Evidence-Based Interventions: Response to the public consultation and next steps

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Evidence-Based Interventions Policy: Response to the public consultation

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Summary and next steps

1. In July 2018, we launched a consultation on the design and implementation of a new programme that aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate.

2. During the 12 week consultation period, we received 707 online responses and 97 individual submissions. We also spoke to 397 individuals by hosting or attending events, including:
   - Patient and public events in Birmingham, London and Leeds.
   - Workshops with individuals with learning disabilities in Leeds and London.
   - The NHS Expo conference in Manchester.
   - NHS Improvement costing forums in Leeds, Birmingham and London.
   - The Guidelines International Network conference in Manchester.
   - Seven online webinars with: Health and Wellbeing Alliance; Healthwatch England; NHS Clinical Commissioners; the NHS Youth Forum; and Voluntary Sector and Community Enterprise organisations.

3. We are grateful to all those who have contributed and helped us refine and strengthen our proposals. We are particularly appreciative of those who attended events, including a focus group for patients in Birmingham with The Patients Association and a workshop in London for clinicians, patients and CCGs hosted by the Academy of Medical Royal Colleges and other national partners in the programme, with 81 participants.

4. We have benefitted from a rich array of suggestions and insights on: the underlying ambitions and goals of the programme; the 17 interventions we proposed and the clinical criteria we set out; and the intended delivery actions we are taking to implement the programme.

5. This report outlines in detail the feedback we received and how this has influenced our proposals. In summary, we have made the following key changes:

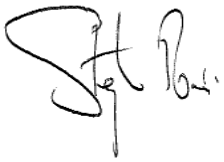
   - Refocused the programme's five goals to ensure a focus on the appropriate use of interventions. We have also strengthened our collaborative approach by establishing a new national steering group which includes patient and clinical representatives. This group has helped shape our response, and will guide our implementation.

   - Revised our clinical criteria following extensive consultation with clinical specialists and CCGs to ensure that they are based on clinical evidence developed by NICE, NICE-accredited or specialist society guidance. Key changes include:

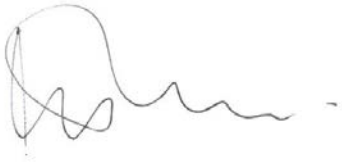
     - Expanding the recommendation wording for the recommendation for carpal tunnel syndrome release, Dupuytren's contracture release, ganglion excision and trigger finger release to align with proposals from the British Society for Surgery of the Hand.

- Excluding children from the clinical criteria related to trigger finger release, Dupuytren's contracture release and snoring surgery as these conditions present differently in children and may indicate more serious underlying conditions.
- Clarifying that children who cannot undergo standard audiometric testing assessments are still able to access specialist advice for grommets for glue ear.

6. We have been working with Frimley Integrated Care System, South West London Sustainability and Transformation Partnership and Hampshire and the Isle of Wight Sustainability and Transformation Partnership to refine our approach. We have found this collaboration invaluable and will invite further systems to join our community to help facilitate the practical implementation of the programme and provide peer support.



Professor Stephen Powis
National Medical Director
Signed on behalf of NHS England



Professor Carrie MacEwen
Chair of the AoMRC
Signed on behalf of the AoMRC[1]

Dr Graham Jackson
NHSCC Co-Chair
Signed on behalf of NHSCC

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Executive Medical Director
Signed on behalf of NHS Improvement

Professor Gillian Leng
Deputy Chief Executive and Director of Health and Social Care
Signed on behalf of NICE

1 Whilst the AoRMC has endorsed the principle of this work, individual Royal Colleges and specialist societies have supported the development of the clinical criteria set out in Appendix 2.

Our overall approach

1.1 Consultation process

7. We held a number of engagement events across the country. We worked with the Health and Wellbeing Alliance, Healthwatch England, the NHS Youth Forum and Voluntary Sector and Community Enterprise to engage with patients, carers and the public via a series of webinars events. NHS Clinical Commissioners also ran a series of webinar events to engage with clinical commissioners; the Academy of Medical Royal Colleges hosted an event for clinicians, CCGs and patients (and in partnership with other national partners in the programme); and we worked with The Patients Association to run a focus group with patients.

8. We received 707 online responses and 97 individual submissions. Responses were received from a wide spectrum of individuals and organisations, including: clinicians, voluntary organisations, patient representative groups, national NHS representative groups, local NHS Trusts and Foundation Trusts, CCGs, Royal Colleges and specialist societies, and individual patients and members of the public.

9. We are very grateful to everyone who contributed to the consultation. The consultation responses provided valuable insights into how the Evidence-Based Interventions programme was received, highlighting areas with significant support as well as areas for improvement. This document sets out the feedback we received and what we have done in response (see Appendix 1 for our Methodology).

1.2 Design principles and overall approach

10. In our consultation, we set out six design principles[2] and five goals (see overleaf) to underpin the programme. The principles and overall approach received a significant amount of support from commissioners, providers and other representative bodies, indicating that there is strong support for a programme to "reduce variation in commissioning practice [and support] clinicians to follow best practice" (ENT UK). This included 95% of providers and 85% of CCGs who responded to the online survey (see Appendix 2 for a full breakdown of responses to each question).

11. Responses from individual patients and citizens were mixed. There was recognition in public events that the ambition of the programme was "a good idea" (patient). However, we also heard repeated concerns that the programme was primarily "about money saving" (patient), rather than reinvesting in better care. Some clinicians questioned the notion of more interventions being "ineffective". 63% of patient representative organisations who responded to the online survey however, agreed with the programme's six design principles.

[2] The six design principles outline our commitment to: clinical research and evidence (as contained in NICE and/or NICE accredited and specialist society guidelines); best practice; engagement, buy-in and patient involvement; and successful implementation that involves a range of activities.

12. In light of these comments, we have reviewed our design principles and five goals, and have made amendments to clarify that this programme is about addressing inappropriate interventions (see below for an amended set of goals). In the words of a clinician who responded to our consultation, the programme is about avoiding “treating things that we shouldn’t”.

13. We recognise that some media coverage of the programme unhelpfully implied that it is driven by financial goals: this is simply not the case. Any savings arising from the reduction in any interventions will be recycled back into local patient care. We also restate our view that reducing inappropriate interventions will allow more headroom for innovation and the adoption of new, proven innovations in both clinical interventions and individuals’ ability to self-care.

14. None of the interventions will be subject to a blanket ban. Category 1 interventions which are appropriate in exceptional circumstances will be available via the Individual Funding Request (IFR) process and Category 2 interventions will be available where patients meet the agreed clinical criteria set out in this report, supported by the prior approval process (see Appendix 3 for technical glossary).

15. We have kept the six design principles as originally proposed, but are refining the hierarchy of goals to reflect the feedback received.

HIERARCHY OF GOALS

i. Reduce avoidable harm to patients. With surgical interventions, there is always a risk of complications. Weighing the risks and benefits of appropriate treatments should be co-produced with patients.

ii. Save precious professional time, when the NHS is severely short of staff professionals should offer appropriate and effective treatment to patients.

iii. Help clinicians maintain their professional practice and keep up to date with the changing evidence base and best practice.

iv. Create headroom for innovation. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of inappropriate interventions. This allows innovation in prescribing and technology to improve patients’ ability to self-care and live with long term conditions.

v. Maximise value and avoid waste. Inappropriate care is poor value for the taxpayer. Resources should be focused on effective and appropriate NHS services

The 17 interventions

1.3 Number of interventions for this phase of the programme

16. The consultation document proposed a list of 17 interventions for the first phase of the Evidence-Based Interventions programme. We asked whether the number of the interventions proposed was appropriate and, if not, whether any interventions should be added or removed.

17. The list of interventions was described by a voluntary organisation as “relatively non-controversial”, and one CCG reflected that “we know of no CCG in the south of England which does not have the majority, if not all, of these interventions covered” by a local commissioning policy. Our online response showed that 88% of national bodies[3], 85% of CCGs and NHS provider organisations agreed that 17 interventions was the right number to start with, providing justifications such as “if they are all regularly prescribed with minimal evidence base for their success then it is logical [to include them]” (patient representative organisation).

18. Individual patients and members of the public expressed concern that the programme would stop access to interventions and remove clinical decision making, although 63% of patient representative organisations agreed that the programme was right to start with 17 interventions. To address this concern, we want to make clear that our aim is to focus clinicians’ time and resources on clinically-appropriate interventions. Clinicians will continue to have discretion to recommend a particular intervention where they deem it appropriate for a patient and it meets the relevant clinical criteria. Similarly all interventions will still be available when certain clinical criteria are met.

19. Many individual patients and members of the public we spoke to suggested that the programme should recognise the need “to continue to engage patients and public” in the further development of the programme, which is why there is further work being carried out to strengthen national collaboration.

20. Several proposals for additional interventions to include in the programme were made. On balance, we will not expand the number of interventions for this phase because we have heard the call to ensure that we can successfully implement the programme before tackling additional interventions. We also want to allow sufficient time to consider the clinical evidence of any further additions. All proposals have been logged and will be considered for future phases.

1.4 Amendments to the clinical criteria

21. We are making a number of amendments to the clinical criteria based on feedback from clinicians, specialist societies, providers, clinical commissioners, and commissioning support units. Changes include refinements and additional

[3] National bodies include those who identified themselves in the online survey as: professional representative body, other healthcare organisation, other NHS organisation, regular or industry.

detail on the clinical criteria to ensure that NICE guidance is quoted more fully (rather than simply references) to capture the nuances of the guidance.

22. Feedback from individual patients and members of the public included requests that treatment continue to be provided where it "enhances [patients'] quality of life and/or diminishes pain" and "enable[s] the patient to continue with daily life and work". Our proposals are based on pre-existing NICE, NICE-accredited and specialist society guidance and that the interventions will still be available to people who meet the clinical criteria set out in this report (for category 2 interventions) and in exceptional circumstances (for category 1 interventions).

23. Tables 1 and 2 summarise the 17 interventions and the changes we have made to the clinical criteria following the consultation feedback. Full details of the final set of clinical criteria, as well as an outline of the clinical evidence base, can be found in the Statutory Guidance to CCGs (Appendix 4). This is supported by a glossary of clinical terms in Appendix 5.

Table 1 - Category 1: Interventions which should not be routinely commissioned or offered

Ref.	Intervention and summary of changes
ENT	
A	**Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))** There was agreement to the inclusion of this intervention in the programme and general agreement to the clinical criteria, including from ENT UK, the professional membership body that represents ear, nose and throat clinicians and related specialities. We received the following suggestions: • To clarify that the intervention only relates to adults and to refine the wording to emphasise that sleep apnoea is excluded. Both of these amendments have been incorporated. • To consider including tonsillectomy and septoplasty for snoring. However, there is evidence to suggest these are appropriate treatments where there is an anatomical abnormality and as such we have not included them. • To wait until revised NICE guidance is published in 2020. As we have clinical consensus with our criteria, we will continue with our current proposals but review our criteria against the new guidance when published. ENT UK has approved our reflections on the above feedback.
Gynaecology	
B	**Dilatation and curettage (D&C) for heavy menstrual bleeding (HMB) in women** There was agreement to the inclusion of this intervention in the programme and general agreement to the clinical criteria, including from the Royal College of Gynaecology. We received the following suggestions:

	• To move alternative treatment references from being a recommendation to being listed as part of the rationale for the intervention. We have considered this but think it is clearer for clinicians to keep it in the recommendation section. • To provide further details that would help primary care in supporting women with heavy menstrual bleeding. We will explore this further with Royal College of General Practitioners. • To change the alternative treatments listed in our criteria to reflect that "there are a number of treatments for HMB, not only medication and IUS" (CCG). We have clarified that these are options for treatment among others. The Royal College of Gynaecology has approved the change to the clinical criteria and our other reflections on the feedback received.
Orthopaedics	
C	**Knee arthroscopy for patients with osteoarthritis** There was agreement to the inclusion of this intervention in the programme and general agreement to the clinical criteria, including from the British Orthopaedic Association (BOA) and the British Association for Surgery of the Knee (BASK) "The BOA and BASK support the decision to place knee arthroscopy for patients with osteoarthritis (OA) onto the list of procedures of limited clinical value" (BOA). We also heard from an NHS provider who stated that "Evidence shows that joint lavage, used alone without debridement, for patients with knee osteoarthritis is not effective and should not be used". We received suggestions for clarification which we have responded to by: • Ensuring that the wording is in line with NICE guidance which states that arthroscopy should not be undertaken unless there are mechanical symptoms. • To clarify this intervention only relates to adults. • Using wording from Royal College of Surgeons/British Orthopaedic Association commissioning guidelines related to pre-operative arthroscopy. • Including meniscal disease in the scope of future phases of the programme, as agreed with clinical experts and the programme's partnership board. The British Orthopaedic Association and the British Association for Surgery of the Knee have approved the changes to the recommendations and clinical criteria.
D	**Injections for non-specific low back pain** There was agreement to the inclusion of this intervention in the programme and general agreement to the clinical criteria, including from the British Association of Spinal Surgeons who stated that they agree "with the rationale, and the evidence as already agreed through NICE." We received suggestions for clarification which we have responded to by:

	• Keeping the title of the recommendation so it remains in line with NICE guidance, which relates to “non-specific” low back pain. • Ensuring the policy is aligned with the National Back Pain Pathway. • Include radiofrequency denervation in the recommendations as an alternative treatment for intractable pain. • Clarifying that Facet Joint Injections are not offered to patients with or without sciatica, as per NICE guidance. • Clarifying that Spinal Epidural Injections should only be offered to patients with sciatica, as per NICE guidance. We also received feedback on the importance of “alternative therapies, such as Physiotherapy intervention and CPPP programmes (The Combined Physical and Psychological Programme) being available” (British Association of Spinal Surgeons). We will work with First Contact Providers (e.g. physiotherapists) to disseminate messaging and implementation of the programme and continue to align the programme with the National Back Pain Pathway. The British Association of Spinal Surgeons has approved the changes to the recommendations and clinical criteria.

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

Ref.	Intervention and summary of changes
E	**Breast reduction** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The Association of Breast Surgery. We received requests for clarification which we have responded to by: • Expanding the wording to include reference to the implications of smoking. • Reconsidering the specification of BMI as a criterion - some feedback suggested that BMI should be 25 for 24 months however others felt BMI should be higher - “Evidence for increased complication puts the cut off at 30” (NHS provider). We have reflected on these views and have decided to keep the criteria as BMI at 27 for 12 months as per the original proposals. • Adding measurement in cup sizes not just weight of breasts so the assessment can be offered in primary care as “standardised measurements techniques are easier” (clinician). • Changing the wording for asymmetric breast reduction surgery to clarify it is not offered “for cosmetic purposes” (CCG). • Considering the inclusion of psychological distress. As noted by an NHS provider “cosmetic surgery should NOT be considered as a

	treatment to improve mental health (as there is a significant risk to patients with body dysmorphia)". Similarly, while there is a psychological dimension for patients seeking these interventions, "as there are no universally accepted and objective measures of psychological distress, such factors are not taken into account in any policy clinical thresholds. Nevertheless, there always remains the option of an application to demonstrate clinical exceptionality through IFR." (CCG). As such we have not amended the clinical criteria. The Association of Breast Surgery has approved the changes to the recommendations and clinical criteria.
Dermatology	
F	**Removal of benign skin lesions** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The British Association of Dermatologists. Other feedback suggested that "removal of Benign skin lesions should also be made IFR only" (CCG). However, due to the clinical evidence presented here, we continue to believe that it should be a Category 2 intervention. In response to requests for clarification: • We are removing the criterion to fund removal of facial legions over 1 centimetre that cause significant disfigurement as this was considered a procedure undertaken for cosmetic purposes. We edited another facial lesion recommendation to narrow it to facial "viral" warts as facial warts may need removal in some cases as they can be difficult to treat with alternative options. • Clarified wording so the recommendation applies to removal of benign skin lesions in all settings as we "should be considering the removal of benign skin lesions from ALL specialties" (NHS provider) The British Association of Dermatology has approved the changes to the recommendations and the clinical criteria.
ENT	
G	**Grommets for Glue Ear in Children** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from ENT UK who stated "We welcome the document, which should reduce variation in commissioning practice across England". They also expressed agreement that "it is made clear that the document only covers the most common indication in each case (glue ear for grommets)". We received requests for clarification which we responded to by: • Adding "acute" to the indication of otitis media.

	• Clarifying that where children are unable to undergo standard audiometric testing and there is judged to be a significant impact on hearing or development, then surgery should be considered. We also received some comments on the issue of grommets for people with Down syndrome, with one response stating “It will unfairly disadvantage the Down syndrome community”: This was addressed by making it clear that the guidance does not apply to people with Down syndrome, as per NICE guidance. ENTUK has approved the changes to the recommendations and the clinical criteria.
H	**Tonsillectomy for recurrent tonsillitis** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from ENT UK. Others also welcomed the inclusion of tonsillectomy in this programme on safety grounds, stating that with regard to children “my experience as a parent and former NHS professional is that strict criteria is required before surgery as it is not a risk free process”. There was also concern that the need for well documented episodes of tonsillitis could drive demand in primary care. • The criteria for documentation of episodes were reworded so as to be less restrictive. We received requests for clarification which we responded to by: • Clarifying that those with acute and chronic renal failure where the treating physician feels tonsillectomy may be beneficial, should be able to access specialist opinion. • Clarifying that in selected cases where streptococcal tonsillitis may have caused glomerulonephritis, should be able to access specialist opinion. ENT UK has approved the changes to the recommendations and the clinical criteria.
General Surgery	
I	**Haemorrhoid surgery** The was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The Association of Coloproctologists of Great Britain and Ireland who stated that they “agree with this evidence-based intervention and support its implementation.” Individual patients also reported their varied experiences, including for example, stating that their haemorrhoid surgery “was not successful and will require another operation in the future” (patient), as compared to another who stated that “surgery has improved my life as they were quite painful and I was losing blood in a great amount” (patient). Agreement was

	expressed by a CCG who stated that “Haemorrhoid surgery should be discouraged when banding is possible” (CCG). We received requests for clarification which we have responded to by: • Clarifying wording on how painful surgery can be and that pain may persist for weeks as some individual patients suggested the document “understated” the pain following haemorrhoid surgery. • Expanding wording to recommend that those who have severe bleeding should access a specialist. • Adding a reference to haemorrhoid artery ligation which may be offered if all other options do not work. The Association of Coloproctologists of Great Britain and Ireland have approved the changes to the recommendation and criteria.
Gynaecology	
J	**Hysterectomy for heavy menstrual bleeding** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The Royal College of Obstetrics and Gynaecology. Support also came from some CCGs and individual patients, as articulated by a patient who stated that “Hysterectomy should not be the ‘go to’ option for heavy bleeding - BECAUSE - no two women are the same - and thus one-size-fits-all solutions to this complex problem should not be in place - I am a patient with this condition.” We received requests for clarification which we responded to by: • Expanding the wording to include more of NICE guidance to make it “more specific” (CCG). For example “NICE NG88 in fact recommends hysterectomy as a first line option for women with fibroids of 3cm or more in diameter” (Doctor) • Continue to work with CCGs, primary care and The Royal College of Obstetrics and Gynaecology to support primary care in their treatment of heavy menstrual bleeding in the community for example by providing information for patients and clinicians.. The Royal College of Obstetrics and Gynaecology have approved the changes to the recommendations and clinical criteria.
Ophthalmology	
K	**Chalazia removal** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The Royal College of Ophthalmologists who stated that they agreed with the design principles. We received requests for clarification which we have responded to by: • Clarifying that this policy does not apply to those with a recurrence or any suggestion of malignancy. • Clarifying that antibiotics should only be used if there is evidence of infection (as per NICE guidance).

	• Rewording the criteria to clarify that the patient must reach at least one of the other criteria and the treating physician has considered all alternative treatments. • Expanding the wording on the risks of steroid injections and surgery near the eye. • Reviewing the relative merits of incision and curettage or triamcinolone injection when the clinical criteria is met, as highlighted by a clinician who stated that "Looking through the "evidence " in the literature surgical treatment seems as effective as 1 or 2 injections with triamcinolone." We have concluded that the risks of both procedures highlighted are acceptable when the clinical criteria are met. • Considering whether formal assessment of the visual field was required. However, the majority of feedback to the consultation (including from the Royal College of Ophthalmologists) was that this would not be beneficial and therefore has not been included. The Royal College of Ophthalmologists have approved the changes to the recommendations and clinical criteria.
Orthopaedics	
L	**Arthroscopic shoulder decompression for subacromial shoulder pain** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The British Orthopaedic Association and the British Elbow and Shoulder Society. The British Orthopaedic Association specifically stated that they "agree with the placement of arthroscopic subacromial decompression in category 2". We received requests for clarity which we have responded to by: • Referencing more fully NICE-accredited guidance by the British Elbow and Shoulder Society. The British Orthopaedic Association and the British Elbow and Shoulder Society have approved the changes to the recommendations and clinical criteria.
M	**Carpal tunnel syndrome release** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from the British Society for Surgery of the Hand. We received requests for clarification which we responded to by: • Adding information provided by the British Society for Surgery of the Hand. • Amending the wording to reflect that while "service planning for the management of Carpal Tunnel Syndrome should include early access to neurophysiological testing the use of nerve conduction studies to diagnose carpal tunnel syndrome" (clinician)., access to neurophysiological testing is not consistent across all CCGs. We

	therefore suggest that nerve conduction studies may be considered in cases where the diagnosis is unclear. The British Society for Surgery of the Hand approved the changes to the recommendations and clinical criteria.
N	**Dupuytren's contracture release in adults** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from the British Society for Surgery of the Hand who stated that "There may be scope to reduce the rates of surgery for Dupuytren's contracture by providing less invasive treatments, such as percutaneous needle fasciotomy and collagenase injection. The choice of treatment should be guided by the severity of the contracture, the age of the patient and rate of progression." (British Society for Surgery of the Hand) We received requests for clarification which we have responded to by: • Changing the recommendation wording using feedback provided by the British Society for Surgery of the Hand in order to provide "clearer definition of severe/moderate symptoms" (CCG). • Excluding children from the policy as Dupuytren's contracture in children may represent a more serious underlying disease. The British Society for Surgery of the Hand approved the changes to the recommendations and clinical criteria.
O	**Ganglion excision** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from the British Society for Surgery of the Hand and the British Orthopaedic Association, who stated that "most patients with ganglia do not need treatment". Positive feedback to this intervention included: a CCG who stated that they had "no substantial disagreement" and an NHS provider who commented that "I doubt we deviate from those criteria at all" (NHS provider). Some CCGs suggested that "ganglion surgery should be re-categorised into Category 1" (CCG). However, based on the clinical evidence, we will consider it more appropriate as a Category 2 intervention. We received requests for clarification which we have responded to by: • Incorporating wording from the British Society for Surgery of the Hand to differentiate between wrist, seed, mucous cyst ganglion. • Rewording the criteria using British Society for Surgery of the Hand feedback to clarify that "MRI is not normally required to diagnose ganglia" (CCG). The British Society for Surgery of the Hand approved the changes to the recommendations and clinical criteria.
P	**Trigger finger release in adults**

	There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from the British Society for Surgery of the Hand. We received requests for clarification which we have responded to by: • Incorporating further references and information provided by British Society for Surgery of the Hand to reflect their NICE-accredited guidance. • Clarifying the wording to reflect that "the wording proposed enforces the requirement for splinting, injection and analgesia. We would propose that this be amended in line with our local policy as all the conservative measures might not be appropriate for every patient" (CCG) and "there is limited evidence to support the use of splints" (clinician). • Excluding children from this recommendation as trigger finger in children may represent a more serious underlying disease. The British Society for Surgery of the Hand approved the changes to the recommendations and clinical criteria.
Vascular Vein Interventions	
Q	**Varicose vein interventions** There was agreement to the inclusion of this proposal in the programme and general agreement to the clinical criteria, including from The Vascular Society. As described by one clinician, "It is high time we had a unified policy for varicose vein treatment across England. The current significant regional variation leads to confusion for both primary care practitioners and patients, quite apart from creating a post code lottery." Similarly, the President of the Royal Society of Medicine Venous Forum expressed support to "stop the increasing trend of rationing treatment for symptomatic varicose veins for non-clinical reasons". We received requests for clarification which we have responded to by: • Changing the title to "varicose veins interventions", to reflect that this policy considers interventions beyond surgery. • Adjusting the messaging as "there is no evidence to support a claim that traditional varicose vein surgery is clinically ineffective" (NHS provider) • Clarifying that a varicose vein intervention will not be funded for "cosmetic" reasons (CCG). • Aligning the recommendation with NICE guidance. Some CCGs reported using a "more restrictive policy" that was not in line with NICE guidance. However, the President of the Vascular Society reported that while there was "little to be gained from interventions for cosmetic reasons, at the other end of the scale there is much to be gained in terms of leg ulcer healing and avoidance which is a significant burden to the NHS" (President of the Vascular Society) The Vascular Society has approved the changes to the recommendation and criteria.

1.5 Status of the 17 clinical criteria

24. In our consultation, we stated that we intended to publish statutory guidance for CCGs on Evidence-Based Interventions under Section 14Z8 of the NHS Act 2006. In discussions, many clinicians and CCGs highlighted the existence of similar, pre-existing local policies - “all of the interventions listed thus far are mirrored in the procedures of limited clinical value policies of many other CCGs up and down the country” (CCG).This raised conflicting views about whether we should require CCGs to have regard to the clinical criteria and if so, the impact that would have on areas where different clinical criteria are currently in place.

25. A predominantly commissioner voice suggested that requiring CCGs to have regard to the clinical criteria “creates a risk of challenge and complaints from the public, campaigning groups and clinicians as to why our commissioning policies are not in line with NHS England's "recommendations" despite our legitimate and rigorous decision-making process” (CCG). Others however, argued that “national standardisation […] is essential if a postcode lottery syndrome is to be avoided” (patient) and that there would be significant benefits and efficiencies for providers if there was “a mandated and consistent approach” (NHS provider).

26. We believe that our proposals are consistent with NICE, NICE-accredited and specialist society guidance (and therefore our proposals), which reflects the most current clinical evidence available. We have therefore decided to issue the clinical criteria for the 17 interventions under Section 14Z8 of the NHS Act 2006 as commissioning guidance (see appendix 4). This means that CCGs should by April 2019, have ‘regard to’ the commissioning guidance, in accordance with the Health and Social Care Act. It is for individual CCGs to determine how they do this.

1.6 Impact of the proposals on protected groups and individuals who experience health inequalities

27. A full Equality Impact Assessment report has been published as a separate document and can be accessed online[4].

28. When reviewing the consultation responses and in discussions at our events, it became clear that there were concerns about those with protected characteristics and in particular about the impact of our proposals on women and vulnerable groups. This is because 3 out of the 17 interventions are specific to women-only conditions and vulnerable groups, such as individuals with learning disabilities, may not have the capacity to understand or challenge the decisions when appropriate.

29. We have worked with the Royal College of Gynaecologists and Obstetricians and used NICE guidance to ensure our clinical criteria for women-specific conditions are based on the most up-to-date research, evidence and professional opinion. We have engaged directly with women, individuals with learning disabilities and

[4] Please visit: https://www.england.nhs.uk/evidence-based-interventions/

organisations that are advocates for both groups during the consultation period to gather their views on our proposals and ensure our clinical criteria do not adversely affect protected groups or individuals who experience health inequalities. We will continue to engage with individuals representing both these groups to co-produce materials and information to support implementation, in particular to meet their needs.

30. Our analysis of the activity data for the protected characteristics age, gender and race indicate that the number of such people accessing these interventions is consistent with rates of access by the wider population. Where this is not the case, the differences in access can be explained by the relative prevalence of conditions among those with protected characteristics. For example, where these differ among people of different ages (such as grommets, tonsillectomies, hysterectomy due to menstrual bleeding and knee arthroscopy), they are consistent with the age groups at which the underlying problem is most prevalent. Similarly, where these differ among people of different races, such as for Dupuytren's contracture, it is expected due to the increased occurrence of the condition in people of white European descent.

Delivery actions

31. In the consultation we proposed 12 actions to support delivery of the programme. This section provides details of our approach to the delivery actions.

1.7 Engaging the system

32. In the consultation, we committed to establishing the following actions:

- Demonstrator communities to test proposals and act as clinical champions to provide peer-to-peer support to other systems
- National collaboration to steer the programme and provide guidance to the system
- Systematic, multi-channel communication and engagement with clinicians, patients and commissioners

1.7.1 Demonstrator communities

33. Over the course of the consultation period, we tested our proposals with a small number of systems that have created and implemented policies similar to the Evidence-Based Interventions programme. This has enabled us to check and improve our understanding of engagement, administration and implementation, and helped us to better understand likely impacts on activity and patient experience.

34. This approach has received positive feedback, with a number of CCGs stating that they “welcome the opportunity to share their experience” (CCG) and that “learning from the differential experience of [CCGs] would be valuable”. One CCG suggested that collaboration between national and local partners would act as a “catalyst in terms of engagement and pace in delivering [our programme] which absolutely underpins addressing unwarranted variation and improving quality of care and value for our STP” (CCG).

35. Currently our demonstrator community includes Frimley Health and Care Integrated Care System, South West London Sustainability and Transformation Partnership and Hampshire and the Isle of Wight Sustainability and Transformation Partnership. We intend to continue working with our demonstrator community and plan to hold discussions with an additional eight systems to expand this community by the end of 2018. We anticipate that these geographies will play an important role as the voice of systems across the country as we move to implementation.

