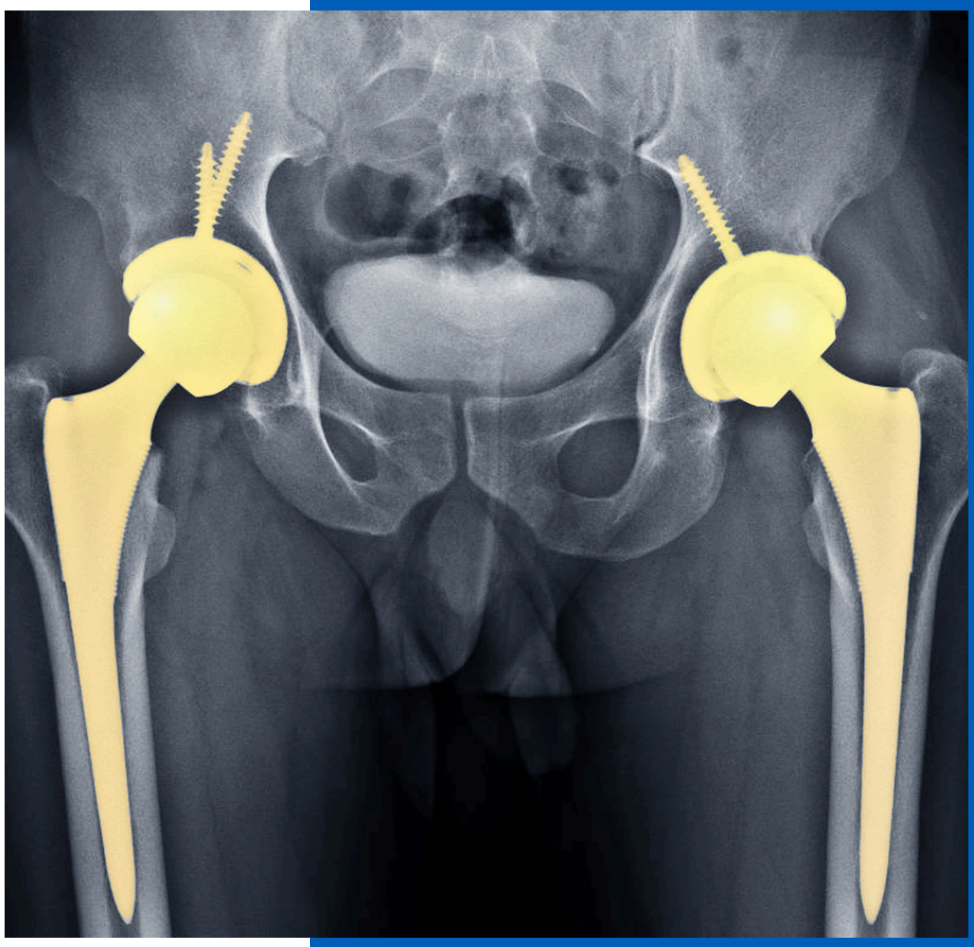
NHS England

GIRFT
GETTING IT RIGHT FIRST TIME

# GIRFT elective primary total hip replacement pathway: an impact assessment of GIRFT resources and interventions

## Specialty: Orthopaedics

March 2026



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## About the GIRFT programme

The Getting It Right First Time (GIRFT) programme is a national programme designed to improve treatment and care by reviewing health services. It undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment, and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the National Health Service (NHS) that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when accumulated across an entire trust – and even more so across the NHS as a whole – deliver substantial benefits.

GIRFT is part of an aligned set of workstreams within NHS England. In Lord Carter's 2016 review of operational efficiency in acute trusts across England, Professor Tim Briggs was thanked for his clinical insights gained from visiting and reviewing elective orthopaedic surgery at 211 NHS providers. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through addressing unwarranted variation and reducing average length of stay (LoS).

The GIRFT programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Hospital System portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies.

The GIRFT model has now been applied in more than 40 different areas of clinical practice. It consists of five key strands:

- Data Gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
- Peer Reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.

- National Report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
- Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.
- Research & Development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

**GIRFT and a Greener NHS**

Climate change is one of the greatest health threats and opportunities of the 21st century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation, GIRFT can play an important role in reducing the carbon emissions associated with care delivery. Through the GIRFT model, there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.

## Purpose

The purpose of this document is to briefly assess the impact of GIRFT Academy resources and products on length of stay (LoS), clinical safety and efficiency, and theatre performance of elective primary total hip replacement which are key GIRFT metrics for this pathway.

