GETTING IT RIGHT FIRST TIME

Orthopaedics and Theatre Efficiency Review

Government of Jersey Health and Community Services

July 2024

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to identify areas of improvement in the orthopaedic service and in theatre efficiency at Jersey General Hospital to address long waiting times and ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets and to

Written by:

Professor Tim Briggs: NHS England Director of Clinical Improvement and Elective Recovery, Chair of GIRFT Programme and Orthopaedic Consultant at RNOH
Graham Lomax: National Implementation Director, GIRFT Programme
Dan Pearce: Head of Specialist Implementation (Theatres & Periop), GIRFT Programme

Contents

Executive Summary

This report follows a review of orthopaedic services and theatre efficiency at Jersey General Hospital (JGH) in April 2024. All staff, both clinical and operational, were very open and honest in providing views on where they felt there were challenges and recognised that there is a real opportunity to improve services. All were enthusiastic about embracing changes in practice, if this would improve services for their local population.

We saw excellent facilities, with many examples of good practice. This confirms our view that JGH has an opportunity to become an exemplar hospital, which will improve care for all patients and encourage additional private patients to use the facilities.

We have identified opportunities for and areas of change to practice that will increase activity by maximising the use of existing resources and assets. There are procedures that should be performed in an outpatient procedure room by default, not inpatient theatres, which would bring JGH into line with GIRFT's 'Right procedure, right place' approach'.

There are opportunities to optimise pathways and increase the number of cases performed per theatre session. These include day case pathways and job planning for staff across the whole of the week to maintain activity across 5-6 days. We found that the staff are willing and excited about the challenges to use the data they have, to effectively identify variation and drive change to improve services.

In total there are 36 recommendations in Section 2 of this report, and we now need to see all of them taken forward at pace to enhance services and improve care. These changes will improve the resilience of elective surgery throughout the year, including in the winter months. JGH need to ensure elective care is delivered 48 weeks per annum. This will have a positive impact on reducing waiting times for patients in both outpatients and for those patients requiring admission for orthopaedic services. Implementing the GIRFT recommendations and guidance will increase throughput and provide capacity to repatriate services from the mainland.

Professor Tim Briggs CBE MBBS(Hons), MD(Res), MCh(Orth), FRCS, FRCS(Ed),
Director of Clinical Improvement and Elective Recovery - NHS England
Chair of The GIRFT Programme, Consultant Orthopaedic Surgeon RNOH.

1. Introduction

Getting It Right First Time (GIRFT) is a national programme in England developed by the GIRFT national team under the chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the chairmanship of Professor Tim Briggs, was commissioned by the Government of Jersey Health and Community Services (HCS) to review their current processes and procedures to improve Orthopaedics services and Theatre Utilisation at Jersey General Hospital. The intention of a critical friend review is to add an external and objective perspective, and to share good practice observed at other Trusts in the UK.

The aim of the project was to:

- Provide support to the development of the theatres dashboard;
- Review Orthopaedic surgery services; benchmark the services against recognised benchmarks in England to identify unwarranted variation and make recommendations for improvement; and
- Review the theatre data collected by Jersey HSC, observe theatres and their surrounding systems in practice and make recommendations for improvement.

The RNOH/GIRFT team undertook a two-day review (Monday 22nd April and Tuesday 23rd April 2024) of the whole elective pathway, specifically of orthopaedics, although observations of other specialties such as ophthalmology and urology were made within JGH too. As part of the review, we met with stakeholders and teams involved in all aspects of the delivery of elective activity at JGH through a combination of structured meetings and observations.

The RNOH/GIRFT review team are grateful for the input of all the staff we met during the review and the time they devoted to the process. All provided an open and honest view of the challenges, but also all felt there was a real opportunity to improve services.

We compiled and reviewed data analysis from three strands of data; two of these strands were questionnaires completed by clinical and ancillary staff relating to the provision of services, pathways and workforce. The third strand related to the orthopaedic service data. This involved combining JGH private and public patient data, Hospital Episode Statistics (HES) and other relevant registry or professional body data.

The range of orthopaedic metrics included:

- Population metrics – patient age profile;
- Key performance indicators – elective orthopaedic activity, length of stay of key procedures, one year return for another procedure analysis, one year and two year revision rates;
- Adult emergency repair of emergency fracture neck of femur activity;

- Surgeon data (number of surgeons and volume of cases including those undertaking low volumes).

This report details the methodology, findings and recommendations arising from the data analysis, deep dive engagement and on-site evidence gathering on orthopaedic and theatre services. We have made 36 recommendations in the report, which we strongly encourage the JGH Executive Team to implement via a Task and Finish group. The first of our recommendations is therefore:

Recommendation 1: JGH to develop a Task and Finish Group to lead on the development of an action plan to implement the RNOH/GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. The RNOH/GIRFT team would expect an action plan and presentation of evidence of changes over the next six months.

2. Table of Recommendations

No.	RNOH/GIRFT Recommendations
1	JGH to develop a Task and Finish Group to lead on the development of an action plan to implement the RNOH/GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. The RNOH/GIRFT team would expect an action plan and presentation of evidence of changes over the next six months.
2	JGH should seek to develop a comprehensive workforce strategy ensuring it provides a unified vision across all inpatient and outpatient staffing roles including the need for succession planning and the development of enhanced and advanced roles.
3	JGH should increase the number of middle grade doctor operating lists and available training opportunities to improve morale and prevent deskilling, ensuring this doctor cohort remain competent in their clinical roles.
4	JGH should undertake a review of the current workforce and identify gaps in rotas where there should be a permanent appointment rather than using long term locums. JGH to consider how to make substantive posts more attractive to staff and work with HR to consider applicants from oversees (particularly where an assessment of comparable training is required to assess whether applicants meet the application criteria).
5	JGH should carry out a review of employment contracts and remove any limitations to allow weekend and out of hours working.
6	HR and department managers should work together to ensure that managers only have to focus on the requirement for the service, leaving the rest to HR. This will reduce the impact on operational delivery.
7	JGH should review Training and Development across all roles to ensure they align with their strategic goals and provide equitable opportunities and access to training. Ensure staff have access to working in different units in Jersey and also off the Island.
8	JGH should explore effective strategies to understand and address the high absence rates.
9	JGH should explore best practice solutions to improve the management of underperforming employees.
10	JGH should ensure that there is rapid engagement of the clinical and operational workforce around the new hospital strategy. This is to help them understand the impacts of a single site two model approach on workforce, equipment and resources and modelling for theatres to run for 48 weeks of the year, 6 days a week.
11	JGH to further share the dashboard with clinical and operational management and monitor the data regularly to drive improvement.

