Black Country Provider Collaborative

NHS

Millichip Suite

7th November 2025, 10:00 to 16:30

West Bromwich Albion Football Club

Working in partnership
Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

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Breakout Session

Richardson Suite – *(Main Room, 1st floor, Amit Rath)*

(A)ENT: Mr. J. Murphy
(B)Ophthalmology: Mr. J. Barry

Millichip Suite *(Main Room, 1st floor, Gurpreet Rai)*

(A)Colorectal: Mr. Ben Liu/Mr. M.Tayyab
(B)Gynaecology: Mr. Ayman Ewies

Bassett Suite *(2nd Floor – Lola Omotoso)*

(A)General Surgery: Mr. S. Mirza
(B)Peri-operative Assessment: Dr A. Pierson

Pennington Suite *(2nd Floor – Alima Bibi)*

(A)Breast Unit/DIEP: P. Browne/A. Alam
(B)Lung Screening: E. Gilliland

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Evolved Colorectal Pathways

Building on collaborative achievements

Mr. Ben Liu

BCPC Clinical lead, Consultant Colorectal Surgeon

Working in partnership

Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

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Colorectal Work Streams

- Faecal Immunochemistry (FIT) pathways
- Advanced colorectal cancer
- Early rectal cancer
- Anal Intraepithelial Neoplasia (AIN)
- NBOCA
- Robotics
- Same day staging CT & MRI sans

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Colorectal Successes

- Implementation of FIT
- Successful outcomes in diagnostic speed
- Colorectal Workshop
- Development of AIN pathway
- Keeping advance colorectal cancer work in the Black Country
- Beginning to standardize early rectal cancer
- Implementation of ERAS and impact on GIRFT

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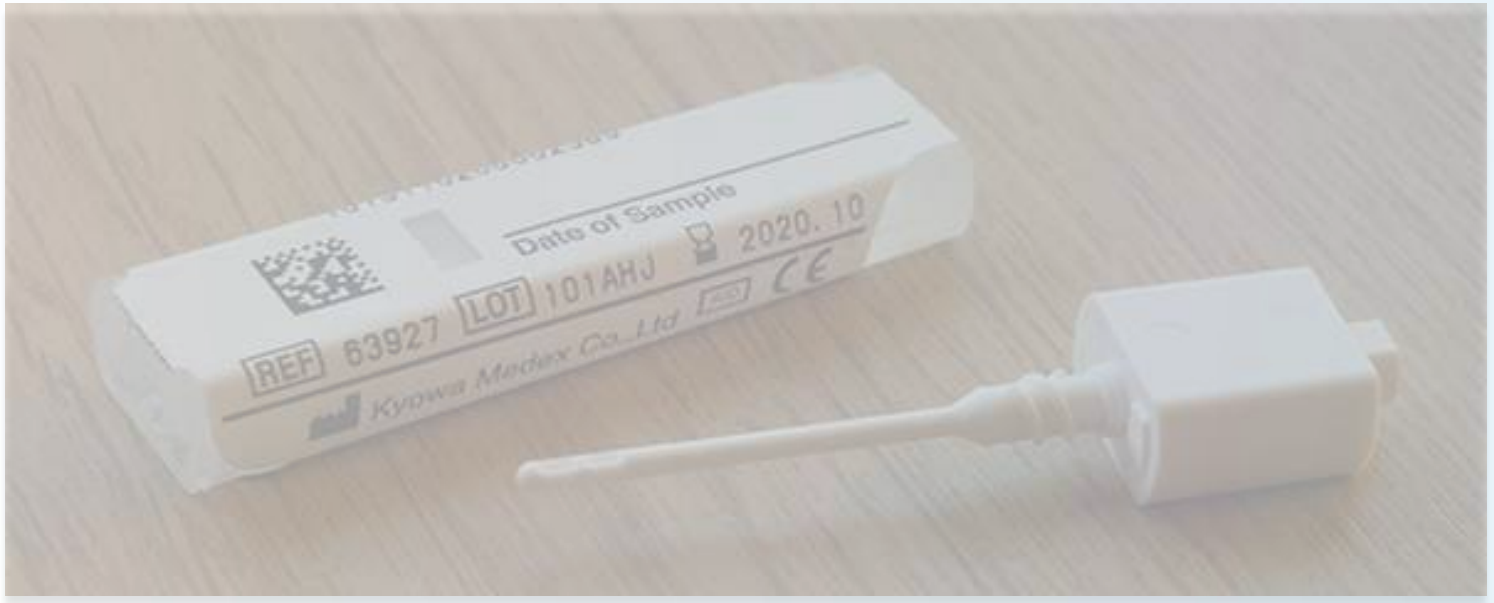
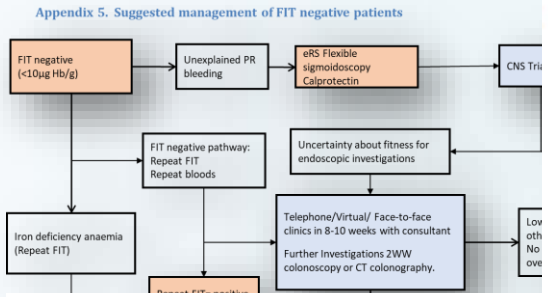
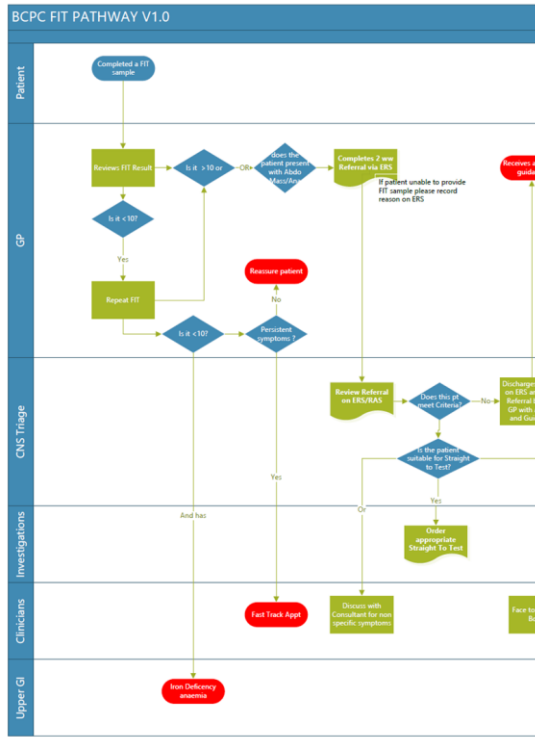
FIT – Faecal Immunochemistry Pathways in the Black Country

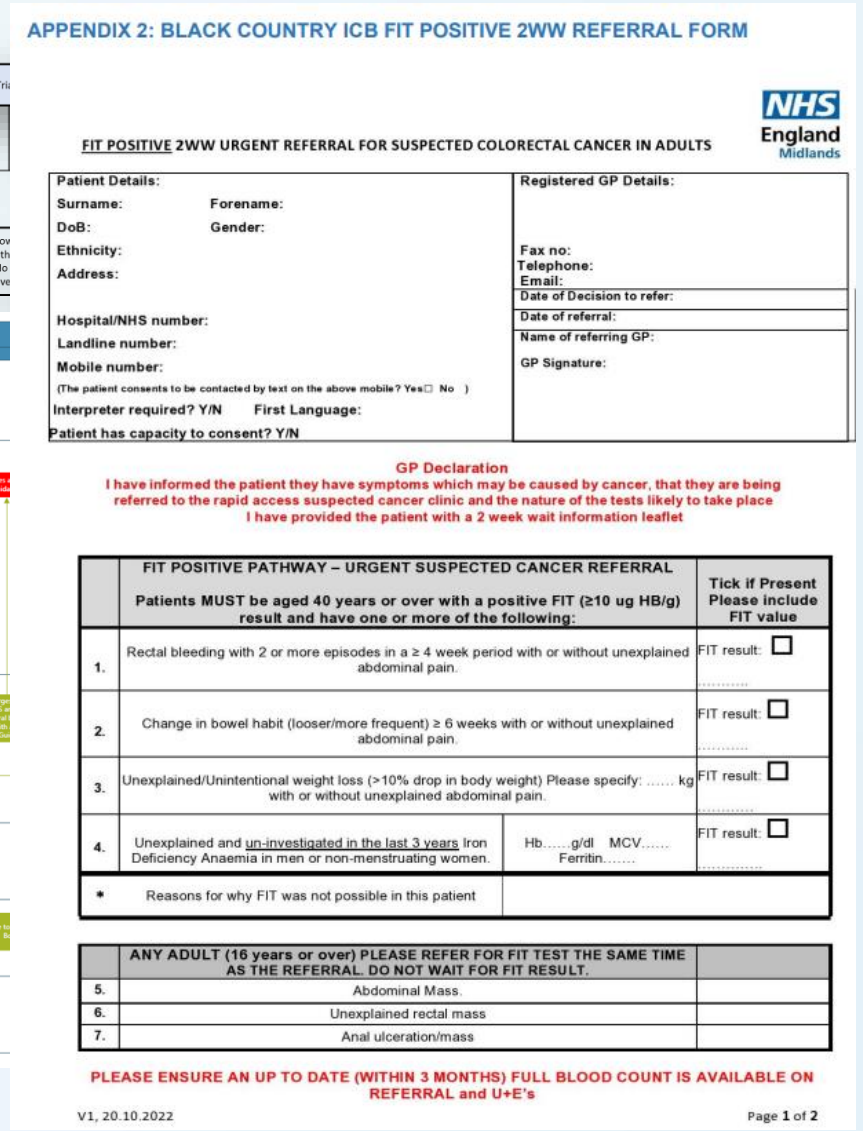


FIT: A national directive with local adaptation & execution

- Faecal Immunochemistry Test (FIT) has high sensitivity for detecting colorectal cancer (CRC)
- FIT stratify CRC risks to guide urgency of investigations
- FIT referral guidelines were published in August 2022, enshrined in NICE and then mandated by NHSE
- BCPC colorectal network has produced and implemented its own **FIT pathway in April 2023** adhering to the national directives and integrating with our own CRC FDS strategy
- Strong partnerships were forged with our Primary Care partners







APPENDIX 2: BLACK COUNTRY ICB FIT POSITIVE 2WW REFERRAL FORM

NHS England Midlands

FIT POSITIVE 2WW URGENT REFERRAL FOR SUSPECTED COLORECTAL CANCER IN ADULTS

Patient Details:	Registered GP Details:
Surname: Forename:	
DoB: Gender:	
Ethnicity:	Fax no:
Address:	Telephone:
	Email:
	Date of Decision to refer:
Hospital/NHS number:	Date of referral:
Landline number:	Name of referring GP:
Mobile number:	GP Signature:
(The patient consents to be contacted by text on the above mobile? Yes☐ No)	
Interpreter required? Y/N First Language:	
Patient has capacity to consent? Y/N	

GP Declaration

I have informed the patient they have symptoms which may be caused by cancer, that they are being referred to the rapid access suspected cancer clinic and the nature of the tests likely to take place

I have provided the patient with a 2 week wait information leaflet

	FIT POSITIVE PATHWAY – URGENT SUSPECTED CANCER REFERRAL Patients MUST be aged 40 years or over with a positive FIT (≥10 ug HB/g) result and have one or more of the following:		Tick if Present Please include FIT value
1.	Rectal bleeding with 2 or more episodes in a ≥ 4 week period with or without unexplained abdominal pain.		FIT result: ☐
2.	Change in bowel habit (looser/more frequent) ≥ 6 weeks with or without unexplained abdominal pain.		FIT result: ☐
3.	Unexplained/Unintentional weight loss (>10% drop in body weight) Please specify: ..... kg with or without unexplained abdominal pain.		FIT result: ☐
4.	Unexplained and un-investigated in the last 3 years Iron Deficiency Anaemia in men or non-menstruating women.	Hb.....g/dl MCV..... Ferritin.....	FIT result: ☐
*	Reasons for why FIT was not possible in this patient		

	ANY ADULT (16 years or over) PLEASE REFER FOR FIT TEST THE SAME TIME AS THE REFERRAL. DO NOT WAIT FOR FIT RESULT.	
5.	Abdominal Mass.	
6.	Unexplained rectal mass	
7.	Anal ulceration/mass	

PLEASE ENSURE AN UP TO DATE (WITHIN 3 MONTHS) FULL BLOOD COUNT IS AVAILABLE ON REFERRAL and U+E's

V1, 20.10.2022 Page 1 of 2

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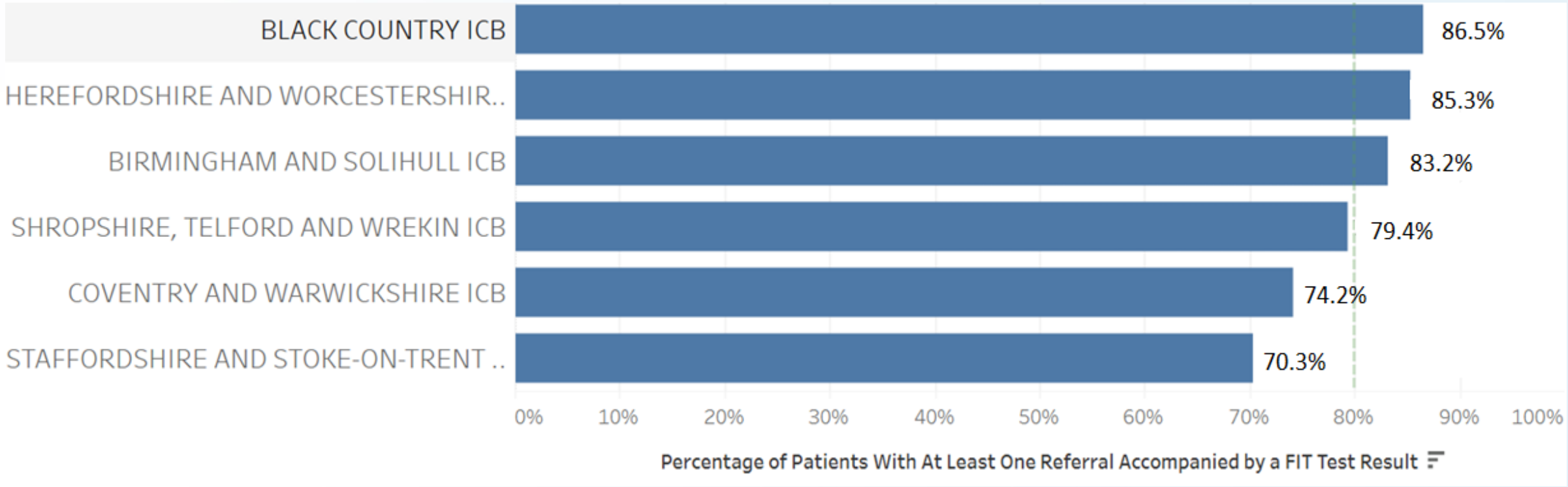
FIT Adoption: Exceeding Expectations



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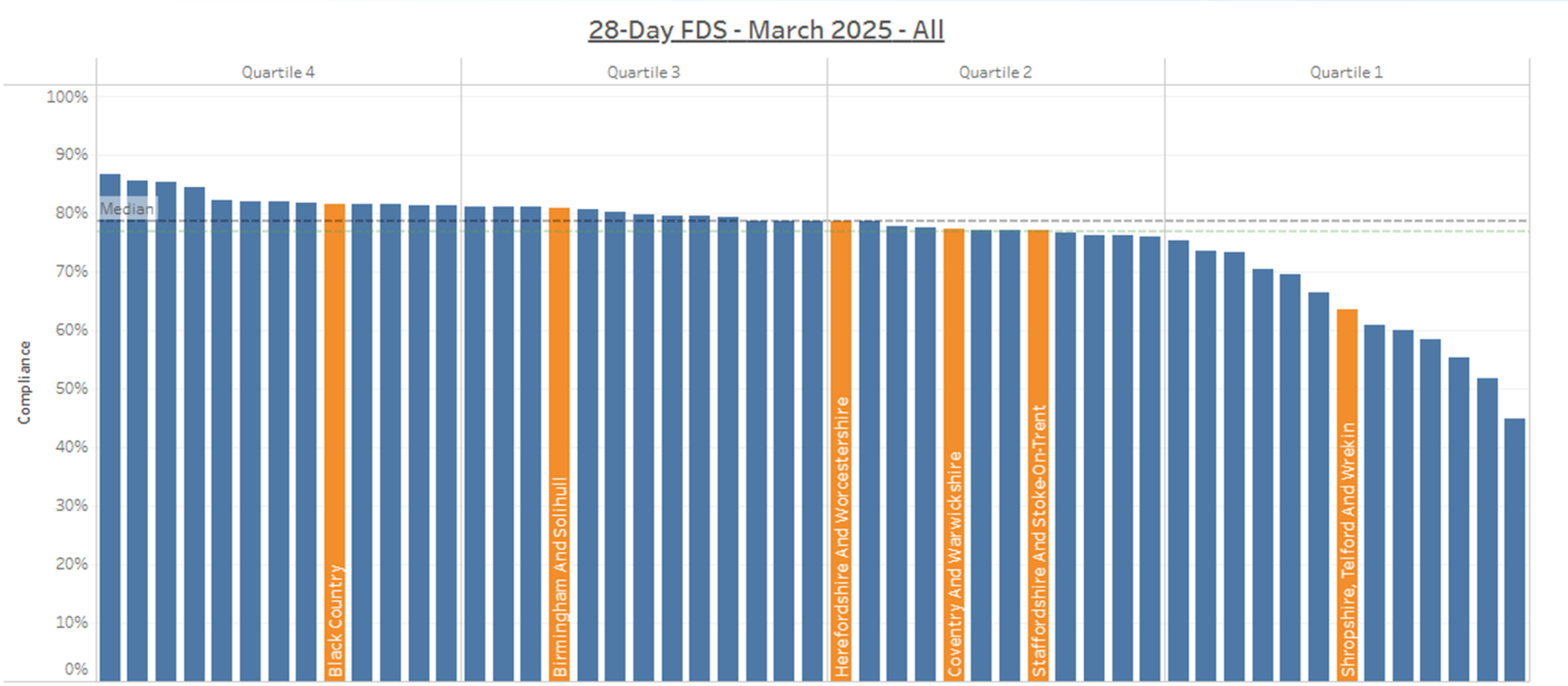
FDS 28 day targets



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Repeat FIT: evidence vs pragmatism

