The Royal Wolverhampton NHS Trust

Health Scrutiny Panel

29th July 2021

Report title	**Proposal to merge Urology Services at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust**
Report of:	**Jane McKiernan** **Senior Programme Manager – Strategy** **The Royal Wolverhampton NHS Trust**

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

SUPPORT the implementation of the proposals outlined in this paper

1.0 Introduction

1.1 The aim of these proposals is to ensure more responsive, safer and quicker urology care provision for the residents of Wolverhampton through a merger of elective and emergency urology services currently provided at both The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT).

1.2 Urology Consultants, specialist nurses and associated management staff will work as one team across both sites.

1.3 Elective inpatient care for both Wolverhampton and Walsall patients will be provided at RWT (no change for Wolverhampton residents).

1.4 Emergency care for both Wolverhampton and Walsall patients will be provided at RWT (no change for Wolverhampton residents).

1.5 The majority of day case procedures will take place at Walsall Manor Hospital, rather than New Cross Hospital or Cannock Hospital.

1.6 Outpatient procedures and follow-up consultations will continue to be undertaken at RWT.

1.7 The proposed merged service model between RWT and WHT will facilitate:

- An increase in the number of elective cases that each consultant in the newly merged team can undertake each year, resulting in a shorter waiting time for elective surgery for patients

- A focus on high volume, low complexity urology procedures (day case) being undertaken at one site (Walsall Manor Hospital), thus freeing up capacity and theatre space at The Royal Wolverhampton NHS Trust's hospital sites for more specialist/complex cases.

- A positive impact on the adoption of consistent processes as each site concentrates on its particular speciality, thus driving up quality and efficiency.

- A focus on health inequalities and actions that can address inequalities in access to, and standards of care.

- Opportunities to drive continuous improvement in outcomes, for instance greater opportunities for participation in research, and for combined investment in service developments.

- Maintaining elective throughput to highest possible levels throughout the pressurised periods by creating facilities and pathways that are as protected as possible from both COVID 19 and other urgent and emergency care pressures on beds, staff, and theatres.

2.0 Background

2.1 Urology services deal with diseases of the male and female urinary tract (kidneys, ureters, bladder and urethra). It also deals with the male reproductive organs. Patients are generally referred for care either as an emergency, requiring assessment and potentially treatment immediately, or through outpatient settings, where care can be planned in a routine fashion (also known as elective care). Elective care requires pathways where a treatment response is needed within days or weeks (e.g. cancer surgery) or can wait longer (e.g. vasectomy, circumcision).

2.2 The Royal Wolverhampton NHS Trust NHS Urology service has been at the forefront of specialist urology provision. It was the first Trust in the West Midlands to utilise robotic surgery, it provides specialist renal surgery for the Black Country and as part of this commitment provides specialist training for consultant colleagues from other Trusts.

2.3 Recruitment to the workforce is largely successful, the team has a complement of 9 consultants (and an additional vacancy of 1), 9 clinical nurse specialists and 6.5 specialist senior supporting doctors.

2.4 Emergency care is well provided, with the adoption as national recommendation, of a dedicated emergency consultant available for 24 hours over each of the 7 days every week.

2.5 However waiting times for elective (planned) surgical procedures remain challenged. RWT has some of the longest waits across the country and in common with many Trusts, the longest waits have grown during the COVID 19 pandemic.

2.6 Meanwhile Walsall Hospital Trust has different challenges to RWT. It has a 4 person consultant body, 2 of these are filled by long term locums. There are 3 supporting specialist doctors, and 3 clinical nurse specialists. The provision of a 24/7 emergency service is at risk because the staffing complement is low and with a poor recruitment history, is not sustainable in the long term.

2.7 With only four consultants, the urology elective service at Walsall Manor Hospital predominantly focuses on low complexity conditions. Many of these cases are performed as day cases. Complex urology cases received at WHT are referred on to specialist sites including to RWT.

2.8 Waiting times for surgical procedures at WHT are not as long as those at RWT.

2.9 The proposal is to join the urology workforce and estate resources of both RWT and WHT, so that care is delivered across both sites with teams working together to provide equity of service for both populations.

2.10 These proposals are supported by the Getting it Right First Time (GIRFT) programme of work[1-2.] This national review of urology services identifies that the delivery of care across the country is best served as a network approach, with hospitals within an area taking the lead for specific aspects of urological care.

2.11 They have recommended an approach to care that includes the concentration of emergency and complex elective care provision on specialised sites, as well as the establishment of hubs concentrating on the provision of high volume low complexity (HVLC) care, mostly common cases that are performed as day cases. It is this approach that Wolverhampton and Walsall are proposing to adopt.

2.12 By concentrating emergency care onto one site at RWT, i.e. providing the need for only 1 on call rota rather than the current 2, consultant time will be freed to increase the number of elective procedures that can be undertaken each year, therefore reducing waiting times.

