

# Case for CHANGE

**EAST CHESHIRE NHS TRUST &  
STOCKPORT NHS FOUNDATION TRUST**



**sustainable hospital services  
for the people of  
eastern Cheshire and Stockport**

## Our Case for Change

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|--|--|---------------|---|
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# Contents

|                   |  |      |
|-------------------|--|------|
|                   | <b>Foreword</b> .....  | P4   |
| 1.                | <b>Executive Summary</b> .....   | P7   |
| 2.                | <b>Introduction &amp; Background</b> .....   | P13  |
| 3.                | <b>Our Ambition</b> .....  | P35  |
| 4.                | <b>Scope</b> .....   | P37  |
| 5.                | <b>Clinical Service Reviews</b> .....  | P41  |
| 5.1               | • Anaesthesia & Critical Care .....  | P43  |
| 5.2               | • Cardiology .....   | P49  |
| 5.3               | • Diabetes & Endocrinology .....   | P56  |
| 5.4               | • Endoscopy .....  | P62  |
| 5.5               | • Gastroenterology.....  | P66  |
| 5.6               | • General Surgery .....  | P73  |
| 5.7               | • Imaging .....  | P79  |
| 5.8               | • Trauma & Orthopaedics .....  | P86  |
| 5.9               | • Women & Children: .....  | P92  |
| 5.9.1             | • Maternity & Gynaecology .....  | P93  |
| 5.9.2             | • Paediatrics & Neonatology .....  | P99  |
| 5.10              | • Clinical Interdependencies .....   | P107 |
| 6.                | <b>People &amp; Culture</b> .....  | P111 |
| 7.                | <b>Financial Context</b> .....   | P120 |
| 8.                | <b>Communications &amp; Engagement</b> .....   | P124 |
| 9.                | <b>Equality Impact</b> .....   | P129 |
| 10                | <b>Summary &amp; Recommendations</b> .....   | P133 |
| <b>Appendices</b> |  |      |
| 1.                | <b>Glossary of Abbreviations</b> .....   | P149 |
| 2.                | <b>Reference Materials</b> .....   | P154 |
| 3.                | <b>Record of Clinical Engagement</b> .....   | P157 |
| 4.                | <b>Report on Listening Exercise</b> .....  | P173 |
| 5.                | <b>Recommended on-site services for hospitals with an<br/>Emergency Department</b> ..... | P178 |

# Foreword

***Our ambition is to work together to deliver services which achieve the best possible outcomes for patients.***

***We will do this by collaborating wholeheartedly across the two organisations, and with our partners in primary care, local authorities, other providers and local people.***

***We will play a central role in our integrated care systems, creating new, sustainable models of care that consistently deliver high quality clinical standards for the populations we serve.***

The NHS has experienced unprecedented clinical and operational pressures in recent years. 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 shone a greater light on the inequalities faced by some of our communities, with poorer access and outcomes experienced.

As such, we know that there are huge challenges for us to address over the coming decade.

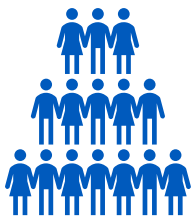
The publication of the national policy document, 'Integrating Care: Next steps to building strong and effective integrated care systems across England' in January 2021, signalled the end of competition as the major driver for quality improvement in healthcare, encouraged all NHS providers to enter collaborative relationships to deliver safe, equitable and effective care that is sustainable into the future.

The Boards of East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (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 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.

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.

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:



## 1. Changing Local Needs:

Our population is growing and people are living longer, with more complex and long-term health care needs. We know that among our population some people have worse health outcomes and have a reduced life expectancy. 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 know that it will not meet the changing needs of our population.



## 2. Workforce:

Across the two hospitals, we simply do not have the workforce we need to deliver all services at both sites. Our critical care and anaesthetic workforce is extremely stretched - a symptom of increased demand during the pandemic as well as the long-standing challenges of recruitment and retention in key specialties that are being experienced right across the NHS. While our clinical teams are highly skilled, they are unable to consistently meet necessary national clinical standards within existing resources.



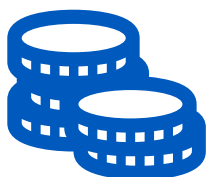
## 3. Fragile Services:

A number of clinical specialties are sub-scale for 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 deliver that level of quality and maintain clinical standards into the future.



## 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. The current configuration of beds does not separate emergency and planned care pathways, so routine procedures are often cancelled because of emergency bed pressures, increasing waiting times. In short, too many patients are waiting too long for care. 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 a sustainable healthcare model, we must use the combined resources of our integrated health and social care systems effectively to target services where they are most needed. We are not currently doing this well enough, with duplication of services across the system. Working collaboratively across a wider population base would allow us to share resources, including workforce, equipment and estate, to provide the services people need.

The combination of these factors means that we will not always be able to deliver the high-quality services and experience we aspire to for our population.

These issues must be addressed – and so it is time to make a 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.

The focus is on how, by working together, we can sustainably provide safe and effective hospital services for the people of eastern Cheshire and Stockport, as well as the additional populations who access acute hospital services provided by ECT and SFT.

This case for change rightly focuses on the problem of clinical sustainability and recovery of planned care services across our system to help us deliver our overall ambition. 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. 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.



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# 1. Executive Summary

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.

Across the country people are looking at new ways of delivering services to adapt to changing needs. Guided by the NHS's Long-Term Plan, Integrated Care Systems are bringing together health and care partners to build joined-up systems of care.

Our case for change focuses on ten acute clinical services across East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (SFT). It describes the current situation and sets out why change is necessary.

As a clinical case for change, this document has been shaped by our clinicians, providing their knowledge and expertise to develop a picture of what could be improved and how we can make our services sustainable.

For each of the clinical areas, it identifies the reasons why change is needed, in terms of:

- **Capacity & Demand**  
the ability of services across the two hospital sites to meet growing demands for care for a growing and ageing population within existing budgets, estates, workforce and facilities;
- **Quality & Outcomes**  
highlighting performance and the ability to deliver clinical standards within existing resources across both sites;
- **Workforce Resilience**  
considering the significant pressure our workforce is under on a daily basis, with challenges of recruitment to key roles; over-reliance on locum and agency staff to fill the workforce gaps; capacity to train the workforce of the future while delivering care; and the difficulties of maintaining skills where clinicians see a limited number of cases.

The case for change highlights a number of clinical opportunities presented by the NHS's plans for provider collaboration to share resources, improve quality, meet growing demand and train more staff by working as part of a wider clinical team in the specialties of:

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

## 1.1 Our Population

East Cheshire NHS Trust and Stockport NHS Foundation Trust serve a combined population of over three-quarters of a million people.

As close neighbours, there are many similarities between the local populations of eastern Cheshire and Stockport. Both areas have a growing population, with above-average life expectancy and increasing rates of long-term health conditions.

The Boards of ECT and SFT consider themselves natural partners for collaboration between hospital services, given the geographical proximity, the range of services provided and patient choice of our services. Our main hospital sites are just half an hour's drive (11.9 miles) apart and see patients from both catchment areas. While ECT is in Cheshire & Merseyside ICS, patients in the north of the area are more likely to travel the shorter distance to SFT than to Mid Cheshire Hospitals NHS Foundation Trust in the same ICS.

We firmly believe that patients should be at the core of our plans and take precedence over organisational structures and boundaries.

## 1.2 Our Trusts

East Cheshire NHS Trust is one of the smallest trusts in England, providing hospital and community healthcare services in eastern Cheshire. The trust employs around 2,270 people and has a budget of £176 million to support a quarter of a million patients each year. With around 350 inpatient beds, ECT delivers the full range of hospital care. However, a number of core services are considered to be 'sub scale' – or too small for an effective hospital service - raising significant concerns for their sustainability.

Stockport NHS Foundation Trust is a medium sized trust with around 700 inpatient beds serving the populations of Stockport, High Peak and eastern Cheshire.

The trust employs around 5,500 people and has a budget of £340 million to support over half a million patients each year. In general, core services are larger in scale, however the hospital has a high number of patients waiting a long time for care and it has limited potential to expand services due to its estate.

The Health and Care Act (2022) and the NHS Long-Term Plan highlight the need for healthcare providers to work together at scale to deliver care in the right place at the right time.

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.

## 1.3 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.



While this case for change articulates the issues surrounding sustainability of acute hospital services, we recognise that they are just one element of the wider health and care system. We will work collaboratively as part of that system – at Place level within Cheshire East and Stockport and at system level with Cheshire & Merseyside and Greater Manchester ICSs – to keep people well, to prevent ill health, deliver local support to manage conditions as close to home as possible, and ensure that efficient hospital services are there when needed.

## 1.4 The Clinical Case for Change

The primary aim of a clinical collaboration must be to deliver benefits for patients – that is, better outcomes and experience, consistently and sustainably.

Our clinical review has identified the following challenges which must be addressed.



### Anaesthesia & Critical Care

The focal point for the case for change in anaesthesia & critical care centres on the fragility and resilience of the anaesthetic workforce.

The small size of ECT's Intensive Care Unit makes it difficult to recruit new anaesthetists in a fiercely competitive market and existing staff have limited time to train and develop junior members of the team. As a result, the department is unable to comply with required national workforce standards within available resources.

Clinical outcomes for patients are currently good, but there is a persistent risk to sustainability associated with subscale activity and a potential for de-skilling among staff.

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



### Cardiology

Demand for cardiology services is high and waiting times are growing. Demand for diagnostic investigations such as echocardiography is also rising.

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

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

ECT has a small consultant workforce of 2.8 WTE which - based on national population recommendations - should be increased to five. Most of the consultants also have clinical sessions at either Manchester Royal Infirmary or Wythenshawe Hospital.

As it stands there is little possibility of a locally provided 24/7 cardiology rota.

Neither trust alone is in a position to deliver CT coronary angiography (CTCA) for the diagnosis of stable chest pain, as recommended by NICE guidance.



### Diabetes & Endocrinology

Around one in six of all people admitted to hospital will have diabetes. Evidence shows there are worse outcomes after surgery and in patients who present with a variety of acute medical conditions if their diabetes is not well controlled.

At ECT there is currently no specialist inpatient diabetology service and no specialist consultant review of hospital patients with diabetes.

The ECT endocrinology outpatient service has now been closed to referrals as there is no consultant in place and the trust's specialist nurse has resigned.

Previous attempts to recruit to the small acute services have been unsuccessful.



### Endoscopy

Demand for endoscopy is increasing year on year due to the ageing population and extension of screening programmes and this growth is expected to continue.

The services are unable to meet current service demand within existing resources and are heavily reliant on private sector capacity at additional cost.

An increase in the 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 is not currently accredited by the Joint Advisory Group on Gastro-Intestinal Endoscopy (JAG). SFT expects results of its JAG accreditation review in May 2022.



### Gastroenterology

Gastroenterology is a major receiver of acute medical admissions and has high demand for outpatient activity.

The main challenge relates to capacity. In addition to the growing demand for endoscopy, there has been a progressive increase in the number of patients admitted with acute or chronic liver disease.

Nationwide, there is a shortage of gastroenterology staff at all levels. This means it is unlikely trusts will be able to recruit to meet the increasing demand.

ECT has not been awarded JAG accreditation and SFT expects results of its JAG accreditation review in May 2022.



### General Surgery

The small number of general surgery consultants at ECT makes the service clinically unsustainable, particularly in relation to the on-call rota.

Additional specialist nurse roles are required at both sites, but these roles are not readily available in an increasingly challenged nursing workforce market.

Specialist support services, such as interventional radiology and Endoscopic Retrograde Cholangiopancreatography (ERCP), are not consistently available, requiring patients to be transferred.

The current allocation of beds for surgery does not effectively meet the needs of the service. However, the current estate is not sufficient for more capacity.

Both trusts have a growing backlog of patients waiting for elective surgery as a result of temporary suspensions during the pandemic, with some patients waiting over two years for planned procedures.



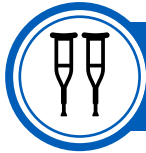
### Imaging

The case for change in imaging is based on the overwhelming increase in demand for radiological imaging and intervention, coupled with the national and local shortage of radiologists.

Recruitment is extremely challenging. Both hospitals have significant levels of vacancies, and a growing proportion of existing posts are filled by consultants who are already working past the standard retirement age.

New consultants are increasingly attracted to larger specialist centres with opportunities to sub-specialise.

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.



## Trauma & Orthopaedics

The case for change in the trauma and orthopaedics relates to the overwhelming impact of the COVID-19 pandemic on the specialty.

If we do nothing, it is predicted that waiting lists at both sites will continue to increase, as a lack of ring-fenced beds for elective orthopaedics at both sites means that cancellations are inevitable when hospital capacity is stretched.

Given the significant number of local people who have already waited over a year for elective T&O surgery, the implications of the status quo are unacceptable for our patients.

Too many patients are already experiencing long waits for surgery because there is no ring-fenced bed capacity for elective orthopaedics.

Patients are experiencing prolonged periods of pain and discomfort whilst waiting for hip and knee surgery, which is adversely impacting experience of local services.



## Women & Children: - Maternity & Gynaecology

Without significant investment in workforce, neither service will be able to meet the requirements set out in the Ockenden Reports.

Even with investment, the workforce is not readily available to recruit into these roles.

ECT also has persistent challenges in recruiting anaesthetic staff, who provide an essential clinical role in obstetric care.

The low number of births in eastern Cheshire means that maintaining skills is more challenging for clinical, midwifery and neonatal staff. This impacts on workforce flexibility and resilience at ECT.



## Women & Children: - Paediatrics & Neonatology

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

The inpatient service at ECT is unable to meet national standards 7 days per week with existing workforce numbers.

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 and investment in consultant workforce would be required at both sites to achieve this.

In relation to neonatal care, neither site meets all national workforce standards, and the interdependency of obstetrics and neonatal services is a key factor in considering the case for change as neonatal activity at ECT is sub scale.

### 1.5 Rationale for Collaboration

The primary aim of a clinical collaboration must be to deliver benefits for patients – that is, better outcomes and experience, consistently and sustainably.

The present and medium-term outlook for clinical services in the NHS is one of increasingly stringent clinical standards and growing demand against a backdrop of workforce shortages in a number of key professional groups.

Larger services tend to be more resilient and are more successful at recruitment and retention of staff. The desire to be part of a high performing team with good peer support is an important factor to newly qualified staff, as is the potential to consolidate or develop sub speciality interests. Participation in teaching and training and in research, development and innovation are also attractive.

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.

### 1.6 Recommendations & 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.

While the services currently delivered at East Cheshire NHS Trust and Stockport NHS Foundation Trust are safe and of good quality, we recognise that it is taking longer to access care and that the current model is not sustainable in light of growing demand and the backlog created by the COVID-19 pandemic.

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.

Collaboration across hospital trusts offers a range of opportunities to meet the challenges of growing demand, limited workforce, estates and funding to consistently deliver the clinical standards we want for our patients.

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.

Key areas to consider in any future model are:



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



- 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?



- Does the model improve recruitment and retention of staff?
- Does it support a consistent 7-day service whenever appropriate?

- Is the model financially viable?



- 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?

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

## 2. Introduction & Background



### East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (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.

Our work spans two health and care systems. Partners across both systems have been involved in the development of this case for change and fully support our proposed programme of work.

Our collaboration focuses on ten acute clinical specialties. We have highlighted many areas of best practice where clinical outcomes are consistently good and we can build on these for the future. However, there are also some persistent issues and challenges which demonstrate that the current configuration of services across the two trusts is not working as effectively as it should for our local populations.

These are set out in this case for change.

As a clinical case for change, this document has been shaped by our clinicians, providing their knowledge and expertise to develop a picture of what we believe is needed to deliver improved outcomes and sustainable services. Ongoing dialogue with patients and the public across both areas have been used to inform the case for change, with specific engagement used to understand current views on our services and local needs.

The Boards of ECT and SFT consider themselves natural partners for collaboration between hospital services, given the geographical proximity and the range of services provided. Our main hospital sites are just 11.9 miles apart and see patients from both catchment areas.

We are clear that patient choice should be at the heart of what we do and take precedence over organisational boundaries.

However, both hospitals acknowledge the importance of continued collaboration with other strategic partnerships across the footprints of the two Integrated Care Systems (ICS).

- ECT has a strategic partnership with Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) to enable the implementation of a shared digital clinical system across both trusts.
- SFT has established a strategic partnership with Tameside & Glossop Integrated Care NHS Foundation Trust (TGIC) and the two trusts will continue to collaborate on that agreed joint work programme.

ECT and SFT will continue to work closely with their Place-based partners in primary care and social care to deliver agreed community transformation programmes.

ECT and SFT have a long and successful track record of working together and our ambition was set out in our published Statement of Intent in December 2021, which signalled our commitment to further develop our strategic collaboration with the aims of:

- delivering better outcomes for patients
- offering staff greater flexibility to develop their skills and experience, and improving recruitment and retention of staff
- ensuring high-quality and sustainable services for the communities ECT and SFT serve; and
- making the best use of available resources.

# 2.1 National Context

**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 (3.2% growth)

**8.6m** **People are living longer**  
 There are 12.4 million people aged 65+ and in 50 years' time there are likely to be an additional 8.6 million

**65%** **Balance of care**  
 65% of people admitted to hospital are 65 or over

**15m** **More long-term conditions**  
 Around 15 million 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

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<sup>[1]</sup>.

During the height of the pandemic the NHS received additional funding to help cope with the pressures, but this is unlikely to continue. Pre-pandemic 67% of hospitals reported a deficit position and overall NHS trusts finished 2018/19 with a deficit of £571m. As no significant funding increases are anticipated, it is clear that large-scale transformation is required to ensure the future sustainability of NHS services.

Over the past two years, the COVID-19 pandemic has demonstrated the importance of different parts of the health and care system working together in the best interests of the public and patients.

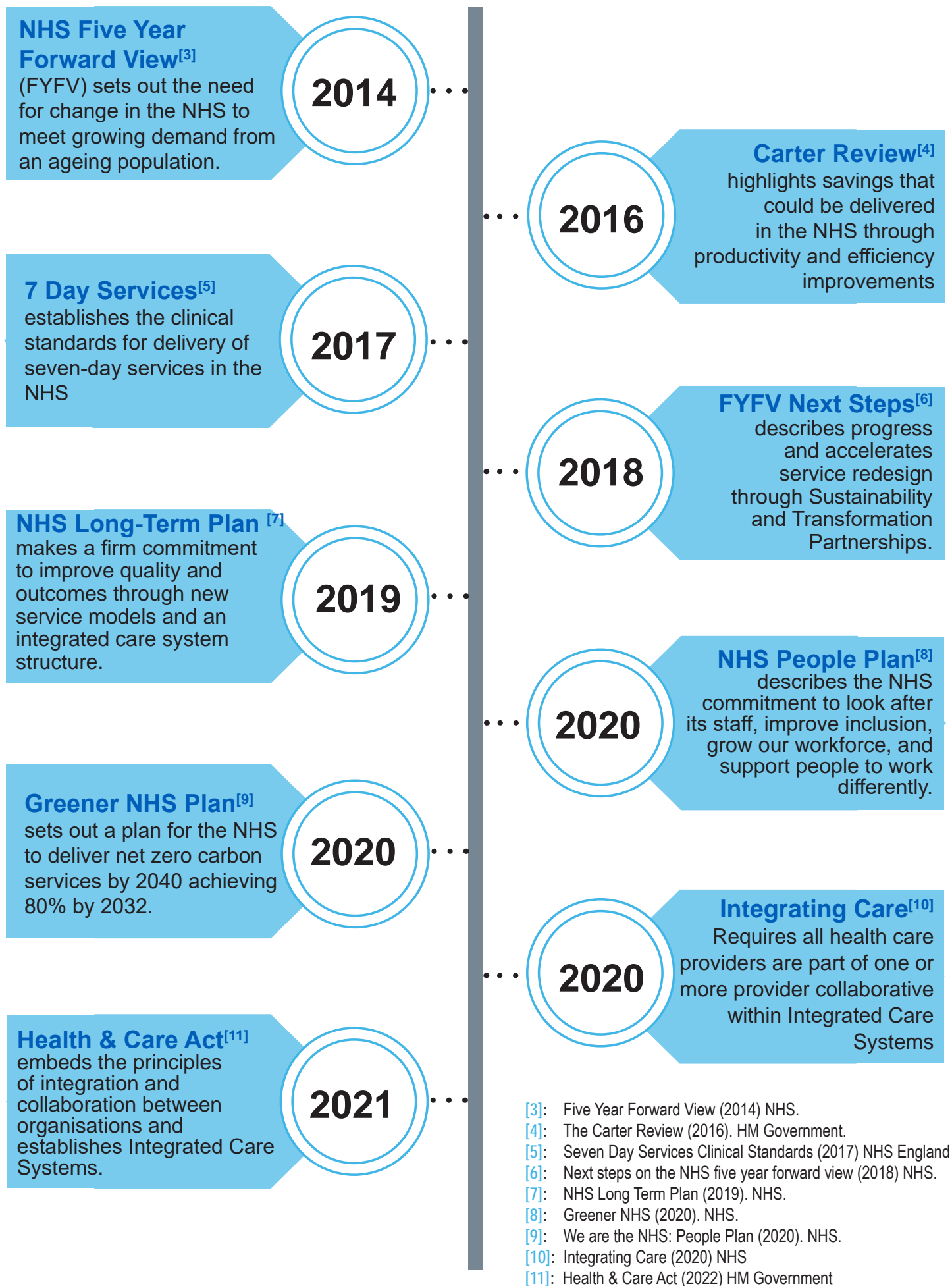
The Health and Care Act passed by parliament in 2022<sup>[2]</sup> implements NHS England's recommendations to support integration through the development of statutory Integrated Care Systems across England from July 2022 .

The Health and Care Act builds on the commitments made in the NHS Long-Term Plan (2019), which describes a long-term vision for a new, integrated model of health and care. It aims to improve the health and well-being of the population through prevention, early intervention and personalised care delivered as close to home as possible.

The Long-Term Plan aims to reduce health inequalities and ensure that wherever you live you have access to the same quality of service. It highlights the need to work together to deliver care in the right place at the right time.

[1]: Closing the gap (2019). The Health Foundation, Nuffield Trust, and The King's Fund.

[2]: Health & Care Act (2022) HM Government





# 2.2 Regional Context

The North West region has three Integrated Care Systems (ICS) and our hospitals work across two of those ICSs:

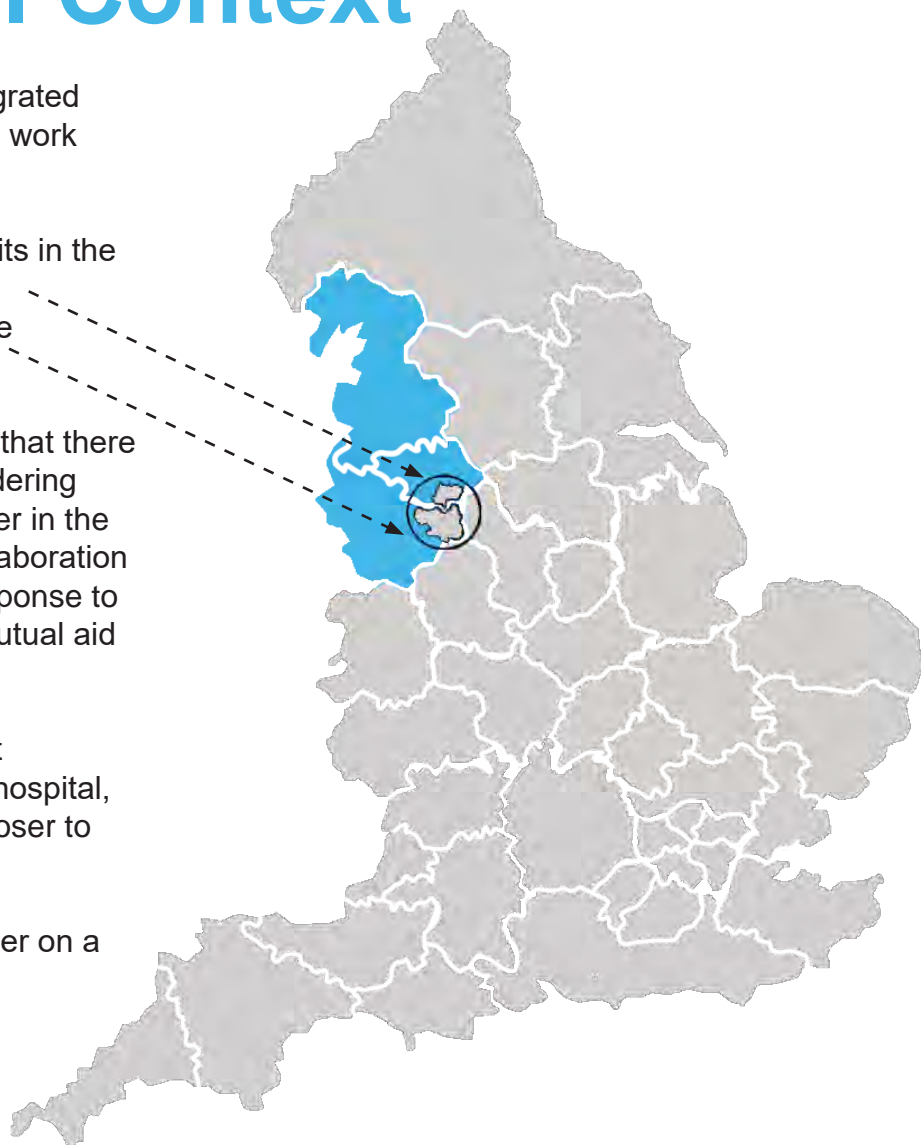
- Stockport NHS Foundation Trust sits in the Greater Manchester ICS.
- East Cheshire NHS Trust sits in the Cheshire & Merseyside ICS.

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.

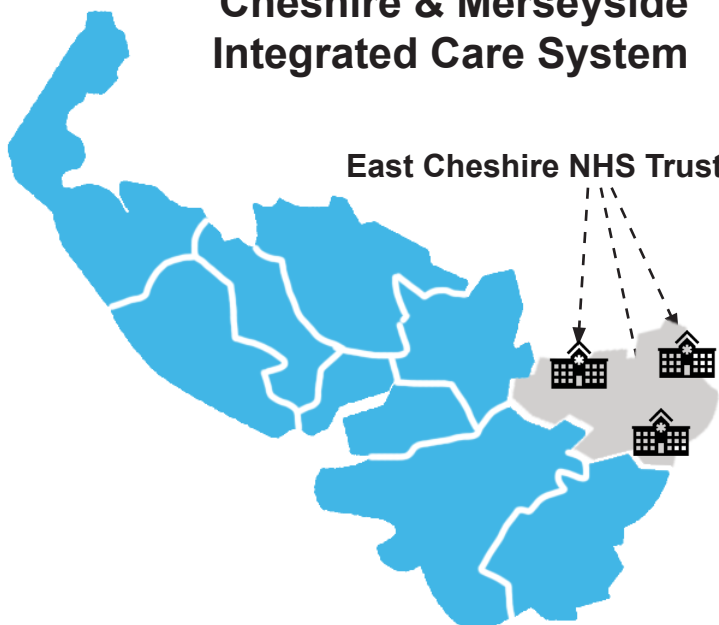
The two hospitals already work together on a number of services:

- Urology
- Breast Screening
- Maternity
- Neonatal services.



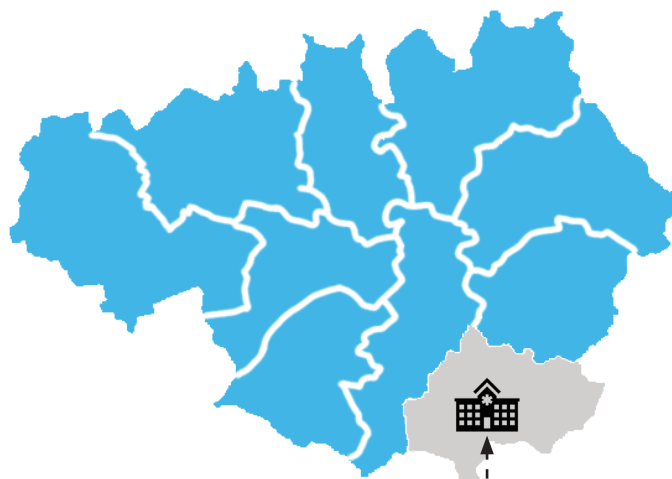
## Cheshire & Merseyside Integrated Care System

East Cheshire NHS Trust



## Greater Manchester Integrated Care System

Stockport NHS Foundation Trust



Integrated Care Systems will become statutory bodies in July 2022<sup>[12]</sup> subject to parliamentary approval. They will take on the NHS commissioning functions of Clinical Commissioning Groups (CCGs) as well as some of NHS England's commissioning functions. They will also be accountable for NHS spending and performance within the system.

Both the Cheshire & Merseyside ICS and the Greater Manchester ICS cover wide geographies and diverse populations with a range of health and care needs.

Central to the Integrated Care System Model is the concept of 'Place'. The ICS framework allows for health and care partners to come together at 'Place' level to coordinate service improvements based on local needs and address the wider determinants of health. A 'Place' typically refers to a population of around 250-500,000 people at Council or Borough level.

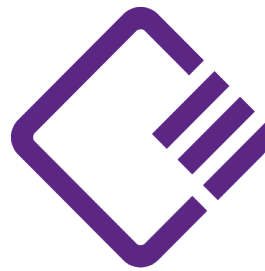
- East Cheshire NHS Trust is part of the Cheshire East Place within Cheshire & Merseyside ICS.
- Stockport Foundation NHS Trust is part of the Stockport Place within Greater Manchester ICS.

Many of the challenges that systems face cannot be solved by any one organisation alone. Places bring together hospital, community, primary care and social care services, developing and strengthening provider models for 'anticipatory' care, embedding models for out of hospital care around specialties, hospital discharge and admission avoidance.

Health care providers are also expected to be part of one or more provider collaboratives within integrated care systems<sup>[13]</sup>.

[12]: Integrated Care Systems: design framework (2021) NHS

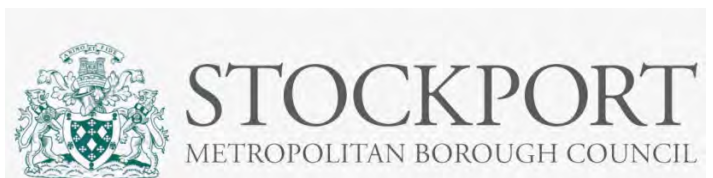
[13]: Integrating Care: next steps to building strong and effective integrated care systems (2020) NHS



## Cheshire and Merseyside

Health and Care Partnership

## Greater Manchester Health and Social Care Partnership



Joining up the provision of services will happen in two main ways:

- **within** Places - between local primary care providers, community services, mental health, social care, voluntary sector partners, community support and hospitals, through Place-based partnerships - '**vertical integration**';
- **between** Places, where similar types of provider organisation work together at scale to deliver shared goals such as reducing unwarranted variation, transforming services or providing mutual aid through a formal provider collaborative arrangement - '**horizontal integration**'.

## 2.3 Local Place Context

As close neighbours, there are many similarities between the local populations of Cheshire East and Stockport.

This case for change looks at the shared population across Cheshire East Place and Stockport Place.

### 2.3.1 Cheshire East Place

Cheshire East Place covers the geographical boundaries of Cheshire East Council. It brings together the leadership, planning and delivery of health and local authority care services.

It is one of nine health and social care ‘places’ in the Cheshire and Merseyside ICS, where the ambition is to work together to join up services across the NHS and local authorities to improve the health and wellbeing of local residents. It brings together:

- Cheshire East Council
- Cheshire & Wirral Partnership NHS FT
- East Cheshire NHS Trust
- NHS Eastern Cheshire CCG
- Mid Cheshire Hospitals NHS FT
- NHS Cheshire CCG
- South Cheshire & Vale Royal GP Alliance
- Eight Care Communities
- Vernova Healthcare CIC's GP-led primary care services
- Healthwatch.

It covers a large geography of 240 square miles – almost five times that of Stockport.

As a largely rural area, it is less densely populated than other parts of the North West and generally more affluent, though there are six small areas (all within Crewe) in the most deprived 10% of areas nationally.

In 2019, Cheshire East Partnership published the Cheshire East Partnership Five Year Plan<sup>[14]</sup> which describes an overall vision:

*“to enable people to live well for longer; to live independently and to enjoy the place where they live.”*

The five-year plan includes four strategic goals:

1. *To develop and deliver a sustainable, integrated health and care system*
2. *To create a financially balanced system*
3. *To create a sustainable workforce*
4. *To significantly reduce health inequalities.*

Key outcomes include:

- Long term planning and prevention to account for future changes in demographics
- Care delivered as locally and as close to home as possible
- Patients receive personalised care, designed around their needs
- Older patients receive the most suitable care, in the most appropriate environment
- All patients across Cheshire East will experience the right care, at the right time, at the right place to meet their healthcare needs.

In delivering these outcomes, patients within Cheshire East will receive the best quality care delivered by experienced clinical staff, tailored to the needs of patients, ultimately resulting in better clinical outcomes. Not only will this create a service which is fit for purpose, but it will ensure that services are sustainable, efficient and accessible for the future.

[14]: Cheshire East Partnership Five Year Plan (2019). Cheshire East Partnership

# Cheshire East

There are around **378,800** people living in Cheshire East<sup>[15]</sup>.

## People are living longer

People in Cheshire East are living longer, with a growing proportion of the population aged 65 or over. **22.5%** of people are aged 65+ (85,300 people) and this is likely to increase by 17,000 by 2027. Average life expectancy is higher than the national average, with women in Cheshire East living on average **83.7** years and men **80.3** years.

## Lifestyles

Smoking prevalence is higher than the national average in Cheshire East - **16.4%** of adults smoke. **17.5%** of adults are inactive and **64.8%** of the population are overweight or obese.

## The local population is growing

The number of residents is expected to grow by **3%** to 390,200 by 2027.

Cheshire East is less diverse than other parts of the North West or the national average. **96.7%** of the population are white.

## Long-term conditions

In the last census less than a fifth of Cheshire East's residents reported that their day to day activities were limited due to a long-term health condition or disability.

The main causes of early death (under the age of 75) are cancer, respiratory disease and cardiovascular disease.

[15]: Cheshire East Joint Strategic Needs Assessment (2019)  
Cheshire East Council



### 2.3.2 Stockport Place

Stockport Place covers the boundaries of Stockport Metropolitan Borough Council. It is one of 10 metropolitan boroughs in Greater Manchester's ICS.

Stockport is made up of a wide range of communities, local villages and district centres. While part of urban Greater Manchester (GM), Stockport also has Cheshire, North Derbyshire and the Peak District on its doorstep, giving the borough a rural aspect.

Stockport Place brings together the leadership of local health and care commissioners and providers to ensure effective services that work together to meet the needs of the local population.

Stockport NHS Foundation Trust is a key partner in the ONE Stockport Borough Plan<sup>[16]</sup>, helping to lead the development of a single plan for health and care within the borough.

Stockport's ONE Health and Care Plan<sup>[17]</sup> aims to build on the innovation, community spirit and outpouring of compassion that brought us together during the pandemic to tackle health inequalities and make Stockport a place where everyone has the best start in life, is supported to live well and age well.

The vision for 2030 sees health and care services working together to improve health and wellbeing for all.

***“We want people to live the best lives they can and feel happy, healthy, included, and independent.”***

[16]: One Stockport (2020) Stockport Council

[17]: ONE Health & Care Plan (2021) Stockport Partners

The plan includes four strategic goals:

- 1. Stockport residents will be healthier and happier***
- 2. Health and wellbeing inequalities will be significantly reduced***
- 3. Safe, high quality health and care services will work together for you***
- 4. Stockport residents will be more independent and empowered to live their best lives.***

Key actions include:

- A radical focus on early help and prevention
- Development of a joint, all-age mental health and wellbeing strategy
- Building an age-friendly borough
- A new neighbourhood model of integrated care out of hospital
- A system charter on quality
- Reducing waiting times after the COVID-19 pandemic
- A joint strategy to build a resilient, valued and inclusive health and care workforce.



# Stockport

There are **291,775** people living in Stockport and **315,655** registered with a local GP Practice<sup>[18]</sup>.

## The local population is growing

The number of Stockport residents grew by **3.6%** over the past decade and is predicted to rise to 306,300 by 2028.

## People are living longer

Stockport has the oldest age profile in Greater Manchester and the population continues to age. **19.9%** of people are aged 65 or over and this is likely to rise to 21% by 2024. Average life expectancy in Stockport is high, with women living on average **83.3** years and men **79.8**.

## High rates of long-term conditions

At least **93,500** people - **40%** of those registered with a Stockport GP - have one or more long-term health conditions. **26%** of adults have three or more lifestyle risk factors associated with ill-health - **25%** drink unhealthily, and **63%** are overweight or obese.

## There are unacceptable differences in health across the borough

While life expectancy in Stockport is above average, there is significant difference within our neighbourhoods, with men in Bramhall South living **11** years longer than those in Brinnington & Central. This variation is also seen in healthy life expectancy - in the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas.

[18]: [www.stockportjsna.org.uk](http://www.stockportjsna.org.uk)



## 2.4 Combined Population

ECT and SFT serve a combined population of over half a million people, treating over three quarters of a million patients a year.

Stockport covers an area of 48.6 square miles, whereas the Cheshire East local authority footprint totals 450 square miles, of which approximately 240 square miles are in 'Cheshire East' to the north as indicated in the map below.

Stepping Hill Hospital is located 11.9 miles to the north of the Macclesfield hospital site. The distance to Stepping Hill increases to 20.4 miles from the Congleton War Memorial Hospital site which is in the south of the eastern Cheshire footprint.

### 2.4.1 Age

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

Across both places there is a higher than average proportion of elderly people with increasingly complex health needs.

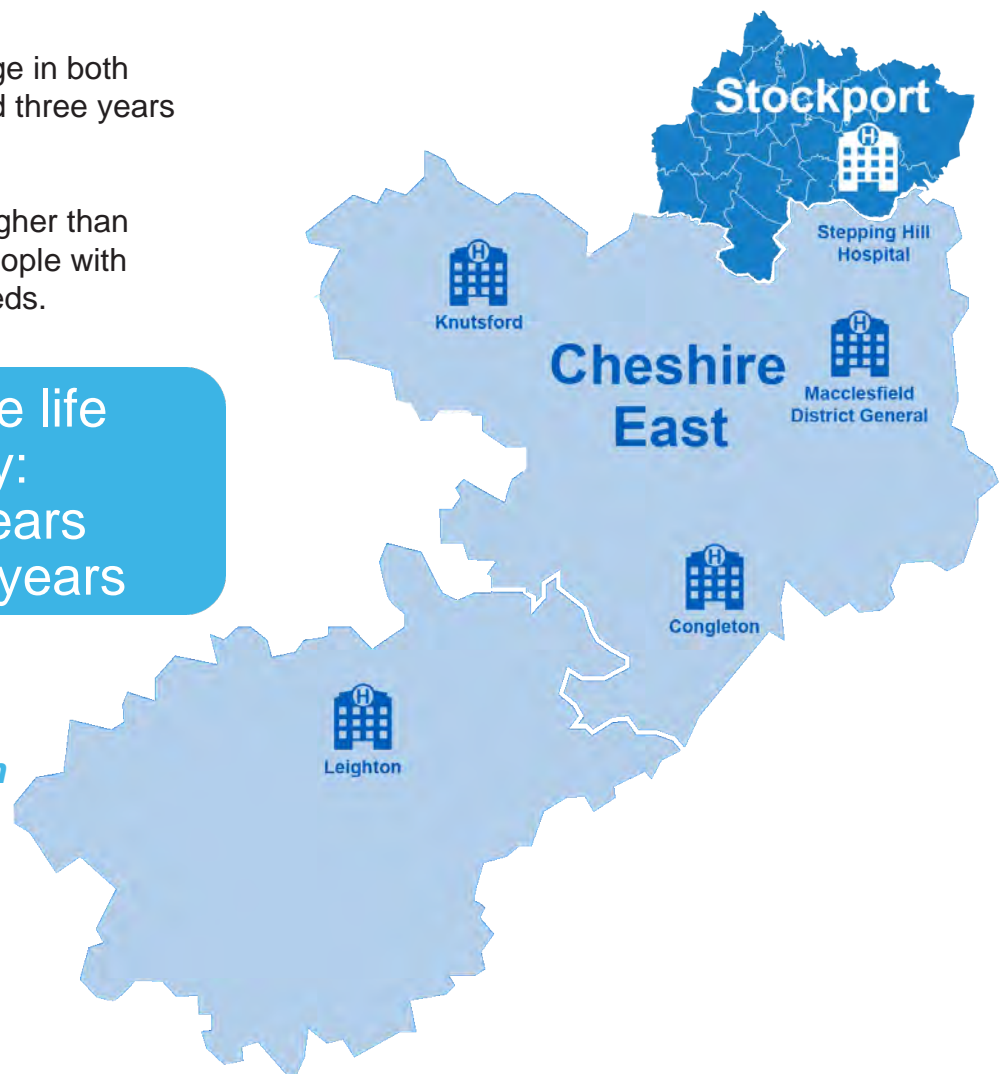
Above average life expectancy:  
Men - 80.2 years  
Women - 83.5 years

*As our population grows, and more people live with long-term conditions, the demands on healthcare services are changing and multiplying.*

Shared population of  
**670,575** people

**830,000** patients treated  
by our trusts each year

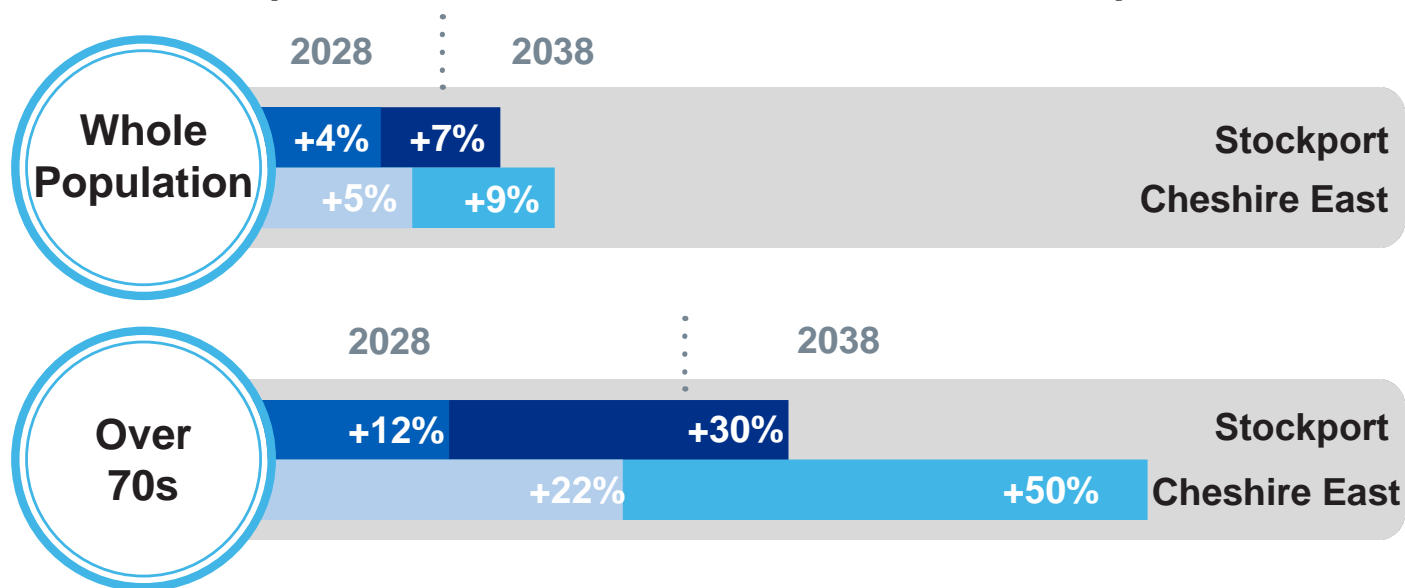
Hospital and community  
services covering an area  
of **288** square miles



The Office for National Statistics (ONS)<sup>[19]</sup> predicts that between 2018 and 2038 the number of patients in Cheshire East is likely to increase by 9% (18,141 people) from 197,296 to 215,437. The growth figures for Stockport CCG are slightly lower with an increase of 7% (19,859) from 291,775 in 2018 to 311,634 patients in 2038.

The most significant growth in our shared population is among people aged 70 and over, which is predicted to increase by 50% in Cheshire East and 30% in Stockport over this same 20 year period.

## Predicted Population Growth in Cheshire East & Stockport:



### 2.4.2 Disability

With an older than average population, both Cheshire East and Stockport have higher rates of people with disabilities and long-term conditions.

At the last census<sup>[11]</sup>, 17.52% of Cheshire East residents and 18.45% of Stockport residents reported having a disability that limits their day-to-day activities.

Based on GP records, 44% of Stockport's population live with one of more long-term conditions, 7.08% have two or more long-term conditions and 2.96% have three or more long-term conditions.

### 2.4.3 Ethnicity

Cheshire East and Stockport are made up of a wide range of communities, unique neighbourhoods, local villages and district centres. We are proud of where we live and celebrate the diversities that make up our local Places. It is important to understand the diversity of our population to ensure that the different health needs of our communities are met. For example, diabetes is more prevalent in people from South Asia and Afro-Caribbean groups, whereas breast cancer is more common in white females than in Asian or black females. Accessing healthcare can also be more difficult for some ethnic groups meaning that health outcomes can be poorer.

[19]: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections>

[20]: <https://www.ons.gov.uk/census/2011census>



In the 2011 UK Census, Cheshire East had a high proportion of white residents - 96.7% of the population, which is significantly higher than the national (86%) and regional average (90%). This figure of 96.7% included residents who identified as white: other (2.6% of the population) which was used in the 2011 UK Census to describe people who self-identify as white (mostly European) persons who are not of the English, Welsh, Scottish or Irish ethnic groupings. This population group almost doubled in size between the 2001 and 2011 census.

In Stockport the black & ethnic minority population has grown from just 4.3% in 2001 to around 8% at the 2011 census. When white ethnic minorities are included, such as Polish, Irish and traveller populations, this percentage rises to 11% of Stockport's registered population. Areas to the west of the borough have the highest proportion of ethnic diversity - particularly among younger populations.

