GIRFT Orthopaedic National Report across Northern Ireland

June 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 Department of Health team for Northern Ireland. It aims to enable the urgent restoration of elective orthopaedics in Northern Ireland 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.

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1. Foreword

Getting It Right First Time (GIRFT) is a national programme designed to improve care by reducing unwarranted variation. The programme initially focused on NHS England Trusts but is now supporting organisations that deliver health services across primary, acute, community and mental health services, in both the public (including the Devolved Nations), and private sector. By tackling variation in the way services are delivered across the NHS and by sharing best practice between providers, GIRFT enables the identification of changes that will help improve care and patient outcomes, as well as delivering improved theatre productivity and efficiencies such as the reduction of unnecessary procedures and cost savings. These improvements in practice can then be shared with other healthcare systems.

Patients in Northern Ireland are now facing unprecedented waiting times for their surgery due to the cessation of elective surgery during the Covid pandemic of which the longest waiting lists are in orthopaedics. The problems facing Northern Ireland are the same as those facing England, with patients experiencing extended waits for their surgery. GIRFT have been instrumental in helping to lead the way in England to restart elective recovery. There is now, more than ever, an urgent need for us to work together on behalf of all patients to share good practice and innovation, to provide timely surgical treatment.

It is now essential that the recommendations I have made in this report are immediately taken forward to improve care for patients and to put in place a structure and new collaborative ways of working across Northern Ireland to deliver them. This will involve the Trusts working together and removing entrenched behaviours and existing boundaries. They must come together and work as a “whole” system supporting and working with each other. Furthermore, it is essential that the changes introduced, to increase elective orthopaedic activity and start to reduce the unacceptably long waiting lists, are resilient during the winter months; they must deliver elective care for 48 weeks per annum. We can no longer accept “shut down” of elective care during winter; it is not in the best interests of patients and will not produce a sustained reduction in waiting lists. This would further erode the morale of clinical staff who are desperate to restart services, but need it to happen in a sustainable manner.

I would like to thank colleagues from the Northern Ireland Department of Health who have been extremely supportive and positive throughout the programme. I would also like to thank the orthopaedic consultants across Northern Ireland who have been candid and honest in sharing their frustrations with the lack of pace in restarting elective surgery in Northern Ireland. I sincerely hope that through this programme of work, we can provide a real stimulus to restart and embed orthopaedic elective recovery and to encourage shared learning between the Northern Ireland and England NHS providers. This will result in improved care and outcomes for the patients of Northern Ireland.

Professor Tim Briggs CBE MBBS(Hons), MD(Res), MCh (Orth), FRCS, FRCS(Ed), Chair of The GIRFT Programme, National Director of Clinical Improvement NHS, Consultant Orthopaedic Surgeon, Director of Strategy and External Affairs RNOHT.

2. Executive Summary

This report is based on the observations from RNOH/GIRFT reviews of orthopaedic services at all the Northern Ireland Trusts. All visits, apart from that to Musgrave Park, Belfast Trust, were carried out virtually.

This report provides plans to urgently restart and transform orthopaedic elective services following the Covid pandemic. It contains a series of recommendations to improve the quality of care for patients, improve staff morale and to ensure that elective surgery is restarted without delay, to reduce waiting lists.

We found that in most Trusts only a small amount of inpatient elective orthopaedic surgery has restarted and there are very limited plans to increase activity "at pace", despite the urgency, resulting in further unnecessary increases in orthopaedic waiting lists.

Generally, there is both low morale and frustration across the orthopaedic workforce in Northern Ireland due to the lack of urgency in the restoration of their elective orthopaedic services and the continuous redeployment of staff.

