Black Country Provider Collaborative

NHS

BCPC Clinical Summit

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

West Bromwich Albion Football Club

WIFI

Network: *TBC*

Password *TBC*

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Welcome & Introductions

Sir David Nicholson KCB CBE

BCPC Chair &
Group Chair - DGFT, RWT, SWBT, WHT

Diane Wake

BCPC Lead CEO &
Group CEO – DGFT & SWBT

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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Welcome

Some quick logistics …

- **No planned Fire Alarms or drills …**
  - If fire alarm goes … then use the nearest fire exits and make way out of the building to the Assembly point (car park).
- **Mobile Phones**
  - Recognise that some may be on-call, but please be courteous and put on silent or vibrate.
- **Washrooms / Toilets**
  - To the left or right of the ‘trunk corridor’.
- **Assistance**
  - Available from the admin team at the front desks
- **Photography**
  - Please advise if you don’t wish to be photographed

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Objectives

- Hear from key leaders about the **emerging healthcare landscape implications** and **emerging priorities**
- Hear from our Clinical Leads about some of the **progress** that has been / is being made **to improve** our quality of care and service performance
- **Contribute, shape** and **influence** the potential initiatives for key 26/27 planning priorities
- Continue to build a **culture of trust** through relationships, and a collaborative way of working

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Overview of the day …

NO.	SUBJECT	TIME
Registration / Refreshments (09:00 – 9:55)		
1.	Welcome & Introductions	10:00
2.	BC & BSOL ICB	10.15
3.	Clinical Improvement Programme	10:35
4.	Developing the Black Country Robotics Strategy	10:45
BREAKOUT SESSION 1		
5.	BCPC Clinical Networks – Short showcase presentation	A) 11:10 B) 11.40
6.	Mohs and Tele-dermatology	12:10
	Lunch & Clinical Networking time (12:30 - 13:30)	

RETURN FROM LUNCH (13:30)		
7.	BCPC Pharmacy Aseptic Transformation	13.30
8.	NHS 10-year Plan	13:50
9.	Aquablation and Spotlight Innovation: GALEAS Bladder Cancer DNA Test	14:10
BREAKOUT SESSION 2		
10.	BCPC Clinical Networks – Short showcase presentation	A) 14:35 B) 15:05
Break (15:35 – 15:45)		
11.	Closing Remarks & Next Steps	15:45
CLOSE (16:00)		

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Attending today …

Delegates from across the following:

- Black Country Provider Collaborative *(BCPC)*
- Sandwell & West Birmingham NHS Trust *(SWBT)*
- The Royal Wolverhampton NHS Trust *(RWT)*
- The Dudley Group NHS Foundation Trust (DGFT)
- Walsall Healthcare NHS Trust (WHT)
- Black County Integrated Care Board *(BC ICB)*
- Primary Care Collaborative (PCC)
- Place Based partnerships (PBPs)
- National & Regional colleagues
- Colleagues from Primary Care, Mental Health & Community partnerships

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Chair & Chief Executive's 'Opening' remarks…

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CEO – some thoughts…

- **Welcome** to our 8th BCPC Clinical Summit
- Positive performance, some '***Amazing***' **work** visible through break-out sessions …
- NHS 10 Year Plan … **time of change**
  - **3 Shifts** – *hospital-community; analogue-digital; sickness-prevention*
  - **New operating model** – *FT's, INT's, IHO's*
  - Slimmed down **NHS Oversight Framework** .. *"earned autonomy"*
  - **Quality standardisation** … *National Service Framework's*
- **Implications** for BCPC being understood …
- Big **THANK YOU**… and long may our collaborative journey continue!

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Birmingham, Black Country and Solihull ICB

Sally Roberts
Birmingham, Black Country and Solihull ICB

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Model ICB - Context

- Integrated Care Boards (ICB's) across the country are required to reduce their running costs by 50%.
- We have been working at pace to plan how we meet the challenge set out by NHS England and the Government to reduce our running costs and achieve the vision detailed in the recently published Model ICB Blueprint.
- The blueprint clarifies the role and purpose of ICBs, recognising the need to build strong strategic commissioning skills to improve population health and reduce inequalities, and focus on the delivery of the government's three strategic shifts:
  - treatment to prevention
  - hospitals to communities
  - analogue to digital
- A small number of ICB leaders were asked to lead the development of the Model ICB Blueprint and we feel the balance of the blueprint is right in terms of how prescriptive it is.
- The blueprint provides a framework for the future to reduce too much national variation; but also gives a basis that will support our planning at a local level to ensure that our plan best fits with the needs of our local populations.

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ICB Functional Changes

- To support the development of the future state, the Model Blueprint Group reviewed a list of functions ICBs currently provide and have grouped them into the following headings:
  - **Grow:** Functions for ICBs to grow/invest in over time to deliver against the purpose and objectives.
  - **Selectively retain and adapt:** Functions for ICBs to retain and adapt including by delivering at scale.
  - **Transfer:** Functions for ICBs to transfer over time.

- These are provided as an indication of the future state; however, the detail and implementation will depend on multiple factors, including the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and in some cases, legislative change.

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ICB Functions

Grow and invest in	Retain and Adapt (inc delivery at scale)
Population Health Management inc data & analytics	Quality Management
Epidemiological capability	
Strategy and Strategic Planning inc pathway redesign	Clinical Governance
Health inequalities and inclusion and expertise	Corporate Governance
Commissioning neighbourhood health	
Commissioning of clinical risk management & intervention	Core Organisational Operations (inc HR, Communications, finance, complaints)
Commissioning of end-to-end pathways	Commissioning functions eg clinical policy
Core payer functions	
Evaluation methodologies	
User involvement	
Strategic Partnerships	

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Review for Transfer from ICBs

Potential	Region	Provider	Other
Provider performance & regulatory oversight (F/P/Q)	✓		
EPRR & System Coordination Centres	✓		
Strategic Workforce planning & development	✓		
Local workforce development inc recruitment		✓	
R&D	✓		
Greener & sustainability		✓	
Digital transformation		✓	
Data collection, management and processing			✓
Infection Prevention and Control			✓

Potential	Region	Provider	Other
Safeguarding			* ✓
SEND			* ✓
Place and Neighbourhood Dev		✓	
Primary Care ops and transformation & PC Medicines Management		✓	
Medicines Optimisation		✓	
Pathway redesign		✓	
CHC			* ✓
Estates and infrastructure		✓	
GP IT			✓

** accountability changes will require legislative change*

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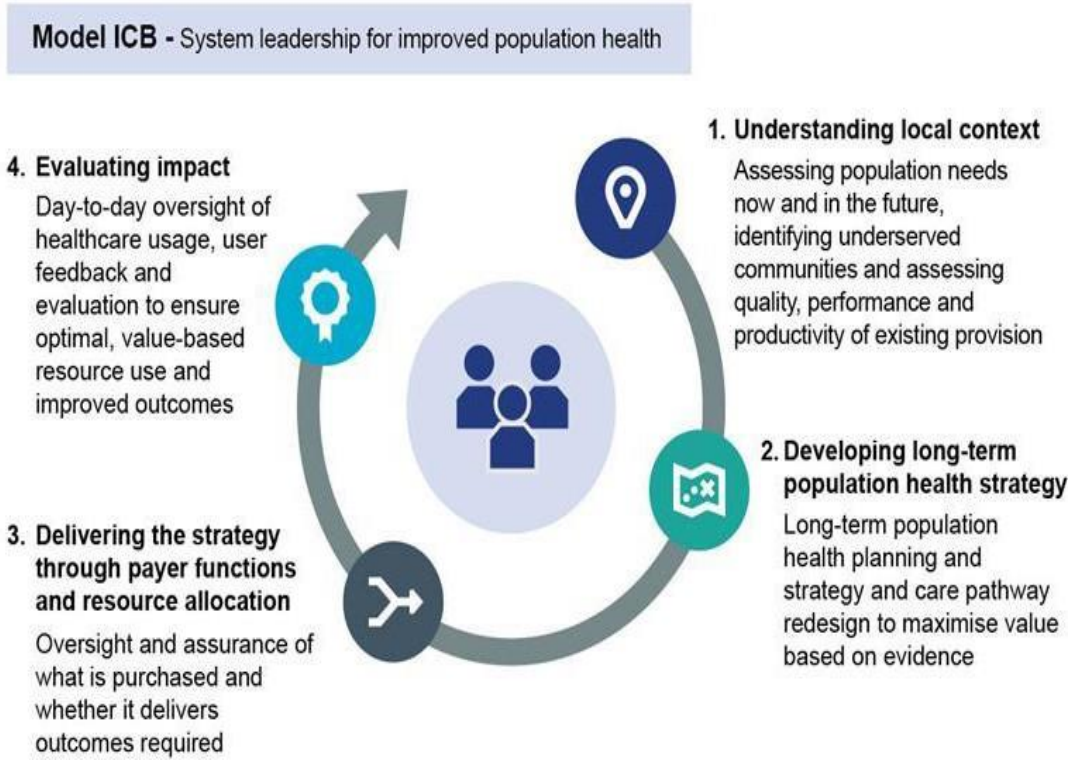
Model Blueprint



- What is clear is that the new ICB model will need to be underpinned by a collaborative approach between ICBs and some shared services across regions.
- This also means that clustered and shared leadership arrangements will be necessary - both to provide the economies of scale that strategic commissioners will need, as well as to deliver the significant running cost reductions.

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Cluster Model

- Across the West Midlands, Chief Executives and Chairs worked to objectively review the range of clustering and joint management options that might be available, taking into account the criteria that has been established nationally, as well as the local deliverability of these options.
- This work concluded that the most suitable option is to develop shared management and leadership arrangements:
  - **Birmingham and Solihull ICB cluster with NHS Black Country ICB.**
  - NHS Coventry and Warwickshire ICB cluster with NHS Herefordshire and Worcestershire ICB.
  - NHS Shropshire, Telford and Wrekin ICB will cluster with NHS Staffordshire and Stoke on Trent ICB.
- The proposed clusters were submitted to NHSE on the 30th May via the ICB Model plans. These clusters have now been approved. The work to develop our structure for our future role as a strategic commissioner is underway.

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Next Steps

- Whilst this is a significant step forward in setting the future direction of our organisation, and a helpful development in establishing how we might deliver our running cost reductions, there is still a lot to work through before we can begin to turn plans into action.

- CEO and Chair roles appointed to: David Melbourne and Danielle Oum.

- Interim cluster roles announced, including CNO (Sally Roberts) and CMO (Ian Sharp) with permanent arrangements set to be in place from December 2025.

- It is of course important that we remain focused on delivery, especially through winter, but also delivery on key performance metrics and financial stability.

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Fit for the Future
The 10 Year Health Plan for England

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The plan for delivery by 2028/2029

HOSPITAL TO COMMUNITY

- **Same-day digital and telephone GP appointments will be available and calls to GPs will be answered more quickly – ending the 8am scramble.**
- **A GP led Neighbourhood Health Service** with teams organised around groups with most need.
- **Neighbourhood Health Centres in every community; increased pharmacy services and more NHS dentists.**
- **Redesigning outpatient and diagnostic services.**
- **Redesigning urgent and emergency care,** allowing people to book into UEC services before attending via the NHS App or NHS 111.
- People with complex needs will have the offer of a **care plan by 2027** and the **number of people offered a personal health budget will have doubled.**
- **Patient-initiated follow-up will be a standard approach.**

ANALOGUE TO DIGITAL

- **The NHS App** will be the front door to the NHS, making it simpler to manage medicines and prescriptions, check vaccine status and manage the health of your children.
- **'HealthStore' to access approved health apps:** Enabling innovative SMEs to work more collaboratively with the NHS and regulators.
- **A Single Patient Record** will mean patient information will flow safely, securely and seamlessly between care providers.
- **Digital liberation for staff** with the scale of proven technology to boost clinical productivity.

SICKNESS TO PREVENTION

- **Health Coach will be launched** to help people take greater control of their health, including smoking and vaping habits later this year.
- **New weight loss treatments and incentive schemes to help reduce obesity.**
- **The Tobacco and Vapes Bill will be passed, creating the first smoke-free generation.**
- **Women will be able to carry out cervical screening at home using self-sample kits from 2026.**

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Clinical Leadership

- **Current Clinical Leadership in the Black Country** supports improvement and innovation in clinical care and fosters integration and collaboration across disciplines, sectors, and organisations.
- **Clinical leads operate across** the BC ICB, Black Country collaboratives, Clinical Networks, and each of the four places.
- **Multi Disciplinary approach** to leadership, which includes:
  - **CNO Forum –** Workforce, safer staffing, clinical risks and issues, IPC, Maternity, Frailty, Greener agenda, Professional development, national CNO agenda.
  - **AHP Council –** Significant workstreams to support AHP colleagues and wider clinical agenda.
  - **Clinical Learning Network's –** Key focus on specific pathways.
  - **Clinical Leadership Group:** Dr Odum chairs on behalf of the system, receives regular CLN updates, opportunity to escalate and discuss clinical system areas e.g.: Winter preparedness, shared system learning opportunity.
  - **System wide Mortality Review Group –** Jointly chaired.

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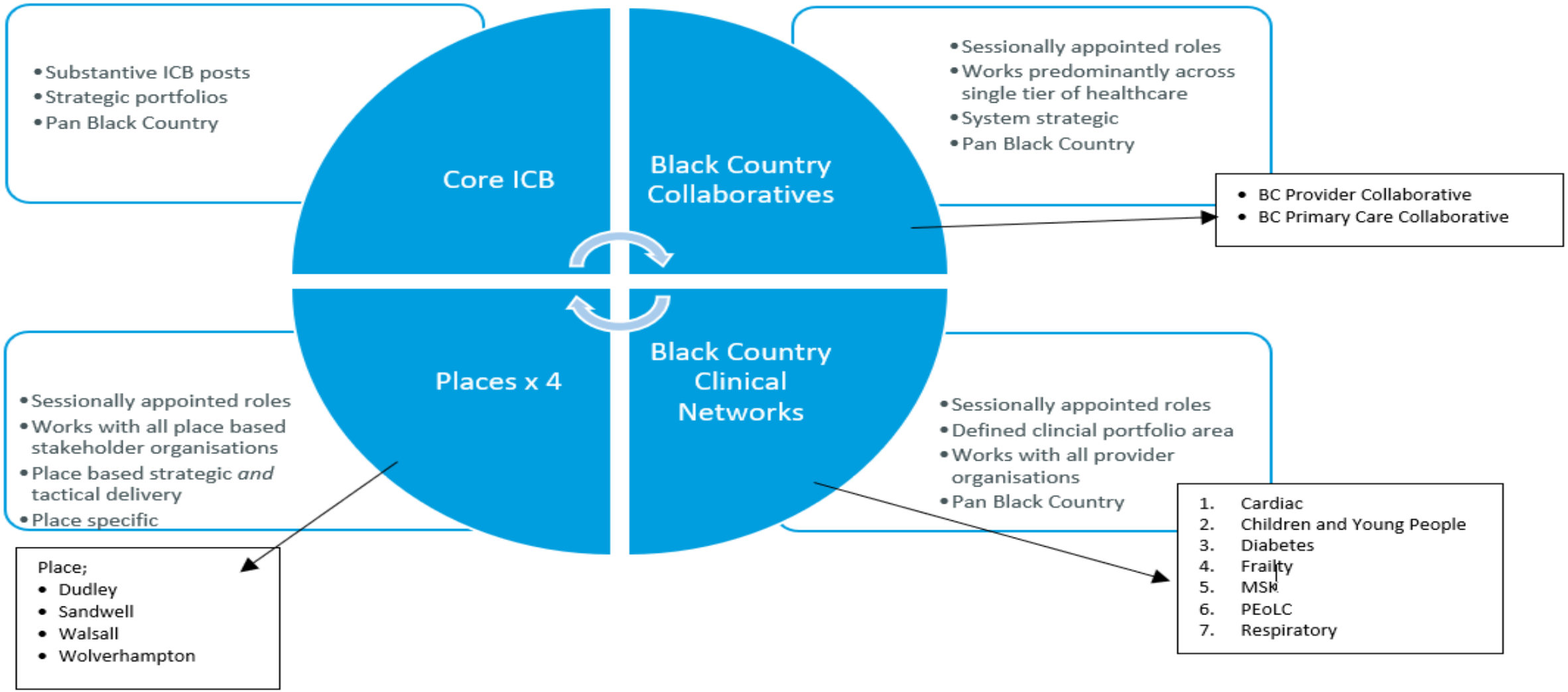

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Clinical Leadership

- **Black Country Clinical Strategy (2024-2027)** – this will be reviewed in light of ICB changes….

- **Clinical Networks** were originally developed to respond to a range of needs of the Black Country population; shared forums for learning, work programmes for delivery, service development, and care pathway redesign with very broad membership across disciplines and organisations (NHS, LA, VCSE).

- **Designated Clinical Leadership** with dedicated project officers progress has been made available in these priority areas.

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CLN's

- **CARDIAC** - The 'Optimised Medication Lipid Management project' saw a significant increase (24%) in the number of patients with cardiovascular disease being treated to cholesterol target. Black Country is the most improved ICB nationally.
- **CARDIAC** – BC passed national average on all CVD Prevent performance metric.
- **FRAILTY** – Positive outputs from a recent Frail-tED review with NHS Midlands, Black Country was the only system regionally to achieve top scores in review (GiRFT Table).
- **DASHBOARD DEVELOPMENT** – Now have a series of condition specific dashboards drawn from PC data which can be cut by place/practice/ethnicity/deprivation/LD/SMI on each metric to support practices and showcase best practice – driving improvement and demonstrating monthly improvement.
- **DIABETES** - Improving Diabetes Footcare Outcomes in the BC (Standardised Pathways & Enhanced Patient Care) - prize-winning entry.
- **CARDIAC** - The Blood Pressure project (BP) increased BP measurements 3-fold/doubled ambulatory blood measure with over 2000 patients having their treatments optimised during this 6-month project.

GIRFT Frail-tED summary – October 24

		Scenario		Black Country				
				Wton	Walsall	SWB	Dudley	System
GIRFT FRAIL-tED	Hospital 1	Direct telephone or virtual access to hospital Frailty assessment service (from NHS111/CAS, ambulance service, community teams or ED streaming).	Older frail patient (with a clinical frailty score of 5 or more) following a non-injurious fall, possible delirium.	2	4	4	3	3
	Hospital 2	Direct access to hospital-based Frailty Unit (from 111/CAS, ambulance service, community teams or ED streaming)1. Frailty assessment - early discharge 2. If admitted will the patient be discharged early the next day.	Hospital presentation for an older person following a collapse at home with no other clinical symptoms other than a postural drop in their blood pressure, who is identified fit for discharge very late evening.	0	0	0	0	0
	Hospital 3	Community Delirium Pathway and direct access to telephone advice for patient with delirium staffed by a person with specialist frailty skills or MH dementia specialist (by community teams/111/CAS/Ambulance Service/GP).	Older patient with frailty who has had an infection and has developed delirium	4	4	4	4	4
	Hospital 4	Direct Access to SDEC/Hot Clinic for ambulatory assessment for a patient with frailty (by community teams/111/CAS/Ambulance Service/GP).	Older frail patient with abnormal blood test, bookable appointment for the following day	2	3	4	4	3
	Hospital 5	Direct access to diagnostics (by community services/111/CAS/Ambulance Service/GP).	Older frail patient with an Isolated wrist injury	2	3	3	3	3
	Hospital 6	Direct access to diagnostics (by community services/111/CAS/Ambulance Service/GP).	A older frail patient with a fall with a head injury on anticoagulants requiring brain imaging	0	0	0	0	0
	Hospital 7	Medication available for weekend discharge from the hospital and to support patients in the community	TTO (to takeout) medicines easily available same day for patients who are being discharged	3	3	3	3	3
	Out of Hospital 1	Direct and timely access to UCR (by community services/111/CAS/Ambulance Service/GP/ hospital based frailty service & discharge teams).	A older frail patient with change in function as a result of a UTI.	4	4	4	4	4
	Out of Hospital 2	Direct access to social care or other support (by community services/111/CAS/Ambulance Service/GP/ hospital based frailty service & discharge teams).	Unpaid carer breakdown which if not resolved would result in a conveyance to an acute hospital requiring rapid access to social care.	4	5	5	3	4
	Out of Hospital 3	Direct and timely access to personal care (by community services/111/CAS/Ambulance Service/GP/ hospital based frailty service & discharge teams).	A new need for social care package, on the same day. Forearm fracture leaving patient with only one functional arm.	4	5	5	4	4
	Out of Hospital 4	Direct and timely access to UCR/Virtual Ward (by community services/111/CAS/Ambulance Service/GP/ hospital based frailty service & discharge teams).	Patient presents with cellulitis who needs IV antibiotics (no sepsis triggers) with increased or new confusion	4	4	4	4	4
	Out of Hospital 5	Direct access to UCR/acute falls service (by community services/111/CAS/Ambulance Service/GP/ hospital based frailty service).	A patient who has fallen with no apparent injury who is unable to get up. Manual handling aids are required to prevent long lies.	4	4	4	4	4
	Out of Hospital 6	Direct and timely access to Community Services (District Nursing) (by 111/Ambulance/CAS/Ambulance Service/GP/hospital based frailty service.	Wound care for initial management in a frail older patient.	3	2	4	3	3
	Out of Hospital 7	Direct access to community equipment services for provision within 8 hours (where appropriate which could include rapid provision of critical equipment for pressure relief or end of life).	New supply or replacement of equipment e.g zimmer frame, commode, pressure relieving mattress and hospital bed.	4	4	4	4	4
	Out of Hospital 8	Direct access to Community Response including Community Palliative Care within 2 hours community response time where needed.	Patient at end of life requiring assessment or having unmanaged symptoms and out of hours medication.	4	4	4	4	4
	Out of Hospital 9	Access to transport services.	Reliable transport for PM discharge on the same day following acute frailty assessment.	2	2	2	2	2
	Out of Hospital 10	Advance Care Planning.	Anticipatory care planning need for visibility of information across all system partners who may be involved in the patient's episode of care.	3	3	3	3	3
	Adm Avoidance 1	Virtual Wards.	Access into step up Virtual Ward for a frail older person.	4	4	5	2	4
	Adm Avoidance 2	Community Nursing Service/UCR response from.	Bleeding/blocked urinary catheter	4	4	4	4	4
	Adm Avoidance 3	Social Services/Care Homes.	Housing crisis due to flooding in the patient's normal place of residence. House becomes uninhabitable eg heating/electricity failure or flooding.	3	5	4	2	4
	Adm Avoidance 4	Community Services/UCR from GPs/111/999/ED/Acute Services.	Care home/community patient requiring community support for an acute deterioration involving fluids, oxygen and IV antibiotics.	4	4	4	4	4
	Adm Avoidance 5	Integrated Hospital Discharge Services.	Weekend discharge - ability to arrange out of hospital services to support a frail older person at discharge including returning a patient to care homes.	3	3	3	3	3

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Considerations….

- Building on strong foundations.
- Opportunity to share and learn from each other across the cluster.
- Focus on whole pathway improvement and potentially redesign (3 Shifts).
- Consider how we better use and align evidence to demonstrate improved outcomes.
- Priorities: Frailty, ND, Perinatal Mortality, CVD??
- Our approach to clinical leadership is working….but more to do…
- Resource and capacity will be reduced, requirement to work differently.
- We will need to better track how clinical leadership influences outcomes, equity, and service transformation.

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Finally….

