STILL WAITING
THE FORGOTTEN PATIENTS

The Patients Association’s annual review of elective surgical procedures in England – access and waiting times
Foreword by Katherine Murphy

Encouraging fair access to treatment and reasonable waiting times is not something that has just arrived on to the Patients Association’s agenda. Ever since the 1990s the organisation has firmly backed the principle of shorter waiting times and universal access to NHS services, as expressed in the NHS Constitution, “based on clinical need, not an individual’s ability to pay”.¹

As debate and reforms regarding the design and role of targets, budgets and financial incentives have developed we have been concerned to hear from patients and healthcare professionals about instances of services being rationed, patients being denied referrals to elective surgery and increasing waits for treatment. As a consequence of the increasing number of calls to our Helpline on this issue, since 2010 we have produced an annual tracking report analysing the number of elective procedures being carried out and comparing this to the average patient waiting time.

Our year-on-year comparison surveys of acute NHS Trusts’ activity have allowed us to gather enough data and to highlight the main emerging themes. We acknowledge that fluctuations of demand are possible and that the introduction of preventative or alternative interventions could play a role in the number of procedures carried out. However, with an increasing demand for treatment and an ageing population, a substantial year-on-year decrease in demand seems unlikely.

Following on from our 2011 and 2012 reports, this report shows there to be a fall in the total number of procedures carried out and a noticeable increase in waiting times for elective surgeries. We must note that improvement has taken place in many of the Trusts who supplied us with data on their activity. However, this is not a consolation for the patients who happen to live in the catchment areas of the worst performing Trusts, and renews our concerns that the “postcode lottery” that has plagued the delivery of NHS treatment continues to worsen.

“The NHS belongs to us all” is the founding principle of the NHS and denotes a concept of equal access to quality treatment that should not be dependent on where people live. A national healthcare system must be just that, and these variations should be highlighted and addressed as a matter of urgency. In such a system the principles of a postcode lottery should not apply, nor should financial considerations outweigh the necessity of providing excellent patient care, always, everywhere.

Katherine Murphy
Chief Executive, Patients Association

¹ NHS Constitution (published 26th March 2013), Second Principle, page 3
The NHS targets and pledges

According to the NHS Constitution, patients have “the right to access services within maximum waiting times”. The waiting time limit is one of the new rights contained in the Constitution. According to the Handbook to the NHS Constitution (which substantiates the document and explains the legal derivation of the rights and responsibilities therein contained), this right is supported by legislation dating back to 1 April 2010.

The right is for patients to “start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions”; and to be “seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.” Where this is not possible, the Handbook to the NHS Constitution goes on to say, the commissioner of treatment must investigate and offer a range of suitable alternative providers.

The Department of Health has furthered their commitment to waiting times with the consultation on strengthening the NHS Constitution which was launched on 5th November 2012 and closed on 28th January 2013. It sought to enforce the Constitution in a number of specific areas recommended by the NHS Future Forum working group on the Constitution. In their report the Government acknowledged the receipt of 357 consultation responses.

The revised Constitution and updated Handbook were published on the 26th March 2013. The revised documents re-state many of the existing waiting times pledges, including; a maximum waiting time of four hours in A&E from arrival to admission (transfer or discharge), a requirement for Ambulance Trusts to respond to 75% of all Category A emergency calls within eight minutes and a target of 95% of all call to be responded to within 19 minutes of a request being made.

At the same time, new waiting times pledges have been included in the updated Handbook to the Constitution. For example, a “maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers”; a “maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer”; and a wait of less than 6 weeks from referral for patients waiting for a diagnostic test.

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Other government pledges in relation to waiting times have been proposed to be removed – e.g. the “access to a primary care professional within 24 hours or a primary care doctor within 48 hours”, now measured through GP Surveys\(^6\).

**Referral to Treatment Waiting times – the Government’s data**

As per the NHS Constitution, the maximum waiting limit of 18 weeks is calculated from a commissioner’s referral to treatment. The Department of Health thus publishes monthly statistics on referral to treatment performance, presented by commissioner, provider and treatment function.

In February 2013 the Department published their annual report on NHS Consultant-led Referral to Treatment (RTT) waiting times\(^7\). The report encompasses the calendar year up to December 2012 and relates to the above-mentioned legal right contained in the NHS Constitution. The regular publication of information on waiting times is considered to be not only an example of good practice, but also a way of ensuring that “the NHS is accountable to the patients and public it serves”\(^8\).