- **Evidence**
  - A single negative FIT has NPV of > 99.5%
  - Two negative FIT reduces colorectal cancer probability to 0.04%
  - A repeat FIT captured 7% of cancers that is otherwise missed on a single neg FIT (East Lancashire)
- **Current practice at Black Country ICB**
  - TWO negative FIT – review in colorectal clinic at 8 weeks timeframe
- **Pragmatism**
  - Admin and logistic difficulties from Primary Care
  - Concerns about adequacy of patient tracking and patient compliance
  - Delays between having first neg FIT result and getting patient to submit second FIT

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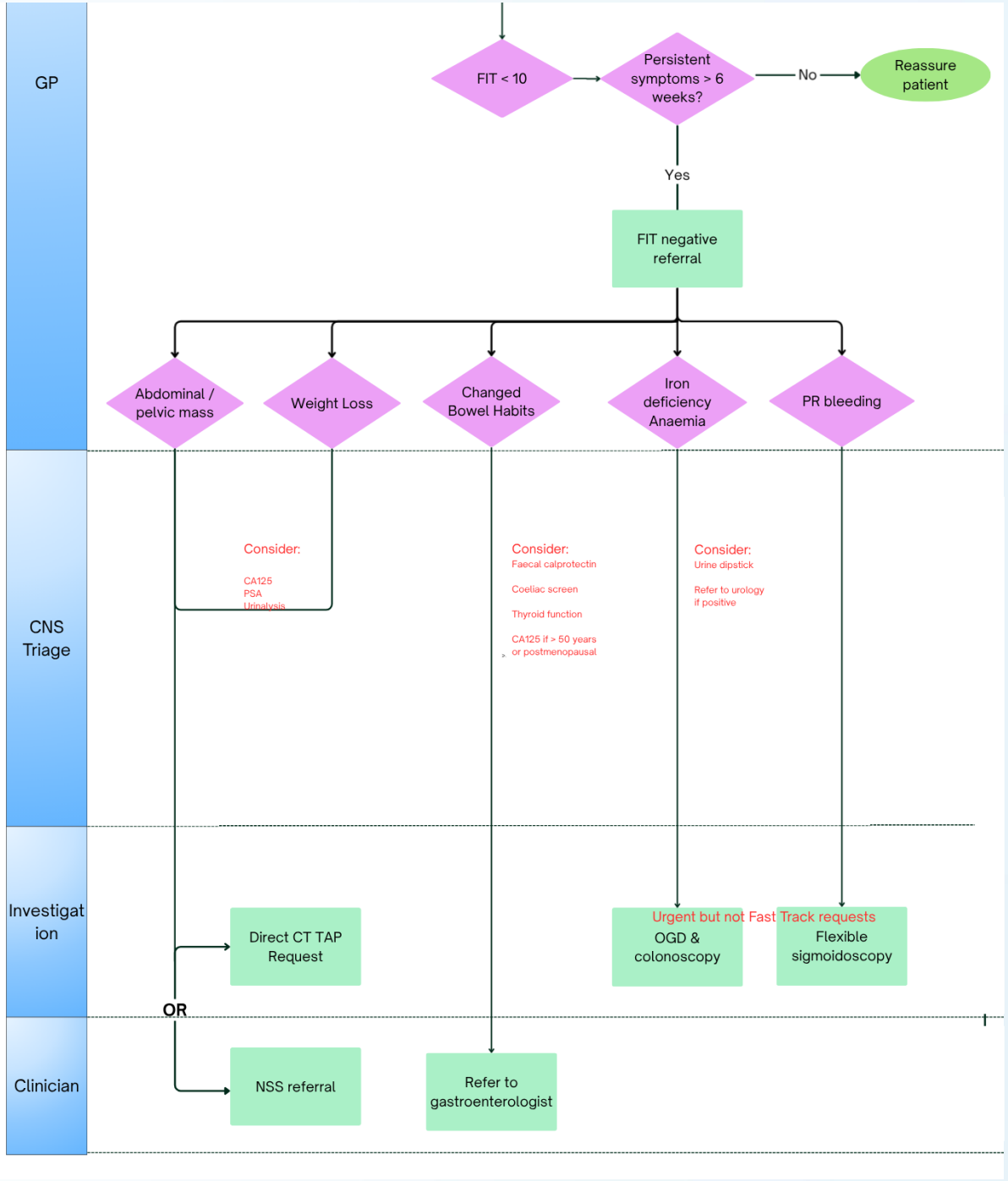
FIT negatives: Decision Tree



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FIT negatives:

Referral pathway

West Midlands cancer alliance

FIT NEGATIVE REFERRAL FOR ADULTS

NHS England Midlands

NHS

Patient Details:	Registered GP Details:
Surname: Forename:	
DoB: Gender:	
Ethnicity:	Fax no:
Address:	Telephone:
	Email:
Hospital/NHS number:	Date of Decision to refer:
Landline number:	Date of referral:
Mobile number:	Name of referring GP:
(The patient consents to be contacted by text on the above mobile? Yes No)	GP Signature:
Interpreter required? Y/N First Language:	
Patient has capacity to consent? Y/N	

PLEASE REVIEW FIT NEGATIVE FLOWCHART ON PAGE 3 of SOP

	Referral Pathways		Please include FIT value
Urgent Referral to Gastroenterology **Patients aged ≥ 40 years with negative FIT (<10 ug HB/g) results and the following:**			
1.	Change in bowel habit ≥ 6 weeks		FIT result: ……
Fast Track Referral for Flexible Sigmoidoscopy **Patients aged ≥ 40 years with negative FIT (<10 ug HB/g) results and the following:**			
2.	Rectal bleeding with 2 or more episodes for ≥ 4 weeks		FIT result: ……
Urgent OGD and Colonoscopy **Patients aged ≥ 40 years with negative FIT (<10 ug HB/g) results and the following:**			
3.	Unexplained **AND** un-investigated in the last year Iron Deficiency Anaemia in men or non-menstruating women.	Hb……g/dl MCV…… Ferritin…….	FIT result: ……
Direct CT Thorax Abdomen & Pelvis Requests or NSS (non-specific symptoms) referral **Patients aged ≥ 40 years with negative FIT (<10 ug HB/g) results and the following:**			
4.	Abdominal mass OR Weight loss ((either documented >5% in three months or with strong clinical suspicion)		FIT result: ……

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FIT Negatives: Tracking Progress

- Drafted New **SOP**
- Ratified at **Colorectal Network Workshop June 2025**
- Developed further with **West Midlands Cancer Alliance**
- Approved at executive level across **all 4 Trusts**
- Discussed at **Black Country Professional Engagement**
- Consensus reached with **Black Country Primary Care Collaborative,** COMMS circulated
- Disseminated to **Black Country Primary Care LMC (local medical committee) and Black Country Cancer Board** for Final approval
- Aim to have 3 months grace period for extraction of existing/old pathways
- **Completed BCPC algorithm now leading as the template for WMCA's own FIT pathway development**

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Squamous intraepithelial lesions of anus and peri-anus

Ms. Maria Mondragon

Consultant Colorectal Surgeon, RWT

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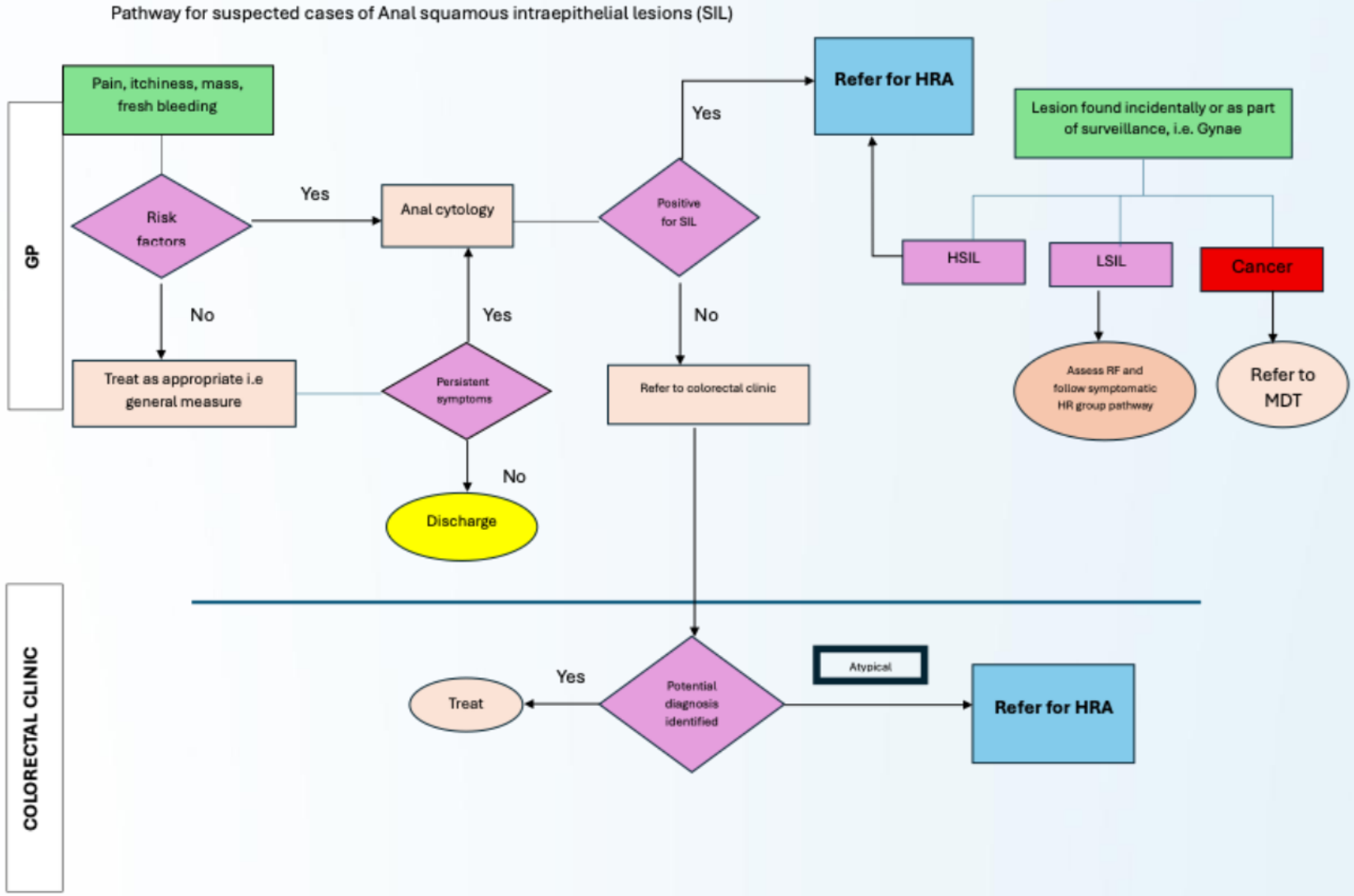
Preliminary AIN Pathway



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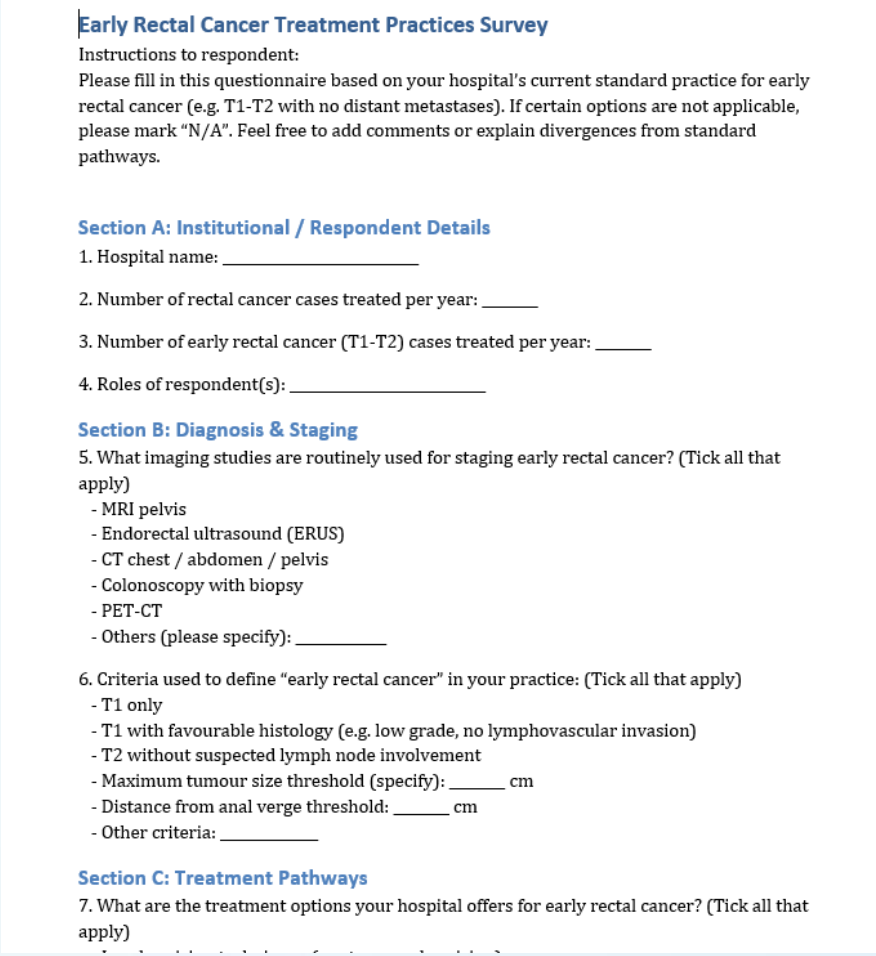
Early Rectal Cancer

- All 4 Trusts provide early rectal cancer treatments
- **Highly variable practices**, diagnoses, patient selection, operative techniques, outcome measurements and salvage plans
- **Mr Pereira has made ICB wide systematic enquiries about current practices and agreement on common standards**



Early Rectal Cancer Treatment Practices Survey

Instructions to respondent:
Please fill in this questionnaire based on your hospital's current standard practice for early rectal cancer (e.g. T1-T2 with no distant metastases). If certain options are not applicable, please mark "N/A". Feel free to add comments or explain divergences from standard pathways.

Section A: Institutional / Respondent Details

1. Hospital name: _____

2. Number of rectal cancer cases treated per year: _____

3. Number of early rectal cancer (T1-T2) cases treated per year: _____

4. Roles of respondent(s): _____

Section B: Diagnosis & Staging

5. What imaging studies are routinely used for staging early rectal cancer? (Tick all that apply)
- MRI pelvis
- Endorectal ultrasound (ERUS)
- CT chest / abdomen / pelvis
- Colonoscopy with biopsy
- PET-CT
- Others (please specify): _____

6. Criteria used to define "early rectal cancer" in your practice: (Tick all that apply)
- T1 only
- T1 with favourable histology (e.g. low grade, no lymphovascular invasion)
- T2 without suspected lymph node involvement
- Maximum tumour size threshold (specify): _____ cm
- Distance from anal verge threshold: _____ cm
- Other criteria: _____

Section C: Treatment Pathways

7. What are the treatment options your hospital offers for early rectal cancer? (Tick all that apply)

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NBOCA – National Bowel Cancer Audit

Up to Q2 of 2024					
	Adjuvant chemo for Stage 3 cancer	Seen by colorectal CNS	30-day Emergency readmission	Unplanned return to theatres	90 days mortality after major colorectal cancer resections
Wolverhampton	55.0%	98.0%	10.4%	9.1%	1.80%
Walsall	69.0%	97.0%	13.0%	8.6%	4.60%
Dudley	56.0%	94.0%	14.3%	7.7%	4.90%
Sandwell	37.0%	97.0%	9.3%	8.3%	4.50%

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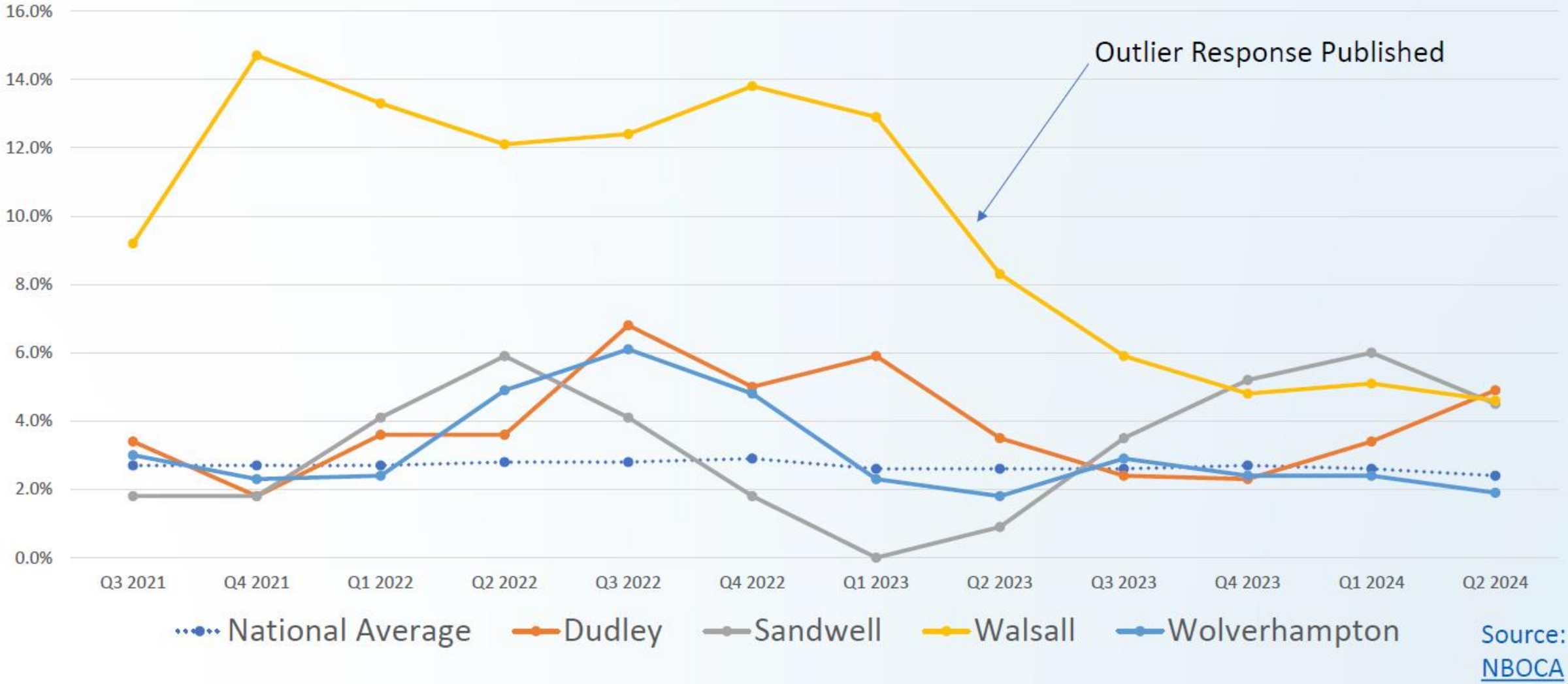
NBOCA: 90-day mortality after major resection



