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Breast surgery

GIRFT Programme Follow-up Report

by Tracey Irvine
GIRFT Clinical Lead for Breast Surgery

April 2026

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Contents

Foreword by Professor Tim Briggs

Breast surgery is a core component of high-quality cancer care, requiring clinical excellence, multidisciplinary working and careful shared decision making with patients. Across England, breast teams continue to provide care of a very high standard, despite sustained pressure from rising demand and increasing complexity.

This report offers a national perspective on how breast surgery services are operating today. It reflects both performance and lived experience across the system. It highlights where services have adapted successfully, where variation persists and where further improvement would deliver the greatest benefit for patients and the NHS.

The report shows that progress has been made. Many services have modernised pathways, refined surgical practice and made better use of data to support improvement. These changes have helped to maintain quality and safety while responding to growing activity and complexity, demonstrating what can be achieved through strong clinical leadership and well-designed systems.

At the same time, the findings underline that variation in practice remains a significant challenge. Differences in access, pathway design and use of interventions continue to affect patient experience and place avoidable pressure on outpatient, theatre and inpatient capacity. Addressing this variation is essential - not to limit care, but to ensure that resources are used where they deliver the greatest value for patients.

The GIRFT principles that underpin this work remain clear: focus on interventions that improve outcomes, reduce activity that does not, and ensure that high-quality data is available to support informed clinical decision making.

This report is intended to support action. It identifies clear priorities for improvement and signposts practical resources to help teams translate insight into local change, aligned with national best practice while reflecting local context.

By maintaining a clear focus on unwarranted variation, value and outcomes, we can continue to strengthen breast surgery services and ensure they remain equitable and centred on the needs of patients.

Professor Tim Briggs CBE

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

Professor Tim Briggs is a consultant orthopaedic surgeon at the Royal National Orthopaedic Hospital NHS Trust.

Statement of support

Association of Breast Surgery

The GIRFT Programme Follow-up Report for breast surgery provides vital evidence for all stakeholders involved in the delivery of breast care services and reinforces the importance of robust data collection and analysis in improving care delivery and maximising available resources.

It highlights significant pressure on current services and the need for co-ordinated, sustainable workforce planning, aligned with the National Cancer Plan for England and the forthcoming NHS workforce review.

The report identifies ongoing and clinically significant regional variation in access to oncology, oncoplastic and reconstructive breast surgery services, as well as variation in the timeliness of patient pathways. It further identifies pathology services as an urgent priority across cancer services, with only 12% of pathology services meeting the Royal College of Pathologists' ten-calendar-day standard for post-operative reporting. This is causing unacceptable delays for patients awaiting further treatment.

National performance against the Faster Diagnosis Standard has also deteriorated, falling below 2021/22 levels. As breast cancer pathways are often prioritised, this may provide a wider indicator of system performance across cancer services.

The report shows that staffing shortages persist despite funding, with long-term vacancies, particularly across diagnostic and nursing roles, continuing to constrain service capacity and threaten sustainability. To help address this, the Association of Breast Surgery is actively working to support nursing roles throughout the breast care pathway.

We must remain committed to delivering sustainable services that provide equitable, timely access to all aspects of breast care for all patients. This report evidences the progress made in adapting to the limited resources available and will help us to implement the changes needed to enhance breast care services moving forward.

Ms Sarah Downey

Association of Breast Surgery President

Executive summary

Breast surgery services in England continue to deliver high-quality, patient-centred care in the face of sustained pressure. This report presents an assessment of the state of breast surgery services today, following on from the 2021 GIRFT Breast Surgery National Report. The analysis draws on national data and insights from GIRFT gateway reviews with Cancer Alliances to assess progress against the 2021 recommendations and to identify priorities for improvement going forward. This report includes a final section containing practical implementation tools designed to support providers in delivering pathway improvements and service changes.

Over the last five years, breast referral volumes have been consistently high, resulting in sustained pressure on diagnostic and outpatient pathways. Services remained busy, and patients were on average marginally older, with more comorbidities in 2025 than in 2021. The five years saw a small increase in breast-conserving surgery (and a corresponding minor decline in mastectomies) and a significant increase in breast-conserving surgery procedures coded as oncoplastic. These trends have important implications for pathway efficiency, clinical capacity and equitable access to care.

Workforce shortages remained prevalent across key specialties (including in some services where posts were fully funded). Such pressures represent an ongoing constraint on service sustainability, while the age profile of the breast workforce, together with frequently-reported reductions in trainee numbers, pose a nationwide challenge for the future. These issues should be addressed nationally to ensure the sustainability of services.

Progress has been made in implementing several of the 2021 GIRFT recommendations. Day case surgery rates improved for most procedures, length of stay for autologous reconstruction reduced, and complication, readmission and implant loss rates remained stable or improved. Going forward, continued improvements in clinical coding (including the introduction of new OPCS-4 codes and national GIRFT coding guidance) will strengthen the quality of data and support further service benchmarking and improvement.

However, unwarranted variation persists across many aspects of care, including follow-up practice, day case surgery rates, access to oncoplastic techniques and breast reconstruction, and the use of neoadjuvant chemotherapy to support breast conservation. Substantial opportunities remain to address outpatient attendances, clinically unwarranted benign and bilateral surgeries, and inefficient use of theatre and bed capacity.

This report reiterates the ongoing relevance of the GIRFT recommendations and sets out clear priorities for the future: accelerating cancer pathways, freeing up clinic and theatre capacity, increasing day case surgery, reducing unnecessary mastectomies and ensuring equitable access to oncoplastic surgery and reconstruction.

Introduction

The GIRFT breast surgery workstream

The GIRFT breast surgery workstream commenced in April 2018. The workstream marked the first national evaluation of the full delivery of breast surgery in England, spanning benign and malignant disease, oncoplastic surgery and reconstruction, regardless of surgical specialty. The GIRFT clinical leads, Fiona MacNeill and Tracey Irvine, conducted peer reviews at 129 acute trusts, analysing data, identifying unwarranted variation, sharing best practice and discussing how services could improve.

As the national report was being finalised in February 2020, the coronavirus pandemic fundamentally altered the landscape of NHS care. It became necessary to reframe the breast surgery recommendations to support service continuity and recovery, so three overarching 'key recovery recommendations' emerged:

1. **Limiting unnecessary hospital attendances**
2. **Minimising unnecessary interventions**
3. **Improving clinical coding and data capture**

The GIRFT National Specialty Report on Breast Surgery was published in February 2021. Since then, Tracey Irvine has led the GIRFT breast surgery workstream, supporting national implementation and helping providers translate the recommendations into local practice.

In 2024/25, GIRFT conducted breast surgery gateway reviews with the 20 Cancer Alliances (CAs) to assess progress in embedding the 2021 recommendations. The process drew on GIRFT gateway metrics, key non-Hospital Episode Statistics (HES) sources[1] and detailed pre-visit questionnaires to construct an unparalleled picture of the breast surgery service in 2025, offering insights not visible from centrally collected data alone.

NHS breast teams continue to deliver high-quality, patient-centred care, despite financial and workforce pressures. While many providers are managing these multifaceted challenges, others face barriers to improving or developing services to keep pace with medical advances and rising demand. The gateway reviews sought to understand the pressures faced by services and to support providers in addressing areas of unwarranted variation.

GIRFT's key recovery recommendations remain as relevant now as they were in 2021. They help providers to focus on high-impact elements of care and reduce or streamline work with limited clinical benefit, which is increasingly essential given rising demand and constrained capacity. Where implemented effectively, they can minimise avoidable attendances and interventions, improve data accuracy and support safe, efficient and high-quality care.

[1] *Including National Audit of Primary Breast Cancer (NAoPri), the Breast and Cosmetic Implant Registry (BCIR), the UK National Flap Registry (UKNFR), National Institute for Health and Care Research clinical trials (NIHR trials), and Cancer Waiting Times (CWT) as well as Model Health System (MHS).*

This report presents the current state of the breast surgery service, drawing together findings from the data analysis and gateway reviews, assessing progress against the 2021 recommendations and identifying priorities and opportunities for future service improvement.

The report also signposts resources intended to support implementation, providing practical guidance for providers seeking to optimise pathways and service delivery.

Note on data sources and time periods
Unless otherwise stated, analyses use Model Health System (MHS) data for the 12-month period to the end of Q2 2025/26. Earlier comparisons refer to the equivalent 12-month period to the end of Q2 2020/21. Data was correct at the time of writing.

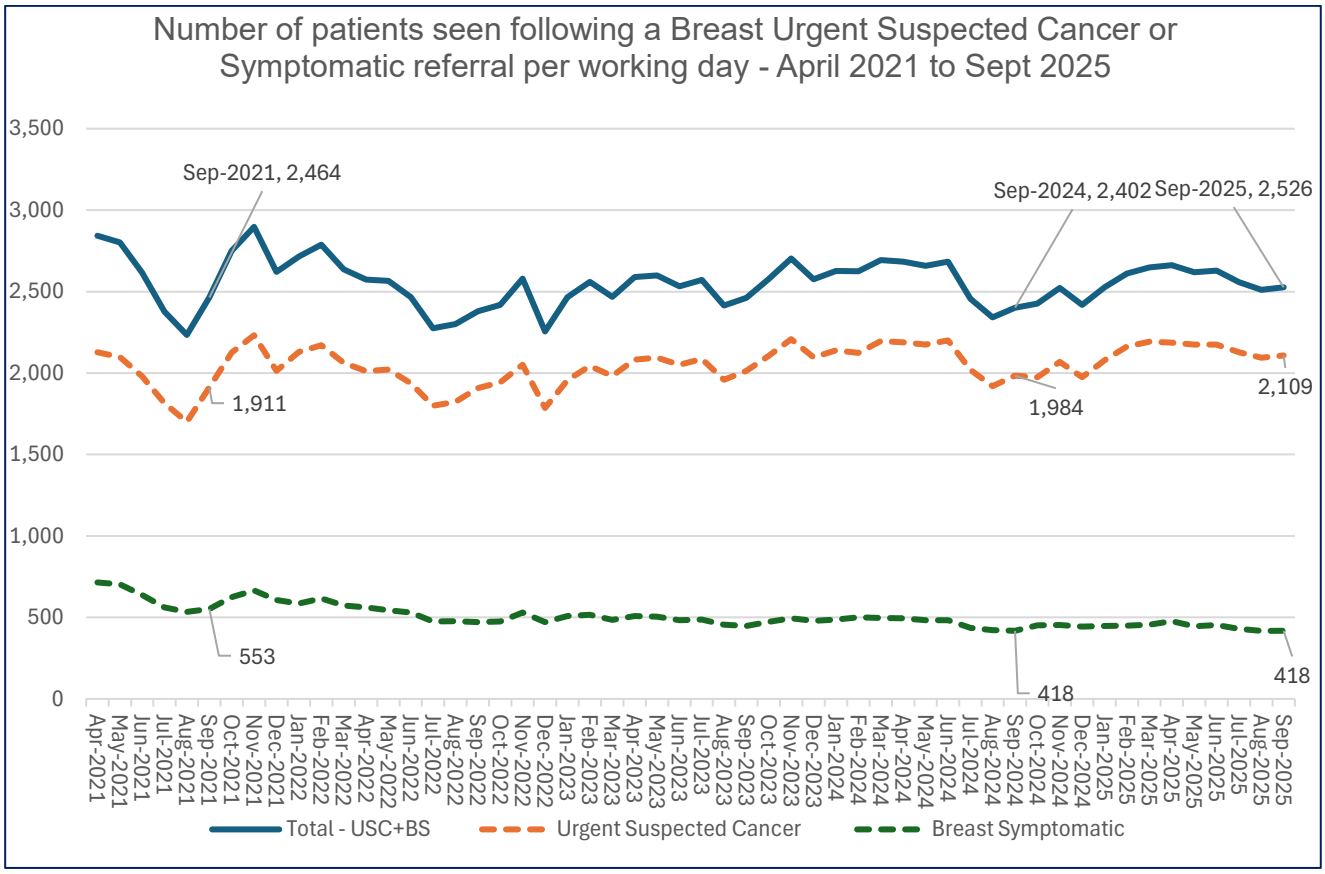
The state of the breast surgery service in 2025

Breast surgery services remain under considerable strain, with sustained referral volumes, heavy clinical and surgical activity and persistent staffing shortages. While some providers have adapted by streamlining pathways, procedures and processes, others are struggling to keep pace with demand and maintain high-quality care. Despite incremental improvement, unwarranted variation persists across key stages of the breast cancer pathway.