1.7.2 National collaboration to steer the programme

36. This programme is being designed, championed and driven by our national collaboration, comprising of NHS England, NHS Clinical Commissioners, NHS Improvement, NICE, the Academy of Medical Royal Colleges and the relevant Royal Colleges.

37. We have further reinforced this collaboration by establishing a national programme board to monitor progress and drive implementation. This board has representation from each of the national collaborators and meets on a regular basis.

38. The role of the Royal Colleges and NHS Clinical Commissioners will continue to be important to successful engagement and building support amongst the clinical community. This policy builds on years of work by the Royal Colleges and their professional leadership which will be important in winning clinical support. It also builds on work carried out by NHS Clinical Commissioners and NHS England regarding low value medicines. Similarly, CCGs already have existing policies for many of these interventions, developed alongside local providers and patient groups. NHS Clinical Commissioners will be able to support CCGs and their constituent GPs to continue to engage in the programme and implement its proposals.

39. In response to concerns from individual patients about the aims and communication of the programme, we will continue to strengthen our collaborative approach. As pointed out by a local Healthwatch, the programme will benefit from “listening to patients that have […] experience of these conditions”. Therefore we have established a new national steering group which includes patient and clinical representatives. This group has helped shape our response, and will guide our implementation.

1.7.3 Systematic, multi-channel communication and engagement

40. Throughout the consultation, we have made use of multiple channels to communicate the policy, making use of on-line questionnaires, social media and webinars as well as focus groups, workshops and consultation events.

41. In our consultation document, we invited additional proposals that would enable effective communication and engagement to support with implementation. Feedback included the use of “modern digital and social media platforms” (other NHS organisation) and to “put information in a video rather than PDFs or websites” (campaigner). It was also suggested that we should have “direct communication with patient groups” (patient representative organisation) and produce “leaflets for patients in surgeries” (professional representative body).

42. We have considered this feedback and will:

    - Work with our demonstrator community to determine what local engagement approaches could be used nationally. For example, Birmingham and Solihull CCG and Sandwell and West Birmingham CCG have been testing and

developing patient information leaflets and have made their web-based public portal much more accessible for patients and clinicians.

- Work with existing patient networks, such as those available to Healthwatch, National Voices and The Patients Association, to develop a set of leaflets aimed at supporting decision making for patients and clinicians for each of 17 interventions by 1 April 2019.

- Work with NHS Digital to ensure that symptom and treatment details on the NHS website reflect the changes we are implementing (to ensure that when members of public search online for information regarding a condition, the details provided reflects the outcomes of this consultation) and are ready by 1 April 2019.

1.8 Aligning incentives

43. In our consultation, we proposed to align the programme with a number of national incentives:

- The NHS Standard Contract for Category 1 and 2 interventions
- National Tariff Payment: Introducing zero payment for Category 1 interventions
- To enable clinicians to apply for Category 1 interventions where they can demonstrate exceptionality through an individual funding request, and require clinicians to seek prior approvals for Category 2 interventions
- E-Referral System: Aligning the electronic systems with the new programme

44. The remainder of this section outlines the feedback and our proposed changes to each of the actions to align incentives.

1.8.1 The NHS Standard Contract and Category 1 and 2 interventions

45. In the consultation, we said that in addition to publishing statutory guidance under Section 14Z8 of the NHS Act 2006, we would consider mandating compliance to the Evidence-Based Interventions programme through the NHS Standard Contract.

46. We asked for views on the proposal to use the NHS Standard Contract as well as comments on the proposed wording. 71% of NHS providers who responded to the online survey were in favour of this approach, as were 85% of CCGs and 61% of clinicians. One respondent described the proposal as "micromanagement" but others felt it was "essential as it will drive adherence to the policy and encourage providers to work with commissioners to only carry out these procedures where [there] will be most benefit" (CCG).

47. After testing our proposal with our demonstrator community and reviewing the feedback, we concluded that we should include new wording in Service Condition 29 of the NHS Standard Contract to ensure the policies set out in this document

are reflected appropriately. Queries we received about the delivery actions outlined in this document are already referenced in the Standard Contract. Further detail on queries around prior approval processes and tariff are set out in the next section and the up-dated wording of the Standard Contract can be found at Appendix 6 and a Technical Glossary in Appendix 3.

1.8.2 Introduce zero payment for Category 1 interventions without IFRs

48. In our consultation, we proposed introducing a form of zero payment for the four Category 1 interventions so that providers are not reimbursed for activity unless in exceptional circumstances and accompanied by an IFR.

49. Two-thirds of commissioners and providers were in agreement with the plan to amend the National Tariff Payment System, with one CCG stating that “financial levers are always useful in enforcing behavioural change”. Although only one fifth of individual patients were in agreement with the proposal, positive comments received during one of our events included “I agree that interventions agreed to be ineffective should not be paid for” (member of the public). Some providers raised concerns about the financial risks these arrangements might create for them - “zero payment does not allow for human error” (NHS provider) - and others queried the interaction with block contracts.

50. We have considered these concerns, in particular the possible impact on NHS providers. We have concluded that the challenges raised are issues that can be addressed during local implementation and that in the interest of ensuring Category 1 interventions are no longer funded, unless accompanied by an IFR, we will work with NHS Improvement to create a new National Variation to the Tariff, subject to the statutory consultation on the 2019/20 National Tariff Payment System.

51. We propose that the National Variation sets out that only activity that meets the IFR criteria will be paid for. Any activity that does not meet this threshold will be reimbursed at £0. This option means that activity undertaken without an IFR will not be reimbursed and will avoid local differentiation in pricing.

1.8.3 Implement an IFR process for Category 1 interventions

52. The four interventions we have classified as Category 1 are interventions that should not be routinely offered to patients unless there is a clinical exception as per the Evidence-Based Interventions Policy. In our consultation, we proposed there be an Individual Funding Request (IFR) undertaken before the interventions are offered.

53. 74% of national bodies, 71% of NHS provider organisations, 64% of clinicians and 62% of CCGs were in agreement that these interventions should only be used in exceptional cases and that IFRs are an appropriate method for monitoring their use. 81% of patient representative groups also agreed although, individual patients and members of the public were concerned about still being able to access the intervention.

54. We have considered the feedback received and because Category 1 interventions are appropriate in exceptional circumstances, we want to ensure that patients still have access to them. The best route to ensure access in exceptional circumstances is through the IFR process. The clinical criteria for Category 1 interventions are in line with NICE guidance and based on national clinical consensus and we expect a very small number of patients to be eligible for these interventions. We encourage CCGs to design IFR processes which utilise relevant available expertise and respond to applicants according to the urgency of their needs.

55. In the consultation document, we also indicated that GPs should be responsible for submitting the IFR request. However, there were some concerns around this proposal as summarised by one CCG who stated that "a case for clinical exceptionality can only normally be evidenced by a specialist health care professional. Normally a GP will not have the extensive knowledge required to argue the case".

56. We have tested this concern throughout our engagement events and with our demonstrator community. We therefore ask local commissioners and providers to agree the most suitable approach in their area and will not mandate who should be responsible other than to suggest that it should be the treating clinician.

57. During our consultation events and in discussions with our demonstrator community a question was raised around when our proposals would be implemented. Some argued that "the process needs to be robustly implemented first" (NHS provider organisation) and stressed the need to have the necessary infrastructure and processes in place. However, one CCG suggested that it would be beneficial to implement "prior to 1 April 2019 to resolve existing waiting lists" (CCG) and a provider commented that it would be "reasonable to apply the changes to waiting lists before 1 April 2019 to comply with NICE guidelines" (provider).

58. 81% of CCGs agreed with the proposals to apply the change from 2019, as did 62% of NHS providers and 57% of clinicians. Furthermore, as summarised by one NHS provider organisation, "providing that there are sufficient mechanisms in place, that have been appropriately tested, there is no reason why this cannot be implemented from 2019."

59. While the NHS Standard Contract and National Tariff Payment System will not be in place until 1 April 2019, feedback from commissioners and providers as well as discussions with our demonstrator community have identified a strong case for a 'transitional' period between the date this document is published and 1 April 2019.

60. The implications and rationale for this transitional period are:

    - **National clinical criteria:** CCGs, providers and clinicians will be expected to implement the clinical criteria for Category 1 interventions from the date that this document is published (28 November 2018). The rationale for this is that we want to ensure patients have access to the most appropriate

intervention as soon as possible and to minimise avoidable harm to patients.

- **Waiting lists:** Changes to reimbursement for Category 1 interventions will come into effect on 1 April 2019 and will apply to all patients added to waiting lists after the statutory consultation on the National Tariff Payment System for 2019/20 is published (expected on 17 January 2019), unless an IFR is in place. This will give NHS trusts and GPs time to change clinical practice before 17 January 2019 while also ensuring that we act quickly so that patients are not subject to inappropriate interventions.

62. Overall, this approach will support commissioners and providers to implement the Evidence-Based Interventions programme by 1 April 2019 when the 2019/20 NHS Standard and 2019/20 National Tariff Payment System come into effect and we begin monitoring local performance.

1.8.4 Prior approval process for Category 2 interventions

61. For the 13 Category 2 interventions, we proposed that clinicians would need to demonstrate that the patient meets the clinical criteria set out in this policy through a prior approval process before patients can access the intervention.

62. 67% of CCGs, 57% of NHS provider organisations and 49% of clinicians agreed with the proposal to use prior approvals. 75% of patient representative groups also agreed compared to 18% of individual patients and members of public. While there were concerns about the prior approval process being “onerous”, and an “administrative burden”, this was contradicted by other views that referred to similar and effective processes in place locally (such as South West London STP), and by those who suggested that “there should always be a prior approval system in place, otherwise there is potential for providers to carry out procedures without assessing eligibility” (CCG).

63. Some respondents suggested undertaking a regular audit or the introduction of further financial levers, rather than the prior approval process. While this was criticised by others as being extremely time intensive and requiring certain data permissions and clinical case note reviews that are difficult to arrange, some CCGs had implemented this where compliance was demonstrated. Some CCGs suggested that the programme not “mandate the use of prior approvals” and that instead each CCG should be able to” decide locally which is the preferred mechanism to implement the clinical thresholds”, particularly where there is “proven compliance”.

64. As with the IFR processes, an area of discussion in the consultation feedback concerned who should be responsible for undertaking the prior approval. Some suggested that the referring or treating clinician should be responsible as the GP would “normally refer for an assessment or a specialist clinical opinion” (CCG). Others suggested it was “appropriate” to place the responsibility with primary care.

65. After considering the feedback, we will not mandate who should be responsible other than to suggest that it should be the treating clinician and ask local

commissioners and providers to agree the most suitable approach in their area for each condition.

66. As with IFRs, while the NHS Standard Contract will not be in place until 1 April 2019, feedback from commissioners and providers as well as discussions with our demonstrator community have identified a strong case for a 'transitional' period between the date this document is published and 1 April 2019.

67. The implications and rationale for this transitional period are:

    - **National clinical criteria:** clinicians will be expected to implement the clinical criteria for Category 2 interventions from the date that this document is published (28 November 2018). The rationale for this is that we want to ensure patients have access to the most appropriate intervention as possible and to minimise avoidable harm to patients.
    - **Waiting times:** changes to reimbursement for Category 2 interventions will come into effect on 1 April 2019 and will apply to all patients added to waiting lists after the statutory consultation on the National Tariff Payment System for 2019/20 is published (expected to be 17 January 2019). This will give NHS trusts and GPs time to change clinical practice before 17 January 2019 while also ensuring that we act quickly so that patients are not subject to inappropriate interventions.

68. Overall, this approach will support commissioners and providers to implement the Evidence-Based Interventions programme for 1 April 2019 when the 2019/20 NHS Standard and 2019/20 National Tariff Payment System come into effect and we begin monitoring local performance.

1.8.5 Aligning electronic referral systems

69. In the consultation, we said we would ensure adherence to the clinical criteria by introducing new referral pathways (an IFR or prior approval depending on the intervention). The following quote illustrates many of the responses: "please make the process less bureaucratic and time consuming. As a busy clinician I have little time and want to spend it on patient care" (clinician). Similarly, members of the public were concerned about "increased waiting times and bureaucracy" (patient).

70. Working with our demonstrator community, it became clear that some systems have found solutions to the bureaucratic challenge. For example, South West London STP has rolled out an electronic system for all prior approvals with clear turn-around requirements for quick decisions. Indeed, the quick turnaround time for prior approval decisions is embedded in the Standard Contract which sets out requirements for systems to "use reasonable endeavours to minimise the number of separate prior approval schemes they operate" and "to set a response time standard for prior approval requests in the contract locally" which must not place at risk achievement of quality or waiting times standards.

71. We will continue to work with our demonstrator community to explore how we can best support local systems. In particular, we will:

- Work with our demonstrator community to look at electronic solutions to help providers, commissioners, clinicians and patients to manage prior approvals that are aligned with our clinical criteria.

- Align the NHS e-Referral Service (e-RS) to the Evidence-Based Interventions programme. The e-Referral Service helps referrers, usually in primary care, to identify appropriate services for their patient. Commissioners could set up ‘Prior Approval’ advice only services where they can host their commissioning polices ensuring the referrers have easy access to them to be able to seek advice on the appropriateness of a referral. If approval is given to proceed with the referral, this will be visible to the provider when the referral is sent to them via the e-Referral Service.

1.9 Managing implementation

72. 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 manage, support and monitor progress. In the consultation, we proposed to implement the following:

- National and local activity targets
- Integrated monthly dashboard to monitor delivery
- Local system audits
- STP and CCG Improvement and Assessment Framework (IAF) indicator
- Aligning CQC inspection with the policy

1.9.1 National and local activity goals

73. In the consultation, we said that the aim of the programme is to prevent avoidable harm to patients and free up clinical time. To achieve this, it is important to understand the current activity numbers and set out the expected reductions in activity for these 17 interventions.

74. A number of consultation responses related to the quality of data and codes that underpin the activity numbers. Our initial assessment for the 17 interventions was that during 2017/18 they were performed 348,201 times. We have worked with clinicians, our demonstrator community and local coding experts to refine the baseline figure in order to recognise, among other issues, CCGs “who have already been working within these areas […] and who may have already seen the benefit in terms of savings in capacity and costs” (CCG). A full list of updated codes can be found in Appendix 7. We will also make the codes available on our website.

75. In our consultation we modelled three illustrative scenarios for Category 1 interventions: 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. We also presented a similar set of illustrative scenarios for Category 2 interventions: 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 quartile, and an ambitious target based on a reduction to the 15th percentile.

76. 77% of commissioners and 55% of national bodies, and 19% of individual patients and members of the public, felt the programme should be ‘ambitious’, stating that “progress and innovation should be encouraged” (patient) and that “if there is evidence of low clinical value then we have a duty to avoid harm and save scarce resources” (clinician). Others however, suggested that the

programme “start gradually” (clinician) and implement change on a “step by step basis to allow gradual alteration of perception” (member of the public). Another member of the public suggested that “there is always resistance to change. Doing something that takes away an option […] will always cause upset”.

77. Based on the feedback received, we believe the NHS should not be providing any inappropriate interventions. That means by April 1st 2019:

    - We expect no Category 1 interventions to be performed unless accompanied by an IFR and therefore the numbers of activity for Category 1 without IFRs to reduce to near zero.

    - In line with views provided during the consultation, we are setting out a conservative activity reduction figure for Category 2. This represents the 25th percentile of the age-sex standardised rate of CCGs rather than the more ambitious 20th percentile as originally suggested in the consultation document.

78. In the consultation, we also set out how we used procedure and diagnosis codes to establish the activity figures for of the 17 interventions. CCGs and providers fed back on our code combinations and working with our demonstrator community, we updated the relevant codes.

79. Table 3 outlines why 2017/18 activity numbers have shifted compared to the figure provided in the consultation document.

Table 3: Main procedure and diagnostic code changes

Intervention	Reason for changes
Surgery for snoring	Excluded 0-17 activity in line with clinical criteria and established less ambitious activity reduction figures.
Knee arthroscopy with osteoarthritis	Removed diagnostic procedure codes in line with clinical criteria and established less ambitious activity reduction figures.
Injections for non-specific low back pain without sciatica	Removed radio-frequency denervation procedure codes in line with clinical criteria and established less ambitious activity reduction figures.
Breast reduction	Removed “removal of prosthesis” for breast procedure code in line with clinical criteria and established less ambitious activity reduction figures.
Hysterectomy for heavy bleeding	Corrected code combination to include procedure codes for hysterectomies and the removal of fallopian tubes in line with clinical criteria and established less ambitious activity reduction figures.
Shoulder decompression	Removed procedures to focus on subacromial shoulder decompression codes in line with clinical criteria and established less ambitious activity reduction figures.
Ganglion excision	Removed non-hand related procedure codes in line with clinical criteria and established less ambitious activity reduction figures.
Varicose veins	NICE guidance published in 2013 widened the indicators for varicose vein surgery and modelled a 25% increase in activity

by 25%. In response, we have adjusted the reduction opportunity activity by 25%.[5]

Using the updated codes to recalculate national activity and reduction figures, we are confirming the national inpatient and day case activity goals in Table 4. We have also set out activity goals by CCG and STP for 2019/20 and 2020/21 in Appendix 4 and will publish this data on our website by the end of 2018.

Table 4: National activity figures

Intervention	No of spells (2017/18) Total CCG activity[6]	CCG Variation (n-fold variation)[7]	CCG Reduction opportunity Activity	CCG Remaining Activity
A Intervention for snoring (not OSA)	812	-[8]	812	0
B Dilatation & curettage for heavy menstrual bleeding	236	-[9]	236	0
C Knee arthroscopy with osteoarthritis	3,437	11.3	3,437	0
D Injection for nonspecific low back pain without sciatica	13,165	31.4	13,165	0
Total: category 1	**17,650**	**-**	**17,650**	**-**
E Breast reduction	2,388	8.4	829	1,559
F Removal of benign skin lesions	116,255	4.1	45,589	70,666
G Grommets	8,669	6.2	3,259	5,410
H Tonsillectomy	32,238	3.0	7,454	24,784
I Haemorrhoid surgery	8,474	4.3	2,801	5,673
J Hysterectomy for heavy bleeding	27,660	3.3	6,536	21,124
K Chalazia removal	6,026	29.7	4,326	1,700
L Shoulder decompression	13,930	9.1	6,807	7,123
M Carpal tunnel syndrome release	44,497	5.3	14,950	29,547
N Dupuytren's contracture release	14,376	4.1	4,113	10,263
O Ganglion excision	6,219	6.4	2,509	3,710
P Trigger finger release	7,789	5.7	2,582	5,207
Q Varicose vein surgery	28,846	8.0	8,633	20,213
Total: category 2	**317,376**	**-**	**110,388**	
Grand Total	**335,026**	**-**	**128,038**	

[5] https://www.nice.org.uk/guidance/cg168
[6] The total CCG activity value excludes non-CCG funded activity,
[7] the variation is the ratio between the 10th highest and 10th lowest age-sex standardised rate between CCGs
[8] 20 CCGs have no activity recorded for this intervention. It has therefore not been possible to calculate an age-sex standardised variation rate for this intervention.
[9] 89 CCGs have no activity recorded for this intervention. It has therefore not been possible to calculate an age-sex standardised variation rate for this intervention.

80. The Evidence-Based Interventions Programme and the clinical criteria for the 17 interventions apply in all care settings. The 2017/18 activity and activity goals set out in the data tables are based on 'all non-emergency spells' which includes day cases and inpatient activity and non-emergency non-elective admissions. This is due to limitations in what we are reliably able to measure nationally. Outpatient activity is therefore not included. We will work with our demonstrator community to improve data for both in and outpatient settings.

81. In the consultation we acknowledged that a number of systems have already started to reduce activity levels. We also stated that if the trend over the past five 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.

82. Since we launched the consultation, local systems have sped up the reduction in activity numbers. On current performance the NHS would achieve our expected reductions for Category 1 in three years and achieve the expected reductions for Category 2 in the next eight to 12 years. We believe we can encourage quicker action by engaging clinicians, patients and implementing the delivery actions set out in this document.

1.9.2 Integrated monthly dashboard to monitor delivery

83. In the consultation, we said we would provide monthly dashboards to monitor delivery. We plan to rollout a joint dashboard which provides a quarterly update on CCG and provider activity for each of the 17 interventions and the 18 items that should no longer be routinely prescribed in primary care[10] . It will include trend analysis and comparative figures as well as target figures. NHS Business Services Authority will support the production of the dashboard which will be available to all CCGs by the end of 2018.

84. The consultation document proposed that we would work with NHS RightCare and NHS Improvement's Getting It Right First Time programme 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. We will move to implement this proposal to support local geographies.

1.9.3 Local system audits to review compliance

85. Working with our demonstrator community, many of which have implemented a system of using local audits for areas that are not making expected progress, we plan on working with NHS Improvement and NHS Clinical Commissioners to review local compliance to the programme. We will include the Evidence-Based Interventions programme in the upcoming planning guidance and will work with our regional and local colleagues to ensure that these plans are understood and implemented. We are working with regional teams in NHS England and NHS Improvement to ensure we can support adherence to the guidance presented in this report as part of local assurance processes.

[10] Further details of the programme can be found here: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

1.9.4 STP and CCG Improvement and Assessment Framework (IAF)

86. Following the consultation, we are proposing the development of an indicator that could be considered for inclusion in the next iteration of the CCG IAF. We have tested this proposal with our demonstrator community and will work with them and NICE to develop the indicator. The indicator would measure performance of local areas against the Evidence-Based Interventions guidance and would be calculated using activity data.

1.9.5 Aligning Care Quality Commission inspection with the policy

87. We will continue to work with the Care Quality Commission to incorporate the clinical guidance on the 17 interventions in to their inspection framework from the roll out of this programme on 1st April 2019. To deliver this we will agree a data sharing protocol with the Care Quality Commission in order to populate their data analysis tool known as 'Insight' with provider activity figures which will inform their inspection programme for NHS trusts.

88. We are also aware that some patients may seek to get access to these treatments privately even if they are not appropriate. To limit the 17 interventions set out in this document from being offered inappropriately, we do not expect NHS providers to offer these interventions privately. We have agreed with CQC that this will be monitored through regional assurance processes and CQC inspections.

1.10 An ongoing programme

89. The consultation document sets out our intention to make the Evidence-Based Interventions programme a much wider, on-going programme, subject to making sufficient progress in the first phase.

90. Subject to getting the aim of the programme right, the majority of those we spoke to agree the programme should be ongoing. From the online responses, 88% of national bodies, 85% of CCGs and 72% of clinicians agreed with the intention of an ongoing programme, with some commenting that "national support with implementation would be helpful" to assist local systems. Furthermore, 69% of patient representative organisations and 64% of NHS providers agreed with this sentiment, with a number of people mentioning that the programme will bring "parity in terms of access to treatment and prevent 'postcode lottery'" (CCG).

91. Suggested changes were made with regard to implementation, including for example "[undertake] careful engagement with CCGs so as to avoid the unintended consequence of undermining existing policies" (CCG) and the need for sharing best practice on a "technology solution" to avoid bureaucratic processes (NHS provider). Others also discussed the need for buy in from stakeholders, in particular patients: "it needs to be done slowly and with good data to show it's worth doing" (clinician) and ensure that the programme has the "trust and understanding of patients" (BMA). These are useful suggestions that we will consider as the programme continues to develop.

92. Acknowledging that similar initiatives have failed in the past because they aimed too wide too soon, we are committed to successfully delivering on the interventions set out in this document. We will monitor progress of this programme ahead of considering further expansion.

Appendix 1: Methodology

Selecting the 17 interventions

1. We initially identified a large number of recommendations from clinical evidence including NICE guidance, national and international Choosing Wisely recommendations, academic studies and local CCGs' work.[11]

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

    - prioritising interventions that we could test our approach on and implement relatively quickly on a large scale. We focused on interventions commissioned by CCGs, where there was high variability in the application of clinical guidelines;
    - 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 Getting It Right First Time programme programme.

3. In addition, we carried out an initial equality impact assessment on the proposals.

4. 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;
    - Interventions that should be commissioned or performed when specific clinical criteria are met.

5. 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.

6. We sought feedback from patients throughout the process. We presented our proposed approach to the Patient and Lay Committee at the Academy of Medical Royal Colleges. 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.

[11] 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.

7. As discussed elsewhere in this report, we have continued to seek a broad consensus of views and have set up a steering group to ensure that the programme can reflect critiques and gain buy-in as it continues to develop.

Analysing the consultation feedback

8. In analysing the consultation feedback, we have been guided by a number of key principles:
   - To ensure that each and every response is processed and considered, including feedback from all forums (online survey, emailed responses and engagement events).
   - To have a documented, transparent process for analysing the responses.
   - To encourage feedback and engagement in the analysis process from the Programme Board and Steering Group.

9. Quantitative data as part of the online survey was processed using data analysis software. Each question was cross-tabulated by respondent type. These are available in Appendix 2.

10. Qualitative data provided as part of the online survey, emailed responses and engagement events was analysed using the following approach:
    - Feedback was first grouped into key themes. This allowed the team to collectively consider all related feedback.
    - All clinically-related material was reviewed by a clinical member of the team.
    - The Programme Board and Steering group were also invited to directly review the consultation feedback.
    - The team then read through all the responses and identified emerging issues that should be discussed further by the Programme Board and Steering Group.
    - Extensive conversations and a number of workshops were also held with patients, clinical experts and specialist societies.
    - Key pieces of feedback and our responses to them were used to form this document.

Appendix 2: On-line survey responses

1. The following table provides a breakdown those who contributed feedback to this consultation as well as how we have grouped responses. We are grateful to all those who have supported this process.

Grouped response categories	Detailed response categories	Online survey	Individual submission	Event
CCG	CCG	27	20	56
Clinician	Clinician	48	2	8
National body	Professional Representative Body / Other Healthcare Organisation	12	27	36
	Other NHS organisation	7	4	29
	Regulator	1	0	0
	Industry	2	0	0
NHS provider	NHS Provider organisation	22	7	176
Patient / member of the public	Patient / Family member	218	19	48
	Member of the public	256		
	Friend or carer of patient	15		
Patient representative organisation	Patient representative organisation	16	5	10
VSO	Voluntary organisation	14	2	12
	Charity	1	0	
Other / Unknown	Other	10	11	23
	Not Answered	4		
	Unknown	42		
Total		***707***	***97***	***397***

2. Note that attendee numbers to the events are approximate due to difficulties in gaining exact numbers for example, with webinars where numbers can fluctuate during the session and it is not always possible to identify if it is the same person re-joining or a new attendee.

Online survey response tables

3. The following tables provide details of the online survey responses. To ease interpretation of the feedback, data has been collated as per the 'Grouped response categories' presented in the table above.

4. The 'N' figure and percentage of those who 'agreed' or selected 'yes' are calculated on the number of people who responded to that question. It does not include those who did not answer the question. Q1 is an exception to this where the percentages provided are cumulative of all respondents.

5. Note that these tables only include the feedback provided to the online survey. Feedback received via email or face-to-face has been analysed and considered alongside the online survey, and has equally influenced the conclusions presented in this report. Due to the format of the feedback, it is not possible to quantify.

Q1. In what capacity are you responding?

Grouped response categories	Percentage of all respondents	N
CCG	4%	27
Clinician	7%	48
National body	4%	25
NHS provider	3%	22
Patient / member of the public	70%	492
Patient representative organisation	2%	16
VSO	3%	21
Other / unknown	8%	56
Total	**100%**	**707**

Q2. Have you read the document: Evidence-Based Interventions: Consultation Document?

Grouped response categories	Percentage 'yes'	N
CCG	100%	27
Clinician	98%	48
National body	100%	25
NHS provider	100%	22
Patient / member of the public	98%	481
Patient representative organisation	100%	16
VSO	86%	21
Other / unknown	92%	52
Total	**97%**	**692**

Q3. Do you agree with our six design principles?

Grouped response categories	Percentage 'agree'	N
CCG	85%	27

Clinician	74%	47
National body	80%	25
NHS provider	95%	22
Patient / member of the public	21%	478
Patient representative organisation	63%	16
VSO	14%	21
Other / unknown	68%	53
Total	**36%**	**689**

Q4. Do you agree that selecting circa 17 interventions is about the right number for this first phase?

Grouped response categories	**Percentage 'agree'**	**N**
CCG	85%	27
Clinician	63%	46
National body	88%	24
NHS provider	85%	20
Patient / member of the public	18%	467
Patient representative organisation	63%	16
VSO	22%	18
Other / unknown	63%	51
Total	**33%**	**669**

Q5. Are there interventions you think we should add for the first phase?

Grouped response categories	**Percentage 'yes'**	**N**
CCG	37%	27
Clinician	26%	47
National body	25%	24
NHS provider	10%	21
Patient / member of the public	8%	461
Patient representative organisation	0%	16
VSO	13%	16
Other / unknown	24%	50
Total	**12%**	**662**

Q6. Are there interventions we should remove?

Grouped response categories	**Percentage 'yes'**	**N**
CCG	26%	27
Clinician	55%	47
National body	22%	23
NHS provider	32%	22
Patient / member of the public	76%	408

Patient representative organisation	33%	15
VSO	62%	13
Other / unknown	43%	49
Total	**65%**	**604**

Q7. Do you have any suggested amendments to the proposed clinical criteria?

