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Evidence-Based Interventions: Guidance for CCGs

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Evidence-Based Interventions: Guidance for CCGs

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Contents

Background

1.1 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.

1.2 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.

1.3 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.[1]

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 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.

[1] 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 Section 3 for full references.

- 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.
- 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 found in Appendix 1.

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[2]).

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 report on the consultation can be found in 'Evidence-Based Interventions Policy: Response to the public consultation and next steps'[3].

1.4 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

[2] [2] Please visit: https://www.england.nhs.uk/evidence-based-interventions/
[3] [3] [3] Please visit: https://www.england.nhs.uk/evidence-based-interventions/

clarifications to the clinical criteria in response to feedback during the consultation period (see Section 3 for the final set of criteria and Appendix 2 for a Clinical glossary). 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 2 for the final set of delivery actions, Section 4 for the local activity goals by CCG, STP and provider, Appendix 3 for a Technical glossary and Appendix 4 for Procedure and diagnostic codes).

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.

1.5 Updating the guidance

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.

Delivery actions

1.6 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.

23. 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.

1.7 Introduce zero payment for Category 1 interventions without IFRs

24. 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.

25. 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 An IFR process for Category 1 interventions and a prior approval process for Category 2 interventions

26. 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.

27. 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. This should, where appropriate, enable referrals to a specialist for an opinion.

28. For the 13 Category 2 interventions, clinicians will need to demonstrate that the patient meets the criteria set out in this guidance. CCGs will need to ensure compliance. Where there are concerns about achieving the desired clinical change and proposed activity reduction goals, we encourage the use of measures such as a prior approval process. In considering the use of prior approval, we propose local areas also consider category 2 interventions be monitored through regular audits and engagement with clinicians and, if needed, be reinforced through financial levers.

29. 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 the treating clinician. This should, where appropriate, enable referrals to a specialist for an opinion.

30. 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 start 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.

1.9 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 4 of this guidance (and see Appendix 4 for Procedure and diagnostic codes). These activity goals will form part of CCGs' overall assessment.

Table 1: National activity figures[4]

	Intervention	No of spells (2017/18) Total CCG activity	CCG Variation (n fold variation)[5]	CCG Activity reduction opportunity	CCG Remaining Activity
A	Intervention for snoring (not OSA)	812	-[6]	812	0
B	Dilatation & curettage for heavy menstrual bleeding	236	-[7]	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		**317,367**	**-**	**110,388**	
Grand Total		**335,017**	**-**	**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. We will work with our demonstrator community to improve data for both in and outpatient settings.

1.10 Integrated monthly dashboard to monitor delivery

[4] National activity figures are based on CCG activity figures excluding activity that could not be attributed to a CCG.
[5] The variation is the ratio between the 10th highest and 10th lowest age-sex standardised rate between CCGs
[6] 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.
[7] 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.

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.[8] 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.

1.11 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.

1.12 STP and CCG Improvement and Assessment Framework

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.

1.13 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.

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

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[9].

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

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

Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).

Number of 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.

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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.[10] 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

[10] 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

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%).

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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[11].

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.

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

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.

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.

References

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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 appropriate speciality service (eg 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.
- 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[12].

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.

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

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

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.

References

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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 (rare) or 2 haemorrhoids that have not improved with dietary

changes, banding or perhaps in certain cases injection, and recurrent grade 3 and 4 haemorrhoids and those with a symptomatic external component.

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.

References

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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).[13] 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.
Number of CCG interventions in 2017/18

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

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.

1.13.1.1.1 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.

1.13.1.1.2 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.

1.13.1.1.3 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.

References

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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 (e.g. 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).

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

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 no treatment is necessary for people with Dupuytren's disease who do not have contracture. Referral to hand surgery should be made for people with Dupuytren's contractures 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 address these questions.
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

Rationale for recommendation

Contractures left untreated usually progress 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 septic 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 that 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. 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 Reference 1. Head L, Gencarelli JR, Allen M, Boyd KU. Wrist ganglion treatment: Systematic review and meta-analysis. J Hand Surg Am. 2015, 40: 546-53 e8. 2. Naam NH, Carr SB, Massoud AH. Intraneural Ganglions of the Hand and Wrist. J Hand Surg Am. 2015 Aug;40(8):1625-30. doi: 10.1016/j.jhsa.2015.05.025. PubMed PMID: 26213199. 3. http://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/ganglion_cyst_leaflet-2016.pdf

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 the 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. [14]

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.

[14] 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.

References

1. NICE Guidance: https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article
2. NICE Guidance: https://www.nice.org.uk/guidance/cg168
3. NICE Quality Standard: https://www.nice.org.uk/guidance/qs67
4. Editor's Choice - Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). Wittens C, Davies AH, Bækgaard N, Broholm R, Cavezzi A, Chastanet S, de Wolf

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Activity goals

This section 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 the previous section.

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. We will work with our demonstrator community to improve data for both in and outpatient settings

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[15]: 2017/18 CCG Activity and activity reduction for Category 1 interventions (A-D) [16]

		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	#	#	#	#	51	51
00D	NHS Durham Dales, Easington and Sedgefield CCG	7	7	#	#	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	#	#	#	#	#	#	15	15
00L	NHS Northumberland CCG	#	#	#	#	6	6	32	32
00M	NHS South Tees CCG	#	#	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	#	#	18	18	24	24
00R	NHS Blackpool CCG	#	#	0	0	13	13	186	186
00T	NHS Bolton CCG	9	9	#	#	16	16	17	17
00V	NHS Bury CCG	#	#	0	0	13	13	74	74
00X	NHS Chorley and South Ribble CCG	7	7	#	#	11	11	163	163
00Y	NHS Oldham CCG	#	#	0	0	17	17	18	18
01A	NHS East Lancashire CCG	15	15	0	0	56	56	59	59
01C	NHS Eastern Cheshire CCG	#	#	0	0	#	#	20	20

[15] 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.
[16] National activity figures are based on CCG activity figures excluding activity that could not be attributed to a CCG.

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

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

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

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

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

10R	NHS Portsmouth CCG	#	#	0	0	11	11	6	6
10V	NHS South Eastern Hampshire CCG	#	#	0	0	7	7	25	25
10X	NHS Southampton CCG	#	#	0	0	16	16	7	7
11A	NHS West Hampshire CCG	5	5	#	#	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	#	#	29	29	42	42
11M	NHS Gloucestershire CCG	7	7	#	#	24	24	12	12
11N	NHS Kernow CCG	#	#	#	#	45	45	29	29
11X	NHS Somerset CCG	#	#	#	#	26	26	7	7
12D	NHS Swindon CCG	#	#	#	#	25	25	#	#
12F	NHS Wirral CCG	#	#	0	0	11	11	58	58
13T	NHS Newcastle Gateshead CCG	10	10	#	#	40	40	161	161
14L	NHS Manchester CCG	#	#	#	#	24	24	95	95
14Y	NHS Buckinghamshire CCG	#	#	#	#	13	13	24	24
15A	NHS Berkshire West CCG	#	#	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	#	#	0	0	18	18	37	37
15E	NHS Birmingham and Solihull CCG	#	#	5	5	89	89	307	307
15F	NHS Leeds CCG	33	33	#	#	57	57	49	49
99A	NHS Liverpool CCG	10	10	#	#	6	6	72	72
99C	NHS North Tyneside CCG	6	6	0	0	7	7	52	52
99D	NHS South Lincolnshire CCG	#	#	#	#	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	#	#	0	0	11	11	193	193
99H	NHS Surrey Downs CCG	#	#	#	#	10	10	243	243
99J	NHS West Kent CCG	8	8	0	0	30	30	123	123
99K	NHS High Weald Lewes Havens CCG	#	#	#	#	7	7	37	37

99M	NHS North East Hampshire and Farnham CCG	#	#	#	#	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	#	#	23	23	68	68
99Q	NHS South Devon and Torbay CCG	6	6	0	0	13	13	178	178
Total		812	812	236	236	3,437	3,437	13,165	13,165

Table 3[17]: 2017/18 CCG Activity and activity reduction for Category 2 interventions (E-K) [18]

		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	#	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	1141	764	56	25	131	0	33	#	175	59	40	31
00L	NHS Northumberland CCG	31	21	803	352	42	14	99	0	14	0	187	48	#	0

[17] 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.
[18] National activity figures are based on CCG activity figures excluding activity that could not be attributed to a CCG.

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	1149	780	82	56	179	58	33	#	203	90	87	78
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	#
00T	NHS Bolton CCG	7	0	414	38	51	16	212	65	30	0	135	20	14	#
00V	NHS Bury CCG	#	0	207	0	28	6	92	0	11	0	83	#	22	15
00X	NHS Chorley and South Ribble CCG	5	0	474	234	21	#	99	21	38	18	83	8	14	8
00Y	NHS Oldham CCG	#	0	278	0	30	0	147	21	28	#	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	#	85	0	43	36
01D	NHS Heywood, Middleton and Rochdale CCG	10	#	339	57	14	0	168	57	27	#	109	23	25	17
01E	NHS Greater Preston CCG	7	#	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	#	376	58	63	33	201	67	34	7	117	26	38	29

01H	NHS Cumbria CCG	32	22	245	0	32	#	234	105	23	0	295	160	#	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	#
01R	NHS South Cheshire CCG	#	0	413	170	15	0	108	30	18	0	88	13	42	36
01T	NHS South Sefton CCG	9	#	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	#	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	#	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	#	506	202	43	17	126	17	55	30	97	#	74	66
02D	NHS Vale Royal CCG	#	0	165	27	12	#	61	15	10	0	44	0	18	14
02E	NHS Warrington CCG	10	#	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	#	0	383	232	11	#	60	11	12	0	55	9	31	27
02H	NHS Wigan Borough CCG	17	7	1012	592	44	12	190	48	44	9	237	106	61	51

02M	NHS Fylde & Wyre CCG	11	5	1071	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	1183	850	45	19	159	46	37	10	165	61	46	38
02Q	NHS Bassetlaw CCG	5	#	123	0	24	13	65	16	17	#	56	8	7	#
02R	NHS Bradford Districts CCG	15	6	401	0	79	40	190	27	46	13	172	49	20	9
02T	NHS Calderdale CCG	9	#	288	10	65	42	152	53	23	0	97	9	#	0
02W	NHS Bradford City CCG	#	0	129	0	27	6	65	0	14	#	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	#	361	51	73	48	180	65	30	5	87	0	10	#
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	#	37	19	61	0	12	7
03F	NHS Hull CCG	18	9	688	327	110	78	325	184	59	29	120	13	12	#

03H	NHS North East Lincolnshire CCG	9	#	155	0	8	0	106	32	23	5	118	52	#	0
03J	NHS North Kirklees CCG	9	#	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	#	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	#	128	0	20	9	72	25	7	0	59	9	6	#
03N	NHS Sheffield CCG	33	16	2174	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	#	163	67	15	0	131	27	7	0
03V	NHS Corby CCG	0	0	94	#	22	13	38	0	21	13	53	24	6	#
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	#	0	235	106	9	0	58	17	14	#	55	15	19	16
03Y	NHS Hardwick CCG	5	#	226	87	18	8	57	14	14	#	81	38	6	#
04C	NHS Leicester City CCG	12	#	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	#	0
04E	NHS Mansfield and Ashfield CCG	12	6	598	350	49	29	143	58	21	0	129	53	#	0
04F	NHS Milton Keynes CCG	17	9	495	152	76	41	200	57	36	6	113	#	32	22
04G	NHS Nene CCG	21	#	975	123	82	11	203	0	129	59	425	160	72	51
04H	NHS Newark & Sherwood CCG	6	#	426	246	35	22	71	15	12	0	59	#	7	#
04J	NHS North Derbyshire CCG	12	#	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	#	72	8	27	11	76	13	18	13
04M	NHS Nottingham West CCG	#	0	252	127	11	#	33	0	14	#	32	0	13	10
04N	NHS Rushcliffe CCG	8	#	367	198	21	9	45	0	11	0	46	0	10	6
04Q	NHS South West Lincolnshire CCG	#	0	198	16	22	9	84	29	36	21	82	25	#	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	#	243	69	19	6	75	19	17	#	103	48	#	0
05A	NHS Coventry and Rugby CCG	25	11	1483	878	45	0	426	171	43	0	209	37	102	86
05C	NHS Dudley CCG	13	#	1247	828	73	41	189	51	21	0	250	124	25	15
05D	NHS East Staffordshire CCG	#	0	155	0	21	7	96	34	13	0	79	23	#	0
05F	NHS Herefordshire CCG	12	6	821	559	93	76	78	5	29	8	69	0	#	0
05G	NHS North Staffordshire CCG	8	#	477	184	34	15	110	19	31	8	145	57	8	#
05H	NHS Warwickshire North CCG	8	#	721	471	25	6	144	62	14	0	106	29	18	12
05J	NHS Redditch and Bromsgrove CCG	7	#	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	#