Referrals

Breast cancer referrals remained largely static between April 2021 and September 2025, with around 2,500 referrals per day nationally, as illustrated in **Figure 1**. The majority were urgent suspected cancer (USC) referrals, which rose by 11%, while breast symptomatic referrals declined by 28%.

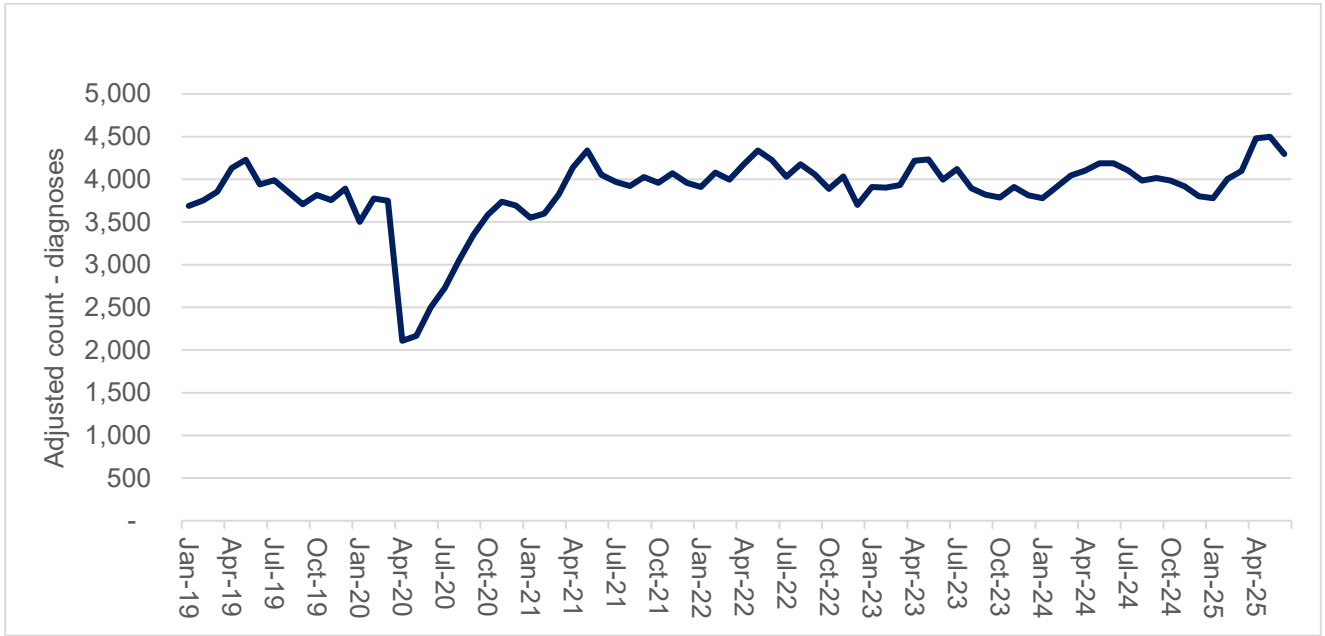
Figure 1: Number of patients seen per working day following a breast USC or breast symptomatic referral



Source: National Cancer Waiting Times Dataset, April 2021 to September 2025.

Conversion rates to cancer diagnoses remained low (5.3% for USC referrals and 1.2% for breast symptomatic referrals) although total breast cancer diagnoses have increased over the last six years, as shown in **Figure 2**.

Figure 2: Number of breast cancer diagnoses by month

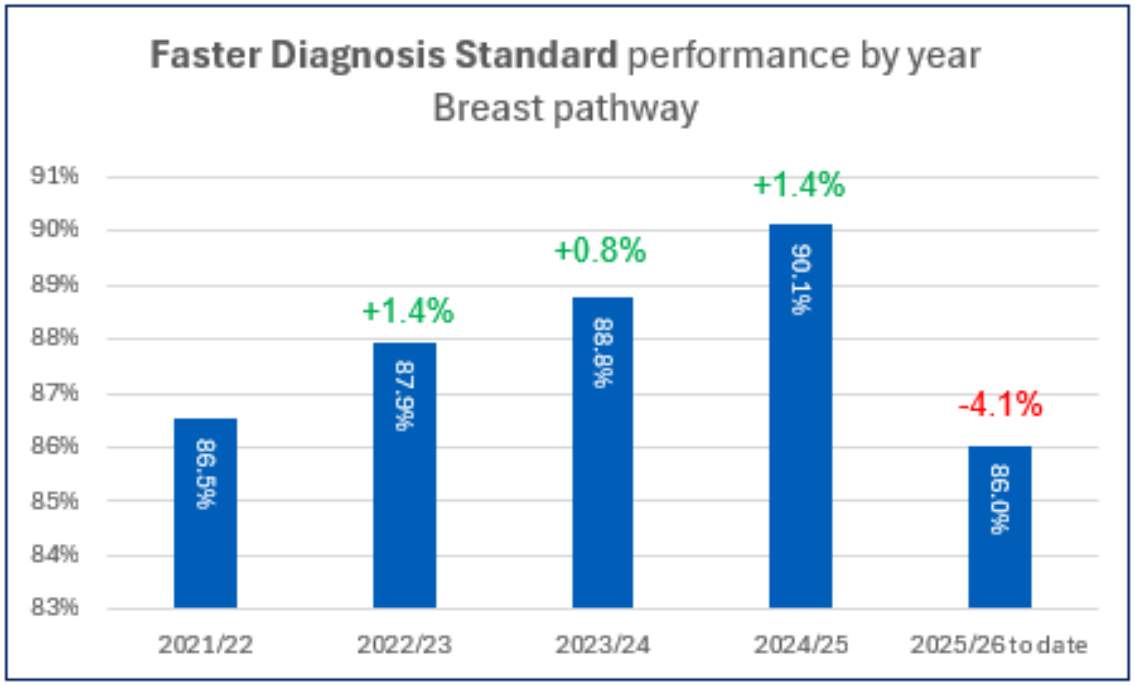


Source: Rapid Cancer Registration Data, January 2019 to June 2025.

Cancer waiting times for breast cancer

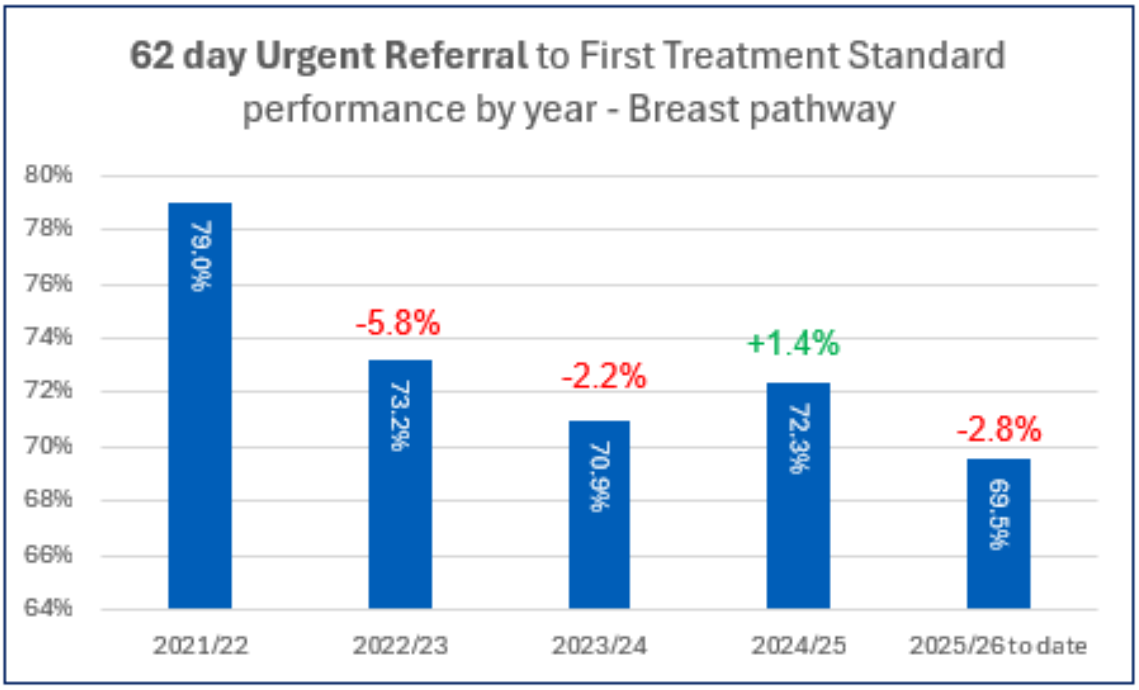
National performance against the faster diagnosis standard (FDS) improved each year following the pandemic until 2025/26, when progress reversed and performance fell below 2021/22 levels. The 62-day referral-to-treatment performance, which pre-pandemic was routinely above 90%, fell to 69.5% in 2025/26 (see **Figure 4**).

