Getting It Right First Time (GIRFT) – How can we improve patient care through a critical review of treatment services?

Tim Briggs, GIRFT programme lead and NHS England National Director for Clinical Improvement, Elective Recovery and UEC

Sundhedsvæsenets Kvalitetsinstitut

GIRFT
GETTING IT RIGHT FIRST TIME

NHS England



Getting it right first time (GIRFT)

Sundhedsvæsenets Kvalitetskonference 2026

Wednesday 28th October 2026 15:30



Professor Tim Briggs CBE

GIRFT Programme Lead

NHS England National Director for Clinical Improvement, Elective Recovery and UEC

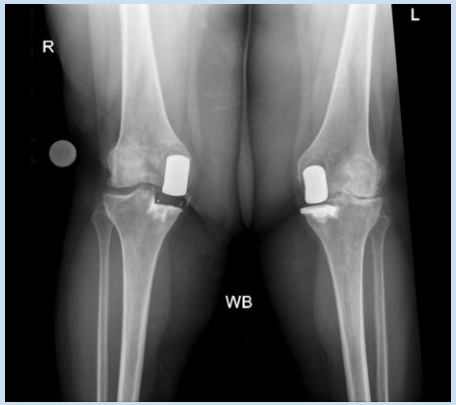
United Kingdom and Denmark: key data

	United Kingdom	Denmark
Population	**~ 69.7 million**	**~ 6 million**
Percentage of population aged 65yrs+ by 2030	**21 – 22%** **15.5 million people*** *of estimated population of 71.2 million	**22.5%** **1.37 million people*** of estimated population of 6.08 million
Annual spend on healthcare per annum	DKK 3.08 trillion **£345 billion** €411.6 billion	**DKK 278 billion** £31.2 billion €37.2 billion
Annual spend of healthcare per person	DKK 44,289 **£4,966** €5,925	**DKK 47,100** £5,281 €6,301
National debt	**£3.72 trillion** 94% of GDP	**DKK 857.4 billion** 27.1% of GDP



65yrs age OA hip





45yrsage

Med uni 3 yrs ago
X2 rev fixed bearing

Med uni 1yr ago

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The **GIRFT** methodology was conceived and developed by consultant orthopaedic surgeon Professor Tim Briggs in 2012 who undertook a pilot review of elective orthopaedic surgery to address a range of observed and undesirable variations in practice.

In the 12 months after the pilot programme, it delivered an estimated **£30m to £50m savings** in orthopaedic care – predominantly through addressing unwarranted variation and reducing average length of stay.

Professor Briggs was appointed to lead the programme for the NHS, working with frontline senior clinicians across surgical and medical specialties and cross-cutting areas.

Simple methodology: clinically-led, data-driven

Clinically led:

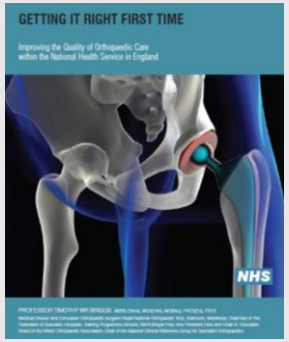
- Past President of the British Orthopaedic Association
- Peer-to-peer review
- data shared, and then we visit clinicians and senior managers:
    - Understand the data
    - What is good?
    - What can they do better?
    - How do they compare to their peers?

We are not regulators

Data driven:

Unique data set for each NHS Trust, including:

- NJR
- HES
- HSCIC
- NHS Comparators
- NHS Indicators
- Productivity Metrics
- PROMS
- National data sources – waiting times etc
- National Hip Fracture Database
- NHS Litigation Authority
- NHS Atlas of Variation
- Arthritis Research UK Musculoskeletal Calculator



- Improved patient experience - **Quality**
- Re-empowering clinicians- **Clinically led**
- Better outcomes in terms of joint longevity, infection – SSI and acquired, complications, readmissions and mortality
- Significant taxpayer savings from reduced complications; infections; readmissions; length of stay and litigation; better directed care pathways; reduction in loan kit costs

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Infection rates for THR/TKR – what did we see?

Surgical site infections – 10 Trusts in same city

	Nos of Orthopaedic processes reported	% with infections – initial patient spell	% with infections – initial patient spell+ readmission
Trust 1	349	1.43%	1.43%
Trust 2	116	1.72%	1.72%
Trust 3	809	1.11%	2.47%
Trust 4	685	0.58%	0.73%
Trust 5	156	3.85%	4.49%
Trust 6	2657	0.68%	1.05%
Trust 7	454	0.00%	0.22%
Trust 8	544	1.47%	2.21%
Trust 9	--	--	--
Trust 10	521	0.00%	0.19%

0.19%-5% (15%) Potential savings by improving quality £250-£300M/year

GIRFT started in Orthopaedics:

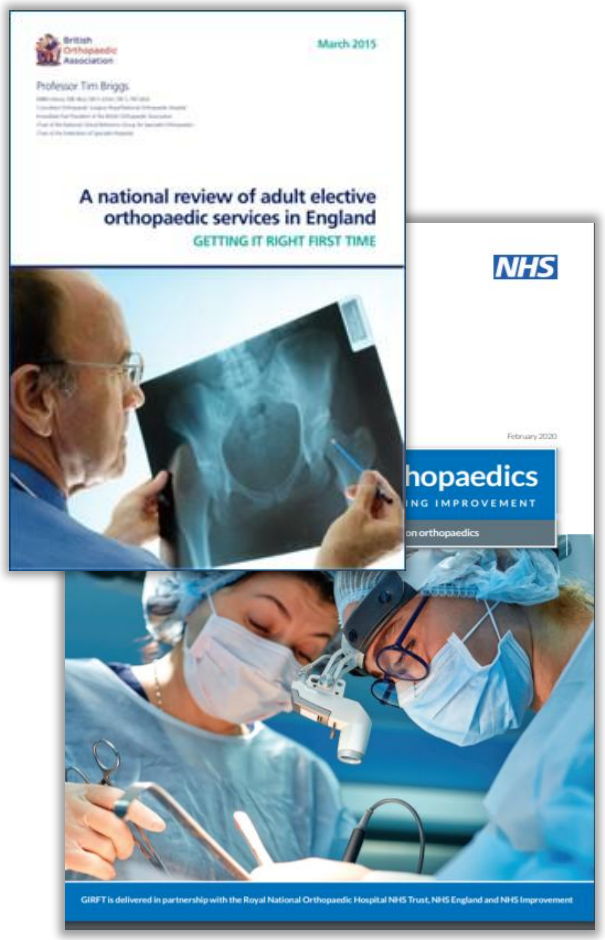
Pre COVID, a clinically-led programme using data and aimed at improving quality and reducing unwarranted variation.
What good looks like

Impact and Results from the orthopaedic pilot - Voluntary

- Reduction in Length of stay – TKR/THR
- Use of Cemented implants – patients70+
- Ring Fenced beds
- Reduction in inappropriate arthroscopy rates
- Low volume surgeons changing practice
- Reduction of emergency readmissions at 30 days
- Lower revision rates for hip and knee replacement
- Year on year reduction in orthopaedic litigation claims (volume)
- Reduction loan kit costs
- Reduction in costs of THR and TKR

Result:

- ✓ **Visited every trust at least twice**
- ✓ **Improved outcomes**
- ✓ **Reduced unwarranted variation**
- ✓ **Results in freeing up bed capacity**
- ✓ **Theatre time – the "right cases"/productivity**
- ✓ **Improves Efficiency and Theatre productivity**

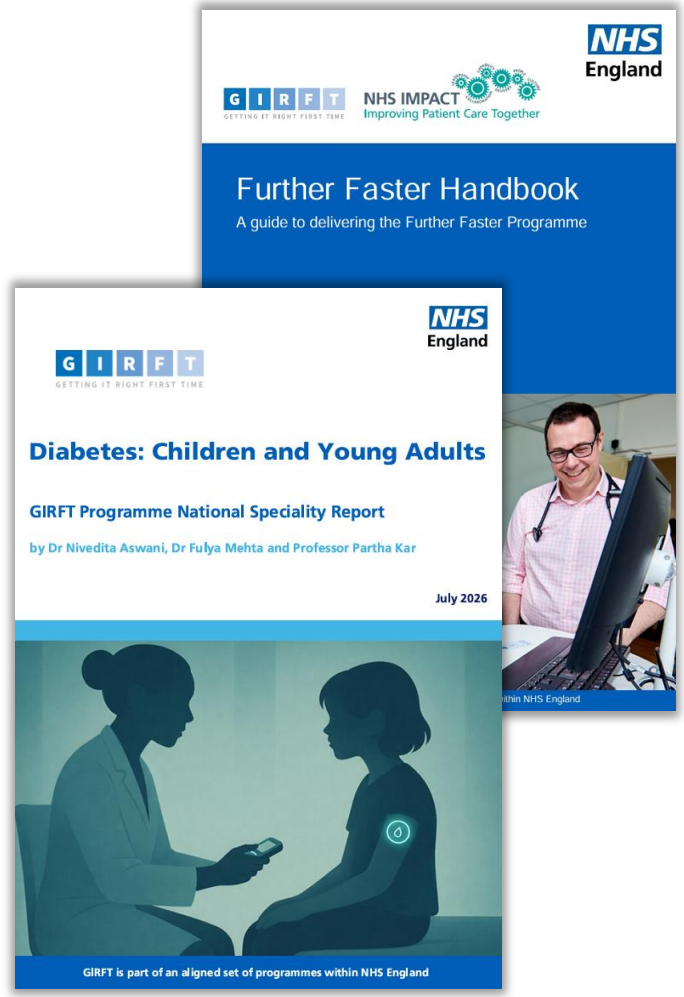


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Growth

From orthopaedics to:

- **53 specialties**
- **9 cross cutting programmes**
- **12 associated projects**



During this time:

- **Development of national data sets**
- **50 national reports published**
- **Movement into NHS England**
- **Growth of implementation and Academy offers**

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Clinical Leadership

96 clinical leads
41 clinical advisors

- Patient-centred
- On-the-ground experience
- Peer respect
- Operational expertise

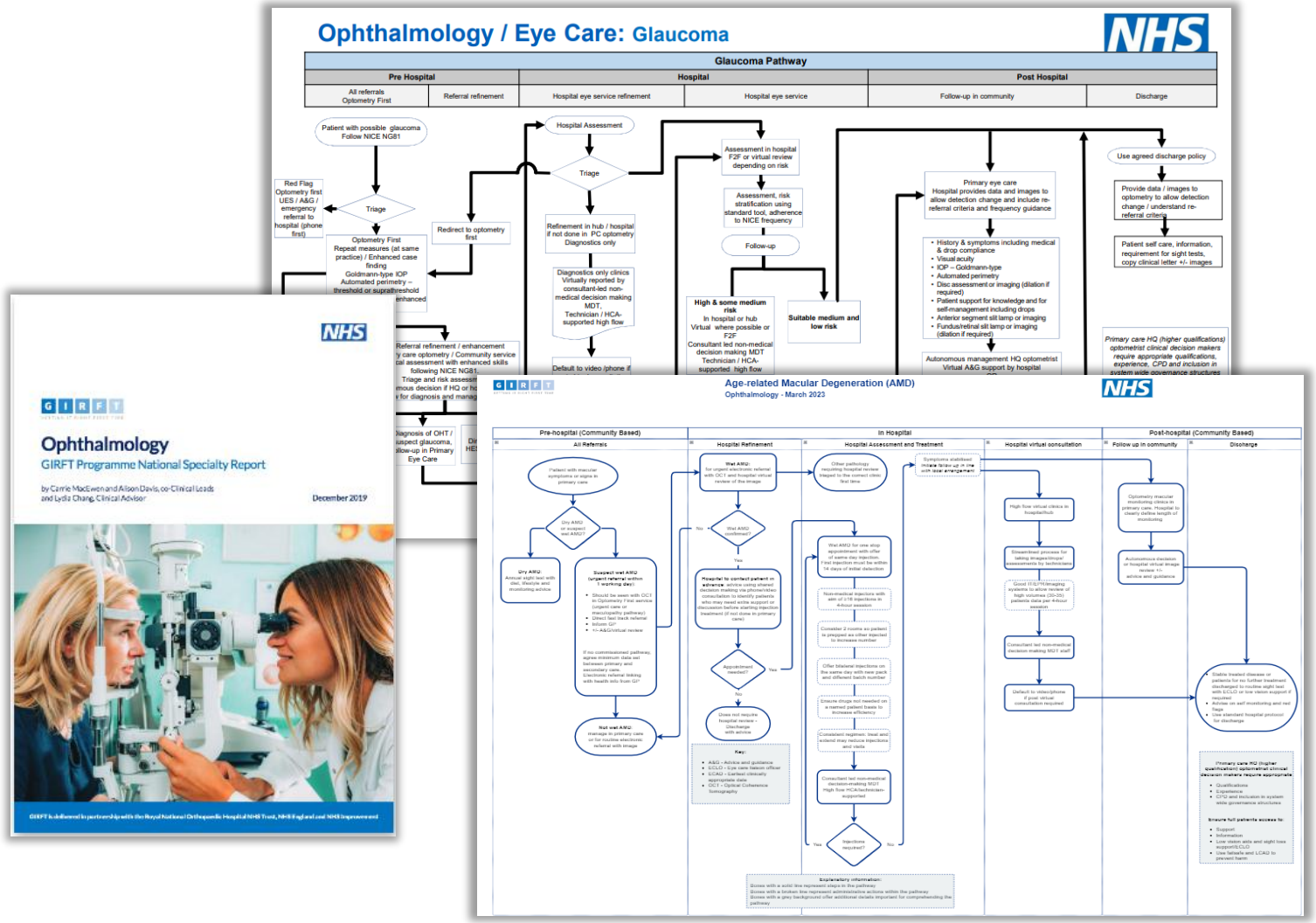


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Clinically-developed content

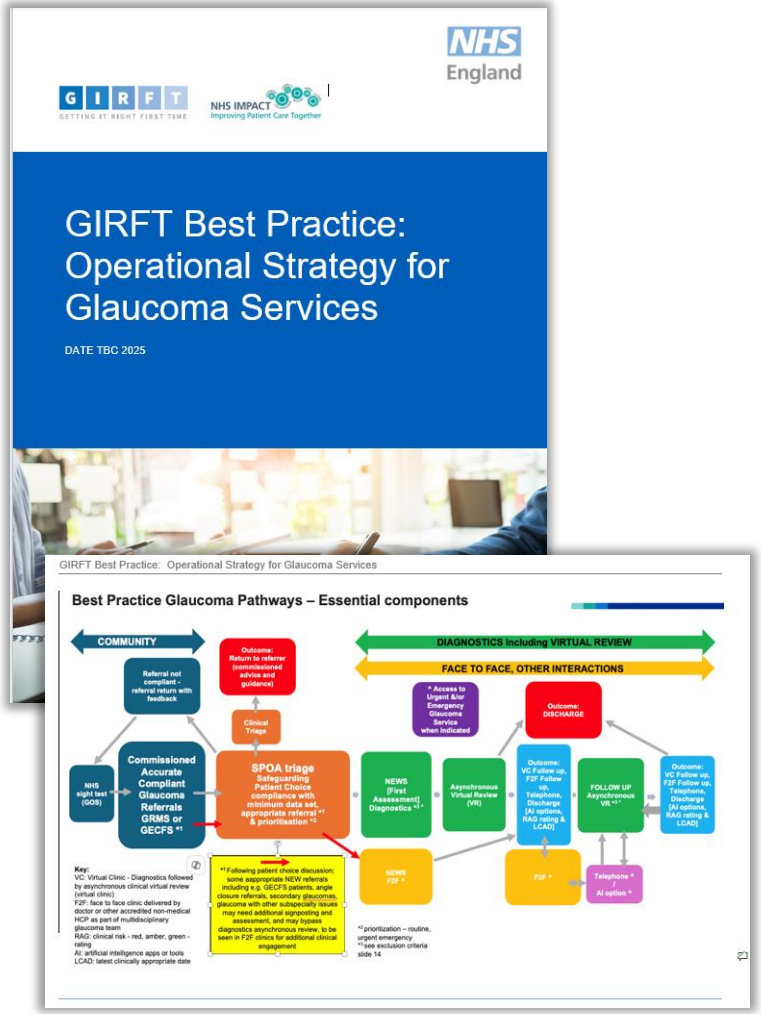
Best practice pathways
Guidance
Toolkits
Webinars

134 best practice pathways, co-developed and co-badged with colleges and societies, are available on the GIRFT website



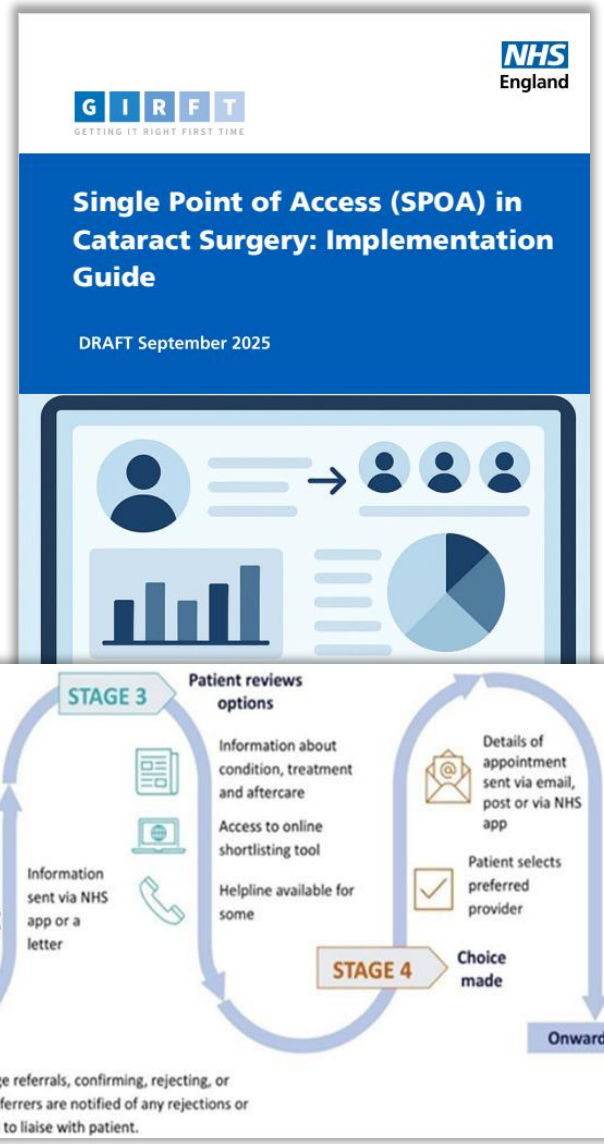
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GIRFT Best practice guidance Glaucoma services & SPOA



Key elements of operational strategy

- Detection in Primary care
- Referral to the Single Point of Access
- Management in secondary care and the community
- Diagnostics
- Continuity of care
- Safe and effective interventions
- Timely and effective follow-Up
- Discharge
- Urgent and emergency care
- Patient communication
- Quality and safety
- Training and research



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Independent reports

National Audit Office (2019) - Recognised the role of GIRFT in supporting trusts to identify recurrent and sustainable savings. Achievements in 2017-18 included reported savings of £1.45billion attributed to GIRFT and Model Hospital.