12	JGH to monitor surgeon performance in consultant appraisals using the National Joint Registry Data.
13	JGH should: • Work with clinical and operational teams to optimise Maxims, review the current lists of procedures, minimise the use of free text to support scheduling and improvements to cases per session and improve reporting structures. • Understand trends using existing data. • Strengthen data visibility and ownership across the pathway. • Collect outcome measures and benchmark against English averages, identifying unwarranted variation and areas of improvement.
14	JGH should review the pre-operative assessment service to identify opportunities to develop a broader MDT team approach, including the input of geriatrics, diabetes etc.
15	JGH should introduce a phone call service to confirm TCI and ensure that patients are fit and have followed their POA instructions etc. We would recommend alongside the pre-TCI calls that opportunities to make every contact count are embedded and teams are encouraged to move from closed questions to open dialogue that can provide patients opportunities to seek clinical input where they may feel that surgery may no longer be required. This will minimise the number of on the day cancellations.
16	JGH should establish a pool of standby patients to fill gaps in theatre schedules promptly, especially when there are cancellations or unexpected openings. This will optimise theatre capacity and ensure efficient use of resources.
17	JGH should review the structure and function of the 6-4-2 theatre scheduling meeting and embed the GIRFT Theatre Scheduling guide. Use trend data to inform the meetings to provide greater insight and intelligence to drive decision-making.
18	JGH should regularly review and present theatre data to identify unwarranted variation.
19	JGH should: • Develop full day operating where appropriate without breaks in lists to maximise the operative time that is available and use a rotation model to ensure all members of the team can take a break but at staggered times. • Increase the number of blended public / private sessions all day sessions. • Implement Golden Patient principles (first on list with auto-send). • Review all job plans, especially for anaesthetists and orthopaedic surgeons, to ensure the best use of elective wards and that beds are fully utilised. • Optimise workflows to ensure efficient patient flow through the day case pathway. This includes pre-assessment, admission, surgery, and discharge. • Increase day case activity, 85% of surgery should be a day case. • Allocate porters to ensure smooth patient flow, timely equipment setup, and efficient room turnover between procedures.
20	JGH should consider moving Trauma sessions to the afternoon, thereby allowing ward rounds to occur in the morning, and better enabling efficient planning for the sessions. **FOLLOWING POST REVIEW FEEDBACK:** If JGH seek to keep the trauma theatre sessions in the AM the following should be put in place: • Agreement that the trauma list is planned the previous day (and time is provided to do this) with a clear golden pt who is not changed to allow prep / consent etc. • That either: ○ The Consultant covering the trauma list is either Job planned to start earlier so that ward rounds can be completed prior to the trauma list starting (planned start time).

	○ Second consultant (or other suitable surgeon) is able to start first case while the consultant covering trauma is completing ward rounds ○ List consultant (trauma) and post take for trauma are managed on independent rosters.
21	JGH to deliver a 'perfect week' aligning with GIRFT specialty standards: cases per theatre session.
22	JGH should undertake a rapid review of the ophthalmology pathway and should consider: • Ceasing routine use of anaesthetists in LA cataract lists; upskill the MDT to deliver blocks where they are needed. • Moving to topical anaesthesia as a default for all suitable cases. • Reviewing ophthalmologists job plans to ensure that operating sessions are protected from pressures. • Reviewing the pre-theatre time to ensure sufficient time is available to review and consent patients; this may be on the day or the day prior to the planned list. • Optimising the pathway to increase the number of cataracts per theatre list: GIRFT specialty standards: cases per theatre session.
23	CSSD should work with JGH to develop an improvement plan focussed on improving flow and kit by: • Reviewing the data in relation to delays and cancellations to inform the potential case for extended opening hours for the facility. • Increasing the number of deliveries to six times a day and introduce 'blue light priority' to drivers at the delivery point. • Addressing the shortage of kit; trauma trays, washers and steriliser. • Ensuring the equipment is cleared each day and by Sunday afternoon ALL equipment has been cleaned and sterilised ready for the next week. • Exploring effective strategies to improve staff morale, address the high absence rates and solutions to better manage of underperforming employees.
24	JGH should establish a single area for surgical admissions to reduce late starts and theatre turnaround times (ideally with close proximity to the theatres).
25	JGH should develop the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff thereby reducing the demands on critical care. (https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-care)
26	JGH should embed the GIRFT Orthopaedic Outpatient Guidance to promote greater adoption of virtual reviews, reduce DNA's and drive Patient Initiated Follow Up (PIFU) whilst ensuring that there are robust mechanisms in place for such patients to gain timely access back into secondary care. JGH should consider adopting GIRFT Outpatient Guidance across other specialties Outpatients - Getting It Right First Time - GIRFT.
27	JGH should validate waiting lists and ensure that patients on waiting lists are communicated with regularly.
28	JGH should increase the use of day surgery, HVLC care pathways and, where appropriate, delivery of care outside of a traditional theatre setting (Right Procedure, Right Place).
29	JGH should: • Adopt a "ring fenced" methodology. • Ensure a maxim of day surgery by default. • Ensure top decile length of stay. • Ensure consultant job planning throughout the week including on Mondays and Fridays to deliver the maximum utilisation of ring-fenced beds.

30	JGH should increase the number of days that theatres are running to ensure that theatres are running for 48 weeks of the year, for 2.5 sessions a day on 6 days a week.
31	Beauport ward to be used more efficiently to maximise capacity, which is currently 14 ring-fenced orthopaedic beds. Whilst we fully support a ring fenced ward, the ward usage must be maximised further. Once the ward has been fully maximized, JGH may want to review the number of beds.
32	JGH should: • Identify those on government contracts and amend the contracts to enable paid working 7 days per week for the physio and occupational therapy teams. Currently weekend working is voluntary and relies on a good-will basis and a day off during the week is given in lieu to compensate. • Undertake a review of the current workforce and identify gaps in rotas where there should be a permanent post to reduce reliance on long term locums. • Review the management of referrals to physiotherapy; proper triage and better communication can help prevent unnecessary referrals. • Work with the occupational therapy team to address the low morale and review where these teams should sit in the organisational structure. • Carry out an annual audit of the PROMS data to identify unwarranted variation and areas for improvement.
33	JGH should establish a full Multi-Disciplinary Team (MDT) for orthopaedic surgery which should include use of the dedicated orthopaedic physio resource through the full patient pathway. The MDT should also include Occupational Health resources at the appropriate time. All revisions must be discussed in the MDT.
34	JGH should: • Undertake a workforce review to determine the number of staff required to provide an efficient service. Further work needs to be done to reduce long term locums and to make substantive posts more attractive to staff; • Consider expanding the skills of their radiographers to allow out-of-hours MRIs for patients presenting with suspected CES. This should be completed within 3-6months. Once a MRI for suspected CES has been performed it can be sent digitally to Southampton for their opinion. • Improve communication and planning between teams to ensure effective use of time and resource; • Undertake a review of current equipment and upgrade where necessary. We were told that the equipment is old and the software on MRI scanner requires updating as currently it is not possible to screen for prostate cancer.
35	JGH should: • Work with the corporate procurement team to centralise the purchasing function and reduce the expenditure on medical supplies. • Continue price benchmarking exercise, comparing data against that of NHS Supply Chain and England Trusts. • Carry out regular stock takes of inventory, including regular checking for expiration dates on implant fixtures.
36	JGH should undertake an annual review of 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. The meetings should be led by senior clinicians and attended by clinical staff and junior doctors (e.g. clinical governance or multidisciplinary meetings), with support from trust legal teams. 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.

