GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Joint Health Scrutiny Committee

Date: 17 March 2026

Subject: Elective Recovery Update

Report of: Dan Gordon, Director Elective Recovery and Reform, NHS Greater Manchester

Purpose of Report

The purpose of this report is to update the Committee on the current position for Elective Care across GM, describe the performance of the system in terms of data and trends, highlight driving factors for current challenges and describe the key components of the GM Elective Recovery Plan

Recommendations:

The GMCA is requested to:

1. To note the improvement in reducing long waits in GM over the last twelve months, plans for improving access to elective care and how this will help reduce waiting times across GM over the next two to three years
2. To consider how we might better communicate with patients around the changes to elective care and manage expectations
3. To consider any practical solutions to support the left-shift, especially primary care integration with community-based models of elective care and the use of specialist advice in GP-patient interactions

Contact Officer

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Elective Recovery Update

1. Introduction

This reports provides an overview on access to Elective Care across Greater Manchester (GM), plans for the coming years and direction of travel on how Elective Care will be delivered in the future.

2. Current Performance: data on wait times, comparisons, and trends

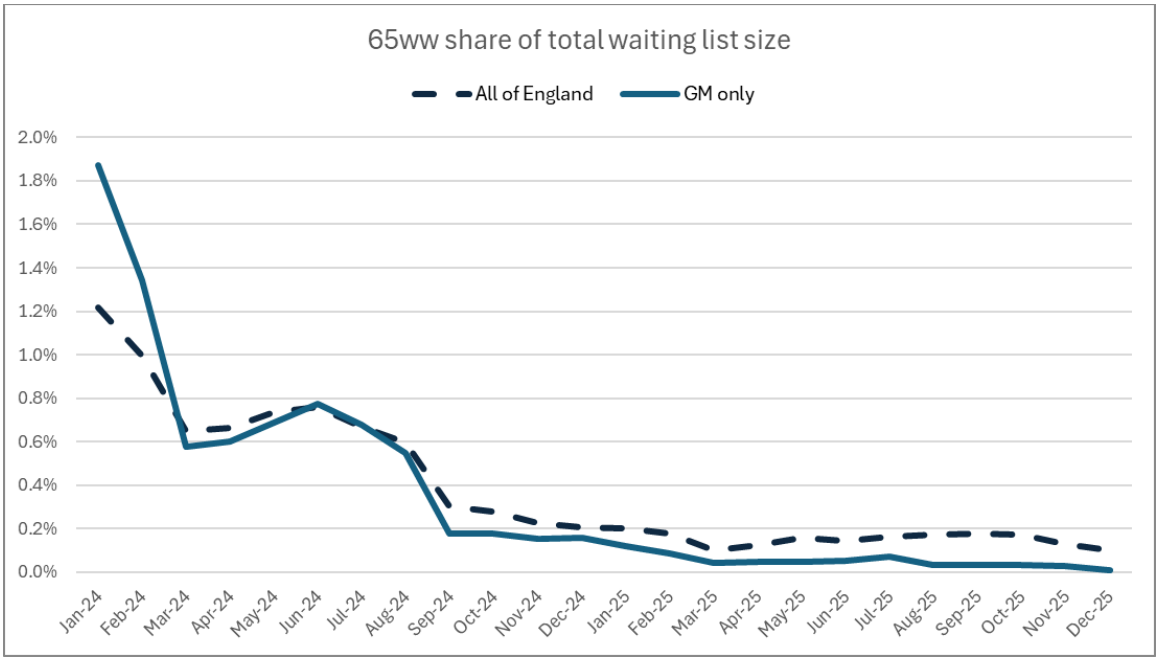
As with the rest of England, access standards for elective care have not been met in GM since 2015. The 92% standard for access to care within 18 weeks was falling prior to COVID and the pandemic exacerbated this trend. The current government has set out plans to return to the 92% constitutional standard by March 2029 and eliminate long-waiting times alongside.

