Reducing spending on low clinical value treatments

Health briefing, April 2011
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Summary

This briefing looks at primary care trusts’ (PCTs) spending on low clinical value treatments and how some PCTs have successfully reduced their spending in this area. By low clinical value treatments we mean those treatments that are either clinically ineffective or not cost-effective.

Most, if not all, PCTs have identified reducing low clinical value treatments within their Quality, Innovation, Productivity and Prevention (QIPP) plans. No single national list of low clinical value treatments exists and PCTs have been developing their own approaches.

The aim is to free up money spent on low clinical value treatments and use it either to deliver a PCT savings plan or to invest in services with better clinical outcomes. Deciding where to spend money and the clinical effectiveness of services commissioned will be just as relevant for GP consortia as they take control of the NHS budget.

Our analysis shows that it is possible for PCTs to reduce their expenditure on low clinical value treatments if they make efforts to do so. Nationally we estimate that a reduction in PCT spending of between £179 million and £441 million is achievable. By looking at the actual and estimated spending and PCT population numbers at the PCTs we visited, it appears that for every person in a PCT’s population an annual reduction in spending of £10 is possible. Nationally, this would suggest an annual reduction in spending of about £500 million. Hospitals would not make the same saving, but there would be increased capacity and money available for treatments of higher clinical value. However, the opportunities will vary for each PCT and some may decide that securing potentially modest reductions is not worth the effort required. For others it may be significant. The Audit Commission has developed a tool to help PCTs identify the likely local potential for reducing spending.

This briefing summarises how PCTs are engaging with this challenge and sets out the progress some PCTs have made towards ensuring the NHS provides the right treatments for the right people.
Introduction

1 The NHS faces the challenge of achieving £20 billion of efficiency savings by 2015. NHS organisations need to achieve these savings despite increasing demand for services and during a time of significant reorganisation. NHS trusts and PCTs need to plan and successfully implement service modernisation to deliver efficient, high-quality services as funding growth slows down. Part of this will involve making sure that fewer treatments with a low clinical value take place and that money is directed towards the delivery of higher value treatments.

2 The QIPP initiative is working at a national, regional and local level to support clinical teams and NHS organisations to improve the quality of care they deliver. Part of the initiative is the ‘right care’ workstream. Sir Muir Grey, the QIPP Right Care lead stated, ‘Providers and clinical networks need to learn how to find value from within their existing budgets by:

- stopping low clinical value interventions or procedures that are still routinely undertaken in the NHS, demonstrating both the clinical rationale and also showing the cost;
- promoting the universal application of high-value activities; and
- releasing the resource.’ (Ref. 1)

3 As part of the QIPP programme, most PCTs and their strategic health authorities (SHAs) are looking at reducing their spending on low clinical value treatments, but they may use different terminology. Low clinical value treatments are those treatments considered to be clinically ineffective or not cost-effective. Terms used by PCTs include ‘low value procedures’, ‘procedures of limited clinical value’ or ‘low priority treatments’.

4 We interviewed representatives from a sample of PCTs, each at varying stages along the path of decommissioning these treatments. Most staff we spoke to were public health professionals. We selected the PCTs because they already had documents publicly available showing that they had made progress in identifying and reducing spending on these treatments. Some were well established, while others were only just starting to think about how to approach it.

Why are low clinical value treatments an issue?

5 PCTs have a statutory duty to keep their spending within the limit set by the Department of Health. Each PCT needs to decide how they are going to spend the limited resources available to them and achieve the best value for money.

6 The NHS Atlas of Variation in Healthcare (Ref. 2) was published in November 2010 to help remove unwarranted variation to increase value...
and improve quality. Clinicians and managers are expected to review the maps contained in the *Atlas* and to identify variations and, where necessary, take action to address them. The *Atlas* refers to low clinical value treatments and highlights two issues:

- Some patients are receiving treatments that some clinicians would consider unnecessary and of no added value.
- There is an opportunity cost to providing low clinical value treatments. PCTs could spend the money better: for example on other types of treatment, either for the people with the same condition or to meet unmet needs in another group of patients.

7 Most, if not all, PCTs are looking at clinical effectiveness of treatments to help them decide what to and what not to spend their money on. Clinical effectiveness is not the only consideration. Cost-effectiveness is important, and considerations can also include equity, ethics, affordability and quality of provision.

