Getting it Right First Time

Dr Rhydian Phillips
GIRFT Policy & Implementation Director
NHS Improvement

July 2017
## NHS: The Challenges

### Increasing Demand

<table>
<thead>
<tr>
<th>Demographic changes</th>
<th>Increasing health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Growing population</strong></td>
<td>2010 – 60m</td>
</tr>
<tr>
<td></td>
<td>2017 – 66m</td>
</tr>
<tr>
<td></td>
<td>2050 – 75m</td>
</tr>
<tr>
<td><strong>Ageing population</strong></td>
<td></td>
</tr>
<tr>
<td>By 2030, 33% of the UK population will be over 60yrs old and by 2031 there will be 15.3m people aged over 65yrs</td>
<td></td>
</tr>
<tr>
<td><strong>Increasing BMI</strong></td>
<td></td>
</tr>
<tr>
<td>By 2050, 60% of men and 50% of women will be obese</td>
<td></td>
</tr>
</tbody>
</table>

### Financial challenges

<table>
<thead>
<tr>
<th>Financial challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>42%</strong> Decrease in NHS bed base since 1994. Currently at 129,299</td>
</tr>
<tr>
<td><strong>£2.45bn</strong> 15/16 Provider deficit</td>
</tr>
<tr>
<td><strong>c.£900m</strong> 16/17 Provisional aggregate net deficit</td>
</tr>
<tr>
<td><strong>c.£1bn – c.£1.7bn</strong> Rising costs in NHS litigation premium from 14/15 to 16/17</td>
</tr>
<tr>
<td><strong>£1.4bn</strong> Annual flow from NHS to independent sector</td>
</tr>
</tbody>
</table>

The challenge of ensuring that savings initiatives are based on clinical evidence.
Variation in the average cost of post-orthopaedic surgery care.

Variation in hip & knee deep infection rate within one city. If all trusts got to 0.19%, this would save the NHS £200-300m p.a., enough for 60,000 replacements.

Large variation in ortho surgeons doing small number of complex procedures: 61% doing less than 11 – driving loan kit costs (£200k av. £760k max per site).

Variation in one city between cemented vs. uncemented hip replacements.

Three times as many facet joint procedures in one half of a city compared to the other.

Some trusts have out hours MRI provision for emergency conditions (e.g. cauda equina) but others do not, and some trust don’t provide blue light transport.
Introducing GIRFT

Improving medical care in the NHS while also identifying significant savings.

Innovative use of data sets to identify unwarranted variations in the way services are delivered

Example data set for orthopaedics pilot:

- Productivity metrics
- National Joint Registry
- National Hip Fracture Database
- Hospital Episode Statistics
- NHS Indicators
- Patient Reported Outcome Measures
- HSCIC
- NHS Atlas of Variation
- NHS Comparators
- National data sources
- NHS Resolution
- Waiting times
- Arthritis Research

- Led by **frontline clinicians** who are expert in the areas they are reviewing
- **Peer to peer engagement** helping clinicians to identify changes that will improve care and deliver efficiencies, and to design plans to implement those changes
- Support across all trusts and STPs to drive **locally designed improvements** and to share best practice across the country
- Agreed **savings targets**: c.£1.4bn per year by 2020-21, starting with between £240m and £420m in 2017-18
GIRFT Outcomes

- Improved patient outcomes
- Improved patient experience
- Improved patient safety

Overall improvement in trust balance sheets

- reduced complications and readmissions
- reduced length of stay
- reduced litigation costs
- better directed care pathways

- Re-empowered clinicians
- Increased functional bed capacity
- Reduced flow of work to independents

Significant taxpayer savings

- reduction in procurement and loan kit costs
- more productive workforce and reduction in locum costs
GIRFT Orthopaedics Pilot: Emerging Lessons

Huge variations in practice and outcomes:
device and procedure selection, clinical
 costs, infection rates, readmission rates, and
 litigation rates.

Scope to tackle many of these variations
and drive improvements through adopting
best practice, reducing supplier costs and
generating savings (e.g. from reduced
readmission and re-operation rates).

