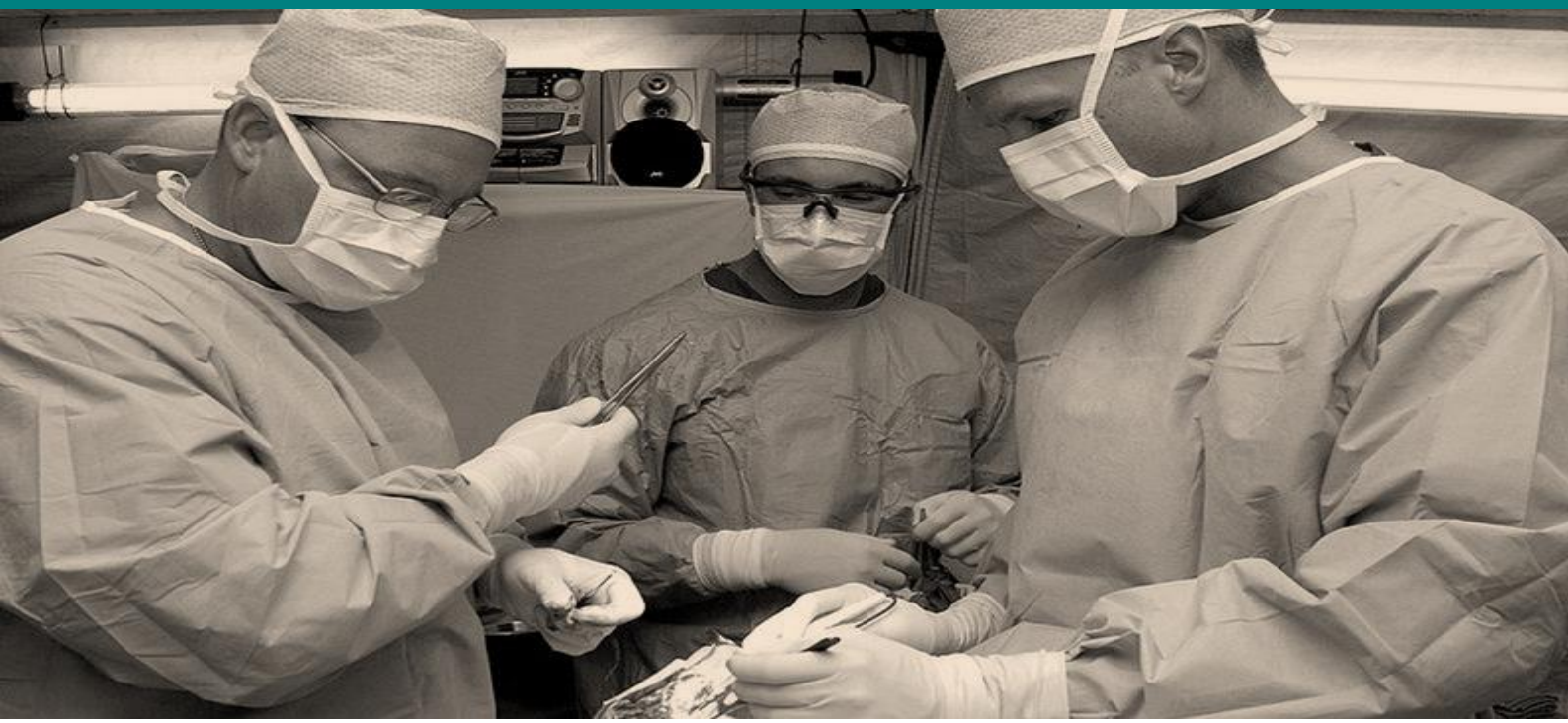
The Patients Association
listening to patients
speaking up for change

Feeling the Wait

Annual Report on Elective Surgery Waiting Times
The Patients Association



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"A year is a very long time to wait if you are immobile, in discomfort or in pain. If a single one of those patients is waiting not out of choice, or for proper clinical reasons, but simply because the NHS has not been able to provide the treatment they need for a whole year then that is unacceptable.

So today I want to announce a new ambition for the NHS: I want this number of people waiting more than a year for their operation to be not in the thousands, not in the hundreds, but as close to zero as possible."

Secretary of State for Health Jeremy Hunt

('NHS Waiting times: job not done', Royal Surrey County Hospital, August 2014)

1. Executive summary

This is our sixth annual report on hospital waiting times for elective surgical procedures in England. The Patients Association believes that all patients should be accessing their legal right to surgery within the 18 week (126 days) waiting time limit as set out in the NHS Constitution. Sadly, over the last five years for too many patients this has not been their experience. This year's report based on 2015 data shows that on the whole, waiting times are getting worse, not better. This report also highlights regional variations in waiting times across England.

The key findings from the report are:

- The total number of patients waiting over 18 weeks for the calendar year of 2015 was 92,739, compared to 51,388 patients waiting over 18 weeks in 2014. Excluding the figures for bariatric and gender operations which we did not collect last year, this represents an increase of 79.5% in the number of patients waiting for over 18 weeks.
- Average waiting times for five procedures (hip replacement, knee replacement, hernia, adenoid and tonsillectomies) are above 100 days, which represents the highest average waiting time in the six years data has been collected by the Patients Association.
- Adenoid operations had the longest average waiting time at 110 days, with a rise of around 15 days from 2014 to 2015.
- Around 10% of Trusts do not have a process to recognise patients' changing needs while on the waiting list. This represents a significant risk to patient safety and patient well-being.
- 77% of Trusts are failing to notify patients of their rights under the NHS Constitution when the 18 week limit has been missed.
- Trusts cancelled an average of 753 patient surgeries 'on the day' in 2015.
- Equipment shortages and/or lack of beds were the most common reasons for surgery cancelled on the day.
- Theatre improvements were the most commonly reported programme being used by Trusts to improve compliance to the 18 week waiting time.
- Two Trusts reported that they have implemented bans for out-of-area procedures. This is incompatible with patient choice rights from the NHS Constitution.

The Freedom of Information request which produced this information was sent to all Trusts in England, and achieved a 78% response rate. This was an improvement on last year's report (71% response rate), with the North and South of England regions improving their response rate, while London and Midlands and the East of England response rate declined on last year.

As part of this research, qualitative research was undertaken with patients on the impact of waiting times on their lives. Indeed, waiting times are more than a statistic; waiting for operations affect patients' health and wellbeing, as well as that of their families. Through our national helpline and interviews conducted for the report with patients who had experienced long waiting times for elective surgery, we have identified three key concerns for patients that we believe must be addressed.

1. **Communication**

   Patients feel like they are chasing communication with Trusts for information on the surgery date and that there is a lack of transparency between Trusts and patients. Patients felt that the onus was on them to call their Trust and ask for information about when they could expect to receive their surgery.

2. **Psychological distress**

   There is a significant psychological burden on patients waiting to be given a date for surgery and for patients whose surgery has been cancelled (often on the day the surgery was due to take place).

3. **Patient safety**

   Patients want to know if long waiting times have caused, or will cause their condition to deteriorate, so they can be prepared for their condition to be different from when they first started waiting. Patients are also concerned that the long waiting times will affect how successful their eventual surgery will be and how much recovery time they will need.

2. Introduction

2.1 The Patients Association and our work on waiting times

The Patients Association is an independent health and social care charity. For nearly 55 years we have campaigned for better access to accurate information for patients and the public; equal access to high quality healthcare for patients, and the right for patients to be involved in all aspects of decision-making regarding their health care. Our motto is 'Listening to Patients, Speaking up for Change', which is the basis of all our campaigns.

Via our helpline, we hear thousands of stories each year from patients, carers, family members and friends about people's experiences of the health and social care services. We use this knowledge to campaign for real improvements across the UK. In addition, our helpline provides valuable signposting and information for patients and supports them as they navigate their way through healthcare services. We have grown increasingly concerned at the waits patients are facing for surgery and the amount of patients who have had their operation cancelled on the day.

Since 2010 the Patients Association has carried out an annual survey on hospital waiting times for elective surgical procedures across the NHS in England. The study's aim is to identify any significant changes in waiting times compared to previous years, both nationally and regionally, as a means of both pushing for improvements and celebrating achievements that have been made.

3. Policy background

The NHS is facing unprecedented financial pressures. NHS providers are expected to make £22 Billion in efficiency savings by 2020-21. In addition, the NHS has been tasked with doing more with less and meeting bold government pledges for a 7-day. This is all within an evolving healthcare landscape with increases in cases of obesity, diabetes and a widening lifestyle gap between the wealthy and the poor. A significant challenge to the NHS is the UK's ageing population; currently three Million people are aged over 80 years old. By 2030, this figure is projected to almost double with the Nuffield Trust estimating that the ageing and growing population could mean we need another 17,000 beds by 2022.[i]

The Five Year Forward View[ii] published in 2014 set out a shared vision for the future of the NHS based around seven new models of care. We welcomed the Five Year Forward View as a realistic roadmap to addressing many financial and structural challenges within the NHS. The Five Year Forward View concluded that the NHS needed action in three key areas: demand, efficiency and funding, in order to address a variable quality of care and deep-rooted health inequalities within a climate of changing patient needs and increasing service pressures. These areas are still relevant today, despite £6 Billion being frontloaded by 2016/7 for the delivery of the View. While NHS England's budget will increase by £7.6 Billion in real terms, this comes as £3 Billion is cut from other areas of health spending.[iii] Many providers continue to struggle; figures released by NHS Improvement showed that NHS Trusts in England ended the financial year in a record deficit of £2.45Bn, £461M worse off than forecast.[iv]

The Forward View into Action Planning for 2015/16 report[v] provided planning guidance for the NHS in order to start delivering the aims contained within the Five Year Forward View. This guidance requires leaders of local and national health and care services to take action on five fronts, one of which is that the local NHS must ensure patients receive the standards guaranteed by the NHS Constitution, including minimum waiting times. It also emphasised the NHS' commitment to giving doctors, nurses and

carers access to all the data, information and knowledge they need to deliver the best possible care.

In July 2015 NHS Improvement was launched as the health sector regulator tasked with driving and supporting urgent improvements at the frontline and the long-term sustainability of the healthcare system. In NHS Improvement's report on performance of the NHS provider sector for the year ended 31 March 2016, further commitments were made to improve waiting times:

"NHS Improvement and NHS England are to work collaboratively to deliver programmes which will reduce the waiting list by ensuring capacity keeps up with demand. Specifically, the programmes will focus on reducing 52-week waiters, optimising referral practice and supporting non-reporting providers to improve data quality and to re-commence reporting." [vi]

Lord Carter's review of efficiency in hospitals argued for a change in NHS culture, his review set out ways non-specialist acute Trusts can reduce unwarranted variation, productivity and efficiency to save £5 Billion a year by 2020 to 2021.[vii] The report made fifteen recommendations related to standardising procedures, creating a more transparent culture and working with neighbouring Trusts.

Lord Carter views quality patient care and good financial management as coefficient, therefore, improving care requires better control of resources, particularly the NHS workforce. The review also identified huge variation for surgery between Trusts with prices paid for hip prosthesis ranging from £788 to £1570 and significantly different infection rates between Trusts for hip and knee replacements from 0.5% to 4%.[viii]

The NHS is dependent on the skill and loyalty of its workforce. However, the NHS is faced with exceptional challenges for the workforce including poor morale, staff shortages, contract disputes and agency spending. A recent survey conducted by the Guardian found 4 in 5 NHS staff had thought about leaving, and staff also reported high levels of stress.[ix] There has been a £400 million increase in agency spending, bringing the total spend to an estimated £3.7 billion on locum doctors, nurses and healthcare staff in 2015-16.[x]. This increase occurred in spite of Trusts being set individual expenditure ceilings for agency nursing staff in September 2015.

Significantly, despite the financial challenges facing the NHS being the toughest in its history, the NHS' commitment to reducing waiting times continues to be a key policy priority.

3.1 Relevance of this research

In December 2015 it was reported that NHS England breached the 18 week waiting time target in October. Non-reporting Trusts were taken into account for the first time since the target was originally achieved in January 2012.[xi] The number of patients waiting for an elective procedure is at its highest level since 2007, estimated at 3.5 million.[xii] Up until this point, targets were being largely met, but every single surgical speciality except ophthalmology, obstetrics and gynaecology missed their targets within that month. In the King's Fund's annual poll of patient satisfaction in the NHS[xiii], one of the top reasons the public gave for being dissatisfied with the NHS was long waiting times.

The Patients Association believe patients' individual clinical needs should always be the most important consideration in accessing health care. No one should wait longer than necessary for surgery. Delaying or denying surgery can prolong painful symptoms for patients and cause additional stress for patients being required to make difficult lifestyle changes. A prolonged wait can also result in poorer outcomes from surgery and is a potential patient safety risk.

3.2 Background to the 18 week target

The 18 week waiting time target was launched in 2004. The 2004 NHS Improvement plan set out the idea for reform with a maximum wait of 18 weeks from the time of referral to a hospital consultant, to the start of treatment. This period is known as referral to treatment (RTT). The report stated that by 2008 'no one will wait longer than 18 weeks for hospital treatment from GP referral. [xiv] This was made a legal right by NHS England and Clinical Commissioning Groups (CCGs) in the responsibilities and standing rules regulation 2012. Moreover, the pledge that patients have the right to access certain services commissioned by NHS bodies within maximum waiting times, is laid out in the NHS Constitution.

3.4 The NHS Constitution and patients' rights

The NHS Constitution is a single document which covers the principles and the values of the NHS, as well as the rights and responsibilities of patients and staff within the NHS. This document seeks to empower patients and the public by setting out what they are entitled to under the NHS. In March 2010, the document was updated to include the right for patients to start consultant-led non-emergency treatment within a maximum period of 18 weeks.

"You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible." [xv]

If patients are not able to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions, the NHS is expected to use reasonable measures to offer a range of alternative providers. Patients' legal right to be treated in 18 weeks applies in all cases except if patients chose to wait longer, or it is clinical necessary that the waiting time is extended. Patients can also exercise their right to choose the hospital they are referred to. However, this depends on the clinical recommendations made to them by their GP or the urgency the treatment is needed, or the specialty of treatment.

3.5 Update to the 18 week target

In June 2015, Sir Bruce Keogh's was asked by Simon Stevens, Chief Executive of NHS England to "review current waiting time measures to ensure they make sense for patients and are operationally well designed." [xvi] Following this review the Referral to Treatment (RTT) standard for incomplete pathways became the sole measure of elective waiting time performance. This attempted to simplify 18 week waiting time targets and avoid the build-up of long waiting lists, with Trusts facing financial penalties and regulatory action for treating patients waiting beyond the 18 week target.

In July 2016, NHS England and NHS Improvement launched a seven-point plan to stabilise NHS finances in 2016/17. [xvii] The plan included a relaxation of the national rules for waiting times targets, replacing national fines with Trust specific initiatives. Previously, 92% of patients are supposed to start treatment within 18 weeks, when this target is breached hospitals are fined £400 per patient before the fines are capped when the rate falls to 90%.

4. Methodology

Requests for information were sent out to 144 Acute NHS Trusts in England, under the Freedom of Information Act 2000. Using The Patients Association's national helpline database and seeking policy advice from experts in the field, we devised 11 questions to provide data for our key concerns around elective surgery. Based upon our previous research into this area and calls to our national helpline, we identified nine key surgical procedure categories. We included the seven surgical procedures surveyed in our previous report to enable trend analysis. These procedures are hip replacements, knee replacements, hernia operations, adenoid operations, gallstone operations, tonsillectomies and cataract operations.

