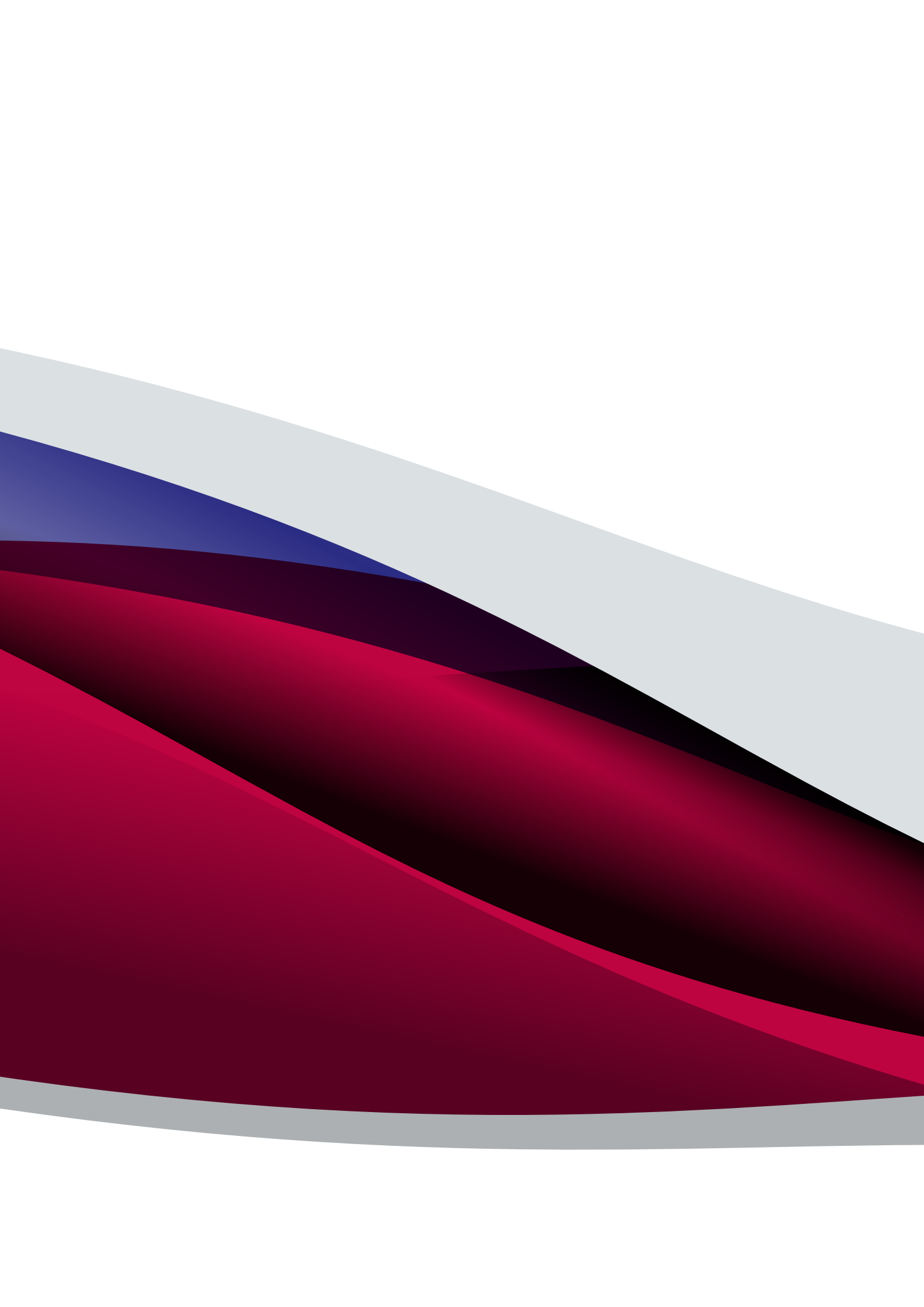


THE GETTING IT RIGHT FIRST TIME PROGRAMME

**Early views from
the provider sector**



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Early views from the provider sector