National Audit Office (2021) - Recognised GIRFT's support for elective recovery through the development of standardised patient pathways based on best practice. The report notes the contribution of these best practice pathways to increasing productivity and throughput through surgical hubs and describes this as a central initiative for addressing backlogs.



GIRFT now Strategic Placement

Policy, funding & regulation

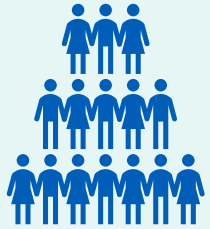
DHSC and NHS England

GIRFT is part of an aligned set of programmes within NHS England.

Priorities – Oversight – Feedback

Who we are

GIRFT is led by clinicians, supported by senior operational leaders, programme management expertise and analytical insight, and grounded in frontline experience and clinical credibility



How we work

We work with teams at provider, system and region level; helping to close the gap between current delivery and best practice. We achieve this through:



Clinical Leadership & Peer Influence

Credible clinical leadership shaping best practice and professional behaviour



Data, Benchmarking & Evaluation

Identifying variation, measuring impact and building confidence in improvement



Targeted Delivery Support

Focused on-site intervention where risk or opportunity is greatest



Scaling & Spread

Proven approaches embedded at pace through programmes, pathways and networks

What we achieve

GIRFT supports the delivery of better care for patients across the NHS



Nationally

Understanding performance across England
Identifying common challenges
Commitment to improvement



Locally

Collaborative clinical and operational support
Shared learning and good practice
Access to national insight



For patients

Reducing unwarranted variation both locally and nationally across multiple workstreams, to improve how patients and public experience the NHS

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GIRFT's theory of change

Clinically-led improvement at scale

Challenge

Rising demand, workforce pressure, and unwarranted variation mean incremental improvement is no longer enough to deliver the NHS 10 Year Plan.

How GIRFT drives change

Clinical Leadership & Peer Influence

Credible clinical leadership shaping best practice and professional behaviour

Data, Benchmarking & Evaluation

Identifying variation, measuring impact and building confidence in improvement

Targeted Delivery Support

Focused intervention where risk or opportunity is greatest

Scaling & Spread

Proven approaches embedded at pace through programmes, pathways and networks

Results

Sustainable change

Respected clinical leadership driving interventions that are sustained post-intervention

Transformational big leaps

- From reactive pressure to stable, evidence-based care
- From fragmented pathways to integrated, patient-centred models
- From variation and inefficiency to consistent, high-quality performance

Patient impact

Safer care, improved productivity, better outcomes for patients — and clinically led improvement that is credible, scalable, and sustainable for the next decade

Elective recovery

GIRFT is running a number of priority programmes helping NHS trusts to deliver routine care and planned operations as quickly as possible and reduce patient waiting lists

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The elective challenge

NHS England has published an elective reform plan to meet the NHS constitutional elective care standards for adults and CYP by the end of the Parliament.
The plans state the actions expected by systems and providers to take in 2025/26 on the journey towards the 18- week standard.

These include:

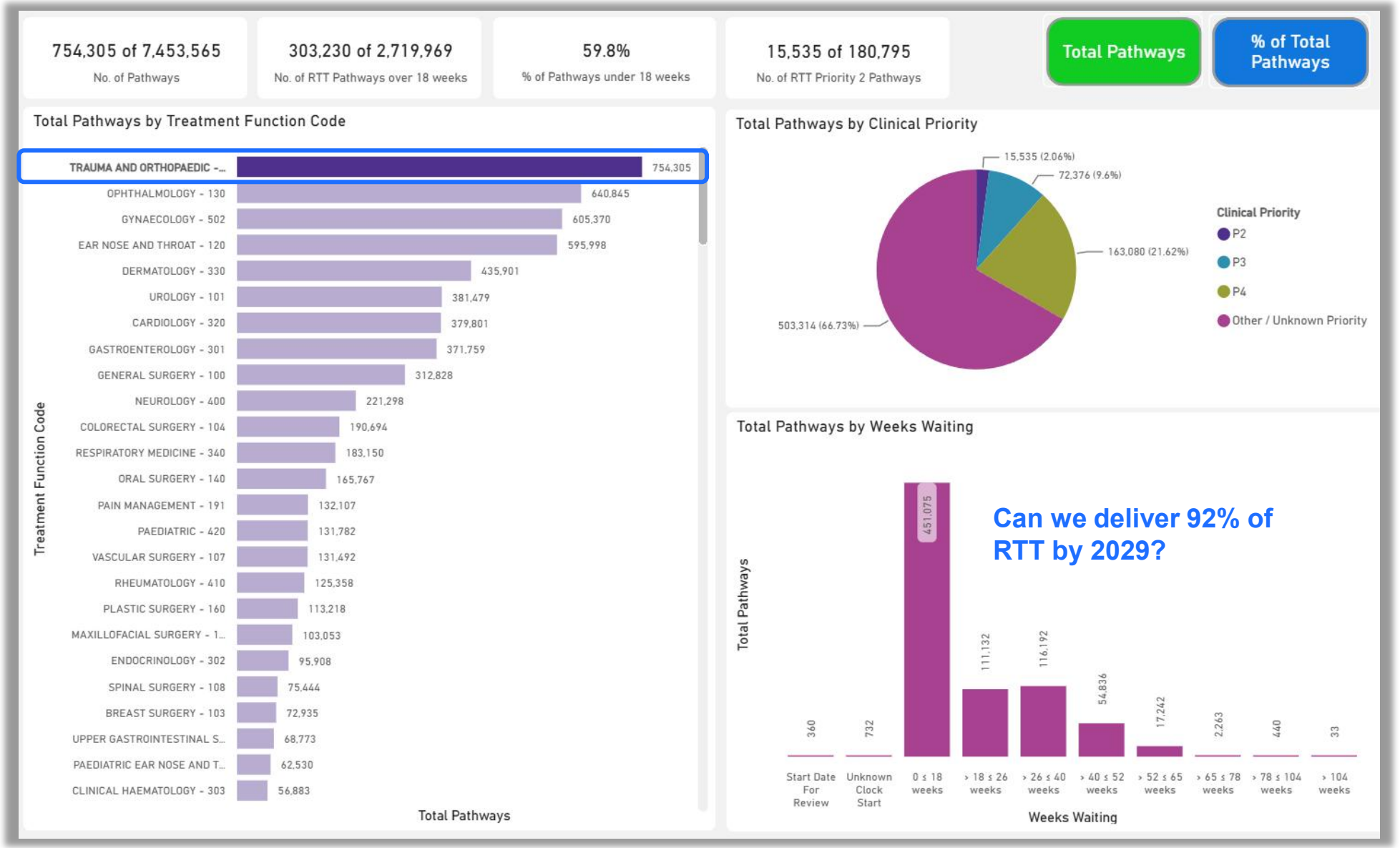
- *delivering activity levels consistent with the national value weighted activity target of 118%*
- *effective demand management*
- *driving pathway reform*
- *maximising utilisation of existing capacity (including in the independent sector)*
- *giving patients choice and control over their care*

The NHS Planning Guidance for 2025/26 and Elective Reform plan clearly state the scale of the elective challenge aligned to the delivery of the following objectives:

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment by 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement.
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026.
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2026 ambition of 99%.

Current England waiting list position

10.12% of total pathways
502,297 non-admitted
252,008 admitted

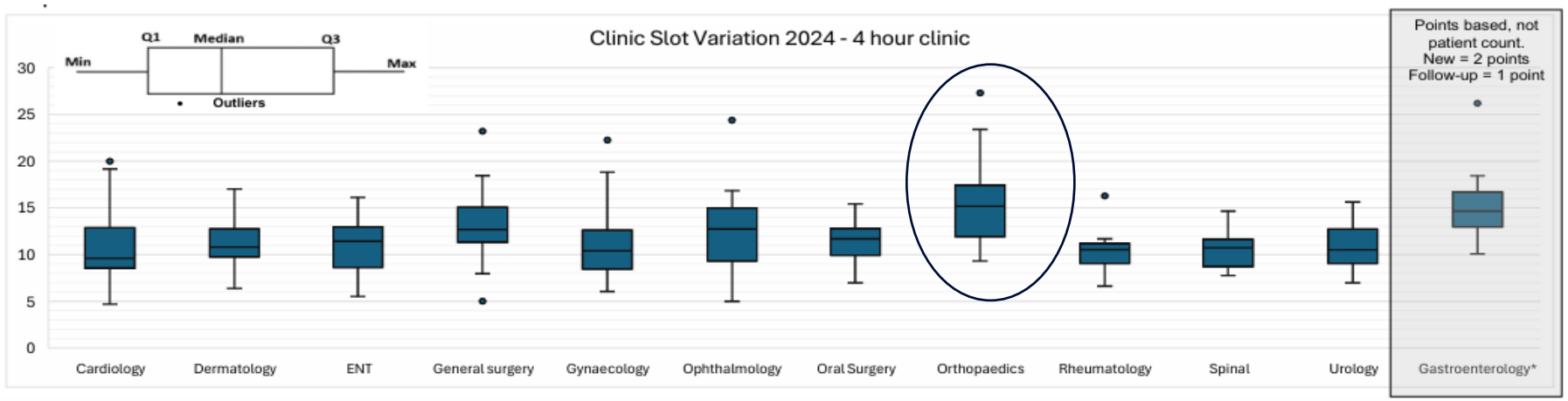


Source: Elective waiting list 13/09/26

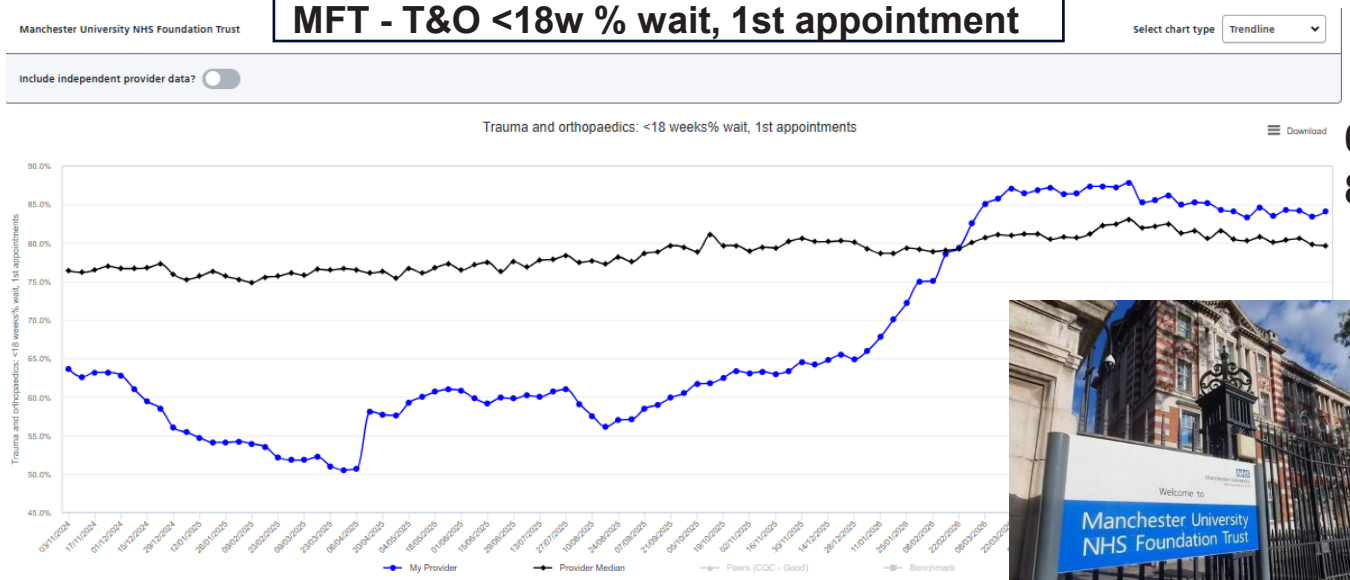
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Outpatients

1-2 Million appointments/year



MFT - T&O <18w % wait, 1st appointment



6/9/26
84.1%

MFT T&O standardising clinic template outcomes:

- ✓ **84% of patients now wait <18 weeks for 1st OPA**
- ✓ **10% more are receiving treatment within 18 weeks**
- ✓ **385 fewer patients waiting >52w**
- ✓ **0 patients waiting >65w**
- ✓ **200 more patients are being seen in outpatients each week**

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Outpatients - GIRFT Further Faster

Clinic templates – 4 Hour clinic +.25PA for admin

Potential opportunity for between one and two million additional outpatient slots per year through standardising clinic templates – the equivalent of an additional week of outpatient activity in every trust in England.

Trusts reporting substantial appointment gains (slots per year) include:

Northern Care Alliance NHS Foundation Trust: ***Estimated 68,700***
University Hospitals of Leicester NHS Trust: ***Estimated 49,000***
London North West University Healthcare NHS Trust: ***26,000***

Follow-up protocols

Clinical audits have been undertaken across Cohort 1 trust to understand current practice and support the quantification of the opportunity:

- **Primary Hip Replacement – 43% of patients were at or below benchmark**
- **Primary Knee Replacements – 45% at or below benchmark**
- **ACL Repair – 59% at or below benchmark**
- **Rotator Cuff Repair – 40% at or below benchmark**
- **Gastro cumulatively indicates c.30% of overdue IBD follow up patients and c.19% of liver patients would not require a planned follow up (with the exception of PIFU triggers)**

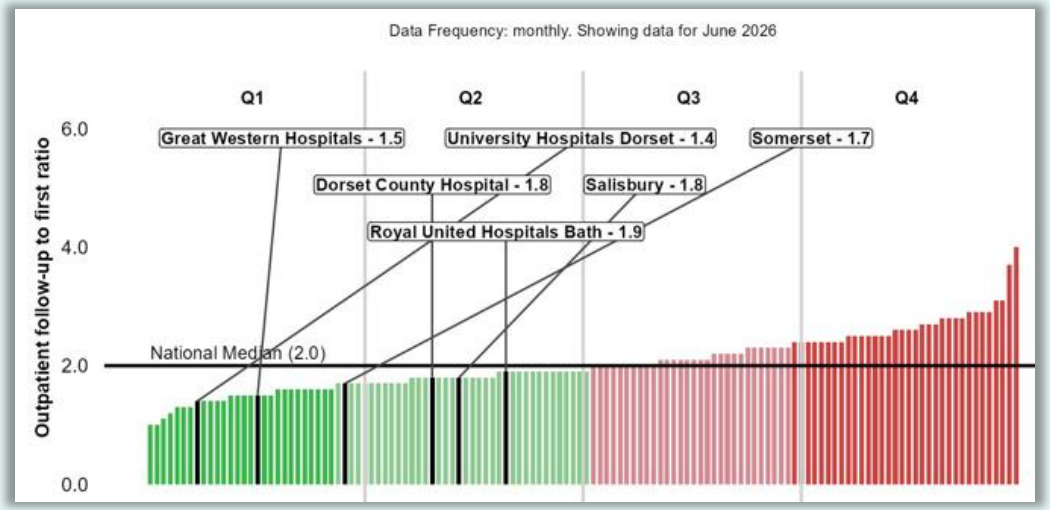


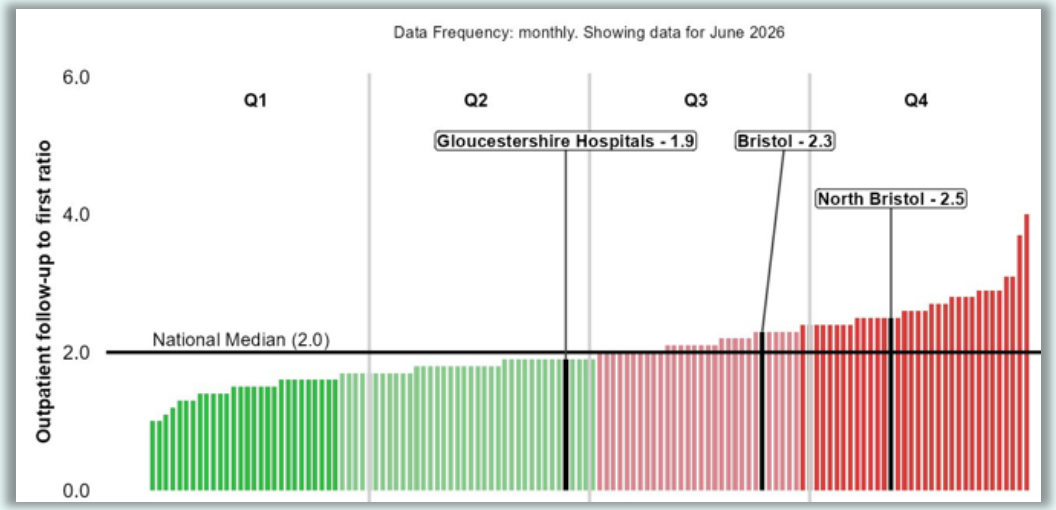
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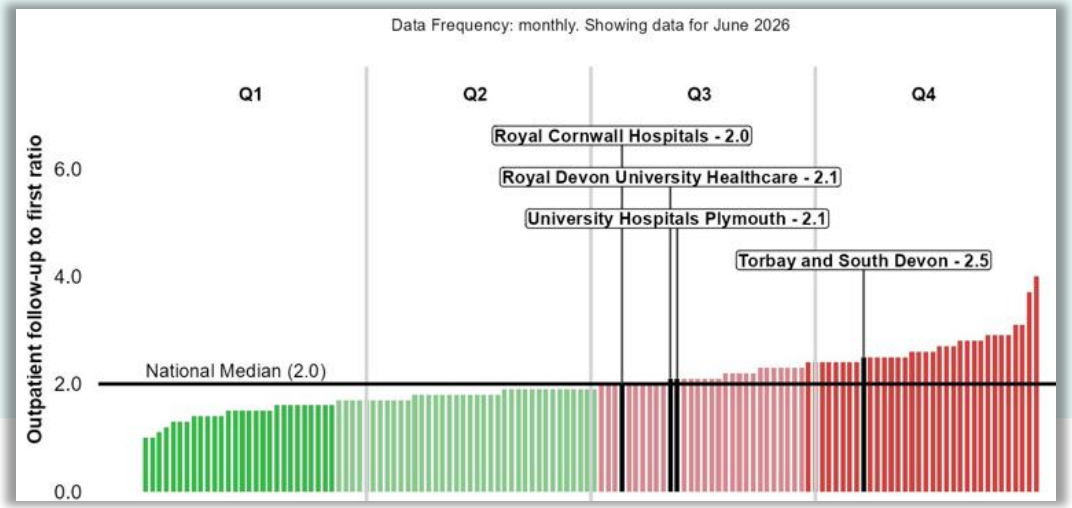
Elective: Follow-up ratio

