November 2026 · Steve Cousens, independent analyst

Summary

The 10 Year Health Plan does not reach its own targets, even on its own assumptions. Taking its claims at face value, 88% of patients wait under 18 weeks by March 2029, not 92%, and the share falls back to 59% by 2035/36 as nurses and then doctors run short. On what the evidence so far supports, it reaches 73% and falls to 53%. A&E stays at about 75% within four hours on every run, against targets of 82% and 85%.

Within 18 weeks (March)	2028/29	2035/36	2045/46
The plan as claimed	88%	59%	42%
The likely outcome	73%	53%	45%
A better way, same budget	88%	71%	88%
Target	92%	92%	92%

Five findings stand out.

1. **Staff, not money, is the limit.** In the likely outcome 21,500 nursing posts are unfilled by 2035/36 and £8.1bn of the budget goes unspent for lack of staff. The plan names no extra nursing or medical school places, and its workforce plan is unpublished.
2. **The overseas and waiting-time targets clash.** Holding waiting times needs about 22% of joiners from overseas in 2035/36 on the plan's own assumptions; held to its 10% path, about 17,000 posts go unfilled.
3. **The arithmetic rests on 2% productivity, about double what has been measured,** and on planning prices below the pay awards already made.
4. **A&E is a problem inside departments.** Three in four four-hour breaches happen before any wait for a bed, and nothing in the plan, or tested here, closes the gap.
5. **One national plan meets 117 different hospitals.** The fullest hospitals, those with the most delayed discharges and those with the worst A&E are largely different trusts, and the plan gives freedom to those doing well and more central control to those with the hardest problems.

The same budget can do better. Training more staff, keeping them longer, recruiting from overseas while home supply builds, aiming discharge help at the fullest hospitals and maintaining the estate reach 88% by 2029, hold 71% in 2035/36 against 53%, and return to

88% by 2045/46. Keeping staff is the cheapest part: cutting leaver rates by a tenth adds about 17 points by 2035/36 where overseas recruitment is limited, for about £0.17bn a year.

The report recommends a costed workforce plan with a retention target, an open choice between the overseas and waiting-time targets, a budget beyond 2028/29, planning on realistic prices and productivity, a maintained estate, discharge help aimed at the fullest hospitals, A&E targets treated as unfunded until a route is shown, and support and freedom that follow need as well as performance.

1. The plan and how it was tested

The 10 Year Health Plan for England, *Fit for the Future*, was published in July 2025. It sets three shifts: from hospital to community, from analogue to digital, and from sickness to prevention. It promises a neighbourhood health service, the abolition of NHS England into the Department of Health and Social Care, and halved running costs for the centre and integrated care boards. Its funding to 2028/29 is the 2025 Spending Review's; beyond that it sets no figure.

This report tests the plan against its own measurable commitments:

- 92% of patients waiting under 18 weeks for planned care by March 2029;
- A&E: 82% of patients seen within four hours by March 2027 and 85% in 2028/29;
- overseas recruits below 10% of NHS joiners by 2035;
- productivity growth of 2% a year, which carries most of its arithmetic;
- all within the budget.

How it was tested

The evidence comes in two kinds, labelled throughout. The first is published data: NHS England's statistics on waiting times, A&E, beds, discharge, diagnostics and the workforce, and the annual accounts of every NHS trust from 2018/19 to 2024/25, at 2024/25 prices. The second is a simulation of England's seven NHS regions and 117 acute trusts, built from those accounts and statistics, which projects demand, staff, cost and performance to 2045/46. It uses ONS population projections, OBR's October 2026 inflation forecasts, the pay awards made for 2026/27 and the Spending Review budget. The model was calibrated on 2018/19–2022/23 and tested against 2023/24–2025/26; section 8 sets out how far to trust it.

In the simulation, waiting times are the outcome, not an input. Each year, planned treatment is the least of three limits: what the budget buys after emergency, A&E, mental health and community care are paid for; what the staff in post can do; and what keeps the waiting list on its path to the target. Four runs answer different questions:

Run	The question	How it is set
The plan as claimed	Does the plan add up on its own assumptions?	Each of the plan's claims taken at face value: 2% productivity, neighbourhood health in full, the centre's cuts made, overseas recruitment falling to 10%
The likely outcome	What will the plan probably achieve?	Each claim replaced by what the evidence so far supports: 1% productivity, the measured effect of neighbourhood health, overseas recruitment at the latest year's level
What it would take	What would meeting the target cost?	The likely outcome's evidence, with the waiting-time target met whatever it costs, and the money and staff it needs reported
A better way, same budget	Can the same money do better?	The likely outcome's evidence and budget, with staff grown at home and kept longer, discharge help aimed at the fullest hospitals and the estate maintained

Every figure in the report is backed by an evidence bank that records its source, method, assumptions and caveats, and the strongest counter-argument to it.

2. Where the NHS is now

The NHS is not overwhelmed at the front door; patients are stuck inside it. Between 2018/19 and 2025/26, emergency admissions through A&E rose 1.1%, but waits of more than 12 hours for a bed rose 175-fold, from 3,262 to 570,957.

England	2018/19	Latest	Standard or target
A&E patients seen within 4 hours	88.0%	74.0% (October 2026)	78% by March 2026; the plan: 82% by March 2027, 85% in 2028/29
Waits of 12+ hours after a decision to admit	3,262 a year	570,957 a year (2025/26)	None

England	2018/19	Latest	Standard or target
Patients a day in hospital who no longer meet the criteria to stay	13,203 (2022/23)	12,978 (2025/26)	None
Waiting list for planned care	4.2m (March 2019)	7.38m (September 2026)	–
Of which waiting under 18 weeks	86.7% (March 2019)	65.8% (September 2026)	92% by March 2029
Patients cared for in corridors, daily	–	3,560 (October 2026)	None (new series from May 2026)
Acute trusts rated Good or better for safety	–	25 of 117	–

A&E: a problem of flow, not demand

Attendances at major A&E departments rose 6.8% over the seven years, and admissions through A&E 1.1%. Almost the same number of patients needed a bed in 2025/26 as in 2018/19. What changed is how long they waited for one: 118 of every 1,000 patients admitted through A&E waited more than 12 hours after the decision to admit, against fewer than one in 2018/19. Measured from arrival rather than from the decision, 12-hour waits are far higher.