**Identifying low clinical value treatments**

8 There is no single national list of low clinical value treatments and so PCTs have been developing their own approaches and lists. Table 1 sets out the different websites consulted by public health staff when seeking evidence for low clinical value treatments and putting together processes to improve pathways of care. The first five are provided or hosted by the National Institute for Health and Clinical Excellence (NICE).

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There is no single national list of low clinical value treatments
For some treatments there is evidence that they are not clinically effective; for others, there is a lack of evidence of their clinical effectiveness. Certain treatments can be effective for particular patients, but not for others. Therefore some PCTs have grouped their lists of ineffective treatments into those:
- they refuse to pay for any longer; and
- where patients must satisfy specific thresholds, so only the right patient gets the right treatment.

Some PCTs have been leading the way, for example Croydon PCT started putting together their list in 2005/06 and have been developing it since. One PCT we visited listed over 100 ‘low priority’ procedures it was targeting. Other lists were more modest. While there was some consistency between lists, it is estimated that PCTs have identified approximately 250 different procedures with limited clinical value. The lists need constant refining as new treatments appear and new evidence emerges.

**Estimating the cost of low clinical value treatments**

To identify the estimated spending on low clinical value treatments we used the list of 34 low priority treatments produced by Croydon PCT. We have no view on the clinical effectiveness of the list, but selected it because it is used by other PCTs in London and has widespread acceptance among commissioners. PCTs elsewhere have used the Croydon list as a starting point and adapted it to suit local circumstances. Others have put together their own lists based on their local specifications. These will also have merit. We analysed the data by each PCT, for each treatment, for each year over a five-year period from 2005/06 to 2009/10.

The treatments on the Croydon list fall into five categories:
- effective procedures where cost-effective alternatives should be tried first;
- effective interventions with a close benefit or risk balance in mild cases;
- potentially cosmetic interventions;
- relatively ineffective procedures; and
- cancelled procedures.

It is estimated that PCTs have identified approximately 250 different procedures with limited clinical value.

These occur when a patient is admitted for a procedure, but the hospital is unable to carry it out. An example would be when there is an emergency and the operating theatre is needed and booked procedures are cancelled.
Appendix 1 lists the 34 procedures under each of these categories. We estimate that in 2009/10, the total spend in England on the procedures on the Croydon list was £1.9 billion. We calculated the amount by working out the average tariff for each of the procedures. Figure 1 shows the amount spent over the past five years in each of the five categories.

Figure 1: **National spending on low clinical value treatments on the Croydon list**

![Bar chart showing national spending on low clinical value treatments on the Croydon list.](chart)

*Source: Audit Commission*

Figure 2 shows the national year-on-year increase in the number of treatments on the Croydon list since 2005.

14 Figure 2 shows the national year-on-year increase in the number of treatments on the Croydon list since 2005.
Figures 1 and 2 show the total national spending and activity. Some of these treatments will have been clinically effective in some circumstances, but these vary by PCT, reflecting variations in local clinical practice and referral patterns. The *NHS Atlas of Variation* illustrates this (Ref. 2).

We have used national data to identify the ‘expected’ level of activity for each PCT. This ‘expected’ value takes into account age and sex breakdown for each type of activity on the list, and the level of deprivation of the PCT. In other words the national average level of activity for the type of people that live within a PCT’s area. We can use this value to estimate the savings, or reductions in spending that are potentially achievable. In this briefing we use the terms savings and reductions in spending to refer to the money released when fewer low clinical value treatments are carried out. It is important to note that hospitals would not see the same reductions in spending, but there would be increased capacity and money available for treatments of higher clinical value.

If PCTs are able to reduce activity to ‘expected’ levels we estimate reductions in spending of £179 million are achievable. This is an average of just over £1 million for each PCT. We can use the same methodology to identify savings if PCTs were able to achieve top quartile performance (in other words, performing as well as the top 25 per cent of PCTs in the country). If all PCTs achieved top quartile performance, £441 million a year could be available for investment in higher priority treatments.
Reducing spending on low clinical value treatments

Figure 3 sets out the observed, ‘expected’ and top quartile levels of spending for the past five years. Some of the year-on-year variation is attributable to changes in the average tariff. While activity continued to increase in 2009/10, overall spending reduced. This is because of reductions in the tariff for the lower cost procedures.

