National Audit Office

REPORT

NHS England's management of elective care transformation programmes

NHS England

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National Audit Office

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NHS England

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

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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.

Part One

Elective care waiting times and elective recovery

1.1 This part introduces elective care and diagnostic waiting times. It describes NHS England's (NHSE's) progress on elective recovery to provide context for the transformation programmes.

NHS elective care

1.2 In broad terms, 'elective care' means non-emergency treatment that is under the care of a consultant. The 2004 NHS Improvement Plan stated that by 2008 no one would wait more than 18 weeks from referral to the start of consultant-led elective treatment. Since April 2013, NHS regulations have included a statutory requirement for 92% of the waiting list to wait no more than 18 weeks from referral.

1.3 To monitor whether it is meeting the 18-week statutory waiting standard, NHSE measures the time between a referral (by a GP, hospital doctor or other clinician) to the first treatment for that condition. The referral starts a 'waiting time clock' and the patient may require a diagnostic test and/or one or more outpatient appointments before the clock can be stopped ('clock stop'). The elective waiting time clock is stopped by the first treatment for that condition, which can be either as an hospital outpatient or an inpatient, or when it is decided that elective care is not required (**Figure 1** overleaf).

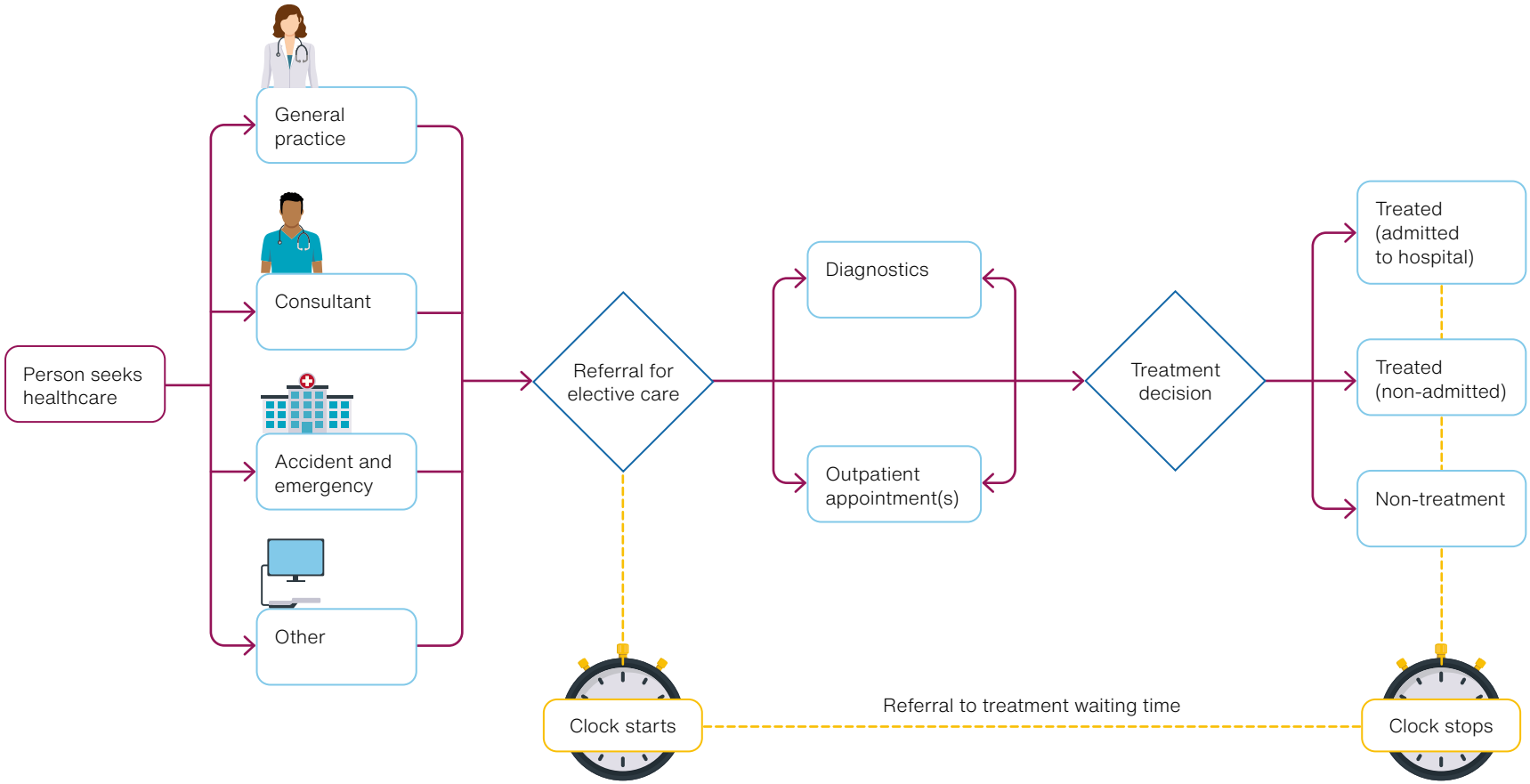
1.4 NHSE reports the number of ongoing elective referral-to-treatment pathways monthly, which is referred to as the elective care waiting list.[5] As at January 2025, patients had been on the waiting list for elective care on 7.43 million pathways. Some people are on more than one pathway. NHSE estimates that 6.25 million individuals were waiting for treatment in January 2025. Patients waited for up to 18 weeks on 4.37 million pathways (59%) and for more than 18 weeks on 3.06 million pathways.

5 An elective pathway is the specific route that a patient takes through the health service from the point of referral to the point of treatment.

Figure 1

Elective care referral to treatment pathway

NHS England measures the time between a referral to the first treatment



Notes

1 Consultant referrals occur when one consultant refers a patient to another consultant.

2 As well as for clinical reasons, non-treatment includes where the patient declines treatment, does not attend, or opts for private treatment.

3 Patients can be referred into services that include a diagnostic test alongside or in place of a first outpatient appointment.

Source: National Audit Office analysis of NHS referral to treatment information

NHS elective recovery

1.5 The 18-week standard was last achieved in September 2015 but waiting times have been growing since 2013.[6] Before the COVID-19 pandemic the waiting list grew from 2.63 million in February 2013 to 4.57 million in February 2020, and the percentage waiting up to 18 weeks for treatment fell from 94% to 83%. During the pandemic the waiting list initially reduced as referrals slowed. The waiting list increased significantly from July 2020.

1.6 NHSE published its *Delivery plan for tackling the COVID-19 backlog of elective care* in February 2022, to set out how it planned to recover elective and cancer care over the three years up to March 2025. This plan aimed to reduce waiting times by increasing capacity, prioritising patients waiting the longest and improving information and support for patients. We reported on the recovery plan's design, early implementation and results in November 2022. We concluded that the recovery target to increase elective activity to 129% of 2019-20 levels and the target to eliminate all waits of longer than 52 weeks by March 2025 were at serious risk of not being achieved, and it was uncertain whether new initiatives would deliver results as quickly as intended.

Reducing the longest waits for elective care

1.7 The recovery plan aimed to reduce the number of long waiting pathways for elective care. It set target dates to eliminate long waiters, stating that its ambition was: "that the waits of longer than a year for elective care are eliminated by March 2025. Within this, by July 2022, no one will wait longer than two years, we will aim to eliminate waits of over 18 months by April 2023, and of over 65 weeks by March 2024." The recovery plan included a caveat that "some patients will choose to wait longer, and a very small number of specific highly specialised areas may need tailored plans to tackle the backlog, as was the case before the pandemic".