3. Project Objectives

The aim of this rapid review programme was to identify how we could restart orthopaedic services in the five Trusts in the short term, whilst introducing changes to transform orthopaedic services across Northern Ireland. This was achieved by:

- Visiting (either virtual or face to face) each Trust to understand the position of the orthopaedic services
- Providing an overview assessment of current services
- Identifying critical pressure points that limit up-scaling of services
- Developing action plans (immediate, 3-6 month and 6+ months, long term) to mitigate against the pressure points and to increase capacity quickly
- Developing action plans (immediate, 3-6 months and 6+ months) to provide short-term improvements in the service model
- 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 to track progress at the end of our work with you.

4. Approach

RNOH/GIRFT has reviewed the orthopaedic services in each of the five Trusts in Northern Ireland. Each Trust was asked to provide information on their current orthopaedic services, hospital provision, waiting list and other information about their services.

We also undertook three virtual "drop in" sessions for all orthopaedic consultants in Northern Ireland to engage with Professor Briggs, who was the Clinical Lead on the programme. This enabled us to understand the issues from a clinical perspective in advance of the visits.

The review meetings, led by Professor Briggs, took place between 11th April 2022 and 6th May 2022. He was joined at the Belfast visit by Professor John Skinner, President of the British Orthopaedic Association. Each session was an opportunity for the Trusts to provide an overview of their orthopaedic services and current issues and to discuss future plans. All the meetings were well attended by a mix of colleagues in orthopaedic roles (clinicians, theatre staff, senior

managers and AHPs), were highly participative and generated excellent discussion. This allowed us to gain a good understanding of the issues facing each Trust and to suggest improvements.

We will continue to work with the Department of Health and the Health and Social Care (HSC) service going forward. This will include a webinar to highlight the findings and recommendations of this review.

5. RNOH/GIRFT Findings and Recommendations

5.1 Elective Recovery Findings

We observed, in some of the data shared with us, that orthopaedic elective surgery in Northern Ireland had delivered some good outcomes for patients prior to the pandemic. However, the waiting list for elective orthopaedic surgery pre-pandemic was increasing and now Northern Ireland has longest waiting lists in orthopaedics across in the UK for the population size.

We saw evidence that orthopaedic **elective surgery had not restarted effectively, with little inpatient activity** taking place and the waiting list is now growing with patients suffering harm. we observed the need for a major step change in leadership and clear decision making to support increasing elective surgery at pace. We are particularly concerned about the lack of restart at Musgrave Park as this is responsible for 65% of total elective activity for Northern Ireland. We walked round the orthopaedic surgery facilities and saw a fantastic infrastructure but very little elective activity.

We think that any further delay to restart and significantly increase the volume of day case and inpatient elective orthopaedic surgery across Northern Ireland is not acceptable. Trusts need to work together and collectively ALL own the problem and provide facilities and mutual aid where possible.

We found a failure in the duty to patients where they are not being fully informed of the potential delays to their surgery and with an honest appraisal of when they can expect to be treated.

We consider that the current governance model in Northern Ireland, where the Chief Executives of Trusts have full delegated accountability for delivery, has led to limited regular oversight and management of Trust performance by the centre and a lack of clear consequences if Trusts are failing. Whilst we have not made recommendations to change this model, we do consider that there needs to be a more structured governance and accountability framework in place, where regular performance data is provided to the centre and accountability meetings take place with each CEO with robust challenge.

5.2 Recommendations for Elective Recovery across Northern Ireland

National Recommendations and Oversight

Recommendation 1: Northern Ireland Trusts must work together as one system to drive the elective orthopaedic recovery (elective recovery across all specialties should follow the same model) with a single PTL. This PTL should be overseen by the recommended Orthopaedic Elective Surgery Recovery Board.

Given the significant lack of progress in restarting orthopaedic elective surgery in Belfast, Belfast Trust should immediately, and prior to any change in the oversight arrangements of Musgrave Park, ring-fence the existing staff and beds at Musgrave Park and make a significant restart to orthopaedic elective surgery.