Figure 3: FDS performance



Source: National Cancer Waiting Times Dataset

Figure 4: 62-day referral to treatment performance



Source: National Cancer Waiting Times Dataset

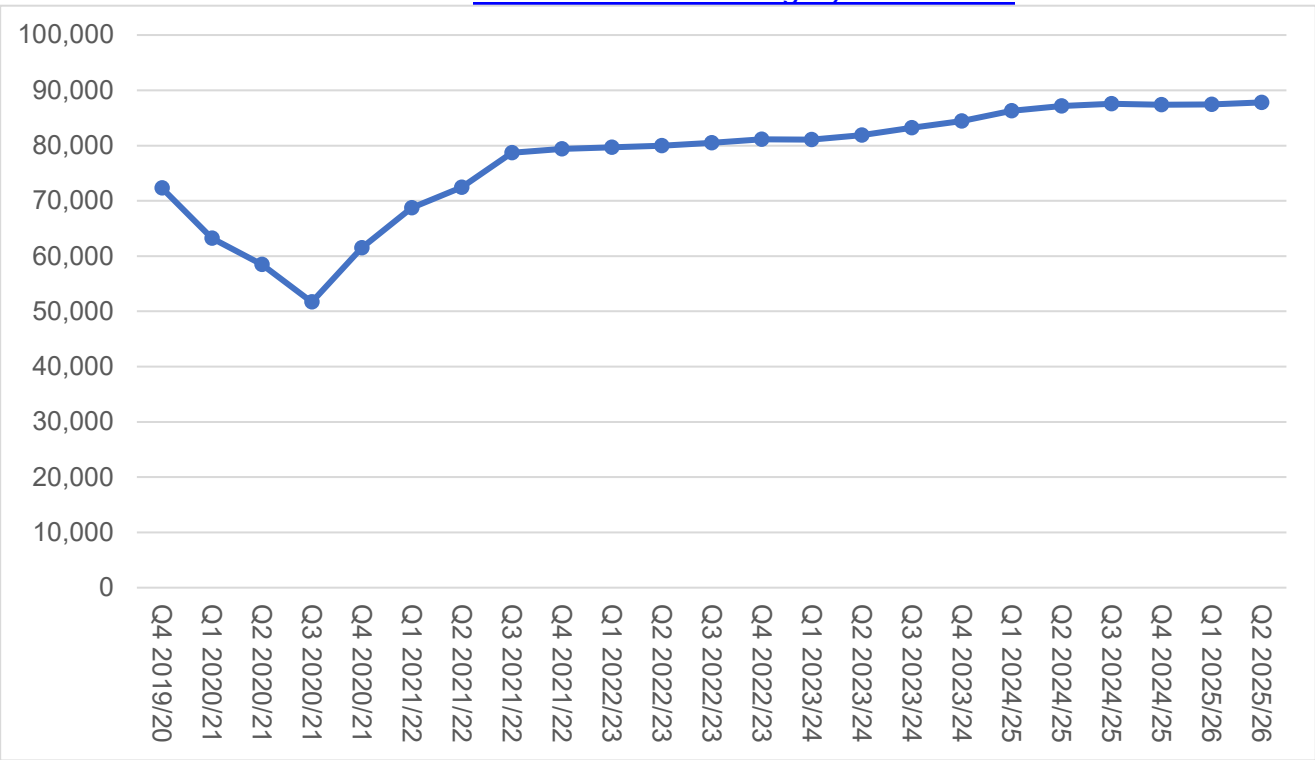
FDS performance varied markedly between patients with and without cancer: for patients with cancer, FDS performance was 65% compared to 88% for those without cancer.

Admissions

Breast surgery admissions have continued to maintain a consistent increase since Q4 2019/20, including recovering fully from the reduction in activity during the pandemic. The total increase over this five-year period, as shown in **Figure 5,** is 21.4%.

Figure 5: Total breast surgery admissions

Source: MHS Number of Breast Surgery admissions –



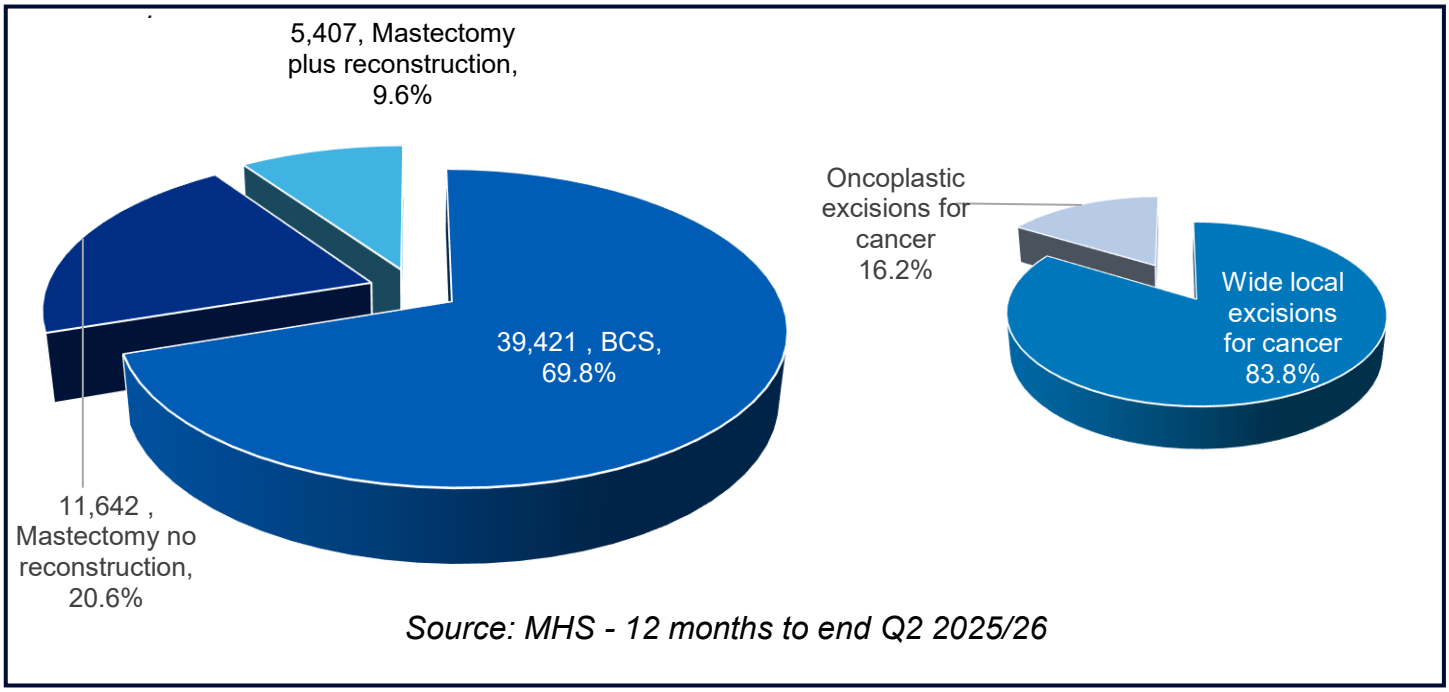
12 months to qtr end Q4 2019/20 and 12 months to end Q2 2025/26.

In the 12 months to Q2 2025/26, the majority of admissions were for patients undergoing their first breast cancer operation. Of these, almost 70% (39,421) had breast-conserving surgery (BCS), while the remainder (17,049) underwent mastectomy. Among mastectomy patients 5,407 (31.7%) had immediate reconstruction, including 1,861 autologous procedures representing around 34% of reconstructions.

Over the five-year period, there was a slight increase in the proportion of BCS procedures, with a corresponding minor decline in mastectomy rates. At the same time, the proportion of BCS procedures coded as oncoplastic increased significantly, from 11.7% to 16.2% between Q3 2020/21 and Q2 2025/26 (data for Q2 2020/21 were not available).

Figure 6 shows the distribution of index breast surgery procedures (which include breast excision for cancer including oncoplastic excisions, mastectomy +/- immediate breast reconstruction) in the latest quarter.

Figure 6: Breast surgery index procedures by number and percentage of total breast surgery admissions



Source: MHS - 12 months to end Q2 2025/26

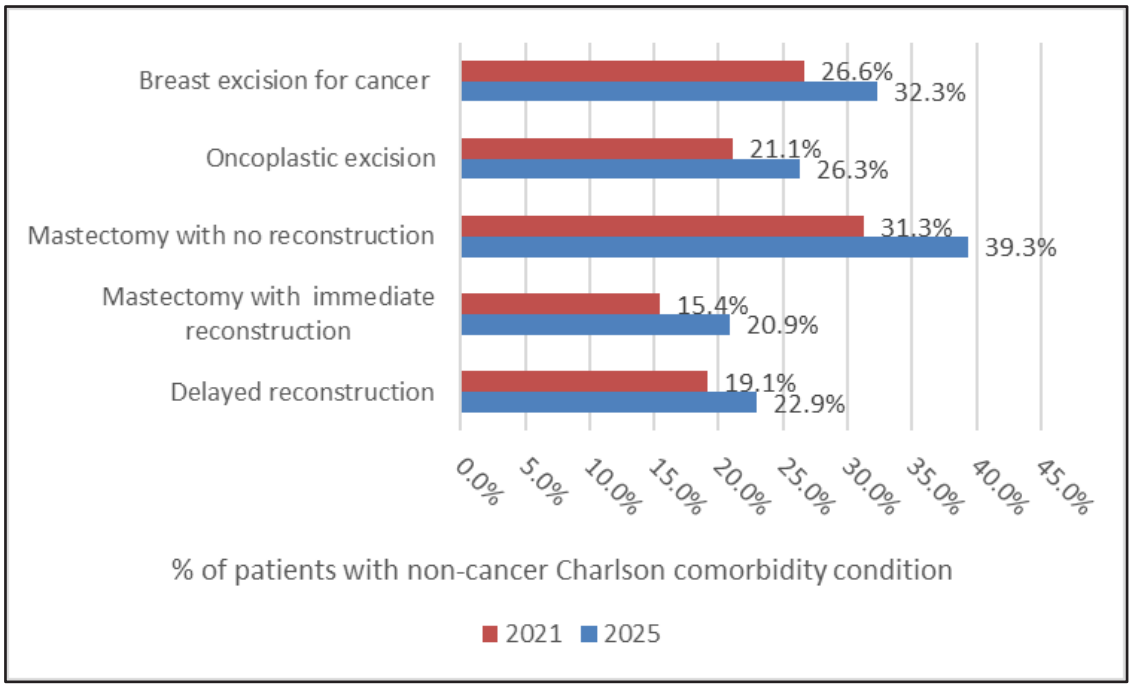
Patient characteristics

Rising volumes and surgical complexity were accompanied by changes in the characteristics of patients treated over the five-year period. The median age of patients increased by approximately one to two years, while the percentage of patients in the most deprived quintile remained stable across all procedure groups, apart from those undergoing delayed reconstruction.[2]

Over the same period, the proportion of patients with a recorded comorbidity increased across all procedure groups **(Figure 7)**. This aligns with feedback from clinical teams that breast cancer patients are presenting with increasing medical complexity.

