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Rebuilding Elective Care and the High Street

A Radical Policy for a Sustainable NHS

Executive Summary

The NHS is approaching a critical tipping point. Elective waiting lists are at record highs, public satisfaction is at record lows, and billions in emergency funding have yielded marginal returns.

This white paper proposes a radical, yet practical reform strategy centred around three core principles: controlling demand, reimagining care delivery outside of hospitals, and revitalising England's high streets through the relocation of elective services.

By shifting care closer to patients and better aligning commissioning with population needs, we can halve elective waiting lists without additional spending. It also offers a high-level plan with concrete implementation steps to achieve this at scale, grounded in real-world evidence and system leadership experience.

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1. Introduction: A System at Breaking Point

The NHS is one of the most cherished institutions in the UK, yet it is also under enormous and unsustainable pressure. Recent years have seen a significant increase in both funding and staffing, particularly in consultant numbers. However, outcomes have not improved accordingly. In fact, the core metrics that matter most to patients—waiting times, access to timely care, and health outcomes—have worsened.

This paradox speaks to a deeper problem: that more money and more staff do not automatically translate into better performance.

The root of this issue lies in the fundamental design of our elective care system. We are managing demand reactively, instead of proactively designing care pathways around population needs and system constraints. The current approach to elective care is fragmented, supply-led, and too often driven by institutional inertia and misaligned incentives.

This paper offers a radical alternative—one that places control, coherence, and community at the heart of reform. It outlines a strategy for moving elective care into the community, consolidating hospital activity, using high street spaces to deliver modern, accessible care, and rebuilding the commissioning infrastructure to reflect what populations actually need.

2. Diagnosing the Problem: Demand, Supply and Misaligned Incentives

2.1. A System that Creates Its Own Demand

Over the past decade, consultant numbers have grown significantly—by more than 50%—yet elective waiting lists continue to rise. This is not because demand is growing inexorably, but because we operate a supply-led system: more staff, more clinics, more referrals. Each new addition to the workforce expands the system's capacity to generate referrals, assessments, tests and listings, irrespective of whether treatment capacity exists or need is substantiated.

Clinicians are often incentivised to assess and list patients even if there is no surgical or procedural slot available. Patients are triaged, investigated, and diagnosed only to sit on long and often inactive waiting lists. In many cases, they wait not because they are acutely unwell, but because the system lacks the tools to decide who genuinely needs treatment and when.

2.2. Unlimited Referral Rights and No Control at the Front Door

Primary care currently refers into secondary care with few alternatives or effective limits. While general practice rightly plays a gatekeeping role, there are no national thresholds for referral, and little ability for systems to manage volume or appropriateness. Referrals are accepted by consultants who, due to professional norms or service pressure, often feel compelled to assess and list even in the absence of timely treatment slots.

This has created a scenario in which the demand entering the system is ungoverned. Hospitals hold disproportionate power to convert assessments into listings, thereby driving up future activity, securing income, and entrenching backlogs.

2.3. Geographic Inequity and Inconsistent Thresholds

Treatment thresholds differ markedly across the country. Some ICBs perform cataract surgery at double the rate of others. Hernia repairs, knee arthroscopies, dermatology follow-ups—rates vary not by clinical need but by local norms, provider capacity, and historic contracting arrangements. This postcode lottery means some populations are overtreated, others undertreated, and the system as a whole becomes inefficient and inequitable.

For example, the National Ophthalmology Database Audit has consistently shown a two-fold variation in cataract surgery rates per 100,000 population between regions. In musculoskeletal care, some areas commission routine knee arthroscopies despite clear guidance that these procedures offer limited clinical value for degenerative conditions. Similarly, thresholds for access to bariatric surgery or fertility treatment differ widely, reflecting arbitrary local policies rather than a coherent national standard.

In ENT and dermatology, variation is just as stark. Some ICBs offer same-day outpatient procedures for benign skin lesions, while others do not fund these at all. Minor surgical procedures, diagnostic imaging access, and thresholds for specialist referral all differ according to historic budgets and local clinician preference rather than patient need.