Source: NBOCA

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State of Nation (Annual) Report 2024
KPIs & Benchmark

Source: NBOCA

NHS

Cancer Alliance/ Trust Name	Clinical Nurses	Rectal cancer volume	90 days mortality	30 day return to theatre	30 day readmission	Stoma unclosed at 18 month	Adj. chemo for Stage 3	Toxicity	Neoadj. for rectal cancers	2-year survival	Number of targets met
Local target	>95%	≥20 cases	≤6%	≤10%	≤15%	≤35%	>50%	<33%	10-60%	>70%	
Overall % meeting target	61	81	96	92	81	41	93	95	89	97	
England % meeting target	62	81	96	92	81	42	94	97	89	97	
Wales % meeting target	40	80	100	100	90	20	100	100	90	100	
West Midlands: Black Country											
Dudley Group NHS Foundation Trust	95	31	6.3	8.4	14.0	49	69	17	22	68.5	**7**
Royal Wolverhampton NHS Trust	96	36	2.7	5.0	9.6	33	76	20	45	91.1	**10**
Walsall Healthcare NHS Trust	92	22	5.4	10.4	17.1	41	66	19	33	70.4	**6**
Sandwell and West Birmingham Hospitals NHS Trust	88	26	2.0	8.2	8.7	55	58	no data	46	88.5	**7**

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Advanced Colorectal Cancers

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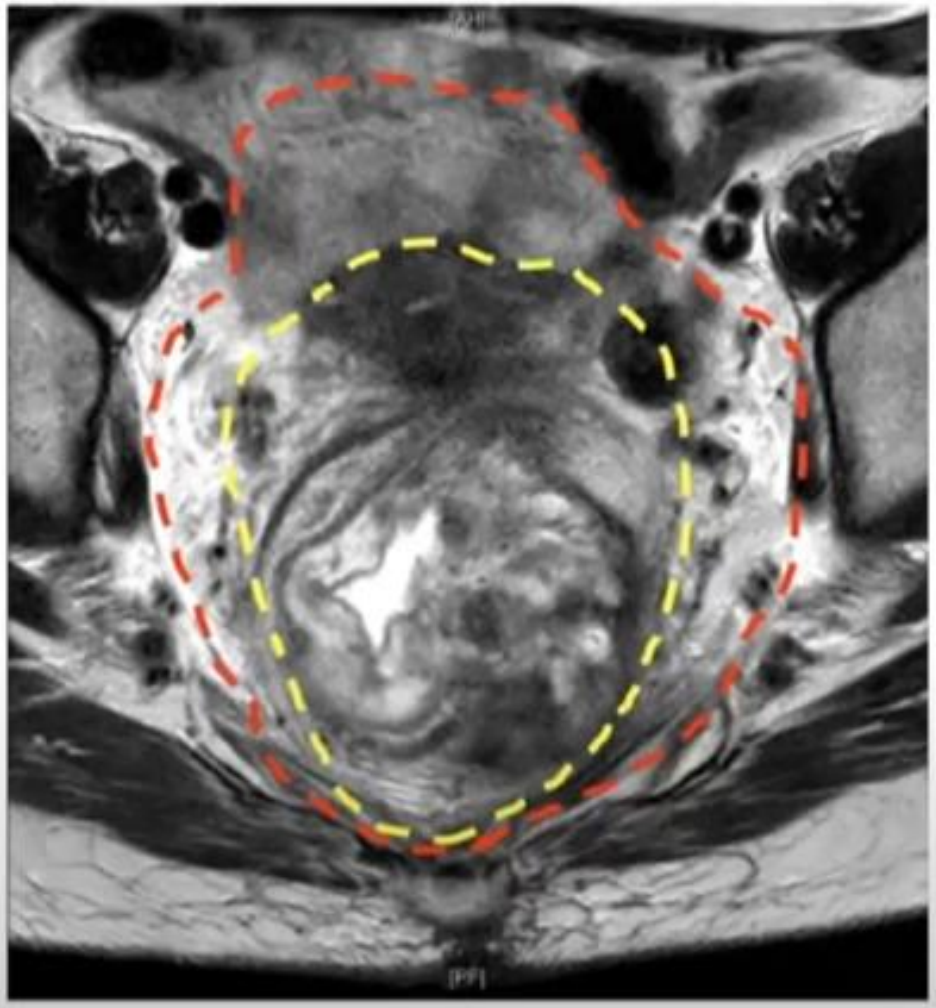

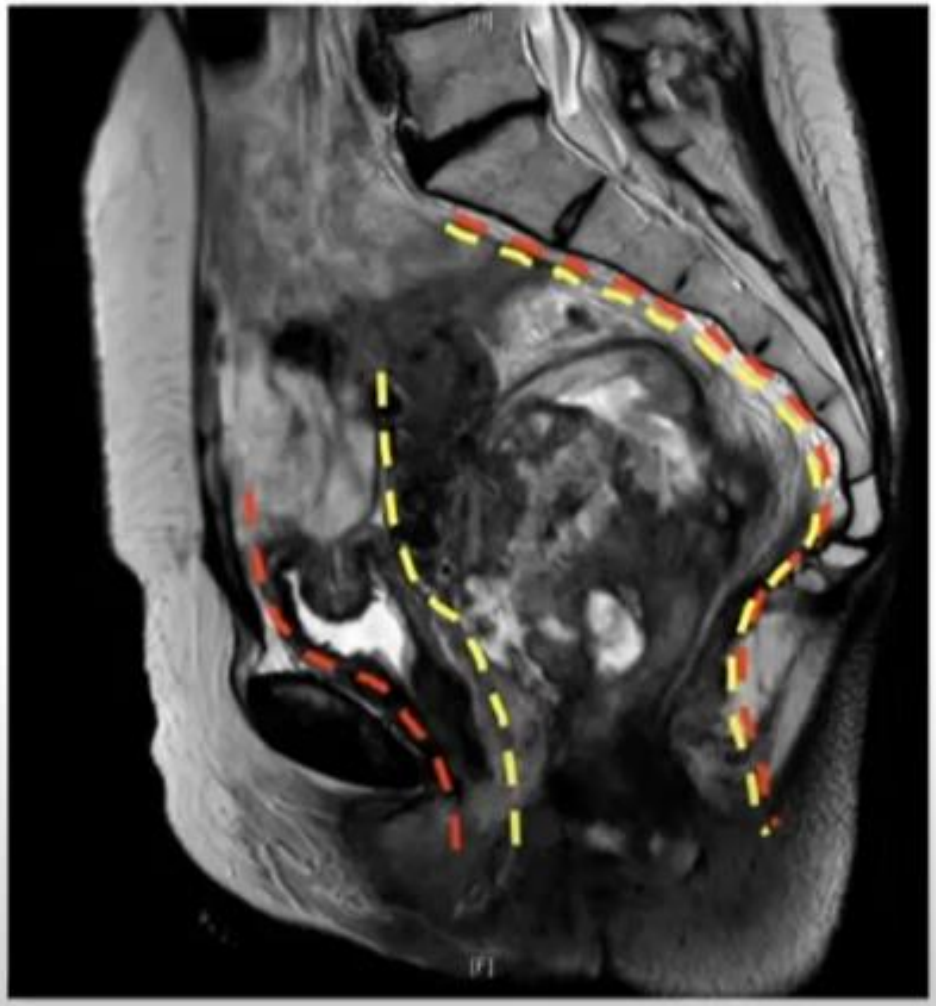

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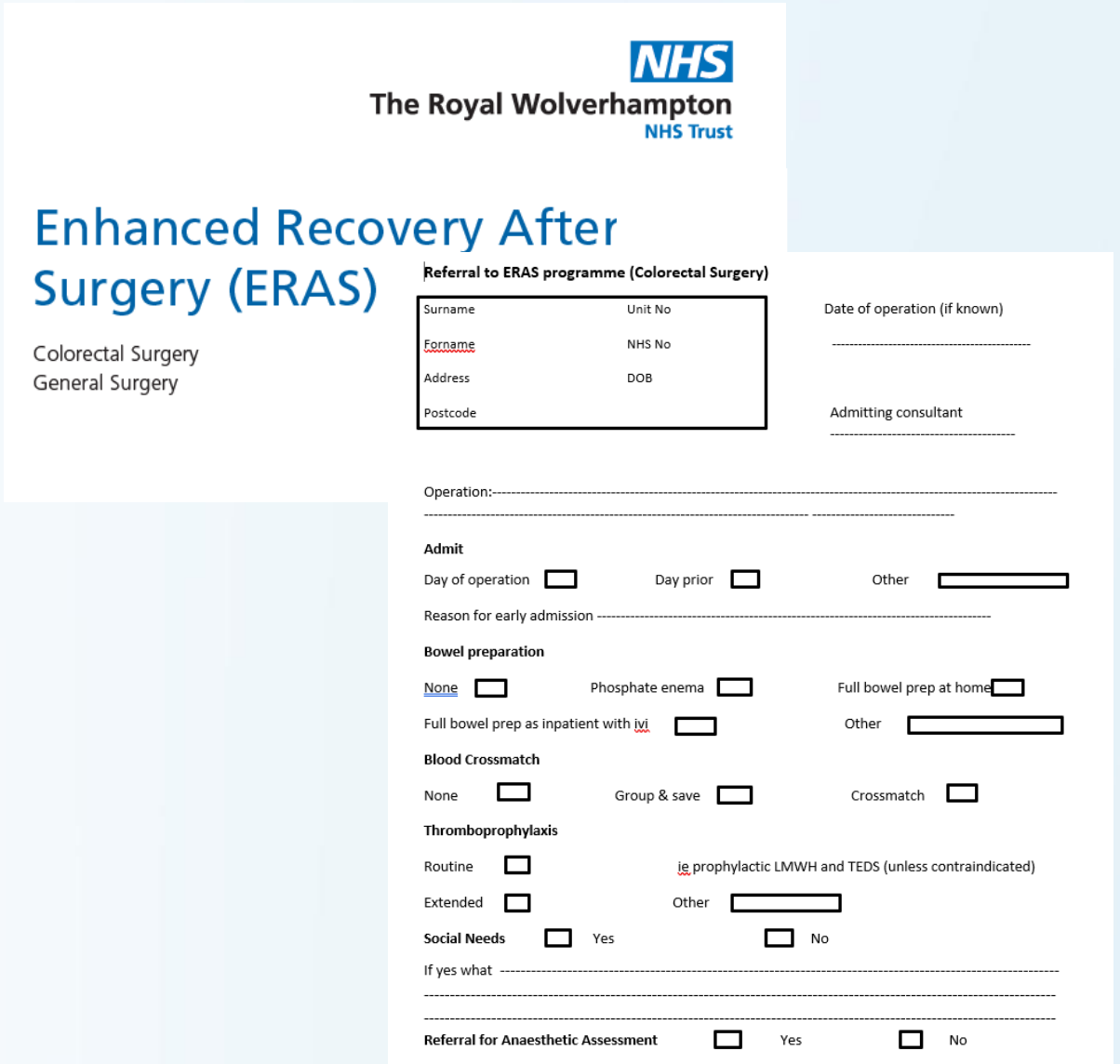
ERAS and GIRFT

- Enhanced recovery after surgery templates were locally adapted in all 4 colorectal units in 2023
- **Dedicated ERAS team nurses** and practitioners were recruited
- Remote monitoring implemented
- Target-driven discharge criteria are being trialed



NHS
The Royal Wolverhampton NHS Trust

Enhanced Recovery After Surgery (ERAS)

Colorectal Surgery
General Surgery

Referral to ERAS programme (Colorectal Surgery)

Surname	Unit No
Forname	NHS No
Address	DOB
Postcode	

Date of operation (if known) ----------

Admitting consultant ----------

Operation:----------

Admit

Day of operation ☐ Day prior ☐ Other ☐

Reason for early admission ----------

Bowel preparation

None ☐ Phosphate enema ☐ Full bowel prep at home ☐

Full bowel prep as inpatient with ivi ☐ Other ☐

Blood Crossmatch

None ☐ Group & save ☐ Crossmatch ☐

Thromboprophylaxis

Routine ☐ ie prophylactic LMWH and TEDS (unless contraindicated)

Extended ☐ Other ☐

Social Needs ☐ Yes ☐ No

If yes what ----------

Referral for Anaesthetic Assessment ☐ Yes ☐ No

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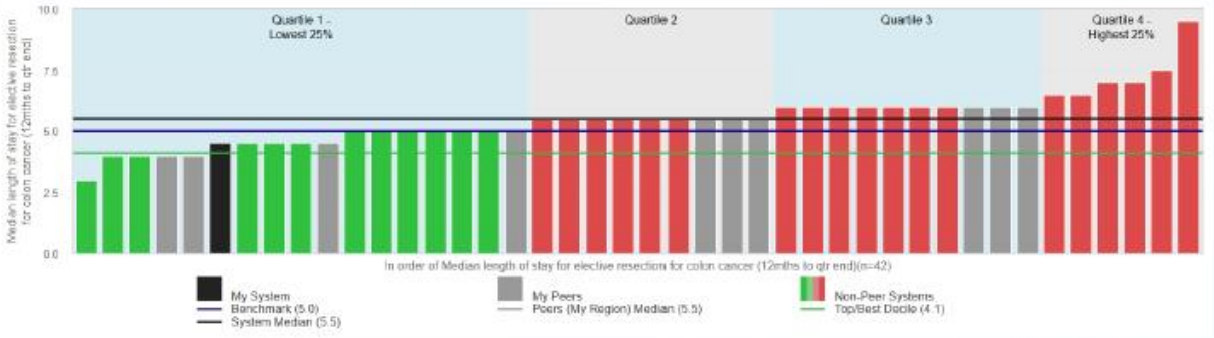
Median length of stay for elective resection for colon cancer -12 months to Qtr end

Period	Benchmark	Midlands	BC	RWT	SWB	DGH	WHT
Q3 23-24	5.0	5.5	6.0	6.0	4.0	6.0	6.0
Q3 24-25	5.0	5.5	4.5	5.0	4.0	5.0	4.0
Change	→0.0	→0.0	↓-1.5	↓-1.0	→0.0	↓-1.0	↓-2.0

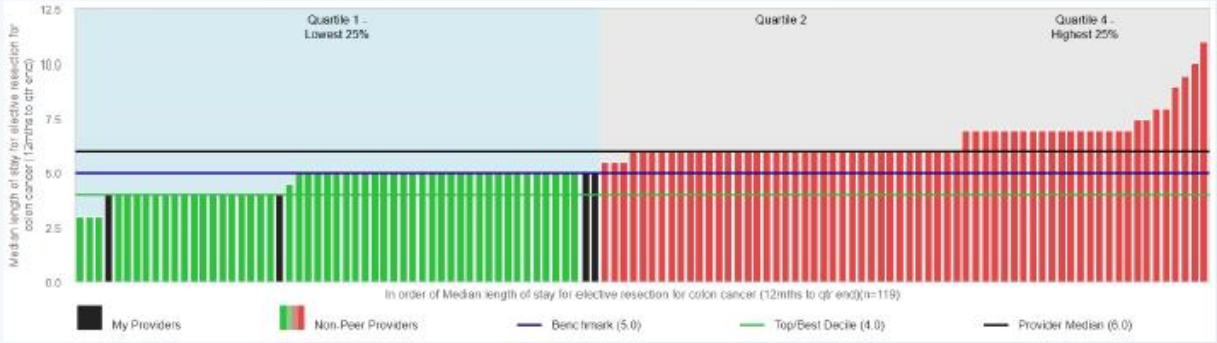
System Value: 4.5 Peer Median: 5.5 Benchmark: 5.0

As a system and as trusts, we are meeting the benchmark with Wolverhampton, Dudley and Walsall all improving in the last 12 months.