The report refers to RTT pathways. These pathways are applicable to patients referred for non-emergency consultant-led treatment and are calculated from referral to start of treatment. Exceptions to the operational standard of 18 weeks are allowed on the grounds of patient choice / convenience; clinical appropriateness; missed patient appointments along the pathway, etc.

Three categories of RTT pathways are commonly identified:

- **Admitted pathways** – also referred to as *inpatient waiting times* – the waiting period is counted from referral to start of inpatient treatment.
  
  *The target for this category of cases is 90%.*

- **Non-admitted pathways** – also referred to as *outpatient waiting times* – these apply to patients whose treatment was paused for treatment or other reasons.
  
  *The target for this category of cases is 95%.*

- A standard for *incomplete pathways* was introduced in April 2012. These refer to the waiting times for patients waiting to start treatment at the end of the month, and are also known as *waiting list waiting times*.
  
  *The target here is 92%.*\(^9\)

The waiting times performance for England, according to the report, has been relatively stable since 2009. The completed RTT pathways for 2012 accounted for 92.2% of admitted cases and 97.5% of

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\(^8\) Ibid, p. 4.

\(^9\) Ibid, p. 5.
non-admitted ones. These figures mark an improvement on the year before, when the figures were 90.5% and 97.3%, respectively. Incomplete pathways figures also appear to mark an improved performance – these accounted for 91.4% in December 2011 and for 94.5% in December 2012.

The median waiting time for patients completing an RTT pathway was 8.5 weeks to start an admitted treatment and 4 weeks to start non-admitted treatment. Due to poor weather conditions and Christmas holidays, waiting times peak in the middle of winter – around December and January.

The number of RTT patients who started consultant-led treatment in 2012 was similar to that observed in previous years and subject to seasonal fluctuations and the number of weekends / bank holidays in the month. An analysis of the RTT data indicates that:

- Each month around 300,000 RTT patients start admitted treatment and around 870,000 start non-admitted treatment.
- A marked improvement in the RTT waiting activity in England is observable with regard to the number of patients waiting for more than 18 weeks and those waiting for more than a year.
- At the end of December 2012, 141,000 patients were waiting for more than the statutory standard of 18 weeks. This compares to double this number at the end of the month in December 2010 and December 2011.
- At the end of 2012, 1,000 patients were waiting for more than a year, while at end of the same month in previous years – 2011 and 2010 – the number of patients waiting for more than a year was around 6,000 and 15,000, respectively.\(^\text{10}\)

**Referral to Treatment Waiting times – the NHS gooroo analysis**

The trends revealed by these statistics are undoubtedly positive. However, it has to be noted that national figures, and even those provided by SHA, tend to mask variations between hospitals. Even though RTT waiting times activity seems to be going in the right direction, there are still long-wait backlogs on England’s NHS waiting lists, as constantly exemplified by the NHS gooroo blog.\(^\text{11}\)

NHS gooroo has reported a big improvement in the number of people waiting for over a year compared to 2011. This number has fallen from over 20,000 in 2011 to 1,147 in November 2012. In fact, the situation is expected to improve even further, given that from April 2013 each provider will face a fine of £5,000 per patient per month for every one-year-waiter they report on their waiting lists.\(^\text{12}\)

The user-friendly map on the NHS gooroo’s website, sourced by official government sources, identifies the hospitals with over 30 people waiting for one year or more. For the month of December 2012 these include:

- *Barts Health NHS Trust;*

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\(^\text{10}\) Ibid, pp. 6-11.

\(^\text{11}\) NHS gooroo blog (2013). Available online at [http://blog.nhsgooroo.co.uk/](http://blog.nhsgooroo.co.uk/)

NHS gooroo showed that three hospitals had much longer waits than the rest of the top ten longest-waiting providers: **Clinicenta Limited** (where the wait for 92% is within the range of 29.9 weeks) and **Barnet and Chase Farm NHS Trust** (where the wait for 92% of patients is up to 21.2 weeks). Number one on this list of top ten worst performers is occupied by **The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust**, where the waits are up to 38.6 weeks (see Table 1). The Trust has been heading this unfortunate classification since September 2012, with the number of waiting weeks continuing to grow.

Table 1 “Top 10 longest-waiting providers”
Source: NHS gooroo blog website

**The new 2013/14 NHS Standard Contract: a solution to the waiting crisis?**

In a positive development in the early weeks of February 2013, NHS England [formerly the NHS Commissioning Board (NHSCB)] has given a high priority to clearing these waiting backlogs. In particular, the new **2013/14 NHS Standard Contract**\(^{13}\), whose production and publication has passed from the Department of Health to the NHS England, has the potential of addressing the very issue of backlogs building up.

