APPENDIX 1

Nottingham University Hospitals NHS
NHS Trust

Trust Headquarters
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Thursday 29 November 2012

Councillor G Klein
Constitutional Services
L H Box 28
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Dear Councillor Klein,

Further to the Committee meeting I attended in September 2012, I am pleased to provide our second quarterly update which describes our improving cancelled operations performance.

In this update I include:

- A summary of the findings of the Mott MacDonald Report (the external review of cancelled operations, published in September 12). The report and our associated commentary was shared with the Committee ahead of publication
- An update on our performance for cancelled operations July-September 12

QUARTERLY UPDATE: 2

Please find below our second quarterly update for the Joint Health Scrutiny Committee, covering each area in turn where information has previously been requested by the Committee.

1. **An update on the progress, and outcomes, of the external review commissioned by the Trust into the upsurge in cancellations**

The report (external review), published in September 12, concluded that there was no single reason for the cancellations. Rather the increased pressure in

our emergency (and then) elective pathways was caused by the unforeseen and complex interaction of inter-related organisational and service changes.

In February 2011 we reduced our capacity at Nottingham City Hospital by 96 beds. We were able to do so safely by reducing internal waits and hence length of stay. The external report describes that the bed reductions did not cause the increase in cancellations. Several months passed between the bed closures and the marked rise in cancelled operations. But the bed closures did reduce the resilience of our system to changes in patient flows.

In April 2011 we changed the flow of patients to our Nottingham City Hospital and Queen's Medical Centre (QMC) campuses. In line with our strategy to develop QMC as our unselected emergency care centre and City Hospital as the focus for planned care and treatment (including emergency treatment) of long-term diagnoses, we directed patients with known illnesses to City Hospital and those with unknown diagnoses/conditions to QMC. Emergency general surgery (and elective gastroenterology) moved to QMC, patients with long-term illnesses were directed to City Hospital.

The report supports our safety and quality reasons for making these changes to the configuration of services across our campuses. It describes that, notwithstanding the significant number of cancellations and the pressure experienced by our hospitals and staff, our clinical outcomes remained among the finest in the country.

However, the report describes that our planned changes in patient flow were in a system which was already stressed. Although it was not immediately apparent in the number of cancellations or in any of the other numbers we track, the swing (daily and weekly) in the number of patients entering and leaving our hospitals had increased. The anticipated move of elective orthopaedics from QMC to City Hospital in April was delayed by staff concerns. Although bed numbers remained the same at QMC in the run up to winter 2011/12, the types of bed changed. Fewer elective beds were readily available for emergency use when there were peaks in demand.

The overall impact was that our system was less able to cope with extreme day-to-day variations in demand, and we took much longer to recover from very busy days, than in previous years.

In the first weeks of January QMC became overfull with emergency patients and we had no reasonable alternative than to cancel planned many operations. Even then it was several weeks until the system re-established an equilibrium and we were able to reduce cancellations.

Like other NHS hospitals we routinely tracked the number of operations cancelled on-the-day of planned surgery, but not all cancellations (including those before-the-day). Because we avoided on-the-day cancellations if at all possible they did not increase until our systems were very stressed, by which time there had already been a very significant increase in before-the-day

cancellations. We were unaware of this huge number of increased cancellations for several weeks.

The report describes that in future we can and should improve our planning to better take account of day-to-day variation in flow in and out of our hospitals. We should not rely on average numbers.

The full report and related action plan are available on our website at www.nuh.nhs.uk. The executive summary is attached as an appendix (Appendix 1).

2. Levels of last minute ('on the day') & prior to the day non-clinical cancelled operations

Mindful of the significant impact of the cancellations on our patients and their families, we have focused our efforts on reducing cancellations for all reasons. We can report that we have largely sustained our significantly improved position since the end of April 2012. Our Chief Executive's Team is sighted and reviews all cancellations weekly and our Trust Board on a monthly basis. This information is published monthly (as in Table 1).

January-October 2012 we cancelled 3,161 operations prior to the day and 977 operations 'on the day' (a total of 4,138 operations). In the same period we performed a total of 106,152 operations at NUH.

Notably, the prior to the day cancellation figures have reduced from 1,894 in Quarter 4 11/12 (Jan-March 12) to 704 in quarter 1 12/13 (April -June 12) and more recently to 443 in quarter 2 for 12/13 (July-September 12).