In the first instance a collaborative management arrangement by all the Trusts using the hospital's services should be established. The Northern and South-Eastern Trusts must have the ability to influence how their patients are treated appropriately at Belfast, as they currently have no say in how their patients are managed. Both the Northern and South Eastern Trusts must also work with Belfast Trust as a matter of urgency, as outlined in recommendations 11 and 13, to improve patient flows in Trauma at the Royal Victoria as Musgrave Park moves toward elective orthopaedics only.

If the agreed patient outcome targets have not been achieved by 1 November 2022, consideration should be made to move management of Musgrave Park to another Trust.

Recommendation 2: The Northern Ireland Department of Health should establish a Northern Ireland Orthopaedic Elective Surgery Recovery Board **immediately,** with responsibility for elective recovery at all Trusts and particularly where elective surgery will be delivered. This Board will oversee demand and capacity, waiting list data, a single PTL, sitreps and the implementation of the recommendations in the RNOH/GIRFT report. This group should meet regularly to review demand, capacity and waiting lists. The Board must include an orthopaedics clinical lead and a senior manager from each Trust. An independent Chair should be appointed for this group, who will drive the change and hold the Trusts to account against agreed plans and targets. Where Trusts are not delivering against plans these should be escalated without delay to the Northern Ireland NHS Executive. This Board may be created as a working group of the newly established Elective Care Management Team.

Recommendation 3: The Northern Ireland Department of Health should request each Trust to provide their Elective Orthopaedic Surgery Recovery plans by the **end of July 2022** for the next 12 months. These must include trajectories to reduce the waiting lists. If these plans fail to demonstrate a significant impact on waiting lists, then the Northern Ireland Department of Health will require explanations from Trust management and leadership, who will be held to account for delivery against hard objectives.
The plans must:

- Set out how the Trusts intend to communicate waiting time positions to patients
- Describe the specific ways in which Trusts will collaborate to address the immediate backlog by putting in place three hubs; Musgrave Park, Western and Southern with "ring fenced" beds and staff at each location

- Provide a month by month plan which shows how increases to pre-pandemic BAU activity will start to reduce waiting lists, including waiting list reduction targets each month
- Ensure the sustained delivery of elective care for 48 weeks per annum, so that the routine shutdown during the winter months is consigned to the past.

Recommendation 4: The Northern Ireland Department of Health should **urgently** develop, in conjunction with Northern Ireland Trusts, a national demand and capacity model across Northern Ireland (starting with orthopaedics). This will identify gaps where the waiting times remain unacceptable and where mutual aid should be utilised either by another Trust, if it has some capacity, or by using the Independent Sector. This must also ensure that Trusts are working collaboratively with available capacity and resources. The review of the plans should ensure openness and transparency on the current and future plans for surgery and waiting lists.

Operational Recommendations

Recommendation 5: Northern Ireland Trusts to provide a weekly sitrep to the centre. The Government should delegate the regular review of these sitreps to the Northern Ireland Orthopaedic Elective Surgery Recovery Board (when established). Escalation should be considered if a Trust's waiting list position is either not improving or deteriorating (the escalation process is to be determined).

The sitreps should include the number of patients and volumes categorised by: ASA score; time on waiting list; expected monthly operations; actual operations undertaken, the agreed targets to reduce lists and delivery against these targets. This should also include the number of operations expected to be delivered as a day case. We suggest that to gain the best momentum in elective recovery, the sitrep should cover all elective surgery and not just orthopaedics. Alongside these sitreps, each Trust should also provide regular theatre utilisation data.

