ANNEX 6 – Swansea Bay Health Board review

SB has three units, Morriston (MDU), Singleton Hospital (SGH) and Neath Port Talbot (NPT). NPT is the only unit that can contribute to inpatient NCSOS option 2 model, with NPT and SGH contributing to the daycase delivery network with SGH having no LF capacity. Historical MDU elective orthopaedic capacity has been utilised for trauma provision although has adequate laminar flow provision but no ringfenced beds due to unscheduled care pressures. Neither Morriston (MDU*) or SGH satisfy any criteria for option 2 for day surgery or inpatient, although the former may have an important regional role for LVHC cases (mainly those with medical complexity and/or needing specialist interdependencies on site e.g. Vascular surgery). At present however, MDU is used sporadically for non-arthroplasty orthopaedics due to lack of ring fencing and this capacity has not been considered in modelling.

- The two theatres in SGH DSU are non-laminar flow and less part of the NCSOS long-term strategy so not included in report 3. However, it is still part of the HB strategy hence included. This site can continue to remain as a hand surgical unit, however, these theatres are used for eyes, plastics and ambulatory trauma (hands, knees). There will be a few hand & wrist arthroplasty case which arguably need to be done in laminar flow – relevant as SB is the highest volume wrist Arthroplasty centre in Wales. This would need to be in NPT. It should also be noted that there is fallow NLF capacity in NPT hence there is scope to transfer the hand unit from SGH DSU into the intended NPT Centre of Excellence.
- NPT is being developed as the SB centre of excellence for elective orthopaedics, spinal and urology surgery. It currently has two laminar flow theatres, one of which is used for spinal surgery and ambulatory trauma. There are also three NLF theatres – two of which are utilised by Urology. As of June 2023 there will be an additional three LF theatres (1-2 of which will be utilised for spinal surgery) and an intended extended scope recovery planned from October 2022. There is a ring fenced ward inpatient orthopaedic ward and a daycase ward. Whilst there is significant daycase capacity, this is for NLF so any use of this can only be considered for non-arthroplasty surgery following National subspecialist CRG discussions. There are also aspirational plans for two further theatres in NPT laminar flow requiring further WG funding which has not been agreed and has not been included in modelling.
- *The SB CEO has stated there are plans to ring fence a 6 bedded ward in MDU for LVHC. This plan is very early in intention as far as the NCSOS are aware and has not been included within modelling.

When modelling around current capacity in SB, the only subspecialties which meet 0% demand model are day surgery knee and foot & ankle. All other subspecialties significantly under-deliver mainly due to lack of theatre (Fig.1). There is nil capacity

for mutual aid except for NLF day surgery, which is not of use as it is already widely available in all health boards.

Current									
	Total Demand	Consultant Capacity	MDU	SGH	SGH DS	NPT		Total	Available Capacity
				NLF	NLF	NLF	LF		
Daycase Capacity			0	0	10	15	6	31	
S&E (87%)	3.75	3.26				2	1.3		
H&W (67%)	7.73	5.18			5.2				16.9
Hip	0.10	0.10							
Knee	2.65	2.65					2.7		
F&A (162%)	2.87	2.87					2.9		
Total	17.13	14.09	0	0	5.2	2	6.9	14.1	
Inpatient Capacity			4	0	0		4	4	
S&E	2.11	1.84	0.844				1		
H&W	0.05	0.03					0.3		
Hip HVLC (199%)	6.84	6.84					1		0.7
Hip LVHC (131%)	1.14	1.14							
Knee HVLC (442%)	8.06	8.06					1		
Knee LVHC (1400%)	1.23	1.23							
F&A (162%)	3.23	3.23	2.7				0.5		
Total	22.69	22.41	0	0	0		3.8	3.8	