Most A&E delays happen before the bed

Three in four type 1 patients who waited over 4 hours in 2025/26 were not waiting for a bed. Of 6.60 million breaches, 1.57 million were waits of 4 hours or more after a decision to admit; the other 5.03 million arose in assessment and treatment inside the department. Fixing discharge would shorten the trolley waits. On its own it would barely move the 4-hour measure: in the simulation, even a 90% cut in delayed discharges raises it by about 0.6 points.

Delayed discharge has not moved

About 13,000 patients a day remain in hospital after they no longer need to be there, around one in eight occupied general and acute beds. The number has not changed in three years, although adult social care spending rose 14% in real terms between 2021/22 and 2024/25. Part of that money went on fees and the National Living Wage; it has not bought more flow out of hospital.

The National Audit Office's 2026 report on patient flow, examined by the Public Accounts Committee in November 2026, puts numbers to this. General and acute bed occupancy rose from 87% to 92%. Patients ready to leave take 14.7% of bed days, about 4.7 million a year, at an estimated cost of £2.7bn. Running at a safe occupancy would need 115,000–120,000 beds against about 103,000. NHS England's chief executive told the committee that the gap could be neither afforded nor staffed.

The waiting list

7.38 million pathways were waiting in September 2026, 65.8% of them within 18 weeks. The longest waits have fallen sharply: 1.6% have waited over a year, against 7.5% in April 2021. But the 18-week share has barely moved in five years, and the plan needs it to reach 92% by March 2029.

Corridor care and safety

NHS England began publishing corridor care in May 2026. In October about 3,560 patients a day were cared for in corridors: 2,720 in A&E and 840 on wards, up from 2,900 in May. Of England's 117 acute trusts, 25 hold a Good rating for safety from the Care Quality Commission and none Outstanding; 89 require improvement and 3 are inadequate. Twenty-one of those ratings are more than three years old.

What this means for the plan

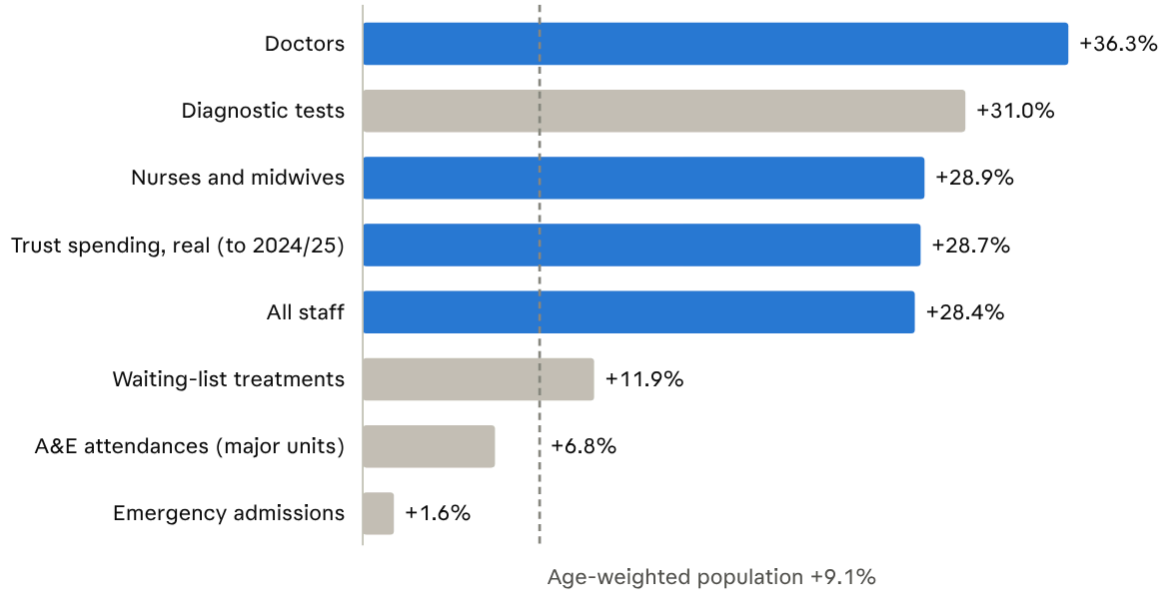
The plan's three shifts (hospital to community, analogue to digital, sickness to prevention) are aimed at demand. The evidence points to flow inside hospitals: beds held by patients who could leave, and departments that cannot assess and treat in time. The plan's A&E targets need 11 points of improvement on the 4-hour measure in under three years. The plan does not show what delivers them, and the simulation finds nothing in it that does.

3. Where the money and staff went

Since 2018/19, NHS trusts have gained 28% more staff and 29% more real spending, but deliver only 2% more emergency admissions, 7% more A&E attendances and 12% more waiting-list treatments. Only diagnostic tests (+31%) kept pace.

Staff and spending grew about 28%; most counted care grew far less

Change 2018/19 to 2025/26, England, NHS trusts. Blue: staff and spending. Grey: care delivered.



NHS Workforce Statistics (trusts, WTE); Hospital Episode Statistics; NHS England A&E, RTT and DM01 statistics; Trust Accounts Consolidation (TAC08) at 2024/25 prices; ONS population, weighted by hospital use at each age

The gap holds for acute trusts alone: staff +27.7%, doctors +37.6%, nurses and midwives +31.7%. Treatments and tests include those carried out by independent providers for the NHS, which if anything flatters the comparison.

Productivity

The Office for National Statistics measured quality-adjusted NHS productivity growth of 1.1% in 2024 and 1.0% in 2025; before the pandemic it averaged about 0.6% a year. The 10 Year Health Plan assumes 2% a year. That assumption carries most of the plan's arithmetic: in the simulation, the difference between 1% and 2% is the difference between 53% and 83% of patients waiting under 18 weeks in 2035/36.

