Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Approve
Item No	6	**Confidential / Freedom of Information Status**	No
Title	Urology Services – Bury System 'End to End' Pathway Review		
Presented By	Ian Mello, Director of Secondary Care Commissioning, NHS Bury CCG		
Author	Mike Ryan, Head of Planning and Delivery, NCA. Catherine Tickle, Commissioning Programme Manager, NHS Bury CCG		
Clinical Lead	Howard Hughes, Clinical Director, Bury CCG Simon Minkoff, Urology Clinical Lead, Bury CCG Laurence Clarke, Consultant Urologist, NCA		
Council Lead			

Executive Summary

A report on the reconfiguration of Secondary Care Urology Services, being led by the Northern Care Alliance (NCA), was presented to the Board in May 2021 (appendix 1). The paper was received by the Board and members requested further information on the 'end to end' clinical pathway and opportunities for delivery of care in primary care and community-based services.

This paper provides Board members with an update on the collaborative work being undertaken by the CCG with NCA, as a means of assurance to the Board that the concerns raised at the previous meeting are being addressed.

A programme of work has commenced with Secondary Care Clinicians, Primary Care Clinicians, Community Services, and other stakeholders. Through a Development Group approach, Bury system partners are reviewing the 'out of hospital' elements of the Urology pathway, alongside the new Secondary Care Urology Model.

Taking an integrated system approach to developing the pathway will ensure that the right care is provided at the right time, in the right place for Bury patients and the secondary care and primary/community parts of the pathway align.

The paper provides the Board with an overview of the work undertaken to date, identifies opportunities for Rapid Action and work being undertaken to review pathways through the Urology Development Group and outlines the proposed governance arrangements through which this programme of work will be held to account.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the update on the work undertaken to date.
- note that a further update on the work of the Development Group and pathway

review/redesign will be provided to the Board in April 2022.

- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Focus on prevention, place-based delivery of care and improved outcomes for patients.					
How do proposals align with Locality Plan?	Focus on system integration, prevention, place-based delivery of care, system efficiencies and improved outcomes for patients.					
How do proposals align with the Commissioning Strategy?	To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce	EIA to be completed and managed by the Development Group					

Implications						
health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
EIA to be completed and managed by the Urology Development Group						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Urology Services – Bury System 'End to End' Pathway Review

1. Introduction

1.1 Following the paper that went to the Board in May 2021 (appendix 1), seeking endorsement of the pan-locality Urology model of care, as part of the Northern Care Alliance (NCA) Urology reconfiguration, work has commenced locally to address the concerns raised by Board members.

1.2 The GM Model of Care (MoC) for Benign Urology was developed through the Improving Specialist Care (ISC) programme. The hub and spoke configuration for the delivery or Benign Urology services was endorsed by the Greater Manchester (GM) Joint Commissioning Board (JCB), though implementation at a GM level were delayed due to COVID-19.

1.3 The Key features of the new secondary care model are:

- A single comprehensive Benign Urology Service delivered within the NCA.
- 'Hub and Spoke' delivery model –
    - Oldham and Salford as inpatient hubs and Rochdale and Bury as spokes.
    - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
    - Single workforce within two integrated functional teams – NCA West & NCA East.
- A disaggregation of the activity from North Manchester, which will align to MFT, and the activity for Bury, Oldham, Salford and HMR which will align to the NCA.

1.4 Clinical Leads from the NCA and Bury CCG are working in partnership, along with other Bury stakeholders, to review the Urology pathway 'end to end' with a particular emphasis on integrating the provision of Urology care between primary, community, and secondary care.

1.5 A Bury system wide Urology Pathway Development Group, chaired by the Head of Planning and Delivery at NCA, has been established to deliver the pathway review and subsequent re-design of elements of the pathway, to ensure that the right care is provided at the right time, in the right place for Bury patients.

2. Purpose of the Paper

2.1 This paper is intended to assure Board members, that whilst the secondary care model is changing, the opportunity to review Bury's primary care and community elements of the pathway is being progressed alongside and aligned with the secondary care reconfiguration.

