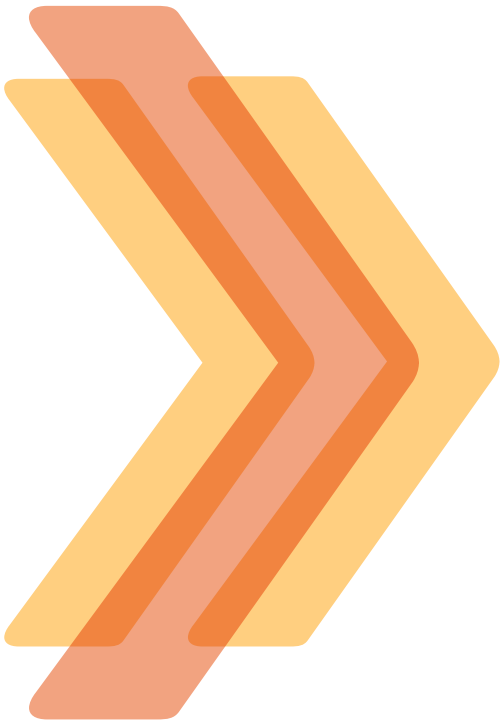
The King's Fund

Ideas that change health care

Tackling variations in clinical care

Assessing the Getting It Right First Time (GIRFT) programme



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Foreword

The NHS in England faces well-known challenges in meeting rising demand for health care within available resources. Previous work by The King's Fund has brought together evidence on the opportunities for improving productivity and has emphasised that many of these opportunities are to be found in changes to clinical practice (**Alderwick *et al* 2015**). Recent work by the **Organisation for Economic Co-operation and Development** (2017) has confirmed our analysis and has documented the extent of wasteful spending on health in many countries.

The evidence that we and others have brought together is not new, but it assumes greater salience at a time when health care budgets across the world are under increasing pressure. The challenge in England and elsewhere is knowing how to act on this evidence to reduce wasteful spending and deliver better value for patients and taxpayers. A particularly promising area of focus is unwarranted variations in clinical practice, building on the seminal work of Jack Wennberg (2010) and researchers who have followed in his wake.

With this in mind, The King's Fund asked Nick Timmins to study and report on work being led by Professor Tim Briggs to document and tackle variations in clinical practice in England. We became aware of this work in 2015 as part of our programme of research and analysis into funding and productivity in the NHS. Our intelligence indicated that Briggs's analysis of variations in orthopaedic surgery was beginning to gather momentum and was being extended to other specialties such as vascular surgery. It was also attracting interest and support at senior levels in government.

In commissioning this work, we wanted to understand how data on clinical variations was being used within the NHS and how this data was being acted on, or not. Anecdotal evidence suggested that managers and clinicians were paying more attention to the work of Briggs and his team than to previous efforts of this kind, and we were curious to know if this was the case and, if so, why. We also wanted to bring this work to the notice of a wider audience at a time when knowledge of what was being done was limited mainly to NHS insiders.

In the time-honoured phrase, the paper that follows should be read as 'the first draft of history' rather than as a definitive analysis. We hope that it provides insights into

a programme that has the potential to make a major difference to patients as well as to the use of resources within an increasingly cash-strapped NHS. Much more work is needed to evaluate the longer-term impact of the programme, but for now this review shows why a focus on unwarranted variations really matters and is beginning to show results.

I would like to thank Nick for bringing to life what might otherwise have come over as a dry and technical topic. Thanks are also due to Tim Briggs and his team for providing us with access to their work and an invitation to attend meetings where they fed back their results to managers and clinicians within the NHS. They took a risk in agreeing that we would retain full editorial control in writing this paper 'warts and all'. The story that unfolds in the following pages shows why their work matters.

Chris Ham

May 2017

Setting the scene

Ronald Reagan once famously quipped that the nine most terrifying words in the English language are 'I'm from the government, and I'm here to help'. But that doesn't, for one moment, stop Michael Horrocks, Professor of Postgraduate Surgery at the University of Bath and a former President of the Vascular Society of Great Britain and Ireland, relaying precisely that message to a room full of vascular surgeons and interventional radiologists. 'We are here to help,' he says. 'We are not the Care Quality Commission. We are here to serve.'

There is a distinct air of tension as this meeting in a hospital in the south of England opens.

Present are not just the consultants but also a sprinkling of senior nurses and middle managers, along with the clinical and medical directors. They are joined later on by the chief executive of the hospital. Fifteen people are in attendance in all.

Professor Horrocks is about to take them through 60 slides of data that they have seen in advance. For the first time, in one place, it presents, pretty much, the whole of their practice: their patient population and its characteristics; how well their screening programme for aortic aneurysm is going; and crucially, their clinical results. These results have been measured, for example, by length of time from presentation to surgery, the quality of pre-operative assessment, the proportion of patients who have to return to theatre, death rates within 30 days of a hospital procedure or an emergency admission to hospital, amputation rates, length of stay and the proportion of patients who are re-admitted to hospital. The hospital's scores on the Friends and Family Test are presented, and these are followed by the consultants' own reports from patients on the outcome of their treatment – their patient-reported outcome measures (PROM) scores. Then come their costs, set out for a range of procedures against the England average.

Much of this data is ranked, so that those in the room can see where they stand against their peers in similar hospitals, and across the country. It includes how often the team has been sued for an operation going wrong, using the most up-to-date data in the previous five-year period – and what that adds, on average, to the cost of each case treated.

Sixty slides sounds a lot. But they are relatively simple. Each one highlights facts from which the staff can see whether their unit is both clinically good and technically efficient, compared with others. For the first time – by drawing on information from more than a dozen sets of data – it puts the clinical, the organisational and the financial all in one place.

