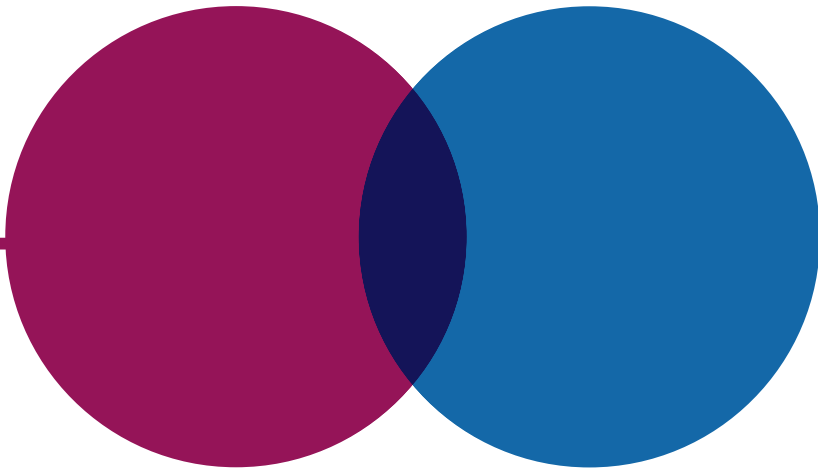

REPORT

NHS England’s management of elective care transformation programmes

NHS England

SESSION 2024-25
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Key facts

7.4mn

referral-to-treatment pathways – the elective care waiting list – as at January 2025, representing around 6.3 million patients

59%

of pathways on the elective care waiting list where people are waiting within the standard of 18 weeks as at January 2025, against a target of 92%

£3.2bn

NHS England's (NHSE's) estimate of capital expenditure on diagnostic transformation (£2.2 billion) and surgical hubs (£1.0 billion) between 2022-23 and 2024-25

99%	reduction in waits of more than two years between February 2022 and January 2025
35%	reduction in waits of more than one year between February 2022 and January 2025 against a target to clear them by March 2025
137	Community Diagnostic Centres (CDCs) operational in their permanent locations in August 2024, and 30 CDCs operating on temporary sites, out of 170 planned to be operational by March 2025
6.4	percentage point improvement in the proportion of waits above six weeks for diagnostic tests between 2022-23 and 2024-25 (averaging 22.3% from April to January). The recovery target is to reduce waits above six weeks for diagnostic tests to 5% of the diagnostic waiting list by March 2025
19	of 37 new surgical hubs reported as complete as at December 2024. Of the remaining 18, seven are due to complete by the end of March 2025 and 11 between April 2025 and July 2026
48%	average shortfall in planned additional elective activity reported by 44 NHS trusts with surgical hubs between April 2023 and September 2024
0.1%	average reduction in follow-up outpatient appointments from June 2022 to July 2023 (months when NHSE reported performance) against a target reduction of 25% by March 2023 compared with 2019-20 levels; NHSE no longer reports progress against this target

Summary

1 Since 2013, the statutory elective care waiting time standard has been that for 92% of elective care pathways, patients should begin treatment within 18 weeks from referral. This was last achieved in September 2015. As at January 2025, around 6.25 million people were waiting for elective care on 7.43 million pathways. Patients waited for up to 18 weeks on 4.37 million pathways (59%) and for more than 18 weeks on 3.06 million pathways.

2 In February 2022, NHS England (NHSE) published a plan to recover elective and cancer care over the three years up to March 2025.[1] This plan aimed to reduce waiting times by increasing capacity, prioritising patients waiting the longest and improving information and support for patients. It also included changes to how care is provided through three transformation programmes.

- **Diagnostic transformation** including £2.3 billion of capital funding for new diagnostic centres and equipment to move patients through diagnostic services more quickly.
- **Surgical transformation** to create surgical hubs to carry out low complexity procedures more efficiently, funded with £1.2 billion of capital from NHSE's £1.5 billion Targeted Investment Fund.
- **Outpatients transformation** to free up capacity by, for example, reducing referrals and follow-up appointments.

