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*LCP on point*

# *Hidden health needs – the elephant in the NHS waiting room*

December 2021

# Contents

# Summary

*The NHS waiting list now stands at 5.8 million, a number that has had much attention in recent months. However, 5.8 million is a substantial underestimate of the total unmet health need.*

*We estimate that the total waiting list number is currently more than 12 million and could rise to 15.5 million in 2023 by taking into account those who would have been expected to join the waiting list if the pandemic had not intervened – the hidden need.*

There are large and persistent geographical inequalities within both the known and hidden waiting list populations. Approaches to tackling the backlog must be both data-driven and proportionate to health need to ensure entrenched inequalities in waiting time and poor health while waiting are not a lasting legacy of the Covid-19 pandemic.

Achieving capacity increases will be a challenge in and of itself, and crucial to increasing capacity will be maintaining quality of care for patients. Further LCP analysis has demonstrated that there may be smart solutions to clearing the backlog by prioritising those with the greatest health need. These proportionate approaches to clearing the backlog may offer triple wins: reduced inequalities, a cleared backlog and economic gains.

**Definitions:**

**Waiting list:** The number of people that have been referred for treatment but have not yet received treatment

**Hidden need:** The number of fewer referrals to treatment during the pandemic compared to the year prior to the pandemic. These are people that are in need of care but have not yet come forward to receive care

**Unmet need:** The sum of the waiting list (the known need) and the hidden need at a given point in time

**RTTs:** Referrals to treatment, occurs when a person seeking care enters the NHS (most often through primary care) and is referred to another part of the health system for treatment

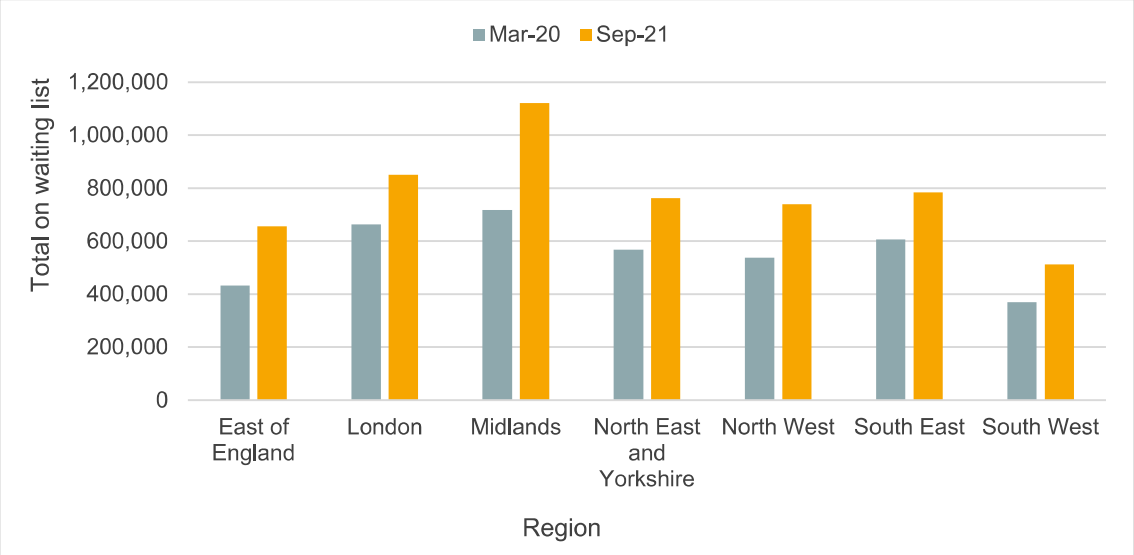
# *Chapter 1 –*

# *Waiting lists: the known need*

*NHS waiting lists have swelled to record highs, with the official total, as visualised in the LCP NHS Waiting List Tracker[1] showing **5.8 million people waiting for elective treatment** across England. Covid-19 has had a dramatic indirect impact on waiting lists. Finite healthcare capacity combined with necessary infection control measures have contributed to the waiting list increasing by 38% compared to when the pandemic began (March 2020). The most recent trends also show that the waiting list is still growing; from August 2021 to September 2021 the list grew by almost 120,000 people.*

Not only is the number of people on the waiting list growing, but the median length of time that people are waiting has hit its highest point (11.9 weeks) since March 2021. This is almost 4.5 weeks longer than the median wait time prior to the pandemic (in February 2020 the median wait time was 7.5 weeks). Over 1 in 3 people are now waiting longer than the NHS target of 18 weeks from point of referral to treatment, whilst almost 1 in 20 is waiting a year for treatment.[2] This means that over 300,000 people are waiting more than a year to start treatment for their illness. It matters that the NHS aims to bring these extreme waiting times in line with the average as individuals may experience greatly reduced quality of life whilst waiting for elective treatment.

*Figure 1. Total number of people on the waiting list by region at the start of the pandemic (Match 2020) and 18 months in to the pandemic (September 2021)*




[1] Most recent data available up to September 2021
[2] NHS Waiting List Tracker (lcp.uk.com)

A closer look into the numbers on the waiting list shows large regional and local inequalities. All regions in England have more people on their waiting lists when compared to the start of the pandemic, some substantially so. The Midlands has seen the greatest increase at 56%, compared to London and the South East with increases of 28% and 29%, respectively. Clinical Commissioning Group (CCG) populations are also experiencing disparities in the size of their waiting lists even after accounting for the size of their populations. NHS Birmingham and Solihull CCG, one of the most deprived areas in England, had the greatest number on its waiting list per 100,000 people, equating to over 2.5 times the size of the NHS Vale of York CCG waiting list per 100,000.

