Sustaining our NHS: the role of efficiency, clinical quality and productivity

Chaired by Professor Nick Harding OBE
Senior Clinical Advisor and Chair for Sandwell and West Birmingham Clinical Commissioning Group
“MAINTAINING A SUSTAINABLE NHS: THE ROLE OF EFFICIENCY, CLINICAL QUALITY AND PRODUCTIVITY”

Professor Tim Briggs
National Director Clinical Quality and Efficiency NHS
Chair of The National GIRFT Programme
Past President of the BOA
GIRFT Objectives - Peer to Peer and Clinically led

- Supporting the following in elective orthopaedic care:
  - Improved patient experience - Quality
  - 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.
  - ALL Trusts visited

What does good look like?

57 National GIRFT Leads
What did pilot show and what are the results?

Huge Variation in my speciality

Results

- Reduction in Length of stay – TKR/THR
- Use of Cemented implants – patients 70+
- Ring Fenced beds
- Reduction loan kit costs
- Reduction in costs of THR and TKR
- Reduction in inappropriate arthroscopy rates
- Low volume surgeons changing practice
- Reduction of emergency readmissions at 30 days

Improved Quality of Care
Reduction of complications
<table>
<thead>
<tr>
<th>Trusts with reduction in revision rates since 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BMI Bishops Wood Hospital (Middlesex)</td>
</tr>
<tr>
<td>2. BMI Goring Hall Hospital (West Sussex)</td>
</tr>
<tr>
<td>3. BMI The Meriden Hospital (West Midlands)</td>
</tr>
<tr>
<td>4. Bradford Royal Infirmary</td>
</tr>
<tr>
<td>5. Cannock Chase Hospital</td>
</tr>
<tr>
<td>6. Charing Cross Hospital</td>
</tr>
<tr>
<td>7. Conquest Hospital</td>
</tr>
<tr>
<td>8. County Hospital Louth</td>
</tr>
<tr>
<td>9. Good Hope Hospital</td>
</tr>
<tr>
<td>10. Hinchingbrooke Hospital</td>
</tr>
<tr>
<td>11. Horton NHS Treatment Centre (Oxfordshire)</td>
</tr>
<tr>
<td>12. Hospital Of St Cross</td>
</tr>
<tr>
<td>13. James Paget University Hospital</td>
</tr>
<tr>
<td>14. King Edward VII Hospital Sister Agnes (Greater London)</td>
</tr>
<tr>
<td>15. Llandough Hospital</td>
</tr>
<tr>
<td>16. New Hall Hospital (Wiltshire)</td>
</tr>
<tr>
<td>17. Peterborough City Hospital</td>
</tr>
<tr>
<td>18. South Tyneside District Hospital</td>
</tr>
<tr>
<td>19. Southampton General Hospital</td>
</tr>
<tr>
<td>20. Southmead Hospital</td>
</tr>
<tr>
<td>21. Spire Alexandra Hospital (Kent)</td>
</tr>
<tr>
<td>22. Spire Clare Park Hospital (Surrey)</td>
</tr>
<tr>
<td>23. Spire Southampton Hospital (Hampshire)</td>
</tr>
<tr>
<td>24. St Albans City Hospital</td>
</tr>
<tr>
<td>25. St Richard’s Hospital</td>
</tr>
<tr>
<td>26. University College Hospital</td>
</tr>
<tr>
<td>27. Withybush General Hospital</td>
</tr>
</tbody>
</table>

Fall in outlier trusts - TKR

Reduction in revision rate
Reduction in infection rate
Better patient satisfaction and outcomes
<table>
<thead>
<tr>
<th>Year of claim Notification</th>
<th>No. of claims</th>
<th>% change in claim volume</th>
<th>Estimated cost of claims end of 2016/17 (£million)</th>
<th>% change in cost of claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>1467</td>
<td></td>
<td>173.0</td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>1617</td>
<td>10.22</td>
<td>175.9</td>
<td>1.65</td>
</tr>
<tr>
<td>2014/15</td>
<td>1519</td>
<td>-6.06</td>
<td>147.7</td>
<td>-16.04</td>
</tr>
<tr>
<td>2015/16</td>
<td>1386</td>
<td>-8.76</td>
<td>143.5</td>
<td>-2.84</td>
</tr>
<tr>
<td>2016/17</td>
<td>1261</td>
<td>-9.02</td>
<td>162.2</td>
<td>13.03</td>
</tr>
</tbody>
</table>

