BONE AND JOINT INFECTION REGISTRY 2025

8th Annual Report

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Foreword

We hope you enjoy reading the 2025 BAJIR report. As you can see we continue to grow, and continue to develop the Registry to make it as usable and useful to teams as possible. With the further development of the MDT software platform via the addition of the e-referral form, we hope that we are offering MDTs an invaluable adjunct to their work. With this we aim to increase engagement and capture more cases to increase the data quantity, and thus the power of the Registry to tackle the complex questions surrounding orthopaedic infection that is at the core of our mission.

We must thank all our sponsors without whom we could not continue the project and the strong support of our orthopaedic society colleagues, in particular BAJIS (the Bone and Joint Infection Society), BASK (British Association of Surgery of the Knee), the BHS (British Hip Society) and all the individuals on the BAJIR team and in hospital teams around the country who continue to support the project with their time and energy. Special thanks must always go to Anji Kingman, the backbone of BAJIR, who provides endless energy for our progress, and our fellows who have produced this report.

It is worth reminding us all of the devasting effects of orthopaedic infection. Orthopaedic surgery can be one of the most transformatory treatments in modern medicine, but orthopaedic infection is catastrophic to patients and their families, and the health systems that care for them. Orthopaedic infection fares significantly worse than many conditions considered to be terrible for patients, for example mortality is greater than many common cancers; this needs improving.

Over the next few years we look forward to continuing to grow the dataset, to confirming data quality, and so to starting to analyse the huge repository of data we accumulate to answer the many questions we all have in this field. Ultimately through this we aim to improve the outcomes for our patients.

Tim Petheram

Introduction

Mission Statement

Our aim is to capture all bone and joint infection cases presenting to UK hospitals, allowing us to improve the care of patients with these conditions through analysis of collected data on their illnesses and treatments

This is the eighth annual report from the Bone and Joint Infection Registry (BAJIR). The objective of the BAJIR is to collect information on patients who are diagnosed with, and treated for, a bone or joint infection in the UK. Obtaining this data will help provide an understanding of the burden of disease in the UK, the current treatment strategies and the outcomes of those treatments.

The data will eventually be used to inform best practice, direct research and provide information for commissioners of healthcare in the UK. Use of the registry in routine clinical practice is supported by current British Association of Orthopaedics (BOA) and specialist society [British Hip Society (BHS), British Association for Surgery of the Knee (BASK)] standards.

We hope you enjoy reading this annual report. This year we cover insights into the progress made within the registry over the last year, as well as highlighting current practice in the areas of musculoskeletal infection. The registry continues to evolve as more NHS Trusts are added, with a particular focus this year on supporting development of the NHS / BASK Revision Knee Network programme.

Thanks to all for supporting us.

Hamish Lowden, Ananth Srinivasan, Tom Baldock, Mike Reed, Tim Petheram

Registry Progress

This year has seen the registry continue to grow, with 56 trusts now successfully registered to participate in the BAJIR. There are now 3891 complete patients records since the registry's inception with 597 new cases added so far in 2025 (Figure 1 and 2). This growth, quality, and completeness of the entered data in BAJIR will continue with many more trusts now successfully registered and submitting data.

The BAJIR MDT *e-Referral form* will be imminently active and enable any clinician caring for patients with bone and joint infections to complete the proforma and refer directly to the regional Microbiology MDT. Once accepted, the referral will be available within the BAJIR MDT software on the MDT list for discussion and data will auto-populate the BAJIR database, streamlining the process and saving precious time. The hip and knee *Aseptic Pathway* is now live and enables surgeons to keep a swiftly accessible, local record of patients undergoing treatment for aseptic arthroplasty pathology. This means that all patients under consideration for revision arthroplasty can be recorded in one place for discussion in MDT meetings and for audit. There have been further improvements made with the regional network MDT functions that now facilitate record sharing and include the ability of the Network to add details on behalf of a member trust/ unit.

Work continues on the Hospital Episode Statistics (HES) - BAJIR linkage, which was delayed due to the merger of NHS Digital into what was NHS England. This work is an essential part of auditing the data quality of information held within BAJIR, to ensure that any analyses of the contained data are accurate, valid and of high quality. Until this data validation check work is complete we are avoiding any significant data analysis, to avoid analysing incomplete or inaccurate data.

For clinicians and health professionals seeking further instructional information on how to navigate BAJIR, please explore our previous seminars for interested users. These can be accessed on YouTube - BAJIR. There are 3 videos available - one each for patient data entry, the MDT software, and for PROMs / Patient Consent - https://www.youtube.com/channel/UCK6ueqeZzcoUpdwlgeekUqg

BAJIR continues to work hand-in-hand with the UK Bone and Joint Infection Society (BAJIS). In the wake of a thoroughly successful meeting in Coventry June 2025, we will continue to work together to develop knowledge regarding best practice in the field of musculoskeletal infection. Please apply to join BAJIS on their website - www.bajis.org

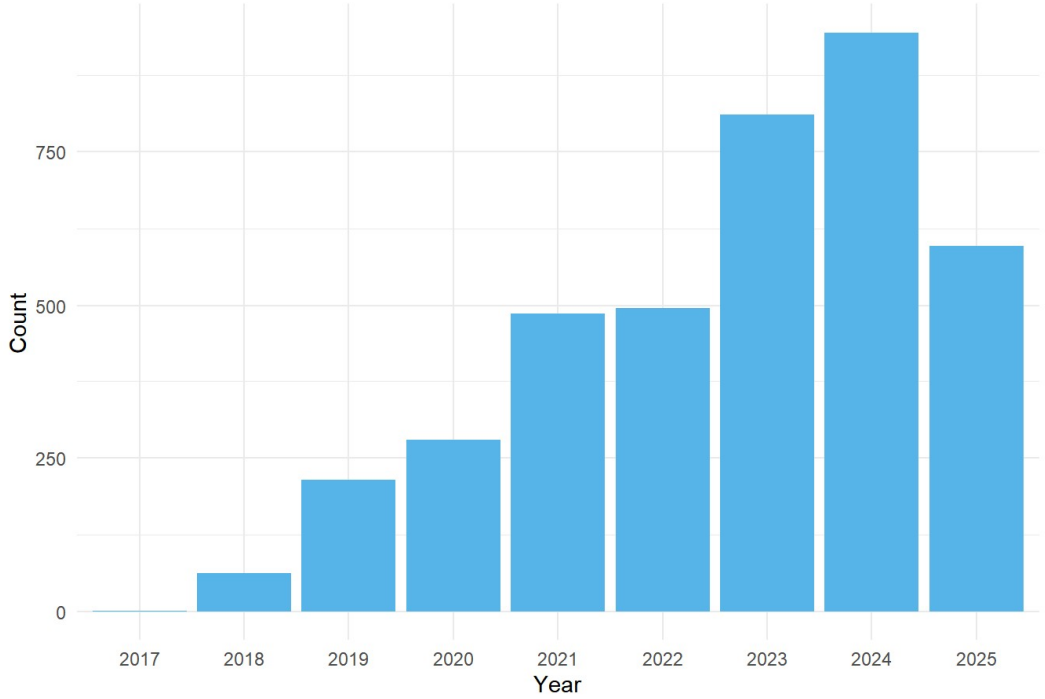


Figure 1. BAJIR submissions per year. 2025 data up to July.

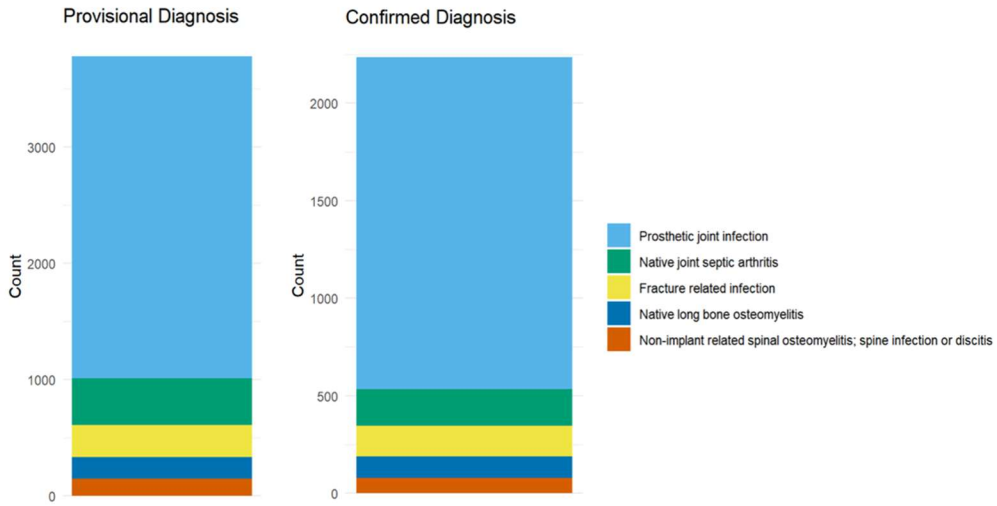


Figure 2. BAJIR submissions by category of bone and joint infection, with tables reporting provision and confirmed diagnoses, respectively.

Table 1: *Submissions to BAJIR by provisional and confirmed diagnosis.*

	Provisional diagnosis	**Confirmed cases**
Prosthetic joint infection	2767 (73.2%)	1700 (76.1%)
Native joint septic arthritis	406 (10.7%)	191 (8.5%)
Fracture related infection	274 (7.3%)	156 (7.0%)
Native long bone osteomyelitis	183 (4.8%)	111 (5.0%)
Non-implant related spinal osteomyelitis, spine implant infection, or discitis	149 (3.9%)	77 (3.4%)
Total	**3779**	2235

Bone and Joint Infection Case Mix

Periprosthetic Joint Infection (PJI)

There have been 2767 case submitted to BAJIR with suspected periprosthetic joint infection (PJI). Of which, 1700 had a confirmed PJI. There is a preponderance for recording both knee (927 cases, 54.5%) and hip prosthetic joint infections (713 cases, 41.9%%), with the recorded number of annual knee cases almost doubling since 2022 (Table 2; Figure 3a and 3b). This coincides with the conceptualisation of the Revision Knee Network. The remaining case mix comprises shoulder, elbow and ankle PJIs.

Table 2: Number of Confirmed PJIs categorised by anatomical location

	Number of Cases (%)	Percentage of Total
Hip	713	41.9
Knee	927	54.5
Shoulder	23	1.4
Elbow	15	0.9
Ankle	18	1.1
Joint Not Specified	4	0.2
Total	**1700**	

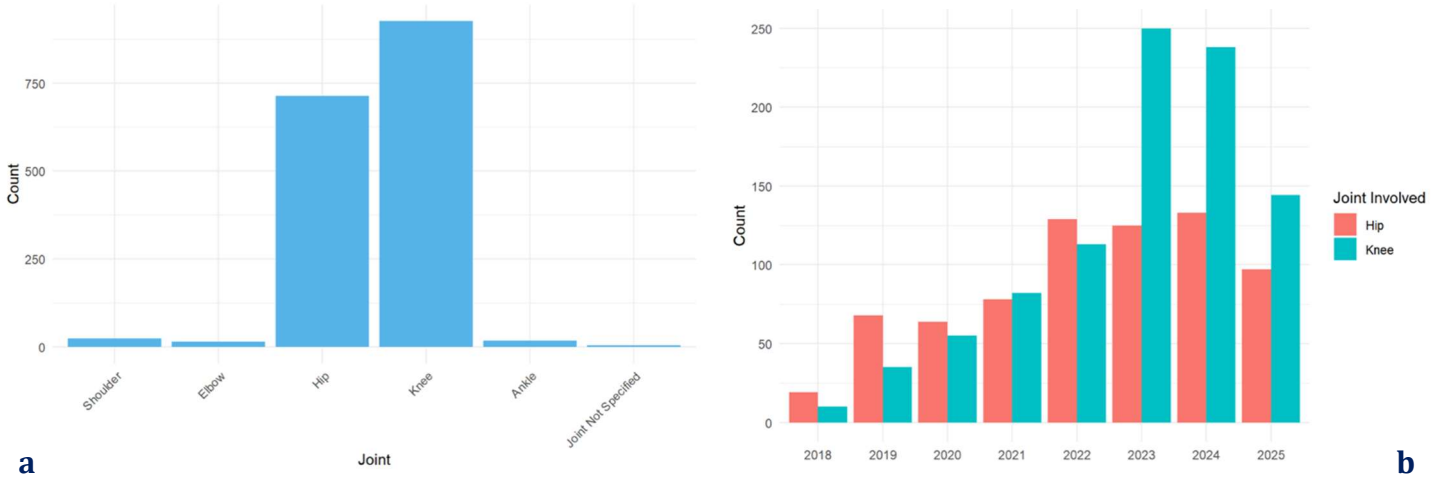


Figure 3. Confirmed PJIs by joint involved. Figures 3a reporting the distribution of involved prosthetic joints. Figure 3b demonstrating the increase in knee PJI cases submitted to registry.

