


Evidence-Based Interventions Policy: Equality and Health Inequalities – Full Analysis Form

Evidence-Based Interventions Policy: Equalities and Health Inequalities Full Analysis Form

Version number: v1.0

First published: 28 November 2018

To be read in conjunction with the Evidence-Based Interventions Policy: Response to public consultation and next steps document

Classification: OFFICIAL

Gateway Ref: 08659

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please email: england.EBinterventions@nhs.net

PART A: General Information

1. Title of project, programme or work:
Evidence-Based Interventions Programme

2. What are the intended outcomes?
In July 2018, we launched a consultation on the design and implementation of a new programme to ensure interventions routinely available on the NHS are evidence-based and appropriate. The aim of the programme is to prevent avoidable harm to patients and to free up clinical time. Any savings arising from the reduction in interventions will be recycled back into local patient care.

Our research has shown that some interventions are not appropriate in certain circumstances, and on occasion, a less invasive but appropriate alternative is available. 17 interventions that fall under this category formed the basis of our consultation and were grouped in to 2 categories. Category 1 interventions which should not be routinely commissioned or performed, and Category 2 interventions which should only be routinely commissioned or performed when specific criteria are met (see appendix C).

We believe that our proposals are consistent with National Institute for Health and Care Excellence (NICE), NICE-accredited and specialist society guidance which reflects the most current clinical evidence available. Therefore, we have decided to issue the criteria for the 17 interventions under Section 14Z8 of the NHS Act 2006 as commissioning guidance. 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.

However, none of these 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 the guidance.

3. Who will be affected by this project, programme or work? Please summarise in a few sentences which of the groups below are very likely to be affected by this work.

- Patients – who already receive these interventions or have conditions that would result in a referral for one of these interventions.
- Staff:
    - commissioners who make decisions about their commissioning policies, payment proposals and local systems such as prior approval and IFR processes
    - primary care staff, in particular, General Practitioners, as they will need to take account of this guidance when assessing and referring patients as well as offer the alternatives recommended

- secondary care clinicians who also need to take account of this guidance when treating patients
- other staff groups (e.g. physiotherapy, nutritionists) who will have a role in offering patients' alternative treatments.

- Partner organisations - (NICE, NHS Clinical Commissioners (NHSCC), Academy of Medical Royal Colleges (AoMRC) and NHS Improvement (NHSI)) have played a key role in finalising the guidance and will support implementation of the changes.

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?
Proposals for clinical guidance

The key consideration of this programme is about equitable access to appropriate, evidence-based interventions. We must also ensure patients are not referred for inappropriate interventions that do not meet their needs. Any savings arising from a reduction in referrals for the 17 interventions will be reinvested to provide appropriate interventions to better meet patient's needs.

Current commissioning guidance for these interventions varies between CCGs across England, which could result in inequalities to the wider population through inappropriate referrals and ineffective use of NHS resources. Resources used on these interventions may reduce the availability of resources on more evidence-based and appropriate treatments. By undertaking this work, we aim to reduce variation of inequalities in health outcomes for the wider population by systematically offering the most up-to-date clinically proven treatments and making the most effective use of NHS resources.

The profile of people who are currently being referred for these interventions has been interrogated by age, sex and ethnicity (Source: SUS), no data is available in respect of the other protected characteristics, but comments from consultees in relation to these groups have been considered. The results show that these interventions are accessed by all age groups, gender and ethnicity. However, some interventions are accessed more (or solely) by a specific group, such as grommets for glue ear in children (children) and hysterectomy for menstrual bleeding (women), but overall, as this guidance applies to the whole population all groups protected by the Equality Act 2010 and/or groups that face health inequalities will be affected by this work.

Consultation

A 12-week consultation was carried out between July 4th and September 28th, 2018. This offered an opportunity for views to be sought from people representing many of the equality groups referred to in this equality and health inequalities impact assessment. Therefore, we included a specific question about the impact on equality and health inequality groups in the Evidence-Based Interventions consultation, see appendix B as well as working directly with individuals from equality groups.

We received 707 online responses and 97 individual submissions. We also spoke to 397 individuals by hosting or attending a number of events, including:

- Patient and public face to face events in Birmingham, London and Leeds

- Workshops with individuals with learning disabilities in Leeds and London
- NHS Expo conference in Manchester
- NHS Improvement costing forums in Leeds, Birmingham and London
- Guidelines International Network conference in Manchester
- Seven online webinars with; Health and Wellbeing Alliance; Healthwatch; NHS Clinical Commissioners; NHS Youth Forum; and Voluntary Sector and Community Enterprises.

Key themes from the analysis of the responses relevant to equality and health inequalities impact assessment have been reflected throughout this document. They have also been taken into account in the Evidence-Based Interventions Policy: Response to the public consultation and next steps document.

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Has due regard been paid to the need to:
   - eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
   - advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it (in particular, by removing or minimising disadvantages arising from that characteristic, meeting particular needs of persons with a protected characteristic, and encouraging people with a protected characteristic to participate in public life or other activity where participation is disproportionately low);
   - foster good relations between persons who share a relevant protected characteristic and persons who do not share it (in particular, by tackling prejudice and promoting understanding).
d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
e) If you cannot answer these questions what action will be taken and when?

5.1. Age

Does the equality group face discrimination in this work area?
Looking at the age profiles of patients referred in 2017/18, the prevalence for these interventions vary across children/young people, adults and older people although the majority are within the 18-64 group which is in line with all elective care. Overall the data demonstrates that some interventions have a similar age profile to all elective interventions and where this differs, such as for grommets, haemorrhoids and varicose veins they are consistent with the age groups at which the underlying problem is most prevalent.