2.13 By concentrating low complexity elective care on one site (Walsall Hospital), the processes adopted will become the standard way of working for that team, adopting a streamlined and consistent approach to care. Typically, this leads to an efficiency of process and we expect to see a resultant increase in throughput and therefore again a reduction in waiting times This approach is an approach tested elsewhere in the country and as noted recommended by GIRFT[3]. We have recently heard from the London NHS hospitals who were able to reduce their waiting lists by 12% by adopting this method across a number of trusts in the last year.

2.14 The approach to centralising HVLC into a hub will also provide a vehicle to drive improvements in quality of care. National guidance suggests that in some parts of the country 85% of urological procedures are performed as a day case. In 2019/20, only 48% of elective urology cases were performed as day cases at RWT and at WHT this was 55%. With improvements in pathways, we expect to increase the number of day cases offered to the residents of both Wolverhampton and Walsall, therefore reducing overnight stays and producing a positive impact on the hospital bed pressures.

2.15 The number of residents of Wolverhampton that will travel to Walsall for day case surgery each year will be approximately 900. These patients would previously have had their day case surgery at New Cross Hospital or Cannock Hospital.

2.16 The decision whether patients will be asked to attend for surgery at WHT will be made based on how likely they can return home on the same day after their surgery. This decision is made by a clinician when they review the case for listing, and takes into account the procedure that is to be undertaken and the frailty of the individual requiring the surgery.

1. Getting it Right First Time: A framework for re-establishing and developing urology services in the COVID-19 era 2021
2. Getting it Right First Time: Innovations, good practice and guidelines for establishing a urology area network 2019
3. Getting it Right First Time: Elective Recovery High Volume Low Complexity (HVLC) guide for systems May 2021

3.0 Decision/Supporting Information (including options)

3.1 We have conducted patient engagement and will present these results at the HOSC meeting.

3.2 We have considered other models of care that produce a hybrid solution, e.g. emergency care is transferred from Walsall to Wolverhampton only at weekends and/or night time. However, these models mean that the gain from shared consultant rotas is marginal, and therefore the impact on producing additional capacity for elective work is small.

3.3 The clinical view, and supported by the GIRFT team visit to both Wolverhampton and Walsall (June 2021), is that the proposal outlined, offers the best solution to the challenges that both trusts face in providing safe and responsive care for urology patients across both Wolverhampton and Walsall catchment areas.

3.4 These changes are also supported by other organisations including Black Country and West Birmingham CCG and West Midlands Ambulance service.

3.5 The service provision described also offers a solution to the requirement to separate elective planned work from emergency work during the time of the COVID-19 pandemic. Indeed a London network of Trusts adopted this approach from Nov 2020, as a way of continuing to offer elective surgery whilst pressures on hospitals were at the highest.

3.6 We are proposing that the transfer of services between the 2 sites happens in 2 phases. Phase 1 would see the transfer of emergency patients from Walsall to Wolverhampton from October 2021. Phase 2 would see the transfer of elective day case patients from Wolverhampton to Walsall from January 2022.

4.0 Implications

4.1 There are no intended or perceived commercial or financial gains or losses relevant to these proposals. The priority is the delivery of safe and responsive care to residents.

4.2 The residents of Wolverhampton will see a decrease in the time that they wait for an operation and therefore an improvement in clinical outcomes, and an increase in the number of individuals offered day case surgery, and a reduction in the number requiring a hospital bed overnight.

4.3 A reduction in the number of patients requiring a hospital bed overnight, reduces the pressure on beds required for patients who are admitted for emergency care.

4.4 Staff will have the opportunity to work across both organisations in a larger team with the opportunity to learn and share skills with colleagues. Recruitment of workforce is expected to be more successful as opportunities to experience a diverse range of work are available.

4.5 Patients from Wolverhampton will be required to travel to Walsall for day case surgery. Currently this surgery is carried out at New Cross Hospital and pre COVID-19 pandemic at Cannock hospital sites. This change will impact approximately 900 Wolverhampton residents each year.

4.5 Patients undergoing day case surgery are not expected to use public transport, particularly when returning home after the procedure. Patients should be escorted home by a relative or friend in a private car or taxi. This is the case which ever hospital the surgery is undertaken at. Some patients may be eligible for hospital transport and these individuals will continue to be offered this solution. Some patients may be eligible to claim travel costs under the Hospital Transport Scheme, and these patients will be supported to complete the necessary claim forms.

4.6 Instead of day case surgery RWT will increase the number of inpatient elective work as patients are transferred from Walsall. The expected increase in elective inpatients is 432/year.

5.0 Schedule of Background Papers

5.1 Further detail relating to this report can be provided by contacting the report writer:

Jane McKiernan
Senior Programme Manager-Strategy
The Royal Wolverhampton NHS Trust

janemckiernan@nhs.net