Two additional procedure categories were added to our survey for this year: bariatric and gender reassignment operations. To explain, the decision to collect data on waiting times for gender reassignment operations follows a key Transgender Equality report which found that the NHS is letting down transgender people.

"The evidence is overwhelming that there are serious deficiencies in the quality and capacity of NHS Gender Identity Services. In particular, the waiting times that many patients experience prior to their first appointment (in clear breach of the legal obligation under the NHS Constitution to provide treatment within 18 weeks) and before surgery are completely unacceptable."[xviii]

Bariatric surgery was also added to the list of procedures for the first time, as this operation has been a contentious issue between national, local commissioners and providers. According to the National Institute for Health and Care Excellence[xix], patients should be offered help at obesity help centres, staffed with experts in weight loss, physical activity, cognitive behavioural therapy and other talking therapies, which make up 'tier 3' services before moving to 'tier 4', bariatric surgery. This surgery is commissioned nationally as opposed to the locally commissioned tier 3 weight management services. However, there is currently variable access to locally commissioned weight management services, which means patients may struggle to access surgery because of services commissioned in their local area.[xx]

This year when Trusts were asked which region/area their Trust belonged to they were asked to select from nine regions rather than four listed in last year's report. We asked this in order to provide a more specific set of geographical results. Trusts who responded and the area they belong to can be seen in Appendix 1.3.

The questionnaires were sent out by email, with a letter from The Patients Association's Chief Executive, Katherine Murphy, explaining the importance of our annual surveys. Several Trusts asked for operational procedure codes for each category of surgery, as the individual procedures with the subcategory of operation can be open to Trust interpretation. The list of procedural codes were provided for each subgroup of operation using OCPS Version 4.7. The full list can be viewed at the start of the Freedom of Information request in Appendix 1.1. The survey comprised of a total of 11 questions and free text was included for further comments and explanations of Trust's answers. Again, a copy of the survey can be found in Appendix 1.1.

Finally, a short note on consistency. For several of our quantitative questions, four Trusts gave 'less than 5' as a response, which is standard procedure when the number of operations or patients is low, to avoid the chance of an individual patient being identified. When these numerical responses were received, we converted these figures to zero for consistency and to ensure our statistical formulae operated correctly.

We decided to use zero in order to ensure we would not exaggerate the waiting time figures for these Trusts. These changes only affect the responses to a single question each for the Trusts. The Trusts and the questions where they provided an answer of less than five can be seen in Table 1.

Table 1

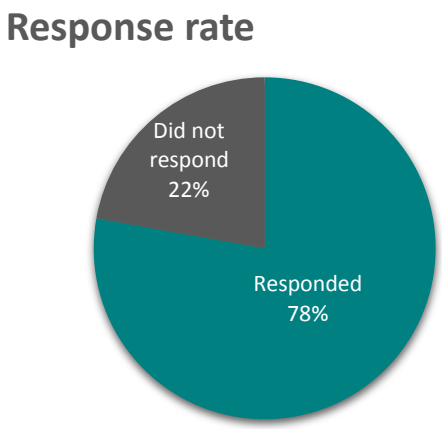
Trust	**Question**
Ipswich Hospital NHS Trust	Question 1, cataract operations.
The Royal Wolverhampton Hospitals NHS Trust	Question 1, cataract operations.
Birmingham Children's Hospital NHS Foundation Trust	Question 4, adenoid operations.
Northern Devon Healthcare NHS Trust	Question 4, adenoid operations; response to Question 11, adenoid operations.

5. Results

5.1 Response rate

A total of 112 NHS Trusts of the 144 Trusts asked completed the request. This provided a response rate of about 78% (77.8%), though some Trusts did not provide responses to all of the questions asked.

Figure 1



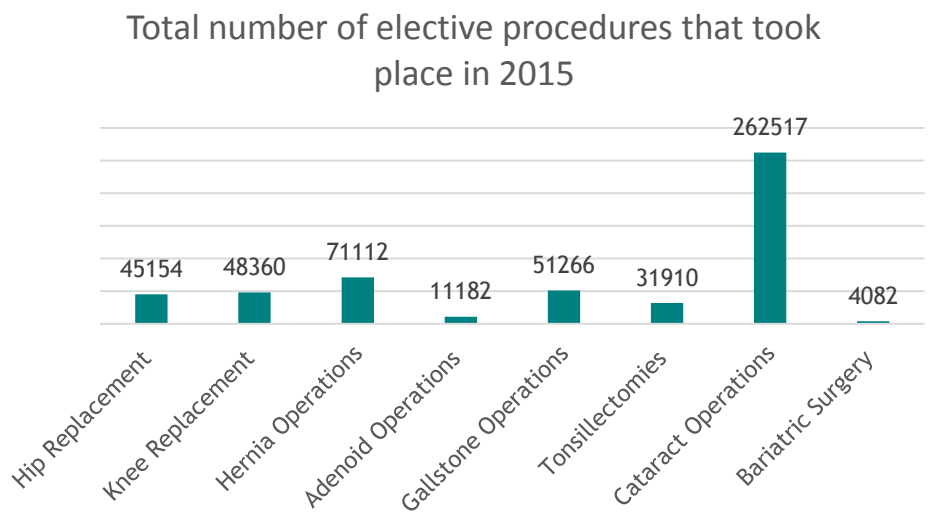
The Freedom of Information request was issued on 14th April 2016 and responses were collected until 13th June 2016. The response rate improved this year, this is likely due to the amount of time we allowed for responses after the initial 20 working days allowed for responses under the Freedom of Information Act, which we extended to reflect the complexity of the request.

Table 2

Response rates compared with previous years (taken from question 2, Hip)				
	2013	**2014**	**2015**	**Change from 2014 to 2015 +/-**
All	53.7%	70.5%	77.8%	7.3%
London	53.7%	62.5%	60.0%	-2.5%
Midlands and East of England	55.6%	79.6%	66.7%	-12.9%
North of England	58.6%	69.2%	91.3%	22.1%
South of England	48.8%	66.7%	83.3%	16.7%

5.2 Waiting times: Annual trends

Figure 2



For the Trusts which responded to our survey, a total number of 525,583 elective procedures took place in 2015 for the eight procedure categories of hip replacement, knee replacement, hernia operations, adenoid operations, gallstone operations, tonsillectomies, cataract operations and bariatric surgery. The most common completed procedure was cataract surgery (262,517), and the least common was bariatric surgery (4,082).

Unfortunately, gender reassignment numbers reported were too low for inclusion and meaningful analysis at below 10 cases. As such, we have excluded these figures from the totals.

5.3 Mean Average waiting time in days

Figure 3

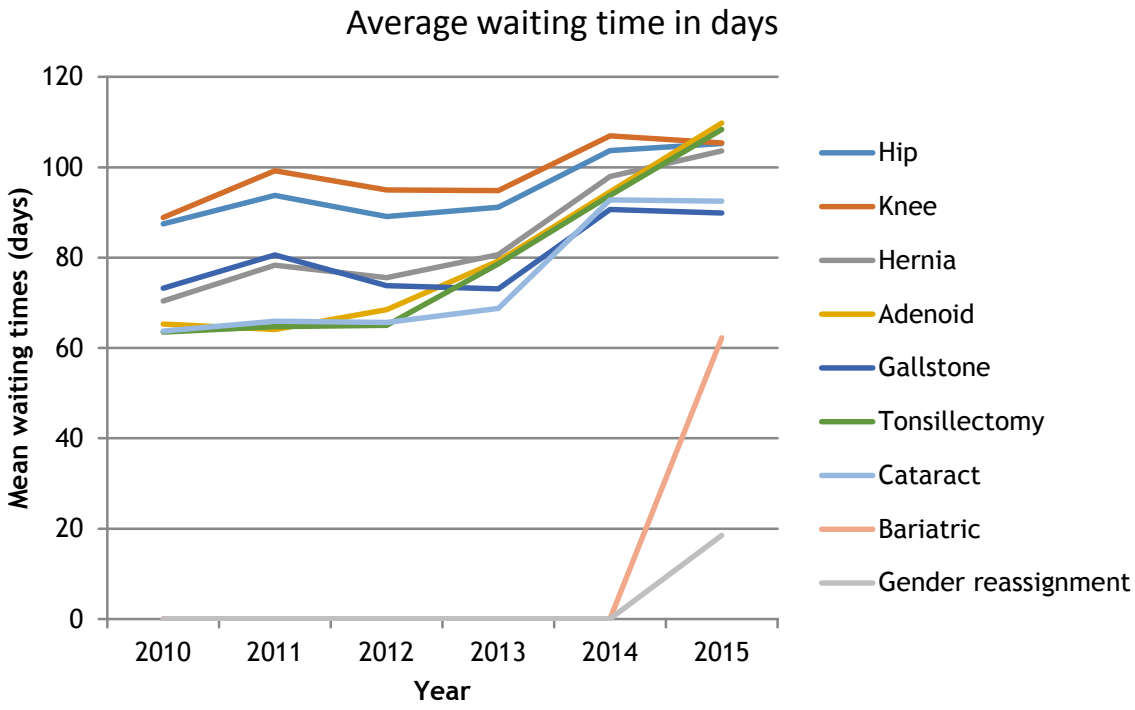


Table 3

Annual comparisons – mean average waiting time in days						
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Hip Replacement	87.5	93.8	89.1	91.2	103.7	105.2
Knee Replacement	88.9	99.2	95.0	94.8	107.0	105.4
Hernia Operations	70.4	78.3	75.6	80.7	98.0	103.6
Adenoid Operations	65.3	64.1	68.5	79.2	94.5	109.8
Gallstone Operations	73.2	80.6	73.8	73.1	90.7	89.9
Tonsillectomies	63.5	64.7	65.0	78.6	93.8	108.4
Cataract Operations	63.7	65.9	65.7	68.8	92.8	92.5
Bariatric Surgery	N/a	N/a	N/a	N/a	N/a	62.2

Responses varied greatly in the mean average waiting times reported. Most Trusts met the 18 week (126 days) target on average for the majority of these procedures. However, many Trusts also reported a large number of people who waited for many of these procedures beyond 18 weeks in breach of the 18 week target (figure 7).

The results reveal that an increase in overall mean waiting times between 2014 and 2015 has occurred for four procedures; hip replacements (+1.6%), hernia operations (+5.6%), adenoid operations (+15.3%) and tonsillectomies (+14.6%). Small decreases in mean waiting times for 2015 compared with 2014 were seen for knee operations (-1.6%), gallstone operations (-0.8%) and cataract operations (-0.3%).

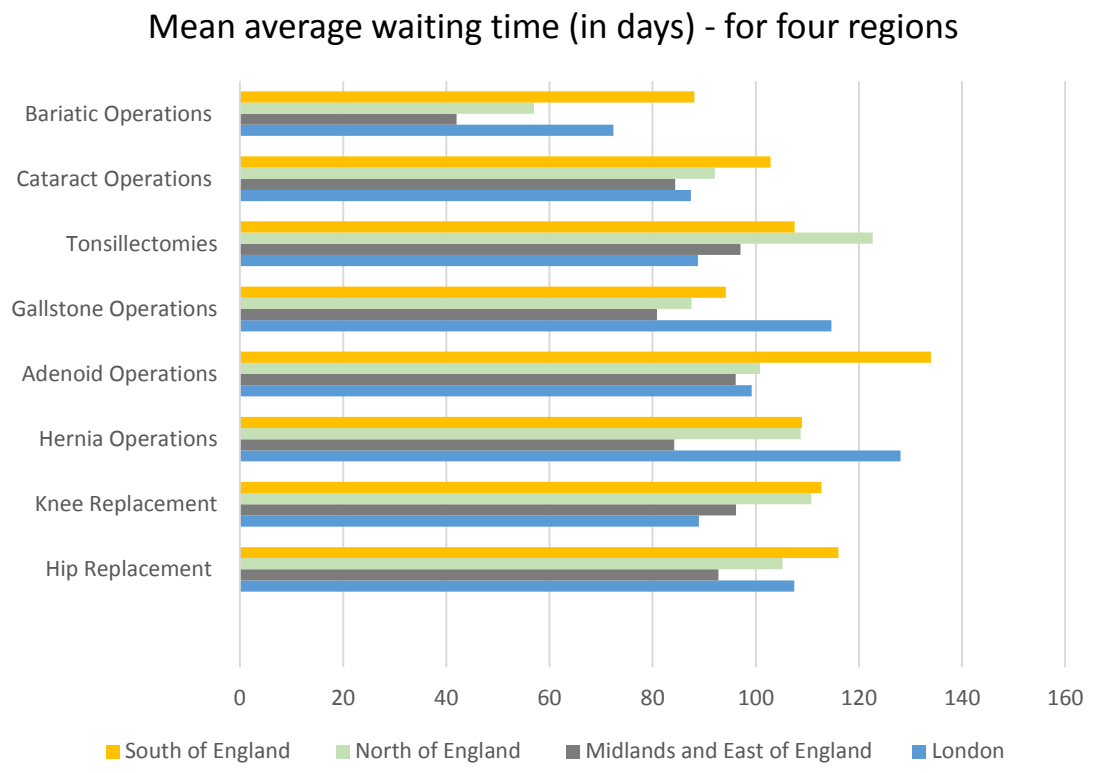
In England, patients are now waiting beyond 100 days on average for hip replacements, knee replacements, hernia operations, adenoid operations and tonsillectomies. In 2014 only two operation categories had a mean average wait of over 100 days: hip and knee replacements.

Adenoid operations had the longest mean wait time at 109.8 days, whereas bariatric surgery had the shortest at 62.2 days.

Graphs for each individual procedure mean waiting time in days in comparison to the last five years can be seen in the Appendix 1.2.

5.4 Mean average waiting time (in days): Regional data

Figure 4



The longest average wait was adenoid operations within the South of England at 134 days. Hernia operations had significant regional variation between regions, with Midlands and East of England reporting an average wait of 84 days compared with London region's 128 days.

Bariatric surgery had the most regional variation, with the South of England having the longest date of 88 days compared with shortest average wait of 42 days in Midlands and East of England. Cataract operations had the lowest regional variation of 18 days, with the South of England having the highest mean average time of 103 days.

The South of England had the longest average wait times for all the combined operations of the four regions, with the Midlands and the East of England had the shortest average wait times when the average wait time in days for each operation was calculated.

5.5 Average waiting time in days for the nine regions

Operations have been split between two graphs for ease of reference.

