London Health Observatory

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Commissioning for Equity Series

Save to Invest

Developing criteria-based commissioning for planned healthcare in London

Executive Summary June 2007

Key Messages

- There is significant, unexplained variation in planned surgical care in London for procedures where there is evidence that service access criteria should be in place.
- Consistent application of evidence-based criteria could avoid ineffective care and ensure more equitable use of resources across London.
- If the common service access criteria developed by Croydon PCT are applied to 34 selected procedures for the whole of London, the opportunities for savings to reinvest in London's health have been estimated to lie between £28 and £93 million for 2005/6.
- Of the 34 procedures we examined, the top ten most common for London were estimated to cost £149m overall in 2005/6. For these procedures alone, between £17 and £63 million could potentially be saved for reinvestment by adopting common access criteria.
- The variation in *hospital admission rates* for the top ten procedures is as great as or greater than the variation in intervention rates *between PCTs.* There are different patterns of variation for different procedures. This suggests that health care commissioners and hospital trusts need to work together to create more effective pathways for patients from primary through to hospital care. No association between intervention rates and deprivation was found at PCT level.
- A relatively simple system for tracking an agreed basket of procedures could be implemented at London, PCT and practice levels, allowing PCTs and their practice-based commissioners to monitor the effects of their commissioning decisions more closely.

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Introduction

This case study provides a summary of work that has been undertaken by the London Health Observatory working with London PCTs to support effective and equitable commissioning for hospital care. It should be seen as "work in progress".

Aims of the case study

- To estimate the potential savings that could be reinvested in London if each London PCT adopted the same access criteria to a selected list of 34 hospital-based procedures.
- To develop a comparative framework for pan-London monitoring at Hospital Trust and PCT levels that could provide relevant information for commissioners and providers on the implementation of agreed criteria.

Building on earlier work with London's PCTs

This work builds on earlier modelling undertaken by Croydon PCT and the LHO to estimate minimum and maximum potential savings for each PCT in London if the same pan-London criteria for commissioning selected procedures were used by all. The data and findings of this earlier work have been shared with London's PCTs and SHA. A review of the evidence supporting the need for criteria for intervention thresholds for the most common procedures has been undertaken by the South West London Public Health Network, and can be downloaded from www.lho.org.uk/viewResource.aspx?id=11206. The full report of the current case study can be found at www.lho.org.uk/viewResource.aspx?id=11334. Data for individual PCTs and hospital trusts can be obtained on request from the LHO. Please contact robel.feleke@lho.org.uk

Estimating potential savings: the Croydon assumptions

Thirty-four procedures, for which there is evidence that service access criteria should be in place, were identified (see Box 1 for a summary). We built our estimates of potential savings on assumptions made by Croydon PCT about minimum and maximum savings that might be achieved for each of these procedures. This was based on an assessment of the minimum and maximum reductions in activity that might be achieved (see Appendix for full list). This paper makes clear that the assumptions about the minimum/maximum savings are based on value judgements as vital information about case mix is not routinely available. Information on methods and assumptions can be found at: www.lho.org.uk/viewResource.aspx?id=11591.

Box 1 Some examples from the "Croydon list" of procedures

Relatively ineffective interventions	Largely cosmetic interventions	Effective interventions with a close benefit/risk balance in mild cases	Effective interventions where cost-effective alternatives should be tried first
• Dilatation and Curettage Under 40 • Grommets • Knee washouts • Spinal cord stimulation • Tonsillectomy • Trigger finger	• Breast, ENT, Ophthalmology, Plastic Surgery • Minor skin lesions • Varicose veins • Orthodontics	• Female genital prolapse/ stress incontinence • Hip, Knee and Joint replacement/revision • Dupuytren's contracture • Wisdom tooth extraction • Simple hernia repair • Cataract surgery	• Carpal tunnel • Hysterectomy for heavy menstrual bleeding

How we calculated potential cost savings

Hospital Episode Statistics from 2005/6 were used as the basis for this work.

Tariffs for procedures, taken from NHS tariff codes for 2005/06, www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4091529&chk=f%2Bcvh8) were identified using Healthcare Resource Groups and procedure codes. Costs incurred were calculated by combining these tariffs with other supplementary tariffs that also took into account longer than average lengths of stay for each procedure. Full details of the method can be found at www.lho.org.ukview Resource.aspx?id=11591.

