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Evidence-Based Interventions: Consultation Document

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Evidence-Based Interventions

Consultation Document

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Overview of the consultation

Subject of this consultation:	Evidence-Based Interventions programme
Scope of this consultation:	Design principles for reducing the delivery of clinically ineffective interventions; the interventions we should target initially and proposed clinical criteria; the overarching goals; delivery actions including proposed new terms in the NHS Standard Contract. We are seeking your views on the proposed policy and delivery programme, with a view to announcing the finalised programme later this financial year.
Who should read this:	Individuals or organisations that may be directly affected by the policies being consulted on or that have a particular interest in the policy scope and objectives. Specifically, this includes patients (and their representatives), GPs, secondary care clinicians, NHS commissioners and providers of NHS-funded services.
Duration:	12 weeks, starting on 4 July 2018 and ending on 28 September 2018.
How to respond or enquire about this consultation:	Enquiries and responses can be shared via an online form at: **https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/**. Alternatively they can be emailed to: **england.EBinterventions@nhs.net**.
After the consultation:	Responses will be taken into account and considered fully before deciding the final approach. Any wording which, following consultation, we determine should be added to the NHS Standard Contract will be included in the 2019/20 version of the Contract, to be published later this financial year.
Getting to this stage and previous engagement:	NHS England has partnered with NHS Clinical Commissioners, the Academy of Royal Medical Colleges and NICE to develop the proposed policy, working in collaboration with the Royal Colleges[1] and patient groups including Healthwatch.

[1] Royal Colleges, in the context of this document, refers to the Royal Colleges of Surgeons including Association of Breast Surgery, Association of Coloproctologists of Great Britain and Ireland (ACPGBI), British Orthopaedic Association (including British Association for Surgery of the Knee (BASK), British Elbow and Shoulder Society (BESS), British Society for Surgery of the Hand (BSSH)), British Association of Otolaryngology (ENTUK), Vascular Society; the Royal Colleges of Physicians including British Association of Dermatology (BAD); the Royal College of Obstetricians and Gynaecologists (RCOG); the Royal College of Anaesthetists (RCoA) including the Faculty of Pain Medicine; the Royal College of General Practitioners (RCGP) and the Royal College of Ophthalmologists (RCOphth).

Introduction

1. Research evidence shows that some interventions are not clinically effective or only effective when they are performed in specific circumstances.[2] And as medical science advances, some interventions are superseded by those that are less invasive or more effective.

2. At both national and local levels, there is a general consensus that the NHS could get better at ensuring that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances.

3. We see five reasons to turn this consensus into action:

HIERARCHY OF GOALS

i. **Reduce avoidable harm** to patients. With surgical interventions, there is always a risk of complications and adverse effects which could be avoided.

ii. **Save precious professional time,** when the NHS is severely short of staff.

iii. **Help clinicians maintain their professional practice** in line with the changing evidence base.

iv. **Create headroom for innovation**. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of least effective interventions performed.

v. **Maximise value and avoid waste.** Ineffective care is poor value for money for the taxpayer and the NHS.

4. Numerous prior initiatives have tried to tackle this issue. The National Institute for Health and Care Excellence (NICE) and Choosing Wisely UK have published important guidance to try to eliminate ineffective practice, but the NHS has not consistently implemented their recommendations.[3] Clinical Commissioning Groups (CCGs) have tried locally to implement change, but they have told us that their efforts need to be better supported by the national statutory and professional

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[2] This includes: NICE *'do not do' recommendations;* NICE *Cost Saving Guidance;* http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/; https://choosingwiselycanada.org/recommendations/; http://www.choosingwisely.org.au/recommendations; http://www.choosingwisely.org/clinician-lists/. See Appendix 8 for full references.

[3] NICE *'do not do' recommendations;* NICE *Cost Saving Guidance;* http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/

bodies. CCGs and the Royal Colleges are now helping to spearhead a national concerted effort.

5. Earlier this year, NHS England and NHS Clinical Commissioners launched a new programme focusing on *items that should not be routinely prescribed in primary care*[4]. As part of a new national collaboration, we are today launching a new counterpart to that programme: the Evidence-Based Interventions programme. This drive is being complemented by new national ambitions to embed personalised care across England, so that shared decision making between patients and clinicians becomes the norm. When interventions are offered, patients should be made aware of the risks and benefits of all options in order to make informed decisions.

6. Working together, we propose to reduce the volume of procedures performed for seventeen specific types of intervention, rapidly and appropriately, so that practice better reflects the research evidence.

[4] https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/

Six Design Principles

i. We will ensure that the programme is **rooted in research**, and evidence-based guidance, on what is, and is not, clinically and cost effective for patients and local communities.

ii. We will seek to **achieve a broad consensus** across the array of professional, patient and NHS organisations. Public and clinical perspectives are critical to our success. The programme will therefore aim to achieve highly effective engagement with clinicians and the public.

iii. We will first develop proof of concept, by having a **relatively narrow initial focus on a few interventions**, rather than pursuing all possible opportunities at once. One of the reasons similar initiatives have failed in the past is because they aimed too wide too soon. Through subsequent phases, the programme could then rapidly expand.

iv. We will establish **clear, quantified national and local goals** based on analysis of unwarranted variation across the country. The final goals will be informed by feedback from the consultation, and widely communicated.

v. We will commit to making **rapid progress.** We intend to demonstrate significant impact by the end of 2019/20.

vi. We will establish a **comprehensive array of specific actions** that will give effect to these goals in the specified timeframe.

Consultation Question
1. Do you agree with our six design principles?

Phase 1: A focus on 17 proposed interventions

7. We initially identified a large number of interventions from clinical evidence including NICE guidelines, Choosing Wisely recommendations, academic studies

and local CCGs' work on Procedures of Limited Clinical Effectiveness (PoLCE), collated through NHS Clinical Commissioners.[5]

8. Taking these as a starting point, we shortlisted them by:

   - prioritising changes that we could test our approach on and implement relatively quickly on a large scale. We focused on surgical interventions commissioned by CCGs, where there was high variability in the application of clinical guidelines (see Appendix 7);

   - working with the Royal Colleges, clinicians, clinical commissioners and professional leaders to refine the list, ensuring clinical consensus and speciality buy-in;

   - working with NHS Clinical Commissioners as the representative organisation for CCGs;

   - initially liaising with a number of patients and patient representative groups to test the proposals and understand their priorities, including Healthwatch; and

   - aligning our approach with national programmes like the NHS RightCare programme and NHS Improvement's GIRFT programme.

9. In addition, we carried out an initial equality impact assessment on the proposals – see Appendix 4 for further details and next steps.

10. The NHS England Medical Advisory Group, comprising national clinical directors, supported the final list of seventeen interventions for consultation, specifically:

    - four interventions that should not be routinely commissioned by CCGs or performed, unless a successful Individual Funding Request (IFR) is made (Category 1) either because they are a) ineffective or b) have been superseded by a less invasive or more effective alternative;

    - thirteen interventions that should only be commissioned by CCGs or performed when specific clinical criteria are met (Category 2) – this is because they have only been shown to be effective in certain circumstances.

11. We are seeking views on these interventions and clinical criteria. The criteria for nine of these interventions are in line with NICE guidelines and one in accordance with the Scottish Intercollegiate Guidelines Network (SIGN). The remaining seven are based on broader clinical evidence.

12. We will revise our list in light of the feedback received and demonstrate how we have responded to the consultation. The final list will be announced later this financial year.

[5] This includes NICE *'do not do' recommendations;* NICE *Cost Saving Guidance;* http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/; https://choosingwiselycanada.org/recommendations/; http://www.choosingwisely.org.au/recommendations; http://www.choosingwisely.org/clinician-lists/. See Appendix 8 for full references.

13. There is a complementary programme of work underway to empower patients and deliver more personalised care. The proposed criteria should be seen against the backdrop of shared decision making and self-care, in which clinicians and patients work together to select treatments based on clinical evidence and patients' informed preferences.

14. We intend to make this a much wider, on-going programme, subject to making sufficient progress in the first phase. We will consult on further interventions in phase two, which will be launched in the new year. We will keep the list under periodic review as the evidence base grows in future years. Phase two will also include specialised services, which are commissioned by NHS England.

15. To this end, we would welcome your recommendations on further interventions that could be added to the initial list. Should you wish to press for additional interventions to be included in the initial list, we ask that you share suggestions by 31 July 2018, along with the supporting clinical evidence and criteria, to enable them to be considered. Recommendations received after 31 July 2018 would still be welcomed and may be used in future rounds.

16. Some local systems have already developed and implemented plans to address the issues set out in this document, engaging and consulting local clinicians, providers and their local populations. We have no desire to reverse legitimate local decision-making and encourage those local systems to continue to make progress in line with their plans. It will be important for the national programme to learn from those furthest on with implementation. We will encourage sharing of learning and peer-to-peer support to other local systems (see demonstrator communities section for further details).

Category 1: Interventions which should not be routinely commissioned or performed

Ref.	Intervention	Summary of Rationale
ENT		
A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA)	In two systematic reviews of a combined 72 primary research studies[6], there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has an up to 16% risk of severe complications (bleeding, airway compromise, death). We therefore propose it is no longer commissioned. A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion.

[6] See Appendix 2 for full references

Gynaecology		
B	Dilatation and curettage (D&C) for heavy menstrual bleeding in women	NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.[7] Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), should be used to investigate heavy periods. Medication and intrauterine devices (IUS), as well as weight loss (if appropriate) should be used to treat heavy periods.
Orthopaedics		
C	Knee arthroscopy for patients with osteoarthritis	NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis. More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and managing pain.[8]
D	Injections for nonspecific low back pain without sciatica	NICE recommends that spinal injections should not be offered for nonspecific low back pain. Alternative options like pain management and physiotherapy have been shown to work.[9]

17. See Appendix 2 for further information about the interventions, the proposed clinical criteria and clinical evidence base. Appendix 1 includes a glossary of clinical terms.

Category 2: Interventions which should only be routinely commissioned or performed when specific criteria are met

Ref.	Intervention	Rationale and where we are seeking your views
E	Breast reduction	The evidence highlights that breast reduction is only successful in specific circumstances and the procedure can lead to complications - for example not being able to breast feed permanently.[10] We are therefore proposing that breast reduction is only undertaken under the criteria outlined in Appendix 2. We would like to seek views on the criteria as part of this consultation. Wearing a

7 https://www.nice.org.uk/guidance/ng88 and https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy – see Appendix 2 for full references.

8 https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117; https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance; https://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not – See Appendix 2 for full references

9 https://www.nice.org.uk/guidance/ng59 – See Appendix 2 for full references

10 See Appendix 2 for full references.

		professionally fitted bra, losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts.
Dermatology		
F	Removal of benign skin lesions	Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined in Appendix 2. Risks from the procedure can include bleeding, pain, infection, and scarring. We would like to seek views on the criteria proposed in Appendix 2.[11]
ENT		
G	Grommets for Glue Ear in Children	Evidence suggests that grommets only offer a short-term hearing improvement in children with glue ear who have no other serious medical problems or disabilities. They should be offered in cases that have a history of persistent (at least 3 months) bilateral, hearing loss as defined by the NICE guidance. Hearing aids can also be offered as an alternative to surgery. [12]
H	Tonsillectomy for recurrent tonsillitis	Recurrent sore throats are a very common condition that present a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the SIGN criteria are met. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.[13]
General Surgery		
I	Haemorrhoid surgery	Numerous interventions exist for the management of haemorrhoids. The evidence recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.[14] Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less

[11] https://www.nice.org.uk/guidance/csg8; https://www.nice.org.uk/guidance/ng12 – see Appendix 2 for full references
[12] https://www.nice.org.uk/Guidance/CG60 – see Appendix 2 for full references
[13] http://www.sign.ac.uk/assets/sign117.pdf;– see Appendix 2 for full references
[14] https://www.nhs.uk/conditions/piles-haemorrhoids/; https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/rcsacpgbirectalbleeding2017documentfinal_jan18.pdf – See Appendix 2 for full references

		severe haemorrhoids.
Gynaecology		
J	Hysterectomy for heavy menstrual bleeding	NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.[15] Heavy periods can be reduced by using medicines or a coil (intrauterine device) or losing weight (if necessary).
Ophthalmology		
K	Chalazia removal	The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a "watch and wait" approach will lead to resolution of many chalazia without the risks of surgery. We propose chalazia be removed only according to the criteria listed in Appendix 2.[16]
Orthopaedics		
L	Arthroscopic shoulder decompression for subacromial shoulder pain	Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases. Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery. Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf In order to facilitate non-operative treatment in primary and intermediate care, BESS and GIRFT have produced patient exercise rehab videos and booklets for GPs and patients to use. http://www.bess.org.uk/index.php/public-area/shpi-videos[17]

[15] https://www.nice.org.uk/guidance/ng88.- See Appendix 2 for full references.
[16] https://cks.nice.org.uk/meibomian-cyst-chalazion - See Appendix 2 for full references
[17] See Appendix 2 for full references

M	Carpal tunnel syndrome release	Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time, splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. We are proposing that surgical treatment of carpal tunnel is only offered under the criteria included at Appendix 2 and would like to seek views on the proposed criteria as part of this consultation.[18]
N	Dupuytren's contracture release	NICE has reviewed the evidence for surgical treatment of Dupuytren's contracture. It found that after 3 to 5 years, the problem had returned in about half of the patients treated. We propose that surgery is only offered according to the criteria outlined in Appendix 2. [19] Physiotherapy and splinting can treat Dupuytren's contracture.
O	Ganglion excision	Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can cause complications, and recurrence is common following surgery. The complications may be similar to or worse than the original problem. We are proposing that Ganglion excision is only offered under the criteria outlined in Appendix 2.[20]
P	Trigger finger release	Trigger finger often resolves following a period of conservative management (splinting, analgesia). Steroid injection can be considered. We are proposing that surgery is only offered in specific cases where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs. We would like to seek views on the proposed criteria in Appendix 2 as part of this consultation.[21]
Vascular Surgery		
Q	Varicose vein surgery	NICE has published detailed guidance on what treatment should be considered for varicose veins and when. Surgery for varicose veins is not recommended before alternative, less invasive options are considered. Surgery is a traditional treatment that involves removal of the vein by ligation (tying off the vein) and 'stripping' out the vein and does not always get rid of varicose veins; they often come back again. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy should be tried before considering surgery. Compression hosiery is not recommended if an interventional treatment is possible.[22]

[18] See Appendix 2 for full references
[19] https://www.nice.org.uk/guidance/ipg43 - See Appendix 2 for full references
[20] See Appendix 2 for full references
[21] See Appendix 2 for full references
[22] https://www.nice.org.uk/guidance/qs67 - See Appendix 2 for further information

18. See Appendix 2 for further information about the interventions, proposed clinical criteria and clinical evidence base. Appendix 1 includes a glossary of clinical terms.

Consultation Questions

2a. Do you agree that selecting circa 17 interventions is about the right number for this first phase? If not, why not?

2b. Are there interventions you think we should add for the first phase? If so, please share your suggestions, along with the clinical evidence and criteria, no later than 31 July 2018 for them to be considered.

2c. Are there interventions we should remove? If so, why?

3. Do you have any suggested amendments to the proposed clinical criteria? If so, why so?

4. Do you agree this should become an on-going rolling programme, subject to making sufficient progress?

5. What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:

- ***groups protected under the Equality Act 2010?[23]***
- ***those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?***

Illustrative activity goals

19. The main reason for introducing this programme is to prevent avoidable harm to patients and free up clinical time and capacity. This means reducing activity for these seventeen interventions. Last year, based on an initial assessment, we estimate the seventeen interventions were performed 348,201 times, amounting to £439m spend (gross figure - see table below). [24] This baseline figure will be subject to further review.

20. For Category 1 interventions, it is reasonable to expect a very significant reduction in activity. We expect that Individual Funding Requests (IFRs) for these interventions will still be permissible, but only made in exceptional circumstances

[23] The following characteristics are protected characteristics as set out in the Equality Act (2010): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.
[24] Appendix 6 sets out how we calculated this.

when the clinician is able to demonstrate why an individual is exceptional compared to the rest of the population with the condition, and would therefore derive benefit. We have modelled three different illustrative scenarios: a conservative target based on a 90% reduction in national activity, a moderate target based on a 95% reduction in national activity, and an ambitious target based on a 99% reduction in national activity:

	Conservative Activity Reduction	Moderate Activity Reduction	Ambitious Activity Reduction
Category 1	**38,651**	**40,794**	**42,507**

Based on this methodology, our initial estimate is that between £48.9m and £53.8m (initial gross figures) could be freed up in capacity for other interventions.

21. For Category 2 interventions, it is more difficult to judge the impact on activity as the clinical criteria are still being agreed. We have modelled three different illustrative scenarios: a conservative target based on a reduction to the 25th percentile of the age-sex standardised rate of CCGs, a moderate target based on a reduction to the 20th percentile of the age-sex standardised rate of CCGs, and an ambitious target based on a reduction to the 15th percentile of the age-sex standardised rate of CCGs:

	Conservative Activity Reduction	Moderate Activity Reduction	Ambitious Activity Reduction
Category 2	**112,989**	**127,211**	**142,949**

Based on this methodology, our initial estimate is that between £133.8m and £173.1m (initial gross figures) could be freed up in capacity for other interventions.

22. We propose to base any initial activity goal on the “moderate” scenario as broken down in the table below. This would result in 168,005 fewer procedures which could free up £203.3m capacity (initial gross figure). However this is an illustrative estimate of the possible opportunities, and we intend to test our assumptions as part of the consultation exercise, before confirming the actual figure later this year.

Ref	Intervention	Activity (2017/18)	Potential activity reduction (conservative)	Potential activity reduction (moderate)	Potential activity reduction (ambitious)
A	Intervention for snoring (not OSA)	733	660	696	726
B	Dilatation & curettage for heavy menstrual bleeding	255	230	242	252
C	Knee arthroscopy with osteoarthritis	11,972	10,775	11,373	11,852
D	Injections for nonspecific low back pain without sciatica	29,976	26,987	28,482	29,676
Total: category 1		**42,936**	**38,651**	**40,794**	**42,507**
E	Breast reduction	3,159	1,095	1,241	1,472

Ref	Intervention	Activity (2017/18)	Potential activity reduction (conservative)	Potential activity reduction (moderate)	Potential activity reduction (ambitious)
F	Removal of benign skin lesions	104,967	44,594	48,871	53,155
G	Grommets	8,661	3,314	3,679	4,190
H	Tonsillectomy	32,103	7,412	9,150	10,737
I	Haemorrhoid surgery	8,461	2,845	3,196	3,550
J	Hysterectomy for heavy bleeding	18,173	4,724	5,510	6,834
K	Chalazia removal	6,755	4,620	4,968	5,251
L	Shoulder decompression	19,730	7,909	8,914	9,844
M	Carpal tunnel syndrome release	43,979	14,836	17,112	19,868
N	Dupuytren's contracture release	14,704	4,236	4,686	5,730
O	Ganglion excision	7,558	2,867	3,279	3,586
P	Trigger finger release	8,220	2,849	3,104	3,345
Q	Varicose vein surgery	28,795	11,690	13,501	15,387
Total: category 2		**305,265**	**112,989**	**127,211**	**142,949**
Grand Total		**348,201**	**151,640**	**168,005**	**185,455**

Further information on how we have calculated the activity can be found in Appendix 6.

23. We know that CCGs are already making efforts to reduce these interventions and we expect to see further, faster progress in 2018/19 in light of this programme.

24. Pace is a core design principle of the programme. If the trend over the past 5 years continued, it would take over a decade to achieve the reductions in activity set out in our "moderate" scenario for Category 1 interventions and 25 years for those in Category 2. For this reason, we will set local activity targets for 2019/20 later this year as part of the planning process.

25. We have increasingly encouraged CCGs and providers to work together through STPs and ICSs to transform services locally. In line with this, we expect CCGs and providers to work collaboratively in implementing these changes and agreeing how any released capacity is deployed for the benefit of patients. They will need to work together with provider clinicians and GPs to ensure the clinical changes are put into effect. It is important in the early stages of implementing the changes that account is taken of the likely financial impact on providers, particularly where the changes in the volume of activity are likely to be significant. We would expect that the freed up capacity will be used for other elective activity, for example to improve performance against the Referral to Treatment (RTT) standards, as part of plans agreed with CCGs. This freed up capacity may reduce the need for NHS providers to outsource procedures, for example in orthopaedics. Providers should not be paid for decommissioned activity as well as additional activity made possible by the freed up capacity. This should be seen in the context of overall elective activity which is expected to rise in 2019/20.

Consultation Questions
6. At what level should we pitch our ambition – ambitious, moderate or conservative? Do you have any suggestions to improve our methodology?

Delivery Actions

26. We propose to take twelve actions to support delivery, as summarised below.

Engaging the system
• National collaboration to steer the programme and provide guidance to the system • Systematic, multi-channel communication and engagement with clinicians, patients and commissioners • Demonstrator communities to test proposals before December 2018 and clinical champions to provide peer-to-peer support to other systems
Aligning incentives to the evidence
• Enable clinicians to apply for Individual Funding Requests for Category 1 interventions where they can demonstrate exceptionality, and require clinicians to seek Prior Approvals for Category 2 interventions • Introduce zero payment for Category 1 interventions • Amend the NHS Standard Contract for Category 1 and 2 interventions • Align the e-referral system with the new programme
Applying a rigorous approach to assess implementation
• Local activity targets for 2019/20 • Integrated monthly dashboard to monitor delivery • Local system audits (commissioner and provider) to review compliance • STP and CCG Improvement and Assessment Framework (IAF) to measure effectiveness • Aligning CQC inspection with the policy

Engaging the system

National collaboration to steer the programme and provide guidance to the system

27. Development of this policy has been driven by a national collaboration, comprising NHS England, NHS Clinical Commissioners, NHS Improvement's Getting it Right First Time programme (GIRFT), NICE, AoMRC and the relevant Royal Colleges. This collaboration will continue to support delivery and identify further interventions for action.