*Figure 2. Number of people on the waiting list per 100,000 by region at the start of the pandemic (March 2020) and 18 months into the pandemic (September 2021)*

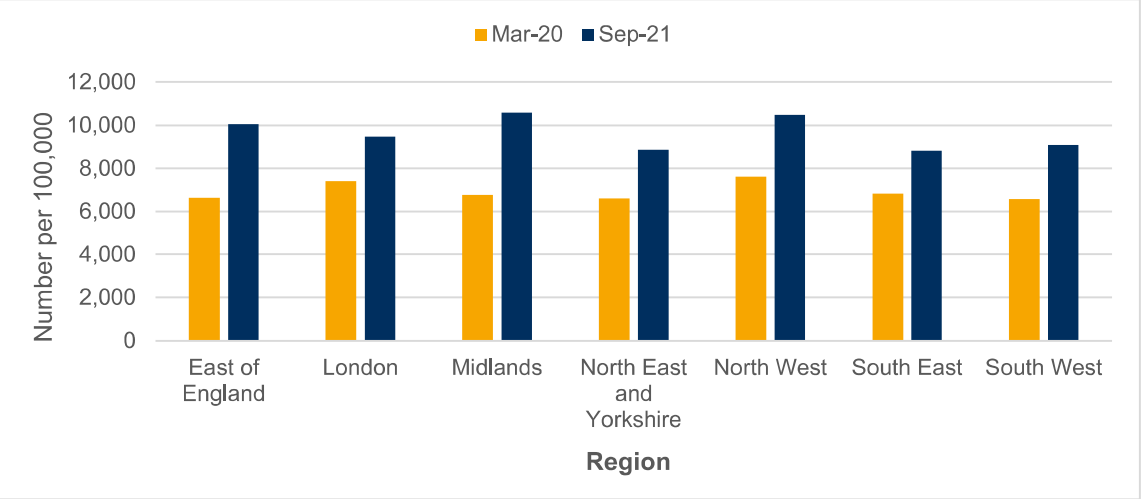



*Table 1. CCGs with highest and lowest waitlists per 100,000 in March-20*

| Rank | Highest CCG waitlists | Waitlist per 100,000 | Rank | Lowest CCG waitlist | Waitlist per 100,000 |
|---|---|---|---|---|---|
| 135 | NHS EAST AND NORTH HERTFORDSHIRE | 9,974 | 1 | NHS MID ESSEX CCG | 1,564 |
| 134 | NHS STOCKPORT | 9,889 | 2 | NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG | 3,087 |
| 133 | NHS HULL CCG | 9,870 | 3 | NHS NORTH CENTRAL LONDON CCG | 4,588 |
| 132 | NHS CASTLE POINT AND ROCHFORD CCG | 9,712 | 4 | NHS VALE OF YORK CCG | 4,745 |
| 131 | NHS MANCHESTER CCG | 9,368 | 5 | NHS FRIMLEY CCG | 5,169 |
| 130 | NHS SOUTHEND CCG | 9,247 | 6 | NHS LEEDS CCG | 5,265 |
| 129 | NHS NORTH WEST LONDON CCG | 8,728 | 7 | NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG | 5,278 |
| 128 | NHS SALFORD CCG | 8,680 | 8 | NHS OXFORDSHIRE CCG | 5,385 |
| 127 | NHS NORTH CUMBRIA CCG | 8,601 | 9 | NHS SHEFFIELD CCG | 5,579 |
| 126 | NHS WEST SUSSEX CCG | 8,574 | 10 | NHS HERTS VALLEYS CCG | 5,848 |

*Table 2. CCGs with highest and lowest waitlists per 100,000 in September-21*

| Rank | Highest CCG waitlists | Waitlist per 100,000 | Rank | Lowest CCG waitlist | Waitlist per 100,000 |
|---|---|---|---|---|---|
| 106 | NHS BIRMINGHAM AND SOLIHULL CCG | 15,521 | 1 | NHS VALE OF YORK CCG | 5,826 |
| 105 | NHS STOCKPORT CCG | 14,666 | 2 | NHS OXFORDSHIRE CCG | 6,184 |
| 104 | NHS SALFORD CCG | 13,196 | 3 | NHS PORTSMOUTH CCG | 7,019 |
| 103 | NHS MANCHESTER CCG | 13,191 | 4 | NHS CHESHIRE CCG | 7,054 |
| 102 | NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG | 12,993 | 5 | NHS FRIMLEY CCG | 7,276 |
| 101 | NHS SOUTHEND CCG | 12,854 | 6 | NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG | 7,360 |
| 100 | NHS CASTLE POINT AND ROCHFORD CCG | 12,845 | 7 | NHS IPSWICH AND EAST SUFFOLK CCG | 7,596 |
| 99 | NHS WEST SUSSEX CCG | 12,831 | 8 | NHS NORTHAMPTONSHIRE CCG | 7,807 |
| 98 | NHS BURY CCG | 12,562 | 9 | NHS TEES VALLEY CCG | 7,849 |
| 97 | NHS STAFFORD AND SURROUNDS CCG | 12,297 | 10 | NHS LEEDS CCG | 7,869 |

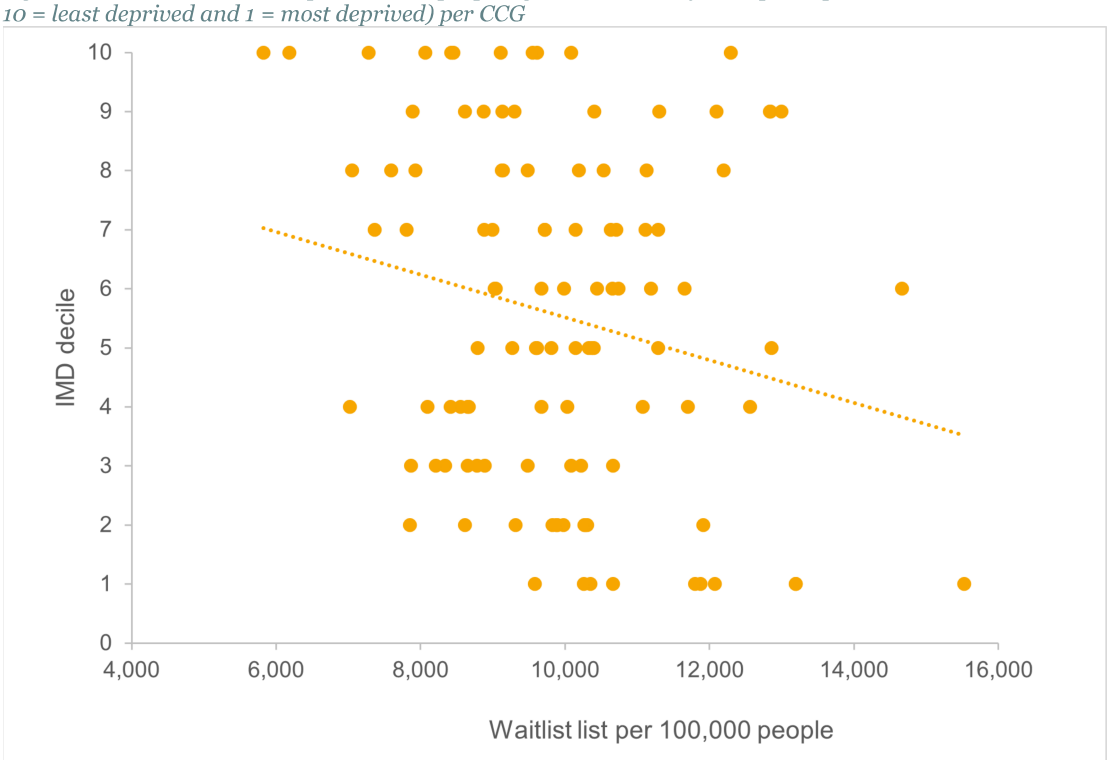
## Associations with potential drivers of the increase in waiting lists