There is a touch of tension in the room because, while this hospital is rated as 'good' by the Care Quality Commission, not all the numbers in the data pack are uniformly excellent. Indeed, this 9.00am meeting has started a little late because, having seen the data, the consultants were rushing to finish off their own presentation to seek to answer what they suspect will be criticisms.

Horrocks is having none of that. He has a deceptively easy but firm manner. 'There will be plenty of chance to comment as we go through,' he says as the team wants to provide answers to what they can see are their less-good figures. 'We are not here to catch you out. We are here to help.'

Over the next two hours, a story emerges, along with a number of practical suggestions as to what can be done to raise quality and to improve both efficiency and productivity. All three are intimately linked. On occasion, but rarely, the clinicians challenge the data. But as Professor Horrocks keeps stressing, 'this is your data' – data provided either by the consultants themselves or by the hospital more generally.

The conversation rapidly heads into the nuts and bolts of how to make the vascular service work better – a conversation being led by someone who is sufficiently senior and eminent for at least the name to be known by almost all of the consultants, and some of them know Horrocks personally. The suggestions for improvement come from both Horrocks and the consultants themselves, who recognise that the way the theatres are used needs to be improved; that so many patients these days are older people for whom the surgeons need to work more closely with their medical colleagues to get their length of stay down; that to get the service's infection rate down, the vascular surgeons need their beds ring-fenced so that emergency medical patients do not introduce infections that get to the surgical wounds.

Horrocks is keen also to make a broader point. 'Vascular surgery came out of general surgery,' he says. He goes on:

> *So it has lived with general surgery's approach that there are elective patients (planned admissions where treatment can usually wait a while) and emergencies; and not much has changed. But the truth is that in vascular surgery there are relatively very few true electives and not that many major emergencies. The majority of cases, in fact, are urgent. The earlier they are dealt with, the better the outcome, with the reduced risk of complications, the reduced risk of amputation, and lower costs. So patients should not go on a waiting list. They are 'urgents'.*

Thus, the service provided by the vascular surgeons and interventional radiologists needs to operate more flexibly, ideally over seven days, re-arranging the theatre time, having ring-fenced beds and removing the concept of the patient belonging to a particular consultant.

Long before the end of the meeting, the tension has gone, with one senior consultant declaring, to murmurs pretty much all round, that much of this 'is music to our ears'.

Other issues crop up. Links with the diabetologists in this hospital trust – diabetes being a key cause of vascular problems and indeed amputations – were once excellent but are now less good. Getting the diabetes service working better out in the community is a priority – to make life better for patients, to reduce admissions, to reduce amputations and to lower costs. That, of course, is not in the hands of the vascular surgeons, let alone the interventional radiologists, or even directly in the hands of either the clinical director for vascular surgery or the hospital's medical director. But the chief executive joins the meeting two-thirds of the way through and is clearly listening.

As Horrocks departs and the staff stay in the room, there is no backlash. There are no comments like 'well, that was a waste of time'. Most of what has been discussed makes sense to almost everyone there. Indeed, one of the more senior, battle-scarred, consultants bemoans that 'we've been saying lots of this for years'. The chief executive bridles. 'Well, that's the past,' she says. 'Let's concentrate on how we're going to get these things done.'

These things include both what the hospital can do – the one bit that everyone in the room can affect – and what needs to be done to persuade national commissioners, clinical commissioning groups and NHS England to buy both the hospital's services and those out in the community better (better both in individual terms for the patient and also in ways that make the money go further), without bankrupting the hospital by removing its business.

This meeting, in the autumn of 2016, is part of GIRFT – one of the uglier acronyms of the National Health Service (NHS). It stands for 'Getting it right first time'. GIRFT is a programme that is pursuing the holy grail of modern medicine – higher quality at lower cost. This is something that the NHS, teetering as it is on the brink, desperately needs. Having started out with orthopaedics, it is now to be applied to 32 different surgical and medical specialisms across the English NHS at a cost of £60 million over three years, a not insignificant sum in a cash-strapped service.

This short report is the result of visits with Professor Horrocks and Professor Briggs, the leads on the vascular and orthopaedic parts of GIRFT, to some half dozen units receiving either a first vascular visit or a follow-up orthopaedic one; interviews with Briggs; Horrocks; Rachel Yates, the programme's Managing Director; Rob Hurd, Chief Executive of the Royal National Orthopaedic Hospital; Lord Carter; and Jeremy Marlow, Executive Director of Operational Productivity at NHS Improvement; a reading of both unpublished, and published, material on GIRFT, the latter being listed at the end as further reading; plus follow-up interviews with some of those who received the visits.

So what is GIRFT?

GIRFT is the brainchild of Professor Tim Briggs, a leading light at the Royal National Orthopaedic Hospital in Stanmore in the north of London. Briggs is something of a force of nature. Still built like the powerhouse of the pack that he was when he played rugby for Blackheath in its glory days when the game was still amateur, he is, as one colleague puts it, 'a man who knocks down doors. He doesn't wait three weeks for a meeting – and that includes with government.' He is also an evangelist for his cause.

In 2012, he was due to become President of the British Orthopaedic Association and, Briggs being Briggs, he was determined to put that to good use. He recognised from working at Stanmore as a clinician and medical director that, as funding tightened, the NHS was going to have to do more for less, and he persuaded the Department of Health and NHS England to put up £200,000 for a pilot study under his presidency to look at clinical variation in orthopaedics. The Royal National Orthopaedic Hospital, being one of Britain's five tertiary centres for orthopaedics, is, like the others, well placed to see the outcome of the worst bits of that variation. These tertiary centres, by definition, do the most difficult orthopaedics. But part of their task is also sorting out things that have gone wrong elsewhere.

