The Minutes of the Derby Medical Society 30th November 2016
Derby Medical School Lecture Theatre

Speaker:
Mr Tim Wilton
Immediate Past President of BOA 2015/16
Past President British Association for Surgery of the Knee 2010-12
Chairman Elect British Editorial Society Bone and Joint Surgery

Quality, Quantity and Value for Money....Can we really have it all in Orthopaedics?

Mr Wilton started by stating his declarations of interest.

Orthopaedics can deliver volume, excellent trauma services and best practice arthroplasty, BUT can we do all these things everywhere in the UK for the best value for money?

Quality relies on:
Collecting data on outcomes
Review and assess data
Assessment may involve comparison between units and surgeons

The types of data collected include actual against expected revision rates for arthroplasty, and revision rates per Centre and for individual surgeons

Drive for better outcomes:
Identify treatment options
Obtain facts about options
Perform only the best treatments

What is the Fact and Outcome?
Facts should be robust against evidence based scrutiny but this is often not the case.
Missing data is critical. Data may be missing as it was not meant to be collected, it may have been deliberating withheld

An example is the controversy regarding knee arthroscopy and the current recommendations that the clinical benefits are very limited.
Why is the treatment still offered? (Statistics based on Mr Wilton's personal data)

- Some patients are made better (50-60%)
- Some patients have no or a minimal improvement (20-30%)
- A small number of patients will have worsening knee pain or function after arthroscopy (10%)

As Mr Wilton explained, most patients want the least invasive treatment option and many patients are prepared to take risk with arthroscopy if it can delay/avoid TKR. Mr Wilton questioned if this is the information surgeons should be giving to patients to ensure informed consent.

Mr Wilton went on to discuss how research trials can be used to make recommendations and protocols for orthopaedic treatments.

But, as the DRAFFT (RCT of locking plate fixation verses K-wiring for distal radial fractures) study demonstrated, recommendations can arise from results which have been obtained from multiple centres (18 in DRAFFT), high numbers of surgeons involved (244 in DRAFFT) with strict eligibility criteria (only 5.2% of distal radial fractures were included).

The study found that there was no difference in outcomes. K-wiring is cheaper so it was concluded that K-wiring should be used.
BUT there were lots of surgeons and only a small percentage of distal radial fractures were included.

The evidence for benefits of Patella resurfacing at the time of TKR is again variable.
There has been an additional tariff for this procedure of around £2500 which may influence practice but the benefits of resurfacing are:

- there is a 20-25% increase in joint revision when patella not resurfaced.
- £300 extra to follow up patient who has not had resurfacing

National Joint Registry
The NRJ allows comparison of surgeons and units.
Data is collected on revision rates, patient outcomes and satisfaction, comparing types of procedures offered and re-operation rates.
Currently data on prostheses that have been withdrawn can be omitted from the data.
Published data variable are difficult to interpret and not fair to tarnish a reputation if a prosthesis that is subsequently withdrawn is used.
There is considerable variation between surgeons and units. Variables include techniques used, implants used, surgical technique.
Poorly informed assumptions are unsafe.
Not all surgeons submit their data so this may skew data.

Publishing outcomes
This is integral to government transparency
Statistical significance in clinical practice P is <0.05 (less than 1 in 20 chance of occurring by chance). People bet on lesser odds and win money!

Presenting Data
Funnel plots

Benefits:	allow comparisons over long period of time with lots of data
	allow surgeons to compare performance against their peers
	allow assessment of long term failures
Disadvantages	cannot assess short term failures
	cannot rapidly identify changes in failure rates
	does not allow others to rank surgeons

Cusam

Benefits	allows rapid identification to changes in failure rates
Disadvantages	does not allow easy monitoring of long term results
	does not allow surgeons to compare themselves against their peers
	does not allow others to rank surgeons

If you don't know your own results surgeons quote published results
Informed consent means quoting your own results

The NHS Future
There is no money left!
£20 billion of savings needed and further "efficiency savings" announced in the recent Budget statement.
NHSI (formally MONITOR) have been tasked with finding ways of delivering surgery more cheaply.

The McKinsey report compared NHS with overseas hospitals
Observations:
Elective THR stays can reduce
Nurse led pre-assessment clinics are satisfactory for 90% of patients
Recommendations for theatre list capacities are needed
Stratify patients according to most suited surgeon
Standardisation of ward care and recovery

Surgeons who do more procedures have lower complication rates
Elective surgery cost saving could be 13-20%

Theatre costs are enormous (£36 per minute)
It means that two joint replacements and one small case per half day list is required per theatre to break even.

Getting it Right First Time
Making savings
Implant costs
National Joint Registry have looked at costs Trusts are paying for implants. Previously this information had been confidential.
There is huge cost variance of THR prostheses from £300 to over £2700
TKR prostheses are £800-£1600 in price range. Unicompartmental prostheses cost as much as TKR
There are some benefits to using different prostheses in younger patients
Personnel costs
LOS

NHSE have reduced the orthopaedic tariff by 11.5% for THR and TKR before McKinsey efficiency measures can be put in place.
If a hip lasts 15 years it costs the NHS £7-50 per week

Improving Quality
Surgeons must keep data on their own outcomes
It allows properly informed patient consent
It may deter some patients from having a procedure
Personal data allows a surgeon to reflect on and change their own outcomes
Should alleviate "cognitive dissonance"

Mr Wilton finished with the parable of the "Benevolent Dolphin"
Only one sailor has been saved by a dolphin!

There were many questions around the issues of:

Remediation for underperforming surgeons
Accuracy of collected data
Releasing information under FoI is not obligatory if the data is felt to be unsafe
Maintaining and assessing surgical skills with "driving tests"
VTE risks following THR surgery and NICE guidelines
Mr Wilton was asked to summarise his time as President of the BOA - "It is impossible to make surgeons do something - you have to persuade them!

Register: 22 members
1 guest
4 medical students

Next meeting: Wednesday 11th January 2017.

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Mr K Jones, President