Please refer to Table 1 (below) for monthly figures for NUH (for 'on the day' and 'total' cancellations) for all reasons January-October 2012 and Table 2 (also below) for the percentage of cancellations (vs total admissions) for the same period.

The total cancellation rate January-March 2012 was 10%, compared to 2.7% for July-September 2012.

DEFINITIONS

- **'On the day' (or 'last minute')** means on or after the day the patient was due to be admitted for their operation (usually on the planned day of the surgery). For example: if a patient is admitted on a Monday for an operation on Tuesday and we cancel the operation on Monday or Tuesday, this would count as an 'on the day' cancellation.

- **'Prior to the day'** means before the day the patient was due to be admitted for their operation (this can range from one day before to several weeks before the scheduled surgery).

Table 1

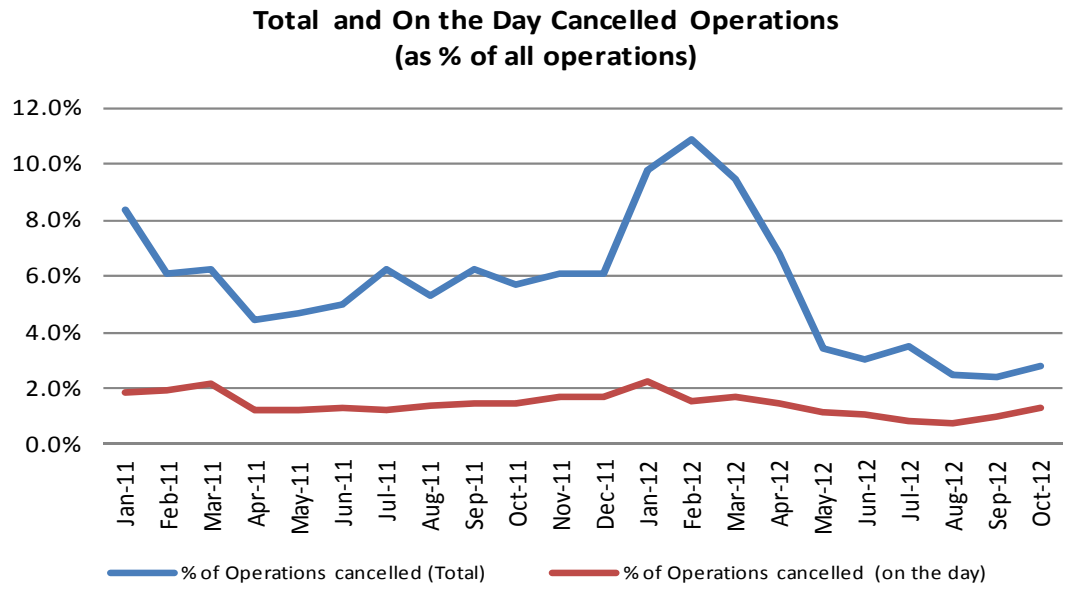
Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Ward Bed Unavailable	417	463	348	156	20	13	21	2	5	24
ICU/HDU Bed Unavailable	21	17	41	42	31	9	13	9	6	11
Clinical Priority	110	105	152	117	89	89	86	92	80	102
Staffing	62	98	83	59	73	44	70	34	29	55
Theatre Time	64	29	41	37	59	11	15	14	14	11
Administrative Error	29	29	31	14	4	9	11	13	11	15
Equipment	10	9	11	12	11	40	57	21	17	9
Other	38	53	52	30	0	1	6	1	1	
Total Cancelled Operations	751	803	759	467	287	216	279	186	163	227
% of Operations cancelled (Total)	9.82%	10.90%	9.44%	6.79%	3.40%	3.04%	3.46%	2.51%	2.36%	2.80%
Cancelled twice for the same procedure					12	19	32	12	10	24
Cancelled 3 times for the same procedure					1	8	16	6	2	3
Cancelled 4 times or more for the same procedure					1	0	5	1	0	0
On the day Cancelled Operations	169	115	135	98	95	73	64	55	66	107
% of Operations cancelled (on the day)	2.21%	1.56%	1.68%	1.43%	1.12%	1.03%	0.79%	0.74%	0.95%	1.32%
Cancelled twice for the same procedure	13	11	11	12	6	2	5	3	1	6
Cancelled 3 times for the same procedure	1	3	5	0	1	0	1	0	0	1
Cancelled 4 times or more for the same procedure	0	0	0	0	1	0	0	0	0	0

A total of 227 operations were cancelled in October (including 107 ‘on the day’). This was higher than the previous months and is the first time since April we have seen an increase in cancellations. This increase was mainly due to ‘on the day’ cancellations due to ward and critical care bed capacity and clinical priority of other patients in theatre.