Figure 5

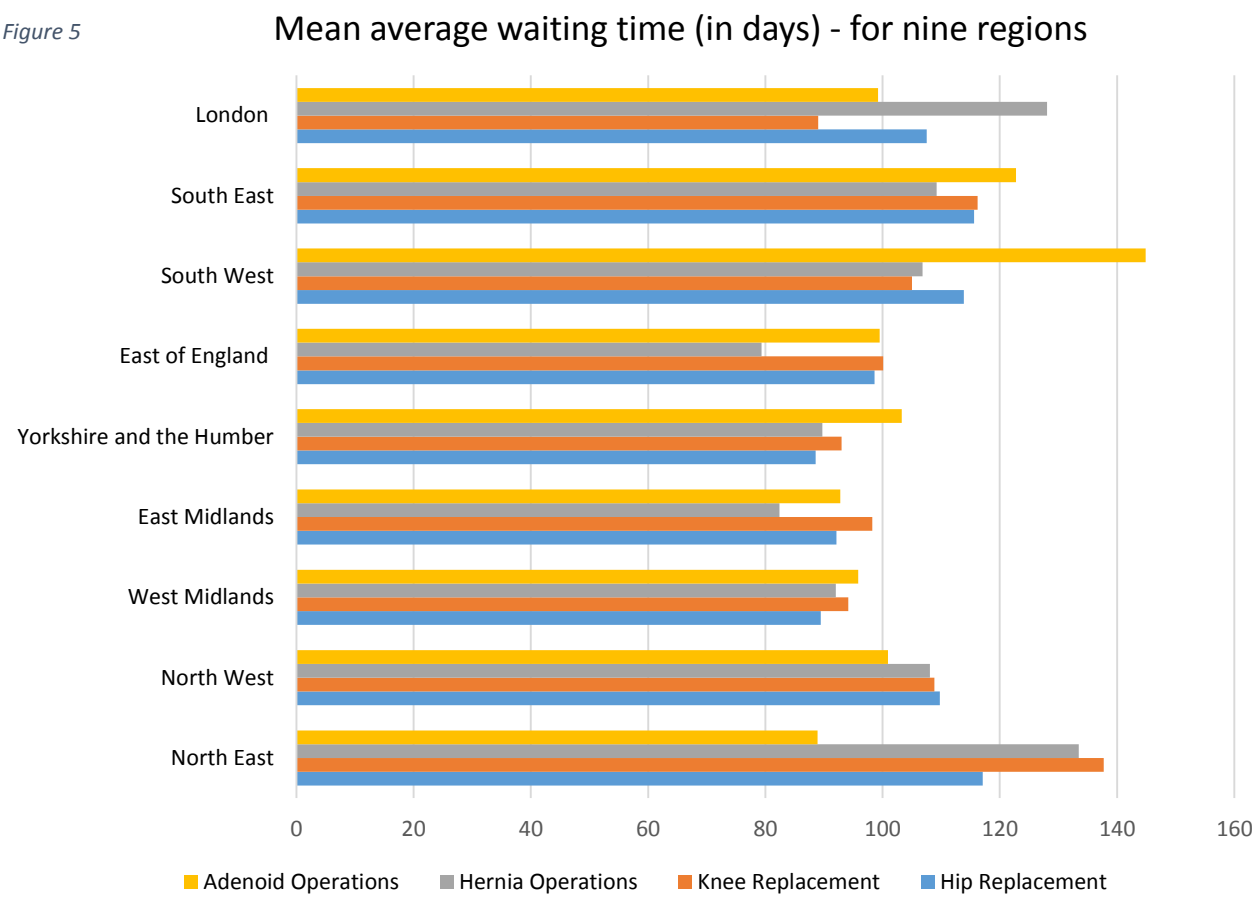
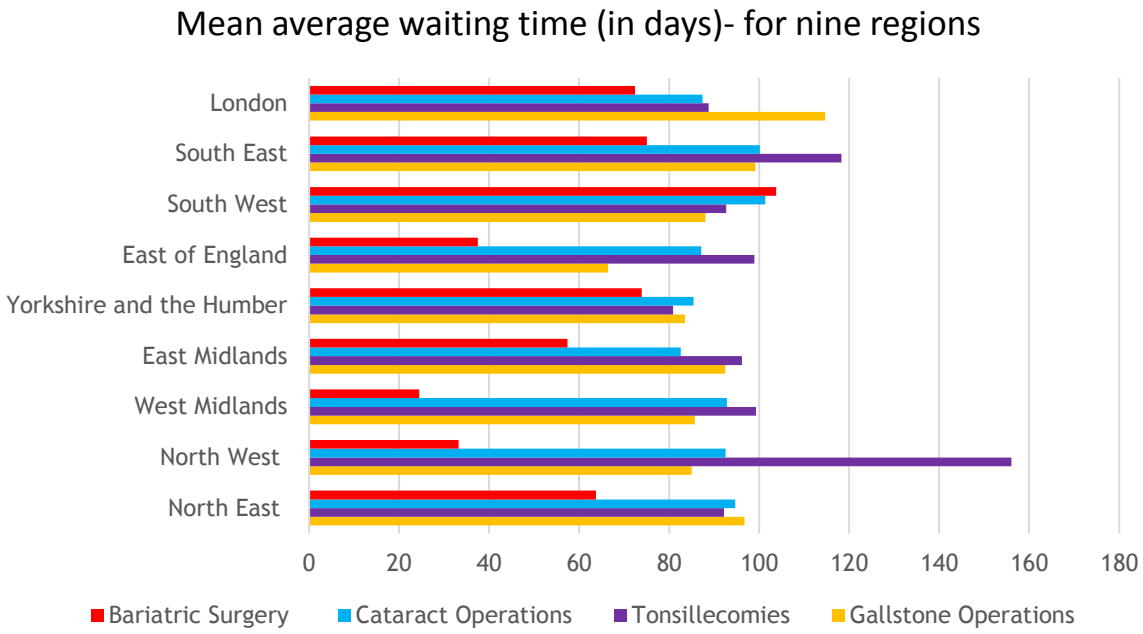


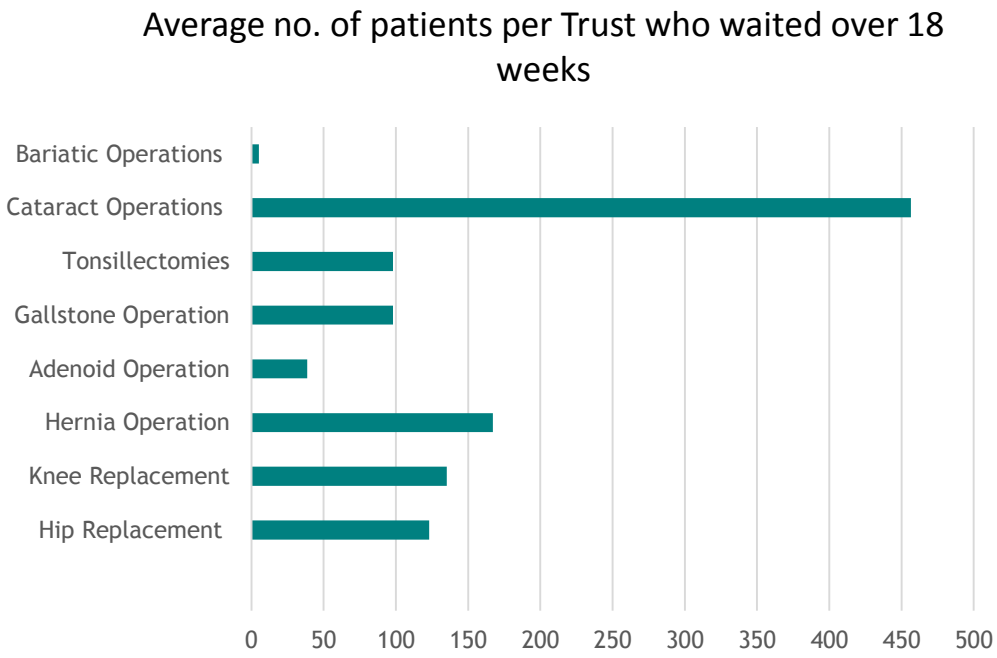
Figure 6



Bariatric surgery had the most regional variation within the 9 regions. The West Midlands had the lowest average waiting time at 25 days, and the South West had the highest at 104 days. Cataract operations had the lowest waiting times in the East Midlands of 83 days and the highest of 101 in the South West. The South West and the South East had the highest waiting time in days of all the regions at a total of 857 days when the average days of all regions are combined. East of England had the shortest waiting time in days of all combined operations at 668 days.

5.6 Average number of patients who waited over 18 weeks

Figure 7



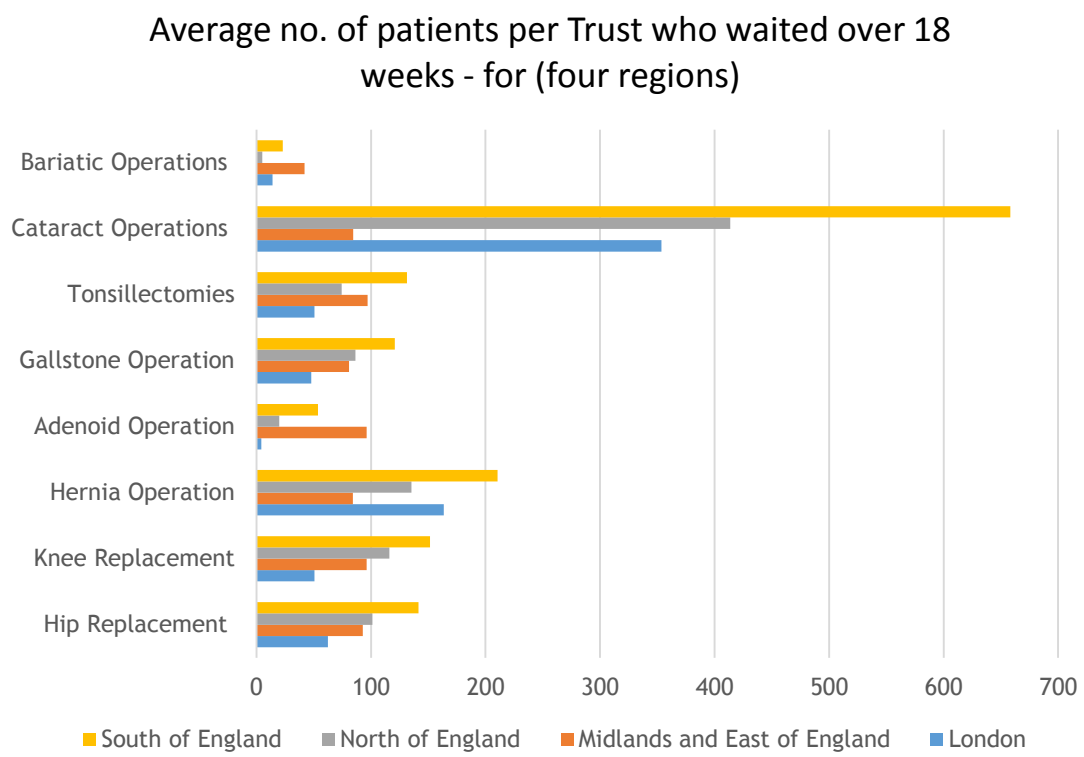
This is the second year where we have asked NHS Trusts for the number of patients who had waited longer than 18 weeks for elective procedures. Going over the 18 week limit, NHS Trusts are technically breaching patients' rights under the NHS Constitution.

The figures for 2015 show that the procedure which had the largest number of patients waiting over 18 weeks was for cataract operations (an average of 456.4 patients) followed by hernia operations (167.0) and knee replacements (135.2).

The total number of patients waiting over 18 weeks for the calendar year of 2015 was 92,739. Excluding the figures for bariatric and gender operations, which were not included in last year's survey, there were 92,258 patients waiting for over 18 weeks. Compared with the 51,388 patients waiting over 18 weeks in our previous survey covering the calendar year of 2014, this represents an increase of 79.5%. This is a substantial increase in the number of patients waiting for elective surgery beyond 18 weeks, and is in keeping with figures from other sources that the number of patients waiting for an elective procedure is at its highest level since 2007. However, we are unable to judge whether this represents a substantial increase in the proportion of all patients undergoing elective surgery – i.e. whether a greater percentage of all patients needing elective surgery are waiting over 18 weeks. This is because we do not have information on the total number of people who underwent elective surgery over this period. It is possible, though less plausible, that the proportion of patients waiting over 18 weeks may have remained the same or declined, as the total number of operations reported by Trusts increased greatly in 2015 compared with 2014, from 439,106 operations in 2014 to 525,587 in 2015. That said, even allowing for the fact that our response rate slightly improved this year, it is highly possible that this increase in the total number of patients waiting over 18 weeks for elective operations represents an increase in the proportion of all patients waiting for these surgeries.

5.7 Average number of patients per Trust who waited over 18 weeks (four regions)

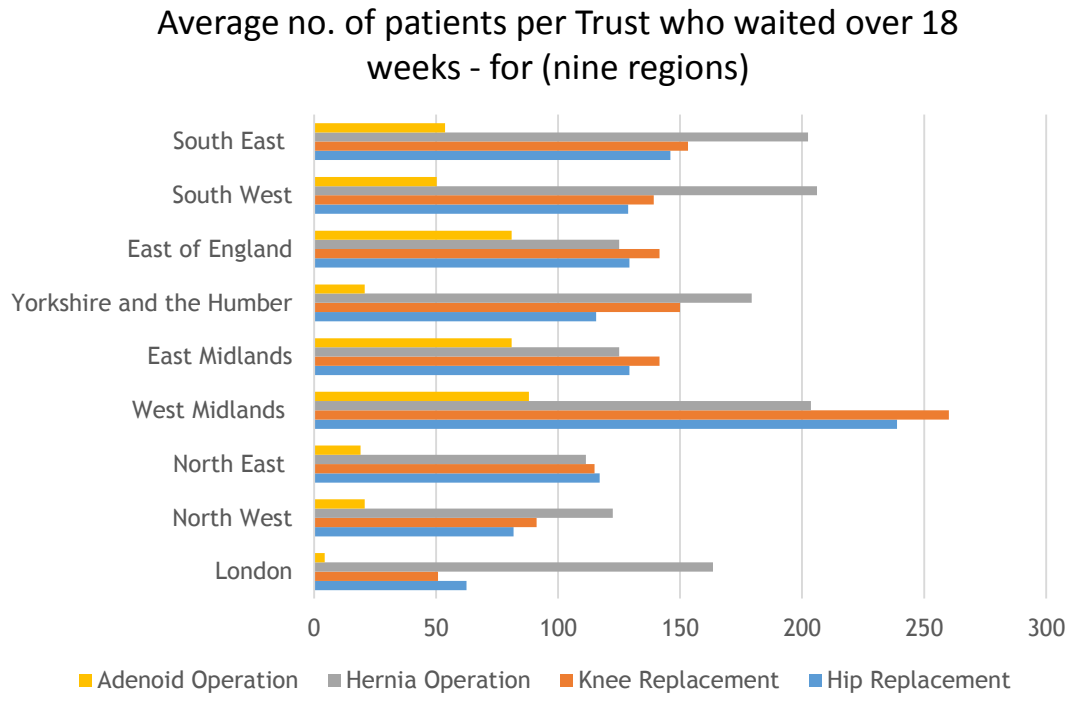
Figure 8



5.8 Average number of patients who waited over 18 weeks for nine regions.

Operations have been split between two graphs for ease of reference.

Figure 9



Cataract operations had the highest number of patients waiting over 18 weeks for the nine regions, with the South East having the most patients waiting of the nine regions at 671 mean average patients. The procedure with the lowest number of patients waiting over 18 weeks was bariatric surgery with a mean average of only one patient waiting over 18 weeks in the East Midlands and the East of England.