There are fair explanations for some of the gap, and they should be weighed:

- Patients may be older and more complex than the counts show.
- Staffing in 2018/19 was unsafe in places, and some growth restored safe levels.
- Much of what trusts do (community care, mental health, follow-up, training) is not in these counts.

Each explains part. None explains why 28% more staff produce 2% more emergency care, and the plan does not say where the extra staff's time goes or how it will be recovered.

Where the staff came from

One joiner in three is not a UK national. In the year to July 2026, 44,700 of 136,800 full-time equivalent joiners came from overseas: 42% of doctors, 35% of nurses and 43% of support staff. The share peaked at 35% in 2022/23 and has eased only slightly, because UK joiners fell almost as fast as overseas ones when trusts cut recruitment. The plan aims for under 10% by 2035; it names no extra nursing or medical school places to replace them, and its promised 10 Year Workforce Plan is unpublished. Nationality is a stand-in for where staff trained, and the plan does not define its 10% measure.

Where the money went

Trust spending rose from £110.8bn in 2018/19 to £142.5bn in 2024/25 at 2024/25 prices (+28.7%), in step with staff. Drugs grew faster than the care delivered: providers' drug spending rose about 2.1% a year more than cost-weighted treatments over the same years. Day-to-day budgets are set to 2028/29 by the 2025 Spending Review (2.7% a year real at October 2026 inflation forecasts); beyond that the plan sets no figure.

4. The foundations

The NHS is running down its buildings, equipment and IT. The maintenance backlog grew by a quarter in two years, to £15.9bn, and in 2024/25 trusts replaced only 54% of the IT that wore out. Maintaining all three properly would cost about £2.7bn a year more capital than trusts now spend.

Buildings

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 the backlog	£3.2bn	£3.2bn	£3.2bn
New backlog arising in the year	£3.9bn	£4.8bn	£4.8bn

About £4.8bn of new backlog arises each year and trusts invest £3.2bn, so it grows by £1.3–1.6bn a year. The £15.9bn often quoted alongside the plan is the size of the backlog, not new money. The 10 Year Capital Plan's Estates Safety Fund, £6.75bn over nine years, is about £0.75bn a year: less than the yearly growth. Even with the fund, and taking it as extra money on top of today's £3.2bn (the plan does not say which), the backlog reaches about £21bn by 2035/36 in the simulation.

Equipment and IT

England, NHS trusts	2022/23	2023/24	2024/25
Plant and machinery bought, % of what wore out (depreciation)	96%	91%	77%
IT bought, % of what wore out (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

At 2024/25's replacement rates the average remaining life of trusts' equipment and IT would fall from about 4.4 years to 1.7 years by 2035/36. Part of the IT fall may be a shift to leased and cloud services, which these lines do not count. Either way, the plan's ambitions for AI and digital care sit on an ageing device estate.

What maintaining them really costs

Two things are needed, and the plan funds neither in full:

1. **Replace equipment and IT as they wear out**: about £0.5bn a year more than at 2024/25's rates.
2. **Clear the building backlog by March 2036 and stop it rebuilding**: about £2.1bn a year more than the plan's £4.0bn a year for backlog maintenance.

Together, trusts' capital spending rises from about £8.0bn to £10.7bn a year. DHSC's capital budget is due to rise from £11.5bn in 2024/25 to £15bn by 2029/30, but most of it goes on new schemes, equipment and IT. Money spent on maintenance is money not spent on treatment: on the same budget, maintaining the estate properly costs about 5 points on the 18-week measure by 2035/36 (section 7). That is the honest price of not letting the estate decay.

5. Testing the plan

The plan does not reach its own targets, even on its own assumptions. Taking those assumptions at face value, 88% of patients wait under 18 weeks by March 2029, not 92%, and the share falls back to 59% by 2035/36 as staff run short. On what the evidence so far supports, it reaches 73% and then falls to 53%. A&E stays at about 75% within 4 hours in every case, against a target of 85%.

Target	Plan on its own assumptions	Likely outcome
92% within 18 weeks by March 2029	88% (2028/29); 59% (2035/36)	73% (2028/29); 53% (2035/36)
A&E: 82% within 4 hours by March 2027, 85% in 2028/29	74.6% (2028/29)	74.3% (2028/29)
Overseas recruits below 10% of joiners by 2035	Met (7%), but about 17,000 posts unfilled in 2035/36	Not met: about 35% needed
Within the budget	Yes, with £20.0bn unspent in 2035/36 for lack of staff	Yes, with £8.1bn unspent in 2035/36 for lack of staff

The model runs from 2025/26 actual figures and moves only through links measured in past data; section 8 sets out how far to trust it.

On its own assumptions

This run takes the plan's claims as given:

- productivity of 2% a year;
- delayed discharges down 6% by 2028/29;
- neighbourhood health in full, with 15% fewer emergency admissions where it covers;
- NHS England and ICB running costs halved;
- the Spending Review's budget to 2028/29, then growth in line with the economy (1.5% a year real);
- overseas joiners falling below 10% of all joiners by 2035/36.

Even so, treatments stop short of 92% in March 2029. After that the 10% path bites. With no extra nursing or medical school places, nurses and then doctors run short: 11,600 nursing and 5,300 doctor posts are unfilled by 2035/36. The 18-week share falls to 59%, and £20bn of the budget goes unspent because the staff to spend it on do not exist.