As at Monday 26 November (at the time of writing this paper), the latest figures for November for total cancellations was 172. This compares to 227 in October, 163 in September, 186 in August, 279 in July, 216 in June and 287 in May.

We have reviewed all reasons for cancellations. We have made significant improvements in relation to cancellations due to bed unavailability. The main reason for cancellation is in relation to patients being rescheduled to accommodate more clinically-urgent patients. We are progressing further work with clinical colleagues to understand how we further reduce these cancellations while also retaining appropriate access for clinically-urgent cases.

Table 2



3. Comparator information from similar major trusts in the region

The Department of Health publishes comparative information for all NHS Trusts on a quarterly basis. This allows NUH to see how we compare with our peer organisations (and other Trusts around the region) for 'on the day' cancellations. The recently- published Department of Health figures for Quarter 2 'on the day' cancellations demonstrate that NUH's position compared to peer hospitals has improved markedly since quarter 1.

The comparative data for Quarter 2 (July-September 2012) was published in November 2012 (see Appendix 1). NUH had 193 'on the day' cancellations for Quarter 2, compared to 286 in quarter 1 (April-June 12) and 454 'on the day' cancellations the previous quarter (December 2011-March 2012), as previously shared with the Committee.

215: Sheffield
204: Cambridge
202: Leicester
193: NUH
188: Leeds
159: Birmingham
135: Bristol

We are confident that the Quarter 3 figures for 2012/13 will show a sustained improvement in our performance as a result of the ongoing actions we are taking to reduce cancellations (as described on page 2).

4. **Benchmarking performance against the national standard, where available**

See response to question 3. The Department of Health comparative data (which is published quarterly) is only available for 'on the day' cancellations. We believe we are first trust in the country to report 'total' cancellations. As these numbers are not routinely collected or made available, as such no comparative data is currently available.

An assessment of the knock-on effect of the upsurge in cancellations on waiting times for non-urgent elective operations, the Committee being concerned that patients suffering cancellations could potentially face ever-longer waiting times for rescheduled operations

We continue to prioritise patients who have operations cancelled when booking operations, to ensure patients have their operations as soon as possible. We have increased the number of patients who we readmit within the 28 day national standard compared to earlier this year. Since April, 81 out of 583 who had their operations cancelled on the day (13.8%) were not readmitted for their operation within the 28 day standard. The national target is 5%.

We have more work to do to improve our performance Vs the 28 day readmission percentage although there are signs that our performance is improving. April 12 – 25 patients (were not readmitted within 28 days), May 12 – 15 patients, June 12 – 11, July 12 – 6, August 12 – 7, September 12 – 9 and October 12 – 8.

There are a very small number of cases each month where either the complexity of the treatment and the resources required to deliver it or the prioritisation of more clinically-urgent patients means it is not possible to offer earlier dates without compromising patient safety or subjecting another patient to cancellation.

If there is any further information that I can provide in advance of the Committee meeting on 11 December please do not hesitate to contact me. I look forward to seeing you at next month's meeting.

Yours sincerely,

Peter Homa, Chief Executive
Appendix 1 – Executive Summary – Mott MacDonald Report (external review)

Executive Summary

Overview

1. This report has been commissioned to identify the main reasons for the high level of elective cancellations at Nottingham University Hospitals NHS Trust (NUH) in the winter of 2011/12. Its findings and recommendations will be used to improve resilience and performance in the future.

2. The path which led to the unacceptably high level of cancellations was complex, and there was no single cause of failure.

3. The trust has maintained its position as one of the best in the country in terms of clinical outcomes. To have sustained this while navigating through the significant disruption of last year is a considerable achievement.

4. The relative contribution of individual factors to the cancellations is difficult to assess, as there were multiple interdependencies and a cumulative impact. We consider the most important single contributor was loss of synchronicity in a planned reconfiguration of services across the Trust's two main campuses. This reconfiguration, moving emergency surgery and undifferentiated medical emergencies to the QMC campus and elective activity to the City campus was undertaken for valid patient safety, clinical quality and workforce sustainability reasons. During the process of reconfiguration the planned revised flow of emergency and elective patients to the two campuses became un-synchronised. This led to a loss of resilience and unpredictable changes in the system when controls were applied in an effort to meet demand and maintain both emergency and elective services.