Grouped response categories	Percentage 'yes'	N
CCG	-	0
Clinician	-	0
National body	100%	1
NHS provider	-	0
Patient / member of the public	52%	29
Patient representative organisation	-	0
VSO	0%	1
Other / unknown	100%	1
Total	**53%**	**32**

Q8. Do you agree this should become an on-going rolling programme, subject to making sufficient progress?

Grouped response categories	Percentage 'agree'	N
CCG	85%	27
Clinician	72%	46
National body	88%	24
NHS provider	64%	22
Patient / member of the public	20%	453
Patient representative organisation	69%	16
VSO	17%	18
Other / unknown	71%	49
Total	**35%**	**655**

Q9. At what level should we pitch our ambition?

Grouped response categories	Ambitious	Moderate	Conservative	N
CCG	77%	19%	4%	26
Clinician	37%	33%	30%	43
National body	55%	32%	14%	22
NHS provider	14%	41%	45%	22
Patient / member of the public	19%	19%	62%	330
Patient representative organisation	33%	40%	27%	15
VSO	27%	9%	64%	11
Other / unknown	48%	29%	23%	48

Total	**28%**	**23%**	**49%**	**517**

Q10. Do you have any suggestions to improve our methodology?

Grouped response categories	Percentage 'yes'	N
CCG	63%	27
Clinician	57%	42
National body	39%	23
NHS provider	36%	22
Patient / member of the public	69%	409
Patient representative organisation	25%	16
VSO	87%	15
Other / unknown	44%	48
Total	**63%**	**602**

Q11. 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?

Grouped response categories	Percentage 'yes'	N
CCG	88%	26
Clinician	27%	44
National body	19%	21
NHS provider	24%	21
Patient / member of the public	3%	423
Patient representative organisation	6%	16
VSO	23%	13
Other / unknown	11%	45
Total	**11%**	**609**

Q12. Do you agree that with our proposals for IFR for Category 1 interventions?

Grouped response categories	Percentage 'agree'	N
CCG	62%	26
Clinician	64%	44
National body	74%	23
NHS provider	71%	21
Patient / member of the public	16%	453
Patient representative organisation	81%	16
VSO	24%	17
Other / unknown	66%	47
Total	**30%**	**647**

Q13. Do you agree that with our proposals for prior approval for Category 2 interventions?

Grouped response categories	Percentage 'agree'	N
CCG	67%	27
Clinician	49%	43
National body	57%	23
NHS provider	57%	21
Patient / member of the public	18%	454
Patient representative organisation	75%	16
VSO	22%	18
Other / unknown	59%	46
Total	**29%**	**648**

Q14. 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?

Grouped response categories	Percentage 'agree'	N
CCG	81%	27
Clinician	51%	43
National body	88%	24
NHS provider	57%	21
Patient / member of the public	18%	447
Patient representative organisation	81%	16
VSO	18%	17
Other / unknown	67%	48
Total	**32%**	**643**

Q15. Do you agree that this change should apply from 2019?

Grouped response categories	Percentage 'agree'	N
CCG	81%	26
Clinician	57%	44
National body	79%	24
NHS provider	62%	21
Patient / member of the public	18%	456
Patient representative organisation	69%	16
VSO	11%	18
Other / unknown	65%	48
Total	**31%**	**653**

Q16. Do you support our intention to mandate compliance with the Evidence Based Interventions Policy through the NHS Standard Contract?

Grouped response categories	Percentage 'yes'	N
CCG	85%	27
Clinician	61%	44
National body	71%	24
NHS provider	71%	21
Patient / member of the public	18%	452
Patient representative organisation	75%	16
VSO	22%	18
Other / unknown	61%	46
Total	**32%**	**648**

Q17. In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5: - Do you support our proposed wording for the new Contract requirements?

Grouped response categories	Percentage 'yes'	N
CCG	84%	25
Clinician	56%	43
National body	71%	24
NHS provider	58%	19
Patient / member of the public	17%	428
Patient representative organisation	73%	15
VSO	24%	17
Other / unknown	58%	45
Total	**30%**	**616**

Q18. In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5: - Do you have any specific suggestions for how the Contract wording could be improved?

Grouped response categories	Percentage 'yes'	N
CCG	52%	25
Clinician	26%	39
National body	43%	23
NHS provider	28%	18
Patient / member of the public	25%	370
Patient representative organisation	13%	15
VSO	20%	15
Other / unknown	16%	45
Total	**26%**	**550**

Q19. 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?

Grouped response categories	Percentage 'agree'	N
CCG	67%	27
Clinician	64%	44
National body	57%	23
NHS provider	65%	20
Patient / member of the public	21%	443
Patient representative organisation	80%	15
VSO	17%	18
Other / unknown	50%	46
Total	**32%**	**636**

Appendix 3: Technical glossary

Prior Approval Schemes: Are referred to in the NHS Standard Contract as a request from a clinician (or provider) to a commissioner to undertake a specific treatment. The Evidence-Based Interventions Programme uses two schemes: Individual Funding Requests for Category 1 interventions and Prior Approval for Category 2 interventions.

Individual Funding Request (IFR): Is a request received from a clinician providing care to a patient, for:

- A specific treatment that is not covered by existing policy or for a service which is not routinely commissioned by a CCG, or

- Where the CCG is responsible for commissioning the service/treatment in question and/or a local policy is in place however the patient does not meet the criteria and is deemed to be clinically exceptional.

Arguments on the basis of exceptionality are requests where a patient is deemed to have exceptional clinical circumstances, i.e. a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at a similar stage of progression as the patient, exceptional to the cohort.

Prior Approval (PA): Is a process in which clinicians demonstrate how a patient meets set threshold criteria prior to referring to secondary care and/or by consultants prior to listing for surgery or performing a procedure for which a CCG routinely commissions and is within agreed contracts.

- Prior Approval means that a General Practitioner and/or provider must seek the agreement of the responsible commissioner to fund a treatment for an individual for an intervention which there is a CCG policy before that treatment is carried out.

- The Prior Approval process then compares requests for elective procedure against a set of threshold criteria for the Prior Approval process.

- On occasions patients may fall outside of the PA threshold criteria and clinicians may appeal by demonstrating how the patient is clinically exceptional. In these cases the request is then considered via the Individual Funding Request process.

Appendix 4: Statutory guidance clinical criteria and activity goals

Background

Who is this guidance for?

1. This guidance is addressed to CCGs, to assist them in fulfilling their duties relating to securing continuous improvements in the quality of services for patients and in outcomes, particularly regarding appropriate clinical interventions. This guidance is issued as general guidance under S14Z8 of the NHS Act 2006. The objective of this guidance is to support CCGs in their decision-making, to address unwarranted variation, and to provide national advice to make local clinical decision-making more appropriate.

2. We expect CCGs to have regard to this guidance in formulating local policies and for clinicians to reflect this guidance in their clinical practice. This guidance does not remove the clinical discretion of clinicians in accordance with their professional duties.

Why have we developed this guidance?

3. We want to reduce the number of inappropriate interventions provided on the NHS. The primary goals of the Evidence-Based Interventions programme are to avoid needless harm to patients and free-up scarce professional time for performing other interventions - including creating headroom for proven innovations. The time saved will be reinvested in patient care.

4. Last year, the 17 interventions listed in this guidance were provided over 335,000 times. We know that across England there is substantial variation in the rate at which these interventions are performed, to an extent that cannot be explained by differences in population demand. This has an impact on clinical outcomes and contributes to perceptions of a so-called ‘postcode lottery’ by members of the public.

5. There is also widespread clinical consensus that NHS resources could be more appropriately targeted towards more clinically appropriate interventions. At a time when demand is exceeding the capacity available, effective use of resources is both a national and local priority.

6. NHS England has partnered with NHS Clinical Commissioners, the National Institute for Health and Care Excellence (NICE), the Academy of Royal Medical Colleges and NHS Improvement to develop this guidance.

7. The guidance, and the Evidence-Based Interventions programme as a whole, is guided by the following five goals:

    - **Reduce avoidable harm to patients.** With surgical interventions, there is always a risk of complications. Weighing the risks and benefits of appropriate treatments should be co-produced with patients.

    - **Save precious professional time**, when the NHS is severely short of staff, professionals should offer appropriate and effective treatment to patients.

    - **Help clinicians maintain their professional practice** and keep up to date with the changing evidence base and best practice.

    - **Create headroom for innovation**. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of inappropriate interventions. This allows innovation in healthcare, prescribing and technology to improve patients' ability to self-care and live with long term conditions.

    - **Maximise value and avoid waste**. Inappropriate care is poor value for the taxpayer. Resources should be focused on effective and appropriate NHS services

8. Our ambition is to support systems to improve clinical outcomes for their population by ensuring that patients only receive interventions for which there is an established, high-quality evidence base. Similarly, we also hope that this national guidance will lead to more standardised local commissioning policies.

How have the recommendations in this guidance been developed?

9. The Evidence-based Interventions Programme has been shaped by six design principles that outline our commitment to: clinical research and evidence (as contained in NICE and/or NICE accredited and specialist society guidelines); best practice; patient and public involvement and engagement; and successful implementation that involves a range of activities.

10. With regard to the final set of 17 interventions listed in this guidance, we initially identified a large number of recommendations from clinical evidence including NICE guidance, national and international Choosing Wisely recommendations, academic studies and local CCGs' work.[12]

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

    - prioritising interventions that we could test our approach on and implement relatively quickly on a large scale. We focused on interventions commissioned

[12] 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 3 for full references.

by CCGs, where there was high variability in the application of clinical guidelines;

- 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 Getting It Right First Time programme programme.

12. In addition, we carried out an initial equality impact assessment on the proposals to determine any differential impacts across groups with protected characteristics. The result of this initial assessment can be found in Appendix 4 of the original consultation document. A final assessment, conducted following a review of the consultation evidence, can be accessed online[13].

13. 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 (referred to as Category 1 interventions);

    - Interventions that should be commissioned or performed when specific criteria are met (referred to as Category 2 interventions).

14. 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. We sought feedback from patients throughout the design process (see Appendix 1 of the full consultation response document for further details).

15. Note that all of the clinical criteria consulted on were developed directly from existing NICE, NICE-accredited or specialist society guidance and local CCG policies, and the final set of wording used has been checked by the relevant Royal Colleges, specialist societies, individual specialists, as well as clinical experts from within NHS England.

16. A full public consultation on the proposals, announced at the NHS England Board Meeting in July 2018, was conducted between the 4th of July and the 28th September 2018. Section 1.4 details the main findings from the consultation and the changes that have been made as a result of what we heard. A more detailed

[13] Please see: https://www.england.nhs.uk/evidence-based-interventions/

report on the consultation can be found in the main body of the consultation response document.

How have the recommendations in this guidance been developed following the results of the consultation?

17. Whilst the overall number of interventions remains unchanged from those listed in the consultation document, we have made important refinements and clarifications to the clinical criteria in response to feedback during the consultation period (see Section 4 for the final set of criteria). These changes include:

    - Expanding the recommendation wording for carpal tunnel syndrome, Dupuytren's contracture release, ganglion excision and trigger finger release to align with proposals from the British Society of the Hand.

    - Excluding children from the criteria related to Dupuytren's contracture release, trigger finger release and snoring surgery as these conditions present differently in children and may indicate more serious underlying conditions.

    - Clarifying that children who cannot undergo normal assessments are still able to access specialist advice for glue ear.

    - Accounting for a wide range of views on coding methodology, testing this with coding experts, clinicians, and demonstrator sites, and updating the activity projections accordingly.

18. We have also refined the delivery actions proposed, clarifying for example, our expectations regarding waiting lists and referrals for category 1 interventions and the interaction with proposed Tariff changes that could take effect from 1 April 2019 (see Section 3 of this appendix for the final set of delivery actions and Section 5 for the local activity goals by CCG, STP and provider).

19. We have also established a new national steering group which includes patient and clinical representatives. This group has helped shape our response, and will guide our implementation. We have also established a demonstrator community of local geographies to test implementation of the Evidence-Based Intervention programme as well as ideas for future phases of the programme.

How will the guidance be updated and reviewed?

20. The Evidence-Based Interventions programme will monitor progress of this programme ahead of considering further expansion.

21. In the full consultation response document, we reference the intention to continue with future phases of the Evidence-Based Interventions programme. These phases represent appropriate points to reconsider the evidence base related to these and other interventions, and we intend to update the guidance through this mechanism as appropriate.

What delivery actions will support implementation of the programme?

The NHS Standard Contract and Category 1 and 2 interventions

22. In addition to publishing statutory guidance under Section 14Z8 of the NHS Act 2006, we are mandating compliance to the Evidence-Based Interventions programme through the NHS Standard Contract (see Section 1.8.1 of the full consultation response document). The new wording will be added to Service Condition 29, as set out below. (See Appendix 3 for the Technical glossary. Note that the definition of Prior Approval Schemes in The NHS Standard Contract includes both Individual Funding Requests and Prior Approval).

Evidence-Based Interventions Policy

29.28 The Parties must comply with their respective obligations under the Evidence-Based Interventions Policy.

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

29.30 The Provider must manage Referrals and provide the Services in accordance with the Evidence-Based Interventions Policy.

29.31 If the Provider carries out

29.31.1 a Category 1 Intervention without evidence of appropriate Prior Approval having been granted by the relevant Commissioner; or

29.31.2 a Category 2 Intervention other than in accordance with the Evidence-Based Interventions Policy, the relevant Commissioner will not be liable to pay for that Intervention.

29.32 For the avoidance of doubt, any Commissioner may, at its absolute discretion, impose by means of a Prior Approval Scheme notified to the Provider in accordance with SC29.24 (Prior Approval Scheme) preconditions in relation to any Category 1 Intervention or Category 2 Intervention more stringent than those set out or referred to in SC29.28 – SC29.31 and/or the Evidence-Based Interventions Policy.

11. For reference, the associated definitions within the Contract will be:

- **Evidence-Based Interventions Policy** - the national policy relating to the commissioning of interventions which are clinically inappropriate or which are appropriate only when performed in specific circumstances, published by NHS England.

- **Category 1 Interventions** - interventions which should not be routinely commissioned or performed, described as Category 1 Interventions in Evidence-Based Interventions Policy.

- **Category 2 Interventions** - interventions which should only be routinely commissioned or performed when specific criteria are met, described as Category 2 Interventions in Evidence-Based Interventions Policy.

Introduce zero payment for Category 1 interventions without IFRs

23. To ensure that Category 1 interventions as described in the Evidence-Based Interventions Policy are no longer funded, unless accompanied by an IFR, we will work with NHS Improvement to create a new National Variation to the Tariff, subject to the statutory consultation on the 2019/20 National Tariff Payment System.

24. We propose that the National Variation sets out that only activity that meets the IFR criteria will be paid for. Any activity that does not meet this threshold will be reimbursed at £0. This option means that activity undertaken without an IFR will not be reimbursed and will avoid local differentiation in pricing.

Implement an IFR process for Category 1 interventions and a prior approval process for Category 2 interventions

25. The four interventions we have classified as Category 1 are interventions that should not be routinely offered to patients unless there is a clinical exception as per the Evidence-Based Interventions Policy. The best route to ensure access in exceptional circumstances is through the IFR process.

26. We therefore ask local commissioners and providers to design IFR processes which utilise relevant available expertise and respond to applicants according to the urgency of their needs. With regard to who should be responsible for submitting the IFR, we will leave it to local areas to decide but suggest that it should be the treating clinician.

27. For the 13 Category 2 interventions, clinicians will need to demonstrate that the patient meets the criteria set out in this guidance through a prior approval process before patients can access the intervention. With regard to who should be responsible for submitting the prior approval, we will leave it to local areas to decide but suggest that it could be either the referring or the treating clinician.

28. While changes to the NHS Standard Contract and National Tariff Payment System will not be in place until 1 April 2019, set out below is the transitional period between the date this document is published and 1 April 2019. The implications and rationale for this period are:

    - **National clinical criteria:** CCGs, providers and clinicians will be expected to implement the criteria for Category 1 and 2 interventions from the date that this document is published (28 November 2018). The rationale for this is that we want to ensure patients have access to the most appropriate intervention as soon as possible and to minimise avoidable harm to patients.

- **Waiting lists:** Changes to reimbursement for Category 1 and 2 interventions will come into effect on 1 April and will apply to all patients added to waiting lists after the statutory consultation on the National Tariff Payment System for 2019/20 is published (expected on 17 January 2019), unless an IFR is in place. This will give NHS trusts and GPs time to change clinical practice before 17 January 2019 while also ensuring that we act quickly so that patients are not subject to inappropriate interventions.

National and local activity goals

29. By April 1st 2019, we expect that:

- No Category 1 interventions be performed unless accompanied by an IFR and therefore the numbers of activity for Category 1 without IFRs to reduce to near zero.

- Category 2 interventions should be reduced to the 25th percentile of the age-sex standardised rate of CCGs.

30. The national inpatient activity goals are set out in Table 1 below. We have also set out activity goals by CCG and STP for 2019/20 and 2020/21 in Section 5 of this guidance.

Table 1: National activity figures

Intervention	No of spells (2017/18) Total CCG activity[14]	CCG Variation (n-fold variation) [15]	CCG Reduction opportunity Activity	CCG Remaining Activity
A Intervention for snoring (not OSA)	812	-[16]	812	0
B Dilatation & curettage for heavy menstrual bleeding	236	-[17]	236	0
C Knee arthroscopy with osteoarthritis	3,437	11.3	3,437	0
D Injection for nonspecific low back pain without sciatica	13,165	31.4	13,165	0
Total: category 1	**17,650**	**-**	**17,650**	**-**
E Breast reduction	2,388	8.4	829	1,559
F Removal of benign skin lesions	116,255	4.1	45,589	70,666
G Grommets	8,669	6.2	3,259	5,410

[14] The total CCG activity value excludes non-CCG funded activity,
[15] the variation is the ratio between the 10th highest and 10th lowest age-sex standardised rate between CCGs
[16] 20 CCGs have no activity recorded for this intervention. It has therefore not been possible to calculate an age-sex standardised variation rate for this intervention.
[17] 89 CCGs have no activity recorded for this intervention. It has therefore not been possible to calculate an age-sex standardised variation rate for this intervention.

H Tonsillectomy	32,238	3.0	7,454	24,784
I Haemorrhoid surgery	8,474	4.3	2,801	5,673
J Hysterectomy for heavy bleeding	27,660	3.3	6,536	21,124
K Chalazia removal	6,026	29.7	4,326	1,700
L Shoulder decompression	13,930	9.1	6,807	7,123
M Carpal tunnel syndrome release	44,497	5.3	14,950	29,547
N Dupuytren's contracture release	14,376	4.1	4,113	10,263
O Ganglion excision	6,219	6.4	2,509	3,710
P Trigger finger release	7,789	5.7	2,582	5,207
Q Varicose vein surgery	28,846	8.0	8,633	20,213
Total: category 2	**317,376**	**-**	**110,388**	
Grand Total	**335,026**	**-**	**128,038**	

31. The Evidence-Based Interventions Programme and the clinical criteria for the 17 interventions apply in all care settings. However, the 2017/18 activity and activity goals set out in the data tables are necessarily based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. This is due to limitations in what we are reliably able to measure nationally. Outpatient activity is therefore not included. This means that these figures are likely to be an underestimate of the true potential for change and we hope that many more patients and clinicians will receive the anticipated benefits of the Evidence-Based Interventions Programme. We will work with our demonstrator community to improve data for both in and outpatient settings.

Integrated monthly dashboard to monitor delivery

32. We plan to rollout a joint dashboard which provides a quarterly update on CCG and provider activity for each of the 17 interventions and the 18 items that should no longer be routinely prescribed in primary care.[18] It will include trend analysis and comparative figures as well as target figures. NHS Business Services Authority will support the production of the dashboard which will be available to all CCGs by the end of 2018.

Local system audits to review compliance

33. With guidance from specialist and primary care clinicians, we will work with NHS Improvement and NHS Clinical Commissioners to review local compliance to the programme. We will include the Evidence-Based Interventions programme in the upcoming planning guidance and will work with our regional and local colleagues to ensure that these plans are understood and implemented. We are working with regional teams in both NHS England and NHS Improvement to ensure we can support adherence to the guidance presented in this report as part of local assurance processes.

STP and CCG Improvement and Assessment Framework

[18] Further details of the programme can be found here: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

34. Following the consultation, we will seek to develop an indicator that could be considered for inclusion in the next iteration of the CCG IAF. We have tested this proposal with our demonstrator community and will work with them and NICE to develop the indicator. The indicator would measure performance of local areas against the Evidence-Based Interventions guidance and would be calculated using activity data.

Aligning CQC inspection with the policy

35. We will continue to work with CQC to incorporate the clinical guidance on the 17 interventions in to their inspection framework from the roll out of this programme on April 1st 2019. To deliver this we will agree a data sharing protocol with the Care Quality Commission in order to populate their data analysis tool known as 'Insight' with provider activity figures which will inform their inspection programme for NHS trusts.

36. We are also aware that some patients may seek to get access to these treatments privately even if they are not appropriate. To limit the 17 interventions set out in this document from being offered inappropriately, we do not expect NHS providers to offer these interventions privately. We have agreed with CQC that this will be monitored through regional assurance processes and CQC inspections.

EVIDENCE-BASED INTERVENTIONS – CLINICAL CRITERIA

A. Adult Snoring Surgery (in the absence of OSA)

Updated description of the intervention

In two systematic reviews of 72 primary research studies, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has up to 16% risk of severe complications (bleeding, airway compromise, death). Therefore 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.

Updated clinical criteria

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 in adults 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. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment of the OSA. 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 CCG interventions in 2017/18
812
Recommendation
It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring. <u>Alternative Treatments</u> 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

Updated description of the intervention

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[19].

Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), can be used to investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) can treat heavy periods.

Updated clinical criteria

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).

[19] https://www.nice.org.uk/guidance/ng88 and https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy

Number of CCG interventions in 2017/18
236

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) can be used to investigate heavy periods. Medication and intrauterine systems (IUS) can 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 1. NICE guidance: https://www.nice.org.uk/guidance/ng88 2. NHS advice: https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy 3. MacKenzie IZ, Bibby JG. Critical assessment of dilatation and curettage in 1029 women. Lancet 1978;2(8089):566–8. 4. 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. 5. 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. 6. 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

Updated description of the intervention

NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis, unless the knee locks (in which case it may be considered). More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and pain

management.[20] If symptoms do not resolve, knee replacement or osteotomy are effective procedures that should be considered.

Updated clinical criteria

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 CCG interventions in 2017/18
3,437
Recommendation
Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective. 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. 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. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is 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%).

[20] 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

References

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D. Injections for nonspecific low back pain without sciatica

Updated description of the intervention

NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work[21].

Updated clinical criteria

Summary of intervention
Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.
Number of CCG interventions in 2017/18
13,165
Recommendation
Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain. For people with non-specific low back pain the following injections should not be offered: • facet joint injections • therapeutic medial branch blocks • intradiscal therapy • prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis • Any other spinal injections not specifically covered above Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block. Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway. 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 non-specific low back pain.

21 https://www.nice.org.uk/guidance/ng59

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 in over 16s

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 non-specific 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 non-specific low back pain after a positive response to a diagnostic medial branch block.
1.3.4 Do not offer imaging for people with non-specific low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

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E. Breast reduction

Updated description of the intervention

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. However in some cases breast reduction surgery is necessary where large breasts impact on day to day life, for example ability to drive a car. Therefore, breast reduction should only be undertaken under specific criteria. Wearing a professionally fitted bra, losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts.

Updated clinical criteria

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 CCG interventions in 2017/18
2,388
Recommendation
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 such as advice on weight loss and managing pain.. • In cases of thoracic/ shoulder girdle discomfort, 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 reduction planned to be 500gms or more per breast or at least 4 cup sizes. • 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. • Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size 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 recommendation 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 following breast cancer treatment..

Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as 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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F. Removal of benign skin lesions

Updated description of the intervention

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 below. Risks from the procedure can include bleeding, pain, infection, and scarring.

Updated clinical criteria

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 CCG interventions in 2017/18
116,255
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 viral warts
- 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 or plastic surgery:

- 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.

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G. Grommets for Glue Ear in Children

Updated description of the intervention

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[22].

Updated clinical criteria

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:

[22] https://www.nice.org.uk/Guidance/CG60

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

Investigation of unilateral glue ear in adults

Number of CCG interventions in 2017/18

8,669

Recommendation

The NHS should only commission 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.
- Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and 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.

The NHS should 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

Updated description of the intervention

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 Scottish Intercollegiate Guidelines Network criteria are met.

Updated clinical criteria

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.

Number of CCG interventions in 2017/18

32,238

Recommendation

The NHS should only commission 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, 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.

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:

- Acute and chronic renal disease resulting from acute bacterial tonsillitis.
- As part of the treatment of severe guttate psoriasis.
- Metabolic disorders where periods of reduced oral intake could be dangerous to health.
- PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

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

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 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)

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 Scottish Intercollegiate Guidelines Network 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.

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I. Haemorrhoid surgery

Updated description of the intervention

Numerous interventions exist for the management of haemorrhoids (piles). 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. 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 severe haemorrhoids.

Updated clinical criteria

Summary of intervention
This procedure involves surgery for haemorrhoids (piles).
Number of CCG interventions in 2017/18
8,474
Recommendation
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 In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.
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 perhaps in certain cases injection, and recurrent and symptomatic

grade 3 and 4 haemorrhoids and those with a symptomatic external component. If rubber band ligation is unsuccessful haemorrhoid artery ligation (HAL) may be necessary.

Haemorrhoid surgery can lead to complications. Pain and bleeding are common and pain may persist for several weeks. 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.

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J. Hysterectomy for heavy menstrual bleeding

Updated description of the intervention

NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding (HMB).[23] Heavy periods can be reduced by using medicines or intrauterine systems (IUS) or losing weight (if necessary).

Updated clinical criteria

Summary of intervention
Hysterectomy is the surgical removal of the uterus.

[23] https://www.nice.org.uk/guidance/ng88

Number of CCG interventions in 2017/18

27,660

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.

1.10.1.1.1 NICE guideline NG88 1.5 Management of HMB

1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

1.10.1.1.2 Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis

1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.

1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed,taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy.

1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.

1.10.1.1.3 Treatments for women with fibroids of 3 cm or more in diameter

1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

1.5.12 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.

1.5.13 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

1.5.14 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

1.5.15 If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation 1.5.10.

1.5.16 Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

For further information, please see:

- https://www.nice.org.uk/guidance/ng88.
- https://www.nhs.uk/conditions/heavy-periods/#Causes

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 routinely 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.

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K. Chalazia removal

Updated description of the intervention

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.

Updated clinical criteria

Summary of intervention
This procedure involves incision and curettage (scraping away) of the contents of the 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. Many but not all resolve within six months with regular application of warm compresses and massage.
Number of CCG interventions in 2017/18
6,026
Recommendation
Incision and curettage (or triamcinolone injection for suitable candidates) 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 warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions
Rationale for recommendation
NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (eg. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used. Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does carry the risk of

raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.

Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm however there are a small number which are persistent, very large, or can cause other problems such as distortion of vision.

In these cases surgery can remove the contents from a chalazion. However all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back. The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding.

Some trials comparing the two treatments suggest 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 but less pain and patient inconvenience. However this is controversial and other studies show that steroid injection is less effective than surgery. Therefore both options can be considered for suitable patients.

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L. Arthroscopic shoulder decompression for subacromial shoulder pain

Updated description of the intervention

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 Getting It Right First Time programme 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

Updated clinical criteria

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 CCG interventions in 2017/18
13,930
Recommendation
Arthroscopic subacromial decompression for pure subacromial shoulder impingement should 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

Updated description of the intervention

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. Surgical treatment of carpal tunnel should only be offered under the criteria included below.

Updated clinical criteria

Summary of intervention
Open or endoscopic surgical procedure to release median nerve from carpal tunnel.
Number of CCG interventions in 2017/18
44,497
Recommendation

- Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment
- Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:
    a. corticosteroid injection(s) (medication injected into the wrist: *good evidence for short (8-12 weeks) term effectiveness*)

    or

    b. night splints (a support which prevents the wrist from moving during the night: *not as effective as steroid injections*)
- Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:
    a. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks;

    or

    b. There is either:
        i. a permanent (ever-present) reduction in sensation in the median nerve distribution;

or

ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

Rationale for recommendation

Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.

In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical effectiveness and long term benefit) should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.

The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.

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N. Dupuytren's contracture release in adults

Updated description of the intervention

NICE recommends for people with Dupuytren's disease who do not have contracture or any significant loss of function no treatment is necessary at this stage. For people with Dupuytren's disease and significant loss of function referral to hand surgery for consideration of percutaneous needle fasciotomy or collagenase injection. Surgery should only be offered according to the criteria listed below.

Updated clinical criteria

Summary of intervention
Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient's life. However none cure the condition which can recur after any intervention so that further interventions are required. Splinting and radiotherapy have not been shown be effective treatments of established Dupuytren's contractures. Several treatments are available: collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others. The need for, and choice of, intervention should be made on an individual basis and should be a shared decision between the patient and a practitioner with expertise in the various treatments of Dupuytren's contractures. No-one knows which interventions are best for restoring and maintaining hand function throughout the rest of the patient's life, and which are the cheapest and most cost-effective in the long term. Ongoing and planned National Institute for Health Research studies aim to answer these conditions.
Number of CCG interventions in 2017/18
14,376

Recommendation

- Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.