[2] *For patients undergoing delayed reconstruction, there has been a steady increase (from 10%–13.8%) in the percentage of patients in the most deprived quintile. The reason for this is unclear.*

Figure 7: Percentage of patients with a non-cancer Charlson comorbidity, by procedure



Source: MHS Breast surgery metrics – 12 months to end Q2 2020/21 and 12 months to end Q2 2025/26

Clinical activity

Breast units remain busy: for every 100 index procedures, the average English unit held 115 new clinics, 166 follow-up clinics and 55 half-day operating sessions per year.[3] However, 96 providers (around 84%) overbooked clinics at least once a week.[4]

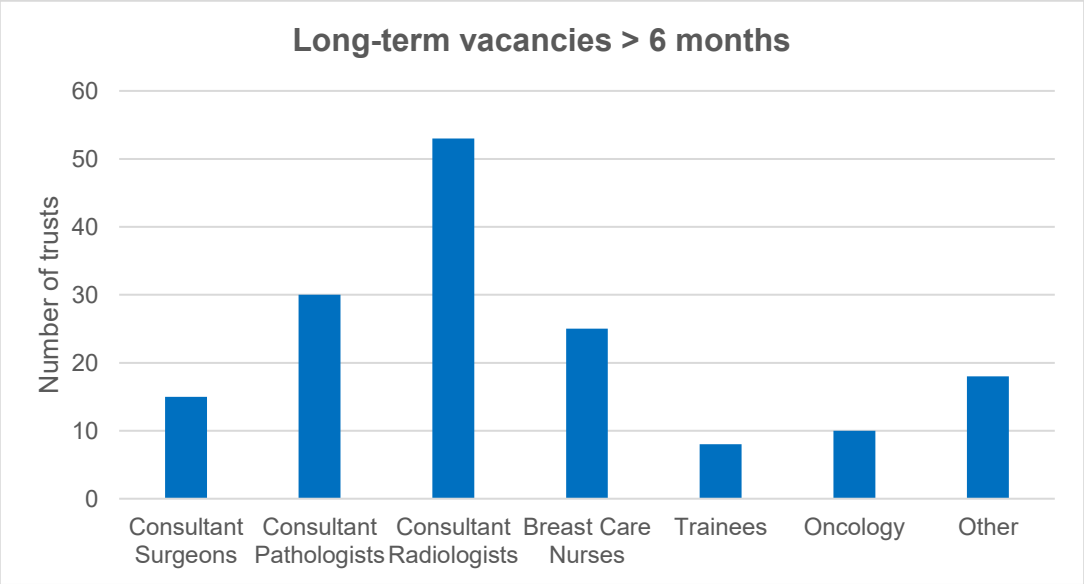
Meanwhile, over a third of providers had a main multidisciplinary meeting (MDM) lasting over three hours, despite the fact that almost half had separate MDMs to cover certain aspects of their service (e.g. screening, benign cases or oncoplastic surgery) to reduce pressure on the main MDM. Around one-third of providers had a dedicated secondary MDM (or a dedicated section for discussion in their main MDM).

[3] *Index procedures include breast excision for cancer including oncoplastic excisions, mastectomy +/- immediate breast reconstruction. This statistic excludes ad hoc activity and is a snapshot, not a benchmark.*
[4] *Based on MHS activity data compared with GIRFT pre-visit questionnaires.*

Workforce

Many staffing shortages occurred despite posts being fully funded: long-term vacancies (over six months) were widespread (**Figure 8**). Shortages in key diagnostic and nursing roles continue to limit service capacity and pose a risk to long-term sustainability.

Figure 8: Prevalence of long-term vacancies

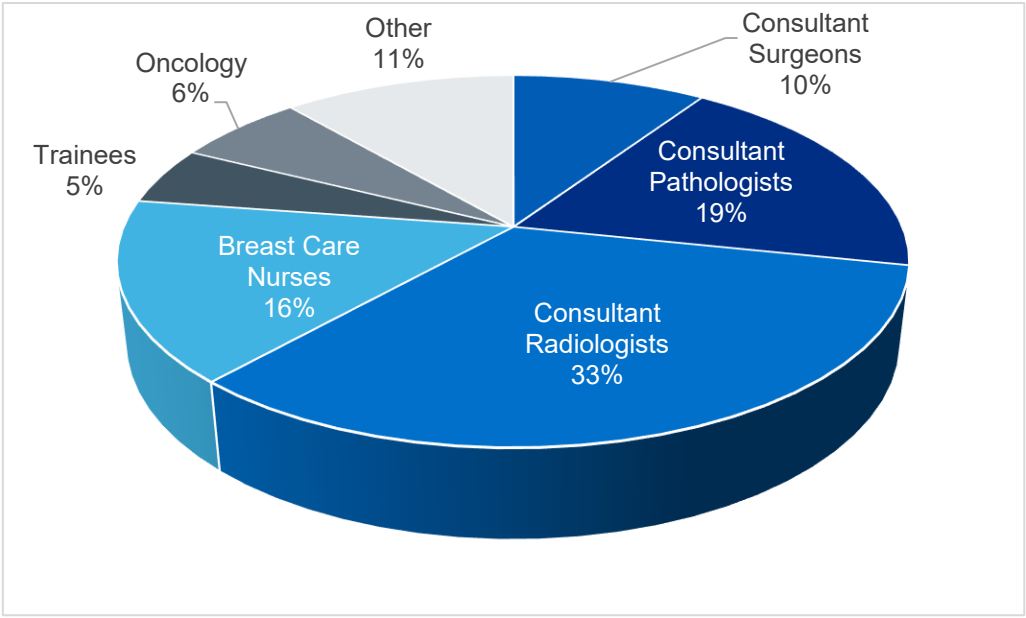


Source: GIRFT Gateway review pre-visit questionnaires

N.B. 'Other' includes CT trainees, specialty doctors, middle grades, ANPs, ACP mammographers and administrators.

As **Figure 9** shows, every CA reported staff shortages, echoing patterns observed in 2021.

Figure 9: Staff shortages by specialty as percentage of all staff shortages[5]



Source: GIRFT Gateway review pre-visit questionnaires.

[5] Long term vacancies over 6 months.

Specialist nursing

Workforce pressures were evident in nursing, with responsibilities of breast cancer nurses (BCNs) and nurses working in breast care (e.g. Advanced Nurse Practitioners (ANPs)) expanding significantly to include endocrine therapy management, lymphoedema clinics, seroma aspiration, triage and FDS clinics. In 2025, 63% of providers reported employing at least one secondary BCN.

Collectively, these factors underscore the central role that breast care nurses and nurses working in breast care play in service delivery. Given the diversification and growing expectations of BCNs and all nurses working within the breast service, it is vital for providers to support them adequately and understand the remit of each nursing role.

The Association of Breast Surgery (ABS) recently conducted a national nursing survey[3] to capture the reality of breast nurse job demands. ABS will issue job planning and banding guidance for providers in light of the expanding scope of the BCN role and the expanding use of all nursing roles to support the breast service. The role of the CNS is emphasised in The NHS National Cancer Plan for England which aims to reduce health care inequalities by providing more training opportunities and career pathways for cancer nurses and support staff.

Out-of-hours cover

In 85% of providers, out-of-hours breast surgery cover was provided by general surgery teams, as breast surgeons rarely participate in general surgical on-call rotas or have dedicated breast on-call rotas. While general surgeons can provide emergency out of hours care, most do not do any elective breast surgery and, as such, the breast surgeons are often contacted directly about their patients to provide advice or out of hours care.

While all plastic surgical units have an on-call service, not all plastic surgeons on the rota can offer microvascular surgery. Some units have adapted their rotas to allow surgeons to be on call on the day of their autologous reconstructions, but many plastic and breast surgery on-call arrangements remain ad hoc and rely on goodwill. These informal arrangements may have sufficed in the past, but the growing complexity of breast, oncoplastic and reconstructive procedures makes this increasingly sub-optimal. Clearer governance for out of hours cover is needed to ensure post-operative patient safety.

Diagnostic capacity and staging variation

Diagnostic capacity is a determinant of cancer waiting times (CWT) performance, but pressures on both radiology and pathology were a prevalent theme in our reviews. In addition to staffing shortages, difficulties or delays arose in accessing key imaging or pathology tests (including vacuum excisions, MRI-guided biopsies, HER2 ISH and germline genetic testing). Such challenges may contribute to ongoing unwarranted variation in staging practices, both in patient cohorts staged and imaging modalities used (e.g. CT, CAP, bone scan and PET-CT). Adherence to the Royal College of Radiologists' guidance on screening and symptomatic breast imaging should support standardisation in this regard and reducing unnecessary investigations will minimise delays in cancer pathways.

Pathology turnaround times also varied extensively between providers. Just over a third of providers could process a core biopsy with full biology within seven days; only 12% met the Royal College of Pathologists' standard of ten calendar days' turnaround for post-operative pathology. The expansion of histopathology capacity outlined in the NHS National Cancer Plan for England should ultimately help address unwarranted variation and improve turnaround times for pathology.

Workforce demographics

The age profile of the breast workforce presents a nationwide challenge for the future. In 2025, 20% of consultant breast radiologists, 69% of consultant breast oncologists and 36% of consultant breast surgeons were aged 55 or over. At the same time, one-third of providers reported having fewer trainees in the last five years (with other professionals in some providers picking up the duties trainees would be expected to perform). Workforce challenges and shortages are likely to intensify as staff retire. Co-ordinated, nationwide forward workforce planning is urgently needed to futureproof the service. The NHS National Cancer Plan includes a commitment to create more training places for consultants, identifying medical and clinical oncology as areas facing specific pressures, in order to help address current shortages. A ten-year workforce plan is due to be published later this year.

Implications

Taken together, the findings indicate that many breast surgery services continue to operate at or beyond capacity in key areas, with overbooked and ad hoc clinics commonplace, increasing surgery volume and complexity, and workforce shortages evident across several key specialties.

Review of recommendations from the GIRFT Breast Surgery National Report

This section summarises progress in implementing the 2021 recommendations, highlighting areas where targets have not yet been achieved or where unwarranted variation persists. Opportunities to continue implementing these recommendations, together with initiatives to support providers in doing so, are set out in the final section of the report.

Key recovery recommendation 1: Limit unnecessary hospital attendances

Many of the recommendations in this report already focus on streamlining the patient pathway and minimising time in hospital with day case surgery, minimising returns to theatre (see our recommendations 3, 4 and 6, on pages 15-16) and patient-led follow up. A key GIRFT recommendation is review and refinement of the new patient referral process (recommendations 1 and 2).

GIRFT Programme Breast Surgery National Specialty Report, 2021

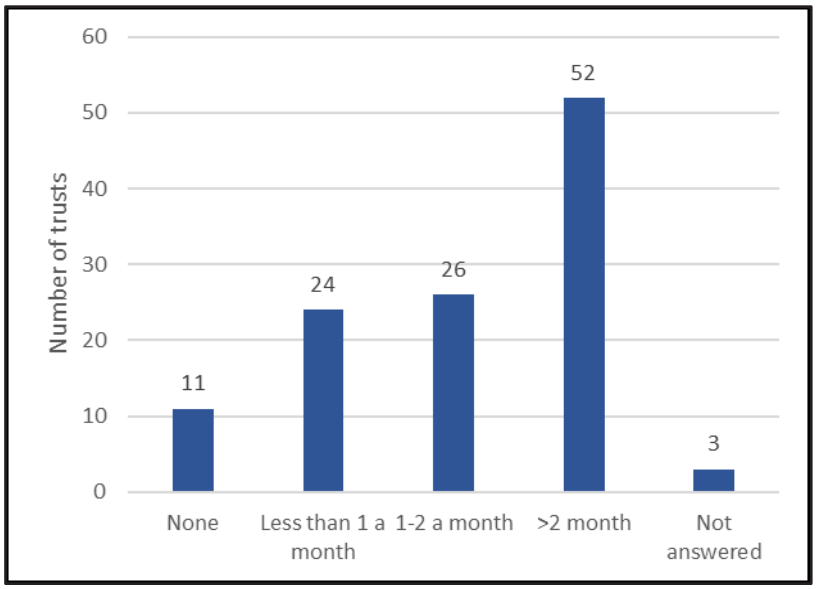
Ensure timely, patient-centred referral and assessment pathways[6]

High referral volumes, together with pathology, radiology and nursing capacity constraints, continue to put immense pressure on referral and assessment pathways.