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	#	72	13	27	10	96	34	#	0
05W	NHS Stoke on Trent CCG	8	0	462	102	47	15	154	19	39	10	206	100	11	#
05X	NHS Telford and Wrekin CCG	9	#	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	#	139	7	35	7	166	64	#	0
06D	NHS Wyre Forest CCG	#	0	152	0	24	13	57	11	11	0	82	33	#	0
06F	NHS Bedfordshire CCG	11	0	1179	578	83	33	204	0	64	14	214	25	28	13
06H	NHS Cambridgeshire and Peterborough CCG	18	0	1276	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	#	202	39	58	46
06M	NHS Great Yarmouth and Waveney CCG	8	#	826	494	67	46	149	53	37	11	115	19	25	18
06N	NHS Herts Valleys CCG	27	9	1043	242	115	45	478	184	89	22	212	0	87	67
06P	NHS Luton CCG	#	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	#	0	633	373	20	6	71	10	20	#	93	18	17	12
06W	NHS Norwich CCG	#	0	690	399	35	13	161	50	26	#	99	16	12	#
06Y	NHS South Norfolk CCG	7	0	736	424	54	33	126	34	31	7	135	41	#	0
07G	NHS Thurrock CCG	#	0	176	0	35	13	144	56	44	26	88	22	40	34
07H	NHS West Essex CCG	10	#	312	0	51	18	262	123	86	53	125	0	21	11
07J	NHS West Norfolk CCG	#	0	635	387	27	12	123	55	27	8	98	25	40	34
07K	NHS West Suffolk CCG	9	#	981	640	49	26	198	97	31	#	130	26	#	0
07L	NHS Barking and Dagenham CCG	#	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	#	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	#	1315	872	63	26	235	80	43	6	180	38	16	5
07R	NHS Camden CCG	10	#	832	522	8	0	95	0	45	18	46	0	43	33
07T	NHS City and Hackney CCG	#	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	#	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	#	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	#	1036	684	37	8	208	82	60	32	137	29	76	67
08G	NHS Hillingdon CCG	9	#	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	#	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	#

08Q	NHS Southwark CCG	13	#	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	#	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	#	299	0	15	0	88	0	54	26	53	0	27	19
09A	NHS Central London (Westminster) CCG	10	#	255	0	6	0	64	0	25	#	33	0	30	22
09C	NHS Ashford CCG	#	0	313	144	25	11	131	70	31	17	62	9	8	#
09D	NHS Brighton and Hove CCG	13	#	816	438	25	0	184	38	72	39	90	0	8	0
09E	NHS Canterbury and Coastal CCG	#	0	621	332	35	17	142	39	46	24	118	34	8	#
09F	NHS Eastbourne, Hailsham and Seaford CCG	7	#	566	289	17	0	141	64	29	8	140	60	25	19
09G	NHS Coastal West Sussex CCG	10	0	1717	993	114	70	350	150	52	0	366	152	#	0
09H	NHS Crawley CCG	6	#	202	43	17	#	100	36	26	12	76	27	#	0
09J	NHS Dartford, Gravesham	12	#	421	88	35	5	180	55	104	77	125	22	17	8

	and Swanley CCG														
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	#	183	0	18	#	137	63	33	13	122	43	11	5
09W	NHS Medway CCG	16	7	577	210	37	#	227	86	46	16	260	145	15	5
09X	NHS Horsham and Mid Sussex CCG	10	#	508	192	39	15	139	36	51	25	117	17	0	0
09Y	NHS North West Surrey CCG	24	13	517	46	42	#	229	64	76	37	146	0	46	34
10A	NHS South Kent Coast CCG	#	0	717	437	34	15	202	117	64	42	120	36	22	16
10C	NHS Surrey Heath CCG	#	0	347	222	23	13	38	0	14	#	54	14	17	14
10D	NHS Swale CCG	6	#	189	47	17	#	115	63	16	#	117	73	#	0
10E	NHS Thanet CCG	#	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	#	22	15
10K	NHS Fareham and Gosport CCG	7	0	207	0	25	5	69	0	21	0	144	58	#	0
10L	NHS Isle of Wight CCG	#	0	136	0	8	0	65	11	35	19	71	9	6	#
10Q	NHS Oxfordshire CCG	45	24	1910	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	#	0
10V	NHS South Eastern Hampshire CCG	10	#	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	#	73	0	#	0
11J	NHS Dorset CCG	31	7	3295	2,185	48	0	255	0	101	16	496	174	133	109
11M	NHS Gloucestershire CCG	30	11	531	0	65	#	275	0	52	0	242	0	24	#
11N	NHS Kernow CCG	31	13	1312	518	101	51	239	9	78	17	234	0	13	0
11X	NHS Somerset CCG	10	0	1170	382	94	43	234	#	63	#	301	66	13	0
12D	NHS Swindon CCG	11	#	243	0	38	11	127	16	43	19	103	12	6	0
12F	NHS Wirral CCG	35	25	1561	1,116	82	50	198	56	23	0	123	0	9	0
13T	NHS Newcastle Gateshead CCG	32	17	1010	374	107	60	208	0	74	23	313	133	21	#
14L	NHS Manchester CCG	15	0	735	45	79	9	369	27	95	36	187	0	90	69
14Y	NHS Buckinghamshire CCG	17	#	523	0	113	55	146	0	60	#	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	2591	1,354	105	7	217	0	130	30	325	0	70	39
15D	NHS Berkshire East CCG	11	0	789	245	53	#	175	0	61	15	193	23	14	0
15E	NHS Birmingham and Solihull CCG	57	23	1858	310	198	48	660	5	112	0	616	162	138	98
15F	NHS Leeds CCG	54	30	1559	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	#
99D	NHS South Lincolnshire CCG	13	8	438	210	24	8	88	20	19	#	99	29	#	0
99E	NHS Basildon and Brentwood CCG	#	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	#	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	#	423	0	44	0	310	93	57	6	241	40	6	0

99K	NHS High Weald Lewes Havens CCG	7	#	535	301	17	#	110	41	16	0	73	0	5	0
99M	NHS North East Hampshire and Farnham CCG	8	#	910	622	42	18	117	15	24	0	118	26	66	59
99N	NHS Wiltshire CCG	11	0	632	0	50	#	202	0	67	15	249	41	15	0
99P	NHS Northern, Eastern and Western Devon CCG	32	#	2498	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		2,388	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 4[19]: 2017/18 CCG Activity and activity reduction for Category 2 interventions (L-Q) [20]

		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	#	182	7	67	#	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

[19] 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.
[20] National activity figures are based on CCG activity figures excluding activity that could not be attributed to a CCG.

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	#	23	5	97	22
00T	NHS Bolton CCG	75	35	270	111	45	0	24	#	62	34	75	0
00V	NHS Bury CCG	47	19	140	29	38	0	26	12	34	14	145	61
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	#	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	#	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	#	42	23	73	0
01T	NHS South Sefton CCG	73	51	94	#	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	#	217	101	69	27	17	#	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	#
02D	NHS Vale Royal CCG	55	40	118	56	40	18	6	0	21	10	49	#
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	#	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	#	90	46	#	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	#	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	#	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	#	23	#	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	#	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	#	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	#	12	0	#	0	98	0
03V	NHS Corby CCG	14	#	16	0	27	14	8	#	9	#	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	#	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	#	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	#	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	#	24	8	17	0

04M	NHS Nottingham West CCG	30	16	86	30	33	13	11	#	13	#	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	#	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	#	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	#	36	7	#	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	#	10	0	32	12	78	0
05J	NHS Redditch and Bromsgrove CCG	70	45	255	153	46	9	23	10	20	#	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	#	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	#	31	#	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	#	33	0	22	#	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	#	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	#	35	0	56	16	14	0	5	0	130	38
06Y	NHS South Norfolk CCG	30	0	92	0	74	22	19	#	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	#	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	#	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	#	42	0	16	0	19	0	113	16
07P	NHS Brent CCG	29	0	164	0	20	0	28	#	26	0	360	220
07Q	NHS Bromley CCG	64	17	206	12	91	28	39	15	70	37	211	66
07R	NHS Camden CCG	#	0	25	0	9	0	#	0	10	0	101	#
07T	NHS City and Hackney CCG	#	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	#	15	0	421	258
07X	NHS Enfield CCG	46	#	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	#	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	#	293	190
08F	NHS Havering CCG	59	23	257	104	51	0	51	32	40	14	116	#
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	#	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	#	196	46

08L	NHS Lewisham CCG	53	14	211	66	25	0	24	#	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	#	174	32	32	0	52	31	29	5	168	52
08P	NHS Richmond CCG	59	29	85	0	38	#	12	0	19	0	103	14
08Q	NHS Southwark CCG	40	#	129	0	28	0	33	11	25	#	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	#	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	#	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	#	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	#	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	#	113	37

09N	NHS Guildford and Waverley CCG	48	18	205	79	62	19	18	#	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	#	17	0	56	21	204	50
10A	NHS South Kent Coast CCG	64	34	92	0	76	29	51	36	25	#	72	0
10C	NHS Surrey Heath CCG	30	16	85	29	29	10	5	0	11	#	44	#
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	#	41	0
10J	NHS North Hampshire CCG	49	18	202	76	41	0	19	#	26	#	11	0
10K	NHS Fareham and Gosport CCG	33	#	200	74	65	20	21	6	49	27	7	0
10L	NHS Isle of Wight CCG	21	0	148	51	33	0	12	#	18	0	#	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	1049	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	#	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	#	51	10	67	24	157	0
14Y	NHS Buckinghamshire CCG	64	0	317	#	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	1143	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	#	45	9	80	34	143	0
99C	NHS North Tyneside CCG	22	0	190	61	70	25	43	27	31	8	98	#
99D	NHS South Lincolnshire CCG	93	69	48	0	36	0	15	#	16	0	52	0
99E	NHS Basildon and Brentwood CCG	58	21	153	0	54	#	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	#	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	#	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	#	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		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 5[21]: 2017/18 STP activity and activity reduction for Category 1 interventions (A-D) [22]

		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
QE1	Healthier Lancashire and South Cumbria STP	68	68	12	12	158	158	1,359	1,359
QF7	South Yorkshire and Bassetlaw STP	35	35	#	#	195	195	721	721
QGH	Herefordshire and Worcestershire STP	#	#	6	6	40	40	109	109
QH8	Mid and South Essex STP	16	16	#	#	106	106	462	462
QHG	Bedfordshire, Luton and Milton Keynes STP	5	5	#	#	61	61	158	158
QHL	Birmingham and Solihull STP	#	#	5	5	89	89	307	307
QHM	Cumbria and North East STP	60	60	9	9	197	197	853	853
QJ2	Joined Up Care Derbyshire STP	19	19	#	#	50	50	364	364
QJG	Suffolk and North East Essex STP	9	9	#	#	53	53	333	333
QJK	Devon STP	19	19	#	#	36	36	246	246
QJM	Lincolnshire STP	8	8	#	#	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	#	#	72	72	440	440
QKS	Kent and Medway STP	24	24	5	5	135	135	852	852

[21] 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.
[22] STP activity figures are the sum of CCG activity figures excluding activity that could not be attributed to a CCG.

QM7	Hertfordshire and West Essex STP	27	27	5	5	65	65	171	171
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	#	#	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	#	#	77	77	94	94
QNQ	Frimley Health & Care ICS (STP)	5	5	#	#	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	#	#	#	#	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	#	#	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	#	#	24	24	12	12
QRL	Hampshire and the Isle of Wight STP	17	17	#	#	84	84	108	108
QRV	North West London Health & Care Partnership (STP)	18	18	21	21	148	148	229	229
QSL	Somerset STP	#	#	#	#	26	26	7	7
QT1	Nottingham and Nottinghamshire Health and Care STP	5	5	#	#	40	40	744	744
QT6	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	#	#	#	#	45	45	29	29
QU9	Buckinghamshire, Oxfordshire and Berkshire West STP	9	9	#	#	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	#	#	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	#	#	29	29	42	42

QWE	South West London Health & Care Partnership (STP)	13	13	#	#	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[23]: 2017/18 STP activity and activity reduction for Category 2 interventions (E-K) [24]

		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
QE1	Healthier Lancashire and South Cumbria STP	71	20	4,804	2,522	289	124	1,179	413	278	110	844	159	159	189
QF7	South Yorkshire and Bassetlaw STP	73	29	4,362	2,460	252	99	637	85	277	123	876	290	290	362
QGH	Herefordshire and Worcestershire STP	27	7	1,507	559	208	134	319	16	82	8	480	164	164	0
QH8	Mid and South Essex STP	22	0	1,836	326	236	112	951	411	205	77	624	138	138	125
QHG	Bedfordshire, Luton and Milton Keynes STP	30	9	1,876	730	188	74	591	121	135	33	386	27	27	43
QHL	Birmingham and Solihull STP	57	23	1,858	310	198	48	660	5	112	0	616	162	162	98
QHM	Cumbria and North East STP	228	129	8,698	4,686	717	418	1,585	299	412	112	2,134	859	859	262
QJ2	Joined Up Care Derbyshire STP	36	#	2,044	672	133	34	597	151	126	16	752	330	330	87
QJG	Suffolk and North East Essex STP	43	13	2,168	896	162	68	758	338	135	29	484	79	79	46

[23] 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.
[24] STP activity figures are the sum of CCG activity figures excluding activity that could not be attributed to a CCG.

