NOVEMBER 2026 · STEVE COUSENS, INDEPENDENT ANALYST · FIGURES CHECKED 14 NOVEMBER 2026, MODEL FIGURES 17 NOVEMBER 2026

Is the 10 Year Health Plan enough? Evidence bank

Every finding in the report *Is the 10 Year Health Plan enough?*, with its figures, source, method, caveats and the strongest counter-argument. Each figure was reproduced from published data on the date above.

DATA

Official statistics, summed or compared. Reproducible by anyone from the named source. Safe to lead with.

DERIVED

Analysis built on official data (a comparison, a classification, a published policy costed). Method stated; open to challenge on method, not on the figures.

MODEL

Simulation results. Depend on the stated assumptions; always quote with them and as a range of outcomes, never as a forecast.

Register

NO.	FINDING	HEADLINE FIGURE	TYPE
D1	12-hour trolley waits	3,262 → 570,957 a year (2018/19 → 2025/26)	DATA
D2	Most A&E breaches are not bed waits	76% of type 1 breaches, 2025/26	DATA
D3	Delayed discharge has not moved	About 13,000 patients a day since 2022/23	DATA
D4	Staff grew far faster than counted activity	Staff +28%, emergency admissions +2%	DATA
D5	The waiting list	7.38m; 65.8% within 18 weeks against 92%	DATA
D6	The estate backlog, and what £15.9bn is	Backlog +25% in two years; £15.9bn is the size, not the funding	DATA

NO.	FINDING	HEADLINE FIGURE	TYPE
D7	Equipment and IT are being run down	IT replaced at 54% of depreciation	DATA
D8	Safety ratings	25 of 117 acute trusts rated Good for safety; none Outstanding	DATA
D9	Corridor care	About 3,560 patients a day, October 2026	DATA
D10	A third of joiners are from overseas	33% of NHS joiners, year to July 2026; the plan aims for under 10%	DATA
D11	Hospital flow: the National Audit Office's figures	Occupancy 87% to 92%; 4.7m bed days a year held by patients ready to leave (£2.7bn)	DATA
A1	Trusts' problems differ	Pressures barely correlated across 117 trusts; freedom goes to those doing well	DERIVED
A2	Maintenance costs twice the depreciation charge	£6.1bn a year against £3.2bn	DERIVED
A3	The medicines agreement's cost	+£7.8bn a year by 2035/36 (England)	DERIVED
M1	The plan on its own assumptions	88% within 18 weeks by March 2029, not 92%	MODEL
M2	The likely outcome	73% by March 2029, about 53% by 2035/36	MODEL
M3	What 92% would take	+12% treatments and +13,000 doctors by 2028/29	MODEL
M4	Standing still costs more than the budget	£10bn a year short by 2035/36	MODEL
M5	Discharge alone does not fix A&E	90% fewer delays: +0.6 points on the 4-hour measure	MODEL
M6	The overseas target and the waiting-time target clash	Needed from overseas: 22% of joiners in 2035/36, not 10%	MODEL
M7	Nurses, not doctors, run out first	21,500 nursing posts unfilled by 2035/36; £8.1bn unspent	MODEL
M8	What the results depend on	Productivity and funding decide it; the model's weak links do not	MODEL
M9	Keeping staff is the cheapest way to add them	Leaver rates 10% lower: 53% to 70% within 18 weeks in 2035/36, for £0.17bn a year	MODEL

Data

D1 12-hour trolley waits DATA

Patients waiting more than 12 hours in A&E after a decision to admit rose from 3,262 in 2018/19 to 570,957 in 2025/26, about 175 times as many, while emergency admissions through A&E hardly changed.

ENGLAND, FINANCIAL YEAR	2018/19	2025/26	CHANGE
Waits of 12+ hours from decision to admit	3,262	570,957	×175
Emergency admissions via A&E	4,766,442	4,818,823	+1.1%
12-hour waits per 1,000 admissions via A&E	0.7	118.5	
All attendances seen within 4 hours	88.0%	74.4%	−13.6 pts

SOURCE NHS England, A&E Attendances and Emergency Admissions, monthly provider files, summed to England for April to March.

CAVEATS Counts the wait from the decision to admit, not from arrival; 12 hours from arrival is far higher. Same definition in both years. October 2026: 74.0% within 4 hours.

REBUTTAL "Demand surged after Covid." Type 1 attendances rose 6.8% and admissions through A&E 1.1% over the period: a 175-fold rise in 12-hour waits is a failure of flow through the hospital, not of demand.

D2 Most A&E breaches are not bed waits DATA

In 2025/26 about three in four type 1 A&E patients who waited over 4 hours were not waiting 4 hours or more for a bed after a decision to admit. Breaches more than doubled since 2018/19 on attendances up 7%.

