Case for CHANGE

EAST CHESHIRE NHS TRUST & STOCKPORT NHS FOUNDATION TRUST

SUMMARY DOCUMENT

sustainable hospital services for the people of eastern Cheshire and Stockport

Foreword

This documents provides a summary of the case for change in hospital services across East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (SFT).

It sets out who we are and why we believe there is a need to change the way we deliver these services.

The case for change considers ten hospital services:

- Anaesthesia & Critical Care
- Cardiology
- Diabetes & Endocrinology
- Endoscopy
- Gastroenterology
- General Surgery
- Imaging
- Trauma & Orthopaedics
- Women & Children: Maternity & Gynaecology
- Women & Children: Paediatrics & Neonatology

It describes these current services at ECT & SFT, the challenges they face and the potential benefits of working together across two hospitals.

It outlines what people have said about our services and what change might mean for local people, patients, their carers and our staff.

Finally, it sets out the next steps in the process.

More information on any section of this case for change can be found in the full document on our website at:

https://localvoices.uk

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Chairman of the Board

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1. What is a Case for Change?

The purpose of a case for change is to review the way the services are currently delivered and to assess what improvements can be made.

1.1 Process

NHS England has clear guidance on the process for planning significant changes to health services and monitor the process through formal gateway reviews.

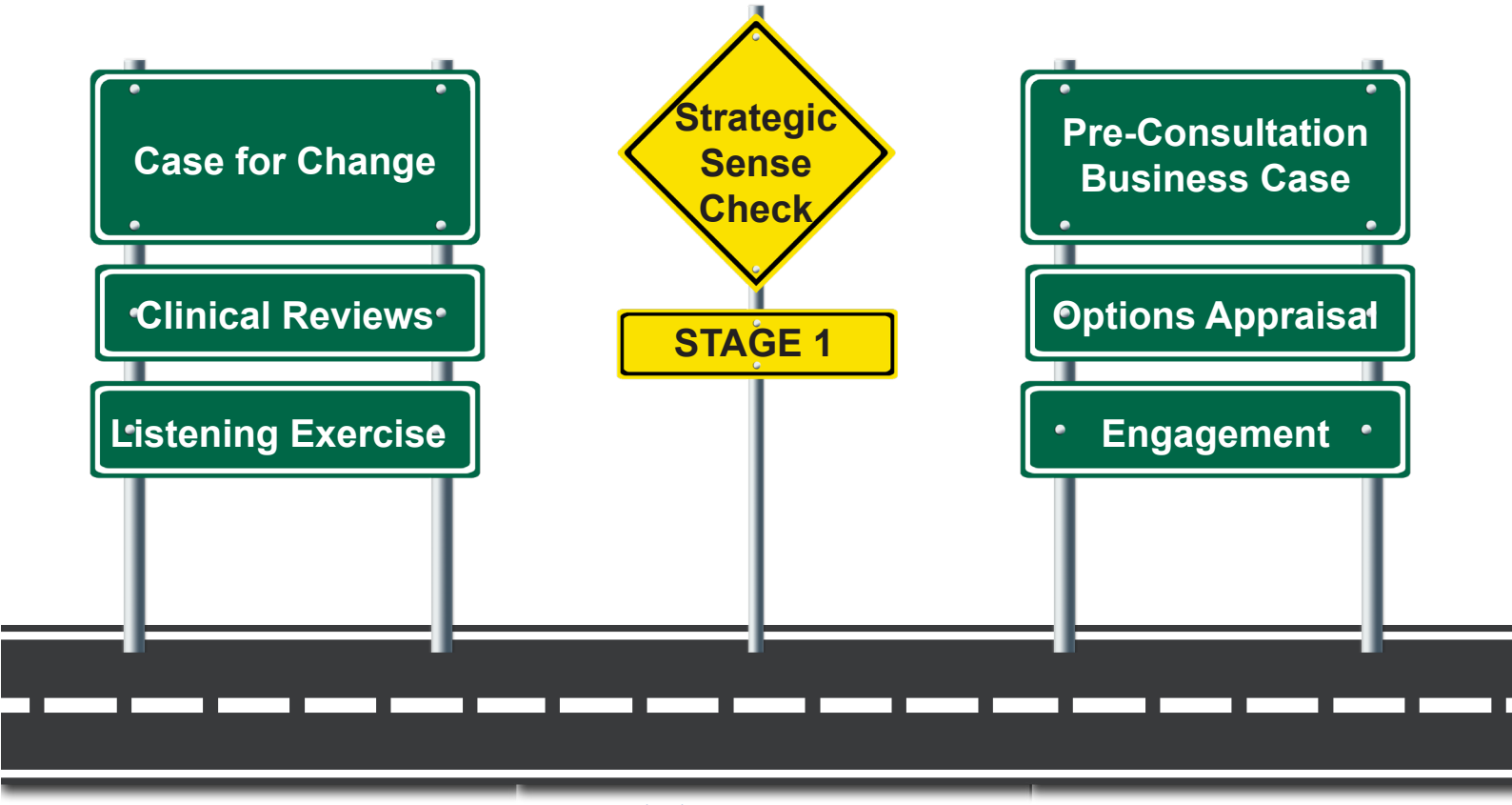
Our case for change is the first step in this process – identifying the reasons why change needs to happen.

This case for change focuses on the problem of clinical sustainability and recovery of planned care services across our system. Information has been gathered through a range of methods including a review of activity, workforce, finance and performance data; feedback from the clinicians who deliver our services; and initial views from patients and carers using our services.

Once we have established what needs to change, we will undertake a collaborative review of how that change can be delivered.

This will involve developing a long-list of options and narrowing it down to a short-list of workable proposals, which we will take out to public engagement at the start of 2023. Our approach will be open-minded, and we will involve a range of stakeholders including the clinicians and staff who deliver our services, patients and carers who access our care, other health providers who refer into our services and system partners such as local authorities and the voluntary sector who support the wider health economy.

We will focus on the benefits that can be delivered for patients by providing high quality care at the right time and in the best place to meet local needs.



June 2022

After public engagement, our short list will go to NHS England for approval around May 2023.

Depending on the scale of change proposed, we will go out to public consultation over the summer in 2023 and submit our final plans to NHS England for decision.

1.2 Case for Change Development

Development of this case for change has involved:

- a review of service data, including workforce numbers, activity levels, performance against clinical standards, finance, patient and staff satisfaction levels
- clinical workshops, bringing together staff from across both hospital sites to discuss what works well in both services and areas for improvement
- a review of previous patient and public engagement to understand local needs and aspirations for health services
- a patient and public listening exercise in early 2022 to assess local views of our services.

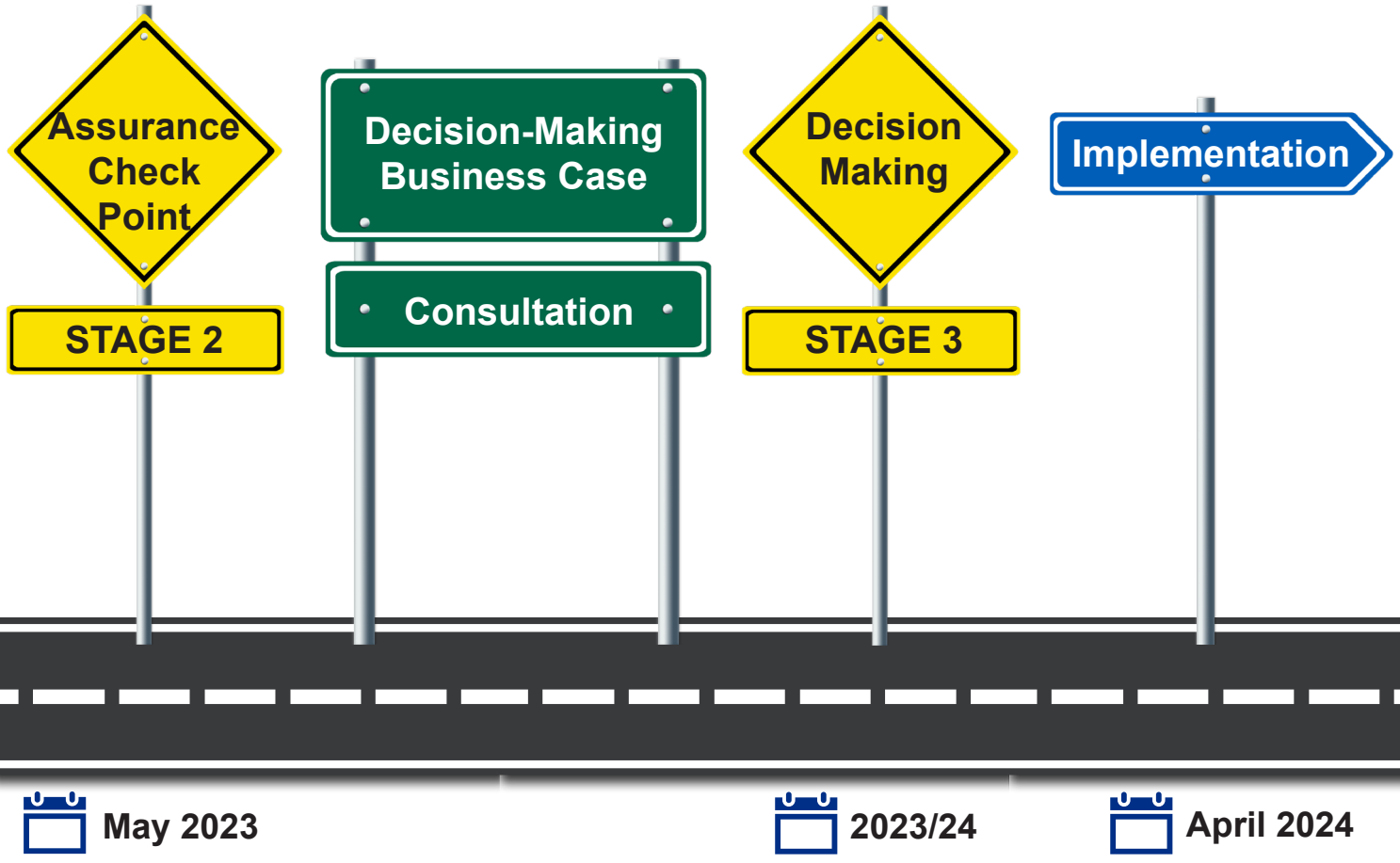
1.3 Case for Change Format

Our case for change focuses on ten acute clinical services across East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (SFT).

- Anaesthesia & Critical Care
- Cardiology
- Diabetes & Endocrinology
- Endoscopy
- Gastroenterology
- General Surgery
- Imaging
- Trauma & Orthopaedics
- Women & Children: Maternity & Gynaecology
- Women & Children: Paediatrics & Neonatology

It describes the current situation and sets out why change is necessary, in terms of:

- Capacity & demand
- Quality & performance; and
- Workforce resilience.



2. Why are we doing this?

3.2%	**Our population is growing** The UK's population grows by around 0.5% a year. By 2030 there will be another 2.1 million people in the UK
8.6m	**People are living longer** There are 12.4 million people aged 65+ and in 50 years' time there is likely to be an additional 8.6m
65%	**Balance of care** 65% of people admitted to hospital are 65 or over
15m	**More long-term conditions** Around 15m people in the UK have a long-term condition (LTC)
x2	**Multiple long-term conditions** Between 2015 and 2035 the number of older people with four or more LTCs is expected to double
£7	**Cost of care** £7 out of every £10 in the NHS is spent on long-term conditions
70%	**Focus of care** 50% of all GP appointments 64% of outpatients and 70% of inpatient bed days are related to LTCs

As our population grows and more people are living longer with multiple long-term conditions, the demand for health services is growing and changing.