**Results:**

- Estimated cost saving of £79m (reduction number of claims) compared with 2013/14 when we adjust for increasing claim cost

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**2017-2018**

NHSR premium
Decreased by £650,000
From pilot to national programme – 37 specialities

Clinical work streams are already underway
Clinical Lead visits already completed
Remaining work streams will kick off by end September 2018

### Implementation until March 2021 with more specialties (oncology, paediatric medicine) to be added subject to business case

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

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

Achieved to date

- Driving change in orthopaedics

National Reports
- General surgery
- Vascular report
- Cardiothoracic report
- Urology
- GIR In Emergency Care
- Litigation pack for every Trust
- GIRFT SSI audit – all 13 surgical specialities

New GIRFT Initiatives
- Mental Health
- Paediatrics
- AQPs – Undertaking and being paid for NHS work
- General Practice – GIRFT Pilot Hammersmith and Fulham and Northumbria
- GIRFT Advice Packs – “Reverse Acute Provider Model” Hot/Cold Split

General Practice GIRFT Pilot
Hammersmith and Fulham 213,000 patients 200 GPs
Northumbria 100,000 patients and 100 GPs
What does good look like?
Pilot completed and report by December 2018
Roll out across 8,500 GP practices in England 2019-2021

We will be working very closely with Rightcare
And Join up the whole pathway

GIRFT Advice Packs
- “Reverse Acute Provider Model” Hot/Cold Split

Note: The content includes various reports and initiatives related to healthcare, focusing on orthopaedics, general surgery, vascular, cardiothoracic, urology, emergency care, and litigation packs. The page also highlights new initiatives in mental health, paediatrics, AQPs, and general practice GIRFT pilots in two different regions.
Has Your Trust Fully Engaged With GIRFT Programme?

Please ask the question of your clinicians and executive team
General Surgery Report

Publish date 4th August 2017

Game Changer for NHS Providers
Urgent need to address unwarranted variation
Will change practice – evidenced based

Clinical and management buy in Good

30% Reduction of emergency surgical admissions with senior decision makers at A and E
305,000 fewer admissions saving £108 million
Reducing Litigation – GIRFT report December 2017

BARTS
The trend is downward:
27 to 14 claims between 13/14 and 16/17

We recognise that spinal surgery is the area requiring most focus. A cross site spinal MDT has now been implemented offer increased peer communication on cases.
## GIRFT SSI Audit - 95 Trusts

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of trusts</th>
<th>Infection Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>38</td>
<td>10.03%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>8</td>
<td>0.83%</td>
</tr>
<tr>
<td>Cranial Neurosurgery</td>
<td>6</td>
<td>4.66%</td>
</tr>
<tr>
<td>Ear Nose and Throat</td>
<td>14</td>
<td>1.20%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>24</td>
<td>1.89%</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>20</td>
<td>1.57%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>18</td>
<td>0.03%</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>7</td>
<td>0.48%</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>29</td>
<td>0.68%</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>7</td>
<td>6.90%</td>
</tr>
<tr>
<td>Spinal Surgery</td>
<td>7</td>
<td>1.09%</td>
</tr>
<tr>
<td>Urology</td>
<td>11</td>
<td>1.91%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>9</td>
<td>2.47%</td>
</tr>
</tbody>
</table>
Implant removal on same breast within 1 year

9.6 Mastectomy and immediate implant only reconstruction

Quality metrics – Re-excisions and re-operations continued

Variation 1% - 28%
Cost of SSI to departments

Reduction of SSI to mean (2.3%) could lead to total savings of:
£70,000 to £260,000 among 9 trusts
On only ONE infection metric

Do you know your infection rate?
Driving change to improve patient flows and efficiency in 2018

• Senior surgeon at front door – reduce acute admissions by 30%
• Senior decision maker in trauma – reduce admissions by 20.7%
• Acute medical admissions, Trusts reducing LoS by 3 days
• Trusts with good fraility pathways – reduce LoS
• Early investigation
• Early mobilisation – reduce de-conditioning

Result: better patient care and more efficient use of provider bed base
The LoS for angioplasty for lower limb vascular disease procedures has seen a significant linear trend reduction in length of stay (LoS) over the course of the 9 quarters to March 2018, resulting in a position better than the National average.