Following extensive consultation with clinical specialists and CCGs, we have removed any restriction on children from the criteria for trigger finger release, Dupuytren's contracture release and snoring surgery. This is so our clinical criteria is based on clinical evidence developed by NICE, NICE-accredited or specialist society guidance.

In addition, some respondents stated children and young people should have access to information that supports them to make an informed decision about their care and treatment where necessary.

Chart 1: Percentage of patients receiving each intervention in 2017/18 by age

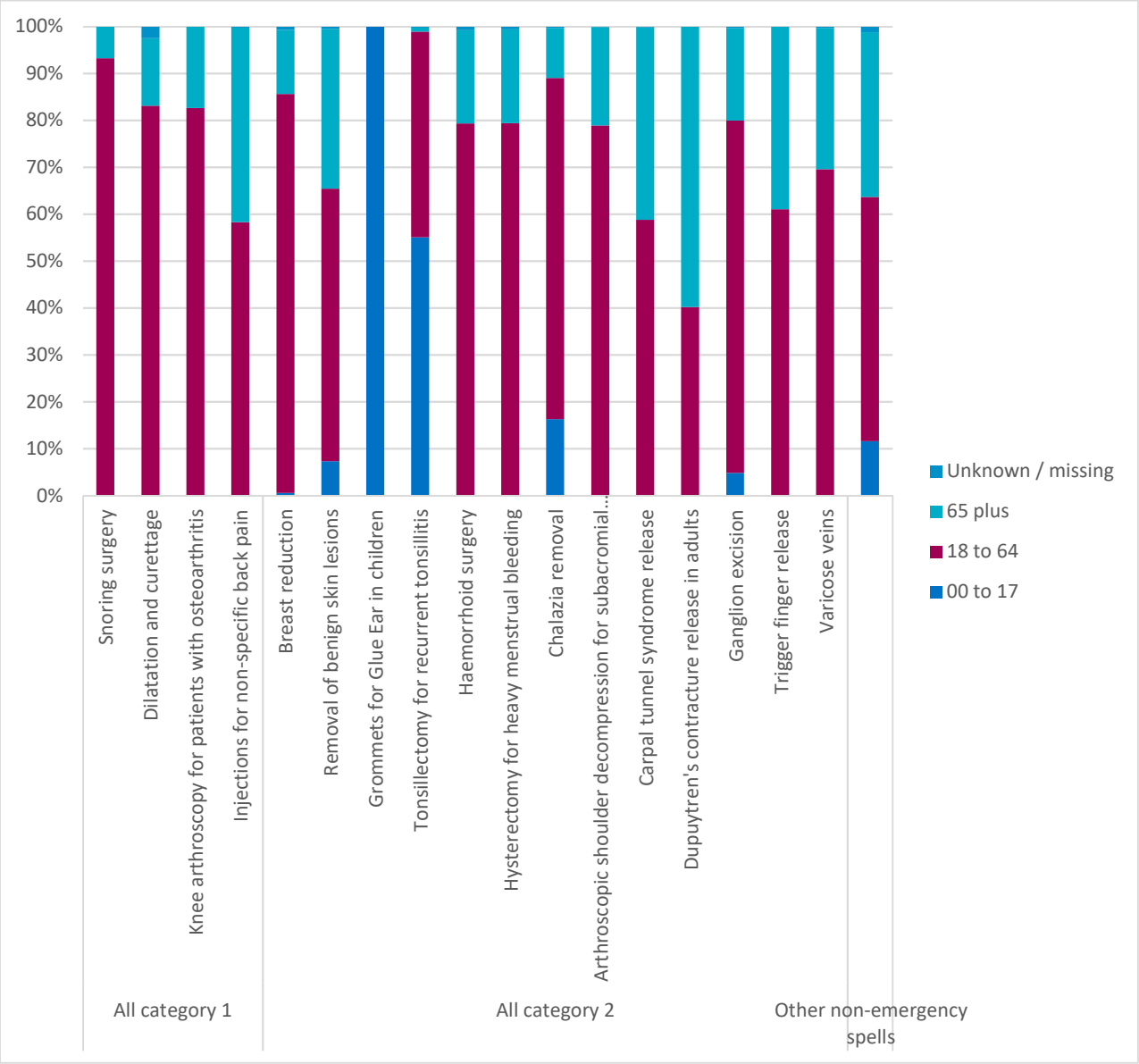


Chart 1: Children and young people are excluded from snoring surgery, knee arthroscopy for patients with osteoarthritis, Dupuytren's contracture release and trigger finger release and grommets for glue ear is specific to children and young people only

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
The clinical guidance has been reviewed and amended to take account of children and young people. For example, the impact on children and young people's mental health has been added as a criterion for removal of benign skin lesions and children and young people have been removed from the clinical criteria for trigger finger release, Dupuytren's contracture release and snoring surgery.

We will continue to use the NHS Youth Forum in an advisory capacity to seek the views of children and young people, to help co-produce materials and information that is accessible.

CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.2. Disability

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the17 interventions and disability so we cannot definitively assess, at a national level, how many people with a disability will be affected.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. A number of people raised issues that vulnerable groups, such as people with a learning disability may be disadvantaged from these proposals. They may not understand why an intervention is not being offered and they may not have the ability to voice their opinion to challenge a decision.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less

invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
There are no expected adverse impacts on the clinically based decisions. However, this protected group as with children and young people may need extra support in understanding the decisions taken, the alternative options and how to access the IFR process.