TYPE 1 (MAJOR) A&E, ENGLAND	2018/19	2025/26	CHANGE
Attendances	15.68m	16.74m	+6.8%
Waited over 4 hours	2.89m	6.60m	+128%
of which 4+ hours after a decision to admit	0.63m	1.57m	+151%
of which the rest	2.27m	5.03m	+122%

SOURCE NHS England, A&E Attendances and Emergency Admissions (type 1 attendances over 4 hours; waits of 4–12 and 12+ hours from decision to admit).

CAVEATS An admitted patient can pass 4 hours from arrival without waiting 4 hours after the decision, so "the rest" includes some admitted patients

slow to reach a decision. Even so, most breaches arise before or without a wait for a bed.

REBUTTAL "Fix discharge and A&E fixes itself." Discharge drives the trolley waits (D1), but the larger part of the breaches happens in assessment and treatment within A&E: capacity, staffing and process in the department itself. See M5.

D3 Delayed discharge has not moved DATA

About 13,000 patients a day stay in hospital after they no longer need to be there, the same as three years ago, although adult social care spending rose 14% in real terms.

ENGLAND	2022/23	2023/24	2024/25	2025/26
Patients a day remaining in hospital after no longer meeting the criteria to reside	13,203	12,737	12,663	12,978

That is about 12% of the 105,680 general and acute beds occupied on average in 2025/26. Adult social care gross current spending: £22.0bn in 2021/22, £29.4bn in 2024/25 (+34% cash, +14% real).

SOURCE NHS England, acute discharge situation report (daily averages, type 1 acute trusts); KH03 bed availability; NHS England Adult Social Care Activity and Finance.

CAVEATS "No longer meeting the criteria to reside" is not the same as "ready to leave"; some wait for NHS community services, not social care. Social care spending also covers working-age adults and wage rises (National Living Wage). The spending and delay years overlap but are not identical.

REBUTTAL "The extra money went on fees and wages." That is the point: more spending has not bought more flow out of hospital.

D4 Staff grew far faster than counted activity DATA

Between 2018/19 and 2025/26 NHS trusts' staff grew 28% and their doctors 36%, while emergency admissions grew 2%, A&E attendances 7% and waiting-list treatments 12%.

ENGLAND, NHS TRUSTS	2018/19	2025/26	CHANGE
Staff (WTE)	1,055,073	1,354,366	+28.4%
Doctors (WTE)	110,849	151,129	+36.3%
Nurses and midwives (WTE)	304,558	392,649	+28.9%
Emergency admissions	6.44m	6.54m	+1.6%
Type 1 A&E attendances	15.68m	16.74m	+6.8%
Waiting-list treatments (RTT completed pathways)	16.51m	18.48m	+11.9%
Diagnostic tests (15 DM01 tests)	23.09m	30.25m	+31.0%
General and acute beds	114,674	116,617	+1.7%
Age-weighted population (hospital use by age)			+9.1%
Trust spending, real 2024/25 prices (to 2024/25)	£110.8bn	£142.5bn	+28.7%

SOURCE NHS Workforce Statistics (trusts); Hospital Episode Statistics; A&E, RTT and DM01 monthly statistics; KH03; Trust Accounts Consolidation (TAC08), deflated to 2024/25 prices.

CAVEATS The table's staff are all trusts (mental health, community and ambulance included), while the activity is mostly acute. Acute trusts alone show the same gap: staff +27.7%, doctors +37.6%, nurses and midwives +31.7% (763,405 to 974,952 WTE). Treatments and tests include those by independent providers for the NHS, which flatters the comparison if anything. Counted activity leaves out much community and mental health work, case complexity and quality. ONS's quality-adjusted healthcare productivity grew 1.1% in 2024 and 1.0% in 2025.

REBUTTAL "Patients are sicker; staffing was unsafe in 2018; training and mental health grew." Each explains part. The plan still assumes 2% a year productivity, about double what ONS has measured, and does not show where the extra staff's output went.

D5 The waiting list DATA

7.38 million pathways were waiting in September 2026, 65.8% of them within 18 weeks. The standard, and the plan's target for March 2029, is 92%.

ENGLAND, RTT INCOMPLETE PATHWAYS	APRIL 2021	MARCH 2026	SEPTEMBER 2026
Waiting	5.12m	7.11m	7.38m

ENGLAND, RTT INCOMPLETE PATHWAYS	APRIL 2021	MARCH 2026	SEPTEMBER 2026
Within 18 weeks	64.6%	65.3%	65.8%
Over 52 weeks	7.5%	1.3%	1.6%

SOURCE NHS England, Referral to Treatment waiting times, England totals.

CAVEATS The 65% interim target for March 2026 was met (65.3%). The very longest waits have fallen sharply; the 18-week share has barely moved in five years.

D6 The estate backlog, and what £15.9bn is DATA

The backlog of maintenance in hospital buildings grew by a quarter in two years, to £15.9bn, because about £4.5bn of new backlog arises each year and trusts invest £3.2bn. The £15.9bn quoted around the 10 Year Plan is the size of the backlog, not new money.

