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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Report of the Auditor General for Wales

March 2023

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

Context

1 Orthopaedics is the branch of surgery that relates to musculoskeletal conditions. Common surgical procedures include hip and knee joint replacement, and diagnostic intervention such as arthroscopy. Orthopaedic surgeons tend to sub-specialise focussing on areas such as major joints, or foot and ankle, shoulder, or wrist.

2 NHS Wales orthopaedic spend had grown year on year to 2019-20 peaking at nearly £396 million. The pandemic saw reduction in activity and spend the following year. But even with the increases in spend pre-pandemic, the size of orthopaedic waiting lists was one of the biggest challenges facing the NHS in Wales. This challenging pre-pandemic position has further deteriorated because of the impact of COVID-19 on planned care activity. In November 2022, of the 748,271 people on the NHS waiting list in Wales, 101,014 were waiting for orthopaedic services.

3 At the time the UK went into lockdown in March 2020, we were concluding our work to follow up progress against our 2015 reports on waiting times for elective care and orthopaedic services. Across both reviews we had found the same story: many patients still face long waiting times. Some progress has been made in specific areas, but we had not seen the sorts of whole system change that is needed to make the planned care system sustainable.

4 In September 2020, we published a report setting out Ten Opportunities for Resetting and Restarting the NHS Planned Care System. We then prepared a broader commentary on Tackling the Planned Care Backlog in May 2022.

5 This report provides a commentary on orthopaedic services. It describes the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the recent nationally coordinated work to modernise services. The report also sets out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services. In some instances, we use long term trends to help illustrate change over time.

Key messages

A note on patients and pathways

Throughout this report we talk about patients waiting for treatment. Our figures are based on NHS Wales's 'open' referral to treatment measure. The measure counts the number of pathways which have started but not yet completed treatment, rather than people. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once. As a result, the total number of people waiting for treatment will be lower than the total number of pathways.

6 Meeting demand for planned orthopaedic services has been a significant challenge for the NHS in Wales over the last 20 years. The impact of COVID-19 has elongated what was already a lengthy waiting list, such that patients are now facing exceptionally long waits to be seen and treated. For many people this means living in pain and discomfort, with a life-limiting condition.

7 Proportionately, there are more than twice as many people waiting in Wales for orthopaedic services as there are in England. In fact, proportionately, there are more people waiting over 36 weeks in Wales than are waiting in England in total[1]. Month on month, the orthopaedic waiting list has been increasing, peaking with 102,699 patients on the waiting list in September 2022. Referral rates dropped during the pandemic, and we estimate that there are around 135,000 potentially 'missing' referrals that could come back into the system, putting further pressure on the waiting list.

1 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022. Direct comparisons are not available with Northern Ireland and Scotland due to differences in the way in which waiting lists are reported.

8 Services have been slow to restart as the immediate impact of the pandemic has lessened, operating on average at around 60% of pre-pandemic activity levels. There is unexplained variation of orthopaedic waits across Wales depending on where you live and the type of procedure you are having. Necessary infection control regimes will continue to have an impact on patient throughput in settings such as operating theatres, but there is scope for current capacity to be used more efficiently by making appropriate use of day case procedures and looking to safely reduce lengths of stay.

9 In the past, the Welsh Government has allocated temporary additional monies to health boards to try and fill the gap between capacity and demand. Whilst this resulted in short term improvements, it did not achieve the sustainable changes to services that were necessary and referral to treatment time waiting list targets[2] for orthopaedics have never been met since the targets were first established in 2009. There needs to be a realistic assessment of capacity. Funding for orthopaedic services has not reflected growing demand and with a predicted 27% growth in over 75s between now and 2030, services need to be sustainably designed to meet that need.

10 We have repeated the wider modelling exercise presented in our Tackling the Planned Care Backlog report in May 2022 for orthopaedic services in order to estimate how long it will take to recover these services. Our optimistic scenario modelling suggests that it could take three years to return orthopaedic waits to pre-pandemic levels. This is based on both a significant drive on community-based prevention, which has shown to have a positive impact on demand, and a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels, noting that current activity is below pre-pandemic levels. Our more realistic scenario indicates that it could be nearer to five years, and our pessimistic scenario indicates that services may never return to pre-pandemic waiting list levels. The scenarios highlight the scale of the challenge facing orthopaedic services in respect of managing demand and building additional capacity.

11 There is some hope, however. NHS Wales has commissioned an in-depth review of orthopaedic services with the Getting It Right First Time team[3] outlining numerous service efficiency, effectiveness, and productivity improvements for acute orthopaedic services. They set out a comprehensive suite of recommendations in their national report and have also provided reports and recommendations to each of the health boards in Wales. Their work sets out the immediacy and urgency needed.

2 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks.

3 Getting It Right First Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

12 Aligned to this, the Welsh Government commissioned the Welsh National Orthopaedic Society to prepare a National Clinical Strategy for Orthopaedics. This thorough and honest appraisal of the current position and service options for the future sets out in the strongest terms the perilous state of services and gives a clear clinical voice on what needs to be done. It will require brave and bold leadership at a ministerial level all the way through to operational and clinical leaders in hospitals to deliver it.

13 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

14 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively, including primary, community and diagnostic services. New technology and improved estate need to be prioritised and health boards must work together to develop regional solutions to help tackle the backlog. In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

Securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with COVID-19 making this significantly worse. It is positive to see that there is a clear commitment to improve orthopaedic services, but urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

Adrian Crompton
Auditor General for Wales

Key facts[4]

37% of people waiting **over 12 months** for orthopaedic treatment[5]

101,014 Total number of people on an orthopaedic waiting list

60% of people waiting **over 26 weeks** for orthopaedic treatment

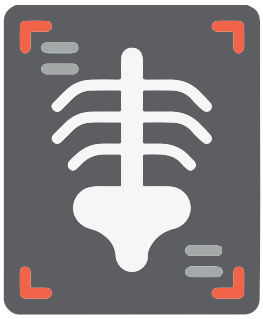
The number of people waiting for orthopaedics accounts for 1/7th of the total NHS waiting list

£395.8m Annual musculoskeletal spend at its peak in 2019-20[6]

£37.2m Annual primary and community musculoskeletal spend in 2020-21[7]

14,639 Number of people waiting more than **two years** (105 weeks) or more for orthopaedic treatment

12,500 Average number of referrals for orthopaedics during 2021-22



10% of people waiting **two years or more** in the Cardiff and Vale area

compared to

23% of people waiting **two years or more** in the Swansea Bay area

13% variation in the percentage of people waiting **two years or more** across health board areas

29-fold increase in the number of people waiting **over 14 weeks** for physiotherapy between March 2020 to November 2022

56% increase in total numbers waiting for orthopaedics from March 2020 to November 2022

4 Data as of November 2022 unless otherwise stated. Data is all-Wales.

5 Welsh Government data used is over 53-week data. The true 12-month position will be marginally higher.

6 The following year (2020-21) spend decreased to £308.2 million. The reduction in expenditure is a direct consequence of reduction in orthopaedic activity during the pandemic. Source: Stats Wales NHS Programme Budget for Musculoskeletal system problems (excluding Trauma)

7 Primary and community musculoskeletal spend forms part of the total annual musculoskeletal spend.

Recommendations

15 The box below sets out recommendations that we think are needed to strengthen the delivery of orthopaedic services. These recommendations are meant to complement those already made in the Getting It Right First Time reports and the new National Clinical Orthopaedics Strategy.

Recommendations

For the Welsh Government

R1 Actions previously taken to tackle orthopaedic performance have had a short-term focus, not delivered sustainable services, and lacked 'buy-in' from local clinical teams. The new national clinical strategy for orthopaedics sets out clinical solutions to deliver sustainable services. We recommend that the Welsh Government now needs to:

- a prepare a clear national delivery plan which sets out the priority actions to be taken over the next three to five years to achieve the clinical strategy. The plan needs to include key deliverables and milestones, and clearly defined roles and responsibilities at a local and national level.
- b ensure that the national delivery plan includes a clear direction for regional models to recognise the opportunities that exist to maximise available capacity and provide centres of excellence that deliver better outcomes.
- c ensure that the national delivery plan encompasses the wider service input needed to deliver effective orthopaedic services. This should include but not be limited to primary and community care capacity, diagnostic capacity, capital and estates, and digital services.
- d ensure that the national delivery plan is reflected in NHS planning guidance and health boards are held to account for implementation through routine performance management arrangements.

Recommendations

R2 The Getting It Right First Time reports at a national and health board level set out clearly a range of recommendations which will help drive improvements in the hospital element of the orthopaedic pathway across Wales, but many of the areas of focus are not new. We recommend that the Welsh Government needs to:

- a ensure mechanisms are in place to obtain assurance from health boards that the Getting It Right First Time recommendations are being implemented.
- b place a significant and constant focus on improving efficiencies and productivity in orthopaedics through its challenge and scrutiny of health boards. This needs to be supported by regular benchmark reporting, and an agreed set of orthopaedic procedures that have been shown to have limited clinical value.

For Health Boards

R3 The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to:

- a ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and
- b ensure that clear action plans are in place to address the things that get in the way of improvement.

Recommendations

R4 Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to:

- a ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and
- b ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.

R5 There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:

- a ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level;
- b ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and
- c put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.

What is the scale of the challenge?

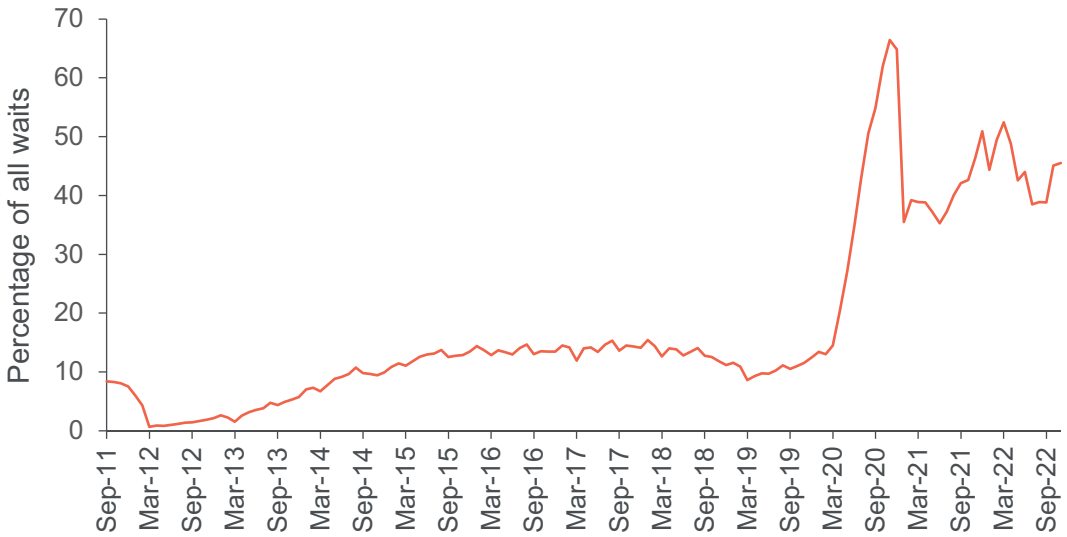
01

Orthopaedic waits have dramatically deteriorated from an already poor position prior to the pandemic

16 Orthopaedic services have not been in a position where they have been able to see and treat people within target timescales since well before the onset of the pandemic. National data show a long-term trend in deteriorating performance against waiting time targets. Since 2011, the national targets of 95% of patients waiting no more than 26 weeks from referral to treatment, and no one waiting over 36 weeks have never been met. At its best, in 2012, 88% of orthopaedic patients were waiting no more than 26 weeks, and 11% waiting over 36 weeks across Wales[8].

17 Immediately before the pandemic, in March 2020, 14% of patients were waiting over 36 weeks. But the pandemic has made a bad position worse. The latest (November 2022) data shows that for those waiting to receive orthopaedic treatment, 46% were waiting over 36 weeks (**Exhibit 2**). This position peaked at 66% in November 2020.

Exhibit 2: Percentage of patients waiting over 36 weeks for orthopaedic treatment by month across Wales, September 2011 – November 2022

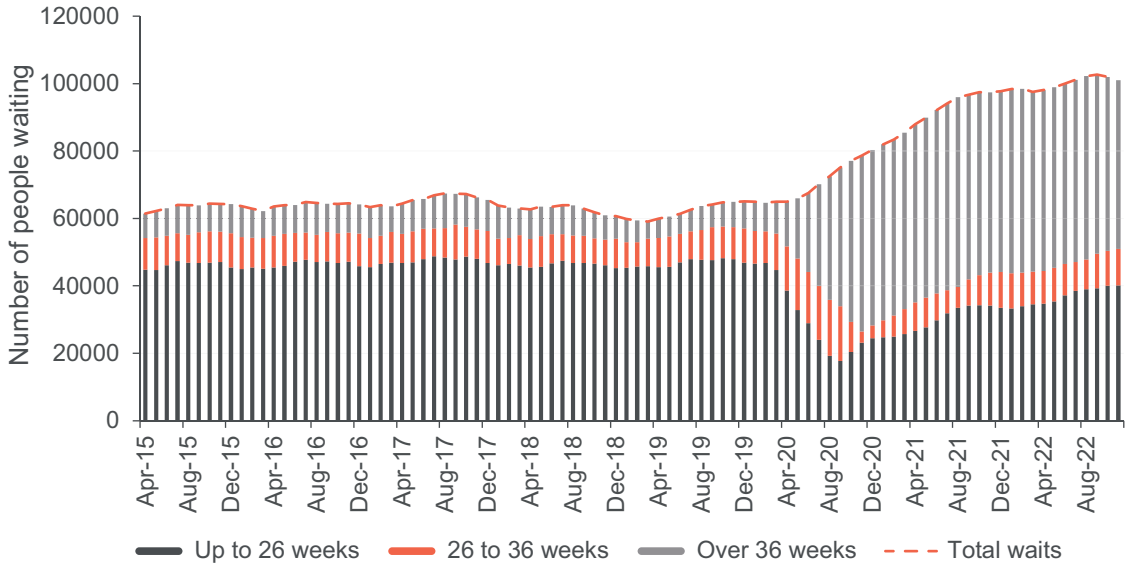


Source: Audit Wales analysis of StatsWales data

8 Data source: Stats Wales, Referral to treatment open pathway data for Trauma and Orthopaedics

18 In March 2020, there were 64,942 people on the orthopaedic waiting list. By September 2022, this had increased to 102,699 people (**Exhibit 3**). This position had slightly improved to 101,014 patients in November 2022. Of those, 50,024 (45.5%) have been waiting more than 36 weeks. More concerning is that of those waiting more than 36 weeks, 37,396 have been waiting over 12 months, and 14,639 have been waiting two years or more.

Exhibit 3: Number of patients waiting for orthopaedic treatment across Wales, April 2015 – November 2022



Source: Audit Wales analysis of StatsWales data

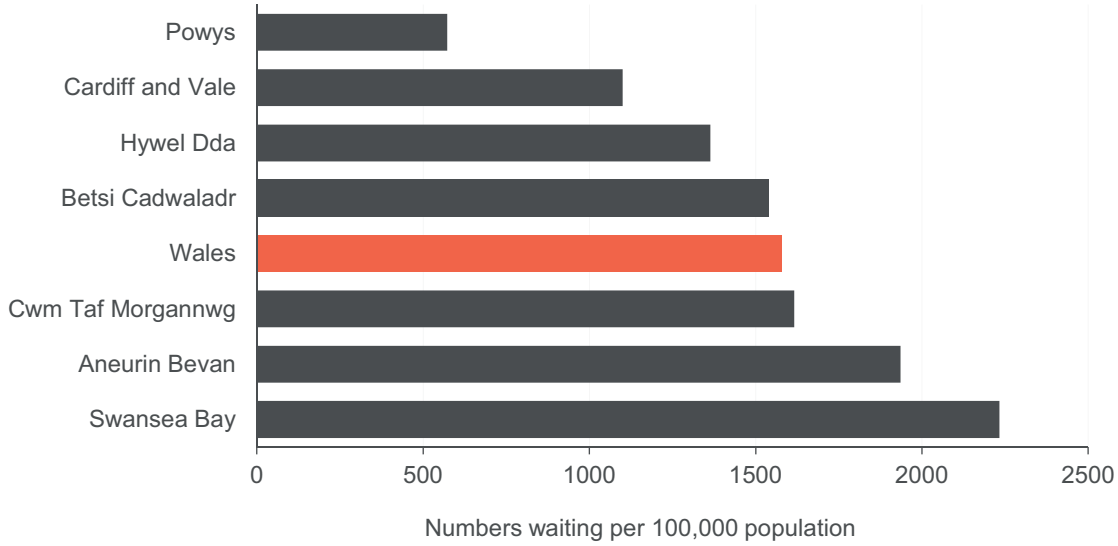
19 To give a broader perspective of the extent of the challenge, in March 2022, 1.3% of the population in England were on an orthopaedic waiting list. In Wales, 3% of the population were on an orthopaedic waiting list[9]. In November 2022 proportionately, there were more people waiting for orthopaedic treatment in Wales over 36 weeks (1.6% of the population) than there were waiting in total in England. These figures do however not take account for the health and age of the respective populations, with the Welsh population generally older and sicker than those in England.

9 Statement by the British Orthopaedic Association, on England and Wales Trauma & Orthopaedics Waiting Times Data for March 2022

The extent of the orthopaedic waiting list shows significant geographical variation across Wales

20 A comparison across health board areas of the total numbers of patients waiting over 36 weeks per 100,000 population shows some stark geographical variations (**Exhibit 4**).

Exhibit 4: Number of patients waiting over 36 weeks for orthopaedic treatment per 100,000 population, by Health Board of residence (November 2022)



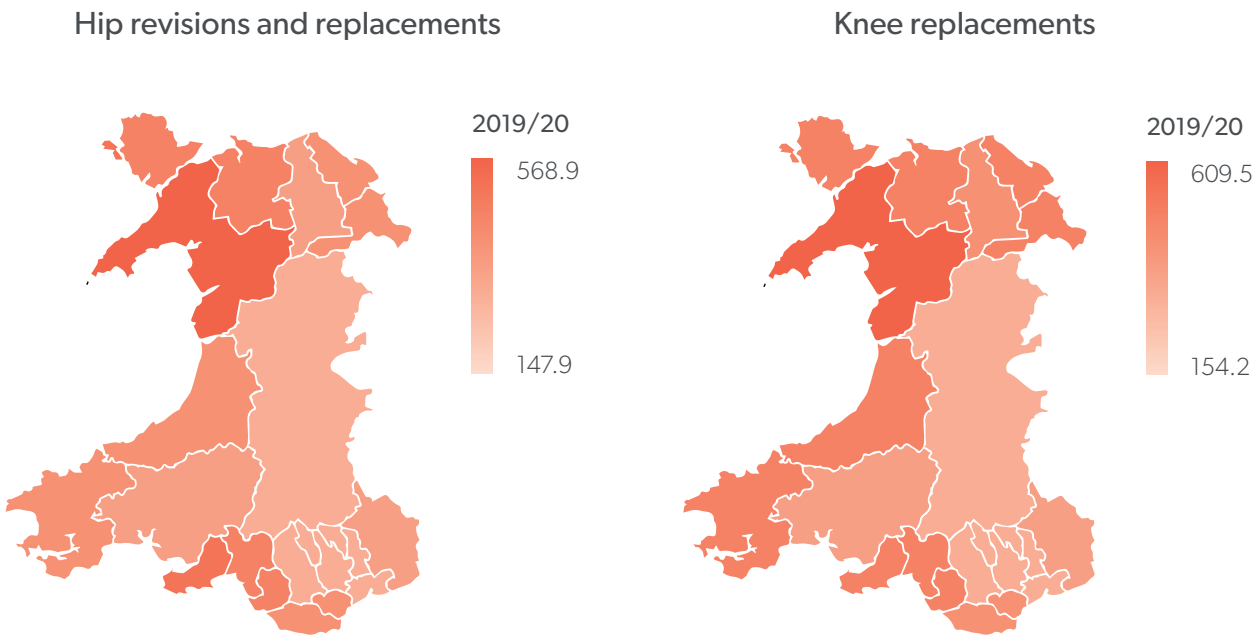
Source: Audit Wales analysis of StatsWales data

21 This geographical variation is equally as noticeable when considering specific orthopaedic procedures such as hip or knee replacement surgery. **Exhibit 5** shows average waits in Wales for hip replacement in 2019-20[10] varied from around 148 days for Powys residents[11] to almost 567 days for Gwynedd residents. A similar, though slightly worse position is observed for patients receiving knee replacement procedures with waits varying from 154 days for Powys residents to almost 610 days for Isle of Anglesey residents in 2019-20.

10 2020-21 procedure level wait data is currently incomplete. We have therefore used the most recent pre-pandemic dataset.

11 Note that some Powys residents will receive treatment from English providers where waiting times are shorter than in Wales.

Exhibit 5: Mean waiting times in days for hip revisions and replacements, and knee replacements for 2019-20, by local authority area



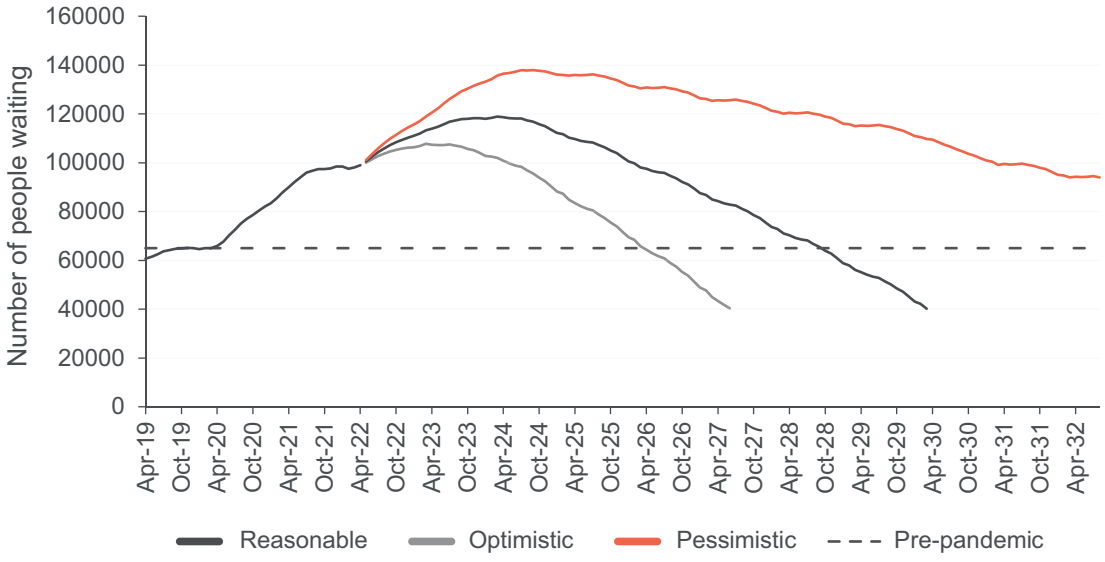
Source: Health Maps Wales, Common Procedure dataset

22 Health Boards are using all possible means to try to reduce the waiting lists. This includes outsourcing, where Health Boards are seeking third-party organisations to provide services on their behalf, such as private healthcare providers or NHS Trusts in England. Outsourcing provides a short-term solution, but this potentially could further widen inequalities of access to care. People living in deprived communities may not be able to travel further to receive their care and those with complex comorbidities may require their procedure in a hospital with intensive care facilities. This may mean those groups of patients face potentially longer waits for their treatment.