Figure 3: Expenditure on low clinical value treatments and estimation of potential savings 2005/06 to 2009/10

To supplement this analysis we linked the actual and estimated reductions in spending and PCT population numbers at the PCTs we visited (Figure 4). It appears that for every person in a PCT's population, an annual £10 saving is possible by reducing treatments with low clinical value. Nationally, this would suggest an annual reduction in spending of about £500 million.
Reducing spending on low clinical value treatments

Figure 4: Individual PCT estimates of maximum potential savings at the PCTs visited

Source: Audit Commission

Figure 5, which is based on our analysis of national data, shows that unsurprisingly the potential for reducing spending varies from one PCT to another. If PCTs are able to achieve ‘expected’ activity levels, the potential reductions in spending per PCT would range from around £14,000 to £6.4 million. If PCTs are able to reduce activity to the levels of the top quartile performers, reductions in spending per PCT would range from £178,000 to £12.5 million.
21 It is important to reiterate that we are not endorsing or suggesting that commissioners should follow the Croydon list. Many PCTs use it as the basis of identifying low clinical value treatments and work has already taken place on identifying the possible spending reductions. Other lists will have equal merit and we could have used an alternative list as the basis of our analysis.

**What should PCTs do?**

22 The tool that identifies potential savings is available for PCTs and auditors to use and can be found here: [www.audit-commission.gov.uk/lowclinicalvalue](http://www.audit-commission.gov.uk/lowclinicalvalue)

23 An example of the types of information the tool provides is included in Appendix 2. The tool sets out the spending for every PCT, by each of the low clinical value treatments on the Croydon list. While our analysis has been standardised to account for local variations, it is only an indicator of the likely reductions in spending that are achievable. It also does not reflect how easily achievable the reductions in spending are, nor any additional cost that may arise elsewhere. It should also be noted that the tool is based on the cost to the PCT and not the cost of the provider in carrying out the treatment. If a PCT successfully manages to reduce the number of treatments that are carried out, the provider’s income will reduce but not

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**We have developed a tool to help PCTs identify the potential for reductions in expenditure**

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**Figure 5: 2009/10 potential savings by individual PCT**

![Graph showing potential savings by individual PCTs](image-url)

*Source: Audit Commission*
necessarily its costs. It will however free up provider capacity to deliver more clinically effective care.

24 Commissioners should use the tool to help identify the size of any potential available savings. For some PCTs the savings are significant, for others less so and the effort required to deliver potentially modest savings may outweigh the savings made, particularly if they could deliver greater savings by directing the effort elsewhere. We have provided guidance to auditors to help them review the PCT’s approach, where the potential to reduce spending on low clinical value treatments is significant. PCTs should also use the tool to help identify whether savings targets in cost improvement and QIPP plans look sensible and update their plans accordingly.

25 During our fieldwork we visited some PCTs that had successfully reduced their spending on low clinical value treatments and they pointed to some key factors.

Leadership

26 The PCTs that appear most successful in decommissioning these treatments all agreed that visible PCT leadership and support – at chief executive and director level – is essential to making the policy work.

27 We also found that groups of PCTs appear more effective in decommissioning than PCTs working individually. This makes for easier and more consistent messages for GPs and consultants, some of whom may otherwise have to deal with various low-priority procedure lists for different PCTs as they straddle geographical boundaries. The move to PCT clusters should make it easier to develop a consistent approach across an area.

28 Some PCTs were working together and using commissioning agencies to manage the entire decommissioning process. One PCT suggested it was more cost-effective to spend a small amount evaluating each low-priority referral, rather than accepting them all without question at a cost of several million pounds.

Involving finance staff

29 The involvement of finance staff varies between PCTs. At some there was no involvement, at others public health and finance staff worked together and gave each other full support. We found that those PCTs that had participation from finance staff had more success in decommissioning treatments and in particular measuring the savings delivered. Some PCTs suggested that finance staff should focus more on numbers of treatments or patients rather than costs, since they are subject to tariff changes and give a misleading impression about progress.
Working with GPs

30 GP engagement with decommissioning low clinical value treatments varied. At some PCTs the GPs were engaged and supportive, whereas at others relations were difficult. It was not clear whether this was because of the PCTs’ overall relationship with their GPs, or the result of inappropriate procedures being embedded and PCTs now taking an unpopular but necessary stance.

