



BONE AND JOINT INFECTION REGISTRY 2026

9th Annual Report

BAJIR ANNUAL REPORT



BAJIR.org





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Foreword

We hope you enjoy reading the 2026 BAJIR report. This is our 9th annual report. Our comprehensive software platform is now largely complete, starting with the new e-referral form accessible online by all, through to MDT software to run MDT meetings and record notes, on to outcomes collection with PROMs, and summary audit data for Revision network audit. This huge piece of work has taken significant time and money, and we have invested in a bid to allow automatic data collection into BAJIR whilst the software package is used in the MDT meeting process. The aim is to avoid data entry duplication and so increase Registry engagement and data completion. Ultimately the huge challenge faced by all Registries, not least in infection with the multiple data fields required to produce useful data, is data entry and engagement. We have thus given as much time, energy and funding to this area as possible to improve this engagement.

With the platform now completely built, we can start to accumulate data at an increasing rate. Importantly we also now need to fill missing data and so ensure data quality. This is being done through the HES linkage project – cross-checking BAJIR data with NHS HES (Hospital Episode Statistics) extract data for cases, finding anomalies and missing data fields for example for missed surgeries, and patient comorbidities. This work is now underway for the first cohort of cases.

Once data quality is also in place, we will finally be in a place to analyse data and start to explore questions we all want answers to in orthopaedic infection. What procedures work best in what patients, with what organisms, and with what adjuncts such as local antibiotic delivery systems to name a few. The power of the Registry will truly lie in the data volume, but this will only be of use once we have ensured data completeness and quality. So there remains a lot of work on the horizon for the team, and contributors around the country!

In the meantime, volume continues to increase, with over 2700 confirmed orthopaedic infections now registered in BAJIR. At this point we must thank the teams from around the country who continue to support and use the database, contributing cases and increasing its power. Please do keep contributing – we are making exciting progress, and it will be worth all the effort in the future, not just for us as healthcare professionals and the science, but of course most importantly to improve outcomes for our patients.

As ever a final word of thanks to our Industry sponsors, to the UK Bone And Joint Infection Society (BAJIS), BASK, the BOA and the BHS and other specialist societies without whom we could not continue.

Onwards and upwards!

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 **ninth** annual report from the Bone and Joint Registry (BAJIR). The BAJIR database is the United Kingdom (UK) Bone and Joint Infection Registry. 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 societies (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 audit programme.

Thanks to all for supporting us.

Hamish Lowdon, Ananth Srinivasan, Tom Baldock, Mike Reed and Tim Petheram



Registry Progress

The 2025-2026 period has seen the registry continue to expand with **59** trusts now successfully registered to participate. This is a testament to the ongoing hard-work of the BAJIR Steering Committee in nationally increasing the awareness and registry engagement. There are now over 4700 complete patient records since the registry's inception (**Figure 1** and **Table 1**), with 455 new cases added so far in 2026 (not included in Figure). This growth, the quality and completeness of the entered data in BAJIR will continue with many more trusts now successfully registered and contemporaneously submitting data.

The BAJIR MDT e-referral form is active, enabling any clinician caring for patients with bone and joint infections to complete the proforma and refer directly to the Regional Infection MDT. Once accepted, the referral becomes available on the BAJIR MDT software for discussion and data will auto-populate the BAJIR database, streamlining the process and saving precious time. Further work is underway to deliver e-referral training packages and live tutorials to all enrolled revision networks and NHS Trusts.

The hip and knee *aseptic* pathway has been live for the past year. Surgeons are able to keep a swiftly accessible, local record of patients undergoing treatment for aseptic arthroplasty. This means that all patients under consideration for revision arthroplasty can be recorded in one place for discussion in MDT meetings and for audit purposes. 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 to deliver the linkage between Hospital Episode Statistics (HES) and the BAJIR. This work remains a priority for the BAJIR steering committee and 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 quality 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 BAJIS - the UK Bone and Joint Infection Society. 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 - BAJIS - the Bone And Joint Infection Society (UK). www.bajis.org



Annual Report Summary by Case Submission

The case submissions to BAJIR continue to grow year on year (**Figure 1**). Case submissions currently total 4792. By the end of 2025, 1042 cases had been successfully submitted. 455 new cases have been submitted so far in 2026.

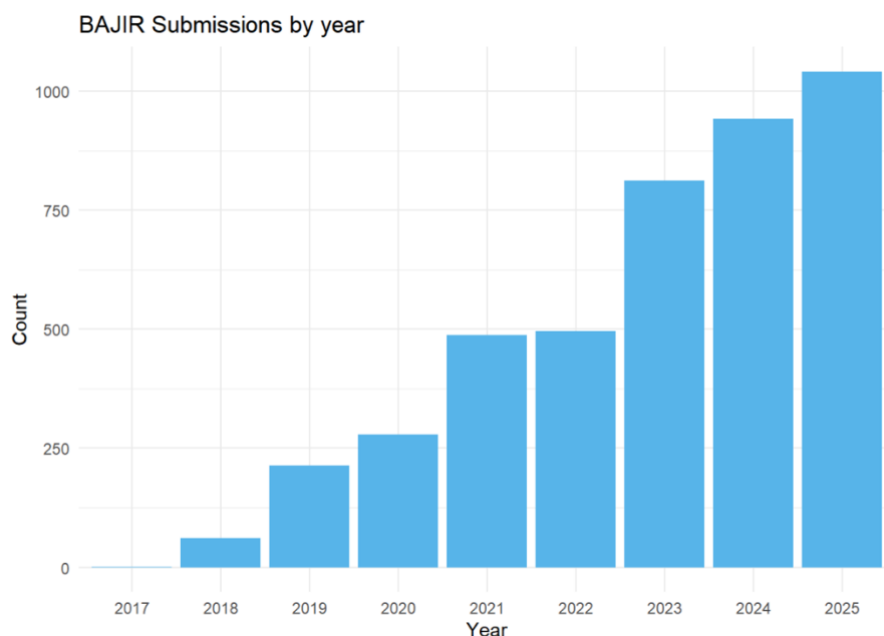


Figure 1. Submissions by year since the inception of BAJIR in 2017

Annual Report Summary by Provisional and Confirmed Diagnosis

The case-mix submitted to BAJIR spans suspected Prosthetic Joint Infections (PJI), PJI – low suspicion, Native Joint Septic arthritis, Fracture-Related Infection (FRI), Native Long Bone Osteomyelitis and spinal infections (**Table 1** and **Figure 2**). PJIs predominate the registry with 2112 (77.3%) confirmed cases.

Table 1: Submissions to BAJIR by provisional and confirmed diagnosis

Diagnoses	Provisional (%)	Confirmed (%)
Prosthetic Joint Infection	3288 (68.6)	2112 (77.3)
Native Joint Septic Arthritis	471 (9.8)	229 (8.4)
Fracture related infection	328 (6.8)	181 (6.6)
Native Long bone osteomyelitis	202 (4.2)	125 (4.6)
Spinal osteomyelitis, Implant infection or discitis	172 (3.6)	85 (3.1)
Cases Submitted via Aseptic Pathway	331 (6.9)	/
Total	4792	2732

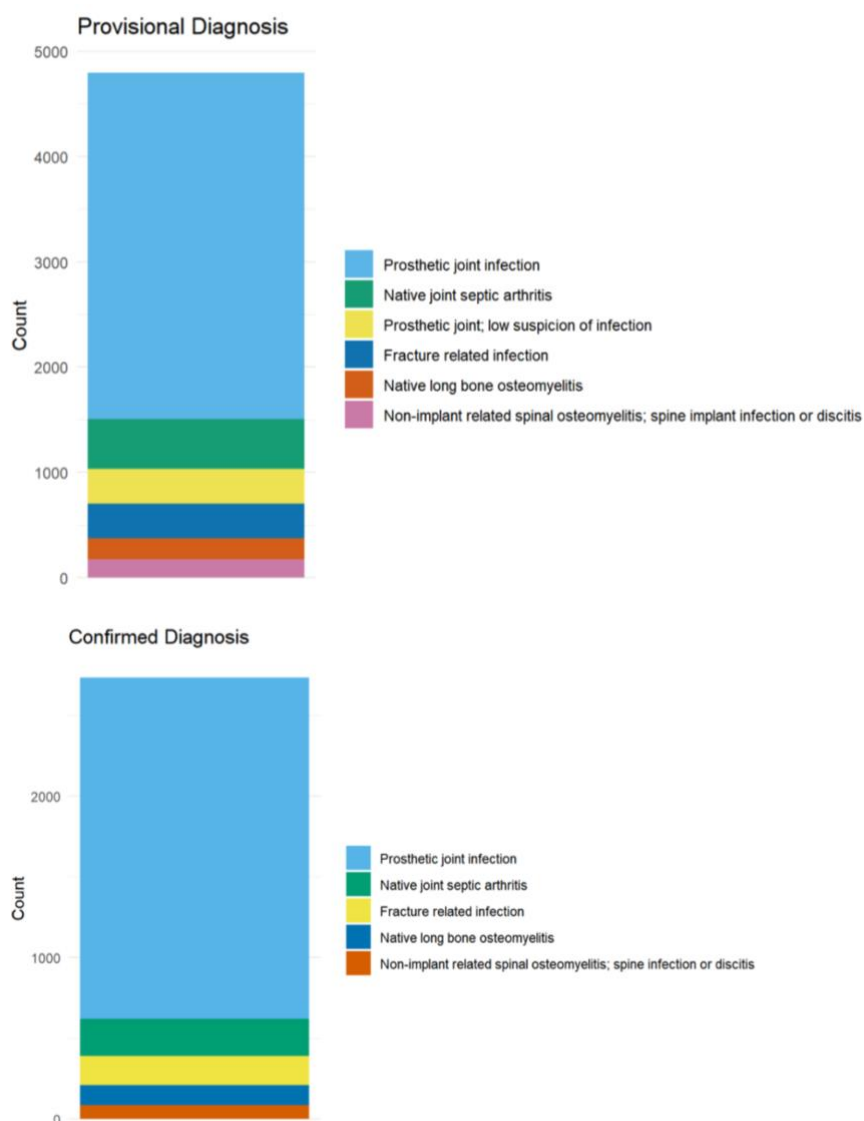


Figure 2: BAJIR submissions by case-mix of bone and joint infections, provisional and confirmed diagnosis.