Recommendation 6: The Northern Ireland Department of Health should issue good practice instructions to all Trusts which include a focus on P2, P3 and 104 week waiters. The HVLC Programme principles should be implemented at all Northern Ireland Trusts for immediate and longer-term benefits alongside other principles and good practice as follows:

- Implementation of a 6 or 7-day service, consisting of 3 session days and including all support. Implement HVLC metrics and theatre productivity to GIRFT/HVLC standards
- Adoption of GIRFT theatre principles and turnaround times (or better)
- Development of enhanced recovery units where possible in each Trust
- Guidance to ensure that patients, admitted for elective surgery, have their pre- operative assessment undertaken prior to admission. This should ensure that all equipment and needs are in place ready for surgery to ensure minimal cancellation rates and ensuring lists are filled;
- Establishment of a pre-habilitation programme across Northern Ireland
- Adopt enhance recovery methodology for all admitted patients
- Adoption and roll out of the initial 11 GIRFT HVLC orthopaedic and spinal pathways
- The requirement of a minimum 4 joints per operating list per day
- Northern Ireland wide agreed start times and turnaround times
- Increase to 130-150% BAU, which is the only way inroads will be made to the waiting list
- 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

Recommendation 7: Elective day case procedures must continue during UEC pressures and during Covid. Day case procedures should be carried out as close to home as possible for the patients. We consider that all trusts should be doing day case procedures on a green pathway. Adoption of a day case programme as per the GIRFT/HVLC recommendations is essential. Further information can be found at: Day case surgery – Getting It Right First Time – GIRFT

Recommendation 8: Patient flow must be improved, ensuring patients are moved off the ward efficiently to either go home or to a step down unit. This is essential for both elective and urgent and emergency patients such as fractured neck of femur. All patients should be treated at the right place at the right time. For example, following a repair of a fractured neck of femur, patients with multiple health problems need to be cared for in a medical bed cognisant of the patient's needs. Pathways need to be established to ensure repatriation to Trusts close to the patients' home in a timely fashion (within an agreed timeframe).

Trust Recommendations

5.3 Belfast Trust

The Belfast Trust delivers a good quality orthopaedics service when up and running with good outcomes of consistently low revision rates for total hip and knee replacement and low infection rates. Prior to Covid, 93% of orthopaedic surgery carried out was performed as day case with low cancellations rates.

The Belfast Trust has historically delivered approximately 65% of all elective orthopaedic surgery in Northern Ireland, including the provision of elective orthopaedic services for South Eastern and Northern Trust. Currently these two Trusts are very frustrated by the lack of progress at Belfast. Belfast Trust receive core funding to treat elective orthopaedic services for patients from these Trusts, but have failed to deliver for these patients. We are unsure if this means a retraction of funding from Belfast Trust to the We did not receive any assurance from the CEO and MD of Musgrave Park that there was a plan in place to address the ever increasing orthopaedic waiting lists. The current plans show no reduction in waiting lists, only increases

Since the closure of the paediatric orthopaedic beds at Musgrave Park, and with no re-provision of these beds elsewhere, paediatric orthopaedics has struggled with increasing waiting times. The Royal Belfast Hospital for Sick Children (RBHSC) are unable to manage both elective and paediatric trauma within scheduled hours and theatre space and beds are limiting factors. RBHSC has been unable to absorb the 280 orthopaedic cases displaced by the closure of the beds at Musgrave Park. Day case paediatric orthopaedic surgery has continued, to the detriment of the inpatient cases. There is an opportunity to restart paediatric orthopaedic surgery on the Musgrave Park site, provided the paediatric services required for back-up are present, including the provision of paediatric trained anaesthetists.

Recommendation 9: Belfast Trust should immediately, and prior to any change in the oversight arrangements of Musgrave Park, ring-fence the existing staff and beds at Musgrave Park and make a significant restart to orthopaedic elective surgery. Northern and South-Eastern must have

the ability to influence how their patients are treated appropriately at Belfast, as they currently have no say in how their patients are managed.

Recommendation 10: Belfast Trust should review the opportunity to utilise the green ring-fenced site at Belfast City for other surgical specialties, as we understand there are currently 5 empty wards. We suggest the establishment of an elective hub for HVLC routine surgical services at the Belfast City site at Musgrave Park. This will decompress the bed pressures at Royal Victoria Hospital to allow the site to focus on specialty work (cardiovascular, neuro & cardiac) and their trauma commitments.