Patients living in more deprived areas are often subject to higher access thresholds, fewer community-based services, and longer travel times—exacerbating health inequalities. Conversely, some regions with greater provider density appear to offer more liberal access, not always tied to need. These inconsistencies undermine trust, reduce efficiency, and make it impossible to plan services equitably at scale.

2.4. Estate and Workforce Constraints

NHS facilities are overburdened, with many operating beyond safe levels of occupancy. At the same time, staffing is strained. Burnout among staff remains high, and recruitment alone cannot solve the bottlenecks if the structural inefficiencies of the system persist.

Beyond operational pressures, the NHS estate presents a significant financial liability. The capital maintenance backlog has now surpassed **£10.2 billion**, with over **£2 billion** classified as high or significant risk. These issues include unsafe electrical systems, degraded operating theatres, and deteriorating infrastructure in patient-facing areas. In many hospitals, money that could be invested in patient care or innovation is instead diverted into keeping unfit buildings functioning.

This backlog is not just a financial problem—it limits the ability to modernise services, deepens inequality in infrastructure across regions, and introduces ongoing safety risks. Simply maintaining the current estate has become economically unsustainable. The rational approach is to consolidate acute activity and repurpose or divest ageing assets while investing in modern, flexible, and lower-cost spaces—like high street hubs—which are cheaper to run, easier to access, and better suited to outpatient and elective activity.

3. Three Principles for Reform

3.1. Control Demand, Don't Chase It

The NHS must shift from an activity-maximisation model to a needs-led model.

Clinically agreed thresholds—based on evidence, population health data, and real capacity—must be enforced at the point of referral and listing. This means introducing decision support systems and referral protocols that stop patients from being listed unless they meet agreed thresholds and the system has capacity to treat them in a timely, effective way.

Such control mechanisms do not reduce access but rather restore clinical integrity and system balance. They enable clinicians to say "not now" or "not here" in cases where patients are unlikely to benefit from intervention, or where alternative community-based support is more appropriate.

Demand management ensures that capacity is used for those most likely to benefit, rather than where the current system promotes those best able to navigate the system.

Controlling demand is also essential for creating equity. In the current system, access to elective care can be influenced by socioeconomic status, health literacy, GP referral patterns, and proximity to high-volume providers. Those who are more articulate, persistent, or well-supported are often listed faster, regardless of clinical priority. Conversely, those in deprived or marginalised communities may wait longer or fall through the cracks entirely.

A needs-based model levels the playing field. By applying consistent thresholds and routing referrals through structured triage (including CATs and MDTs), we can ensure that patients are prioritised according to need, not privilege. This is particularly important in specialties such as orthopaedics, gynaecology, dermatology, and mental health—where historic variation has driven deep disparities in access.

Crucially, demand control allows the NHS to plan more effectively. If we can predict and shape the inflow of patients based on clinical thresholds and population data, we can match it to existing or forecast capacity. This makes waiting lists more manageable, patient pathways more transparent, and the entire system more resilient.

In short, controlling demand is not about denying care. It is about applying fairness, evidence-based practice, transparency, and strategic thinking to who is treated, when, and how. It is a prerequisite for equity—and for the long-term sustainability of the NHS.

When presented with a decision in activity-maximisation system, hospitals choose to deliver services within their current remit. This self-fulfilling decision making dynamic needs to be uncoupled from the those that also derive income from the activity.

3.2. Move Elective Care Out of Hospitals

The hospital must no longer be the default setting for elective care. Many procedures, consultations, diagnostics, and follow-ups can—and should—be delivered in community or high street settings. This shift is not just about convenience—it is a strategic necessity.

Firstly, hospitals are under unprecedented pressure. Emergency admissions, delayed discharges, and rising acuity mean that elective care often gets deprioritised or postponed. Operating theatres are frequently unavailable due to bed shortages, anaesthetic staffing gaps, or infection control measures. By preventing activity by the creation of healthier populations and the appropriate decanting of routine elective activity out of acute sites, we can protect planned care from these operational risks and ensure a more stable, predictable patient journey. There needs to be a fundamental shift to proactive management of our population and patients.

