

Elective Recovery High Volume Low Complexity (HVLC) guide for systems

May 2021



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Purpose of this guide



As the NHS steps up efforts to increase elective activity to the maximum possible levels during the first half of 2021/22, the HVLC programme has been asked to be the vanguard of the elective recovery campaign.

Central to this will be the setting of delivery plans for HVLC activity in early May, across ALL six specialties and 29 pathways, utilising best practice, theatre efficiencies and productivity and day case rates as outlined by GIRFT.

This guide provides a comprehensive view of the HVLC programme and is intended to support NHS region and system leaders in your understanding and communication of the programme, and to enable the development of your local HVLC delivery plans.

This programme was developed in a true partnership with the London region and, as it is rolled out nationally, will be regionally-led, system-delivered and GIRFT-enabled.

Professor Tim Briggs

National GIRFT programme lead, national lead for HVLC work and National Director of Clinical Improvement

May 2021

Acknowledgements



GIRFT would like to acknowledge the support of the London region and its senior team in developing this programme, namely Regional Director Sir David Sloman and Regional Medical Director Dr Vin Diwakar.

It has been a true partnership and shows what can be achieved when we all work collaboratively together.

We would also like to thank the following, who have been critical to the success of the London regional/GIRFT pilot:

- David Probert, CEO of Moorfields: senior sponsor for programme
- Paul Bennett, Senior Responsible Officer
- Arlene Wellman, Chief Nurse
- Johanna Moss, Programme Director
- Amanda Quincey, Deputy Programme Director
- Ann Hepworth, Head of Improvement
- Aine Donnelly, Senior Programme Manager

The ask of regions and systems



Requirement from each region:

- Regional Director and Regional Medical Director support
- Signed up to ALL principles: equity of access, top decile of clinical outcomes
- Theatre principles (operational excellence) and theatre efficiencies – cases per list.
- Working “shoulder to shoulder” with Independent Sector on a level playing field
- Strong PMO – CEO champion, dedicated project management/improvement support
- Clinical lead per speciality/system and region, working closely with GIRFT speciality national clinical lead
- Start with six specialties, with oversight board/region co-chaired by National Director of Clinical Improvement and Regional Medical Director with both clinical and programme leads

Requirement from each system

- Agree adoption at “pace”
- Buy-in and commitment to adopt the pathways, tailored to local needs, as a system
- Clinical leads across each system for each speciality
- Gateway reviews, D/C at 85%, theatre principles, 29 pathways
- All underpinned by data analytics – Model Health System and theatre returns monthly
- Model Health System regular review embedded into “business as usual”

The ask continued



GIRFT enabled with support:

- To work with each ICS to deliver the changes required at pace
- GIRFT national clinical leads to support regional/systems leads with gateway reviews, facilitation, advice and support
- GIRFT facilitated learning networks, connecting the regional/system clinical leads nationally to support rapid dissemination, adoption and joint working to address shared challenges
- Webinars/support for staff to use Model Health System and other specific topics e.g. day surgery
- Help to support those systems where change is slow
- Regular review of data and feedback

Support from regional/system finance:

- Financial air cover – for system working “we are all in this together”
- Financial reward for clinical speciality systems to re-invest in their services to incentivise continual improvement at system level. As we ask clinical services to go “above and beyond”, we must invest in them.

Alignment with the National Pathway Improvement Programme



End to end pathways

- Transformational / promotes new model
- End to end pathways using digital approaches
- Better quality, experience and productivity
- Covers all care settings and sectors
- Considers inequalities and prevention
- **Contributes to elective recovery by creating capacity and reducing demand**

HVLC

- Adherence and consistency with optimal care
- Largely focused on hospital episode
- Better quality, experience and productivity
- Initially focused on small number of elective specialties (29 pathways) with greatest impact
- **Contributes to elective recovery by creating capacity**

* UEC focused on delivering National UEC Programme priorities

HVLC aims and guiding principles



Programme aims

- The High Volume Low Complexity improvement programme (HVLC) has been commissioned by Amanda Pritchard, Pauline Philip, Hugh McCaughey and Professor Tim Briggs to aid recovery of elective services post Covid wave 3
- The programme is led by Professor Tim Briggs and the GIRFT team in partnership with NHS Improvement
- Covering 50-60% of W/L activity, it will be a key element of the overarching Elective Recovery Programme, focusing on
 1. **Trauma and orthopaedics, including spinal surgery**
 2. **Ophthalmology**
 3. **Urology**
 4. **ENT**
 5. **Gynaecology**
 6. **General surgery**
- It is based on the early success seen in London in orthopaedics and ophthalmology

Our programme principles

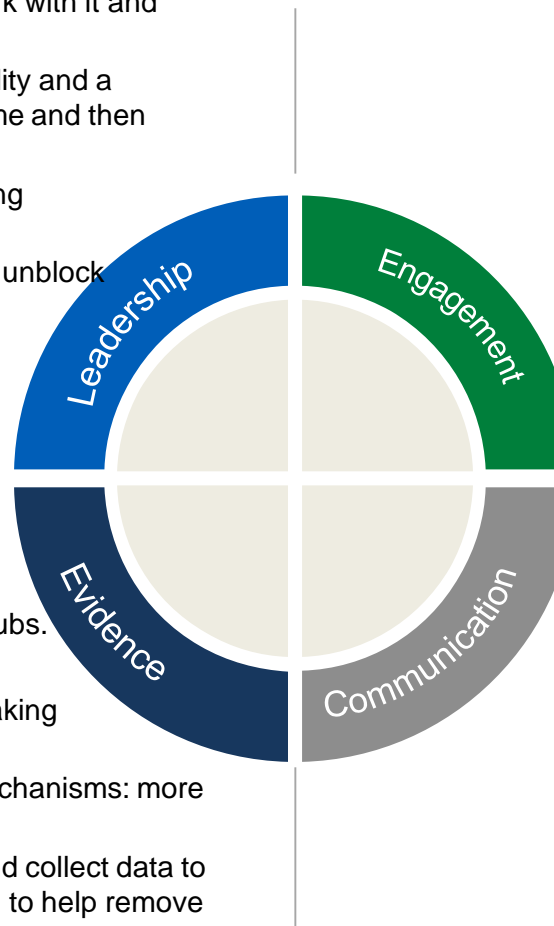
- **Focus at system level (ICS/STP) to drive equity of access and excellent clinical outcomes for the population** through standardisation of pathways and adoption of best practice via:
- Drive for **'top decile' GIRFT** performance of clinical outcomes, productivity and equity of access.
- Standardised procedure level **clinical pathways** agreed across all providers within a system, developed or tailored for local needs by Specialty Advisory Groups (or equivalent group e.g. clinical lead or expert advisory panel) supported by professional societies.
- Establish **Fast Track Surgical Hubs where possible** within each system for the high volume elective procedures.
- Agree principles for working across clinical and operational groups e.g. **Theatre principles**.

“The principles have been amazing – they have given us the framework to get on and do - 8 months in we regularly use them to test whether we are doing the right thing.” **Hospital CEO**

Success is based on leadership, engagement, evidence and communication

- **Clinical leadership** is key: start by building on and strengthening existing clinical networks. Link local clinical leadership with GIRFT: work with it and recognise the sum is greater than its parts.
- Appoint existing **senior leaders** (e.g. CEOs) who have credibility and a track record of success. Make it clear that they own the outcome and then give autonomy.
- **Senior and right sized delivery support** which links to existing governance.
- **Regional leadership** to provide support to systems helping to unblock barriers, Everyone, including leaders, need to work **at pace**, while recognising the benefits of working 'smarter' across a system in order to reduce pressures on an already fatigued workforce.