Prosthetic Joint Infection Microbiology

Organisms were isolated in 1253 cases (73.7%), with the 447 cases (26.3%) where either culture was negative OR organism not specified. *Staphylococcus aureus*, coagulase-negative *Staphylococcus* spp., *Streptococcus spp.* and *Enterobacteriaceae* are the most frequently isolated organisms with more than one organism isolated in 106 cases (6.2%) (Table 3, Figure 4).

Table 3: Organisms isolated in Prosthetic Joint Infection

Organism	Number of Cases	Percentage of Total
Staphylococcus aureus	350	20.6
Coagulase-negative *Staphylococcus spp.*	264	15.5
Streptococcus spp.	167	9.8
Enterobacteriaceae	127	7.5
More than one isolate	106	6.2
Others	64	3.8
Enterococcus spp.	48	2.8
Pseudomonas spp. (or other non-fermenting GNB)	36	2.1
Cutibacterium acnes	34	2.0
Other anaerobes	23	1.4
Fungi	11	0.6
Corynebacterium spp.	10	0.6
Cutibacterium spp.	4	0.2
Vancomycin Resistant Enterococci (VRE)	4	0.2
Acinetobacter spp.	2	0.1
Mycobacteria spp.	2	0.1
HACEK	1	0.1
No Specified Bacteria OR Culture negative	447	26.3
Total	1700	

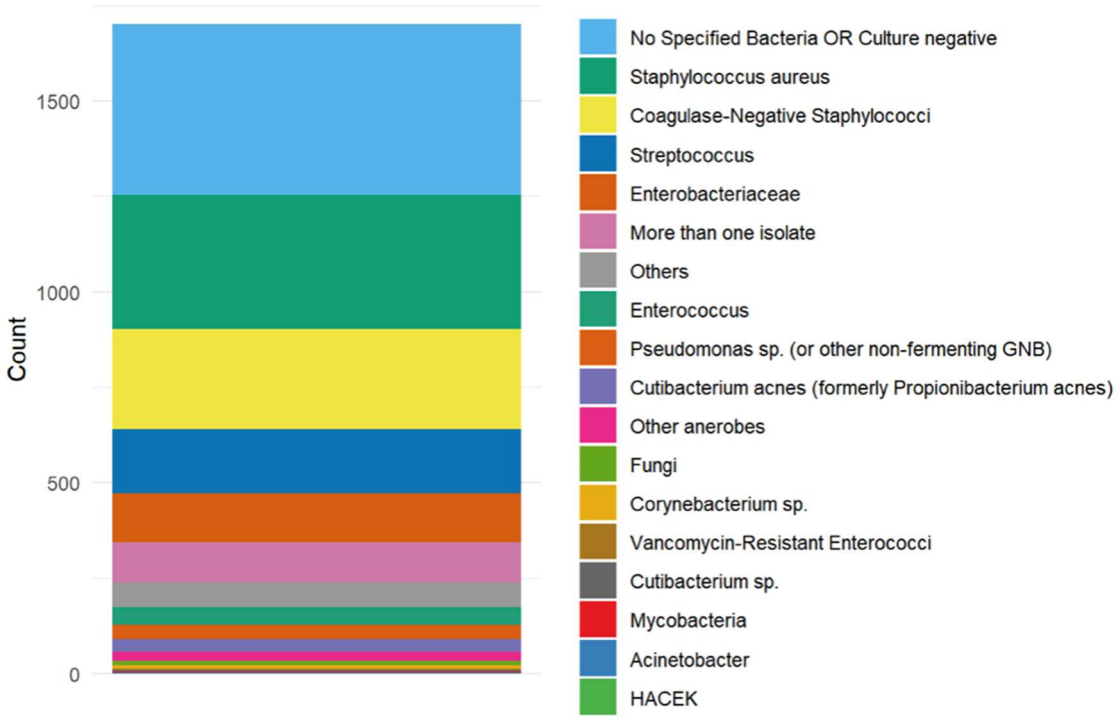


Figure 4. Organisms isolated in Prosthetic joint infections, HACEK defined as Haemophilus, Aggregatibacter, Cardiobacterium, Eikenella, Kingella

Treatment for Suspected Prosthetic Joint Infection

Index procedure data (the first infection eradication or suppression procedure performed) was available for 1970 (71.1%) of cases (Table 4, **Figure 5**). The most common operations performed were DAIR with modular exchange (523 cases)**;** the first stage of a two stage revision (493 cases)**;** single stage revision (417 cases); DAIR without component exchange (189 cases) and open washout (113 cases).

Table 4: Frequency of index operations performed for Prosthetic Joint Infections

	Number of Cases	Percentage of Total
Two Stage Procedure		
First Stage Joint Replacement / Arthrodesis	493	25.0
Second Stage Joint Replacement / Arthrodesis	38	1.9
Repeat First Stage	22	1.1
DAIR		
With Modular Exchange	523	26.5
Without Component Exchange	189	9.6
Washout		
Open	113	57.3
Arthroscopic	64	3.25
Single Stage		
Revision	417	21.2
Arthrodesis	5	0.3
Amputation	7	0.4
Open Biopsy	15	0.8
Removal of fracture fixation implant	24	1.2
Operation not specified	39	2.0
No Surgery at present	21	1.1
Total	1970	

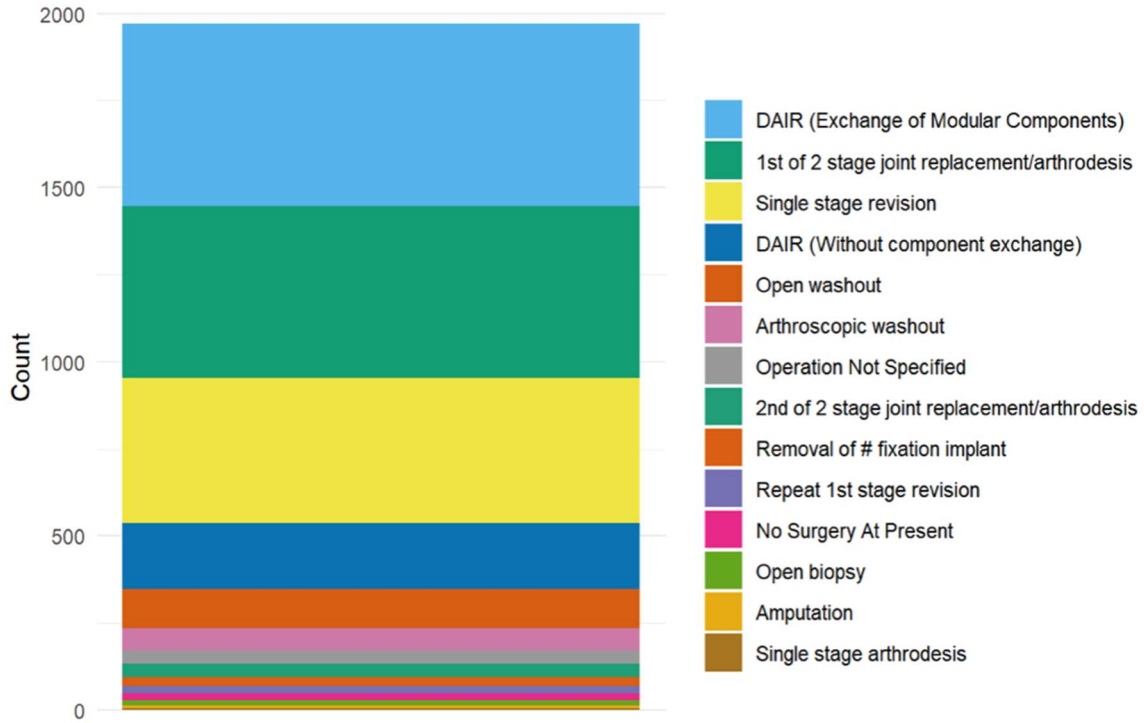


Figure 5. Index procedures performed in suspected Prosthetic joint infections.

Native Joint Septic Arthritis

A total of 191 cases with confirmed native joint infection have been submitted to BAJIR. The most common joints involved were: knee (78 cases); hip (51 cases); shoulder (36 cases) and ankle (12 cases) (Table 5, Figure 6). Pathogens were isolated in 111 (58.1%) cases (Table 6, Figure 7). The predominant organism identified was *Staphylococcus aureus* (41 cases, 21.5%) followed by *Streptococcus spp* (23 cases, 12.0%). A total of 317 procedures were added for all cases of suspected native joint septic arthritis. Table 7, Figure 8).

Table 5: Confirmed Native Septic Arthritis cases by joint involved

	Number of Cases (%)	Percentage of Total
Knee	78	40.8
Hip	51	26.7
Shoulder	36	18.8
Ankle	12	62.8
Wrist	6	3.1
Elbow	2	1.0
Sternoclavicular	2	1.0
Joint Not Specified	4	2.1
Total	**191**	

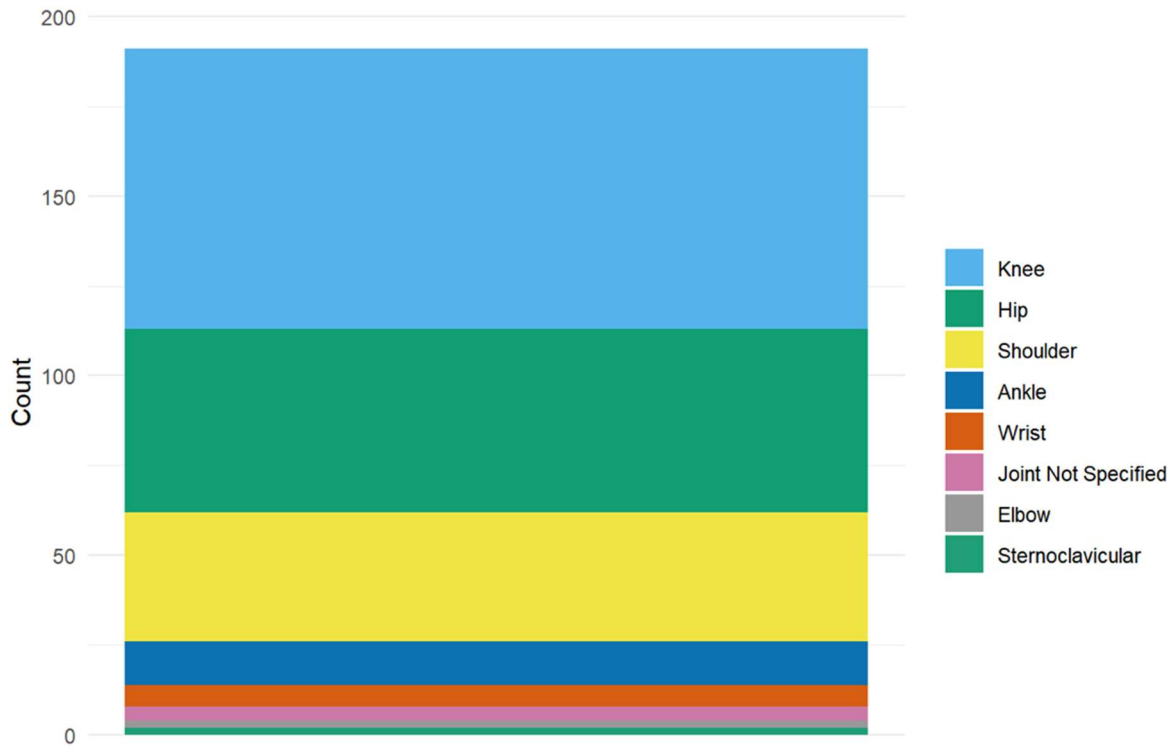


Figure 6. Confirmed native joint septic arthritis by joint

Table 6: Organisms isolated in Native Joint Septic Arthritis

Organism	Number of Cases	Percentage of Total
Staphylococcus aureus	41	21.5
Streptococcus spp.	23	12.0
Coagulase-negative *Staphylococcus spp.*	9	4.7
More than one isolate	9	4.7
Others	9	4.7
Enterobacteriaceae	6	3.1
Cutibacterium acnes	3	1.6
Enterococcus spp.	3	1.6
Other anaerobes	3	1.6
Pseudomonas spp. (or other non-fermenting GNB)	2	1.0
Cutibacterium spp.	2	1.0
Fungi	1	0.5
Fungi	11	0.6
No Specified Bacteria OR Culture negative	80	41.9
Total	191	

