How much would it really cost to fix the waiting list crisis in the English NHS, and to what extent might the independent sector be needed? Candesic senior partner **Michelle Tempest** and senior engagement manager **Jack Zeng** have analysed the figures, and worked out how waiting lists could become a thing of the past – for the right price

Counting the cost of fixing the waiting list crisis

Patients in England are already meant to wait no longer than 18 weeks between GP referral and treatment starting, ideally less, and during this waiting period any pre-treatment hospital appointments, tests, scans and other necessary procedures should take place.

There is some leeway built into the guidance. The NHS Constitution for England – the government commitment to make the NHS accountable – sets the standard at the point where 92% of people waiting for elective (non-urgent) treatments such as cataract or knee replacement wait no longer than this for their first treatment.

Yet only around 40% of patients are treated on target. How much would it cost to get to the point we should be within five years?

First, consider the sheer scale of the problem. The latest available NHS Referral to Treatment figures, for March 2024, show the waiting list standing at 7.54 million cases, with approximately 6.29 million individual patients waiting for treatment. Around 3.23 million of these have been waiting for over 18 weeks, and over 309,000 of these patients have been waiting over a year for treatment. The median waiting time for treatment, at 14.9 weeks, is over double the pre Covid median wait in March of 2019.

One solution, proposed by Labour pre-election, is to make use of spare capacity in the independent sector, and squeezing more out of a better-funded NHS. This would require a significant increase in appointments (Labour suggested 40,000 additional appointments, scans and operations per week) – and getting the NHS to do more in the evenings and at weekends while leaning into independent sector capacity.

Labour said the policy would cost £1.3bn in the first year funded by closing non-dom tax loopholes and clamping down on tax dodgers but did not set out the overall budget for the project. What would such an approach actually cost? Candesic has done the modelling to work it out, and the extent to which the NHS and independents would need to increase capacity.

> SPARE CAPACITY EXISTS WITHIN THE INDEPENDENT SECTOR AND PROVIDERS WOULD CLEARLY BE QUEUING UP TO HELP

A current breakdown of the waiting list figure of 7,538,800 cases based on NHS England statistics follows. This shows around 4.3 million have been waiting under 18 weeks, with the remainder (around 3.2 million incomplete pathways) for longer, including in 232 cases for more than two years. In order to hit the 92% target, and assuming the waiting list does not continue to increase – the number of incomplete pathways waiting over 18 weeks would need to be cut to just 375,000 (see Figure One).

To achieve this, a combination of the NHS and the independent sector would need to deliver an additional 950,000 admitted procedures over five years – 190,000 additional admitted patient procedures (inpatient or day care) per year (see Figure Two).

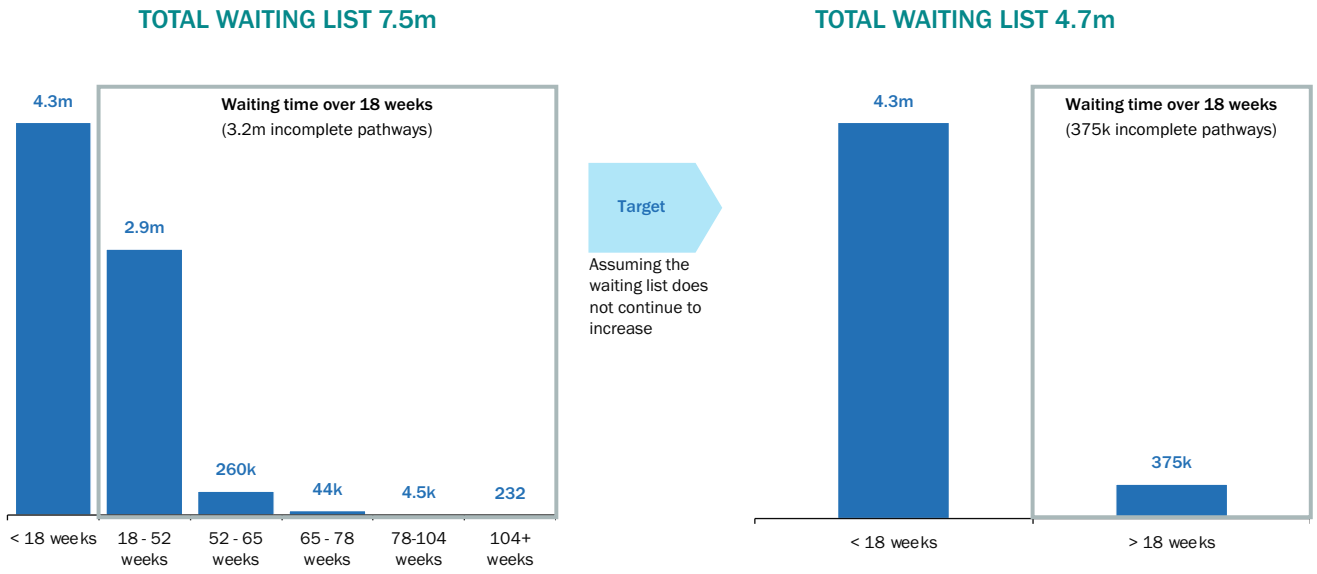
Based on 2024 volumes, if NHS England increased its activity to achieve the target, it would need to increase elective activity by 7%, a jump from 2.9 million completed admitted elective pathways to 3.1 million.