5.9 Average number of extra days patients waited for surgery beyond the 18 week limit for all regions

Figure 10

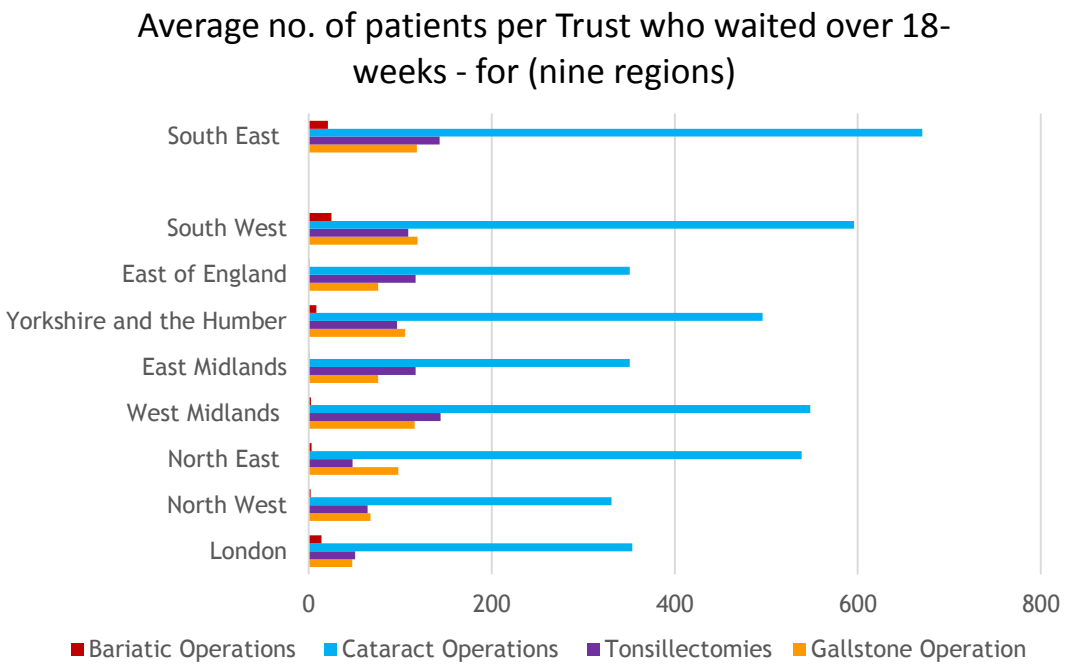
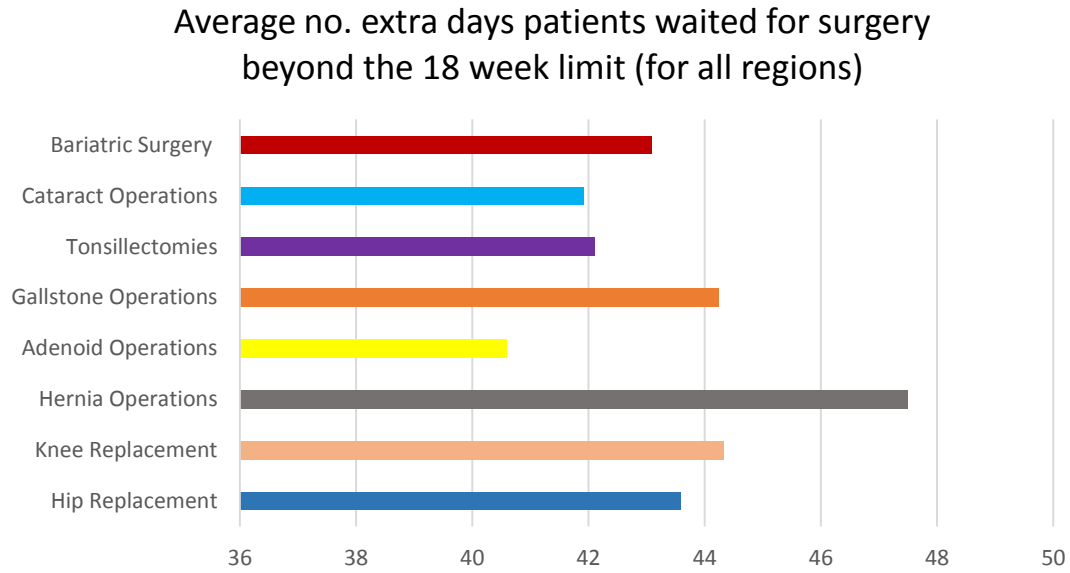


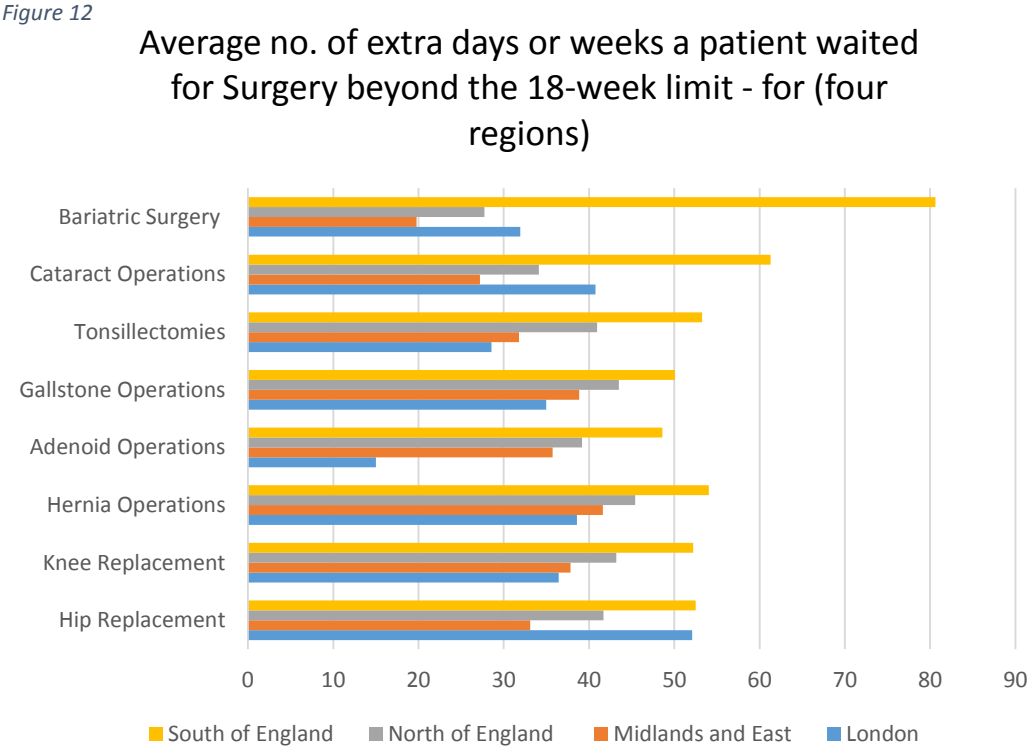
Figure 11



For the patients who had waited beyond the 18 week limit, we asked Trusts to tell us how many days on average this set of patients had to wait. Patients waiting for hernia operations beyond the 18 week limit had the longest additional wait time, with patients waiting for surgery beyond the 18 week limit for 48 days on average. For all other procedures, patients waited an average of over 40 days beyond 18 weeks. Adenoid operations had the lowest additional waiting time at 41 days on average.

5.10 Average number of extra days patients waited for surgery beyond the 18 week limit for four regions.

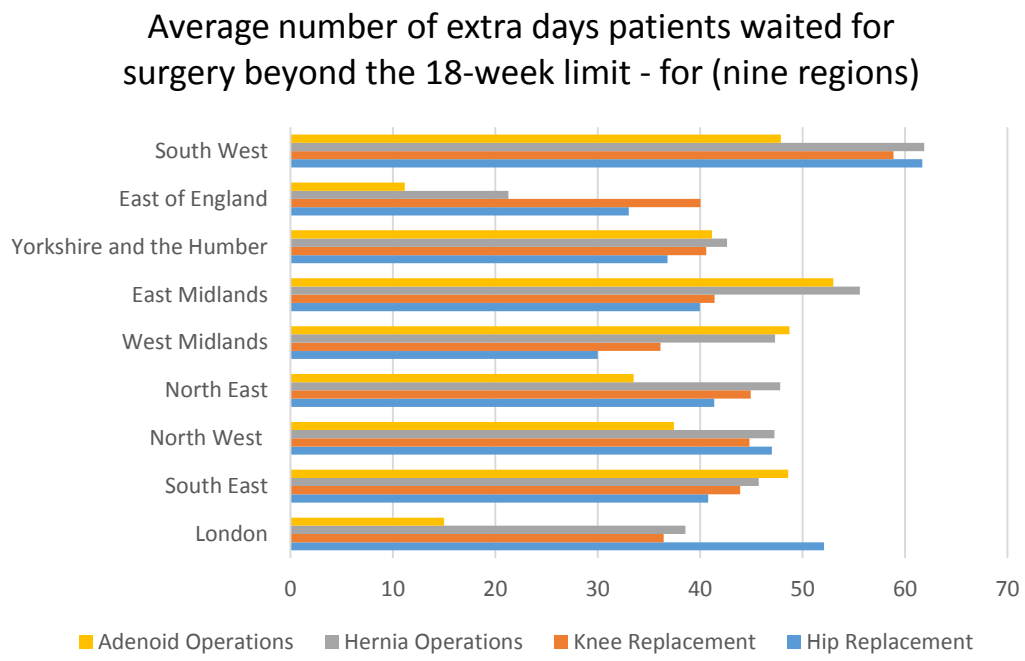
Figure 12



5.11 Average number of extra days patients waited for surgery beyond the 18 week limit for nine regions.

Operations have been split between two graphs for ease of reference.

Figure 13



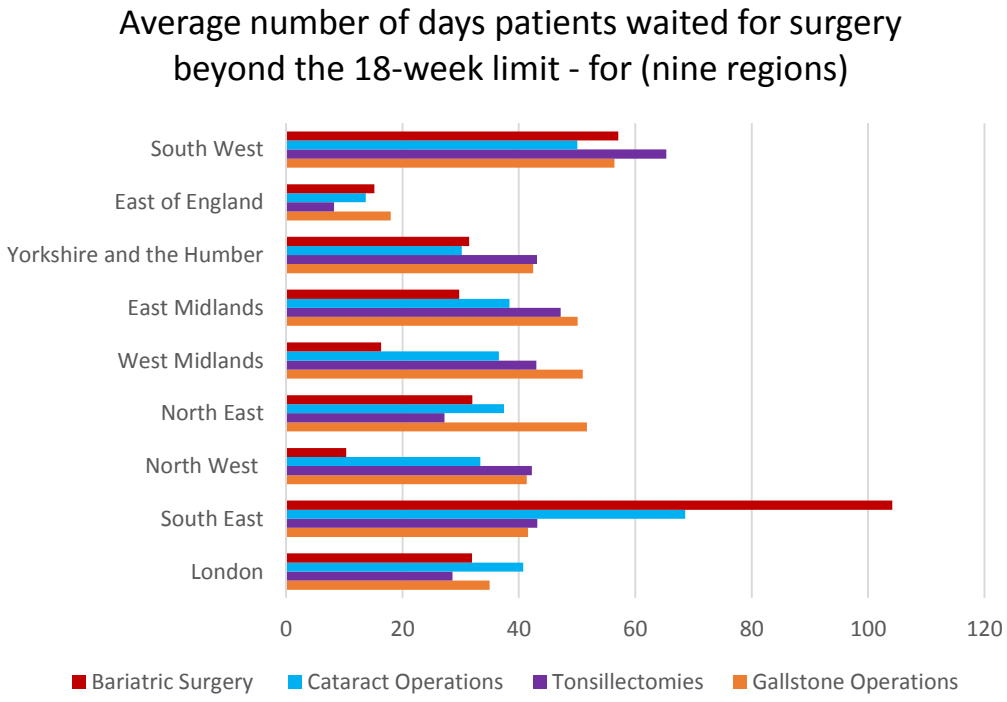
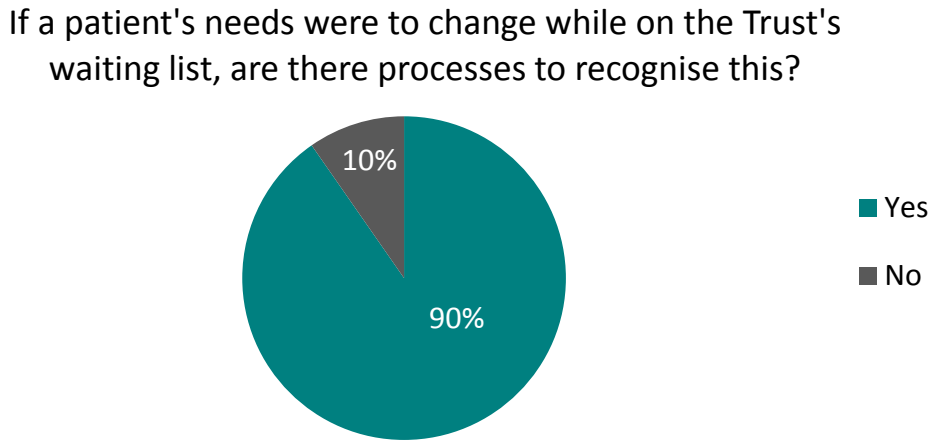


Figure 14

5.12 Changing clinical needs

Figure 15



Of the 93 Trusts that responded to this question, 90% of Trusts had a process to recognise changing patients' needs while they are waiting on the Trust's waiting list.

Trusts that did have a process to recognise patients' needs changing were asked to describe what was in place, and could select more than one answer.

Common pathways and processes would appear to be:

Table 4

Process to recognise patient needs	**Number of Trusts applying this process**
Pre-operative assessment	31
Active monitoring process and ongoing risk stratification undertaken at specialist level	15
Patient-led	13 - Many Trusts stated that patients will need to notify them, or emphasise that the patient needs to keep them informed)
GP notification, following patient appointment	12
Patient preparation	10 - Many Trusts stated that patients are given advance information about what to do and who to contact if their circumstances change

These processes are not mutually exclusive; many Trusts outlined multiple ways in which a change in a patient's circumstances is captured.

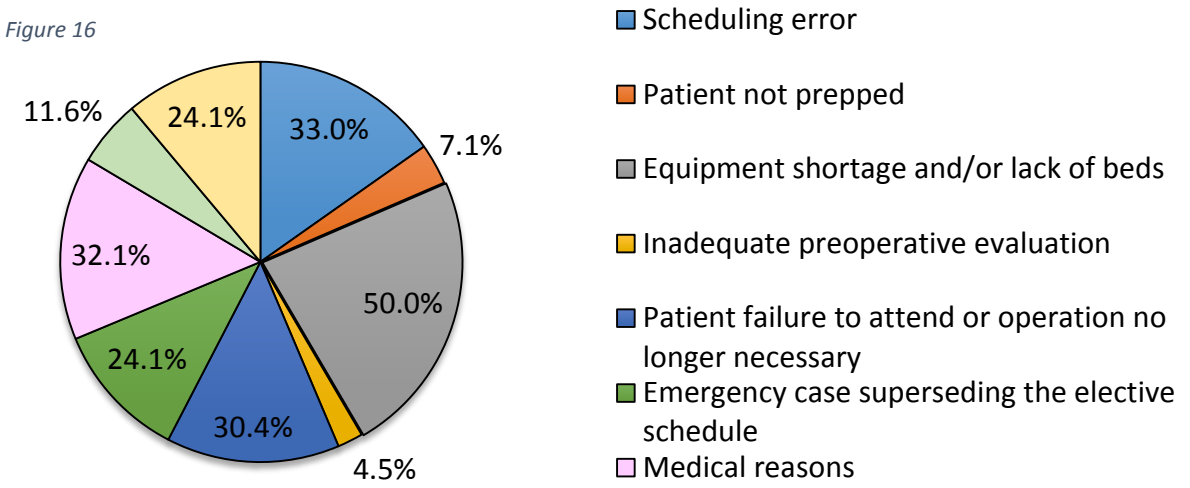
5.13 Surgeries cancelled on the day

Trusts were asked to provide the total number of patient surgeries cancelled on the day for the calendar year of 2015. A total of 99 Trusts responded to this question and the mean average number of operations cancelled was 752.6. The total number of surgeries cancelled by individual Trusts ranged from 8 to 3269. This is the first year the Patients Association has collected data on cancelled operations and this will be monitored in subsequent reports.

5.14 Common reasons surgery is cancelled on the day

Most common reasons surgery is cancelled on the day

Figure 16



Trusts shared the most common reasons surgery was cancelled on the day. Trusts were asked to self-select the most common reasons within their Trust from eight options and 'other', allowing Trusts to add qualitative detail if required.