ENGLAND, NHS TRUSTS, 2024/25 PRICES	2022/23	2023/24	2024/25
Backlog maintenance	£12.7bn	£14.3bn	£15.9bn
of which high or significant risk	£6.8bn	£7.9bn	£9.1bn
Investment to reduce backlog	£3.2bn	£3.2bn	£3.2bn
New backlog arising in the year	£3.9bn	£4.8bn	£4.8bn

The 10 Year Capital Plan's Estates Safety Fund, £6.75bn over nine years, is about £0.75bn a year: less than the £1.3–1.6bn a year by which new backlog outruns investment. On these figures the backlog keeps growing even with the fund.

SOURCE NHS England, Estates Returns Information Collection (ERIC), PFI sites included; DHSC, 10 Year Capital Plan for Health and Social Care (July 2026). Arising = the year's growth plus the investment made.

CAVEATS ERIC is trust-reported and survey-based; backlog costs are estimates. Whether the fund is additional to existing investment is not stated in the plan.

REBUTTAL "Capital budgets are rising to £15bn." DHSC's whole capital budget, most of it for new schemes, equipment and IT; the maintenance gap stays unless investment in existing buildings rises by over £1.3bn a year.

D7 Equipment and IT are being run down DATA

In 2024/25 trusts replaced their plant and machinery at 77% of its depreciation and their IT at 54%, down from 96% and 80% two years earlier. The IT estate has about three years of life left.

ENGLAND, NHS TRUSTS	2022/23	2023/24	2024/25
Plant and machinery bought, % of its depreciation	96%	91%	77%
IT bought, % of its depreciation	80%	65%	54%
Plant and machinery, years of life left	5.6	5.6	5.3
IT, years of life left	3.5	3.4	3.1

SOURCE Trust Accounts Consolidation (TAC14, property, plant and equipment): additions and depreciation by asset type; life left = net book value / depreciation. Trusts only.

CAVEATS Leased and cloud services are not in these lines, so part of the IT fall may be a shift to services, not neglect.

D8 Safety ratings DATA

Of England's 117 acute trusts, 25 hold a Good rating for safety and none Outstanding; 89 require improvement and 3 are inadequate.

LATEST CQC SAFE RATING, 117 ACUTE TRUSTS	TRUSTS
Good	25
Requires improvement	89
Inadequate	3
Rating more than 3 years old	21
Rating more than 5 years old	4

SOURCE Care Quality Commission, Latest ratings (monthly file), with East Sussex's November 2026 ratings added.

CAVEATS "Latest" is the trust-level rating or a main hospital's, whichever CQC published last (the rule used throughout); Safe domain only. Ratings of different ages are not strictly comparable.

D9 Corridor care DATA

NHS England's new corridor-care statistics show about 3,560 patients a day cared for in corridors in October 2026: 2,720 in A&E and 840 on wards, up from 2,900 in May.

ENGLAND, DAILY AVERAGE	MAY	JUN	JUL	AUG	SEP	OCT 2026
A&E	2,242	2,439	2,300	2,297	2,550	2,718
Wards	658	749	728	678	760	840

SOURCE NHS England, Corridor Care statistics (monthly, from May 2026), England total.

CAVEATS A new, experimental series: definitions and trust coverage are still settling, and there is no earlier history. The autumn rise is partly seasonal.

D10 A third of joiners are from overseas DATA

In the year to July 2026, 33% of staff joining NHS trusts and other NHS organisations were not UK nationals: 44,700 of 136,800 full-time equivalent joiners. For doctors it was 42%, for nurses and health visitors 35%. The 10 Year Health Plan aims for under 10% by 2035. The share peaked at 35% in 2022/23 and has eased only slightly, because UK joiners fell almost as fast.

ENGLAND, JOINERS WHO ARE NOT UK NATIONALS, AS A SHARE OF JOINERS OF KNOWN NATIONALITY	YEAR TO SEPT 2019	YEAR TO SEPT 2023	YEAR TO JULY 2026
All staff groups	22%	35%	33%
Hospital and community doctors	40%	50%	42%
Nurses and health visitors	28%	49%	35%
Scientific, therapeutic and technical staff	17%	28%	22%
Support to doctors, nurses and midwives	20%	36%	43%
Midwives	6%	18%	10%
All joiners (full-time equivalent)	155,100	205,800	136,800
Joiners who are not UK nationals (full-time equivalent)	33,300	71,000	44,700

SOURCE NHS England, NHS Workforce Statistics: joiners and leavers by nationality (staff in NHS trusts and other core organisations, full-time equivalent), England. Joiners of unknown nationality (about 1,500 in the latest year) are left out of the share.

