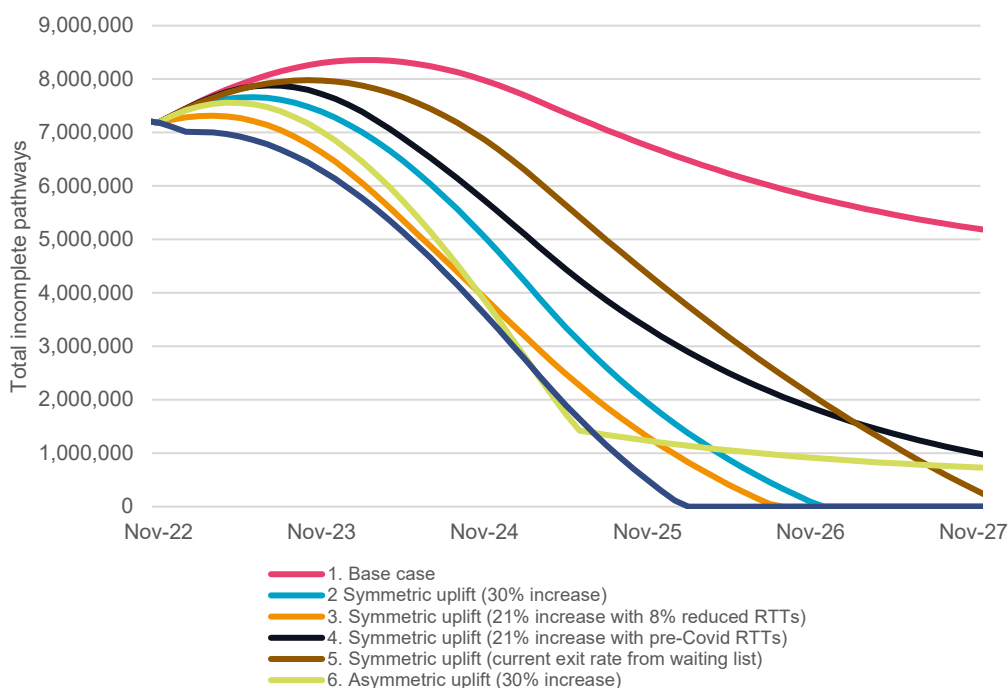
This should be a matter of concern for the NHS given that a 21% increase in completed pathways still remains an ambitious target, although more achievable than the 30% increase in completed pathways that appeared to be suggested when the ERP was first published.

The asymmetric scenario demonstrates that, due to the large proportion of health needs that require outpatient care, increasing outpatient capacity has the potential to clear waiting lists at a quicker short term rate, with this slowing after the outpatient backlog has been cleared and the focus shifts to clearing the inpatient backlog.

In the shorter term, the number of people exiting the waiting list without receiving NHS treatment is a key driver of the NHS waiting lists as it affects overall demand. We explore this in Scenario 5, where the exit rate from the waiting list continues at the current rate of 3.0%, which is lower than the pre-Covid-19 average exit rate (6.3%). By October 2025, a sustained lower exit rate would equate to 2.6 million more people on the waiting list than if the exit returned to usual (higher) pre-Covid levels.

The private care scenario demonstrates that, should more people with hidden health needs accumulated during the Covid-19 pandemic seek private care, the NHS waiting lists would be significantly reduced. However, this situation would exacerbate inequalities. Effectively a two-tier healthcare system would be created between 1) an increasing minority of those who can afford private care, either personally or through their employer, and 2) the majority who are left on waiting lists for NHS care and unable to afford private medical care. This could also exacerbate geographical inequalities through the observed regional differences in referrals through the independent sector.

Figure 10. Projected total incomplete pathways from December 2022 until November 2027 for all scenarios.



When including patients with hidden need in addition to those already on the waiting lists in the projections, i.e. the total unmet need (Figure 11), it becomes clear that the proportion of people