- Ongoing commitment to hear and support the clinical voices across our cluster.
- We will continue to promote shared leadership, psychological safety, and cross-sector respect to sustain engagement.
- Thankyou for all that you continue to deliver.

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Any Questions?

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Clinical Improvement Programme

Celebrating Success

Dr Jonathan Odum

BCPC CMO, Interim DGFT Medical Director

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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Background / Context …

- The Clinical Improvement Programme has been the key focus of a significant proportion of the BCPC work from its inception
- Nine, then 11 (now 16) clinical networks established … focusing initially on two key exam questions … 'elective recovery' and improving 'cancer health outcomes'
- **Engagement** and active participation has been strong, strengthening trust and relationships across the four partners over the last 4 years.
- Its worth reflecting on our collective journey through the sometimes subtle yet important successes that have been achieved, or being progressed

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Our Clinical Lead Networks

- **Breast** – Martin Sintler *(SWBT)*
- **Critical care** – Shameer Gopal *(RWT)*
- **Colorectal** – Ben Liu *(RWT)* & Shantanu Rout *(SWBT)*
- **ENT** – John Murphy *(RWT)*
- **Gen Surgery** – Salman Mirza *(WHCT)*
- **Gynaecology** – Ayman Ewies *(SWBT)*
- **Orthopaedics** – Mr. Will Hart *(RWT)*
- **Ophthalmology** – John Barry *(DGFT)*
- **Peri-Op Med** – Anna Pierson *(DGFT)*
- **SKIN** – James Halpern *(WHCT)* & Aaron Wernham *(RWT)*
- **Urology** – Pete Cooke *(RWT)*
- **Pharmacy** – Puneet Sharma *(SWBT)*
- **Robotics** – David Mak *(RWT)*

New - *Vascular, Gynae-Oncology & Renal Medicine*

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The ‘value’ of Collaboration

No single provider can meet all patient needs — collaboration transforms care from fragmented to integrated, ***better patient outcomes*** with a *one stop service for patients deemed as optimal for patient experience.*

Equity and inclusion

- Ensure all voices are heard & represented
- Transparency, trust and accountability

Shared Expertise

- Combines Knowledge
- Encourages innovation through diverse perspectives

Greater Impact

- Aligns efforts to tackle complex challenges such as Health Inequalities and System resilience
- Pooling resources

Continuous learning

- Facilitates data sharing, benchmarking, improvement cycles
- Culture of feedback, adaptation, evidence-based practice

Efficiency

- Encourages rapid adoption of best practices and new technologies
- Fosters continuous improvement and learning

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Benefits of our Clinical Networks

Improved Quality, resilience & Transformation

- All BCPC workstreams

Expected Improved Health Equity & Inequalities

- Breast DIEP
- Robotics Access

Faster, more accurate Diagnoses

- Urology Galeas Bladder Cancer DNA test, rather than an invasive Cystoscopy

Improved Patient Experience & Outcomes

- Colorectal FIT programme
- Delivery of Mohs/Teledermatology
- NBOCA best practice
- Peri/pre-operative health screening – best in class

GIRFT Improvement

- Individual GIRFT Unit Review and review of Network services by the GIRFT Team. Highlight many improvements but there is a **need to transform services**

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Benefits of our Clinical Networks

Improved Cancer Target expectation

- Teledermatology
- Colorectal FIT programme
- Galeas Cancer DNA Testing

Stronger Partnership with Communities

- Vascular unit capacity
- FIT improvement programme

Collaboration

- Links with primary care collaboration e.g. Advice & Guidance

Enhanced Productivity

- Ophthalmology – HVLC Cataract pathway implementation
- Biologics switching
- SKIN clinical guidelines for use in Primary & community care to support appropriate referrals into the acute sector
- Commenced – ENT referral pathways from primary care to through to secondary care through use of Electronic Referral Service (ERS)

BCPS

- Its one of the two highest performing pathology networks in the country

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Developing the Black Country Robotics Strategy

Mr. David Mak

BCPC RSSG Clinical Lead,
RWT Robotic Surgery Clinical Lead,
Consultant Urological 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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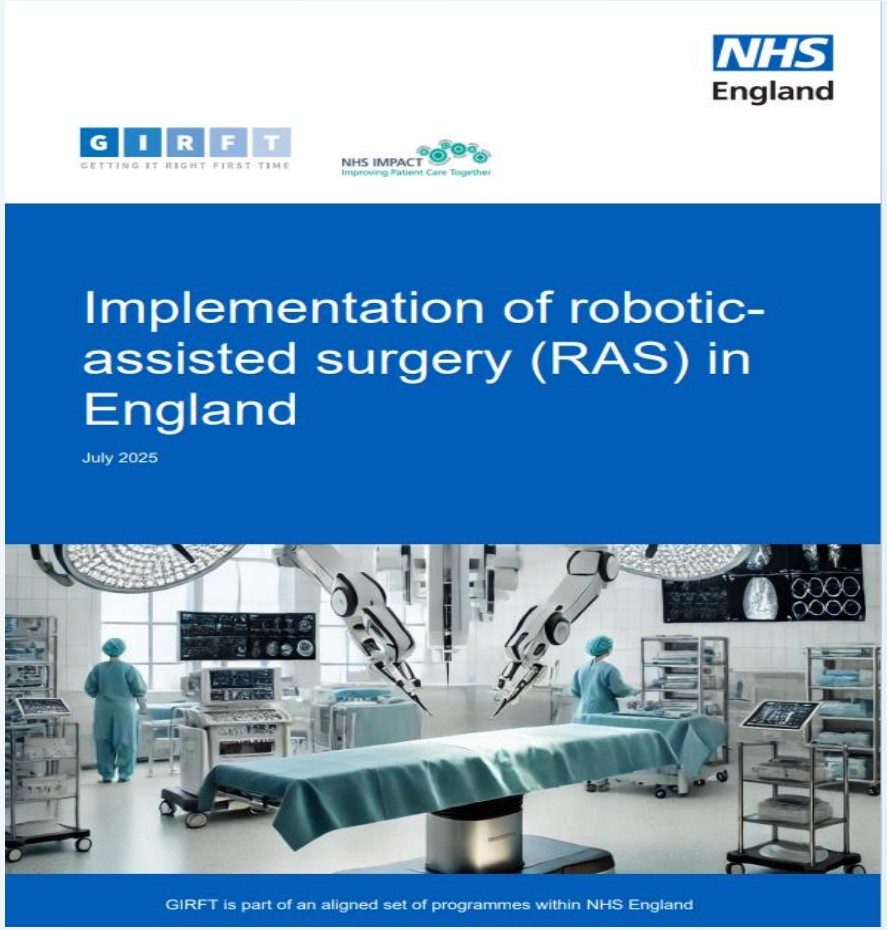
Context – Robotic Assisted Surgery *(RAS)*

National Momentum:

GIRFT (May 2025)

- Procurement
- Safety establishing RAS
- Safety initiating RAS
- Training
- Evaluation and safety monitoring



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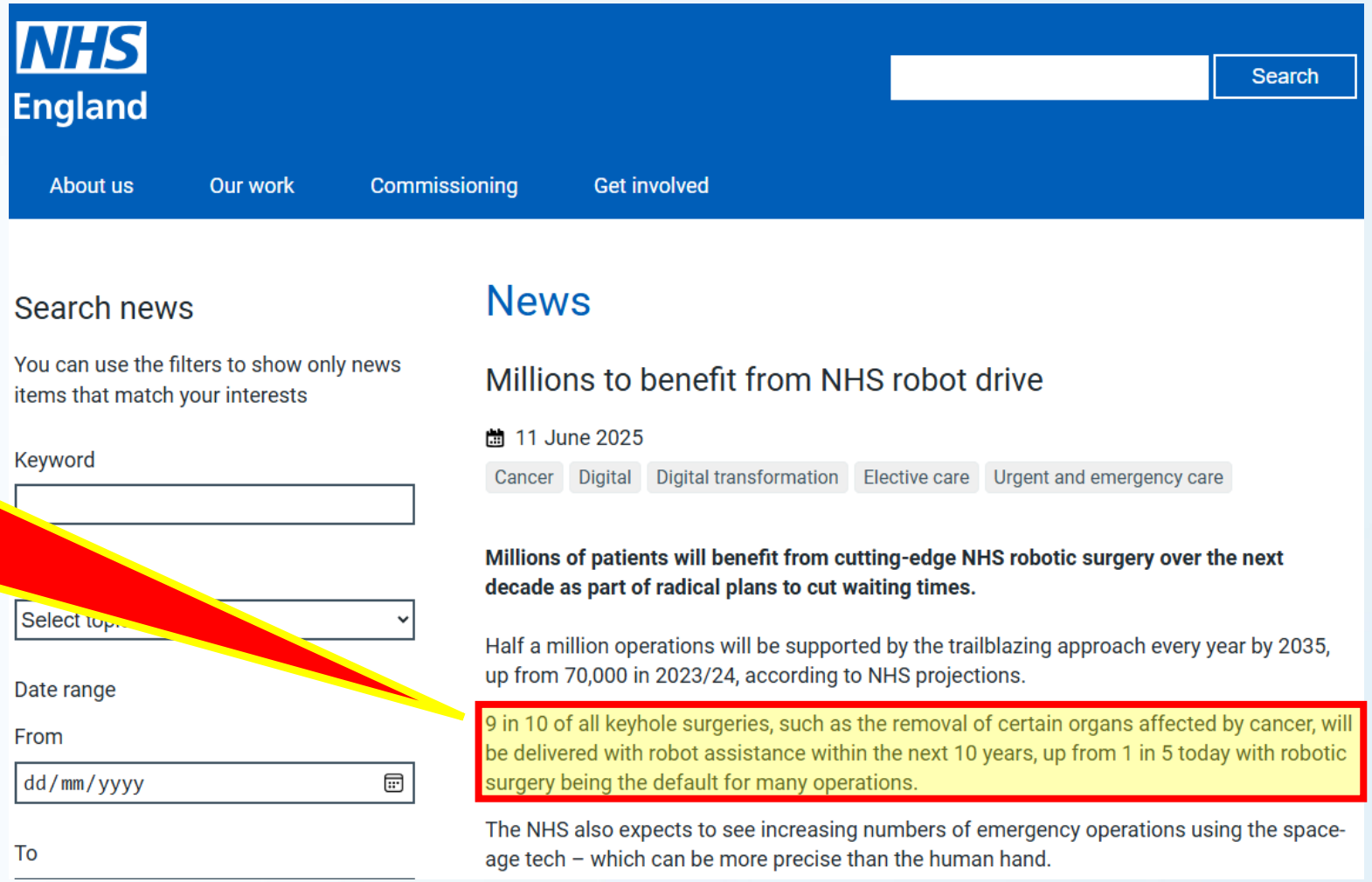
Context – Robotic Assisted Surgery *(RAS)*

National Momentum:

9 IN 10 OF ALL KEYHOLE SURGERIES, such as the removal of certain organs affected by cancer, **WILL BE DELIVERED WITH ROBOT ASSISTANCE WITHIN THE NEXT 10 YEARS**



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Millions to benefit from NHS robot drive

11 June 2025

Cancer | Digital | Digital transformation | Elective care | Urgent and emergency care

Millions of patients will benefit from cutting-edge NHS robotic surgery over the next decade as part of radical plans to cut waiting times.

Half a million operations will be supported by the trailblazing approach every year by 2035, up from 70,000 in 2023/24, according to NHS projections.

9 in 10 of all keyhole surgeries, such as the removal of certain organs affected by cancer, will be delivered with robot assistance within the next 10 years, up from 1 in 5 today with robotic surgery being the default for many operations.

The NHS also expects to see increasing numbers of emergency operations using the space-age tech – which can be more precise than the human hand.

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Context – Robotic Assisted Surgery *(RAS)*

National Momentum:

NHS 10 Year Health Plan for England (July 2025)

Big bet 5: By 2035, robots will deliver care with unprecedented precision

The Future of Healthcare: surgeons will perform complex procedures with ever more sophisticated robotic assistance, enhancing precision, minimising invasiveness, and speeding up recovery. Pharmacy automation will ensure medication gets to patients quickly, easily and safely.

Beginning next year, we will expand surgical robot adoption in line with NICE guidelines

From 2029, we will establish national registries for robotic surgery data and develop telesurgery networks

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Hospital trust showcases use of AI

Science, Innovation and Technology Secretary Peter Kyle, pict
New Cross Hospital

NHS Sandwell and West Birmingham NHS Trust

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Innovative HIT list tackles surgery waiting lists

10th Sep 2025

Walsall Manor becomes first district hospital to offer robot arm-assisted surgery

Robot arm-assisted surgery for hip and knee replacement patients is now being offered at Walsall Manor Hospital, the first district general hospital in the

NHS Sandwell and West Birmingham NHS Trust

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Robots to remove types of throat cancer

First robotic TAMIS surgery performed in Birmingham and Black Country

25th Jun 2025

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New robot aiding surgery at Wolverhampton hospital

7 June 2022

Surgeons Pete Cooke, Nuha Yassin and David Mak are among those using the robots to perform procedures

Dudley Group consultant delivers a UK first in renal robotic surgery

Dudley Group consultant delivers a UK first in renal robotic surgery

15th December 2023 - Press Releases and Statements

Advanced robotic arm now used in joint replacement surgeries in Dudley

Advanced robotic arm now used in joint replacement surgeries in Dudley

17th January 2024 - Press Releases and Statements

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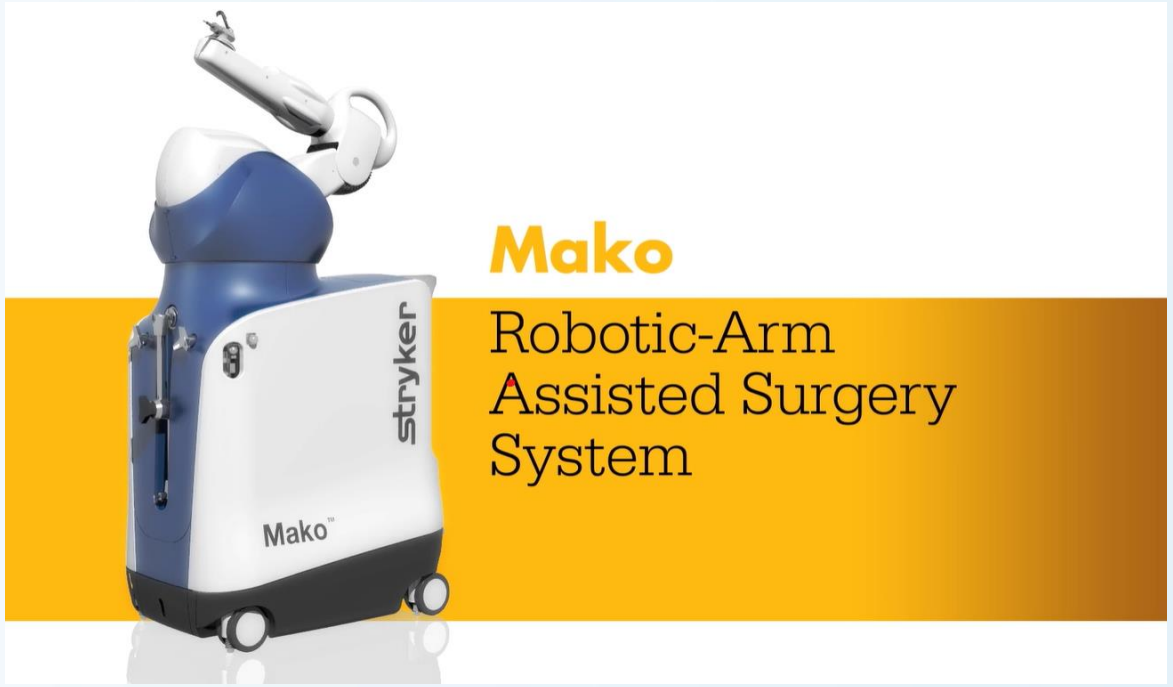
Current RAS Status



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Current RAS Status

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Current RAS Status

Urology	Gynaecology	Thoracic Surgery	ENT
Colorectal	Gynae-Oncology / Gynaecological Cancer	General Surgery	Orthopaedics

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Key System Wide Challenges

RAS Capacity

Difference in RAS capacity across Trusts – affecting waiting lists

Workforce

RAS trained surgeons and wider surgical teams to support RAS

Access to RAS

Variable patient access to RAS - inequitable

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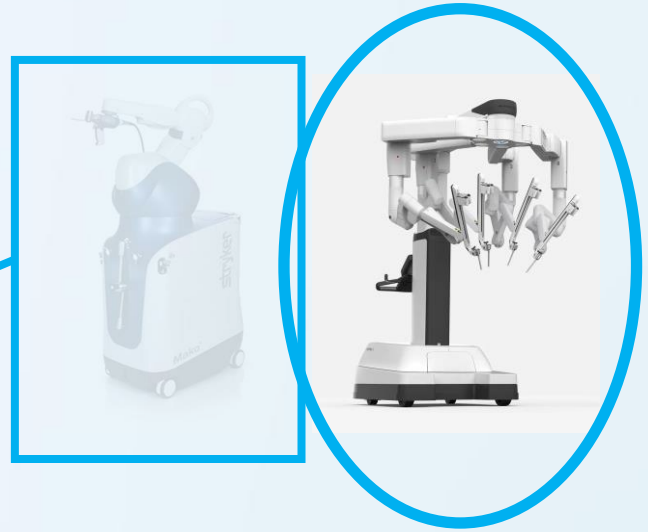
Variable RAS Access



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Strategic Objectives

Enhance equitable access to RAS

- Aim to ensure all patients have access to RAS where there is clinical benefit

Workforce Readiness

- Strengthen workforce competency
- Establish sustainable workforce to support RAS services

Procedure Variance

- Standardise RAS procedures with evidence-based benefit (where available)
- Collaboration between RAS teams (where co-dependence of surgical specialities exist)
- Focus on patient outcomes
- Implement NICE / GIRFT guidance

Procurement and Expansion

- Reduce procurement inequalities to mitigate financial risks for future procurement
- Support expansion of RAS programmes where appropriate

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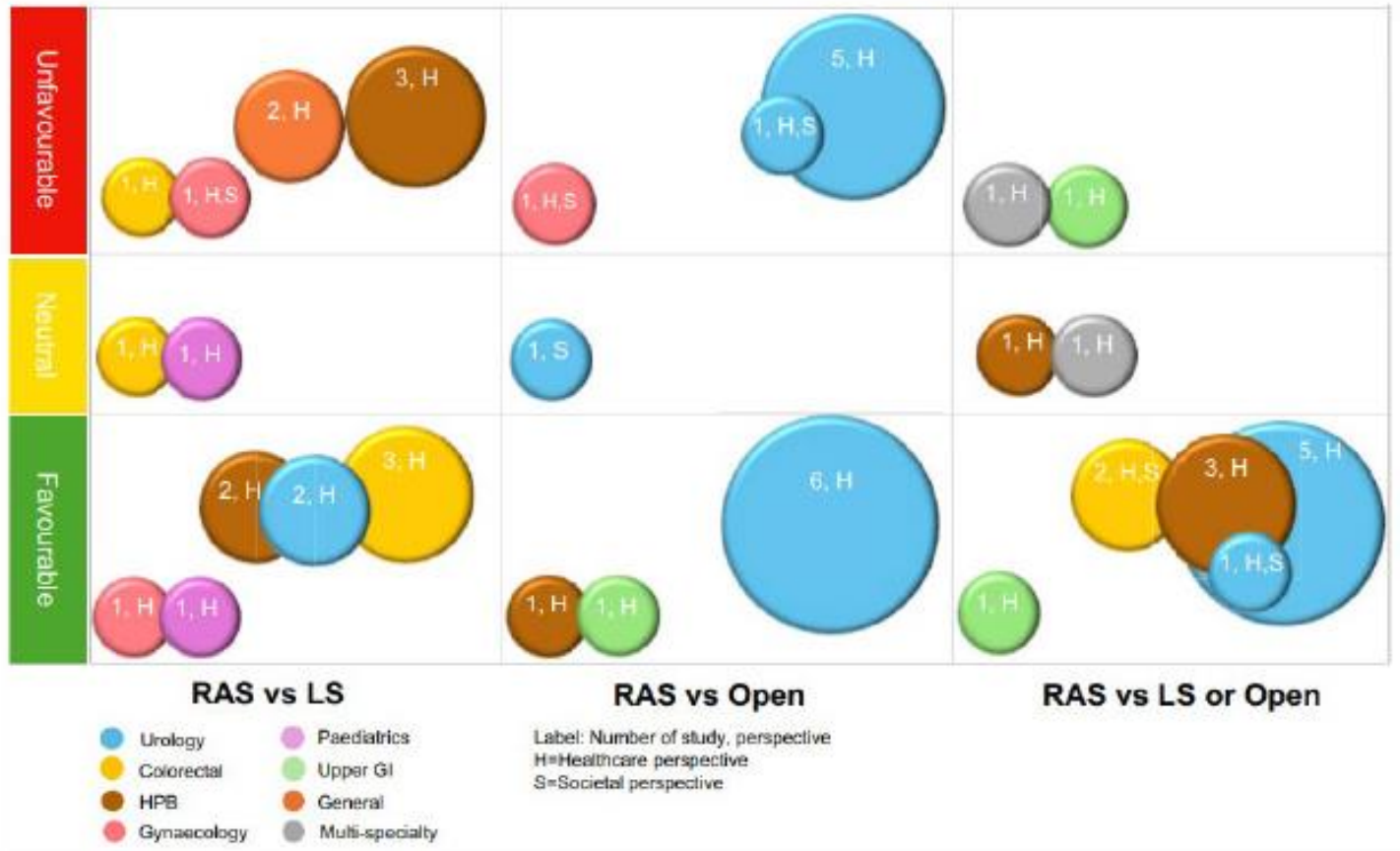
Evidence of cost-effectiveness

Mixed evidence from studies:

- 58% favour RAS
- 32% unfavourable
- 10 % neutral



NICE

Robotics on the rise -NICE's role in robotic-assisted surgery evaluation.
Dr Anastasisa Chalkidou - Programme Director HealthTech - National Institute for Health and Care Excellence

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Early Value Assessment - NICE

NICE launched in 2024 two early value assessments (EVAs) for robotic-assisted surgery:

- One EVA focusing on soft tissue procedures
- One EVA on orthopaedic procedures

Key considerations for the value proposition of RAS for soft-tissue:

- RAS can make minimally invasive surgery an option for some procedures and for people who did not have this option before
- Technologies aim to improve recovery times, reduce complications, and help the NHS streamline access to minimally invasive techniques
- Improved ergonomics with robot assistance makes it easier for surgeons to do technically challenging surgery

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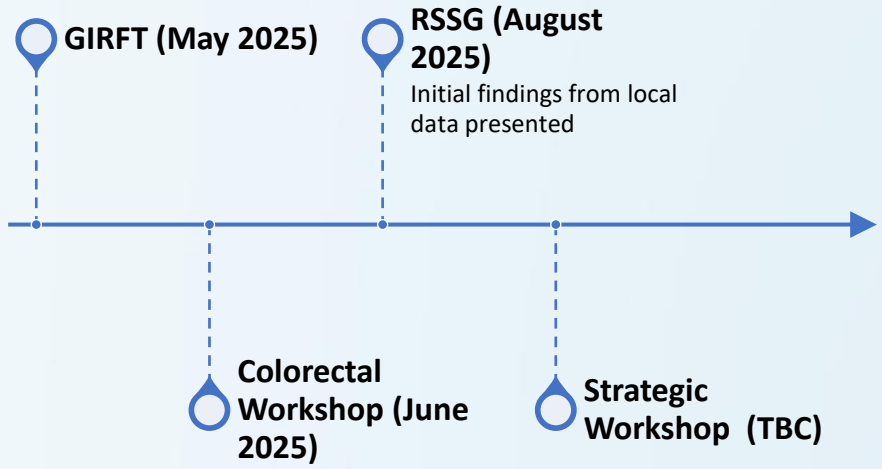
Shaping the Future for Robotic Surgery