Bone and Joint Infection Case Mix

Periprosthetic Joint Infection

3288 (68.6%) cases submitted to BAJIR were suspected to have a prosthetic joint infection (PJI), of which 2112 were subsequently deemed to have a confirmed PJI. Knee and hip PJI cases predominate the registry with 1199 (56.8%) and 839 (39.7%) cases, respectively. The remaining case-mix is composed of shoulder (31, 1.5%), ankle (21, 1.0%) and elbow (17, 0.8%) (**Table 2** and **Figure 3**). A significant increase in recorded knee cases since 2022 was noted, a trend coinciding with the establishment of the Revision Knee Network (**Figure 4**).

Table 2: Number of Confirmed PJIs categorised by anatomical location

	Number of Cases (%)	Percentage of Total
Knee	1199	56.8
Hip	839	39.7
Shoulder	31	1.5
Ankle	21	1.0
Elbow	17	0.8
Joint Not Specified	5	0.2
Total	2112	

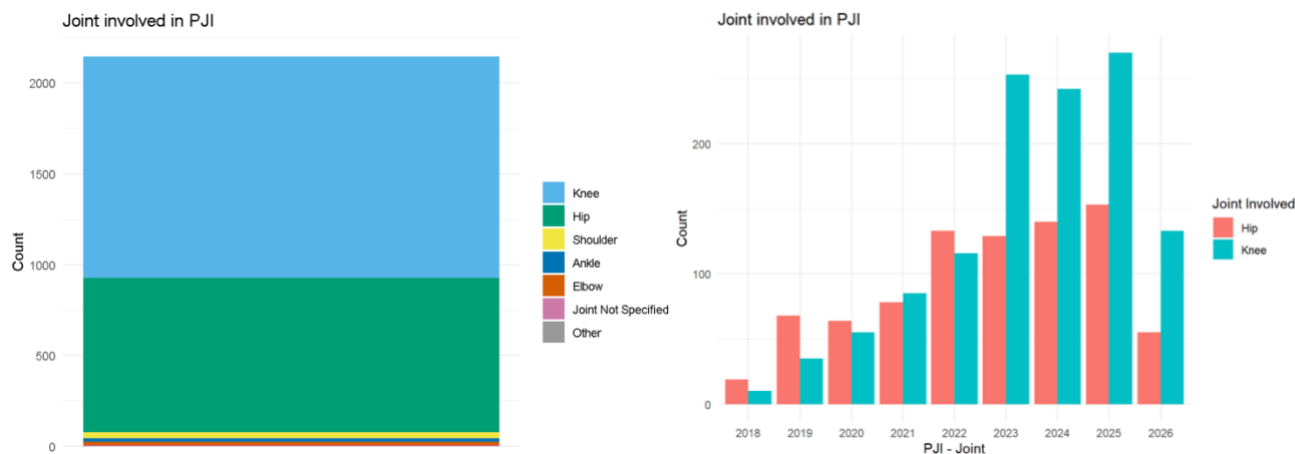


Figure 3: Confirmed Prosthetic Joint Infections categorised by joints involved. **Figure 4:** Hip and Knee PJI case submission presented year by year since registry inception demonstrating the increase in knee PJI cases submitted to registry since the establishment of the Revision Knee Network in 2002.



Prosthetic Joint Infection Microbiology

Organisms were isolated in 1550 cases (73.3%), with 562 cases either being culture negative or organism not specified. *Staphylococcus aureus*, coagulase-negative *Staphylococcus spp.*, *Streptococcus spp.* and Enterobacteriaceae remain the most frequently isolated organisms. Polymicrobial infections were recorded in 115 cases (5.4%) (**Table 3**).

Table 3: Organisms isolated in Prosthetic Joint Infection

	Number of Cases	Percentage of Total
<i>Staphylococcus aureus</i>	437	20.7
Coagulase Negative <i>Staphylococci</i>	323	15.3
<i>Streptococcus spp.</i>	216	10.2
Enterobacteriaceae	151	7.1
Polymicrobial	115	5.4
Others (<5 cases)	94	4.5
Enterococcus	58	2.7
<i>Pseudomonas spp.</i> (or other non-fermenting GNB)	47	2.2
<i>Cutibacterium acnes</i> (formerly <i>Propionibacterium acnes</i>)	40	1.9
Other anaerobes	31	1.5
Fungi	13	0.6
<i>Corynebacterium spp.</i>	12	0.6
Vancomycin-Resistant Enterococci	7	0.3
<i>Cutibacterium spp.</i>	6	0.3
No Specified Bacteria	562	26.6
Total	2112	



Prosthetic Joint Infection Treatment

Index procedure data (the first infection eradication or suppression procedure performed) was available for 2397 patients with 3305 surgeries performed overall. The most common operations performed were Debridement Antibiotics and Implant Retention (DAIR, 867), first stage of a two stage revision/ arthrodesis (604) and single stage revisions (510) (**Table 4**).

Table 4: Index operations performed for suspected Prosthetic Joint Infection

	Number of Cases	Percentage
Two Stage Procedure		
First Stage Joint Replacement / Arthrodesis	604	25.2
Second Stage Joint Replacement / Arthrodesis	43	1.8
Repeat First Stage	27	1.1
DAIR		
Exchange of Modular Components	631	26.3
Without Component Exchange	236	9.8
Washout		
Arthroscopic	75	3.1
Open	134	5.6
Single Stage		
Revision	510	21.3
Arthrodesis	13	0.5
Amputation	7	0.3
Open Biopsy	16	0.7
Removal of fracture fixation implant	33	1.4
No Surgery at present	24	1.0
Operation not specified	44	1.8
Total	2397	



Native Joint Septic Arthritis

A total of 471 suspected cases of native joint septic arthritis have been submitted to the database, of which 229 cases were subsequently confirmed. The most common joints involved were the knee (96, 41.9%), hip (60, 26.2%) and shoulder (38, 16.6%) (**Table 5** and **Figure 5**). Organisms were isolated in 136 (59%) cases. *Staphylococcus aureus* and *Streptococcus Spp.* remained the most frequent pathogens (**Table 6** and **Figure 6**). A total of 398 operations were undertaken for native joint septic arthritis. Arthroscopic (174) and open washouts (103) remained the mainstay of surgical management (**Table 7** and **Figure 7**).

Table 5. Confirmed Native Septic Arthritis cases by joint involved

	Number of Cases (%)	Percentage of Total
Knee	96	41.9
Hip	60	26.2
Shoulder	38	16.6
Ankle	16	7.0
Wrist	8	3.5
Elbow	5	2.2
Other sites (<5 cases)	6	2.6
Total	229	



Figure 5: The distribution of native joint septic arthritis by anatomical site.



Table 6: Organisms isolated in Native Joint Septic Arthritis

	Number of Cases	Percentage
<i>Staphylococcus aureus</i>	59	25.8
<i>Streptococcus spp.</i>	26	11.4
Others (<5 cases)	25	10.9
Polymicrobial	10	4.4
Coagulase Negative <i>Staphylococci</i>	9	3.9
Enterobacteriaceae	7	3.1
No Specified Bacteria	93	40.6
Total	229	