Comparing variation in the procedures across London

In order to compare the variation in these procedures across London, we calculated both directly age-standardised PCT (resident-based) rates for each procedure as well as crude hospital-specific rates based on hospital catchment populations.

Key Findings

Potential savings for reinvestment

- Gross costs for these ten procedures across London were estimated to be £149m in 2005/06.
- Applying the Croydon assumptions, opportunities for savings to reinvest in London were estimated to lie between £28 and £93 million for 2005/6.

Box 2 London's top ten most common procedures from the "Croydon List" in 2005/6

1	Minor skin procedures
2	Cataract surgery
3	Cancelled procedures
4	Inguinal, umbilical and femoral hernias
5	Tonsillectomy
6	Knee replacement surgery
7	Wisdom teeth extraction
8	Varicose vein surgery
9	Carpal tunnel surgery
10	Hysterectomy for menorrhagia

Box 3 Examples of estimated minimum and maximum potential savings from the top ten procedures for London from the "Croydon List" (2005/6)

	Numbers undertaken across London	Total cost incurred (£ millions)	Estimated minimum saving (£ millions)	Estimated maximum saving (£ millions)
Procedures	40459	37.2	3.7	9.3
Tonsillectomy	8535	7.3	0.7	6.6
Varicose vein surgery	5289	5.6	1.1	4.5
Hysterectomy for heavy menstrual bleeding	4262	10.9	1.1	7.6

Different practices in PCTs and hospitals?

- There are wide variations in admission rates for the top ten procedures both between London's PCTs and hospital trusts, with no association with deprivation at PCT level.
- The variation in *hospital rates* for the different procedures was as great as or greater than the variation in intervention rates *between PCTs*. This suggests that variation in hospital clinical practice is likely to be as important as variation in primary care referral practice.
- The pattern of variation between hospitals varies for different procedures, suggesting that differences in clinical practice *between hospital* specialties are likely to be important too. This underlines the importance of a local understanding of primary and secondary clinical practice, as well as commissioning patterns for each procedure.

The example of hysterectomy for heavy menstrual bleeding

We illustrate opposite how a common commissioning approach to reduce variation in hysterectomy rates across South West London might be tackled across the whole of London.

Rationale

- Relevance to London: Within London, hysterectomy is the 10th most common procedure on the "Croydon List", costing over £10million in London in 2005/06.
- The evidence base: NICE guidelines (www.nice.org.uk/guidance/CG44) and a systematic review of the evidence concluded that more conservative treatment with intrauterine levonorgestrel improved the quality of life for women with heavy menstrual bleeding of benign origin as effectively as hysterectomy and was also more cost-effective.
- Commissioning recommendations: Hysterectomy for heavy menstrual bleeding will only be funded after a trial with intrauterine levonorgestrel has not relieved symptoms or is contraindicated; or other effective treatments have failed in line with NICE guidelines.

Understanding the variation

Figures 1a, 1b, 2a and 2b provide an example of how a pan-London system of comparative monitoring could be used to identify outliers and monitor the implementation of local commissioning decisions.

The variation in hysterectomy rates in London

There is an 3.7 fold variation in hysterectomy rates between PCTs and a 4.0 fold variation between hospital trust rates.

No association between intervention rates and deprivation was found at PCT level.

Explanation of outlying positions and can only come from a local understanding of clinical and commissioning practice.

Towards a pan-London monitoring system for criteria-based commissioning of planned care

A monitoring system to support decisions such as those made in South West London needs both comparative information between trusts to ensure inequities are reducing, and real-time monitoring of trends within individual PCTs and hospital trusts to ensure high levels of intervention are falling. The line graphs, on page six, show how the comparative information could be complemented by real-time monitoring. Rising or falling trends and costs can be picked up in contract monitoring discussions. Information on the variations in intervention rates for the other procedures in the "top ten" on the Croydon List can be found at: www.lho.org.uk/viewResource.aspx?id=11623.