Recommendation 11: Belfast Trust should work with others Trusts to reduce the number of neck of femur fractures (NOFs) referred to Belfast by carrying out the procedure at their Trust. If Trusts are unable to carry out NOFs, there has to be an agreement that within 48-72hrs of surgery the patients are repatriated back to the Trust they are referred from. This will free up acute beds at Royal Victoria and improve patient flows. Current trauma and rehabilitation cases should be removed from the Musgrave Park site as elective only is introduced.

Recommendation 12: Belfast Trust should consider moving paediatric orthopaedics back to Musgrave Park, as there is no capacity at the children's hospital to increase the throughput of cases.

Recommendation 13: Royal Victoria to develop a strategy to reorganise and improve the relationship between orthopaedics and anaesthetics for trauma services. The Northern Ireland Department of Health and Belfast Trust to identify an anaesthetist on the Musgrave Park site who will head up and drive innovative anaesthetic techniques to reduce length of stay and increase day case rates whilst maintaining patient safety.

5.4 Southern Trust

The Southern Trust delivers approximately 15% of elective orthopaedic activity at a combined trauma and orthopaedic unit at Craigavon Area Hospital (with day case surgery in South Tyrone Hospital). Since Covid, there has been little to no orthopaedic activity being delivered in Southern Trust for protracted periods and services have yet to resume.

Recommendation 14: Southern Trust to develop an improvement strategy to progress P2 and 104 week cases.

5.5 Western Trust

The Western Trust delivers approximately 20% of elective orthopaedic activity at a combined trauma and orthopaedic unit at Altnagelvin with a standalone day case unit on site. There is evidence that there has been more success at maintaining levels of activity through the day case unit during Covid. We observed a motivated workforce, however morale is becoming low. Western Trust needs to ring fence elective orthopaedic inpatient beds and maintain this all year round.

There is a lack of rehab capacity and community services. However, a programme is underway to improve discharge and maximise patient flow. This must be progressed without delay.

5.6 Northern Trust

All fracture and orthopaedic inpatient activity is undertaken at the Western and Belfast Trusts. The Northern Trust interfaces are primarily in the areas of ED assessment and transfer, as well as providing an orthopaedic assessment service, fracture clinics and rehabilitation (including a regional facility at Whiteabbey).

Recommendation 15: Northern Trust should improve patient flow of FNOF patients with early mobilisation and community hospitals to adopt best practice from Whiteabbey Hospital. There must be a safety net in place for any early complications. Effective care at home is going to be critical, so plans for this need to be in place without delay. For complex spines, there needs to be an out-reach service from Musgrave Park hospital.

Recommendation 16: Northern Trust to consider dividing trauma into simple and complex cases.

5.7 South Eastern Trust

All orthopaedic work is undertaken in Belfast Trust with a fracture unit at Ulster Hospital.

Recommendation 17: South Eastern Trust provide an excellent ICATs service which they should share with other Trusts for adoption across Northern Ireland.

Supporting Recommendations

5.8 Workforce and Training

We observed **very low morale from the workforce in some Trusts,** largely due to their frustration at being redeployed to support other services (particularly the nursing staff) and due to the lack of urgency to restart elective surgery despite the obvious need. This will continue to have a detrimental effect on staff morale and delivery of services unless it is addressed.

There are anomalies in how staff are scheduled to work in theatres, which leads to organisational inefficiencies. RNOH/GIRFT were told that theatre staff are paid per “shift” e.g. 8am – 5pm, while surgeons and anaesthetists are paid per “session” with enhanced hours for anaesthetics pre and post-operative management. The lack of timetabled shift time, to support the delivery of post operating activity by theatre staff, often leads to the cancellation of later cases as the list will over-run or leads to regular under booking of lists. This also happens when theatres change surgeon or specialty between morning and afternoon session.

