



NATIONAL QUALITY BOARD

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Paper for:

Decision	Discussion	Information
	X	

GETTING IT RIGHT FIRST TIME PROGRAMME: UPDATE

SUMMARY

This paper provides an update on the Getting It Right First Time Programme to enable an exploration of how the NQB member organisations can support this work.









PURPOSE

The NQB is asked to:

- 1) **Confirm** its continuing support for the GIRFT programme;
- 2) **Develop** new data collections as GIRFT identifies deficiencies in some of the data sets for each speciality, in conjunction with NHS Digital;
- 3) **Support** enhanced measurement and management of data compliance as recommended in GIRFT reports, in conjunction with NHS Digital;
- 4) **Issue** guidance on reducing/stopping procedures of low clinical value, via NICE; and
- 5) **Use** GIRFT data and quality outcomes to place trainees in centres where clinical outcomes are best, via HEE.



ALB Involvement in development and sign-off of paper:

			
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GETTING IT RIGHT FIRST TIME

1. What is GIRFT?

- 1.1 Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. The GIRFT programme is one of the NHS Improvement workstreams designed to improve operational efficiency in NHS hospitals in response to the Lord Carter review.
- 1.2 Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a day to day basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

2. What is the GIRFT Methodology?

- 2.1 The programme is made up of a series of more than 30 work streams, each led by a prominent clinician chosen from the specialty they are reviewing and endorsed by the relevant Royal College or Professional society for that specialty.
- 2.2 Each clinician heads a project to compile a data and insight driven report into their specialty, combining publicly available information, including Hospital Episode Statistics (HES), other relevant registry or professional body data, and the results of a questionnaire issued to all the trusts being reviewed. The report will look at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets.



- 2.3 A data pack is produced and issued to every trust being reviewed, which is then followed by a meeting at the trust with medical staff and senior trust managers. At each meeting the clinical leads review the findings with their peers, which provides more context to unwarranted variations and opens up a discussion around individual practice and any challenges the trusts face. It is also an opportunity to share best practice and any solutions that have already helped reduce variations.
- 2.4 After at least 40 trust reviews have been completed, the clinical lead oversees the creation of a national GIRFT report into their specialty. The report presents the original data, GIRFT's findings, examples of best practice and an action plan of proposed changes and improvements. Crucially this action plan provides detailed evidence of the benefits changes can bring and is supported by an implementation programme managed by GIRFT.
- 2.5 At trust level the recommendations found in each specialty are collated into a single implementation plan. Trust data is uploaded to the Model Hospital portal, which will be the gateway for accessing GIRFT information for all providers and commissioners.
- 2.6 Our success to date in helping providers 'get it right first time' has been possible due to our specialty level attention-to-detail. We have approached quality in a uniquely detailed, comprehensive and clinically-led way. This has allowed us to mobilise clinicians to realise novel improvements, as well as opportunities that have been well-understood for some time.

3. GIRFT pilot in orthopaedics

- 3.1 The original orthopaedic surgery report, which coined the term "Getting It Right First Time", was published in March 2015 and set out a raft of recommendations. These recommendations have been adopted by trusts and have delivered real benefits. An NHS survey amongst 70 of the 140 trusts visited by Professor Briggs' review revealed total savings of between £20m and £30m for 2014/15 as a result of adopting GIRFT's recommendations, with a further £15m to £20m of savings for 2015/16. If extrapolated across all the providers reviewed these savings would increase to an estimated £40m to £60m in 2014/15 and £30m to £40m for 2015/16:



- a) The recommendation to adopt cemented hip replacements for patients aged over 65 has led to a 10% increase in the use of this method, saving an estimated £4.4m p.a;
 - b) Reduced length of stay for hip and knee operations has freed up 50,000 beds annually;
 - c) Trusts have moved to more ring-fenced orthopaedic beds, reducing cross infection;
 - d) An increase in localised consolidated working between trusts, sharing resources and maximising the number of procedures carried out;
 - e) 75% of trusts have renegotiated the costs of implant stock and rationalised their use;
 - f) Greater awareness of costs has led to reduced use of expensive “loan kit”;
 - g) Litigation claims are down from 1,758 in 2013/14 to 1,505 in 2015/16;
 - h) A GIRFT “Pricing Letter”, providing transparency of the prices different orthopaedic trusts pay for prosthesis, is now used by consultants selecting implants; and
 - i) In 2016 the British Orthopaedic Association used GIRFT principles in published guidance to ensure best practice amongst its members.
- 3.2 Having visited over 140 providers at 200 sites and meeting with over 2,000 people involved in delivering orthopaedic care, the GIRFT orthopaedic review is now beginning its second round and is re-visiting all trusts to see what changes have been made, how GIRFT’s recommendations have been received, what has improved and whether there are new challenges to tackle.