Current services were not designed to meet these changing needs. The NHS as a whole does not have enough skilled professionals to deliver every service in every area, and it is becoming harder to keep up with rising costs.

Both trusts are committed to delivering safe, sustainable, high-quality hospital services that meet local needs.

To do this, we recognise that we need to change the way we work to ensure that we have the right skills and equipment to deliver the high standards we expect for our population.

2.1 National Context

NHS organisations across the country are facing significant workforce and financial pressures as a result of growing demand for healthcare from an ageing population.

There are huge vacancies across the NHS workforce. Based on current trends, the NHS will have a shortfall of 108,000 nurses in 10 years' time.

Even before the COVID-19 pandemic, healthcare services were struggling to meet growing demand related to demographic changes and persistent challenges in recruiting and retaining a qualified and committed workforce. The pandemic also shighlighted the inequalities faced by some of our communities, with poorer access to services and poorer outcomes.

2.2 Local Context

While our hospitals deliver a good standard of safe care, we recognise that our services are not sustainable and are not consistently delivering NHS constitutional standards seven days a week. Operational performance is extremely challenged. We also recognise the significant workforce challenges, the need to support our teams and to create greater resilience in services.

The Boards of ECT and SFT consider each other to be natural partners for collaboration, given the geographical proximity and the range of services provided, acknowledging also the importance of other strategic partners. While ECT is in the Cheshire and Merseyside Integrated Care System (ICS), the two trusts work together as part of the Greater Manchester hospital system and have worked particularly closely over the past two years in the response to the pandemic.

Both trusts have experienced challenges delivering services due to growing demand and a lack of specialist staff, but we have managed to maintain high quality care for local people by supporting each other – for example, ECT delivers vital breast services for Stockport residents and SFT provides high-quality rheumatology care for the residents of Cheshire East.

We believe that there are five key issues that need to be addressed.

1. Changing Local Needs:

Our population is growing and people are living longer, with more complex and long-term health care needs. Access to healthcare services varies among community groups, with some more likely to use urgent and emergency care. Continuing to deliver the same services in the same way is not sustainable, and we that it will not meet the changing needs of our population.

2. Workforce:

Across the two trusts, we simply do not have the workforce we need to deliver all services at both sites. While our clinical teams are highly skilled, they are unable to consistently meet national clinical standards within existing resources.

3. Fragile Services:

A number of clinical specialties are too small to meet the needs of our population. Despite having dedicated and hard-working clinical teams, these services are not sufficiently resilient. Though clinical outcomes are currently good, it is becoming more challenging for both trusts to maintain that level of quality and clinical standards.

4. Patient Flow:

When a hospital has sufficient staff, beds, theatres and funding, patients can be seen in a timely manner, treated effectively, and supported to go back into the community to recuperate, making space for the next patient. This is effective patient flow.
The COVID-19 pandemic exacerbated existing challenges. As a result, waiting times for planned procedures at ECT and SFT increased significantly. Thousands of patients have already waited more than a year for surgery and routine procedures are often cancelled because of emergency bed pressures. If no action is taken, it could take three to five years to reduce the surgical backlog to pre-pandemic levels.

5. Effective Use of Resources:

To build sustainable services, we must use the combined resources of our integrated health and social care systems effectively. We are not currently doing this well enough, with duplication of services across the system. Working collaboratively across a wider population base could help us to share resources, including workforce, equipment and estate, to provide the services people need.

Why are we concerned about small services?

Small services are more likely to be challenged in their ability to meet clinical standards as they may not have enough staff to provide sufficient staffing 24/7 or they may not see enough patients to retain staff skills. As a smaller trust, ECT has a number of small - or sub-scale - services. Operationally, it is more difficult for smaller services to flex capacity to manage increases in activity, they are less resilient to planned and unplanned staff absences and this may impact patient access to the service.

For many years, ECT has had a good track record in developing strategic clinical partnerships to support smaller services and maintain local access, on a specialty-by-specialty basis as challenges have arisen.

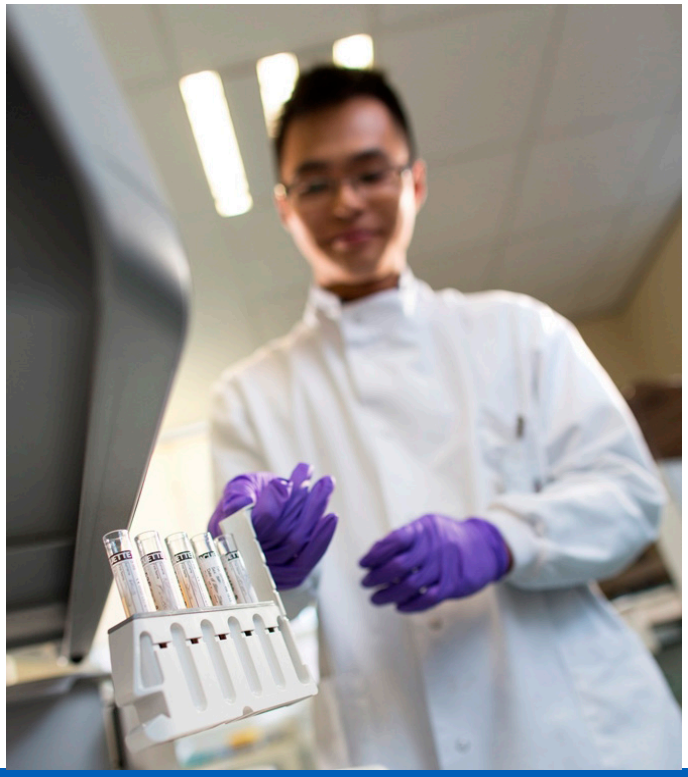
Though SFT is a larger trust, it too has been challenged to deliver all specialties, resulting in collaborative arrangements with other trusts to maintain services for local people.

In 2019, the workforce challenges in rheumatology became so significant that it was no longer possible to recruit medical or nursing staff to the service. This impacted on patient access times and waiting times increased. In discussion with commissioners, it was agreed that the ECT rheumatology service would transition to SFT and a larger, more resilient service offer is now available to both local populations.

While Stockport patients have seen no negative impact on the strong service they receive, the change has benefited the clinical service, improving resilience and skills in a wider team.

In 2019, SFT and the NHS Stockport CCG took the difficult decision to suspend the Breast Service at SFT due to the shortage of specialist staff required to deliver safe and sustainable care. With growing demand and gaps in key specialist roles, the trust struggled to meet the national standard waiting time of two weeks for suspected breast cancer. To ensure that Stockport residents have timely access to vital services, patients referred by their GP can now choose to attend the Breast Service at Macclesfield, Tameside, or Wythenshawe Hospitals. The Breast Cancer Screening service is delivered locally by East Cheshire NHS Trust.

In 2020, Clinical Haematology, a small but critically essential service run by a single-handed consultant at ECT, became impossible to sustain following the retirement of the consultant. The service was successfully transitioned to The Christie FT, which has strengthened resilience and sustained local access.



The resilience of sub-scale anaesthetic and critical care services at ECT was also significantly tested in March 2020 when there was an urgent need to flex capacity to receive an increased number of emergency admissions requiring critical care and ventilation during the COVID-19 pandemic.

As a result, the anaesthetic team was no longer able to provide support to the maternity ward at Macclesfield and the trust took the diffiult decision to temporarily suspend all briths at ECT.

The intention is to reinstate the full suite of obstetric, midwifery and neonatal services on the Macclesfield site once it is safe to do so. The workforce challenges in anaesthetics are such that this is not yet possible. In the meantime, ECT has agreed to continue the suspension of births until April 2023.

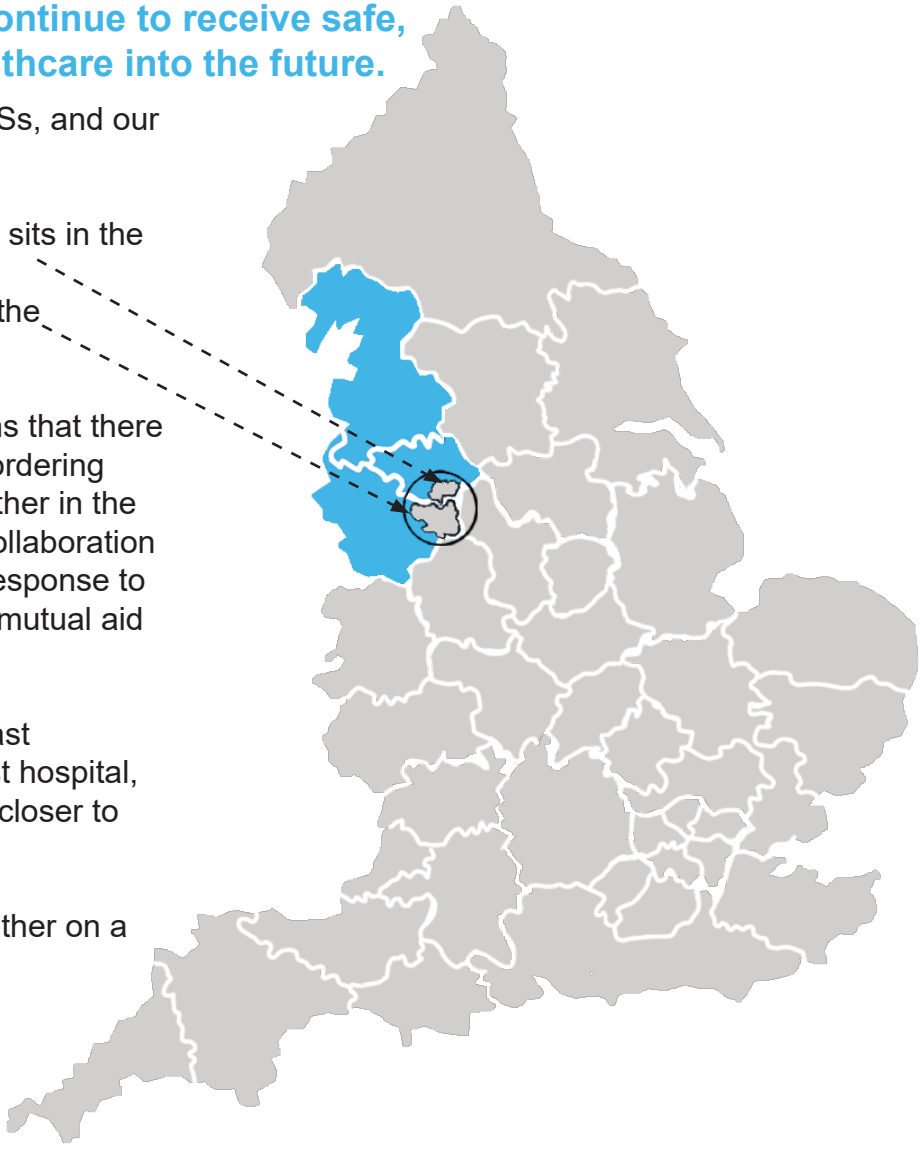
Strengthening the resilience and clinical sustainability of all sub-scale services is crucial to maintaining high-quality local services.

3. About Us

ECT and SFT have agreed to work together to strengthen the way services are delivered to ensure the populations of Eastern Cheshire, Stockport and the surrounding areas continue to receive safe, high-quality sustainable healthcare into the future.

The North West region has three ICSs, and our hospitals work across two of those:

- Stockport NHS Foundation Trust sits in the Greater Manchester ICS.
- East Cheshire NHS Trust sits in the Cheshire & Merseyside ICS.