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KEY POINTS

- NHS trusts support the *Getting it right first time* (GIRFT) programme and, overall, their experiences and early engagement with the central and regional teams have been positive.
- Trusts value the GIRFT programme for its clear emphasis on quality improvement, clinical engagement and better outcomes for patients. An open and constructive dialogue will be an important cultural determinant of the programme's credibility with clinicians.
- Trusts welcome that the GIRFT programme is a data driven collaboration between trusts and the national level. Clinical engagement is most effective when data and analysis have been presented as the beginning of a conversation with clinicians, rather than as the 'final word' on performance.
- Refining datasets to capture the most important and meaningful metrics will be important, particularly in clinical specialties where current datasets are insufficiently granular to support nuanced debate about unwarranted variation. Specialties with less developed datasets, especially mental health, will require significant co-production with trusts before analysis can offer meaningful insight.
- However, we need to recognise that data is only the starting point in a complex process to eliminate unwarranted clinical variation. Trusts report that while the GIRFT data is a good starting point for the conversation, more work is required to actually identify why the variation exists; establish what is warranted and what is unwarranted, agree how to tackle this, deliver the changes to clinical practice required and unlock the savings originally identified.
- The GIRFT programme aims to save around £1.4bn per year by 2020/21, which equals just over a quarter of the financial gap facing the NHS by 2020/21. However, caution is required when using headline financial savings. National bodies must set savings targets that are realistic and which take in to account the complex factors affecting the pace by which trusts can eliminate unwarranted variation. While trusts are fully committed to implementing the programme, our view is that the sector will struggle to deliver all the savings identified within the expected timescales due to the complexity of the change process required and multiple dependencies linked to this.
- The NHS continues to deliver productivity improvements that significantly outperform historic trends and the wider economy; the GIRFT programme must act as an enabler for those efforts and compliment the existing productivity efforts that are underway.
- Trusts wish to avoid at all costs the GIRFT data and approach being used as a regulatory tool. Any punitive use of GIRFT will undermine the objective and judgement free approach which has underpinned the programme to date. Our view is that regulatory levers would do little to increase the scale and pace of savings delivered, and at the same time would erode the clinical buy in required for this work to succeed.

INTRODUCTION

This briefing provides an overview of the *Getting it right first time* (GIRFT) programme, a partnership between the NHS Royal National Orthopaedic Hospital Trust and NHS Improvement, to support NHS foundation trusts and trusts to improve care quality and increase operational productivity by reducing unwarranted variation in care. The programme encompasses 35 clinical and medical specialties delivered in acute hospitals, with work underway to expand into mental health services.

In August 2017, we set out our early views on the GIRFT programme, which had developed from initial feedback and issues raised in discussions with senior leaders from our member NHS foundation trusts and trusts. In this we highlighted:

- the necessity – and difficulty – of distinguishing between warranted and unwarranted variation, given a range of factors, including geography, case mix, and staffing profiles
- the need for more rich and detailed data to gain true insight into variation than is currently available for most clinical specialties
- while data is a good starting point to discuss tackling unwarranted clinical variation, it is only one step in a complex process to identify why the variation exists, establish whether it is warranted or unwarranted, agree what needs to be done to reduce the unwarranted variation, put in place a change programme to support this, deliver the necessary changes to clinical practice and unlock the savings required; the critical importance of a true partnership approach from the GIRFT team to ensure front-line clinical engagement and collaboration in devising solutions to reduce unwarranted variation
- the significant resource implications for staff to participate properly in GIRFT, and for trusts to respond appropriately to reduce variation and deliver improvement
- the fact that even the best-case scenario for GIRFT-related savings and productivity outcomes offer a small proportion of the estimated funding shortfall for the NHS by 2020/21. The NHS will still need significant investment to successfully implement the GIRFT programme, at a time of significant operational challenge.

This briefing offers further exploration of these issues, through trusts' views on the GIRFT programme and how the wider health and care system can ensure that GIRFT's ambitions are realised in a sustainable and clinically-led way. It has been informed by senior trust leaders' feedback about their experience so far working with the programme and its national leadership team. We held telephone interviews with 11 senior clinical, operational and financial staff and received written views from six trusts. We also held a roundtable of 25 trusts with NHS Improvement to discuss operational productivity in the context of the Carter review, on 20 September 2017, that was attended by board-level representatives from across acute, specialist, mental health and community trusts.

The first part of the briefing offers an overview of the GIRFT programme's origins and structure, the GIRFT methodology and implementation. The second part explores trusts' perspectives on the programme, and our recommendations for trusts and national bodies to help ensure the programme can embed and succeed as a sustainable contribution to clinical quality improvement.

OVERVIEW OF THE GIRFT PROGRAMME

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The GIRFT programme commenced as a national programme in November 2016, building on the original work of consultant orthopaedic surgeon Professor Tim Briggs who pioneered the programme in orthopaedics.

The GIRFT programme is one element of the government's response to the recommendations of Lord Carter's *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* report, published in June 2015. In that report, Lord Carter examined data from all acute trusts in England and developed eight headline recommendations across clinical and non-clinical domains designed to reduce unwarranted variation in the delivery of care. The first recommendation was to develop an efficiency metric for NHS providers to use, to review performance against their peers and create a baseline for improvement. The GIRFT programme's use of benchmarking trusts to identify variance in performance is a practical manifestation of this approach. Whilst the programme is not formally mandatory for trusts to participate in, trusts are strongly encouraged to be involved.