Many providers have demonstrated that it is possible to rise to the challenge: between September and November 2025, the top 20 providers had an average FDS performance of 97.6%, highlighting that timely diagnosis is achievable with efficient, well-streamlined pathways. In contrast, the bottom 20 providers had an average performance of 63.1%.

In response to high volumes, many providers host extra diagnostic clinics (**Figure 10**).

Figure 10: Extra diagnostic clinics required



Source: Gateway reviews pre-visit questionnaires.

[6] *See recommendation 1 of the GIRFT Breast Surgery National Specialty Report.*

The majority of these extra clinics (74%) offer a 'one-stop' or 'triple diagnostic assessment' (TDA) model.[7] TDAs remain central to the delivery of timely, patient-centred and streamlined referral pathways, and are recommended by the National Audit of Primary Breast Cancer (NAoPri). However, reliance on ad hoc arrangements is not sustainable and leaves the clinics vulnerable to funding freezes (which may partly explain the recent decline in CWT performance). Protecting TDA capacity should be a priority for providers.

Support better self-management through public health messaging[8]

Work continues with key stakeholders to reinforce the importance of breast health awareness and to encourage regular self-examination, supporting the #KnowYourNormal and Breast Cancer Now's Touch Look Check messaging. It is also important that policy makers recognise breast health as an integral component of all women's health initiatives.

Minimise unnecessary outpatient attendances[9]

Follow-up activity has historically varied substantially between providers, reflecting differences in local practice rather than patient need or preference. Five-year follow-up data showed considerable variation, with an approximately ten-fold difference in the number of appointments (ranging from around two to 20 appointments) following breast-conserving surgery (including oncoplastic procedures) and mastectomy without reconstruction. This level of variation highlights a significant opportunity to release clinic capacity.

The NHS National Cancer Plan prioritises transformation of outpatient care and recommends reduction of unnecessary appointments through patient-initiated follow-up (PIFU). Within breast services, while 75% of providers reported that most patients were managed via PIFU using a variety of remote digital monitoring services,[10] approximately 25% of patients nationwide still lacked any access to PIFU in 2025. This gap indicates an ongoing opportunity to reduce avoidable follow-up activity.

Minimise hospital stays[11]

The GIRFT Breast Surgery National Report identified clear opportunities to reduce length of stay (LoS) as analysis of MHS data shows that shorter LoS is not associated with higher rates of complications or readmissions.

Day case rates

As **Table 1** shows, the proportion of breast surgery procedures undertaken as day cases increased over the five-year period. BADS targets for day case surgery for benign diseases were met, although targets for other procedures were not. There is currently no BADS target for day case implant-based reconstruction but day case rates for this procedure also increased.

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[7] *Incorporating clinical examination, mammography, ultrasound and image-guided biopsy*
[8] *See recommendation 2 of the GIRFT Breast Surgery National Specialty Report.*
[9] *See recommendation 3 of the GIRFT Breast Surgery National Specialty Report.*
[10] *Including most frequently Somerset, Infoflex, Careflow and EPIC.*
[11] *See recommendation 4 of the GIRFT Breast Surgery National Specialty Report.*

Table 1: Day case surgery rates

Procedure	National median (2021*)	Range (2021*)	National median (2025†)	Range (2025†)	BADS target	Providers meeting/ exceeding target (2025)
Excision for benign disease	94.6%	69.0%–100.0%	95.9%	73.0%–100.0%	95%	73/115
Excision for malignant disease	81.7%	25.2%–94.0%	88.9%	57.4%–99.0%	95%	12/114
Oncoplastic excision	61.5%	0%–100.0%	71.9%	7.7%–100.0%	75%	45/102
Mastectomy with no reconstruction	35.4%	0%–86.3%	61.2%	1.8%–91.9%	75%	23/115
Mastectomy with implant-only reconstruction	4.7%	0%–78.9%	23.1%	0%–91.7%	NA	N/A

*Source: MHS - *12 Months to end Q2 2020/21; †12 months to end Q2 2025/26.*

Length of stay for autologous procedures

The national median LoS for mastectomy with autologous reconstructions reduced from 5 to 3.8 days over the five year period. However, substantial variation remains, with LoS ranging from 2.3 to 5.5 days across providers. Almost one in four providers achieved discharge within three days, demonstrating that shorter stays are achievable.

Key recovery recommendation 2: Minimise unnecessary interventions

As full surgical services return, equity of access across the country remains paramount… it is essential that patients have access to the best and most appropriate oncoplastic techniques and reconstruction (recommendation 5). Theatre resource will always be at a premium so we must carefully consider selection of procedures to ensure patients do not undergo more surgery than is necessary (recommendations 6 and 8). That includes taking steps to reduce planned and unplanned readmissions, through applying surgical best practice.

GIRFT Programme Breast Surgery National Specialty Report, 2021

Ensure equity of access to oncoplastic surgery and breast reconstruction[12]

Breast conservation

The aesthetic and psychological benefits of BCS over mastectomy means it should be regarded as the default approach where safe and clinically appropriate. Reducing clinically unwarranted mastectomies (by opting for BCS) is vital in reducing demand for resource-intensive reconstruction and releasing surgical capacity for those who really need it.

Nationally, the BCS rate showed a modest increase of 6.3% over five years (from 63.8% to 70.1%). However, persistent variation (51.5%–87.3% in the latest data period) cannot be explained purely by clinical case-mix differences (such as stage at presentation or the proportion of screen-detected cancers). Providers in the top decile achieved approximately 79% or higher in the latest data period.

Mastectomy rates may reflect, in part, provider concern about the safety of BCS in multifocal disease, but BCS with adjuvant radiotherapy has an acceptably low five-year local recurrence rate[13] with equivalent or better survival outcomes, and a lower risk of complications than mastectomy.[14]

The use of neoadjuvant chemotherapy (NACT) can support BCS over mastectomy in eligible patients with stage II–IIIA HER2+ or triple negative disease,[15] but there remains significant regional and age-related variation in NACT uptake. NaoPri found that only half of eligible patients were offered NACT, with one in five providers offering NACT to fewer than 40% of patients.

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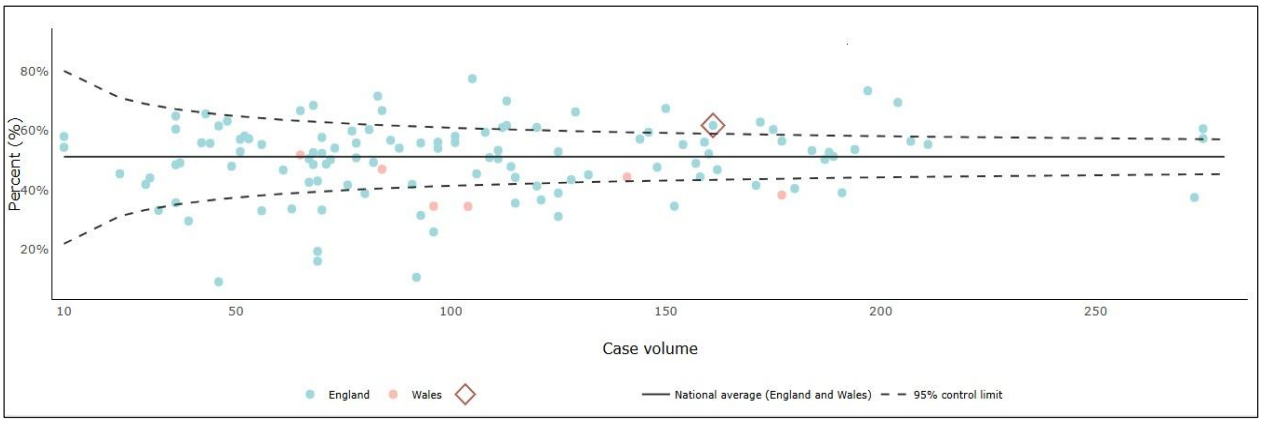
[12] *See recommendation 5 of the GIRFT Breast Surgery National Specialty Report.*
[13] *Boughey, J.C., Rosenkran, K.M. Ballman K.V., et al, 2023. Local recurrence after breast-conserving therapy in patients with multiple ipsilateral breast cancer: Results from ACOSOG Z11102 (Alliance). J Clin Oncol Off J Am Soc Clin Oncol.; 41 (17); pp. 3184-3193.*
[14] *Fisher, B., Anderson, S., Bryant, J., et al, 2002. Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy, and lumpectomy plus irradiation for the treatment of invasive breast cancer. N Engl J Med; 347(16); pp. 1233-1241.*
[15] *NICE (2018, updated 2025) Early and locally advanced breast cancer: diagnosis and management guidance.*

Figure 11: Percentage of people who received neoadjuvant chemotherapy (NACT)



Source: National Audit of Primary Breast Cancer (NaoPri) – State of the Nation Report (01 January 2020 –31 December 2022).[16]

Oncoplastic procedures

In the past it has been difficult to assess whether or not variation in BCS rates was due to limited availability of oncoplastic conservation techniques, because procedures were not always accurately coded. However, the proportion of BCSs coded as oncoplastic increased significantly over five years (from 11.7% to 16.2%). Forthcoming coding changes and guidance (discussed below) should help to ensure that procedures are adequately captured in the future.

The number of providers holding regular oncoplastic MDMs rose from 38% to 68% over five years (although 48% of these MDMs still do not have a plastic surgeon present).