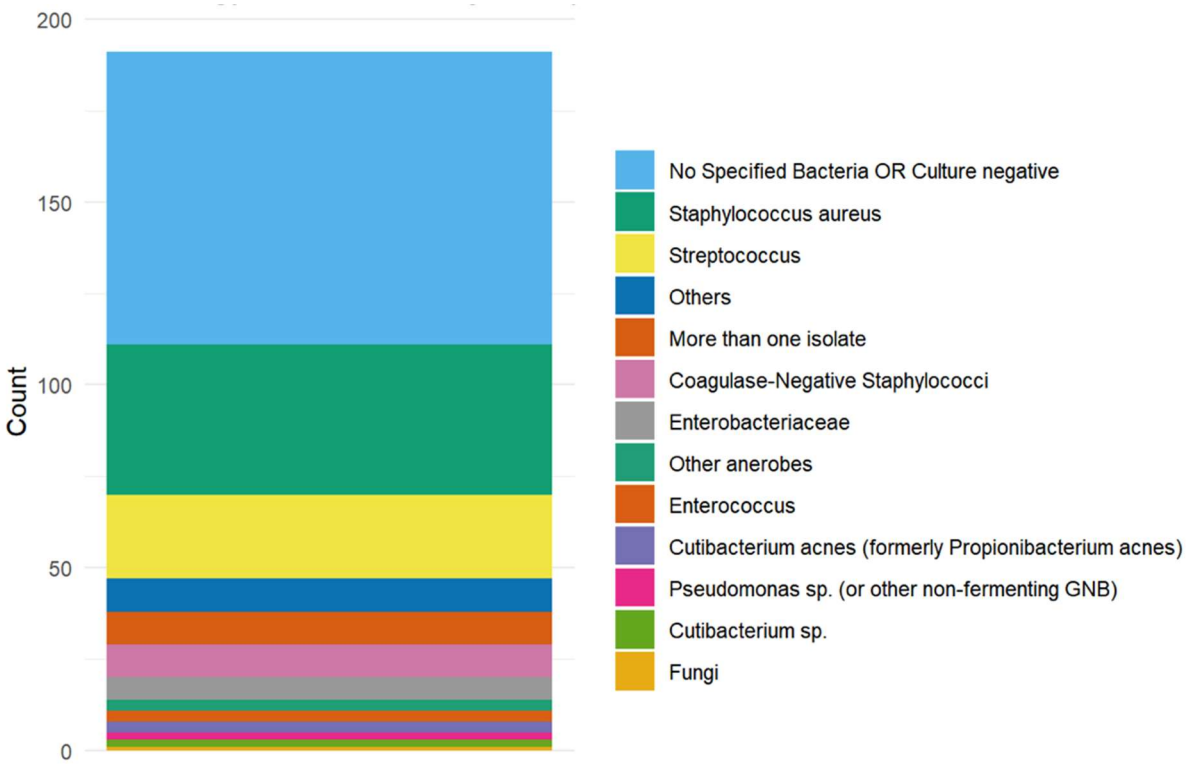


Figure 7. Organisms isolated in Native Joint Septic Arthritis

Table 7: Procedures performed for suspected cases of native joint septic arthritis

Organism	Number of Cases	Percentage of Total
Arthroscopic washout	139	43.8
Open washout	83	26.1
Excision and spacer	33	10.4
Joint replacement	27	8.5
Combination of Procedures	15	4.7
Arthroscopic washout and Synovectomy	8	2.5
No Specified Operation	6	1.8
Amputation	3	0.9
Excision without spacer	3	0.9
Total	317	

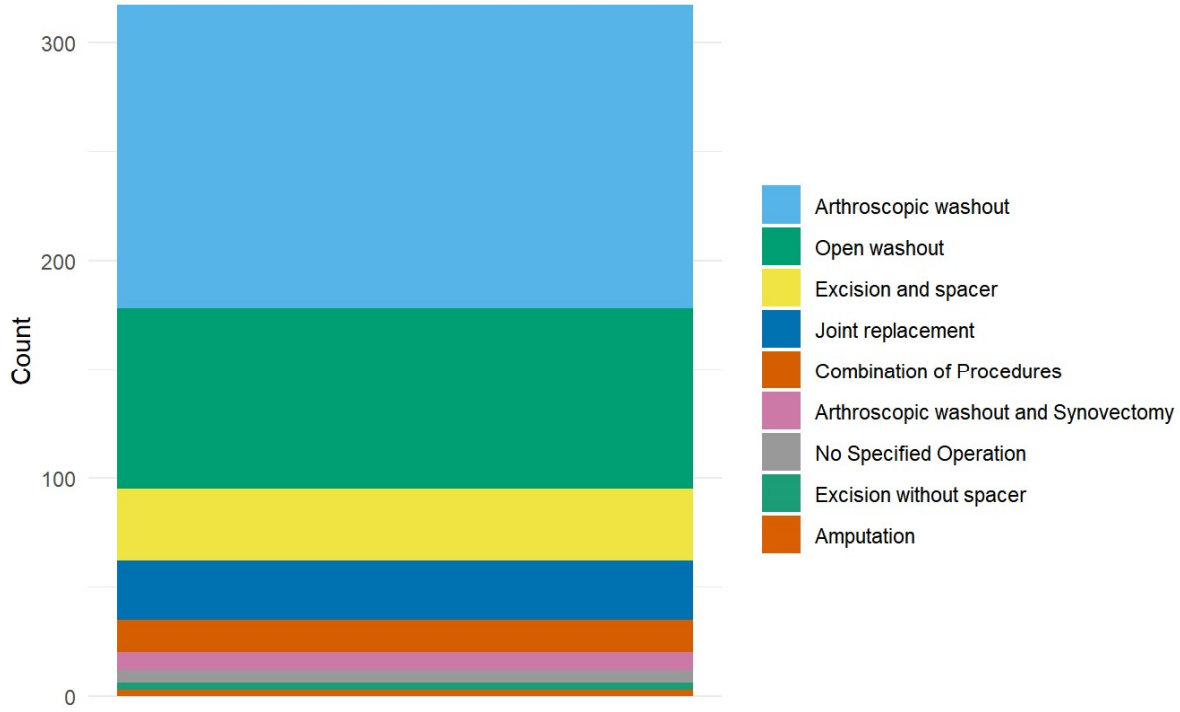


Figure 8: Procedures performed for suspected cases of native joint septic arthritis

Osteomyelitis

Thus far 111 cases with confirmed osteomyelitis have been submitted to BAJIR. The commonly affected bones were the femur (23.4%), tibia (18.9%) and foot (15.3%) (Table 8, Figure 9). Microbiological data was available for 77 (69.4%) patients (Table 9, Figure 10). *Staphylococcus aureus* was the predominant organism (21.6%), followed by polymicrobial infection (11.7%) and *Enterobacteriaceae* (9.9%). Treatment data was available in 42 cases and is summarised in Table 10 and Figure 11: 16 patients received an incision and drainage; eight patients underwent non-segmental resections with or without reaming and 3 patients underwent segmental resections, and 4 patients had metalwork removed.

***Table 8**. Site of Osteomyelitis in confirmed cases.*

	Number of Cases (%)	Percentage of Total
Femur	26	23.4
Tibia	21	18.9
Foot	17	15.3
Pelvis	8	7.2
Fibula	6	5.4
Humerus	6	5.4
Clavicle	3	2.7
Femur &Tibia	2	1.8
Hand	2	1.8
Radius & Ulna	2	1.8
Tibia and Fibula	2	1.8
Tibia and Foot	2	1.8
Humerus, Radius, Ulna and Hand	1	0.9
Patella	1	0.9
Scapula and Humerus	1	0.9
Bone Not Specified	11	9.9
Total	**111**	

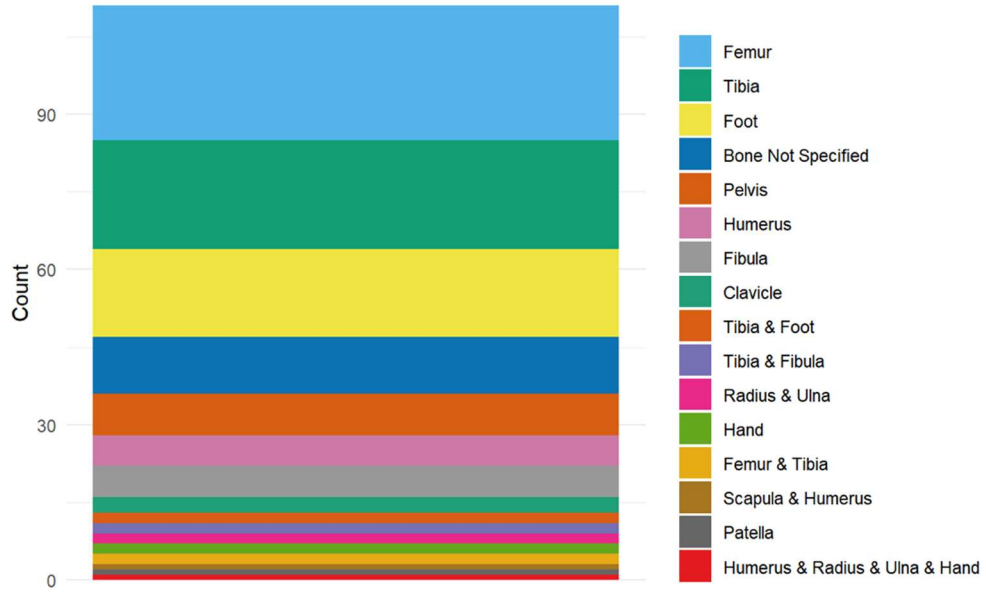


Figure 9. Site of osteomyelitis

Table 9. *Organisms isolated in Osteomyelitis*

Organism	Number of Cases	Percentage of Total
Staphylococcus aureus	24	21.6
More than one isolate	13	11.7
Enterobacteriaceae	11	9.9
Coagulase-negative *Staphylococcus spp.*	9	8.1
Others	5	4.5
Streptococcus spp.	5	4.5
Pseudomonas spp. (or other non-fermenting GNB)	4	3.6
Cutibacterium acnes	3	2.7
Corynebcterium spp.	1	0.9
Enterococcus spp.	1	0.9
Other anaerobes	1	0.9
No Specified Bacteria OR Culture Negative	34	30.6
Total	111	

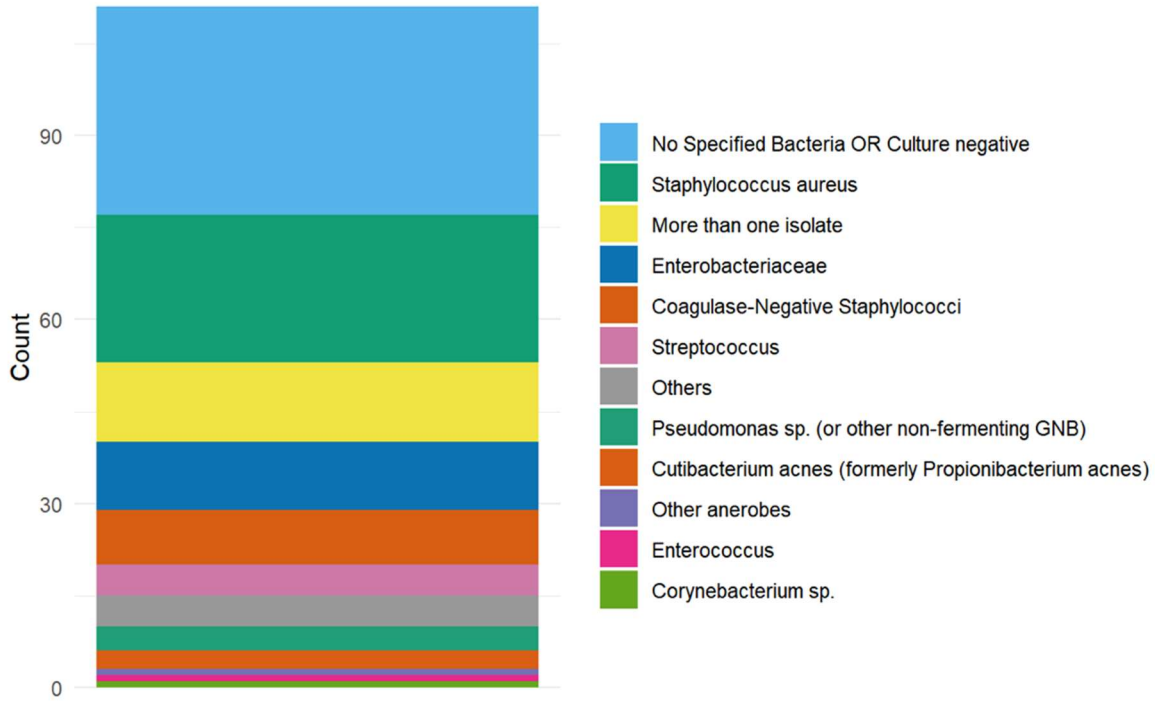


Figure 10. Organisms isolated in Osteomyelitis

Table 10. *Operation performed for suspected cases of osteomyelitis*

	Number of Cases (%)	Percentage of Total
Incision and Drainage	16	38.1
Removal of hardware	4	9.5
Non-segmental resection	6	14.3
Segmental resection	3	7.1
Non-segmental Resection and reaming	2	4.8
No documented procedure	11	26.2
Total	**42**	

