GIRFT
GETTING IT RIGHT FIRST TIME

AUGUST 2017

General Surgery

GIRFT Programme National Specialty Report
Executive Summary

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Royal College of Surgeons
ADVANCING SURGICAL CARE

NHS
Royal National Orthopaedic Hospital
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Improvement

Foreword from John Abercrombie, GIRFT Clinical Lead for General Surgery

I was delighted to have the opportunity to lead the Getting It Right First Time (GIRFT) programme for general surgery. I have visited 50 hospitals meeting many brilliant and inspirational surgical and administrative colleagues. No one should doubt that we all want the same thing: to improve outcomes for patients with surgical illnesses. There is a tremendous appetite to understand how well we are performing and thereby help us to deliver that improvement. All of the professional associations and societies (RCS Eng, ASGBI, AUGIS, ACPGBI, BOMSS, The Pelvic Floor Society) with whom I have met have wholeheartedly supported the GIRFT concept. The response from those hospitals that we have visited has been almost universally positive, responding to the challenge in a constructive and imaginative fashion that makes me both very proud of the profession and optimistic for its future.

The findings and effect of the pilot GIRFT project in orthopaedic surgery has been most impressive, highlighting variations in practice and outcome as well as identifying easily achievable cost savings. There are similar challenges in general surgery. Issues of regional variations in service and access to care through commissioning have been well documented. Variation in clinical practice and the quality of care is also known by the profession but remains an unsolved problem. A person with a given condition should be able to walk into any department and get roughly the same advice, treatment and outcome. It is clear that this is not being achieved and that the results of care, in some areas, appear to lag behind other European countries and the USA.

This project offers us the chance to take a step back: to look at the way we work and the outcomes we deliver as a profession; and to examine those same things with fellow surgeons and senior hospital managers, understanding the different ways we can deliver similar - or sometimes better - results.

The GIRFT data gives us a more detailed picture of general surgery in individual hospitals than ever before, highlighting the considerable variation in patient pathways and provisioning. That information has been used to shape valuable changes in practice in many hospitals. Yet at the same time, it feels as though we have barely scratched the surface.

The data shows the variation, but we still do not truly understand the fundamental underlying problems that explain it. While we - the GIRFT programme team and the individual hospitals - have pinpointed many of the key challenges faced in general surgery, we don't yet have the insights to resolve them.

The NHS is very good at process measurement. Unfortunately this does not necessarily reflect the quality of care and thereby promote best practice. How can we set about improving team and personal performance when we do not measure it? To borrow an analogy from Matthew Syed's influential *Black Box Thinking*, we are "playing golf in the dark".

This is exacerbated by the fact that much of what we do measure risks being counter-productive. We measure how many deaths occur at the hand of a surgeon, but we do not celebrate how many lives they save and improve. We measure how quickly patients receive an operation for colorectal cancer, but not the success of those operations or alternative treatments. These politically derived measures are not clinically driven or motivated; they do not help improve our service or our skills, nor do they lead to better outcomes for patients. They may even have adverse consequences by inducing surgeons to adopt risk-averse behaviour.

There is, however, much we could measure that would make a difference: surgical performance; the number of urgent - if not emergency - patients who receive care within a given time; readmissions and infection rates. Linking such data to the different procedural approaches used, we can truly understand what the safest and most effective procedures are in NHS practice rather than clinical trials. The American College of Surgeons National Surgical Quality Improvement Program is a shining example that challenges us all.

Many of our recommendations focus on building that next level of insight. While there are some that enable almost immediate improvements and efficiency savings - notably around reducing the staggering variation in procurement - many are focused on longer-term transformation.

This report builds on the work carried out by Professor Tim Briggs supported by Lord Carter and his Model Hospital project. It has the benefit of serious political investment which shows a real intent to help us care for our patients more effectively.

It is an exciting opportunity. I am convinced that the GIRFT project will help build a better surgical service that is even more rewarding to work within than the one we have today.

John Abercrombie
MB BS FRCS

John Abercrombie is Consultant Colorectal Surgeon at Queen's Medical Centre, Nottingham. His areas of specialist practice are in inflammatory bowel disease, abdominal wall reconstruction, the surgery of intestinal failure and bowel cancer screening colonoscopy.

Royal College of Surgeons

The Royal College of Surgeons is a strong supporter of the Getting It Right First Time Initiative which has shone a light on variation in surgical practice and processes across the NHS. Surgical change is most effective when driven by surgeons themselves and we are pleased to see this report is no exception to that principle. As a professional body that exists to advance surgical care, we believe the recommendations have the potential to improve the quality and experience of care that patients receive, as well as deliver important cost savings to the health service.

