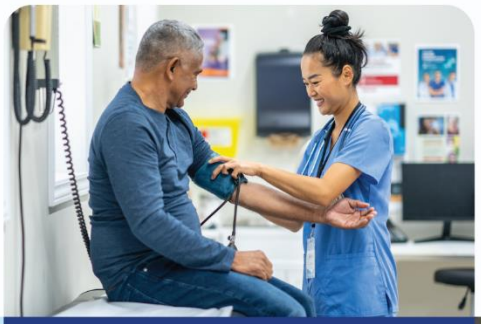
Department of Health & Social Care

NHS England

Reforming elective care for patients



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Forewords

Nye Bevan founded our NHS on the principle that it would be there for us when we need it, and free at the point of use for everyone.

For three quarters of a century, the NHS has lived up to this promise – not least for me. Like millions of others, the NHS brought me into the world, and it saved my life just three years ago.

As a cancer survivor, I know the difference getting quick access to treatment can make – it can be life or death. I want every patient to feel safe in the knowledge they will receive quality, timely care that works around their lives.

But for too long, and despite the best efforts of our incredible NHS staff, getting a referral has made patients feel worried, uncertain and fearful about the future.

Over 6 million people are currently on a waiting list, waiting for over 7 million episodes of care, like a test or an operation. This is not some abstract number. Every person on that list is someone who could be worried about a lump, waiting for life-saving treatment, or putting their life on hold for a new hip.

For those millions of people, the fundamental promise of our NHS – that it will be there for us when we need it – has not been delivered.

This can’t go on.

This plan sets out our proposals to reform elective care, return to the constitutional standard of 92% of patients receiving treatment within 18 weeks, and build a sustainable NHS that is fit for the future.

There are great things happening in pockets all over the system. We will take the best of the NHS to the rest of the NHS, roll out technological transformation to speed up processes and we will make no bones about busting bureaucracy – we need more activity, and less waste.

But our success won’t just be in getting the numbers down, it will be in whether elective care looks and feels different to patients and to NHS staff. More empowerment and more choice will make for better care.

The most appropriate setting to treat patients won’t always be in hospital. The actions in this plan will reform elective care, giving patients timely local access to diagnostic testing, with

straight to test pathways and action to reform outpatient care, including reducing unnecessary follow up appointments, freeing up clinical time for those who need it.

We will set the funding and design incentives to make that happen and will expect and oversee improvement from all trusts, not just those languishing at the bottom of a table.

Our 10 Year Health Plan will say more about the three big shifts our NHS needs to be fit for the future: from hospital to community, from analogue to digital, and from sickness to prevention – all of which are fundamental to the future of elective care. This plan will lay the groundwork for these to happen.

This elective care reform plan sets out the steps needed to return to short waiting times and restore patients' confidence in the NHS.

The Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care

Since its inception in 1948, the NHS has constantly changed and adapted as the public's needs have evolved. By embracing science and innovation, the NHS of today can now deliver far more, and far more effective, treatment options than were available even at the start of my career. Genomic medicine is allowing ever more precise diagnosis and personalised treatment. 3D imaging and printing is allowing for ever more complex procedures to take place safely. And widespread advances in techniques and technology – including robotic surgery and remote monitors – are allowing an ever greater proportion of people to avoid staying in hospital for procedures, and to avoid attending at all for routine checks. By continually pushing to do things better – in these ways and in many others – the NHS has not only cared for the nation but supported economic growth, by helping people spend more years in good health and able to work.

But at various points in our history, the pace of change has not kept up with the speed with which people's needs have grown. This has been particularly true for elective care. Before March 2020, waiting lists for non-urgent care were rising due to the challenges set out in Lord Darzi's important report – a combination of fewer staff, capital starvation and high bed occupancy. In common with healthcare systems across the world, the pandemic inevitably took a huge toll on NHS waiting lists, but with resilience at a low ebb due to these factors, our ability to bounce back quickly was significantly hampered.

The NHS is now delivering more elective care than ever before, and long waits are coming down. When we set out the delivery plan for the post-pandemic recovery of elective care in February 2022, our main ambition was to tackle the very long waits which had amassed as a result of Covid-19. Thanks to the hard work and ingenuity of NHS staff, and despite unprecedented levels of industrial action in the intervening years, significant progress has been made. At the time of writing, two-year waits have been all but eradicated, and 18-month waits have been reduced by 96%. This has largely been achieved by increasing capacity and activity; over the last year alone, frontline teams delivered 18 million treatment starts, while diagnostic tests and urgent cancer checks also reached record levels.

Despite this progress, too many patients are still waiting too long for care. By the end of 2024, around one in nine people in England were waiting for elective care – around 1 million more than in February 2022 – and the total waiting list has grown by over 1.3 million pathways. And while the proportion of those waiting for more than a year has decreased by almost half, the proportion waiting for longer than the 18-week constitutional standard is still too high.

The government is providing the NHS with the resources it needs to continue to deliver more activity than before the pandemic, but achieving meaningful

improvements for patients will also require us to keep on doing things differently. While the primary focus over the last three years has been driving more activity, NHS teams have also been reforming the way we work to increase productivity. New facilities like community diagnostic centres and surgical hubs haven't just added more of the same kind of capacity, but allowed local services to use it in smarter ways, including high-intensity lists where focused teams power through lots of the same surgeries in one day. The continued rollout of technologies like electronic patient records, the NHS App and the Federated Data Platform has similarly shown significant promise in improving productivity and patient experience – both in their own right and as the vital underpinnings for other applications such as artificial intelligence and imaging networks. Continuing to improve productivity by maximising the combined benefits of these investments and opportunities, as well as an ongoing focus on operational and clinical improvement, will be essential to returning to the 18-week standard by the end of this Parliament.

We are determined not to hit the target but miss the point; the reforms set out in this plan are focused on improving how people access and experience routine care, as much as they are about waiting times. Simply put, this is a plan with patients at its heart – we will champion their needs first and foremost, providing care closer to home where possible, with a focus on convenience, and ultimately, cutting waiting times for the public. It will also offer patients informed choice, greater control and more personalised, joined-up care – making them a true partner in their care journey. By learning from what is already working well in some parts of the country, as well as improving experience by placing more information and power in people's hands through the NHS App, we will put patients – and what matters most to them – front and centre.

The ambitions set out in this plan are rightly stretching and will require action from across the NHS and beyond. With demand growing and rising complexity of need, we cannot underestimate the scale of the task ahead – it will require relentless reform and innovation that brings the best of the NHS to every part of the country, alongside the right capacity and technology to ensure our staff have the latest productivity-boosting tools at their disposal.

The NHS has done this before, and we can do it again. The history of the NHS is one of constant change and adaptation to meet the needs of patients and the public – coupled with the commitment and drive of NHS staff, providing the platform to deliver this plan. It is the achievements of our staff to date which give us the optimism the NHS can overcome its current challenges – as we have done in the past – while simultaneously making the improvements needed for patients now and in the future.

Amanda Pritchard, NHS Chief Executive

Our plan for reforming elective care

Elective care covers a broad range of planned, non-emergency services – from tests and scans to outpatient appointments, surgery and cancer treatment.

