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Royal National Orthopaedic Hospital NHS Trust

NHS Improvement

GIRFT
Clinical Variation and Quality

KATHARINE HALLIDAY

GIRFT is delivered in partnership with the RNOH and the Operational Productivity Directorate of NHS Improvement

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NHS Improvement

NHS: The Challenges

Increasing Demand

Demographic changes

Growing population

2010 – 60m
2017 – 66m
2050 – 75m

Ageing population

By 2030, 33% of the UK population will be over 60yrs old and by 2031 there will be 15.3m people aged over 65yrs

Increasing BMI

By 2050, 60% of men and 50% of women will be obese

Increased health needs

- >65% patients admitted are 75 years of age or older
- People living longer will expect to remain active

129% **Increase in total hospital episodes**

- Total hospital episodes:
  7.9m in 1994
  18.1m in 2014

Financial challenges

42 % Decrease in NHS bed base since 1994. Currently at 129,299

£2.45bn 15/16 Provider deficit

c.£900m 16/17 Provisional aggregate net deficit

c.£1bn – c.£1.4bn Rising costs in NHS litigation premium from 14/15 to 15/16

£1.4bn Annual flow from NHS to independent sector

The risk that savings initiatives are not based on clinical evidence

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NHS: The Challenges

Unwarranted variation across trusts

0.19% - 4.49%

Variation in hip & knee deep infection rate within one city. If all trusts got to 0.19% this would save the NHS £200-300m p.a, enough for 60,000 replacements

£531 - £2,803

Variation in average cost of post orthopaedic surgery care

4% vs 98%

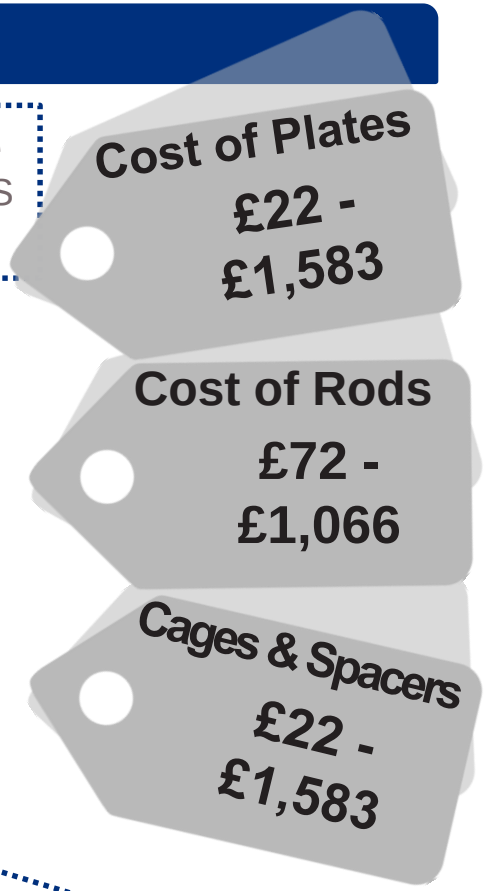
Variation in one city between cemented vs uncemented hip replacements

Large variation in ortho surgeons doing small number of complex procedures:
61% doing less than 11 – driving loan kit costs (£200k av. £760k max per site)

3x

Three times as many facet joint procedures in one half of a city compared to the other

Some trusts have out of hours MRI provision for emergency conditions (e.g. cauda equina) but others do not, and some trust don't provide blue light transport



Prof Tim Briggs 2012

- Considerable variation in process and outcomes
- Clinical teams unaware
- Compiled Dashboard of metrics
- Visited every trust in England and discussed results with clinicians and managers

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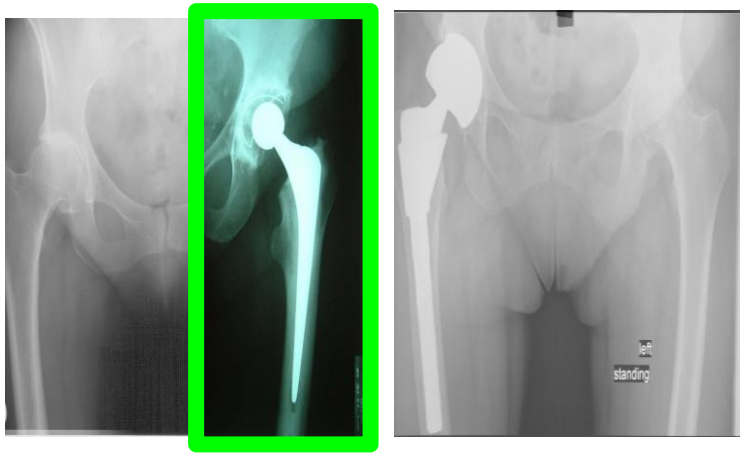
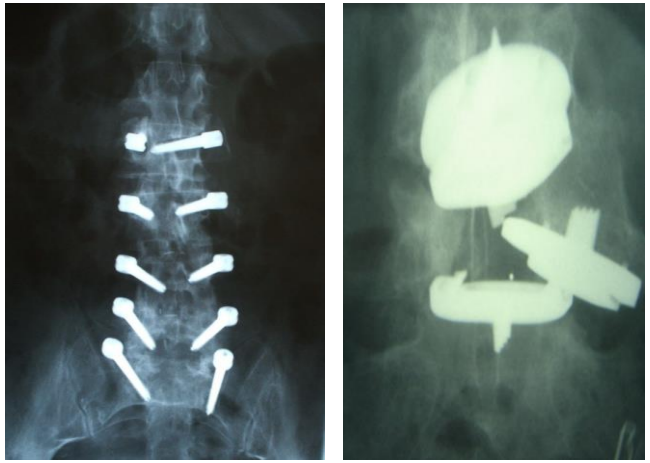
GIRFT Emerging Lessons