On some metrics GM came out of COVID in a worse position than almost any other region. For instance, it had a large share of all patients waiting over 2 years in 2022 when recovery plans were first put in place. As such, the system has been on a journey to reduce the longest waiting times from over 2 years (104 weeks) to 1 year. However, it has been recovering faster than the rest of England.

2.1 65-week waiters

Last year we reported that GM accounted for 1 in 25 of all patients in England waiting over 65 weeks (677 as of November 2024) and this was an improvement compared to 1 in 6 in August 2023 (>16,000 patients). As of December 2025, this has fallen further to 1 in 180 of all patients in England, which equated to 41 patients with more than half of patients choosing to delay care due to Christmas (i.e., they could have been treated but decided not to), effectively eliminating waits over 65 weeks.

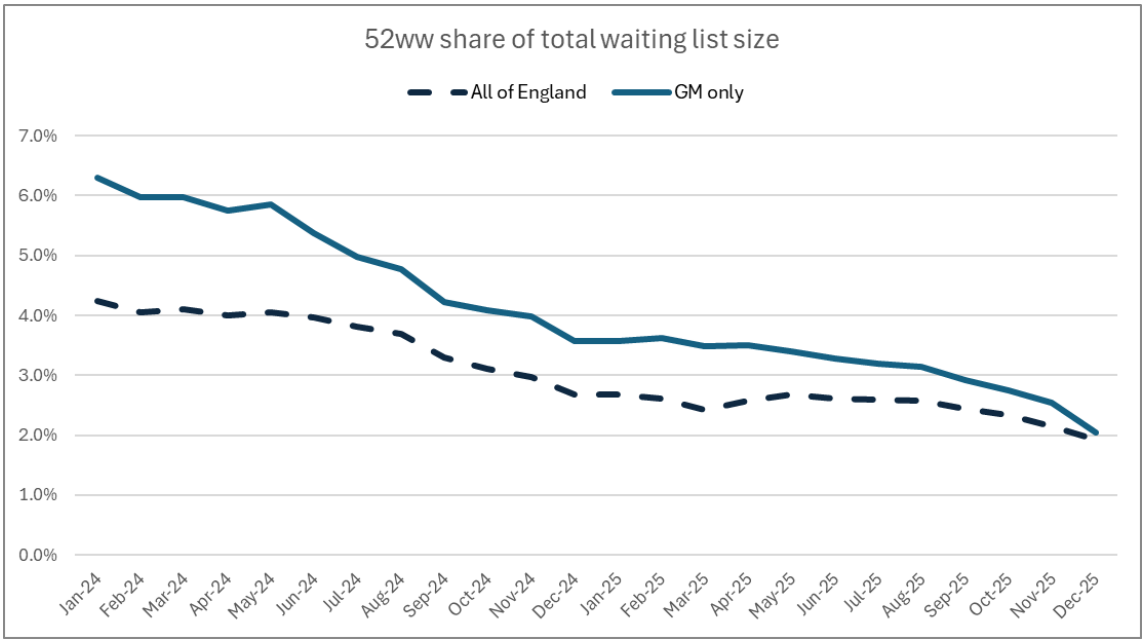
Figure 1: Comparison of 65ww share of list size GM vs All of England



2.2 52-week waiters

In December we hit a significant milestone as patients in GM are no longer more likely to wait 52 weeks than patients in the rest of the NHS. Last year GM had 17,769 patients waiting over a year to begin treatment (November 2024, 4% of the total waiting list compared to 3% nationally), and this has fallen to 8,477 as of December 2025 (2% of the total waiting list compared to 2% nationally). We expect to bring this to close to 1% of the waiting list by the end of March 2026 and are aiming to eliminate waits over a year in the next 18 months.