The GIRFT programme sets minimum volumes e.g. 4 joints per list, supported by the BOA, so if everyone worked to that pattern, and finished once the cases had been completed, the lists would become far more productive.

Recommendation 18: Northern Ireland Department of Health should ensure that the existing workforce reviews consider orthopaedic specific issues including a recruitment drive to recruit the appropriate level of nursing staff. The orthopaedic workforce review should consider a range of urgent issues as follows:

- Staff must be ring-fenced and no longer redeployed to support other services. This may allow recruitment of staff who have retired

- Allow part time working, we believe that this will help recruitment of new and retired staff and ensure work life balance
- Upskilling and effective utilisation current workforce
- The lack of effective training for trainees. The current volume of elective orthopaedic surgery is far too low for meaningful learning to take place, as a consequence trainee log book numbers for elective orthopaedic surgery are low
- The lack of engagement with clinicians. Strong leadership from managers and clinicians, working shoulder to shoulder, will be critical to success
- Improvements to job planning and workforce planning both immediately and for the future
- Addressing scheduling issues to help support efficient elective recovery planning. This could include the movement towards activity based consultant contracts rather than session based, and a review of theatre staff shift patterns to maximise efficiency without putting undue pressure on staff to work outside of contracted hours.

5.9 Independent Sector

We consider that the benefits of NHS and Independent sector partnership working is not effective across Northern Ireland. As we move forward this needs to change, as it is essential that the NHS and Independent Sector work together for the "good" of all patients. The need for the Independent sector is clear, particularly to provide additional capacity until waiting lists reach an acceptable level. We were told that many of the nursing staff have resigned from their NHS Trust to work for Independent Sector Providers.

Recommendation 19: Develop a model for Trusts to identify their independent sector partners who will become embedded within that system. Trusts should validate waiting lists to identify patients that are suitable for the independent sector to carry out work where capacity in Trusts is not available.

5.10 Finance, Commissioning and Data

We observed that the current funding model does not encourage and reward delivery. For example, we noted that, although funding for elective surgery has been top sliced from other Trusts and allocated to Belfast Trust, it has not delivered these services. We asked where this top sliced funding had been spent and were not provided with an answer. Clearly there is no delivery oversight.

Funding for orthopedic services in Northern Ireland is also very low when compared to the rest of the UK.

	Orthopaedic Budget	**Per Capita**	**% of Health Budget**
England	c80% of £10bn for MSK	c£150	6-8%
Scotland	£480m	£90	4%
Wales	£350m	£114	4%
Northern Ireland	£112m	£60	2.4%

Data provided by Chair of Division in Northern Ireland

Recommendation 20: The Northern Ireland Department of Health should review the current funding model. Due to block contracts being in place, there are no incentives to deliver additional

cases (Trusts receive the funding regardless of their delivery success) and detrimental to patients receiving their care. There needs to be a model which incentivises output in terms of both quality and quantity of patient outcomes. The amount of funding allocated for orthopaedic services should also be reviewed.

Recommendation 21: Northern Ireland Department of Health to consider allowing their data becoming part of the Model Health System in England, allowing benchmarking and ensuring best practice, wherever that might be and learning through the use of data. We would encourage this for all the Devolved Nations. Prof Briggs is happy to provide support to deliver this.