We will use our national steering group (membership includes patient representatives, The Patients Association and National Voices) and the existing patient networks our steering group partners have access to help co-produce materials and information to support implementation, in particular this equality group.

We will emphasise the need for an advocate to support vulnerable groups, such as individuals with a learning disability, when attending a doctor's appointment to support discussions about what the most appropriate treatment is for the individual.

We will produce easy read pamphlets on the 17 interventions to describe the changes we are implementing.

CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.3. Gender reassignment

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the17 interventions and gender reassignment so we cannot definitively assess, at a national level, how many people will be affected. None of the interventions included in the proposed guidance are used for the purposes of gender reassignment as it is specific to breast hyperplasia.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. There were no results from the consultation that indicated this for gender reassignment.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less

invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.4. Marriage and civil partnership

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the17 interventions and marriage/civil partnership so we cannot definitively assess, at a national level, how many people in a marriage/civil partnership will be affected.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. There were no results from the consultation that indicated this for people in a marriage/civil partnership.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.5. Pregnancy and maternity

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the17 interventions and pregnancy/maternity so we cannot definitively assess, at a national level, how many people will be affected. None of the interventions in the guidance are used for conditions that are closely related to pregnancy or maternity.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. There were no results from the consultation that indicated this for pregnancy or maternity.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

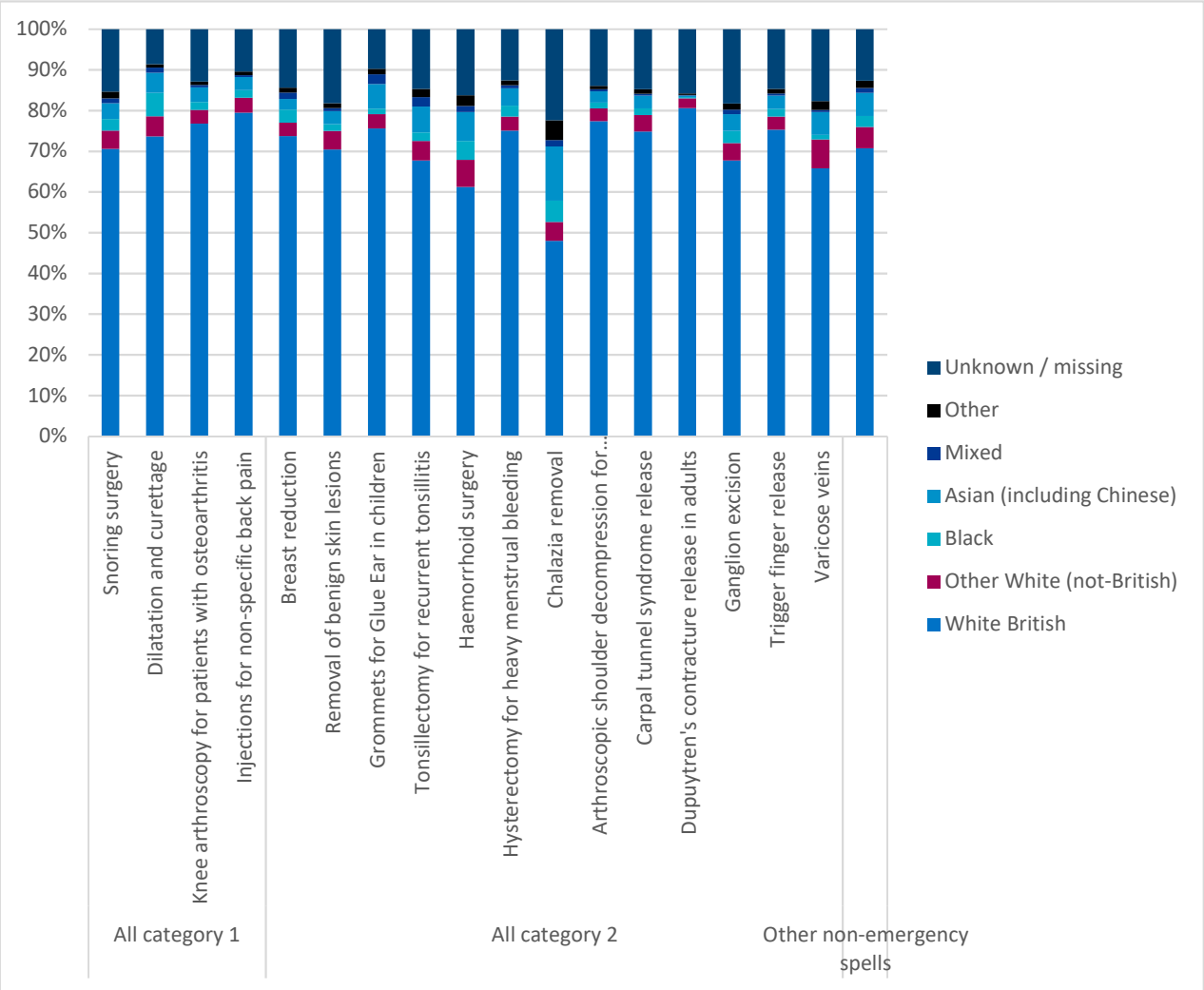
Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.6. Race

Does the equality group face discrimination in this work area?
Looking at the ethnicity profiles of patients referred in 2017/18, the prevalence for these interventions are similar to all elective care. The majority of the analysis demonstrated no substantial difference between the proportion of these interventions that are accessed by ethnic groups compared to the white British group when you take account of the different age groups. The exceptions are for chalazia removal which is less common in the white British group (48%) and higher in the Asian group (12%) and unknown groups (22%) and Dupuytrens contracture release in adults which is more common in the white British group (80%) compared to the others, although this is expected due to the increased occurrence in people of white European descent.