28. We will reinforce this collaborative approach through new governance arrangements, including:

- a new national steering group comprising representatives from the national collaboration, as well as the Royal Colleges to identify new priorities for action and provide guidance to the system;

- a programme management group to monitor progress and drive implementation, working with local systems.

29. The role of the Royal Colleges and NHS Clinical Commissioners will be particularly important in building engagement and support amongst the clinical community. This policy builds on years of work by the Royal Colleges and their professional leadership and will be important in winning clinical hearts and minds. Similarly, CCGs already have existing policies for many of these interventions, built upon their local work with providers and patient groups. NHS Clinical Commissioners will be able to help – as they have with other policies – in building from this position and ensuring the necessary engagement between CCGs and their GPs.

Systematic, multi-channel communication and engagement with clinicians, patients and commissioners

30. We will use multiple channels to communicate the policy and support local systems to implement the changes.

31. We will publish statutory guidance for CCGs on Evidence-Based Interventions, under Section 14Z8 of the NHS Act 2006. We will hold roadshows and webinars for commissioners to support them to implement the changes.

32. The Royal Colleges will disseminate further information to members of their Associations and Colleges on implementing the criteria, via their communications channels. Clinical champions will be identified for each intervention to support spread and adoption across the system.

33. We will support virtual collaborative meetings to discuss differences and opportunities for improvement and action across communities.

34. We also will work with Healthwatch to ensure appropriate patient engagement.

Consultation Question
7. What further suggestions do you have to enable effective communication and engagement to support with implementation?

Demonstrator Communities to test proposals before December 2018 and provide peer-to-peer support to other systems

35. In the next few weeks, in parallel to this consultation, we will identify a small number of exemplar geographies, which are furthest advanced in implementing the clinical recommendations for the seventeen interventions. We will invite these geographies to form a reference group to further test our proposals and assumptions, including the opportunities to reduce activity. As part of this, we will monitor the volume of IFRs and prior approvals for the seventeen interventions, which should only be used in exceptional circumstances.

36. We will also ask these geographies to share learning and provide peer-to-peer support to other systems in implementing the final policy.

Consultation Question
8. Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018? Please list.

Aligning incentives to the evidence

Enable clinicians to apply for Individual Funding Requests (IFR) for Category 1 interventions where they can demonstrate exceptionality, and require clinicians to seek Prior Approval for Category 2 interventions

37. The approach we are proposing will mean that the interventions set out in this document will not be routinely offered to NHS funded patients or offered only if specific criteria apply. However, we recognise that there will be cases where clinicians consider that an exception should be made because of the particular needs of a patient.

- **Individual Funding Request for Category 1 interventions**: We propose that GPs should use their local CCG's IFR process to seek approval to refer a patient for a Category 1 intervention where they can demonstrate exceptionality. For example, when the clinician is able to demonstrate that

the individual is different in some way from all patients with the condition AND they can provide the evidence for why this individual might benefit more from the procedure than other similar patients. IFRs are a well-established process which allows clinicians to apply to the relevant commissioner to fund treatments that are not routinely provided by the NHS. A panel of healthcare professionals and commissioners reviews such applications and the evidence before reaching a decision.

- **Prior approval for Category 2 interventions:** Similarly, we propose that GPs should seek prior approval from the relevant CCG to refer patients for Category 2 interventions. This would be a less onerous process than IFR, through which GPs would demonstrate to the CCG that the patient meets the criteria for referral set out in this policy. The CCG would then review the application and make a decision. We propose to outline a single, best practice way of doing the prior approval for the thirteen Category 2 interventions to support GPs with implementation with NHS Clinical Commissioners.

38. In general, our expectation is that it will be clear at the point of GP referral that the referral is specifically being considered with a view to one of the seventeen Category 1 and Category 2 procedures to be carried out. Because of this, our view is that it will be appropriate for the GP to initiate the IFR (where they can demonstrate exceptionality for Category 1 interventions) or prior approval process, rather than this being done by the provider clinician. Where approval is received, the GP will be able to confirm this to the receiving provider clinician, so that the provider can proceed to carry out the treatment. Note also that, in exceptional circumstances, a GP may wish to seek IFR approval for Category 2 treatment for a patient who does not meet the clinical criteria set out in Appendix 2.

39. There may be situations where a patient potentially needing a Category 1 or 2 treatment is identified by a provider clinician only following GP referral or, perhaps, emergency admission or A&E attendance. In this situation, the provider clinician would be expected to follow the existing NHS Standard Contract provisions on onward referral (which might entail referring the patient back to the GP, so that the GP could consider further treatment options). In any event, as a backstop, we propose to amend the NHS Standard Contract to include a provision (see section below) to the effect that a provider will not be paid for carrying out a Category 1 or 2 intervention without evidence of either IFR approval (Category 1) or other prior approval (Category 2).

Consultation Question
9a. Do you agree that with our proposals for IFR for Category 1 interventions? If not, what alternative(s) would you propose? ***9b. Do you agree that with our proposals for prior approval for Category 2 interventions? If not, what alternative(s) would you propose?***

Introduce zero payment for Category 1 interventions without IFRs

40. For the four Category 1 interventions we propose to no longer routinely commission, we will consider how the National Tariff and the NHS Standard Contract could be changed to support this clinically led change. For the Tariff, we will consider removing Category 1 from the scope of the National Tariff price or establishing a national variation, so that providers are not paid for activity unless in exceptional circumstances, where prior approval of an IFR has been given by the commissioner. We want to implement this change as quickly as possible, and are proposing it applies from April 2019. We would welcome views on this. If an IFR is made, providers would be paid under the existing tariff.

41. Our proposal is to work with NHS Improvement and providers to change the tariff for the Category 1 interventions from April 2019 and include it in the National Tariff consultation document for 2019/21.

42. For the thirteen Category 2 interventions we propose are only commissioned when specific criteria are met, instead, new arrangements will be specified in the national NHS Standard Contract (see section below).

Consultation Question
10a. Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made? ***10b. Do you agree this change should apply from 2019? If not, why not?***

Amend the NHS Standard Contract for Category 1 and 2 interventions

43. We propose, with effect from 1 April 2019, to mandate compliance with the Evidence-Based Interventions policy through the NHS Standard Contract. (The NHS Standard Contract is published by NHS England and is mandated for use by NHS commissioners when commissioning healthcare services, other than primary care, from all providers, whether NHS Trusts, Foundations Trusts or other organisations such as independent sector providers of NHS services.)

44. Our proposed additions to the Contract will support and reinforce the arrangements we are looking to introduce through the National Tariff. In summary, they will:

    - require both commissioners and providers to comply with the Evidence-Based Interventions policy; and

    - enable the commissioner to withhold payment for the relevant procedure where the provider treats a patient without evidence of IFR approval (Category 1) or other prior approval (Category 2).

45. See Appendix 5 for the proposed wording for the NHS Standard Contract.

Consultation Question
11a. Do you support our intention to mandate compliance with the Evidence- Based Interventions policy through the NHS Standard Contract? ***In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:*** ***11b. Do you support our proposed wording for the new Contract requirements?*** ***11c. Do you have any specific suggestions for how the Contract wording could be improved?***

Aligning the e-referral system with the new programme

46. Engagement with GPs, as well as provider clinicians, will be key to successful implementation of the new policy. Clearly GPs will need to be familiar with the policy in making referrals. We will work with the Royal College of General Practitioners to ensure the changes are communicated directly to GPs.

47. We intend to exclude Category 1 interventions from the e-referral system except where an IFR has been agreed and we will work with CCGs and GPs on how best to implement this.

48. Prior to the clinical criteria being confirmed in December 2018, we will encourage clinicians to ensure their patients are fully informed of the risks of proceeding with these interventions.

Applying a rigorous approach to assess implementation

49. Previous attempts to decommission interventions on the basis of clinical evidence have faltered through lack of sustained national and local drive and the absence of formalised levers to support implementation. We intend to rectify this through the introduction of new levers and a range of measures to monitor and support progress. Nationally, NHS England will ultimately be accountable for successful implementation of the policy, aided by the clear delivery commitment of our partners. We will also look to Trust Boards and CCG Governing Bodies to provide focus and drive in implementing the new policy.

Local activity targets for 2019/20

50. We will break down the national aggregate activity reduction opportunity into local STP and potentially CCG targets for 2019/20. We know that a number of organisations are already trying to implement at least some of the changes proposed in this document. We encourage all organisations to make progress

this year on implementing the Evidence-Based Interventions policy. STP and potentially CCG and Trust level targets will be published later this financial year as part of the planning process.

51. In financially challenged systems, accelerated progress on implementing the Evidence-Based Interventions policy will be an integral part of recovery plans.

Integrated monthly dashboard to monitor delivery

52. We will produce a monthly dashboard to monitor outcomes. For each intervention, we will monitor the trend data against target volumes and spend. Where there is significant variance, we will work with commissioners and providers to understand the causes and where necessary, support them to address any issues.

53. The dashboard will provide a summary of how effectively this programme is being implemented across England. We intend to combine the monitoring data and dashboard for this programme with our low value medicines programme to simplify reporting for commissioners and providers.

54. We will work with NHS RightCare and NHS Improvement's Getting It Right First Time programme (GIRFT) to consider how we can use the information from our dashboard to support the delivery of their programmes and to target support on "outlier" health systems.

Local system audits (commissioner and provider(s)) to review compliance

55. We will expect local systems (commissioner and provider(s)) to undertake an annual audit (starting in 2019/2020) to ensure compliance with the Evidence-Based Interventions policy. CCGs will need to ensure that they are not paying for interventions that should not be routinely commissioned, unless prior approval has been agreed. Providers will need to ensure that they are acting in accordance with the Evidence-Based Interventions policy.

STP and CCG Improvement and Assessment Framework (IAF) to measure effectiveness

56. NHS England will consider the inclusion of an indicator of progress on *items that should not be routinely prescribed in primary care* and the Evidence-Based Interventions policy in the evolving CCG and STP assessment frameworks. This will be based on work with the demonstrator communities to test the proposals before December 2018.

Aligning CQC inspection with the policy

57. We are working with the Care Quality Commission (CQC) to consider how we can incorporate information about how effectively providers are applying this guidance into their inspection methodology and quality ratings. CQC will consider whether to include this as part of the effectiveness domain for providers, as they go through their regular refresh of the inspection methodology.

Consultation Question
12. Given the mixed record of applying research-based evidence to decommission ineffective treatments, do you agree that we should introduce the range of performance management measures proposed above? If not, why not?

Next steps

58. The consultation will run from 4 July to 28 September 2018. Following the close of the consultation, we will analyse and consider all responses received to inform our final approach, which will be announced later this financial year.

How to provide feedback

59. If you would like to respond to this consultation you can do so by:

1. Using the **online web-form** at: **https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/**. Questions from the online form are listed in the next section.

2. **Written responses** can also be submitted to **england.EBinterventions@nhs.net**. Please note that we will not be able to respond to every response individually.

60. In addition we will be holding a number of events to gather further clinical, professional and patient views. This will include:

- **Events**
  - NHS England will be holding two open events for patients to discuss the proposals and share feedback.
  - The first event will be held in Leeds on Wednesday 22 August (12.00 to 14.00) and the second in London on Thursday 23 August (10.00 to 12.00).
  - To register your interest, please email: **england.EBinterventions@nhs.net**

- **Healthwatch webinar**
  - Healthwatch England will be hosting a webinar at 10am on 6 August for their members to discuss and share feedback on the proposals.
  - Healthwatch members can register their interest by emailing: Joshua.edwards@healthwatch.co.uk.

61. We will also be holding a series of webinars for:

- CCGs in collaboration with NHS Clinical Commissioners
- Providers of NHS-funded services

Further details will be communicated in due course.

Summary of Consultation Questions

Please note this is an adapted version of a questionnaire designed for an internet web page. To view the questionnaire in its intended format and submit responses please visit: **https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/**.

It is our intention to publish a summary of the responses we receive to this consultation on the NHS England website in due course. You can respond with your name and/or organisation, you can remain anonymous or ask that your details are kept confidential and excluded from the published summary of responses. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential.

Please also be aware that the summary may include details taken from any area of the consultation response, and so please bear this in mind when providing your comments. If you would prefer any particular comments are kept confidential (i.e. not published) please make this clear.

If you provide us with any personal information (i.e. name or email address) we will process, hold and store this in accordance with the General Data Protection Regulation and the Data Protection Act 2018. Your details will be kept for the minimum time necessary.

Introduction

In what capacity are you responding?

- Patient/Family member, friend or carer of patient/Member of the public/Patient representative organisation/Voluntary organisation or charity/Clinician/Clinical Commissioning Group/NHS Provider organisation/Industry/Other NHS Organisation/Other Healthcare Organisation/Professional Representative Body/Regulator/Other (please specify)

Name (optional)

Email address (optional)

Have you read the document: *Evidence-Based Interventions: Consultation Document?*

- **Yes**
- **No**

Design principles

1. Do you agree with our six design principles?

Phase 1: A focus on 17 proposed interventions

2a. Do you agree that selecting circa 17 interventions is about the right number for this first phase? If not, why not?

2b. Are there interventions you think we should add for the first phase? If so, please share your suggestions, along with the clinical evidence and criteria, no later than 31 July 2018 for them to be considered.

2c. Are there interventions we should remove? If so, why?

3. Do you have any suggested amendments to the proposed clinical criteria? If so, why so?

4. Do you agree this should become an on-going rolling programme, subject to making sufficient progress?

5. What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:

- ***groups protected under the Equality Act 2010?[25]***
- ***those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?***

Illustrative activity goals

6. At what level should we pitch our ambition – ambitious, moderate or conservative? Do you have any suggestions to improve our methodology?

Engaging the system: systematic, multi-channel communication and engagement with clinicians, patients and commissioners

7. What further suggestions do you have to enable effective communication and engagement to support with implementation?

[25] The following characteristics are protected characteristics as set out in the Equality Act (2010): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Engaging the system: Demonstrator Communities to test proposals before December 2018 and provide peer-to-peer support to other systems

8. Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018? Please list.

Require Individual Funding Requests for Category 1 interventions and Prior Approvals for Category 2 interventions

9a. Do you agree that with our proposals for IFR for Category 1 interventions? If not, what alternative(s) would you propose?

9b. Do you agree that with our proposals for prior approval for Category 2 interventions? If not, what alternative(s) would you propose?

Introduce zero payment for Category 1 interventions

10. Do you agree with our intention to Mandate through the National Tariff that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?

Amend the NHS Standard Contract for Category 1 and 2 interventions

11a. Do you support our intention to mandate compliance with the Evidence Based Interventions Policy through the NHS Standard Contract?

In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:

11b. Do you support our proposed wording for the new Contract requirements?

11c. Do you have any specific suggestions for how the Contract wording could be improved?

Applying a rigorous approach to assess implementation

12. Given the mixed record of applying research-based evidence to decommission ineffective treatments, do you agree that we should introduce the range of performance management measures proposed above? If not, why not?

Appendix 1: Glossary

AoMRC	Academy of Medical Royal Colleges
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
ENT	Ear, Nose and Throat
GIRFT	Getting it Right First Time
IAF	Improvement and Assessment Framework
ICS	Integrated Commissioning System
IFR	Individual Funding Request
NHSCC	NHS Clinical Commissioners
NICE	National Institute for Health and Care Excellence
OSA	Obstructive Sleep Apnoea
PoLCE	Procedures of Low Clinical Effectiveness
RCoA	Royal College of Anaesthetists
SIGN	Scottish Intercollegiate Guidelines Network
STP	Sustainability and Transformation Partnership
SUS	Secondary Uses Service

Clinical Glossary

Acromio-clavicular joint: a joint at the top of the shoulder between the clavicle and the scapula

Amenorrhoea: not having periods (bleeding from the womb)

Analgesia: medication to get rid of pain

Apnoea: Temporary pausing / stopping of breathing

Arthroscope: small camera that is inserted into a joint to examine the inside of the joint

Arthroscopic shoulder decompression: surgery to take out small pieces of bone and soft tissue (like tendons) from inside the shoulder by keyhole surgery

Arthroscopic washout: operation where an arthroscope (camera) is inserted in to a joint along with fluid that is drained out again.

Asymptomatic: not causing any symptoms (problems), for example not causing pain

Atrophic tympanic membrane: Thinned, collapsing or retracting ear drum that can affect hearing or lead to erosion of hearing bones

Benign skin lesions: lumps or bumps on the skin that are not suspicious for skin cancer

Biopsy: small sample of tissue, for example the lining of the womb, is taken out for examination under a microscope

Breast hyperplasia: enlargement of the breasts

Breast reduction: surgery to reduce the size of the breast by removing fat, breast tissue and skin

Calcific tendinopathy: a condition where small particles or crystals collect in the tendons that connect muscle to bone. It occurs most commonly in the shoulder.

Carpal tunnel syndrome: pressure on a nerve in the wrist causing pain, tingling or numbness in the fingers

Cervix: opening of the womb

Chalazia (meibomian cyst): small lump in the eyelid caused by a blocked and swollen oil gland

Chronic venous insufficiency: a condition where the veins are not working properly and blood pools or collects in the vein and is not returned to the heart

Complex regional pain syndrome: severe pain and swelling in the hand that sometimes occurs following surgery

Deep vein thrombosis: blood clot that develops in one of the large veins in the body for example in the lower leg

D&C: dilatation and curettage, a procedure where the opening to the womb (the cervix) is widened (dilated) and the lining of the womb is scraped out (curettage)

Digital artery: blood vessel in a finger

Distal interphalangeal joint mucous cysts: ganglions or fluid filled sacks that occur near the tip of the finger at the joint near the nailbed

Dupuytren's contracture: small nodules or thickening on the tendons in the hand that prevent the fingers from straightening completely

Endothermal ablation: radio waves or lasers are used to seal off the varicose vein

Fasciectomy: removing thickened tissue by surgery

Fasciotomy: cutting or dividing thickened tissue

Fibroids: growths in the uterus (womb) that are not cancer but can cause heavy periods and pain

Ganglion: small cyst or fluid filled sac that arises near a joint or a tendon, for example at the wrist, the ganglion can press on a nerve causing pain or tingling.

Ganglion excision: surgery to remove a ganglion and the stalk from the tendon it is attached to.

Globus: Persistent feeling of something in the throat when there is nothing there

Glue Ear: Build up of fluid in the middle part of the ear, behind the ear drum.

Grommet: Tiny plastic tube inserted through ear drum during a surgical procedure

Gynaecomastia: enlargement breast tissue in men

Haemarthrosis: bleeding inside a joint, for example the knee joint

Haemorrhiods (piles): swellings containing blood vessels that come from inside the bottom

Heavy menstrual bleeding: heavy bleeding from the womb during a woman's period

Hypermastia: excessively large breasts

Hysterectomy: surgery to remove the uterus (womb)

Hysteroscopy : camera test of the womb

Iatrogenic fissuring: a cut or tear in the anus caused by a complication of a surgical intervention

Incontinence: lack of control over going to the toilet (urine or stool), so not being able to hold in stool.

Intertrigo: skin rash that develops in between skin folds

Intrauterine system (IUS): small plastic device that is inserted into the womb via the cervix

Ligation: tying off

Locked finger: the finger cannot be straightened

Obstructive sleep apnoea (OSA): Throat can partially or completely close whilst sleeping, temporarily stopping or reducing breathing which can disturb sleep and oxygen levels.

Oophorectomy: removal of the ovaries during surgery

Osteoarthritis: a degeneration of the joints, especially the knees and hips that affects people from middle age onward, causing stiffness and pain in the joints

Osteotomy: surgery where bone in a joint is shaved away to re-align a joint that has become crooked

Otitis Media: Infection in the middle part of the ear behind the ear drum

Parapharyngeal abscess: Collection of pus in deep spaces of neck that may have spread from a tonsil infection

Pulmonary embolism: a blocked blood vessel in the lung that can be life threatening if not treated quickly

Radiofrequency denervation: procedure where the nerves that are connected to the small joints in the spine (facet joints) are destroyed to numb pain

Rotator cuff tear: a tear in the tendons that connect muscles to the top of the humerus (the bone in the upper arm bone). A tear can cause pain or weakness in the arm.

Sciatica: tingling and pain in the buttocks and travelling down the leg due to irritation of the sciatic nerve

Sclerotherapy: injection of a substance into the varicose vein to shrink it

Shoulder girdle dysfunction: pain and restricted movement of the shoulder

Spinal injection: using a needle to insert medication, for example steroid, into the back around the nerves near the spine

Splinting: a support is used to keep a body part from moving to allow it to heal

Stenosis: tightening of an opening in the body, for example the anus

Subacromial pain or impingement: the bones and tendons in the shoulder rub against each other when the arm is raised, causing pain.

Subcutaneous lesion: a lump or bump that lies underneath the skin Trigger finger: tightening of the tendons in a finger that prevent the finger from being completely straightened.

