



To: **National Quality Board**

For meeting on: 20 September 2016

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Report for:

Decision	Discussion	Information
	X	X

TITLE: Developments in the “Getting it right first time” (GIRFT) programme

Summary:








This purpose of this paper is to provide an update to NQB on developments in the “*Getting it right first time*” (GIRFT) programme which features targeted self-assessment and peer review by clinical services in acute providers at local level of data relating to:

- clinical outcomes,
- processes (including revisions),
- patient experience,
- patient pathways,
- network arrangements,
- financial impacts and
- waiting times.

Recommendations / Action(s) requested:

The NQB is asked to note the update.

ALB Involvement in development and sign-off of paper:

						
			X			X



Getting It Right First Time Programme

Update on progress and future expansion

Mary Newman

GIRFT System integration



Introduction

GIRFT is a programme featuring targeted self-assessment and peer review by clinical services in acute providers at local level of data relating to :

- clinical outcomes,
- processes (including revisions),
- patient experience,
- patient pathways,
- network arrangements,
- financial impacts and
- waiting times.



The approach

- The GIRFT is complementary to other programmes in the NHS, but is also something new in the way it pulls together and compares multiple data sources.
- We want to help providers to understand the real issues relating to their quality or productivity in a national clinical and operational context, identifying the multiple incidences of variation that cannot be centrally tracked, understood or tackled at present.
- GIRFT data will have value to other workstreams inc RightCare, CQC, STP development.



National Clinical Governance Committee

- One of the Carter recommendations was that a coordinated national clinical governance committee be established to ensure coordination and collaboration across the many Arms Length Bodies (NHSE, NHSI, CQC, NICE etc.).
- The committee met for the first time in August and is now working to align the many different work-streams that are in play across the system.



The GIRFT approach



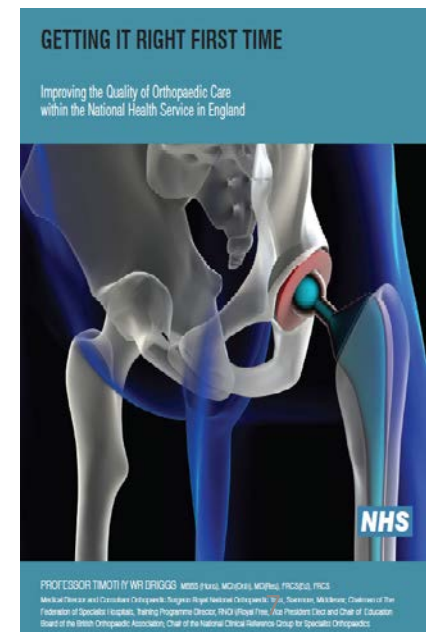
Key features of the approach

- Consolidated view of all available data and metrics relevant to clinical and financial performance.
- Peer to peer review by a leading clinician, using data as evidence to guide discussion on variation in clinical practice, management approach and variation in methodology (eg prosthesis selection).
- Offers clinical teams the opportunity to benchmark themselves nationally and explore how clinical evidence is considered and informs their practice.
- Highly detailed approach facilitates an extensive understanding of the links between practice, outcome and cost drivers, which in turn enable a series of recommendations to be developed.



Inception: addressing orthopaedics

- The first 'Getting it right first time' (GIRFT) report, published in 2012, suggested that changes could be made in orthopaedics to improve pathways of care, patient experience, and outcomes - with significant cost savings.
- The GIRFT project was funded as a national professional pilot across England.
- Project was led by Professor Tim Briggs and hosted - on behalf of the British Orthopaedic Association - at the Royal National Orthopaedic Hospital in Stanmore.





Orthopaedic data sources

A comprehensive orthopaedic report/data pack was created for each provider. Data sources included:

- NJR (disappointingly not all data is available by provider – e.g. Longevity/revision rate by different prosthesis/weight bearing surface etc)
- HES
- HSCIC
- NHS Comparators
- NHS Indicators
- Productivity Metrics
- PROMS
- National data sources – waiting times etc
- National Hip Fracture Database
- NHS Litigation Authority
- NHS Atlas of Variation/RightCare
- Arthritis Research UK Musculoskeletal Calculator



What did the GIRFT Pilot tell us?

1. Huge variations in practice and outcomes in terms of device and procedure selection, clinical costs, infection rates, readmission rates, and litigation rates.
2. Scope to tackle many of these variations and drive short, medium and longer- term improvements in quality of delivery (through adopting best practice), reducing supplier costs (for example of implants) and generating savings.