Chart 2: Percentage of patients receiving each intervention by ethnicity



Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment.

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
The chalazia removal and Dupuytren's contracture release clinical criteria has been reviewed to ensure it is based on NICE, NICE-accredited and specialist society guidance

and that the interventions will still be available to people who meet the criteria and in exceptional cases through an individual funding review where appropriate.

CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.7. Religion or belief

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the17 interventions and religion or belief, so we cannot definitively assess, at a national level, how many people will be affected. We have not identified any religious beliefs that would make an individual more or less likely to receive the interventions included in the guidance.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. There were no results from the consultation that indicated this for religion or belief.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

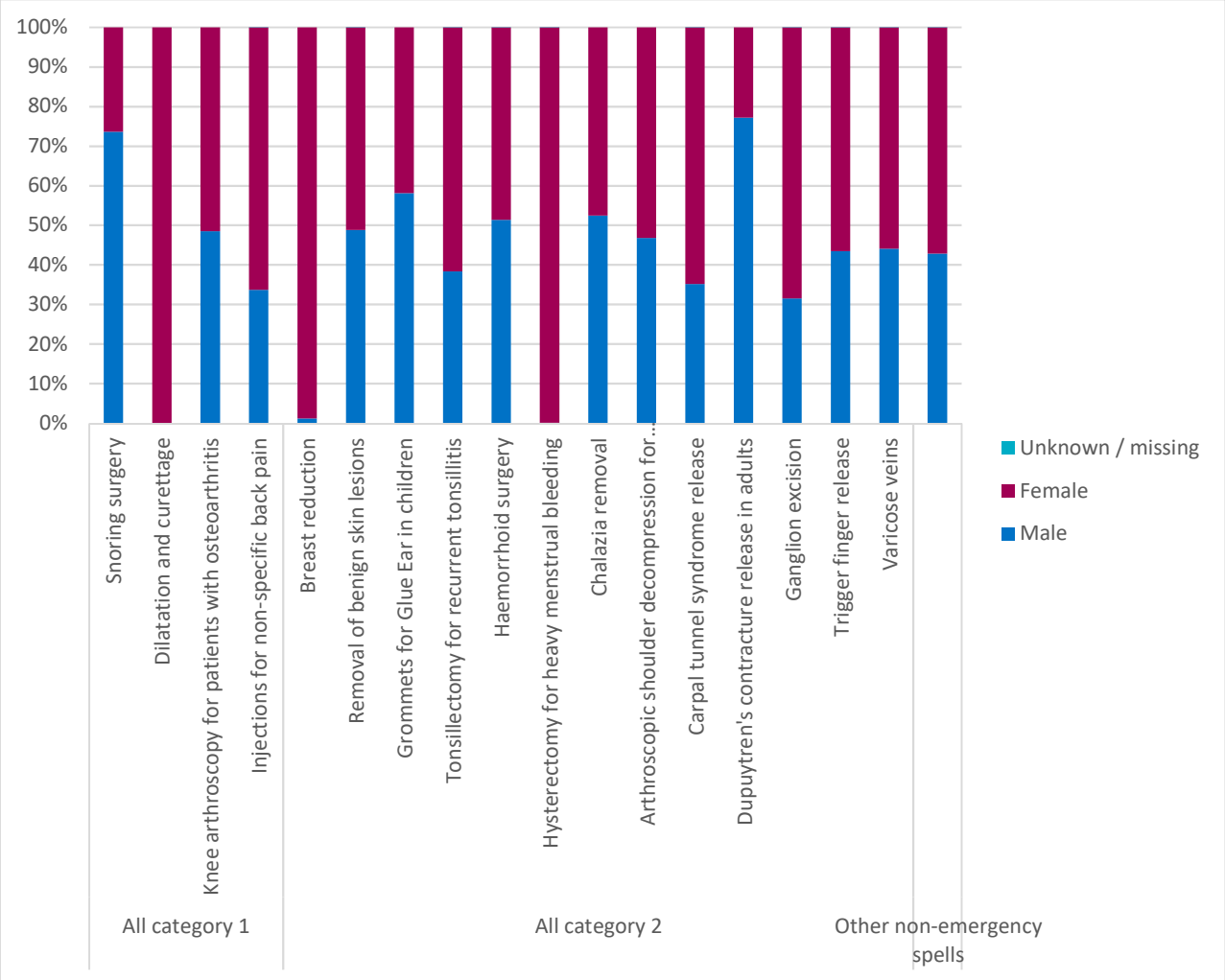
Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve

5.8. Sex or gender

Does the equality group face discrimination in this work area?
Overall the data demonstrates that on average slightly more women are referred for both the category 1 (60%)and the category 2 (56%) interventions than males. This is because there are two interventions that are provided only to women (menstrual dilatation and curettage and hysterectomy), and one which is predominantly women (breast reduction). Because of this a number of the consultation responses referred to gender as the equality group and women as the equality characteristic that was most likely to be disproportionately affected by this work.

Chart 3: Percentage of patients receiving each intervention by gender



Could the work tackle this discrimination and/or advance equality or good relations?

