NHS Efficiency Summit: Variation, Value and Improving Patient Care

Future NHS Stage

11 September 2017

13:00 – 14:00

Speakers:

- Professor Sir Muir Gray – Founder, NHS RightCare
- Celia Ingham Clark - Medical Director, Clinical Effectiveness, NHS England
- Professor Tim Briggs – Chair, Getting It Right First Time (GIRFT), NHS Improvement
- Henry Black – Chief Financial Officer, NE London STP
- Professor Matthew Cripps – National Director, NHS RightCare, NHS England

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Muir:

I've had 45 years in the NHS in 23 re-organisations of the structure, most of which have made no difference at all! There have been two big ones, '74 brought us all together, '87 drove us all apart and Lansley aggravated that. So, we're now in a new era with new demands.

What I see happening is very welcome trends because we recognise that structure really doesn't matter. What does matter is culture, the culture of the NHS and we'll hear today about two aspects of culture, one is the collaborative culture of working together and the second is the culture of stewardship, everybody feeling responsible for the stewardship of resources.

We say to clinicians that if we screw up the NHS there won't be one in 20 years' time, that's what stewardship is all about. The systems are starting to think across the whole piece from prevention to long-term care.

Now, when we start to look ahead we can see in the past we had commissioners and providers and we still have the RightCare programme focused primarily on commissioners, and the GIRFT focused primarily on clinicians. I want you to think of a spectrum. If we take the value proposition, we think of the spectrum of value.

We developed the concept of triple value, allocative value and how we allocated the money optimally to different groups, to cancer or mental health, and technical value, are we using the money properly? It is more than efficiencies, because it also means are we seeing the right people. When we see the look at the variation in some places we're over treating people and in other places we're not seeing the right people.

Usually it's poor people that we're not seeing. Poor people get less joint replacement than wealthy people. It is not the right way to use the resources. And then there's personalised value.

Now, at the commissioner end, it's very clear that the commissioners have to decide how much for muscular skeletal and how much for children and how much for old people.

The clinician's job is to help the individual patient, make the decision that is right for them. But in the middle, there are all sorts of fascinating decisions being made about, for example, how much resource do we put into asthma or bronchitis or sleep apnoea and that's where providers, commissioners and clinicians come together.

This workshop you're attending is about value and value is more than efficiency. It's a really great platform because you are going to hear from four perspectives, from the NHS England perspective and then at the local population perspective, from an STP, and then the two projects that started

necessarily in the commissioner end and in the provider end, RightCare and GIRFT that are now part of the spectrum.

We will start with Celia Ingham Clark from NHS England. She's a surgeon but she exemplifies the fact that most of the people who manage resources are clinicians and as my old director of finance said, "It's the docs who spend the money." Celia; over to you.

Celia:

Thank you very much, Muir. Good afternoon. I was asked to talk about what efficiency means for me as a clinician and as a leader in NHS England.

Basically, the practical thing is that it is about doing the same or preferably more better quality for the same or less money. But I think it is also important to consider the impact of efficiency on people, first of all, on staff, because staff tell us they're really, really busy with managing many competing priorities and also patients.

They have better things to do usually than sit waiting to be seen in clinic or sit waiting on the ward for the consultant's ward round. It is about not wasting people's time.

My background is as a surgeon and then as a Trust medical director and then I had a regional lead on quality and a national role on transforming inpatient care so I've had an opportunity to see initially hospital surgery in terms of efficiency and then to spread to a much wider arena.

As a clinician, all of the way through my career I saw resource limitations, not enough outpatient slots, not long enough outpatient slots, not enough theatre slots, not enough beds and the impact not just of not enough beds in your own hospital but in other hospitals when you're trying to make an emergency transfer happen. Those problems are still happening today.

So, what are the opportunities? Well, first of all, in terms of clinics, GPs now have the opportunity to access consultant advice remotely where appropriate rather than necessarily sending a patient in.