1.8 By their target dates, the number of long waits reduced as follows (**Figure 2** overleaf).

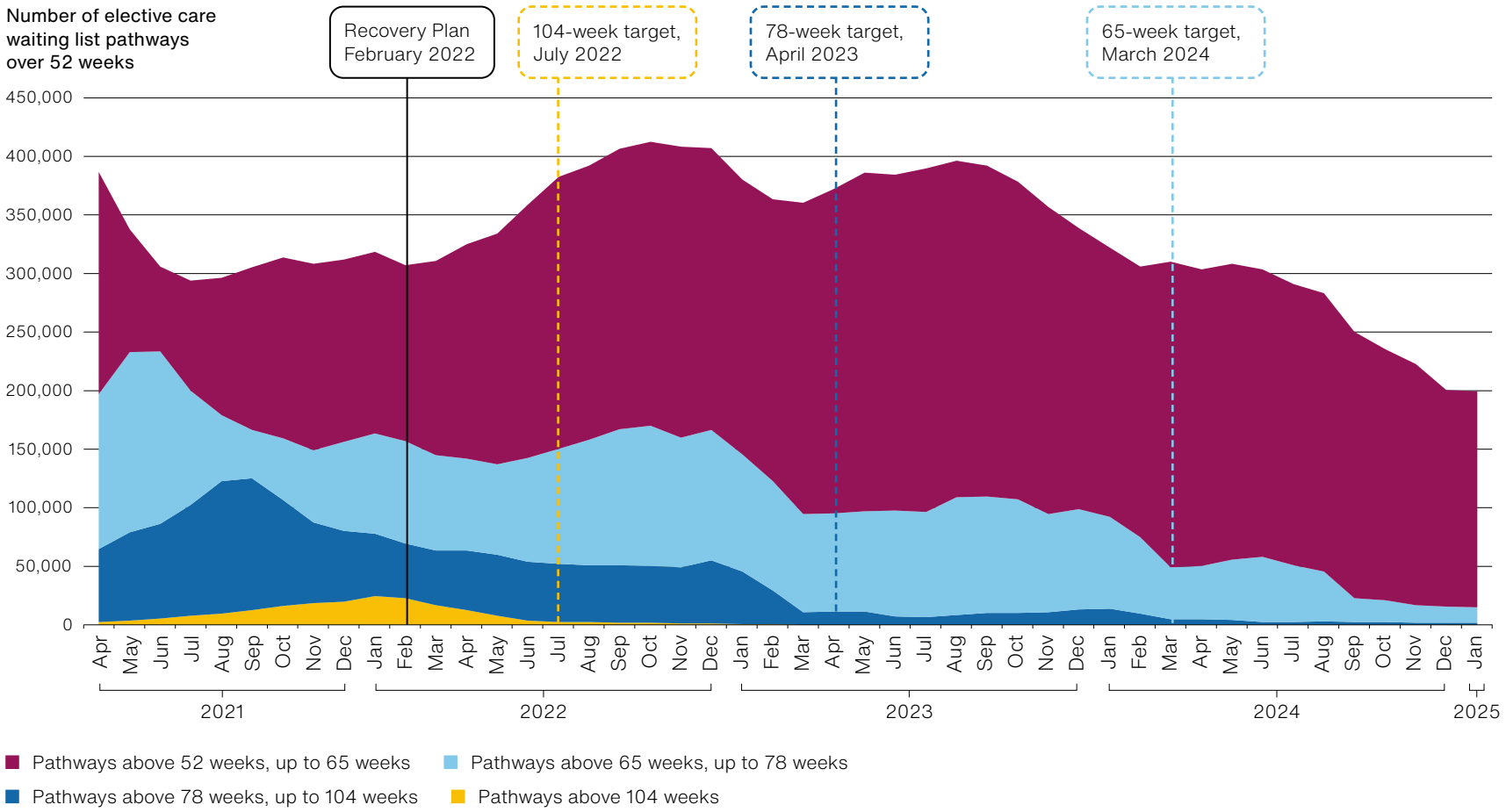
- Waits of more than 104 weeks reduced by 87% (from around 23,000 in February 2022 to 2,890 in the reported statistics in July 2022).
- Waits of more than 78 weeks reduced by 83% (from around 69,000 in February 2022 to 11,000 in April 2023).
- Waits of more than 65 weeks reduced by 69% (from around 157,000 in February 2022 to 49,000 in March 2024).

6 Throughout this report, we use NHS England's (NHSE's) referral-to-treatment statistics on elective waiting times which include NHSE's estimates for missing data. NHSE published these statistics from December 2022. On average, between August 2007 and November 2024, the size of the waiting list increases by around 2% when the estimates for missing Trusts are included.

Figure 2

Elective recovery long waiter cohorts, April 2021 to January 2025

NHS England has made significant progress in reducing long waits



Notes

1 The elective recovery plan, published in February 2022, aimed to eliminate waits of more than 104 weeks by July 2022, waits of more than 78 weeks by April 2023, and waits of more than 65 weeks by March 2024.

2 The final elective recovery long wait target is to eliminate waits of longer than a year for elective care by March 2025. This Figure shows cohorts by length of wait. As at January 2025 there were approximately 200,000 pathways over 52 weeks.

3 From February 2024, community services pathways were no longer included in the referral-to-treatment dataset, moving to the Community Health Services dataset.

Source: National Audit Office analysis of NHS England waiting time data

1.9 As at January 2025 (latest available data) there were 198,868 pathways above 52 weeks, comprising 139 pathways over 104 weeks, 1,866 pathways over 78 and up to 104 weeks; 12,970 pathways over 65 and up to 78 weeks, and 183,893 pathways over 52 and up to 65 weeks. 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%.

1.10 NHSE will not meet its target to eliminate waits over 52 weeks by March 2025. It has reduced the number waiting over 52 weeks from 306,479 in February 2022 to 198,868 in January 2025, a reduction of 35%. The 2025-26 operational planning guidance replaced this target with a new target to reduce the proportion of people waiting over 52 weeks to less than 1% of the total waiting list by March 2026. As at January 2025, this stood at 3% of the waiting list.

Increasing elective activity

1.11 NHSE's 2022 recovery plan aimed to deliver around 30% more elective activity by 2024-25 than before the pandemic. NHSE committed to increasing the percentage of referral-to-treatment clock stops in every year of recovery, (including pathways avoided through providing Advice and Guidance), rising to 129% of 2019-20 levels by 2024-25 (**Figure 3** overleaf).[7] So far in 2024-25, NHSE has achieved 116%.

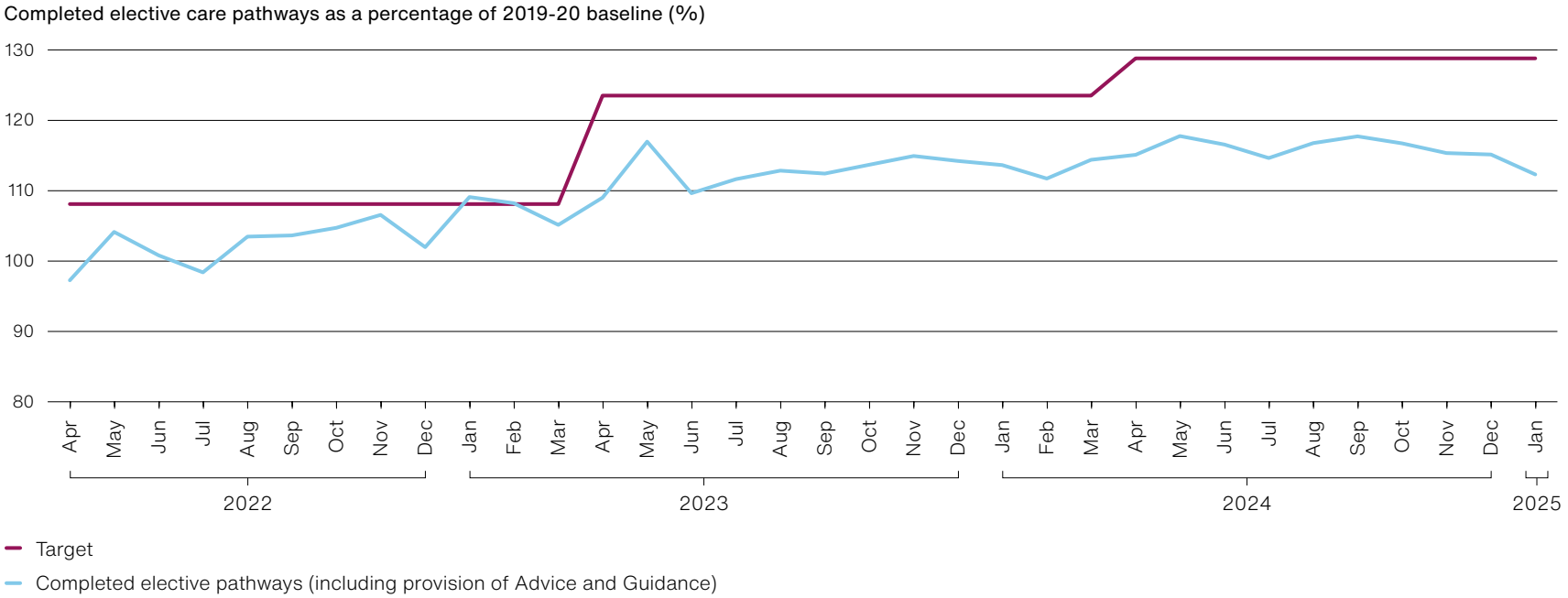
1.12 NHSE faced significant operational challenges during 2023 and 2024 with sustained industrial action across multiple staff groups. NHSE has estimated that strikes resulted in 442,000 fewer completed pathways, 1.5% of the total number of pathways completed between December 2022 and July 2024 (29.1 million). The total number of pathways behind plan (excluding Advice and Guidance) was a cumulative 3.5 million between December 2022 and July 2024, meaning that strikes accounted for 12% of the shortfall. NHSE told us that lower than expected productivity, and higher than expected levels of COVID infection, non-elective demand and inflation during 2023 and 2024 had also impacted on its ability to increase elective activity. These factors were outside NHSE's planning assumptions. Their impact is hard to quantify, and we have not validated the scale of any impact.

7 Advice and Guidance allows GPs to deliver advice provided by a hospital clinician, prior to or instead of an elective referral.