Performance is measured by the constitutional standard: 92% of patients should wait no longer than 18 weeks from referral to treatment. As set out in the Plan for Change, we will meet this standard by March 2029. We will also improve performance against the cancer waiting time standards.

While NHS staff have worked extremely hard in the aftermath of the pandemic to tackle the elective backlog – reducing long waits and treating the most clinically urgent cases – the NHS is a long way from meeting the required standards. Waiting lists have risen for the last decade. Continuing to do what we have been doing will not work: major reform to elective care is needed.

In October 2024 the waiting list stood at 7.5 million pathways, with 6.3 million patients waiting for an appointment, procedure or operation. More than two-fifths of these waits were for over 18 weeks. The 62- and 31-day cancer waiting time standards were last met in 2014/15 and 2019/20 respectively.

NHS care in the future, under this plan, will be increasingly personalised and digital. We will focus on improving experience and convenience, empowering people with choice and control over when and where they will be treated.

Different models of care will be more widely and consistently adopted. The use of artificial intelligence (AI) and other technology to deliver care will be more widespread and will help boost productivity.

We will reform how elective care is overseen and funded. Money will increasingly follow the patient, and incentives will drive improvements in waiting times.

To meet the 18-week standard and reform elective care by March 2029, we are focusing on:

- **empowering patients** by giving them more choice and control, and by establishing the standards they can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible
- **reforming delivery** by working more productively, consistently – and in many cases differently – to deliver more elective care

- **delivering care in the right place** to make sure patients receive their care from skilled healthcare professionals in the right setting
- **aligning funding, performance oversight and delivery standards**, with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level

Summary of commitments

We will meet the 18-week standard by March 2029. By March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026. We then expect sufficient increases annually (exact figures to be confirmed in the planning guidance) to reach 92% in 2029. We will also improve performance against the cancer waiting time standards. Further details will be set out in a dedicated national cancer plan and the annual operational planning guidance.

A comprehensive set of reforms will deliver the commitment to meet the 18-week standard by March 2029. This broad programme of work represents both an unrelenting focus on delivering effective and productive elective care, as well as making sure new ways of working are in place.

Empowering patients by giving them more choice and control and establishing expected standards for making their experience of planned NHS care as smooth, supportive and convenient as possible.

1. NHS England will:

    i. work with patients, carers and their representatives to publish the minimum standards patients should expect to experience in elective care – September 2025

    ii. actively promote and monitor patients' right to choose when and where they receive care

    iii. collate and publish data to help improve the uptake of national health inequalities initiatives, throughout 2025/26

    iv. expand the NHS App and Manage Your Referral website to improve information and appointment management on elective care for patients, as well as parents and carers through proxy access – March 2027

v. work with providers to make the NHS App and Manage Your Referral website the default route so patients can choose their elective provider or decide not to make that choice themselves

2. Integrated care boards will:

   i. ensure patients and their carers are aware of the new experience expectations for elective care and their right to choose their care – September 2025

   ii. set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges – March 2025

3. NHS elective care providers will:

   i. name an existing director who is responsible for improving experience of care in each ICB and provider – April 2025

   ii. make customer care training available to non-clinical staff with patient-facing roles, as well as ensure take up of the training already available on the e-Referral Service (e-RS) to support effective referral, booking and waiting list management processes

   iii. implement agreed local interventions to reduce disparities for groups who face additional challenges accessing healthcare

   iv. by the end of March 2025, 85% of acute trusts will enable patients to view appointment information via the NHS App

   v. by March 2027, the NHS App will be significantly expanded to improve information for patients in elective care, as well as their parents and carers through proxy access

   vi. make the NHS App and Manage Your Referral website the default route so patients can choose their elective provider or decide not to make that choice themselves

Reforming delivery by working more productively, consistently – and in many cases differently – to deliver more elective care.

1. NHS England will:

   i. provide quicker access for patients to common surgical procedures by launching 17 new and expanded surgical hubs by June 2025

ii. deliver significantly improved elective pathways by extending the minimum standards for community diagnostic centres (CDCs) to open 12 hours per day, 7 days a week, delivering same-day tests and consultations, an expanded range of tests, with direct referral from primary and community care, new consulting rooms and at least 10 straight-to-test pathways – March 2026

iii. boost bone density scanning (DEXA) capacity by investing in up to 13 DEXA scanners to support improvements in early diagnosis and bone health, particularly in the highest priority locations. This will provide an estimated 29,000 extra scans

iv. refresh the relationship with the independent sector with a new, published Partnership Agreement, the first of its kind in 25 years, setting out how we will work together to reduce the elective care waiting list – January 2025

2. Integrated care boards will:

i. make optimal use of the new diagnostic capacity by implementing the new standards for CDCs, particularly increasing direct referrals and rolling out at least 10 straight-to-test pathways – March 2026

ii. ensure contracts with the independent sector are in place to mitigate the waiting list challenges in each system, as well as a broader range of diagnostic tests

3. NHS elective care providers will:

i. make optimal use of the new diagnostic capacity by implementing the new standards for CDCs, particularly extended opening hours, increasing same day tests and consultations and the range of tests offered

ii. ensure a range of options are in place for patients to have more responsive and accessible follow-up care, including standardising remote consultations, remote monitoring and digital support for patient initiated follow-up (PIFU) across all major specialties

Care in the right place to make sure patients receive their care from skilled healthcare professionals in the right setting.

1. NHS England will:

i. ensure both primary care and secondary care are funded to deliver Advice and Guidance (A&G), by splitting the existing elective tariff to deliver better

outcomes for patients. In an expansion of the current approach, GPs will receive £20 per A&G request, to recognise the importance of their role in ensuring patient care takes place in the most appropriate setting. We expect this to increase uptake, with more patients benefitting from their GP accessing rapid specialist advice, so they receive the care they need in primary and community care settings, as opposed to being added to the elective waiting list. This expansion will deliver up to 4 million advice requests from GPs in 2025/26 (up from 2.4 million in 2023/24), which we expect could increase diversions from elective care from 1.2 million in 2023/24 to 2 million in 2025/26

ii. support systems to optimise the use of A&G by providing access to a range of metrics, dashboards and toolkits

iii. work with patients, carers and clinicians to establish a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, so that patients can benefit from this innovative practice – September 2025

iv. set out clear expectations for significant elective care reform to be delivered in at least 5 specialties – ENT, gastroenterology, respiratory, urology and cardiology

v. increase the quality and expand the availability of elective reform Federated Data Platform (FDP) products, and support adoption of the FDP to 85% of all secondary care trusts – March 2026

vi. work with primary and community care clinicians to expand functionality within NHS e-RS and the NHS App to support delivery of expectations on referral optimisation and patient choice

2. Integrated care boards will:

i. consistently optimise referrals using Advice and Guidance and effective triage, increasing the proportion of patients being treated in the most appropriate care setting – March 2026

ii. expand remote monitoring across all long-term conditions where clinically appropriate, helping to remove up to 500,000 lower value follow-up appointments per year from 2026/27 onwards

iii. implement all requirements in the Delivery plan for recovering access to primary care, including those that support effective working across primary and secondary care

iv. standardise pathway referral criteria, maximise Advice and Guidance opportunities, and put in place clinical triage standard operating procedures for high-volume specialties

v. by September 2026, dedicated system leadership will focus on reducing variation in discharge processes and expand opportunities for self-management through shared decision-making tools

vi. transform pathways with opportunity to deliver activity in the community, starting with at least the following 5 priority specialties; ENT, gastroenterology, respiratory, urology and cardiology

3. NHS elective care providers will:

i. ensure PIFU is offered as standard in all appropriate pathways – March 2026

ii. significantly increase the uptake of PIFU to at least 5% of all outpatient appointments, including through the enhanced identification of suitable patients using AI and automation – March 2029

iii. implement a consistent model of ‘collective care’ approaches, including group appointments and one-stop clinics, so that patients can benefit from this innovative practice

iv. work with system partners to implement standardised pathway referral criteria, maximise Advice and Guidance opportunities, and put in place clinical triage standard operating procedures for high-volume specialties

Aligning finance, performance oversight and delivery standards with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level.