CAVEATS Nationality stands in for where staff trained: it counts UK-trained overseas nationals (international students) as overseas and UK nationals who trained abroad as UK, so it is close to, not the same as, international recruitment. The plan does not define its 10% measure. GP practices are not included. The total fell by a third from 2022/23 as trusts cut recruitment.

D11 Hospital flow: the National Audit Office's figures DATA

The National Audit Office's 2026 report on patient flow from A&E, examined by the Public Accounts Committee on 2 November 2026, confirms the pressure on beds and the cost of delays, and puts the bed gap at 12,000 to 17,000 beds that NHS England says it can neither afford nor staff.

ENGLAND	FIGURE
General and acute bed occupancy (before → after)	87% → 92%
Bed days taken by patients ready to leave (share; a year)	14.7%; about 4.7 million
Estimated cost of delayed discharge (£ a year)	£2.7bn
Beds needed to run at a safe occupancy, against beds now	115,000–120,000 against about 103,000
A&E patients waiting 12+ hours from arrival (share of attendances)	about 3% before Covid → about 10% in 2025/26
Cost per A&E patient (2024/25 prices)	£211 (2018/19) → £280 (2024/25)
Spending on A&E (£ a year)	£4.3bn (2018/19) → £6.6bn (2024/25)
A&E staff, all groups (growth)	more than 20%, faster than attendances

SOURCE

National Audit Office, *Managing the flow of patients through hospital from A&E* (HC 588), as stated by members and witnesses at the Public Accounts Committee, oral evidence, HC 764, 2 November 2026. The 12,000–17,000 is the difference between the beds needed and those available; the committee chair quoted the NAO's 9,000–14,000 beds as making "a huge difference".

CAVEATS

Taken from the hearing transcript, not the report itself; check against HC 588 before quoting. The occupancy figures' years are as the NAO states them. The NAO reports that NHS England saw bed occupancy as the "key driver" of falling A&E performance; the trust data here (D2, A1) find most breaches happen before any wait for a bed.

Derived

A1 Trusts' problems differ DERIVED

England's acute trusts do not share one set of problems. A trust with full beds is no more likely to have long scan waits, a long waiting list or poor A&E, so national levers applied uniformly miss most trusts, and the fix has to be worked out trust by trust. The plan's reforms give that freedom to trusts that are doing well; those with the hardest problems get more central direction and less money.

117 ACUTE TRUSTS, 2024/25: IN THE WORST QUARTER FOR	TRUSTS
Beds and discharge (occupancy or delayed discharges)	51
A&E delays that occupancy does not explain	23
Long waiting list (months of treatment)	30
Few treatments per doctor	30
Diagnostic waits	29
None of these / one / two or more	22 / 44 / 51

117 ACUTE TRUSTS, 2025/26	LOW END: 1 TRUST IN 10 IS BELOW	MIDDLE TRUST	HIGH END: 1 TRUST IN 10 I
General and acute beds occupied in winter (%; 89 trusts above 92%)	90%	94%	
Delayed patients a day per 100 general and acute beds	14	21	
A&E waits of 4+ hours after a decision to admit, per 1,000 emergency admissions	126	345	

117 ACUTE TRUSTS, 2025/26	LOW END: 1 TRUST IN 10 IS BELOW	MIDDLE TRUST	HIGH END: 1 TRUST IN 10 I
through A&E			
Major (type 1) A&E patients seen within 4 hours (%)	48%	60%	
Planned care: waiting under 18 weeks, March 2026 (%)	60%	65%	

DO THE SAME TRUSTS HAVE EACH PROBLEM? 2025/26, WORST 47 TRUSTS (40%) ON EACH MEASURE	TRUSTS IN BOTH	IF UNRELATED (CHANCE)
Fullest in winter, and most delayed patients per bed	22	19
Worst A&E (type 1, 4 hours), and fullest in winter	16	19
Worst A&E, and worst waiting times for planned care	22	19

METHOD

Each trust's 2024/25 occupancy, delayed patients per 100 beds, A&E breaches beyond what occupancy predicts, waiting list in months of treatment, treatments per doctor and 6-week diagnostic share; the worst quarter on each flagged. Correlations between pressures are at most about 0.2, except long lists with fewer treatments per doctor (−0.44).

ALSO

2025/26 (report section 6): A&E performance is unrelated to how full a trust is (rank correlation 0.00) and closely related to breaches before any wait for a bed (−0.88). The 23 trusts with the most A&E bed waits hold 40% of them while admitting 30% of emergency patients through A&E. Planned treatments per doctor fell at 100 of 112 trusts since 2018/19 (middle trust −20%).