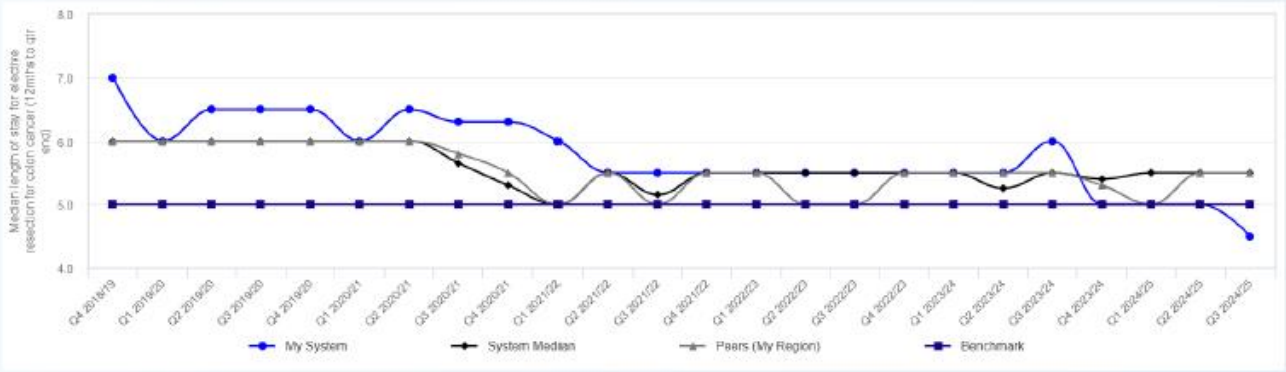
ICB Variation



Provider Variation



Source:
View metric - Median length of stay for elective resection for colon cancer (12mths to qtr end) - Model Health System



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Thank you & Questions.

https://blackcountryprovidercollaborative.nhs.uk/

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Colorectal Improvement Project

Mr. M Tayyab

Colorectal Lead

Walsall Manor Hospital

Walsall Healthcare NHS Trust

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2022 Financial year	NBOCA-National Average published July 2023	Figures presented by project team 01/01/2022 - 31/05/2023 (Based on only major resections)
Total patients operated on during this timeframe		
Proportion of patients having emergency Major resection	14%	39.20%
Adverse event rate following elective major resection for colorectal CA	14(GIRFT)	14.50%
Adverse event rate following elective major resection for rectal CA	20(GIRFT)	29.40%
Length of stay > 5 days	<60%	73.40%
30-day post-op mortality	1.70%	6.30%
90-day post-op mortality	2.80%	10.90%
30-day readmission excluding 0 days LOS	12.50%	14.10%
30-day readmission including 0 days LOS		21.90%
30-day unplanned return to theatre (URTT)	<6.8%	6.30%
Ileostomy formation rate at time of anterior resection		56.70%
Cumulative Rectal cancer resection volume**		20 (across 17 Months)

Walsall Healthcare NHS Trust

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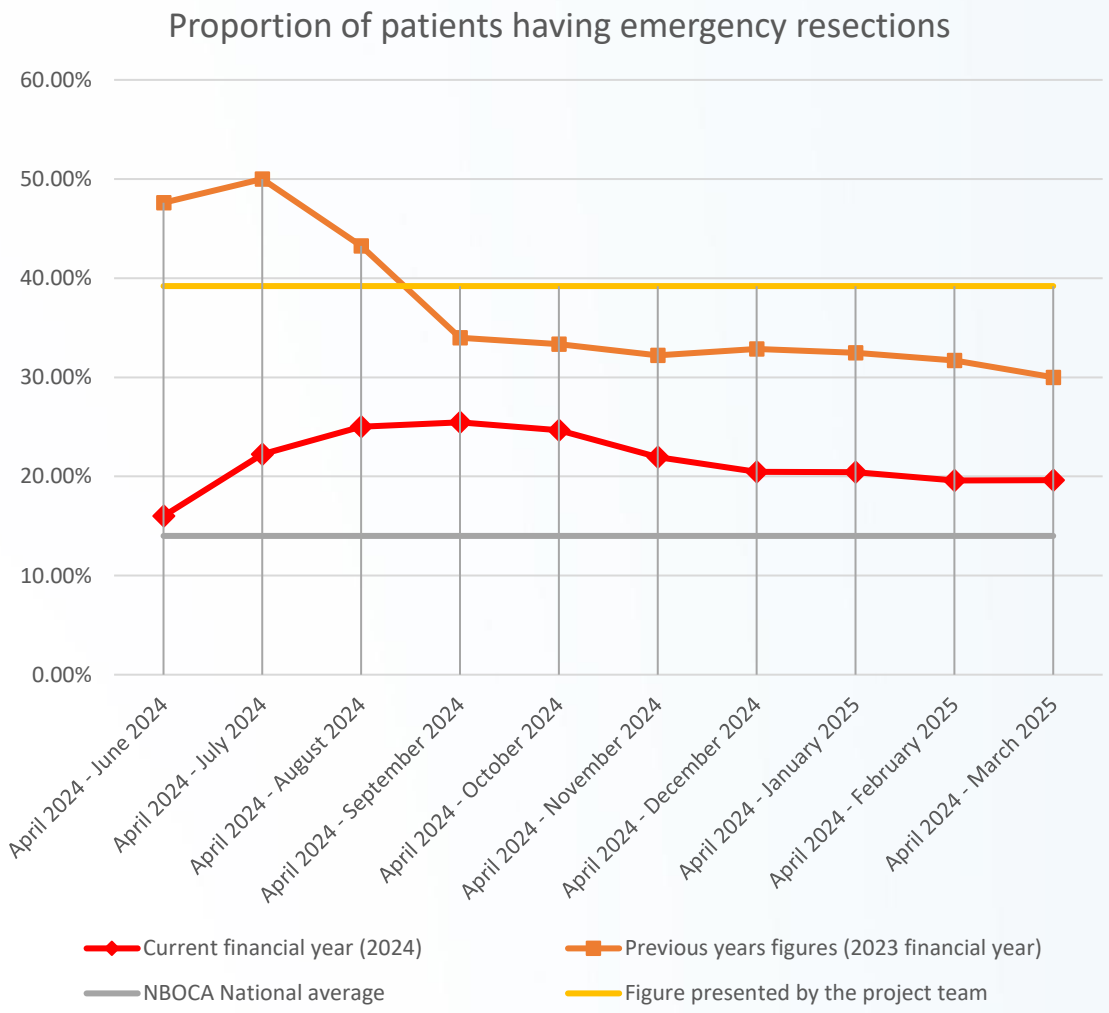

Proportion of patients having emergency Major resection

Walsall Healthcare NHS Trust

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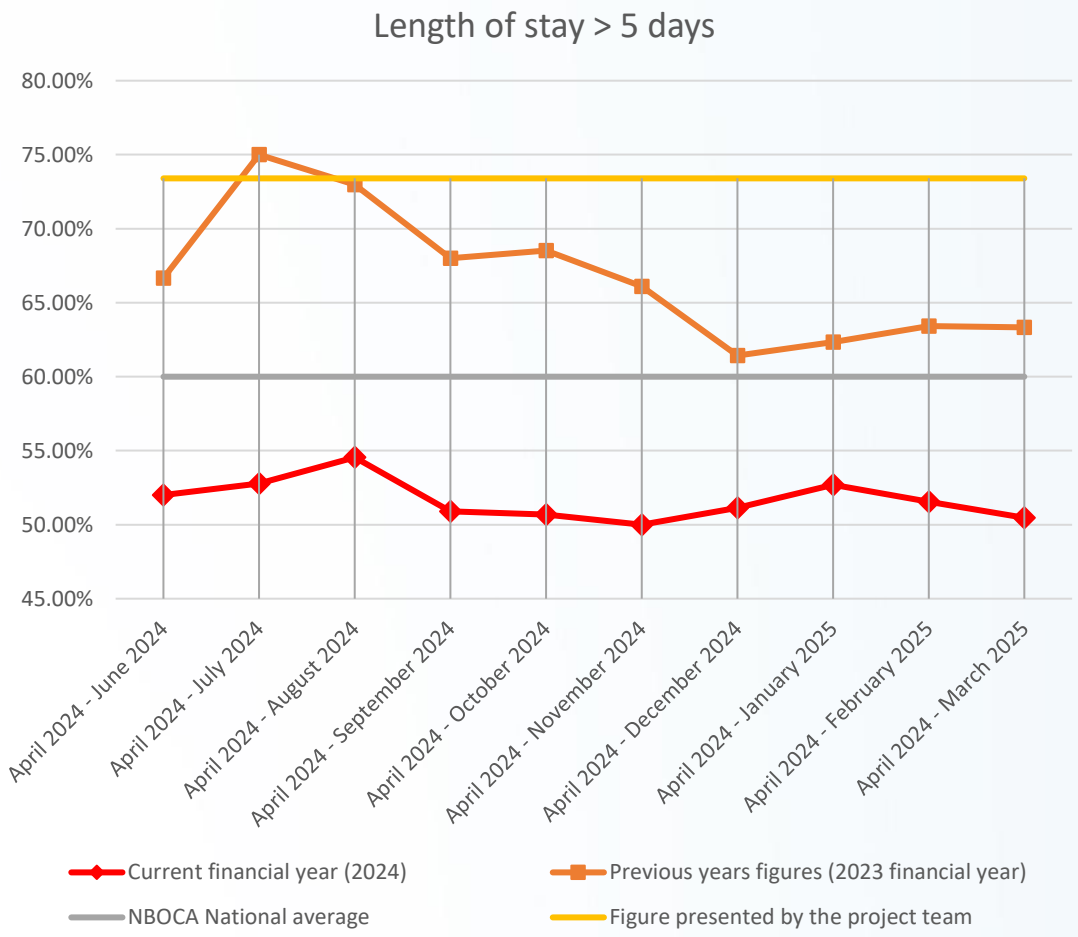

Length of stay > 5 days

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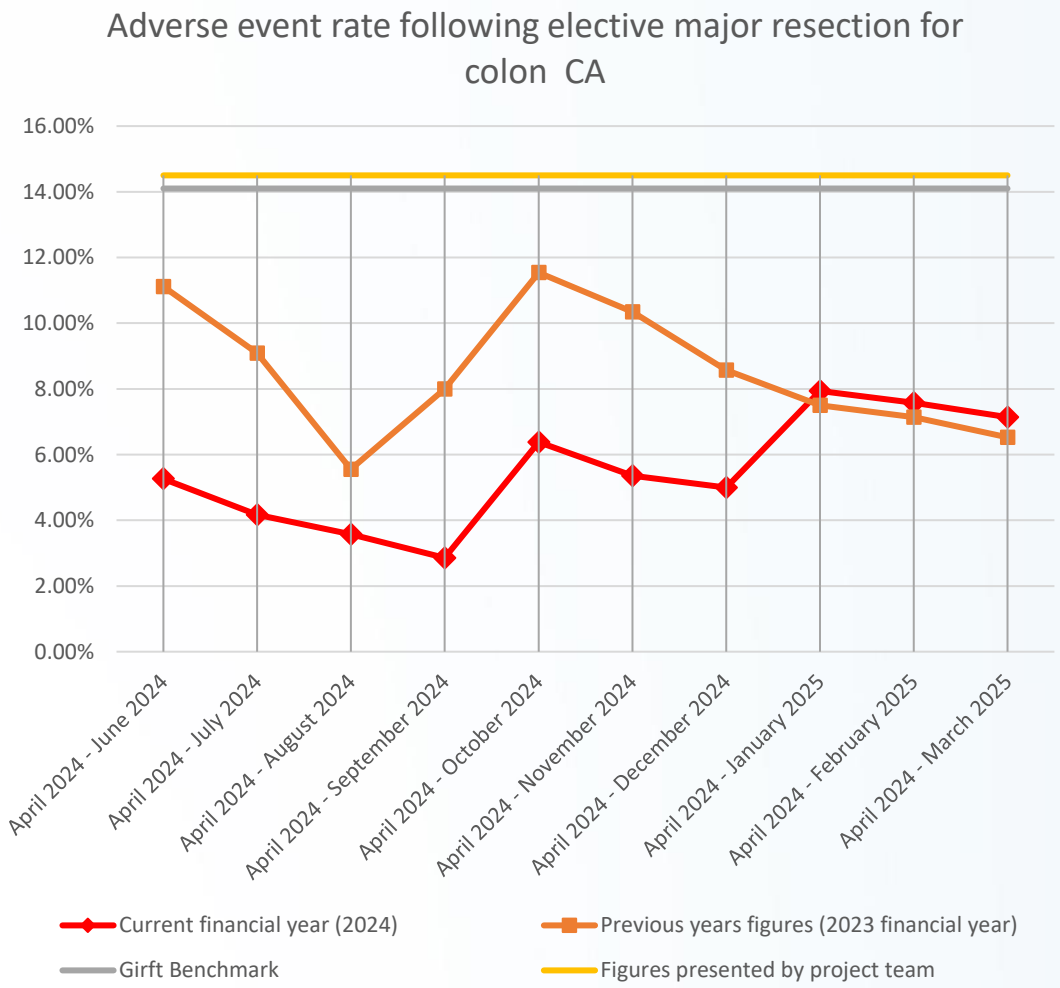

Adverse events (colon)

Walsall Healthcare NHS Trust

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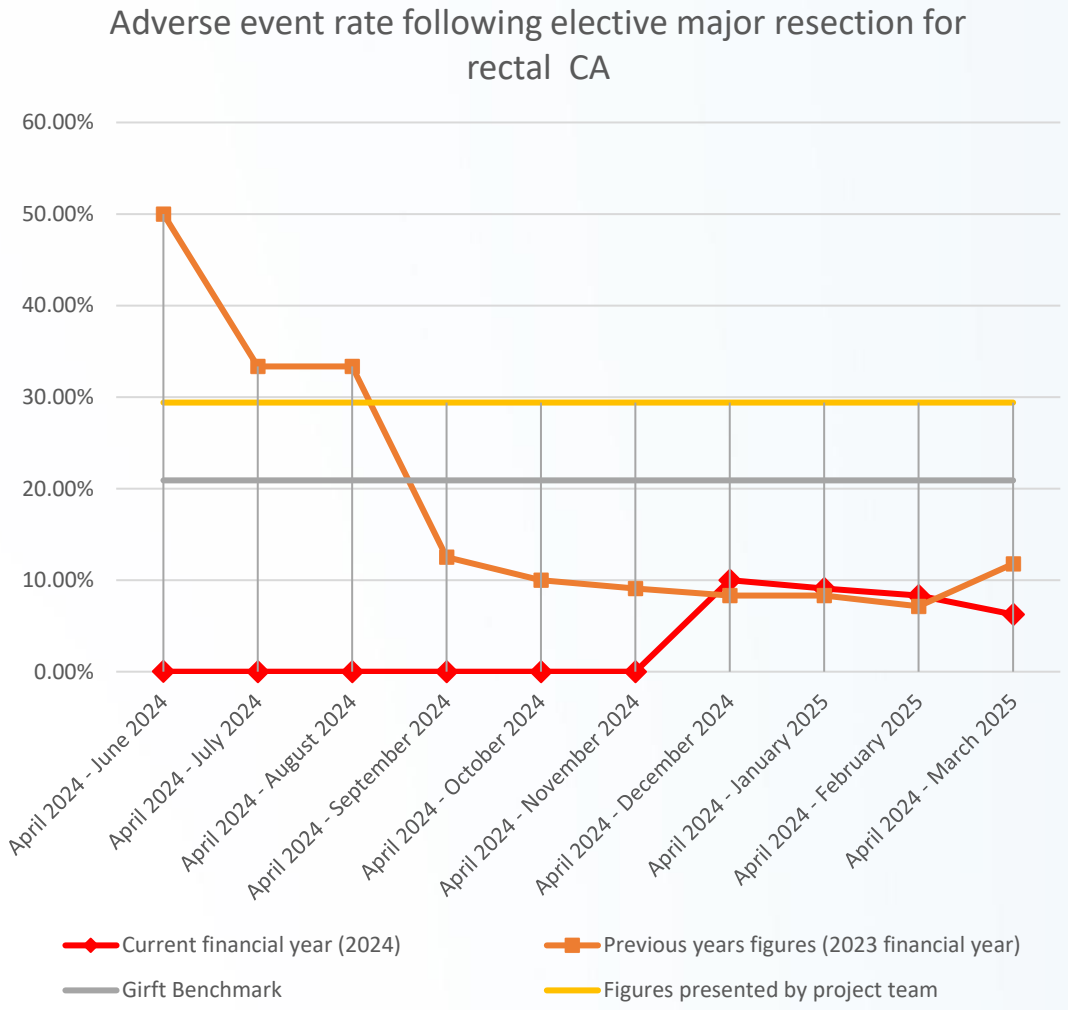

Adverse events (rectum)

Walsall Healthcare NHS Trust

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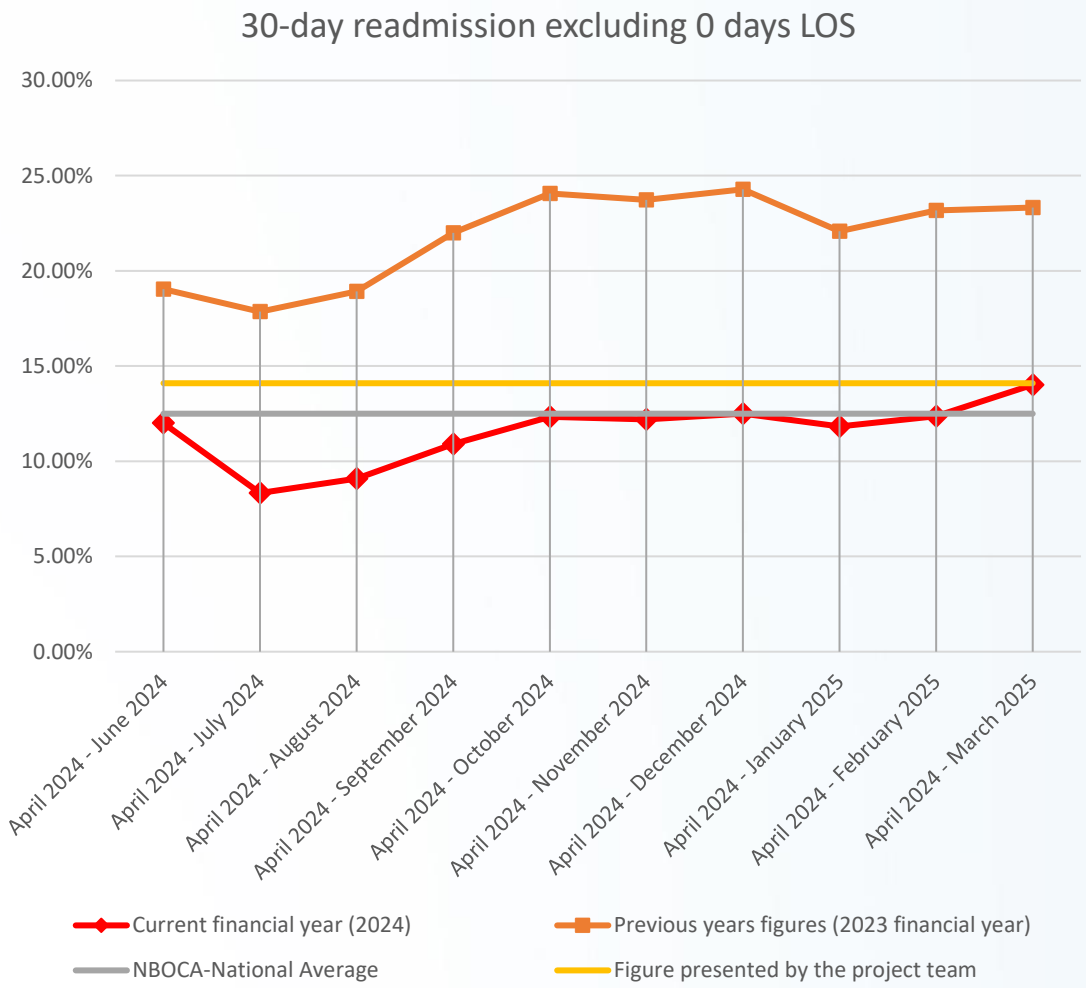

30-day readmission rate (excluding 0 day)