3. Background - Urology Secondary Care Reconfiguration

3.1 The NCA new model of care previously presented to Board members will allow for a single NCA wide Urology team, under a single leadership, with standardised processes and governance. Sub speciality teams will remain in place delivering MDTs across the NCA localities.

3.2 In-patient High Acuity Complex Hubs will operate at Salford Royal Hospital and Royal Oldham Hospital, both part of the Northern Care Foundation NHS Trust. The Salford 'Hub' will service the people of Bury, with Fairfield acting as a 'spoke' in the new architecture, to support high volume low acuity patients, based on a proven model at Rochdale Infirmary.

3.3 The remodelling of Urology Care at NCA, through the hub and spoke model, provides an opportunity for NCA Clinicians to work in partnership with Primary Care and Community services in Bury, to enhanced the offer into the locality and ensure greater alignment of the pathway from primary/community into secondary care.

3.4 The planned development of Urology Investigation Units (UIU) will allow for the delivery of ambulatory pathways delivered 'closer to home.' Through the Bury Urology Development Group, it is intended that Bury stakeholders, including patient representatives, will work with NCA to define the scope of the locality based UIU and explore opportunities where appropriate for delivery of care at a neighbourhood level within the Bury locality.

4. Initial Primary Care Engagement

4.1 The Consultant Urological Surgeon from NCA and the CCG Clinical Lead for Urology delivered an update to Bury Primary Care Colleagues on the reconfiguration of Urology Services at NCA and the single service model in October 2021. This took place through the Bury GP webinar chaired by the CCG Clinical Chair.

4.2 Primary Care colleagues were given the opportunity to ask questions, discuss the new model of care and explore what it means for Primary Care and Bury patients with the Urology Consultant who sits on the NCA Urology Delivery Board.

4.3 The session outcome, despite a limited number of questions from GPs, was a clear commitment made by NCA and CCG Clinical Leads to work in partnership with Primary Care and Community Services to explore the model of care required to redesign an integrated pathway.

4.4 Primary Care colleagues were invited to volunteer to be part of the Urology Development Group, where this pathway work is being undertaken.

4.5 Through the GP webinar, discussions between the Secondary Care Clinical Lead and CCG Clinical Lead, and learning from other interrelated programmes of work e.g. Phlebotomy review and NES Pathology Group, the following were identified as key areas of focus:

- Review of the Prostate Pathway and management of PSA in Primary Care
- Review of follow up pathways in primary care and secondary care
- Utilisation of lower tier services and third sector services
- Use of non - medical workforce in the Bury pathway
- To scope the requirements for a Urology Investigation Unit (UIU) to support in the identification of suitable site in the community from which to host a service
- Development of UIUs
- Access to PSA lab results for Bury GPs and other necessary pathology
- Access to Phlebotomy and Diagnostics within the pathway
- Role of Community Based Services e.g., Incontinence and District Nursing
- Exploring Bury estates for potential out of hospital delivery
- Implementing Advice &Guidance (A&G) into the pathway and Patient Initiated Follow Up (PIFU).
- Review of interrelated pathways e.g., Urology and Gynaecology and links to Gynaecology and Physiotherapy (see 5.2 below)
- Links to GM and Bury Cancer pathways (see 5.2 below)

4.6 In addition to the areas above, it was suggested at the webinar that the pathway re-design work could facilitate work to look at boundary-spanning, primary-secondary care interface roles and the possibility of identifying funding sources for a pilot of a Physician Associate for the Urology pathway work as a 'test of change.'

4.7 Through the Development Group these conversations will be extended to engage with PCN Directors and GP Federations.

5. Development Group – Overview

5.1 Terms of Reference (ToR) for the group were tabled at the first meeting and have been signed off by system partners. The first meeting provided an opportunity to review the proposed membership of the group.

5.2 Urological Oncology and gynaecology were identified as interdependencies and it was acknowledged that links will need to be made with staff from these specialities through the Development Group, as and when required. An action to seek patient input into the pathway review from the Bury Patient Involvement and Participation Group (PIP) was agreed and is being progressed.