Black Country Robotic Surgery Steering Group

- Quarterly meetings
- Laid foundation work

Recent Insights: Colorectal workshop (June 2025) and RSSG meeting (August 2025) revealed critical gaps:

- Inequalities in Procurement
- Workforce Readiness
- Variance in Procedures
- Utilisation Variables



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Shaping the Future for Robotic Surgery

Strategic Workshop (Q4 2025):

- Convene stakeholders across all four Trusts
- Explore critical challenges
- Identify additional areas impacting equity, sustainability and outcomes
- Align on population needs, resource allocation, and cross- specialty collaboration

Longterm Plan (2026-2030):

- Develop a phased roadmap aligned with GIRFT and BCPC priorities
- Embed governance, data standards, and workforce planning
- Ensure sustainable and equitable RAS expansion

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Shaping the Future for Robotic Surgery

Trust Robotic Surgery User Groups

- Facilitate shaping strategy for RAS in the BC
- Supporting RAS workforce development
- RAS utilisation and outcome reporting
- Identifying risks to service sustainability

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Thank You

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Breakout Session - 1

BCPC Clinical Networks –
Short showcase presentations

Refreshments available within rooms

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Breakout Session - 1

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
(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/ S. Alam
(B) **Lung Screening**: E. Gilliland

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ENT

Right Patient, Right Clinic, First Time

Mr. John Murphy

ENT Clinical Lead

Consultant ENT Surgeon, Divisional Medical Director RWT

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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NHS e-Referral service

- Triage referrals - Docman
  - Subspeciality access
- Referral Advice Service - RAS
  - Advice and Guidance
- Clinical Advice Service - CAS
  - Triage
  - A&G
  - Straight to test
  - Patient Management

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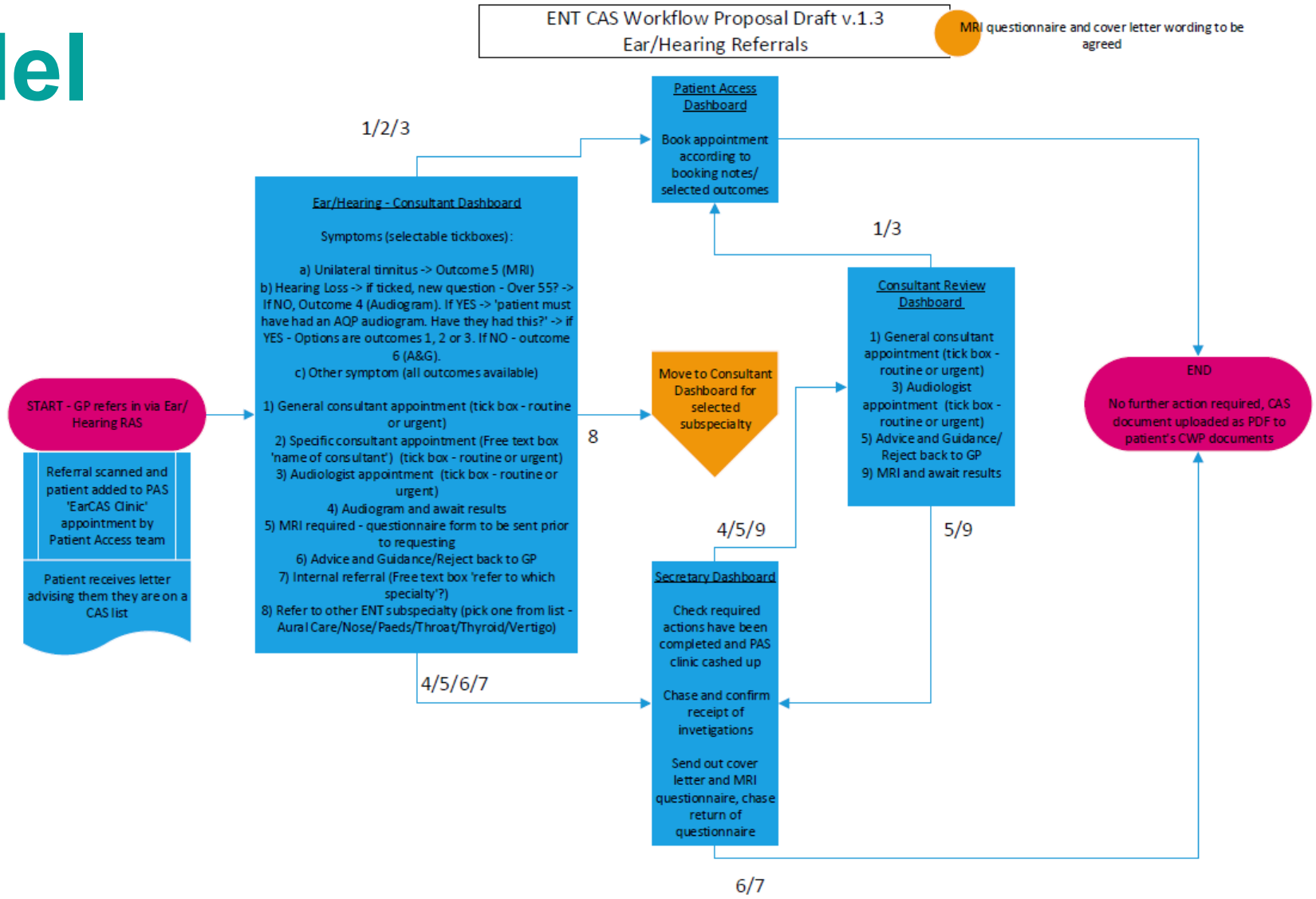
CAS Model



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Discussion

- CAS fits with the 10-year plan
  - Analogue to Digital
  - Hospital to Community
  - Sickness to Prevention

- Patient benefit needs to be clear
- It needs collaboration
- Is not mechanism to push work into Primary Care

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Questions

- How can we **standardise triage** and **referral criteria** across the BCPC to reduce unnecessary variation?

- What support do referring clinicians need to make **“first time right”** referrals?

- Could we **expand** the **Clinical Advice Service (CAS)** model to other ENT sub-specialties?

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Ophthalmology

Seeing the Future : Digital Transformation in Action

Mr. John- Sebastian Barry

Consultant Ophthalmologist (Paediatric Ophthalmology)

Clinical Service Lead Ophthalmology – Dudley, Black Country ICS Ophthalmology Clinical Lead

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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Ophthalmology: Celebrating System Progress

- Full implementation of Medisight EPR across all providers → first specialty to achieve digital standardisation in the BCPC.
- Launch of GERS (Glaucoma Enhanced Referral Service) in Wolverhampton → improved referral quality and 50% reduction in unnecessary secondary care referrals.
- Collaborative cross-system delivery model with strong links between primary and secondary care

Celebration:

- Ophthalmology is one of the most digitally advanced and integrated networks in the region.

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HVLC Cataract Pathway

- High-Volume Cataract Lists at RHH achieving 21–23 cases per day (weekend) – up from 16 (and 10 weekday baseline).
- Trainee involvement embedded; GIRFT standard now being reached on selected lists
- Aim: expand weekday throughput and introduce Immediate Sequential Bilateral Cataract Surgery (ISBCS) as next phase.

Celebration:

- Demonstrable throughput gains without compromising patient safety or training quality.

Next Step:

- Consolidate weekday efficiency and align all providers to 8-case benchmark lists

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Digital Integration and Communication

- **Medisight EPR** now live across all providers → enables data-sharing, mutual aid, and consistent clinical documentation
- **Cinapsis integration** with Medisight (Dudley innovation) recognised in Trust's *Committed to Excellence* Award – automatic referral upload improving safety and communication
- Supported BSOL adoption and wider interoperability

Celebration:

- First fully digital clinical specialty across BCPC, with live referral-to-record linkage

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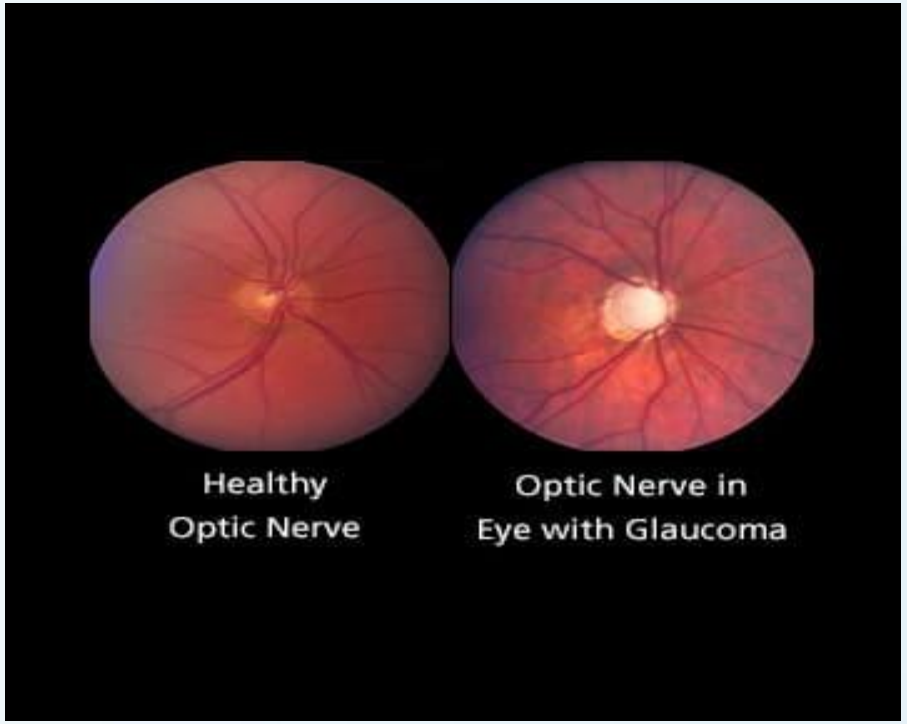
GERS – Glaucoma Enhanced Referral Service

- Major collaboration between community optometrists and hospital services
- ICB contracting team finalising pathway rollout across the ICS
- Expected 50% reduction in unnecessary referrals; improved quality and triage efficiency
- **Celebration:** A genuine example of integrated working between LOC and hospital ophthalmology teams



- **Next Step:** Confirm audit, inclusion of disc imaging and extend learning to medical retina triage

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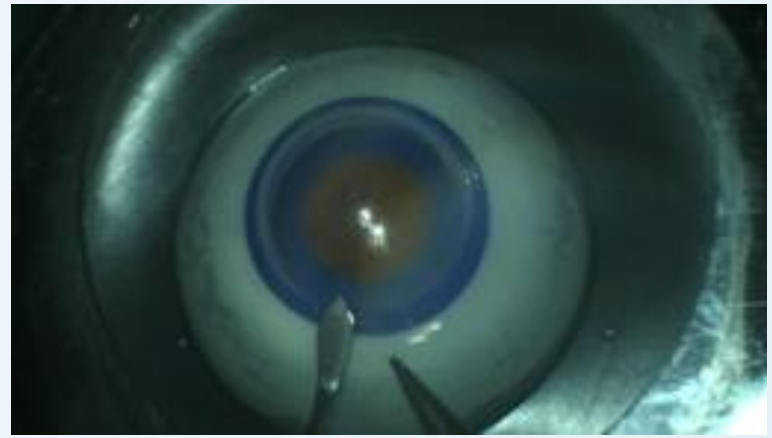
Innovation & Clinical Efficiency

Area	Key Development	Impact
Biosimilars	Ongavia introduced (Lucentis alternative); Aflibercept biosimilar in pipeline	Capacity release and reduced injection burden
AHP Workforce	Orthoptist training expansion for paediatric and anterior segment care	Consultant time refocused to complex cases
Comms Videos	Suite of short patient information videos being produced (HVLC cataract, paediatrics, consent)	Improved patient engagement and e-consent alignment
Mutual Aid & Hubs	Corbett Hub model praised by ICB as excellent practice	Forms blueprint for GIRFT/NHSE type diagnostic hub planning



Celebration: Ophthalmology is leading innovation in both clinical efficiency and digital transformation

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Challenges & Next Priorities

Challenges:

- ED/urgent care pathway pressure (BMEC capacity and rota fragility)
- Workforce pressures across VR and paediatric sub-specialties
- Limited funding for mutual aid expansion and diagnostic hub scale-up

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Challenges & Next Priorities

Next Priorities:

- Consolidate HVLC cataract efficiency across all sites
- Roll out GERS pathway system-wide and embed shared audit process
- Accelerate biosimilar adoption and reinvest savings into capacity
- Secure funding and governance for expanded diagnostic hub network

NHS
The Dudley Group
NHS Foundation Trust

CATARACT SURGERY EXPLAINED ON A MODEL EYE

What happens in routine cataract surgery?

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Summary

- Ophthalmology has delivered system-leading progress in 2025:
  - First specialty to achieve full EPR integration across all sites
  - Digital interoperability between primary and secondary care through Cinapsis–Medisight linkage
  - GERS successfully reducing unnecessary referrals
  - Cataract HVLC lists exceeding GIRFT expectations
  - Patient education videos, biosimilar innovation, and workforce development driving forward efficiency and safety
- Celebration: Ophthalmology demonstrates what successful collaboration, digital maturity, and clinical innovation can achieve across the BCPC

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Questions

- How can we build on **Ophthalmology's digital success** to support other specialties?
- What **lessons** from GERS can **inform other community-to-hospital referral pathways?**
- How can we **sustain innovation momentum** while **addressing VR and paediatric workforce pressures**?

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Mohs & Tele-dermatology

Early findings and insights to some of the key delivery benefits of these service SKIN Clinical Network developments

Dr Aaron Wernham

Joint BCPC Clinical Lead - Dermatology

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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Workstream

- Mohs Micrographic Surgery
- Tele-dermatology
- Primary care guidelines and referral thresholds
- ICB wide service specification

Metrics

- Skin Cancer
- RTT

GIRFT Visit

Risks

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Mohs Micrographic Surgery

- ICB wide service, well established.
- Supporting most complex BCC, now also SCC and rare cancers such as DFSP.
- Increasing efficiency and capacity, now up to 500 cases annually can be supported.
- Pathways commenced with Shropshire and Staffordshire working well.
- Plan to commence an accredited fellowship in 2026.

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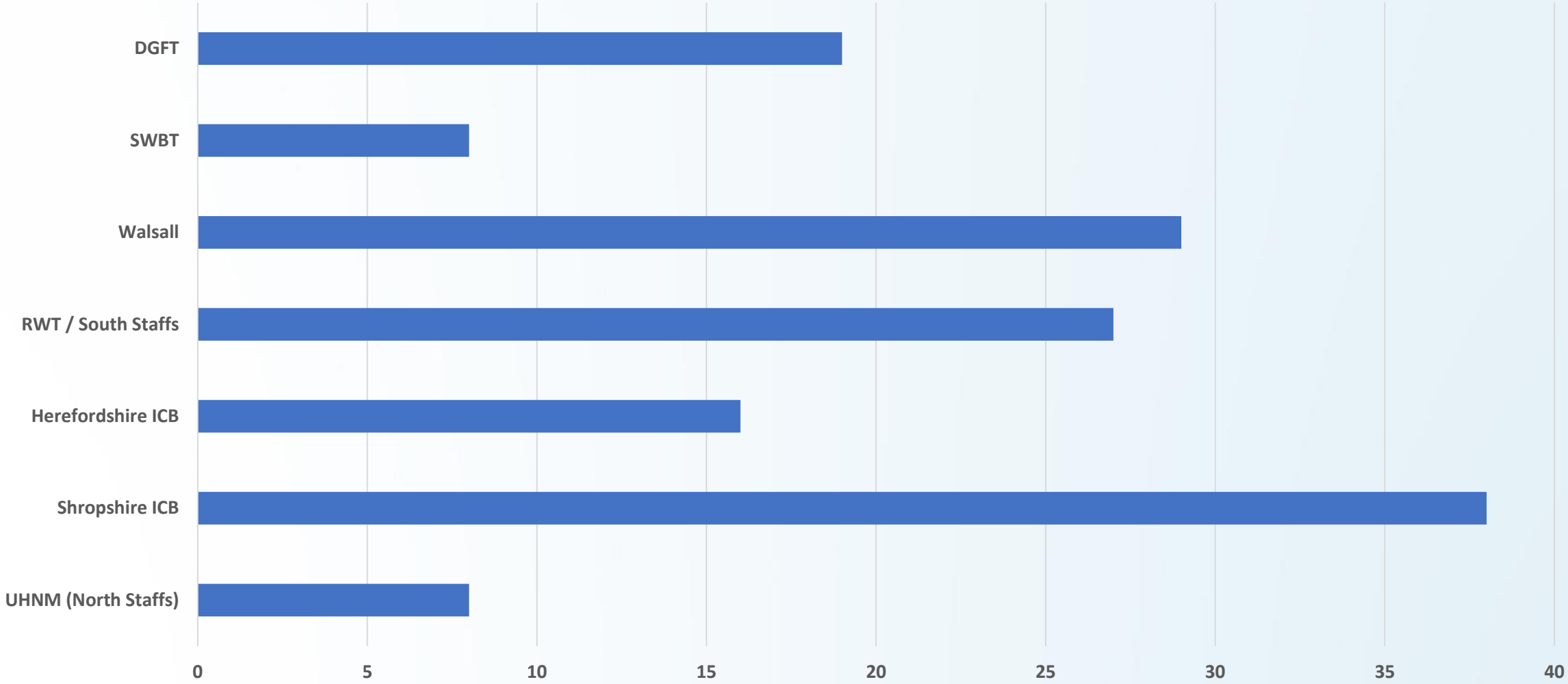
Case Mix based on current waiting list



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Waiting time in weeks for non urgent cases

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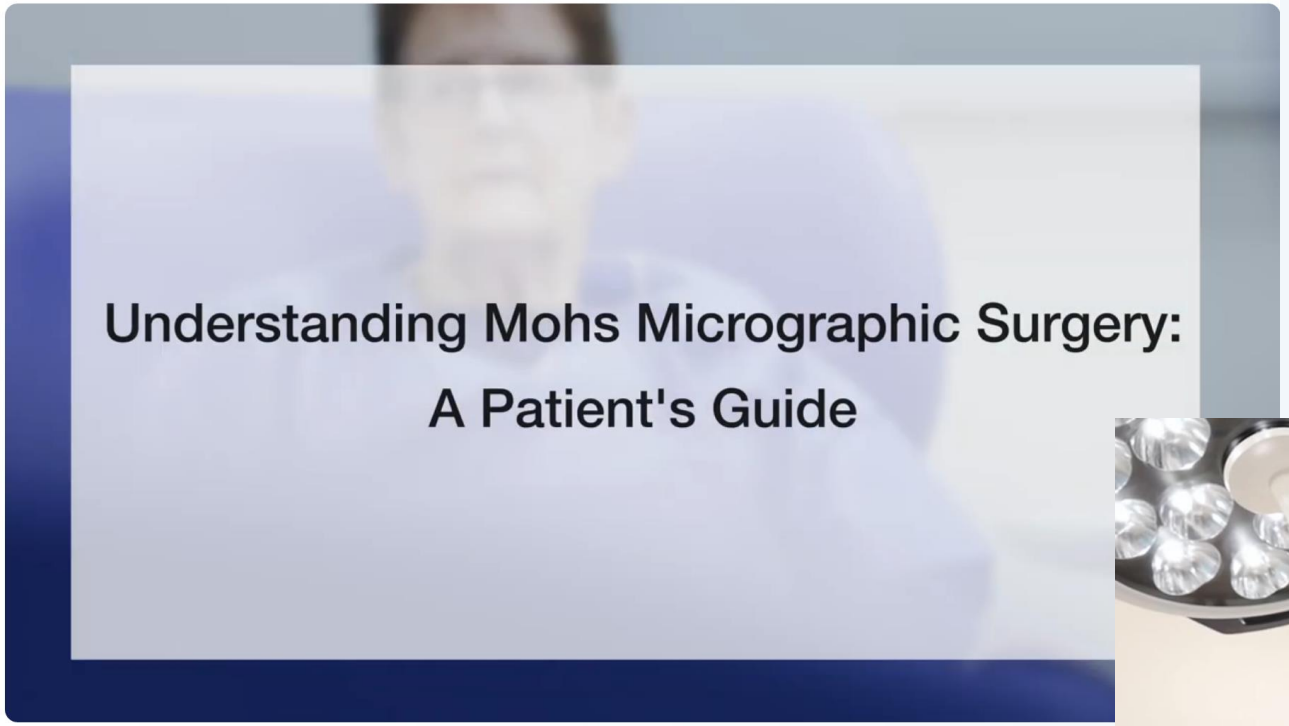

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From a special advisor to the CQC undertaking hospital inspections for 40 years

*I would like to comment about the **outstanding service** I have had from Dr. Wernham and the whole of the Mohs team.*

*It matters not who I am but to quantify my opinion I am a recently retired head of department at a local hospital and was previously a special advisor to the **CQC** having been on over 40 inspections covering services in NHS trusts, private hospitals and independent providers including several Harley St practices.*

*Consequently, I have an informed opinion and can say that the **Mohs department at New Cross is the best I have seen in relation to care, and I would have had no hesitation in recommending to inspectors on an inspection that the service was outstanding from booking to the procedure itself and aftercare**.*

*The **kindness was humbling** and everyone involved in my care showed all the qualities that the hospital and CEO should be rightly proud of.*