- An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for:
    a. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.
    or
    b. severe thumb contractures which interfere with function

- NICE concluded that collagenase should only be used for:
    a. Participants in the ongoing clinical trial (HTA-15/102/04)
    or
    b. Adult patients with a palpable cord if:
        i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints;
        and
        ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Rationale for recommendation

Contractures left untreated usually progress if left untreated and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.

Common complications after collagenase injection are normally transient and include skin breaks and localised pain. Tendon injury is possible but very rare. Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness.

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O. Ganglion excision

Updated description of the intervention

Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can be unnecessary, can cause complications, and recurrence is common following surgery. The complications may be similar to or worse than the original problem. Ganglion excision should only be offered under the criteria outlined below.

Updated clinical criteria

Summary of intervention

Ganglia are cystic swellings containing jelly-like fluid which form around the wrists or in the hand. In most cases wrist ganglia cause only mild symptoms which do not restrict function, and many resolve without treatment within a year. Wrist ganglion rarely press on a nerve or other structure, causing pain and reduced hand function.
Ganglia in the palm of the hand (seed ganglia) can cause pain when carrying objects.
Ganglia which form just below the nail (mucous cysts) can deform the nail bed and discharge fluid, but occasionally become infected and can result in aseptic arthritis of the distal finger joint.

Number of CCG interventions in 2017/18

6,219

Recommendation

Wrist ganglia

- no treatment unless causing pain or tingling/numbness or concern (worried it is a cancer);
- aspiration if causing pain, tingling/numbness or concern
- surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.

Seed ganglia are painful

- puncture/aspirate the ganglion using a hypodermic needle
- surgical excision only considered if ganglion persists or recurs after puncture/aspiration.

Mucous cysts

- no surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity.

Rationale for recommendation

Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation (provide a figure). Aspiration of wrist ganglia may relieve pain and restore hand function, and “cure” a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly.
Complication and recurrence are rare after aspiration and surgery for seed ganglia

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P. Trigger finger release in adults

Updated description of the intervention

Trigger finger often resolves over time and is often a nuisance rather than a serious problem. If treatment is necessary steroid injection can be considered. Surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs.

Updated clinical criteria

Summary of intervention

Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in a tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

Number of CCG interventions in 2017/18

7,789

Recommendation

Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with:

a. one or two steroid injections which are typically successful *(strong evidence)*, but the problem may recur, especially in diabetics;
or
b. splinting of the affected finger for 3-12 weeks *(weak evidence)*.

Surgery should be considered if:

a. the triggering persists or recurs after one of the above measures (particularly steroid injections);
or
b. the finger is permanently locked in the palm;
or
c. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods;
or
d. diabetics.

Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

Rationale for recommendation

Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week *(strong evidence)* but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

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Q. Varicose vein interventions

Updated description of the intervention

NICE has published detailed guidance on what treatment should be considered for varicose veins and when interventions for varicose veins (endothermal ablation, sclerotherapy or surgery) should be offered. Surgery is a traditional treatment that involves removal of the vein, patients can get recurrence of symptoms which may need further treatment. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy are less invasive than surgery and have replaced surgery in the management of most patients. However surgery is the most appropriate in some cases. Patients with symptomatic varicose veins should be offered treatment of their

varicose veins. Compression hosiery is not recommended if an interventional treatment is possible. [24]

Updated clinical criteria

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 CCG interventions in 2017/18
28,846
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;- *1.* Symptomatic * primary or recurrent varicose veins. *2.* Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. *3.* Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. *4.* A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). *5.* 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.

[24] https://www.nice.org.uk/guidance/qs67

For further information, please see:

- https://www.nice.org.uk/guidance/qs67
- https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article
- 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.

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Activity reduction goals

This appendix sets out the 2017/18 activity baseline for STPs, CCGs and providers.

The data tables for STPs and CCGs also set out the expected activity reduction in response to the national clinical criteria set out in .

We have segmented the activity and activity reduction into the following tables:

- Table 2: 2017/18 CCG activity and activity reduction for Category 1 interventions (A-D)
- Table 3: 2017/18 CCG activity and activity reduction for Category 2 interventions (E-K)
- Table 4: 2017/18 CCG activity and activity reduction for Category 2 interventions (L-Q)
- Table 5: 2017/18 STP activity and activity reduction for Category 1 interventions (A-D)
- Table 6: 2017/18 STP activity and activity reduction for Category 2 interventions (E-K)
- Table 7: 2017/18 STP activity and activity reduction for Category 2 interventions (L-Q)
- Table 8: 2017/18 provider activity baseline estimates for Category 1 interventions (A-D) and total category 1 activity
- Table 9: 2017/18 provider activity baseline estimates for Category 2 interventions (E-Q) and total Category 2 activity.

The Evidence-Based Interventions Programme and the clinical criteria for the 17 interventions apply in all care settings. However, the 2017/18 activity and activity goals set out in the data tables are necessarily based on ‘all non-emergency spells’ which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what we are reliably able to measure nationally, outpatient activity is therefore not included. This means that these figures are likely to be an underestimate of the true potential for change and we hope that many more patients and clinicians will receive the anticipated benefits of the Evidence-Based Interventions Programme.

Note: the Category 1 activity reduction goals do not include Individual Funding Request (IFR) activity.

Note: the sum of the 2017/18 activity values in the provider table do not exactly match those in the CCG and STP tables as we have not excluded non-CCG activity from provider table.

Table 2[25]: 2017/18 CCG Activity and activity reduction for Category 1 interventions (A-D)

		A Surgery for snoring		B Dilatation & curettage for heavy menstrual bleeding		C Knee arthroscopy with osteoarthritis		D Injection for nonspecific low back pain without sciatica	
		No of spells		No of spells		No of spells		No of spells	
CCG code	CCG name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
00C	NHS Darlington CCG	0	0	1	1	4	4	51	51
00D	NHS Durham Dales, Easington and Sedgefield CCG	7	7	1	1	11	11	114	114
00J	NHS North Durham CCG	7	7	0	0	15	15	38	38
00K	NHS Hartlepool and Stockton-on-Tees CCG	4	4	1	1	1	1	15	15
00L	NHS Northumberland CCG	4	4	3	3	6	6	32	32
00M	NHS South Tees CCG	4	4	0	0	7	7	35	35
00N	NHS South Tyneside CCG	5	5	0	0	11	11	74	74
00P	NHS Sunderland CCG	7	7	0	0	23	23	108	108
00Q	NHS Blackburn with Darwen CCG	8	8	1	1	18	18	24	24
00R	NHS Blackpool CCG	4	4	0	0	13	13	186	186
00T	NHS Bolton CCG	9	9	2	2	16	16	17	17
00V	NHS Bury CCG	1	1	0	0	13	13	74	74
00X	NHS Chorley and South Ribble CCG	7	7	1	1	11	11	163	163
00Y	NHS Oldham CCG	3	3	0	0	17	17	18	18
01A	NHS East Lancashire CCG	15	15	0	0	56	56	59	59
01C	NHS Eastern Cheshire CCG	4	4	0	0	4	4	20	20

[25] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

01D	NHS Heywood, Middleton and Rochdale CCG	4	4	1	1	14	14	63	63
01E	NHS Greater Preston CCG	17	17	2	2	4	4	254	254
01F	NHS Halton CCG	6	6	4	4	9	9	11	11
01G	NHS Salford CCG	3	3	0	0	22	22	55	55
01H	NHS Cumbria CCG	5	5	0	0	68	68	165	165
01J	NHS Knowsley CCG	7	7	1	1	2	2	46	46
01K	NHS Morecambe Bay CCG	7	7	6	6	39	39	429	429
01R	NHS South Cheshire CCG	2	2	0	0	15	15	50	50
01T	NHS South Sefton CCG	6	6	0	0	3	3	74	74
01V	NHS Southport and Formby CCG	2	2	0	0	4	4	24	24
01W	NHS Stockport CCG	4	4	0	0	9	9	15	15
01X	NHS St Helens CCG	2	2	0	0	3	3	25	25
01Y	NHS Tameside and Glossop CCG	2	2	0	0	31	31	77	77
02A	NHS Trafford CCG	4	4	0	0	15	15	41	41
02D	NHS Vale Royal CCG	0	0	0	0	10	10	17	17
02E	NHS Warrington CCG	3	3	5	5	16	16	10	10
02F	NHS West Cheshire CCG	2	2	0	0	8	8	143	143
02G	NHS West Lancashire CCG	4	4	2	2	2	2	19	19
02H	NHS Wigan Borough CCG	2	2	1	1	11	11	24	24
02M	NHS Fylde & Wyre CCG	6	6	0	0	15	15	225	225
02N	NHS Airedale, Wharfedale and Craven CCG	2	2	0	0	4	4	23	23
02P	NHS Barnsley CCG	5	5	1	1	53	53	163	163
02Q	NHS Bassetlaw CCG	5	5	0	0	44	44	53	53
02R	NHS Bradford Districts CCG	10	10	0	0	44	44	24	24
02T	NHS Calderdale CCG	5	5	2	2	20	20	54	54
02W	NHS Bradford City CCG	3	3	1	1	7	7	5	5
02X	NHS Doncaster CCG	3	3	2	2	62	62	326	326
02Y	NHS East Riding of Yorkshire CCG	13	13	2	2	26	26	42	42
03A	NHS Greater Huddersfield CCG	9	9	0	0	23	23	47	47

03D	NHS Hambleton, Richmondshire and Whitby CCG	1	1	0	0	4	4	8	8
03E	NHS Harrogate and Rural District CCG	3	3	0	0	8	8	1	1
03F	NHS Hull CCG	15	15	0	0	22	22	23	23
03H	NHS North East Lincolnshire CCG	0	0	0	0	48	48	10	10
03J	NHS North Kirklees CCG	2	2	2	2	10	10	9	9
03K	NHS North Lincolnshire CCG	3	3	0	0	26	26	28	28
03L	NHS Rotherham CCG	5	5	1	1	28	28	139	139
03M	NHS Scarborough and Ryedale CCG	1	1	0	0	9	9	3	3
03N	NHS Sheffield CCG	17	17	0	0	8	8	40	40
03Q	NHS Vale of York CCG	2	2	2	2	24	24	15	15
03R	NHS Wakefield CCG	3	3	1	1	70	70	33	33
03T	NHS Lincolnshire East CCG	2	2	1	1	39	39	174	174
03V	NHS Corby CCG	0	0	3	3	6	6	31	31
03W	NHS East Leicestershire and Rutland CCG	1	1	0	0	18	18	73	73
03X	NHS Erewash CCG	3	3	1	1	2	2	68	68
03Y	NHS Hardwick CCG	2	2	0	0	12	12	90	90
04C	NHS Leicester City CCG	2	2	0	0	29	29	58	58
04D	NHS Lincolnshire West CCG	3	3	0	0	37	37	45	45
04E	NHS Mansfield and Ashfield CCG	3	3	0	0	18	18	86	86
04F	NHS Milton Keynes CCG	1	1	1	1	19	19	48	48
04G	NHS Nene CCG	5	5	10	10	57	57	93	93
04H	NHS Newark & Sherwood CCG	1	1	1	1	6	6	101	101
04J	NHS North Derbyshire CCG	10	10	0	0	19	19	143	143
04K	NHS Nottingham City CCG	1	1	0	0	11	11	248	248
04L	NHS Nottingham North and East CCG	0	0	0	0	3	3	155	155
04M	NHS Nottingham West CCG	0	0	0	0	0	0	59	59
04N	NHS Rushcliffe CCG	0	0	0	0	2	2	95	95
04Q	NHS South West Lincolnshire CCG	2	2	1	1	14	14	102	102
04R	NHS Southern Derbyshire CCG	4	4	3	3	17	17	63	63
04V	NHS West Leicestershire CCG	3	3	0	0	18	18	91	91

04Y	NHS Cannock Chase CCG	0	0	1	1	11	11	12	12
05A	NHS Coventry and Rugby CCG	14	14	8	8	43	43	88	88
05C	NHS Dudley CCG	3	3	1	1	43	43	48	48
05D	NHS East Staffordshire CCG	0	0	0	0	16	16	5	5
05F	NHS Herefordshire CCG	1	1	0	0	10	10	2	2
05G	NHS North Staffordshire CCG	2	2	2	2	9	9	16	16
05H	NHS Warwickshire North CCG	3	3	0	0	37	37	9	9
05J	NHS Redditch and Bromsgrove CCG	0	0	3	3	9	9	27	27
05L	NHS Sandwell and West Birmingham CCG	4	4	2	2	44	44	71	71
05N	NHS Shropshire CCG	1	1	1	1	11	11	17	17
05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	1	1	1	1	17	17	27	27
05R	NHS South Warwickshire CCG	10	10	4	4	12	12	24	24
05T	NHS South Worcestershire CCG	0	0	2	2	14	14	56	56
05V	NHS Stafford and Surrounds CCG	3	3	0	0	6	6	15	15
05W	NHS Stoke on Trent CCG	1	1	0	0	18	18	19	19
05X	NHS Telford and Wrekin CCG	0	0	1	1	9	9	6	6
05Y	NHS Walsall CCG	2	2	3	3	42	42	27	27
06A	NHS Wolverhampton CCG	2	2	1	1	10	10	57	57
06D	NHS Wyre Forest CCG	1	1	1	1	7	7	24	24
06F	NHS Bedfordshire CCG	1	1	2	2	28	28	67	67
06H	NHS Cambridgeshire and Peterborough CCG	9	9	1	1	31	31	171	171
06K	NHS East and North Hertfordshire CCG	7	7	1	1	18	18	59	59
06L	NHS Ipswich and East Suffolk CCG	4	4	1	1	14	14	211	211
06M	NHS Great Yarmouth and Waveney CCG	14	14	2	2	16	16	15	15
06N	NHS Herts Valleys CCG	19	19	3	3	34	34	80	80
06P	NHS Luton CCG	3	3	0	0	14	14	43	43
06Q	NHS Mid Essex CCG	0	0	2	2	61	61	21	21
06T	NHS North East Essex CCG	3	3	2	2	16	16	51	51

06V	NHS North Norfolk CCG	14	14	3	3	3	3	27	27
06W	NHS Norwich CCG	12	12	1	1	2	2	42	42
06Y	NHS South Norfolk CCG	9	9	1	1	8	8	75	75
07G	NHS Thurrock CCG	2	2	0	0	9	9	17	17
07H	NHS West Essex CCG	1	1	1	1	13	13	32	32
07J	NHS West Norfolk CCG	3	3	2	2	11	11	53	53
07K	NHS West Suffolk CCG	2	2	0	0	23	23	71	71
07L	NHS Barking and Dagenham CCG	2	2	2	2	11	11	50	50
07M	NHS Barnet CCG	4	4	1	1	10	10	71	71
07N	NHS Bexley CCG	2	2	0	0	8	8	66	66
07P	NHS Brent CCG	2	2	3	3	23	23	37	37
07Q	NHS Bromley CCG	3	3	0	0	26	26	143	143
07R	NHS Camden CCG	1	1	1	1	3	3	37	37
07T	NHS City and Hackney CCG	1	1	0	0	5	5	107	107
07V	NHS Croydon CCG	4	4	1	1	17	17	50	50
07W	NHS Ealing CCG	2	2	6	6	22	22	23	23
07X	NHS Enfield CCG	5	5	1	1	6	6	104	104
07Y	NHS Hounslow CCG	3	3	0	0	9	9	16	16
08A	NHS Greenwich CCG	5	5	0	0	8	8	43	43
08C	NHS Hammersmith and Fulham CCG	2	2	4	4	10	10	23	23
08D	NHS Haringey CCG	3	3	1	1	10	10	32	32
08E	NHS Harrow CCG	2	2	3	3	36	36	25	25
08F	NHS Havering CCG	6	6	1	1	18	18	78	78
08G	NHS Hillingdon CCG	5	5	1	1	35	35	45	45
08H	NHS Islington CCG	7	7	0	0	6	6	54	54
08J	NHS Kingston CCG	0	0	0	0	3	3	47	47
08K	NHS Lambeth CCG	11	11	0	0	16	16	85	85
08L	NHS Lewisham CCG	4	4	1	1	5	5	20	20
08M	NHS Newham CCG	5	5	0	0	5	5	27	27
08N	NHS Redbridge CCG	5	5	0	0	12	12	83	83
08P	NHS Richmond CCG	0	0	0	0	2	2	16	16

08Q	NHS Southwark CCG	6	6	0	0	9	9	83	83
08R	NHS Merton CCG	3	3	3	3	3	3	85	85
08T	NHS Sutton CCG	3	3	0	0	4	4	145	145
08V	NHS Tower Hamlets CCG	7	7	0	0	12	12	29	29
08W	NHS Waltham Forest CCG	2	2	2	2	12	12	40	40
08X	NHS Wandsworth CCG	3	3	0	0	4	4	105	105
08Y	NHS West London CCG	1	1	2	2	10	10	32	32
09A	NHS Central London (Westminster) CCG	1	1	2	2	3	3	28	28
09C	NHS Ashford CCG	1	1	0	0	3	3	81	81
09D	NHS Brighton and Hove CCG	6	6	3	3	6	6	118	118
09E	NHS Canterbury and Coastal CCG	3	3	0	0	13	13	151	151
09F	NHS Eastbourne, Hailsham and Seaford CCG	3	3	2	2	13	13	19	19
09G	NHS Coastal West Sussex CCG	12	12	1	1	31	31	205	205
09H	NHS Crawley CCG	0	0	0	0	11	11	159	159
09J	NHS Dartford, Gravesham and Swanley CCG	3	3	0	0	15	15	112	112
09L	NHS East Surrey CCG	0	0	0	0	12	12	141	141
09N	NHS Guildford and Waverley CCG	2	2	3	3	3	3	61	61
09P	NHS Hastings and Rother CCG	1	1	0	0	10	10	28	28
09W	NHS Medway CCG	5	5	2	2	37	37	38	38
09X	NHS Horsham and Mid Sussex CCG	0	0	0	0	7	7	115	115
09Y	NHS North West Surrey CCG	3	3	2	2	2	2	163	163
10A	NHS South Kent Coast CCG	1	1	1	1	11	11	139	139
10C	NHS Surrey Heath CCG	1	1	1	1	3	3	14	14
10D	NHS Swale CCG	1	1	1	1	13	13	34	34
10E	NHS Thanet CCG	2	2	1	1	13	13	174	174
10J	NHS North Hampshire CCG	0	0	0	0	8	8	10	10
10K	NHS Fareham and Gosport CCG	1	1	0	0	10	10	15	15
10L	NHS Isle of Wight CCG	2	2	0	0	14	14	16	16
10Q	NHS Oxfordshire CCG	4	4	0	0	15	15	7	7

10R	NHS Portsmouth CCG	2	2	0	0	11	11	6	6
10V	NHS South Eastern Hampshire CCG	4	4	0	0	7	7	25	25
10X	NHS Southampton CCG	3	3	0	0	16	16	7	7
11A	NHS West Hampshire CCG	5	5	2	2	18	18	29	29
11E	NHS Bath and North East Somerset CCG	0	0	9	9	11	11	11	11
11J	NHS Dorset CCG	7	7	3	3	29	29	42	42
11M	NHS Gloucestershire CCG	7	7	2	2	24	24	12	12
11N	NHS Kernow CCG	4	4	1	1	45	45	29	29
11X	NHS Somerset CCG	4	4	2	2	26	26	7	7
12D	NHS Swindon CCG	1	1	3	3	25	25	1	1
12F	NHS Wirral CCG	2	2	0	0	11	11	58	58
13T	NHS Newcastle Gateshead CCG	10	10	3	3	40	40	161	161
14L	NHS Manchester CCG	4	4	4	4	24	24	95	95
14Y	NHS Buckinghamshire CCG	3	3	2	2	13	13	24	24
15A	NHS Berkshire West CCG	2	2	0	0	35	35	7	7
15C	NHS Bristol, North Somerset and South Gloucestershire CCG	7	7	7	7	41	41	12	12
15D	NHS Berkshire East CCG	2	2	0	0	18	18	37	37
15E	NHS Birmingham and Solihull CCG	3	3	5	5	89	89	307	307
15F	NHS Leeds CCG	33	33	3	3	57	57	49	49
99A	NHS Liverpool CCG	10	10	2	2	6	6	72	72
99C	NHS North Tyneside CCG	6	6	0	0	7	7	52	52
99D	NHS South Lincolnshire CCG	1	1	1	1	14	14	105	105
99E	NHS Basildon and Brentwood CCG	5	5	0	0	13	13	23	23
99F	NHS Castle Point and Rochford CCG	5	5	0	0	12	12	208	208
99G	NHS Southend CCG	4	4	0	0	11	11	193	193
99H	NHS Surrey Downs CCG	1	1	2	2	10	10	243	243
99J	NHS West Kent CCG	8	8	0	0	30	30	123	123
99K	NHS High Weald Lewes Havens CCG	1	1	2	2	7	7	37	37
99M	NHS North East Hampshire and Farnham CCG	2	2	1	1	9	9	38	38

99N	NHS Wiltshire CCG	8	8	8	8	67	67	28	28
99P	NHS Northern, Eastern and Western Devon CCG	13	13	2	2	23	23	68	68
99Q	NHS South Devon and Torbay CCG	6	6	0	0	13	13	178	178
Total		812	812	236	236	3,434	3,437	13,165	13,165

Table 3[26]: 2017/18 CCG Activity and activity reduction for Category 2 interventions (E-K)

		E Breast reduction		F Removal of benign skin lesions		G Grommets		H Tonsillectomy		I Haemorrhoid surgery		J Hysterectomy for heavy bleeding		K Chalazia removal	
		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells	
CCG code	CCG name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
00C	NHS Darlington CCG	4	0	224	82	38	27	53	6	33	21	75	31	18	14
00D	NHS Durham Dales, Easington and Sedgefield CCG	17	8	730	343	126	99	164	42	50	19	208	88	68	59
00J	NHS North Durham CCG	7	0	792	461	96	74	136	23	42	15	169	69	18	10
00K	NHS Hartlepool and Stockton-on-Tees CCG	26	17	1,141	764	56	25	131	0	33	2	175	59	40	31
00L	NHS Northumberland CCG	31	21	803	352	42	14	99	0	14	0	187	48	4	0
00M	NHS South Tees CCG	17	8	966	591	30	0	134	0	59	29	161	49	25	16
00N	NHS South Tyneside CCG	11	6	497	291	29	14	131	65	14	0	119	57	48	43
00P	NHS Sunderland CCG	19	10	1,149	780	82	56	179	58	33	3	203	90	87	78

[26] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

00Q	NHS Blackburn with Darwen CCG	5	0	261	55	42	21	131	43	39	22	73	11	59	53
00R	NHS Blackpool CCG	11	6	787	557	29	13	131	59	10	0	77	9	9	3
00T	NHS Bolton CCG	7	0	414	38	51	16	212	65	30	0	135	20	14	4
00V	NHS Bury CCG	2	0	207	0	28	6	92	0	11	0	83	4	22	15
00X	NHS Chorley and South Ribble CCG	5	0	474	234	21	3	99	21	38	18	83	8	14	8
00Y	NHS Oldham CCG	2	0	278	0	30	0	147	21	28	3	139	47	47	39
01A	NHS East Lancashire CCG	9	0	689	208	84	44	284	111	77	38	191	45	92	80
01C	NHS Eastern Cheshire CCG	7	0	223	0	14	0	131	49	26	3	85	0	43	36
01D	NHS Heywood, Middleton and Rochdale CCG	10	3	339	57	14	0	168	57	27	3	109	23	25	17
01E	NHS Greater Preston CCG	7	1	531	276	17	0	131	32	33	12	75	0	13	6
01F	NHS Halton CCG	16	12	344	180	23	9	86	27	21	7	77	25	25	21
01G	NHS Salford CCG	9	2	376	58	63	33	201	67	34	7	117	26	38	29
01H	NHS Cumbria CCG	32	22	245	0	32	3	234	105	23	0	295	160	3	0
01J	NHS Knowsley CCG	14	9	488	284	25	8	126	51	37	20	119	55	30	25
01K	NHS Morecambe Bay CCG	19	8	608	135	58	29	215	71	57	20	197	57	12	1
01R	NHS South Cheshire CCG	2	0	413	170	15	0	108	30	18	0	88	13	42	36
01T	NHS South Sefton CCG	9	4	391	189	23	8	112	46	15	0	95	33	39	34
01V	NHS Southport and Formby CCG	9	5	311	133	15	5	50	3	8	0	73	20	10	6
01W	NHS Stockport CCG	9	0	572	169	58	27	224	90	51	18	143	18	19	9
01X	NHS St Helens CCG	8	2	531	271	40	21	134	50	37	16	154	73	49	43
01Y	NHS Tameside and Glossop CCG	7	0	292	0	56	30	222	110	44	18	157	60	33	25
02A	NHS Trafford CCG	9	2	506	202	43	17	126	17	55	30	97	1	74	66
02D	NHS Vale Royal CCG	1	0	165	27	12	1	61	15	10	0	44	0	18	14

02E	NHS Warrington CCG	10	3	426	148	21	0	106	11	43	20	87	0	28	21
02F	NHS West Cheshire CCG	13	5	761	411	46	22	142	32	15	0	129	22	14	6
02G	NHS West Lancashire CCG	4	0	383	232	11	1	60	11	12	0	55	9	31	27
02H	NHS Wigan Borough CCG	17	7	1,012	592	44	12	190	48	44	9	237	106	61	51
02M	NHS Fylde & Wyre CCG	11	5	1,071	825	27	13	128	65	12	0	93	20	16	11
02N	NHS Airedale, Wharfedale and Craven CCG	5	0	282	69	51	35	79	12	24	7	93	28	24	19
02P	NHS Barnsley CCG	5	0	1,183	850	45	19	159	46	37	10	165	61	46	38
02Q	NHS Bassetlaw CCG	5	1	123	0	24	13	65	16	17	4	56	8	7	3
02R	NHS Bradford Districts CCG	15	6	401	0	79	40	190	27	46	13	172	49	20	9
02T	NHS Calderdale CCG	9	2	288	10	65	42	152	53	23	0	97	9	4	0
02W	NHS Bradford City CCG	3	0	129	0	27	6	65	0	14	2	34	0	20	15
02X	NHS Doncaster CCG	15	5	382	0	71	39	117	0	29	0	146	22	6	0
02Y	NHS East Riding of Yorkshire CCG	32	22	854	425	77	51	229	113	46	13	196	66	14	5
03A	NHS Greater Huddersfield CCG	10	3	361	51	73	48	180	65	30	5	87	0	10	2
03D	NHS Hambleton, Richmondshire and Whitby CCG	10	5	578	373	37	25	40	0	14	0	73	10	11	6
03E	NHS Harrogate and Rural District CCG	11	6	165	0	34	20	67	2	37	19	61	0	12	7
03F	NHS Hull CCG	18	9	688	327	110	78	325	184	59	29	120	13	12	2
03H	NHS North East Lincolnshire CCG	9	4	155	0	8	0	106	32	23	5	118	52	3	0
03J	NHS North Kirklees CCG	9	3	411	178	42	20	153	58	29	10	113	42	60	54
03K	NHS North Lincolnshire CCG	15	9	187	0	11	0	81	7	20	1	119	49	5	0

03L	NHS Rotherham CCG	15	7	500	163	40	13	140	23	63	36	178	75	119	111
03M	NHS Scarborough and Ryedale CCG	5	1	128	0	20	9	72	25	7	0	59	9	6	2
03N	NHS Sheffield CCG	33	16	2,174	1,447	72	15	156	0	131	73	331	124	229	210
03Q	NHS Vale of York CCG	26	15	327	0	44	14	189	34	44	7	128	0	21	10
03R	NHS Wakefield CCG	26	15	763	288	108	71	355	192	72	33	217	69	75	63
03T	NHS Lincolnshire East CCG	19	11	452	98	24	2	163	67	15	0	131	27	7	0
03V	NHS Corby CCG	0	0	94	1	22	13	38	0	21	13	53	24	6	3
03W	NHS East Leicestershire and Rutland CCG	17	7	553	108	50	19	183	47	49	14	213	74	43	33
03X	NHS Erewash CCG	3	0	235	106	9	0	58	17	14	3	55	15	19	16
03Y	NHS Hardwick CCG	5	1	226	87	18	8	57	14	14	3	81	38	6	2
04C	NHS Leicester City CCG	12	1	521	73	59	14	269	54	54	17	154	26	103	90
04D	NHS Lincolnshire West CCG	15	8	395	85	57	34	169	60	21	0	114	21	4	0
04E	NHS Mansfield and Ashfield CCG	12	6	598	350	49	29	143	58	21	0	129	53	4	0
04F	NHS Milton Keynes CCG	17	9	495	152	76	41	200	57	36	6	113	2	32	22
04G	NHS Nene CCG	21	1	975	123	82	11	203	0	129	59	425	160	72	51
04H	NHS Newark & Sherwood CCG	6	2	426	246	35	22	71	15	12	0	59	3	7	3
04J	NHS North Derbyshire CCG	12	3	653	252	31	6	151	36	42	10	231	107	42	33
04K	NHS Nottingham City CCG	16	6	742	329	49	12	161	0	51	18	129	18	42	29
04L	NHS Nottingham North and East CCG	5	0	400	199	19	4	72	8	27	11	76	13	18	13
04M	NHS Nottingham West CCG	3	0	252	127	11	2	33	0	14	4	32	0	13	10
04N	NHS Rushcliffe CCG	8	4	367	198	21	9	45	0	11	0	46	0	10	6