Systematic Review: Literature review of multiple existing research studies to answer defined research question

Tendon bowstringing: tendon comes away from its attachments and causes difficulty in bending the finger

Therapeutic mammoplasty: breast surgery to remove cancer and reshape the breast

Thrombophlebitis: inflammation that causes a blood clot in a vein causing redness and pain

Transtympanic instillation of medication: Injection of medication through the ear drum e.g. for the treatment of balance problems or sudden nerve related hearing loss.

Trigger finger release: surgery to cut the tendon sheath (the coat around the tendon) to release the tendon.

Truncal reflux: backflow of blood the wrong way through a vein

Truncal vein: superficial vein in the body, lying outside the muscles but underneath the skin

Varicose veins: veins that are swollen, enlarged, and twisted, usually in the legs

Venous disease: a long term condition related to veins including varicose veins and chronic venous insufficiency

Appendix 2 – Proposed clinical criteria for the 17 interventions

Interventions that should not be routinely commissioned, with patients only able to access such treatments where they successfully make an Individual Funding Request

A. Snoring Surgery (in the absence of OSA)

Summary of intervention
Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. This guidance relates to surgical procedures to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring and should not be applied to patients with diagnosed obstructive sleep apnoea. It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.
Number of interventions in 2017/18
733
Proposal
It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to that NHS are proposing that this procedure should no longer be routinely commissioned. **Alternative Treatments** There are a number of alternatives to surgery that can improve the symptom of snoring. These include: • Weight loss

- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)

Rationale for Recommendation

In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.

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B. Dilatation and curettage (D&C) for heavy menstrual bleeding in women

Summary of intervention
Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).
Number of interventions in 2017/18
255
Recommendation
D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) should be used to investigate heavy periods. Medication and intrauterine systems (IUS) should be used to treat heavy periods. For further information, please see: • **https://www.nice.org.uk/guidance/ng88** • **https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy**
Rationale for Recommendation
NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix. **References** • **https://www.nice.org.uk/guidance/ng88** • **https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy** • MacKenzie IZ, Bibby JG. Critical assessment of dilatation and curettage in 1029 women. Lancet 1978;2(8089):566–8. • Ben-Baruch G, Seidman DS, Schiff E, et al. Outpatient endometrial sampling with the Pipelle curette. Gynecologic and Obstetric Investigation 1994;37(4):260–2. • Gimpelson RJ, Rappold HO. A comparative study between panoramic hysteroscopy with directed biopsies and dilatation and curettage. A review of 276 cases. American Journal of Obstetrics and Gynecology 1988;158(3 Pt 1):489–92. • Haynes PJ, Hodgson H, Anderson AB, et al. Measurement of menstrual blood loss in patients complaining of menorrhagia. British Journal of Obstetrics and Gynaecology 1977;84(10):763–8.

C. Knee arthroscopy for patients with osteoarthritis

Summary of intervention
Arthroscopic washout of the knee is an operation where an arthroscope (camera) is inserted in to the knee along with fluid. Occasionally loose debris drains out with the fluid, or debridement, (surgical removal of damaged cartilage) is performed, but the procedure does not improve symptoms or function of the knee joint.
Number of interventions in 2017/18
11,972
Recommendation
Arthroscopic knee washout should not be used as a treatment for osteoarthritis because it is clinically ineffective. More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. In younger people with osteoarthritis, other procedures such as osteotomy may be appropriate. For further information, please see: • **https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117** • **https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance** • **https://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not** • **http://www.escape-pain.org/**
Rationale for Recommendation
NICE has reviewed the evidence for how well knee washout works for people with osteoarthritis. Seven clinical trials and three case studies have shown that knee wash out for people with osteoarthritis did not reduce pain nor improve how well their knees worked. There was a small increased risk of bleeding inside the knee joint (haemarthrosis) (2%) or blood clot in the leg (deep vein thrombosis) (0.5%). References 1. https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117 2. https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance 3. https://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not 4. Moseley JB, O'Malley K, Petersen NJ et al. (2002) A controlled trial of

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D. Injections for nonspecific low back pain without sciatica

Summary of intervention
Spinal injections of local anaesthetic and steroid in people with nonspecific low back pain without sciatica.
Number of interventions in 2017/18
29,976
Recommendation
Sciatica is tingling, pain or weakness in the leg due to irritation of the sciatic nerve. Spinal injections of local anaesthetic and steroid should not be offered for patients with nonspecific low back pain without sciatica, as they are unproven clinically.

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Radiofrequency denervation (destroying the nerve that supplies the painful facet joints in the spine) can be considered according to NICE guidance.

For further information, please see:

- **https://www.nice.org.uk/guidance/ng59**

Rationale for Recommendation

NICE guidelines recommend that spinal injections should not be offered for nonspecific low back pain.

Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.

Exclusion criteria for the NICE NG59 include:
Conditions of a non-mechanical nature, including;

- Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
- Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)

Neurological disorders (including cauda equina syndrome or mononeuritis)
Adolescent scoliosis
Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.

NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica
Spinal injections
1.3.1 Do not offer spinal injections for managing nonspecific low back pain.
Radiofrequency denervation
1.3.2 Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:
non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.
1.3.3 Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.
1.3.4 Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

References

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Interventions that should only be commissioned or performed when specific criteria are met

E. Breast reduction

Summary of intervention
Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.
Number of interventions in 2017/18
3,159
Proposal
We propose that the NHS will only provide breast reduction for women if all the following criteria are met • The woman has received a full package of supportive care from their GP and a physiotherapy assessment has been provided. • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Breast size is disproportionate to chest wall circumference • Breast reduction planned to be 500gms or more per breast. • Body mass index (BMI) is <27 and stable for at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery Ideally no further pregnancies are planned.

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation. Surgery can be approved for a difference of 150 - 200gms size difference as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months.

Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

This proposal does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process.

Gynaecomastia: Surgery for gynaecomastia is not funded under the NHS. Surgery can be performed for gynaecomastia secondary to treatment for prostate cancer.

Rationale for Recommendation

One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.

Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).

References

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3. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. British Journal of Plastic Surgery, 56(3), 230–236.

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11. https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/

F. Removal of benign skin lesions

Summary of intervention
Removal of benign skin lesions means treating asymptomatic lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a small risk of infection, bleeding or scarring and is not usually offered by the NHS if it is just to improve appearance. In certain cases, treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to pre-malignant lesions and other lesions with potential to cause harm.
Number of interventions in 2017/18
104,967
Recommendation
This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:

- benign moles (excluding large congenital naevi)
- solar comedones
- corn/callous
- dermatofibroma
- lipomas
- milia
- molluscum contagiosum (non-genital)
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- spider naevi (telangiectasia)
- non-genital viral warts in immunocompetent patients
- xanthelasmata
- neurofibromata

The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year
- There is repeated infection requiring 2 or more antibiotics per year
- The lesion bleeds in the course of normal everyday activity
- The lesion causes regular pain
- The lesion is obstructing an orifice or impairing field vision
- The lesion significantly impacts on function e.g. restricts joint movement
- The lesion causes pressure symptoms e.g. on nerve or tissue
- If left untreated, more invasive intervention would be required for removal
- Facial lesions > 1cm that cause significant disfigurement
- Facial warts in all ages causing significant psychological impact
- Facial spider naevi in children causing significant psychological impact
- Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

The following are *outside* the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
- Removal of lesions other than those listed above.

Referral to dermatology:

- The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria.
- Requests for treatment where a patient meets the criteria do not require prior approval or an IFR.
- This policy applies to all providers, including general practitioners (GPs), GPs

with enhanced role (GPwer), independent providers, and community or intermediate services.

For further information, please see:

- **https://www.nice.org.uk/guidance/csg8**
- **https://www.nice.org.uk/guidance/ng12**

Rationale for Recommendation

There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning.

References

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G. Grommets for Glue Ear in Children

Summary of intervention

This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children.

Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing. Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems.

Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include:

- Recurrent otitis media
- Atrophic tympanic membranes
- Access to middle ear for transtympanic instillation of medication

Investigation of unilateral glue ear in adults

Number of interventions in 2017/18

8,661

Proposal

We are proposing the NHS only commissions this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met:

- All children must have had specialist audiology and ENT assessment.
- Persistent bilateral otitis media with effusion over a period of 3 months.
- Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.
- The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.
- It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see: https://www.nice.org.uk/Guidance/CG60

The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age).

Rationale for Recommendation

In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.

We are proposing that the NHS only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit.

References:

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H. Tonsillectomy for Recurrent Tonsillitis

Summary of intervention

This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children.

Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person's ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be normally funded , these include :

- Obstructive Sleep Apnoea / Sleep disordered breathing in Children
- Suspected Cancer (e.g. asymmetry of tonsils)
- Recurrent Quinsy (abscess next to tonsil)
- Emergency Presentations (e.g. treatment of parapharyngeal abscess)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Number of interventions in 2017/18

32,103

Proposal

We are proposing that the NHS only commissions this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance:

- Sore throats are due to acute tonsillitis AND
- The episodes are disabling and prevent normal functioning AND
- Seven or more, well documented, clinically significant, adequately treated sore throats in the preceding year OR
- Five or more such episodes in each of the preceding two years OR
- Three or more such episodes in each of the preceding three years.

Further information on the SIGN guidance can be found here:
http://www.sign.ac.uk/assets/sign117.pdf

It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future.

Rationale for Recommendation

Recurrent sore throats are a very common condition that presents a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the SIGN criteria are met.

The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267, 159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. The Getting it Right First Time ENT report is due late 2018 and will present updated figures on readmission rates in relation to tonsillectomy.

There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation.

References

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I. Haemorrhoid surgery

Summary of intervention

This procedure involves surgery for haemorrhoids (piles).

Number of interventions in 2017/18

8,461

Proposal

Often haemorrhiods (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.

Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically:

- Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or
- Irreducible and large external haemorrhoids

Rationale for Recommendation
Surgery should be performed, according to patient choice and only in cases of persistent grade 1 or 2 haemorrhoids that have not improved with dietary changes, banding or injection, and recurrent and symptomatic grade 3 and 4 haemorrhoids and those with a symptomatic external component. Haemorrhoid surgery can lead to complications. Pain and bleeding are common but usually resolve spontaneously. Urinary retention can occasionally occur and may require catheter insertion. Infection, iatrogenic fissuring (tear or cut in the anus), stenosis and incontinence (lack of control over bowel motions) occur more infrequently. References 1. Watson AJM, Bruhn H, MacLeod K, et al. A pragmatic, multicentre, randomised controlled trial comparing stapled haemorrhoidopexy to traditional excisional surgery for haemorrhoidal disease (eTHoS): study protocol for a randomised controlled trial. Trials. 2014;15:439. doi:10.1186/1745-6215-15-439. 2. Watson AJM, Hudson J, Wood J, et al. Comparison of stapled haemorrhoidopexy with traditional excisional surgery for haemorrhoidal disease (eTHoS): a pragmatic, multicentre, randomised controlled trial. *Lancet (London, England)*. 2016;388(10058):2375-2385. doi:10.1016/S0140-6736(16)31803-7. 3. Brown SR. Haemorrhoids: an update on management. *Therapeutic Advances in Chronic Disease*. 2017;8(10):141-147. doi:10.1177/2040622317713957. 4. https://www.nhs.uk/conditions/piles-haemorrhoids/ 5. https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/rcsacpgbirectalbleeding2017documentfinal_jan18.pdf

J. Hysterectomy for heavy menstrual bleeding

Summary of intervention
Hysterectomy is the surgical removal of the uterus.
Number of interventions in 2017/18
18,173
Recommendation
Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.

For further information, please see:

- **https://www.nice.org.uk/guidance/ng88.**
- https://www.nhs.uk/conditions/heavy-periods/#Causes
- Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63.
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Rationale for Recommendation

NICE's Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for women with heavy menstrual bleeding.

Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of

hysterectomy, menopausal-like symptoms occur.

K. Chalazia removal

Summary of intervention

This procedure involves incision and curettage (scraping away) of chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks and many resolve within six months with regular application of heat packs and massage.

Number of interventions in 2017/18

6,755

Proposal

Incision and curettage of chalazia should only be undertaken if at least **one** of the following criteria have been met:

- Has been present for more than 6 months and has been managed conservatively with heat, lid cleaning and massage for 4 weeks
- Alternative treatment (e.g. injection with triamcinolone) has been considered
- Where it interferes significantly with vision.
- Where it interferes with the protection of the eye by the eyelid through affecting lid closure or lid anatomy
- Where it is a source of infection that has required medical attention twice or more within a six month time frame.
- Where it is a source of infection causing an abscess requiring drainage
- If malignancy (cancer) is suspected, lesion will be removed, in common with all suspicious lesions

Rationale for Recommendation

Surgery can drain the fluid out of the chalazion but all surgery carries risks. Most people will experience some discomfort, swelling and sometimes bruising of the eyelids after surgery and the cyst can take some weeks to disappear even after successful surgery. In a proportion the chalazion can come back. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote serious risk to the eye and vision from any procedure in the eyelids. The alternative option of an injection of a steroid (triamcinolone) can be tried in suitable cases but may not be as effective and there are some risks with that.

Warm compresses alone or in combination with antibiotic (chloramphenicol, tobramycin or antibiotic/dexamethasone drops and ointment) are all effective first-line treatment options for chalazia. Many chalazia resolve within a few weeks, especially the acutely presenting ones, and the majority will resolve in 6/12 months and can be safely left alone to recover in many cases without any harm. However, there are that are very persistent, very large or cause issues. There have been some trials suggesting that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction and less pain and patient inconvenience. However this is controversial and many feel it is less effective than

steroids and there are still risks including rarely serious ones from the injection of steroid near the eye. It remains an option in suitable patients.

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L. Arthroscopic shoulder decompression for subacromial shoulder pain

Summary of procedure
Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically. .
Number of procedures in 2017/18
20,401
Proposal
We propose that arthroscopic subacromial decompression for pure subacromial shoulder impingement is only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.
.

Rationale for Recommendation

Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function[1]. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.

On the other hand, a more recent prospective randomised trial comparing the long term outcome (10 year follow up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment.[3]

Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails.[4,5] There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.[6]

A review of the literature identified one further systematic review that looked at the effectiveness of surgery.[2] The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.

Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.[7]

Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.

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M. Carpal tunnel syndrome release

Summary of intervention
Open or endoscopic surgical procedure to release median nerve from carpal tunnel.
Number of interventions in 2017/18
43,979
Proposal
Surgical treatment of carpal tunnel should be provided if the following criteria are met: • Patient has acute, severe symptoms that persist for more than three months after conservative therapy with either local corticosteroid injection (medication injected into the wrist) and/or nocturnal splinting (stopping the wrist from moving during the night with a support); **OR** • Mild to moderate symptoms persist for at least four months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least eight weeks); **OR** • There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction (moving the thumb away from the hand); **AND**

- Severe symptoms significantly interfering with daily activities and sleep which have been assessed.

Rationale for Recommendation

Carpal tunnel syndrome is very common, and mild acute symptoms usually get better over time or with treatments like splinting at night and pain relief.

In persistent and severe cases intervention may be indicated. Corticosteroid injection should be considered as a first line. In refractory (keeps coming back) or severe case surgery should be considered.

Surgical outcomes correlate with severity of symptoms and electrophysiological evidence of nerve entrapment. Surgical outcomes are poorer in patients with very mild or very severe symptoms. Complications include postoperative infection and pain, and persistent or recurrent symptoms.

While surgery is not always successful and alternative options should be tried first, for people where there is severe trapping of the median nerve, surgery may be necessary to improve symptoms.

References

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N. Dupuytren's contracture release

Summary of intervention

Surgical treatment – fasciotomy (cutting the thickening inside the palm) or

fasciectomy (removing the thickening inside the palm) - for Dupuytren's contracture. Dupuytren's contracture is when the connective tissue in the hands becomes thicker than normal. This has the effect of making the palm and/or fingers tighten so it becomes difficult to stretch and use the fingers.

Number of interventions in 2017/18

14,704

Recommendation

Surgery should be avoided in cases where there is no contracture, and in patients with a mild contracture that is not progressing and does not impair function. Less invasive techniques percutaneous needle fasciotomy (PNF, where the thickening in the palm is cut by using a needle inserted through the skin) or collagenase injection (injecting medication into the thickened tissue in the palm) can be considered in suitable cases.

The criteria for surgical treatment of Dupuytren's contracture should be:

- Conservative and non-operative treatment tried; **AND**
- Patient has loss of extension in one or more joints exceeding 25 degrees; **OR**
- Patient has at least 10 degrees loss of extension in two or more joints.

For further information, please see:

- **https://www.nice.org.uk/guidance/ipg43**

Rationale for Recommendation

NICE has reviewed the evidence for surgical treatment of Dupuytren's contracture. It found that after 3 to 5 years, the problem had returned in about half of the patients treated. It appeared that the procedure was more likely to be successful in patients with less severe tightening and/or where the tightening was across the finger joints. Alternative options include physiotherapy and splinting.

Common complications reported in the studies include skin breaks, localised pain and nerve injuries. NICE's Specialist Advisors listed nerve injury, tendon injury and infection as the major complications of the procedure, with one Advisor stating a complication rate of 1% or less.

References

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O. Ganglion excision

Summary of intervention

Many people have ganglia (small, noncancerous lumps) on the tendons of the wrists or hands. Most people live comfortably with ganglia and they usually resolve spontaneously over time. Ganglia are usually painless but can cause tingling or pain if they press on a nerve. Ganglion excision involves removing the ganglion and the stalk from the tendon it is attached to.

Number of interventions in 2017/18

7,558

Proposal

Ganglion excision should only be provided in the following cases:

- The ganglion is painful seed ganglia and of diagnostic uncertainty; **OR**
- In patients presenting a significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts; **OR**
- The ganglia are mucoid cysts arising at the distal interphalangeal joint and disturbing nail growth or discharging; **OR**
- The ganglion is causing significant functional impairment and/or pain unrelieved by aspiration or injection.

If there is diagnostic uncertainty after diagnostic tests have been performed (e.g. MRI) then referral to a specialist soft tissue cancer service should be considered.

Alternative options include pain relief or needle aspiration of the ganglion.

Rationale for Recommendation

There is little evidence to show ganglion excision effectiveness. Most ganglia get better on their own.

Ganglion excision can cause complications similar to the original problem. This can include damage to tendons, nerves and blood vessels and the ganglion may grow back after the procedure.

Reference

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P. Trigger finger release

Summary of intervention

Trigger finger release surgery is incision of the tendon sheath to release the tendon via open or percutaneous route. Trigger finger is when a tender nodule occurs at the base of a finger or thumb and causes snapping or locking of the finger flexor tendon. In most cases, trigger finger is a nuisance rather than a serious condition.

Number of interventions in 2017/18

8,220

Proposal

Surgery should be only performed in specific cases where alternative measures have not been successful. Alternative treatments include rest, single dose steroid injection, splinting, and non-steroidal anti-inflammatory drugs.
Surgery should only be offered in the following situations

- No response to conservative management (splinting, analgesia) AND
- At least one cortisone injection AND
- Persistent or recurrent triggering, or for a locked finger.

Rationale for Recommendation

Surgery is normally successful but recovery is often weeks and complications can occur. Complications of trigger finger release surgery can include infection, pain, stiffness, digital artery or nerve damage, tendon bowstringing, and complex regional pain syndrome, which causes pain and swelling in your hand after surgery – this usually resolves itself after a few months, but there can be permanent problems. Conservative treatment results in resolution of symptoms in most cases.

References

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Q. Varicose vein surgery

Summary of intervention

There are various interventional procedures for treating varicose veins. These include endothermal ablation, ultrasound guided foam sclerotherapy and traditional surgery (this is a surgical procedure that involves ligation and stripping of varicose veins) all of which have been shown to be clinically and cost effective compared to no treatment or treatment with compression hosiery. Varicose veins are common and can markedly affect patients quality of life, can be associated with complications such as eczema, skin changes, thrombophlebitis, bleeding, leg ulceration, deep vein thrombosis and pulmonary embolism that can be life threatening.

Number of interventions in 2017/18

28,795

Recommendation

1.1 Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

1.2 Refer people to a vascular service if they have any of the following;-

- Symptomatic * primary or recurrent varicose veins.
- Lower‑limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
- Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).
- A healed venous leg ulcer.

*Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).”

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment

1.3 Refer people with bleeding varicose veins to a vascular service immediately

1.4 Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

For further information, please see:

1.https://www.nice.org.uk/guidance/qs67 (NICE QUALITY STANDARD)

2.https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article

3,https://www.nice.org.uk/guidance/cg168

Rationale for Recommendation

International guidelines, NICE guidance and NICE Quality standards provide clear evidence of the clinical and cost-effectiveness that patients with symptomatic varicose veins should be referred to a vascular service for assessment including duplex ultrasound.

Open surgery is a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein), this is still a valuable technique, it is still a clinically and cost-effective treatment technique for some patients but has been mainly superseded by endothermal ablation and ultrasound guided foam sclerotherapy.

Recurrence of symptoms can occur due to the development of further venous disease, that will benefit from further intervention (see above). NICE guidance states that a review of the data from the trials of interventional procedures indicates that the rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%.

For people with confirmed varicose veins and truncal reflux NICE recommends:

- Offer endothermal ablation of the truncal vein.
- If endothermal ablation is unsuitable, offer ultrasound‑guided foam sclerotherapy.
- If ultrasound‑guided foam sclerotherapy is unsuitable, offer surgery.
- Consider treatment of tributaries at the same time

- Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. Complications of non-intervention include decreasing quality of life for patients, increased symptomatology, disease progression potentially to skin changes and eventual leg ulceration, deep vein thrombosis and pulmonary embolism.