Cemented: £650 Uncemented: £5,300

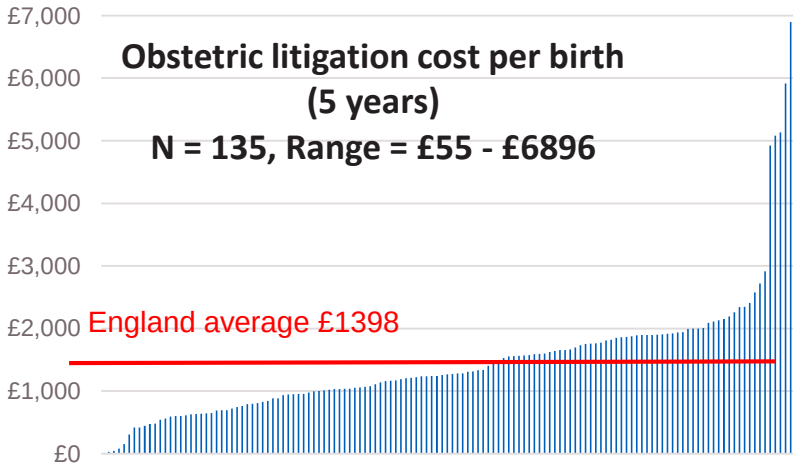
No evidence that hip on right provides better outcome for over 70s

Lower back pain surgery costs >£100m per annum with little evidence of efficacy



Huge variation between trusts in litigation averages:

- General surgery: £17 - £477
- Urology: £4 - £117
- Vascular: £1 - £6,353
- Obs & Gynae: £55 - £6,896



And the impacts are already emerging……

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Litigation

- £65 billion
- 1.5% of NHS budget
- £368% increase in last 9 years only 50% increase in activity
- 1 trust spent £44.7m in NHS resolution
- Payout /citizen
  - US- £9
  - UK- £24

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GIRFT Outcomes

- Improved patient outcomes
- Improved patient experience
- Improved patient safety
- Re-empowered clinicians
- Increased functional bed capacity
- Reduced flow of work to independents

Overall improvement in trust balance sheets

- reduced complications and readmissions
- reduced length of stay
- reduced litigation costs
- better directed care pathways

£ Significant taxpayer savings

- reduction in procurement and loan kit costs
- more productive workforce and reduction in locum costs

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GIRFT Orthopaedics Pilot: estimated impact to date

c.£50m
savings over two years and improved quality of care

50,000
beds freed up annually by reduced length of stay for hip & knee operations

£4.4m
estimated savings p.a, from increased use of cemented hip replacements for patients aged over 65 – reducing readmissions

75%
of trusts have renegotiated the costs of implant stock and reduced use of expensive 'loan kit'

	2013-14	2015-16
Litigation cases	1,600	1,350
Litigation cost	£215m	£138m

Litigation claims and the associated costs have been reduced significantly

British Orthopaedic Association
Caring for Patients; Supporting Surgeons

British Orthopaedic Association used GIRFT principles in best practice guidance to its members

A pricing letter provides transparency of the prices different orthopaedic trust pay for prosthesis, aiding procurement

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From pilot to national programme

25 Clinical work streams are already underway

800 Clinical lead visits already completed

10 Remaining work streams will kick off in waves between Nov 17 - Mar 18

Wave	Start Date	Workstreams	Total
1	2012	Orthopaedics	1
2	Jan 2015	General surgery, Spinal, Vascular, Neurosurgery	5
3	Jan 2016	Urology, Cardiothoracic, Paediatric surgery, Ophthalmology, ENT, Oral & Maxillofacial, Obstetrics & Gynaecology	12
4	Apr 2017	Emergency medicine, Cardiology, Dentistry	15
5	May 2017	Breast surgery, Diabetes/Endocrinology, Imaging/ Radiology	19
6	Jul 2017	Anaesthetics/Perioperative, Intensive & Critical Care, Renal	22
7	Sep 2017	Acute & General medicine, Stroke, Neurology	25
8	Nov 2017	Geriatrics, Respiratory, Dermatology, Trauma Surgery	29
9	Jan 2018	Rheumatology, Pathology, Outpatients	32
10	Mar 2018	Gastroenterology, Mental Health, Plastic surgery	35