Figure 3

Planned elective recovery trajectory and actual performance, compared with 2019-20 levels, April 2022 to January 2025

The number of completed elective care pathways has increased compared with 2019-20, but has remained below NHS England's (NHSE's) targeted levels



Notes

1 The elective recovery plan aimed to increase elective care activity to 108% in 2022-23, 124% in 2023-24 and 129% in 2024-25 compared with 2019-20 levels.

2 Advice and Guidance allows GPs to seek advice from a hospital clinician, prior to or instead of an elective referral. Including this metric in the number of completed elective pathways allows a comparison with NHSE's calculation of its overall elective activity target of 129%.

Source: National Audit Office analysis of published NHS England elective recovery management information

Diagnostics

Diagnostic tests and waiting times

1.13 Elective care patients may require a diagnostic test or procedure (an image, measurement or an examination to inform a diagnosis) depending on the condition under investigation. NHSE measures the waiting times and activity for 15 key diagnostic tests. The diagnostic waiting time clock starts when the request for the diagnostic test is made (by a GP, hospital-based clinician or other route), then stops when the person receives the test. NHSE's diagnostic test waiting list is a separate data collection from the elective care waiting list. The degree of overlap between them is unknown.

1.14 In addition to diagnostic tests where patients are on a waiting list, the NHS also carries out unscheduled diagnostic tests (following an emergency admission or in Accident & Emergency departments) and planned (or surveillance) diagnostic tests where tests are carried out at specific times as part of a treatment plan. In January 2025, of a total of 2.5 million diagnostic tests in the NHS, 1.7 million (68%) were waiting list tests, 0.5 million (21%) were unscheduled and 0.3 million (11%) were planned.

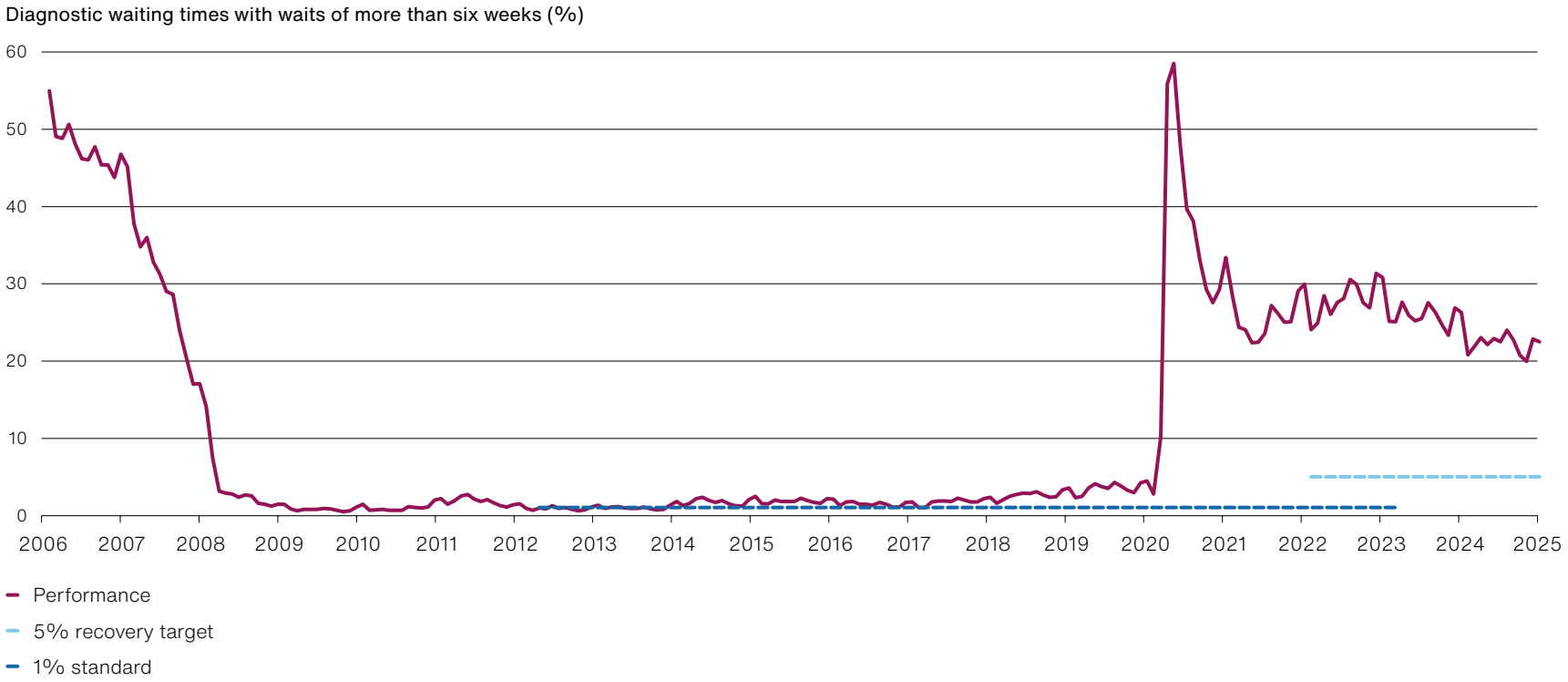
1.15 The NHS constitutional pledge is that patients should not wait six weeks or longer for waiting list diagnostic tests. To support the overall 18-week elective care waiting time standard, a six-week diagnostic 'milestone' was introduced from March 2008. The 2012-13 Operating Framework for the NHS in England stated that less than 1% of patients should wait more than six weeks for a diagnostic test. This 99% diagnostic standard was last met in November 2013 and last featured in the NHS Standard Contract 2022-23, so was in place as an operational standard up to March 2023.

1.16 Following the COVID-19 pandemic, NHSE set an elective recovery target for 95% of patients needing a diagnostic test to receive it within six weeks by March 2025, or alternatively, for no more than 5% of waits for diagnostic tests to be more than six weeks. In April to January 2022-23, 28.7% of diagnostic tests were above six weeks (monthly average). In April to January 2024-25, 22.3% of diagnostic tests were above six weeks (monthly average), a 6.4 percentage point improvement. As at January 2025, patients waited more than six weeks on 22% (364,000) of diagnostic tests. NHSE is not on track to meet the recovery target (**Figure 4** overleaf).

Figure 4

Diagnostic waiting time performance, January 2006 to January 2025

NHS England (NHSE) is not on track to meet the elective recovery target to reduce waits for diagnostic tests of more than six weeks to 5% by March 2025



Notes

1 The diagnostic performance standard of 1% was introduced from April 2012. It last featured in the NHS Standard Contract 2022-23, so was in place as an operational standard until March 2023. It states that 99% of patients should wait less than six weeks for 15 key tests.

2 Following the COVID-19 pandemic, NHSE set a recovery target of 5%, shown as a dotted line from February 2022, when it was announced. It states that 95% of patients will wait less than six weeks for these diagnostic tests by March 2025.

3 NHSE measures the waiting times for 15 key diagnostic tests. These tests do not include those where people have planned diagnostic tests as part of a treatment plan, nor the national screening programme, or tests for expectant mothers or tests while a patient is admitted to a hospital.

Source: National Audit Office analysis of NHS England published data and performance targets

Admitted and non-admitted elective care

Waiting times for admitted and non-admitted elective care

1.17 As well as counting the total number of patients on pathways waiting for elective care, NHSE also reports the time between referral and treatment for completed elective pathways. These pathway waiting times have been stopped either by an admission to hospital or through non-admitted care. Admissions to hospital as an inpatient or a day case are referred to collectively as 'admitted pathways'.

1.18 The elective waiting times of 3.47 million pathways were stopped in 2023-24 by a treatment that involved an admitted pathway (20% of a total of 17.4 million clock stops for admitted and non-admitted treatment in 2023-24). This remains lower than the highest level of 3.85 million clock stops in 2014-15. The median waiting time for admitted care has increased from 8.8 weeks in September 2011 to 12.6 weeks in September 2024.

1.19 Outpatient care includes visits to specialists to seek an opinion, a diagnosis, or support to manage a long-lasting condition, where the patient is not admitted to hospital. Some outpatient attendances will complete a referral-to-treatment pathway, or stop the elective waiting time clock. In 2023-24, 13.9 million elective pathways were completed non-admitted pathways. This is the highest number of non-admitted completed pathways, up from 13.4 million in 2019-20. In 2023-24, 80% of completed elective pathways were in non-admitted care. The median waiting time for non-admitted care increased from 4.5 weeks in September 2011 to 10.0 weeks in September 2024.

Part Two

NHS England's elective transformation programmes

2.1 This part examines NHS England's (NHSE's) progress in delivering three elective recovery transformation programmes and the outcomes that these programmes have achieved.

The elective recovery transformation programmes

2.2 When we reported in 2022, NHSE was running 13 programmes to support elective recovery. This report focuses on three of these programmes, which aim to change how NHS care is provided – diagnostic, surgical and outpatients transformation and contribute to the overall goals of elective recovery. All three programmes pre-existed NHSE's 2022 elective recovery plan, which runs until March 2025.