Secondly, hospital infrastructure is expensive to maintain and inflexible by design. Many NHS Trusts are burdened with ageing estates ill-suited to modern care delivery. Elective care—especially daycases, diagnostics, and outpatient consultations—can be provided more efficiently in purpose-built community facilities or repurposed high street units. These are easier to access, quicker to set up, and significantly cheaper to run.

Thirdly, this model better aligns with the future direction of health and care policy. The UK Labour Party's 2024 health mission commits to shifting care out of hospitals and closer to home, with a particular focus on diagnostics and outpatient services. The party has pledged to create new health centres in underused community spaces and expand elective capacity outside traditional hospital settings. This agenda reflects a growing consensus across the political spectrum: that the future of elective care is distributed, accessible, and locally embedded.

Moreover, moving elective care into the community enables greater integration with mental health, primary care, and social care services. Patients with complex needs—frailty, multi-morbidity, or poor mental health—are often failed by the hospital-centric model. Community-based elective hubs can host multidisciplinary teams, link into voluntary sector support, and provide a more holistic approach to pre- and post-operative care.

From a patient perspective, the benefits are equally compelling. Travelling to large, distant hospitals for routine appointments is a source of frustration—especially for older adults and those without access to transport. Community settings are more familiar, less intimidating, and easier to navigate. Evidence shows that patients are more likely to attend and engage with services delivered closer to home.

In short, moving elective care out of hospitals is not simply a matter of capacity. It is a way to future-proof the NHS, align with national policy priorities, reduce estate costs, and provide a better experience for patients. It is also essential to creating the space that acute hospitals need to focus on what only they can do: emergency and complex care.

3.3. Commission By Design, Not By Rollover

We need to regain the grip and the bravery to commission well. Annual planning based on last year's activity was never and is no longer fit for purpose.

The practice of commissioning by rollover—where the current year's activity and budget are based on what was delivered in the previous year—has led to a deeply entrenched cycle of inefficiency, inequity, and stagnation. It has become one of the most significant and overlooked policy failures in elective care.

Rollover commissioning assumes that past activity is a reliable proxy for future need. In reality, it entrenches historical inequalities, locks in provider-centric patterns of care, and inhibits innovation. If a Trust delivered a high volume of low-value interventions last year, those same patterns are rewarded

and perpetuated this year. Conversely, areas that have worked to manage demand more appropriately may find themselves penalised with reduced funding or capacity.

This model also prevents commissioners from reallocating resources toward emerging priorities. Demographics shift, technology advances, population health needs evolve—but rollover commissioning leaves little room to respond dynamically. It reduces commissioning to a transactional, backward-looking exercise rather than a strategic tool for improvement.

Moreover, it reinforces systemic fragmentation. Providers are incentivised to maintain or increase their own activity levels to protect future income, regardless of system-wide priorities. Collaboration suffers. Opportunities to shift care out of hospital, integrate mental health or prevention, or pool resources across settings are missed.

In some areas, the result is stark: persistent overprovision of certain procedures, underprovision of others, and glaring variation in access and outcomes between neighbouring systems. National audits (e.g. in orthopaedics, ophthalmology, and gastroenterology) consistently show that where commissioning remains activity-based rather than outcomes-based, quality suffers and waste increases.

Commissioning must be reimagined as a design and management function—anchored in population health data, evidence-based thresholds, and live visibility of capacity. Rather than asking, “What did we do last year?”, systems must ask, “What do people need this year, and how do we deliver it in the most effective, equitable way?”

By breaking free from rollover logic, commissioners can rebalance the system, reward value over volume, and ensure that resources follow need—not inertia.

Commissioners need to regain the authority to manage their providers through effective contract and provider management. The NHS missed the opportunity to implement the international best practice resulting in the providers and suppliers holding too much influence over buying and payment decisions. This starts with reinstating the basic principles of contract definition, monitoring and activity validation.

4. The High Street as a Healthcare Frontier

4.1. A Deteriorating NHS Estate

The NHS is sitting on a crumbling and inefficient estate that is unfit for the future of healthcare delivery. As of 2023, the capital maintenance backlog in the NHS has exceeded £10.2 billion, with over £2 billion classified as either high or significant risk. These critical risks include unsafe power and ventilation systems, leaking roofs, cracked walls, and fire safety deficiencies in patient areas. Hospitals are not only clinically constrained but physically decaying.