5.3 The aims, objectives and key principles agreed by the group in the ToR reflect the request from the Board to consider the opportunity for 'place based' primary and community care. They also support the vision and ambitions set out in the Bury 'Let's Do it Strategy,' to improve the wellbeing and health outcomes of the Bury population. The pathway review will be based on codesign and accountability for shared decision making, with a focus on wellbeing, prevention and early intervention and neighbourhood working.

5.4 The Development Group meetings act as platform for stakeholders to integrate and develop relationships, define the local need and desired outcomes for Bury patients, explore opportunities, and agree transformation/re-design opportunities.

5.5 The Development Group will also oversee the implementation of a programme plan to include monitoring and evaluation.

5.6 The Urology programme of work will act as another 'test of change,' along with Orthopaedics, in the Bury system to support learning that can be scaled up across other specialties in the NCA to aid elective recovery.

6. Progress to Date

6.1 At the first meeting the Bury Community Team provided an update on the current community pathway, with clinicians from Continence and Stoma supporting this discussion. The following areas were identified as areas of opportunity from the initial discussion:

- Review of the Trial Without Catheter Pathway (TWOC) due to increasing demand
- Integration across secondary care and community services
- Review of the diagnostic pathway
- Review of community data to include patients presenting acutely with retention, post-operative referrals and referrals from A&E and cost.

6.2 An update on the secondary care pathway transformation was shared by NCA partners to ensure all group members were aware of the changes taking place. The following areas of opportunity were identified from the initial discussion:

- Realignment of ambulatory pathways
- Establishing specialist nursing workforce with presence in the Bury locality – interface roles between primary and secondary care
- Reviewing future bed capacity requirements
- Maintenance of 'Hot' Urology Lists – maximise theatre capacity
- Review of secondary care data and costs
- Learning from current Prostate Pathway in Salford
- Learning from the advanced triage pilot commenced with Salford and learning from the planned pilot of A&G in Salford
- information sharing - access to shared care records and opportunities from the NCA new Electronic Patient Referral (EPR) System

6.3 The following areas of opportunity were identified at the second meeting of the group, from a presentation of the current primary care pathway led by the CCG Clinical Lead:

- Currently Primary Care pathways are based on clinician's individual knowledge, experience, and review of published guidelines.
- Patient experience may be variable with potential inequalities arising.
- This is an opportunity to develop a more integrated and consistent service partnered between primary care, community care, and secondary care.
- New pathway will require softer boundaries, increased co-operation, less duplication of investigation, and meaningful use of Advice & Guidance and Patient Initiated Follow-Up.

- Improved referrals will identify where illness impacts on occupation or social care enabling social prescribing and signposting to lifestyle services.

7. Rapid Action Opportunities

7.1 The following 'quick wins' have been agreed by the group as the outcome of the first two meetings. Named leads have been identified to progress these at pace alongside more medium/longer term work on the wider pathway reviews:

- Review of the Prostate pathway and agreeing the optimal pathway
- Review of the TWOC pathway and agreeing the optimal pathway
- Trail of advanced triage in Bury based on the Salford pilot results.

8. Transformation Work Programme

8.1 A high level system workplan has been developed and agreed by the group as an iterative document. The plan includes the 'quick win's' and the key elements of the pathway (primary care and community) for review and redesign. Key within the action plan is alignment of new pathway with the new secondary care model of care.

8.2 The 'quick wins' and pathway reviews will be progressed in parallel. The Group Chair is meeting with named leads for each area of the plan to agree the key deliverables and milestones for the work programmes, after which the plan will be updated.

8.3 Analysis of the Urology data and finances across the pathways is being undertaken. An existing Performance and Data Group supporting the Orthopaedic Improvement work, as part of the wider Elective Care Programme, will provide the forum to bring pathway 'experts' together with BI, finance, patient representative and Public Health to agree the scope of the analysis required.

8.4 Building upon the existing group will allow the methodology developed for the analysis of inequalities in access to Orthopaedic services to be replicated for Urology, to ensure the pathways have a lens on equity and inclusion.