Armed with an initial dataset of hospital activity, clinical outcomes and costs for each orthopaedic unit in England, using data drawn from a dozen sources, including the National Joint Registry, Briggs visited all of the orthopaedic units in the country in a year, accompanied on many of them by Rob Hurd, Chief Executive of the Royal National Orthopaedic Hospital, or Rachel Yates, head of the hospital's policy unit and now Managing Director of the whole GIRFT programme. On the way they proved that the engine of Briggs's motor is capable of well over 100,000 miles. They visited the units of 144 acute trusts, embracing 220 hospitals, in meetings that involved more than 1,600 consultants and 400 managers. Only one unit declined their presence.

Each was sent its data ahead of the visit. The results were eye-watering. Surgical site infections varied from less than 0.2 per cent (the figure that happens to be achieved by Stanmore and by England's four other specialist orthopaedic hospitals but that others also achieve) to 5 per cent – a 25-fold variation. Infection rates of around 2 per cent were not uncommon. Aside from being a deeply unpleasant experience

for the patient, treatment of an infected joint costs around £75,000 to £100,000, according to GIRFT. Surgical wound infections take beds, cost money and lengthen waits for other patients. They are awful for the patient, and awful for productivity.

Active rehabilitation after hip fracture is known to improve results. But fewer than 50 per cent of patients who had had hip fractures were receiving physiotherapy. For fractured neck of femur – a broken hip – the average percentage of patients having to return to theatre within 30 days was 2.37 per cent. The range was from nought to over 7 per cent. Revision rates for hips varied from 0.4 per cent to 1.4 per cent at one year, and from 1.6 per cent to 3.4 per cent at five years. These are small percentages, but still represent a three-fold variation. Revisions are more costly and complex and have less-good clinical outcomes for patients than primary replacement. When you have a new hip, you want it to last. And, according to Briggs, there is now overwhelming evidence from the National Joint Registry and elsewhere that in those aged over 65 – who are the chief recipients of hip replacements – a relatively simple cemented joint produces excellent long-term clinical results. Such joints are also among the least expensive. Yet, on average across England fewer than 40 per cent of people over the age of 65 received cemented hips, with some units using them in only 5 per cent of cases and others in 95 per cent of cases. The price being paid for different types of hip implant – and there are more than 200 of them in use – varied from £761 to £3,669. The price being paid for identical cemented implants ranged from £595 to £854. And if there was widespread variation in orthopaedics, the results for spinal surgery, which initially received a lighter look, were, Briggs says, 'like the wild west'. The variations in the type of procedure for similar conditions, and in the equipment used, were even greater.

There is extensive evidence that clinical results improve where surgeons do higher numbers of particular types of case a year. The evidence suggests that there is a 'magic number' – surgeons who do at least 35 a year tend to do better (**Briggs 2015**, p 18). GIRFT found that the average per surgeon for hip replacements was 52 a year. Yet almost a quarter of surgeons were doing 10 or fewer hip replacements a year, and 16 per cent were doing five or fewer. For the more costly and complex hip and knee revisions, 45 per cent of surgeons were undertaking five or fewer of the former a year, and almost 60 per cent were doing five or fewer of the latter a year – even when they worked in units where colleagues were doing considerably more. When hospitals do limited numbers of revisions and other more complex procedures, they often have to hire in the specialist kit needed, rather than having it on the shelf – so-called 'loan kit'. So low volumes equal high loan-kit costs, which equal high costs and, on average,

less-good results. Hospitals were spending an average of £200,000 a year on loan kit, with one spending £750,000. This is a waste of money and, clinically, for the patient, it is not good.

'What all that amounts to is huge and unacceptable variation that is producing inferior clinical care that is costing money and delaying treatment for other patients,' Briggs says. 'Quite simply, we cannot afford it.'

It is important here to stress that these huge variations in clinical care – disturbing though some of them are – are far from unique to the NHS. They can be found in health systems all around the world, although the quantity of data generated by the NHS as a national system with standardised datasets and some key national audit databases tends to make it easier to assemble on a national basis (*see* **Agency for Healthcare Research and Quality website**; Wennberg 2010).

But the extent of unacceptable variation, and the ability to tackle it, means that Briggs is not among those who would go on bended knee to the Prime Minister and the Chancellor seeking more money for the NHS. It is up to clinicians and managers to sort this out, he says. He comments:

> *Money for social care aside, where there is a massive problem, there is no way right now I would ask for more money for the NHS. The waste and variation out there is unbelievable and we have got to get our act together across all the specialties to improve quality and unwarranted variation and complications. And it is not just orthopaedics.*
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> *The variation out there is enormous. For example, if you have your tonsils taken out, you would think you could get that right, wouldn't you? The re-admission rate at 30 days varies from 4 per cent to 27 per cent. If you have a ventriculoperitoneal shunt, the revision rate at 28 surgical centres varies from 4 per cent to 44 per cent at two years. And the infection rate varies from 0.2 to 6 per cent. Totally unacceptable. So we have got to put that right.*

And the 'we' here are the clinicians, working with the managers. Not for Briggs the idea that this might be someone else's problem. It is the clinicians' work at issue here, and it is they who need to tackle this.

He says (and these quotes are from one of his standard introductions to the many groups of clinicians he has addressed over the past few years):

> *I am passionate about that. As President of the British Orthopaedic Association, I went around the world looking at different health care systems. And I believe the NHS is the best in the world, not least because every health system has the sort of variation we are seeking to tackle here. But if the NHS is going to survive we are going to have to sort this.*

He tells the assembled clinicians:

> *We are all going to be patients in this room – everybody – and you have to make sure it [the NHS] is going to look after us when we need it. And I want to make sure patients get the best care. I am a taxpayer, and I have two kids doing medicine, and I want them to be able to work in a health service that is fit for purpose. So we have all got to act. Getting it right first time improves care and saves money. So we have all got to change to achieve that.*

In the face of rising demand and limited resources, Briggs declares, 'there is no other option if the NHS is to balance its books and deliver the services its patients deserve'.

