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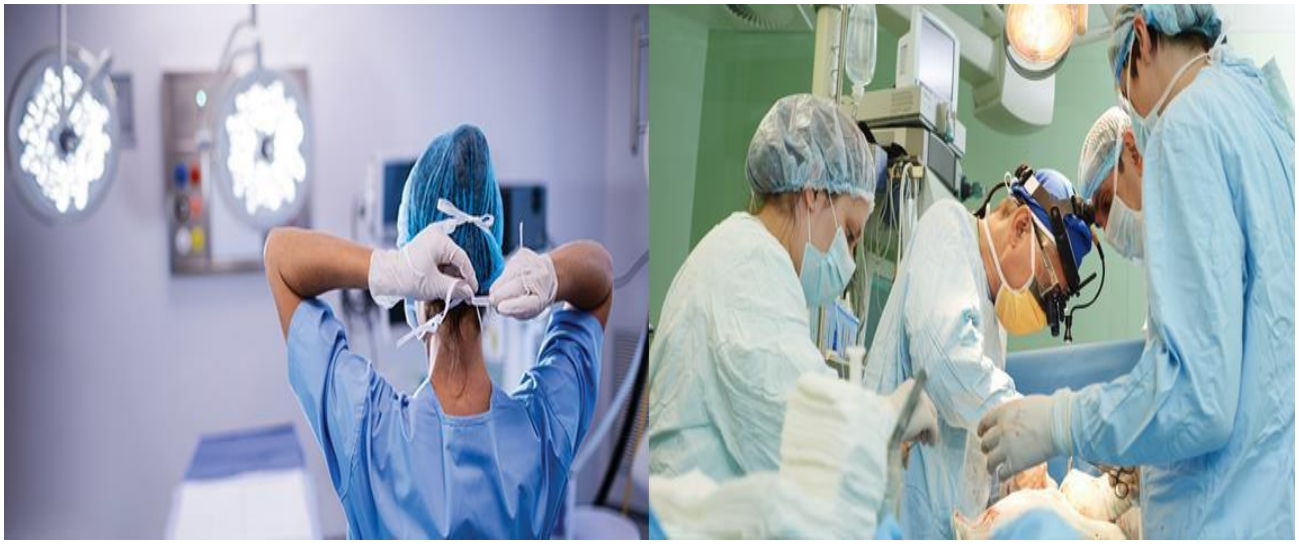
GETTING IT RIGHT FIRST TIME

# GIRFT Orthopaedic Review

## Swansea Bay University Health Board

May 2022



*This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) team and the Wales Planned Care Board team. It aims to enable the urgent restoration of elective orthopaedics and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.*

## Introduction

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Welsh Government, to conduct a full review of Welsh Orthopaedic Services using the GIRFT methodology and HVLC principles. Throughout, the team has worked very closely with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) team and will continue to do so. In addition to reports for each Health Board, RNOH/GIRFT will write a National Wales Orthopaedic report detailing the findings and the priority and cross cutting recommendations. This report will dovetail with the National Clinical Strategy for Orthopaedic Surgery (NCSOS) report.

The ambition of the programme is to help each Welsh Health Board and NHS Wales to urgently restore elective orthopaedics to the maximum levels possible and identify examples of innovative, high quality and efficient service delivery in the system. The programme will look at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. It also will aim to assess whether the Health Boards are using their existing resources and provisions effectively and delivering the best outcomes for patients.

The RNOHGIRFT team conducted a programme of data analysis, followed by a virtual “deep dive” engagement with SBUHB, delivered by Professor Tim Briggs CBE (GIRFT Programme Chair and National Director of Clinical Improvement for the NHS) on Friday 11th February 2022. This report details the findings and recommendations arising from the data analysis and deep dive engagement and is a companion document to the GIRFT data pack.