QJK	Devon STP	37	#	2,938	1,271	299	192	547	44	121	10	759	262	262	0
QJM	Lincolnshire STP	50	27	1,483	409	127	53	504	176	91	22	426	102	102	0
QK1	Leicester, Leicestershire and Rutland STP	47	14	1,794	399	185	73	701	180	144	31	594	174	174	167
QKK	Our Healthier South East London STP	74	25	4,254	1,996	157	32	1,048	186	388	189	778	111	111	134
QKS	Kent and Medway STP	63	16	3,666	1,468	252	66	1,407	561	401	208	1,168	425	425	34
QM7	Hertfordshire and West Essex STP	46	10	2,064	242	303	139	1,134	431	321	160	577	6	6	184
QMF	East London Health & Care Partnership (STP)	39	#	3,518	1,295	211	8	1,313	291	400	202	561	29	29	561
QMJ	North London Partners in Health & Care (STP)	45	5	3,836	1,988	92	0	723	32	236	83	304	0	0	225
QMM	Norfolk and Waveney Health & Care Partnership (STP)	23	#	3,520	2,077	203	110	630	202	141	30	540	119	119	68
QNC	Staffordshire and Stoke on Trent STP	44	9	2,179	702	175	64	646	153	148	30	782	325	325	#
QNQ	Frimley Health & Care ICS (STP)	22	#	2,046	1,089	118	32	330	15	99	18	365	63	63	73
QNX	Sussex and East Surrey STP	73	19	4,775	2,272	274	96	1,293	478	310	109	1,066	308	308	24
QOC	Shropshire and Telford and Wrekin STP	16	#	644	15	59	13	161	0	46	0	250	47	47	0
QOP	Greater Manchester Health and Social Care Partnership (STP)	87	14	4,731	1,161	466	150	1,951	502	419	124	1,404	305	305	324
QOQ	Humber, Coast and Vale STP	105	60	2,339	752	270	152	1,002	395	199	55	740	189	189	19
QOX	Bath and North East Somerset, Swindon and Wiltshire STP	34	10	1,143	7	99	14	379	16	132	35	425	53	53	0

QPM	Northamptonshire STP	21	#	1,069	124	104	24	241	0	150	72	478	184	184	54
QR1	Gloucestershire STP	30	11	531	0	65	#	275	0	52	0	242	0	0	#
QRL	Hampshire and the Isle of Wight STP	48	#	2,505	289	200	35	826	55	170	19	965	232	232	16
QRV	North West London Health & Care Partnership (STP)	106	43	2,878	278	178	19	885	15	421	174	597	31	31	207
QSL	Somerset STP	10	0	1,170	382	94	43	234	#	63	#	301	66	66	0
QT1	Nottingham and Nottinghamshire Health and Care STP	50	18	2,785	1,449	184	78	525	81	136	33	471	87	87	61
QT6	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	31	13	1,312	518	101	51	239	9	78	17	234	0	0	0
QU9	Buckinghamshire, Oxfordshire and Berkshire West STP	83	31	2,919	990	240	72	640	0	136	#	500	0	0	0
QUA	The Black Country and West Birmingham STP	59	19	2,912	1,229	186	44	847	149	191	60	819	300	300	86
QUE	Cambridgeshire and Peterborough STP	18	0	1,276	94	155	60	557	116	72	0	389	34	34	55
QUY	Bristol, North Somerset and South Gloucestershire STP	28	0	2,591	1,354	105	7	217	0	130	30	325	0	0	39
QVV	Dorset STP	31	7	3,295	2,185	48	0	255	0	101	16	496	174	174	109
QWE	South West London Health & Care Partnership (STP)	91	45	1,565	0	127	9	741	42	301	128	575	85	85	32
QWO	West Yorkshire and Harrogate (Health	142	65	4,359	1,110	630	345	1,936	674	534	263	1,183	204	204	201

	& Care Partnership) STP														
QWU	Coventry and Warwickshire STP	50	21	2,643	1,404	119	30	743	292	76	0	470	104	104	102
QXU	Surrey Heartlands Health & Care Partnership (STP)	47	21	1,859	695	89	#	440	64	161	66	391	38	38	34
QYG	Cheshire and Merseyside STP	151	77	6,503	3,184	371	130	1,591	454	344	105	1,289	271	271	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[25]: 2017/18 STP activity and activity reduction for Category 2 interventions (L-Q) [26]

		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
QE1	Healthier Lancashire and South Cumbria STP	423	184	1,482	507	650	289	271	149	263	90	1,404	668
QF7	South Yorkshire and Bassetlaw STP	456	250	1,358	515	430	136	312	205	292	143	380	14
QGH	Herefordshire and Worcestershire STP	148	52	1,147	661	229	51	130	72	103	19	492	142
QH8	Mid and South Essex STP	277	110	741	129	267	39	109	39	108	10	610	167
QHG	Bedfordshire, Luton and Milton Keynes STP	180	81	630	144	172	11	52	#	87	10	261	0
QHL	Birmingham and Solihull STP	246	90	894	262	224	19	84	0	121	13	1,143	655
QHM	Cumbria and North East STP	385	45	2,646	820	985	321	492	266	494	168	2,407	1,036
QJ2	Joined Up Care Derbyshire STP	330	183	1,199	589	357	139	150	77	211	101	433	23

[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.
[26] STP activity figures are the sum of CCG activity figures excluding activity that could not be attributed to a CCG.

QJG	Suffolk and North East Essex STP	113	20	800	291	213	12	88	24	92	#	683	247
QJK	Devon STP	299	127	955	201	447	172	107	31	228	96	614	107
QJM	Lincolnshire STP	343	230	127	0	198	20	39	#	32	0	309	11
QK1	Leicester, Leicestershire and Rutland STP	175	40	752	159	178	11	72	13	115	12	203	0
QKK	Our Healthier South East London STP	250	33	1,026	129	256	28	180	48	213	64	892	171
QKS	Kent and Medway STP	521	268	1,105	216	449	84	304	175	247	69	560	57
QM7	Hertfordshire and West Essex STP	264	69	1,131	288	324	48	161	57	184	45	662	49
QMF	East London Health & Care Partnership (STP)	194	29	949	228	181	0	278	137	193	47	1,019	256
QMJ	North London Partners in Health & Care (STP)	132	#	568	0	118	0	67	#	119	13	633	56
QMM	Norfolk and Waveney Health & Care Partnership (STP)	199	53	430	7	322	83	65	#	59	0	638	175
QNC	Staffordshire and Stoke on Trent STP	309	166	791	136	391	152	73	#	146	27	738	247
QNQ	Frimley Health & Care ICS (STP)	264	161	472	75	158	30	31	0	70	9	214	#
QNX	Sussex and East Surrey STP	710	438	1,889	738	535	141	302	165	340	137	871	103
QOC	Shropshire and Telford and Wrekin STP	256	185	654	355	180	71	93	58	93	39	282	66
QOP	Greater Manchester Health and Social Care Partnership (STP)	803	417	2,532	1,087	730	226	388	184	476	208	1,427	432
QOQ	Humber, Coast and Vale STP	585	386	1,339	527	500	200	108	18	258	116	905	324
QOX	Bath and North East Somerset, Swindon and Wiltshire STP	416	306	286	9	285	97	76	13	139	46	314	12
QPM	Northamptonshire STP	213	112	496	114	192	53	93	41	102	30	187	0
QR1	Gloucestershire STP	68	0	706	324	187	51	52	8	96	29	146	0
QRL	Hampshire and the Isle of Wight STP	377	123	1,763	695	446	93	219	89	302	114	102	0

QRV	North West London Health & Care Partnership (STP)	165	10	829	0	198	11	173	33	138	#	2,107	1,198
QSL	Somerset STP	135	53	715	357	216	85	18	0	158	95	210	0
QT1	Nottingham and Nottinghamshire Health and Care STP	382	242	900	335	312	116	106	33	181	80	181	0
QT6	Cornwall and the Isles of Scilly Health & Social Care Partnership (STP)	225	142	677	314	246	111	62	21	103	38	483	226
QU9	Buckinghamshire, Oxfordshire and Berkshire West STP	390	161	1,327	347	406	85	89	0	216	55	517	0
QUA	The Black Country and West Birmingham STP	355	184	1,010	395	208	6	86	8	124	31	1,047	486
QUE	Cambridgeshire and Peterborough STP	101	0	812	316	205	38	85	21	119	33	143	0
QUY	Bristol, North Somerset and South Gloucestershire STP	342	216	823	305	343	170	64	0	141	52	115	0
QVV	Dorset STP	493	381	1,049	548	321	140	79	23	135	48	346	0
QWE	South West London Health & Care Partnership (STP)	298	108	869	128	222	#	171	66	185	52	814	191
QWO	West Yorkshire and Harrogate (Health & Care Partnership) STP	871	525	2,433	1,035	882	423	501	322	422	189	2,015	951
QWU	Coventry and Warwickshire STP	236	108	1,054	527	209	38	90	26	135	43	391	22
QXU	Surrey Heartlands Health & Care Partnership (STP)	207	84	799	289	225	54	80	26	161	73	458	80
QYG	Cheshire and Merseyside 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[27]: 2017/18 provider activity baseline estimate for Category 1 interventions (A-D) and total category 1 activity [28]

		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
Provider code	Provider name	2017/18 activity	2017/18 activity	2017/18 activity	2017/18 activity
8G301	RYALLS ANN (COUNSELLOR)	0	0	0	7
8G326	THE SPENCER WING	0	0	0	27
AAH01	TETBURY HOSPITAL TRUST	#	0	0	0
ADP02	KIMS HOSPITAL (NEWNHAM COURT)	0	0	14	52
AHH01	FOSCOTE COURT (BANBURY) TRUST	0	0	0	0
AJX01	SUSSEX MSK PARTNERSHIP 2 LTD	0	0	11	#
AVQ01	ONE ASHFORD HOSPITAL	0	0	0	0
RXG00	WILTSHIRE HEATH AND CARE LLP	0	0	0	0
NAM01	PROBUS SURGICAL CENTRE	0	0	0	0
NAM02	MENEAGE STREET SURGERY	0	0	0	0
NAM04	LISKEARD COMMUNITY HOSPITAL	0	0	0	0
NAM06	MORRAB SURGERY	0	0	0	0
NEQ01	PHOENIX HEALTH SOLUTIONS LIMITED	0	0	0	0
NFH01	SOMERSET SURGICAL SERVICES	0	0	#	0
NHW03	WIMBOURNE COMMUNITY HOSPITAL (STANDARD HEALTH)	0	0	#	0
NN401	TYNESIDE SURGICAL SERVICES	0	0	#	16

[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.
[28] Provider activity figures include activity that could not be attributed to a CCG.

NN501	TRAFFORD GENERAL HOSPITAL	#	0	0	0
NN801	THE SPENCER WING (RAMSGATE ROAD)	0	0	0	33
NN802	THE SPENCER WING (WILLIAM HARVEY HOSPITAL)	0	0	0	9
NNE02	DORKING GENERAL HOSPITAL	0	0	#	57
NQM01	ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE	0	0	#	0
NT202	NUFFIELD HEALTH, BOURNEMOUTH HOSPITAL	0	0	0	0
NT204	NUFFIELD HEALTH, BRENTWOOD HOSPITAL	0	0	#	0
NT206	NUFFIELD HEALTH, BRISTOL HOSPITAL (CHESTERFIELD)	0	0	#	0
NT209	NUFFIELD HEALTH, CAMBRIDGE HOSPITAL	0	0	#	0
NT210	NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER	0	0	#	0
NT211	NUFFIELD HEALTH, CHELTENHAM HOSPITAL	0	0	0	0
NT212	NUFFIELD HEALTH, CHICHESTER HOSPITAL	0	0	#	16
NT213	NUFFIELD HEALTH, DERBY HOSPITAL	0	0	#	0
NT214	NUFFIELD HEALTH, WESSEX HOSPITAL	0	0	0	0
NT215	NUFFIELD HEALTH, EXETER HOSPITAL	0	0	0	0
NT218	NUFFIELD HEALTH, HAYWARDS HEATH HOSPITAL	0	0	0	0
NT219	NUFFIELD HEALTH, HEREFORD HOSPITAL	0	0	0	0
NT224	NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL	0	0	#	0
NT225	NUFFIELD HEALTH, LEEDS HOSPITAL	11	0	8	0
NT226	NUFFIELD HEALTH, LEICESTER HOSPITAL	0	0	0	0
NT229	NUFFIELD HEALTH, NEWCASTLE UPON TYNE HOSPITAL	0	0	0	0
NT230	NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	0	0	6	#

NT233	NUFFIELD HEALTH, PLYMOUTH HOSPITAL	0	0	0	0
NT235	NUFFIELD HEALTH, SHREWSBURY HOSPITAL	0	0	#	0
NT237	NUFFIELD HEALTH, TEES HOSPITAL	0	0	#	0
NT238	NUFFIELD HEALTH, TAUNTON HOSPITAL	#	0	#	#
NT239	NUFFIELD HEALTH, TUNBRIDGE WELLS HOSPITAL	0	0	0	#
NT241	NUFFIELD HEALTH, WOKING HOSPITAL	0	0	0	15
NT242	NUFFIELD HEALTH, WOLVERHAMPTON HOSPITAL	0	0	#	15
NT245	NUFFIELD HEALTH, YORK HOSPITAL	0	0	#	0
NT301	SPIRE SOUTH BANK HOSPITAL	0	0	9	0
NT302	SPIRE BRISTOL HOSPITAL	0	0	7	0
NT304	SPIRE SOUTHAMPTON HOSPITAL	0	0	16	0
NT305	SPIRE PORTSMOUTH HOSPITAL	0	0	#	0
NT308	SPIRE GATWICK PARK HOSPITAL	0	0	#	26
NT309	SPIRE SUSSEX HOSPITAL	0	0	#	#
NT310	SPIRE TUNBRIDGE WELLS HOSPITAL	0	0	#	0
NT312	SPIRE ALEXANDRA HOSPITAL	0	0	19	0
NT313	SPIRE WELLESLEY HOSPITAL	0	0	9	140
NT314	SPIRE LONDON EAST	#	0	17	159
NT315	SPIRE BUSHEY HOSPITAL	0	0	7	0
NT316	SPIRE HARPENDEN HOSPITAL	#	0	14	0
NT317	SPIRE CAMBRIDGE LEA HOSPITAL	0	0	7	0
NT318	SPIRE NORWICH HOSPITAL	0	0	#	0
NT319	SPIRE HARTSWOOD HOSPITAL	0	0	9	0
NT320	SPIRE PARKWAY HOSPITAL	0	0	8	#
NT321	SPIRE LITTLE ASTON HOSPITAL	0	0	69	0
NT322	SPIRE LEICESTER HOSPITAL	0	0	22	0
NT324	SPIRE CHESHIRE HOSPITAL	#	0	12	0
NT325	SPIRE MURRAYFIELD HOSPITAL	0	0	5	5