References

NICE Guidance: https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-

varicose-veins/300594.article

NICE Guidance: https://www.nice.org.uk/guidance/cg168

NICE Quality Standard: https://www.nice.org.uk/guidance/qs67

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A Randomized Trial of Early Endovenous Ablation in Venous Ulceration.Gohel MS1, Heatley F1, Liu X1, Bradbury A1, Bulbulia R1, Cullum N1, Epstein DM1, Nyamekye I1, Poskitt KR1, Renton S1, Warwick J1, Davies AH1; EVRA Trial Investigators. N Engl J Med. 2018 May 31;378(22):2105-2114. doi: 10.1056/NEJMoa1801214. Epub 2018 Apr 24

Appendix 1 includes a glossary of the clinical terms used in this document.

Appendix 3: Methodology

1. We started by reviewing national and international evidence on interventions that are not clinically effective.

2. We identified over a large number of procedures during our initial search:

    - NICE *'do not do' recommendations*[26]
    - NICE *Cost Saving Guidance*[27]
    - *Choosing Wisely UK Guidance published by AoRMC*[28]
    - *Choosing Wisely* international guidance [29]
    - NHS Clinical Commissioners *Procedures of Limited Clinical Effectiveness (PoLCE)*
    - NHS Improvement's *Get It Right First Time* (GIRFT) programme
    - Academic literature review
    - Discussions with leading clinicians and national clinical directors

3. We shortlisted these recommendations by liaising with clinicians, patients, commissioners and policy makers to help us understand what priorities were important to patients and clinicians, as well as achievable for CCGs.

4. Acknowledging that similar initiatives have been launched before, our initial focus was on changes that we could test our approach on and implement relatively quickly. For this reason, we did not include at this stage any recommendations that required new equipment or medicines to replace them. We only included recommendations that addressed surgical procedures (e.g. operations, or minor operations) and did not include any public health interventions (e.g. smoking cessation). We only included recommendations that referred to procedures where there is supporting data (e.g. cost codes), so that we could look at the number of procedures performed and also monitor this number in the future. We also did not include any procedures that are rarely offered in the NHS (i.e. less than 300 procedures in England per year).

5. In addition, the list was reviewed and refined by National Clinical Directors, Rightcare and GIRFT leads, NICE, AoRMC, the Royal Colleges, NHS Improvement, NHS Clinical Commissioners, the Patient and Lay Committee at AoMRC and a patient, public and carer workshop.

6. Finally, we segmented the seventeen interventions into two groups:

    - Interventions that should not be routinely commissioned, with patients only able to access such treatments where they successfully make an individual funding request;

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[26] NICE *'do not do' recommendations*; NICE *Cost Saving Guidance*;
[27] NICE *Cost Saving Guidance*;
[28] http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/#1476651640539-f279ec69-9e40
[29] https://choosingwiselycanada.org/recommendations/; http://www.choosingwisely.org.au/recommendations; http://www.choosingwisely.org/clinician-lists/.

- Interventions that should be commissioned or performed when specific criteria are met.

7. Each individual intervention was reviewed by one or more appropriate clinical groups. The NHS England Medical Advisory Group, comprising national clinical directors, supported the final shortlist.

8. We sought feedback from patients throughout the process. We presented our proposed approach to the Patient and Lay Committee at the AoMRC. There was consensus that we were taking a fair and evidence based approach, that was equitable. A patient and public workshop was also held on 15 May 2018 which received a positive response. In addition we have discussed the proposals with Healthwatch and considered their views.

Appendix 4: Equality Impact Assessment

1. Throughout the development of the policies and processes cited in this document, we have:

    - Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic[1] (as cited under the Equality Act 2010) and those who do not share it; and

    - Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

2. We are completing a full Equality and Health Inequalities Assessment (EHIA) as part of this consultation which we will publish alongside the consultation response and other guidance documents. As part of the EHIA we will be engaging with representatives from relevant protected characteristics and asking specific questions in the consultation:

Consultation Questions
What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for: • ***groups protected under the Equality Act 2010?[30]*** • ***those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?***

[1] The following characteristics are protected characteristics as set out in the Equality Act (2010): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

[30] The following characteristics are protected characteristics as set out in the Equality Act (2010): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Appendix 5: Proposed wording for the NHS Standard Contract

1. The detailed Contract wording we propose is shown below. We intend that this should be included in the 2019/20 version of the Contract, which will be published later this financial year and which will take effect from 1 April 2019.

2. The full, updated content of the 2019/20 Contract will be subject to separate consultation later this financial year. However, we have decided to consult now on the draft Contract wording to support implementation of the Evidence-Based Interventions policy, so that the NHS can see our intentions in the round, in terms of both policy and implementation, and can comment on both.

3. We anticipate that these new provisions would be added to Service Condition 29 of the Contract, which already contains related arrangements for Prior Approval Schemes put in place locally by commissioners.

4. The new provisions would apply only in those contracts which include provision of acute and community services and only in the full-length version of the Contract. (The Contract is published in two versions – a full-length version, typically used for high-value services, and a shorter-form version used with contracts of lower financial values, typically with smaller non-NHS providers).

5. Note that the capitalised terms in the Contract wording below are “defined terms” – that is, they have a specific meaning, set out in the full list of definitions at the rear of the General Conditions of the Contract. Most of the defined terms used below are already used in the Contract; the only new ones relate directly to the Evidence-Based Interventions policy.

Proposed contract wording

6. The proposed Contract wording is set out in italics below:

Evidence-Based Interventions policy

1. *The Parties must comply with their respective obligations under the Evidence-Based Interventions policy.*

2. *The Commissioners must use all reasonable endeavours to procure that, when making Referrals, Referrers comply with the Evidence-Based Interventions policy.*

3. *The Provider must manage Referrals and provide the Services in accordance with the Evidence-Based Interventions policy.*

4. *If the Provider carries out a Category 1 or Category 2 Intervention, without evidence of appropriate Prior Approval having been granted by the relevant Commissioner, the relevant Commissioner will not be liable to pay for that Intervention.*

Consultation Questions
We welcome feedback on any aspect of the proposed Contract wording, but we would particularly value views on the following specific questions: • ***Do you support our intention to mandate compliance with the Evidence-Based Interventions policy through the NHS Standard Contract?*** • ***Do you support our proposed wording for the new Contract requirements?*** • ***Do you have any specific suggestions for how the Contract wording could be improved?***

Appendix 6: Technical appendix

1. For each of the 17 interventions the clinical definitions have been converted into combinations of one or more OPCS procedure codes and ICD-10 diagnosis codes. This process was informed by a combination of NICE and other clinical guidance along with local work on identification of the appropriate codes.

2. Our analysis is based on SUS+ data of spells completing in 2017/18. The following descriptors use Microsoft SQL Server structure but are easily adaptable to other systems. For reference:

    - A “%” symbol represents a wildcard for zero or more characters.
    - Values in square brackets mean “one of these characters”. E.g. [03] mean 0 or 3 and [0-3] means 0 or 1 or 2 or 3.
    - The field “der_diagnosis_all” is a concatenation of all diagnosis fields in all episodes within the spell.

A. Intervention for snoring (not OSA)

```
der.Spell_Dominant_Procedure in ('F324','F325','F326') and
der.Spell_Primary_Diagnosis not like '%G473%'  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

B. Dilatation & curettage for heavy menstrual bleeding

```
der.Spell_Dominant_Procedure in ('R281','Q101','Q103','Q112')
and   APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')  and
apcs.der_diagnosis_all not like '%O0[0-8]%' and
apcs.der_diagnosis_all not like '%O6[0-9]%' and
apcs.der_diagnosis_all not like '%O7[0-5]%'
```

C. Knee arthroscopy with osteoarthritis

```
der.Spell_Dominant_Procedure in
('W878','W871','W879','W821','W822','W823','W828','W829','W851
','W852','W853','W858','W859','W831+KNEE','W832+KNEE','W833+KN
EE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE
','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE')
and   APCS.Patient_Classification IN ('1','2') and
```

```
APCS.Admission_Method IN ('11','12','13')  and
(APCS.Age_At_Start_of_Spell_SUS between 61 and 120) and
apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
apcs.der_diagnosis_all not like '%M234%'
```

D. Injections for nonspecific low back pain without sciatica

```
left(der.Spell_Dominant_Procedure,4) in
('V481','V482','V483','V484','V485','V486','V487','V488','A521
','A522','A528','A529','V544','A543','A544','A545','A572','A57
3','A574','A575','A577','A735','W903') and
left(der.spell_primary_diagnosis,4) in
('G834','G551','M430','M431','M471','M472','M478','M479','M480
','M510','M511','M512','M513','M518','M519','M541','M543','M54
4','M545','M549') and apcs.der_procedure_all like '%Z67[67]%'
and   APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

E. Breast reduction

```
der.Spell_Dominant_Procedure in ('B311','B303')  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')  and
apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
```

F. Removal of benign skin lesions

```
der.Spell_Dominant_Procedure in
('S064','S063','S065','S066','S067','S068','S069','S081','S082
','S083','S088','S089','S091','S092','S093','S094','S095','S09
8','S099','S101','S102','S111','S112','D021','D022','D028','D0
29') and APCS.Der_Diagnosis_All not like '%C43%' and
Der_Diagnosis_All not like '%C44%' and Der_Diagnosis_All not
like '%C460%' and Der_Diagnosis_All not like '%C490%'  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

G. Grommets

```
der.Spell_Dominant_Procedure in ('D151','D289') and
(der.Spell_Primary_Diagnosis like 'H65[23]%' or
der.Spell_Primary_Diagnosis like 'H66[1-9]%') and
(apcs.age_at_start_of_Spell_SUS between 1 and 17 or
apcs.age_at_start_of_Spell_SUS between 7001 and 7007 ) and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

H. Tonsillectomy

```
der.Spell_Dominant_Procedure in
('F342','F341','F343','F344','F345','F346','F347','F348','F349
','F361')  and   APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')  and
apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
apcs.der_diagnosis_all not like '%G47%' and
apcs.der_diagnosis_all not like '%J36%'
```

I. Haemorrhoid surgery

```
der.Spell_Dominant_Procedure in
('H512','H511','H513','H518','H519')  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')  and
apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
```

J. Hysterectomy for heavy bleeding

```
der.Spell_Dominant_Procedure in
('Q074','Q072','Q078','Q079','Q082','Q088','Q089')  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')  and
apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
apcs.der_diagnosis_all not like '%O0[0-8]%' and
apcs.der_diagnosis_all not like '%O6[0-9]%' and
apcs.der_diagnosis_all not like '%O7[0-5]%'
```

K. Chalazia removal

```
der.Spell_Primary_Diagnosis in ('H001')  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

L. Shoulder decompression

```
(der.Spell_Dominant_Procedure ='W844+SHOULDER' or
(der.Spell_Dominant_Procedure ='O291' and
apcs.der_procedure_all like '%Y767%')) and
APCS.Patient_Classification in ('1','2') and
APCS.Admission_Method in ('11','12','13')
```

M. Carpal tunnel syndrome release

```
der.Spell_Dominant_Procedure in ('A651','A659') and
der.Spell_Primary_Diagnosis like '%G560%'  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

N. Dupuytren's contracture release

```
der.Spell_Dominant_Procedure in
('T522','T521','T525','T526','T541','Z894','Z895','Z896','Z897
')  and   APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

O. Ganglion excision

```
der.Spell_Dominant_Procedure in
('T592','T591','T593','T594','T598','T599','T601','T602','T603
','T604','T608','T609') and der.Spell_Primary_Diagnosis like
'%M674%'  and   APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

P. Trigger finger release

```
der.Spell_Dominant_Procedure in
('T692+HAND','T691+HAND','T698+HAND','T699+HAND','T701+HAND','
T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T7
29+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and
der.Spell_Primary_Diagnosis like '%M653%'  and
APCS.Patient_Classification IN ('1','2') and
APCS.Admission_Method IN ('11','12','13')
```

Q. Varicose vein surgery

```
der.Spell_Dominant_Procedure in
('L832','L838','L839','L841','L842','L843','L844','L845','L846
','L848','L849','L851','L852','L853','L858','L859','L861','L86
2','L863','L868','L869','L871','L872','L873','L874','L875','L8
76','L877','L878','L879','L881','L882','L883','L888','L889')
and   APCS.Patient_Classification IN ('1','2') and
der.Spell_Primary_Diagnosis like ('%I8[03]%') and
APCS.Admission_Method IN ('11','12','13')
```

Appendix 7: Variation in activity

This appendix sets out the variation in activity by STP, CCG and by providers. We have segmented the graphs between:

- those interventions that should not be routinely commissioned by CCGs or performed, unless a successful Individual Funding Request (IFR) is made (Category 1) either because they are a) ineffective or b) have been superseded by a less invasive or more effective alternative;

- those interventions that should only be commissioned by CCGs or performed when specific clinical criteria are met (Category 2) – this is because they have only been shown to be effective in certain circumstances.

The following pages include charts outlining:

- Category 1 Summary by STP: STP level variation in the age-sex standardised rate per 100,000 population in 2017/18 for Category 1 interventions

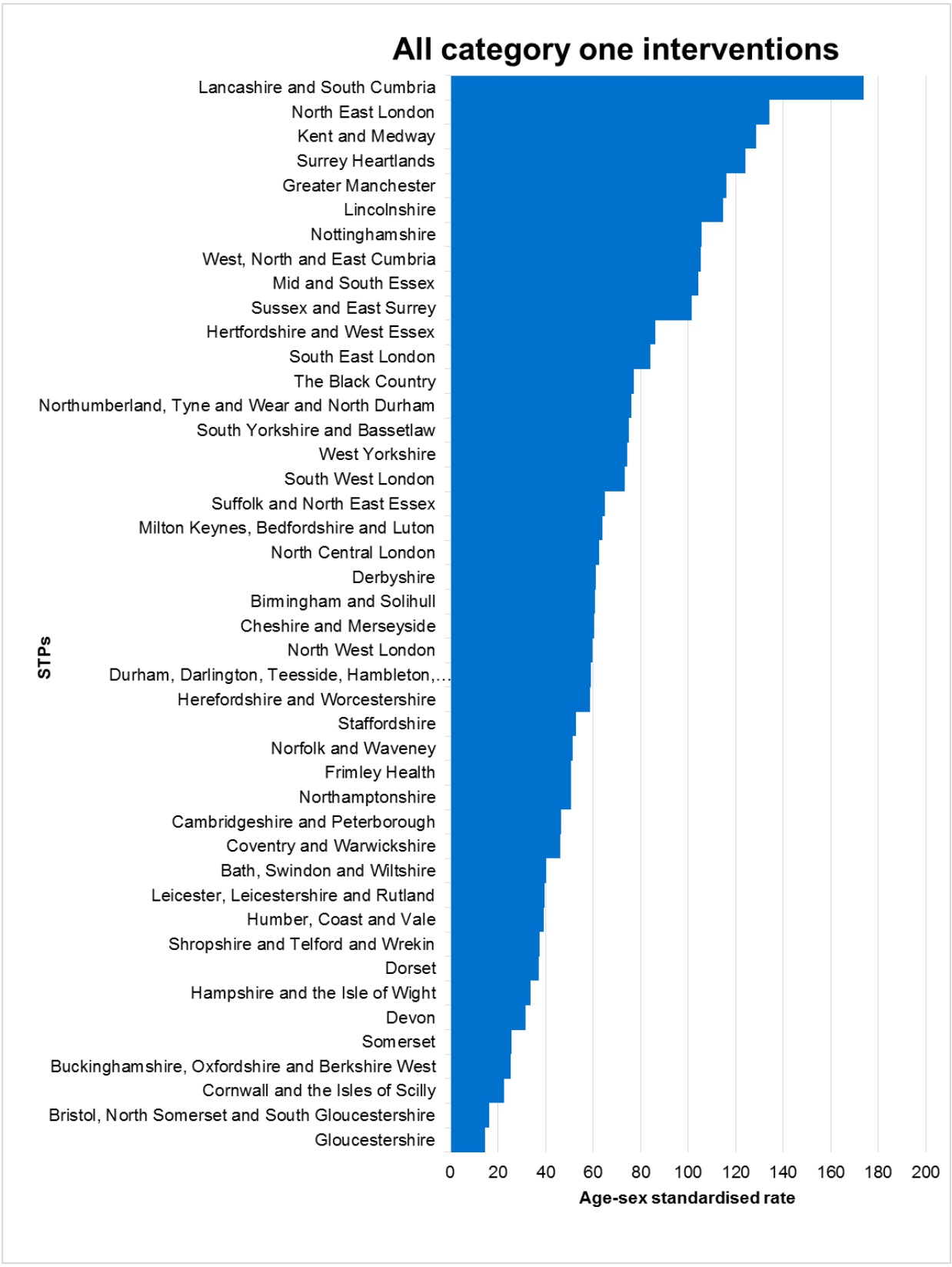
- Category 1 Summary by CCG: CCG level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 1 interventions. The highest 50 CCGs are shown.

- Category 1 Summary by Provider: Provider charts showing the count of spells by provider for Category 1 interventions. The highest 50 providers are shown.

- Cartogram for Category 1 interventions by Region, STP and CCG: Cartograms highlighting variation in the activity rates for the Category 1 interventions in 2017/18 at Region, STP and CCG level. Specifically they show the age-sex standardised rate of activity per 100,000 population for each intervention.