Many of the answers are already out there

There is great appetite from clinicians and
managers locally to adopt GIRFT practices.

While some issues can be addressed by
individuals or within trusts, some are best
tackled across networks of sites / trusts

No consensus on best practice in areas without
NICE or formal professional body guidance. This
provides a significant opportunity to drive
efficiency.
GIRFT Emerging Lessons

Cemented: £650  Uncemented: £5,300

No evidence that hip on right provides better outcome for over 70s

Huge variation between trusts in litigation averages:
- General surgery: £17 - £477
- Urology: £4 - £117
- Vascular: £1 - £6,353
- Obs & Gynae: £55 - £6,896

Lower back pain surgery costs >£100m per annum with little evidence of efficacy

And the impacts are already emerging......
GIRFT Orthopaedics Pilot: estimated impact to date

- c.£50m savings over two years and improved quality of care
- 50,000 beds freed up annually by reduced length of stay for hip & knee operations
- £4.4m estimated savings p.a. from increased use of cemented hip replacements for patients aged over 65 – reducing readmissions
- 75% of trusts have renegotiated the costs of implant stock and reduced use of expensive ‘loan kit’

2013-14 | 2015-16
---|---
Litigation cases | 1,600 | 1,350
Litigation cost | £215m | £138m

Litigation claims and the associated costs have been reduced significantly. British Orthopaedic Association used GIRFT principles in best practice guidance to its members. A pricing letter provides transparency of the prices different orthopaedic trust pay for prosthesis, aiding procurement.
From pilot to national programme

18 Clinical work streams are already underway
700 Clinical lead visits already completed
16 Remaining work streams will kick off in waves between Jul 17 - Mar 18

Trusts can start to implement their changes once they receive their data packs

<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>18</td>
</tr>
<tr>
<td>6</td>
<td>Jul 2017</td>
<td>Anaesthetics/Perioperative, Intensive &amp; Critical Care, Renal</td>
<td>21</td>
</tr>
<tr>
<td>7</td>
<td>Sep 2017</td>
<td>Acute &amp; General medicine, Stroke, Neurology</td>
<td>24</td>
</tr>
<tr>
<td>8</td>
<td>Nov 2017</td>
<td>Geriatrics, Respiratory, Dermatology, Trauma Surgery</td>
<td>28</td>
</tr>
<tr>
<td>9</td>
<td>Jan 2018</td>
<td>Rheumatology, Pathology, Outpatients</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>Mar 2018</td>
<td>Gastroenterology, Mental Health, Plastic surgery</td>
<td>34</td>
</tr>
</tbody>
</table>

GIRFT National Reports to be published during 2017-18:
- General Surgery (July)
- Vascular Surgery
- Urology
- Cranial Neurosurgery
- Spinal Surgery
- ENT
- Oral & Maxillofacial
- Cardiothoracic Surgery
- Paediatric Surgery
- Obs & Gynaec
- Ophthalmology

Implementation phase projected to last until spring 2021
Building a national programme structure

GIRFT is putting in place a comprehensive programme to help implement GIRFT report recommendations nationally:

- 34 National Reports on specialties co-badged by their national professional bodies
- A national report each on litigation & clinically driven effective hospital management
- Report & model approach on procurement
- A GIRFT Implementation Plan for each trust
- Collating data/plans at regional level of each STP and CCGs (working with RightCare)
- A series of targeted best-practice campaigns to highlight key opportunities.
- A rich database of GIRFT metrics across all trusts and workstreams accessed via the NHSI Model Hospital.
- Developing approach to benefits measurement – financial and non-financial

Monthly Oversight Group including GIRFT, NHSI, NHSE/RightCare

OVERSIGHT & LEADERSHIP
Jeremy Marlowe – Accountable Officer & Joint SRO
Rob Hurd – Joint SRO
Professor Tim Briggs - Programme Chair, National Director of Clinical Quality & Efficiency

REVIEW
Rachel Yates
Managing Director & Deputy SRO
- Clinical workstream data production
- Deep dive visits in every workstream to every provider in England
- Clinical workstream report delivery
- Procurement review
- Litigation review
- Registry & Audit review
- Information governance