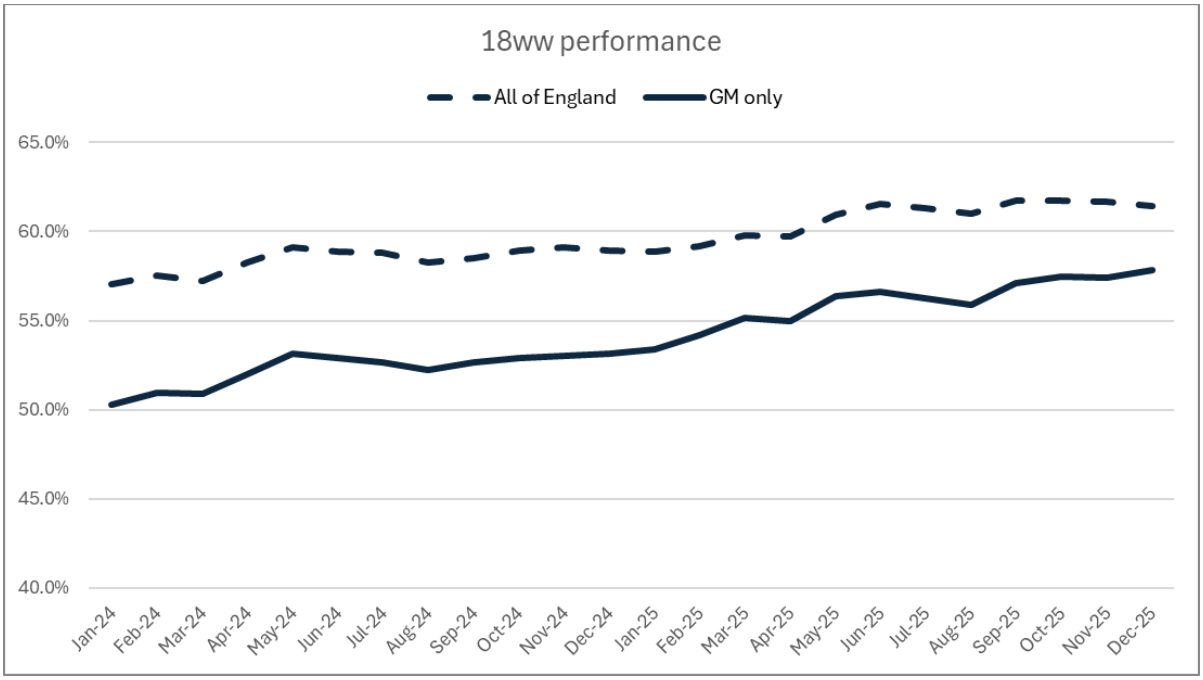
Figure 2: Comparison of 52ww share of list size GM vs All of England



2.3 18-week waits

The NHS is now on a 3-year plan to return to 92% of patients initiating treatment in 18 weeks. This will be the most challenging target to achieve but GM are on an improving trajectory and have made progress faster than the rest of England. Two years ago just over 50% of patients in GM began treatment within 18 weeks of a referral. This has improved to 58% and is expected to exceed 60% by the end of March 2026. Across the whole of the NHS 61% of patients now start treatment within 18 weeks of a referral but this compares to 57% in January 2024. So whilst GM still lags the wider NHS it has improved at almost twice the rate than the NHS as a whole over the last two years (see Figure 3).