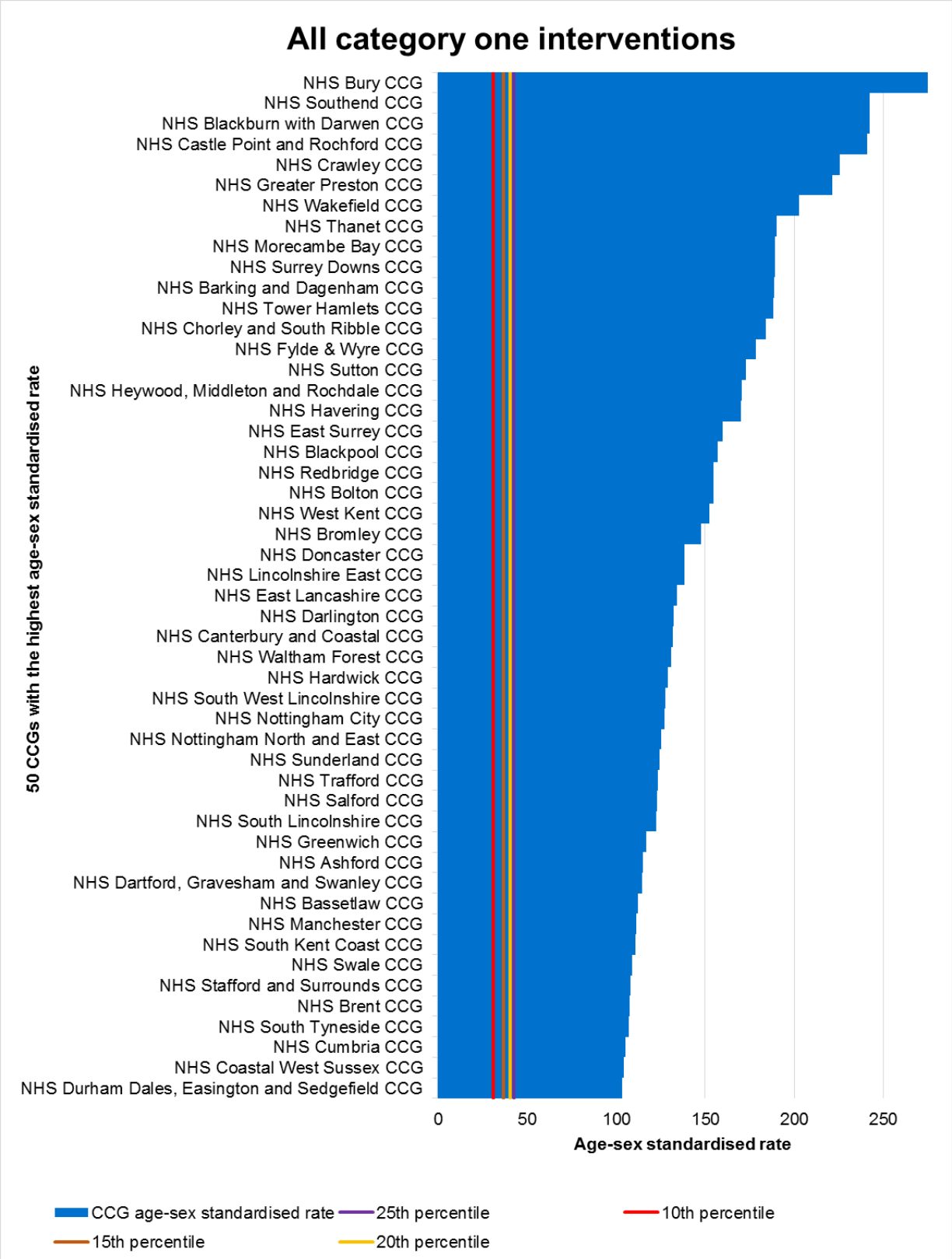
Category 1 interventions

STP level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 1 interventions

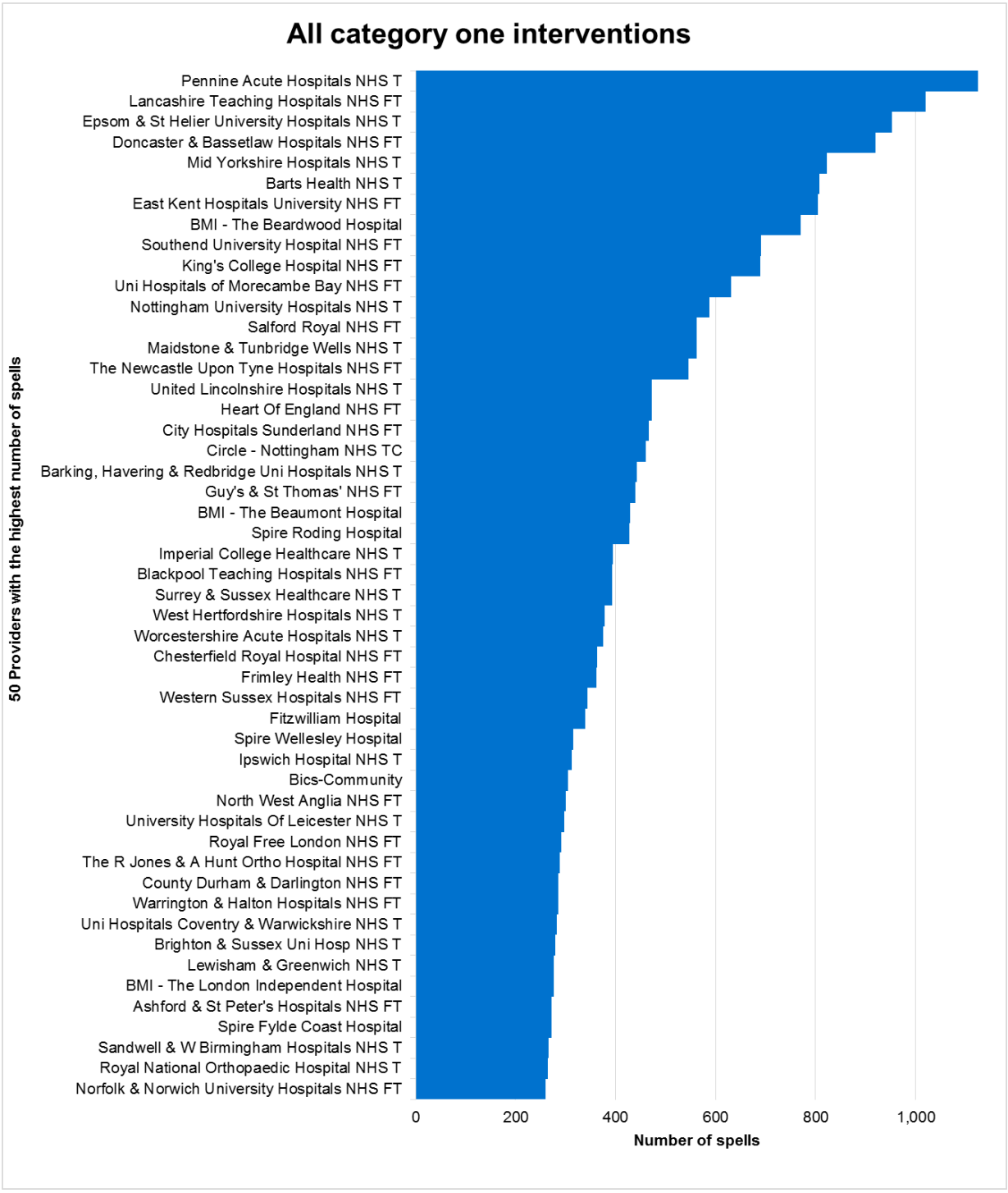


CCG level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 1 interventions (highest 50 CCGs)

The lines indicate the level of the 10th, 15th, 20th and 25th percentiles of CCGs

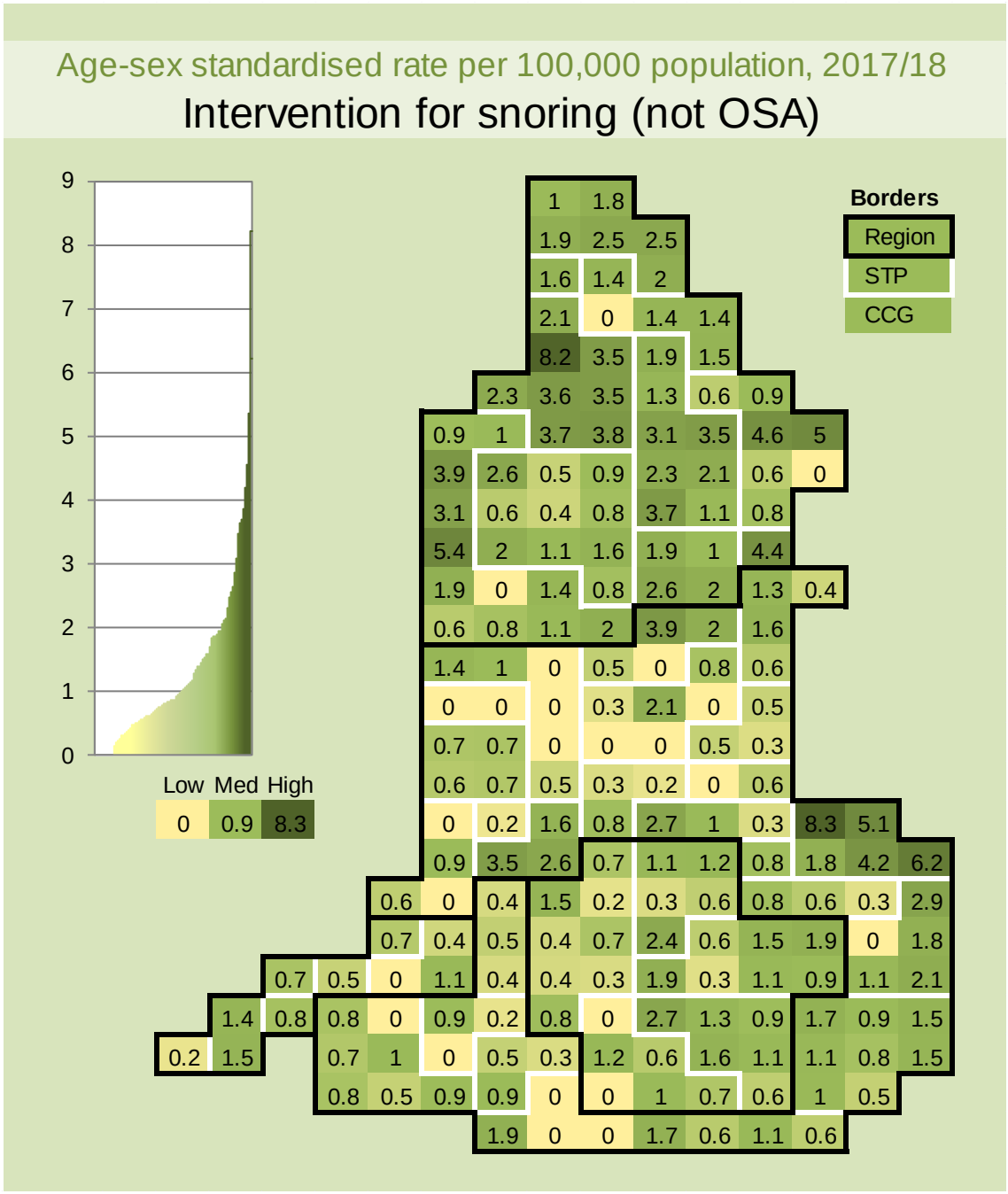


Provider charts showing the count of spells by provider for Category 1 interventions (highest 50 providers)

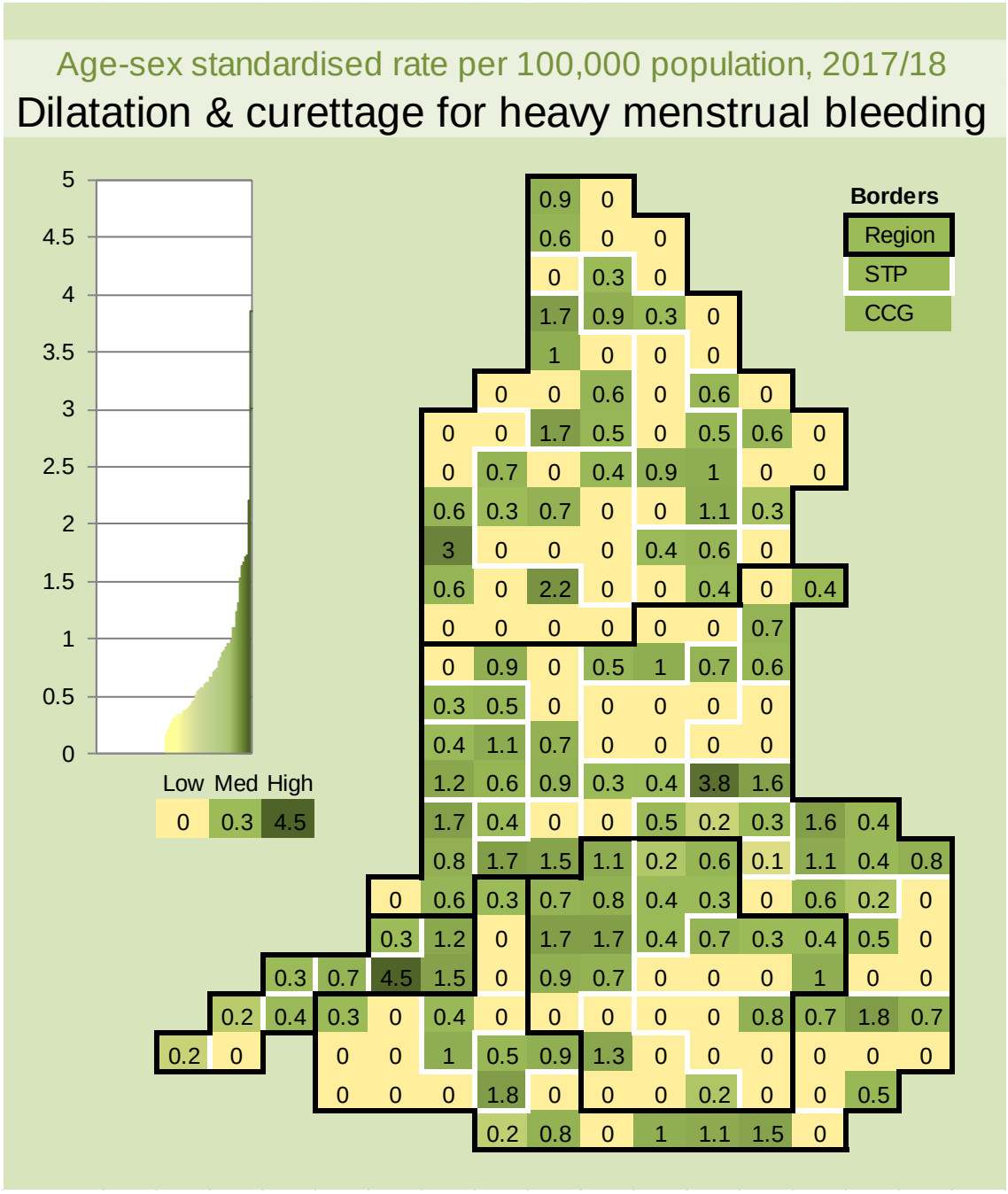


Cartograms for Category 1 interventions

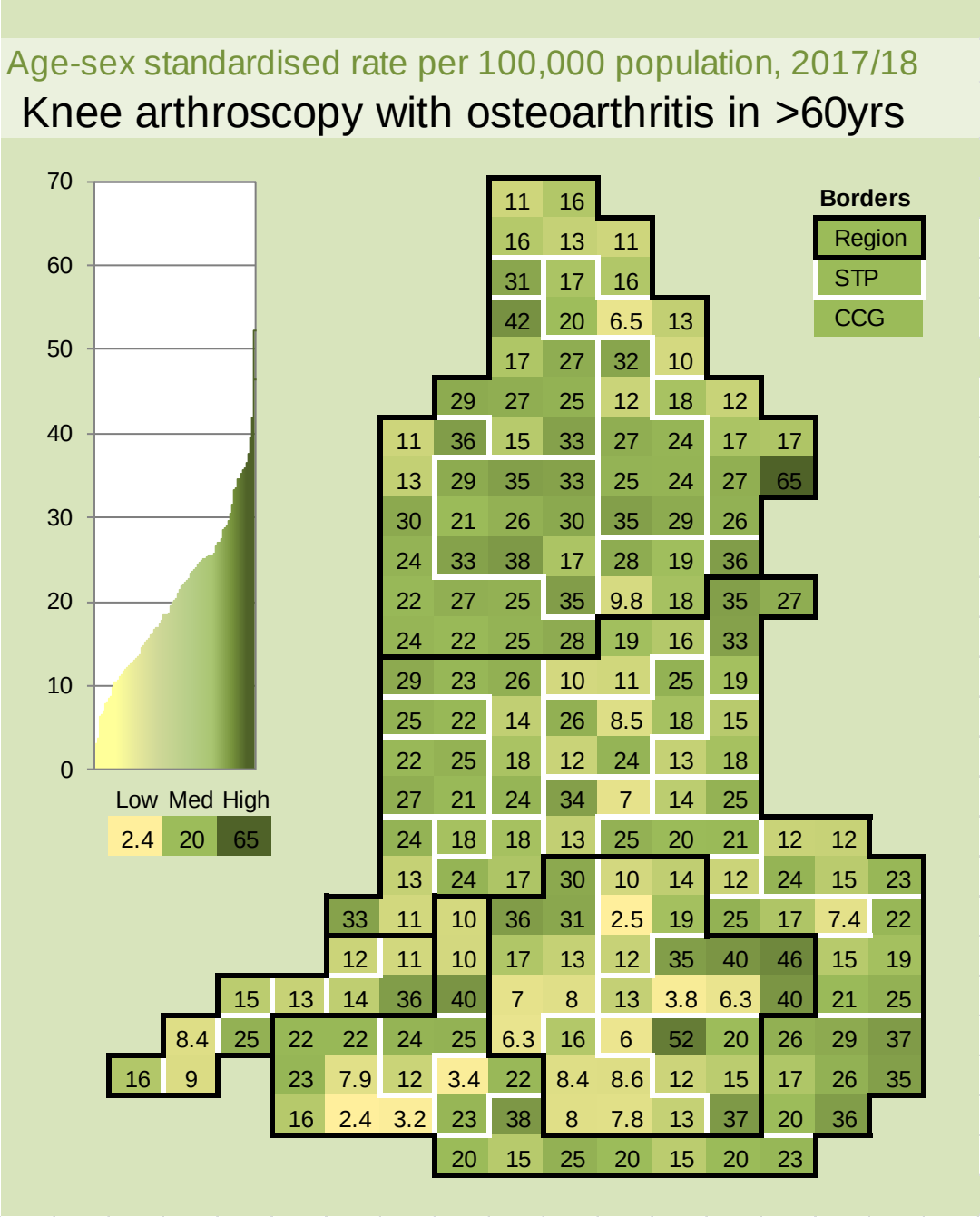
A. Snoring Surgery (in the absence of OSA)



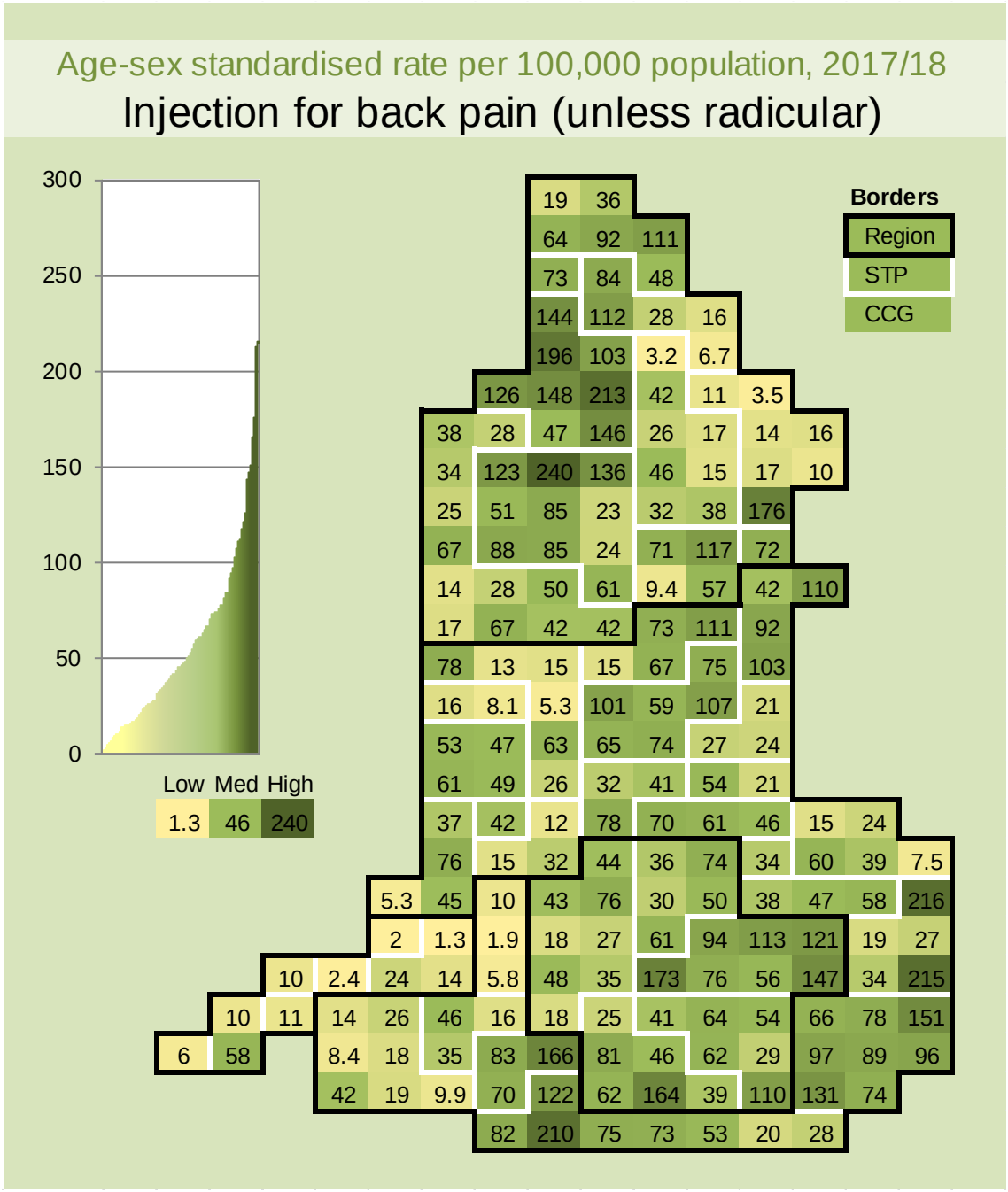
B. Dilatation and curettage (D&C) for heavy menstrual bleeding in women



C. Knee arthroscopy for patients with osteoarthritis



D. Injections for nonspecific low back pain without sciatica

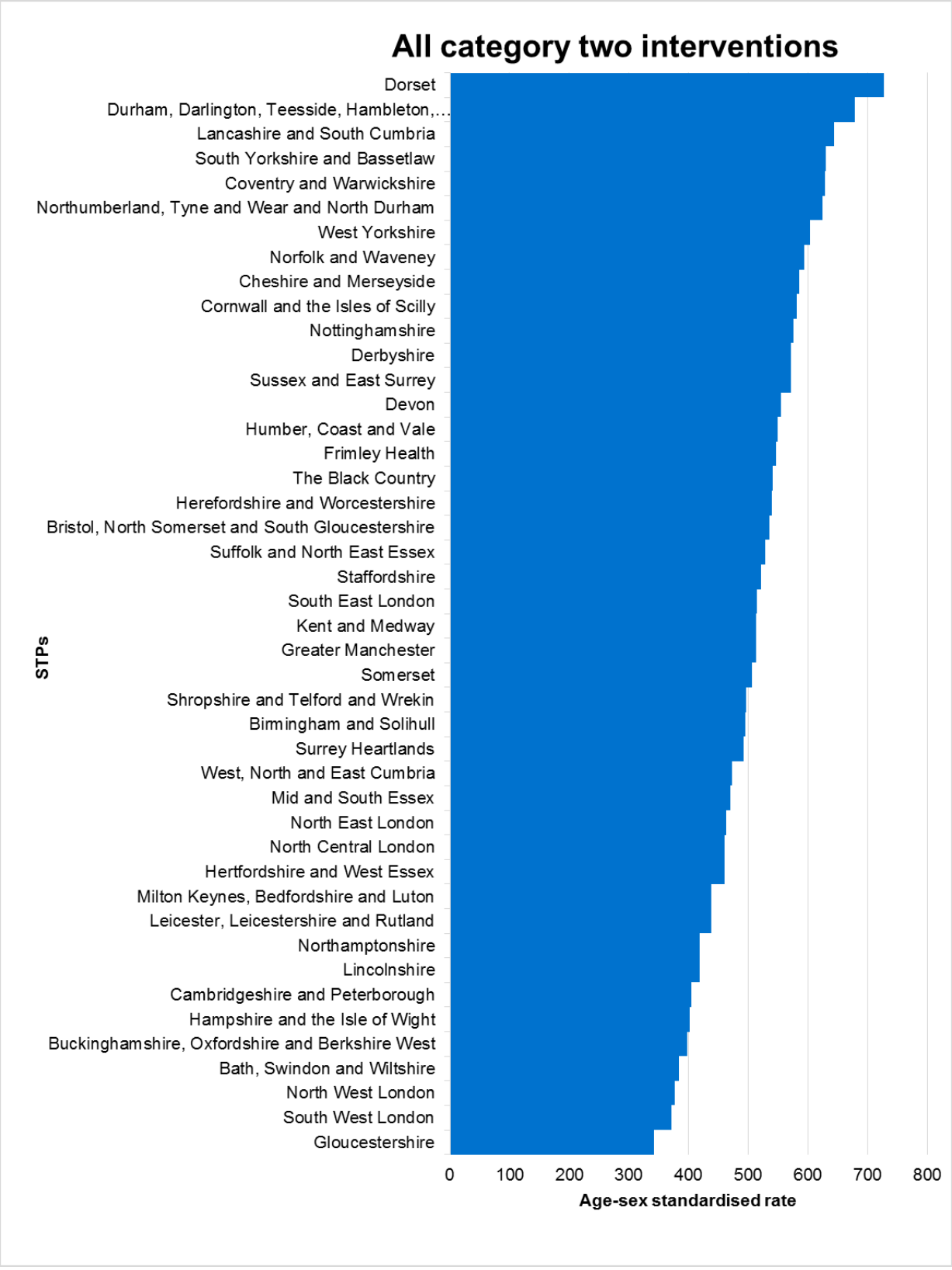


Category 2 interventions

The following pages include charts outlining:

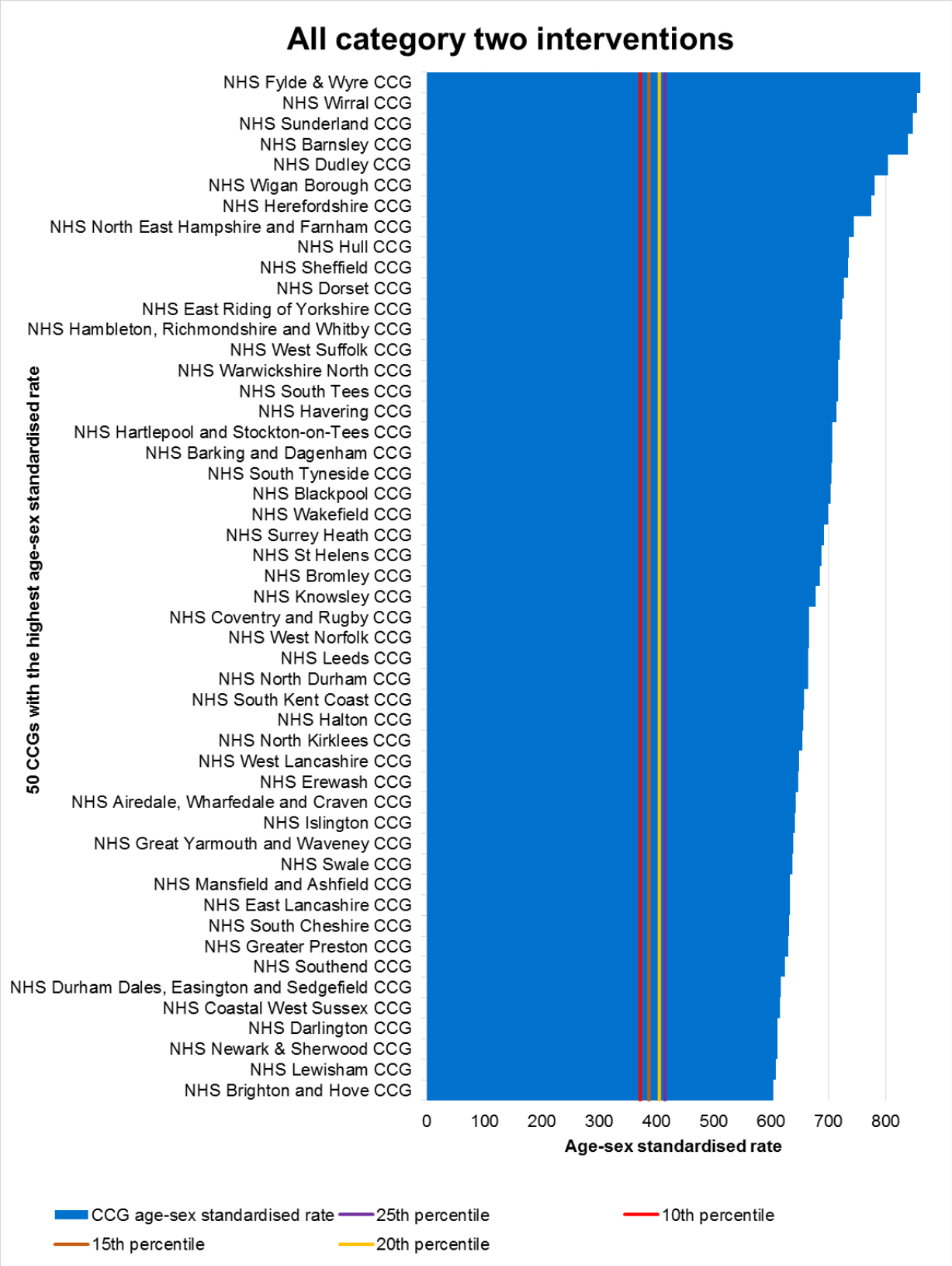
- Category 2 Summary by STP: STP level variation in the age-sex standardised rate per 100,000 population in 2017/18 for Category 2 interventions
- Category 2 Summary by CCG: CCG level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 2 interventions. The highest 50 CCGs are shown.
- Category 2 Summary by Provider: Provider charts showing the count of spells by provider for Category 2 interventions. The highest 50 providers are shown.
- Cartogram for Category 2 interventions by Region, STP and CCG: Cartograms highlighting variation in the activity rates for the Category 2 interventions in 2017/18 at Region, STP and CCG level. Specifically they show the age-sex standardised rate of activity per 100,000 population for each intervention.

STP level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 2 interventions

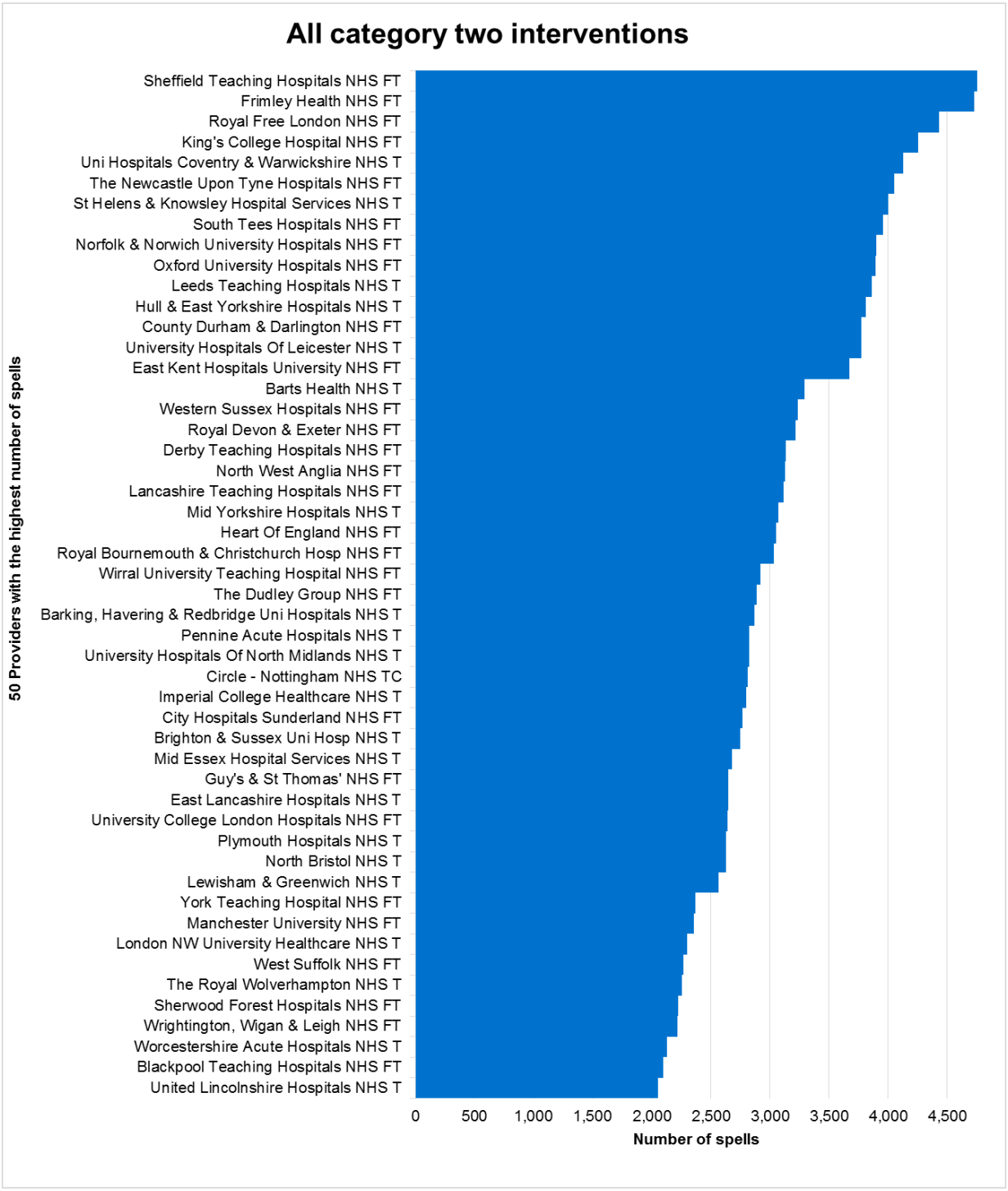


CCG level variation in age-sex standardised rate per 100,000 population in 2017/18 for Category 2 interventions (highest 50 CCGs)

The lines indicate the level of the 10th, 15th, 20th and 25th percentiles of CCGs

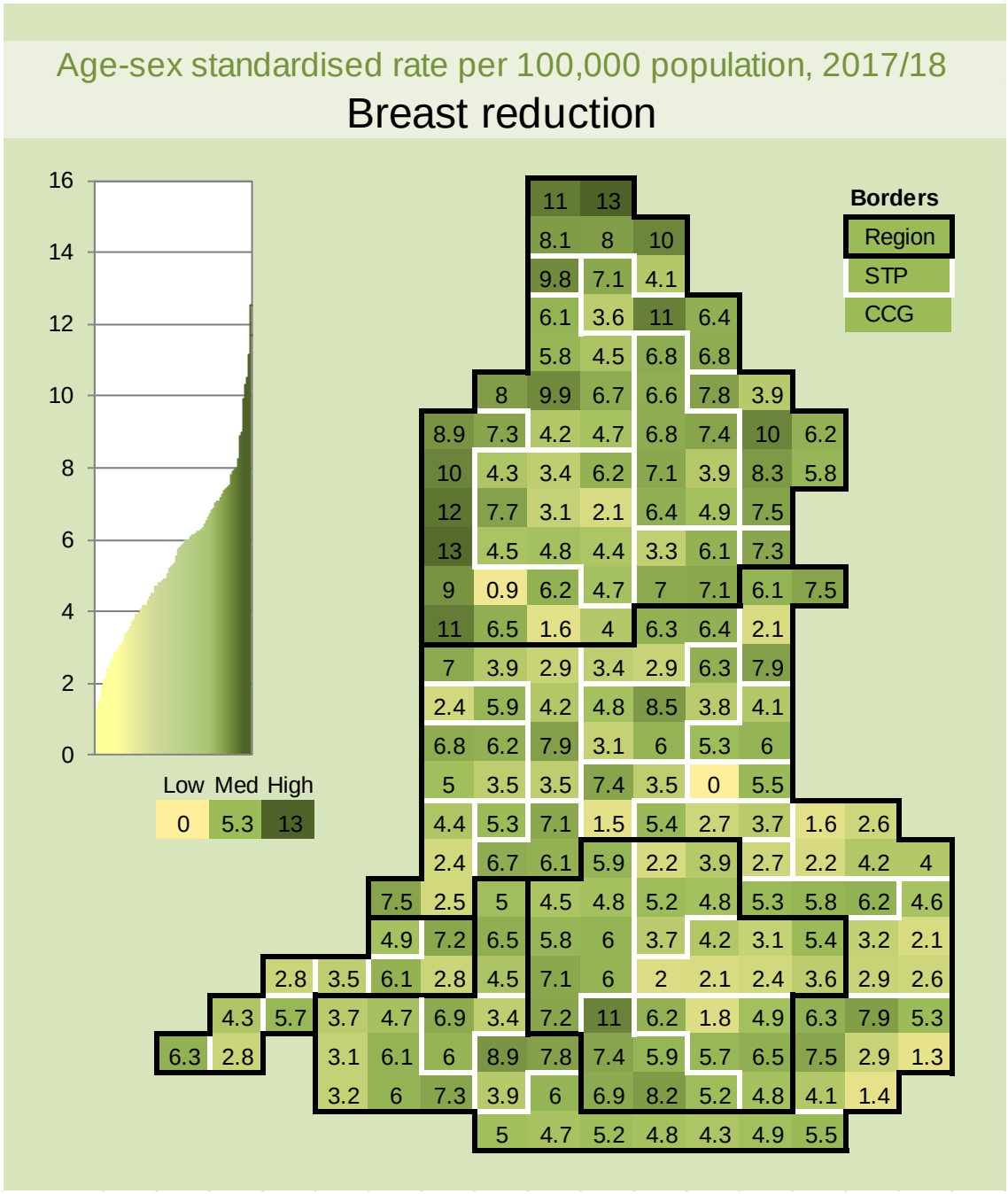


Provider charts showing the count of spells by provider for Category 2 interventions (highest 50 providers)