4. From pilot to national programme

- 4.1 Since GIRFT began life as a review of orthopaedic surgery supported by the Royal National Orthopaedic Hospital (RNOH), it has grown into a national programme focussing on more than 30 medical specialties, ranging from general surgery to mental health. Following £60 million of additional Government funding, GIRFT is now a partnership between the RNOH and the Operational Productivity Directorate of NHS Improvement.
- 4.2 The methodology laid down by Professor Tim Briggs in his original review remains the same. As with the orthopaedic pilot, the focus continues to be on identifying and reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.
- 4.3 GIRFT also remains a programme led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a day to day basis. Clinical leads visit every trust carrying out the specialties they are reviewing, investigating data with their peers and discussing the individual challenges they face and highlighting improvements that are already in place.

5. The wider programme and its potential

- 5.1 The GIRFT programme has now been expanded to cover 35 workstreams across surgery, medicine, clinical services and cross cutting issues. 25 clinical workstreams are already underway and over 800 visits to Trusts have now been held. The remaining 10 workstreams will kick off in waves between November 2017 – March 2018. The expansion of the GIRFT programme means it should help save the NHS £1.5bn per year. *A full list of the workstreams is available under 'Annexe A'.*



6. National report on General Surgery

- 6.1 The GIRFT General Surgery Report was the first national GIRFT report to be published since the GIRFT methodology was rolled out to cover more than 30 specialties. It was written by John Abercrombie, GIRFT Clinical Lead for General Surgery and Colorectal Surgeon at Queen's Medical Centre Nottingham, and co-badged by the Royal College of Surgeons, following his review of NHS trusts in England carrying out General Surgery.
- 6.2 The NHS delivers more than a million general surgery procedures every year, which can range from bowel cancer surgery through to the placement of gastric bands. The demand for procedures is growing and admissions increased by 27% between 2003/04 and 2013/14. While this was a very different specialty to orthopaedics, at its heart the GIRFT methodology remains the same.
- 6.3 The report set out 20 recommendations with opportunities to improve patient care and outcomes while delivering potential efficiencies of over £160m annually:
- a) Introducing consultant-led surgical assessments at the 'front door' of acute hospitals could lead to up to 30% fewer general surgery emergency admissions a year where no operation is delivered and could cut the NHS's annual cost for this by £108m;
 - b) A reduction in the length of stay for elective colorectal surgery patients from the current average of 10.2 days to the 5.5 days in the best performing hospitals, would ensure patients didn't have to stay in hospital for so long and would free up to 84,000 bed days, equivalent to a saving of £23.6m;
 - c) A reduction in the length of stay for appendicectomy patients from an average of 3.5 days to 2 days would ensure people were back home more quickly and would free up 30,000 bed days for other patients, equivalent to a cost reduction of £8.5m;
 - d) Reducing elective general surgical admissions without any surgical procedure, which are rarely necessary, would save close to £7m a year;



- e) Reducing some hospitals' high levels of emergency readmission at 30 days for gall bladder surgery to the national average would save £1m in bed days;
- f) Similarly, if providers with high 30 day emergency readmission rates following appendicectomy reduced their readmission rates to the national average, this would free up £5.8m worth of bed days;
- g) If all patients received gall bladder surgery within 14 days of diagnosis, as opposed to the national average of 23% of patients, more people would be treated in a timely fashion with fewer readmitted for later surgery, and up to £5m saved;
- h) If all trusts reversed surgical stomas following colorectal cancer resection, where appropriate, in the recommended time frame of 6 months rather than 18 months, this would provide a better experience for patients and could save almost £2.4 million annually; and
- i) For a basket of surgical supplies, procurement costs varied from £1,467 to £2,336. If all hospitals procured these items at the lowest price, national costs would reduce by 59%.

6.4 Mr Abercrombie and the GIRFT review team are continuing to visit hospitals carrying out general surgery, and will visit every trust in England by the end of 2017/18.

7. Implementing GIRFT recommendations

7.1 GIRFT is putting in place a comprehensive programme to help implement the recommendations highlighted in each national report including support to individual providers to implement these recommendations locally. At a local level, the responsibility for implementing GIRFT recommendations for individual trusts, is with the trusts themselves. However, as with the national report recommendations, the GIRFT programme has developed a regional structure to provide support, guidance and assistance to individual local trusts in achieving their implementation plans.

7.2 By late 2017 a series of regional GIRFT Hubs will be set up as centres from which clinical and project delivery leads can visit trusts, commissioners and



Sustainability and Transformation Partnerships in each region on a regular basis advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust-specific recommendations emerging from the clinical lead visits. These teams will help to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice.

