The Future of Commissioning for Planned Surgery

Getting it right for orthopaedics
Learning from the first round of 'Getting it Right First time'

Royal College Surgeons England

Wednesday 27th January 2016

Department of Health

Department of Health

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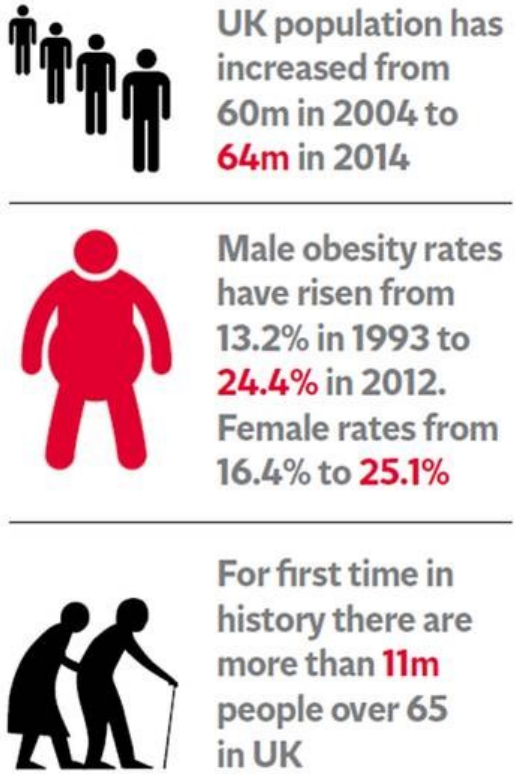
Past President of the British Orthopaedic Association

Background: MSK in the NHS

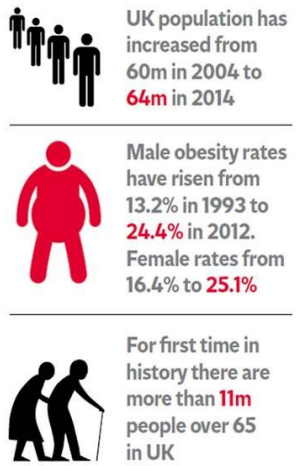
- Annual musculoskeletal disease budget = £5-£7 billion

- 33% of surgical workforce
- 25% surgical interventions in secondary care
- Referrals increasing by 7- 8% per annum



Background: The NHS in UK – "The Perfect Storm"

- Growing population – 60M in 2010 now 64M in 2014
- Ageing population – By 2030 33% >60 yrs. 15.3M >65yrs by 2031
- Population living longer and expecting to remain active
- Increasing BMI – by 2050 60% men / 50% women will be obese.
- >65% patients admitted are 75 yrs age or greater

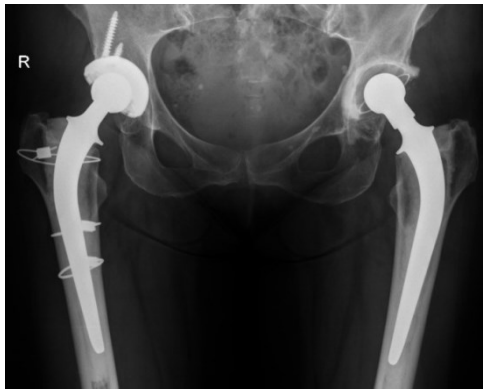


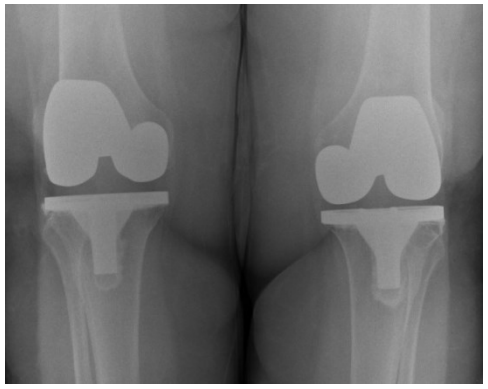
Examples of current practice

THR and TKR

- 47,000 in 2004
- 181,000 in 2013
- >200,000 in 2014
- Each increasing by over 7% annually

Cost effective £7.50 per week
15 yr survivorship 90%





In the last five years……

- 92.1% increase in revision total knee
- 49.1% increase in revision total hip replacement
- Annual increase of 18.4% and 9.8% respectively
- Other joint replacements -10% annual increase

£1.5 -£2 Billion over next 10 years

Background: Recent News NHS settlement

- The NHS settlement for 2016-2017 has given the provider sector some breathing space but also challenges.
- £3.8billion additional funding from the Treasury, and the 1.06% inflation uplift together with only a 2% tariff efficiency factor (most providers were expecting 3.8%)
- Provides some short term stability.
- In real terms 1% per annum real terms increase funding next 5 years
- However the provider sector will still need to critically evaluate itself to maintain long term sustainability. This will require efficiency planning, and some centralisation of services across all sectors of provider provision

The NHS will be underfunded by Billions

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In reality…

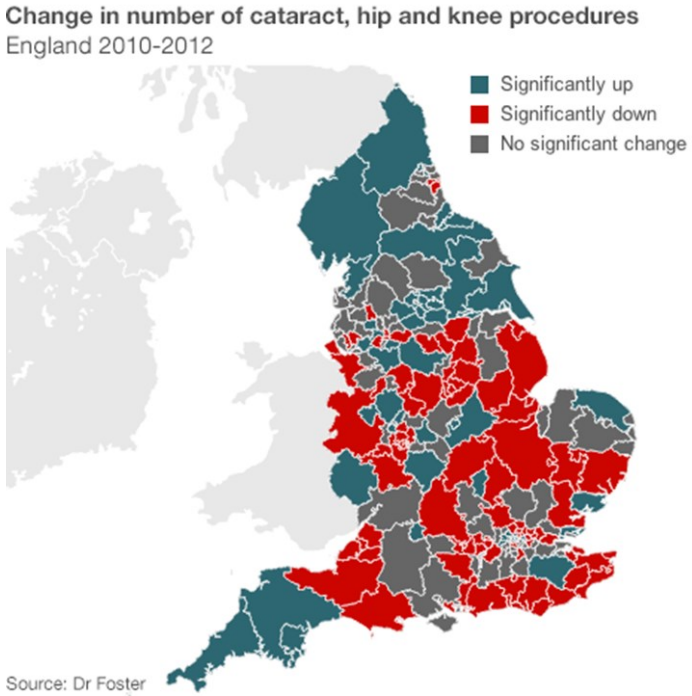
CCGs under significant financial pressure

The pressure is on GPs NOT to refer increasing numbers of patients for Orthopaedic care

New Devon CCG deficit of £14.5 Million last year

New criteria "Urgent and Necessary measures"

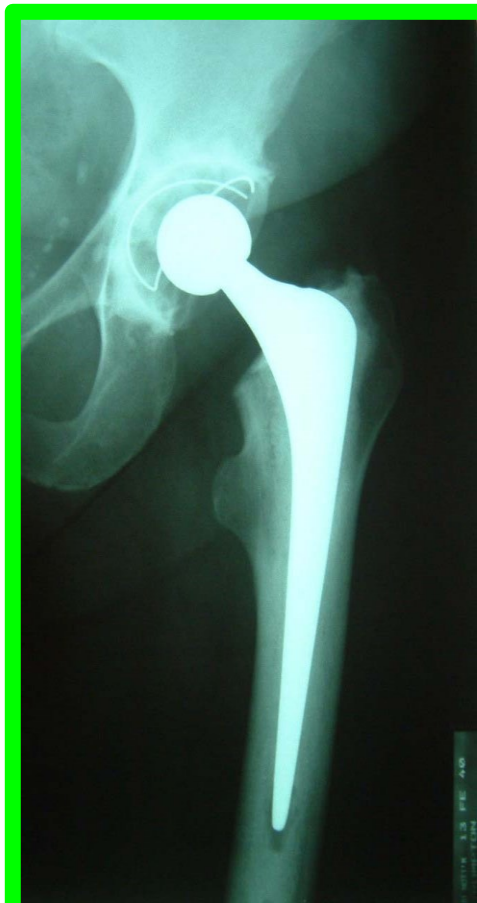
Aim: Balance the books



* Requiring patients with a BMI over 35 to lose 5% of their weight or to get under BMI 35 before planned surgery
* Requiring patients to stop smoking for at least eight weeks before planned surgery
* Suspension of some types of shoulder surgery

This will dominate the health agenda

CCGs don't know what they are buying



Demand Management – Rationing

De-commission services

Dr. Foster Annual Report

Procedures of low clinical value

We need to find another way

Clinically led!!