NT327	SPIRE MANCHESTER HOSPITAL	0	0	5	0
NT332	SPIRE LEEDS HOSPITAL	0	0	13	0
NT333	SPIRE WASHINGTON HOSPITAL	0	0	15	49
NT337	SPIRE LIVERPOOL HOSPITAL	#	0	#	12
NT338	SPIRE YALE HOSPITAL	0	0	0	0
NT339	SPIRE REGENCY HOSPITAL	0	0	0	9
NT343	SPIRE THAMES VALLEY HOSPITAL	0	0	5	0
NT344	SPIRE DUNEDIN HOSPITAL	0	0	#	0
NT345	SPIRE CLARE PARK HOSPITAL	0	0	5	13
NT347	SPIRE FYLDE COAST HOSPITAL	#	0	8	155
NT348	SPIRE ELLAND HOSPITAL	0	0	#	5
NT350	SPIRE METHLEY PARK HOSPITAL	0	0	43	9
NT351	SPIRE HULL AND EAST RIDING HOSPITAL	0	0	35	30
NT364	SPIRE MONTEFIORE HOSPITAL	0	0	0	47
NT401	BMI - THE ALEXANDRA HOSPITAL	0	0	10	9
NT402	BMI - BATH CLINIC	0	0	15	#
NT403	BMI - THE BEARDWOOD HOSPITAL	#	0	17	#
NT404	BMI - THE BEAUMONT HOSPITAL	#	0	6	#
NT405	BMI - BISHOPS WOOD	#	0	9	11
NT406	BMI - THE BLACKHEATH HOSPITAL	0	0	#	#
NT408	BMI - THE CHAUCER HOSPITAL	0	0	0	8
NT409	BMI - CHELSFIELD PARK HOSPITAL	0	0	#	5
NT410	BMI - THE CHILTERN HOSPITAL	0	0	#	0
NT411	BMI - THE CLEMENTINE CHURCHILL HOSPITAL	#	0	39	#
NT412	BMI - THE DROITWICH SPA HOSPITAL	0	0	10	0
NT413	BMI - THE ESPERANCE HOSPITAL	0	0	0	0
NT414	BMI - FAWKHAM MANOR HOSPITAL	0	0	0	#
NT416	BMI - HENDON HOSPITAL	0	0	#	0
NT417	BMI - GORING HALL HOSPITAL	0	0	#	8
NT418	BMI - THE HAMPSHIRE CLINIC	0	0	#	6

NT419	BMI - THE HARBOUR HOSPITAL	0	0	0	0
NT420	BMI - THE HIGHFIELD HOSPITAL	#	0	23	#
NT421	BMI - THE KINGS OAK HOSPITAL	#	0	0	#
NT422	BMI - THE LONDON INDEPENDENT HOSPITAL	0	0	7	9
NT423	BMI - THE MANOR HOSPITAL	0	0	0	0
NT424	BMI - THE MERIDEN HOSPITAL	#	0	10	0
NT427	BMI - THE PARK HOSPITAL	0	0	#	#
NT428	BMI - THE PRINCESS MARGARET HOSPITAL	0	0	#	0
NT429	BMI - THE PRIORY HOSPITAL	0	0	5	0
NT430	BMI - THE RIDGEWAY HOSPITAL	0	0	#	0
NT431	BMI - THE RUNNYMEDE HOSPITAL	0	0	#	7
NT432	BMI - THE SANDRINGHAM HOSPITAL	0	0	#	0
NT433	BMI - SARUM ROAD HOSPITAL	0	0	6	0
NT434	BMI - THE SAXON CLINIC	0	0	#	#
NT435	BMI - THE SHELBURNE HOSPITAL	0	0	#	0
NT436	BMI - SHIRLEY OAKS HOSPITAL	0	0	5	12
NT437	BMI - THE SLOANE HOSPITAL	0	0	#	#
NT438	BMI - THE SOMERFIELD HOSPITAL	0	0	#	5
NT439	BMI - THE SOUTH CHESHIRE PRIVATE HOSPITAL	0	#	7	0
NT440	BMI - THORNBURY HOSPITAL	0	0	0	0
NT441	BMI - THREE SHIRES HOSPITAL	0	0	9	0
NT443	BMI - THE WINTERBOURNE HOSPITAL	0	0	#	0
NT445	BMI THE EDGBASTON HOSPITAL	0	0	#	0
NT446	BMI ST EDMUNDS HOSPITAL	0	0	#	0
NT447	BMI THE DUCHY HOSPITAL	0	0	5	#
NT448	BMI THE HUDDERSFIELD HOSPITAL	8	0	21	0
NT449	BMI THE LANCASTER HOSPITAL	0	0	11	9
NT450	BMI THE LINCOLN HOSPITAL	0	0	22	0
NT451	BMI THE CAVELL HOSPITAL	0	0	#	#

NT455	BMI MOUNT ALVERNIA HOSPITAL	0	0	0	6
NT457	BMI WOODLANDS HOSPITAL	0	0	5	7
NT490	BMI SOUTHEND PRIVATE HOSPITAL	0	0	0	0
NT497	BMI GISBURNE PARK HOSPITAL	#	0	31	#
NTE02	ST HUGH'S HOSPITAL	0	0	54	0
NTP11	SOUTHAMPTON NHS TREATMENT CENTRE	#	0	12	#
NTP13	BARLBOROUGH NHS TREATMENT CENTRE	0	0	7	6
NTP15	NORTH EAST LONDON TREATMENT CENTRE CARE UK	#	0	#	0
NTP16	WILL ADAMS NHS TREATMENT CENTRE	0	0	#	0
NTPAD	ST MARY'S NHS TREATMENT CENTRE	0	0	0	0
NTPAE	THE CROFT SHIFA HEALTH CENTRE	0	0	0	0
NTPH1	SHEPTON MALLET NHS TREATMENT CENTRE	0	0	8	#
NTPH2	EMERSONS GREEN NHS TREATMENT CENTRE	#	#	6	0
NTPH3	DEVIZES NHS TREATMENT CENTRE	0	#	#	0
NTPH5	PENINSULA NHS TREATMENT CENTRE	0	0	#	0
NTX01	ONE HEALTH GROUP LTD	0	0	0	#
NTX06	ONE HEALTH GROUP CLINIC - OSSET	0	0	0	#
NTX09	ONE HEALTH GROUP CLINIC - GAINSBOROUGH	0	0	0	#
NTX11	ONE HEALTH GROUP CLINIC - THORNBURY	0	0	#	5
NTX12	ONE HEALTH GROUP CLINIC - CLAREMONT	0	0	#	0
NV302	CIRCLE BATH HOSPITAL	0	18	13	#
NV313	CIRCLE - NOTTINGHAM NHS TREATMENT CENTRE	0	#	6	398
NV323	CIRCLE READING HOSPITAL	0	0	#	#
NVC01	ASHTEAD HOSPITAL	0	0	#	34
NVC02	THE BERKSHIRE INDEPENDENT HOSPITAL	0	0	0	0

NVC04	DUCHY HOSPITAL	0	0	33	0
NVC05	EUXTON HALL HOSPITAL	0	#	10	11
NVC06	FITZWILLIAM HOSPITAL	#	0	8	100
NVC07	FULWOOD HALL HOSPITAL	#	#	#	11
NVC08	MOUNT STUART HOSPITAL	0	0	#	0
NVC09	NEW HALL HOSPITAL	#	0	#	#
NVC0M	RAMSAY CROYDON DAY HOSPITAL	0	0	0	0
NVC0R	TEES VALLEY HOSPITAL	0	0	0	0
NVC11	NORTH DOWNS HOSPITAL	0	0	#	17
NVC12	OAKLANDS HOSPITAL	#	0	18	0
NVC13	OAKS HOSPITAL	0	0	#	35
NVC14	PARK HILL HOSPITAL	#	0	6	36
NVC15	PINEHILL HOSPITAL	0	0	#	29
NVC16	RENACRES HOSPITAL	0	#	#	30
NVC17	ROWLEY HALL HOSPITAL	0	0	5	11
NVC18	SPRINGFIELD HOSPITAL	0	0	30	16
NVC19	RIVERS HOSPITAL	0	0	0	31
NVC20	THE YORKSHIRE CLINIC	16	0	#	51
NVC21	WEST MIDLANDS HOSPITAL	#	#	19	61
NVC22	WINFIELD HOSPITAL	0	0	#	0
NVC23	WOODLAND HOSPITAL	0	8	9	#
NVC25	HORTON NHS TREATMENT CENTRE	0	0	15	0
NVC27	BOSTON WEST HOSPITAL	0	#	13	22
NVC28	CLIFTON PARK HOSPITAL	0	0	26	0
NVC29	COBALT HOSPITAL	0	0	0	0
NVC31	BLAKELANDS HOSPITAL	0	0	0	0
NVC35	TEES VALLEY TREATMENT CENTRE	0	0	#	0
NVC40	WOODTHORPE HOSPITAL	0	0	#	5
NVC44	THE WESTBOURNE CENTRE	0	0	0	0
NVG01	FAIRFIELD HOSPITAL	0	0	#	0
NVM01	COBHAM DAY SURGERY HOSPITAL	0	0	0	0

NVM02	EPSOM DAY SURGERY LIMITED	0	0	0	0
NW612	HCA - 52 ALDERLEY ROAD	0	0	#	0
NWF01	BENENDEN HOSPITAL	0	0	#	25
NWX11	BICS-COMMUNITY	0	0	#	165
NXM01	THE HORDER CENTRE - ST JOHNS ROAD	0	0	16	11
NXM04	THE MCINDOE CENTRE	0	0	0	25
NXP04	HATHAWAY MEDICAL CENTRE	0	0	0	0
NXP17	WHITE HORSE HEALTH CENTRE - IHG	0	0	0	0
NXP20	LAWN MEDICAL CENTRE	0	0	0	0
NXP37	ASPEN CENTRE	0	0	0	0
NXP40	LITFIELD HOUSE MEDICAL CENTRE	0	0	0	0
NXP41	IHG CRAVEN ROAD	0	0	0	0
NYW01	ASPEN - THE HOLLY	#	0	9	16
NYW02	ASPEN - PARKSIDE HOSPITAL	0	0	0	6
NYW03	ASPEN - HIGHGATE HOSPITAL	0	0	#	20
NYW04	ASPEN - CLAREMONT HOSPITAL	0	0	#	7
PHS	PHOENIX HEALTH SOLUTIONS LTD	0	0	0	0
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	#	#	13	27
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0	0	0
R1F	ISLE OF WIGHT NHS TRUST	#	0	6	14
R1H	BARTS HEALTH NHS TRUST	12	#	17	77
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	8	5	19	0
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	#	#	5	67
RA3	WESTON AREA HEALTH NHS TRUST	0	0	14	0
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	#	12	0
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	5	0	#	#
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	6	0	13	179

RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	6	#	53	0
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	0	12	271
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	8	#	14	169
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0	0	8	35
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	0	#	13	26
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	0	#	41	74
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	#	0	#	25
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	#	#	8	#
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	#	0	#	0
RBK	WALSALL HEALTHCARE NHS TRUST	#	#	25	6
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	#	0	7	37
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	9	#	6	31
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0	0	0
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0	0	#
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0	14	63
RBV	THE CHRISTIE NHS FOUNDATION TRUST	0	#	0	#
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	0	#	#	14
RC1	BEDFORD HOSPITAL NHS TRUST	0	0	19	0
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	6	#	10	86
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	#	#	8	7
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	#	0	11	0

RCF	AIREDALE NHS FOUNDATION TRUST	0	0	#	#
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	0	0	0	0
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	5	#	#	64
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	#	#	9	20
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	6	#	0	29
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0	#	19	54
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	0	10	14
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	#	#	12	#
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	5	#	16	86
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0	#	0
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	0	#	8	5
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	0	0	#	0
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	#	#	10	22
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	7	0	#	98
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	#	0	0
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	0	0	0	104
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	7	#	16	27
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	5	#	48	0
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	7	#	28	0

RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	12	0	20	205
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	6	#	29	181
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	15	#	15	#
RGQ	IPSWICH HOSPITAL NHS TRUST	#	#	13	227
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	#	0	30	94
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	#	#	#	#
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	9	#	#	61
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	#	0	7	#
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	22	0	7	58
RHU	PORTSMOUTH HOSPITALS NHS TRUST	9	0	28	34
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	#	0	29	#
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	27	#	14	230
RJ2	LEWISHAM AND GREENWICH NHS TRUST	7	0	12	11
RJ6	CROYDON HEALTH SERVICES NHS TRUST	#	#	6	5
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	#	#	#	159
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	9	5	16	#
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	5	0	25	34
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	0	#	25	0
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	#	0	31	23
RJN	EAST CHESHIRE NHS TRUST	#	0	#	0

RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	#	0	5	131
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	#	0	43	260
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	#	#	18	145
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	6	0	17	#
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	20	6	28	125
RKE	WHITTINGTON HEALTH NHS TRUST	0	0	8	#
RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	0	11	9
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	#	#	6	73
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	23	0	14	134
RLQ	WYE VALLEY NHS TRUST	#	0	9	0
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	#	#	45	#
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	35	5	#	134
RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	#	0	#	47
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	#	0	18	142
RMC	BOLTON NHS FOUNDATION TRUST	7	#	9	5
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	#	0	29	71
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	#	#	50	5
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	#	#	12	29
RN7	DARTFORD AND GRAVESHAM NHS TRUST	0	0	16	103
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	#	#	45	#

RNH	NEWHAM UNIVERSITY HOSPITAL NHS TRUST	0	0	0	0
RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	#	0	59	20
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	#	#	32	110
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	#	#	7	0
RNZ	SALISBURY NHS FOUNDATION TRUST	5	0	21	14
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	0	0	0	0
RP5	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	7	#	117	678
RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0	0	0	0
RPA	MEDWAY NHS FOUNDATION TRUST	9	#	29	37
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	#	0	0	0
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	0	0	0	0
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	0	#	0	0
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	14	0	#	#
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	#	#	45	#
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	#	0	16	59
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	#	#	#	#
RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	#	0	#	139
RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	#	7	48	308
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	0	#	53	15

RR8	LEEDS TEACHING HOSPITALS NHS TRUST	17	#	19	52
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0	0	10	#
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	0	#	33
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	#	0	0	11
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	17	#	#	163
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0	0	0	0
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	19	#	8	269
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	6	#	21	9
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0	#	15	15
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	6	#	14	44
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	#	0	#	#
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	#	#	#	157
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	0	#	23	232
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	8	0	9	62
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	6	33	400
RVJ	NORTH BRISTOL NHS TRUST	0	#	15	8
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	#	#	18	383
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	7	#	37	454

RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	0	#	#	12
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	#	0	5	#
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	#	0	0	0
RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	#	#	12	11
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	5	#	23	177
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	27	#	14	25
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	6	#	40	220
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	#	0	28	184
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	5	0	8	72
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	10	#	14	33
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	#	#	5	#
RWJ	STOCKPORT NHS FOUNDATION TRUST	#	0	#	7
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	0	6	12	92
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	#	8	14	12
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	6	#	22	86
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	#	0	15	385
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	#	#	6	#
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	0	#	33	8
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	7	5	7	99
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	#	0	19	65

RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	#	0	17	255
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	35	0	#	632
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	5	#	#	128
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	#	0	8	22
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	14	#	23	#
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	#	#	9	19
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0	0	#	0
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	18	30	54
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	9	#	27	143
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0	0	0	0
Total		819	237	3,455	13,180

Table 9[29]: 2017/18 provider activity baseline estimate for Category 2 interventions (E-Q) and total Category 2 activity [30]

		E Breast reduction	F Removal of benign skin	G Grommets	H Tonsillectomy	I Haemorrhoid	J Hysterectomy for	K Chalazia removal	L Shoulder decompre	M Carpal tunnel syndrome	N Dupuytrens	O Ganglion excision	P Trigger finger release	Q Varicose vein
		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**
8G301	RYALLS ANN (COUNSELLOR)	0	0	0	0	0	0	0	0	0	0	0	0	0
8G326	THE SPENCER WING	0	21	0	#	#	31	0	8	0	#	0	0	0
AAH01	TETBURY HOSPITAL TRUST	0	32	0	0	0	0	0	0	18	0	0	0	0
ADP02	KIMS HOSPITAL (NEWNHAM COURT)	0	109	0	8	19	50	0	68	132	39	18	43	0
AHH01	FOSCOTE COURT (BANBURY) TRUST	0	0	0	0	0	#	0	0	18	#	#	0	0
AJX01	SUSSEX MSK PARTNERSHIP 2 LTD	0	27	0	0	0	0	0	48	169	31	30	20	0
AVQ01	ONE ASHFORD HOSPITAL	0	#	0	0	#	#	0	0	#	17	9	#	0
RXG00	WILTSHIRE HEATH AND CARE LLP	0	#	0	0	0	0	0	0	0	0	0	0	0
NAM01	PROBUS SURGICAL CENTRE	0	#	0	0	0	0	0	0	307	#	0	#	0
NAM02	MENEAGE STREET SURGERY	0	0	0	0	0	0	0	0	#	0	0	0	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.
[30] Provider activity figures include activity that could not be attributed to a CCG.

NAM04	LISKEARD COMMUNITY HOSPITAL	0	0	0	0	0	0	0	0	#	0	0	0	0
NAM06	MORRAB SURGERY	0	0	0	0	0	0	0	0	#	0	0	0	0
NEQ01	PHOENIX HEALTH SOLUTIONS LIMITED	0	#	0	0	0	0	11	0	20	0	#	0	10
NFH01	SOMERSET SURGICAL SERVICES	0	108	0	0	0	0	0	0	34	22	5	12	0
NHW03	WIMBOURNE COMMUNITY HOSPITAL (STANDARD HEALTH)	0	0	0	0	0	0	0	0	19	7	0	0	0
NN401	TYNESIDE SURGICAL SERVICES	5	36	0	0	18	14	0	14	8	8	#	6	8
NN501	TRAFFORD GENERAL HOSPITAL	0	24	0	26	#	0	0	11	72	28	30	10	0
NN801	THE SPENCER WING (RAMSGATE ROAD)	0	36	0	#	7	53	0	15	#	5	#	#	0
NN802	THE SPENCER WING (WILLIAM HARVEY HOSPITAL)	0	0	0	0	0	0	0	0	0	0	0	0	0
NNE02	DORKING GENERAL HOSPITAL	0	5	0	#	8	5	0	21	38	6	#	#	27
NQM01	ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE	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	#	0
NT204	NUFFIELD HEALTH, BRENTWOOD HOSPITAL	0	#	#	32	0	49	0	7	12	#	0	0	0
NT206	NUFFIELD HEALTH, BRISTOL HOSPITAL (CHESTERFIELD)	0	0	0	0	6	0	0	#	21	#	#	#	0

NT209	NUFFIELD HEALTH, CAMBRIDGE HOSPITAL	0	0	0	0	0	0	0	#	12	9	#	#	0
NT210	NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER	0	0	0	0	0	0	0	6	0	0	0	0	0
NT211	NUFFIELD HEALTH, CHELTENHAM HOSPITAL	0	#	0	0	0	0	0	5	0	0	0	0	0
NT212	NUFFIELD HEALTH, CHICHESTER HOSPITAL	0	10	0	0	0	25	0	39	54	22	#	7	0
NT213	NUFFIELD HEALTH, DERBY HOSPITAL	0	#	0	25	0	0	0	11	#	0	0	0	0
NT214	NUFFIELD HEALTH, WESSEX HOSPITAL	0	#	0	0	0	5	0	48	74	32	12	12	0
NT215	NUFFIELD HEALTH, EXETER HOSPITAL	0	0	0	0	6	0	0	5	0	0	0	0	0
NT218	NUFFIELD HEALTH, HAYWARDS HEATH HOSPITAL	0	0	0	0	0	0	0	13	#	#	0	0	0
NT219	NUFFIELD HEALTH, HEREFORD HOSPITAL	0	5	0	#	13	#	0	#	#	11	#	#	0
NT224	NUFFIELD HEALTH, WARWICKSHIRE HOSPITAL	0	#	0	0	0	0	0	16	32	12	8	12	0
NT225	NUFFIELD HEALTH, LEEDS HOSPITAL	0	9	0	114	78	79	0	69	143	47	20	44	0
NT226	NUFFIELD HEALTH, LEICESTER HOSPITAL	0	#	0	134	0	5	0	0	33	6	#	6	0
NT229	NUFFIELD HEALTH, NEWCASTLE UPON TYNE HOSPITAL	0	0	0	0	0	0	0	#	0	0	0	0	0
NT230	NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	0	8	0	0	0	0	0	124	129	70	21	34	0
NT233	NUFFIELD HEALTH, PLYMOUTH HOSPITAL	0	19	0	0	5	0	0	22	#	37	7	12	0

NT235	NUFFIELD HEALTH, SHREWSBURY HOSPITAL	0	10	0	0	0	0	0	44	135	32	25	14	0
NT237	NUFFIELD HEALTH, TEES HOSPITAL	0	6	0	0	0	0	0	18	62	31	12	19	0
NT238	NUFFIELD HEALTH, TAUNTON HOSPITAL	0	#	0	31	0	9	0	20	123	43	0	30	0
NT239	NUFFIELD HEALTH, TUNBRIDGE WELLS HOSPITAL	0	#	0	12	#	0	0	9	10	#	5	#	0
NT241	NUFFIELD HEALTH, WOKING HOSPITAL	0	#	0	0	0	0	0	9	24	5	#	5	0
NT242	NUFFIELD HEALTH, WOLVERHAMPTON HOSPITAL	0	#	0	0	0	0	0	25	65	18	#	20	#
NT245	NUFFIELD HEALTH, YORK HOSPITAL	0	#	0	0	0	0	0	32	16	21	0	#	0
NT301	SPIRE SOUTH BANK HOSPITAL	0	12	0	15	20	34	0	22	186	43	42	28	0
NT302	SPIRE BRISTOL HOSPITAL	0	0	0	0	0	0	0	139	175	100	9	45	0
NT304	SPIRE SOUTHAMPTON HOSPITAL	0	6	0	0	0	5	0	51	47	7	10	10	0
NT305	SPIRE PORTSMOUTH HOSPITAL	0	#	0	0	0	0	0	36	34	6	#	5	0
NT308	SPIRE GATWICK PARK HOSPITAL	0	#	0	0	0	#	0	9	8	#	#	0	12
NT309	SPIRE SUSSEX HOSPITAL	0	14	0	5	#	28	0	22	65	17	20	17	0
NT310	SPIRE TUNBRIDGE WELLS HOSPITAL	0	12	0	8	#	14	0	15	20	15	11	5	0
NT312	SPIRE ALEXANDRA HOSPITAL	0	137	0	0	12	42	0	15	17	6	5	9	0
NT313	SPIRE WELLESLEY HOSPITAL	0	25	0	0	0	0	0	58	108	52	36	11	0
NT314	SPIRE LONDON EAST	0	134	0	27	19	25	0	20	26	9	12	#	0
NT315	SPIRE BUSHEY HOSPITAL	0	41	0	0	8	0	0	23	17	7	5	5	0

NT316	SPIRE HARPENDEN HOSPITAL	0	34	0	27	0	0	0	13	34	13	7	10	0
NT317	SPIRE CAMBRIDGE LEA HOSPITAL	0	5	0	0	0	0	0	21	0	0	0	#	0
NT318	SPIRE NORWICH HOSPITAL	0	0	0	0	0	0	0	32	0	0	0	0	0
NT319	SPIRE HARTSWOOD HOSPITAL	0	6	0	19	0	0	0	13	37	16	10	9	0
NT320	SPIRE PARKWAY HOSPITAL	0	5	0	0	18	53	0	77	99	33	16	21	0
NT321	SPIRE LITTLE ASTON HOSPITAL	0	26	0	0	0	56	0	58	51	26	9	#	0
NT322	SPIRE LEICESTER HOSPITAL	0	22	0	0	0	0	0	51	52	16	16	15	0
NT324	SPIRE CHESHIRE HOSPITAL	#	127	0	32	26	12	0	18	63	43	11	14	83
NT325	SPIRE MURRAYFIELD HOSPITAL	0	22	0	16	5	#	0	48	108	23	6	17	94
NT327	SPIRE MANCHESTER HOSPITAL	0	27	0	#	#	0	0	11	37	17	13	11	64
NT332	SPIRE LEEDS HOSPITAL	0	154	9	123	63	0	0	85	230	55	59	42	0
NT333	SPIRE WASHINGTON HOSPITAL	0	32	0	#	18	18	0	14	62	27	21	15	229
NT337	SPIRE LIVERPOOL HOSPITAL	0	14	0	61	41	16	0	71	200	40	16	37	0
NT338	SPIRE YALE HOSPITAL	0	0	0	0	0	0	0	0	#	0	#	0	0
NT339	SPIRE REGENCY HOSPITAL	0	10	0	18	19	32	0	35	66	38	31	13	0
NT343	SPIRE THAMES VALLEY HOSPITAL	0	#	0	#	8	17	0	8	#	#	0	0	0
NT344	SPIRE DUNEDIN HOSPITAL	0	#	0	0	5	0	0	32	28	8	6	13	0
NT345	SPIRE CLARE PARK HOSPITAL	0	#	0	5	#	0	0	12	19	5	#	#	0
NT347	SPIRE FYLDE COAST HOSPITAL	0	25	0	46	5	22	0	18	38	26	6	11	117

