Mr. James Hunter

Mr. James Hunter is the national clinical lead for Paediatric Trauma and Orthopaedic GIRFT and works as a consultant Paediatric T&O surgeon at Nottingham University Hospitals NHS Trust. He has been a consultant at Nottingham since 1995. He took a full part in the adult trauma rota for 21 years before focusing solely on children’s care. Mr. Hunter is a past president of BSCOS (2010-2012) and was the chairman of the AO international expert group for Paediatrics from 1997 to 2016. He was a member of the specialist advisory committee from 2013 to 2019, latterly as the lead for national recruitment of orthopaedic registrars. He was one of the developers of the comprehensive classification of paediatric long bone fractures and has a strong interest in the treatment of simple fractures. He was one of the authors of the BOA standards on supracondylar fractures of the humerus and the early management of the paediatric forearm fracture.

Abstract

When I was approached by the British Society for Children's Orthopaedic Surgery (BSCOS) to apply to be the clinical lead for GIRFT in paediatric T&O, I was initially reticent, wondering if GIRFT methodology would prove suitable in our specialty. My colleagues, however, were persistent and so it was in the summer of 2019 we found ourselves sifting through a number of data sources to see what would be useful to colleagues around the country. I had convinced myself that spending the years between 60 and 62 visiting children's orthopaedic units round England would be interesting and pleasurable. As it turned out I sat in my office in Nottingham conducting “visits” through Teams.

National data does not provide significant insights into any but the most common paediatric orthopaedic conditions. For information on treating Perthes' disease and slipped upper femoral epiphysis we need to look to investigations such as the British Orthopaedic Surgery Surveillance (BOSS). There was however plenty of information on the treatment of simple fractures, and the revelation that NHS England spends as much on upper limb fractures in children as it does on the rest of paediatric orthopaedics combined.

We also found large numbers of operations being done for DDH despite the efforts being made to detect this condition early and treat it in infancy. Changes to the NIPE pathway may smooth the referral process, but few children's orthopaedic surgeons believe they will reduce the incidence of late diagnosis and many believe that the opportunities for successful early treatment will be reduced. For these reasons we are suggesting that the appropriate authorities look again at the feasibility of universal ultrasound screening, practised in many if not most neighbouring countries in continental Europe.

Much of the work in paediatric orthopaedics is done in outpatients rather than the operating theatre, for example the early treatment of DDH and clubfoot. Procedures done in clinic are under-recorded throughout England for the reason that, even under tariff, they were not properly rewarded. We have recommended that this be addressed.

Coding both of diagnoses and operative procedures is extremely variable. During my visits many colleagues told me that they felt the data underestimated their activity and were able to demonstrate this through their own logbooks. There are therefore recommendations concerning the practice of coding and communication with coders so that the NHS can have access to reliable data.

We did find that some trusts and surgeons were performing very low numbers of major operations. This is very similar to the findings of the GIRFT report in paediatric general surgery and urology, and represents a nettle that needs grasping. I am very conscious that centralisation of major operations would strip out the local service that is required for the bulk of paediatric orthopaedics and leave general T&O colleagues less well supported for specialist children’s trauma. This is why we are recommending carefully thought out network arrangements with input from high volume tertiary centres, accompanied by dual surgeon operating as potential solutions that do not disrupt the service.

In the course of my visits, I saw many fine examples of high quality and innovative practice in children's T&O. Many of those responsible have kindly described their work in the case studies contained in the report. When it is published I would urge readers not to skip past these, as they contain many golden ideas that could be introduced almost anywhere without huge resource implications.