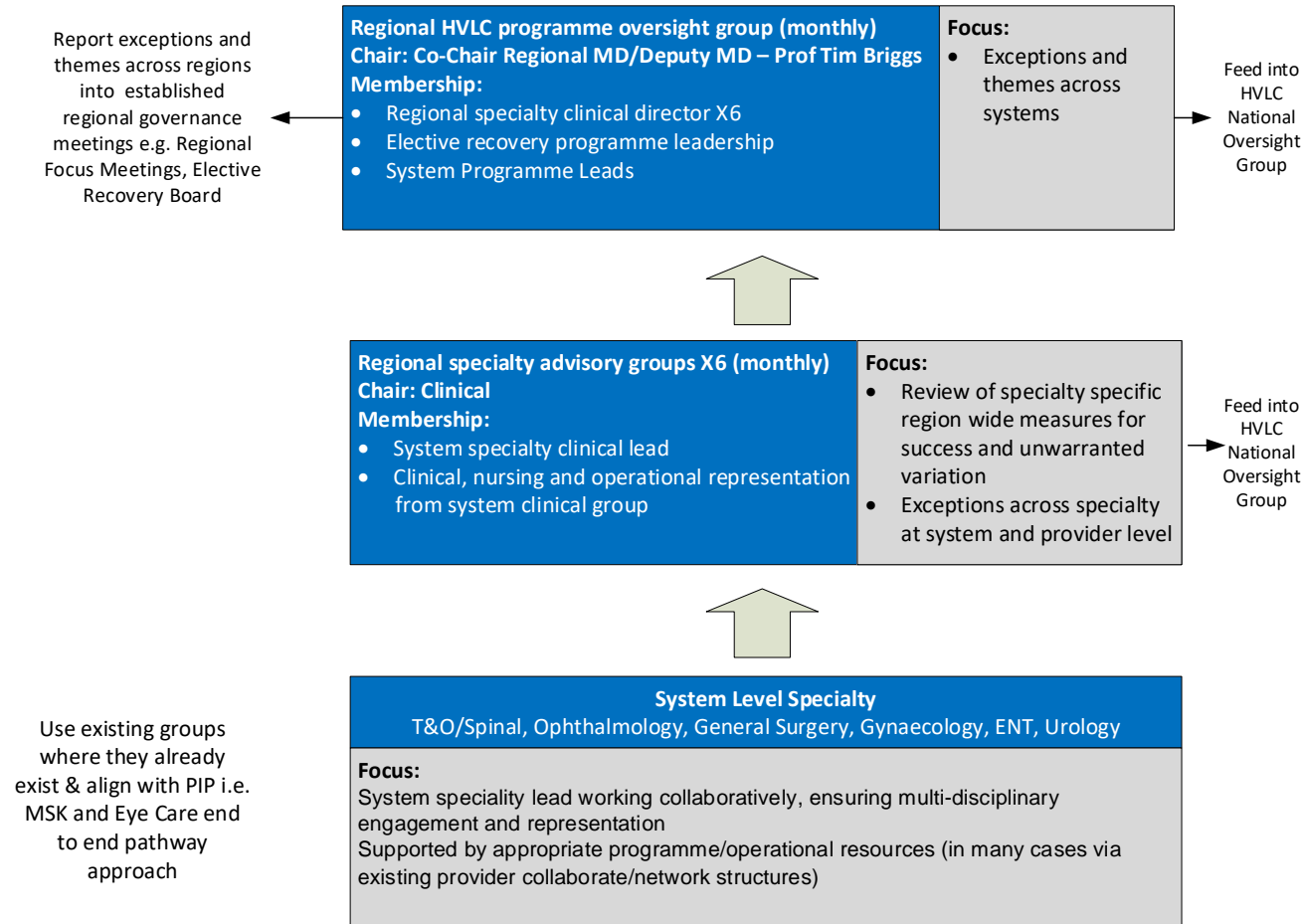
- Be guided by the evidence, constantly **correcting the course**, trying different things, based on evidence (and anecdote) e.g. hubs.
- Gathering **staff and patient** feedback is central to learning.
- Collecting **real-time data** on hub activity is critical to decision making (but can be challenging)
- Embed within existing **information gathering** and reporting mechanisms: more data returns are *not* the answer.
- Recognise the **inequalities** that systems inherently promote, and collect data to surface these. Establishing standard protocols and a single PTL to help remove unnecessary variation.



- Use recovery post Covid as an intervention to **develop nascent systems and redefine the region's role**.
- Engagement needed at top, middle and 'shop floor'.
- Bottom-up engagement needed for the adoption of pathways. **Local clinical and operational managers** need support, guidance and capacity (give colleagues permission to stop doing other things).
- "Middle" engagement at **system level** is critical. System leaders need to let local teams act, but then need to quickly resolve issues escalated to them. They need to be skilled at having difficult conversations.
- Engagement by **regional level** is critical. Be clear that you are in a supportive, not performance management role.

- Agree key **principles**, "**why**" and **outcomes** up front: constantly remind each other of your purpose.
- Many concepts are new, or mean different things to different people. **Define these early** (e.g. hubs).
- Daily (and then twice weekly) 15-minute video calls with **all CEOs** to keep them informed and get feedback.
- Ensure everyone (from national teams to front line) is connected through **consistent messaging**. In particular, it must be made crystal clear that we all own the problem and realise fundamental reform is required.
- Embed a **dedicated comms expert** as part of your team, draw on expertise in CCGs, CSUs, etc.

Leadership and governance



HVLC & Pathway Improvement Programme (PIP) governance will be aligned/ integrated i.e. Eye care and MSK

Regional specialty meetings will be established across the region, with clinical leads representing each system. These will be chaired by a regionally appointed specialty clinical lead, supported by the GIRFT/PIP national clinical leads.

This provides an opportunity to network, share ideas, innovations, good practice and discuss continued challenges and solutions – with clear escalation processes, and programme management support.

Where there are existing clinical networks or similar groups already established that can effectively perform this function, there should be no requirement to establish a separate group.

This group will connect into a national group comprising all the regional specialty leads, chaired by the national GIRFT lead along with Royal College/society representation.

Approach – key components

The 'How'

What we think everyone should **definitely do**.



Prioritise Clinical Networks and Leads	Visible, hands on Regional leadership – enabling not scorekeeping	Successful CEO as the SRO
Theatre principles and standards	Strong, senior and right sized delivery support	Collect the data you need, not what you have
Design and implementation of procedure level clinical pathways	Focus on the clinical outcomes needed not the interventions to get there	Voice of the citizen – ask them what they want

Deliberate dialogue with key stakeholders – an example from London

- 1 People wanted patients to be prioritised so those who were worst affected would get surgery first
- 2 It is reasonable to expect that some patients may decide to delay their procedure
- 3 It is reasonable to reduce choice of where people receive planned care in an effort to control the risk of spread of Covid-19
- 4 It is reasonable to expect that, where possible, initial contact with patients should be virtual given the need to protect staff and other patients from potential exposure to Covid-19
- 5 It is reasonable to expect that patients should take practical steps to access services responsibly as they too have a role in controlling the risk of spread of Covid-19
- 6 It is reasonable to expect that in making future decisions about the delivery of healthcare services, decision makers must pay consideration to the impact and implications on specific groups

The 'What'

Valuable learning, but each region and systems are likely to have **different opportunities** and issues and so the interventions may be different.

Fast Track Surgical Hubs	Work driven through the system leadership teams to help progress maturity
Working to the top of licence	System Level Data – single PTL and performance reporting at a system level

The 'What Else'

Acknowledge the additional more acute challenges to tackle following Covid e.g.

Staff wellbeing and welfare	Acknowledge & addresses inter-dependencies across pathways
Proper use of Independent sector and involvement in the GIRFT pathways	Single national sharing and learning hub?