## Target audience

The intended audience for this impact assessment is staff working in the NHS and Department of Health and Social Care (DHSC) interested in understanding how GIRFT Academy resources and products contribute to better health care and a reduction in unwarranted variation of care across the NHS in England.

# Background to the study

Elective total hip replacement and elective total knee replacement are the two most common elective orthopaedic procedures conducted in the NHS each year, with very similar numbers of each procedure. Across all of surgery, only cataract surgery has a higher number of elective procedures each year. Total hip replacement is also a relatively resource intensive procedure. Recent studies have reported decreases in LoS over the last ten years, with per patient financial and carbon emissions savings associated with these changes.[1] In the last three to five years, day case elective total hip replacement surgery has become increasingly common in some providers, with day case rates of over 20% seen for a small number of providers. Unpublished findings suggest that, in carefully selected patients, day case surgery is safe. The move to day case surgery has also been accompanied by an increase in day-one discharges, with some trusts putting in place a protocol for two-day stay only by exception.

An academic study published by the GIRFT programme identified strong evidence that in patients aged 70 years and over, uncemented fixation in total hip replacement was associated with significantly higher rates of revision, supporting the recommendation made in the GIRFT national report to use cemented fixation in patients over 70 years old.[2]

# Methodology

## Assessment design

This was an exploratory analysis of information obtained from Model Health System and the GIRFT Academy resource repository, administrative data from the UK Hospital Episode Statistics (HES) database and Theatre Productivity Data Collection (TPDC). The HES database is collected by NHS England and includes data for NHS hospital activity in England. It provides much of the underlying data source for Model Health System. The TPDC covers surgical theatre activity in England and included data on day cancellations.

## Data extraction

### Key GIRFT metrics

For this assessment, we were interested in LoS, clinical safety and efficiency, and theatre performance of elective primary total hip replacement which are key GIRFT's metrics for this clinical area. The metrics are defined on Model Health System as:

- LoS;
- emergency readmission within 30 days of discharge following a procedure;

- cemented or hybrid hip fixation for patients aged 70 years and over.

## GIRFT Academy products

We identified relevant GIRFT Academy products and resources published between March 2015 and August 2024:

- A national review of adult elective orthopaedic services in England (March 2015)[3]
- Getting It Right in Orthopaedics – Reflecting on success and reinforcing improvement (February 2020)[4]
- Orthopaedics elective primary total hip replacement pathway (November 2022 and January 2026)[5]
- Orthopaedic Elective Surgery - Guide to delivering perioperative ambulatory care for patients with hip and knee pain requiring joint replacement surgery (March 2023)[6]
- Theatre Productivity Programme Practical Guides - Module 2: Theatre Waiting List Management and List Allocation (July 2024)[7]
- Theatre Productivity Programme Practical Guides - Module 3: Theatre scheduling (July 2024)[8]
- Theatre Productivity Programme Practical Guides - Module 4: Patient Preparation and Effective Theatre Flow (July 2024)[9]
- Theatre Productivity Programme Practical Guides - Module 5: Surgical discharge (July 2024)[10]
- Further Faster Orthopaedics Handbook - Master handbook (August 2024)[11]

## GIRFT clinical leads' activities

The GIRFT national clinical lead in elective orthopaedic surgery during its lifetime has been Professor Tim Briggs. Professor Briggs has visited every NHS hospital trust in England with an orthopaedic service. During visits the following activities will have supported change:

- Presented the findings of the national report and discussed it in the local context.
- Provided feedback to local teams on progress against the key metrics.
- Identified innovative practice.
- Identified the need for GIRFT Academy products.

- Promoted the use of Academy products and discussed them within the local setting.

All these activities will have helped to drive improvement across the key metrics.

### GIRFT implementation interventions

GIRFT leads and manages several improvement initiatives to implement change of clinical practice in orthopaedics. These include:

- High volume, low complexity (HVLC) programme – reducing waiting lists for high volume, routine surgery.
- Further Faster programme – streamlining patient pathways and reducing waiting times.
- Elective surgical hubs programme
- The National Consultant Information Programme (NCIP)
- The LoS project
- Focused support

### Time period

This impact analysis covered 11 financial years from 2014/15 to 2024/25 during which time (March 2015 onwards) key GIRFT Academy products were published promoting more efficient patient care and increased theatre productivity for elective primary total hip replacement.

## Data management and analysis

All data was stored and analysed within secure NHS IT environment server space. Data was analysed using standard descriptive statistics as appropriate to the data (e.g. mean, median, frequency).