8.5 Named leads to attend the Planning and Data group have been agreed and an initial meeting is being arranged to scope the work. The data analysis will feed back into the Development Group.

8.6 Any impact of the secondary care reconfiguration on Bury patients and their families, such as access to care at Salford Royal, will be explored as part of the work of the Development Group. Through the pathway re-designs opportunities for 'place based' care will be a key priority.

8.7 Links will also be made with the VCFA to support the pathway work to consider support for patients and families where access to care is required outside of the Bury locality.

8.8 An Equality Impact Assessment (EIA) will be completed by the Development Group and any risks highlighted fed into the pathway redesign work to identify opportunities to mitigate the risk of inequity in access to care.

8.9 Another key principle of the re-design will be efficiencies and improved flow of patients. During the Development Group discussions, it has been acknowledged that the pathway can't be linear, and a key part of the transformation will be getting the interface between community, primary care and secondary care correct, through a blurring of organisation boundaries and ensuring the right care is provided at the right time by the right professional. It is hoped that the new pathways will allow for a more streamlined and efficient journey for patients that supports flow through the whole system.

9. Governance

9.1 The Development Group will sit within the newly proposed Bury Elective Care and Cancer governance architecture, subject to its sign off, reporting into the Elective Care and Cancer Recovery and Reform Board, due to commence in December 2021. In the short term whilst the new governance structures are being implemented the Development Group will report into the Bury Elective Care Recovery and Reform Group.

9.2 Embedding the pathway work within the Elective Care and Cancer architecture will afford it links to interrelated programmes of work e.g., diagnostics, elective improvement work, While You Wait, A&G and PIFU and the NCA led Being Well Programme that supports delivery of the NCA Recovery Strategy, which includes Elective Care.

9.3 By embedding the Urology pathway work within a robust Bury system governance framework, with clear lines of accountability, it is hoped that Board members will feel sufficiently assured that the Bury Urology pathways are being looked at in its entirety, 'end to end, 'and allow Board members the confidence to endorse the secondary care pan locality model, whilst the associated Bury pathway work is completed as a transformation programme within the Elective Care and Cancer governance.

10. Bury System Commitment

10.1 In line with the changing health and social care landscape and the transition to Integrated Care Systems (ICS), NCA and Bury CCG are committed to undertaking at pace the review and redesign of the Urology pathway as outlined in this paper.

10.2 The integrated system Development Group model, supported by NCA and Bury CCG Senior Leaders, will remove traditional divisions between hospitals and GPs, between physical and mental health, and between NHS and council led service.

10.3 Through a place based partnership approach that ensures 'systemness,' NCA and Bury CCG will deliver to the Locality Board a Urology pathway that is patient-focused and maximises the opportunities for high-quality care across the many parts of the system to maximise value for Bury residents.

11. Risks

11.1 The Board is asked to note that the Secondary Care Urology reconfiguration, overseen by the NCA Urology Board, which has senior CCG representation, is a NCA pan-locality approach. Therefore, any delays to the endorsement of the model by a locality will in turn impact upon the phased implementation across the localities, as outlined in the previous paper brough to the Board (appendix 1).

11.2 The assurances provided in this paper, with regards to the work being carried out on the pathway review and opportunities to provide care 'closer to home, 'is intended to mitigate the risk of delays to the secondary care implementation.

11.3 There is a risk that the new primary and community pathways are still in development and alignment with the new secondary care model may require unknown investment. This risk will be mitigated through the Development Group ensuring it is fully cited on the secondary care developments as they progress, and primary care and community are fully engaged with the pathway redesigns. Progress will be reported to the new Elective Care and Caner Board and risks escalated as required.

11.4 The reconfiguration of secondary care services and provision of inpatient care at SRFT for Bury patients may present a risk in terms of widening the inequalities gap. Completing an EIA, a focus on placed based care and strong links with the VFCA to support the 'end to end' pathway development will help to mitigate this risk.