But why on earth is GIRFT needed?

On the face of it, it is an entirely reasonable question to ask why we need GIRFT. Since at least the late 1980s, under one scheme or another, money has been provided, or time has been provided, or both, for clinical audit. The mechanisms have changed over the years, from allocated money to time in consultants' contracts, and on occasion back and forth again.

Back in 1988, for example, the National Confidential Enquiry into Perioperative Deaths (NCEPOD) started looking at surgical and anaesthetic deaths in hospital, a programme that has retained the same acronym but has grown over the years into the National Confidential Enquiry into Patient Outcome and Death. This now embraces medicine, maternity, mental health and child health and has moved beyond the simple issue of deaths (an unquestionable outcome) to patient outcomes more generally. Equally, and again since the later 1980s, increasingly sophisticated data has become available about hospitals' costs for particular procedures – a development hugely reinforced by the introduction in the mid-2000s of the tariff, or price list, for NHS procedures, a mechanism that still drives a considerable part of many hospitals' income.

As early as 1988, The King's Fund published a report entitled *Health care variations: assessing the evidence,* which included chapters on variations in surgical practice, perioperative deaths, length of stay and hospitalisation rates (Ham 1988).

In the late 1990s, the National Vascular Registry started a clinical audit of carotid interventions where patients need surgery following a transient ischaemic attack or minor stroke. It has since been extended into abdominal aortic aneurysm repairs and lower limb revascularisation procedures, recording many metrics about quality of care. Since 2002, the National Joint Registry has provided a means for surgeons to report their results to help establish the long-term effectiveness, and cost-effectiveness, of different types of implant.

Since 1999, the National Institute for Health and Care Excellence (NICE) has been producing guidance on best practice across a wide range of medical and surgical procedures. And since the early 2000s, hospitals have had 'clinical governance'

aimed at measuring whether their constituent parts comply with best practice. Starting in 2012, registration with the General Medical Council has involved a process of 'revalidation' where doctors are required to demonstrate, usually every five years, that they are up to date with and fit to practise in their chosen field and able to provide a good level of care. On top of that, all hospitals are subject to inspection by the Care Quality Commission. And so on. This list is anything but exhaustive. And if anyone doubts that clinicians examining the quality of their work against their peers does not improve things, then there is the shining example of cardiac surgeons who, after the scandal of the Bristol Royal Infirmary paediatric cardiac surgery deaths in the late 1990s, voluntarily started to publish all their results to each other, moving England from having a relatively poor performance to, for a time, having the best results from cardiac surgery in Europe, results that – as others also improve – remain among the best. So if the NHS has all this already, why is GIRFT needed? Because, its advocates argue, GIRFT is different.

So what is different about GIRFT?

Many of the clinical audit databases, such as the National Joint Registry and the National Vascular Registry, are voluntary. Doctors do not have to enter their data, although many do and more are doing so as revalidation starts to bite. Then there is the simple fact that the data that provides a full picture of a clinician's practice – not just clinical outcomes, but also activity, costs, performance against their peers and litigation rates – is scattered around for any individual clinician in a dozen or so datasets, and for clinicians as a whole around dozens of them, not all of them easy to find. To get going in the first place, GIRFT had to assemble the skills to pull them together. And then there is the time factor. Time to do all of this in an NHS that, as the money has tightened since 2010, and as demand has kept on rising, has come under steadily increasing pressure.

Rob Hurd, Chief Executive of the Royal National Orthopaedic Hospital, who has undertaken some 160 visits as part of GIRFT – GIRFT revisits hospitals, as we shall see, rather than these meetings being a one-off – confesses to being 'slightly cynical about all this when Tim [Briggs] first suggested it. It sounded like motherhood and apple pie. We've all known about various forms of variation for many years, but how do you actually change it?'

What is different about GIRFT, he says, is first that it puts all the data together easily in one place. The interactions between outcomes of care and cost become more transparent. Second, it involves peer-to-peer review. Each specialty is led by an acknowledged leading light in their field. So no one can say that the person presenting the data does not know what they are talking about. Third, he says that:

> *…it is supportive. It is peer-to-peer review in support of behaviour change. It is not a regulated, turning up to beat people process over where things are going wrong. It is a professional review, supported by the professional associations and the Royal Colleges – with a bit of NHS teeth in it in that if you go back a year later and nothing has changed then people are going to be paying more attention to the dashboards of data as they keep coming out. These show how people are performing and they are now being regularly updated.*

Fourth, and unlike the Care Quality Commission, it is the same team conducting the programme across the country for each of the specialisms, so there is consistency. And fifth, at its best, it is the clinicians in each specialty sitting down with the clinical directors, medical directors, middle managers and chief executive going through the data at a granular level in ways that reveal what needs to be done better and with data that itself points to a better way of doing that.

Hurd says:

> *One would expect clinicians to be reviewing evidence and looking at practice and adopting changes. How many of something do you do a year? What types of products do you use? Are you looking at your own variation peer to peer? You might expect that would be professional practice. But in some cases it wasn't out there. You can find endless publications of best practice pathways, and evidence on what 'good' looks like, and what should be happening. But who had spoken to the clinicians on the front line to say 'what is actually happening?' and 'how many of these things are you doing?' and 'what products are you using, and what are your outcomes?'.*
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> *People did not know what their litigation rates were, people did not know what their revision rates were, people didn't know where they stood against their peers. Now that is not across the board. Some people were very aware of it, and reviewed it, and examined their own practice. But in a busy world, I would not say that was the common approach across the NHS.*

And there can, Hurd says, be understandable disconnects in the conversations locally. 'So local management would be talking about productivity, and access targets, with everybody working hard to cope with all the pressures on the system, but with very little discussion on detailed clinical practice and what that was doing to outcomes, to productivity and to finances.'