3. Jersey HCS Organisational Structure

The organisational structure of Health & Community Services (HCS) within Jersey is characterised by Care Groups, each led by a Chief of Service supported by a Lead Nurse and General Managers. Lead Nurses and General Manager's report to the Chief of Service, who in turn reports to the Managing Director. The Clinical and Professional Care Groups, some of which operate in partnership with external entities, are organised into the following key Care Groups:

- **Mental Health Services**
- **Adult Social Care**
- **Medical Services**
- **Surgical Services**
- **Primary, Preventative and Immediate Care** *with Adult Therapies and Community Dental*
- **Women's, Children's and Family Services**

The Surgical Services Care Group (SSCG) oversees a bed capacity of 74 surgical inpatient beds within JGH, including 7 intensive care beds. Additionally, the Day Surgery Unit (DSU) consists of 28 beds for patients undergoing surgical day case procedures. Daily operational bed counts are subject to fluctuations owing to various operational factors. SSCG employs a Surgical Flow Coordinator who works to create capacity across surgical wards for both emergency and elective patients, collaborating closely with operational teams, clinical site staff, ward staff, ICU and theatres. The hospital is equipped with 6 main operating theatres of which 3 are laminar flow, with an additional two theatres dedicated to day surgery units alongside a minor ops suite. For endoscopic procedures, the hospital has two endoscopy theatres, situated within the Aubin ward.

4. Private Patient Services in Jersey HCS

Private Patient Services in HCS generated £12.2 million in 2023 and caters to both patients with private medical insurance and those who self-fund their healthcare.

Approximately 30% of the population, over 30,000 individuals, have private healthcare insurance. SSGC's private work generates income to support service delivery costs, helps to reduce waiting times and consequently helps to increase public capacity. The availability of private practice is considered crucial to attracting consultants and practitioners to work in Jersey.

Private patient services encompass inpatient, day case and outpatient treatment and provide access to intensive care, pathology, radiology, physiotherapy, endoscopy, audiology and clinical investigations within JGH. Sorel ward is a private patient's ward specifically designed for private patients with 14 beds. However, it is also used in emergencies for infection control management purposes in line with operational procedures and hospital escalation policies.

5. General Findings and Recommendations

This section includes findings and recommendation that are relevant to both the orthopaedics and theatre review.

5.1 Workforce

The Island has challenges due to the size of JGH which results in different models for delivery of care compared to those that we may see and make recommendations on when reviewing services within a provider in England. This is primarily seen where teams must be able to cover a wider range of specialities or sub specialisations than we would see in providers in

England who, due to specialisation of services will have teams who support smaller areas of practice. The teams we spoke to have worked hard to overcome these challenges with some excellent recruitment of staff within theatres to address challenges in this area.

The theatre team are all multi-skilled across the theatre practitioner roles (Scrub, Anaesthetics and Recovery) and are trained to work across all elective and non-elective specialities, including on call. This provides a high degree of resilience within theatres; however, delivering this type of workforce requires far more training time for new starters than would be usual in hospitals where the theatre workforce is split into distinct specialities. They still require agency staff within theatres but this is viewed as necessary in order to provide the needed capacity to fully develop the new team. The theatre team are also looking to develop Surgical First Assistants within theatres, to provide additional resilience and support to the surgical medical teams where middle grades or fellows may not be available to support a list. These roles will ensure that theatre productivity and efficiency is increased or maintained where these lists may typically have been just consultant only previously.

We observed some excellent examples of role development and innovative approaches to workforce development. However, we observed some inconsistency between departments, rather than there being a clearly defined organisational workforce strategy. This included development of non-medical (nursing and AHP) practitioners and nurse consultants. However, as these had been developed at speciality level, we felt there was more opportunity to standardise practice and ensure that enhanced and advanced nursing and AHP roles were fully utilised to the top of their licence. This would provide significant opportunity for on-island career progression, would support specialities where medical input was scarce and support the development of minor surgical services which could be nursing or AHP led (such as the use of surgical care practitioners). It would also provide additional capacity by removing lower complexity surgery from medical workloads so that their skill set could be targeted at more complex activity.

Given the challenges on the Island in terms of workforce resilience and the potential for 'single points of failure', a clear focus on a more strategic approach to workforce development would support the services in the short, medium and long term.

Recommendation 2: JGH should seek to develop a comprehensive workforce strategy ensuring it provides a unified vision across all inpatient and outpatient staffing roles including the need for succession planning and the development of enhanced and advanced roles.

The orthopaedic workforce for JGH is detailed in **Figure 1.**

Figure 1 Orthopaedic Workforce JGH

	Total no. persons	Total persons doing out of hours on-calls	Total WTE employed
Consultant	3 (2)	3	3 (2)
SAS/career staff grade	1 Associate Specialist 4 Middle Grade	5	5
Nursing/PA Band 8	1	-	1
Nursing/PA Band 7	2 (specialist nurses)	-	2
Nursing/PA Band 6	1 ward manager		
Nursing/PA Band 5	2.8 deputy		2.8

We were told that the middle grade doctor surgical lists had been reduced or reallocated and given to consultants who would perform the surgical tasks more quickly. This has had a negative impact on staff morale and has deskilled middle grade doctors and increased the risk of them leaving Jersey for other opportunities. We felt that if this happened, recruitment to these vacant posts would be difficult.

Recommendation 3: JGH should increase the number of middle grade doctor operating lists and available training opportunities to improve morale and prevent deskilling, ensuring this doctor cohort remain competent in their clinical roles.

We were also told that there is a relatively high use of locums, agency staff and interims. Given the high cost of these and a need for a more permanent workforce to ensure continuity, the board need to develop a strategy to ensure on-going recruitment.

Recommendation 4: JGH should undertake a review of the current workforce and identify gaps in rotas where there should be a permanent appointment rather than using long term locums. JGH to consider how to make substantive posts more attractive to staff and work with HR to consider applicants from oversees (particularly where an assessment of comparable training is required to assess whether applicants meet the application criteria).

We heard that some of the pay and grading arrangements in place are not supporting the workforce models required. For example, we heard that physiotherapists and occupational therapists are on civil service contracts which limits the ability to support on-call rotas, especially at weekends, which are required for these roles. Currently, appropriate weekend cover relies on a good-will, voluntary basis. This is neither sustainable nor cost effective.

Recommendation 5: JGH should carry out a review of employment contracts and remove any limitations to allow weekend and out of hours working.

We were told that more could be done by HR to support recruitment and that recent changes in the recruitment system mean that departmental managers now have to spend much more time on the recruitment process themselves which impacts on their other work.

Recommendation 6: HR and department managers should work together to ensure that managers only have to focus on the requirement for the service, leaving the rest to HR. This will reduce the impact on operational delivery.

Expanding staff's knowledge and experience by working in different units can be incredibly beneficial. This provides opportunities to broaden skill sets and learn different pathways and specialties across different environments.

We were told about inconsistencies in the training and development offered to staff and that this has an impact on morale.

Recommendation 7: JGH should review Training and Development across all roles to ensure they align with their strategic goals and provide equitable opportunities and access to training. Ensure staff have access to working in different units in Jersey and also off the Island.

For some of the areas we met, we were told that absence rates were quite high.

Recommendation 8: JGH should explore effective strategies to understand and address the high absence rates.

In the areas we covered we were told that performance management of underperforming staff could be improved. It was felt that in some areas there was a reluctance to tackle these issues.