Without significant intervention, orthopaedic waits may never return to pre-pandemic levels

23 We have used national data to work out how long it could take NHS Wales to get orthopaedic waiting lists back to March 2020 levels[12]. We developed three illustrative scenarios: **reasonable**, **pessimistic**, and **optimistic**. The modelling (**Exhibit 6**) for our optimistic scenario suggests that the orthopaedic waiting list could peak in 2023 but return to pre-pandemic levels by 2026. The reasonable model would see waiting lists return to pre-pandemic levels by 2028, noting that pre-pandemic performance was itself not meeting Welsh Government targets. The pessimistic scenario may never see a return to pre-pandemic waiting list levels.

Exhibit 6: Illustrative scenarios of waiting list numbers for orthopaedic services across Wales



Source: Audit Wales analysis of StatsWales data

12 **Appendix 1** sets out how we modelled the scenarios.

24 The key variables in our modelling cover the rate at which patients are added to the orthopaedic waiting list over time, the rate at which patients are removed from the list, the potential growth in demand, and the extent to which potentially 'missing' referrals or latent demand returns (discussed later in this report). Our optimistic modelling is also based on assumptions around increasing current activity through increased capacity by 25% by 2025 and reducing the referral demand through prevention and early treatment (such as increased use of CMATS). Our modelling does not consider possible new or more complex demand because of changes in population health.

Long waits for treatment are affecting many people's physical and mental health

25 While orthopaedic and musculoskeletal problems are not, in themselves, life threatening, they can be debilitating and can significantly affect people's quality of life. Many patients waiting for treatment will be experiencing discomfort and pain daily which can lead to a loss in mobility and independence, which in turn can cause wider deterioration in physical and mental health. For some patients this can impact on their ability to work and for many patients there will be an increased need for ongoing support from GPs to help manage their condition. Prolonged waits for joint related problems can also result in further deterioration which could make the required surgery more problematic and potentially less effective.

26 In its submission to the Senedd's Health and Social Care Committee inquiry into the impact of the waiting list backlogs on people in Wales, the Board of Community Health Council's (CHCs)[13] highlighted that orthopaedic services were one of the most common services that the local CHCs were hearing about. In a report by the Swansea Bay Community Health Council on the lived experiences of people waiting for elective orthopaedic surgery, 92% of patients reported a deterioration in their condition. Nearly three-quarters agreed the length of time they had been waiting for surgery had affected their mental health and wellbeing.

13 Inquiry into the impact of the waiting times backlog on people who are waiting for diagnosis or treatment in Wales: Board of Community Health Councils

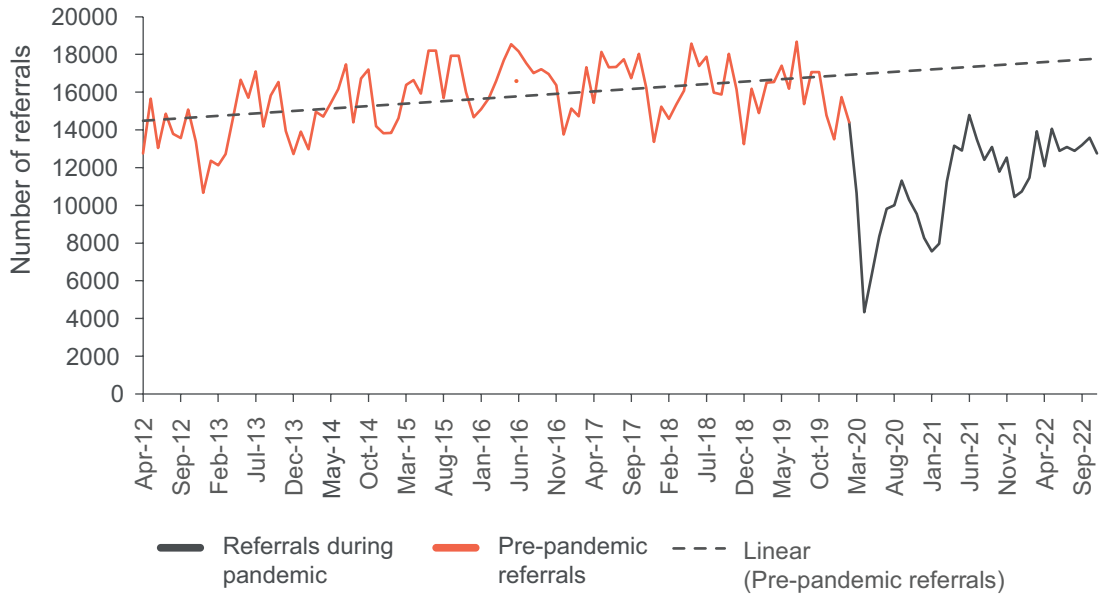
What is impacting the recovery of orthopaedic services?

02

Referral rates are not yet back to pre-pandemic levels

27 The change in the pattern of orthopaedic referrals during the pandemic is like that experienced across planned care services more generally, with a sharp decline in referrals at the onset of the pandemic[14] (**Exhibit 7**). Referrals have not yet returned to pre-pandemic levels. When comparing the level of referrals between March 2020 and March 2022, against 2019-20 referral levels, around 135,000 referrals are 'potentially missing'.

Exhibit 7: Number of orthopaedic referrals across Wales, April 2012 – November 2022



Source: Audit Wales analysis of StatsWales data

28 NHS Wales is currently benefitting from rates of orthopaedic referrals continuing to be lower than pre-pandemic levels. The waiting list position would otherwise be substantially worse. Some of the missing referrals or latent demand may never appear due to, for example, people choosing to seek private treatment, but it is expected that a proportion of the unmet demand will appear and further exacerbate the challenges being faced by orthopaedic services.

14 Note that referral patterns vary significantly by Health Board.

Although radiology and physiotherapy services are recovering, increased demand is adding to delays in orthopaedic pathways

29 Timeliness of orthopaedic treatment is dependent on the timeliness of each stage of the orthopaedic pathway[15] which will include other services such as radiology services and physiotherapy. Since the beginning of the pandemic, the total number of patients across Wales waiting for a consultant referred radiology test increased from 23,979 in March 2020 to 33,121 in November 2022. The total number of people across Wales waiting for a GP referred radiology test increased from 18,703 in March 2020 to 30,175 in November 2022.

30 Of particular interest to orthopaedic services are waits for diagnostic magnetic resonance imaging (MRI) and ultrasound scans. While the number of people waiting has increased, positively the number of people waiting less than the target wait of eight weeks is now at, or marginally better, than levels experienced pre-pandemic, suggesting good progress had been made to recover services. The number and proportion of people waiting over 14 weeks however has grown substantially across both diagnostic tests due to the increased demand (**Exhibit 8**).

15 A pathway is an agreed common approach for a course of care. For orthopaedic patients, this would typically include some or all the following: GP referral, first outpatient appointment, diagnostic test and/or therapy intervention, preoperative assessment, MRSA and COVID-19 screening, consenting, surgery and follow-up outpatient appointment.

Exhibit 8: Number and proportion of patients waiting over 14 weeks for diagnostic tests across Wales in March 2020 and November 2022

	March 2020		November 2022	
	Number	%	Number	%
MRI – Consultant referred	34	3.6%	1,344	10.4%
MRI – GP referred	1	0.04%	478	14.6%
Ultrasound Scan – Consultant referred	55	0.7%	2,361	19.5%
Ultrasound Scan – GP referred	18	0.1%	6,611	26.7%

Source: Audit Wales analysis of StatsWales data

31 Access to physiotherapy presents a similar but more concerning picture. The number of adults waiting for physiotherapy increased from 16,253 in March 2020 to over 32,269 in November 2022. Although more patients are now being seen by a physiotherapist within eight weeks compared to pre-pandemic levels, the number of patients waiting over 14 weeks for physiotherapy has increased 29-fold from 148 in March 2020 to 4,202 in November 2022. Numbers waiting however are gradually reducing. Long therapy waits will not only have an impact on the timeliness of orthopaedic pathways but can also undermine preventative efforts to reduce people's need for surgery.

Capacity and efficiency were already problematic prior to the pandemic, and a slow restart of orthopaedic services has exacerbated the backlog

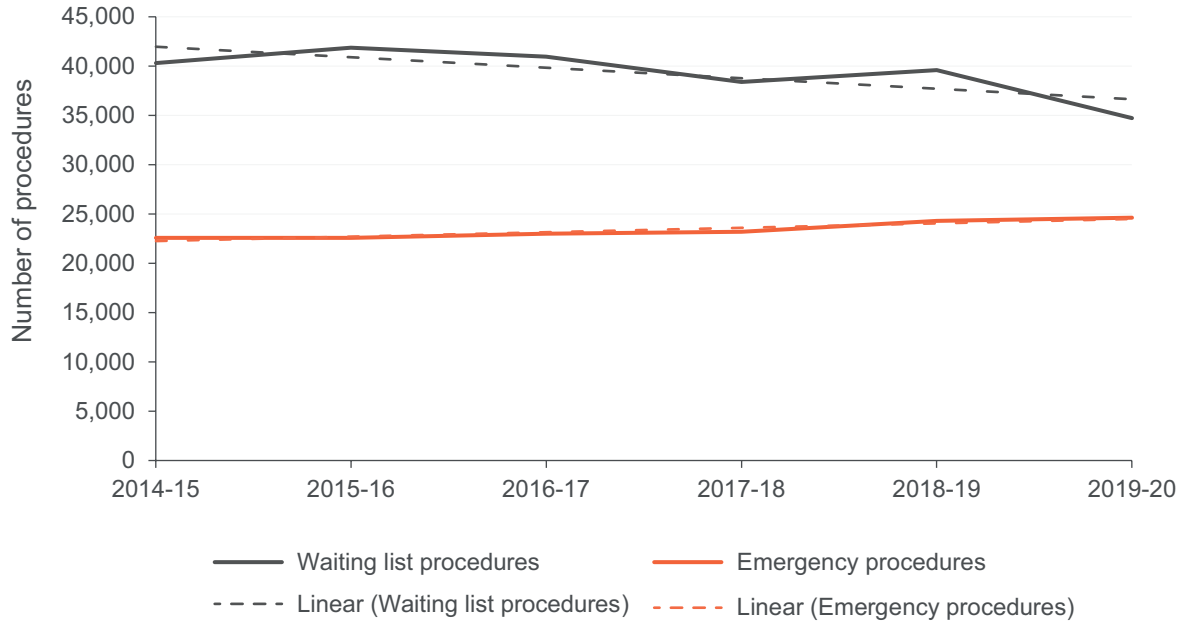
32 For several years there has been insufficient NHS orthopaedic capacity to meet demand. Prior to the pandemic, NHS Wales typically commissioned around 45,000 procedures for the Welsh population, with around 40,000 procedures provided though 'core' activity and waiting list initiatives[16]. The remainder was commissioned from other non-NHS Wales providers[17]. Outsourcing and waiting list initiatives have been short-term measures to improve waiting lists and provide capacity but had done nothing to ensure the sustainability of orthopaedic services.

16 Waiting list initiatives are used by NHS bodies to tackle waiting lists and meet national targets. They involve a short-term increase in capacity such as extra clinics at nights and at weekends, and the use of private healthcare provision.

17 Audit Wales analysis of Patient Episode Data Wales orthopaedic waiting list procedure data, NHS Wales provider versus total commissioned.

33 Over the six years leading up to the onset of the pandemic, the deployment of trauma and orthopaedic capacity changed. National data shows a 10% increase in emergency trauma activity between 2014-15 and 2019-20 which has placed pressure on capacity for planned care. For the same period, there was a 14% decrease in orthopaedic waiting list activity[18] (**Exhibit 9**). The shift between orthopaedic waiting list activity to trauma may not have been readily noticed over such a long period of time but will have had an impact on the capacity to tackle the already existing waiting list backlog. Changes to pension rules for NHS consultants have also impacted on waiting list activity due to a reduction in the willingness of consultants to take on waiting list initiatives.

Exhibit 9: Trend in emergency trauma and orthopaedic waiting list activity, based on the number of procedures, 2014-15 and 2019-20



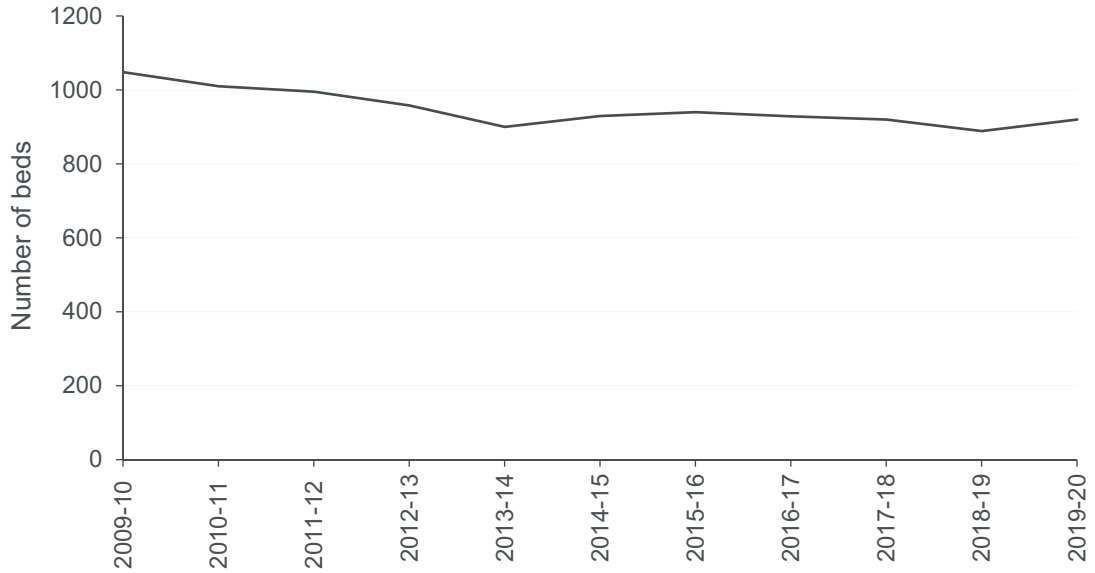
Source: Audit Wales analysis of Patient Episode Database for Wales

34 Capacity constraints also occurred because of a reduction of beds and wider urgent and emergency care pressures resulting in cancellations of orthopaedic activity. **Exhibit 10** shows the total number of orthopaedic beds declined by 12% from 1,048 in 2009-10 to 920 in 2019-20[19].

18 The numbers of waiting list procedures reduced disproportionately in 2019-20. We have assumed this is because of the onset of the pandemic.

19 2020-21 Bed data cannot be compared to previous years because it is based on a different source, definitions, and hospital types.

Exhibit 10: Trend in number of trauma and orthopaedic beds, 2009-10 to 2019-20



Source: Audit Wales analysis of StatsWales data

35 Bed capacity has also further reduced over the last two years with the continual need for health boards to respond to COVID-19 cases and retain infection control measures.

36 Orthopaedic services can operate models with fewer beds if the surgical element of the pathway is well planned, patients are prepared and educated, and processes enable effective and timely discharge. Enhanced recovery approaches also help to reduce length of stay. However, our data analysis indicates lengths of stay have not reduced for many years. Average combined trauma and orthopaedic lengths of stay have stayed at around seven days between 2014-15 and 2019-20[20], with substantial variability in lengths of stay by health board. Our data analysis also indicates around a 25% reduction in day case activity between 2014-15 and 2019-20.

20 Audit Wales analysis of Patient Episode Database for Wales

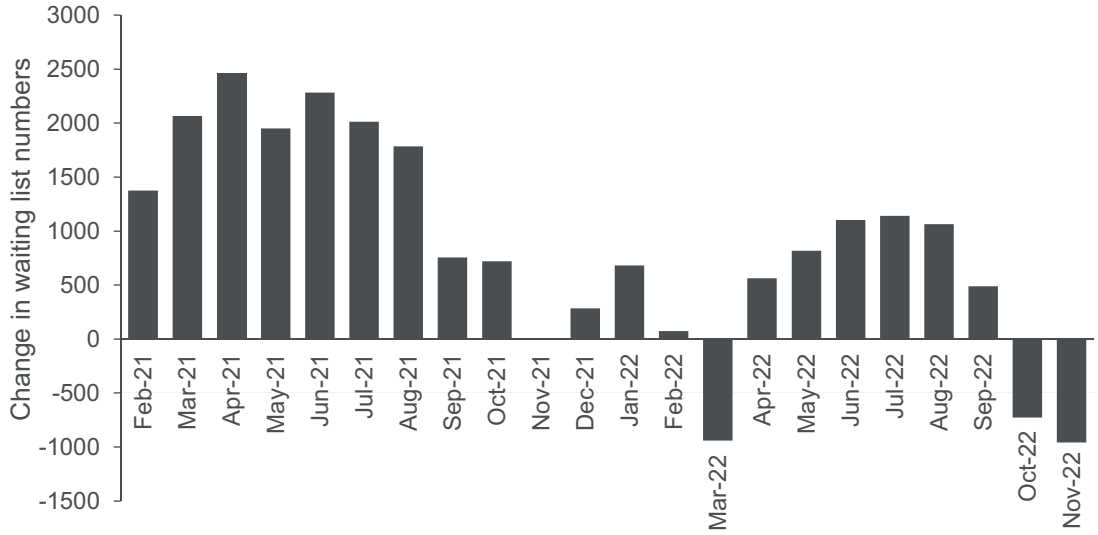
37 Orthopaedic services have been slow to restart since the lessening in the impact of the pandemic in 2021 and since the last major (omicron) COVID-19 wave in early 2022. Services are currently still far off the levels of activity seen prior to the pandemic. Current inpatient and day case orthopaedic activity across Wales is around 60% of pre-pandemic levels[21]. Most health boards are also only achieving around 20% to 30% of their orthopaedic procedures as day cases. NHS Wales is targeting around 60% in future. Day case (and very short stay) provides a significant opportunity for utilising existing capacity better.

38 Based on changes to waiting lists on a month-by-month basis, orthopaedic capacity is currently not meeting demand, resulting in monthly increases in the number of patients waiting (**Exhibit 11**). In 2021-22, the Welsh Government provided extra funding to health boards to buy additional short and medium-term capacity to support the recovery of planned care services, including orthopaedics. Historically NHS Wales would have looked to NHS England for additional capacity, but they too are struggling to recover their own waiting lists. Consequently, requests for additional capacity through private providers have been greater than the supply available and the ability of health boards to secure the additional capacity needed has been limited. This is particularly the case for orthopaedics. Some medium-term additional capacity has been secured using temporary expansions to health boards' existing clinical estate, such as using demountable units to create operating theatres.

39 Funding has also supported administrative and clinical validation of waiting lists to ensure that only those who need treatment are waiting. However, these have tended to be undertaken as one-off exercises to cleanse waiting lists at year end, resulting in a temporary reduction in waiting lists in March. Funding to support the ongoing recovery of planned care has continued and will be available to health bodies for a further three years.

21 Audit Wales analysis of Welsh Government, unvalidated orthopaedic statistics

Exhibit 11: Month-by-month change in waiting lists numbers across Wales, February 2021 – November 2022



Source: Audit Wales analysis of StatsWales data

Orthopaedic services have not kept up with demand and previous national funding initiatives have failed to secure sustainable service improvements

40 Basic analysis of trend data indicates that demand for orthopaedic services is growing. Furthermore, forecasts by the Office of National Statistics indicate a 27% growth of over 75-year-olds (from around 307,000 to 390,000) living in Wales between 2020 and 2032. While positive, this will likely drive further growth in demand for orthopaedic services as more people will be living with age-related orthopaedic and musculoskeletal conditions. This additional demand needs to be planned for and funded.

41 Given that orthopaedic waiting lists pre-COVID-19 were deteriorating, it is unrealistic to think that without significant changes, current capacity will ever result in sustainable service recovery. Indeed our 'optimistic' scenario modelling (**Exhibit 6**) is based on a gradual increase of commissioned orthopaedic capacity (whether provided by NHS Wales or externally commissioned) and/or productivity levels to 5% above pre-pandemic levels noting that services are currently only running at about 80% of pre-pandemic levels. Our model also assumes that services can curtail any growing demand.

42 There has been a history of short-term funded national initiatives for orthopaedic services in Wales. In June 2001, the then Minister for Health and Social Services announced a £12 million package to reduce orthopaedic waits to 36 weeks. Much of this was non-recurrent and consequently had limited ongoing impact. In 2005, the Welsh Government launched its orthopaedic plan for Wales. This initially brought down waits but again did not result in sustainable service improvements. In 2011, the national orthopaedic programme began its aim to eliminate over-36-week waits. At the same time, the then Minister for Health and Social Services announced £65 million over three years to make orthopaedics best in class. Our 2015 report[22] considered the £65 million investment. We reported that orthopaedic services have become more efficient in the past decade, but NHS Wales was not well placed to meet future demand. Whilst there had been a focus on securing immediate reductions in waiting times, less attention had been paid to developing more sustainable, long-term solutions to meet demand. Since then, NHS Wales has struggled to meet its orthopaedic waiting list targets.

43 Planning for elective orthopaedic services needs to have a clear focus on the short, medium, and longer term, and be supported by realistic assessments of capacity and demand. The short-term focus must be on speeding up recovery of services and addressing existing inefficiencies in the system, the medium-term on building sustainable service models which will start to tackle the backlog; whilst the longer- term view needs to take account of population demographics in forecasting future demand on services, and what is needed to meet that demand.