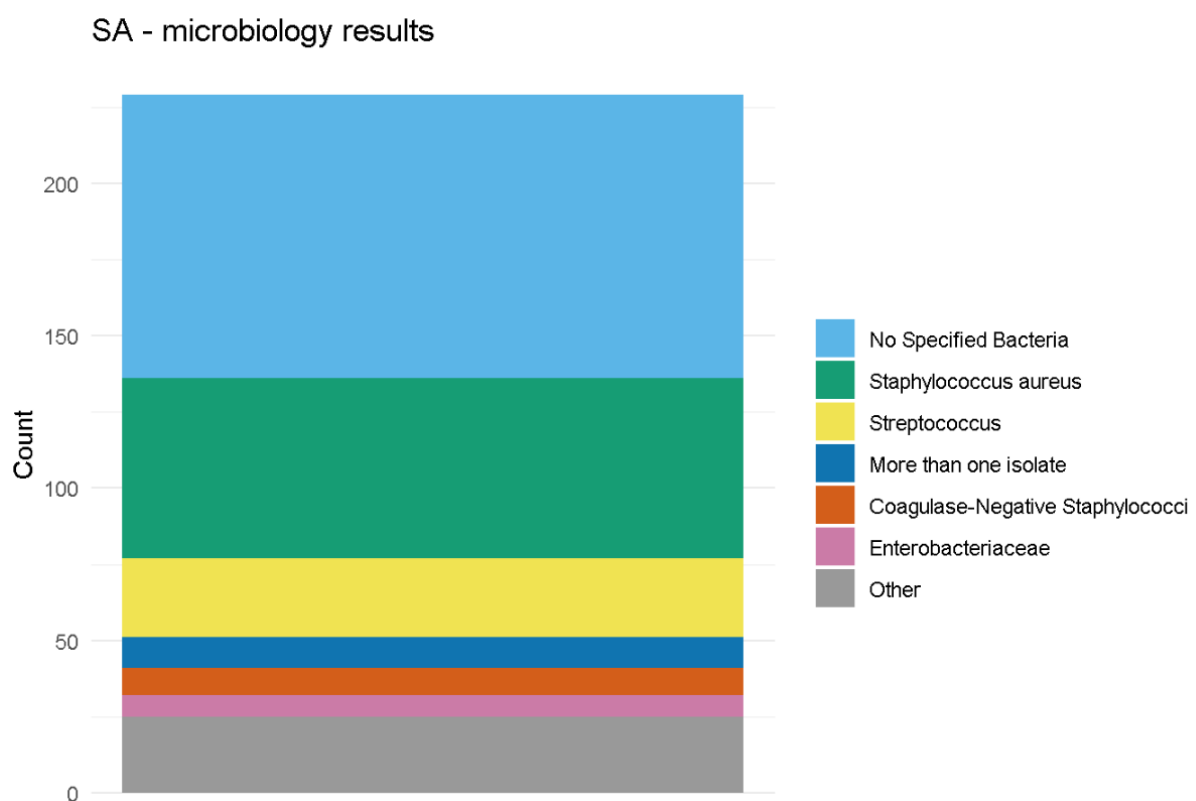


Figure 6: Organisms isolated in Native Septic Joint Infection



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

Organism	Number of Cases	Percentage of Total
Arthroscopic washout	174	43.7
Open washout	103	25.9
Excision and spacer	39	9.8
Joint replacement	36	9.0
Combination of Procedures	17	4.3
Arthroscopic washout and Synovectomy	16	4.0
Other (<5 cases)	7	1.7
No Specified Operation	6	1.5
Total	398	

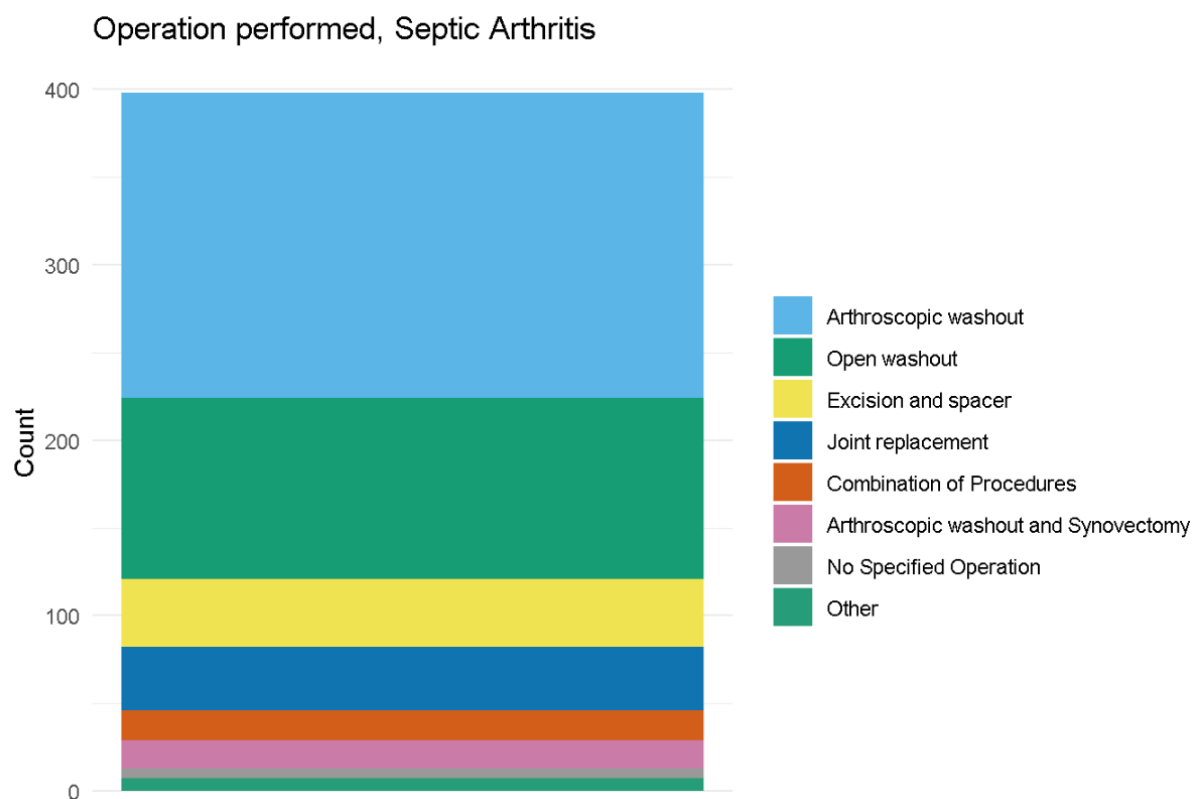


Figure 7: The distribution of surgical procedures for native joint septic arthritis.



Osteomyelitis

Thus far, 202 patients with suspected osteomyelitis have been submitted to BAJIR with 125 confirmed cases. The most commonly affected bones were the femur (27, 21.6%), tibia (24, 19.2%) and foot (21, 16.8%). The distribution of osteomyelitis by anatomical site is demonstrated in **Table 8** and **Figure 8**. Microbiological data was available for 87 (67%) patients. *Staphylococcus aureus* (38, 30.4%) and polymicrobial (27, 21.6%) infections were most common (**Table 9** and **Figure 9**).

Table 8. Site of Osteomyelitis in confirmed cases.

	Number of Cases	Percentage of Total
Femur	27	21.6
Tibia	24	19.2
Foot	21	16.8
Pelvis	12	9.6
Humerus	7	5.6
Fibula	6	4.8
Other (<5 cases)	17	13.6
Bone Not Specified	11	8.8
Total	125	

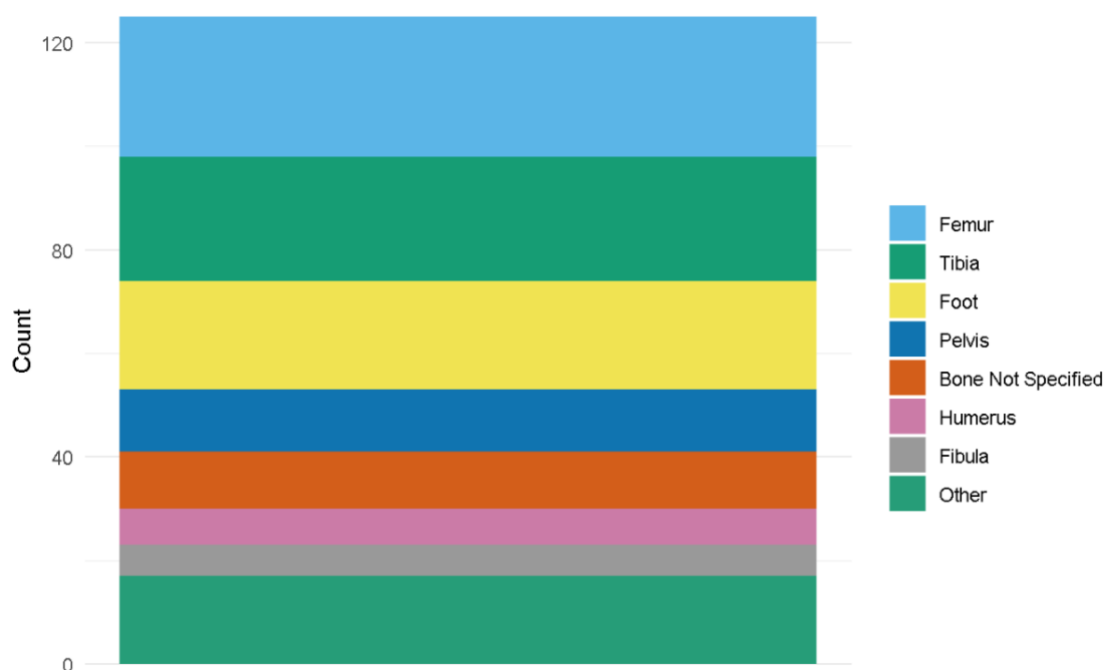


Figure 8: The distribution of osteomyelitis by anatomical site.