Instead of penalising hospitals for treating long-waiting patients (as in the case of the Contract’s previous draft), this new version of the Contract adds new penalties for building up backlogs and reduces the legacy penalties for treating long-waiters. These new penalties apply per specialty and per month. They are calculated as a percentage of underachievement (according to the 18 weeks

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target) and respective percentage deduction from the revenue for the month for the specialty in question.\textsuperscript{14}

This commitment to positive change reflects the requirements set out in \textit{Everyone Counts: Planning for Patients 2013/14}\textsuperscript{15}. The NHS England’s publication refers to those patients who are still waiting unacceptably long for their treatment. That is why it advocates “zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, including contractual fines when this occurs.”\textsuperscript{16} \textit{Everyone Counts} also refers to a requirement for all letters for first outpatient appointments to include information on the right of patients to be treated within maximum waiting times and what they can do if they are concerned that they will be waiting longer. It also explores the possibility for providers to inform patients of their estimated waiting time.

\textbf{Evidence of growing pressures and increasing waiting times}

The Patients Association’s Helpline is at the core of our campaigns as our main information source. It was calls and letters to our Helpline that made us realise that patient access to treatment and related waiting times are an issue of concern. In 2010 patients complained to us that they had been unable to access operations, such as hip replacements – something that had not been a problem before. People were also reporting longer waits than previously experienced. The concerns of patients, their families and carers were echoed by medical professionals, who were concerned that Primary Care Trusts (PCTs) were placing restrictions on treatments and surgical procedures, which would undoubtedly have an impact on the quality of patient care.

Each year as part of this annual review, we have sent out Freedom of Information (FOI) requests to every NHS Acute Trust nationwide, asking them to provide details about the numbers of certain procedures carried out in their Trust. The numbers are requested for the current and the previous calendar year. For example, the request we sent out in 2011 referred to the period 2009/10 and the request sent out in 2012 referred to the period 2010/11. We also inquire about the waiting times (in days) for the procedures in question.

An additional trigger to our latest FOI request, sent out in January 2013, has been the growing amount of evidence that access to treatment is being suppressed. A commonly cited cause of these reported pressures is the demanding task of delivering the savings the NHS has been set to find as part of the “Nicholson Challenge”. Authoritative sources have been referring to the problem during the last few months (see the National Audit Office review\textsuperscript{17}, the King’s Fund’s mid-term assessment

\begin{footnotes}
\item[16] Ibid, p. 20.
\end{footnotes}
of the state of healthcare under the Coalition government\textsuperscript{18} and the Public Accounts Committee’s Thirty-ninth Report on the NHS efficiency savings\textsuperscript{19}).

\textbf{Procedures of “limited clinical value”}

The procedures that we inquired about mostly fall in the category of so-called “procedures of limited clinical value”. This category, according to the Audit Commission, refers to treatments that are “either clinically ineffective or not cost-effective”\textsuperscript{20} According to the Audit Commission’s estimates, freeing up money spent on low clinical value treatments could lead to a reduction in PCT spending of between £179 million and £441 million\textsuperscript{21}.

The definition of such procedures was dictated by the need to live up to the Quality, Innovation, Productivity and Prevention (QIPP) challenge. The latter consists in the task, set by the government, for the NHS to realise £20 billion of efficiency savings in the five years up to 2015, while enjoying a steady, yet minimal, year-on-year increase of its budget. This has been widely known as the “Nicholson’s Challenge”, named after the NHS chief executive Sir David Nicholson.

Within their QIPP plans, most PCTs have identified the importance of reducing low clinical value treatments. Clinical effectiveness and cost effectiveness are both considered as desirable outcomes from such a reduction. However, no single list of low clinical value treatments exists at a national level, which left PCTs to develop their own approaches.

It has been estimated that PCTs have identified approximately 250 different procedures of limited clinical value. One of the pioneers in the establishment of such a list has been Croydon PCT, whose list of 34 procedures is given as an example in the Audit Commission’s report because it has been adopted by other PCTs in London and has enjoyed widespread acceptance among commissioners. The treatments on the Croydon list fall into five different categories, which are as follows:

- effective procedures where cost-effective alternatives should be tried first (e.g. anal procedures, bilateral hip surgery, carpal tunnel surgery, etc.);
- effective interventions with a close benefit or risk balance in mild cases (e.g. cataract surgery, hip and knee revisions, primary hip replacement, etc.);
- potentially cosmetic interventions

\textsuperscript{20} The Audit Commission (2011) Reducing spending on low clinical value treatments, Health briefing, April 2011, p. 2.
\textsuperscript{21} Ibid, p. 2.
(e.g. aesthetic surgery, incisional and ventral hernias, varicose veins, etc.);
- relatively ineffective procedures
  (e.g. grommets, spinal cord stimulation, tonsillectomy, etc.); and
- cancelled procedures.  