'Equipment shortages and/or lack of beds' was the most frequently selected reason with 50% of Trusts reporting this option. This was followed by 'scheduling errors' including lack of theatre time (33.0%) and surgeons unavailable (36.6%). Inadequate preoperative evaluation (4.5%) was the least common reason surgery was cancelled on the day.

28 Trusts responded with qualitative answers to 'other' for reasons surgery was cancelled on the day. These are grouped in Table 5.

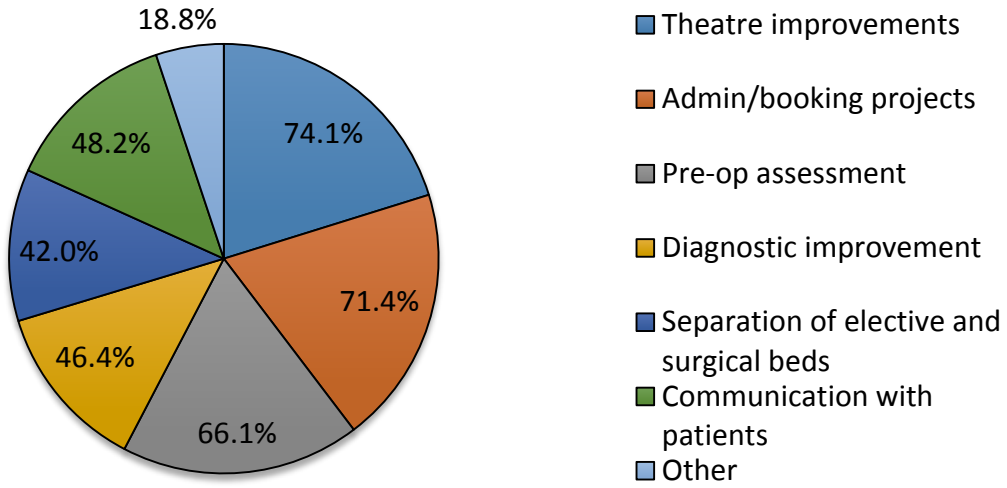
Table 5

Reason surgery was cancelled on the day	**Number of Trusts**
Theatre list overran / lack of theatre time	10
Patient cancellations / patient refused treatment	8
Patient unfit / clinical reasons	7
Bed unavailable	4
Equipment unavailable / failure	2
Surgery no longer required	2
Surgeon unavailable	2
Admin error	1
Theatre used for an emergency	1
Hospital cancellation	1

5.15 Improvement processes

Most common programmes to improve waiting times

Figure 17



Trusts were asked if they had implemented any improvement programs to improve access to meeting the recommended waiting times. Trusts were asked to select from six categories.

Theatre improvements was the improvement most commonly reported; 82.9% of Trusts reported that they were implementing this programme. This was followed by admin/booking projects and pre-operative assessment.

20 Trusts provided qualitative answers when asked to specify 'other' improvement programs to improve access to meeting the recommended waiting time. The responses provided to 'other' that fit the six categories are displayed in Table 6.

Table 6

Improvement programs	**Number of Trusts**
Theatres Improvement	5
Admin/booking projects	4
Pre op assessment	3
Diagnostic	1
Separation elective and emergency beds	2
Communication with patients	2
Theatres Improvement	5

Other' responses which did not fit with the six categories above are collected below in Table 7.

Table 7

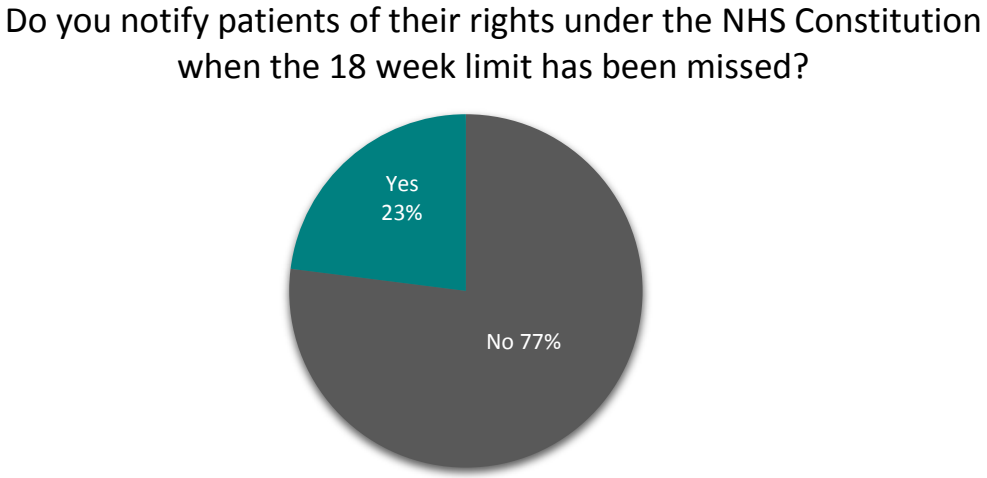
Improvement Programs	Number of Trusts
Demand and capacity management	3
Staff training	2
Transferring patients waiting to other providers	2
Expansion of facilities	1
Additional temporary staffing	1
Sharing assets across providers e.g. MRI and theatres	1
Pooling waiting lists across providers	1
Designing new care pathways	1
Strengthening management oversight on waiting lists	1
IT solutions	1
Cancelled operations project	1

5.16 Bans on procedures

Trusts were asked if they had implemented any bans on referrals for any type of elective procedures. 99 Trusts provided a response for this question and two Trusts said that they had implemented bans on referrals. However neither Trust proceeded to name which procedures were banned.

5.17 Notifying patients of their rights under the NHS Constitution

Figure 18



Trusts were asked whether they notified patients of their rights under the NHS Constitution when the 18 week limit had been missed. 100 Trusts responded to this question, with 77% saying they did not notify patients of their rights, while 23% said they did notify.

Trusts were asked to specify how they notified patients of their rights. Their responses are listed in Table 8. Leaflets and information available on the Trust website were the most common method.

The qualitative responses indicate that most of the procedures in place required patients to take a proactive approach to finding the information. Only two Trusts made specific reference to their procedure after the 18 week limit had been missed. Trusts that were providing information about the NHS Constitution mostly did so at the beginning of a patient's pathway.

Table 8

Method to notify patients of their rights under the NHS Constitution	**Number of Trusts**
Leaflet	6
Information available on Trust website	5
Patient Enquires	4
Information contained within the first letter of communication	3
Information contained within all appointment letters	2
Discussions	2
Advertising alternative providers	1
NHS Choices website	1
Patient telephoned and offered a consultant with a shorter waiting time	1

6. Introduction to themes and case studies from our helpline

Waiting times are more than a statistic, and behind every figure is a patient waiting for their surgery. We hear about the impact of delayed and cancelled operations every day on our national helpline from patients and their relatives. Delayed and cancelled operations limit independence, affect wellbeing and mobility, and can also create financial pressures on patients and their families. Prolonged waiting times frequently increase the pain and suffering of patients and this could be avoided by timely surgery. Patients continually express their concern to us that delays will reduce the effectiveness of their operation, meaning patient safety is often a risk. Waiting times can have a negative and significant impact on the health gain from surgeries such as hip and knee operations and therefore it is crucial that they are performed as soon as possible to minimise further patient risk. We have also found that delayed waiting times negatively impact a patient's overall perception of the healthcare service based on quality, satisfaction and likeability.

The Patients Association have chosen six case studies of patients and their relatives who have called our helpline which we believe best illustrate the problems on waiting times we continually hear about. Patients were asked a series of questions during a telephone interview about waiting for elective surgery, after which their answers were then written up into personal accounts and sent to the patients for approval.

6.1 The following questions were asked to patients:

1. What surgery were you waiting for or which surgery are you currently waiting for?
2. How long did you wait/have you been waiting for surgery?
3. Were you aware of the 18 week target time for elective surgery?
4. Are you aware of the NHS Constitution and the waiting time rights contained within this document?
5. Were you able to keep working while you were on the waiting list for surgery/was there any financial implications to your wait?
6. Were aspects of your wellbeing affected (e.g. social, relationships, mental wellbeing)?
7. Did you consider going for private treatment?
8. Were the reasons for your delay in your surgery communicated to you?
9. Were you given any support when your surgery was delayed?
10. What could have made your experience better?
11. Has your experience changed how you view the NHS?
12. Why did you reach out to The Patients Association?

These case studies serve to highlight the human cost of waiting in processes that have fallen far short of good practice. While we are aware that this small number of stories cannot seek to represent a national picture - indeed some of the cases can be seen as outlier experience compared to the quantitative data we have collected - these stories seek to highlight the human experience behind waiting times.

There is a need for providers to retain patients' trust and loyalty through timely service and transparency. Whilst these cases do not represent the practice of all Trusts in England, we believe the accounts provide a vital insight into the issues patients face, which should contribute to the national debate to improve waiting times.

We have identified three core issues from the interviews that were conducted and from our wider case study database that need to be addressed.

- **Issue One - *Communication***

Patients felt that the onus was on them to call their Trust and ask for information about when they could expect to receive their surgery.

Lack of communication between Trusts and hospitals is a major cause for concern. Patients often feel like they have been forgotten about, which adds to the stress caused by delays. This results in a lack of trust between patients and the NHS. Patients have detailed how they are often passed from person to person and given no real answer to their problems. Many patients have spoken about feeling like there was a lack of transparency given the difficulty they had in obtaining information.

- **Issue Two- Psychological distress**

There is a significant psychological burden on patients waiting to be given a date for surgery and for cancellations on waiting times.

We have heard how the wait to be given a surgery date can cause psychological distress for patients. Not being given a date means that patients are constantly waiting and wondering when they will be seen, disrupting both their daily lives and any plans they may wish to make for the future. This causes an increased and unnecessary burden on patients already affected by their existing condition, which is also often felt by patient's families.

- **Issue Three - Patient Safety**

Patients want to know if long waiting times have caused, or will cause their condition to deteriorate, so they can be prepared for their condition to be different from when they first started waiting. Patients are also concerned that the long waiting times will affect how successful their surgery will be. Patients often have less mobility and suffer significant pain when they are subjected to long waiting times.

Patients are often not monitored throughout their wait for surgery, meaning that their condition may have altered considerably from when they last saw a clinician. This can result in patients needing more invasive or riskier surgery due to increased pain or suffering that could be avoided with timely surgery. Patients should be entitled to know how their wait will affect their surgery and if this will have any further complications. Not knowing how their condition may have changed and if the recovery time will be longer means that patients may not be able to plan for the future, further disrupting their lives.

7. Case studies

7.1 Case study – One

Mr A is 84 and has had one knee replacement, but is in need of a second. He has been waiting a year for surgery and within this time no one has told him about the 18 week referral to treatment target or explained his rights under the NHS Constitution. He has felt a significant amount of pain in his knee and has fallen several times. He is now starting to feel pain in his other leg.

"In August 2015 I was told my operation was urgent. I phoned the hospital every month and the first time I got through to the consultant's secretary I was told I wasn't even on the list and that they needed more time. I was put on the list and told the operation would be in January, then I was told February, then it was March, and then they couldn't tell me when it would be.

I have a date now, but when I called my doctor to tell him I could not get a date for the operation although he tried, he still got nowhere. The only thing I was able to do is call the hospital and tell them how much pain I was in and that I had fallen over a few times, but it didn't seem to make much of a difference.

One morning I was trying to do some gardening, I fell over and bruised all my ribs, cut my legs, cut my elbow and I had to lay there for ten minutes because I couldn't get up. I can't even go shopping with my wife, I just can't walk around or stand for any period of time; it's massively affecting my quality of life. I had a bout of depression over this, thankfully I am over that now. The reasons for the delay in my operation were never communicated to me and this has made me feel left in the dark. One time I phoned to ask when I would get my date for surgery they told me I was on the second list, which is the list if anyone drops out, but that didn't mean a thing to me. If they were to give you a date, even if it was a long way ahead it would make a big difference.

It's definitely changed how I view the NHS; it's the not being able to get information that's the big thing. You seem to be pinned to the house most of the time.

People have been very nice to me, but nothing's happened. The thing is you don't really want to complain, you don't want to feel like you're trying to jump in front of people. We have always been used to taking our place in life and that's what you expect to do now, but no one's taking any notice so something has got to be done. That's why I got in touch with The Patients Association. That's when things started to change, we knew we were being overlooked. I finally got my surgery in June when they called me and asked if I would go private, I had the surgery two weeks later."

7.2 Case Study - Two

Mr. B is 72, in April 2016 he had surgery for gall bladder removal, he was experiencing abdominal pain and was referred to A&E by his doctor in June 2015. Last year he went on the waiting list, but was sent an appointment for 7.30 am in November, which he had to decline because he lived too far away from the hospital to be able to have surgery at that time in the morning without a pre-admission stay. He asked to be referred to a closer hospital which caused a further delay.

"My operation on 2nd February 2016 was cancelled because there were not enough beds available, **I had to just keep my fingers crossed and hope my symptoms wouldn't worsen when in actual fact they did and I was rushed to hospital** on 7th March. I was kept in hospital for five days and the consultant was unaware that I had an operation scheduled. I had my operation on 7th April 2016, which went ahead despite the junior doctor's strike, the operation was 100% successful and I believe they did a good job.

What I do realise is that at all times they are under pressure. There are not enough doctors and too many patients. I felt like it was the best that could have been done for me.

Waiting caused disruption in my life because I had many episodes of quite severe symptoms. I was confined to my bed and taking painkillers to try and subdue the symptoms. From when I was referred to the hospital last June (2015) to the point where I had an operation on 7th April 2016, I had lost over a stone in weight, I had become really thin and I physically deteriorated quite quickly. I had no strength or energy and I looked shocking. I had been fit and luckily that fitness sustained me throughout, I feel like any lesser person may not have survived it. I am grateful that after my operation that the weight is back on and I can do some jobs now that I couldn't before.

I realise now more than ever that the NHS is a jewel in the crown of this country and it should be maintained. For me my experience was one of understanding, I felt the NHS were struggling themselves and I have got nothing but praise for the brilliance of the team with the little resources they have. They did the best they could under a lot of pressure."

7.3 Case study - Three

Mr C has been waiting for a hip revision. He was first referred in November 2014 and got a date for the operation in June 2016. He was not told about his rights under the NHS Constitution and there was no conversations about whether he had changing clinical needs or discussions around his wellbeing.

"I must have rung them twenty times, all you do is get passed from one person to another. I was unable to celebrate my 40th wedding anniversary as I wasn't sure what the date of my surgery would be. I feel the system would be improved if there were one to one conversations with someone who would come out with a straight answer and say 'no you're not coming in for the next few months', then you can carry on with your life, but not knowing means that you have to put everything on hold in case you do get the call to come in.

My experience has changed how I view the NHS and now I wouldn't take anything at face value, I felt like I was just an NHS number. I think there is a lack of transparency, I don't know whether it's to do with the figures and hospitals trying to get these within the government guidelines. **Because my surgery has been left so long it's going to be more invasive. When I was first seen by the doctor he told me that I couldn't wait any longer because of the risk of further damage. Patients are being put at risk by long waiting times, it means it's a much longer and riskier surgery**."

7.4 Case study – Four

Ms D has been on the waiting list for spinal surgery for six months, the reason given for the delay in the surgery is the surgeon's broken hand and a junior doctor's strike.

"Nobody has kept me in the loop, I have had to make three phone calls to the surgeon's secretary in order to get any information. They keep telling me how many other people are on the list and that it isn't their problem. What I want to know is how far I am up the list? How close am I to actually getting something done? When it came to the 18 weeks being up I contacted The Patients Association because I wasn't sure what I was supposed to do, this is really restricting my life.