1. NHS England will:

i. update the Payment Scheme to reflect elective priorities, including with a stronger focus on activity that directly ends a patient’s wait for their care, and by developing, testing and introducing relevant tariffs throughout the duration of this plan

ii. run a capital incentive scheme for providers that improve the most in meeting RTT standards

iii. deliver the NHS IMPACT Clinical and Operational Excellence Programme to apply proven improvement approaches for elective reform, including training for

at least 8,000 clinical and operational leaders in effective elective pathway management – March 2026

iv. run a strong elective performance oversight programme, including through tiering which contributes to the new NHS Oversight and Assessment Framework, with greater transparency on the performance and delivery of elective care

v. set expectations for outpatient activity as part of job planning within providers, to clearly describe the types and balance of activity clinicians should be undertaking, including sessions within the community

2. Integrated care boards will:

   i. reflect elective activity targets and funding allocations in local commissioning arrangements

3. NHS elective care providers will:

   i. put robust arrangements in place to performance manage and deliver elective care targets and standards, including making best use of NHS IMPACT improvement support, national metrics, dashboards and toolkits

   ii. work with system partners to ensure adoption of best practice including reformed patient pathways, improved clinical job planning and partnership with the independent sector to improve productivity and patient experience

Empowering patients

1. Patients are at the heart of the NHS and must have far more choice and control over when and where they receive their care. This will improve patient experience, making healthcare feel more like any other service in their lives. It will also help patients receive treatment faster by giving them informed choice. Increasing patient power, aligned to how money flows across the system, will also incentivise improvement in services and access.

2. Elective care needs to be designed around patients. Currently, patients might see a GP, get referred to a hospital they haven't been able to choose, be booked for inconvenient diagnostic appointments and potentially face long waits for an appointment or surgery – and without receiving clear and regular updates.

3. Under these reforms, our aim is to transform this experience. It will be normal for a patient to have an informed conversation with their GP about their referral and to choose where they would like to be seen from a range of options on the NHS App. They could use the NHS App to book a wider range of services in convenient locations, such as community settings, get their results quickly on the NHS App and be able to see the next steps, such as a remote consultation or surgery. Patients should also be able to easily contact their provider for any necessary follow-up, rather than being called back at intervals that don't suit their circumstances.

Example of a reformed elective pathway: ear, nose and throat (ENT)

Sarah has sinus pain and hearing issues. She makes an appointment with her GP using the NHS App. The nurse practitioner assesses her and refers Sarah directly to the local community diagnostic centre (CDC) for a CT scan. The CDC is in her local shopping centre so Sarah books an appointment to coincide with errands she needs to do that day. She receives her CT scan result via the NHS App when she arrives home from shopping, and at the same time the result goes to her GP practice.

The nurse practitioner and ENT registrar discuss Sarah's presentation and diagnostics at a multi-professional meeting. They agree the rhinitis can be managed in primary care without Sarah needing to go to hospital, but her hearing loss does need a consultant's care.

Sarah is told about her referral and chooses her appointment using the NHS App at a time and location that best fits around her life. She chooses a hospital on the NHS App based on the information it shows about waiting times, hearing loss, clinical outcomes and patient satisfaction rates.

At the appointment, she receives multiple investigations and treatment on the same day, including a hearing test by an audiologist, a further MRI scan, a nasoendoscopy and a prescription. The audiologist makes an onward referral for a hearing aid.

Sarah has another appointment 2 weeks later to discuss her ongoing care. She booked this appointment on the NHS App and was offered a remote consultation or the option to go to a community-based clinic to see the consultant. At the same time, Sarah is provided with more information about her condition via the NHS App and decides she is happy with the progress of her care and doesn't need a follow-up appointment. She tells the consultant via the NHS App and receives information on how she can initiate an appointment if things change.

4. Currently, only 8% of bookings after a referral are made on the Manage Your Referral website or the NHS App. We will improve how patients can make choices about their care by:

   - making the NHS App and Manage Your Referral website the default routes so patients can choose their provider or decide not to make that choice themselves
   - improving the information available to patients so they can make an informed choice based on what is important to them (for example, distance, waiting time, Care Quality Commission rating)
   - providing clear, timely and accessible information so patients are aware of their right to choose, and the options available to them – including NHS-funded options in the independent sector
   - raising awareness of NHS patient transport services, especially in areas with greater deprivation
   - ensuring patients can conveniently access specialist care in a remote consultation where appropriate

5. We will work with patient representative groups to report on the extent to which patients are being offered choice. NHS England will publish data that can be ranked on all aspects of choice to help patients make informed decisions. We will include a question in the 2026 GP Patient Survey to understand more about patients' experience of making choices about their care.

Improving patients' experience

6. Patients can fall through gaps between services and don't receive updates about their care. This experience, particularly when waits are long, can exacerbate anxiety and frustration, as well as contribute to adverse health outcomes and inequalities. It can also create pressures in other areas of the NHS – for example, patients contacting their GP practice to try and find out what is happening with their care.

7. While they wait for planned care, patients should know that as a minimum they can expect to:

   - have information to help them choose, and an informed conversation with their referring clinician about their options, including where they receive their care and how long they are likely to wait

- receive a shortlist of providers to choose from, including providers in the independent sector (paid for by the NHS) where possible and appropriate. They can either choose during their appointment or at home and book their appointment via the Manage Your Referral website or the NHS App
- receive confirmation from their provider within 5 working days that their referral has been received
- get clear information about what they can expect next (for example, how long they might wait for their appointment) and details about how and when they can contact their provider
- get clear communications that meet their needs throughout their time on the waiting list – including to check whether they still want to be on the list
- have the option to choose an appointment that suits them (subject to availability at their provider)
- receive information on how to change their appointment

8. These are minimum requirements that all providers and systems must facilitate and communicate to patients. We expect most providers and systems to go further and faster. We will continue to work with patients and carers, including through the 10 Year Health Plan engagement process, to set out a more detailed plan for how patients should expect to interact with the NHS in future.