Since we first became alerted to this apparent trend we have expressed concern that such moves to limit or delay access to such procedures was myopic and reckless. Whilst the conditions included on such lists are rarely life threatening, many have significant implications for the quality and standard of living for the intended patient, where delays in receiving their treatment can lead to recovery and rehabilitation issues a later date - and in some cases can affect their ability to return to work.

Important stakeholders have raised similar concerns. For example, the Royal College of Surgeons (RCS), have been alarmed by the potential implications of extending the term of ‘procedures of limited clinical value’ to many proven operations, known to enhance the health of people and improve their quality of life.  

In their briefing issued in January 2011, the Royal College argued that certain procedures were being stopped in certain Trusts, on occasion against clinical advice. In particular they warned about: emerging geographic health inequalities, the lack of publicity and / or consultation with the local community and the arbitrary nature surrounding the introduction of many of these decisions. The Royal College of Surgeons argued that many of these procedures, deemed of low clinical value, actually prevent complications and that “denying them ultimately endangers the lives of patients and the standard of treatment available in the NHS.”

The College strongly recommended that decisions to include surgeries in a list of low clinical value procedures should be taken by clinicians who have seen the patient and that procedures which are known to “alleviate pain, improve mobility and quality of life, but the benefits of which are not seen immediately, should remain core NHS activity.” They also thought that Trusts should be working with expert clinicians in identifying ineffective procedures, rather than relying on purely economic considerations.

The Audit Commission pointed at some key factors in making PCTs’ policy of reducing low clinical value procedures effective. These included: support from the leadership; consultation with finance staff; joint working with GPs, clinicians in secondary care, and the public. They mentioned the work underway as part of the Right Care strand of QIPP to help clinicians and commissioners to work together and develop the clinical evidence base behind commissioning decisions and priorities for spending.

22 Ibid, p. 5.
In fact, the Right Care report on value based clinical commissioning, issued in December 2011\textsuperscript{25}, is based on the discussions held between clinicians and commissioners in two Strategic Health Authorities (SHAs). It recommends that “limited lists and blanket bans, which do not take account of the healthcare needs of individual patients, and result in postcode lotteries, should be abandoned.” It also reflects an aspect of the discussion which has identified the term ‘procedures of limited clinical value’ as a barrier to clinical engagement and proposes alternative terminology, such as ‘value based’ or ‘effective clinical commissioning’\textsuperscript{26}.

The procedures that we asked about

The FOI request that we sent out to Trusts in 2011, and then in 2012, asked about the number of Hip and Knee replacements, Bariatric Surgery, Hernia Operations, Tonsillectomies, Adenoid Operations, Gallstone Operations, Hysterectomies and Cataract Operations.

The FOI that we circulated in 2013 (regarding the period 2011/12) has seen a slight change in the procedures we asked about. We have removed Hysterectomies and Bariatric surgery from the list and added three new elective procedures relating to: Myringotomies, Varicose veins and Carpal tunnel syndrome.

Bariatric surgery was excluded from the list of requested categories due to the small number of Trusts that replied with data in this area to our 2012 FOI. Hysterectomies were also excluded from the list of procedures following discussions which indicated that the reduction in hysterectomy interventions could be due to better management of the condition rather than financial decisions only.

Many, if not all, of these procedures have been included in some Trusts’ lists of procedures of limited clinical value. Our assumption, derived from our contact with patients and Helpline staff, has been that these procedures are being rationed in response to QIPP efficiency plans.

In fact, we found that 10,757 (5.4\%) fewer procedures were carried out in 2010 than in 2009, marked by a significant drop in the number of Bariatric procedures, Hernia operations, Hip replacements, Knee replacements and Tonsillectomies and by an increase in waiting times for Hip replacements, Knee replacements, Hysterectomies and Gallstone operations. Cataract waiting times saw a slight reduction and bariatric surgery – a significant reduction in waiting times.

