BURY CARE ORGANISATION PROJECT REVIEW

Super Saturday Day Case Initiative

1 surgeon: 2 Theatres & 2 Anaesthetists: 1 day: 10 primary hip & knee replacements

How Fairfield Hospital achieved performing 10 joint replacements in 1 day with 1 Surgeon, with 2 Registrars, 2 Anaesthetists in 2 Theatres achieving GIRFT top decile metrics Day Case principles.

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Contents

Executive Summary

The Bury Care Organisation tested a new way of working within Fairfield Hospital Theatres by holding a “Super Saturday Orthopaedics List”.

This initiative was to achieve the top decile of GIRFT principles having already adopted the philosophy described by GIRFT project. These include use of an orthopaedic ring-fenced unit, with standardised kit and consistent staff to deliver the right number of cases, with a short LoS. More recently this has included a target of 10% as daycase arthroplasty procedures.

The project took place one Saturday in July and successfully treated 10 patients in 1 day between 2 theatres as opposed to the ‘business as usual’ number of 3 - 4 per theatre in 1 day.

The project realized the following benefits:

- Treated 10 patients under 1 named Surgeon utilising 2 theatres in 1 day
- Long waiters reduced by 10 (average wait 48 weeks with longest wait at 81 weeks)
- Improved patient care and experience
- Staff morale improvements
- Reduced length of stay
- 80% Daycase arthroplasty achieved
- Improved theatre productivity and utilisation
- Set new benchmark for unit to strive to achieve

This test of change has concluded that the pilot was successful and that the Model could be utilised for cases across any speciality. It has also provided a baseline case for change for 6 day working in the future and improving flow within the same bed numbers.

Purpose of Document

The purpose of this document is to;

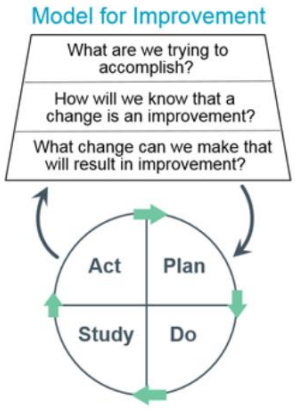
- provide detail on the approach taken to the Super Saturday Project
- document the findings from the pilot and proposed next steps
- provide a framework that can be adopted to test small scale change in other areas
- provide some helpful hints based on the Essential Enablers and lessons learnt within this PDSA cycle and test of change which can be used as reference to facilitate other similar projects
- be shared both locally and with other trusts wishing to replicate this way of working and partake in a test of change project

Super Saturday Project planning

The approach

It was agreed that the approach to be taken for this project would be to use PDSA, or Plan-Do-Study-Act, as this is an approach readily used and recognised in the Trust and is an iterative, four-stage problem-solving model used for improving a process or carrying out small scale change.

Using PDSA cycles can help clinicians deliver improvements in patient care through a structured experimental approach to learning and tests of change. The PDSA approach facilitates individual, team and organisational learning.



Refer to Appendix 1 and 2 to review the Project Members and project plan.

What are we trying to accomplish?

- Utilise existing resources effectively to tackle long waits within Orthopaedics

How will we know that a change is an improvement?

- Achieve an improvement in theatre metrics, whilst maintaining quality outcomes for patient

What changes can we make that will result in an improvement?

- To push boundaries of theatre productivity and Enhanced recovery to achieve goals of top decile for GIRFT Hip / knee arthroplasty.
- Utilising 2 theatres, 1 surgeon, operating on 10 patients in 1 day

Activities within 'Plan' Stage

What we agreed;

- **To Pilot a 'Super Saturday' Arthroplasty list**:
  - 10 joint replacements of hips and knees,
  - 2 theatres, 2 anaesthetists and 1 surgeon
- **Testing the concepts of:**
  - Maximise utilisation with dual lists
  - Maximise Enhanced recovery & daycase arthroplasty
  - Do patients like it?
- **Intention to rollout routinely if successful:**
  - Reset benchmark & Increase DC rates
  - Reduce departmental LoS
  - Create extra capacity without impacting weekday activity
  - Reduce waiting list
- **Metrics**
  - Number of procedures delivered, utilisation, low LoS & increased Day surgery rates, achievement of GIRFT metrics
  - Projected impact if rolled out as Business As Usual (BAU)