As a result of this concern we engaged directly with organisations representing women by inviting them to respond to the consultation. 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.

When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?

When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
Taking into account the consultation results we are continuing to engage with organisations that advocate for women and inviting them to contribute to the co-production of materials and information to support implementation.

CCGs will be required to assess the impact on their population with regard to the particular demographics of the population they serve.

5.9. Sexual orientation

Does the equality group face discrimination in this work area?
There is no routinely collected data on access to the 17 interventions and sexual orientation so we cannot definitively assess, at a national level, how many people will be affected. There is no established link between the interventions proposed in this guidance and sexual orientation.

During the consultation, responses were monitored to ascertain if there were likely unintended consequences on the equality groups. There were no results from the consultation that indicated this for sexual orientation.

Could the work tackle this discrimination and/or advance equality or good relations?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment. The most appropriate alternative may be less invasive reducing risk and offering further health benefits where it involves a lifestyle change.

Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and outcomes for all patient groups as well as compliance with the other public sector equality duties by ensuring the offer of appropriate treatment**.**

Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
CCGs will also be required to assess the impact on their population with regard to the particular demographics of the population they serve.

6. Implications of our work for the health inclusion groups listed below.

Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work[1], please answer the following questions:

f) Does the health inclusion group experience inequalities in access to healthcare?
g) Does the health inclusion group experience inequalities in health outcomes?
h) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?
i) Could the work assist or undermine compliance with the duties to reduce health inequalities?
j) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
k) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
l) If you cannot answer these questions what action will be taken and when?

6.1. Alcohol and / or drug misusers

There is no data available on the prevalence of alcohol and / or drug misuse with regards to who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.2. Asylum seekers and /or refugees

There is no data available on the prevalence of asylum seekers and/or refugees who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.3. Carers

There is no data available on the prevalence of carers who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.4. Ex-service personnel / veterans

There is no data available on the prevalence of ex-service personnel / veterans who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.5. Those who have experienced Female Genital Mutilation (FGM)

There is no data available on the prevalence of those who have experienced Female Genital Mutilation (FGM) who are currently accessing the interventions in the review.

There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.6. Gypsies, Roma and travellers

There is no data available on the prevalence of Gypsies, Roma and travellers who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.7. Homeless people and rough sleepers

There is no data available on the prevalence of homeless people and rough sleepers who are currently accessing the interventions in the review.

A number of consultation responses highlighted this guidance could impact on individuals that do not have a fixed address from accessing the necessary treatments.

As part of the delivery actions to support implementation, we have considered what needs to be in place to support referrals for any of these interventions via accident and emergency which will be worked through with demonstrator sites and CCGs / providers going forward. Also, treatment may include less invasive alternatives where appropriate following implementation which would be beneficial for a homeless person or someone who sleeps rough.

6.8. Those who have experienced human trafficking or modern slavery

There is no data available on the prevalence of those who have experienced human trafficking or modern slavery who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.9. Those living with mental health issues

The interventions are not specific to individuals with mental health issues. However, the inclusion of mental health issues as criterion for why some of these interventions should be offered was highlighted in a number of consultation responses.

This was recognised as an appropriate criterion, resulting in amendments to the clinical criteria for benign skin lesions.

Beyond the need to include mental health as selection criterion, there was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.10. Sex workers

There is no data available on the prevalence of sex workers who are currently accessing these interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.11. Trans people or other members of the non-binary community

There is no data available on trans people or other members of the non-binary community who are currently accessing the interventions in the review. There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

6.12. The overlapping impact on different groups who face health inequalities

There is no data available on different groups who face health inequalities who are currently accessing the interventions in the review.

There was no indication from the consultation results that the proposals would result in this health inclusion group experiencing inequalities in access to healthcare or health outcomes.

7. Other groups that face health inequalities that we have identified.

Have you have identified other groups that face inequalities in access to healthcare?

Does the group experience inequalities in access to healthcare and/or inequalities in health outcomes?

Short explanatory notes - other groups that face health exclusion.
As we research and gather more data, we learn more about which groups are facing health inequalities. If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

If you have not identified additional groups, that face health inequalities, just say not applicable or N/A in the box below.

Yes Complete section 8	No Go to section 9	**N/A**

8. Other groups that face health inequalities that we have identified.

Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes in relation to these other groups that face health inequalities?
Could the work undermine compliance with the duties to reduce health inequalities and, if so, what action should be taken to reduce any adverse impact?
Is the work going to help NHS England to comply with the duties to reduce health inequalities?

If you have identified other groups that face health inequalities please answer the questions below. You will only answer this question if you have identified additional groups facing important health inequalities.

PART C: Promoting integrated services and working with partners
Short explanatory notes: Integrated services and reducing health inequalities. Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.
9. Opportunities to reduce health inequalities through integrated services. Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

Yes Go to section 10	**No** Go to section 11	Do not know

10. How can this work increase integrated services and reduce health inequalities? Please explain below, in a few short sentences, how the work will encourage more integrated services that reduce health inequalities and which partners we will be working with.
PART D: Engagement and involvement
11. Engagement and involvement activities already undertaken. **How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs?** NHS England has established a programme board with its partner organisations that are all signatories on the consultation and a steering group with all the key stakeholders for the programme. The programme board includes; NHS Clinical Commissioners (NHSCC), Academy of Medical Royal Colleges (AoMRC), NICE and NHS Improvement. The steering group includes representatives from: • NHSCC • NHSI • NICE • AoMRC • National Voices • Patients Association • Patient representatives • NHS Providers

- British Medical Association
- CQC.