On what the evidence supports

The likely outcome replaces each of the plan's settings with what has been measured so far:

Setting	Plan's claim	Evidence so far
Productivity	2% a year	1% a year (ONS: 1.1% in 2024, 1.0% in 2025)

Setting	Plan's claim	Evidence so far
Delayed discharges	6% fewer by 2028/29	No change: 13,700 a day in April–September 2026, 8% more than a year earlier
Neighbourhood health	15% fewer emergency admissions, at once	6% fewer by year 3, none in year 1 (the 2015–2018 vanguards)
ICB running costs	Halved	Cut by a third (NHS England's own 2026/27 forecast)
NHS England and DHSC staff	Halved	Half of that cut made
Overseas recruitment	Falling to 10% of joiners	Held at the latest year's level: 44,700 in the year to July 2026

On these settings the 18-week share peaks at 74% in 2027/28 and then declines every year, to 53% in 2035/36 and 45% by 2045/46. The binding limit is nursing: 21,500 nursing posts unfilled by 2035/36, with £8.1bn of the budget unspent.

What 92% would take

Meeting the waiting-time target on the same evidence needs:

- about 12% more planned treatment than in 2025/26;
- about 13,000 more doctors by 2028/29, rising to 29,000 by 2035/36;
- medical school places doubled, nursing places up 80%, specialty training posts nearly tripled;
- overseas recruitment without a limit until home-trained staff arrive.

The money is close to sufficient: the cost is £0.9bn a year above the budget in 2035/36. The staff are not, on current training or under the plan's overseas target.

Standing still costs more than the budget

With no productivity growth, simply holding waiting times at 65% and A&E where it is costs more than the budget from 2030/31: £1.5bn short that year and £10.6bn short by 2035/36. Without productivity growth, the budget does not even buy today's service.

What is missing

Five gaps account for the shortfall:

1. **A workforce plan.** The plan names no extra nursing, midwifery or medical school places, and its 10 Year Workforce Plan is unpublished. Its 10% overseas target and its waiting-time target cannot both be met: keeping waiting times needs about 22% of joiners from overseas in 2035/36 even on the plan's own assumptions.
2. **Money after 2028/29.** The plan sets no budget beyond the Spending Review. It relies on productivity of 2% a year, about double what has been measured, and that assumption carries most of its arithmetic.
3. **Maintenance.** The backlog grows from £15.9bn to about £21bn by 2035/36 on the plan's funding (section 4).
4. **Flow out of hospital.** No target for delayed discharges, which have not moved in three years.
5. **A&E.** This is the plan's weakest point. It needs 11 points of improvement on the 4-hour measure in under three years. Three quarters of breaches happen inside the department, before any wait for a bed (section 2). Even a 90% cut in delayed discharges moves the measure by about 0.6 points. The plan names no costed measure that closes the gap. Closing England's shortfall of about 1,700 A&E consultants would cost about £0.33bn a year, and the evidence for its effect ranges from nothing to about 2.7 points. On every run here, including the alternative in section 7, A&E stays near 75%. The 82% and 85% targets are aspirations, not outcomes of anything the plan funds. National bodies read the problem differently: the National Audit Office reports that NHS England saw bed occupancy as the key driver of falling A&E performance. Across England's acute trusts, A&E performance is unrelated to how full a trust is (section 6); it moves with what happens inside the department.

6. One plan, 117 different hospitals

The plan sets national targets and national levers. England's 117 acute trusts start from very different places, and their problems are not the same problem at different sizes: the fullest trusts, the trusts with the most delayed patients and the trusts with the worst A&E are largely different trusts. A lever spread evenly lands mostly where it is not the problem.