In some trusts, he says, morale was really bad, with the clinicians feeling that they were not being engaged in any sort of solution:

> *They had become the workhorses to churn through the volumes to hit the waiting-list targets, and that was all. Management was not engaged with the clinical outcomes.*

So some of this is about giving clinicians the tools with which to regain an influence over their own practice that some of them feel they have lost. The most depressing visits were to places where the clinicians almost seemed to have given up hope. We'd go through their data and they'd shrug their shoulders and look at their shoes and say 'it is all too difficult, we turn up at work, do what we need to do, and go home'. That was not a regular feature. But at a handful of hospitals we found that. And those are the places that you really worry about.

So part of what we wanted to do – and not just in the worst places – was to create the common language for managers and clinicians around outcomes for patients and quality of care and the impact that has on productivity and finance. If you are starting from that point, then the productivity discussion, and the access and waiting-list discussions, become a lot easier because you are on common ground from the start. What you are trying to do is build a sustainable service for better patient outcomes.

Across the piece, there is the issue of transparency. According to the National Joint Registry, there are 20 manufacturers of hip implants, which between them offer well over 200 different types of prosthesis. When GIRFT asked what hospitals were paying for prostheses, the reply was usually the salesperson's assurance that 'you are getting the best deal in the country'. As the data on what hospitals were actually paying began to be assembled, it became clear that was anything but the case.

On the visits – and The King's Fund has been on a sprinkling of both first and second visits to produce this paper – there can be what Hurd describes as 'the grief cycle', where people do not believe the data:

But these datasets pile up. And by the end of it people are saying 'yes, it probably is a bit unreasonable that of the 12 surgeons in this unit, three of us are doing less than two of these operations a year, and maybe we should consolidate that'. Maybe it is a bit unreasonable that within Manchester you have most of the elbow replacement surgery taking place in one hospital but elsewhere people are dabbling in ones and twos and that ought to be consolidated.

I am on the board of the National Joint Registry, and it does a fantastic job of collecting a load of data and publishing some wonderful reports every year. But what is happening as a result? You need something like GIRFT to catalyse change. You can't just expect, by publishing a report, that all our surgeons will change their practice. You need someone to be out there, saying 'why are you still doing things that the Joint Registry shows are not good practice?'. And it doesn't work by sending out a letter to the chief executive, who forwards it on to the manager of their orthopaedic department who is busy doing 500 other things. It does work with senior peer-to-peer review, which hopefully should be taking place anyway, and maybe this methodology will encourage it – building it into business as usual with, a year down the road, Professor Briggs turning up again asking why we are still having the same conversation about these things that look out of kilter with best practice.

Vignettes from the visits and conversations about GIRFT

GIRFT is aimed at raising quality and saving money as a by-product, by getting it right first time. But it can also help hospitals to stay solvent. Here are some vignettes from the encounters that the programme has had.

- A clinical director in a north-west hospital at a very well-attended orthopaedic revisit says: 'We had five surgeons doing revision hips, but it is down to four and it will be three. Revision knees – we had six and that is dropping to four. We had three doing ankles and now it is two. We have had a gradual rationalisation over three years.' 'Good,' says Briggs. 'Good. But you have to do these things at greater pace.' At the same hospital, the fact that fewer surgeons are concentrating on these more complex cases has led to a much lower bill for 'loan kit'. The hospital now has the kit on the shelf.
- Briggs is adamant about a number of key issues – not least that orthopaedic beds need to be ring-fenced in order to reduce infection rates by excluding medical admissions who have not been screened for methicillin-resistant staphylococcus aureus (MRSA) and other infections. On the visits, some units variously report that they have had ring-fenced beds but have lost them from time to time under winter pressures. In the initial trawl, some 40 per cent of units did not have ring-fenced beds. 'You tell the management next time they breach the ring-fence then the whole unit closes down for a deep clean,' Briggs says. 'That will stop them doing it. We have to keep the beds ring-fenced to keep infections down. It is the essential standard needed to deliver safe, cost-effective, quality care.' One trust says that having had a visit from GIRFT has made it easier for them to defend their ring-fenced beds.
- In a trust in the east of England, a GIRFT visit led to the hospital renegotiating its implant contracts, saving around £150,000 a year, then making a similar saving from renegotiating the cost of its trauma packs. Another trust had lowered its procurement costs for hip implants after an initial visit but at a subsequent visit was still paying around £700 plus VAT for cemented prostheses. 'Still too much,' Briggs says. 'The best price in the country is £438 at Basingstoke, and I can tell you that volume is not related to price in most of the places I have been.' He goes on: 'Now, you are not putting your data for what

you are paying for your hips, your knees, your shoulders, elbows and ankles into the National Joint Registry. Now today is Thursday. Can you start doing that on Monday, please?' There is a short pause before someone says, 'Yes. Possibly not on Monday. But next week'. Once all trusts are entering that data, each will be allowed to see the other's purchasing costs, Briggs says. 'That will give us a transparency on pricing we have never had before.'