9. At a national level, we will deliver important digital interventions to improve patients' experience while they wait for their care:

- by the end of March 2025, patients at over 85% of acute trusts will be able to view information about their elective appointments on the NHS App
- by March 2027, parents and carers will have proxy access for the NHS App to manage secondary care appointments and treatment options on behalf of others
- by March 2027, we will:
    - significantly improve information about waiting times and other factors patients consider important (such as patient experience measures) on the NHS App
    - review the role and functionality of My Planned Care, which currently provides average waiting times and other information for patients waiting for care
    - capture a patient's reasonable adjustments and communication needs which will follow them throughout their care journey

10. We will work with digital transformation teams in integrated care boards (ICBs) and providers and with groups at risk of digital exclusion to ensure solutions are inclusive, while providing high quality, non-digital options for those who want and need them. We also expect each ICB and provider to reduce the impact of digital inequalities.

11. Strong NHS leadership is essential to make sure all staff put patients' and carers' experience first. As a first step, by April 2025, all acute trusts and ICBs must:

    - name an existing director who will be responsible for improving patients' experience of their care, and improving the experience for patients and their carers while they wait for elective care
    - review and improve operational processes that affect how patients and their carers receive correspondence and access information on waiting times
    - make customer care training available to non-clinical staff with patient-facing roles, as well as ensure take up of the training already available on the e-Referral Service (e-RS) to support effective referral, booking and waiting list management processes

12. By March 2026, trusts should use the Experience of Care Improvement Framework self-assessment, which will shortly be updated. This will help them to understand the extent to which a focus on improving patient experience is embedded in their leadership, culture and operational processes and to inform continuous improvements in line with NHS IMPACT. The self-assessment results should be discussed at board level as part of routine reporting on patient experience.

Health inequalities improvement

13. Delivering the 18-week standard and reforming elective care must be done equitably and inclusively for all adults, children and young people. There is also geographical variation: for example, 65.1% of existing waits are within 18 weeks in the North East and Yorkshire region, whereas this figure is only 55.1% in the East of England. People living in disadvantaged areas are 1.8 times more likely to wait over a year than someone living in one of the least deprived areas. Patient choice and empowerment will contribute to equitable and inclusive reform, especially through the expected minimum requirements for patient experience. To further tackle health inequalities we will:

    - strengthen the accountability and oversight of providers for addressing health inequalities in elective care, while providing flexibility to tackle the issues of most relevance to patients locally

- improve the submission and quality of demographics data to increase understanding and insight into health inequalities
- create communities of practice across organisations with similar patient populations to share learning about how to reform elective care equitably and inclusively
- review existing national health inequalities improvement initiatives to develop them and increase their uptake, including:
    - reviewing local patient transport services and improving signposting to and accessibility of them for patients
    - ensuring consistency in the availability of accessible and alternative language communication templates
    - supporting the expansion of the Health Equity and Referral to Treatment tool, as well as reviewing and embedding other waiting list prioritisation tools, including those for children and young people
    - working with primary and community care to ensure care coordinators support vulnerable and disadvantaged patients, especially those with multiple long-term conditions
- prioritise areas with greater health inequalities for future investment of new capacity, for example, community diagnostic centres
- offer tailored communication, especially in areas with significant inequalities, to raise awareness of the choices patients can make

14. ICBs and providers should set a clear vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges. Specific expectations for systems are to:

- support trusts to make demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes
- undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches
- embed health inequalities data into performance reporting with a quarterly review at board level

- develop and monitor action plans to reduce inequalities in access and quality of care
- offer peer support and share best practice across providers

Reforming delivery

15. We will fund the activity needed to meet the 18-week standard by March 2029, including by providing an additional 40,000 appointments a week within the first year of this Parliament. These appointments include elective spells for chemotherapy, radiotherapy and endoscopy, outpatient attendances (excluding follow-up appointments without a procedure) and diagnostic tests.

Productive care

Reform diagnostic pathways

16. Elective, cancer and diagnostic standards are interrelated and so must be improved together. There are 1.63 million waits for the 15 major diagnostic tests and demand is rising. With 170 community diagnostic centres (CDCs) due to be up and running by the end of March 2025, these centres can take on more of the growing diagnostic demand within elective care. We will also deliver additional CDC capacity in 2025/26 by expanding a number of existing CDCs and building up to 5 new ones. Recognising there is more progress to make, we expect waiting times for diagnostics to improve significantly by the end of March 2025.

17. By providing a wider range of and capacity for tests and more consulting rooms, CDCs can improve elective pathways for both urgent cancer pathways and routine diagnostic pathways. They can reduce pathway length and make care more productive by providing multiple same-day tests and consultations, as well as significantly reduce the need for lower clinical value outpatient appointments.

18. To improve the NHS Constitution standard for diagnostics, the cancer waiting time standards and the referral to treatment standard, we expect all CDCs and hospital-based diagnostic services to:

- be open 12 hours a day, 7 days a week
- deliver the optimal standards of tests per hour – such as 4 CT scans per hour – to use diagnostic capacity productively
- remove low value test referrals to maximise capacity

- develop and deliver at least 10 straight-to-test pathways by March 2026, focusing on the diagnostic tests patients are waiting the longest for locally
- identify local opportunities to improve performance against the Faster Diagnosis Standard to reduce the number of patients waiting too long for a confirmed diagnosis of cancer

19. Using funding made available by the new government in 2024/25, we will also boost bone density scanning (DEXA) capacity by investing in up to 13 DEXA scanners to support improvements in early diagnosis and bone health, particularly in the highest priority locations. This will provide an estimated 29,000 extra scans.

20. Sufficient capacity should be explicitly included in plans for new CDC rollout to meet demand and performance expectations for cancer diagnosis – either through direct provision or by freeing up capacity in trusts to undertake more complex cancer diagnostics.

Case study: Clatterbridge Community Diagnostic Hub and Elective Hub development

Clatterbridge CDC opened in 2021 and has been housed alongside Cheshire and Merseyside's Elective Hub since November 2022. Having easy access to CT, MRI, X-ray, ultrasound and physiology diagnostics alongside 10 theatres has enabled clinical teams to diagnose patients more quickly and to treat patients needing more complex care. Estate capacity has increased by 60%, facilitating an estimated 6,000 more procedures a year. Patients have given excellent feedback and lengths of stay have reduced.

To build on this success, the team is now looking to add an enhanced recovery unit to the centre. They are also exploring one-stop pathways where patients can receive an appointment, be scanned, and undergo pre-operative screening on the same day to reduce the number of patients who will require further face-to-face peri-operative assessments.

Optimise surgical pathways and theatre productivity by using surgical hubs and perioperative care efficiently

21. Elective surgical hubs can offer patients quicker access to common procedures, free up beds in acute trusts for more complex patients and boost productivity. Hubs mainly focus on providing high volume low complexity surgery, bringing together skills and

expertise under one roof – reducing waiting times for some of the most common procedures such as cataract surgeries and hip replacements. There are more than 110 elective surgical hubs operational in England, and we are ramping up the number of hubs over the next 3 years so more operations can be carried out. To ensure best and productive practice is being adopted in all surgical hubs, NHS England will further develop the GIRFT Elective Hub Accreditation programme throughout 2025/26.