Professor Derek Alderson
President, Royal College of Surgeons

Executive summary

Every year the NHS delivers more than a million general surgery procedures. This umbrella term in fact covers some of the most complex and important surgery conducted by the NHS: life-saving, life-lengthening and life-enhancing operations to deal with all aspects of abdominal disease. It includes surgery for bowel cancer, the removal of gallstones, anti-reflux procedures and gastric bands and bypasses.

There are thousands of highly committed general surgeons in the NHS delivering these procedures each day, to an exceptionally high standard of patient care. General surgery is undertaken in almost every hospital trust and demand for procedures is growing fast: from 2003/04 to 2013/14, there was a 27% increase in admissions.

Given such a high and diverse volume of work - general surgeons also deal with complex illnesses for which surgery may not be required - general surgery was recognised early as a field that stands to benefit from the Getting It Right First Time (GIRFT) programme. This new programme, funded by the Department of Health and jointly overseen by NHS Improvement and the Royal National Orthopaedic Hospital NHS Trust, seeks to identify variation within NHS care and then learn from it.

GIRFT is one of several ongoing work streams designed to improve operational efficiency in NHS hospitals. In particular, it is part of the response to Lord Carter's review of productivity, and is providing vital input to the Model Hospital project. It is also closely aligned with programmes such as RightCare, New Care Models, and Sustainability and Transformation Plans (STPs) - all of which seek to improve standards while delivering efficiencies.

The GIRFT programme

Under the GIRFT programme, data from many NHS sources is consolidated and analysed to provide a detailed national picture of a particular area of practice. This process highlights variations in care decisions, patient outcomes, costs and other factors across the NHS. The data is reviewed by experienced clinicians, recognised as experts in their field, who visit individual hospital trusts to discuss the data with senior management and the clinical teams involved in the specialty under review. Discussion focuses on areas where the trust's approach appears to differ from the national norm.

Where the data indicates the trust may be underperforming in some way, this is explored in more detail to see whether there is an alternative explanation for the data; where appropriate, the trust can then draw on the expertise of the GIRFT clinical leads as they discuss specific challenges they face and consider potential changes to practice.

Conversely, where the data indicates the trust is outperforming its peers, the clinical leads seek to understand what the trust is doing differently and how its approach could be adopted by others to improve performance across the NHS. The analysis and visits lead not only to targeted action within individual trusts, but also a national report, including recommendations, backed by an implementation programme to drive change.

The approach was first used in orthopaedic surgery and, within 12 months of completing the analysis and visits, led to an estimated £30m to £50m savings in orthopaedic care - predominantly through changes that reduced average length of stay and improved procurement.

Opportunities in general surgery

Examination of both national data and local practice in general surgery has identified similar opportunities to improve patient experience and outcomes and make more effective use of NHS resources. In particular, there are opportunities to learn from the trusts where readmission rates following complex surgery are lowest, where the use of day case surgery for less complex procedures is most common and where the proportion of patients with stoma 18 months after surgical resection for colorectal cancer is smallest.

If all trusts reached the national average in these three areas, it would potentially save the NHS half a million pounds a year; more significantly, it would make an enormous difference to patients' lives.

- Nationally, one in five patients who undergoes colorectal cancer surgery requires readmission to hospital within 90 days - but in some trusts the figure is just 10%. The GIRFT programme has sought to understand what these best performers are doing differently.
- According to the British Association of Day Surgery, at least 20% of anti-reflux surgery should be possible as a day case. The GIRFT review found that a handful of trusts undertake around 50% of procedures as day cases - and in one case, around 80%. Yet most trusts do not at present offer anti-reflux surgery on a day case basis. Data indicates that there is no detrimental impact on patient outcomes from day surgery, but it offers an improved patient experience and a cost efficiency for the trust - so there appears to be an opportunity to learn from those routinely using day surgery.
- Surgical resection for rectal cancer is a complex procedure and patients typically need a stoma (such as a colostomy or ileostomy) after the operation. Modern surgical practice means that the majority of stomata should be reversible, but the data shows substantial variation in the proportion of patients who still have a stoma 18 months after surgery. In some areas, three-quarters of patients still have a stoma; in others, it is less than a quarter and in four trusts the figure was zero. Given the vast impact on quality of life, and the fact that the cost to the NHS of providing care in the community to an individual with a stoma is around £6,000 per year, it is only logical that the approach taken by these latter trusts should be examined in more depth - with recommendations relating to this.