- **Implementation strategy agreed and governance in place**
- **Collaboration agreements with national and local partners being delivered**
- **Regional implementation support network being put into place**
- **Benefits measurement & tracking approach developed**

Implementation until March 2021 with more specialties (oncology, paediatric medicine) to be added subject to DH business case later this autumn

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Imaging and Radiology

- Gail Roadknight - Project manager
- Andrew Boasman - Analyst
- Kath Halliday - Clinical Lead

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Variation

- Children 3X as likely to have WBCT in adult trauma centre
- % CT within 1 hour for Stroke by CCG - 6.4X (14.3-91.3%)
- CT – 4.6 X
- MRI – 6.4 X

National Imaging Optimisation and Delivery Board (NIODB)

- NHSI- Operational Productivity
- Pathology and Radiology
- “Developing and understanding of unwarranted variation within Pathology and Imaging provision and guiding the consolidation of services across the country to deliver quality and efficiency gains’
- Chaired by Erika Denton
- Representation from RCR, SCoR, NCD, AXREM …
- Collecting large amounts of NATIONAL data

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Model Hospital

- Real time data
- Hospital level
- Allow trusts to monitor their own performance
- Still under development
- NIODB and GIRFT will influence content

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GIRFT Implementation Pathway

PHASE 1:

Preparation

Clinical Leads set review priorities & parameters per clinical workstream

GIRFT Data Team harvest data & prepare trust data packs

Month 0-7

PHASE 2:

Data Pack Implementation

GIRFT Review Team issues data packs to trusts, copied to NHSI Region teams.

Trusts use data packs to build GIRFT Implementation Plan per workstream assisted by GIRFT Hub, and start to deliver improvements

Month 7-32

PHASE 3:

Clinical Lead Visit Findings Implementation

Clinical Leads & GIRFT Review Team visit trusts

Trusts add visit recommendations to Implementation Plans, assisted by GIRFT Hub, and continue to deliver improvements

Month 9-32

PHASE 4:

National Report Implementation

Clinical Leads & GIRFT National Team publish workstream National Report

Trusts add report recommendations to Implementation Plans, assisted by GIRFT Hub, and continue to deliver improvements

Month 14-32

PHASE 5:

Review

GIRFT Data Team refresh & reissue trust data pack

Clinical Leads & GIRFT Review Team revisit trusts

Trusts update Implementation Plan, assisted by GIRFT Hub, and continue to deliver improvements

Month 23-35

PHASE 6:

Complete Implementation & Transition to BAU

GIRFT Hub Teams assist trusts to complete actions in Implementation Plans and transition improvements into business as usual

To month 36

- Ongoing support for trusts from GIRFT Hub Teams to aggregate individual workstream implementation plans, taking a strategic look at priorities and solutions across trusts and local health economies.
- Ongoing collaboration between GIRFT Hub Teams and regional teams from NHSI, NHSE & RightCare to dovetail approaches and ensure that GIRFT priorities are mainstreamed into local NHS improvement plans (see detail below)

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General data

- Description of dept
- Workload
- Staffing
- Waiting
- Reporting (how much, by whom, costs)
- Etc etc
  - Initally NHSBN, subsequently NIODB, CQC?

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Sentinel conditions HES/DID

- Stroke
- Appendicitis in Children
- Abdominal pain in adults
- Colorectal cancer
- Pulmonary embolus
- Seizures
- Back Pain/MRI
- Volume of imaging/service
- Breast surgery. Use of MRI/vacuum biopsy

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Questionnaire

- Dept specific patient feedback /staff survey
- Critical alert systems
- Litigation/incidents
- ISAS
- RCR/SOR audits
- CPD/MDT for reporting radiographers
- MRI protocol for trauma knee/ rectal cancer
- Electronic order comms?
- Can you see images and reports from other hospitals instantaneously?
- FTE for requesting/receiving PACS transfers?
- No of images auto reported?

Intervention questions

- Nephrostomy
- Abscess drainage
- biliary drainage
- Arteriography/Embolisation for GI bleeding
- Vascular (EVAR, Thrombolysis)
- Neuroradiology (MT, coiling)
  - 9-5, weekend daytime, 24/7 (Always/sometimes)

ON SITE

- Look around Dept
- Report a paediatric x-ray
- Vet and protocol MRI

Principles

- Clinically lead
- Reduce unwarranted variation
- Evidence based
- Concentrate on QUALITY and resource savings will follow

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