In many cases, essential clinical services are delivered in buildings that are 50–70 years old. The cost of maintaining these sites is escalating year on year, diverting investment away from service innovation and infrastructure modernisation. According to NHS Providers, the current backlog would require at least £4–5 billion in immediate investment just to bring the most at-risk facilities up to a basic standard of safety and compliance.

This unsustainable position has serious consequences:

• Safety risks: Patients and staff are exposed to increasing environmental hazards.

• Service disruption: Essential maintenance can cause cancellation of procedures, closure of wards, or delayed diagnostics.

• Inefficiency: Ageing buildings are more expensive to heat, cool, light, and maintain.

• Missed opportunity: Capital tied up in outdated estate cannot be reinvested in modern, flexible care settings.

Yet despite these risks, there is limited national strategy to rationalise the estate in line with changing patterns of care. Much of the NHS capital is still based on a model of hospital-centric, inpatient-heavy care—when the policy direction is moving decisively toward daycase, community-based and digital-first delivery.

The solution lies in consolidating acute services into smaller, purpose-built hubs and diverting elective, diagnostic, and outpatient services into lower-cost, accessible, and modern spaces in the community—particularly the high street.

The NHS is obsessed by bricks and mortar and we often miss the opportunity to deliver services different. The increased utilisation of technology should be at the heat of any new estates strategy and should be viewed as the “new estate”.

4.2. The Decline of the High Street

At the same time, English high streets are facing an existential crisis. The structural decline of retail, accelerated by online shopping and changing consumer behaviour, has left town centres hollowed out. According to the British Retail Consortium and the Local Data Company:

- Over 50,000 retail units are currently vacant across the UK.
- High street vacancy rates remain stubbornly high at 13.8% nationally, with even higher rates in northern towns and coastal communities.
- More than 1 in 6 shops on high streets in some towns are classified as derelict or long-term disused.
- Footfall in town centres has dropped by 15–20% compared to pre-pandemic levels.

This dereliction is not just economic—it is civic. Empty shops reduce the vibrancy, safety, and social fabric of communities. They lower property values, attract anti-social behaviour, and contribute to a sense of neglect. In many areas, residents must now travel further for essential services, which are increasingly centralised in out-of-town retail parks or clinical super-sites.

Local authorities are under pressure to regenerate high streets but often lack the investment or anchor tenants needed to stimulate recovery. Meanwhile, the NHS continues to deliver low-complexity services in overbuilt, inefficient hospital settings.

4.3. A Bold Opportunity

Repurposing high street units into elective care hubs is an opportunity to solve both problems at once. This model would:

- Reduce strain and costs on NHS acute estates
- Bring care closer to patients in familiar and accessible environments
- Create civic anchors that drive footfall and revitalise town centres
- Enable multi-agency collaboration through co-location with social care, mental health, public health and voluntary services

These hubs could be designed as:

- Community Diagnostic Centres (CDCs) offering imaging, phlebotomy, ECGs, and other high-volume diagnostics
- Elective Day Units for minor procedures and interventions
- Outpatient clinics for pre- and post-operative consultations
- Wellbeing Hubs integrating mental health, rehab, prevention, and social prescribing

High street locations offer faster fit-out times, lower operational costs, and easier planning consent than new hospital buildings. They are closer to where people live and often better served by public transport. They are also more inclusive - removing the stigma and friction that some patients experience when navigating large, complex hospital campuses.

By aligning the NHS's estate strategy with high street regeneration, we can also unlock cross-sector investment. Local authorities, combined authorities, and regional mayors are already working on levelling-up plans, place-based investment frameworks, and town deal funding. NHS investment in health hubs could be catalytic - drawing in broader economic, housing, and digital infrastructure partnerships.

In short, the decline of the high street and the deterioration of the NHS estate are both urgent problems. Together, they form the basis of a radical and deliverable solution.

