The following recommendations were produced by the British Orthopaedic Association and the British Orthopaedic Directors Society to highlight where resources could be released in NHS orthopaedics services, while maintaining or enhancing quality.

**Themes**

- Discharge planning and length of stay
- Trauma
- Unnecessary referral
- Procedures of questionable value
- In-theatre efficiency
- Implants
- Cancellations
- System-wide issues

**Context**

Orthopaedics are behind most other specialties in meeting the 18 weeks target.

However, it began from a much lower starting point. Pathway redesign work so far has resulted in a 300 per cent improvement on June 2007.

Improvements beyond this point will be very hard, particularly with population changes and orthopaedics having the highest number of surgical admissions.

Current practice leads to a lot of short-term, expensive treatment being done just before the 18 week deadline, evening and weekend work etc. Such eleventh hour interventions are not sustainable, particularly with rising demand.

So a priority for the specialty is to do more surgery, more quickly, but in the present context it also needs to save money too.

**Discharge planning and length of stay**

There is good practice in discharge planning amongst the best units, but significant variation – both between orthopaedic surgeons and the quality of local social services.

Enhanced recovery is being done in some form across the country, but could be done better.

Improvements could be made by having more active, consultant-level participation in multi-disciplinary musculoskeletal assessment clinics, alongside the other relevant professions (for example, social care and physiotherapy). Where problems are identified, they should be referred to the appropriate specialty (for example, geriatrics, anaesthetics or general practice) before they can go onto the surgical waiting list.

A further development that would help would be if patients were not referred by their GP for consideration of surgery until they had undergone a fitness check in primary care. This could identify in advance those factors (particularly chronic diseases) that are likely to delay admission or discharge.

Improvements in this area could have a significant impact on costs, it was thought.

**Pre-operative assessment**

All patients coming for elective surgery should have a robust pre-operative assessment with input at an appropriate (i.e. consultant) level.

An unintended consequence of this that would
need to be investigated first is whether these changes could generate greater demand for high dependency beds (for patients with more significant co-morbidities). This could result in more on-the-day cancellations if those beds are unavailable.

**Trauma**

Trauma surgery for orthopaedics is likely to be a more fertile ground for cost savings than elective.

It is hard to manage, historically neglected and underfunded. Because of the unpredictability of trauma it can be difficult to match capacity to demand.

Trauma needs to be allowed to be given greater priority by orthopaedic surgeons and the organisations they are part of.

In general, surgeons’ job planning should not mean that they do elective surgery whilst they are on call for trauma at that time.

It should be both a surgical and managerial aim to get all patients, including those with fractured neck of femur, operated on within 48 hours. Every extra hour in bed raises cost and risks of complications, which lead to significant unnecessary costs.

**Unnecessary referral**

Knowledge of orthopaedics amongst GPs is inadequate given the proportion of their patients exhibiting orthopaedic problems. One solution to this could be local orthopaedic surgeons meeting with their primary care colleagues and commissioners to set local guidelines for what to refer and when, and what to do before referring etc.

Map of Medicine could be used to support this, as has been done in Devon over the last 18 months. Work is already ongoing to develop a competency package on the most common aspects of orthopaedics to develop GPs’ competencies.

There is significant potential for savings through improved musculoskeletal (MSK) services. More robust and efficient pathways would ensure the appropriate use of surgery where indicated and could save the use of unnecessary resources.

Once a patient has been referred for an operation, there is a disincentive for refusing this if it would be of questionable value to them – it takes half an hour to explain to that patient why the operation will not go ahead, versus five minutes to say yes. Therefore, in principle the surgical team who put the patient on the waiting list should be the team who perform the operation.

‘Choose and Book’ creates inefficiency when primary care refers to the wrong specialist. Surgeons within a unit are not allowed to refer to each other, meaning they must send the patient back to the GP, who will have to find another slot with the correct surgeon. Allowing surgeons to refer to each other, as well as senior input at the front end of referral (and also greater continuity of care) would all help with this problem.

**Procedures of limited benefit**

There are, for a number of reasons, unnecessary surgical interventions, or at least interventions of limited benefit, that are currently done.

Triage is one area that generates unnecessary costs (for example, scans) when conducted by inadequately trained and supported staff.
MRI use is a significant example of overuse:

- A local investigation by one of the group showed 80 per cent of use was unnecessary and just created unnecessary onward referral.
- Access to MRI could be restricted to consultant-level. At present it is grossly overused through being able to be requested by many different practitioners (for example, physiotherapists) and at low levels of seniority.
- Alternatively, access to MRI could be restricted so that those requesting it:
  - have been properly trained to interpret the results
  - are able to speak to the person who writes the report (who is often based overseas at present).

Overuse of MRI is also encouraged by strategic health authorities purchasing generous bulk contracts from commercial companies. This incentivises overuse to use up the full quota.

**In-theatre efficiency**

There are significant gains still to be made in the efficiency with which theatres are run, although the extent to which orthopaedics on its own can make a contribution to this is limited.

The anaesthetist, surgeon and their teams need to be available and present well in advance of the scheduled list start-time to ensure full use of the available resources.

Consideration could be given to all-day theatre lists, which would help ease the log-jam that currently builds up towards the end of each day. Alternatively, more focus could be placed on using the existing five days more effectively before allowing theatre time to amorphously expand.

**Implants**

The current system, where each individual hospital purchases its own implants, is sub-optimal.

There are often over 100 variants for a particular implant, for example hip replacements, when in 90 per cent of cases surgeons could use only those few recommended in NICE guidelines.

The following caveats should be added to this:
- room for innovation must be allowed
- where there is a particular reason why a surgeon wishes to do something differently, they should discuss it with and seek the approval of their peers.

Use of implants in trauma needs to be rationalised in a similar way to that of joints, i.e. a registry.

There may be scope for increased use of plaster of Paris rather than implants as the cost is low but quality of care can be just as high. However, this would require rediscovery of some of the skills needed.

**Cancellations**

Some of the current best practice in managing cancellations needs to be replicated more widely. For example, meeting with the
whole unit team on a weekly basis to look at cancellations that occurred and assess how they might have been avoided.

One of the major causes of cancellations is a lack of capacity.

**System-wide issues**

Consultants are currently paid extra for extra work (for example, clinics and operating lists) and are therefore incentivised to take less time doing basic patient work and ward rounds. This pushes these tasks onto senior house officers (who have less continuity of care with the patient) and results in tests being repeated with no one really managing the patient’s care.

On the issue of theatre efficiency, work to bring anaesthetists more closely into a team working culture would be effective.

The thresholds that junior doctors must reach before being promoted are getting lower, meaning the competencies of career grade orthopaedic surgeons are lower than they used to be and a higher proportion of the service is being delivered by non-consultants. A proper career pathway for pre-consultant-level doctors is needed.

Medical school training in orthopaedics/trauma, often as little as two weeks, is insufficient given the pervasiveness of these conditions at all levels of the NHS.

The European Working Time Directive needs to be recognised as a cause of much unnecessary cost. Agency bills have risen significantly as a result. Many trusts are finding it difficult to employ staff to fill their rotas.

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