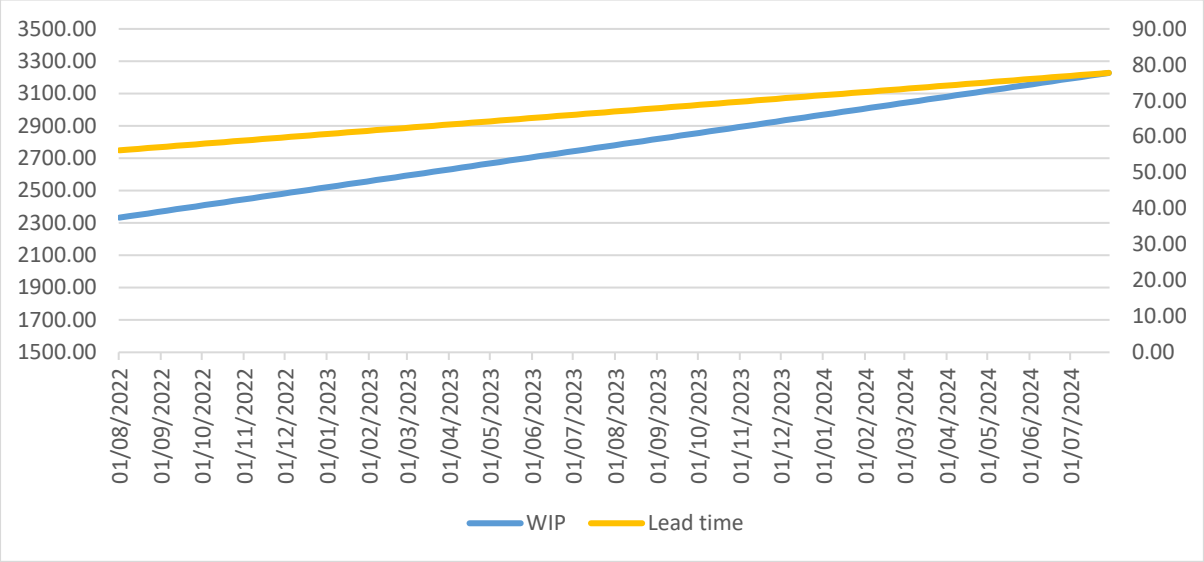
SB Fig 1. 0% model current situation

When modelling for June 2023 and the additional three LF theatres being commissioned, the inpatient capacity significantly increases in NPT (fig. 2).

June 2023									
	Total Demand	Consultant Capacity	MDU	SGH	SGH DS	NPT		Total	Available Capacity
				NLF	NLF	NLF	LF		
Daycase Capacity			0	0	10	15	6	31	
S&E (87%)	3.75	3.26				2	1.3		
H&W (67%)	7.73	5.18			5.2				
Hip	0.10	0.10					0.1		16.8
Knee	2.65	2.65					2.7		
F&A (162%)	2.87	2.87					2.9		
Total	17.13	14.09	0	0	5.2	2	6.9	14.2	
Inpatient Capacity			0	0	0		22	22	
S&E	2.11	1.84					1.8		
H&W	0.05	0.04					0.5		
Hip HVLC (199%)	6.84	6.84					6.84		0.37
Hip LVHC (131%)	1.14	1.14					1.14		
Knee HVLC (442%)	8.06	8.06					8.06		
Knee LVHC (1400%)	1.23	1.23					1.23		
F&A (162%)	3.23	3.23					3.23		
Total	22.69	22.41	0	0	0		22.37	22.37	