Recommendation 9: JGH should explore best practice solutions to improve the management of underperforming employees.

5.2 New Hospital Strategy

There was significant variation in the extent to which colleagues were engaged or even aware about the plans for the new hospital development. We heard about the strategy for either a single or two site option, with an acute and ambulatory model. We understand that the need for rapid engagement with the clinical and operational teams was fully recognised; clearly this will be critical in terms of planning and delivering a successful transition. It was positive to hear that as part of the plans there was an understanding for the need to increase the number of Minor Operative Procedure rooms (MOPs). We observed a number of cases being undertaken in main theatres that could safely be moved into these environments to release core capacity. We highlighted that MOPs would require investment in equipment and staff to ensure the full realisation of the benefits.

Recommendation 10: JGH should ensure that there is rapid engagement of the clinical and operational workforce around the new hospital strategy. This is to help them understand the impacts of a single site two model approach on workforce, equipment and resources and modelling for theatres to run for 48 weeks of the year, 6 days a week.

5.3 Data and Digital

RNOH/GIRFT identified unwarranted variation across several metrics detailed in the GIRFT orthopaedic data pack. The detail around this variation and the recommended improvements can be found in the Orthopaedics Action Plan in **Annex A.**

JGH have developed a theatre dashboard that allows consultants and managers to review clinical activity and performance outcomes. RNOH/GIRFT Chief Data Analyst, Ed Bramley-Harker met virtually with the Jersey data team to provide insights and advice about improving the theatre dashboard. He found that the dashboard uses a comprehensive cohort of key metrics that identifies activity and measures outcomes. On the visit, we saw less evidence of operational and clinical teams using the data to inform planning and review actual versus planned utilisation. We encourage the data team to keep engaging with clinical and operational teams and to explore how data can be made more easily accessible and used consistently to inform planning and review of throughput.

Recommendation 11: JGH to further share the dashboard with clinical and operational management and monitor the data regularly to drive improvement.

JGH are due to start recording orthopaedic data on the National Joint Registry (NJR). RNOH/GIRFT supports this and encourages JGH to analyse the reports on performance outcomes in joint replacement surgery. All surgical consultants should show all their practice data at their annual appraisal, including their JGH patient and private practice data. In addition, all consultants should sit down with their colleagues who carry out joint replacements and share their data to learn from each other.

Recommendation 12: JGH to monitor surgeon performance in consultant appraisals using the National Joint Registry Data.

JGH has recently adopted Maxims as the electronic patient record (EPR) solution for the Island. Throughout the visit, the challenges with this system were highlighted by all staff groups, either through a feeling of lack of training on the system to be able to use it correctly,

or where there was a perception that Maxims did not support effective working and flows across all stages of the pathway. We heard of issues with the use of intended procedures not directly relating to the surgery that was intended by the surgeon, due to the way in which the theatre reports were collated. This made it more challenging to ensure lists were well booked and the checks on kit etc. were made. There is clearly some optimisation work that needs to be supported to ensure that the system is working for clinical and operational teams. We would strongly encourage a review of the current list of procedures to ensure that these are relevant and agreed with the surgical teams to minimise the use of free text. This will also mean that procedure time data will become more valuable to support scheduling and improvements to cases per session by being more understandable and accurate for clinical staff on what procedure is intended.

The staff we spoke to highlighted the challenges with Maxims and e-listing for clinicians which they felt was taking significantly longer than with the previous systems. There also appeared to be a lag when new procedure codes were required, and as highlighted earlier we would suggest that this is an area of focus.

Recommendation 13: JGH should:

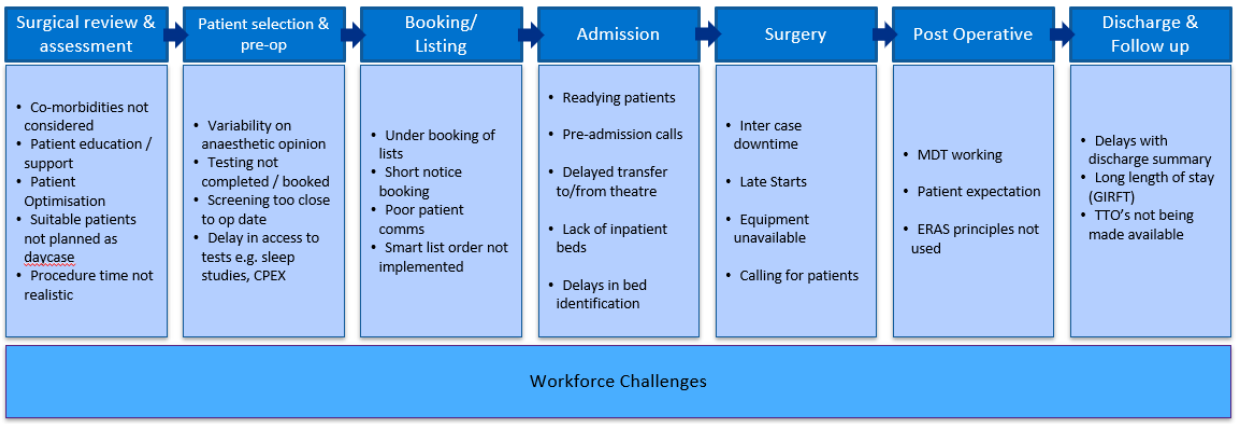
- **Work with clinical and operational teams to optimise Maxims, review the current lists of procedures, minimise the use of free text to support scheduling and improvements to cases per session and improve reporting structures.**
- **Understand trends using existing data.**
- **Strengthen data visibility and ownership across the pathway.**
- **Collect outcome measures and benchmark against English averages, identifying unwarranted variation and areas of improvement.**

6. GIRFT Theatre Pathway Review Findings and Recommendations

This section lays out the findings and recommendations arising from the review of Theatre productivity by the RNOH/GIRFT Theatre Review team.

Theatre productivity is influenced at all stages of the theatre pathway which is represented below in Figure 2.

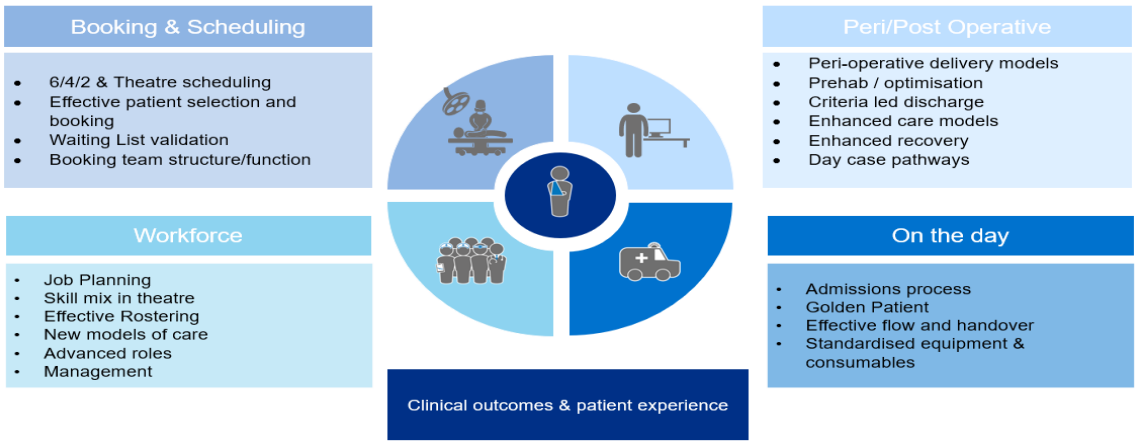
Figure 2: Theatre Productivity Pathway



6.1 Area of Focus

The team focussed its review on the areas shown in Figure 3.