London

Provision of Care is the Key

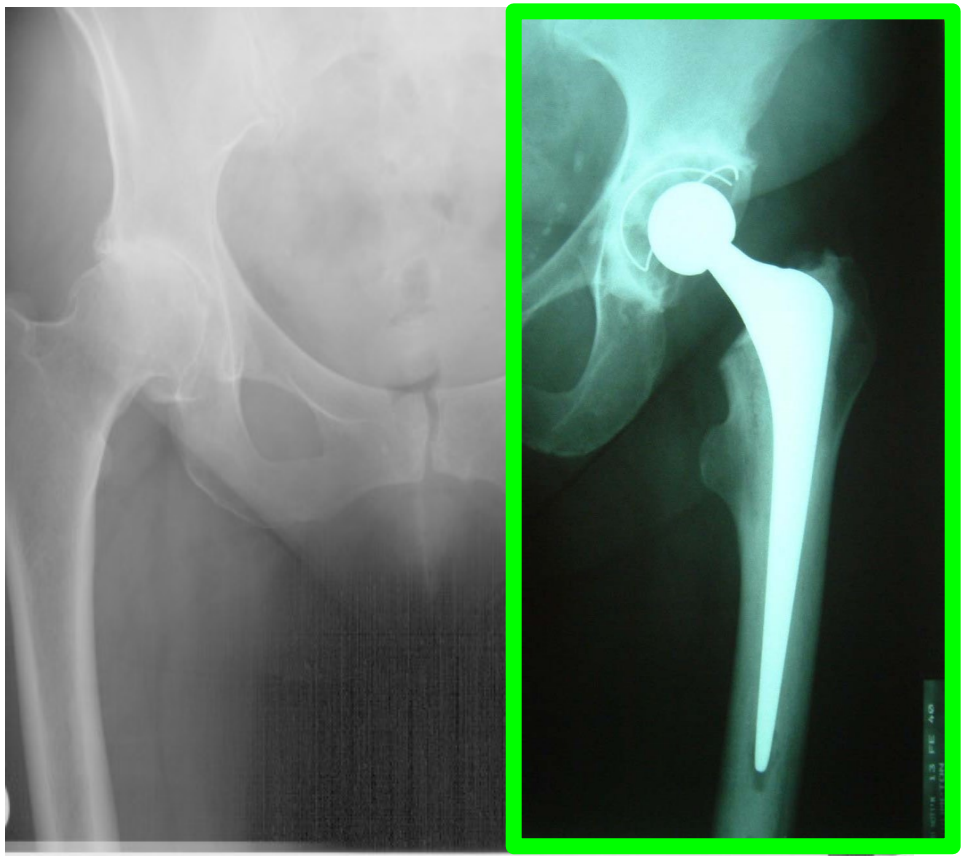
- Annual Health Budget ***£1***6 Billion
- ***£***1 Billion into primary care
- ***£***2 Billion into Mental Health
- ***£***13 Billion spent in HOSPITALS (Providers)

- In London 23 Trusts carrying out 13% of total orthopaedic and spinal elective activity in England

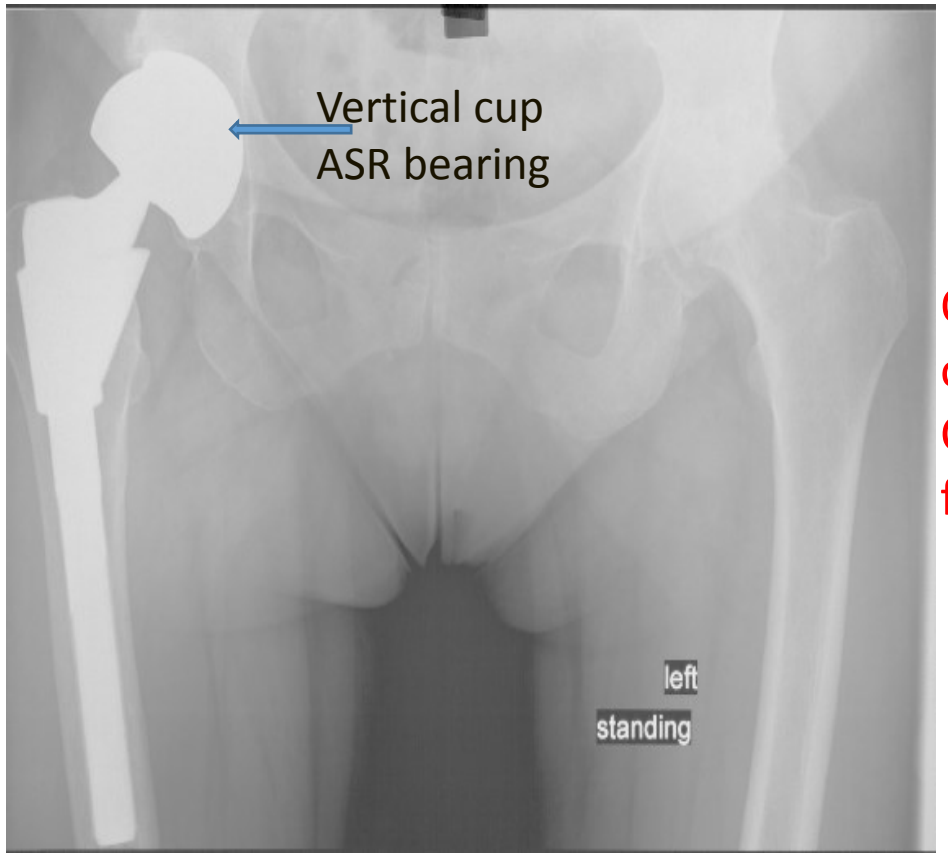
- Provision of Care is 80% of the cost ie Secondary care providers

- We as Clinicians need to make the changes to our practice

How do we justify this?



Grade 1V OA right Hip
Age at primary implantation- 65 years

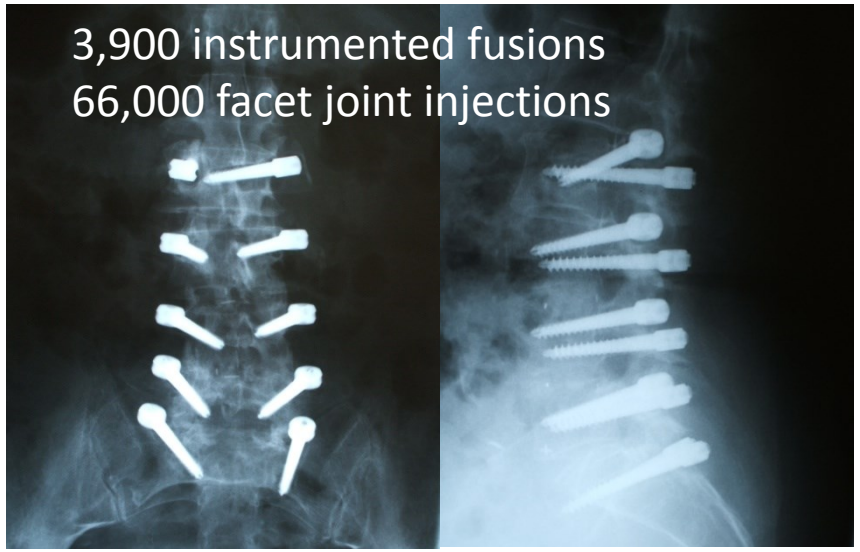


Our Acetabular cup of
Choice is Tantalum for all !!!!

Cost of Implant - £3500-£4,000
Cost of bearing/cup - £1300+
£5,000

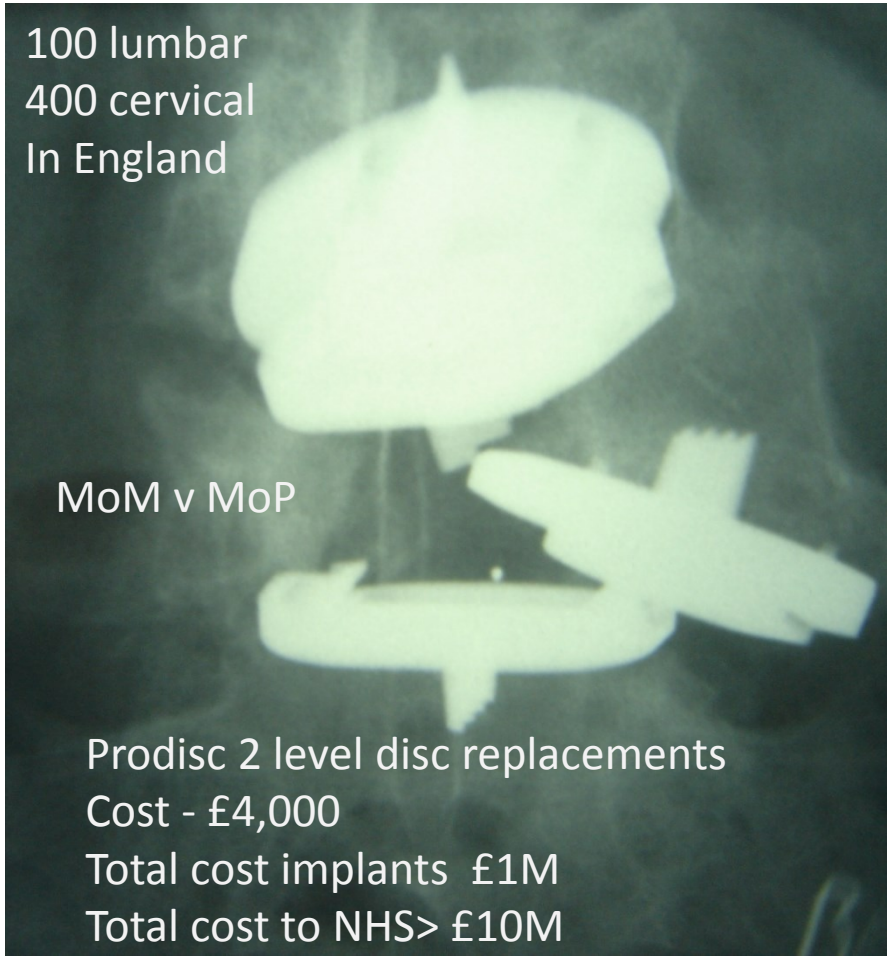
Surgery for Low Back Pain

TOTAL COST £100m+



Dynesys L2 – S1
Cages L3/4 & L4/5
Cost -£ 6,000
Evidence of efficacy in long-term - NIL
Cost of implants £16M
Total cost to NHS is >£39M (2 level)

Fritzell et al ESJ 2003
Hagg et al ESJ 2003



No long-term data
Difficult revision – with mortality risk

Data from Spinal Taskforce Chair J.Carvell

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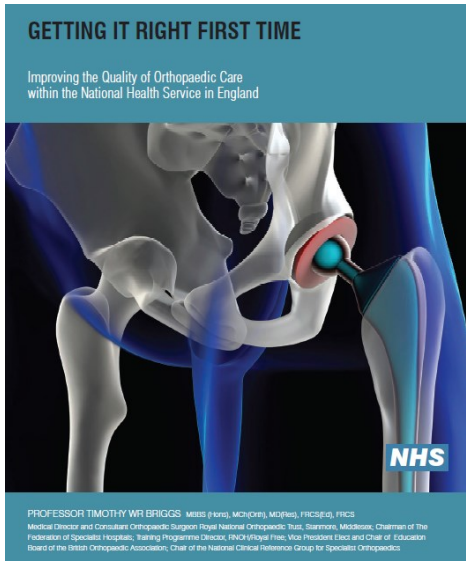
GIRFT Objectives

- Supporting the following in elective orthopaedic care:
  - Improved patient experience
  - Re-empowering clinicians
  - Improved patient safety
  - Better outcomes in terms of joint longevity, infection – SSI and acquired, complications, readmissions and mortality
  - Significant taxpayer savings from reduced complications; infections; readmissions; length of stay and litigation; better directed care pathways; reduction in loan kit costs; and introduction of evidence based procurement and procedure selection.