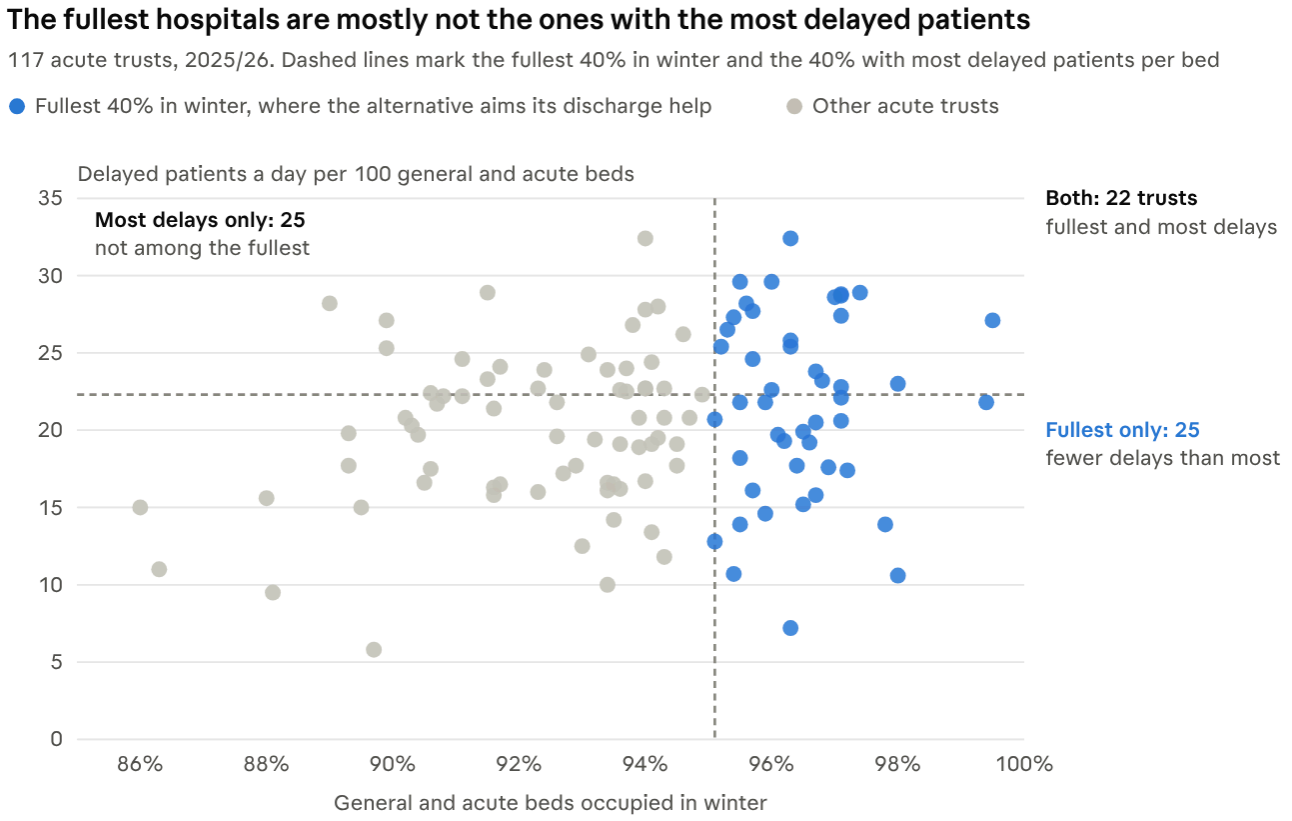
Different starting points

England's acute trusts, 2025/26	Low end: 1 trust in 10 is below	Middle trust	High end: 1 trust in 10 is above	Against the plan or a known threshold
General and acute beds occupied in winter (%)	90%	94%	97%	89 of 117 above 92%, where A&E bed waits climb steeply
Delayed patients a day per 100 general and acute beds	14	21	28	No national target
A&E waits of 4+ hours after a decision to admit, per 1,000 emergency admissions through A&E	126	345	591	No national target
Major (type 1) A&E patients seen within 4 hours (%)	48%	60%	71%	2 trusts at 78% or more, none at 85% (the targets count all A&E types, which run higher)
Planned care: waiting under 18 weeks, March 2026 (%)	60%	65%	73%	None at 92%; 9 at 75% or more; 12 below 60%
Waiting list, in months of referrals	3.1	4.1	5.0	–

Each figure is one trust's; the middle trust is the median, with half the trusts above it and half below. A higher figure is worse in every row except the two A&E and waiting-time shares, where higher is better.

The spread is widest where the plan says least. Bed waits per emergency admission differ almost fivefold between the low and high ends, and the 23 trusts with the most bed waits hold 40% of them while admitting 30% of emergency patients through A&E. Waiting-time performance differs less: no trust is at 92%, and only nine are at 75%.

The problems sit in different trusts



NHS England bed availability and occupancy (winter) and discharge (NCTR) statistics; the report's trust baseline, 2025/26

Of the 47 fullest trusts in winter, 22 are also among the 47 with the most delayed patients per bed: barely more than the 19 that chance alone would give. A&E performance is unrelated to how full a trust is (a rank correlation of 0.00) and closely related to breaches that happen before any wait for a bed (−0.88). The trusts with the worst A&E are no more likely than others to be the fullest: 16 of the worst 47 are, against 19 by chance.

The obvious way to aim discharge money, at the trusts with the most delayed patients, therefore misses most of the trusts where delays cost A&E most. Section 7 shows the result: the same discharge budget aimed at the fullest 40% of trusts avoids about 19% more A&E waits for a bed than spreading it evenly, and aimed at the most delays per bed, about 31% fewer. A&E improvement has to go department by department, because the trusts that fail the 4-hour standard are mostly failing it inside the department.

Productivity starts from different places

Since 2018/19, staff grew faster than planned treatments at 90 of the 112 acute trusts with figures for both years. Planned treatments per doctor fell at 100 of them: the middle trust does a fifth fewer than in 2018/19, and only 12 do more. A national 2% a year assumes every trust improves alike. The spread shows where the room is, and that the trusts which

held their output per doctor have something to teach the rest. Trust counts move when services transfer between trusts, and treatments that independent providers carry out for the NHS are not counted at the trust; England's figures in section 3 include them.

Same plan, different results

The model's trust results share their region's staff, budget and levers, and differ by each trust's starting point and its own demand. Even so, the spread is wide.

Acute trusts waiting under 18 weeks (March), 114 trusts with results	Plan as claimed, 2028/29	Likely outcome, 2028/29	Alternative, 2028/29	Alternative, 2035/36
Middle trust	85%	70%	85%	75%
Trusts at 92% or more (number)	6	0	9	6
Trusts below 60% (number)	2	11	2	26

When England reaches 88% in 2028/29 on the plan's own assumptions, the middle trust is at 85% and only six reach 92%. On A&E, 17 to 20 trusts reach 78% within 4 hours on every run, and one reaches 85%.

Who decides

If the right action differs trust by trust, it has to be worked out trust by trust. For the trusts that most need that, the plan's reforms move the other way.

Freedom is earned. The first six advanced foundation trusts, approved in May 2026, gained more operational and financial freedom from 1 June 2026, and eligibility to apply depends on strong performance in NHS England's oversight framework. Even these freedoms are limited: their financial flexibilities are managed nationally within capital allocation, and there are no workforce freedoms. Trusts that perform poorly are placed in segment 4 of the framework, which means a co-ordinated national response and potential intervention. Deficit support funding is removed by the end of 2028/29, except where NHS England agrees otherwise, and a trust receiving it cannot rise above segment 3. In the last quarter of 2025/26, 108 trusts were in deficit.

NHS England's league table for the first quarter of 2026/27 shows where the trusts stand. Of the 116 acute trusts in both its table and this report, 7 are in segment 1, 12 in segment 2, 78 in segment 3 and 19 in segment 4. Of the 47 fullest trusts in winter, only 3 are in

segments 1 or 2. Fourteen trusts sit in segment 3 with scores at the level of segment 2 or better, the mark of the deficit cap (inferred from the published scores; the table's own cap column was not available), and half of them are among the fullest 47. Their waiting times are better than most (a middle value of 70% within 18 weeks), but they run full, with about 23 delayed patients per 100 beds: the trusts where section 7 finds discharge help pays most. The framework's scores follow waiting times (rank correlation 0.56) but barely follow how full a trust is (0.20) and not its delayed discharges (0.01).

So the trusts with the hardest local problems get more central direction and less money, at the point where the fix is most local. Not everything can be local. The supply of staff (training places, overseas recruitment, national pay), the budget beyond 2028/29, social care capacity and the capital total are national decisions. But the actions are local: where discharge help goes, how an A&E department runs, where productivity can come from, how a trust keeps its staff. The national task is to set the money and the staff supply, and to match support to need as well as freedom to performance.