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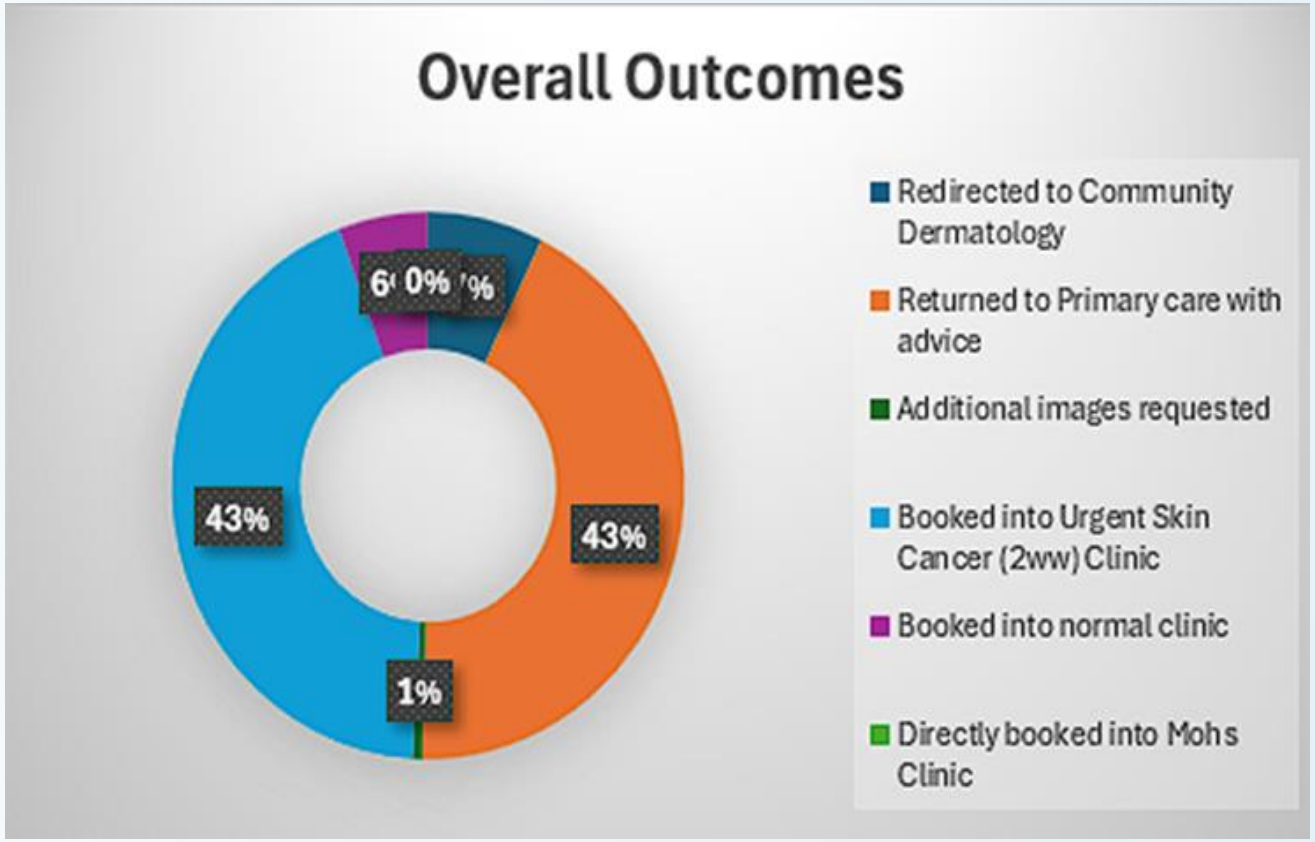
Tele-dermatology

- Well established at WHT, RWT & DGFT
  - Now live at SWBH
- Recent audit of WHT/RWT data:
  - 7,856 cases over 9 months
  - Only 43% needed USC (2ww) appointment
  - Mean time to review 17hrs

- **Expansion planned to include non-cancer and paediatric pathways**



RWT & WHT data; N = 7856

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Teledermatology Data – Qtr 1 (24/25) to Qtr 1 (25/26)

Teledermatology Standard: 50% of USC referrals managed through teledermatology

	Qtr 1 (24/25)			Qtr2 (24/25)			Qtr3 (24/25)			Qtr4 (24/25)			Qtr1 (25/26)		
	The number of urgent suspected skin cancer referrals managed through teledermatolo	The number of urgent suspected skin cancer referrals received by secondary care within the	%	The number of urgent suspected skin cancer referrals managed through teledermatolo	The number of urgent suspected skin cancer referrals received by secondary care within the	%	The number of urgent suspected skin cancer referrals managed through teledermatolo	The number of urgent suspected skin cancer referrals received by secondary care within the	%	The number of urgent suspected skin cancer referrals managed through teledermatolo	The number of urgent suspected skin cancer referrals received by secondary care within the	%	The number of urgent suspected skin cancer referrals managed through teledermatolo	The number of urgent suspected skin cancer referrals received by secondary care within the	%
BC ICB															
DGH	916	1258	72.81%	1128	1513	74.55%	1068	1508	70.82%	796	1222	62.92%	1143	1602	71.35%
RWH	777	1481	52.46%	620	1617	38.34%	776	1332	58.25%	773	1103	70.08%	831	1301	63.87%
WHT	195	683	28.55%	485	941	51.54%	374	638	58.62%	347	736	47.15%	450	968	46.49%
SWB	33	1057	3.12%	56	1166	4.80%	6	1080	0.55%	10	920	1.09%	11	877	1.25%
BSol ICB															
UHB	3722	3722	100.00%	4198	4198	100.00%	3532	3532	100.00%	6306	6307	100.00%	4340	4340	100.00%
CW ICB															
UHCW	1	1186	0.84%	102	2528	4.03%	111	2147	5.17%	50	1881	2.66%	233	2515	9.26%
SWFT	113	2159	5.23%	0	1222	0.00%	2	1084	0.18%						
HW ICB															
WVT	621	621	100.00%	730	730	100.00%	624	624	100.00%	553	553	100.00%	450	809	55.62%
WAHT	0	2270	0.00%	0	2371	0.00%	0	2369	0.00%	0	0		0	2478	0.00%
SSoT ICB															
UHNM	3147	3147	100.00%	3534	3534	100.00%	2948	2948	100.00%	2511	2511	100.00%	3279	3279	100.00%
STW ICB															
SATH	1356	2474	54.81%	1808	2975	60.77%	1489	2383	62.48%	1217	2047	62.09%	1663	2656	62.61%
West Midlands	10881	20058	54.00%	12661	22795	56.00%	10930	19645	55.63%	12563	17280	72.70%	12400	20825	59.54%

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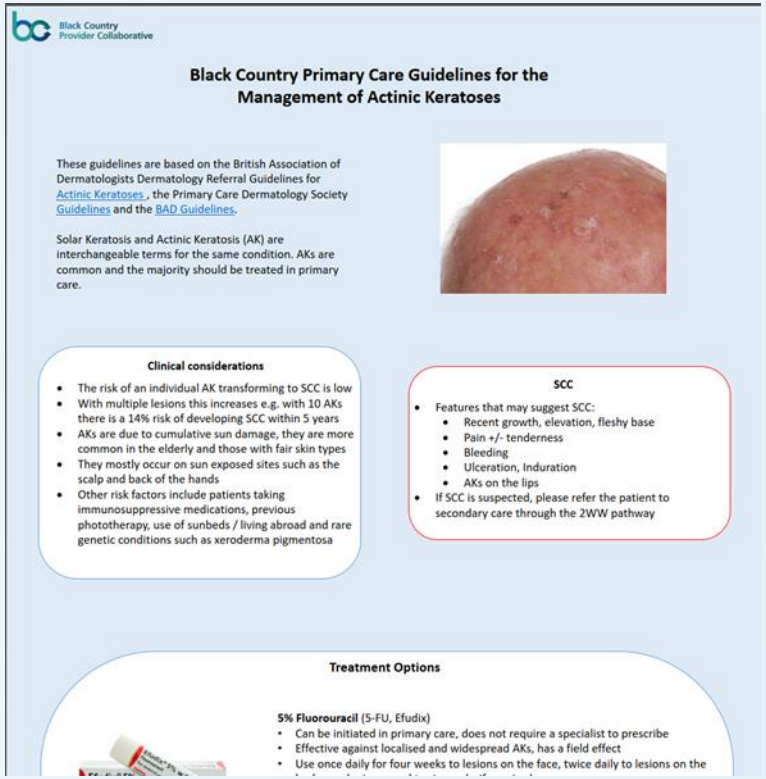
Primary Care Guidelines & Referral Thresholds

- **Significant variability** of delivery of dermatology in primary care
  - Substantial number of patients referred to secondary care that could have been managed in primary care
- An initial batch of **20 primary care guidelines** for common condition has been created
  - **Inclusive of referral thresholds** to clarify what should be managed in primary care secondary care
- Recently **agreed ICB process for approving primary care guidelines** through the primary/interface steering group, electronic system developed to hold depositary of all regional guidelines
  - Dermatology guidelines to be trialled as first specialty in this new process



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Black Country Primary Care Guidelines for the Management of Actinic Keratoses

These guidelines are based on the British Association of Dermatologists Dermatology Referral Guidelines for Actinic Keratoses , the Primary Care Dermatology Society Guidelines and the BAD Guidelines.

Solar Keratosis and Actinic Keratosis (AK) are interchangeable terms for the same condition. AKs are common and the majority should be treated in primary care.

Clinical considerations

- The risk of an individual AK transforming to SCC is low
- With multiple lesions this increases e.g. with 10 AKs there is a 14% risk of developing SCC within 5 years
- AKs are due to cumulative sun damage, they are more common in the elderly and those with fair skin types
- They mostly occur on sun exposed sites such as the scalp and back of the hands
- Other risk factors include patients taking immunosuppressive medications, previous phototherapy, use of sunbeds / living abroad and rare genetic conditions such as xeroderma pigmentosa

SCC

- Features that may suggest SCC:
  - Recent growth, elevation, fleshy base
  - Pain +/- tenderness
  - Bleeding
  - Ulceration, Induration
  - AKs on the lips
- If SCC is suspected, please refer the patient to secondary care through the 2WW pathway

Treatment Options

5% Fluorouracil (5-FU, Efudix)

- Can be initiated in primary care, does not require a specialist to prescribe
- Effective against localised and widespread AKs, has a field effect
- Use once daily for four weeks to lesions on the face, twice daily to lesions on the

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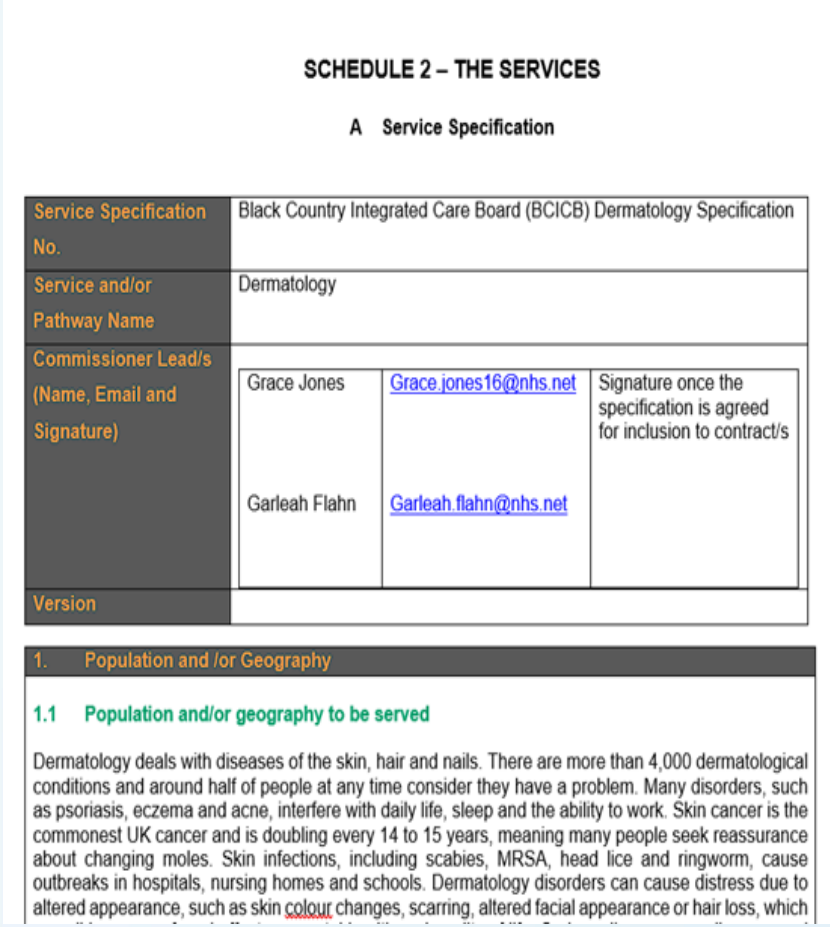
ICB Wide Service Specification

- A substantial piece of work is being undertaken to develop a comprehensive service specification for Dermatology across the ICB
- Dermatology has been chosen as the first specialty, with a plan for future service specifications for all specialities
- Likely to be a lead provider, holding a single waiting list for the ICB, with subcontracting to both other acute providers and community/intermediate providers
- **First step to a system wide integrated Dermatology service**



SCHEDULE 2 – THE SERVICES

A Service Specification

Service Specification No.	Black Country Integrated Care Board (BCICB) Dermatology Specification		
Service and/or Pathway Name	Dermatology		
Commissioner Lead/s (Name, Email and Signature)	Grace Jones Garleah Flahn	Grace.jones16@nhs.net Garleah.flahn@nhs.net	Signature once the specification is agreed for inclusion to contract/s
Version			

1. Population and /or Geography

1.1 Population and/or geography to be served

Dermatology deals with diseases of the skin, hair and nails. There are more than 4,000 dermatological conditions and around half of people at any time consider they have a problem. Many disorders, such as psoriasis, eczema and acne, interfere with daily life, sleep and the ability to work. Skin cancer is the commonest UK cancer and is doubling every 14 to 15 years, meaning many people seek reassurance about changing moles. Skin infections, including scabies, MRSA, head lice and ringworm, cause outbreaks in hospitals, nursing homes and schools. Dermatology disorders can cause distress due to altered appearance, such as skin colour changes, scarring, altered facial appearance or hair loss, which

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Skin Cancer Metrics

Skin Cancer Waiting Times Data – 12 months Aug 2024 – Jul 2025

Suspected Skin Cancer 28-day FDS: Standard is 75% shifting to 80% by Mar 2026

Skin 28-day FDS (National Target 75% shifting to 80% Mar 26)												
	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
BC ICB												
DGH	94.1%	87.0%	80.9%	85.1%	92.1%	93.2%	99.5%	99.1%	96.2%	83.0%	78.8%	92.3%
RWH	89.0%	85.9%	95.4%	95.7%	97.7%	98.6%	99.4%	98.9%	99.2%	98.2%	98.1%	99.5%
SWBT	95.1%	96.3%	98.5%	89.1%	96.8%	91.8%	94.6%	88.2%	79.1%	77.5%	86.5%	78.0%
WHT	97.2%	95.8%	96.9%	99.4%	86.1%	98.0%	82.7%	96.2%	98.4%	97.3%	96.9%	95.5%
BSoL ICB												
UHB	85.1%	87.0%	85.3%	86.3%	82.9%	86.1%	90.7%	93.3%	91.2%	92.4%	88.8%	90.1%
CW ICB												
UHCW	83.4%	84.3%	78.3%	78.5%	88.2%	79.2%	85.7%	85.3%	86.3%	85.0%	84.4%	87.1%
SWFT	86.6%	90.6%	88.7%	88.5%	89.7%	90.7%	92.5%	89.8%	88.0%	90.7%	50.3%	12.2%
HW ICB												
WAHT	89.0%	88.9%	86.1%	77.2%	78.3%	83.4%	90.2%	87.0%	87.5%	86.8%	91.0%	82.8%
WVT	87.9%	87.6%	93.6%	95.2%	97.3%	96.8%	100.0%	98.1%	97.0%	97.2%	98.1%	97.2%
SSoT ICB												
UHNM	87.4%	85.8%	86.8%	85.9%	97.6%	82.4%	96.9%	84.9%	88.3%	90.8%	89.4%	91.0%
STW ICB												
SATH	87.2%	87.7%	88.7%	88.4%	85.9%	83.7%	88.6%	85.0%	91.1%	93.1%	91.6%	95.1%
West Mids	88.1%	87.8%	87.0%	85.9%	87.0%	86.6%	91.0%	90.2%	90.6%	89.9%	87.9%	87.6%
NATIONAL	82.9%	81.7%	83.3%	84.5%	86.4%	84.6%	89.5%	89.4%	88.4%	85.7%	85.4%	83.3%

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Skin Cancer Metrics

Skin Cancer Waiting Times Data – 12 months Aug 2024 – Jul 2025
Suspected Skin Cancer 62-day: Standard is 70%

Skin 62-day (National Target 70%)													
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
BC ICB													
DGH	84.9%	75.4%	86.7%	91.9%	68.9%	80.0%	81.2%	80.0%	78.8%	85.2%	73.1%	95.5%	83.3%
RWH	78.3%	79.2%	86.0%	76.1%	83.6%	90.8%	83.3%	90.7%	93.2%	90.6%	100.0%	83.8%	97.4%
SWBT	91.7%	64.7%	72.7%	88.9%	64.5%	72.7%	100.0%	75.0%	75.0%	63.2%	77.7%	73.7%	86.5%
WHT	95.5%	89.4%	100.0%	98.5%	95.7%	93.0%	97.6%	95.3%	100.0%	100.0%	100.0%	100.0%	94.7%
BSol ICB													
UHB	84.4%	89.4%	79.1%	76.4%	82.8%	82.3%	90.9%	72.4%	85.1%	84.3%	87.5%	76.9%	90.7%
CW ICB													
UHCW	90.6%	77.0%	72.6%	71.1%	78.4%	86.7%	86.7%	75.0%	91.0%	93.3%	79.6%	88.5%	83.4%
SWFT	68.3%	81.4%	74.5%	78.1%	84.1%	82.9%	80.5%	50.0%	72.3%	77.8%	80.9%	59.1%	72.7%
HW ICB													
WAHT	76.6%	76.0%	77.8%	63.6%	60.5%	71.1%	87.6%	78.3%	81.6%	74.4%	67.5%	74.5%	58.7%
WVT	76.2%	93.8%	93.3%	94.7%	100.0%	100.0%	100.0%	95.2%	97.4%	93.9%	96.2%	100.0%	90.7%
SSoT ICB													
UHNM	86.0%	82.8%	90.7%	75.0%	91.8%	73.3%	90.9%	86.0%	87.2%	74.7%	100.0%	82.5%	92.0%
STW ICB													
SATH	67.7%	64.4%	53.6%	65.4%	80.8%	90.6%	86.0%	85.7%	93.8%	87.5%	94.5%	97.3%	81.3%
West Mids		79.8%	78.7%	76.8%	79.6%	83.1%	88.2%	79.1%	87.1%	85.7%	86.8%	83.8%	83.7%
NATIONAL		85.8%	84.0%	82.9%	82.9%	84.4%	84.1%	85.3%	89.5%	88.6%	87.4%	90.0%	86.4%

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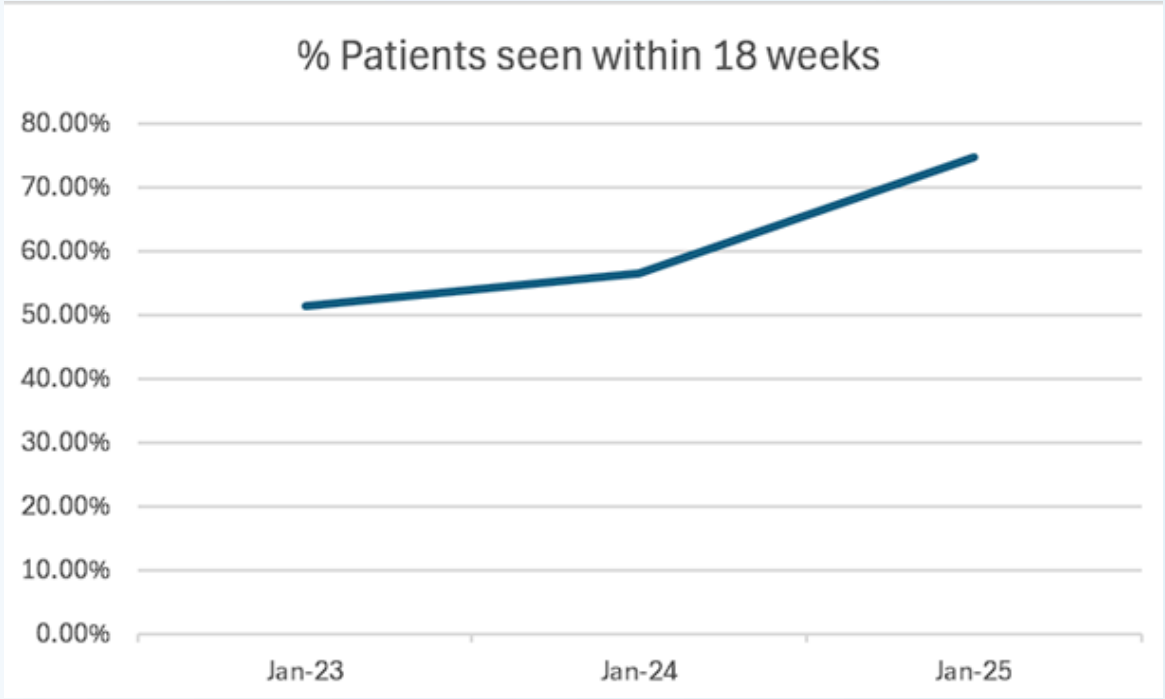
RTT Metrics

	% Seen within 18 weeks	% Waiting 52 weeks+
National	64%	2.5%
Black Country	74.7%	0.9%
BSOL	71.3%	1.4%
Shropshire	56.3%	1.4%
Staffordshire	58.9%	4.8%
Coventry	60.9%	4.3%

The Black Country ICB RTT Dermatology:

- **Best performing ICB** in the West Midlands
- **Significantly better than national average**
- **52-week waits nearly eliminated** (eliminated at WHT and RWT Trusts)



The Black Country ICB RTT Dermatology:

- **Consistent improvement over time**

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GIRFT Visit

- On the 11th September 2025 there was a **GIRFT Dermatology visit** led by **Prof Levell**
- The Black Country was assessed as a whole, covering Dermatology services at all four acute trusts
- **Very positive** informal feedback
  - Impressed at the **momentum of projects** within the Black Country
  - **Most GIRFT recommendations now met**
  - No concerning areas identified

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Risks

Demand

- Ever increasing demand, especially on fast-track skin cancer pathways
  - e.g. Walsall - **100% increase in 2ww referrals** compared to last year
  - Increased out of area referrals
    - Fragility of Dermatology services in Staffordshire, Shropshire and Worcestershire

ERF Cap

- Financially limits activity and future expansion
  - e.g. Walsall has completed **over £200k of Dermatology** activity so far, this financial year that **will not be funded by the ICB**
    - Unless cap is lifted, RTT and cancer targets are going to worsen

↑Demand ✚ Capacity Cap → ↑Waiting lists

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Thank you & Questions.