Table 9. Organisms isolated in Osteomyelitis

Organisms	Cases	Percentage
<i>Staphylococcus aureus</i>	27	21.6
Polymicrobial	14	11.2
Enterobacteriaceae	11	8.8
Coagulase Negative <i>Staphylococci</i>	9	7.2
<i>Streptococcus spp.</i>	6	4.8
Others (<5 cases)	6	4.8
No Specified Bacteria	38	30.4
Total	125	

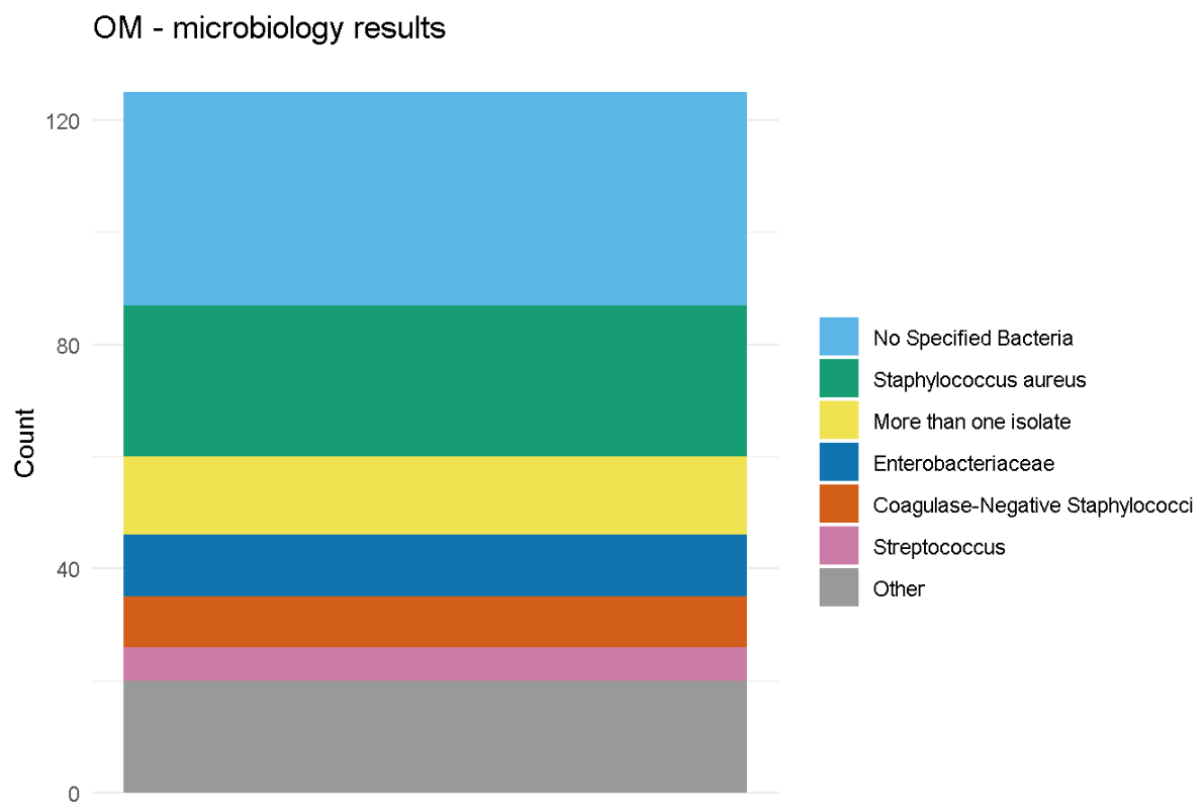


Figure 9: Organisms isolated in Osteomyelitis



Surgical data was available in 64 (51%) cases. Incision and drainage of osteomyelitis foci remained the mainstay of management (27, 42.1%). Other operations recorded include non-segmental resection and reaming, metalware removal and biopsy for diagnostic purposes (**Table 10** and **Figure 10**).

Table 10: Operative procedures undertaken for Osteomyelitis

	Number of Cases (%)	Percentage of Total
Incision and Drainage	27	42.2
Non-segmental resection and reaming	11	17.2
Removal of Metalware	6	9.4
Biopsy Alone	5	7.8
Other (<5 cases)	3	4.7
No Specified Operation	12	18.8
Total	64	

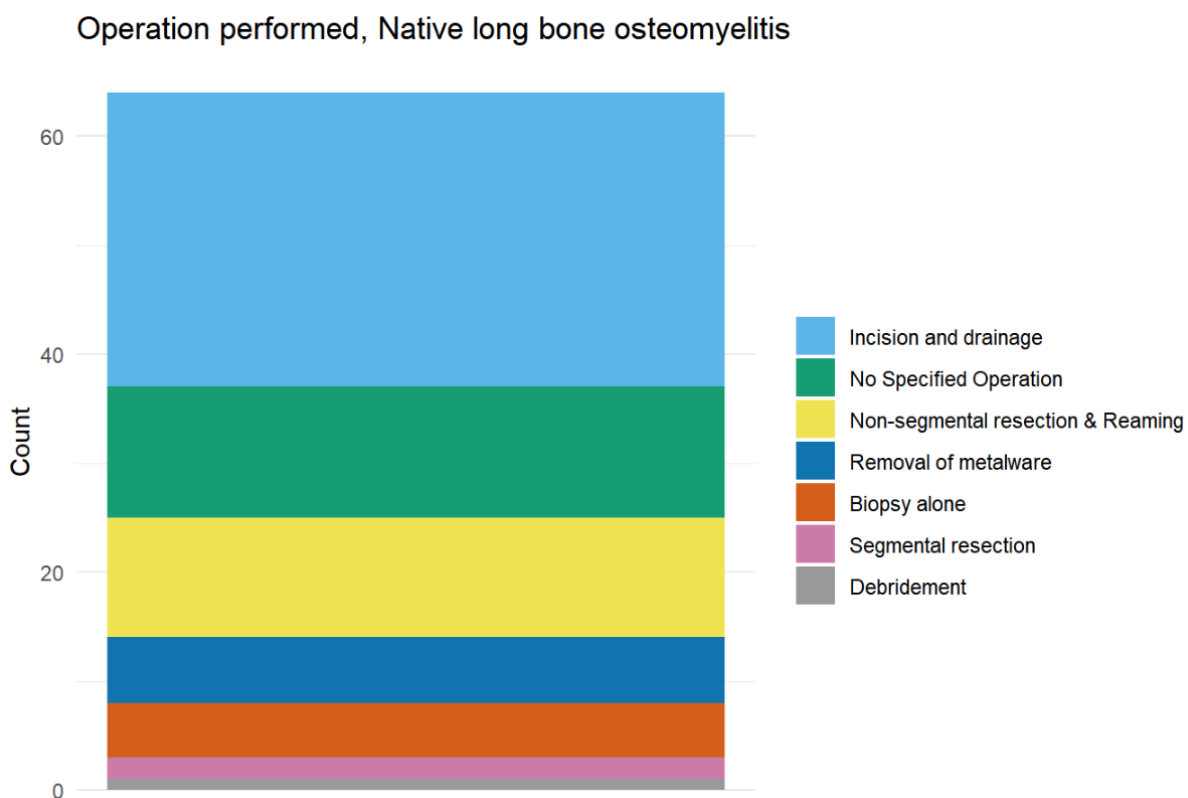


Figure 10. Operative procedures undertaken for osteomyelitis.



Fracture Related Infection

There were 328 cases with suspected fracture-related infections (FRI) submitted to BAJIR since the inception of the new pathway started in 2022. 181 patients had confirmed FRIs. The most commonly affected sites were the tibia (68, 37%), femur (47, 26%), foot (11, 6.1%), humerus (11, 6.1%) and fibula (7, 3.9%) (**Table 11** and **Figure 11**).

Organisms were identified in 154 (85%) patients. *Staphylococcus aureus*, Coagulase negative *Staphylococcus spp*, *Enterobacteriaceae* and polymicrobial infections predominated (**Table 12** and **Figure 12**).

Data regarding degree of clearance was available in 109 (44%) cases (**Table 13** and **Figure 13**). 28 patients underwent revision fixation with the choice of osteosyntheses demonstrated in **Table 14** and **Figure 14**. In 55 patients, dead-space was managed with a dissolvable antibiotic carrier, 38 required none while the remaining were managed with reconstructive surgery (**Table 15** and **Figure 15**). There were significant missing data in these fields with the exception of data on revision osteosyntheses.



Table 11: Fracture Related Infection by anatomical location

Bone involved	Number of Cases (%)	Percentage of Total
Tibia	68	37.6
Femur	47	26.0
Foot	11	6.1
Humerus	11	6.1
Fibula	7	3.9
Bone Not specified	6	3.3
Ulna	6	3.3
Tibia & Fibula	5	2.8
Other (<5 cases)	20	11.0
Bone Not Specified	6	3.3
Total	156	

