

Excess bed day incentive scheme

Summary

1. This document sets out the key recommended features of voluntary local incentive schemes to reduce excess bed days, which will in turn:
 - Improve patient flow and efficiency in acute hospitals to improve patient outcomes and experience
 - Help acute hospitals reduce super-stranded patients by 25% to reduce the patient harm that comes from excessive stays in hospitals and create the extra capacity needed for elective and emergency care
 - Recognise that community providers need to be appropriately reimbursed if they are to care for more patients
 - Share the benefits across participating organisations
 - Encourage more integrated working on delayed discharges, 'stranded' patients and reducing length of stay
2. **Annex 1** provides background information.
3. Local areas are expected to adopt an excess bed day incentive scheme to improve patient experience and improve efficiency across the local health economy. This is particularly important for the CCGs with the highest excess bed day spend per head of weighted population. The CCGs which lie in the highest quartile of CCGs ranked by excess bed days per head of weighted population, are shown in Annex 2.

Proposed key features of local incentive schemes

4. Community and acute providers should agree with the CCG a baseline level of excess bed days that the CCG will have to fund if the status quo remains and a target for the reduction of this number in the local acute provider that will result from focused management and investment in community services. The community provider, CCG and acute provider should then agree a plan to reduce the number of excess bed days and transfer patients to the most appropriate setting.
5. If the total number of excess bed day payments by the CCG to the acute provider falls, then all the savings to the CCG should be transferred to the community provider, unless the local partners agree to share the savings in a different way. If the CCG and/or acute provider agree to invest in community services in advance to share the upfront risk with the community provider, they should expect to recover their investment and a share of any additional savings if the programme is successful.
6. Most of the service changes necessary to deliver the reduction in excess bed days should be achievable through targeted management within the community services, with any additional investment in staff and services funded by the resulting reduction in excess bed days and a monthly transfer of resources from the CCG.

7. The CCG, acute provider and community provider should agree a series of KPIs for any investment in community services, such as:
 - a. A specified number of community beds and community teams available
 - b. The planned growth in beds or non-inpatient staff
 - c. Community bed occupancy to remain below a set percentage and domiciliary productivity to go up through more efficiency work
 - d. Community discharge planning team available 7 days per week
 - e. Admissions are accepted by the community provider 7 days per week
8. Where there are multiple community providers supporting the same acute provider, local agreement will be required on how funds will be distributed and how risk will be shared.
9. The reduction in excess bed days should contribute to freeing up capacity in the acute setting and continued improvements in patient flow through the hospital. Most parts of the country are currently not meeting waiting time standards or reducing their emergency bed occupancy to the required levels to confidently prepare for winter. As a result, it may be possible to use this freed up capacity to provide elective activity that is covered by existing contracts without an adverse impact on CCG finances.
10. Where acute providers are able to over-perform their elective contract, the provider and commissioner should discuss the affordability of using any freed capacity to further increase levels of activity.
11. It is likely that in taking targeted action to reduce excess bed days, there will also be some reductions in length of stay for some patients who are current long stayers but below the excess bed day trim point. This will help to offset the loss of income for the acute provider and improve patient flow to help meet the 4-hour A&E standard.

Local and national monitoring

12. Local areas should set clear and specific targets for the reductions in excess bed days that they are seeking to achieve from targeted action – with clarity about the specialties (some or all) to which these targets apply.
13. Routine monitoring of these metrics, along with regular local performance reviews, should identify early on where actions are having the desired effect and where they are not. Discussions about any remedial action to return to plan should happen regularly and with reference to performance in peer organisations.
14. Nationally, we will regularly publish statistics of excess bed days by CCG and provider.

National tariff payment system

15. Where local areas have agreed contracts using national prices as specified in the National Tariff Payment System (NTPS), the commissioner will need to submit a

local variation to NHS England and NHS Improvement to confirm any new arrangements. To help reduce burden locally, NHS England and NHS Improvement will produce some exemplar templates that can be used to submit this information.