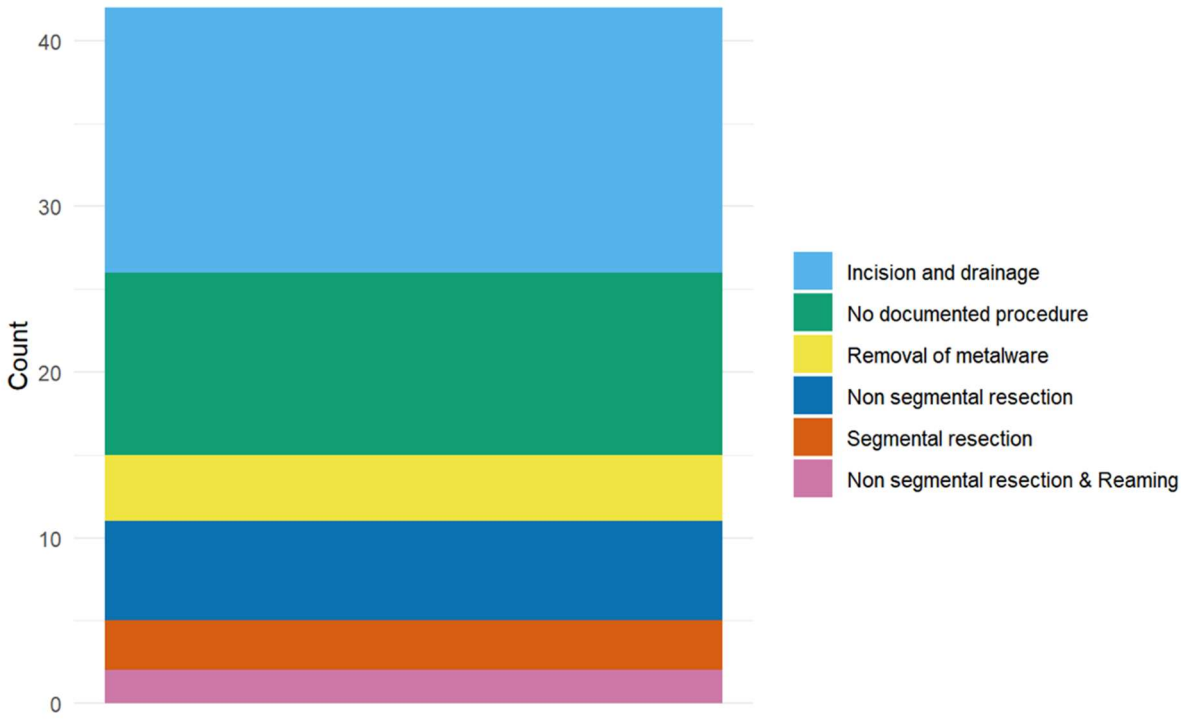


Figure 11. Operations performed for Osteomyelitis

Fracture-Related Infection

There were 274 cases with suspected fracture-related infections submitted to BAJIR since the inception of the new pathway in 2022. Overall, 156 patients had confirmed fracture-related infections. The most common sites were the tibia (62, 39.7%) and femur (41, 26.3%) (Table 11, Figure 12). Microbiology data was available for 130 (83.3%) patients with the predominant organisms being *Staphylococcus aureus* (53, 34%), *Enterobacteriaceae* (20, 12.8%), polymicrobial infections (17, 10.9%) and coagulase-negative *Staphylococcus spp.* (15, 9.6%) (Table 12, Figure 13). Data regarding degree of clearance was available in 103 (53.4%) cases (Table 13, Figure 14).

A total of 193 procedures for confirmed and unconfirmed fracture-related infection cases have been submitted to BAJIR. Choice of revision fixation modality was available for 27 patients with ring fixation predominating (Table 14, Figure 15). Dead-space management technique was available to report in 92 (47.7%) cases (Table 15, Figure 16).

Table 11. *Fracture Related Infection by site*

	Number of Cases (%)	Percentage of Total
Tibia	62	39.7
Femur	41	26.3
Foot	8	5.1
Humerus	7	4.5
Fibula	6	3.8
Ulna	5	3.2
Pelvis	4	2.6
Radius	4	2.6
Tibia & Fibula	3	1.9
Hand	2	1.3
Radius & Ulna	2	1.3
Femur & Patella	1	0.6
Patella	1	0.6
Scapula	1	0.6
Tibia & Foot	1	0.6
Bone Not Specified	8	5.1
Total	**156**	

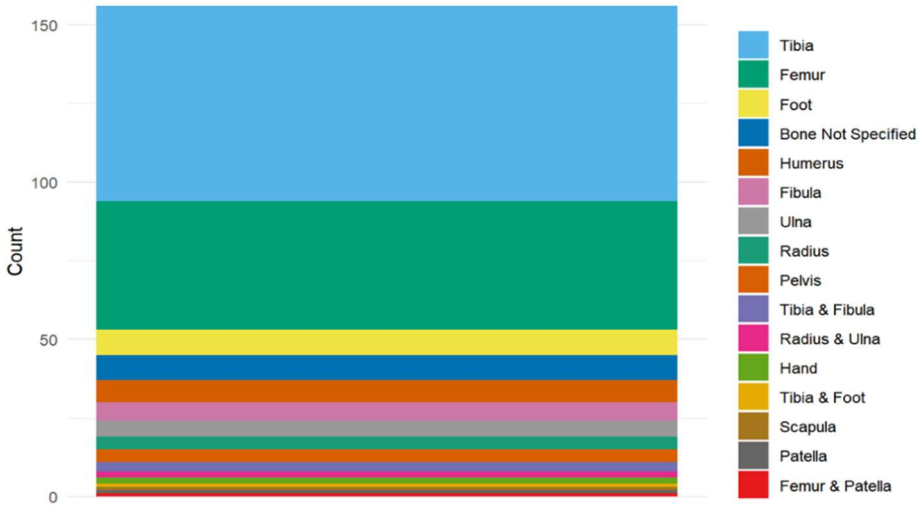


Figure 12. Site of fracture related infections

Table 12. *Fracture Related Infection by site*

Organism	Number of Cases	Percentage of Total
Staphylococcus aureus	53	34.0
Enterobacteriaceae	20	12.8
More than one isolate	17	10.9
Coagulase-negative *Staphylococcus spp.*	15	9.6
Pseudomonas spp. (or other non-fermenting GNB)	7	4.5
Other Anaerobes	6	3.8
Others	4	2.6
Enterococcus spp.	3	1.9
Corynebcterium spp.	2	1.3
Streptococcus spp.	2	1.3
Fungi	1	0.6
No Specified Bacteria OR Culture Negative	26	16.7
Total	156	

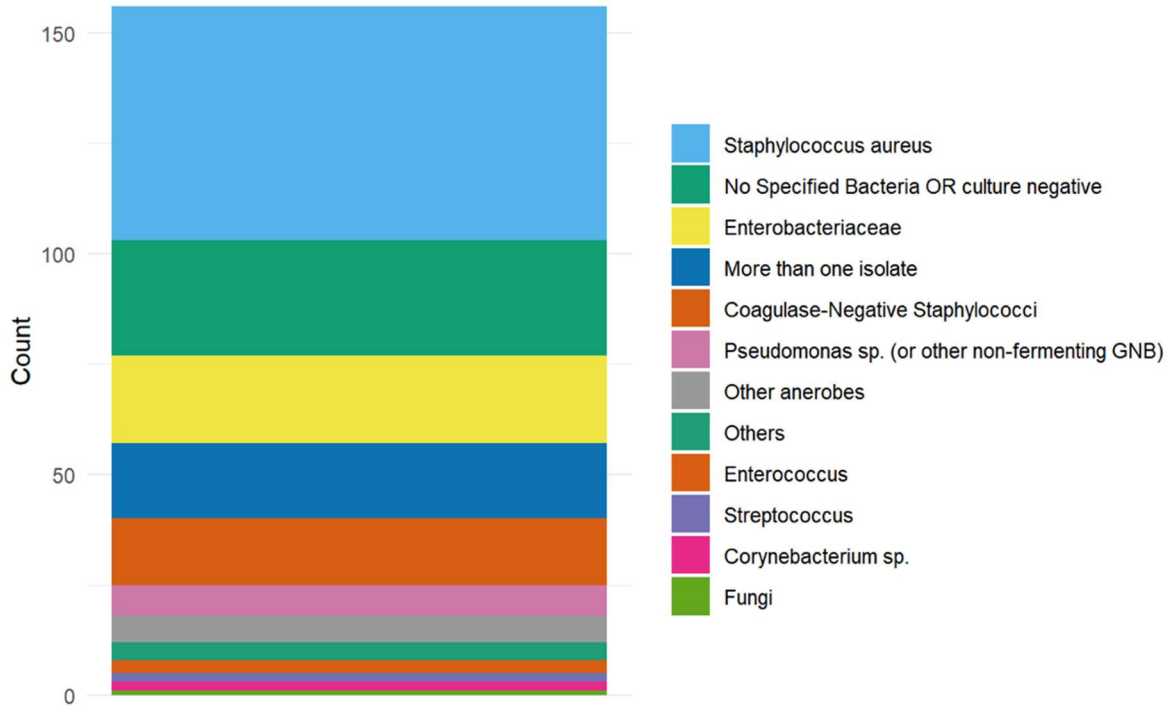


Figure 13. Organisms isolated in fracture-related infection

***Table 13**. Degree of clearance in suspected Fracture related Infection procedures.*

	Number of Cases (%)	Percentage of Total
Clearance of active disease areas	71	36.8
Clearance of all abnormal bone	18	9.3
Partial clearance	5	2.6
Debulking/ Decompression	1	0.5
Sampling	8	4.1
Not documented	90	46.6
Total	**193**	

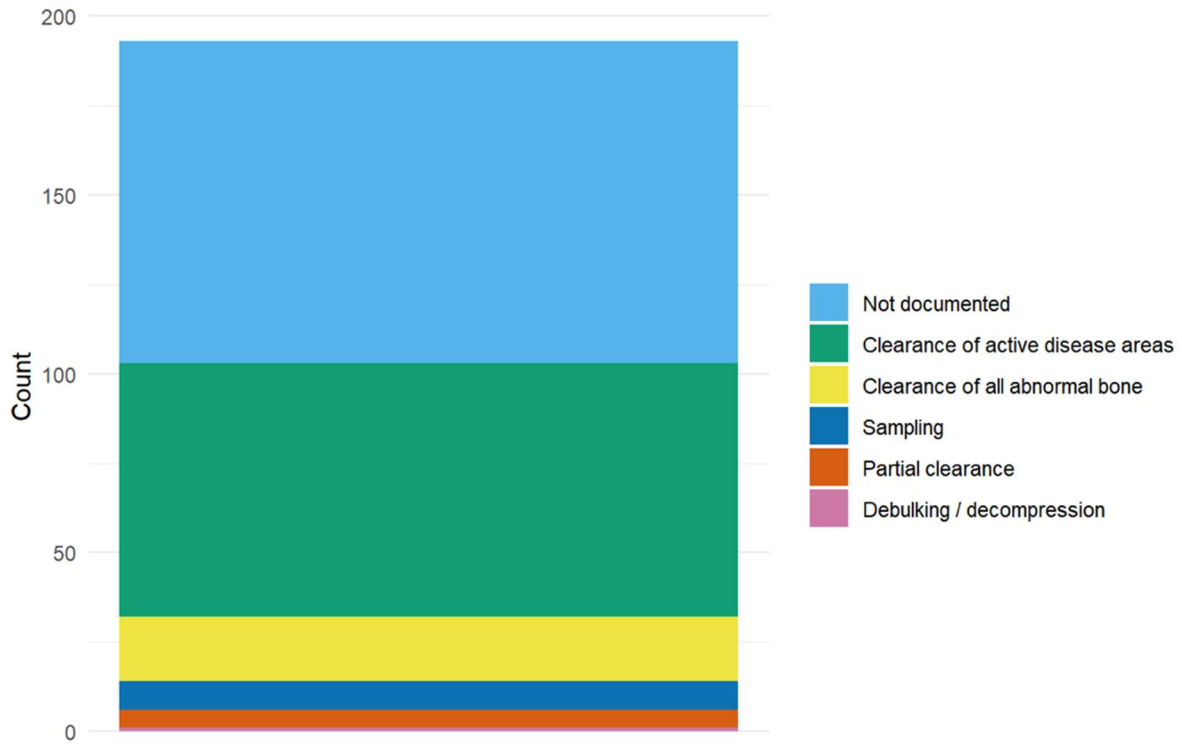


Figure 14. Degree of clearance in fracture-related infection procedures.