Activities within the 'Do' stage

What we did

- Pilot extra Saturday list without impacting weekday activity
  - 10 arthroplasty cases:
    2 Total Hip replacement
    5 Total knee replacements
    3 Uni-compartmental knee replacements
- 8 joints replacements as daycase with 2 TKRs discharged at 23 hours. 80% daycase rate.
- No additional outpatient follow-ups or hospital wound checks
- Additional physio time to enable daycase discharge
- Additional Pharmacy support
- 2 Anaesthetists and 1 middle grade to enable continual running of lists
- Consideration of extra ward staff as per weekday activity
- Finance agreed and Executive approval obtained
- Clinical operating model with position on list to support dual running and those most likely to achieve daycase discharge for total joints done first.
- Last patient on each list accepted as 23 hour stay.
- Clinical process in place to identify appropriate patients
- Task and Finish Group established

Activities with the 'Study'

What we achieved:

- The Metrics were agreed in advance:
  Operational success achievements were:
    Patient write up – admitted time, operative time, discharge time
    6-4-2 i.e. utilisation, DNAs: 0, Cancellations: 0, touch time average of 47 mins per case
    Weekend Working model trialled
    Patient feedback was positive
  Performance Metrics achieved
    Unit LoS (2.1)
    Waiting list and waiting times projection (reduction of 10 patients in one day longest wait 81 weeks with ave. wait at 48wks)
- Completed a 'Wash up' session to discuss issues, problems, success, feasibility of regular Super Saturday session
- Staff feedback: Good morale & staff were excited, this created a buzz around the list.
  Staff chose to be part of it through self interest – no agency staff used.
  Staff were tired but felt good at the end of list.
  Team agreed break times between themselves and very keen to do more lists.
  Sets benchmark of what is achievable with adoption by consultants within unit and region.

Activities with 'Act'

What we will do next;

- Consider:
  - Operational issues discussed within the debrief
  - Impact and success (metrics)
  - Staff and patient feedback
- Feasibility of rolling out Saturday session on a routine basis
  - What changes would have to be made

    - Cost analysis & Business Case
- Decision post options appraisal: Adopt, adapt or abandon

Essential Enablers to the overall Project

- HAVING A CLINICALLY LED PROJECT TEAM WITH EFFECTIVE SENIOR LEVEL MANAGEMENT SUPPORT AND INVOLVEMENT WAS KEY TO SUCCESFUL DELIVERY.
- HAVING CLARITY ON THE AIM AND PURPOSE ON THE OUTSET.
- PLAN AHEAD - START EIGHT WEEKS PRIOR IF YOU CAN.
- BUILD MOMENTUM AND SENSE OF 'BUZZ' WITHIN ALL SUPPORTING TEAMS.
- IDENTIFYING DEDICATED ADMIINSTRATIVE SUPPORT TO CO-ORDINATE SCHEDULING AND BOOKNG SO AS TO REDUCE IMPACT ON OTHER SERVICES.
- DEDICATED TASK AND FINISH TEAM TO PRODUCE ACTION PLAN AND DELIVERY
- EXECUTIVE SUPPORT

Patient Pathway Steps

Patient Selection

1. Agree selection of ASA1- 3 patients from the waiting lists requiring primary hip or knee (total/uni) replacements.
2. Excluded revisions or those needing HDU level support.
3. List reviewed by the project lead consultants and patients identified.
4. Tracking list created (see below).
5. Dedicated Booking & Scheduling resource allocated to the project who oversees the whole process from selection, pre-op & COVID screening steps.
6. The Booking & Scheduling support contacted each patient to discuss their mobility and any comorbidity that might have developed; confirmed with the patient that they were happy to accept the date and reassured them about the measures in place to reduce Covid-19 transmission at the hospital as well as ensuring all necessary pre-admission steps were taken.
7. Patient lists were subsequently generated, and all patients were formally scheduled in order of list as per table below:-