LEAGUE TABLE

NHS England's acute league table, Q1 2026/27, matched to 116 of the 117 trusts here: 7 in segment 1, 12 in segment 2, 78 in segment 3, 19

in segment 4. Of the 47 fullest in winter, 3 are in segments 1–2; of the 47 with the worst A&E, 6 are, and 12 are in segment 4. Fourteen trusts are in segment 3 with scores at segment-2 level or better (at or below 2.30, the highest segment-2 score) - the deficit cap, inferred because the saved table did not show its cap column; 7 of them are among the fullest 47 and 8 among those with the most delays per bed, and their middle trust has 70% within 18 weeks. The segment scores follow waiting times (rank correlation −0.56 with the 18-week share) and A&E (−0.37), but barely occupancy (0.20) and not delays (0.01). Warrington and Halton is not in the table.

WHO DECIDES

Freedom is earned. The first six advanced foundation trusts were approved in May 2026, with more operational and financial freedom from 1 June 2026; eligibility depends on strong performance in NHS England's oversight framework. Their financial freedoms are managed nationally within capital allocation, and there are no workforce freedoms. Trusts performing poorly are placed in segment 4 (a co-ordinated response and potential intervention). Deficit support funding is removed by the end of 2028/29 except where NHS England agrees, and a trust receiving it cannot rise above segment 3. 108 trusts were in deficit in the last quarter of 2025/26 (NHS England, oversight framework segmentation summary). Sources: NHS England, Advanced Foundation Trust Programme policy framework; NHS Oversight Framework 2026/27; medium-term planning framework, revenue finance and contracting guidance.

CAVEATS

One year for each table; the cut-offs (worst quarter, worst 40%) are choices, though the low correlations do not depend on them. Trust counts move when services transfer between trusts. The deficit cap is inferred from the scores, not read from NHS England's cap column, and the segment 2/3 boundary is taken as the highest segment-2 score; the league table is Q1 2026/27, the measures 2025/26.

REBUTTAL

"National targets need national programmes." Targets can be national while the money and support follow each trust's binding constraint. "Freedom must be earned." Then support has to follow need: the trusts that most need to act differently are the ones least able to.

A2 Maintenance costs twice the depreciation charge DERIVED

Keeping trusts' buildings, equipment and IT as they are costs about £6.1bn a year, roughly twice trusts' £3.2bn depreciation charge, because buildings are revalued and their depreciation does not measure their wear.

METHOD	New backlog arising (£4.5bn a year, 2022/23–2024/25 average, ERIC) + plant and machinery replaced at its depreciation (£0.94bn) + IT replaced at its depreciation (£0.68bn), against total depreciation of £3.2bn (TAC14, 2024/25). Real 2024/25 prices.
CAVEATS	Backlog arising is an estimate built from ERIC's year-on-year change; it includes inflation in building costs above the general deflator.

A3 The medicines agreement's cost DERIVED

The UK–US medicines agreement commits NHS spending on new medicines to rise from 0.3% of GDP in 2026 to 0.6% by 2036: for England, about £1.3bn a year more by 2028/29 and £7.8bn a year more by 2035/36, in today's prices.

SOURCE	UK–US medicines agreement (December 2025; text published April 2026, as reported by Covington, 8 May 2026); House of Commons Library CBP-10850 (calendar-year steps: 0.35% by end-2028, 0.4% by 2030, 0.6% by 2036). England at 84.6% of UK population.
CHECK	Matches the BMJ's £1.3bn for 2028 and the IFS's £9.1bn for the UK in 2036.
CAVEATS	"New medicines" is not defined in any published source; how much displaces existing drug spending is unknown.

Model

England results from the simulation, 2024/25 prices. Each preset is described on the Simulation page; the key settings are below. Waiting times follow from what the budget buys within the staff available, except in M3 and M4, where the waiting-time setting drives treatments and the budget gap is reported.

M1 The plan on its own assumptions MODEL

Taking the 10 Year Plan's own assumptions, the waiting list reaches about 88% within 18 weeks by March 2029, not 92%. With overseas recruitment cut to under 10% of joiners and no new training places, nurses and then doctors run short (about 17,000 posts unfilled by 2035/36, see M6) and the 18-week share falls back to about 59% by 2035/36, with money left unspent for lack of staff.

ENGLAND	2025/26	2028/29	2030/31	2035/36
Within 18 weeks (March)	65.2%	87.7%	84.7%	59.1%
Doctors needed for the care delivered (WTE)	151,100	156,500	155,400	152,200
Doctors in post (WTE)	151,100	156,500	155,400	146,900
Nurses needed for the care delivered (WTE)	367,500	380,400	377,800	369,900
Nurses in post (WTE)	367,500	378,300	375,000	358,300
Budget unspent for lack of staff	–	£6.8bn	£10.5bn	£20.0bn

ASSUMPTIONS

Productivity 2% a year; agency spending −30%; NHS England and ICB running costs −50%; delayed discharges −6% by 2028/29; neighbourhood health in full (15% fewer emergency admissions); backlog maintenance £4.0bn a year; overseas joiners falling below 10% of joiners by 2035/36; 4,000 new specialty training posts; budget: the 2025 Spending Review to 2028/29, then real GDP growth.