3 We reported on NHSE's progress with the elective recovery plan in November 2022 and concluded that there were significant threats to recovery, including uncertainty about whether new initiatives would deliver results as quickly as intended.[2] In this report, we take a closer look at NHSE's management of these three transformation programmes, what they have delivered to date and whether NHSE is learning lessons from its experience and applying this learning as it develops its future plans. The report covers:

- NHSE's overall progress on elective care recovery (Part One);
- NHSE's progress in delivering its main elective recovery transformation programmes and the outcomes achieved (Part Two);
- management and oversight of the transformation programmes (Part Three); and
- NHSE's learning and application of lessons from its elective recovery transformation programmes (Part Four).

1 NHS England, *Delivery plan for tackling the COVID-19 backlog of elective care*, February 2022.
2 Comptroller and Auditor General, *Managing NHS backlogs and waiting times in England*, Session 2022-23, HC 799, National Audit Office, November 2022.

4 Fieldwork took place between September and December 2024 and our methods and evidence base are described in further detail in Appendix One. Beyond these three transformation programmes, we have not examined NHSE's progress in implementing other activities and initiatives in its elective recovery programme. To provide context for the transformation programmes, we have examined NHSE's progress in increasing elective activity and reducing long waits for elective care. We have not examined NHSE's performance on cancer.

5 Progress against goals for elective recovery was adversely affected by the challenging operational environment. NHSE estimates that industrial action during 2023 and 2024 resulted in 442,000 fewer completed pathways over this period (which we estimate is 12% of the elective activity shortfall for the period). NHSE told us that there had also been lower than expected productivity, and higher than expected levels of COVID-19 infection, non-elective demand and inflation during 2023 and 2024. All of these factors were outside NHSE's planning assumptions and reduced its ability to deliver elective recovery objectives. We recognise that these factors will have had an impact on NHSE's ability to implement elective care transformation programmes but that impact is hard to quantify. We have not validated the scale of any impact as the focus of our study was on NHSE's management of its elective care transformation programmes.

6 On January 2025, NHSE published a new elective care reform plan which committed that 65% of patients would wait less than 18 weeks for elective treatment by March 2026, as a staging post to achieving the statutory waiting time standard of 92% by March 2029.[3] Although we have noted how NHSE has reflected learning from experience to date in its elective care reform plan in Part Four, we have not assessed whether the new plan is likely to be successful. In 13 March 2025, the Government announced that NHSE would be abolished within two years. All references to future actions of NHSE in this report should be read as encompassing whatever arrangements the Department for Health & Social Care (DHSC) puts in place to deliver the responsibilities currently delivered by NHSE.

3 Department of Health & Social Care and NHS England, *Reforming elective care for patients, January 2025*.

Key findings

Elective care recovery

7 **Overall, NHSE has made progress towards elective recovery, but at levels slower than that anticipated in the 2022 plan.** Factors that have impacted on elective recovery are outlined in paragraph 5, above.

- **NHSE has not delivered the total additional activity it aimed to for elective recovery.** NHSE aimed to deliver 129% of 2019-20 levels of elective activity by 2024-25. So far in 2024-25 it has delivered 116%. Consequently, fewer people are leaving the waiting list than NHSE anticipated (paragraphs 1.5 to 1.12 and Figure 3).
- **NHSE has broadly achieved its aim of eliminating 104-week and 78-week waits for treatment.** The February 2022 elective recovery plan aimed to end the longest waits for elective care. It set a series of milestones, aiming to eliminate waits of more than 104 weeks by July 2022, more than 78 weeks by April 2023 and more than 65 weeks by March 2024. Between February 2022 and January 2025, waits of more than 104 weeks reduced by 99%, waits of more than 78 weeks reduced by 97% and waits of more than 65 weeks by 90% (paragraphs 1.7 to 1.9 and Figure 2).
- **NHSE has made progress against, but will not deliver on time, elective recovery targets to end elective care waits of more than a year by March 2025.** NHSE aimed, that by March 2025, people would not wait for more than a year (or only on a very small number of pathways, either in highly specialised areas or where patients chose to wait longer). The number of pathways where people have waited for more than a year has reduced by 35% from around 310,000 pathways in February 2022 to around 200,000 pathways in January 2025 (paragraphs 1.5 to 1.10 and Figure 2).
- **NHSE has made limited progress in reducing long waits for diagnostic tests.** The diagnostic recovery target is to reduce waits above six weeks for diagnostic tests to 5% of the diagnostic waiting list by March 2025 (the long-term standard is 1%). In April to January 2022-23, 28.7% of waits for diagnostic tests were above six weeks (monthly average). In April to January 2024-25, 22.3% of waits for diagnostic tests were above six weeks (monthly average), a 6.4 percentage point improvement (paragraphs 1.15 and 1.16).