22. NHS England's Right Procedure Right Place programme encourages a shift from admitted inpatient activity to outpatient procedures, reducing pressure on surgical facilities. NHS England will review relevant tariffs to support this type of shift. Local providers should work with the Right Procedure Right Place programme to decide how to embed and maintain surgical hub approaches to reflect local requirements. Sufficient capacity should be explicitly included in plans for surgical hub rollout to meet demand and performance expectations.

23. Productivity and reform in CDCs and surgical hubs will also be underpinned by investment in digital interventions. This will include all pathology and imaging networks reaching maturity in 2025, and continuing to roll out the i-Refer clinical decision support tool, which supports secondary care clinicians to order fewer unnecessary tests. It will also include using the Federated Data Platform (FDP) inpatient solution and using commercial digital and AI solutions to support surgical productivity and reduce the administrative burden on surgical and administrative teams.

Case study: South West London Elective Orthopaedic Centre's use of surgical hubs

In response to high cancellation rates and waiting times of up to 18 months for elective orthopaedic treatments in South West London, 4 NHS trusts have partnered to create the South West London Elective Orthopaedic Centre.

The centre delivers elective orthopaedic surgery in a ring-fenced surgical hub away from emergency activity, helping to improve quality of care and performance. The centre has recorded excellent outcomes, high patient satisfaction rates and low complication rates for high volumes of activity over a sustained period, with fewer patients staying overnight. Since the centre was set up patients are waiting less time for their surgery and their operation is less likely to be cancelled.

24. Optimising the care patients receive before, during and after surgery (known as 'perioperative' care) can increase productivity by reducing cancellations, reducing

length of stay, and minimising postoperative complications. It can also increase the number of patients suitable for day case surgery by encouraging them to take part in prevention activities and take control of their health so they are ready for surgery, such as smoking cessation and weight loss programmes. Stopping smoking 4 weeks before surgery means patients have a 25% lower risk of respiratory complications and 30% lower risk of wound healing complications than those who continue to smoke. To support this, NHS England will:

- extend the Digital Weight Management Programme to people waiting for knee and hip replacements in 2025/26
- ask providers to give patients a date for their routine (non-cancer) procedure only once they have been confirmed in their pre-assessment as fit to proceed
- from April 2025, establish an acceptable maximum number for each system of short notice cancellations due to clinical reasons. Providers are required to review their current level of cancellations and ensure these are reported to NHS England
- closely monitor productivity metrics, including length of stay and short notice cancellations, and raise with providers where these metrics are out of step with similar providers
- work through Cancer Alliances to support improvements in prehabilitation for people about to undergo cancer treatment

Further strengthen the relationship with the independent sector

25. We need to use all available capacity, including in the independent sector (IS) – paid for by the NHS at NHS prices and free at the point of use. We are refreshing the NHS and IS relationship to have a sustainable, equitable and efficient system that provides stability and certainty for all providers.

26. Alongside this plan we are publishing an NHS and IS Partnership Agreement – the first of its kind for 25 years. This sets out the expectations for reducing the elective care waiting list, maintaining quality and patient safety, and how both parties will support the most challenged specialties. For example, there are currently 260,000 women waiting more than 18 weeks for gynaecology treatment – we will increase the relative funding available to support activity in challenged specialties like gynaecology and ENT. The agreement also ensures patients in deprived areas are offered choice of providers as a priority. In addition, we will:

- review NHS prices, particularly for activity where the IS can significantly help to reduce NHS waiting times. As a result, we expect an increase in ENT and gynaecology elective activity in 2025/26
- work with the IS to review clinical exclusion criteria, with the expectation that a broader range of patients will be safely treated by the IS as a result
- work with the IS to enable its systems to be more closely aligned with those in the NHS around a national set of standards, so patients can more easily see appointments and results on the NHS App
- encourage ICBs to put in place longer-term contracting arrangements to ensure greater choice for patients
- deliver plans with national and local professional NHS trainee programmes to provide access to training within the IS (where appropriate and required)

Care in the right place

27. Elective care typically takes place via a hospital outpatient appointment with a specialist. This is a resource-intensive and often unproductive model and might not provide a convenient experience for patients and their carers. Reforming this cannot be achieved by simply shifting care to other parts of the health and care system working as they are now – more integrated working between primary and secondary care, community, diagnostics, tertiary centres and the independent sector is essential. Digital solutions, updated financial flows, appropriate job planning, and time and investment will all be required to ensure change is productive and sustainable.

Optimise referrals through partnership working

28. In the past, patients would typically be referred to hospital without any input from a clinician in the relevant specialty. To ensure that only those patients whose care can best be provided in an acute setting are referred, we must build on the improvements made to how primary, community and secondary care work together – a recent Academy of Medical Royal Colleges report demonstrates how a more joined-up interface can improve all patient care, including electives.

29. A range of approaches must be used to embed referral optimisation in reformed elective care (non-cancer) pathways. Advice and Guidance services enhance two-way communication between clinical colleagues to help them deliver appropriate care in a timely manner.

30. Clinical triage prioritises patients with the most urgent health needs and can be used to redirect referrals to an alternative service better suited to the patient's needs. Effective triage delivers appropriate pathway choice and can happen at any point across the primary and secondary care interface, including via single point of access models. However, national data indicates there is significant unwarranted variation in the levels of triage carried out.

31. To reform elective care by optimising referrals using Advice and Guidance and triage, NHS England will:

- ensure both primary care and secondary care are funded to deliver Advice and Guidance (A&G), by splitting the existing elective tariff to deliver better outcomes for patients. In an expansion of the current approach, GPs will receive £20 per A&G request, to recognise the importance of their role in ensuring patient care takes place in the most appropriate setting. We expect this to increase uptake, with more patients benefitting from their GP accessing rapid specialist advice, so they receive the care they need in primary and community care settings, as opposed to being added to the elective waiting list. This expansion will deliver up to 4 million advice requests from GPs in 2025/26 (up from 2.4 million in 2023/24), which we expect could see an increase in diversions from elective care from 1.2 million in 2023/24 to 2 million in 2025/26. To support systems to optimise the use of specialist advice, we will provide access to:
  - new Model Health System metrics and dashboards – opportunities dashboard for systems and 4-metric overview, by organisation
  - regularly updated resources including on referral optimisation and GIRFT's Advice and Guidance toolkits and templates
- develop supporting resources by March 2026, including an implementation toolkit for triage services and standard operating procedures for routine pre-investigations and sub-specialty booking criteria, where they don't already exist

32. We will ask systems to work with their providers to develop clear and accessible:

- pathway referral criteria, including for pre-referral investigations carried out in diagnostic settings and which are visible to referrers, by July 2025
- commissioning arrangements for A&G services, including resource allocation through job planning, by September 2025

- triage standard operating procedures for high-volume specialties, outlining referral criteria, investigation requirements and sub-specialty booking criteria, by December 2026

33. The above must be implemented in a way that upholds patients' rights to choice. To support this, NHS England will set clear expectations in April 2025 that ensure referral assessment services and clinical assessment services offer patient choice.