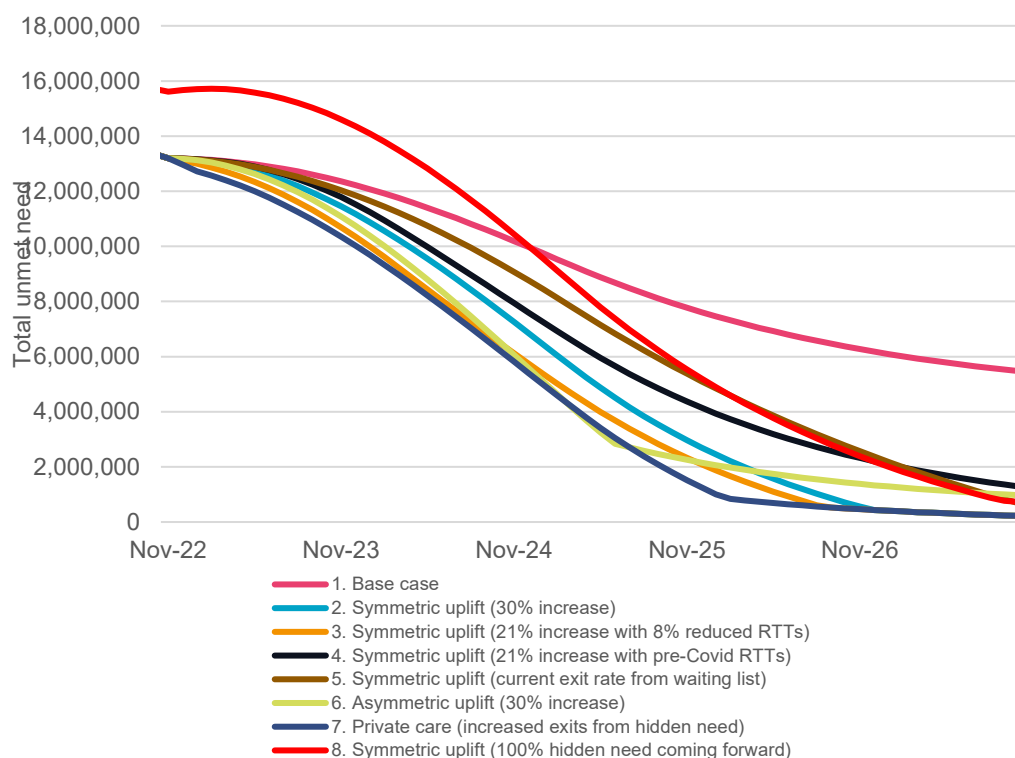


with hidden need that come forward for care will affect the NHS elective backlog. To illustrate this, we have included an 8th scenario (where all assumptions are as for Scenario 2, except 100% of the hidden need comes forward for care).

For this scenario, the peak of total unmet need greatly exceeds any other scenario, at an estimated 15.7 million in February 2023. Unmet need would remain greater than for all other scenarios where the ERP is implemented until October 2026, when the pool of people with hidden need would have diminished.

For all scenarios modelled, the total unmet need is currently peaking at over 13.1 million, this decreases gradually over the first half of 2023 followed by a faster rate of reduction. This is likely to be of great concern to the NHS given the suggestion that we are likely to be currently either at, or just past, the peak of total elective unmet need.

Figure 11. Projected unmet need from November 2022 until November 2027 for all scenarios.



Under all scenarios where an uplift to capacity is assumed, total unmet need decreases over time and drops below four million by May 2026 and to under two million by February 2027. Where they differ is in the path to reaching this position. The asymmetric uplift scenario shows more people being cleared from the waiting list sooner, reflecting the fact that around 80% of patients on the waiting list are typically treated as outpatients, so targeting resources in this area is expected to have a greater short-term effect in terms of pure patient numbers. However, from 2025 we expect the rate of reduction to slow down under this scenario as the waiting list becomes more imbalanced, with a higher proportion of patients needing inpatient admissions.



## 05 Conclusion

The impacts of the Covid-19 pandemic continue to be felt by the NHS, with elective waiting lists reaching record highs. Total unmet need may be currently peaking, resulting in extreme short-term pressure on the NHS. Inequalities within the waiting list have widened over the year, with the East of England and the Midlands with highest number of people waiting after adjusting for population size.

However, the ERP has begun to have some impact. Waits of over two years have significantly reduced to only 2 per 100,000 people nationally, whilst waits of over 18 months are also down from their peak. But more must be done to reduce geographical and clinical inequalities. Since the ERP was formally introduced, the East of England has seen a much larger increase in the number of people waiting over one year for care than any other region after adjusting for population. Similarly, the number of those waiting over one year for gynaecological care has significantly increased since the implementation of the ERP, whilst simultaneously reducing for orthopaedic patients.

Our projections suggest that if the ERP achieves its targeted uplift in NHS capacity, waiting lists could be expected to peak in April 2023 at 7.3 million people, reducing to 1.5 million by October 2025, six months after the ERP achieves its maximum increase in capacity. However, if only 2/3 of the planned increase in capacity is achieved, the waiting lists could be expected to peak at 7.9 million people in July 2023, reducing to 3.5 million people in October 2025, leaving an additional 2 million waiting for NHS elective treatment. Current evidence suggests that the NHS is unlikely to achieve its planned increase in capacity, with monthly inpatient and outpatient capacity being 3% less and 2% more, respectively, than pre-Covid-19 levels at the end of 2022.