The elective care transformation programmes

8 **The main intended outcomes of the transformation programmes are closely related to overall recovery performance.** The diagnostic, surgical and outpatients transformation programmes were three of 13 programmes NHSE brought together to deliver the aims of the 2022 elective recovery plan. The overall aims of elective recovery were to increase elective activity, treat patients who had been waiting the longest and recover diagnostic waiting times. These three transformation programmes aimed to contribute to the overall goals of elective recovery by increasing capacity in diagnostic, surgical and outpatients services (paragraphs 1.6, 1.16 and 2.2).

9 **The diagnostic and surgical transformation programmes are achieving some but not all their programme objectives.**

- **Community diagnostic centres (CDCs) are delivering additional capacity and have met goals to increase numbers of diagnostic tests.** NHSE estimates that between 2022-23 and 2024-25, it will have drawn down £2.2 billion (out of £2.3 billion allocated capital funding) to be spent by local NHS systems (integrated care boards and their partner NHS trusts) for diagnostic transformation, including for new CDCs. In August 2024, 137 CDCs were operational in their permanent locations and 30 were operating from temporary sites out of 170 planned to be operational by March 2025. 141 out of 170 planned CDCs will be fully operational at their permanent location by March 2025. For the diagnostic waiting list tests, published data show that CDCs provided 7% of the total across the NHS in 2023, growing to 13% in 2024 as CDC activity expanded. The total diagnostic tests carried out by CDCs has been tracked weekly by the programme, and was an average of 2% above targeted weekly levels between July 2021 and November 2024 (paragraphs 2.7 to 2.9).
- **NHSE has made progress with establishing surgical hubs but is not on track to deliver planned activity levels.** The Targeted Investment Fund (TIF) programme board tracks capital spending and additional elective activity for the 47 new hubs and 26 hub expansions or improvements that it funded. From 2022-23 and up to March 2025, NHSE estimates that it will spend £1.0 billion on new surgical hubs and expanding existing hubs. The TIF programme reported on the building of 37 new hubs and the expansion or improvement of 18 existing hubs in December 2024. Nineteen of these 37 new hubs and eight of these 18 expanded hubs are reported as complete. For the 18 remaining new hubs, seven are reported as due to be complete before the end of March 2025 (with four hubs off-track) and 11 hubs are scheduled to complete between May 2025 and July 2026 (with seven hubs off-track). NHS trusts with surgical hubs have reported their additional elective activity, with 44 reporting activity out of 53 that had planned to in September 2024. The additional elective activity reported by 44 NHS trusts with surgical hubs funded through NHSE's TIF is, on average, 48% below planned activity levels between April 2023 and September 2024 (paragraph 2.16).