Producing the evidence to validate previous assumptions meant GIRFT was of high interest to the call by Lord Carter for acute trusts to take a series of steps to tackle “unwarranted variation” in quality and finances.



What else did the GIRFT Pilot tell us?

3. In areas of clinical activity where there is no NICE or formal guidance from the BOA or other professional sub-specialty association, there is still no consensus as to what constitutes best practice.

This tendency is consistent with an assumption of significant opportunity to find quality and efficiency gains.

Eg The orthopaedic review's 15 recommendations suggested NHS hospitals could save £5bn a year by 2020/21, and help trusts improve performance and patient care.



GIRFT general recommendations

The recommended measures to tackle wide disparities in running costs, staff sickness absence and prices paid for supplies and services in orthopaedics were predictable and included:

- moving to e-rostering systems
- adopting 'model hospital' standards
- prioritising the role of procurement
- working more closely with neighbouring hospitals
- improvements in staff productivity and
- The need for a strategy to address the "major problem" of delayed transfers in care.



GIRFT significance

The decisions that clinicians make every day are the true NHS ‘change agents’.

The GIRFT process puts clinicians and management analysts on the same page....in a way which encourages clinicians’ commitment ie the critical friend/peer to peer approach.

As a result, it was agreed there should be an expansion and adoption of the GIRFT programme into other surgical specialties

The National Orthopaedic Alliance Project became one of the NHSE Vanguard. This will drive delivery of the GIRFT Orthopaedic Pilot and the Effective Elective Care project that Monitor undertook last year (and which the GIRFT team collaborated with) – representing a shared recognition of the value of the work.



GIRFT beyond orthopaedics

Funded by DH in March 2015 to roll out the methodology to other specialties.



Activity across surgical specialties

- General Surgery - just over 40 deep dive visits have been completed. A draft version of the national report containing recommendations for General Surgery is underway and is set to be finalised and published in the next few weeks.
- Vascular Surgery - 23 deep dive visits have been completed since June 2016.
- Neurosurgery - the initial individualised reports are complete and deep dive visits commenced in August.
- Ear, Nose and Throat Surgery – data analysis has been undertaken and trust reports have been in development during the summer.
- Cardiac Surgery - data and engagement with key stakeholders is underway and deep dive visits are planned in January 2017.



Activity across surgical specialties

- Urology Surgery – data acquisition and analysis has been underway over the summer and a pilot visit has taken place.
- Paediatric Surgery - data harvesting and mining has begun during the summer.
- Obstetrics and Gynaecology Surgery - data harvesting and mining has begun during the summer.
- Ophthalmology Surgery - data harvesting and mining has begun during the summer.
- Oral and Maxillofacial Surgery - is in the data harvesting and mining, and early analysis is underway.



Next steps for GIRFT



Next 6 months

- Spinal Surgery - 27 deep dive visits have been booked for the autumn with more planned in the New Year.
- General Surgery deep dive visits are ongoing, however, the core requirement of 30 has been completed to enable a draft national report to be produced. This is set to be finalised and published in the autumn.
- Vascular Surgery – 24 deep visits are scheduled for the autumn and work is about to commence of the national report.
- Neurosurgery – Nine visits are planned for the autumn.
- Ear, Nose and Throat Surgery – reports are expected to be completed in September with deep dives taking place from November through to early 2017.
- Cardiac surgery – data analysis and report production will be taking place over the autumn.



Next 6 months

- Urology Surgery – reports will be complete in early September with 32 visits already in the diary from September 2016.
- Paediatric Surgery - we aim to produce reports in November/December and hold a pilot during this period. Reports will then be sent to trusts ahead of deep dive visits that will begin in December
- Obstetrics and Gynaecology Surgery - it is planned that initial individualised reports are produced in December with deep dives commencing in January 2017
- Ophthalmology Surgery - individualised reports are planned for November ahead of deep dive visits that will begin in December.
- Oral and Maxillofacial Surgery - initial individualised reports are to be produced in October to be sent to trusts ahead of deep dive visits starting in November.



Next steps

- The programme will sit alongside the Carter work.
- Planning is underway to expand the programme, involving doubling the number of specialties by moving into medical specialties, working closely with the Model Hospital work in the Carter programme and developing an implementation infrastructure.
- A major review of data collection and use will be required to support this and discussions are likely to begin in the late Autumn.