I can't apply for employment because I don't know what I am going to be like after my surgery, whether it will work or not, whether an employer will allow me to have up to six weeks off when I have just started a new job. Waiting has a financial implication and it's getting me down, I am in immense pain and I am not getting anything from the hospital, they are not forthcoming at all.

The test from last October will be out of date because my doctor said there had been significant deterioration from the ones from May to October. So from October to now there will be another deterioration. It won't just be the same. I haven't been seen by a doctor in the last 6 months, you would think they want to be plotting the progress or deterioration or what's happening to you. Making excuses doesn't help someone when they are waiting for an operation that's going to improve their lives. **I want to know; is my condition is going to deteriorate because you have made me wait six months? So that I can be psychologically prepared for it to be different to what it was six months ago.**

Communication on a regular basis could have made my experience better, when you're on the waiting list for that amount of time it's so important that they update you. If I was told in January there was nothing they could do then I'd be able to learn to live with what I have got, but because they said something can be done it plays with your mind. You think, "well this must be dangerous I have slipped discs and I'm walking around like that and my doctor is telling me to try and avoid slips, falls and car accidents", it could be catastrophic basically. I was never given an option of going to a different surgeon or hospital because of the delay, I was under the impression that my only solution was to wait. I have sympathy that the NHS is under pressure, but I think people waiting for surgery still need explanations."

7.5 Case study – Five

Mrs E's husband needs a hip replacement, and he went to see a doctor in December 2015, where later he was told that he could try physiotherapy to see if this improved his condition. When this failed to improve his condition he was referred for surgery at the end of February 2016. He still does not have a confirmed date for his surgery.

"We were aware of the 18 week referral to treatment target because we looked it up online. We also looked up NICE Guidelines. My husband tried to make an appointment for surgery at his preferred Trust online, but there were no consultant appointments available. This meant that he was referred back to a musculoskeletal specialist at another Trust, which he had already seen, although didn't realize at the time. When the initial Trust finally said that they could do the operation there we had wasted 2 months, and the consultant had complete disregard for the fact that he was originally referred elsewhere at the beginning of March. He was insistent that the 18 week target starts from the second time that he was referred, which was

at the end of April. I also feel that my husband's doctor should have told him about the 18 week target. We wouldn't have known about it or where to look if a friend hadn't told us about it. Neither of us ever really use our doctor and we do feel let down by the system. My husband also feels that the Trust, which was further away from where he lived, didn't care about trying to carry out his surgery as he lives in a different area. If a patient has a choice then it shouldn't matter where you come from.

My husband is a self-employed as a farmer, so it is really important that he knew when his surgery was going to take place. His work is seasonally dependent so lambing time was a real nightmare as he had still not got his surgery. I work full time too and although I would be able to help on the farm my bosses wanted to know when his surgery was so they could prepare for me taking time off, getting farm hands is a financial burden for us.

No-one has yet being able to help us, or tell us who to contact to find out something, and we feel like we are hitting a brick wall. All we want to know is an idea of a date. As we have been so messed about it is not looking like being anywhere close to being within the 18 week target, and this is a serious problem for us, as once October comes, and all our cattle are inside, and the sheep needing more care outside then there is a lot more work, and we will need to pay someone to do this. It is a very big worry for me that my husband will be wanting to do things on the farm before he really should be and cause himself even more harm."

7.6 Case study - Six

Ms F has been waiting for upper GI surgery since March of this year and now has a date set for June. After calling up due to the immense pain she was told she would likely be waiting 36-40 weeks as her consultant was off sick and they couldn't provide an exact date. She was not told of her rights under the NHS Constitution and was not given any support or guidance about alternatives throughout her delay.

"I was put on the waiting list around Easter time and when I went to get some test results I was told that my consultant was off sick and that the new consultant couldn't help me until he had contacted my old consultant. I was suffering from immense pain, feeling like my life was being put on hold, so I called up and spoke to the secretary who said I wouldn't be having surgery for roughly 36-40 weeks. That's when I contacted The Patients Association as I didn't know what to do. I was advised to write to the Chief Executive of the Trust, who eventually helped get a date sorted. I found this process a bit intimidating, but if I had not done this and been put through to another consultant my life would still be on hold and I would still be waiting for surgery.

Whilst I was waiting I asked if I could go to another hospital or if there were any other alternatives and they just said no and didn't explain anything to me. The delay has caused a real problem as I'm a teacher and continually kept having to take days off until I was no longer able to work anymore. Being off sick has caused me extra stress as I was constantly monitored and asked why I was unable to work. It has completely taken over my life as I can barely eat or do anything else. At one point I even considered going private as I wasn't being given any information.

It's very easy to feel disheartened when you haven't been given any support during the delay such as information about other options, or about my rights under the NHS constitution. I felt like a burden asking about my surgery.

Although the Chief Executive and the new consultant have been very helpful I'm not impressed with the NHS. I shouldn't have had to be so persistent and reach out to the hospital so much to get any information, they should have communicated much better with me in the first place.

8. Findings and Conclusions

Too many patients are waiting too long for surgical procedures. Behind waiting time statistics there are patients who are forced to put their life on hold, suffering psychological distress, pain and having to suffer the financial burden of in many cases not being able to work. Patients are distinctly aware of the safety risks of waiting too long for surgery. Many of those interviewed spoke about the worry they feel that their surgery will be more intrusive, less successful and have a longer recovery time. Timely access to high quality compassionate care must remain a key priority for the NHS despite financial pressures.

This report has shown an increase in operation waiting times for four operations (hip replacement, knee replacement, hernia, adenoid and tonsillectomies) between 2014 and 2015. The data also suggests that the average waiting times for these procedures are above 100 days. Many NHS Trusts are continuing to fail to meet the 18 week target for many of these procedures, and virtually all Trusts have some patients who are waiting more than 18 weeks. In 2015, 92,739 patients waited over 18 weeks, compared with 51,388 patients in 2014 for at least one of the procedures covered by our survey.

While 2015 saw a renewed commitment to meeting waiting times in a number of policy announcements, there remains a regional disparity among waiting times, with a 'postcode lottery' for timely access to surgical treatment. Variations remain at all stages of the pathway, though we were encouraged to see improvement programs being put in place by Trusts to improve waiting times. It is essential that good practice is shared between Trusts in order to benefit patients nationally. With most Trusts identifying equipment shortages and/or lack of beds as the main reason surgery was cancelled, there is still much to be done to ensure that Trusts have the right resources is especially important as demand continues to rise.

For the NHS Constitution to have value it must be actively promoted as a resource to empower patients to exercise their rights to excellent care at every stage of their care pathway, within a compassionate, respectful NHS. It is therefore a significant concern that 77% of Trusts who responded said that they are not notifying patients of their rights under the NHS Constitution when the 18 week limit has been missed.

The Patients Association continues its pledge to work with the NHS to help bring waiting times down and build a more responsive health service with less variation between Trusts. Patients and their families should not have to wait any longer because of where they live. We also recognise that patients have a key role to play in reducing waiting times. While there are often legitimate reasons patients cancel their operation on the day, we must continue to encourage patients to attend appointments and to inform services as early as possible if they will be unable to attend. We all have a shared responsibility to work towards improving our NHS.

9. Limitations

Our results demonstrate a continued rise in waiting times for elective surgery, in keeping with the trends seen in our previous annual reports on this subject. However, for any quantitative research, it is important to recognise and identify limitations within the data collected, or methods used to collect and analyse this data.

This is the first year that we have chosen to expand the Freedom of Information request beyond the questions obtaining data in the number of procedures that took place and the average waiting time in days, referral to treatment waiting times problems and the number of patients who waited over 18 weeks. As such, there are a range of findings from this year's report which are new, and cannot be compared against our previous reports.

We identified a need to improve several of these questions for future surveys. For questions 7 and 8 where Trusts were invited to answer the most common reasons surgery was cancelled on the day and whether the Trust had implemented any improvement programs to improve access to meeting the recommended waiting times, Trusts were not given a set number of answers they could tick, therefore some Trusts selected more answers than others. The question related to patients surgeries cancelled on the day was queried by some Trusts, asking for clarity on whether this referred to all operations, elected operations or those with the listed procedural codes. This may mean that a small minority of answers to these questions may over- or under-estimate the surgery cancellation figures.

It was also noted that several Trusts were unable to provide data to questions 3 and 4 where Trusts were asked to set out the mean average waiting time (in days) and set out the number of patients who waited over 18 weeks due to changes in the way in which this data is recorded by the Trusts. This makes it difficult to obtain a true national picture on the specific issue tackled by these questions.

There are also limitations on the range of data obtained. While the maximum response rate achieved was 78% not all Trusts gave answers to all of the questions. When compiling both the mean average waiting times and the mean average number of patients for whom the RTT time exceeded 18 weeks, we controlled for Trusts which either did not respond to these questions or did not hold the relevant data. The list of Trusts that responded to this year's survey are not the exact same Trusts that replied to the 2014 survey, indeed there are Trusts that replied to 2015 survey who did not reply to the 2014 survey.

However, given that the responses are from the clear majority of all NHS Trusts, the larger dataset could be considered a firmer guide to the trends in waiting times. Our overall finding that elective surgery waiting times has increased broadly in line with recent reporting on issue.[xxi]

10. Recommendations

- The rights of patients contained within the NHS Constitution should be upheld and promoted by all Trusts, using a set of common standards. Patients should not have to proactively seek their rights contained within this document.
- Patients should be told of their rights under the NHS Constitution at the start of their waiting process and they should also be made aware of their rights after the 18 week target has been missed.
- Patients should be provided with as much information before their operation as possible and the length of time they will need to recover which would allow them to pre-empt possible dates and arrange alternative plans to ensure they are available.
- Patients should be kept informed of changes to their operation date, in a way they have chosen that fits around their needs, e.g. via email, letter, texts, and/or phone calls.
- Patients must have access to support throughout the waiting time and their clinical needs and well-being must be monitored.
- NHS England and the Government should continue to research and identify Trusts that have successful improvement programs in place and facilitate shared learning.

11. Appendices

Appendix 1.1 – Freedom of Information request

Freedom of Information: Elective Surgery

Dear Sir/Madam,

The Patients Association is a national independent health and social care charity which listens to the experiences of patients and speaks up for change. We continue to hear via our Helpline and through our own research that there are regional variations in waiting times for certain elective surgical procedures. We have undertaken activities to monitor this situation over the previous six years, and continue to do so.

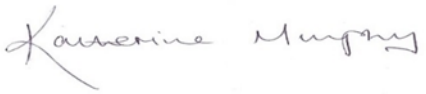
In response to these continued reports, we are carrying out an investigation into the waiting times for 9 procedures across NHS trusts in England. These procedures are:

- Hip
- Knee
- Hernia
- Adenoid
- Gallstone
- Tonsillectomy
- Cataract
- Bariatric
- Gender reassignment

Please refer to the procedure codes for each operation category.

The Patients Association would like to obtain this information under a Freedom of Information Act 2000 Request. I expect your response within the statutory period of 20 working days. The specific questions are detailed below please complete and return to Ruby@patients-association.com

I look forward to hearing from you.



Yours faithfully,

Katherine Murphy, Chief Executive

The Patients Association

Hip Replacements
W37Total prosthetic replacement of hip joint using cement W37.1 Primary total prosthetic replacement of hip joint using cement W37.2 Conversion to total prosthetic replacement of hip joint using cement W37.3 Revision of total prosthetic replacement of hip joint using cement W37.4 Revision of one component of total prosthetic replacement of hip joint using cement W37.8 Other specified W37.9 Unspecified W37.0 Conversion from previous cemented total prosthetic replacement of hip joint **W38Total prosthetic replacement of hip joint not using cement** W38.1 Primary total prosthetic replacement of hip joint not using cement W38.2 Conversion to total prosthetic replacement of hip joint not using cement W38.3 Revision of total prosthetic replacement of hip joint not using cement W38.4 Revision of one component of total prosthetic replacement of hip joint not using cement W38.8 Other specified W38.9 Unspecified W38.0 Conversion from previous uncemented total prosthetic replacement of hip joint **W39Other total prosthetic replacement of hip joint** W39.1 Primary total prosthetic replacement of hip joint NEC W39.2 Conversion to total prosthetic replacement of hip joint NEC W39.3 Revision of total prosthetic replacement of hip joint NEC W39.4 Attention to total prosthetic replacement of hip joint NEC W39.5 Revision of one component of total prosthetic replacement of hip joint NEC W39.6 Closed reduction of dislocated total prosthetic replacement of hip joint W39.8 Other specified W39.9 Unspecified W39.0 Conversion from previous total prosthetic replacement of hip joint NEC **W93Hybrid prosthetic replacement of hip joint using cemented acetabular component** W93.1 Primary hybrid prosthetic replacement of hip joint using cemented acetabular component W93.2 Conversion to hybrid prosthetic replacement of hip joint using cemented acetabular component

W93.3 Revision of hybrid prosthetic replacement of hip joint using cemented acetabular component
W93.8 Other specified
W93.9 Unspecified
W93.0 Conversion from previous hybrid prosthetic replacement of hip joint using cemented acetabular component

W94Hybrid prosthetic replacement of hip joint using cemented femoral component
W94.1 Primary hybrid prosthetic replacement of hip joint using cemented femoral component
W94.2 Conversion to hybrid prosthetic replacement of hip joint using cemented femoral component
W94.3 Revision of hybrid prosthetic replacement of hip joint using cemented femoral component
W94.8 Other specified
W94.9 Unspecified
W94.0 Conversion from previous hybrid prosthetic replacement of hip joint using cemented femoral component

W95Hybrid prosthetic replacement of hip joint using cement
W95.1 Primary hybrid prosthetic replacement of hip joint using cement NEC
W95.2 Conversion to hybrid prosthetic replacement of hip joint using cement NEC
W95.3 Revision of hybrid prosthetic replacement of hip joint using cement NEC
W95.4 Attention to hybrid prosthetic replacement of hip joint using cement NEC
W95.8 Other specified
W95.9 Unspecified
W95.0 Conversion from previous hybrid prosthetic replacement of hip joint using cement NEC

Orthopaedics - Knee Replacements

W40Total prosthetic replacement of knee joint using cement
W40.1 Primary total prosthetic replacement of knee joint using cement
W40.2 Conversion to total prosthetic replacement of knee joint using cement
W40.3 Revision of total prosthetic replacement of knee joint using cement
W40.4 Revision of one component of total prosthetic replacement of knee joint using cement
W40.8 Other specified
W40.9 Unspecified
W40.0 Conversion from previous cemented total prosthetic replacement of knee joint

W41Total prosthetic replacement of knee joint not using cement

W41.1 Primary total prosthetic replacement of knee joint not using cement
W41.2 Conversion to total prosthetic replacement of knee joint not using cement
W41.3 Revision of total prosthetic replacement of knee joint not using cement
W41.4 Revision of one component of total prosthetic replacement of knee joint not using cement

W41.8 Other specified
W41.9 Unspecified
W41.0 Conversion from previous uncemented total prosthetic replacement of knee joint

W42Other total prosthetic replacement of knee joint
W42.1 Primary total prosthetic replacement of knee joint NEC
W42.2 Conversion to total prosthetic replacement of knee joint NEC
W42.3 Revision of total prosthetic replacement of knee joint NEC
W42.4 Attention to total prosthetic replacement of knee joint NEC
W42.5 Revision of one component of total prosthetic replacement of knee joint NEC
W42.6 Arthrolysis of total prosthetic replacement of knee joint
W42.8 Other specified
W42.9 Unspecified
W42.0 Conversion from previous total prosthetic replacement of knee joint NEC