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Lunch & Networking

(12:30 to 13:30)

Please inform Catering Staff of Dietary requirements

- Halal
- Nut allergy
- Shellfish/Seafood allergy
- Egg
- Gluten free
- No beef/pork
- Vegetarian/Vegan
- Pescatarian
- Lactose Intolerance
- Dairy

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Welcome Back

RETURN FROM LUNCH (13:30)		
7.	**BCPC Pharmacy Aseptic Transformation**	13.30
8.	**NHS 10-year Plan**	13:50
9.	**Aquablation and Spotlight Innovation: GALEAS Bladder Cancer DNA Test**	14:10
BREAKOUT SESSION 2		
10.	**BCPC Clinical Networks – Short showcase presentation**	A) 14:35 B) 15:05
Break (15:35 – 15:45)		
11.	**Closing Remarks & Next Steps**	15:45
CLOSE (16:00)		

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BCPC Pharmacy Aseptic Transformation

Ruckie Kahlon
Chief Pharmacist, DGFT; Programme Lead

Steven Shanu
Deputy Chief Pharmacist, DGFT; Programme Manager

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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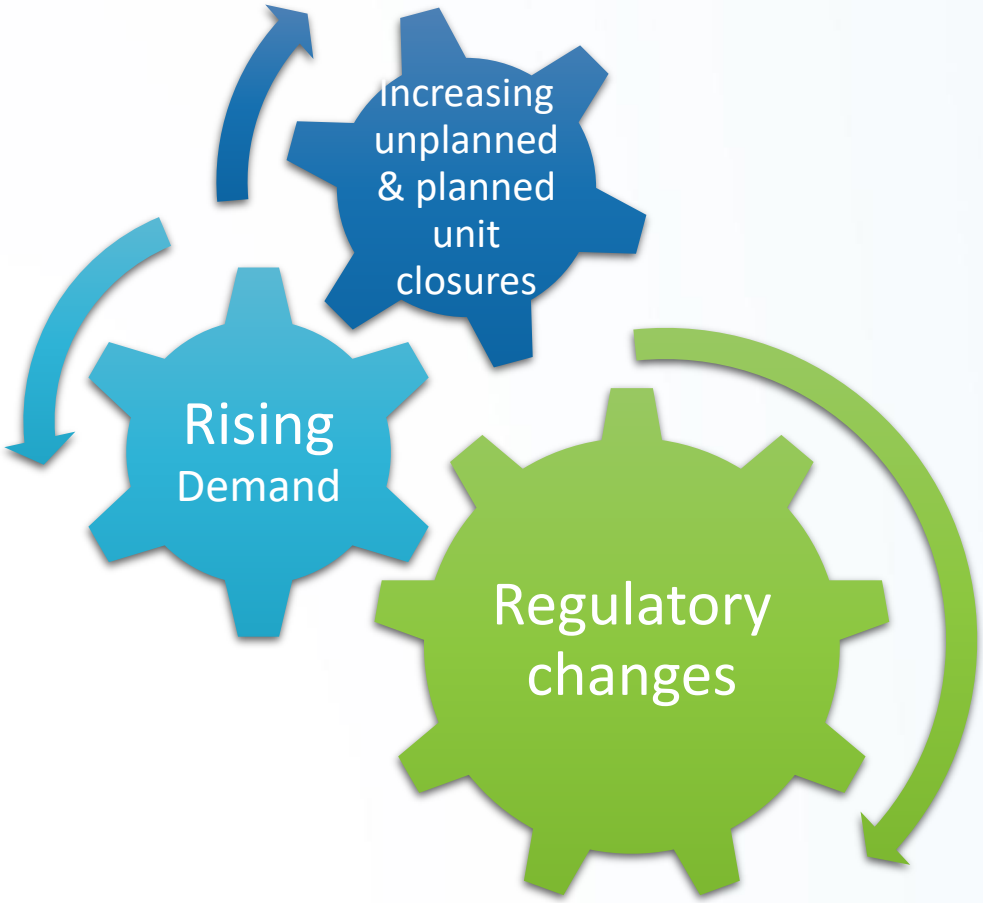
Key Drivers



Regulatory changes

- Units beyond lifecycle, fragile & non-compliant with current regulations
- Increasing number of planned and unplanned downtime
- Limited space that negatively impacts on workflow and performance
- All units unable to meet MHRA requirements for licencing
- Unit risks all escalated to MEDIUM RISK by NHSE SPS Quality Assurance Auditors

Aseptic Unit Unplanned and Planned Failures

- Walsall – unplanned shutdown since Jan 2024
- SWB unit planned shutdown for 12 weeks and using DGFT for emergency treatments
- DGFT reopened Sept 2025 after 16 week planned preventative maintenance
- Reliant on outsourced service for BCP (£££££) with limited private sector capacity
- High waste risk associated (£700k in 2024 for WHT)
- Patient treatment delays, complaints & deferrals

Rising demand

- Positive CDC early diagnosis impact
- Increased demand for systemic anti-cancer treatment – new NICE approved treatments
- Limited facility & personnel capacity to meet surge

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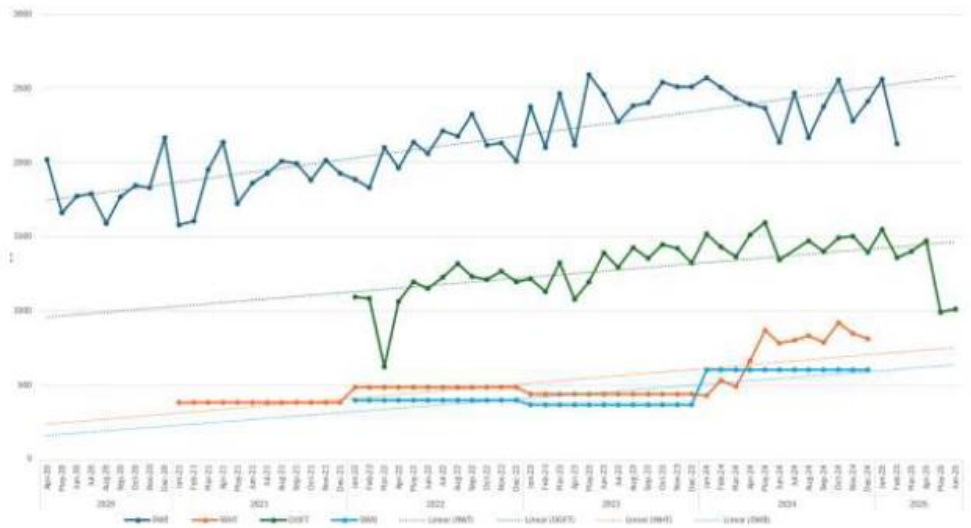
Case for Change: Why Action is Urgent

Rising Demand & Current Gap in-inhouse capacity: Overreliance on private sector outsourcing.

Vulnerabilities in Supply Chain and patient treatment delays.

Financial Risk: Outsourcing is costly, unsustainable, and lacks capacity.



Production of aseptic molecules over time across the BCPC (2020 – 2025)

	Russells Hall Hospital, Dudley	New Cross Hospital, Wolverhampton	Sandwell Hospital	Walsall Manor Hospital
Unit capacity (doses)	7,389	13,798	4,838	6,112
Actual doses prepared	9,031	22,004	4,632	8,772*
2024 capacity utilisation (internally prepared)	122%	159%	96%	144%
2024 capacity utilisation (including outsourced)	204%	208%	150%	144%

Capacity Utilisation for 2024 (denotes fully outsourced figure)*

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Case for Change: Why Action is Urgent

- **Future Demand:** SACT activity is projected to rise by 97% by 2040. Current infrastructure cannot meet future demands.
- Long lead time for new estate
- Units have shifted from low to high risk to patient safety

Figure 2-1: Projected total increase in demand for aseptic services to 2040 (including intravenous antimicrobials

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Overview…

Challenge:

All four BCPC aseptic units are non-compliant with section 10 regulatory standards and (EU's GMP and MHRA standards)

All units are operating beyond safe capacity.

QA standards will evolve for section 10 units in next 2 years

Risk:

Immediate threat to patient safety, care, quality and financial sustainability.

Inability to meet 62-day cancer tx standard

Health inequalities concern from tx delay

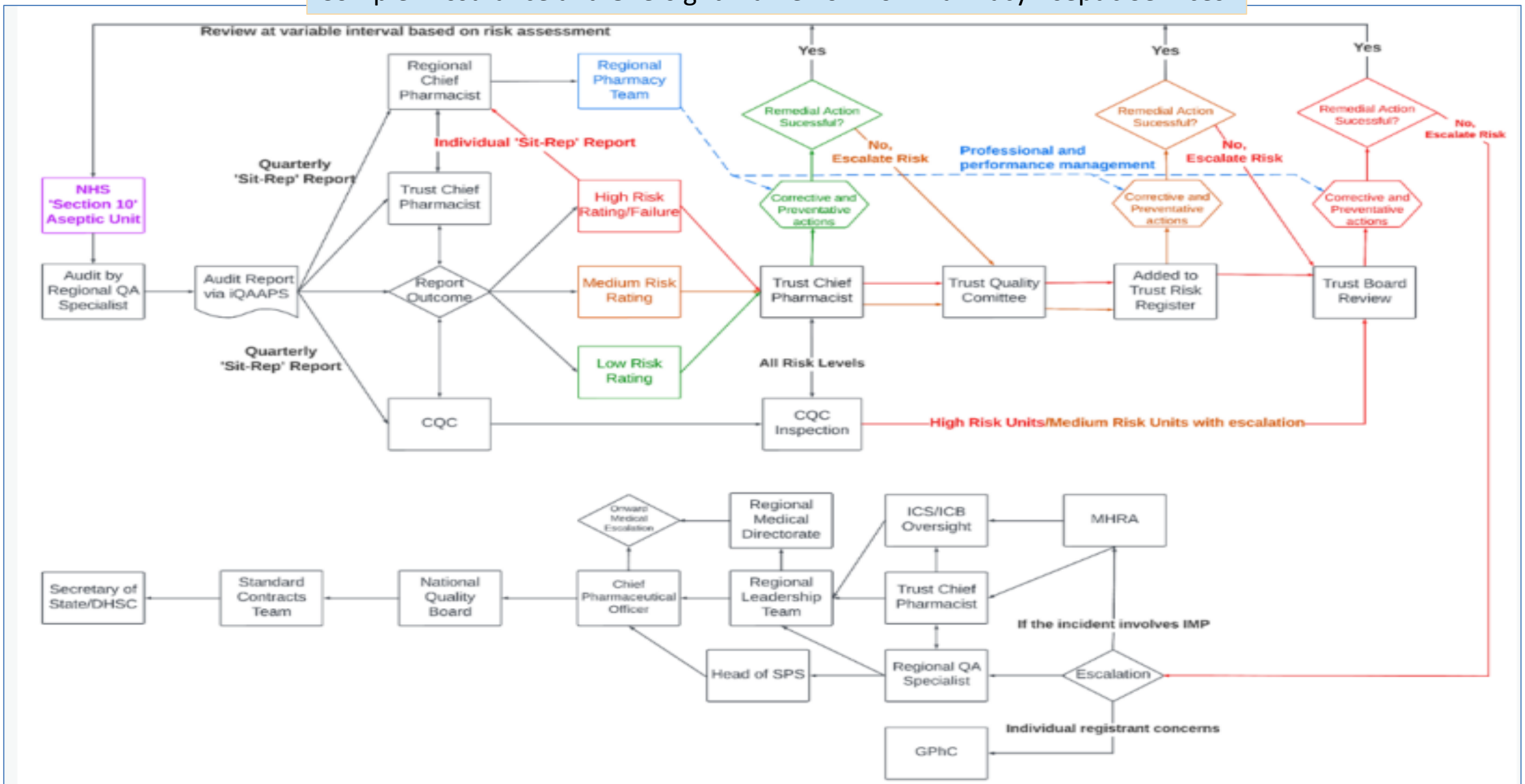
Need:

Urgent short-term remediation and long-term strategic transformation.

Proposal:

Explore aseptic transformation through licensing, unit rationalisation, development of hub & spoke models to deliver compliant, scalable and sustainable aseptic services.

Complex Assurance and Oversight Framework for Pharmacy Aseptic Services



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Background

JPC Commissioned Aseptic Services Transformation and Feasibility Study

June 2024

Regional Quality Assurance reviewed compliance of unit aging, frail, non-compliant

October 2024

Feasibility & SOC tender procurement begins

January 2025

Gilling Dodd appointed. All ICB estate assessed for feasibility. Extended to SOC for JPC commission

March 2025

DGFT 14-week maintenance shutdown

May 2025

SWB maintenance shutdown – timeframe tbc

October 2025

All units expected to be medium/high risk with escalating service demand, operating over capacity

2026

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Strategic Outline Case

- Held two workshops with wide range of stakeholders
- Developed scope and preferred service design
- Assessed strategic benefits
- Developed critical success factors that enable aseptic transformation
- Agreed spending objectives
- Produced high level capital costs - considerable limitation of these due to long list of assumptions
- Not possible to determine revenue costs due to lack of clarity on models
- Explored shortlisted options to assess the impact of agreed critical success factors

A "Case for Change" (i.e. what are the problems) with possible high-level options for consideration, recommendations (including anything that might need to keep the 'wheels on the road') and some practical next steps.

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Critical Success Factors

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REF	CSF DESCRIPTION
QUALITY & SAFETY	
CSF001	**Enhanced Clinical Environment and Capacity** Facilities are physically improved, meet all mandated standards (GMP, HBN) for licensing, and provide sufficient, flexible, and adaptable capacity (operating at a maximum of 80%) to meet current and projected aseptic provision and all treatment demands for at least the next 5-10 years.
CSF002	**Sustainable and Skilled Workforce** The service is supported by a robust, sustainable, and skilled workforce, evidenced by improved staff experience, recruitment, retention, and the presence of suitably trained, qualified, and content personnel, leading to a low-error service.
CSF003	**Optimised and Compliant Service Delivery** Service processes are streamlined, standardised where appropriate, and fully compliant, leading to optimal patient treatment delivered at the right time and in the right place, with a proactive approach to service management.

REF	CSF DESCRIPTION
FINANCE & PERFORMANCE	
CSF004	**Value for Money** The financial case for the project clearly demonstrates value for money in terms of the benefits it will deliver
CSF005	**Affordability** The financial case for the project clearly demonstrates that it is affordable within the available capital and revenue funding envelope
CSF006	**Project Deliverability** The project can secure necessary services, works, and supplies from a capable and competitive market that has the capacity and appetite to deliver the defined requirements effectively, to the required standards, and in a way that achieves value for money
PATIENT OUTCOMES & EXPERIENCE	
CSF007	**Demonstrable Improvement in Patient Outcomes and Experience** The project delivers measurable improvements in patient outcomes, evidenced by improvements against cancer targets and reducing delays, and enhances patient experience, as reflected in satisfaction surveys
CSF008	**Environmental Sustainability** Facilities and operational solutions align with strategic sustainability plans and meet all relevant government environmental requirements

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Options Appraisal Examples...

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Options (not exhaustive)	Meets GMP compliance	Increased Capacity	Funding Needed?	Timeline	Hubs MHRA licensed?	Spokes S10 Compliant	Commercial opportunities	IV antimicrobials	Business Continuity Enabled?	Improved Staff Experience
0 (Do nothing)	X	X	X	X	X	X	X	X On ward	X	X
1 (Do Minimum) Re-provide all facilities across 4 sites	✓	✓ 10 years post	✓ Trust CDEL	X	X Not fully	✓	X	X	X Limited	X Limited
2 (One Hub Four Spokes)	✓	✓ 10 years post	✓ National PDC and BC ICB Revenue	✓ 5 years post approval	✓	✓	✓ Potential including clinical trials	✓ Most at hub	✓ Limited for hub	✓
3 (Two Hub Two Spokes)	✓	✓ 10 years post	✓ **COSTLY** National PDC and BC ICB Revenue ask	✓ 3 years post approval	✓	✓	✓ Potential including clinical trials	✓ Almost all in Hubs	✓	✓
4 (Two Hubs Four Spokes)	✓	✓ 15 years post	✓ **COSTLY** National PDC/ Industry Support	✓ 3 years post approval	✓	✓	✓	✓ Almost all in Hubs	✓	✓

Note: Currently 19 aseptic dispensing isolators across BCPC with a gap of between 7 to 18 isolators to meet ongoing demand. Preferred model will be determined by which sites chemotherapy treatment services reside across BCPC

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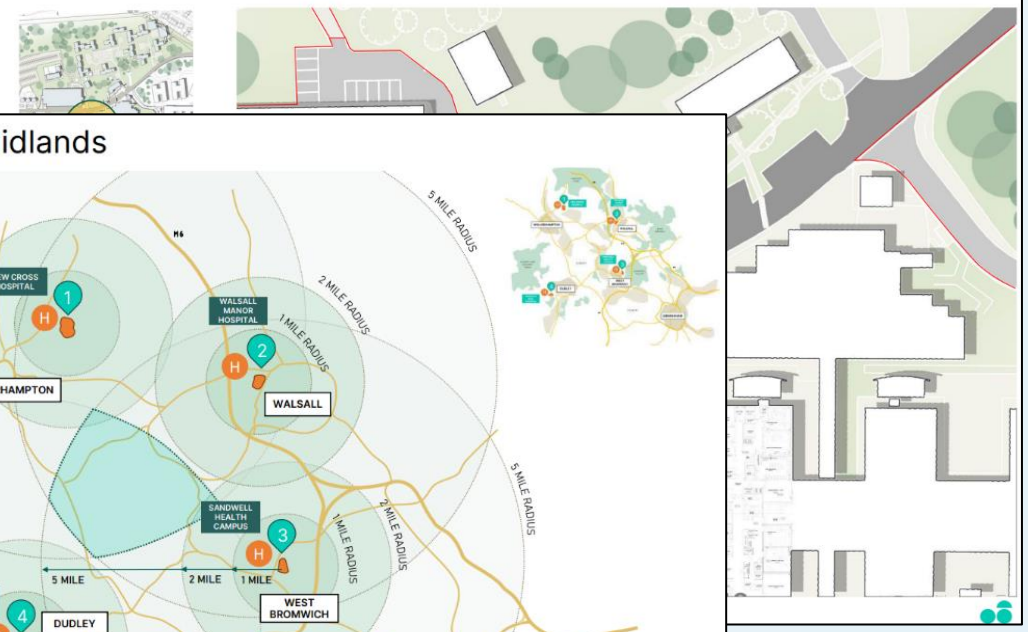
Site Feasibility

3.30 Russells Hall Hospital

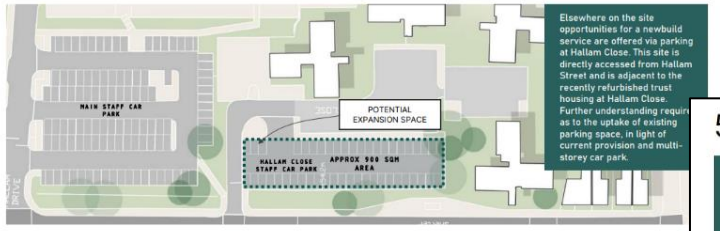
Mechanical and Electric Potential for Future Development

There are 132kV dual circuit passing through the site that fall part of Penn GSP. There is a local substation that feeds the site called new Russells Hall. There are 2 DNO ring main units with constraint panels. One acts as a backup supply, where the normal supply comes directly from the Primary Dudley 11kV sub. The alternative feeder comes also from the same primary, but from another transformer and starts from a T on a ring cable that feeds other customers downstream. It also appears that they have synchronisable generators on site, hence the constraint panels. HV cables appear to be triplex all 300sqmm, which should be good for 8MVA. All subject to DNO's confirmation.

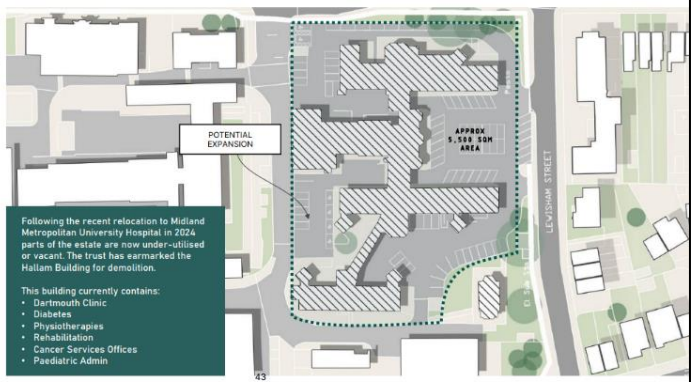
3.32 Russells Hall Hospital – Option B



3.46 Sandwell Health Campus – Option B & C



Elsewhere on the site opportunities for a newbuild service are offered via parking at Hallam Close. This site is directly accessed from Hallam Street and is adjacent to the recently refurbished trust housing at Hallam Close. Further understanding requir as to the uptake of existing parking space, in light of current provision and multi-storey car park.



- Vacant site ready for immediate redevelopment.
- Direct access to a Hallam Road without coming onto the Sandwell Health Campus site.
- Loss of parking has already been addressed with the new multi-storey car park on the site.
- Redevelopment of the site is at an early stage which could incorporate this development.
- Small site suitable for a small unit but would not be suitable for a large single hub model
- Redevelopment of the site is at an early stage which could incorporate this development.
- Large enough site to support a wide range of aseptic unit models including a central hub model.
- Direct access to a Lewisham Street without coming onto the Sandwell Health Campus site.
- Existing buildings on the site which require demolition.

Following the recent relocation to Midland Metropolitan University Hospital in 2024 parts of the estate are now under-utilised or vacant. The trust has earmarked the Hallam Building for demolition.

This building currently contains:
- Dartmouth Clinic
- Diabetes
- Physiotherapies
- Rehabilitation
- Cancer Services Offices
- Paediatric Admin

The Dudley Group NHS Foundation Trust
Aseptic Services Study Review
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5.0 Context | The West Midlands

When looking for alternative sites located centrally within the Black Country regions (Dudley, Wolverhampton, West Bromwich and Walsall) we have looked for sites located within the intersecting radius of each Hospital site.

When the reach is reduced to 2 miles, an underserviced zone within Wednesbury, Bilston and Tipton can be observed.

CONTEXT PLAN KEY
- Denotes 1 mile radius
- Denotes 2 mile radius
- Denotes 5 mile radius
- Hospital site location
- Hospital name

1 **New Cross Hospital** Wolverhampton, General Hospital
2 **Walsall Manor Hospital** Walsall, Acute General Hospital
3 **Sandwell Health Campus** West Bromwich, General Hospital
4 **Russells Hall Hospital** Dudley, General Hospital

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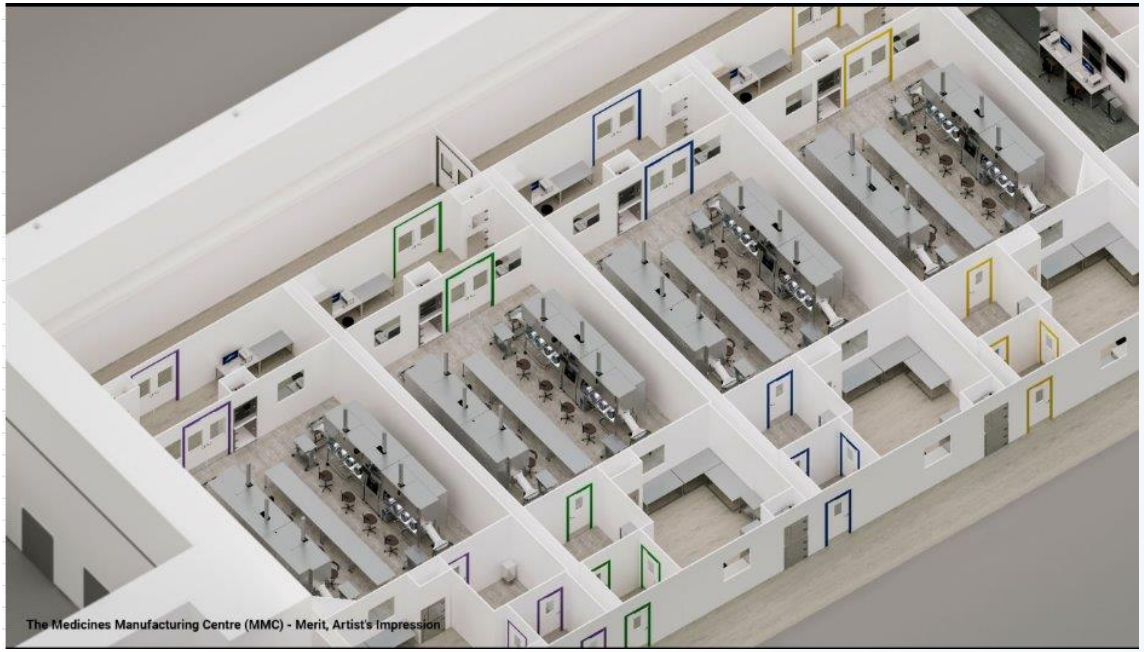
Future Vision... To be agreed



Visual interpretation of the inside of aseptic unit

Picture taken from
Appendix 5-1 Site Feasibility Report

Current Group Position

RWT and Walsall

- RWT Wrekin House – aseptic unit and radiopharmacy build complete
- Revenue case pending approval 29.10.25 to enable new unit commissioning from June 26 and operational Dec 26
- Organisational form prohibits supply from RWT to WH unless RWT granted MHRA licence
- Insufficient capacity in new RWT unit and may require change in workforce shift patterns
- WH air handling failure since Jan 2024
- Considerable waste at WH associated £700k in 2024
- RWT - Cancer centre Haem & Onc services
- WHT - OPD Onc services via UHB SLA – change?