- At one trust, since its initial visit, the use of cemented hips has risen from 55 per cent to 65 per cent in people over the age of 65. 'Excellent', Briggs says. 'Keep going.'
- Part of GIRFT's aim is to improve overall productivity. It throws up issues where the coding of activity is poor, making it harder to measure outcomes and efficiency. But there are cases where poor coding is also costing individual hospitals money under the tariff. On one visit, there is a stunned moment when the consultants are challenging the validity of some of the data from the hospital episode statistics. It doesn't show what the consultants think they are doing. 'But it's your data,' Horrocks points out. 'Yes,' say the consultants. 'But the coders won't let us see it. They say it would sully the data purity.' 'But it's clear from this,' says Horrocks, 'that you have cases coded wrong. So you are losing money. That's got to change.' By contrast, at another hospital, on an orthopaedic revisit, the consultants report that they are now working much more closely with the clinical coders – producing not just more accurate coding but also a higher income for the hospital. These two examples do not necessarily lead to an overall efficiency gain – the extra money for the hospitals comes from the NHS commissioners. But they would help with the individual hospital's deficit.
- Changing practice means individual clinicians changing what they do. Some embrace this; others do not. At one trust, Briggs asks why the length of stay has suddenly come down. 'Because the one amongst us who wouldn't change has retired,' the clinical director reports, to laughter all round. 'Good,' Briggs says. 'I went to a trust where the length of stay for revision hips was 23 days. Why? Because they had a surgeon who was keeping them in bed for six weeks. Six weeks! Unbelievable. We stopped that behaviour that day. Told him that either he got his patients out of bed, or if he was worried about that, that he stopped doing the procedure.'
- Some more general lessons – which require consultant co-operation, including a willingness to work shifts at less social hours – are emerging, for example: having consultant surgeons and physicians as the first point of reference, for diagnoses that are not entirely clear, once they have been seen in accident and

emergency (A&E). Having experienced consultants rather than junior doctors do that has led to a 30 per cent reduction in admissions in some hospitals, and often fewer tests.

- Some chief executives have firmly embraced the GIRFT programme. One in the east of England says: 'It is the equivalent of free consultancy from the real experts in the field. The visits we have had have been extremely useful. But my impression is that not all chief executives go to these sessions. I wasn't able to make the first orthopaedic visit, but it definitely had an impact, and I now try to go to them all as they happen.'
- A medical director of a south of England trust says that the vascular visit 'has definitely changed what we do. But it is an ongoing thing. It doesn't happen overnight. The initial response of a clinician tends to be to rubbish the data that questions their practice. Our upper limb surgeons are still questioning the data. Our lower limb ones have bought into it and changed what they do.'
- Briggs has a particular issue with 'any qualified provider' and the use of the private sector. In orthopaedics, the data appears to show that money is being spent on arthroscopies that are not clinically indicated, in some cases because they are being contracted for by the local clinical commissioning group, by-passing the NHS trust. 'We are leaking £450 million a year in orthopaedics to the private sector,' he says, 'and we have got to compete to get that money back if we are to stay solvent. You have to get your ring-fenced beds sorted so that you can increase the elective orthopaedic activity to get that money back and spend it better.' That observation is received in silence at the meeting, with no challenge to it. But, in practice, at least some of this private work is undertaken by the surgeons themselves – as one of them acknowledges after the meeting. There is a conflict of interest here over where this work – and what type of work – is done.

So what has GIRFT achieved?

The clearest answer to the question of what GIRFT has achieved will come next year, as the programme has commissioned University College London to undertake a comprehensive study of the original orthopaedics stream (Barratt *et al* 2017). In the meantime, there are some pretty spectacular figures flying around.

Briggs on occasion has cited savings of £60 million to £90 million from the original programme, which, given its initial cost of £220,000, is an utterly remarkable rate of return. If those figures are right, one would want to buy shares in the project.

Take the cost figures first. The initial pilot was largely undertaken by Briggs and his team donating much of their time from their day jobs. When orthopaedics seemed to be producing good initial results, GIRFT was extended to 11 other surgical specialties, including vascular; general surgery; spinal; ear, nose and throat (ENT); urology; oral and maxillofacial and ophthalmology at a cost of £2.5 million and then, in November 2016, to a total of 32 specialties, including many branches of medicine as well as surgery, at a cost, over three years from 2017, of £60 million.

The big difference in costs from the original pilot is due to the programme being, so to speak, standardised and institutionalised, according to Jeremy Marlow, Executive Director of Operational Productivity at NHS Improvement, to which GIRFT has moved having initially been launched as a Department of Health project. The clinical leads – all very senior medics with good reputations – have to be paid for their time in a programme that requires yet more data analysis and will involve, as the orthopaedic pilot came to do, return visits to follow things up and check whether improvements to the service have resulted. The return visits are seen as crucial to maintaining momentum and ensuring that the programme does indeed produce results, not least where units are struggling.

The savings from the orthopaedic visits also need unpacking. The figures come chiefly from a questionnaire that the GIRFT programme circulated to 142 orthopaedic units in January 2016, to which 71 – 50 per cent – replied. They identified savings of between £20 million and £30 million since GIRFT's visit, with an additional £15 million to £20 million forecast for the succeeding 12 months. Once extrapolated out to all 142 trusts, that produces initial savings of between £40 million and £60 million, with another £30 million to £40 million to come –

although in practice there is no means of knowing whether those who replied to the survey were doing better or worse than those who did not. And those savings need dividing between those that genuinely release cash, and those where productivity gains have been 'monetised' – gains that have had a cash price put on them as a way of measuring their impact.

This is a standard way of seeking to put a value on productivity gains in the public sector – a methodology also used by the Office for National Statistics and the National Audit Office, for example. But it does mean that to understand the 'savings', there is a distinction between those that immediately release cash, and those that do not necessarily do so, even if, in the long run, they may prove to.

So, for example, procurement savings do indeed release cash – if you spend less on joint implants, or meshes for hernia repairs, or stents or pharmaceuticals, that money can be used elsewhere, spent in other ways. Many of the other savings, while they are very real in terms of using resources better, do not instantly release cash, even though some may eventually – if, for example, more procedures can be done in fewer facilities. In practice, demand usually fills the additional staff, theatre time, and beds that are released by higher productivity. Some 50 per cent of orthopaedic units are currently failing to meet the 18-week standard wait from referral to completion of care, and orthopaedics accounts for around a quarter of all surgical interventions. So the 'savings' from reduced infection rates, fewer returns to theatre, fewer revisions and so on in practice means that more patients are treated on time to a better standard, rather than that cash is being released – at least in the short term.