The GIRFT programme's work covers 35 surgical and medical specialties, of which 25 have commenced, along with six cross cutting work streams (table 1). The remaining specialties will begin in waves from summer 2018. There are currently 150 trusts participating in the GIRFT reviews, and all hospitals in England will be approached to take part. Following the publication of the GIRFT national general surgery report in August 2017, vascular surgery is the next GIRFT national report, due in February 2018.

The mental health services stream within the medical specialties is in very early development, but the programme will be looking to reduce out of area placements and unwarranted variation in quality in three areas:

- adult mental health acute and crisis care services
- children and young people's mental health services including Tier 4 CAMHS
- long-term complex care and locked rehabilitation wards.

The programme doesn't currently apply to community and ambulance trusts.

Table 1
The GIRFT programme's work streams

Surgical specialties	Medical specialties	Clinical services	Cross cutting areas
Breast surgery	Acute and general medicine	Imaging and radiology	Medicines optimisation
Cardiothoracic surgery	Anaesthesia and perioperative medicine	Intensive and critical care	Frailty and brain conditions
Cranial neurosurgery	Cardiology	Outpatients	Litigation
Ear, nose and throat	Dermatology	Pathology	Policy levers
General surgery	Diabetes		Procurement
Obstetrics and gynaecology	Emergency medicine		Surgical site infection audit
Ophthalmology surgery	Endocrinology		
Oral and maxillofacial	Gastroenterology		
Orthopaedic	Geriatric medicine		
Paediatric	Hospital dentistry		
Plastic surgery and burns	Mental health		
Spinal surgery	Neurology		
Trauma surgery	Renal medicine		
Urology surgery	Respiratory		
Vascular surgery	Rheumatology		
	Stroke		

Funding and projected returns

GIRFT is supported with £60m of funding from the Department of Health and Social Care (the department) but is part of NHS Improvement's operational productivity programme, as one of eleven sub-programmes designed to support all NHS Trusts to deliver increased productivity, reduce unwarranted variation and improve quality of services.

A detailed independent review of the original GIRFT orthopaedic programme is also currently underway led by University College London, due to conclude in December 2018.

The GIRFT programme is one of the key pillars of the NHS operational productivity programme. NHS Improvement aims to generate between £1bn and £1.8bn of productivity gains in 2017/18, with an overall productivity saving target of £6bn by 2020/21. Of this, the GIRFT programme is aiming to deliver between £240m to £420m in 2017/18 and £1.4bn per year by 2020/21. Out of the areas currently identified by NHS Improvement, the GIRFT programme has one of the most ambitious savings target attached to it – the proposed savings identified, for example, are larger than identified savings from E-rostering and more effective job planning.

Although the projected GIRFT savings could account for just over a quarter of the financial gap facing the NHS by 2020/21, caution is required when interpreting any headline financial savings taken which have been extrapolated from top-level benchmarking data from trusts. Furthermore, identifying the savings does not automatically incentivise the changes required on the ground to achieve them. There is complex work required to agree how to tackle the underlying factors, deliver the changes to clinical practice required, and release cash savings or – more feasibly, improve the overall productivity of current resource allocations. This work takes time and must be achieved in consideration of matters specific to local contexts, such as the implications of fixed and variable costs.

It is also important to recognise that trusts are already actively engaged in efforts to reduce unwarranted variation, drive out wasteful spending and deliver savings. NHS trusts already achieved £3.1bn of savings through cost improvement programmes (CIPs) in 2016/17, £200m more than in 2015/16. The NHS is also currently outperforming its historic productivity, as well as recent UK economy productivity. The University of York calculated that productivity increased across the NHS by an average of 1.7% a year between 2009/10 and 2014/15, above the long-run average for the NHS of 0.9% and above recent whole economy productivity of 0.4% a year.

The NHS has a strong track record of delivering savings and efficiencies, as evidenced by work over the past seven years since the NHS budget has been under substantial pressure. In this way, the GIRFT programme should be seen as building on existing initiatives and efforts across the sector to unlock efficiency savings, with the key difference being the type of national support and focus put into the programme and the primacy of clinical engagement.

Leadership and structure

Delivery of the GIRFT programme is a partnership approach between the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement. An executive team is jointly led by Professor Tim Briggs, as chair of GIRFT and NHS Improvement's national director of clinical quality and efficiency, Dr Jeremy Marlow, executive director of operational productivity, NHS Improvement, and Rob Hurd, chief executive of the Royal National Orthopaedic Hospital NHS Trust, as joint senior responsible officers of the programme

Each clinical specialty has a national lead with responsibility for managing a national review of their specialty, visiting every trust that undertake that service. There are currently 41 appointed clinical leads and advisors. The majority of clinical leads have been recruited with assistance from their specialty's Royal College or professional society.