Our early work looks as if that's likely to be more efficient and save costs. There's also the opportunity to shift some clinics into the community, have them led by nurse specialists with back-up by an expert consultant behind that for example Partha Kar the consultant in diabetes who works with us has done that in his own practice in the south of England. You can also run virtual follow-up clinics. We have some early work on virtual fracture clinics that is looking very promising. What about theatres? In our own Trust, we had late theatre starts and long delays between cases.

We dealt with that by building an admissions area next door to the theatres, so the inpatient nurses didn't have to be involved with patients until after their procedure and patients could walk to theatre and it made it much smoother.

Also, as GIRFT recommends, if you ring-fence your elected beds whether in the day surgery unit or on an inpatient basis or have a stand-alone elective unit like the south-west London orthopaedic centre, it gives you the opportunity to protect those beds and use them more efficiently. We know that every winter we double the number of respiratory acute admissions to hospital but not every hospital doubles the number of respiratory wards in the winter.

Instead, they leave those respiratory patients as outliers on all sorts of other wards. First of all, that blocks the surgical beds and prevents elective operations. Secondly, it's really inefficient.

Doctors talk about doing safari ward rounds. It is bad for patients; they don't get seen by the right specialist nurses or the right physiotherapists so they

have poorer care and longer length of stay. So, creating an extra respiratory ward in the winter is well worth doing. We know that but not everyone does it yet.

On the surgical side, we know now for emergency general surgery, if you put a surgeon at the front to see and assess the patients you can reduce the number of emergency admissions for assessment significantly and you can set up emergency day case surgery for abscesses so instead of a patient traditionally having to be admitted to hospital and wait one or two nights for that 15-minute slot in theatre when nobody else wants it and staffed for most of that time, the patient with a superficial abscess can be sent home and brought in for a day case procedure.

What about staff? Being efficient for staff, first of all, is getting rid of those long outlier ward rounds.

Secondly, it's the idea of that admissions unit next to the theatre so the anaesthetists don't have to hunt the hospital for where the patients admitted. Many you will have seen the TV programme with St Mary's where there was a whole team set up to do a major, major elective case and they all had to be stood down on the day because there was no bed for that patient to be admitted to.

That's really, really inefficient. What about patient flow efficiency? Well, first of all, emergency admissions are still typically clerked repeatedly during the admission process, being clerked once properly ought to be enough.

If you have access to the primary care record you can pull data from that rather than to have gain that information from scratch from the patient or their carers. Also, of course, there is the issue of the patient who is awaiting the consultant ward round for a decision on what happens next in their pathway.

Many of you particularly in relation to your own family members will be aware of situations where it happens at a weekend and your family member is waiting until Monday for the consultant ward round before the next part of their pathway happens.

There is lots of scope for improvement and we can do something about this jointly.

For me, efficiency is about doing more for the same or less money, while maintaining or preferably improving the quality of care. It is not about not wasting people's valuable time and that's staff and patients. Thank you.

Muir:
Since 1987, we've isolated hospitals from the populations they serve. We have isolated hospitals from one another by the competition.

So, hospitals have become institutionalised, the staff have become institutionalised. When I first met Tim Briggs, he was going into hospitals who all thought they were doing a great job and he was pointing out maybe they weren't when they compared themselves with others.

That did not greatly increase his popularity among everyone there but he was doing the right thing. Since then, when he was president of the British orthopaedic association, he has been given responsibility for the whole span of hospital services, to overcome the isolation and institutionalisation to make people look at their services and it's called Getting It Right First Time. Tim, over to you.

Tim:
Thank you very much indeed, Muir. Thank you for inviting me. Really, I'm going to present to you what I really want to get out of Getting It Right First

Time as we move forward in the NHS over the next few years. It's about improving the quality care we deliver to patients, reduce unwanted variation and complications. It came from orthopaedics because I'm an orthopaedic surgeon. I was also medical director at the RNOH. And could see in 2010 we had to do things differently in order to provide ongoing high-quality care for our patients. It's all about improving the quality we deliver by re-empowering our clinicians.