Approach - key interventions

Design/tailor and implementation of procedure level clinical pathways

Develop/tailor 29 standardised surgical pathways, supported by the specialist societies and relevant Royal Colleges and sign off by the regional Clinical Advisory Group. Access best practice support e.g. National Day Surgery Delivery Pack.

Fast Track Surgical Hubs

Focus on clearing backlog at a system level - developing hub sites which are Covid protected to ensure efficiency, high productivity and maximising patient safety. Access best practice support e.g. Cataract Hubs and High Flow Cataract Lists.

Re-thinking roles and supporting the workforce

Support new ways of working to improve job satisfaction to work 'smarter' rather than 'harder' e.g. break down the tasks of the clinical teams against the standardised pathway, map them to clinical competencies and arrange rapid skills development to upskill clinical teams as well as distributing tasks to support staff.

Theatre principles and standards

Theatre productivity standards, e.g. 10 cataracts on half day list; agreeing principles around start and finish times; standardising turnaround times between cases, and BAU expectation of day case rates at 85%. Develop day surgery as the default and challenge day surgery rates using benchmarking data.

System level data

Setting the outcomes with clinicians at the top decile for clinical outcomes including developing a 'gateway' process centred on a clinically led, data driven discussion to challenge unwarranted variation at system level.

Clinical leads

Establishing regional specialty clinical leadership groups (Specialty Advisory Groups or Expert Advisory Groups) to work with the system clinicians, supported by the national clinical leadership, to develop and deliver the changes.

Programme phasing

Phase 1 - maximise current facilities

Appoint clinical leadership with senior sponsors
29 pathways across six surgical specialties
Ensuring theatre productivity data returns every monthly
Theatre efficiency – start on time, short turn around, appropriate finish time
Theatre productivity for each speciality– eg 10 cataracts on half day list, 4 joint replacements on all day list
85% of ALL surgical procedures must be day surgery
Urgent setting up of elective hub sites where possible – open to all in system
Model demand and capacity across system according to GIRFT “top decile”, D/C rates and theatre prod standards

Phase 2

Utilise freed up efficiency bed and theatre gains
Extended session days and six-day working
Continue setting up of Elective Hub sites
Embed Independent Sector hospitals into each system
Utilise Independent Sector to fill the demand and capacity “gap”
NHS trusts and Independent Sector working “shoulder to shoulder”
Offer for targeted support from GIRFT and Improvement

Phase 3

Maintain elective care during Winter 2021/2022
Low volume high complexity case mix- centralise/networks
Continue to identify Elective Hub sites
Medical pathways in top five specialties responsible for long stayers
Best practice pathways – for high bed usage surgical non elective care -#NoF -completed
Work with RCP to develop these pathways – work with two regions to test and refine
Develop use of benchmark data and reducing variation at consultant level through NCIP (National Consultant Information Programme)
Continued improvement through GIRFT Academy through adoption of best practice and learning

- ✓ **All underpinned by:**
 - Data
- ✓ Model Health System data
- ✓ Theatre productivity data – monthly
- ✓ Independent Hospital data included
- ✓ Regular review and action by systems and regions

Potential opportunities

- We face a hugely challenging time in the coming months and years: distressing levels of harm being caused as a result of a lack of access to care; tired staff; IPC guidance impacting on productivity; variable performance for our communities pre-pandemic.
- We need to think differently and at pace – each week lost is a week longer for our communities to access their care and need to target throughput well in excess for pre-pandemic BAU.
- We have identified an approach that has the potential to help.
- We have started work with the Royal College of Physicians as we urgently need to expand the approach into the main medical specialties.

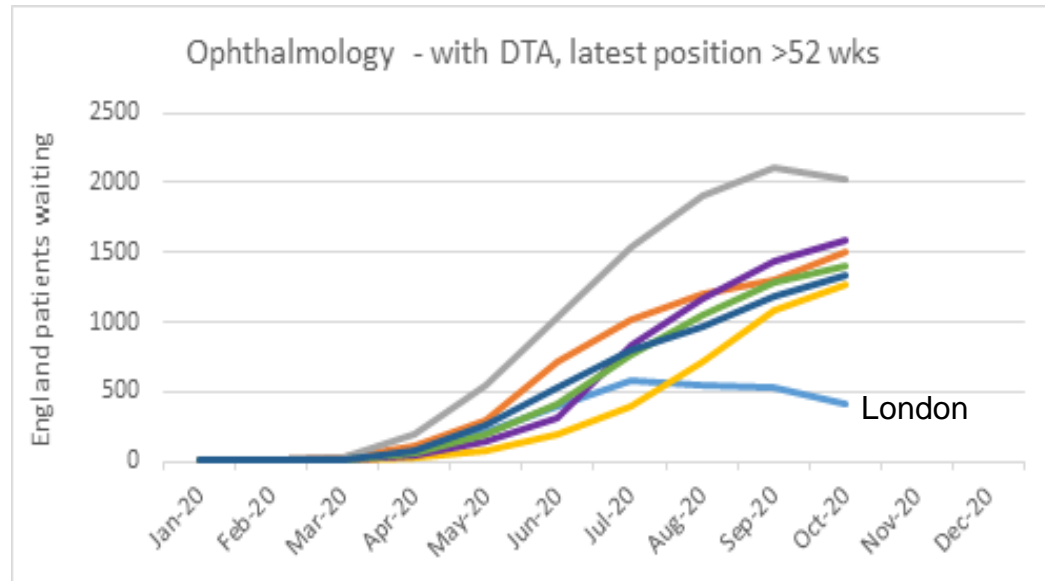
Potential gains nationally per annum by achieving Top Decile outcomes through adopting best practice pathways 12

	Total Potential Bed Day Saving
Elective Orthopaedic Surgery	228,000
Hip Fracture LOS	279,000
BADS All specs except Ortho	250,500
Respiratory - COPD, Asthma, Pneumonia	188,155
Total	945,655
	Total Additional Cases
Cataract pathway	99,153

The new NOF service in NE London has a LOS of 9.2 days. Achieving this nationally would equate to **528,000** bed day saving

These bed day savings equate to between **2,600 & 3,000** beds

Realising the opportunities – examples of success



London has the lowest number of ophthalmology patients waiting more than 52 weeks with a DTA (i.e. awaiting surgery), and between May and October has reduced the overall waiting list

Examples of mutual aid are emerging in ophthalmology, including:

- 307 patients transferred from Hillingdon to Central Middlesex
- Over 800 patients transferred from Kings to South West London

Moorfields Cataract Drive:



Supported by over 80 volunteers covering nearly 200 shifts provided by St John Ambulance



Eight operating theatres provided 725 cataract procedures in 6 days. (Weekly average is usually 120)

Oxford University Hospital

NHS Foundation Trust

- The NOC Resume Programme has delivered improved productivity
- 25% increase in cases/week in planned orthopaedic surgery
- Utilisation improved to mean 91% (OUH target >85% met)
- Efficiency improved to mean 82% (approaching OUH target >85%)
- Improved usage of theatre lists – *focus on planning & allocation*
- Reduced cancellations on planned lists - *due to emergency theatre*
- Work to do on late starts/finishes – *improve efficiency to >85%*
- Further reports - *effect of introducing the new Emergency List*

“The project has transformed our relationship with the region. They have been a true partner and enabler of the improvements we needed to make”

ICS Lead

Realising the opportunities – examples of success

Barking, Havering and Redbridge
University
Hospitals NHS Trust

Trauma and Orthopaedics team
'Perfect Week' 7 day challenge

NHS

135 joint replacements

Target: 100

88 day case surgeries

Target: 80

27 spinal procedures

Target: 25



Compares
to 51 cases
'bau'



BONES PROJECT REVIEW

BHRUT Orthopaedic NHS Elective
Surgery – High Volume Week

135 Arthroplasties and 85 day cases

Elective hub models

Elective hub sites allow utilisation of the existing estate to the maximum benefit, enabling focus on clearing backlog at a system level.