NT348	SPIRE ELLAND HOSPITAL	0	6	0	0	35	57	0	62	98	31	17	19	34
NT350	SPIRE METHLEY PARK HOSPITAL	0	19	0	28	#	32	0	46	72	13	9	13	100
NT351	SPIRE HULL AND EAST RIDING HOSPITAL	0	356	0	14	#	48	0	121	70	35	10	66	0
NT364	SPIRE MONTEFIORE HOSPITAL	0	#	0	0	46	7	0	7	21	#	#	#	0
NT401	BMI - THE ALEXANDRA HOSPITAL	0	79	0	0	8	26	0	69	99	39	15	25	#
NT402	BMI - BATH CLINIC	0	7	0	#	13	22	0	12	#	7	0	0	0
NT403	BMI - THE BEARDWOOD HOSPITAL	0	7	0	9	43	7	0	17	60	20	10	21	0
NT404	BMI - THE BEAUMONT HOSPITAL	0	16	0	38	25	38	0	39	62	11	#	27	0
NT405	BMI - BISHOPS WOOD	0	39	0	12	10	19	0	#	20	16	11	#	0
NT406	BMI - THE BLACKHEATH HOSPITAL	0	29	0	8	6	26	0	#	7	#	#	#	0
NT408	BMI - THE CHAUCER HOSPITAL	0	55	0	12	38	33	0	5	24	52	35	11	0
NT409	BMI - CHELSFIELD PARK HOSPITAL	0	15	0	21	#	27	0	9	16	#	#	#	0
NT410	BMI - THE CHILTERN HOSPITAL	0	0	0	#	5	11	0	7	0	0	0	0	0
NT411	BMI - THE CLEMENTINE CHURCHILL HOSPITAL	0	33	0	14	35	18	0	13	56	7	10	6	0
NT412	BMI - THE DROITWICH SPA HOSPITAL	0	18	0	11	#	43	#	39	130	31	22	10	33
NT413	BMI - THE ESPERANCE HOSPITAL	0	28	0	13	10	19	0	6	#	#	0	#	0
NT414	BMI - FAWKHAM MANOR HOSPITAL	0	32	0	#	18	16	0	8	10	5	#	#	0

NT416	BMI - HENDON HOSPITAL	0	10	0	0	#	22	0	#	16	#	6	5	19
NT417	BMI - GORING HALL HOSPITAL	0	#	0	0	0	58	0	8	30	14	5	12	0
NT418	BMI - THE HAMPSHIRE CLINIC	0	23	0	11	7	7	0	19	17	5	#	#	0
NT419	BMI - THE HARBOUR HOSPITAL	0	0	0	#	#	0	0	#	81	0	0	0	0
NT420	BMI - THE HIGHFIELD HOSPITAL	0	38	0	33	16	56	0	71	62	70	42	48	0
NT421	BMI - THE KINGS OAK HOSPITAL	0	21	0	0	#	11	0	40	53	11	5	7	0
NT422	BMI - THE LONDON INDEPENDENT HOSPITAL	0	156	0	10	67	#	0	14	60	7	9	8	#
NT423	BMI - THE MANOR HOSPITAL	0	#	0	0	0	7	0	#	#	0	0	#	0
NT424	BMI - THE MERIDEN HOSPITAL	0	6	0	18	#	37	0	52	68	7	10	6	0
NT427	BMI - THE PARK HOSPITAL	0	62	0	#	9	86	0	34	0	0	0	0	0
NT428	BMI - THE PRINCESS MARGARET HOSPITAL	0	#	0	0	8	14	0	6	5	#	0	#	0
NT429	BMI - THE PRIORY HOSPITAL	0	#	0	0	0	32	0	21	43	#	8	6	0
NT430	BMI - THE RIDGEWAY HOSPITAL	0	#	0	12	38	15	0	14	10	8	#	#	0
NT431	BMI - THE RUNNYMEDE HOSPITAL	0	24	0	0	9	0	0	0	#	0	0	#	0
NT432	BMI - THE SANDRINGHAM HOSPITAL	0	#	0	0	14	0	0	0	0	0	0	0	0
NT433	BMI - SARUM ROAD HOSPITAL	0	5	0	#	0	6	0	9	38	24	9	8	0
NT434	BMI - THE SAXON CLINIC	0	18	0	0	#	5	0	26	46	7	5	11	0

NT435	BMI - THE SHELBURNE HOSPITAL	0	6	0	0	0	0	0	14	0	0	0	0	0
NT436	BMI - SHIRLEY OAKS HOSPITAL	0	8	0	7	13	41	0	19	89	16	22	13	15
NT437	BMI - THE SLOANE HOSPITAL	0	#	0	25	8	9	0	#	10	#	0	#	0
NT438	BMI - THE SOMERFIELD HOSPITAL	0	32	0	7	#	40	0	5	14	8	5	9	0
NT439	BMI - THE SOUTH CHESHIRE PRIVATE HOSPITAL	0	16	0	22	6	27	0	41	80	21	6	20	0
NT440	BMI - THORNBURY HOSPITAL	0	#	0	0	33	71	0	10	21	10	7	#	0
NT441	BMI - THREE SHIRES HOSPITAL	0	45	0	0	35	37	0	42	158	35	26	21	0
NT443	BMI - THE WINTERBOURNE HOSPITAL	0	7	0	0	0	0	0	113	43	18	#	11	0
NT445	BMI THE EDGBASTON HOSPITAL	0	12	0	0	8	43	0	23	62	14	22	10	0
NT446	BMI ST EDMUNDS HOSPITAL	0	0	0	0	#	11	0	0	21	0	0	0	0
NT447	BMI THE DUCHY HOSPITAL	0	#	0	7	0	0	0	9	14	#	#	#	24
NT448	BMI THE HUDDERSFIELD HOSPITAL	0	8	0	51	8	12	0	40	47	6	0	9	0
NT449	BMI THE LANCASTER HOSPITAL	0	30	0	0	#	#	0	17	18	21	12	9	0
NT450	BMI THE LINCOLN HOSPITAL	0	#	0	0	0	0	0	7	0	0	0	0	0
NT451	BMI THE CAVELL HOSPITAL	0	36	0	13	0	47	0	17	11	5	0	#	0
NT455	BMI MOUNT ALVERNIA HOSPITAL	0	8	0	15	0	13	0	0	#	6	#	#	0
NT457	BMI WOODLANDS HOSPITAL	0	24	0	6	32	52	0	#	106	53	26	18	74

NT490	BMI SOUTHEND PRIVATE HOSPITAL	0	70	0	0	0	0	#	0	56	0	#	#	0
NT497	BMI GISBURNE PARK HOSPITAL	0	14	0	38	#	10	#	34	57	22	7	15	0
NTE02	ST HUGH'S HOSPITAL	0	14	0	#	#	20	0	56	87	13	#	#	0
NTP11	SOUTHAMPTON NHS TREATMENT CENTRE	0	213	0	96	14	45	0	#	165	10	47	25	8
NTP13	BARLBOROUGH NHS TREATMENT CENTRE	0	#	0	0	0	0	0	122	0	18	26	26	0
NTP15	NORTH EAST LONDON TREATMENT CENTRE CARE UK	0	298	0	0	78	0	25	7	190	45	82	43	26
NTP16	WILL ADAMS NHS TREATMENT CENTRE	0	180	0	0	0	0	18	0	52	11	26	9	45
NTPAD	ST MARY'S NHS TREATMENT CENTRE	0	123	0	0	5	0	0	0	240	44	17	46	0
NTPAE	THE CROFT SHIFA HEALTH CENTRE	0	0	0	0	0	0	12	0	0	0	0	0	0
NTPH1	SHEPTON MALLET NHS TREATMENT CENTRE	0	22	0	5	#	5	#	18	277	49	5	54	0
NTPH2	EMERSONS GREEN NHS TREATMENT CENTRE	0	59	0	45	#	57	36	0	251	98	31	29	79
NTPH3	DEVIZES NHS TREATMENT CENTRE	0	15	0	10	#	0	8	0	#	42	7	13	11
NTPH5	PENINSULA NHS TREATMENT CENTRE	0	8	0	0	0	0	0	69	202	59	30	40	0
NTX01	ONE HEALTH GROUP LTD	0	40	0	0	#	0	0	#	5	0	0	0	0
NTX06	ONE HEALTH GROUP CLINIC - OSSET	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	#	0	0	0	0
NTX11	ONE HEALTH GROUP CLINIC - THORNBURY	0	79	0	0	8	18	0	48	115	33	15	21	0
NTX12	ONE HEALTH GROUP CLINIC - CLAREMONT	0	33	0	0	#	9	0	16	22	8	#	#	0
NV302	CIRCLE BATH HOSPITAL	0	40	0	18	16	80	0	165	90	73	11	26	120
NV313	CIRCLE - NOTTINGHAM NHS TREATMENT CENTRE	0	1,444	0	0	58	99	#	116	656	131	64	110	117
NV323	CIRCLE READING HOSPITAL	0	14	0	16	22	24	0	67	66	19	5	20	0
NVC01	ASHTEAD HOSPITAL	0	33	0	6	15	7	0	15	40	10	10	#	24
NVC02	THE BERKSHIRE INDEPENDENT HOSPITAL	0	5	0	0	#	#	0	34	66	15	8	10	0
NVC04	DUCHY HOSPITAL	0	41	0	0	27	0	0	17	119	123	27	43	104
NVC05	EUXTON HALL HOSPITAL	0	175	0	15	35	40	0	64	95	68	24	11	0
NVC06	FITZWILLIAM HOSPITAL	0	9	0	29	13	55	0	99	47	14	8	#	24
NVC07	FULWOOD HALL HOSPITAL	0	92	0	15	27	36	0	72	122	61	39	20	131
NVC08	MOUNT STUART HOSPITAL	0	84	0	11	21	68	0	39	99	59	5	21	0
NVC09	NEW HALL HOSPITAL	0	13	0	13	5	33	0	165	49	41	11	18	0
NVC0M	RAMSAY CROYDON DAY HOSPITAL	0	0	0	0	0	0	0	0	#	0	0	0	0
NVC0R	TEES VALLEY HOSPITAL	0	63	0	0	#	0	0	0	#	#	#	#	0
NVC11	NORTH DOWNS HOSPITAL	0	34	0	0	11	15	0	22	45	#	6	#	17
NVC12	OAKLANDS HOSPITAL	0	46	0	30	#	22	0	48	155	44	48	51	0
NVC13	OAKS HOSPITAL	0	79	0	9	16	25	0	28	14	26	14	7	126

NVC14	PARK HILL HOSPITAL	0	7	0	#	0	0	0	#	21	9	9	6	0
NVC15	PINEHILL HOSPITAL	0	16	0	22	37	32	0	#	61	9	7	17	0
NVC16	RENACRES HOSPITAL	0	37	0	12	13	16	5	40	52	26	#	9	0
NVC17	ROWLEY HALL HOSPITAL	0	15	0	0	16	46	0	60	44	29	0	18	0
NVC18	SPRINGFIELD HOSPITAL	0	17	0	78	49	74	15	23	66	15	10	11	0
NVC19	RIVERS HOSPITAL	0	7	0	25	99	65	0	0	111	14	#	16	#
NVC20	THE YORKSHIRE CLINIC	0	262	0	69	55	21	#	117	333	154	85	60	0
NVC21	WEST MIDLANDS HOSPITAL	0	8	0	14	15	102	0	16	104	26	7	15	0
NVC22	WINFIELD HOSPITAL	0	8	0	6	8	8	0	8	98	20	5	15	0
NVC23	WOODLAND HOSPITAL	0	41	0	8	27	55	9	16	70	52	36	25	0
NVC25	HORTON NHS TREATMENT CENTRE	0	13	0	0	0	0	0	154	325	58	16	46	0
NVC27	BOSTON WEST HOSPITAL	0	6	0	0	0	0	0	97	#	18	#	0	30
NVC28	CLIFTON PARK HOSPITAL	0	#	0	0	0	0	0	58	69	43	#	11	0
NVC29	COBALT HOSPITAL	0	87	0	0	9	0	0	#	35	19	27	13	23
NVC31	BLAKELANDS HOSPITAL	0	61	0	0	21	0	14	70	125	21	20	27	0
NVC35	TEES VALLEY TREATMENT CENTRE	0	664	0	0	25	0	0	6	104	41	27	19	9
NVC40	WOODTHORPE HOSPITAL	0	16	0	0	#	25	0	36	105	47	12	28	0
NVC44	THE WESTBOURNE CENTRE	0	72	0	0	0	0	39	0	52	0	#	5	48
NVG01	FAIRFIELD HOSPITAL	0	166	0	23	18	53	#	9	63	13	5	5	162
NVM01	COBHAM DAY SURGERY HOSPITAL	0	394	0	0	0	0	0	0	27	18	10	6	8