Yet the numbers on the waiting list are likely an underestimate of the true health needs of the population. When accounting for both those already on the waiting list and those with hidden need, we expect that the total unmet need may currently be peaking at over 13 million people, or over 1 patient pathway needed for every 4 people in England. The proportion of those with hidden need coming forward for care over the next year remains to be seen, however, with 2022 not seeing a sudden increase in that population coming forward for care.

Whilst there have been elements of progress thus far for the ERP, the most difficult milestones lay ahead. There is a clear need to continue to strengthen NHS capacity, although the road to doing so will be challenging given such large health needs of the population and continuing challenges in staffing hospitals. Policy makers should continue to focus on addressing geographical and clinical inequalities in the waiting list.



## 06 Appendix

We have made updates to the following parts of the underlying model to reflect developments over the year:

- The starting point for our projection of the number of new inpatient and outpatient completed pathways, and the rate at which patients are assumed to exit the waiting list without receiving treatment, has been moved forward to capture the most recent data.
- We have increased the averaging period for calculating the initial rate at which patients are assumed to exit the waiting list without receiving treatment from 3 months to 12 months, with the aim of reducing the impact of short-term fluctuations in the historic exit rate.
- We have made several updates to our estimate of the hidden need, and these are discussed in more detail, along with their implications, below.

### Hidden need

As the direct impacts of the Covid-19 pandemic have reduced substantially we have assumed that, from 1 May 2022, everyone who needs elective care comes forward for treatment, i.e. on aggregate there is no new hidden need from this date. Over the period from 1 October 2021 to 30 April 2022, the amount of new monthly hidden need tapers down linearly from the July-September 2021 average to zero.

In practical terms, the decrease in hidden need reflects the decreasing likelihood over time that any reduction in new referrals to treatment, relative to pre-pandemic rates, is attributable to patients deferring coming forward for NHS care to a later date because of the pandemic; this might be due to people living with conditions and not seeking care compared to what they would have previously done, seeking alternative care or entering the healthcare system via alternative routes (i.e. via emergency/urgent care). New referrals to treatment over the 12 months to 30 September 2022 continued to be 4-5% below pre-pandemic rates. This suggests that there may not be a sudden influx of hidden need entering the public NHS as previously expected.

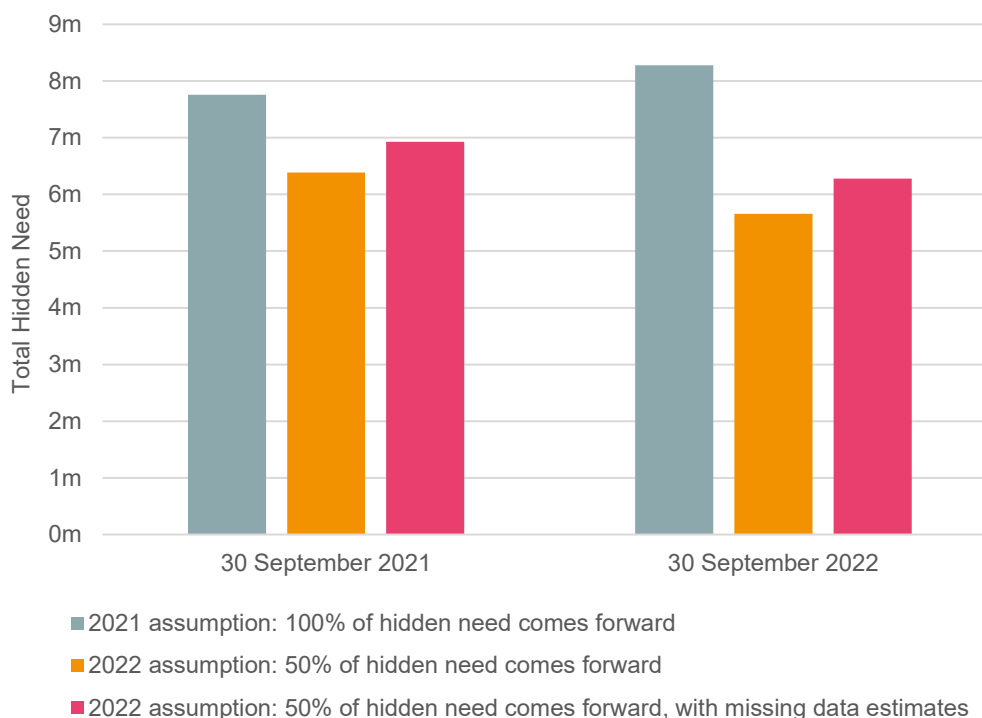
Secondly, we have assumed that 1.35% of patients with hidden need exit the hidden need state each month without joining the visible waiting list or receiving NHS treatment. This is analogous to the exit rate assumption applied in projecting the visible waiting list and is designed to reflect deaths, recoveries and patients seeking private healthcare. The rate of 1.35% per month has been chosen to result in 50% of all patients who acquired hidden need during the pandemic ultimately coming forward to join the visible waiting list. This proportion is in line with modelling proposed by [the Institute for Fiscal Studies \(IFS\)](#).