2.3 Capital funding was planned for two of the three programmes. NHSE planned to spend a total of £3.5 billion of capital funding from 2022-23 to 2024-25, comprising £2.3 billion for diagnostic transformation and £1.2 billion for surgical transformation. This is around 11% of the Department of Health & Social Care's total actual or planned capital spending over this period (around £33 billion).

Diagnostic transformation

The diagnostic transformation programme

2.4 The 2019 NHS Long Term Plan stated that "capacity in diagnostic services has not kept pace with demand". The 2020 NHSE-commissioned review of diagnostic capacity by Professor Sir Mike Richards then recommended that acute and elective diagnostics should be separated wherever possible to increase efficiency and that Community Diagnostic hubs should be established.[8]

2.5 NHSE formed the diagnostic transformation programme in 2021. From September 2022 the programme reported its objective as "transform [the] diagnostics model and create additional capacity through Community Diagnostic Centres (CDCs), more equipment on acute sites, networking, increasing operational productivity, developing the workforce and reducing unnecessary testing".

8 Professor Sir Mike Richards, *Diagnostics: Recovery & Renewal – Report of the Independent Review of Diagnostic Services for NHS England*, October 2020.

2.6 The government allocated £2.6 billion of capital funding to diagnostic transformation in the four years from 2021-22 to 2024-25 (£325 million in 2020-21 and £2.3 billion in the three years from 2022-23 to 2024-25). CDCs were also allocated £2.0 billion of revenue funding in the three years from 2022-23 to 2024-25. NHSE's 2022 diagnostic transformation business case stated that the investment was required to return diagnostic waiting lists to 2019-20 levels by March 2025 and meet the six week diagnostics waiting time target. The initial announcement on 1 October 2021 was for 40 CDCs and following the allocation of £2.3 billion of capital funding on 27 October 2021, the February 2022 elective recovery plan included an ambition to establish more than 160 CDCs.

Diagnostic transformation progress to date

2.7 Since 2022-23, and as at February 2025, NHSE has drawn down £2.1 billion of capital funding (of the £2.3 billion allocated) to local NHS systems (integrated care boards and their partner NHS trusts) for diagnostic transformation, including the cost of new CDCs. NHSE estimates it may draw down up to £2.2 billion from 2022-23 to 2024-25. The allocated diagnostic revenue funding of £2.0 billion was reduced by NHS pay award and industrial action costs to an estimated £1.8 billion.

2.8 The programme has approved 170 permanent CDCs, to be operational by March 2025. As at August 2024, 167 CDCs were live, with 137 CDCs operational in their permanent locations and 30 operating on temporary sites. 141 CDCs will be fully operational at their permanent location by March 2025. NHSE first asked for ministerial approval of 139 CDC locations in August 2022 but ministers only approved 58 CDCs at that point, due to differences between successive ministers over whether sites should be located on existing acute sites or separate from them. Final approval for remaining sites was given in August 2023.

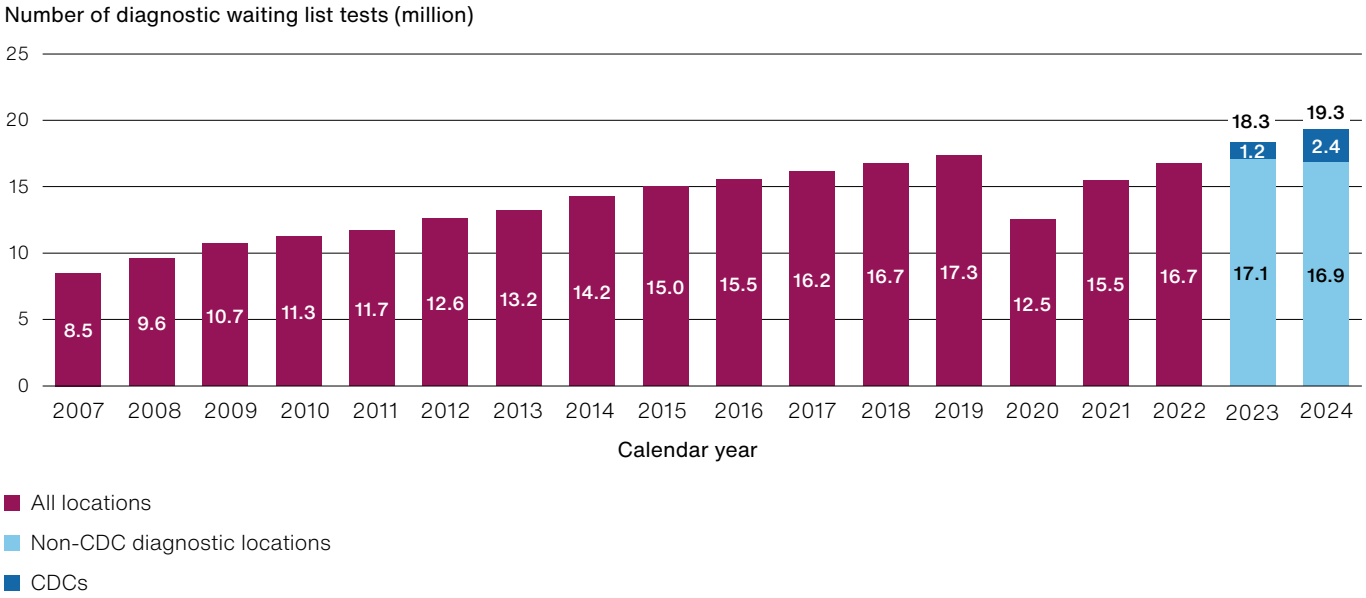
2.9 The total number of diagnostic tests carried out by CDCs has been tracked weekly by the programme and has been approximately at targeted levels throughout. Between July 2021 and November 2024 CDC activity was, on average, 2% above planned levels. For diagnostic tests for patients on a waiting list, published data show that CDCs provided 1.2 million tests in 2023 (around 7% of the total number of diagnostic waiting list tests carried out across the NHS) growing to 2.4 million tests in 2024 (around 13% of the total) as CDC activity increased (**Figure 5** overleaf).[9] Between 2007 and 2019, diagnostic waiting list tests increased by an average of 6% per year. Diagnostic waiting list tests then decreased in 2020 and then recovered to exceed 2019 levels from 2023. Between 2023 and 2024 the total diagnostic waiting list tests increased by 6%, but waiting list tests performed outside of CDCs reduced from 17.1 million to 16.9 million.

9 Published data include reporting on diagnostic activity in CDCs as a separate category from March 2023.

Figure 5

Number of diagnostic waiting list tests carried out in Community Diagnostic Centres (CDCs) and all other diagnostic locations, 2007 to 2024

CDCs provided 1.2 million (7%) of 18.3 million diagnostic waiting list tests carried out across the NHS in 2023, growing to 2.4 million (13%) of 19.3 million in 2024



Notes

1 NHSE measures the waiting times and activity for 15 key diagnostic tests. This chart shows the tests carried out where a patient had waited on a waiting list. It does not include planned (surveillance) or unscheduled tests, which are when people have planned diagnostic tests as part of a treatment plan or tests while a patient is admitted to a hospital.

2 Published diagnostic statistics include reporting on diagnostic activity in CDCs as a separate category from March 2023.

Source: National Audit Office analysis of NHS England published data

2.10 Although CDCs have provided an increasing proportion of diagnostic activity, NHSE is not on track to achieve its diagnostic waiting list reduction targets. As at January 2025, 22% of patients waited more than six weeks for diagnostic tests against the recovery target of 5% (Figure 4). Internal NHSE analysis in June 2024 indicated that the 95% recovery target will not be met by March 2025 due to a shortfall of around 3.6 million tests. NHSE attributes this shortfall to:

- a reduction in CDC revenue funding in 2022-23 to support staff costs and in 2023-24 to mitigate the financial impact of industrial action (36%);
- unscheduled activity in trusts (34%);
- ministerial approval delays in 2022-23 followed by an instruction to accelerate, meaning that the activity plans approved for some CDCs were unfeasible (19%); and
- delayed investment in acute settings (8%), financial restrictions (2%) and industrial action (1%).

2.11 The 2025-26 NHS operational planning guidance does not include a specific diagnostic waiting time target. However, NHSE has told us that it will continue to monitor diagnostic waiting times. The guidance includes a new time to first appointment target which includes both diagnostic and outpatients appointments.

Surgical transformation

The surgical transformation programme

2.12 The surgical transformation programme stemmed from the earlier 'Getting it right first time' (GIRFT) programme – a clinician-led approach which aims to reduce unwarranted variation between NHS surgical services. GIRFT is also associated with approaches to tackle long waiting lists with stand-alone, elective surgical units that aim to maintain resources for planned care by segregating from facilities carrying out emergency surgery. In May 2021, GIRFT recommended that the NHS could remove patients from the waiting list by adopting approaches to target high-volume, low-complexity (HVLC) elective pathways, that is, in the six specialties with the highest volume of low-complexity surgical procedures.[10]

2.13 The surgical transformation programme has been funded from the Targeted Investment Fund (TIF). The 2021 Spending Review included £1.5 billion of TIF investment, to include capital for new surgical hubs and increased bed capacity and equipment to help elective services recover for the period 2022-23 to 2024-25. In August 2022, NHSE estimated that it would spend around £1.2 billion, or 80%, of the £1.549 billion 2022-23 to 2024-25 TIF on surgical hubs including £968 million (62%) on new surgical hubs and £280 million (18%) on expanding existing hubs.