The number of Covid-19 cases at CCG level is significantly correlated with the number on the waiting list (Figure 3). Population size naturally accounts for much of that association, and it must be noted that areas of high population size carry a twin burden of Covid-19 and high waiting lists. Given this additional burden of healthcare costs in these CCGs are likely to be higher, as such any additional funding must be proportionate to CCGs population size. Unsurprisingly, CCGs with the highest total numbers of Covid-19 cases are in densely populated areas of London. NHS North East London, North West London and South East London were the three CCGs that had the most Covid-19 cases. However, when population size is accounted for, the North West region CCGs were particularly hard hit in terms of Covid-19 cases per capita. Waiting list size per 100,000 and Covid-19 cases per 100,000 were weakly associated with each other.

Levels of deprivation (defined using IMD Indices of Multiple Deprivation score) are weakly correlated with the number of people on the waiting list, and within any given IMD decile large variations in waiting list size can be seen. However, the two extremes of CCG waiting list sizes reflect deprivation levels and inequalities. Taking the two CCGs with the most (NHS Birmingham and Solihull CCG) and least (NHS Vale of York) number of people per 100,000 on their respective waiting lists in September 2021, NHS Birmingham and Solihull CCG falls into the most deprived IMD decile (1) whilst NHS Vale of York falls into the least deprived decile (10).

*Figure 3 Total on the waiting list by total Covid-19 cases per CCG*

*Figure 4 Total on the wait list per 100,000 people by IMD (Indices of Multiple Deprivation) score decile (where decile 10 = least deprived and 1 = most deprived) per CCG*




It should be noted that a given patient with multiple conditions may be counted more than once on the waiting list. Although this suggests a degree of double counting where 'number of people/patients' are referred to, from an NHS perspective the burden remains the same if multiple appointments are required. Data in the charts and regional totals presented here account only for CCGs and not those placed on waiting lists at commissioning hubs, national totals presented here (and on the LCP NHS Waiting List Tracker) include commissioning hub data.

# ***Chapter 2 –***
# *Hidden need: an unknown that cannot be ignored*

*Excessive waiting lists are only part of the problem facing the NHS. People on waiting lists have been referred for treatment, have entered the health system and have not yet received care. They are included in data published by NHS and make up the unmet need that is 'known'. However, there is also an unquantified, unknown, 'hidden need' made up of those who still require treatment for a health condition but have not yet sought care. The disruption the healthcare system and our day-to-day lives caused by the pandemic has understandably impacted health-seeking behaviour for many who would have come forward for care but chose not to due to the risk of being infected with Covid-19, or who were unable to secure appointments.*

The term 'unmet need' used in this report refers to the total of those on the waiting list plus the hidden need population. The combination of the known need of those on the waiting list and the prospect of the hidden need coming forward for care led Sajid Javid, Secretary of State for Health and Social Care, to suggest in July 2021 that waiting lists could reach as high as 13 million without further intervention.

Our analysis estimates the total current **hidden need to be 7.8 million people** across England but, as with the waiting lists, this number is distributed very unequally across regions and smaller areas. When hidden need is combined with the current known need of those on the waiting list, the total number reaches 13.6 million, suggesting Sajid Javid's 13 million could already be a reality.

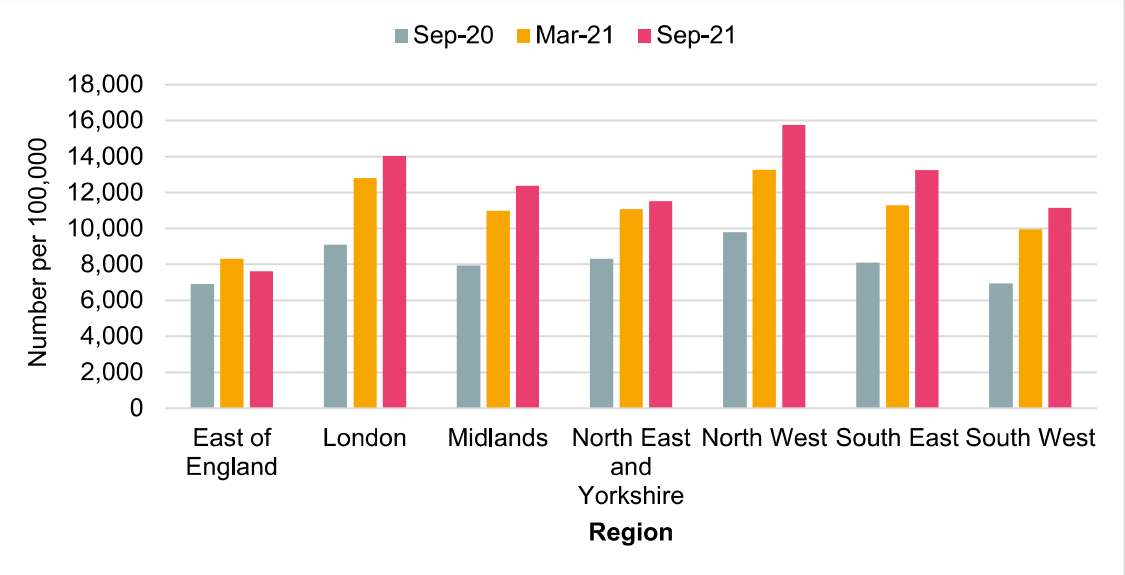
In this analysis, hidden need has been calculated by comparing the difference between monthly referrals to treatment (RTTs) in the year prior to the pandemic (three-month rolling average from February 2019 to February 2020) to the monthly RTTs during the pandemic (March 2020 – present). The difference is used to estimate the number of referrals who have not come forward for treatment, the hidden need. Hidden need was assumed to be zero prior to the pandemic, hence our estimate is excess hidden need since the pandemic began. It should be noted that, within the hidden need, a small proportion of these people may never enter the NHS system due to, for example, death, or seeking alternative private healthcare. For this analysis, the proportion that do not ever enter the NHS for their given health needs is assumed to be negligible.