04Q	NHS South West Lincolnshire CCG	3	0	198	16	22	9	84	29	36	21	82	25	1	0
04R	NHS Southern Derbyshire CCG	16	0	930	227	75	20	331	84	56	0	385	170	53	36
04V	NHS West Leicestershire CCG	18	6	720	218	76	40	249	79	41	0	227	74	56	44
04Y	NHS Cannock Chase CCG	7	3	243	69	19	6	75	19	17	2	103	48	2	0
05A	NHS Coventry and Rugby CCG	25	11	1,483	878	45	0	426	171	43	0	209	37	102	86
05C	NHS Dudley CCG	13	4	1,247	828	73	41	189	51	21	0	250	124	25	15
05D	NHS East Staffordshire CCG	4	0	155	0	21	7	96	34	13	0	79	23	2	0
05F	NHS Herefordshire CCG	12	6	821	559	93	76	78	5	29	8	69	0	4	0
05G	NHS North Staffordshire CCG	8	1	477	184	34	15	110	19	31	8	145	57	8	1
05H	NHS Warwickshire North CCG	8	2	721	471	25	6	144	62	14	0	106	29	18	12
05J	NHS Redditch and Bromsgrove CCG	7	1	185	0	35	17	61	0	15	0	126	55	5	0
05L	NHS Sandwell and West Birmingham CCG	15	0	870	220	52	0	316	25	79	25	241	54	89	71
05N	NHS Shropshire CCG	7	0	447	15	33	7	101	0	28	0	152	21	8	0
05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	7	0	522	231	37	17	139	49	21	0	153	63	6	0
05R	NHS South Warwickshire CCG	17	8	439	55	49	24	173	59	19	0	155	38	13	4
05T	NHS South Worcestershire CCG	5	0	349	0	56	28	123	0	27	0	203	76	7	0
05V	NHS Stafford and Surrounds CCG	10	5	320	116	17	4	72	13	27	10	96	34	1	0
05W	NHS Stoke on Trent CCG	8	0	462	102	47	15	154	19	39	10	206	100	11	2

05X	NHS Telford and Wrekin CCG	9	3	197	0	26	6	60	0	18	0	98	26	5	0
05Y	NHS Walsall CCG	17	9	532	181	27	0	203	66	56	28	162	58	8	0
06A	NHS Wolverhampton CCG	14	6	263	0	34	3	139	7	35	7	166	64	2	0
06D	NHS Wyre Forest CCG	3	0	152	0	24	13	57	11	11	0	82	33	2	0
06F	NHS Bedfordshire CCG	11	0	1,179	578	83	33	204	0	64	14	214	25	28	13
06H	NHS Cambridgeshire and Peterborough CCG	18	0	1,276	94	155	60	557	116	72	0	389	34	85	55
06K	NHS East and North Hertfordshire CCG	9	0	709	0	137	76	394	124	146	85	240	6	125	106
06L	NHS Ipswich and East Suffolk CCG	18	6	465	0	48	10	219	50	47	4	202	39	58	46
06M	NHS Great Yarmouth and Waveney CCG	8	1	826	494	67	46	149	53	37	11	115	19	25	18
06N	NHS Herts Valleys CCG	27	9	1,043	242	115	45	478	184	89	22	212	0	87	67
06P	NHS Luton CCG	2	0	202	0	29	0	187	64	35	13	59	0	16	8
06Q	NHS Mid Essex CCG	5	0	616	105	108	70	234	66	66	25	212	52	20	8
06T	NHS North East Essex CCG	16	6	722	256	65	32	341	191	57	21	152	14	11	0
06V	NHS North Norfolk CCG	3	0	633	373	20	6	71	10	20	1	93	18	17	12
06W	NHS Norwich CCG	1	0	690	399	35	13	161	50	26	3	99	16	12	4
06Y	NHS South Norfolk CCG	7	0	736	424	54	33	126	34	31	7	135	41	3	0
07G	NHS Thurrock CCG	4	0	176	0	35	13	144	56	44	26	88	22	40	34
07H	NHS West Essex CCG	10	1	312	0	51	18	262	123	86	53	125	0	21	11
07J	NHS West Norfolk CCG	4	0	635	387	27	12	123	55	27	8	98	25	40	34

07K	NHS West Suffolk CCG	9	1	981	640	49	26	198	97	31	4	130	26	4	0
07L	NHS Barking and Dagenham CCG	4	0	627	388	16	0	197	70	40	19	73	0	80	73
07M	NHS Barnet CCG	7	0	864	363	28	0	163	0	52	10	71	0	49	36
07N	NHS Bexley CCG	8	1	401	102	33	6	172	59	56	31	132	37	16	8
07P	NHS Brent CCG	15	5	477	48	19	0	106	0	60	22	91	0	65	52
07Q	NHS Bromley CCG	13	3	1,315	872	63	26	235	80	43	6	180	38	16	5
07R	NHS Camden CCG	10	2	832	522	8	0	95	0	45	18	46	0	43	33
07T	NHS City and Hackney CCG	2	0	356	16	28	0	100	0	62	31	42	0	97	86
07V	NHS Croydon CCG	16	5	433	0	23	0	156	0	59	17	189	37	18	5
07W	NHS Ealing CCG	22	11	526	28	22	0	136	0	86	41	103	0	31	17
07X	NHS Enfield CCG	10	0	600	206	24	0	202	32	25	0	84	0	50	39
07Y	NHS Hounslow CCG	16	8	225	0	22	0	158	7	43	11	64	0	34	24
08A	NHS Greenwich CCG	3	0	345	14	19	0	193	42	51	22	132	26	49	39
08C	NHS Hammersmith and Fulham CCG	12	6	209	0	30	11	110	8	35	12	46	0	41	33
08D	NHS Haringey CCG	12	3	683	322	14	0	152	0	51	18	67	0	56	45
08E	NHS Harrow CCG	13	6	319	0	21	0	92	0	32	5	66	0	34	25
08F	NHS Havering CCG	10	2	1,036	684	37	8	208	82	60	32	137	29	76	67
08G	NHS Hillingdon CCG	9	1	568	202	43	8	131	0	86	55	141	31	25	15
08H	NHS Islington CCG	6	0	857	575	18	0	111	0	63	37	36	0	81	72
08J	NHS Kingston CCG	11	5	207	0	31	9	99	0	46	24	71	0	4	0
08K	NHS Lambeth CCG	20	9	574	120	16	0	139	0	89	47	119	0	42	28
08L	NHS Lewisham CCG	17	8	935	566	14	0	168	5	60	27	130	10	38	27
08M	NHS Newham CCG	7	0	301	0	37	0	244	31	87	49	94	0	89	76
08N	NHS Redbridge CCG	6	0	567	207	36	0	215	54	46	15	94	0	121	111
08P	NHS Richmond CCG	19	13	216	0	19	0	106	7	36	12	42	0	11	4
08Q	NHS Southwark CCG	13	4	684	322	12	0	141	0	89	56	85	0	38	27
08R	NHS Merton CCG	12	6	196	0	13	0	115	8	45	21	70	0	14	6
08T	NHS Sutton CCG	16	10	152	0	20	0	118	27	32	12	125	48	6	0

08V	NHS Tower Hamlets CCG	2	0	305	0	31	0	140	0	86	56	48	0	96	85
08W	NHS Waltham Forest CCG	8	0	326	0	26	0	209	54	19	0	73	0	73	63
08X	NHS Wandsworth CCG	17	6	361	0	21	0	147	0	83	42	78	0	31	17
08Y	NHS West London CCG	9	2	299	0	15	0	88	0	54	26	53	0	27	19
09A	NHS Central London (Westminster) CCG	10	4	255	0	6	0	64	0	25	2	33	0	30	22
09C	NHS Ashford CCG	3	0	313	144	25	11	131	70	31	17	62	9	8	4
09D	NHS Brighton and Hove CCG	13	4	816	438	25	0	184	38	72	39	90	0	8	0
09E	NHS Canterbury and Coastal CCG	2	0	621	332	35	17	142	39	46	24	118	34	8	1
09F	NHS Eastbourne, Hailsham and Seaford CCG	7	1	566	289	17	0	141	64	29	8	140	60	25	19
09G	NHS Coastal West Sussex CCG	10	0	1,717	993	114	70	350	150	52	0	366	152	4	0
09H	NHS Crawley CCG	6	2	202	43	17	2	100	36	26	12	76	27	4	0
09J	NHS Dartford, Gravesham and Swanley CCG	12	4	421	88	35	5	180	55	104	77	125	22	17	8
09L	NHS East Surrey CCG	11	5	248	16	27	7	132	50	31	12	82	9	0	0
09N	NHS Guildford and Waverley CCG	6	0	451	162	18	0	97	0	39	16	126	38	6	0
09P	NHS Hastings and Rother CCG	9	3	183	0	18	1	137	63	33	13	122	43	11	5
09W	NHS Medway CCG	16	7	577	210	37	4	227	86	46	16	260	145	15	5
09X	NHS Horsham and Mid Sussex CCG	10	3	508	192	39	15	139	36	51	25	117	17	0	0
09Y	NHS North West Surrey CCG	24	13	517	46	42	3	229	64	76	37	146	0	46	34
10A	NHS South Kent Coast CCG	3	0	717	437	34	15	202	117	64	42	120	36	22	16

10C	NHS Surrey Heath CCG	3	0	347	222	23	13	38	0	14	3	54	14	17	14
10D	NHS Swale CCG	6	2	189	47	17	4	115	63	16	4	117	73	4	0
10E	NHS Thanet CCG	3	0	405	210	25	10	100	38	37	22	125	66	5	0
10J	NHS North Hampshire CCG	5	0	351	63	33	10	119	19	10	0	94	2	22	15
10K	NHS Fareham and Gosport CCG	7	0	207	0	25	5	69	0	21	0	144	58	2	0
10L	NHS Isle of Wight CCG	1	0	136	0	8	0	65	11	35	19	71	9	6	1
10Q	NHS Oxfordshire CCG	45	24	1,910	990	86	17	299	0	40	0	164	0	11	0
10R	NHS Portsmouth CCG	7	0	238	0	28	5	99	0	14	0	129	50	4	0
10V	NHS South Eastern Hampshire CCG	10	3	251	0	19	0	74	0	21	0	151	61	6	0
10X	NHS Southampton CCG	5	0	344	14	21	0	158	14	12	0	121	30	5	0
11A	NHS West Hampshire CCG	13	0	978	212	66	15	242	11	57	0	255	22	15	0
11E	NHS Bath and North East Somerset CCG	12	6	268	7	11	0	50	0	22	1	73	0	2	0
11J	NHS Dorset CCG	31	7	3,295	2,185	48	0	255	0	101	16	496	174	133	109
11M	NHS Gloucestershire CCG	30	11	531	0	65	4	275	0	52	0	242	0	24	4
11N	NHS Kernow CCG	31	13	1,312	518	101	51	239	9	78	17	234	0	13	0
11X	NHS Somerset CCG	10	0	1,170	382	94	43	234	2	63	2	301	66	13	0
12D	NHS Swindon CCG	11	4	243	0	38	11	127	16	43	19	103	12	6	0
12F	NHS Wirral CCG	35	25	1,561	1,116	82	50	198	56	23	0	123	0	9	0
13T	NHS Newcastle Gateshead CCG	32	17	1,010	374	107	60	208	0	74	23	313	133	21	4
14L	NHS Manchester CCG	15	0	735	45	79	9	369	27	95	36	187	0	90	69

14Y	NHS Buckinghamshire CCG	17	1	523	0	113	55	146	0	60	2	185	0	15	0
15A	NHS Berkshire West CCG	21	6	486	0	41	0	195	0	36	0	151	0	13	0
15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28	0	2,591	1,354	105	7	217	0	130	30	325	0	70	39
15D	NHS Berkshire East CCG	11	0	789	245	53	1	175	0	61	15	193	23	14	0
15E	NHS Birmingham and Solihull CCG	57	23	1,858	310	198	48	660	5	112	0	616	162	138	98
15F	NHS Leeds CCG	54	30	1,559	514	151	63	695	265	259	174	309	7	60	32
99A	NHS Liverpool CCG	27	12	889	255	55	6	337	84	91	39	215	30	73	56
99C	NHS North Tyneside CCG	22	15	563	275	42	21	76	0	23	0	156	65	8	1
99D	NHS South Lincolnshire CCG	13	8	438	210	24	8	88	20	19	1	99	29	3	0
99E	NHS Basildon and Brentwood CCG	4	0	326	0	41	12	254	128	40	11	123	14	49	40
99F	NHS Castle Point and Rochford CCG	6	0	350	96	27	11	165	90	35	15	92	15	23	17
99G	NHS Southend CCG	3	0	368	125	25	6	154	71	20	0	109	35	32	26
99H	NHS Surrey Downs CCG	17	8	891	487	29	0	114	0	46	13	119	0	5	0
99J	NHS West Kent CCG	18	3	423	0	44	0	310	93	57	6	241	40	6	0
99K	NHS High Weald Lewes Havens CCG	7	1	535	301	17	1	110	41	16	0	73	0	5	0
99M	NHS North East Hampshire and Farnham CCG	8	1	910	622	42	18	117	15	24	0	118	26	66	59
99N	NHS Wiltshire CCG	11	0	632	0	50	3	202	0	67	15	249	41	15	0
99P	NHS Northern, Eastern and Western Devon CCG	32	4	2,498	1,247	232	150	419	28	79	0	550	178	28	0

99Q	NHS South Devon and Torbay CCG	5	0	440	24	67	42	128	16	42	10	209	84	0	0
Total		2,392	829	116,676	45,589	8,678	3,259	32,345	7,454	8,493	2,801	27,683	6,536	6,042	4,326

Table 4[27]: 2017/18 CCG Activity and activity reduction for Category 2 interventions (L-Q)

		L Shoulder decompression		M Carpal tunnel syndrome release		N Dupuytren's contracture release		O Ganglion excision		P Trigger finger release		Q Varicose vein surgery	
		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells	
CCG code	CCG name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
00C	NHS Darlington CCG	13	0	100	37	43	21	23	15	17	6	57	11
00D	NHS Durham Dales, Easington and Sedgefield CCG	46	4	182	7	67	4	34	13	31	0	184	57
00J	NHS North Durham CCG	27	0	162	17	51	0	39	21	31	5	210	103
00K	NHS Hartlepool and Stockton-on-Tees CCG	12	0	127	0	58	0	51	30	22	0	260	137
00L	NHS Northumberland CCG	59	10	320	111	132	54	46	23	72	34	171	22
00M	NHS South Tees CCG	28	0	356	193	104	47	38	18	49	20	188	67
00N	NHS South Tyneside CCG	29	7	91	0	47	15	20	9	32	15	190	122
00P	NHS Sunderland CCG	35	0	259	96	82	24	60	40	50	21	433	312
00Q	NHS Blackburn with Darwen CCG	29	7	134	49	28	0	22	10	27	12	132	66
00R	NHS Blackpool CCG	24	0	77	0	60	23	16	4	23	5	97	22
00T	NHS Bolton CCG	75	35	270	111	45	0	24	3	62	34	75	0
00V	NHS Bury CCG	47	19	140	29	38	0	26	12	34	14	145	61

[27] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

00X	NHS Chorley and South Ribble CCG	83	57	118	11	83	44	47	34	14	0	75	0
00Y	NHS Oldham CCG	73	41	46	0	55	12	27	10	36	13	200	102
01A	NHS East Lancashire CCG	98	47	386	178	111	37	68	42	63	26	395	239
01C	NHS Eastern Cheshire CCG	62	31	122	0	100	53	41	26	32	9	155	61
01D	NHS Heywood, Middleton and Rochdale CCG	72	42	203	84	50	9	29	13	31	10	223	131
01E	NHS Greater Preston CCG	76	49	153	45	83	46	43	29	31	12	110	28
01F	NHS Halton CCG	18	0	115	43	32	6	11	2	31	18	117	62
01G	NHS Salford CCG	41	9	320	193	85	43	64	46	71	49	64	0
01H	NHS Cumbria CCG	72	24	329	127	138	63	35	12	53	17	213	68
01J	NHS Knowsley CCG	45	22	129	40	31	1	12	0	32	16	93	26
01K	NHS Morecambe Bay CCG	59	9	412	199	165	87	47	22	67	29	313	160
01R	NHS South Cheshire CCG	111	85	247	139	77	38	17	4	42	23	73	0
01T	NHS South Sefton CCG	73	51	94	3	46	14	7	0	7	0	60	0
01V	NHS Southport and Formby CCG	33	14	108	25	43	13	9	0	13	0	97	39
01W	NHS Stockport CCG	88	45	356	178	127	66	44	23	44	13	103	0
01X	NHS St Helens CCG	29	1	217	101	69	27	17	3	37	16	150	65
01Y	NHS Tameside and Glossop CCG	122	88	198	63	67	20	25	8	24	0	83	0
02A	NHS Trafford CCG	47	14	190	58	85	41	39	23	32	9	103	3
02D	NHS Vale Royal CCG	55	40	118	56	40	18	6	0	21	10	49	3
02E	NHS Warrington CCG	40	9	145	22	56	14	10	0	22	0	124	32
02F	NHS West Cheshire CCG	48	11	186	29	81	25	22	3	37	9	126	12
02G	NHS West Lancashire CCG	31	15	93	25	46	21	8	0	18	6	95	46
02H	NHS Wigan Borough CCG	135	89	441	256	99	33	59	36	75	42	274	135
02M	NHS Fylde & Wyre CCG	23	0	109	0	74	31	20	8	20	0	187	107
02N	NHS Airedale, Wharfedale and Craven CCG	52	29	190	94	91	56	34	23	33	16	136	67
02P	NHS Barnsley CCG	110	74	204	57	72	20	53	35	46	20	123	14
02Q	NHS Bassetlaw CCG	83	66	69	0	32	6	20	11	33	20	15	0
02R	NHS Bradford Districts CCG	97	55	354	184	115	58	45	23	39	9	280	151

02T	NHS Calderdale CCG	52	21	247	125	69	26	26	11	27	5	125	33
02W	NHS Bradford City CCG	15	2	90	46	4	0	8	0	6	0	70	30
02X	NHS Doncaster CCG	106	62	226	46	99	36	75	53	40	8	53	0
02Y	NHS East Riding of Yorkshire CCG	141	95	391	192	141	66	35	13	93	57	205	65
03A	NHS Greater Huddersfield CCG	94	61	148	15	38	0	15	0	13	0	179	79
03D	NHS Hambleton, Richmondshire and Whitby CCG	15	0	184	87	57	20	10	0	20	2	114	46
03E	NHS Harrogate and Rural District CCG	53	29	141	38	63	26	11	0	25	7	125	52
03F	NHS Hull CCG	117	79	304	153	90	38	23	3	80	53	191	75
03H	NHS North East Lincolnshire CCG	70	46	167	69	57	22	6	0	11	0	61	0
03J	NHS North Kirklees CCG	53	29	111	13	53	20	48	35	29	12	162	87
03K	NHS North Lincolnshire CCG	59	34	84	0	50	12	13	1	23	4	60	0
03L	NHS Rotherham CCG	56	20	261	113	79	27	37	19	41	15	58	0
03M	NHS Scarborough and Ryedale CCG	55	37	99	22	39	10	10	1	13	0	73	18
03N	NHS Sheffield CCG	101	28	598	299	148	47	127	87	132	80	131	0
03Q	NHS Vale of York CCG	143	95	294	91	123	52	21	0	38	2	315	166
03R	NHS Wakefield CCG	120	69	272	64	181	108	109	83	69	32	337	181
03T	NHS Lincolnshire East CCG	133	96	18	0	64	1	12	0	2	0	98	0
03V	NHS Corby CCG	14	4	16	0	27	14	8	2	9	2	22	0
03W	NHS East Leicestershire and Rutland CCG	88	40	213	11	61	0	36	13	34	0	70	0
03X	NHS Erewash CCG	29	15	128	70	47	26	8	1	17	6	41	0
03Y	NHS Hardwick CCG	54	39	87	24	31	8	23	15	28	16	30	0
04C	NHS Leicester City CCG	36	0	231	59	27	0	16	0	42	12	69	0
04D	NHS Lincolnshire West CCG	64	32	25	0	62	14	10	0	5	0	110	11
04E	NHS Mansfield and Ashfield CCG	73	46	124	15	56	17	11	0	38	18	48	0
04F	NHS Milton Keynes CCG	118	81	247	106	51	6	24	4	35	10	72	0

04G	NHS Nene CCG	199	108	480	114	165	39	85	39	93	28	165	0
04H	NHS Newark & Sherwood CCG	72	52	89	8	44	14	16	6	18	3	35	0
04J	NHS North Derbyshire CCG	149	105	348	164	131	63	65	44	71	38	111	0
04K	NHS Nottingham City CCG	119	80	318	165	73	25	40	15	67	41	43	0
04L	NHS Nottingham North and East CCG	44	22	152	62	57	25	12	1	24	8	17	0
04M	NHS Nottingham West CCG	30	16	86	30	33	13	11	4	13	3	20	0
04N	NHS Rushcliffe CCG	44	26	131	55	49	22	16	7	21	7	18	0
04Q	NHS South West Lincolnshire CCG	53	33	36	0	36	5	2	0	9	0	49	0
04R	NHS Southern Derbyshire CCG	98	24	636	331	148	42	54	17	95	41	251	23
04V	NHS West Leicestershire CCG	51	0	308	89	90	11	20	0	39	0	64	0
04Y	NHS Cannock Chase CCG	44	25	127	49	54	26	10	0	16	2	135	77
05A	NHS Coventry and Rugby CCG	120	60	495	251	70	0	44	10	47	5	211	22
05C	NHS Dudley CCG	65	21	378	192	72	6	27	5	40	7	313	178
05D	NHS East Staffordshire CCG	7	0	85	4	36	7	4	0	13	0	68	8
05F	NHS Herefordshire CCG	22	0	303	182	62	17	25	11	32	10	100	15
05G	NHS North Staffordshire CCG	77	46	147	15	83	35	16	0	36	12	134	39
05H	NHS Warwickshire North CCG	46	19	235	124	41	1	10	0	32	12	78	0
05J	NHS Redditch and Bromsgrove CCG	70	45	255	153	46	9	23	10	20	2	140	64
05L	NHS Sandwell and West Birmingham CCG	56	0	136	0	56	0	18	0	16	0	351	146
05N	NHS Shropshire CCG	163	117	422	222	119	45	62	40	64	28	189	48
05Q	NHS South East Staffordshire and Seisdon Peninsula CCG	26	0	168	37	59	12	11	0	25	1	167	71
05R	NHS South Warwickshire CCG	70	29	324	152	98	37	36	16	56	26	102	0
05T	NHS South Worcestershire CCG	32	0	434	245	90	22	68	46	41	7	166	30
05V	NHS Stafford and Surrounds CCG	54	32	80	0	68	34	11	0	25	8	119	52
05W	NHS Stoke on Trent CCG	101	63	184	31	91	38	21	1	31	4	115	0
05X	NHS Telford and Wrekin CCG	93	68	232	133	61	26	31	18	29	11	93	18
05Y	NHS Walsall CCG	158	122	150	1	33	0	22	3	19	0	152	40

06A	NHS Wolverhampton CCG	76	41	346	202	47	0	19	0	49	24	231	122
06D	NHS Wyre Forest CCG	24	7	155	81	31	3	14	5	10	0	86	33
06F	NHS Bedfordshire CCG	45	0	300	38	94	5	17	0	37	0	120	0
06H	NHS Cambridgeshire and Peterborough CCG	101	0	812	316	205	38	85	21	119	33	143	0
06K	NHS East and North Hertfordshire CCG	69	0	516	191	119	12	65	25	101	45	228	0
06L	NHS Ipswich and East Suffolk CCG	15	0	469	225	75	0	22	0	36	0	280	104
06M	NHS Great Yarmouth and Waveney CCG	66	32	157	7	74	18	10	0	16	0	141	35
06N	NHS Herts Valleys CCG	154	69	398	54	145	34	63	20	53	0	310	49
06P	NHS Luton CCG	17	0	83	0	27	0	11	0	15	0	69	0
06Q	NHS Mid Essex CCG	69	14	156	0	76	0	26	0	47	7	131	0
06T	NHS North East Essex CCG	67	20	111	0	70	0	31	7	27	0	201	52
06V	NHS North Norfolk CCG	36	9	46	0	62	14	11	0	8	0	110	26
06W	NHS Norwich CCG	30	1	35	0	56	16	14	0	5	0	130	38
06Y	NHS South Norfolk CCG	30	0	92	0	74	22	19	3	11	0	151	50
07G	NHS Thurrock CCG	22	0	81	0	23	0	8	0	12	0	42	0
07H	NHS West Essex CCG	41	0	217	43	60	2	33	12	30	0	124	0
07J	NHS West Norfolk CCG	37	11	100	0	56	13	11	0	19	0	106	26
07K	NHS West Suffolk CCG	31	0	220	66	68	12	35	17	29	2	202	91
07L	NHS Barking and Dagenham CCG	30	5	144	54	25	0	44	30	22	7	116	40
07M	NHS Barnet CCG	26	0	150	0	35	0	9	0	35	0	138	0
07N	NHS Bexley CCG	27	0	133	3	42	0	16	0	19	0	113	16
07P	NHS Brent CCG	29	0	164	0	20	0	28	3	26	0	360	220
07Q	NHS Bromley CCG	64	17	206	12	91	28	39	15	70	37	211	66
07R	NHS Camden CCG	4	0	25	0	9	0	4	0	10	0	101	3
07T	NHS City and Hackney CCG	4	0	73	0	25	0	44	23	31	11	124	13
07V	NHS Croydon CCG	77	25	257	57	53	0	54	27	43	9	153	0
07W	NHS Ealing CCG	23	0	134	0	32	0	32	3	15	0	421	258
07X	NHS Enfield CCG	46	4	153	0	16	0	15	0	25	0	137	9

07Y	NHS Hounslow CCG	16	0	129	0	21	0	26	5	24	0	337	219
08A	NHS Greenwich CCG	33	0	172	41	38	0	26	6	22	0	124	15
08C	NHS Hammersmith and Fulham CCG	15	0	51	0	13	0	18	3	6	0	209	127
08D	NHS Haringey CCG	29	0	142	0	30	0	18	0	19	0	143	23
08E	NHS Harrow CCG	13	0	103	0	22	0	17	0	24	1	293	190
08F	NHS Havering CCG	59	23	257	104	51	0	51	32	40	14	116	3
08G	NHS Hillingdon CCG	48	10	145	0	58	11	39	19	25	0	190	72
08H	NHS Islington CCG	27	0	98	0	28	0	21	3	30	13	114	21
08J	NHS Kingston CCG	74	48	108	8	31	0	11	0	17	0	68	0
08K	NHS Lambeth CCG	33	0	175	7	32	0	42	14	32	4	196	46
08L	NHS Lewisham CCG	53	14	211	66	25	0	24	2	45	21	100	0
08M	NHS Newham CCG	12	0	82	0	6	0	24	0	21	0	215	83
08N	NHS Redbridge CCG	38	1	174	32	32	0	52	31	29	5	168	52
08P	NHS Richmond CCG	59	29	85	0	38	2	12	0	19	0	103	14
08Q	NHS Southwark CCG	40	2	129	0	28	0	33	11	25	2	148	28
08R	NHS Merton CCG	20	0	113	6	29	0	20	5	29	11	135	47
08T	NHS Sutton CCG	17	0	158	57	34	2	36	23	42	24	93	15
08V	NHS Tower Hamlets CCG	17	0	143	38	19	0	27	6	17	0	150	49
08W	NHS Waltham Forest CCG	34	0	76	0	23	0	36	15	33	10	130	16
08X	NHS Wandsworth CCG	51	6	148	0	37	0	38	11	35	8	262	115
08Y	NHS West London CCG	12	0	59	0	18	0	7	0	8	0	188	86
09A	NHS Central London (Westminster) CCG	9	0	44	0	14	0	6	0	10	0	109	26
09C	NHS Ashford CCG	27	9	31	0	34	8	11	2	7	0	41	0
09D	NHS Brighton and Hove CCG	53	13	237	84	77	29	58	36	67	41	180	57
09E	NHS Canterbury and Coastal CCG	47	18	93	0	63	18	52	36	19	0	34	0
09F	NHS Eastbourne, Hailsham and Seaford CCG	74	46	190	63	43	0	36	22	25	3	97	9
09G	NHS Coastal West Sussex CCG	191	117	546	214	155	36	55	19	103	45	203	0
09H	NHS Crawley CCG	47	30	146	80	18	0	10	1	18	6	44	0