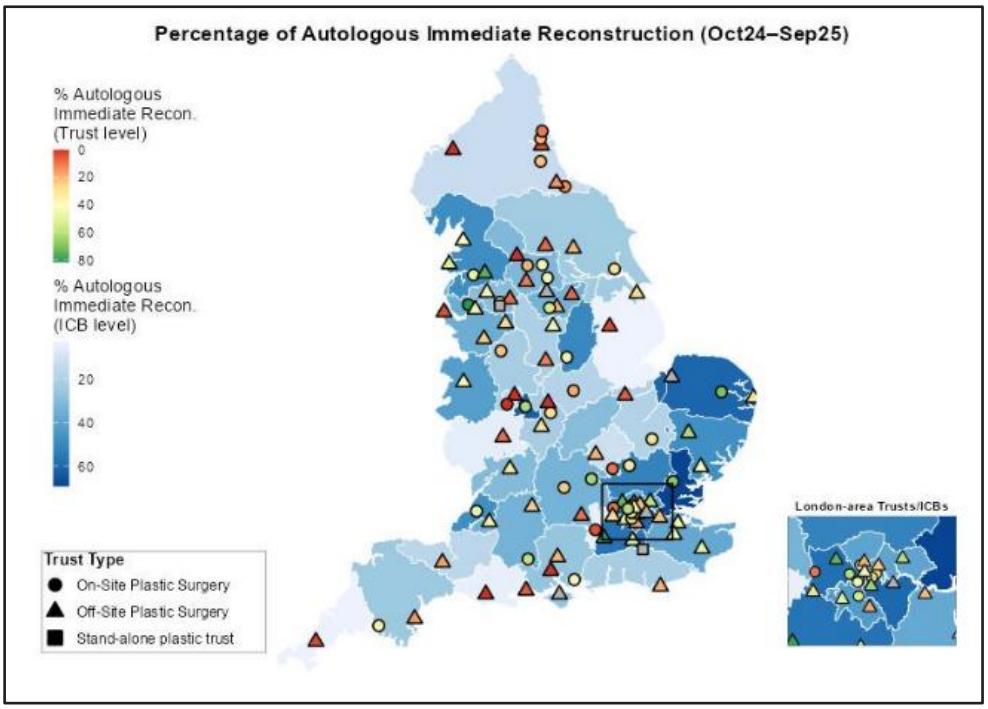
Almost 20% of providers are still unable to deliver the full range of oncoplastic procedures, such as chest wall perforator flaps. Providers unable to offer full oncoplastic capability should adopt networked referral pathways.

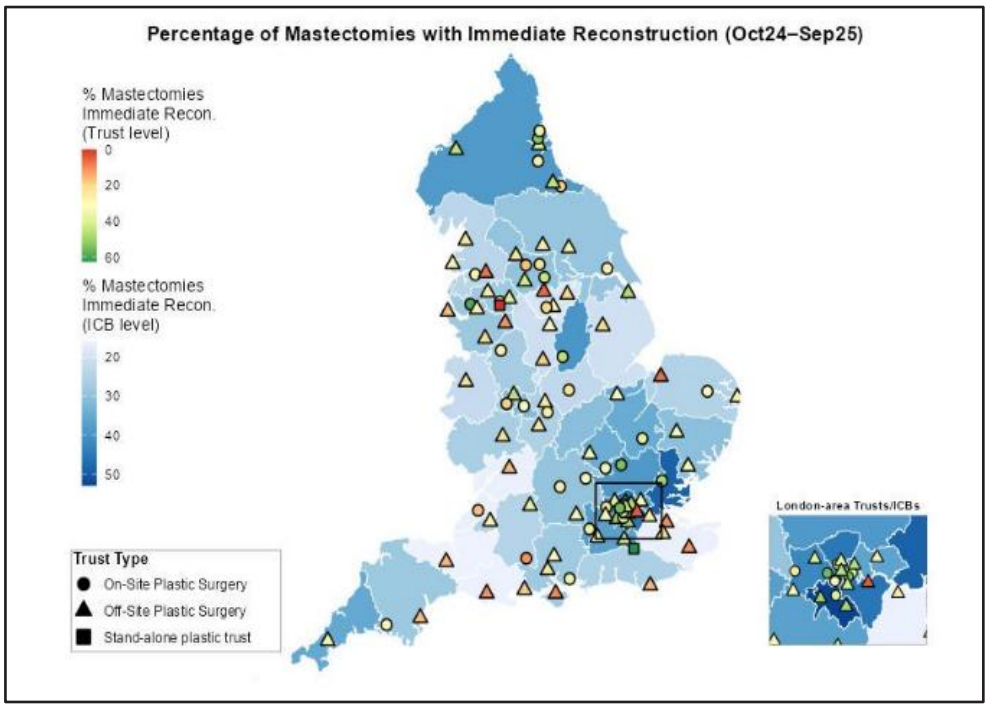
Breast reconstruction

As shown in **Figure 12**, unwarranted variation in access to breast reconstruction surgery persisted in 2025, particularly for autologous reconstruction.

[16] *National Audit of Primary Breast Cancer (2025) State of the Nation report*

Figure 12: Access to breast reconstruction by referring provider





Source: MHS Breast surgery metrics - 12 months to qtr end Q2 2025/26

Reduce unplanned readmissions and returns to theatre[17]

Readmissions

Emergency readmission rates remained similar to 2021 levels (≤0.6% change) for most breast excisions and mastectomy procedures. Complication and haematoma rates also remained stable over the five-year period across all procedures (with complication rates improving slightly for immediate reconstructions). This stability (particularly for mastectomy) is reassuring, given the reductions in mean LoS, increases in day case surgery rates and the growing proportion of patients with comorbidities over the same period.[18]

However, readmissions following oncoplastic procedures increased slightly over five years (from 2.3% to 3.4%), which may reflect improved coding of complex oncoplastic procedures rather than a true increase.

Implant loss and take-back procedures

The implant loss rate declined slightly from 7.3% to 6.7% over five years; almost a third of providers reported no implant losses in the latest data period. Some providers attributed these improvements to better case selection. Variation in implant loss rates persisted for mastectomy and immediate reconstruction; although such variation may be influenced by small procedural volumes, where a very small number of events can produce disproportionately large percentage values.

Similarly, take-back procedures (return to theatre within the same admission) for mastectomy with immediate autologous-only reconstruction declined marginally from 3.0% to 2.6%. Eleven providers (35%) reported no take-back procedures in the latest data period; rates ranged from 0%–7.7%. Model Health System does not capture flap loss rates but the UK National Flap Registry (UKNFR) data shows a 5% return to theatre within 30 days, while total flap loss remains low at just over 1%.

The overall downward trend for both implant loss and take-back procedures suggest improvements in pre- and peri-operative decision-making and practice.

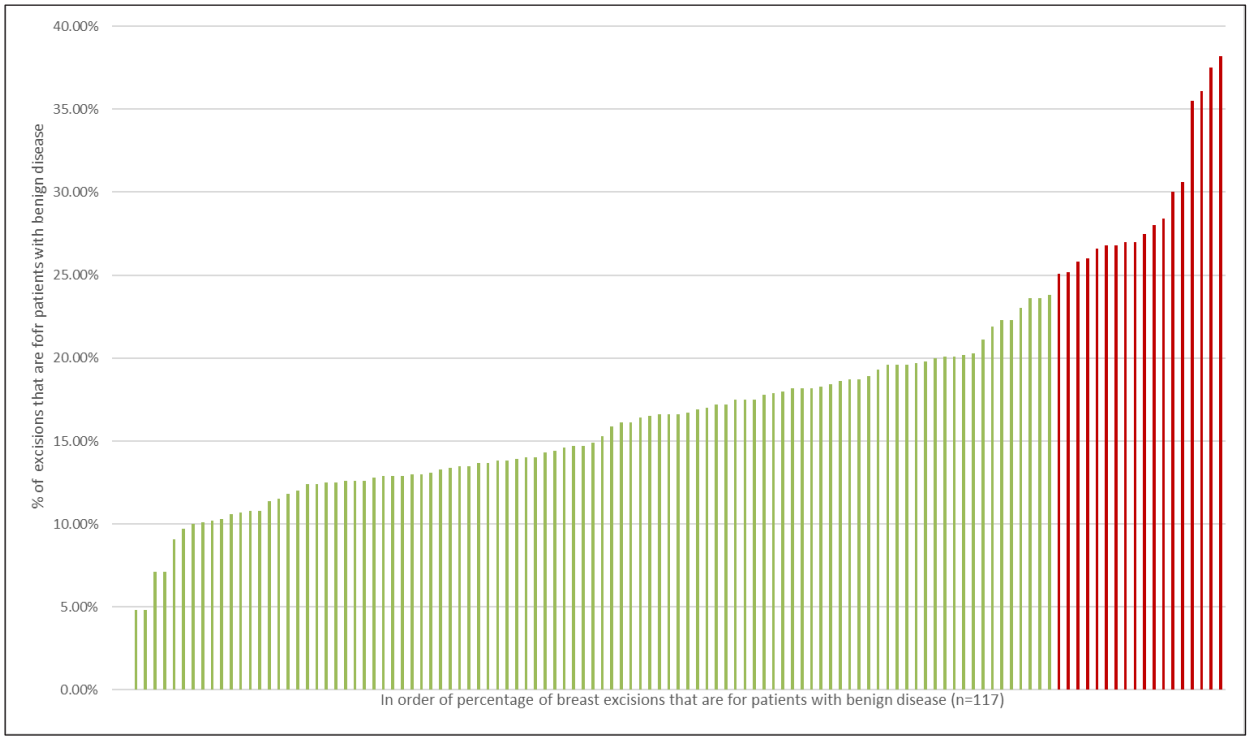
Avoid unnecessary surgery[19]

Breast excisions for benign disease

Benign excision rates remained largely static (with a small increase from 15.6% to 16.9% over five years) although substantial variation persisted (**Figure 13**).

[17] *See recommendation 6 of the GIRFT Breast Surgery National Specialty Report.*
[18] *A limitation in interpreting readmission rates is ongoing inconsistency in coding, as many providers code wound-review clinic attendances as emergency readmissions, inflating their apparent rates.*
[19] *See recommendation 8 of the GIRFT Breast Surgery National Specialty Report.*

Figure 13: Variation in percentage of breast excisions that are for patients with benign disease



Source: MHS Percentage of breast excisions that are for patients with benign disease - 12 months to qtr end Q2 2025/26.

Margins, re-operations and revisions

There was a modest reduction in re-excisions (margin re-excision or conversion to mastectomy) in both breast conservation (1.1% decrease from 18.5% to 17.4% over five years) and oncoplastic breast conservation (1.1% decrease from 17.1% to 16.0% over five years).

Although the absolute percentage change was small, the high volume of procedures means these figures represent hundreds of patients avoiding a second operation for re-excision. Further opportunities remain to prevent more patients from having additional surgery, improve pathways through cancer treatment and release theatre capacity. The forthcoming ABS margins toolkit should assist providers in this regard.