5. Reporting systems were not sensitive enough to changes in processes (in emergency and elective services) and did not pick up early warnings that resilience had been lost and that consequently (1) elective cancellations were higher than should be expected and (2) there was an increasing underlying number of emergency patients placed on non-core-specialty wards (outliers).

6. If individual services had considered more fully the impact of local changes on the overall capacity of the system, and had this been more visible to the leadership team, the Trust could have managed the loss of synchronicity (and hence resilience) more effectively.

7. The removal of 96 beds from the City Hospital campus in February 2011 did not itself cause the increase in cancellations, though it was one of the many elements increasing stress on the system.

8. A number of other internal and external factors relating to patient volumes and case-mix have been investigated as possible contributory factors to the rise in cancellations. These include: an increased number of emergency admissions, an increase in the acuity of ED attendances and subsequent admissions, an increasing age of emergency admissions, and a longer length of stay of emergency admissions. The report finds that these played a relatively minor part in the system deterioration and increased cancellations.

Key Findings

KF1: Changes made to the organisation of services across the two campuses resulted in a loss of resilience in the system : it was unable to cope with the combination of peak demands for emergency admissions and continuing elective demand, and to recover from the destabilisation caused by the emergency peaks. The changes caused the system to behave in an unexpected manner, rendering forecasts and planning assumptions invalid. This was a novel situation that could not have been predicted from previous experience.

KF2: Disparate information systems and flows made collation of a clear and unified picture challenging. Information provided to all levels of Trust management no longer represented the whole system, due to multiple planned and tactical changes (both local and corporate).

KF3: The growing problem was not visible early. In retrospect the system had probably changed (become unstable and unpredictable) by September 2011. Indeed there is some evidence that there had been a change in the system (to a different but relatively steady state) at least a year earlier (before the closure of beds in February 2010 and before the service reconfigurations through 2011/12). But the Trust's routine reports (supporting decision-making) did not signal the growing system failure until December 2012.

KF4: A multitude of local and corporate process workarounds were enacted to cope with a system that was becoming unstable and not reacting as it had previously to changes in demand or to control measures. Rather than reasserting control, in the absence of an understanding of the fundamental system-wide issues, these workarounds amplified the instability.

Conclusion

9. There was no single cause of the increased cancellations in winter 11/12. Three factors were pre-eminent:

a. Although most individual decisions about the emergency and elective pathways over the period were reasonable, they were based on incomplete data and forecast models which over-relied on average previous numbers (rather than 'worst case' numbers and variation).

b. Service moves between QMC and City (reconfiguration) did not happen with the anticipated choreography. This led to a loss of flexibility of bed use at QMC; notably the number of beds readily available for emergencies (the potential outlier "buffer") at QMC was reduced. The availability of beds for elective operations (at QMC and City) became more difficult to predict. This inefficiency in bed use coincided with a period in which emergency and elective volumes were unsteady because of Christmas and bank holidays. To maintain capacity for emergencies the Trust cancelled an increasing number of electives. In an effort to maintain elective activity the Trust rescheduled elective operations as soon as there seemed to be some capacity. This led to an increased swing in the pattern of flow into and out of the hospital beds. The day-to-day and week-to-week fluctuation in availability of beds for operations increased dramatically. Such a system is unstable, difficult to control, and lacks resilience if faced with short-term (days or even hours) increases in demand.

c. There was limited awareness of this instability and loss of resilience, the swinging day-by-day flow, and the number of cancellations, because information on prior-to-the-day cancellations was not routinely collated across the trust, or escalated through its performance management mechanisms. On-the-day cancellations, which the Trust did track, are a much less sensitive indicator of system deterioration. This in turn meant that the corporate response, integrated across all directorates, was later than it might have been. By the time of this corporate escalation and response there had been many hundreds of additional prior-to-the-day cancellations.

10. The combination of a severe loss of resilience, inadequate information flows and an inability to fully coordinate cancellations led to an increasingly unstable system, running with a high background level of cancellations (to which the 2010 system change may have contributed earlier). In this circumstance a relatively minor seasonal increase in demand over the winter of 2011/12 had a disproportionate impact because the system could no longer cope with any further variation (or increase) in demand. The planned responses to cope with even short-term (hours or days) changes in demand were no longer sufficient, and the Trust found itself in uncharted waters, requiring wholesale cancellation of operations – a situation that had not been modelled, so decisions could not be based on any reliable projections.