5. Case Studies and Precedents: What's Already Working?

While the concept of shifting elective and diagnostic care out of hospitals and into more local, accessible settings may seem radical in a UK context, it is already working in practice—both within the NHS and internationally. This section highlights a number of live examples that demonstrate how this model can deliver better access, more efficient care, and improved patient experience.

5.1. Community Diagnostic Centres (CDCs) – England

Launched as part of the NHS Long Term Plan, CDCs are designed to provide faster and more convenient access to diagnostic services outside of hospital settings. Early evaluations show reductions in hospital footfall, improved patient satisfaction, and quicker diagnostic turnaround times. CDCs offer imaging, phlebotomy, endoscopy, and cardiology diagnostics in community or retail settings.

Key learning: Locating services in retail parks or community centres can deliver cost-effective, high-quality care that relieves hospital pressure. CDCs provide a blueprint for how targeted investment in diagnostics can unlock wider system capacity.

5.2. Virtual Clinics and Follow-Ups – Norfolk and Norwich

Norfolk and Norwich University Hospitals Trust implemented virtual outpatient clinics to manage post-operative care and long-term conditions. The initiative led to a 20% reduction in unnecessary follow-up appointments and improved patient compliance.

Key learning: Digital infrastructure enables risk-based follow-up models that free up consultant time and reduce unnecessary hospital visits. Patients prefer the flexibility and speed of remote consultations where clinically appropriate.

5.3. Trafford Health Hub – Greater Manchester

In 2023, Trafford Council and NHS partners repurposed an empty Debenhams unit into a multi-use health and wellbeing hub. The facility now includes a diagnostic suite, vaccination clinic, GP services, mental health support, and social care navigation.

Key learning: Co-location drives footfall, reduces barriers to access, and enhances interagency collaboration. Civic regeneration and healthcare improvement can go hand in hand.

5.4. Ambulatory Surgical Centres – Canada

Across Canada, ambulatory surgical centres have been developed to deliver elective surgeries such as cataracts, hernia repairs, and minor orthopaedics. These centres operate independently from hospitals

but are fully integrated into regional health systems. They achieve lower infection rates, higher throughput, and shorter waiting times.

Key learning: Dedicated elective hubs outside hospital campuses improve flow and reduce cancellations due to emergency pressures. They offer safe, efficient alternatives that can scale nationally.

5.5. Polyclinics and Diagnostic Hubs – Singapore

Singapore's Ministry of Health has created a network of polyclinics that combine general practice, diagnostics, chronic disease management, and minor procedures. These facilities are purpose-built and digitally enabled, with integrated pharmacy and laboratory services on-site.

Key learning: A single access point for a range of services simplifies the patient journey and ensures high utilisation of infrastructure. Care is coordinated, not fragmented.

5.6. Kaiser Permanente – United States

The integrated care model used by Kaiser Permanente prioritises decentralised access to diagnostics, specialist care, and follow-up services via a mix of virtual, community-based, and hospital-centred facilities. Their regional centres act as elective and diagnostic hubs supported by strong data analytics.

Key learning: Integrated systems that own both care delivery and financing have strong incentives to reduce unnecessary referrals and maximise efficiency of elective care.

These case studies demonstrate that the shift away from hospital-centric elective care is not only possible—it is already happening. The UK can build on these lessons by creating high street-based elective hubs tailored to local need, supported by technology, and integrated into broader place-based systems. The task now is not invention, but replication and adaptation at scale.

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6. Economic Rationale and Cost Modelling

A central tenet of this white paper is that the transformation of elective care in England can be achieved **without spending more money overall**. In fact, if implemented strategically, the proposed reforms could deliver substantial economic returns—both to the NHS and to the wider economy.

6.1. NHS Estate Costs and Opportunity Savings

The current NHS capital maintenance backlog of over **£10.2 billion** represents not only a liability but a missed opportunity. If just 30% of elective outpatient and diagnostic services were moved out of hospital and into high street hubs:

- The NHS could reduce its acute estate footprint by an estimated **15–20%**.
- This would release up to **£2–3 billion** in avoidable maintenance and refurbishment costs.
- Operational savings (utilities, staffing, support services) could deliver **£300–500 million annually** by shifting to lower-cost community-based facilities.