Walsall Healthcare NHS Trust

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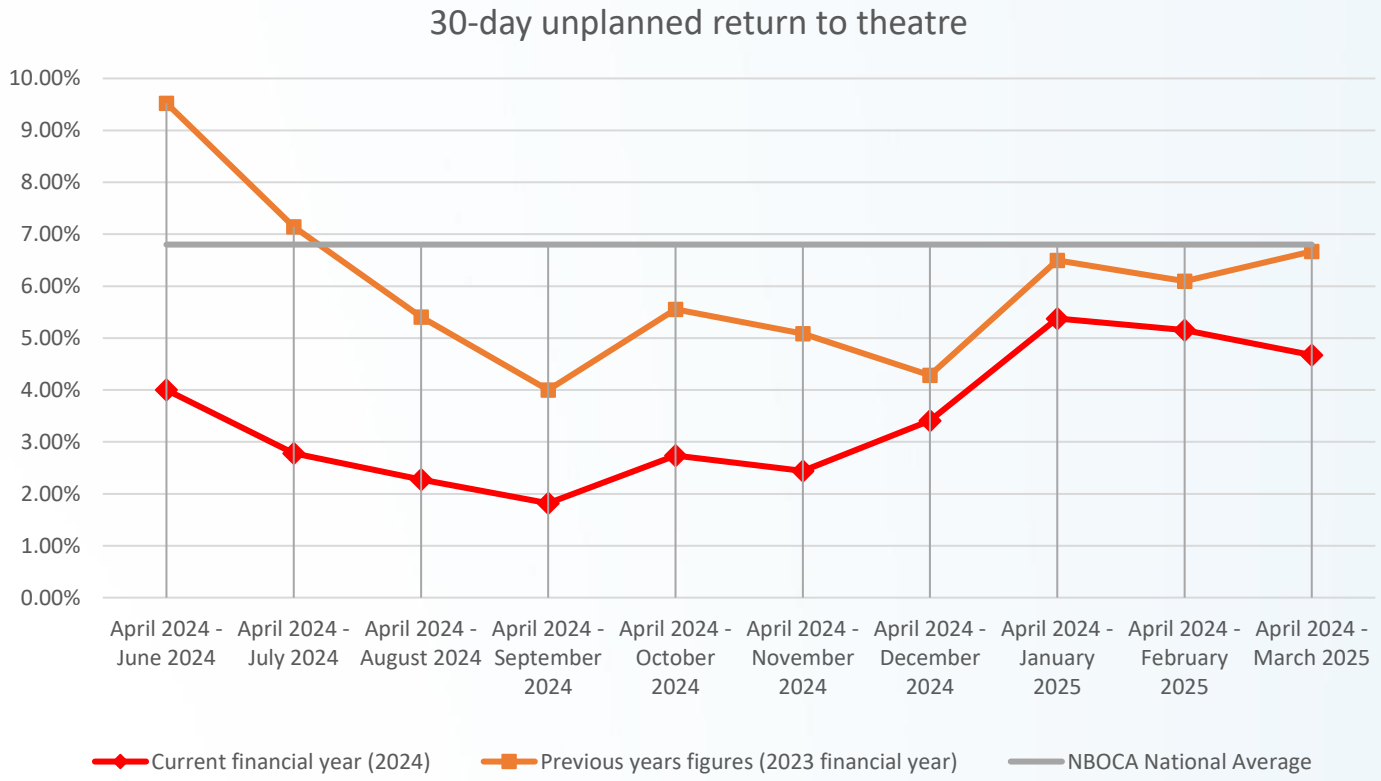

30-day return to theatre

Walsall Healthcare NHS Trust

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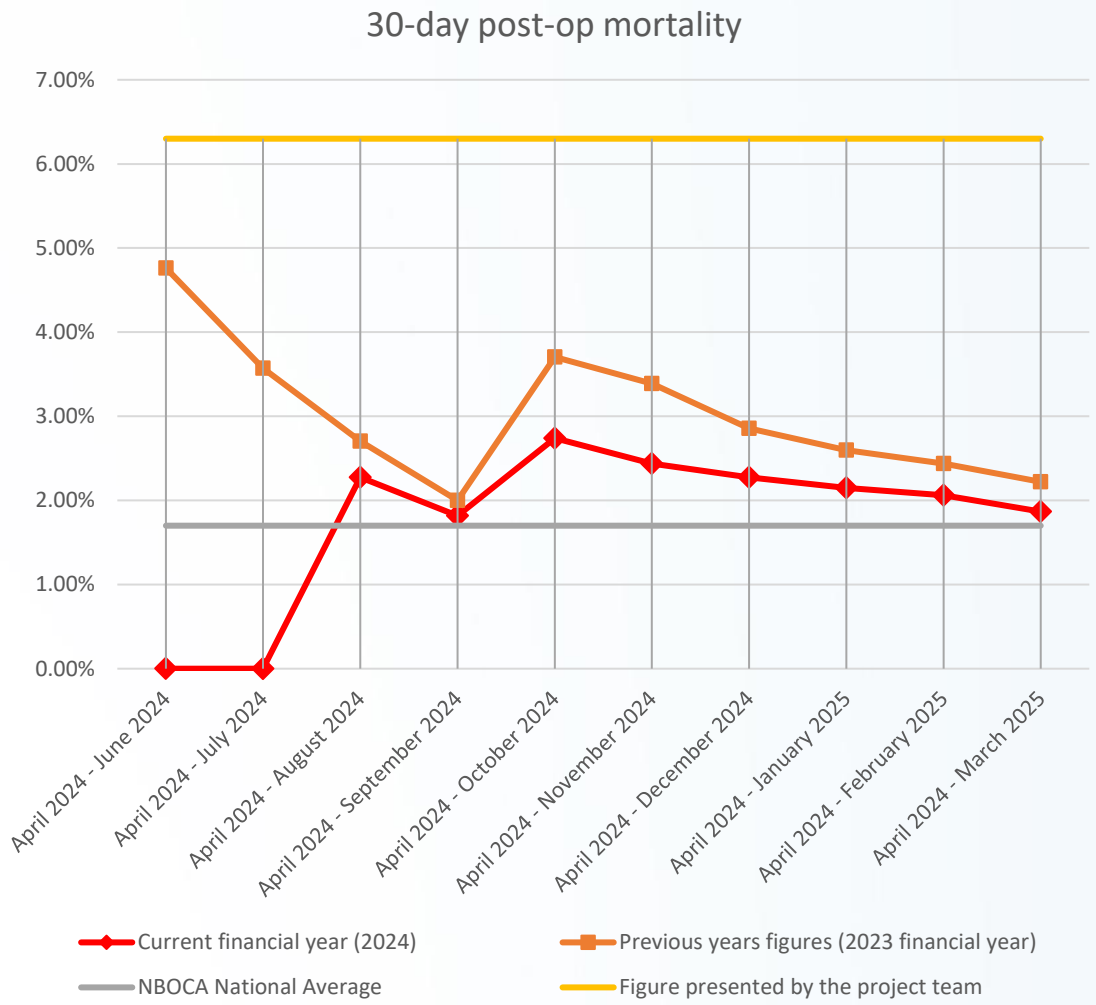

30 days mortality

Walsall Healthcare NHS Trust

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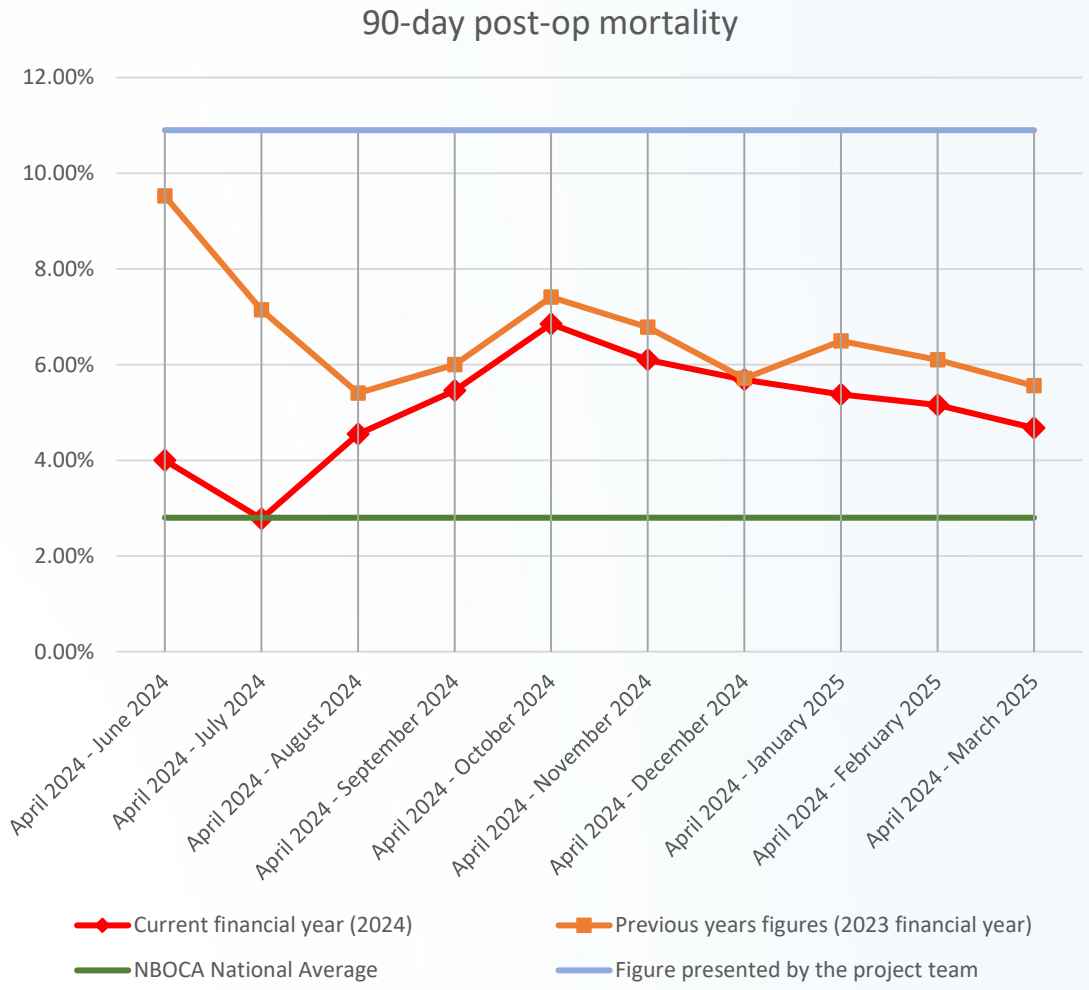

90 days mortality

Walsall Healthcare NHS Trust

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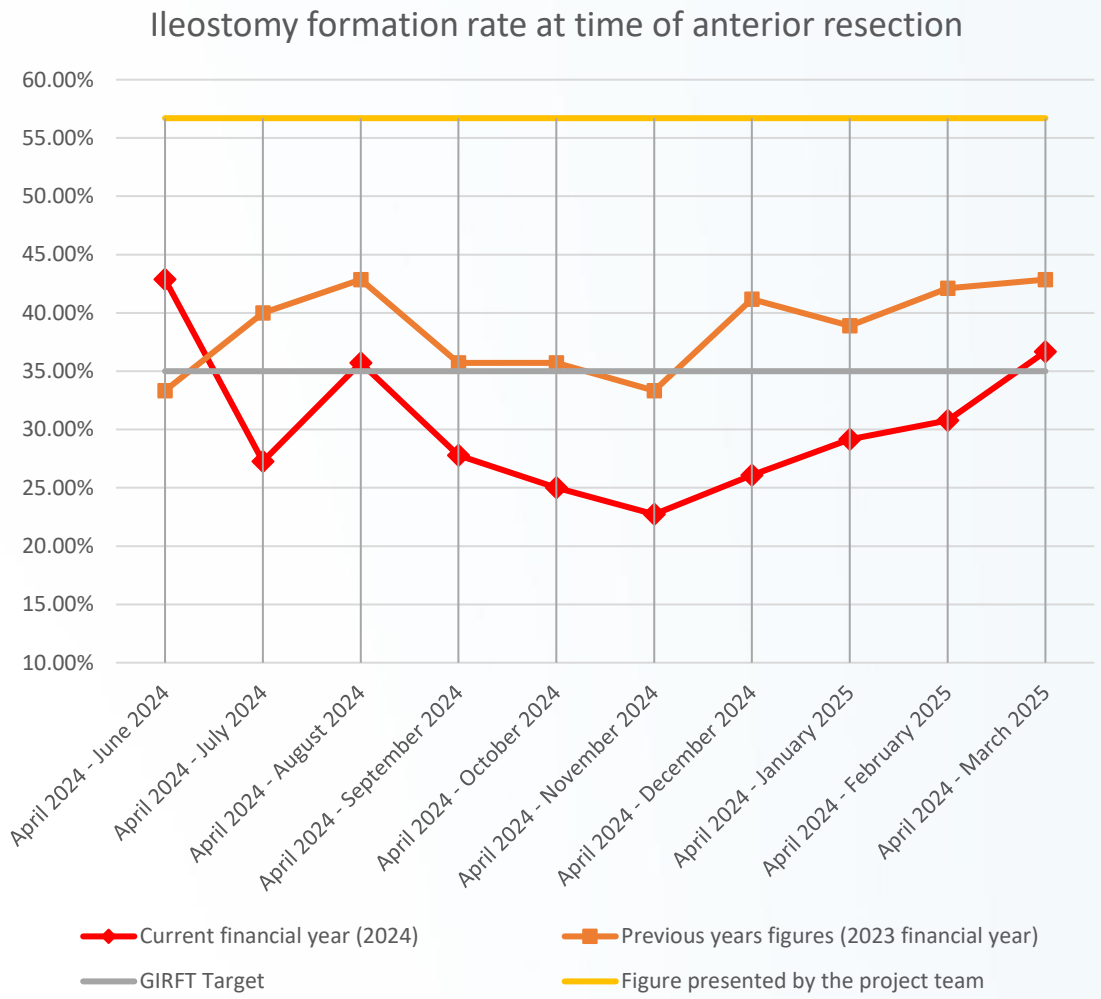

Ileostomy formation rate at time of anterior resection

Walsall Healthcare NHS Trust

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Demographics and Risk Factors

Of the 24 patients who died, 20 (83%) were over 70 years old, and 15 (62.5%) were over 80 years old.

15 surgeries (62.5%) were emergency procedures, with the remaining 9 (37.5%) being elective.

Most patients 21/24, 87.5%) were classified as ASA III or above, with 9 (37.5%) classified as ASA IV or above.

9/24 (37.5%) ASA IV patients underwent surgery (six emergency and three elective).

Walsall Healthcare NHS Trust

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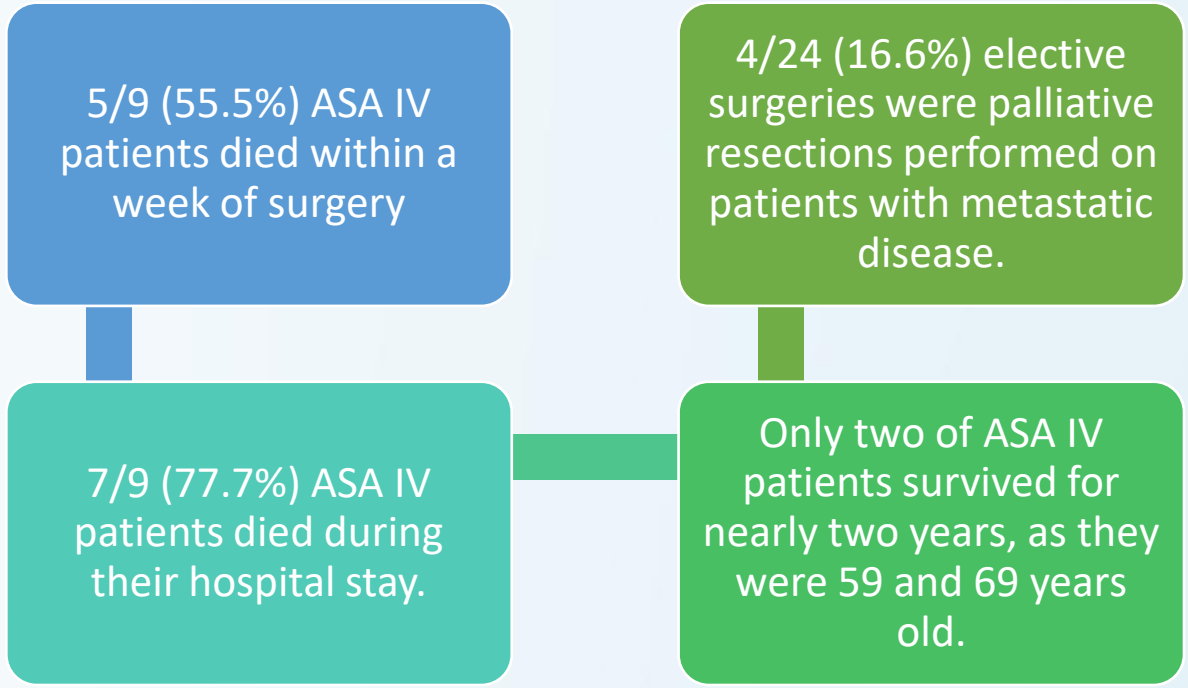
Demographics and Risk Factors



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Challenges Identified

01

A significant proportion (62%) of the colorectal cancer population presented as ASA III or above, reflecting the complexity of managing these high-risk patients.

02

Social deprivation is a key factor in Walsall, with a high index level impacting healthcare outcomes.

03

Over 35% of colorectal cancer patients presented as emergencies (e.g., obstruction or perforation), contributing to poor short- and long-term outcomes.

04

No/limited access to bowel stenting

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Acknowledged Issues

We recognise that some poor outcomes were influenced by clinical decision-making.

Specifically:

- A higher number of resections were performed on palliative patients.
- Major surgeries were sometimes undertaken instead of less invasive palliative approaches to improve comfort.
- Bowel cancer screening patients were taken away from us, but did not get them back.

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Patients' source

1. Emergency Presentation >1/3rd
2. Elective pathway <2/3rd
   a. GP referrals (Standardization of 2WW referral pathway)
   b. Bowel cancer screening-Got possibly half of Walsall patients back

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Community / GP engagement

Community Engagement and Early Diagnosis:

Strengthened collaboration with GPs to streamline referrals.

Public awareness campaigns to promote recognition of bowel habit changes and increase participation in bowel cancer screening programs.