11. Focus should now be brought to aligning the resources on the two sites with the demand on them. This needs to be supported by an accurate and timely picture of the status of the trust's emergency and elective systems, which will require unification of its information systems to enable effective decision-making.

Appendix 2 – Benchmarking figures published by the Department of Health

The number of last minute cancelled elective operations in the quarter for non-clinical reasons, NHS provider organisations in England for Quarter 2 (July-September 2012)

SHA Code	Organisation Code	Organisation Name	Number of last minute elective operations cancelled for non clinical reasons	Number of patients not treated within 28 days of last minute elective cancellation
-	-	**England (Excluding Independent Sector)**	**13,122**	**577**
-	-	**England (Including Independent Sector)**	**13,154**	**590**

Q30	RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	28	0
Q30	RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	82	1
Q30	RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	15	0
Q30	RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	130	0
Q30	RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	61	0
Q30	RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	100	7
Q30	RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	36	0
Q30	RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	80	1
Q31	NT497	BMI GISBURNE PARK HOSPITAL	0	0
Q31	RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	74	12
Q31	RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	90	0
Q31	RBQ	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	5	0
Q31	RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5	0
Q31	RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	89	10
Q31	RBV	THE CHRISTIE NHS FOUNDATION TRUST	2	0
Q31	REM	AINTREE UNIVERSITY HOSPITAL NHS	82	9

		FOUNDATION TRUST		
Q31	REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	27	1
Q31	RET	THE WALTON CENTRE NHS FOUNDATION TRUST	47	3
Q31	RJN	EAST CHESHIRE NHS TRUST	22	0
Q31	RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	55	0
Q31	RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	144	1
Q31	RM3	SALFORD ROYAL NHS FOUNDATION TRUST	54	0
Q31	RMC	BOLTON NHS FOUNDATION TRUST	94	1
Q31	RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST	35	0
Q31	RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	73	4
Q31	RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	55	1
Q31	RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	130	3
Q31	RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	168	22
Q31	RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	63	3
Q31	RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	92	2
Q31	RW6	PENNINE ACUTE HOSPITALS NHS TRUST	141	0
Q31	RWJ	STOCKPORT NHS FOUNDATION TRUST	97	3
Q31	RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	119	3
Q31	RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	54	0
Q31	RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	128	5
Q31	RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	103	5
Q32	NTP23	ECCLESHILL NHS TREATMENT CENTRE	29	13
Q32	RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	143	0
Q32	RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	151	1
Q32	RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	35	0
Q32	RCF	AIREDALE NHS FOUNDATION TRUST	31	0
Q32	RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	15	0
Q32	RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	51	0
Q32	RFR	THE ROTHERHAM NHS FOUNDATION TRUST	72	0
Q32	RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	215	2
Q32	RJL	NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST	75	0
Q32	RP5	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	83	0
Q32	RR8	LEEDS TEACHING HOSPITALS NHS TRUST	188	7

Q32	RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	163	0
Q32	RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	75	0
Q32	RXF	MID YORKSHIRE HOSPITALS NHS TRUST	86	0
Q33	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	63	2
Q33	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	59	1
Q33	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	75	1
Q33	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	126	0
Q33	RTG	DERBY HOSPITALS NHS FOUNDATION TRUST	61	0
Q33	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	190	68
Q33	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	202	15
Q33	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	193	22
Q33	RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	18	0
Q34	R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0
Q34	RBK	WALSALL HEALTHCARE NHS TRUST	42	0
Q34	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	11	0
Q34	RJD	MID STAFFORDSHIRE NHS FOUNDATION TRUST	80	4
Q34	RJE	UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST	229	3
Q34	RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	50	0
Q34	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	94	2
Q34	RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	18	0
Q34	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	72	0
Q34	RLQ	WYE VALLEY NHS TRUST	17	0
Q34	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	37	1
Q34	RLU	BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST	4	0
Q34	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	40	0
Q34	RQ3	BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	107	6
Q34	RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	150	0
Q34	RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	8	0
Q34	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	159	0
Q34	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS	90	1