If independents were to do the same,

FIGURE ONE
WAITING LIST REDUCTION (NUMBER OF INCOMPLETE PATHWAYS/REFERALS THAT ARE YET TO BE RESOLVED)

CURRENT WAITING LIST COMPOSITION BY AMOUNT OF WAIT TIME, MARCH 2024

END TARGET OF WAITING LIST, MARCH 2029



SOURCE NHS ENGLAND; CANDESIC RESEARCH AND ANALYSIS

again based on 2024 volumes, it would require an increase of 13%, from 1.5m complete admitted pathways to 1.7m (see Figure Three). This presupposes a five-year period, with 190,285 procedures needed per year, making the number of total independent procedures around 1,463,000.

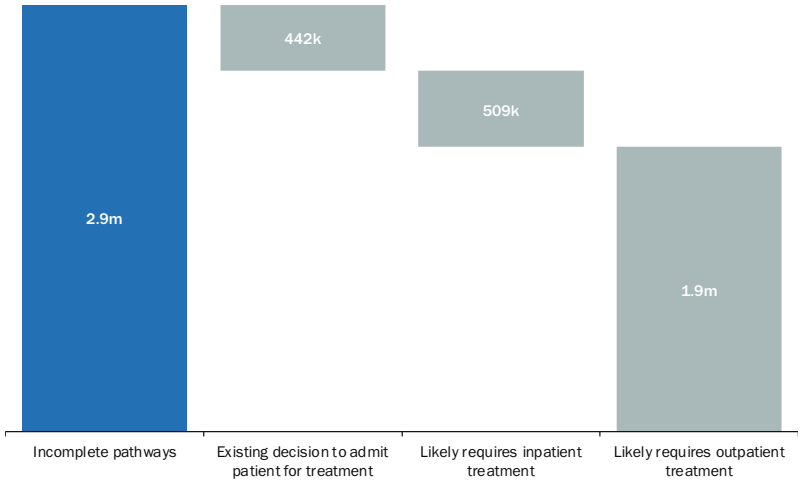
Of course, any solution is likely to require both the NHS and independents to contribute, and this presupposes that there would be capacity to help. As for the independent sector, generally it does have some spare capacity, it does have some spare capacity, rarely reaching 85% utilisation.

Insourcing would appear to be one obvious way forward and such a move would no doubt be welcomed by existing insourcing businesses operating in England – groups like insourcing, digital

FIGURE TWO
BREAKDOWN OF REQUIRED TREATMENT TO ACHIEVE TARGET

TO ACHIEVE THIS THE ENGLISH HEALTH SYSTEM, THE NHS AND INDEPENDENT SECTOR, WILL NEED TO DELIVER AN ADDITIONAL 950,000 ADMITTED PROCEDURES

NUMBER OF INCOMPLETE PATHWAYS
(REFERRALS THAT ARE YET TO BE RESOLVED, MARCH 2024)



WHAT THIS MEANS FOR THE HEALTHCARE SYSTEM

950,000
additional admitted patient procedures

190,000
additional admitted patient procedures per year over five years

16,000
additional admitted patient procedures per month

SOURCE NHS ENGLAND; CANDESIC RESEARCH AND ANALYSIS

triage and recruitment solutions group HBSUK which helps healthcare providers reduce waiting times by providing both online outpatient services and on-site clinical capacity, and insourcing supplier 18 Week Support which specifically serves NHS trusts looking to manage RTT (referral to treatment) pathways and achieve 18 week target times.

But what of cost? Candesic has, again, done some modelling, calculating first the average cost per patient, and taking into account both waiting list length and average cost per patient by speciality, weighting its figures accordingly.

On this basis, Candesic was able to calculate the cost per year (£510,222,865) and month (£42,518,572) required to hit a five-year target.