2.14 The surgical transformation programme focuses on delivering hubs and ensuring they are working productively. NHSE aims to ensure that existing surgical capacity is used productively before making any additional investment. GIRFT productivity standards are for theatres to be used for the maximum amount (defined as 'touch time utilisation' at paragraph 2.17), and run for 2.5 sessions a day, six days a week, 48 weeks of the year. NHSE will consider additional investment where the productive use of surgical hubs to provide additional capacity can be guaranteed.

10 The six specialties GIRFT identified were ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, urology and ear, nose and throat.

2.15 The 2022 investment case for surgical hubs set wider outcomes which are dependent on wider NHS performance. It stated that surgical hub sites would play a crucial role in increasing overall elective activity by 10% in 2022-23 (compared with 2019-20) and 30% by 2024-25 (the overall elective recovery target to increase elective activity to 129% of 2019-20 levels by 2024-25, see paragraph 1.11 and Figure 3). However, this overall aim is dependent on achievements outside of surgical hubs, notably in outpatients given the higher volume of elective clock stops in that area. Submissions to ministers in 2022 to approve hub locations provide detail on the programme's planned outputs, stating that 57 new hubs will provide an additional 122 operating theatres to enable an additional 880,000 admitted procedures and 1.1 million non-admitted procedures over the three years from 2022-23 to 2024-25, including 500,000 admitted procedures and 575,000 non-admitted procedures in 2024-25.

Surgical transformation progress to date

2.16 TIF reporting states that, since April 2022, £1.4 billion of capital funding has been allocated to all TIF schemes, and £1.2 billion had been spent up to December 2024. NHSE initially estimated that around 80% of TIF would be spent on surgical hubs (paragraph 2.13). The TIF programme board tracks capital spending and additional elective activity for the 47 new hubs and 26 hub expansions or improvements that it funded. NHSE's current estimate of capital spending on new surgical hubs and expansions between 2022-23 and 2024-25 is £1.0 billion. We found that the progress data that (a) the surgical transformation programme reports to its board; and (b) the TIF reports to its board are different.

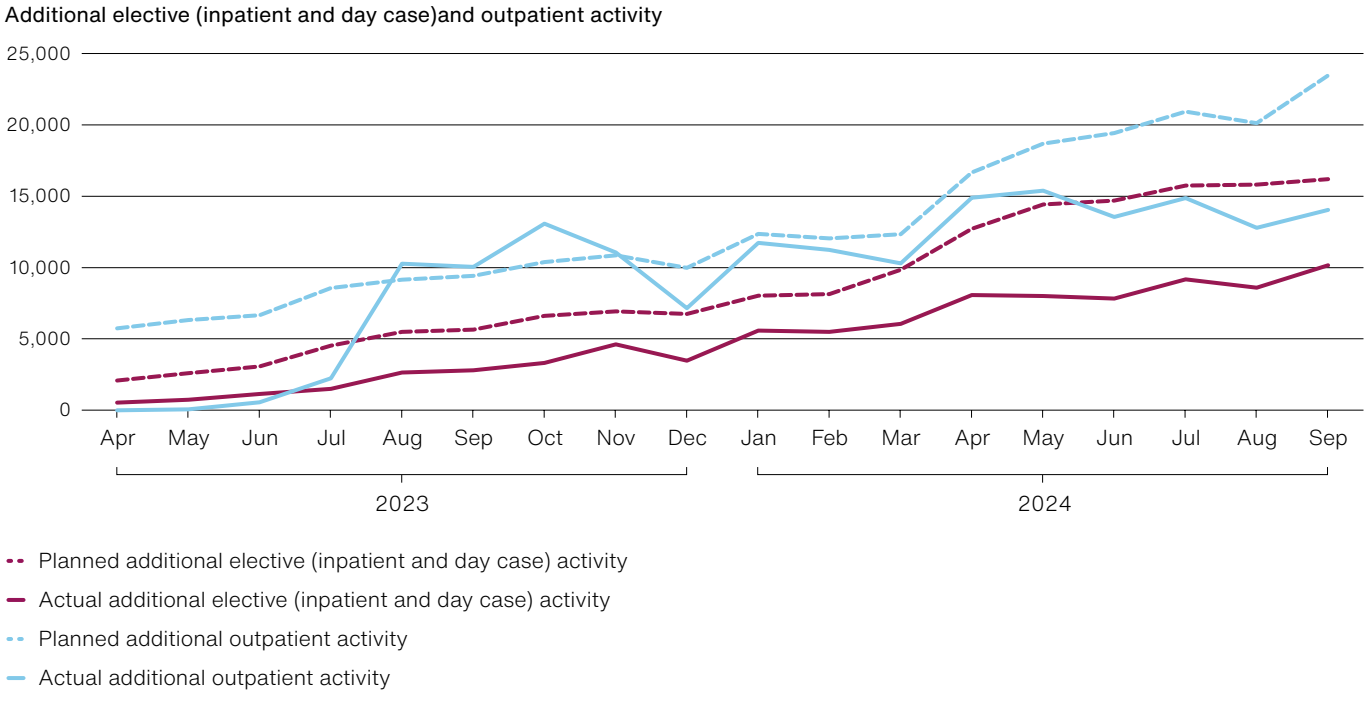
- The surgical transformation programme reported in August 2024 that **22 out of 47** new TIF-funded hubs (47%) were operational. Including surgical hubs that were set up before September 2022, the programme reported that a total of 112 hubs were operational at the end of December 2024 out of 134 planned by the end of 2026. While other NHSE groups track spend and surgical hub activity (the TIF programme board, for example, see bullet below), the surgical transformation programme does not itself monitor spend or progress against elective activity targets, or report this information up to the elective recovery board.

- TIF reported in December 2024 on the status of schemes and additional elective activity. It reported that **19 out of 37** new surgical hubs (51%) were complete. For the 18 remaining new hubs, seven are scheduled to be complete before March 2025. Of these, two are reported as on track to meet their expected patient-ready and in-use date. One is reported as at risk and four as off-track. Eleven new hubs are scheduled to be complete between April 2025 and July 2026 and seven of these are off-track. Of the expanded or improved hubs, eight out of 18 were reported as complete. TIF reporting data show that the additional elective and outpatient activity delivered by surgical hubs is considerably below planned levels (**Figure 6**). As at September 2024, 28 out of the 34 NHS trusts with new surgical hubs that had planned to report additional elective activity and 16 out of 19 NHS trusts that had received TIF funding to expand hubs were reporting additional elective activity (a total of 44 out of 53). Reported additional elective activity was below planned monthly levels by an average of 48% between April 2023 and September 2024.

Figure 6

Planned and actual additional elective activity delivered by NHS trusts with surgical hubs funded through Targeted Investment Fund (TIF) schemes, April 2023 to September 2024

NHS England (NHSE) monitors additional elective activity for NHS trusts with surgical hubs funded through TIF schemes. Additional activity is below planned levels for both elective (inpatient and day case) and outpatients activity



Note

1 As at September 2024, 28 out of the 34 NHS trusts with new surgical hubs that had planned to report additional elective activity and 16 out of 19 NHS trusts that had received TIF funding to expand hubs were reporting additional elective activity (a total of 44 out of 53).

Source: National Audit Office analysis of NHS England data

2.17 The surgical transformation programme tracks how much hubs are being used. Overall, utilisation of surgical hubs has increased. NHSE internally reports data on 'touch time utilisation' (percentage of total hours of surgery performed within scheduled theatre time) for comparison between surgical hubs. For the months reported, touch time utilisation increased from an average of 75% in 2022-23 to 78% in 2023-24 against a target of 80% by March 2024. The programme aims to achieve 85% utilisation in 2024-25 and has averaged 79% up to the end of January 2025.

2.18 There is a disconnect between the reporting on surgical hubs and the intended outcomes of the surgical transformation programme. The programme measures and reports on how much the surgical hubs are being used but the transformation programme is intended to increase overall elective activity. This disconnect is problematic because NHSE does not know what level of activity surgical hubs have contributed to its overall target to increase total elective activity to 129% of 2019-20 levels by 2024-25 (paragraph 2.15).

2.19 The surgical transformation programme does not report data which allow elective activity within surgical hubs to be meaningfully compared with non-surgical hub theatres. In 2022 the surgical transformation programme aimed to enable an additional 880,000 admitted procedures and 1.1 million outpatient procedures in the three years to 2024-25 (paragraph 2.15). NHSE does not have information on whether this was achieved. Looking more broadly, the NHS is behind these intended activity levels. For the two completed years, 2022-23 and 2023-24, NHSE intended surgical hubs to contribute to an overall additional 380,000 inpatient waiting list removals and 525,000 outpatient waiting list removals. Including elective activity undertaken by hubs and other surgical theatres, the NHS carried out a net 250,000 fewer inpatient elective care waiting list removals in 2022-23 and 2023-24 than it did in 2019-20 (a shortfall of around 630,000 completed pathways), and 227,000 more outpatient waiting list removals than it did in 2019-20 (43% of the overall intended outputs). NHSE attributes activity shortfalls to wider issues including increases in non-elective activity and delays in discharging patients from hospitals.