GIRFT examples



Early indications of the scale of variation

- **Bowel cancer** - % of patients with stoma 18 months after surgery – 2014
- Variation in stoma rates at 18 months in colorectal cancer have been identified at between 0% and 78% retaining a stoma post-surgery for colorectal cancer. This is against best practice in most cases and anecdotal evidence (to be supported by data in due course) suggests that this leads to increased litigation. The scale of the impact of this should be seen in light of the following data:
- *Estimation data source: 2014 data from the 2015 National Bowel Cancer Audit annual report appendix*

% of patients with stoma 18 months after surgery	49.86%
Annual number of patients with stoma 18 months after surgery	15,303



Early indications of the scale of variation

- **Blood perfusion during cardiac surgery – Cost (£) – 2014/15**
- The cost of blood products for perfusion during heart bypass procedures vary from £500 to £2,500 per operation. A model of the potential savings this offers is described below:
- *Estimation data source: 2015 National Cardiac Benchmarking Collaborative Annual data report*

Estimated number of theatre sessions	38,077
Average perfusion cost per theatre session (£)	£1,245
Range of perfusion cost per theatre session (£)	£544 - £2,094
Total estimated perfusion cost (£)	£47,416,454
Estimated annual cost saving if average perfusion cost per theatre session was reduced to £544 (£)	£26,702,273



Early indications of the scale of variation

- **Primary cranial tumour** – Return for another neurosurgical procedure within 1 year – 2014/15
- Re operation rates in neuro surgery within 1 year vary between 5% and 17% requiring a further procedure within one year post surgery for a malignant cranial tumour.
- **Estimation data source: 2012/13 to 2014/15 HES – cost calculated using national tariff**

Annual number of patients receiving surgery for primary cranial tumour	2,384
% patients who return for another neurosurgical procedure within 1 year	12.43%
Range of return rates	5.10% - 17.69%
Average cost of the return neurosurgical admission (£)	£9,219
Estimated annual cost saving if return rate was reduced to 5% (£)	£1,628,090



Early indications of the scale of variation

- **Head & neck cancer (oral & maxillofacial)** – Return for another oral & maxillofacial procedure within 90 days – 2014/15
- Following oral and maxillofacial cancer surgery the rate of return for another procedures within 90 days varies from 8.33% to 80.56%.
- *Estimation data source: 2012/13 to 2014/15 HES – cost calculated using national tariff*

Annual number of patients receiving surgery by an oral & maxillofacial surgeon for head & neck cancer	5,480
% patients who return for another oral & maxillofacial procedure within 90 days	33.83%
Range of return rates	8.33% - 80.56%
Average cost of the return oral & maxillofacial admission (£)	£3,869
Estimated annual cost saving if return rate was reduced to 8% (£)	£5,475,907



Early indications of the scale of variation

- **Tonsillectomy** – Emergency readmission within 30 days – 2014/15
- Following a tonsillectomy the rate of emergency readmission within 30 days varies from 3.68% to 24.77%.
- *Estimation data source: 2012/13 to 2014/15 HES – cost calculated using national tariff*

Annual number of patients receiving tonsillectomy procedure	40,834
% emergency readmission within 30 days	10.60%
Range of emergency readmission rates	3.68% - 24.77%
Average cost of the emergency readmission (£)	£928
Estimated annual cost saving if emergency readmission rate was reduced to 4% (£)	£2,501,450



Early indications of the scale of variation

- **Specialist urological procedure (Cystectomy, Prostatectomy, Nephrectomy, PCNL) – Emergency readmission within 30 days – 2014/15**
- Following a specialist urological procedures the rate of return for an emergency readmission within 30 days varies from 5.32% to 28.21%.
- *Estimation data source: 2012/13 to 2014/15 HES – cost calculated using national tariff*

Annual number of patients receiving a specialist urological procedure	18,498
% emergency readmission within 30 days	13.43%
Range of emergency readmission rates	5.32% - 28.21%
Average cost of the emergency readmission (£)	£2,393
Estimated annual cost saving if emergency readmission rate was reduced to 5% (£)	£3,732,937



Early indications of the scale of variation

- **Surgery for Abdominal Aortic Aneurysm** – Emergency readmission within 30 days – 2014/15
- Following surgery for abdominal aortic aneurysm the rate of emergency readmission within 30 days varies from 4.35% to 21.74%.
- *Estimation data source: 2012/13 to 2014/15 HES – cost calculated using national tariff*

Annual number of patients receiving surgery for AAA	7,294
% emergency readmission within 30 days	10.79%
Range of emergency readmission rates	4.35% - 21.74%
Average cost of the emergency readmission (£)	£3,007
Estimated annual cost saving if emergency readmission rate was reduced to 4% (£)	£1,490,207