16. Areas of the country that have already agreed local variations to prices specified in the national tariff should still agree a local incentive scheme if it is likely to reduce length of stay in the acute provider by an amount greater than planned. Where areas are operating with some form of block or fixed payment, the published national prices for excess bed days could be used as a starting point for local negotiation.

Annex 1 - Background

1. Some patients stay in hospital longer than others, even if they have similar characteristics and receive similar treatment. In order to fairly reimburse hospitals when patients remain in hospital longer than expected, the national tariff payment system requires that CCGs pay an additional amount to the provider per day after a pre-determined length of stay¹, which varies by HRG – an excess bed day payment. In 2017/18 commissioners paid providers £0.6bn² in excess bed day payments. However, the number of excess bed days varies across the country, and the highest quartile of CCGs pay for almost three times the rate of excess bed days compared to the ones in the lowest quartile. This is after controlling for each CCG's weighted population and so cannot be explained by casemix alone.
2. If all CCGs had an excess bed day rate per head of weighted population equal to the average of the upper quartile of performers, around 1 million bed days would be freed up from acute hospitals, offering better patient experience and improved patient flow across the hospital. This offers the potential to free up around £0.2bn of the £0.6bn paid in excess bed days to be invested in community services to provide care closer to home for tens of thousands of patients.

Patients with long lengths of stay

3. There are likely to be three main reasons that patients stay in hospital for a longer than expected period triggering these excess bed day payments:
 - Even within the same HRG, the complexity of patients' needs varies. Some patients will stay in hospital for good medical reasons, probably within specialist centres.
 - In some cases, patients could be discharged sooner with more consistent clinical practice and organisation within the hospital.
 - Some patients will be medically fit for discharge but cannot be discharged because of delays in setting up the health and care support packages needed to support them at home.
4. Some stranded patients (patients with a length of stay of 7 days or more) and super stranded patients (patients with a length of stay of 21 days or more) could be discharged from hospital earlier with better service integration between acute and community organisations. Some of these stranded and super stranded patients will have stayed in hospital for a period of time which triggers excess bed day payments.

¹ This 'trimpoint' is calculated for each HRG as the upper quartile plus 1.5 times the interquartile range. Each trimpoint is published in the national tariff payment system document.

² Providers reported they incurred £1.4bn of excess bed day costs in 2016/17 reference costs (£1.2bn relating to non-elective admissions). For payment purposes, the tariff is calculated on a spell basis rather than an episode basis (as in reference costs) and a floor of 5 days is introduced which prevents an incentive to keep very short staying patients in one extra day to trigger an excess bed day payment, which may be a relatively high amount compared to the cost of the spell. Taken together, the payment system explicitly reimburses around half of the provider self-reported excess bed day costs in reference costs through excess bed day payments.

New local incentive schemes

5. By creating a local incentive scheme which aims to reduce the number of stranded and super stranded patients, resources which were being used by commissioners to pay for long staying patients in hospital (the excess bed day payments) can be redeployed to other parts of the health system to provide more opportunities to discharge patients in a more timely manner, when medically fit to do so.
6. Local areas should seek to reduce lengths of stay across the inpatient setting by following best practice guidance on discharging patients and with regard to levels in peer organisations. NHS Improvement has published the “Good practice guide: Focus on improving patient flow³” which may be used as the starting point for a best practice discussion.
7. The guide sets out:

“The outcome of following best practice is that patients are discharged as soon as they no longer benefit from acute hospital care and in most cases, discharge is to a person’s usual place of residence. The core principles to follow to achieve such an outcome are:

- *Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell.*
 - *On admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital.*
 - *A clear clinical care plan must be set for all patients within 14 hours of admission, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge.*
 - *There should be a strong focus on ‘simple’ discharges. The SAFER patient flow bundle and ‘Red2Green days’ tools should be used routinely to ensure the most appropriate care for patients on all hospital wards.*
 - *Board rounds should take place on all hospital wards each morning. The multidisciplinary team should review the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient.*
 - *Duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission (see below).*
 - *There should be a single point of access for health and social care to support ‘discharge to assess’. Integrated discharge teams should be linked to an integrated intermediate tier of local services.”*
8. Local areas should focus on how better use of community and out of hospital services can improve patient flow in the hospital. This may require investment in additional community capacity or redesigning how existing community services interact with patients who are in hospital.