To treat the savings figures with some caution, however, is not to question the value of the programme. Evidence that it really is producing change on the ground includes the following.

- A long-term trend that saw uncemented hip replacements rising and cemented ones declining has been reversed. Between 2012 and 2014, the proportion of people over the age of 65 receiving cemented hips rose from 45 per cent to 55 per cent.
- Length of stay for primary hip and knee replacements has fallen by half a day, freeing up the equivalent of 50,000 bed days.
- Orthopaedics sees more litigation when things have gone wrong than any other surgical specialty, and claims had been rising over the years. In 2013/14, the number of claims rose by 8 per cent. But in 2014/15, they fell by 5 per cent, and by another 8 per cent in 2015/16.

- Three-quarters of hospitals that responded to the questionnaire referred to earlier, report that they have renegotiated their contracts for implants, achieving lower prices. GIRFT should shortly have a picture of all of the prices paid across the country, allowing even better deals to be done.
- Costs for 'loan kit' have fallen as surgeons rationalise who is doing which type of the less common procedures, and where.
- It is too soon for formal feedback from the vascular visits, but Professor Horrocks says that anecdotally he is being told of organisational changes both within hospitals and between hospitals in the deployment of both surgeons and interventional radiologists to improve the service.

Briggs is careful to state:

> *I am not saying that GIRFT is responsible for all of that, not at all. But getting out there, showing people the data, getting a discussion going between colleagues and everyone who works on the team is having a positive effect. It is changing behaviour and changing practice for the better.*

What challenges does GIRFT face?

GIRFT faces a number of challenges, not least universal buy-in. On the visits that The King's Fund joined, the number of people, and their seniority, varied widely, from a meeting with almost 40 people in the room, who included senior managers, nurses and physiotherapists, along with the chief executive – in other words, the complete team for the service – to one where just three surgeons and one relatively junior service manager turned up.

The meeting of four people was at a hospital where morale was clearly not good. The surgeons reported that many physiotherapists and nurses had moved across to agency contracts, working partly in the NHS and partly in the private sector – where in fact they were often working for NHS patients as a significant proportion of the hospital's work was being contracted out by the hospital itself to try to meet waiting-time targets. It was doing this when it was in financial trouble to a degree that was serious even by current standards. Even at this hospital, however, where the surgeons who did attend included a newly appointed one, a grizzled old hand and one in the middle, there was instant engagement with the data and a desire, on the part of these surgeons at least, to use it for improvement. This thinly attended meeting was atypical.

It was not, however, unique. On the early visits for the first round in general surgery, John Abercrombie, the clinical lead, found at one extreme that he had a meeting with six surgeons and no managers, while at the other the chief executive, chief operating officer and other senior managers were there, but no surgeons.

While the level of engagement with clinicians, and then with their managers, clearly varies, both matter. The great strength of the programme is that it is clinically led. But without management there is a limit to what it can achieve.

Some of the issues that get debated can get into decidedly granular detail that is directly in the control of clinicians – for example, precisely the best way to organise imaging equipment for vascular surgery in so-called 'hybrid' theatres where this equipment is on hand. As another example, in orthopaedics, the type of prosthesis

used, and the number of particular types of procedure that each surgeon does within a unit, are within the clinicians' control, as they are at times across units where surgeons are already working in networks.

But much also requires management action – acceptance, for example, that for a properly safe environment, ring-fenced beds are needed for both orthopaedics and vascular surgery. The consultants need enforceable agreements that medically ill patients who carry the risk of importing infection into the unit will not be admitted to these wards.

Other issues require management action within the hospital that the clinicians can advocate but not enforce – seven-day physiotherapy for joint replacement, for example. Examples cropped up where units have had that, have lost it, have got it back again, only to see it once again under threat. Or take an example from vascular surgery – avoiding operations that should be avoided. For that to happen, the vascular surgeons need an effective diabetes service that stops patients deteriorating to the point where amputations become necessary. Some of that requires action within the hospital. But it also requires a good diabetic service outside of the hospital setting, which depends on both the primary and community services that the local clinical commissioning groups, rather than the hospital, choose to buy.

And while this is clinically led, Briggs is crystal clear: 'These problems will be solved by clinicians and managers working together.' Equally, Horrocks says: 'There is a limit to what clinicians can achieve on their own. Much of this requires management engagement.'

So there is a question of bandwidth – how much time do senior managers have to engage with this amid the day-to-day task of managing hospitals under acute pressure? One possibility is that more of them will find the time as the results emerging from GIRFT show that the programme not only improves patient care but also raises productivity and saves money.

The dashboards of data confirm what has been long known and/or suspected – that infection rates fall in many surgical specialties when elective cases are placed in ring-fenced beds or in dedicated elective units into which medical emergencies who have not been screened for infection are not admitted. But that creates a challenge for the hospital: where to put the urgent and emergency medical admissions when – as is happening more often across the year rather than just over winter – the A&E service and the medical beds are overloaded? The more the evidence shows that ring-fenced beds are the answer for surgery, the harder that question becomes.

One more vignette. At the time of the first visit to a unit that covers two big hospitals with a third nearby, there was a pretty detailed plan to run one of the hospitals as a purely elective unit covering the non-emergency patients from all three sites. At the revisit, the unit's results have evidently improved since the first visit, for which Briggs is full of genuine praise. But the plan hasn't happened. 'Why not?' Briggs asks. 'No capital,' is the answer, 'it ran out' – and the third hospital resisted the change. They are still working on it. For more difficult cases, surgeons at the third hospital now operate at the larger of the two others, working with colleagues in ways that, the data shows, have improved results. But that is not the dedicated elective unit that was planned. 'You have got to find a way of ring-fencing these beds,' Briggs says. 'We know,' is the answer. It is said by a voice that does not reflect despair. It does come from someone who can't quite see how it can be done.