Different models should be chosen appropriate to local circumstances:

- Developing hub sites which are Covid-19 protected
- Single specialty
- Multiple specialty

Advantages

- Safe for patients
- Safe for staff – shielding staff happy to work
- Efficient – standard testing and minimal IPC in theatre

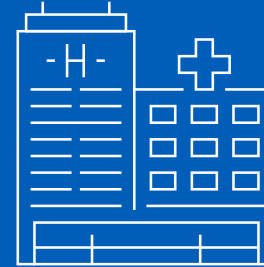
Emergent Elective Hub Models within London

Hub Model	One-off, intensive "drives"	Mutual aid	Hub delivered outside BAU	Hub delivered as BAU	Hub dedicated & delivered as BAU
Definition	<ul style="list-style-type: none"> • Hub embedded within general hospital • No physical separation between hub and other operating flows • Short-term focus on specific pathways • May include some movement of patients and staff 	<ul style="list-style-type: none"> • Hub may be standalone or embedded • Hospitals make theatre capacity available to other teams • Short-term focus on specific pathways • May include some movement of patients and staff 	<ul style="list-style-type: none"> • Hub may be standalone or embedded • Additional capacity created by teams working extended days/weekends • May include some movement of patients and staff 	<ul style="list-style-type: none"> • Hub embedded within general hospital • No physical separation between hub and other operating flows • Permanent list dedicated to hub activity • Routine movement of patients and staff 	<ul style="list-style-type: none"> • Hub physically separated from other operating flows; may be separate site • Permanent list dedicated to hub activity • Routine movement of patients and staff
Example	Example BHRUT "bones blitz"	Example Moorfields/RFL paediatric list	Example Orpington	Example Riverside, Charing Cross Hospital	Example SWELEOC, Croydon Hospital

Elective hub models – Croydon



Croydon Health Services NHS Trust has created a **dedicated elective surgery fast track hub** within its existing footprint



“If we can hold this over the winter, then I think the separation of...elective and emergency care becomes the norm. I think if we do this, we will never ever turn back.” **Consultant surgeon**

- Physically separate emergency and elective theatre units. The **Croydon Elective Centre**, in what was the **hospital's blue zone**, means Croydon is running at **120% of pre-lockdown activity levels** for routine procedures such as cancer, cardiac, and hip operations, making it among the top performers in the country. In July it was running at 27%.
- treating **5 out of the 6 high volume low complexity procedures**
- **utilising 9 rather than 11 theatres** saving 20 theatre sessions (total of 80 hours)
- **improved treatment time** for e.g. acute cholecystitis from 30% to 80% of patients having emergency surgery on their first admission
- **improved mobilisation and time** to theatre for fractured Neck of Femurs



Elective hub models – SWLEOC, Cheltenham and Gloucester, United Lincolnshire



SWLEOC

- SW London in early 2000s – elective orthopaedic surgery delivered across four trusts. Prior to establishment of SWLEOC, significant challenges in waiting times, patient experience, variable clinical outcomes and financial performance
- Consistent delivery of top decile performance across GIRFT metrics in clinical outcome, patient experience & productivity. Delivered financial surplus by year 2, increasing year on year. (2015 = **£3.6m** surplus compared to **£4.2m** loss pre EOC)

Cheltenham and Gloucester

- Improved clinical outcomes (inc mortality) and patient experience (inc reduced cancellations, and staff experience (inc training))
- Delivered approx £5m financial benefit
- C&G rolling out to other specialties, inc General Surgery

United Lincolnshire

- Moved from –ve outlier to top decile LOS performance, and improved patient experience (reduced cancellations and waiting times – improved RTT from 80% to 92%)
- Increased resilience i.e. through Covid 2nd wave
- Financial improvement of approx £4.2m
- Demonstrated efficacy of model with geographically distant sites – i.e. 34 miles apart

Theatre principles



Running of theatres – Surgical hub theatres are expected to run at full capacity, +10 hour days, 6 days per week and all day theatre lists should be the default. Staff should be staggered to allow for breaks without breaking the list for lunch.

6-4-2 theatre planning – Meetings should take place including operational, theatre and medical staff to optimise lists and ensure appropriate staffing and equipment is in place, plus any specific patient needs e.g. translation services. The order of the list should be signed off by the surgeon and the anaesthetist, including ‘golden patient’ – there should be a robust escalation process for any changes to a list once it is locked down.

Patient contact before surgery – Patients should be called 5 days prior to surgery to check there are no changes to their circumstances and that they will be attending for the procedure as planned. This should include a check that appropriate transportation is in place for those patients requiring it, in line with the proposed ‘patient transport principles’.

On the day of surgery – Patients should be admitted on the day of their surgery to a dedicated admissions area (not to a ward) for the appropriate checks. It is strongly recommended that admission times be staggered e.g. 7.30am, 10.30am, 2.30pm.

Theatre start times – Start times should be standardised – typically 8am for the huddle by the team, with start 8.30am for anaesthetic start, and ‘knife to skin’ at before 9am.

Patient turnaround – Turnaround time between cases should be 10-15mins.

Equipment, prosthesis and consumables – These should be standardised within the hub, in accordance with the clinical pathways.

Workforce models – These should build in prospective cover to ensure all lists within the theatre template are covered – hubs should expect no more than 3% of sessions to go uncovered.

Criteria led discharge – This should be in place for patients from the DSU/ward with clear instructions and contact information. A nurse should telephone patients 24 hours post discharge to check their recovery is as expected and signpost the patient as required i.e. to standardised follow up (as per pathway) or to escalate as appropriate if there is a problem.

Theatre utilisation reviews – Reviews of the previous week’s theatre utilisation should take place with representatives from the triumvirate of CD, GM, lead nurse. This should include detail on: cancellations (clinical and non clinical), conversions from day case to inpatient stay, or any length of stay over the agreed pathways, numbers of dropped/fallow sessions, exceptions to cases per list standards and on time starts/overruns and turnaround times. The key messages and mitigating actions stemming from these meetings should be clearly communicated to the wider teams.

Senior leadership walkarounds – These should take place regularly (particularly start and end of day), with forum for feedback from staff.

Productivity – Hubs should hit established productivity levels. For example, 10 cataracts on a list (8 on a training list) or 4 joints on a 2 session day – see pathways

Data – All trusts should participate in submitting theatre data to the Model Health System.

GIRFT specialty standards cases per theatre session

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
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

Theatre productivity data collection



- To support improved theatre utilisation, regions should work through systems to ensure that all acute providers are submitting monthly theatre data.
- The national theatres productivity data collection was made available to submit data on a monthly basis from September 2020 and a number of providers have now submitted data to March 2021. However **NOT ALL** providers are returning this data
- Metrics looking at theatre productivity are available in the Model Health System at provider and system level now. We also have a product to allow more detailed exploration of the data at individual theatre level.
- <https://model.nhs.uk/>
- The trust contact will need to create a user account on the NHS England / Improvement website Insights Platform using the following link:
- <https://www.england.nhs.uk/insights-platform/>

Month	Data submission deadline	Submit data for period	Available in Model Health System* by no later than
April	24 May 2021	1 Feb 2021 - 30 Apr 2021	27 May 2021
May	22 June 2021	1 Mar 2021 - 31 May 2021	25 Jun 2021
June	22 July 2021	1 Apr 2021 - 30 Jun 2021	27 Jul 2021
July	23 August 2021	1 May 2021 - 31 Jul 2021	26 Aug 2021
August	22 September 2021	1 Jun 2021 - 31 Aug 2021	27 Sep 2021
September	22 October 2021	1 Jul 2021 - 30 Sep 2021	27 Oct 2021
October	22 November 2021	1 Aug 2021 - 31 Oct 2021	25 Nov 2021
November	22 December 2021	1 Sep 2021 - 30 Nov 2021	27 Dec 2021
December	24 January 2022	1 Oct 2021 - 31 Dec 2021	27 Jan 2022
January	22 February 2022	1 Nov 2021 - 31 Jan 2022	25 Feb 2022
February	22 March 2022	1 Dec 2021 - 28 Feb 2022	25 Mar 2022
March	22 April 2022	1 Jan 2022 - 31 Mar 2022	27 Apr 2022