A 12-week consultation was carried out between July 4th and September 28th, 2018. This offered an opportunity for views to be sought from people representing many of the equality groups referred to in this equality and health inequalities impact assessment. Therefore, we included a specific question about the impact on equality and health inequality groups in the evidence-based interventions consultation.

We received 707 online responses and 97 individual submissions. We also spoke to 397 individuals by hosting or attending a number of events, including:

- Patient and public face to face events in Birmingham, London and Leeds
- Workshops with individuals with learning disabilities in Leeds and London
- NHS Expo conference in Manchester
- NHS Improvement costing forums in Leeds, Birmingham and London
- Guidelines International Network conference in Manchester
- Seven online webinars with; Health and Wellbeing Alliance; Healthwatch; NHS Clinical Commissioners; NHS Youth Forum; and Voluntary Sector and Community Enterprises.

Key themes from the analysis of the responses relevant to the equality and health inequalities impact assessment have been reflected throughout this document. They have also been taken account of in the Evidence-Based Interventions Policy: Response to the public consultation and next steps document.

12. Which stakeholders and equalities and health inclusion groups were involved?

NHSCC, NHSI, NICE, AoMRC, National Voices, The Patients Association, patient representatives, NHS Providers, NHS Confederation, NHS Partners, British Medical Association and CQC.

The consultation had involvement of a number of stakeholders and equalities and health inclusion groups (see response 11 above).

13. Key information from the engagement and involvement activities undertaken.

Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?

Stakeholders are broadly supportive of the work on the proposals for the 17 interventions and concerns relating to the equalities and health inequalities raised by stakeholders are reflected throughout this review.

14. Stakeholders were not broadly supportive but we need to go ahead.

If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?

For some of the 17 interventions and implementation mechanisms there are groups that are not broadly supportive of the specific recommendations. Further details can be found in the Evidence-Based Interventions Policy: Response to the public consultation and next steps document (Nov 2018).

15. Further engagement and involvement activities planned.

Are further engagement and involvement activities planned? If so what is planned, when and why?

We plan to hold a number of further engagement and involvement activities, including:

- Publication of the Evidence-Based Interventions Policy: Response to the public consultation and next steps document that includes the clinical criteria for the 17 interventions end of 2018
- Ongoing engagement throughout January – April 2019 with all sectors (primary care, commissioners, providers and patients and the public) to raise awareness, understanding and embed change to support implementation.
- National steering group meetings with individual patient representatives as well as organisations that represent patients.

In addition, we will we will use existing patient networks from our steering group partners, to help co-produce and advise on materials and information to support implementation.

PART E: Monitoring and Evaluation

16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work

Analysis, reporting and consideration of the SUS data and consultation responses.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

SUS data sources.

Responses to the evidence-based intervention consultation.

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- **important equalities or health inequalities data gaps or**
- **gaps in relation to monitoring and evaluation?**

Yes	No

There is currently no nationally collected data for 6 of the 9 equality groups and additional health improvement groups for the interventions in this review.

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

If you have identified important gaps and you have identified action to be taken, what action are you planning to take, when and why?

We think that individual CCGs may have more insight on this when looking at their local population data and we will encourage them to consider this as part of local consultation and impact assessments.

PART F: Summary analysis and recommended action		
20. Contributing to the first PSED equality aim. Can this work contribute to eliminating discrimination, harassment or victimisation?		
Yes	**No**	Do not know
If yes please explain how, in a few short sentences		
21. Contributing to the second PSED equality aim. Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.		
Yes	No	Do not know
Currently patients could be receiving interventions that are not appropriate for their needs. By setting national direction on when certain interventions should be commissioned this programme encourages NHS commissioners and providers to implement policy about reviewing patients' needs with the doctor to identify the most appropriate treatment for that individual. This enables patients to have access to the most effective treatment to achieve the best outcome, which may be less invasive and offer further health benefits where it is a lifestyle change. Through ensuring effective use of NHS resources, the programme will enable local systems to provide appropriate treatments to optimise wider population benefit and outcomes.		
22. Contributing to the third PSED equality aim. Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.		
Yes	No	Do not know
If yes please explain how, in a few short sentences The evidence-based interventions programme is a partnership with NHS Clinical Commissioners, NICE, Academy of Medical Royal Colleges and NHS Improvement. The approach is based on working collaboratively with our partner organisations. An example of this is that all our partners are joint signatories on the consultation and the Evidence-Based Interventions Policy: Response to the public consultation and next steps document which includes the clinical criteria for the 17 interventions. Fostering of good relationships was also enhanced through engagement with a number of other key stakeholders including charities and patient groups prior, during and post consultation. The consultation also provided an opportunity for organisations,		

health professionals, patients and the public to contribute to the development of the guidance and all other outputs and decisions regarding the delivery actions (implementation mechanisms).

We will continue this work through our ongoing engagement programme to support implementation with our national steering group and we will use existing patient networks from our steering group partners.

23. Contributing to reducing inequalities in access to health services.

Can this policy or piece of work contribute to reducing inequalities in access to health services?

Yes	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient, meaning patients will receive the most appropriate treatment.

There are also wider population gains for those patients who will receive treatments supported by the resource saved from stopping doing interventions that are not appropriate in some cases and re-directed in to providing treatments that are.

An additional benefit is where an alternative treatment involves a lifestyle change that has an added health benefit for the individual.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

Yes	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

As section 23

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

As section 23

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?