13 Acute Provider Trusts

Potential opportunity in SW equivalent to +72,000 additional New Patient appointments per annum





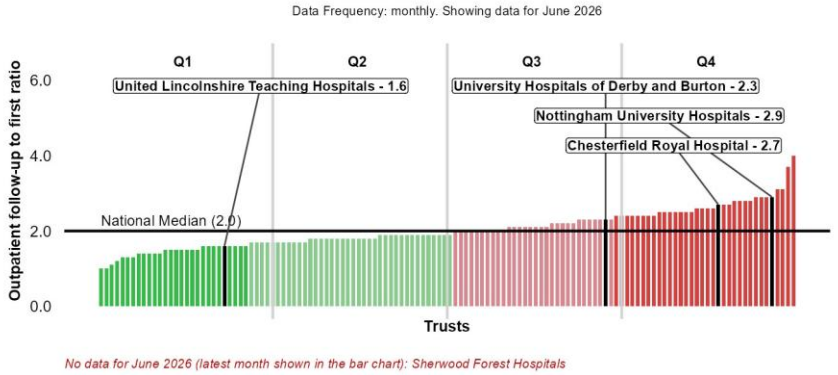


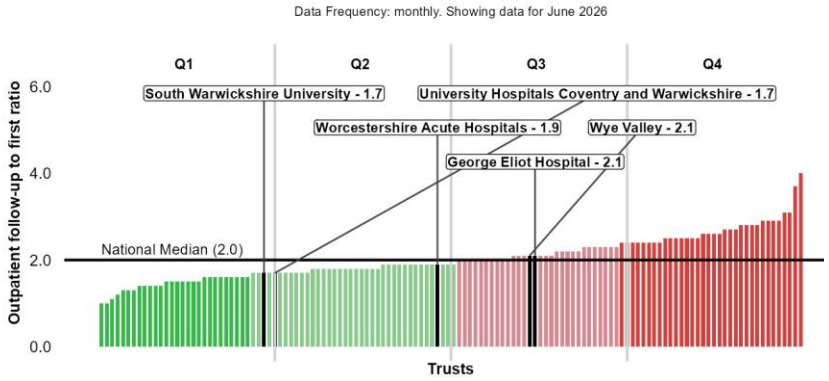
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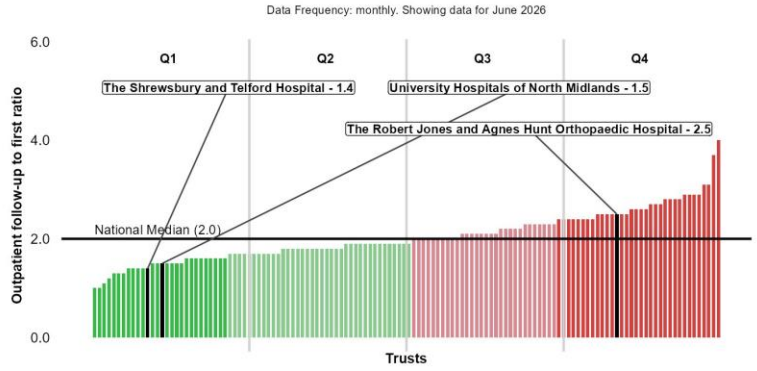
Midlands – follow-up ratios

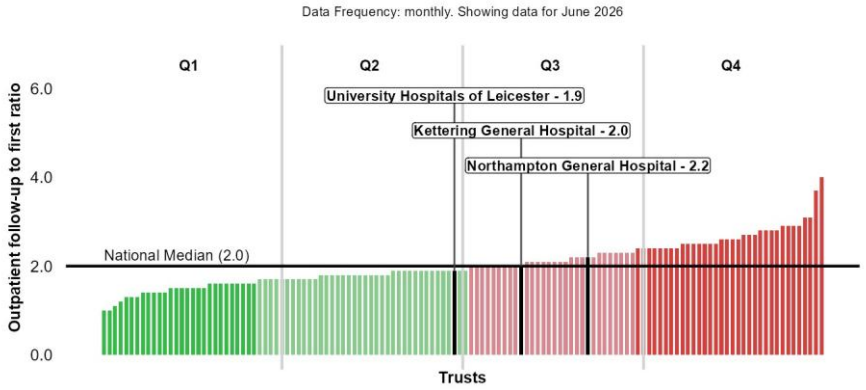
22 Acute Provider Trusts

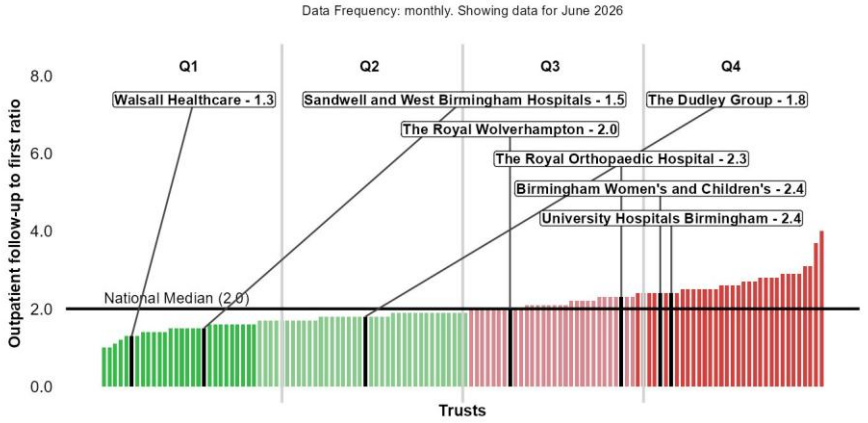
Potential opportunity in Midlands equivalent to +161,000 additional New pt appts per annum











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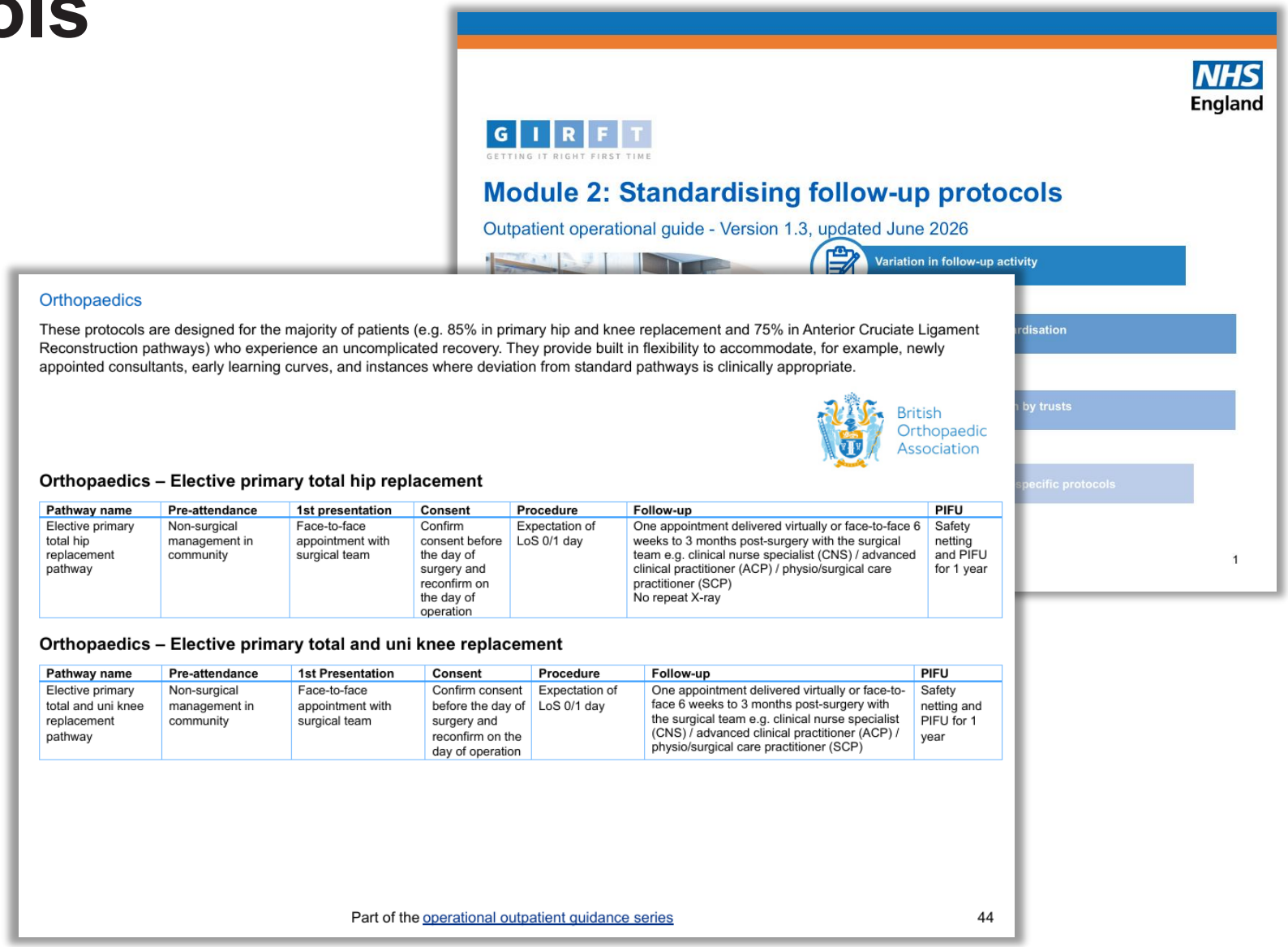
Follow-up protocols

12 specialties

98 clinical pathways

Co-badged by colleges and societies

- Continuously updated
- Working with providers to embed into practice



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Module 2: Standardising follow-up protocols

Outpatient operational guide - Version 1.3, updated June 2026

Variation in follow-up activity

rdisation

by trusts

specific protocols

1

Orthopaedics

These protocols are designed for the majority of patients (e.g. 85% in primary hip and knee replacement and 75% in Anterior Cruciate Ligament Reconstruction pathways) who experience an uncomplicated recovery. They provide built in flexibility to accommodate, for example, newly appointed consultants, early learning curves, and instances where deviation from standard pathways is clinically appropriate.

British Orthopaedic Association

Orthopaedics – Elective primary total hip replacement

Pathway name	Pre-attendance	1st presentation	Consent	Procedure	Follow-up	PIFU
Elective primary total hip replacement pathway	Non-surgical management in community	Face-to-face appointment with surgical team	Confirm consent before the day of surgery and reconfirm on the day of operation	Expectation of LoS 0/1 day	One appointment delivered virtually or face-to-face 6 weeks to 3 months post-surgery with the surgical team e.g. clinical nurse specialist (CNS) / advanced clinical practitioner (ACP) / physio/surgical care practitioner (SCP) No repeat X-ray	Safety netting and PIFU for 1 year

Orthopaedics – Elective primary total and uni knee replacement

Pathway name	Pre-attendance	1st Presentation	Consent	Procedure	Follow-up	PIFU
Elective primary total and uni knee replacement pathway	Non-surgical management in community	Face-to-face appointment with surgical team	Confirm consent before the day of surgery and reconfirm on the day of operation	Expectation of LoS 0/1 day	One appointment delivered virtually or face-to-face 6 weeks to 3 months post-surgery with the surgical team e.g. clinical nurse specialist (CNS) / advanced clinical practitioner (ACP) / physio/surgical care practitioner (SCP)	Safety netting and PIFU for 1 year

Part of the operational outpatient guidance series

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Specialty follow-up to first ratio opportunity

Method: activity is summed across the ICB's trusts per specialty, then the pooled ICB follow-up:first ratio shifted to two benchmarks, both calculated per specialty over the 12 months below. National average (mean) = total follow-up / first attendances. National upper quartile = the 25th percentile of individual trusts' ratios, excluding trusts with under 100 first attendances. Benchmarks may differ from the monthly benchmarks published on Model Hospital. Released follow-up capacity can be reallocated as new appointments or utilised for other organisational priorities.
Period: 1 July 2025 - 30 June 2026

	Actual activity / ratio			Shifted to national average ratio								Shifted to national upper quartile ratio							
						Re-use capacity		Revised total		Net change				Re-use capacity		Revised total		Net change	
Modelling assumptions	New pts seen	F/up pts seen	F/up ratio	Target ratio	F/ups released	New	F/up*	New	F/up	New	F/up	Target ratio	F/ups released	New	F/up*	New	F/up	New	F/up
TOTAL (specialties shown)	**530,481**	**1,163,889**	**2.2**		**-173,974**	**46,091**	**105,037**	**576,572**	**1,094,952**	**46,091**	**-68,937**		**-410,074**	**131,458**	**212,117**	**661,939**	**965,932**	**131,458**	**-197,957**
Trauma & Orthopaedics	73,366	114,124	1.6	1.6	0	0	0	73,366	114,124	0	0	1.3	-21,274	8,182	10,355	81,548	103,205	8,182	-10,919
Urology	31,591	66,773	2.1	2.2	0	0	0	31,591	66,773	0	0	1.8	-10,839	2,852	5,050	34,443	60,984	2,852	-5,789
ENT	44,058	47,976	1.1	1.2	0	0	0	44,058	47,976	0	0	0.9	-6,996	3,042	2,829	47,100	43,809	3,042	-4,167
Gastroenterology	14,842	39,086	2.6	1.4	-18,349	6,327	8,840	21,169	29,577	6,327	-9,509	1.0	-23,630	9,452	9,843	24,294	25,299	9,452	-13,787
Gynaecology	43,801	47,006	1.1	1.0	-2,202	734	751	44,535	45,555	734	-1,451	0.8	-12,003	4,287	3,426	48,088	38,429	4,287	-8,577
Cardiology	31,027	25,655	0.8	1.1	0	0	0	31,027	25,655	0	0	0.7	-5,046	2,294	1,524	33,321	22,133	2,294	-3,522
Dermatology	23,242	66,315	2.9	1.7	-26,367	8,240	14,162	31,482	54,110	8,240	-12,205	1.3	-36,009	12,860	16,769	36,102	47,075	12,860	-19,240
General Surgery	44,977	66,932	1.5	1.3	-6,553	2,340	3,142	47,317	63,521	2,340	-3,411	0.8	-29,034	12,623	10,637	57,600	48,535	12,623	-18,397
Ophthalmology	58,967	222,135	3.8	3.0	-42,915	9,537	28,985	68,504	208,205	9,537	-13,930	2.3	-86,075	22,651	52,266	81,618	188,326	22,651	-33,809
OMFS	15,985	25,968	1.6	1.4	-4,320	1,490	2,017	17,475	23,665	1,490	-2,303	1.0	-10,685	4,274	4,086	20,259	19,369	4,274	-6,599
Clinical Haematology	3,762	40,707	10.8	7.8	-11,468	1,233	9,584	4,995	38,823	1,233	-1,884	5.7	-19,197	2,666	15,245	6,428	36,755	2,666	-3,952
Diabetes	3,193	15,893	5.0	4.9	-279	44	213	3,237	15,827	44	-66	3.9	-3,287	609	2,403	3,802	15,009	609	-884
Elderly Medicine	2,448	8,534	3.5	1.3	-5,341	1,908	2,488	4,356	5,681	1,908	-2,853	0.8	-6,547	2,847	2,310	5,295	4,297	2,847	-4,237
Endocrinology	5,319	14,552	2.7	2.6	-879	214	551	5,533	14,224	214	-328	2.0	-4,109	1,174	2,305	6,493	12,748	1,174	-1,804
Neurology	12,062	37,498	3.1	2.0	-13,244	3,784	7,609	15,846	31,863	3,784	-5,635	1.4	-20,341	7,014	9,977	19,076	27,134	7,014	-10,364
Obstetrics	22,739	78,294	3.4	3.2	-5,014	1,067	3,438	23,806	76,718	1,067	-1,576	1.8	-37,306	11,305	20,378	34,044	61,366	11,305	-16,928
Paediatrics	18,377	27,666	1.5	1.0	-9,751	3,900	3,802	22,277	21,717	3,900	-5,949	0.6	-16,245	7,736	4,808	26,113	16,229	7,736	-11,437
Physiotherapy	44,603	93,855	2.1	2.4	0	0	0	44,603	93,855	0	0	2.0	-5,619	1,605	3,176	46,208	91,412	1,605	-2,443
Renal Medicine	1,882	16,722	8.9	7.6	-2,341	257	1,966	2,139	16,347	257	-375	4.2	-8,772	1,539	6,501	3,421	14,451	1,539	-2,271
Respiratory Medicine	26,300	53,017	2.0	1.8	-6,655	2,017	3,555	28,317	49,917	2,017	-3,100	1.3	-18,563	6,630	8,685	32,930	43,139	6,630	-9,878
Rheumatology	7,940	55,181	6.9	4.6	-18,296	2,999	13,933	10,939	50,818	2,999	-4,363	3.4	-28,497	5,816	19,545	13,756	46,229	5,816	-8,952

Specialties with no recorded activity at this trust: Spinal Surgery.