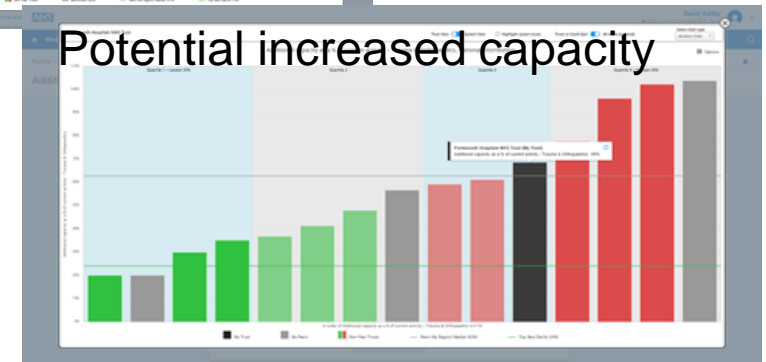
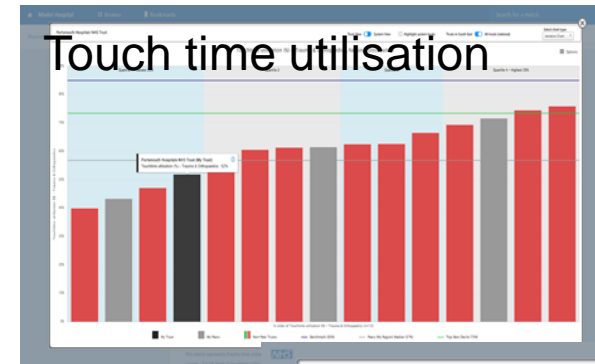
Theatre utilisation

“real time” data driving improved efficiency

NHS Improvement - Model Hospital

Category	Metric	Data period	Trust value	Peer median	National median
Volumes	Number of theatres - Trauma & Orthopaedics	Jul 2020	4	6	5
	Number of lists - Trauma & Orthopaedics	Jul 2020	48	41	35
	Planned number of 4 hour sessions - Trauma & Orthopaedics	Jul 2020	108	83	57
	Number of cases - Trauma & Orthopaedics	Jul 2020	144	127	110
	Average number of cases per 4 hour session - Trauma & Orthopaedics	Jul 2020	1.3	1.5	1.3
Touchtime utilisation	Touchtime utilisation (%) - Trauma & Orthopaedics	Jul 2020	52%	57%	85%
Efficiency	Average late start (minutes) - Trauma & Orthopaedics	Jul 2020	38	37	55
	Average intercase downtime (minutes) - Trauma & Orthopaedics	Jul 2020	49	45	49
	Average early finish (minutes) - Trauma & Orthopaedics	Jul 2020	253	33	78
	% of overruns to all lists - Trauma & Orthopaedics	Jul 2020	8%	31%	23%
	% of emergency surgery conducted within elective lists - Trauma & Orthopaedics	Jul 2020	0.0%	4.3%	0.0%
Capacity	Number of additional cases there is capacity to treat - Trauma & Orthopaedics	Jul 2020	99	63	39
	Additional capacity as a % of current activity - Trauma & Orthopaedics	Jul 2020	69%	63%	57%
	Additional capacity (%) including 5% on the day cancellation rate - Trauma & Orthopaedics	Jul 2020	60%	55%	49%

- Theatre data to Model Hospital
- Orthopaedics has 4 theatres (48 lists)
- Touch time utilisation T&O – 52%
- Average late starts – 38 minutes
- Average inter-case downtime - 49 mins
- Average early finish – 253 mins
- % of overruns – 8%



Day surgery key principles

85% of all elective surgery (with minimal exceptions e.g. arthroplasty) should default to a day surgery pathway

1. Surgical teams should embrace the BADS Directory of Procedures and develop day surgery pathways and protocols for all appropriate procedures
2. Default patients undergoing procedures within the BADS Directory to a day case pathway
3. Ensure all potential day surgery patients are listed and coded with a day surgery management intent
4. Ensure preoperative assessment protocols for patient selection are inclusive rather than exclusive of day surgery
5. Progress towards the development of dedicated day surgery units
6. Progress towards the provision of dedicated day surgery teams
7. Establish a multidisciplinary day surgery management team
8. Ensure all day surgery patients are admitted to a dedicated admissions area
9. Embrace use of day case operating trolleys over hospital beds
10. Establish protocols for anaesthesia, perioperative analgesia and take-home medication
11. Ensure that day surgery is a consultant or experienced SAS delivered service, with clear training pathways for the future workforce
12. Equip day surgery facilities with high quality equipment
13. Ensure day surgery patients are discharged through a dedicated day surgery ward staffed by nurses with expertise in day surgery nurse led discharge
14. Ensure the day surgery discharge ward has no capacity to accept inpatient activity and support this with a commitment from managerial teams to protect this policy even at times of escalation
15. Ensure patients are telephoned the day after surgery for clinical support and patient outcome data collection
16. Audit day surgery outcomes and benchmark performance against the BADS Directory of Procedures, the BADS Directory of Procedures National Dataset and the Model Hospital
17. Ensure appropriate coding of procedures to capture accurate activity in benchmarking data (such as Model Hospital and the BADS Directory of Procedures National Dataset)



https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/10/National-Day-Surgery-Delivery-Pack_Sept2020_final.pdf

Elective surgery capacity and demand planning: using the independent sector to close the gap

1. GIRFT have been working closely with major independent sector (IS) providers, who are committed to adopting the standardised pathways across the 29 procedures, ensuring transparency of data to support an integrated system approach to HVLC.
2. To facilitate this further, NHS activity within IS providers will be available on Model Hospital soon.
3. GIRFT is piloting an approach to mapping HVLC capacity at a system level to support planning, including the effective use of IS with a view to sharing with systems.
4. This approach uses the GIRFT benchmark standards to identify the additional activity that could be achieved through
 - Reducing variation by applying/tailoring the best practice clinical pathways, planning to reach these standards over the coming months
 - Recalculating demand following the move to phase 2 HVLC standards of extended session days and 6 day working
5. By mapping the forecast demand to the planned activity levels, systems will identify the gap between capacity and demand and will actively engage with the independent sector to close this gap

Cataract hubs and high flow cataract surgery



- A cataract hub delivers an end to end pathway that facilitates high quality, high flow cataract lists, using standardised pathways that have been agreed across the region.
- This pathway includes streamlined referral processes, shared decision making, pre-operative assessment, pre-op dilation, consent, surgery, post-operative care, follow-up with community optometrists, and return of the data required for the National Ophthalmology Database (NOD) audit.
- Hubs provide a pooled resource to deliver a significant proportion of the high flow low complexity (HFLC) cataract surgery for a population (ICS or region) rather than just for a particular trust.
- The hubs use standardised operating processes and patient information which are agreed across the ICS or region by all relevant stakeholders.
- A facility that provides hub care should have a suitable layout to facilitate high flow clinics and theatre lists and to offer COVID-19 protected care.
- Where possible, hubs should ideally be set up to facilitate three session days, seven-day working, with surgical teams and patients travelling to a well-located regional site. Hubs also need to train the next generation of surgeons in HFLC surgery, and all hubs must agree to provide teaching on high flow lists.
- The hub and the pathway processes are inseparable. In order to have a high flow of patients on the day of surgery, robust preoperative processes before the day of surgery are needed