Bypass/revascularisation for lower limb vascular disease procedures has also seen a linear trend reduction in over the period, resulting in a position almost matching the National average.

For both procedure groups, the National position has not shown much variation.
The national average 30 day emergency readmission rate following CABG procedures was over 14% in 2015/16.

If all Trusts were able to move a rate of 12.5% (the best quartile value), then there is an opportunity to remove over 70 admissions. Trusts have achieved this reduction in 2 years.
The national average daycase rate for TURBT was over just under 11% in 2015/16. If all Trusts were able to move to a rate of 14% (the best quartile value), then there is an opportunity to convert 200 elective admissions to daycase admissions. The majority of this forecast change has already occurred.
Case Study: The Ian Paterson Case
Would GIRFT Have Highlighted Outlier Status Earlier?

- 750-1000 victims of negligent or unnecessary breast operations 1998-2012
- Unnecessary surgery on those who did not have cancer
- Insufficient resection for those that did – Cleavage Sparing Mastectomy - twice the relapse rate of full mastectomy
- Convicted of 17 counts of wounding with intent and three counts of wounding in his treatment of 9 women and 1 man
- £37m fund for negligence - Spire Healthcare £27.2m and the Heart of England NHS Foundation Trust in Birmingham £10m
- The NHS has already paid out about £18m in costs and damages to 256 patients.
Breast Surgery GIRFT

6.5 Quality outcomes by procedure - Re-excisions and re-operations

<table>
<thead>
<tr>
<th>Metric</th>
<th>Source and Period</th>
<th>Values</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WLE</td>
<td>MX</td>
<td>MX + immediate reconstruction</td>
<td>Delayed reconstruction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implant</td>
<td>Implant + flap</td>
<td>Autologous</td>
<td>Implant</td>
<td>Implant + flap</td>
</tr>
<tr>
<td>Number of procedures</td>
<td>HES Apr 2014 - Mar 2017</td>
<td>1,724</td>
<td>422</td>
<td>408</td>
<td>13</td>
<td>372</td>
</tr>
<tr>
<td>Re-excisions following WLE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd breast excision (re-excision or mastectomy) on same breast &lt; 1 yr post-procedure</td>
<td>HES Apr 2013 - Mar 2016</td>
<td>18.53%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2nd breast excision (re-excision or mastectomy) on same breast &gt; 1 yr and &lt; 5 years post-procedure</td>
<td>HES Apr 2009 - Mar 2012</td>
<td>4.16%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>WLE following a mastectomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WLE on same breast &lt;5 years post procedure</td>
<td>HES Apr 2009 - Mar 2012</td>
<td>NA</td>
<td>0.37%</td>
<td>7.04%</td>
<td>5.71%</td>
<td>6.41%</td>
</tr>
<tr>
<td>Reconstruction adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of subsequent operations* on patient &gt; 90 days and &lt; 5 years post first reconstruction procedure</td>
<td>HES Apr 2009 - Mar 2012</td>
<td>NA</td>
<td>NA</td>
<td>1.55</td>
<td>1.29</td>
<td>0.93</td>
</tr>
<tr>
<td>Implant removal on same breast &lt; 1 yr post-procedure (bilateral procedures counted twice)†</td>
<td>HES Apr 2013 - Mar 2016</td>
<td>NA</td>
<td>NA</td>
<td>4.48%</td>
<td>5.41%</td>
<td>NA</td>
</tr>
</tbody>
</table>