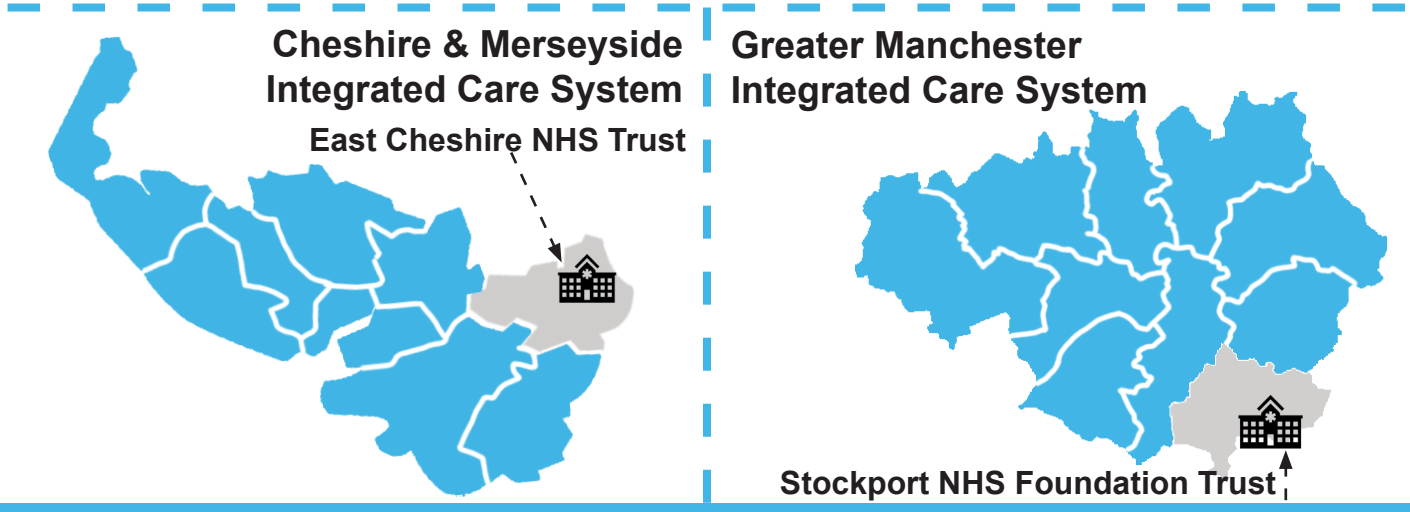


However, our local geography means that there is a lot of cross-over between the bordering areas, with both trusts working together in the Manchester hospital system. This collaboration has been strengthened during the response to COVID-19, with hospitals providing mutual aid to support patients.

For many patients in the North of East Cheshire, Stepping Hill is the closest hospital, while many Stockport residents are closer to East Cheshire services.

The two hospitals already work together on a number of services:

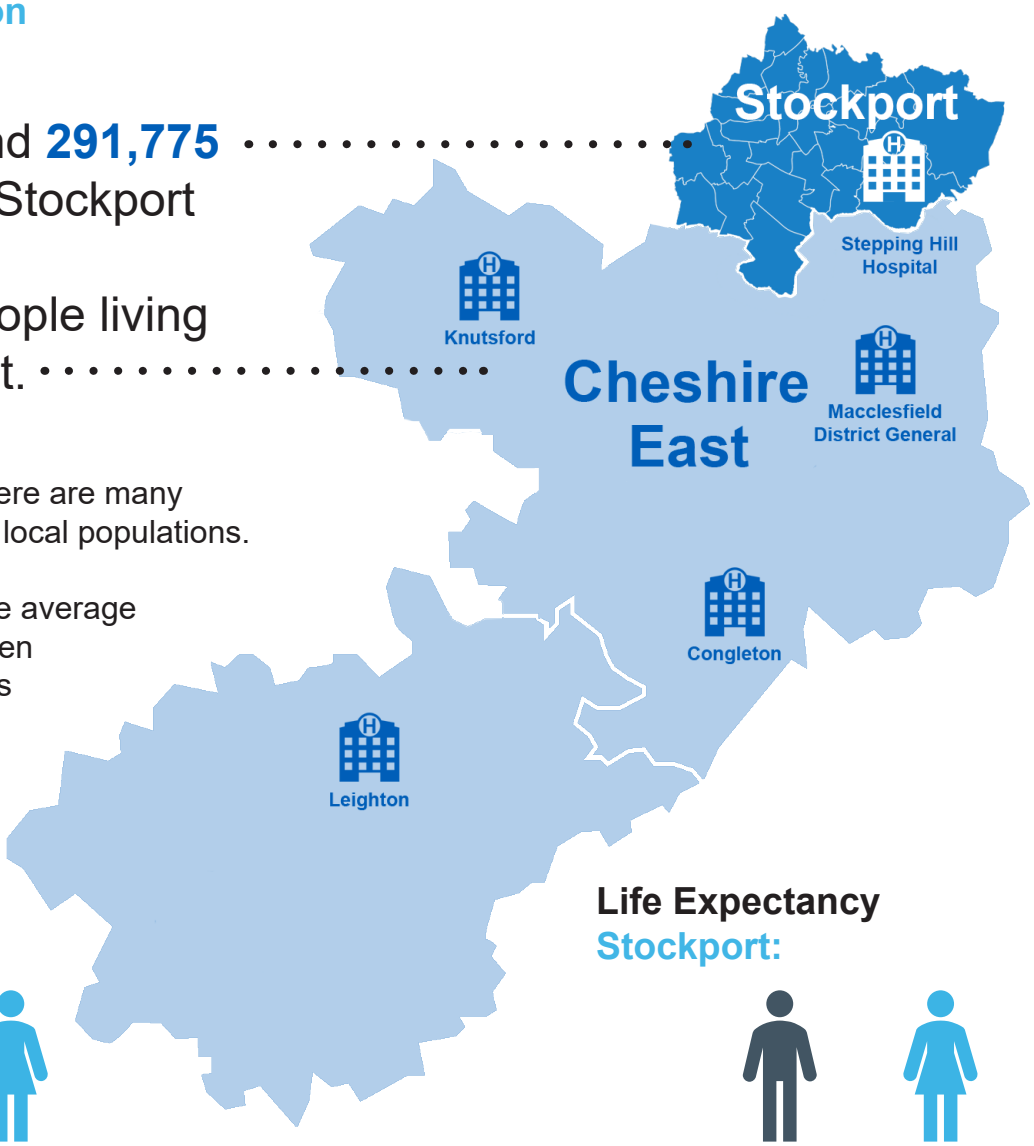
- Urology
- Breast Screening
- Maternity
- Neonatal services.



3.1 Our Population

There are around **291,775** people living in Stockport

and **378,800** people living in Cheshire East.



As close neighbours, there are many similarities between the local populations.

Life expectancy is above average in both areas, with women living around three years longer than men.

Life Expectancy
Cheshire East:

80.3 83.7

Life Expectancy
Stockport:

79.8 83.3

Across both areas the population is growing, with a higher than average proportion of elderly people with increasingly complex health needs.

Between 2018 and 2038 the number of patients is likely to increase by 9% in Cheshire East and 7% in Stockport. Among people aged 70 and over, the population is predicted to increase by 50% in Cheshire East and 30% in Stockport.

Both areas have higher than average rates of people with disabilities and long-term conditions - 17.52% of Cheshire East residents and 18.45% of Stockport residents report having a disability that limits their day-to-day activities.

Cheshire East and Stockport are made up of a wide range of communities. 89% of Stockport's population and 94.24% of Cheshire East are white British. Black and ethnic minority communities have almost doubled over the last decade to 5.76% in Cheshire East and 11% in Stockport.

While Cheshire East and Stockport are relatively affluent compared to the national average, both areas have pockets of deprivation. 17.4% of Stockport's residents live in the most deprived areas, compared to just 7.7% of Cheshire East residents, while 25.6% of Stockport's residents live in the most affluent, compared to 41.9% of Cheshire East residents.

3.2 Our Organisations

ECT is one of the smallest trusts in England, providing hospital and community healthcare services to patients in eastern Cheshire, as well as Staffordshire, Derbyshire and Stockport.

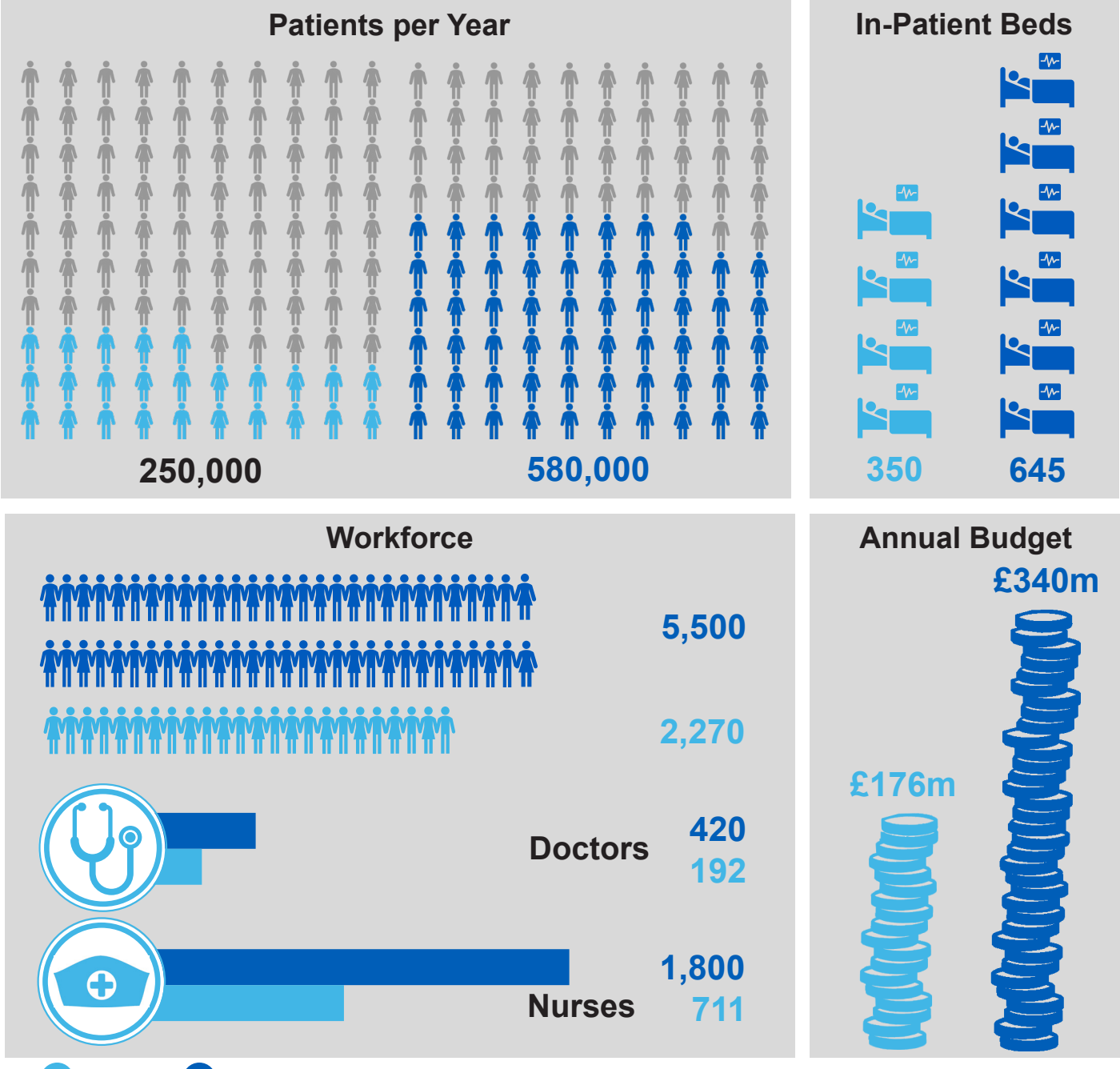
The trust has 350 inpatient beds and employs around 2,270 people. In 2019/20 ECT had an annual budget of £176 million.