Figure 1a Direct standardised rates* (DSR) per 100,000 for hysterectomy, by London PCT

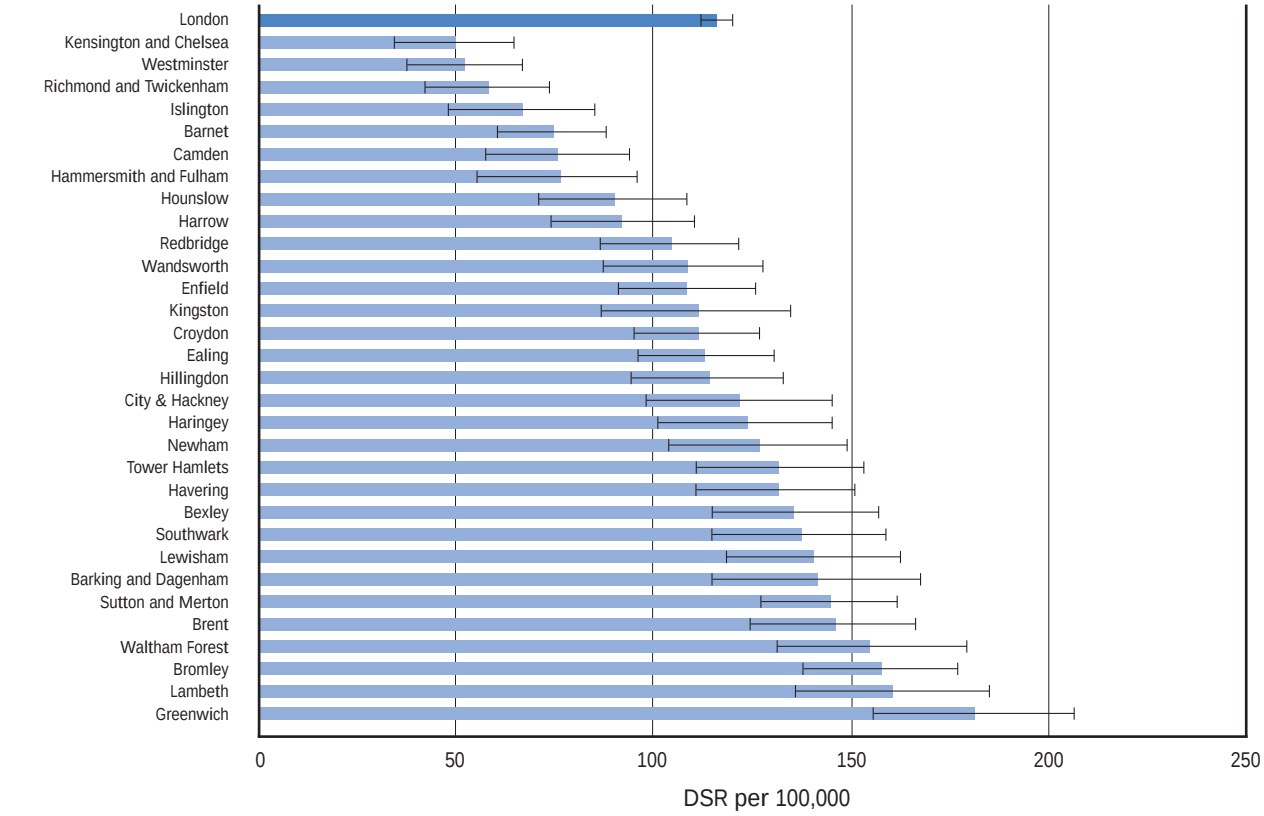
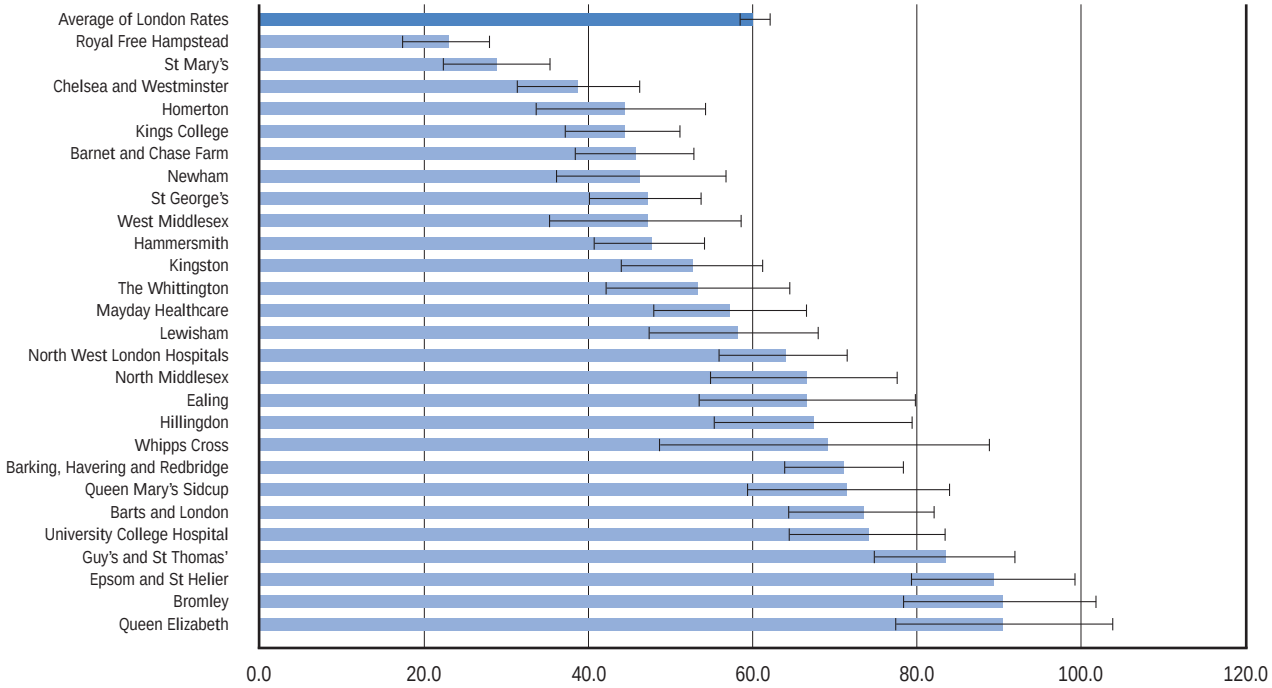