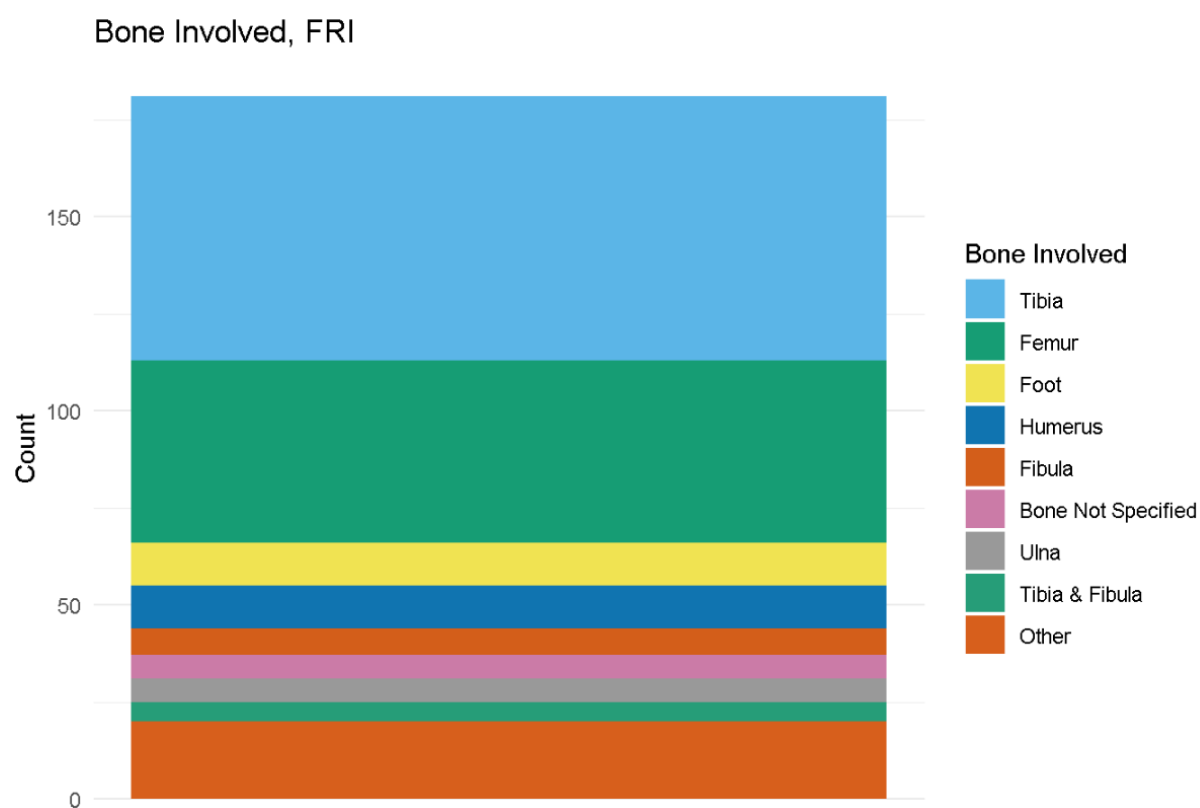


Figure 11: Fracture Related Infection by anatomical location



Table 12: Organisms isolated in Fracture Related Infections

Organism	Number of Cases	Percentage of Total
<i>Staphylococcus aureus</i>	62	34.3
No Specified bacteria	27	14.9
Enterobacteriaceae	26	14.4
Coagulase-negative <i>Staphylococcus spp.</i>	19	10.5
More than one isolate	15	8.3
Other Anaerobes	7	3.9
<i>Pseudomonas spp. (or other non-fermenting GNB)</i>	7	3.9
Others (<5 cases)	18	9.9
Total	181	

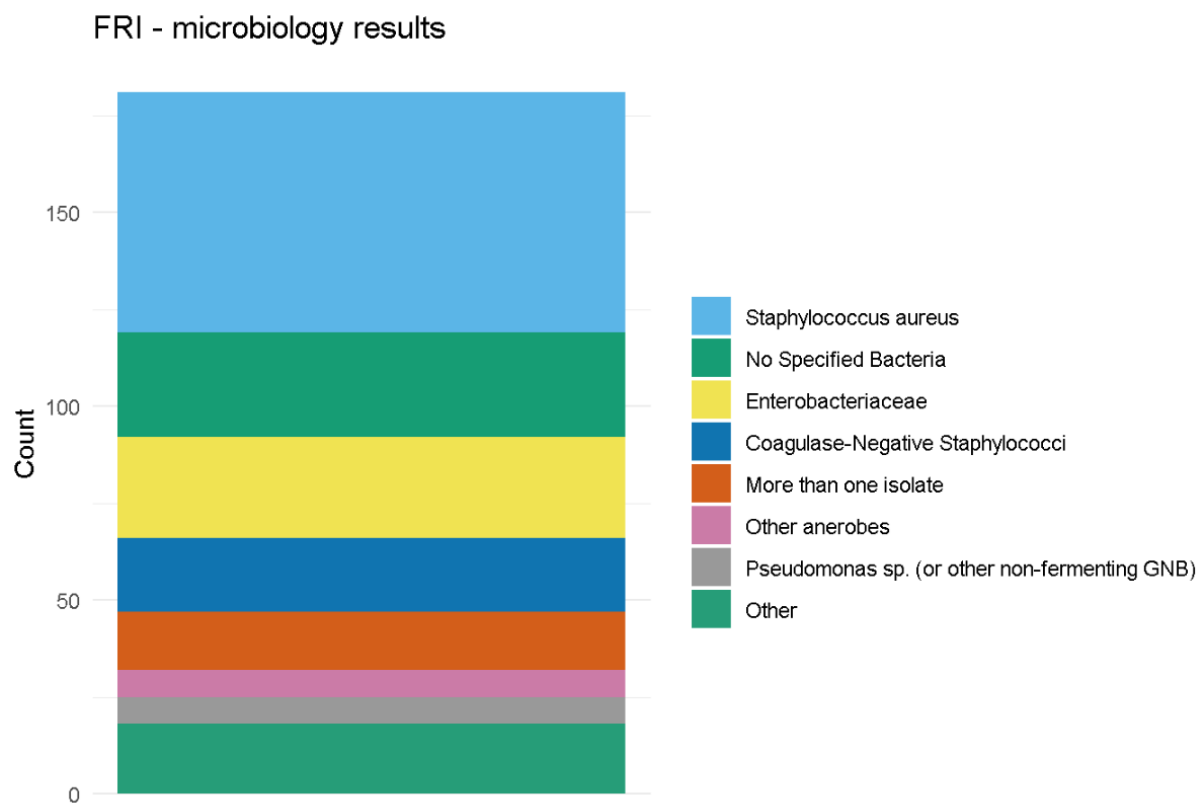


Figure 12: Organisms identified in FRI cases



Table 13: Degree of clearance in FRI

	Number of Cases (%)	Percentage of Total
Clearance of active disease areas	76	31.0
Clearance of all abnormal bone	19	7.8
Partial clearance	5	2.0
Other (<5 cases)	1	0.4
Sampling	8	3.3
NA	136	55.5
Total	245	

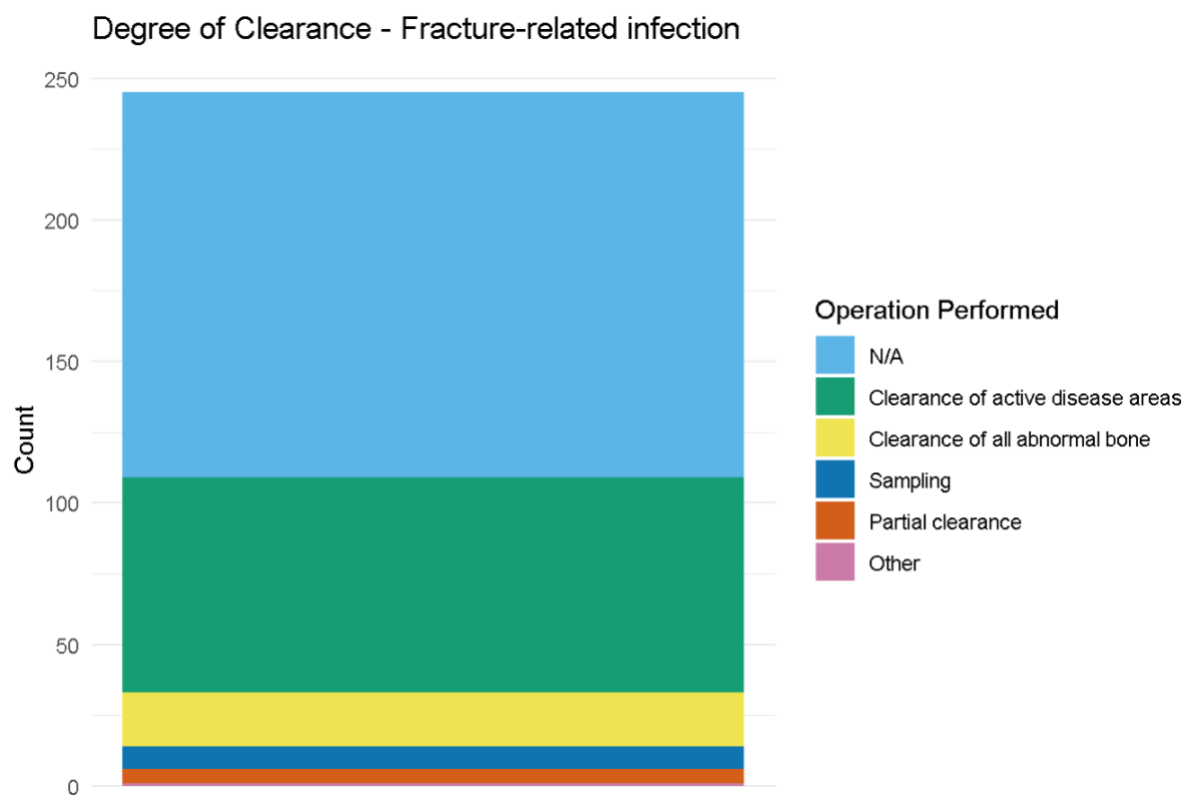


Figure 13: Degree of clearance in Fracture Related Infections

**Table 14:** Revision fixation in Fracture Related Infections

	Number of Cases
Ring fixator (Definitive)	13
Plate (Definitive)	6
Exchange Nailing (Definitive)	5
Other (<5 cases)	4
Total	28