Looking back throughout the pandemic our analysis shows that, similar to the waiting list numbers, the present hidden need is at a record high. In September 2020, six months into the pandemic, the hidden unmet need is estimated to have been 5.1 million people, increasing to 7.1 million people one year after the pandemic began, in March 2021, before hitting record numbers, with the most recent estimates being 7.8 million some 18 months after the pandemic began.

*Figure 5. Total hidden need by region 6 months, 12 months, and 18 months into the pandemic*


As with those on the waiting list, the burden of hidden need is not distributed equally. In absolute terms, the Midlands and London have shown comparably high levels of hidden need throughout the pandemic, by contrast the South West and East have had the lowest levels of hidden need. The East of England was the only region that managed to reduce its hidden need between March 2021 (544,000) and September 2021 (497,000) such that hidden need in the East of England as of September 2021 was only 10% greater than the same figure six months into the pandemic, in September 2020. In contrast, hidden need in the South West region saw a 61% increase over the same period, despite having comparable figures to the East in September 2020. The variability of how hidden need accumulated from region to region over the course of the pandemic highlights which geographical areas may expect their waiting lists to increase the most in the coming months and years.

*Figure 6. Hidden need per 100,000 people by region 6 months, 12 months, and 18 months into the pandemic*



The North West region has the greatest hidden need relative to its population after adjusting by population (Figure 6). By September 2021, the hidden need had reached almost 16,000 per 100,000 people, equating to over twice as many per capita compared to the East of England. The unequal burden of unmet need is also reflected at the CCG level. CCGs from the North West accounted for 50% of the 10 CCGs with the greatest hidden need at 6 and 18 months into the pandemic. (In September 2020, these were NHS Southport and Formby CCG, NHS Heywood, Middleton and Rochdale CCG, NHS Oldham CCG, NHS West Lancashire CCG and NHS Bury CCG. However, by September 2021 NHS Manchester CCG entered the 10 CCGs with greatest hidden need whilst NHS West Lancashire dropped out).

*Table 2. CCGs with highest and lowest hidden need per 100,000 in September-2020*

| Rank | CCG | Hidden need | Rank | CCG | Hidden need |
|---|---|---|---|---|---|
| 106 | NHS SOUTHPORT AND FORMBY CCG | 14,407 | 1 | NHS MID ESSEX CCG | -5,239 |
| 105 | NHS BARNSLEY CCG | 13,643 | 2 | NHS BRADFORD DISTRICT AND CRAVEN CCG | 3,234 |
| 104 | NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG | 13,170 | 3 | NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG | 4,889 |
| 103 | NHS OLDHAM CCG | 13,089 | 4 | NHS WEST ESSEX CCG | 4,930 |
| 102 | NHS CALDERDALE CCG | 12,245 | 5 | NHS VALE OF YORK CCG | 5,552 |
| 101 | NHS CASTLE POINT AND ROCHFORD CCG | 12,046 | 6 | NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG | 5,747 |
| 100 | NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG | 11,967 | 7 | NHS GLOUCESTERSHIRE CCG | 6,001 |
| 99 | NHS WEST LANCASHIRE CCG | 11,926 | 8 | NHS KERNOW CCG | 6,053 |
| 98 | NHS BURY CCG | 11,480 | 9 | NHS DEVON CCG | 6,075 |
| 97 | NHS NORTH EAST ESSEX CCG | 11,354 | 10 | NHS FYLDE AND WYRE CCG | 6,164 |

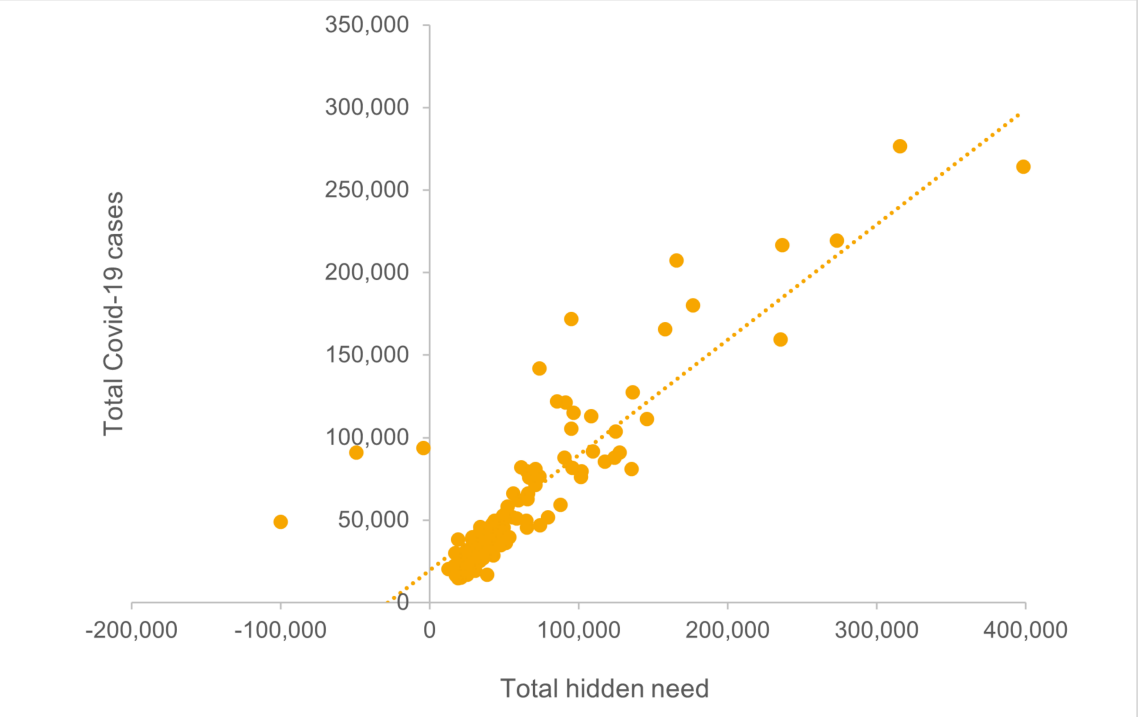
*Table 4. CCGs with highest and lowest hidden need per 100,000 in September-21*