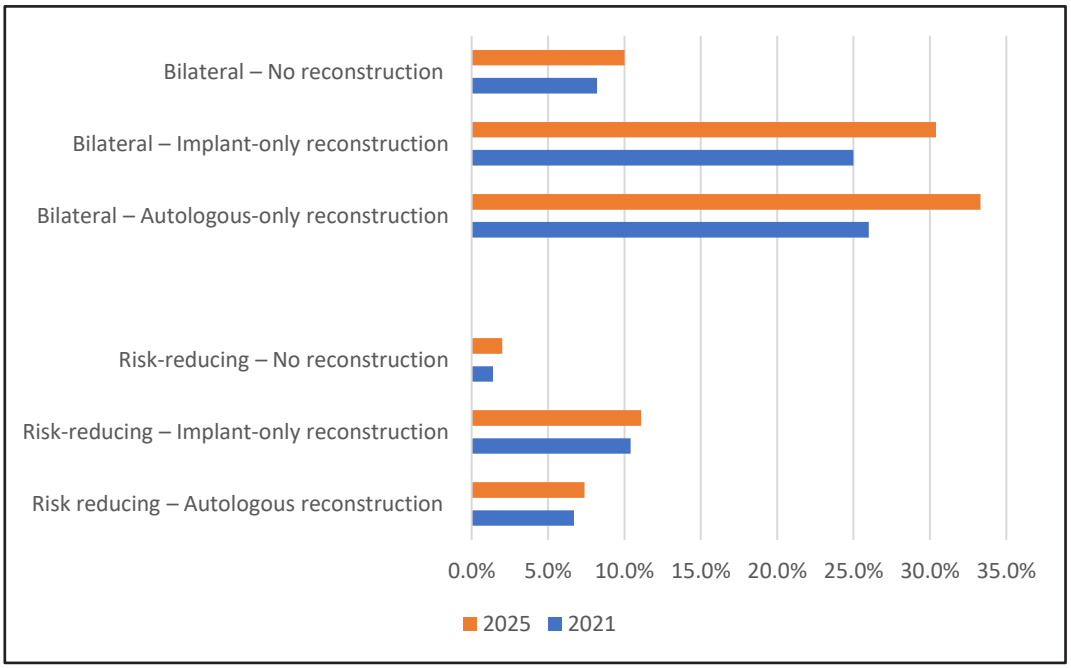
Model Health System data is not sufficiently mature to support revision trend analysis as this metric requires five years of data and a further five years of follow-up. However, comparison with the GIRFT Breast Surgery National Report indicates a reduction in revision rates. The average number of additional procedures per patient undergoing implant reconstruction decreased from 1.6 (range 0.4–3.0) to 0.8 (range 0.1–1.9) while the average number of additional procedures per patient undergoing autologous reconstruction decreased from 1.3 (range 0.0–3.2) to 0.8 (range 0.1–1.5).

Teams report that due to the increased pressure on theatre time they are often performing symmetrising procedures at the same time as the reconstruction, which may explain some of this decrease.

Bilateral mastectomies

The proportion of bilateral mastectomies increased over the five-year period. This increase does not appear to be accounted for clinically: the rate of risk-reduction surgery among gene-positive cancer patients changed only marginally (**Figure 14**), while simultaneous bilateral cancer presentations remain uncommon (at around 4% of new diagnoses).[20]

Figure 14: Percentage of mastectomies that are bilateral and risk reduction surgery by reconstruction type



Source: MHS Breast surgery metrics - 12 months to qtr end Q2 2020/21 and 12 months to qtr end Q2 2025/26.

Symmetry is often cited as the rationale for bilateral breast surgery, but the evidence does not support this. Adjustment surgery is most commonly required following bilateral mastectomy undertaken for risk reduction, suggesting a mismatch between patient expectations and achievable aesthetic outcomes.

Many bilateral mastectomies therefore appear to be clinically unwarranted. Given that bilateral autologous reconstruction often requires the involvement of two consultant surgeons, and that national workforce shortages continue to limit access to reconstruction, it is essential that surgical resources are used appropriately and to greatest clinical benefit.

[20] *Kheirelseid, E.A.H., Jumustafa, H., Miller, N. et al 2011. Bilateral breast cancer: Analysis of incidence, outcome, survival and disease characteristics. Breast Cancer Res Treat, 126 (1); pp. 131-140.*

Key recovery recommendation 3: Improve clinical coding and data capture

It is important as we move forward into the 'new normal' that we seize the opportunities afforded by the crisis to evaluate and adopt successful innovations and practice changes. Quality data will be key not only to understanding our progress but also to track the impact of COVID-19 on patterns of care and patient outcomes; that is the basis on which we can then plan services (see recommendations 11, 12 and 13).

GIRFT Programme Breast Surgery National Specialty Report, 2021

Improve consistency and accuracy of HES coding/data[21]

Work has been undertaken with the ABS, plastic surgeons, the GIRFT coding team and the relevant expert working group within the National Casemix Office to secure approval for new OPCS-4 codes. It is important that providers apply all of the codes consistently. This depends on surgeons clearly documenting procedures in their operation notes, and coders being fully aware of the range of oncoplastic techniques now in routine use.
GIRFT has also produced coding guidance for aspects of breast surgery services (see Priorities and opportunities for the future section below). Guidance should continue to be applied consistently by surgeons and coders to improve the quality and completeness of data capture going forward.

Link HES and NCRAS data to support outcome monitoring[22]

While it has not yet been possible to link National Cancer Registration and Analysis Service (NCRAS) and HES data within MHS, this remains an objective for the future.

Ensure 95% completeness in BCIR and UKNFR registries within three months of surgery[23]

It is a Secretary of State mandate that all devices implanted into patients be recorded in national device registries. The Breast and Cosmetic Implant Registry (BCIR) has been migrated from the legacy NHS Digital platform to the Outcomes and Registries Programme and transferred to a new platform, which now includes fields capturing relevant patient risk factors. Work is ongoing to develop patient-reported outcomes metrics, and to refine appropriate clinical outcomes metrics. As outcomes analysis develops, it is critical that surgeons enter or validate their data to ensure patient complexity is accurately reflected and outcomes can be interpreted appropriately.

In 2024, overall BCIR ascertainment was 81% across both the NHS and the independent sector. Most missing records related to patients undergoing explant procedures without replacement, indicating the need for improved case capture in this area.

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[21] *See recommendation 11 of the GIRFT Breast Surgery National Specialty Report*
[22] *See recommendation 12 of the GIRFT Breast Surgery National Specialty Report*
[23] *See recommendation 13 of the GIRFT Breast Surgery National Specialty Report*

Ascertainment has not previously been examined within the UKNFR. However, comparison with Q2 24/25 MHS data for immediate autologous reconstruction suggests registry capture of less than 20%, highlighting a substantial opportunity to improve engagement with this registry. The UKNFR also captures partial breast reconstruction activity, although many surgeons were unaware of this. It is not possible to isolate this activity in MHS from other oncoplastic procedures but discussions during gateway reviews suggest this is a further area for improvement.

Other recommendations from the GIRFT Breast Surgery National Report

	Summary recommendation	Progress/comment
7	Incorporate PROMs for oncoplastic, reconstructive and aesthetic procedures.	A decision was taken to pause this recommendation to allow for post-COVID recovery. The intention is to progress this work in the near future.
9	Reduce admissions/surgery for mastitis to 1% or less of excisional breast surgery admissions.	Surgery for mastitis has declined; it now constitutes 0.5% of all breast excision operations.
10	Reduce inequity in access to aesthetic breast surgery for anomalies.	The Academy of Medical Royal Colleges together with GIRFT have published guidance on breast prosthesis removal and updated the guidance on bilateral breast reduction.
14	Improve procurement of devices/ consumables via transparency and consolidation.	Developments in the procurement and monitoring of medical devices include: the provision of dashboards by the Spend Comparison Service, which have improved price transparency and enabled providers to compare themselves to their peers; and the Outcomes Registries and Scan4Safety programmes, which enable better traceability of implanted medical devices. Together, these initiatives promote a clearer view of spend and outcomes.
15	Reduce litigation costs using the GIRFT five-point plan.	The number of litigation claims has fallen from 61 in 2018/19 to 27 in 2022/23 along with the total cost, although individual claims are more costly.
16	Identify breast surgery negligence claims nationally to detect variation early.	Breast surgery litigation claims are now separated out manually every year to allow separate reports; it is not yet possible to do this at source.
17	Align breast surgery workforce planning with the NHS People Plan.	ABS has produced job planning guidance to assist with aligning the workforce and the NHS People Plan; this should help ensure the administrative burden on clinicians is not increased by EPRs and that access to theatre is maintained. Providers are also encouraged to consult the RCS surgical workforce census.

Priorities and opportunities for the future

Significant opportunities remain to improve breast cancer pathways by reducing unwarranted variation at key points in the pathway, focusing particularly on faster diagnosis, releasing clinical and surgical capacity, and improving equity of access and outcomes.

Speed up cancer pathways

Streamlining referrals

Variation in performance, alongside the recent national decline in meeting CWT targets, indicates that opportunities remain to improve referral and diagnostic pathways.

NHS England's Best practice timed diagnostic pathway for breast cancer provides the national framework for achieving timely diagnosis within 28 days and should be used as the organising structure for local referral and triage models. Teams need to remember that in order to give a diagnosis by day 28 patients should be seen in the first two weeks of the pathway, ideally by day ten, and that low risk pathways should be monitored to ensure they are safe and these patients still need to meet FDS.

In addition, a number of recent initiatives provide practical mechanisms to support implementation of the timed pathway and should be explored.

Useful resources

- Best practice timed diagnostic pathway for breast cancer and Implementation guidance demonstrate how diagnosis can be achieved within 28 days.
- GIRFT Breast cancer FDS handbook (login required).
- Triage models: directing patients to the most appropriate clinic or investigation, including triage to alternative pathways or low-risk clinics. See the GIRFT FDS Handbook for examples.
- TDAs: enabling prompt confirmation or exclusion of cancer; NAoPri promotes the use of the TDA field in the Cancer Outcomes and Services Dataset (COSD) to accurately reflect the presence of a TDA.
- Breast pain pathways: dedicated pathways can reduce pressure from symptomatic referrals;
    - ABS's ASPIRE (Breast pain pathway rapid evaluation) supports implementation.
    - GIRFT's Breast pain webinar discusses the development and implementation of breast pain pathways.
- GIRFT's CWT best practice webinar: showcases exemplars to support improved CWT delivery.

Free up clinic capacity

PIFU for all providers: saving 45,000 outpatient appointments over five years

There is wide unwarranted variation in the number of outpatient appointments following breast surgery procedures. Addressing this variation could release clinic capacity, particularly for providers who routinely see patients more frequently than their peers.

For example, if all providers matched the top quartile average of 6.7 follow-up appointments per patient following a breast excision for cancer, almost 45,000 appointments could be saved nationally over five years, freeing capacity for patients with greater clinical need. Similar savings could be achieved by reducing variation in follow-up appointments after mastectomy procedures.

Providers not already doing so should implement PIFU, in line with national guidance.

Useful resources

- NHS England Implementing patient initiated follow up: guidance for local health and care systems.
- GIRFT Outpatient operational guide: Module 2: Standardising follow-up protocols provides practical advice for developing follow-up pathways.

Free up theatre capacity

Reduce benign excision rates: saving over 1,100 operations per year

Persistent unwarranted variation in benign excision rates (as shown in **Figure 13**) represents a substantial national opportunity to release surgical capacity without compromising patient outcomes.

Providers should analyse their benign excision rates, understand local drivers of high rates and implement measures to reduce unnecessary surgery. Doing so could release capacity for malignant and more complex cases. ABS guidance listed in the Useful resources section below may assist in this regard.

If all providers achieved at least the national median of 16.6% of total excisions, over 1,100 procedures could be avoided annually across the country.

Avoiding mastectomy and promoting equitable access to reconstruction

Initiatives that reduce unnecessary mastectomy could release theatre capacity and promote equity of access to BCS (including oncoplastic techniques) and reconstruction. This is particularly important for providers with high overall or bilateral mastectomy rates.