44 While NHS Wales needs to focus on getting services back up and running to meet the demands being placed on them, there is also a duty on health boards to be maintaining a focus on keeping people safe while they are waiting for treatment. Lack of communication from health boards whilst waiting was identified as an issue in the CHC reports. Very few health boards have put arrangements in place to monitor patients on waiting lists and provide the contact needed to reassure patients and provide advice and support as necessary.

22 Audit Wales Review of Orthopaedic Services, 2015

What action is being taken?

03

Community-based prevention and treatment are having a positive impact on reducing demand, but capacity is an issue

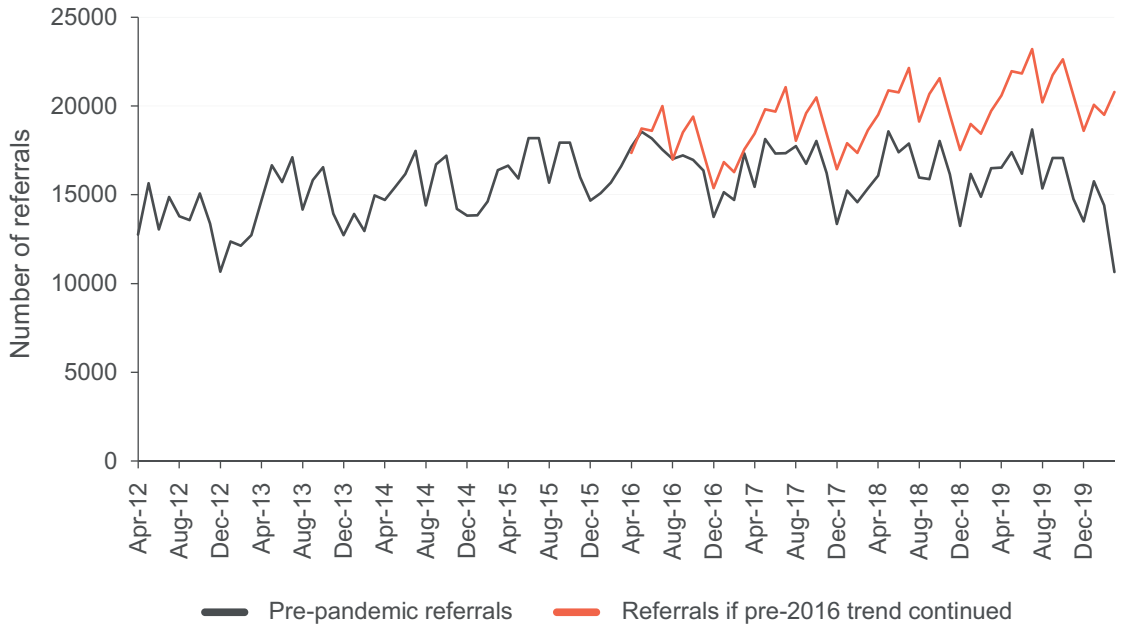
45 For several years, the Welsh Orthopaedic Board has helped to influence developments in orthopaedic services. The Board has overseen the rolling out of preventative approaches such as Community Musculoskeletal Assessment and Treatment Services (CMATS)[23], and more recently First Contact Practitioners (FCPs)[24]. While community-based musculoskeletal services began far earlier in some health boards, for most they started to be rolled out more comprehensively from 2016.

46 While it is difficult to attribute cause and effect directly to the achievements of the community-based prevention, national data suggests that efforts between 2016 and 2020 helped stem the growth in referrals. **Exhibit 12** shows referral trends, and a change in the referral trajectory had community-based prevention not been in place. We have applied a forecast trendline to highlight how the referrals may have increased if the pattern of demand seen between 2012-2016 continued into 2016-2020. With an aging population over this time, we would have expected to see a continued growth in referrals. But this has not been the case.

23 CMATS were developed to provide a community-based service for the assessment and treatment of musculoskeletal-related pain and conditions.

24 First contact practitioner is a new model evolving across the UK which involves placing physiotherapists directly into GP practices to see and treat patients who come into the practice with musculoskeletal problems.

Exhibit 12: Actual orthopaedic referrals compared with predicted referrals from 2016 onwards had community-based schemes not been in place, April 2012- December 2019



Source: Audit Wales analysis of StatsWales data

47 But capacity for CMATS has been an issue. Although waits for CMATS are not included as part of the standard waiting times, our recent work on orthopaedic services identified that CMATS waits could be up to four months. All referrals for orthopaedic services are made via CMATS, and only at the point in which is it considered that CMATS intervention is not appropriate, are referrals passed on to orthopaedic services. For many patients, this will be at the point the referral is triaged by the CMATS which can typically take up to a week. But for some, onward referral to orthopaedic services may not happen until they have waited and been seen by the CMATS.

48 Our recent work also identified inconsistencies in the CMATS model across Wales, with differences in the range of multidisciplinary professionals that make up the team, and differences in the ability for CMATS to refer directly for diagnostic tests. We also found potential duplication of effort between CMATS which include physiotherapists and FCPs and a risk that overall waits for treatment are elongated because of the need to access both FCPs and CMATS before onward referral to orthopaedic services.

49 One scheme to support people is the National Exercise Referral Scheme (NERS). Funded by the Welsh Government and run by the 22 local authorities, the scheme provides opportunities for people with long term conditions to make and maintain healthier lifestyle choices. This is provided through physical activity and behaviour change with the aim to improve health and wellbeing. One intervention is focused on low back pain[25], with another focused on weight management. Although numbers are small, the shift to virtual working in response to the pandemic has provided an opportunity to increase capacity and support people on waiting lists. In its latest report[26], over 25,000 participants attended one of the virtual, outdoor, or indoor activities put in place to support the wider NERS programme. However, due to the pandemic, the NERS was unable to take new referrals. This has now been changed, but services are heavily reliant on the short-term funding available from the Welsh Government and the support of local authority facilities such as leisure centres to run activities.

There is a clear commitment to improve and transform orthopaedic services nationally, although this may take time to achieve

50 Service efficiency, clinical productivity and effectiveness of hospital based orthopaedic services has been an aim in Wales for a long time. NHS Wales has developed clinical pathways based on best practice. But in the past, these clinical pathways have not always been well implemented and there continues to be variation in approaches across health boards.

25 NERS Low Back Pain Intervention

26 All Wales NERS Infographic Quarter Two, 2021-22

51 More recently NHS Wales has commissioned the Getting It Right First Time (GIRFT) team to review acute orthopaedic services. The reviews started in early 2022 and covered all seven health boards and 21 hospital sites that provide orthopaedic services in Wales, comparing clinical practice with England. Recommendations to health boards focussed on:

- strengthening leadership, through health board specific orthopaedic steering groups;
- reducing unwarranted and inappropriate variation in clinical practice, performance, and efficiency;
- engaging staff in change and improvements to orthopaedics and understanding the drivers that are affecting morale;
- implementing waiting list recovery at pace;
- better arrangements to support patients prior to admission, and better discharge planning;
- improving the consistency of collection and use of patient reported outcome measures;
- improving surgical site infection data recording and reducing deep infection rates to 0.5% or lower;
- creating short, medium, and long-term multi-disciplinary workforce plans; and
- building elective orthopaedic recovery plans, including capacity and demand planning on a health board and broader regional footing, multi-disciplinary workforce planning, ring-fencing elective capacity and boosting short-term theatre capacity.

52 The GIRFT team's national report to the Welsh Government includes 28 recommendations spanning but not limited to leadership, safety, workforce, efficiency and clinical practice. The recommendations from both the national and local reports need implementing swiftly and effectively.

53 At the same time as the GIRFT work, the Welsh Government, through the Welsh Orthopaedic Board, commissioned the Welsh Orthopaedic Society to prepare a clinical strategy for Wales. This strategy provides a thorough and honest appraisal of the current position of orthopaedic services. It sets out the need for new leadership through a Welsh Orthopaedic Network and a requirement for the development of orthopaedic hub sites to better protect waiting list activity from unscheduled care pressures, and to enable efficient high volume low complexity centres of excellence.

54 Regional treatment centre hubs offer a good solution to provide protected orthopaedic capacity and deliver best in class levels of efficiency in the medium and longer term. But these will take time, investment, and cooperation across health boards to implement. As an immediate action, some health boards are creating additional operating theatre capacity in the short term, as mentioned in **paragraph 38**.

What else needs to be done?

04

Several challenges need to be addressed if services are not just going to tackle the orthopaedic backlog, but be sustainable for the future

55 This report sets out the huge scale of challenge that is faced in Wales. The extent of the numbers of patients waiting, limited capacity available and potential for further growth in demand provide a concerning landscape not just in the short term but also the medium term. All that can be done must be done within the current operating environment, but there remain several risks to longer-term improvement.

56 From our discussions, the Welsh Government and NHS Wales recognise the scale of the challenge, but lessons must be learnt from previous initiatives. The national strategy developed by the Welsh Orthopaedics Board must be accompanied by buy-in from local clinical teams to ensure that changes are embedded and sustained.

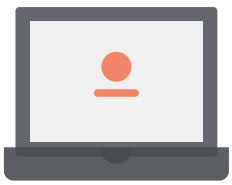
57 A renewed focus on driving efficiencies is needed to maximise already stretched resources but this cannot be done in isolation. A whole system focus is needed to ensure that other services that support the orthopaedic pathway are also working effectively. New technology and improved estate need to be prioritised and regional solutions need to be much more at the core of delivery plans.

58 In the context of many patients having to wait a very long time for their treatment, information on experience and outcomes also needs to be at the heart of decision making.

59 These key actions are explored further in the exhibit below.

Exhibit 13: Key actions for NHS Wales to tackle the challenges in orthopaedic services

Lessons must be learnt from previous initiatives which have failed to secure service transformation 	Together the new clinical strategy and the GIRFT reports provide the most comprehensive assessment on the position of orthopaedic services in Wales. It is positive that the Welsh Government and NHS Wales are recognising the scale of the challenge. But the response to these cannot be the same as we have seen in response to previous orthopaedics plans; fundamental embedded change is needed.
National plans must be accompanied by buy-in from local clinical teams 	Our recent work in orthopaedics, whilst recognising good intent from the Welsh Orthopaedics Board to improve and transform services, highlighted the variability in which that intent translated into practice across health boards. Where national directives to implement service changes have been set in the past, implementation has often been slow, inconsistent, and without the 'buy-in' of local clinical teams. The strategy needs to be underpinned by clear and defined programmes of activity and bold leadership will be needed at all levels to ensure that the new clinical strategy delivers a consistent service across Wales.

A renewed focus on efficiencies is needed 	The GIRFT reports have a clear focus on improving efficiency and productivity in orthopaedics, and ultimately delivering better outcomes for the people of Wales. But this focus is not new. NHS Wales has been focusing on reducing length of stay, improving theatre productivity, reducing follow-up rates, and minimising cancellations for some time, but inefficiencies still exist. There needs to be a significant and constant focus in this area. Regular benchmarking reporting needs to be in place to enable challenge and scrutiny to happen locally and nationally, supported by clear action plans to address the things that get in the way of improvement.
A whole system and wider patient pathway focus is needed 	The GIRFT reports and clinical strategy quite rightly focus on orthopaedic services, but effective delivery is reliant on wider services across the NHS. Capacity of enabling clinical services such as diagnostics and therapies to support timely diagnosis, prevention and treatment in the community and effective discharge needs to be available.
Investment in new technologies and improved estate needs to be prioritised 	Digital solutions offer further opportunities for efficiencies but need to be effectively piloted and evaluated to ensure wider investment delivers value. Capital and revenue investment needs to be carefully prioritised to get most impact, considering where opportunities exist to make better use of digital initiatives and estate development.

Regional solutions to meet current and future demand need to be pursued with much more rigour	Developing regional service models has been notoriously difficult in the past but regional working provides opportunity to maximise available capacity and provide centres of excellence that deliver better outcomes. Some health boards are starting to work together to look at regional solutions, but these are limited and often as a reactive response to short-term capacity issues. Regional models need to be at the core of orthopaedic delivery plans, and not around the margins with small scale low impact initiatives, which has been the case previously.
Information on patient experience and outcomes must be used extensively to shape clinical decisions and advice to patients	A greater focus needs to be given to patient experience and outcomes. The roll out of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) for orthopaedic services is still variable across Wales. These have been an ambition for a long time but are not well used to inform future investment and more importantly dis-investment and value-based decisions. At a patient level, outcomes should inform choice and 'what matters' discussions. More also needs to be done to support consistent clinical decision making. For example, establishing a common list of procedures not normally undertaken and setting criteria such as BMI thresholds, if surgery for some patient groups would not result in positive outcomes. Our earlier audit work found health boards were working to different lists of procedures considered ineffective.

Appendices

1 Our approach

Our approach

The evidence base for our work comes from reviews of documents on orthopaedic and musculoskeletal services, data analysis, observation of the Welsh Orthopaedic Board and more recently the Orthopaedic Summit in August 2022, and interviews with Welsh Government and NHS officials. We also build on evidence captured prior to the pandemic from health boards.

Our data analysis is based on Welsh Government data on StatsWales, Health Maps Wales, Patient Episode Dataset Wales, and bespoke data requests to NHS officials.

Our scenario modelling in **Exhibit 6** draws on some initial modelling work carried out by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- removals are calculated by taking the number of patients waiting over four weeks (ie they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- additions are the people reported in the monthly figures who have been waiting less than four weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 6**). We accounted for the possible pent-up demand (see **paragraph 26**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario, with the optimistic scenario assuming that no pent-up demand returns. **Exhibit 14** sets out our modelling assumptions.

Exhibit 14: Waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90.0%	85.0%
Annual increase in additions 2025 onwards	-0.1%	0.0%	-0.2%
Latent 'missing' referral demand presenting	5.0%	10.0%	0.0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80.0%	80.0%	80.0%
2023-24	90.0%	85.0%	95.0%
2024-25	100.0%	95.0%	105.0%
2025 onwards	102.5%	100.0%	105.0%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.

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Orthopaedic Services in Wales – Tackling the Waiting List Backlog

A comparative picture for Hywel Dda University Health Board

Audit year: 2018

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary

Introduction

1 This report supplements our national report on orthopaedics services and provides additional analysis of the orthopaedic waiting list position at Hywel Dda University Health Board (the Health Board). The report presents a range of data to inform discussion and oversight of the current challenges associated with the recovery of orthopaedic services at the Health Board. It includes several prompts and questions for board members to inform debate and obtain assurance that improvement actions are having the desired effect.

2 **A note on the data**: In some instances, the most up to date data available is prior to the pandemic. In others, the data available since the onset of the pandemic is not comparable because of service changes over this period. Therefore, we have:

- selected data and indicators to help stimulate board member and senior manager discussion and scrutiny on specific aspects of orthopaedic service delivery.
- used long-term trends and calculations to help present a perspective on orthopaedic services both in relation to the current position and taking a more strategic longer-term outlook.

3 In May 2022, the Getting It Right First-Time (GIRFT) team[1] issued its national report on orthopaedic services in Wales and provided additional local feedback to each health board. The local report for the Health Board was finalised in May 2022. The findings presented here seek to complement rather than duplicate the GIRFT reviews. We have recommended that relevant health board committees receive a progress update against the GIRFT recommendations alongside the Audit Wales national report and the locally tailored data briefing.

4 We have presented the findings in this report under the following headings:

- The scale of the waiting list
- Referrals and demand
- Resources and capacity
- Outpatient models

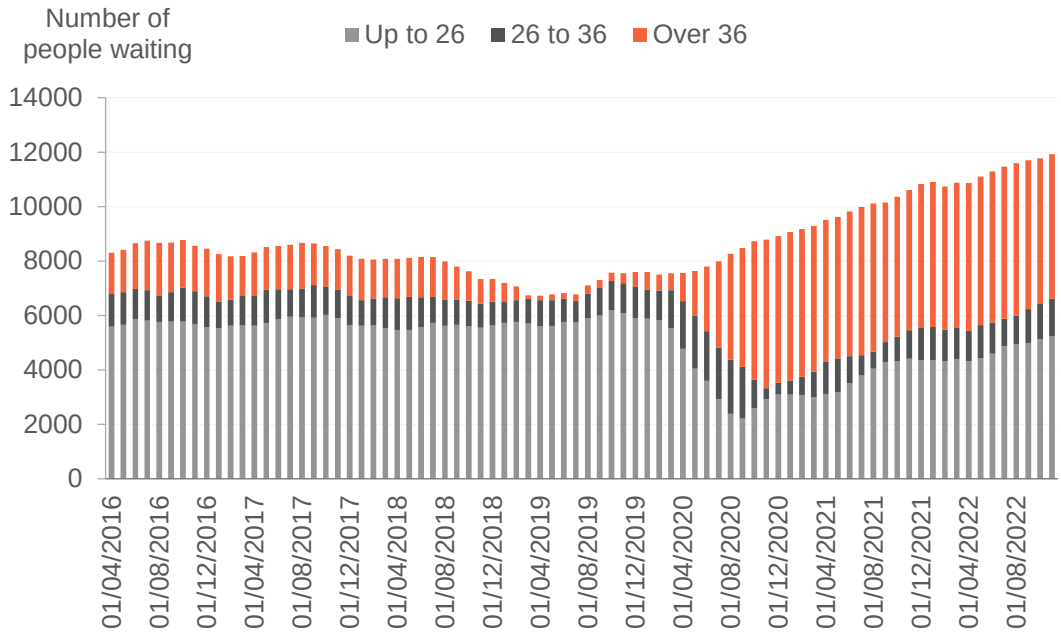
[1] Getting It Right First-Time is a national programme designed to improve the treatment and care of patients through review and benchmarking.

Detailed report

The scale of the waiting list

5 **Exhibit 1** shows the overall trend in orthopaedic waits at the Health Board since 2016. It shows a picture common to most health boards with a sharp increase in the numbers waiting since the start of the pandemic and within those figures, a significant increase in the numbers facing longer waits.

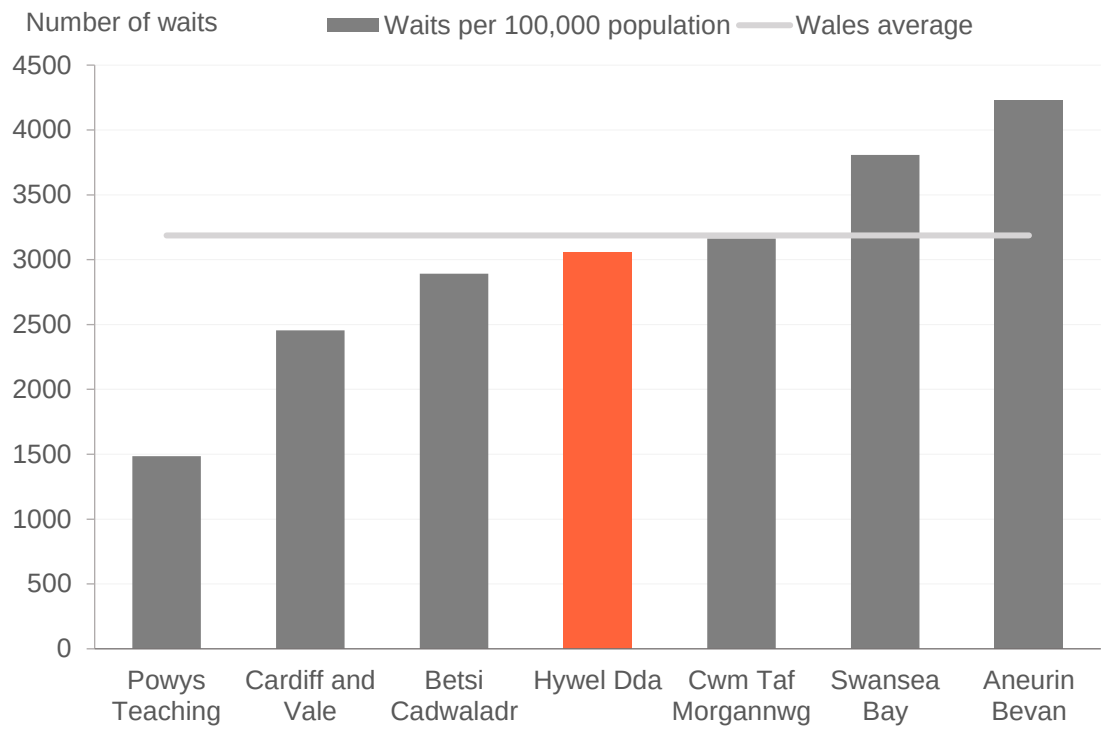
Exhibit 1: Total orthopaedic waits, by weeks waiting – Hywel Dda University Health Board (April 2016 – November 2022)



Source: Audit Wales analysis of Stats Wales

6 Comparatively the number of patients on orthopaedic waiting lists relative to population varies across Wales. **Exhibit 2** shows the number of orthopaedic open pathways (waits) per 100,000 population as of November 2022, with the Health Board figure below the Wales average. This variance may occur because of demographic differences, such as age and deprivation, different primary care referral approaches, different community-based approaches for prevention, treatment, and onward referral. But it is also likely to show that some health boards have been able to a secure a better match between capacity and demand than others.

Exhibit 2: Total number of orthopaedic waits per 100,000 population, November 2022



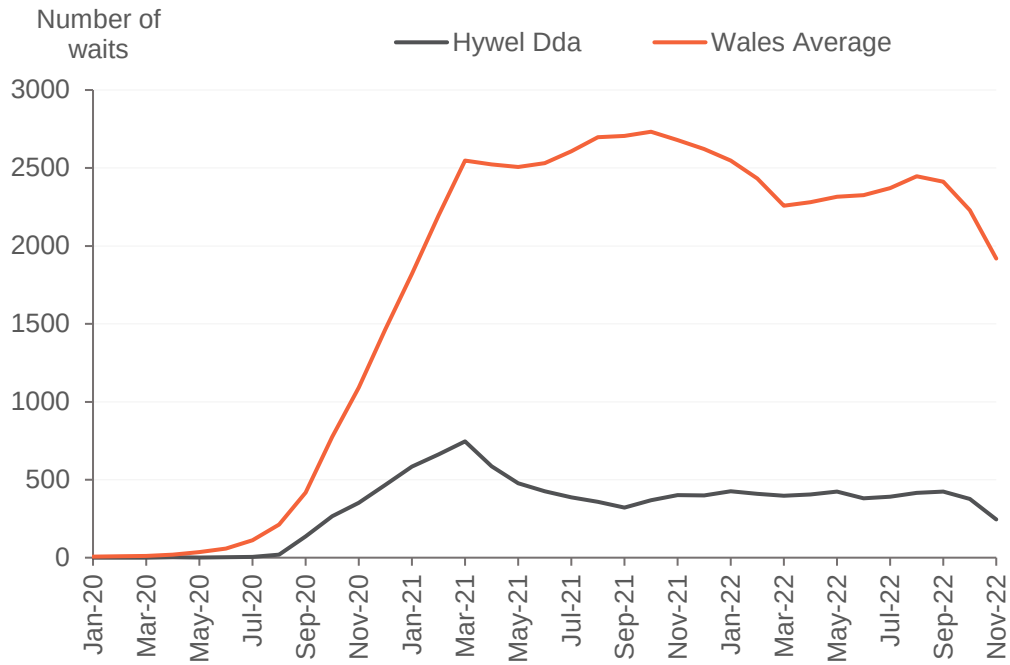
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What factors are contributing to the Health Board's comparative performance on overall orthopaedic waits relative to population?