## The GIRFT and High-Volume Low Complexity (HVLC) Programmes

Getting It Right First Time (GIRFT), is a clinically led, data driven programme of healthcare quality improvement, developed in the NHS in England. The fundamental belief of the GIRFT programme is that within a healthcare system, unwarranted variation exists across a range of clinical processes (such as patient pathways, clinical practice, procurement and prevention of litigation), and addressing this unwarranted variation can deliver better quality of care and outcomes for patients. The core principle of the programme is that it is a clinically led, peer-to-peer, data driven approach to healthcare improvement.

GIRFT is an enabler of the High Volume Low Complexity Programme (HVLC). This is aimed at supporting elective recovery, post pandemic, and the development of standardised patient pathways across regions. The programme supports the establishment of fast-track surgical hubs for high-volume procedures, where possible, and helps partners to agree system-wide theatre principles (e.g. accepting day surgery as the default), and theatre efficiencies (e.g. the number of cases per theatre list). It has led to the reduction of patient waiting lists for operations and to improvements in outcomes and access to care, helping the people who have the most urgent health needs receive treatment fastest.

## Programme Objectives

The aim of the programme is to identify improvement opportunities within orthopaedic services in Wales in order to inform short, medium and long-term transformation plans. This is done by:

- identifying system and organisation level unwarranted variation in access to and outcomes from care being delivered
- driving for ‘top decile’ GIRFT performance of outcomes, productivity and equity of access
- standardising procedure-level clinical pathways to be agreed across all providers

developed by 'expert advisory panels' supported by professional societies and the work of the Wales Clinical Orthopaedic Strategy team
- informing the decision making process on the potential establishment of surgical hubs for high volume elective procedures
- agreeing principles for working across clinical and operational groups e.g. theatre principles
- leaving a legacy of sustainable quality improvement by working in partnership with your clinical, operational, and analytical teams so that you are able continue implementation and tracking progress at the end of our work with you.

Central to these objectives will be the creation of delivery plans for HVLC activity by March 2022 to develop pathways, utilise best practice, and improve theatre efficiency and productivity and day case rates as outlined by GIRFT best practice.

## The Current State of Orthopaedics in NHS Wales

The number of people waiting to start treatment in Wales is at record high. Elective orthopaedics has been at a standstill for almost 2 years with growing waiting lists. With over 30% of 104-week waiters being for an orthopaedic procedure (see Table 1), it is imperative that orthopaedic elective care is restarted with immediate effect.

***Table 1***

| Waiting List | Patients - All Wales | Patients - Orthopaedics | Percentage |
|---|---|---|---|
| RTT Pathways | 124371 | 35439 | 28% |
| 104 week waiters | 27234 | 11799 | 43% |
| 80+ week waiters | 38539 | 16053 | 42% |

*(Data as of December 2021)*

As a result of elective orthopaedics being on hold for almost 2 years, patients have been treated by the Independent Sector whilst staff at the hospitals in Wales have had no facilities or theatres to carry out elective work. This has caused frustration for consultants and has demonstrated poor use of an expensive resource. In addition, this has had a negative effect on trainee orthopaedic surgeons, who have been struggling to access the appropriate training in elective orthopaedics.

## Impressions and Outcomes of the SBUHB Deep Dive Meeting on 11th Feb 2022.

RNOH/GIRFT were impressed by the engagement of Health Board staff with this Programme and the excellent attendance at the deep dive meeting. This provides an insight into the level of concern that Health Board staff have about the current orthopaedic service provision. The meeting consisted of a review of the Health Board data and discussions about the key issues and risks surrounding the urgent restart and effective delivery of orthopaedic services. We identified several areas of unwarranted variation in the data we reviewed at the meeting. The detail around this variation and the recommended improvements can be found in the **Orthopaedics Action Plan in Annex A.**

RNOH/GIRFT have made several cross cutting and priority **executive recommendations.** We think the implementation of these recommendations is essential if the Health Board is to deliver robust and durable orthopaedic services effectively and safely for patients in the short, medium, and long term. We strongly believe that is the best way to make a significant reduction of orthopaedic waiting lists. We request that the Health Board Executive Team provide a response to these high priority recommendations.