Then there are decisions that have to be made outside the hospital that involve either a significant reconfiguration of services or changes in what is purchased, from where, by the clinical commissioning groups – changes, in other words, that involve both clinicians and managers on more than one site and in broader parts of the health system.

There is the question of how GIRFT fits in with the sustainability and transformation plans, which, in some parts of the country, appear to have been assembled with little or no clinical input. There is also the question of how it fits in with RightCare – NHS England's drive to reduce unwarranted variation in the commissioning of services, and to seek to provide patients with better information and tools to decide on their own treatment. RightCare is focused at the commissioning end; GIRFT at the level of individual clinical practice. But, as is acknowledged in the March 2017 follow-up to the ***NHS five year forward view*** (NHS England 2017), these two quality improvement programmes require closer collaboration.

Hurd says that the GIRFT visits do indeed throw up cases where services clearly need consolidating between different institutions, and at the local level that can be politically toxic. He comments:

> *No one is saying that a visit from GIRFT will sort out the emergency configuration across a region. But GIRFT can provide evidence that feeds into the equation to help make that case. It can provide evidence that underpins what the benefits might be for a local sustainability and transformation plan. And even without that, there are still plenty of things that clinicians and managers can do locally to change the way we operate.*

It is also likely that GIRFT will prove easier to do in some specialisms than others. Both orthopaedics and vascular, for example, have national registries of activity and outcomes for either large parts of the specialty (in the case of orthopaedics) or some parts of the practice (in the case of vascular surgery). These are rich datasets on which to build comparison. Oral and maxillofacial surgery, by contrast, has no equivalent registries, and pilot visits for this workstream revealed that some hospitals with such a unit had failed to submit any data with that specialty code to the hospital episode statistics. Nonetheless, an initial dashboard of performance data has been created for the specialty and the first formal round of visits is starting. It is clear more generally that the quality of the data is crucial if it really is to drive change. Some of the more extreme figures thrown up may prove to be coding, misreporting or other errors.

Some of these challenges are being addressed as the programme evolves. In 2016, for example, a meeting of all medical directors was convened to push the programme – a gathering that all but a few attended. And as the revisits take place and Briggs finds that progress has got stuck following unproductive meetings between trusts and commissioners, he is now offering to return to help to broker deals.

On one revisit, he says: 'We need to get all the hospitals, with the managers and consultants in the room, with the local CCGs [clinical commissioning groups] and all the datasets, and come up with a plan for how we are going to drive the change that will keep the system afloat. I am more than happy to come back and do that.' He cites a similar meeting in Devon that, he says, has led to changes in the way care will be commissioned in future. 'The CCGs just need a bit of help,' he says, 'and I am happy to help you do that. We are here to help, not to be difficult.'

So what is GIRFT's potential?

GIRFT's potential is clearly considerable. For a start – whatever the suspicions ahead of a unit receiving the first of its visits – this is not a fear-inducing Care Quality Commission inspection. It is not a managerial initiative. It is clinically led, reinforcing the clinical audit that is meant to be happening anyway. It provides, in one easily accessible place, the clinical, performance and financial picture for each unit. It reveals what are, at times, frightening variations in the outcome of clinical care that no one – neither patients nor clinicians – would want to see. It harnesses the natural desire of clinicians to do the best for their patients, while providing some of the evidence and some of the tools to do precisely that.

With the evidence there for all to see, GIRFT can restart conversations with management about quality where those have slipped away, while providing additional evidence for how to improve things when those relationships are already good.

It has the advantage – as many initiatives that genuinely change things require – of a driven, forceful leader in Briggs. It is part of Lord Carter's continuing productivity drive and it has the backing of ministers, good project support, some cash behind it and the interest of the Treasury.

It now has the medical and surgical Royal Colleges, and many of the specialist societies, actively supporting it. And, based on the limited available evidence to date, it is producing real gains in procurement, in productivity and in quality, although it will be a while before the full picture around all three of these emerges. More robust data that shows it to be having a real impact is likely to increase its uptake in the less enthusiastic parts of the NHS.

GIRFT's potential also lies in it being a methodology for decidedly local improvement. When the £22 billion of productivity savings that the NHS is required to make by 2020/21 are discussed, it tends to be the big initiatives that attract the headlines – the sustainability and transformation plans; capping and cutting the agency staff bill; the attempts at big, centralised, procurement savings or back-office rationalisations. But, as The King's Fund argued in its ***Better value in the NHS*** report in 2015 (Alderwick *et al* 2015), changes to clinical practice also have a crucial part to play. Peter Hyman, one of Tony Blair's special advisers, in a different context (education), commented that 'real "delivery" is about the grind,

not just the grand' (Hyman 2005, p 384), and as argued in ***Better value in the NHS***, 'it is the accumulation of many small improvements over time that matters, rather than the futile quest for a giant leap forward' (Alderwick *et al* 2015, p 5).

GIRFT offers a means to do that, moving beyond the issuance of guidance, or best practice pathways, or other forms of exhortation or audit. It can lead to practical discussions, unit by unit across the country, on the means to raise quality, and thus save money locally, with that then being followed up. It may not be the stuff of headlines. But it may well be a route to some real gains.

For it to succeed, however, requires not just the clinical engagement that – with some notable exceptions – appears often to be produced by the presentation of GIRFT data, but also the managerial engagement and action that is there in some places, but is clearly missing in others. And it will need to be sustained.

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About the author and acknowledgements

About the author

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He is also the author of *The five giants: a biography of the welfare state,* a full updated third edition of which is due out in October 2017.

Between 1996 and 2012 Nick was public policy editor and commentator at the *Financial Times* and is also a visiting professor in social care at the London School of Economics and in public management at King's College, London. He was president of the Social Policy Association between 2008 and 2011 and is also an honorary Fellow of the Royal College of Physicians.

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