READING IT

Doctors in post fall because of recruitment, not productivity. Productivity of 2% a year means each treatment needs fewer staff; it does not cut staff. Doctors needed for the care delivered stay about level (151,100 in 2025/26, 152,200 in 2035/36), because treatments grow about as fast as productivity. Doctors in post fall below that, to 146,900, because the 10% overseas path leaves 5,300 doctor posts and 11,600 nursing posts empty (M6); and with nurses short, fewer treatments are done, which lowers the doctors needed. In the likely outcome (M2, M7) overseas recruitment stays at today's level, and doctors rise to 172,200 by 2035/36.

CAVEATS

The later collapse depends on the workforce supply modelling (leavers, training lags) and on the plan naming no extra training places; the 10 Year Workforce Plan it promised has not been published.

REBUTTAL

"The workforce plan will fix supply." Then its places and cost belong in the plan's costings now: a medical school place started in 2026 produces a consultant in the late 2030s.

M2 The likely outcome MODEL

With each of the plan's settings at what the evidence so far supports, the 18-week share reaches about 73% by March 2029 and falls to about 53% by 2035/36, with the waiting list rising to 8.1 million.

ENGLAND	2025/26	2028/29	2030/31	2035/36
Within 18 weeks (March)	65.2%	73.3%	65.3%	53.4%
Waiting list (March)	6.84m	5.82m	6.61m	8.14m

ASSUMPTIONS

As M1, except productivity 1% a year (ONS measured 1.1% in 2024 and 1.0% in 2025); no cut in delayed discharges; neighbourhood health on the vanguard evidence (6% fewer emergency admissions, three years' lag); ICB cuts a third; overseas joiners capped at the latest year's level.

CAVEATS

Model waiting lists count NHS-funded pathways by patients' region, so the 2025/26 level differs slightly from the published 7.11m. A best estimate, not a forecast: the back-test shows the model is no better than "no change" at predicting waiting lists, and better on the flows that drive them.

M3 What 92% would take MODEL

Reaching 92% within 18 weeks by March 2029 needs about 12% more planned treatment than 2025/26 and about 13,000 more doctors, rising to 29,000 more by 2035/36, with medical school places doubled and no limit on overseas recruitment.

ENGLAND	2025/26	2028/29	2030/31	2035/36
Planned treatments (RTT pathways completed)	18.7m	21.1m	20.5m	21.2m
Doctors in post (WTE)	151,100	164,200	167,300	180,100
Budget left over (short if negative)	–	£1.3bn	£1.8bn	−£0.9bn

ASSUMPTIONS

The likely outcome's evidence (productivity 1% a year), with treatments set to reach and hold 92%; medical school places doubled to 15,000 by 2031/32, nursing places +80%, GP training places +40%, first-year specialty posts nearly tripled; overseas recruitment unlimited.

CAVEATS

Whether the doctors can be recruited at all is the binding question: the money is close to sufficient, the staff are not available on current

training and the plan's overseas target.

M4 Standing still costs more than the budget MODEL

Simply holding waiting times and A&E where they are, with no productivity growth, costs more than the budget from 2030/31: about £1.5bn short that year and £10.6bn short by 2035/36.

ASSUMPTIONS	The default run: waiting times held at 2025/26 (65% within 18 weeks); productivity 0%; pay rising with prices; demand from ONS population projections and ageing (referrals weighted by who uses outpatient care at each age, other hospital care by bed days); budget as M1.
CAVEATS	Sensitive to productivity: each 1% a year of productivity is worth several £bn a year by 2035/36 (see the Simulation page's cost curve).

M5 Discharge alone does not fix A&E MODEL

In the model, cutting delayed discharges by 90% raises the 4-hour measure by only about 0.6 points, because most breaches are not bed waits (D2) and trusts refill freed beds.

ASSUMPTIONS	Two-part A&E: bed waits driven by winter occupancy with a sharp rise above 92%; other breaches by crowding. Occupancy held at 2025/26 levels except through long-stay patients.
CAVEATS	The link from occupancy to breaches below 92% is weak in trust data; the trolley waits in D1 respond more than the 4-hour measure does.

M6 The overseas target and the waiting-time target clash MODEL

The plan aims for overseas recruits to fall below 10% of joiners by 2035/36. On the plan's own assumptions the NHS would need about 22% of its joiners from overseas that year to keep its waiting times; held to the 10% path, posts go unfilled from 2027/28, about 17,000 by 2035/36, and the 18-week share falls to 59%.