From that, we get better outcomes, squeeze out the unwanted variation and from that we would get significant savings. What we did in orthopaedics on the elective side, we collected 12 sets of data, including litigation data, and get it into a report to send to each Trust. Once they had that report, we went to visit them and over the last two years, I visited every single hospital in England, Wales, Scotland and Northern Ireland and we have found significant variation. So, what did the pilot tell us and what can we do about it?

In orthopaedics there was huge variation in practice and outcomes, there was variation in terms of infection rates and litigation rates, but there is no doubt there is scope out there to tackle many of these variations and actually what I found visiting most hospitals is that many of the answers actually are already out there. Here on the slide on the left, it is patients who are over 60 who have an arthroscopy of the knee and have a knee replacement within a year. All those red blobs are outliers.

We found in some Trusts 20% of patients were having that sort of intervention, which we could say is a waste of time and you'd be correct. Now when we back out there we see a huge change in practice with now rates as low as 3% and just moving that one matrix is saving the NHS a million pounds every two months.

This is a Trust we went to St Helen's in Knowsley saying what they are paying for their hip and knee replacements. Look at the savings they've made in one

year on hearing the data about what other people are paying for implants.

What we found across the piece just by showing that data on the GIRFT pilot, we have seen a significant reduction in length of stay for hip and knee replacement, use of appropriate implants in the elderly age group, and ring fencing beds to increase productivity and reduce infection rates and other aspects that have seen 45 to £50 million of savings over two years just by scratching the surface and as a result of improved quality of care.

One thing we have also seen is by showing litigation data and that has been a topic in the press over the last two weeks is that when we started our GIRFT visits we saw increase in the number of litigation claims in elective orthopaedics, but in the last 2014/2015 and 2015/2016 we have seen a 5% and an 8% drop in the absolute number of claims by just showing the data and asking trusts to look at their litigation and orthopaedics and act upon it.

That again has saved about £45-50 million by improving quality. What is going to drive the change is data. By December of this year we will have 270 metrics for orthopaedics for every single Trust in our data warehouse which will be accessible through the Model Hospital Portal.

As we ramp up the GIRFT programme, now we have a grant of £60 million from the Secretary of State in November last year, we are now going to look at 34 specialities and we already have 18 clinical work streams out there and there have been over 800 individual hospital visits by these national leads that we have appointed and we will see significant change as a result in practice. So, I don't know if any of you have seen but the General Surgical National Report was published in 2017 and it's a game-changer for NHS providers.

There is an urgent need for all of us to address unwanted variation and it will change practice and it will be evidence-based. For instance, 80% of general surgeons do not know their infection rates. If you can have a general surgeon

as a senior decision-maker behind the front door of A&E you can reduce your hospital admission rate by 30%. Do we have examples where that has been achieved, absolutely right. Nottingham is a good example and Fife in Scotland another example.

Again, in general surgery, you can see on the left-hand side is patients who have an elective colorectal operation, the best length of stay is 5.5 days the average is 10.2 days, why is there such variation? On the right-hand side each of the blobs are a trust in England and your readmission rate from a cholecystectomy, where your gall bladder is removed varies form 0 – 12 % We have to understand why that is the case.

So, between September and January we had the General Surgical Report, we are going to have the national vascular report, surgery litigation report neurosurgery and urological and Spinal National Report and by December 2018 we will have data sets available on, it's going backwards, sorry about this. We will have data sets available on 34 specialities, guys can you do something about that? It's going backwards? It's doing itself. So, we will have data sets available by December 18 on all 34 specialities which will give us between 6,500 and 10,000 individual metrics on every single trusts and then we are going to let trusts look at their data and then when we're happy with it we will let Trusts look at everyone else's data.

This is an example in surgical specialities litigation, I don't want you to look at the numbers but just look at the graphs and the variation and it doesn't matter what speciality you look at it's something we have to understand because we have to reduce the litigation costs across providers and I hope this will stimulate the debate amongst individual Trusts to improve their litigation. And what happens is all of this data will sit behind the model hospital which is part of NHSI, you will access it there and then go to the portal to you will be able to access by December 2018, as I said between 6,500 and 10,000 data sets. So, will it deliver? Well the King's Fund did a report which was published in

June of 2017 and they think GIRFT has huge potential to drive the change.