ECT was rated 'Good' by the Care Quality Commission (CQC) with areas of 'Outstanding' practice following inspections in 2019.

Stockport NHS Foundation Trust is a medium sized trust serving the populations of Stockport, High Peak and eastern Cheshire.

It is an integrated community and acute trust employing over 5,500 staff with an annual budget of around £340 million.

Following a CQC inspection in early 2020, SFT was rated as 'Requires Improvement'. An improvement plan was developed to address issues identified. Progress was demonstrated in a recent inspection of urgent and emergency care, which has now been rated as 'Good'.



3.3 Workforce

Together, ECT and SFT employ 7,700 people, and so together are among the biggest employers in the area.

Around 8% of the workforce are doctors; 32% nursing staff; 21% clinical support staff; 7% allied health professionals; 2% healthcare scientists; 3% scientific and technical professionals; around 20% work in administrative and clerical roles; and 7% work in estates and ancillary roles.

Both trusts face challenges around workforce sustainability:

- the vacancy rate is almost 6% at ECT and 7.5% at SFT
- staff turnover rate is 12.6% at ECT and 14.7% at SFT
- sickness absence is similar to the national NHS average at around 5.9%.

As is the case with the NHS nationally, much of our workforce is aged 50 or over, posing a challenge around future sustainability as staff retire.

Staff Group	Whole-Time Equivalents	
	ECT	SFT
Medical & Dental	192.1	422.7
Nursing & Midwifery	711.9	1,768.6
Allied Health Professionals	219.1	396.5
Healthcare Scientists	26.9	102.8
Additional Clinical Services	471.8	1,129.1
Additional Professional Scientific & Technical	61.1	169.3
Administrative & Clerical	553.3	1,031.6
Estates & Ancillary	35.5	408.0
TOTAL	**2,271.7**	**5,428.5**

3.4 Financial Context

The services reviewed as part of this case for change make up over half of all inpatient activity at ECT (57.7%), 40.8% of the trust's outpatient activity and 28.9% of the Trust's income.

For SFT, the services account for around 40.2% of inpatient activity. 49.0% of outpatient activity and 26% of the trust's income.

4. Our Ambition

Our ambition is to work together across our clinical teams to create high-quality hospital services for our shared population.

In doing so, we aim to:

improve the health and wellbeing of local people

reduce health inequalities, offering the same high standard of access and care across the patch

deliver national standards and clinical excellence

make our hospitals great places to work, improving staff wellbeing and attracting people with the right skills and potential

harness technology to deliver state of the art care, connected to out of hospital services

share knowledge, skills and resources to increase capacity and efficiency

ensure that our services are sustainable and able to meet growing needs long into the future

make a positive impact on our local area through improved health, employment and training opportunities.

Hospital care is a central element of the wider health and care system. We will work collaboratively as part of that system to:

- keep people well;
- prevent ill health;
- provide local support to manage conditions as close to home as possible;
- and ensure that efficient hospital services are there when needed.

With a growing population and increasing demand for care, there is simply not enough staff or resources to offer every service on every site at the standard we aspire to for our population.

We want to ensure the same model of high quality care is delivered to all of our patients, no matter which part of the area they come from.

Some services will intrinsically need to be delivered across each site to respond to crisis in a timely way and ensure the safety of our population.

For very specialist and once-in-a-lifetime care, we propose greater collaboration to ensure that we have consultant cover 24/7, state of the art equipment, ample space, high quality facilities, and sufficient nursing staff to guarantee high quality care.

By working together to manage the workload, we aim to reduce waiting times and improve outcomes.

Delivering truly excellent care will allow us to attract the brightest and the best to work in a system they can be proud of, with opportunities to learn and develop their careers, including use of new roles.

Efficient use of our shared resources would also support financial sustainability in the long-term, allowing us to reinvest in further improvements and flex to meet the needs of local people.

5.1 Anaesthesia & Critical Care

Critical Care is the medical specialty that supports patients with life-threatening conditions, those recovering from major surgery who require intensive post-operative care and patients who need organ support to recover from severe infections, neurological problems, post-operative complications, heart attacks or strokes.

Level 2 (high dependency) requires a minimum of one nurse for every two patients, while Level 3 (intensive) critical care requires at least one nurse per patient.

Any hospital with a 24-hour emergency department must have level 3 critical care provision.

The ICU at ECT is extremely small, with just seven critical care beds. Medical staffing is provided by the anaesthetics department, which also supports theatres, maternity and the emergency department. This capacity was tested during the COVID-19 pandemic, resulting in the temporarily suspension of births at ECT.

ECT's critical care services were rated 'Good' by the CQC in 2019, however it is acknowledged that the size of the unit impacts the trust's ability to comply with national standards.

The ICU at SFT has capacity for 20 beds, with separate intensive care and high dependency units.

A minimum of two dedicated intensive care medicine (ICM) staff are resident 24-hours a day with additional staff during working hours.

The trust has an excellent reputation, with a full complement of consultants, a training unit for ICM doctors, and participation in research.

SFT's ICU was rated as 'Good' by the CQC.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	199	152
Level 3 Beds (number commissioned)	7	4
Level 2 Beds (number commissioned)	6	2
Length of Stay (days)	15.6	13.0

Workforce*

	ECT	SFT
Intensive Care Consultants	12.0	8.0
Tier 2 Doctors	20.0	11.0
Tier 1 Doctors	14.0	0.0
Specialist & Registered Nurses	68.6	31.0

ECT SFT

* Whole-time equivalents

Capacity & Demand

England has some of the lowest rates of critical care beds per head of population in Europe.

Both ICUs are currently constrained by their estate:

- At ECT, the small size of the unit restricts the ability to accommodate all patients at times of peak demand and some patients have to be cared for on acute wards.
- At SFT, there is only one side room. Estates work was completed in Jan 2022 to install four isolation pods within the existing unit, providing a total of five individual rooms.

During the COVID-19 pandemic demand for consultant anaesthetists increased significantly, putting a strain on ECT's small team.

Quality & Outcomes

Clinical outcomes for patients are currently good, but there is a persistent risk to sustainability at ECT due to the small size of the service.

The critical care service at SFT is almost fully compliant with Guidelines for the Provision of Intensive Care Services (GPICS), with the exception of the standard on multi-disciplinary team working.

Inspection and audit of the ECT service resulted in a 'good' rating, with no evidence to suggest that quality is compromised by the size of the unit. However, service resilience and clinical sustainability at ECT is fragile due to workforce constraints and with limited medical staffing resources, it is not possible to comply with all national GPICS staffing standards.

Workforce Resilience

Nationally, there is a lack of trained doctors to meet growing demand for critical care - particularly intensive care physicians.

ECT's ICU currently has three medical vacancies. Recruitment to the small unit has proved challenging, with the majority of intensive care consultants appointed by the large teaching hospitals.

The recruitment of skilled and experienced critical care nurses is also challenging, reflecting the national context.

As the anaesthetist team at ECT also covers maternity services, the trust will struggle to comply with both critical care and maternity workforce standards without additional investment and recruitment of staff.

The Case for Change

Critical Care:

» Neither service is currently achieving all GPICS workforce standards, with the issue particularly acute at ECT.

» With a projected increase in demand for critical care services, these strains will only increase over time.

» Workforce constraints at ECT make it very difficult to maintain current clinical standards in critical care.

» The sustainability of critical care services is essential to support 24hr ED services on the Macclesfield site and if the challenges in critical care are not resolved the negative impact on other core services is inevitable.

Anaesthetics:

» Action is required to strengthen the resilience of the anaesthetic and critical care workforce so that essential clinical standards are met and sustained.

5.2 Cardiology

Cardiology is one of the largest medical specialties, focusing on the diagnosis and treatment of disorders of the heart and circulatory system. The NHS Long Term Plan includes a specific focus on the prevention, diagnosis and management of cardiovascular disease (CVD).

Cardiothoracic surgeons, who specialise in cardiac surgery, only work at specialist centres. Patients who present to an emergency department with an acute coronary syndrome (heart attack/myocardial infarction or unstable angina) may be referred directly to specialist centres for urgent assessment and treatment. Less acute presentations are seen in rapid access chest pain clinics at the local hospitals.

ECT has a small, specialised team of cardiac consultants, nurses and physiologists who offer a comprehensive range of investigations and treatments to approximately 8,000 patients each year.

The Cardiology ward at Macclesfield has 28 beds which are shared with general medicine.

The Cardio-Respiratory Department provides a wide range of investigations and treatments.

The cardiac rehabilitation team provide support and education for patients and is currently in the process of setting up a community heart failure rehabilitation programme.

The Cardiology Department at SFT treats approximately 20,000 people each year. It has 28 cardiology beds - 24 beds in a shared medical ward, plus eight in a Heart Care Unit.

GPs can refer patients with certain categories of chest pain for a prompt assessment in the rapid access chest pain clinic.

SFT has a dedicated pacing suite for the pacemaker implantation service. A rehabilitation service is provided for patients recovering from a heart attack or coronary surgery, including counselling, a clinic and exercise programme.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	1,388	307
Elective Admissions	15	2
Day Case Procedures	448	50
Outpatient Appointments	20,242	12,271*

Workforce**

	ECT	SFT
Consultants	7.6	2.9
Tier 2 Doctors	1.0	0.8
Tier 1 Doctors	8.0	4.0
Specialist & Registered Nurses	3.0	4.7

ECT SFT * includes 4,500 direct access GP patients ** Whole-time equivalents

Capacity & Demand

During the COVID-19 pandemic, much of the elective surgical programme was paused or restricted, creating delays in access to treatment. At present, some patients are waiting 24-months for follow up review and waiting times are growing.

Cheshire East and Stockport have ageing populations, with increasing risk of local prevalence of cardiovascular disease. As such, demand is expected to increase.

Some patients are being admitted to hospital for treatment of heart failure because ambulatory care services are not currently in place.

Quality & Outcomes

All hospitals receiving acute medical admissions should have a cardiologist on call 24/7 who is able to return to the hospital as required. This is not in place at either site.

Neither site currently delivers angiography within 72 hours of admission due to patients needing to be transferred to specialist centres

Delays in transfer to specialist centres for interventional procedures impact on patient flow, prolonging length of stay.

Average length of stay is around 8.8 days.

Workforce Resilience

ECT has just 2.8 WTE consultants, who also contribute to clinical sessions at specialist centres. Based on national recommendations, there should be five.

With such a small team, covering annual leave and sickness absence is a particular challenge as there is no flexibility to provide cover for absent colleagues without significantly disrupting senior input to the cardiology ward. Subsequently, outpatient clinics and day case procedures are cancelled, which delays care and treatment for these patients.

SFT's eight consultants have a ‘consultant of the week’ model and provide seven-day cover until 7 pm.

Retention of highly skilled and experienced nurses is a concern in the context of national workforce challenges and cardiology nursing roles are very demanding. Cardiology specialist nurses are important and highly valued members of the team.

The Case for Change

- Patients are waiting too long for consultant assessment and diagnostic services.
- Delays in transfer to specialist centres for interventional procedures impact inpatient flow and prolong length of stay for patients.
- Both sites have relatively small coronary care units, which are not resourced to meet national workforce standards.
- The ECT service does not have enough consultants to meet growing referral demand and manage the backlog.
- Cardiology specialty input out of hours is sub optimal, with ECT patients cared for by general and acute physicians at weekends.
- Patients cannot access first line diagnostic services locally, due to a lack of radiology staff, delaying care and treatment.
- Neither trust provides an inpatient angiography service for acute coronary syndromes - NICE recommends this is available within 3-days.
- Some patients are being admitted to hospital for treatment of heart failure because comprehensive ambulatory care services are not currently in place.