What this means

National targets, and money spread evenly, suit a system whose parts are alike. The NHS's parts are not. Four changes follow, set out in section 9:

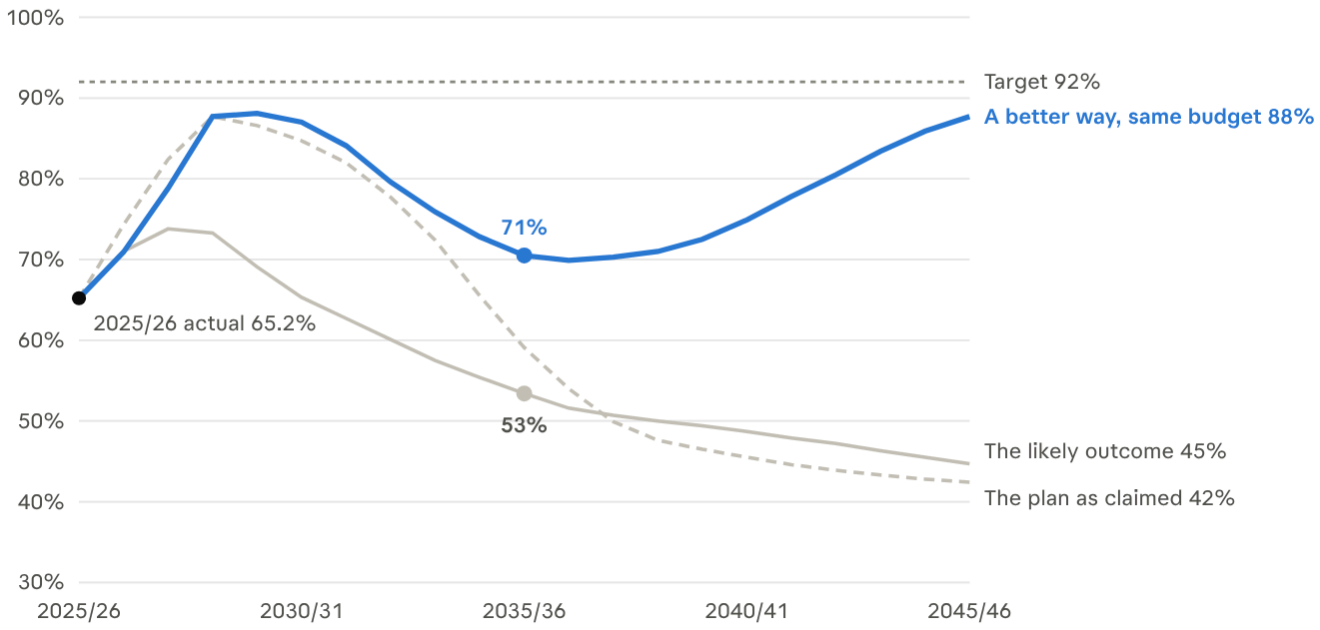
- aim discharge help at the trusts that run fullest in winter, not at those with the most delayed patients;
- support A&E improvement department by department, starting with the trusts where most breaches happen before anyone needs a bed;
- set productivity expectations trust by trust, from where each starts, and learn from the trusts that held their output per doctor;
- give trusts with the hardest problems multi-year funding and improvement support tied to their own diagnosed plan, rather than central direction and a shrinking deficit allowance.

7. A better way

There is a better way within the same budget. It reaches 88% of patients within 18 weeks by March 2029, what the plan achieves only on its own optimistic assumptions, but on the evidence instead. It then holds 71% in 2035/36, against 53% in the likely outcome, and recovers to 88% by 2045/46 as home-trained staff arrive. It does this by spending the money the plan leaves idle for lack of staff.

Same budget, different use: 71% within 18 weeks in 2035/36, not 53%

England, patients waiting under 18 weeks for planned care, March of each year; 2025/26 actual, later years simulated



NHS England RTT statistics (2025/26); the report's simulation for later years, same budget in all three runs (Spending Review to 2028/29, then 1.5% a year real)

The alternative starts from the likely outcome's evidence: productivity 1% a year, neighbourhood health at its measured effect, the centre's cuts part made. It keeps the plan's budget and changes how the money and the workforce are used.

The package

Element	What changes	Cost, 2035/36	Taken out of the package, 2035/36	What it buys
Overseas recruitment as needed	No cap until home supply arrives	–	69% within 18 weeks (−1.3 points); 66% by 2045/46 (−21 points)	No posts left empty
Staff kept longer	Leaver rates 10% lower by 2028/29	£0.18bn a year (£12,000 per leaver kept), less about £0.09bn of recruiting saved	71% (+0.3 points)	14,700 staff a year kept; 13,600 fewer overseas joiners a year

Element	What changes	Cost, 2035/36	Taken out of the package, 2035/36	What it buys
Training places	Medical school +50%, specialty training posts doubled, nursing +40%, GP training +20%	£0.9bn a year	73% (+2.7 points)	7,600 fewer overseas joiners a year, from the early 2030s
Discharge help at the fullest hospitals	Delayed discharges −25% by 2028/29, aimed at the fullest 40% of acute trusts, beds kept open, the care that replaces them paid for	£0.15bn a year	71% (+0.6 points)	About 98,000 fewer A&E waits for a bed a year; a quarter fewer delayed patients
The estate maintained	Backlog cleared by March 2036; equipment and IT replaced as they wear out	£2.1bn a year	76% (+5 points)	£21bn backlog cleared; no estate decay

Read the fourth column as the price of each element in waiting times: training and maintenance cost money up front on a fixed budget, and the package pays for them with fewer treatments in the early 2030s. In return the NHS depends less on overseas recruitment and stops its buildings and equipment decaying.

Why it works

The likely outcome is short of staff, not money: £8.1bn goes unspent in 2035/36. The alternative removes that limit. It recruits from overseas while home training builds up, keeps more of the staff it has, and trains more. With staff available, the budget becomes the limit, and every pound is spent: the package leaves under £1bn unspent in 2035/36.