³ <https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow>

Variations in levels of excess bed days

9. CCG commissioned activity data shows that there were around 2.3m excess bed days in 2017/18, around 38 excess bed days per 1,000 population, but this hides variation at CCG level. The lowest quartile CCGs had on average 21 excess bed days per 1,000 weighted population, compared to 57 in the highest quartile. Table 2 shows the summary by quartile, ranking CCGs from highest to lowest number of excess bed days per head of weighted population.
10. Annex 2 shows each CCG ranked by excess bed days per 1,000 weighted population.
11. Specialty level data also shows variation, with paediatric specialties incurring the highest proportions of bed days classed as excess bed days. In raw numbers, nervous system, digestive system and respiratory system accounted for around 0.8 million excess bed days, around one third of the total number of bed days including non-CCG commissioned activity. Annex 3 shows the differences between specialties.

Table 2 – summary excess bed days by CCG quartile and reduction opportunity

Quartile	Excess bed days	Weighted Population	Excess bed days per head of weighted population	Reduction if everyone at the lowest quartile rate
1	921,041	16,126,731	57.1	575,363
2	630,676	16,794,551	37.6	270,683
3	395,553	13,067,381	30.3	115,452
4	272,896	12,731,257	21.4	-
All	2,220,166	58,719,921	37.8	961,498

12. Local incentive schemes could be targeted at the specialties with the largest number of excess bed days and/or specialties where the number of excess bed days appears to be a significant problem compared to peer organisations.

Annex 2 – Variation in the number of excess bed days January-December 2017

CCG Name	Excess Bed Days	Weighted Population	Excess bed days per 1000 weighted population
NHS City and Hackney CCG	26,517	217,080	122.2
NHS Trafford CCG	23,002	255,599	90.0
NHS Manchester CCG	46,861	570,358	82.2
NHS Lewisham CCG	19,781	250,728	78.9
NHS Portsmouth CCG	15,174	203,159	74.7
NHS South Sefton CCG	13,620	189,449	71.9
NHS Dorset CCG	62,622	897,136	69.8
NHS Bath and North East Somerset CCG	13,850	198,603	69.7
NHS Cumbria CCG	26,023	381,336	68.2
NHS West Hampshire CCG	40,777	602,187	67.7
NHS Nene CCG	42,067	651,154	64.6
NHS Lancashire North CCG	28,491	443,878	64.2
NHS Southampton CCG	15,743	264,745	59.5
NHS East Lancashire CCG	25,974	442,508	58.7
NHS Fareham and Gosport CCG	12,521	214,680	58.3
NHS Leeds CCG	47,638	841,070	56.6
NHS Dartford, Gravesham and Swanley CCG	13,854	253,318	54.7
NHS South Eastern Hampshire CCG	12,342	226,776	54.4
NHS North Hampshire CCG	11,913	219,566	54.3
NHS North East Hampshire and Farnham CCG	11,873	219,039	54.2
NHS Oxfordshire CCG	34,264	635,244	53.9
NHS Buckinghamshire CCG	26,687	496,338	53.8
NHS Sutton CCG	9,286	178,215	52.1
NHS Cannock Chase CCG	8,093	155,613	52.0
NHS Corby CCG	3,961	76,311	51.9
NHS Surrey Heath CCG	4,900	95,014	51.6
NHS Doncaster CCG	18,298	361,467	50.6
NHS Stockport CCG	18,131	359,726	50.4
NHS Fylde & Wyre CCG	9,703	196,564	49.4
NHS Swindon CCG	10,431	212,607	49.1
NHS Norwich CCG	10,624	219,904	48.3
NHS Somerset CCG	31,515	652,509	48.3
NHS Tameside and Glossop CCG	13,772	285,253	48.3
NHS Wiltshire CCG	25,080	521,815	48.1
NHS Bexley CCG	10,783	231,344	46.6
NHS Greenwich CCG	11,064	238,883	46.3
NHS Blackburn with Darwen CCG	8,780	190,599	46.1
NHS Herefordshire CCG	9,244	202,417	45.7
NHS North Norfolk CCG	9,653	211,415	45.7
NHS West Leicestershire CCG	17,059	373,722	45.6
NHS West Kent CCG	21,099	466,097	45.3
NHS East Surrey CCG	8,031	177,628	45.2
NHS Eastbourne, Hailsham and Seaford CCG	10,297	229,883	44.8
NHS Surrey Downs CCG	12,813	287,086	44.6
NHS Lambeth CCG	12,333	279,652	44.1
NHS Ealing CCG	14,725	335,225	43.9
NHS Sheffield CCG	25,691	588,192	43.7
NHS Bromley CCG	14,081	325,636	43.2
NHS Newcastle Gateshead CCG	24,591	573,862	42.9
NHS Southport and Formby CCG	6,699	158,608	42.2
NHS Blackpool CCG	9,155	217,079	42.2