2.20 Research by the Health Foundation found that areas across the NHS that had adopted surgical hubs had higher levels of elective activity post-COVID-19 than they would have had without the hubs. The University of York is currently undertaking a four-year evaluation to explore the effects of hubs on key performance outcomes.

Outpatients transformation

The outpatients transformation programme

2.21 NHSE has aimed to free up capacity in outpatient services to allow more patients from the waiting list to be seen. In 2022, based on plans to redesign outpatients services in NHSE's 2019 Long Term Plan, NHSE set a target to reduce outpatient follow-up appointments by 25% compared with 2019-20 levels by March 2023 and asked local NHS systems to achieve this through the 2022-23 operational planning guidance.

2.22 The aims of the outpatients transformation programme, in September 2022, were to:

- reduce outpatient follow up appointments by 25% by March 2023;
- reduce waiting time for first outpatient elective appointments;
- expand patient-initiated follow-up (PIFU) to all major outpatient specialties, moving or discharging 5% of all outpatient attendances to PIFU pathways by March 2023;
- increase the use of specialist advice including Advice and Guidance (which allows GPs to deliver advice provided by a hospital clinician, prior to or instead of an elective referral), to a ratio of 16 advice requests per 100 first outpatient attendances; and
- increase the percentage of outpatient appointments delivered by video and telephone to 25%.

Outpatients programme progress to date

2.23 The outpatients programme spent £52 million from 2021-22 to 2023-24. NHSE could not provide any modelling or evidence explaining the achievability of the target to reduce outpatient follow-up appointments by 25%. We have not seen evidence of an assessment of the funding and resources required to achieve these reductions. NHSE initially planned to meet this target by March 2023. The target was then extended to March 2024.

2.24 Performance reporting was sporadic. Performance against the 25% target was reported to the elective recovery board in eight out of 24 months where this indicator was live . Follow-up appointments reduced by an average of 0.1% in the months that performance was reported (between June 2022 and July 2023). NHSE considers that the sustained period of industrial action in 2023 and 2024 has made it difficult to gain traction on the outpatients programme, partly because of the need to rearrange outpatients appointments over the period and partly because it has been difficult to secure clinical buy-in on the changes.

2.25 In February 2024, NHSE proposed a new indicator to increase the proportion of appointments that lead to elective waiting list removals (clock stops) to 46% and made this a national NHS objective for the 2024-25 operational planning guidance, asking NHS providers and systems to increase the proportion of outpatients appointments that lead to no further appointments by 4.5 percentage points in 2024-25, compared with their levels in 2022-23. By September 2024, national performance against this target was 45% up from 44% in February 2024. From April 2024 the outpatients transformation programme was no longer a separate programme with its own governance arrangements and was brought more formally under the umbrella of the elective recovery board (described in Part Three of this report).

2.26 We have not seen any evidence that the outpatients transformation programme has reduced waiting times, and there has been mixed progress and inconsistent reporting on other measures NHSE uses to monitor outpatients transformation. This indicates that NHSE's understanding of the changes that the programme aimed to deliver is limited. This is reflected in the targets that NHSE has set and the indicators that it monitors.

- **Advice and Guidance:** NHSE immediately exceeded its target to avoid referrals by providing specialist advice. In 2022 NHSE aimed for GPs to make 16 specialist advice requests for every 100 outpatient first attendances by March 2023. NHSE expected this ratio to build from around 12 per 100 in June 2022 to 16 in March 2023. The requests exceeded the target in the first month of reporting (22 per 100 in June 2022) and published information on the number of pathways diverted by providing specialist advice and guidance shows a monthly average of 210,000 in 2024-25 (April to January) compared with around 150,000 in the same period in 2022-23. NHSE has responded to the greater-than-expected demand from GP services for specialist advice by producing templates for dermatology, gastroenterology, paediatrics and urology.
- **Remote consultations:** The proportion of remote consultations declined during the programme. The percentage of outpatient appointments delivered remotely decreased from 21.5% in June 2022 to 18.8% in November 2023 against a target of 25%.
- **PIFU:** This indicator has been inconsistently reported to the elective recovery board and repeatedly extended. In 2022, NHSE set a target to increase take-up of PIFU to 5% by March 2023. An increase of 1.8% was reported to the elective recovery board for the financial year 2022-23 up to March 2023. The 5% target was not included in the 2024-25 *operational planning guidance*. The January 2025 *Reforming elective care for patients* plan reinstated the 5% target, with the aim of achieving it by 2029. NHSE's internal reporting is that PIFU utilisation was 3% in November 2024.

2.27 The 2025-26 NHSE operational planning guidance included a new target to increase the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026. The target includes both outpatient and diagnostic appointments.

Part Three

Management and oversight of the programmes

3.1 This part examines NHS England's (NHSE's) management and oversight of the transformation programmes including the arrangements for governance, performance and financial management, progress monitoring and the action it takes when programmes are not delivering. In examining NHSE's approach, we have drawn on principles set out in our published *Framework to review programmes*.[11]

Governance and performance reporting

3.2 The Elective Oversight Board, chaired by the Department of Health & Social Care (DHSC) and attended by other parts of government, tracks activity and provides governance for funding requests for the elective recovery programme. In addition, NHSE established an **elective recovery board** whose role has included holding accountability for the overall elective recovery programme, tracking progress and monitoring risks. This board has overseen all the programmes that support elective recovery, including the three transformation programmes we have examined in this report. Below the elective recovery board, NHSE has arrangements for managing the transformation programmes.

- **Diagnostic transformation:** The diagnostic programme has the most established governance structure of the transformation programmes. The governance arrangements aim to combine locally-led programmes with assurance at a national level through reporting. Groups for the different technical diagnostic activities feed into a national diagnostic board which also receives input from regional diagnostic boards, industry and clinical advisory groups. There is additional governance and reporting on capital spending involving DHSC (paragraph 3.7). We saw evidence of in-depth reporting and actions being reported and monitored at these different levels of governance, and evidence that NHSE has considered which issues should be addressed at these different levels.

11 National Audit Office, *Framework to review programmes*, update, April 2021.

- **Surgical transformation:** Governance was less developed than for diagnostic transformation. A national-level elective hub oversight group for surgical transformation meets monthly and compares actual hub activity to planned activity. The terms of reference for this group had not been agreed as at October 2024. Additional oversight on capital spending is provided outside of the programme through the reporting requirements of the Targeted Investment Fund (TIF) delivery board (paragraph 2.13).
- **Outpatients transformation:** We have seen limited evidence of governance within the outpatients programme. NHSE reported information on the outpatients programme into the elective recovery board. The outpatients board was brought more formally under the umbrella of the elective recovery board in April 2024.

3.3 Good governance structures provide strong and effective oversight, challenge and direction. In particular, decision-making boards need consistent, timely and clear information including a balance of quality, performance, cost and output measures so that they can monitor progress against baselines and targets, and assess whether they are achieving planned objectives. Decision-makers need to monitor the right indicators so that they are alert to emerging issues and can take prompt corrective action when needed.

3.4 While multiple groups and boards monitor progress, performance and spending on the transformation programmes (as set out above), we found that NHSE's governance arrangements for the programmes were not sufficiently joined up. Our review of information reported to the elective recovery board identified a range of issues.

- We found gaps in reporting to the board. For example, there were no performance data on individual programmes reported to the board between December 2023 and August 2024.
- Key indicators were not being reported consistently to the board, making it difficult to track and understand performance trends and build a picture of performance over time. There was limited information on trends and progress against programme milestones with frequent format changes that made it difficult to become familiar with the material presented, as the following examples show.
    - Of six performance indicators reported to the board on the surgical programme, five were reported inconsistently or were changed over time. There was also a reporting gap of over six months during 2023.
    - Performance against the key outpatients programme target to reduce outpatient appointments by 25% was reported to the board in eight out of 24 months that the indicator was live (paragraph 2.24). Of eight performance indicators reported on the outpatients programme, only four were reported consistently.

    - We found that data on numbers of operational surgical hubs reported to the surgical transformation board and to the TIF board differed. Data on the additional elective activity delivered by surgical hubs were only reported to the TIF board. None of these data were reported to the elective recovery board.

- While key indicators on the transformation programmes were not reported consistently, very large volumes of indicators on long waiting pathways and overall elective activity were presented to the board each month. For example, in February 2023, performance reporting included 760 statistics on overall elective activity and long waiting pathways before descriptions of the transformation programmes.

- The outpatients programme would have benefited from more active risk management. The risks – that the 25% reduction target didn't have an evidence base, that there was a lack of evidence on the impact on services and that the programme was at risk of disruption due to an NHSE change process –remained throughout the programme. NHSE was slow to raise the Red/Amber/Green rating from amber to red despite the lack of progress on meeting the overall performance target (paragraph 2.24).