DGFT and SWBH

- Oldest units across BCPC
- DGFT - large cancer unit OPD Oncology and OPD and In-patient Haem services with Stem cell transplant service
- SWB- Haem in-patient and OPD services
- Both aseptic units undergoing extensive PPM = unit closure and outsourcing arrangements
- RAAC throughout DGFT site – opportunity to explore aseptic unit rebuild?
- Sandwell Health Campus site potential availability for aseptic unit build

Decisions needed to explore possible delivery models and associated system capital allocation.
Move SOC to OBC to enable anticipated national bid process after Nov 2025

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Decisions...

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Decisions within SOC – discussed at each organisation		Outputs
D1	Agree the strategic direction of aseptic service transformation across the BCPC as a collaborative. Alongside the impact of ICB clustering with BSOL. This will be critical to identify the most appropriate model for aseptic production moving forward.	Broad agreement on need for transformation, collaboration and inclusion of BSOL
D2	Following a decision on D1, determine the organisational appetite to deliver aseptic provision as a single entity hosted by one Trust, in group pairs, multiple entities, or a joint venture or other wholly owned model.	Group pairing is occurring naturally through existing build work and planned care discussions
D3	Determine the preferred configuration for acute service delivery and business continuity: an all-in-one hub, multiple spokes, or a hybrid model.	Options appraisal to explore in OBC
D4	Decide on site selection for new builds or refurbishments, including whether to pursue expansion at specific sites. This will include determining organisational willingness to identify spaces for vacation should refurbishment be preferred, or whether to proceed with new builds as the default.	Options appraisal to explore in OBC
D5	Assess our risk appetite: Decide whether to aim for full compliance (which will require new builds) or accept partial compliance through refurbishment	Broad agreement that aseptic services across all sites are extremely vulnerable. Current medium high risk not tolerated and requires reduction to low
D6	If moving to licensed hub and spoke: Determine if production of key high volume intravenous antimicrobials could move from wards to a new aseptic facility.	Large scale operations require exploration with BSOL
D7	Decide whether to maintain the current projected 25% level of outsourcing or aim to reduce / eliminate outsourcing by increasing in-house capacity.	Low level outsourcing is likely to remain to support existing demand and to enable business continuity
D8	Consideration of the provision of systemic anti-cancer therapy provision across BCPC constituent Trusts as this directly impacts aseptic service provision	Potential discussions between RWT and WHT

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Recommendations...

Proximity	Recommendations	
Short Term (2025/26-2027)	R1	Commitment of required capital to re-operationalise the Walsall aseptic unit in either the 2025/26 or 2026/27 financial years. If approved, this will increase available internal capacity and reduce external spend on private suppliers.
	R2	Commitment of required revenue to fully operationalise the new aseptic unit at Wolverhampton as outlined in the original business case for the facility.
	R3	**Following decisions made, support the progression of this SOC to OBC stage and frame the parameters (as per decisions).**
	R4	Continue engagement with aseptic pathfinder sites to identify what has been successful and what learning can be taken to the BCPC to ensure project success
	R5	Continue engagement with BSOL, East Midlands and other local systems to identify potential opportunities for collaboration in relation to aseptic transformation.
	R6	Determine if production of key high volume intravenous antimicrobials could move from wards to a new aseptic facility as part of the development on the OBC.

Proximity	Recommendations	
Medium Term (2026/27-2027/28)	R7	Undertake the economic and financial appraisals during the OBC following agreement of options
	R8	Board level engagement with NHSE / HMT to support the progress of the OBC through national governance
	R9	Commitment of required capital and revenue funding to stabilise the facility at Sandwell and provide additional capacity prior to implementation of the full recommended transformation.
	R10	Engagement with national pharmacy bodies and NHS England to socialise the aims, objectives and benefits of the BCPC Aseptic Transformation project and its progress.
	R11	Begin implementation of standardised aseptic digital systems across all four Trusts.
Long Term (2027/28-2029/30)	R12	Implementation of the full proposals set out in the OBC, alongside benefits monitoring and delivery.
	R13	Begin consideration of wider pharmacy transformation across BCPC to deliver further benefits of service integration.

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Financial impact - uncertain

- Unclear until preferred model is better understood and agreed
- High level financial modelling provided within SOC - PLEASE TREAT WITH EXTREME CAUTION
  - Due to the levels of uncertainty, a mitigated **optimism bias level of 37%** has been utilised in calculating the high-level capital cost estimates.
  - Modelling undertaken using pathfinder industrial scale manufacturing assumptions
- NOTE: SOC purpose is to assess the strategic direction and case for change
- Outline business case will provide accurate financial impact assessments of preferred way forward options.

Appendix 4-8 sets out high level capital costs

*Context: DGFT ED Resus Build cost £16.9M however if the aseptic footprint provided for industrial Hub= £66.26m (revised option 1 would be £44M over 3 sites)

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Next Steps: Strategic Outline Case to OBC

1. SOC draft circulated for review
2. SOC socialised at each Trust and ensure decisions needed on strategic direction of each aseptic unit and chemotherapy provision is fully assessed at each site and recommendations considered
3. Each site to feedback to R. Kahlon by 31st Oct 2025
4. Present SOC decisions at BCPC Executives 03.11.2025 to assess local decisions and recommendations and derive a collective way forward
5. Presented BCPC Executive decisions and way forward at JPC 21.11.2025
6. Next steps? Operationalise decisions to: Agree system approach for aseptic capital OBC funding and bid for national capital funds

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"Failure to act now risks the total collapse of aseptic provision across all BCPC sites and a systemic inability to treat some of the most acutely unwell patients without the scale of supply chain to act as a supplier of last resort."

Aseptic Services Feasibility & Strategic Outline Case
Gilling Dodd & Partners

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Thank you & Questions.

https://blackcountryprovidercollaborative.nhs.uk/

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The NHS 10-year Plan

What it means for us, the importance of accurate counting and coding

Preparing for a rules-based environment

Dinah McLannahan

BCPC Chief Finance Lead

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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Background

- NHS 10-year plan published July 2025

- Three shifts:
  - Hospital to Community
  - Sickness to Prevention
  - Analogue to Digital

- NHS must become, “fit for the future”

- Clinicians are central to this transformation

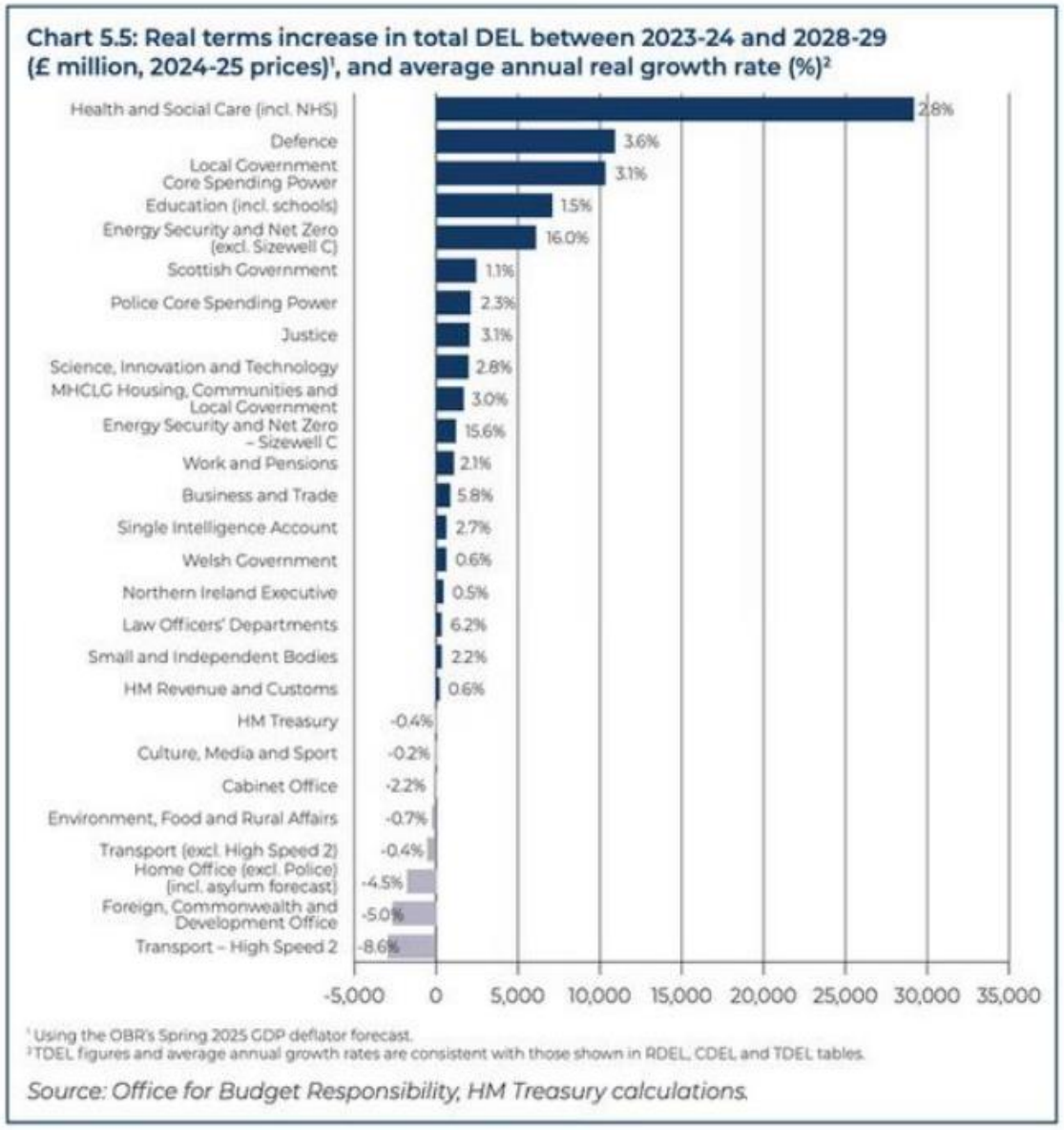
NHS Funding

Phase 2 of the Spending Review concluded with Chancellor's announcement on 11 June, which confirmed DHSC's SR settlement:

- 2.8% average annual real-terms growth for RDEL
- Flat real-terms growth for CDEL

The settlement will support delivery of priority commitments:

- Improving elective performance (Plan for Change)
- Achieving 2% annual productivity growth
- Repairing critical infrastructure and safety issues in the NHS
- Supporting reform and delivery of the three shifts and the 10 Year Health Plan.



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Implications

- Funding is rising, but the growth in spending is higher!
- Several systems require **non-recurrent deficit support to balance**
- For 25/26, the Black Country system is in receipt of **£95m of non-recurrent deficit support**
- Non-recurrent = **not guaranteed** for future years
- **Cost pressures are strong**: inflation, pay awards, rising demand, ageing population, new technologies, backlog care

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New Rules Based Environment

UNTIL NOW - Flexible, discretionary regime

GOING FORWARD

- Performance metrics and league tables – provider accountability
- Multi year planning
- Financial sustainability
- Sustained productivity improvements
- Block contracts to activity based payment
- Commissioning for outcomes
- Decision making pushed downwards
- Stronger scrutiny of financial performance
- Rules based frameworks
- **The NHS must live within its means**
- Non-recurrent support and one-off interventions disappearing

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New Rules Based Environment – *what does it mean for us in practice?*

ICBs

Strategic Commissioners – Improving population health through contracts with providers across the system, incentivising improved outcomes and 10-year plan delivery objectives through payment mechanisms and contracts

Providers

- Delivery
- Recurrent cost control
- Financial sustainability and efficiency
- Productivity improvement, waste reduction, asset use efficiency - **not more funding**
- Shift from hospital to virtual, community and neighbourhood care
- Early intervention and prevention
- Admission avoidance and proactive management of LTCs
- Value, improvement and outcomes
- Not inputs (cost) and outputs (activity)
- Transparent performance metrics
- Workforce strategy must align with new models of care
- COLLABORATION

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"*Deconstructing the blocks*"

- Contracts historically block – inequitable / poor value
- What would our income be if paid by activity, now?
- National exercise underway
- Black Country early indications – **Income > Activity £123m**
- Inconsistent picture across the system, significant work required
- Trusts in deficit AFTER deficit support – costs too high, activity too low

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In Summary …

1. **Understand the costing information for your specialty or service.** There are multiple resources available to you via your costing team, Model Health, Power BI dashboards etc – use it to inform and drive your service improvement

2. **Coding is important –** if it is incomplete, your productivity will appear poor in comparison to others whose coding is better

3. **Close working with your finance manager** to understand your financial performance alongside your outcomes

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Thank you & Questions.

https://blackcountryprovidercollaborative.nhs.uk/

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Urology Clinical Network

Aquablation and Spotlight Innovation: GALEAS Bladder Cancer DNA Test

Mr. Pete Cooke
BCPC Clinical Lead,
Consultant Urological Surgeon (RWT)

Philippa Browne
BCPC Associate Director - Transformation & Improvement

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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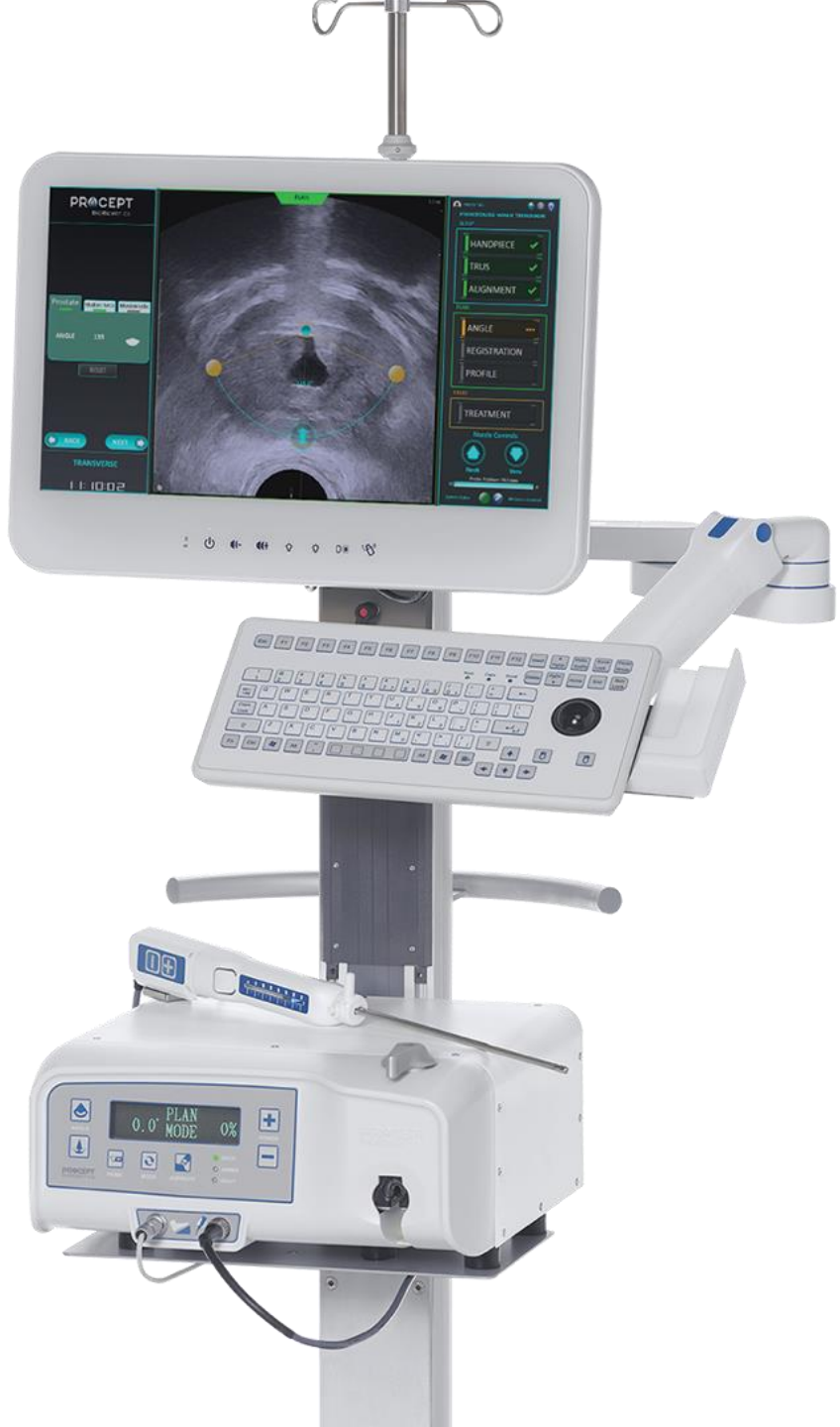
Introduction

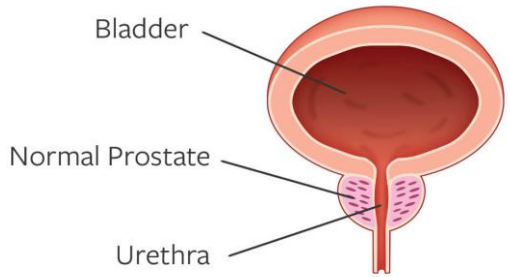
- 2 new technological developments in Urology
- Aquablation for BPH
- Galeas Urine DNA test for bladder cancer
- Presented to BCPC Executive team - 6th October 2025

AQUABLATION® THERAPY

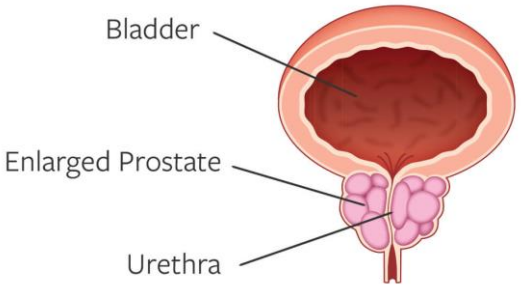


BPH IS A SIGNIFICANT MEN'S HEALTH DISEASE: UK

NORMAL PROSTATE



ENLARGED PROSTATE



> 1 Million

Patients on BPH Medication in JULY 2024 within the UK

35,000

Approximate number of BPH surgeries carried out across the UK ANNUALLY

Significant and increasing backlogs unable to access treatment

18-24

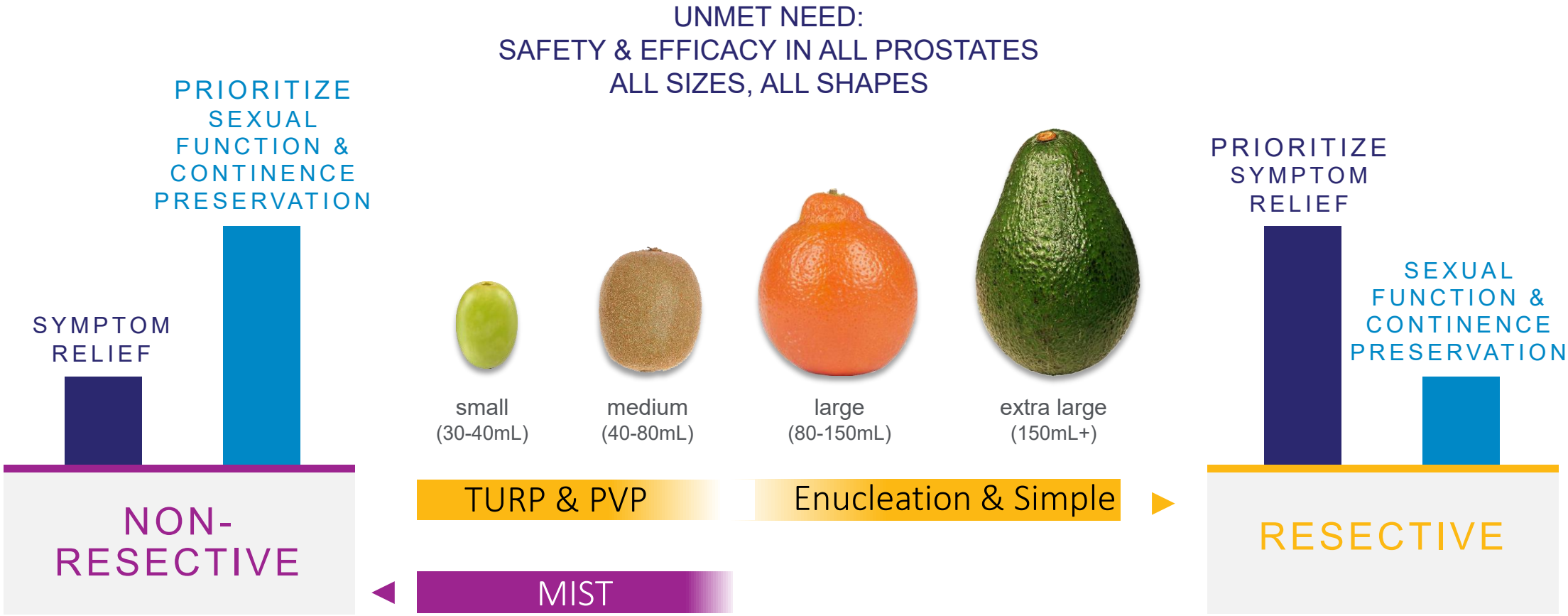
Months estimated time men are waiting to be treated within the NHS

The population over 50 is due to increase by a further 20% over the next 10 years

1. IMS Health NDTI Urology Specialty Profile, July 2012-June 2013
2. Roehrborn, CG, Rosen, RC. Medical therapy options for aging men with benign prostatic hyperplasia: focus on alfuzosin 10 mg once daily. Clinical Interventions in Aging 2008:3(3).
3. Data on File, PROCEPT BioRobotics
4. United Nations – Population Division, 2022 (https://ourworldindata.org/grapher/population-by-age-group-with-projections)
5. Launer BM, McVary KT, Ricke WA, Lloyd GL. The rising worldwide impact of benign prostatic hyperplasia. BJU Int. 2021 Jun;127(6):722-728. doi: 10.1111/bju.15286. Epub 2020 Nov 21. PMID: 33124118; PMCID: PMC8170717.
6. Zaman Huri H, Hui Xin C, Sulaiman CZ. Drug-related problems in patients with benign prostatic hyperplasia: a cross sectional retrospective study. PLoS One. 2014 Jan 27;9(1):e86215. doi: 10.1371/journal.pone.0086215. PMID: 24475089; PMCID: PMC3903504.
7. Gilling PJ, Barber N, Bidair M, et al. Five-year outcomes for Aquablation therapy compared to TURP: results from a double-blind, randomized trial in men with LUTS due to BPH. Can J Urol. 2022;29(1):10960-10968

UNMET NEED IN BPH SURGICAL INTERVENTION

LEGACY TREATMENT OPTIONS ARE LIMITED TO PROSTATE SIZE



PVP: Photovaporization of Prostate
MIST: Minimally Invasive Surgical Technology.
BPH size ranges: AUA Guidelines: Surgical Management of BPH/Lower Urinary Tract Symptoms (2018, amended 2019, 2020) Published 2018, Amended 2019, 2020.
Tanneru et al: An Indirect Comparison of Newer Minimally Invasive Treatments for Benign Prostatic Hyperplasia: A Network Meta-Analysis Model, 2020