		TRUST		
Q34	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	85	1
Q34	RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	207	45
Q34	RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST	0	0
Q35	5PT	SUFFOLK PCT	2	0
Q35	NNQ01	BRAINTREE COMMUNITY HOSPITAL	2	0
Q35	RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	140	6
Q35	RC1	BEDFORD HOSPITAL NHS TRUST	34	4
Q35	RC9	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	30	1
Q35	RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	99	15
Q35	RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70	4
Q35	RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	25	0
Q35	RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	96	3
Q35	RGN	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	101	11
Q35	RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	53	2
Q35	RGQ	IPSWICH HOSPITAL NHS TRUST	56	0
Q35	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	39	0
Q35	RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	204	7
Q35	RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	226	37
Q35	RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	186	6
Q35	RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST	45	2
Q35	RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	62	10
Q35	RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	103	6
Q35	RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	23	0
Q35	RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	2	0
Q36	R1H	BARTS HEALTH NHS TRUST	243	0
Q36	RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	102	0
Q36	RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	28	0
Q36	RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	14	0
Q36	RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	29	3
Q36	RAX	KINGSTON HOSPITAL NHS TRUST	18	1
Q36	RC3	EALING HOSPITAL NHS TRUST	25	0

Q36	RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	83	2
Q36	RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	12	0
Q36	RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	94	1
Q36	RJ2	LEWISHAM HEALTHCARE NHS TRUST	50	7
Q36	RJ6	CROYDON HEALTH SERVICES NHS TRUST	61	0
Q36	RJ7	ST GEORGE'S HEALTHCARE NHS TRUST	78	2
Q36	RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	118	12
Q36	RKE	THE WHITTINGTON HOSPITAL NHS TRUST	20	0
Q36	RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	36	0
Q36	RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	39	0
Q36	RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	7	0
Q36	RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	19	2
Q36	RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	6	0
Q36	RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	152	14
Q36	RT3	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	92	0
Q36	RV8	NORTH WEST LONDON HOSPITALS NHS TRUST	112	1
Q36	RVL	BARNET AND CHASE FARM HOSPITALS NHS TRUST	88	0
Q36	RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	74	0
Q36	RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	190	6
Q36	RYQ	SOUTH LONDON HEALTHCARE NHS TRUST	372	17
Q37	NTP16	WILL ADAMS NHS TREATMENT CENTRE	1	0
Q37	RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	68	2
Q37	RDU	FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	40	0
Q37	RN7	DARTFORD AND GRAVESHAM NHS TRUST	44	2
Q37	RPA	MEDWAY NHS FOUNDATION TRUST	80	0
Q37	RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	0
Q37	RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	12	0
Q37	RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	35	2
Q37	RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	103	8
Q37	RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	39	0
Q37	RXC	EAST SUSSEX HEALTHCARE NHS TRUST	53	1
Q37	RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	96	0

Q37	RYR	WESTERN SUSSEX HOSPITALS NHS TRUST	115	3
Q38	R1F	ISLE OF WIGHT NHS TRUST	34	6
Q38	RD7	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	175	18
Q38	RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	70	0
Q38	RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	92	6
Q38	RHU	PORTSMOUTH HOSPITALS NHS TRUST	82	1
Q38	RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	67	5
Q38	RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	29	0
Q38	RTH	OXFORD UNIVERSITY HOSPITALS NHS TRUST	Data not returned	Data not returned
Q38	RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	15	0
Q38	RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	60	2
Q39	5QH	GLOUCESTERSHIRE PCT	0	0
Q39	RA3	WESTON AREA HEALTH NHS TRUST	2	0
Q39	RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	43	0
Q39	RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	135	11
Q39	RA9	SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	92	10
Q39	RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	97	0
Q39	RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	64	0
Q39	RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	41	0
Q39	RD1	ROYAL UNITED HOSPITAL BATH NHS TRUST	131	0
Q39	RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	77	1
Q39	RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0
Q39	RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	65	1
Q39	REF	ROYAL CORNWALL HOSPITALS NHS TRUST	99	1
Q39	RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0	0
Q39	RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	131	6
Q39	RK9	PLYMOUTH HOSPITALS NHS TRUST	199	5
Q39	RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	56	0
Q39	RNZ	SALISBURY NHS FOUNDATION TRUST	83	4
Q39	RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	200	4
Q39	RVJ	NORTH BRISTOL NHS TRUST	82	17