IMPLEMENTATION
Rhydian Phillips
Policy & Implementation Director & Deputy SRO
- National policy lever delivery
- GIRFT implementation by clinical workstream and by trust/region
- Procurement review implementation
- Litigation review implementation
- Programme governance
- Communications/stakeholder relations
- Evaluation and sustainability
## Types of GIRFT recommended changes

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Implementation Timeframe (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Changes in practice employed by clinicians and teams to apply best practice and reduce unwarranted variation</td>
<td>Individual clinician</td>
</tr>
<tr>
<td><strong>2</strong> Tactical changes to service that enable reduction in unwarranted variation e.g. by improving patient pathways</td>
<td>Trust tactical improvements</td>
</tr>
<tr>
<td><strong>3</strong> Strategic changes involving redesign of services e.g. separation of services into ‘hot’ and ‘cold’ acute and elective sites</td>
<td>Trust strategic improvements</td>
</tr>
<tr>
<td><strong>4</strong> Where services need re-designing across a network of trusts, or STPs are required to deliver change</td>
<td>Local network</td>
</tr>
<tr>
<td><strong>5</strong> National level change through adjustments to national guidance, policy or standard setting</td>
<td>National</td>
</tr>
</tbody>
</table>
GIRFT Implementation: local

GIRFT Hubs will be set up by autumn, with clinical and project delivery leads who will support trusts, commissioners STPs and ACCs to …

Build and deliver implementation plans reflecting:
1. The variations highlighted in trusts’ data packs
2. The improvement priorities discussed in Clinical Lead visits
3. The recommendations set out in each National Report

Provide concentrated additional resources for trusts that require intensive support, with trusts helping to pay for additional GIRFT project managers

Disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice

Hubs will work to GIRFT P&I Director & NHSI Op Prod Regional Directors, who will ensure GIRFT delivery is fully embedded in NHSI Regional SMTs’ plans
GIRFT Implementation: national

GIRFT is working with a range of clinical and governmental bodies to implement national levers that will help trusts to deliver their recommendations on the ground. This includes:

- Working with Royal Colleges, national professional associations/societies and NICE on best practice guidance and definitive treatment positions.
- Working with NHS England and NHS Improvement to ensure GIRFT is reflected in any future evolution to regulation or national guidelines e.g. Single Oversight Framework.
- Working with NHS bodies such as RightCare, the Care Quality Commission and the National Clinical Audit Programme to ensure a complementary approach and to streamline requests to providers.

NHSI MODEL HOSPITAL will house key metrics on each GIRFT specialty, with access to a database of up to 10,000 sub metrics across all trusts including National Clinical Improvement Programme metrics helping to drive professional validation processes.
Sustainable GIRFT Implementation

- We cannot afford to let the gains made by GIRFT slip back after a few years
- GIRFT will work with partners to make sure we sustain improvements by:

- Looking at the **lessons** of previous transformation programmes in the NHS that have failed to deliver sustained change
- Helping clinical leaders at trusts to drive a **culture of continuous quality improvement** locally linked to professional training and revalidation programmes
- Challenging trusts that reach national average performance in areas where they are currently outliers to go on to **match the best performers** over time
- Seeking to replicate the National Orthopaedic Alliance **Vanguard model** (part of NHSE New Care Models programme) in other specialties as vehicles for maintaining the GIRFT approach long term
- Working with clinicians and managers to improve efficiency and patient outcomes by **reconfiguring services** e.g. ‘hot’ and ‘cold’ sites, or streamlining specialties into a smaller number of clinical service line management chains
- Working across specialties, building **networks** to realise deeper, longer-lasting gains than can be achieved within each specialty alone
- Ensuring that GIRFT recommendations are incorporated into future iterations of **best practice guidance and regulation**
- Creating and disseminating **model approaches** to: procurement, data registry, site reconfiguration etc.
Conclusion & questions

Through all our efforts, local or national, we 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.

For more information visit www.GettingItRightFirstTime.co.uk
Follow us on Twitter @NHSGIRFT and on LinkedIn