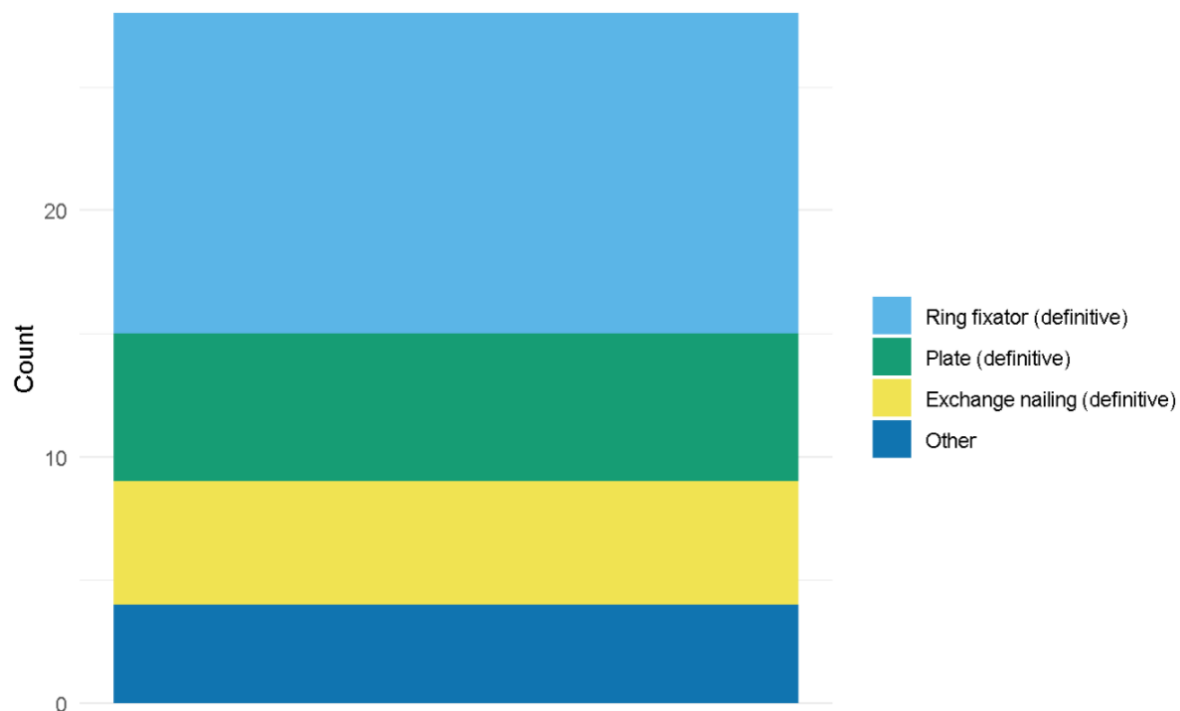
**Figure 14:** Revision fixation in Fracture Related Infections



Table 15: Dead Space Management in Fracture Related Infections

	Number of Cases (%)	Percentage of Total
NA	144	58.8
Resorbable antibiotic carrier	55	22.4
None	38	15.5
Other (<5 cases)	8	3.3
Total	245	

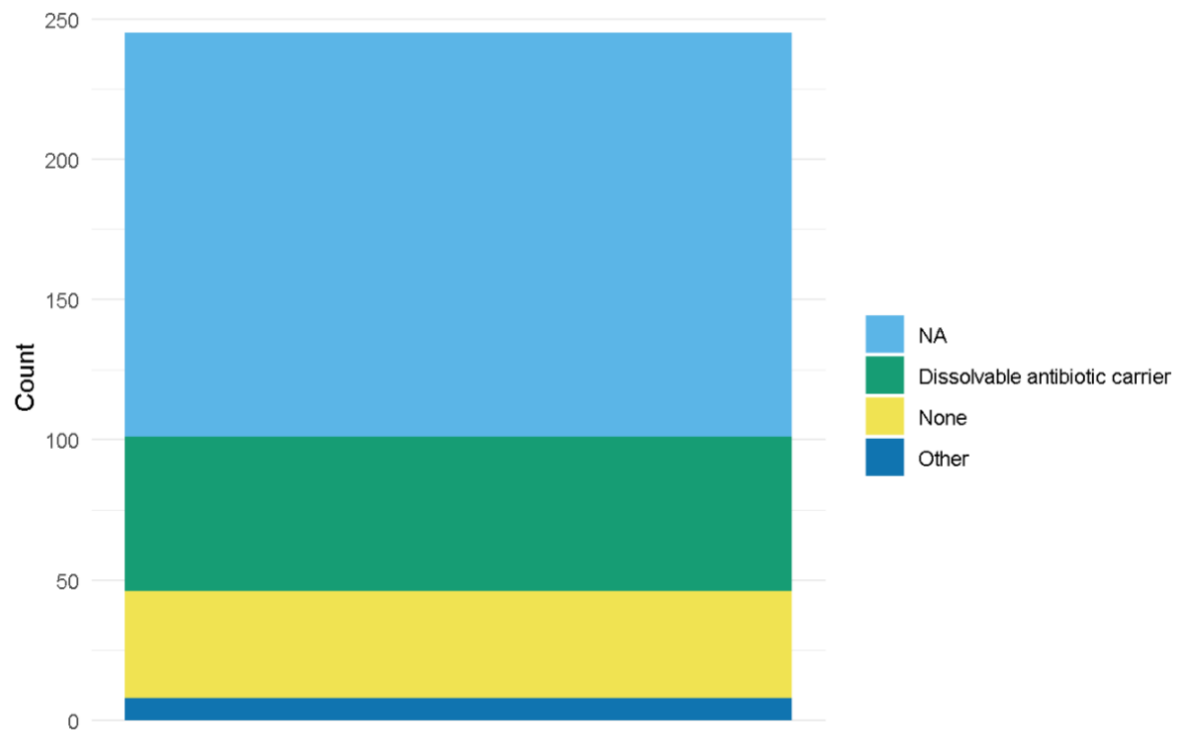


Figure 15: Dead-space management in Fracture Related Infections



Local Antibiotic Carrier and Antibiotic Use

1568 cases used local antibiotic carriers in the treatment of bone and joint infections and have been entered into the registry. The most commonly recorded strategies were the use of non-resorbable carrier alone (531, 33.9%), resorbable carriers alone (440, 28.1%) or a combination of both (295, 18.6%) (**Table 16** and **Figure 16**).

Table 16. The use of local antibiotic carriers

	Number of Cases (%)	Percentage of Total
Non-resorbable Carrier	531	33.9
Resorbable carrier	440	28.1
Resorbable + Non-resorbable carrier	292	18.6
Other (including <5 cases)	94	6.0
Resorbable carrier + Other	33	2.1
Non-resorbable carrier + Other	11	0.7
NA	167	10.7
Total	1568	

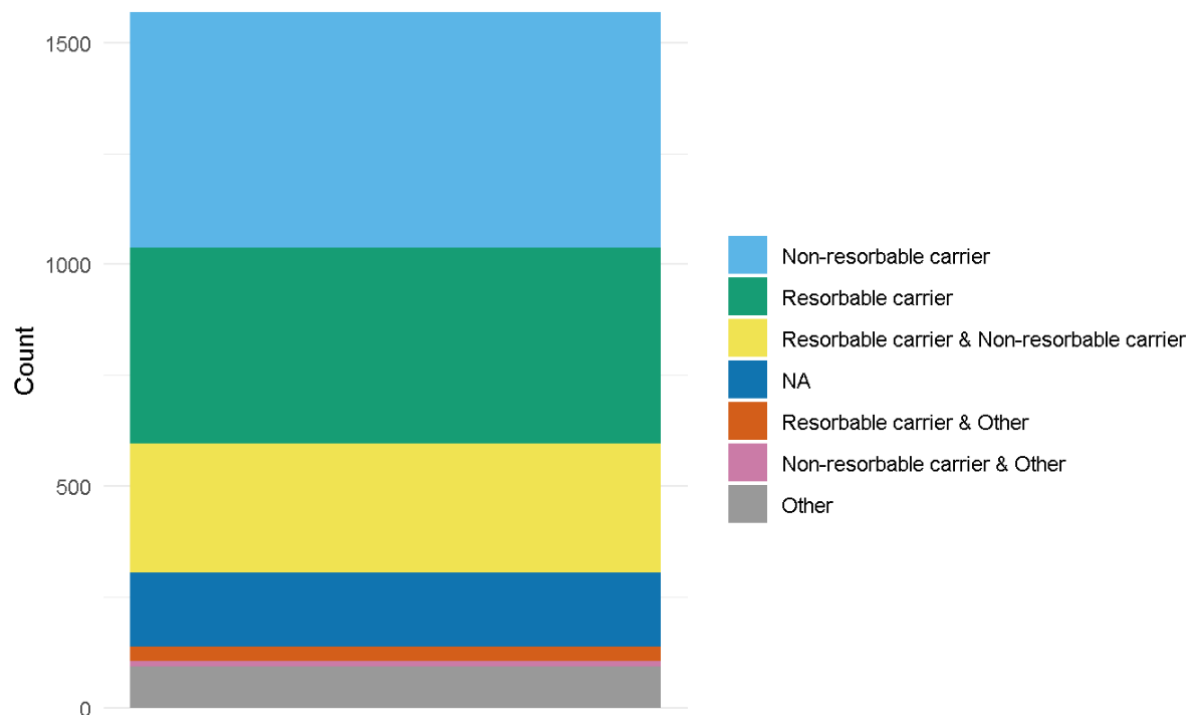


Figure 16: Local antibiotic carrier use



The combination of gentamicin and vancomycin remained the local antibiotic of choice (536, 34.2%), followed by Vancomycin alone (434, 27.7%) and a combination of Meropenem and Vancomycin (102, 6.5%). If utilised in less than 10 cases, the antibiotic was coded as 'other' for the purposes of this report. In 10 cases (0.6%), local antibiotics were not utilised (**Table 17** and **Figure 17**).