***Table 14**. Method of definitive stabilisation for fracture-related infections*

	Number of Cases (%)
Ring fixator (Definitive)	13
Exchange Nailing (Definitive)	5
Plate (definitive)	5
Nail (definitive)	2
Plate (definitive) + Exchange nailing (temporary)	1
Stabilisation internal & Plate (definitive)	1
Total	**27**

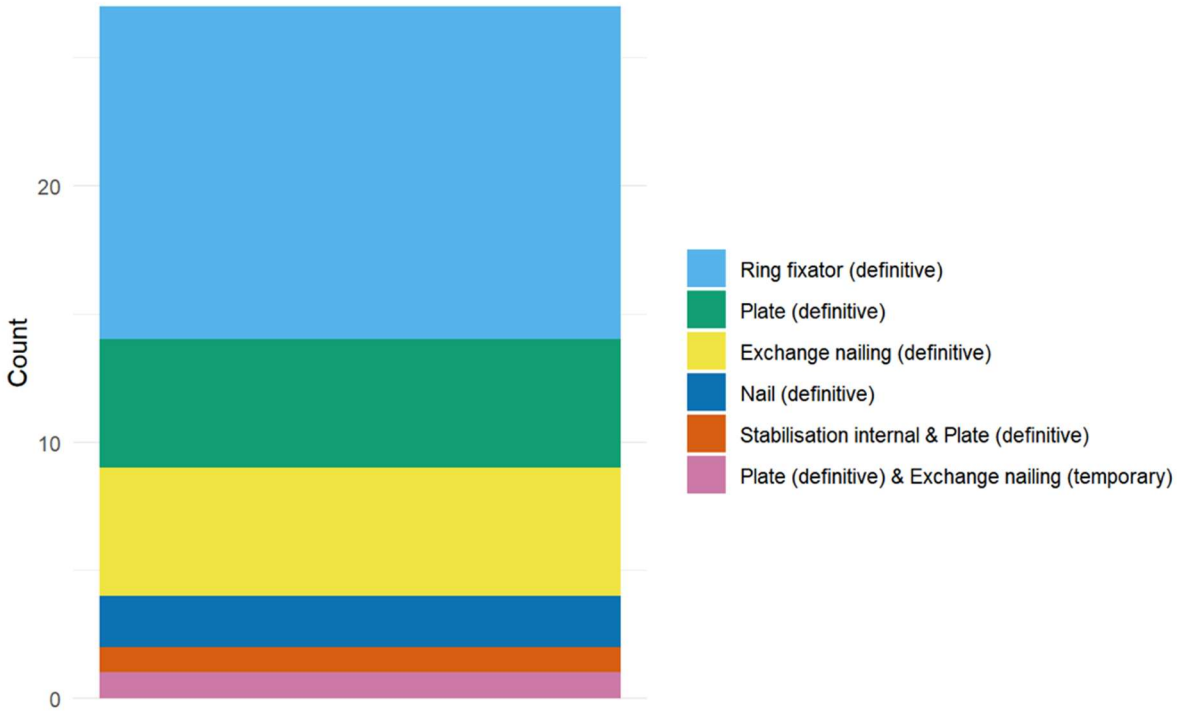


Figure 15. Method of definitive stabilisation for fracture-related infections

***Table 15**. Dead Space Management*

	Number of Cases (%)	Percentage of Total
Resorbable antibiotic carrier	55	28.5
None	31	16.1
Non-resorbable antibiotic carrier	2	1.0
Resorbable and Non- resorbable antibiotic carrier	1	0.5
Free Flap	1	0.5
Free Flap & resorbable antibiotic carrier	1	0.5
Local Flap	1	0.5
Not documented	101	52.3
Total	**193**	

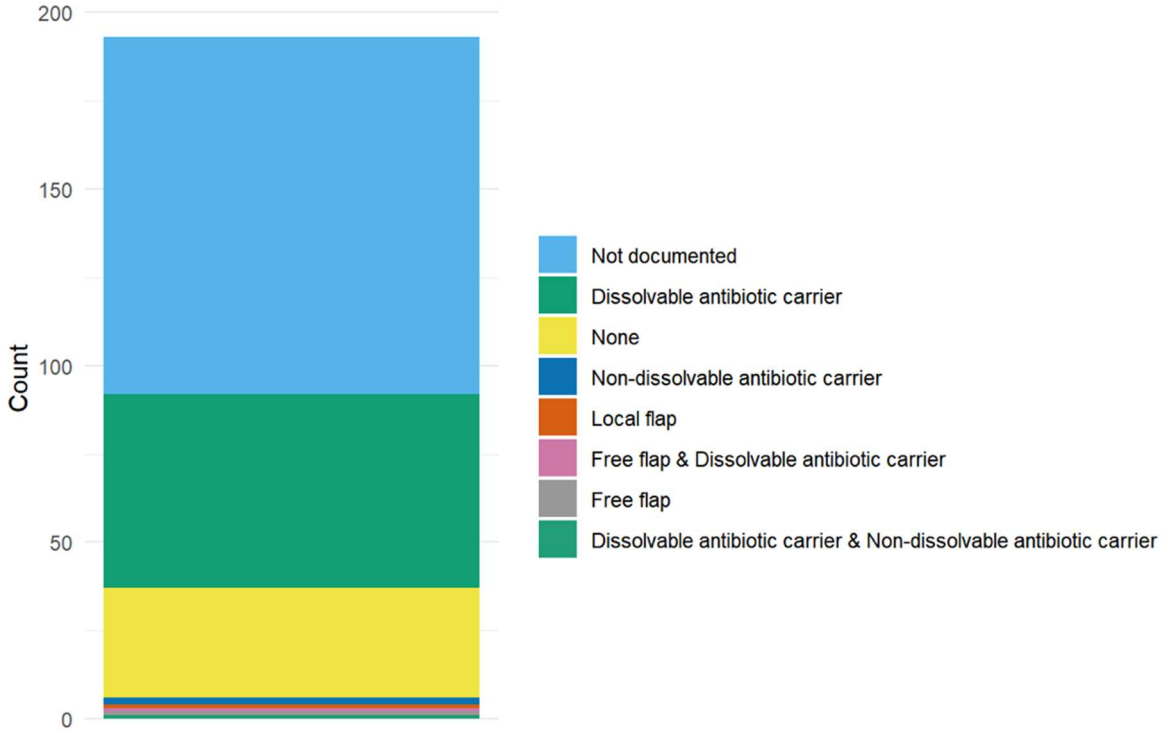


Figure 16. Dead Space Management in Fracture Related Infection

Local Antibiotic Carrier and Antibiotic Use

A total of 1150 cases used local antibiotic carriers in the treatment of bone and joint infections and have been entered into the registry. The most commonly used were non-resorbable carriers alone (436, 34.0%), resorbable carriers alone (364, 28.4%) and a combination of both (236, 18.4%) (Table 16, Figure 17). A combination of gentamicin and vancomycin was the predominant local antibiotic choice (437, 40.6%); followed by Vancomycin alone (359, 33.4%) (Table 17, Figure 18). If less than ten cases in the registry, the antibiotic used was coded as 'other' for the purposes of this report.

Table 16. *Antibiotic carrier used in Bone and Joint Infection Management*

	Number of Cases (%)	Percentage of Total
Non-resorbable Carrier	436	34.0
Resorbable carrier	364	28.4
Resorbable & Non-resorbable carrier	236	18.4
Other	71	5.5
Resorbable carrier & Other	30	2.3
Non-resorbable carrier & Other	9	0.7
Resorbable & Non-resorbable carrier & Other	2	0.2
Resorbable carrier & Bone graft	1	0.1
Resorbable & Non-resorbable carrier & Bone graft	1	0.1
Not Documented	132	10.3
Total	**1282**	

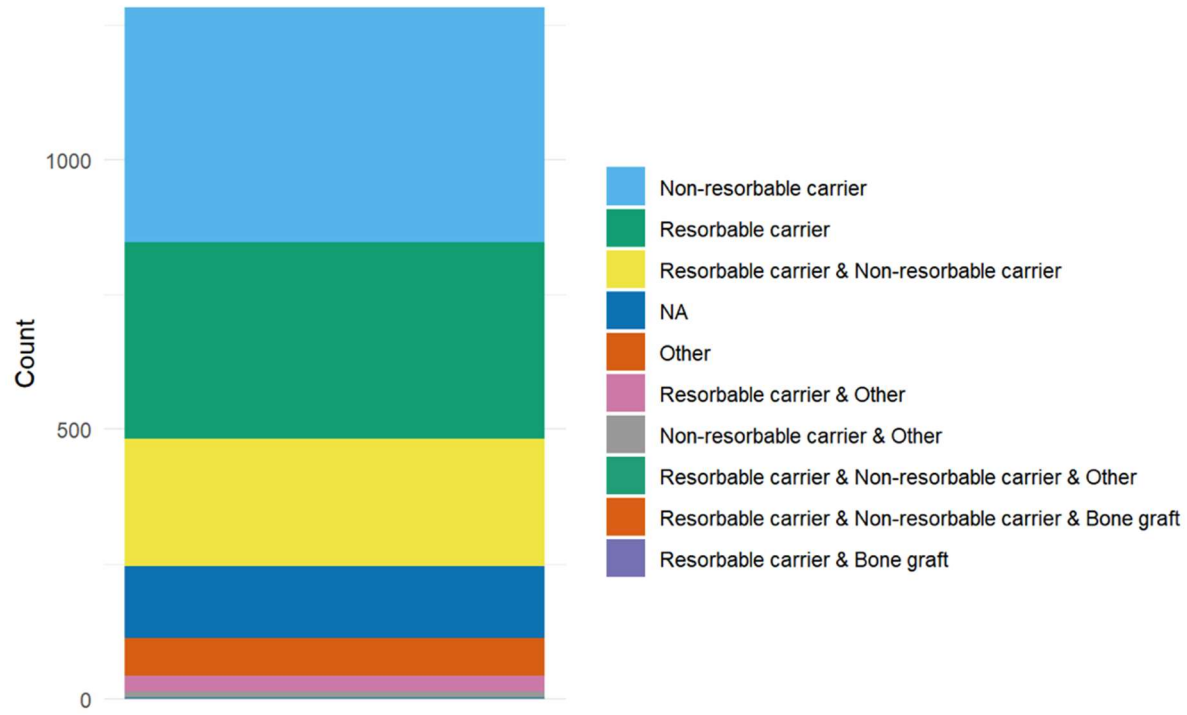


Figure 17. Antibiotic carrier used in Bone and Joint Infection Management

***Table 17**. Local antibiotics used in Bone and Joint Infections*

	Number of Cases (%)	Percentage of Total
Gentamicin & Vancomycin	437	40.6
Vancomycin	359	33.4
Other	87	8.1
Meropenem & Vancomycin	69	6.4
Gentamicin	45	4.2
Meropenem	29	2.7
Gentamicin & Meropenem & Vancomycin	19	1.8
Gentamicin & Meropenem	16	1.5
Clindamycin & Gentamicin	15	1.4
Total	**1076**	