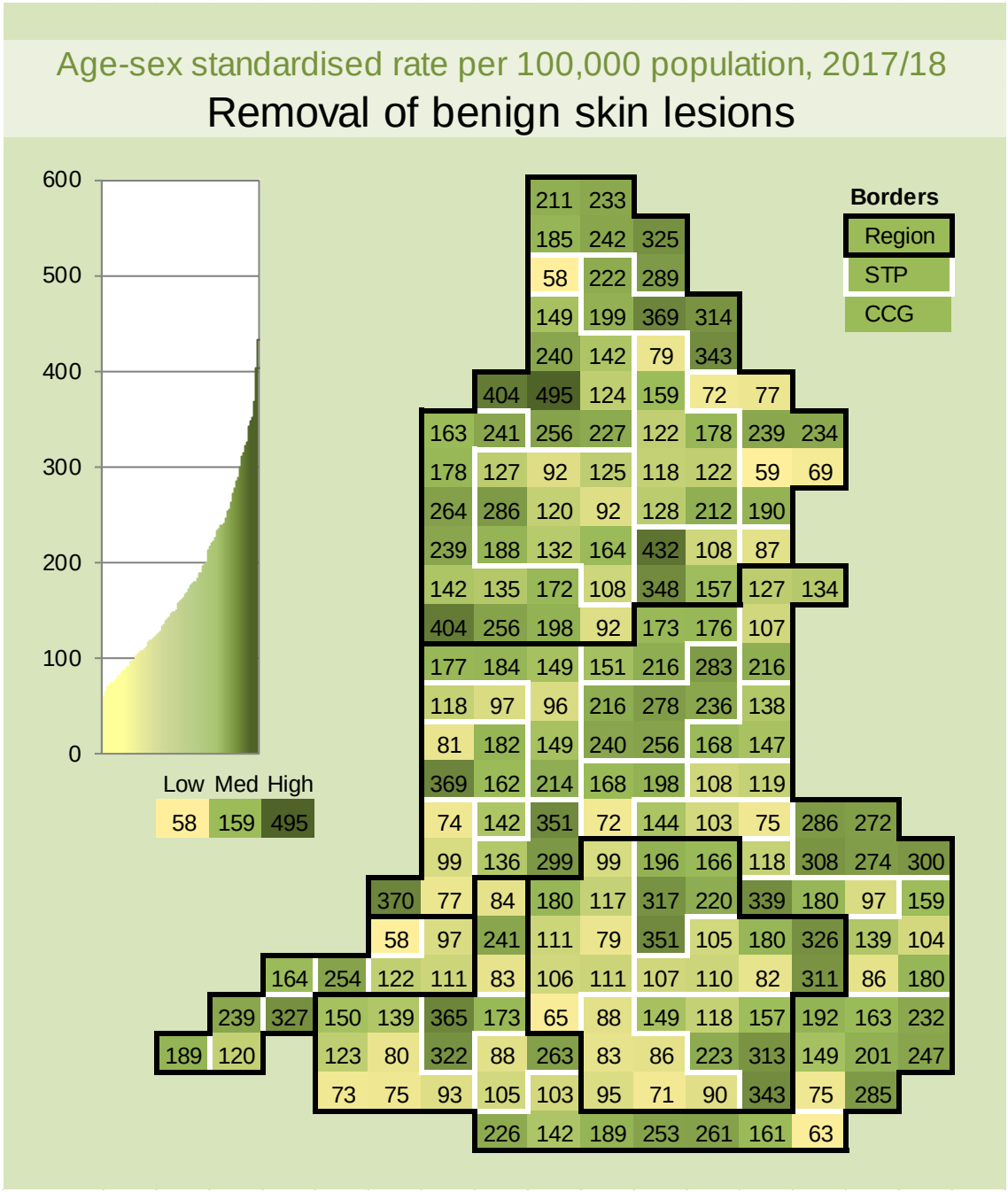


Cartograms for Category 2 interventions

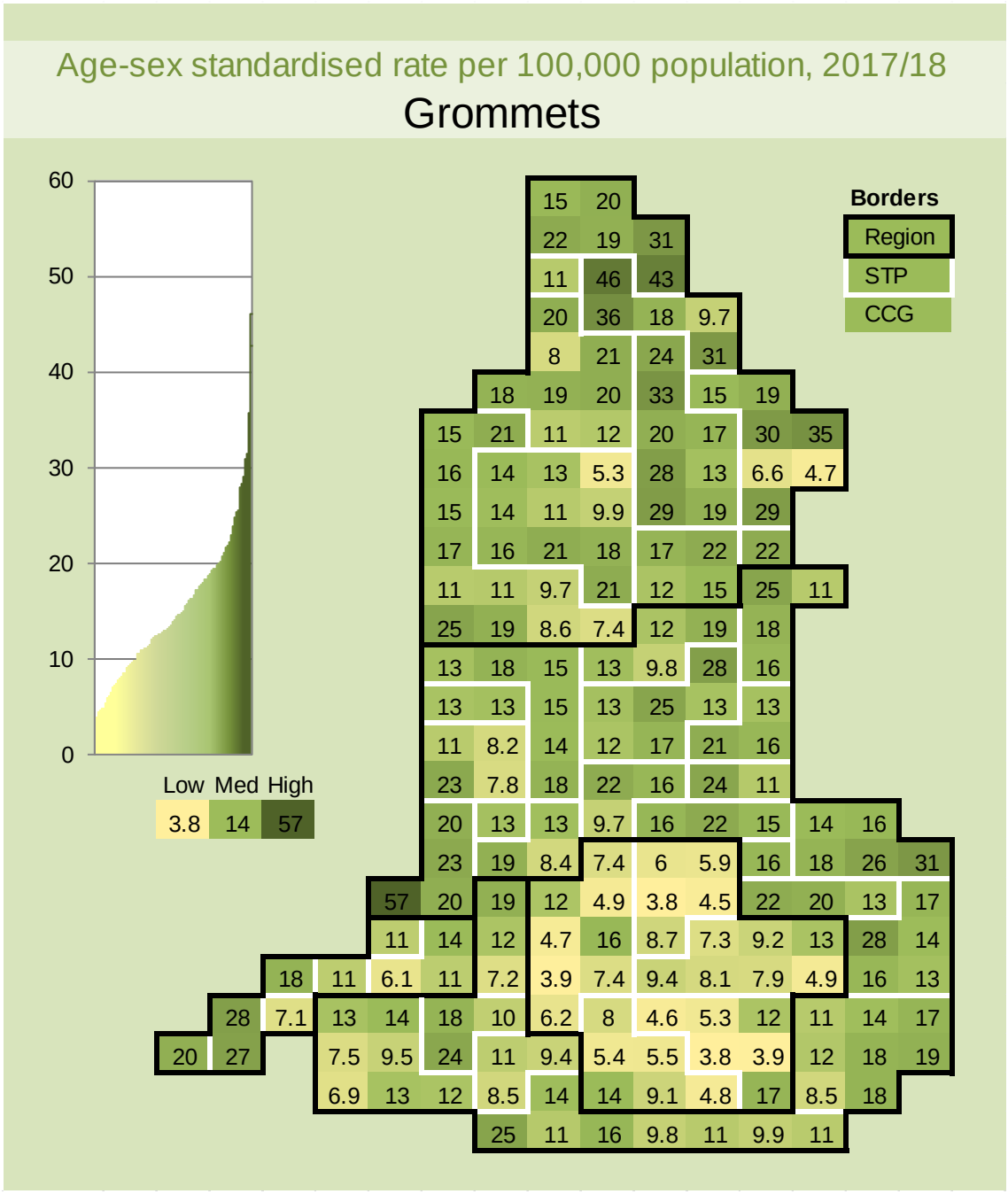
E. Breast reduction



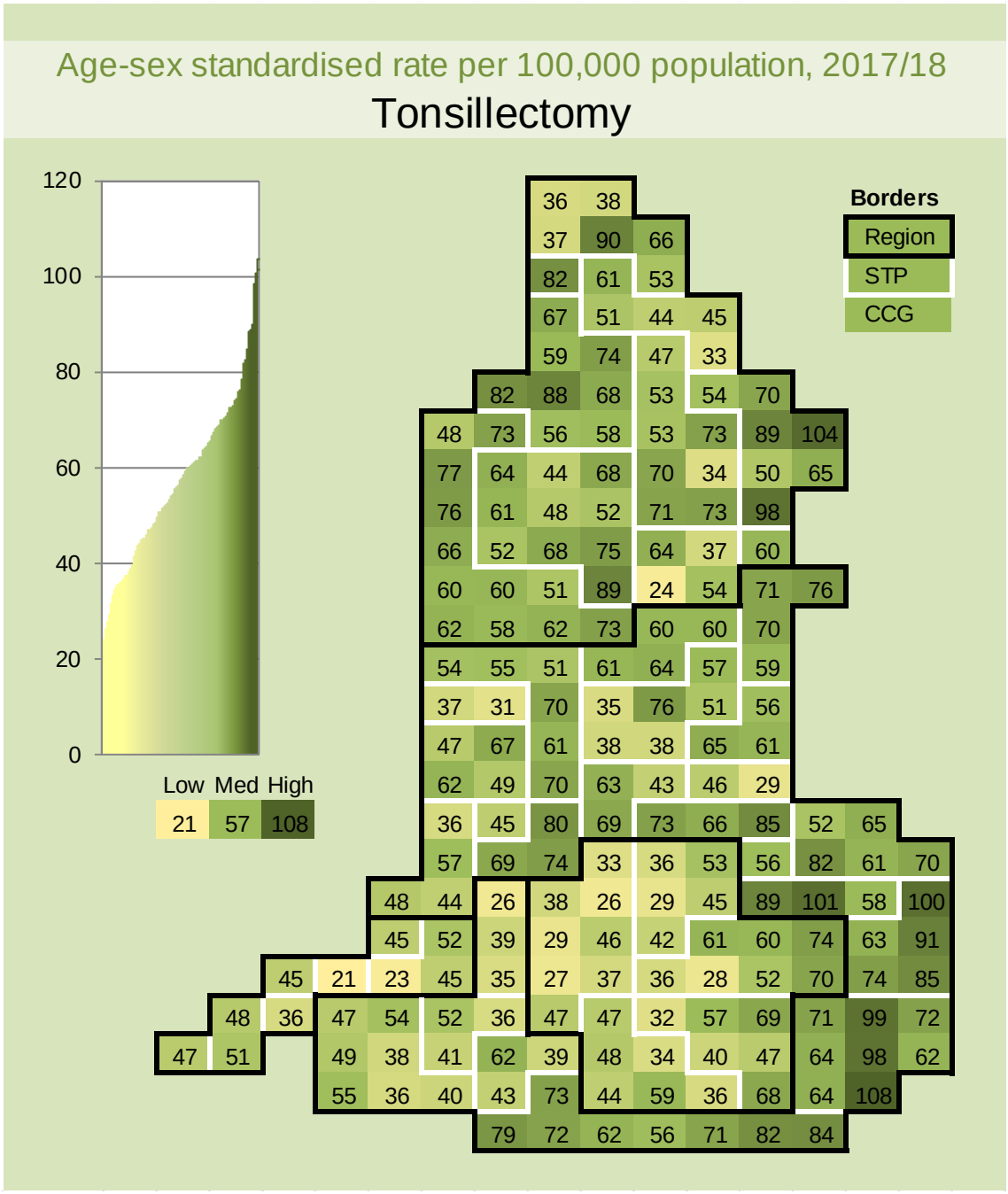
F. Removal of benign skin lesions



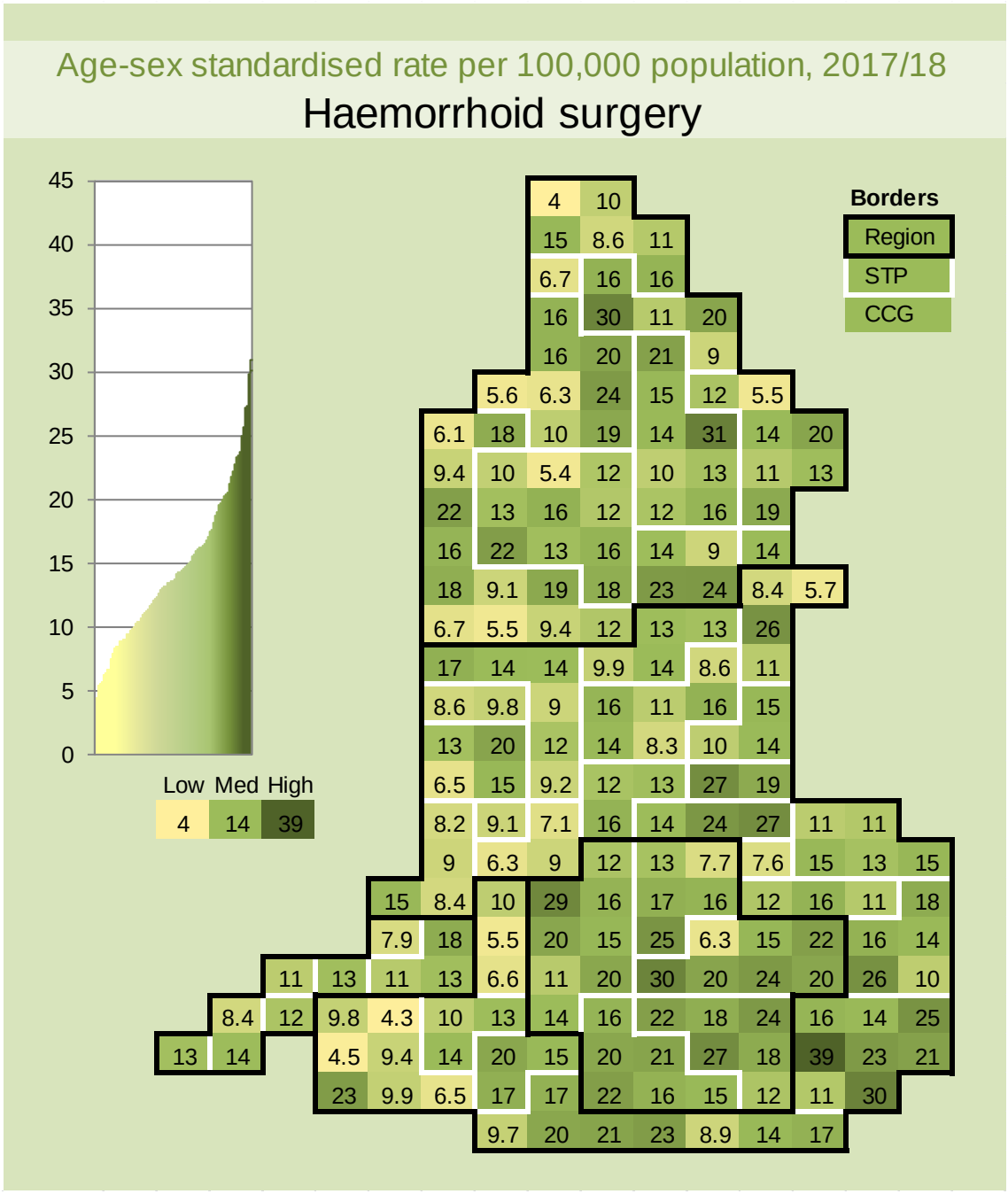
G. Grommets for Glue Ear in Children



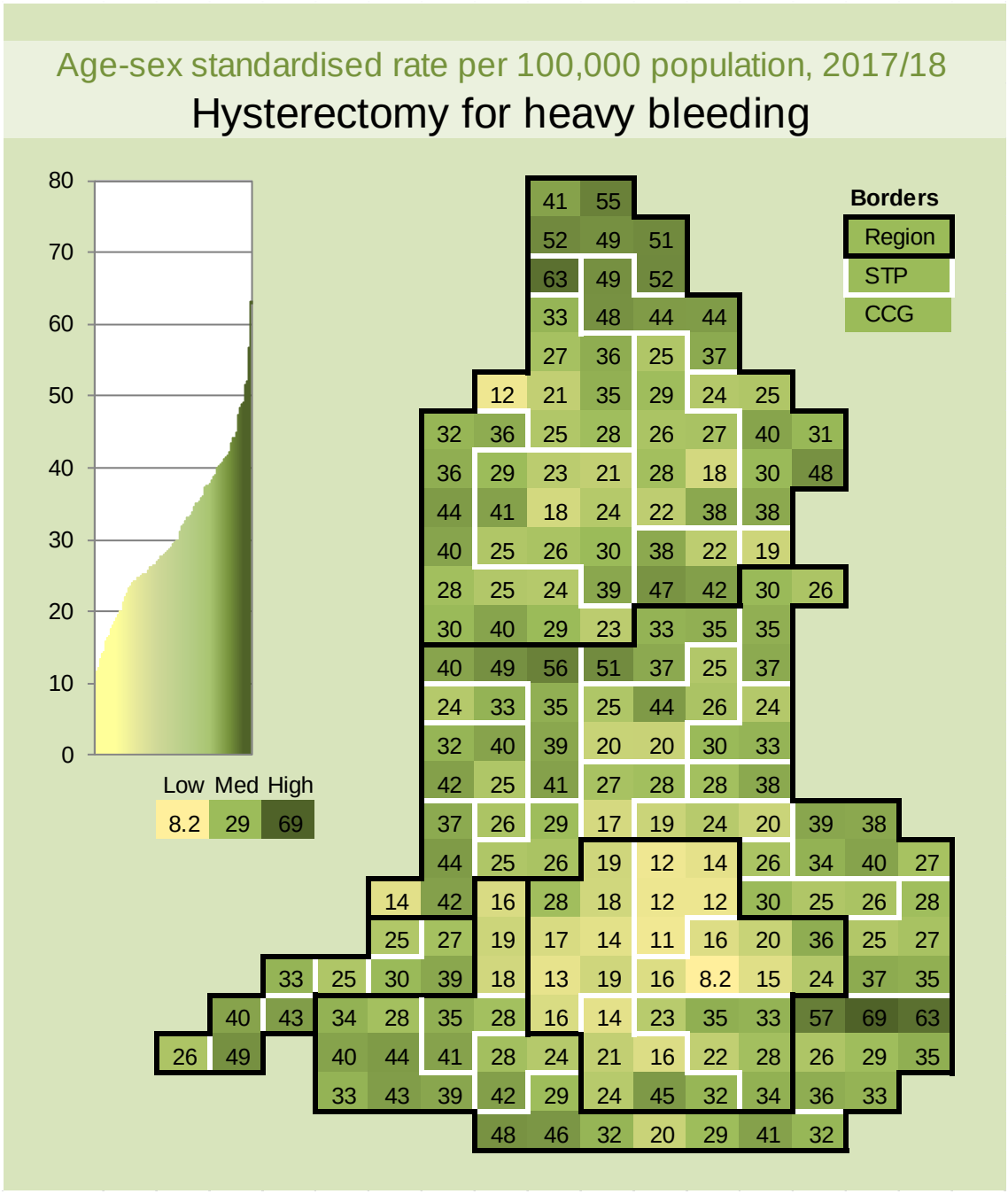
H. Tonsillectomy for Recurrent Tonsillitis



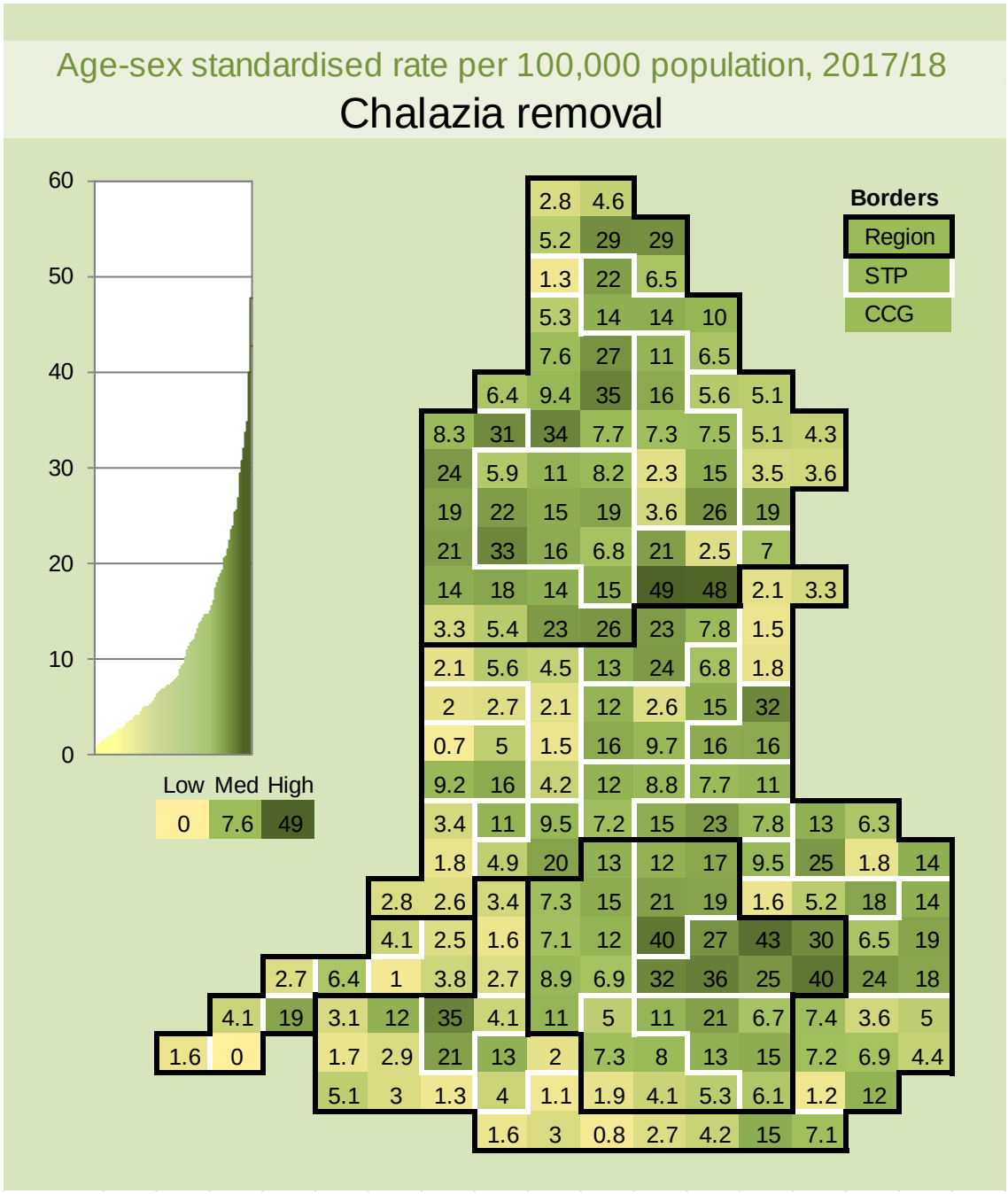
I. Haemorrhoid surgery



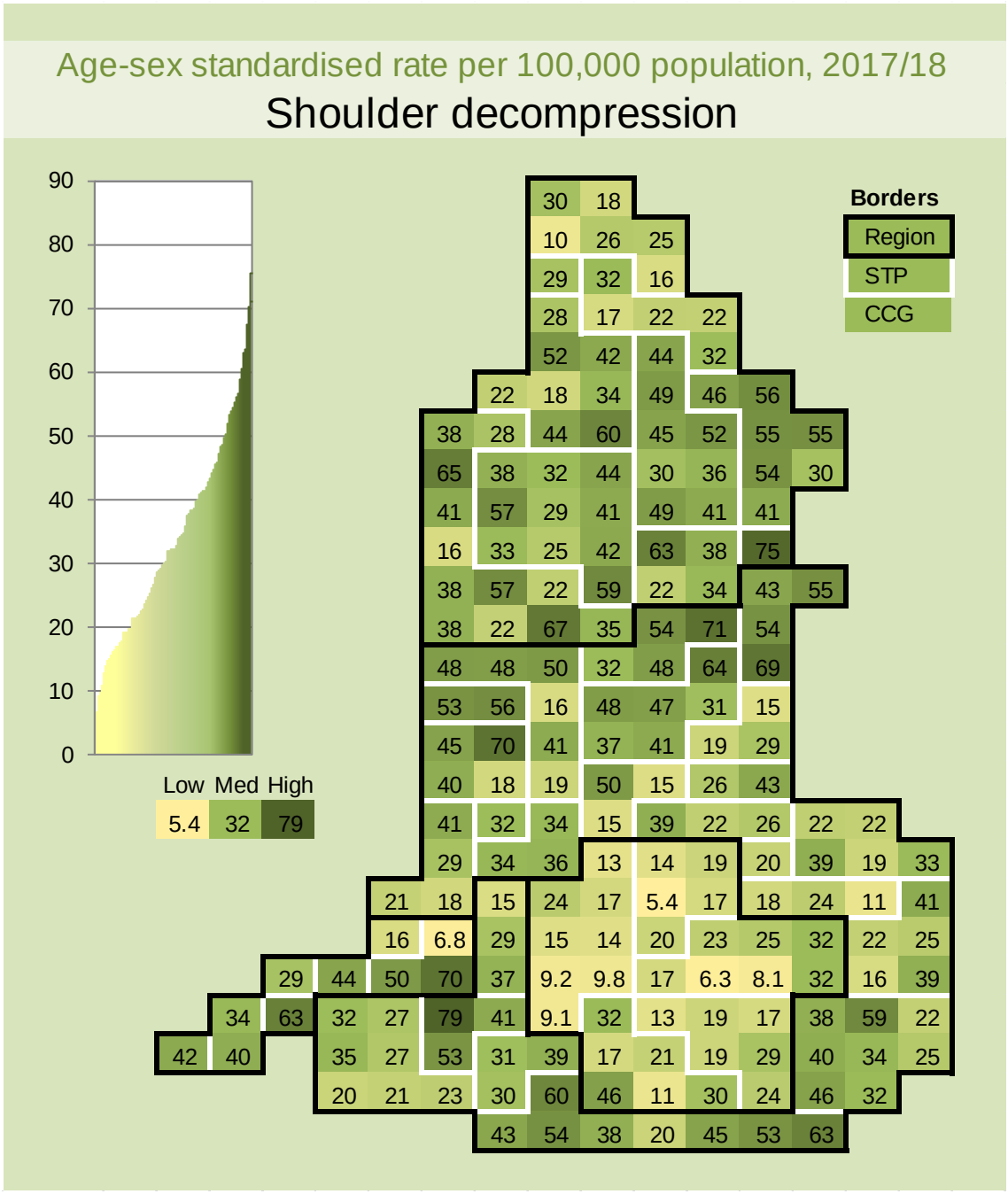
J. Hysterectomy for heavy menstrual bleeding