Figure 1b Hospital-specific rates** for hysterectomy for London acute Trusts



Sources: HES 2005/06, ONS mid-year female population estimates.
*DSRs for PCTs are based on hospital spells. **Hospital-specific rates are crude rates based on hospital episodes; catchment populations based on methods published by the Eastern Region Public Health Observatory (www.erpho.org.uk/viewResource.aspx?id=9480). Trusts with less than ten observations have not been included.

Quarterly monitoring of hysterectomy trends, Quarter 1 2004/05 to Quarter 2 2006/07: the example of two PCTs

Figure 2a PCT 1: A rising trend

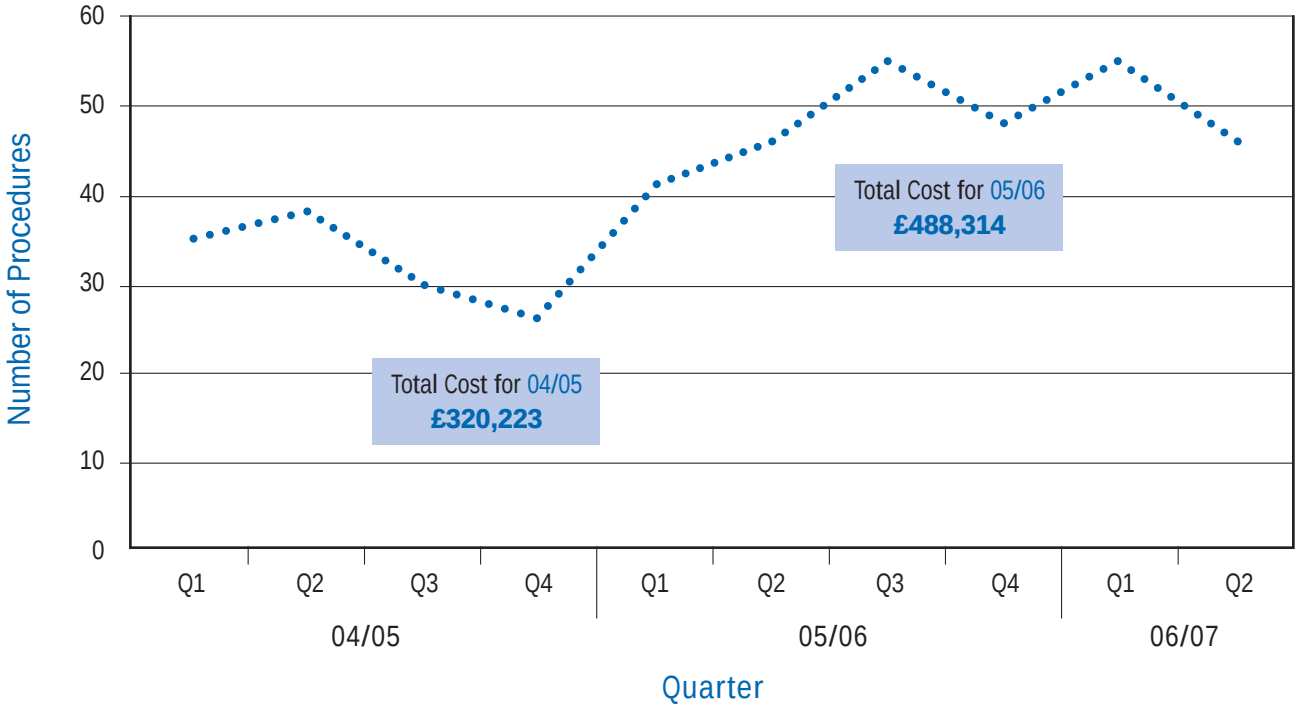