Figure 3: Comparison of 18ww performance GM vs All of England

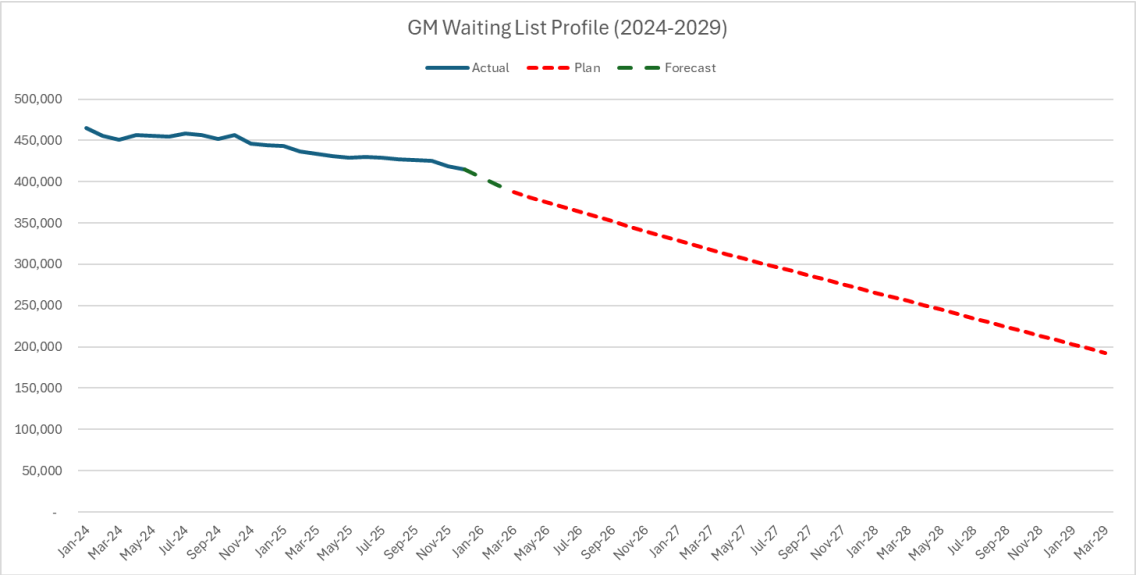


Improving RTT 18-week performance is much more challenging than reducing long-waiters, it requires a whole pathway approach and significant reduction of the total waiting list size. To put this into context, to move performance from 50% to 58% GM have incrementally removed 56,000 patients waiting over 18 weeks in the last 2 years. Every percentage point improvement in 18 weeks requires around 4,000 patients to be incrementally treated and over the next 3 years GM will need to incrementally remove 60,000 patients from the waiting list each and every year to meet the NHS target – this is twice the current rate.

3. Medium Term Plan

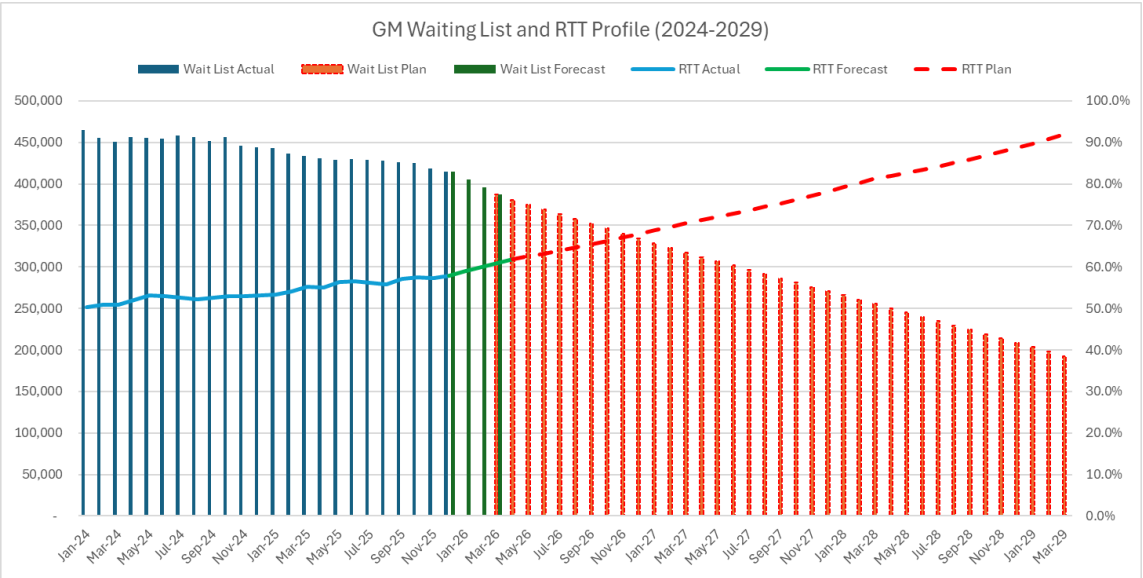
The NHS annual planning round for 26/27 has required ICBs to commit to delivering a multi-year plan that brings the total waiting list size down in line with the level needed to deliver 92% target by March 2029 (Figure 4).