The survey sent out to acute hospitals in 2012 returned similar results. In total, there were 18,628 fewer operations performed in 2011 compared to 2010, accounting for a drop of 4.6\% in the total number of operations carried out across the areas that we questioned. Waiting times increased by 6\% in 2011 when compared to 2010 in seven of the eight categories we asked about. The biggest drop in procedures was observed with regard to cataract surgery, where 7.5\% fewer procedures were carried out. In terms of waiting times, the biggest percentage change was observed for knee, hernia and Gallstone operations – they all increased by 10\%.

\textsuperscript{25} QIPP Right Care Team (2011) Value Based Clinical Commissioning of Elective Surgical Care; Emerging Views of Commissioners & Surgeons and Production of High Value Care Pathways, December 2011.
\textsuperscript{26} Ibid, p. 4.
Methodology

The current report has set itself the task to determine whether the number of operations in 10 distinct categories (hip replacement, knee replacement, hernia operations, tonsillectomies, adenoid operations, myringotomies, gallstone operations, cataract operations, varicose veins and Carpal tunnel syndrome procedures) and the waiting times attached have undergone significant change in the period between 2011 and 2012. We recognise that hospital activity is not a constant and undergoes seasonal fluctuations.

However, due to a combination of pressures - including, but not limited to, the unique needs of an increasingly ageing population and the increasing strain felt by A&E services - we remain concerned that in response to these pressures, and compounded potentially by budgetary needs, demand is being artificially managed rather than services being improved / restructured so as to respond more effectively to the needs of patients.

The Patients Association has also been concerned for some time that these pressures are beginning to exacerbate the regional differentiation in both quality and access to services that has been dubbed the “NHS postcode lottery”. In order to identify whether this is still an issue of concern, we have also considered the geography of Trusts and the existence of any trends at a national or regional level.

In the first days of January 2013 we sent out requests under the Freedom of Information (FOI) Act 2000 to all acute Trusts in the country. Once the statutory period for response to FOI requests – 20 working days – had elapsed, we sent a follow-up email to all the Trusts who had not acknowledged receipt of our request and allowed for a further response time of 20 working days for the latter.

The FOI request that we sent out to acute Trusts was designed in a user-friendly and easy-to-complete format. Accompanied by a short introductory letter, the request was divided in two logical sections:

Section 1 (Questions 1 and 2)) enquired about the number of individual elective procedures that took place within the Trust in 2011 and 2012, respectively.

Section 2 (Questions 3 and 4)) enquired about the average waiting time (in days), within the Trust, for each of the listed procedures in 2011 and 2012, respectively.

Next to each of the procedures, as part of each of the questions, a blank editable field was provided to be filled in by the Trust with the respective figure. In cases where the specific procedure was not provided by the Trust, a N/A indication was to be used.

Example:

1) Please set out the number of individual elective procedures that took place in your Trust in 2011 for the following categories:

27 Please note, response received after 19th March 2013 have not been taken into consideration.

28 Please note, a copy of the FOI questionnaire sent to Trusts, please refer to the Appendix of the report.
2) Please set out the number of individual elective procedures that took place in your Trust in 2012 for the following categories:

(vii) Gallstone operations

... 123 ...

3) Please set out the average waiting time (in days), within your Trust, for each of the following procedures in 2011:

(vii) Gallstone operations

... 62 ...

4) Please set out the average waiting time (in days), within your Trust, for each of the following procedures in 2012:

... 62 ...

Out of the 163 requests for information that we sent out, we received 127 responses. This equals a response rate of 78% and a serious improvement on the response rate from the past two years. In comparison, just over a third of Trusts provided us with a response to our request in 2011 (62 out of 170) and nearly two-thirds (95 out of 150) of Trusts replied to our request in 2012.

9 of the 36 Trusts that failed to provide us with a response have also failed to provide us with an acknowledgement of receipt. The remaining 28 acknowledged receipt of the information request.

Table 1. Numbers of FOI request sent / returned and number of responses which have been counted

<table>
<thead>
<tr>
<th>Number of FOI requests sent</th>
<th>Number of FOI requests returned</th>
<th>Rejected responses with regard to number of procedures</th>
<th>Rejected responses with regard to waiting times</th>
<th>Specialist Trusts - procedures N/A</th>
<th>Total responses counted – number of procedures</th>
<th>Total responses counted – waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>163</td>
<td>127</td>
<td>4</td>
<td>9</td>
<td>7</td>
<td>116</td>
<td>111</td>
</tr>
</tbody>
</table>

Table 1 above shows the total number of FOI requests sent, the number of responses received as of 19th March 2013, as well as the responses that we had to reject for one reason or another. More
responses were received after the 19th of March but, unfortunately, due to time and capacity constraints, these have not been considered in the analysis.