Seven GIRFT regional hubs headed by implementation managers will function as centres from which clinical and project delivery leads can support and advise on delivering recommendations emerging from the clinical lead visits. In addition, the GIRFT regional hubs will support the implementation of the national report recommendations into local practice.

Operation

We outline below the main processes that take place when a clinical specialty is reviewed as part of the GIRFT Programme.

Methodology and six-phase implementation process at trust level

Phase 1 – preparation: GIRFT specialty clinical leads examine trust data looking for unwarranted variations; differences between trusts in areas such as effective procedures, length of hospital stay, infection rates and costs. The GIRFT team analyses data from multiple data sources, including hospital episode statistics, NHS Litigation Authority, and relevant data streams for each clinical area including registry and professional body data.

Phase 2 – data pack distribution: A bespoke data pack is produced for each trust delivering the specialty under review. This helps clinicians and managers understand what the variations are, what needs to be done to address them and explore the challenges they face.

Phase 3 – clinical lead visits: The GIRFT clinical lead undertakes a number of 'deep dive' visits to present the trust report and discuss the data with the hospital team. GIRFT regional hubs aid trusts with interpreting their datasets, building and delivering the implementation plans.

Phase 4 – national report publication: After at least 40 trust reviews have been completed for a clinical specialty, the emerging trends from the visits to trusts and analysis of datasets enable the lead clinician to write a national report. The national report presents the original benchmark data, GIRFT’s findings, examples of best practice, and an action plan of proposed changes and improvements, supported by an implementation programme. Where appropriate, these national recommendations are added to trust implementation plans.

Phase 5 – data refresh: Core GIRFT data will be updated on an annual basis to enable trusts to monitor progress and, where necessary, reprioritise implementation efforts. The GIRFT analytics team refreshes and re-issues the trust data packs, and the specialty clinical leads revisit trusts.

Phase 6 – transition to business as usual: Regional hub teams support trusts to complete actions in the implementation plans and transition improvements into business as usual. Across the programme, more than 1,000 ‘deep dive’ visits to around 150 trusts have taken place so far.

The first specialty report of the new programme, covering general surgery, was published in August 2017, with the vascular surgery report due in February 2018. Of the GIRFT reviews currently underway, cranial neurosurgery, cardiothoracic surgery and urology are the most advanced and therefore closest to the publication of their respective national reports.

As noted earlier, each trust will work with regional GIRFT teams to develop an implementation plan in a given specialty. This will be informed by the relevant national specialty report as well as the local GIRFT review. The implementation plan will be updated on a rolling basis by the GIRFT regional team to ensure alignment with relevant national initiatives including NHS RightCare (NHS England’s national programme for reducing unwarranted variation in commissioning) and sustainability and transformation partnerships (STPs). The model hospital portal – an NHS Improvement tool that allows users to compare productivity, quality and responsiveness data, an approach which emerged from the Carter review – will act as the gateway for accessing GIRFT information for all providers and commissioners.

Timescales

NHS Improvement expect that clinical specialty reviews take between 6-24 months depending on size of the workstream. It is anticipated that the average workstream will take 36 months from initiation to ‘business as usual’ activity at the trust. If the final wave of specialty reviews start in the summer of 2018, all workstreams are projected to be ‘business as usual’ across all trusts by March 2021, though it is recognised that formal support for GIRFT may need to extend longer than this timeframe if roll-out takes longer than planned.

TRUST PERSPECTIVES ON THE GIRFT PROGRAMME

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The value of the GIRFT programme

Our engagement with trusts has indicated that trusts recognise there is significant potential for GIRFT to enable both clinical quality and operational productivity improvements.

"The GIRFT programme is a major advance in clinically-led, clinically interpreted benchmarking. It is delivered in a non-partisan manner by experienced clinicians who do know the breadth and depth of the work that is being discussed and can bring a wealth of information gained from visiting all the other sites in England delivering that same service."

Chief Executive, teaching hospital

Trusts have seen benefits from the GIRFT approach in terms of reinforcing arguments locally, supporting their case for change.

"GIRFT has been useful in supporting our orthopaedic argument, for example, that beds for those recovering from orthopaedic surgery need to be protected and not released back in to general use. GIRFT data highlighted the potential costs involved of not doing this."