Case study: Primary and secondary care interface working

Berkshire West has recently created a Primary Care Partnership Manager role to act as a liaison between local primary and secondary care. This has helped to:

- improve resolution of GP PALS concerns, with most being addressed within 30 working days
- achieve benefits like joint multi-disciplinary team clinics and direct access to imaging and specialist referrals
- introduce transformational initiatives such as direct optician referrals and digital records sharing
- improve patient flow, accessibility and the integration of services across the healthcare system

GPs, clinical directors and other stakeholders have fed back that the new role, which is funded by the hospital trust, has been invaluable in improving the local primary and secondary care interface.

Optimised and productive clinical pathways

34. Over 80% of all elective pathways conclude without patients needing hospital admission. In addition to commitments made throughout this plan, there are other well-established approaches that can improve clinical and operational productivity in outpatient care, reducing outpatient follow-up appointments of lower value to patients and clinicians by over 1 million. These include using patient initiated follow-up (PIFU) (and personalised stratified follow up on cancer pathways), and remote monitoring through patient engagement portals (PEPs).

35. PIFU gives patients greater control of their elective care by enabling them to initiate appointments only when they need them, such as when their symptoms change. PIFU reduces the number of outpatient follow-up appointments, as patients are not booked for a follow-up by default. Systems will offer PIFU to patients with long-term conditions as standard in all appropriate pathways by March 2026. To support the expansion of PIFU to at least 5% of all outpatient appointments by March 2029, NHS England will:

    - pilot digital options for signing-up patients for PIFU via the NHS App
    - enhance how patients suitable for PIFU are identified using artificial intelligence and automation

36. Using data analysis and informed by Royal College resources and recommendations, NHS England will take a phased approach to optimising clinically-led pathways, reflecting the required shift of care from hospital to community. We will set out clear expectations for significant elective reform to be delivered in 5 initial specialties. These are large volume specialties with waiting list challenges – for example, due to either the current size of the waiting list or the speed at which it is increasing – and a high proportion of non-surgical care: ENT, gastroenterology, respiratory, urology and cardiology. Specific additional actions for each are outlined below. GIRFT will also continue to support elective reform for children and young people across all medical and surgical specialties. Below we set out the types of reform that can be delivered.

37. ENT is currently mainly delivered in secondary care, including tinnitus and simple ear infections, although approximately 30% of referrals can be managed earlier and in a more convenient setting. In ENT services, we will bolster the community offer by expanding non-surgical community-based ENT services, maximising pharmacy first approaches and developing one-stop clinical models to support patients needing ear care and patients with rhinitis. We will reduce unwarranted variation in surgical pathways, supporting nationwide adoption of high-flow operating lists and promoting greater ENT and paediatric ENT access at surgical hubs.

Case study: South West London offers hearing assessments in the community

The ICB implemented a 12-month hearing health pilot pathway across 20 community pharmacies using a mobile-based three-in-one otoscopy device, enabling trained pharmacy staff to perform digital otoscopy, earwax removal and hearing checks on patients.

7,648 patients were referred by 72 GP practices to the 20 community pharmacies where 36% of patients were seen within 1 week, and 87% within 4 weeks. Almost 70% of patients were able to complete their treatment and only 3% of completed appointments resulted in a recommendation for the patient to be referred to secondary care, including ENT or audiology.

Patient experience of the service was incredibly positive with 99% of patients reporting they were happy with the service received, and 98% would recommend it to family and friends.

38. In urology, we will expand coverage of urology investigation units (UIU) and continue to develop the evidence base to aid future capital investment. We will support systems to identify and use technology-enabled care solutions for increased remote monitoring and management of follow-up for certain conditions, including prostate cancer.

39. In gastroenterology, we will develop an integrated pathway across primary, community and secondary care for common gastroenterology conditions. We will also drive the rapid adoption of remote monitoring in appropriate gastroenterology pathways, which reduces consultant-led outpatient appointments by over 50%.

40. In respiratory, we will scale up the breathlessness pathway beyond the current 15 CDCs, and pilot digitally enabled models for managing long-term respiratory pathways.

41. In cardiology, we will reduce the number of unnecessary diagnostics undertaken by increasing specialist input earlier in care pathways, developing standard pathways for common outpatient presentations (such as palpitation) and increasing timely access to cardiac diagnostic tests, including through straight to test.

42. NHS England will support initiatives in other high-volume specialties. In gynaecology we will support the delivery of innovative models offering patients care closer to home and piloting gynaecology pathways in CDCs for patients with post-menopausal bleeding. In trauma and orthopaedics we will continue to support increased capacity

and productivity through elective surgical hubs and GIRFT's best practice outpatient pathways.

43. With support from Cancer Alliances, cancer pathway improvement work will focus on:

- managing demand more effectively at the front end of cancer pathways by using faecal immunochemical testing (FIT) for the risk stratification of lower gastrointestinal referrals, and by completing the rollout of breast pain pathways and unscheduled bleeding pathways for women receiving HRT
- improving cancer pathway efficiency by using teledermatology for urgent suspected skin cancer referrals and local anaesthetic biopsies for prostate cancer pathways led by allied health professionals, and ensuring sufficient capacity for triple-assessment on the breast cancer pathway
- maximising the productivity of cancer diagnostic and treatment pathways by regularly assessing supply and demand for systemic anti-cancer therapy and radiotherapy treatment, personalised stratified follow-up (PSFU) pathways for patients on breast, prostate, colorectal and endometrial pathways to support self-management, and targeting variation in access through cancer clinical audits

Case study: North Bristol NHS Trust clinically-led pathway redesign

North Bristol NHS Trust has introduced an ambulatory proctology service, which means patients are treated using local anaesthetic in non-theatre settings and do not have to stay overnight.

Procedures are carried out by 1 surgeon, with no other support staff required, and patients have a 30-minute recovery period. The ambulatory approach reduces recovery time for patients who go home the same day, increasing the number of patients who can be seen and improving patient satisfaction.

Complication rates are low – of 175 procedures, 2 patients needed further follow up post operation, and 3 patients required strong pain killers. This means surgeries are easier to schedule as they need fewer staff and can take place in more locations. This service increases activity, and at a lower cost, to reduce long waits.

44. Embedding neighbourhood health approaches is one significant way for care to be delivered earlier. Specialist input is provided as and when needed (especially from

geriatricians and paediatricians) – sometimes without requiring onward referral for elective care – and maximising convenience for patients. Children and young people hub models are an example of this type of care – reducing new patient hospital appointments by 39%. These hubs also provide scope for a further 42% of appointments to be moved from hospital settings to GPs through earlier specialist intervention.

Using resources differently and outpatient transformation

45. NHS England will set out a consistent clinical model of 'collective care' approaches by September 2025. These are not currently commonplace across the NHS, and these innovative approaches can be more convenient for patients and carers and more efficient for staff, as well as provide the opportunity for peer support. Examples include:

    - group appointments, where patients with long-term conditions are supported together, either in-person or remotely
    - clinics where patients can be assessed and diagnosed or reviewed on the same day
    - 'super clinics', where a wider range of clinicians working at the top of their licence are responsible for seeing patients while being overseen by an accountable consultant

46. Using resources differently also requires reducing or stopping unnecessary interventions. The Evidence-Based Interventions (EBI) programme, created by both doctors and patients, identified a set of 57 tests, treatments and procedures that are now no longer routinely carried out because evidence tells us they are either ineffective, inappropriate, or can sometimes do more harm than good. As a result, over 1.5 million inappropriate or unnecessary interventions have been avoided.