OVERSEAS SHARE OF JOINERS NEEDED IF NOT LIMITED	2028/29	2035/36	2045/46
The plan on its own assumptions (M1)	29%	22%	27%
The likely outcome (M2)	37%	35%	39%
The likely outcome with more training places and better retention	33%	24%	32%

THE PLAN HELD TO ITS 10% PATH	2028/29	2030/31	2032/33	2035/36
Overseas share of joiners	23%	18%	13%	7%
Posts unfilled (full-time equivalent)	2,000	2,800	6,700	16,900
of which nurses	2,000	2,800	6,100	11,600
of which doctors	0	0	700	5,300
Within 18 weeks (March)	88%	85%	78%	59%

ASSUMPTIONS Joiners needed = the staff the care delivered needs, plus leavers replaced; UK joiners come from current training (plus the 4,000 specialty posts), and overseas recruits fill the rest. The third row adds medical school places +50%, specialty training posts doubled, nursing places +40%, GP training places +20% and leaver rates 10% lower.

CAVEATS Rests on the model's leaver rates, the share of trained staff who join the NHS, and staff needed per treatment. Every case dips in 2029/30: that is the end of the push to clear the waiting list, not a fall in need. The model starts from the published shares (D10: 33% of joiners in the year to July 2026, nurses 35%, doctors 42%).

REBUTTAL "Home training will replace overseas recruitment." Even with the expanded training above, about a quarter of joiners are still needed from overseas in 2035/36, and more later as demand grows.

M7 Nurses, not doctors, run out first MODEL

In the likely outcome, with overseas recruitment held at the latest year's level and no extra degree places, the shortage is nurses and scientific and therapy staff. Doctors hold up until about 2040 because of the specialty training deal. The money is there but cannot be spent.

LIKELY OUTCOME (M2): POSTS UNFILLED (FULL-TIME EQUIVALENT)	2028/29	2030/31	2035/36	2045/46
Nurses	5,200	7,800	21,500	61,300
Scientific, therapeutic and technical staff	1,400	2,200	8,100	26,900
Doctors	0	0	0	6,300
Budget unspent for lack of staff	£5.3bn	£6.4bn	£8.1bn	£28.9bn

ASSUMPTIONS As M2: overseas joiners capped at the latest year's level (44,700 in the year to July 2026, 84% of the 2023/24–2025/26 average); no extra nursing or midwifery degree places; specialty training posts +23% (the June 2026 resident doctors' deal).

CAVEATS Nursing need follows the care delivered at today's staffing per treatment, rising slowly as it has since Covid; a different skill mix would move the gap between staff groups.

M8 What the results depend on MODEL

Two assumptions decide the outcome: productivity growth and the health budget after 2028/29. The links the model grades as weak (social care to long stays, GP access to A&E) move waiting times by nothing and the 4-hour measure by under half a point. Extra money does nothing for the likely outcome, which is short of staff, not money.

WITHIN 18 WEEKS (MARCH)	LIKELY OUTCOME 2035/36	ALTERNATIVE 2028/29	ALTERNATIVE 2035/36	AL
Central case (productivity 1% a year; budget growth 1.5% a year real from 2029/30)	53%	88%	71%	
Productivity 0% a year (clinical and administration)	41%	75%	41%	
Productivity 2% a year (clinical and administration;	83%	92%	92%	

WITHIN 18 WEEKS (MARCH)	LIKELY OUTCOME 2035/36	ALTERNATIVE 2028/29	ALTERNATIVE 2035/36	AL
the plan's assumption)				
Budget growth from 2029/30: 1.8% a year real	53%	88%	85%	
Budget growth from 2029/30: 2.0% a year real	53%	88%	91%	
Budget growth from 2029/30: 2.5% a year real	53%	88%	92%	
About 1,700 more A&E consultants (£0.33bn a year) paid from the same budget	–	87%	70%	
Prices at NHS England's planning factors for 2026/27–2028/29 (pay 2.1% a year, other costs about 2%), not the awards made (3.3%, doctors 3.5%) and OBR's forecasts	53%	92%	83%	
Pay award 2027/28 at 2.4% (DHSC's planning figure) rather than CPI (3.1%)	53%	90%	74%	

WITHIN 18 WEEKS (MARCH)	LIKELY OUTCOME 2035/36	ALTERNATIVE 2028/29	ALTERNATIVE 2035/36	AL
Weak links at either end of their range	53%	88%	71%	

READING IT

The alternative is the likely outcome's evidence with staff grown at home and recruited from overseas as needed, discharge help aimed at the fullest hospitals and the estate maintained, on the same budget. 92% is the target and the most the model plans for. Extra budget in the likely outcome goes unspent (£8bn in 2035/36 at 1.5% growth, £25bn at 2.5%) because there are not the staff to use it.