10 The outcomes the diagnostic and surgical transformation programmes sought to achieve have not yet been met.

- The **diagnostic transformation** programme aimed to build diagnostic capacity and meet the recovery target. As at January 2025, 22% of patients waited more than six weeks for diagnostic tests against the March 2025 5% recovery target. NHSE attributes around one third of the shortfall to reductions in planned revenue funding for CDCs and one third to additional unscheduled (emergency) diagnostic tests in NHS trusts, which reduces the capacity of CDCs to support elective recovery (paragraphs 1.15, 1.16, 2.6, 2.10 and 2.11, and Figure 4).
- The **surgical transformation** programme aimed to increase the number of surgical hubs and help achieve the overall outcome of increasing elective activity to 129% of 2019-20 levels by 2024-25. NHSE does not yet know what level of activity hubs have contributed to performance against this overall target, which averages 116% so far in 2024-25. NHSE attributes the shortfall in activity to wider issues including increases in non-elective activity and delays in discharging patients from hospitals. An NHSE-commissioned Health Foundation report found that, immediately post-COVID-19, recovery of elective activity was faster in trusts with surgical hubs than it would have been without the hubs (paragraphs 1.11 and 2.14 to 2.20 and Figure 6).

11 NHSE aimed to free up outpatients capacity but has struggled to deliver outpatients transformation during the elective recovery period. On average, 80% of elective pathways that leave the waiting list in a month are in non-admitted elective care. The outpatients transformation programme aimed to free up capacity in outpatients services to allow more patients from the waiting list to be seen. From 2021-22 to 2023-24 the outpatients programme spent £52 million. The links between the outpatients programme and the outcomes it aimed to achieve have been the weakest of the three transformation programmes. NHSE introduced a target to reduce outpatient follow-up appointments by 25% compared with 2019-20 levels by March 2023. Follow-up appointments reported to the elective recovery board reduced by 0.1% between June 2022 and July 2023 (the months where NHSE reported performance). NHSE could not provide any modelling or evidence explaining the achievability of the target to reduce follow-up outpatient appointments by 25%, nor any assessment of the resources required to achieve this reduction. NHSE no longer reports progress against this target. Instead, it set a national NHS objective to increase the proportion of appointments that lead to elective waiting list removals to 46% and asked NHS systems to increase the proportion of outpatient appointments that lead to elective waiting list removals by 4.5 percentage points in 2024-25, compared with their levels in 2022-23. For 2025-26 NHSE will focus on reducing time to first appointment, aiming for 72% of first appointments to be within 18 weeks by March 2026 (paragraphs 1.19 and 2.21 to 2.27).

Management and oversight of the transformation programmes

12 NHSE's governance arrangements for the transformation programmes have not been sufficiently joined up or effective. The role of NHSE's elective recovery board is to provide overall strategic oversight and governance of elective recovery including monitoring risks and recommending actions for the transformation programmes. Other groups and boards also play an oversight role, with the Targeted Investment Fund (TIF) delivery board and the Capital Delivery Oversight Group (CDOG) monitoring progress, performance and spending on surgical hubs and CDCs respectively. The Elective Oversight Board, chaired by DHSC and attended by other parts of government, tracks activity and provides governance for funding requests for the elective recovery programme. However, we found that the information reported to NHSE's elective recovery board did not provide a clear picture of progress over time on the transformation programmes, with gaps in the data reported, key indicators not being reported consistently and a lack of reporting of progress against milestones. The outpatients programme would have benefitted from more active risk management. The outpatients board was brought more formally under the umbrella of the elective recovery board in April 2024. NHSE recognises the need for more joined-up governance arrangements for the transformation programmes and plans to introduce a new national oversight board to replace the elective recovery board (paragraphs 3.2 to 3.5).

13 The elective recovery board does not assess whether NHSE has the right balance of investment across the transformation programmes to reduce waiting lists. Decision makers need to assess whether resources are being deployed in the right areas to deliver intended outcomes. The elective recovery board has not played a role in monitoring operational (capital or resource) expenditure on the surgical and diagnostic programmes because this is carried out by the TIF delivery board and CDOG. NHSE monitors national programme spend on outpatients transformation, but the elective recovery board is not responsible for monitoring how much local NHS systems are spending in implementing outpatients transformation. This means that the board has not had the information it needs to assess and take decisions on the balance of investment across the programmes. In 2022, NHSE's internal auditors recommended that NHSE include financial status updates as part of monthly reporting. However, the board decided against implementing this recommendation given NHSE's overall financial processes and because the programmes sit within wider directorate budgets (paragraphs 3.6 to 3.8).