Annex 1. Table of recommendations

RNOH/GIRFT Recommendations
Northern Ireland Trusts must work together as one system to drive the elective orthopaedic recovery (elective recovery across all specialties should follow the same model) with a single PTL. This PTL should be overseen by the recommended Orthopaedic Elective Surgery Recovery Board. Given the significant lack of progress in restarting orthopaedic elective surgery in Belfast, Belfast Trust should immediately, and prior to any change in the oversight arrangements of Musgrave Park, ring-fence the existing staff and beds at Musgrave Park and make a significant restart to orthopaedic elective surgery. In the first instance a collaborative management arrangement by all the Trusts using the hospital's services should be established. The Northern and South-Eastern Trusts must have the ability to influence how their patients are treated appropriately at Belfast, as they currently have no say in how their patients are managed. Both the Northern and South Eastern Trusts must also work with Belfast Trust as a matter of urgency, as outlined in recommendations 11 and 13, to improve patient flows in Trauma at the Royal Victoria as Musgrave Park moves toward elective orthopaedics only. If the agreed patient outcome targets have not been achieved by 1 November 2022, consideration should be made to move management of Musgrave Park to another Trust.
The Northern Ireland Department of Health should establish a Northern Ireland Orthopaedic Elective Surgery Recovery Board immediately, with responsibility for elective recovery at all Trusts and particularly where elective surgery will be delivered. This Board will oversee demand and capacity, waiting list data, a single PTL, sitreps and the implementation of the recommendations in the RNOH/GIRFT report. This group should meet regularly to review demand, capacity and waiting lists. The Board must include an orthopaedics clinical lead and a senior manager from each Trust. An independent Chair should be appointed for this group, who will drive the change and hold the Trusts to account against agreed plans and targets. Where Trusts are not delivering against plans these should be escalated without delay to the Northern Ireland NHS Executive. This Board may be created as a working group of the newly established Elective Care Management Team.
The Northern Ireland Department of Health should request each Trust to provide their Elective Orthopaedic Surgery Recovery plans by the end of July 2022 for the next 12 months. These must include trajectories to reduce the waiting lists. If these plans fail to demonstrate a significant impact on waiting lists, then the Northern Ireland Department of Health will require explanations from Trust management and leadership, who will be held to account for delivery against hard objectives.

The plans must:

- Set out how the Trusts intend to communicate waiting time positions to patients
- Describe the specific ways in which Trusts will collaborate to address the immediate backlog by putting in place three hubs; Musgrave Park, Western and Southern with "ring fenced" beds and staff at each location
- Provide a month by month plan which shows how increases to pre-pandemic BAU activity will start to reduce waiting lists, including waiting list reduction targets each month
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The Northern Ireland Department of Health should urgently develop, in conjunction with Northern Ireland Trusts, a national demand and capacity model across Northern Ireland (starting with orthopaedics). This will identify gaps where the waiting times remain unacceptable and where mutual aid should be utilised either by another Trust, if it has some capacity, or by using the Independent Sector. This must also ensure that Trusts are working collaboratively with available capacity and resources. The review of the plans should ensure openness and transparency on the current and future plans for surgery and waiting lists.

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- Adoption of GIRFT theatre principles and turnaround times (or better)
- Development of enhanced recovery units where possible in each Trust
- Guidance to ensure that patients, admitted for elective surgery, have their pre- operative assessment undertaken prior to admission. This should ensure that all equipment and needs are in place ready for surgery to ensure minimal cancellation rates and ensuring lists are filled;
- Establishment of a pre-habilitation programme across Northern Ireland
- Adopt enhance recovery methodology for all admitted patients
- Adoption and roll out of the initial 11 GIRFT HVLC orthopaedic and spinal pathways
- The requirement of a minimum 4 joints per operating list per day
- Northern Ireland wide agreed start times and turnaround times
- Increase to 130-150% BAU, which is the only way inroads will be made to the waiting list