* Subsequent operations include readmissions with a code considered to indicate a reconstruction, reconstruction adjustment or re-excision
† Implant reconstruction coded as bi-lateral are counted twice so denominator = Number of implants. If a patient has undergone a bilateral implant procedure, and experiences two implant losses or an implant loss coded as bi-lateral within the time period, this will count as two losses in the numerator

Excessive follow-up in OPD
Benign to malignant ratio skewed
Higher recurrence rate at 1 and 5 years

Outcomes
Better patient care
Avoidance of unnecessary operations
Avoidance of harm
Significant reduction in litigation costs
GIRFT Will deliver Quality and Efficient care

• The most ambitious patient quality improvement programme in the history of the NHS
• Clinically led and data driven. “What does good look like?”
• Support from ALL
• Reports, action plans and implementation team – no hiding
• Empowering - Clinicians at the heart of the change – “shoulder to shoulder”
• Outcomes – improved quality, reduced unwarranted variation and complications. We are NOT regulation

• Joined up working with Rightcare and Elective care Transformation programme to provide the data ask from STPs ACS

I want and need complete buy-in from the whole workforce to implement the changes required
MSK Pathway Work – Elective Care

Professor Peter Kay

National Clinical Director for MSK

england.electivecare@nhs.net

Right person, right place, first time

www.england.nhs.uk/elective-care-transformation
## Opportunities for collaboration

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Prevention</th>
<th>Problem Presents</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Support/ Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td>Prevention Broadly eg Obesity, smoking</td>
<td>Referral pathways to appropriate secondary care eg joint replacement rates per 100k population</td>
<td>Referral pathway to conservative treatment eg physio</td>
<td>Operative Intervention Non-operative Intervention</td>
<td>PROMs Other Other GIFT Guidance, Trust Data Packs Good Practice Manuals Data Portal Recommendations Site Visit Report Logic Models</td>
</tr>
<tr>
<td><strong>Problem Presents</strong></td>
<td>Prevention: early detection eg osteoprosis, frailty</td>
<td>Revision, readmits, LOS, mortality, finance, litigation, hip implant type, reducing small no surgeons etc</td>
<td>Advice and guidance, MSK triage services First contact practitioners</td>
<td>Reduce referrals to secondary care for MSK related conditions Reduce Inequalities in access and outcomes reduce unwarranted variation</td>
<td>MSK Handbooks, Evaluations Logic Models</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Orthopaedics, Spinal, Rheumatology eg joint replacement rates per 100k population</td>
<td>Advice and guidance, MSK triage services First contact practitioners</td>
<td>Report PROMs in focus packs</td>
<td>Reduce referrals to secondary care for MSK related conditions Reduce Inequalities in access and outcomes reduce unwarranted variation</td>
<td>MSK Optimal Pathways, MSK Focus Packs, GP Practice packs, STP Packs, MSK Logic Models, Bespoke analytics, Storyboards, Case Books, Patient Stories, working with Spec Comm</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Referral pathways to appropriate secondary care eg joint replacement rates per 100k population</td>
<td>Advice and guidance, MSK triage services First contact practitioners</td>
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<td><strong>Support/ Resource</strong></td>
<td>Prevention Broadly eg Obesity, smoking</td>
<td>Referral pathways to appropriate secondary care eg joint replacement rates per 100k population</td>
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<td>PROMs Other Other GIFT Guidance, Trust Data Packs Good Practice Manuals Data Portal Recommendations Site Visit Report Logic Models</td>
</tr>
</tbody>
</table>

### Right person, right place, first time

- **GIRFT**
  - Orthopaedics, Spinal, Rheumatology eg joint replacement rates per 100k population
  - Revision, readmits, LOS, mortality, finance, litigation, hip implant type, reducing small no surgeons etc
  - Advice and guidance, MSK triage services First contact practitioners

- **ECTP**
  - Advice and guidance, MSK triage services First contact practitioners

- **RightCare**
  - MSK Pathways, Falls And Fragility Frailty, Population approach
  - Support FCP, MSK Triage, FCP
  - High Impact Interventions eg Osteoporosis, Back Pain, Rheumatoid Arthritis, Support FCP, Advice & Guidance, MSK Triage Services, Integrated Care Models, Medicines Optimisation and Medicines Value Programme, Pain Management programmes