## Findings and Executive Recommendations

We found clinical staff morale to be low. There was frustration that changes to restart orthopaedic surgery, following Covid, are taking much longer than necessary.

The RNOH/GIRFT team found that the plans to restart elective surgery and to reduce significant waiting lists are not widely known and seem to be lacking pace. This may be contributing to issues with patient safety (whilst they are stuck on long waiting lists) and staff morale. We found that patients on long waiting lists were deconditioning and their conditions worsening; this was becoming a duty of candour issue.

In our review of data across SBUHB and in individual hospitals, we note that there is variance in performance between hospitals. This suggests a lack of collaboration and that they are working in silos

RNOH/GIRFT therefore make the following **executive recommendations** to SBUHB:

| Executive Recommendations |
|---|
| 1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as one Health Board and not hospital by hospital. |
| 2. Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation. |
| 3. Ensure that the orthopaedics lead is empowered and provided with the right support needed to implement the changes required to minimise unwarranted variation and that regular progress is provided to the Executive Team and Steering Group. |
| 4. SBUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent needto re-engage with clinicians to rebuild trust and ensure that clinicians are listened to and involved at each stage of restart and change proposals. It is imperative that clinicians are an integral part of the “sign off” and delivery of changes. |
| 5. Implement elective recovery at pace. We are aware that capital investment is currently limited. However, most of our recommendations rely on better use of existing assets and using revenue budgets and resources more efficiently. We expect that an urgent initial plan, which sets out how the Health Board will fully restart orthopaedic surgery tobe in place, no later than the end of March 2022. Any barriers or risks to delivery of thisplan need to be urgently resolved. The plan should include a communication and engagement plan with all patients so that patients fully understand the timetable for their surgery. |
| 6. Carry out a staff survey without delay to understand the issues affecting staff morale and how these can be addressed. We consider that improved and open communicationwith colleagues about the short, medium, and long term plans will help to improve staff morale. We do recognise, that there are a number of recent factors affecting staff morale. |
| 7. Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient’s home prior to admission. For emergency admissions (e.g. fracture neck of femur), these should be assessed early on during their admission to agree their likely support package, which can be tweaked if the patient’s condition changes. Currently, a Social Services assessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficient use of valuable beds, thereby reducing elective surgical admissions. We need a risk share between the Hospitals and Social Services as elective patients are disadvantaged due to lack of bed availability. |

8. Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recorded and used across all Health Boards.
9. Set up a cross Health Board initiative to ensure that litigation claims are regularly reviewed in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. Claims should be discussed in clinical governance meetings to share the learning; junior doctors should also be involved in these review meetings. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed. Note that we did find some good practice in reviewing litigation claims but we think it could be improved.
10. Create and implement a workforce plan both short, medium and long term which supports the Health Board Plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.
11. Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.
12. As part of the medium and longer term orthopaedic plan, all outsourcing and external commissioning of services should be reviewed. The aim should be to deliver all outsourced activity to the same level and standard e.g. the minimum number of knee revisions by one consultant.
13. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following:

    a. Carry out full demand and capacity collaboration with Hywel Dda based at Morriston Hospital. GIRFT supports the planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve SBUHB.
    b. Provide a weekly sitrep to the Executive on waiting lists to include the number of patients and volumes categorised by: ASA score; time on waiting list; operationscarried out; expected monthly operations; forward targets to reduce lists and delivery against these targets. This should also include the number of operationsexpected to be delivered as a day case. We suggest that to gain the best momentum in elective recovery that the sitrep should cover all elective surgery and not just orthopaedics. In our report to the Welsh Government, we will be recommending that these sitreps are provided weekly until Elective Recovery is ontrack and less of a risk to patients.
    c. Establish a delivery model to restart elective recovery. This needs to be established at pace. GIRFT supports collaboration with Hywel Dda UHB and using Prince Philip Hospital to centralise more complex arthroplasty work regionally and a recovery strategy to develop the Neath Port Talbot site as a

regional elective orthopaedic centre for HVLC shared with both Hywel Dda and Cwm Taf Morgannwg HB's if appropriately staffed and resourced. Longer term strategies must be in line with the NCSOS recommendations which GIRFT support.