Published in 2012



Data sources – 12 sets of data collected for each trust

- Data accumulation and collation is complete
- A comprehensive orthopaedic dashboard has been created for each provider. Data sources include:
  - NJR (disappointingly not all data is available by provider – e.g. Longevity/revision rate by different prosthesis/weight bearing surface etc)
  - HES
  - HSCIC
  - NHS Comparators
  - NHS Indicators
  - Productivity Metrics
  - PROMS
  - National data sources – waiting times etc
  - National Hip Fracture Database
  - NHS Litigation Authority
  - NHS Atlas of Variation
  - Arthritis Research UK Musculoskeletal Calculator

Visits started in September
Peer to Peer review
Trust receives data 14 -21 days before visit
We want to understand the data

UNIQUE Data Set For Each Trust

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NHS England GIRFT – Report published March 2015

NHS Wales GIRFT – Report sent CMO August 2015

NHS Scotland GIRFT - Report completed

NHS NI GIRFT – April 2016

Southern Ireland – June 2016

Number of hospital visited 243

Number of clinicians seen – 1900+

Senior managers - 600+

Lessons learnt

Lesson 0 **Data is key and data set is broadly accurate**

Clinical engagement with clinically led peer review excellent - good template for future reviews

1. Huge variation in practice
2. Low volumes of specialist activity
3. Cemented vs. Uncemented
4. NJR compliance and use
5. Morale
6. Procurement
7. The Capacity Gap and AQP
8. Changing Behaviour
9. Networks/Hub and Spoke
10. Follow the Evidence

Lesson 1.Variation in Practice…Huge and widespread

National average…	Range
Cost of post surgery is ….£1,021	*£531 to £2,083*
Deep Infection Rates for THR/TKR	*0.2% - 5%*
ODEP 10A Acetabular use is…20.2%	*0% to 100%*
Knee Arthroscopy washout/TKR in one year	Huge variation
Return to theatres # NOF in 30 days is… 2.37% Stock take of Rehabilitation	*0% to 7%* *Generally poor*

Surgical site infections – 10 Trusts in same City

	Nos of Orthopaedic processes reported	% with infections – initial patient spell	% with infections – initial patient spell+ readmission
Trust 1	349	1.43%	1.43%
Trust 2	116	1.72%	1.72%
Trust 3	809	1.11%	2.47%
Trust 4	685	0.58%	0.73%
Trust 5	156	3.85%	4.49%
Trust 6	2657	0.68%	1.05%
Trust 7	454	0.00%	0.22%
Trust 8	544	1.47%	2.21%
Trust 9	--	--	--
Trust 10	521	0.00%	0.19%

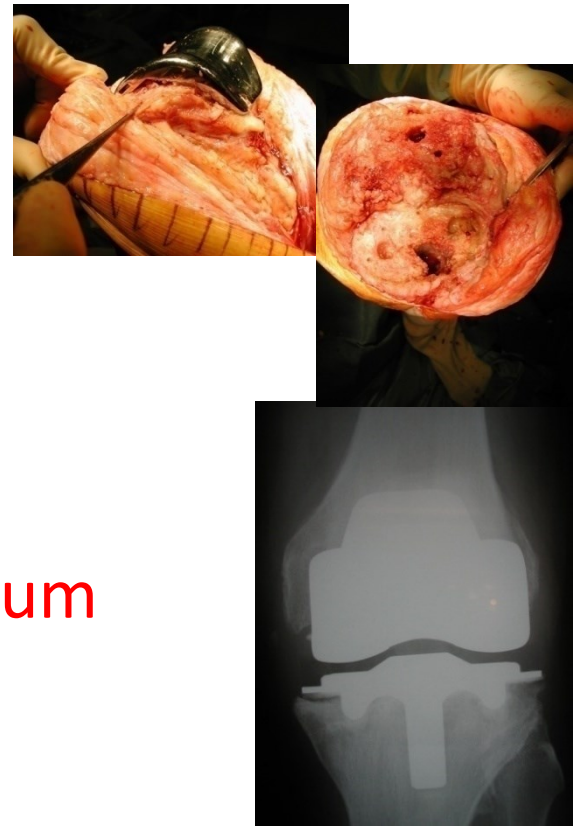
0.19% - 4.49%

Setting Standards
Patient Outcomes - Cost of Infection

- **Prevention**
- SOHs – infection rate THR/TKR = 0.2%
- National Infection rate = 1- 5%

- **Treatment**
- Average cost £75,000- £100,000
- Hidden costs – loan kit £1000 – £9,000 + per case

- Savings to NHS annually = £200- £300million per annum
- Up to 60,000 joint replacements



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Total Knee Replacements within 1 year of Arthroscopy (%)
Timeframe: 1 Jan 09 to 31 Dec 11 (TKRs: 1 Jan 09 to 31 Dec 12)
(Patients aged 60 and over)

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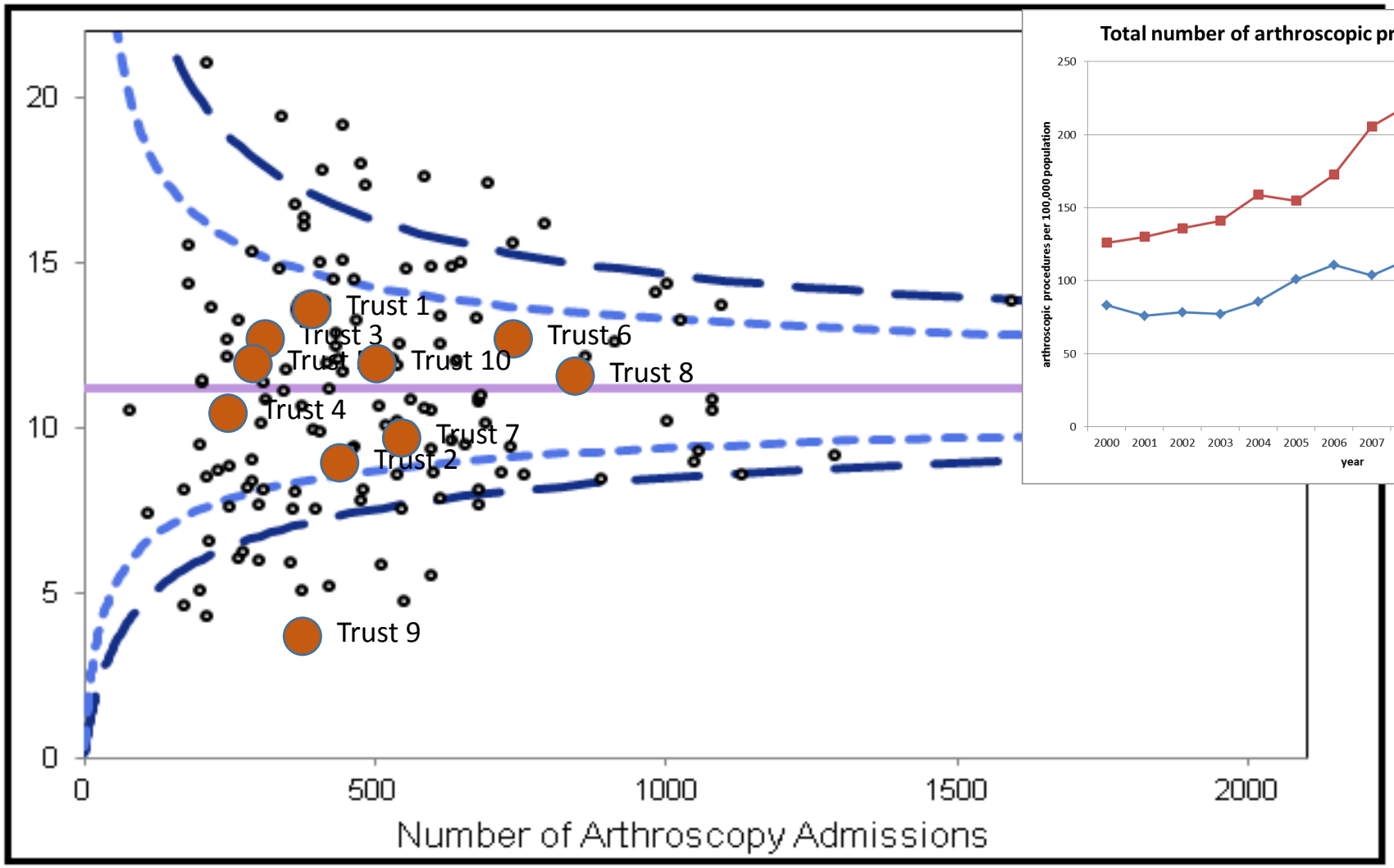

Source: NEQOS Trauma & Orthopaedic dashboard

Variation in Practice…Huge and widespread

National average…	Range
Litigation cost per spell is…£54.48	*£0 to £151*
Cost of implants	Huge variation
Loan Kit Costs per Trust	Average £200,000
Choice of implants by Consultant	Huge variation
Low volumes of specialist activity Spinal Services	*Surgeons ”having a go”* *Variable disinvestment*

Litigation data – 10 Trusts same City *(trust number not shown)*

Claims in 2011/12	Estimated Cost of claims during 2011/12	Estimated Cost per Orthopaedic Spell
*	*	*
12	£1,214,315	£99.28
5	£661,890	£41.55
3	£472,500	£50.56
6	£945,000	£43.04
10	£1,418,375	£36.47
7	£1,102,500	£60.27
29	£3,987,113	£134.90
8	£644,655	£31.13
16	£2,090,698	£50.39

National average cost per orthopaedic spell is £54.42

* Permission from trust not given to access this data.