Any changes that we make to services must therefore include the needs of all ethnic groups as it is important that we do not disadvantage those who may have greater health needs or who may have difficulties accessing care.

| Ethnicity                  | White British | Other White | Black | Asian | Mixed Race | Other Ethnicity |
|----------------------------|---------------|-------------|-------|-------|------------|-----------------|
| <b>Cheshire East</b>       | 94.24%        | 2.46%       | 0.38% | 1.64% | 1.05%      | 0.23%           |
| <b>Stockport</b>           | 89.00%        | 3.10%       | 0.70% | 4.90% | 1.80%      | 0.60%           |
| <b>Combined Population</b> | 91.96%        | 2.74%       | 0.89% | 3.03% | 1.00%      | 0.38%           |

### 2.4.4 Religion and Belief

In the 2011 UK Census, both Cheshire East and Stockport had a high proportion of people recording their religion as Christian.

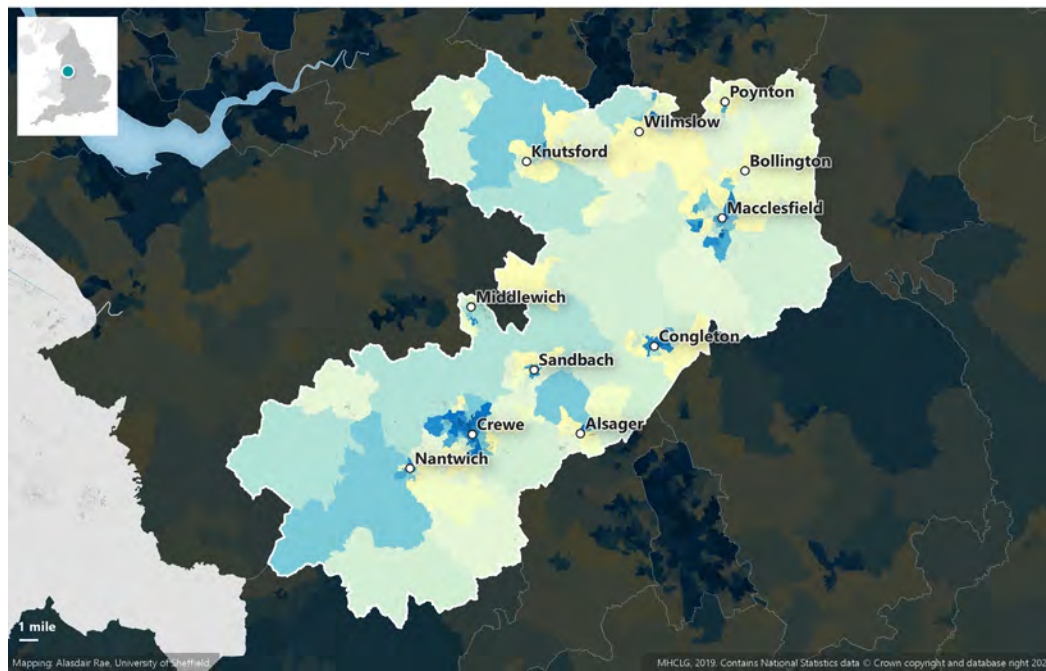
| Religion              | Cheshire East |        | Stockport |        | Combined Population |        |
|-----------------------|---------------|--------|-----------|--------|---------------------|--------|
| <b>Christian</b>      | 254,940       | 68.88% | 179,055   | 63.21% | 433,995             | 66.42% |
| <b>Buddhist</b>       | 882           | 0.24%  | 853       | 0.30%  | 1,735               | 0.27%  |
| <b>Hindu</b>          | 1,328         | 0.36%  | 1,666     | 0.59%  | 2,994               | 0.46%  |
| <b>Jewish</b>         | 581           | 0.16%  | 1,340     | 0.47%  | 1,921               | 0.29%  |
| <b>Muslim</b>         | 2,438         | 0.66%  | 9,431     | 3.33%  | 11,869              | 1.82%  |
| <b>Sikh</b>           | 279           | 0.08%  | 330       | 0.12%  | 609                 | 0.09%  |
| <b>Other religion</b> | 1,065         | 0.29%  | 964       | 0.34%  | 2,029               | 0.31%  |
| <b>No religion</b>    | 83,973        | 22.69% | 71,126    | 25.11% | 155,099             | 23.74% |
| <b>Not stated</b>     | 24,641        | 6.66%  | 18,510    | 6.53%  | 43,151              | 6.60%  |

### 2.4.5 Deprivation

Both Cheshire East and Stockport are relatively affluent compared to the national average<sup>[21]</sup>. However, both areas have pockets of deprivation. 17.4% of Stockport’s residents live in the most deprived quintile, compared to just 7.7% of Cheshire East residents, while 25.6% of Stockport’s residents live in the most affluent quintile, compared to 41.9% of Cheshire East residents.

There is a significant difference in health outcomes between people in the more affluent and deprived areas of the footprint.

#### Index of Multiple Deprivation 2019 - Cheshire East

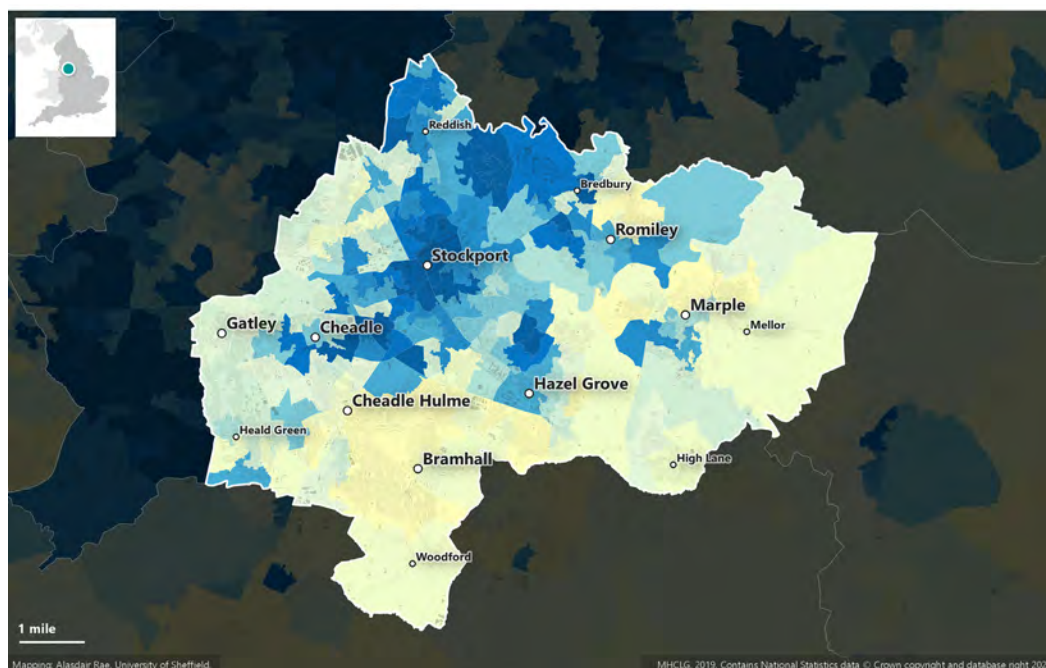


Relative Level of Deprivation:

Less Deprived



#### Index of Multiple Deprivation 2019 – Stockport



More Deprived

[21]: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>

## 2.5 East Cheshire NHS Trust

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

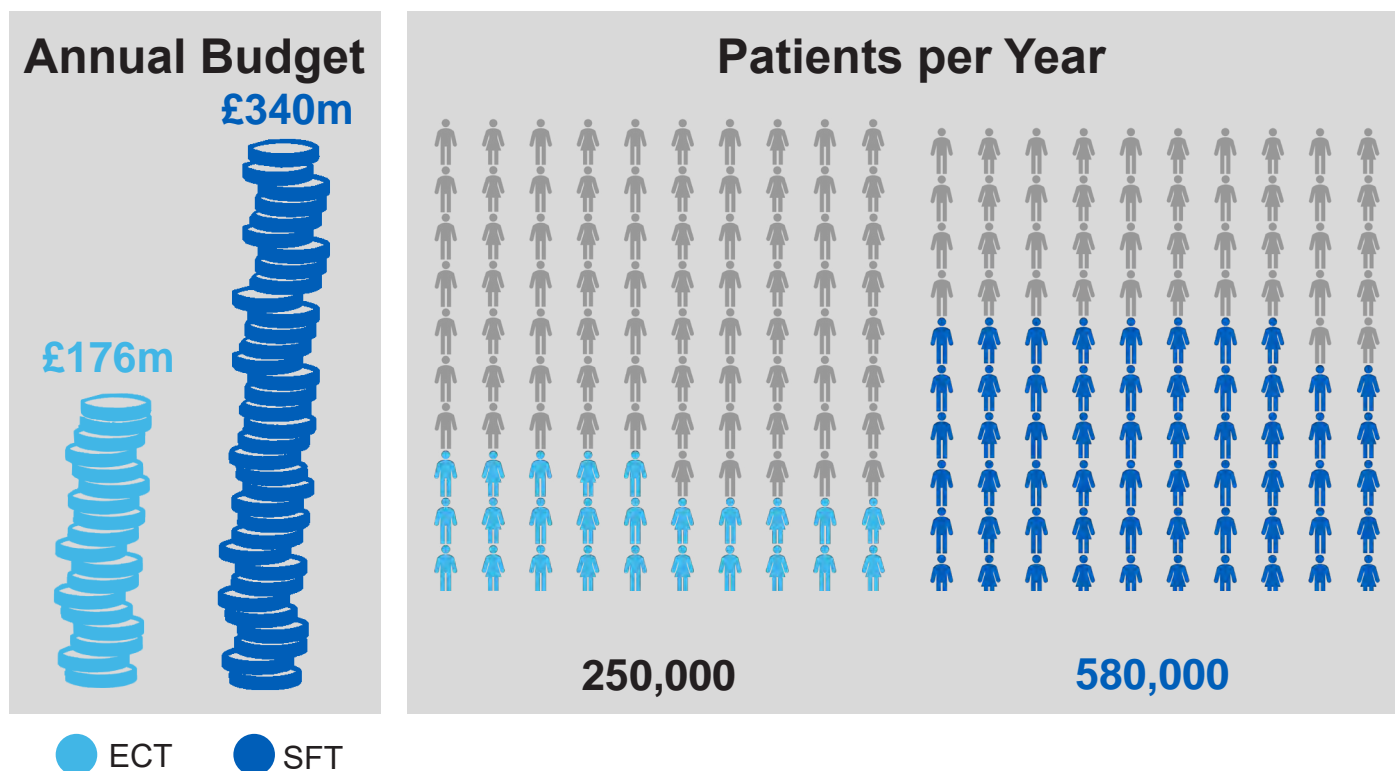
The trust comprises a small district general hospital (DGH) in the centre of Macclesfield; a community hospital in Congleton providing outpatient clinics and intermediate care; and a further community outpatient facility in Knutsford. In total, the trust has 350 inpatient beds and employs around 2,270 people. In 2019/20 ECT had an annual budget of £176 million.

Macclesfield DGH runs an emergency department, predominantly medical inpatient beds, outpatient clinics and diagnostics. Around 92% of all elective activity on the site is undertaken as a day case procedure, with adult inpatient provision for elective general surgery, gynaecology, and orthopaedics. The Macclesfield hospital site was chosen for a significant capital investment in radiotherapy services with the construction of a £26million purpose built 'Christie at Macclesfield' facility which opened in December 2021.

Congleton community hospital provides 26 intermediate care beds and outpatient facilities, while the Knutsford community facility delivers purely outpatient services. Community services are also provided from a range of locations across the five East Cheshire care communities:

- Macclesfield;
- Knutsford;
- Chelford, Handforth, Alderley Edge and Wilmslow (CHAW);
- Congleton and Holmes Chapel (CHOC); and
- Bollington, Disley and Poynton (BDP).

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



## 2.6 Stockport NHS Foundation Trust

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.

The main hospital site is Stepping Hill Hospital, which provides emergency, surgical and medical services. In addition, SFT offer a number of specialist services:

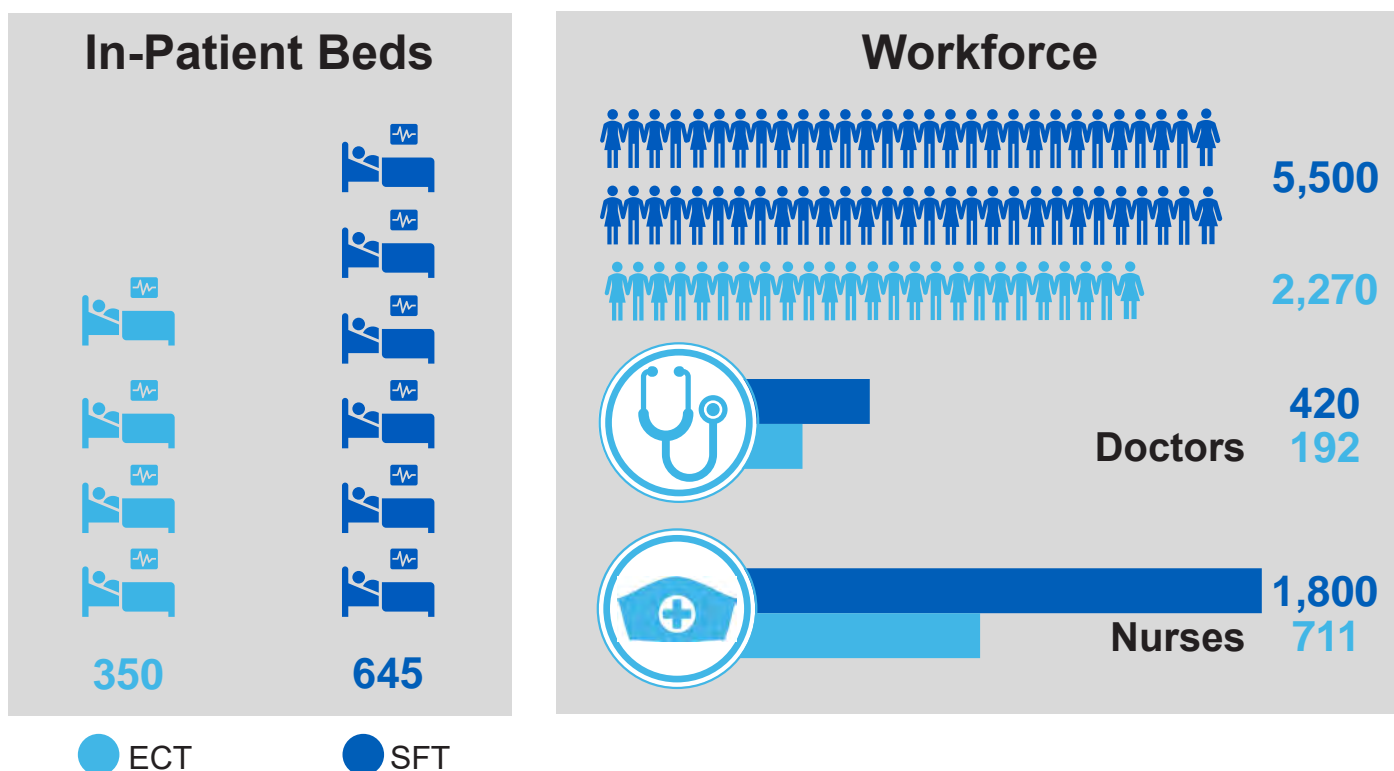
- one of three specialist stroke centres in GM with services rated as the best in England;
- SFT delivers Urology services for the populations of Stockport, Tameside and Cheshire with a national reputation for excellence;
- one of the largest orthopaedic services in the region - one of only two trusts in GM delivering cervical-spine surgery; and
- one of four designated specialist sites for acute and general surgery in Greater Manchester.

In general, core services are larger in scale than ECT, have more staff and are more sustainable. There are also more sub-specialisms which broaden the service offer to patients.

SFT delivers community health services across 24 health centres and community clinics in Stockport. The trust works closely with local primary care and social care teams to deliver community services as an integrated service at neighbourhood level. SFT also supports a number of community and intermediate care beds, including:

- 24 beds in the Meadows Transfer to Assess and intermediate nursing care facility;
- 4 beds at Swanbourne Gardens, providing overnight breaks for children and young people with severe learning disabilities; and
- 50 Discharge to Assess beds at Bramhall Manor.

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’.



### 2.7 Challenges Faced by Both Hospitals

There are a number of issues faced by both hospitals that we believe could be improved by working together.

#### 2.7.1 Changing Local Needs

The ageing population and increasing demand for our services have placed a significant financial strain on hospital and community services. At the same time, local authority budgets are under significant pressure, reducing social care and public health provision. This has a direct impact on hospitals, with a consistently high number of patients who are medically fit for discharge but cannot leave as they are waiting for social care packages or placements.

We need to work in partnership with primary care social care and commissioners to meet these challenges.

#### 2.7.2 Financial Pressures

East Cheshire NHS Trust reported small surpluses in 2019/20 and 2020/21 as a result of additional funding allocated by NHSE. It is anticipated the trust will deliver a breakeven financial position for 2021/22 working within the Cheshire and Merseyside system, however it is recognised that the trust has a structural deficit of around £30m, relating to scale and the payment by results regime. The trust has a good track record of delivering its finance savings programme but has been increasingly challenged in the identification of recurrent savings.

SFT has a significant underlying financial deficit of around £85m. It is anticipated the trust will break even in 2021/22, working within the Greater Manchester system. However, the trust's long term financial plan indicates that SFT will require continued financial support and sustained efficiency measures at levels in excess of the national requirement.

#### 2.7.3 Estates

ECT's Macclesfield Hospital was built in the early 1980s and has a structural life of 60 years. As such, it will require significant maintenance over the next five years. The site is densely populated and use of floor space is high. Many areas, including the inpatient wards are no longer compliant with Healthcare Building Notes (HBN) guidance on space requirements.

SFT's main site at Stepping Hill Hospital has been deteriorating for some years and requires significant investment to meet standards. The hospital has grown incrementally, with multiple additions and extensions added to the estate over time, resulting in inefficient space planning with services, and facilities that need to be near to each other dispersed across the hospital estate.

All available space within the estate has been used, leaving no room for the growing number of patients coming to the hospital each year. The ED is already at or over-capacity, making it difficult to cope with surges in activity.

Responding to the recent infection prevention and control requirements to segregate COVID-19 positive patients has been particularly challenging for both hospitals and required significant capital investment in the ECT's critical care unit.



## 2.7.4 Capacity & Demand

The COVID-19 pandemic has had a significant impact on health and care services across the system. At the start of the pandemic, hospitals across the country mobilised surge protocols, cancelling non-urgent procedures to ensure sufficient space and staff were made available to manage the pandemic.

While all of our hospital services continued throughout the pandemic, the need to prioritise urgent cases and separate wards to prevent the spread of infection has left hospitals with a significant backlog of patients waiting for routine care.

## 2.7.5 Workforce Resilience

While demand for healthcare has grown, the number of qualified healthcare professionals has not increased at the same speed and so our workforce is under significant pressure. Hospitals across the country struggle to recruit the number of staff they need to deliver safe services 7 days a week.

We want to improve staff wellbeing by creating resilient teams.

A number of core clinical services at ECT are considered sub-scale – or too small for an effective hospital service - raising concerns about their sustainability over time. This challenge, relating to a number of small specialities serving a low volume of patients, makes it more difficult to meet clinical standards and attract staff who want to work as part of a bigger team.

ECT's Board recognises that strong strategic partnerships are required to maintain clinical sustainability and preserve local services.

While SFT is a larger trust, compared with hospitals across the country it is considered medium-sized and often struggles to compete with specialist tertiary care centres for key staff.



### 2.8 Why Are We Concerned About Sub-Scale Services?

Small services are more likely to be challenged in their ability to meet clinical standards. As a smaller trust, ECT has a number of sub-scale clinical 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 in the clinical teams 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.

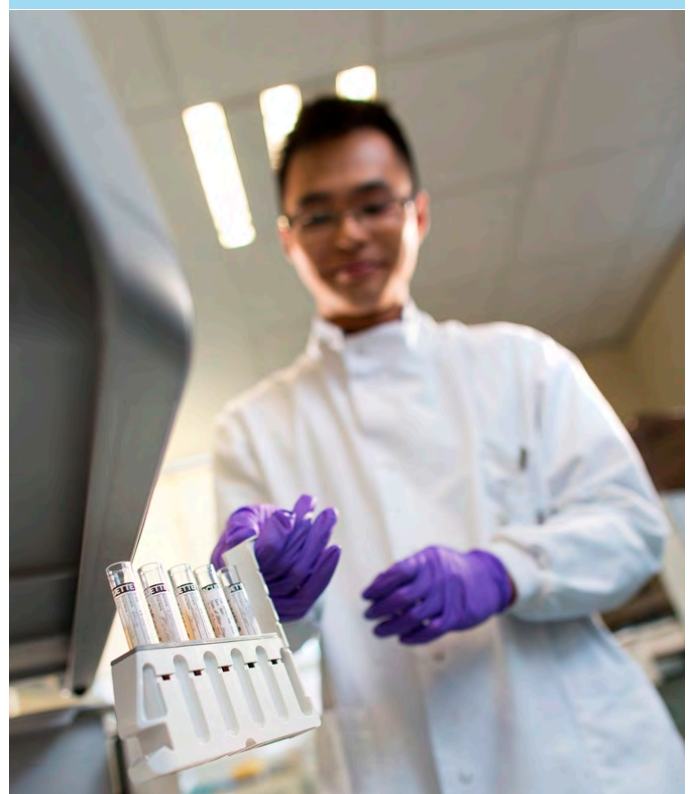
Though SFT is a larger trust, it too has been challenged to deliver all specialties, resulting in collaborative arrangements with other trusts to maintain services for local people.

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. This highlights the interdependency between services like obstetrics and anaesthetics, where additional pressure in one specialty area exposed the fragility of cross-cover workforce arrangements.

The publication of the interim Ockenden report<sup>[22]</sup> in December 2020 and the final report<sup>[23]</sup> in March 2022 highlighted serious practice concerns at Shrewsbury and Telford Hospital NHS Trust with recommendations

for all maternity service providers to improve the safety of maternity services throughout the country. 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 subscale services is crucial to maintaining local access.**

[22]: Interim Ockenden Report (2020). HM Government.

[23]: Final Ockenden Report (2022). HM Government.





### 2.9 Developing the Strategic Clinical Case for Change

NHS England has clear guidance<sup>[24]</sup> 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 before designing options for change.

A Programme Board was established to lead this piece of work to:

- design and implement high quality, integrated and sustainable hospital services for the populations served by ECT and SFT
- ensure these hospital services form a key part of an integrated service offer spanning primary, community, social and hospital care.

This will be achieved through joint working on three levels:

- between clinical teams across ECT and SFT
- between the hospital and primary, community, social care, voluntary sector and community support in each area
- in partnership with patients, care and local people.

Intended outcomes of the programme are:

- to create a compelling vision for each site
- to improve health outcomes and reduce health inequalities
- to sustain and improve good clinical outcomes in line with national requirements, addressing variation between services
- to ensure optimal outcomes 7 days a week
- to improve recruitment and retention of staff through greater flexibilities and enhanced opportunities to develop skills and experience, with an increased focus on research, education, and training.
- to ensure value for money for services in scope.

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 ongoing 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 and changing needs as a result of the COVID-19 pandemic. A separate report from this exercise is available in appendix 4.

In addition, this case for change includes evidence and insights from a variety of sources, including forums attended by clinicians, patients, and other key stakeholders. It is informed by critical analysis of our performance, benchmarked against national standards.

In developing this case for change, our programme has engaged in monthly dialogue with NHSE regulators through a Stage 1 review process. This includes assurance on programme governance and workstream management.

[24]: Planning, assuring and delivering service change for patients (2018) NHSE

## 2.9.1 Clinical Engagement

An independent clinical advisor with significant knowledge, experience, and understanding of strategic service change in a hospital setting was appointed to lead the work across the two organisations.

This independent clinical oversight has given our case for change an objective level of scrutiny, check and challenge.

Clinically led workstreams were established, engaging and involving clinical leaders, senior nurses, midwives, therapists and operational managers in the programme of work which focuses on ten clinical specialties.

The workshop and engagement process was designed to facilitate clinically focused conversations to consider the case for change in the ten services identified.

A comprehensive service overview and accompanying data packs were prepared in advance of workshops which provided the context for each clinical service and supported the discussion on opportunities and challenges.

The case for change was considered within workshops from three perspectives:

- delivery of clinical standards and outcomes
- demand and capacity in each specialty;
- workforce resilience.

Following the conclusion of the workshops, further engagement and feedback sessions were held separately with each clinical service team. These sessions reflected on output from the workshop sessions and were an opportunity for both the clinical teams and the independent clinical advisor to feedback on any other issues or concerns.

A full record of clinical engagement to date can be found in appendix 3.



# 3. 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 propose bringing together clinical teams 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, such as urgent and emergency care, will intrinsically need to be delivered across existing sites 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.

# 4. Scope



## 4.1 Identifying Clinical Services in Scope

The Boards of ECT and SFT agree that working collaboratively could enable both trusts to:

- Ensure clinical standards are met, leading to better outcomes for patients
- Improve workforce recruitment and retention
- Optimise use of estates and facilities
- Provide opportunities for restoration and recovery of clinical services
- Improve financial efficiency
- Improve clinical models for the benefit of patients.

The scope of clinical specialties included in the joint review process was based on clinical knowledge and an operational understanding of the associated strengths, issues and risks faced by current services at both trusts.

The main criteria for inclusion in the review included:

- Specialties with sub-scale clinical activity
- Single-handed consultant specialties
- Services with persistent workforce resilience challenges
- Services that are unable to consistently meet national clinical standards.

We refer to these services '**fragile**'.

In addition, the impact of the COVID-19 pandemic on operational delivery was considered. Services were added into scope where it was felt that collaboration could support the recovery of services most impacted by the pandemic, even if they do not meet the criteria above.

In considering service changes, it is crucial to understand the impact any change could have on other clinical specialties. These clinically interdependent services, such as the impact on emergency medicine, acute and general medicine, and pathology are considered in section 5.11.

There is no agreed NHS definition of a **fragile** service.

We have therefore adopted a working definition of a fragile service as one which is unlikely to be able to sustain high quality care during the upcoming 12-month period.

To help us make the process consistent and objective, we have developed a template of indicative metrics and red flags to assess fragility of a speciality. This uses the three themes in our case for change:

### **Capacity & Demand:**

- does the organisation struggle to deliver a full service?
- are parts of the service closed?
- are parts of the service delivered under a Service Level Agreement (SLA) which itself is fragile?




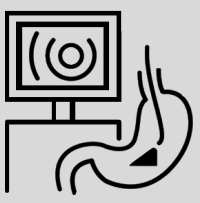

### **Quality & Performance:**






- do services struggle to consistently meet national standards?
- are there concerns around incidents, harm or complaints from patients?

### **Workforce Resilience:**

- are there sufficient staff to deliver the service?
- are there crucial posts that are difficult or impossible to recruit to?
- are there a number of key people close to retirement?

This process is about developing a clear view of where the service pressures exist now and where they are likely to develop over the next 12- 24 months. It is about planning ahead to ensure there are no service failures which would be detrimental to our patients.

| Clinical Service  | Rationale for Inclusion  |
|---|--|
|  <p><b>Anaesthesia &amp; Critical Care</b></p> | <p>ECT has one of smallest level 3 intensive care units in England, with anaesthetic/intensivist workforce challenges at consultant and middle grade tiers.</p> <p>Level 3 critical care provision is essential for delivery of 24h ED services, making strategic partnership vital to support clinical sustainability on Macclesfield site.</p>   |
|  <p><b>Cardiology</b></p>                      | <p>Both trusts have links to the same specialist tertiary centre at Wythenshawe hospital.</p> <p>This is a large outpatient specialty with a high volume of diagnostics. Collaboration offers the opportunity for improved access and population health benefits.</p>  |
|  <p><b>Diabetes &amp; Endocrinology</b></p>   | <p>The ECT service consists of a single-handed locum consultant and the Trust has struggled to recruit to a permanent role.</p> <p>The service has been commissioned from multiple providers and is facing immediate workforce sustainability issues.</p>  |
|  <p><b>Endoscopy</b></p>                     | <p>Both sites have a significant backlog of activity as a result of the COVID-19 pandemic.</p> <p>Different workforce models offer the potential to share good practice and expertise between sites to strengthen delivery; address clinical resilience in rotas; and explore opportunities for subspecialisation, including capsular endoscopy and better access to specialist procedures such as ERCP.</p> |
|  <p><b>Gastronenterology</b></p>             | <p>This is a large outpatient specialty, with opportunities for collaboration on endoscopy and links to General Surgical model.</p> <p>ECT faces workforce sustainability challenges and has struggled to recruit to this specialty.</p>   |

| Clinical Service   | Rationale for Inclusion   |
|--|---|
|  <p><b>General Surgery</b></p>  | <p>General Surgery is a sub-scale service at ECT, especially for elective inpatient activity.</p> <p>Both sites have estates and infrastructure issues limiting the amount of day case activity they can deliver alone.</p> <p>While there are good clinical outcomes at both sites, the Trusts are not compliant with national clinical standards for workforce, which would require significant investment in the consultant workforce.</p>   |
|  <p><b>Imaging</b></p>  | <p>All other clinical specialties rely fundamentally on access to a well-functioning imaging service.</p> <p>There are immediate workforce sustainability issues at both sites due the lack of radiologists at a national level.</p>  |
|  <p><b>Trauma &amp; Orthopaedics</b></p>                                   | <p>Service resilience has been compromised frequently by surges in non-elective activity leading to the cancellation of surgical procedures as inpatient bed were unavailable. Across both sites there is a significant backlog of elective patients waiting for treatment.</p> <p>Current services are not compliant with national clinical workforce standards.</p>   |
|  <p><b>Women &amp; Children: <i>Maternity &amp; Gynaecology</i></b></p>   | <p>Maternity services at ECT are sub-scale with just 1500 births per annum. Lack of resilience was exposed during the COVID-19 pandemic due to pressures on anaesthetic workforce capacity.</p> <p>SFT's maternity service is constrained by workforce challenges, though expansion is being implemented as part of a wider quality improvement plan.</p> <p>ECT's inpatient gynaecology service is small, with just 1-2 beds used predominantly for day case and outpatient procedures. The current service does not meet national clinical workforce standards.</p> |
|  <p><b>Women &amp; Children: <i>Paediatrics &amp; Neonatology</i></b></p> | <p>ECT's level 1 neonatal service is sub-scale, with year-on-year reductions in admissions. This service is a critical interdependency for hosting a maternity service.</p> <p>ECT's paediatric inpatient service is also sub-scale. Paediatrics is a key interdependency for the Emergency Department. Though there is a high volume of outpatients, there is very little sub-specialist activity. The current service does not meet national clinical workforce standards.</p>  |



# 5. Clinical Service Reviews



Service reviews were undertaken jointly by the clinical and operational leads at each trust.

Each service provided a range of data to benchmark what service is offered, the workforce, activity and performance.

Workshops were then facilitated to bring together clinicians and operational leads across each service to understand the challenges faced by each team and the successes of each department; to agree the standards we aspire to deliver; and to discuss how these ambitions can be delivered.

For each service review, there is an overarching description of the specialty and a snapshot of the service offered at each trust.

This snapshot deliberately uses data from 2019/20 in order to give a clear picture of the service before the impacts of COVID-19. Workforce data relates to March 2021 to demonstrate the latest position and the impact of the pandemic on our staff.

Medical staff are divided into three groups, in line with the Royal College of Physicians definitions, as shown in the image below from the British Medical Journal (BMJ)<sup>[25]</sup>:

Feedback from clinical workshops is then used to set out the challenges we face in delivering high quality services and the impact of the COVID-19 pandemic on service provision.

This is structured in terms of:

- Capacity & Demand
- Quality & Outcomes
- Workforce Resilience.

Finally, there is a summary of the clinical case for change for each specialty.

Service reviews are set out below in alphabetical order.



[25]: <https://www.bmj.com/content/362/bmj.k3136>

# 5.1 Anaesthesia & Critical Care

Critical Care - also known as intensive care - is the medical specialty that supports patients with life-threatening conditions. An Intensive Care Unit (ICU) is a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management and monitoring of patients who are very ill. It provides specialist expertise and the facilities to support vital organ functions.

Critical Care supports patients who need invasive treatment and those recovering from major surgery who require intensive post-operative care. Critical Care is also used to support patients who need organ support to recover from conditions such as:

- Severe infections (such as sepsis);
- Acute respiratory infections;
- Neurological problems;
- Post-operative complications; and
- Cardio-vascular incidents (heart attacks or strokes).

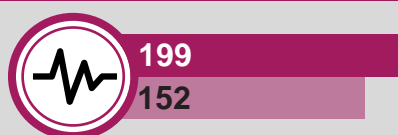
Critical Care encompasses all areas that provide level 2 (high dependency) and / or level 3 (intensive care) care as defined by the Intensive Care Society<sup>[26]</sup>. Any hospital with a 24-hour emergency department must have level 3 critical care provision. Due to the severity of their illness, critical care patients require more nursing and medical input than patients on a general ward. Level 2 High Dependency requires a minimum of one nurse for every two patients, while Level 3 Critical Care requires at least one nurse per patient, as set out in the Guidelines for Provision of Intensive Care Services (GPICS)<sup>[27]</sup>.

ICU staff also provide services outside of the ICU, such as emergency response to a deteriorating patient (rapid response teams) and critical care outreach services.

[26]: Levels of Critical Care for Adult Patients (2009) Intensive Care Society

[27]: Guidelines for Provision of Intensive Care Services Guidelines for Provision of Intensive Care Services (2019)

## Activity



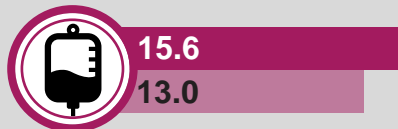
**Emergency Admissions**  
(Non-Electives)



**Level 3 Beds** (number commissioned)



**Level 2 Beds** (number commissioned)



**Length of Stay** (days)

| Specialty Case Mix (19/20)         | ECT | SFT  |
|------------------------------------|-----|------|
| Emergency Department               | 0   | 2    |
| Breast Surgery                     | 2   | 1    |
| Cardiology                         | 1   | 0    |
| Critical Care Medicine             | 0   | 1    |
| Ear, Nose & Throat (ENT)           | 1   | 9    |
| General Medicine                   | 183 | 285  |
| General Surgery                    | 109 | 287  |
| Gynaecology                        | 8   | 4    |
| Obstetrics (hospital bed or birth) | 8   | 0*   |
| Trauma & Orthopaedics              | 27  | 41   |
| Urology                            | 0   | 63** |

● ECT ● SFT

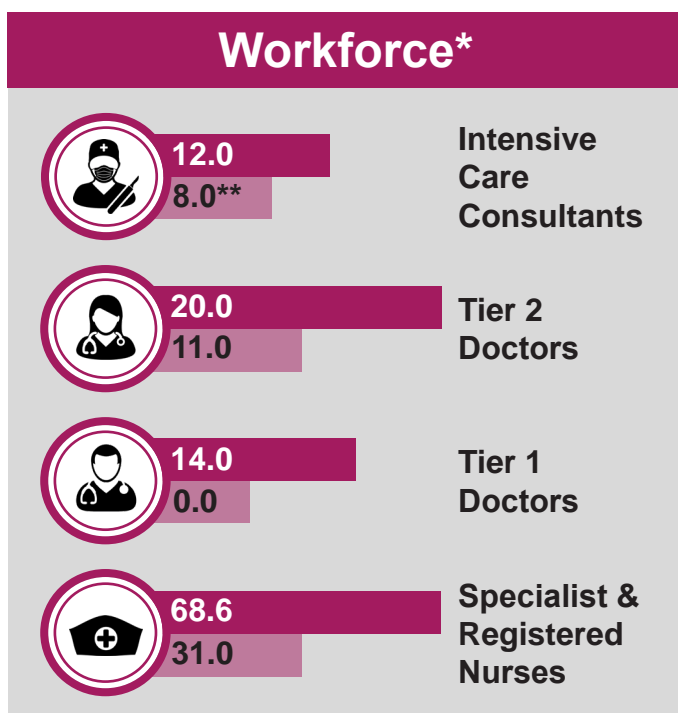
\* patients requiring high dependency obstetrics care at SFT are admitted to the bespoke high care unit within maternity which is coded as anaesthetics or surgery  
 \*\* urology admissions to critical care for SFT includes patients from ECT and SFT as all complex inpatient activity is undertaken at SFT

The ICU at SFT has physical capacity for 20 beds, with separate intensive care and high dependency units. SFT is commissioned to deliver 7 Level 3 and 6 Level 2 beds. During the COVID-19 pandemic this capacity was expanded to 18 beds.

The medical workforce at SFT is made up of 12 intensive care and anaesthetics consultants and two single specialty intensive care medicine (ICM) consultants who provide 24-hour cover to the ICU and a consistent seven-day service. A minimum of two dedicated ICM staff are resident 24-hours a day with additional staff available during working hours.

The trust has an excellent reputation among peers, with a full complement of consultants approved by the Faculty of Intensive Care Medicine (FFICM), a training unit for ICM doctors, and participation in ICU research.

SFT's ICU was rated as 'Good' by the CQC. During the COVID-19 pandemic, the unit was expanded to meet guidance on infection prevention. The department achieved excellent COVID-19 survival and Intensive Care National Audit & Research Centre (ICNARC) outcomes, despite a huge increase in patient numbers.



● ECT ● SFT \* Whole-time equivalents

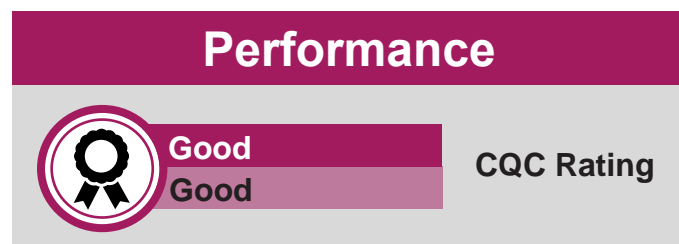
The ICU at Macclesfield DGH is extremely small by modern standards in terms of the numbers of patients and staff; and the size of the estate. The trust has seven critical care beds and is commissioned to deliver four Level 3 and two Level 2 beds, which are used flexibly to accommodate patient need.

Demand for critical care is largely driven by acute medical admissions, as there is limited complex surgical activity at ECT.

Medical staffing is provided by the anaesthetics department, which also provides cover to theatres, maternity and the emergency department. The trust's rota of middle-grade anaesthetists is heavily dependent on bank and agency doctors. Mutual aid arrangements are in place with GM providers to support transfers of care, with SFT the designated 'buddy' site for ECT if required.

At the start of the COVID-19 pandemic in March 2020, the trust had to establish two geographically separate areas for the provision of critical care to segregate potentially infectious patients. This significantly increased pressure on the small medical and nursing teams. A £2m capital upgrade was completed in February 2022 to provide a new seven-bed unit.

ECT's critical care services were rated 'Good' by the CQC in 2019, however it is acknowledged that workforce constraints and the sub-scale nature of the service impact the trust's ability to comply with national standards. Since that CQC inspection, the resilience of the unit has been significantly tested by the COVID-19 pandemic.



\*\* ECT Consultants cover both ICU and general anaesthetics, while SFT consultants cover ICU only



### Capacity & Demand

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

The Faculty of Intensive Care Medicine (FICM) predict an increase in the number of critical care beds required over the next five years. NHS England has acknowledged the demand for level 2 and level 3 critical care will continue to grow in the long term.

Both CCUs 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. Currently, some patients who require level 2 high dependency care have to be cared for on acute wards due to a lack of space in the CCU. This will continue to be a challenge with a maximum of 7 beds available in the upgraded unit. Risks are mitigated by the

critical care outreach service and specialist advice from anaesthetists to the wards. Additional capacity for level 3 care can also be sought from surrounding hospitals through mutual aid.

- At SFT, CCU accommodation is challenging, with only one side room for a 20 bed unit. 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, critical care capacity was flexed to segregate COVID-19 patients from other patients by using the theatre recovery unit.

Nationally, the Intensive Care Society is requesting an increase in level 2 capacity to support growing demand. However, any expansion requires additional workforce, and this remains a significant challenge.



### Quality & Outcomes























The Guidelines for the Provision of Intensive Care Services (GPICS) are described by clinicians as “the blueprint for how intensive care should be run”.

The critical care service at SFT is almost fully compliant with GPICS guidelines, with the exception of the standard on multi-disciplinary team (MDT) 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. While there are over 100 GPIC recommendations, the following table only covers key standards relating to workforce or senior clinical cover.

It is acknowledged that clinical network and strategic partnership arrangements need to be strengthened to maintain good outcomes.

| Standard    | Measure   | ECT  | SFT   |
|-------------|---|--|---|
| GPICs-v2 1  | Patients' care must be led by a consultant in Intensive Care Medicine, who will have daytime Direct Clinical Care Programmed Activities identified in their job plan. These programmed activities will be exclusively in Intensive Care Medicine and the Consultant will not be responsible for a second specialty at the same time.                                |     |    |
| GPICs-v2 2  | Consultant work patterns must deliver continuity of care.   |     |    |
| GPICs-v2 3  | The daytime consultant to patient ratio must not normally exceed a range between 1:8 and 1:12. This ratio is complex and needs to be cognisant of the seniority and competency of junior staff, the reason for admission (e.g. standard post-operative care pathway) and the number and complexity of emergency admissions. The night-time ratio cannot be defined. |     |    |
| GPICs-v2 4  | The daytime intensive care resident to patient ratio should not normally exceed 1:8.  |     |    |
| GPICs-v2 5  | All staff that contribute to the resident rota must have basic airway skills.   |     |    |
|             | All critical care units must have immediate 24/7 on-site access to a doctor or ACCP with advanced airway skills   |  * |   |
| GPICs-v2 6  | There must be a designated Clinical Director and/or Lead Consultant for Intensive Care Medicine.  |   |  |
| GPICs-v2 7  | A consultant in Intensive Care Medicine must be immediately available 24/7. The consultant responsible for intensive care out of hours must be able to attend within 30 minutes.  |   |  |
| GPICs-v2 8  | A small number of units that remain staffed overnight by an anaesthetic consultant without daytime ICM sessions, by necessity dictated by the unit's size and remoteness, must also have a consultant in Intensive Care Medicine available for advice 24/7, either by local agreement or from within the Critical Care Network.                                     |   | N/A   |
| GPICs-v2 9  | A consultant in Intensive Care Medicine must undertake ward rounds twice a day, seven days a week.  |   |  |
| GPICs-v2 10 | The ward round must have daily input from nursing, microbiology, pharmacy and physiotherapy and regular input from dietetics, speech and language therapy, occupational therapy and clinical psychology to assist decision making. The nurse in charge should be present in person for the ward round.  |   | Partially<br>**   |
| GPICs-v2 11 | Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout.  |   |  |

\* Prior to suspension the rota was not compliant as middle grades provided cross cover to maternity and critical care unit and, as such might not be immediately available.

\*\* In relation to MDT: the nurse in charge is present on all ward rounds and daily input is available from physiotherapy, pharmacy and microbiology on site and present Monday – Friday with telephone availability input for micro and pharmacy at weekends.



## Workforce Resilience

Delivering sufficient critical care goes beyond physical infrastructure, requiring sufficient numbers of trained staff.

Nationally, there is a lack of trained doctors to meet growing demand for critical care - particularly intensive care physicians. While the NHS has invested in additional physical resources for critical care during the COVID-19 pandemic, many hospitals are struggling to recruit enough staff to make use of the extra resources. And while data is still emerging, it is increasingly clear that the pandemic is taking a substantial toll on those who support and deliver critical care services<sup>[28]</sup>.

Workforce resilience is key to sustainability. The critical care service at ECT is viewed as unattractive and unsustainable because of the rota pattern. Anaesthetic workforce challenges at ECT are only expected to worsen in the short to medium term, with at least two of the eight anaesthetic consultants due to retire in the next three years.

Recruitment to the small critical care unit has proved challenging as applicants worry about the long-term sustainability of the unit. ECT's ICU currently has three medical vacancies. However, the market is highly competitive, and the majority of intensive care consultants are appointed by the large teaching hospitals.

Skill maintenance and career progression is also more challenging in smaller hospitals as larger units have better opportunities to recruit and attract staff to advanced clinical practice roles.

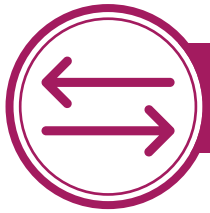
Given that the anaesthetist team at ECT also covers maternity services, the trust will struggle to comply with both critical care and maternity workforce standards in the context of the Ockenden Reports without additional investment and recruitment of staff.

The recruitment of skilled and experienced critical care nurses is also challenging, reflecting the national context. Recruitment of less experienced nurses supports numbers within the unit, however the skill mix is diluted by more junior nursing staff as they develop competence and confidence in the role. This can increase clinical risk.

Consequently, workforce resilience and sustainability are major drivers of the case for change in Critical Care.



[28]: Critical Care Services in the English NHS (2020) The King's Fund.



## The Case for Change

The focal point for the case for change in anaesthesia & critical care centres on the fragility and resilience of the anaesthetic workforce.

The small size of ECT's Intensive Care Unit makes it difficult to recruit new anaesthetists in a fiercely competitive market and staff already in post have limited time to train and develop junior members of the team. As a result, the department is unable to comply with required national workforce standards within available resources.

Clinical outcomes for patients are currently good, but there is a persistent risk to sustainability associated with subscale activity and a potential for de-skilling among staff who see such a small number of patients.