<https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/03/Cataract-Hubs-and-High-Flow-Cataract-Lists.pdf>

[Cataract Pathway Video](#)

HVLC pathways already available for the six specialties in scope



Best Practice Library - Getting It Right First Time - GIRFT

Specialty	Specific procedures (90%-95% Day Surgery)	Specialty	Specific procedures (90%-95% Day Surgery)
ENT	1 Endo sinus surgery	Orthopaedics	16 Anterior cruciate ligament reconstruction
	2 Nasal airway surgery		17 Therapeutic shoulder arthroscopy
	3 Myringoplasty		18 Total hip replacement
	4 Tonsillectomy		19 Total Knee replacement
Gynaecology	5 Diagnostic laparoscopy		20 Uni Knee replacement
	6 Endometrial ablation		21 Bunions
	7 Hysteroscopy	Spines	22 Lumbar decompression/discectomy
	8 Laparoscopic hysterectomy		23 Cervical spine decompression/fusion
	9 Vaginal hysterectomy		24 Medical branch/facet joint injections
Urology	10 Bladder outflow obstruction		25 Lumbar nerve root blocks/therapeutic epidurals
	11 Bladder tumour resection	26 One or 2 level posterior lumbar fusion	
	12 Cystoscopy Plus	General Surgery	27 Laparoscopic cholecystectomy
	13 Minor peno-scrotal surgery		28 Inguinal hernia
	14 Uteroscopy and stent management		29 Paraumbilical hernia
Ophthalmology	15 Cataract		

Other pathways in development by GIRFT at request by systems and as BAU



Whilst not within scope of HVLC programme additional pathways are in development and will be available via [Best Practice Library](#)

- Oral and maxillofacial surgery
- **Cardiology**
- **Cardiothoracic surgery**
- Respiratory
- Gastroenterology
- Acute and general Medicine
- Diabetes
- Peri-op Medicine

Specialty	Specific procedures (90%-95% Day Surgery)	Specialty	Specific procedures (90%-95% Day Surgery)
Cardiology	30 Heart failure 31 Cardiac rhythm management 32 Valve disease 33 Stable chest pain (with A&GM) 34 Unstable chest pain (with A&GM) 35 Endocarditis	Neurosurgery	56 Pituitary surgery 57 Intrinsic brain tumour 58 Extrinsic brain tumour 61 Pain (TBC) 62 Subarachnoid haemorrhage
Gastro	36 Iron Deficiency /anaemia? 37 Inflammatory bowel? 38 Referral optimisation (triage)?	Cardiac surgery	64 Acute revascularisation 65 Aortic dissection 67 Endocarditis
Respiratory	39 Cough 40 Breathlessness 41 COPD 42 Asthma 43 Pulmonary Embolism (with A&GM) 44 Non Pneumonia	Thoracic surgery	68 Airway intervention 70 Pleural sepsis
Diabetes	45 Foot care 46 Perioperative pathway for diabetes	Oral Surgery	72 Removal of impacted teeth in children 73 Extraction of teeth in adults 75 Extraction of teeth in children 76 Le fort I maxillary osteotomy in patients 16+ 78 Mandibular osteotomy in patients 16+ 80 Bimaxillary osteotomy in patients 16+ 81 Elective # mandible adults 83 Elective # zygomatic complex adults 84 Elective orbital # adults 86 Removal of impacted wisdom teeth, wisdom teeth, impacted teeth and retained roots of teeth in adults
Geriatrics	47 Frailty Tool (with A&GM)		
Renal	48 AKI Stage 1 (with A&GM) 49 AKI Stage 2 (with A&GM)		
Acute and General Medicine	50 AKI Stage 1 (Renal) 51 AKI Stage 2 (with Renal) 52 Pulmonary Embolism (with Respiratory) 53 Stable chest pain (with Cardio) 54 Frailty Tool (with Geriatrics) 55 Unstable chest pain (with Cardio)		

Gateway (benchmarking) process



Specialty 'Gateways'

- Relevant metrics – clinical quality and outcomes specific to the specialty.
- 'GIRFT standard' has been set – predominantly these have been set at the top decile of national performance in 2019/20.
- Reviewed regularly – drive for continuous improvement.

Aggregated system (ICS) level data

- Trust level breakdown for each.
- Trend series data to support tracking progress over time.

Gateway review meeting

- Led by the GIRFT national clinical lead with clinicians and operational colleagues from across the system.
- Follows the core GIRFT approach of clinician to clinician data-driven discussion.
- To identify the unwarranted variation and support steps to address, providing appropriate challenge, advice and support, including the use of best practice clinical pathways and other resources.

Regional specialty meetings are established across the region, with clinical leads representing each system, supported by the GIRFT national clinical lead. This provides an opportunity to network, share ideas, innovations, good practice and discuss continued challenges and solutions.

Monitoring and evaluation



- The use of 'real time' data is critical to the programme and, as described, systems should use the following data sources to track implementation, inform continuous improvement and evaluate the success of the programme:

System level monitoring and evaluation

- Model System
 - GIRFT clinical improvement metrics
 - Theatre utilisation

Provider level monitoring and evaluation

- Model Hospital
 - GIRFT clinical improvement metrics
 - Theatre utilisation

Individual level monitoring and evaluation

- National Consultant Information Programme (NCIP) - consultant level data
 - Online portal to provide NHS consultants with a single point of access to outcomes data covering, orthopaedics, ophthalmology, urology, ENT, general surgery, gynaecology (+paediatric surgery and oral and maxillofacial surgery)

GIRFT Best Practice Library

The Best Practice Library brings together, in one place, the knowledge of best practice gained through our GIRFT deep-dive visits to hospitals and clinically-led national reports. This knowledge will support data-driven healthcare improvement in the UK and internationally.

The Best Practice Library will cover 40 specialties and cross-cutting themes, and will signpost healthcare providers and healthcare professionals to established best practice, support for implementation and an evidence base to support the case for change.

We are already able to share over 30 procedure pathways, developed across London, together with a comprehensive guide to increasing day case activity.

Click on a specialty below to view the Best Practice Library resources

+ Recent updates and additions are highlighted in blue.



[Orthopaedics >](#)

- + Sentinel metrics listed
- + Hip and knee replacement pathway
- + Case studies



[Urology >](#)

- + Sentinel metrics listed
- + 4 pathways added
- + Framework document added



[Day case >](#)

- + National day surgery delivery pack
- + Appendix document with pathways
- + Webinar recording



[Ophthalmology >](#)

- + Sentinel metrics listed
- + Cataract pathways
- + Case studies



[Diabetes >](#)

- + Type 1 diabetes
- + Inpatient Care
- + Diabetic Footcare



[Pathways >](#)

- + 28 pathways
- + 7 specialties

The majority of the documents referenced within this guide plus many more are available via the

[Best Practice Library - Getting It Right First Time – GIRFT](#)

And as

[Best Practice Library – HVLC Programme](#)