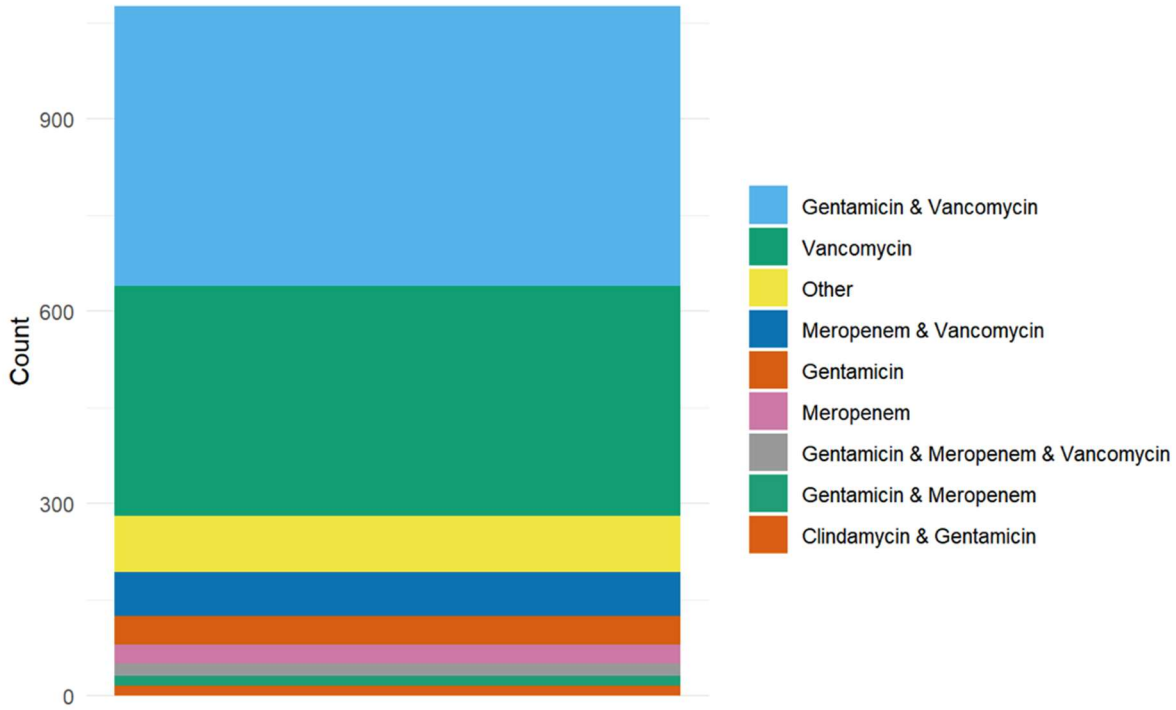


Figure 18. Local antibiotics used in Bone and Joint Infections

Patient Recorded Outcome Measures (PROMS)

Patient reported outcome measures (PROMs) are collected at baseline, 6 months, and annually from patients submitted to BAJIR. Local units are required to collect and record baselines PROMs in BAJIR. The last year has seen the launch of openOutcomes™ digital PROMs collection by BAJIR, an update from the previous manual paper PROMs collection. BAJIR automatically triggers a pathway with openOutcomes™ once infection has been confirmed, a patient has consented and provided an email address. The patient will receive an email link to complete their PROMs online. The outcome measure is the EuroQol five-dimension (EQ-5D-3L™) score, as this aligns with the outcome measure used in the NHS PROMs programme.

The EQ-5D-3L™ has two parts. The EQ-5D-3L™ self-classifier asks patients to self-score five dimensions of health: mobility, selfcare, usual activities, pain/discomfort, and anxiety/ depression. Each dimension has three levels of severity (mild, moderate, severe), giving 243 possible health profiles. These profiles can then be converted into a single score as a global summary of a perceived health by the patient. These scores have been validated for different national populations to account for cultural differences of perceived health. For the United Kingdom, scores range from -0.594 to 1, with a score of 1 (full health) and 0 (death). Negative scores are defined as a state "worse than death." Of the 243 possible health states amongst the UK population, 84 have negative utility scores and hence are deemed "worse than death". The ability to score health states "worse than death" reduces the floor effect of this score, allowing greater granularity when quantifying severe disability and poor health. The measure is reliable, responsive, and validated in a number of populations and musculoskeletal pathologies.

The EQ-visual analogue scale (EQ-VAS) is a vertical visual analogue scale that takes values between 100 (best imaginable health) and 0 (worst imaginable health), on which patients provide a global assessment of their health. The EuroQol Group, which developed and owns the copyright to the EQ-5D-3L™, recommends that both of these parts be used. The data can be analysed and reported in terms of the profile itself, an index number derived from the profile using a standard set of weights, or the EQ-VAS.

These are collected at baseline, six months, one year, two year, and five year timepoints. Table 18 outlines the responses received, as well as the number of complete EQ-5D-3L™ and VAS scores available at each timepoint. A state "worse than death" was reported by in 27% of complete baseline EQ-5D-3L™ scores, 14% at six months, 11% at one year, 10% at two year, and 22 % at five years. Figures 19-22 summarise the trajectory of EQ-5D-3L™ scores for all patients, as well as for patients with a diagnosis of prosthetic joint infection, sub-categorised by the first procedure listed on BAJIR. For the sub-categorised groups, only scores up to two years are reported due to current low numbers at five year follow up.

***Table 18**. Response rate by year*

	Any PROMs	EQ-5D-3L	VAS
Baseline	457	443	435
6 Months	614	603	585
1 Year	515	506	490
2 Years	222	218	213
5 Years	51	50	47

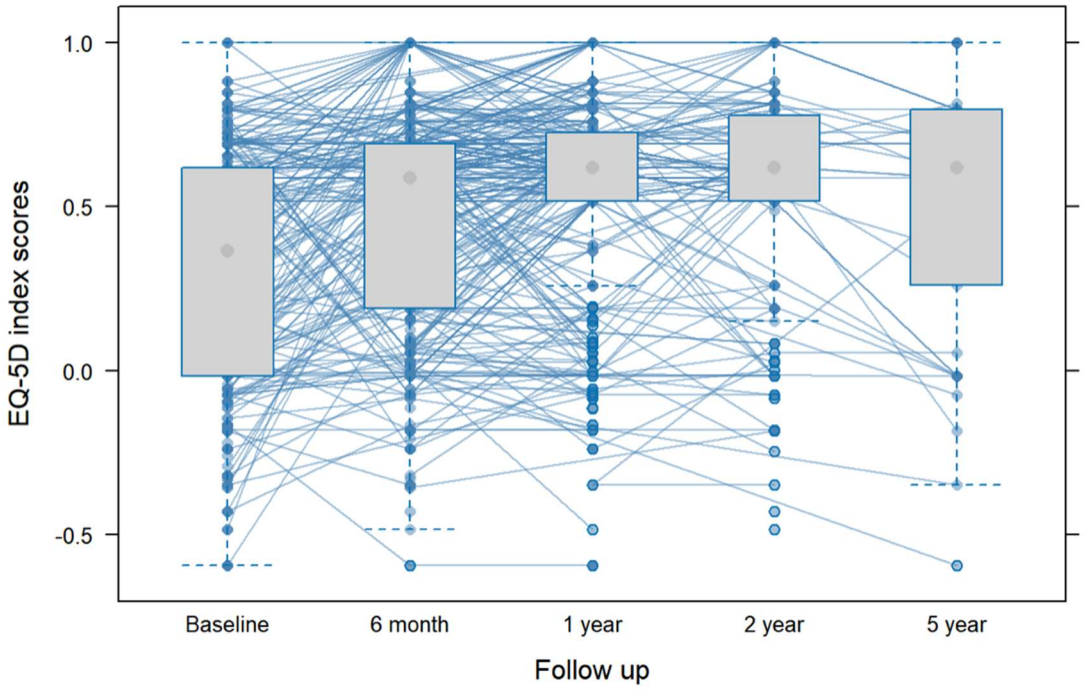


Figure 19. EQ-5D-3L™ for all patients. Central point represents median, box shows interquartile range (Q1–Q3), whiskers extend to 1.5×interquartile range

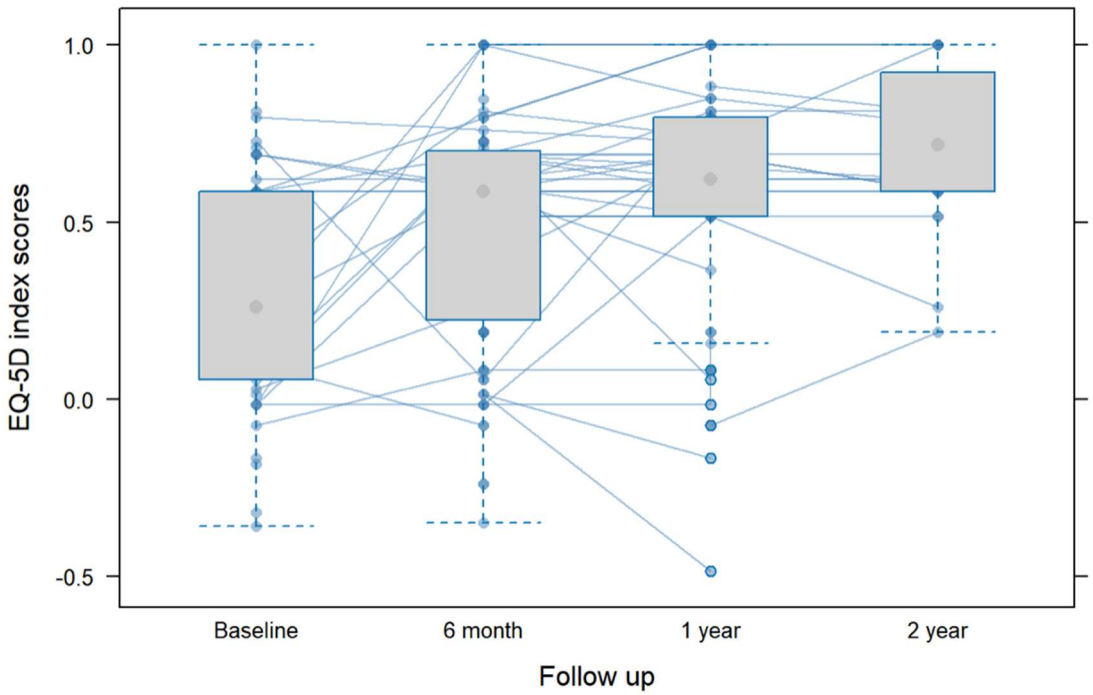


Figure 20. EQ-5D-3L™ for patients undergoing single stage revision for PJI. Central point represents median, box shows interquartile range (Q1–Q3), whiskers extend to 1.5×interquartile range

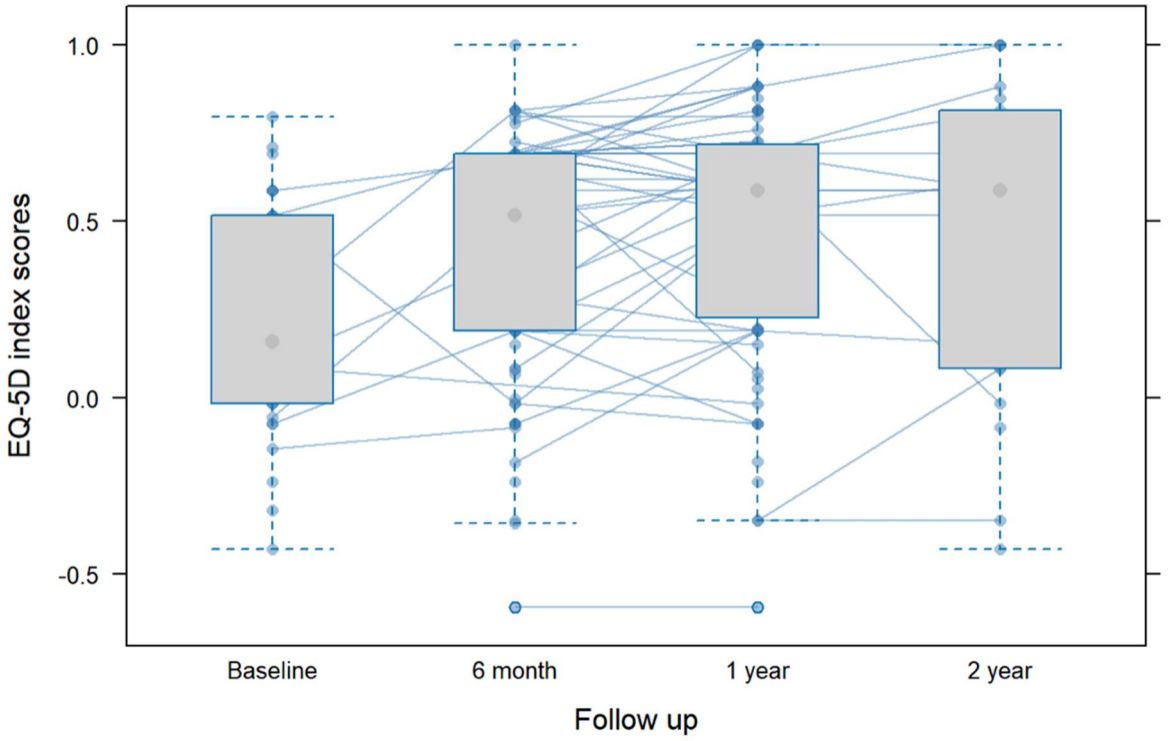


Figure 21. EQ-5D-3L™ for patients undergoing first stage revision for PJI. Central point represents median, box shows interquartile range (Q1–Q3), whiskers extend to 1.5×interquartile range