**The case for change can be summarised as follows:**

### *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.

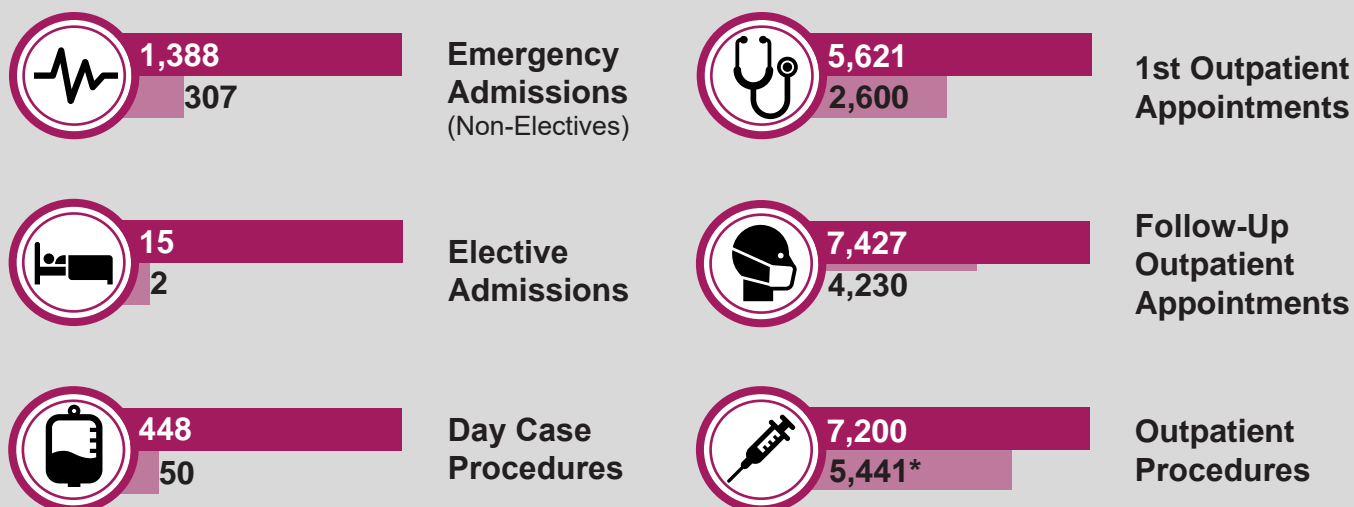
Cardiology Services offer tests, investigations, and treatment for patients with cardiac problems. Non-invasive tests such as electrocardiograms and echocardiographs are offered in most district general hospitals. Coronary angiogram is usually performed at specialist centres but specialist cardiac imaging with CT/MRI scan is increasingly replacing angiography.

Cardiothoracic surgeons, who specialise in cardiac surgery, only work at specialist centres. Many cardiac procedures which previously required major surgery can now be done in a minimally invasive fashion via a catheter inserted into the coronary arteries or into the heart cavities.

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.

The NHS Long Term Plan includes a specific focus on the prevention, diagnosis and management of cardiovascular disease (CVD), which includes irregular heart rhythms such as atrial fibrillation (AF) which can cause stroke, valvular heart disease and disorders of the heart muscle, and atherosclerosis -the build-up of fatty deposits in the arteries which increases the risk of blood clots and damage to the arteries in organs.

## Activity



● ECT    ● SFT

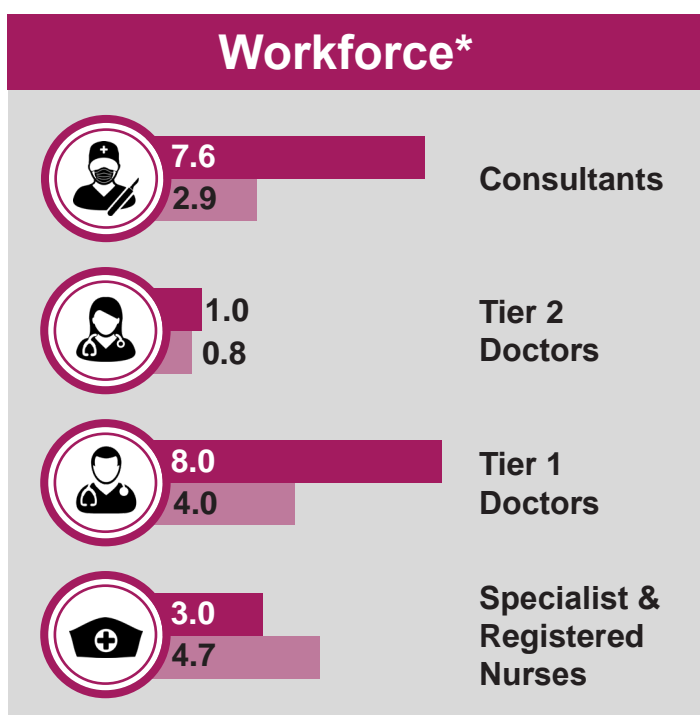
\* includes 4,500 direct access GP patients

The cardiology teams at ECT and SFT have worked collaboratively for many years to optimise cardiology pathways, with specialist centre liaison and support from MFT.

ECT has a small, highly specialised team of cardiac consultants, nurses and physiologists who offer a comprehensive range of investigations and treatments using state-of-the-art techniques and technology both at Macclesfield District General Hospital and within the community. The service sees approximately 7,800 outpatients each year. It also admits 50 patients a year for planned day case procedures and 300 patients admitted via the emergency department.

The team comprises three substantive consultants, one specialty doctor, two Tier 2 doctors who contribute to the on-call rota and six specialist cardiology nurses. It has good links with the tertiary centre at Wythenshawe with two consultants working across sites for Percutaneous Coronary Intervention (PCI) and Permanent Pacemaker (PPM) procedures. MFT provide one pacing clinic per week.

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



● ECT ● SFT \* Whole-time equivalents

The service performs standard Cardiac Diagnostic tests including dobutamine stress echocardiogram (DSE), transoesophageal echocardiogram (TOE) and pacemaker checks.

The infrastructure and facilities to support cardiac pacing procedures at ECT is suboptimal. Invasive procedures such as PPM and PCI are provided by surrounding specialist centres.

The cardiology teams work closely with the Cardio-Respiratory Department (CRD), which provides a wide range of diagnostic investigations and treatments. The cardiac rehabilitation team provide support and education for patients and is currently in the process of setting up community heart failure rehabilitation programme.

The Cardiology Department at SFT comprises eight consultant cardiologists, plus ten staff grade and junior doctors, supported by a team of three specialist cardiac nurses, physiologists and support staff.

The larger SFT service treats approximately 18,000 people each year in outpatient clinics, 1,400 emergency admissions and 450 day-case procedures. There are 28 cardiology beds at SFT - 24 beds in a shared medical ward, plus eight in a Heart Care Unit.

SFT offer inpatient and outpatient services:

- The cardiac ward provides facilities for cardiac monitoring (telemetry) and specialist patient management in the dedicated beds on this ward
- The ECG department is the focus of cardiac investigations such as echocardiography
- GPs can refer patients with certain categories of chest pain for a prompt assessment in the rapid access chest pain clinic.
- The ambulatory blood pressure monitoring service offers highly specialised evaluation of suspected hypertension and is nationally recognised for its expertise.

- SFT has a dedicated pacing suite for the pacemaker implantation service
- A rehabilitation service is provided for patients recovering from a heart attack, coronary intervention, coronary artery bypass grafting and valve surgery. This provides a comprehensive counselling service, clinic and exercise programme.

SFT benefits from a strong and cohesive

consultant team, many of whom are experts in subspecialties such as imaging, myocardial perfusion imaging (MPI), TOE and DSE.

Most consultants hold joint contracts with MFT and provide clinical sessions at the cardiac specialist centre at Wythenshawe. The service also benefits from visiting consultants from MFT running clinics at SFT, including a weekly paediatric cardiology clinic.



## Capacity & Demand

Along with many other NHS services, cardiology has been affected by the impact of the COVID 19 pandemic, with much of the elective surgical programme either paused or restricted throughout the pandemic, meaning most planned day case activity was cancelled. This has created some delays in access to treatment and the clinical teams are focused on ensuring clinically urgent patients are prioritised.

At present, some patients are waiting 24-months for follow up review, and the service is not meeting 18-week diagnostic standards. The average waiting time at SFT is currently 6.5 months.

| Standard                          | Measure   | ECT | SFT |
|-----------------------------------|---|-----|-----|
| 18 weeks RTT Standard             | 92% of patients should receive treatment within 18 weeks of GP referral       | ✗   | ✗   |
| 6-week diagnostic access standard | 99% of patients requiring ECHO should receive test within 6 weeks of referral | ✗   | ✗   |

Reducing this backlog will not be achievable within existing resources as there are not enough consultants in the ECT service.

Cardiology services are likely to face changing demand in the future, due to a combination of national and local factors:

- Both trusts have an ageing population, with increasing risk of local prevalence of cardiovascular disease.
- Both boroughs have pockets of deprivation with worse health outcomes. In addition, growing ethnic minority communities in each area experience coronary disease differently – e. g. members of the South Asian population may experience coronary problems earlier, have a higher prevalence of hypertension, and may become diabetic with a lower Body Mass Index (BMI)
- As people survive coronary disease, they continue to need long term support. It is expected that pacemaker and heart failure services will see an increase in demand in future years
- Valve clinic demand will increase as there is no prevention for the disease.
- Diagnostics which were previously seen as specialised have become more common, like CT coronary angiogram (CTCA) for patients with chest pain - both ECT and SFT have an ambition to offer this service.
- Currently neither ECT nor SFT provide a ST-segment elevation myocardial infarction (STEMI) service, although NICE guidelines recommend this should be available within three days, and it would improve inpatient length of stay if this service was provided locally.



## Quality & Outcomes

In their national review of cardiology services in 2021, GIRFT found that acute cardiology services are centred around hospitals rather than care pathways<sup>[29]</sup>, which can be detrimental to patients and risks inappropriate duplication of provision. Their recommendations encompass workforce, diagnostic and treatment services as well as timely access to specialist advice and support.

Clinical teams at both trusts have assessed compliance against the 25 recommendations shown below.

| GIRFT Measure  | ECT     | SFT     |
|--|---------|---------|
| All hospitals must deliver cardiology services as part of a defined and agreed network model.  |         |         |
| All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who is able to return to the hospital as required.   |         |         |
| All NHS consultant cardiologists should, by default, participate in an on-call rota for general and/or specialist cardiology.  | Partial | Partial |
| All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff are trained, accredited and authorised to prescribe medications relevant to their role.  | Partial | Partial |
| All outpatient referrals should be triaged with maximum use made of the Electronic Referral Service (ERS) Advice and Guidance function.  |         |         |
| For the acute chest pain pathway, all networks should provide 7/7 acute coronary syndrome (ACS) lists, accessible to all hospitals in the network. Where cardiac surgery is required, this should by de-fault be undertaken within seven days of coronary angiography. |         |         |
| In each hospital there should be a specialist consultant lead for HF, supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams, with regular joint multi-disciplinary meetings (MDMs).                              |         |         |
| All networks should ensure that rehabilitation is offered to all eligible patients, including those with HF.   | Partial | Partial |
| All networks should ensure pathways are in place for the diagnosis and management of patients with heart valve disease.  |         |         |
| Arrhythmia pathways should incorporate rapid access clinics  |         |         |
| Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review.  |         |         |
| Networks should ensure that all hospitals have ready access CTCA including CT-fractional flow reserve, with all of the images reported by appropriately trained cardiologists and/or radiologists.   |         | Partial |

[29]: Getting It Right First Time: Cardiology Report (2021). GIRFT.

| GIRFT Measure  | ECT     | SFT     |
|--|---------|---------|
| All trusts should ensure that audit teams are appropriately resourced to provide weekly uploads of data to the national cardiac registries.        | ✗       | ✗       |
| Trusts must ensure that there is regular clinical validation of coded data, especially that of co-morbidities                                      | ✔       | ✗       |
| Care pathway redesign using digital tools needs to be clinically led and patient centred.  | ✗       | ✗       |
| All networks should implement robust evidence-based prescribing guidelines which are regularly reviewed and cover both primary and secondary care. | Partial | Partial |

Neither site is compliant with NICE standard 185 on ensuring angiography within 72 hours of admission due to patients needing to be transferred to the specialist centre at MFT for CTCA and interventional procedures. Neither trust has access to onsite CTCA (NICE standard 95).

Average length of stay is around 8.8 days. The rapid transfer of patients to tertiary centres for cardiology diagnostics and care have been delayed due to non-availability of beds which is a persistent challenge





## Workforce Resilience

The national GIRFT report highlighted national challenges in workforce recruitment in cardiology and recommended that:

- recruitment into training schemes needs to be increased, particularly for cardiac physiology and the development of extended roles, including that of the advanced clinical practitioner (ACP), should be encouraged for all appropriate cardiovascular health professionals
- staff should be able to work across trusts within a network
- all NHS cardiologists should by default participate in appropriate general and/or subspeciality on-call rotas
- consultant ward rounds should be job planned and undertaken, preferably as a consultant of the week model, seven days a week reviewing all acute and longer-stay cardiology patients ensuring continuity of care; and
- appropriate diagnostic and interventional services should run seven days per week to ensure prompt access and to reduce length of stay.

The ECT medical workforce is sub scale with 2.8 WTE consultants who also contribute to clinical sessions at specialist centres. These consultants provide 1:3 on-call consultant of the week rota, where all admissions on weekdays are allocated to that Consultant, GP queries are directed to them and new referral gradings are also undertaken by them. The frequency is impacted by consultant leave and other absence and is considered onerous and undesirable in attracting any potential future applicants. Consultants do not participate in the ECT general medicine on-call arrangements out of hours, although there is a commitment to provide 1:19 on-call support for the specialist service at MFT.

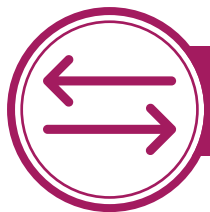
Patients admitted to the ECT cardiology ward over the weekend are managed by a team of general physicians and do not receive specialty assessment as there is no local cardiology specialty service at weekends.

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 has a strong consultant team, with consultants providing 1:6 on-call and a well-established consultant of the week rota which includes weekend cover 09:00-17:00h. However, there is a lack of flexibility outside of this rota and this was recognised in SFT's GIRFT.

The SFT consultant team includes two electrophysiologists who work out of the tertiary MFT centre. Beyond the team of consultants, there is also a strong nursing team including three specialist coronary care nurses, focused on rapid access chest pain clinics, education and training, as well as specialist support from allied health professionals.

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 MDT.



## The Case for Change

The cardiology specialty is challenged by the level of demand for consultant services and a backlog of patients waiting for clinical assessment and treatment, which cannot be managed within existing resources.

### *The case for change can be summarised as follows:*

- »» GIRFT recommendations are not being met and diagnostic access standards are not being achieved. Patients are waiting too long for consultant assessment and diagnostic services, which delays treatment.
- »» Both sites have relatively small coronary care units. These are not resourced to meet the workforce standards required and income does not cover staffing costs.
- »» The ECT service is subscale and there are not enough consultants to provide the capacity required to meet referral demand and manage the backlog of patients.
- »» The provision of cardiology specialty input out of hours, particularly at ECT, is sub optimal, with patients receiving care from general and acute physicians over the weekend.
- »» The ambition to expand services at the two trusts, for example to provide CTCA and CMR, is constrained by workforce challenges in radiology. This means patients cannot access first line diagnostic services locally, delaying care and treatment.
- »» Neither trust provides an inpatient angiography service for acute coronary syndromes, although NICE guidelines recommend this should be available within 3-days.
- »» Delays in transfer to specialist centres such as MFT for interventional procedures such as angioplasty and diagnostic CTCA impacts inpatient flow at SFT and ECT, prolonging length of stay for patients.
- »» 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.

Endocrinology encompasses thyroid disease, lipid disorders, adrenal disease, bone and calcium disorders, pituitary disease, and endocrine related effects of cancer treatment.

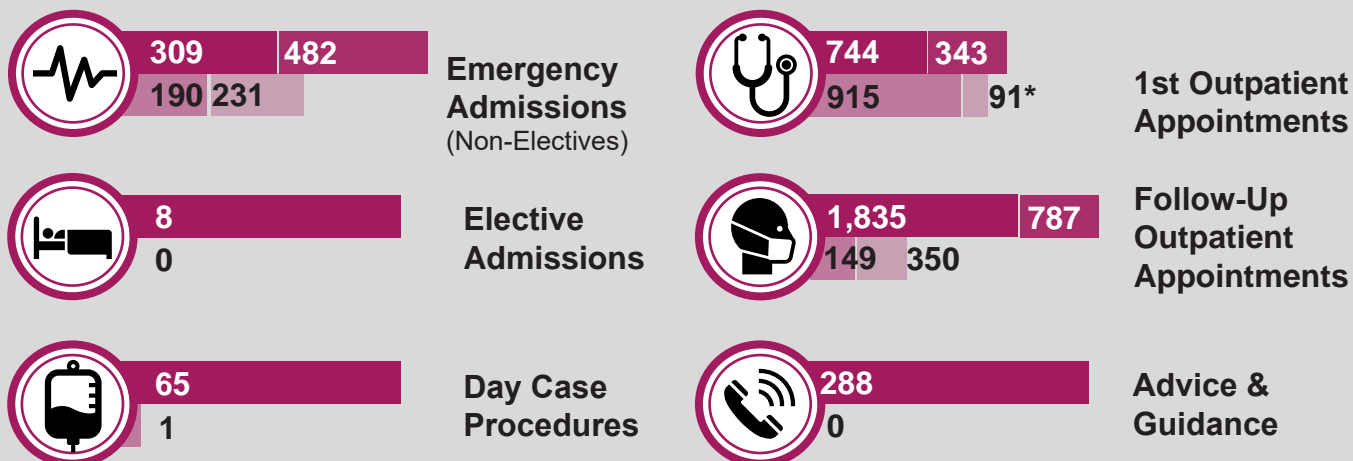
Diabetes is the most common endocrine disorder. Around 8-9% of the population of Cheshire East and Stockport have diabetes, which is broadly in line with the national average:

- Type 1 diabetes reduces the body’s capacity to produce insulin. It is irreversible and all people with type 1 diabetes need to take insulin for life.
- People with type 2 diabetes may produce insulin, but their bodies may not be able to use it effectively. It is commonly associated with obesity, physical inactivity, raised blood pressure, disturbed blood lipid levels and risk of developing clots and cardiovascular complications.
- Other types of diabetes associated with pancreatic disease or rare syndromes.

Diabetes and endocrinology physicians treat patients holistically, and increasingly work jointly with colleagues in primary and community care. The specialty is primarily outpatient based, however diabetes and endocrinology physicians are also required to support patients admitted to hospital.

Nearly 17% of all hospital inpatients at ECT and SFT 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. Patient outcomes are much improved if diabetes control is good, making urgent access and review by a specialist diabetes team essential.

## Activity



\* Diabetes outpatients for ECT relates to paediatrics

● ECT - endocrine   
 ● ECT - diabetes   
 ● SFT - endocrine   
 ● SFT - diabetes



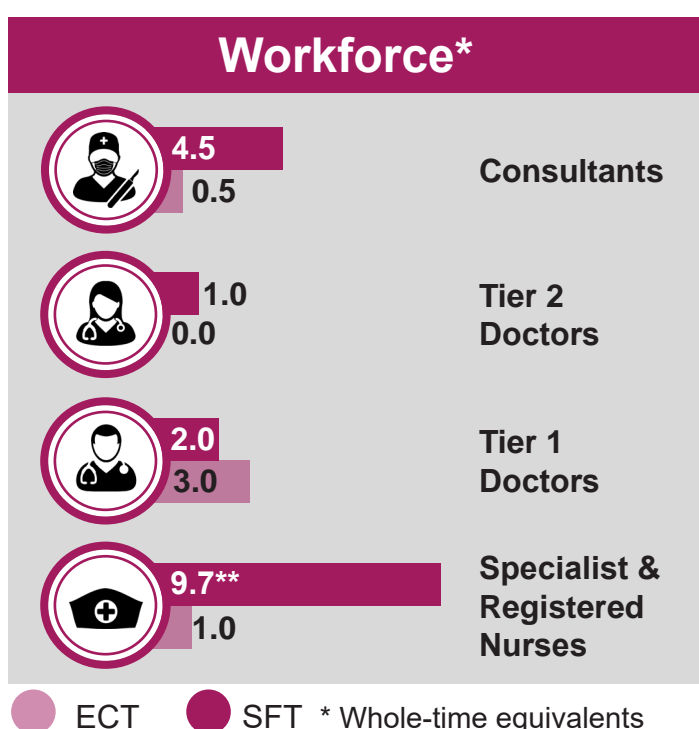
## Our Case for Change

Local diabetes and endocrinology services are commissioned differently for Cheshire and Stockport populations.

ECT provides a small endocrinology outpatient service and specialist input and review of hospital inpatients with diabetic and endocrinology conditions. ECT also provides a smaller paediatric diabetes service for around 120 patients, with approximately 10-15 new patients per year. The paediatric diabetic service is supported by a paediatrician with a special interest in diabetes who runs a monthly clinic and a tertiary endocrinologist who undertakes a joint clinic in Macclesfield four times a year.

Transition arrangements are in place to support young people aged 16-19 on insulin who are referred into adult secondary care at MFT or North Midlands. The ECT paediatric diabetes team works through the transition programme with the young person and the specialist nurse will accompany them to their first appointment in adult services. Young people who have multiple daily injections are supported to transition to the GP and specialist nurse at their practice.

In 2016, Cheshire East 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.

Since 2016, the team at ECT has largely focused on endocrinology, providing specialist care to approximately 900 new outpatients a year. The inpatient service is delivered by an experienced general medical specialty doctor, supported by general physicians in the management of emergency cases.

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

Services include:

- Diagnostic service
- Pregnancy service
- Young people's service, including transition from paediatrics
- Type 1 Diabetes service, including pump technology
- Insulin and injectable therapies for complex cases
- Patient and staff education programmes
- Diabetic foot clinic.

Most day case procedures are diagnostic tests to support outpatient investigation. Benign thyroid surgery and adrenal surgery is offered on site. Parathyroid surgery is provided at MFT and Pituitary surgery at Salford Royal.

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 for thyroid, adrenal, bone, pituitary, gonadal and metabolic medicine disorders that do not fall within the remit of the Diabetes specialty.

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



## Capacity & Demand

There is significant variation in the two services. Pre-pandemic, ECT had 422 hospital spells a year, while SFT saw 864. ECT undertook 1,505 outpatient appointments a year, compared to 3,997 at SFT.

The COVID-19 pandemic has had a significant impact on the Diabetes and Endocrinology service at SFT as clinical staff were re-deployed to support the pandemic response, the most urgent patients were prioritised to be seen by clinicians, and most outpatient appointments became either telephone or video calls. As a result, waiting lists for specialty appointments have increased.

The diabetes and endocrinology service at ECT lacks resilience and is unable to comply with

clinical standards as there is a shortfall in the capacity required to effectively manage the demand. Consequently, ECT is not currently taking any new outpatient referrals.

In terms of future demand, national data shows that the rate of diabetes is growing:

- around one fifth of inpatients at the trusts have diabetes
- both our populations are older than the national average and rates of diabetes can be 20% higher in older people
- rates of obesity have grown significantly over the last decade, increasing the risk of Type 2 diabetes
- both areas have seen a growth in ethnic minority populations, which tend to have higher rates of diabetes, even without a raised Body Mass Index.



## Quality & Outcomes

Most patients with diabetes are effectively managed in primary care and community settings by their GP and multi professional clinical teams. This case for change focuses on hospital-based provision.

Hospital patients with diabetes have higher infection rates, longer lengths of stay and higher mortality rates than people without diabetes. GIRFT<sup>[30]</sup> has calculated that the risk of developing diabetic ketoacidosis – a potentially life-threatening complication of diabetes – are between 40-60 times higher when a patient is in hospital due to lack of effective management.

National standards suggest that trusts should have a dedicated multi-disciplinary diabetes inpatient team to help patients manage their condition and reduce risk. ECT is unable to

comply with this requirement due to recruitment challenges and the sub scale service which comprises a single-handed consultant and specialist nurse.

Neither trust currently provides a seven-day service with at least one multi-disciplinary team member, such as a specialist diabetes inpatient nurse available for part of the day on Saturday and Sunday. Evidence shows that 7-day diabetes inpatient nursing helps reduce excess length of stay.

Both sites have developed an electronic system for notifying inpatient nurses of patients who are admitted with a known diagnosis of diabetes, however this relies on the diagnosis being communicated within the referral from primary care.







[30]: Getting It Right First Time: Diabetes Report (2021). GIRFT.

SFT has networked point of care glucose monitoring and ketone monitoring which enables remote triage of patients. When a patient attending ED tests positive for ketones, the inpatient diabetes team will go to the ED and support staff to manage the clinical risks.

Mandatory training in management of insulin is in place at both trusts.

SFT has implemented a perioperative pathway,

including the secondment of a diabetes surgical nurse, which has improved recording of HbA1c, blood glucose checking in the ward, theatre and recovery, a significant reduction in hypoglycaemia from 12% to 9%, a reduction in hyperglycaemia from a mean of 4.4 events to 2.7. There was also a decrease in diabetes related complications (14% to 4%) and the risk of wound healing-related complications also reduced from 5% to 3%.

| Measure  | ECT   | SFT   |
|--|---|---|
| Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.  | Only compliant 5 days a week  | Only compliant 5 days a week  |
| People with diabetes are assessed for psychological problems, which are then managed appropriately.  |   |   |
| People with diabetes with or at risk of foot ulceration receive regular review by a foot-protection team and those requiring urgent medical attention are treated by a multidisciplinary foot-care team within 24 hours. | Only compliant 5 days a week  | Part-Pathway  |
| People with diabetes admitted to hospital are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin.      | Only compliant 5 days a week  | Only compliant 5 days a week  |
| People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.   |  |  |
| People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.  |  |  |



## Workforce Resilience

ECT's diabetes and endocrinology service is sub scale and has functioned with a single-handed consultant for several years. The low volume of patients seen by the service makes it difficult to attract, recruit and retain consultants. The trust currently has no substantive consultant in post and has been unsuccessful in repeated recruitment efforts, relying on locum cover since 2019.

Feedback from prospective candidates suggests that a single-handed post is unattractive to potential applicants and the service is perceived to be under resourced due to scale of service. The ECT post does not include diabetes outpatients, which may discourage applicants. The requirement for this post to participate in the trust's general medical on call rota is also seen as a major challenge.

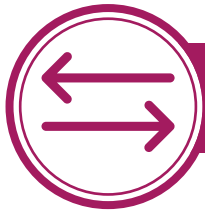
The loss of clinical continuity, skills, knowledge and expertise at consultant level has impacted the wider team and increased pressure on service delivery. Discussions are taking place with SFT to urgently explore opportunities for closer collaborative working and peer support for the single specialist nurse.

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. Community based services are well prepared to support patients with diabetes, but will increasingly require support from acute providers in overcoming the more complex challenges of therapeutic options including insulin pumps and continuous blood sugar monitoring.

In comparison to ECT, the SFT service has a more resilient workforce:

- over the last 10 years the service has grown from 2 to 4.5 consultants
- the service runs a Consultant of the Week model (COW) which is seen as ideal
- there is increasing inpatient activity and skills development has been protected
- the ward-based nursing team are highly skilled and knowledgeable in the care of patients with diabetes and endocrinology conditions.



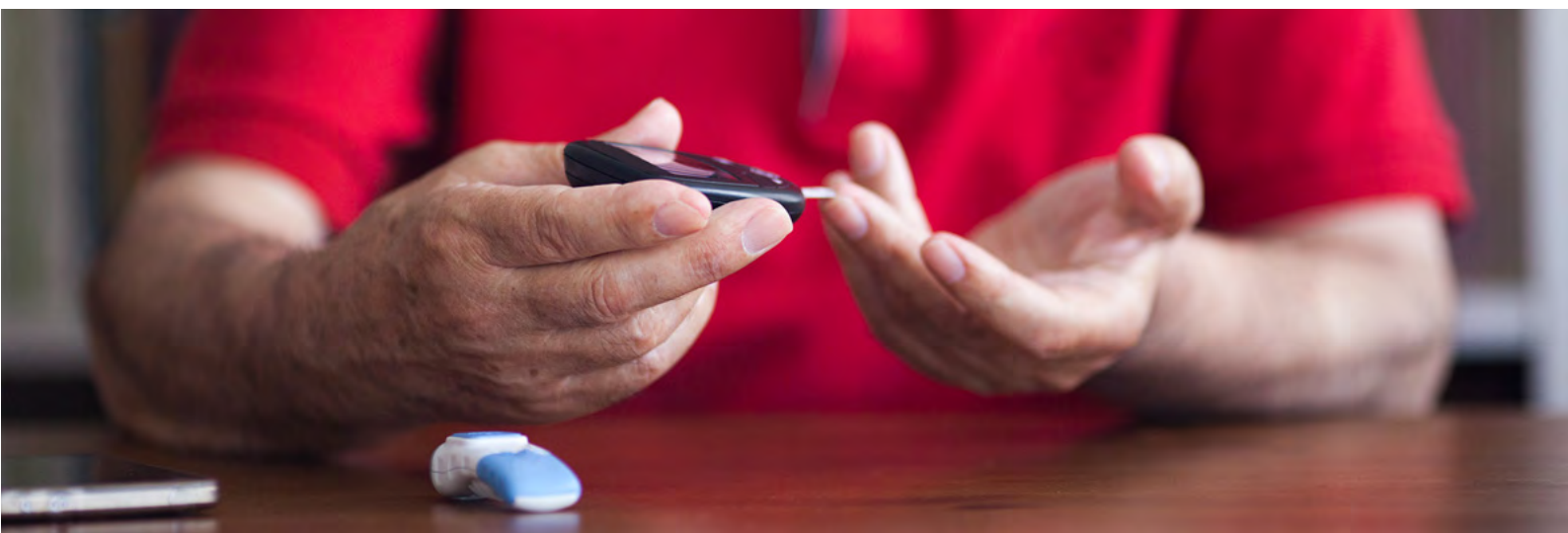


## The Case for Change

The case for change in diabetes and endocrinology relates predominantly to the size of the service at ECT and the pressures this places on recruitment, retention and training of a small team.

*The case for change can be summarised as follows:*

- »»» Around one in six hospital inpatients has diabetes and rates in the local population are likely to increase in future years due to ageing demography with increased lifestyle risk factors. By working together we will be able to prepare for this more effectively.
- »»» The ECT service model is sub scale with a single-handed consultant post that has proved impossible to recruit to, resulting in the service relying on a series of consultant locums in recent years. This has impacted continuity and limited the opportunity to develop the service and optimise pathways of care. The service is currently closed to new referrals and partnership working is essential to maintain local provision.
- »»» Recruitment to specialist posts is challenging at both sites and there are opportunities to more effectively align workforce resources and capacity across secondary, community and primary care as much of the ongoing care and support is delivered out of hospital.
- »»» Clinical standards for inpatient care are not being consistently achieved on either site and there is an opportunity to strengthen specialist MDTs to ensure specialist advice and input is accessible for inpatients with diabetes 7 days per week.
- »»» Secondary care provision prioritises care delivery around the needs of frail elderly patients, and there is an opportunity at both sites to enhance the care of younger people with type 1 diabetes and offer a more locally accessible service for those patients who currently have to travel out of area.



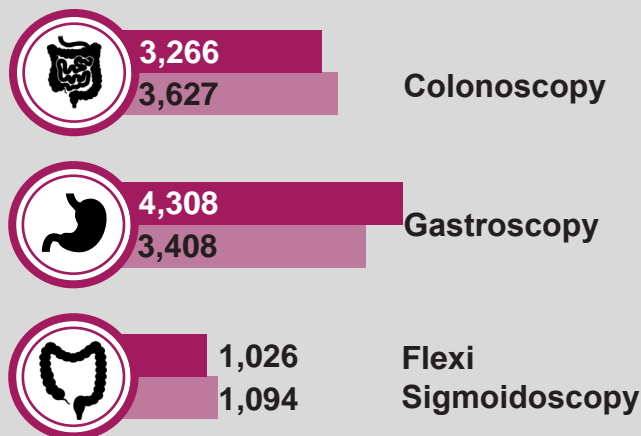
# 5.4 Endoscopy

Endoscopy is a procedure where organs inside the body are examined using an instrument called an endoscope. An endoscope is 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 (duodenum), to investigate problems such as difficulty swallowing or persistent abdominal pain; diagnose conditions such as stomach ulcers or reflux; and to treat conditions such as bleeding ulcers, a blockage in the oesophagus, polyps or small tumours.
- **Colonoscopy:** used to look at the rectum and colon. The procedure is used for routine cancer screening in people aged over 50. Small growths (polyps) can be removed during the colonoscopy before they have the opportunity to develop into a colorectal cancer.
- **Flexible Sigmoidoscopy:** used to look inside the lower part of the bowel and check for ulcers, polyps or other abnormalities.
- **Bronchoscopy:** used to look at the airways and upper part of the lungs where there are unexplained symptoms related to the chest, such as persistent cough, coughing up blood, wheezing, hoarseness, noisy breathing, or shortness of breath.
- **ERCP:** Endoscopic retrograde cholangiopancreatography is used to look at the biliary tree pancreatic duct and to remove gallstones from the bile duct.

This review focuses on upper and lower GI procedures that are undertaken by the clinical teams in general surgery and gastroenterology.

## Activity



| Available Weekly Sessions by Specialty (Mar-21) | ECT       | SFT       |
|---|-----------|-----------|
| Gastroenterology                                | 12        | 15        |
| General Surgery                                 | 9         | 11        |
| Nurse Endoscopists                              | 1         | 7         |
| Respiratory (Bronchoscopies)                    | 2         | 1         |
| Bowel Screening                                 | 2         | 0         |
| ERCP  | 1         | 3         |
| Unallocated                                     | 6         | 0         |
| <b>Total Sessions</b>                           | <b>33</b> | <b>37</b> |

● ECT   ● SFT

## Our Case for Change

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. Single-sex sessions are undertaken for elective patients by a medical team from general surgery and gastroenterology with nurse endoscopists. However, there are six endoscopy lists each week that cannot be staffed due to a lack of skilled endoscopists, especially in colonoscopy.

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.

Capacity is very challenged with 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 has been procured at weekends through waiting list initiatives and use of private sector providers. This has had a positive impact on waiting lists, but at significant additional cost.

Out of normal working hours, patients requiring emergency endoscopy are managed in the main theatres.

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 runs single-sex lists and has an eight-bed recovery area with one private cubicle for emergency other sex patients.

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

Endoscopy staff provide nursing support in radiology as required for insertion of colonic and upper GI stents as well as assistance to theatre staff during emergency GI endoscopy procedures. Out-of-hours emergency endoscopy is performed by the on-call gastroenterology consultant and on-call endoscopy nurse, supported by theatre staff.

The department provides training for both medical and nursing staff.



\* Whole-time equivalents

● ECT ● SFT



## Capacity & Demand

Demand for endoscopy services has been growing over recent years due to expansion of the national bowel cancer screening programmes and ageing populations. The Richards review<sup>[31]</sup> of diagnostics in the UK found that demand for gastroscopy procedures is growing by 3% a year, colonoscopy activity is increasing by 5.3% a year and demand for flexible sigmoidoscopy has grown by 8.4% a year and is expected to continue for the next three to five years.

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

ECT is unable to meet the current level of demand within its core workforce capacity and the expected growth in demand in future years will only exacerbate the situation. The service is reliant on additional sessions provided at an increased cost at the weekend to achieve urgent access standards, despite having six weekday endoscopy sessions available.

SFT's endoscopy unit is too small for the current levels of activity and relies on the use of additional space in theatre for extra capacity. Development of a 4th endoscopy room is expected to be completed in summer 2022, however this is still unlikely to meet future demand increases. During the pandemic, the number of telephone assessments increased significantly, however access to suitable office accommodation is extremely limited.



## Quality & Outcomes

The Joint Advisory Group on Gastro-Intestinal endoscopy (JAG) is responsible for accreditation of endoscopy units against a set of standards and quality framework.

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.

Plans to reapply for JAG accreditation were constrained by the backlog of patients waiting for endoscopy and ongoing challenges of segregating patients in the small recovery area as a result of the COVID-19 pandemic.

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

The impact of measures associated with COVID-19 pandemic has further increased waiting times at both trusts, however, this backlog of cases should not adversely impact on JAG accreditation, if waiting lists are validated and a recovery plan is in place.

[31]: DIAGNOSTICS: recovery and renewal (2020). Professor Sir Mike Richards

[32]: Impact of the COVID-19 pandemic on UK endoscopic activity and cancer detection (2020). Rutter et al.





### Workforce Resilience

ECT is unable to meet current levels of demand with its core workforce and relies on additional weekend sessions to meet activity levels. To meet future demand, both ECT and SFT teams have indicated that they would need to recruit three additional gastroenterology consultants. However, the ability to recruit skilled and competent endoscopists is a significant challenge.

It is anticipated that seven-day working is likely to be required within core job plans.

The current on-call rota for emergency GI bleeds at ECT out of hours is unsustainable. Though consultants are only called in around 10 times a year, the on-call rota is likely to impact on the trust's ability to recruit new consultants.

ECT's ERCP service consists of just one consultant, providing one session a week. Urgent access to ERCP is available 7 days via an integrated service arrangement with MFT, whereby patients are transferred to Wythenshawe when the ECT consultant is unavailable.

SFT is unable to support a seven-day ERCP service in line with NHS 7-day standards as there are limited nurses and doctors who are skilled in this area, requiring patients transfers for urgent cases.

Recruitment of nurse endoscopists has been extremely challenging for ECT. SFT have recruited eight new nurses, and training is being provided on an ongoing basis.



### The Case for Change

The case for change in endoscopy is driven by growing activity and significant workforce challenges at both sites, though this is more pressing at ECT.

**The case for change can be summarised as follows:**

- » Demand for endoscopy is increasing year on year due to the ageing population and extension of screening programmes and this growth is expected to continue.
- » Additional endoscopy capacity is likely to be required but this is reliant on the availability of workforce skilled in endoscopy.

- » The services are unable to meet current service demand within existing resources and are heavily reliant on private sector capacity at additional cost.
- » It is anticipated that seven-day working is likely to be required within core job plans.
- » Emergency ERCP services are not currently provided on either site 7 days a week. This needs to change to support earlier diagnosis and improve hospital flow.
- » 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<sup>[33]</sup>. Liver disease has continued to rise steadily for decades, while deaths due to cancer or heart disease have decreased. It is the biggest cause of death in people aged between 35 and 49, and the third leading cause of death before the age of 75.

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). Some will have had additional training in hepatobiliary endoscopy (ERCP) or small bowel endoscopy (wireless capsule endoscopy or enteroscopy). Most gastroenterologists are dual accredited, meaning they can practice general medicine as well as their own specialty.

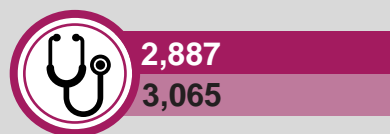
This specialty is highly investigative, using blood tests, X-rays, scans and endoscopy to identify clinical problems. Teams support patients with a range of conditions such as:

- Inflammatory Bowel Disease – Crohn’s disease and ulcerative colitis
- Hepatitis – inflammation of the liver caused by viruses (hepatitis A-E), alcoholic liver disease, and autoimmune liver disorders, where the body attacks its own cells
- Upper Gastrointestinal Cancer – for the monitoring, management and treatment of disease
- Gastrointestinal symptoms and issues – including fibroscans to assess liver fibrosis, and hydrogen breath tests to assess lactose intolerance/ bacterial overgrowth.

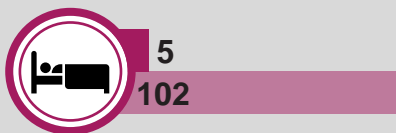
## Activity



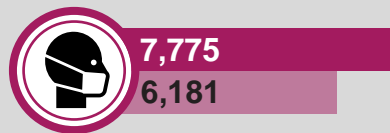
**Emergency Admissions**  
(Non-Electives)



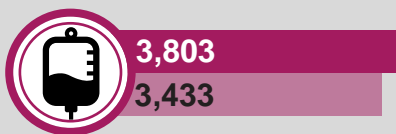
**1st Outpatient Appointments**



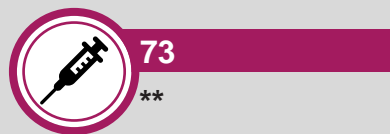
**Elective Admissions**



**Follow-Up Outpatient Appointments**



**Day Case Procedures**  
(incl. endoscopy)



**Outpatient Procedures**

\* Non-electives for Gastroenterology are admitted under General Medicine and not coded separately  
 \*\* Outpatient Procedures at ECT are included in the Day Case figures

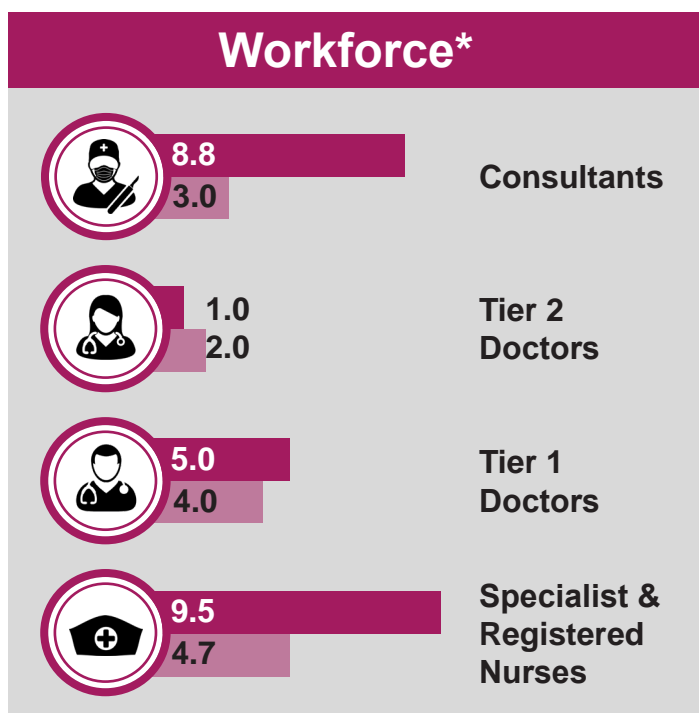
## Our Case for Change

Gastroenterology services at ECT incorporate a collaborative medical and surgical approach to the prevention, diagnosis and treatment of gastrointestinal diseases including cancer and support for patients. The aim is to provide a patient focused approach.

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. The service benefits from a highly skilled and dedicated MDT including consultants, gastroenterology specialist nurse and endoscopy specialist nurses, supporting provision of:

- Endoscopy
- Fibroscans
- Inflammatory bowel disease management
- Hepatology including viral hepatitis
- Nutrition support and dietetics
- Gastroenterology inpatient ward
- Cancer pathway
- Gastroenterology outpatient services

Most gastroenterology procedures are delivered as day cases. ECT has a 28-bed gastroenterology inpatient ward located on the first floor of the main hospital building.



● ECT ● SFT \* Whole-time equivalents

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

- liver service - providing diagnostic and treatment facilities for patients with alcoholic liver disease, autoimmune liver disease, hemochromatosis and fatty liver disease;
- inflammatory bowel disease; and
- day-case diagnostic facilities for endoscopy and liver biopsy.

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.

The innovative service has developed:

- specialist pathways to support rapid access IBD, rapid access jaundice, and coeliac pathway
- a new Fibro scan service;
- a pancreatitis clinic will be piloted in the coming months
- a 24h GI bleed rota in partnership with Tameside General Hospital
- capsule endoscopy, enabling patients to access cancer testing from home with four recorders to support the whole of the South East Sector
- a nurse-led Medical Day Case Unit, reducing bed days by focusing on early assessment and intervention; and
- collaborative pathways with primary care.

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. A specialty triage process is in place to ensure that gastroenterology patients are placed on the dedicated ward to prevent general medical admissions to the ward.



## Capacity & Demand

National data suggests that demand for gastroenterology is rising at an unprecedented rate. Even pre-COVID-19, GIRFT identified extensive variation in waiting times nationally – for example, waiting times for a new patient appointment in a gastroenterology clinic varied from 1 to 27 weeks.

Growing demand for both diagnostic and therapeutic endoscopy exceeds available capacity. Lifestyle factors such as diet and alcohol consumption mean an increasing proportion of the population is at risk of gastro-intestinal disease. Many conditions that previously required surgical intervention, such as gastrointestinal bleeding or removal of some colonic polyps, can now be assessed and treated using endoscopy. And the drive for earlier cancer diagnosis, including the introduction of more screening tests has put a significant pressure on gastroenterology services.

In 2019, a survey by the British Society of Gastroenterologists (BSG)<sup>[34]</sup> demonstrated that 61% of hospitals ran endoscopy lists on a Saturday, and 34% on a Sunday just to meet growing demand. SFT and ECT are both heavily reliant on outsourcing and insourcing endoscopy at weekends to meet the increased demand from outpatient referrals and there is a need to increase weekend services further to meet growing demand.

Some of the recent growth in activity relates to the impact of COVID-19:

- implications of COVID-19 infections, e.g. abdominal pain
- virtual clinics requesting more investigations









- backlog of patients not presenting with issues during the pandemic and an associated increase in urgent two-week access referrals
- increase in the prevalence of liver disease as a result of high alcohol consumption during lockdown.

Although the pandemic caused a temporary reduction in referral rates into both services, demand is rapidly returning to pre-pandemic rates. The pandemic also resulted in rapid service transformation, with many outpatient clinics moved to virtual or telephone appointments. This change is broadly seen as a positive development, in line with the NHS Long Term Plan and is expected to continue.

Gastroenterology beds often come under pressure from other medical specialities, limiting capacity and impacting on waiting times for patients. There is aspiration within the ECT service to ring-fence some elective beds for gastroenterology patients in line with the model at SFT, but this has not yet been achieved. 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% (see table over page).

Length of stay at ECT is impacted by delays in transfers of care to community settings. Where inpatient ERCP is required, delays arise because there is only one on site ERCP list each week. Improvement in length of stay (LOS) at both SFT and ECT could be achieved if a gastroenterologist reviewed complex specialty patients on admission instead of a general physician.

[34]: The shape of gastroenterology services in the UK in 2019 (2020) British Society of Gastroenterologists

| Standard   | Measure   | ECT   | SFT   |
|--|---|---|---|
| 2-week access standard (93%)                         | Maximum 2 week wait to see a specialist for all patients referred with suspected cancer symptoms                |  |  |
| 62-day cancer pathway standard (85%)                 | Maximum 62 day wait from urgent referral for suspected cancer to the first definitive treatment for all cancers |  |  |
| 18-week referral to treatment pathway standard (92%) | Maximum 18 week wait from time of referral to consultant-led treatment  |  |  |
| No 52 week waits                                     | Zero patients waiting more than 52 weeks from referral to first treatment                                       |  |  |





















## Quality & Outcomes



IBD UK<sup>[35]</sup> is a partnership of 17 professional bodies, royal colleges and patient organisations working together to improve care and treatment for everyone affected by Inflammatory Bowel Disease. Their main aim is to ensure that everyone with IBD has consistent, safe, high-quality personalised care, wherever they live in the UK, and core standards have been developed to support this. Clinical teams have self-assessed compliance and are fully committed to continually improving the quality of care provided.