Table 17. The use of local antibiotics

	Number of Cases (%)	Percentage of Total
Gentamicin + Vancomycin	536	34.2
Vancomycin	434	27.7
Meropenem + Vancomycin	102	6.5
Other	100	6.4
Gentamicin	53	3.4
Meropenem	36	2.3
Gentamicin & Meropenem & Vancomycin	25	1.6
Gentamicin & Meropenem	20	1.3
Clindamycin & Gentamicin	16	1.0
Nil antibiotic used	10	0.6
Data not entered	236	15.1
Total	1568	

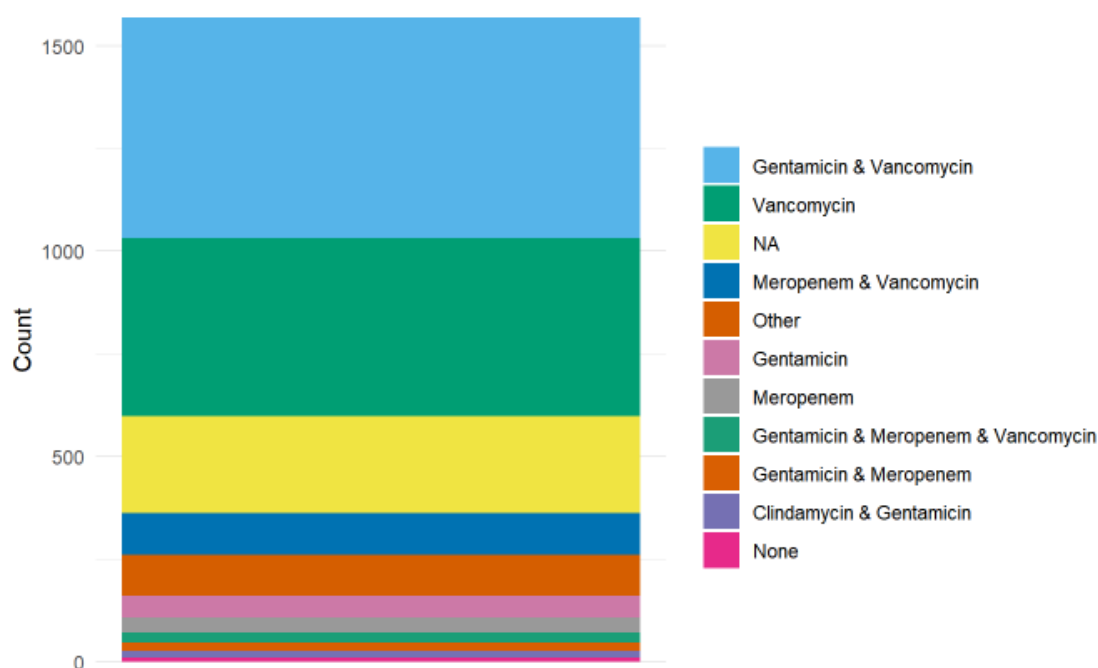


Figure 17. The use of local antibiotics



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. OpenOutcomes™ digital PROMs collection by BAJIR is now established, an update from the previous manual paper PROMs collection. BAJIR automatically triggers a pathway with OpenOutcomes™ once infection has been confirmed, the 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. **Figure 18** box-plots demonstrates the EQ-5D-3L™ trend.





Table 18. A summary of PROMs collected at baseline, 6 months, 1 year, 2 year and 5 year intervals.

	Any PROMs	EQ-5D-3L	VAS
Baseline	470	455	448
6 Months	772	760	739
1 Year	683	669	655
2 Years	331	322	319
5 Years	74	72	71
Total	909	899	786

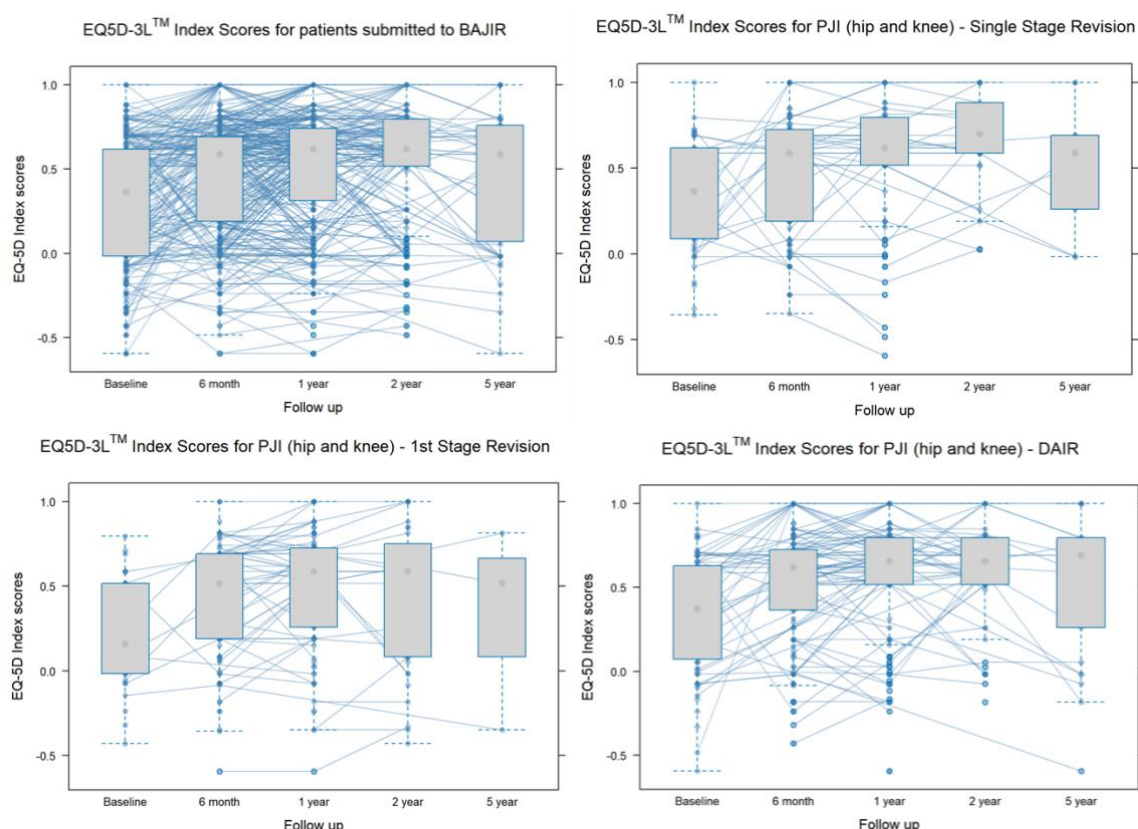


Figure 18. Box-plots of EQ5D-3L™ scores for patients submitted to BAJIR and subgroup analysis of Hip and Knee PJIs undergoing single stage revision, 1st stage revision and DAIR procedure. Scores were collected at baselines, 6 months, 1 year, 2 years and 5 years.



Aseptic Pathway

Many MDTs around the country discuss aseptic cases as well as PJI, 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. The addition of the aseptic pathway makes 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 on the aseptic pathway are accessible to local users, but not to the central BAJIR team as they are not of interest to the project and fall outside 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 :	15

Date of diagnosis :	15	
Diagnosis :	☐ Prosthetic joint infection ☐ Native joint septic arthritis ☐ Non-implant related spinal osteomyelitis; spine implant infection or discitis ☐ Native long bone osteomyelitis ☐ Fracture related infection ☒ Prosthetic joint; low suspicion of infection	
Referred to MDT :	☐ No ☒ Yes	
Presence of sinus pre-treatment :	☒ No ☐ Yes	
Affected side :	☐ Left ☒ Right	
Joint involved :	☐ Sternoclavicular ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☒ Knee ☐ Ankle	
Specific diagnosis :	☐ Stiffness ☒ Component loosening ☐ Implant fracture ☐ Dislocation / subluxation ☐ Unexplained pain ☐ Other ☐ Patella malposition ☒ Instability ☒ Component wear ☐ Wear of poly ☐ Malalignment ☐ Extensor mechanism ☐ Periprosthetic fracture ☐ Aseptic loosening ☐ Component dissociation ☐ Progressive arthritis remaining joint e.g. patella	
Joint / prosthesis present at index site :	☐ No ☒ Yes ☐ Unknown	
Date primary procedure carried out :	Year: 2010 Month: unknown Day:	

Surgery	
Diagnosis :	Prosthetic joint; low suspicion of infection
Date of operation :	05 June 2025
Operating unit/trust :	Northumbria Healthcare NHS Foundation Trust
Revision complexity :	☒ 1 ☐ 2 ☐ 3
Operation for aseptic prosthetic joint :	☐ Single stage revision ☐ ORIF ☐ Conversion partial arthroplasty to total arthroplasty ☐ Patella resurfacing ☐ Removal of fracture fixation implant ☐ Amputation ☐ Single stage arthrodesis
Unit type :	☐ PAU ☐ RU ☒ MRC
Degree of bone loss at time of surgery - AORI classification Distal Femur :	1
Degree of bone loss at time of surgery - AORI classification Proximal Tibia :	1
Change from planned procedure :	☒ No ☐ Yes
Loan kit used :	☒ No ☐ Yes
Post-operative support unit bed (Level 1.5 care) available :	☒ No ☐ Yes
Plastic surgery input required :	☒ No ☐ Yes
Vascular input required :	☒ No ☐ Yes
OrthoDx Synviscortest performed :	☒ No ☐ Yes



Referral Form

As part of our ongoing close work with the BASK Revision Knee Network project, a need for a universal referral form was evident. With very kind financial support and involvement of the BASK Revision Knee Network team, we have developed an e-referral form via BAJIR. The BAJIR MDT e-referral form is active and enables any clinician (no BAJIR registration or login is required) caring for patients with bone and joint infections to record pertinent information on the proforma and refer directly to their regional MDT. The form is completed via the HSCN web portal. The form fields have been created after consideration of existing referral pathways cross the country, with mandatory fields marked. A BAJIR record is automatically created and relevant information automatically completed in the Registry, and all fields helpful to the MDT discussion will carry through to the MDT module for discussion.