Overseas recruitment remains essential. About 52,500 joiners a year come from overseas in 2028/29, over a quarter more than today's level. That falls to 36,000 in 2035/36 as home-trained staff arrive (24% of joiners), then rises again with demand. A 10% target is not reachable on any run here; the honest choice is between recruiting from overseas and longer waits.

Keeping staff, and what recruiting costs

Recruiting costs money on top of pay, and the model counts it: about £10,000 for each recruit from overseas (agency fees, visas, flights, accommodation and exam preparation; the Nuffield Trust found £2,000–£12,000 a nurse depending on the country, and a study for the Royal College of Nursing £16,900), and about £2,000 for a UK joiner (advertising, checks and induction time). Only joiners above or below today's numbers are counted, because today's recruiting is already in trusts' costs.

Retention is costed per leaver kept. No NHS evaluation publishes that figure: the strongest study, of NHS Improvement's 2018–19 retention programme, found leaver rates 0.4 points lower but gave no cost. A scheme pays for everyone in it, not only those who would have left, so the model takes £12,000 per leaver kept, NHS Improvement's estimate of what replacing a nurse costs. Leaver rates 10% lower keep about 14,700 staff a year by 2035/36, at about £0.18bn a year.

What that is worth depends on what limits the NHS:

- **With overseas recruitment open**, as in the alternative, each leaver kept is one recruit fewer. Retention replaces about 13,600 overseas joiners a year and saves about £0.09bn of recruiting, so it pays for itself at about £6,000 per leaver kept. At £12,000 it costs 0.3 points on the 18-week measure. Here its case is the overseas target, not money.
- **With overseas recruitment limited**, as in the likely outcome or on the plan's 10% path, staff are the limit and retention is the cheapest way to add them. On the likely outcome's evidence, leaver rates 10% lower lift the 18-week share from 73% to 80% in 2028/29 and from 53% to 70% in 2035/36, for about £0.17bn a year. That run leaves £8.1bn unspent for lack of staff, so even at several times the assumed cost the money is there.

The 10% is an assumption, not a measured effect. It is about twice what the 2018–19 programme achieved for nurses (0.4 points on a leaver rate of about 8%), so a retention plan has to do more than that programme did.

Targeting discharge help

The same discharge budget does more when it is aimed. Spread evenly across acute trusts, a 25% cut avoids about 74,000 A&E waits for a bed in 2028/29. Aimed at the 40% of trusts that run fullest in winter, it avoids 88,000 (+19%). Aimed at the trusts with the most delayed patients per bed, which is the obvious target, it avoids only 51,000 (−31%): those trusts are often not the ones above 92% occupancy, where bed waits climb steeply. Section 6 sets out why national levers applied uniformly miss most trusts.

What it depends on

Within 18 weeks, 2035/36	Likely outcome	Alternative
Central case	53%	71%
Productivity 0% a year	41%	41%
Productivity 2% a year	83%	92%
Budget growth 2.0% a year real from 2029/30 (instead of 1.5%)	53%	91%

Two things decide it. Productivity first: without it no package works, and at the plan's 2% the alternative meets the target throughout. Then money after 2028/29: about 2% a year real growth holds the 2029 gains, while extra money does nothing for the likely outcome, which cannot spend it. The order matters: fix staff supply first, and funding then counts.

What it does not fix

A&E. The alternative's discharge help shortens trolley waits, but the 4-hour measure stays at about 75%, as in every other run. About 1,700 more A&E consultants would cost £0.33bn a year, and paid from the same budget would cost about 1 point on the 18-week measure. Their effect on the 4-hour measure is uncertain, from nothing to about 2.7 points, so they are shown as an option, not counted. Reaching 85% needs changes inside A&E departments that no one has yet costed or shown to work at scale. The plan's A&E targets should be treated as unfunded until it shows how they will be met.

8. Uncertainty and limits

The simulation tests the plan's arithmetic; it is not a forecast. Its main conclusions rest on two assumptions that are policy choices and can be argued about openly, productivity and money after 2028/29, rather than on the model's weakest links.

How far to trust the model

The model was calibrated on 2018/19–2022/23 and then tested on 2023/24–2025/26 without seeing them. Against two simple forecasts (no change, and the recent trend) it does better on flows (admissions, A&E attendances, referrals, treatments, delayed discharges and cost) and no better on stocks (the waiting list and bed occupancy). So the projections start from 2025/26's actual figures and move only through links measured in

past data. Links the model grades as weak, such as social care spending to long hospital stays and GP access to A&E attendances, are shown as ranges. The diagnostics projections are not robust and are not quoted in this report.

What the results depend on

Within 18 weeks, March 2035/36	Likely outcome	Alternative
Central case (productivity 1% a year; budget growth 1.5% a year real from 2029/30)	53%	71%
Productivity 0% a year	41%	41%
Productivity 2% a year (the plan's assumption)	83%	92%
Budget growth 1.8% a year real from 2029/30	53%	85%
Budget growth 2.0% a year real from 2029/30	53%	91%
Prices at NHS England's planning factors for 2026/27–2028/29 (pay 2.1% a year)	53%	83%
Pay award 2027/28 at 2.4% (DHSC's planning figure) rather than CPI (3.1%)	53%	74%
About 1,700 more A&E consultants (£0.33bn a year) paid from the same budget	–	70%
The model's weak links at either end of their range	53%	71%

Productivity dominates. At the plan's 2% a year, the likely outcome holds 83% and the alternative meets the target. Money matters only once staff are available: extra budget changes nothing in the likely outcome, which leaves it unspent, and lifts the alternative by up to 21 points. Prices matter for the same reason: on NHS England's planning factors, which assume pay rises below those already awarded, the alternative would do about 12 points better. The weak links move nothing.