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Patient flow must be improved, ensuring patients are moved off the ward efficiently to either go home or to a step down unit. This is essential for both elective and urgent and emergency patients such as fractured neck of femur. All patients should be treated at the right place at the right time. For example, following a repair of a fractured neck of femur, patients with multiple health problems need to be cared for in a medical bed cognisant of the patient's needs. Pathways need to be established to ensure repatriation to Trusts close to the patients' home in a timely fashion (within an agreed timeframe).
Belfast Trust should immediately, and prior to any change in the oversight arrangements of Musgrave Park, ring-fence the existing staff and beds at Musgrave Park and make a significant restart to orthopaedic elective surgery. Northern and South-Eastern must have the ability to influence how their patients are treated appropriately at Belfast, as they currently have no say in how their patients are managed.
Belfast Trust should review the opportunity to utilise the green ring-fenced site at Belfast City for other surgical specialties, as we understand there are currently 5 empty wards. We suggest the establishment of an elective hub for HVLC routine surgical services at the Belfast City site at Musgrave Park. This will decompress the bed pressures at Royal Victoria Hospital to allow the site to focus on specialty work (cardiovascular, neuro & cardiac) and their trauma commitments.
Belfast Trust should work with others Trusts to reduce the number of neck of femur fractures (NOFs) referred to Belfast by carrying out the procedure at their Trust. If Trusts are unable to carry out NOFs, there has to be an agreement that within 48-72hrs of surgery the patients are repatriated back to the Trust they are referred from. This will free up acute beds at Royal Victoria and improve patient flows. Current trauma and rehabilitation cases should be removed from the Musgrave Park site as elective only is introduced.
Belfast Trust should consider moving paediatric orthopaedics back to Musgrave Park, as there is no capacity at the children's hospital to increase the throughput of cases.
Royal Victoria to develop a strategy to reorganise and improve the relationship between orthopaedics and anaesthetics for trauma services. The Northern Ireland Department of Health and Belfast Trust to identify an anaesthetist on the Musgrave Park site who will head up and drive innovative anaesthetic techniques to reduce length of stay and increase day case rates whilst maintaining patient safety.
Southern Trust to develop an improvement strategy to progress P2 and 104 week cases.
Northern Trust should improve patient flow of FNOF patients with early mobilisation and community hospitals to adopt best practice from Whiteabbey Hospital. There must be a safety net in place for any early complications. Effective care at home is going to be critical, so plans for this need to be in place without delay. For complex spines, there needs to be an out-reach service from Musgrave Park hospital.
Northern Trust to consider dividing trauma into simple and complex cases.

South Eastern Trust provide an excellent ICATs service which they should share with other Trusts for adoption across Northern Ireland.
Northern Ireland Department of Health should ensure that the existing workforce reviews consider orthopaedic specific issues including a recruitment drive to recruit the appropriate level of nursing staff. The orthopaedic workforce review should consider a range of urgent issues as follows: • Staff must be ring-fenced and no longer redeployed to support other services. This may allow recruitment of staff who have retired • Allow part time working, we believe that this will help recruitment of new and retired staff and ensure work life balance • Upskilling and effective utilisation current workforce • The lack of effective training for trainees. The current volume of elective orthopaedic surgery is far too low for meaningful learning to take place, as a consequence trainee log book numbers for elective orthopaedic surgery are low • The lack of engagement with clinicians. Strong leadership from managers and clinicians, working shoulder to shoulder, will be critical to success • Improvements to job planning and workforce planning both immediately and for the future • Addressing scheduling issues to help support efficient elective recovery planning. This could include the movement towards activity based consultant contracts rather than session based, and a review of theatre staff shift patterns to maximise efficiency without putting undue pressure on staff to work outside of contracted hours.
Develop a model for Trusts to identify their independent sector partners who will become embedded within that system. Trusts should validate waiting lists to identify patients that are suitable for the independent sector to carry out work where capacity in Trusts is not available.
The Northern Ireland Department of Health should review the current funding model. Due to block contracts being in place, there are no incentives to deliver additional cases (Trusts receive the funding regardless of their delivery success) and detrimental to patients receiving their care. There needs to be a model which incentivises output in terms of both quality and quantity of patient outcomes. The amount of funding allocated for orthopaedic services should also be reviewed.
Northern Ireland Department of Health to consider allowing their data becoming part of the Model Health System in England, allowing benchmarking and ensuring best practice, wherever that might be and learning through the use of data. We would encourage this for all the Devolved Nations. Prof Briggs is happy to provide support to deliver this.

Annex 2. Timeline for Recommendations