7 In April 2022, Welsh Government published its programme for transforming and modernising planned care and reducing waiting lists in Wales. This sets out five ambitions to reduce waiting times in Wales. The first one being 'No one should be waiting longer than a year for their first outpatient appointment by the end of 2022'. **Exhibit 3** shows the number of orthopaedic waits for first outpatient appointment longer than a year. As of November 2022, there were 245 patient pathways in the Health Board which were waiting longer than a year. This is the second lowest level in Wales.

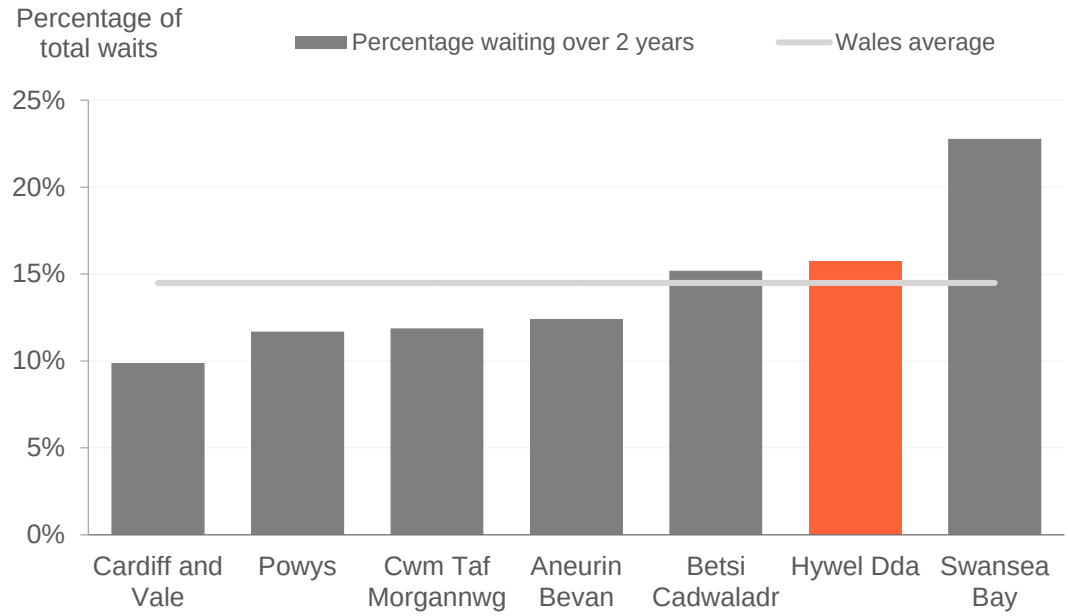
Exhibit 3: Total number of orthopaedic waits over a year, waiting for a first outpatient appointment – Hywel Dda University Health Board



Source: Audit Wales analysis of Stats Wales

8 The second key ambition set out in the Welsh Government's planned care programme is to eliminate the number of people waiting longer than two years in most specialities by March 2023. As at the end of November 2022, there were around 1,872 patient pathways waiting over two years for orthopaedic services in the Health Board. This number is the fourth highest in Wales. From our wider analysis, the trends across Wales indicate that health boards are now starting to focus on the growth in extremely long waits. But there is clearly more to do and a finite capacity. **Exhibit 4** shows a comparative picture of long waits. As a proportion of total waits, the proportion waiting over two years in the Health Board is in line with the Wales average. Exhibit 4 indicates that there is inequality for long waits depending on where people live.

Exhibit 4: Percentage of orthopaedic waits over 2 years, by residence, November 2022



Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- Is the Health Board likely to meet the targets set out in the Welsh Government's national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan?
- How is the Health Board communicating with patients to tell them how long their wait is likely to be and what to do if their condition deteriorates?
- What is the Health Board doing to prioritise those most at risk of coming to harm because of a delay?
- Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?

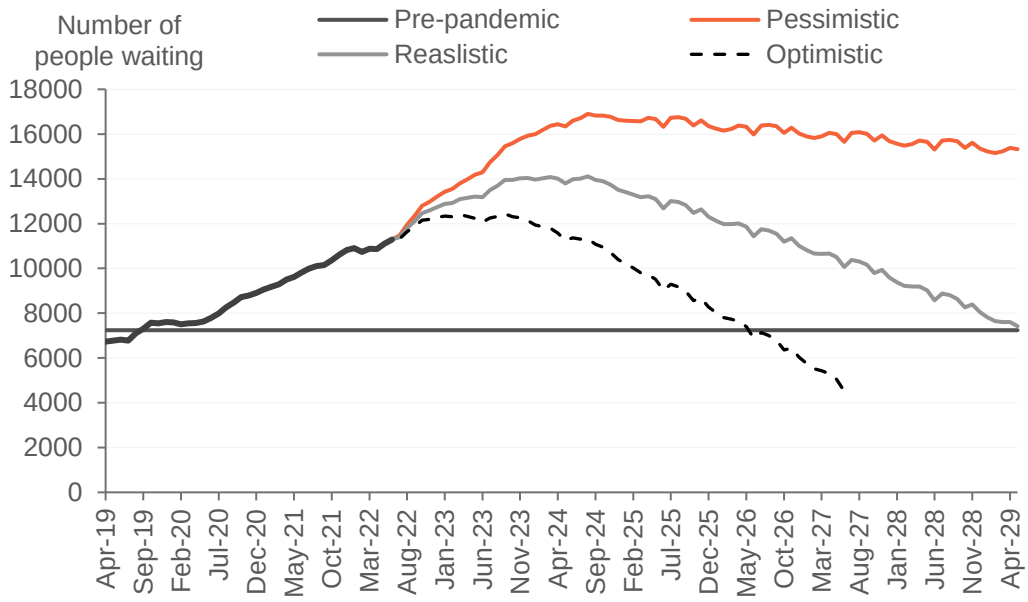
9 **Exhibit 5** provides an illustrative scenario (optimistic, realistic, and pessimistic) for the possible length of time that it could take to return orthopaedic waits to pre-

pandemic levels[2]. Our scenario model is based on pre-pandemic levels of capacity, new demand (additions) and activity (removals), future growth in referral demand, and future growth in capacity and/or activity levels.

10 The scenario model also assumes the levels of pent-up demand hitting the system. Pent-up demand being caused by lower-than-expected referrals since the onset of the pandemic. The model does not assume growth in referral demand due to population changes. The scenarios we have presented are based on assumptions which may alter over the coming years.

11 In the most optimistic model scenario, the Health Board's orthopaedic waits would not return to pre-pandemic levels until the middle of 2026. This is based on a move towards a 5% increase in orthopaedic surgical capacity and activity compared to pre-pandemic levels. Clearly the timeframe for recovery will reduce if the pent-up demand does not materialise, demand does not grow year-on-year, the Health Board increases internal capacity or productivity, or if there are opportunities for outsourcing. The realistic and more pessimistic modelling scenarios would not see waiting list number return to pre-pandemic for many years, if at all.

Exhibit 5: Illustrative scenarios of orthopaedic waiting list numbers – Hywel Dda University Health Board



Source: Audit Wales analysis of Stats Wales data

[2] **Appendix 1** sets out how we modelled the scenarios.

12 **Exhibit 6** shows the extent of the variation in waits for hip and knee replacement surgery across Wales prior to the pandemic when this data was last available in 2020. At that time, waits for knee and hip replacements in the Health Board were mixed. Variation shows differences between service capacity and waiting list management. As health boards across Wales try to reduce waiting lists through outsourcing, there is potential for further widening of inequalities of access to care.

Exhibit 6: Mean waiting times (in days) for knee and hip replacement and revision surgery, 2019-20[3]

Health Board	County	Knee	Hip
Betsi Cadwaladr	Isle of Anglesey	609.5	363.9
	Gwynedd	604.4	568.9
	Conwy	409.3	344.3
	Denbighshire	266	212.7
	Flintshire	232.4	221
	Wrexham	236.1	226.6
Hywel Dda	Ceredigion	252.4	213.1
	Pembrokeshire	246.4	238
	Carmarthenshire	221.1	180.9
Swansea Bay	Swansea	362.7	373.2
	Neath Port Talbot	323.1	331.8
Cardiff and Vale	Vale of Glamorgan	229	216.3
	Cardiff	241.9	210.1
Powys	Powys	154.2	147.9
Aneurin Bevan	Caerphilly	185.8	165.2
	Blaenau Gwent	200.2	157.1
	Torfaen	182.1	164.7
	Monmouthshire	180.2	160.2
	Newport	196.6	164.1
Cwm Taf Morgannwg	Rhondda Cynon Taf	177.8	150.8
	Bridgend	317.6	294.9
	Merthyr Tydfil	175.3	161.1

Source: Audit Wales analysis of Health Maps Wales

[3] Table Key: Under 36 weeks 26-36 weeks Over 36 weeks

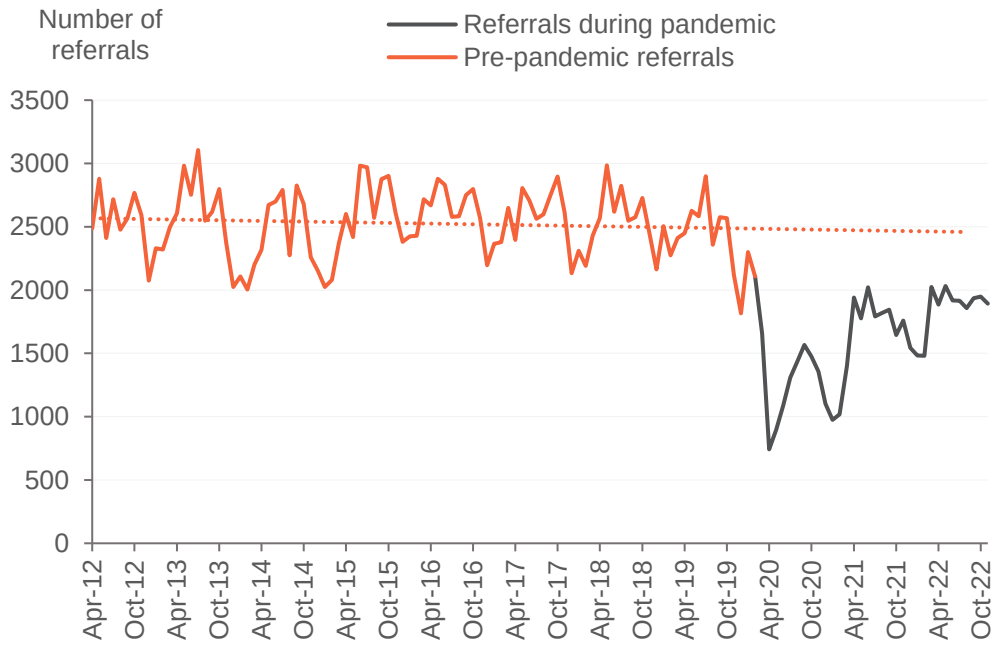
Suggested board member questions

- Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?
- What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?

Referrals and demand

13 **Exhibit 7** shows the trend in the Health Board's orthopaedic referrals over time and the significant reduction in referrals during the pandemic. The volume of the Health Board's orthopaedic referrals continues to remain below pre-pandemic average referral levels[4].

Exhibit 7: Trend in referrals to the orthopaedic waiting list, April 2012 to November 2022 – Hywel Dda University Health Board



Source: Audit Wales analysis of Stats Wales data

[4] Based on average referral rates for 2019-20

14 The extent of the lower levels of referrals during the last couple of years suggests that patients who would have normally been referred potentially still have a need for treatment. Our calculations suggest around 135,000 orthopaedics latent or 'lost' referrals across Wales. The numbers vary quite significantly by health board with the Health Board having the second highest proportion (**Exhibit 8**). The effect of this latent demand returning to the system and referral demand returning to pre-pandemic levels more generally, will be to make an already challenging waiting list recovery position even more daunting.

Exhibit 8: Number of potentially latent 'lost patients' between March 2020 and March 2022

Health Board	Latent 'lost' referrals	Percentage of all-Wales total
Aneurin Bevan	42,438	32%
Hywel Dda	22,860	17%
Cwm Taf Morgannwg	18,294	14%
Cardiff and Vale	17,576	13%
Betsi Cadwaladr	15,987	12%
Swansea Bay	13,046	10%
Powys	4,204	3%
Total	**134,406**	

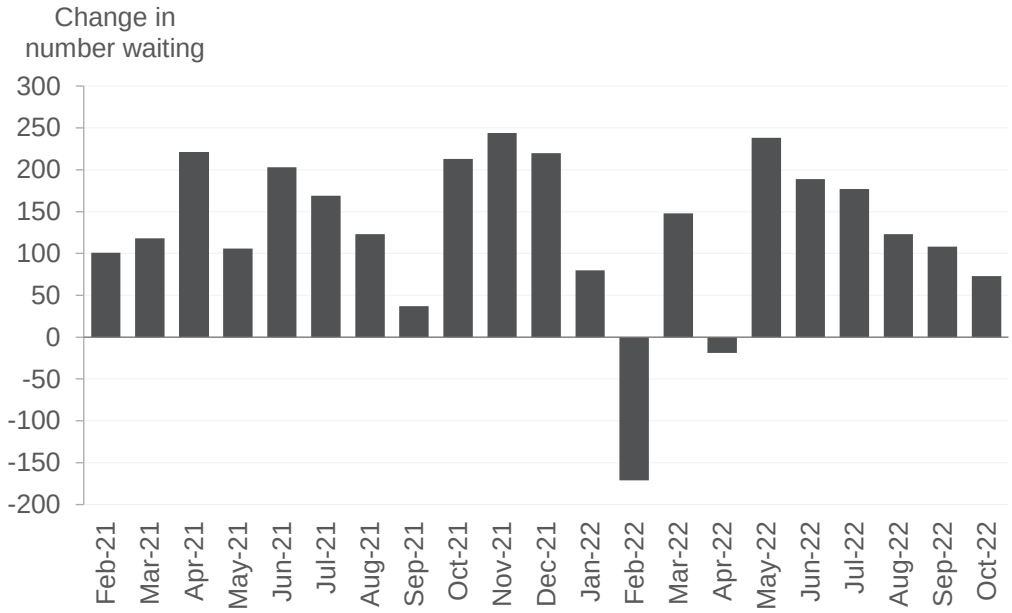
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone?
- Does the Health Board have a good understanding of the current and future demand for orthopaedic services?
- How is the Health Board ensuring that only appropriate referrals are made into secondary care services?
- Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further?

15 **Exhibit 9** shows a month-on-month trend of orthopaedic waits, i.e., whether and by how much each month the waiting list has increased or decreased. Across Wales, some health boards have recently managed to stem the growth in waits in some months, either using short-term additional capacity to meet demand or through validation exercises to cleanse waiting lists. But these reductions have not been sustained. With referrals starting to return to pre-pandemic levels, it illustrates the difficulty health boards are having balancing capacity to meet levels of demand.

Exhibit 9: Month-on-month change in numbers of orthopaedic waits – Hywel Dda University Health Board



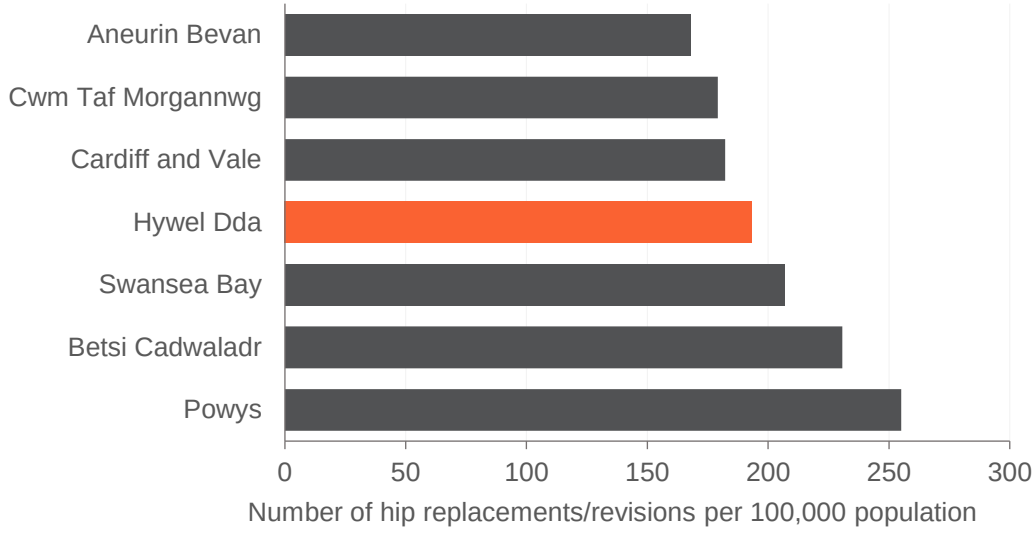
Source: Audit Wales analysis of Stats Wales

Suggested board member questions

- What is the Health Board doing to stem the growth in the numbers of people waiting?
- To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?
- How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?

16 **Exhibit 10** provides a comparative historical average trend in the rate of hip revisions or replacements over three years from 2017 to 2020 per 100,000 population. While there are demographic differences in each health board, the exhibit shows quite wide variation which is unlikely due to demographics alone.

Exhibit 10: Admission rates for hip replacements/revisions per 100,000 population based on a three-year average, 2017-18 to 2019-20



Source: Audit Wales analysis of Health Maps Wales

Board member questions

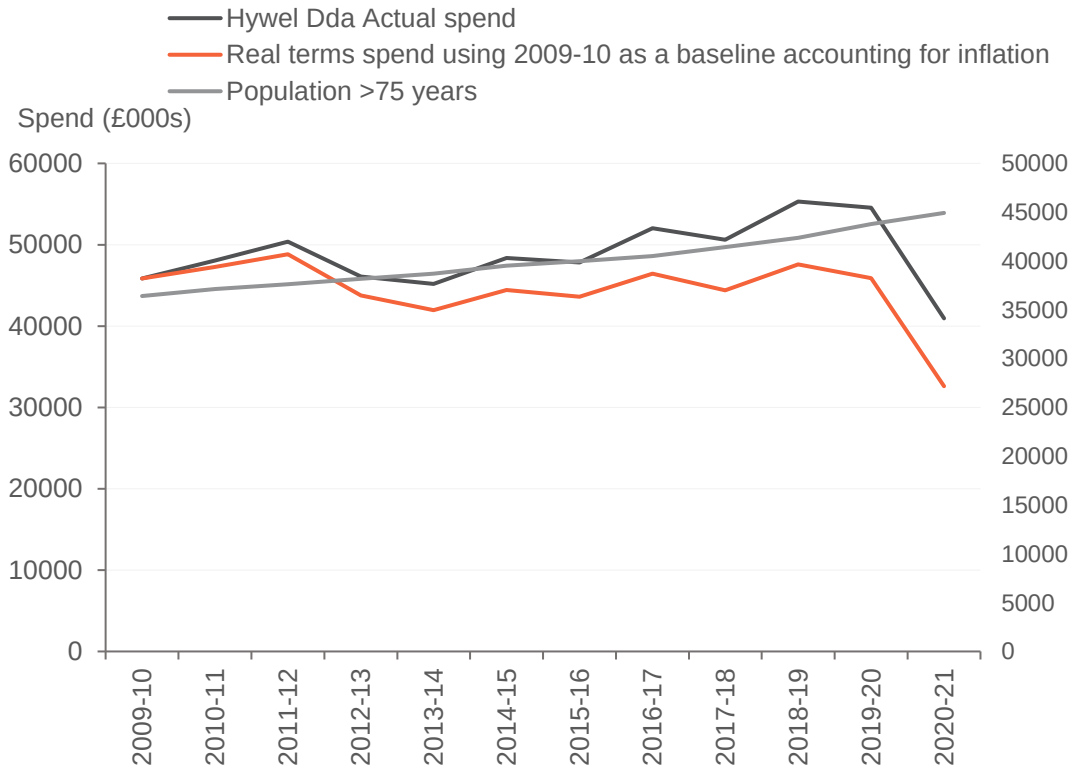
- Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency?
- Does the Health Board understand whether the procedures are delivering positive outcomes for patients?

Resources and capacity

17 **Exhibit 11** provides a long-term perspective on actual spend[5] on orthopaedic services in the Health Board, and the spend adjusted for inflation (i.e., real terms). In general, and across Wales, the pre-pandemic 'real terms' spend on orthopaedics has remained largely static up until the impact of the pandemic.

18 Service demand is linked to an aging population, with the number of people aged 75 and over increasing by around 19% between 2009 and 2020. This trend is expected to continue. Between 2020 and 2032 across Wales the number of people aged 75 and over is forecast to grow by a further 27%, which could create additional strain on orthopaedic services already struggling to recover.