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

[35]: <https://ibduk.org/about-ibd-uk>

| Standard                              | Measure  | ECT   | SFT   |
|---------------------------------------|--|---|---|
| IBD UK<br>Statement 2.2               | Patients who are referred with suspected IBD should be seen within four weeks, or more rapidly if clinically necessary   |    |    |
| IBD UK<br>Statement 2.3               | Patients presenting with acute severe colitis should be admitted to a centre with medical and surgical expertise in managing IBD that is available at all times  |    |    |
| IBD UK<br>Statement 3.1               | All newly diagnosed IBD patients should be seen by an IBD specialist and enabled to see an adult or paediatric gastroenterologist, IBD nurse specialist, specialist gastroenterology dietitian, surgeon, psychologist and expert pharmacist in IBD as necessary  |    |    |
| IBD UK<br>Statement 3.4               | After diagnosis, all outpatients with IBD should be able to start a treatment plan within 48 hours for moderate to severe symptoms and within two weeks for mild symptoms  |    |    |
| IBD UK<br>Statement 4.3               | Rapid access to specialist advice should be available to patients to guide early flare intervention, including access to a telephone/email advice line with response by the end of the next working day  |  |  |
| IBD UK<br>Statement 6.1               | Patients requiring inpatient care relating to their IBD should be admitted directly, or transferred within 24-48 hours, to a designated specialist ward area under the care of a consultant gastroenterologist and/or colorectal surgeon   |  |  |
| IBD UK<br>Statement 6.4               | Children and adults admitted as inpatients with acute severe colitis should have daily review by appropriate specialists.  |  |  |
| 7 day Services<br>Clinical Standard 2 | All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.   |  |  |
| 7 day Services<br>Clinical Standard 8 | All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. |  |  |



# Workforce Resilience

Recruitment and retention of gastroenterologists has been highlighted as a concern nationally, with 45% of consultant gastroenterologist posts unfilled in a very competitive market<sup>[36]</sup>. The consultant workforce gap in gastroenterology was identified in the 2021 GIRFT report, which references the Royal College of Physicians previous guidance that six WTE gastroenterologists are required per 250,000 population. It also acknowledged that this did not take into account the creation of the national bowel screening programme, the increase in six- or seven-day services, or the steady increase in liver disease. It is therefore likely that this number now needs to be higher.

Reflecting the national situation, local gastroenterology services rely on staff working additional hours at an enhanced rate (insourcing) and outsourcing to private sector providers. This means that expanding the workforce to match growing demand is not currently possible.

Two of the three ECT consultants currently work a job plan that exceeds 13 programmed activities (PAs) per week. This exceeds recommended job plans and exacerbates the risk to individual resilience and wellbeing. The RCP Consultant Wellbeing Survey in 2020 indicated that gastroenterology has the highest risk of burnout with worse mental wellbeing scores.

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

[36]: Workforce Report 2020 (2021) The British Society of Gastroenterology

Gastroenterologists may take on some general medicine work, but over time it is recommended that this should be reduced wherever possible as the associated workload impacts consultants' capacity to manage gastroenterology cases. Enabling ECT clinicians to withdraw from the on-call rota would require the appointment of three additional general or acute physicians.

SFT has seen high consultant turnover rates, in part because the service is constantly evolving, but also because of competition for staff from larger specialist centres nearby.

The ECT team identify workforce resilience as a major concern. With only three consultants it is difficult to deliver a comprehensive service and there is a lack of capacity to reduce the current backlog of patients. A business case is currently under development to expand the nursing, consultant, and non-clinical support, however this is reliant on the ability to recruit.





## The Case for Change

The case for change in gastroenterology primarily relates to the year-on-year increase in outpatient and inpatient referral demand against a background of significant workforce challenges.

*The case for change can be summarised as follows:*

- »» Demand for gastroenterology has increased significantly over recent years.
- »» Clinical standards for 14h consultant review are not being achieved at either site.
- »» SFT and ECT are both heavily reliant on outsourcing and insourcing endoscopy at weekends to meet the increased demand from outpatient referrals.
- »» There is variation in how and when complex inpatients receive specialty review, with no specialty input to wards at the weekend at ECT. It is likely that this is adversely impacting length of stay.
- »» Outpatients are waiting too long for specialist assessment and treatment, and access standards are not being achieved.
- »» There are persistent difficulties in recruiting to consultant posts nationally and locally, which is impacting workforce resilience of substantive consultants, associated with lack of capacity and the additional burden of insourcing.





# 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<sup>[37]</sup> relates to common conditions of the gall bladder and hernia repair.

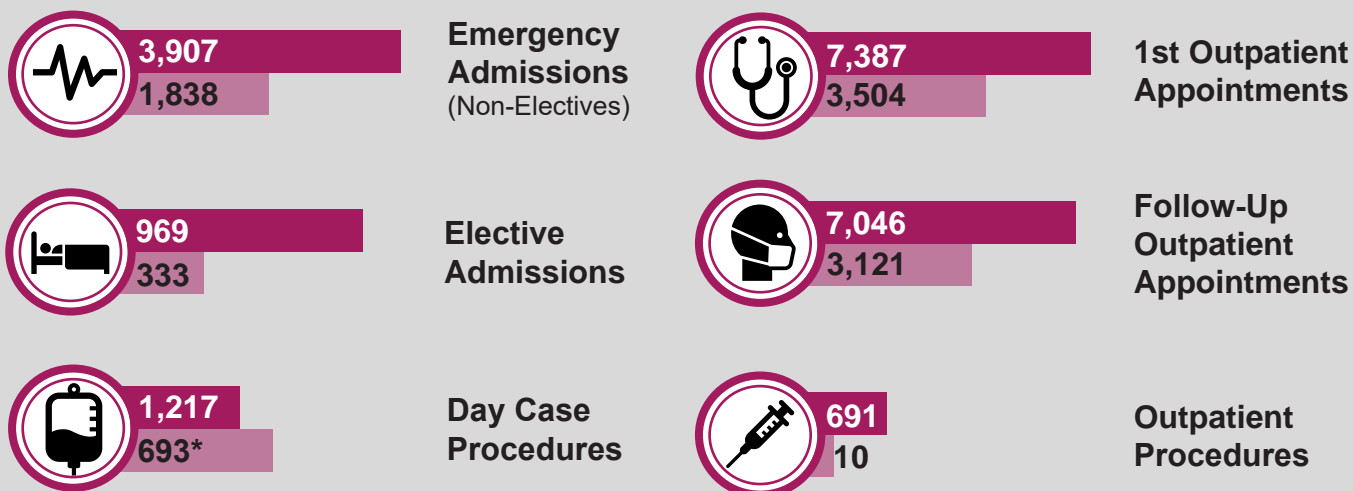
Acute abdominal pain is the most frequent symptom for emergency attendances requiring surgery. Common conditions requiring emergency surgery include appendicitis, strangulated hernia, cholecystitis, bowel obstructions and bowel perforations.

Laparoscopic, or minimally invasive surgery – also known as ‘key hole surgery’ – is now widely used within general surgery. These techniques are popular with patients as there is less scarring, a shorter recovery time and improved outcomes.

Both ECT and SFT currently offer a range of general surgery services for both planned and emergency procedures. Both services are rated as ‘good’ by the CQC.

Neither trust provides services in relation to upper GI cancer, bariatrics, endocrine or transplants. Highly specialised operations for cancer are usually undertaken in regional specialist units such as The Christie. Transplant surgery including kidney and liver transplantation is also undertaken at specialist regional ‘tertiary’ centres in Liverpool and Manchester for kidney and Leeds for liver transplants.

## Activity



\* ECT's day case figures do not include the 2,823 endoscopic procedures undertaken in the Endoscopy Treatment Unit – these numbers are covered in the Endoscopy review.

● ECT ● SFT

[37]: <https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/general-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 - 13 for planned surgery and 21 for emergencies with a further 12 surgical day-case beds available.

Most planned procedures at ECT are performed as a day case (67%). ECT has a purpose-built Surgical Treatment Unit (STU) which includes a standalone theatre and recovery area, enabling efficient management of day case procedures.

One of the seven theatres at ECT is reserved daily for emergency general surgery. In line with best practice, emergency surgery is performed within normal working hours wherever possible.

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.

\* Whole-time equivalents

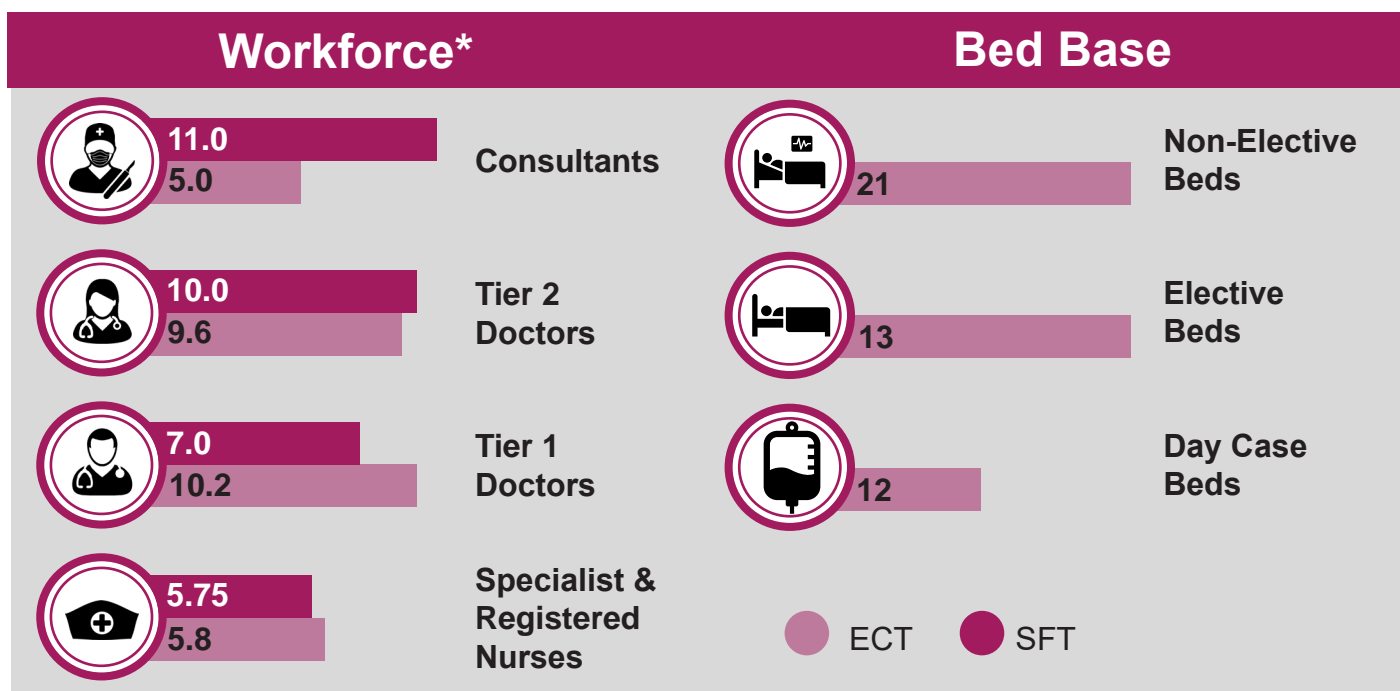
SFT is the designated specialist hub for general surgery in the South East Sector of GM. It has 11 consultants, with eight specialising in colorectal surgery and three specialising in benign upper GI surgery. Paediatric surgery is delivered by one of the consultants alongside visiting surgeons from Manchester Children's Hospital. SFT also has a general surgeon who undertakes robotic assisted surgery.

Stepping Hill Hospital has 16 main operating theatres and two maternity theatres, 11 of which are laminar flow. The hospital also has a standalone day case facility for minor procedures only requiring local anaesthetic. General surgery is allocated 23 elective theatre sessions per week. However, access to routine surgery has been significantly disrupted by the COVID-19 pandemic.

Emergency general surgery is provided 24/7. One of the hospital's 16 theatres is dedicated to emergency surgery.

The general surgery team offer 16 outpatient clinics per week at Stepping Hill and two clinics a month from Buxton. SFT also runs a GP advice and guidance service.

According to the National Emergency Laparotomy Audit (NELA) SFT is one of top four trusts in the country for mortality rates.





## Capacity & Demand

The size of service at ECT means it is more challenging to balance capacity and demand.

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.

Investment in a purpose-built 'Same Day Emergency Care' (SDEC) Unit has recently been completed, which provides surgical assessment capacity adjacent to the ED. There is a very low volume of patients requiring emergency general surgery overnight, but it is still necessary to ensure a fully equipped and staffed emergency theatre is available when needed.

Elective inpatient surgery workload is also very low in volume (333 per year) and managed on a separate ward alongside surgical day case patients. Only a small number of patients remain on the ward overnight. The ability to flex capacity to treat more elective inpatients is constrained by available beds which are shared for day case activity.

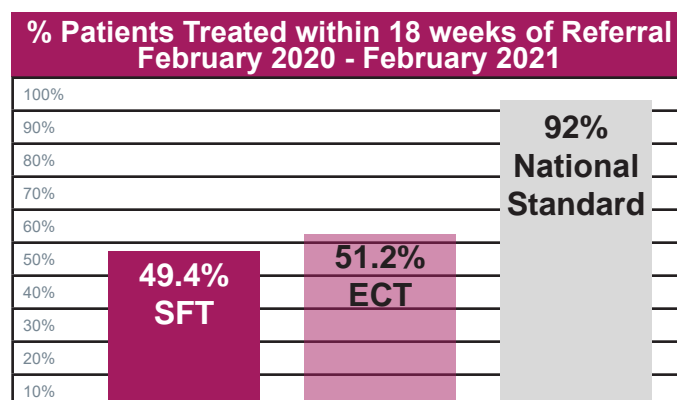
Having a small critical care unit means that ECT is not always able to meet the surgical standard for post-operative care in higher risk surgical patients.

Access to essential clinical support services is more challenging in smaller hospitals. For example, access to interventional radiology at ECT is inconsistent because of persistent workforce shortages. As a consequence, drainage of abscesses may be delayed and patients may need to be transferred to other sites.

Endoscopic Retrograde Cholangiopancreatography (ERCP) is carried out by only one gastroenterology physician at ECT, limiting capacity to a single list each week. At all other times patients must be transferred off site to another unit.

SFT has a significant backlog of planned surgical procedures, with more patients waiting over 52 weeks than ever before.

In the year to February 2021, just 51.2% of ECT patients and 49.4% of SFT patients were treated within 18 weeks of referral. This situation is mainly due to the temporary cessation of non-urgent inpatient activity during the COVID-19 pandemic.



Recovery of performance to the national standard of 92% of patients being treated within 18-weeks of referral is likely to be very challenging at both sites as GP referrals – particularly for suspected cancer - are increasing.



## Quality & Outcomes

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

| National Emergency Laparotomy Audit 18/19                 | National Mean | AHSN* | ECT   | SFT   |
|---|---------------|-------|-------|-------|
| 30 day risk adjusted mortality                            | 9.3%          | N/A   | 12.1% | 2.4%  |
| CT reported by radiology consultant before surgery        | 62%           | 65%   | 71%   | 40%** |
| Risk of death documented before surgery                   | 84%           | 91%   | 97%   | 82%   |
| Arrival in theatre within appropriate timescale           | 83%           | 82%   | 86%   | 89%   |
| Consultant surgeon in theatre (risk of death $\geq 5\%$ ) | 96%           | 98%   | 98%   | 98%   |
| Admitted to critical care (risk of death $\geq 5\%$ )     | 86%           | 86%   | 59%   | 85%   |
| Unplanned return to theatre (crude value)                 | 5%            | 4%    | 7%    | 4%    |
| Postoperative length of stay (number of days)             | 16            | 18    | 14    | 14    |

\* Academic Health Science Network

\*\* SFT outsources much of its radiology reporting. This activity, which is reported by a radiology consultant, is not included in NELA audits





Both ECT and SFT perform well across the suite of metrics included in the National Bowel Cancer Audit (NBOCA). Clinical analysis indicates some slight variation in practice and outcomes with potential for improved patient outcomes:

- Higher rates of laparoscopic surgery at ECT
- Higher rates of robotic surgery at SFT
- Average 90-day risk adjusted mortality outcomes for ECT and good outcomes at SFT.

| National Bowel Cancer Audit 18/19                        | National Mean | GM Mean | ECT  | SFT  |
|--|---------------|---------|------|------|
| No. patients having major surgery according to the Audit | -             | -       | 78   | 107  |
| Laparoscopic surgery attempted (%)                       | 72            | 62      | 67   | 44   |
| Adjusted 90-day mortality (%)                            | 2.9           | 2.7     | 3.5  | 1.7  |
| Risk adjusted length of stay $>5$ days (%)               | 62            | 66      | 71   | 79   |
| Adjusted 30-day unplanned readmission rate (%)           | 11.8          | 12.6    | 13.6 | 16.6 |
| Proportion of patients who underwent APER (%)            | 24            | 31      | 28   | 6    |
| Proportion of patients who underwent Hartmanns (%)       | 10            | 5       | 11   | 25   |
| Adjusted 18-month ileostomy rate using HES/PEDW (%)      | 28            | 29      | 54   | 40   |

Neither service is fully compliant with the 7-day clinical standards, which require all patients to be reviewed by a consultant within 14 hours of admission.

- In ECT, this is due to the small workforce of just five consultants, where ten consultants are recommended to support compliance.
- SFT does not have a routine evening ward round. However, SFT have introduced a 'straight to CT' approach that ensures that the right patients are admitted to general surgery sooner, enabling some of the benefits of the 14-hour review standard.
- SFT's weekend on call consultant covers the emergency theatre as well as all surgical wards.

| 7 Day Services Standard - 90%        | Measure  | ECT Compliance  | SFT Compliance  |
|--------------------------------------|--|---|---|
| Clinical Standard 2                  | All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.   |  |  |
| Clinical Standard 8 - ongoing review | All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. |  |  |



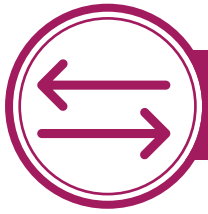
## Workforce Resilience

The general surgery service at ECT has a small consultant workforce. As a consequence, consultants work a high frequency of on-call shifts (1:5), which does not offer the work life balance some surgeons may be seeking. If a consultant were absent, left or retired, the trust may struggle to recruit a replacement. This would increase the pressure on the remaining consultants and the trust would need to pay more for locum cover – neither of which is a sustainable solution.

At SFT the consultant rota has become more onerous and demanding, with increased activity and operational pressures impacting the wider team. The junior doctor rota at SFT is shared with the urology service, which also supports patients from East Cheshire and Tameside. Trainees work a 1:9 rota, which presents a challenge at weekends, when there is only one registrar, often making the workload unmanageable.

Both sites recognise the added value that specialist nurses bring to the surgical team. Not having suitable people in post also affects cancer targets, and national bowel cancer audit results.

A collaborative approach to workforce planning could help address these weaknesses by providing cross-cover arrangements and improving overall service resilience to surges in demand.



## The Case for Change

The case for change in General Surgery largely relates to the sub-scale service at ECT, but also includes challenges meeting clinical standards at both sites and the significant impact of the COVID-19 pandemic on waiting times for surgical procedures.

East Cheshire has relatively small numbers of emergency laparotomies and major elective procedures, making it difficult for consultants to maintain skills. To achieve the necessary standards, significant investment would be needed in general surgery. Instead, a different way of delivering surgical care is required.

### The case for change can be summarised as follows:

- »»» The small number of general surgery consultants at ECT makes the service clinically un-sustainable, particularly in relation to the on-call rota.
- »»» The intensity of the consultant rota at SFT is becoming more challenging over time and additional workforce capacity is required.
- »»» Additional specialist nurse roles are required at both sites, but trained staff are not readily available in an increasingly challenged nursing workforce market.
- »»» The level of demand for emergency surgery overnight is low at ECT, but emergency theatre facilities and skilled staff must be readily accessible and available when needed. This is not making best use of the resources we have available to optimise patient care.
- »»» Robotic assisted surgery is rapidly advancing but cannot be delivered without sufficient scale given its cost and complexity.
- »»» Surgical sub-specialisation is likely to continue for certain colorectal procedures, which will further decrease the number of patients undergoing colorectal cancer surgery at ECT.
- »»» 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 to RMCH for general surgery, which SFT has insourcing pathways. Working together could provide a better service for local children.
- »»» Specialist support services, such as interventional radiology and ERCP, are not consistently available, requiring patients to be transferred between sites for services that should be available where surgery is taking place.
- »»» The current allocation of beds for surgery does not effectively meet the needs of the service. Additional medical specialty beds would ringfence capacity for planned procedures and reduce the frequency of cancelled operation. However, sufficient space is not available on the current estate.
- »»» Both trusts have a growing backlog of patients waiting for elective surgery as a result of temporary service suspensions during the COVID-19 pandemic, 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 techniques, equipment, radiotracers, and interventional expertise. It has contributed significantly to improvements in healthcare by providing accurate and measurable findings which inform and guide most medical treatments. Many clinical specialties are dependent on radiology services for the diagnosis, prognosis, treatment and monitoring of disease progression or recurrence.

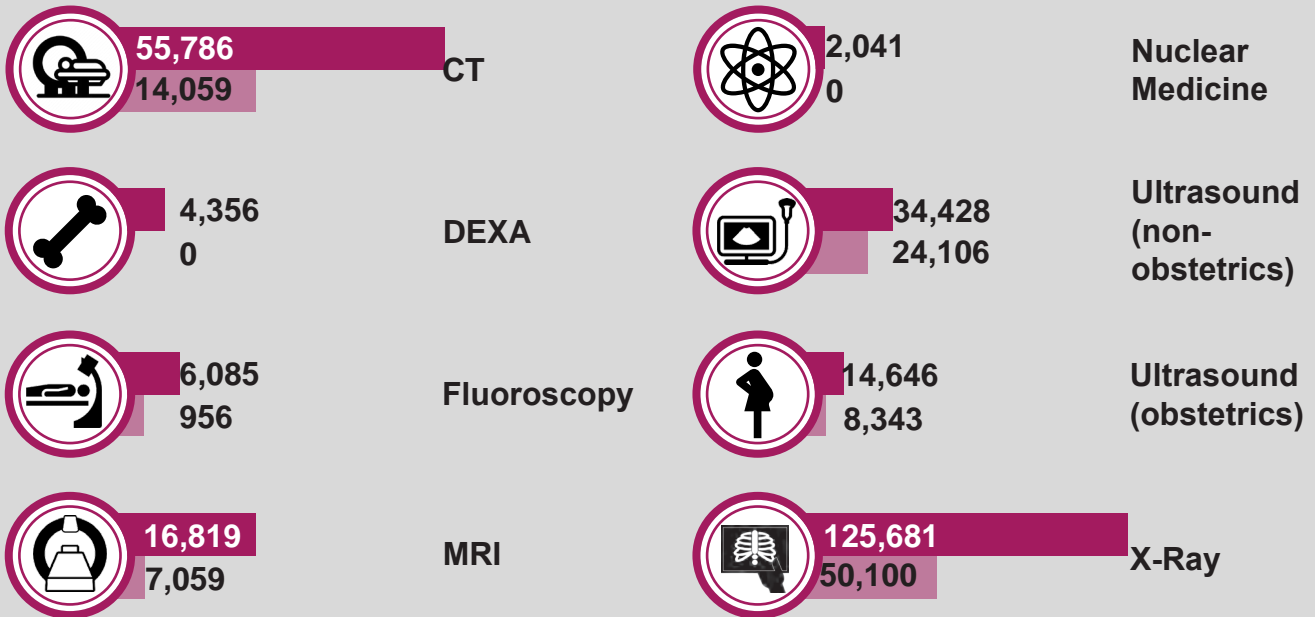
Radiology encompasses a variety of imaging techniques, including:

- **Computerised Tomography (CT):** a scan that uses X-rays and a computer to provide cross sectional imaging of inside of the body;
- **Dual Energy X-ray Absorption (DEXA):** to diagnose or assess the risk of osteoporosis;
- **Fluoroscopy:** specialist X-ray procedures such as barium meals and barium enemas;
- **Interventional Radiology:** where specially trained radiologists use a range of treatment techniques, guided by real-time images, which can avoid the need for surgery and help to ensure that treatment is given as accurately as possible;
- **Magnetic Resonance Imaging (MRI):** which uses strong magnetic fields to produce cross-sectional images of the inside of the body, providing detail without the use of radiation;
- **Nuclear Medicine:** where injected radiopharmaceuticals travel round the body and bind to targeted areas which are then imaged, allowing the observation of blood flow and other changes such as heart stress tests;
- **Screening:** tests such as mammography for early diagnosis of disease;
- **Ultrasound Scans (US):** ultrasonic imaging without radiation; and
- **X-Ray:** used to look at bones, joints, and some soft tissues.

Advanced imaging technology allows for treatment options ranging from traditional radiotherapy treatments of cancer growths, 'hybrid imaging' fusing imaging and targeted radiopharmaceutical treatments, through to 'Radiomics', which uses artificial intelligence to further enhance imaging data and diagnostic accuracy. New state of the art technology is continually being introduced and both departments have fully replaced analogue X-ray equipment with quicker digital imaging equipment which has enhanced the quality of imaging and assisted with patient flow.

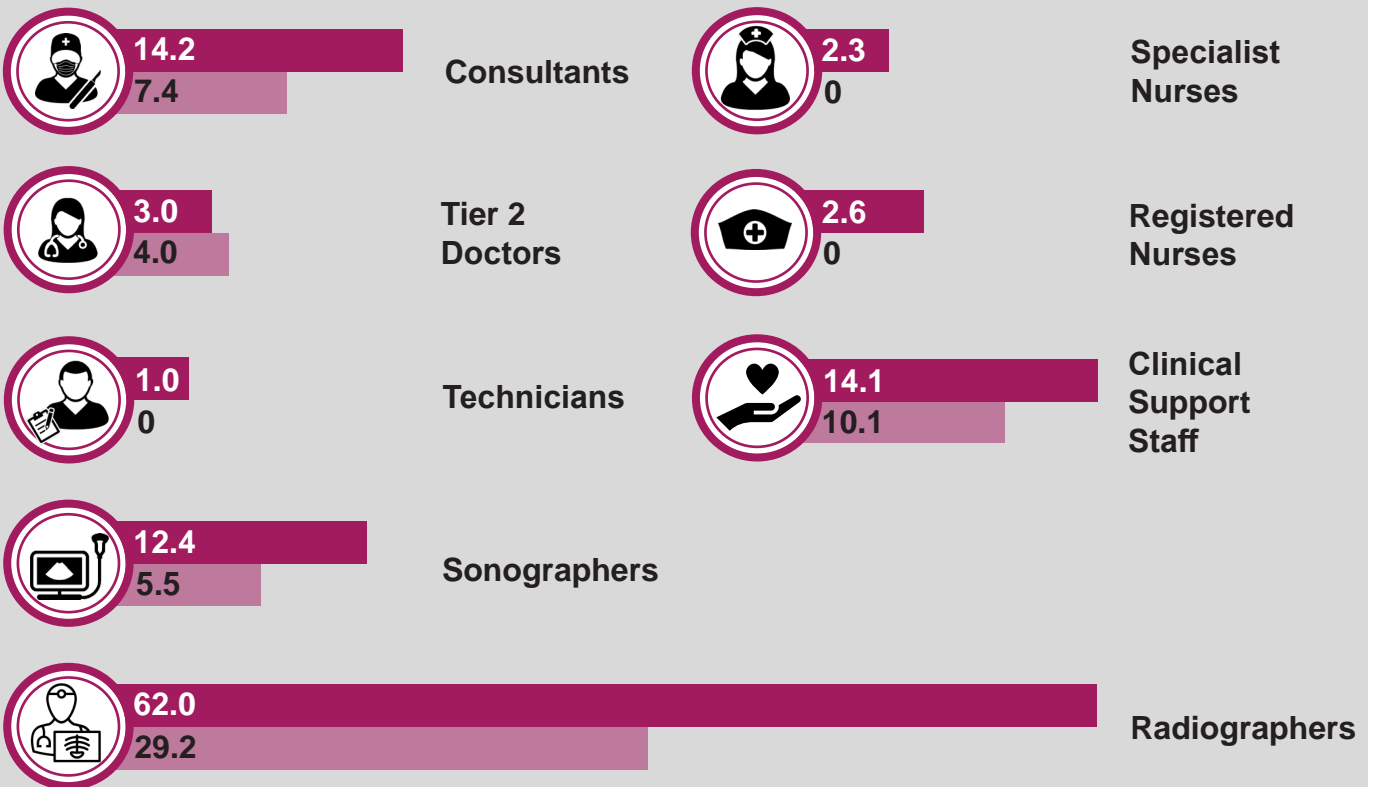
Both sites have a Picture Archive Communication System (PACS) digital archiving solution, which allows all radiological images to be stored digitally, eliminating the need to store X-ray film and allowing clinicians to view the images both in the hospital and remotely. However, the two trusts use different PACS systems, so images are not directly transferrable between teams.

## Activity



● ECT ● SFT

## Workforce\*



● ECT ● SFT

\* Whole-time equivalents



## Current Service

Imaging services at ECT are led by a team of 7.4 WTE 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.

Both sites provide:

- General & Emergency radiography;
- CT scanning;
- Fluoroscopy;
- Interventional Radiology;
- Magnetic Resonance Imaging; and
- Ultrasound scanning - abdominal, musculoskeletal & obstetric.



In addition, SFT also provides:

- DEXA scanning;
- Radionuclide imaging - Nuclear Medicine;
- Non-vascular Interventional radiology ; and
- Dental radiography for GP, dental clinics and emergency patients.

Both hospitals have recently invested in imaging equipment. ECT now has two CT scanners and upgraded ultrasound facilities, however there is only one MRI scanner, limiting capacity. SFT now has five CT scanners and two MRI scanners.

ECT's imaging services are also provided at three peripheral sites: Knutsford District Community Hospital, Congleton War Memorial Hospital, and Handforth health clinic. All three deliver ultrasound services, with X-ray facilities in Knutsford and Congleton.

ECT provides the NHS breast screening services for the populations of Crewe, Cheshire East and Stockport. The Victoria Breast Unit at ECT has two mammography machines and 3 Ultrasound machines, providing diagnostic imaging for patients attending screening and symptomatic breast care services. A mobile unit also delivers breast screening in the Stockport area.

SFT provides DEXA scanning for both the populations of Stockport and Tameside.

The COVID-19 pandemic impacted provision of imaging services with some short-term reduction in capacity, largely due to workforce availability challenges. Both services already support remote reporting options, with consultants having access to home-based technology. In addition, reporting for out of hours emergency CT scans at ECT is outsourced to private sector providers to maximise consultant day-time availability.



## Capacity & Demand

Across the country, demand for NHS imaging services has been growing year on year and the NHS's Getting It Right First Time (GIRFT) report in 2020 acknowledged that radiology services are struggling to keep pace with demand<sup>[38]</sup>. In 2012/13, there were just over 35 million radiological examinations performed across the NHS in England. By 2018/19, that had risen to over 43 million. The fastest growth has been in the more complex modalities – MRI and CT. This means that some patients are waiting too long for essential diagnostic tests and this pattern of growth is expected to continue.

SFT is a stroke centre and has a large orthopaedic department which both create significant demands on radiology services. The trust also undertakes DEXA scans for Tameside and East Cheshire, with higher volume activity than any other trust in GM, which has made compliance with access standards very challenging.

Changes in clinical practice have been highlighted as drivers of increasing demand. Radiology is being used earlier and more extensively in the diagnostic pathway and imaging is central to a growing number of screening programmes and health checks. The development of 'same day emergency care' services (SDEC) has placed additional pressure on already stretched radiology services as additional real time capacity is required. The development of optimal timed pathways for several cancers, e.g. lung and prostate, require more scans, delivered earlier. Straight-to-test pathways, such as SFT's acute abdominal process, have been successful in reducing waiting times in the ED and inpatient admission, but have increased CT referrals. And the expansion of national screening programmes has increased demand for imaging services.

ECT's radiology department delivers around 105,000 scans a year, while SFT undertakes almost 260,000 procedures a year.

The impact of COVID-19 has increased demand for follow up CT scanning. In addition, delays in routine appointments have resulted in a significant increase in urgent cancer referrals. Both trusts are experiencing increased demand for MRI scans as part of the elective recovery programme and recovery of cancer standards post-lockdown which is expected to continue for some considerable time.

In addition, the use of interventional radiology (IR) is expanding, offering precise and minimally invasive life-saving treatments as an alternative to surgery, such as complex biopsies, the insertion of a catheter to unblock a kidney (nephrostomy) or blocking a blood vessel to stop bleeding (embolisation). Given the urgency of these procedures, the ideal situation would be for this service to be made available 24/7 in all hospitals, however IR is highly specialised and neither trust is currently able to provide 24/7 access to IR procedures in-house due to a lack of access to day case beds within the radiology department. In addition, ECT does not have the required nursing staff within the radiology workforce to support interventional patient care.

The future development of community diagnostic centres (CDCs) may relieve pressure on acute hospitals, but there will continue to be a requirement for radiologist expertise and input as well as wider specialist roles, which will place an additional burden on the workforce. Additionally, these should increase demand for other specialities as patients will be treated earlier in the disease pathway.

[38]: Getting It Right First Time: Radiology Report (2020). GIRFT



## Quality & Outcomes

The imaging services at ECT and SFT meet most of the clinical standards set out by the Royal College of Radiologists (RCR), with the exception of the standards highlighted below.

| Standard   | Measure  | ECT Compliance | SFT Compliance |
|------------|--|----------------|----------------|
| BFCR(18)1  | Standards for interpretation and reporting of imaging investigations – 10% of images should be peer reviewed                             |                |                |
| BFCR (17)1 | Standards for providing a 24-hour interventional radiology service   |                |                |
| GIRFT 2020 | All radiology services should have access to dedicated facilities to admit and discharge day case patients for interventional procedures |                |                |

Peer review of reported images is recommended by the RCR, but is very challenging to deliver with increasing rates of demand. Dual reporting is currently in place only for breast services. Quality assurance is provided for cancer pathways via Multi-Disciplinary Team reviews and via clinical review meetings for orthopaedics. While there is no national target, both services also monitor the time it takes to report results of scans to the referring clinician. The teams have developed local performance indicators and work collaboratively to share good practice.

The rapid cessation of all but the most urgent imaging during the COVID-19 pandemic significantly reduced the number of images for reporting, supporting most trusts to eliminate their reporting backlog. 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 waiting more than 13 weeks for imaging. However, clinical teams have identified increasing pressure as elective recovery continues, particularly in non-urgent imaging. Without further action performance is likely to deteriorate.

| Standard                      | Measure  | ECT Compliance | SFT Compliance |
|-------------------------------|--|----------------|----------------|
| 6-week access standard        | 99% of patients will have imaging assessment within 6 weeks of referral for test |                |                |
| 13-week access to diagnostics | 0% patients wait longer than 13 weeks for diagnostic test                        |                |                |

Earlier diagnosis is a key part of improving cancer survival rates. The NHS Long Term Plan aims to transform cancer care so that from 2028, 75% of cancers will be diagnosed at an early stage and an extra 55,000 people each year will survive for five years or more following their cancer diagnosis. The Faster Diagnosis Standard (FDS) requires patients to be diagnosed or have cancer ruled out within 28 days of referral. This means that people with cancer can begin their treatment as soon as possible. However, rapid access to imaging and reported results will increase pressure on imaging services and impact on the ability to deliver quality standards.



## Workforce Resilience

Nationally, there is a significant shortage of trained imaging professionals. This has a knock-on effect at both trusts, with ongoing vacancies that are hard to recruit to. While the ECT team has 56.2 whole-time equivalent (WTE) staff in post, the budget is for 61.4 WTEs, with unfilled vacancies in consultant, specialty doctor and radiographer roles. At SFT, there are 111.6 whole-time equivalent staff in post, however the imaging budget is for 132.6, with a particular gap in the number of consultants and radiographers.

Both trusts are committed to training and developing their staff, including extended and enhanced roles. However, retention of highly skilled staff is extremely challenging in the current workforce market and staff are attracted to specialist diagnostic centres and higher paid roles.

In addition, the radiologist workforce at both trusts is becoming increasingly fragile as a number of consultants approach retirement age. Consultants working past standard retirement age often opt for reduced hours, limiting capacity that radiologists have to supervise additional trainees and develop aspiring consultants. Recruitment efforts have had limited success, reflecting the national shortfall. Consultant gaps are currently covered by internal locums at SFT and outsourcing of reporting at ECT, however this is not financially sustainable.

The consequence of this situation is that both organisations rely heavily on the private sector for out-sourcing and insourcing radiological reporting.

Outsourcing is a common method used by trusts to reduce reporting backlogs by sending images electronically to an external provider, where radiologists report on these images. It is commonly used overnight, especially at smaller trusts, as this means the hospital's radiologists are not required to work night shifts and will therefore be available in the department during the day.

Insourcing is when a trust brings in locum providers or pays their own staff on top of their contract for additional capacity – usually at weekends or evenings. However, this can lead to staff burnout.

The hospitals would like to move this activity back in-house but are limited by a lack of capacity due to low numbers of radiologists. NHS England estimates that over the next five years an additional 2,000 radiologists and 3,500 radiographers will be required<sup>[39]</sup>. Addressing the shortfall requires an integrated approach to the use of extended roles and advanced practice.

Coronary CT angiograms are currently conducted at Wythenshawe hospital for both trusts. Demand for this minimally invasive test - predominantly used for patients with angina - is increasing rapidly. Both hospitals' cardiology services are keen to offer a local service, but while the hospitals have the high-resolution CT scanning equipment required to do the test, there is limited capacity for specialist reporting, or upskilling staff.

Further challenges exist in recruiting and training dedicated radiology nurses. While there are recognised shortages of nurses across the NHS, the lack of dedicated radiology nurses impacts the delivery of specialist procedures such as Interventional Radiology.

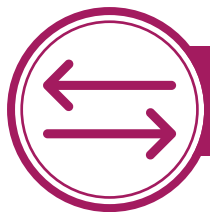
Both trusts take part in national apprenticeship schemes, but struggle to backfill roles while staff are training.

The national development of Community Diagnostics Centres (CDC), in response to the Richards Review<sup>[39]</sup> aims to provide additional diagnostic capacity. Until more imaging staff have been trained, this will only put additional pressure on the existing workforce.

GIRFT recommends that all trusts move to a network model of service delivery in line with the NHS strategy<sup>[40]</sup> to optimise workforce capacity, skills and access to training.

[39]: DIAGNOSTICS: recovery and renewal (2020). Professor Richards

[40]: Transforming Imaging Services (2019) NHS



# The Case for Change

The case for change in imaging is based on the overwhelming increase in demand for radiological imaging and intervention, coupled with the national and local shortage of radiologists.

### The case for change can be summarised as follows:

- »» 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.
- »» New consultants are increasingly attracted to larger specialist centres with opportunities to sub-specialise .
- »» 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.
- »» The two sites are restricted in their ability to share imaging results due to their different PACS systems.
- »» Demand will continue to grow according to national predictions and if action is not taken waiting times will be impacted, especially for non-urgent patients.
- »» The further expansion of radiographer roles is constrained by recruitment and retention challenges.
- »» Development of CDCs is likely to increase demand for imaging staff, further adding to recruitment and retention issues.
- »» 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, and the parts of the body that enable movement – ligaments, tendons, muscles and nerves. T&O surgeons assess and treat injuries such as fractured bones or dislocated joints, as well as congenital and degenerative conditions of the musculoskeletal system. Common procedures include: telescopic joint examination (arthroscopy); bone fracture repair; joint replacements (arthroplasty); general repair of damaged muscle or tendons and corrective surgery.

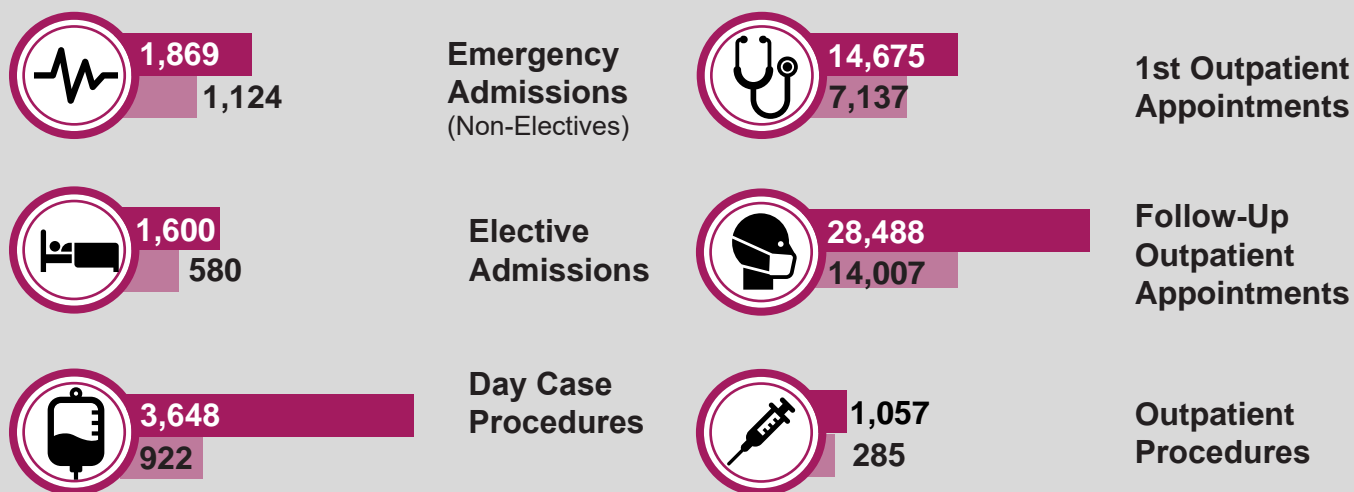
Major trauma describes serious and often multiple injuries that may require lifesaving interventions and is the biggest cause of death in people under 45 years in the UK. The designated major trauma centres the North West (for patients with severe life-threatening trauma) are located at University Hospital North Midlands, Salford Royal Hospital, Manchester Royal Infirmary, the Royal Manchester Children’s Hospital, Alder Hey Children’s Hospital and Aintree University Hospital.

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.

ECT and SFT are both members of the Greater Manchester Orthopaedic Alliance (GMOA), bringing together clinicians, academics and service providers in Greater Manchester to improve services, education, training and research.

Both trusts offer planned and emergency trauma and orthopaedic services and are rated as ‘Good’ by the CQC.

## Activity



● ECT   ● SFT

## Our Case for Change

The ECT service comprises eight consultants:

- three sub-specialise in hip and knee surgery
- one in hip knee, foot and ankle surgery
- one in knee, foot and ankle surgery
- two in shoulder, elbow and hand surgery
- one sub-specialises in hand surgery.

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. Orthopaedic surgeons have access to five laminar flow theatres on the Macclesfield site with 16 elective lists and seven trauma lists each week. A dedicated outpatient facility with x-ray, plaster and treatment rooms provides nine orthopaedic and fracture clinics a week. The service also provides virtual clinics each week, where medical notes and x-rays are reviewed electronically without the patient being present in the clinic.

ECT is designated as a Local Emergency Hospital and does not routinely receive patients with life-threatening trauma. Pathways are in place to ensure that 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 or Salford Royal; joint replacements are carried out at SFT or Wrightington Wigan & Leigh NHS Foundational Trust (WWL); and patients with bone tumours are referred to a specialist bone tumour unit.

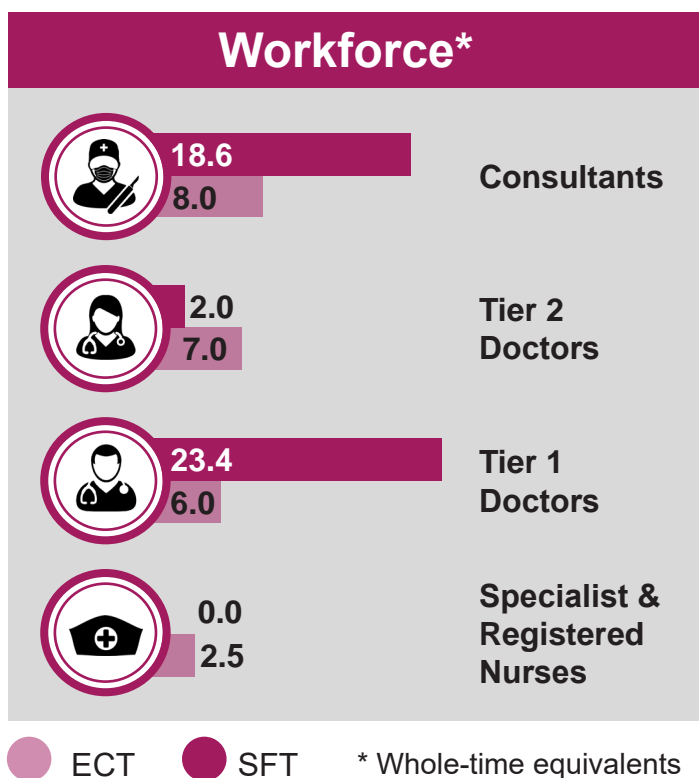
SFT's T&O team includes 20 consultants:

- four sub-specialise in knees
- three sub-specialise in hips
- one in lower limb arthroplasty
- three sub-specialise in hands
- three sub-specialise in shoulders
- two sub-specialise in foot and ankle; and
- four sub-specialise in spinal surgery.

SFT is a designated Emergency Trauma Unit. It has 15 main operating theatres and two maternity theatres - 11 of which are laminar flow. Minor procedures which only require a local anaesthetic are undertaken in a day case facility with a small operating theatre and six trolley beds. Orthopaedic surgeons have one dedicated trauma theatre each day, and 48 elective theatre sessions per week, including five elective/trauma 'acute' lists. Core bed capacity comprises 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.

Outpatient clinics are delivered largely from one dedicated outpatient clinic suite, close to x-ray and plaster room facilities. Fracture clinics run Monday to Friday with general fracture and sub-specialty appointments. A daily virtual fracture clinic is in place, including at weekends - the elective outpatient service delivers much of its follow up activity virtually via telephone and video-conferencing facilities.

Stockport's T&O service also runs a community tier 2 orthopaedic assessment service, led by allied health professional (AHP). The service also operates a GP advice and guidance service, and patient initiated follow up (PIFU) pathways.