31 PCTs told us that as GPs have limited time with individual patients, they want the policy to be clear so they can explain it to patients quickly. This requires clear information that is easy to find and follow. PCTs reported that GPs were happy, and perhaps also relieved, to cite PCT policy as the reason that certain procedures are not permitted.

32 One PCT suggested that having an individual local GP to support decommissioning low value treatments was helpful as GPs are able to positively influence their peers. Some PCTs were considering how technology could help make GPs aware of low-value lists, specifically whether real-time flash messages about specific procedures could be used when patients are put on to the referral system. Some PCTs have developed template letters for GPs to give to patients explaining why the treatment will not be carried out.

33 This will become simpler when GP consortia are created and become responsible for commissioning services for their patients. They will be able to decide themselves the treatments they will and will not commission.

PCTs and clinicians in secondary care

34 Some PCTs we visited staged successful events to communicate the policy to large groups of clinicians. These have been successful, enabling clinicians to take part in and help shape the policy. One PCT said that it was ‘less scared’ about involving clinicians in the decision-making process, and recognised that this was of greater benefit to patients in the long term. Another PCT said that it was critical to have credible medical input to the development of the process so that it was accepted by clinicians and to enable an informed debate to take place about the evidence base.

35 At some PCTs, patient referrals were rejected by hospital clinicians, particularly in the areas of cosmetic surgery, dermatology and fertility treatments. Sometimes by written correspondence even before they see the patient.

36 Winning over both GPs and clinicians in secondary care is essential if spending on low clinical value treatments is to reduce. The appropriateness of treatments should be considered – and if possible agreed – by PCTs, GPs and secondary care clinicians. Some low clinical value treatments may be a valuable income source to acute trusts which
they may be reluctant to lose. In which case there is even more reason for PCTs to invest time in collaboration and winning the debate.

Managing performance

37 PCTs are not going to get savings out without putting effort in. This includes getting data on the uptake of low clinical value treatments, updating contracts to reflect policy, and if necessary making tough and sometimes unpopular decisions to enforce the policy.

38 Several PCTs stressed that if they did not monitor performance data they would lack credibility with GPs and clinicians. PCTs need to be on top of what procedure codes are used, and ensure that these are both the right codes and up to date, as they change.

Process

39 Many PCTs have set up groups with names such as ‘Exceptional Funding Treatment Panel’ or ‘Individual Funding Request Group’ that manage decisions and set local priorities. These groups receive, consider and decide individual requests for funding low clinical value treatments, where the relevant list shows exceptions are allowable in certain circumstances.

40 PCTs’ views were that the process needs to work so only a manageable number of requests pass on to this group. PCTs often had flowcharts available on their websites that show the path and checkpoints that need following. The scrutiny given to ineffective treatments, and at which points the decision to approve or reject treatments was made, varied from one PCT to another. The flowcharts need to be clear and well considered.

Communications with patients and the public

41 Ideally PCTs should have a single contact point for low clinical value treatments, to ensure the right message is given, in an understandable and consistent format both to the public and individual patients.

42 PCTs should be open about their lists and the processes which govern approvals by exception. For example this can include putting it on their websites, organised both alphabetically and by speciality to make procedures easy to find.

43 Some PCTs have done extensive public consultations even about minor treatments. Particular difficulties have emerged when the debates were not purely about clinical issues, but touched on other social or religious attitudes, as with the case of circumcision.

44 The public will want to see that the appropriate research and reasoned consideration of clinical effectiveness has gone into deciding which treatments have low clinical value.
**Duplication of effort**

45 The effective engagement of clinicians requires providing evidence about the effectiveness of treatments. The PCTs we spoke to recognised there was much clinical evidence of varying quality and quantity available, but they felt there was no central body that acted as a repository for the information. They reported that having a national evidence base would reduce duplication and provide valuable support to commissioners and clinicians when deciding about which procedures to decommission and where to invest their limited money.

46 The PCTs we spoke to were carrying out their own independent evaluations of clinical effectiveness, which duplicates effort. Most PCTs agreed that for some procedures the evidence is clear-cut (for example grommets); for others there was more ambiguity (for example carpal tunnel surgery). One PCT stated that if a procedure is ineffective, then that should be the case for all PCTs. All the PCTs we spoke to were keen to have quality, pooled evidence as a tool to support local decisions. It is surprising that NICE has not produced this, given that it is responsible for several of the different lists. Many of the people we spoke to suggested that NICE would be the ideal body to champion decommissioning and to provide a single evidence base. PCTs felt that consistency in the evidence base would also make the position clearer for secondary care clinicians who may receive patients from several different PCTs, all with potentially different lists.