Exhibit 11: Actual spend and real terms spend on orthopaedics vs aging population profile – Hywel Dda University Health Board



Source: Audit Wales analysis of Stats Wales - Health programme budget and population mid-year estimates

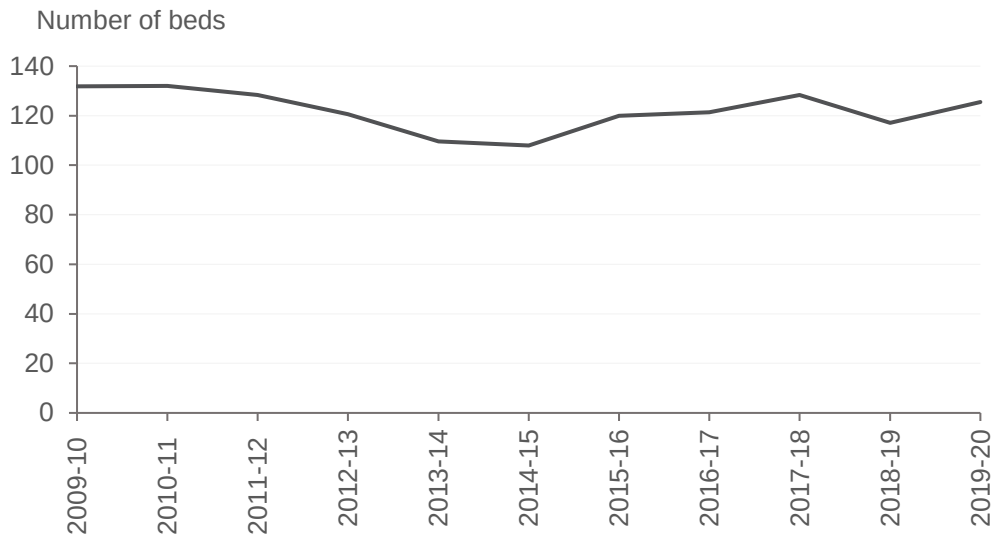
[5] Based on NHS Programme Budget spend for musculoskeletal system problems (excluding trauma)

Suggested board member questions

- If the older population continues to grow, but real terms spend on orthopaedics does not keep pace, can the Health Board ensure that future service models will be sustainable?

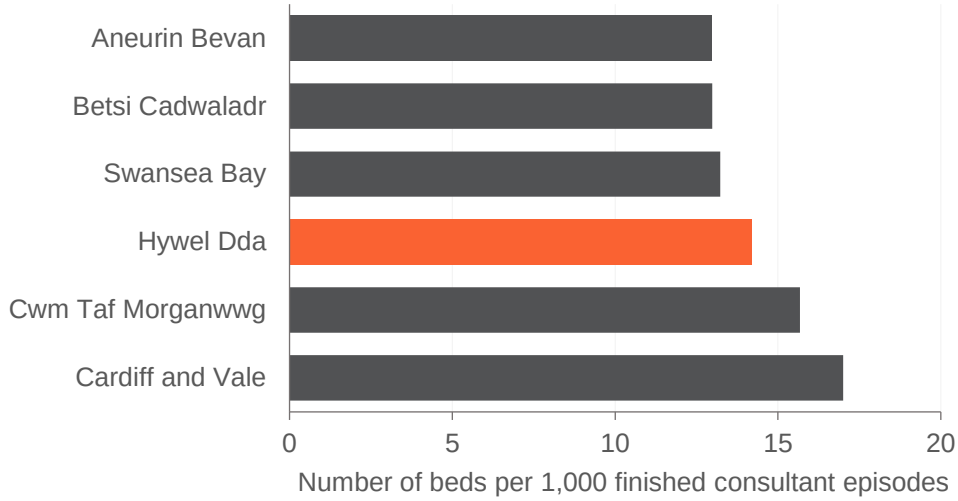
19 **Exhibit 12** and **Exhibit 13** provide trend and comparative data on the number of available orthopaedic beds. The Health Board has one of the highest level of beds per 1,000 finished consultant episodes. Given the potential increase in orthopaedic demand due to a growing elderly population, health boards will need to assess whether they can meet demand within existing bed capacity. The extent that efficiencies in bed utilisation can be made and the extent that elective orthopaedic beds can be protected from wider unscheduled care pressures will determine whether current and future demand can be met with the current bed capacity.

Exhibit 12: Trauma and orthopaedic bed availability - Hywel Dda University Health Board



Source: Audit Wales analysis of Stats Wales

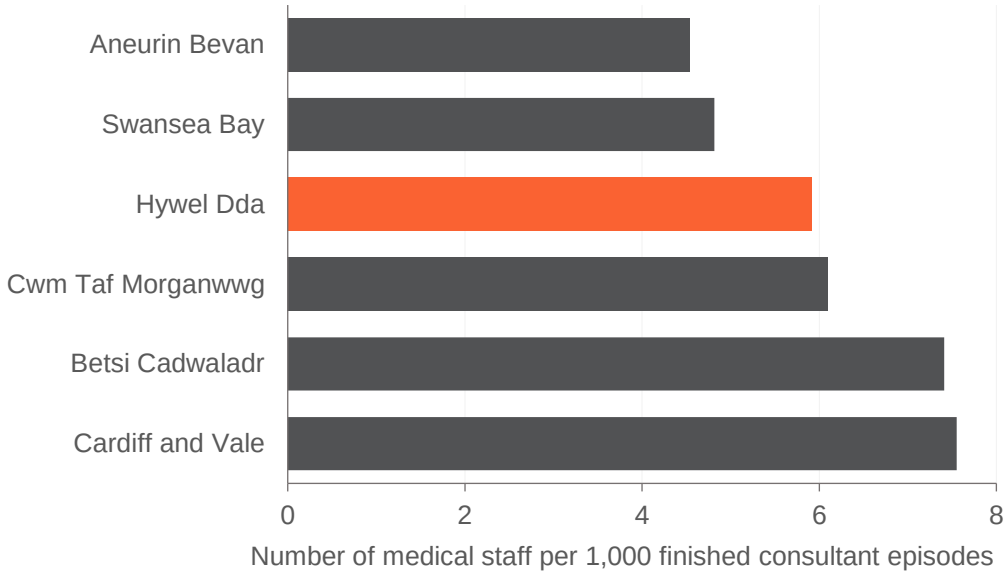
Exhibit 13: Comparison of trauma and orthopaedic beds per 1,000 finished consultant episodes 2019-20



Source: Audit Wales analysis of Stats Wales and PEDW data

20 **Exhibit 14** provides a comparative perspective of the medical workforce. The Health Board has the third lowest level of medical staff per 1,000 finished consultant episodes. The variation visible across Wales may be due to operational differences in ways of working. However, there is a need to consider optimal staffing levels, efficiencies, productivity, and different pathway models that maximise prudent healthcare principles. As part of this we would expect to see health boards planning on a regional footing to develop high-volume low complexity regional capacity to improve productivity and reviewing consultant job plans as part of pathway redesign.

Exhibit 14: Comparison of trauma and orthopaedic medical workforce (WTE) per 1,000 finished consultant episodes 2019-20



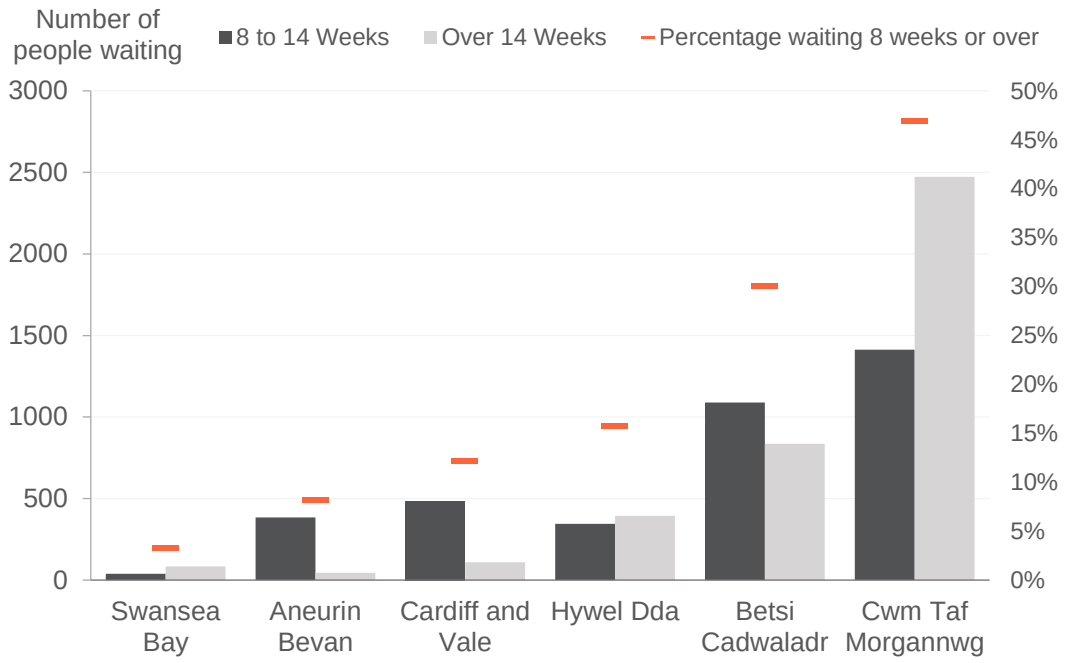
Source: Audit Wales analysis of Stats Wales and PEDW data

Board member questions

- To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps?
- What are the workforce risks and challenges?
- How is the Health Board working regionally to create high volume low complexity capacity?
- What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?

21 People with musculoskeletal conditions often need diagnostic tests to provide clarity on the cause and extent of their problems. The Welsh Government targets say that patients should wait no longer than eight weeks for diagnostic tests. The Health Board has comparative longer waits for diagnostic tests. Delays in diagnostic tests are likely to impact on the overall timeliness of orthopaedic treatment. At present there is wide variation in the number and proportion of delays in access to radiology services across Wales (**Exhibits 15 and 16**).

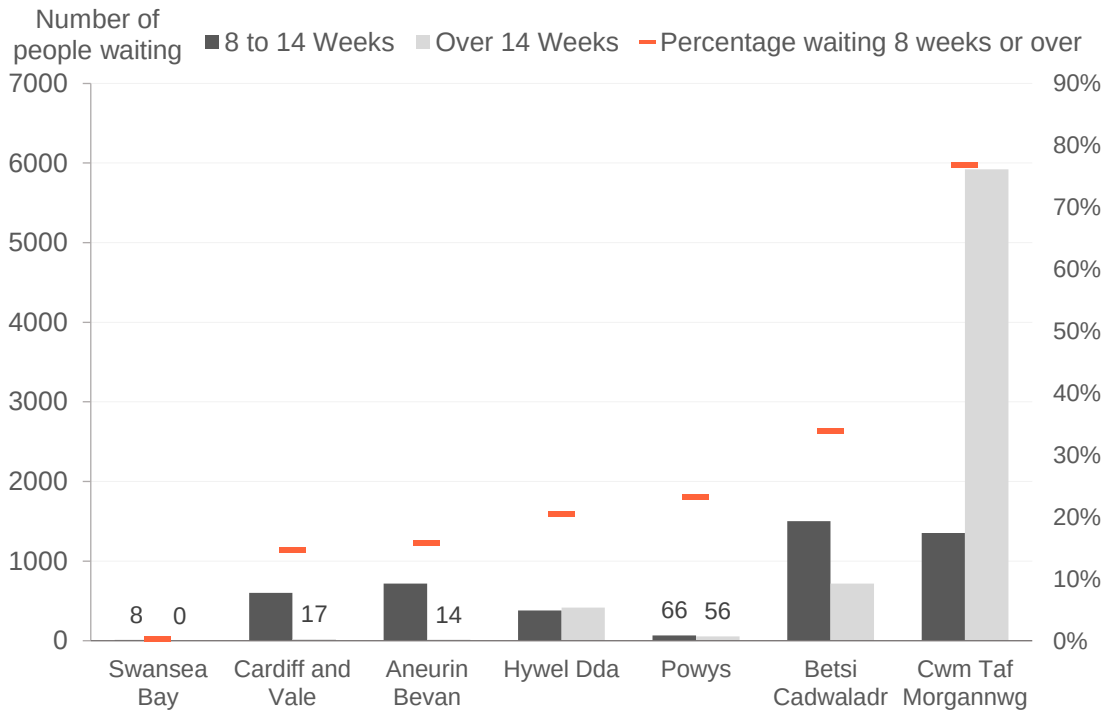
Exhibit 15: Number and percentage of waits for consultant referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

Note: Powys consultant referred radiology requests are too low to be visible in the chart.

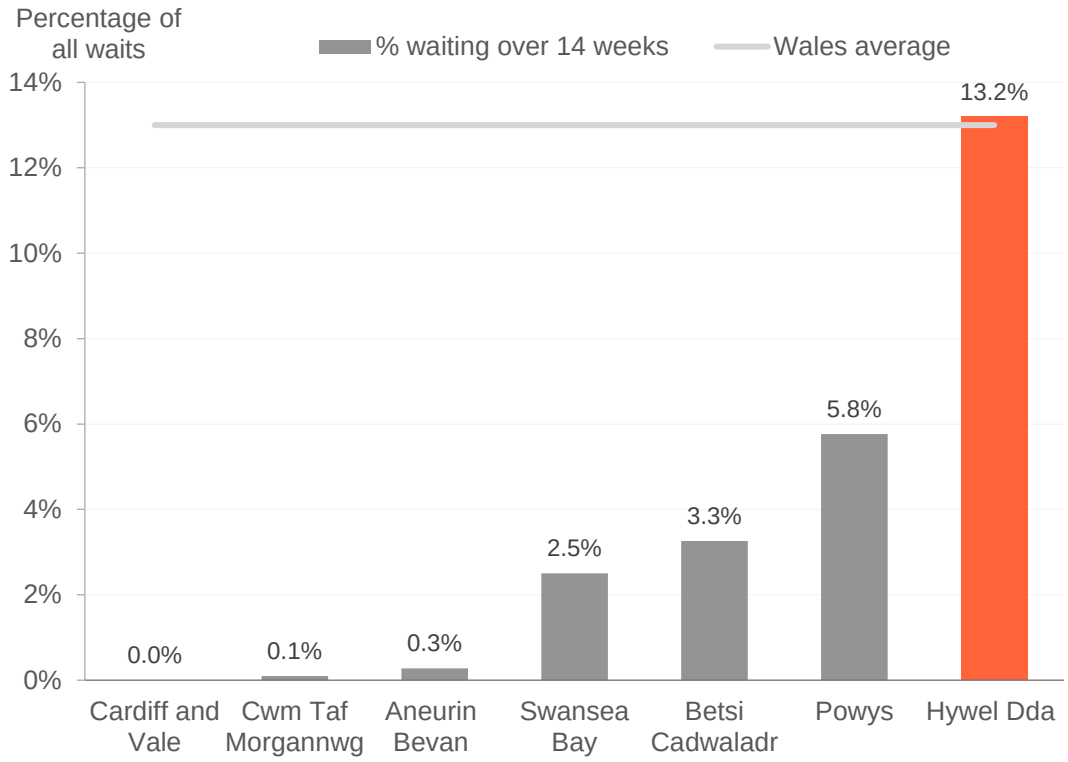
Exhibit 16: Number and percentage of waits for GP referred radiology waiting eight weeks or over, November 2022



Source: Audit Wales analysis of Stats Wales

22 People with musculoskeletal conditions also often require physiotherapy. **Exhibit 17** shows the proportion of people waiting for physiotherapy who are waiting over the Welsh Government target of 14 weeks. The Health Board has the highest level of patients waiting over 14 weeks.

Exhibit 17: Percentage of waits over 14 weeks for physiotherapy, November 2022



Source: Audit Wales analysis of Stats Wales

Board member questions

- To what extent is radiology or physiotherapy capacity having an impact on the timeliness of the overall orthopaedic pathway?
- Are there costed plans to match demand and capacity in those areas if required?

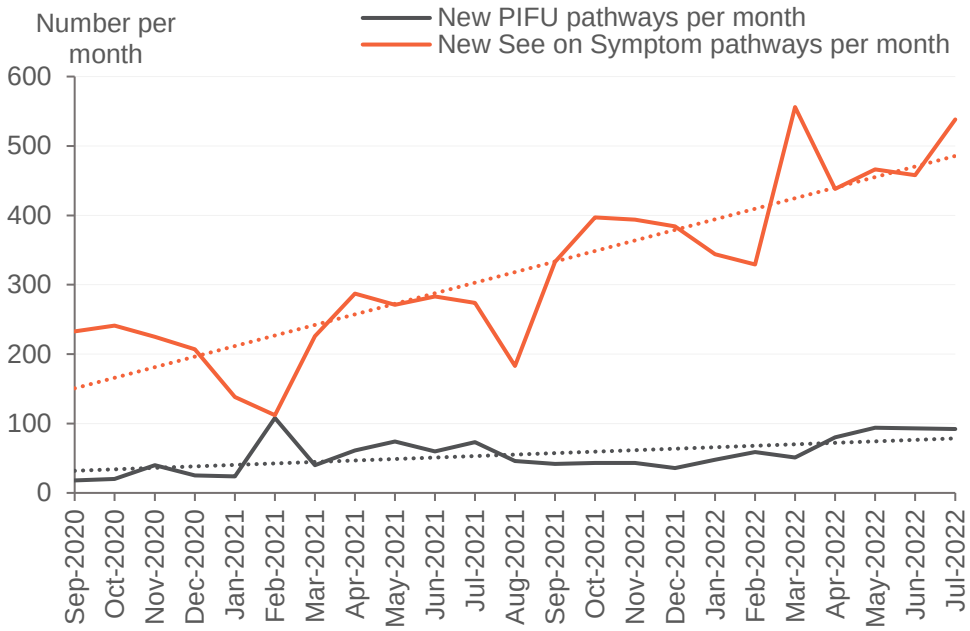
Outpatient models

23 Health boards are implementing new ways of working. The pandemic resulted in a greater extent of 'digitally enabled' working. This helped enable continuation of some services at times where face-to-face appointments were not available. Health boards are also on a journey of implementing new outpatient pathways known as 'see on symptom (SOS)' and 'patient initiated follow up (PIFU).' These approaches are designed to reduce unnecessary follow up outpatient appointments. The aim is

to improve efficiency, reduce unnecessary patient journeys, empower patients to manage their own condition and provide access when they need it.

24 **Exhibit 18 and 19** show the trend in the uptake of new 'see on symptom' and 'patient initiated follow up' pathways. In most health boards in Wales, we are seeing growth in the use of these new pathways but compared to overall numbers of follow up outpatient appointments, these new approaches remain in the minority. For the Health Board, positive progress has been made adopting both initiatives, particularly with SOS pathways. The extent to which PIFU pathways have been adopted is the highest in Wales, albeit that numbers remain relatively low.

Exhibit 18: Trend in adoption of new Patient Initiated Follow Up and See on Symptom pathways per month – Hywel Dda University Health Board (September 2020 - July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 19: Average number of Patient Initiated Follow Up and See on Symptom pathways per month compared to average number of follow up outpatient appointments (based on 2018-19 activity levels)[6]

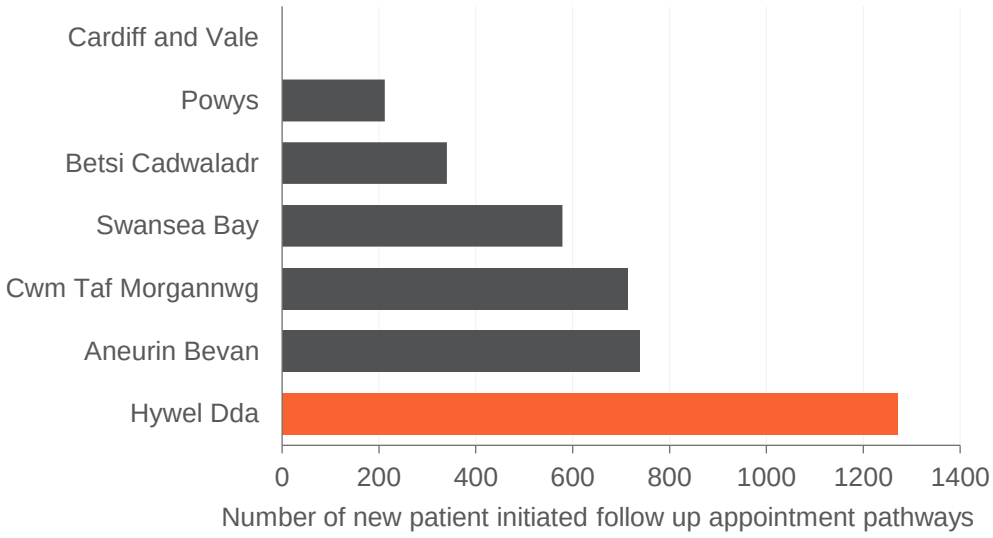
Health Board	Follow up outpatient appointments per month (18/19) average	'Patient Initiated Follow up' pathways per month (21/22)	'See on symptoms' pathways per month (21/22 average)
Abertawe Bro Morgannwg	5283	N/A	N/A
Aneurin Bevan	5840	31	607
Betsi Cadwaladr	4352	15	128
Cardiff and Vale	4317	0	1275
Cwm Taf	2529	N/A	N/A
Cwm Taf Morgannwg	N/A	3	15
Hywel Dda	3428	53	336
Powys	98	11	259
Swansea Bay	N/A	38	507

Source: Audit Wales analysis of Welsh Government provided data

25 **Exhibits 20 and 21** provide a comparison of the numbers of new 'see on symptom' and 'patient initiated follow up' pathways. These are actual numbers and have not been adjusted or weighted for organisational size.

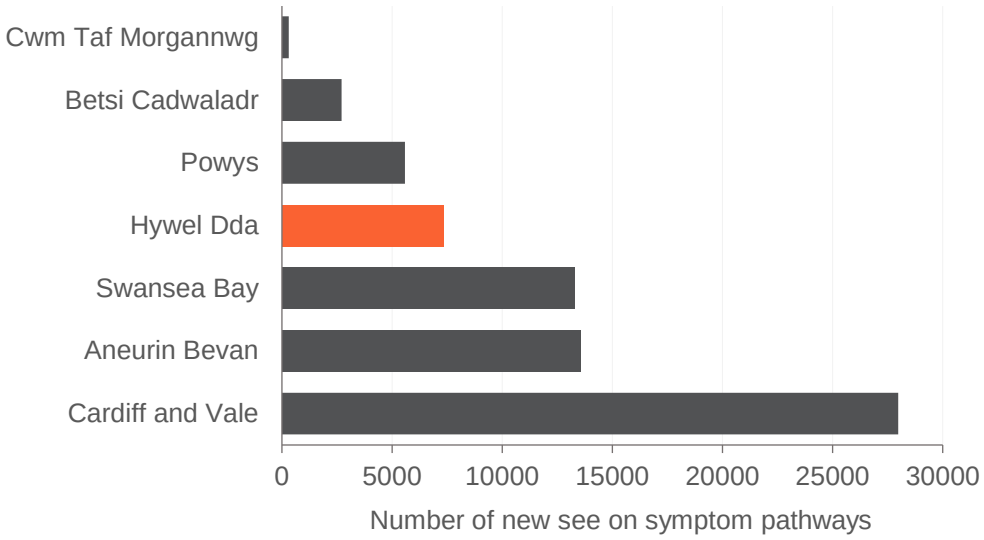
[6] Total follow up outpatient activity levels have not been publicly reported on StatsWales since 2018-19

Exhibit 20: Comparison of total new Trauma and Orthopaedic patient initiated follow up appointment pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Exhibit 21: Comparison of total new Trauma and Orthopaedic See on Symptom Pathways by Health Board, most recent 12-month period (August 2021 to July 2022)



Source: Audit Wales analysis of Welsh Government provided data

Board member questions

- Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers?
- Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time?
- To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?