14. Develop a strategy to release at pace, some of the unscheduled care beds in Morriston to re-establish this as an orthopaedic pathway for the tertiary services that only Morriston can provide e.g. Spinal Surgery, and Orthopaedic procedures that require complex regional interdependencies that only Morriston can provide e.g. Vascular, Renal, Plastics.
15. Develop an enhanced recovery unit in Neath Port Talbot operated 24 hours a day, seven days a week that allows upskilled nurses to provide care and assessment to the sickest and most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.
16. Upskill and empower therapy staff to undertake greater roles.
17. Ensuring plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.
18. Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFTtheatre principles and expected productivity as a steer.
19. Where there is recognised "good practice" in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.
20. Review emergency and urgent pathways to improve patient flow.
21. Review the MSK tertiary services that have competing demands for Morriston bed and theatre capacity i.e. spinal surgery and ortho-plastics. Providing the appropriate level of resource for these services will enable the HB to plan and unlock capacity for complex elective Orthopaedics.
22. Review of patients that are deconditioning on the waiting list, identify patients that require urgent care.
23. Determine effective and efficient follow up plans, which should be carried out virtually if possible.
24. Where there is recognised "good practice" in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.
25. Maximise theatre capacity and communicate plans of Neath Port Talbot ElectiveHub clearly with consultants
26. Carry out a review of Covid pathways to ensure they are aligned on a regional level e.g. number of days' that patients should isolate for carpel tunnel surgery
27. Continue to work with CTMUHB as part of the Neath Port Talbot development as a hub and ensure that there are standardised Covid rules for surgery at NorthPort Talbot. Review of theatre staff and job planning to introduce a dedicated consistent orthopaedic theatre team this will improve theatre efficiency, quality and safety of patient care.
28. A regional approach to rationalising hip and knee theatre kits
    a. Review of trauma, spinal and elective capacity, and services to be undertaken at Morriston Hospital

## Annex A: Orthopaedics Action Plan

| Activity/ Metric | Meeting outputs | Agreed actions / Recommendations |
|---|---|---|
| **Elective hip replacement** | | |
| Fixation method for elective hip replacements (%) − Patients 65+ years | Low usage of cemented hip fixations being used in patients over 65+years (approx. 30%).<br><br>SBUHB primarily use hybrid hip fixations for patients >65+years. (Approx. 50%). | **RNOH/GIRFT recommends:** SBUHB to increase the usage of fully cement hip fixations in patients over 65+years. At least 80% of patients over 70 years of age should be receiving a fully cemented or hybrid hip replacement. This is compliant with the standardised Hip replacement in HVLC (High Volume Low Complexity) endorsed by the BOA. |
| 5 and 10-Year Revision Rate Hip Primary | Good 5-year elective hip revision rates, this is likely to improve even further if hospital were to increase the usage of cemented hip fixations.<br><br>Morriston Hospital has extremely high 90-day elective hip mortality rates. A review of the elective hip mortality rates has been carried out – there were no themes identified in this review. A cleansing exercise of the data was also carried out. | **Opportunity for learning best practice:** Hywel Dda UHB have a high usage of fully cemented hip fixations on patients over 65+ years and have better outcomes and low revision rates.<br><br>**RNOH/GIRFT recommends:** For SBUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation.<br><br>**RNOH/GIRFT recommends:** For Morriston Hospital to review the 90-day elective hip mortality rates. |
| **Elective knee replacement** | | |
| 5 and10-Year Revision Rate Elective Knee<br><br>- | Good 5-year and 10-year knee revision rates across both sites.<br><br>Good 90-day elective knee mortality rates. | **RNOH/GIRFT recommends**: ALL Hip and knee revisions to be discussed in appropriate Health Board / Regional MDT's prior to surgical intervention. |