Providers are encouraged to prioritise approaches that support the appropriate use of NACT, shared decision making and consistent MDT practice to ensure patients are offered the full range of suitable surgical options.

Useful resources

- ABS's Multidisciplinary guidance for NACT: supports identification of suitable patients and standardisation of practice. All MDTs should apply this guidance.
- ABS's Mastectomy avoidance toolkit: clarifies misconceptions and outlines practical actions to reduce unnecessary mastectomies. All MDTs should access this.
- ABS's benign guidance:
    - Guidelines for the investigation and management of spontaneous nipple discharge in the absence of a breast lump.
    - ABS summary statement: Management of fibroadenomas.
- New national codes and GIRFT coding guidance:
    - GIRFT clinical coding: breast conserving surgery
    - GIRFT clinical coding: mastectomy and breast reconstruction
- GIRFT and Breast Cancer Now's Further Faster breast reconstruction handbook: highlights good practice and supports providers to prioritise high-impact improvement actions. MDTs should review the checklists.
- Breast Cancer Now Delivering real choice: sets out recommendations to reduce inequity of access.

Reducing bilateral mastectomies

A significant number of unwarranted bilateral mastectomies (for unilateral breast cancer) continue to be performed across the country. Where these are not undertaken for risk reduction, they represent avoidable use of theatre and surgical capacity.

Providers performing these surgeries should review their practice and seek to reduce rates where clinically appropriate, supported by consistent MDT discussion and patient counselling.

Useful resources

- GIRFT and Breast Cancer Now's Further Faster breast reconstruction handbook: includes discussion of risk-reducing mastectomy.
- ABS's Summary statement on contralateral mastectomy for unilateral breast cancer: provides practical guidance managing requests for a contralateral mastectomy (CM) at the time of the index mastectomy or at a later date.

Release bed days

Reducing unnecessary or prolonged inpatient stays represents a significant opportunity to release bed capacity, improve patient flow and support elective recovery across breast services. The actions below focus on increasing day case surgery and reducing LoS where clinically appropriate and safe.

Increasing day case rates: saving an average of 45 bed days per provider

Unwarranted variation in day case rates persists (**Table 1** above) and is particularly marked for mastectomy. While some providers consistently deliver high rates of day case surgery (for example, 25 providers now meet the 75% British Association of Day Surgery (BADS) benchmark for day case mastectomy without reconstruction, while 33 providers perform over half their implant reconstructions as a day case), others remain well below the benchmarks.

Day case surgery offers several advantages, notably reducing the risk of cancellation for breast surgery patients when system capacity is constrained (particularly during periods of operational pressure such as winter). Day case pathways also represent a significant opportunity to release inpatient bed capacity. If all providers achieved the BADS/GIRFT day case benchmarks almost 5,300 bed days could be released nationally.

Table 2 illustrates the potential bed-day release if all providers achieved BADS/GIRFT day case benchmarks.

Table 2: Bed day opportunities for day case procedures

Procedure	Benchmark (GIRFT/BADS)	National median (2025)	Potential bed days if all providers meet benchmark
Breast excision for malignant disease	95%	88.9%	2,574
Oncoplastic excisions	75%	71.7%	449
Mastectomy with no reconstruction	75%	61.2%	2,277
Total	-	-	**5,300**

The next iteration of the BADS Directory of Procedures is to set a day case target of 75% for mastectomy with implant-only reconstruction. Currently, only 16 providers meet or exceed this target. If all providers offering implant-only reconstruction met the target, a further 1,100 bed days could be saved.

BADS will also be releasing new targets for specific oncoplastic procedures in the next BADS review.

Providers not currently achieving BADS or GIRFT benchmarks should prioritise the adoption of day case pathways.

Reduce length of stay for autologous reconstructions

There remains unwarranted variation in LoS for patients undergoing immediate autologous reconstruction, representing a further opportunity to release bed capacity. If all providers with an average LoS above the national median of 3.8 days were able to meet the national median, over 700 bed days could be saved nationally.

Providers with LoS above the national median should review peri-operative and post-operative pathways including enhanced recovery protocols and discharge planning to assess if patients could be safely discharged sooner.

Useful resources

- BADS' bed-day opportunity metrics on MHS: quantify potential bed-day release by increasing day case and outpatient rates to BADS benchmarks.
- BADS' guidance (Day case breast surgery handbook) and annual 'breast surgery as day surgery' conference: provide practical, evidence-based support for providers.
- Enhanced recovery pathways: discussed in the GIRFT Further Faster breast reconstruction handbook.

Ensure accurate data to support service improvement

Reliable data is essential in benchmarking, interpreting variation and helping prioritise improvement initiatives. Providers (particularly breast surgeons and clinical coding teams) should continue to focus on improving data capture, including applying coding guidance to strengthen the quality, accuracy and completeness of data capture.

Useful resources

- GIRFT coding guidance for breast conservation and for mastectomy with or without reconstruction.
- National Consultant Information Programme (NCIP) allows consultants to review their own data: improving clinical quality, patient safety and supporting career development.
- Forthcoming GIRFT coding guidance on axilla and revision surgery.

Conclusion

This report demonstrates that progress has been made across several aspects of the breast cancer pathway, reflecting the sustained commitment of breast teams to delivering patient-centred, safe and effective care in an increasingly pressurised system.

At the same time, the report highlights that persistent unwarranted variation remains. Much of this is not due to patient need or preference but reflects differences in provider pathways and local practices. Addressing aspects of the service where variation persists represents a significant opportunity to reduce unnecessary interventions and make better use of limited clinical and surgical capacity.

The analysis highlights the potential to release substantial capacity across outpatient clinics, theatres and inpatient beds. This includes avoiding thousands of outpatient appointments and hundreds of benign excisions, increasing day case surgery, reducing length of stay for autologous procedures and minimising clinically unwarranted mastectomies.

Taken together, these changes would improve patient flow through the pathway, support timely diagnosis and treatment, and help services respond more effectively to rising demand and ongoing workforce constraints.

Continuing to implement the recommendations from the 2021 GIRFT Breast Surgery National Report, particularly the key recovery recommendations discussed in this report, remains critical to improving efficiency and to promoting equity, sustainability and quality of care for patients in the years ahead.

GIRFT remains committed to enabling change by continuing to highlight unwarranted variation and providing the practical resources that breast teams need to drive improvement, while delivering efficient, high-quality patient care.

Further information

- GIRFT (2026) Breast cancer best practice Faster Diagnosis Standard implementation handbook
- GIRFT (2026) Outpatient operational guide Module 2: Standardising follow-up protocols
- GIRFT (2026) Webinar: Developing and Implementing Breast Pain Pathways
- Department of Health & Social Care (2026) The National Cancer Plan for England: delivering world class cancer care
- GIRFT (2025) Webinar: Best practice in achieving breast cancer waiting time targets
- GIRFT (2025) GIRFT clinical coding: breast conserving surgery
- GIRFT (2025) GIRFT clinical coding: mastectomy and breast reconstruction
- GIRFT/BCN (2025) Further Faster Breast Reconstruction Handbook
- ABS (2025) Mastectomy Avoidance Toolkit
- Royal College of Radiologists (2025) Royal College of Radiologists' Guidance on screening and symptomatic breast imaging
- National Audit of Primary Breast Cancer (2025) State of the Nation report
- NICE (2018, updated 2025) Early and locally advanced breast cancer: diagnosis and management guidance
- ABS (2025) Job Planning Guidance for Consultant Breast Surgeons (login required)
- Royal College of Surgeons of England (2025) UK surgical workforce census
- NHS England (2024)
- Academy of Medical Royal Colleges (2024) Evidence-based interventions programme: Breast prosthesis removal
- ABS (2023) NACT Guideline
- Breast Cancer Now (2022) Delivering real choice: the future of breast reconstruction in England
- Royal College of Pathologists (2021) Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening
- GIRFT (2021) Breast Surgery Programme National Specialty Report
- NHS England (2020) Implementing personalised stratified follow-up pathways
- British Association of Day Surgery (BADS) Day Case Breast Surgery (login required)
- ABS (2019) Summary Statement: Guidelines for the investigation and management of spontaneous nipple discharge in the absence of a breast lump

- ABS (2019) Summary Statement: Management of fibroadenomas
- ABS (2017) Summary Statement: contralateral mastectomy for unilateral breast cancer
- ABS ASPIRE (Breast Pain Pathway Rapid Evaluation)
- BAPRAS UK National Flap Registry
- GIRFT National Consultant Information Programme (NCIP)
- NHS England Model Health System
- NHS England Breast and Cosmetic Implant Registry

Abbreviations

ABS	Association of Breast Surgery
AO	Autologous-only reconstruction
BADS	British Association of Day Surgery
BCN	Breast cancer nurse
BCIR	Breast and Cosmetic Implant Registry
BCS	Breast-conserving surgery
CA	Cancer Alliance
CAP	Chest, abdomen and pelvis (CT imaging)
CWT	Cancer waiting times
DIEP	Deep inferior epigastric perforator (flap)
EPR	Electronic patient record
FDS	Faster Diagnosis Standard
HES	Hospital Episode Statistics
HER2	Human epidermal growth factor receptor 2
ISH	In situ hybridisation
IO	Implant-only reconstruction
LoS	Length of stay
MHS	Model Health System
MDM	Multidisciplinary meeting
NAoPri	National Audit of Primary Breast Cancer
NACT	Neoadjuvant chemotherapy
NCRAS	National Cancer Registration and Analysis Service
OPCS-4	Office of Population Censuses and Surveys Classification of Interventions and Procedures (version 4)
PET-CT	Positron emission tomography–computed tomography
PIFU	Patient-initiated follow-up
PROMs	Patient-reported outcome measures

RCP	Royal College of Pathologists
RCR	Royal College of Radiologists
TDA	Triple diagnostic assessment
UKNFR	UK National Flap Registry
USC	Urgent suspected cancer

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About GIRFT and the GIRFT Academy

About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is a clinically led national programme designed to identify and minimise unwarranted variation in treatment and care delivered. It undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Health System portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The GIRFT model has now been applied in more than 50 different areas of clinical practice. It consists of five key strands:

1. Data gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
2. Peer reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.
3. National report and Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
4. Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.
5. Research and development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

For the latest version of this document, please see www.gettingitrightfirsttime.co.uk or Getting It Right First Time - FutureNHS Collaboration Platform

GIRFT and a greener NHS

Climate change is one of the greatest health threats and opportunities of the 21st century. The NHS is acting now to mitigate and adapt to this threat in order to protect the health of current and future generations. Doing so will not only protect the environment but will also bring many health, social and financial benefits. As the largest employer in the UK, contributing 4.6% of national emissions, the NHS is both part of the challenge and the solution.

Through its endeavour to improve the quality of care within the NHS by reducing unwarranted variation, GIRFT can play an important role in reducing the carbon emissions associated with care delivery. Through the GIRFT model, there is the opportunity to identify changes that will help reduce the NHS carbon footprint and therefore improve patient care now and in the future.

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