Why? Its data-driven, peer-to-peer review by clinicians, it's non-confrontational, highlights where clinicians are doing good work and highlights where they need to improve. What is great about this programme is they have the support of absolutely everyone from politicians, arm's lengths bodies, clinicians and Royal colleges and everyone.

So, the next steps are 34 special visits to all trusts. We need to know what does good look like? We will implement the solutions from the national reports over the next three years and what we will be using is clinical evidence to drive the change and behaviour. And it will mean different ways of working and it will provide the clinical evidence of both local trust level, network and STP level to drive the change and will mean some centralisation of services, we will have to develop hot and cold sites and ring-fenced beds as Celia has alluded to and it will result in high quality care and also best value. Thank you very much.

Muir:

It's one thing I disagree with, it's not data, it's leadership and you are giving great leadership to the team. It's words that change the numbers so Tim is really bringing about a big change there. The introduction to the next session, I would like to say one of my favourite songs is by the Everly Brothers, Bye, Bye, Love Hello Loneliness. This is the BMJ this week, farewell CCGs hello ACSs. We are now seeing a shift towards population-based systems and Simon has chosen the name Accountable Care Systems and the midwives are going to be the STPs and Henry Black is going to give us an insight about this process of transformation without structural reorganisation.

Henry:

Thank you very much. Good afternoon, everyone. It's a great pleasure to be here. My name is Henry Black. In my day job, I am the CFO for Tower

Hamlets, CCG, but for the last 18 Months I have been the lead CFO for north east London STP.

We have heard from some of the eminent leaders in some of the techniques we are using to drive out variation but I have been asked to give a bit of a flavour and a reflection as to how this has kind of being translated into implementation if you like, in terms of local STPs taking some of these things forward.

So, I will talk through our approach that we are driving in north east London, our single financial strategy, the governance and committee structures and processes that we have put in place to try to support that collaboration and then give a couple of brief examples as to some of the work we are doing to take the agenda forward.

So, a quick overview of north-east London. This is our STP footprint. The first thing to say is we have undergone a bit of a rebranding exercise recently, moving away from the STP acronym. The NHS loves a bit of a pointless rebranding exercise, but in this instance there is a point to it, I think moving, the STPs were brought in as part of the planning guidance and we don't collectively consider ourselves 20 organisations working in collaboration to be a plan, we are a partnership, so the STP acronym doesn't quite fit anymore, also it's generally seen as a health construct and it's important to ensure that local authority partners are equally at the table and to be able to generate a kind of bottom up and authentic sense of identity to a partnership, it's important to create that kind of identity.

The geographical area that we cover is, I suppose in kind of national context it is not a large size geographically but it's a big population, these slides are doing their own thing. So, we have the best part of two million population, we have got huge diversity both in terms of culture, but also in terms of health outcomes, so one of the things we are here today to talk about is how to

identify and then drive out variation in care and variation in outcome. So, it strikes me that a crucial way of doing this is to extend the kind of scope of management where strategically sensible, so that the different organisations within one geographical area can compare one against the other and use benchmarking techniques like GIRFT and Rightcare to give better care for the whole population. Some of our wicked issues.

As I said we have huge diversity, we have some of the richest parts of the country, we have the city of London with the banking district and The Square Mile and we have the Canary Wharf which has a large density of wealthy population and then living cheek by jowl we have some of the most deprived populations in the country. So, we have inner city Hackney and Newham and Dagenham amongst others, all with different populations and different needs. So I said I would talk about our single financial strategy, so this is a kind of fairly, we are breaking new ground in terms of the comfort zone of and which Muir referred to before about how organisations now need to come together to collectively deliver systems financial balance, so we have a single financial strategy, the sovereign organisations obviously retain their statutory responsibility to deliver their own objectives but the ability to be able to see and reflect on how certain, if you like traditional contracting behaviours impact on one another is a very useful exercise and genuine demand management and cost control I think we have all proven to ourselves that those objectives can't really be delivered by organisations working in isolation.