NHS High Weald Lewes Havens CCG	7,465	177,500	42.1
NHS Liverpool CCG	24,663	586,438	42.1
NHS Berkshire East CCG	15,704	378,345	41.5
NHS Stafford and Surrounds CCG	6,846	167,613	40.8
NHS Bristol, North Somerset and South Gloucestershire CCG	38,730	953,317	40.6
NHS Greater Preston CCG	9,308	230,302	40.4
NHS Hillingdon CCG	10,943	273,940	39.9
NHS Stoke on Trent CCG	12,475	313,471	39.8
NHS Wandsworth CCG	10,204	256,506	39.8
NHS Southwark CCG	9,295	234,166	39.7
NHS Milton Keynes CCG	10,054	254,054	39.6
NHS North Tyneside CCG	10,563	270,230	39.1
NHS Brighton & Hove CCG	10,028	258,192	38.8
NHS Kernow CCG	27,017	697,744	38.7
NHS Scarborough and Ryedale CCG	5,358	138,940	38.6
NHS Walsall CCG	11,800	306,479	38.5
NHS Merton CCG	6,515	169,756	38.4
NHS Harrogate and Rural District CCG	6,469	169,512	38.2
NHS Lincolnshire East CCG	11,767	308,392	38.2
NHS Birmingham and Solihull CCG	48,050	1,266,141	37.9
NHS West Lancashire CCG	5,004	133,970	37.4
NHS Great Yarmouth & Waveney CCG	10,639	287,302	37.0
NHS South Norfolk CCG	8,857	240,043	36.9
NHS Haringey CCG	8,833	240,267	36.8
NHS Guildford and Waverley CCG	7,218	198,026	36.4
NHS West Norfolk CCG	8,090	223,153	36.3
NHS Horsham and Mid Sussex CCG	8,223	228,204	36.0
NHS Coventry and Rugby CCG	17,274	479,962	36.0
NHS Lincolnshire West CCG	8,660	243,831	35.5
NHS Herts Valleys CCG	20,601	580,985	35.5
NHS South East Staffs and Seisdon Peninsular CCG	8,594	242,721	35.4
NHS Northumberland CCG	14,485	409,423	35.4
NHS East Leicestershire and Rutland CCG	11,731	332,164	35.3
NHS North Staffordshire CCG	8,582	243,080	35.3
NHS Gloucestershire CCG	22,916	650,153	35.2
NHS North East Lincolnshire CCG	6,444	183,472	35.1
NHS Enfield CCG	9,976	285,730	34.9
NHS West Cheshire CCG	10,372	297,504	34.9
NHS North, East, West Devon CCG	35,991	1,038,992	34.6
NHS Thurrock CCG	5,473	158,695	34.5
NHS North Durham CCG	10,004	290,923	34.4
NHS South Tyneside CCG	6,948	203,511	34.1
NHS Hounslow CCG	7,974	234,920	33.9
NHS Tower Hamlets CCG	6,915	203,725	33.9
NHS Berkshire West CCG	14,641	431,535	33.9
NHS Durham Dales, Easington and Sedgefield CCG	12,532	371,673	33.7
NHS Cambridgeshire and Peterborough CCG	28,784	857,008	33.6
NHS Croydon CCG	11,593	345,575	33.5
NHS Harrow CCG	7,354	220,364	33.4
NHS Hastings & Rother CCG	7,095	212,725	33.4
NHS Waltham Forest CCG	8,052	242,212	33.2
NHS Airedale, Wharfedale and Craven CCG	6,069	184,522	32.9
NHS Coastal West Sussex CCG	19,690	601,829	32.7
NHS Eastern Cheshire CCG	7,334	225,743	32.5
NHS Halton CCG	5,136	158,601	32.4
NHS Thanet CCG	5,370	166,617	32.2
NHS Crawley CCG	3,888	121,615	32.0