ASSUMPTIONS

Prices: 2026/27 pay as awarded (Agenda for Change 3.3%, doctors and dentists 3.5%), then CPI-linked (OBR, October 2026); non-pay at CPI; clinical negligence at NHS England's CNST increases for 2026/27–2028/29 (8.0%, 5.9%, 5.5%). NHS England's medium-term planning framework assumes pay of 2.1% a year (a placeholder) and a 2% general efficiency factor, the same 2% productivity as the plan. The gap matters: in 2023/24 pay awards above the inflation the budget was set on left "an unfunded pressure of about £1.6 billion… about the level of the aggregate deficit" (NHS England's chief financial officer, Public Accounts Committee, 25 November 2024). Productivity is set separately for clinical staff (treatments per clinician, tests per team) and administration; the productivity rows move both together. Recruiting above pay and retention schemes are costed (M9). The A&E consultants row takes their cost out of the budget left for planned care; their benefit, 0 to +2.7 points on the 4-hour measure (central 0), comes from outside the model and is not in the waiting-time figures.

CAVEATS

The history's link from doctors to treatments (0.54% more treatments per 1% more doctors, range 0.08–1.0) is used in the back-test, not the projections: treatments there are set by the budget and the staff needed per treatment, so its uncertainty shows through productivity.

M9 Keeping staff is the cheapest way to add them MODEL

Where overseas recruitment is limited, leaver rates 10% lower lift the share waiting under 18 weeks from 53% to 70% in 2035/36, for about £0.17bn a year. Where it is

open, retention replaces about 13,600 overseas recruits a year and pays for itself on recruiting costs alone at about £6,000 per leaver kept.

THE LIKELY OUTCOME (M2), ENGLAND	2028/29	2035/36	2045/46
Within 18 weeks (March), as M2	73.3%	53.4%	44.7%
Within 18 weeks (March), leaver rates 10% lower	80.1%	70.5%	52.7%
Leavers kept (full-time equivalent a year)	13,400	14,500	15,600
Cost of retention schemes at £12,000 per leaver kept (£ a year, 2024/25 prices)	£0.16bn	£0.17bn	£0.19bn
Budget unspent for lack of staff, as M2 (£, 2024/25 prices)	£5.3bn	£8.1bn	£28.9bn
THE ALTERNATIVE (SECTION 7): WHAT LEAVER RATES 10% LOWER SAVE, ENGLAND	**2028/29**	**2035/36**	**2045/46**
Leavers kept (full-time equivalent a year)	13,600	14,700	16,800
Overseas joiners not needed (full-time equivalent a year)	11,000	13,600	11,000
Recruiting cost saved (£ a year, 2024/25 prices)	£0.08bn	£0.09bn	£0.11bn
Break-even: recruiting saved per leaver kept (£)	£6,200	£6,300	£6,600
Within 18 weeks (March): with retention at £12,000 per leaver kept, against none (percentage points)	−0.2	−0.3	−0.2

READING IT

In the likely outcome staff are the limit and money is left over, so retention adds treatments and its cost does not take any away. In the alternative, overseas recruits fill any gap, so a leaver kept is a recruit not needed: waiting times are unchanged before its cost, and retention's case is the overseas target. Break-even is below the overseas recruiting cost (£10,000) because some leavers kept replace UK joiners (£2,000) or support staff of other nationalities, who mostly already live in the UK.

ASSUMPTIONS

Leaver rates 10% lower by 2028/29, phased in from 2026/27, for every staff group. Retention costed at £12,000 per leaver kept: NHS Improvement's 2018 estimate of what replacing a nurse costs (a scheme pays for everyone in it, not only those who would have left). Recruiting above pay, for joiners above or below 2023/24–2025/26 numbers: £10,000 per overseas recruit of a registered group (Nuffield Trust, 2021: £2,000–£12,000 a nurse by country, £8,987 to the trust for its Philippines example; Swansea Bay, 2023: about £9,000; a study for the Royal College of Nursing: £16,900), £2,000 per UK joiner (assumption: direct costs about £400 a nurse at one trust, plus

	induction time). Vacancy cover while posts are empty is costed separately (premium staff).
CAVEATS	No NHS evaluation publishes a cost per leaver kept. The strongest causal study, of NHS Improvement's 2018–19 retention support programme, found leaver rates 0.4 points lower; for nurses (about 8% a year) that is about 5%, half the 10% assumed. Nationality stands in for overseas recruitment (D10).
REBUTTAL	"Retention schemes are expensive." At £12,000 per leaver kept they cost about £0.17bn a year; the likely outcome leaves £8.1bn unspent because the staff do not exist. The question is whether a scheme can deliver the cut, not whether it is affordable.

Model credibility

- Calibrated on 2018/19–2022/23 and tested on 2023/24–2025/26 without seeing them. Against two simple forecasts (no change; trend) it does better on flows (admissions, A&E attendances, referrals, treatments, delays, cost) and no better on stocks (the waiting list, bed occupancy). Projections therefore start from 2025/26 actuals and move only through measured links.
- Links graded "weak" (social care to long stays; GP access to A&E) are shown as ranges.
- Diagnostics projections are not robust (scan queues build and then empty over twenty years) and are not used in the report.
- The same model runs for 114 of England's 117 acute trusts, each from its own 2025/26 figures.