Judgement
Tissue damage
Procedure
Unsatisfactory Outcome

Lesson 2 Low volumes of routine and specialist activity

Too many surgeons are still ‘having a go’ at complex procedures

May apply to large and small hospitals e.g. smaller and non-specialists hospitals with high numbers per surgeon

Additional analysis – (144 Trusts)

Primary Hip Analysis	Primary Knee (TKR only)Analysis
10% surgeons undertake 37% of operations	10% surgeons undertake 32% of operations
20% surgeons undertake 56% of operations	20% surgeons undertake 50% of operations
30% surgeons undertake 70% of operations	30% surgeons undertake 63% of operations
40% surgeons undertake 80% of operations	40% surgeons undertake 74% of operations
50% surgeons undertake 87% of operations	50% surgeons undertake 83% of operations
60% surgeons undertake 93% of operations	60% surgeons undertake 89% of operations
40% of surgeons undertake 7% of operations	40% of surgeons undertake 11% of operations

Knees – 12 month surgeon profile (144 Trusts)

Category	Total Operations*	Total Surgeons	Average Ops per surgeon	Nos of surgeons conducting 5 or fewer (%)	Nos of surgeons conducting 10 or fewer (%)
Total Knee	80299	1675	47.9	109 (6.5%)	263 (15.7%)
Unicondylar Knee Replacement	7068	719	9.8	352 (49%)	535 (74.4%)
Patello-Femoral Replacement	1304	390	3.3	313 (80.3%)	369 (94.6%)
Knee Revision	6309	1011	6.3	531 (53.0%)	818 (81.7%)

Source: NHS Choices website, 2012 data. (%)

Note: Not all consultants have consented to releasing this data. If this is the case for the Trust, then the values above may under-represent the true values for the Trust. A full listing of the consultants who have not consented, and their reasons for doing so can be found at the NHS Choices website.

** To create totals those with a note of <5 are counted as 5, this may impact on the average number per surgeon.*

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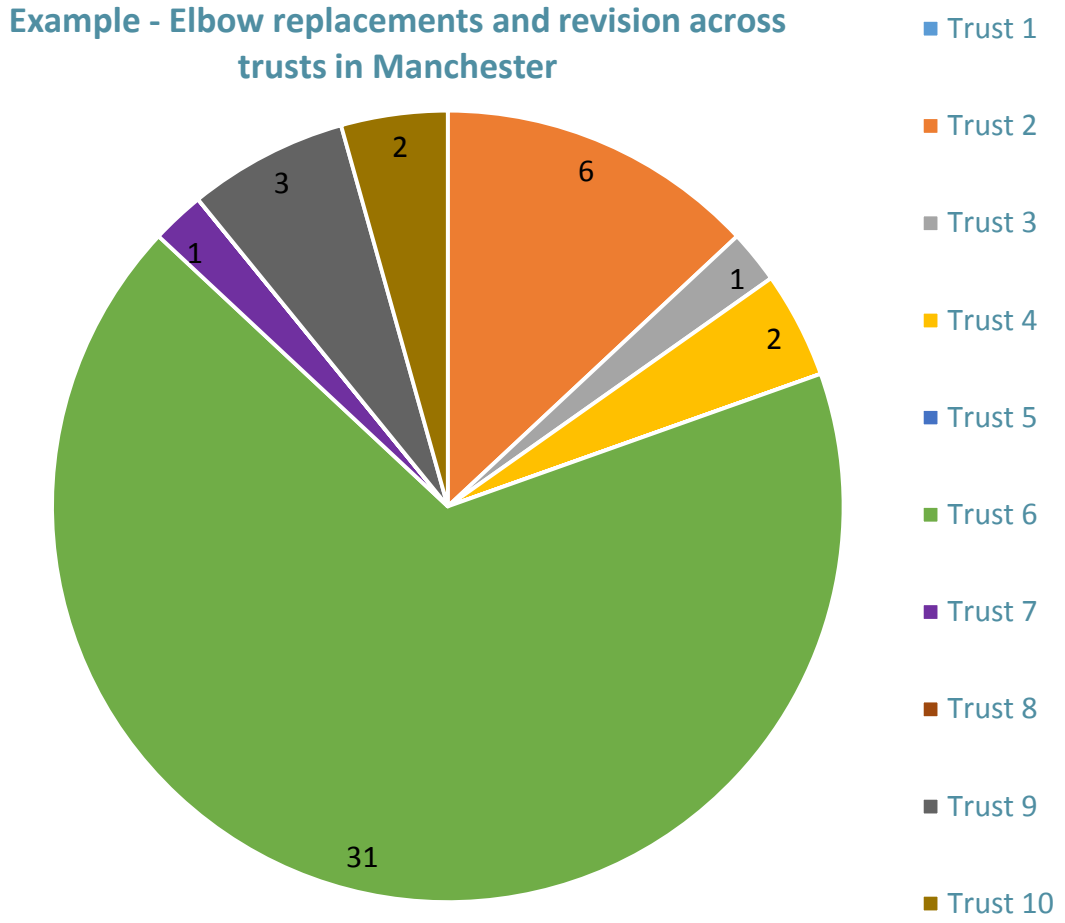
Low volumes of specialist activity

- Average 21 shoulder replacements per trust (increased by 8 higher volume specialist centres) Usually 6 at most centres
- Average 4 elbow replacements (increased by 11 higher volume centres)
- Average 4 ankle replacements (increased by 11 higher volume specialist centres – generally less than 2 at most trusts)
- Average 59 spinal fusions (increased by 15 higher volume specialist centres).



46 elbow replacements

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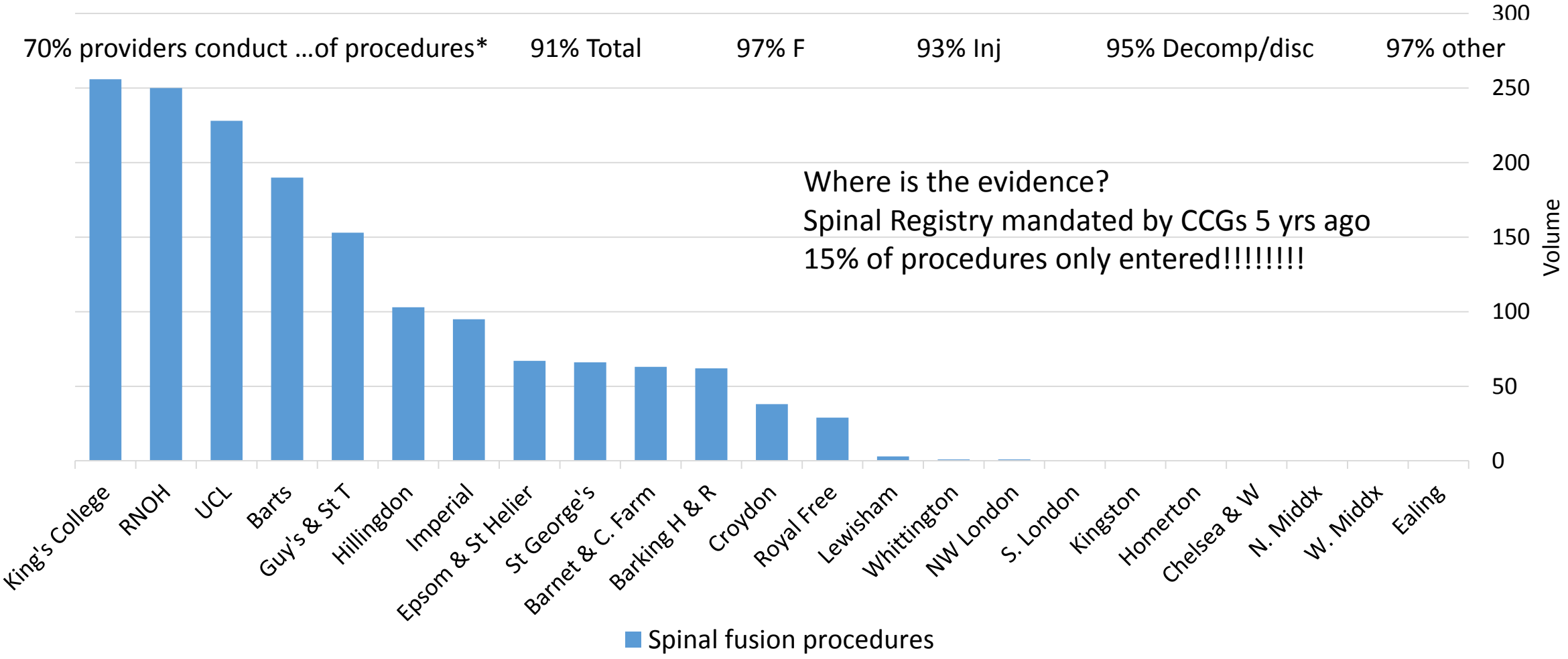
Spinal Fusion Procedures (London)



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Lesson 3- Changing surgeon behaviour – Evidence based