Deputy Chief Operating Officer, acute hospital

Some early beneficial impacts reported by trusts included:

- centralisation of surgical activity, creating centres of excellence
- more uniformity in purchasing of goods and supplies
- positive impact on orthopaedics waiting list management
- encouraging and supporting clinicians to improve the delivery rate of certain procedures, on the basis of benchmark performance data
- improving coding and facilitating better conversations between clinicians and coders, and therefore helping to develop a more solid evidence base for the relevant clinical pathways.

Engagement with the GIRFT team

Trusts generally felt that their involvement with the GIRFT programme so far has been a helpful enabler of clinical engagement, and was therefore supporting them to make progress on operational productivity improvements.

The credibility of the programme's clinical leads is vital to securing engagement and challenging longstanding clinical variation. It is important to stress that trusts recognised a strong desire in their senior clinical workforce to improve their practice and deliver gains in quality and cost. However, the GIRFT programme's data must be matched with sound and authoritative clinical judgment which clinicians can engage with, question, and debate.

Early feedback on the effectiveness of the specialty leads is positive, but continued attention should be given to the recruitment, retention and support of what will be, at times, a very challenging role. Alongside the usefulness of visits from the clinical lead, the wider engagement of the GIRFT programme with the relevant professional associations and medical royal colleges is a vital driver of successful clinical engagement. Trusts have frequently reported that the breadth and depth of support from clinical communities for the GIRFT programme has been indispensable for engaging their local workforce in the programme.

Given the importance of GIRFT to the aggregate operational productivity savings identified by NHS Improvement, it is critical the programme is also an iterative process, focusing on the ongoing lessons learnt from the individual reviews, as more specialties are reviewed and move into the implementation phase.

Building and sustaining strong clinical engagement

Clinical engagement was helped by two distinct features of the GIRFT programme. Firstly, the degree of organisational independence the programme appears to have from NHS Improvement and other national operational productivity initiatives.

“The peer-to-peer element provides clinical engagement which is very valuable and in conjunction with benchmarking can generate a real spur to change from the clinical body itself, often otherwise hard to achieve.”

Medical Director, district general hospital trust

It was also frequently reported that previous engagement with NHS Improvement and other bodies under the auspices of the Carter programme of work was driven by a narrative of cost savings. The GIRFT programme’s approach of focusing on quality first was significantly more effective in engaging clinicians than focusing on cost savings.

Realising the benefits of the programme is contingent first and foremost on maintaining the prioritisation of clinical leadership and engagement. This is based in confidence from and in the GIRFT programme team and the wider system that there is genuine willingness on the part of trusts and their clinicians to improve when the evidence indicates that there is scope for improvement.

In addition, while the clinical leadership of the GIRFT process is essential, for it to embed across the trust culturally and operationally, early and sustained communication between the GIRFT team and relevant trust directors is essential. Trusts are keen to work with NHS Improvement and the GIRFT programme to ensure that vital clinical improvements are embedded and sustained beyond the duration of the formal GIRFT programme to March 2021.

THE CHALLENGES OF THE GIRFT PROGRAMME

4

The complexity of the work

The process of identifying what is warranted vs unwarranted variation, right through to actually changing clinical practice and unlocking savings is an inherently complex and resource intensive process. The scale of the change management and clinical input required should not be underestimated.

Trusts tell us that although they are actively wishing to engage with the GIRFT programme, they are working in an increasingly pressured and fragile environment, with widespread operational and workforce challenges. They are therefore finding it difficult to consistently enable the frequency, quality, and depth of discussions and follow up work needed, given the time and complexity involved. Furthermore, participating in GIRFT requires a significant investment of time from clinicians, senior medical leaders and other board-level staff, such as financial and operational directors. Trusts tell us that they sometimes struggle to provide sufficient time for senior management to support the programme's implementation given the competing pressures currently faced.

The GIRFT programme must also take into account the reality that not all unwarranted variation can be tackled due to locally specific circumstances. Variation exists across the provider sector in terms of centrally controlled funding and payment activity, which has a knock-on impact on the quality and productivity of a trust's services:

"The hospital in which I work has a lower-level funding per unit of activity than nearly all other NHS hospitals... which largely reflects factors without any real-world justification, and which creates a postcode lottery which is centrally determined."

Medical Director, district general hospital trust

Changing clinical practice

Trusts widely commented that embedding clinical practice will take time, and there are a number of very legitimate reasons why it might be an iterative process.

For example, implementing changes to clinical practice will require substantial re-training in many cases, and in the interim might lead to short term error-rates increase as clinicians embed new techniques. There might also be a legitimate argument, in the current climate, to focus on stabilising performance before attempting to change clinical practice which, in the short time, might undermine performance further.