**Conclusion**

47 Unsurprisingly we found variation between PCTs in their approaches to decommissioning low clinical value treatments. If PCTs are to reduce spending to the levels of the best performers, there is still much work to do. However, for some commissioners it will be the case that the likely savings will not be worth the effort of changing referral and clinical practice.

48 The overriding factor will be the reason behind the decision to decommission the treatments. For example, is it to: save money and invest it in more clinically appropriate care; stop patients having treatment for which there is no clinical evidence to support; or a combination of the two?

49 Those that have successfully decommissioned low clinical value treatments point to some key success factors. These are set out below.
- High-level PCT leadership and endorsement are essential. Successfully reducing expenditure on these treatments takes time and effort and will be difficult to achieve if it is not supported by the board. Involvement of finance staff is also helpful.
- GPs and secondary care clinicians need to be involved in the decision-making process about what procedures should be included within the policy and how it should be implemented.
- The list of low value treatments should be based on the latest clinical evidence.
- Just having a policy about low clinical value treatments is not enough. Effective PCT communication with GPs and clinicians in secondary care is important. Without this the chances of success reduce. Both groups respond best to arguments about clinical effectiveness and ineffectiveness, not cost savings.
- The policy also needs communicating to the general public in an accessible and easy to understand format.
- Once a policy has been produced, performance needs to be monitored and any deviations followed up. PCTs will lack credibility if they do not do this. Contracts should be updated to reflect and, if necessary, enforce the policy. PCTs need to be prepared to withhold payments or the policy itself will be ineffective.
- PCTs should consider how they deal with appeals. The policy should be written in such a way to minimise this, but it is inevitable that there will be challenges.

50 The main stumbling block for commissioners is developing the evidence base. Currently many PCTs hold lists of treatments that they judge to be of low clinical value. Some PCTs we visited argued that if there was evidence that a treatment was inappropriate at one part of the country then this was likely to be the case across the country. We welcome the steps the Department of Health is taking to address this. As part of the Right Care strand of QIPP, work is underway to help clinicians and commissioners to work together to develop the clinical evidence base required to support commissioning decisions and set priorities for their spending. This will help reduce the work required to decommission low value treatments, but local support and buy-in will still be critical to achieving success.

51 Decommissioning cannot be achieved without investing time and effort, but it is a process that has enabled some PCTs to release millions of pounds to spend on treatments that have better outcomes for patients.
Appendix 1: Croydon list of low priority treatments

Effective procedures where cost-effective alternatives should be tried first
- Anal procedures
- Bilateral hip surgery
- Carpal tunnel surgery
- Elective cardiac ablation
- Hysterectomy for heavy menstrual bleeding

Effective interventions with a close benefit or risk balance in mild cases
- Cataract surgery
- Cochlear implants
- Dupuytren's Contracture (tightening of tendons)
- Non-surgical female genital prolapse/stress incontinence
- Surgical female genital prolapse/stress incontinence
- Hip and knee revisions
- Knee joint surgery
- Other joint prosthetics or replacements
- Primary hip replacement
- Wisdom teeth extraction

Potentially cosmetic interventions
- Aesthetic surgery – breast
- Aesthetic surgery – ear, nose and throat
- Aesthetic surgery – ophthalmology
- Aesthetic surgery – plastics
- Incisional and ventral hernias
- Inguinal, umbilical and femoral hernias
- Minor skin surgery for non-cancerous lesions
- Orthodontics
- Other hernia procedures
- Varicose veins

Relatively ineffective procedures
- Back pain: injections and fusion
- Dilation and curettage for women under 40
- Grommets (surgery for glue ear)
- Jaw replacement
- Knee wash-outs
- Spinal cord stimulation
- Tonsillectomy
- Trigger finger

Cancelled procedures
Appendix 2: Illustration of the tool

Reducing PCT expenditure on treatments with low clinical value
Potential savings for Carpal tunnel surgery

Appendix 3: References


Appendix 4: Additional reading


The Right Care website also contains useful information.

Appendix 5: Acknowledgements

We are grateful to the organisations that took part in our fieldwork:
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- NHS Barnet
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