3.5 In August 2024, NHSE began reporting information to the elective recovery board in a different format to improve the board's effectiveness. The pack included a programme report showing progress against milestones and a performance report which included clearer charts showing performance against key metrics. However, the links between programmes (and their total impact on waiting times or costs) remain unclear. We have not seen subsequent reports to allow us to judge whether data are being reported and used consistently. We understand that as part of its January 2025 elective care reform plan, NHSE is reviewing its reporting on elective transformation.

Financial reporting

3.6 Monitoring spend over time and against budget allows decision-makers to assess whether programmes have capacity to deliver, whether resources are being deployed in the right areas, and whether there is robust financial management in place. Our *Framework to review programmes* emphasises the importance of accurate and timely reporting on the funding and resources used to achieve progress to date compared with expectations. Tracking revenue as well as capital spend allows decision makers to understand the totality of funding and resources being used on the programme.

3.7 The elective recovery board does not have a full picture of what the NHS is spending across the transformation programmes to inform decisions on how they should be resourced. The diagnostic transformation programme monitors both capital and resource spending against its budget. NHSE also monitors capital spending against budget for TIF programmes, which includes funding for surgical transformation. The Capital Delivery Oversight Group, which is jointly chaired by NHSE and DHSC, also approves and monitors capital expenditure on Community Diagnostics Centres (CDCs). NHSE has tracked programme spending on the outpatients programme, spending £52 million on transformation activities over the three years to 2023-24. However, the elective recovery board is not responsible for monitoring how much local NHS systems are spending in implementing outpatients transformation. The monthly reports to the elective recovery board have not routinely included any financial reporting on operational (capital or resource) expenditure or any information on programme running costs. This lack of complete information makes it difficult for the board to assess whether it has the right balance of investment across the transformation programmes to deliver NHSE's commitments on reducing waiting times.

3.8 NHSE's internal auditors have raised concerns about the level of financial reporting. In 2021-22, the auditors recommended that NHSE include updates on the financial status of the programmes as part of the monthly reporting cycle. In June 2022 the elective recovery board agreed that "given the overall financial processes and procedures within the organisation, and the fact that programmes sit within wider directorate budgets" it would not action this recommendation.

Taking action when programmes are not delivering

3.9 Ongoing evaluation and review help ensure that programmes are on track to deliver their objectives and intended benefits, or help identify where action is needed to address problems. Our *Framework to review programmes* also highlights that programmes should be sufficiently flexible to deal with setbacks and changes.

3.10 NHSE and other parties have carried out some monitoring and evaluation of the transformation programmes, demonstrating different levels of maturity between the programmes.

- **Diagnostic transformation:** NHSE monitors performance across its CDCs so that it can understand why performance is weaker at specific sites and can make changes as needed. More broadly, Healthwatch has reviewed patient experience at CDCs. This review recommended further evaluation to understand the wider impact of CDCs on the diagnostic system. NHSE's diagnostic programme has evidence that it has undertaken this analysis.

- **Surgical transformation:** The surgical transformation programme is focused on performance within surgical hubs only. The programme has a process for accrediting surgical hubs which identifies areas for improvements and sets timelines for addressing issues, with progress on accreditation reported to the elective recovery board.
- **Outpatients transformation:** NHSE has evaluated initiatives to reduce the number of patients who did not attend their appointments. External researchers have also evaluated patient-initiated follow-up services and their impact, reporting findings in January 2024.

3.11 However, while NHSE took steps to build support from clinicians and local NHS systems in the outpatients programme, it did not make significant changes to the programme until 2024.

- By September 2022, NHSE had recognised that it was not making any progress towards its target to reduce follow-up outpatient appointments by 25% (paragraph 2.24). Between September 2022 and October 2023 NHSE tried various initiatives to engage local NHS systems with the change needed, including 'Super September' to raise awareness of the programme, 'self-certification' to engage providers, and a 'further faster' approach to engage clinicians. It also sought support from the Royal Colleges in a 'call to arms' round table event.
- In 2024, NHSE made more fundamental changes to reset its work to reform outpatients services. As discussed above, NHSE integrated the work of the former outpatients programme fully into the elective recovery board. In terms of activities, it redesigned the programme around specific clinical pathways. Staff we spoke to in local NHS systems welcomed this change in focus. Moving away from a 'one size fits all approach' is also in line with National Audit Office good practice guidance on improving services by managing demand.

Part Four

Learning lessons from the programmes

4.1 This part examines how NHS England (NHSE) has learned and applied lessons from its elective recovery transformation programmes.

2025 elective care reform plan

4.2 On 6 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. To meet the 18-week elective care standard and reform elective care by March 2029, including recovering to 65% by March 2026, NHSE's new plan includes a focus on:

- **Empowering patients:** NHSE plans to empower patients by giving them greater choice and control over their care and by establishing standards which allow elective care to be more supportive and as convenient as possible.
- **Reforming delivery:** NHSE aims to work more productively and consistently to deliver more elective care. Its plans include 17 new and expanded surgical hubs by June 2025, expanded opening hours for Community Diagnostic Centres (CDCs) and more responsive and accessible follow-up outpatient care.
- **Delivering care in the right place:** NHSE aims to make sure that patients receive their care in the right setting. Its plans include: improvements to the provision of Advice and Guidance as an alternative to outpatient care including funding GPs to provide this; specialty specific plans for improving outpatient care; and action to avoid unnecessary appointments by increasing take-up of patient-initiated follow-up.
- **Aligning funding, performance oversight and delivery standards:** NHSE aims to clarify responsibilities and incentives for reform, ensure robust oversight of performance and set clear expectations for how elective care will be delivered locally.

Learning from experience

4.3 Programmes can learn from experience on current or previous initiatives if they apply systematic learning from programme performance, analyse the reasons for deviations from plan and whether these issues are likely to re-occur, and carry out evaluations to identify lessons for future programmes. In addition, organisations can improve how lessons are learned internally by establishing a culture of continuous improvement rather than solely learning lessons after the event. Our good practice guide on systematic improvement highlights the benefits of 'closing the learning gap' between the rate at which people and teams learn.[12]

4.4 Learning from experience is crucial if NHSE is to improve productivity and outcomes for patients. Our findings in Parts Two and Three of this report show that NHSE has made good progress in delivering some elements of the diagnostic and surgical transformation programmes, but that there are opportunities for NHSE to learn lessons from its experience to date on all three transformation programmes. We would expect NHSE to share and apply learning across the elective care transformation programmes.

4.5 In particular, we found that, from the outset and up to recent requests for additional funds, the diagnostic programme has the clearest links between the investment made, its outputs (numbers of tests carried out) and intended outcomes (shorter waiting times). When progress in achieving outcomes has been off-track the programme has sought and provided explanations to explain the shortfalls. 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.

Evidence of learning

4.6 Much of the substantive content supporting the elective care reform plan remains to be set out in future operational planning guidance and work with providers. Although it is too early to conclude on whether NHSE's new elective care reform plan will be successful, we have considered whether the plan, alongside other action NHSE has taken, indicates learning from the three transformation progammes examined in this report.

4.7 We have used the categories in our 2022 *Framework to review portfolios* as most appropriate for a forward look (**Figure 7** on pages 36 and 37).[13] Our observations relate only to the three programmes considered in this report and do not reflect any judgement on the overall coherence or success of the *Reforming elective care for patients* plan.

12 National Audit Office, series of three good practice guides on how to improve operational services, February 2023.
13 National Audit Office, *Framework to review portfolios,* January 2022.

Figure 7

Learning from the diagnostic, surgical and outpatients transformation programmes

There is evidence that NHS England (NHSE) is applying learning from the transformation programmes to its new *Reforming elective care for patients* plan, with scope for further improvement