O18Hybrid prosthetic replacement of knee joint using cement
O18.1 Primary hybrid prosthetic replacement of knee joint using cement
O18.2 Conversion to hybrid prosthetic replacement of knee joint using cement
O18.3 Revision of hybrid prosthetic replacement of knee joint using cement
O18.4 Attention to hybrid prosthetic replacement of knee joint using cement
O18.8 Other specified
O18.9 Unspecified
O18.0 Conversion from previous hybrid prosthetic replacement of knee joint using cement

Hernia operations

G23.1 Repair of oesophageal hiatus using thoracic approach
G23.2 Repair of diaphragmatic hernia using thoracic approach NEC
G23.3 Repair of oesophageal hiatus using abdominal approach
G23.4 Repair of diaphragmatic hernia using abdominal approach NEC
G23.8 Other specified
G23.9 Unspecified

G24.1 Antireflux fundoplication using thoracic approach
G24.2 Antireflux operation using thoracic approach NEC
G24.3 Antireflux fundoplication using abdominal approach
G24.4 Antireflux gastropexy

G24.5 Gastroplasty and antireflux procedure HFQ
G24.6 Insertion of Angelchick prosthesis
G24.8 Other specified
G24.9 Unspecified

G25.1 Revision of fundoplication of stomach
G25.2 Adjustment to Angelchick prosthesis
G25.3 Removal of Angelchick prosthesis
G25.8 Other specified
G25.9 Unspecified

T19.1 Bilateral herniotomy
T19.2 Unilateral herniotomy
T19.3 Ligation of patent processus vaginalis
T19.8 Other specified
T19.9 Unspecified

T20.1 Primary repair of inguinal hernia using insert of natural material
T20.2 Primary repair of inguinal hernia using insert of prosthetic material
T20.3 Primary repair of inguinal hernia using sutures
T20.4 Primary repair of inguinal hernia and reduction of sliding hernia
T20.8 Other specified
T20.9 Unspecified

T21.1 Repair of recurrent inguinal hernia using insert of natural material
T21.2 Repair of recurrent inguinal hernia using insert of prosthetic material

T21.3 Repair of recurrent inguinal hernia using sutures
T21.4 Removal of prosthetic material from previous repair of inguinal hernia
T21.8 Other specified
T21.9 Unspecified

T22.1 Primary repair of femoral hernia using insert of natural material
T22.2 Primary repair of femoral hernia using insert of prosthetic material
T22.3 Primary repair of femoral hernia using sutures
T22.8 Other specified
T22.9 Unspecified

T23.1 Repair of recurrent femoral hernia using insert of natural material
T23.2 Repair of recurrent femoral hernia using insert of prosthetic material

T23.3 Repair of recurrent femoral hernia using sutures
T23.4 Removal of prosthetic material from previous repair of femoral hernia
T23.8 Other specified
T23.9 Unspecified

T24.1 Repair of umbilical hernia using insert of natural material
T24.2 Repair of umbilical hernia using insert of prosthetic material
T24.3 Repair of umbilical hernia using sutures
T24.4 Removal of prosthetic material from previous repair of umbilical hernia
T24.8 Other specified
T24.9 Unspecified

T25.1 Primary repair of incisional hernia using insert of natural material
T25.2 Primary repair of incisional hernia using insert of prosthetic material
T25.3 Primary repair of incisional hernia using sutures
T25.8 Other specified
T25.9 Unspecified

T26.1 Repair of recurrent incisional hernia using insert of natural material
T26.2 Repair of recurrent incisional hernia using insert of prosthetic material
T26.3 Repair of recurrent incisional hernia using sutures
T26.4 Removal of prosthetic material from previous repair of incisional hernia
T26.8 Other specified
T26.9 Unspecified

T27.1 Repair of ventral hernia using insert of natural material
T27.2 Repair of ventral hernia using insert of prosthetic material
T27.3 Repair of ventral hernia using sutures
T27.4 Removal of prosthetic material from previous repair of ventral hernia
T27.8 Other specified
T27.9 Unspecified

T97.1 Repair of recurrent umbilical hernia using insert of natural material
T97.2 Repair of recurrent umbilical hernia using insert of prosthetic material
T97.3 Repair of recurrent umbilical hernia using sutures
T97.8 Other specified
T97.9 Unspecified
T98.1 Repair of recurrent ventral hernia using insert of natural material
T98.2 Repair of recurrent ventral hernia using insert of prosthetic material

T98.3 Repair of recurrent ventral hernia using sutures

T98.8 Other specified
T98.9 Unspecified

Adenoid

E20.1 Total adenoidectomy
E20.2 Biopsy of adenoid
E20.3 Surgical arrest of postoperative bleeding of adenoid
E20.4 Suction diathermy adenoidectomy

E20.8 Other specified
E20.9 Unspecified

Gallstone operations

J18.1 Total cholecystectomy and excision of surrounding tissue
J18.2 Total cholecystectomy and exploration of common bile duct
J18.3 Total cholecystectomy NEC
J18.4 Partial cholecystectomy and exploration of common bile duct
J18.5 Partial cholecystectomy NEC
J18.8 Other specified
J18.9 Unspecified

J21.1 Open removal of calculus from gall bladder

J23.3 Exploration of gall bladder
J23.8 Other specified
J23.9 Unspecified
J24.1 Percutaneous drainage of gall bladder
J24.2 Percutaneous fragmentation of calculus in gall bladder
J24.3 Percutaneous dissolution therapy to calculus in gall bladder

J26.1 Extracorporeal fragmentation of calculus in gall bladder

J33.1 Open removal of calculus from bile duct and drainage of bile duct
J33.2 Open removal of calculus from bile duct NEC

J37.2 Operative cholangiography through cystic duct
J37.3 Direct puncture operative cholangiography

J38.1 Endoscopic sphincterotomy of sphincter of Oddi and removal of calculus HFQ

J41.1 Endoscopic retrograde extraction of calculus from bile duct
J41.3 Endoscopic retrograde lithotripsy of calculus of bile duct

J42.3 Endoscopic retrograde removal of calculus from pancreatic duct

J49.1 Endoscopic removal of calculus from bile duct along T tube track
J49.2 Percutaneous removal of calculus from bile duct along T tube track

J52.1 Extracorporeal lithotripsy of calculus in bile duct

J60.2 Open removal of calculus from pancreatic duct

J68.1 Extracorporeal shockwave lithotripsy of calculus of pancreas

ENT – Tonsillectomies
F34.1 Bilateral dissection tonsillectomy F34.2 Bilateral guillotine tonsillectomy F34.3 Bilateral laser tonsillectomy F34.4 Bilateral excision of tonsil NEC F34.5 Excision of remnant of tonsil F34.6 Excision of lingual tonsil F34.7 Bilateral coblation tonsillectomy F34.8 Other specified F34.9 Unspecified F36.6 Excision of lesion of tonsil

Ophthalmology - Cataract operations (A code from Block C75 will always be assigned in the primary procedures position followed by a code from Blocks C71-C74)
C71.1 Simple linear extraction of lens C71.2 Phacoemulsification of lens C71.3 Aspiration of lens C71.8 Other specified C71.9 Unspecified C72.1 Forceps extraction of lens C72.2 Suction extraction of lens C72.3 Cryoextraction of lens C72.8 Other specified C72.9 Unspecified

C73.1 Membranectomy of lens
C73.2 Capsulotomy of anterior lens capsule
C73.3 Capsulotomy of posterior lens capsule
C73.4 Capsulotomy of lens NEC
C73.8 Other specified
C73.9 Unspecified

C74.1 Curettage of lens
C74.2 Discission of cataract
C74.3 Mechanical lensectomy

C74.8 Other specified
C74.9 Unspecified

C75.1 Insertion of prosthetic replacement for lens NEC
C75.2 Revision of prosthetic replacement for lens
C75.3 Removal of prosthetic replacement for lens
C75.4 Insertion of prosthetic replacement for lens using suture fixation

C75.8 Other specified
C75.9 Unspecified

General Surgery - Bariatric Surgery

G28.1 Partial gastrectomy and anastomosis of stomach to duodenum
G28.2 Partial gastrectomy and anastomosis of stomach to transposed jejunum
G28.3 Partial gastrectomy and anastomosis of stomach to jejunum NEC
G28.4 Sleeve gastrectomy and duodenal switch
G28.5 Sleeve gastrectomy NEC
G28.8 Other specified
G28.9 Unspecified

G30.1 Gastroplasty NEC
G30.2 Partitioning of stomach NEC
G30.3 Partitioning of stomach using band
G30.4 Partitioning of stomach using staples
G30.5 Maintenance of gastric band
G30.8 Other specified
G30.9 Unspecified

G31.1 Bypass of stomach by anastomosis of oesophagus to duodenum
G31.2 Bypass of stomach by anastomosis of stomach to duodenum

G31.3 Revision of anastomosis of stomach to duodenum
G31.4 Conversion to anastomosis of stomach to duodenum
G31.5 Closure of connection of stomach to duodenum
G31.6 Attention to connection of stomach to duodenum
G31.8 Other specified
G31.9 Unspecified
G31.0 Conversion from previous anastomosis of stomach to duodenum

G32.1 Bypass of stomach by anastomosis of stomach to transposed jejunum
G32.2 Revision of anastomosis of stomach to transposed jejunum
G32.3 Conversion to anastomosis of stomach to transposed jejunum
G32.4 Closure of connection of stomach to transposed jejunum
G32.5 Attention to connection of stomach to transposed jejunum
G32.8 Other specified
G32.9 Unspecified
G32.0 Conversion from previous anastomosis of stomach to transposed jejunum

G38.7 Removal of gastric band

Gender Reassignment Surgery
X15.1 Combined operations for transformation from male to female X15.2 Combined operations for transformation from female to male X15.3 Code retired - refer to introduction X15.4 Construction of scrotum X15.8 Other specified X15.9 Unspecified

Name of Trust	
Name of Trust's CCG	

Freedom of Information: Elective Surgery

1. **Which Regional/Area Team does your hospital belong to?**
   Please tick **ONE** of the following options:

North East	
North West	
West Midlands	
East Midlands	
Yorkshire and the Humber	
East of England	
South West	
South East	
London	

2. **Please set out the number of individual elective procedures that took place in your Trust in 2015 for the following categories –**

Procedure	Number
Hip Replacement	
Knee Replacement	
Hernia Operations	
Adenoid Operations	
Gallstone Operations	
Tonsillectomies	
Cataract Operations	
Bariatric Surgery	
Gender Reassignment Surgery	

3. **Please set out the mean average waiting time (in days), within your Trust, for each of the following procedures in 2015 – Please also include referral to treatment (RTT) waiting time**

Procedure	Average Waiting Time (Days)	Referral to Treatment
Hip Replacement		
Knee Replacement		
Hernia Operations		
Adenoid Operations		
Gallstone Operations		
Tonsillectomies		
Cataract Operations		
Bariatric Surgery		

Gender Reassignment Surgery		

4. **Please set out the number of patients who waited over 18 weeks, within your Trust, for each of the following procedures in 2015 –**

Procedure	Number of people who waited over 18 weeks
Hip Replacement	
Knee Replacement	
Hernia Operations	
Adenoid Operations	
Gallstone Operations	
Tonsillectomies	
Cataract Operations	
Bariatric Surgery	
Gender Reassignment Surgery	

5. **If a patients needs were to change while on the Trust's waiting list is there a process to recognise this?**

Yes	
No	

If yes, please describe

6. **What number of patient's surgeries were cancelled on the day in the calendar year of 2015?**

7. **Please tick the most common reasons surgery is cancelled on the day?**

Scheduling errors – i.e. lack of theatre time, surgeon unavailable	
Patient not prepped – i.e. not fasted	
Equipment shortages and/or lack of beds	
Cancellation due to inadequate preoperative evaluation	

Patient failing to attend or operation no longer necessary	
Emergency case superseding the elective schedule	
Medical reasons – on-going infection, illness of family member	
Low Staffing levels	

Other, please specify

8. Have you implemented any improvement programs to improve access to meeting the (recommended) waiting time?

Theatre Improvements	
Admin / booking projects	
Pre-op assessment	
Diagnostic improvement	
Separation of elective and emergency beds	
Communication with patients	

Other, please specify

9. Have you implemented any bans on out of area referrals for any types of elective procedures?

Yes	
No	

If yes, for which procedures?

10. Do you notify patients of their rights under the NHS Constitution when the 18 week limit has been missed?

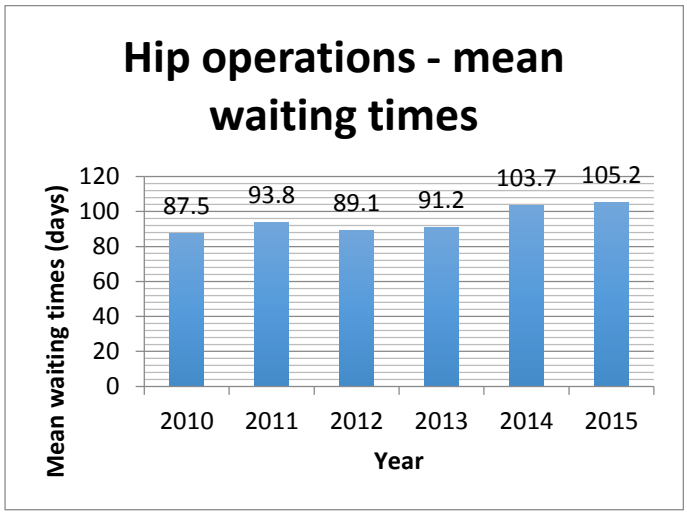
Yes	
No	

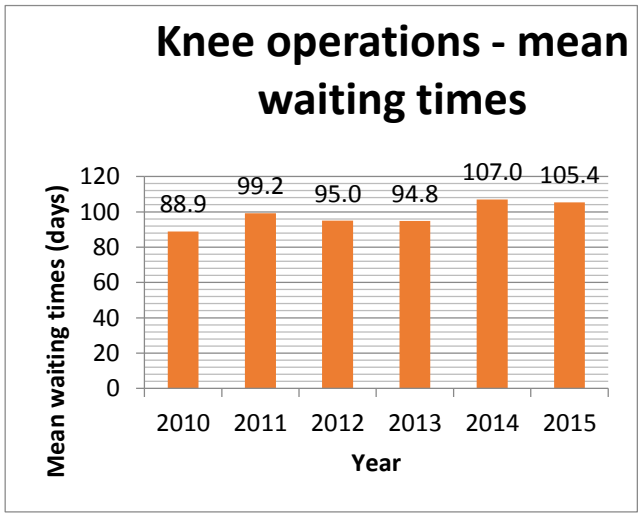
If Yes, how?

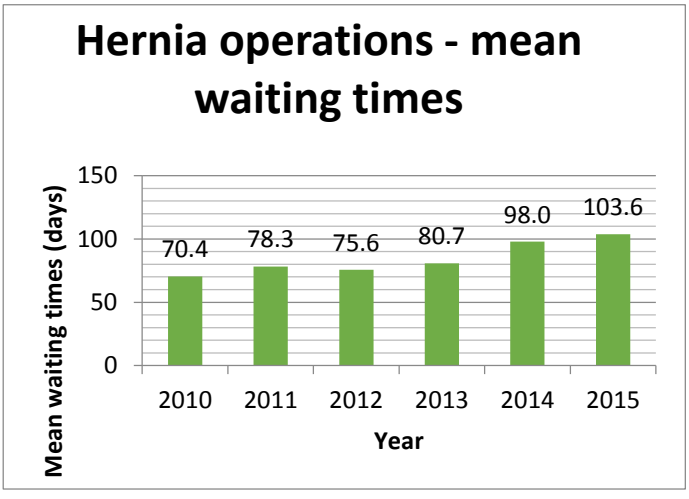
11. On average how many extra days or weeks did patients wait for surgery beyond the 18 week limit?