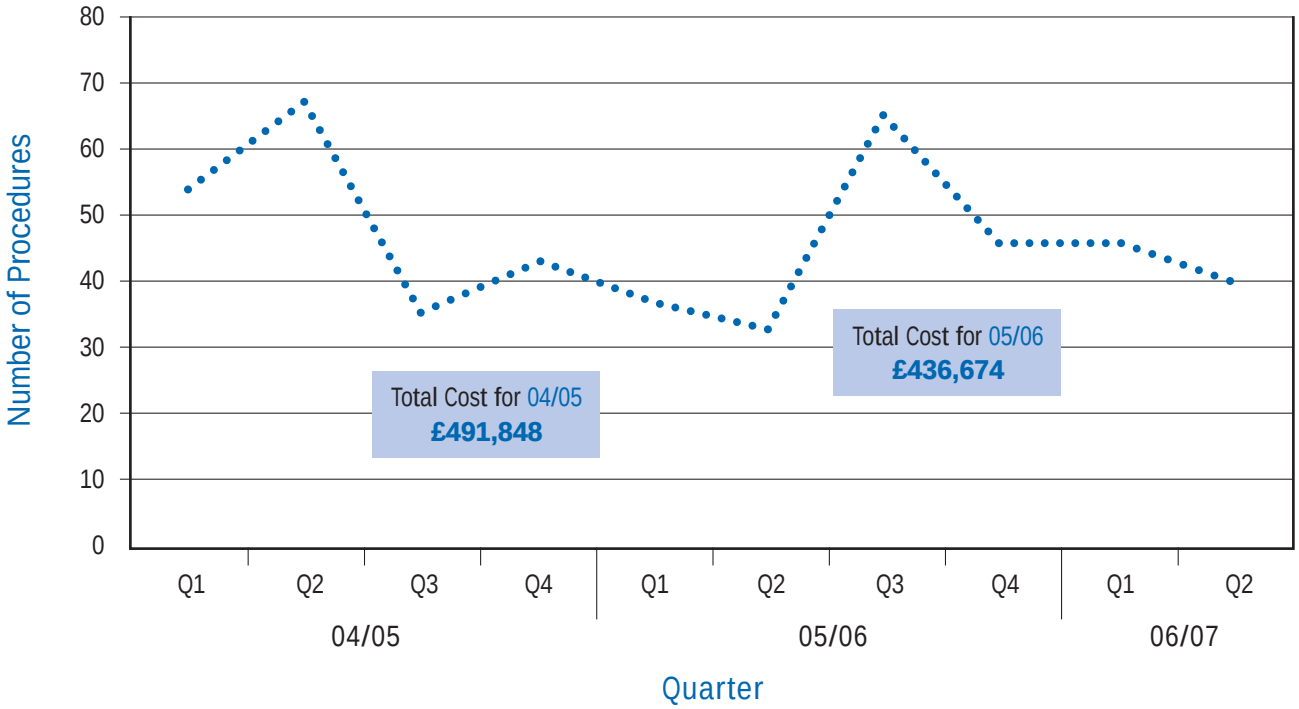


Figure 2b PCT 2 : A falling trend



Source: Hospital Episode Statistics

Issues raised for commissioners

Improving the consistency of pan-London decision-making

At present decisions about thresholds for clinical interventions are made inconsistently in both primary and secondary care across London. Most PCTs currently have their own unique criteria and local mechanisms for decision-making and monitoring. The example of the South West London PCTs is relatively exceptional. As a pan-London approach to commissioning is being developed, could decision-making about access to planned care become more efficient and consistent?