UNMET NEED IN BPH SURGICAL INTERVENTION

LEGACY TREATMENT OPTIONS ARE LIMITED TO PROSTATE SIZE

small (30-40mL) | medium (40-80mL) | large (80-150mL) | extra large (150mL+)

AQUABLATION® THERAPY

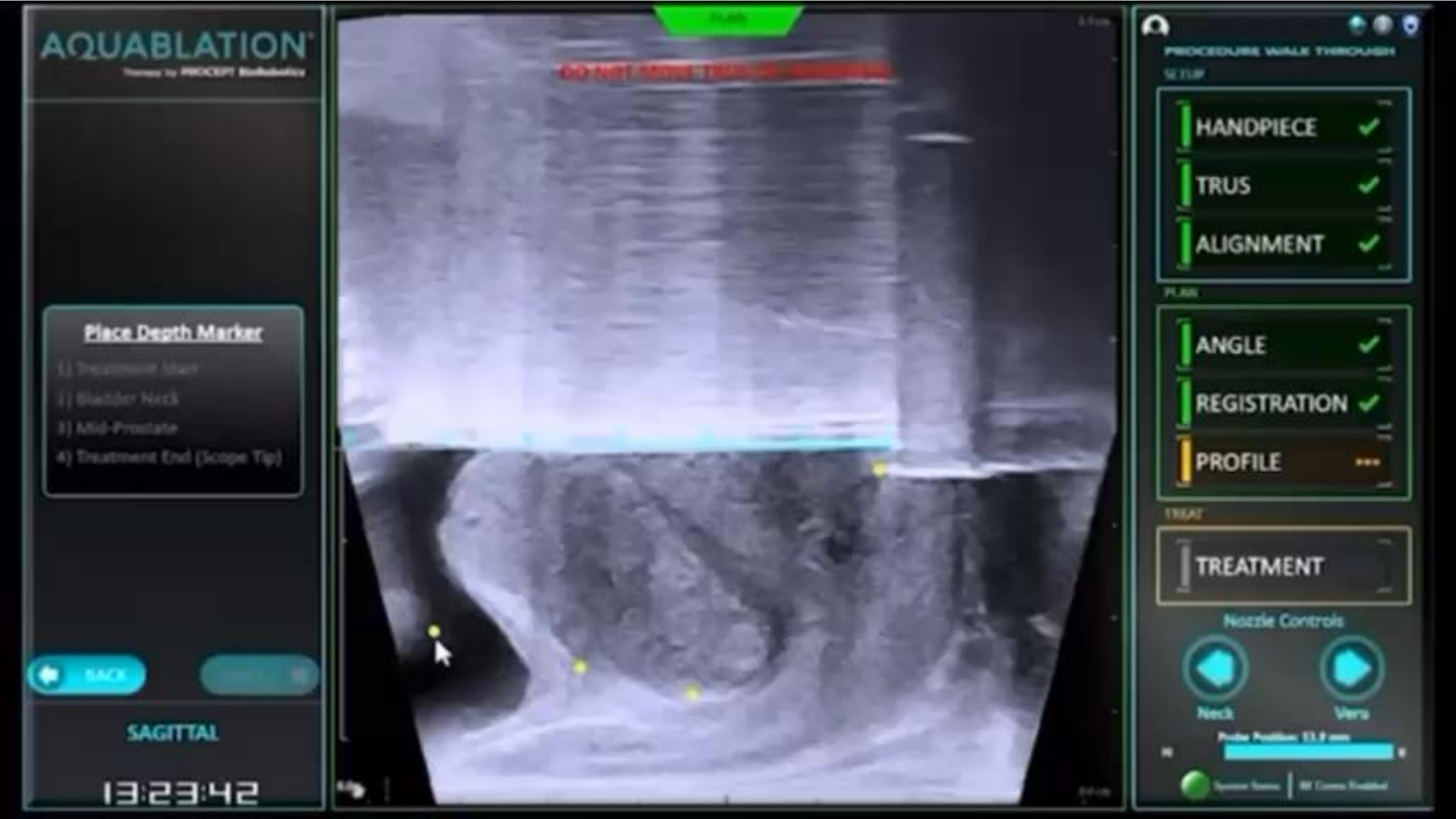
CLINICAL VALUE

- Limits the compromise of safety & efficacy
- Treats all prostate sizes & shapes
- Better patient outcomes

STRATEGIC VALUE

- Helps drive Day Case surgery
- 7-10 Procedures in a full day list
- Any surgeon any size

BPH size ranges: AUA Guidelines: Surgical Management of BPH/Lower Urinary Tract Symptoms Published 2018, Amended 2019, 2020.


AQUABLATION
Therapy by PROCEPT BioRobotics
Place Depth Marker
1) Treatment Start
2) Bladder Neck
3) Mid-Prostate
4) Treatment End (Scope Tip)
BACK
SAGITTAL
13:23:42
PROCEDURE WALK THROUGH
SETUP
HANDPIECE
TRUS
ALIGNMENT
PLAN
ANGLE
REGISTRATION
PROFILE
TREAT
TREATMENT
Nozzle Controls
Neck
Vera

AQUABLATION THERAPY
EVIDENCE BASED MEDICINE

META-ANALYSIS

- 4 clinical studies
- 425 patients
- Prostate volume 20 – 150 mL
- 1 year follow – up

- Analysis of sub-groups:
  1. Above or below 100 mL
  2. Absence or presence of obstructive median lobe

WATER STUDY

WATER II STUDY

OPEN WATER STUDY

FRANCAIS WATER STUDY

AVERAGE RESULTS ACROSS ALL SUB-GROUPS

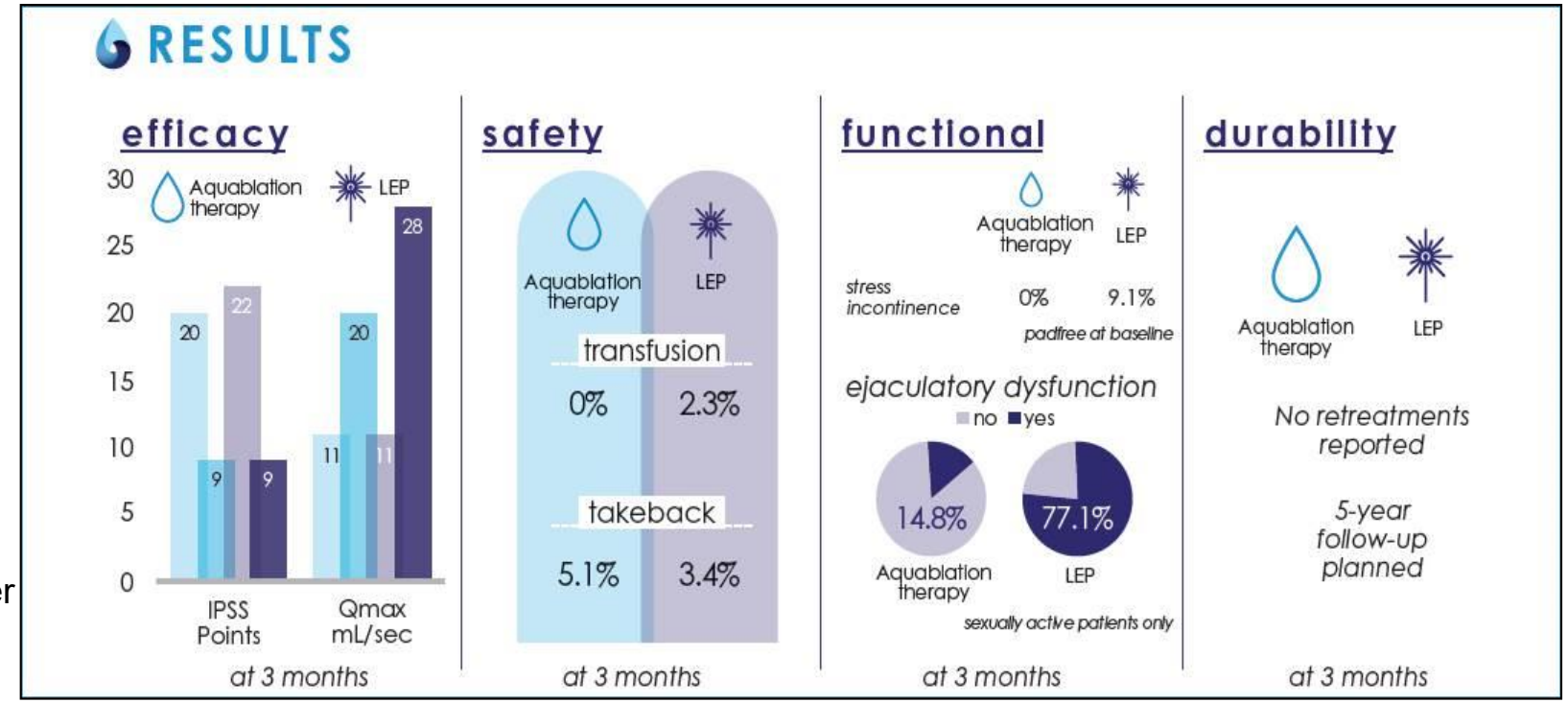
IPSS IMPROVEMENT	16 points
URINARY PEAK FLOW RATE	20.5 mL/sec
QUALITY OF LIFE IMPROVEMENT	3.3 points
POST VOID RESIDUAL IMPROVEMENT	62 mL
EJACULATORY DYSFUNCTION	10.8%
ERECTILE DYSFUNCTION	0%
INCONTINENCE	0.5%

1. Elterman et al. Meta-analysis with individual data of functional outcomes following Aquablation for lower urinary tract symptoms due to BPH in various prostate anatomies, 2021 BMJ

WATER III: Aquablation vs. Transurethral Laser Enucleation of Large Prostates

(80 -180mL) in Benign Prostatic Hyperplasia, *Ritter et al. 2025 EAU Abstract*

- 98 AB vs 88 HoLEP
- 80-180mL Glands
- 6-Month results part of a 5 year follow up study
- Aquablation and HoLEP had no difference in short term symptom improvement, bleeding risk, and PVR reduction
- HoLEP was superior to Aquablation in volume reduction and uroflow (Qmax)
- Aquablation was superior to HoLEP in lower ejaculatory dysfunction and stress incontinence



Conclusions:

Aquablation and LEP had no difference in short-term symptom improvement, bleeding risk, and PVR reduction. LEP was superior to Aquablation in volume reduction and urinary flow improvement. Aquablation was superior to LEP in lower ejaculatory dysfunction and stress incontinence.

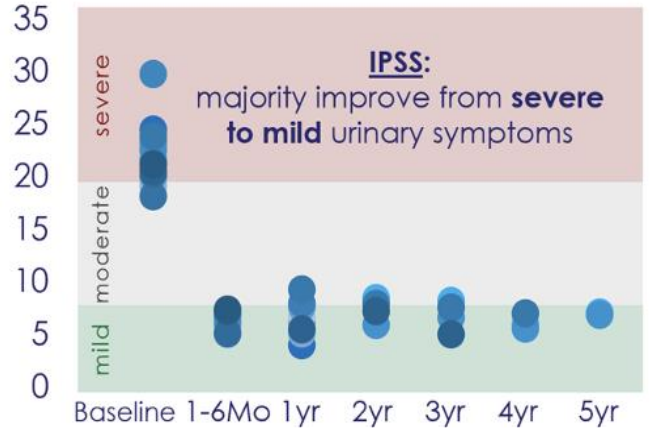
AQUABLATION THERAPY

AGGREGATED DATA FROM 18 PUBLICATIONS

Variety of Patients

Total Patients	Avg. Age	Size Range	Median Lobe	In Retention
3,834	67	12-363	60%	30%

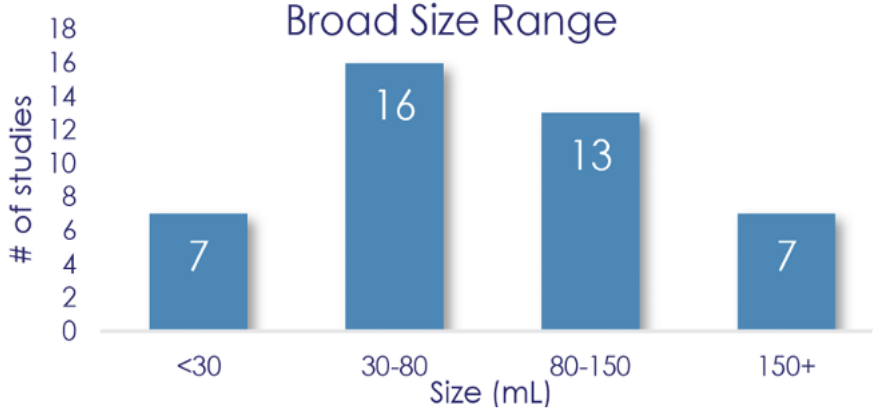
EFFICACY



FUNCTIONAL

	avg.	med.(IQR)
Ejaculatory Dysfunction *(%)*	**7.1**	5(0-15)
Erectile Dysfunction *(%)*	**0**	0(0-0)
Incontinence *(%)*	**0.2**	0(0-0)

Broad Size Range



SAFETY

Day Case	Outpatient
Surgery Center	Hospital
~5-hour discharge	<23-hour discharge

Transfusion *(%)* **1.4** | 2(1-3)

avg. | med.(IQR)

DURABILITY

	avg.	med.(IQR)
Annual Surgical Retreatment *(%)*	**0.5**	0(0-1)
Average Reported Follow Up *(Months)*	**29**	12 (4.5-13.5)

ACCELERATING ADOPTION IN THE UK

100+ Urological surgeons currently utilize Aquablation therapy to treat men with BPH across the UK.

40+ Aquablation centres currently providing patients access to robotically controlled heat-free technology.

5 Aquablation workshop centres providing surgeons the ability to view live procedures and learn from experienced users.

NHS

Ramsay Health Care

Nuffield Health

Spire Healthcare

HCA Healthcare UK

The London Clinic

Cromwell Hospital

benenden health

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Waiting List Patient Considerations …

- Reduces risk of CAUTIs (Catheter Associated Infections) & blockages
- Reduces antibiotic usage and risk of antibiotic resistance
- Reduces cost of **catheter changes** in primary and secondary care
- Reduces cost of prescriptions (tamsulosin, finasteride, erectile dysfunction drugs- PDE5I, antibiotics)
- Release of capacity in catheter clinic, District Nurse Services and Emergency Dept
- Reduces cost of repeated urine microscopy tests
- **Releases GP consultation time** to discuss side effects and infections
- Improves theatre efficiency and reduction of waiting lists
- Releases in-patient capacity
- **Reduces patient suffering and anxiety**
- **Equalises patient access**
- **Recognises patient choice**

Existing NHS treatment for BPH

Complication Rates and Associated Costs

Complication	HES Data	Per Patient Cost	Aquablation
BPH Re-Admission Rate	7.1%	£3,326	<1%
BPH Retreatment Rate at 1 year	2.2%	£4,750	1.25%
TURP Average Transfusion Rates	13%	£329	<1%
National Day Case Average for BPH	12.7%	N/A	>90% (2 NHS Hospitals)
BPH patients staying more than 1 night	41%	£324 per night	Day Case/One night stay
Post TURP stricture	6.25%	£2,513	<1%
Catheter Associated Infection Rate https://pmc.ncbi.nlm.nih.gov/articles/PMC7328505/	10.8%	£9,800	N/A
Scheduled but failed to achieve day case	65%	£324 per night	92% day case

GALEAS™/BLADDER

GENETIC EARLY CANCER TESTING

nonacus

Leading provider of innovative genetic testing, providing non-invasive diagnostic products to laboratories worldwide.

- Complete product + software combination
- Efficient DNA technology
- Pharma-ready collaboration

West Midlands Combined Authority

Department for Science, Innovation & Technology

GALEAS™ BLADDER

GALEAS Bladder: A highly sensitive, non-invasive, urine based molecular test

Tumour cells are shed from bladder cancer and present in urine

DNA from tumour cells are extracted and sequenced via NGS

23

GENES

NGS panel targeting the most relevant genes associated with BC

450

SOMATIC MUTATIONS

DNA changes within a gene that have not been inherited

Professor Richard T. Bryan
MBChB PhD MRCS FAcadTM

Department of Cancer and Genomic Science

Director of the Bladder Cancer Research Centre

Professor in Urothelial Cancer Research

UNIVERSITY OF BIRMINGHAM

11 **Years**

of development led by University of Birmingham

~4000

Patient samples tested

5

Published studies

8

Future studies in progress

Bladder cancer is one of the UK's most expensive cancers to manage

High volume of referrals are unnecessary

Burden on staff & resources
Cancer pick up rate lower than expected 2-9%.

High cost of waiting times

<10% survival rate at 5 years if diagnosed at stage 4

High cost of diagnosis

Bladder cancer is one of the most expensive Cancers to manage

High cost of recurrence

Survivors experience a 70% recurrence rate

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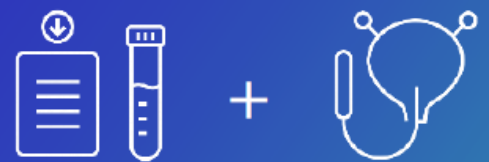
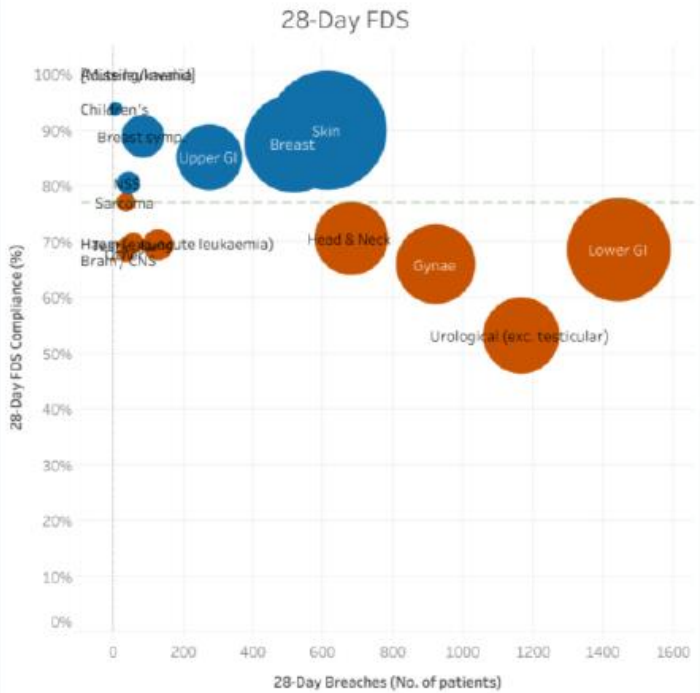


Supports meeting FDS targets - fewer unnecessary cystoscopies, faster answers for patients.

The challenge facing the NHS

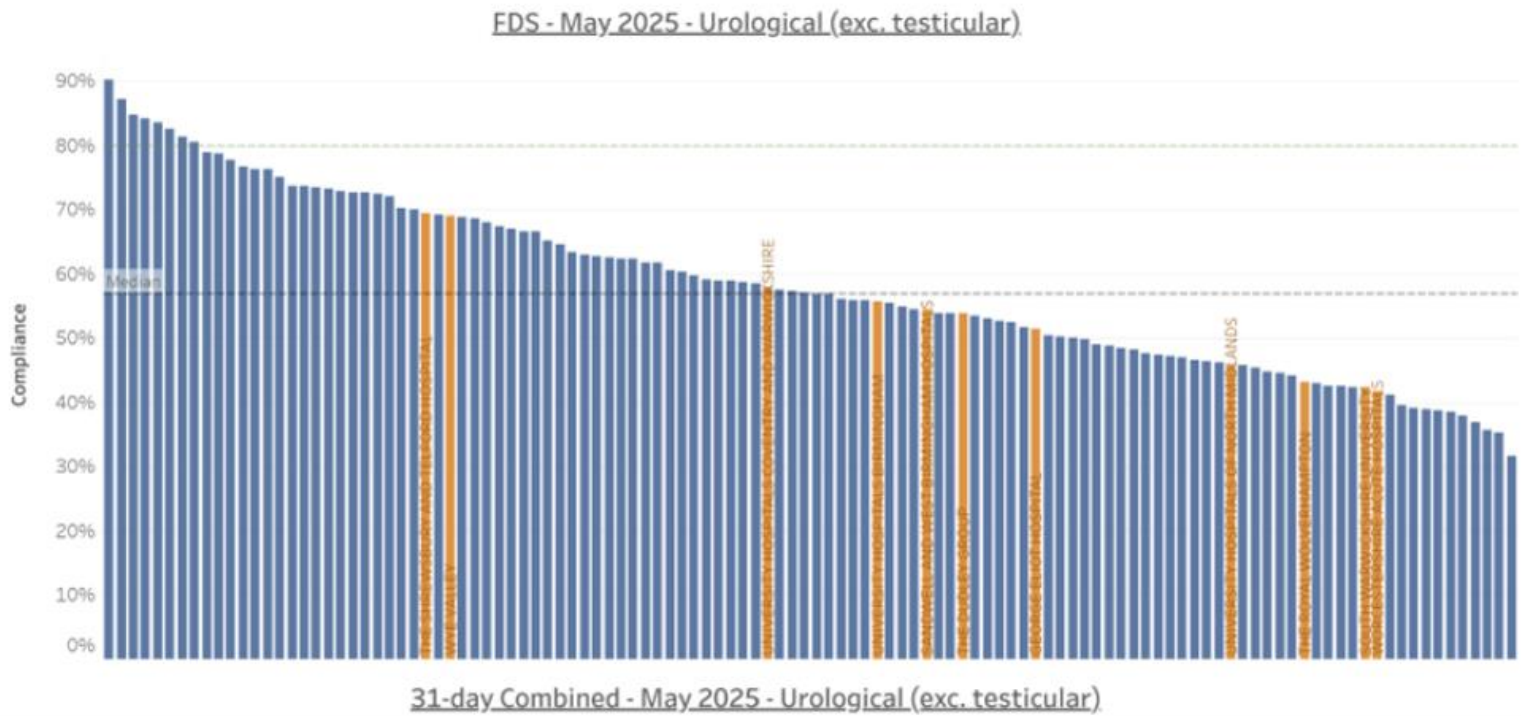
A System Under-pressure

~50% Cancer pathways

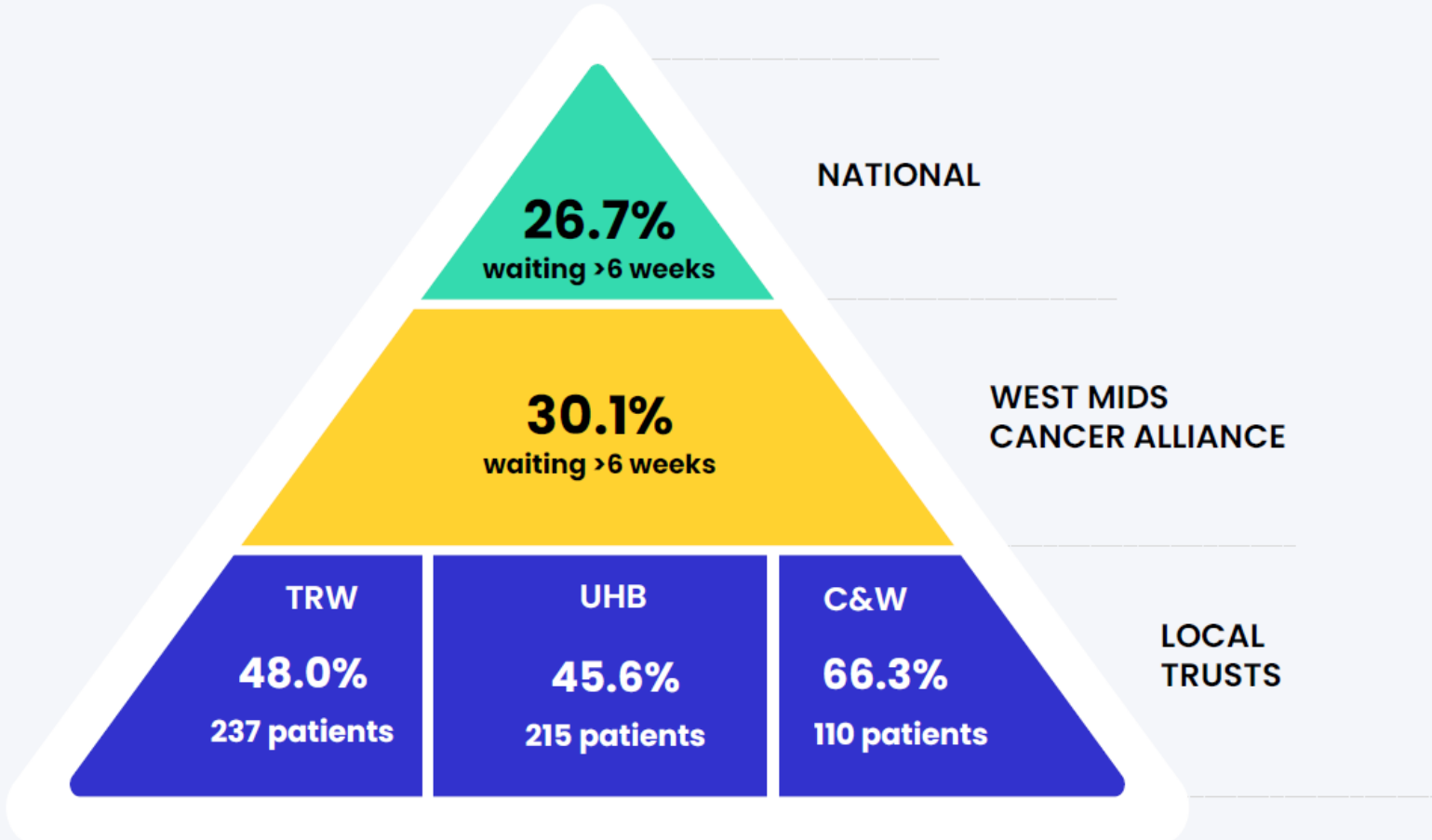


Urology Services Under-pressure

48/52 ICBs



30% of patients wait over 6 weeks for a cystoscopy



Diagnostic Waiting Times and Activity Report

Galeas Bladder can;