Productivity opportunity / year	Shift to national average	Shift to national upper quartile
New appointments added / year	46,091	131,458
as % of current new activity	*8.7%*	*24.8%*
Reduction in follow-ups / year	68,937	197,957
as % of current follow-up activity	*5.9%*	*17.0%*

King’s College Hospital – Outpatient Transformation

GIRFT have been supporting Kings since Sept 24

In 12 months to September 2025 the Outpatient Transformation programme has:

- Reduced long waits (>52wks) by **73.7%**
- Reduced the waiting list by **16%** despite rising demand
- Increased new outpatient activity by **49%***
- Increased no. of patients completing treatment pathway by **16.4%**
- Improved RTT - **5%** more patients waiting less than 18 weeks
- Achieved **112%** ERF value month on month
- Driving the delivery of **£6.6m** Elective Productivity CIP
- Improved Workforce productivity by 1.9 points to **5.7%**
- Improved the No. of patients who report their FFT score
- Increased No. rating experience at or above the 94% target

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*without equivalent increases in staffing

NHS
King’s College Hospital
NHS Foundation Trust

GIRFT Digital pathways

GIRFT is progressing 30 '**Digital First**' clinical pathways in partnership with FDP, the NHS App and Isla Healthcare, moving them towards live implementation.

- Twelve pathways are currently live across five trusts, with expansion to eight trusts expected in the coming weeks.
- Initial benefits are in line with or above forecast.
- Scaling the 30 pathways in 12 Specialties across England is projected to avoid **1.2 million activities**.

Orthopaedic/Spinal pathways:

- Primary THR, TKR and Uni-knee
- ACL reconstruction
- Carpal tunnel decompression
- Shoulder arthroscopy
- Lumbar spinal injection

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Examples of pathway list and approval status

Specialty	Pathway ID	Pathway	Status
Ear, Nose and Throat Surgery	FFU01	Endoscopic Sinus surgery	Complete
Ear, Nose and Throat Surgery	FFU02	Nasal airway surgery	Complete
Urology	FFU03	LUTS	Complete
Trauma and Orthopaedics	FFU04	Primary THR, THR and Uni Knee	Complete
Trauma and Orthopaedics	FFU05	ACL reconstruction	Complete
Trauma and Orthopaedics	FFU06	Carpal tunnel decompression	Complete
Trauma and Orthopaedics	FFU07	Shoulder arthroscopy	Complete
Spinal services	FFU08	Adult: Lumbar injections	Complete
Dermatology	FFU09	Acne	Complete
Dermatology	FFU10	Psoriasis / eczema	Complete
General Surgery	FFU11	Hernia surgery	Complete
General Surgery	FFU12	Lap Chole	Complete
Cardiology	FFU13	Aortic Stenosis	Complete
Ophthalmology	FFU14	Glaucoma	In progress
OMFS	FFU15	TMD	Complete
Colorectal Surgery	FFU16	Hemorrhoids	Complete
Spinal services	PAC01	Spinal surgery	In progress
Neurology	PAC02	Headaches	In progress
Pain	PAC03	Pain management	In progress
Ophthalmology	PAC04	Medical Retina	Not started
Gynaecology	PAC05	Unscheduled bleeding	In progress
CYP	PAC06	Allergies	Complete
CYP	PAC07	JIA	Complete

GIRFT Digital pathways: summary impact (projected)

This graph shows the benefits from pathways which have gone live within the programme extrapolated to see what the impact would be at a national level

496.4K

Proven evidenced figure

Live pathways with confirmed benefits, incl. the PSA pathway

~1.21M

Forecast ceiling, incl. PSA

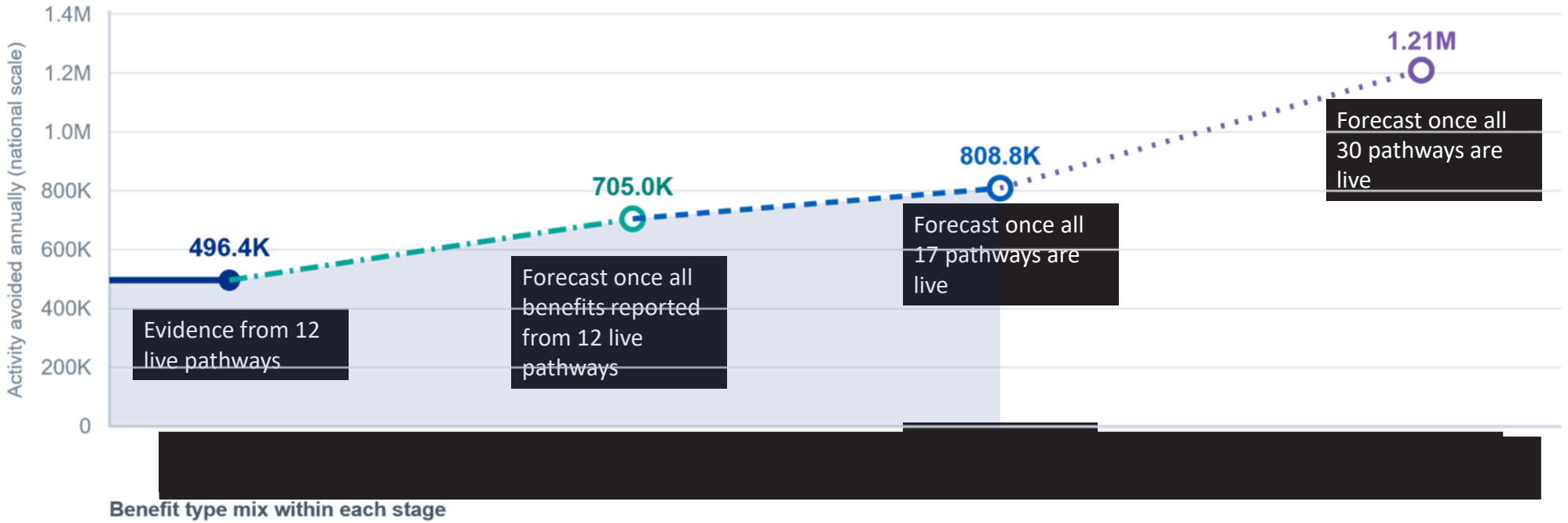
If every pathway performs as estimated

COMPARATOR

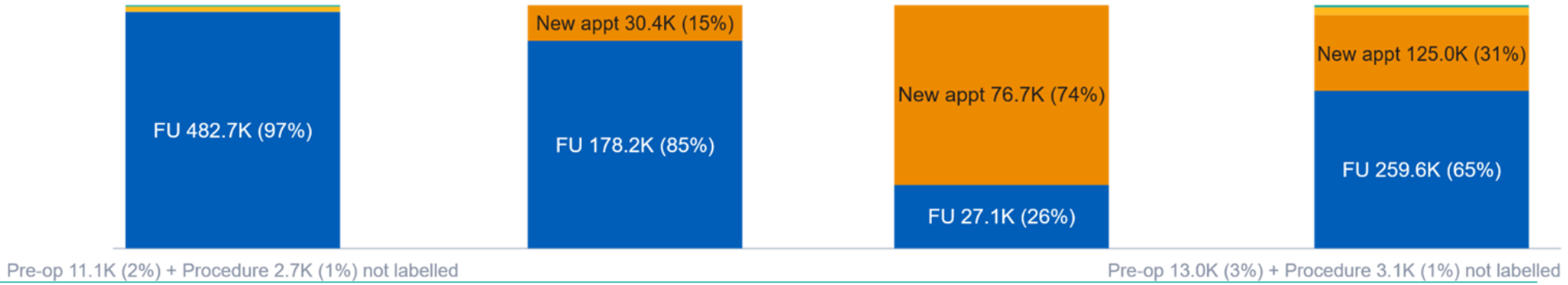
Straight to Test Programme

~72.5K appointments avoided per annum

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Benefit type mix within each stage



Pre-op 11.1K (2%) + Procedure 2.7K (1%) not labelled

Pre-op 13.0K (3%) + Procedure 3.1K (1%) not labelled

Theatre productivity

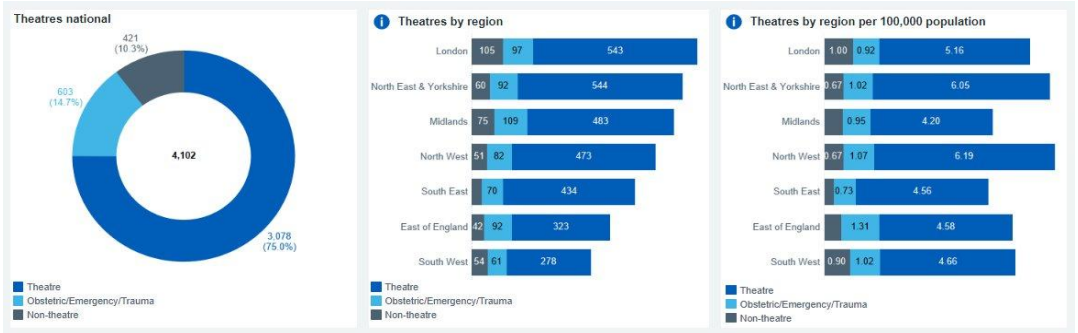
There is significant variation across England on how well operating theatres are utilised. GIRFT is working with providers and ICBs to:

- **improve data quality and data collection** to help trusts to understand what is driving reduced theatre productivity and how to increase theatre throughput;
- support theatre teams to **develop new roles and skill mix** and to improve staff recruitment, retention and well-being;
- deliver '**Right Procedure, Right Place**' by moving procedures to the most appropriate setting, from traditional theatres to outpatients and community settings;
- **improve theatre booking and scheduling** and effective flow of surgical lists to minimise delays to patients.
- **maximise day case** throughput to 85% - no more than 15% of elective surgical procedures should be delivered as an inpatient admission.



Theatre utilisation dashboard

- Use of theatre time - GIRFT has set a target for systems and providers to achieve 85% theatre touch-time utilisation supporting sustainable elective recovery.

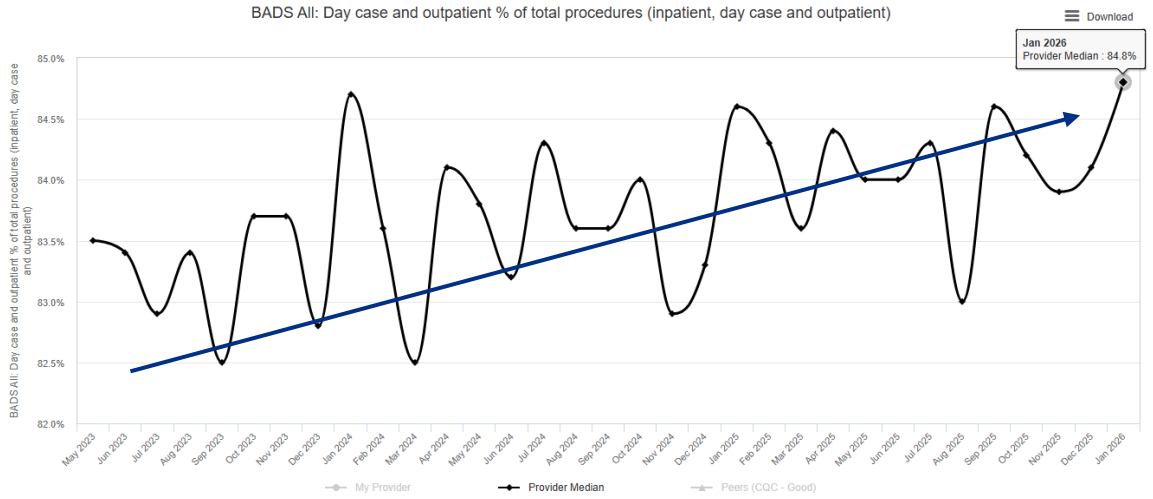


- GIRFT and Model Health System are working together to improve the intelligence available on theatre utilisation.
- A GIRFT dashboard shows trusts' touch-time – the amount of time spent operating on a patient compared to the time planned for that theatre session.
- Aids planning and understanding of how requirements may change over time.
- Dashboard allows trusts to drill down into their data and filter results by specialty, type of list, day of the week and even individual theatres.

Example of impact in GIRFT Theatre Programme

Since establishing the National Theatre Programme, Theatre utilisation has increased from a pre-covid level of **76%**, to its current rate of **81.2%**. Similarly, day case surgery rates are the highest they have ever been at **84.8%** compared with pre-covid level of **79.4%.**

Use of theatre time	• All systems to achieve 85% capped theatre utilisation and meet or exceed the wider theatre productivity measures (late start, early finish, intercase downtime)
Surgical planned procedure setting	• No more than 15% of all elective surgical procedures should be delivered as an inpatient admission by maximising daycase throughput to 85% and moving patients down the gradient of care
Improving productivity / throughput	• All providers/systems to be delivering throughput at HVLC cases per list • All providers to minimise cancellations for avoidable clinical and non clinical reasons.
Increasing capacity and activity	• Theatre estate for all providers should be fully utilised 6 days a week, 48 weeks of the year • All providers to have recovered their HVLC activity to above pre-covid activity levels.
Resilience	• All providers to have access to a fully ring-fenced elective surgical facility • HVLC activity to be maintained in winter months



Outstanding theatre teams
Developing new roles and how skill mix can support local theatre teams to improve recruitment, retention and staff wellbeing.

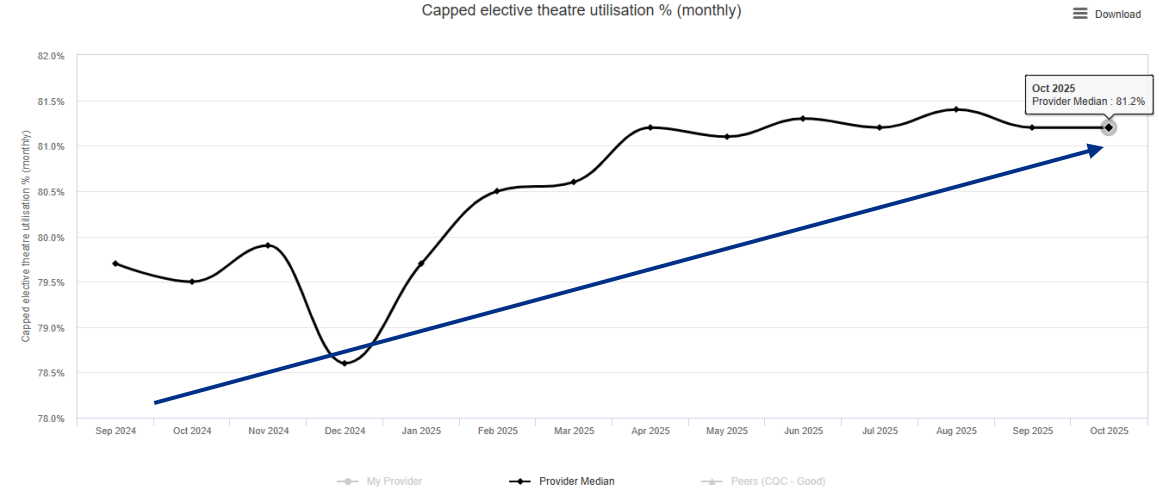
Theatre productivity
Improving theatre booking and scheduling and effective flow on the day to minimise avoidable delays for patients.

Surgical hubs
Using the outputs of the theatre programme to embed top decile working in all hubs.



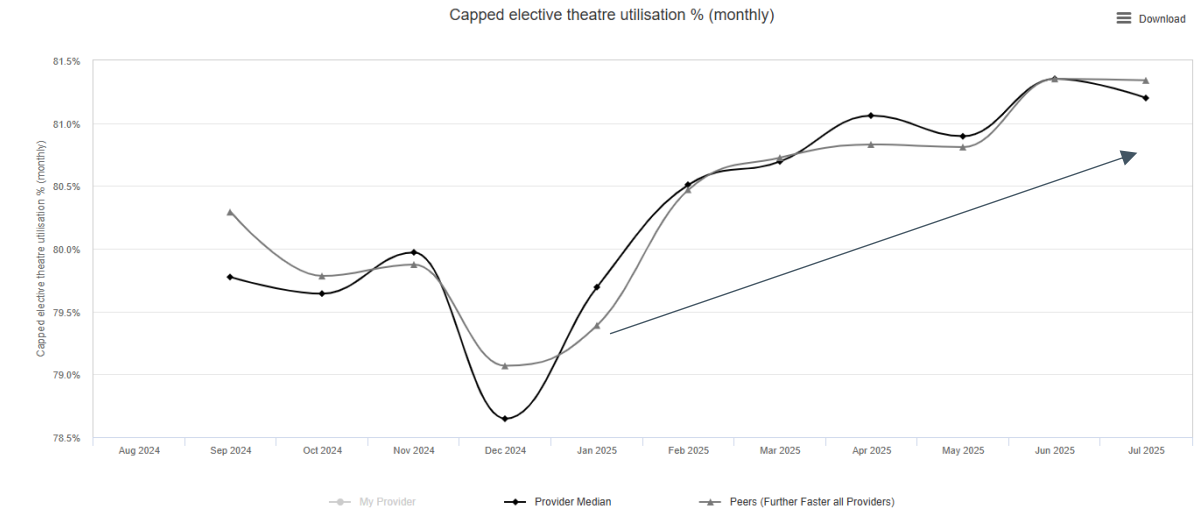
Right Procedure, Right Place
Building on work started during Covid, supporting providers in moving procedures to the most appropriate setting, from traditional theatres to outpatient and community settings.