## 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.

Activity varies throughout the year and the ability to deliver elective orthopaedic inpatient care is significantly impacted by emergency bed pressures during the winter period. From December to April inpatient T&O surgery is reduced significantly as elective beds are occupied by acute medical patients. This has a significant impact on waiting times and both sites struggle to effectively ring-fence bed capacity for elective orthopaedics.

In 2019/20 90.7% of patients at SFT and 65.55% at ECT were treated within the target 18 weeks of referrals. Trauma and Orthopaedics was one of the most severely affected specialties during the COVID-19 pandemic and by February 2021, this performance had reduced significantly to just 60.6% at SFT and 35.72% at ECT.

Both ECT and SFT have a significant backlog of patients waiting for planned T&O procedures. In February 2021 575 patients across the two hospitals had been waiting over a year for planned T&O surgery, compared to just nine before the pandemic.

| Period        | Measure  | Target | ECT    | SFT    |
|---------------|--|--------|--------|--------|
| 2019/2020     | Number of patients treated within 18 weeks of referral             | >92%   | 62.55% | 90.70% |
|               | Number of patients waiting more than 52 weeks for elective surgery | 0      | 9      | 0      |
| February 2021 | Number of patients treated within 18 weeks of referral             | >92%   | 35.72% | 60.60% |
|               | Number of patients waiting more than 52 weeks for elective surgery | 0      | 364    | 211    |







## Quality & Outcomes

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

Stockport performs strongly on the National Joint Registry (NJR) clinical outcomes for hip and knee surgery. The service is above average for hip revision rates and one of the best in the country for knee revision rates.

The Royal College of Physicians benchmark study for 2020 showed ECT was in the top performance quartile nationally with 69.8% of cases meeting best practice criteria. SFT performs well against the Best Practice Tariff (BPT) measures for hip, knee, and spinal surgery. ECT's monthly performance for the hip fracture BPT quality indicator has improved

in recent years to a 12 month average of 68.5%, while SFT's performance ranged between 50-55%.

Neither service is currently delivering national clinical standards on 7 day services:

- ECT consultant job plans include on-site presence on weekend mornings only, as it is not cost effective to roster evening consultant cover on site given the low volume emergency activity
- SFT have one consultant on call at the weekend. This consultant is resident onsite in the daytime but is also allocated to the all-day trauma operating list. It is not possible for this one consultant to review ward inpatients at the same time.

| Standards                     | Measure   | ECT (SCU)                           | SFT (LNU)                |
|-------------------------------|---|-------------------------------------|--------------------------|
| 7 Day Services Standard 2     | All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital | N/A as not a designated Trauma Unit |                          |
| Best Practice Tariff          | Hip fracture Best Practice Tariff (BPT) Quality indicator   | Monthly variance 50%-68%            | Monthly variance 32%-57% |
| NICE Clinical guideline CG124 | NICE guidelines for hip fracture management recommend orthogeriatrician assessment as part of a multi-disciplinary management approach.   |                                     |                          |

Despite repeated recruitment attempts, neither site has appointed a specialist orthogeriatrician to support the care of older people who have suffered a fracture, in accordance with NICE guidelines. This has a direct impact on average length of stay (LOS) for patients. The national average LOS is approximately 17 days but is 2.5 days longer at SFT and 4 days longer at ECT.

Length of stay in hospital for orthopaedic patients is also impacted by delays in transfer of care to community rehabilitation and intermediate care.

In the past year, LOS for hip fractures has reduced nationally, largely driven by COVID-19 and increased efforts within health care systems to facilitate early discharge, which may not be sustainable in the context of national workforce challenges.

New clinical requirements mean that knee revisions should be carried out at major revision centres for complex cases (either WWL or Broadgreen) or at revision units, such as SFT.



## Workforce Resilience

Orthopaedic services at ECT and SFT are relatively stable, and recruitment is less challenging than in other specialties. However, both services have been challenged in providing access to an ortho geriatrician. This is a key constraint in achievement of best practice tariff for fragility fractures, with performance across the trusts at around 50%.

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.

Access to out of hours spinal MRI scanning to exclude serious conditions requiring urgent surgical intervention is challenging at both sites due to a lack of suitably trained radiographers.

This can mean that patients must be sent urgently to Salford Royal Hospital for diagnostic scan.

National guidance suggests that to maintain skills, surgeons should undertake at least 35 total hip replacements a year<sup>[41]</sup>. Both trusts are well above this volume. For lower limb revision rates, surgeons should be carrying out 20 procedures per year. Due to low volume of patients requiring revision arthroplasty, ECT clinicians are unable to maintain surgical skills (operating on around seven patients each year). Consequently, patients are referred to SFT or WWL for surgery. Clinicians have also highlighted the opportunity to strengthen resilience and improve patient pathways by collaborating in low volume areas of complex ankle joint surgery.

<sup>41]</sup>: GIRFT National report (2015) GIRFT



## The Case for Change

The case for change in the trauma and orthopaedics relates to increasing demand and the impact of the COVID-19 pandemic on the specialty. If we do nothing, it is predicted that waiting lists at both sites will continue to increase, as a lack of ring-fenced beds for elective orthopaedics at both sites means that cancellations are inevitable when hospital capacity is stretched.

Given the significant number of local people who have already waited over a year for elective T&O surgery, the implications of the status quo are unacceptable for our patients.

### The case for change can be summarised as follows:

- »» Patient access standards are not being met and patients are experiencing prolonged periods of pain and discomfort while waiting for hip and knee surgery. With an older population, demand for trauma & orthopaedics has been and will continue to grow and there is an opportunity for the skilled clinical teams to collaborate on sustainable solutions that meet the needs of both populations
- »» Too many patients are already experiencing long waits for surgery. Ring-fencing bed capacity for elective orthopaedics could alleviate the pressure.
- »» 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. A larger clinical service is more likely to attract interested applicants.
- »» There is no green site - or COVID-free environment without the competing pressures from emergency patients - for elective patients across Stockport and East Cheshire and private provider capacity is already saturated. Working together on a joint solution which would benefit all patients is more likely to gain support for the capital investment that would be required for this.
- »» New clinical requirements mean that knee revisions should be carried out at revision units or major revision centres, which would be beneficial for patients and make best use of collective capacity.

# 5.9 Women & Children

Women’s & Children’s is a wide-ranging area of healthcare that focuses on treating conditions affecting women’s reproductive healthcare and children. Services are generally divided into four main specialties:

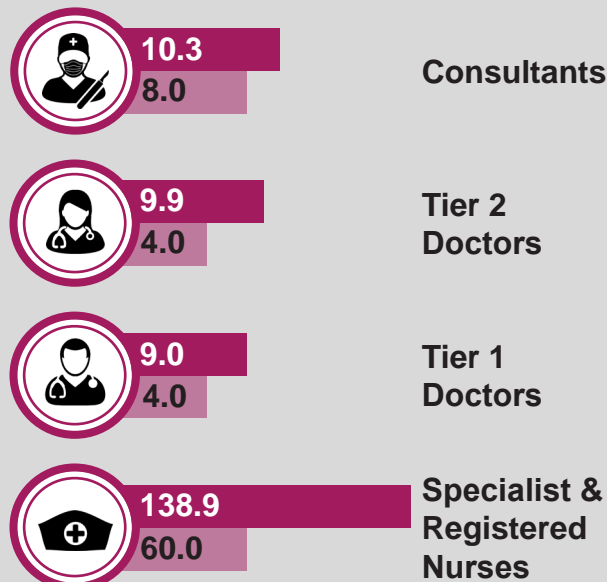
- **Gynaecology** – focusing on women’s reproductive health
- **Obstetrics & Maternity** - supporting women through pregnancy and birth
- **Neonatology** – specialist care for newborn babies; and
- **Paediatrics** – focusing on children’s health care.

The clinical review of Women & Children’s services was divided into two areas:

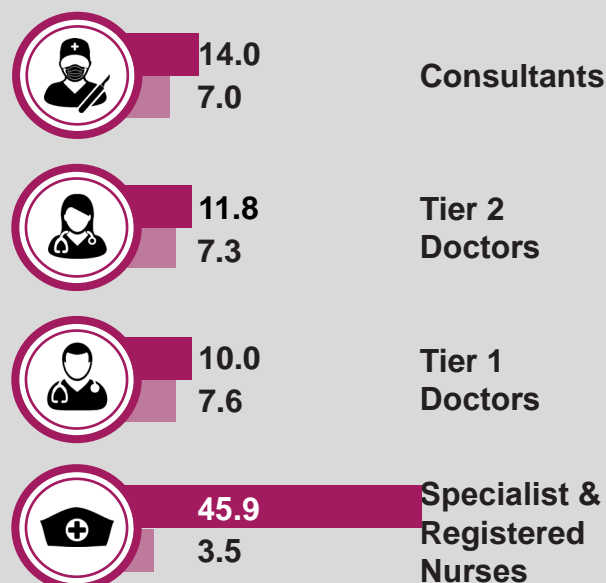
- Maternity & Gynaecology
- Paediatrics & Neonatology.



## Maternity & Gynaecology Workforce\*



## Paediatrics & Neonatology Workforce\*



● ECT ● SFT

\* Whole-time equivalents

# 5.9.1 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 with ultrasound scanning facilities, an inpatient maternity unit with three standard and two water-birth ensuite rooms, 22 antenatal/postnatal beds and a dedicated obstetrics theatre.

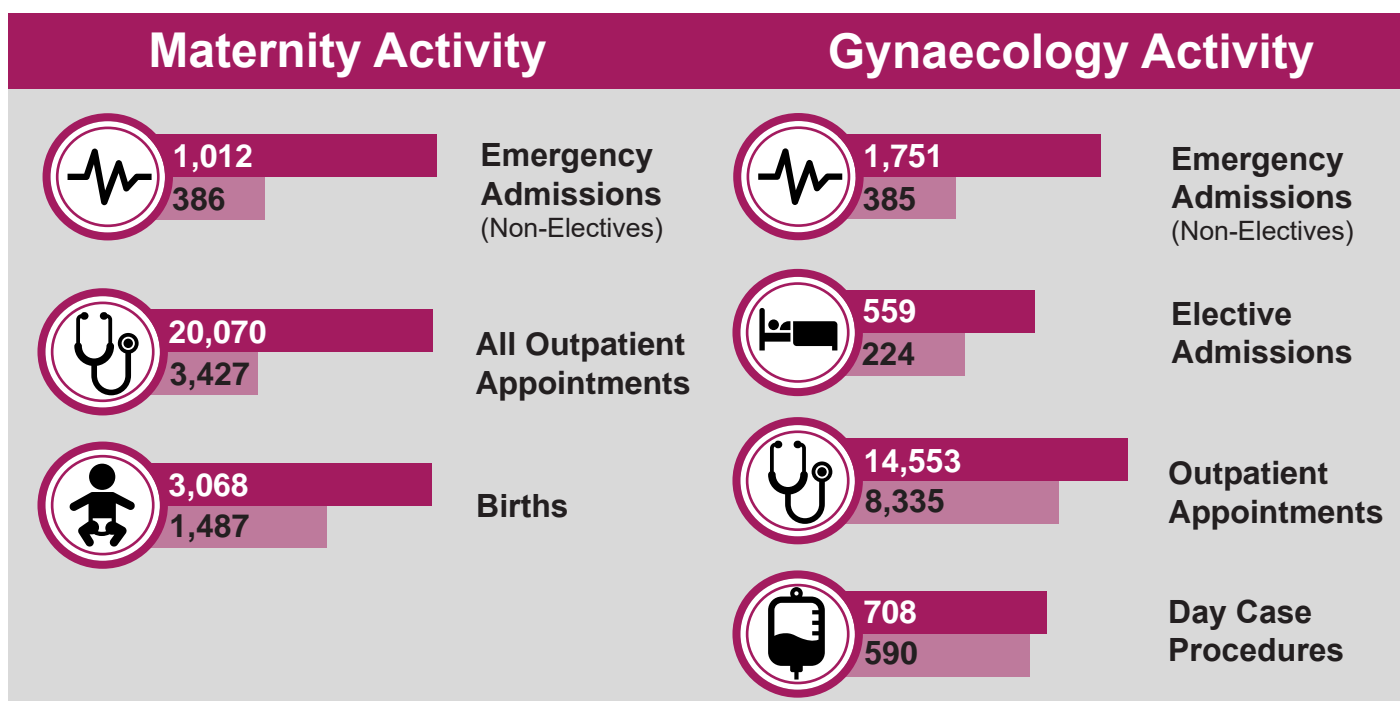
In addition, community midwifery antenatal and postnatal clinics are held in locations across eastern Cheshire with home births offered to all women.

ECT has six substantive consultants who share obstetrics and gynaecology commitments, and all contribute to the on-call rota. Complex foetal-maternal medicine is jointly managed through relationships with neighbouring specialist units at St Mary’s in Manchester and Liverpool Women’s Hospital.

The maternity service supported the births of around 1,500 babies a year (4 per day), aided by a Level 1 neonatal unit. There were 3,427 antenatal and postnatal attendances plus 1,487 hospital and 23 home births.

In 2019, ECT’s maternity service was rated ‘Good’ by the CQC in all five areas.

In March 2020, the ECT maternity inpatient service was temporarily suspended, due to critical care pressures associated with COVID-19.



● ECT   ● SFT

\* SFT Obstetric patients requiring a high level of care admitted to high care area in Maternity, not ICU

Local 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, including SFT.

The trust is committed to reinstating the service on the Macclesfield site when safe to do so. As such, the trust has embarked on a parallel process to explore the options for how this can be achieved. The output of this process is due in late June / early July 2022 and will then feed into this work as required.

Both ECT & SFT services are part of the Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS).

SFT's 10 obstetric consultants undertake a 1:8 on call rota. The team also includes a specialty and associate specialist (SAS) doctor. The 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.

The service works closely with the trust's level 2 Local Neonatal Unit (LNU).

SFT's antenatal clinic and ultrasound department are situated on the ground floor of the women's unit on the Stockport hospital site. Postnatal care is provided in the community.

The community midwifery team works within the Stockport Family integrated service alongside health visitors, social workers and early years specialists. This service is regarded as an exemplar model for the delivery of integrated children's services. Community based services are also provided in Buxton.

In 2020 SFT's maternity service was rated "requires improvement" by the CQC, mostly related to the number of midwives.

Supported by the Maternity Safety and Support

Programme, the service has improved in all on all areas of concern.

Additional midwifery staffing has recently been employed to meet the Birthrate Plus<sup>[42]</sup> requirements. The trust has invested in delivery suite co-ordinators 24 hours per day and an expansion in consultant numbers to match the requirements of the Interim Ockenden Review<sup>[43]</sup>.

### Gynaecology

ECT provides inpatient, outpatient and cancer gynaecology services on the Macclesfield site. However, the number of patients who use gynaecology inpatient and cancer services at the trust is very small.

Outpatient gynaecology clinics are hosted in a recently built women's outpatient facility. Prior to the COVID-19 pandemic general outpatient clinics were also provided in Knutsford, Leek, Wilmslow, Congleton and Handforth.

In 2019/20 there was an average of four admissions per week and around 12 day cases.

The ambulatory gynaecology service offers several 'one stop' clinics providing comprehensive diagnostic and therapeutic procedures.

SFT provides gynaecology services at Stepping Hill Hospital, including inpatient, outpatient and cancer services as well as a Gynaecology Assessment unit.

Outpatient clinics are held in dedicated outpatient facilities on the ground floor of the women's unit.

The ambulatory gynaecology service offers one-stop clinics and nurse-led early pregnancy and pregnancy loss support services.

The trust has a dedicated gynaecology ward with 10 inpatient beds and a four bedded assessment unit. There are currently 11 theatre lists per week including one robotic list.

[42]: <https://www.rcm.org.uk/media/2367/birthrate-plus-what-it-is-and-why-you-should-be-using-it.pdf>

[43]: Interim Ockenden Report (2020). HM Government



## Capacity & Demand

Most maternity units in the UK support between 2,500 and 4,000 births a year. SFT’s maternity unit sees on average 3,260 births a year. The maternity service at ECT is one of the smallest in the country and the number of births has decreased over time from 1,983 in 2009/10 to 1,510 in 2019/20 - a reduction of 23%.

A clinical senate review of neonatology provision at ECT in 2018 stated that although no clinical concerns were brought to the attention of the review team, *“the issue with the (maternity) service is fundamentally its size, currently it is not cost effective for the trust due to the limited activity levels and requirements to meet staffing standards. The fragility of the neonatal service is the key factor here in considering whether the options that retain the obstetric service are really viable”*.

National population predictions suggest a relatively static position over the next 10 to 20 years, with a 0.8% increase in women aged 15-44 in eastern Cheshire by 2038 and a 3.9% increase in Stockport.

| Women Aged 15-44      | Cheshire East | Stockport | Combined Population |
|-----------------------|---------------|-----------|---------------------|
| 2018                  | 29,752        | 51,367    | 91,119              |
| 2028                  | 30,474        | 53,867    | 84,341              |
| 2038                  | 29,997        | 53,368    | 83,365              |
| Cumulative Difference | + 0.8%        | + 3.9%    | + 2.8%              |

In recent years there has been a fundamental shift in gynaecology away from major open surgery for many conditions to day case / ambulatory surgery and medical management. This change in activity has been apparent on both sites, though the procurement of a state of the art da Vinci robot on the SFT site may offer an additional benefit to high-risk gynaecological patients who have complex pelvic diseases requiring surgical intervention. More generally, gynaecological demand is likely to increase marginally on both sites in coming years, consistent with the expected increase in the age of the local populations.





## 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 / Obstetrics Anaesthetists Association (RCoA /OAA) recommendations around workforce levels. SFT’s service complies with these standards.

The Interim Ockenden Report<sup>[44]</sup> provided a series of ‘essential and immediate’ actions to ensure that all maternity services are safe and comply with key recommendations already in existence. Neither site is fully compliant with these recommendations, however working together since 2020 has helped strengthen

the trusts’ ability to respond to the Ockenden recommendations.

Both sites will face challenges to meet the new recommendations set out in the Final Ockenden Report<sup>[45]</sup>.

Neither site is achieving the 7-day clinical standard for consultant review within 14 hours of emergency admission in gynaecology. Activity numbers are low at ECT with 385 non elective inpatient admissions in 2019/20.

SFT delivers the Royal College of Midwives (RCM) staffing standards, while ECT does not deliver on supernumerary labour ward coordinators.

Both sites deliver the Birth Rate Plus ratio of midwives to births and deliver the 10 safety actions required under the clinical negligence scheme for trusts (CNST) standards.

| Standards      | Measure  | ECT      | SFT      |
|----------------|--|----------|----------|
| RCoA/OAA       | Dedicated duty anaesthetist 24/7 for labour ward           |          |          |
| RCoA/OAA       | 12 consultant anaesthetist sessions for maternity          |          |          |
| Ockenden       | Twice daily consultant led ward round for maternity        | Partial  | Imminent |
| 7-day Services | Consultant review within 14 hours of admission (gynae)     |          | Partial  |
| RCM            | Midwifery staffing – supernumerary labour ward coordinator |          |          |
| RCM            | 1:1 Care in established labour                             |          |          |
| Birthrate Plus | Midwife to birth ratio 1:28 or less                        | <br>1:26 | <br>1:25 |
| CNST*          | Compliance with 10 safety actions                          |          |          |

\* ECT’s latest submission was in 2018/19. SFT’s latest submission was in July 2020

[45]: Interim Ockenden Report (2020). HM Government

[46]: Final Ockenden Report (2022). HM Government





## Workforce Resilience

At ECT, workforce sustainability for the maternity and gynaecology specialty relates to the resilience of medical staff rotas - specifically the middle grade anaesthetic rota, which covers both obstetrics and anaesthetics. Immediate access to senior anaesthetic expertise is an essential component of safe maternity care in obstetric units. In light of the national shortage of trained anaesthetists, ECT has experienced a persistent challenge with recruitment of middle grade anaesthetic staff.

The challenge to ECT's anaesthetic workforce is expected to worsen in the short to medium term, with at least two of the eight anaesthetic consultants reaching the standard NHS pension age in the next three years. With a small maternity and critical care unit, ECT will struggle to attract trained anaesthetists to replace these consultants. Cross-cover arrangements between critical care and maternity are unlikely to be sustainable in future due to the workforce recommendations

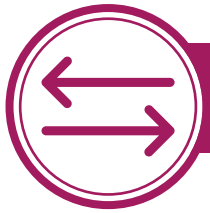
in the Ockenden Reports.

There are also gaps in specialist midwife roles at ECT, such as bereavement and diabetes, which would require additional funding.

Skill maintenance and career progression is more challenging in smaller units, and this also applies to nursing. Larger units have more opportunities to recruit and attract staff to advanced clinical practice roles.

Workforce capacity for colposcopy at both ECT and SFT is challenging. ECT has a limited number of trained colposcopists. The SFT clinical team have experienced an increase in referrals in colposcopy and have a backlog of routine patients awaiting assessment and treatment. While two-week cancer access standards are being maintained, interim plans are required to increase local capacity in colposcopy.





## The Case for Change

The case for change in the maternity and gynaecology largely relates to workforce resilience at ECT, as well as the ability of both trusts to fully comply with national clinical standards and Ockenden recommendations within available resources.

While patient outcomes are currently good, there is a persistent risk to sustainability at ECT associated with low volume activity, creating a risk of potential de-skilling among staff in future.

**The case for change can be summarised as follows:**

### *Gynaecology:*

- »» Neither site is achieving the 7-day clinical standard in gynaecology which requires consultant review within 14 hours of emergency admission. Working together as a larger clinical team would provide both sites with the opportunity to realign resources and meet national clinical standards.
- »» The gynaecology inpatient service at ECT is sub-scale, with an average of four elective and seven emergency admissions per week. Working together would enable clinical teams to optimise patient pathways and make better use of available resources.

### *Maternity:*

- »» Neither service is currently meeting the national clinical standards and the requirements set out in the Ockenden Reports, largely due to workforce challenges. Working together would strengthen our ability to respond to these challenges, optimise available resources and respond to the Ockenden recommendations.
- »» ECT is particularly challenged in meeting the standards expected of a consultant delivered obstetric service as services are sub scale. Due to the small size of ECT's Maternity and Critical Care Units, the (tier 2) middle grade anaesthetic doctor covers both the labour ward and critical care unit, which does not comply with standards as they may not be immediately available when needed. ECT's anaesthetic consultant workforce is unable to deliver twice daily multidisciplinary ward rounds or the requirement to have a dedicated anaesthetist for the labour ward. The ability to recruit and retain accredited intensive care consultants is a key challenge in a highly competitive market and consultant turnover is highly likely in the short term, which would bring the service under considerable pressure. A parallel review is currently underway at ECT to review anaesthetic rota arrangements at the interface with maternity services.
- »» The relatively low number of births in Eastern Cheshire means that maintaining skills is more challenging for clinical, midwifery and neonatal staff. Skills retention in obstetric anaesthesia would likely require rotation of staff between sites and being part of a larger clinical team would improve workforce resilience and flexibility at both sites.

## 5.9.2 Paediatrics & Neonatology

Paediatrics is the area of medicine that manages clinical conditions affecting infants, children and young people. Paediatrics can be divided into three main areas:

- General Paediatrics - hospital outpatient and inpatient services covering children from birth to the age of 16
- Neonatology - looking after premature babies or those with problems at birth;
- Community paediatrics - looking after children with developmental, social or behavioural problems and those with a physical disability.

Neonatal care is delivered in 161 Neonatal Units across England<sup>[46]</sup>:

- 44 Neonatal Intensive Care Units
- 77 Local Neonatal Units
- 35 Special Care Units

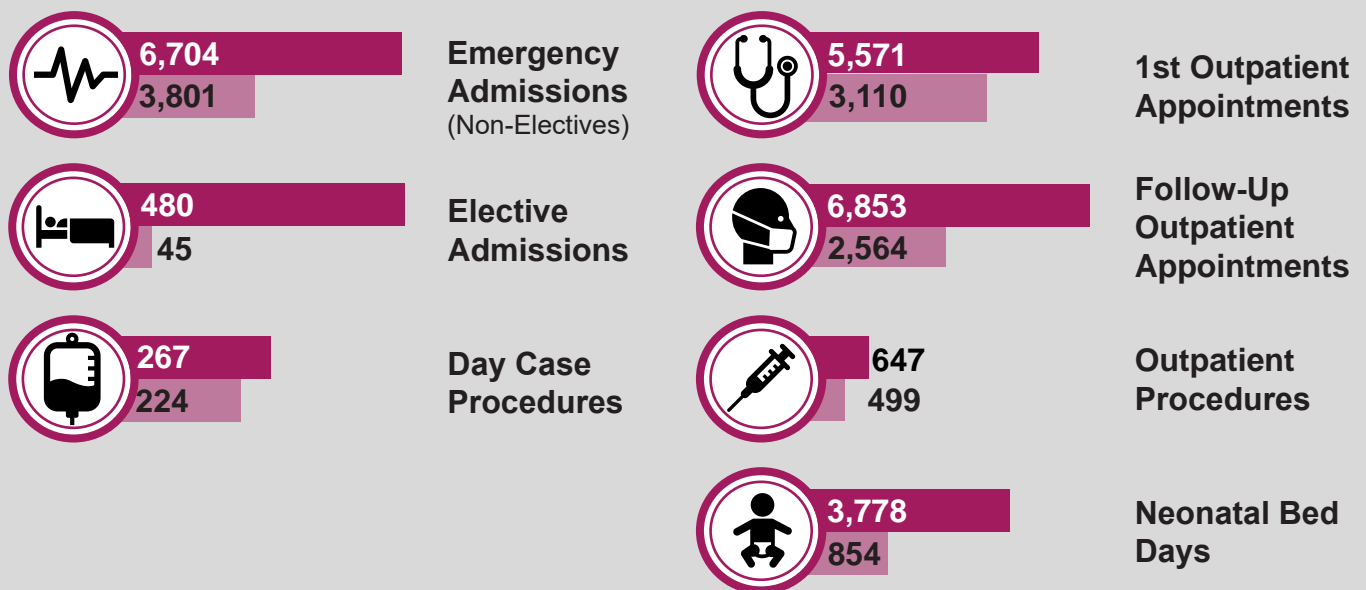
Neonatal Intensive Care Units (NICU)

provide care for the whole range of neonatal care. They are staffed to care for the sickest and most premature babies. Staff work closely with their local maternity teams and foetal medicine services. All babies born at less than 27 weeks of gestation (28 for multiple babies) or at a birthweight lower than 800g should receive perinatal and early neonatal care in a maternity service with a NICU facility.

Local Neonatal Units (LNU) provide care for babies born after 27 weeks of gestation (after 28 for multiple births) and babies weighing over 800g. This includes short-term intensive care where necessary and babies born at 27-31 weeks who require high dependency care.

Special Care Units (SCU) 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 care.

### Paediatrics Activity



● ECT ● SFT [46]: Implementing the Recommendations of the Neonatal Critical Care Transformation Review (2019) NHS

## Paediatrics

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.

Paediatric inpatient services are provided at Macclesfield's children's unit, which has ten side rooms, a six-bedded bay and five paediatric observation beds. The paediatric service operates a home-first model, using the skills of the specialist and community nursing teams to reduce admissions and length of stay.

The unit supports children's surgical services in planned day case ENT and dental with eight to ten admissions per week, as well as unplanned orthopaedic and general surgery.

ECT has seven paediatric consultants, providing expertise in allergy, autism, respiratory, epilepsy, neonatology, neurological conditions, diabetes, endocrinology, immunisation, safeguarding, research and teaching. Visiting consultant outpatient clinics are hosted on site for urology, allergy, endocrinology, paediatric general surgery, nephrology, neurology, cardiology and rheumatology.

Patients requiring paediatric intensive care beds are stabilised and transferred using the North West Paediatric Transfer Service (NWTs).

Patients requiring more complex treatment are transferred to tertiary centres with cardiac issues going to Alder Hey Children's Hospital and head injuries to Manchester Children's Hospital (MCH).

The community paediatric service delivers a range of assessments, clinics and therapy to support child development, feeding issues, looked after children's health assessments, autism, and long-term conditions.

The Children's Community Nursing Service provides nursing care in the child's own home for children with chronic conditions, complex needs, and support following a hospital admission.

SFT has 13 paediatric consultants with expertise in allergy, respiratory, epilepsy and neurological conditions, diabetes and endocrinology, chronic fatigue, cardiology, gastroenterology, eating disorders, autism, immunisation, ADHD, child sexual abuse and safeguarding. The unit also supports children's surgical services in orthopaedics, ENT and ophthalmology.

Facilities on the Stockport site include a purpose built 'Tree House' children's unit with 20 medical inpatient beds, four surgical beds (three days per week), an 8-bed assessment and observation unit, and a 2-bed high dependency unit. On the ground floor is an outpatient unit with a day case investigation suite, integrated healthy young minds service alongside paediatric therapy services. Outpatient services also cover specialist clinics, with visiting consultants from MCH and St Mary's in areas such as endocrinology, cystic fibrosis, nephrology, cardiology and neurology.

SFT offers integrated community and hospital services so that a child has only one paediatrician. There are extensive community services, including a child development unit, a children's learning disability team and a respite provision for children with severe physical and learning disabilities.

SFT's paediatric team also runs a multi-disciplinary service for children with neuro developmental problems and disability, including therapists, a specialist nurse and two consultant paediatricians. Family support and respite care is provided by a nurse led team for children with severe learning disabilities and associated behaviour problems. The service also provides home and school-based intervention programmes for these children.

### Neonatal Service

Pre-COVID, ECT's paediatric medical team were clinically responsible for the care of babies in the Special Care Unit (SCU) providing a combination of resident and on call 24 hour, 7-day medical cover. The eight-cot unit was re-designated from a Local Neonatal Unit (LNU) to a SCU in August 2019, in line with a 2018 Clinical Senate review recommendation which reflected the local needs.

The SCU accepts admission of babies from 32 weeks gestation. A very small number of infants who do not meet admission criteria are transferred to a level 2 or 3 unit. Infants of less than 32 weeks gestation, and those who required specialist neonatal care, are transferred to neighbouring trusts and tertiary centres, usually Liverpool Women's Hospital.

A flexible four-bed Transitional Care Unit (TCU) is available within the postnatal ward, jointly supported by postnatal midwives, Maternity Care Assistants (MCA), Neonatal unit nursing and medical staff. Separate parent accommodation on the SCU is available for one family at a time - limited by estate within the maternity footprint. Allied health professional input to the unit includes pharmacists, dietitians and specialist speech and language therapy. There is support from radiology for cranial ultrasound and ophthalmology for retinopathy of prematurity screening.

There has always been an ethos at ECT not to separate babies from their mothers whenever this can be clinically avoided. This means short-stay admissions to the SCU are low and 92% of admissions are over 24 hours duration. ECT also has a low term admission rate (3.4% of live births), which is in line with national drivers to reduce full term admissions to neonatal care.

In 2019/20, there were 105 admissions to the unit, with 854 care days. Occupancy was low at 32% occupancy and suggests this unit is sub scale.

As previously described, in 2020, ECT temporarily suspended its maternity and neonatal services due to a lack of anaesthetist cover caused by the COVID-19 pandemic. Neonatal staff were moved to neighbouring hospitals to support eastern Cheshire mothers giving birth in other areas. As set out in the section on Maternity services, the trust has embarked on a separate process to explore the best service model to return services to the Macclesfield site. This work will report in June / July 2022 and will then feed into wider discussions re future service models.

SFT runs a Local Neonatal Unit (LNU) as part of the Greater Manchester clinical network. The unit has 17 cots - two intensive care, three high dependency, and 12 special care - for infants over 27 weeks gestation, including short term ventilation. There is a four-bed transitional care bay on the neonatal unit with transitional care also provided on the post-natal ward in the maternity unit.

In 2019/20 there were 344 admissions to the LNU and 3778 care days. Babies below 27 weeks gestation or with extreme respiratory conditions requiring surgery are transferred to the tertiary unit at St Mary's Hospital in Manchester, or Bolton or Oldham should St Mary's have no capacity.

SFT's neonatal unit was extended and refurbished in 2009 providing ensuite parent bedrooms, a full kitchen, play facilities, breast feeding rooms and a transitional care unit for babies to stay with their mothers until they are ready for discharge home.

Medical cover is provided by the paediatric team with a lead consultant paediatrician with an interest in neonatology. The nursing team is led by a senior nurse manager. The LNU has support from radiology for ultrasound.



## Capacity & Demand

The North West Neonatal Operational Delivery Network (NWODN) monitors capacity and demand activity for both trusts. Both units may be asked to accept transfers from other local neonatal units during periods of peak demand, in line with local criteria protocols.

With a larger clinical workforce, the service at SFT is better placed to meet current demand for care. Population projections from the Office for National Statistics suggest a relatively stable population of children and young people over the next 20 years – 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.

| Children Aged 0-14 | Cheshire East | Stockport | Combined Population |
|--------------------|---------------|-----------|---------------------|
| 2018               | 32,736        | 53,677    | 86,413              |
| 2028               | 32,115        | 52,865    | 84,980              |
| Change             | - 1.8 %       | - 1.5 %   | + 1.7 %             |



ECT has a small Special Care Baby Unit with low bed occupancy, which makes compliance with workforce standards more challenging than in larger units where there are economies of scale. In 2019/20, there were 105 admissions to the unit, with 854 care days, and 32% occupancy level.



Specialty benchmarking data indicates that ECT’s paediatric inpatient activity is also sub-scale. The trust has low volumes of planned paediatric surgery making it difficult to maintain skill sets, with the exception of ENT, dental and oral surgery which are provided by a partner trust on the site.

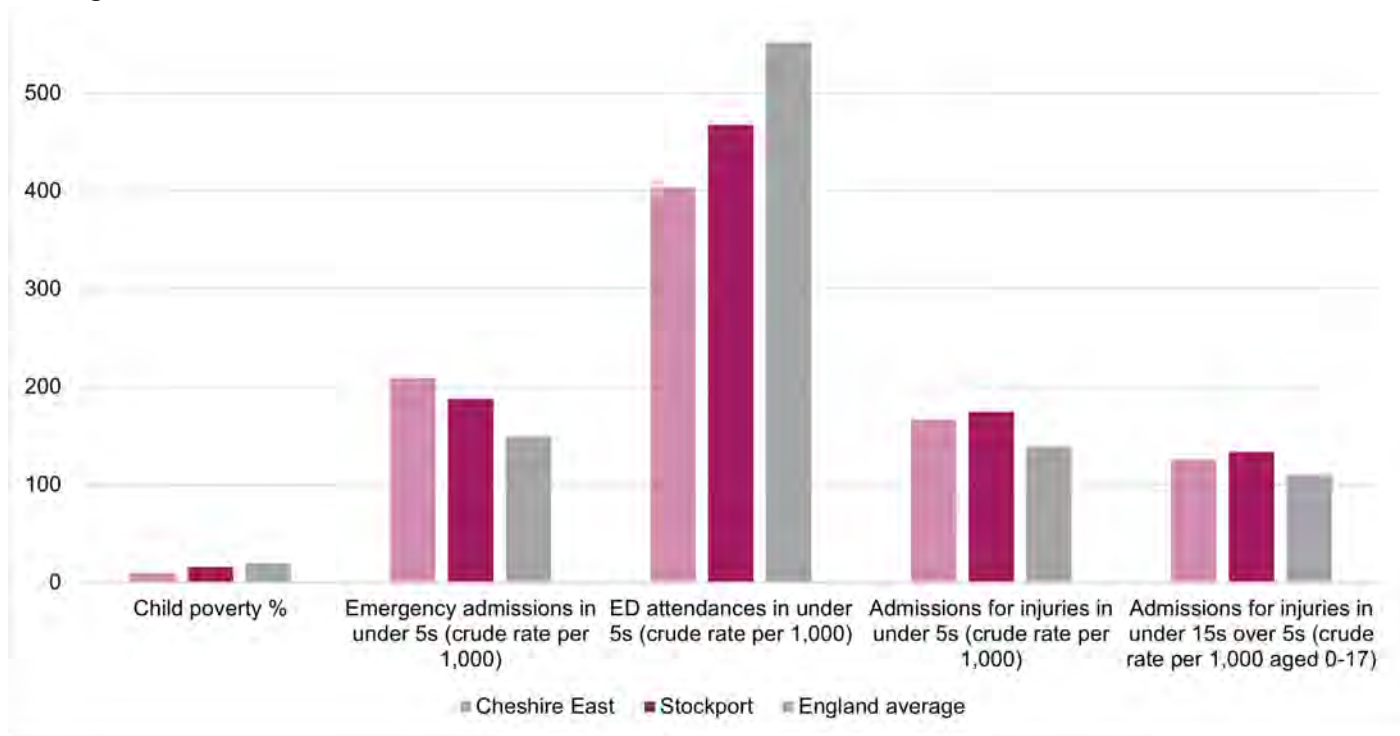
ECT provides 84% of emergency paediatric care for the local population, with most children (85%) discharged on the day of admission or after a single night in hospital.

The Cheshire East ‘Transforming Care for our Population’ programme is looking to review paediatric pathways, developing more responsive community services that would potentially prevent many ED attendances and short stay admissions to hospital. While this is the right thing for local children, the consequence of reducing admissions to the already small ECT service may further compound current sustainability issues.



## Quality & Outcomes

Across eastern Cheshire and Stockport there are lower than average rates of child poverty and ED attendances among under 5s. However, the emergency admission rate is higher than the national average.






















| Source          | Indicator   | Cheshire East | Stockport | England Average |
|-----------------|---|---------------|-----------|-----------------|
| DCLG 2015       | Child poverty %   | 9.7           | 15.8      | 19.9            |
| HES 13/14-15/16 | Emergency admissions in under 5s (crude rate per 1,000)                       | 208.9         | 187.9     | 149.2           |
| HES 11/12-15/16 | ED attendances in under 5s (crude rate per 1,000)                             | 403.3         | 467.6     | 551.6           |
| HES 11/12-15/16 | Admissions for injuries in under 5s (crude rate per 1,000)                    | 166.7         | 174.2     | 138.8           |
| HES 11/12-15/16 | Admissions for injuries in under 15s over 5s (crude rate per 1,000 aged 0-17) | 125.9         | 133.2     | 110.1           |

\* SFT emergency admission figures include Paediatrics Observation Unit attendances > 4 hours

Both services have been inspected by the CQC in the last 3 years. SFT’s children and young people’s services were rated as ‘Requires Improvement’ due to children being admitted to Treehouse Ward with mental health issues. Improvements have been made in this area with investment in staff training including a mental health nurse educator, redesigned admission paperwork and link nurses in place. ECT’s service was rated ‘Good’ by the CQC.

Both trusts meet the NHS standard of 92% of patients being treated within 18 weeks of referral.

Standards for acute, general paediatric care are set out by the Royal College of Paediatrics and Child Health (RCPCH)<sup>[47]</sup>. Both trusts are compliant with most of the RCPCH standards.

| Standards                          | Measure  | ECT   | SFT   |
|------------------------------------|--|---|---|
| RCPCH Facing the Future Standard 1 | A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week. (The direction of travel and the RCPCH's five year strategic plan is that there should be a consultant present for at least 12 hours a day, seven days a week).   |    |    |
| Standard 2                         | Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, or more urgently if required   |    | standard met nine months a year   |
| Standard 3                         | Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.  |    |    |
| Standard 4                         | At least two medical handovers every 24 hours are led by a consultant paediatrician*.  |    |    |
| Standard 5                         | Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.         |   |   |
| Standard 6                         | Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician*.   |  |  |
| Standard 7                         | All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.   |  |  |
| Standard 8                         | All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time   |  |  |
| Standard 9                         | Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.   |  |  |
| Standard 10                        | All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report. |  |  |

\* or equivalent staff, associate specialist or specialty doctor who is trained and assessed as competent to work on the paediatric consultant rota





[47]: Facing the Future - standards for acute general paediatric services (2015). Royal College of Paediatrics and Child Health



## Our Case for Change

To achieve the RCPCH standard of all new admissions being seen by a consultant within 14 hours ECT would require at least ten consultants, not seven. SFT is only compliant with this standard during nine months of the year when twilight shifts are in operation and would require another 1-2 consultants to deliver in full.

In relation to neonatal care, neither trust meets all standards within the British Association of Perinatal Medicine (BAPM) framework.

| Standards   | Measure  | ECT (SCU)   | SFT (LNU)   |
|-------------|--|---|---|
| BAPM/ NNCCR | Tier 1 Medical Staff – Immediately available 24 hours a day in an SCU  |  | N/A   |
| BAPM        | Tier 2 Medical Staff – Immediately available to support at busiest times in an SCU   |  | N/A   |
| BAPM        | Tier 2 Medical Staff – LNUs should provide an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00-22.00, seven days a week. | N/A   | standard met Mon-Fri  |
| BAPM/RCN    | 70% of the NNU nursing establishment should be qualified in specialty  |  |  |



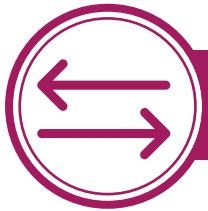
## Workforce Resilience

Both ECT and SFT's paediatric services operate under a joint acute and community model. This provides both trusts with a challenge, as the same consultants cover the community clinics and acute care. ECT only has seven consultants to cover both acute and community areas.

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. It is recognised that teams may need to employ rotational working or another form of on-going education to maintain skills. An education programme is in place, including scenario training.

Providing training and continuity of supervision to trainees is a challenge at ECT in terms of the time available to support them within a small consultant team. Previously consultants were only required to support trainees on placement with them, however the deanery has requested that consultants continue to offer support to that trainee throughout a segment of their training. This is an example of how rising standards for the benefit of patients and staff are increasingly challenging the ability of organisations to meet them.

System pathway changes, aiming to reduce ED attendances and hospital admissions, would result in a lack of exposure to a full range of paediatric conditions and could potentially de-skill clinicians.



## The Case for Change

The case for change in Paediatrics and Neonatology relates to the challenges of sub-scale services at ECT, as well as the ability of both trusts to deliver clinical workforce standards for paediatrics and neonates within available resources.

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

### The case for change can be summarised as follows:

- »» The inpatient service at ECT is sub-scale and unable to meet national standard 7 days per week with existing workforce numbers. Future service developments to enhance primary and community care for unwell children will further reduce the number of paediatric hospital admissions, exacerbating the current challenges associated with sub scale inpatient activity and the risk of staff becoming de-skilled. Alternative models of care need to be considered to strengthen resilience, sustainability and compliance with the standards expected of a high-quality service.
- »» In relation to neonatal care, neither site meets all national workforce standards and working together would provide an opportunity to achieve compliance and strengthen workforce resilience at both sites in line with neonatal network strategy. The interdependency of obstetrics and neonatal services is a key factor in considering the case for change as neonatal activity is also sub scale. Working as a larger clinical team provides opportunities for enhancing skills retention, improving workforce flexibility and strengthening rota resilience at both sites.
- »» 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 and investment in consultant workforce would be required at both sites to achieve this. Working together as a larger consultant team would provide opportunities for strengthening clinical pathways between secondary care and community services, enabling senior clinical expertise to focus on the specialist clinical and advisory role at the interface with primary care, for the benefit of young patients in Stockport and East Cheshire.



# 5.10 Clinical Interdependencies

More and more patients now have multiple medical conditions that require the input of a range of specialists, diagnostics and treatments to deliver effective hospital care. This clinical interdependency is more relevant in some specialties, which are unable to function effectively without immediate access to input and support from other clinical teams.

The clinical teams of ECT and SFT have therefore considered what is required to deliver their core functions, specifically in relation to the 10 core services described in this case for change.

Both sites have 24-hour emergency departments which are out of scope of this case for change. These are Type 1 ED departments, comprising a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

The ED is the first point of hospital contact for patients attending hospital in an emergency. ED services require multi-skilled, multi-professional clinical teams, available 24 hours a day, with the expertise to provide safe triage, rapid diagnosis and appropriate clinical stabilisation, irrespective of age, diagnosis and severity of illness. In addition, on-site or instantly available clinical, diagnostic and administrative support is required, as well as immediate access to hospital beds, ambulatory care pathways, social care and mental health services. A table can be found in appendix 5 with the national recommendations on the services that a hospital with an emergency department needs on site.

The critical interdependencies of acute inpatient services have been described in a review by the South-East Coast Clinical Senate<sup>[48]</sup>, which defined the key relationships that are necessary to deliver sustainable high-quality care. The services that are required to maintain the core functions of a District General Hospital are:

### *Diagnostic services*

- Pathology, plain radiology and CT scanning – each available 24 hours a day, with immediate reporting, to enable rapid diagnosis for conditions such as acute stroke, the acute abdomen, and major vessel disease. including pulmonary vascular disease.

### *Critical care services*

- With capacity to treat and prevent poor outcomes, including death, of the small numbers (typically <2%) of emergency attendees that are critically ill.

### *Paediatric expertise*

- A significant proportion of emergency department attenders are children, so the ability to appropriately assess the severity of a child's illness is essential. This expertise can be provided within the ED team itself, or through consultant-led paediatric teams with access to inpatient beds, either on site, or via robust, networked pathway arrangements at geographically close specialist paediatric units - the model of care in a number of large cities.

[48]: The Clinical Co-Dependencies of Acute Hospital Services (2014). South East Coast Clinical Senate

### *Acute medicine, including geriatric medicine expertise*

- To deliver rapid diagnosis, treatment and improved outcomes for adult patients with an acute medical illness. This requires a consultant led acute medicine team working within an AMU 7 days per week, for a minimum of 12 hours per day. It is essential that this team has the capability to undertake comprehensive geriatric assessment.

### *Acute surgery and acute orthopaedics (on-site or as part of network-based support)*

- To deliver rapid diagnosis, treatment and improved outcomes for adult patients with acute surgical and orthopaedic illness. Units without comprehensive critical care facilities and consultant support should not be undertaking complex surgery or accepting high-risk patients.

### *Access to inpatient speciality medicine, general surgical and orthopaedic surgical beds*

- Approximately 30% of patients attending the ED require onward hospital admission for further investigation or specialist treatment. The attendance to admission conversion rate varies greatly according to the age of the patient - being typically up to 50% in the very elderly or those with multiple co-morbidities.

### *Mental Liaison Health Services*

- Readily accessible (within 2 hours) psychiatric expertise helps reduce both admission and readmission rates in people with mental health problems.

Strong and more integrated relationships between provider organisations and their clinicians within and across regions are required to maximise the range of options available to provide the highest quality services in the most accessible and sustainable way possible.