Unlocking savings

Unlocking the savings identified through headline benchmarking metrics is an inherently complex process. There will be a whole host of factors which mean that trusts might take a substantial amount of time to unlock these, perhaps because clinical reconfiguration might be required, or that trusts might not be able to realise the full scale of savings earmarked.

The extrapolation of cash savings from top level benchmark data should be treated with caution, as trust feedback on GIRFT recommendations suggests that in many cases upfront investment will be required to deliver changes where the GIRFT data indicates they are warranted – for example to staff rostering, diagnostics and facilities.

“We had already delivered the main savings they [the GIRFT team] identified on length of stay. They also made some very expensive recommendations for capital upgrades, which we’ve not been able to progress.”

Chief Operating Officer, district general hospital trust

Validity of the GIRFT programme data

Trusts explained that there can be significant issues with the quality of data being produced by the central team to inform conversations with trusts. For example, by using old and historical data as the starting point for conversations with local clinicians, it is difficult for the trust to challenge the GIRFT team’s view that significant service improvements have occurred in the time since. This can mean that, unless the GIRFT team acknowledges this shortcoming explicitly in their engagement, initial conversations with clinicians may be less productive.

“In many cases the data was two years old and therefore resulted in conversation regarding historical practice. In many cases the problems had been resolved. The historical nature would also allow obfuscation, as claims to a much improved current position could not be challenged.”

Medical Director, large regional hospital trust

Data quality challenges can also inhibit the triangulation of financial and clinical datasets needed to interrogate sources of variation locally.

“Perhaps the biggest variation was within the data, making clinical and financial comparisons impossible. This was driven by a variety of counting and contractual variations with different units counting clinical activity in different ways. The conversation was spent on explaining the apparent statistical variation rather than on clinical variation.”

Medical Director, large regional hospital trust

Where substantive concerns over the data existed, clinical engagement was more challenging to secure and the outputs from the GIRFT programme were less useful in informing trusts' operational plans. Clearly, the appropriate selection, use and maintenance of data in the GIRFT programme are important for establishing the programme's credibility with clinicians at the outset.

"We have had five or six visits. They have mostly been either helpful or neutral. The ones which were neutral were because the lead clinicians or the team were not sufficiently aware of the detail underpinning the data, and so couldn't answer questions about what it incorporated. Having said that, it has been a good start in most areas and we have found it helpful and welcome the process continuing to mature and more reliable data coming from it."

Chief Operating Officer, teaching hospital

Some trusts had concerns over how valid the GIRFT programme's analysis could be in those clinical specialties which have limited robust datasets to work with. In those specialties a primary data capture may be required in the future; this would place a potentially significant burden on involved trusts.

"The interpretation of the data is influenced by the views of the attending expert. On occasion this has been contrary to the views of the majority of the clinical team. The programme should concentrate on procedures and interventions that have a clear evidence base and a national consensus view."

Medical Director, teaching hospital

However, it is important to recognise that too much data could obscure clarity of insight into performance and inhibit change on the ground. Some trusts felt that there were almost too many GIRFT datasets, and were concerned about retaining focus on the most impactful metrics alone. Given the developmental stage of the GIRFT datasets, it is also essential for the programme's ongoing credibility with trusts that GIRFT data is used in a non-judgemental way.

The data packs generated by GIRFT must be seen as the starting point in a conversation with trusts rather than the authoritative position, until such time that confidence across the trusts is established in the datasets and the timeliness of the data included. It is also important that GIRFT provides value for trusts in terms of the diagnostic tools to help trusts deliver clinical change off the back of the analysis, so they are 'closing the loop' – without this assistance, for many organisations GIRFT will continue to feel like 'feeding the beast' with insufficient return on the effort it takes to do it.

RECOMMENDATIONS FOR THE GIRFT PROGRAMME

5

Alignment with existing trust activities

Trusts are engaged in a range of initiatives to improve quality and improve operational efficiency that predate the GIRFT programme and indeed the Carter review. This has two important consequences.

First, trusts are delivering existing improvement programmes that are likely pursuing related but distinct goals from those that may be highlighted by the GIRFT programme. For example, there are acute care collaboration vanguard projects which seek to improve the quality of clinical services across a grouping of providers. Some trusts are already using GIRFT data as one of a number of sources to inform specialty reviews undertaken as part of their business planning process. It should be up to trusts to determine how to integrate the work of GIRFT into existing business as usual activities to make best use of the data and intelligence provided. In addition, the GIRFT programme should work with trusts to ensure that any new implementation plans developed locally are fully aligned with existing trust plans to deliver improvements in operational productivity. Where appropriate, GIRFT recommendations that go with the grain of existing improvement plans in trusts will increase the likelihood of delivering long term transformation.