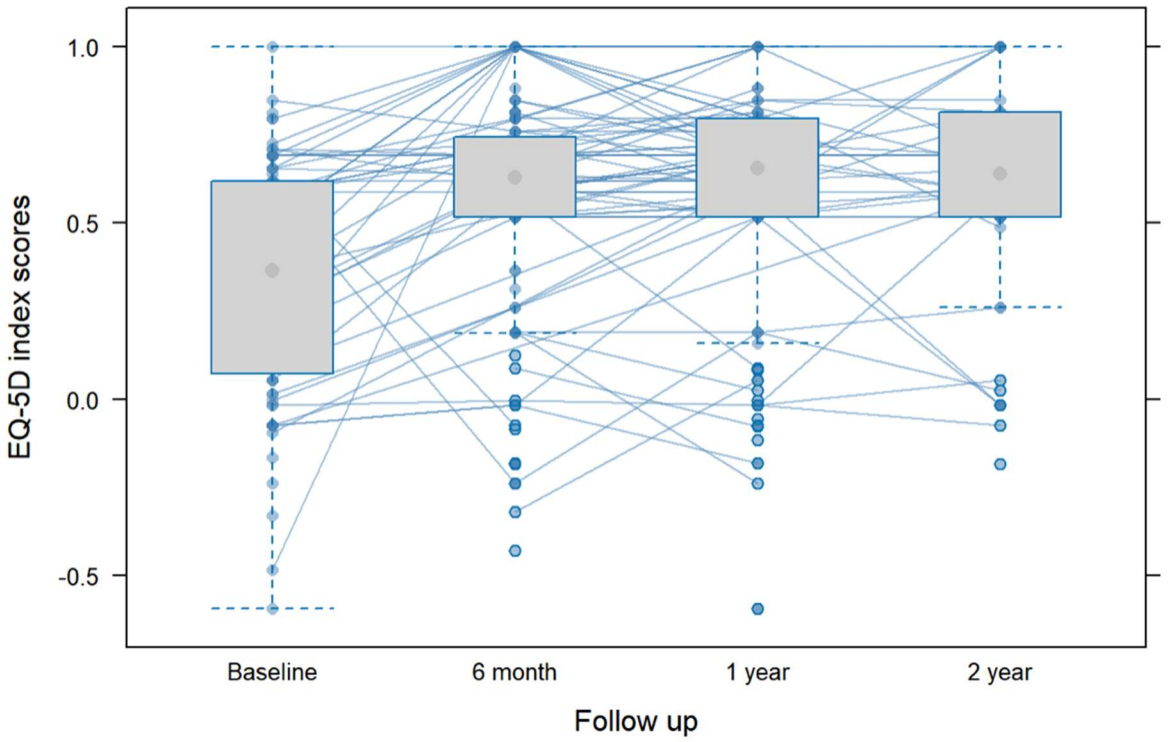
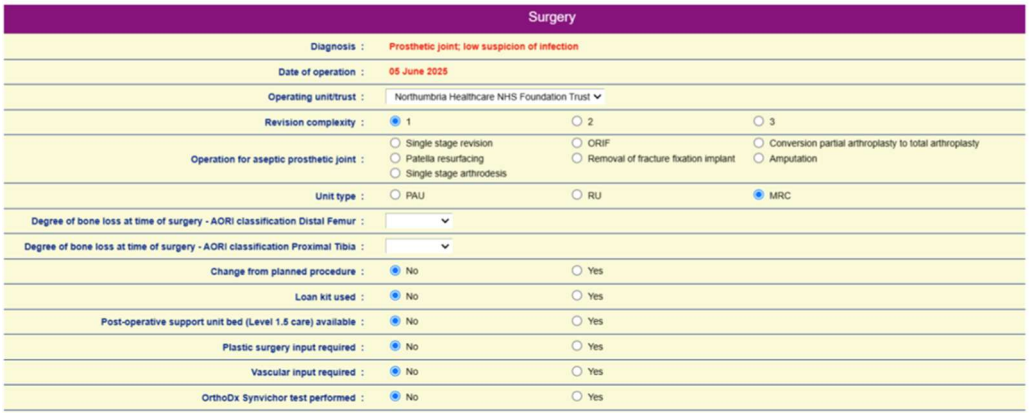
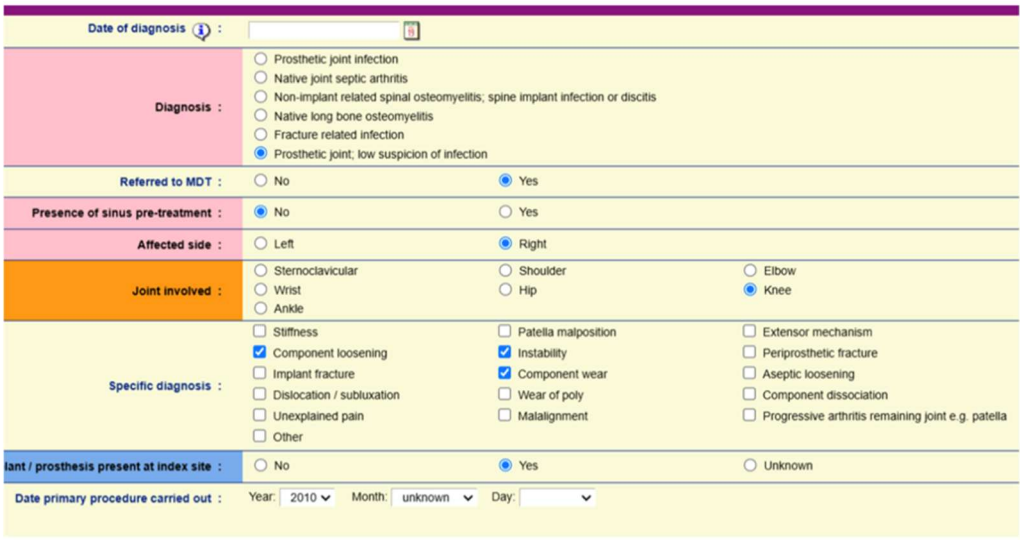


Figure 22. EQ-5D-3L™ for patients undergoing DAIR procedure for PJI. Central point represents median, box shows interquartile range (Q1–Q3), whiskers extend to 1.5×interquartile range

Aseptic Pathway

Following feedback from end users of BAJIR, we have now launched Aseptic Pathways for Hip and Knee. Many MDTs around the country discuss aseptic cases as well as septic, thus having the ability to use BAJIR MDT software for all cases in a meeting offers significant benefit. We have created a comprehensive dataset to allow these aseptic cases to be submitted, discussed and outcomes recorded within BAJIR software, making the BAJIR MDT software comprehensive in its ability to run Orthopaedic MDT meetings. Further joints will be added with time as requested by users. The records of patients without confirmed infection are accessible to local users, but not to the central BAJIR team as they are not of interest to the project and fall without our remit. The addition has been developed purely to aid our colleagues in their valuable MDT work. If infection is confirmed at some point later in the patient's journey, then the patient will be enrolled onto the full National BAJIR and their data automatically migrated to the full Registry.





	Registry Diagnosis
Diagnosis / nature of suspected or confirmed infection :	Prosthetic joint; low suspicion of infection
Presence of sinus pre-treatment :	No
Affected side :	Left
Joint involved :	Knee
Diagnosis :	○ No infection or infection not confirmed ○ Prosthetic joint infection ○ Native joint septic arthritis ○ Non-implant related spinal osteomyelitis; spine infection or discitis ○ Native long bone osteomyelitis ○ Fracture related infection ◉ Prosthetic joint; low suspicion of infection
Date final infection (Registry) diagnosis :	

E-Referral Form

As part of our ongoing close work with the BASK Revision Knee Network project and what was NHS England, a need for a universal referral form became clear. With very kind financial support from that project and involvement of their team we have thus developed an e-referral form for BAJIR. The BAJIR MDT e-referral form will soon be active and enable any clinician (no BAJIR login required!) caring for patients with bone and joint infections to record pertinent information on the proforma and refer directly to any MDT registered with BAJIR.

The MDT summary will be pre-populated from the referral and BAJIR record. MDT discussion, along with clinicians in attendance, will be recorded and finalised into a PDF which can be accessed by the referrer, printed and filed in patient notes. Screenshots of the e-referral proforma are attached to the appendix of this document (Appendix 1). Please note that they are still in development.