What is assumed rather than measured

- **Productivity.** 1% a year, from the Office for National Statistics' measures for 2024 (1.1%) and 2025 (1.0%). The plan and NHS England's planning framework assume 2%. NHS England's internal measure showed 1.8% for 2024/25 in November 2024; the official figure for 2024 came in at 1.1%.
- **Care per treatment.** Staff per counted treatment rise about 0.7% a year, as they did 2022/23–2024/25. NHS England puts the rise in A&E patients' complexity at 2–3% a year; if that applies more widely, more of the past staff growth is justified and less

productivity is recoverable.

- **Retention.** Leaver rates 10% lower in the alternative is an assumption, about twice what NHS Improvement's 2018–19 programme measured for nurses. Its cost, £12,000 per leaver kept, is NHS Improvement's estimate of what replacing a nurse costs; no evaluation publishes a cost per leaver kept.
- **Recruitment.** £10,000 per recruit from overseas and £2,000 per UK joiner, above pay, from published ranges of £2,000–£17,000 per overseas nurse.
- **Where staff come from.** Nationality stands in for overseas recruitment: it counts UK-trained overseas nationals as overseas and UK nationals who trained abroad as UK.
- **Neighbourhood health.** 6% fewer emergency admissions and 4.3% fewer A&E attendances where it covers, from the 2015–2018 vanguards, against the plan's 15%. NHS England has cited a 23% fall in A&E referrals in frailty pilots; that data is unpublished and has no comparison group.
- **Prices after 2026/27.** Pay follows CPI from 2027/28 (OBR, October 2026). The 2026/27 awards are as made (3.3%, doctors 3.5%) and clinical negligence follows NHS England's increases to 2028/29.

What the model does not do

- **A&E inside the department.** Three in four four-hour breaches happen before any wait for a bed. The model links A&E to occupancy, delayed discharge and attendances, not to how departments run, so it cannot show what would close that gap. The effect of more A&E consultants comes from outside the model.
- **Trusts on their own.** Each trust's results share its region's staff, budget and levers and differ by its own starting point and demand, so they show spread, not a trust-level plan.
- **Primary care.** A shortfall of GPs is shown but not fed back into A&E attendances or admissions.
- **The waiting list's level.** The model counts NHS-funded pathways by patients' region, so its 2025/26 list (6.84 million) differs from the published figure.
- **The deficit cap.** Which trusts the oversight framework's deficit rule caps (section 6) is inferred from published scores, not read from NHS England's data.

What would change the conclusions

Three things would. Productivity of 2% a year, delivered and measured, would largely remove the staffing problem. Budget growth of about 2% a year real after 2028/29 would let the alternative hold its gains. And overseas recruitment held to the plan's 10% path without more home training would make every outcome worse. None of them changes the

direction of the findings: the plan misses its own targets, staff rather than money is the limit, the overseas and waiting-time targets clash, and nothing in the plan, or tested here, gets A&E to its targets.

9. Recommendations

The plan's aims are right. What it lacks is the staff to deliver them, an honest account of what they cost, and a way of reaching hospitals whose problems differ. Nine changes would close most of the gap; the section that sets out the evidence for each is shown.

Staff

1. **Publish the workforce plan, costed, with training places and a retention target** (sections 5 and 7). The plan names no extra nursing, midwifery or medical school places, and the workforce plan it promised has no date. Medical school places +50%, specialty training posts doubled and nursing places +40% cost about £0.9bn a year by 2035/36; a medical school place started in 2026 produces a consultant in the late 2030s, so the decision is needed now.
2. **Set a retention target, and evaluate what delivers it** (section 7). Cutting leaver rates by a tenth is the cheapest way to add staff where overseas recruitment is limited: from 53% to 70% within 18 weeks in 2035/36 in the likely outcome, for about £0.17bn a year. The measured effect of past schemes is about half that, so schemes should be tested and the effective ones scaled.
3. **Choose openly between the overseas target and the waiting-time target** (section 5). On the plan's own assumptions, holding waiting times needs about 22% of joiners from overseas in 2035/36; held to 10%, about 17,000 posts go unfilled. Until home training arrives, the honest choice is overseas recruitment or longer waits.

Money

4. **Set the budget beyond 2028/29** (sections 7 and 8). About 2% a year real growth from 2029/30 holds the gains once staff supply is fixed. Before it is, extra money goes unspent.
5. **Plan on realistic prices and productivity** (sections 3 and 8). NHS England's planning framework assumes 2% productivity and pay rises of 2.1% a year; the Office for National Statistics measured about 1%, and the 2026/27 awards were 3.3% and 3.5%. In 2023/24, the same kind of gap left about £1.6bn of unfunded pay pressure, roughly the system's deficit. Plans should state the arithmetic and fund the difference.
6. **Maintain the estate** (section 4). Clearing the £15.9bn maintenance backlog by 2036, and replacing equipment and IT as they wear out, costs about £2.7bn a year more capital than trusts now spend. On a fixed budget that costs about 5 points on the 18-

week measure by 2035/36, the honest price of stopping the decay.

Flow and A&E

7. **Aim discharge help at the hospitals that run fullest in winter, and pay for the care that replaces the bed** (sections 6 and 7). The same money aimed at the fullest 40% of acute trusts avoids about a fifth more A&E waits for a bed than spreading it evenly; aimed at the trusts with the most delayed patients, about a third fewer.
8. **Treat the A&E targets as unfunded until a costed route is shown, and fix departments one by one** (sections 2 and 5). Three in four four-hour breaches happen inside the department, and nothing in the plan, or tested here, moves the measure much. Support should go department by department, measuring in-department delays as well as the four-hour total, and the effect of more A&E consultants should be evaluated before it is relied on.

Who decides

9. **Let support and freedom follow need as well as performance** (section 6). Trusts' problems differ in kind, so the fix has to be worked out trust by trust. The trusts with the hardest problems should get multi-year funding and improvement support tied to their own diagnosed plan, rather than central direction and a shrinking deficit allowance. The oversight framework should measure flow (occupancy and delayed discharges) as well as waiting times; at present its scores barely register either.