# Findings

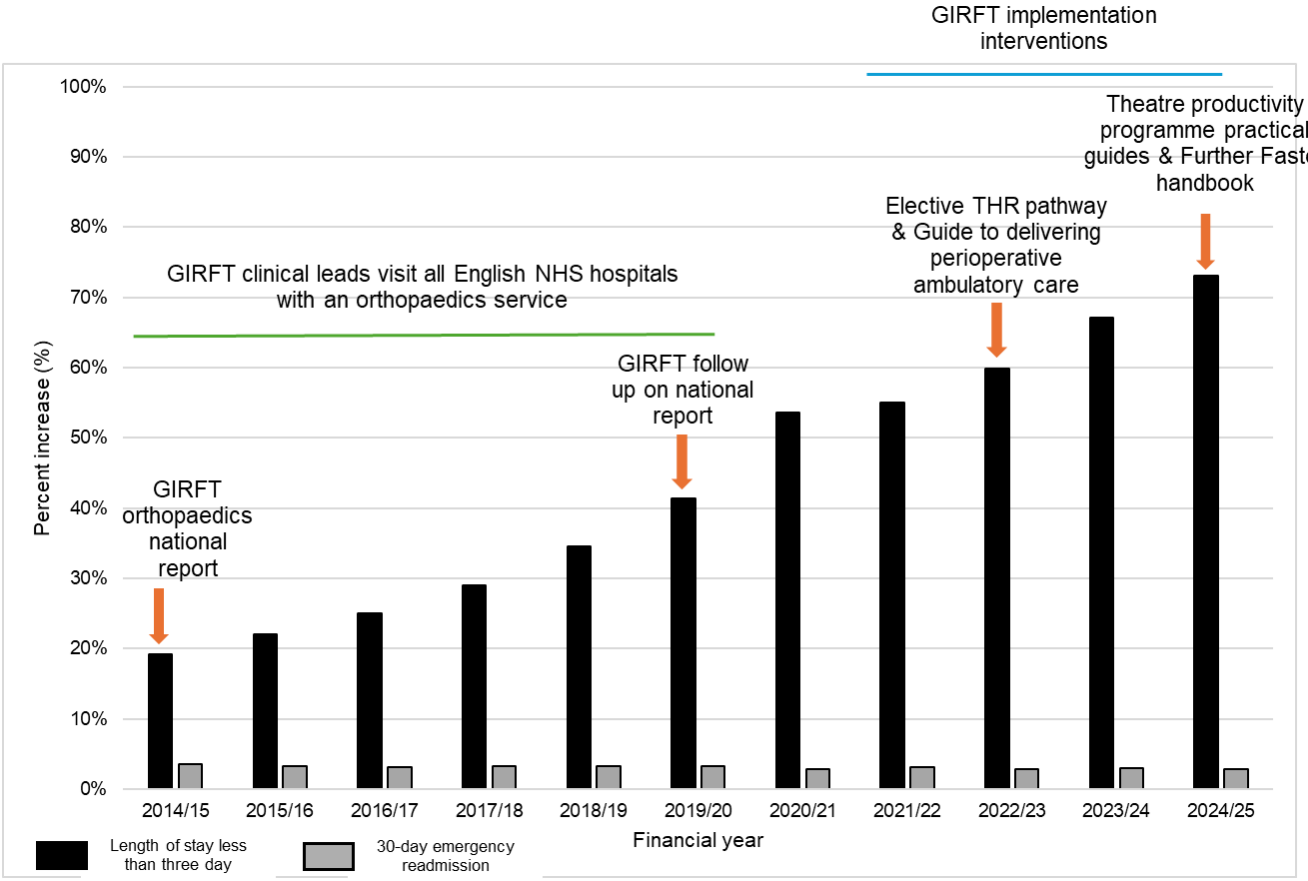
## Length of stay and 30-day readmission rates

LoS data was found to be non-normally distributed and so is summarised using the median, rather than the mean. The median LoS halved from four days in 2014//15 to two days in 2024/25. For further analysis, LoS was dichotomised as at, or above the median and below the median (three days) across the entire eleven years of data (770,627 patients).

Between 2014/25 and 2024/25, there has been a sharp 53.9% increase from 19.2% to 73.1% in patients staying for less than three days after elective total hip replacement (**Figure 1**). In

2024/25, the best performing trusts had a median LoS of one day, with nine trusts discharging over 80% of patients within three days (best performing trust 95% of patients) and four trusts having a day case rate of over 20% (best performing trust 28%). In that same period, the rate for 30-day emergency readmission following total hip replacement remained relatively stable at around 3% (**Figure 1**).