Other opportunities identified relate to rethinking the balance between elective and emergency provision, so that patients who would benefit from surgery within days (i.e. as soon as practical, rather than needing life-saving surgery immediately) can be diagnosed and scheduled in swiftly. This shift in balance not only benefits the patient but can also mean that the surgery required is less complex and costly than it would be further down the line. Several trusts have adopted a model where general surgeons are available to examine patients on first admission and surgical rosters are designed to allow this flexibility, and the indications are this benefits patients and the trust as a whole. Further study of this model is recommended.

Learning from the data, learning from peers

Every hospital visited by the GIRFT team has found the process extremely valuable and a number have already begun to take action in response to some of the opportunities identified. However, it is also clear that clinical leads and senior managers at many trusts were surprised by some of the variation, and by some of the approaches taken by peers, even where this variation had been previously recognised at a national level.

For example, during GIRFT visits, one common area of discussion was around the wide national variation in the use of radiotherapy for rectal cancer and chemoradiotherapy for oesophageal cancer. In some trusts, 80% of rectal cancer patients receive radiotherapy before a surgical procedure; in others, radiotherapy is seldom employed. This is a vast difference but its impact on outcomes is unclear.

When this data was presented to clinical teams during GIRFT visits, many were genuinely surprised at the variation. National audits demonstrate the variation has been consistent - but clinical practice has not changed. The surprise of the trusts indicates that many were unaware of how their peers elsewhere have been managing the same conditions.

A clear benefit of the GIRFT programme is that it draws together valuable insight from data-driven reports, audits and peer to peer discussion, and spurs trusts to rethink their approaches based on this information. Nationally, it would appear there is a significant further opportunity to study patient outcomes and gain a greater insight into the effectiveness, or otherwise, of pre-operative radiotherapy.

However, there is a further factor to consider here: that of professional development for surgeons. At present, this is largely left to surgeons themselves to co-ordinate; there is no formal programme or assessment. This is not just true of general surgery but of all surgical disciplines. While the majority of surgeons are both conscientious and professionally curious, studying new approaches through journals and conferences, it can mean surgeons not keeping abreast of developments in their specialist field.

One key recommendation from this strand of the GIRFT programme is to add a new dimension to professional development of surgeons. By learning directly from peers, fellow surgeons, in other hospitals, who are using different approaches, there are opportunities to study surgical technique, infection control, anaesthesia - all aspects of the surgical process.

This is particularly important for general surgeons who may carry out a wide range of different procedures on a relatively infrequent basis. The data shows that while some hospitals in England undertake over 22,000 general surgery procedures a year, others undertake fewer than 4,000, and may carry out some of the more complex procedures only a handful of times per year. Learning from those who repeatedly conduct successful procedures seems desirable for all and the report makes several recommendations related to this.

Improving data quality and accuracy

This leads into another key issue that the GIRFT programme in general surgery has raised: that of how success is measured. While the programme team has been able to gather and analyse a range of data to provide a more detailed national picture than ever before, it is nonetheless true that the data currently available about general surgery on the NHS is extremely limited.

Clearly, there has been a significant amount of activity in recent years to improve data - requiring hospitals to measure performance in more ways and gather information about a range of factors. Yet there is still much we can do to improve the quality of this data. Patient Reported Outcome Measures (PROMs) are not yet widely validated in general surgery, though a number of projects have been developing and validating effective PROMs in some benign conditions, including incisional hernia, oesophageal reflux, gallbladder disease and laparoscopic cholecystectomy.

Most strikingly of all, 71% of emergency general surgery activity nationally is recorded in Hospital Episode Statistics under the generic diagnostic code of "abdominal and pelvic pain". As a result, we cannot gain a true understanding of the demand for emergency general surgery - what conditions are being dealt with and what procedures are being used - nor its effectiveness.

The NHS needs more accurate data and to reduce the variation in the way it is recorded across trusts using diagnosis and procedure codes. Only by improving data quality will the NHS know how well it is treating patients and how it can improve patient treatment and care.

The GIRFT programme also identified concerns with some of the data that is currently measured. For example, the key measure of surgical performance at present is mortality rate: the number of patients who died within a set period after surgery by a particular surgeon. This is a crude measure, taking no account of the type of procedure or of co-morbidities. The easiest way to improve performance would simply be to avoid potentially higher risk procedures.

Yet there are other key indicators of surgical performance and patient experience that are not routinely measured, such as readmission rates and wound infection. Just four of the 50 hospitals that had participated in the GIRFT review programme (prior to publication of this report) were able to report wound infection rates reliably, even though infection can be a direct cause of readmission or further treatment - at best distressing and painful for the patient and incurring further potentially avoidable costs for the trust.