47. We must ensure appointments are offered to people who need them most. In 2023/24 there were 8 million missed appointments in elective care. Although the reasons for this are varied, this is a significant loss of activity and productivity. Focused action reduces missed appointments: a national effort in early 2023 to identify the reasons for them and to enhance two-way communication between hospitals and patients reduced missed appointments by 0.6 percentage points in participating trusts. We will replicate these actions throughout the duration of this plan and use the results of AI work to predict who will miss appointments to save up to 1 million missed appointments. Similarly, validation is a well-established practice that ensures waiting lists are accurate and that all patients on a waiting list need to be on it. NHS England will ensure

validation is, for the first time, formally reflected as a form of activity within the 2025/26 NHS Payment Scheme.

48. Finally, a range of evidence and data – including from clinical audits and outpatient appointment classification tools – strongly indicates that a significant proportion of care or treatment could have been provided differently, if it was needed at all. NHS England will work with Royal Colleges, specialty associations and NICE to understand what is driving clinical activity that may not be needed and what can enable more consistent practice. We will also continue to improve data quality and reporting to provide better insight.

Using digital and data to improve productivity

49. Delivering the 18-week elective standard by March 2029 can only be achieved by improving how we use digital technologies and data. National development and support for elective care reform will be focused on 3 digital initiatives: the NHS App, the Federated Data Platform and the electronic referral service (e-RS).

50. The NHS App will become the single, comprehensive and trusted digital front door to care for patients. With 36 million registered users and 85% of acute hospitals connected by March 2025, the NHS App will improve communication and shared decision-making between patients and clinicians. By March 2026, we will ensure all acute and specialist acute trusts make at least 70% of all elective care appointments available for people to view and manage through the NHS App. We will also build on the success of digitising appointment letters by making more types of content about patients' treatment available on the NHS App – such as discharge letters – by December 2025.

51. As well as encouraging and supporting patients to use the NHS App, we also need to ensure NHS trusts are adopting digital patient engagement portals (PEPs). These enable patients and their healthcare team to send messages and share documents, and for the NHS App to host patient questionnaires to help validate waiting lists, monitor patients remotely and gather information before an appointment. Providers need to make these digital tools available to all clinical teams within their organisations, along with the appropriate support to adopt and embed them in clinical and administrative workflows. NHS England will continue to provide support to all acute trusts adopting these technologies, and through the GIRFT programme will provide targeted on-the-ground improvement resources and tailored support packages to trusts struggling to fully embed the features of PEPs.

52. Expanding the use of the Federated Data Platform (FDP) provides an opportunity to consolidate multiple frontline operational systems into a single view, facilitating more effective and efficient clinical and operational decisions. In elective care, the FDP provides a suite of solutions including patient tracking, smart scheduling for diagnostics, the capability to have a shared patient tracking list, and discharge management to support flow. Using the FDP has helped to reduce the administrative burden on staff, increase coordination between trusts, and reduce waiting times for patients. 89 secondary care trusts are using the FDP. We will continue to drive adoption, aiming for 85% coverage of acute trusts by the end of March 2026. To make the most of the FDP, providers need to nominate an FDP lead and adopt a selection of elective care solutions and associated implementation timelines.

53. NHS e-RS is a national digital platform for referring patients from primary care into elective care services and is a significant enabler of patient choice. Ongoing development throughout 2025/26, as well as further investment and continuous improvement of e-RS beyond then, will support effective joint clinical decision making, improving the quality of information shared between primary and secondary care through standardised referral guidelines. Work with primary and secondary care clinicians to improve e-RS functionality will focus on:

    - accepting and rejecting referrals
    - standardising referral information, including data to enable better prioritisation of children and young people and service naming conventions
    - developing the ability to only categorise services as triage where appropriate
    - improving clarity for patients by ensuring triage slot dates do not appear in the NHS App, and providing clarity for referrers on the outcome of triage
    - continued development and rollout of web access to e-RS for other care settings, reducing the reliance on analogue referrals
    - increasing digital integration of e-RS with hospital systems by adopting e-RS application programming interfaces (APIs)

54. Beyond these programmes of work, we will ensure remote consultations and remote monitoring are being used consistently across the NHS to strengthen our ability to deliver more personalised and productive outpatient care.

55. Remote monitoring of conditions at home or away from direct clinical settings saves time and is more convenient for patients. It also improves productivity by supporting

PIFU, ensuring appointments happen only when clinically needed, rather than automatically scheduled for all patients at routine intervals, which can lead to lower clinical value activity. Using digital questionnaires through PEPs and the NHS App, NHS England will:

- expand remote monitoring so it is a standard offer across all long-term conditions where clinically appropriate, removing up to 500,000 lower value follow-up appointments per year from 2026/27 onwards
- integrate and automate remote monitoring tools with clinical and administrative systems to reduce the manual burden on local services
- produce remote monitoring technical blueprints to support the sharing of best practice across providers

56. Currently there are pockets of digital innovation across the NHS, including the use of AI. These include:

- being able to share patient test results, which clinicians can access from anywhere in England. This helps to reduce repeat testing
- automated patient scheduling and notifications, so that patients receive appointments tailored to their needs and can manage them through the NHS App
- automated test requesting and results, enabling clinicians to easily order tests and get direct access to results
- image sharing to optimise test reporting capacity and to deliver results in a timely way
- AI prediction that helps prevent missed appointments and maximise clinic utilisation by supporting teams to fill appointments that patients can no longer use. Specific areas of opportunity include using AI to identify patients at highest risk of non-attendance, raising awareness of vulnerable patient groups who can then receive targeted support
- using AI to reduce workforce pressures by streamlining administrative tasks and enabling dynamic appointment scheduling to better facilitate consultant job planning

57. In 2025/26 we will work to see these approaches adopted on a much wider scale.

Aligning funding, performance oversight and delivery standards

58. Delivering the constitutional standards requires funding mechanisms, performance oversight and delivery standards to provide the right incentives to drive reform, improvement and productivity.

Financial reform

59. It is important for providers (NHS and independent sector) to have funding certainty so they will continue to be paid in line with the number of patients they treat, based on a planned level of activity agreed with commissioners. ICBs will be set individual activity targets and allocated funding needed to deliver the 18-week standard. Increasingly, money will follow the patient and those organisations that perform the best will get the most reward, so that incentives drive improvement.

60. This funding certainty will be complemented by changes to the way some elective care is paid for. These changes will begin in 2025/26 (subject to consultation on the NHS Payment Scheme). We will:

- increase the price paid by the NHS for some ENT and gynaecology procedures with the largest waiting lists. This will ensure all providers are fairly reimbursed. This is one example of how we will review relevant tariffs throughout the duration of this plan to ensure they reflect our priorities and incentivise the most productive activity
- introduce best practice tariffs to encourage a shift of activity from day case to outpatient settings for 6 procedures
- identify, throughout 2025/26, up to 30 further areas of clinical activity, and work with clinicians and finance colleagues to develop and test best practice tariffs, with the expectation they will be introduced system-wide in 2026/27
- identify how to better link payment more closely to activity that directly ends a patient's wait for their care

61. Advice and Guidance, validation and remote monitoring are examples of newer ways of working that provide care for patients in a more personalised way. Taking our lead from innovative systems, we will develop and test tariffs and payment models in 2025/26 for widespread adoption by commissioners and providers in 2026/27 and beyond.