**Figure 1:** Proportion of patients with a stay of less than three days and 30-day readmission rates following elective total hip replacement (n = 770,627).

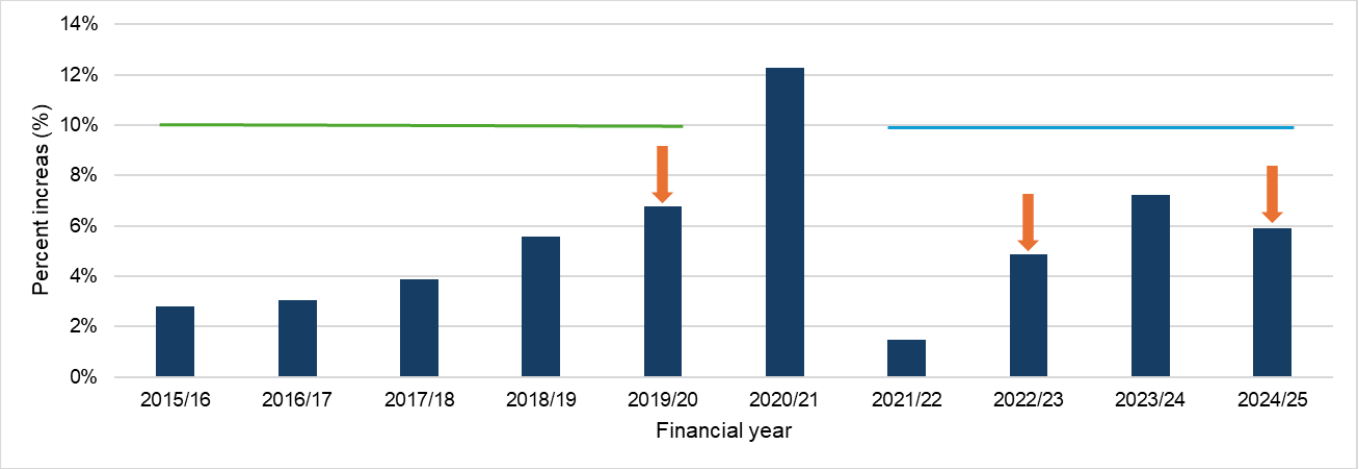



*Note: The financial years during which GIRFT Academy products were published are marked with an orange arrow. The green line indicates clinical lead visits to trusts offering elective total hip replacement surgery. Between 2013/14 and 2019/20, 291 visits occurred. The blue line indicates when specific GIRFT implementation interventions took place.*

In 2020/21 and 2023/24, respectively, there have been notable increases in LoS of less than three days from the previous year's value (12.3% increase on the previous year in 2020/21 and 7.2% increase on the previous year in 2023/24; **Figure 2**). Each of these financial years was preceded by the publication of GIRFT Academy products the previous year. During the years when no publications occurred, this increase ranged between 1.5% and 6.8%. However, the overall increase of short LoS over time is also attributable to the 291 clinical lead visits that took place between 2014/15 and 2019/20 to trusts offering elective total hip replacement

surgery and targeted GIRFT implementation interventions (e.g., Further Faster, LoS project etc.) happening between 2021/22 and 2024/25.