14 NHSE has taken steps to evaluate how well the transformation programmes are progressing, but was slow to make significant changes to outpatients transformation. There are examples of evaluating progress on all three programmes. NHSE monitors how well diagnostic centres are performing, and the process for accrediting surgical hubs identifies areas for improvement and sets timelines for addressing issues. In contrast, while NHSE took steps to build support from clinicians and local NHS systems on outpatients transformation during 2022 and 2023, it did not identify the need for more fundamental changes to the under-performing programme until 2024. Changes included refocusing outpatients transformation around specific clinical pathways. Although it is too early to assess the effectiveness of the changes to outpatients pathways, local systems we spoke to welcomed them. We note that moving away from a 'one size fits all' approach is in line with National Audit Office guidance on improving services (paragraphs 3.9 to 3.11).[4]

Learning lessons from the transformation programmes.

15 The diagnostic programme has the clearest links between its output and intended outcomes, and it has demonstrated a developing understanding of systemic issues. The diagnostic programme, from the outset, and up to recent requests for additional funds, has demonstrated the most developed understanding of the relationship between the investment made, its output (numbers of tests carried out) and intended outcomes (shorter waiting times). When these have been off-track the programme has sought to explain the differences. We did not see this depth of understanding with the surgical hubs programme. Despite NHSE's ambition to transform outpatients services, the programme has not had the same impetus or prioritisation (paragraph 4.5).

16 NHSE's new elective care reform plan reflects lessons learned to date from the three main transformation programmes, and there is scope for further improvements. In January 2025, NHSE published *Reforming elective care for patients* which sets out its ambitions for improving elective care. This built on a previous government announcement in October 2024 to allocate a further £1.5 billion of capital funding for new surgical hubs and diagnostic scanners in 2025-26. Although it is clearly too early to conclude on the likely success of this new plan, we have considered whether the plan, alongside other action NHSE has taken, indicates learning from the three transformation programmes examined in this report. We found that NHSE has developed its plans in important areas such as making further capital investment in infrastructure to increase activity, changes to the outpatients programme – including funding GPs to provide Advice and Guidance as an alternative to outpatient appointments – and evaluating programmes to understand how they are working. However, we also found scope to strengthen clinical leadership, target-setting and performance reporting to ensure that decision-makers are clearly focused on achieving the ambitions in the reform plan (paragraphs 4.2 to 4.7 and Figure 7).

4 National Audit Office, *Improving services – understanding and managing demand*, February 2023.

17 **The more successful programmes have been based on securing clinical support.** Our guidance on major programmes highlights the need for effective stakeholder engagement to ensure that those who must implement the programme buy into it. On the broader elective recovery programme, national medical leadership is provided by National Clinical Directors embedded within the programme. Specifically, on the transformation programmes, clinical engagement has worked best when there has been good use of data, credibility of the programme's aims, close working between national and local clinical leaders and specific and expert peer-to-peer support in delivery (paragraphs 4.8 and 4.9).

- The diagnostic transformation programme was initiated by an NHSE-commissioned independent review by Professor Sir Mike Richards. This review helped give credibility to proposed changes to diagnostic transformation. Clinicians welcomed much-needed investment in diagnostic equipment and expansion of diagnostic capacity.
- Surgical transformation has benefitted from clinical leadership, the support of the Royal College of Surgeons of England and deep use of data, and has developed over a number of years, helping build engagement from local NHS systems and clinicians.

18 **The less-successful outpatients transformation programme did not secure full clinical support, but NHSE has now set new incentives and priorities.** Local NHS systems told us that they accepted that outpatients services could be improved. The Royal College of Physicians also told us that it believed outpatients services should be transformed, but a targeted approach to an arbitrary reduction in follow up appointments would have a limited impact. Balancing the health risks of the people whose conditions require follow-up in outpatients, and the people waiting to be seen for the first time, is an ongoing challenge for NHSE. Although NHSE acted to engage local systems in 2022 and 2023, for example, by appointing clinical advisors to support the programme, it considers that the impact of industrial action in 2023 and 2024 made it difficult to make the changes on the scale it wanted to. Following the 2024 programme reset, NHSE is seeking more local and specialty-specific clinical support for the programme and providing new financial incentives to clinicians (paragraphs 2.24, 4.9 and 4.10).