In addition to that we have a lot of work on a new payment model which I will talk more about in a minute and a risk share mechanism that supports the ability for providers to be able to work collectively.

So, a bit about our governance and committee structures if you like, these are the new and different ways of working that we have introduced to move away from traditional adversarial contracting and try to work in collaboration and deliver common goals.

Our financial strategy owns the single financial strategy, very high level tight group, we then have the Operational Delivery Group which was very successful last year in delivering a single plan. All of the partners working together with their own operating plan timetables and statutory requirements but alongside that a single plan that clearly identified where there is potential for one organisation's plans to have a detrimental impact on others. We have a control total monitoring tool, which, for the first time gives us a reporting mechanism that flushes out where contractual differences are clearly the case, where providers are expecting in their plans more income than commissioners are expecting to spend and that is a very useful piece of, well it's transparent reporting that we have never had before.

All of this is supported by three operational delivery boards which are operational in focus. Those are the local system level forums for clinicians, ops people and transformation managers, instead of working in their silos all coming together to use the RightCare and the GIRFT techniques to deliver a single plan. I am getting the nod. So, a very quick overview of two pieces of work that we are doing, using the GIRFT principles. We are doing a site optimisation review on three of our biggest sites, they are not configured in the way one would hope optimally they would be, a large PFI site a smaller DDH and a mental health facility clearly the opportunities for applying GIRFT principles to ensure that the right things happen in the right place, rather than just where the organisations have allowed them to emerge through clinical and operational features, that is a key benefit from collaborative working and finally payment reforms, so we have a huge consultation exercise across all 20 partners, including health and wellbeing boards, Healthwatches and the like.

Trying to design a new payment system that is capable of delivering accountable care and supporting outcomes rather than payment by activity measures and the old traditional ways of working but I've run out of time so I'll

leave it there.

Muir: Our final speaker is the ying to the yang of GIRFT, Matthew Cripps. He is a classic scholar so he brings the Greek philosophers and Julius Caesar! He brings this different approach. He, like Tim, has had to take a leadership role in working with top management and finance colleagues, because Matthew is also finance qualified, to make them think about balancing the books and seeing what they can load on to some other budget but to think about values. So, Matthew is the director of the RightCare programme.

Matthew:
Thank you, Muir. I was going to apologise if I come across as melancholy but I have lost a ten-pound bet to Muir! I find myself quite cheered by the experience so we were outside earlier and he claimed he was going to stick to four minutes in his introductory speech! I guffawed on the basis he has never stuck to any time in his speech in his life. I bet him he couldn't! He kept it within 3.48 seconds.

I realised I've actually practised what RightCare preaches. I've invested to save because I've discovered something that no-one else previously knew which is that you can keep Muir to time but way of a financial incentive! Anyway... you have heard from people far more expert than me on the clinical aspects so I thought I would just give you a few examples of real financial efficiency being delivered via population healthcare improvement to demonstrate that this really can and does work.

So, Blackpool CCG adopted the RightCare approach before it was mandated by NHS England. They reduced frequent calls amongst the top 50 callers by 89%. And A&E attends by 93% and admissions by 82%, saving £2 million. Population healthcare improvement that drives financial efficiency.

This work was the prototype for our high impact intervention work on high intensity users and is now in dozens of other local health economies having the same and similar impact. Bradford CCGs, they focused via their lens on CVD and stroke and reduced deaths by stroke by 210 in the first year of impact saving £1.6 million. That's the prototype of our CVD prevention optimal pathway you can get from our website.

Slough via their complex case management innovation, they adopted the RightCare approach and reduced A&E demand by 24% and non-elective admissions by 17% in the target population. The percentage drop in associated spend is greater than that because this impact is all at the most complex more expensive end. The RightCare rollout began last year in the first third of local health economies adopted it and had part-year effect last year.