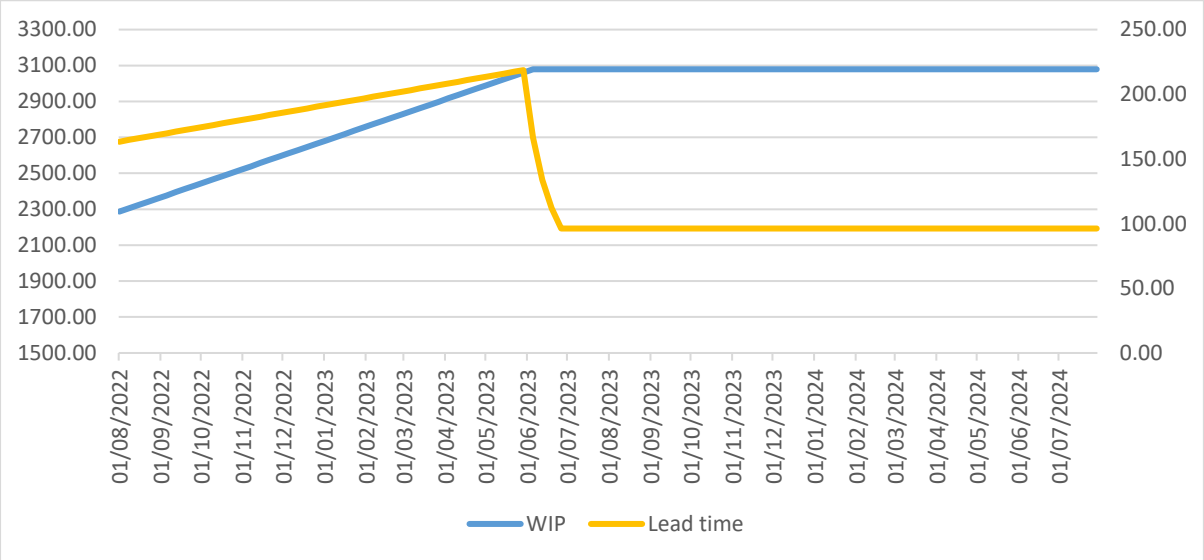
SB Fig 2. June 2023

Daycase will still be restricted by lack of laminar flow theatres (fig. 3) although this could be mitigated by reducing inpatient use of the laminar flow theatres.



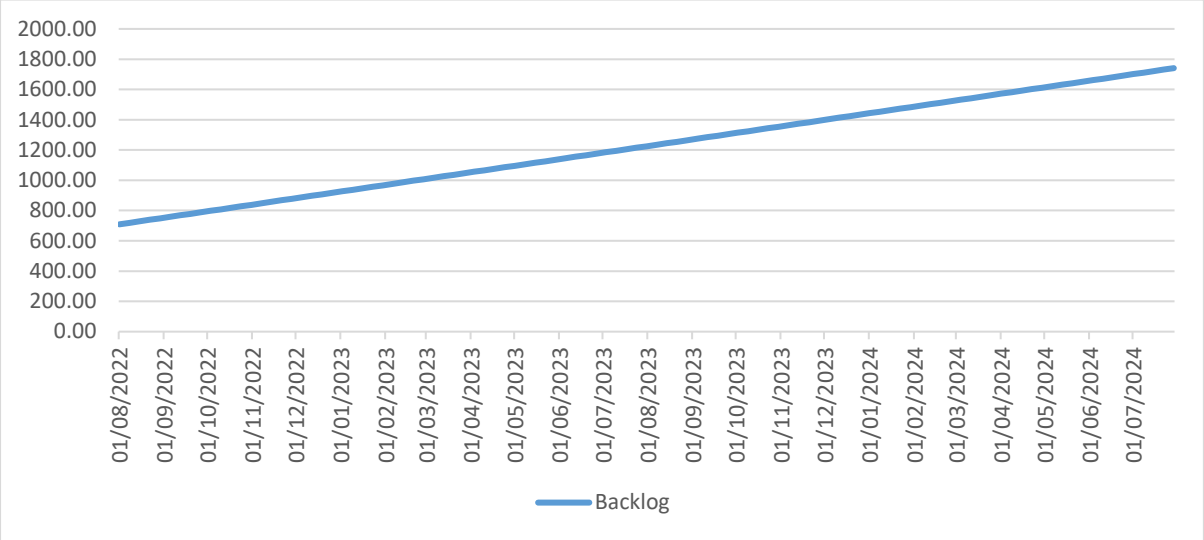
***SB Fig.3. SB DSU backlog with June 2023 model*.**

SB will have the estate and consultant workforce to meet 0% model for all subspecialties except shoulder and hand. These are constrained by workforce so regional models and additional recruitment may be required. This is assuming (a) all theatres can be staffed (b) interdependencies can match the complexity case mix. (Fig. 4).



SB Fig. 4. SB IP backlog with June 2023 model. NOTE: THIS ASSUMES NPT CAN MANAGE ALL LVHC "Morriston only patients".

This latter point is the main issue with NPT and highlighted in NCSOS report 3. The mitigation proposed by the HB for this is to redevelop LVHC orthopaedics in MDU through the aforementioned 6 bedded unit. Current SB pre-assessment data suggests that 31% of the IPWL is unsuitable for NPT and are categorised as "Morriston only patients" (MOPs). Therefore, without mitigation, whilst the overall IPWL will remain static, there will be an ever-increasing MOP list. (Fig. 5).



SB Fig. 5. MOP backlog, without intervention.

However, whilst this delivers the 0% IP model for SB in isolation, there is no useful capacity for regional / mutual aid with the majority being NLF.

It should also be noted that this modelling does not take into account potential repatriation of NPT CTM delivered patients.

Fragilities in SB interdependency workforce through vacancies and inability to manage existing theatre and anaesthetic workforce across the entire HB represent a major risk for delivery of recovery. Workforce is spread thinly across the HB and staff groups reluctant to work in new sites or undertake alternative casemix e.g. DC unit staff reluctant to undertake IP casemix