NVM02	EPSOM DAY SURGERY LIMITED	0	243	0	0	8	0	0	0	38	11	#	9	25
NW612	HCA - 52 ALDERLEY ROAD	0	12	0	#	0	0	7	0	#	7	#	6	0
NWF01	BENENDEN HOSPITAL	0	19	0	15	9	21	0	29	23	17	9	6	0
NWX11	BICS-COMMUNITY	0	13	0	0	0	0	0	32	153	27	55	40	0
NXM01	THE HORDER CENTRE - ST JOHNS ROAD	0	13	0	0	0	0	0	145	37	12	11	8	0
NXM04	THE MCINDOE CENTRE	0	12	0	0	0	0	0	24	49	36	15	20	0
NXP04	HATHAWAY MEDICAL CENTRE	0	#	0	0	0	0	0	0	8	0	0	0	0
NXP17	WHITE HORSE HEALTH CENTRE - IHG	0	#	0	0	0	0	0	0	#	0	0	0	0
NXP20	LAWN MEDICAL CENTRE	0	0	0	0	0	0	0	0	5	0	0	0	0
NXP37	ASPEN CENTRE	0	0	0	0	0	0	0	0	25	0	0	0	0
NXP40	LITFIELD HOUSE MEDICAL CENTRE	0	0	0	0	0	0	0	0	9	0	0	0	0
NXP41	IHG CRAVEN ROAD	0	0	0	0	0	0	0	0	13	0	0	0	0
NYW01	ASPEN - THE HOLLY	0	94	0	44	#	26	0	23	86	25	21	17	0
NYW02	ASPEN - PARKSIDE HOSPITAL	0	7	0	0	0	#	0	12	17	#	8	7	0
NYW03	ASPEN - HIGHGATE HOSPITAL	0	67	0	11	#	0	0	7	15	5	#	7	0
NYW04	ASPEN - CLAREMONT HOSPITAL	0	8	0	0	12	26	0	17	33	#	#	#	0
PHS	PHOENIX HEALTH SOLUTIONS LTD	0	44	0	0	0	0	7	0	35	0	#	0	22
R0A	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	29	904	82	344	73	160	91	56	192	75	30	28	267
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	25	0	0	0	0	0	0	49	5	9	#	0

R1F	ISLE OF WIGHT NHS TRUST	0	123	7	64	35	63	5	19	127	30	8	14	0
R1H	BARTS HEALTH NHS TRUST	20	796	127	705	139	239	49	48	303	42	60	50	726
R1K	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	#	713	57	267	121	113	8	17	153	25	27	25	760
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	5	547	32	118	50	194	#	55	252	94	23	53	0
RA3	WESTON AREA HEALTH NHS TRUST	0	29	0	0	17	16	0	49	94	61	5	25	0
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	343	13	0	19	96	9	40	139	32	#	37	0
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	0	1,395	106	202	35	95	43	0	86	#	0	9	0
RA9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	#	188	65	100	12	134	0	20	172	56	#	17	105
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	34	552	109	216	25	162	43	25	214	37	9	21	304
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0	408	49	272	57	181	111	74	151	38	20	17	328
RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	50	2,490	45	424	84	141	25	35	282	123	33	62	568
RAN	ROYAL NATIONAL ORTHOPAEDIC	0	114	0	0	0	0	0	13	11	0	#	0	0

	HOSPITAL NHS TRUST													
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	#	126	0	0	23	71	25	40	137	11	17	22	0
RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	0	510	0	0	73	135	9	57	193	72	43	28	191
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	13	392	38	201	92	109	12	185	218	85	24	33	119
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	#	348	75	133	39	172	5	32	179	57	13	38	196
RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	8	337	20	92	22	142	10	136	251	94	14	32	69
RBK	WALSALL HEALTHCARE NHS TRUST	10	443	21	168	57	127	0	125	103	22	18	16	133
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	27	1,563	75	180	21	110	#	82	427	105	15	23	261
RBN	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	57	2,478	46	223	59	253	86	31	292	104	36	66	121
RBQ	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	#	0	0	0	0	0	0	0	0	0	0	0
RBS	ALDER HEY CHILDREN'S NHS	0	471	128	303	0	0	20	0	0	0	6	0	0

	FOUNDATION TRUST													
RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	#	474	28	169	22	93	78	116	252	85	6	30	87
RBV	THE CHRISTIE NHS FOUNDATION TRUST	#	279	0	0	#	52	0	0	0	0	0	0	0
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	#	456	5	0	#	73	7	40	121	39	18	40	109
RC1	BEDFORD HOSPITAL NHS TRUST	#	1,027	50	70	30	113	5	15	131	36	5	15	114
RC9	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	5	310	44	336	52	100	20	24	167	45	16	21	102
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	29	426	67	281	48	193	20	166	403	113	34	45	545
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	15	182	50	111	41	101	27	65	196	78	16	32	0
RCF	AIREDALE NHS FOUNDATION TRUST	#	88	48	0	19	118	28	32	127	37	16	9	130
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	0	275	96	114	#	0	19	0	#	0	11	0	0
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	#	775	35	166	28	107	58	30	131	53	8	20	135

RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	19	104	39	111	19	90	#	57	84	58	6	21	#
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	#	1,439	22	150	10	171	0	0	#	0	#	#	0
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	17	371	81	193	16	120	35	59	150	44	9	9	43
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	#	130	60	272	51	146	0	62	128	43	#	6	108
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	5	393	78	350	49	117	7	49	85	39	11	18	100
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	25	2,220	117	338	105	378	97	283	472	160	34	66	334
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	93	0	0	#	0	0	0	70	26	#	#	0
RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	#	1,413	0	0	59	149	124	184	505	173	52	78	261
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	0	48	0	0	12	86	0	17	58	34	11	25	0
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	30	926	85	164	30	150	7	163	99	73	25	33	244

REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	13	507	0	134	28	0	46	84	104	51	8	10	195
REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	5	0	0	0	391	0	0	0	0	0	0	0
RET	THE WALTON CENTRE NHS FOUNDATION TRUST	0	#	0	0	0	0	0	0	#	0	0	0	0
RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	5	1,542	57	391	44	178	137	48	189	27	17	18	201
RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	#	1,070	38	164	33	140	34	85	128	51	32	26	109
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	9	407	35	132	58	168	125	58	219	71	29	30	0
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	8	538	29	128	19	191	24	80	228	75	42	44	66
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	17	1,288	102	366	54	311	59	77	532	138	46	76	94
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6	790	67	201	32	84	31	63	147	46	10	13	37
RGQ	IPSWICH HOSPITAL NHS TRUST	15	288	39	204	43	197	59	13	478	70	17	35	248

RGR	WEST SUFFOLK NHS FOUNDATION TRUST	7	1,185	73	174	30	138	0	34	233	74	45	30	253
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10	353	84	400	23	173	23	35	329	94	56	64	47
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	19	1,733	133	230	61	291	15	65	195	171	37	96	128
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	0	401	36	175	11	223	11	29	221	38	38	24	23
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	51	2,374	0	116	109	338	252	119	677	168	133	143	207
RHU	PORTSMOUTH HOSPITALS NHS TRUST	25	554	94	348	52	368	9	51	313	129	34	77	29
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	20	312	44	182	8	97	19	43	183	44	9	27	118
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	73	903	48	343	110	160	19	70	255	63	80	60	416
RJ2	LEWISHAM AND GREENWICH NHS TRUST	0	1,062	68	539	61	222	#	54	333	52	40	60	82
RJ6	CROYDON HEALTH SERVICES NHS TRUST	7	266	18	108	40	135	0	49	163	37	33	29	138
RJ7	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	45	586	29	241	97	79	0	#	209	47	47	57	396

RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	15	391	48	173	22	126	#	84	330	86	40	53	62
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	34	1,148	97	279	70	434	10	52	180	101	16	31	419
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	#	317	61	251	28	180	8	6	186	51	15	15	15
RJL	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	20	262	15	223	45	278	8	75	161	71	22	28	0
RJN	EAST CHESHIRE NHS TRUST	7	140	7	101	14	77	34	24	77	55	17	12	0
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	17	655	44	124	#	119	8	20	141	56	17	26	58
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	8	2,307	60	188	139	278	26	131	385	129	51	97	434
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	#	1,001	103	271	33	153	9	124	248	99	22	59	96
RK9	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	15	1,007	111	294	34	274	11	93	306	70	18	27	408
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	36	2,092	66	596	39	235	140	80	442	65	26	34	300
RKE	WHITTINGTON HEALTH NHS TRUST	0	671	0	0	67	34	0	21	119	28	22	26	32

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
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	12	452	48	234	66	293	9	91	503	130	38	62	364
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	0	655	175	447	27	203	231	29	233	68	42	41	624
RLQ	WYE VALLEY NHS TRUST	5	848	92	70	15	54	#	16	309	49	25	26	100
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	0	290	0	0	20	76	0	36	205	29	10	32	38
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	12	2,069	94	290	80	336	21	55	150	230	39	25	474
RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	19	414	9	77	33	63	0	29	111	43	#	19	216
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	0	246	50	118	30	106	0	21	321	73	33	51	0
RMC	BOLTON NHS FOUNDATION TRUST	11	420	55	193	9	128	11	34	158	24	14	23	73
RMP	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	#	236	51	189	46	132	#	105	127	41	16	20	88

RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	12	231	50	181	52	182	#	22	149	81	33	48	91
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	14	555	73	231	36	195	25	58	367	89	36	54	14
RN7	DARTFORD AND GRAVESHAM NHS TRUST	8	398	#	0	166	203	0	81	233	45	42	37	162
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	14	1,506	63	204	16	208	23	56	298	51	22	27	449
RNH	NEWHAM UNIVERSITY HOSPITAL NHS TRUST	0	#	0	0	0	0	0	0	0	0	0	0	0
RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	14	118	26	221	11	241	#	40	274	76	15	37	176
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	#	344	59	126	59	181	7	41	68	44	13	29	52
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	10	467	34	86	27	208	50	58	141	46	22	22	119
RNZ	SALISBURY NHS FOUNDATION TRUST	26	717	37	121	15	84	8	135	31	33	9	29	62
RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	0	952	91	88	0	0	0	0	#	0	0	0	0
RP5	DONCASTER AND BASSETLAW TEACHING	17	366	98	180	52	205	5	123	301	124	98	70	84

	HOSPITALS NHS FOUNDATION TRUST													
RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0	#	0	0	0	0	1,098	0	0	0	0	0	0
RPA	MEDWAY NHS FOUNDATION TRUST	10	267	83	465	31	249	0	82	95	13	16	11	102
RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	64	942	0	18	0	0	#	0	208	96	48	39	#
RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	56	203	0	#	#	7	0	0	0	0	0	0	0
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	0	458	232	246	0	279	7	0	0	0	6	0	0
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	32	110	0	136	46	#	42	109	160	41	26	47	11
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	47	1,470	112	249	25	193	6	39	221	114	41	67	164
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	11	664	79	288	100	144	5	46	244	72	51	50	142
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	5	151	42	205	44	68	7	32	121	39	14	13	159
RQX	HOMERTON UNIVERSITY	#	322	0	107	60	33	0	#	91	32	81	39	0

	HOSPITAL NHS FOUNDATION TRUST													
RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	14	1,178	45	292	56	303	#	62	347	109	10	42	632
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	18	61	0	0	29	211	0	25	167	98	78	71	114
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	51	1,543	143	418	107	220	43	144	370	125	97	66	561
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	15	395	39	165	27	159	56	183	569	184	70	113	178
RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	0	94	0	0	0	0	0	50	258	69	10	40	0
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	71	769	0	170	31	#	5	26	157	10	16	16	650
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	#	1,423	60	474	83	89	0	44	130	22	20	28	228
RT3	ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0	#	0	#	0	0	0	0	0	0	0	0	0
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	68	2,018	188	403	55	318	22	#	290	107	56	34	448

RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	22	402	60	240	35	210	21	50	558	175	44	76	122
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	40	547	0	0	22	242	0	103	449	180	52	93	0
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	11	706	80	369	45	365	14	87	686	232	57	121	293
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	56	2,289	75	322	28	183	7	35	385	130	27	65	260
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	18	355	32	240	66	132	73	78	288	41	14	46	236
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	#	424	60	300	86	209	#	96	312	65	13	33	147
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	34	1,878	113	296	63	264	55	21	411	106	18	42	606
RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	300	59	213	62	204	10	30	383	122	29	55	0
RVJ	NORTH BRISTOL NHS TRUST	36	1,688	0	0	71	175	#	150	182	81	16	27	133
RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	0	211	46	218	52	242	11	53	281	61	51	80	141

RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	0	1,844	120	552	120	290	39	108	243	128	78	48	172
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	21	148	0	0	27	166	0	12	124	48	46	20	0
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	273	20	0	9	124	45	22	103	34	7	9	177
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	0	17	0	17	#	0	#	0	36	6	#	#	0
RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	363	92	242	56	108	151	12	62	27	16	7	47
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	12	597	46	394	51	244	103	148	409	68	50	68	656
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	54	1,253	191	497	101	236	21	97	519	196	33	97	470
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	37	813	90	324	68	224	11	90	27	119	19	5	210
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	51	1,452	166	497	126	504	196	76	478	97	29	61	157
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	24	147	48	328	47	231	7	35	113	42	19	23	85
RWG	WEST HERTFORDSHIRE	16	426	96	338	58	166	68	102	196	40	22	31	253