Moving towards evidence-based decisions

The South West London effectiveness reviews have shown that it has been possible to identify a practical way forward for common procedures. It is clear however, that whilst the evidence is still patchy on case-severity and cost-effectiveness, careful value judgements need to be made in discussion with clinicians about thresholds for intervention. Other methods have been used elsewhere, but all depend on a mix of evidence and judgement. Can such judgements be made transparently and consistently across London so that there is clarity and agreement between commissioners, clinicians, patients and their families? Unless this is the case, implementation will, in practice, be difficult - as has been found historically.

Moving towards pathway-based commissioning

It is clear that the intervention pathway for patients is determined by decisions made by both primary and secondary care practitioners. Commissioners will need to devise means of balancing the whole pathway of care in future rather than the historical focus on secondary care only. This will be even more important as more of these procedures are shifted from the hospital to primary care settings.

Monitoring criteria-based access to planned care

We have demonstrated that the implementation of a simple framework for regular monitoring of access to care at both PCT and hospital levels could be devised for London. Undertaking such work once for all commissioners would enable comparisons to be made and followed over time. This monitoring would be both at London and individual PCT level and could be extended to practice-based commissioners.

Can savings for reinvestment be made in practice?

It has been argued that it has been difficult to demonstrate actual savings in the past from criteria-based commissioning. This is partly because commissioning tools were historically imprecise, but the advent of payment by results should address this issue. Any savings for reinvestment would also have to take the cost of alternative treatments into account.

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About the London Health Observatory (LHO)

What does the LHO do?

We provide information, data, and intelligence on Londoners' health and healthcare for practitioners, policymakers, and the public. We are one of nine regional Public Health Observatories in England set up in 2001 by the Department of Health. The LHO takes the national lead role in monitoring health inequalities, ethnicity and tobacco.

Want to know more about us?

Click on the following link: www.lho.org.uk/AboutUs/AboutTheLHO.aspx which tells you more about who's who at the LHO and our work programme. Better still, become a registered user and access more of our services.

If you would this summary in larger text please contact the LHO on 020 7932 3961

Appendix to summary: the full "Croydon List"* and estimated minimum and maximum savings

	Minimum Reduction (%)	Maximum Reduction (%)
1) Relatively ineffective interventions		
Dilation and Curettage for women under 40	10	70
Tonsillectomy	10	90
Grommets (surgery for glue ear)	10	90
Knee Washouts	20	90
Trigger Finger	10	33
Spinal Cord Stimulation	0	50
Jaw Replacement	5	10
Back Pain: Injections and Fusion (1)	20	90
2) Potentially cosmetic interventions		
Aesthetic Surgery - Breast	50	80
Aesthetic Surgery - ENT	20	60
Aesthetic Surgery - Ophthalmology	20	30
Aesthetic Surgery - Plastics	20	95
Minor Skin surgery for non-cancerous lesions	10	25
Orthodontics	5	80
Varicose Veins	20	80
Incisional and Ventral Hernias	10	75
Inguinal, Umbilical and Femoral Hernias	25	50
Other Hernia Procedures	10	30
3) Effective interventions with a close benefit / risk balance in mild cases		
Female Genital Prolapse/stress incontinence (surgical)	10	25
Female Genital Prolapse/stress incontinence (non-surgical) (treatment for loosening of muscles supporting the female reproductive organs)	5	25
Primary Hip replacement	15	30
Knee joint surgery	15	30
Hip and Knee joint Revisions	15	30
Dupuytren's Contracture (tightening of the tendons)	10	33
Wisdom Teeth Extraction	0	24
Cataract Surgery	5	25
Cochlear Implants (inner ear surgery for nerve deafness)	0	25
Other Joint Prosthetics/replacements	15	30
4) Effective interventions where cost effective alternatives should be tried first		
Hysterectomy for non-cancerous heavy menstrual bleeding	10	70
Carpal Tunnel surgery	10	33
Anal Procedures	5	15
Bilateral Hip surgery	15	30
Elective Cardiac Ablation	5	50

** Cancelled procedures are included on the list with a 10% min and 100% max estimated saving*