09J	NHS Dartford, Gravesham and Swanley CCG	74	39	186	43	54	6	36	18	35	10	165	57
09L	NHS East Surrey CCG	79	54	192	91	40	6	13	0	20	2	113	37
09N	NHS Guildford and Waverley CCG	48	18	205	79	62	19	18	2	45	23	107	14
09P	NHS Hastings and Rother CCG	105	77	220	98	81	36	60	46	45	23	71	0
09W	NHS Medway CCG	82	43	248	90	50	0	46	26	46	18	80	0
09X	NHS Horsham and Mid Sussex CCG	87	53	236	94	71	23	46	29	36	11	92	0
09Y	NHS North West Surrey CCG	82	32	325	121	68	1	17	0	56	21	204	50
10A	NHS South Kent Coast CCG	64	34	92	0	76	29	51	36	25	2	72	0
10C	NHS Surrey Heath CCG	30	16	85	29	29	10	5	0	11	1	44	3
10D	NHS Swale CCG	34	19	145	83	21	0	19	11	21	10	18	0
10E	NHS Thanet CCG	34	14	74	0	52	20	19	9	19	3	41	0
10J	NHS North Hampshire CCG	49	18	202	76	41	0	19	3	26	4	11	0
10K	NHS Fareham and Gosport CCG	33	3	200	74	65	20	21	6	49	27	7	0
10L	NHS Isle of Wight CCG	21	0	148	51	33	0	12	1	18	0	4	0
10Q	NHS Oxfordshire CCG	189	94	681	292	183	52	50	0	105	38	256	0
10R	NHS Portsmouth CCG	28	0	177	67	42	6	15	0	44	25	8	0
10V	NHS South Eastern Hampshire CCG	38	7	230	96	75	27	20	5	43	19	13	0
10X	NHS Southampton CCG	50	17	213	85	26	0	48	29	34	12	18	0
11A	NHS West Hampshire CCG	158	78	593	246	164	40	84	45	88	27	41	0
11E	NHS Bath and North East Somerset CCG	76	49	119	6	58	19	13	0	18	0	89	6
11J	NHS Dorset CCG	493	381	1,049	548	321	140	79	23	135	48	346	0
11M	NHS Gloucestershire CCG	68	0	706	324	187	51	52	8	96	29	146	0
11N	NHS Kernow CCG	225	142	677	314	246	111	62	21	103	38	483	226
11X	NHS Somerset CCG	135	53	715	357	216	85	18	0	158	95	210	0
12D	NHS Swindon CCG	12	0	126	3	50	9	27	11	31	9	101	6
12F	NHS Wirral CCG	126	79	524	324	113	42	22	0	34	0	303	158
13T	NHS Newcastle Gateshead CCG	27	0	346	84	136	48	93	58	86	40	289	88

14L	NHS Manchester CCG	103	35	368	115	79	2	51	10	67	24	157	0
14Y	NHS Buckinghamshire CCG	64	0	317	3	140	33	15	0	46	0	156	0
15A	NHS Berkshire West CCG	137	67	329	52	83	0	24	0	65	17	105	0
15C	NHS Bristol, North Somerset and South Gloucestershire CCG	342	216	823	305	343	170	64	0	141	52	115	0
15D	NHS Berkshire East CCG	122	64	215	0	66	0	10	0	29	0	128	0
15E	NHS Birmingham and Solihull CCG	246	90	894	262	224	19	84	0	121	13	1,143	655
15F	NHS Leeds CCG	335	230	880	456	268	129	205	147	181	108	601	271
99A	NHS Liverpool CCG	154	88	327	66	91	4	45	9	80	34	143	0
99C	NHS North Tyneside CCG	22	0	190	61	70	25	43	27	31	8	98	3
99D	NHS South Lincolnshire CCG	93	69	48	0	36	0	15	3	16	0	52	0
99E	NHS Basildon and Brentwood CCG	58	21	153	0	54	3	10	0	10	0	109	0
99F	NHS Castle Point and Rochford CCG	69	42	170	54	64	22	29	16	17	0	164	82
99G	NHS Southend CCG	59	33	181	75	50	14	36	23	22	3	164	85
99H	NHS Surrey Downs CCG	77	34	269	89	95	34	45	24	60	29	147	16
99J	NHS West Kent CCG	159	92	236	0	99	3	70	37	75	26	109	0
99K	NHS High Weald Lewes Havens CCG	74	48	122	14	50	11	24	12	26	6	71	0
99M	NHS North East Hampshire and Farnham CCG	112	81	172	46	63	20	16	0	30	8	42	0
99N	NHS Wiltshire CCG	328	257	41	0	177	69	36	2	90	37	124	0
99P	NHS Northern, Eastern and Western Devon CCG	233	105	667	106	316	113	95	31	186	88	507	107
99Q	NHS South Devon and Torbay CCG	66	22	288	95	131	59	12	0	42	8	107	0
Total		14,020	6,807	44,545	14,950	14,394	4,113	6,239	2,509	7,798	2,582	28,908	8,633

Table 5[28]: 2017/18 STP activity and activity reduction for Category 1 interventions (A-D)

		A Surgery for snoring		B Dilatation & curettage for heavy menstrual bleeding		C Knee arthroscopy with osteoarthritis		D Injection for nonspecific low back pain without sciatica	
		No of spells		No of spells		No of spells		No of spells	
STP code	STP name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
QF7	South Yorkshire and Bassetlaw STP	35	35	4	4	195	195	721	721
QGH	Herefordshire and Worcestershire STP	2	2	6	6	40	40	109	109
QH8	Mid and South Essex STP	16	16	2	2	106	106	462	462
QHG	Bedfordshire, Luton and Milton Keynes STP	5	5	3	3	61	61	158	158
QHL	Birmingham and Solihull STP	3	3	5	5	89	89	307	307
QHM	Cumbria and North East STP	128	128	21	21	355	355	2,212	2212
QJ2	Joined Up Care Derbyshire STP	19	19	4	4	50	50	364	364
QJG	Suffolk and North East Essex STP	9	9	3	3	53	53	333	333
QJK	Devon STP	19	19	2	2	36	36	246	246
QJM	Lincolnshire STP	8	8	3	3	104	104	426	426
QK1	Leicester, Leicestershire and Rutland STP	6	6	0	0	65	65	222	222
QKK	Our Healthier South East London STP	31	31	1	1	72	72	440	440
QKS	Kent and Medway STP	24	24	5	5	135	135	852	852
QM7	Hertfordshire and West Essex STP	27	27	5	5	65	65	171	171

[28] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

QMF	East London Health & Care Partnership (STP)	28	28	5	5	75	75	414	414
QMJ	North London Partners in Health & Care (STP)	20	20	4	4	35	35	298	298
QMM	Norfolk and Waveney Health & Care Partnership (STP)	52	52	9	9	40	40	212	212
QNC	Staffordshire and Stoke on Trent STP	7	7	4	4	77	77	94	94
QNQ	Frimley Health & Care ICS (STP)	5	5	2	2	30	30	89	89
QNX	Sussex and East Surrey STP	23	23	8	8	97	97	822	822
QOC	Shropshire and Telford and Wrekin STP	1	1	2	2	20	20	23	23
QOP	Greater Manchester Health and Social Care Partnership (STP)	36	36	8	8	172	172	479	479
QOQ	Humber, Coast and Vale STP	34	34	4	4	155	155	121	121
QOX	Bath and North East Somerset, Swindon and Wiltshire STP	9	9	20	20	103	103	40	40
QPM	Northamptonshire STP	5	5	13	13	63	63	124	124
QR1	Gloucestershire STP	7	7	2	2	24	24	12	12
QRL	Hampshire and the Isle of Wight STP	17	17	2	2	84	84	108	108
QRV	North West London Health & Care Partnership (STP)	18	18	21	21	148	148	229	229
QSL	Somerset STP	4	4	2	2	26	26	7	7
QT1	Nottingham and Nottinghamshire Health and Care STP	5	5	1	1	40	40	744	744
QT6	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	4	4	1	1	45	45	29	29
QU9	Buckinghamshire, Oxfordshire and Berkshire West STP	9	9	2	2	63	63	38	38
QUA	The Black Country and West Birmingham STP	11	11	7	7	139	139	203	203
QUE	Cambridgeshire and Peterborough STP	9	9	1	1	31	31	171	171
QUY	Bristol, North Somerset and South Gloucestershire STP	7	7	7	7	41	41	12	12
QVV	Dorset STP	7	7	3	3	29	29	42	42

QWE	South West London Health & Care Partnership (STP)	13	13	4	4	33	33	448	448
QWO	West Yorkshire and Harrogate (Health & Care Partnership) STP	70	70	9	9	243	243	245	245
QWU	Coventry and Warwickshire STP	27	27	12	12	92	92	121	121
QXU	Surrey Heartlands Health & Care Partnership (STP)	6	6	7	7	15	15	467	467
QYG	Cheshire and Merseyside STP	46	46	12	12	91	91	550	550
Total		812	812	236	236	3,437	3,437	13,165	13,165

Table 6[29]: 2017/18 STP activity and activity reduction for Category 2 interventions (E-K)

		E Breast reduction		F Removal of benign skin lesions		G Grommets		H Tonsillectomy		I Haemorrhoid surgery		J Hysterectomy for heavy bleeding		K Chalazia removal	
		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells	
STP code	STP name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
QF7	Leicester, Leicestershire and Rutland STP	73	29	4,362	2460	252	99	637	85	277	123	876	290	407	362
QGH	Our Healthier South East London STP	27	7	1,507	559	208	134	319	16	82	8	480	164	18	0
QH8	Kent and Medway STP	22	0	1,836	326	236	112	951	411	205	77	624	138	164	125
QHG	Hertfordshire and West Essex STP	30	9	1,876	730	188	74	591	121	135	33	386	27	76	43
QHL	East London Health & Care Partnership (STP)	57	23	1,858	310	198	48	660	5	112	0	616	162	138	98
QHM	North London Partners in Health & Care (STP)	299	149	13,502	7208	1,006	542	2,764	712	690	222	2,978	1018	597	451
QJ2	Norfolk and Waveney Health & Care Partnership (STP)	36	4	2,044	672	133	34	597	151	126	16	752	330	120	87
QJG	Staffordshire and Stoke on Trent STP	43	13	2,168	896	162	68	758	338	135	29	484	79	73	46
QJK	Frimley Health & Care ICS (STP)	37	4	2,938	1271	299	192	547	44	121	10	759	262	28	0

[29] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

QJM	Sussex and East Surrey STP	50	27	1,483	409	127	53	504	176	91	22	426	102	15	0
QK1	Shropshire and Telford and Wrekin STP	47	14	1,794	399	185	73	701	180	144	31	594	174	202	167
QKK	Greater Manchester Health and Social Care Partnership (STP)	74	25	4,254	1996	157	32	1,048	186	388	189	778	111	199	134
QKS	Humber, Coast and Vale STP	63	16	3,666	1468	252	66	1,407	561	401	208	1,168	425	85	34
QM7	Bath and North East Somerset, Swindon and Wiltshire STP	46	10	2,064	242	303	139	1,134	431	321	160	577	6	233	184
QMF	Northamptonshire STP	39	2	3,518	1295	211	8	1,313	291	400	202	561	29	632	561
QMJ	Gloucestershire STP	45	5	3,836	1988	92	0	723	32	236	83	304	0	279	225
QMM	Hampshire and the Isle of Wight STP	23	1	3,520	2077	203	110	630	202	141	30	540	119	97	68
QNC	North West London Health & Care Partnership (STP)	44	9	2,179	702	175	64	646	153	148	30	782	325	30	3
QNQ	Somerset STP	22	1	2,046	1089	118	32	330	15	99	18	365	63	97	73
QNX	Nottingham and Nottinghamshire Health and Care STP	73	19	4,775	2272	274	96	1,293	478	310	109	1,066	308	57	24
QOC	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	16	3	644	15	59	13	161	0	46	0	250	47	13	0
QOP	Buckinghamshire, Oxfordshire and Berkshire West STP	87	14	4,731	1161	466	150	1,951	502	419	124	1,404	305	423	324
QOQ	The Black Country and West Birmingham STP	105	60	2,339	752	270	152	1,002	395	199	55	740	189	61	19
QOX	Cambridgeshire and Peterborough STP	34	10	1,143	7	99	14	379	16	132	35	425	53	23	0
QPM	Bristol, North Somerset and South Gloucestershire STP	21	1	1,069	124	104	24	241	0	150	72	478	184	78	54
QR1	Dorset STP	30	11	531	0	65	4	275	0	52	0	242	0	24	4

QRL	South West London Health & Care Partnership (STP)	48	3	2,505	289	200	35	826	55	170	19	965	232	60	16
QRV	West Yorkshire and Harrogate (Health & Care Partnership) STP	106	43	2,878	278	178	19	885	15	421	174	597	31	287	207
QSL	Coventry and Warwickshire STP	10	0	1,170	382	94	43	234	2	63	2	301	66	13	0
QT1	Surrey Heartlands Health & Care Partnership (STP)	50	18	2,785	1449	184	78	525	81	136	33	471	87	94	61
QT6	Cheshire and Merseyside STP	31	13	1,312	518	101	51	239	9	78	17	234	0	13	0
QU9	Leicester, Leicestershire and Rutland STP	83	31	2,919	990	240	72	640	0	136	2	500	0	39	0
QUA	Our Healthier South East London STP	59	19	2,912	1229	186	44	847	149	191	60	819	300	124	86
QUE	Kent and Medway STP	18	0	1,276	94	155	60	557	116	72	0	389	34	85	55
QUY	Hertfordshire and West Essex STP	28	0	2,591	1354	105	7	217	0	130	30	325	0	70	39
QVV	East London Health & Care Partnership (STP)	31	7	3,295	2185	48	0	255	0	101	16	496	174	133	109
QWE	North London Partners in Health & Care (STP)	91	45	1,565	0	127	9	741	42	301	128	575	85	84	32
QWO	Norfolk and Waveney Health & Care Partnership (STP)	142	65	4,359	1110	630	345	1,936	674	534	263	1,183	204	285	201
QWU	Staffordshire and Stoke on Trent STP	50	21	2,643	1404	119	30	743	292	76	0	470	104	133	102
QXU	Frimley Health & Care ICS (STP)	47	21	1,859	695	89	3	440	64	161	66	391	38	57	34
QYG	Sussex and East Surrey STP	151	77	6,503	3184	371	130	1,591	454	344	105	1,289	271	380	298
Total		2,388	829	116,255	45,589	8,669	3,259	32,238	7,454	8,474	2,801	27,660	6,536	6,026	4,326

Table 7[30]: 2017/18 STP activity and activity reduction for Category 2 interventions (L-Q)

		L Shoulder decompression		M Carpal tunnel syndrome release		N Dupuytren's contracture release		O Ganglion excision		P Trigger finger release		Q Varicose vein surgery	
		No of spells		No of spells		No of spells		No of spells		No of spells		No of spells	
STP code	STP name	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction	2017/18 activity	Activity reduction
QF7	Leicester, Leicestershire and Rutland STP	456	250	1,358	515	430	136	312	205	292	143	380	14
QGH	Our Healthier South East London STP	148	52	1,147	661	229	51	130	72	103	19	492	142
QH8	Kent and Medway STP	277	110	741	129	267	39	109	39	108	10	610	167
QHG	Hertfordshire and West Essex STP	180	81	630	144	172	11	52	4	87	10	261	0
QHL	East London Health & Care Partnership (STP)	246	90	894	262	224	19	84	0	121	13	1,143	655
QHM	North London Partners in Health & Care (STP)	808	229	4,128	1327	1,635	610	763	415	757	258	3,811	1704

[30] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

QJ2	Norfolk and Waveney Health & Care Partnership (STP)	330	183	1,199	589	357	139	150	77	211	101	433	23
QJG	Staffordshire and Stoke on Trent STP	113	20	800	291	213	12	88	24	92	2	683	247
QJK	Frimley Health & Care ICS (STP)	299	127	955	201	447	172	107	31	228	96	614	107
QJM	Sussex and East Surrey STP	343	230	127	0	198	20	39	3	32	0	309	11
QK1	Shropshire and Telford and Wrekin STP	175	40	752	159	178	11	72	13	115	12	203	0
QKK	Greater Manchester Health and Social Care Partnership (STP)	250	33	1,026	129	256	28	180	48	213	64	892	171
QKS	Humber, Coast and Vale STP	521	268	1,105	216	449	84	304	175	247	69	560	57
QM7	Bath and North East Somerset, Swindon and Wiltshire STP	264	69	1,131	288	324	48	161	57	184	45	662	49
QMF	Northamptonshire STP	194	29	949	228	181	0	278	137	193	47	1,019	256
QMJ	Gloucestershire STP	132	4	568	0	118	0	67	3	119	13	633	56
QMM	Hampshire and the Isle of Wight STP	199	53	430	7	322	83	65	3	59	0	638	175
QNC	North West London Health & Care Partnership (STP)	309	166	791	136	391	152	73	1	146	27	738	247
QNQ	Somerset STP	264	161	472	75	158	30	31	0	70	9	214	3
QNX	Nottingham and Nottinghamshire Health and Care STP	710	438	1,889	738	535	141	302	165	340	137	871	103
QOC	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	256	185	654	355	180	71	93	58	93	39	282	66

QOP	Buckinghamshire, Oxfordshire and Berkshire West STP	803	417	2,532	1087	730	226	388	184	476	208	1,427	432
QOQ	The Black Country and West Birmingham STP	585	386	1,339	527	500	200	108	18	258	116	905	324
QOX	Cambridgeshire and Peterborough STP	416	306	286	9	285	97	76	13	139	46	314	12
QPM	Bristol, North Somerset and South Gloucestershire STP	213	112	496	114	192	53	93	41	102	30	187	0
QR1	Dorset STP	68	0	706	324	187	51	52	8	96	29	146	0
QRL	South West London Health & Care Partnership (STP)	377	123	1,763	695	446	93	219	89	302	114	102	0
QRV	West Yorkshire and Harrogate (Health & Care Partnership) STP	165	10	829	0	198	11	173	33	138	1	2,107	1198
QSL	Coventry and Warwickshire STP	135	53	715	357	216	85	18	0	158	95	210	0
QT1	Surrey Heartlands Health & Care Partnership (STP)	382	242	900	335	312	116	106	33	181	80	181	0
QT6	Cheshire and Merseyside STP	225	142	677	314	246	111	62	21	103	38	483	226
QU9	Leicester, Leicestershire and Rutland STP	390	161	1,327	347	406	85	89	0	216	55	517	0
QUA	Our Healthier South East London STP	355	184	1,010	395	208	6	86	8	124	31	1,047	486
QUE	Kent and Medway STP	101	0	812	316	205	38	85	21	119	33	143	0
QUY	Hertfordshire and West Essex STP	342	216	823	305	343	170	64	0	141	52	115	0
QVV	East London Health & Care Partnership (STP)	493	381	1,049	548	321	140	79	23	135	48	346	0

QWE	North London Partners in Health & Care (STP)	298	108	869	128	222	4	171	66	185	52	814	191
QWO	Norfolk and Waveney Health & Care Partnership (STP)	871	525	2,433	1035	882	423	501	322	422	189	2,015	951
QWU	Staffordshire and Stoke on Trent STP	236	108	1,054	527	209	38	90	26	135	43	391	22
QXU	Frimley Health & Care ICS (STP)	207	84	799	289	225	54	80	26	161	73	458	80
QYG	Sussex and East Surrey STP	794	431	2,332	848	779	255	219	47	388	135	1,490	458
Total		13,930	6,807	44,497	14,950	14,376	4,113	6,219	2,509	7,789	2,582	28,846	8,633

Table 8[31]: 2017/18 provider activity baseline estimate for Category 1 interventions (A-D) and total category 1 activity

		A Surgery for snoring	B Dilatation & curettage for heavy menstrual bleeding	C Knee arthroscopy with osteoarthritis	D Injection for nonspecific low back pain without sciatica	Category 1 total
		No of spells	No of spells	No of spells	No of spells	No of spells
Provider code	Provider name	2017/18 activity	2017/18 activity	2017/18 activity	2017/18 activity	2017/18 activity
8G301	RYALLS ANN (COUNSELLOR)	0	0	0	7	7
8G326	THE SPENCER WING	0	0	0	27	27
AAH01	TETBURY HOSPITAL TRUST	1	0	0	0	1
ADP02	KIMS HOSPITAL (NEWNHAM COURT)	0	0	14	52	66
AHH01	FOSCOTE COURT (BANBURY) TRUST	0	0	0	0	0
AJX01	SUSSEX MSK PARTNERSHIP 2 LTD	0	0	11	2	13
AVQ01	ONE ASHFORD HOSPITAL	0	0	0	0	0
RXG00	WILTSHIRE HEATH AND CARE LLP	0	0	0	0	0
NAM01	PROBUS SURGICAL CENTRE	0	0	0	0	0
NAM02	MENEAGE STREET SURGERY	0	0	0	0	0
NAM04	LISKEARD COMMUNITY HOSPITAL	0	0	0	0	0
NAM06	MORRAB SURGERY	0	0	0	0	0
NEQ01	PHOENIX HEALTH SOLUTIONS LIMITED	0	0	0	0	0
NFH01	SOMERSET SURGICAL SERVICES	0	0	1	0	1
NHW03	WIMBOURNE COMMUNITY HOSPITAL (STANDARD HEALTH)	0	0	3	0	3
NN401	TYNESIDE SURGICAL SERVICES	0	0	3	16	19

[31] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

NN501	TRAFFORD GENERAL HOSPITAL	4	0	0	0	4
NN801	THE SPENCER WING (RAMSGATE ROAD)	0	0	0	33	33
NN802	THE SPENCER WING (WILLIAM HARVEY HOSPITAL)	0	0	0	9	9
NNE02	DORKING GENERAL HOSPITAL	0	0	2	57	59
NQM01	ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE	0	0	1	0	1
NT202	NUFFIELD HEALTH, BOURNEMOUTH HOSPITAL	0	0	0	0	0
NT204	NUFFIELD HEALTH, BRENTWOOD HOSPITAL	0	0	2	0	2
NT206	NUFFIELD HEALTH, BRISTOL HOSPITAL (CHESTERFIELD)	0	0	1	0	1
NT209	NUFFIELD HEALTH, CAMBRIDGE HOSPITAL	0	0	1	0	1
NT210	NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER	0	0	3	0	3
NT211	NUFFIELD HEALTH, CHELTENHAM HOSPITAL	0	0	0	0	0
NT212	NUFFIELD HEALTH, CHICHESTER HOSPITAL	0	0	2	16	18
NT213	NUFFIELD HEALTH, DERBY HOSPITAL	0	0	1	0	1
NT214	NUFFIELD HEALTH, WESSEX HOSPITAL	0	0	0	0	0
NT215	NUFFIELD HEALTH, EXETER HOSPITAL	0	0	0	0	0
NT218	NUFFIELD HEALTH, HAYWARDS HEATH HOSPITAL	0	0	0	0	0
NT219	NUFFIELD HEALTH, HEREFORD HOSPITAL	0	0	0	0	0
NT224	NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL	0	0	2	0	2
NT225	NUFFIELD HEALTH, LEEDS HOSPITAL	11	0	8	0	19
NT226	NUFFIELD HEALTH, LEICESTER HOSPITAL	0	0	0	0	0

NT229	NUFFIELD HEALTH, NEWCASTLE UPON TYNE HOSPITAL	0	0	0	0	0
NT230	NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	0	0	6	2	8
NT233	NUFFIELD HEALTH, PLYMOUTH HOSPITAL	0	0	0	0	0
NT235	NUFFIELD HEALTH, SHREWSBURY HOSPITAL	0	0	1	0	1
NT237	NUFFIELD HEALTH, TEES HOSPITAL	0	0	2	0	2
NT238	NUFFIELD HEALTH, TAUNTON HOSPITAL	2	0	1	1	4
NT239	NUFFIELD HEALTH, TUNBRIDGE WELLS HOSPITAL	0	0	0	2	2
NT241	NUFFIELD HEALTH, WOKING HOSPITAL	0	0	0	15	15
NT242	NUFFIELD HEALTH, WOLVERHAMPTON HOSPITAL	0	0	2	15	17
NT245	NUFFIELD HEALTH, YORK HOSPITAL	0	0	2	0	2
NT301	SPIRE SOUTH BANK HOSPITAL	0	0	9	0	9
NT302	SPIRE BRISTOL HOSPITAL	0	0	7	0	7
NT304	SPIRE SOUTHAMPTON HOSPITAL	0	0	16	0	16
NT305	SPIRE PORTSMOUTH HOSPITAL	0	0	3	0	3
NT308	SPIRE GATWICK PARK HOSPITAL	0	0	1	26	27
NT309	SPIRE SUSSEX HOSPITAL	0	0	3	2	5
NT310	SPIRE TUNBRIDGE WELLS HOSPITAL	0	0	1	0	1
NT312	SPIRE ALEXANDRA HOSPITAL	0	0	19	0	19
NT313	SPIRE WELLESLEY HOSPITAL	0	0	9	140	149
NT314	SPIRE LONDON EAST	4	0	17	159	180
NT315	SPIRE BUSHEY HOSPITAL	0	0	7	0	7
NT316	SPIRE HARPENDEN HOSPITAL	2	0	14	0	16
NT317	SPIRE CAMBRIDGE LEA HOSPITAL	0	0	7	0	7
NT318	SPIRE NORWICH HOSPITAL	0	0	2	0	2
NT319	SPIRE HARTSWOOD HOSPITAL	0	0	9	0	9

NT320	SPIRE PARKWAY HOSPITAL	0	0	8	1	9
NT321	SPIRE LITTLE ASTON HOSPITAL	0	0	69	0	69
NT322	SPIRE LEICESTER HOSPITAL	0	0	22	0	22
NT324	SPIRE CHESHIRE HOSPITAL	2	0	12	0	14
NT325	SPIRE MURRAYFIELD HOSPITAL	0	0	5	5	10
NT327	SPIRE MANCHESTER HOSPITAL	0	0	5	0	5
NT332	SPIRE LEEDS HOSPITAL	0	0	13	0	13
NT333	SPIRE WASHINGTON HOSPITAL	0	0	15	49	64
NT337	SPIRE LIVERPOOL HOSPITAL	2	0	4	12	18
NT338	SPIRE YALE HOSPITAL	0	0	0	0	0
NT339	SPIRE REGENCY HOSPITAL	0	0	0	9	9
NT343	SPIRE THAMES VALLEY HOSPITAL	0	0	5	0	5
NT344	SPIRE DUNEDIN HOSPITAL	0	0	2	0	2
NT345	SPIRE CLARE PARK HOSPITAL	0	0	5	13	18
NT347	SPIRE FYLDE COAST HOSPITAL	4	0	8	155	167
NT348	SPIRE ELLAND HOSPITAL	0	0	3	5	8
NT350	SPIRE METHLEY PARK HOSPITAL	0	0	43	9	52
NT351	SPIRE HULL AND EAST RIDING HOSPITAL	0	0	35	30	65
NT364	SPIRE MONTEFIORE HOSPITAL	0	0	0	47	47
NT401	BMI - THE ALEXANDRA HOSPITAL	0	0	10	9	19
NT402	BMI - BATH CLINIC	0	0	15	2	17
NT403	BMI - THE BEARDWOOD HOSPITAL	2	0	17	1	20
NT404	BMI - THE BEAUMONT HOSPITAL	3	0	6	4	13
NT405	BMI - BISHOPS WOOD	1	0	9	11	21
NT406	BMI - THE BLACKHEATH HOSPITAL	0	0	1	1	2
NT408	BMI - THE CHAUCER HOSPITAL	0	0	0	8	8
NT409	BMI - CHELSFIELD PARK HOSPITAL	0	0	4	5	9
NT410	BMI - THE CHILTERN HOSPITAL	0	0	2	0	2
NT411	BMI - THE CLEMENTINE CHURCHILL HOSPITAL	1	0	39	2	42

NT412	BMI - THE DROITWICH SPA HOSPITAL	0	0	10	0	10
NT413	BMI - THE ESPERANCE HOSPITAL	0	0	0	0	0
NT414	BMI - FAWKHAM MANOR HOSPITAL	0	0	0	1	1
NT416	BMI - HENDON HOSPITAL	0	0	2	0	2
NT417	BMI - GORING HALL HOSPITAL	0	0	2	8	10
NT418	BMI - THE HAMPSHIRE CLINIC	0	0	1	6	7
NT419	BMI - THE HARBOUR HOSPITAL	0	0	0	0	0
NT420	BMI - THE HIGHFIELD HOSPITAL	1	0	23	1	25
NT421	BMI - THE KINGS OAK HOSPITAL	1	0	0	1	2
NT422	BMI - THE LONDON INDEPENDENT HOSPITAL	0	0	7	9	16
NT423	BMI - THE MANOR HOSPITAL	0	0	0	0	0
NT424	BMI - THE MERIDEN HOSPITAL	1	0	10	0	11
NT427	BMI - THE PARK HOSPITAL	0	0	4	3	7
NT428	BMI - THE PRINCESS MARGARET HOSPITAL	0	0	2	0	2
NT429	BMI - THE PRIORY HOSPITAL	0	0	5	0	5
NT430	BMI - THE RIDGEWAY HOSPITAL	0	0	3	0	3
NT431	BMI - THE RUNNYMEDE HOSPITAL	0	0	1	7	8
NT432	BMI - THE SANDRINGHAM HOSPITAL	0	0	3	0	3
NT433	BMI - SARUM ROAD HOSPITAL	0	0	6	0	6
NT434	BMI - THE SAXON CLINIC	0	0	2	3	5
NT435	BMI - THE SHELBURNE HOSPITAL	0	0	1	0	1
NT436	BMI - SHIRLEY OAKS HOSPITAL	0	0	5	12	17
NT437	BMI - THE SLOANE HOSPITAL	0	0	4	3	7
NT438	BMI - THE SOMERFIELD HOSPITAL	0	0	3	5	8
NT439	BMI - THE SOUTH CHESHIRE PRIVATE HOSPITAL	0	1	7	0	8
NT440	BMI - THORNBURY HOSPITAL	0	0	0	0	0
NT441	BMI - THREE SHIRES HOSPITAL	0	0	9	0	9
NT443	BMI - THE WINTERBOURNE HOSPITAL	0	0	4	0	4