Figure 3 Areas of focus of the theatre efficiency review:



6.2 Selecting and preparing patients

6.2.1 Pre-operative Assessment

The pre-operative assessment (POA) service is located on a separate site by the Airport. The unit is primarily nurse led and three sessions of consultant time has recently been added to the service (not formally funded). The team appeared to be well engaged in delivering the service in line with the five core standards for early screening and risk assessment. POA pull patients directly from the waiting list and triage patients to either face to face or telephone assessments alongside identifying those patients where a formal POA is not required e.g. Local Anaesthetic (LA) cases, etc. There was an acknowledgement that there remained some work to be done in ensuring non cancer patients are only provided with a “To Come In” (TCI) once passed fit, though considerable progress has already been made, for which the team should be commended. The outcomes of POA and optimisation are entered into Maxims to support prioritisation. There is currently no formal geriatric support to POA, which would further enhance development of the service and ensure that optimisation opportunities are expanded to drive further improvements in length of stay and day surgery rates.

Recommendation 14: JGH should review the pre-operative assessment service to identify opportunities to develop a broader MDT team approach, including the input of geriatrics, diabetes etc.

6.2.2 Theatre Booking

There are five booking clerks responsible for the booking of public patients within the organization. Private booking is done separately. The team aims to book theatre lists out to four weeks, with urgent cases aiming for a TCI within four weeks of listing, ‘soons’ in 3-5 months and then chronologically for routines. The booking clerks have regular meetings with their consultants to discuss and plan lists, which appears to work well. The team were concerned about the move to limit public inpatient admission to 4 males and 4 females per day and there was a meeting planned for later in the week to discuss how this would be managed.

There is a text reminder service in place that sends texts at 1 week prior to TCI and 3 days prior, but this is one way rather than two way, and we understood that this is not fully deployed. Due to the levels of on the day cancellations where “procedure is not required” or “patient did not attend” we would recommend that a phone call service is established. This would be to confirm TCI and that patients are fit and have followed their POA instructions to help minimise these on the day cancellations. The high levels of DNA also indicate that patients do not feel that there is an opportunity to go back to their clinical team when their symptoms may have changed or when they do not feel that surgery is the correct option.

Recommendation 15: JGH should introduce a phone call service to confirm TCI and ensure that patients are fit and have followed their POA instructions etc. We would recommend alongside the pre-TCI calls that opportunities to make every contact count are embedded and teams are encouraged to move from closed questions to open dialogue that can provide patients opportunities to seek clinical input where they may feel that surgery may no longer be required. This will minimise the number of on the day cancellations.

As Jersey HSC are making good progress with moving to patients being passed fit prior to a TCI being offered, we recommend that consideration is given to developing lists of patients who are willing to take short notice cancellation appointments or implementing standby patients (in effect overbooking theatre lists). Also, JGH could make an offer for patients that if they are not operated on, they are guaranteed a date in the following 4-6 weeks. An outline of these processes can be found in the GIRFT Theatre Booking Guide.

Recommendation 16: JGH should establish a pool of standby patients to fill gaps in theatre schedules promptly, especially when there are cancellations or unexpected openings. This will optimise theatre capacity and ensure efficient use of resources.

6.2.3 Theatre Scheduling

During our visit we were able to observe a cut down version of the 6-4-2 meeting, which was chaired by the anaesthetic lead and had representatives from booking, specialities and theatres. The meeting reviewed upcoming lists and list allocation with some limited look back of previous performance, supported by in house reporting. There was an acknowledgement that lists were, in some cases, planned light but that this was difficult to challenge effectively due to the issues with procedure codes and use of free text.

Whilst we were not able to observe a full meeting, we would recommend that the structure and function of this group is reviewed, in line with the GIRFT Theatre Scheduling guide, and ensure that trend data is more easily accessible to identify trends in performance to identify opportunities for continuous improvement.

Recommendation 17: JGH should review the structure and function of the 6-4-2 theatre scheduling meeting and embed the GIRFT Theatre Scheduling guide. Use trend data to inform the meetings to provide greater insight and intelligence to drive decision-making.

6.2.4 Theatre Data

There was variation with regard to whether Surgeons included anaesthetic time or not in their predicted procedure time. Clearly this variation makes the total predicted utilisation figure inconsistent. In the absence of specific personalised data developed over time, we would recommend adopting a standard of ‘x’ minutes, with all those involved agreeing what the standard number of minutes should be.

From what we observed in the 6-4-2, and from our discussions with various members of the teams, there is a lack of longitudinal trend data to inform the meetings in terms of genuine improvement trends as opposed to simple comparisons with the previous week. We think there is sufficient data to suggest there is a significant opportunity to analyse it and present it in a way that would provide greater insight and intelligence to drive decision-making.

Recommendation 18: JGH should regularly review and present theatre data to identify unwarranted variation.

Clearly, engagement from surgical specialties in the Theatre Utilisation Group is critical, and must be at an appropriately senior level to ensure that rapid decision making, and follow up actions are taken, including direct discussion with individuals when required. As recommended above, the provision of more insightful data trends and correlation should support this engagement.

6.2.5 Theatre Productivity and Flow

6.2.5.1 Theatre session planning

Due to the mixed public and private nature of Jersey's health economy, consultant theatre sessions are currently split between public and private. During the visit we were told that there is a drive to moving these to blended sessions where both public and private patients will be treated on the same lists. This would support more effective use of clinical time. However, teams will need to be mindful of managing capacity between the two streams to ensure neither is disadvantaged. Sessions are 3.5 hours as standard, with some all-day operating; however, where this occurs, the list breaks for lunch, which can lead to reduced productivity across the full day. Consideration should be given, as part of the move to blended sessions, to developing full day operating where appropriate. This will maximise the operative time that is available and this move should also explore ensuring lists do not routinely break for lunch through staggering breaks for staff groups. Where anaesthetic capacity is a constraint to delivering this, the team can consider scheduling a local anaesthetic case during the session to release the anaesthetic team for their break.

We were told that the anaesthetists and surgeons start work at different times, resulting in a delay to theatre start times. There are also delays in transitioning patients from the ward to the operating theatres.

Recommendation 19: JGH should:

- **Develop full day operating where appropriate without breaks in lists to maximise the operative time that is available and use a rotation model to ensure all members of the team can take a break but at staggered times.**
- **Increase the number of blended public / private sessions all day sessions.**
- **Implement Golden Patient principles (first on list with auto-send).**
- **Review all job plans, especially for anaesthetists and orthopaedic surgeons, to ensure the best use of elective wards and that beds are fully utilised.**
- **Optimise workflows to ensure efficient patient flow through the day case pathway. This includes pre-assessment, admission, surgery, and discharge.**
- **Increase day case activity, 85% of surgery should be a day case.**
- **Allocate porters to ensure smooth patient flow, timely equipment setup, and efficient room turnover between procedures.**

6.2.5.2 Trauma Theatre

Currently trauma is scheduled each morning, with an additional afternoon session on Fridays. There are significant challenges with efficiency of these lists, particular in relation to start times.