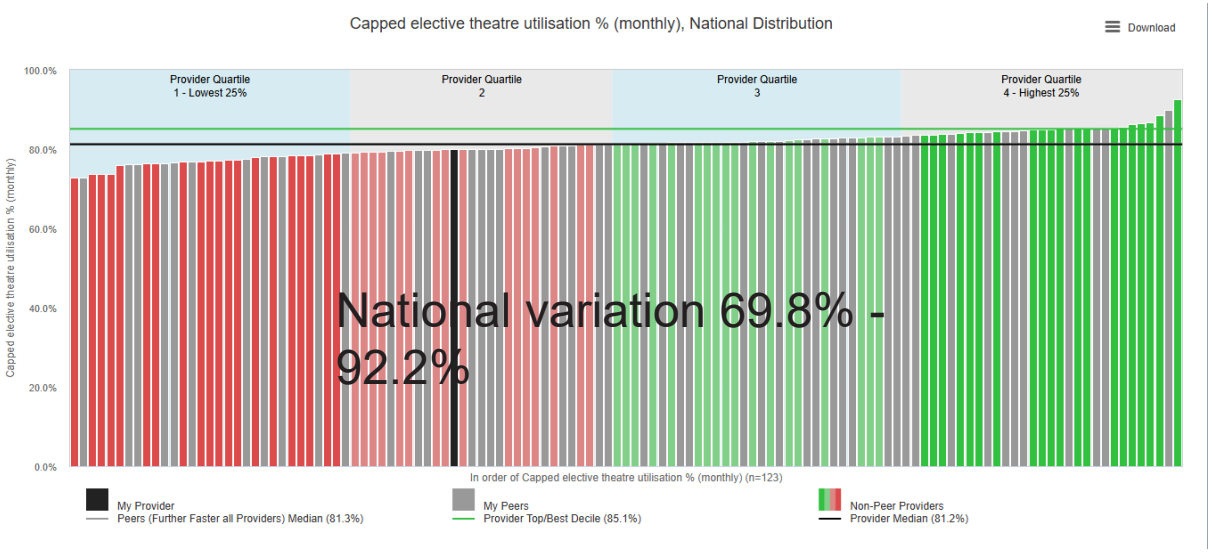
Data driven change
Improving theatre metrics to support systems in identifying where challenges are in their theatre pathways to allow targeted solutions to be deployed at pace.



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Capped elective theatre utilisation





Since establishing the GIRFT Theatre & Peri-op Programme, Theatre utilisation has increased from a pre-covid level of 76%, to its current rate of **81.2%** nationally.



- Theatre Productivity Series Module 1 : Theatre Booking
- Theatre Productivity Series Module 2 : Theatre Waiting List Management and List
- Theatre Productivity Series Module 3 : Theatre Scheduling
- Theatre Productivity Series Module 4: Patient Preparation and Effective
- Theatre Productivity Series Module 5: Surgical Discharge
- Theatre Productivity Series Module 6: Workforce Planning and Deployment

Theatre Programme Workstreams

The graphic below demonstrates the main reasons for low theatre productivity, based on GIRFT data and what we have identified through working directly with a number of providers delivering intensive support. We know that optimising each step of the process will provide incremental gains in theatre productivity.

Outstanding Theatre Teams
Developing new roles and how skill mix can support local theatre teams to improve recruitment, retention and staff wellbeing.

Theatre Productivity
Improving theatre booking and scheduling and effective flow on the day to minimise avoidable delays for patients.

Surgical Hubs
Using the outputs of the theatre programme to embed top decile working in all hubs.

Right Procedure, Right Place
Building on work started during Covid, supporting providers in moving procedures to the most appropriate setting, from traditional theatres to outpatient and community settings.

Data Driven Change
Improving theatre metrics to support systems in identifying where challenges are in their theatre pathways to allow targeted solutions to be deployed at pace.

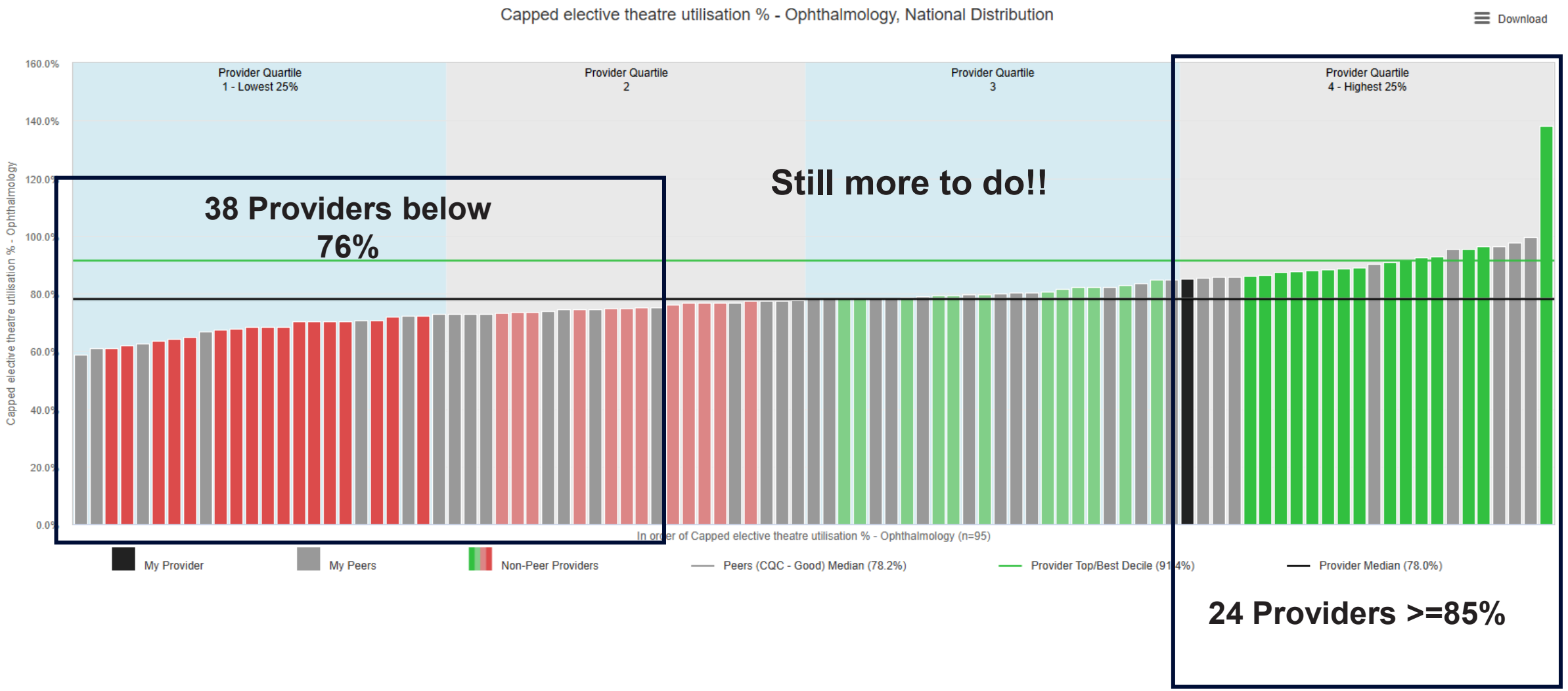
GIRFT Anaesthetics & Perioperative Medicine
- Day Surgery as default
- Enhancing Recovery
- Gateway Reviews

Perioperative Programme
Led by NCD for Perioperative Care, an aligned programme of work with a focus on:
- Pre-screening
- Prehabilitation / Optimisation
- Enhanced Care
- Digital Peri-op

- veloping a Pool of ssed Fit Patients
- ide to Preoperative sting - Local Anaesthetic
- plementing High Flow ts

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Capped Theatre Utilisation – Variation Ophthalmology



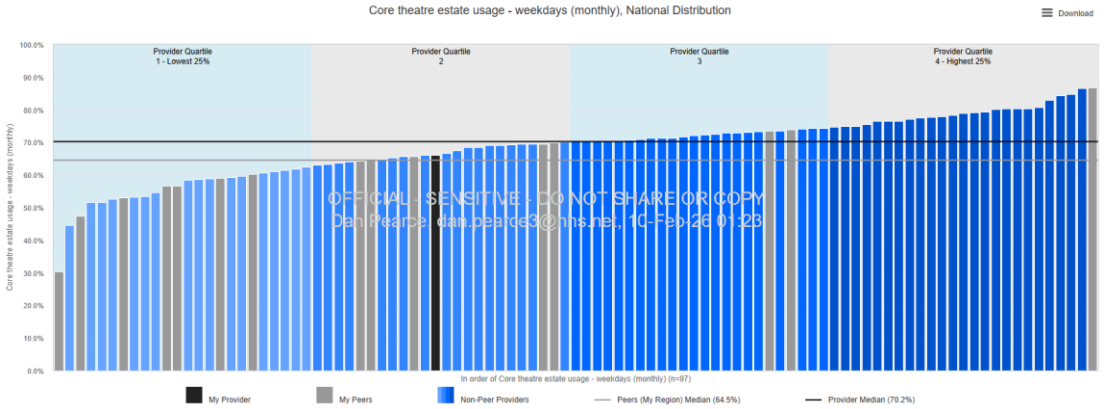
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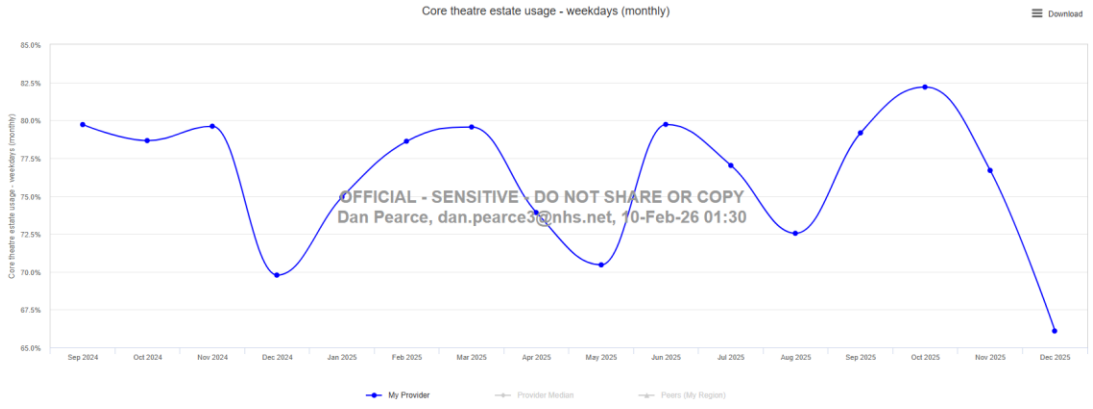
Theatre Productivity – Estate Usage

Impact on Productivity: Making best use of weekday theatre estate, with each theatre operational for a minimum of 8 hours a day 5 days a week ensures that we are making best use of our physical resources, this maximizes throughput in core activity ensuring more patients can be treated and generally results in less additional infrastructure costs of running theatres at weekends. There are potential additional workforce costs associated with running these models but can be mitigated to some degree by providers understanding their local workforce challenges, so if surgeon availability is the limiting step, then running parallel lists with resident doctors will mitigate against this, similarly if there are anaesthetic workforce pressures then LA only lists can be utilized.

	Theatre Estate usage - Weekday
Benchmark	95%
Provider Median	70.2%
Peer Group (Trust Size, Clinical Output)	73.8%
Current Provider Position	66.1% (equiv to 6,049 hours)

Productivity Opportunity (additional cases per month)				
Total available monthly theatre time (hours)	**Cases per session (current)**	**Peer Group Opportunity**	**Provider Median Opportunity**	**Benchmark Opportunity**
9,152	1.8	317	169	1,190





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Clinical improvements can be supported through implementation of:

- Theatre & perioperative improvement guides
- High flow theatres
- LA only lists (where workforce constraints exist)

GIRFT Specialty Standards: Cases per Theatre Session

Why did we need to do this?

Because of theatre inefficiencies and in some places poor utilisation of existing resources/assets

Speciality	Pathway	no of cases per 4 hr list
ENT	Endo sinus surgery	2
	Nasal airway surgery	3
	Myringoplasty	2
	Tonsillectomy	3
General Surgery	Inguinal Hernia	4
	Laparoscopic Cholecystectomy	3
	Paraumbilical Hernia	4
Gynaecology	Operative laparoscopy	4
	Endometrial ablation	8
	Hysteroscopy	8
	Laparoscopic hysterectomy (with or without removal of ovaries)	3
	Vaginal hysterectomy (anterior/posterior vaginal wall repair)	2-3
Urology	TURP	3
	TURBT	4
	Hydrocele	4
	Epididymal cyst excision	5
	Ureteroscopy and laser	3-4
	Vasectomy	6
	Cystoscopy and stent change	4
	Cystoscopy plus biopsy	5
	Cytolitholapaxy	4
	Circumcision	4
Ophthalmology	Cataract - with junior trainee	8
	Cataract - high flow	10
Orthopaedics (limbs)	Anterior Cruciate Ligament Reconstruction	3
	Bunions	4
	Therapeutic Shoulder Arthroscopy	4
	Total Hip Replacement	2
	Total Knee Replacement	2
	Uni Knee Replacement	2

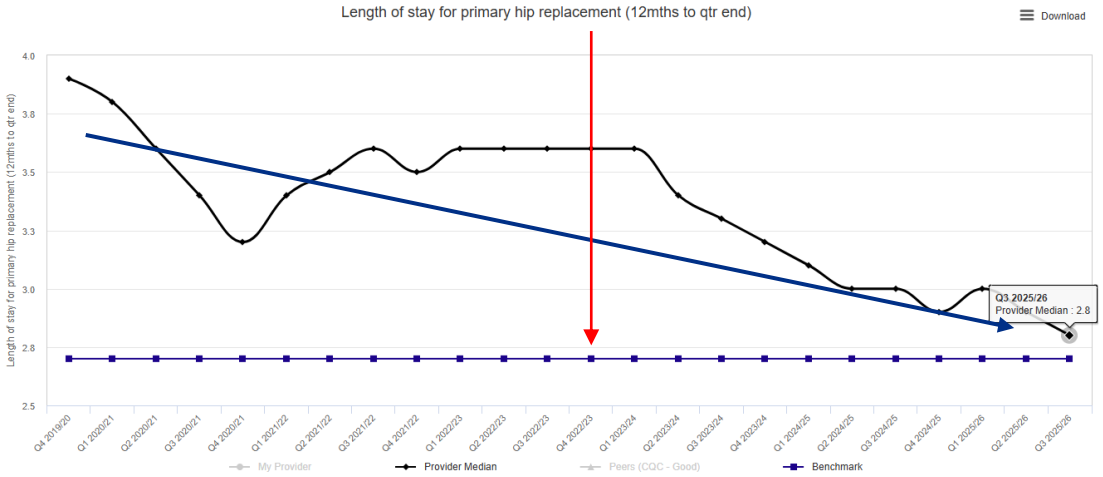
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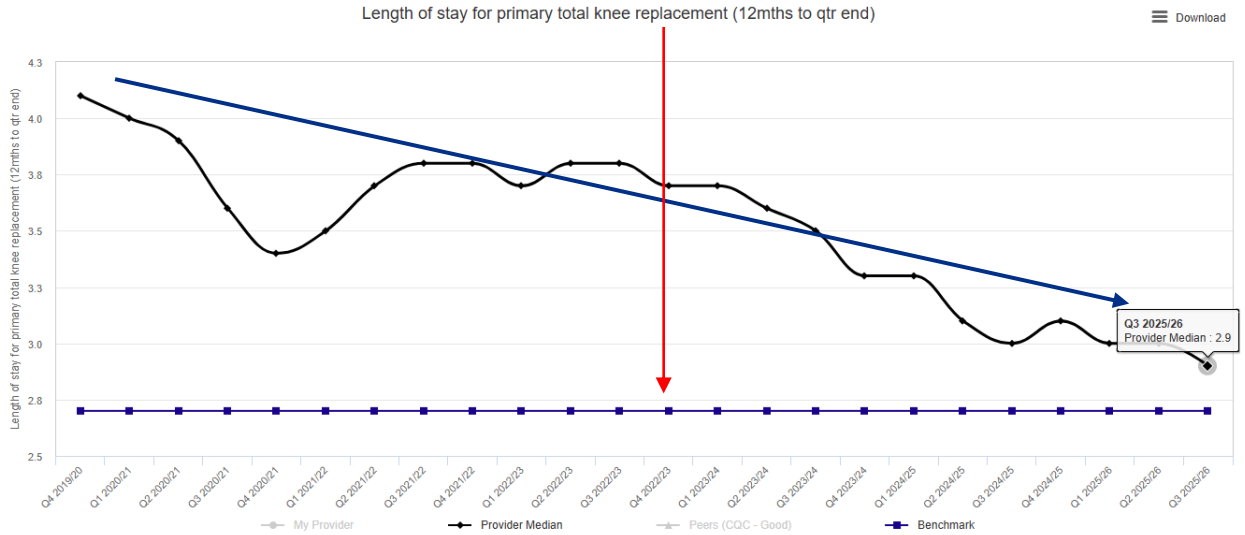
GIRFT impact: Orthopaedic elective hip & knee

LOS for Hip & Knee replacements has been a sentinel GIRFT metric. Through the widespread adoption of the GIRFT best practice pathway, supported by the focused support team, there has been a national reduction from:

4.1 days to 2.8 days for Hips (>17,000 bed days)
4.4 days to 2.9 days for Knees (>12,000 bed days)

Publication of the GIRFT Ambulatory Hip and Knee Replacement Guide in March 23

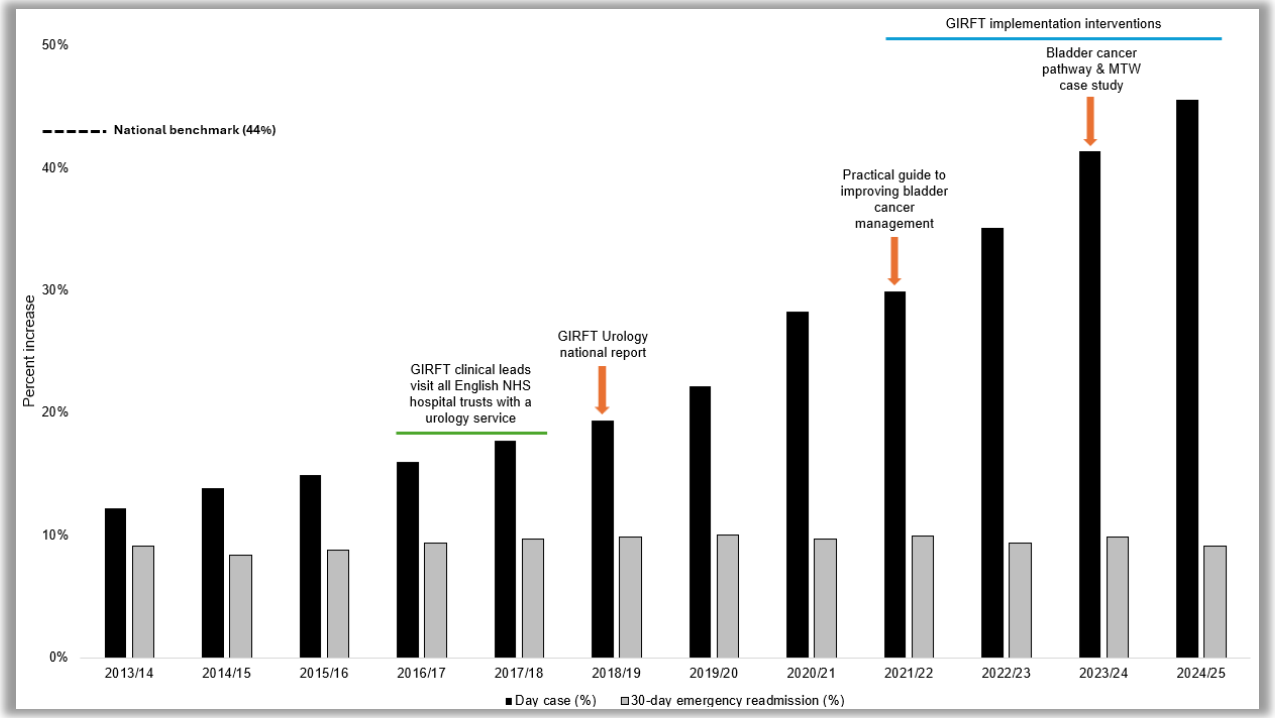




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GIRFT Urology: TURBT (transurethral resection of bladder tumour)

Question: How have day case rates changes over time and how might GIRFT have influences this change



All England day case rate and 30-day emergency readmission for TURBT

- Provision of TURBT as a day case procedure has been a focus of the urology team since the National report of 2018
- Provider median for day cases for TURBT increased from 12% in 2013/14 to 46% in 2024/25
- 30-day emergency readmission rates remained stable
- GIRFT has developed a range or resources and on-site support to help drive this change

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Elective Surgical Hubs

Separating Elective from UEC Changing Govt Policy

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GIRFT Elective Surgical Hub Programme

Background

- Prof Briggs has worked at RNOH (specialised surgical Hub) for 34 years.
- Proved the concept across 5 Trusts from 2015-2018 for Simon Stevens.
- Hubs have seen systematic growth following the advent of GIRFT in 2012, its HVLC Programme in 2021, and the introduction of the Elective Surgical Hub Accreditation Scheme in 2022.
- NHS elective surgical hubs having a proven role to play in increasing elective activity, improving efficiency, and reducing the length of time patients spend in hospital.
- They are a cornerstone of NHS England's strategy to tackle the elective backlog and deliver timely, high-quality care.