Appendix 1

Scenario modelling

Our scenario modelling in **Exhibit 5** draws on some initial modelling work conducted by the NHS Delivery Unit. The calculation we used, following the work of the Delivery Unit, was:

- Removals are calculated by taking the number of patients waiting over 4 weeks (i.e., they are not new patients that month) and subtracting that from the total waiting list in the previous month. This gives a proxy for the numbers of patients removed from one month to the next.
- Additions are the people reported in the monthly figures who have been waiting less than 4 weeks – indicating they have been added to the waiting list in the last month. Whilst monthly additions give a reasonable measure of additions, some of those included may have already been waiting but had their 'clock' reset for some reason, for example not turning up for multiple appointments. It is also possible that some people may not be counted if they were added and removed before the data was captured at the end of each month.

Our modelling provides scenarios for the length of time it could take NHS Wales to bring orthopaedic waiting lists back to March 2020 levels using three scenarios: reasonable, pessimistic, and optimistic (**Exhibit 5**). We accounted for the possible pent-up demand (**see Exhibit 8**) by evenly spreading differing proportions of the potential missing 135,000 referrals over 2022 to 2024. Those proportions varied depending on a reasonable, pessimistic, or optimistic scenario. **Exhibit 22** sets out our modelling assumptions.

Exhibit 22: Waiting list modelling assumptions

Assumptions	Reasonable	Pessimistic	Optimistic
Additions 2022-2025 compared to 2019-20	87.5%	90%	85%
Annual increase in additions 2025 onwards	99%	100%	98%
Latent 'missing' referral demand presenting	5%	10%	0%
Activity/removals compared to 2019-20 levels during:			
2022-23	80%	80%	80%
2023-24	90%	85%	95%
2024-25	100%	95%	105%
2025 onwards	102.5%	100%	105%

Source: Audit Wales

Our analysis highlights the scale of the possible challenge and the length of time it could take to clear the backlog of people waiting for treatment. The scenarios we have presented in the report are based on assumptions which may alter over the coming years.

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GETTING IT RIGHT FIRST TIME

GIRFT Orthopaedic Review

Hywel Dda 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 HDUHB, delivered by Professor Tim Briggs CBE (GIRFT Programme Chair and National Director of Clinical Improvement for the NHS) on Friday 4th 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 a 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 HDUHB Deep Dive Meeting of 4th 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. Whilst we identified areas of unwarranted variation in the data we reviewed at the meeting, we also found some impressive areas of practice where the Health Board were performing at the top when compared to other Health Boards. The detail around this variation and the recommended improvements can be found in the **Orthopaedics Action Plan in Annex A. It is essential that HDUHB maintain the excellent performance they have demonstrated in some areas once orthopaedic services are restored.**

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 HDUHB 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 HDUHB:

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. There is currently an appointed Orthopaedics Health Board Clinical Lead (CL). This is a key strength of the Hywel Dda Orthopaedic service, which is lacking in some of the other Health boards that have multiple silo Orthopaedic units. The CL clearly projects a unified voice from the 3 Orthopaedic units in Hywel Dda despite their geographical distance. We are concerned however that the CL is not supported by the HB in making the essential operational and strategic changes required. We recommend that through enhanced management support, the Orthopaedics Clinical Lead role is enabled to instigate Health Board level change at pace and empowered to provide steer and direction to the Health Board executive team on regional models of working with neighbouring Health Boards.
4. HDUHB 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 they 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. 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.
6. 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 on using revenue budgets and resources more efficiently. We expect that an urgentinitial 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.
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. We recognise that the Health Board do review litigation claims, which we are pleased to see. They should, however, broaden this to a programme which ensures 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 still be improved.

10. 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 reviews of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.

11. As part of the medium and longer term orthopaedic planning, 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.

12. 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 planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve HDUHB.
    b. Set up a weekly sitrep specifically focused on elective recovery with the Executive.This should include all patients waiting for elective orthopaedic surgery and sub-categorised by: ASA score; time on waiting list; both expected and actual operations carried out on a weekly basis and reasons, if underperformance. There needs to be close scrutiny of forward projections to reduce waiting lists with robust targets set. These should also include adoption of the HVLC pathways and ensure 90% of those cases are Day Case. We suggest that to gain optimum 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 on track and the risk to patients is reduced.

c. Establish a delivery model to restart elective recovery. This needs to be established at pace. RNOH/GIRFT supports the development of Prince Philip Hospital (PPH) as the designated HVLC centre for the HB and as a centre for more complex LVHC work. There is also an opportunity to develop PPH as a regional LVHC centre in collaboration with SBU. Centralisation of trauma services to a single site in the South of Hywel Dda at Glangwili General hospital (GGH) would provide additional capacity at the Withybush General Hospital (WGH) site creating additional capacity for ambulatory trauma and short stay elective workload. Increased elective capacity at the BGH site would provide additional regional capacity for South Gwynedd (BCU) and West Powys. Ensure this unit is appropriately staffed.
d. Develop a recovery plan of how to effectively utilise Glanwilli (Trauma Centre) Bronglais and Withybush Hospitals.
e. Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.
f. Develop an enhanced recovery unit 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.
g. Upskill and empower therapy staff to undertake greater roles.
h. Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.
i. Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.
j. Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day
k. Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring “top decile” outcomes and using the GIRFT theatre principles and expected productivity as a steer.
l. 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.
m. Review emergency and urgent pathways to improve patient flow.
n. Review patients that are deconditioning on the waiting list and identify patients that require urgent care.
o. Determine effective and efficient follow up plans, which should be carried out virtually if possible.
p. Review patients with high BMI and weight management services and identify improvement strategies and how to best respond to patients wanting surgery with high BMI.

13. 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 to the success of 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.

Annex A: Orthopaedics Action Plan

Activity/ Metric	Meeting outputs	Agreed actions / Recommendations
Elective hip replacement		
Fixation method for elective hip replacements (%) − Patients 65+ yea	**Exemplar practice identified:** HDUHB predominantly use cemented hip fixations for patients over 65+ years, demonstrating good practice guidance is being followed.	**RNOH/GIRFT recommends:** *This recommendation is being achieved at HDUHB.* 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 practice identified:** Good 5-year elective hip revision rates, this is likely due to using cemented hip fixations, evidence shows using cemented hip fixations in patients over 65+years have better outcomes. Good 90-day mortality rates.	**RNOH/GIRFT recommends:** HDUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation.
Elective knee replacement		
5 and10-Year Revision Rate Elective Knee -	Glanwili Hospital no longer carries out elective knee revisions, this service has been centralised and is now carried out at the Trauma Centre. **Good practice identified:** HDUHB have good 5-year elective knee revision rates. Excellent elective knee revision rates at Prince Philip Hospital – 2 standard deviations below the mean. Good 90-day mortality rates.	**RNOH/GIRFT recommends:** to rationalise hip and knee prostheses across the Health Board to improve services. This will result in better familiarisation of the kit, and in improved theatre efficiencies, helping to reduce waiting lists and costs to the NHS. **RNOH/GIRFT recommends**: All revisions and primary patella-femoral, elbow and ankle replacement cases to be discussed in appropriate MDTs prior to surgical intervention. .

Elective joint procedure for adults – PEDW		
Hip Procedures Knee Procedures Shoulder Procedures Elbow Procedures Hand and Wrist Procedures Ankle Procedures	HDUHB have low hip and knee revision activity, this indicates consultants at Prince Philip Hospital and Withybush Hospital are performing primary operations to a high standard. Arthroscopy data looks to be underreported - generally the arthroscopy data is poor. Patients that need a shoulder replacement after significant trauma will have this carried out at Prince Philip Hospital. As part of the National Strategy Programme, an all Wales pathway is currently being developed. High shoulder subacromial decompression activity at Prince Philip. All cases go through the appropriate pathway including physiotherapy before being offered surgery. Ankle arthrodesis (fusion) and complex reconstruction foot procedures are carried out at two sites (Prince Philip and Withybush). HDUHB are currently working towards centralising foot and ankle activity at one hospital. High volumes of ankle replacements in comparison to ankle fusions. This is likely to be a coding error. **<u>Good practice identified:</u>** - Shoulder replacement surgery has been centralised and carried out at Prince Philip Hospital. (The data shows 2x shoulder replacements were carried out at Glangwili Hospital, these were identified as trauma cases.) - Elbow and ankle replacements are carried out at Prince Philip Hospital. Single surgeon practice.	**RNOH/GIRFT recommends:** to undertake a review of arthroscopy and ankle activity data to identify the correct volumes and develop an improvement strategy to improve reporting of this data. This will be developed through the NCSOS project foot and ankle subspecialty and final reports. **RNOH/GIRFT recommends:** to review NHS shoulder subacromial decompression activity ensuring evidence is being used and these patients have gone through the appropriate pathway including physiotherapy before being offered surgery. **RNOH/GIRFT recommends:** to reconfigure foot and ankle procedure surgery to be carried out at one hospital. **RNOH/GIRFT recommends**: to review ankle replacements and ankle fusion data to understand if this a coding error.

	- All shoulder subacromial decompression cases go through appropriate pathway including physiotherapy before being offered surgery - HDUHB are planning to centralise foot and ankle activity to be carried out at one hospital.	
Elective joint replacement length of stay (days) PEDW		
Primary hip replacement Revision hip replacement Primary knee replacement Revision knee replacement Primary shoulder replacement Revision shoulder replacement Primary elbow replacement Revision elbow replacement Wrist replacement Primary ankle replacement Revision ankle replacement Knee ligament reconstruction Shoulder sub acromial decompression Shoulder rotator cuff Wrist arthrodesis (fusion) Ankle arthrodesis (fusion)	Variation in length of stay rates across the hospitals in HDUHB. Withybush has longer length of stay rates than the national average for patients receiving a hip replacement. There are high hip and knee revision length of stay rates. TWRB: Centralise hip and knee revision activity to reduce length of stay rates. Primary ankle replacement length of stay is longer than the national average. **Good practice identified:** Good primary elbow length of stay rates.	**RNOH/GIRFT recommends:** HDUHB to undertake a review of hip and knee primary and revision length of stay rates and develop an improvement strategy. **Opportunity for learning best practice** 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 **RNOH/GIRFT recommends:** to review ankle replacement length of stay rates and establish an improvement strategy. **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: Best practice library - day surgery - Getting It Right First Time - GIRFT
Primary hip		
Elective primary hip replacement with cemented fixation for patients 70+ Years	**Exemplar practice identified:** Excellent usage of cemented hip fixations being used for patients over 70+ years.	**RNOH/GIRFT recommends**: to cement THR in patients over 70 years old provides best outcomes.

Average length of stay for patients receiving elective primary hip replacement (days)	Length of stay is in line with the national average, there is room for improvement.	**RNOH/GIRFT recommends:** to consider measuring in hours opposed to days.
Return for another hip procedure (on the same side) within 1 year for patients 60+ years	**Exemplar practice identified:** Excellent return to theatre rates for another hip procedure within 1 year.	**RNOH/GIRFT recommends:** to consider post-operative follow ups to be carried out virtually.
Primary Knee		
Elective knee replacement for patients 60+ years average length of stay	Length of stay is in line with the national average, there is room for improvement.	**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: 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 practice identified:** Excellent return to theatre rates for another knee procedure within 1 year.	**RNOH/GIRFT recommends:** to consider post-operative follow ups to be carried out virtually.
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:** HDUHB 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	**Exemplar practice identified:** Excellent length of stay rates for patients receiving a shoulder replacement.	
Return for another shoulder procedure (on same side) within 1 year, for patients 60+ years	**Good practice identified:** Excellent return to theatre rates for another shoulder procedure within 1 year.	

Surgeon Data		
Number of surgeons assigned to providers over three-year period	Low volume surgery identified in primary hip, hip revision, knee primary and knee revision. HDUHB: This data looks incorrect as primary hip replacements are not carried out at Glangwili Hospital. All arthroplasty surgeons carry out at least one hip or knee replacement per week. There is some low volume hip and knee revision surgery carried out.	**RNOH/GIRFT recommends:** HDUHB to undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering less than 10 hip and knee revisions 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
Procedures with adverse events - % of procedures with an adverse event		
2020 (1 year) National Joint Registry (NJR) Data Hip Knee	Good adverse event rates for hip and knee across the Health Board. Slightly high hip adverse event rates at Prince Philip Hospital. **Bronglais** Hip Primary: 0.00% Knee Primary: 0.00% **Glangwili:** Hip Primary: 0.00% Knee Primary: 0.00% **Prince Philip** Hip Primary: 1.29% Knee Primary: 0.00% **Withybush** Hip Primary: 1.12% Knee Primary: 0.00% **HDUHB** Hip Primary: 0.98% Knee Primary: 0.00%	**RNOH/GIRFT recommends**: to review adverse events for primary hip at Prince Philip Hospital. A review of the theatre adverse events/ NJR data to be carried out annually.
PROMs - Average health gain - Case-mix adjusted Oxford hip/knee score		

<table>
<tr>
<td>2019/20 (1 year)
Hip Primary
Hip Revision
Knee Primary
Knee Revision</td>
<td>
<table>
<tr><th>Bronglais</th><th>Glangwili</th><th>Prince Philip</th><th>Withybush</th></tr>
<tr><td>0</td><td>NA</td><td>0.44</td><td></td></tr>
<tr><td>0</td><td></td><td>0</td><td></td></tr>
<tr><td>0</td><td></td><td>0.22</td><td></td></tr>
<tr><td>0</td><td></td><td>0</td><td></td></tr>
</table>
</td>
<td>RNOH/GIRFT recommends: to discuss and review PROMs score internally on an annual basis.</td>
</tr>
<tr><td colspan="3">Surveillance of surgical site infection (SSI) - orthopaedics - percentage of procedures with an infection - elective procedures</td></tr>
<tr>
<td>2019/20 (1 year)
Hip replacement - Inpatient
Hip replacement - Inpatient and Readm.
Knee replacement - Inpatient
Knee replacement - Inpatient and Readm.</td>
<td>
<table>
<tr><th>Metric</th><th>Bronglais General Hospital</th><th>Glangwili General Hospital</th><th>Prince Philip Hospital</th><th>Withybush General Hospital</th></tr>
<tr><td>Hip replacement</td><td>2019 2020
0 0</td><td>N/A</td><td>2019 2020
0 0</td><td></td></tr>
<tr><td></td><td></td><td></td><td>0.44 0</td><td></td></tr>
<tr><td>Hip replacement - Inpatient and Readmission</td><td>0 0</td><td></td><td>0 0</td><td></td></tr>
<tr><td>Knee replacement – Inpatient</td><td>0 0</td><td></td><td>0.22 0</td><td></td></tr>
<tr><td>Knee replacement - Inpatient and Readmission</td><td></td><td></td><td>N/A</td><td></td></tr>
</table>
</td>
<td>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.</td>
</tr>
<tr><td colspan="3">Litigation</td></tr>
<tr>
<td>Total number of Claims T&O claims

The total costs involved for T&O</td>
<td>Number of claims: 112

Total costs of claims: £ 5,968,469.43</td>
<td>RNOH/7GIRFT recommends: HDUHB to regularly review the 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, inquestsand serious untoward incidents (SUI) and where aclaim has not already been reviewed as a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed.</td>
</tr>
</table>

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Orthopaedic Services Review (National and Local Audit Wales Reports and GIRFT Orthopaedics Report)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Keith Jones, Director, Secondary Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit & Risk Assurance Committee is requested to consider the actions taken to date against the recommendations of both the 'Orthopaedic Services in Wales - Tackling the Waiting List backlog – A comparative picture for Hywel Dda University Health Board' report and the Getting It Right First Time (GIRFT) Orthopaedic Recommendations report and to take assurance that these are adequate and timely. Please refer to reports attached.

Cefndir / Background

The 'Orthopaedic Services in Wales - Tackling the Waiting List backlog' report provides a comparative picture for Hywel Dda University Health Board which supplements the national report on orthopaedics services and provides additional analysis of the orthopaedic waiting list position at Hywel Dda University Health Board (the Health Board). The report presents a range of data to inform discussion and oversight of the current challenges associated with the recovery of orthopaedic services at the Health Board. It includes several prompts and questions for Board members to inform debate and obtain assurance that improvement actions are having the desired effect.

In its publication of 'Orthopaedic Services in Wales - Tackling the Waiting List backlog – A comparative picture for Hywel Dda University Health Board' (February 2023), Audit Wales recommended that health board committees receive a progress update against the GIRFT recommendations alongside the Audit Wales national report and the locally tailored data briefing.

Prior to the above report's publication, The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was asked to undertake a review of secondary care Orthopaedic services in Wales. Using the GIRFT methodology to develop data packs, services were benchmarked against data from all health boards across Wales and against Hospital Episode Statistics (HES) data in England. The review encompassed orthopaedic services across 6 Health Boards and 21 hospitals in Wales and assessed the extent of variation across the 21 sites and compared clinical practice with data from orthopaedic services in England

The RNOH/ GIRFT team conducted a programme of data analysis, followed by a virtual “deep dive” engagement session with Health Board staff, delivered by Professor Tim Briggs CBE (GIRFT Programme Chair and National Director of Clinical Improvement for the NHS) on 4 February 2022. The final report was received on 5 May 2022.

GIRFT is a national programme 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 final version of the GIRFT Orthopaedic Recommendations Report was received by the Health Board in May 2022. The updated actions against these recommendations and to that of Annex A of that report are attached.

The Audit Wales Orthopaedic Report made national recommendations for Health Boards; these are noted below and responded to within the attached Audit Wales Organisational Response report, along with a position statement against each of the suggested questions for Board members highlighted in the report.

For Health Boards	
R3	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.
R4	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.
R5	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.

Asesiad / Assessment

GIRFT Recommendations and Actions

A detailed response relating to each recommendation can be found within the GIRFT Orthopaedic Response and Annex A attached.

Of the recommendations, 21 are rated green (complete) and 7 rated amber (in progress).

Delivery plans for 2023/24 are reflected in the Health Board's Annual Plan for 2023/24, endorsed by the Board.

'Orthopaedic Services in Wales - Tackling the Waiting List backlog – A comparative picture for Hywel Dda University Health Board' – Recommendations and Actions

All three recommendations for Health Boards (listed above) have been completed. A position statement in respect of the individual suggested questions for Board members is also included in the response template.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is requested to **CONSIDER** the findings and recommendations outlined within the GIRFT Recommendations and Actions report and the Orthopaedic Services in Wales Audit Report and **TAKE ASSURANCE** from the progress achieved by the Orthopaedic Clinical Team to date and the further work currently in development.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical. 3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. 3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and

	internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1009 - 20
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 4. Efficient 5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 3. Data to knowledge 4. Learning, improvement and research 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	2c Workforce and OD strategy 3a Transforming Urgent and Emergency Care programme 4a Planned Care and Cancer Recovery 6b Pathways and Value Based Healthcare
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Audit Wales and GIRFT Reports
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	The GIRFT Recommendations were reviewed with the national GIRFT team over a period of 6 months post publication

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	See attached Integrated Impact Assessment
Ansawdd / Gofal Claf: Quality / Patient Care:	See attached Integrated Impact Assessment

Gweithlu: **Workforce:**	See attached Integrated Impact Assessment
Risg: **Risk:**	Not applicable
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed By	Evidence (Insert)
Financial/Service Impacts				
1. Has the new proposal/service model been costed? If so, by whom?	**Y**	**The 2023/24 Orthopaedic Delivery Plan has been costed and agreed as part of the Annual Plan** **The longer term plans will be addressed within the Regional Plan**	**K Jones, D Binding**	HDUHB Planned Care Recovery Fund
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?	**N**	**Funding for the 2023/24 Orthopaedic Delivery Plan has been sought from WAG and endorsed by the Board via the Annual Plan**		
3. Is the new proposal/service model affordable from within existing budgets?	**N**	**No - Funding for the 2023/24 Orthopaedic Delivery Plan has been sought from WAG and endorsed by the Board via the Annual Plan**		
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?	**Y**	**This is identified within the Orthopaedic Delivery Plan**		
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?	**N**			
6. What is the financial or efficiency payback (prudency), if any?	**Y**	**2023/24 Orthopaedic Delivery Plan will Deliver increased stage 4 treatment activity to reduce 104 week waits.**		
7. Are there risks if the new proposal/service model is not put into effect?	**Y**	**Patients will have to wait longer for treatment and potentially come to harm**		

8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)	**Y**	**The delivery of the 2023/24 Orthopaedic Plan will require SBUHB patients to travel to PPH for treatment. The longer term Regional Plan may necessitate changes to patient pathways and patient travel for care across the region.**		
9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?	**Y**	**During all terms there will be a need for staff and patient negotiation/ consultation.**		
10. Are capital requirements identified or funded?	**N**	**Not for the 2023/24 Orthopaedic Plan**		
11. Will capital projects need to be completed in time to support any service change proposed?	**N**	**No**		
12. Has a Project Board been identified to manage the implementation?	**N**	**There will be the development of a Regional Network Board**		
13. Is there an implementation plan with timescales to performance manage the process and risks?	**N**	**N/A**		
14. Is there a post project evaluation planed for the new proposal/service model?	**N**	**N/A**		
15. Are there any other constraints which would prevent progress to implementation?	**N**	**Funding and subsequent staffing**		
Quality/Patient Care Impacts				
16. Could there be an impact on patient outcome/care?	**Y**	**Decreased waiting times and improved clinical outcomes as a result**		
17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.	**N**	**The 2023/24 Orthopaedic Plan and longer term Regional Plan will reduce inequity and access in service provision across the Region**		

18. Is there any potential for inconsistency in approach across the Health Board?	**N**	**Variations in service delivery are monitored and addressed in conjunction with the GIRFT Recommendations Action Plan**		
19. Is there are potential for postcode lottery/commissioning?	**N**	**The Regional solution is designed to mitigate postcode lottery**		
20. Is there a need to consider exceptional circumstances?	**Y**	**Any exceptional circumstances will be addressed by the Regional Network Board**		
21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?	**Y**	**Waiting times would increase if Plan not enacted.** **Plan will improve patient outcomes, access, reduce further deterioration and more intensive procedures caused by deterioration.**		
22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?	**Y**			
23. Can clinical engagement be evidenced in the design of the new proposal/service model?	**Y**	**GIRFT was led by clinicians and all HDUHB clinicians are involved in addressing their recommendations. The Regional discussions across Wales are being led by the Clinical Lead for T&O at HDUHB**		
24. Are there any population health impacts?	**Y**	**Waiting times would increase if Plan not enacted.** **Plan will improve patient outcomes, access, reduce further deterioration and more intensive procedures caused by deterioration.**		
Workforce Impact				
25. Has the impact on the existing staff/WTE been determined?	**Y**	**Staffing recruitment challenges have been identified**		

26. Is it deliverable without the need for premium workforce?	**N**	**Due to staffing challenges there may be a need for premium workforce**		
27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?	**N**	**Staff are fully engaged in all service change**		
28. Is there potential for professional body/college/union involvement?	**Y**	**There will be the potential for involvement**		
29. Could there be any perceived interference with clinical freedom?	**N**	**Full clinical involvement and reference to NICE and other national standards will be adhered.**		
30. Is there potential for front line staff conflict with the public?	**N**			
31. Could there be challenge from the 'industries' involved?	**N**	**Full clinical involvement and reference to NICE and other national standards will be adhered.**		
32. Is there a communication plan to inform staff of the new arrangements?		**The Regional Plan will address this**		
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?		**The Regional Plan will address this**		
34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?		**The Regional Plan will address this**		
Risk Impact				
32. Has a risk assessment been completed?		**The Regional Plan will address this**		
33. Is there a plan to mitigate the risks identified?		**The Regional Plan will address this**		
Legal Impact		**N/A**		
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or				

regulations that should be considered before a decision is made?				
35. Is there a likelihood of legal challenge?				
36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?				
37. Is there any existing contract and/or notice periods?				
Reputational Impact		**The Regional Plan will address these issues as, should they arise**		
38. Is there a likelihood of public/patient opposition?				
39. Is there a likelihood of political activity?				
40. Is there a likelihood of media interest?				
41. Is there the potential for an adverse effect on recruitment?				
42. Is there the likelihood of an adverse effect on staff morale?				
43. Potential for judicial review?				
Privacy Impact		**N/A**		
44. Have the Information Governance Team been contacted about the project to assess whether a Data Protection Impact Assessment (DPIA) needs to undertaken?				