Examples

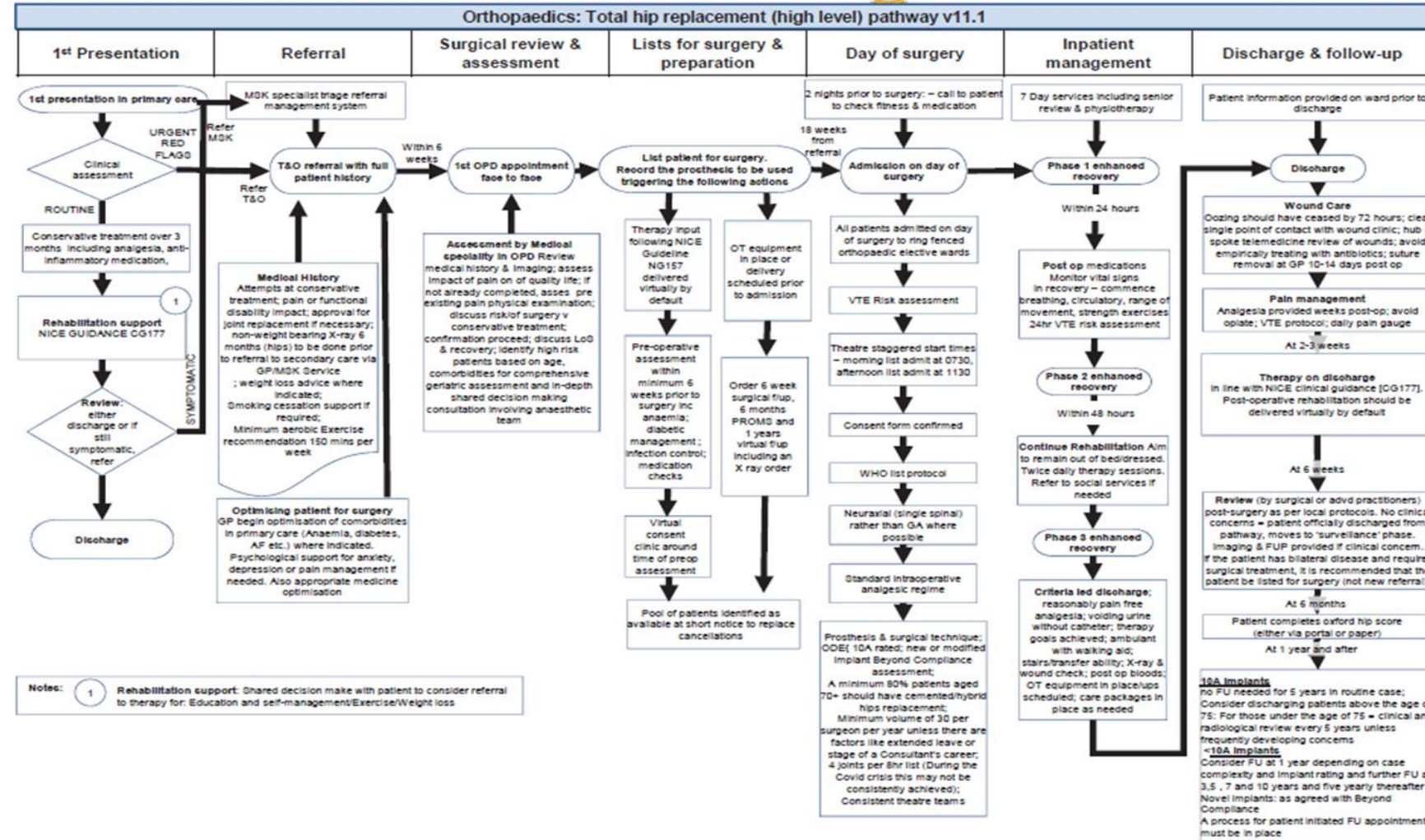
Example pathway

Review date: 31 Oct 2021
 Orthopaedics: Total hip replacement



British Orthopaedic Association

GIRFT
 GETTING IT RIGHT FIRST TIME



Example gateway/sentinel metrics

AN Other ICS

Q2 2020/21

Metric Name - GIRFT metadata	GIRFT standard
Productivity equivalent to 4 total hip or knee joint replacements in all-day list (8 hours)	4.0
Cemented or hybrid hip replacement for patients 70+ years	99.1%
Length of stay for primary hip replacement	2.7
Emergency readmission in 30 days following primary hip replacement	3.2%
Length of stay for primary total knee replacement	2.7
Emergency readmission in 30 days following primary total knee replacement	3.8%
Percentage of FNOF patients meeting best practice criteria	90.0%
Surgical site infection rate following surgery for FNOF	3.0%
Surgical site infection rate for elective primary arthroplasty	1.0%
Day case rate for Trauma and Orthopaedics treatment function (Quarterly Data)	93.0%
Conversion from day case to inpatient rate for Trauma and Orthopaedics treatment function (Quarterly Data)	1.5%
Cancellation in T&O for non-clinical reasons	0.0%
Cancellation in T&O for clinical reasons	1.4%

Trust A		
Numerator	Denominator	Value
81	81	100.0%
697	159	4.4
3	159	1.9%
662	143	4.6
7	143	4.9%
201	233	86.3%
18	219	8.2%
3	2,124	0.1%
132	2,124	6.2%

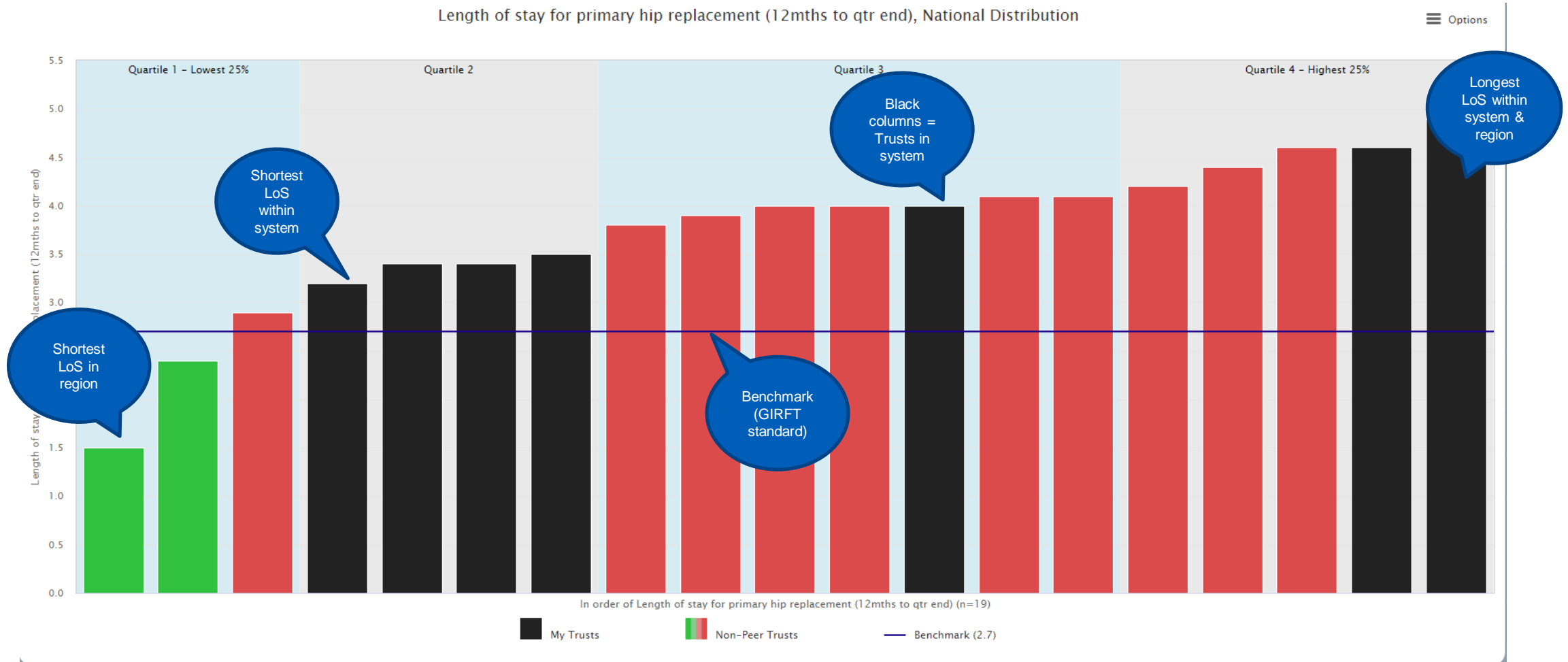
Trust B		
Numerator	Denominator	Value
138	182	75.8%
1,394	323	4.3
16	323	5.0%
1,282	292	4.4
12	292	4.1%
323	352	91.8%
9	332	2.7%
8	3,135	0.3%
113	3,135	3.6%