The two examples of readmissions and wound infection rates are not chosen by accident. Not only are they both already monitored in other countries, but there is also established guidance in the UK that encourages trusts to gather, analyse and learn from this information. This is included in the Royal College of Surgeons' guidance for the conduct of morbidity and mortality meetings. Trusts run meetings which focus on deaths and major complications but do not reliably take account of readmission and surgical site infection rates.

The data analysed by the GIRFT programme already demonstrates just how valuable this information can be to individual trusts and to the NHS as a whole. By improving the quality of data we collect and focusing on data that can give us a richer insight into care quality, we can do much more. Many of the recommendations from this report are therefore related to data.

Opportunities in procurement

One area where data is easily obtained and compared is around procurement - and the GIRFT programme has identified this as a key opportunity to identify marginal gains that together can have a major impact.

For general surgery, trusts were asked to provide information on recent prices paid for some common surgical instruments and consumables. The responses showed wide variation: if all trusts had purchased this basket of goods at the lowest unit price, the total cost would be £1,466.98. If all were procured at the highest cost, the price would be £2,335.52 - some 59% higher. While there were some differences in the items purchased, these did not appear to have a clinical impact.

No one trust purchased all the items at the highest price, nor the lowest; some might negotiate a great price for one item but pay an above average rate for another. Buying in bulk had no discernible cost benefit.

Clearly, there are opportunities here for cost savings and for greater consistency across trusts; recommendations relate to how greater consistency could be achieved.

Examples of best practice

Throughout our review of general surgery at trusts in England we found examples of best practice; initiatives and good ideas that could bring benefits if adopted by other trusts. Below are some examples of what we found.

Independent assessment of quality

Ipswich Hospital has signed up to the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). Two nursing colleagues are employed to make assessments of surgical wounds and to monitor other complications. This data is entered onto the ACS NSQIP database, allowing the trust to compare its performance against the whole database as well as similar sized hospitals in the USA.

Strong and sustained early recovery after surgery

The Countess of Chester Hospital is home to one of the best performing colorectal teams. They have a very low readmission rate with short lengths of stay for their group of rather elderly and frail patients. This is achieved by a tightly knit group of surgeons with a consistent approach to patients supported by a skilled team to help patients recover rapidly from surgery.

Personalised fluid charts

Bournemouth Hospital introduced a personalised fluid balance chart that allows the foundation doctors to produce bespoke fluid prescriptions for patients based upon a defined protocol.

Consultant-led surgical triage

A number of trusts have introduced consultant-led surgical triage and ambulatory emergency surgical systems. These have consistently shown that 30% of acute surgical admissions can be avoided. Inspired by these vanguard units (Bath, Derby and Blackburn), Nottingham University Hospital introduced an emergency general surgical service (NEGSS) and surgical triage unit (STU) in 2015. This new model was brought in to improve service efficiency, patient care and experience; recognising that there were high numbers of inappropriate referrals/admissions, unnecessary admissions and delayed senior decisions.

A senior member of their general surgery team covers the “front door” of the admissions unit between the hours of 8am and 5pm, seven days a week, taking telephone calls from all sources of referral including A&E, the ambulance service, and medical and nursing colleagues in primary care. Patients can be seen on the surgical triage unit or in the A&E department and the surgeon then makes the decision as to whether the patient goes home or is admitted. The unit has the facility to undertake ultrasounds, quick blood tests and x-rays if needed. This has shown a 15% reduction in inappropriate referrals and a 57% increase in same day discharge. By the end of 2015, the trust's length of stay reduction was 2,635 bed days. These two reductions have helped towards Nottingham NHS health care saving £2.1 million.

Mathematical model for emergency theatre sizing

This model was designed to work out where to place additional theatre time in order to reduce the waiting time for emergency surgical patients. It did this by taking the historical emergency waiting list information based on urgency code (CEPOD) and whether the patient was an adult or a child. It remodelled theatre capacity in order to shape it to predicted volumes of activity. It allowed experimentation with different solutions in order to produce the best answer and has led to an increased theatre resource being made available for emergency work.

Recommendations

This report makes 20 recommendations, spread across five themes - data and performance measurement; procurement; choice, commissioning and care pathways; surgical performance; and efficiency and emergency provision. Each is supported by a series of actions which form a key part of the implementation programme.