In addition, decommissioning legacy buildings and disposing of surplus land could generate one-off **capital receipts** in the range of **£1–2 billion**, which could be reinvested into modern infrastructure and digital platforms.

6.2. Workforce Efficiency and Productivity

Staff productivity is currently constrained by inefficient workflows, high administrative burden, and mismatched capacity. By redesigning elective care around streamlined, digital-enabled hubs:

- Consultant time could be freed up through risk-based follow-up models and triaged referrals.
- Administrative overheads could be reduced by 10–15% through automation and standardisation.
- Surgical hubs could increase procedure throughput by **20–25%** due to fewer cancellations and better use of theatre time.

This translates into more patients treated per pound spent, and lower cost per case without compromising safety or quality.

6.3. System-Level Avoided Costs

Long elective waits contribute to rising emergency admissions, avoidable A&E attendances, and deteriorating health. Conservative modelling suggests:

- Every **month of delay** for a hip or knee replacement leads to increased falls, pain management costs, and reduced independence.
- Patients with untreated depression while on waiting lists cost **6x more** in total healthcare utilisation.
- Addressing elective care early avoids later crises, which are far more expensive to manage.

If waiting times for major elective procedures were halved, the NHS could avoid:

- **£800 million/year** in unplanned care costs across emergency and primary care.
- **£1 billion/year** in lost economic output from delayed return to work or long-term sickness absence.

6.4. Impact on Local Economies

High street elective hubs would stimulate economic activity and civic regeneration:

- Each hub could support **50–100 local jobs**, both clinical and non-clinical.
- Co-location with social care, pharmacy, and voluntary sector partners would generate multiplier effects across local services.
- Increased footfall to struggling town centres would benefit neighbouring businesses and support local growth strategies.

Investment in health infrastructure is one of the most effective forms of public capital spending. Analysis from the Centre for Progressive Policy suggests that each £1 spent on community-based healthcare returns **£3–4** in economic and social value.

6.5. Summary Forecast: Net Impact by 2028

Impact Area	Estimated Benefit by 2028
Estate rationalisation	£2–3 billion capital savings
Operational cost savings	£1.2–2 billion cumulative
Avoided emergency/acute costs	£2–3 billion cumulative
Increased economic participation	£3–5 billion in recovered output
Local economy regeneration impact	£1–2 billion indirect uplift

Total potential net benefit: £9 - 15 billion over five years, if scaled and sustained nationally.

This is a compelling case not just for reform, but for strategic investment and reallocation. The economic logic is clear: **better planned, community-based elective care is cheaper, more efficient, and more socially valuable than the status quo.**

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7. Policy Levers and Enablers

Delivering the proposed transformation of elective care will require aligned action across multiple levels of the system—national, regional, and local. While much of the operational delivery can be led by Integrated Care Systems (ICSs) and Trusts, success depends on the right policy environment, funding signals, regulatory frameworks, and partnerships. This section expands on the specific enablers each actor must provide, and why they are critical.

7.1. Department of Health and Social Care (DHSC)

The DHSC must set the strategic policy direction and funding architecture for reform. National leadership is required to:

- **Create a national commissioning framework for elective care**: This would mandate population-based treatment thresholds and reduce unjustified variation. Without this, local systems will struggle to hold providers accountable or rationalise activity.
- **Introduce capital funding streams for repurposing commercial spaces**: The move to high street hubs requires upfront capital, even if the long-term costs are lower. Matched or challenge funding models could unlock local innovation.
- **Link elective recovery funding to estate rationalisation and demand control**: Too often, short-term elective recovery pots have been spent on additional lists or agency staff, without changing the underlying system. Tying funding to transformation outcomes ensures sustainability.

DHSC now plays a vital role in implementation, oversight, and technical enablement. Its leadership should focus on:

- **Expanding and accelerating Community Diagnostic Centres and elective hubs**: CDCs are already working. DHSC should move faster to replicate successful models and embed them into ICS planning.
- **Developing digital triage and referral tools**: National platforms that support Threshold to Treat (TTT) and Threshold to Admit (TTA) protocols are essential for demand control.
- **Holding providers accountable for variation and thresholds**: Through GIRFT, CQUINs, or regulatory levers, DHSC must ensure that local providers adopt standardised, needs-based thresholds.