Conclusion on value for money

19 NHSE has focused its elective transformation activities on diagnostics, surgical and outpatients, aiming to see more patients sooner and to improve the productivity of these services. In the context of an operational environment where challenges have included industrial action, low productivity and high inflation, the transformation programmes have not yet met their goals to support elective recovery. While diagnostic transformation has demonstrated positive features of programme management, including tracking, clear reporting, and management of costs, outputs and outcomes, the surgical and outpatients programmes require more rigorous oversight from NHSE if they are to deliver the outcomes required.

20 With the January 2025 plan to reform elective care and reduce waiting lists, the government plans to continue to run the transformation programmes for several more years, including further capital investment in surgical hubs and diagnostic centres. It now has an opportunity to ensure that it learns lessons from its experience in the first phase of the programmes. There are signs that it is doing so in some areas as it makes changes to the outpatients programme, does more to seek buy-in from local NHS systems and clinicians, and re-sets programme governance arrangements. To achieve its aims on elective reform and secure value for money from the transformation programmes, NHSE will need to better understand the outcomes they are delivering for patients, and assess whether it is focusing its resources in the right areas to improve elective care.

Recommendations

21 These recommendations are intended to support NHSE as it develops and takes forward the 2025 elective care reform plan to meet the 18-week waiting time target within five years.

a **NHSE plans to reset its central oversight arrangements for elective recovery. As it establishes its new national level oversight board for the transformation programmes it should:**

- ensure that performance information reported to the board is prioritised, clear and consistent so that the board has a clear view of trends over time and issues arising. Performance indicators should relate to the outcomes that the programmes are aiming to achieve;
- include programme costs in board reporting to enable the assessment of the relative cost and value of elements of the recovery plan, and to support decision making on the allocation of resources;
- ensure that the risk information reported to the board is up to date and timely and reflects current performance and progress on each programme against planned trajectories; and
- when a programme is not delivering, as the outpatients transformation programme was not, highlight this in reports to the board. The board should document decisions about what it has done to address this.

b **The national level oversight board should assess whether it has the right balance of investment across the transformation programmes and other initiatives, including capital and resource spending, to achieve the required reduction in elective care waiting times.** It should assess:

- the level of both capital and resource expenditure on the programmes;
- the contribution the transformation programmes have made to date to reduce waiting times and modelling to understand how they are expected to achieve outcomes in future, including the relationship between meeting performance targets and reducing waiting times; and
- the dependencies between the transformation programmes and other initiatives for reducing waiting times, including how they will work together to bring elective recovery back on track.

c **The national level oversight board should play an active role in ensuring that lessons are learned on and between the transformation programmes.** Practical steps may include reviews, workshops or problem-solving sessions to allow everyone involved to share their perspectives and experiences, and giving people the opportunity to work alongside other teams.

d **NHSE should do more to secure buy-in from clinicians across its programmes.** It should achieve this by:

- continuing to build support and endorsement nationally by strengthening its work with Royal Colleges and through national clinical directors embedded in the elective recovery programme;
- aligning national and local clinical ambitions and expectations;
- using data and modelling to demonstrate the case for change; and
- building support locally through peer-to-peer engagement.

e **Having brought oversight of the outpatients transformation into the wider elective recovery programme, NHSE should:**

- make a full assessment of the lessons learned to date. NHSE should set out how these lessons will be incorporated in its plans for taking the transformation forward;
- strengthen risk and programme management; and
- set out how it expects achievement of targets to translate into reduced waiting times and assess their deliverability. This deliverability assessment should set out the key actions that are needed to ensure that targets are delivered and an implementation plan including the resources required and the milestones NHSE will need to meet. NHSE should be clear on how this plan differs from its previous activity which has not delivered a reduction in outpatient appointments.