| Rank | CCG | Hidden need | Rank | CCG | Hidden need |
|---|---|---|---|---|---|
| 106 | NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG | 22,931 | 1 | NHS MID ESSEX CCG | -25,275 |
| 105 | NHS SOUTHPORT AND FORMBY CCG | 21,777 | 2 | NHS BRADFORD DISTRICT AND CRAVEN CCG | -8,326 |
| 104 | NHS BARNSLEY CCG | 21,690 | 3 | NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG | -480 |
| 103 | NHS OLDHAM CCG | 20,096 | 4 | NHS WEST ESSEX CCG | 6,143 |
| 102 | NHS MANCHESTER CCG | 19,824 | 5 | NHS NORTH CENTRAL LONDON CCG | 6,285 |
| 101 | NHS CALDERDALE CCG | 19,412 | 6 | NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG | 7,058 |
| 100 | NHS THURROCK CCG | 19,297 | 7 | NHS KERNOW CCG | 7,610 |
| 99 | NHS NORTH EAST ESSEX CCG | 19,076 | 8 | NHS VALE OF YORK CCG | 7,781 |
| 98 | NHS NORTH WEST LONDON CCG | 18,938 | 9 | NHS FRIMLEY CCG | 8,251 |
| 97 | NHS BURY CCG | 18,883 | 10 | NHS NORFOLK & WAVENEY CCG | 8,794 |

Three CCGs (NHS Mid Essex CCG, NHS Bradford District and Craven CCG, and NHS Cambridge and Peterborough CCG) had negative hidden need by September 2021, suggesting that RTTs during the pandemic were greater than in the year prior to the pandemic, i.e. the CCGs were performing better in terms of elective procedure output during the pandemic. The reasons for this are not clear. There are several possibilities, including differences in geographical commissioning to alternative areas during the peak of the pandemic according to relative capacity.

When comparing hidden need to Covid-19 cases and deprivation levels, the patterns are similar to those observed when the known need is compared to the two variables. There is strong correlation with Covid-19 cases, which may be largely explained by population sizes. London-based CCGs carry the highest absolute burden of hidden need and Covid-19 cases. NHS North West London CCG, NHS North East London CCG and NHS South East London CCG, which make up three of the top four most populous CCGs, also make up the top three CCGs with greatest hidden need and Covid-19 cases. Similarly to the population-adjusted numbers on the waiting list, there is a weak positive correlation between total Covid-19 cases per 100,000 and hidden need per 100,000. For example, NHS Heywood, Middleton and Rochdale CCG, which has the highest hidden need relative to its population size, also had relatively high Covid-19 rates per capita.

*Figure 7. Total hidden need by total Covid-19 cases per CCG*



# *Chapter 3 –*
# *The future*

*A critical question for the NHS is how the scale of the unmet need problem may unfold over the coming years. To help address this question our analysis explores how the waiting list and hidden need can be expected to develop over four different possible scenarios, one where there is no Government intervention to tackle the backlog, and three with varying levels of intervention.*

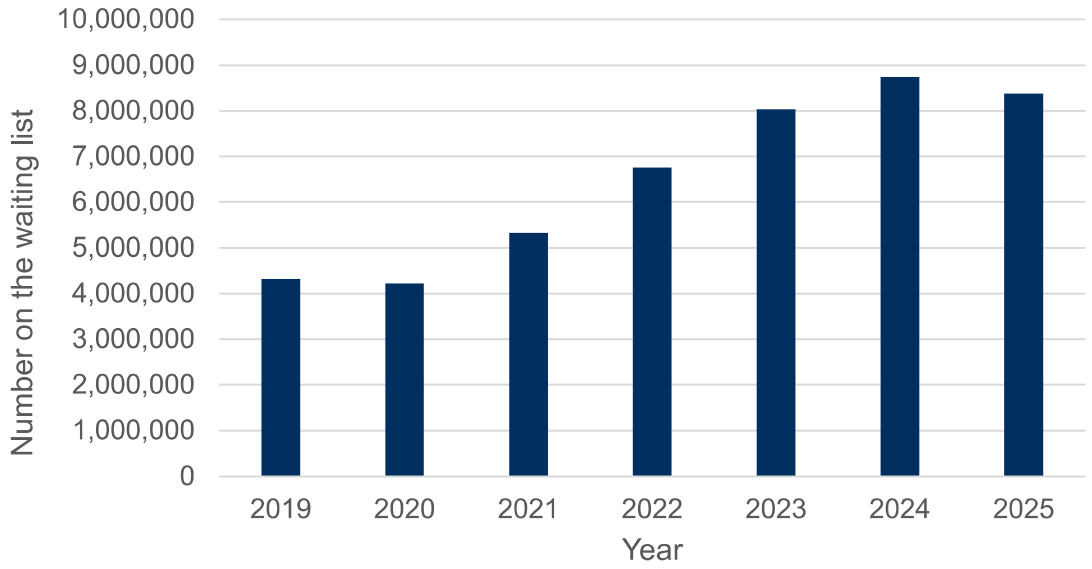
We have developed these scenarios with a set of basic assumptions:

- To date, nobody from the hidden need population has come forward to join the waiting list.
- The same number of people needed elective care during the pandemic as they did in the year prior to the pandemic.
- Going forwards, the number of new patients needing treatment each month will be constant, in line with the current rates (July-September 2021).
- Going forwards, the number of patients admitted for both inpatient and outpatient treatment each month will initially be in line with the current rate.
- These 'current rate' figures increase linearly from 2022 to 2025, before levelling out at a specified percentage above the pre-Covid-19 levels (to simulate NHS capacity increase, or lack of, due to interventions designed to clear the backlog).
- Patients start to come forward from the hidden need population to join the waiting list in 2022, at a rate which increases linearly from 0% until 2025, before levelling out at 5% of the total hidden need per month.
- In line with historical data, an allowance is made for patients leaving the waiting list for reasons other than receiving treatment, e.g. death, recovery or seeking alternative private healthcare.