- **Choosing Wisely**
  - Commissioning guidance: Interventional Rx for backpain, Hip arthroplasty, Knee arthroscopy and arthroscopy, shoulder decompression
  - Shared Decision Making
## Opportunities for collaboration (2)

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Prevention</th>
<th>Problem Presents</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Support/ Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health/ Local Authority</td>
<td>Prevention Broadly eg Obesity, smoking</td>
<td>Prevention: early detection eg osteoprosis, frailty</td>
<td>Referral pathway to appropriate secondary care eg red flag symptoms</td>
<td>Operative intervention</td>
<td>Non-operative Intervention</td>
</tr>
<tr>
<td>STP Priorities</td>
<td>LifeCourse Approach, Wider Determinants of health, reducing inequalities, risk factors, Work &amp; health, Health and Wellbeing Boards</td>
<td>Referral pathway to conservative treatment e.g. physio</td>
<td></td>
<td></td>
<td>Joint Strategic Needs Assessment, MSK ROI Tools, Knowledge and Intelligence Hubs,</td>
</tr>
<tr>
<td>NHSI Op Prod</td>
<td></td>
<td></td>
<td></td>
<td>Theatre productivity</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Wave 1 Handbooks and Case Studies

- The handbook is a guide to ‘what, why and how’ ideas can be implemented locally to transform MSK services.
- It is informed by Wave 1 of rapid testing and include early outcomes and links to further evidence.

Rethinking referrals
1. MSK Triage and Clinical Review
2. Standardised referral templates
3. First Contact Practitioner (FCP) Service

Self-management support
4. MSK Self-management Education
5. Patient Passport

Transforming outpatients
6. Telephone follow up

Rethinking referrals: A Spotlight

MSK Clinical Review and Triage
MSK triage services provide a single point of access for local MSK referrals. They provide specialist clinical review of incoming referrals and triage patients to the most appropriate setting for further treatment and/or diagnosis.


Standardised referral template
A standardised MSK referral template is a document available on primary care IT systems that guides referrers to provide appropriate referral information. The template improves the quality of referrals and underpins effective triage, thereby helping patients to be directed to the right care setting, first time. It complements a single point of access covering, for example, a T&O and MSK service.

First contact practitioner
A First Contact Practitioner is usually an Advanced Practice Physiotherapist who has the advanced skills necessary to assess, diagnose and manage musculoskeletal problems. A First Contact Practitioner service enables patients who would usually present to the GP in primary care with an MSK issue to either refer themselves directly into existing physiotherapy services or see a First Contact Practitioner who is.
# Shared Decision Making and Self-Management Support: A Spotlight

## MSK Self-management education

Self-management education supports patients to understand and manage their own condition effectively. It enables patients to understand the variety of options available to them and facilitates informed, shared decision making. Self-management education encourages and empowers patients to take responsibility for their own health and wellbeing through behavioural change and improve their quality of life.

## Patient passport

A patient passport is a document that supports people with MSK conditions to take an active role in their care, self-manage effectively and access support when they need it. It adheres to NICE guidance on patient information (CG177, 1.3.1). The passport encourages users to make shared decisions about their care and provides information on self-management techniques and support available locally.

[https://www.england.nhs.uk/elective-care-transformation/handbooks-and-case-studies/]

Right person, right place, first time
Transforming Outpatients: A Spotlight

Telephone follow up

Telephone follow up allows selected patients (e.g. post-intervention or post-diagnostic) to access healthcare virtually as opposed to face-to-face.

High Impact Intervention: MSK Triage

What...

- MSK conditions affect **1 in 4 of the adult population**, approximately 9.6 million adults in the UK.

- The NHS England RightCare programme has identified that 31% of total elective opportunities involve musculoskeletal pathways.

- Clinical triage services provide **specialist clinical review of referrals** after a GP has made a referral for a musculoskeletal condition.

- CCGs are delivering timely MSK triage with collaboration between clinicians in both primary and secondary care and clear referral criteria.