The responses returned by 7 of the Trusts have been rejected due to their specialist tertiary or community nature.

In 4 of the cases no responses have been counted (neither on number of procedures, nor on waiting times), because of:

- missing/incomplete information;
- Trusts merging, so data not comparable;
- the majority of services being moved to an external unit, so data not comparable;
- an odd system of calculation of numbers of procedures / waiting times.

For an additional 5 cases the information provided by Trusts on waiting times has not been counted due to:

- a new IT system being implemented within the Trust and data unavailable;
- information on waiting times not collected per procedure;
- data not recorded in such format by the Trust;
- data not held by the Trust;
- information provided not lending itself to calculation of average waiting times.

The principle which guided the collection of valid cases was that the Trust would have at least one procedure which would lend itself to year-on-year comparison. In total, 116 cases were counted with regard to the number of procedures performed and 111 were counted with regard to waiting times.

Our FOI request asked for figures in 10 distinct elective surgical categories. Not all of the NHS Trusts in our sample, however, provided / held data on all of the categories we requested about. Analyses on operations and waiting times were therefore performed on the basis of the available figures. Figure 2 below shows how many cases Trusts’ representations accounted for.

**Table 2: Number of cases analysed per procedure**

<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>Number of operations performed</th>
<th>Average waiting time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip replacement</td>
<td>105</td>
<td>98</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>105</td>
<td>98</td>
</tr>
<tr>
<td>Hernia operations</td>
<td>111</td>
<td>107</td>
</tr>
<tr>
<td>Tonsillectomies</td>
<td>99</td>
<td>94</td>
</tr>
<tr>
<td>Adenoid operations</td>
<td>99</td>
<td>92</td>
</tr>
<tr>
<td>Myringotomies</td>
<td>98</td>
<td>93</td>
</tr>
<tr>
<td>Gallstone operations</td>
<td>102</td>
<td>95</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td>93</td>
<td>89</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>99</td>
<td>90</td>
</tr>
<tr>
<td>Carpal tunnel syndrome</td>
<td>110</td>
<td>103</td>
</tr>
</tbody>
</table>
Each of the above ten categories has been analysed separately to determine the year on year changes in the number of procedures in terms of both absolute differences and percentage change between 2011 and 2012.

Table 3: Total number of operations performed for each category of operations performed, including the absolute and percentage differences between 2011 and 2012.

<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>No of procedures 2011</th>
<th>No of procedures 2012</th>
<th>Absolute difference in number of procedures</th>
<th>Percentage change between 2011 and 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip replacement (N=105)</td>
<td>40,404</td>
<td>41,569</td>
<td>+1165</td>
<td>+2.88%</td>
</tr>
<tr>
<td>Knee replacement (N=105)</td>
<td>45,245</td>
<td>44,976</td>
<td>-269</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Hernia operations (N=111)</td>
<td>66,368</td>
<td>67,614</td>
<td>+1246</td>
<td>+1.88%</td>
</tr>
<tr>
<td>Tonsillectomies (N=99)</td>
<td>31,674</td>
<td>31,677</td>
<td>+3</td>
<td>+0.01%</td>
</tr>
<tr>
<td>Adenoid operations (N=99)</td>
<td>8,656</td>
<td>8,740</td>
<td>+84</td>
<td>+0.97%</td>
</tr>
<tr>
<td>Myringotomies (N=98)</td>
<td>22,907</td>
<td>22,742</td>
<td>-165</td>
<td>-0.72%</td>
</tr>
<tr>
<td>Gallstone operations (N=102)</td>
<td>38,642</td>
<td>39,949</td>
<td>+1307</td>
<td>+3.38%</td>
</tr>
<tr>
<td>Cataract surgery (N=93)</td>
<td>228,585</td>
<td>226,352</td>
<td>-2233</td>
<td>-0.98%</td>
</tr>
<tr>
<td>Varicose veins (N=99)</td>
<td>16,623</td>
<td>16,296</td>
<td>-327</td>
<td>-1.97%</td>
</tr>
<tr>
<td>Carpal tunnel syndrome (N=110)</td>
<td>30,915</td>
<td>29,435</td>
<td>-1480</td>
<td>-4.79%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>530,019</strong></td>
<td><strong>529,350</strong></td>
<td><strong>-669</strong></td>
<td><strong>-0.13%</strong></td>
</tr>
</tbody>
</table>

As visible from Table 3 above, the total number of operations for the sample of Trusts we considered has decreased by 669 (or by 0.13%) between 2011 and 2012.