Theme 1: Data and performance measurement

1. Improve coding of emergency general surgical activity.
2. Introduce national policy levers to drive case ascertainment (completeness) in national audit programmes to a level approaching 100%.
3. Improve routine data collection quality.
4. Enhance national audit programmes by recording the number of patients with a relevant diagnosis, not just those who underwent a surgical procedure.
5. Design and progress implementation of an optimum care pathway for colorectal patients, and review national cancer targets in light of the resulting evidence.

Theme 2: Procurement

6. Instigate pricing transparency in procurement for general surgery, and use the resulting insight to deliver more cost-effective procurement.
7. Review options for consolidation of procurement at a national level.
8. Identify centres of good procurement performance, and understand what factors lead to the most favourable procurement prices.

Theme 3: Choice, commissioning and care pathways

9. Require reversible risk factors to be addressed prior to non-urgent procedures, using a patient-centred approach utilising shared decision-making.
10. Where not already described, define optimal care pathways in national guidance so they can be implemented locally with minimal, if any, variation. Optimal care pathways already defined in guidance should be implemented locally with minimal, if any, variation.

Theme 4: Surgical performance

11. Adopt a "zero-tolerance" approach to known avoidable surgical complications, on which there should be reliable data and national guidance.
12. Strengthen the clinical morbidity and mortality meetings by expanding the current focus on deaths and major complications.
13. Improve understanding of the causes of litigation and take action to reduce common errors that lead to claims.
14. Make available and require at appraisal surgeon-level intelligence on activity and outcomes.
15. Develop a means of identifying the best performing teams and enable others to visit them as part of continuing professional development (CPD).
16. Conduct a national review, assessing the NHS model of clinical autonomy against international comparators, with a view to reducing unwarranted variation in clinical practice.

Theme 5: Efficiency and emergency provision

17. Require data to be collected routinely about operation duration to establish a measurable benchmark for different types of procedures.
18. Undertake a capacity planning study to enable theatre capacity to be principally organised around emergency care.
19. Provide consultant-delivered emergency general surgery in each trust.
20. Require every trust to identify a consultant lead for emergency general surgery, with allocated time in their job plan.

Further recommendations will follow as the programme moves into implementation and as the available data increases.

Next steps: implementation

This report has underlined a need to transform services and practice at pace, to reduce variation and, in so doing, deliver a higher quality, more sustainable service. As such, NHS Improvement's objective is for GIRFT implementation in general surgery to be complete, and a new business as usual phase reached, by April 2019. The principal mechanism for doing this will be delivery of tailored implementation plans in each trust, which will translate this report to meet local needs.

Trusts should begin developing their implementation plan, based on:

- the indicators for which they are a negative outlier, of which GIRFT has provided a summary in their trust general surgery data pack
- the specific recommendations reported to the trust following the GIRFT visit[1]
- the recommendations in this national report.

In developing and delivering their implementation plans trusts should prioritise:

- the recommendations most emphasised in the GIRFT visit report, which would be based on both the data and the discussions during the visit
- the recommendations in this national report highlighted for immediate action.

To achieve the results we all want, it is vital that clinicians, management and all staff within trusts work shoulder to shoulder to progress these plans. Where this report recognises that national guidance, or any other national support, is needed prior to provider implementation, this is reflected in the timescales associated with our recommendations. Beyond immediate actions by trusts, we would specifically ask Clinical Commissioning Groups and NHS Rightcare to note action 10D (recommendation 10, theme 3), on access to bariatric surgery, for delivery by December 2017.

NHS Improvement and the GIRFT programme team recognise that developing implementation plans and delivering against them may be challenging. As such, GIRFT hubs based in regional locations across England will, from autumn 2017, support trusts by providing advice and management support, including advice on developing and troubleshooting implementation plans. The hubs will also lead a buddying process to help spread best practice between trusts, and manage dependencies with other transformation efforts including STPs, acute care collaborations (ACCs) and NHS RightCare. The core GIRFT data will be updated on an annual basis, to enable trusts to monitor progress, and where necessary reprioritise their implementation efforts.

The GIRFT programme team will work with national bodies, professional bodies and others to develop policy levers that can help accelerate delivery. In the interim, we encourage national bodies, professional bodies, CCGs, STP leads, ACCs and RightCare to keep GIRFT informed of interdependent transformation efforts. We are also working to build our policy and national support offer. Specifically, we expect:

- **By October 2017:** that NHS England and NHS Improvement will have agreed national policy proposals to support implementation. Consultation will then be undertaken as needed, for a final implementation date to be determined. By October, STPs, NHS RightCare delivery partners and Accountable Care Collaborations will also have begun joint working with the GIRFT Hubs, following contact from the hubs.
- **By early November 2017:** progress will have been made on developing clinical guidance, such as that referred to in recommendations 5, 9, 10 and 19, along with the pricing list referenced in recommendation 6.
- **By February 2018:** progress will have been made on all other national deliverables required to support improved procurement, reduced litigation and CPD.
- **By August 2018 to April 2019:** any further clinical and professional guidance will be delivered, along with the improvements to national audit programmes called for in recommendation 4. Research findings and subsequent national deliverables will be delivered. This will enable the new business as usual phase for general surgery.