Patient Surname	theatre list order	Operation	Pre-Op Booked	preop passed	COVID SWAB TIME 28/07	Weeks Wair
P3	A1	TOTAL PROSTHETIC REPLACEMENT OF HIP JOINT USING CEMENT (RIGHT TOTAL HIP REPLACEMENT)	YES	YES	08:30am	81
P10	A2	OTHER TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT (LEFT TOTAL KNEE REPLACEMENT)	YES	YES	07:45	33
P5	A3	TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT USING CEMENT (LEFT KNEE LATERAL UNICOMPARTMENTAL ARTHROPLASTY ? LEFT)	YES	YES	11:00am	2
P6	A4	OTHER TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT (LEFT MEDIAL UNI KNEE REPLACEMENT)	YES	YES	07:30am	26
P1	A5	OTHER TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT (LEFT TOTAL KNEE REPLACEMENT*YC 19-L*)	YES	YES	10:30	78
P2	B1	OTHER TOTAL PROSTHETIC REPLACEMENT OF HIP JOINT (LEFT TOTAL HIP REPLACEMENT YC19)	YES	YES	08:45am	36
P9	B2	TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT USING CEMENT (LEFT TOTAL KNEE REPLACEMENT)	YES	YES	08:15	33
P8	B3	TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT USING CEMENT (RIGHT MEDIAL UNICOMPARTMENT KNEE REPLACEMENT +/- TOTAL YC19)	YES	YES	07:45	74
P4	B4	TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT USING CEMENT (LEFT TOTAL KNEE REPLACEMENT yc19 PT REJ HF)	YES	YES	07:30am	77
P7	B5	OTHER TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT (LEFT TOTAL KNEE REPLACEMENT)	YES	YES	11:15am	37

Essential Enablers

- THE CLINICAL LEAD WAS KEY TO IDENTIFYING SUITABLE PATIENTS - INVOLVE A LEAD ANAESTHETIST IN THIS PROCESS.
- HOSPITAL STAFF SPEAKING TO PATIENTS DIRECTLY TO ADDRESS CONCERNS ABOUT COVID MADE A DIFFERENCE TO PATIENTS' CONFIDENCE ABOUT HAVING SURGERY.
- DEDICATED SUPPORT TO ASSIST WITH TRACKING AND DELIVERING NOTES AND CO-ORDINATE ALL ACTIVITES REQUIRED FOR THE ADMISSION PROCESS

Scheduling, Booking and Admission processes inc. Pre-operative assessment

1. One consultants PTL was reviewed in chronological order – 25 patients were chosen although 10 patients were for listing to allow for patients who wished to decline the offer or who potentially may be unable to proceed once screening processes had been completed
2. All patients eligible were ASA1-3. BMI was not an exclusion. Some patients had procedures before and were advocates of enhanced recovery to those with no experience.
3. Where patients did not have a valid pre-op this was fast tracked.
4. Fairfield Hospital is a Green site with a ring-fenced orthopaedic unit, planned elective care facility therefore bed management was controlled and unlikely to be impacted by Emergency admissions.
5. Pre-op & other screening outcomes were communicated on a daily basis to the Directorate manager in order to record attendance and whether the patient was fit to proceed.
6. Pennine enhanced recovery programme does not include joint school.
7. Outcomes were tracked.

Essential Enablers

- A DEDICATED SCHEDULING AND BOOKING RESOURCE ENSURES ALL PRE-OP & COVID SCREENING STEPS WERE TAKEN AND CO-ORDINATED
- CONSIDER THE POST OP BED REQUIREMENTS WHEN PLANNING PATIENTS ENSURING IT DOES NOT IMPACT ON WEEKDAY LISTS.
- CONSIDER PATIENTS WHO ALREADY HAVE PRE-OP WHERE POSSIBLE

COVID & other screening

1. Screening and outcomes form part of the tracking processes to ensure all patients are fit to proceed. At the time of this pilot 11 days social distance was required plus, 3 days swab and isolation period.
2. Patients were booked into a COVID pre-screening clinic which took place on one day and timings recorded (see patient selection section table above).
3. Outcomes were checked daily by the Admin team in order to update the PAS system and book other patients into slots if existing patients had tested positive.

Essential Enablers

- A ONE-STOP SCREENING MODEL WAS PUT IN PLACE FOR COVID
- EXISTING PRE-OP PROCESSESS UTILISED BUT BOOKED AND TRACKED VIA THE PROJECT BOOKING AND SCHEDULER

Communications and Engagement – Patient and Staff

1. The project put in place a central schedule and booking resource who contacted all the patients listed by telephone and talked them through the screening and admissions process.
2. The Pre-Assessment Team offered reassurance to patients and could escalated any concerns to the booking and schedule resource to escalate and discuss with clinician and if necessary, a follow-up phone call would be made.
3. At either pre-assessment or pre-screening, the patients received a letter asking them to bring in their regular medication with a current prescription.
4. Patients' expectations were managed by all members of the pathway without need for a joint school. They were advised of potential for daycase or overnight stay – 8 out of the 10 patients were discharged on the day. 2 discharged the following morning.