The combined impact of these hidden need updates is shown in Figure 12 below. Applying an exit rate to the hidden need that accumulated between 1 March 2020 and 30 September 2021 reduced the total hidden need at 30 September 2021 from the figure of 7.8 million quoted in our previous 2021 report down to 6.4 million, a decrease of 18%. When accounting for the new waiting lists with missing data that the NHS report, the decrease in hidden need would have



been 12%, to 6.9 million. In last year's calculations, we projected that total hidden need would increase to 8.3 million as of 30 September 2022. However, after tapering the new hidden need to zero and allowing for exits as described above, the estimate of hidden need (without missing data estimates) as of 30 September 2022 would be 5.7 million, a decrease of 32% on last year's projection. When accounting for the missing data the reduction is 24%, to a total hidden need of 6.3 million.

Figure 1212. Difference between hidden need using 2021 report assumptions and updated assumptions at September 2021 and September 2022



## Scenario updates

We have also reconsidered the scenarios we compare against the baseline with no intervention:

- We have removed the scenario where the uplift in capacity reaches pre-Covid-19 levels immediately, as this has not played out in practice over 2021/22.
- We have explored the impact of varying the key driving factors of the waiting list (explored in main report body)
  - This includes detail published in the NAO report: Managing NHS backlogs and waiting times in England (shown in Table 2)
- To reflect an observed trend of NHS patients seeking private care over 2021/22, we have introduced a 'private care' scenario, which assumes that a certain proportion of patients (5.0-12.5%) who would have normally sought NHS care instead opt for private care each month. This is described in more detail below.



Table 2. NHS England's planned trajectory to increase elective activity. Scenarios 3 and 4 of the Projections section explore these reported planned increases in elective activity using the increase staggered by year

Financial year	NHSE estimate of actual completed pathways	NHSE projection of completed pathways	NHSE projection of additional pathways avoided by advice and guidance	Total projection of pathways
2019-20	17.3mn (100.0%)			
2022-23 (plan)		17.6mn (101.8%)	1.1mn (6.4%)	18.7mn (108.1%)
2023-24 (plan)		20.0mn (115.5%)	1.4mn (8.0%)	21.3mn (123.5%)
2024-25 (plan)		20.9mn (120.9%)	1.4mn (8.0%)	22.3mn (128.8%)

Source: National Audit Office and NHSE

### Private Care Scenario

A [survey](#) commissioned by Engage Britain and carried out in July 2022 revealed that 10% of UK adults were using private healthcare, of whom around half (i.e. 5% of the total UK adult population) would normally prefer to use the NHS where they can. By comparison, based on the total number of completed NHS elective care pathways, we estimate that 35% of adults in England received treatment within the NHS over the same year. This implies that approximately 12.5% ( $= 5\% / (5\% + 35\%)$ ) of patients who would normally have been treated on the NHS over the year were instead treated privately.

This observed trend of more patients opting for private care in 2021/22 will have largely been captured in the raw data for new, incomplete, and completed treatment pathways and hence reflected in our unmet need estimates up to November 2022. However, our existing projection models did not make an explicit allowance for this trend potentially continuing into the future.

We have therefore introduced the private care scenario, which assumes a shift in public perceptions towards private care going forwards, relative to before the pandemic. This translates into the following modelling assumptions:

- The proportion of all patients needing new treatment that go straight to private care is 5%. This is derived as the approximate reduction in the average monthly number of new RTTs in the 12 months to September 2022 relative to the pre-Covid-19 rate (14 months to February 2020).
- The proportion of patients with hidden need going straight to private care is initially 12.5% in October 2022, tapering down to 5% in April 2025. The taper reflects the expectation that, as waiting times reduce going forwards, a diminishing proportion of patients with hidden need will opt for private care ahead of joining the NHS waiting list.
- The proportion of patients on the waiting list in September 2022 switching to private care is 7.5%. This is derived as the difference between the 12.5% of NHS patients who are assumed to go private at some point in the treatment journey and the 5% observed reduction in new RTTs over 2021/22 relative to pre-Covid-19 levels, which we assume in this scenario represents patients who had already opted to go private before joining the waiting list.



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