NHS Central London (Westminster) CCG	4,640	146,412	31.7
NHS South West Lincolnshire CCG	4,572	144,550	31.6
NHS Wirral CCG	13,473	426,931	31.6
NHS Calderdale CCG	6,950	220,868	31.5
NHS Ipswich and East Suffolk CCG	13,290	424,469	31.3
NHS Hartlepool and Stockton-on-Tees CCG	10,887	347,891	31.3
NHS Isle of Wight CCG	5,103	163,266	31.3
NHS Wakefield CCG	13,217	424,899	31.1
NHS Brent CCG	8,820	283,808	31.1
NHS Leicester City CCG	10,273	331,199	31.0
NHS South Lincolnshire CCG	5,728	185,709	30.8
NHS Basildon and Brentwood CCG	8,317	271,765	30.6
NHS Bradford City CCG	3,320	109,441	30.3
NHS North Derbyshire CCG	10,190	336,867	30.2
NHS East Staffordshire CCG	4,423	146,462	30.2
NHS North Lincolnshire CCG	5,804	192,201	30.2
NHS Knowsley CCG	6,361	213,757	29.8
NHS Warrington CCG	7,128	241,459	29.5
NHS Redditch and Bromsgrove CCG	5,322	183,574	29.0
NHS Bradford Districts CCG	10,444	360,291	29.0
NHS Luton CCG	5,879	203,911	28.8
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	5,172	181,041	28.6
NHS Redbridge CCG	7,142	250,020	28.6
NHS Richmond CCG	4,537	159,232	28.5
NHS Hammersmith and Fulham CCG	4,484	157,434	28.5
NHS Sandwell and West Birmingham CCG	15,232	536,637	28.4
NHS Ashford CCG	3,511	123,723	28.4
NHS South Worcestershire CCG	9,240	326,281	28.3
NHS Islington CCG	5,488	195,959	28.0
NHS Salford CCG	8,016	290,402	27.6
NHS Bedfordshire CCG	12,597	458,656	27.5
NHS Chorley and South Ribble CCG	5,717	209,310	27.3
NHS Bury CCG	5,939	218,292	27.2
NHS Warwickshire North CCG	5,528	204,482	27.0
NHS South Kent Coast CCG	6,163	228,072	27.0
NHS West Essex CCG	8,189	304,993	26.8
NHS Vale of York CCG	9,300	346,418	26.8
NHS Barking & Dagenham CCG	4,792	179,892	26.6
NHS Darlington CCG	3,288	123,586	26.6
NHS Bolton CCG	8,688	328,539	26.4
NHS Dudley CCG	9,790	371,654	26.3
NHS South Devon and Torbay CCG	9,255	351,400	26.3
NHS Sunderland CCG	8,617	329,794	26.1
NHS North Kirklees CCG	5,058	196,381	25.8
NHS Havering CCG	7,299	283,904	25.7
NHS Swale CCG	2,926	114,915	25.5
NHS Greater Huddersfield CCG	6,051	239,249	25.3
NHS East and North Hertfordshire CCG	13,982	558,094	25.1
NHS South Warwickshire CCG	7,405	296,467	25.0
NHS Oldham CCG	6,401	260,361	24.6
NHS Hambleton, Richmondshire and Whitby CCG	3,907	161,553	24.2
NHS Nottingham City CCG	8,059	333,680	24.2
NHS Barnet CCG	8,155	338,916	24.1
NHS Heywood, Middleton & Rochdale CCG	6,182	262,159	23.6
NHS Shropshire CCG	8,182	358,388	22.8
NHS Camden CCG	4,453	195,156	22.8
NHS Medway CCG	6,642	292,570	22.7