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| **Elective joint procedure for adults – PEDW** | | |
| Hip Procedures<br>Knee Procedures<br>Shoulder Procedures<br>Elbow Procedures<br>Hand and Wrist Procedures<br>Ankle Procedures | Low joint replacement activity reported. Joint replacements were not carried out at Neath Port Talbot until 2020. The data reported in the GIRFT datapack for Neath Port Talbot relate to the Cwm Taf surgeons. Due to lack of ring-fenced beds at Morriston site, the majority of the arthroplasty activity was outsourced, some carried out by their own surgeons in the independent sector (in their own time, in uncontracted sessions).<br><br>Elective knee revisions and shoulder replacements are being carried out across 2x hospitals.<br><br>Arthroscopy data looks to be underreported, generally the arthroscopy data is poor.<br><br>Low elbow activity reported.<br><br>Good practice identified:<br>- Reduced the number of surgeons and all hip revisions are carried out at one site, Morriston Hospital.<br>- SBUHB are part of the ankle network, ankle activity is sent to Cardiff where the volumes are higher. | **RNOH/GIRFT recommends:** Repatriate the joint replacement activity that is likely being outsourced to other providers.<br><br>**RNOH/GIRFT recommends:** Re-organise elective knee revision and shoulder replacement to be carried out at one hospital.<br><br>**RNOH/GIRFT recommends:** Undertake a review of arthroscopy to identify the correct volumes and develop an improvementstrategy to improve reporting of this data.<br><br>**RNOH/GIRFT recommends:** Review of elbow activity, centralise this activity at regional / national level where an appropriate volume of surgery is being carried out; with kit on the shelf and dual-surgeon operating. |
| **Elective joint replacement length of stay (days) PEDW** | | |
| Primary hip replacement<br>Revision hip replacement<br>Primary knee replacement<br>Revision knee replacement<br>Primary shoulder replacement | Morriston Hospital has higher length of stay rates in primary hip, knee and shoulder replacements comparison to the national average. Extremely high hip and knee revision lengths of stay. | **RNOH/GIRFT recommends:** Morriston to undertake a review of primary hip, knee, and shoulder replacements along with revision hip length of stay rates and develop an improvement strategy. |

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| Revision shoulder replacement<br>Primary elbow replacement<br>Revision elbow replacement<br>Wrist replacement<br>Primary ankle replacement<br>Revision ankle replacement<br>Knee ligament reconstruction<br>Shoulder sub acromial decompression<br>Shoulder rotator cuff<br>Wrist arthrodesis (fusion)<br>Ankle arthrodesis (fusion) | NOF length of stay has improved from 21 days to 18 days – target is to reduce NOF length of stay to 11 days.<br><br>Shoulder rotator cuff repair and ankle arthrodesis length of stay at the Morriston is higher than the national average, this may be due to coding issues.<br><br>Good practice identified:<br>- Neath Port Talbot has excellent length of stay rates | **RNOH/GIRFT recommends:** SBUHB to undertake a review of fracture neck of femur, hip and knee primary and revision length of stay rates and develop an improvement strategy.<br><br>**RNOH/GIRFT recommends:** Improve enhanced recovery by having a physiotherapy service available on weekends to mobilise patients for earlier discharge. When SBUHB develop the elective hubs, it is imperative that they are staffed appropriately to maximise outcomes and improve patient flow.<br><br>**Opportunity for learning best practice**<br>A fully integrated 'discharge to assess' system for returning patients home safely from hospital has been implemented in Swindon. NHS England » Swindon's discharge to assess model<br><br>**RNOH/GIRFT recommends:** Morriston to review shoulder rotator cuff repair and ankle arthrodesis length of stay rates and develop an improvement strategy.<br><br>**RNOH/GIRFT recommends**: to consider whether hip and knee day case surgery could be more broadly used for some patient groups. National day Surgery Delivery Pack can be found via the following link:<br>Best practice library - day surgery - Getting It Right First Time - GIRFT |