The most substantial decrease in procedures related to carpal tunnel syndrome, where 1480 less procedures were performed in 2012 than in 2011 – a drop of almost 5%. Varicose veins operations also saw a drop of nearly 2 percentage points. A decrease in the number of operations performed was also notable in the case of cataract surgery (2233 fewer procedures = 1%); Myringotomies (165 fewer procedures = 0.7%); and knee replacements (269 fewer procedures = 0.6%).

This decrease, however, did not apply to all categories of procedures. According to the data we received, the number of hip replacements, hernia operations and gallstone operations saw an increase. The increases were: 3% in the case of hip replacement procedures; nearly 2% in the case of hernia operations; and almost 3.4% in the case of gallstone operations. Adenoid operations also saw a slight increase in numbers of approximately 1%. Tonsillectomy procedures remained unchanged between 2011 and 2012.
Table 4: Mean waiting times for each category of operations performed, including the absolute and percentage differences between 2011 and 2012.

<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>Mean waiting times in 2011 (days)</th>
<th>Mean waiting times in 2012 (days)</th>
<th>Absolute difference between 2011 and 2012 (days)</th>
<th>Percentage difference between 2011 and 2012 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip replacement (N=98)</td>
<td>91.55 (92)</td>
<td>89.09 (89)</td>
<td>-2.46</td>
<td>-2.68%</td>
</tr>
<tr>
<td>Knee replacement (N=98)</td>
<td>96.88 (97)</td>
<td>94.96 (95)</td>
<td>-1.92</td>
<td>-1.98%</td>
</tr>
<tr>
<td>Hernia operations (N=107)</td>
<td>76.48 (76)</td>
<td>75.59 (76)</td>
<td>-0.89</td>
<td>-1.16%</td>
</tr>
<tr>
<td>Tonsillectomies (N=94)</td>
<td>65.35 (65)</td>
<td>65.03 (65)</td>
<td>-0.32</td>
<td>-0.49%</td>
</tr>
<tr>
<td>Adenoid operations (N=92)</td>
<td>66.96 (67)</td>
<td>68.46 (68)</td>
<td>+1.5</td>
<td>+2.24%</td>
</tr>
<tr>
<td>Myringotomies (N=93)</td>
<td>61.72 (62)</td>
<td>63.18 (63)</td>
<td>+1.46</td>
<td>+2.37%</td>
</tr>
<tr>
<td>Gallstone operations (N=95)</td>
<td>74.26 (74)</td>
<td>73.76 (74)</td>
<td>-0.5</td>
<td>-0.67%</td>
</tr>
<tr>
<td>Cataract surgery (N=89)</td>
<td>64.87 (65)</td>
<td>65.66 (66)</td>
<td>+0.79</td>
<td>+1.22%</td>
</tr>
<tr>
<td>Varicose veins (N=90)</td>
<td>82.28 (82)</td>
<td>80.41 (80)</td>
<td>-1.87</td>
<td>-2.27%</td>
</tr>
<tr>
<td>Carpal tunnel syndrome (N=103)</td>
<td>65.50 (66)</td>
<td>65.21 (65)</td>
<td>-0.29</td>
<td>-0.44%</td>
</tr>
<tr>
<td>Mean for all procedures:</td>
<td>74.59 (75)</td>
<td>74.14 (74)</td>
<td>-0.45</td>
<td>-0.60%</td>
</tr>
</tbody>
</table>

The yearly waiting time averages were calculated across the mean of each category of operations. In addition to the absolute difference in waiting times (in days), the percentage difference between referral to treatment waiting times in 2011 and 2012 was also considered.

According to Table 4 above, Trusts’ performance with regard to average waiting times has improved slightly between 2011 and 2012. The mean of 75 days in 2011 compares to 74 days in 2012 meaning that patients have waited half a day less, on average.

The biggest improvement in waiting, according to the above figures, has been for patients waiting for hip replacement, knee replacement and varicose vein procedures. These patients have waited 2-2.5 days less, on average. Waiting times for hernia operations, tonsillectomies, gallstone and carpal tunnel syndrome procedures have also decreased – even if the average decrease has been of less than one day.