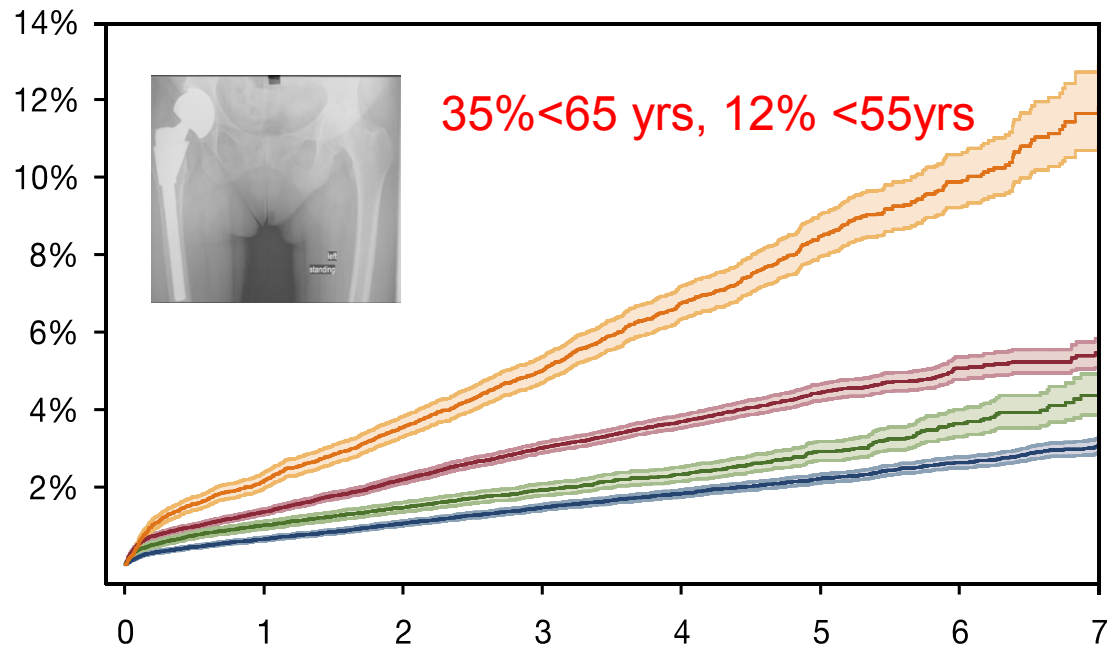

Figure 3.1

Risk of revision following primary hip replacement (cumulative hazard with 95% confidence intervals), by prosthesis type.

Primary THR procedures 2005 and 2010

- Cemented THR – 54% in 2005 reducing to 36% in 2010
- Cementless THR – 22% in2005 increasing to 43% in

22,000 - £6.7 Million

42,000 - £80+ Million

We need to change consultant behaviour

Commercial company driven, New technologies

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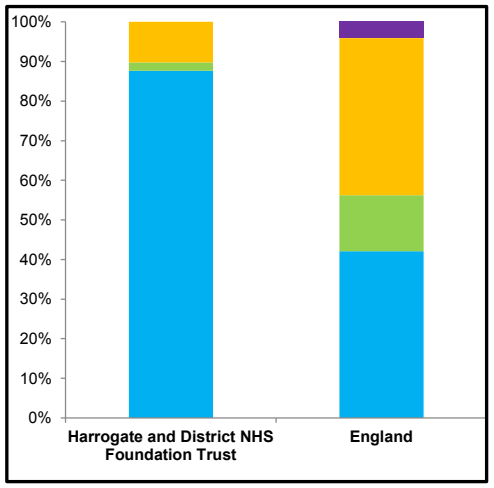
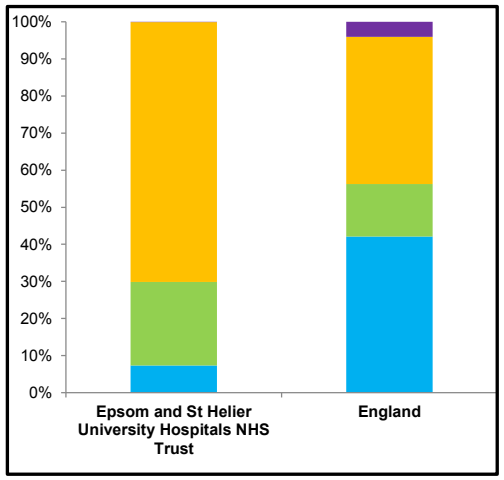
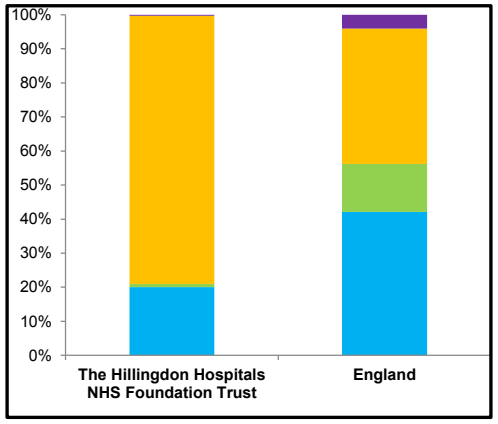
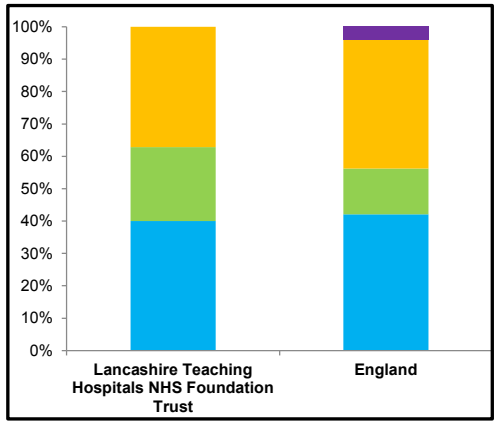
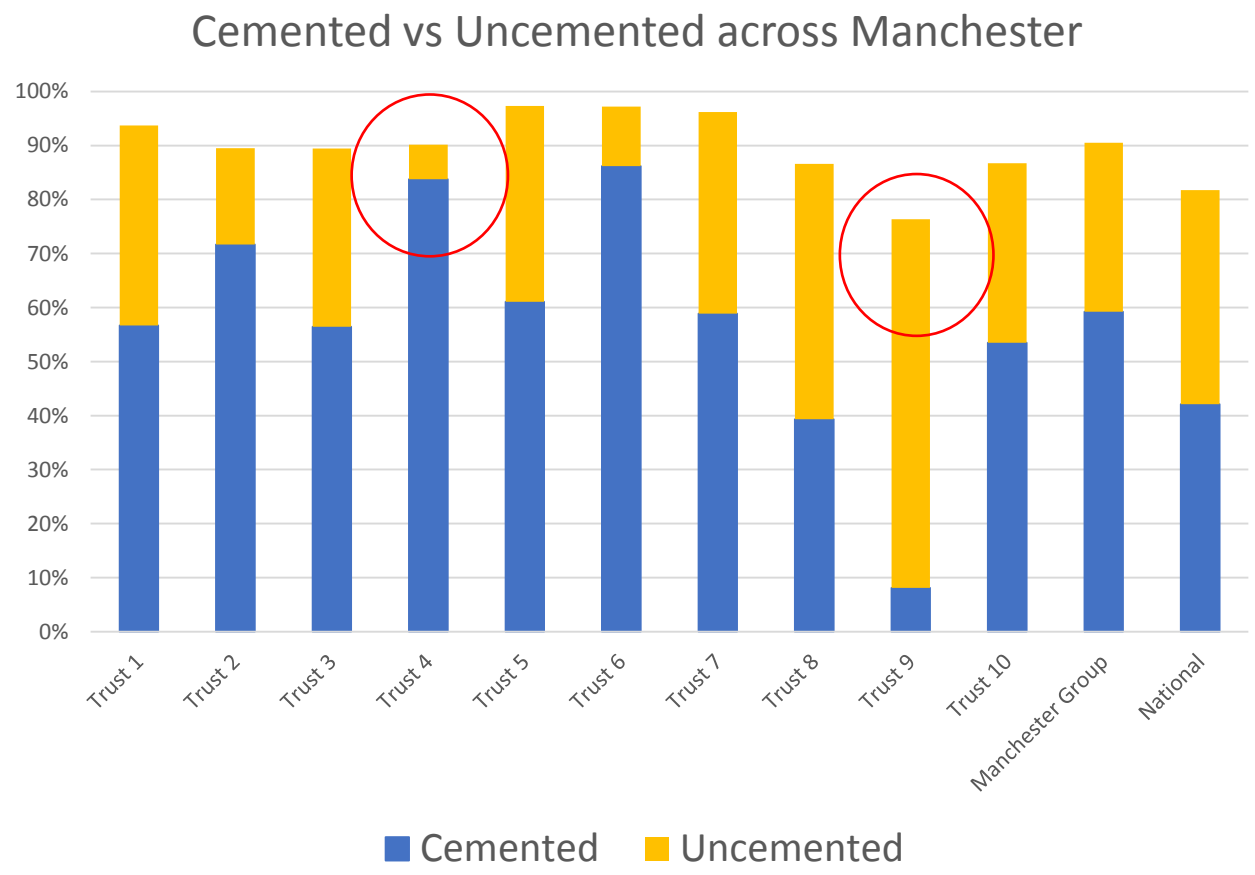
Is there a need for more robust national guidance on cement?