7.2. Local Authorities and Combined Authorities

As place leaders, local authorities are uniquely positioned to support the regeneration of the high street and alignment of services. They should:

- **Identify and prioritise vacant or underused high street properties**: Councils can use local asset registers and town deal plans to bring forward suitable spaces.
- **Use planning and regeneration powers**: Local authorities can streamline change-of-use processes and provide tax or business rate incentives for health hubs.
- **Align public health priorities with elective planning**: Deprivation, frailty, obesity and mental health issues often intersect with long waits for care. Integrated planning ensures resources are targeted where impact is greatest.

7.3. Integrated Care Boards (ICBs)

ICBs are at the centre of delivery. They must:

- **Commission services based on population need, not historical volume**: This requires robust data, clear thresholds, and political courage to shift resources.
- **Reduce unjustified variation in intervention rates**: By publishing comparative dashboards and acting on outliers, ICBs can promote equity and efficiency.
- **Lead the redesign of elective pathways around place**: ICBs should plan services around neighbourhood footprints, linking primary, diagnostic, and elective care into coherent patient journeys.
- **Develop integrated workforce and estate plans**: Moving care into the community requires rethinking where people work, how they're trained, and how they're supported across boundaries.

Why These Levers Matter

System transformation is rarely achieved by directive alone. Change needs to be enabled, resourced, and de-risked. The actions above are not about central control -they are about creating the conditions in which local systems can act decisively and confidently.

Without national thresholds, ICSs will lack the legitimacy to standardise care. Without capital investment, community hubs cannot be built. Without digital triage, referrals cannot be managed safely. And without clear accountability, variation and inefficiency will persist.

These are not marginal enablers - they are the critical scaffolding on which the next chapter of NHS elective care must be built.

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8. Roadmap to Halve Waiting Lists by 2028

This roadmap provides a structured, time-bound approach to delivering the proposals set out in this white paper. It is based on the principles of staged transformation, starting with foundational enablers and moving toward system-wide implementation and optimisation. The timeline is deliberately ambitious - because the scale of the elective care crisis demands urgency.

2024–25: Foundation Phase

1. Publish national thresholds for high-volume procedures: A national set of Threshold to Treat (TTT) guidelines for 20–30 high-volume procedures (e.g., cataracts, hip replacements, hernia repairs, endoscopy) should be developed. These will form the clinical basis for referral acceptance, pathway design, and commissioning decisions.

2. Pilot high street elective hubs in 10 diverse locations: Pilot projects should be launched across urban, rural, and coastal systems to convert underused commercial units into elective care hubs. These pilots will help identify the estate, workforce, and governance enablers needed for national rollout.

3. Deploy real-time commissioning dashboards in 3 ICBs: Commissioning platforms that provide live data on capacity, demand, and intervention rates should be trialled. These dashboards will support needs-based commissioning, contract management, and variation analysis.

4. Establish the Elective Transformation Programme Office (ETPO): A national delivery unit should be created under DHSC to coordinate the reform programme, manage policy coherence, and support local implementation.

2025–26: Scaling Phase

5. Implement TTT and TTA protocols in 50% of systems: All referrals and surgical listings in participating ICBs should pass through digitally enabled triage based on population need and real-time capacity. This will embed demand control into clinical practice.

6. Expand the CDC model to include minor procedures and pre-op pathways: The existing Community Diagnostic Centre programme should evolve to deliver not just tests, but care. This includes basic pre-operative workups, virtual MDTs, and low-complexity elective procedures.

7. Launch CATs 2.0 in every ICS: Revise and relaunch Clinical Assessment and Treatment Services as full MDT hubs, physically co-located with diagnostics, mental health, and rehabilitation. CATs 2.0 should act as a gatekeeper and optimiser of elective flow.

8. Commission against intervention rate benchmarks: ICBs must begin commissioning elective activity based on agreed intervention rates per 100,000 population. Any planned over- or under-activity should be explained and justified.