Action	Public Sector Equality Duty	Health Inequality	By when	By whom
Ensure the opportunity to challenge any decision about accessing these interventions remains through an IFR process and that prior approval is applied appropriately. Processes should be open, transparent and understood by the local population.	Yes	Yes	April 2019	CCGs, clinicians (primary & secondary care)
Produce easy read pamphlets on the 17 interventions to describe the changes we are implementing by December 2018.	Yes	Yes	Support publication of guidance	NHSE, NHSCC, AoMRC, NICE, NHSI
National steering group meetings with individual patient representatives as well as organisations that represent patients. We will use existing patient networks from our steering group partners, to help co-produce and advise on materials and information to support implementation.	Yes	Yes	Post consultation	NHSE, NHSCC, AoMRC, NICE, NHSI
Emphasise the need for an advocate to support vulnerable groups, such as individuals with a learning disability, when attending a doctor's appointment. Include in our supporting tools.	Yes	Yes	Post consultation	CCGs, clinicians (primary & secondary care)

Continue to use the NHS Youth Forum in an advisory capacity to seek the views of children and young people, to help co-produce materials and information that is accessible.	Yes	Yes	Post consultation	NHSE, NHSCC, AoMRC, NICE, NHSI

Appendix A: Activity for each intervention by equality group in 2017/2018

Table 1: Number of patients receiving each intervention by ***age***

Row Labels	00to17	18to64	65plus	Unknown / missing
All category 1	**0.0%**	**65.0%**	**34.8%**	**0.2%**
Snoring surgery	n/a	93.3%	6.7%	0.0%
Dilatation and curettage	0.0%	83.1%	14.4%	2.5%
Knee arthroscopy for patients with osteoarthritis	n/a	82.7%	17.3%	0.0%
Injections for non-specific back pain	0.0%	58.3%	41.5%	0.2%
All category 2	**11.4%**	**59.6%**	**28.6%**	**0.3%**
Breast reduction	0.6%	85.1%	13.6%	0.7%
Removal of benign skin lesions	7.3%	58.1%	34.1%	0.4%
Grommets for Glue Ear in children	100.0%	n/a	n/a	0.0%
Tonsillectomy for recurrent tonsillitis	55.1%	43.8%	0.9%	0.2%
Haemorrhoid surgery	0.1%	79.2%	19.9%	0.8%
Hysterectomy for heavy menstrual bleeding	0.0%	79.4%	20.0%	0.6%
Chalazia removal	16.3%	72.8%	10.6%	0.3%
Arthroscopic shoulder decompression for subacromial pain	0.0%	78.9%	21.0%	0.1%
Carpal tunnel syndrome release	0.1%	58.8%	41.0%	0.2%
Dupuytren's contracture release in adults	n/a	40.2%	59.8%	0.0%
Ganglion excision	4.9%	75.1%	19.8%	0.3%
Trigger finger release	n/a	61.1%	38.9%	0.0%
Varicose veins	0.1%	69.5%	30.1%	0.3%
Other non-emergency spells	**11.6%**	**52.1%**	**35.1%**	**1.2%**
All non-emergency spells	**11.6%**	**52.3%**	**34.9%**	**1.2%**

Table 1: Children and young people are excluded from snoring surgery, knee arthroscopy for patients with osteoarthritis, Dupuytren's contracture release and trigger finger release and grommets for glue ear is specific to children and young people only

Appendix A: Activity for each intervention by equality group in 2017/2018

*Table 2: Number of patients receiving each intervention by **ethnicity***

Row Labels	White British	Other White (not-British)	Black	Asian (including Chinese)	Mixed	Other	Unknown / missing
All category 1	**78.5%**	**3.7%**	**2.0%**	**3.3%**	**0.5%**	**0.9%**	**11.1%**
Snoring surgery	70.6%	4.5%	2.8%	3.9%	1.2%	1.6%	15.4%
Dilatation and curettage	73.7%	4.9%	5.8%	4.9%	1.2%	0.8%	8.6%
Knee arthroscopy for patients with osteoarthritis	76.8%	3.4%	1.9%	3.6%	0.6%	0.9%	12.9%
Injections for non-specific back pain	79.5%	3.7%	1.9%	3.2%	0.5%	0.9%	10.4%
All category 2	**71.1%**	**4.5%**	**1.8%**	**4.1%**	**0.9%**	**1.4%**	**16.2%**
Breast reduction	73.7%	3.3%	3.3%	2.6%	1.6%	1.2%	14.4%
Removal of benign skin lesions	70.4%	4.6%	1.6%	3.3%	0.7%	1.2%	18.2%
Grommets for Glue Ear in children	75.6%	3.5%	1.4%	6.0%	2.4%	1.3%	9.7%
Tonsillectomy for recurrent tonsillitis	67.7%	4.8%	2.1%	6.4%	2.3%	2.1%	14.7%
Haemorrhoid surgery	61.2%	6.7%	4.6%	7.1%	1.5%	2.6%	16.2%
Hysterectomy for heavy menstrual bleeding	75.0%	3.5%	2.6%	4.3%	0.8%	1.2%	12.6%
Chalazia removal	48.0%	4.6%	5.2%	13.4%	1.6%	4.8%	22.4%
Arthroscopic shoulder decompression for subacromial pain	77.4%	3.2%	1.4%	2.7%	0.6%	0.8%	14.0%
Carpal tunnel syndrome release	74.8%	4.1%	1.6%	3.2%	0.5%	1.1%	14.8%
Dupuytren's contracture release in adults	80.6%	2.4%	0.3%	0.4%	0.2%	0.3%	15.8%
Ganglion excision	67.7%	4.3%	3.0%	4.1%	1.1%	1.5%	18.3%
Trigger finger release	75.3%	3.2%	1.9%	3.3%	0.5%	1.1%	14.7%
Varicose veins	65.8%	7.1%	1.1%	5.6%	0.6%	2.1%	17.7%
Other non-emergency spells	**70.7%**	**5.3%**	**2.6%**	**5.7%**	**1.2%**	**1.7%**	**12.7%**
All non-emergency spells	**70.8%**	**5.2%**	**2.6%**	**5.7%**	**1.2%**	**1.7%**	**12.8%**