Aim

By ringfencing care, hubs aim to:

1) Increase productivity and efficiency in planned surgeries,
2) reduce cancellations,
3) reduce waiting times, and
4) improve patient experience and staff satisfaction.

Objectives

Clinically led and data driven, the objectives of the National GIRFT Elective Surgical Hub Team are to:

1) manage the investment and drive the expansion of hubs across England (e.g. TIF funding),
2) establish a blueprint and ensure a baseline standard across all NHS elective surgical hubs (e.g. Accreditation Scheme), and
3) optimise and improve hub capability (e.g. GIRFT HOW).

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There are currently 128 NHS elective surgical hubs in operation across all 7 regions of England.

NHS Elective Surgical Hubs

Characteristics

- NHS elective surgical hubs range in size and configuration; from single theatre units within an acute site, to expansive purpose-built facilities housing up to 14 theatres.
- Average size is 4 theatres per hub.
- They **primarily focus on providing HVLC surgery** in both adults and children, with an emphasis on ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, ear nose and throat, and urology.
- Characteristically all hubs:
  - ✓ Operate as a distinct self-contained unit with a dedicated hub management team.
  - ✓ Exclusively perform planned surgery in at least one of the HVLC specialties.
  - ✓ Have dedicated facilities and staff who are not used to support operational pressures elsewhere.
  - ✓ Are committed to embedding the HVLC principles of 6-day operating, 48 weeks per year, 2.5 session days and 85% theatre utilisation.
- There are three different types of elective surgical hub: 1) standalone, 2) integrated, and 3) ringfenced. Roughly even split of each.

Key benefits:

- More efficient use of theatre capacity and increased throughput.
- **Increased resilience against winter pressures.**
- Streamlined pathways and shorter length of stay.
- Application of innovative, more sustainable workforce
- **Reduced pressure on staff and improving morale, training opportunities, recruitment & retention.**

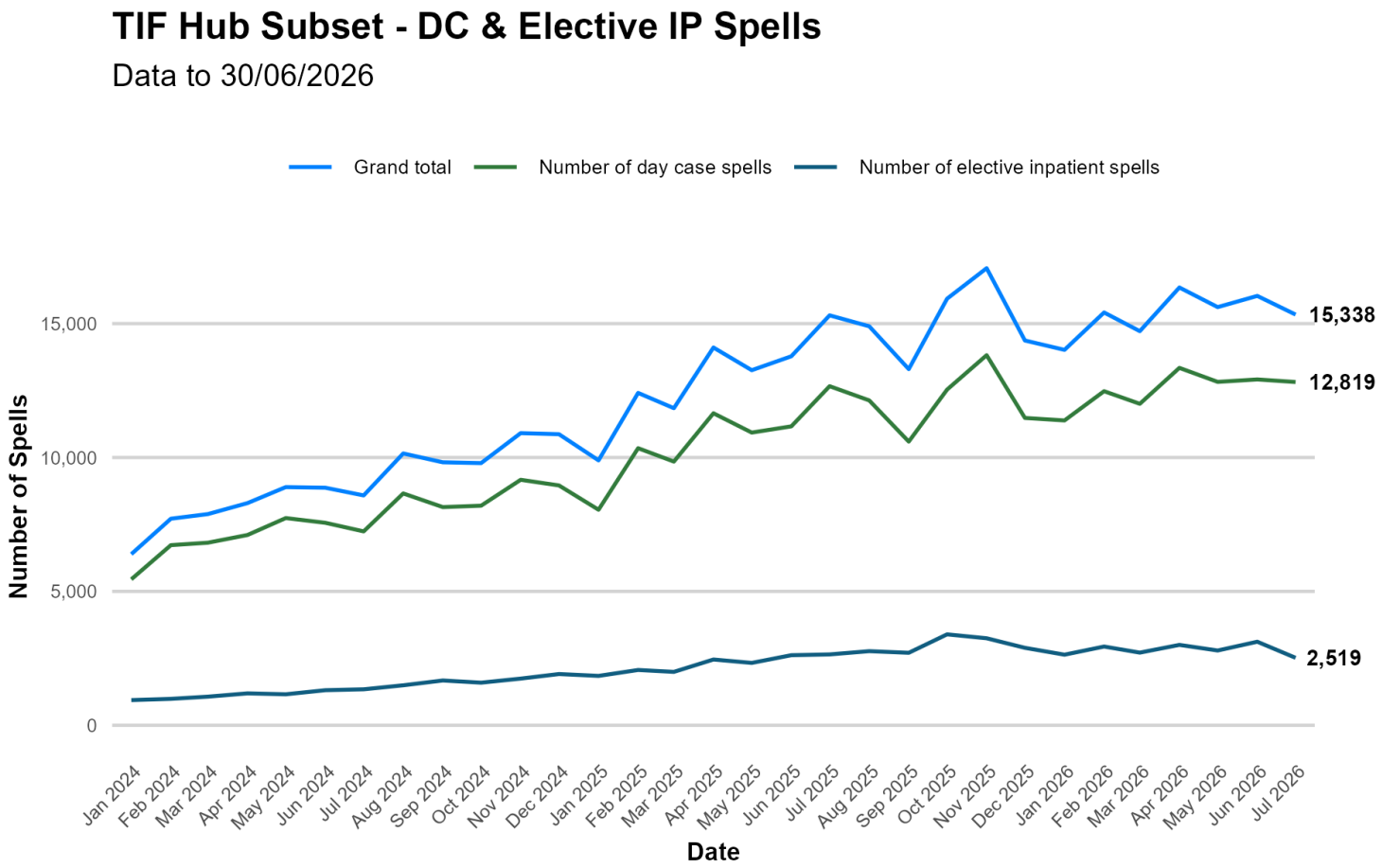
NHS Elective Surgical Hubs (pre existing 84 new 44)

Targeted Investment Fund

Elective hubs have been shown to increase productivity and activity, contributing to the overall reduction in waiting lists.

In the 12 months between April 2024 and March 2025 over 2.3 million daycase, inpatient and outpatient procedures were delivered in elective surgical hubs in England.

Roughly £1bn was invested in the hub estate as part of a capital allocation for elective transformation, with hubs in receipt of funding demonstrating an (ave.) **11% increase in provider inpatient and day case activity.**



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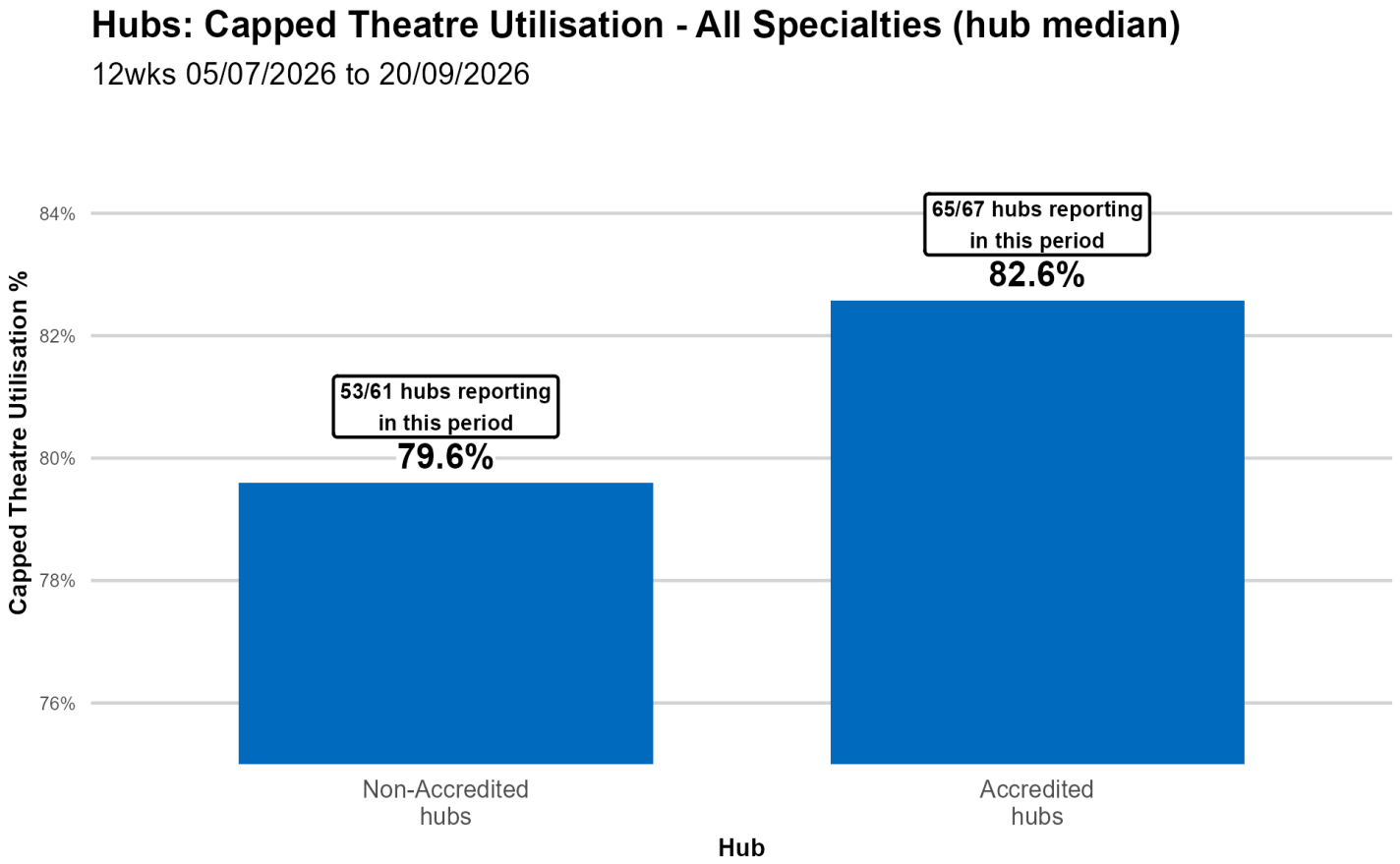
NHS Elective Surgical Hubs

Accreditation Scheme

The GIRFT programme runs a national accreditation scheme for elective surgical hubs across England.

The scheme is designed to assess hubs against a set of clinical and operational standards, ensuring high-quality care, efficient patient pathways, and effective use of resources.

- There are 128 hubs in operation across England.
- 92 hubs are accredited.
- Expectation that 95% of operational hubs will have gone through the Accreditation process by 2026.



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Royal College of Surgeons of England

GIRFT Hub Optimisation Week

Context

- In December 2025, Professor Tim Briggs and Mark Cubbon jointly wrote to the CEOs of all trusts with elective surgical hubs requesting their participation in the GIRFT HOW.
- Overwhelming positive response to the initiative, with 108 NHS Elective Surgical Hubs confirming their participation in the GIRFT HOW, equating to ~90% of eligible hubs.
- There has been no financial incentive. Instead, there has been a shared sense of purpose towards a common goal of optimising our hubs for the benefit of our staff and our patients.
- The GIRFT HOW has had a tangible impact on hub productivity.



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Royal College of Surgeons of England

Royal College of Anaesthetists

Centre for Perioperative Care

British Orthopaedic Association

GIRFT HOW: National-level impact

01 REDUCE LOST TIME
Cleaner session delivery

- Late starts ↓ 27.6%
- Intercase downtime ↓ 9.9%
- Early finishes ↓ 12.8%

02 IMPROVE EACH LIST
Higher in-session productivity

- Capped utilisation 81.4 → 85.5%
- Cases per 4-hour list ↑ 6.9%

03 RUN MORE SESSIONS
Better use of staff and estate

- Equivalent sessions ↑ 9.0%

More staffed theatre time made available

04 DELIVER MORE CARE
Additional cases through hubs

NUMBER OF CASES

10.5–16.6% increase

Statistically significant • $p < 0.001$

ADDITIONALITY SIGNAL

More cases through hubs than session growth alone would explain

At a National level there was an overall increase in total theatre cases (hubs and non-hubs) compared to baseline run rates

WHY IT MATTERS

RTT RECOVERY
More patients treated

PATIENT EXPERIENCE
Shorter, more reliable waits

STAFF EXPERIENCE
Better planned sessions

NHS RESOURCES
Better use of staff and estate

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Hubs: a summary from independent academia

- **Hubs increase hip and knee replacement activity at host trusts by around 19%.** Separate analysis across HVLC specialties finds a 14.5% increase in physician productivity.
- **Reductions in waiting time emerge from the second year after hub opening**, initially modest, becoming more substantial.
- **No cream-skimming at trust level:** hubs expand activity without significantly changing the overall mix of patients treated, including deprivation and complexity.
- **Some within-trust sorting:** hub sites treat slightly less complex patients than other NHS sites, but the difference is modest. Private providers are far more selective treating patients with notably lower deprivation and fewer comorbidities.

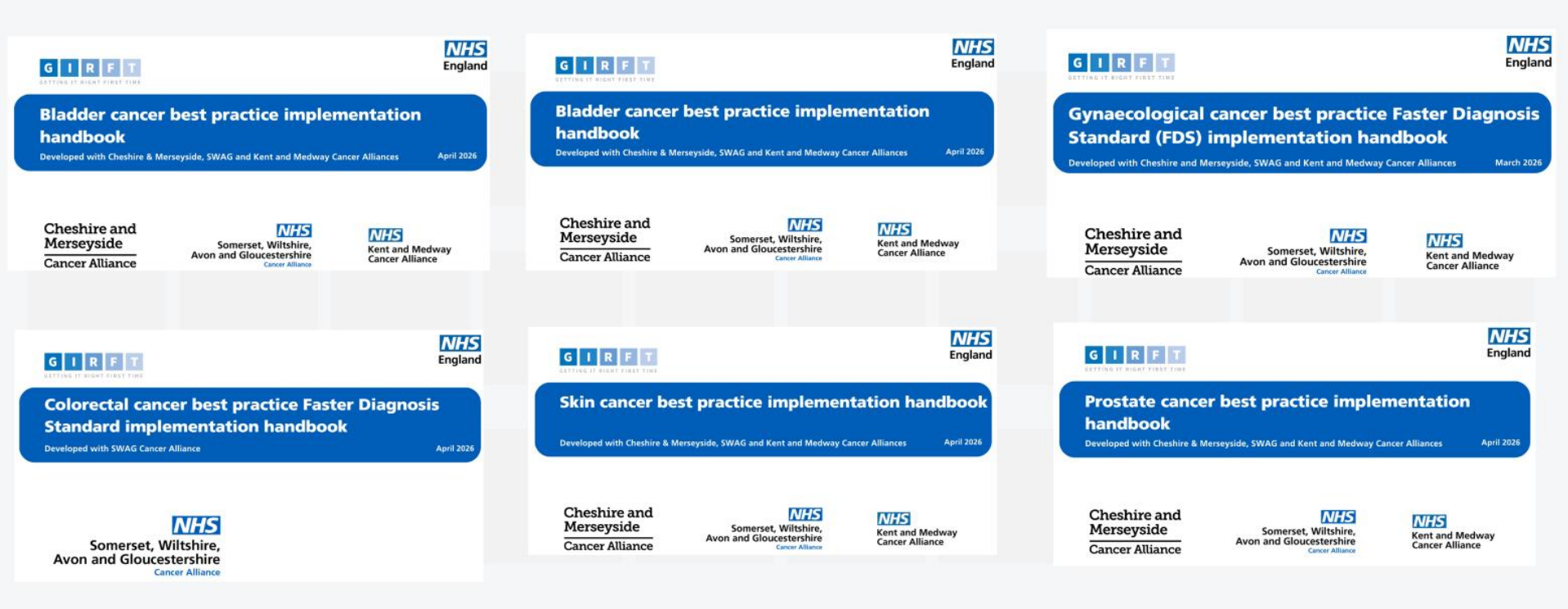
CHE Centre For Health Economics
Part of University of York

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GIRFT Cancer Pathways

Cross Cutting

As part of the national cancer plan, NHSE's Cancer Programme is producing cancer manuals with input from all GIRFT cancer clinical leads.