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Public campaign on raising cancer awareness- Team

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Prehabilitation

Fit patients → Exercise / Physio

Less fit→ Community nurse

Palliative

Mechanical/Chemical bowel prep

Role of Geriatric

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Intraoperative

Standardised anaesthesia

Spinal
Physiological optimization
Goal-directed therapy
Use of Edwards
Adequate analgesia

Dedicated colorectal anaesthetists

Two surgeons operating

Nurses training

Post operative

COLORECTAL CONSULTANT WARD ROUND (EVERY DAY)

COLORECTAL GRAND ROUND (FRIDAYS) **CHEST PHYSIO/ MOBILISATION/ ERAS IMPLEMENTATION**

THEATRE STAFF EDUCATION

TEAM ENGAGEMENT /CULTURE

MEDICAL INPUT FOR GENERAL SURGICAL PATIENTS

DEDICATED ENHANCED LEVEL CARE (LEVEL 1+)

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QIPS monitoring colorectal improvement project

Consultant ward round in colorectal patients

Medical consultant input in general surgical patients

Standardised colorectal anaesthetist audit

Two surgeons operating for complex colorectal cases

Perioperative care audit

Standardised ward - round for general surgery project

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Targets needing more attention

Community engagement

Dedicated enhanced level care (Level 1+)

Two surgeons operating

Nurses training in theatre

Medical input for surgical patients

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Emergency presentation

DECISION MAKING

OPERATING ON PALLIATIVE PATIENTS

PREDICTIVE SCORING SYSTEMS

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QIPS monitoring colorectal improvement project

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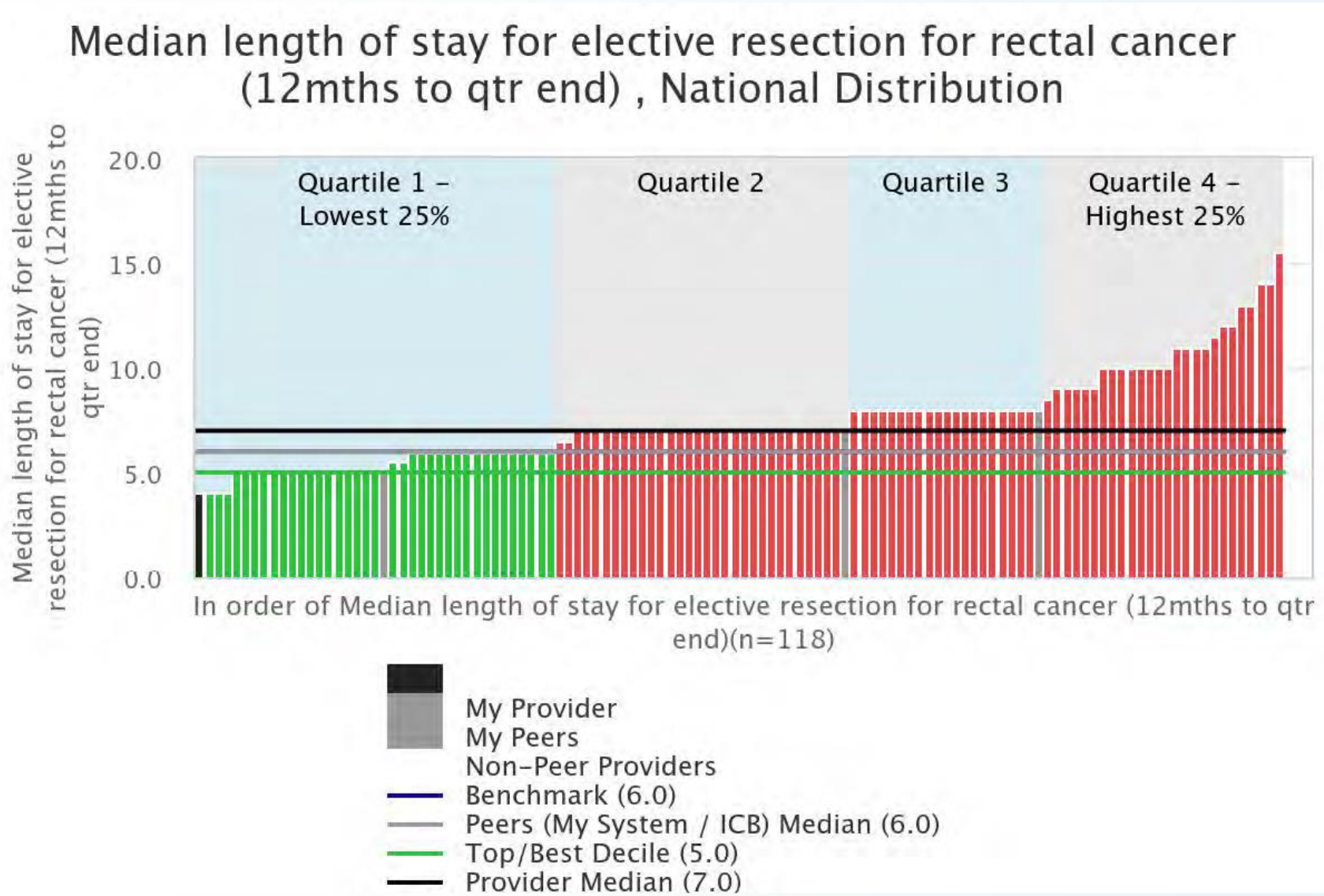
Median length of stay for elective resection for rectal cancer (12mths to qtr end) , National Distribution



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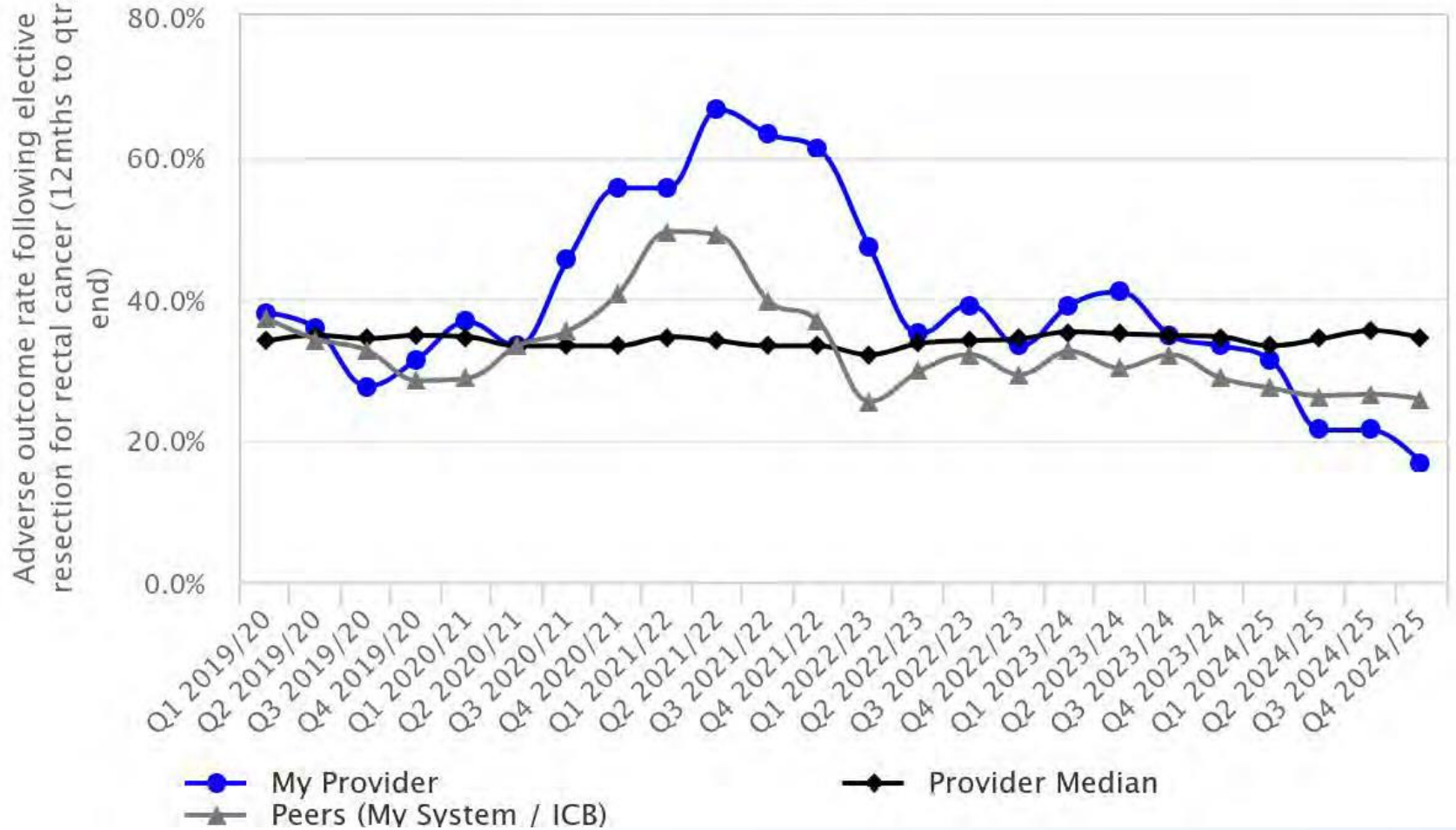
Adverse outcome rate following elective resection for rectal cancer (12mths to qtr end)



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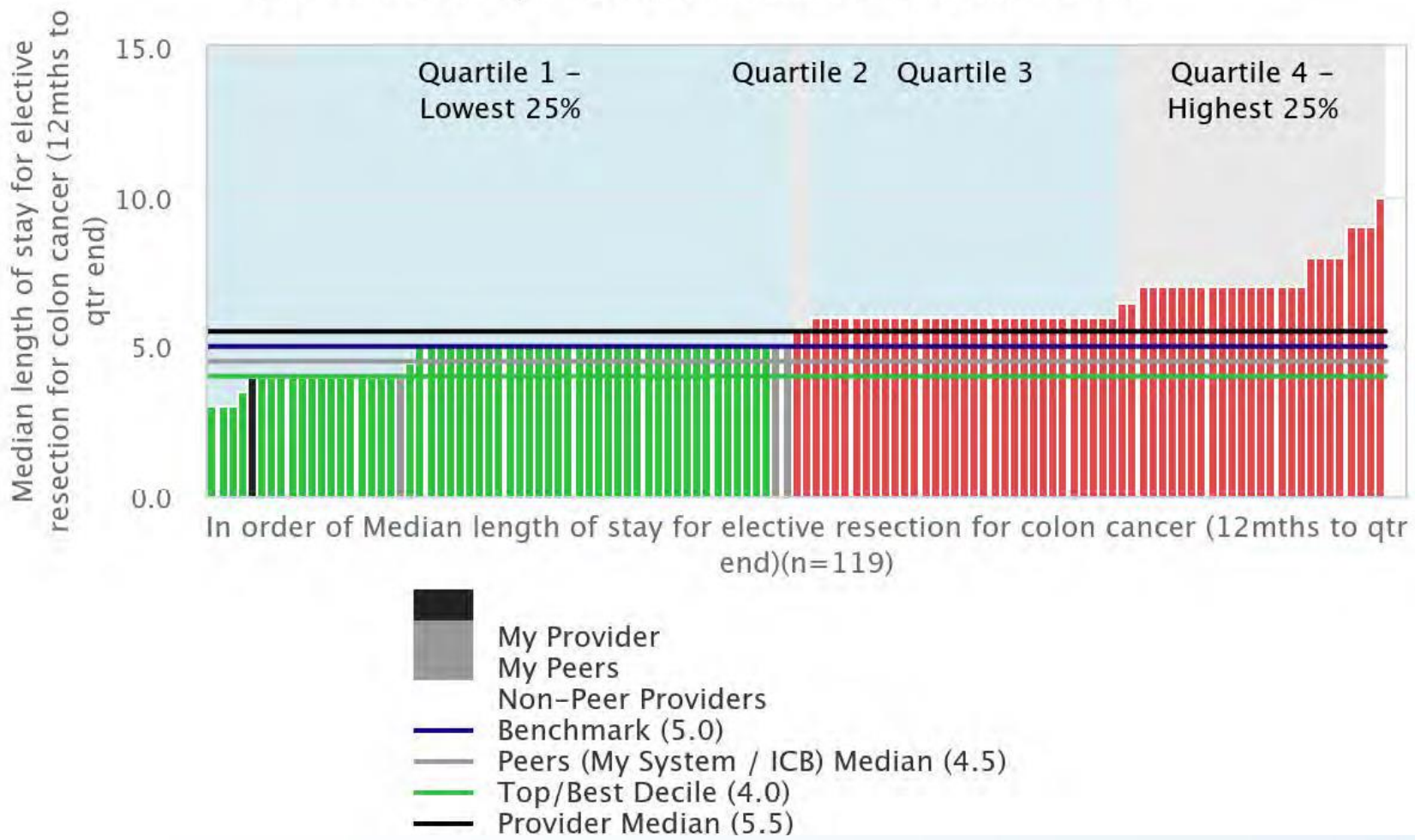

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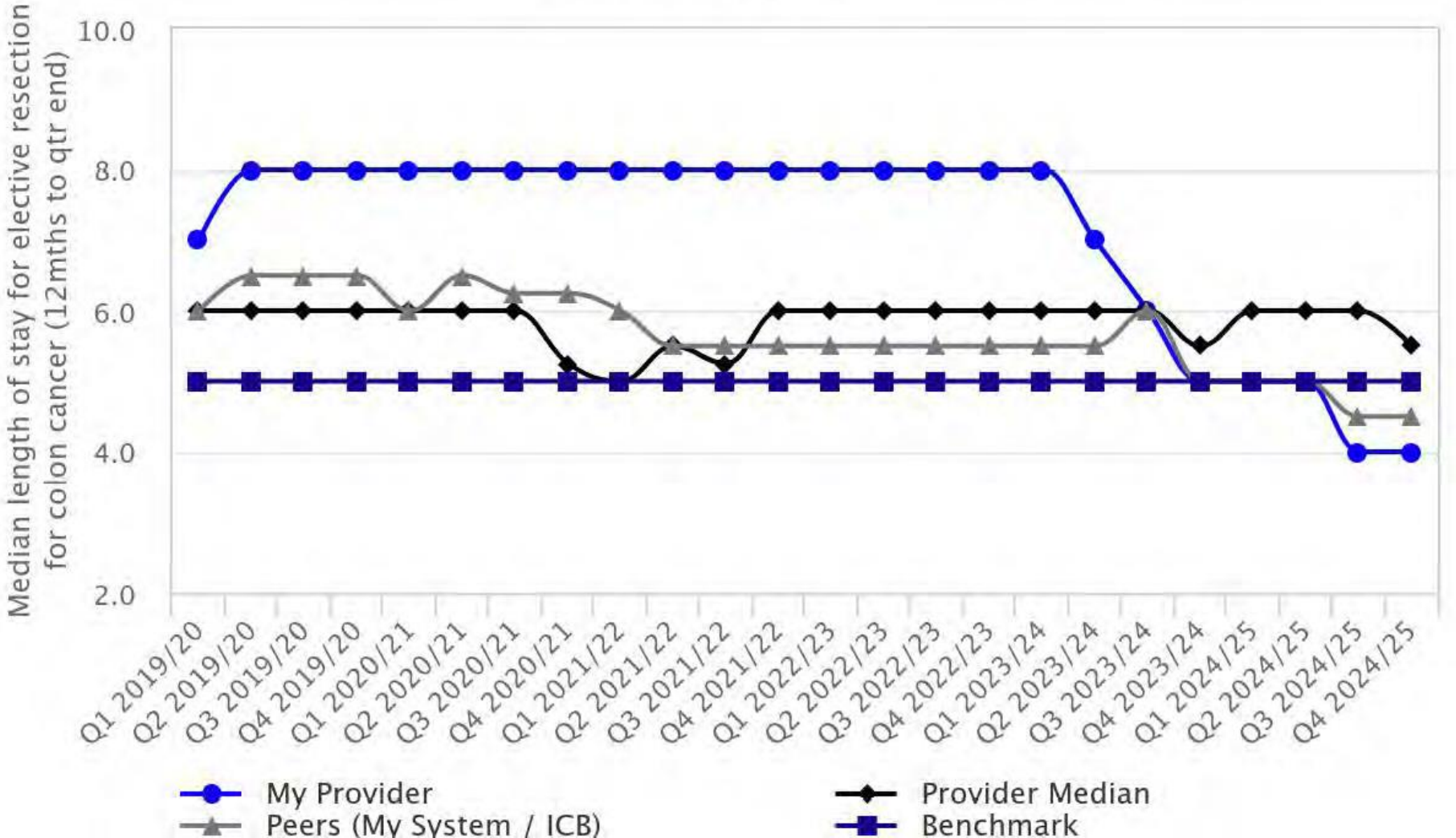

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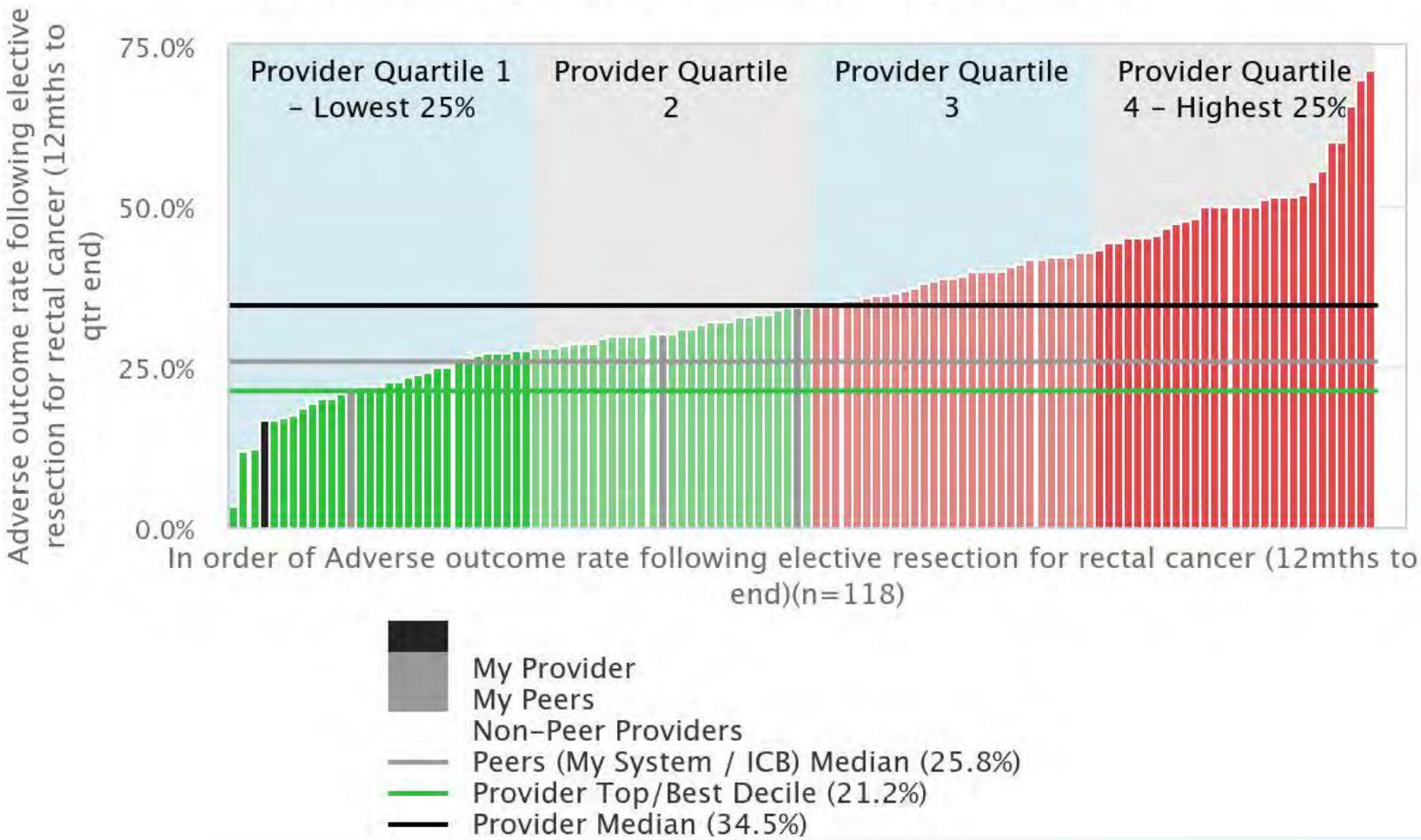