Increasingly specialised interventional care is centralised and must be delivered via clinical networks to ensure rapid and equitable access to care. Clinical pressures during the COVID-19 pandemic have strained some of the networks in their capacity to ensure timely access to care, requiring a reassessment as to what should reasonably be delivered locally as opposed to centrally.

The development of this case for change has enabled clinicians from ECT and SFT to work together in assessing the clinical context and inter-dependencies for local service provision and sustainability.

The clinical interdependencies relating to the specialties in this case for change are summarised below.



## Key Clinical and Service Interdependencies

| Clinical Speciality          | Clinical Interdependencies   |
|------------------------------|--|
| Anaesthetics & Critical Care | <ul style="list-style-type: none"> <li>Acute medical, surgical, diagnostic, anaesthetic and radiology services should be co-located on site.</li> <li>In-reach access to ENT, gynaecology, interventional radiology and urology.</li> <li>Access to appropriate recovery and critical care support is needed in surgical units to manage complex and acutely ill patients</li> <li>Urgent diagnostic haematology and biochemistry, transfusion and blood bank</li> </ul> |
| Cardiology                   | <ul style="list-style-type: none"> <li>Imaging, echocardiography and electrocardiography</li> <li>Cardiology access is essential to support the management of an unselected patient case-mix via ED.</li> </ul>  |
| Diabetes & Endocrinology     | <ul style="list-style-type: none"> <li>Essential to support the management of an unselected patient case-mix via ED.</li> <li>Essential to support the effective clinical management of inpatients with diabetes (circa 20% of inpatients)</li> <li>Haematology and Biochemistry</li> </ul>  |
| Endoscopy                    | <ul style="list-style-type: none"> <li>Imaging</li> <li>Gastroenterology</li> <li>Emergency management of gastrointestinal bleeding (Non elective or elective inpatient)</li> </ul>  |
| Gastroenterology             | <ul style="list-style-type: none"> <li>Essential to support the management of an unselected patient case-mix via ED.</li> <li>Diagnostic imaging and endoscopy</li> </ul>  |



| Key Clinical and Service Interdependencies |   |
|--|---|
| Clinical Specialty                         | Clinical Interdependencies  |
| General Surgery                            | <ul style="list-style-type: none"> <li>• Essential to support the management of an unselected patient case-mix via ED, enabling appropriate investigations and triage to occur, with medical back up from acute and general medicine as well as elderly medicine.</li> <li>• General anaesthetics</li> <li>• On-site gastrointestinal advice with facilities for urgent endoscopy</li> <li>• Acute cardiology services available for advice</li> <li>• Diagnostic imaging required on-site include routine X-ray and ultrasound, CT and MRI, with access to nuclear medicine which could be networked.</li> <li>• Diagnostic haematology and biochemistry, transfusion and blood bank</li> <li>• Less invasive surgical techniques are increasing such as interventional radiology which must be available for patients, ideally on-site to save transfer of patients, but could be networked with adequate out-of-hours in-reach, or patient transfer protocols.</li> <li>• Urgent access to paediatrics, when operating on children.</li> </ul> |
| Imaging                                    | <ul style="list-style-type: none"> <li>• Essential to the diagnostic function of all acute clinical specialties</li> </ul>  |
| Trauma & Orthopaedics                      | <ul style="list-style-type: none"> <li>• Essential to support the management of an unselected patient case-mix via ED</li> <li>• General anaesthetics</li> <li>• Imaging</li> <li>• Urgent diagnostic haematology and biochemistry, transfusion and blood bank</li> <li>• Urgent access to paediatrics, when operating on children.</li> </ul>  |
| Women & Children                           | <p>Maternity &amp; Gynaecology:</p> <ul style="list-style-type: none"> <li>• General anaesthetics</li> <li>• Adult critical care</li> <li>• Neonatology</li> <li>• Urgent diagnostic haematology and biochemistry, transfusion and blood bank</li> </ul> <p>Paediatrics and Neonatology:</p> <ul style="list-style-type: none"> <li>• Essential to support the management of an unselected paediatric patient case-mix via ED.</li> <li>• Neonates is a critical interdependency with maternity</li> <li>• Imaging , particularly urgent diagnostics such as haematology, biochemistry, blood bank, transfusion, and electrocardiography</li> </ul>   |

In summary, in developing this case for change, clinical teams have considered sustainability in the context of the relevant clinical interdependencies to ensure that challenges to resilience and sustainability are fully understood.

# 6. People & Culture



**The NHS’s greatest strength is its people, and as demand for healthcare continues to grow, it is essential that NHS staff get the support they need to do their jobs effectively<sup>[49]</sup> .**

A recurring theme across all of the clinical service reviews is workforce capacity, which is key to delivering sustainable services across Stockport and East Cheshire. While demand for healthcare has grown, the number of qualified healthcare professionals has not increased at the same speed and so our workforce is under significant pressure. Hospitals across the country are struggling to recruit the number of staff they need to deliver safe services 7 days a week.

Across the two organisations, we simply do not have the workforce we need to deliver all services at all sites 7 days a week. Our critical care and anaesthetic workforces are extremely stretched - a symptom of increased demand during the pandemic as well as the long-standing challenges of recruitment and retention in key specialties that are being experienced right across the NHS. While our clinical teams are highly skilled, they are unable to consistently meet necessary national standards within existing resources.

**6.1 People Plan**

Our workforce and the needs of our patients are changing and so is the way we deliver care. Shortages of clinical staff nationally, an older workforce, and changes to education pathways mean our workforce profile is evolving. There are also opportunities to make best use of emerging technology and to support new models of working.

Both organisations have in place a People Plan, which sets out priorities for each trust. Closely aligned to the NHS Long Term Plan, these plans demonstrate a commitment to the workforce, outlining how staff will be supported with more flexible working opportunities, continuing professional development, embracing diversity and a culture of respect and fair treatment for all.

The plans are very much aligned, as demonstrated in the trusts’ respective People Plan priorities:

| People Plan Priorities   |   |
|--|---|
| ECT  | SFT   |
| <ul style="list-style-type: none"> <li>• Making ECT the best place to work</li> </ul>  | <ul style="list-style-type: none"> <li>• A great place to work</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Taking urgent action on staff shortages</li> </ul>                                  | <ul style="list-style-type: none"> <li>• Fully staffed teams where opportunities and support are given to staff to look after their health and wellbeing</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Developing our staff</li> </ul>   | <ul style="list-style-type: none"> <li>• Supporting exciting and rewarding careers across our integrated system</li> <li>• Developing staff to enhance our excellent care to patients</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Enabling a compassionate and inclusive leadership and management culture</li> </ul> | <ul style="list-style-type: none"> <li>• Consistently well-led by ensuring the support and development of our leaders to delivery of an open and inclusive culture; where staff and leaders work together to ensure improvements are achieved.</li> </ul> |

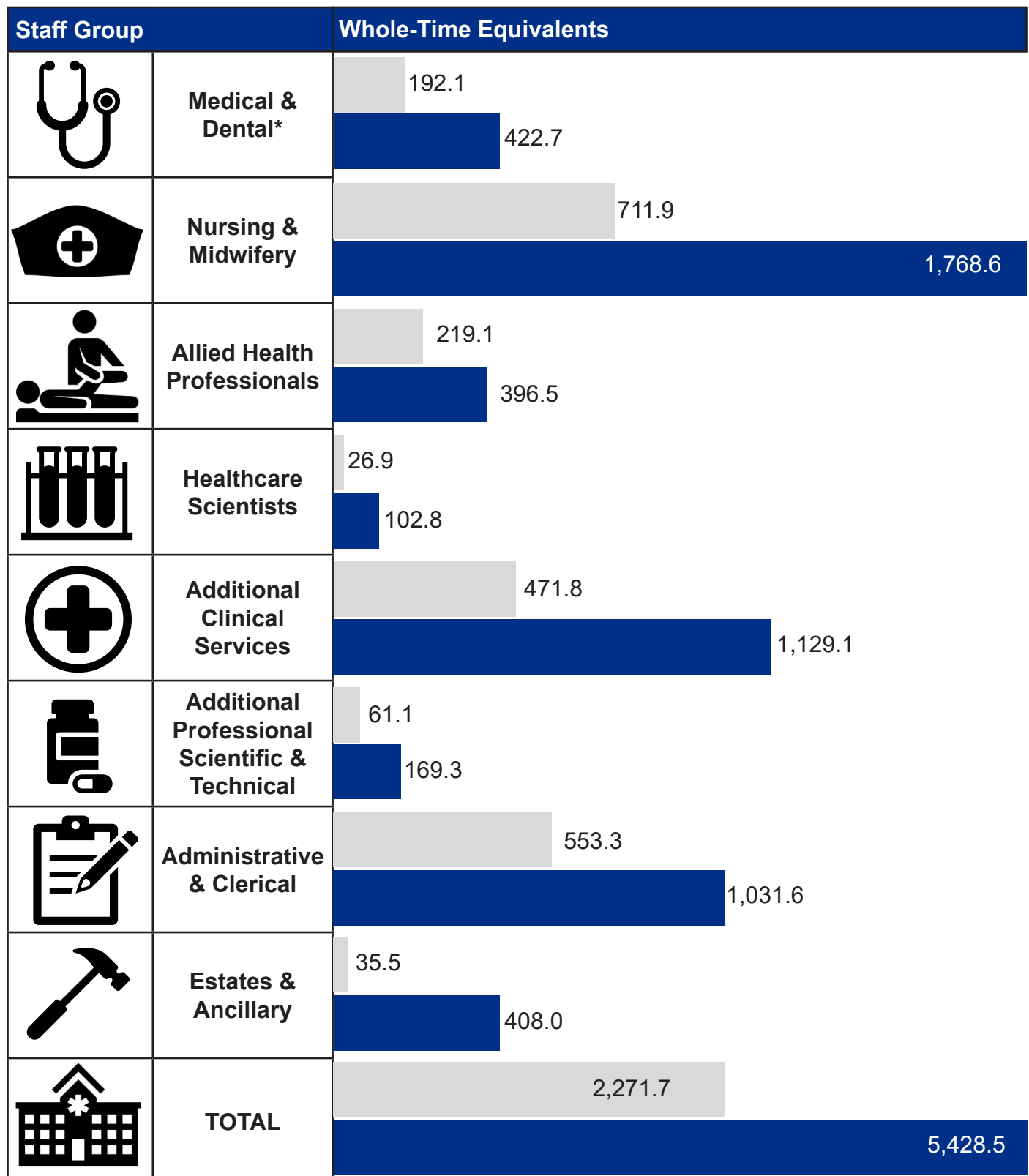
The healthcare needs of the future will be different from today and our workforce and the way we work with our partners needs to reflect this. Our People Plans seek to create a positive and sustainable future for our staff, setting out how each trust will work in partnership with teams to deliver high quality, safe, integrated hospital and community services that ensure patients receive the best care in the right place at the right time.

[49]: We are the NHS: People Plan (2020). NHS

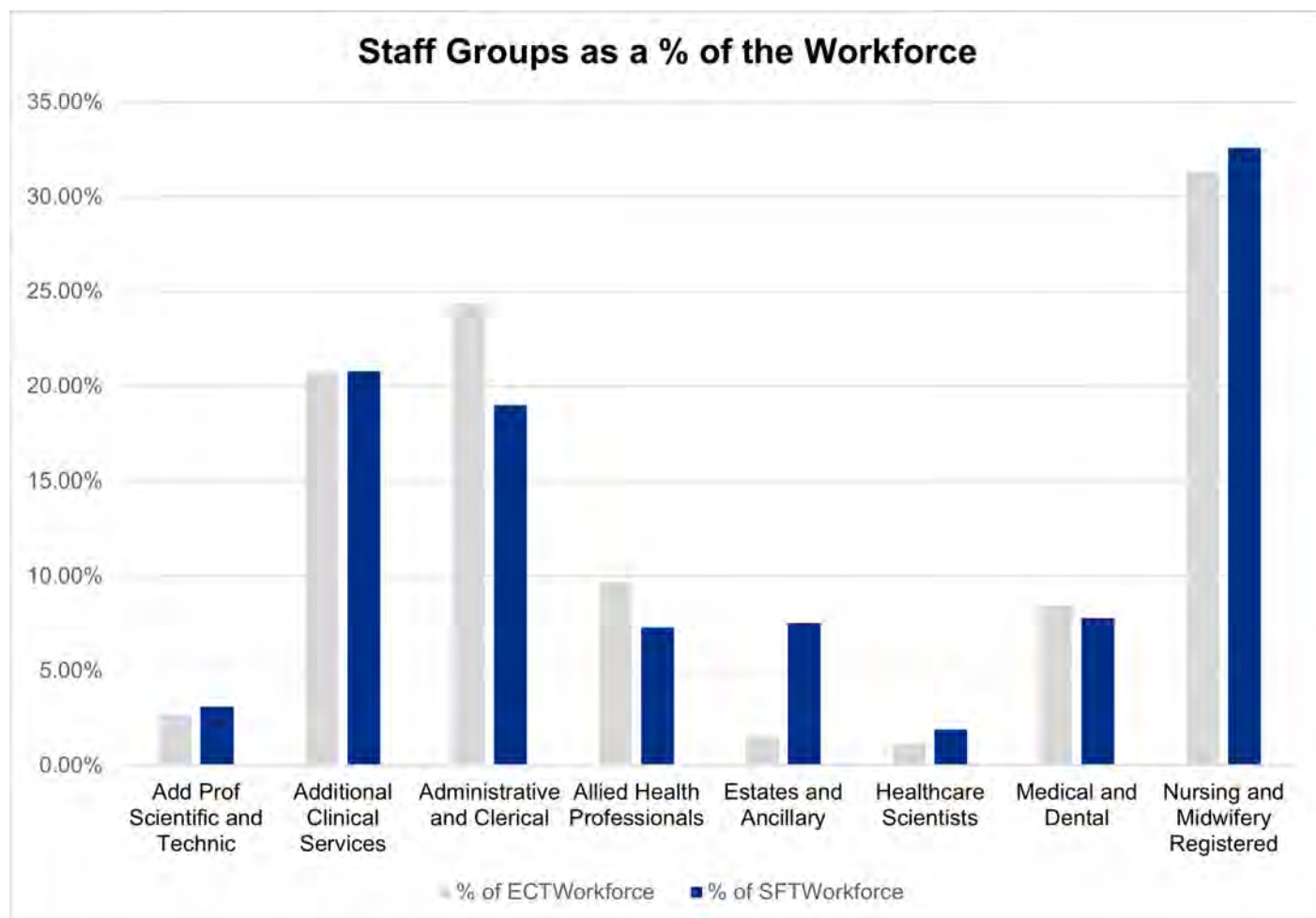


## 6.2 Workforce Summary and Characteristics

Together, East Cheshire NHS Trust and Stockport NHS Foundation Trust employ 7,700 people. As such, we 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.



\* Please note: Junior doctors employed by the lead employer are not included in these figures



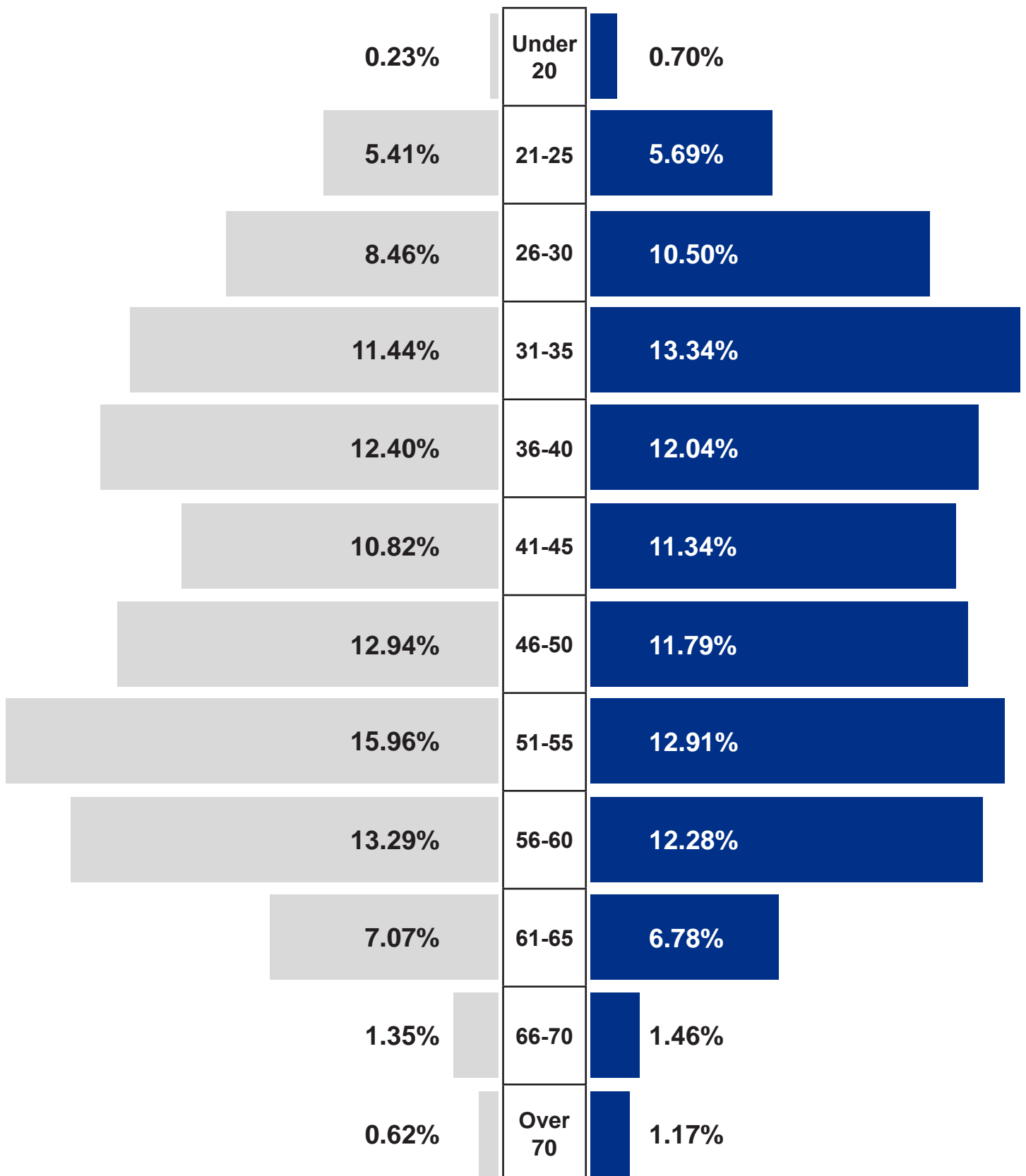
Both trusts face challenges around workforce sustainability, with the vacancy rate at almost 6% at ECT and 7.5% at SFT.

Turnover of staff is high, at around 12.6% at ECT and 14.7% at SFT.

The sickness absence rate at both trusts is similar to the national NHS average at around 5.9%.

| Staff Group                      | Vacancy Rate |        | Turnover Rate |        | Sickness Absence |       |
|----------------------------------|--------------|--------|---------------|--------|------------------|-------|
|                                  | ECT          | SFT    | ECT           | SFT    | ECT              | SFT   |
| Add Prof Scientific & Technic    | 13.93%       | 13.92% | 18.06%        | 17.37% | 5.34%            | 4.87% |
| Additional Clinical Services     | 1.37%        | 6.44%  | 10.23%        | 14.72% | 8.48%            | 8.18% |
| Administrative and Clerical      | 7.72%        | 4.91%  | 13.90%        | 16.70% | 4.37%            | 4.55% |
| Allied Health Professionals      | 8.75%        | 8.38%  | 10.75%        | 13.75% | 5.84%            | 3.88% |
| Estates and Ancillary            | 4.51%        | 10.62% | 15.79%        | 16.27% | 4.87%            | 7.10% |
| Healthcare Scientists            | 7.90%        | 7.33%  | 20.69%        | 12.09% | 5.81%            | 3.22% |
| Medical and Dental               | 1.95%        | 1.12%  | 6.45%         | 11.09% | 3.39%            | 1.95% |
| Nursing and Midwifery Registered | 13.79%       | 10.11% | 14.59%        | 13.74% | 6.13%            | 6.96% |

## Age Profile of the Workforce





## East Cheshire NHS Trust

The biggest staff group at ECT is Nursing and Midwifery, making up 31.3% of the workforce.

ECT has several small teams that are particularly vulnerable to absence or vacancies. Several other services operate on the minimum numbers required for safe on-call rotas such as General Surgery and Paediatric Services.

Over 50% of staff at ECT work part-time. In many areas this is a positive figure, demonstrating the commitment in the NHS people plan to be 'flexible at all levels' and supporting the work-life balance of our employees. However, in areas where on-call rotas are required this can result in a high reliance on locum or bank staff. 32% of the trust's Medical and Dental staff work part-time.

More than half of the workforce is aged over 46 - 50.6% compared to a national average of 42.3% of NHS employees. Within the Nursing and Medical Staff Groups approximately 50% of the workforce is over 46 years old.



## Stockport NHS Foundation Trust

The biggest staff group at SFT is Nursing and Midwifery, making up 31.6% of the workforce.

The trust has a diverse range of staff. When looking at skills mix, the trust has a ratio of 1 senior manager for every 16.5 employees. On the wards, the Trust has a balance of 1.1 support staff for every clinician / senior staff.

Almost half of SFT's employees work part-time (47%) which demonstrates our commitment to flexible working patterns. 17% of the Medical and Dental workforce work less than full time.

The most prominent feature of our workforce is its age profile with half of staff aged over 46 years and 34% over 55 years old. 43% of nurses are over 46 and 39% of medical and dental staff. A high proportion of the clinical workforce is already in their fifties and therefore more likely to retire in the coming 5 to 10 years. Only 0.07% of the workforce is aged under 25 years.



## 6.3 Staff Survey

The NHS Staff Survey is aligned to the seven promises set out in the NHS People Plan. The results are used to benchmark organisations across the country.

Both trusts saw their overall staff engagement scores improve in the 2021 survey with staff reporting that they would recommend the trust as a place to work and that they consider patients to be the top priority.

Survey results demonstrated that staff across both trusts are feeling tired due to high levels of absence and the growing demands at work. This reflects a national position as a result of the increased pressure on NHS services created by the COVID-19 pandemic and both trusts have seen an increase in the number of staff thinking about leaving.

| Staff Survey 2021 - areas of improvement   |   |
|--|---|
| ECT  | SFT   |
| <b>Compassionate Culture</b> with improved support from Managers to support Health & Wellbeing and listen to staff concerns                          | <b>Compassionate Culture</b> – a year on year increase in numbers recommending the trust as a place to work, with care of patients and acting on concerns raised felt to be top priorities. |
| <b>Equality, Diversity &amp; Inclusion</b> with improvements relating to our people’s experience of discrimination and implementation of adjustments | <b>Equality, Diversity and Inclusion</b> - responses show a reduction in those who reported discrimination while national comparators show an increase.                                     |
| <b>Autonomy &amp; Control</b> such as feeling trusted and the ability to show initiative, alongside good ‘team’ support                              | <b>Raising Concerns</b> - Staff feel empowered to raise concerns and our responses in this area have improved above the benchmark average.  |
|  | <b>Team Working</b> has improved markedly across all questions, staff report they understand each other’s roles and enjoy working with in the team.   |

## 6.4 Recruitment & Retention

Both trusts are considered good places to work and are large employers in the local area. However, national shortages in several key occupations impact on many of the services outlined in this case for change. This is of particular significance within nursing, allied health professionals (AHPs) and medical vacancies in certain specialties.

With smaller teams, ECT has struggled to recruit specialist clinical and medical staff - especially at consultant level. This is attributed to the limited scope of procedures within some specialties, proximity to several large teaching hospitals which are seen as more attractive places to work, and the impact smaller teams has on the frequency consultants are required to cover on-call rotas.

SFT has several clinical services where vacancies are hard to fill at consultant level, which reflects national shortages.

A reliance on newly qualified staff is likely to remain a strong recruitment strategy, however the trust is also keen to grow its own, develop staff into registered roles, and adopt further new posts, such as advanced clinical practitioners, physicians associates and nurse associates.

Both ECT and SFT have made investments to support international recruitment in 2022/23, predominantly for nursing and midwifery, but also including AHPs and the medical workforce. These approaches are often targeted to support a reduction in hard-to-fill vacancies and build sustainability within services.

Working collaboratively across clinical services could strengthen the workforce and provide greater resilience for the future as well as offering our staff greater opportunities to develop skills and expertise. In developing options for future services, the impact of change on the trusts’ workforces will need to be a key priority, particularly where proposed collaboration could result in a change to where individuals are based.

## 6.5 Equality, Diversity & Inclusion

Equality, Diversity & Inclusion (EDI) is a central feature of delivering compassionate care and maintaining a highly skilled, quality-driven workforce. Both trusts believe that the EDI agenda is critical to building a sustainable workforce that is truly reflective of the diverse communities we serve. We also believe that in building a diverse workforce, we will increase the talent pool from which we recruit and build services that are responsive to the needs of the local community.

ECT benefits from the diverse talent and cultural heritage within its workforce and actively seeks to deliver programmes and activities designed to further advance equality and equitable treatment of all staff. Examples include:

- staff networks supporting BAME, LGBT+ and Disabled/Carer colleagues
- equality and diversity training for staff which goes beyond the statutory and mandatory requirements for working in the NHS
- creation of paid employment opportunities / apprenticeships for colleagues with learning disabilities
- a BAME Leadership programme in collaboration with place partners
- disability confident leader status (1st trust in the UK to achieve this).



SFT's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results highlighted the inequalities that exist for our staff. Data showed a lack of diversity within the trust's leadership and across some elements of the workforce and employees from protected groups reporting poorer experience of working at the trust.

- while SFT's workforce is more ethnically diverse than the local population – particularly among medical roles - there is under-representation of ethnic minority groups at higher pay grades across both clinical and non-clinical roles
- there is significant under-representation of staff with disabilities or long-term conditions compared to the local population. Just 3.2% of the workforce have a disability or long-term condition. This is a feature at all pay grades, but more so at higher bands and in clinical roles.

In response to the findings, the trust has developed an EDI strategy, which includes a focus on:

- board level EDI sponsors
- equality advocates and champions across the trust
- ongoing staff networks supporting BAME, LGBT+ and Disabled/Carer colleagues
- safe space listening events for staff
- equality and diversity training for staff which goes beyond the statutory and mandatory requirements for working in the NHS
- diversity events to celebrate LGBT history month, Black history month, Transgender day of remembrance, Ramadan and other religious observations
- sponsored internships for local people with learning disabilities
- a 10-week pre-employment programme of vocational learning for people who are unemployed
- development of internal leadership offers.

## 6.6 Organisational Development

Both trusts have organisational development plans in place to support and develop our staff.

ECT is committed to fostering a leadership culture that is people-centred, engaging, inclusive and well-led. Enablers include leadership development programmes for senior clinical leaders and those who aspire to be leaders of the future, alongside a specific leadership development programme for colleagues from ethnic minority groups. Key elements include:

- a focus on good quality appraisals
- new arrangements for talent management and succession planning, supported by a range of OD interventions including internal coaching
- a range of online programmes
- a Continuous Professional Development plan which addresses priority training needs and upskilling
- apprenticeship programmes and development opportunities
- targeted line manager training in areas such as managing distributed teams, personal resilience and challenging conversations.

SFT's organisational development agenda aims to improve the performance and health of teams and services by enhancing people's collective abilities to achieve shared goals, through interventions that are based on the values of respect, inclusion, collaboration, authenticity, self-awareness and empowerment.

Our OD commitment is all about meeting the need for training and development in new and innovative ways to ensure that vital skills are developed to provide even better patient care and retain staff. Key initiatives include:

- Improve the learning & development experience,
- Apprenticeship programmes at all levels
- Encourage students to flourish, and
- Multi-professional approach to clinical skills development & preceptorship
- Leadership development programmes to ensure an open and inclusive culture.

## 6.7 Workforce Wellbeing

The impact of the pandemic on our workforce cannot be underestimated. We are extremely proud of the amazing efforts made by staff, however two years of intense surge response and managing significant staff shortages, combined with efforts to manage the growing backlog of elective care and the vaccine programme have taken their toll on the NHS workforce as a whole. Both trusts have identified an increase in sickness levels and the number of staff considering early retirement or a move out of the NHS.

The NHS Long Term Plan aims to improve the health and wellbeing of all staff. Both trusts have several initiatives in place for workforce health & wellbeing.

ECT has run several 'Big Conversations', where staff shared stories and experiences of working during the pandemic. Output included:

- creation of Departmental Healthy Workplace Allies, who share information, offer 'in the moment' wellbeing support to colleagues and contribute to the development of Wellbeing delivery plans
- 1:1 Health & Wellbeing Conversations each year for all staff with their line manager to identify how the organisation could help their wellbeing
- launch of Schwartz Rounds, where staff come together to discuss the emotional and social aspects of working in healthcare.

SFT's work focuses around three priorities:

- promoting positive lifestyle behaviours in a healthy and supportive working environment
- ensuring all staff are aware have access to the health and wellbeing services available
- promoting a culture that encourages self-care of physical and mental health and wellbeing.

SFT has signed the NHS Northwest Pledge to foster a person-centred holistic wellbeing approach and invested in a staff psychology and wellbeing service.

# 7. Financial Context





To build a sustainable model of care, services must use the combined resources of our integrated health and social care systems to effectively deliver services where they are most needed. We are not currently doing this well enough, with duplication of services across the system. Working collaboratively across a wider population base would allow us to share resources, including workforce, equipment and estate, to provide the services people need and make the best use of financial resources across the health and social care system.

## 7.1 National Financial Context

The NHS Long Term Plan (LTP) recognised the financial pressures faced by the NHS as systems continue to see increasing demand for healthcare services from a growing and ageing population. The Plan set out major reforms to the NHS financial architecture, payment systems and incentives. It established a new Financial Recovery Fund and 'turnaround' process, so that the NHS can progressively return to financial balance over the next five years – at a national, system and individual organisation level.

The 2021 Spending Review (SR21) provided the NHS with a three-year budget covering 2022/23 to 2024/25. The government committed to spending an additional £8 billion to tackle the waiting list backlog over the next three years. SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

During the COVID-19 pandemic, the NHS shifted to simplified finance and contracting arrangements that supported systems to focus on responding to immediate operational challenges. The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. For ECT and SFT this means working within the two systems of Cheshire & Merseyside and Greater Manchester.

There is a strong emphasis on partner organisations working together to deliver the new duties on ICSs and trusts.

## 7.2 Local Financial Context

ECT has an annual income of approximately £176m, while SFT's income is around £340m.

In 2019/20 and 2020/21 ECT reported small surpluses as a result of additional funding allocated by NHS England. It is anticipated the trust will deliver a break-even financial position for 2021/22, working within the Cheshire and Merseyside system, however it is recognised that the trust has an underlying structural deficit of around £30m, relating to scale and the payment by results regime. The organisation has a good track record of delivering its finance savings programme but has been increasingly challenged in the identification of recurrent savings.

SFT delivered a surplus of £2.6m in 2019/20 and a deficit of £6.1m in 2020/21; both of which were in line with the plans agreed with NHSE/I. It is anticipated that the trust will deliver a breakeven financial position for 2021/22 working within the Greater Manchester system. However, without system funding the trust has an underlying deficit of c.£85m which also relates to scale, payments by results regime and the layout and condition of its main site.

The following tables provide an overview of the trusts' income.

| <b>ECT Income</b>                | <b>Inpatients</b> |               | <b>Outpatients</b> |               | <b>Other</b>    |               | <b>Total</b>   |
|----------------------------------|-------------------|---------------|--------------------|---------------|-----------------|---------------|----------------|
| <b>Source</b>                    | <b>Activity</b>   | <b>£000s</b>  | <b>Activity</b>    | <b>£000s</b>  | <b>Activity</b> | <b>£000s</b>  | <b>£000s</b>   |
| NHS Cheshire CCG                 | 29,311            | 49,226        | 136,110            | 14,664        | 150,715         | 48,019        | 111,909        |
| NHS Derby & Derbyshire           | 1,861             | 3,546         | 8,567              | 1,020         | 7,425           | 1,281         | 5,847          |
| NHS England                      | 1,186             | 1,062         | 2,198              | 351           | 3,385           | 7,164         | 8,577          |
| NHS GM CCGs                      | 177               | 259           | 719                | 81            | 968             | 168           | 508            |
| NHS North Staffordshire          | 1,658             | 3,182         | 8,316              | 865           | 5,384           | 1,072         | 5,119          |
| NHS Stockport CCG                | 538               | 1,022         | 5,245              | 719           | 5,512           | 490           | 2,231          |
| NHS Stoke on Trent CCG           | 192               | 290           | 1,525              | 176           | 512             | 72            | 539            |
| Non-Contract Activity            | 318               | 603           | 963                | 103           | 1,867           | 1,336         | 2,042          |
| Other patient care income        |                   |               |                    |               |                 | 6,157         | 6,157          |
| <b>TOTAL Patient Care Income</b> | <b>34,923</b>     | <b>58,587</b> | <b>162,680</b>     | <b>17,875</b> | <b>173,901</b>  | <b>65,760</b> | <b>142,929</b> |
| Other Income                     |                   |               |                    |               |                 | 33,777        | 33,777         |
| <b>TOTAL Trust Income</b>        | <b>34,923</b>     | <b>58,587</b> | <b>162,680</b>     | <b>17,875</b> | <b>173,901</b>  | <b>99,537</b> | <b>176,706</b> |

| <b>SFT Income</b>                | <b>Inpatients</b> |                | <b>Outpatients</b> |               | <b>Other</b>     |                | <b>Total</b>   |
|----------------------------------|-------------------|----------------|--------------------|---------------|------------------|----------------|----------------|
| <b>Source</b>                    | <b>Activity</b>   | <b>£000s</b>   | <b>Activity</b>    | <b>£000s</b>  | <b>Activity</b>  | <b>£000s</b>   | <b>£000s</b>   |
| Local Authority                  |                   |                |                    |               |                  | 5,511          | 5,511          |
| NHS Cheshire CCG                 | 9,169             | 10,621         | 15,511             | 1,885         | 7,988            | 1,655          | 14,161         |
| NHS Derby & Derbyshire           | 12,413            | 16,565         | 32,181             | 3,512         | 260,461          | 4,285          | 24,362         |
| NHS England                      | 3,830             | 7,613          | 17,557             | 2,609         | 584              | 4,445          | 14,667         |
| NHS GM CCGs                      | 7,404             | 10,834         | 15,284             | 1,732         | 10,349           | 2,735          | 15,301         |
| NHS North Staffordshire          | 152               | 169            | 376                | 49            | 102              | 20             | 238            |
| NHS Stockport CCG                | 75,570            | 102,640        | 234,453            | 24,787        | 1,239,398        | 62,730         | 190,158        |
| NHS Stoke on Trent               | 48                | 53             | 117                | 15            | 41               | 8              | 7              |
| Non-Contract Activity            | 715               | 1,218          | 1,408              | 144           | 1,834            | 375            | 1,736          |
| Other patient care income        |                   |                |                    |               |                  | 11,164         | 11,164         |
| <b>TOTAL Patient Care Income</b> | <b>109,301</b>    | <b>149,713</b> | <b>316,887</b>     | <b>34,733</b> | <b>1,520,756</b> | <b>92,928</b>  | <b>277,373</b> |
| Other Income                     |                   |                |                    |               |                  | 63,300         | 63,300         |
| <b>TOTAL Trust Income</b>        | <b>109,301</b>    | <b>149,713</b> | <b>316,887</b>     | <b>34,733</b> | <b>1,520,756</b> | <b>156,228</b> | <b>340,673</b> |

### 7.3 Financial Context of the Clinical Services Under Review

The services reviewed as part of this case for change make up over half of all inpatient activity at East Cheshire NHS Trust (57.7%), 40.8% of the trust's outpatient activity and 28.9% of the Trust's income. For Stockport NHS FT, the services account for around 40.2% of inpatient activity, 49.0% of outpatient activity and 26% of the trust's income.

## Sustainable Hospital Services across eastern Cheshire & Stockport

| ECT                         | Activity         |                     | Income       |                      |                   |
|-----------------------------|------------------|---------------------|--------------|----------------------|-------------------|
| Service                     | Service Activity | % of Trust Activity |              | Service Income £000s | % of Trust Income |
|                             |                  | Inpatient           | Outpatient   |                      |                   |
| Anaesthesia & Critical Care | 632              | 1.4%                | 0.1%         | 3,097                | 1.9%              |
| Cardiology                  | 12,630           | 1.0%                | 4.8%         | 2,388                | 1.4%              |
| Diabetes & Endocrinology    | 1,526            | 0.1%                | 0.9%         | 381                  | 0.2%              |
| Endoscopy                   | 6,098            | 17.5%               |              | 2,997                | 1.8%              |
| Gastroenterology            | 9,989            | 2.1%                | 5.7%         | 3,537                | 2.1%              |
| General Surgery             | 9,498            | 8.2%                | 4.1%         | 6,975                | 4.2%              |
| Imaging                     | 85,979           |                     | 1.3%         | 4,259                | 2.6%              |
| Trauma & Orthopaedics       | 24,203           | 7.9%                | 13.2%        | 11,617               | 7.0%              |
| Women & Children            |                  |                     |              |                      |                   |
| • Obstetrics                | 5,500            | 5.4%                | 0.1%         | 7,447                | 4.5%              |
| • Gynaecology               | 9,534            | 3.4%                | 5.1%         | 2,752                | 1.6%              |
| • Paediatrics               | 13,324           | 11.7%               | 5.6%         | 5,350                | 3.2%              |
| • Neonatology               | 124              | 0.4%                |              | 517                  | 0.3%              |
| <b>TOTAL</b>                | <b>178,405</b>   | <b>57.7%</b>        | <b>40.8%</b> | <b>48,220</b>        | <b>28.9%</b>      |

| SFT                         | Activity         |                     | Income       |                      |                   |
|-----------------------------|------------------|---------------------|--------------|----------------------|-------------------|
| Service                     | Service Activity | % of Trust Activity |              | Service Income £000s | % of Trust Income |
|                             |                  | Inpatient           | Outpatient   |                      |                   |
| Anaesthesia & Critical Care | 1,135            | 0.9%                | 0.1%         | 7,159                | 2.1%              |
| Cardiology                  | 17,410           | 1.1%                | 5.1%         | 4,808                | 1.4%              |
| Diabetes & Endocrinology    | 3,586            | 0.1%                | 1.1%         | 488                  | 0.1%              |
| Endoscopy                   | 9,324            | 8.5%                |              | 4,612                | 1.4%              |
| Gastroenterology            | 12,118           | 1.0%                | 3.5%         | 1,980                | 0.6%              |
| General Surgery             | 21,920           | 6.3%                | 4.7%         | 13,668               | 4.0%              |
| Imaging                     | 79,278           | 0.0%                | 11.9%        | 4,592                | 1.3%              |
| Trauma & Orthopaedics       | 50,066           | 7.2%                | 13.3%        | 25,841               | 7.6%              |
| Women & Children            |                  |                     |              |                      |                   |
| • Obstetrics                | 10,292           | 3.0%                |              | 15,019               | 4.4%              |
| • Gynaecology               | 17,603           | 2.8%                | 4.6%         | 5,845                | 1.7%              |
| • Paediatrics               | 25,177           | 9.0%                | 4.7%         | 9,145                | 2.7%              |
| • Neonatology               | 1,306            | 1.2%                |              | 2,465                | 0.7%              |
| <b>TOTAL</b>                | <b>248,080</b>   | <b>40.2%</b>        | <b>49.0%</b> | <b>88,464</b>        | <b>26.0%</b>      |

While the basis of this case for change is clinically driven, it is supported by updated national financial guidance which demonstrates a commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan with a continued focus on integration to support the cost-effective delivery of healthcare into the future.

# 8. Communications & Engagement



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.

## 8.1 Engagement Approach

Our approach to engagement across local NHS partners is open and inclusive.

In the past, people have expressed their frustration at public sector organisations asking the same questions again and again. For this reason, we started with a review of existing information, including reports from previous surveys and engagement events, patient satisfaction surveys, and the compliments and complaints received by our services to feed into our clinical case for change.

Where possible, our approach has been to go to local people, rather than expecting them to come to us, so we have attended community events, local group meetings, forums and strategic boards to understand local views. We have used numerous methods to engage with the public such as stakeholder briefings, newsletters, workshops, focus groups, traditional media such as newspaper articles

and local radio, and digital methods including social media, emails and surveys

We understand that many communities are not able to or simply do not want to attend public events and therefore we have undertaken targeted conversations with a wide range of people to hear from voices across all of our community groups. This has been informed by an Equality Impact Analysis and with the support of amazing local organisations who have told us how they would like to be engaged, shared our information with their communities and provided feedback on their behalf.

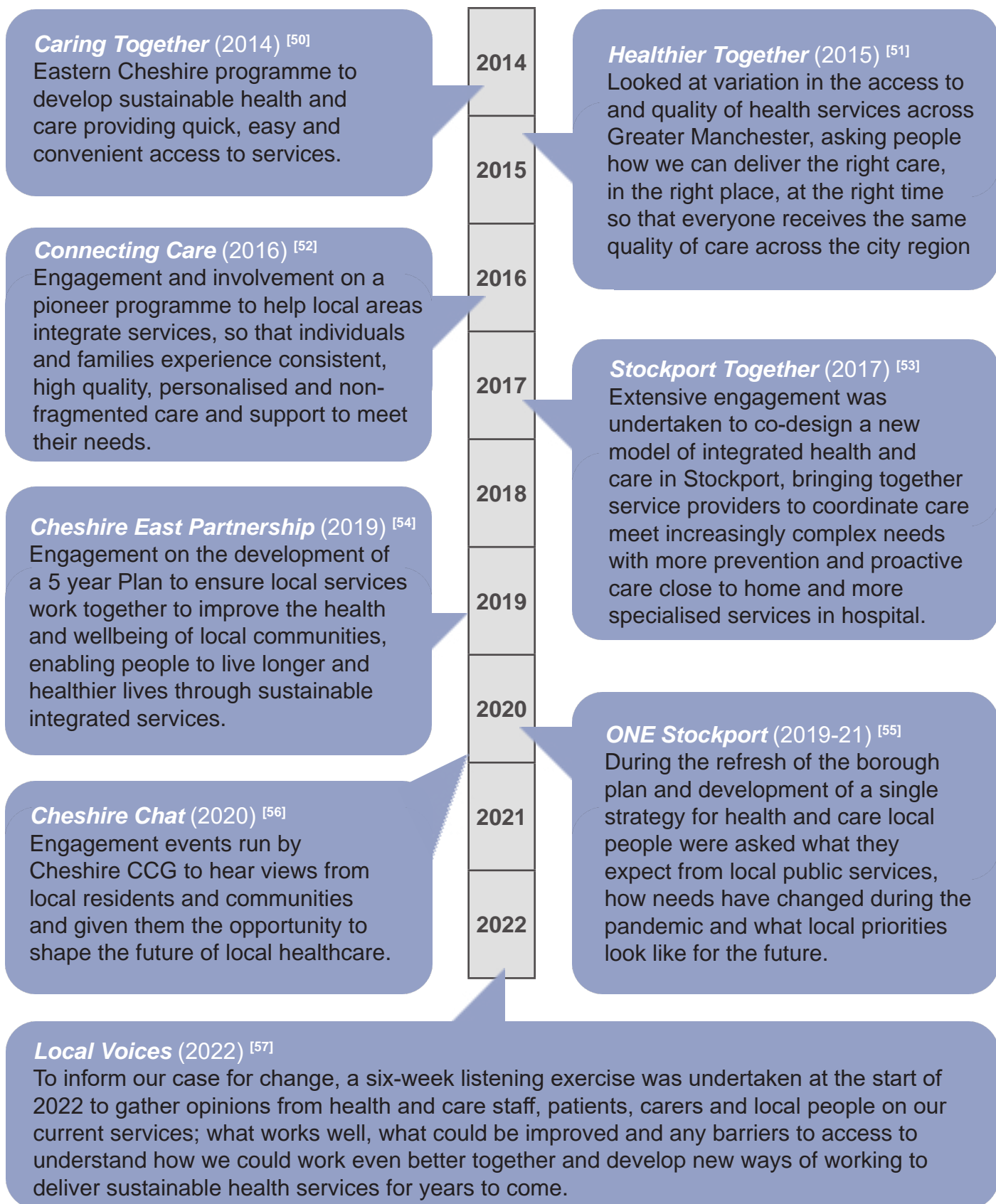
Since the onset of the COVID-19 pandemic we have been limited in how we can engage with local people, to ensure that infection prevention principles are followed, and vulnerable people are not put at risk. As such, the range of engagement methods used has focused primarily on virtual communications, including social media, online surveys and virtual engagement sessions online.

To ensure a wide range of views, we have spoken to a wide range of people, from: the regulators who oversee quality of services; the commissioners who contract us to deliver services; the organisations and staff who deliver health and care locally; to the people who use our services and representatives of the many communities we serve.

| Key Stakeholder Groups   |   |   |   |
|--|---|---|---|
| Regulators   | Commissioners   | Providers   | Patients & Public   |
| <ul style="list-style-type: none"> <li>• NHS England</li> <li>• CQC</li> <li>• Health Scrutiny Committees</li> <li>• Health &amp; Wellbeing Boards</li> <li>• Local politicians</li> </ul> | <ul style="list-style-type: none"> <li>• ICSs</li> <li>• CCGs</li> <li>• Local Authorities</li> <li>• Place Boards</li> </ul> | <ul style="list-style-type: none"> <li>• Health &amp; Care Staff</li> <li>• NHS Trusts</li> <li>• Community Healthcare</li> <li>• GP Practices</li> <li>• Mental Health</li> <li>• Social Care</li> <li>• Voluntary Sector</li> </ul> | <ul style="list-style-type: none"> <li>• Healthwatch</li> <li>• Trust Governors &amp; Members</li> <li>• Patient Groups</li> <li>• Carers</li> <li>• Community Groups</li> <li>• Advocacy Groups</li> <li>• General Public</li> </ul> |

## 8.2 The Conversation to Date

Over recent years there has been an ongoing conversation with local people about their health needs and how we can best meet them. The figure below gives an overview of some of the main strategic conversations in recent years.



## 8.3 What You Have Said So Far

We are humbled by the overwhelming support of local people for both East Cheshire NHS Trust and Stockport NHS Foundation Trust. 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 strategic 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 7 days a week

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.

People said that they 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.

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.