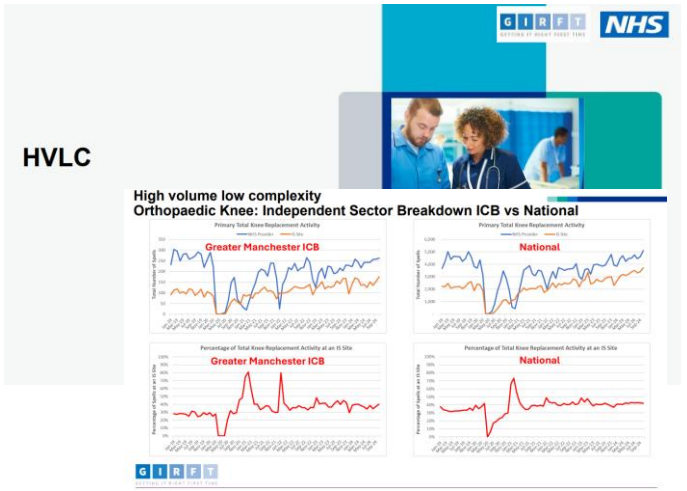


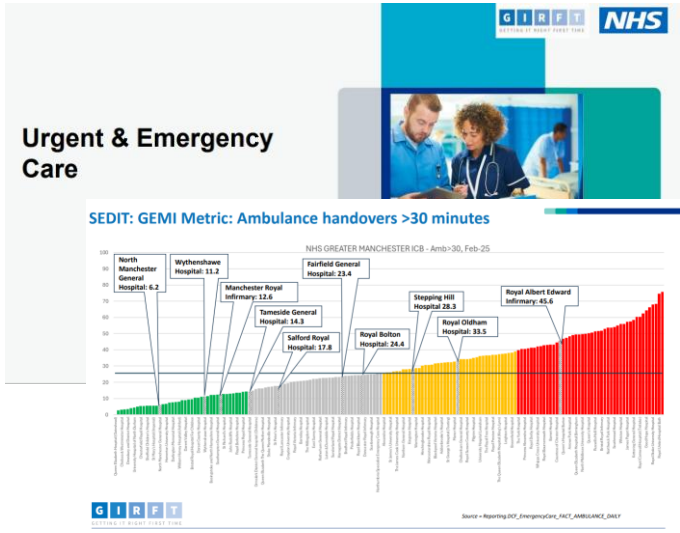
GETTING IT RIGHT FIRST TIME

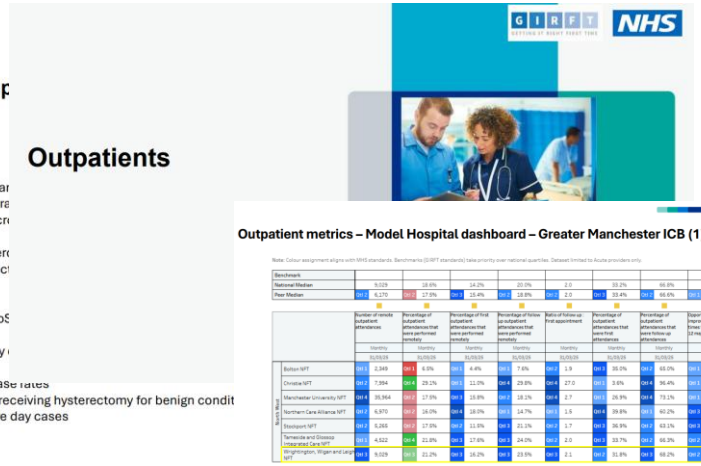
GIRFT ‘Productivity’ Packs to every trust quarterly

What this pack aims to achieve

- This pack follows on from the GIRFT ICB visits
- It allows Trusts to look at their data, compare with others and drive improvement
- It covers **Outpatients, Theatres, CYP, Cancer, and UEC**
- We ask that the pack is reviewed at Trust Board Level and plans made and implemented to improve
- We ask that there is a particular focus on OPD especially around 18 weeks
- This pack will be refreshed every 3 months and include areas of improvement and concern





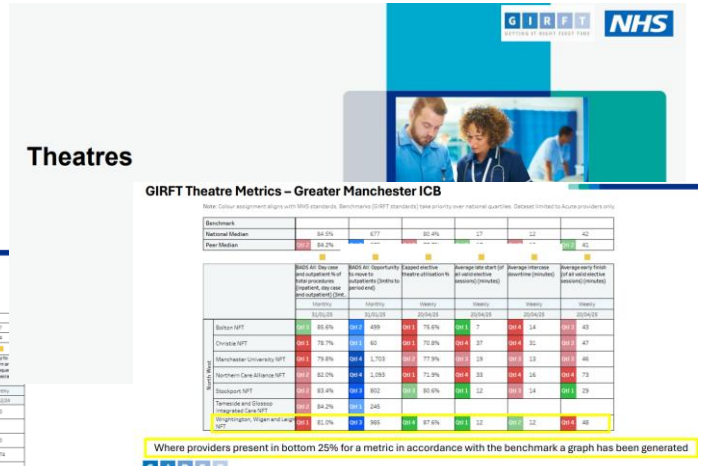


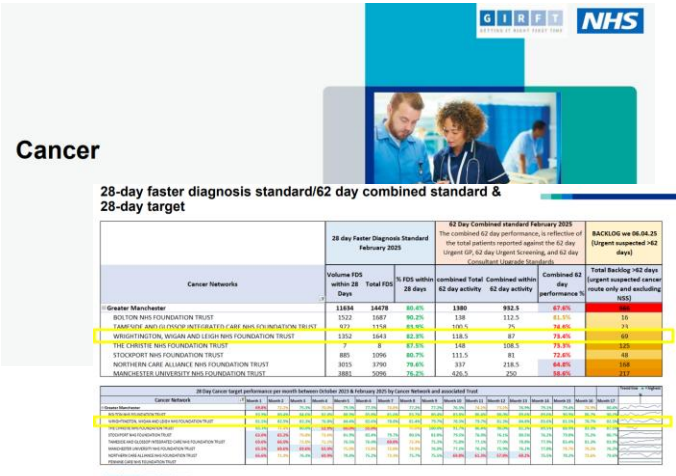
Potential productivity opportunities to sup

Outpatients
- **Opportunity** to increase PIFU utilisation rate
- **Opportunity** to reduce DNAs (all specialties)
- **Opportunity** to increase percentage of outpatient attendar
- **Opportunity** to improve utilisation rate for specialist referra
- **Opportunity** to improve turn around times for requests acr

Theatres
- **Opportunity** to improve BADS day case and outpatient per
- **Opportunity** to reduce average early finish for all valid elec

HVLC
- **Opportunity** to reduce Primary Hip Replacement LoS
- **Opportunity** to reduce Primary Total Knee replacement LoS
- **Opportunity** to reduce FNOF LoS
- **Opportunity** to improve Tonsillectomy (ENT Surgeons) day
- **Opportunity** to increase Ureteroscopy day case rates
- **Opportunity** to increase Elective Cholecystectomy day case rates
- **Opportunity** to improve minimal access rate for patients receiving hysterectomy for benign condit
- **Opportunity** to increase HVLC Cataract surgery procedure day cases





GETTING IT RIGHT FIRST TIME

How does research support GIRFT?



diabetesresearchandclinicalpractice 207 (2024) 111062

Contents lists available at ScienceDirect

Diabetes Research and Clinical Practice

journal homepage: www.journals.elsevier.com/diabetes-research-and-clinical-practice

Improving the outcomes for people with diabetes unde
observational study of the Improving the Peri-operative
with Diabetes (IP3D) intervention

Gerry Rayman[a,b,c], Emma Page[a,b], Steve Hodgson[d], William Henley
William K. Gray[a,*]

[a] Getting It Right First Time Programme, NHS England, London, UK
[b] The Ipswich Diabetes and Endocrine Centre, Ipswich Hospital, East Suffolk and North Essex NHS Foundation Trust, Ipsw
[c] The Medical School, University of East Anglia, Norwich, UK
[d] RSM UK Consulting LLP, Cambridge, UK
[e] Department of Health and Community Sciences, University of Exeter Medical School, Exeter, UK
[f] Department of Surgery, Royal National Orthopaedic Hospital NHS Trust, Stanmore, London, UK

Royal College of Surgeons of England

UPPER GI SURGERY

Ann R Coll Surg Engl 2023; 000: 1–8
doi 10.1308/rcsann.2023.0111

Association of day-case rates with post COVID-19 recovery of elective laparoscopic cholecystectomy activity across England

FM Ayyaz[1,2], J Joyner[1,5], M Cheetham[1,4], TWR Briggs[1,5], WK Gray[1]

[1]Getting It Right First Time Programme, NHS England and NHS Improvement, UK
[2]Manchester University NHS Foundation Trust, UK
[5]Croydon Health Services NHS Trust, UK
[4]The Shrewsbury and Telford Hospital NHS Trust, UK
[5]Royal National Orthopaedic Hospital NHS Trust, UK

ABSTRACT

Introduction The aim of this study was to investigate the safety of day-case laparoscopic cholecystectomy, and the association between day-case rates and, post the COVID-19 pandemic, recovery of activity to prepandemic levels for integrated care boards (ICBs) in England.

Methods This was a retrospective observational study of the Hospital Episodes Statistics (HES) data set. Elective laparoscopic cholecystectomies for the period 1 January 2019 to 31 December 2022 were identified. Activity levels for 2022 were compared with those for the whole of 2019 (baseline). Day-case activity was identified where the length of stay recorded in the HES was zero days.

Results Data were available for 184,252 patients across the 42 ICBs in England, of which 120,408 (65.3%) were day-case procedures. By December 2022, activity levels for the whole of England had returned to 88.2% of prepandemic levels. The South West region stood out as having recovered activity levels to the greatest extent, with activity at 97.3% of prepandemic levels during 2022. The South West also had the highest postpandemic day-case rate at 74.9% of all patients seen as a day-case during 2022; this compares with an England average of 65.3%. At an ICB level, there was a significant correlation between day-case rates and postpandemic activity levels ($r = 0.362$, $p = 0.019$). There was no strong or consistent evidence that day-case surgery had poorer patient outcomes than inpatient surgery.

Conclusions Recovery of elective laparoscopic cholecystectomy activity has been better in South West England than in other regions. Increasing day-case rates may be important if ICBs in other regions are to increase activity levels up to and beyond prepandemic levels.

Open access

BMJ Health & Care Informatics

Data
Episodes Statistics database

Flavien Hardy ,[1,2] Johannes Heyl,[1,2] Katie Tucker,[3] Adrian Hopper,[1,4]
Maria J Marchā,[5] Tim W R Briggs,[1,6] Jeremy Yates,[5,7] Jamie Day,[1]
Andrew Wheeler,[1] Sue Eve-Jones,[1] William K Gray [1]

To cite: Hardy F, Heyl J, Tucker K, *et al*. Data consistency in the English Hospital Episodes Statistics database. *BMJ Health Care Inform* 2022;**29**:e100633. doi:10.1136/bmjhci-2022-100633

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjhci-2022-100633).

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Check for updates

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ABSTRACT

Background To gain maximum insight from large administrative healthcare datasets it is important to understand their data quality. Although a gold standard against which to assess criterion validity rarely exists for such datasets, internal consistency can be evaluated.

We aimed to identify inconsistencies in the recording of mandatory International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10) codes within the Hospital Episodes Statistics dataset in England.

Methods Three exemplar medical conditions where recording is mandatory once diagnosed were chosen: autism, type II diabetes mellitus and Parkinson's disease dementia. We identified the first occurrence of the condition ICD-10 code for a patient during the period April 2013 to March 2021 and in subsequent hospital spells. We designed and trained random forest classifiers to identify variables strongly associated with recording inconsistencies.

Results For autism, diabetes and Parkinson's disease

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Large-scale administrative healthcare datasets are increasingly being used to support decision-making, but very little work has been done to assess the quality and consistency of the data.

WHAT THIS STUDY ADDS

⇒ The study offers a novel assessment and analysis of the data quality of the Hospital Episode Statistics dataset in the recording of mandatory diagnoses for patients with autism, type II diabetes mellitus with

Research methods and reporting

OPEN ACCESS

Environmental Lessons Learned and Applied (ELLA): a new framework for identifying, prioritising and implementing decarbonisation interventions in clinical care pathways

m K Gray ,[2] Chantelle Rizan,[3]
cGain ,[5] Manraj Phull,[6]
nson,[8] Edward Nickell,[2]
gs,[2] John S McGrath[2,10]

EUROPEAN UROLOGY OPEN SCIENCE 52 (2023) 44–50

anurology.com

Day-case Compared to Inpatient
ladder Tumour Surgery in England:
Study Using Administrative Data

ohn[Gf], Maria van Hove[Gf], John McGrath[Gf],
m K. Gray[G,*]

Received: 1 May 2026 | Revised: 15 June 2026 | Accepted: 20 July 2026

DOI: 10.1111/codi.70622

RESEARCH ARTICLE

Ileostomy creation for rectal cancer in England: An observational study of variation, and correlates using administrative data

Naomi Olagunju[1,2] | Mark Cheetham[1,2] | Katrein Savage[1] | Tim W. R. Briggs[1,3] | William K. Gray[1]

[1]Getting it Right First Time Programme, NHS England, London, UK
[2]Shrewsbury and Telford Hospital NHS Trust, Shrewsbury, UK
[3]Royal National Orthopaedic Hospital,

Abstract

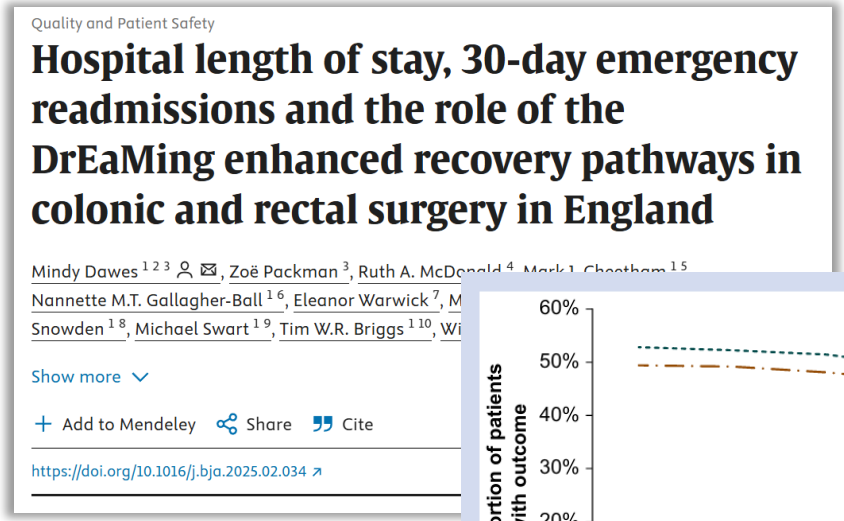
Aims: The decision to create an ileostomy following anterior resection is a clinical one based on the judgement of the surgical team. However, there are few data to support decision-making. This study aimed to explore variation in, and factors associated with,

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Post-operative care: implementation of DrEaMing (drinking, eating and mobilising)

Question: Does DrEaMing reduce patient length of stay without increasing early emergency readmissions?

- The DrEaMing initiative aims to improve post-operative recovery through early drinking, eating and mobilising
- Adoption of GIRFT enhanced recovery pathways reduced the length of stay of patients undergoing colorectal surgery, with no negative impacts to emergency readmission
- Greater compliance with DrEaMing was associated shorter hospital stay



Quality and Patient Safety

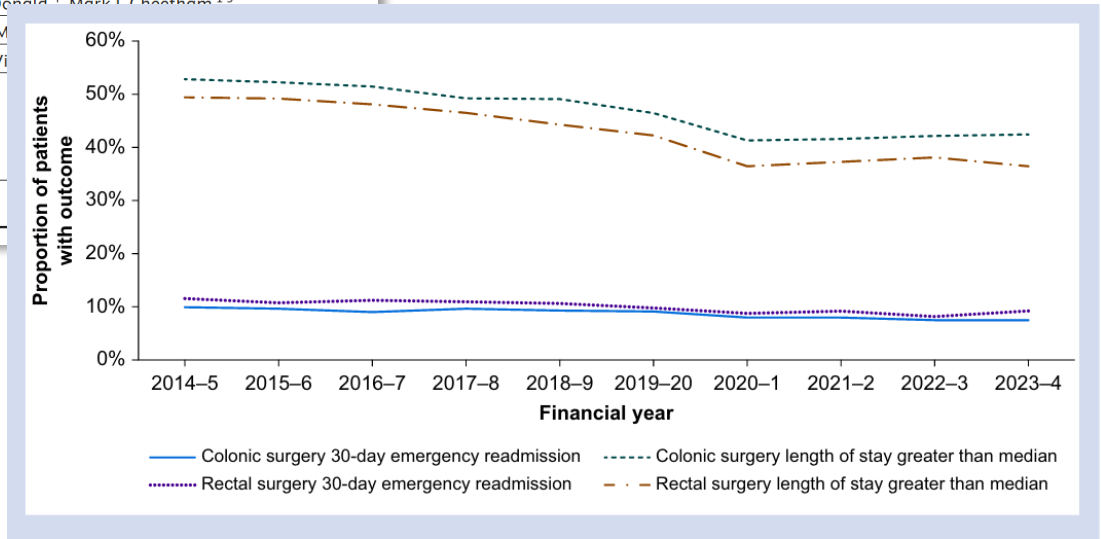
Hospital length of stay, 30-day emergency readmissions and the role of the DrEaMing enhanced recovery pathways in colonic and rectal surgery in England

Mindy Dawes [1 2 3], Zoë Packman [3], Ruth A. McDonald [4], Mark J. Cheetham [1 5], Nannette M.T. Gallagher-Ball [1 6], Eleanor Warwick [7], M... Snowden [1 8], Michael Swart [1 9], Tim W.R. Briggs [1 10], Wi...