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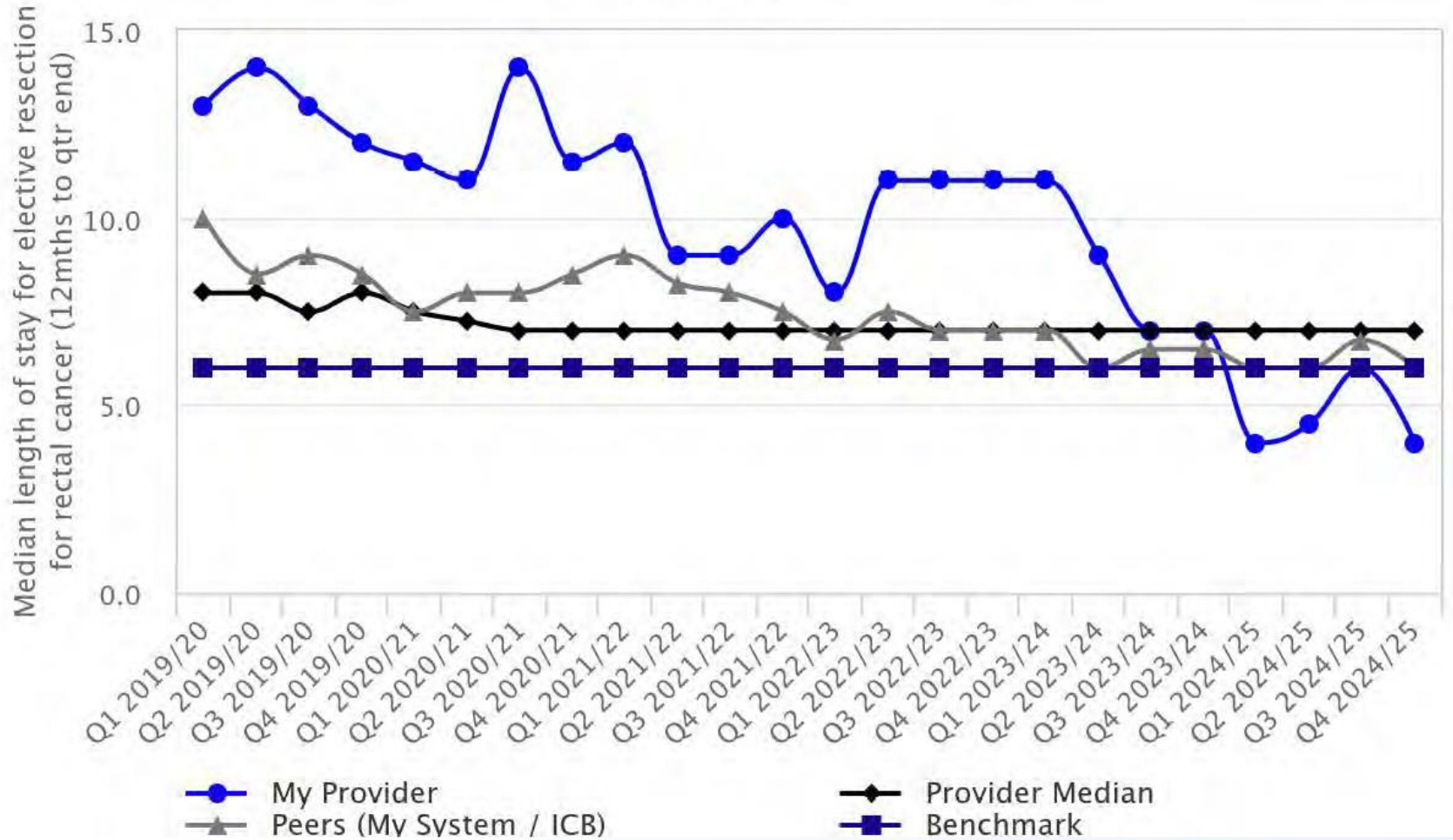

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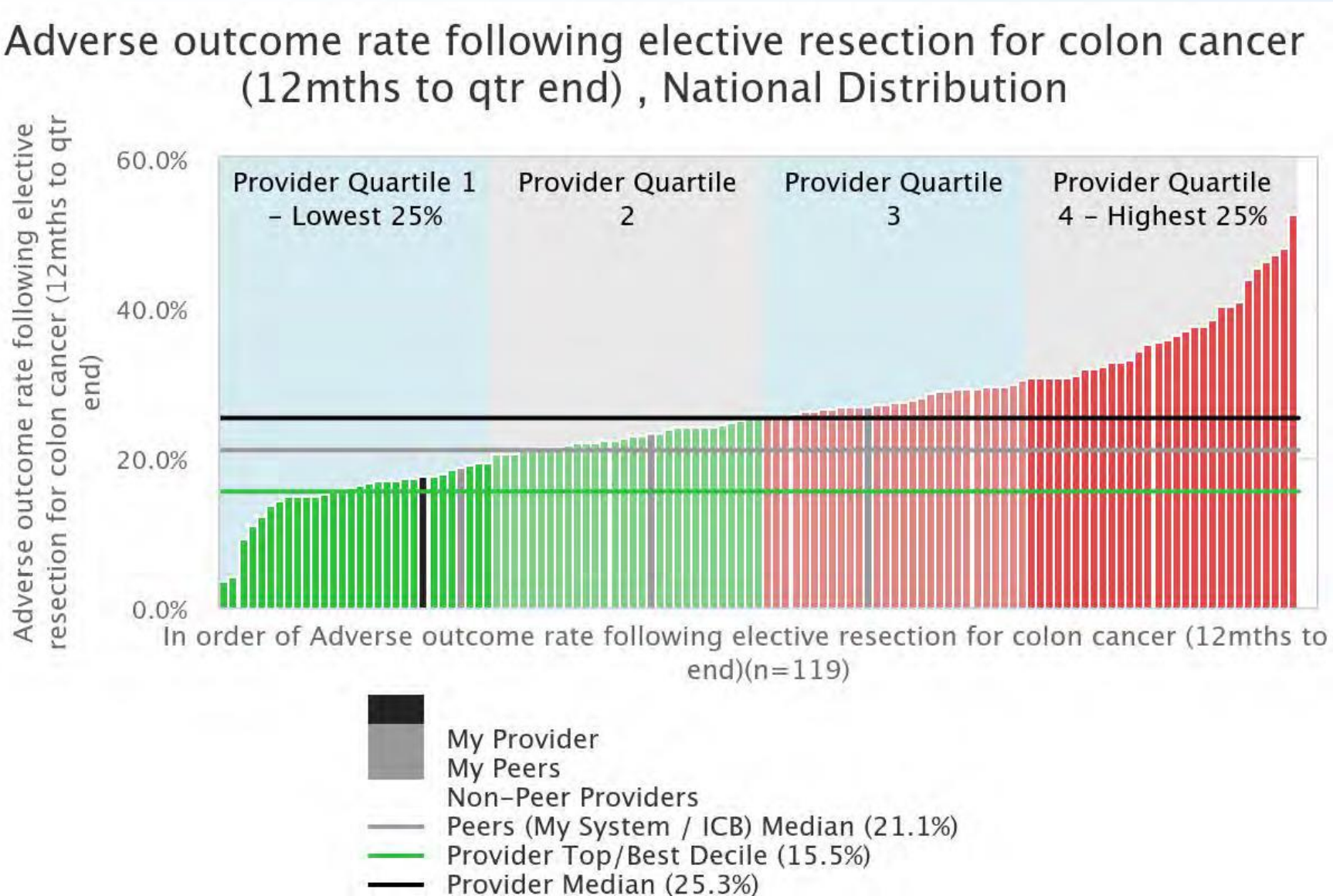

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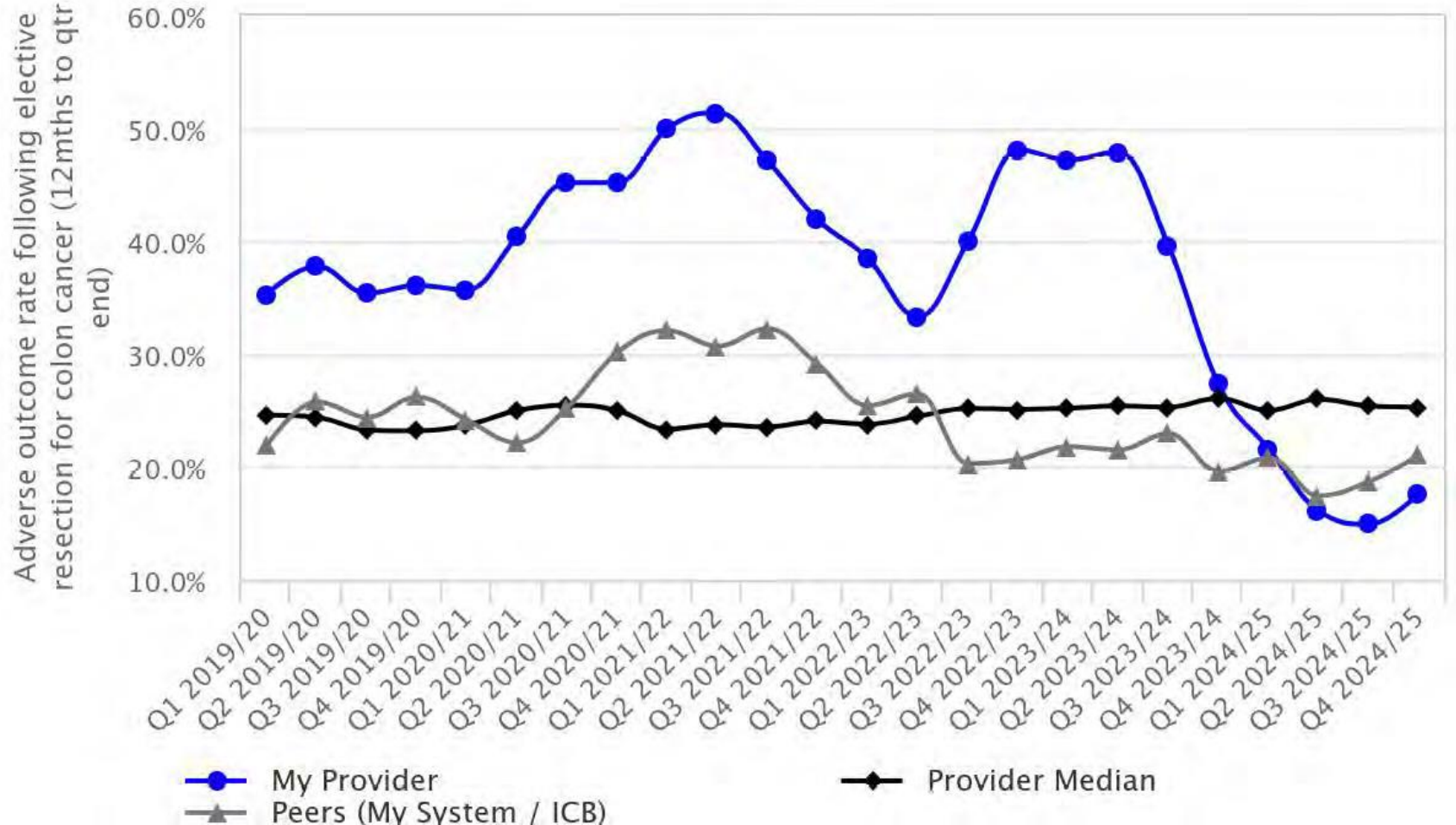

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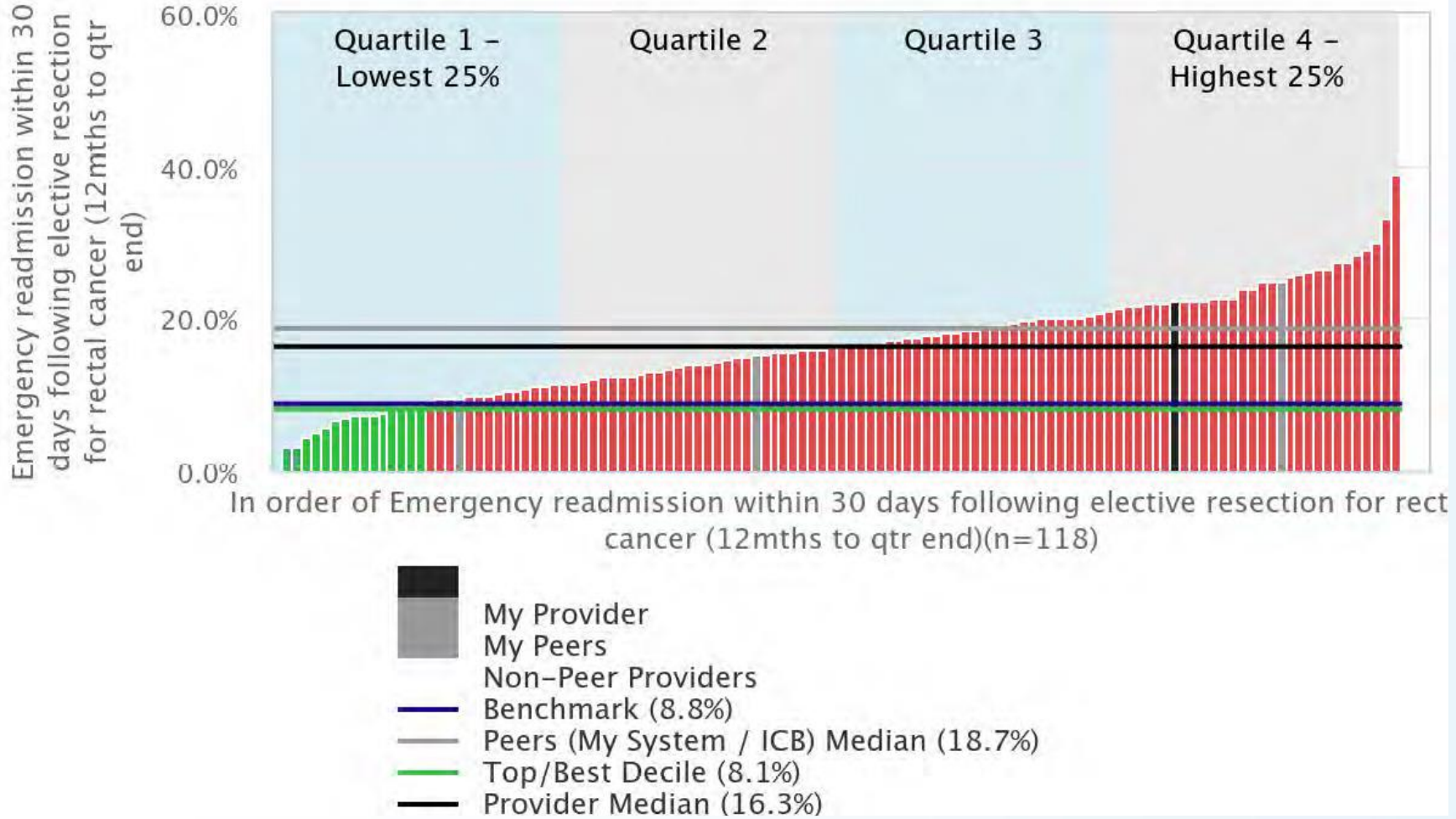
Emergency readmission within 30 days following elective resection for rectal cancer (12mths to qtr end) , National Distribution



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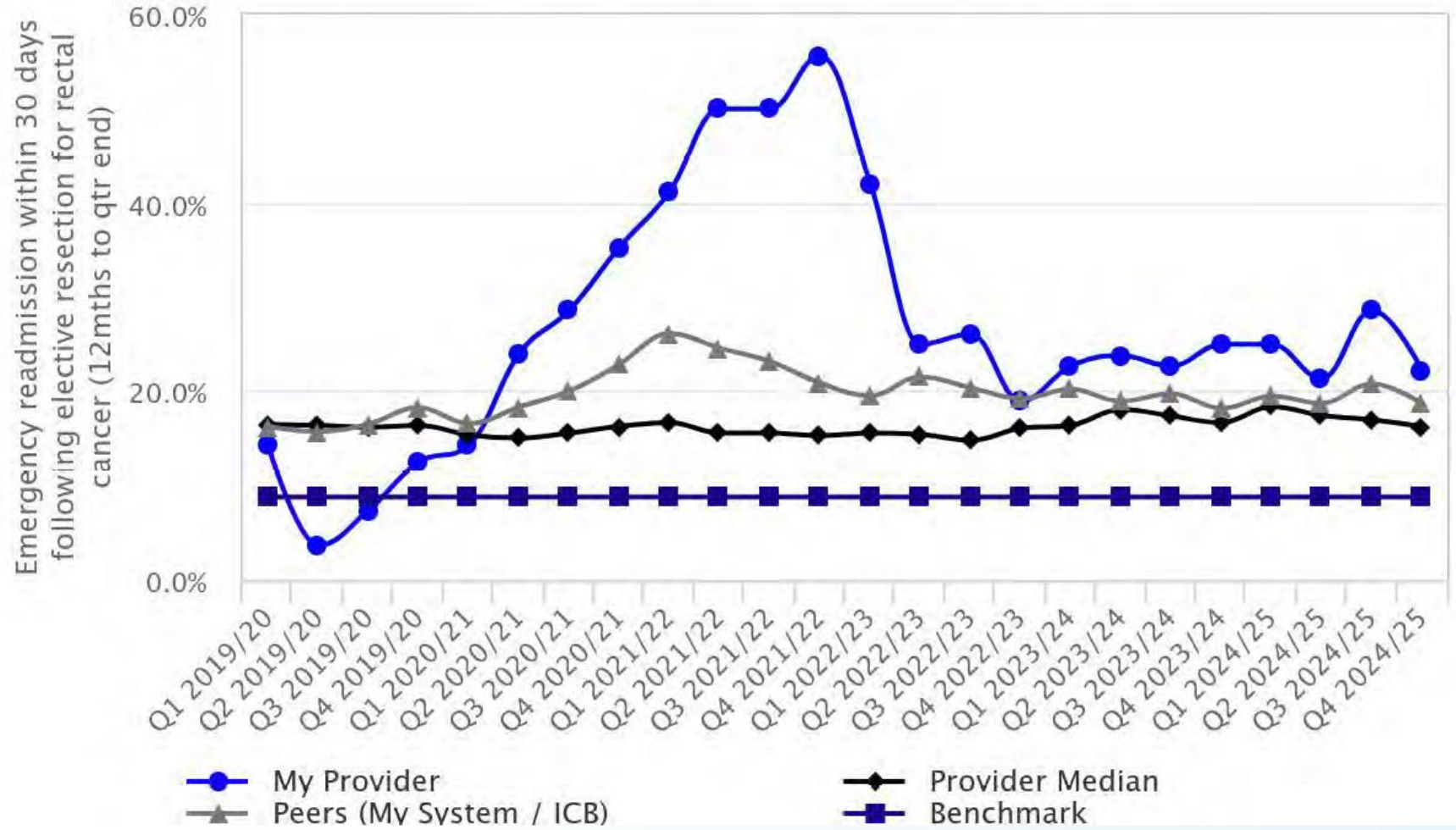