5.3 Diabetes & Endocrinology

Diabetes and Endocrinology is a broad-ranging specialty covering conditions caused by abnormalities of hormone production or action, and the endocrine glands that produce them.

Around one in six of all people admitted to hospital will have diabetes and 90% will have been admitted for other conditions such as pneumonia or planned surgical procedures. They are treated by staff across various surgical and medical disciplines, who may not be experienced in diabetes management. Patient outcomes are much improved if diabetes control is good, making urgent access and review by a specialist diabetes team essential.

ECT has a small endocrinology outpatient service and specialist input and review of hospital inpatients with diabetic and endocrinology conditions. ECT also has a small paediatric diabetes service for around 120 patients.

In 2016, Cheshire CCG redesigned diabetes services for the local population, strengthening out of hospital care. Outpatient services for adults with diabetes are now provided by Vernova CIC, a community-based service run by a sessional consultant diabetologist, a local GP with special interest in diabetes, and a team of specialist nurses.

SFT provides community and outpatient services for diabetes and endocrinology, as well as specialist review of inpatients.

The diabetes service comprises three consultants and a dedicated team of specialist nurses, specialist midwife, specialist dieticians, high risk podiatrists and diabetes educators.

The specialist endocrine service offers two clinics per week.

The community diabetes specialist nursing service compliments the hospital service with holistic care focused on education, support and advice.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	791	421
Elective Admissions	8	0
Day Case Procedures	65	1
Outpatient Appointments	3,709	1,505

Workforce*

	ECT	SFT
Consultants	4.5	0.5
Tier 2 Doctors	1.0	0.0
Tier 1 Doctors	2.0	3.0
Specialist & Registered Nurses	9.7**	1.0

ECT SFT * Whole-time equivalents ** figure includes community diabetes nurses

Capacity & Demand

Nationally, the rate of diabetes is growing and, with it, demand for services.

The COVID-19 pandemic has had a significant impact on the service at SFT as clinical staff were re-deployed. As a result, waiting lists for specialty appointments have increased.

Moving outpatient activity into the community has reduced the size of the acute service at ECT, making it sub-scale.

The ECT endocrinology service has been closed to referrals as there is no consultant in place.

Quality & Outcomes

Trusts should have a dedicated multi-disciplinary diabetes inpatient team to help patients manage their condition and reduce risk. ECT is unable to meet this standard.

There is currently no inpatient diabetology service at ECT and no specialist review of hospital patients with diabetes.

Neither trust currently provides a seven-day service with at least one multi-disciplinary team member available for part of the day at weekends.

Workforce Resilience

The low volume of patients seen at ECT makes it difficult to attract, recruit and retain consultants.

There is currently no substantive senior medical staff at ECT and the trust's specialist nurse has resigned. Previous attempts to recruit to the small acute services have been unsuccessful.

The delivery model for diabetes care in eastern Cheshire is split across a range of providers, reducing training opportunities for junior doctors and so trainees have been withdrawn from ECT by the NHS Deanery, which is responsible for postgraduate medical training.

The Case for Change

- Around one in six hospital inpatients has diabetes and rates are growing.
- The ECT service model is sub scale with a single-handed consultant post that has proved impossible to recruit to, resulting in the service being closed to new referrals currently.
- Recruitment to specialist posts is challenging at both sites.
- Clinical standards for inpatient care are not being consistently achieved on either site.
- There is an opportunity at both sites to enhance the care of younger people with type 1 diabetes who currently have to travel out of area.

5.4 Endoscopy

Endoscopy is a procedure where organs inside the body are examined using an instrument called an endoscope - a long, thin, flexible tube that has a light and a camera at one end to show images on a screen. The main types of procedure are:

- ***Gastroscopy:*** used to look inside the oesophagus, stomach and first part of the small intestine;
- ***Colonoscopy:*** used to look at the rectum and colon;
- ***Flexible Sigmoidoscopy:*** used to look inside the lower part of the bowel and check for ulcers, polyps or other abnormalities.

The Endoscopy and Treatment Unit (ETU) at ECT was rated as 'good' by the CQC and has benefitted from recent investment in equipment.

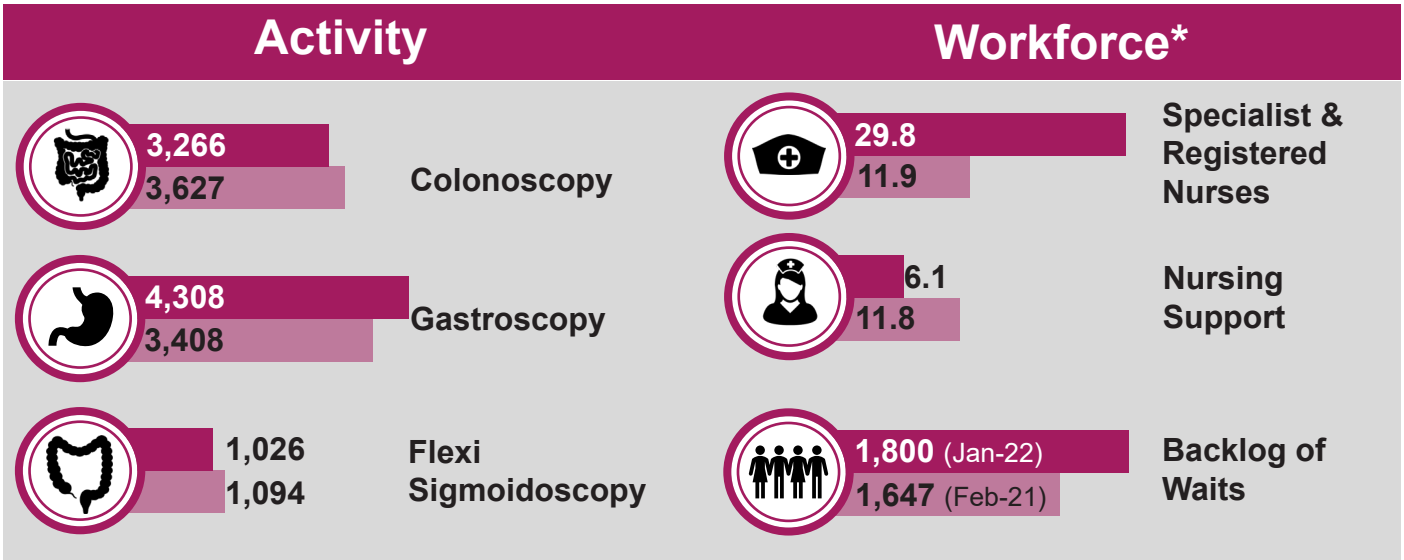
The ETU has three endoscopy rooms and five recovery trolleys, providing 30 sessions each week, however, there are six lists each week that cannot be staffed due to a lack of skilled endoscopists, especially in colonoscopy.

Specialist expertise is provided by The Christie for oncology; Manchester FT for hepatobiliary and advanced ERCP; and Salford Royal for cancer of the stomach and oesophagus. A weekly list of transnasal endoscopy is due to begin soon.

SFT's endoscopy department provides a range of diagnostic and therapeutic procedures, performed by medical staff from gastroenterology, general surgery, and nurse endoscopists.

The unit has three procedure rooms and a fourth in the main operating theatres for inpatient endoscopy. It has an eight-bed recovery area with one private cubicle.

A twice-daily inpatient list is provided for urgent upper GI bleeds or urgent inpatients.



Capacity & Demand

Demand for endoscopy services has grown due to expansion of the national bowel cancer screening programmes and ageing populations.

At the start of the COVID-19 pandemic, endoscopy activity reduced to only 5% of normal levels[32]. This has generated a significant backlog in the number of patients waiting for an endoscopy procedure.

ECT had a backlog of 1,647 patients waiting at the end of February 2021. 45% of these patients had been waiting for 13 weeks or more.

Additional capacity was procured at weekends. This has had a positive impact on waiting lists, but at significant additional cost.

Quality & Outcomes

Endoscopy standards are accredited by the Joint Advisory Group on Endoscopy (JAG).

SFT was assessed in June 2021 and expects to be accredited following the publication of the review in May 2022.

The ECT endoscopy service lost JAG accreditation in early 2020 as there is a mixed-sex recovery area whenever there is an emergency patient procedure in ETU.

Achievement of the national six-week access standard for diagnostics remains a significant challenge at both ECT and SFT.

Workforce Resilience

ECT has just two gastroenterology consultants plus one locum, which means most endoscopies are performed by general surgeons. The trust has two nurse endoscopists - both semi-retired - and has been unable to recruit more.

The current on-call rota for emergency GI bleeds at ECT out of hours is unsustainable. It is delivered by just 3 gastroenterologists, putting a strain on the workforce.

To meet future demand, both ECT and SFT teams would need to recruit three additional gastroenterology consultants. However, the ability to recruit skilled and competent endoscopists is a significant challenge.

The Case for Change

- Demand for endoscopy is increasing year on year due to the ageing population and extension of screening programmes.
- Nationally there is a lack of staff skilled in endoscopy.
- The services are unable to meet current demand and are heavily reliant on private sector capacity at additional cost.
- Emergency ERCP services are not currently provided on either site seven days a week.
- An increase in consultant workforce is required to meet future demand across both sites, but recruitment to gastroenterology posts is challenging.
- The ECT service is not compliant with all standards and neither trust is currently accredited by JAG.

5.5 Gastroenterology

Gastroenterology is the branch of medicine dedicated to disorders of the gastrointestinal tract (oesophagus, stomach, small and large bowel), the liver, pancreas, and gallbladder. Gastroenterology conditions are becoming more prevalent, partly due to lifestyle changes in the population, such as increases in obesity and harmful levels of drinking.

Gastroenterologists support patients with gastrointestinal (GI) symptoms in outpatient clinics, on hospital wards and in endoscopy – screening, diagnosing and treating GI conditions.
All specialists are trained in upper gastrointestinal (GI) endoscopy and most will be trained in lower GI endoscopy (flexible sigmoidoscopy and colonoscopy). Most gastroenterologists are dual accredited, meaning they can practice general medicine as well as their own specialty.

ECT takes a collaborative medical and surgical approach to the prevention, diagnosis and treatment of gastrointestinal diseases, including cancer and support for patients.

The service is led by three gastroenterology consultants, supported by a team of two staff grade doctors, four junior doctors, five specialist nurses, plus a highly skilled gastroenterology ward team.

Most gastroenterology procedures are delivered as day cases. ECT has a 28-bed gastroenterology inpatient ward.

SFT offers both inpatient and outpatient services for a range of upper and lower gastrointestinal disorders.

The service is led by a team of nine consultants, supported by a highly skilled, multi-professional team consisting of two Tier 2 and six Tier 1 doctors as well as two physician associates and ten specialist nurses.

SFT's gastroenterology consultants do not participate in the general medical on-call rota which enables them to provide dedicated time to the gastroenterology ward.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	*	477
Elective Admissions	5	102
Day Cases (incl. endoscopy & outpatient procedures)	3,876	3,433
Outpatient Appointments	10,662	9,246

Workforce**

	ECT	SFT
Consultants	8.8	3.0
Tier 2 Doctors	1.0	2.0
Tier 1 Doctors	5.0	4.0
Specialist & Registered Nurses	9.5	4.7

* Non-electives for Gastroenterology are admitted under General Medicine
** Whole-time equivalents

Capacity & Demand

Demand for gastroenterology is rising at an unprecedented rate, linked to lifestyle factors such as diet and alcohol consumption.