45. Has a full DPIA been undertaken – Please contact Information.Governance3@wales.nhs.uk for the template.				
Equality Impact (unless otherwise completed as part of the accompanying SBAR)		**N/A**		
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)				
47. Has a full EqIA been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)				
48. Have any negative/positive impacts been identified in the EqIA documentation?				

Organisational response

Report title: Orthopaedic Services in Wales – Tackling the Waiting List Backlog

Completion date: June 2023

June 2023

Document reference: National Report and 3293A2022

Ref[1]	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level. We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time	The organisation has a detailed GIRFT action plan against which it monitors recommendations. Improvement is monitored across many operational weekly and monthly meetings and its impacts on capacity to meet national wait targets. The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual	**COMPLETED**	**LYDIA DAVIES-SDM T&O**

	recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	Plan. The proposed Regional Network Board will undertake capacity and demand planning across the region further supporting the longer term development of regional pathways, based on the GIRFT principles.		
R4	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist. We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	a) CMATS is appropriately staffed and reflects Welsh Government Practice b) First Contact Practitioners have clear pathways and are preventing unnecessary GP interventions and referral to CMATS. Duplication of effort does not exist. CMATS triage all Orthopaedic referrals within the HB except those with a clinical urgency of USC and paediatric referrals. CMAT waits are currently 6 weeks.	**COMPLETED**	**JOHN DAVIES- HEAD OF PHYSIOTHERAPY SERVICES**
R5	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms. We recommend that health boards need to:		**COMPLETED**	**L DAVIES- SDM, T&O**

	a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	a) The T&O Management team and service work very closely with the VBHC (Value Based Health and Care) team in the implementation and collection of PROMS. PROMS is collected for all hip and knee arthroplasty patients at prehabilitation stage (since February 2022) and at one year post-surgery to inform decision making and monitor potential deterioration. PROMS are similarly used within the Upper limb pathway b) Adherence to INNU and Do not do procedures are reinforced within the service and waiting lists are scrutinised for compliance. Patient pathways are reviewed to minimise unnecessary interventions c) The WLSS (Waiting List Support Service) – has contacted all inpatients who will have waited > 36 weeks at 31.3.23. Hip and knee replacement Patients have been offered a prehabilitation online package and support to maximise fitness whilst they wait. Patients raising concerns about deterioration have been contacted by the team which includes nurses, physios, and OTs to identify issues and have signposted patients accordingly or referred to the Consultant- as		

		considered appropriate for F2F clinic review.		

Page	Board member question	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations
6	What factors are contributing to the Health Board's comparative performance on overall orthopaedic waits relative to population	• The HB has, up until March 2020, been able to secure a better match between capacity and demand, achieving a RTT wait of 36 weeks or below for the two financial years preceding the pandemic. • Whilst the COVID 19 pandemic impacted significantly on increased waiting lists beyond levels previously recorded, the HB has been, and remains, the most consistent deliverer of RTT waiting list reduction milestones in Wales. Factors contributing to this include: • Experience and expertise within the HB's Planned Care team leading to robust demand and capacity planning, development of coherent delivery plans and active monitoring of plan delivery. • The creation of the Waiting List support Service has maintained communication with patients during and since Covid and referring patients to the prehabilitation service to assist in maintaining good health whilst awaiting surgical intervention. • The T&O Prehabilitation Service support health optimisation and tailored input/advice to patients by providing a programme that includes physical exercise sessions, advice on the self-management of symptoms, healthy life-style advice, nutritional advice, home safety advice and advice on mood and wellbeing, to improve post-operative and longer-term health outcomes and patient experience • On-going robust administrative and clinical validation of patients on waiting lists

		• Early adoption and implementation of virtual review appointments during the pandemic • The Clinical Musculoskeletal Assessment and Triage Service (CMATS) has had a positive impact on managing demand and providing support to patients who would otherwise be directly referred to Orthopaedics • Active engagement within the Orthopaedic clinical team with best practice guidance and adherence to clinical standards of care delivery.
8	Is the Health Board likely to meet the targets set out in the Welsh Government's national recovery plan for planned care? If not, when does it anticipate achieving the key milestones set out in the plan?	• The HB met the ministerial target of having no orthopaedic waits over a year, waiting for a first outpatient appointment at 31.3.23 and will maintain this target**.** • Eliminate the number of people waiting longer than two years in most specialities by March 2023 – due to the extent of the backlog which developed during the pandemic, it is predicted that at 31.3.24 there will be circa 1900 orthopaedic inpatients waiting in excess of 2 years. Full recovery of the pre-pandemic waiting list position is not anticipated before 2027. • The short term elective recovery restart plan is reflected within the Orthopaedic Delivery Plan and detailed within the Annual Plan which has endorsed by the Board. • The establishment of the Regional Orthopaedic Board will produce the longer term delivery plan to attain this target.
8	How is the Health Board communicating with patients to tell them how long their wait is likely to be and what to do if their condition deteriorates?	• The WLSS (Waiting List Support Service) – contacted all inpatients who will have waited > 36 weeks at 31.3.23. Hip and knee replacement Patients have been offered a prehabilitation online package and support to maximise fitness whilst they wait. Patients raising concerns about deterioration have been contacted by the team which includes nurses, physios, and OTs to identify issues and have signposted patients accordingly or referred to the Consultant- as considered appropriate for F2F clinic review.
8	What is the Health Board doing to prioritise those most at risk of coming to harm because of a delay?	• The Pre-assessment Screening service contacted all patients where there was a plan to treat by 31/3/22 to make initial health assessments before the patients attends full surgical pre-assessment in advance of surgery.

		• The WLSS (Waiting List Support Service) – contacted all inpatients who will have waited > 36 weeks at 31.3.23. Hip and knee replacement Patients have been offered a prehabilitation online package and support to maximise fitness whilst they wait. Patients raising concerns about deterioration have been contacted by the team which includes nurses, physios, and OTs to identify issues and have signposted patients accordingly or referred to the Consultant- as considered appropriate for F2F clinic review • The T&O Prehabilitation Service support health optimisation and tailored input/advice to patients by providing a programme that includes physical exercise sessions, advice on the self-management of symptoms, healthy life-style advice, nutritional advice, home safety advice and advice on mood and wellbeing, to improve post-operative and longer-term health outcomes and patient experience.
8	Does the Health Board have information to indicate whether orthopaedic patients are coming to harm because of delays in their diagnosis and treatment? If so, what does this show and what action is being done to minimise the harm?	• The WLSS (Waiting List Support Service) – contacted all inpatients who will have waited > 36 weeks at 31.3.23. Hip and knee replacement Patients have been offered a prehabilitation online package and support to maximise fitness whilst they wait. Patients raising concerns about deterioration have been contacted by the team which includes nurses, physios, and OTs to identify issues and have signposted patients accordingly or referred to the Consultant- as considered appropriate for F2F clinic review.
11	Has the Health Board undertaken any recent analysis of variation in waiting times by type of surgery and hospital site? If so, what does the analysis show?	• The Health Board produces a daily RTT SITREP. This provides a breakdown of all specialties by stage and wait time (36 week;52 week;102 week)and can be filtered by site, consultant, clinical condition, urgency, etc. This is scrutinised to ensure all patients are managed in accordance with ministerial targets and urgency and alongside theatre and outpatient capacity, resources are utilised appropriately to address. • This analysis shows that all patients who will have waited >104 weeks at 31.3.24 will be inpatients. The vast majority of these patients are awaiting primary hip and knee replacement surgery. As the majority of these patients are pooled, site is irrelevant and all inpatient activity in the south of the Health Board takes place at Prince Philip Hospital, Llanelli

11	What action is the Health Board taking to reduce variations in lengths of wait for the same treatment across different hospital sites?	• The HB has supported the pooling of patients across clinicians and sites, as appropriate for many years - patients are offered treatment with alternative consultants and at various sites, dependent upon capacity. To support this all clinicians have had consenting appointment slots incorporated into their clinic templates to review and consent patients
12	To what extent is the Health Board seeing, or expecting to see, the latent demand return? If not expected to return, does the Health Board know where the demand has gone?	• Outpatients – since Covid, although there has been an annual increase in outpatient additions to the waiting list, this still remains 15% less referrals than during 2019/20. • Treatments - since Covid, although there has been an annual increase in total additions to the waiting list, this still remains 36% less additions than during 2019/20. • Further national review is required to inform an evidenced assessment of the factor influencing reduced demand in the early post-pandemic period.
12	Does the Health Board have a good understanding of the current and future demand for orthopaedic services?	• The HB has a good understanding of the current and future p0redicted demand for orthopaedic services and has a well-developed capacity and demand tool to monitor this. A daily RTT SITREP supports monitoring by site, clinician and clinical condition. A weekly follow up SITREP is similarly produced • The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. • The proposed Regional Network Board will undertake longer term capacity and Demand planning across the region beyond 2023/24. This will build on the demand and capacity assessment undertaken via the NCSOS Wales review of orthopaedic services completed during 2022.

12	How is the Health Board ensuring that only appropriate referrals are made into secondary care services	• The electronic referral system supports immediate contact with/advice for with all referrers when referrals are received so that inappropriate referrals can be declined or additional advice requested by consultants. • The Orthopaedic service is also creating electronic 'Health pathways' for GP's concerning treatment advice and referral guidance. • Patients referred into the orthopaedic pathway are assessed via the CMATs MSK service.
12	Are community-based prevention and treatment approaches such as Clinical Musculoskeletal Assessment and Treatment Services operating effectively, and are there opportunities to exploit community-based services further	• The above will further support ensuring all community treatment options are considered before referral to secondary care. • First Contact Practitioners further support community based care
13	What is the Health Board doing to stem the growth in the numbers of people waiting?	• 'Health pathways' will assist in ensuring patients are only referred once all appropriate conservation treatment options have been considered. • Significant progress has been achieved in reducing the volume of patients awaiting outpatient assessments and day case procedures
13	To what extent has list validation been the main factor in reducing waiting lists? To what extent are removals because of validation due to administrative issues? If so, what lessons are being learnt?	• The HB has had an internal validation team for many years, however validation is not the main factor in reducing waiting lists and average weekly ROTT (which includes validation) has remained stable since 2019. • Any trends in pathway inaccuracies are tracked back to individuals/ services and training needs analysis undertaken and implemented to prevent repetition
13	How is the Health Board ensuring the elective orthopaedic capacity is protected from unscheduled care and wider pressures?	• The HB has ring fenced elective inpatient beds at Prince Philip and Bronglais Hospitals. Daily scrutiny meetings across all hospitals sites monitor unscheduled flow issues and identify mitigations. Inter departmental week day 'Trauma Huddles' also monitor trauma demand specifically and seek to re-direct patients as capacity and demand permit.

14	Has the Health Board undertaken any analysis to understand whether there is a higher or lower rate of procedures, such as hip and knee replacements, than would be expected for the local population? If so, what does it show and are there opportunities for improving productivity and efficiency?	• Analysis of historical access and referral rates informed the development of the CMATs service in recent years. • Further population based analysis will be progressed via the proposed establishment of a regional Orthopaedic Network Board which will inform the development of pathways for the longer term development of the service across South West Wales.
14	Does the Health Board understand whether the procedures are delivering positive outcomes for patients?	GIRFT identified that: • HDUHB have low hip and knee revision activity, this indicates consultants are performing primary operations to a high standard. **Exemplar practice identified:** Return for another hip procedure (on the same side) within 1 year for patients 60+ years - Excellent return to theatre dates for another hip procedure within 1 year • Return admission within 1 year for another knee procedure on the same knee for patients 60+ years following primary knee replacement - Good practice identified**:** Excellent return to theatre rates for another knee procedure within 1 year • Return for another shoulder procedure (on same side) within 1 year, for patients 60+ years – **Good practice identified:** • Excellent return to theatre rates for another shoulder procedure within 1 year. • Good adverse event rates for hip and knee across the Health Board.
16	If the older population continues to grow, but real terms spend on orthopaedics does not keep pace, can the Health Board ensure that future service models will be sustainable?	• The development of the Regional Network Board will develop capacity and demand plans for the longer term and identify the associated workforce challenges across SW Wales
18	To what extent does the Health Board currently have the capacity to meet orthopaedic service demand? Where are there capacity gaps?	• The Health Board is forecasting 1895 in patent breaches waiting > 104 weeks at 31st March 2024. The main challenge is the recruitment of theatre and anaesthetic staff to enable all theatre capacity to be fully utilised.

18	What are the workforce risks and challenges?	• The main challenge is the recruitment of theatre and anaesthetic staff to enable all theatre capacity to be fully utilised
18	How is the Health Board working regionally to create high volume low complexity capacity	• Service delivery is planned in accordance with HVLC programme principles. Clinicians from HB fully involved and integrated with Welsh Orthopaedic Network CRG's to deliver changes to pathways and ensure improved efficiency and productivity • The Health Board is working collaboratively with SBUHB to utilise all capacity available to address wait times. • The establishment of the Regional Orthopaedic Board will plan capacity for the longer term
18	What is the Health Board doing to create greater levels of efficiency in orthopaedic pathways?	• Creation of Health Pathways by clinical condition for GP's:- Conservative treatments to be offered in advance of referral and referral criteria • Reinforced follow up guidance by procedure- eliminating variation, and unnecessary attendances and creating capacity • Regular Audits by the Clinical Lead on the above broken down by Consultant • Additional day case capacity has ensured day cases are treated on HVLC day theatre session and not in LVHC main theatre environments • Theatre list loading has been standardised across the Health Board and is scrutinised weekly • 2 joint sessions take place when operationally and case mix feasible. • Pathways are administratively and clinically validated for wait time accuracy and efficient delivery of care • Implementation of First contact pathway physiotherapy practitioners across the HB to identify appropriate patients for orthopaedic surgery and referral into the service.
21	To what extent is radiology or physiotherapy capacity having an impact on the timeliness of the overall orthopaedic pathway?	• There are staffing and equipment replacement challenges in radiology causing greater waits in some modalities. Mitigations in radiology service delivery have minimised impact on pathways

		• Similarly, physiotherapy support on elective wards is challenged but mitigations are in place using physio and OT support staff
21	Are there costed plans to match demand and capacity in those areas if required?	• Costed plans have been produced to support various options to provide planned increases in capacity
25	Is the Health Board adopting Patient Initiated Follow Ups and See on Symptoms pathways at sufficient pace? If not, what are the barriers?	• SOS/PIFU - At 31.3.23 - Total 14,455 patients on either a SOS or PIFU pathway across trauma and orthopaedic pathways (SOS= 12,187/PIFU 2268) In March alone T&O added 756 to a SOS or PIFU pathway
25	Are consultant job plans being reviewed to adapt to new outpatient models and maximise use of their time?	• Job planning sessions take place annually, or as required, involving the Clinical Lead and management team. • Outpatient and theatre session allocation and utilisation are discussed and agreed, ensuring standardisation between subspecialists, as appropriate. Staffing models and workforce planning(use of therapists, etc) to support the consultants sub specialisation are considered to maximise use of their time
25	To what extent are digital/virtual outpatient appointments being used? Is this delivering a better and more efficient service?	• During Covid the T&O Service considered the use of multiple virtual platforms to review elective patients it was unable to see face to face. Telephone consultations were the chosen medium • However, it was determined that for the majority of sub specialisms face to face consultations were necessary. Current usage is: NEW - 87.5% face to face, 12.5% virtual FOLLOW UP - 63% face to face, 37% virtual

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as oneHealth Board and not hospital by hospital.	June 2022 - Recommendation was accepted by HDUHB. GIRFT findings and recommendations to be presented to the Quality Safety and Assurance Committee for consideration and agrement for a Steering Group to be convened	Lydia Davies	Jun-22	N/A	Green	The decision was made not to proceed with the establishment of an Orthopaedic Steering Group as it was more favourable to proceed with the proposed Regional Orthoapedic Network Board (the Memoradum of Understanding of which has been accepted by the Board) to plan on a Regional basis as agreed by the Arch Recovery Group
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R2. Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review Annex A and implement improvement	Lydia Davies	Jun-22	May-23	Green	18/04/2023 - Annex A Action plan has been reviewed by the Service
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R3. There is currently an appointed Orthopaedics Health Board Clinical Lead (CL). This is a key strength of the Hywel Dda Orthopaedic service, which is lacking in some of the other Health boards that have multiple silo Orthopaedic units. The CL clearly projects a unified voice from the 3 Orthopaedic units in Hywel Dda despite their geographical distance. We are concerned however that the CL is not supported by the HB in making the essential operational and strategic changes required. We recommend that through enhanced management support, the Orthopaedics Clinical Lead role is enabled to instigate Health Board level change at pace and empowered to provide steer and direction to the Health Board executive team on regional models of working with neighbouring Health Boards.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	The Clinical Lead is supported by a Service Delivery Manager (SDM), Service Manager and Service Support Manager for the Specialty and a Senior Nurse Manager (SNM). The CL, SDM and SNM form the trimvirate for the specialty. The specialty management team meet weekly with the CL to discuss operational, governance, financial, staffing and clinical stategy. The CL is involved in strategic and operational decisions within the organisation and fully involved in the Regional and National agenda for Orthopaedics. The CL is however unable to directly influence parts of that pathway that are outside his remit, e.g. availability of ring fenced beds, anaesthetic provision, allocation of theatre capacity or POAC.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R4. HDUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent need to re-engage with clinicians to rebuild trust and ensure that they 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	amber	SDM, Service Manager and Service Support Manager meets with the Clinical Lead on a weekly basis to discuss and agree, action and escalate, as required, specialty strategic and operational issues at local, Regional and national level. This is cascaded to clinicians on all sites via the Local clinical leads and via the monthly Departmental meeting, as appropriate. The longer term strategy for orthopaedic provision remains to be confirmed and will be addressed by the Regional Orthopaedic Network Board. 2023/24 Orthopaedic Delivery is reflected in the Annual Plan

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R5. 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 communication with 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jul-22	N/A	Green	A Staff Discovery Action Plan outlines the learning gained from several staff surveys and progress against relevant actions. June 2022 - There was a nursing survey led by Swansea University and the Health Board linked with it's cultural workforce specialists to draw up a supportive framework to address these issues particularly for wider team Head of Culture and Workforce Experience reports into HB with regular feedback obtained from staff. Morale has naturally improved as services reestablished themselves in line with pre-covid and job plans.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R6. 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 on 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 to be in place, no later than the end of March 2022. Any barriers or risks to delivery of this plan 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jul-22	N/A	Green	The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. The Health Board is forecating circa 1900 inpatent breaches waiting > 104 weeks at 31st March 2024
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R7. 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jul-22	Jun-23	Amber	Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R8. 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	The T&O Management team and service work very closely with the VBHC (Value Based Health and Care) team in the implementation and collection of PROMS (Patient Reported Outcome Measures). PROMS is collected for all arthroplasty patients at prehabilitation stage (since February 2022) and at one year post-surgery. Further roll out of PROMS to other subspecialties to be considered