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|---|---|---|
| **Primary hip** | | |
| Elective primary hip replacement with cemented fixation for patients 70+ Years | SBUHB are outliers in the usage of cemented hip fixations being in >70+years.<br><br>Good practice identified:<br>- SBUHB have rationalised the number of hip and knee prosthesis across the Health Board. | **RNOH/GIRFT recommends**: Cement THR in patients over 70 years old provides best outcomes. |
| Average length of stay for patients receiving elective primary hip replacement (days) | Good length of stay at Neath Port Talbot Hospital.<br><br>Morriston has higher lengths of stay compared to other providers. | **RNOH/GIRFT recommends:** Consider measuring in hours opposed to days. |
| Return for another hip procedure (on the same side) within 1 year for patients 60+ years | Good practice identified<br>Excellent return to theatre rates for patients requiring another hip procedure. | |
| **Primary Knee** | | |
| Elective knee replacement for patients 60+ years average length of stay | Variation between sites, likely to be due to Morriston treating more complex patients. | **RNOH/GIRFT recommends:** to consider whether hip and knee day case surgery could be more broadly used for some patient groups. National day Surgery Delivery Pack can be found via the following link:<br>Best practice library - day surgery - Getting It Right First Time - GIRFT |
| Return admission within 1 year for another knee procedure on the same knee for patients 60+ years following primary knee replacement | Good return to theatre rates. | |
| Elective knee replacement for patients 60+ years who had an arthroscopy less than 1 year previously | Noted: the data for this metric will not currently a true reflection of the activity as many of the pts are still on the w/list over 1yr. | **RNOH/GIRFT recommends:** For SBUHB to undertake regular peer arthroplasty reviews of surgeon level data also reviewing low volume activity. |
| **Primary Shoulder** | | |
| Elective shoulder replacement for patients 60+ years average length of stay | Good shoulder replacement length of stay rates. | |
| Return for another shoulder procedure (on same side) within 1 year, for patients 60+ years | Excellent return to theatre rates. | |

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| **Surgeon Data** | | |
| Number of surgeons assigned to providers over three-year period | Low volume surgery identified in primary hip, hip revision and knee revision.<br><br>There were issues with the NJR data, patients were coded under admitting consultants. This is historical data error. A data cleansing exercise has been carried out. | **RNOH/GIRFT recommends:** SBUHB to undertake a review low volume surgeons across the totality of their practice. Surgeons delivering low volumes of both hip and knee revisions annually should no longer be performing this surgery. Operations delivered by surgeons who perform a very low volume of that surgery type are associated with increased lengths of stay, complications, and cost. |
| **Procedures with adverse events - % of procedures with an adverse event** | | |
| 2020 (1 year) National Joint Registry (NJR) Data<br><br>Hip<br>Knee | Good practice identified:<br><br>0%<br>0% | **RNOH/GIRFT recommends**: An annual review of the theatre adverse events/ NJR data. |
| **PROMS** | | |
| 2019/20 (1 year)<br><br>Hip Replacement<br>Knee Replacement<br>Hip Replacement<br>Knee Replacement Revision | There were no PROMS available. PROMS is not collected locally. | **RNOH/GIRFT recommends:** to arrange for PROMS to be collected locally, discuss and review PROMs score internally on an annual basis. |
| **Surveillance of surgical site infection (SSI) - orthopaedics - percentage of procedures with an infection - elective procedures** | | |
| 2019/20 (1 year)<br>Hip replacement - Inpatient<br>Hip replacement - Inpatient and Readm.<br>Knee replacement - Inpatient<br>Knee replacement - Inpatient and Readm. | There were no SSI data available.<br><br>SBUHB consultants confirmed there has been high infection rates due to the lack of ring-fenced beds. | **RNOH/GIRFT recommends:** Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular review of infected cases should be undertaken for learning. |

| **Litigation 2018-2019** | | |
|---|---|---|
| Total number of Claims T&O claims<br><br>The total costs involved for T&O | 2x claims<br><br>£898,325.00 | **RNOH/GIRFT recommends:** SBUHB to regularly review with the litigation claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI) and where a claim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed. |