11.5 Issues with the current flow of patients across the system and bed blockages in the secondary care services presents a risk to the optimal functioning of the new pathways. The close working relationships that the pathway will bring between secondary care surgical consultants and primary and secondary care clinicians, will mean that patients are only progressed for surgery where it is considered essential and where appropriate all other means of treatment have been exhausted. This will help to reduce demand in secondary care.

12. Recommendations

12.1 The Board is asked to:

- receive the update on the work undertaken to date.
- note that a further update on the work of the Development Group and pathway review/redesign will be provided to the Board in April 2022.
- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align

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November 2021

NHS
Bury
Clinical Commissioning Group

Meeting:			
Meeting Date	26 May 2020	**Action**	Receive
Item No.		**Confidential**	No
Title	Urology Services Across Bury, Oldham, Rochdale, and Salford		
Presented By	Ian Mello, Director of Commissioning		
Author	Mike Ryan, Head of Planning and Delivery, NCA North East Sector Commissioners		
Clinical Lead	Howard Hughes, Clinical Director		

Executive Summary

A Greater Manchester (GM) Model of Care (MoC) for Benign Urology was developed through the GM Improving Specialist Care Programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the Greater Manchester Joint Commissioning Board (JCB), though implementation has been delayed due to COVID-19.

As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local Urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve local Urology services. This work is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

This delivery model, which is designed to deliver high quality and accessible services for our patients, would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

This paper, which has been co-authored by the locality commissioners and the NCA, is seeking endorsement of the proposed pan-locality delivery model.

Recommendations

- Endorse the key design features of the pan-locality delivery model, which are fully consistent with the Greater Manchester Model of Care (MoC).
- Support a phased approach to mobilisation overseen by the Programme Board.

Links to CCG Strategic Objectives

SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐

Links to CCG Strategic Objectives	
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Requirements re: consultation/engagement and impact assessments being considered by the Programme Board.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Urology Services Across Bury, Oldham, Rochdale and Salford

1.0 Executive Summary

1.1 Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve Urology services. This is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

1.2 There are significant service resilience issues and unwarranted variation in Urology services within Greater Manchester (GM). In response to this, the GM Improving Specialist Care (ISC) programme developed a GM-wide Model of Care (GM MoC), which was subsequently endorsed by the GM Joint Commissioning Board (JCB).

1.3 The NCA provides the majority of urological care for the populations Bury, Rochdale, Oldham and Salford. Working with local commissioners, a pan-locality delivery model has been developed which is fully aligned with GM ISC MoC.

1.4 This delivery model, which is designed to deliver high quality and accessible services for our patients, is described in more detail below but in essence would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

1.5 This paper, which has been co-authored by the locality commissioners and the NCA, is seeking endorsement of the proposed pan-locality delivery model.

2.0 Background

2.1 A GM MoC for Benign Urology was developed through the ISC programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the GM JCB, though implementation has been delayed due to COVID-19.

2.2 As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

2.3 North Manchester General Hospital (NMGH) is currently the main delivery site for inpatient (IP) Urology services for Bury, Rochdale and Oldham, though – as part of the GM MoC – in the future this site will become a spoke, with IP activity undertaken at one of designated GM hub sites (of which there are anticipated to be five), with most IP activity flowing to Royal Oldham Hospital (ROH), Salford Royal Hospital (SRH) or Manchester Royal Infirmary (MRI).[1]

2.4 Currently 1 in 5 new patient pathways ends in a procedure and a minority of these require an IP stay. Around 80% of the IP activity undertaken at NMGH is from Bury, Oldham and HMR. At SRH the vast majority of IP activity is from the Salford locality.

[1] The other two hubs in GM would be Stepping Hill Hospital (Stockport) and Bolton Hospital).

3.0 The Proposed Pan-Locality Delivery Model

3.1 The proposed pan-locality delivery model is fully aligned to the approved GM MoC and will support the delivery of a single urology service across Bury, Rochdale, Oldham and Salford.

3.2 By delivering a more integrated model of care within each locality, only a small number of patients requiring an IP stay will need to move between sites, thus improving patient experience and continuity of care, reducing inefficiencies and maximising patient safety.