The total number of outpatient appointments required would be around 2.4 million, which over five years would equate to around 40,000 additional appointments being needed per month.

Looking at a five-year period, to eradicate the waiting list, Candesic calculates this would mean treating around 6.8 million people, 1.3 million on the waiting list needing admission and around 5 million not needing admission. With an admitted patient cost of around £2,700 and non-admitted patients costs of around £347 the total cost comes to a little over £6.175bn.

If the waiting list issue were solvable by simply throwing money at it, the figure to eradicate the waiting list in a year Candesic calculates to be a shade over £6bn.

More realistically however, a five-year plan to solve the waiting list crisis (ie hitting the NHS Constitution for England 92% target for treatment starting within 18 weeks of referral) is more practical, whether it is funded by a non-dom crackdown/clampdown on tax dodgers as has been suggested in some quarters, or other means.

However, funding alone is not enough, and the prospect of success of any such plan comes with significant caveats.

The first fundamental question any plan must address, perhaps even before looking at financing, is where do we find the staff? Candesic's calculation of the many, many thousands of additional fulltime employees needed to truly tackle the waiting list suggests this is likely the real sticking point, to the extent even a five-year solution could be a tall order.

Any staffing solution here would need to look at issues such as the expansion of medical schools and nurse training, ethical recruitment from abroad perhaps combined with further simplification of entry procedures and accreditation regulations for international healthcare workers, better retention strategies linked to competitive pay and benefits but also career progression and training, and increasing use of data-driven planning using predictive analytics to anticipate future staffing needs.

The NHS in particular has found it difficult to retain staff – a high workload and the pandemic saw a huge increase in stress and burnout while recent strikes over pay have further highlighted dissatisfaction with the status quo.

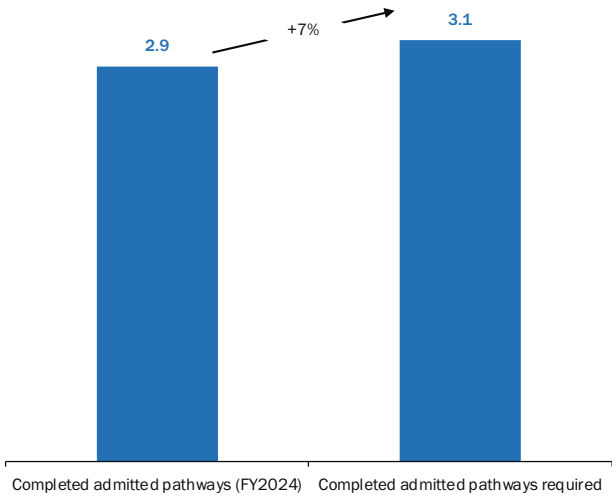
Assuming sufficient staff might be found, an appropriate division of labour would then need to be struck between the NHS and independent providers. Provided treatment remains free at the point of use, this would appear to be increasingly acceptable to a public historically sceptical of any perceived erosion of traditional NHS hospital services.

Spare capacity exists within the independent sector and providers would clearly be queuing up to help – but the real winners here would be patients. The best waiting list is surely one with no one in it.

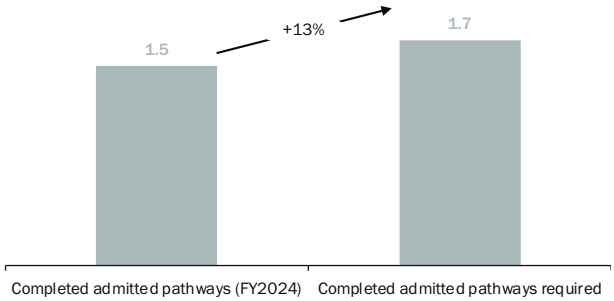
FIGURE THREE
INCREASE IN ACTIVITY

THIS WOULD REQUIRE THE NHS TO INCREASE ELECTIVE ACTIVITY BY 7% OR INDEPENDENTS TO INCREASE THEIR TOTAL ACTIVITY BY 13%

INCREASE IN ACTIVITY IF **ONLY THE NHS** INCREASED ACTIVITY (BASED ON FY2024 VOLUMES)
MILLIONS OF COMPLETED ADMITTED PATHWAYS



INCREASE IN ACTIVITY IF **ONLY THE INDEPENDENT SECTOR** INCREASED ACTIVITY (BASED ON FY2024 VOLUMES)
MILLIONS OF COMPLETED ADMITTED PATHWAYS



SOURCE PHIN; NHS ENGLAND; CANDESIC RESEARCH AND ANALYSIS