Although the pandemic caused a temporary reduction in referral rates into both services, demand is rapidly returning to pre-pandemic levels.

Gastroenterology beds often come under pressure from other medical specialities, limiting capacity and impacting on waiting times for patients. At the time of writing, only 49% of gastroenterology patients at ECT and 48.7% at SFT were treated within 18 weeks of referral, against a national standard of 92%.

Quality & Outcomes

Neither trust is compliant with national standards requiring consultant review within 14 hours of hospital admission and twice daily ward rounds. While SFT has more consultant input to the ward during the week, weekend cover is not routinely provided and patients are reviewed by the physician on call if clinically required.

ECT has not been awarded JAG accreditation and SFT is awaiting results of its review.

Workforce Resilience

Recruitment and retention of gastroenterologists is a concern nationally, with 45% of consultant gastroenterologist posts unfilled in a very competitive market.

Local gastroenterology services rely on staff working additional hours at an enhanced rate (in-sourcing) and out-sourcing to private sector providers.

Two of the three ECT consultants currently work a job plan that exceeds recommended levels, increasing the risk to their resilience and wellbeing.

ECT consultants are part of the 1:10 on call rota for general medicine medicine and a 1:3 on-call rota for GI bleeds. SFT's consultant gastroenterologists do not participate in the general medicine rota.

The Case for Change

- Demand for gastroenterology has increased significantly over recent years.
- SFT and ECT are both heavily reliant on expensive out-sourcing and in-sourcing at weekends to meet the demand.
- Outpatients are waiting too long for specialist assessment and treatment, and access standards are not being achieved.
- Clinical standards for 14h consultant review are not being achieved at either site.
- There is variation in how and when complex inpatients receive specialty review, with no specialty input to wards at the weekend at ECT.
- There are persistent difficulties in recruiting to consultant posts, which is impacting workforce resilience.

5.6 General Surgery

General Surgery is one of the largest specialties in the UK with many sub-specialties, such as breast surgery, colorectal, endocrine, gastrointestinal surgery, transplants, and vascular surgery.

General surgeons perform a wide range of procedures and require extensive of knowledge and skills to deal with surgical emergencies. As such, they are essential to supporting the Emergency Department.

Around 80% of planned general surgery in the UK relates to common conditions of the gall bladder and hernia repair. Acute abdominal pain is the most frequent symptom for emergency attendances requiring surgery.

The general surgery service at ECT is relatively small, with just five consultants, providing eight outpatient clinics each week. Four of the five consultants specialise in colorectal surgery and also undertake endoscopy procedures as part of their job plan. The service does not operate on children under eight years.

There are 34 surgical inpatient beds and a further 12 surgical day-case beds.

Outside of normal working hours, acute surgical problems are managed by experienced specialty doctors with consultant support available on site within 30 minutes as required.

SFT is the designated specialist hub for general surgery in the South East of GM. It has 11 consultants, including a general surgeon who undertakes robotic assisted surgery.

The trust has 16 main operating theatres and two maternity theatres. The hospital also has a standalone day case unit for minor procedures only requiring local anaesthetic. Emergency general surgery is provided 24/7.

SFT is in the top four trusts in the country for mortality rates.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	3,907	1,838
Elective Admissions	969	333
Day Case Procedures	1,217	693*
Outpatient Appointments	15,124	6,635

Workforce

	ECT	SFT
Consultants	11.0	5.0
Tier 2 Doctors	10.0	9.6
Tier 1 Doctors	7.0	10.2
Specialist & Registered Nurses	5.8	5.8

* ECT's day case figures do not include the 2,823 endoscopies undertaken in ETU – these numbers are covered in the Endoscopy review.

Capacity & Demand

Access to routine surgery has been significantly disrupted by the COVID-19 pandemic. SFT has a significant backlog of planned surgical procedures, with more patients waiting over 52 weeks than ever before.

Capacity at both sites is constrained due to beds not being ringfenced for elective surgery.

ECT has access to only one surgical ward for emergency inpatients, including gynaecology. When the surgical ward is full there is an impact on patient flow from the Emergency Department and patients have to wait longer for bed.

ECT's general surgery team has a key interdependency with critical care and it can be a challenge to admit higher risk patients.

Quality & Outcomes

Both trusts perform generally well against national recommendations. However, ECT is challenged in consistently achieving all standards due to lower volume activity and case mix.

Emergency surgery standards may be compromised at ECT due to limited access to critical care beds post operatively for higher risk patients.

Outcomes for bowel cancer surgery are satisfactory, but mortality rates at ECT may be impacted by access to critical care beds post operatively for higher risk patients.

As ECT has a relatively small number of patients, retention of surgical skills can be challenging for staff.

Workforce Resilience

ECT has five consultant general surgeons, but only four participate in the on-call rota. Lack of resilience in the consultant on call rota would compromise a seven-day emergency general surgery service over time.

SFT has had difficulties in recruiting colorectal cancer nurse specialists, which can affect targets.

During the pandemic, surgical wards became medical wards to meet demand and a number of surgically trained nurses have left the service.

The Case for Change

- The small number of consultants at ECT makes the service clinically unsustainable, particularly in relation to the on-call rota.
- SFT also requires additional workforce capacity to manage its consultant rota.
- Additional specialist nurse roles are required at both sites, but trained staff are not readily available.
- Demand for emergency surgery overnight is low at ECT, but theatres must be staffed in case needed - this is not the best use of the resources we have available.
- The sub scale critical care service at ECT is unable to consistently support the admission of higher risk patients following emergency and complex procedures.
- Children under eight are currently transferred out of area for general surgery.
- Both trusts have a growing backlog of patients waiting for elective surgery, with some patients waiting over two years for planned procedures.

5.7 Imaging

Radiology is the branch of medicine dedicated to the diagnosis and treatment of a wide range of clinical conditions using specialised imaging. Many clinical specialties are dependent on radiology services for the diagnosis, prognosis, treatment and monitoring of diseases.

Advanced imaging technology also allows for minimally invasive treatment options, such as radiotherapy treatments for cancer or angioplasty, where a balloon or stent is inserted to open a narrowed or blocked artery.

Imaging services at ECT are led by a team of 7.4 consultant radiologists, supported by four Tier 2 doctors and a team of highly skilled specialty staff and support workers, delivering around 105,000 scans a year.

The Radiology Department at SFT is almost double the size with 14 consultants, three Tier 2 doctors, 62 radiographers and a highly skilled team of Advanced Practitioners, Specialist Nurses, and Assistant Practitioners, delivering around 260,000 scans a year.

As a larger service, SFT offers more services, including DEXA scanning, Nuclear Medicine, Non-vascular Interventional radiology; and Dental radiography.

ECT provides the NHS breast screening services for the populations of Crewe, Cheshire East and Stockport.

Activity

	ECT	SFT
CT	14,059	55,786
DEXA	0	4,356
Fluoroscopy	956	6,085
MRI	7,059	16,819
Nuclear Medicine	0	2,041
Ultrasound (non-obstetrics)	24,106	34,428
Ultrasound (obstetrics)	8,343	14,646
X-Ray	50,100	125,681

Workforce*

	ECT	SFT
Consultants	7.4	14.2
Tier 2 Doctors	4.0	3.0
Radiographers	29.2	62.0
Sonographers	5.5	12.4
Specialist Nurses	0	2.3
Registered Nurses	0	2.6
Clinical Support Staff	10.1	14.1
Technicians	0.0	1.0

* Whole-Time Equivalents

Capacity & Demand

Demand for imaging services has grown significantly over recent years and is expected to continue to rise. Changes in pathways mean that patients require more scans, earlier in the pathway, and more complex scans that take more time.

SFT is a stroke centre and has a large orthopaedic department, which both create significant demands on radiology services.

The impact of COVID-19 has increased demand for follow up CT scanning.

It is not possible to meet current service demand within existing resources and both sites are heavily reliant on outsourcing clinical reporting to private sector providers.

Quality & Outcomes

Neither trust has the workforce capacity to meet Royal College standards on peer review of imaging reports.

Neither trust is currently able to provide 24/7 access to Interventional Radiology procedures in-house due to a lack of access to day case beds within the radiology department.

Both sites are currently achieving the NHS standard of 99% of patients receiving their diagnostic test within six weeks of a referral, and no patients wait more than 13 weeks for imaging. However, there is increasing pressure on the services as elective recovery continues, particularly in non-urgent imaging. Without further action performance is likely to deteriorate.

Workforce Resilience

Nationally there is a shortage of trained imaging professionals. This impacts both trusts, with a particular gap in the number of consultants and radiographers.

Both hospitals have significant levels of vacancies, and a growing proportion of consultants are already past the normal retirement age. Consultant gaps are covered by locums at SFT and outsourcing of reporting at ECT, however this is not financially sustainable.

Further challenges exist in recruiting and training dedicated radiology nurses, which impacts on the delivery of specialist procedures such as Interventional Radiology.

Retention of highly skilled staff is extremely challenging as staff are attracted to specialist diagnostic centres.

The Case for Change

- The imaging workforce at both sites is increasingly fragile. Recruitment is extremely challenging, and both hospitals have significant levels of vacancies.
- A growing proportion of existing posts are filled by consultants who are already past standard retirement age.
- It is not possible to meet current service demand within existing resources and both sites are heavily reliant on outsourcing clinical reporting to private sector providers.
- Demand continues to grow and if action is not taken waiting times will be impacted.
- Both sites lack the infrastructure and facilities to provide interventional radiology for patients.
- Local access to CT coronary angiography is constrained by the limited capacity available to develop the specialist skills required for imaging and reporting.

5.8 Trauma & Orthopaedics

Trauma and Orthopaedic (T&O) surgeons diagnose and treat a wide range of conditions relating to the musculoskeletal system. This includes bones, joints, ligaments, tendons, muscles and nerves.

SFT is a trauma unit, seeing serious trauma patients, while ECT is a designated local emergency hospital, which means that it does not routinely receive acute trauma patients. There are six major trauma centres the North West where the trusts can refer patients with severe life-threatening trauma.

Both trusts offer planned and emergency trauma and orthopaedic services and are rated as 'good' by the CQC.

The Macclesfield site has 38 inpatient orthopaedic beds, 13 elective beds and 25 emergency beds, with a further 12 surgical day case beds available to the specialty.

ECT is designated as a Local Emergency Hospital and does not routinely receive patients with life-threatening trauma. Acute trauma patients are triaged by ambulance and transferred to the nearest designated trauma unit (at SFT) or major trauma centre depending on the severity of their injuries.

ECT does not deliver spinal surgery; revision or replacement of previously fitted artificial joints; or surgery for bone tumours. Patients requiring spinal surgery are referred to SFT.

SFT is a designated Emergency Trauma Unit. It has 15 main operating theatres and two maternity theatres. It has 17 ring-fenced elective beds and two trauma wards comprising 48 beds. The service also has shared access to a surgical day case procedure ward with 22 trollies.

Stockport's T&O service also runs a community tier 2 orthopaedic assessment service, led by allied health professionals.

Activity

ECT	SFT	
1,869	1,124	Emergency Admissions (Non-Electives)
1,600	580	Elective Admissions
3,648	922	Day Case Procedures
44,220	21,429	Outpatient Appointments

Workforce*

ECT	SFT	
18.6	8.0	Consultants
2.0	7.0	Tier 2 Doctors
23.4	6.0	Tier 1 Doctors
0.0	2.5	Specialist & Registered Nurses

ECT SFT * Whole-Time Equivalents

Capacity & Demand

Prior to the COVID-19 pandemic, the ECT service delivered around 21,400 outpatient appointments and 2,600 hospital spells a year, while SFT managed 44,200 outpatient appointments and 7,100 hospital spells a year.