	HOSPITALS NHS TRUST													
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	9	427	131	285	53	146	117	14	315	82	48	53	129
RWJ	STOCKPORT NHS FOUNDATION TRUST	#	287	53	195	39	140	7	75	342	115	38	37	#
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	9	484	101	225	19	284	6	57	484	80	43	32	345
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	5	207	28	110	45	57	54	35	153	37	11	30	205
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	9	470	158	364	27	153	11	70	335	66	34	15	289
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	60	789	107	302	61	239	81	145	43	53	14	5	0
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	6	605	35	273	58	194	38	60	143	55	36	22	128
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	35	1,010	120	410	66	232	120	73	148	217	126	86	420
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	14	1,226	58	333	64	177	9	98	287	96	42	65	316
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	27	758	33	292	77	211	184	37	27	41	8	7	229
RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	14	1,468	51	211	12	119	17	13	107	90	13	26	0

RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	25	1,796	47	230	15	137	40	43	113	62	49	15	531
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	28	2,331	216	217	59	298	46	60	237	80	55	40	109
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	19	351	119	35	30	113	5	18	274	132	16	43	138
RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	13	592	118	323	64	210	124	50	350	81	55	54	552
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	#	405	52	145	42	202	6	98	166	46	25	25	274
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0	267	0	0	12	0	61	18	103	57	10	16	52
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	84	557	26	275	116	245	139	28	174	26	18	16	1,064
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	10	1,608	85	205	30	297	#	125	422	106	39	80	205
RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0	0	#	0	0	0	0	0	0	0	0	0	0
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

Appendix 1: Equality and Health Inequalities Analysis Form

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

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

Version number: Final

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 reference: 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

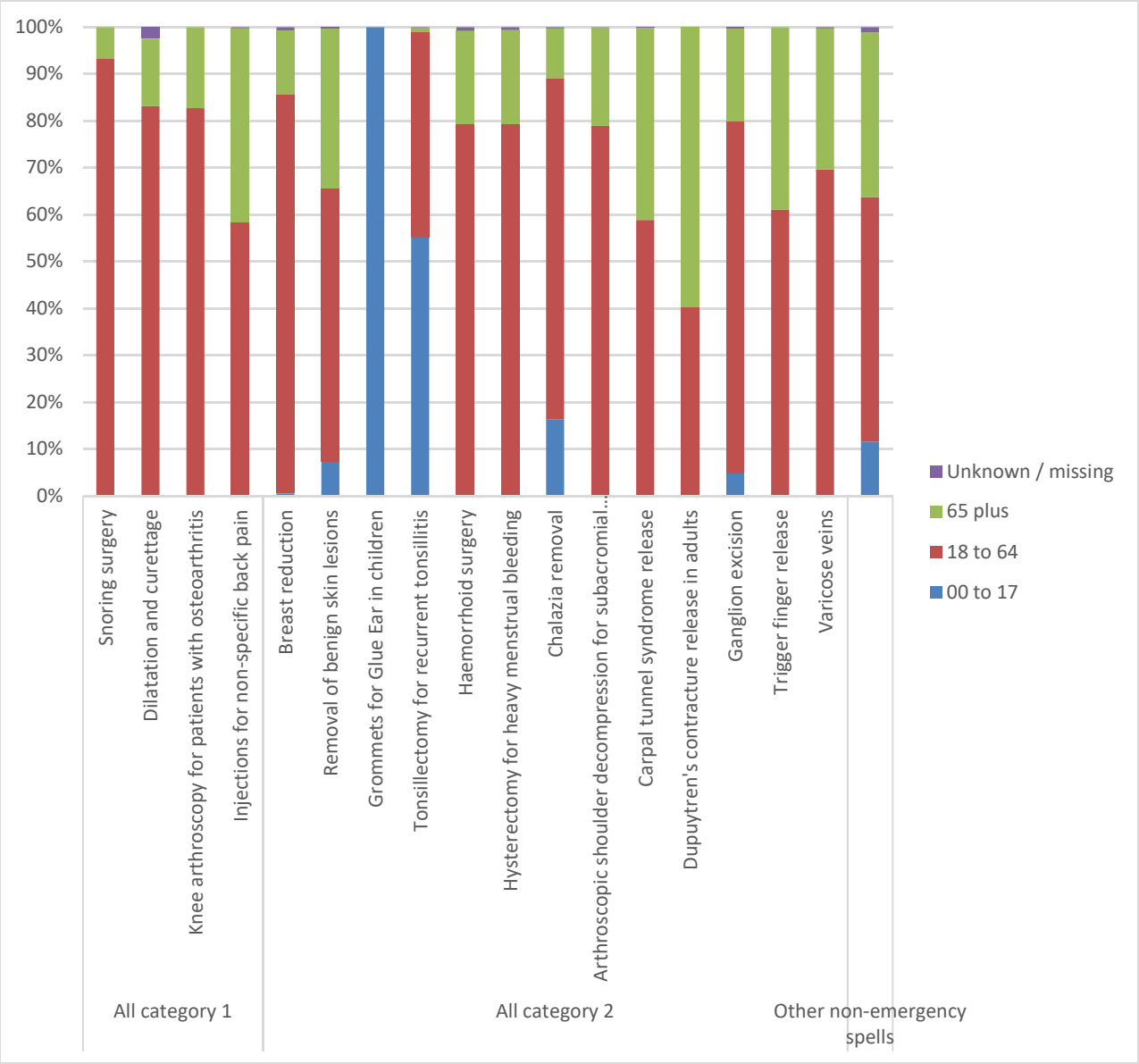


Chart 1: Children and young people are excluded from snoring surgery, knee arthroscopy for patients with osteoarthritis, Dupuytren's contracture release and trigger finger release and grommets for glue ear is specific to children and young people only

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.

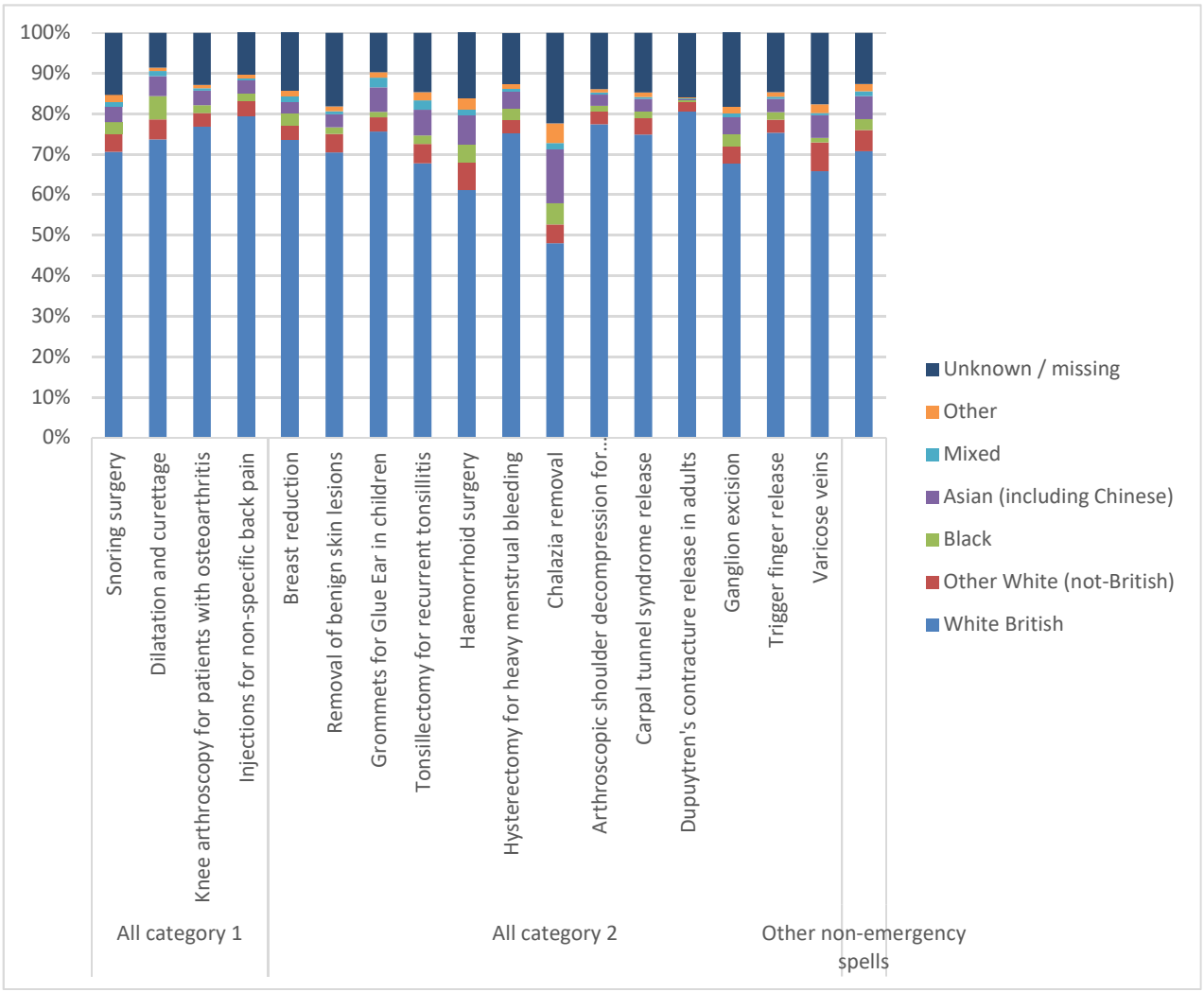
Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and 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.

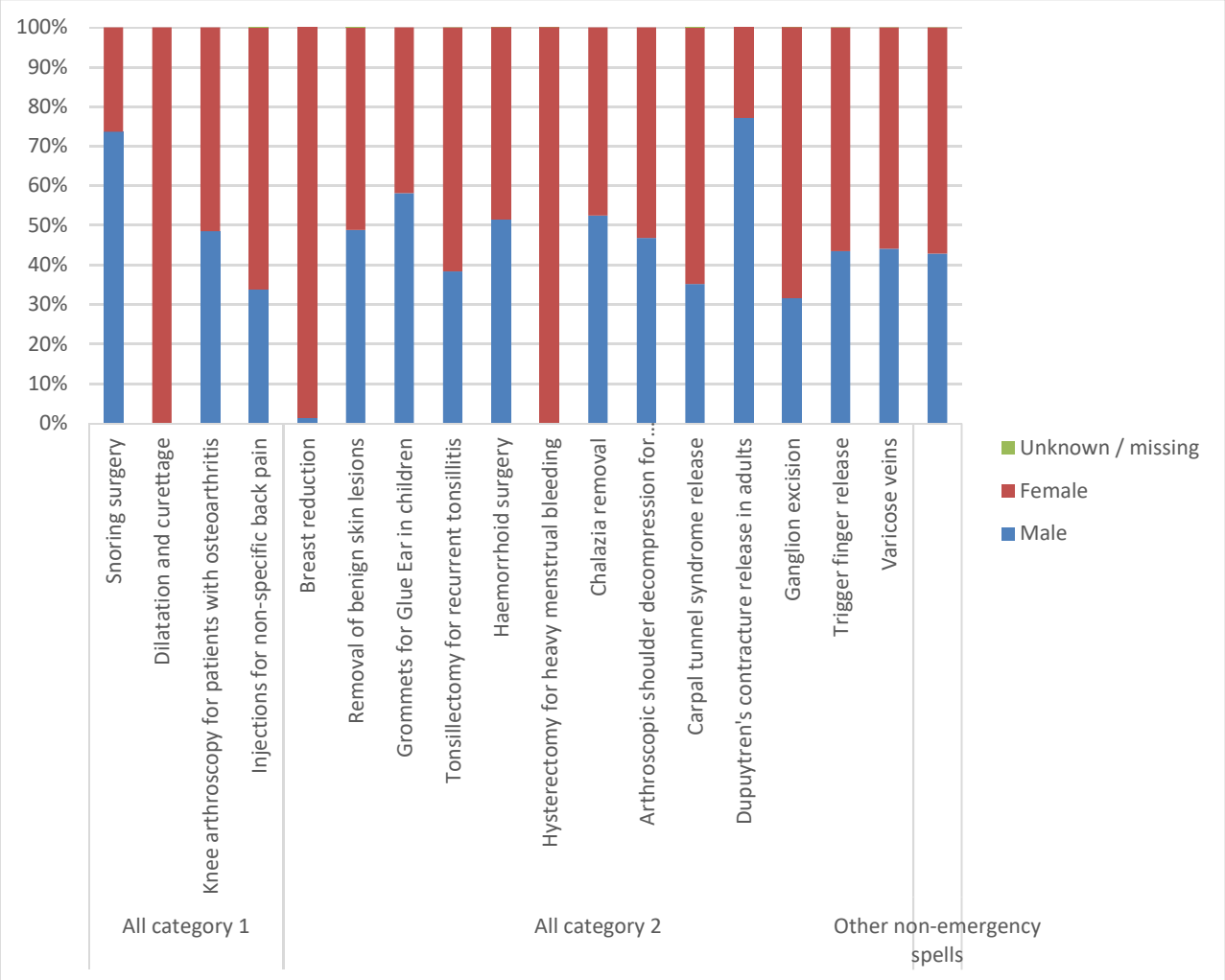
Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
When implemented, this guidance should prompt consideration of what is the most appropriate treatment in discussion between the doctor and their patient. The work aims to reduce health inequalities in access and 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[31], 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

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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.

Appendix 2: 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 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 refers to 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: Procedure and diagnostic codes

The coding for the interventions in this guidance has been updated since publication. To avoid any confusion it has been removed from this copy of the guidance.

Please refer to the EBI website for a complete list of coding for all Evidence-based Interventions, or to the individual intervention you are interested in.