See Appendix 4 to see quotes provided by staff and patients with regard to Super Saturday.

Essential Enablers

- ENSURE THAT HOSPITAL STAFF ARE CONTACTING PATIENTS TO DISCUSS ANY CONCERNS RELATED TO COVID-19 OR THE ADMISSION PROCESS
- ENSURE PATIENTS ARRIVING BY TRANSPORT ARE MONITORED TO ENSURE A BACK UP PLAN IS IN PLACE SHOULD THIS FAIL ON THE DAY
- ***THE VALUE OF CONSISTENT AND EMPATHETIC PATIENT COMMUNICATION SHOULD NOT BE UNDERESTIMATED; ITS EFFECT ON PATIENT EXPERIENCE IS SIGNIFICANT.***

Inpatient / Day Case Admission

1. This project utilised existing resources at the Fairfield site on the green floor where Beds would not be impacted by Emergency admissions.
2. Additional resources were obtained with Pharmacy, Radiology and ward staffing.
3. On the Super Saturday a Senior Physio delivered the rehabilitation having mapped the needs of patients and time required to support daycase discharge. They worked till 8pm on the day.
4. Patients consent/confirmation was obtained as soon as admission began at 7:00 am.
5. All admissions arrived at the same time in the morning (7:00am)
6. Pharmacy were notified in advance (TTOs done in advance where possible to avoid delayed discharge).
7. Discharge planning commenced on Admission – this worked well as patients expectations had been managed from Pre-op that the aim would be to discharge on the day.
8. Senior Management on call team were aware of the event as were the Bed Management Team.

Essential Enablers

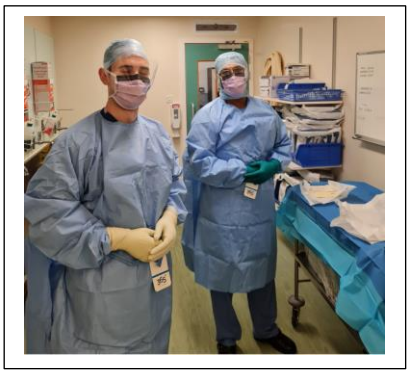
- REVIEW EXISTING RESOURCES TO ENSURE BED AVAILABILITY FOR THESE PATIENTS IS NOT IMPACTED – WHERE THIS IS A POTENTIAL CONSIDERATION MUST BE GIVEN TO RING FENCE THESE BEDS TO ENSURE THE PATIENTS ARE NOT INCONVENIENCED AND THE ADDITIONAL WORK HAS NOT BEEN IN VAIN!
- CONSIDER POST OP RECOVERY REQUIRED AND ALLOCATE THIS ACCORDINGLY

Theatres

1. Theatre 1 & 2 at Fairfield were allocated to the pilot as these are opposite one another. This facilitated the model whereby the Anaesthetic team could perform their duties and the Consultant could transfer from one theatre to the other as a registrar finished skin closure on the case.
2. The model used in this pilot was
    a. 2 theatres, 1 surgical team, anaesthetic team present in both WHO checklists, meticulous planning of anaesthetic time, opening and closing as well as implant time.

b. Consultant Surgeon went from one theatre to another.
c. Registrar would close up skin and organise x-rays etc while other team had anaesthetised and positioned patient in next theatre room ready for the time-out.
d. Patient go to recovery, had x-ray within theatres prior to return to ward.
e. Short acting spinal in daycase patients used as part of enhanced recovery. This meant motor function recovered quicker to support physio input and aid discharge on the day.
f. Standard discharge criteria used by physio.

3. Consultants and theatre support staff were identified in advance to cover the pilot.
4. Consultants identified prosthetic requirements for each patient prior to the day and ensured this was available in stock.
5. Theatre utilisation was maximised with prompt starts, fast turnaround times and delays between cases were minimised (one problem on the day was that the deep clean between cases had not formed part of the planning process but this did not prove to be an issue on the day – however this team will be involved for any future pilots).
6. Patients went to recovery area, post-op x-ray and then back to the ward for enhanced recovery.