NT445	BMI THE EDGBASTON HOSPITAL	0	0	3	0	3
NT446	BMI ST EDMUNDS HOSPITAL	0	0	4	0	4
NT447	BMI THE DUCHY HOSPITAL	0	0	5	1	6
NT448	BMI THE HUDDERSFIELD HOSPITAL	8	0	21	0	29
NT449	BMI THE LANCASTER HOSPITAL	0	0	11	9	20
NT450	BMI THE LINCOLN HOSPITAL	0	0	22	0	22
NT451	BMI THE CAVELL HOSPITAL	0	0	3	1	4
NT455	BMI MOUNT ALVERNIA HOSPITAL	0	0	0	6	6
NT457	BMI WOODLANDS HOSPITAL	0	0	5	7	12
NT490	BMI SOUTHEND PRIVATE HOSPITAL	0	0	0	0	0
NT497	BMI GISBURNE PARK HOSPITAL	2	0	31	1	34
NTE02	ST HUGH'S HOSPITAL	0	0	54	0	54
NTP11	SOUTHAMPTON NHS TREATMENT CENTRE	2	0	12	4	18
NTP13	BARLBOROUGH NHS TREATMENT CENTRE	0	0	7	6	13
NTP15	NORTH EAST LONDON TREATMENT CENTRE CARE UK	1	0	2	0	3
NTP16	WILL ADAMS NHS TREATMENT CENTRE	0	0	1	0	1
NTPAD	ST MARY'S NHS TREATMENT CENTRE	0	0	0	0	0
NTPAE	THE CROFT SHIFA HEALTH CENTRE	0	0	0	0	0
NTPH1	SHEPTON MALLET NHS TREATMENT CENTRE	0	0	8	3	11
NTPH2	EMERSONS GREEN NHS TREATMENT CENTRE	2	1	6	0	9
NTPH3	DEVIZES NHS TREATMENT CENTRE	0	1	2	0	3
NTPH5	PENINSULA NHS TREATMENT CENTRE	0	0	3	0	3
NTX01	ONE HEALTH GROUP LTD	0	0	0	1	1
NTX06	ONE HEALTH GROUP CLINIC - OSSET	0	0	0	4	4

NTX09	ONE HEALTH GROUP CLINIC - GAINSBOROUGH	0	0	0	4	4
NTX11	ONE HEALTH GROUP CLINIC - THORNBURY	0	0	3	5	8
NTX12	ONE HEALTH GROUP CLINIC - CLAREMONT	0	0	2	0	2
NV302	CIRCLE BATH HOSPITAL	0	18	13	3	34
NV313	CIRCLE - NOTTINGHAM NHS TREATMENT CENTRE	0	2	6	398	406
NV323	CIRCLE READING HOSPITAL	0	0	4	1	5
NVC01	ASHTEAD HOSPITAL	0	0	2	34	36
NVC02	THE BERKSHIRE INDEPENDENT HOSPITAL	0	0	0	0	0
NVC04	DUCHY HOSPITAL	0	0	33	0	33
NVC05	EUXTON HALL HOSPITAL	0	1	10	11	22
NVC06	FITZWILLIAM HOSPITAL	1	0	8	100	109
NVC07	FULWOOD HALL HOSPITAL	1	2	1	11	15
NVC08	MOUNT STUART HOSPITAL	0	0	2	0	2
NVC09	NEW HALL HOSPITAL	3	0	1	1	5
NVC0M	RAMSAY CROYDON DAY HOSPITAL	0	0	0	0	0
NVC0R	TEES VALLEY HOSPITAL	0	0	0	0	0
NVC11	NORTH DOWNS HOSPITAL	0	0	3	17	20
NVC12	OAKLANDS HOSPITAL	1	0	18	0	19
NVC13	OAKS HOSPITAL	0	0	4	35	39
NVC14	PARK HILL HOSPITAL	1	0	6	36	43
NVC15	PINEHILL HOSPITAL	0	0	4	29	33
NVC16	RENACRES HOSPITAL	0	2	1	30	33
NVC17	ROWLEY HALL HOSPITAL	0	0	5	11	16
NVC18	SPRINGFIELD HOSPITAL	0	0	30	16	46
NVC19	RIVERS HOSPITAL	0	0	0	31	31
NVC20	THE YORKSHIRE CLINIC	16	0	1	51	68
NVC21	WEST MIDLANDS HOSPITAL	1	1	19	61	82
NVC22	WINFIELD HOSPITAL	0	0	1	0	1

NVC23	WOODLAND HOSPITAL	0	8	9	3	20
NVC25	HORTON NHS TREATMENT CENTRE	0	0	15	0	15
NVC27	BOSTON WEST HOSPITAL	0	1	13	22	36
NVC28	CLIFTON PARK HOSPITAL	0	0	26	0	26
NVC29	COBALT HOSPITAL	0	0	0	0	0
NVC31	BLAKELANDS HOSPITAL	0	0	0	0	0
NVC35	TEES VALLEY TREATMENT CENTRE	0	0	1	0	1
NVC40	WOODTHORPE HOSPITAL	0	0	2	5	7
NVC44	THE WESTBOURNE CENTRE	0	0	0	0	0
NVG01	FAIRFIELD HOSPITAL	0	0	2	0	2
NVM01	COBHAM DAY SURGERY HOSPITAL	0	0	0	0	0
NVM02	EPSOM DAY SURGERY LIMITED	0	0	0	0	0
NW612	HCA - 52 ALDERLEY ROAD	0	0	2	0	2
NWF01	BENENDEN HOSPITAL	0	0	1	25	26
NWX11	BICS-COMMUNITY	0	0	2	165	167
NXM01	THE HORDER CENTRE - ST JOHNS ROAD	0	0	16	11	27
NXM04	THE MCINDOE CENTRE	0	0	0	25	25
NXP04	HATHAWAY MEDICAL CENTRE	0	0	0	0	0
NXP17	WHITE HORSE HEALTH CENTRE - IHG	0	0	0	0	0
NXP20	LAWN MEDICAL CENTRE	0	0	0	0	0
NXP37	ASPEN CENTRE	0	0	0	0	0
NXP40	LITFIELD HOUSE MEDICAL CENTRE	0	0	0	0	0
NXP41	IHG CRAVEN ROAD	0	0	0	0	0
NYW01	ASPEN - THE HOLLY	1	0	9	16	26
NYW02	ASPEN - PARKSIDE HOSPITAL	0	0	0	6	6
NYW03	ASPEN - HIGHGATE HOSPITAL	0	0	1	20	21
NYW04	ASPEN - CLAREMONT HOSPITAL	0	0	1	7	8
PHS	PHOENIX HEALTH SOLUTIONS LTD	0	0	0	0	0

R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	3	1	13	27	44
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0	0	0	0
R1F	ISLE OF WIGHT NHS TRUST	2	0	6	14	22
R1H	BARTS HEALTH NHS TRUST	12	1	17	77	107
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	8	5	19	0	32
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	4	3	5	67	79
RA3	WESTON AREA HEALTH NHS TRUST	0	0	14	0	14
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	1	12	0	13
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	5	0	1	1	7
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	6	0	13	179	198
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	6	1	53	0	60
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	0	12	271	293
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	8	2	14	169	193
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0	0	8	35	43
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	0	3	13	26	42
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	0	2	41	74	117
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	3	0	2	25	30
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	1	1	8	3	13
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	1	0	2	0	3

RBK	WALSALL HEALTHCARE NHS TRUST	2	2	25	6	35
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	2	0	7	37	46
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	9	3	6	31	49
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0	0	1	1
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0	14	63	77
RBV	THE CHRISTIE NHS FOUNDATION TRUST	0	3	0	1	4
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	0	1	1	14	16
RC1	BEDFORD HOSPITAL NHS TRUST	0	0	19	0	19
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	6	1	10	86	103
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	3	3	8	7	21
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	4	0	11	0	15
RCF	AIREDALE NHS FOUNDATION TRUST	0	0	1	1	2
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	0	0	0	0	0
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	5	2	3	64	74
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	3	1	9	20	33
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	6	3	0	29	38
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0	1	19	54	74

RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	0	10	14	29
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	3	3	12	4	22
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	5	2	16	86	109
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0	2	0	2
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	0	1	8	5	14
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	0	0	1	0	1
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	2	1	10	22	35
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	7	0	2	98	107
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	2	0	0	2
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	0	0	0	104	104
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	7	3	16	27	53
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	5	1	48	0	54
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	7	1	28	0	36
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	12	0	20	205	237
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	6	2	29	181	218
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	15	2	15	1	33
RGQ	IPSWICH HOSPITAL NHS TRUST	4	1	13	227	245
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	1	0	30	94	125

RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	1	4	2	9
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	9	1	2	61	73
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	2	0	7	2	11
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	22	0	7	58	87
RHU	PORTSMOUTH HOSPITALS NHS TRUST	9	0	28	34	71
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	2	0	29	4	35
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	27	2	14	230	273
RJ2	LEWISHAM AND GREENWICH NHS TRUST	7	0	12	11	30
RJ6	CROYDON HEALTH SERVICES NHS TRUST	1	1	6	5	13
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	2	2	159	166
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	9	5	16	4	34
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	5	0	25	34	64
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	0	2	25	0	27
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	2	0	31	23	56
RJN	EAST CHESHIRE NHS TRUST	2	0	2	0	4
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	2	0	5	131	138
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	2	0	43	260	305
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	4	1	18	145	168

RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	6	0	17	1	24
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	20	6	28	125	179
RKE	WHITTINGTON HEALTH NHS TRUST	0	0	8	3	11
RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	0	11	9	20
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	2	1	6	73	82
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	23	0	14	134	171
RLQ	WYE VALLEY NHS TRUST	1	0	9	0	10
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	1	1	45	1	48
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	35	5	4	134	178
RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	4	0	1	47	52
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	3	0	18	142	163
RMC	BOLTON NHS FOUNDATION TRUST	7	2	9	5	23
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3	0	29	71	103
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	2	4	50	5	61
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	1	1	12	29	43
RN7	DARTFORD AND GRAVESHAM NHS TRUST	0	0	16	103	119
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	3	1	45	3	52
RNH	NEWHAM UNIVERSITY HOSPITAL NHS TRUST	0	0	0	0	0

RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	4	0	59	20	83
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	4	3	32	110	149
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1	2	7	0	10
RNZ	SALISBURY NHS FOUNDATION TRUST	5	0	21	14	40
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	0	0	0	0	0
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	7	2	117	678	804
RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0
RPA	MEDWAY NHS FOUNDATION TRUST	9	3	29	37	78
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	3	0	0	0	3
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	0	0	0	0	0
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	0	1	0	0	1
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	14	0	3	1	18
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	1	1	45	1	48
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	2	0	16	59	77
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1	1	3	4	9
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2	0	3	139	144
RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	2	7	48	308	365

RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	0	2	53	15	70
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	17	3	19	52	91
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0	0	10	1	11
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	0	2	33	35
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	2	0	0	11	13
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	17	1	2	163	183
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0	0	0	0	0
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	19	1	8	269	297
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	6	1	21	9	37
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0	3	15	15	33
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	6	2	14	44	66
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4	0	1	2	7
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	3	1	3	157	164
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	0	1	23	232	256
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	8	0	9	62	79
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	6	33	400	447
RVJ	NORTH BRISTOL NHS TRUST	0	3	15	8	26

RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	4	2	18	383	407
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	7	2	37	454	500
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	0	1	2	12	15
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2	0	5	3	10
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	3	0	0	0	3
RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	1	12	11	27
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	5	1	23	177	206
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	27	1	14	25	67
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	6	1	40	220	267
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	4	0	28	184	216
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	5	0	8	72	85
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	10	1	14	33	58
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	4	1	5	3	13
RWJ	STOCKPORT NHS FOUNDATION TRUST	2	0	3	7	12
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	0	6	12	92	110
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	3	8	14	12	37
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	6	1	22	86	115
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1	0	15	385	401

RXC	EAST SUSSEX HEALTHCARE NHS TRUST	4	2	6	1	13
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	0	3	33	8	44
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	7	5	7	99	118
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	3	0	19	65	87
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	3	0	17	255	275
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	35	0	3	632	670
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	5	2	4	128	139
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	2	0	8	22	32
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	14	1	23	2	40
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1	2	9	19	31
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0	0	1	0	1
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	18	30	54	110
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	9	1	27	143	180
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0	0	0	0	0
Total*		819	237	3,455	13,180	17,691

*Please note that these numbers include non-CCG related activity which we could not identify. This explains the difference in total values set out in Tables 1-3 and Tables 4-6.

Table 9[32]: 2017/18 provider activity baseline estimate for Category 2 interventions (E-Q) and total Category 2 activity

		E Breast reduction	F Removal of benign skin lesions	G Grommets	H Tonsillectomy	I Haemorrhoid surgery	J Hysterectomy for	K Chalazia removal	L Shoulder decompression	M Carpal tunnel syndrome	N Dupuytren's	O Ganglion excision	P Trigger finger release	Q Varicose vein surgery	Category 2 total
		No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells	No of spells
Provider code	**Provider name**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**	**2017/18 activity**
8G301	RYALLS ANN (COUNSELLOR)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8G326	THE SPENCER WING	0	21	0	1	3	31	0	8	0	2	0	0	0	66
AAH01	TETBURY HOSPITAL TRUST	0	32	0	0	0	0	0	0	18	0	0	0	0	50
ADP02	KIMS HOSPITAL (NEWNHAM COURT)	0	109	0	8	19	50	0	68	132	39	18	43	0	486
AHH01	FOSCOTE COURT (BANBURY) TRUST	0	0	0	0	0	2	0	0	18	4	1	0	0	25
AJX01	SUSSEX MSK PARTNERSHIP 2 LTD	0	27	0	0	0	0	0	48	169	31	30	20	0	325
AVQ01	ONE ASHFORD HOSPITAL	0	2	0	0	2	2	0	0	4	17	9	1	0	37
RXG00	WILTSHIRE HEATH AND CARE LLP	0	1	0	0	0	0	0	0	0	0	0	0	0	1
NAM01	PROBUS SURGICAL CENTRE	0	1	0	0	0	0	0	0	307	2	0	2	0	312
NAM02	MENEAGE STREET SURGERY	0	0	0	0	0	0	0	0	2	0	0	0	0	2

[32] Figures based on 'all non-emergency spells' which includes day cases and inpatient activity and also non-emergency non-elective admissions. Due to limitations in what can be reliably measured nationally, outpatient activity is not included.

NAM04	LISKEARD COMMUNITY HOSPITAL	0	0	0	0	0	0	0	0	4	0	0	0	0	4
NAM06	MORRAB SURGERY	0	0	0	0	0	0	0	0	4	0	0	0	0	4
NEQ01	PHOENIX HEALTH SOLUTIONS LIMITED	0	3	0	0	0	0	11	0	20	0	2	0	10	46
NFH01	SOMERSET SURGICAL SERVICES	0	108	0	0	0	0	0	0	34	22	5	12	0	181
NHW03	WIMBOURNE COMMUNITY HOSPITAL (STANDARD HEALTH)	0	0	0	0	0	0	0	0	19	7	0	0	0	26
NN401	TYNESIDE SURGICAL SERVICES	5	36	0	0	18	14	0	14	8	8	3	6	8	120
NN501	TRAFFORD GENERAL HOSPITAL	0	24	0	26	1	0	0	11	72	28	30	10	0	202
NN801	THE SPENCER WING (RAMSGATE ROAD)	0	36	0	3	7	53	0	15	2	5	1	1	0	123
NN802	THE SPENCER WING (WILLIAM HARVEY HOSPITAL)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NNE02	DORKING GENERAL HOSPITAL	0	5	0	2	8	5	0	21	38	6	1	2	27	115
NQM01	ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NT202	NUFFIELD HEALTH, BOURNEMOUTH HOSPITAL	0	46	0	0	0	26	0	0	39	9	5	2	0	127
NT204	NUFFIELD HEALTH, BRENTWOOD HOSPITAL	0	1	1	32	0	49	0	7	12	2	0	0	0	104

NT206	NUFFIELD HEALTH, BRISTOL HOSPITAL (CHESTERFIELD)	0	0	0	0	6	0	0	4	21	4	2	4	0	41
NT209	NUFFIELD HEALTH, CAMBRIDGE HOSPITAL	0	0	0	0	0	0	0	3	12	9	2	4	0	30
NT210	NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER	0	0	0	0	0	0	0	6	0	0	0	0	0	6
NT211	NUFFIELD HEALTH, CHELTENHAM HOSPITAL	0	1	0	0	0	0	0	5	0	0	0	0	0	6
NT212	NUFFIELD HEALTH, CHICHESTER HOSPITAL	0	10	0	0	0	25	0	39	54	22	4	7	0	161
NT213	NUFFIELD HEALTH, DERBY HOSPITAL	0	4	0	25	0	0	0	11	1	0	0	0	0	41
NT214	NUFFIELD HEALTH, WESSEX HOSPITAL	0	3	0	0	0	5	0	48	74	32	12	12	0	186
NT215	NUFFIELD HEALTH, EXETER HOSPITAL	0	0	0	0	6	0	0	5	0	0	0	0	0	11
NT218	NUFFIELD HEALTH, HAYWARDS HEATH HOSPITAL	0	0	0	0	0	0	0	13	4	1	0	0	0	18
NT219	NUFFIELD HEALTH, HEREFORD HOSPITAL	0	5	0	3	13	4	0	3	1	11	2	3	0	45
NT224	NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL	0	2	0	0	0	0	0	16	32	12	8	12	0	82
NT225	NUFFIELD HEALTH, LEEDS HOSPITAL	0	9	0	114	78	79	0	69	143	47	20	44	0	603

NT226	NUFFIELD HEALTH, LEICESTER HOSPITAL	0	3	0	134	0	5	0	0	33	6	1	6	0	188
NT229	NUFFIELD HEALTH, NEWCASTLE UPON TYNE HOSPITAL	0	0	0	0	0	0	0	2	0	0	0	0	0	2
NT230	NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	0	8	0	0	0	0	0	124	129	70	21	34	0	386
NT233	NUFFIELD HEALTH, PLYMOUTH HOSPITAL	0	19	0	0	5	0	0	22	1	37	7	12	0	103
NT235	NUFFIELD HEALTH, SHREWSBURY HOSPITAL	0	10	0	0	0	0	0	44	135	32	25	14	0	260
NT237	NUFFIELD HEALTH, TEES HOSPITAL	0	6	0	0	0	0	0	18	62	31	12	19	0	148
NT238	NUFFIELD HEALTH, TAUNTON HOSPITAL	0	1	0	31	0	9	0	20	123	43	0	30	0	257
NT239	NUFFIELD HEALTH, TUNBRIDGE WELLS HOSPITAL	0	1	0	12	2	0	0	9	10	2	5	4	0	45
NT241	NUFFIELD HEALTH, WOKING HOSPITAL	0	3	0	0	0	0	0	9	24	5	4	5	0	50
NT242	NUFFIELD HEALTH, WOLVERHAMPTON HOSPITAL	0	3	0	0	0	0	0	25	65	18	3	20	1	135
NT245	NUFFIELD HEALTH, YORK HOSPITAL	0	1	0	0	0	0	0	32	16	21	0	1	0	71
NT301	SPIRE SOUTH BANK HOSPITAL	0	12	0	15	20	34	0	22	186	43	42	28	0	402
NT302	SPIRE BRISTOL HOSPITAL	0	0	0	0	0	0	0	139	175	100	9	45	0	468

NT304	SPIRE SOUTHAMPTON HOSPITAL	0	6	0	0	0	5	0	51	47	7	10	10	0	136
NT305	SPIRE PORTSMOUTH HOSPITAL	0	3	0	0	0	0	0	36	34	6	2	5	0	86
NT308	SPIRE GATWICK PARK HOSPITAL	0	2	0	0	0	2	0	9	8	3	3	0	12	39
NT309	SPIRE SUSSEX HOSPITAL	0	14	0	5	1	28	0	22	65	17	20	17	0	189
NT310	SPIRE TUNBRIDGE WELLS HOSPITAL	0	12	0	8	3	14	0	15	20	15	11	5	0	103
NT312	SPIRE ALEXANDRA HOSPITAL	0	137	0	0	12	42	0	15	17	6	5	9	0	243
NT313	SPIRE WELLESLEY HOSPITAL	0	25	0	0	0	0	0	58	108	52	36	11	0	290
NT314	SPIRE LONDON EAST	0	134	0	27	19	25	0	20	26	9	12	2	0	274
NT315	SPIRE BUSHEY HOSPITAL	0	41	0	0	8	0	0	23	17	7	5	5	0	106
NT316	SPIRE HARPENDEN HOSPITAL	0	34	0	27	0	0	0	13	34	13	7	10	0	138
NT317	SPIRE CAMBRIDGE LEA HOSPITAL	0	5	0	0	0	0	0	21	0	0	0	1	0	27
NT318	SPIRE NORWICH HOSPITAL	0	0	0	0	0	0	0	32	0	0	0	0	0	32
NT319	SPIRE HARTSWOOD HOSPITAL	0	6	0	19	0	0	0	13	37	16	10	9	0	110
NT320	SPIRE PARKWAY HOSPITAL	0	5	0	0	18	53	0	77	99	33	16	21	0	322
NT321	SPIRE LITTLE ASTON HOSPITAL	0	26	0	0	0	56	0	58	51	26	9	3	0	229
NT322	SPIRE LEICESTER HOSPITAL	0	22	0	0	0	0	0	51	52	16	16	15	0	172

NT324	SPIRE CHESHIRE HOSPITAL	2	127	0	32	26	12	0	18	63	43	11	14	83	431
NT325	SPIRE MURRAYFIELD HOSPITAL	0	22	0	16	5	1	0	48	108	23	6	17	94	340
NT327	SPIRE MANCHESTER HOSPITAL	0	27	0	1	1	0	0	11	37	17	13	11	64	182
NT332	SPIRE LEEDS HOSPITAL	0	154	9	123	63	0	0	85	230	55	59	42	0	820
NT333	SPIRE WASHINGTON HOSPITAL	0	32	0	4	18	18	0	14	62	27	21	15	229	440
NT337	SPIRE LIVERPOOL HOSPITAL	0	14	0	61	41	16	0	71	200	40	16	37	0	496
NT338	SPIRE YALE HOSPITAL	0	0	0	0	0	0	0	0	2	0	1	0	0	3
NT339	SPIRE REGENCY HOSPITAL	0	10	0	18	19	32	0	35	66	38	31	13	0	262
NT343	SPIRE THAMES VALLEY HOSPITAL	0	1	0	2	8	17	0	8	1	1	0	0	0	38
NT344	SPIRE DUNEDIN HOSPITAL	0	2	0	0	5	0	0	32	28	8	6	13	0	94
NT345	SPIRE CLARE PARK HOSPITAL	0	3	0	5	1	0	0	12	19	5	1	4	0	50
NT347	SPIRE FYLDE COAST HOSPITAL	0	25	0	46	5	22	0	18	38	26	6	11	117	314
NT348	SPIRE ELLAND HOSPITAL	0	6	0	0	35	57	0	62	98	31	17	19	34	359
NT350	SPIRE METHLEY PARK HOSPITAL	0	19	0	28	3	32	0	46	72	13	9	13	100	335
NT351	SPIRE HULL AND EAST RIDING HOSPITAL	0	356	0	14	1	48	0	121	70	35	10	66	0	721
NT364	SPIRE MONTEFIORE HOSPITAL	0	2	0	0	46	7	0	7	21	2	3	3	0	91

NT401	BMI - THE ALEXANDRA HOSPITAL	0	79	0	0	8	26	0	69	99	39	15	25	2	362
NT402	BMI - BATH CLINIC	0	7	0	3	13	22	0	12	2	7	0	0	0	66
NT403	BMI - THE BEARDWOOD HOSPITAL	0	7	0	9	43	7	0	17	60	20	10	21	0	194
NT404	BMI - THE BEAUMONT HOSPITAL	0	16	0	38	25	38	0	39	62	11	4	27	0	260
NT405	BMI - BISHOPS WOOD	0	39	0	12	10	19	0	1	20	16	11	3	0	131
NT406	BMI - THE BLACKHEATH HOSPITAL	0	29	0	8	6	26	0	4	7	2	3	2	0	87
NT408	BMI - THE CHAUCER HOSPITAL	0	55	0	12	38	33	0	5	24	52	35	11	0	265
NT409	BMI - CHELSFIELD PARK HOSPITAL	0	15	0	21	1	27	0	9	16	3	2	2	0	96
NT410	BMI - THE CHILTERN HOSPITAL	0	0	0	3	5	11	0	7	0	0	0	0	0	26
NT411	BMI - THE CLEMENTINE CHURCHILL HOSPITAL	0	33	0	14	35	18	0	13	56	7	10	6	0	192
NT412	BMI - THE DROITWICH SPA HOSPITAL	0	18	0	11	3	43	4	39	130	31	22	10	33	344
NT413	BMI - THE ESPERANCE HOSPITAL	0	28	0	13	10	19	0	6	4	1	0	1	0	82
NT414	BMI - FAWKHAM MANOR HOSPITAL	0	32	0	1	18	16	0	8	10	5	4	3	0	97

NT416	BMI - HENDON HOSPITAL	0	10	0	0	3	22	0	3	16	3	6	5	19	87
NT417	BMI - GORING HALL HOSPITAL	0	2	0	0	0	58	0	8	30	14	5	12	0	129
NT418	BMI - THE HAMPSHIRE CLINIC	0	23	0	11	7	7	0	19	17	5	2	4	0	95
NT419	BMI - THE HARBOUR HOSPITAL	0	0	0	1	3	0	0	1	81	0	0	0	0	86
NT420	BMI - THE HIGHFIELD HOSPITAL	0	38	0	33	16	56	0	71	62	70	42	48	0	436
NT421	BMI - THE KINGS OAK HOSPITAL	0	21	0	0	1	11	0	40	53	11	5	7	0	149
NT422	BMI - THE LONDON INDEPENDENT HOSPITAL	0	156	0	10	67	3	0	14	60	7	9	8	1	335
NT423	BMI - THE MANOR HOSPITAL	0	3	0	0	0	7	0	1	2	0	0	4	0	17
NT424	BMI - THE MERIDEN HOSPITAL	0	6	0	18	2	37	0	52	68	7	10	6	0	206
NT427	BMI - THE PARK HOSPITAL	0	62	0	3	9	86	0	34	0	0	0	0	0	194
NT428	BMI - THE PRINCESS MARGARET HOSPITAL	0	4	0	0	8	14	0	6	5	2	0	2	0	41
NT429	BMI - THE PRIORY HOSPITAL	0	4	0	0	0	32	0	21	43	3	8	6	0	117
NT430	BMI - THE RIDGEWAY HOSPITAL	0	4	0	12	38	15	0	14	10	8	1	3	0	105
NT431	BMI - THE RUNNYMEDE HOSPITAL	0	24	0	0	9	0	0	0	4	0	0	3	0	40

NT432	BMI - THE SANDRINGHAM HOSPITAL	0	3	0	0	14	0	0	0	0	0	0	0	0	17
NT433	BMI - SARUM ROAD HOSPITAL	0	5	0	2	0	6	0	9	38	24	9	8	0	101
NT434	BMI - THE SAXON CLINIC	0	18	0	0	1	5	0	26	46	7	5	11	0	119
NT435	BMI - THE SHELBURNE HOSPITAL	0	6	0	0	0	0	0	14	0	0	0	0	0	20
NT436	BMI - SHIRLEY OAKS HOSPITAL	0	8	0	7	13	41	0	19	89	16	22	13	15	243
NT437	BMI - THE SLOANE HOSPITAL	0	2	0	25	8	9	0	3	10	4	0	4	0	65
NT438	BMI - THE SOMERFIELD HOSPITAL	0	32	0	7	2	40	0	5	14	8	5	9	0	122
NT439	BMI - THE SOUTH CHESHIRE PRIVATE HOSPITAL	0	16	0	22	6	27	0	41	80	21	6	20	0	239
NT440	BMI - THORNBURY HOSPITAL	0	4	0	0	33	71	0	10	21	10	7	3	0	159
NT441	BMI - THREE SHIRES HOSPITAL	0	45	0	0	35	37	0	42	158	35	26	21	0	399
NT443	BMI - THE WINTERBOURNE HOSPITAL	0	7	0	0	0	0	0	113	43	18	3	11	0	195
NT445	BMI THE EDGBASTON HOSPITAL	0	12	0	0	8	43	0	23	62	14	22	10	0	194
NT446	BMI ST EDMUNDS HOSPITAL	0	0	0	0	3	11	0	0	21	0	0	0	0	35