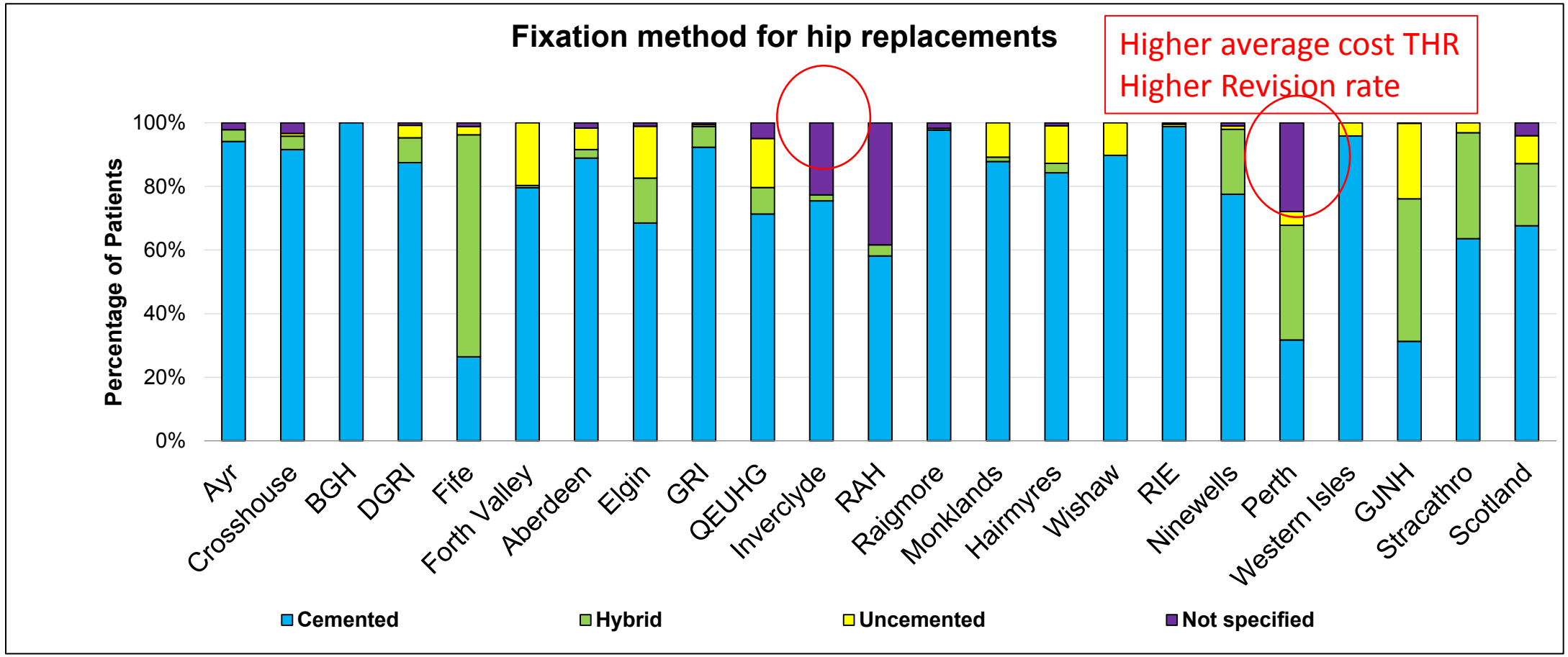






NB – not part of confidential NJR dataset

Fixation Methods – Hospitals in Scotland (>65yr)



Source: Scottish Arthroplasty Project (Operations in 2014)

Country Borough of Teeside
(red line indicates boundary)

North Tees Hospital Catchment Population 226,798

South Tees Hospital Catchment Population 523,256

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North and South Tees LAT Analysis (GIRFT)

Spinal

	North Tees And Hartlepool (FT)	South Tees Hospitals (FT)
Population	226,798	523,256
Epidural	691	245
Facet joint	924	304
Injection into joint	132	49
Nerve root	243	529
Others	111	63
Total	**2101**	**1190**

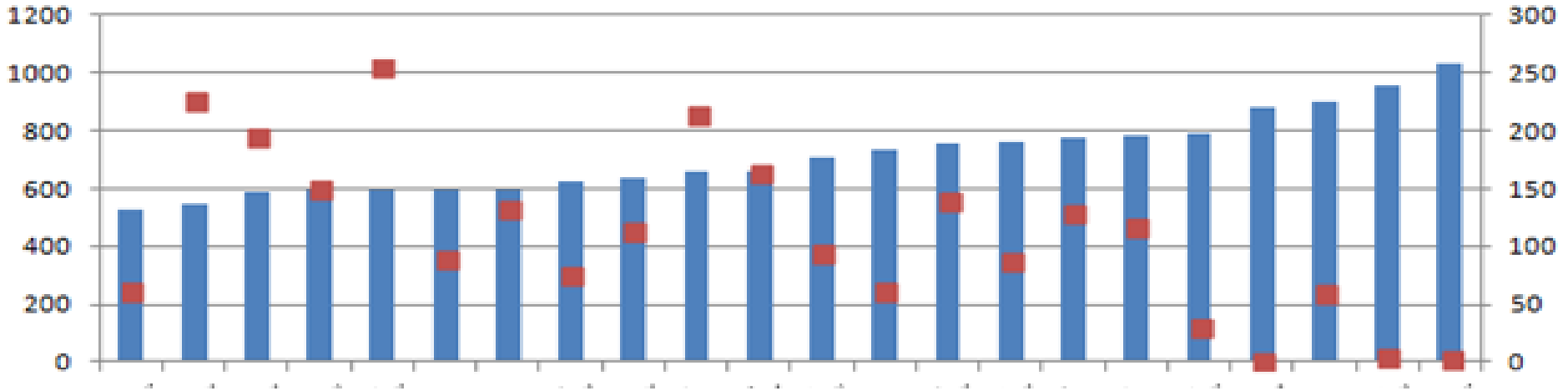
Disc and Fusion

	North Tees And Hartlepool (FT)	South Tees Hospitals (FT)
Population	226,798	523,256
Anterior lumbar fusion (+/- decompression)	-	3
Cervical spine: decompression (+/- fusion)	95	133
Lumbar decompression discectomies (without fusion)	140	527
Primary posterior lumbar fusion (+/- decompression)	116	65
Revision lumbar decompression	7	35
Revision lumbar fusion (+/- decompression)	7	9
Total	**365**	**772**

Why the variation in practice and interventions?

Note: Using Commissioning Spinal Services - getting the service back on track definitions

Findings – Hip Stem Brand Pricing by Trust (NJR Pilot)

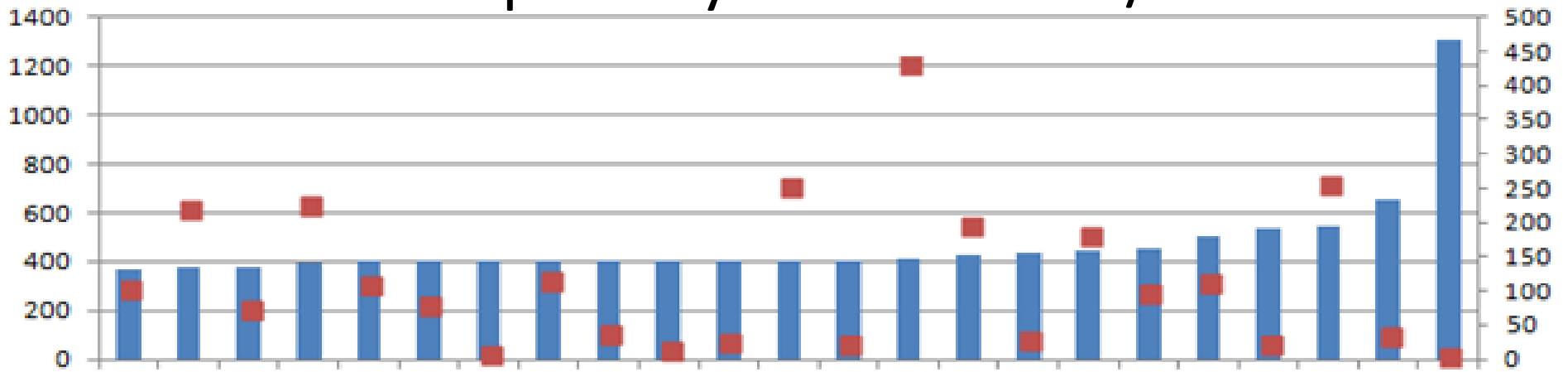


Cemented THR
£595-£822

Uncemented THR
£1225-£2529

Uncemented THR
Ceramic/Ceramic
£1722-£3411

Transparency letter on THR/TKR



Primary TKR
£1050-£2466
Max £4,000

Average Brand Price
Number Used

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COST OF IMPLANTS

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Hugh Variation in Cost of Spinal Implants
>10,000 products available within spinal catalogues for hospital

Screws - £32 -£600 – mono/poly nut included?

Rods (static and dynamic) - £72 - £1,066

Peek

Cages and Spacers - £26 -£3,200 diverse ar

Plates £22-£1,583

1cc of artificial bone graft to fill the c-spine cages with ranges

Comparisons across suppliers difficult as systems not being of standard design

Lesson 5 Loss of Morale/Disengagement

Loss of Morale is a serious problem in some trusts. Results in disengagement and conflict

The lack of ring fenced orthopaedic beds, and in some cases ring fenced orthopaedic theatres/theatre staff – is undermining good practice and is often experienced as a lack of commitment to the service by management.

Top down management is NOT working

Shoulder to shoulder is working

GIRFT and Ring Fenced beds

40% of trusts NO true ring fenced beds

Trust 1 Loss of "Ring fenced beds" during winter.
10 infected Knee/Hip Replacements during this period

Trust 2 "Ring fenced beds" breached by "clean surgical patients ENT"
Increased incidence of streptococcus wound infections in TKR/THR

Lesson 6. The Capacity Gap/Any Qualified Provider

>50% 0f Trusts cannot hit 18 weeks

Different models

Trusts losing 10% -40% of elective activity to AQP £££Billions/year – risk of destabilisation of health economy

33% of NHS Hip and Knee replacement done by AQP

AQPs – Cherry picking, multiple co-morbidites , complex cases, emergency readmissions.