NHS Barnsley CCG	6,917	307,646	22.5
NHS Newham CCG	5,925	264,411	22.4
NHS Erewash CCG	2,412	108,765	22.2
NHS Telford & Wrekin CCG	4,158	188,294	22.1
NHS Wolverhampton CCG	6,538	297,820	22.0
NHS Rushcliffe CCG	2,772	128,065	21.6
NHS Hardwick CCG	2,737	127,828	21.4
NHS North East Essex CCG	8,273	388,378	21.3
NHS Wyre Forest CCG	2,769	130,900	21.2
NHS East Riding of Yorkshire CCG	7,485	356,864	21.0
NHS Southern Derbyshire CCG	11,560	555,118	20.8
NHS Canterbury and Coastal CCG	4,574	223,349	20.5
NHS St Helens CCG	5,102	251,202	20.3
NHS Nottingham North & East CCG	3,369	169,926	19.8
NHS South Cheshire CCG	4,109	207,657	19.8
NHS Kingston CCG	3,080	155,975	19.7
NHS Wigan Borough CCG	7,668	391,934	19.6
NHS Mansfield & Ashfield CCG	4,374	224,984	19.4
NHS Rotherham CCG	5,525	290,655	19.0
NHS Nottingham West CCG	1,890	102,169	18.5
NHS Vale Royal CCG	2,193	118,826	18.5
NHS North West Surrey CCG	5,889	344,291	17.1
NHS South Tees CCG	5,893	347,079	17.0
NHS Newark & Sherwood CCG	2,579	153,507	16.8
NHS Bassetlaw CCG	2,272	135,283	16.8
NHS Southend CCG	2,917	193,739	15.1
NHS Mid Essex CCG	5,413	381,847	14.2
NHS Castle Point and Rochford CCG	2,791	198,962	14.0
NHS Hull CCG	4,020	315,368	12.7
NHS West Suffolk CCG	3,352	273,650	12.2
All CCG commissioned	2,220,166	58,719,921	37.8

Annex 3 – Variation in the number of excess bed days by specialty (including CCG and specialised commissioned activity)