The pandemic saw a significant number of elective orthopaedic procedures suspended. Both ECT and SFT have a significant backlog of patients waiting for planned T&O procedures. It will take several years for the waiting time to be reduced to pre-pandemic levels.

Even before the pandemic, the lack of ring-fenced elective beds impacted on elective surgery capacity. Patients are experiencing prolonged periods of pain and discomfort while waiting for hip and knee surgery, with a consequent increase in recovery time.

Quality & Outcomes

T&O services across both hospitals have been rated as 'good' by the CQC.

Outcomes remain good, however waiting lists numbers are high and delays are common.

Neither trust has been able to recruit ortho-geriatricians who supervise the older patients recovering particularly from trauma. This condition carries a high 28 day postoperative mortality and morbidity, which is mitigated by ortho-geriatrician involvement.

The national average length of stay is approximately 17 days but is 2.5 days longer at SFT and 4 days longer at ECT.

Workforce Resilience

Orthopaedic services at ECT and SFT are relatively stable, and recruitment is less challenging than in other specialties.

Neither trust currently has problems recruiting consultants, however, both services have been challenged in recruiting an ortho geriatrician.

During the pandemic, a number of theatre staff left the organisations when many non-urgent surgeries were delayed. There is a risk around capacity to fill these roles as services return to pre-pandemic levels.

National guidance suggests that to maintain skills, surgeons should undertake at least 20 lower limb revision procedures per year. Due to low volume of patients, ECT clinicians are operating on around seven patients each year.

The Case for Change

- Demand for T&O services is growing as our population ages.
- The COVID-19 pandemic created a significant backlog of elective surgery in the specialty.
- Patient access standards are not being met and patients are experiencing prolonged periods of pain and discomfort while waiting for hip and knee surgery.
- A lack of ring-fenced beds for elective orthopaedics at both sites results in frequent cancellations - increasing waiting times.
- Ortho-geriatric input to optimise the clinical management of hip fracture patients is not being achieved, impacting on length of stay for T&O patients.
- New clinical requirements mean that knee revisions should be carried out at revision units or major revision centres.

5.9 Maternity & Gynaecology

Obstetricians provide medical and surgical care to pregnant women, while midwives provide midwifery care to all pregnant women, either in conjunction with an obstetrician or as the sole practitioner where no risk factors have been identified.

Gynaecologists provide medical and surgical care to women with diseases of the reproductive tract either before, during or after their reproductive years. Most doctors in the specialty practice both obstetrics and gynaecology, but some doctors sub-specialise as their careers progress.

Prior to the COVID-19 pandemic, ECT's maternity and gynaecology services were delivered from the Macclesfield site in a purpose-built antenatal unit, supporting the births of around 1,500 babies a year.

In March 2020, the ECT maternity inpatient service was temporarily suspended, due to critical care pressures associated with COVID-19. Women continue to receive antenatal support through the midwifery team on site and have the choice of giving birth at home or at neighbouring hospitals.

ECT provides inpatient and cancer gynaecology services, however patient numbers are very low.

Outpatient gynaecology clinics are hosted in a recently built women's outpatient facility.

SFT's maternity unit has a 28-bed inpatient ward and a delivery suite with 15 en-suite delivery rooms. Stockport Birth Centre is a midwifery led service for women with low-risk pregnancies, and has two birthing rooms with pools and eight postnatal beds.

SFT's antenatal clinic and ultrasound department are in the women's unit. Postnatal care is provided in the community.

The Gynaecology service provides inpatient, outpatient and cancer services as well as an Assessment unit, ambulatory gynaecology, and nurse-led early pregnancy and pregnancy loss support services.

The trust has a dedicated gynaecology ward with 10 inpatient beds and an assessment unit.

Activity

	ECT	SFT
Emergency Admissions (Non-Electives)	1,012	386
Outpatient Appointments	20,070	3,427
Births	3,118	1,510

Workforce*

	ECT	SFT
Consultants	10.3	8.0
Tier 2 Doctors	9.9	4.0
Tier 1 Doctors	9.0	4.0
Specialist & Registered Nurses	138.9	50.0

ECT SFT * Whole-Time Equivalents

Capacity & Demand

The maternity service at ECT is one of the smallest in the country and the number of births has decreased by 23% over the last decade.

National population predictions suggest a relatively static position over the next 10 to 20 years.

ECT has a capacity issue related to anaesthetist cover for the maternity ward.

In March 2020 ECT temporarily suspended all births at Macclesfield due to a lack of aesthetic cover related to the COVID-19 pandemic.

Both sites deliver the recommended ratio of midwifes to births.

Quality & Outcomes

ECT's maternity service was rated 'Good' by the CQC in 2019, while in 2020 SFT's service was rated as 'requires improvement'. Supported by the Maternity Safety and Support Programme, the service has improved on all areas of concern.

Due to its small size, ECT's maternity service did not meet the Royal College of Anaesthetists recommendations around workforce levels. SFT's service complies with these standards.

Neither trust is fully compliant with the Ockenden recommendations.

Neither site is achieving the seven-day clinical standard for consultant review within 14 hours of emergency admission in gynaecology.

Workforce Resilience

SFT has invested in recruiting additional obstetric consultant posts in response to the Ockenden Report.

ECT has struggled to recruit midwives since the transfer of hospital births to SFT. There are gaps in specialist midwife roles at ECT, such as bereavement and diabetes, which would require additional funding.

For births to return to the Macclesfield site, the trust needs a separate anaesthetic team for maternity. This would be a challenge in terms of the number of anaesthetists available nationally and available funding.

Workforce capacity for colposcopy at both ECT and SFT is challenging.

The Case for Change

- Neither site is achieving the seven-day clinical standard in gynaecology which requires consultant review within 14 hours of emergency admission.
- The gynaecology inpatient service at ECT is sub-scale.
- Neither service is currently meeting the maternity requirements set out in the Ockenden Reports, largely due to workforce challenges.
- ECT is particularly challenged in meeting the standards expected of a consultant delivered obstetric service as services are sub scale.
- The relatively low number of births in Cheshire East means that maintaining skills is more challenging for clinical, midwifery and neonatal staff.

5.10 Paediatrics & Neonatology

Paediatrics is the area of medicine that manages clinical conditions affecting infants, children and young people. Neonatology sub-specialises in looking after premature babies or those with problems at birth.

- Neonatal Intensive Care Units provide the whole range of neonatal care, including support for or the sickest and most premature babies.
- Local Neonatal Units provide care for babies born after 27 weeks of gestation or 28 for multiple births and babies weighing over 800g.
- Special Care Units provide local care for babies born at 32 weeks or more and over 1000g birthweight who require only special care or short-term high dependency.

ECT's paediatric service is delivered by a multi-disciplinary team, providing consultant-led outpatient and inpatient services, community paediatrics and a children's community nursing service. The paediatric service has been rated 'Good' by the CQC with high levels of patient and parent satisfaction.

Patients requiring paediatric intensive care or specialist services are stabilised and transferred using the Paediatric Transfer Service.

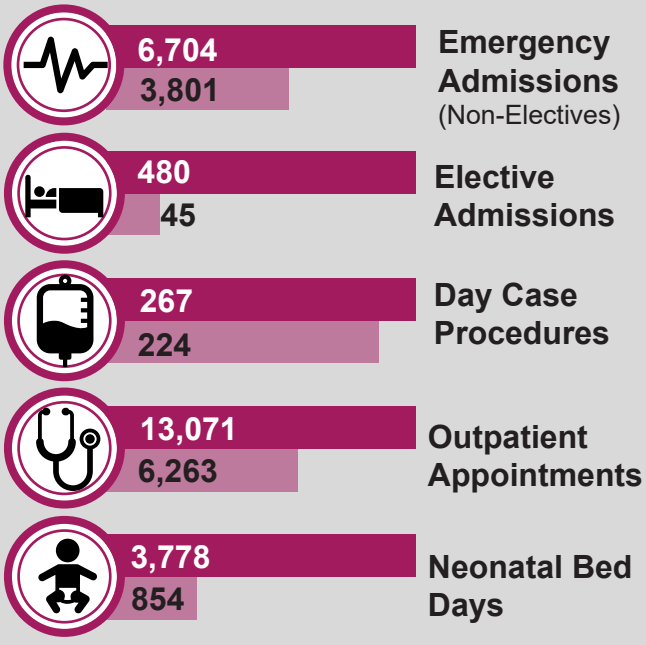
Currently there is no neonatal in-patient service at ECT as the consultant led maternity facility is

Facilities on the Stockport site include a purpose built children's unit with 20 medical inpatient beds, four surgical beds (three days per week), an eight-bed assessment and observation unit, and a two-bed high dependency unit. There is an outpatient unit with a day case investigation suite, integrated healthy young minds service alongside paediatric therapy services.

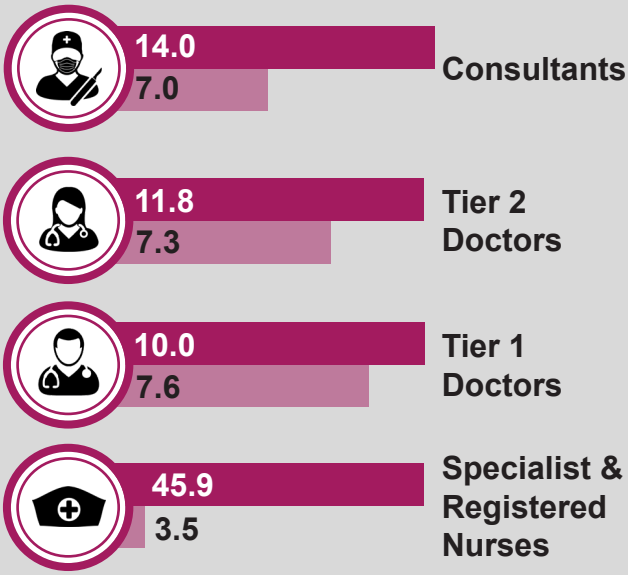
SFT offers integrated community and hospital services so that a child has only one paediatrician.

SFT runs a Local Neonatal Unit.

Activity



Workforce*



ECT SFT * Whole-Time Equivalents

Capacity & Demand

Population projections suggest a relatively stable population of children and young people – with a slight reduction of around 2% by 2038. But while growing demand is not a significant pressure in this specialty, there are some issues around workforce capacity to meet current demands at ECT.

Activity at ECT is too low to warrant the number of staff required to meet national standards seven days a week.

Future service developments to enhance primary and community care for unwell children will reduce the number of paediatric hospital admissions, exacerbating the challenges of a sub scale service.

Quality & Outcomes

Outcomes for both neonates and paediatrics are currently good, but there is a persistent risk to sustainability at ECT associated with the impact of subscale activity and potential for staff de-skilling.

National clinical standards are heavily weighted to the presence and availability of senior appropriately qualified professional staff. Neither ECT nor SFT is complaint with current standards.

Workforce Resilience

Both ECT and SFT's paediatric services deliver both hospital and community care. This provides a challenge, as the same consultants cover the community clinics and acute care.

SFT has 13 WTE consultants, ECT has seven. Both trusts require additional consultant posts to deliver a 7-day service. Recruitment to medical middle grade post has proven difficult at ECT.

A minimum of three additional consultants would be required at ECT to achieve the standard for all children to be seen by a consultant paediatrician within 14 hours of admission.

The low activity volumes at ECT makes it more challenging to maintain skills and competencies for neonatal nurses and medical staff who are not exposed to the same wide range of clinical presentations as a large unit.