- 7.3 In general, local trusts are expected to take a number of actions to ensure GIRFT improvements are delivered successfully. These would include:
- a) Appointing a trust GIRFT champion (usually the trust MD or CEO) and specialty level champions;
 - b) Analysing data packs on receipt, with support from hubs, so that implementation starts at the earliest opportunity;
 - c) Agreeing actions set out in an implementation plan with help from hubs;
 - d) Ensuring that culture as well as processes are improved in order to deliver sustainable change;
 - e) Taking advantage of the good practice examples available and using the hubs to help them “buddy up” with other trusts;
 - f) Having rounded conversations about strategic improvements with the relevant local partners (CCGs, STPs, NHSE commissioners etc) to agree workable plans for improving whole pathways; GIRFT and RightCare can help facilitate those conversations; and
 - g) Ensuring that actions include work to mitigate unintended negative consequences of any necessary changes; again hubs and GIRFT national team are in place to help identify and achieve suitable mitigations.
- 7.4 GIRFT will be working closely with other NHS bodies and programmes working at regional and trust level, such as RightCare, to ensure a complementary approach and to streamline requests to providers.
- 7.5 To complement the local approach, GIRFT will also be working nationally with a wide range of clinical, governmental and public bodies to design a series of complementary levers that will help trusts to deliver the



recommendations on the ground. This will range from working with the Royal Colleges and national professional associations and societies on best practice guidance, to working with NHS England and NHS Improvement to ensure that GIRFT recommendations are reflected in any future evolution to regulation or national guidelines.

- 7.6 Through all our efforts, local or national, GIRFT will strive to embody the 'shoulder to shoulder' ethos which has become GIRFT's hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

8. Surgical Site Infection Audit

- 8.1 Over the course of GIRFT deep dive visits to trusts, it has become apparent that trusts vary in the surgical site infection rates and that in many cases, the infection rates for each specialty are not known to trusts and surgeons.

- 8.2 GIRFT has established a Surgical Site Infection (SSI) Audit to identify the surgical site infection rates of specific procedures within key surgical specialties and assess local practice in the prevention of surgical site infection for the specified procedures.

- 8.3 The audit is designed to be run by junior doctors working within the surgical specialties in individual trusts and serves as a unique opportunity for them to be involved in a national audit. The planned timeline is that data returns will be submitted to the GIRFT programme on 10th November 2017. These will be used between November 2017 and January 2018 to prepare and develop a national report.

- 8.4 Implementing GIRFT surgical infection audit findings will improve patient outcomes and deliver significant savings, a potential £1.5bn over 5 years in orthopaedics alone.



9. Other upcoming milestones

- 9.1 The next national reports on vascular, urology, spinal surgery and cranial neurosurgery are due to be released by March 2018. A business case will be presented to the Department of Health to add oncology and paediatric medicine as two new work streams to the programme. Litigation data will also be shared with Trusts to help drive patient care improvements leading to reduction of litigation costs. GIRFT has also agreed to deliver Sir Norman William's vision for the National Clinical Improvement Programme (NCIP) initiative.
- 9.2 A task and finish group is being established to develop regional collaboration with RightCare and the NHSE National Elective Care Transformation Programme. This will report to both oversight groups in November.

10. Factors to our success

- 10.1 For GIRFT to be a success it needs the backing of clinicians and senior trust managers, both in terms of supporting the programme, but also using the visits as an opportunity to highlight best practice and innovations that can be shared with other trusts, as well as shining a light on the challenges clinicians face.
- 10.2 GIRFT's success has been acknowledged in an independent report by Nicholas Timmins for the Kings Fund. Timmins interviewed the GIRFT team and clinicians and accompanied Professor Tim Briggs on a number of his trust visits. The report said, "The evidence to date suggests that the GIRFT programme is achieving what it has set out to achieve – higher-quality care in hospitals at lower cost – with the engagement of both clinicians and management in the process."
- 10.3 Through all our efforts, local or national, GIRFT will strive to embody the 'shoulder to shoulder' ethos which has become GIRFT's hallmark as we support clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.



ANNEXE A: GIRFT Workstreams

1. Orthopaedic Surgery
2. Spinal Surgery
3. General Surgery
4. Vascular Surgery
5. Urology
6. Cranial Neurosurgery
7. Ear, Nose and Throat Surgery
8. Paediatric Surgery
9. Oral and Maxillofacial Surgery
10. Obstetrics and Gynaecology
11. Ophthalmology Surgery
12. Cardiothoracic Surgery
13. Trauma Surgery
14. Breast Surgery
15. Plastic Surgery and Burns
16. Acute and General Medicine
17. Dentistry
18. Emergency Medicine
19. Cardiology
20. Geriatric Medicine
21. Renal
22. Stroke
23. Mental Health
24. Respiratory
25. Dermatology
26. Neurology
27. Rheumatology
28. Gastroenterology
29. Diabetes
30. Endocrinology
31. Anaesthetic and Perioperative Medicine
32. Intensive and Critical Care
33. Imaging and Radiology
34. Outpatients
35. Pathology

The GIRFT leadership team

- Dr Jeremy Marlow, Executive Director of Operational Productivity and joint SRO of GIRFT;
- Professor Tim Briggs, Chair of GIRFT and NHS Improvement's National Director for Clinical Quality and Efficiency;
- Rob Hurd, CEO of the Royal National Orthopaedic Hospital and joint SRO of GIRFT;
- Rachel Yates, Managing Director of GIRFT and Deputy SRO;
- Dr Rhydian Phillips, Director, Policy & Implementation and Deputy SRO;
- Nicola Joyce, Director of the GIRFT Review Team