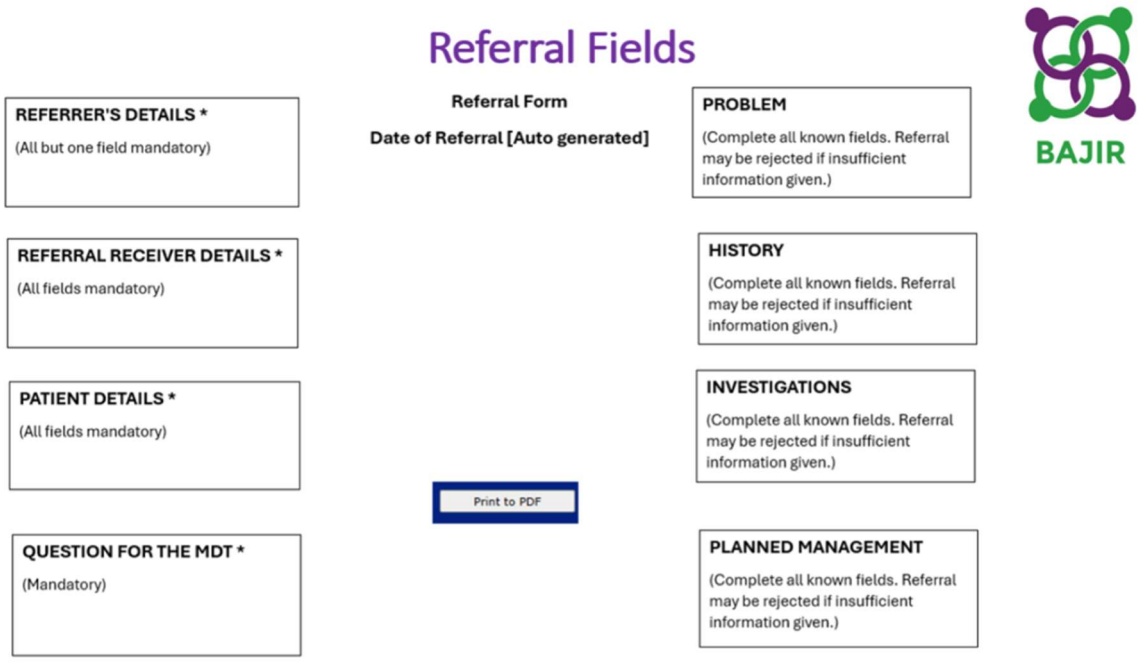


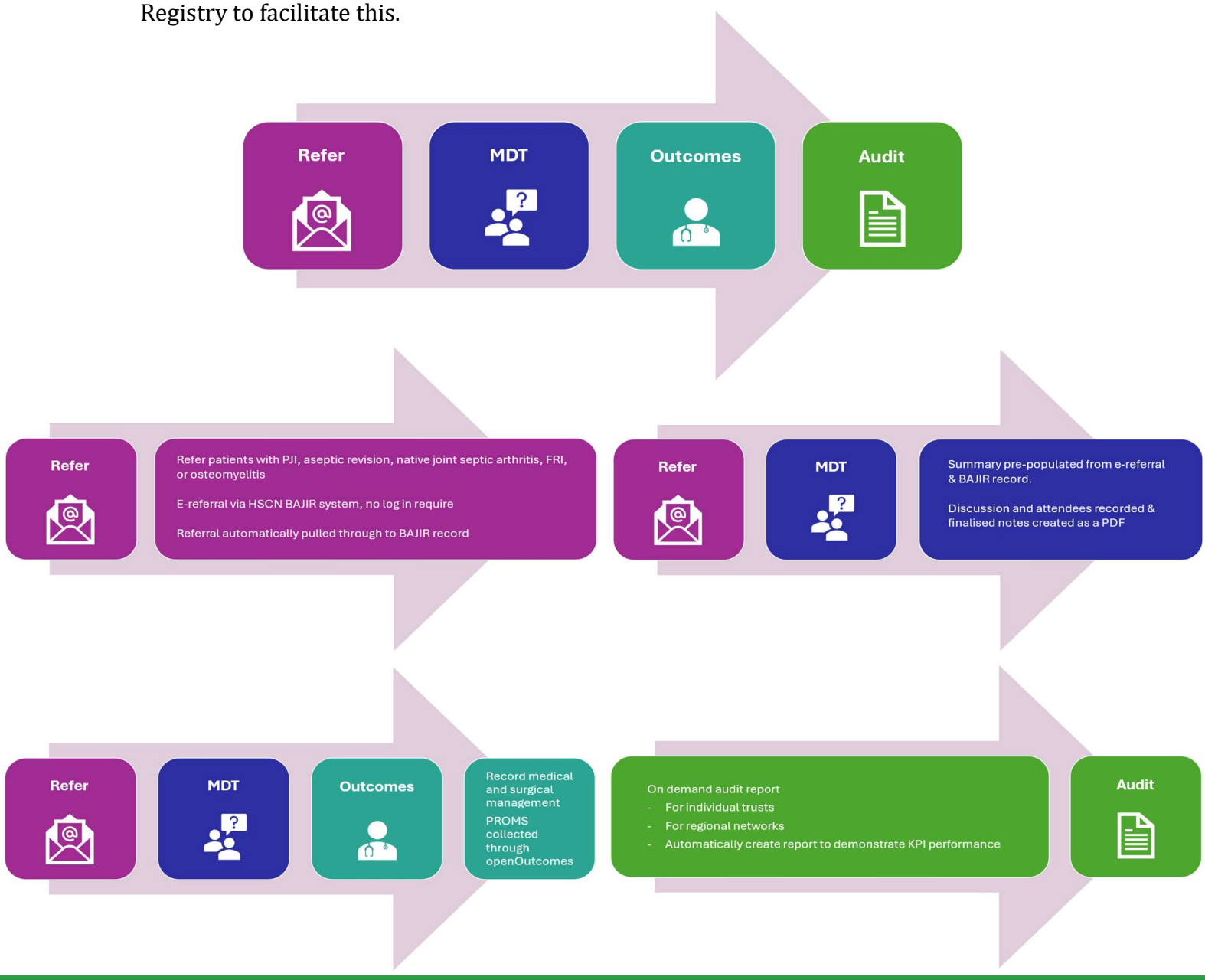
Figure 23. Basic fields outlining the structure of the e-referral form

MDT Complete Software Platform

We have worked hard over the last few years to develop a comprehensive software platform for Orthopaedic MDTs around the country. With the addition of the e-referral form this is now complete, offering a seamless software package to allow teams to use BAJIR software for the patient's entire journey from referral through MDT meeting organisation, discussion, documentation and outcome, to an iterative patient specific file to record further events in their journey. With an audit function also in place teams can review the work they are doing within the MDT and very easily access data required for the national revision knee project, for example.

By providing help for MDTs we aim to increase engagement, data entry, and so increase our dataset.

The graphic below demonstrates the software we now have in place embedded in the Registry to facilitate this.



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The BAJIR team are incredibly thankful for the ongoing support received from our Industry partners. Their generous financial support is crucial to the growth and development of the registry.

Many thanks to the companies listed below:

ADLER ORTHO
BONESUPPORT
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NHS England
ORTHODx
openOutcomes
Revision Knee Working Group
smith&nephew
stryker
ZIMMER BIOMET
DENDRITE CLINICAL SYSTEMS

BAJIR Steering Committee

Andy Toms (BASK)

Simon Jameson (BHS)

Amar Rangan (BESS)

Rhidian Morgan-Jones (BOA / BAJIS)

Sarah Johnson-Lynn (BOFAS)

Will Eardley (BTS)

Erik Lenguerrand (Scientist)

Lucinda Barrett (Microbiologist)

Neil Jenkins (Microbiologist)

Martin Sarungi (Scotland)

Nigel Westwood (Patient representative)

Deepa Bose (Member at large)

Adam Watts (Member at large)

Pedro Foguet (Member at large)

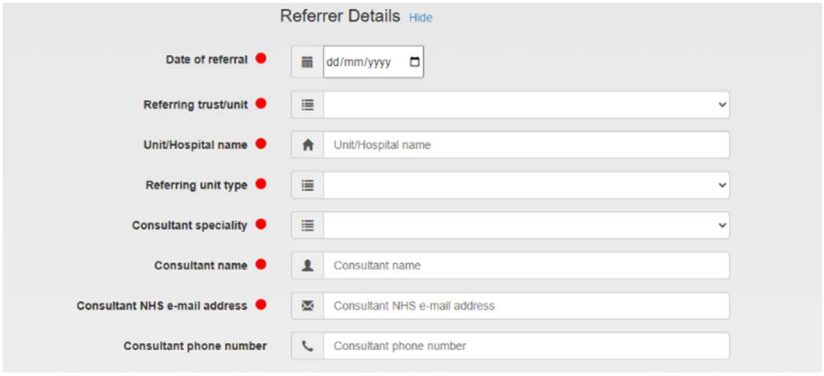
Jamie Ferguson (Member at large)

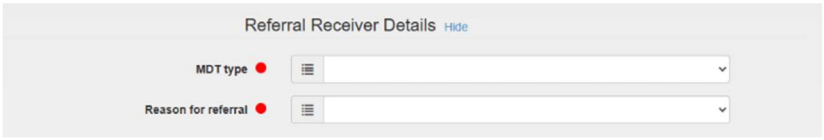
Abtin Alvand (Member at large)

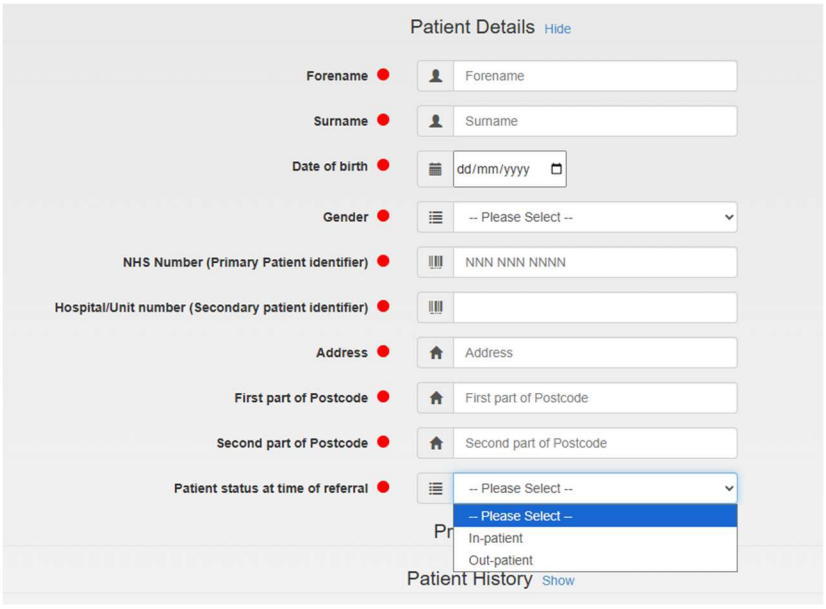
Appendix

Appendix 1: E-Referral proforma screenshots

Each section will be available via a drop-down box under the section heading. Please note, these are still in development.







Appendix 1 Continued: E-Referral proforma screenshots

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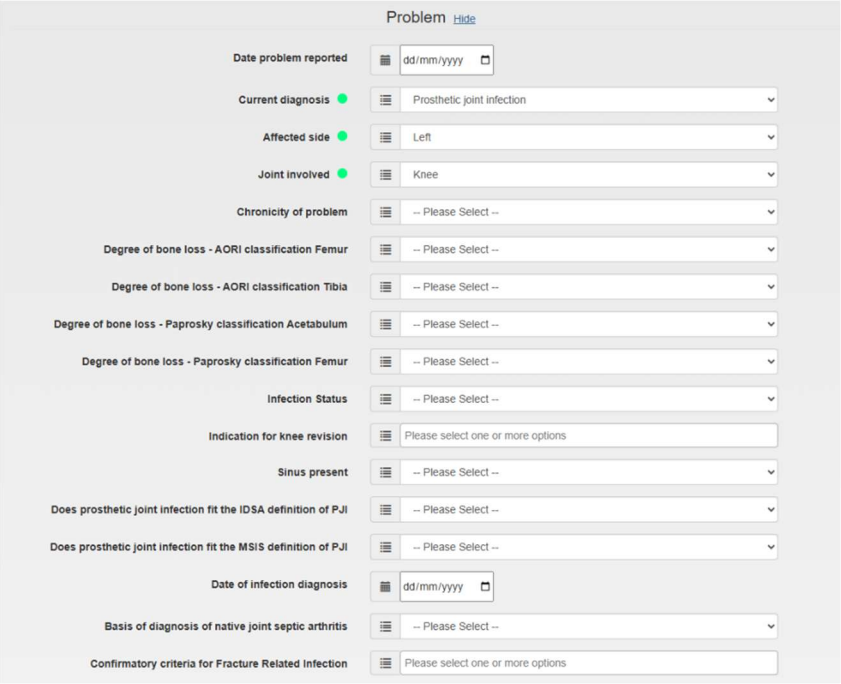

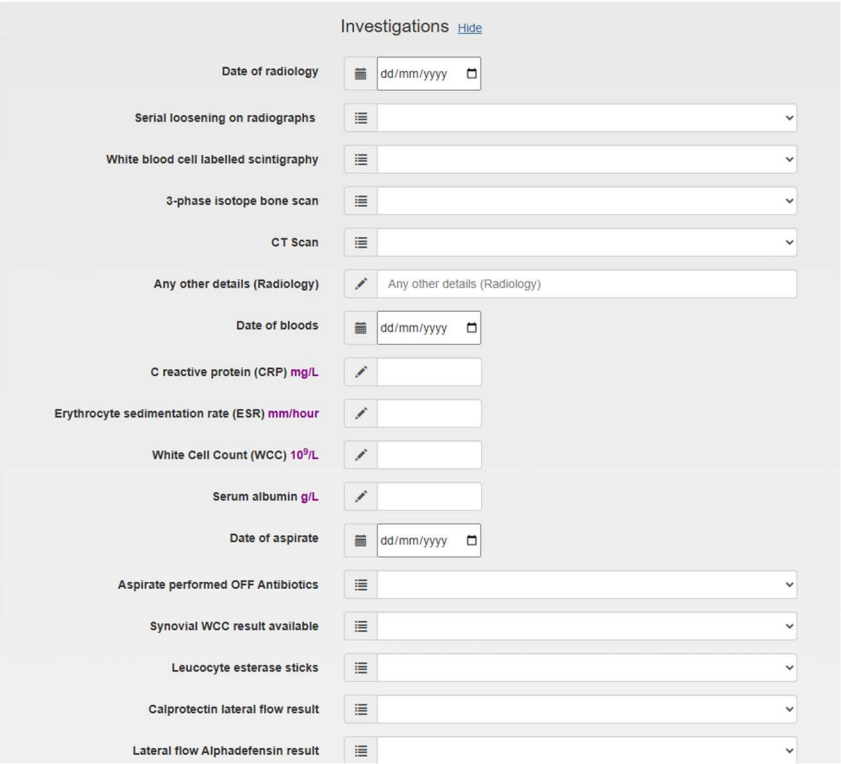

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