3.3 Key features of the pan-locality model are:

- A single comprehensive Benign Urology Service delivered across Bury, Rochdale, Oldham and Salford.
- Hub-and-spoke delivery model –
    - ROH and SRH as inpatient hubs and Rochdale Infirmary and Fairfield General Hospital as spokes.
    - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
- Single workforce within two integrated functional teams – NCA West & NCA East.
- Bury, Rochdale and Oldham IP activity currently undertaken at NMGH being aligned with the hub-and-spoke model, but recognising that patients (and their GPs) will be free to choose their service provider.
- Expansion and enhancement of clinic & diagnostic capacity at each site in the form of UIUs - increasing local access to urology services.
- A full range of sub-speciality services (e.g. stone services, andrology etc.) will be offered, in line with the GM MOC.

3.4 A phased implementation of the pan-locality model is proposed, particularly recognising the dependency on estate developments (i.e. the delivery of the agreed capital development on the ROH site and the redevelopment of NMGH site).

3.5 The final end-state is delivery of the GM MoC. This will include decommissioning of PAT IP services at NMGH and the full establishment of both ROH and SRH as hub sites. It is anticipated that the majority of patients requiring an IP episode will be cared for at ROH, with some being cared for at SRH or MRI, depending on catchment areas.

4.0 Summary of Drivers for Change

4.1 The pan-locality delivery model is fully aligned to the approved GM MoC for Benign Urology and addresses the following drivers for change:

- Risks to service sustainability, ability to meet performance requirements (exacerbated by COVID), and inequalities in access. Implementation of the first phases of the pan-locality delivery model will begin to address these issues.
- Recommendations made in the national Getting It Right First Time (GIRFT) report for Benign Urology, largely relating to the reduction of unwarranted variation in both access and outcomes, and the future development of the urological workforce. The pan-locality delivery model addresses these issues.
- If a new delivery model is not implemented, there will be increased movements of patients between providers, impacting upon continuity of care.
- MFT's long term model sees no IP surgical activity being delivered at NMGH, reinforcing the need to establish a new model that delivers more care as close to home as possible.

5.0 Impact and Benefits

5.1 The pan-locality model will deliver high quality care for urology patients, address longstanding health inequalities, make the best possible use of available capacity, utilise new ways of working and increase the amount of care that is delivered locally.

5.2 The provision of UIUs in each locality will mean that a number of daycase and diagnostic procedures, where patients currently travel to an inpatient site, will be delivered closer to home. UIUs will also increase outpatient capacity in each locality. Discussions have commenced between Bury CCG Commissioners and NCA to scope the requirements for a UIU to support in the identification of suitable site(s) in the community from which to host the service. Access to diagnostics to support urology investigations will form part of the CCGs work to develop an overarching Diagnostic Strategy for Bury.

5.3 The provision of sub-speciality services will improve patient experience and outcomes.

5.4 Working as a single NCA-wide team will address long-standing sustainability issues, improve recruitment and retention of clinical staff, increase service resilience, and allow the development of pathways that will reduce unwarranted clinical variation.

5.5 The proposed hub-and-spoke arrangements would see Bury and Salford patients that are referred into the service having their IP episode at the Salford Royal hub site. Rochdale and Oldham patients referred into the service would be cared for at the ROH hub. Patients and GPs would, of course, continue to be able to choose other providers within GM.

5.6 This would mean that some patients who currently access IP services at NMGH may have to travel further e.g. patients in the south of Bury and Rochdale, though it is anticipated that as part of the GM MoC and MFT's plans there will not be an IP service on NMGH site.

5.7 Based upon 2019/20 data the number of elective episodes of care from each CCG area undertaken at NMGH and therefore impacted by the GM MoC is as follows.

Bury CCG	HMR CCG	Oldham CCG	Salford CCG
776	822	813	No Change

6.0 Recommendations

6.1 Commissioners are asked to endorse the key design features of the pan-locality delivery model, which are fully consistent with the GM MoC, and a phased approach to mobilisation overseen by the Programme Board.