- They are commonly delivered by NHS (hospital or community) or independent providers in a community setting.

- Referrals are often reviewed by physiotherapists, advanced physiotherapy practitioners, or GPwSIs who specialise in MSK conditions.
High impact intervention: MSK Triage (2)

What...

- MSK triage is designed to drive establishment of **specialist triage services** so that patients are seen by the right professional first time.

- It does not require an integrated triage and treatment service, although these can be best practice arrangements.

- The specification relates to all body parts and includes pain and rheumatological MSK-related conditions.

- Exemptions will be defined locally e.g. urgent referrals for cancer.

- MSK triage services **can reduce referrals to secondary care by up to 30%**, with patients often seen in other community based services.

- This means that those patients who need to be seen by a hospital consultant are seen as quickly as possible.
At the end of July 18, **90% of CCGs had rolled out MSK triage**, with all others making significant progress.

In order to articulate impact of the MSK triage the ECTP undertook an impact audit at the end of Q4 17/18. Provisional headlines:

- Across all MSK triage schemes approximately **50% of all patient referrals reviewed were diverted from secondary care**.

- Those CCGs that were compliant with the MSK triage specification by the end of December 2017 had a **significantly lower working day adjusted referrals seen rate** per 1,000 population at 9.7 compared to those CCGs not compliant with the specification (11.3).

- When comparing the same 2 month epoch from 16/17 to 17/18 those CCGs that were compliant with the MSK specification saw a **10% reduction in referrals** compared to a 3% reduction in those that were not compliant.
High impact intervention: First Contact Practitioner - a spotlight (1/3)

What...

- The first contact practitioner (FCP) role should be situated at the beginning of the MSK pathway and considered part of the GP team. They should be the **first point of contact for patients** and will be a real alternative to GPs for patients with MSK conditions.

- They will be **providing new expertise and increased capacity** to general practice and providing patients with faster access to the right care.

- They are qualified autonomous clinical practitioners who are able to assess, diagnose, treat and discharge a person without a medical input.

- All FCPs will demonstrate compliance with the Health Education England (HEE) and NHSE Capability Framework.

- Focusses on **physiotherapists** providing an FCP service in MSK care - where there is already a strong evidence base.
First Contact Practitioner (FCP): a spotlight (2/3)

Why...

- FCPs will be able to **lead the care of a significant number of patients** in general practice who present with MSK conditions.

- This will reduce existing GP staff workload and increases practice capacity, but also supports faster access to advice and self care expertise.

- Evidence from the recent and on-going pilots demonstrate:
  - quicker recovery for patients
  - integration of Shared Decision Making early into a patient’s pathway
  - improved use of diagnostic capacity
  - more appropriate referrals into secondary care
  - good patient experience

- It is **supported by the British Medical Association and the Royal College of GPs.**
First Contact Practitioner (FCP): a spotlight (3/3)

How...

- National policy framework, but **local design** and implementation

- It will be a shift from the traditional provision of community or hospital based therapy services to physiotherapists being part of a **frontline multidisciplinary team**.

- FCP services can’t be developed in isolation and need to be part of wider MSK **pathway redesign** with all stakeholders having equal voices

- FCP services will:
  - be accessible directly or via the GP practice
  - allow onward referral independent of the GP
  - focus on providing high-quality assessment and advice and not excessive follow up
  - support patient self-management
Elective Care Transformation Programme

Examples of Other Transformation Initiatives

CCGs and STPs can use resources and learning developed by **NHS England’s Elective Care Transformation Programme** to help address the steady rise in elective care referrals.