NT447	BMI THE DUCHY HOSPITAL	0	1	0	7	0	0	0	9	14	1	2	3	24	61
NT448	BMI THE HUDDERSFIELD HOSPITAL	0	8	0	51	8	12	0	40	47	6	0	9	0	181
NT449	BMI THE LANCASTER HOSPITAL	0	30	0	0	4	4	0	17	18	21	12	9	0	115
NT450	BMI THE LINCOLN HOSPITAL	0	2	0	0	0	0	0	7	0	0	0	0	0	9
NT451	BMI THE CAVELL HOSPITAL	0	36	0	13	0	47	0	17	11	5	0	1	0	130
NT455	BMI MOUNT ALVERNIA HOSPITAL	0	8	0	15	0	13	0	0	3	6	2	1	0	48
NT457	BMI WOODLANDS HOSPITAL	0	24	0	6	32	52	0	4	106	53	26	18	74	395
NT490	BMI SOUTHEND PRIVATE HOSPITAL	0	70	0	0	0	0	2	0	56	0	3	3	0	134
NT497	BMI GISBURNE PARK HOSPITAL	0	14	0	38	4	10	1	34	57	22	7	15	0	202
NTE02	ST HUGH'S HOSPITAL	0	14	0	3	1	20	0	56	87	13	3	3	0	200
NTP11	SOUTHAMPTON NHS TREATMENT CENTRE	0	213	0	96	14	45	0	1	165	10	47	25	8	624
NTP13	BARLBOROUGH NHS TREATMENT CENTRE	0	3	0	0	0	0	0	122	0	18	26	26	0	195
NTP15	NORTH EAST LONDON TREATMENT CENTRE CARE UK	0	298	0	0	78	0	25	7	190	45	82	43	26	794
NTP16	WILL ADAMS NHS TREATMENT CENTRE	0	180	0	0	0	0	18	0	52	11	26	9	45	341

NTPAD	ST MARY'S NHS TREATMENT CENTRE	0	123	0	0	5	0	0	0	240	44	17	46	0	475
NTPAE	THE CROFT SHIFA HEALTH CENTRE	0	0	0	0	0	0	12	0	0	0	0	0	0	12
NTPH1	SHEPTON MALLET NHS TREATMENT CENTRE	0	22	0	5	3	5	1	18	277	49	5	54	0	439
NTPH2	EMERSONS GREEN NHS TREATMENT CENTRE	0	59	0	45	4	57	36	0	251	98	31	29	79	689
NTPH3	DEVIZES NHS TREATMENT CENTRE	0	15	0	10	2	0	8	0	2	42	7	13	11	110
NTPH5	PENINSULA NHS TREATMENT CENTRE	0	8	0	0	0	0	0	69	202	59	30	40	0	408
NTX01	ONE HEALTH GROUP LTD	0	40	0	0	2	0	0	1	5	0	0	0	0	48
NTX06	ONE HEALTH GROUP CLINIC - OSSET	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NTX09	ONE HEALTH GROUP CLINIC - GAINSBOROUGH	0	0	0	0	0	0	0	0	1	0	0	0	0	1
NTX11	ONE HEALTH GROUP CLINIC - THORNBURY	0	79	0	0	8	18	0	48	115	33	15	21	0	337
NTX12	ONE HEALTH GROUP CLINIC - CLAREMONT	0	33	0	0	4	9	0	16	22	8	4	4	0	100
NV302	CIRCLE BATH HOSPITAL	0	40	0	18	16	80	0	165	90	73	11	26	120	639
NV313	CIRCLE - NOTTINGHAM NHS TREATMENT CENTRE	0	1,444	0	0	58	99	1	116	656	131	64	110	117	2,796

NV323	CIRCLE READING HOSPITAL	0	14	0	16	22	24	0	67	66	19	5	20	0	253
NVC01	ASHTEAD HOSPITAL	0	33	0	6	15	7	0	15	40	10	10	1	24	161
NVC02	THE BERKSHIRE INDEPENDENT HOSPITAL	0	5	0	0	4	2	0	34	66	15	8	10	0	144
NVC04	DUCHY HOSPITAL	0	41	0	0	27	0	0	17	119	123	27	43	104	501
NVC05	EUXTON HALL HOSPITAL	0	175	0	15	35	40	0	64	95	68	24	11	0	527
NVC06	FITZWILLIAM HOSPITAL	0	9	0	29	13	55	0	99	47	14	8	4	24	302
NVC07	FULWOOD HALL HOSPITAL	0	92	0	15	27	36	0	72	122	61	39	20	131	615
NVC08	MOUNT STUART HOSPITAL	0	84	0	11	21	68	0	39	99	59	5	21	0	407
NVC09	NEW HALL HOSPITAL	0	13	0	13	5	33	0	165	49	41	11	18	0	348
NVC0M	RAMSAY CROYDON DAY HOSPITAL	0	0	0	0	0	0	0	0	1	0	0	0	0	1
NVC0R	TEES VALLEY HOSPITAL	0	63	0	0	1	0	0	0	4	1	1	1	0	71
NVC11	NORTH DOWNS HOSPITAL	0	34	0	0	11	15	0	22	45	3	6	2	17	155
NVC12	OAKLANDS HOSPITAL	0	46	0	30	4	22	0	48	155	44	48	51	0	448
NVC13	OAKS HOSPITAL	0	79	0	9	16	25	0	28	14	26	14	7	126	344
NVC14	PARK HILL HOSPITAL	0	7	0	2	0	0	0	4	21	9	9	6	0	58
NVC15	PINEHILL HOSPITAL	0	16	0	22	37	32	0	1	61	9	7	17	0	202
NVC16	RENACRES HOSPITAL	0	37	0	12	13	16	5	40	52	26	2	9	0	212
NVC17	ROWLEY HALL HOSPITAL	0	15	0	0	16	46	0	60	44	29	0	18	0	228

NVC18	SPRINGFIELD HOSPITAL	0	17	0	78	49	74	15	23	66	15	10	11	0	358
NVC19	RIVERS HOSPITAL	0	7	0	25	99	65	0	0	111	14	2	16	1	340
NVC20	THE YORKSHIRE CLINIC	0	262	0	69	55	21	2	117	333	154	85	60	0	1,158
NVC21	WEST MIDLANDS HOSPITAL	0	8	0	14	15	102	0	16	104	26	7	15	0	307
NVC22	WINFIELD HOSPITAL	0	8	0	6	8	8	0	8	98	20	5	15	0	176
NVC23	WOODLAND HOSPITAL	0	41	0	8	27	55	9	16	70	52	36	25	0	339
NVC25	HORTON NHS TREATMENT CENTRE	0	13	0	0	0	0	0	154	325	58	16	46	0	612
NVC27	BOSTON WEST HOSPITAL	0	6	0	0	0	0	0	97	2	18	2	0	30	155
NVC28	CLIFTON PARK HOSPITAL	0	1	0	0	0	0	0	58	69	43	3	11	0	185
NVC29	COBALT HOSPITAL	0	87	0	0	9	0	0	2	35	19	27	13	23	215
NVC31	BLAKELANDS HOSPITAL	0	61	0	0	21	0	14	70	125	21	20	27	0	359
NVC35	TEES VALLEY TREATMENT CENTRE	0	664	0	0	25	0	0	6	104	41	27	19	9	895
NVC40	WOODTHORPE HOSPITAL	0	16	0	0	1	25	0	36	105	47	12	28	0	270
NVC44	THE WESTBOURNE CENTRE	0	72	0	0	0	0	39	0	52	0	2	5	48	218
NVG01	FAIRFIELD HOSPITAL	0	166	0	23	18	53	4	9	63	13	5	5	162	521
NVM01	COBHAM DAY SURGERY HOSPITAL	0	394	0	0	0	0	0	0	27	18	10	6	8	463
NVM02	EPSOM DAY SURGERY LIMITED	0	243	0	0	8	0	0	0	38	11	4	9	25	338
NW612	HCA - 52 ALDERLEY ROAD	0	12	0	1	0	0	7	0	4	7	2	6	0	39

NWF01	BENENDEN HOSPITAL	0	19	0	15	9	21	0	29	23	17	9	6	0	148
NWX11	BICS-COMMUNITY	0	13	0	0	0	0	0	32	153	27	55	40	0	320
NXM01	THE HORDER CENTRE - ST JOHNS ROAD	0	13	0	0	0	0	0	145	37	12	11	8	0	226
NXM04	THE MCINDOE CENTRE	0	12	0	0	0	0	0	24	49	36	15	20	0	156
NXP04	HATHAWAY MEDICAL CENTRE	0	2	0	0	0	0	0	0	8	0	0	0	0	10
NXP17	WHITE HORSE HEALTH CENTRE - IHG	0	1	0	0	0	0	0	0	2	0	0	0	0	3
NXP20	LAWN MEDICAL CENTRE	0	0	0	0	0	0	0	0	5	0	0	0	0	5
NXP37	ASPEN CENTRE	0	0	0	0	0	0	0	0	25	0	0	0	0	25
NXP40	LITFIELD HOUSE MEDICAL CENTRE	0	0	0	0	0	0	0	0	9	0	0	0	0	9
NXP41	IHG CRAVEN ROAD	0	0	0	0	0	0	0	0	13	0	0	0	0	13
NYW01	ASPEN - THE HOLLY	0	94	0	44	1	26	0	23	86	25	21	17	0	337
NYW02	ASPEN - PARKSIDE HOSPITAL	0	7	0	0	0	2	0	12	17	4	8	7	0	57
NYW03	ASPEN - HIGHGATE HOSPITAL	0	67	0	11	1	0	0	7	15	5	4	7	0	117
NYW04	ASPEN - CLAREMONT HOSPITAL	0	8	0	0	12	26	0	17	33	4	1	1	0	102
PHS	PHOENIX HEALTH SOLUTIONS LTD	0	44	0	0	0	0	7	0	35	0	3	0	22	111
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	29	904	82	344	73	160	91	56	192	75	30	28	267	2,331

R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	25	0	0	0	0	0	0	49	5	9	2	0	90
R1F	ISLE OF WIGHT NHS TRUST	0	123	7	64	35	63	5	19	127	30	8	14	0	495
R1H	BARTS HEALTH NHS TRUST	20	796	127	705	139	239	49	48	303	42	60	50	726	3,304
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2	713	57	267	121	113	8	17	153	25	27	25	760	2,288
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	5	547	32	118	50	194	4	55	252	94	23	53	0	1,427
RA3	WESTON AREA HEALTH NHS TRUST	0	29	0	0	17	16	0	49	94	61	5	25	0	296
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	343	13	0	19	96	9	40	139	32	2	37	0	730
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	0	1,395	106	202	35	95	43	0	86	1	0	9	0	1,972
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	4	188	65	100	12	134	0	20	172	56	2	17	105	875
RAE	BRADFORD TEACHING HOSPITALS NHS	34	552	109	216	25	162	43	25	214	37	9	21	304	1,751

	FOUNDATION TRUST														
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0	408	49	272	57	181	111	74	151	38	20	17	328	1,706
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	50	2,490	45	424	84	141	25	35	282	123	33	62	568	4,362
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0	114	0	0	0	0	0	13	11	0	4	0	0	142
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	2	126	0	0	23	71	25	40	137	11	17	22	0	474
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	0	510	0	0	73	135	9	57	193	72	43	28	191	1,311
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	13	392	38	201	92	109	12	185	218	85	24	33	119	1,521
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	4	348	75	133	39	172	5	32	179	57	13	38	196	1,291
RBD	DORSET COUNTY HOSPITAL NHS	8	337	20	92	22	142	10	136	251	94	14	32	69	1,227

	FOUNDATION TRUST														
RBK	WALSALL HEALTHCARE NHS TRUST	10	443	21	168	57	127	0	125	103	22	18	16	133	1,243
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	27	1,563	75	180	21	110	4	82	427	105	15	23	261	2,893
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	57	2,478	46	223	59	253	86	31	292	104	36	66	121	3,852
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	1	0	0	0	0	0	0	0	0	0	0	0	1
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	471	128	303	0	0	20	0	0	0	6	0	0	928
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	474	28	169	22	93	78	116	252	85	6	30	87	1,442
RBV	THE CHRISTIE NHS FOUNDATION TRUST	1	279	0	0	2	52	0	0	0	0	0	0	0	334
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	1	456	5	0	4	73	7	40	121	39	18	40	109	913

RC1	BEDFORD HOSPITAL NHS TRUST	3	1,027	50	70	30	113	5	15	131	36	5	15	114	1,614
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	5	310	44	336	52	100	20	24	167	45	16	21	102	1,242
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	29	426	67	281	48	193	20	166	403	113	34	45	545	2,370
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	15	182	50	111	41	101	27	65	196	78	16	32	0	914
RCF	AIREDALE NHS FOUNDATION TRUST	1	88	48	0	19	118	28	32	127	37	16	9	130	653
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	0	275	96	114	1	0	19	0	1	0	11	0	0	517
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	4	775	35	166	28	107	58	30	131	53	8	20	135	1,550
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	19	104	39	111	19	90	2	57	84	58	6	21	2	612

RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	3	1,439	22	150	10	171	0	0	1	0	2	2	0	1,800
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	17	371	81	193	16	120	35	59	150	44	9	9	43	1,147
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	130	60	272	51	146	0	62	128	43	2	6	108	1,010
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	5	393	78	350	49	117	7	49	85	39	11	18	100	1,301
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	25	2,220	117	338	105	378	97	283	472	160	34	66	334	4,629
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	93	0	0	3	0	0	0	70	26	3	3	0	198
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	4	1,413	0	0	59	149	124	184	505	173	52	78	261	3,002

RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	0	48	0	0	12	86	0	17	58	34	11	25	0	291
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	30	926	85	164	30	150	7	163	99	73	25	33	244	2,029
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	13	507	0	134	28	0	46	84	104	51	8	10	195	1,180
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	5	0	0	0	391	0	0	0	0	0	0	0	396
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	0	2	0	0	0	0	0	0	3	0	0	0	0	5
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	5	1,542	57	391	44	178	137	48	189	27	17	18	201	2,854
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	2	1,070	38	164	33	140	34	85	128	51	32	26	109	1,912
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	9	407	35	132	58	168	125	58	219	71	29	30	0	1,341
RFS	CHESTERFIELD ROYAL HOSPITAL	8	538	29	128	19	191	24	80	228	75	42	44	66	1,472

	NHS FOUNDATION TRUST														
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	17	1,288	102	366	54	311	59	77	532	138	46	76	94	3,160
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6	790	67	201	32	84	31	63	147	46	10	13	37	1,527
RGQ	IPSWICH HOSPITAL NHS TRUST	15	288	39	204	43	197	59	13	478	70	17	35	248	1,706
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	7	1,185	73	174	30	138	0	34	233	74	45	30	253	2,276
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10	353	84	400	23	173	23	35	329	94	56	64	47	1,691
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	19	1,733	133	230	61	291	15	65	195	171	37	96	128	3,174
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	0	401	36	175	11	223	11	29	221	38	38	24	23	1,230
RHQ	SHEFFIELD TEACHING HOSPITALS NHS	51	2,374	0	116	109	338	252	119	677	168	133	143	207	4,687

	FOUNDATION TRUST														
RHU	PORTSMOUTH HOSPITALS NHS TRUST	25	554	94	348	52	368	9	51	313	129	34	77	29	2,083
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	20	312	44	182	8	97	19	43	183	44	9	27	118	1,106
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	73	903	48	343	110	160	19	70	255	63	80	60	416	2,600
RJ2	LEWISHAM AND GREENWICH NHS TRUST	0	1,062	68	539	61	222	3	54	333	52	40	60	82	2,576
RJ6	CROYDON HEALTH SERVICES NHS TRUST	7	266	18	108	40	135	0	49	163	37	33	29	138	1,023
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	45	586	29	241	97	79	0	3	209	47	47	57	396	1,836
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	15	391	48	173	22	126	3	84	330	86	40	53	62	1,433
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	34	1,148	97	279	70	434	10	52	180	101	16	31	419	2,871

RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	4	317	61	251	28	180	8	6	186	51	15	15	15	1,137
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	20	262	15	223	45	278	8	75	161	71	22	28	0	1,208
RJN	EAST CHESHIRE NHS TRUST	7	140	7	101	14	77	34	24	77	55	17	12	0	565
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	17	655	44	124	1	119	8	20	141	56	17	26	58	1,286
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	8	2,307	60	188	139	278	26	131	385	129	51	97	434	4,233
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	2	1,001	103	271	33	153	9	124	248	99	22	59	96	2,220
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	15	1,007	111	294	34	274	11	93	306	70	18	27	408	2,668
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	36	2,092	66	596	39	235	140	80	442	65	26	34	300	4,151
RKE	WHITTINGTON HEALTH NHS TRUST	0	671	0	0	67	34	0	21	119	28	22	26	32	1,020

RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	84	0	0	0	0	0	127	284	94	33	51	0	673
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	12	452	48	234	66	293	9	91	503	130	38	62	364	2,302
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	0	655	175	447	27	203	231	29	233	68	42	41	624	2,775
RLQ	WYE VALLEY NHS TRUST	5	848	92	70	15	54	4	16	309	49	25	26	100	1,613
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	0	290	0	0	20	76	0	36	205	29	10	32	38	736
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	12	2,069	94	290	80	336	21	55	150	230	39	25	474	3,875
RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	19	414	9	77	33	63	0	29	111	43	2	19	216	1,035
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	0	246	50	118	30	106	0	21	321	73	33	51	0	1,049

RMC	BOLTON NHS FOUNDATION TRUST	11	420	55	193	9	128	11	34	158	24	14	23	73	1,153
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	1	236	51	189	46	132	1	105	127	41	16	20	88	1,053
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	12	231	50	181	52	182	3	22	149	81	33	48	91	1,135
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	14	555	73	231	36	195	25	58	367	89	36	54	14	1,747
RN7	DARTFORD AND GRAVESHAM NHS TRUST	8	398	1	0	166	203	0	81	233	45	42	37	162	1,376
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	14	1,506	63	204	16	208	23	56	298	51	22	27	449	2,937
RNH	NEWHAM UNIVERSITY HOSPITAL NHS TRUST	0	1	0	0	0	0	0	0	0	0	0	0	0	1
RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	14	118	26	221	11	241	3	40	274	76	15	37	176	1,252
RNQ	KETTERING GENERAL HOSPITAL	4	344	59	126	59	181	7	41	68	44	13	29	52	1,027

	NHS FOUNDATION TRUST														
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	10	467	34	86	27	208	50	58	141	46	22	22	119	1,290
RNZ	SALISBURY NHS FOUNDATION TRUST	26	717	37	121	15	84	8	135	31	33	9	29	62	1,307
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	0	952	91	88	0	0	0	0	2	0	0	0	0	1,133
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	17	366	98	180	52	205	5	123	301	124	98	70	84	1,723
RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0	2	0	0	0	0	1,098	0	0	0	0	0	0	1,100
RPA	MEDWAY NHS FOUNDATION TRUST	10	267	83	465	31	249	0	82	95	13	16	11	102	1,424
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	64	942	0	18	0	0	3	0	208	96	48	39	1	1,419
RPY	THE ROYAL MARSDEN NHS	56	203	0	2	1	7	0	0	0	0	0	0	0	269

	FOUNDATION TRUST														
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	0	458	232	246	0	279	7	0	0	0	6	0	0	1,228
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	32	110	0	136	46	3	42	109	160	41	26	47	11	763
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	47	1,470	112	249	25	193	6	39	221	114	41	67	164	2,748
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	11	664	79	288	100	144	5	46	244	72	51	50	142	1,896
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	5	151	42	205	44	68	7	32	121	39	14	13	159	900
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	4	322	0	107	60	33	0	4	91	32	81	39	0	773
RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	14	1,178	45	292	56	303	4	62	347	109	10	42	632	3,094

RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	18	61	0	0	29	211	0	25	167	98	78	71	114	872
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	51	1,543	143	418	107	220	43	144	370	125	97	66	561	3,888
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	15	395	39	165	27	159	56	183	569	184	70	113	178	2,153
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	94	0	0	0	0	0	50	258	69	10	40	0	521
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	71	769	0	170	31	1	5	26	157	10	16	16	650	1,922
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	4	1,423	60	474	83	89	0	44	130	22	20	28	228	2,605
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0	1	0	2	0	0	0	0	0	0	0	0	0	3
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS	68	2,018	188	403	55	318	22	1	290	107	56	34	448	4,008

	FOUNDATION TRUST														
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	22	402	60	240	35	210	21	50	558	175	44	76	122	2,015
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	40	547	0	0	22	242	0	103	449	180	52	93	0	1,728
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	11	706	80	369	45	365	14	87	686	232	57	121	293	3,066
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	56	2,289	75	322	28	183	7	35	385	130	27	65	260	3,862
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	18	355	32	240	66	132	73	78	288	41	14	46	236	1,619
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	2	424	60	300	86	209	3	96	312	65	13	33	147	1,750
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	34	1,878	113	296	63	264	55	21	411	106	18	42	606	3,907

RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	300	59	213	62	204	10	30	383	122	29	55	0	1,475
RVJ	NORTH BRISTOL NHS TRUST	36	1,688	0	0	71	175	1	150	182	81	16	27	133	2,560
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	0	211	46	218	52	242	11	53	281	61	51	80	141	1,447
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	0	1,844	120	552	120	290	39	108	243	128	78	48	172	3,742
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	21	148	0	0	27	166	0	12	124	48	46	20	0	612
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	273	20	0	9	124	45	22	103	34	7	9	177	823
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	0	17	0	17	2	0	2	0	36	6	4	4	0	88
RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	363	92	242	56	108	151	12	62	27	16	7	47	1,183

RW6	PENNINE ACUTE HOSPITALS NHS TRUST	12	597	46	394	51	244	103	148	409	68	50	68	656	2,846
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	54	1,253	191	497	101	236	21	97	519	196	33	97	470	3,765
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	37	813	90	324	68	224	11	90	27	119	19	5	210	2,037
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	51	1,452	166	497	126	504	196	76	478	97	29	61	157	3,890
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	24	147	48	328	47	231	7	35	113	42	19	23	85	1,149
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	16	426	96	338	58	166	68	102	196	40	22	31	253	1,812
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	9	427	131	285	53	146	117	14	315	82	48	53	129	1,809
RWJ	STOCKPORT NHS FOUNDATION TRUST	4	287	53	195	39	140	7	75	342	115	38	37	1	1,333
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	9	484	101	225	19	284	6	57	484	80	43	32	345	2,169
RWW	WARRINGTON AND HALTON HOSPITALS	5	207	28	110	45	57	54	35	153	37	11	30	205	977

	NHS FOUNDATION TRUST														
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	9	470	158	364	27	153	11	70	335	66	34	15	289	2,001
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	60	789	107	302	61	239	81	145	43	53	14	5	0	1,899
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	6	605	35	273	58	194	38	60	143	55	36	22	128	1,653
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	35	1,010	120	410	66	232	120	73	148	217	126	86	420	3,063
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	14	1,226	58	333	64	177	9	98	287	96	42	65	316	2,785
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	27	758	33	292	77	211	184	37	27	41	8	7	229	1,931
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	14	1,468	51	211	12	119	17	13	107	90	13	26	0	2,141
RXN	LANCASHIRE TEACHING HOSPITALS NHS	25	1,796	47	230	15	137	40	43	113	62	49	15	531	3,103

	FOUNDATION TRUST														
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	28	2,331	216	217	59	298	46	60	237	80	55	40	109	3,776
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	19	351	119	35	30	113	5	18	274	132	16	43	138	1,293
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	13	592	118	323	64	210	124	50	350	81	55	54	552	2,586
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	2	405	52	145	42	202	6	98	166	46	25	25	274	1,488
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0	267	0	0	12	0	61	18	103		10	16	52	596
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	84	557	26	275	116	245	139	28	174	26	18	16	1,064	2,768
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	10	1,608	85	205	30	297	3	125	422	106	39	80	205	3,215
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Total*		2,392	116,676	8,678	32,345	8,493	27,683	6,042	14,020	44,545	14,394	6,239	7,798	28,908	318,213

*Please note that these numbers include non-CCG related activity which we could not identify. This explains the difference in total values set out in Tables 1-3 and Tables 4-6.

Appendix 5: 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 6: The NHS Standard Contract

12. Amendments to the Contract wording are shown below. We intend that this will 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.

13. These new provisions will be added to Service Condition 29 of the Contract, which already contains related arrangements for Prior Approval Schemes put in place locally by commissioners.

14. The new provisions will 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).

15. 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. (See Appendix 3 for the Technical glossary. Note that the definition of Prior Approval Schemes in The NHS Standard Contract includes both Individual Funding Requests and Prior Approval).

16. The specific wording amendments, to be added to Service Condition 29 of the contract, are as follows:

Evidence-Based Interventions Policy

29.28 The Parties must comply with their respective obligations under the Evidence-Based Interventions Policy.

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

29.30 The Provider must manage Referrals and provide the Services in accordance with the Evidence-Based Interventions Policy.

29.31 If the Provider carries out

29.31.1 a Category 1 Intervention without evidence of appropriate Prior Approval having been granted by the relevant Commissioner; or

29.31.2 a Category 2 Intervention other than in accordance with the

Evidence-Based Interventions Policy, the relevant Commissioner will not be liable to pay for that Intervention.

29.32 For the avoidance of doubt, any Commissioner may, at its absolute discretion, impose by means of a Prior Approval Scheme notified to the Provider in accordance with SC29.24 (Prior Approval Scheme) preconditions in relation to any Category 1 Intervention or Category 2 Intervention more stringent than those set out or referred to in SC29.28 – SC29.31 and/or the Evidence-Based Interventions Policy.

17. For reference, the associated definitions within the Contract will be:

- **Evidence-Based Interventions Policy** - the national policy relating to the commissioning of interventions which are clinically inappropriate or which are appropriate only when performed in specific circumstances, published by NHS England.

- **Category 1 Interventions** - interventions which should not be routinely commissioned or performed, described as Category 1 Interventions in Evidence-Based Interventions Policy.

- **Category 2 Interventions** - interventions which should only be routinely commissioned or performed when specific criteria are met, described as Category 2 Interventions in Evidence-Based Interventions Policy.

Appendix 7: Procedure and diagnostic codes

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, NICE-accredited and specialist society guidance alongside engagement with our demonstrator sites to identify the appropriate codes.

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.

Adult snoring surgery (not OSA)
when left(der.Spell_Dominant_Procedure,4) in ('F324','F325','F326') and der.Spell_Primary_Diagnosis not like '%G473%' and APCS.Age_At_Start_of_Spell_SUS between 18 and 120 then 'A_snoring'

Dilatation and curettage for heavy menstrual bleeding
when left(der.Spell_Dominant_Procedure,4) in ('Q103') 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]%' then 'B_menstr_D&C'

Knee arthroscopy with osteoarthritis
when der.Spell_Dominant_Procedure in ('W821','W822','W823','W828','W829','W851','W852','W853','W858','W859','W861+KNEE','W831+KNEE','W832+KNEE','W833+KNEE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and der.Spell_Primary_Diagnosis like 'M1[57]%' then 'C_knee_arth'

Injections for nonspecific low back pain without sciatica
when left(der.Spell_Dominant_Procedure,4) in ('A521','A522','A528','A529','A577','A735','V363','V368','V369','V382','V383','V384','V385','V386','V388','V389','V544','W903') and left(der.spell_primary_diagnosis,4) in

('G834','G551','M518','M519','M541','M543','M544','M545','M549') and apcs.der_procedure_all like '%Z67[67]%' then 'D_low_back_pain_inj'

Breast reduction
when left(der.Spell_Dominant_Procedure,4) in ('B311') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'E_breast_red'

Removal of benign skin lesions
when left(der.Spell_Dominant_Procedure,4) in ('S063','S064','S065','S066','S067','S068','S069','S081','S082','S083','S088','S089','S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112','D021','D022','D028','D029') and APCS.Der_Diagnosis_All not like '%C4[3469]%' then 'F_skin_lesions'

Grommets for glue ear in children
when left(der.Spell_Dominant_Procedure,4) 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) then 'G_gromm'

Tonsillectomy for recurrent tonsillitis
when left(der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') 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%' then 'H_tonsil'

Haemorrhoid surgery
when left(der.Spell_Dominant_Procedure,4) in ('H511','H512','H513','H518','H519') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'I_haemmor'

Hysterectomy for heavy menstrual bleeding
when left(der.Spell_Dominant_Procedure,4) in ('Q072','Q074','Q078','Q079','Q082','Q088','Q089') 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]%' then 'J_hysterec'

Chalazia removal
when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C124','C191','C198') and left(der.Spell_Primary_Diagnosis,4) in ('H001') then 'K_chalazia'

Arthroscopic shoulder decompression for subacromial shoulder pain
when (der.Spell_Dominant_Procedure ='W844+SHOULDER' or (der.Spell_Dominant_Procedure ='O291' and apcs.der_procedure_all like '%Y767%')) and (der.Spell_Primary_Diagnosis like 'M754%' or der.Spell_Primary_Diagnosis like 'M2551%') then 'L_should_decom'

Carpal tunnel syndrome release
when left(der.Spell_Dominant_Procedure,4) in ('A651','A659') and der.Spell_Primary_Diagnosis like '%G560%' then 'M_carpal'

Dupuytren's contracture release in adults
when left(der.Spell_Dominant_Procedure,4) in ('T521','T522','T525','T526','T541') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and left(der.Spell_Primary_Diagnosis,4)='M720' then 'N_dupuytr'

Ganglion excision
when left(der.Spell_Dominant_Procedure,4) in ('T591','T592','T598','T599','T601','T602','T608','T609') and der.Spell_Primary_Diagnosis like '%M674%' then 'O_ganglion'

Trigger finger release in adults
when 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','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'

Varicose vein interventions
when left(der.Spell_Dominant_Procedure,4) in ('L832','L838','L839','L841','L842','L843','L844','L845','L846','L848','L849','L851','L852','L853','L858','L859','L861','L862','L863','L868','L869','L871','L872','L873','L874','L875','L876','L877','L878','L879','L881','L882','L883','L888','L889') and der.Spell_Primary_Diagnosis like ('%I8[03]%') then 'Q_var_veins'