62. We will run a capital incentive scheme for providers who perform well or improve the most in meeting RTT standards. This is one example of how providers and systems

who perform well or significantly improve will be recognised under the new NHS Oversight and Assessment Framework.

Robust performance oversight and supporting challenged providers

63. NHS England's annual operational planning guidance is the primary mechanism for formally setting objectives for the system. Throughout the duration of this reform plan the guidance will focus on the 18-week standard. To meet the 18-week standard by March 2029, we expect performance to increase from the current 58% (in December 2024) to 65% by March 2026, with every trust expected to deliver a minimum 5 percentage point improvement by March 2026. We then expect sufficient increases annually (exact figures to be confirmed in the planning guidance) to reach 92% in 2029. We will also improve performance against the cancer waiting time standards. Further details will be set out in a dedicated national cancer plan and the annual operational planning guidance.

64. In the short term NHS England will continue to set expectations for further reductions in waits of a year or more, as well as expectations for reducing the time to first appointment for all patients.

65. Elective, cancer and diagnostics performance will be assessed through an enhanced, dedicated tiering process. This will identify and support the most challenged providers. Tiering will be part of the new NHS Oversight and Assessment Framework, which will assess providers and ICBs against a wide range of delivery metrics, including elective care, as well as improved population health, reduced inequality of outcomes, high patient satisfaction and effective use of resources. For providers with longstanding elective performance issues we will use an independent diagnostic process to understand and analyse the root causes and provide mandatory intensive support, including through NHS IMPACT, GIRFT and embedded managers and clinicians where appropriate. We will also discuss with those providers any burdens that create a barrier to focusing on elective reform and put in place plans to remove them. Conversely, through the new NHS Oversight and Assessment Framework we will also identify high performing ICBs and providers that could benefit from additional freedoms.

66. For cancer, we will continue to provide direct support via Cancer Alliances to deliver improved operational performance and to improve survival rates. This will include a focus on improving performance where patients are currently waiting the longest.

67. Transparency is vital to help patients understand how their local and national health services are performing. NHS England will publish a suite of adult and children's elective performance metrics (including 18-week performance, long waits and waiting times) in an accessible format that can be ranked and used by both NHS staff and the public. NHS England will also publish data that can be ranked on all aspects of choice. This will sit alongside, and make use of, published information on NHS England's website and will be available on the NHS App.

68. Finally, we will increase the availability and use of elective, cancer and outpatient data. We will improve our understanding of clinical conditions by expanding diagnostic coding in elective care, with expectations that this will be standard practice in acute providers by March 2027. This will improve strategic planning, clinical and operational decision making, and reduce variation by increasing understanding of patient diagnoses and clinical activity outside appointments. It will also support more accurate data and diagnostic information in primary care records.

Delivery standards

69. The GIRFT handbooks and NHS IMPACT productivity guides are unequivocal in what good elective care looks like. Systems and providers will be expected to consistently focus on the smaller aspects of service delivery that can make a big difference, including:

- fully understanding and consistently applying the referral to treatment and cancer waiting times rules, with regular and good quality validation of waiting lists
- effective patient tracking list meetings to provide operational grip, including understanding the percentage of patients on the waiting list who have a booked appointment
- more productive use of outpatient clinic capacity including through overbooking approaches, reducing missed appointments, and running short notice cancellation lists
- streamlining cancer multi-disciplinary team meetings by adopting and expanding locally determined, pathway-specific standards of care
- clinic templates and job planning, which clearly set out the types and balance of activity clinicians should be undertaking, including sessions within the community
- embedding theatre scheduling, look back and list allocation within planning and scheduling for elective surgery

70. Best practice case studies and how to guides for delivering highly productive diagnostic services are available on FutureNHS. Trusts with a diagnostic service below the lower threshold of the optimal utilisation rate will be asked to sign up to a programme consisting of expert-facilitated webinars and learning collaboratives, with the most challenged trusts receiving hands on support with clinically-led visits.

71. Beginning in January 2025, NHS England will establish a Task and Finish Group to work in partnership with clinical and operational staff, to set out by September 2025 clear expectations for administrative practice and operational management in the delivery of elective care. Providers will be expected to consistently meet these delivery standards. We will also provide a suite of metrics that will demonstrate operational grip and monitor these on a regular basis to provide confidence in how elective care is being delivered.

72. While support and professional development for operational staff is already available, these offers should be better coordinated and promoted. In addition, clinical staff will benefit from education and training to support their development to independent clinical practice and reformed ways of working set out in this plan, including in areas such as multi-professional working, clinical skills, shared decision making and supporting patients with their care remotely. We also need to ensure that supervision (including of resident doctors) as well as time for clinical leadership is appropriately allocated in job planning and that independent sector providers enable appropriate access to training opportunities within their organisation.

73. The NHS IMPACT Clinical and Operational Excellence Programme scales the use of improvement approaches to deliver enhanced performance in quality, access and productivity. In 2025/26 the programme will provide new support to deliver this plan by:

- training 8,000 clinical and operational leaders in how to manage elective pathways effectively
- designing and delivering a development programme to help create the conditions to drive improvement across organisations, working with 25 boards in the first instance
- publishing and promoting improvement guides for outpatients and theatres, which include best practice co-produced with clinicians and operations managers
- creating 2 new compartments in the Model Health System reporting on a range of process, outcome and quality indicators that reflect the improvement guides

- establishing learning and improvement networks focused on improving performance on time to first outpatient appointment. Each network will be led by a local chief executive and operate on a regional footprint
- increasing improvement capacity by, for example, using GIRFT and the Elective Care Intensive Support Team, to support non-tiered elective improvement activity
- establishing a national Outpatient Improvement Collaborative that will use an improvement methodology to work with a small group of high performing providers and systems to co-design, test, evaluate and iterate the future model of outpatient pathways

74. The Further Faster 20 (FF20) programme is working with 20 trusts in areas of high economic inactivity. Its aim is to rapidly reduce waiting times and support people returning to the workforce. The programme delivers a series of FF20 masterclasses on subjects such as community musculoskeletal services, obesity services and managing gastrointestinal conditions. In addition, GIRFT clinical and operational teams will provide bespoke, on-site support to trusts to enable more rapid implementation of best practice across elective care pathways, as well as monthly meetings for all senior trust leads to ensure the programme is being delivered and to share learning and provide additional support.

75. By March 2026, NHS England will develop an online repository of national and regional training options to support operational colleagues to make the most use of limited resources. Peer support networks and tailored training resources for cancer managers and cancer multi-disciplinary team coordinators will be delivered, run in collaboration with regions, Cancer Alliances and cancer services operational teams.