<table>
<thead>
<tr>
<th>High Impact Interventions - specifications 2017</th>
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<tbody>
<tr>
<td>• MSK triage</td>
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<td>• Clinical Peer review</td>
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<th>Re-thinking referrals</th>
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<tbody>
<tr>
<td>• Advice and guidance services</td>
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<tr>
<td>• MSK triage and clinical review</td>
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<td>• Standardised referral templates</td>
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<th>Self-management support</th>
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<tr>
<td>• Self-management education</td>
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<td>• Self-management support for long term conditions</td>
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<td>• Patient passports</td>
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<th>Transforming outpatients</th>
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<tr>
<td>• Patient-initiated, rapid access and virtual follow-up</td>
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<td>• Telephone follow-up</td>
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- Alerts to referring GPs using the e-RS when a local provider has long waiting times for the service their patient needs. The system suggests alternative local providers with shorter waiting times.
Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

Margaret Mead
Find out more

Visit the Elective Care Transformation Programme, GIRFT and NHS RightCare’s webpages at:
https://www.england.nhs.uk/elective-care-transformation/
http://gettingitrightfirsttime.co.uk/
https://www.england.nhs.uk/rightcare/

Join the Elective Care Transformation Programme’s community of practice on the FutureNHS Collaborative (Kahootz) at https://future.nhs.uk/connect.ti/ECDC/group
or email
england.electivecare@nhs.net
info@gettingitrightfirsttime.co.uk
rightcare@nhs.net
NHS RightCare

Tessa Walton
Director of NHS Delivery, NHS England
Senior Responsible Officer for NHS RightCare and the NHS Delivery Unit
My observations – 6 months in

System planning and delivery - **Productivity vs. demand management**

**Extensive data from national sources in one place** – but not enough systems are using it collectively to understand their population needs and to inform high impact transformation.

**Pockets of transformation across the country** needing national and regional spread.

One of the few national programmes with a **delivery support infrastructure** - are systems making the best use of them and how can we better join up with other programmes?

**New Clinical Lead** – Professor Nick Harding

> “We used NHS RightCare data to identify variation in all clinical areas to and developed clinical plans to address CVD and Respiratory conditions.”

STP Clinical Lead - Chair of a Clinical Leadership Group
The NHS RightCare Solution

- Care can be improved for populations and groups of patients, clinicians and systems
- Interpretation of variation data to produce insight, showing where care can be clinically improved
- Delivery Partners identify trends and provide the expertise and tools to support change delivery
- Collaborative working to improve care
What has NHS RightCare helped to deliver?

Case Studies

North West London: CVD and Stroke prevention (8 months)
- Prevented 6 deaths
- 13 Atrial Fibrillation stroke admissions,
- 79 avoided outpatient referrals
- £112,000 net saving

High Intensity Users: Rolled out to 30% plus of CCGS
- Social Prescribing
- Reduced 30-80% of A&E attendances and admissions
- Reduced 40-90% 999 calls
- Won Kate Granger award for Compassionate Care

Impact in 2017/18
- Patient Outcomes:
  - 77% of the 44 patient outcomes improved
- Activity growth:
  - 1.65% points lower for elective admissions activity.
- Financial benefits
  - £567m of QIPP savings in 17/18
  - Forecast £744m in 18/19
### Population Health and Site Configuration Drivers

- **Substantially higher population of over 80s**
- **The STP is one of the highest % for short stay dementia admissions**
- **Two sites running off services at the Provider**

### Activity and Expenditure Trends

- **Acute spend is consistently higher than planned.** High CCG spend on acute vs out of hospital (primary care and community).
- **17/18 non-elective activity increased by 6% and associated bed days are significantly higher than peer average.** Higher number of A&E attendances for the 70+ group.
- **10% reduction in FTE GPs since Sept 16 (compared to national average of 4%).** Smaller reduction in referral rates (-1%) compared to peers (-5%).
- **High dependency on agency and bank spend.**

### Key Workstreams for Delivery (Key System Drivers)

1. **MSK**
2. **Frailty and Ambulatory Care**
3. **Complex Discharge**

### Value of Opportunities Identified:

- **£30.3m – £61.2m**

### Key Findings: One Page Overview

#### Value of Opportunities Identified:

- **£30.3m – £61.2m**

#### Activity and Expenditure Trends

- **MSK is one of the highest areas of spend for CCGs (£65m), £15m higher than average.** A high level of activity flows to the independent sector (7% – 11%) with an Independent Provider having a five year contract (c£76m).
- **Mental health highest spend but represents low levels of investment.**
- **Local Authority spend is high for Better Care programme (totals more than £60m) - the benefits derived from the schemes are not clear.** CHC spend in 17/18 was £51m, anticipated to increase by 8% in 18/19. Care home utilisation at 40%.