Once the new business as usual has been reached: reviews of the NHS model of clinical autonomy and national cancer targets should be conducted.

[1] Trusts which have already been visited by the GIRFT clinical lead will either have already received this, or will receive it imminently. Trusts which have not been visited yet will receive their recommendations within one month of the visit. Trusts should be starting to build their implementation plans already as they have received their data packs.

GIRFT General Surgery Report Recommendations

THEME 1: DATA AND PERFORMANCE MEASUREMENT

Recommendation 1: Improve coding of emergency general surgical activity

Recommendation	Actions	Timeline
Improve coding of emergency general surgical activity.	**1A:** Surgeons to meet trust regularly with information team and coders to review activity attributed to them.	**1A:** For immediate action.
	1B: Trust management to ensure emergency general surgery data is incorporated into the appraisal intelligence as per recommendation 14.	**1B:** For immediate action.
	1C: GIRFT to create speciality-specific methodology focused on accuracy of coding, beyond the current validity methods, working with national bodies, such as NHS Digital, as appropriate.	**1C:** For completion by April 2019.
	1D: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**1D:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 2: Introduce national policy levers to drive case ascertainment (completeness) in national audit programmes to a level approaching 100%

Recommendation	Actions	Timeline
Introduce national policy levers to drive case ascertainment (completeness) in national audit programmes to a level approaching 100%.	National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	Agreement on national policy proposals to be achieved by October 2017.

Recommendation 3: Improve routine data collection quality

Recommendation	Actions	Timeline
Improve routine data collection quality.	**3A:** Mandated national audits to report data completeness and field validity, reporting at a provider level the proportion and count of submissions that are both complete and valid.	**3A:** For completion by April 2019.
	3B: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**3B:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 4: Enhance national audit programmes by recording the number of patients with a relevant diagnosis, not just those who underwent a surgical procedure

Recommendation	Actions	Timeline
Enhance national audit programmes by recording the number of patients with a relevant diagnosis, not just those who underwent a surgical procedure.	**4A:** GIRFT programme to develop a methodology to collect data on patients who have surgical illness but do not undergo an operation, including the reason why no operation occurred.	**4A:** For completion by April 2019.
	4B: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**4B:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 5: Design and progress implementation of an optimum care pathway for colorectal patients, and review national cancer targets in light of the resulting evidence

Recommendation	Actions	Timeline
Design and progress implementation of an optimum care pathway for colorectal patients, and review national cancer targets in light of the resulting evidence.	**5A:** GIRFT clinical lead to work with the Association of Coloproctology of Great Britain and Ireland (ACPGBI) to design the optimum care pathway for patients presenting with suspected colorectal cancer, and other urgent colorectal cases.	**5A:** Progress to have been made by early November 2017.
	5B: GIRFT to progress implementation of this pathway with providers.	**5B:** For implementation, to a new business as usual stage, by April 2019.
	5C: A review to be conducted on national cancer targets, in light of evidence emerging from 5B.	**5C:** To be conducted after new business as usual stage is reached.

THEME 2: PROCUREMENT

Recommendation 6: Instigate pricing transparency in procurement for general surgery and use the resulting insight to deliver more cost-effective procurement

Recommendation	Actions	Timeline
Instigate pricing transparency in procurement for general surgery and use the resulting insight to deliver more cost-effective procurement.	**6A:** GIRFT to work with the PPIB team to develop a specified list of surgical items and consumables that meet the correct standard at the most rational price point.	**6A:** Progress to have been made by early November 2017.
	6B: GIRFT and PPIB to identify centres of good procurement performance, and providers to implement the best practice identified.	**6B:** Progress to have been achieved by February 2018.
	6C: NHS Improvement to enable pricing transparency for items on the specified list.	**6C:** Agreement on national policy proposals to be achieved by October 2017.
	6D: Trust management to ensure this list is used to reduce costs.	**6D:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 7: Review options for consolidation of procurement at a national level

Recommendation	Actions	Timeline
Review options for consolidation of procurement at a national level.	**7A:** GIRFT to engage with relevant national programmes to develop solutions, within the scope of the programme's procurement work stream.	**7A:** Progress to have been achieved by February 2018.