Recommendation 20: JGH should consider moving Trauma sessions to the afternoon, thereby allowing ward rounds to occur in the morning, and better enabling efficient planning for the sessions.

FOLLOWING POST REVIEW FEEDBACK:

If JGH seek to keep the trauma theatre sessions in the AM the following should be put in place:

- **Agreement that the trauma list is planned the previous day (and time is provided to do this) with a clear golden patient who is not changed to allow prep / consent etc.**
- **That either:**
  - **The Consultant covering the trauma list is either Job planned to start earlier so that ward rounds can be completed prior to the trauma list starting (planned start time).**
  - **Second consultant (or other suitable surgeon) is able to start first case while the consultant covering trauma is completing ward rounds**
  - **List consultant (trauma) and post take for trauma are managed on independent rosters.**

6.2.5.3 Cases per session

We observed several lists that were delivering far fewer cases per session than we would expect (other areas such as orthopaedics and urology were already delivering good cases per session). Whilst we understand that there were several factors that were impacting this, ensuring we make best use of our operative sessions is critical if we are minimise waiting lists. As staffing recruitment is now almost complete, as is the associated training of the team, we recommend that the theatres team, working with specialty teams start to plan for events in theatres. For example a 'perfect week', where all teams work in collaboration to deliver to the GIRFT recommended cases per session or where, if these do not exist, they look at productivity differentials in weekend lists as an opportunity to make productivity gains through sessions.

Recommendation 21: JGH to deliver a 'perfect week' aligning with GIRFT specialty standards: cases per theatre session.

6.3 Cataract Surgery

We were informed that Jersey HSC has allocated approx. £100,000 for a 12month project to drive down the ophthalmology waiting list. This will be done by transferring 500 patients requiring cataract surgery to Southampton for their treatment.

GIRFT and the Royal College of Ophthalmologists recommend a minimum of 8 cataracts per 4 hour theatre session on a training list (10 on a non-training list). This includes all but the very highest complexity procedures. We would recommend a rapid initiative with the whole ophthalmology team to understand what would need to be in place to achieve these standards. We also noted that all lists include the provision of a consultant anaesthetist. This is contrary to standard practice in the vast majority of NHS units, and the GIRFT pathway recommends topical anaesthesia. Where there are requirements for GA cases, these would normally be cohorted into specific lists. There was a clear view expressed from a senior anaesthetist that this wouldn't be possible; however, we would recommend that analysis be undertaken to explore the possibility.

In the interim, there did however appear to be an opportunity to increase cases by ensuring adequate pre-theatre time is allocated for the review of patients. This would enable a reduction in theatre time that could increase cases per session. The theatre and anaesthetic team felt this would be a positive initial step. There is also an opportunity to look at job plans for the

ophthalmologists to ensure that operating sessions are protected from pressures such as being on call, which the management team reported as being one of the barriers highlighted by the ophthalmology team.

Recommendation 22: JGH should undertake a rapid review of the ophthalmology pathway and should consider:

- **Ceasing routine use of anaesthetists in LA cataract lists; upskill the MDT to deliver blocks where they are needed.**
- **Moving to topical anaesthesia as a default for all suitable cases.**
- **Reviewing ophthalmologists job plans to ensure that operating sessions are protected from pressures.**
- **Reviewing the pre-theatre time to ensure sufficient time is available to review and consent patients; this may be on the day or the day prior to the planned list.**
- **Optimising the pathway to increase the number of cataracts per theatre list: GIRFT specialty standards: cases per theatre session.**

6.4 Sterile Services

The Central Sterile Services Department (CSSD) is located offsite approximately 1.5 miles away from the hospital. We were told that this creates a problem with tray turnaround which then has an impact on the time it takes to process trays that have bodily fluids dried on them.

The department is open 16.5 hours a day, Monday to Friday 6:00am – 10:30pm; Saturday from 7:00am to 4:00pm and Sunday 7:00am to 12:00pm. There are 5 deliveries each day and we were told that there are delays with delivering and collecting equipment as the drivers often have to wait in a queue at the hospital delivery point. This results in delays of up to 45 minutes.

The service is operated by 14 production staff. The team turnaround an average of 1000 IMS trays, 800 supplementary devices, 180 washer cycles and 45 steriliser cycles per month. Some of the devices are loaned from the mainland. There are currently 5 washers and 3 sterilisers. We were told that CSSD requires two additional washers and one additional steriliser to provide an efficient service. They say space for extra equipment is at a premium; however, it is essential that this space is identified at both the hospital and CSSD site. There is only one trauma tray, therefore this tray takes priority over the elective timetable.

We were told that the team has good retention rates and delivers an in-depth training programme. However, we were also told that that there are some workforce challenges within the department; staff are on manual worker contracts, there is long term sickness within the department and 9 of the 14 members of the team are being performance managed due to high absence rates. As written in the workforce section of this report, RNOH/GIRFT recommend that JGH should explore best practice solutions to improve the management of underperforming employees and address high rates of absence. A workforce review is being carried out and has identified that the service would require an uplift of 3 WTE's to deliver a sustainable, effective service.

We were informed that there are pressures with kit because two lower limb consultants operate on the same day. When reviewing the job plans, this will need to be considered.
We were also informed that there is a plan to increase private work at the weekends especially Saturday. It is essential that the CSSD workforce are valued as they are critical to its success. Furthermore, some of the "profit" from private practice at the weekend should be utilised to pay for extra hours for CSSD staff to work on Saturdays and Sundays. This would ensure that

all equipment from the week is processed and sterilised so that on the Monday morning everyone starts with a clean sheet.

Recommendation 23: CSSD should work with JGH to develop an improvement plan focussed on improving flow and kit by:

- **Reviewing the data in relation to delays and cancellations to inform the potential case for extended opening hours for the facility.**
- **Increasing the number of deliveries to six times a day and introduce 'blue light priority' to drivers at the delivery point.**
- **Addressing the shortage of kit; trauma trays, washers and steriliser.**
- **Ensuring the equipment is cleared each day and by Sunday afternoon ALL equipment has been cleaned and sterilised ready for the next week.**
- **Exploring effective strategies to improve staff morale, address the high absence rates and solutions to better manage of underperforming employees.**

7. Surgical Wards and Environment Findings and Recommendations

7.1 Surgical Admissions Lounge (SAL)

There are clear advantages to having a single area for surgical admissions to reduce late starts and theatre turnaround times, and typically we would recommend this where it's possible, ideally in close proximity to the theatres. We were told that it had been trialled but wasn't considered to be necessary. A data driven root cause analysis in relation to cancellations and delays should be used to drive this consideration and whether the introduction of this area could reduce cancellations. We heard about frequent delays at multiple admission locations. However, there are other ways to mitigate these issues through process and communication. For example, there is an excellent forward wait area in main theatres that does not appear to be routinely used. Using this more systematically, encouraging surgeons to ask for the next patient to be sent for when they are approaching the end of their current procedure, would be a simple step to take.