Essential Enablers

- ENSURE DISCUSSIONS HAVE TAKEN PLACE WITH STERILE SERVICES TO ENSURE THE EQUIPTMENT KITS / TRAYS CAN BE AVAILABLE
- ENSURE CONSIDERTION IS GIVEN TO ALLOW FOR DEEP CLEAN OF THEATRES BETWEEN CASES

Post-Operative

1. Senior Physio presence was available for the pilot - therefore those patients expected to be discharged on the Day of Surgery (DOS) these could be prepared for rapid discharge.
2. The Ward team collaborated with the Pharmacy Dept. to organise pre-packed TTOs.
3. Information leaflets about post-op and discharge advice were given to all patients on admission.
4. Junior doctors were based on the wards and supported with ward rounds, medical review, and completing the EDS rapidly.
5. Post-op letters, leaflets and advice was given to each patient, as per standard practice.
6. Discharge summaries were done on the day.

Essential Enablers

- MANAGE THE PATIENT EXPECTATIONS AROUND DISCHARGE FROM AS EARLIER AS THE FIRST PHONE CALL
- INVOLVE PREOP TO ENABLE THEM TO REITERATE THE 'DAY CASE' ADMISSION POTENTIAL
- INVOLVE WARD STAFF TO ENSURE DISCHARGE PLANNING COMMENCES ON ADMISSION
- INVOLVE THE SUPPORTING SERVICES (PHARMACY, PHYSIO, RADIOLOGY) SO DISCHARGE CAN BE OPTIMISED

Benefits and Outcomes

The pilot has demonstrated the following benefits and outcomes;

Patient

- 8 out of the 10 patients were discharged the same day with only 2 patients requiring an overnight stay and discharged on the Sunday.
- Patient Satisfaction – patient feedback has been extremely positive

Staff

- Morale – during these pressured times staff reported that they were happy to be involved in improvement
- No Agency staff was required for the day as Rota and Additional scheduling ensure that substantive staff could be available and take part in the pilot – this facilitated great team working and communication

Organisation

- Finance – the cost approx. £14k vs potential PbR income of £62k - £119k (dependant on case mix) – See Appendix 4 for Breakdown of costs
- Finance – no agency costs were incurred
- Finance – patients being discharge the same day lowers the inpatient stay costs per patient
- Future innovation – this pilot has shown a successful test of change and could be used again as a pilot for any speciality that could work in this way
- Future innovation – the outcome from this pilot will provide an outline case for future 6 day working and the development of a Business Case for a longer term plan in the Trust

Lessons learnt

This section specifically details some of the lessons we learnt from our first PDSA pilot and we will incorporate into future plans for this way of working for future Super Saturdays. This document provides some useful hints and tips throughout if you wish to replicate this pilot at your trust.

1. Need to inform Decontamination Quality & Production team next time to inform them that large volume of kit being used (had a potential to impact on weekday list due to turnaround time). On this occasion, due to the hard work from the Decontamination Team, this did not adversely impact on the Saturday list, or workday week lists planned the following week, but for future initiatives this team will be involved from the planning stages.

2. Two unforeseen challenges with spinal were experience (this was difficult to predict) but managed to recover time on the day – may need to consider contingency planning for the next event.
3. Specifically ordered list to do hips first but had to change order of list due to patient transport delay. This can happen and need to incorporate patient transport issues and contingency plans for future events.
4. There was pressure in the morning to get patients reviewed and Surgeon was unable to see which patients were to be brought in via transport. For future events will look to start earlier and provide clarity of patient transport and include in decision making for list. There was not time to stagger patient admissions or review patients on the ward

This document provides the Essential Enablers and some useful hints and tips throughout to help you replicate this initiative in any Speciality at any Trust and can act as a guide / checklist for planning your Super Saturday event.