**Figure 2:** Year-on-year increase of short LoS for less than three days.

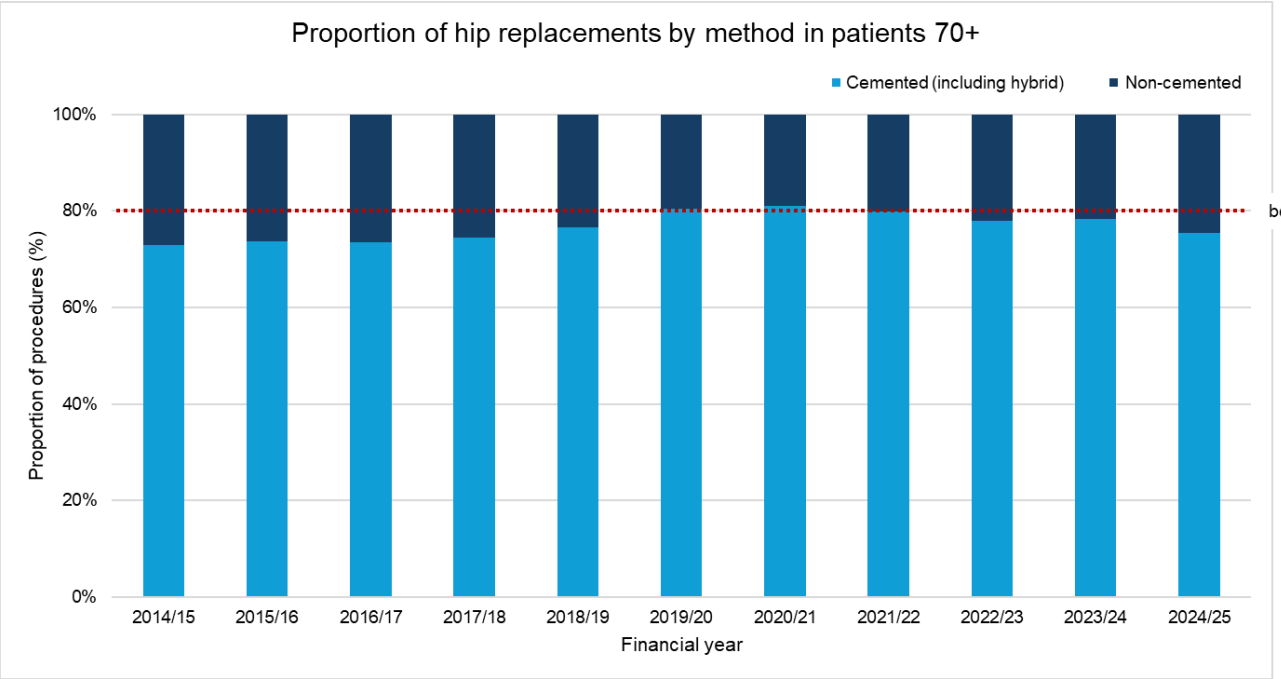



*Note: The financial years during which GIRFT Academy products were published are marked with an orange arrow, the green line indicates clinical lead visits to trusts offering elective total hip replacement surgery. Between 2013/14 and 2019/20, 291 visits occurred. The blue indicates when specific GIRFT implementation interventions took place.*

## Hip replacement fixation methods in patients 70+ years old

At the beginning of the included time period, the recommended use of cement in hip replacements was at 72.9% in 2014/15 (**Figure 3**). This rate reached its peak in 2020/21 at 81.0% (an 8.1% rate increase) exceeding GIRFT's target of 80%.[2] However, this trend reversed thereafter to 75.5% by 2024/25.

**Figure 3:** Proportion of hip replacement fixation method in patients over 70 years of age. GIRFT set the benchmark for this fixation method at 80% (red line).




## Strengths and Limitations

GIRFT has worked closely with organisations and stakeholders looking to improve patient care, clinical safety and service efficiency through increasing short LoS and improving theatre performance during this period, although it is difficult to establish a direct correlation between GIRFT interventions and products, and the subsequent improvement of the quality of care in the specialty.

In addition, theatre productivity data collection is not mandated, so the data set is not complete.

## Wider context

The elective hubs programme, managed by GIRFT, was established following the COVID-19 pandemic to help trusts to set up elective surgical hubs that would be separate to acute and emergency care and allow elective care to be protected from wider pressures on services. Analysis by The Health Foundation suggests that trusts with an elective surgical hub are more productive, with shorter stays than trusts without a hub.[12] The expansion of these hubs is likely to be a driver for some of the reductions in LoS seen for hip procedures. For orthopaedics, trusts with an elective surgical hub have also been shown to have higher rates of resident doctor training than non-hub trusts.[13] GIRFT has also recommended that hip precautions are not used by trusts to minimise post-procedural dislocations. A study from 2022 found that the

use of hip precautions did not reduce dislocation rates but was associated with a stay of an additional day in hospital on average.[14]

## Conclusions

LoS of less than three days post-procedure substantially increased between 2014/15 and 2024/25 during which time GIRFT clinical leads visited all trusts offering elective total hip replacement surgery, targeted GIRFT implementation interventions took place and GIRFT products were published as part of these initiatives and interventions. The biggest increases in short LoS occurred when GIRFT Academy products were published the previous financial year, indicating that publishing GIRFT's recommendations positively impacted on the adoption of best clinical practise for total hip replacement.

The 30-day emergency readmission rates stayed broadly the same throughout the study period, suggesting that shorter stay did not result in an increase in rates of early emergency return to hospital.

GIRFT recommends the use of cement in total hip replacements as the preferred fixation method.[2] Even though use of cement has exceeded GIRFT's benchmark in 2020/21, the increasing trend of its use has reversed ever since, highlighting that more GIRFT interventions are likely needed to encourage the use of cement in total hip replacements.

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