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https://doi.org/10.1016/j.bja.2025.02.034



Led by Mindy Dawes: GIRFT Fellow and senior nurse at University Hospitals Birmingham

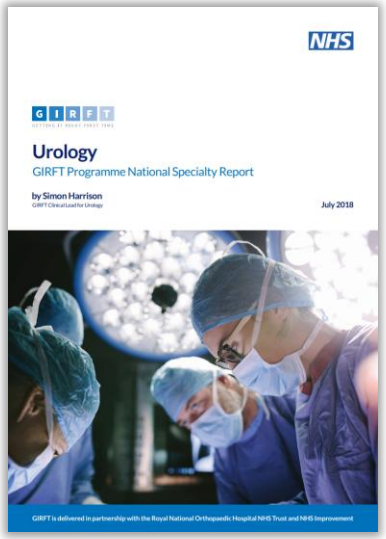
Supported by the Chief Nurse's Office at NHS England (Zoe Packman)

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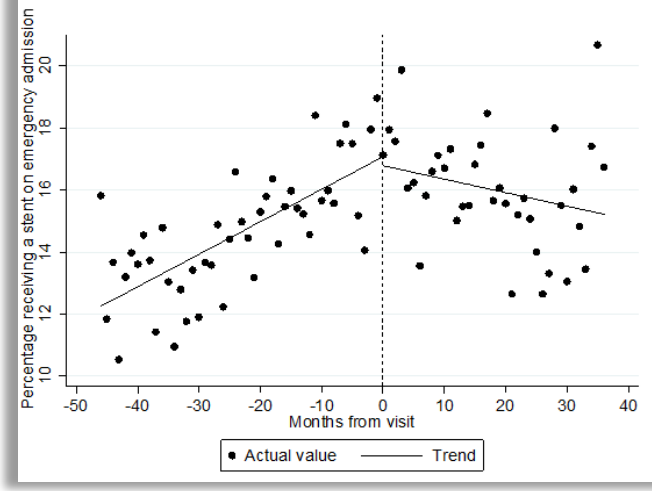
GIRFT impact: Urology stones

Reducing the use of ureteric stents a first line treatment for stones, and increased use of shockwave lithotripsy or ureteroscopy were both focus areas of the urology team in their National Specialty Report, following visits to England NHS providers of urology services.

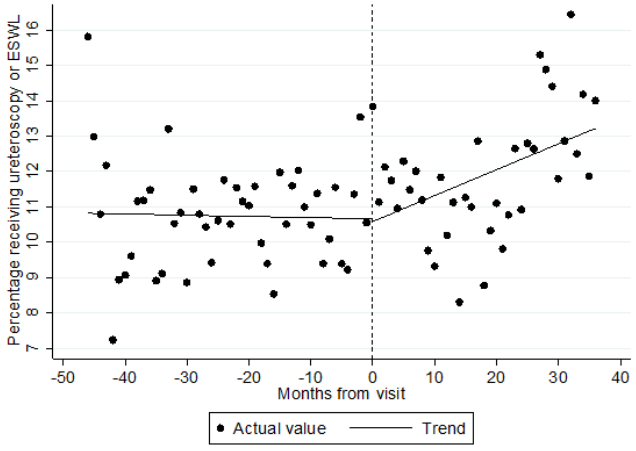
The charts show the change in provider behaviour for these two treatments, with the date of their GIRFT visit as the step-change:



Significant reduction in use of ureteric stents as first line treatment for stones



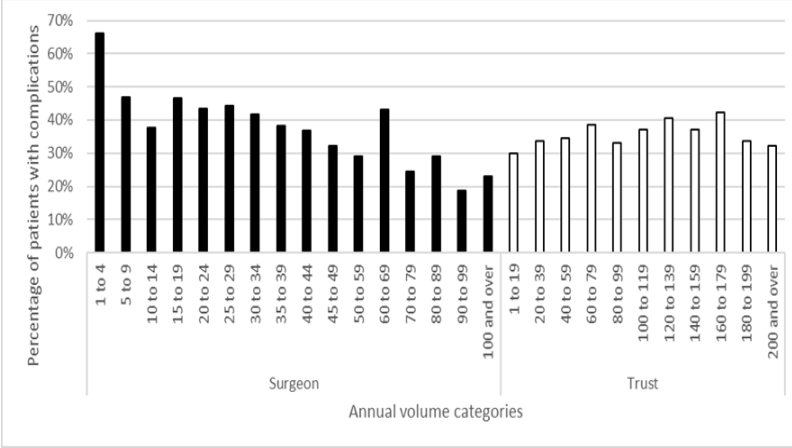
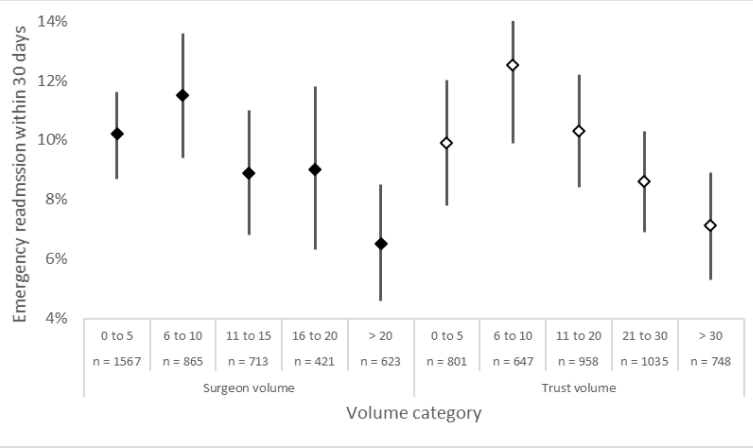
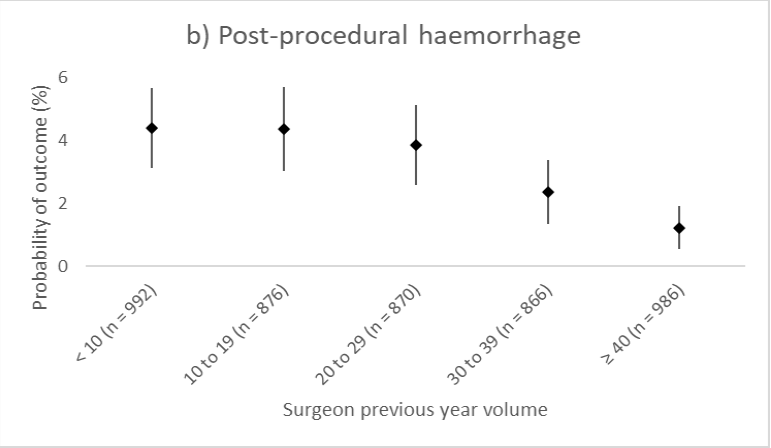
Significant increase in use of shockwave lithotripsy or ureteroscopy as first line treatment for stones



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Examples of comparison of outcomes for those meeting and not meeting a recommendation

Improvement in patient outcomes by reducing low volume surgery:

Higher complication rates in low volume thyroid surgeons	Higher complication rates in low volume adrenal surgeons and trusts	Higher complication rates in low volume pituitary surgeons
		
Gray WK, Aspinall S, Tolley N, Day J, Lansdown M. The volume and outcome relationship for thyroidectomy in England. Langenbecks Arch Surg. 2021;406(6):1999-2010.	Gray WK, Day J, Briggs TWR, Wass JAH, Lansdown M. Volume-outcome relationship for adrenalectomy: analysis of an administrative dataset for the Getting It Right First Time Programme. Br J Surg. 2021;108(9):1112-1119.	Gray WK, Navaratnam AV, Phillips, N et al The volume-outcome relationship for endoscopic transsphenoidal pituitary surgery in England: analysis of an administrative dataset for the Getting It Right First Time programme

GETTING IT RIGHT FIRST TIME

Changing practice

Centralisation of complex procedures:

- Knee revision centres - BASK
- Elbow networks – BESS (JR/MF)

Next:

- Ankle replacements/fusions- BOFAS (David Townsend)

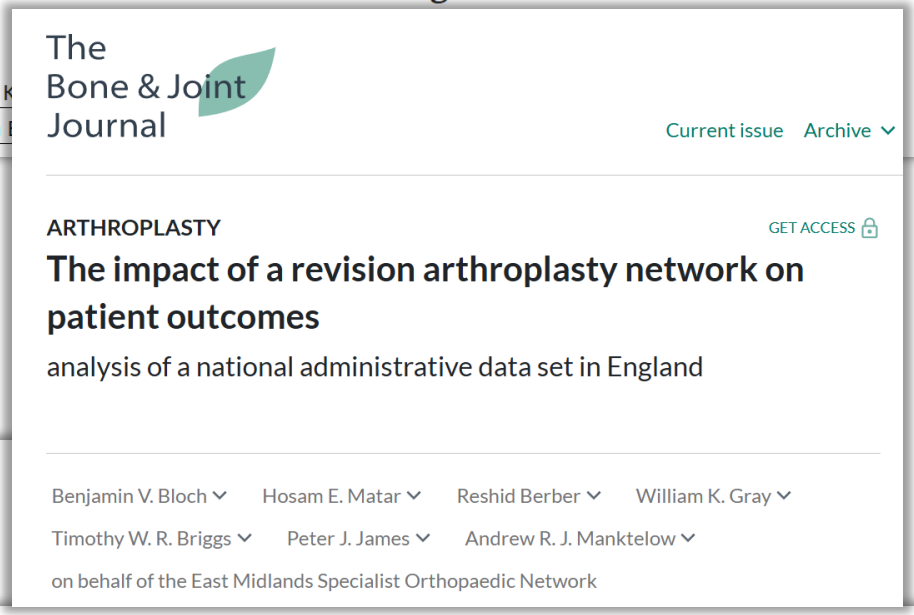
(January 2027)



Research article ● Open access Under a Creative Commons license ↗ Get rights and content ↗

Evaluating the impact of revision knee arthroplasty networks in England: an analysis of temporal trends in referral patterns, surgical volumes and early outcomes using hospital episode statistics data for England between 2012 and 2024

Alexander H. Matthews [a b c d], William K
Phillips [b c], Abtin Alvand [d g], Benjamin



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ARTHROPLASTY GET ACCESS

The impact of a revision arthroplasty network on patient outcomes

analysis of a national administrative data set in England

Benjamin V. Bloch Hosam E. Matar Reshid Berber William K. Gray
Timothy W. R. Briggs Peter J. James Andrew R. J. Manktelow
on behalf of the East Midlands Specialist Orthopaedic Network



KSSTA Knee Surgery Sports Traumatology Arthroscopy THE OFFICIAL CLINICAL JOURNAL OF ESSKA

KNEE ARTHROPLASTY Open Access

Higher hospital volume reduces early failure rates in single-stage revision TKR for infection: An analysis of the United Kingdom National Joint Registry and National Administrative Databases

Alexander H. Matthews, William K. Gray, Jonathan P. Evans, Ruth Knight, Jonathan T. Evans, Sarah E. Lamb, Tim Briggs, Andrew Porteous, Shiraz A. Sabah, Abtin Alvand ... See all authors



KSSTA Knee Surgery Sports Traumatology Arthroscopy THE OFFICIAL CLINICAL JOURNAL OF ESSKA

KNEE ARTHROPLASTY Open Access

Higher surgeon volume reduces early failure in first time revision of non-infected total knee arthroplasty: An analysis using data from the United Kingdom National Joint Registry

Alexander H. Matthews, William K. Gray, Jonathan P. Evans, Jonathan T. Evans, Sarah E. Lamb, Andrew Porteous, Tim Briggs, Shiraz A. Sabah, Abtin Alvand, Andrew D. Toms, Andrew J. Price

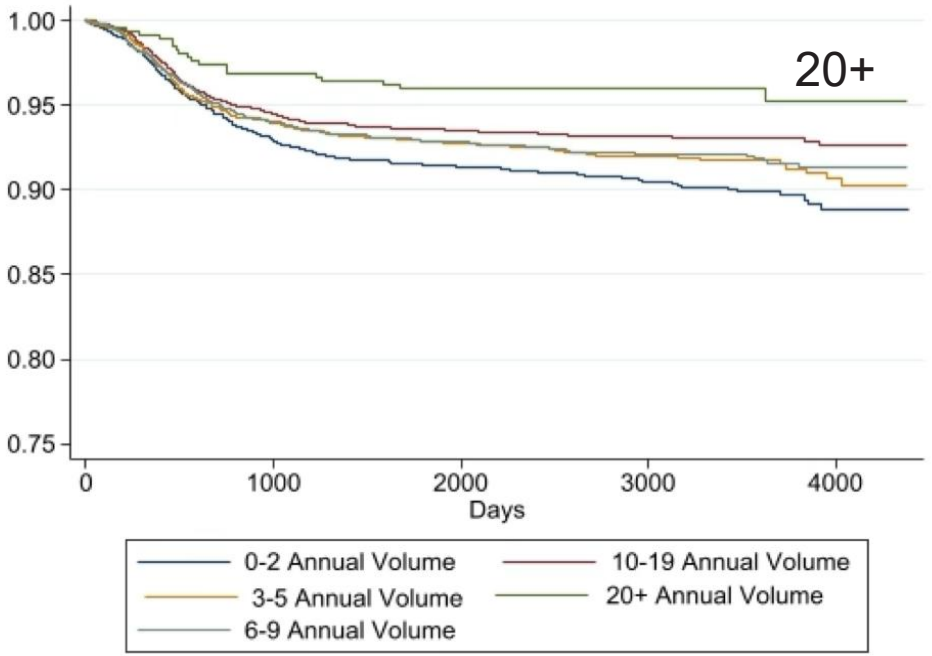
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Ankle arthritis surgery: Volume – Outcome relationships

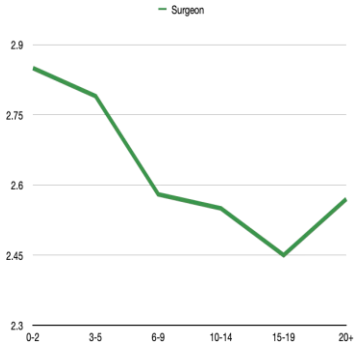
Question: Does performing more ankle replacements or ankle fusions improve outcomes

Led by Rebecca Martin: GIRFT Fellow and Trauma and Orthopaedics trainee Northumbria Healthcare NHS Foundation Trust and supported by ORUK and BOFAS

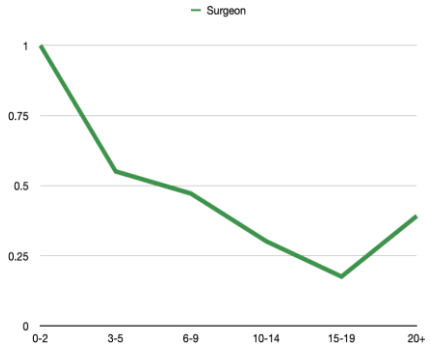
- **Total ankle replacement:** Surgeon or hospital volume was not associated with revision rates
- **Total ankle replacement:** Surgeon volume was associated with improved short-term outcomes (lower 30-day complication-related readmission and shorter length of stay



Implant survival at different volume categories



Length of Stay



Complications

- **Ankle arthrodesis:** Increasing surgeon volume (but not hospital trust volume) was associated with significantly lower 2- and 5-year revision

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Spinal Services: lumbar medial branch blocks / facet joint injections

Question: Has GIRFT National Report recommendation to avoid repeat spinal injections for low back pain been implemented?

Led by Jacob Koris and Elizabeth Ojelade: GIRFT Fellows and orthopaedic registrars at Royal National Orthopaedic Hospital

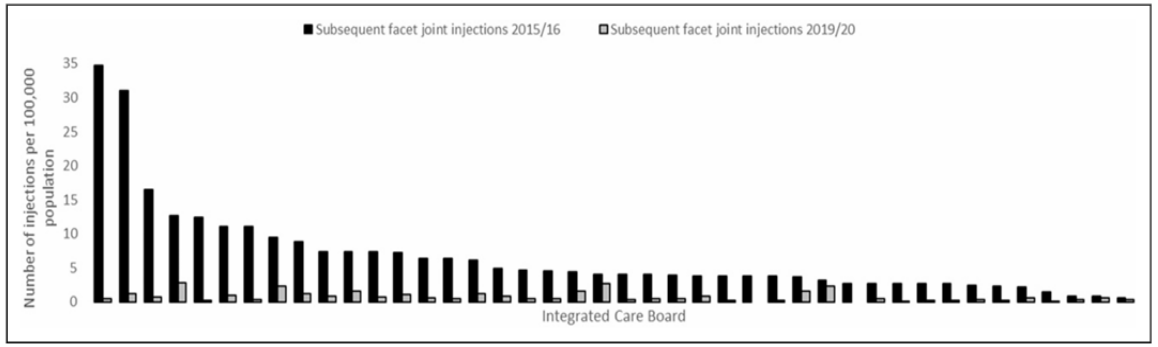
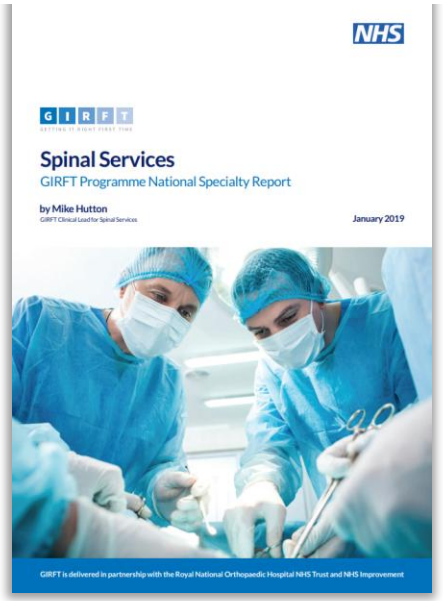


Figure 2. Number of patients with a repeat injection per 100,000 population for each Integrated Care Board in England for 2015/16 and 2019/20 (Integrated Care Boards anonymised for confidentiality).

- Repeated use of spinal injections for low back pain has little benefit for patients and was recommended to be discontinued by GIRFT
- Over five years from 2015/16 to 2019/20 repeat injections fell from 4,018 per annum to 424 per annum
- The financial cost of injections decreased from £27.6 million in 2015/16 to £7.9 million in 2019/20
- Over the same five year period 2.8 kilotonnes of CO_2e saved



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