Recommendation 8: Identify centres of good procurement performance and understand what factors lead to the most favourable procurement prices

Recommendation	Actions	Timeline
Identify centres of good procurement performance, and understand what factors lead to the most favourable procurement prices.	**8A:** GIRFT and PPIB to identify centres of good procurement performance and work with them to generate an understanding of related factors, to inform national procurement consolidation as per recommendation 7.	**8A:** Progress to have been achieved by February 2018.

THEME 3: PATIENT CHOICE, COMMISSIONING AND CARE PATHWAYS

Recommendation 9: Require reversible risk factors to be addressed prior to non-urgent procedures, using a patient-centred approach utilising shared decision-making

Recommendation	Actions	Timeline
Require reversible risk factors to be addressed prior to non-urgent procedures, using a patient-centred approach utilising shared decision-making.	**9A:** Guidance to be developed by GIRFT on the management of reversible risk factors prior to surgery, with the involvement of the Royal College of Surgeons of England (RCSE) and the Association of Surgeons of Great Britain and Ireland (ASGBI), working with the Royal College of Anaesthetists, and the GIRFT perioperative care project.	**9A:** Progress to have been made by early November 2017.
	9B: Providers to adhere to new guidance.	**9B:** For action upon completion of 9A.
	9C: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**9C:** Agreement on national policy proposals to be achieved by Oct 2017.

Recommendation 10: Where not already described, define optimal care pathways in national guidance so they can be implemented locally with minimal, if any, variation. Optimal care pathways already defined in guidance should be implemented locally with minimal, if any, variation

Recommendation	Actions	Timeline
Where not already described, define optimal care pathways in national guidance so they can be implemented locally with minimal, if any, variation. Optimal care pathways already defined in guidance should be implemented locally with minimal, if any, variation.	**10A:** Optimal care pathways to be defined by GIRFT, in new national guidance, to address the following issues: the use of radiotherapy for rectal cancer; the surgical approach for colorectal cancer; persistent abdominal stomata.	**10A:** Progress to have been made by early November 2017.
	10B: Surgeons to implement the pathways referred to in 10A, and trust management to facilitate and monitor this.	**10B:** For implementation upon completion of 10A.
	10C: Surgeons to implement the British Association of Day Surgery guidelines on anti-reflux procedures. Trust management to facilitate and monitor delivery.	**10C:** For immediate action.
	10D: Commissioners to ensure that access to bariatric surgery complies with the recommendations in the NICE guideline "Obesity: identification, assessment and management". This should be delivered by amending any contrary referral or prior approval policies and auditing results.	**10D:** Local policy to be amended by December 2017.
	10E: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**10E:** Agreement on national policy proposals to be achieved by October 2017.

THEME 4: SURGICAL PERFORMANCE

Recommendation 11: Adopt a "zero-tolerance" approach to known avoidable surgical complications, on which there should be reliable data and national guidance

Recommendation	Actions	Timeline
Adopt a "zero-tolerance" approach to known avoidable surgical complications, on which there should be reliable data and national guidance.	**11A:** GIRFT to establish an audit of incisional hernia in England.	**11A:** Progress to have been made by early November 2017.
	11B: Trust management and surgeons to ensure all cases of surgical complications are discussed in morbidity and mortality meetings, with a view to reducing incidence towards 0%.	**11B:** For immediate action.
	11C: Surgeons and trust management should consider adoption of the "small bite" technique to minimise hernia risk.	**11C:** For immediate action.
	11D: Surgeons and trust management to ensure mesh repair is used as routine for incisional hernia repair.	**11D:** For immediate action.
	11E: Surgeons and trust management to ensure an infection prevention bundle is in place.	**11E:** For immediate action.
	11F: GIRFT to ensure national guidance is developed on the surgical risks noted, and others as considered appropriate.	**11F:** For completion by April 2019.
	11G: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**11G:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 12: Strengthen the clinical morbidity and mortality meetings by expanding the current focus on deaths and major complications

Recommendation	Actions	Timeline
Strengthen the clinical morbidity and mortality meetings by expanding the current focus on deaths and major complications.	**12A:** GIRFT to collaborate with national bodies to agree plan for improved morbidity and mortality meetings.	**12A:** Progress to have been made by early November 2017.
	12B: Surgeons to implement this plan. Trust management to facilitate this practice, and audit of it.	**12B:** For immediate action following completion of 12A.
	12C: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**12C:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 13: Improve understanding of the causes of litigation and take action to reduce errors that lead to claims