Underlines the importance of;

a) a level playing field in terms of governance

b) incentive to ensure that specialist work can be identified accurately by coding and that the tariff covers the cost

c) Lower tariff price for AQPs

Highlights the need for ring fenced orthopaedic beds in NHS – elective units

Short term solution for patients but long term financial destabilisation of DGHs within NHS especially with financial austerity

WE NEED TO REPATRIATE THIS WORK BACK INTO THE NHS

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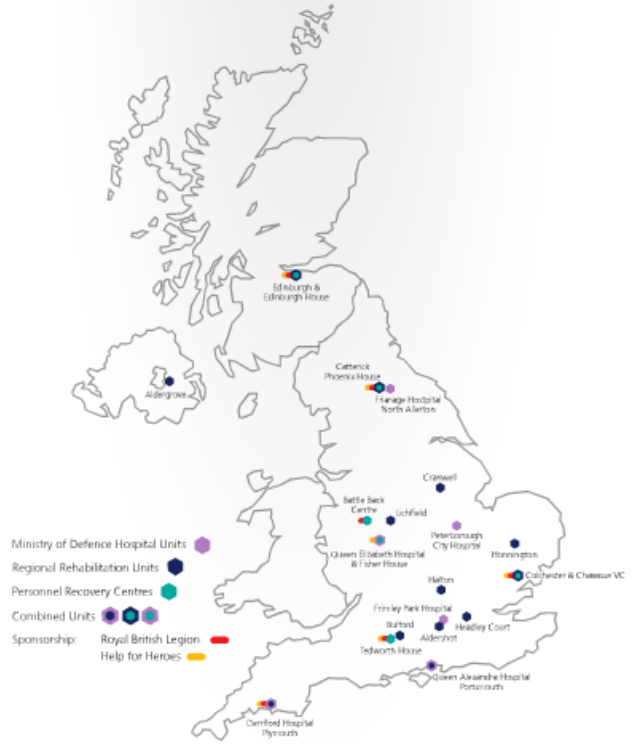
Patients wait six months to leave hospital

Stuck on the wards
Patients who waited for four weeks or longer for discharge after being declared fit to leave. Year to March 31 2015*

		Longest wait
Royal Berkshire NHS Foundation Trust	91 patients	132 days
University Hospital Southampton NHS Foundation Trust	207	179
University Hospitals Coventry and Warwickshire	48	154
Kings' College NHS Foundation Trust	16	149

*Delays incurred after serving of a Section 5 under the Community Care (Delayed Discharges)

Currently up to 30% of patients occupying acute beds in the provider network are ready to be discharged, their medical or surgical condition treated. These "bed blockers" occupy beds costing £675 per day to staff and run



Ministry of Defence Hospital Units (MDHUs)	Regional Rehabilitation Units (RRUs)		Personnel Recovery Centres (PRCs)
Queen Elizabeth Hospital, Birmingham	Aldergrove	Aldershot	Edinburgh House, Edinburgh
Frimley Park Hospital, Surrey	Bulford	Catterick	Chavasse VC House, Colchester
Friarage Hospital, Northallerton	Colchester	Cranwell	Tedworth House, Tidworth
Peterborough City Hospital, Cambridgeshire	Edinburgh	Halton	Phoenix House, Catterick
Derriford Hospital, Plymouth	Headley Court	Honnington	Battle Back Centre, Lilleshall
Queen Alexandra Hospital, Portsmouth	Litchfield	Plymouth	Hasler Plymouth
	Portsmouth		(Brydon House, Germany)

Figure 13: UK map showing the position of MDHUs, RRUs, PRCs and sponsorship centres from The RBL and H4H

Reduce Admissions

Specialist clinics in community
Senior clinical assessment in A&E – Fife Consultant Surgeon on-call in hospital.
Surgical admissions reduced by 30%

Increase Early Discharge

Enhanced Recovery Programme
Hospital at home / SWOT Warwickshire
Step down/Rehabilitation Beds – local / network

£2 million funding
First NHS Veterans Rehab Unit
Open to all NHS patients
Acute bed £675/day
Rehab bed £200/day

Results – LOS and Functional Outcome

Ed Dunstan et al FIFE Hospital

	LoS days (median, IQR)	Preop HHS (mean, SD)	Postop HHS (median, IQR)	Change HHS (median, IQR)	Good/excellent (HHS>80)
Traditional Rehabilitation	5 (3)	48.3 (±12.6)	94 (13)	43 (17)	89.8%
ERP	3 (1)	49.3 (±10.7)	95 (13)	42 (14)	88.8%
p-value	<0.001	0.15	0.35	0.16	0.62

What did the GIRFT Pilot in Orthopaedics tell us?

- Huge variations in practice and outcomes in terms of device and procedure selection, clinical costs, infection rates, readmission rates, and litigation rates.
- Scope to tackle many of these variations and drive short, medium and longer- term improvements in quality of delivery (through adopting best practice), reducing supplier costs (for example of implants) and generating savings, for example from reduced readmission and re-operation rates.
- Many of the answers are already out there
- There is no consensus as to what constitutes best practice in areas of activity where there is no NICE or formal guidance from the BOA or other professional sub-specialty association. This provides a significant opportunity to drive efficiency.

British Orthopaedic Association
Caring for Patients; Supporting Surgeons

Lesson 7. The Outlook

GETTING IT RIGHT FIRST TIME

Improving the Quality of Orthopaedic Care within the National Health Service in England

Need to control costs – "think of cost"

Surgeons must collect and use the evidence base

Changing surgeon behaviour - Complex cases "Don't have a go"!!

The Low Volume Surgeon – higher volume usually means better outcomes

Networks will be required - The complex cases and revision burden is growing and the rate increasing –

Increasing complexity means more two surgeon operations – right for quality, right for litigation protection but reduction in capacity/throughput.

New surgeons will have less experience as a result of changes to training and will need to work alongside a mentor for a long period – again a stress on productivity.

British Orthopaedic Association
Caring for Patients; Supporting Surgeons

GETTING IT RIGHT FIRST TIME

Improving the Quality of Orthopaedic Care within the National Health Service in England

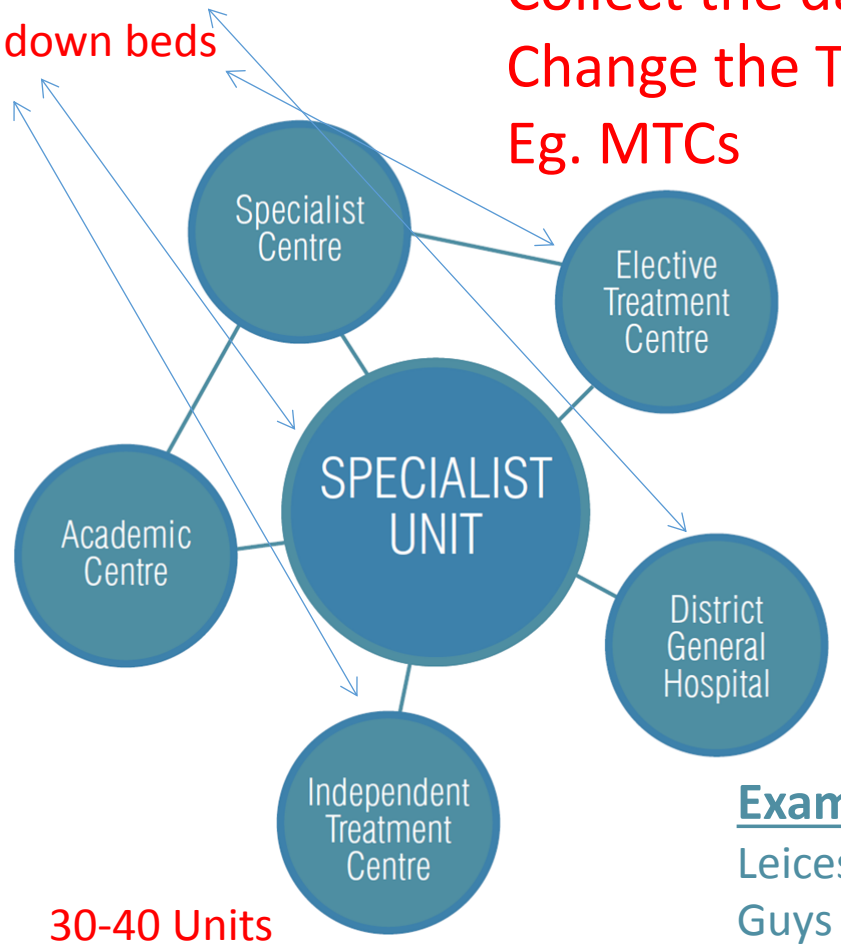
Lesson 8. –Networks /Hub & Spoke Model

STANDARDS

"Getting it right first time"- Pilot orthopaedics in England	Clinical Reference Group for Specialised Orthopaedics
• **Critical Mass of Specialists - One site Specialist Units** • **Networks** • **"Ring fenced elective beds"** • **Dedicated theatres** • **MDT working** • **Range of models/networks**	• **Defines specialist units and centres** • Minimum numbers • Gold standard • Infection rate <1% • Audit • Robust Review of outcomes

Improving quality
Improving training
Elderly population not disadvantaged
Patients will feel safe
Significant savings

Rehabilitation
Step down beds



Fewer Centres
Collect the data
Change the Tariff
Eg. MTCs

30-40 Units
London 5-6

Examples
Leicester
Guys
Northern

Model Hospital and Productivity

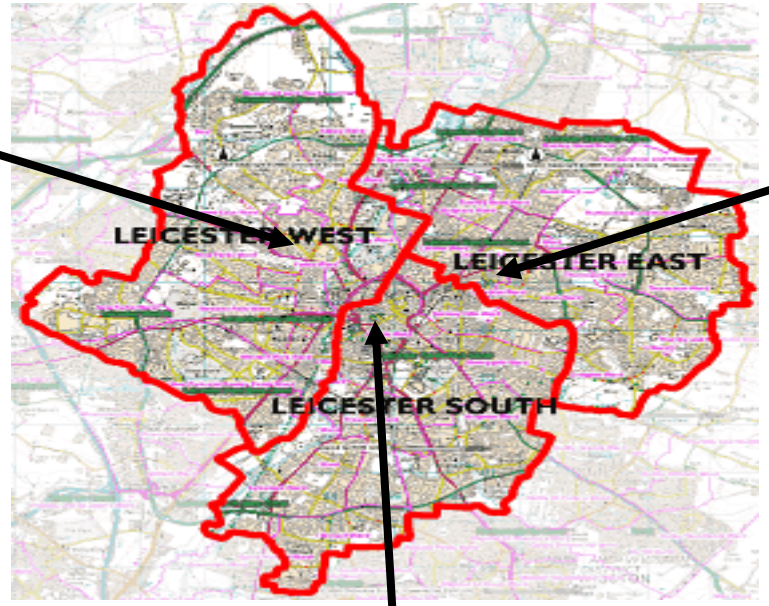
- **Productive Theatre**
- **2 session day – 4 cemented joint replacements (or equivalent)**
- **40% of operating theatre time spent operating**
- **Whole pathway in hospital streamlined and efficient**
- **Enhanced recovery programme – 50% home day 3, 50% home by day 5.**
- **Anaesthetics vital to achieving this – block room, regional anaesthetics**