However, there have also been procedures which have left patients waiting longer in 2012 than in 2011. Adenoid operations and Myringotomies have seen an average increase of 1.5 days in referral to treatment waiting times. Patients waiting for cataract surgery have also waited longer in 2012 than they did in 2011 – an average increase of almost 1 day.

With a less than 1 per cent change in both the total number of procedures and the average waiting times, we have decided to take a closer look at the regional trends. To do this, we have grouped
Trusts by the respective SHA cluster that they fall into – namely, North, Midlands and East, London and South. The following analysis was only based on the Trusts which responded to the Freedom of Information request.

**Regional Analysis: Number of operations**

36 of the analysed Trusts belong to NHS North of England, 38 of them fall under NHS Midlands and East, 18 Trusts classify as part of NHS London with the remaining 24 constituting part of NHS South of England. Taking a look at the graphs below, it is more than obvious that the situation is much less clear-cut when analysing the situation at the regional level. The regional findings present a much more interesting and revealing picture of the situation on the ground than the aggregated data would imply.

**NHS North of England**

**Fig. 1 Total number of procedures – NHS North of England – Year-on-year comparison**

<table>
<thead>
<tr>
<th></th>
<th>North 2011</th>
<th>North 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>580.24</td>
<td>589.47</td>
</tr>
<tr>
<td>Median</td>
<td>346.00</td>
<td>356.00</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>1120.703</td>
<td>1095.524</td>
</tr>
</tbody>
</table>
Looking at Fig.1 and Statistics table 1 above, it is clear that there has been an increase in the total number of procedures across the ten categories, among Trusts in the North of England. 2,871 more operations were carried out in 2012, compared to 2011, an increase of 1.6%. The mean number of operations also increased from 580 in 2011 to nearly 590 in 2012.

---

### NHS South

**Fig. 2 Total number of procedures – NHS South of England – Year-on-year comparison**

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>South 2011</td>
<td>104500</td>
<td>106849</td>
<td>211349</td>
</tr>
<tr>
<td>South 2012</td>
<td>106849</td>
<td>110000</td>
<td>221849</td>
</tr>
</tbody>
</table>
Fig. 2 and Statistics table 2 testify to another case of year-on-year increase in the number of procedures performed in NHS Trusts who responded to our FOI request. The 104500 operations performed in 2011 compare to 106849 performed in 2012 – an increase of 2349 procedures, or 2.2%.

**Statistics table 2**

<table>
<thead>
<tr>
<th></th>
<th>South 2011</th>
<th>South 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>479.36</td>
<td>490.13</td>
</tr>
<tr>
<td>Median</td>
<td>290.00</td>
<td>307.50</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>680.818</td>
<td>689.538</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maximum</td>
<td>4050</td>
<td>4011</td>
</tr>
<tr>
<td>Sum</td>
<td>104500</td>
<td>106849</td>
</tr>
</tbody>
</table>

**NHS Midlands and East**

Fig. 3 Total number of procedures – NHS Midlands and East – Year-on-year comparison

![Graph showing the number of procedures in NHS Midlands and East for 2011 and 2012 with a year-on-year comparison. The data is as follows:](image_url)
Statistics table 3

<table>
<thead>
<tr>
<th></th>
<th>Midlands and East 2011</th>
<th>Midlands and East 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>500.04</td>
<td>485.08</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>319.00</td>
<td>299.00</td>
</tr>
<tr>
<td><strong>Std. Deviation</strong></td>
<td>693.734</td>
<td>645.768</td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>5052</td>
<td>5255</td>
</tr>
<tr>
<td><strong>Sum</strong></td>
<td>176515</td>
<td>171235</td>
</tr>
</tbody>
</table>

In contrast to the trends observed in NHS North and NHS South, Trusts in NHS Midlands and East have seen a decrease in the total number of procedures performed. These have fallen from 176,515 in 2011 to 171,235 in 2012 – a difference of 5280, or a decrease of 3%. The mean number of operations in the ten categories we asked about also decreased from 500 to 485.

**NHS London**

Fig. 4 Total number of procedures – NHS London – Year-on-year comparison

Statistics table 4

<table>
<thead>
<tr>
<th></th>
<th>London 2011</th>
<th>London 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
<td>493.16</td>
<td>488.78</td>
</tr>
</tbody>
</table>
Fig. 4 and Statistics table 4 show that NHS London also presents a fall in the total number of operations performed in 2012, compared to 2011. The number of procedures fell from 68549 to 67940 – in total, a fall of 609 procedures, or 1%. The mean number of procedures performed also fell – from 493 in 2011 to 489 in 2012.