Recommendation 24: JGH should establish a single area for surgical admissions to reduce late starts and theatre turnaround times (ideally with close proximity to the theatres).

7.2 Enhanced Care

GIRFT recommend the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff. This reduces the demand for Critical Care beds, which are a scarce resource. We heard about various cohorts of patients currently being treated in CCU for whom this would be relevant (e.g. non-invasive ventilation patients). We referred to the example of Enhanced Care in Cornwall, which is a model we would suggest JGH considers.

Recommendation 25: JGH should develop the use of Enhanced Care models to increase the clinical threshold for patients on inpatient wards through upskilling of ward staff thereby reducing the demands on critical care. (https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-care)

8. Orthopaedics Review Findings and Recommendations

This section lays out the findings and recommendations arising from the review of orthopaedic services.

8.1 Outpatients

Orthopaedic outpatient flows occur in two ways. Patients can be seen in the private setting by consultants and then referred in for public treatment or patients can be referred to the hospital outpatient department. Orthopaedic outpatient services are delivered in the Gwyneth Huelin Wing. Orthopaedic outpatient clinics are carried out by consultants and middle-grade doctors. Approximately 10 patients are seen in each 4-hour session, 7 of the appointments being for new patients and 3 for follow up appointments.

Improving this element of the service, by reducing the number of follow up appointments where appropriate, thereby freeing up capacity for new patients, would reduce pressure on the constrained outpatients. GIRFT have produced guidance to standardise clinical prioritisation, thereby optimising outpatient capacity and resources in outpatients to improve patient pathways and experience. We were told that appointments were lost due to DNA's.

Recommendation 26: JGH should embed the GIRFT Orthopaedic Outpatient Guidance **to promote greater adoption of virtual reviews, reduce DNA's and drive Patient Initiated Follow Up (PIFU) whilst ensuring that there are robust mechanisms in place for such patients to gain timely access back into secondary care. JGH should consider adopting GIRFT Outpatient Guidance across other specialties** Outpatients - Getting It Right First Time - GIRFT.

Recommendation 27: JGH should validate waiting lists and ensure that patients on waiting lists are communicated with regularly.

8.2 Day Surgery

The Day Surgery Unit (DSU) current opening times are between 6:00am -8:00pm. To maximise the use of the unit, JGH should extend the opening hours to 10:00pm, allowing operating up to 6:00pm. The DSU is an excellent facility with many examples of good practice. The procedure room had a high specification, and there were various procedures in main theatres that could be safely undertaken in the procedure room, whilst there were procedures taking place in the procedure room that could be performed in a standard outpatient room. Moving operations down the gradient of care is a core aim within GIRFT's Right Procedure Right Place programme, as it makes better use of estates, releasing core capacity for other patients.

Recommendation 28: JGH should increase the use of day surgery, HVLC care pathways and, where appropriate, delivery of care outside of a traditional theatre setting (Right Procedure, Right Place).

8.3 Elective Care Surgery

Currently the surgical floor is being utilised for non-elective flow with elective admissions being made across the private patient and elective ward. During the visit we were informed of the plans to re-establish the surgical floor as the main admissions area for public inpatient admissions (excluding orthopaedics) with an initial cap of 4 male and 4 female beds planned to be ring fenced. Consideration needs to be given to the theatre schedule and case types being planned throughout the week to ensure that this does not result in a bottle neck where patients with long lengths of stay are front loaded into the week, which will result in potential for beds to become a constraint later in the week.

Recommendation 29: JGH should:

- **Adopt a "ring fenced" methodology.**
- **Ensure a maxim of day surgery by default.**
- **Ensure top decile length of stay.**
- **Ensure consultant job planning throughout the week including on Mondays and Fridays to deliver the maximum utilisation of ring-fenced beds.**

Beauport Ward is an orthopaedic and trauma unit with 14 ring fenced beds. We were told that orthopaedic elective surgery does not take place every day and at the time of our visit (Monday), we only observed two patients on the ward.

Recommendation 30: JGH should increase the number of days that theatres are running to ensure that theatres are running for 48 weeks of the year, for 2.5 sessions a day on 6 days a week.

Recommendation 31: Beauport ward to be used more efficiently to maximise capacity, which is currently 14 ring-fenced orthopaedic beds. Whilst we fully support a ring fenced ward, the ward usage must be maximised further. Once the ward has been fully maximized, JGH may want to review the number of beds.

8.4 Therapies and Radiology

The outpatient physiotherapy workforce is detailed in **Figure 4.**

Figure 4 Outpatient physiotherapy workforce

	Total no. persons	Total WTE employed
Grade 11	4	3.3
Grade 10	9	5
Grade 9	1	1
Grade 6	1	1

The aquatic therapy workforce is detailed in Figure 5.

Figure 5 Aquatic therapy workforce

	Total no. persons	Total WTE employed
Grade 11	1	0.5
Grade 10	vacancy	0.5
Grade 8	1	0.8

Patients from secondary care, primary care, rheumatology, lymphedema and pain clinic (just Aquatic therapy) are seen in the above services. It is not a standalone service for the trauma and orthopaedic department.

The physiotherapy team comprises of 10.3 WTE's, of which 3 are locums who have been employed for a number of years. The service operates 08:30am-5:30pm on Monday to Friday and 9:00am-5:00pm on a weekend. Weekend cover is predicated on staff volunteering, on a good will basis.

The occupational therapy team comprises 3 Occupational Therapists and 1 Rehab Support Worker. We were told that some of the occupational therapy service's main challenges are due to inappropriate referrals from primary care and an increase in activity due to the recent

rheumatology review. The morale within the team was extremely low. We were told that the team sits under a different service area and tends to work as a silo.

The therapy teams are regularly collecting EQ-5D index patient reported outcome measures (PROMS) data; however, the data is not currently being submitted to a national registry and therefore the team are unable to benchmark their outcomes against other providers. There are plans in place for JGH to join the NJR, which will enable the team to measure their clinical outcomes.

Recommendation 32: JGH should:

- **Identify those on government contracts and amend the contracts to enable paid working 7 days per week for the physio and occupational therapy teams. Currently weekend working is voluntary and relies on a good-will basis and a day off during the week is given in lieu to compensate.**
- **Undertake a review of the current workforce and identify gaps in rotas where there should be a permanent post to reduce reliance on long term locums.**
- **Review the management of referrals to physiotherapy; proper triage and better communication can help prevent unnecessary referrals.**
- **Work with the occupational therapy team to address the low morale and review where these teams should sit in the organisational structure.**
- **Carry out an annual audit of the PROMS data to identify unwarranted variation and areas for improvement.**

Recommendation 33: JGH should establish a full Multi-Disciplinary Team (MDT) for orthopaedic surgery which should include use of the dedicated orthopaedic physio resource through the full patient pathway. The MDT should also include Occupational Health resources at the appropriate time. All revisions must be discussed in the MDT.

The radiology service is available between 08:30am-5:30pm on Monday to Friday. The team provides urgent and emergency examinations outside these hours, and some MRI and ultrasound examinations in the evenings and at weekends. The on call out-of-hours service relies on staff volunteering to cover the service. We were told that there are recruitment challenges within the service and work has been carried out to recruit from overseas. Approximately 65% of the team are employed under a locum contract.