Leicester 2012

GLENFIELD

(Elective)

OPD & Diagnostics Only



GENERAL

(Elective)

7 Theatres

33 Consultants

3 Wards

ROYAL INFIRMARY (Trauma, Paeds & Sarcoma)

3 Theatres 25 Consultants 3 Wards

Department of Health

GETTING IT RIGHT FIRST TIME

Improving the Quality of Orthopaedic Care within the National Health Service in England

Clinically-led quality and efficiency programme

- A Department of Health 3 year programme under the NHS Procurement & Efficiency Programme, across ten clinical specialties utilising the methodologies of Getting It Right First Time :

- Elective Orthopaedics – implement solutions
- Cardiothoracic
- General Surgery
- Oral and Maxillofacial
- Urology and Renal
- Neurosurgery
- Gynaecology & Obstetrics
- Paediatric Surgery
- Ear Nose and Throat (ENT)
- Vascular
- Ophthalmology

→ Spines

Funded with £2.6 Million
3 year programme

Comprehensive Spending Review
£63 million – all specialities in provider side

Department of Health

GETTING IT RIGHT FIRST TIME

Improving the Quality of Orthopaedic Care within the National Health Service in England

Orthopaedic Quality &Efficiency Goais

Short Term	Medium Term	Long Term
Reductions in: • Prostheses costs • Loan kit costs • Readmission rates • Length of stay • Surgical site infection	Reductions in: • National variation for procedures • Outliers in national registries • Infection/complication rates	Reductions in: • Revision surgery • Readmissions • Litigation numbers and rates

Implementation

Letter to ALL Trusts in England – CEO, Chairman, Medical Director, Clinical Lead in Orthopaedics, CQC

Questions: What have you done to improve orthopaedic services since our visit?

January- Updated GIRFT Report. What has changed? Visits to the Good and Bad

Mandated to implement solutions

Reduce THR/TKR prices, eliminate loan kit costs, reduce infection rate THR/TKR < 0.5%, reduce litigation by 50%

Savings £2 Billion over 5 years

Data will drive change -Example draft dashboard Dashboard April 2016

Registries
Spinal

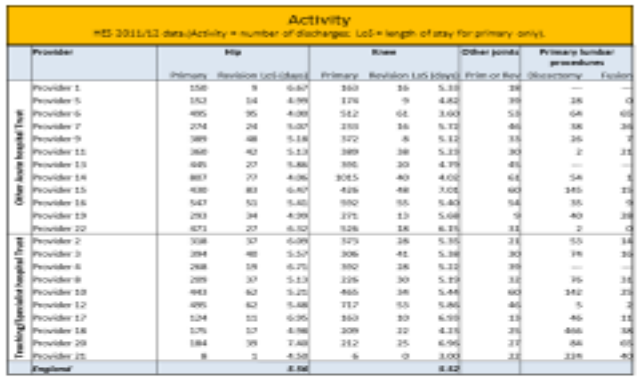
National Joint Registry

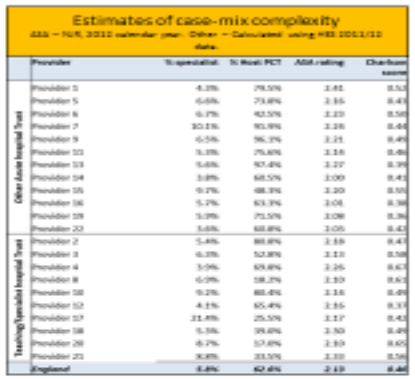
HIPS
KNEES
ANKLES
ELBOWS
SHOULDERS
PROMs

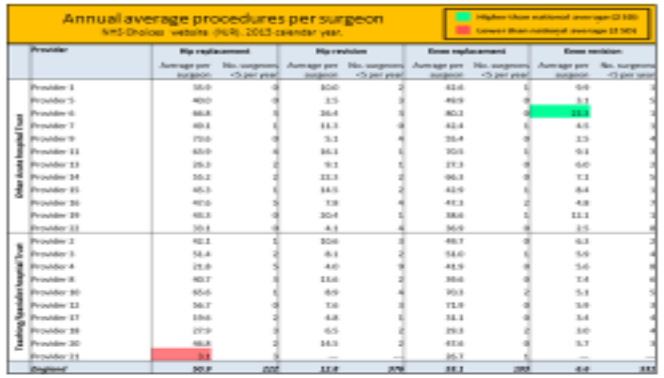
Mandatory entry
Pricing entry

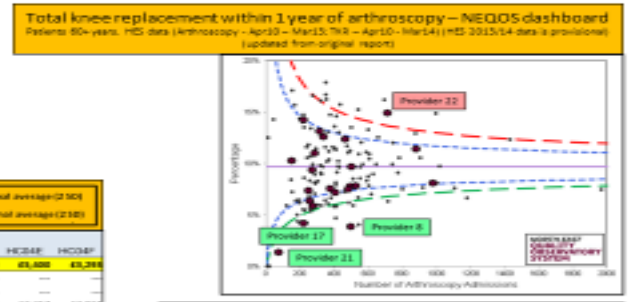
3 monthly

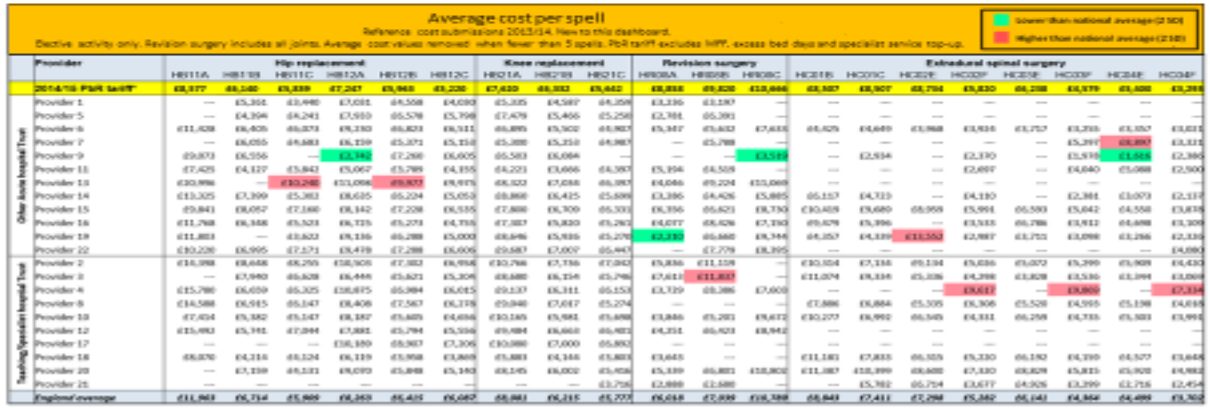
Orthopaedic surgery dashboard
General statistics

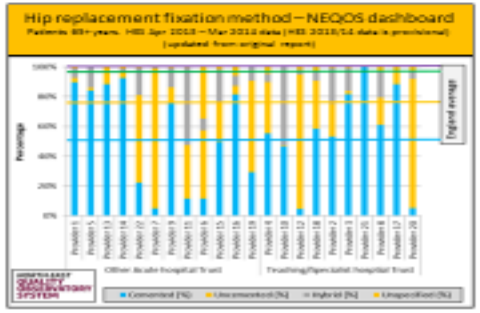












Deep infection rates
Re-admission rates
Prostheses costs
Unit outcomes

11th Annual Report
2014
National Joint Registry for England, Wales and Northern Ireland
Surgical data to 31 December 2013

Key outcomes of the programme

Supporting delivery of the Five Year Forward View:
"NHS gets infrastructure and operating investment to rapidly move to new care models and ways of working leading to bigger efficiency gains worth 2-3% per year, combined with staged funding increases will close the £30bn gap in full"

- Delivering a clinically-led, provider-side focused catalyst for:

  - ✓ Improvements in quality and reductions in costs.
  - ✓ Informing the setting up and/or enhancing of robust clinical networks.
  - ✓ Supporting the direction of travel being developed by the Clinical Reference Groups who guide specialised commissioning within NHS England.
  - ✓ Enhancing the quality and consistency of care. *This will provide reassurance to CCGs that what they purchase will be consistent across England and of the highest quality and at the most effective price.*
  - ✓ Tackling price variations of medical devices to reduce cost and assure efficient and sustainable supply.

To maintain timely care with ageing and financial austerity we must: "Get it Right First Time"

- Accumulate and follow the evidence- transparency
- Must do things differently – change behaviour Complex cases are not for everyone
- Re-empower clinicians, environment "Ring fenced beds"
- Reduce variation in practice
- Appropriate selection of patients for right procedure
- Implants – outcome and cost
- Maximise outcome
- Reduce complications – infection
- Litigation – contain and reduce
- Private Companies – Ethical behaviour

- Providers
- Procurement
- Lean Management
- Productivity

Outcome Improving Care, Reducing Unwanted Variation, Best Value

Tinkering with Tariff changes will not work!!!!!

Lesson 9 Clinicians must provide the solutions

Clinicians can drive the change

We need to “stand up to the plate”

Thank-you

Providers and CCGs need to work in collaboration