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R9. We recognise that the Health Board do review litigation claims, which we are pleased to see. They should, however, broaden this to a programme which ensures 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 still be improved.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	There is a robust minuted Directorate governance meeting which feeds into OpsQSE as needed All complaints, SUIs, Never Events etc are reviewed by those involved in the cases and the Portfolio triumvurate management team sign off all responses and actions needed to address shortafalls in service delivery. A Learning From Event presentation is produced by the consultant involved in the case and presented at the Trauma and Orthopaedic Departmental meeting. This meeting is attended by all disciplines associated with the care of Trauma and Orthopaedic patients. Portfolio management meet weekly with the Concerns Team to ensure timely responses are maintained.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R10. 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 reviews of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	SSI rates have been capatured for **all** joint replacement surgery within the Health board since March 2022. Rates are below recommended levels Further consideration is being given to the collection of SSI rates for non arthroplasty procedures
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R11. As part of the medium and longer term orthopaedic planning, 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.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	This is completed as part of the governance process which is built in as part of EOI (Expressions of Interest) and the tender process. The Directorate meet regularly with external providers to discuss these reports. No orthopaedic outsourcing has taken place since pre-Covid.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12a. 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: Carry out full demand and capacity planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve HDUHB.**	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. Green pathways exist at PPH and BGH with Orthopaedic ringfenced inpatientbeds on each The proposed Regional Network Board will undertake Capacity and Demand planning across the region
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12b. 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: Set up a weekly sitrep specifically focused on elective recovery with the Executive.This should include all patients waiting for elective orthopaedic surgery and sub categorised by: ASA score; time on waiting list; both expected and actual operations carried out on a weekly basis and reasons, if underperformance. There needs to be close scrutiny of forward projections to reduce waiting lists with robust targets set. These should also include adoption of the HVLC pathways and ensure 90% of those cases are Day Case. We suggest that to gain optimum 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	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	The service collates a SITREP which is scrutinised weekly at Watchtower alongside the Specialty Capacity and Demand tool. The SITREP provides a break down of all specialties by stage and wait time (36 week;52 week;102 week)and can be filtered by site, consultant, clinical condition, urgency. This is scutinised to ensure all patients are managed in accordance with ministerial targets and urgency and alongside theatre and outpatient capacity, resources are utilised appropriately to address.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12c. 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: Establish a delivery model to restart elective recovery. This needs to be established at pace. RNOH/GIRFT supports the development of Prince Philip Hospital (PPH) as the designated HVLC centre for the HB and as a centre for more complex LVHC work. There is also an opportunity to develop PPH as a regional LVHC centre in collaboration with SBU. Centralisation of trauma services to a single site in the South of Hywel Dda at Glangwili General hospital (GGH) would provide additional capacity at the Withybush General Hospital (WGH) site creating additional capacity for ambulatory trauma and short stay elective workload. Increased elective capacity at the BGH site would provide additional regional capacity for South Gwynedd (BCU) and West**	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Lydia Davies	Jun-22	N/A	Green	The short term elective recovery restart plan is reflected within the Orthopeadic Inpatient Delivery Plan within the Annual Plan and has endorsed by the Board. The establishment of the Regional Orthopaedic Board will produce the longer term delivery plan. The plan for recovery adopts the GIRFT recommendations. There is no planned change to the current configuration of trauma services at Glangwili Hospital . .
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12d. 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: Develop a recovery plan of how to effectively utilise Glanwilli (Trauma Centre)Bronglais and Withybush Hospitals.**	June 2022- Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as identified through the develoment of a recovery plan of how to effectively utilise Glanwilli (Trauma Centre)Bronglais and Withybush Hospitals.	Lydia Davies	Jun-22	N/A	Green	Recovery plan referenced in update for Rec 12c above.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12e. 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: Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.**	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as identified within the Health Board's Transforming Urgent and Emergency Care Programme	Lydia Davies	Jul-22	N/A	Green	Health Board Transforming Urgent & Emergency Care Programme launched June 2022. This work is on-going. Regional collaboration considers all options to reinvigorate elective capacity
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12f. 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: Develop an enhanced recovery unit 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.**	June 2022 - Recommendation was accepted by HDUHB. Consider an enhanced recovery unit 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.	Lydia Davies	Jun-22	N/A	Green	Demand for post operative intensive support is low in Orthopaedic elective treatments and therefore plans for an enhanced recovery unit have not currently been prioritised. This issue will be revisited in the development of Regional Plans for Orthopaedic provision

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12g. 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: Upskill and empower therapy staff to undertake greater roles.**	June 2022 - Recommendation was accepted by HDUHB - to consider Upskilling and empowering therapy staff to undertake greater roles.	Lydia Davies	Jun-22	NH/A	Green	The upskilling and empowerment of therapy staff has included: - Maintenance programmes and support to patients currently on an orthopaedic waiting list or pending surgery. - Supporting patients ready for surgery to optimise outcomes - Building capacity- numerous business cases developed for numerous developments to enhance orthopaedic pathways - Role redesign - Strategic engagement and influence - Research 1. Direct therapy engagement in the trial of the use of the "Robot" in PPH 2. Prehabilitation element has been developed for inclusion in the "My Pathway" app for testing
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12h. 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: Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.**	June 2022 - Recommendation was accepted by HDUHB - Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	Lydia Davies	Jun-22		Amber	The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7). The Orthoapedic Portfolio Management team and CL are fully supportive of such expansions

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12i. 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: Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.**	June 2022 - Recommendation was accepted by HDUHB - Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	Lydia Davies	N/K		Amber	Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12j. 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: Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day**	June 2022 - Recommendation was accepted by HDUHB - Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	Lydia Davies	Jun-22		Amber	Pre-operative assessment pathways are subject to current review in line with NHS Wales IP&C guidance and is being undertaken through an EQuIP project. This is not a rate limiter for Orthopaedics

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12k. 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: Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.**	June 2022 - Recommendation was accepted by HDUHB - Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	Lydia Davies	Jun-22		Amber	Service delivery planned in accordance with HVLC programme principles. Clinicians from HB fully involved and integrated with Welsh Orthopaedic Network CRG's to deliver changes to pathways and ensure improved efficiency and productivity Theatre staffing and anaesthetist shortfalls (which would provide dedicated and consistent workforce to support flow in theatre environment), treat in turn and the clinical urgency of patients all currently contribute to not routinely achieving 2 joints per theatre session across BGH and PPH (only sites where joints are carried out). This situation is being monitored so compliance is achieved whenever possible. List loading for GA and LA theatre sessions has been standardised across all sites/consultants and to maximise throughput and efficiency adopting HVLC programme and GIRFT principles. Maintaining thses standards is assured via the weekly Theatre User Groups and Theatre Scheduling meetings
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12l. 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: **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.**	June 2022 - Recommendation was accepted by HDUHB - 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.	Lydia Davies	Jun-22	N/A	Green	Health Board is fully engaged with NHS Wales Planned Care Programme.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12m. 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: Review emergency and urgent pathways to improve patient flow.**	Review emergency and urgent pathways to improve patient flow.	Lydia Davies	Jun-22	N/A	Green	Health Board Transforming Urgent & Emergency Care Programme launched June 2022.
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12n. 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: Review patients that are deconditioning on the waiting list and identify patientsthat require urgent care.**	June 2022 - Recommendation was accepted by HDUHB - Review patients that are deconditioning on the waiting list and identify patientsthat require urgent care.	Lydia Davies	Jun-22	N/A	Green	The WLSS (Waiting List Support Service) – as detailed above- has contacted all inpatients who will have waited > 36 weeks at 31.3.23. Hip and knee replacement Patients have been offered a pre-habilitation online package and support to maximise fitness whilst they wait. Patients raising concerns about deterioration have been contacted by the team which includes nurses, physios, and OTs to identify issues and have signposted patients accordingly or referred to the Consultant- as considered appropriate for F2F clinic review.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12o. 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: Determine effective and efficient follow up plans, which should be carried outvirtually if possible.**	June 2022 - Recommendation was accepted by HDUHB - Determine effective and efficient follow up plans, which should be carried outvirtually if possible.	Lydia Davies	Jun-22	N/A	Green	Virtual fracture clinics and follow up elective clinics are regularly reviewed by the Clinical Lead to assess efficiency against clinical need and national guidance. SOS/PIFU - At 31.3.23 - Total 14,455 patients on either a SOS or PIFU pathway across trauma and orthopaedic pathways (SOS= 12,187/PIFU 2268) In March alone T&O added 756 to a SOS or PIFU pathway PROMS is collected for all arthroplasty patients at prehabilitation stage (since February 2022) to capture early data on the patient for comparative purposes later in their pathway and identification of service need and at one year post-surgery. Currently reviewing further collection at joint school (approx 3 months before surgery). Consultant views also being sought, following GIRFT suggestion, as to the validity of continuing with collection and review at 1 year post operatively for arthroplasty patients as surgical outcomes suggest this is not required. Further roll out of PROMS to other subspecialties to be considered
RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R12p. 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: Review patients with high BMI and weight management services and identify improvement strategies and how to best respond to patients wanting surgery with high BMI.**	June 2022 - Recommendation was accepted by HDUHB - Review patients with high BMI and weight management services and identify improvement strategies and how to best respond to patients wanting surgery with high BMI.	Lydia Davies	Jun-22	N/A	Green	The Screening service contacted all patients where there was a plan to treat by 31/3/22 to make initial health assessments before the patients attends full surgical preassessment in advance of surgery. The T&O Prehabilitation Service support health optimisation and tailored input/advice to patients by providing a programme that includes physical exercise sessions, advice on the self-management of symptoms, healthy life-style advice, nutritional advice, home safety advice and advice on mood and wellbeing, to improve post-operative and longer-term health outcomes and patient experience.

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RNOH_GIRFTOR_0522	May-22	Getting It Right First Time (GIRFT) Orthopaedic Review	Lydia Davies	Director of Operations	R13. 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 to the success of 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.	June 2022 - Recommendation was accepted by HDUHB - 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.	Lydia Davies			Amber	The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. The development of a Regional Network Board will prioritise plans for the longer term and identify associated workforce across SW Wales

Annex A: Orthopaedics Action Plan

Activity/ Metric	Meeting outputs	Agreed actions / Recommendations	Position Statement as at (May 2023)
Elective hip replacement			
Fixation method for elective hip replacements (%) − Patients 65+ yea	**Exemplar practice identified:** HDUHB predominantly use cemented hip fixations for patients over 65+ years, demonstrating good practice guidance is being followed.	**RNOH/GIRFT recommends:** *This recommendation is being achieved at HDUHB.* 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.	**HDUHB already has high usage of cemented THR (best in Wales) which we need to maintain. Currently 2 different systems being utilised within the HB which could be rationalised to a single system**
5 and 10-Year Revision Rate Hip Primary	**Good practice identified:** Good 5-year elective hip revision rates, this is likely due to using cemented hip fixations, evidence shows using cemented hip fixations in patients over 65+years have better outcomes. Good 90-day mortality rates.	**RNOH/GIRFT recommends:** HDUHB to require annual peer review of Surgeon Level Reports from the NJR which should be noted in the appraisal documentation.	**HDUHB has 2 very high volume revision surgeons for both TKR and THR who deal with the majority of revision workload HB wide. There are 2 very low volume revision surgeons who cannot maintain sufficient volumes moving forward. Concentrating volumes within a cohort of 3 surgeons at present demand levels would be most appropriate as there are service sustainability issues for acute revisions and peri-prosthetic fractures at times of leave etc. This will be addressed during upcoming job planning discussions**

Elective knee replacement			
5 and10-Year Revision Rate Elective Knee	Glangwili Hospital no longer carries out elective knee revisions, this service has been centralised and is now carried out at the Trauma Centre. **Good practice identified:** HDUHB have good 5-year elective knee revision rates. Excellent elective knee revision rates at Prince Philip Hospital – 2 standard deviations below the mean. Good 90-day mortality rates.	**RNOH/GIRFT recommends:** to rationalise hip and knee prostheses across the Health Board to improve services. This will result in better familiarisation of the kit, and in improved theatre efficiencies, helping to reduce waiting lists and costs to the NHS. **RNOH/GIRFT recommends**: All revisions and primary patellafemoral, elbow and ankle replacement cases to be discussed in appropriate MDT's prior to surgical intervention.	**HDUHB already has one of the lowest variation of implant usage in Wales. Clinically driven rationalisation will be undertaken collaboratively. See above comments for THR revision in relation to TKR revision.** **Complex lower limb arthroplasty MDT being set up.** **Low volume arthroplasty e.g TER, TAR, PFJR to be discussed via National clinical networks within WON and specialty specific CRG's to avoid duplication**
Elective joint procedure for adults – PEDW			
Hip Procedures Knee Procedures Shoulder Procedures Elbow Procedures Hand and Wrist Procedures Ankle Procedures	HDUHB have low hip and knee revision activity, this indicates consultants at Prince Philip Hospital and Withybush Hospital are performing primary operations to a high standard. Arthroscopy data looks to be underreported - generally the arthroscopy data is poor. Patients that need a shoulder replacement after significant trauma will have this carried out at Prince Philip Hospital. As part of the National Strategy Programme, an all Wales pathway is currently being developed. High shoulder subacromial decompression activity at Prince Philip.	**RNOH/GIRFT recommends:** to undertake a review of arthroscopy and ankle activity data to identify the correct volumes and develop an improvement strategy to improve reporting of this data. This will be developed through the NCSOS project foot and ankle subspecialty and final reports. **RNOH/GIRFT recommends:** to review NHS shoulder subacromial decompression activity ensuring evidence is being used and these patients have gone through the appropriate pathway including physiotherapy before being offered surgery. **RNOH/GIRFT recommends:** to reconfigure foot and ankle procedure surgery to be carried out at one hospital.	**There are major clinical coding issues identified within all HB's. NCSOS/WON are working with the Delivery unit to develop an appropriate and clinically relevant dashboard to allow weekly sit rep to highlight variation in activity. Clinical Lead has met with Clinical Coding lead and waiting list teams to provide a simplified coding process to more accurately capture cases being listed locally. This is likely to be further amended once specialty specific CRG's within WON report back with their outputs in terms of standardised coding Nationally.**

	All cases go through the appropriate pathway including physiotherapy before being offered surgery. Ankle arthrodesis (fusion) and complex reconstruction foot procedures are carried out at two sites (Prince Philip and Withybush). HDUHB are currently working towards centralising foot and ankle activity at one hospital. High volumes of ankle replacements in comparison to ankle fusions. This is likely to be a coding error. Good practice identified: - Shoulder replacement surgery has been centralised and carried out at Prince Philip Hospital. (The data shows 2 x shoulder replacements were carried out at Glangwili Hospital, these were identified as trauma cases) - Elbow and ankle replacements are carried out at Prince Philip Hospital. Single surgeon practice. - All shoulder subacromial decompression cases go through appropriate pathway including physiotherapy before being offered surgery - HDUHB are planning to centralise foot and ankle activity to be carried out at one hospital.	**RNOH/GIRFT recommends:** to review ankle replacements and ankle fusion data to understand if this a coding error.	**All SAD's are provided with exhaustive non operative treatment according to GIRFT and BESS pathway.** **F+A CRG within WON will further develop principles of ankle arthritis clinical network to ensure appropriate MDT as above** **Shoulder revision surgery and complex primary undertaken as dual consultant procedures.** **Total elbow replacement volumes very low with a single surgeon undertaking. S+E CRG within WON to further advise on clinical network and requirements necessary with likely rationalisation to 1 or 2 centres in Wales or clinical network of visiting surgeon to ensure dual consultant operating.**

Elective joint replacement length of stay (days) PEDW			
Primary hip replacement Revision hip replacement Primary knee replacement Revision knee replacement Primary shoulder replacement Revision shoulder replacement Primary elbow replacement Revision elbow replacement Wrist replacement Primary ankle replacement Revision ankle replacement Knee ligament reconstruction Shoulder sub acromial decompression Shoulder rotator cuff Wrist arthrodesis (fusion) Ankle arthrodesis (fusion)	Variation in length of stay rates across the hospitals in HDUHB. Withybush has longer length of stay rates than the national average for patients receiving hip replacement. There are high hip and knee revision length of stay rates. TWRB: Centralise hip and knee revision activity to reduce length of stay rates. Primary ankle replacement length of stay is longer than the national average. **<u>Good practice identified:</u>** Good primary elbow length of stay rates.	**RNOH/GIRFT recommends:** HDUHB to undertake a review of hip and knee primary and revision length of stay rates and develop an improvement strategy. **Opportunity for learning best practice** 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. **RNOH/GIRFT recommends:** to review ankle replacement length of stay rates and establish an improvement strategy. **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: Best Practice library – day surgery – Getting It Right First Time - GIRFT	**In patient surgery now centralised in a single unit leading to reduction in LOS overall.** **LOS for primary TKR, THR and TSR remains low.** **Challenges of moving to day case arthroplasty as a result of patient cohort and medical complexity but principles of process agreed within T+O and actively engaging with anaesthetic colleagues.** **TAR LOS likely to be affected by low volumes/clinical coding errors and currently not impacting upon bed utilisation- further scrutiny required.**
Primary Hip			
Elective primary hip replacement with cemented fixation for patients 70+ Years	**Exemplar practice identified:** Excellent usage of cemented hip fixations being used for patients over 70+ years.	**RNOH/GIRFT recommends:** to cement THR in patients over 70 years old provides best outcomes	**See comments above**
Average length of stay for patients receiving elective primary hip replacement (days)	Length of stay is in line with the national average, there is room for improvement.	**RNOH/GIRFT recommends:** to consider measuring in hours opposed to days	**See comments above**
Return for another hip procedure (on the same side) within 1 year for patients 60+ years	**Exemplar practice identified:** Excellent return to theatre dates for another hip procedure within 1 year.	**RNOH/GIRFT recommends:** to consider post-operative follow ups to be carried out virtually.	**Adoption of best practice pathways as per GIRFT and NCSOS needs to be formally agreed. Most FUP arthroplasty activity is already virtual and APP delivered e.g arthroplasty practitioner (Band 7/8).**

			No further action required at this stage
Primary Knee			
Elective knee replacement for patients 60+ years average length of stay	Length of stay is in line with the national average, there is room for improvement.	**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: Best practice library - day surgery - Getting It Right First Time - GIRFT	**See comments above**
Return admission within 1 year for another knee procedure on the same knee for patients 60+ years following primary knee replacement	**Good practice identified:** Excellent return to theatre rates for another knee procedure within 1 year.	**RNOH/GIRFT recommends:** to consider post-operative follow ups to be carried out virtually.	**See comments above**
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:** HDUHB to undertake regular peer arthroplasty reviews of surgeon level data also reviewing low volume activity.	**See comments above**
Primary Shoulder			
Elective shoulder replacement for patients 60+ years average length of stay	**Exemplar practice identified:** Excellent length of stay rates for patients receiving a shoulder replacement.		**See comments above**
Return for another shoulder procedure (on same side) within 1 year, for patients 60+ years	**Good practice identified:** Excellent return to theatre rates for another shoulder procedure within 1 year.		**See comments above**
Surgeon Data			
Number of surgeons assigned to providers over three-year period	Low volume surgery identified in primary hip, hip revision, knee primary and knee revision. HDUHB: This data looks incorrect as primary hip replacements are not carried out at Glangwili Hospital. All arthroplasty surgeons carry out at least one hip or knee replacement per week. There is	**RNOH/GIRFT recommends:** HDUHB to undertake a review of low volume surgeons across the totality of their practice. Surgeons delivering less than 10 hip and knee revisions 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.	**See comments above. This will be reviewed at job planning and discussed with individuals.**

<table>
<tr><td></td><td>some low volume hip and knee revision surgery carried out.</td><td></td><td></td></tr>
<tr><td colspan="4">Procedures with adverse events - % of procedures with an adverse event</td></tr>
<tr><td>2020 (1 year) National Joint Registry
(NJR) Data

Hip
Knee</td><td>Good adverse event rates for hip and knee across the Health Board. Slightly high hip adverse event rates at Prince Philip Hospital.

<u>Bronglais</u>
Hip Primary: 0.00%
Knee Primary: 0.00%

<u>Glangwili:</u>
Hip Primary: 0.00%
Knee Primary: 0.00%

<u>Prince Philip</u>
Hip Primary: 1.29%
Knee Primary: 0.00%

<u>Withybush</u>
Hip Primary: 1.12%
Knee Primary: 0.00%

<u>HDUHB</u>
Hip Primary: 0.98%
Knee Primary: 0.00%</td><td>RNOH/GIRFT recommends: to review adverse events for primary hip at Prince Philip Hospital. A review of the theatre adverse events/ NJR data to be carried out annually.</td><td>Adverse events reviewed immediately within monthly Dept meeting to ensure learning rapidly disseminated</td></tr>
<tr><td colspan="4">PROMs – Average health gain – Case-mix adjusted Oxford hip/knee score</td></tr>
<tr><td>2019/20 (1 year)
Hip replacement – Inpatient
Hip replacement – Inpatient and Readm.
Knee replacement – Inpatient
Knee replacement – Inpatient and Readm.</td><td><table><tr><th>Bronglais</th><th>Glangwili</th><th>Prince Philip</th><th>Withybush</th></tr><tr><td>0</td><td>N/A</td><td>0.44</td><td></td></tr><tr><td>0</td><td></td><td>0</td><td></td></tr><tr><td>0</td><td></td><td>0.22</td><td></td></tr><tr><td>0</td><td></td><td>0</td><td></td></tr></table></td><td>RNOH/GIRFT recommends: to discuss and review PROMs score internally on an annual basis.</td><td>PROMS “data dump” and analysis requested. Proposal of an annual arthroplasty outcomes/NJR review session involving all orthopaedic clinicians as part of arthroplasty MDT</td></tr>
</table>

<table>
<tr><th colspan="4">Surveillance of surgical site infection (SSI) – orthopaedics – percentage of procedures with an infection – elective procedures</th></tr>
<tr>
<td>2019/20 (1 year)
Hip replacement - Inpatient
Hip replacement - Inpatient and Readm.
Knee replacement - Inpatient
Knee replacement - Inpatient and Readm.</td>
<td>
<table>
<tr><th>Metric</th><th colspan="2">Bronglais General Hospital</th><th>Glangwili General Hospital</th><th colspan="2">Prince Phillip Hospital</th></tr>
<tr><td>Hip replacement</td><td>2019
0</td><td>2020
0</td><td>N/A</td><td>2019
0</td><td>2020
0</td></tr>
<tr><td></td><td></td><td></td><td></td><td>0.44</td><td>0</td></tr>
<tr><td>Hip replacement - Inpatient and Readmission</td><td>0</td><td>0</td><td></td><td>0</td><td>0</td></tr>
<tr><td>Knee replacement – Inpatient</td><td>0</td><td>0</td><td></td><td>0.22</td><td>0</td></tr>
<tr><td>Knee replacement - Inpatient and Readmission</td><td></td><td></td><td></td><td>N/A</td><td></td></tr>
</table>
</td>
<td>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.</td>
<td>SSI data collected for all joint replacements across the HB since the centralisation of inpatients procedures at BGH and PPH – March 2022.</td>
</tr>
<tr><th colspan="4">Litigation</th></tr>
<tr>
<td>Total number of Claims T&O Claims

The total costs involved for T&O</td>
<td>Number of claims: 112

Total costs of claims : £5,968,469.43</td>
<td>RNOH/GIRFT recommends: HDUHB to regularly review the 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.</td>
<td>Claims are discussed openly and transparently in an anonymised “no blame” manner within Dept monthly meetings so that learning can be provided quickly. Further progress of claims are shared periodically including expert evidence and additional learning points.
No further action required.</td>
</tr>
</table>