Cauda Equina Syndrome (CES) is a spinal surgical emergency which can lead to lower limb paralysis and loss of bowel, bladder and sexual function if not assessed and treated urgently. The GIRFT report showed that more than 20% of litigation claims for spinal surgery in England relate to CES. When acute CES is suspected, timely diagnosis is crucial, and there should be access to a 24/7 MRI imaging service in these cases. Once a MRI for suspected CES has been performed, it can be sent digitally to Southampton for their opinion.

We were told that there is a substantial amount of time spent waiting to see patients from other departments. Improving communication between the teams and better planning and preparation will reduce this waiting time and enhance the service.

We heard that the scanning equipment is old and the software on the MRI scanner requires updating as it is currently not possible to screen for prostate cancer.

Recommendation 34: JGH should:

- **Undertake a workforce review to determine the number of staff required to provide an efficient service. Further work needs to be done to reduce long term locums and to make substantive posts more attractive to staff;**

- **Consider expanding the skills of their radiographers to allow out-of-hours MRIs for patients presenting with suspected CES. This should be completed within 3-6months. Once a MRI for suspected CES has been performed it can be sent digitally to Southampton for their opinion.**
- **Improve communication and planning between teams to ensure effective use of time and resource;**
- **Undertake a review of current equipment and upgrade where necessary. We were told that the equipment is old and the software on MRI scanner requires updating as currently it is not possible to screen for prostate cancer.**

9. Procurement

The purchasing of medical equipment and supplies is devolved across various teams with a reliance on a self-serve function via JGH requisitioners for non-managed stock and a team of buyers within Five Oaks who manage the managed inventory stock (clinical and non-clinical) purchasing function. The Directorate is also supported by limited procurement expertise resource provided by the current Treasury and Exchequer Commercial Services function to undertake complex and high-risk procurement activity.

The annual budget for non-pay expenditure for HCS medical equipment and supplies is £8.6m. (The budget and respective spend does not include the purchase of HCS capital replacement equipment which is funded separately via the HCS Capital Equipment programme budget).

A strategy paper is in development that aims to improve the service and reduce expenditure by centralising the purchasing function to build resilience including investment in the development of existing HCS buyers and requisitioners who possess the knowledge and experience. Current activity is also focused around maximising the opportunities to purchase via platforms such as NHS Supply Chain. We fully support this initiative.

Recommendation 35: JGH should:

- **Work with the corporate procurement team to centralise the purchasing function and reduce the expenditure on medical supplies.**
- **Continue price benchmarking exercise, comparing data against that of NHS Supply Chain and England Trusts.**
- **Carry out regular stock takes of inventory, including regular checking for expiration dates on implant fixtures.**

10. Litigation Claims

Figure 6 shows the number of orthopaedic litigation claims and the costs associated with the claims for publicly funded patients.

Figure 6

Year	Number of orthopaedic claims	Cost of Orthopaedic Claims
2021	8	£180,000
2022	11	£400,000
2023	5	£20,000

*This is not a complete reflection of orthopaedic claims as this data does not include private patient claims.

Recommendation 36: JGH should undertake an annual review of 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. The meetings should be led by senior clinicians and attended by clinical staff and junior doctors (e.g. clinical governance or multidisciplinary meetings), with

support from trust legal teams. 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.

Annex A - Orthopaedic Action Plan

Metric	Meeting Outputs	Actions / Recommendations
Fixation method for elective hip replacements (%) – Patients 70+ years	High usage of uncemented hip fixations being used 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 endorsed by the BOA.
Elective joint procedure for adults (cases)	Primary hip replacement – 160 Revisional hip replacement – 14 Primary knee replacement – 77 Revisional knee replacement – 6 Primary shoulder replacement – 8 Revisional shoulder replacement – 0 Ankle procedures are referred to Southampton.	Annual peer review of the NJR data to be carried out at subspecialty level with all consultants present and documenting of this should be integral to the continuation of Consultant Practicing Privileges. All revisions and primary, elbow and ankle replacement cases to be discussed in appropriate MDTs prior to surgical intervention.
Elective joint replacement length of stay (days)	Primary hip replacement – 3.2 Revisional hip replacement – 6.6 Primary knee replacement – 3.1 Revisional knee replacement – 3.7 Primary shoulder replacement – 5.5	Review shoulder replacement length of stay data, this could be coding issue. Consider whether hip and knee replacement day case surgery could be more broadly used for some patient groups.
Primary hip - return in one year	High primary hip return to theatre rates approx. 5-6%.	Undertake review of all orthopaedic readmission surgery data to identify themes, understand outcomes and establish an improvement strategy. This to be audited on an annual basis,
Primary hip - 1-year revision rate	Slightly high 1-year primary hip revision rates.	Undertake review of primary hip revision surgery data to identify themes, understand outcomes and establish an improvement strategy.
Primary hip - 2-year revision rate	Good 2-year primary hip revision rates.	
Primary knee - length of stay (days)	Good length of stay for primary knee procedures, better than the England average.	

Primary knee - return in one year	Good primary knee return to theatre rates, better than the England average.	
Primary knee - 1-year revision rate	Good primary knee 1-year revision rates, in line with the England average.	
Primary knee - 2-year revision rate	Good primary knee 2-year revision rates, in line with the England average.	
Primary knee - arthroscopy in previous year	Good primary knee - arthroscopy in previous year rates.	
Primary shoulder - length of stay (in days)	Outlier in terms of high primary shoulder length of stay rates.	Undertake review of primary shoulder length of stay data. There is a small volume of primary shoulder activity recorded, it may skew the data if one patient has a longer length of stay.
Primary shoulder - return in one year	Outlier in terms of high primary shoulder return to theatre in 1-year rates (approx. 17%).	Undertake review of primary shoulder return to theatre rates to identify themes, understand outcomes and establish an improvement strategy.
Average length of stay (days) for repair of emergency fracture neck of femur for years 74 and under	Excellent length of stay rates for repair of emergency fracture neck of femur for years 74 and under, 10 days. England average is 17days.	
Average length of stay (days) for repair of emergency fracture neck of femur for years 75 and older	High length of stays rates for repair of emergency fracture neck of femur for years 75 and older. We were told that there are delays with discharging the trauma patients because the community package of care is not available.	Undertake a review of length of stays rates for repair of emergency fracture neck of femur for years 75 and older to identify themes, understand outcomes and establish an improvement strategy. By implementing the RNOH/GIRFT recommendation of extending therapy services to 7-days and mobilising the patient faster will support in reducing the length of stay for these patients.
Number of orthopaedic procedures carried out by each surgeon	The data identified a variance in procedure volumes and several surgeons doing 5 procedures or less per annum within the totality of their practice.	Undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering less than 10 hip and knee revisions

	We were told that the middle grade doctor lists were reduced and lists were given to specialist grade doctors that would perform the surgery quicker. This has had a negative impact on staff morale and deskilling middle grade doctors. The national guidelines for totality of practice in certain procedures recommend the following: • Unicompartmental Knee Replacement: no less than 12 procedures a year per consultant (referenced by the NJR as best practice). • Ankle replacements: a minimum of 10 a year (BOFAS).	over three years 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.