The early evaluation from that part-year effect is coming through and is showing shifts such as in respiratory where across those CCGs they've moved from a 6.7% growth in respiratory activity to a 7% reduction and a similar shift in spend. GU activity was going up at 3.8% and is now coming down at 10.9%. The financial impact of that activity shift is it has gone from an 11% growth to an 8% reduction and so on and so on.

It would be remiss of me as a former finance director and driving this programme forwards with my team not to make the point that the RightCare approach is built on the foundations of optimal financial management. It is built on the principles and teaching of the Chartered Institute of Public Finance accountants and on the work of CIMA as well and our work on value is built into CIMA's global management principles. If you are CIMA qualified here, you are obliged to follow the RightCare approach!

Muir:

Before I pass over to our distinguished facilitator Gavin Esler, what I'd like you

to do is turn to your neighbour and introduce yourself and talk for two minutes how it will change what you do when you go back after this conference.

Two-minute discussion starting now.
5, 4, 3, 2, 1. You must stop talking! Carol, you must stop talking! Gavin, over to you.

Question: Hi. My name is Matthew Atkinson; I'm a public health doctor. Do you think we will get to the point where acute hospitals feel responsible for the care of their entire population? And if so, do you think that will be because of financial incentives or because of a cultural shift?

Gavin:
Tim perhaps. Who would like to take that?

Tim:
I think it's a very good question. I have to say the first thing we have to do on the provider side, if you look at London as an example, we spend a billion a year on primary care, two billion on mental health and then 13 billion on the provider side. What we are trying to do with GIRFT at the moment, we are trying to get the provider side where we squeeze out all of the unwanted variation and unnecessary complications and improve care to make sure we get best value.

We link in very much with RightCare and we look at it across the whole pathway of care to make sure that all of the patient populations and patients, therefore, flow through the system as effectively and efficiently as we can getting the right outcome. What you're asking really is there going to be a blurring, if you like, between primary and secondary care? I think primary care is changing, although I work in the secondary care sector and I wouldn't want to second guess that.

I think there is a much more coming together of the whole pathway with time to make sure we get best value and best outcome. I personally think that will happen.

Muir:
How many people in the audience from hospital management? My question to you -- this is sales -- my question to the hospital chief executives, are you are in the real estate business or the knowledge business? Now, some of them looked very baffled about that.

But the president of Toyota said that Toyota is a knowledge company, you have to know about plastic, steel and competitors in the future. It's up to us, up to public health not to try to persuade them with the words "public health" because they don't like that but ask them are they in the real estate business or the knowledge business. It will inevitably happen.

The work that Tim is doing and the work of RightCare is going to blur that completely and we're going to go back to a collaborative way of working so it will happen.

Question: My name is David Cartwright, I'm a patient amongst other things. I quite agree with what the surgeon said about people waiting to go to theatres and then being told after waiting eight or nine hours there's no bed for them to go to after surgery and they have to wait.

My question is very simple, how on a piece of A5 paper will you explain to the communities, to the people that want the services, how are they going to act as them and where are they going to get the best results?

Celia:
We give information for patients and the public through the NHS Choices website. If you want to find out about any particular service that's the place to

look.

We know the sorts of numbers that make a difference in terms of cancelled operations, so if hospitals are full above 85%, it then becomes really difficult to run them efficiently and so that's one of the things that's monitored now, the level of bed occupancy and having cut beds for years and years and years, hospitals are now beginning to increase them again a bit which is the right thing to do, notwithstanding the financial situation that we're in, because it is so inefficient to do things like cancelling people on the day.

Gavin: Henry, would you like to come in on that?

Henry:
Yes. It is interesting. Many of the issues that create the situation that you describe are within our control but they're just not necessarily within the control of one organisation working on their own.