- **Remove waiting lists**
- **Improve patient experience**
- **Give time back to clinicians**
- **Save money**

GALEAS™/BLADDER

Unique molecular diagnostic identifying all stages & grades of bladder cancer

FOR PATIENTS

- Pain-free urine test
- Home sample collection
- Rapid test results

FOR CLINICIANS

- Consistently accurate diagnostic from ISO 15189 lab
- Patient specific prognosis
- Expected patient responses to specific therapies

FOR HEALTHCARE SYSTEMS

- Reduces unnecessary cystoscopies by c.50%, which could save the NHS time and money
- On-demand testing without the need for hospital visits

Cystoscopy

Standard of care for the last 100 years

FOR PATIENTS

- Hospital appointment with uncertain waiting times
- Painful & damaging procedure with recovery time off work
- Variability of care depending on the site

FOR CLINICIANS

- Yes or no determination only, based on what's visible
- Patients seen as one group without risk differentiation

FOR HEALTHCARE SYSTEMS

- Highly specialised urologists & nurses required for every procedure
- Beds, ward space and special equipment required
- Treatment of complications

Early NHS RWE data shows concordance with cystoscopy

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GALEAS™ /BLADDER

744* Triage NHS

94%	87%	99.5%
SENSITIVITY	SPECIFICITY	NPV

GALEAS™ /BLADDER

710 Triage UNIVERSITY OF BIRMINGHAM

92%	86%	>99%
SENSITIVITY	SPECIFICITY	NPV

Cystoscopy

85%	87%	96%
SENSITIVITY	SPECIFICITY	NPV

HOSPITAL	PATIENTS
Royal Berkshire	125
Leeds	105
Leicester	697
Kingston	239
Dorset County	128
Manchester	131
Edinburgh	79
TOTAL	**1,597**

Most patients don't have cancer

CANCER RATE

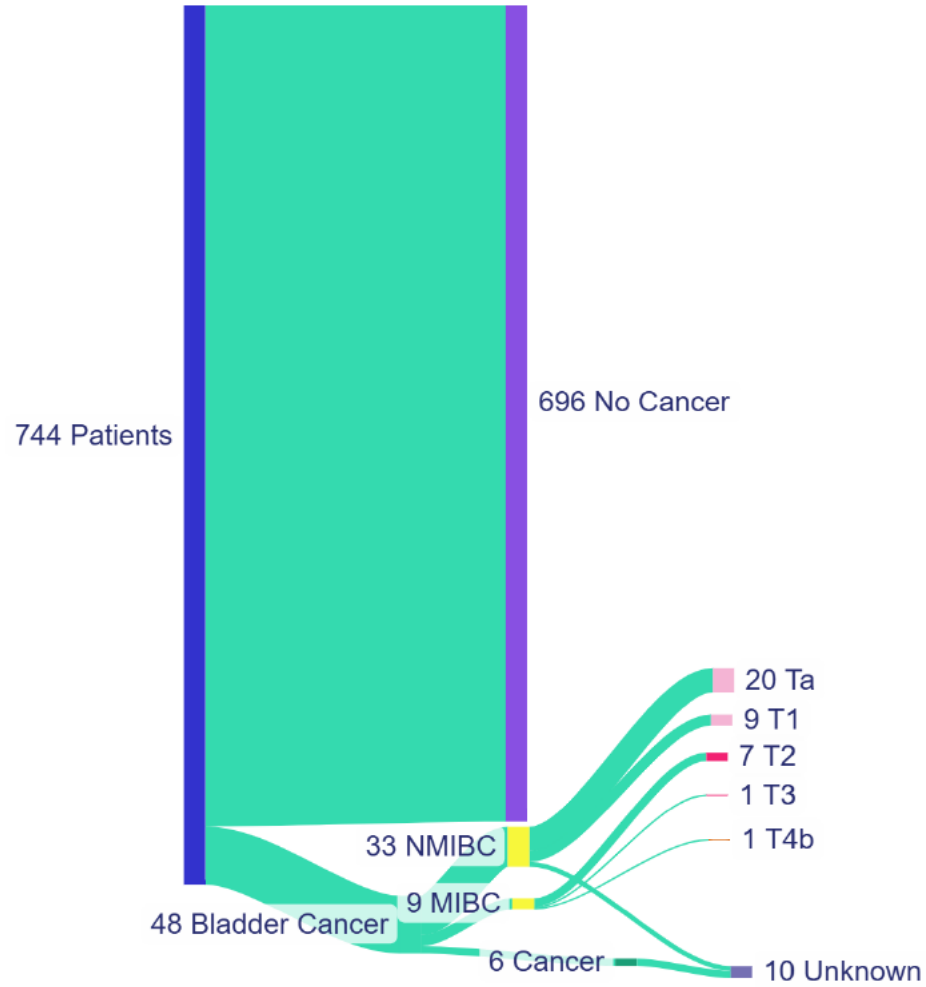
6.5%

/BC-RECON 2-9%

REFERRALS (Haematuria status)

65% Visible VS **35%** Non-visible

79% NMIBC VS **21%** MIBC

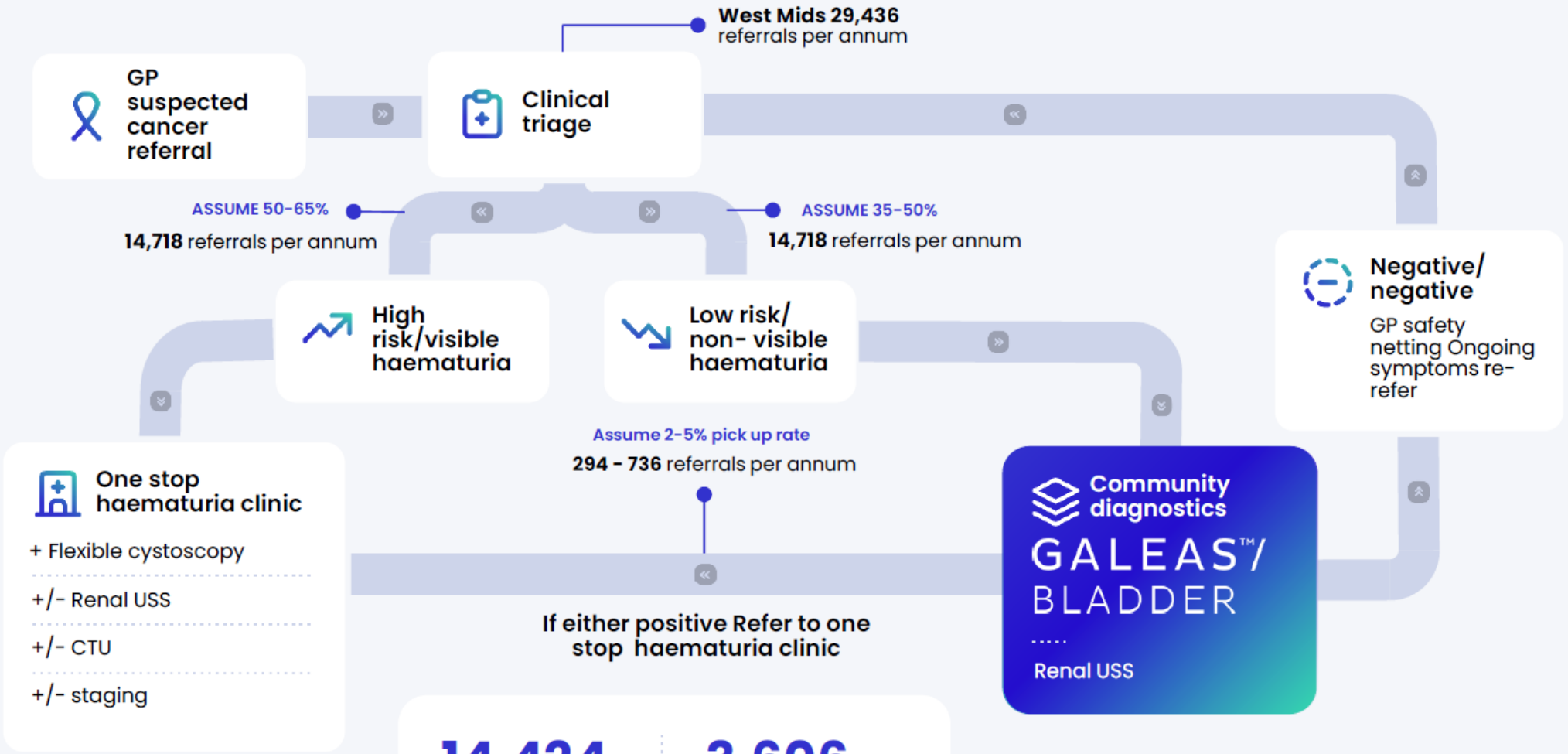


Potential for System Adoption

1. **Haematuria Triage**
   - Primary care
   - Secondary care VH/NVH
2. **Surveillance**
   - De-escalation
   - Adjunctive – Double negative
   - Post treatment
3. **Upper Tract Urothelial Cancer (UTUC)**
4. **Screening High Risk Patients**

Example pathway – Low risk (NVH) referrals

YHEC
York Health Economics Consortium



14,424
Cystoscopies removed

3,606 hrs
Clinician time re-allocated

Process Flow

Patient sample requested

Referral made via API to portal

Sequencing and Analysis

Clinical reporting via portal

Patient next steps identified

- End-to-end service is **ISO 15189:2022**
- GALEAS Bladder has **UKCA marking**
- Client portal is a web-based LIMS, **ISO 27001 accredited**
- **API connection** points to EHR systems are available

"Having had over twenty cystoscopies, resulting in significant complications, I would welcome a urine test with equivalent accuracy to cystoscopy"

Brigadier
Gareth Collett CBE

"Action Bladder Cancer UK are pleased to see the Galeas test now being used in a clinical setting. Using this test in the early stages of the diagnostic journey has exciting potential to help save patients from undergoing unnecessary invasive procedures"

CEO Action
Bladder Cancer UK
Jeannie Rigby

Patient, clinician and NHS value

REDUCTION OF CYSTOSCOPIES PER YEAR

14,424

NHS Digital

CLINICIAN TIME BACK (HOURS) PER YEAR

3606

Hours assuming 15min per flexi

COSTED AT BELOW CURRENT TARIFF

<£291

Per Galeas Bladder test

TRAVELLED FOR APPOINTMENTS

259,632 km

Average 9 km per appointment each way

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Conclusion

- Exciting technological developments
- Potential significant impact on BPH and bladder cancer pathways
- Good scientific data, clinical and regional support
- Modest capital investment
- Potentially negotiable/flexibility
- Significant long term cost savings
- Significant improvements in clinical outcomes and patient satisfaction

Watch this space for clinical and business case development

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Thank you & Questions.

https://blackcountryprovidercollaborative.nhs.uk/

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Breakout Session - 2

BCPC Clinical Networks – Short showcase presentation

Refreshments available within rooms

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Breakout Session - 2

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. 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/
S. Alam
(B) **Lung Screening**: E. Gilliland

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Break

15:35 to 15:45

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Closing remarks & Next Steps

Dr Jonathan Odum

BCPC CMO, Interim DGFT Medical Director

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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Thank you & Safe Journey home

https://blackcountryprovidercollaborative.nhs.uk/

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Pharmacy Collaborative Clinical Network

Puneet Sharma

Chief Pharmacist (SWBT)

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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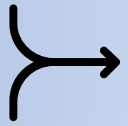
Pharmacy Programmes for 2025

ASEPTIC SERVICES TRANSFORMATION 

MEDICINES VALUE 

PHARMACY WORKFORCE RETENTION 

SECONDARY CARE FORMULARY HARMONISATION 

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ASEPTIC SERVICES TRANSFORMATION –Celebrations and Successes

Purpose of this programme:

- Develop an aseptic services transformation strategy and deliver a feasibility study that will provide next steps in replacing aging, fragile aseptic estate across the Black Country to provide a robust and sustainable service to meet the oncology / haematology / medical infusion / clinical trials needs across the Black Country.

Outputs to date:

- SOC written and submitted to each BC ‘Group’ execs of acute Trusts and to BCPC executive. To proceed to OBC. Strategy long list completed.

Next Steps:

- Strategy finalisation will drive OBC and affordability
- Further engagement/exploration with national funding streams and potential commercial partners

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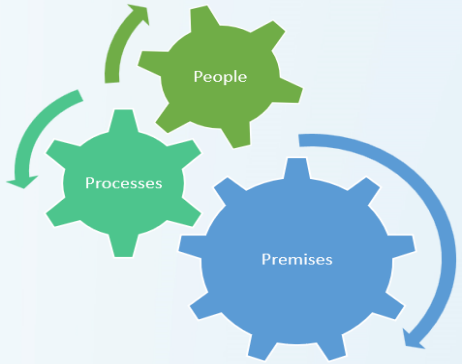
Aseptic Services Transformation Benefits

- Alignment with cancer services demand growth and delivery plans and with that improved patient outcomes
- A quality technical aseptic service across the BC that meets QA and QC standards aligned to MHRA licensed production units
- Reliability and resilience in both the fabric of the units and services overall
- Increased standardisation of production in certain areas, with efficiencies and workforce stability associated with that
- Potential to increase capacity for clinical trials and ATMPs

Service Fragility Concerns - recap

3 main areas of risk to a patient that receives a treatment prepared by a pharmacy aseptic unit



3 main areas of control to manage the risk and need Harmony to provide assurance of product quality

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MEDICINES VALUE – Celebrations and Successes

Purpose of this programme:

- To facilitate rapid uptake of best value biologic medicines, including biosimilars, across all specialities of the 4 Acute Black Country Providers:
  - ✓ Maximise savings opportunities to help the ICS meet its financial goals and reinvest savings to improve patient care.
  - ✓ Standardise clinical pathways and reduce variation in practice where clinically appropriate.
  - ✓ Aligns with NHSE Better Value Medicines Opportunities so cohesive approach across care boundaries
- Focus on aligning non high-cost medicines use across BC with opportunity to deliver savings associated with better value medicines and alignment with Black Country Integrated Medicines Optimisation Board (IMOB).
- Supporting GIRFT across several clinical specialties including Ophthalmology, Rheumatology, Gastroenterology and Dermatology.
- From Jan ’26 onwards – review and opportunities for medicines waste reduction in hospital setting

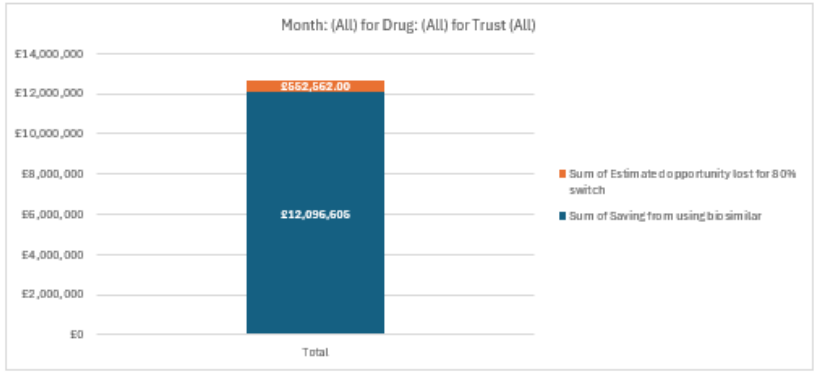
Together these objectives:

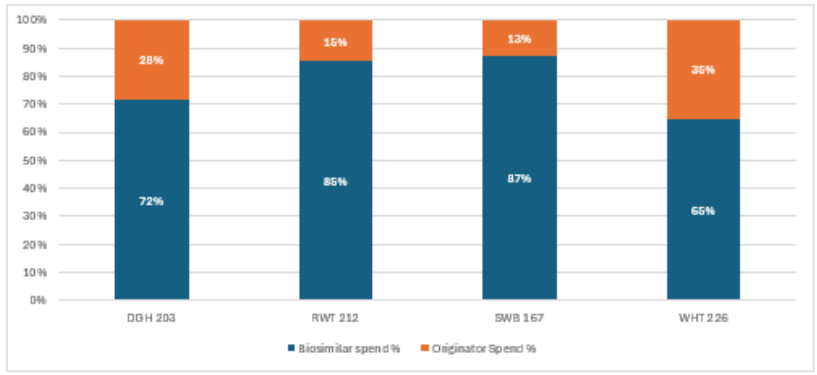
- Improve health equalities, access to medicines and our overall financial position
- Drive further collaboration and alignment with patient experiences and expectations in primary/secondary care

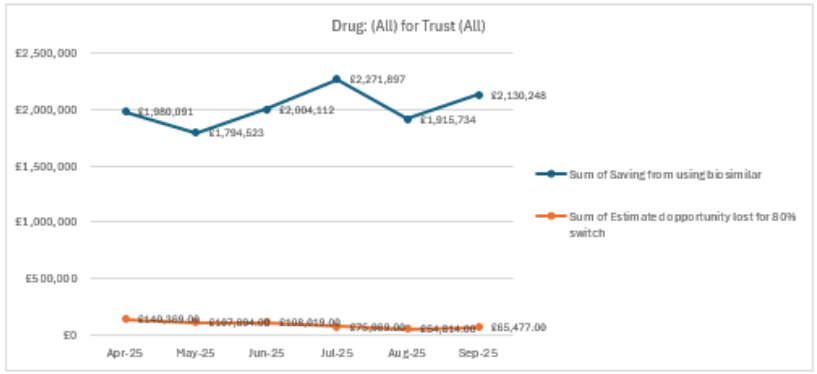
MEDICINES VALUE – Celebrations and Successes

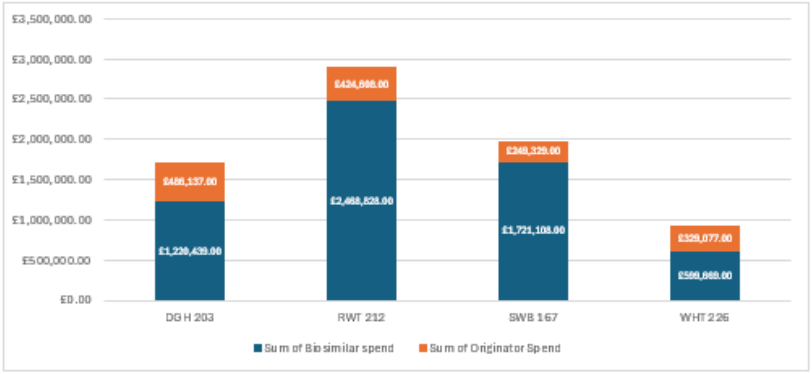
Biosimilars & In-tariff

- YTD total of over £12m in cost savings and cost avoidance realised already for the BC ICS for biologics alone.
- Switch plans in place at each Trust for all key biologics molecules this year – harmonized approach that considers individual Trust needs
- BAU start/switch strategy in progress for biologics going forward to aid more agile switching and make it BAU for each specialty – with an appropriate level of support from Pharmacy.
- Predicted FYE for in-tariff / low-cost medicines of £434k across the BC acute providers on top of above.









Black Country Provider Collaborative

NHS

PHARMACY WORKFORCE RETENTION Celebrations and Successes

Purpose of this programme

The Pharmacy Network Workforce Sub-Group will ensure that pharmacy workforce issues across all four Trusts are dealt with in a cohesive and co-ordinated manner, by support and set-up of appropriate task and finish groups to address relevant topics in a timely way. Example of joint approach is the Eylea switch coming in Jan/Feb ’26. Even more cohesive and proactive/planned than Lucentis from last year.

The group will act to align workforce plans, pathways and training programmes across three key workstreams; workforce planning, education & training, recruitment and retention.

Together enables better patient care through upskilling and improved retention across all workforce groups. More efficient and cost effective utilisation of registered staff by expanding roles for unregistered staff

Achievements so far

- Future workforce/development – STEP programme outline harmonised for both registered and unregistered staff to grow skills and retention from within
- Focus on foundation year training and independent prescribing from this year’s cohort
- Harmonisation of induction packs
- Protected learning time framework

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SECONDARY CARE FORMULARY HARMONISATION

The purpose of this programme is to:

- Identify and reduce inappropriate variation in ‘hospital only’ medicines use
- Identify savings opportunities through purchasing in line with national medicines contracts and adoption of best value contract lines
- ‘Do it once’ approach to formulary applications to reduce duplication of work

- A joint formulary group is now active. BC formulary now live and replaces each local version
- Links in with IMOB formulary applications and harmonisation
- Next steps are to work on upcoming Single National Formulary (SNF) which will be our national formulary (under the 10 yr plan) – due in 2 years, but implementation across primary / secondary care may be challenging