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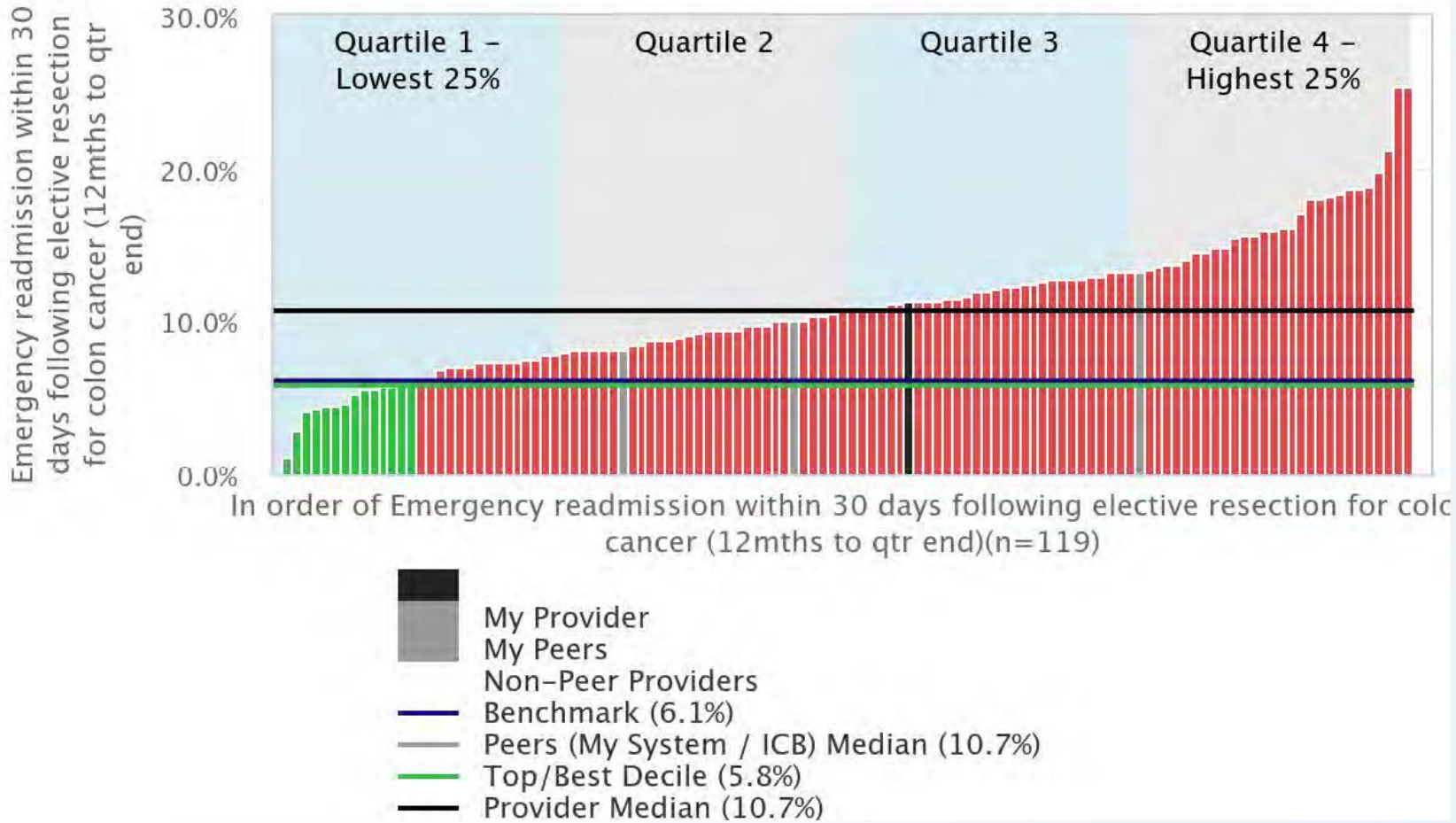

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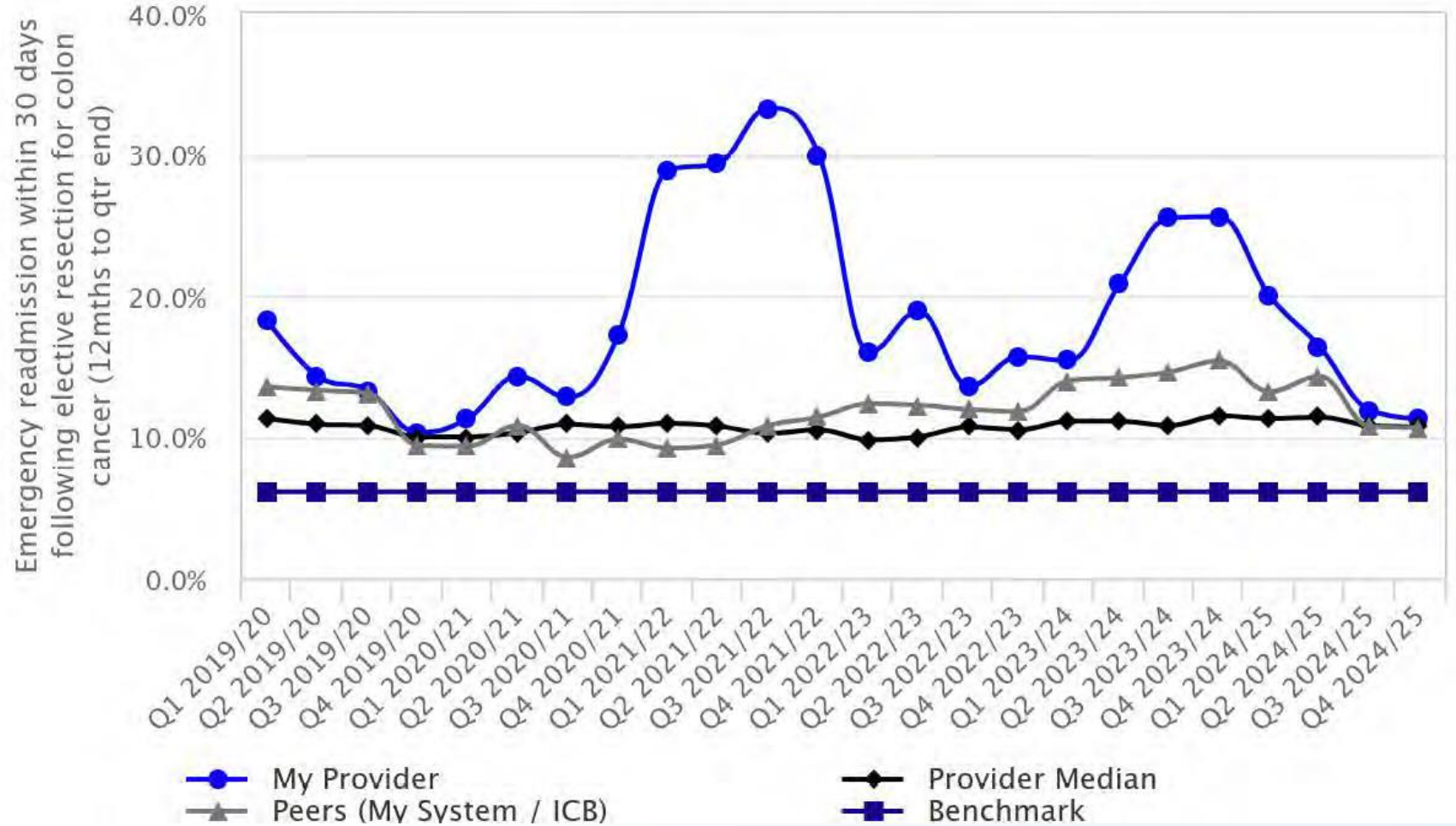

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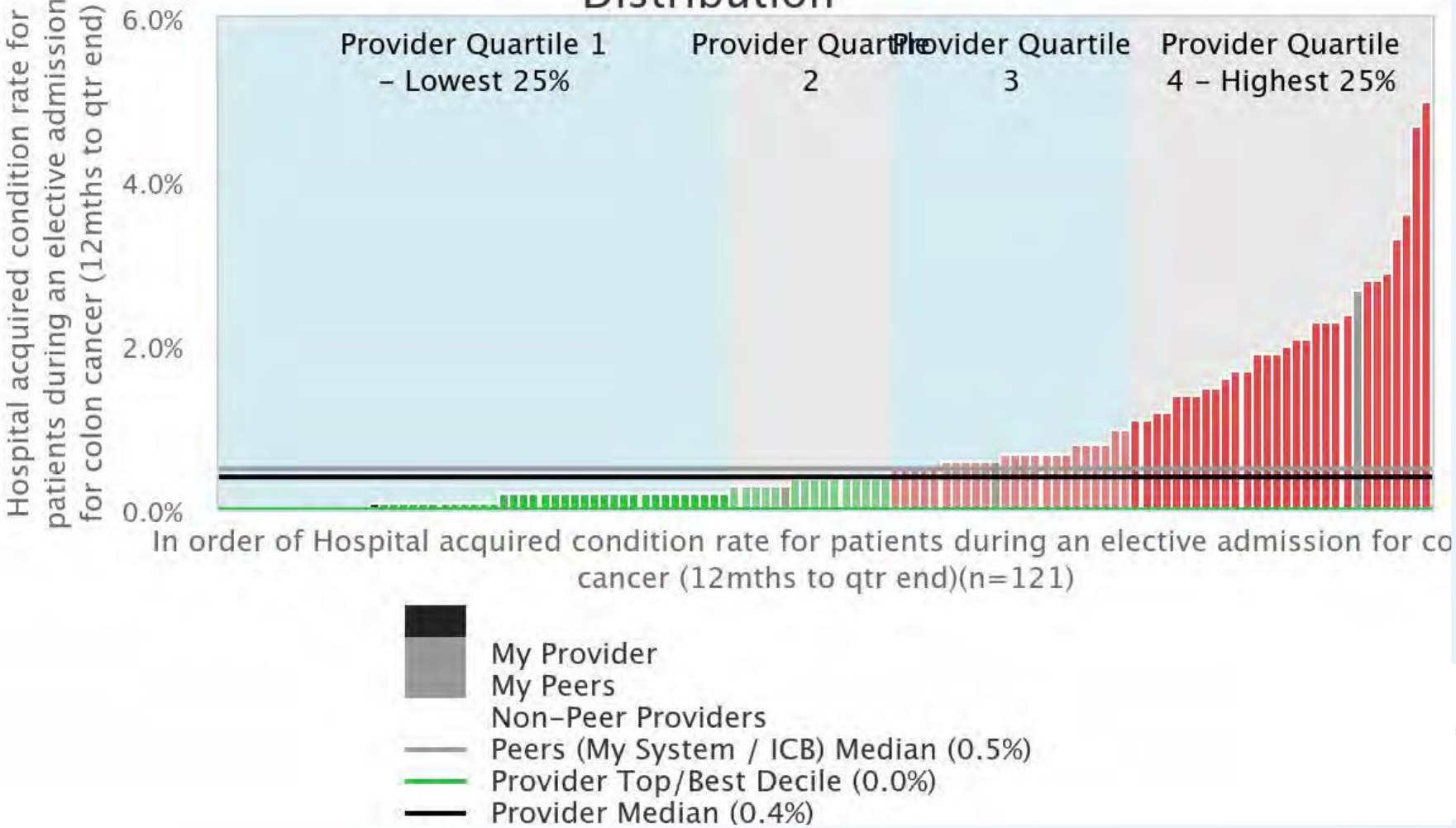
Hospital acquired condition rate for patients during an elective admission for colon cancer (12mths to qtr end) , National Distribution



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Gynaecology

Rebuilding Stronger: GIRFT Insights and Future Pathways

BCPC Clinical Council Progress Update

Dr. Ayman Ewies

BCPC Clinical lead, Consultant Gynaecologist

Working in partnership

Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

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GIRFT Provider Visits – System Summary

- All four Trusts (DGFT, SWBH, WHT, RWT) completed GIRFT on-site reviews (June–August 2025).
- Network received individual feedback letters and a consolidated summary highlighting system-wide themes.

Strengths & Exemplary Practice:

- DGFT & WHT established day case hysterectomy & achieved short length of stay.
- SWBH is maintaining high ambulatory rates (89%) and robust gynae-oncology provision.
- RWT maintains high patient experience standards through adaptable service delivery despite workforce pressures.
- All sites engaged in productive theatre utilisation and pooled-list working.

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GIRFT Provider Visits – System Summary

Challenges / Opportunities:

- Coding accuracy and data alignment (Model Hospital vs local audits).
- Variable theatre utilisation (55–85%) and recovery setup differences.
- Workforce fragility in radiology, gynaecological oncology and endometriosis services.
- Need for consistent criteria-led discharge and day-case pathways.

Next Step:

- Addressing cross-cutting themes within the network.

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GIRFT Provider Visits – System Summary

Theme	DGFT	WHT	SWBH	RWT	System Opportunity
Leadership & Culture	Highly collaborative, stable triumvirate	Excellent MDT culture, high morale	Dynamic, rebuilding after site move	Passionate team under pressure	Leverage strong local leadership to embed shared GIRFT delivery model
Minimal-Access Surgery / LoS	Exemplar LoS ≤ 2 days; skill mix limited (4 lap surgeons)	High MA rate > 70%; LoS ≈ 1 day	39% TLH; Workforce Review	MA ≈ 49%; LoS 2.0–2.2 days	Expand laparoscopic training Workforce Review
Endometriosis	Staffing loss – risk to accreditation	Affiliated to RWT	Accredited Centre	Accredit Centre	System review of sustainable BCES model
Theatre Productivity	82–84% utilisation; pooled lists	92% utilisation; exemplary pooled-list protocol	74–85%; data variation	71–85%; scope to improve TTO & discharge	System theatre productivity benchmarking and sharing of DGFT/WHT models
Outpatients / DNAs / PIFU	DNA 6.4%, PIFU 3%; room to improve	DNA 8.6%, PIFU 7–9%	DNA high; implementing 2-way comms	DNA 7–8%, PIFU 2%	System-wide Outpatient Transformation & unified referral guidance
Cancer & Hysteroscopy	74% OP hysteroscopy; CDC bid approved	80% OP rate; Entonox use expanding	89% OP rate, Centre of Excellence, 1-stop clinic model	Level 2 centre; 1-stop clinic model	Align cancer pathways and hysteroscopy standards across network
Workforce	Lacks dedicated gynae radiologist	Stable workforce, robot BC underway	Shortage of laparoscopic surgeons	Consultant vacancies + reduced capacity	Workforce planning across BCPC

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Black Country Endometriosis Service (BCES)

Currently:

- Updated Service Specification (Feb 2025) endorsed and operational across the four-site model (3 Centres and 1 Unit).

Challenges:

- Detailed data analysis completed – variation in waits, access, and MDT consistency.
- Radiology issue at Dudley.
- Consultant Workforce Issues (One main consultant per centre)

Black Country Endometriosis Service (BCES)

Celebration:

- Network-wide agreement that service redesign is required to ensure sustainability under forthcoming BSGE standards (2026–27).
- A Comprehensive Discussion Paper for service development has been circulated for consultation.

Next step:

- Collate consultation feedback and prepare an Executive summary paper outlining potential future configurations.

Complex Vulval Services

Challenges:

- Service & Leadership gap following the departure of the service lead.
- MDT Coordinator post proposed and included within BCPC funding considerations.

Celebration:

- Multi-site collaboration and service alignment started (unfortunately, now on hold)
- Patient information leaflets finalised, aligned to national guidelines.

Next step:

- Replace the vacant post in Pan Birmingham Cancer Centre (difficult at the moment).
- Confirm interim clinical leadership and progress MDT Coordinator funding case for approval.

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Sandwell Hub Development

Celebrating Progress

- Major milestone in the establishment of the South Black Country Elective Surgical Hub, located at Sandwell Health Campus.
- Gynaecology confirmed as one of the core day-case specialities, alongside General Surgery and Orthopaedics.
- Strong collaboration between SWBH, DGFT, and BCPC teams – joint business case submitted and supported at system level.

Next Step

- The capital allocation bid submitted to NHS England is under national review.
- Once approved, procurement of theatre equipment and instrumentation will begin + estates refurbishment

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Sandwell Hub Development

- Proposed deadline: by end of 2025/26 financial year.
- Phase 1 of implementation: moving SWBH Gynaecology day-case activity to Sandwell theatres.

Challenges

- Capital approval timelines, national review and procurement lead times may impact start dates.
- Ongoing workforce and capacity planning to support transfer of activity into the hub.

Future Aspirations

- Use hub development to boost HVLC productivity and theatre utilisation + standardised pathways across south.

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Overall Summary

Celebrations:

- Completion of GIRFT visits across all providers.
- Strong partnership working and clinical engagement.
- Endometriosis service is ready for Executive review.
- Sandwell Hub progress marks a major strategic step forward.

Challenges:

- Workforce fragility in endometriosis & laparoscopic surgery, radiology gaps, gynaecological oncology, vulva services.
- Variable day-case efficiency and data reconciliation.

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Overall Summary

Next Steps:

- Present System GIRFT Action Plan.
- Agree on the best model for endometriosis service which is safe and productive.
- Continue Hub implementation and align 2025/26 priorities to delivery phase.

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Questions

- How should we respond to the **forthcoming BSGE accreditation standards** (2026–27)?
- What model will ensure resilience in the Endometriosis and Vulval services long term?
- How can the new Sandwell Elective Hub best support high-volume, low-complexity gynaecology?