Second, senior operational colleagues in trusts will have detailed knowledge of the particular challenges their trust faces in improving operational productivity. While clinical leadership of the GIRFT process is essential, the GIRFT team must make the fullest possible use of the contextual knowledge the trust's executive team can provide.

Aligning with system level plans

The programme has started to develop beyond an initial trust by trust review, to one which brings trusts within an STP together, either instigated by the STP in question or required by the specialty under review.

This will work for some STPs but not all, and it should be up to individual trusts and partners to decide the best forum to take the work forward. In some instances, it will be a logical direction of travel given that eliminating unwarranted variation will require system level not just individual trust level change. But, for other trusts, focusing on eliminating clinical variation within a single organisation first might be a better place to start.

Alignment with existing programmes and the national bodies

Given the significant burden on the capacity of trust clinical and operational staff, it is vital that the GIRFT programme avoids duplication and is aligned with existing improvement programmes at any given trust. More broadly, the national level collaboration agreements

that are to be put in place between the GIRFT programme and NHS England, RightCare, NHS Benchmarking and NICE must set out in clear terms the responsibilities of each body and initiative.

Realism on pace of change and scale of opportunities

Trusts are doing all they can to deliver unprecedented improvements in operational productivity, and are committed to continuing these efforts. However, the significant lead times for more complex improvements need to be acknowledged. For example, operational productivity improvements that require closing, opening or repurposing estate are not likely to be realised in the short-term, and may require significant capital investment that remains difficult for trusts to access. This reality may stymie progress in a number of clinical specialties, and the GIRFT programme team will secure the confidence of trusts and clinicians if they clearly communicate their awareness of the macro environment trusts operate in.

For example, before conducting any analysis of the performance of a given specialty within a trust, it would be helpful if the GIRFT programme was aware of the relevant productivity and transformation programmes already taking place. The review would help GIRFT understand the specific contextual challenges and opportunities facing the trust, and would enable them to tailor their engagement and analysis appropriately.

The central team has acknowledged that some of the changes necessitated by a full implementation of a specialty review might require substantial clinical reconfiguration which might fundamentally alter change the business and workforce model for a particular trust, for example the creation of a hot and cold site for non-elective and elective work.

This might improve the overall provision of care in the wider health and care economy and savings might also flow to the system. However, individual trusts will typically have fixed-costs which can not be switched off immediately – investment and/or double running might be required. Given the unprecedented financial constraints operating in the provider sector, many trusts would struggle to absorb this cost pressure.

In addition, realism is required on the scale of the operational productivity improvements the GIRFT programme can unlock. There are methodological challenges involved in disaggregating the impact of the GIRFT programme from the existing work of trusts to improve operational productivity; there is a risk, then, of overestimating the headline savings available and placing an unrealistic target on the provider sector.

Support

Analytical support

Trusts frequently reported that they struggled to find the analytical capacity to make the fullest possible use of the data produced by the GIRFT programme. In some areas there may be a gap between the analysis presented in the local trust GIRFT report and the practical implementation support needed to deliver clinical change. As the GIRFT programme in a given clinical specialty moves into the implementation phase, the regional hubs should develop and tailor their support offer directly to the individual needs of trusts.

The GIRFT programme's analysis is being used by some partners in the local health and care economy to understand the financial implications and opportunities of reconfiguration options at the STP level. Where GIRFT data is used to inform STP level plans, additional analysis capacity should be provided by the programme to enable the development of a robust, shared set of financial assumptions.

Wider support

The general view from trusts is that they faced a shortage of clinical and management capacity to take some of the GIRFT recommendations forward. Consideration should be given, for example, as to whether NHS Improvement and the regional teams could support in providing or backfilling staff so that clinicians and managers are able to lead the local delivery of the programme.

The GIRFT programme is usefully focused on enabling sustainable improvements in trusts that will embed in their 'business as usual' working practices. The GIRFT programme's regional hubs should focus on supporting capability building within a trust, as well as additional implementation capacity. At the most light-touch level, this might look like the creation of toolkits, process guides, and the sharing of best practice between trusts.

Support rather than regulatory tool

There may be a temptation by NHS Improvement to consider the regulatory levers at their disposal, if providers are unable to unlock savings at the scale and pace expected, in an attempt to accelerate change. This would be entirely counterproductive.

"GIRFT must not lose sight of the difficulties of local variation, and not become a stick with which to beat trusts. We have numerous challenges arising from disparate sites, recruitment challenges due to geography, and therefore we need to accept that changes will take time and might require structural and system wide solutions."