## The base case – current rates with no intervention

The base case scenario explores how the known waiting list and hidden need may develop if no additional measures are put in place by the Government to address the backlog. While the number on the waiting list decreased in 2020 due to the pandemic (see Figure 9), NHS data has shown that in 2021 the waiting list has begun to increase, with a monthly average of 5.32 million people, 26% more than the monthly average in 2020. Our projections suggest large year-on-year increases could be maintained over 2022 and 2023 with annual increases of 27% and 19% respectively, leading to a potential waiting list peak of 8.8 million by 2024 (whilst averaging 8.7 million over the entirety of that year). The predicted waiting list peak in 2024 would be a 102% increase compared to pre-Covid-19 levels in 2019.

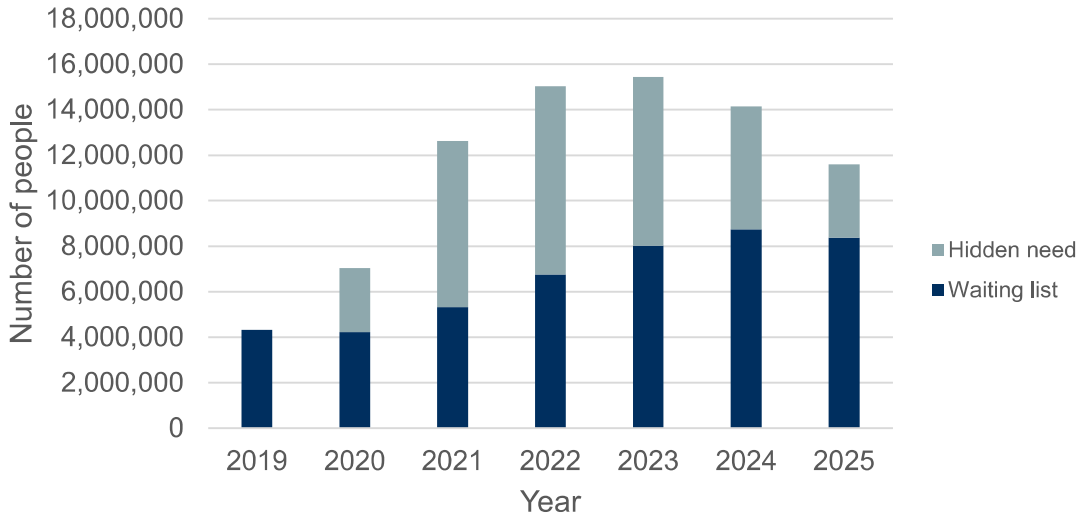
*Figure 8. Projected average annual total of those on the waiting list in the base case (no intervention to clear the backlog) until 2025*




The prospect of the waiting list reaching such unprecedented highs in the coming years underscores the imperative for government intervention to assist the NHS in clearing the waiting list without negatively impacting other services. Yet the full potential scale of the problem facing the NHS only becomes apparent when the hidden need of the population is considered in tandem with waiting list projections.

Whereas the known waiting list alone is projected to peak by 2024, the inclusion of projected hidden need brings the predicted peak in the total unmet need (waiting list plus hidden need) forward to 2023. The projected unmet need in England could peak at over 15.5 million. These figures would put the NHS, and specifically patients, in a frightening position that could inflict lasting damage on both the health and wellbeing of patients, and on the healthcare system itself.

*Figure 9. Projected average annual total unmet need in England (broken down by number on the waiting list and hidden need) until 2025*



## Government and NHS intervention – three options

In recognition of the mounting problem of the backlog of people requiring care (either on the waiting list or hidden), over the course of 2021 the Government announced a host of funding and policy interventions. The detail and sufficiency of these measures is discussed in Chapter 4, but it is important to note here that the Government hopes that these interventions will lead to a 30% increase in NHS capacity compared to pre-Covid-19 levels.

We have developed three scenarios reflecting this 30% uplift in capacity to estimate the impact on the total unmet need in coming years. The three scenarios are:

i) symmetric uplift in capacity across inpatient and outpatient services from May 2022;
ii) a symmetric uplift in capacity that reaches pre-Covid-19 capacity levels immediately; and
iii) an asymmetric uplift whereby outpatient capacity is increased faster than inpatient capacity.