Figure 4: GM Waiting List Size – Actual (Jan '24 to Dec '25), Plan to March 29



If we overlay 18ww performance (Figure 5) we can see that GM will need to deliver a 10 percentage point (p.p.) improvement in each of the next 3 years compared to 8 p.p. over the last 2 years. NHS England have provided additional hospital funding that covers half of the required waiting list reduction. The rest requires a different approach to delivering elective care.

Figure 5: GM Waiting List and RTT Actuals and 2026-29 Plan



4. Transforming how we deliver elective care

The national elective plan and subsequent planning guidance has set out a vision for how elective care should be delivered in the future. The vision is for care closer to home, reducing the need to visit hospital by transforming how we deliver more specialised elective care through community services, and directly within primary care with the support of specialist advice and community-based diagnostics. In addition, planning guidance reiterates a need to address unwarranted variation in how care is delivered, and requires providers and commissioners to systematically address this and ensure healthcare spending delivers value for money.

The focus is on patients being treated in outpatient, or non-admitted settings of care. Such patients account for 80% of the waiting list and have contributed to 90% of the growth in the waiting list since COVID. Transforming how care is delivered in non-admitted settings is important to addressing this growth in the waiting list and reducing waiting times for patients across GM.

Over the last twelve months we have begun to lay the foundations for how we work differently in the future:

- GM Elective programme has worked with providers to develop and agree a single GM Access Policy so that patients are provided the same high-level of care regardless of where they attend hospital
- Since April Trusts have been participating in NHSE-led validation sprints to ensure waiting lists are an accurate representation of demand
- In the summer, Leigh surgical hub treated the first paediatric patients for 30 years as part of an initiative to expand paediatric surgical capacity in GM
- In September we began to increase capacity for patients to be seen in community-based clinics with an initial focus on ENT and Gynaecology
- In October we launched a pan-GM Advice and Guidance service that allows GPs from across GM access to timely, high-quality specialist advice via telephone or messaging, this supplements existing advice services provided by our NHS Trusts – the use of specialist advice has almost doubled in the last 12 months and this represents a new way of enabling patients to receive timely care

Over the next twelve months we will be expanding and deepening some of this work, in line with the national planning guidance:

- Extending the pan-GM A&G service for a further 12 months, supplementing hospital-led services and the shift toward single point of access in certain specialties, including expanding to other areas such as mental health
- From April we will be testing new “single point of access” models to support patients to receive appropriate care faster – this is part of an overhaul of outpatient care and the requirement is to roll out across 10 specialties in each trust from October – we want to co-create this with primary and secondary care in GM to ensure this is joined up
- Commissioning additional community provision across GM, linking primary care and secondary care via the single point of access – priority will be given to ENT, Gynaecology and Dermatology where we have developed single GM service specifications
- We will work with NHS England to move to monitoring adherence to the GM access policy, using an agreed set of KPIs to monitor how closely providers are working to the principles and identifying areas for ongoing improvement such as patient communications
- Implement the national “Getting It Right First Time” (GIRFT) follow-up protocols in hospitals and reduce unnecessary follow-ups to ensure patients are only seen when they are needed, releasing capacity for others
- We are also exploring use of the Federated Data Platform (FDP) and how this might be used to better balance demand and capacity across the system with more of this to come in the following year

5. Recommendations

The Committee is asked:

- To note the improvement in reducing long-waits in GM over the last twelve months, plans for improving access to elective care and how this will help reduce waiting times across GM over the next two to three years
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