9. Decommission low-value or obsolete interventions: Each ICB should identify and begin phased decommissioning of at least 10 low-value procedures, using NHS EBI and GIRFT frameworks. Savings should be redirected to priority pathways.

2026–28: Optimisation Phase

10. Transition 30% of outpatient and diagnostic activity out of hospitals: At least one-third of current outpatient appointments and basic diagnostics should move into community and high street settings. This transition should be supported by estate divestment and workforce reallocation.

11. Integrate elective and urgent care capacity planning: ICSs must develop unified models of capacity planning, linking elective hubs, CDCs, and urgent treatment centres into a shared platform. This will reduce disruption and allow for true system resilience.

12. Embed population-based commissioning into ICS governance: Elective planning should be overseen by a dedicated ICS commissioning sub-committee with accountability for population equity, access, and outcomes. This structure should oversee contract alignment, threshold adherence, and provider incentives.

13. Institutionalise the high street elective hub model: Successful hubs from earlier phases should be adopted permanently, with formal lease or ownership arrangements, capital investment, and digital infrastructure. These should be written into long-term ICS infrastructure and workforce plans.

14. Achieve a 25–30% reduction in elective waiting lists: Through improved flow, demand control, and site reconfiguration, the national elective waiting list should reduce by at least one-quarter by the end of 2028—without additional revenue funding.

This roadmap is bold but achievable. It balances technical realism with political ambition and can be flexed to suit local conditions. Crucially, it connects national policy levers with local delivery capacity in a way that previous elective recovery plans have failed to do.

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9. Conclusion: A Blueprint for Sustainable Elective Care

This white paper sets out a radical yet achievable plan to transform elective care in England. The core message is simple: **we can halve waiting lists without spending more, but only if we fundamentally redesign how elective care is structured, commissioned, and delivered.**

It is no longer credible to argue that the problem lies solely in insufficient funding or workforce numbers. The challenge is structural—an outdated estate, inconsistent treatment thresholds, provider-driven demand, and a lack of coherent planning between agencies. This paper proposes a future-ready system: one that is decentralised, digitally enabled, and rooted in population need.

At the heart of this transformation is a shift away from hospitals as the default site of care. By repurposing high street space, we can provide more accessible, cost-effective services while revitalising struggling communities. By applying consistent thresholds and commissioning against need, we can reduce unwarranted variation and improve equity. And by aligning national policy, local delivery, and real-time data, we can finally gain control of demand.

This is not just a technical proposition—it is a civic one. It is about designing a system that is more human, more local, and more sustainable. One that meets people where they are, rather than forcing them to navigate a system built for another era.

A Call to Action

To Government and DHSC:

- Establish the policy and capital investment framework to make this possible.
- Mandate thresholds, reform commissioning logic, and fund high street hub development.
- Champion this vision publicly to give systems the political cover to act.

To NHS England:

- Accelerate the rollout of CDCs and CATs 2.0.
- Embed real-time analytics, triage, and capacity dashboards into system planning.
- Use performance frameworks to drive adoption of thresholds and variation reduction.

To Integrated Care Boards (ICBs):

- Shift from rollover planning to population-based commissioning.
- Publish intervention rate benchmarks and commit to action on unjustified variation.
- Work with local partners to identify, fund, and activate high street care sites.

To Providers and Trusts:

- Embrace the redistribution of activity and support the transition to elective hubs.
- Invest in clinical leadership and service redesign to align with new thresholds.
- Contribute to regional equity through collaboration, not competition.

To Local Authorities and Combined Authorities:

- Offer space, regeneration support, and co-investment in civic health infrastructure.
- Integrate care planning with local economic and housing strategies.
- Make the NHS a cornerstone of the new high street.

To Patients and the Public:

- Engage with new models of care and share experiences of what works.
- Participate in local consultations and co-design of services.
- Demand fairness, access, and transparency—not just faster treatment, but better care.

We have the tools. We have the evidence. We have the economic case. What we now need is **resolve**—from every part of the system—to build a future where elective care is timely, equitable, and delivered in the right place.

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