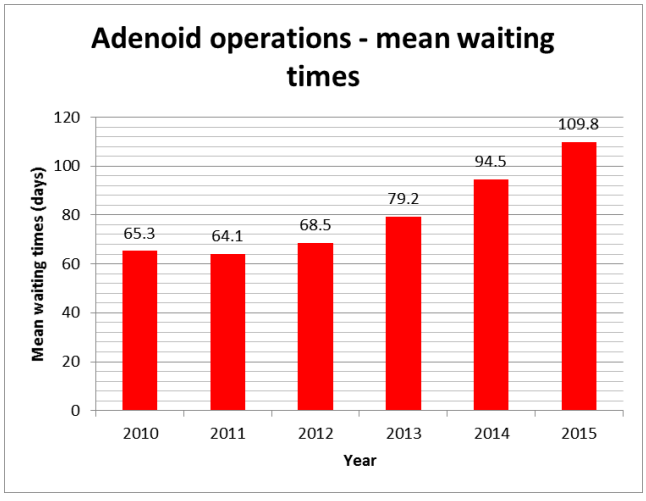
Procedure	Number
Hip Replacement	
Knee Replacement	
Hernia Operations	
Adenoid Operations	
Gallstone Operations	
Tonsillectomies	
Cataract Operations	
Bariatric Surgery	
Gender Reassignment Surgery	

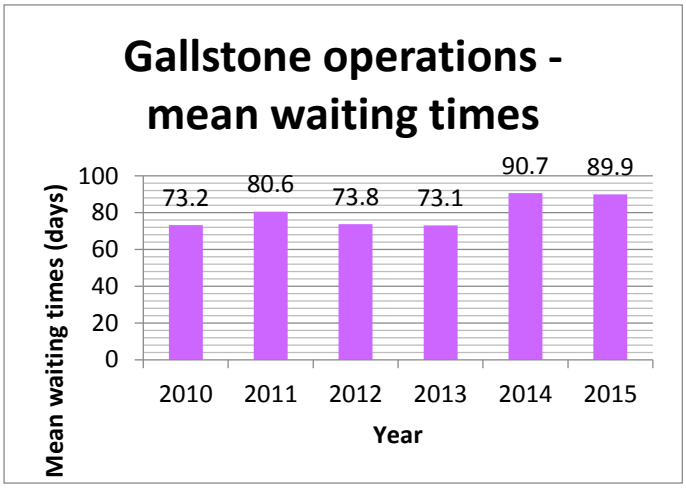
Appendix 1.2 - Mean waiting times annually for individual procedures from 2010 - 2015

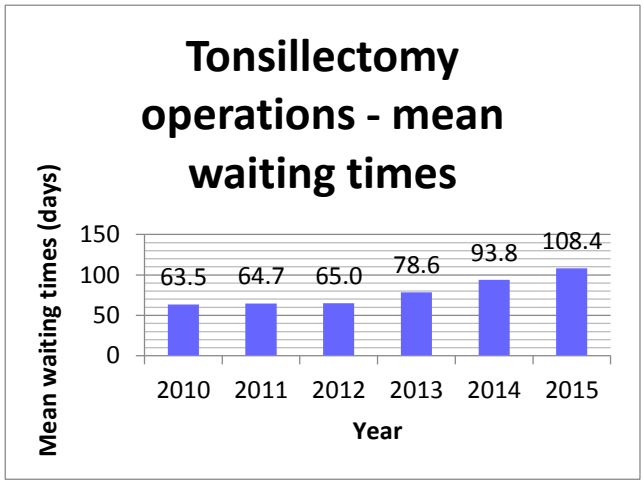


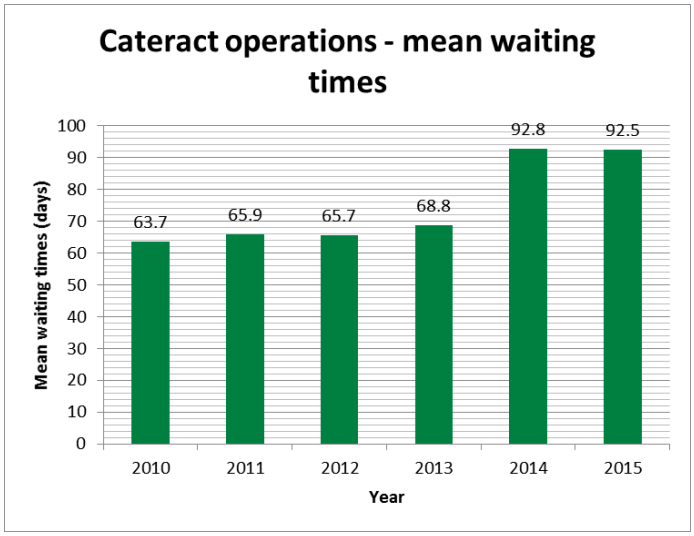




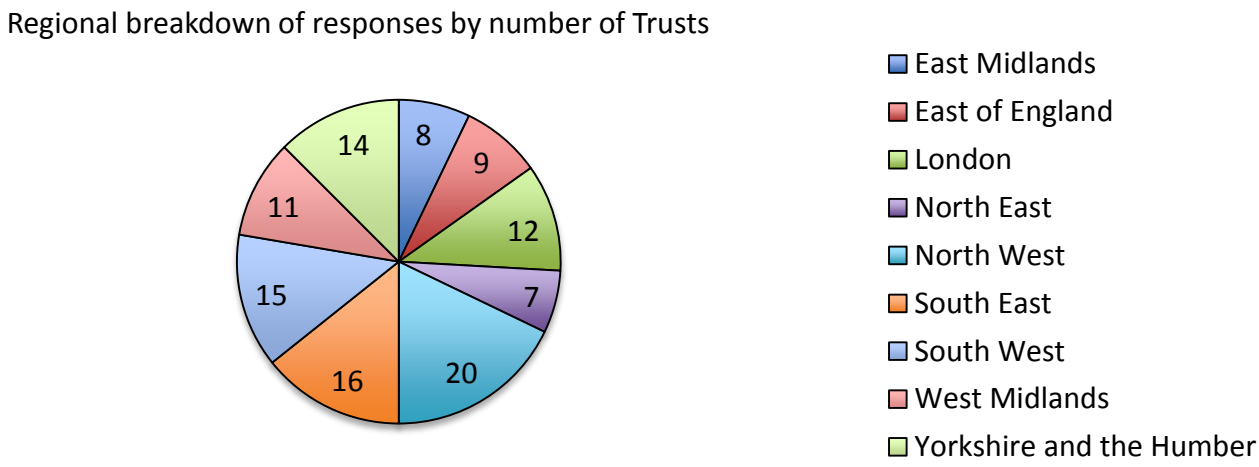






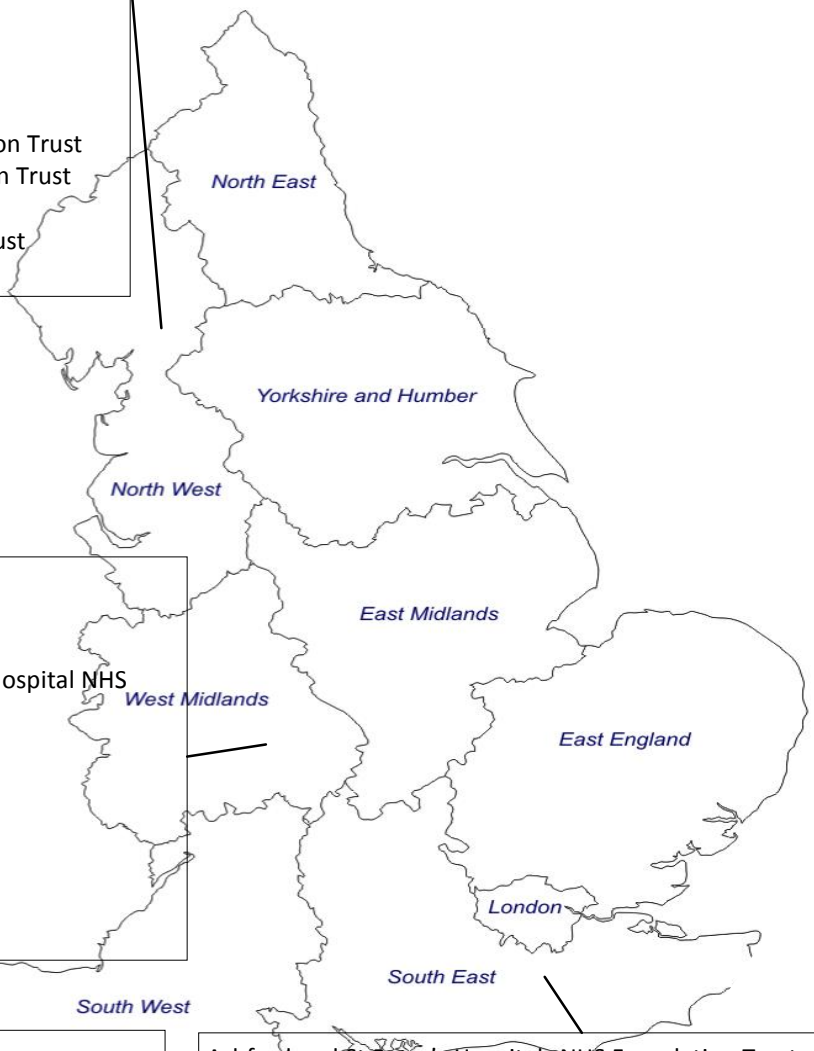


Appendix 1.3 – Regional breakdown of responses by number of Trusts



Appendix 1.4- Trusts that responded and the region they belong to.

Aintree University Hospital NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Bolton NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
East Cheshire NHS Trust
East Lancashire Hospitals NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Pennine Acute Hospitals NHS Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Salford Royal NHS Foundation Trust
St Helens and Knowsley Hospitals NHS Trust
Stockport NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Warrington and Halton Hospitals NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust



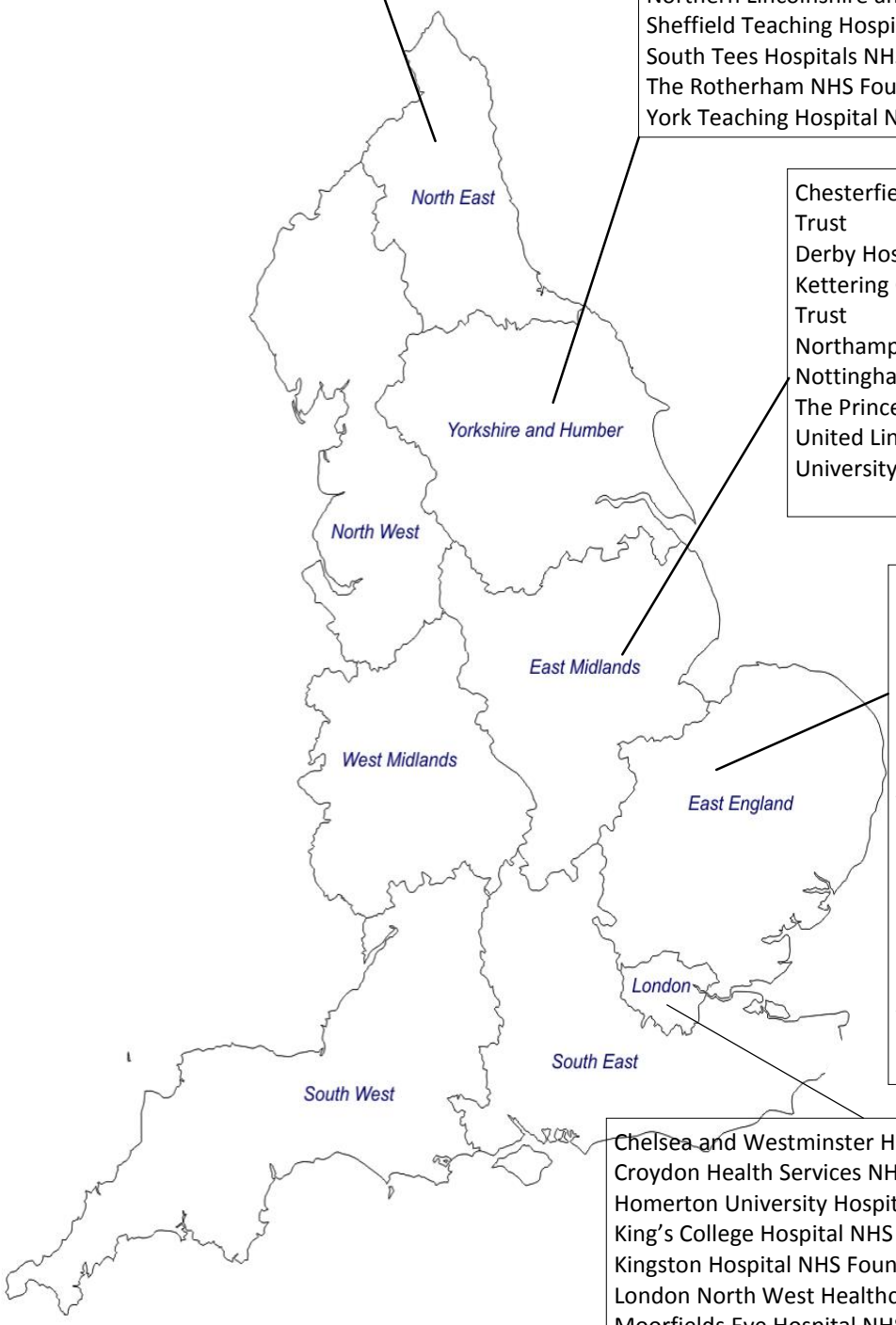
Birmingham Children's Hospital NHS Foundation Trust
Burton Hospitals NHS Foundation Trust
George Eliot Hospital NHS Trust
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
South Warwickshire NHS Foundation Trust
The Dudley Group NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
Walsall Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust
Wye Valley NHS Trust

Dorset County Hospital NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
Plymouth Hospitals NHS Trust
Poole Hospital NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust
Yeovil District Hospital NHS Foundation Trust

Ashford and St Peter's Hospitals NHS Foundation Trust
Brighton and Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare NHS Trust
Dartford and Gravesham NHS Trust
East Kent Hospitals University NHS Foundation Trust
East Sussex Healthcare NHS Trust
Frimley Health NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Medway NHS Foundation Trust
Milton Keynes Hospital NHS Foundation Trust
Oxford University Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Royal Berkshire NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
Western Sussex Hospitals NHS Foundation Trust.

County Durham and Darlington NHS Foundation Trust
Gateshead Health NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
North Tees and Hartlepool NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
South Tyneside NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Airedale NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Hull and East Yorkshire Hospitals NHS Trust
Leeds Teaching Hospitals NHS Trust
Mid Yorkshire Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust



Chesterfield Royal Hospital NHS Foundation Trust
Derby Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust
Nottingham University Hospitals NHS Trust
The Princess Alexandra Hospital NHS Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals of Leicester NHS Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
East and North Hertfordshire NHS Trust
Ipswich Hospital NHS Trust
Luton and Dunstable University Hospital NHS Foundation
Southend University Hospital NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust
Croydon Health Services NHS Trust
Homerton University Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Kingston Hospital NHS Foundation Trust
London North West Healthcare NHS Trust
Moorfields Eye Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
The Hillingdon Hospitals NHS Foundation Trust
The Whittington Hospital NHS Trust
University College London Hospitals NHS Foundation Trust

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