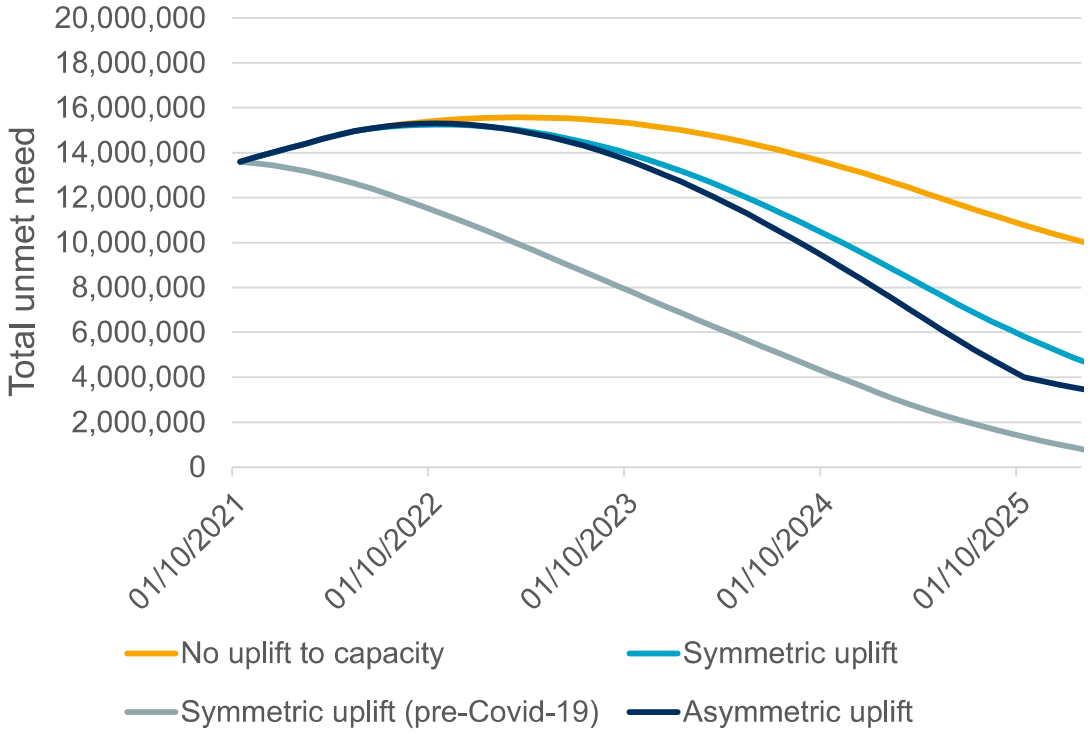
In the first symmetric uplift scenario, both inpatient and outpatient capacity continues at current levels through the coming winter until 1 May 2022. After this point, there is a linear increase in both inpatient and outpatient capacity to 30% above pre-Covid-19 levels over the period to May 2025. Current rates of capacity continue until May 2022, as we assume any intervention will not have an immediate effect, particularly given the likely pressures from Covid-19 (and potentially influenza) during the winter months. In this scenario, we see a peak in total unmet need in October 2022 (at 15.3 million). Following this there is a steady reduction in total unmet need to 4.9 million by the end of 2025.

The second intervention scenario explores how a symmetric uplift would play out should the NHS rates of referral and treatment pick up immediately to pre-Covid-19 levels (termed Symmetric uplift (pre-Covid-19) in Figure 10. 10). Although current rates are yet to recover to pre-Covid-19 rates, this scenario has been included to demonstrate what a best-case scenario could look like in terms of clearing the backlog of unmet need. In this best case, the analysis suggests that, with immediate improvement in referrals and uplift to capacity, the total unmet need could be reduced to below 1 million by the end of 2025.

Thirdly, it is possible that we will see an asymmetric increase in outpatient versus inpatient capacity, where outpatient procedures exceed inpatient ones. This accounts for the fact that there are significantly more outpatient NHS attendances than inpatient ones, and also that the government announced funding of £250 million in NHS technology to modernise diagnostics in November 2021.[3] This funding is intended to reduce the time needed to diagnose a health problem by making it easier to share patient results, tests and scans across the necessary clinical staff.

[3] £250 million in NHS technology to modernise diagnostics - GOV.UK (www.gov.uk)

*Figure 10. NHS unmet need projections (including national total on the waiting list and hidden need) until December 2025*




Projecting such an asymmetric uplift scenario suggests that the total backlog of unmet need may be cleared initially at a faster rate than in the symmetric uplift scenario. When compared to the symmetric uplift scenario this results in a further 1 million people being cleared from the unmet need backlog by October 2024. However, at the midpoint of 2025 the rate of reduction slows as the relevant proportion of unmet need that requires inpatient admittance increases. The asymmetric uplift scenario projects the total unmet need to have reduced to 3.5 million people by the end of 2025, 0.9 million less than in the symmetric uplift scenario.

Although there is much uncertainty as to whether the differences between the symmetric and asymmetric uplift scenarios presented here will materialise, they serve to highlight the wide range of potential outcomes depending upon the pace and effectiveness of resource allocation in the crucial coming months.

# *Chapter 4 –*

# *Do proposed interventions go far enough?*

*Our analysis and projections suggest that the total unmet health need of the known and hidden waiting list populations may reach 15.5 million in 2023, well above the 13 million proposed by Secretary of State for Health and Social Care Sajid Javid. Our analysis allows for disaggregation according to the known waiting list numbers and the hidden unmet need, capturing those who would have been expected to join the waiting list in the absence of the pandemic.*

Prior estimates, such as the 13 million cited by Sajid Javid, generally assume that the hidden need population all join the waiting list simultaneously. This seems unlikely, and has not yet been observed, hence our projections take an incremental approach in transferring people from the hidden unmet need population to the known waiting list. The pace at which these patients join the known waiting list and how this varies across geographies and specialties is unknown, yet could have a substantial impact on elective demand. Such estimates, and the potential variation in these estimates, must be part of a resilient elective recovery plan from NHS England.

In what has been termed the 'biggest catch-up programme in the history of the NHS', the Government announced £36 billion of funding for the health and social care system in September 2021.[4] Intended to be spread over the next three years, the funding will be raised via a ringfenced Health and Social Care Levy from higher National Insurance Contributions and increased rates of dividend tax. The Government hopes that this package of measures will increase NHS capacity to 110% of planned activity levels by 2023/24, through additional appointments, treatments and support. In addition to funds raised through the Health and Social care bill, a £5.9 billion cash injection specifically to clear the elective backlog has been announced. This funding will include £2.3 billion to increase diagnostic capacity through 100 new community diagnostic hubs, £2.21 billion to support innovative use of digital technology, and £1.5 billion for new surgical hubs.

Whilst additional funding to tackle the backlog is welcomed, funding alone is unlikely to be sufficient. First, resources must be targeted proportionately to need. Our analysis highlights the vast differences in need, both in the known waiting list and hidden unmet need, with 2.6 and 3.7 fold differences respectively when accounting for population size. Secondly, of equal importance to funding is the workforce, which is key to increasing capacity

[4] Record £36 billion investment to reform NHS and Social Care - GOV.UK (www.gov.uk)

and providing patient care. Ongoing challenges with maintaining and/or growing the NHS workforce has been well documented; a Health Workers Foundation survey recently found that almost one in three frontline staff reported a strong likelihood of leaving the NHS in the coming year.[5] These worrying statistics highlight that a cash injection is far more complex than a case of hiring more staff to clear the backlog of unmet need. Consequently, there needs to be a focus on policy interventions that increase efficiencies rather than ones that require large additions to the labour force. In recognition of workforce issues, in November 2021 the Department of Health and Social Care announced major reforms to the NHS workforce. Health Education England (HEE) will merge with NHS England and NHS Improvement. According to HEE chairman Sir David Behan it is hoped that the merger will help align service and financial planning to workforce planning and development.[6]

The recently announced £250 million fund for modernising diagnostics provides some promise in further increasing efficiencies within existing structures, and is one potential reason that outpatient appointments may recover more quickly than inpatient appointments. If this programme enables more effective legitimate sharing of patient investigation results between neighbouring hospitals and clinicians, it could enable more effective collaboration across local geographies to reduce patient waiting times.