I think that's the key thing about STPs create the environment and the conditions in which collaboration and accountable care can be delivered but what it really needs is a step change for organisations who do look after patients along the pathway and do work in a system, whether they like it or not, is not, you know, a set of individual isolated kind of units but is one system that needs to work as one system and needs to operate in a way that prevents those unnecessary cancellations from happening whether it's through better and more flexible bed management or a better aligned care management or through partners working together to ensure that discharges happen when they're meant to, so these cancellations don't take place.

Gavin:
Some more thoughts? Anybody else? We have a couple more minutes left. The gentleman they front and then the gentleman behind.

Question: Hi, I wanted to ask you a bit about when you find these efficiencies in secondary care, one of the challenges that I think lots of us are facing at the moment is how we then get that money to flow to other areas of our system to support them in working in different ways. I think there's a lot of talk about more money in primary care and growing our primary care services, what are your thoughts on the steps we should be taking to get that money to move?

Matthew:
So we like inventing acronyms in RightCare! Our latest one is called CROC, which stands for the co-ordinated reallocation of capacity, which is exactly that agenda.

There is... it comes back to the question previously. Beds, diagnostic and outpatient clinics, a lot of the stuff in secondary care, a significant proportion of it is the manifestation of unwarranted variation.
And delivering or eradicating that unwarranted variation involves putting more stuff in the other bits of the system prior to secondary care.

The co-ordinated reallocation of capacity is an attempt -- and it is going to happen at STP level with CCGs and providers driving it -- is to take the resources around that capacity that is being used film ends for unwarranted variation and shift it across but to do it together because it can't... we have been trying to do something like this for years and it hasn't yet worked.

Our belief is that it hasn't yet worked because we have not, one, identified which bits of capacity shouldn't be used for that and should be used for that instead, sometimes it's that bed should be used as a bed for something else, and sometimes it's that bed shouldn't be a bed and it should be a community physio service and so on.

The first bit is to get consensus in the local health economy what is the capacity that is being used and where do we need to reallocate it so that it's being used for warranted activity and it's coming. We had our first national workshop last week with all of the ALBs and the Department of Health and STP leaders and so on. It is coming.

Muir:
I don't like the word saving, there is the DNCA, anyone know what that is? It's a district nurse and a care assistant. That is £80,000 a year, I think we need to represent that on how he we could employ. We want to get the health service to do more, not less, more of the high-level things and that is the line for the future. We need to be very clear he wants to do more high-level operations and quite right, but we only get the high rate if we shift to the high value. DNCA.

Gavin: A lot better than Bitcoin.

Question: Andrew Dillan, Chief Executive of NICE, how do we define the "right" in RightCare and getting It Right First Time.

Gavin: That is called a hospital pass in rugby.

Briggs:
What we have tried to do in getting it right first time is to get everyone to improve to the average. If we start with that then not only will patient outcome be better but also you will make the efficiencies we want to see in the system. The great thing is once you have data sets and you have 34 specialities and 6,500-10,000 individual metrics for each Trust, once you let Trusts look at other Trusts data and it's very open and transparent no one likes being in the bottom 25% and that will drive the agenda very much. What the patient wanted to know early on is how do patients know where they will get the best treatment? I was asked this when I was with Muir at the NHS England Board

three months ago, what we got up and running we know it's accurate and we can reproduce it and we can have it on the website and that should make it transparent and we should let patients see it, that will drive the change and I hope make it right on right year after year

Matthew:

In RightCare we don't have the answers, we have the access to the people with the answers such as NICE and you have the ability locally to bring all of the key stakeholders and local experts together to add to all of that evidence that is created nationally and decide for yourself what right is, you know your populations and you know your systems

As long as you are foe focussing your improvement method on the area you need to focus on, the rest is for you to do, you can look at the evidence when it's known and answer you agree that something that comes from NICE or the National Clinical Director or Royal college is right, build it into your optimum design, but it has to be your design otherwise it won't be right. Then you can deliver that, because you will have consensus on that because you have agreed locally this is what this should look like.

Muir:

We are almost out of time, is there someone there? No, thank you very much and thank you to your distinguished panel, thank you.