Recommendation	Actions	Timeline
Improve understanding of the causes of litigation and take action to reduce errors that lead to claims.	**13A:** GIRFT to produce guidance outlining the causes of litigation in general surgery and strategies to ensure claims are reduced.	**13A:** Progress to have been achieved by February 2018.
	13B: Providers and training programmes to use this guidance for practice and education purposes.	**13B:** For action following completion of 13A.
	13C: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**13C:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 14: Make available and require at appraisal surgeon-level intelligence on activity and outcomes

Recommendation	Actions	Timeline
Make available and require at appraisal surgeon-level intelligence on activity and outcomes.	**14A:** Trust management to ensure all appraisals are informed with required intelligence input, including the alternative measures of surgical performance listed earlier.	**14A:** For immediate action.
	14B: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**14B:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 15: Develop a means of identifying the best performing teams and enable others to visit them as part of CPD

Recommendation	Actions	Timeline
Develop a means of identifying the best performing teams and enable others to visit them as part of CPD.	**15A:** GIRFT to develop methodology to identify high performing teams.	**15A:** Progress to have been achieved by February 2018.
	15B: Royal Colleges, Health Education England (HEE) and other CPD providers or certificating bodies to develop and roll out mechanism for formal CPD accreditation for peer visits.	**15B:** Progress to have been achieved by February 2018.
	15C: GIRFT to facilitate a programme of peer visits and buddying.	**15C:** For action upon completion of 15A and 15B, to reach new business as usual by April 2019.

Recommendation 16: Conduct a national review, assessing the NHS model of clinical autonomy against international comparators, with a view to reducing unwarranted variation in clinical practice

Recommendation	Actions	Timeline
Conduct a national review assessing the NHS model of clinical autonomy against international comparators, with a view to reducing unwarranted variation in clinical practice.	**16A:** GIRFT team to engage with all relevant national stakeholders to determine scope and organisation of the review.	**16A:** For completion by April 2019.
	16B: An appropriate national body to conduct the review and report recommendations.	**16B:** For immediate action, following completion of 16A.
	16C: GIRFT team to develop implementation strategy, as appropriate.	**16C:** For immediate action, following completion of 16B.

THEME 5: EFFICIENCY AND EMERGENCY PROVISION

Recommendation 17: Require data to be collected routinely about operation duration to establish a measurable benchmark for different types of procedures

Recommendation	Actions	Timeline
Require data to be collected routinely about operation duration to establish a measurable benchmark for different types of procedures.	**17A:** Data indicating "operation duration" to be collected and included in the Model Hospital.	**17A:** Progress to have been made by February 2018.
	17B: GIRFT to commission research assessing "optimum" operation durations.	**17B:** Progress to have been achieved by November 2017.
	17C: Benchmarks resulting from 17B to be included in the Model Hospital.	**17C:** For action upon completion of 17B.
	17D: Surgeons and trust management to utilise this information to drive efficiency improvements.	**17D:** For action upon completion of 17C.

Recommendation 18: Undertake a capacity planning study to enable theatre capacity to be principally organised around emergency care

Recommendation	Actions	Timeline
Undertake a capacity planning study to enable theatre capacity to be principally organised around emergency care.	**18A:** GIRFT to undertake study and produce guidance based on resulting insight.	**18A:** For immediate action.
	18B: Surgeons and trust management to implement this guidance.	**18B:** For immediate action following completion of 18A.
	18C: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**18C:** For implementation upon completion of 18A.

Recommendation 19: Provide consultant-delivered emergency general surgery in each trust

Recommendation	Actions	Timeline
Provide consultant-delivered emergency general surgery in each trust.	**19A:** GIRFT to provide national guidance on best practice in emergency general surgery, reflecting the need for consultant-delivered care, and drawing on existing evidence concerning increasing throughput.	**19A:** Progress to have been made by early November 2017.
	19B: Providers to reshape the emergency general surgical service to ensure consultant-delivered care.	**19B:** For immediate action following completion of 19A.
	19C: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**19C:** Agreement on national policy proposals to be achieved by October 2017.

Recommendation 20: Require every trust to identify a consultant lead for emergency general surgery, with allocated time in their job plan

Recommendation	Actions	Timeline
Require every trust to identify a consultant lead for emergency general surgery, with allocated time in their job plan.	**20A:** Providers to identify relevant emergency general surgery lead, with allocated time in their job plan.	**20A:** For immediate action.
	20B: National policy levers to be developed by GIRFT in collaboration with national bodies, such as NHS England and NHS Improvement, as appropriate.	**20B:** Agreement on national policy proposals to be achieved by October 2017.

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The full report and executive summary are also available to download as
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