#### Key Workstreams for Delivery (Key System Drivers)

1. **MSK**
2. **Frailty and Ambulatory Care**
3. **Complex Discharge**

#### Key Findings: One Page Overview

- **17/18 non-elective activity increased by 6% and associated bed days are significantly higher than peer average.**
- **Higher number of A&E attendances for the 70+ group.**
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- **High dependency on agency and bank spend.**
NHS RightCare Priorities 2018-20

1. Support **System Working**

2. Spread optimal prevention pathways nationally and regionally – opportunities;
   - **MSK** (Back pain, Osteoporosis, Fragility Fractures) **500 fewer beds, £50m** indicative saving on admissions
   - **CVD** (CHD and Stroke combined) **3100 saved lives** per year **£270m** indicative saving on admissions
   - **Respiratory** (COPD, bronchitis, emphysema and asthma combined) **1560 saved lives** per year, **£230m** indicative saving on admissions

3. Develop a clear **delivery methodology** to include;
   - System readiness assessment (in conjunction with GIRFT)
   - Light touch or intensive support to delivery change

4. Maintain and build closer synergy and alignment with other **national programmes**
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Surrey Heartlands Health and Care Partnership

Dr Claire Fuller
Partnership Lead, Surrey Heartlands
Our partnership approach to improving health and social care

Devolution
Surrey Heartlands Clinical Academy
Citizen led Engagement
System wide efficiencies workshop

• Over 100 staff from across the health & social care system attended workshop on 1st February 2018, bringing together national teams to present our local data, including:
  - Getting it Right First Time (GIRFT)
  - Right Care
  - Model Hospital
  - Coordinated Reallocation of Capacity Programme (CRoC)

• Opportunities identified and prioritised to take forward at ICS, ICP and organisational level, (including QIPP ideas and outputs from DoFs workshop)
Opportunities

• New opportunities were identified, including elements of:
  - Ophthalmology, dermatology, outpatients
  - Medicines Management
  - Shared Decision Making
  - Cardiovascular
  - Advice & Guidance
  - Procedures of Limited Clinical Value

• Further modelling undertaken by Business Intelligence leads (health & Public Health teams) to update data & take account of work already completed

• Included demographic projections to 2039 to inform future need
Work Underway - Examples

• System wide agreement of Planned Care pathway principles
  • Co designed with citizens/patients/clinicians. Will then ‘test’ against ophthalmology & dermatology redesign

• Transformation Funding agreed for Shared Decision Making programme
  • Piloting in MSK, in partnership with Arthritis UK (aiming to reduce hip / knee surgical admissions by 6%) & then roll out

• Range of Medicines Management projects underway, including
  • Central pharmacy store (4 acute Trusts) & in house aseptics unit
  • Electronic prescribing & system wide medication safety lead
Work Underway - Examples

- Cardiovascular (hypertension & atrial fibrillation)
  - Implementing blood pressure + checks by community pharmacists & simple checks & signposting by community & voluntary groups (co designed by citizens)

- Advice & Guidance
  - secondary and primary care clinicians working collaboratively to review flows of patients and options for new models of care – now looking at further utilisation of digital models of review

- Procedures of Low Clinical Value
  - Looking at using research and innovation and moving care into procedures that use Artificial Intelligence
Next Steps

• Implementation & continual review of opportunities

• Implementation of ‘SODA’ (Surrey Office of Data Analytics) & Academy Intelligence Unit to support system wide transformation

• Implementation of Clinical Engagement Networks to develop & agree system level outcomes (5 outcomes agreed by March 2019)

• Working with IHI (Institute of Healthcare Improvement) to develop Surrey Heartlands’ approach to Quality Improvement to provide staff with the tools to implement change
What questions do you have?
Contact us

- www.england.nhs.uk/rightcare
- www.gettingitrightfirsttime.co.uk
- www.england.nhs.uk/elective-care-transformation
- www.surreyheartlands.co.uk

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