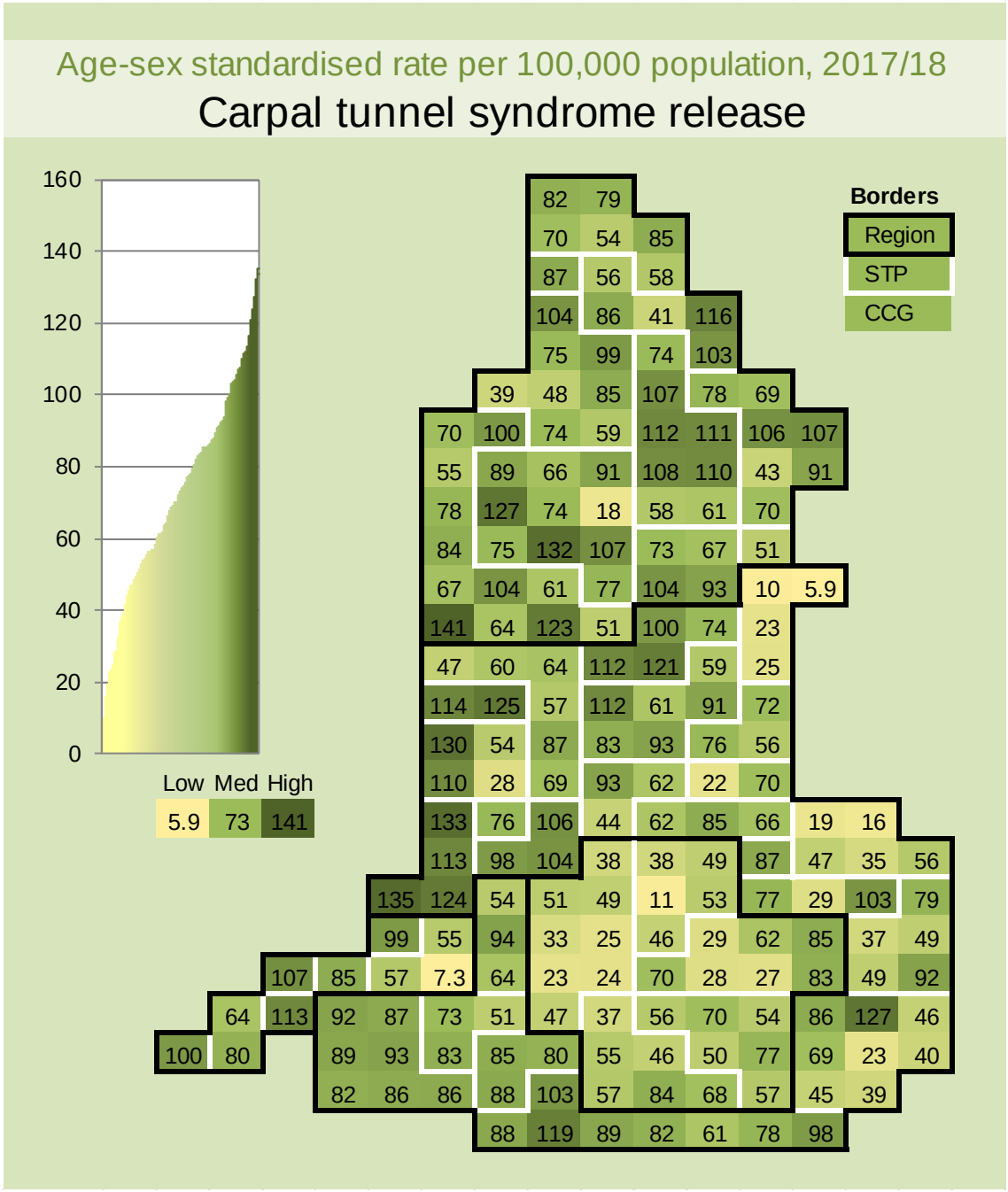
K. Chalazia removal



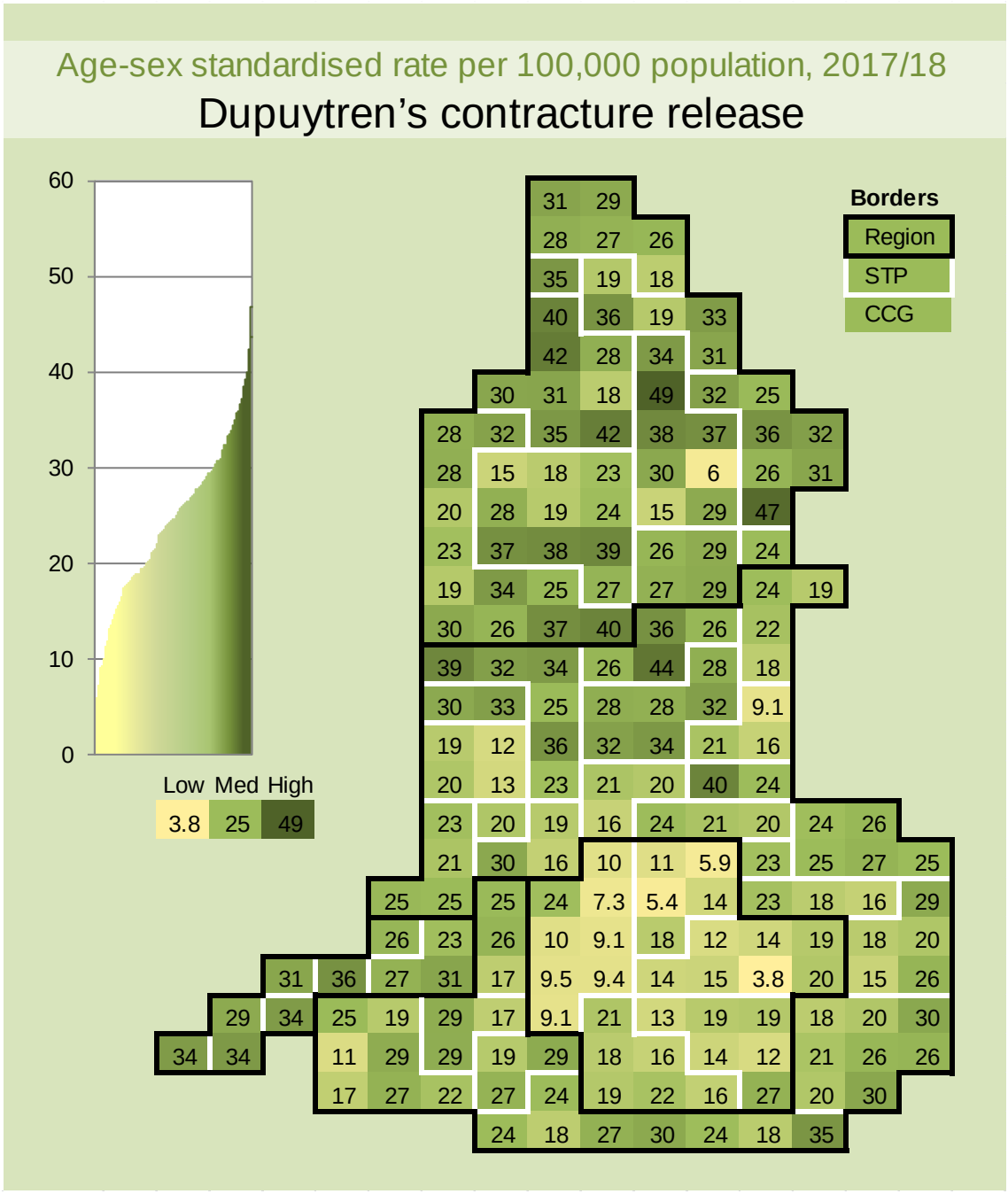
L. Arthroscopic shoulder decompression for subacromial shoulder pain



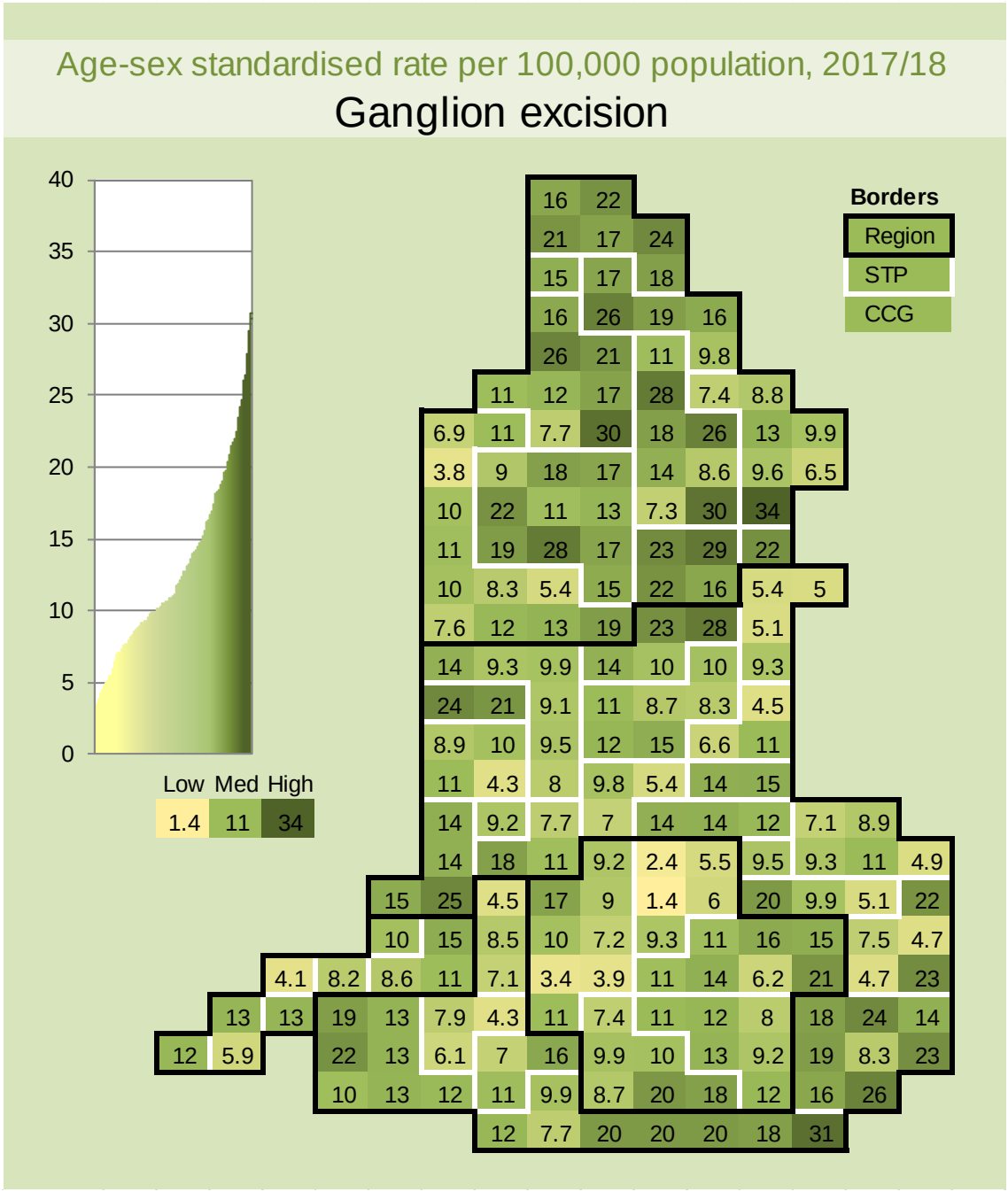
M. Carpal tunnel syndrome release



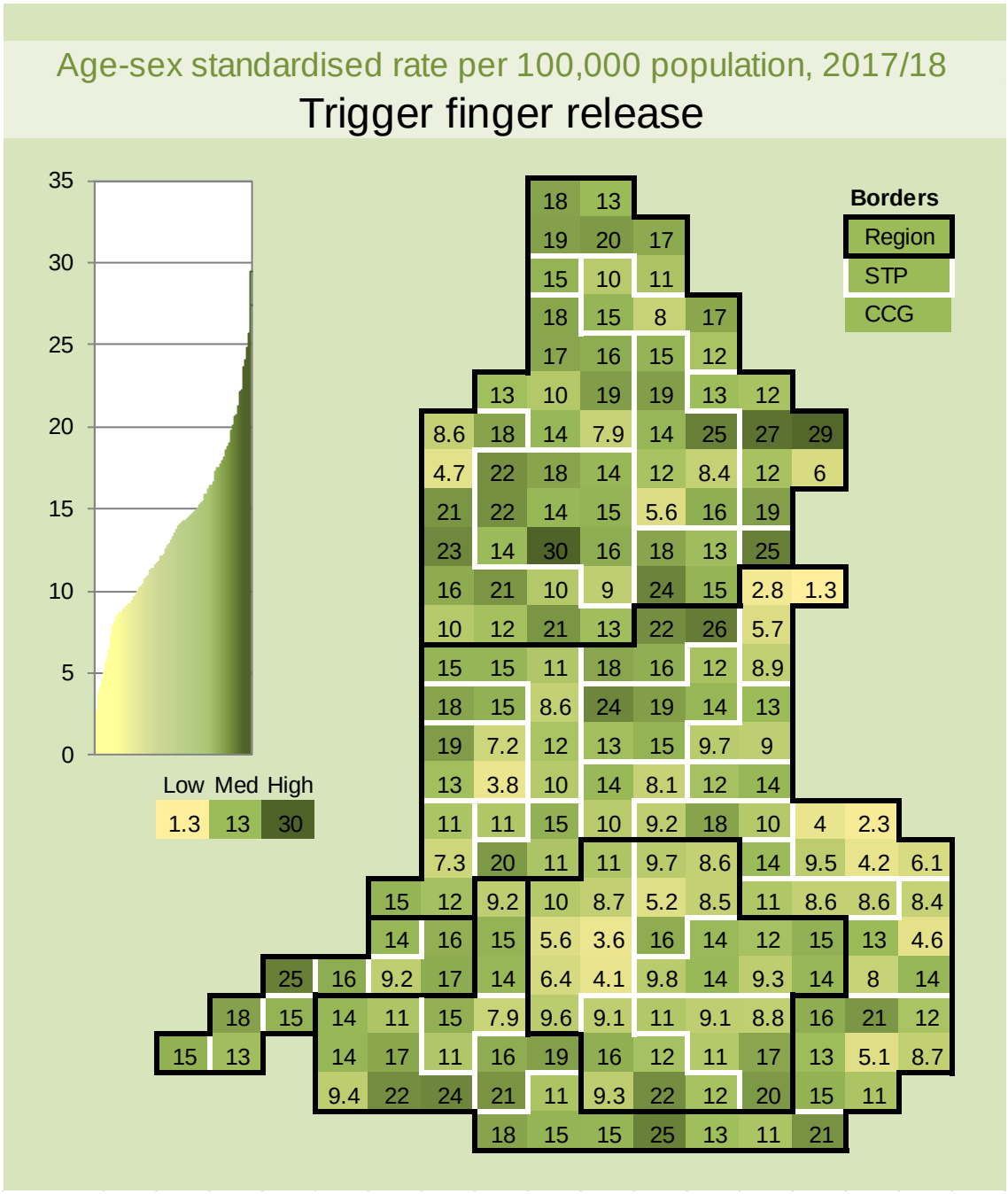
N. Dupuytren's contracture release



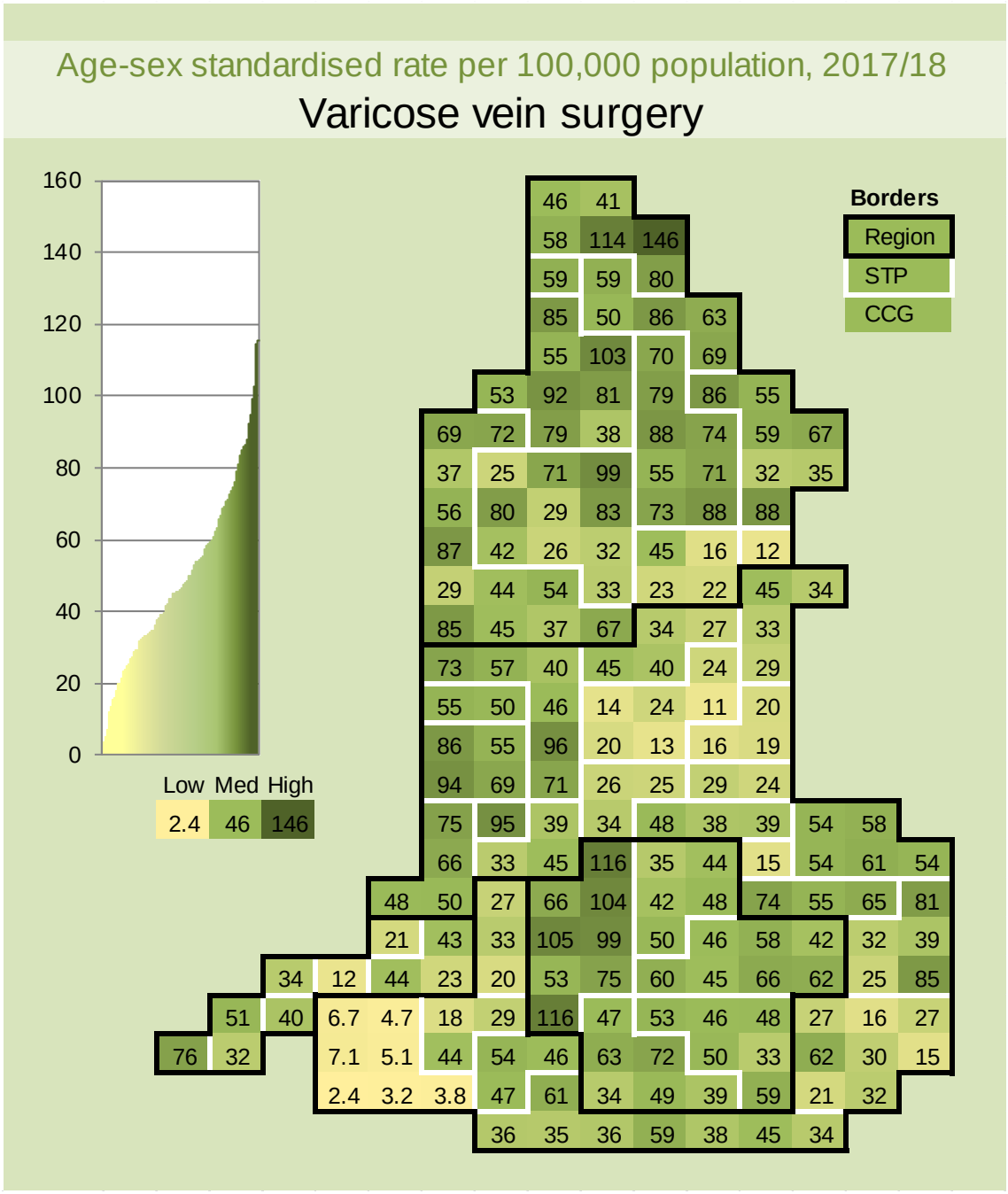
O. Ganglion excision



P. Trigger finger release



Q. Varicose vein surgery



Appendix 8: References

General References

Choosing Wisely UK Recommendations:
http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/

Choosing Wisely Australia Recommendations:
http://www.choosingwisely.org.au/recommendations

Choosing Wisely Canada Recommendations:
https://choosingwiselycanada.org/recommendations/

Choosing Wisely Recommendations (US):
http://www.choosingwisely.org/clinician-lists/

NICE Do Not Do Recommendations:
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjvhO7_0t_bAhUpJsAKHeO4DKQQFggnMAA&url=https%3A%2F%2Fwww.nice.org.uk%2Fmedia%2Fdefault%2Fsharedlearning%2F716_716donotdobookletfinal.pdf&usg=AOvVaw3RMj1RaPBm8GQdzXRcRNZV

NICE Cost Saving Guidance:
https://www.nice.org.uk/about/what-we-do/into-practice/cost-saving-guidance

NICE Guidance (various – see below)

A. Snoring Surgery (in the absence of OSA): References

Franklin KA, Anttila H, Axelsson S, Gislason T, Maasilta P, Myhre KI, Rehnqvist N. Effects and side-effects of surgery for snoring and obstructive sleep apnoea-a systematic review. Sleep. 2009 Jan. 32(1):27-36

Jones TM, Earis JE, Calverley PM, De S, Swift AC. Snoring surgery: A retrospective review. Laryngoscope. 2005 Nov 115(11): 2015-20.
https://www.ncbi.nlm.nih.gov/pubmed/16319615

Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs. Health Technol Assess 2009;13(3).
https://www.ncbi.nlm.nih.gov/pubmed/19091167

B. Dilatation and curettage (D&C) for heavy menstrual bleeding in women: References

Ben-Baruch G, Seidman DS, Schiff E, et al. Outpatient endometrial sampling with the Pipelle curette. Gynecologic and Obstetric Investigation 1994;37(4):260–2.

Haynes PJ, Hodgson H, Anderson AB, et al. Measurement of menstrual blood loss in patients complaining of menorrhagia. British Journal of Obstetrics and Gynaecology 1977;84(10):763–8.

Gimpelson RJ, Rappold HO. A comparative study between panoramic hysteroscopy with directed biopsies and dilatation and curettage. A review of 276 cases. American Journal of Obstetrics and Gynecology 1988;158(3 Pt 1):489–92.

MacKenzie IZ, Bibby JG. Critical assessment of dilatation and curettage in 1029 women. Lancet 1978;2(8089):566–8.

NICE guidance: **https://www.nice.org.uk/guidance/ng88**

NHS Choices: https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy

C. Knee arthroscopy for patients with osteoarthritis: References

Bernard J, Lemon M, Patterson MH. (2004) Arthroscopic washout of the knee – a 5-year survival analysis. The Knee 11: 233–5.

Chang RW, Falconer J, Stulberg SD et al. (1993) A randomized, controlled trial of arthroscopic surgery versus closed-needle joint lavage for patients with osteoarthritis of the knee. Arthritis & Rheumatism 36: 289–96.

Escape Pain: **http://www.escape-pain.org/**

Forster MC, Straw R. (2003) A prospective randomised trial comparing intra-articular Hyalgan injection and arthroscopic washout for knee osteoarthritis. The Knee 10: 291–3.

Harwin SF. (1999) Arthroscopic debridement for osteoarthritis of the knee: predictors of patient satisfaction. Arthroscopy: The Journal of Arthroscopic and Related Surgery 15: 142–6.

Hubbard MJS. (1996) Articular debridement versus washout for degeneration of the medial femoral condyle. Journal of Bone and Joint Surgery (British) 78-B: 217–19.

Jackson RW, Dieterichs C. (2003) The results of arthroscopic lavage and debridement of osteoarthritic knees based on the severity of degeneration: a 4- to 6-

year symptomatic follow-up. Arthroscopy: The Journal of Arthroscopic and Related Surgery 19: 13–20.

Kalunian KC, Moreland LW, Klashman DJ et al. (2000) Visually-guided irrigation in patients with early knee osteoarthritis: a multicentre randomized controlled trial. Osteoarthritis and Cartilage 8: 412–18.

Moseley JB, O'Malley K, Petersen NJ et al. (2002) A controlled trial of arthroscopic surgery for osteoarthritis of the knee. The New England Journal of Medicine 347: 81–8.

NICE Guidance: https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117

NICE Guidance: https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance

NICE Do Not Do Recommendations: https://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not

D. Injections for nonspecific low back pain without sciatica: References

Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul-Aug;15(4):E363-404.

Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53.

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