## Local innovations to tackle inequalities in waiting times and health while waiting

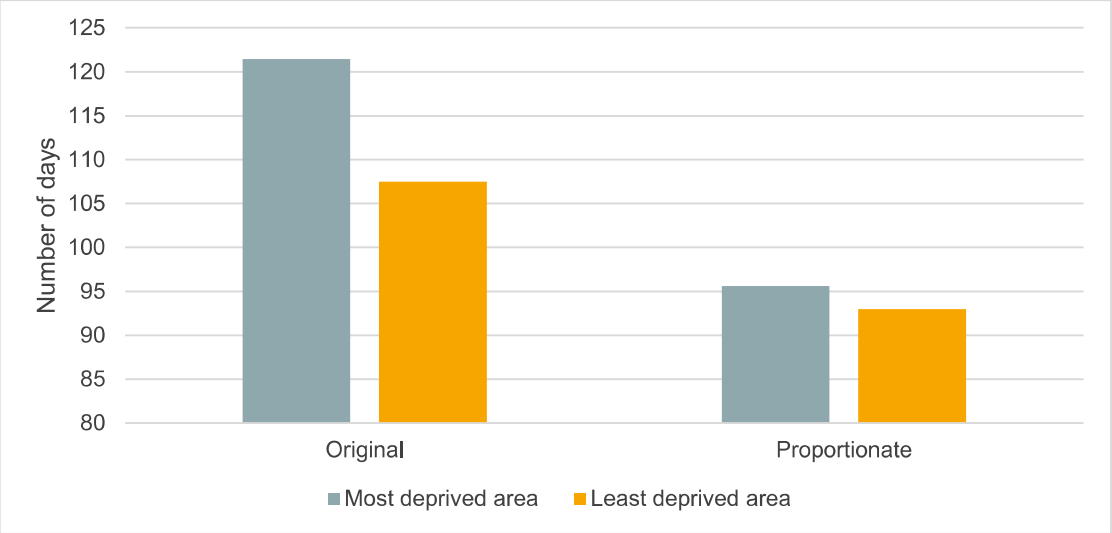
National approaches and resource allocation must be complemented with local, place-based innovation and collaboration. While inequalities exist across England with large variations in need from one CCG to another, inequalities also exist within local populations. Identifying inequalities in either waiting times and/or health while waiting can identify patient groups at most need for targeted action.

We recently worked with Northumbria Healthcare NHS Foundation Trust to identify if there was an opportunity to reallocate resources in a proportionate way that targeted patients with the greatest health need while they were waiting on Orthopaedic lists. The full case study can be read here. Briefly the analysis found:

- Waiting times were equal across different population groups (e.g. deprivation).
- However, there were large inequalities in health while waiting, with those living with obesity, smokers and those from the most deprived 10% of the population likely to be in poor health.
- Patients in the poorest health stood to gain the most from receiving an operation (e.g. total knee replacement).
- A 'proportionate approach' to slightly modify waiting times according to health need could both improve the health of the waiting list population and reduce inequalities in health while waiting.
- This proportionate approach could also have a positive economic impact resulting in a net benefit of £191/per person.
- Northumbria Healthcare NHS FT have some of the smallest waiting lists in the country. The benefits - both population health, inequalities and economic – would be greater in areas with larger waiting lists with longer waiting times such as Norfolk and Waveney CCG.
- Our proportionate approach to waiting list resource allocation targets those with the greatest need, reducing days spent in poor health across population groups, and closing the gaps between them.

[5] Healthcare worker survey reveals 73% of NHS staff have considered leaving in the last 12 months | Charity Today News
[6] Major reforms to NHS workforce planning and tech agenda - GOV.UK (www.gov.uk)

*Figure 9. Average number of days spent in poor health in the most and least deprived areas under the original and proportionate approach in the LCP Northumbria case study*




It is our view that a similar approach of quantitative health-based resource allocation should be used in targeting capacity allocation resource to extract the most value from additional funding, reducing the total burden placed on the NHS and targeting patients and geographies with the greatest need.

# Conclusion

*The pandemic has taken both NHS waiting lists and those with hidden unaddressed health needs to record highs. These two factors make up the total unmet health need of the population, people who need care but are yet to receive it. Underlying the waiting lists and hidden need numbers are geographical inequalities, at both regional and CCG level. The Midlands has the highest waiting list after accounting for population size, closely followed by the North West. Analysis also shows that the North West has been hit disproportionately hard in terms of accumulated hidden need 18 months into the pandemic.*

Yet the worst may be far from over. Our projections suggest that, if current rates of treatment and referrals continue without intervention to clear the backlog, the unmet need in England could peak at over 15.5 million people early in 2023. This number exceeds the Department of Health and Social Care's (DHSC) own prediction of 13 million on the waiting list. However, the DHSC figure perhaps unrealistically suggests those with hidden need all come forward for care at the same time so are placed on the waiting list simultaneously. A more incremental approach for those coming forward for care is taken here, such that the known waiting list number, currently 5.8 million, could peak at 8.8 million people in 2024.

The Government's proposed interventions aim to increase NHS elective capacity by 30% compared to pre-Covid-19 levels. Our projections find that achieving this uplift in capacity would reduce the projected waiting list need (both known and hidden) substantially, reaching 9.2 million by the end of 2024. Allocation of additional elective recovery resources therefore requires much consideration. The approach should be grounded in data to ensure resources are targeted proportionately to the total waiting list need, including the known and hidden unmet need, alongside incentivising appropriate splits between inpatient and outpatient uplifts. Proportionate approaches to clearing the backlog may offer triple wins: reduced inequalities, a cleared backlog and economic gains.

LCP INSIGHT CLARITY ADVICE

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