Appendix A: Activity for each intervention by equality group in 2017/2018

*Table 3: Number of patients receiving each intervention by **gender***

Row Labels	Male	Female	Unknown / missing
All category 1	**37.9%**	**62.1%**	**0.0%**
Snoring surgery	73.6%	26.4%	0.0%
Dilatation and curettage	0.0%	100.0%	0.0%
Knee arthroscopy for patients with osteoarthritis	48.5%	51.5%	0.0%
Injections for non-specific back pain	33.6%	66.4%	0.0%
All category 2	**41.9%**	**58.1%**	**0.0%**
Breast reduction	1.2%	98.8%	0.0%
Removal of benign skin lesions	48.8%	51.2%	0.0%
Grommets for Glue Ear in children	58.1%	41.9%	0.0%
Tonsillectomy for recurrent tonsillitis	38.3%	61.7%	0.0%
Haemorrhoid surgery	51.4%	48.6%	0.0%
Hysterectomy for heavy menstrual bleeding	0.1%	99.9%	0.0%
Chalazia removal	52.5%	47.5%	0.0%
Arthroscopic shoulder decompression for subacromial pain	46.8%	53.2%	0.0%
Carpal tunnel syndrome release	35.2%	64.8%	0.0%
Dupuytren's contracture release in adults	77.1%	22.9%	0.0%
Ganglion excision	31.5%	68.5%	0.0%
Trigger finger release	43.4%	56.6%	0.0%
Varicose veins	44.0%	56.0%	0.0%
Other non-emergency spells	**42.8%**	**57.2%**	**0.0%**
All non-emergency spells	**42.8%**	**57.2%**	**0.0%**

Appendix B: Evidence-Based Interventions consultation question and key themes from the analysis of responses

---

Q14. What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:

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

Respondent type	Key themes - summary
Clinician	• 2 respondents stated there would be a positive impact • The equality groups respondents stated as having a potential negative impact on included; vulnerable groups (3) or women (2)
CCG	• 1 respondent stated there would be no negative impact • The equality group respondents stated as having a potential negative impact on was women (2)
National body	• 4 respondents stated there would be no negative impact and 2 respondents stated there would be a positive impact • The equality groups respondents stated as having a potential negative impact on included; access in general (1) or vulnerable groups (2)
NHS provider organisation	• 2 respondents stated there would be a positive impact • The equality groups respondents stated as having a potential negative impact on included; access in general (3) or vulnerable groups (1)
Other / unknown	• 3 respondents stated there would be no negative impact and 2 respondents stated there would be a positive impact • The equality groups respondents stated as having a potential negative impact on included; vulnerable groups (12), individuals without a permanent address (1) or women (1)
Patient / member of the public	• 13 respondents stated there would be no negative impact • The equality groups respondents stated as having a potential negative impact on included; access in general (103), women (76), vulnerable groups (27), individuals without a permanent address (5) or travellers (1)

Patient representative organisation	• One respondent stated there would be no negative impact and 1 respondent stated there would be a positive impact • The equality groups respondents stated as having a potential negative impact on included; access in general (6) or individuals without a permanent address (1)
VSO / Charity	• The equality groups respondents stated as having a potential negative impact on included; access in general (6) or women (4)

Appendix C: The list of 17 interventions grouped into **Category 1** and **Category 2**

Category 1: Interventions which should not be routinely commissioned or performed	
Intervention	*Summary of intervention*
ENT	
Snoring surgery	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.
Gynaecology	
Dilatation and curettage for heavy menstrual bleeding	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).
Orthopaedics	
Knee arthroscopy for patients with osteoarthritis	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.
Injections for non-specific low back pain	Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.

Category 2: Interventions which should only be routinely commissioned or performed when specific criteria are met	
Intervention	*Summary of intervention*
General surgery	
Breast reduction	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.
Dermatology	
Removal of benign skin lesions	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.
ENT	
Grommets for Glue Ear in children	This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children. Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing. Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems. Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include: • Recurrent acute otitis media • Atrophic tympanic membranes • Access to middle ear for transtympanic instillation of medication Investigation of unilateral glue ear in adults
Tonsillectomy or recurrent tonsillitis	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.
General surgery	
Haemorrhoid surgery	This procedure involves surgery for haemorrhoids (piles).
Gynaecology	
Hysterectomy for heavy menstrual bleeding	Hysterectomy is the surgical removal of the uterus.
Ophthalmology	
Chalazia removal	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.
Orthopaedics	
Arthroscopic shoulder decompression for subacromial shoulder pain	Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.
Carpal tunnel syndrome release	Open or endoscopic surgical procedure to release median nerve from carpal tunnel.
Dupuytren's contracture release in adults	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.
Ganglion excision	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.
Trigger finger release in adults	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.
Vascular Vein Intervention	
Varicose veins interventions	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.