Framework element[1]	Learning from the transformation programmes	Scope for further improvement
Purpose	Community Diagnostic Centres (CDCs) are delivering additional capacity and have met goals to increase numbers of diagnostic tests. NHSE's plan recognises this by extending minimum standards for CDCs including expanding their operational hours. Utilisation of surgical hubs has increased, and NHSE is increasing the number of hubs. Advice and Guidance (A&G) from hospital clinicians and delivered by GPs has been recognised as a useful route to support potential referrals. NHSE's plan introduces remuneration for GPs making A&G referrals.	Clinical leadership for the significant changes required across the outpatients transformation programme has been harder to achieve, compared with that existing on the diagnostic and surgical transformation programmes. NHSE has increased the national leadership of the outpatients programme but there is scope for clearer regional clinical leadership (recommendation d).
Governance	NHSE told us that it has learned lessons from its experience to date, feedback from Internal Audit and from the emerging findings in this report and recognises that it needs to strengthen its governance arrangements and how they are joined up. Alongside the new elective care reform plan, NHSE plans to re-set its governance arrangements through introduction of a new national oversight board to replace the elective recovery board (ERB).	We have highlighted the need for governance arrangements to adapt over time to reflect different risks and new priorities as programmes evolve.[2] As part of improving arrangements for central oversight of the programmes (recommendation a), NHSE should ensure that the objectives and terms of reference of the oversight board are clearly focused on achieving the ambitions in NHSE's new Reforming elective care for patients plan. When a programme is not delivering, this should be highlighted in the reports to the board, and the board should document decisions about what it has done to address this.
Information	The oversight board needs consistent information that provides a clear view of expected trajectories for activity and impact, trends over time and issues arising to allow open and transparent dialogue about risk and progress (recommendation a). Information available to the ERB was inconsistent and incomplete. NHSE recognises that it needs to improve the information that is reported to the board and intends to do this as part of strengthening governance arrangements alongside the new elective care reform plan.	NHSE should ensure that information reported to the oversight board provides a clearer picture of progress by prioritising the information NHSE thinks is most critical to its success, focusing more on performance against clear and consistent baselines for costs, trajectories, delivery and impact on waiting lists. The board could review how it uses the information to ensure it meets its needs (recommendation a).
Planning	NHSE's target to reduce follow-up outpatients appointments by 25% was not supported by analysis of its achievability or the funding and resources required. However, NHSE no longer measures performance against this target and has removed the target from operational planning guidance and reporting packs.	NHSE should ensure that it has a clear rationale for the targets it sets and carry out analysis or modelling to determine how meeting targets will deliver desired outcomes. In particular, more analysis is needed of how achieving the proposed new outpatients target to reduce the time patients wait for their first outpatient appointment will contribute to shorter waiting times overall (recommendation e). NHSE should also ensure that it has clinical and local support for changes to the outpatients programme, including the new target (recommendation d). Overall costs for programmes could be included in reporting to the oversight board 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 (recommendation a).

Figure 7 *continued*
Learning from the diagnostics, surgical and outpatients transformation programmes

Framework element[1]	Learning from the transformation programmes	Scope for further improvement
Alignment	NHSE has started to commission evaluation of the work, interconnections and impact of the transformation programmes.	The oversight board could play an active role in ensuring that lessons are learned across the transformation programmes. For example, evaluations undertaken at programme level should provide the board with the information it needs for assurance that the programmes are delivering as planned and adding value (recommendation c).
Risk	On the outpatients programme, NHSE was slow to revise its risk profile and respond to evidence that the programme was not delivering. However, it made a range of changes to the programme in 2024 and there are signs that these have been welcomed by local NHS systems and providers.	NHSE should ensure that the risk information reported to the oversight board is up to date and timely and reflects current performance and progress on each programme (recommendation a). There is scope for the board to make more structured use of risk profiles (which will change over time as programmes progress and evolve). The board could more clearly articulate its risk appetite and take a view of the aggregate risk across the overall elective recovery programme.

Notes

1 Elements are drawn from the National Audit Office's good practice guide on *Framework to review portfolios*, published in January 2022.

2 Comptroller and Auditor General, *Lessons learned from major programmes*, Session 2019–2021, HC 960, National Audit Office, November 2020.

Source: National Audit Office analysis

Securing clinical buy-in

4.8 In addition to the elements set out in Figure 7, clinical leadership is a value in and of itself in the clinically focused NHS. The National Audit Office *Framework to review programmes* highlights the importance of identifying stakeholders, clarifying their roles and responsibilities, actively considering them in programme design, and having a plan for managing and communicating with stakeholders. This helps secure buy-in from the people who are involved in implementing the programme, including Integrated Care Boards (ICBs), providers and clinicians.

4.9 NHSE engaged clinicians on the programme in various ways, including through working with the professional bodies that represent them. It has embedded National Clinical Directors within the elective recovery programme to provide medical leadership. Specifically on the transformation programmes:

- **Diagnostic transformation** was initiated by an NHSE-commissioned independent review by Professor Sir Mike Richards. This review helped give proposed changes to diagnostic transformation credibility, and clinicians welcomed much-needed investment in diagnostic equipment and expansion of diagnostic capacity. However, the Royal College of Radiologists (which represents clinicians involved in the programme) has reported a widening gap between the capacity of the radiologist workforce and the escalating demand for imaging services. It also reported that 41% of NHS trusts with CDCs say that CDCs have led to an unmanageable increase in workload. The Society of Radiographers has raised similar concerns.
- The **surgical transformation** programme benefitted from clinical leadership through 'Getting it Right First Time', a clinically-led programme to improve healthcare, and from support from the Royal College of Surgeons of England to achieve 'buy-in' from clinicians. Clinical engagement comprised:
    - identification, accreditation and dissemination of good practice;
    - support from Royal Colleges; and
    - in-person engagement through clinical champions.
- **Outpatients transformation** involves clinicians across a wide range of specialties and securing their engagement has been more challenging. Furthermore, NHSE considers that industrial action in 2023 and 2024 made it difficult to gain traction with clinicians and make changes locally at the scale it wanted to. Local NHS systems we spoke to told us that while they accepted that outpatients services could be improved, they did not agree that reducing follow-up appointments was the right way to tackle high numbers of outpatient appointments, as patients requiring follow-up were known to require clinical management. The Royal College of Physicians did not support the target to reduce follow-up appointments, but worked with NHSE on a wider transformation plan through a series of clinical summits and associated work in 2023. NHSE appointed clinical advisors to support the programme from December 2022 to May 2024. In July 2023, with little progress towards meeting the target, NHSE met with Royal Colleges, specialist societies and patient representatives to gain support for the programme.

4.10 Following the 2024 re-set of the outpatients programme (paragraph 3.11), there are signs that NHSE is now achieving better engagement with local NHS systems on outpatients transformation. Local systems we spoke to have welcomed 'Further Faster' initiatives including helpful information packs and specialism-specific plans and resources. There is also a focus on five priority specialties as part of the January 2025 elective care reform plan. Focusing on these priority areas will allow more constructive engagement with stakeholders.

Appendix One

Our audit approach

Our audit approach

1 Our independent conclusions on NHS England's (NHSE's) elective care transformation programmes (diagnostic, surgical and outpatients transformation) were reached by analysing and synthesising evidence collected through fieldwork between September 2024 and December 2024. The report was updated with the latest available waiting time and activity statistics, released in March and covering the period up to January 2025, so that the report would be up-to-date at the time of publication.

2 Fieldwork was structured around three overarching areas, covering: what NHSE was aiming to achieve through its elective care transformation programmes; the arrangements for central oversight of these programmes; and what the programmes have delivered to date and whether NHSE is learning lessons from its experience and applying this learning as it develops its future plans.

3 Our analytical framework comprised four evaluative criteria which considered: NHSE's overall progress on elective care recovery; NHSE's progress in delivering its elective recovery transformation programmes and the outcomes achieved; NHSE's management and oversight of the transformation programmes including the role of its board; and NHSE's learning and application of lessons from its elective recovery transformation programmes.

Our evidence base

Interviews

4 To inform scoping and fieldwork on our audit we conducted interviews with the following.

- **NHSE:** We interviewed the programme management team for elective care recovery and key staff from each of the three elective care transformation teams (diagnostic, surgical and outpatients transformation).
- **Department of Health & Social Care (DHSC):** We interviewed officials with responsibility for DHSC's oversight of NHSE's programmes.

- **Stakeholders:** We interviewed key stakeholders to understand their perspectives or research they had carried out. These included: the Health Foundation, the Royal College of Radiologists and the Royal College of Physicians.

Document review

- **NHSE documents:** We reviewed documents including policy papers and reports, project management information, delivery plans, risk reporting, business cases and impact assessments, details of governance arrangements, internal audit, evaluations and lessons learned reports. We used this documentary evidence to triangulate testimonial evidence from interviews.
- **DHSC documents:** We reviewed documents relating to DHSC's oversight of NHSE's transformation programmes.
- **Other documents:** We reviewed research by stakeholders including the Health Foundation, Healthwatch, the University of York, Nuffield Trust, the Royal College of Surgeons of England, the Royal College of Radiologists and the Royal College of Physicians.

Data analysis

5 We analysed NHSE's elective care recovery performance reporting to analyse trends over time and whether the transformation programmes are delivering higher service outputs than at the outset. We also analysed how targets have changed over time and how NHSE uses and reports performance data to track progress and inform decision making.

6 We analysed published data on elective care waiting times and diagnostics to report on performance against elective care long waiter targets, the level of elective activity delivered, diagnostic waiting time performance, and trends in diagnostic activity.

7 We carried out high-level analysis of capital expenditure on the programmes.

Visits and interviews with local NHS systems and hubs

8 We invited five local NHS systems to participate in our study. Three agreed to participate and two declined. The Integrated Care Boards (ICBs) we visited to get their perspectives on NHSE's management of the transformation programmes were:

- Cheshire and Merseyside ICB;
- Gloucestershire ICB; and
- Humber and North Yorkshire ICB.

We interviewed staff with responsibility for elective care recovery programmes on behalf of the ICB and visited surgical hubs and community diagnostic centres. We also reviewed key documents relating to elective care recovery at these ICBs.

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