The MDT summary is pre-populated from the referral and BAJIR record. MDT clinicians in attendance, discussion and plan is 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).

The screenshot shows the BAJIR National Referral Portal interface. At the top, there is the BAJIR logo and the British Association of Knee Surgeons logo. Below the logos, a heading reads "Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision." This is followed by three bullet points: "Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.", "The primary contact name and e-mail address MUST be the patient's consultant. However, another person may complete the referral on their behalf and can continue to update and monitor the progress of the referral by adding their own e-mail address as the secondary contact.", and "Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification."

The form is divided into two main sections: "Referrer Details" and "Referral Receiver Details".

Referrer Details (indicated by a red dot for mandatory fields):

- Date of referral: A date picker showing "dd/mm/yyyy".
- Referring trust/unit: A dropdown menu.
- Unit/Hospital name: A text input field.
- Referring unit type: A dropdown menu.
- Consultant speciality: A dropdown menu.
- Consultant name: A text input field.
- Consultant NHS e-mail address: A text input field.
- Consultant phone number: A text input field.

Below the Referrer Details section, there is a checkbox labeled "I confirm the progress of the referral will be actively monitored to ensure continuing patient care."

Referral Receiver Details (indicated by a red dot for mandatory fields):

- MDT type: A dropdown menu.
- Reason for referral: A dropdown menu.

At the bottom of the form, there are several expandable sections: "Patient Details", "Problem", "Patient History", "Investigations", "Planned Management", and "MDT". Each section has a "Show" link. Below these sections are two buttons: "Save and come back later" and "Submit".

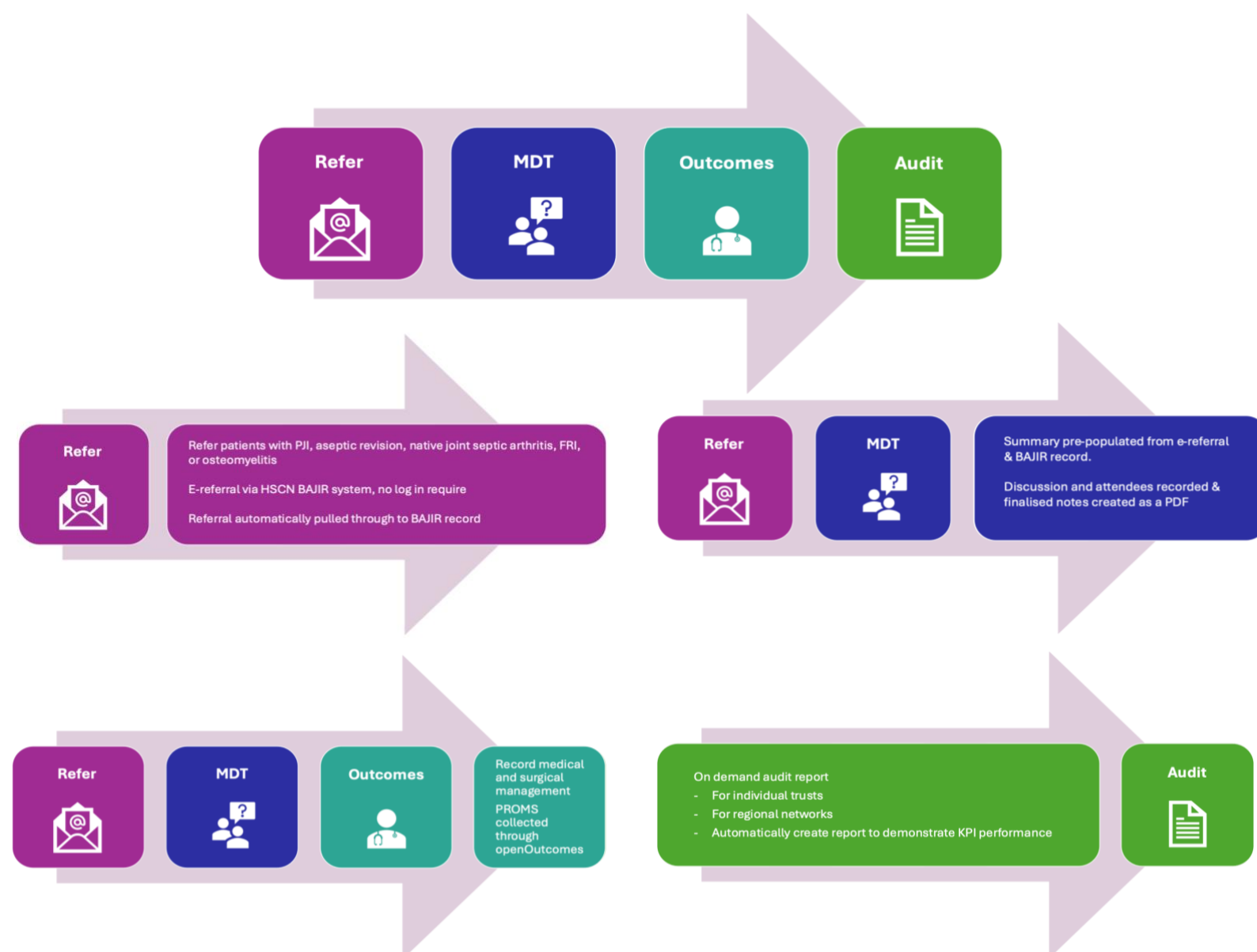


MDT Complete Software Platform

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.





Acknowledgements & Financial Support

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:





Appendix 1. E-referral Form Referrer Walk-Through



BAJIR National Referral Portal - **DEMONSTRATION**



Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision.

- Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.
- The primary contact name and e-mail address MUST be the patient's consultant. However, another person may complete the referral on their behalf and can continue to update and monitor the progress of the referral by adding their own e-mail address as the secondary contact.
- Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification.

Referrer Details [Show](#)

Referral Receiver Details [Show](#)

Patient Details [Show](#)

Problem [Show](#)

Patient History [Show](#)

Investigations [Show](#)

Planned Management [Show](#)

MDT [Hide](#)

Question for the MDT ●

Agree with plan? Prophylactic Abx advised? Dose?

[Save and come back later](#)

[Submit](#)

Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision.

- Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.
- The primary contact name and e-mail address MUST be the patient's consultant. However, another person may complete the referral on their behalf and can continue to update and monitor the progress of the referral by adding their own e-mail address as the secondary contact.
- Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification.

Date of referral ●

Referring trust/unit ●

Unit/Hospital name ●

Referring unit type ●

Consultant speciality ●

Consultant name ●

Consultant NHS e-mail address ●

Consultant phone number ●

confirm the progress of the referral will be actively monitored to ensure continuing patient care. ●

Re

MDT type ●

Reason for referral ●

Forename ●

Surname ●

Date of birth ●

Gender ●

NHS Number (Primary Patient identifier) ●

Hospital/Unit number (Secondary patient identifier) ●

Address ●

First part of Postcode ●

Second part of Postcode ●

Patient status at time of referral ●

Date problem reported ●

Current diagnosis ●

Affected side ●

Question for the MDT ●

Agree with plan? Prophylactic Abx advised? Dose?

[Save and come back later](#)

[Submit](#)



BAJIR National Referral Portal - DEMONSTRATION



Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision.

- Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.
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- Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification.

Referrer Details [Show](#)

Referral Receiver Details [Show](#)

Patient Details [Show](#)

Problem [Show](#)

Patient History [Show](#)

Investigations [Show](#)

Planned Management [Show](#)

MDT [Hide](#)

Question for the MDT ●

[Save and come back later](#)

[Submit](#)

BAJIR Referral Saved - DEMONSTRATION

Thank you for entering data in the referral form.

You will receive an e-mail containing a link to a page where you can complete the data entry and submit the referral.

If you did not receive an e-mail you can review the status of this referral using the link below.

Please make a note of the url and then close the browser window.

<https://demo.e-dendrite.com/csp/bajir/CustomPages/BAJIR/Referral/Referral.html?rkey=MTcxMzQwNiAwMDAwMDExOA==>

[Copy to Clipboard](#)



BAJIR National Referral Portal - **DEMONSTRATION**



Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision.

- Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.
- The primary contact name and e-mail address **MUST** be the patient's consultant. However, another person may complete the referral on their behalf and can continue to update and monitor the progress of the referral by adding their own e-mail address as the secondary contact.
- Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification.

Referral status



Pending



BAJIR National Referral Portal - **DEMONSTRATION**



Streamlined e-referral form for bone & joint infections and revision arthroplasty, including aseptic revision.

- Please complete all mandatory sections (indicated by red dot.) Once all mandatory fields have been completed, it is possible to save progress and continue to update the referral form later.
- The primary contact name and e-mail address **MUST** be the patient's consultant. However, another person may complete the referral on their behalf and can continue to update and monitor the progress of the referral by adding their own e-mail address as the secondary contact.
- Please note local guidance and other mandatory fields may be required for referral acceptance, please contact your local/regional MDT co-ordinator for further clarification.

Referral status



Accepted