HRG Subchapter	Total bed days	Excess bed days	Excess bed days as a proportion of all inpatient bed days
Paediatric Immune System Disorders	1,731	1,106	64%
Eyes and Periorbital Procedures and Disorders	96,841	23,429	24%
Pain Management	1,371	274	20%
Paediatric Nervous System Disorders	70,126	13,035	19%
Paediatric Non-Malignant Haematological Disorders	21,982	3,795	17%
Paediatric Rheumatology Disorders	23,642	4,049	17%
Paediatric Gastroenterology Disorders	119,025	19,854	17%
Skin Procedures	60,807	10,112	17%
Ear, Nose, Mouth, Throat and Neck Disorders	346,181	57,235	17%
Paediatric Diabetology, Endocrinology and Metabolic Disorders	26,071	4,200	16%
Paediatric Hepatobiliary Disorders	6,623	937	14%
Spinal Procedures and Disorders	683,256	95,454	14%
Poisoning, Toxic Effects, Special Examinations, Screening and Other Healthcare Contacts	956,443	129,901	14%
Paediatric Cardiology Disorders	26,991	3,478	13%
Paediatric Haematological-Oncology Disorders	67,756	8,104	12%
Musculoskeletal and Rheumatological Disorders	688,994	80,579	12%
Diabetic Medicine	209,172	24,189	12%
Neurological Imaging Interventions	36,156	4,157	11%
Paediatric Medicine	139,142	15,918	11%
Haematological Procedures and Disorders	608,126	61,917	10%
Nervous System Procedures and Disorders	2,991,163	302,863	10%
Paediatric Ear Nose and Throat Disorders	50,630	5,084	10%
Orthopaedic Disorders	833,615	83,338	10%
Ear, Nose, Mouth, Throat and Neck Procedures	176,954	17,354	10%
Paediatric Renal Disorders	24,532	2,392	10%
Multiple Trauma	623,473	57,529	9%
Renal Procedures and Disorders	1,730,942	159,258	9%
Endocrine System Disorders	70,829	6,493	9%
Paediatric Dermatology Disorders	14,528	1,330	9%
Paediatric Trauma Medicine	34,270	3,135	9%
Skin Disorders	699,627	61,183	9%
Metabolic Disorders	280,312	23,838	9%
Vascular Imaging Interventions	170,515	14,095	8%
Breast Procedures and Disorders	105,453	8,661	8%
Urological and Male Reproductive System Procedures and Disorders	752,575	61,741	8%
Paediatric Respiratory Disorders	233,874	19,038	8%
Infectious Diseases and Immune System Disorders	1,970,442	158,291	8%
Digestive System Procedures and Disorders	3,582,366	287,780	8%
Musculoskeletal Imaging Interventions	11,005	875	8%
Cardiac Disorders	1,865,677	145,736	8%
Open and Interventional Procedures for Congenital Heart Disease	60,733	4,678	8%
Vascular Open Procedures and Disorders	524,473	39,186	7%
Orthopaedic Non-Trauma Procedures	1,213,890	77,436	6%
Interventional Cardiology for Acquired Conditions	776,441	48,485	6%
Female Reproductive System Disorders	146,553	8,919	6%
Paediatric Infectious Diseases	200,595	11,159	6%
Respiratory System Procedures and Disorders	4,722,526	249,535	5%
Hepatobiliary and Pancreatic System Disorders	749,115	37,558	5%
Hepatobiliary and Pancreatic System Endoscopic Procedures	205,721	10,228	5%
Hepatobiliary and Pancreatic System Open Procedures	204,133	9,940	5%
Orthopaedic Trauma Procedures	1,335,230	62,952	5%
Neonatal Disorders	475,117	22,196	5%
Thoracic Imaging Interventions	3,706	155	4%
Gastrointestinal Imaging Interventions	46,727	1,801	4%
Hepatobiliary and Pancreatic Imaging Interventions	40,962	1,383	3%
Female Reproductive System Procedures	231,193	7,796	3%
Obstetric Medicine	1,444,971	47,356	3%
Paediatric Ophthalmic Disorders	8,346	250	3%
Open Cardiac Procedures for Acquired Conditions	218,727	4,370	2%
Urological Imaging Interventions	5,498	64	1%
Dental and Orthodontic Procedures	4,315	-	0%
Breast Imaging Interventions	2,128	-	0%