Appendices

Appendix 1: Project Group Members

Name and Role
Mr Aqeel Bhutta, Clinical Director for Orthopaedics
Janet Stanton, Assistant Director of Nursing for Surgery and Clinical Support
Katy Alcock, Assistant Director of Allied Health Professions
Diane Elford, Lead clinical Pharmacist
Chris Poole, Head of Pharmacy
Rebecca Neill, Ward Manger Ward 14
Sarah Wiseley, Managing Director for Scheduled Care
Laurence Bond, Directorate Manager for Elective Orthopaedics
Lisa Lowe, Workforce Co-Ordinator (Trauma & Vascular)
Tracey Jenkinson, Theatre Manager
Vicky Kennedy, Physiotherapist, Allied Health Professionals
Amanda Vaughan, Assistant Directorate Manager for Clinical Support Services
Keighley Parker, Lead Nurse for Surgery
Andy McAllister, System Delivery Manager, Greater Manchester
Stephanie Antrobus, Radiology Directorate Manager
Dionne Johnson, Team Leader, Pre-Operative Assessment
Asia Bibi, Programme Manager, GM Elective Recovery and Reform Programme
Andy McAllister, NHSEI

Appendix 2: Project plan

Northern Care Alliance NHS Group

Super Saturday Ortho Super Saturday (08:00 - 18:00) - 10 Joints, 2 Theatres, 1 Surgeon

Date	Description of Action	Owner/ Lead	By When	Risk Assessment	Action Status	Review Comments
21 June 2021	Staffing Model	Directorate Manager	16 July 2021	Green	Complete	Staffing Model approved and discussed with relevant Teams Staff recruitment needed. Discussed during T&O 09/07/2021 - each area to staff and FU meeting to be arranged via T&O group
21 June 2021	Finance Model	Directorate Manager	21 June 2021	Green	Complete	Paper submitted to Investment Committee - approved on 09/07/2021. Finance to come from ERF.
09 July 2021	T&O Group	Directorate Manager	09 July 2021	Green	Complete	First meeting held 09/07/2021. Next meeting 16/07/2021. Weekly meetings may become twice weekly.
09 July 2021	Measurement Metrics	Directorate Manager	09 July 2021	Green	Complete	09/07/2021 - basic metrics completed
09 July 2021	Patient Identification	Directorate Manager and Project Clinical Lead	19 July 2021	Green	Complete	Look on PTL - PRE-OP - BOOKED -
09 July 2021	Lists on TM	Booking and Scheduling co-ordinator	19 July 2021	Green	Complete	To add 2 all day sessions Book patients for equipment review
09 July 2021	Clinical Operational Model	All Clinical Teams	19 July 2021	Green	Complete	Clinical teams to discuss operational side of the day including best way to utilise theatres with patients.
31 July 2021	Review Post Event	All	15 August 2021	Green	Complete	Measure metrics and audits
28 July 2021	Comms	Directorate manager	28 July 2021	Green	Complete	

Appendix 3: Financials

Surgeons		Total Cost
Grade	*Hours*	£13,804.50
Cons	12.5	
Reg	12.5	
Reg	12.5	
SHO	12.5	
Anaesthetics		
Grade	*Hours*	
Cons	12.5	
Cons	12.5	
Middle Grade	12.5	
Ward Staff		
Grade	*Hours*	
Band 7	10	
Band 6	10	
Band 2	10	
Physio		
Grade	*Hours*	
Band 7	12	
Band 6	7.5	
Band 6	12	
Band 5	4.5	
Pharmacy		
Grade	*Hours*	
Band 5	10	
Theatre		
Grade	*Hours*	
Band 6	10	
Band 6	10	
Band 6	10	
Band 5	10	
Band 5	10	
Band 5	10	
Band 5	10	
Band 5	10	
Band 3	10	
Band 2	10	
Band 2	10	
Band 2	10	
Band 2	10	
Band 2	10	
Band 2	10	
Radiology		
Grade	*Hours*	
Band 6	12	

Income

The below describes the average prices for both procedures. It is unknown yet what the case mix will be; however, it is safe to assume, given the income for both, that the income made would more than cover the approximate cost, even if we added on costs (facilities etc.) of approx. 30% to the above finance.

- Average price for a Knee DC or IP is £7,531 (cc score 0-1 £6,205, cc score 8+ = £9,301)
- Average price for Hip DC or IP is £8,359 (cc score 0-1 = £6,229, cc score 10+ = £11,941)

Note: Costings in this project did not include any overheads (approx. 23%) or additional costs associated with the workup beforehand and after work.

This table has been provided to give a breakdown and overview of the staff used and hours costed for this initiative and provide indicative costs.

Appendix 4: Patient feedback used at Team Brief.