Example Model Hospital – LoS THR

Region/system level data illustrating wide variation within a system

Length of stay for primary hip replacement (12mths to qtr end), National Distribution

Options

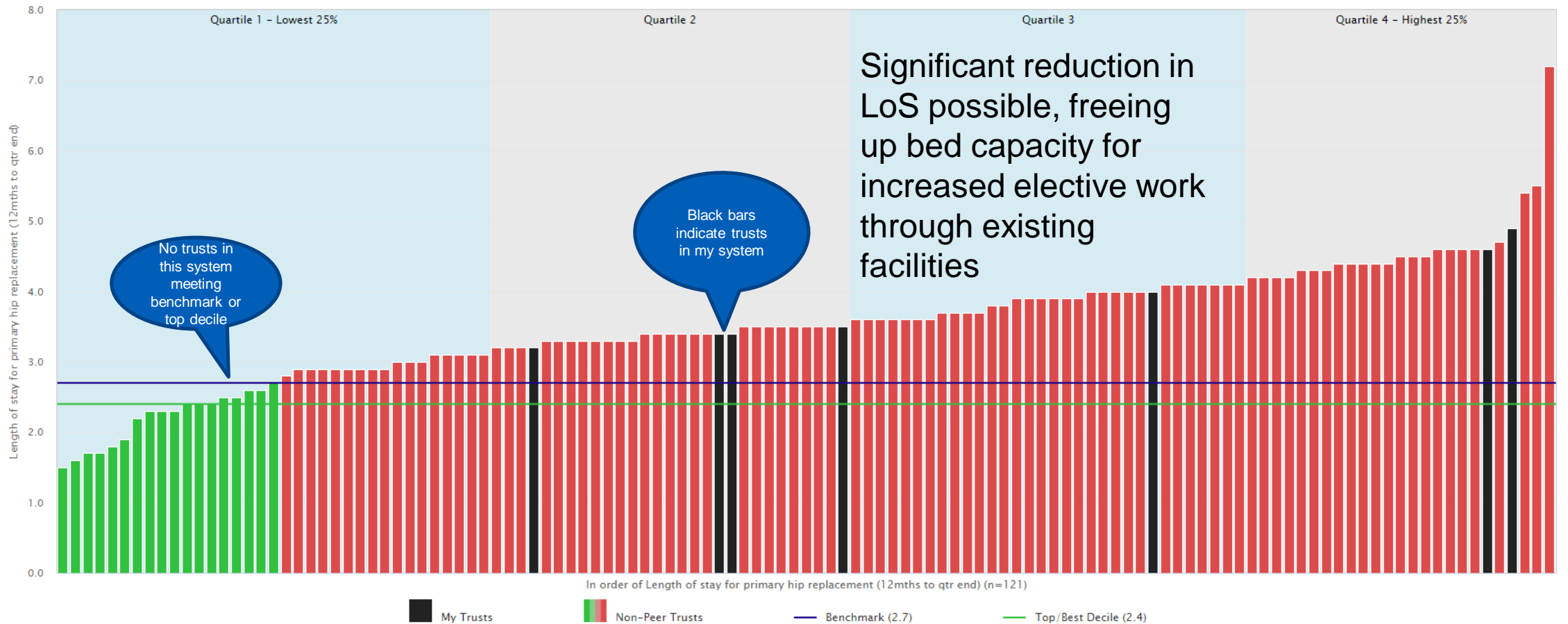


Example Model Hospital

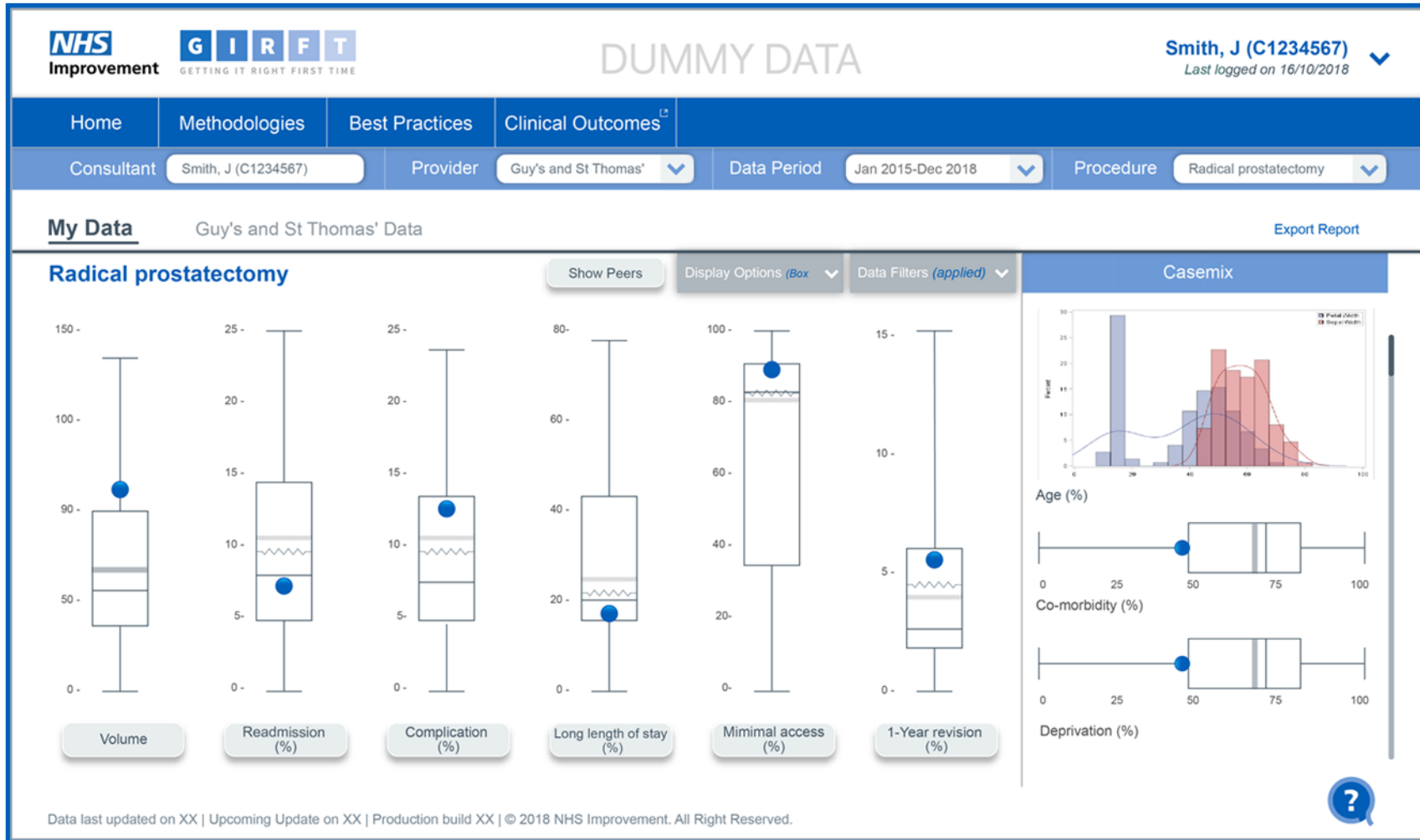
– ALL trusts level LOS THR illustrating national variation

Length of stay for primary hip replacement (12mths to qtr end), National Distribution

Options



Example NCIP consultant dashboard



More information



For more information regarding best practice examples/best practice library please contact

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