The Case for Change

- The inpatient service at ECT is sub scale and unable to meet national standards seven days a week with existing workforce numbers.
- Future service developments to enhance primary and community care will reduce the number of paediatric hospital admissions, increasing the risk of staff becoming de-skilled.
- Neither site is fully compliant with the requirement for all children admitted with an acute medical problem to be seen by a consultant paediatrician within 14 hours of admission.
- In relation to neonatal care, neither site meets all national workforce standards.
- The interdependency of obstetrics and neonatal services is a key factor in considering the case for change as neonatal activity is also sub scale.

6. What people have said

Though our case for change concentrates mainly on the clinical aspects that drive the need to review our services, it is also influenced by views from local people about:

- their healthcare needs;
- their experiences of our current services – both as staff delivering those services and as the patients and their carers who use them; and
- what people would like to see from our services in the future.

Over recent years there has been an ongoing conversation with local people about their health needs and how we can best meet them.

We are humbled by the overwhelming support of local people for both ECT and SFT. Responses from engagement over recent years, patient satisfaction surveys, and patient choice of our services show that both trusts are key anchor institutions within our communities.

During the COVID-19 pandemic there was an outpouring of support for NHS services and a recognition of the dedication of our healthcare workforce.

A key theme of responses to our ongoing conversations has been the importance of having safe, high-quality services and people understand that this will require a change to the way services have traditionally been delivered:

Local people recognise the challenges we face in growing demand for services and the shortage of staff to deliver every service at every site seven days a week

People want to see more care delivered close to home with a greater emphasis on preventing ill health and proactively managing conditions so that our population is less reliant on hospital care.

There are real challenges for people in rural areas accessing health services, and those with limited access to transportation.

When people are seriously ill, they want quick access to tests and diagnosis close to home. Many people said they would be happy to travel further for expert treatment by specialists.

As the country begins to recover from the COVID-19 pandemic, we are beginning to hear more worries about the amount of time it takes for routine care and the impact this has on people's lives.

People highlighted the importance of having local and emergency services. They also acknowledged the success of specialist hub-and-spoke models, where patients are triaged and / or stabilised at their local hospital and transferred to a dedicated unit for highly specialist care.

6.1 Listening Exercise

The engagement over recent years has been strategic in nature – ongoing conversations, which have varied across the areas served by the two trusts.

Between Monday 21st February and Saturday 2nd April 2022, NHS Cheshire and NHS Stockport Clinical Commissioning Groups, alongside ECT and SFT undertook a listening exercise to understand how health and care services could be improved and sustained in the future.

Together, we launched a period of stakeholder engagement with our patients, staff and other interested people in the areas we serve to ensure they are at the heart of the work we do and to hear their views on what currently works well, what could be improved, and whether there are any barriers that stop people from accessing health services.

Around 250 responses were received across the catchment area of circa 500,000 people. This response rate is slightly lower than would be expected for an exercise such as this (expected approx. 350).

The engagement survey was distributed via social media, a dedicated website, paper copies sent to children's centres and libraries via each partner organisation. The survey reached all staff and stakeholders including GP surgeries via digital methods and where requested, paper copies. Seldom heard groups were also reached using established patient experience routes and contacts via stakeholder groups. The engagement exercise reach and methods of communication were considered proportional to the size and nature of the exercise.

All but one response was received from individuals (one collective organisational) response. The geographical spread of the responses is generally representative of the catchment area of the CCGs and trusts in terms of numbers, ethnic groups and respondents' ages. Some 35% of responses were from NHS staff, 35% from patients, 15% from the public and the remaining responses from carers and others.Around 78 percent of responses were aligned to East Cheshire NHS Trust with a lower response rate from the Stockport area and other NHS organisations.

The majority of comments related to Women's and Children's services (50%), with Urgent and Emergency Care at 30%, closely followed by community (26%) and Imaging (18%). The main themes emerging from the open-ended questions were that: Services are generally good; staff are generally good but low in numbers; waiting times are poor and communication could be improved. There were comments around women's and children's services, with concerns raised over travel and the need to bring these back to Macclesfield. A general level of concern was expressed about the need for ED services to remain at both hospital sites. Waiting times were raised as an issue in both ED and for other areas of care, and parking and public transport were common themes throughout feedback.

This is the start of a much broader conversation. We will continue to involve and engage our communities, staff and partners in designing services and models of care that best meet local needs and aspirations.

7. What could this mean for me?

While the services delivered at ECT and SFT are currently safe and of good quality, they do not always meet the national clinical standards of best practice that we aspire to deliver for local people.

To deliver these aspirational targets, it has become clear that a service and its workforce need to be of a certain scale.

Larger services tend to be more resilient and more successful at recruitment and retention of staff who generally want to be part of high performing teams with good peer support, to develop sub-speciality interests, and to participate in teaching, training and research.

Clinical collaboration increases the scale of a service, which increases the number of staff and the case mix. This offers potential benefits of improved resilience and capacity to address growing demand.

The impact of any changes on local people will depend on the type of change undertaken. The table below shows the wide range of service models trusts can use when collaborating – ranging from minor changes to teams to full integration of services.

We know that if we do nothing our services will struggle to meet growing demand and deliver the same level of quality. This would have a negative impact on local people, with longer waits for hospital care and a risk of lower standards.

Working together could potentially change the how or where staff work. It also offers greater opportunities for career progression, specialisation, training, and participation in research.

For patients, collaboration offers the potential of improved outcomes, better consultant cover, and shorter waiting times. It may mean that some services are only delivered at one of the two trusts, to ensure there are enough staff to provide safe services 7 days a week, so some patients may have to travel further for more specialist care.

Spectrum of Single Service Models			
Shared pathways / standards across each specialty	**Shared staff and assets across a specialty**	**Differentiated sites / hub and spoke for each specialty**	**Single site for each specialty**
• Standardised care pathways and protocols across all teams who provide that service • Each team must adhere to minimum staffing requirements • Shared clinical data • Shared audit processes	• One clinical team shared between sites (joint rota) • Shared assets, e.g., theatres, cath labs, outpatient suites	• Coordinated services across multiple sites with some sites providing care for high complexity / risk cases and other sites providing care for lower risk patients • Common protocols and rapid transfer arrangements between sites	• All resources for a single specialty pooled on a single site

7.1 Impacts of Change

We recognise that change could have a different impact on people. Collaborative working across hospitals poses the risk of reducing access to services for people with mobility issues or limited access to transportation.

The overarching aim of this work is to improve outcomes for local people and to reduce the inequalities in health outcomes that exist within our populations.

Should this case for change be approved, the next step would be to develop options for how things could be improved.

As such, we will undertake equality impact assessments of all options, ensuing that there is no unintentional negative impact on protected groups and taking every opportunity, where possible, to improve outcomes from those who currently suffer health inequalities. To do this, we will work with local groups to ensure that all impacts and opportunities are considered.

8. Next Steps

Providers of NHS clinical services have an obligation to deliver sustainable, safe and effective care. Services should:

- ensure equity of access to the service to all of the population
- avoid variation in clinical standards and outcomes
- meet the expectations of patients, families and carers.
- be part of a fully integrated health and social care system.

Our clinical reviews set out a number of areas where our current services fall short of our aspirations for local people.

The case for change is the start of the conversation about how we deliver high quality hospital care for our population, long into the future.

The next stage will be to develop options for meeting these challenges, which will be co-produced and assessed with our clinicians and the populations we serve.

The co-designed options will be assured by NHS England and discussed with local people, including consultation where appropriate.

Below is a timeline of our plan for developing and assessing these options.

Key areas to consider in any future model are:

Quality

- Does the new model maintain or improve clinical quality, outcomes and experience?

Access

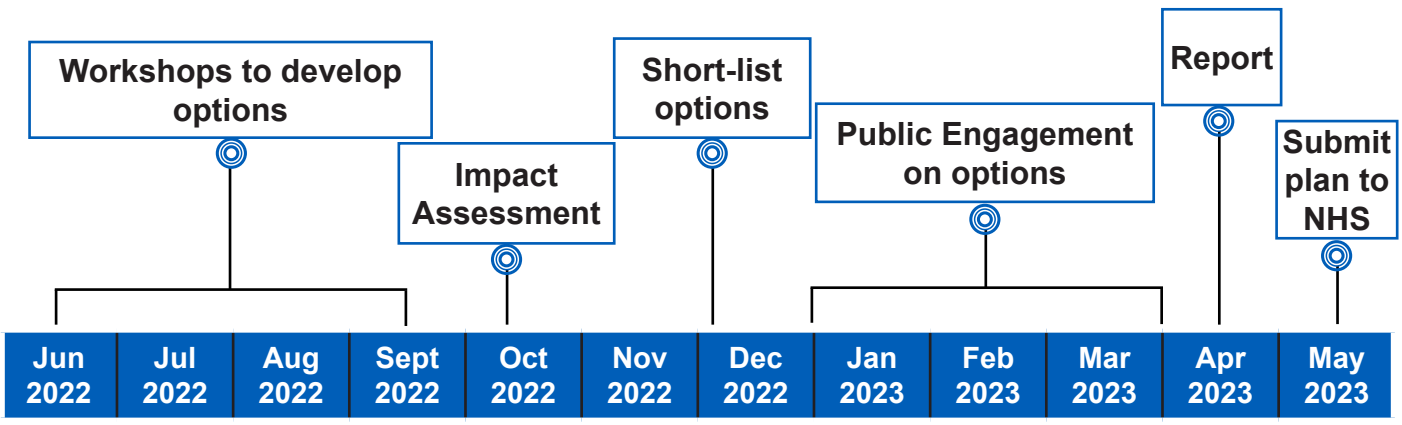
- Does the model support sustainable delivery of growing demand?
- Will the model maintain or improve equality of access and support care closer to home wherever possible?

Sustainability

- Does the model improve recruitment and retention of staff?
- Does it support a consistent seven-day service whenever appropriate?
- Is the model financially viable?

Deliverability

- Is the model supported by local people and clinicians?
- Is the transition to the new model achievable and does it support the development of place-based health and care services within the integrated care systems?



8.1 Assurance Process

NHS England has an assurance process for managing complex programmes of service change[1] to ensure that proposals meet the government's four tests of service change and NHS England's test for proposed bed closures.

Four Tests of Service Change

1. Strong public and patient engagement.
2. Consistency with current and prospective need for patient choice.
3. Clear, clinical evidence base.
4. Support for proposals from clinical commissioners.

In 2017, NHS England introduced a new test for any proposal including plans to significantly reduce hospital bed numbers. This requires systems to provide assurance that their proposals meet at least one of three conditions.

The NHS Bed Test

1. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it
2. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat stroke, will reduce specific categories of admission
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example, the Getting It Right First Time programme)

NHSE will put together an assurance panel to consider whether proposals meet the tests above, are deliverable, affordable and value for money.

[1]: Planning, assuring and delivering service change for patients (2018) NHS

8.2 How You can Get Involved

The case for change is the start of the conversation about how we deliver high quality hospital care for our population, long into the future.

The next stage will be to develop options for meeting these challenges, which will be co-produced and assessed with our clinicians and the populations we serve.

Our approach will be open-minded, and all options will be considered. We will involve a range of stakeholders including the clinicians and staff who deliver our services, patients and carers who access our care, other health providers who refer into our services and system partners such as local authorities and the voluntary sector who support the wider health economy.

Our focus will be on the benefits that can be delivered for patients by providing high quality, integrated care at the right time and in the best place to meet local needs.

More information can be found on the trusts' websites:

- **www.eastcheshire.nhs.uk**
- **www.stockport.nhs.uk**

Or on the engagement site at:

- **https://localvoices.uk**

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