Finance Director, acute trust

There are already issues and risks with the model hospital – which the GIRFT data is starting to feed in to – being used for a regulatory purpose to underpin the Care Quality Commission’s use of resources assessment. The true value in the model hospital lies in the transparency of data benchmarking offered to trusts, and overly relying on it to exercise a regulatory judgement might undermine this. To add another regulatory lever in an attempt to accelerate change would undermine one of the key benefits of the programme, which is that it is intended to be non-judgemental. Embedding change can only work fully if owned and implemented at a local level, rather than being imposed or mandated on trusts.

REFLECTIONS FOR TRUSTS

Doing things differently

Trusts now have access to an increasing range of data sources that can help them to reshape the care they provide, including GIRFT, the NHS Benchmarking Network, RightCare and the Model Hospital. There are recognised challenges with reliability and validity within the datasets relating to interpretation of definitions and trusts' coding practices but the clinical engagement and reflection on best practice that the GIRFT process is unlocking across the sector is creating strong opportunities to deliver tangible improvements in patient outcomes. Trusts have told us that they are positive about the potential for GIRFT data and further respectful, constructive clinical engagement to drive change.

We heard about early successes and improvements made in trusts that have used the GIRFT programme data to develop stretching plans to deliver improvements. As NHS Improvement develops its implementation support as part of the GIRFT programme, it is vital for trusts to engage and shape this work through providing regular feedback to regional teams. The programme is in an early stage and therefore it is crucial that trust perspectives and views shape its rollout.

Understanding value and patient outcomes

Trusts are charged by the national health bodies with delivering improvements in quality while controlling or reducing costs. NHS providers have demonstrated time and time again that, when given the appropriate support, they are capable of securing impressive improvements in operational productivity while maintaining high standards of patient care. It is understandable that trusts have sometimes regarded quality improvement and cost control as being in tension. One of the central premises of the GIRFT programme, however, is that improving clinical quality also tends to reduce costs for the relevant health and care system.

It is important that trusts are able to quantify the 'value' they add for a patient; the health outcomes achieved, relative to the cost of achieving those outcomes. As indicated by the increasing adoption of patient level information costing systems (PLICS) by trusts, providers are actively developing more detailed understandings of the health outcomes they achieve and the costs of achieving them.

Nonetheless, trusts should continue to make every effort to ensure they have the costing and coding resources, financial information systems, analysis capacity and strategic focus required to continue to deliver high quality care while improving operational productivity.

Aligning with other programmes of work

The inputs and outputs of the GIRFT programme should as far as possible be integrated within existing programmes of work rather than viewed as a programme in isolation. It is well known that trusts are under considerable pressure, facing capacity constraints to deliver on all the requirements expected of them locally and nationally, and at the same time, project management and change management resources are at a premium. The trusts we spoke to raised the importance of integrating the GIRFT programme within business as usual outputs as much as possible, such as clinical service strategy reviews and cost improvement programmes. That way the programme can accelerate existing programmes of work.

Some trusts are establishing a central corporate coordinating function for following up with clinical specialties on their implementation plans. In some places these teams are coordinating trust resources for both GIRFT derived and wider operational productivity programmes.

CONCLUSION

NHS trusts continue to deliver productivity improvements that significantly outperform the historic NHS trend and the wider economy. As the early feedback in this briefing shows, NHS providers remain committed to addressing unwarranted variation in care where it can be identified. While we are yet to enter the implementation phase in the majority of the clinical specialties addressed by the GIRFT programme, it is positive that the programme's clinical engagement has thus far been experienced by trusts as respectful and constructive. As a programme focused on supporting clinicians and trusts to tackle complex challenges, this is essential.

Despite the additional revenue funding announced in the November 2017 budget, there remains a fundamental mismatch between the funding available to providers and the costs they incur delivering high-quality care. The GIRFT programme is forecast to generate £1.5bn in efficiency savings annually by 2020/21, making a key contribution to the aggregate provider efficiency challenge, however this alone will fall significantly short from closing the financial gap.

Given the scale of savings the GIRFT programme is expected to help realise, careful monitoring of its progress is required, particularly as it progresses into the clinical specialties that have limited or poor quality data available. It would be wrong to undermine the potential of the GIRFT programme by placing unrealistic financial expectations on the clinicians and trusts, or by holding trust finances 'hostage to fortune' on GIRFT outcomes.

Clinical quality improvement must remain the focal point and driver of the GIRFT programme. Clinical engagement is most effectively engaged when data and analysis are presented as the beginning of a conversation with clinicians, rather than as the 'final word' on performance.

Finally, trusts felt that the GIRFT programme's data and analysis should not be used as a regulatory lever. Using the data to make regulatory judgment on trusts, when it does not present a clear and consistent picture across the provider sector, could undermine the programme's positive impact as a galvanising force for clinical quality improvement.

Contact

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