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

As the country begins to recover from the COVID-19 pandemic, we are beginning to hear more and more worries about the amount of time it takes for routine care

[50]: <https://mentalhealthpartnerships.com/project/caring-together-in-eastern-cheshire/>

[51]: [www.healthiertogethergm.nhs.uk](http://www.healthiertogethergm.nhs.uk)

[52]: <https://www.pas.gov.uk/sites/default/files/documents/connecting-care-cheshire--910.pdf>

[53]: Stockport Clinical Commissioning Group Stockport Together ([stockportccg.nhs.uk](http://stockportccg.nhs.uk))

[54]: <https://www.cheshireeast.gov.uk/pdf/livewell/adults/cheshire-east-partnership-5-year-plan-2019-2024.pdf>

[55]: One Stockport | All together as one

[56]: Cheshire Chat - Cheshire CCG

[57]: [www.localvoices.uk](http://www.localvoices.uk)

### 8.4 Listening Exercise

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

Between Monday 21st February and Saturday 2nd April 2022, NHS Cheshire, and NHS Stockport Clinical Commissioning Groups, alongside East Cheshire NHS Trust and Stockport NHS Foundation Trust 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 with the intention of determining what currently works well, what could be improved, and whether there are any barriers that stop people from accessing health services.

The full report will be available in mid-May however indicative reports to date show that 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 exercise 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 that of the CCGs and trusts in terms of numbers, ethnic groups and respondents ages. 35% of responses were from NHS staff and 35% from patients, 15% from public members and the remaining responses from carers and others. 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%). In terms of the detail, early indications show that 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. Specifically, 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. Parking and public transport were common themes throughout feedback.

A summary report on our listening exercise will be made available in Appendix 4. A copy of the full engagement report can be found at: <https://localvoices.uk>

**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.**



# 9. Equality Impact



Everyone in Stockport and East Cheshire is likely to use health and care services at some point in their lives, so we recognise that our services and the decisions we take have a major impact on the lives and wellbeing of local people.

## 9.1 Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act (2010)<sup>[58]</sup>, requires public sector organisations, in the exercise of their functions, to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different community groups
- foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between people who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to tackle prejudice, and promote understanding.

The characteristics given protection under the Equality Act 2010 are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation.

## 9.2 Diversity & Health Outcomes

The populations of both East Cheshire and Stockport are older than the national average, with higher life expectancy, and subsequently a higher rate of long-term conditions and disabilities requiring support from health services.

Around 20% of the population is aged 65 or older, with the Office for National Statistics expecting this to reach around 30% by 2038. More than half of older people have a long-term health condition and one in five have two or more long-term conditions. By the age of 85, 87% have a long-term condition and 53% have two or more. The age profile is older in areas of affluence.

Average life expectancy is around 80.2 years for men and 83.5 years for women. There is a significant difference in health outcomes between the more affluent and deprived areas, with men in the most affluent area of Stockport living 11 years longer than those in the most deprived area of the borough and the decline in health starts at age 55 in the most deprived areas, compared to 71 in the most affluent areas.

Around 18% of the shared population report having a disability that limits their day-to-day activities. Rates of disability increase with age, and for those aged 65+ almost half of all people reported having a long-term condition. Women are more likely than men to have a disability, and people from some ethnic and religious groups – especially some Asian Muslims – appear more likely to report a long-term condition or disability. In both cases, the differences tend to become more accentuated at older ages, so for example nearly 2 in 3 Pakistani and Indian women over 65 had a LTC or disability in 2001.

[58]: Equality Act 2010 (legislation.gov.uk)

**Age Profile:**

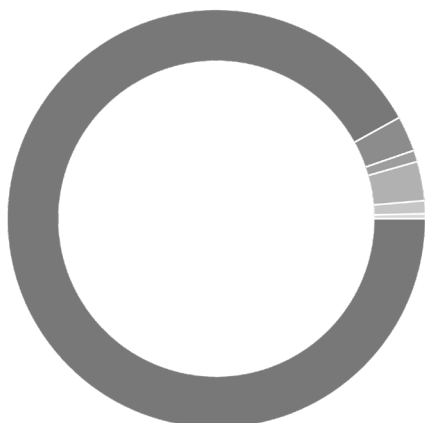
**20%** Aged 65+  
**5k** Births a year

**Life Expectancy:**

**80.2 : 83.5**



**Ethnicity:**



**91.96%** White British  
**2.74%** White Other  
**0.89%** Black  
**3.03%** Asian  
**1.00%** Mixed Race  
**0.38%** Other

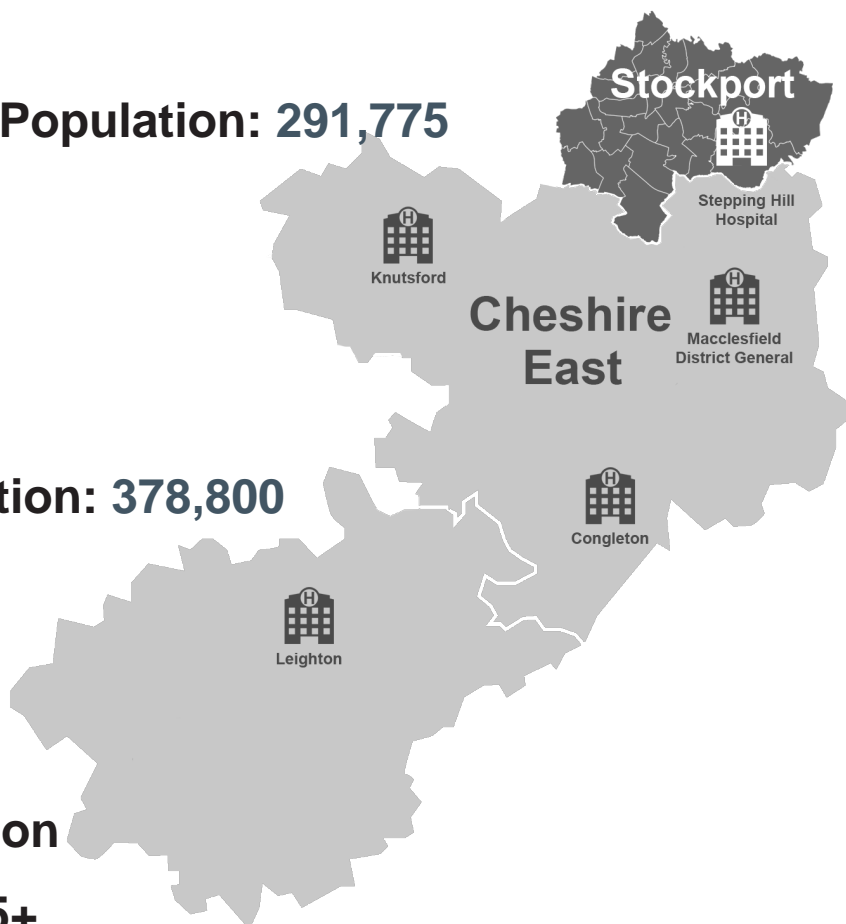
**Religion:**

**66.4%** Christian  
**23.7%** Atheist  
**1.82%** Muslim  
**0.46%** Hindu  
**0.29%** Jewish  
**0.27%** Buddhist  
**0.09%** Sikh  
**0.31%** Other

**c40k LGB**  
**c3k Trans**

**Population: 291,775**

**Population: 378,800**



**Disabilities:**

**18%** Whole Population  
**50%** People Aged 65+  
**66%** Indian & Pakistani Women Aged 65+

Both areas benefit from the diversity within their communities. While there is less ethnic diversity than the national average and in neighbouring areas across the Integrated Care Systems the respective trusts belong to, there has been a marked increase in ethnic diversity in both areas over the past decade and in the diversity of religious beliefs within communities.

91.96% of the combined population is white British, with 2.74% from another white background, 0.89% from a black ethnic background; 3.03% Asian; 1.0% mixed race and 0.38% of the combined population coming from another ethnic background.

At the last census, there were marked variations in rates of long-term illness or disability which restricted daily activities between different ethnic groups. After taking account of the different age structures of the groups, Pakistani and Bangladeshi men and women had the highest rates of disability - around 1.5 times higher than their White British counterparts.

66.4% of the combined population are Christian, 23.7% have no religion, 1.82% are Muslim, 0.46% Hindu, 0.29% Jewish, 0.27% Buddhist, 0.09% Sikh, and 0.31% hold another religious belief.

On average there are around 3,300 births a year in Stockport and 1,500 in East Cheshire. Birth rates are higher in areas of deprivation and among ethnic minority groups, where populations tend to be younger.

It is estimated that 0.3-0.7% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to between 2,000 and 4,500 people.

Trans people experience some of the most significant health inequalities, with 30% reporting that their health was 'poor' or 'very poor' compared to 8% of the non-transgender population.

Around 5-7% of the UK population is LGB,

which equates to between 34-47,000 people across the shared population. While health outcomes are generally similar to the population as a whole, the LGB population reports higher rates of poor mental wellbeing.

Both Stockport and East Cheshire are relatively affluent compared to the national average. However, both areas have pockets of deprivation. 17.4% of Stockport's residents live in the most deprived quintile, compared to just 7.7% of East Cheshire residents. 25.6% of Stockport's residents live in the most affluent quintile, compared to 41.9% of East Cheshire residents. There is a significant difference in health outcomes between people in the more affluent and deprived areas of the footprint.

The review of our services offers a unique opportunity to consider how change can be used to reduce inequalities in access to our services, in the experience of our services and in health outcomes.

### 9.3 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 vital 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 part of this process we are committed to ensuring that no community groups is worse off. As such, we will undertake equality impact assessments of all options, ensuring 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.

# 10. Summary & Recommendations



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 current or future 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 increasing demand.

## **Both trusts are committed to delivering safe, sustainable, high-quality hospital services that meet changing 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.

This case for change highlights the clinical reasons why changes must be made and the opportunities presented by further collaboration between the two trusts.

### **10.1 Clinical Standards, Workforce & the Scale of Services**

Clinical standards are defined by regulators and professional bodies such as the Royal Colleges and specialty associations. They are designed to ensure that organisations and services deliver consistently good outcomes.

While the services currently delivered at East Cheshire NHS Trust and Stockport NHS Foundation Trust are safe and of good quality, they do not always meet the national clinical standards of best practice that the trusts aspire to deliver for local populations.

National standards are often focused on appropriate staffing - both in terms of numbers and relevant professional qualifications - and the ability to deliver this standard sustainably

7 days a week, 365 days of the year.

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

- The larger the scale, the bigger the workforce, increasing a service's ability to recruit and retain staff and to cope with absences.
- The larger the scale the more likely it is that there will be staff with specialist skills and knowledge which can be offered to the population, address the inequalities of access that arise when subspecialist skills are confined to a small number of tertiary centres.
- The larger the size of a service, the less likelihood of variability.
- The converse is that the smaller the service, the less likely it is to be able to consistently deliver high quality care and the service may be considered fragile.

Sustainability requires a robust workforce model that delivers a service compliant with national clinical standards. In today's environment maintaining a skilled workforce is a challenge to all acute providers and there are some specialties with vacant posts in even the largest trusts.

We consider a fragile service to be one which may be unable to continue to deliver high quality care over the next 12 months. This is most often due to inability to recruit and retain appropriately qualified clinical staff.

It is within this context and the developing challenges to sustainability, that a collaborative service focus, rather than an organisational focus must be considered.

### 10.2 The Rationale for Collaboration

The primary aim of a clinical collaboration must be to deliver benefits for patients – that is, better outcomes and experience, consistently and sustainably.

For each service we must also consider the clinical interdependencies and the potential impact on the organisations' core functions, the relationships with primary, community care and social care and the principle that care must be delivered locally whenever possible and centralised only when necessary to ensure equity of access and address health inequalities.

Other organisations have been through a similar process. This experience suggests four common themes for delivering patient benefits:

**1**

#### **Service Delivery by a Single Integrated Team**

- Avoiding duplication - over two thirds of all specialties and support service functions in acute trusts are duplicated
- Higher volume, standardised services deliver better outcomes - The Royal Colleges, Improving Outcomes Guidance, Clinical Networks and NHS national guidelines increasingly relate patient outcomes to population size and emphasise the importance of sufficient clinical volume
- Equity of access for the combined population served.
- Consolidating services onto fewer sites where larger numbers of patients are treated, improvements in treatment

**2**

#### **Service Delivery via Best Practice Pathways with a Single Infrastructure**

- Avoiding variation in practice. Patients receive the same service and access to the same range of treatments, regardless of the timing and site
- Technology investment (eg robotic surgery) available to all
- Patient records unified with access to information for both clinicians and patients
- A single patient tracking list and reporting system to ensure equity
- Outcomes Guidance, Clinical Networks and NHS national guidelines increasingly relate patient outcomes to population size and emphasise the importance of sufficient clinical volume
- Equity of access for the combined population served.
- Consolidating services onto fewer sites where larger numbers of patients are treated, improvements in treatment processes, and investment in estate and infrastructure.

## 3

### Service Delivery via a Shared Workforce

- Recruiting, developing and retaining a sustainable workforce
- Creating sustainable 7-day *essential* services locally, e.g. Critical Care, Emergency Medicine
- Creating sustainable 7-day *specialist* services where appropriate.

## 4

### Creating a Service of Scale

- Giving a broader educational and training experience for students and trainees
- Improving the opportunities for innovation and research.

## 10.3 Summary of the Clinical Case for Change & Potential Benefits of Collaboration

The present and medium-term outlook for clinical services in the NHS is one of increasingly stringent clinical standards and growing demand against a backdrop of workforce shortages in a number of key professional groups.

Larger services tend to be more resilient and more successful at recruitment and retention of staff. The desire to be part of a high performing team with good peer support is an important factor to newly qualified staff, as is the potential to consolidate or develop sub speciality interests. Participation in teaching and training and in research, development and innovation are also attractive.

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.



# Anaesthesia & Critical Care

Without a level 3 critical care facility a hospital with an Emergency Department accepting unselected urgent cases would not be considered safe. Critical Care also underpins the medical and surgical inpatient services, including complex elective surgical procedures. Without appropriate medical, nursing and other clinical staffing levels, a fully functional level 3 (Critical Care) facility cannot be maintained 24/7.

|  |   |
|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• During the COVID-19 pandemic demand for consultant anaesthetists increased significantly, putting a strain on ECT's small team.</li> </ul>   |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• Clinical outcomes for patients are currently good, but there is a persistent risk to sustainability associated with subscale activity and a potential for de-skilling among staff who see such a small number of patients.</li> <li>• The key workforce safety standards, or Guidelines for the Provision of Intensive Care (GPIC), which challenge the sustainability of the ECT service relate to the numbers and availability of consultant and middle grade intensivists and anaesthetists. By the very nature of critical care medicine, such staff must be available 24/7 for emergency situations. SFT's Critical Care department are almost fully compliant with GPIC guidelines.</li> </ul> |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• The small size of ECT's Critical Care Unit makes it difficult to recruit new anaesthetists in a fiercely competitive market.</li> <li>• Large teaching hospitals attract the majority of newly qualified intensive care staff – ECT has successfully recruited to only two consultant posts in the past ten years. SFT faces a similar, though less acute, challenge.</li> <li>• A standalone service at ECT would require not just investment in staff, but successful recruitment, which appears challenging currently and in the immediate future</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• Recruitment and retention is likely to be more successful in a larger-scale, combined service across SFT and ECT</li> <li>• A larger team would allow 24/7 staffing cover to meet workforce standards</li> <li>• ECT has a newly refurbished Critical Care unit with isolation facilities and negative pressure ventilation to reduce cross infection risk, which should be attractive to potential job applicants.</li> <li>• Options of rotation within a larger team would support training and reduce the risk of de-skilling.</li> </ul>  |
| <b>Urgency of Change</b>                   | <p>This is a fragile service, requiring action within 12 months to ensure sustainability.</p>   |

# Cardiology

Both ECT and SFT cardiological departments provide a range of services locally with the more specialist and interventional procedures at the tertiary centres at MFT and Wythenshawe. This DGH/Tertiary centre split is found in many health care economies, however, the balance of local versus centralised services is variable. Cardiac surgery or interventional procedures which require surgical presence on site can only be delivered at the tertiary centres.

|  |  |
|--|--|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• Outpatient follow-up demand is high and waiting times are growing.</li> <li>• Demand for diagnostic investigations such as echocardiography is increasing.</li> <li>• Some patients are being admitted to hospital for treatment of heart failure because ambulatory care services are not currently in place.</li> <li>• Delays in transfer to specialist centres for interventional procedures impact on patient flow, prolonging length of stay.</li> </ul>  |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• Clinical standards for cardiology are based on cardiology networks.</li> <li>• Getting it right first time (GIRFT) recommendation is that 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.</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• ECT have a small consultant workforce of three WTE which - based on national population recommendations - should be increased to five. SFT have eight.</li> <li>• Most of the consultants also have clinical sessions at either Manchester Royal Infirmary or Wythenshawe.</li> <li>• SFT consultants have a 'consultant of the week' model and provide seven-day cover until 7 pm.</li> <li>• ECT consultants do not provide cover out of normal working hours. As it stands there is little possibility of a locally provided 24/7 cardiology rota.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• There is agreement that the investigation of chest pain and heart failure should be available locally and should include CTCA as a NICE recommendation for the diagnosis of stable chest pain (currently provided at a tertiary centre). However, neither trust is in a position to do this alone.</li> <li>• Many complex diagnostic and therapeutic services are provided by the network at tertiary centres. Local provision, however, could be significantly enhanced.</li> <li>• The consultant workforce at ECT could be made more sustainable through joint working and recruitment.</li> <li>• Provision of a comprehensive ambulatory heart failure and arrhythmia service would reduce admissions to hospital.</li> </ul> |
| <b>Urgency of Change</b>                   | <p>Moderate risk in light of consultant numbers at ECT and waiting time backlog.</p>   |

# Diabetes & Endocrinology

Around one in six of all people admitted to hospital will have diabetes. Evidence shows there are worse outcomes after surgery and in patients who present with a variety of acute medical conditions if their diabetes is not well controlled. Severe hypoglycaemia and diabetic ketoacidosis are more common in type 1 diabetes patients when in hospital.

|  |  |
|--|--|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• Diabetes is generally managed in primary care and the community. More complex therapies such as insulin pumps and continuous glucose monitoring may require greater hospital centre support. However, moving activity into the community has reduced the size of the acute service, making it sub-scale.</li> <li>• The ECT endocrinology service has now been closed to referrals as there is no consultant in place.</li> </ul> |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• At ECT there is currently no inpatient diabetology service and no specialist review of hospital patients with diabetes. Evidence shows that when diabetes is not well controlled, patients can have worse outcomes after surgery.</li> </ul>  |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• 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.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• Consultants and specialist nurses prefer working in a team.</li> <li>• Single handed practitioners or very small teams are a barrier to recruitment and retention – as has proven to be the case at ECT.</li> <li>• Joint recruitment and working by ECT and SFT would benefit both organisations.</li> </ul>   |
| <b>Urgency of Change</b>                   | <p>This is a fragile service. Action is already in progress to support East Cheshire patients now that the endocrinology outpatient service has now been closed to referrals.</p>  |

# Endoscopy

Endoscopy is a key diagnostic gastroenterological investigation. It is a high-volume procedure which is critical in identifying oesophageal, stomach and colon cancer and in differentiating these conditions from the many benign causes of symptoms such as abdominal pain, difficulty swallowing and bleeding. The trusts have a different approach to service delivery with endoscopy delivered predominantly by medically trained gastroenterologists at SFT and by a mixture of general surgeons and gastroenterologists at ECT. SFT offers a wider range of specialist services.

|  |   |
|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• Waiting lists have grown significantly during the COVID-19 pandemic, compromising prompt diagnosis and treatment. Waiting lists pressures are likely to increase as the criteria for referral are extended to a younger age group.</li> </ul>  |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• Standards pertaining to the procedures themselves are accredited by the Joint Advisory Group on Endoscopy (JAG).</li> <li>• ECT has not been awarded JAG accreditation and SFT is awaiting results of its review.</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• Both ECT and SFT need to expand their clinical workforce.</li> <li>• The out of hours GI bleed rota at ECT is currently delivered by just 3 gastroenterologists, putting a strain on the workforce.</li> </ul>   |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• Collaboration offers significant patient benefits relating to improved access to specialist procedures such as ERCP, EUS, fibroscan, and capsular endoscopy.</li> <li>• Potential exists to better maximise use of estate and workforce capacity at both sites by using available endoscopy sessions at ECT to meet demand that cannot be met at SFT.</li> <li>• Collaboration could support a more robust out of hours GI bleed rota - the ECT service delivered by three gastroenterologists is not sustainable.</li> <li>• Both ECT and SFT need to expand their clinical workforce. Joint recruitment of medical and specialist nurse endoscopists is more likely to be successful.</li> </ul> |
| <b>Urgency of Change</b>                   | Moderate risk related to growing waits for diagnostics and an unstable GI bleed rota at ECT.  |

# Gastroenterology

Gastroenterology is a major receiver of acute medical admissions. Generally, patients who present with non-surgical abdominal conditions would be admitted under the care of a gastroenterology specialist. This service is inextricably linked to the endoscopy service, though gastroenterologists are not the sole professional group involved in delivery of the service.

The trusts have different models of care with the eight consultants at SFT providing a specialist Gastroenterology on-call rota, while the three consultants at ECT are part of the acute general internal medicine rota.

|  |   |
|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>In addition to the growing demand for endoscopy, there has been a progressive increase in the number of patients admitted with acute or chronic liver disease. The major challenge at present relates to capacity. Many trusts are running six- or seven-day services in endoscopy and on ward rounds to boost capacity and improve patient flow.</li> </ul>                             |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>ECT has not been awarded JAG accreditation and SFT is awaiting results of its review.</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>The Workforce Report produced by the British Society of Gastroenterologists highlights a nationwide shortage of available gastroenterology staff at all levels.</li> <li>This means it is unlikely trusts will be able to recruit to meet the increasing demand.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>A larger scale service would be better placed to recruit and retain staff.</li> <li>A wider team would be able to offer a 6- or 7-day service to address waiting list delays.</li> <li>Collaboration also offers the potential for more efficient use estate.</li> <li>Potential for joint recruitment of nurse endoscopists, which both organisations very keen to progress.</li> </ul> |
| <b>Urgency of Change</b>                   | <p>Moderate risk related to workforce capacity at ECT.</p>  |

# General Surgery

A number of common acute conditions such as appendicitis and peritonitis require urgent access to surgery and, in some cases, post-operative admission to critical care. Similarly, patients undergoing complex abdominal surgery such as bowel resection for cancer may require critical care support.

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|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>SFT's elective service is still not back to pre-pandemic capacity and waiting lists are growing as surgical teams concentrate on urgent care like delivering the 2-week cancer target.</li> <li>ECT's general surgery team has a key interdependency with critical care and it can be a challenge to admit higher risk patients.</li> <li>Capacity at both sites is constrained due to beds not being ringfenced for elective surgery.</li> </ul>  |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>Both trusts have good outcomes following emergency laparotomy.</li> <li>Emergency surgery standards may be compromised at ECT due to limited access to critical care beds post operatively for higher risk patients.</li> <li>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.</li> <li>As ECT have relatively small number of patients, retention of surgical skills can be challenging for staff.</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>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 7-day emergency general surgery service over time.</li> <li>SFT has had difficulties in recruiting colorectal cancer nurse specialists, which can affect targets.</li> <li>SFT has a shortage of nurses on the wards. During the pandemic, surgical wards became medical wards to meet demand and a number of surgically trained nurses have left the service.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>Collaboration would support delivery of a robust call-rota, though post-operative access to critical and high dependency care may require a single site for emergency surgery. This would need to be supported by a robust clinical pathway for the emergency department, including accurate diagnosis via a 'straight to CT' policy for urgent cases.</li> <li>The situation is similar for complex elective procedures.</li> <li>Centralising colorectal surgery would increase resilience and sub-specialisation.</li> <li>Creation of a shared green site with ringfenced beds for elective surgery would support both trusts to manage waiting lists.</li> <li>Robotic surgery is currently only offered at SFT – collaboration offers the potential to extend this to ECT patients without significant investment</li> </ul> |
| <b>Urgency of Change</b>                   | <p>This is a fragile service in terms of the continuity of the consultant on-call rota at ECT, requiring action within 12 months to ensure sustainability.</p>  |

# Imaging

Demand for imaging services has grown significantly over recent years and is expected to continue to rise. Changes in pathways meant that patients require more scans, earlier in the pathway. Furthermore, the complexity of imaging has increased in recent years, increasing the time it takes to deliver scans and report on results. The major challenge throughout the NHS is that continuous growth in activity has not been matched by a commensurate increase in staff.

Imaging diagnostics are essential for cancer pathways and many elective pathways. Reducing the time from referral to diagnosis and treatment is crucial to improving the prognosis of patients in many conditions but particularly in the cancer pathways.

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| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>Over the next 12 months, increased demand will impact on the Trusts' ability to deliver the six-week waiting standard.</li> <li>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.</li> <li>Demand will only increase with outstanding elective work, and the roll out of the diagnostic cancer pathways.</li> <li>SFT has scanning capacity but shortage of staffing, which affects reporting turnaround.</li> <li>The national community diagnostic centre programme may support investment in additional scanning equipment, but is likely to further stretch workforce capacity.</li> </ul> |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>Neither trust has the workforce capacity to meet Royal College standards on reviewing imaging reports</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>High service demand means recruitment is extremely challenging across the country.</li> <li>Both hospitals have significant levels of vacancies, and a growing proportion of consultants are already past the normal retirement age.</li> <li>Difficulties in recruitment also impacts on the trusts' ability to attract trainees. ECT has an established apprenticeship scheme, but trainees often don't stay once trained</li> <li>New consultants are increasingly attracted to larger specialist centres with opportunities to sub-specialise.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>Collaboration offers the potential for resilience</li> <li>Recruitment and retention should be improved in a larger service.</li> <li>This will also favour the development of sub-specialty skills, such as reporting of CTCA and musculoskeletal MRI.</li> <li>ECT have a well-developed reporting from home model which is attractive to professional staff and could be replicated for SFT.</li> <li>A collaborative apprenticeship programme and a joint approach to developing an interventional radiology service are areas for development.</li> </ul>   |
| <b>Urgency of Change</b>                   | <p>It was agreed that Imaging could be described as a fragile service, due to the capacity and demand. It is also a key interdependency for many areas, which needs to be considered with other services in their case for change.</p>  |

# Trauma & Orthopaedics

The case for change in the trauma and orthopaedics relates to the overwhelming impact of the COVID-19 pandemic on the specialty. If we do nothing, it is predicted that waiting lists at both sites will continue to increase, as a lack of ring-fenced beds for elective orthopaedics at both sites means that cancellations are inevitable when hospital capacity is stretched.

Both trusts deliver urgent trauma and elective orthopaedic services. With two fully functioning emergency departments, it is considered necessary to maintain trauma services at both sites.

|  |   |
|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• The COVID-19 pandemic saw a significant number of elective orthopaedic procedures suspended.</li> <li>• It will take several years for the waiting time to be reduced to pre-pandemic levels.</li> <li>• Even before the pandemic, the lack of ring-fenced elective beds impacted on elective surgery capacity.</li> <li>• Patients are experiencing prolonged periods of pain and discomfort while waiting for hip and knee surgery, with a consequent increase in recovery time.</li> </ul>  |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• Outcomes remain good, however waiting lists numbers are high, delays are common.</li> <li>• 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.</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• Neither trust currently has problems recruiting consultants.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• The orthopaedic 'Getting it right first time' (GIRFT) programme recommends splitting elective surgery from emergency trauma services to reduce elective cancellations and improve quality – where surgeons see high volumes of elective joint replacements, the risk of infection is significantly reduced.</li> <li>• There is a significant potential for developing an elective centre for use by both trusts, separated from the main ward blocks.</li> <li>• As demand for elective orthopaedics continues to grow with an ageing population, a medium-term solution is required by both trusts.</li> </ul> |
| <b>Urgency of Change</b>                   | <p>Waiting list pressures will continue. This represents a high level of burden upon the older cohort of the population.</p>  |



# Women & Children: Maternity & Gynaecology

The safety of maternity services across the country has been subject to considerable scrutiny due to poor neonatal outcomes in a number of trusts. The subsequent Ockenden Report identified key areas for immediate action, relating to training and staffing among obstetricians and midwives and consultant anaesthetists.

The case for change in the maternity and gynaecology largely relates to workforce resilience at ECT.

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|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• There has been no significant change in the birth rate in recent years, although the number of births at Macclesfield has reduced significantly over the past decade.</li> <li>• In March 2020 ECT temporarily suspended all births at Macclesfield due to a lack of anaesthetic cover related to the COVID-19 pandemic</li> </ul>   |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• Neither ECT or SFT are fully compliant with the Ockenden recommendations or the Royal College of Anaesthetists guidelines</li> <li>• A dedicated anaesthetic on call rota for the labour ward and twice daily consultant obstetrician led ward rounds are a challenge.</li> </ul>  |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• SFT has invested in recruiting additional obstetric consultant posts in response to the Ockenden Report.</li> <li>• ECT has struggled to recruit midwives since the transfer of hospital births to SFT.</li> <li>• For intrapartum care to return to the Macclesfield site, a separate anaesthetic rota for maternity needs to be in place. This would be a challenge in terms of the number of anaesthetists available nationally and cost implications.</li> </ul> |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• Both trusts are more likely to be compliant with the current safety standards through a close collaboration.</li> <li>• ECT alone is unlikely to be able to comply even with investment due to the size of the service and recruitment challenges.</li> </ul>  |
| <b>Urgency of Change</b>                   | <p>Both trusts must become compliant with increasingly stringent standards which are dependent on highly skilled workforce, staffing levels, recruitment, and retention.</p> <p>Action plans for compliance with Ockenden requirements must be submitted within the next 12 months.</p>   |

# Women & Children: Paediatrics & Neonatology

Both SFT and ECT have paediatric outpatient services and in-patient beds for children and young people up to 16 years. The length of stay for admitted children is generally short – over 80% staying no more than one day in hospital. Currently there is no neonatal in-patient service at ECT as the consultant led maternity facility is located on the SFT site.

|  |   |
|--|---|
| <b>Capacity &amp; Demand</b>               | <ul style="list-style-type: none"> <li>• Activity at ECT is too low to warrant the number of staff required to meet national standards 7 days a week.</li> <li>• 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.</li> </ul>   |
| <b>Quality &amp; Outcomes</b>              | <ul style="list-style-type: none"> <li>• 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.</li> <li>• Clinical standards of both the Royal College Paediatric and Child Health, the British Association of Perinatal Medicine and RCN are heavily weighted to the presence and availability of senior appropriately qualified professional staff.</li> <li>• Neither ECT nor SFT is compliant with current standards</li> </ul>   |
| <b>Workforce Resilience</b>                | <ul style="list-style-type: none"> <li>• SFT has 13 WTE consultants ECT has seven. Despite this, both trusts require additional consultant posts to deliver a 7-day service.</li> <li>• Recruitment to medical middle grade post has proven difficult at ECT.</li> <li>• 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.</li> </ul>  |
| <b>Potential Benefits of Collaboration</b> | <ul style="list-style-type: none"> <li>• Collaboration would support the trusts to deliver challenging workforce standards.</li> <li>• A single in-patient site may offer the most realistic opportunity to deliver against standards. However, both emergency departments at ECT and SFT require specialist advice and review of relevant cases, which emergency medicine trained clinicians do not feel as confident to manage.</li> <li>• The high number of in patient stays which are less than one day suggests that children are admitted for review and a short period of observation rather than for urgent treatment interventions. A satisfactory solution to this may involve investment in acute community based paediatric services.</li> </ul> |
| <b>Urgency of Change</b>                   | Moderate related to scale of service at ECT. Requires primary care and community involvement to offer a new service model.  |

## 10.4 Recommendations & Next Steps

While the services currently delivered at East Cheshire NHS Trust and Stockport NHS Foundation Trust are safe and of good quality, we recognise that it is taking longer to access care and that the current model is not sustainable in light of growing demand.

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 aspiration for local people and where both trusts need to change to continue to deliver safe, quality care into the future.

Collaboration across hospital trusts offers a range of opportunities to meet the challenges of growing demand, limited workforce, estates and funding to consistently deliver the clinical standards we want for our patients.

- for East Cheshire NHS Trust this relates primarily to being part of a larger-scale service, providing resilience in the workforce and a wider case mix to support recruitment, retention, and opportunities for sub-specialisation.
- for Stockport NHS Foundation Trust, being part of a larger-scale service offers a potential solution to manage growing backlogs resulting from the pandemic and to effectively balance the competing pressures of planned and emergency care.

As such, it is the recommendation of this case for change that East Cheshire NHS Trust and Stockport NHS Foundation Trust work together to consider alternative models of care that will enable the two organisations to deliver high quality hospital care for the local population, long into the future.

### 10.4.1 Next Steps

Options should be co-produced and assessed by our clinicians and the populations they serve, considering the various models of collaboration<sup>[59]</sup>.

[59]: Single Hospital Service Review (2016) Manchester Health & Wellbeing Board

| 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   |
| <ul style="list-style-type: none"> <li>• Standardised care pathways and protocols across all teams who provide that service</li> <li>• Each team must adhere to minimum staffing requirements</li> <li>• Shared clinical data</li> <li>• Shared audit processes</li> </ul> | <ul style="list-style-type: none"> <li>• One clinical team shared between sites (joint rota)</li> <li>• Shared assets, e.g., theatres, cath labs, outpatient suites</li> </ul> | <ul style="list-style-type: none"> <li>• Coordinated services across multiple sites with some sites providing care for high complexity / risk cases and other sites providing care for lower risk patients</li> <li>• Common protocols and rapid transfer arrangements between sites</li> </ul> | <ul style="list-style-type: none"> <li>• All resources for a single specialty pooled on a single site</li> </ul> |

This will require further engagement with clinicians, staff, patients and the public to ensure that local needs and aspirations are at the heart of proposals.

Key areas to consider in any future model will include:



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



- 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?



- Does the model improve recruitment and retention of staff?
- Does it support a consistent 7-day service whenever appropriate?
- Is the model financially viable?



- 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 system?

Should this case for change be accepted, we will follow this process to ensure that our proposals are fair, and evidence based.

NHSE will put together an assurance panel consisting of staff suitably qualified to consider evidence submitted against the tests outlined above, as well as other checks, including deliverability, affordability and value for money.

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

## 10.4.2 Assurance Process

NHS England has an assurance process for managing complex programmes of service change<sup>[46]</sup> to ensure that proposals meet the government's four tests of service change and NHS England's test for proposed bed closures.

The government's **four tests of service change** are:

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.

### 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)

# Appendix 1: Glossary of Abbreviations

The table below outlines the abbreviations and acronyms used in the report.

| Abbreviation | Name   |
|--------------|--|
| ACP          | Advanced Clinical Practitioner                                 |
| ACPGBI       | Association of Coloproctology of Great Britain And Ireland     |
| AfC          | Agenda for Change  |
| AHP          | Allied Health Professional                                     |
| AHSN         | Academic Health Science Network                                |
| ANDU         | Antenatal Day Assessment Unit                                  |
| BAPM         | British Association of Peri Natal Medicine                     |
| BCBV         | Better Care Better Value                                       |
| BCIS         | British Cardiovascular Intervention Society                    |
| BDP          | Bollington, Disley and Poynton Care Community                  |
| BMI          | Body Mass Index  |
| BMJ          | British Medical Journal  |
| BPT          | Best Practice Tariff   |
| BSG          | British Society of Gastroenterologists                         |
| BTA          | Business Transfer Agreement                                    |
| C&M          | Cheshire & Merseyside  |
| CCG          | Clinical Commissioning Group                                   |
| CCNS         | Children's Community Nursing Service                           |
| CCU          | Critical Care Unit   |
| CD           | Clinical Director  |
| CDC          | Community Diagnostics Centre                                   |
| CEO          | Chief Executive Officer  |
| CESR         | Certificate of Eligibility for Specialist Registration         |
| CHAW         | Chelford, Handforth, Alderley Edge and Wilmslow Care Community |
| CHOC         | Congleton And Holmes Chapel Care Community                     |
| CIC          | Community Interest Company                                     |
| CIP          | Cost Improvement Plan  |
| CMA          | Competition and Markets Authority                              |
| CNST         | Clinical Negligence Scheme for Trusts                          |
| COPD         | Chronic Obstructive Pulmonary Disease                          |
| CPoC         | Collaboration Proof Of Concept                                 |
| CQC          | Care Quality Commission  |
| CQUIN        | Commissioning For Quality and Innovation                       |
| CT           | Computerised Tomography  |
| CTCA         | CT Coronary Angiography  |
| CVD          | Cardiovascular Disease   |
| CVF          | Competing Values Framework                                     |
| D2A          | Discharge To Assess  |

| Abbreviation | Name  |
|--------------|---|
| DEXA         | Dual Energy X-Ray Absorption                                      |
| DGH          | District General Hospital   |
| DHSC         | Department Of Health & Social Care                                |
| DNA          | Did Not Attend  |
| DSE          | Dobutamine Stress Echocardiogram                                  |
| DTOC         | Delayed Transfer of Care  |
| EBITDA       | Earnings Before Interest, Taxation, Depreciation and Amortisation |
| ECT          | East Cheshire Trust   |
| ED           | Emergency Department  |
| EDI          | Equality, Diversity & Inclusion                                   |
| EIA          | Equality Impact Assessment  |
| EPR          | Electronic Patient Record   |
| ERCP         | Endoscopic Retrograde Cholangiopancreatography                    |
| ESD          | Early Supported Discharge   |
| ETU          | Endoscopy And Treatment Unit                                      |
| EUR          | Effective Use of Resources  |
| FBC          | Full Business Case  |
| FDS          | Faster Diagnosis Standard   |
| FFICM        | Faculty Of Intensive Care Medicine                                |
| FM           | Facilities Management   |
| FT           | Foundation Trust  |
| FY           | Financial Year  |
| FYFV         | The NHS Five Year Forward View                                    |
| GI           | Gastrointestinal  |
| GIRFT        | Getting It Right First Time                                       |
| GM           | Greater Manchester  |
| GMEC LMS     | Greater Manchester and Eastern Cheshire Local Maternity System    |
| GMHSCP       | Greater Manchester Health & Social Care Partnership               |
| GMOA         | Greater Manchester Orthopaedic Alliance                           |
| GP           | General Practitioner  |
| GPICS        | Guidelines for the Provision of Intensive Care Services           |
| HASU         | Hyper Acute Stroke Unit   |
| HMRC         | Her Majesty's Revenue & Customs                                   |
| HMT          | Her Majesty's Treasury  |
| HR           | Human Resources   |
| HSMR         | Hospital Standardised Mortality Ratio                             |
| HW           | Healthwatch   |
| HWBB         | Health & Wellbeing Board  |
| I&E          | Income And Expenditure  |
| ICB          | Integrated Care Board   |
| ICD          | Implantable Cardioverter Defibrillator                            |
| ICM          | Intensive Care Medicine   |
| ICNARC       | Intensive Care National Audit & Research Centre                   |

| Abbreviation | Name   |
|--------------|--|
| ICS          | Integrated Care System                                       |
| ICU          | Intensive Care Unit  |
| IM&T         | Information Management & Technology                          |
| IMD          | Index Of Multiple Deprivation                                |
| IR           | Interventional Radiology                                     |
| ISAS         | Imaging Services Accreditation Scheme                        |
| IT           | Information Technology                                       |
| JAG          | Joint Advisory Group on GI Endoscopy                         |
| JCAG         | Joint Clinical Advisory Group                                |
| JCF          | Junior Clinical Fellow                                       |
| JSNA         | Joint Strategic Needs Assessment                             |
| JV           | Joint Venture  |
| KPI          | Key Performance Indicator                                    |
| LNU          | Local Neonatal Units   |
| LOS          | Length Of Stay   |
| LTC          | Long-Term Condition  |
| LTP          | The NHS Long-Term Plan                                       |
| MCA          | Maternity Care Assistant                                     |
| MCH          | Manchester Children's Hospital                               |
| MCHFT        | Mid-Cheshire Hospitals NHS Foundation Trust                  |
| MDT          | Multi-Disciplinary Team                                      |
| MPI          | Myocardial Perfusion Imaging                                 |
| MRI          | Magnetic Resonance Imaging                                   |
| NBOCA        | National Bowel Cancer Audit                                  |
| NCEPOD       | National Confidential Enquiry Into Patient Outcome And Death |
| NED          | Non-Executive Director                                       |
| NEL          | Non-Elective   |
| NELA         | National Emergency Laparotomy Audit                          |
| NHS          | National Health Service                                      |
| NHSE         | NHS England  |
| NIA          | Non Invasive Ventilation                                     |
| NICE         | The National Institute for Health And Care Excellence        |
| NICU         | Neonatal Intensive Care Unit                                 |
| NJR          | National Joint Registry                                      |
| NOUS         | Non-Obstetric Ultrasound Scan                                |
| NPV          | Net Present Value  |
| NTDA         | NHS Trust Development Authority                              |
| NW           | North West   |
| NWODN        | North West Neonatal Operational Delivery Network             |
| NWTS         | North West Paediatric Transfer Service                       |
| O&G          | Obstetrics & Gynaecology                                     |
| OAA          | Obstetric Anaesthetists Association                          |
| OBC          | Outline Business Case  |

| Abbreviation | Name   |
|--------------|--|
| OD           | Organisational Development                         |
| ONS          | Office For National Statistics                     |
| OOH          | Out Of Hours                                       |
| OSC          | Overview Scrutiny Committee                        |
| PAs          | Programmed Activities                              |
| PACS         | Picture Archiving and Communication System         |
| PALS         | Patient Advice and Liaison Service                 |
| PAS          | Patient Administration System                      |
| PBCIP        | Post Business Case Implementation Plan             |
| PbR          | Payments By Results                                |
| PCI          | Percutaneous Coronary Intervention                 |
| PCN          | Primary Care Network                               |
| PDC          | Public Dividend Capital                            |
| PET-CT       | Position Emission Topography – Computed Topography |
| PFI          | Private Finance Initiative                         |
| PHE          | Public Health England                              |
| PID          | Project Initiation Document                        |
| PIFU         | Patient Initiated Follow Up Pathways               |
| PMI          | Patient Master Index                               |
| PMO          | Programme Management Office                        |
| POBS         | Paediatric Observation Unit                        |
| POD          | Point Of Delivery                                  |
| POLCV        | Procedures Of Limited Clinical Value               |
| PPCI         | Primary Percutaneous Coronary Intervention         |
| PPI          | Patient & Public Involvement                       |
| PPM          | Permanent Pacemaker                                |
| PRM          | Provider Regulation Meeting                        |
| PTIP         | Post Transaction Implementation Plan               |
| PTL          | Patient Tracking List                              |
| QIPP         | Quality, Innovation, Productivity and Prevention   |
| R&D          | Research & Development                             |
| RCM          | Royal College of Midwives                          |
| RCOA         | Royal College of Anaesthetics                      |
| RCPCH        | The Royal College of Paediatrics And Child Health  |
| RCR          | The Royal College of Radiologists                  |
| RIS          | Radiology Information System                       |
| RTT          | Referral To Treatment Time                         |
| SAS          | Specialty And Associate Specialist                 |
| SAU          | Surgical Assessment Unit                           |
| SCC          | Spinal Cord Compression                            |
| SCU          | Special Care Unit                                  |
| SDEC         | Same Day Emergency Care                            |
| SECCS        | South East Coast Clinical Senate                   |



| Abbreviation | Name  |
|--------------|---|
| SFI          | Standing Financial Instruction  |
| SFT          | Stockport NHS Foundation Trust  |
| SHMI         | Summary Hospital-Level Mortality Indicator                            |
| SIFT         | Service Increment for Training  |
| SLA          | Service Level Agreement   |
| SMBC         | Stockport Metropolitan Borough Council                                |
| SR21         | The 2021 Spending Review  |
| SRO          | Senior Responsible Officer  |
| SSNAP        | Sentinel Stroke National Audit Programme                              |
| ST           | Specialty Trainees  |
| STEMI        | ST-segment Elevation Myocardial Infarction                            |
| STF          | Sustainability And Transformation Fund                                |
| STP          | Sustainability And Transformation Plan                                |
| SVCO         | Superior Vena Cava Obstruction  |
| T&O          | Trauma & Orthopaedics   |
| TGIC         | Tameside & Glossop Integrated Care NHS Foundation Trust               |
| TIA          | Transient Ischaemic Attack  |
| TOE          | Transoesophageal Echocardiogram                                       |
| TUPE         | Transfer Of Undertakings (Protection of Employment) Regulations 2006  |
| US           | Ultrasound Scan   |
| WLI          | Waiting List Initiatives  |
| WTE          | Whole-Time Equivalent   |
| WWL          | Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust |

## Appendix 2: Reference Materials

- **2030 vision. How will technology shape healthcare in the next decade?** (2020) NHS Confederation. Available from: <https://www.nhsconfed.org/articles/2030-vision>
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# Appendix 3: Record of Clinical Engagement

| ANAESTHETICS & CRITICAL CARE |   |              |          |          |          |          |
|------------------------------|---|--------------|----------|----------|----------|----------|
| Name                         | Role  | Organisation | Date     |          |          |          |
|                              |   |              | 04/05/21 | 24/05/21 | 14/03/22 | 19/04/22 |
| John Hunter                  | Medical Director  | ECT          | ✓        | ✓        | ✓        |          |
| Andrew Loughney              | Medical Director  | SFT          |          | ✓        | ✓        | ✓        |
| Peter Williams               | Clinical Advisor  | Independent  | ✓        | ✓        | ✓        | ✓        |
| Andy Bailey                  | Deputy Director of Strategy & Partnerships                        | SFT          | ✓        |          |          |          |
| Simon Brown                  | General Manager - Urgent Care and Frailty                         | ECT          | ✓        | ✓        | ✓        | ✓        |
| Sam Burnett                  | Business Planning Manager   | SFT          | ✓        | ✓        |          |          |
| Heather Cooper               | Consultant Nurse - Critical Care                                  | ECT          | ✓        |          | ✓        |          |
| Belinda Dean                 | Head of Nursing, Acute & Intensive Care                           | ECT          |          |          |          | ✓        |
| Lynne Evans                  | Associate Nurse Director  | SFT          | ✓        | ✓        | ✓        |          |
| Hywel Garrard                | Consultant - Critical Care  | SFT          | ✓        |          |          |          |
| Andrew Gorman                | Clinical Lead - Anaesthetics                                      | ECT          | ✓        |          | ✓        | ✓        |
| Sarah Harrison               | Project Manager   | ECT/SFT      | ✓        | ✓        |          |          |
| Karen Hatchell               | Business Group Director   | SFT          | ✓        | ✓        | ✓        |          |
| Matt Jackson                 | Deputy Clinical Director - Critical Care                          | SFT          |          | ✓        | ✓        | ✓        |
| Lisa Kirkup                  | Associate Director; Allied Health and Planned Care                | ECT          | ✓        | ✓        |          | ✓        |
| Marc Lyons                   | Clinical Lead - Critical Care                                     | ECT          | ✓        | ✓        |          |          |
| Sheena Morris                | Strategic Planning Officer  | ECT          |          |          | ✓        |          |
| Dave Nunns                   | Associate Director of Strategy                                    | ECT          | ✓        | ✓        |          |          |
| Joe O'Brien                  | Matron  | SFT          | ✓        | ✓        |          |          |
| Liz Owen                     | Matron  | ECT          | ✓        |          |          |          |
| Kath Senior                  | Director of Clinical Strategy                                     | ECT          | ✓        | ✓        | ✓        |          |
| Liz Thomas                   | Clinical Director   | SFT          | ✓        | ✓        | ✓        |          |
| Bob Unwin                    | Business Manager - Critical Care                                  | SFT          |          | ✓        |          |          |
| James Wilmott                | Consultant Anaesthetist   | ECT          |          |          | ✓        |          |
| Jo Young                     | Deputy Director of Operations Acute and Integrated Community Care | ECT          | ✓        | ✓        | ✓        | ✓        |
| Gordon Yuill                 | Clinical Director - Anaesthetics                                  | SFT          | ✓        | ✓        | ✓        |          |

| CARDIOLOGY          |  |              |            |            |            |
|---------------------|--|--------------|------------|------------|------------|
| Name                | Role   | Organisation | Date       |            |            |
|                     |  |              | 25/10/2021 | 09/11/2021 | 18/03/2022 |
| John Hunter         | Medical Director                             | ECT          | ✓          |            |            |
| Andrew Loughney     | Medical Director                             | SFT          | ✓          | ✓          | ✓          |
| Peter Williams      | Clinical Advisor                             | Independent  | ✓          | ✓          | ✓          |
| Nadine Armitage     | Divisional Director                          | SFT          | ✓          | ✓          | ✓          |
| Marta Babores       | Clinical Director                            | ECT          | ✓          |            | ✓          |
| Angela Barrett      | Directorate Manager                          | SFT          | ✓          | ✓          | ✓          |
| Sam Burnett         | Business Planning Manager                    | SFT          | ✓          | ✓          |            |
| Arzu Cubukcu        | Consultant Cardiologist                      | ECT          | ✓          |            |            |
| Jennifer Hemmings   | General Manager                              | ECT          | ✓          | ✓          | ✓          |
| Fran Jackson        | Improvement/Project Practitioner             | ECT          |            |            | ✓          |
| Sarah Harrison      | Project Manager                              | ECT/SFT      |            |            | ✓          |
| Ngai Kong           | Associate Medical Director                   | SFT          |            | ✓          | ✓          |
| Philip Lewis        | Clinical Director - Cardiology               | SFT          | ✓          | ✓          | ✓          |
| Carl Miller         | Operational Manager                          | ECT          | ✓          | ✓          | ✓          |
| Dave Nunns          | Associate Director of Strategy               | ECT          | ✓          | ✓          |            |
| Stuart Russell      | Consultant Cardiologist                      | ECT          |            | ✓          | ✓          |
| Dilraj Sandher      | Deputy Medical Director                      | SFT          |            | ✓          |            |
| Martha Scott        | Principal Physiologist                       | ECT          | ✓          | ✓          |            |
| Kath Senior         | Director of Clinical Strategy                | ECT          |            | ✓          |            |
| Jacqueline Williams | Associate Director, Service Transformations. | ECT          |            |            | ✓          |

| DIABETES & ENDOCRINOLOGY |  |              |            |  |          |
|--------------------------|--|--------------|------------|--|----------|
| Name                     | Role   | Organisation | Date       |  |          |
|                          |  |              | 15/10/2021 |  | 21/04/22 |
| John Hunter              | Medical Director   | ECT          | ✓          |  |          |
| Andrew Loughney          | Medical Director   | SFT          | ✓          |  | ✓        |
| Peter Williams           | Clinical Advisor   | Independent  | ✓          |  |          |
| Nadine Armitage          | Divisional Director  | SFT          |            |  | ✓        |
| Angela Barrett           | Divisional Manager   | SFT          | ✓          |  | ✓        |
| Richard Bell             | Consultant; Diabetes and Endocrine                                 | SFT          | ✓          |  | ✓        |
| Angela Dawber            | Head of Strategic Planning   | SFT          | ✓          |  |          |
| Kate Gascoyne            | Business Planning Manager  | SFT          | ✓          |  |          |
| Jennifer Hemming         | General Manager Acute Care   | ECT          | ✓          |  |          |
| Sarah Ingleby            | Associate Nurse Director   | SFT          | ✓          |  |          |
| Ngai Kong                | Associate Medical Director for Medicine                            | SFT          | ✓          |  |          |
| Carl Miller              | Operational Manager, Medicine                                      | ECT          |            |  | ✓        |
| Dave Nunns               | Associate Director of Strategy                                     | ECT          | ✓          |  |          |
| Jo Young                 | Deputy director of Operations, Acute and Integrated Community Care | ECT          |            |  | ✓        |

| ENDOSCOPY           |   |              |            |            |            |
|---------------------|---|--------------|------------|------------|------------|
| Name                | Role  | Organisation | Date       |            |            |
|                     |   |              | 07/05/2021 | 24/05/2021 | 04/03/2022 |
| John Hunter         | Medical Director  | ECT          | ✓          | ✓          |            |
| Andrew Loughney     | Medical Director  | SFT          | ✓          | ✓          | ✓          |
| Peter Williams      | Clinical Advisor  | Independent  | ✓          | ✓          | ✓          |
| Marta Babores       | Deputy Medical Director   | ECT          |            |            | ✓          |
| Sam Burnett         | Business Planning Manager   | SFT          | ✓          | ✓          |            |
| Caroline Culverwell | Business Manger -<br>Gastroenterology & General<br>Surgery                          | SFT          |            | ✓          | ✓          |
| John Dillon         | Diagnostic Services Manager -<br>Radiology & Endoscopy                              | ECT          | ✓          |            | ✓          |
| Lynn Evans          | Associate Nursing Director -<br>Surgery, GI & Critical Care                         | SFT          |            | ✓          | ✓          |
| Asimina Gaglia      | Clinical Lead   | SFT          |            |            | ✓          |
| Claire Hall         | Deputy Clinical Director - General<br>Surgery                                       | SFT          | ✓          |            |            |
| Sarah Harrison      | Project Manager   | ECT          | ✓          | ✓          | ✓          |
| Karen Hatchell      | Business Group Director - Surgery,<br>GI & Critical Care                            | SFT          | ✓          | ✓          |            |
| Jennifer Hemming    | General Manager Medicine  | ECT          |            |            |            |
| Wisam Jafar         | Clinical Director   | SFT          | ✓          | ✓          | ✓          |
| Collin Kaydon       | Assistant Directorate Manager   | SFT          |            |            |            |
| Lisa Kirkup         | Associate Director of Operations<br>(Planned Care and Clinical Support<br>Services) | ECT          | ✓          | ✓          | ✓          |
| Konrad Koss         | Clinical Lead - Endoscopy   | ECT          | ✓          | ✓          | ✓          |
| Nicola Mercer       | Matron  | SFT          |            |            | ✓          |
| Carl Miller         | Operational Manager - Medicine  | ECT          |            |            | ✓          |
| Sheena Morris       | Strategic Planning Officer  | ECT          |            |            | ✓          |
| Steven Murphy       | Service Lead - Endoscopy  | SFT          | ✓          | ✓          |            |
| Dave Nunns          | Associate Director of Strategy  | ECT          | ✓          | ✓          | ✓          |
| Ramasamay Saravana  | Consultant Gastroenterologist   | ECT          |            |            | ✓          |
| Kath Senior         | Director of Clinical Strategy   | ECT          | ✓          | ✓          |            |
| Rebecca Simmons     | Business Planning Manager   | SFT          | ✓          | ✓          |            |



| GASTROENTEROLOGY    |   |              |            |            |            |
|---------------------|---|--------------|------------|------------|------------|
| Name                | Role  | Organisation | Date       |            |            |
|                     |   |              | 18/11/2021 | 10/12/2021 | 04/03/2022 |
| John Hunter         | Medical Director  | ECT          | ✓          | ✓          |            |
| Andrew Loughney     | Medical Director  | SFT          | ✓          | ✓          | ✓          |
| Peter Williams      | Clinical Advisor  | Independent  | ✓          | ✓          | ✓          |
| Marta Babores       | Deputy Medical Director   | ECT          |            |            | ✓          |
| Sam Burnett         | Business Planning Manager   | SFT          | ✓          |            |            |
| Caroline Culverwell | Business Manger - Gastroenterology & General Surgery                          | SFT          |            | ✓          | ✓          |
| John Dillon         | Diagnostic Services Manager - Radiology & Endoscopy                           | ECT          |            |            | ✓          |
| Lynn Evans          | Associate Nursing Director - Surgery, GI & Critical Care                      | SFT          | ✓          |            | ✓          |
| Asimina Gaglia      | Clinical Lead   | SFT          |            |            | ✓          |
| Claire Hall         | Deputy Clinical Director - General Surgery                                    | SFT          |            |            |            |
| Sarah Harrison      | Project Manager   | ECT/SFT      |            |            | ✓          |
| Karen Hatchell      | Business Group Director - Surgery, GI & Critical Care                         | SFT          |            |            |            |
| Jennifer Hemming    | General Manager Medicine  | ECT          | ✓          | ✓          |            |
| Wisam Jafar         | Clinical Director   | SFT          | ✓          | ✓          | ✓          |
| Collin Kaydon       | Assistant Directorate Manager   | SFT          | ✓          |            |            |
| Lisa Kirkup         | Associate Director of Operations (Planned Care and Clinical Support Services) | ECT          |            |            | ✓          |
| Konrad Koss         | Clinical Lead - Endoscopy   | ECT          | ✓          | ✓          | ✓          |
| Nicola Mercer       | Matron  | SFT          | ✓          |            | ✓          |
| Carl Miller         | Operational Manager - Medicine  | ECT          | ✓          |            | ✓          |
| Sheena Morris       | Strategic Planning Officer  | ECT          |            |            | ✓          |
| Steven Murphy       | Service Lead - Endoscopy  | SFT          |            |            |            |
| Dave Nunns          | Associate Director of Strategy  | ECT          | ✓          | ✓          | ✓          |
| Ramasamay Saravana  | Consultant Gastroenterologist   | ECT          | ✓          | ✓          | ✓          |
| Kath Senior         | Director of Clinical Strategy   | ECT          |            |            |            |
| Rebecca Simmons     | Business Planning Manager   | SFT          |            |            |            |
| Sheena Morris       | Strategic Planning Officer  | ECT          |            |            | ✓          |

| GENERAL SURGERY     |  |              |            |            |            |
|---------------------|--|--------------|------------|------------|------------|
| Name                | Role   | Organisation | Date       |            |            |
|                     |  |              | 30/04/2021 | 21/05/2021 | 08/03/2022 |
| John Hunter         | Medical Director                                   | ECT          | ✓          | ✓          | ✓          |
| Andrew Loughney     | Medical Director                                   | SFT          | ✓          | ✓          | ✓          |
| Peter Williams      | Clinical Director                                  | Independent  | ✓          | ✓          | ✓          |
| Andy Bailey         | Deputy Director of Strategy & Partnerships         | SFT          | ✓          | ✓          |            |
| Sam Burnett         | Business Planning Manager                          | SFT          | ✓          |            |            |
| Caroline Culverwell | Business Manager - General Surgery                 | SFT          | ✓          | ✓          |            |
| Sarah Dean          | Operational Manager - General Surgery              | ECT          | ✓          | ✓          | ✓          |
| Lynn Evans          | Associate Nurse Director                           | SFT          | ✓          |            |            |
| Kate Gascoyne       | Business Planning Manager                          | SFT          | ✓          | ✓          |            |
| Adele Gatley        | General Manager - Planned Care                     | ECT          | ✓          |            |            |
| Katy Greensdale     | Matron - General Surgery                           | SFT          |            | ✓          |            |
| Kayode Habeeb       | Clinical Lead General Surgery                      | ECT          | ✓          | ✓          | ✓          |
| Claire Hall         | Consultant   | SFT          | ✓          | ✓          | ✓          |
| Sarah Harrison      | Project Manager                                    | ECT/SFT      |            |            | ✓          |
| Karen Hatchell      | Business Group Director                            | SFT          | ✓          | ✓          | ✓          |
| Natasha Henley      | Clinical Director                                  | SFT          | ✓          | ✓          | ✓          |
| Quasim Humayun      | Consultant   | SFT          |            |            | ✓          |
| Annela Hussain      | E, D and I Lead                                    | SFT          |            | ✓          |            |
| Usman Khan          | Clinical Director Planned Care                     | ECT          | ✓          | ✓          |            |
| Lisa Kirkup         | Associate Director, Allied Health and Planned Care | ECT          | ✓          | ✓          |            |
| Lizzi Moussa        | E, D and I Lead                                    | SFT          |            | ✓          |            |
| Dave Nunns          | Associate Director of Strategy                     | ECT          | ✓          | ✓          | ✓          |
| Jonathan O'Brien    | Director of Strategy and Partnerships              | SFT          |            |            | ✓          |
| Nnamdi Okolie       | Business Manager                                   | SFT          |            |            | ✓          |
| Kath Senior         | Director of Clinical Strategy                      | ECT          | ✓          | ✓          | ✓          |
| Karen Smith         | Head of Nursing, Allied Health and Planned Care    | ECT          | ✓          | ✓          | ✓          |
| Lucy Tideswell      | Strategic Planning Officer                         | ECT          |            | ✓          |            |

| IMAGING         |  |              |          |          |          |          |
|-----------------|--|--------------|----------|----------|----------|----------|
| Name            | Role   | Organisation | Date     |          |          |          |
|                 |  |              | 22/10/21 | 01/11/21 | 11/03/22 | 22/04/22 |
| John Hunter     | Medical Director                                   | SFT          | ✓        | ✓        |          |          |
| Andrew Loughney | Medical Director                                   | SFT          | ✓        |          | ✓        | ✓        |
| Peter Williams  | Clinical Advisor                                   | Independent  | ✓        | ✓        | ✓        | ✓        |
| Marta Babores   | Deputy Medical Director                            | ECT          |          |          | ✓        |          |
| Stuart Cooper   | Operational Lead                                   | SFT          | ✓        | ✓        | ✓        | ✓        |
| Angela Dawber   | Head of Strategic Planning                         | SFT          |          |          | ✓        | ✓        |
| John Dillon     | General Manager, Diagnostics                       | ECT          | ✓        | ✓        | ✓        | ✓        |
| Najmul Huq      | Clinical Director                                  | SFT          |          |          | ✓        | ✓        |
| Lisa Kirkup     | Associate Director, Allied Health and Planned Care | ECT          | ✓        | ✓        |          |          |
| Mong-Yang Loh   | Clinical Director                                  | SFT          | ✓        | ✓        | ✓        |          |
| Sheena Morris   | Strategic Planning Officer                         | ECT          |          |          | ✓        | ✓        |
| Dave Nunns      | Associate Director of Strategy                     | ECT          | ✓        | ✓        |          |          |
| Dilraj Sandher  | Deputy Medical Director                            | SFT          |          | ✓        |          |          |
| Kath Senior     | Director of Clinical Strategy                      | ECT          | ✓        |          | ✓        | ✓        |
| Robin Sil       | Consultant Radiologist                             | ECT          | ✓        |          | ✓        |          |
| Sue Tebby-Lees  | Clinical Lead, Consultant Radiologist              | ECT          |          | ✓        |          |          |
| Zoe Turner      | Divisional Director                                | SFT          |          |          | ✓        | ✓        |
| Fiona Walton    | Head of AHP Services/Clinical Director             | ECT          |          |          | ✓        |          |

| TRAUMA AND ORTHOPAEDICS |  |              |          |          |          |          |
|-------------------------|--|--------------|----------|----------|----------|----------|
| Name                    | Role   | Organisation | Date     |          |          |          |
|                         |  |              | 27/04/21 | 18/05/21 | 01/03/22 | 06/04/22 |
| John Hunter             | Medical Director                                   | ECT          | ✓        | ✓        | ✓        |          |
| Andrew Loughney         | Medical Director                                   | SFT          |          |          |          |          |
| Peter Williams          | Clinical Director                                  | Independent  | ✓        | ✓        | ✓        | ✓        |
| Andy Bailey             | Deputy Director of Strategy & Partnerships         | SFT          | ✓        | ✓        |          |          |
| Keith Barnes            | Consultant Orthopaedic Surgeon                     | ECT          | ✓        | ✓        |          |          |
| Rashpal Bassi           | Clinical Lead                                      | ECT          | ✓        | ✓        | ✓        |          |
| Lynn Evans              | Associate Nurse Director                           | SFT          | ✓        | ✓        | ✓        |          |
| Kate Gascoyne           | Business Planning Manager                          | SFT          | ✓        | ✓        |          |          |
| Adele Gatley            | General Manager Surgery                            | ECT          | ✓        | ✓        | ✓        |          |
| Sarah Harrison          | Project Manager - East Cheshire NHS Trust          | ECT/SFT      | ✓        | ✓        | ✓        |          |
| Karen Hatchell          | Business Group Director                            | SFT          | ✓        |          | ✓        |          |
| Lisa Kirkup             | Associate Director, Allied Health and Planned Care | ECT          | ✓        | ✓        | ✓        |          |
| Tahir Mahmud            | Consultant Orthopaedic Surgeon                     | ECT          | ✓        |          |          |          |
| Barnes Morgan           | Clinical Director                                  | SFT          | ✓        | ✓        | ✓        | ✓        |
| Sheena Morris           | Strategic Planning Officer                         | ECT          |          |          | ✓        | ✓        |
| Dave Nunns              | Associate Director of Strategy                     | ECT          | ✓        | ✓        |          |          |
| Sue Roberts             | Operational Manager                                | ECT          | ✓        | ✓        | ✓        | ✓        |
| Dilraj Sandher          | Associate Medical Director                         | SFT          | ✓        | ✓        | ✓        |          |
| Kath Senior             | Director of Clinical Strategy                      | ECT          | ✓        | ✓        | ✓        |          |
| Karen Smith             | Head of Nursing, Allied Health and Planned Care    | ECT          | ✓        | ✓        | ✓        | ✓        |
| Andrew Tunnicliffe      | Associate Business Group Director                  | SFT          | ✓        | ✓        | ✓        | ✓        |

| WOMEN & CHILDREN: MATERNITY & GYNAECOLOGY |   |              |          |          |          |          |
|---|---|--------------|----------|----------|----------|----------|
| Name                                      | Role  | Organisation | Date     |          |          |          |
|   |   |              | 26/04/21 | 17/05/21 | 18/03/22 | 20/04/22 |
| John Hunter                               | Medical Director  | ECT          | ✓        | ✓        | ✓        |          |
| Andrew Loughney                           | Medical Director  | SFT          |          | ✓        | ✓        | ✓        |
| Peter Williams                            | Clinical Advisor  | Independent  | ✓        | ✓        | ✓        | ✓        |
| Jyotsna Acharya                           | Clinical Lead and Consultant Obstetrician & Gynaecologist     | ECT          | ✓        | ✓        |          | ✓        |
| Andy Bailey                               | Deputy Director of Strategy & Partnerships                    | SFT          |          |          |          |          |
| Nicky Biggar                              | Deputy Head of Midwifery                                      | ECT          | ✓        | ✓        | ✓        |          |
| Sonia Chachan                             | Clinical Director   | SFT          | ✓        | ✓        | ✓        |          |
| Surendran Chandrasekaran                  | Consultant Paediatrician                                      | ECT          |          |          |          |          |
| Kelly Curtis                              | Business Manager  | SFT          | ✓        | ✓        | ✓        | ✓        |
| Sarah Fullwood                            | Matron  | SFT          |          |          |          |          |
| Bo Hamilton Cody                          | Head of Midwifery and Children's Services                     | ECT          | ✓        | ✓        | ✓        |          |
| Kate Gascoyne                             | Business Planning Manager                                     | SFT          | ✓        | ✓        |          |          |
| Sarah Harrison                            | Project Manager   | ECT/SFT      | ✓        | ✓        |          |          |
| Carrie Heal                               | Consultant Lead Neonates                                      | SFT          |          |          | ✓        | ✓        |
| Sharon Hyde                               | Head of Midwifery   | SFT          | ✓        |          |          |          |
| Alison Jobling                            | Associate Medical Director                                    | SFT          | ✓        | ✓        |          | ✓        |
| Joe Kabyemela                             | Consultant Obstetrician & Gynaecologist                       | ECT          | ✓        | ✓        |          |          |
| Sheena Morris                             | Strategic Planning Officer                                    | ECT          |          |          | ✓        |          |
| Elizabeth Newby                           | Clinical Director   | SFT          |          |          | ✓        | ✓        |
| Dave Nunns                                | Associate Director of Strategy                                | ECT          | ✓        | ✓        | ✓        |          |
| Rachel Owen                               | Consultant Obstetrician & Gynaecologist                       | SFT          | ✓        | ✓        |          |          |
| Rachel Patton                             | Deputy Head of Midwifery                                      | SFT          |          |          | ✓        | ✓        |
| Madhavi Pureti                            | Consultant Obstetrician & Gynaecologist                       | SFT          | ✓        |          |          |          |
| Kath Senior                               | Director of Clinical Strategy                                 | ECT          | ✓        | ✓        | ✓        |          |
| Jo Shippey                                | Paediatric Matron   | ECT          |          |          | ✓        | ✓        |
| Rebecca Simmons                           | Business Planning Manager                                     | SFT          |          |          |          |          |
| Zoe Turner                                | Divisional Director   | SFT          |          |          |          | ✓        |
| Fiona Walton                              | Deputy Director of Operations, Allied Health and planned care | ECT          | ✓        | ✓        | ✓        | ✓        |
| Gail Whitehead                            | Clinical Lead Paediatrics & Neonates                          | ECT          |          |          | ✓        | ✓        |
| Rachael Whittington                       | Associate Nurse Director                                      | SFT          |          |          | ✓        | ✓        |
| Claire Woodford                           | Business Group Director                                       | SFT          | ✓        | ✓        |          |          |

| WOMEN & CHILDREN: PAEDIATRICS & NEONATOLOGY |   |              |          |          |          |          |
|---|---|--------------|----------|----------|----------|----------|
| Name  | Role  | Organisation | Date     |          |          |          |
|   |   |              | 26/04/21 | 17/05/21 | 18/03/22 | 20/04/22 |
| John Hunter                                 | Medical Director  | ECT          | ✓        | ✓        | ✓        |          |
| Andrew Loughney                             | Medical Director  | SFT          |          |          | ✓        | ✓        |
| Peter Williams                              | Clinical Advisor  | Independent  | ✓        | ✓        | ✓        | ✓        |
| Jyotsna Acharya                             | Clinical Lead and Consultant Obstetrician & Gynaecologist     | ECT          |          |          |          | ✓        |
| Andy Bailey                                 | Deputy Director of Strategy & Partnerships                    | SFT          |          | ✓        |          |          |
| Nicky Biggar                                | Deputy Head of Midwifery                                      | ECT          | ✓        | ✓        | ✓        |          |
| Sonia Chachan                               | Clinical Director   | SFT          |          |          | ✓        |          |
| Surendran Chandrasekaran                    | Consultant Paediatrician                                      | ECT          | ✓        | ✓        |          |          |
| Kelly Curtis                                | Business Manager  | SFT          | ✓        | ✓        | ✓        | ✓        |
| Sarah Fullwood                              | Matron  | SFT          | ✓        | ✓        |          |          |
| Bo Hamilton Cody                            | Head of Midwifery and Children's Services                     | ECT          | ✓        | ✓        | ✓        |          |
| Kate Gascoyne                               | Business Planning Manager                                     | SFT          | ✓        | ✓        |          |          |
| Sarah Harrison                              | Project Manager   | ECT/SFT      |          | ✓        |          |          |
| Carrie Heal                                 | Consultant Lead Neonates                                      | SFT          | ✓        | ✓        | ✓        | ✓        |
| Sharon Hyde                                 | Head of Midwifery   | SFT          |          |          |          |          |
| Alison Jobling                              | Associate Medical Director                                    | SFT          | ✓        | ✓        |          | ✓        |
| Joe Kabyemela                               | Consultant Obstetrician & Gynaecologist                       | ECT          |          |          |          |          |
| Sheena Morris                               | Strategic Planning Officer                                    | ECT          |          |          | ✓        |          |
| Elizabeth Newby                             | Clinical Director   | SFT          | ✓        | ✓        | ✓        | ✓        |
| Dave Nunns                                  | Associate Director of Strategy                                | ECT          | ✓        | ✓        | ✓        |          |
| Rachel Owen                                 | Consultant Obstetrician & Gynaecologist                       | SFT          |          |          |          |          |
| Rachel Patton                               | Deputy Head of Midwifery                                      | SFT          |          |          | ✓        | ✓        |
| Madhavi Pureti                              | Consultant Obstetrician & Gynaecologist                       | SFT          |          |          |          |          |
| Kath Senior                                 | Director of Clinical Strategy                                 | ECT          | ✓        | ✓        | ✓        |          |
| Jo Shippey                                  | Paediatric Matron   | ECT          | ✓        | ✓        | ✓        | ✓        |
| Rebecca Simmons                             | Business Planning Manager                                     | SFT          | ✓        | ✓        |          |          |
| Zoe Turner                                  | Divisional Director   | SFT          |          |          |          | ✓        |
| Fiona Walton                                | Deputy Director of Operations, Allied Health and planned care | ECT          | ✓        | ✓        | ✓        | ✓        |
| Gail Whitehead                              | Clinical Lead Paediatrics & Neonates                          | ECT          | ✓        | ✓        | ✓        | ✓        |
| Rachael Whittington                         | Associate Nurse Director                                      | SFT          | ✓        | ✓        | ✓        | ✓        |
| Claire Woodford                             | Business Group Director                                       | SFT          | ✓        |          |          |          |

| Joint Clinical Advisory Group (JCAG) |   |              |              |          |          |
|--------------------------------------|---|--------------|--------------|----------|----------|
| Name                                 | Job Title   | Organisation | Meeting Date |          |          |
|                                      |   |              | 18/02/22     | 18/03/22 | 24/04/22 |
| Andrew Loughney                      | Medical Director  | SFT          | ✓            | ✓        | ✓        |
| John Hunter                          | Medical Director  | ECT          | ✓            | ✓        |          |
| Peter Williams                       | Independent Clinical Advisor  | Independent  | ✓            | ✓        | ✓        |
| Jyotsna Acharya                      | Clinical Lead, Obstetrics & Gynaecology                             | ECT          | ✓            |          |          |
| Dr Javaid Ali                        | Primary Care Representative   | SCCG         | ✓            | ✓        | ✓        |
| Catherine Allbright                  | Equality Diversity & Inclusion Rep                                  | ECT          | ✓            |          | ✓        |
| Marta Babores                        | Clinical Director   | ECT          | ✓            | ✓        |          |
| Tom Bartram                          | Clinical Lead, Emergency Department                                 | ECT          |              |          |          |
| Rashpal Bassi                        | Clinical Lead, Trauma & Orthopaedics                                | ECT          | ✓            | ✓        | ✓        |
| Richard Bell                         | Consultant, Diabetes and Endocrinology                              | SFT          |              | ✓        | ✓        |
| Karl Bonnici                         | Associate Medical Director, Integrated Care                         | SFT          |              |          |          |
| Kate Daly-Brown                      | Director of Nursing & Quality                                       | ECT          | ✓            | ✓        | ✓        |
| John Dillon                          | Head of Diagnostics   | ECT          | ✓            |          |          |
| Fiona Doorey                         | Head of Communications & Engagement                                 | ECT          |              |          | ✓        |
| Nicola Firth                         | Chief Nurse DIPC  | SFT          |              |          |          |
| Andrew Gorman                        | Clinical Lead, Anaesthetics   | ECT          |              |          |          |
| Kayode Habeeb                        | Clinical Lead, General Surgery                                      | ECT          | ✓            | ✓        |          |
| Dr Rachel Hall                       | General Practice Representative                                     | CCCG         |              |          | ✓        |
| Sarah Harrison                       | Project Manager   | ECT/SFT      | ✓            | ✓        |          |
| Natasha Henley                       | Associate Medical Director, GI & Critical Care                      | SFT          | ✓            | ✓        | ✓        |
| Alison Jobling                       | Associate Medical Director, Women, Children and Diagnostic Services | SFT          | ✓            | ✓        |          |
| Steven Kershaw                       | Medical Staff Committee Chair                                       | SFT          |              |          |          |
| Usman Khan                           | Clinical Director   | ECT          | ✓            |          |          |
| Ngai Kong                            | Associate Medical Director, Medicine & Clinical Support             | SFT          | ✓            | ✓        |          |
| Shivakuma Krishnamoorthy             | Associate Medical Director, Hospital Care, Medical Staff, Stroke    | SFT          | ✓            | ✓        | ✓        |
| Sheena Morris                        | Strategic Planning Officer  | ECT          |              |          | ✓        |
| Mahu Reddy                           | Clinical Director, Emergency Director                               | SFT          |              |          |          |
| Dilraj Sandher                       | Deputy Medical Director   | SFT          |              |          |          |
| Kath Senior                          | Director of Clinical Strategy                                       | ECT          | ✓            | ✓        | ✓        |
| Neela Surange                        | Medical Staff Committee Chair                                       | SFT          | ✓            |          | ✓        |
| Sue Tebby-Lees                       | Clinical Lead, Radiology  | ECT          |              |          |          |
| Gail Whitehead                       | Clinical Lead, Paediatrics & Neonates                               | ECT          | ✓            | ✓        | ✓        |
| James Willmott                       | Clinical Lead, ICU  | ECT          | ✓            |          |          |
|                                      |   |              |              |          |          |

**Engagement with Stockport GPs  
5th April 2022**

| <b>Name</b>        | <b>Role</b>   |
|--------------------|---|
| Dr Darren Aspinall | Medical Director, Viaduct Care CIC                                      |
| Stacey Davidson    | Pharmacy Lead, Stockport Integrated Pharmacy service                    |
| Dr Ranjit Gill     | Clinical Director, Victoria Primary Care Network                        |
| Dr James Higgins   | Clinical Director, Tame Valley Primary Care Network                     |
| Dr Becky Locke     | Clinical Director, Heatons Primary Care Network                         |
| Dr Viren Mehta     | Clinical Director, Cheadle Primary Care Network                         |
| Dr Tim Merchant    | Clinical Director, Viaduct Care CIC                                     |
| Dr Louise Monk     | Clinical Director, Bramhall & Cheadle Hulme Primary Care Network        |
| Anita Rolfe        | Executive Nurse, NHS Stockport CCG                                      |
| Dr Rukhsana Salim  | Clinical Director, Hazel Grove, High Lane & Marple Primary Care Network |
| Paul Stevens       | Local Medical Committee   |
| Dr Simon Woodworth | Medical Director, NHS Stockport CCG                                     |



**Engagement with Stockport Stockport One Health & Care Shadow Locality Board, 29th March 2022**

| <b>Name</b>      | <b>Role</b>  |
|------------------|--|
| Cllr J Wells     | Cabinet Member for Adult Care & Health, Stockport Metropolitan Borough Council (Chair) |
| Ms A Green       | Chief Accountable Officer, NHS Stockport CCG   |
| Ms K James       | Chief Executive, Stockport NHS Foundation Trust  |
| Ms J McGrath     | Chief Executive, Sector 3  |
| Dr V Mehta       | Primary Care Representative  |
| Mrs A Rolfe      | Executive Nurse, NHS Stockport CCG   |
| Ms C Simpson     | Chief Executive, Stockport Metropolitan Borough Council                                |
| Mr M Cullen      | Chief Finance Officer, Stockport CCG   |
| Mr J Graham      | Director of Finance, Deputy Chief Executive, Stockport NHS FT                          |
| Ms A Harper      | Head of Communications and Engagement, NHS Stockport CCG                               |
| Mrs M Maguinness | Director of Integrated Commissioning, NHS Stockport CCG                                |
| Ms K Rees        | Service Director Strategy and Commissioning, Stockport Metropolitan Borough Council    |
| Miss A Newton    | Corporate Support Administrator, Stockport CCG (Minutes)                               |

**Engagement with Stockport CCG Governing Body  
20th April 2022**

| <b>Name</b>     | <b>Role</b>  |
|-----------------|--|
| Mr P Winrow     | Lay Member for Audit & Governance, Chair                     |
| Mr M Cullen     | Chief Finance Officer, Stockport CCG                         |
| Dr M Richardson | General Practice Representative                              |
| Mr P Riley      | Lay Member for Primary Care Commissioning                    |
| Ms A Rolfe      | Interim Accountable Officer & Executive Nurse, Stockport CCG |
| Mr C McGuire    | Interim Deputy Director of Corporate Affairs                 |
| Ms A Harper     | Head of Communications and Engagement                        |
| Mr A Bailey     | Deputy Director for Strategy and Partnerships at SFT         |

**Engagement with Stockport CCG Governing Body  
6th May 2022**

| <b>Name</b>     | <b>Role</b>   |
|-----------------|---|
| Ms M Maguinness | Director of Integrated Commissioning                |
| Mr D Phillips   | Lay Member for Patient & Public Involvement         |
| Dr M Richardson | General Practice Representative                     |
| Mr P Riley      | Lay Member for Primary Care Commissioning           |
| Ms A Rolfe      | Interim Chief Accountable Officer, Executive Nurse  |
| Mr P Winrow     | Lay Member for Audit & Governance                   |
| Dr M Valluri    | General Practice Representative                     |
| Ms L Rigg       | Interim Deputy Director of Corporate Affairs        |
| Ms N Hussein    | Interim Corporate Affairs Manager                   |
| Ms A Harper     | Head of Communications and Engagement               |
| Ms F Vaughan    | Corporate Administrator (Minutes)                   |
| Mr J O'Brien    | Director of Strategy and Partnerships, Stockport FT |

**Engagement with Cheshire Place Executives, Chairs and GP representatives  
28 February 2022**

| <b>Name</b>            | <b>Role</b>  |
|------------------------|--|
| Rachael Charlton       | Interim Deputy Chief Executive, East Cheshire NHS Trust                          |
| Helen Charlesworth-May | Executive Director, Adult Health & Integration, Cheshire East Council            |
| Sam Corcoran           | Leader, Cheshire East Council  |
| Sheena Cumiskey        | Chief Executive, Cheshire & Wirral Partnership NHS Foundation Trust              |
| Denis Dunn             | Chair, Mid Cheshire Hospitals NHS Foundation Trust                               |
| Dr Dave Holden         | Chair, Cheshire East ICP Transformation Board/ Clinical Lead – Southern PCNs/CCs |
| Justin Johnson         | Chief Executive, Vernova, Community Interest Company                             |
| Dr Paddy Kearns        | Chair, Cheshire East ICP Board / Clinical Lead – Eastern PCNs / CCs              |
| Lynn McGill            | Chair, East Cheshire NHS Trust   |
| Dr Steven Michael OBE  | Independent Chair, Cheshire East Place Partnership                               |
| Ged Murphy             | Interim Chief Executive, East Cheshire NHS Trust                                 |
| Lorraine O'Donnell     | Chief Executive, Cheshire East Council   |
| Dr Anushta Sivananthan | Medical Director, Cheshire & Wirral Partnership NHS Foundation Trust             |
| James Sumner           | Chief Executive, Mid Cheshire Hospitals NHS Foundation Trust                     |
| Clare Watson           | Accountable Officer, NHS Cheshire Clinical Commissioning Group                   |
| Dr Andy Wilson         | Clinical Chair, NHS Cheshire Clinical Commissioning Group                        |
| Isla Wilson            | Chair, Cheshire & Wirral Partnership NHS Foundation Trust                        |

**Engagement with NHS Cheshire CCG Place Committee  
21 April 2022**

| Name             | Role                                    |
|------------------|---|
| Dr Andrew Wilson | Chair, NHS Cheshire CCG (Cheshire East) |
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**Engagement with Eastern Cheshire GP Practices' Meeting  
6 May 2022**

| Name              | Role                                     | Organisation                                       |
|-------------------|--|--|
| Laura Cunningham  | PCN Lead                                 | Middlewood PCN                                     |
| Lynne Garner      | Practice Manager                         | Kenmore MC   |
| Dr Daniel Harle   | GP / Care Community Lead                 | Broken Cross Surgery / Macclesfield Care Community |
| Helen Hawthorne   | Practice Manager                         | South Park Surgery                                 |
| Shaun Liu         | Practice Manager                         | Alderley Edge MC                                   |
| Dr Mark Lumb      | GP / Director / Deputy Clinical Director | South Park Surgery / Vernova / Macclesfield PCN    |
| Dr Gareth Morelli | GP / Director                            | Middlewood Partnership / Vernova                   |
| Joanne Morton     | PCN Manager                              | CHAW PCN   |
| Samantha Pownall  | Executive Manager                        | Knutsford Medical Partnership                      |
| Elaine Skepper    | Practice Manager                         | Chelford Surgery                                   |
| Sheila Williamson | Managing Director                        | Middlewood Partnership                             |

# Appendix 4: Report on Listening Exercise

## 1 Executive summary

### 1.1 Introduction

East Cheshire NHS Trust (ECT) and Stockport NHS Foundation Trust (SFT) aim to ensure the people they care for across Eastern Cheshire, Stockport and the surrounding areas continue to receive safe, high quality sustainable healthcare into the future.

The trusts and clinical commissioning groups (CCGs) wanted to hear what patients, staff and other stakeholders felt they needed to do to improve the following services:

- Cardiology
- Critical care and anaesthetics
- Diabetes and endocrinology
- Gastroenterology and endoscopy
- General surgery
- Imaging (X-ray and radiology)
- Trauma and orthopaedics
- Urgent and emergency care (A&E)
- Women's and children's services
- Planned care
- Community services.

### 1.2 Communications and engagement

Respondents were able to have their say by sending correspondence and completing the survey. Awareness of the engagement was increased through the following channels:

- Stakeholder engagement
- Press and media
- Engagement documents
- Websites and a dedicated engagement microsite
- Social media.

### 1.3 Numbers of respondents

The survey was live between 21 February 2022 to 2 April 2022 and received 273 responses.

### 1.4 Findings

Findings are set out over the page by clinical specialty.

## 1.4.1 Cardiology

**Number of respondents:** Overall, 38 respondents indicated they wanted to comment on cardiology services with 24 respondents accessing cardiology services in the last three years.

**Top location:** Macclesfield District General Hospital (12 / 50%) and Stepping Hill Hospital (12 / 50%)

**Rating of service:** Overall, 12 (50%) respondents rated services very good or good and 7 (29%) respondents rated services poor or very poor.

**Top themes on service:**

- Negative – Access – Waiting time for services is too long (9 / 28%)
- Positive – Staff – Staff were professional and friendly (7 / 22%)
- Positive – Quality of services – Services provided are good (5 / 16%).

## 1.4.2 Critical care and anaesthetics

**Number of respondents:** Overall, 28 respondents indicated they wanted to comment on critical care and anaesthetics services with 10 respondents accessing critical care and anaesthetics services in the last three years.

**Top location:** Macclesfield District General Hospital (9 / 90%).

**Rating of service:** Overall, 9 (90%) respondents rated services very good or good and no respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Staff – Staff were professional and friendly (5 / 25%)
- Positive – Quality of services – Services provided are good (5 / 25%)
- Observation – Staff – Consider greater support for staff (e.g. recognition) (3 / 23%).

## 1.4.3 Community services

**Number of respondents:** Overall, 72 respondents indicated they wanted to comment on community services with 44 respondents accessing community services in the last three years.

**Top location:** At home (15 / 34%).

**Rating of service:** Overall, 23 (53%) respondents rated services very good or good, and 10 (23%) respondents rated services poor or very poor.

**Top themes on service:**

- Observation – Staff – Consider the need for adequate staffing (11 / 21%)
- Negative – Communication – Communication with patients requires improvement (10 / 19%)
- Observation – Service provision – Increased provision of services is required (e.g. to reduce hospital stays) (8 / 15%)
- Positive – Staff – Staff were helpful and friendly (8 / 15%).

### 1.4.4 Diabetes and endocrinology

**Number of respondents:** Overall, 30 respondents indicated they wanted to comment on diabetes and endocrinology services with 17 respondents accessing diabetes and endocrinology services in the last three years.

**Top location:** Macclesfield District General Hospital (7 / 41%).

**Rating of service:** Overall, 11 (69%) respondents rated services very good or good, and 4 (25%) respondents rated services poor or very poor.

**Top themes on service:**

- Observation – Staff – Ensure appropriate staffing (e.g. specialist expertise) (6 / 26%)
- Negative – General – Services provided were poor (5 / 22%)
- Negative – Staff – Concern over lack of specialists (e.g. endocrine consultant, adult diabetologist) (5 / 22%).

### 1.4.5 Gastroenterology and endoscopy

**Number of respondents:** Overall, 39 respondents indicated they wanted to comment on gastroenterology and endoscopy services with 27 respondents accessing gastroenterology and endoscopy services in the last three years.

**Top location:** Macclesfield District General Hospital (16 / 59%).

**Rating of service:** Overall, 19 (70%) respondents rated services very good or good, and 2 (7%) respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Quality of services – Services provided are good (16 / 49%)
- Positive – Staff – Staff are professional and helpful (11 / 33%)
- Observation – Staff – Ensure adequate staffing (e.g. more staff, share specialists knowledge) (5 / 15%).

### 1.4.6 General surgery

**Number of respondents:** Overall, 34 respondents indicated they wanted to comment on general surgery services with 19 respondents accessing general surgery services in the last three years.

**Top location:** Stepping Hill Hospital (10 / 53%).

**Rating of service:** Overall, 15 (79%) respondents rated services very good or good, and 1 (5%) respondent rated services poor or very poor.

**Top themes on service:**

- Positive – Quality of services – Services provided are good (9 / 36%)
- Observation – Staff – Ensure appropriate staffing (4 / 16%)
- Observation – Integration – Ensure greater integration between healthcare providers (4 / 16%).

## 1.4.7 Imaging (X-ray and radiology)

**Number of respondents:** Overall, 49 respondents indicated they wanted to comment on imaging (X-ray and radiology) services with 40 respondents accessing imaging (X-ray and radiology) services in the last three years.

**Top location:** Macclesfield District General Hospital (22 / 55%).

**Rating of service:** Overall, 33 (83%) respondents rated services very good or good, and 4 (10%) respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Staff – Staff were professional and friendly (14 / 37%)
- Positive – Quality of services – Services provided are good (e.g. efficient) (14 / 37%)
- Negative – Access – Concern over long waiting time for services (e.g. availability of appointments) (9 / 24%).

## 1.4.8 Planned care

**Number of respondents:** Overall, 41 respondents indicated they wanted to comment on planned care services with 18 respondents accessing planned care services in the last three years.

**Top location:** Macclesfield District General Hospital (10 / 56%).

**Rating of service:** Overall, 12 (67%) respondents rated services very good or good, and 3 (17%) respondents rated services poor or very poor.

**Top themes on service:**

- Negative – Access – Concern over waiting lists to access care (e.g. backlog) (7 / 28%)
- Negative – Communication – Communication with patients requires improvement (6 / 24%)
- Positive – Quality of services – Services provided are good (5 / 20%).

## 1.4.9 Trauma and orthopaedics

**Number of respondents:** Overall, 38 respondents indicated they wanted to comment on trauma and orthopaedics services with 20 respondents accessing trauma and orthopaedics services in the last three years.

**Top location:** Macclesfield District General Hospital (15 / 75%).

**Rating of service:** Overall, 14 (74%) respondents rated services very good or good, and 2 (11%) respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Quality of services – Services provided are good (6 / 20%)
- Negative – Access – Waiting time for services is long (6 / 20%)
- Observation – Service provision – Ensure provision of trauma and orthopaedic services locally (5 / 17%)
- Observation – Cost and efficiency – Ensure sufficient resources and capacity to meet demand (5 / 17%).



### 1.4.10 Urgent and emergency care (A&E)

**Number of respondents:** Overall, 88 respondents indicated they wanted to comment on urgent and emergency care (A&E) with 74 respondents accessing urgent and emergency care (A&E) in the last three years.

**Top location:** Macclesfield District General Hospital (46 / 63%).

**Rating of service:** Overall, 48 (66%) respondents rated services very good or good, and 19 (26%) respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Quality of services – Services provided are good (19 / 26%)
- Negative – Access – Concern over long waiting time to be seen (14 / 19%)
- Negative – Staff – Concern over inadequate staffing (e.g. lack of staff) (10 / 14%)
- Positive – Staff – Staff were professional and helpful (10 / 14%).

### 1.4.11 Women's and children's services

**Number of respondents:** Overall, 141 respondents indicated they wanted to comment on women's and children's services with 114 respondents accessing women's and children's services in the last three years.

**Top location:** Macclesfield District General Hospital (81 / 72%).

**Rating of service:** Overall, 81 (73%) respondents rated services very good or good, and 17 (15%) respondents rated services poor or very poor.

**Top themes on service:**

- Positive – Quality of care – Quality of care was good (e.g. antenatal, postnatal care) (34 / 29%)
- Positive – Staff – Staff were professional and helpful (33 / 27%)
- Observation – Service provision – Consider the need to re-open maternity unit at Macclesfield Hospital (23 / 19%).

### 1.4.12 Travel and transport

**Top travel method:** Car (236 / 87%).

**Average travel time:** 26 minutes.

**Top themes on travel issues:**

- Parking – Difficulties parking at hospital (e.g. spaces, cost) (87 / 40%)
- General – No issues (85 / 39%)
- Transport – Lack of adequate public transport (16 / 7%).

***A copy of the full engagement report can be found at:***

<https://localvoices.uk>

## Appendix 5: Recommended on-site services for hospitals with an Emergency Department

| On site services recommended for hospitals with emergency departments, including adult surgical patients  | Additional services that should 'in-reach' if not based on-site   |
|---|---|
| <ul style="list-style-type: none"> <li>• Acute and General Medicine</li> <li>• Elderly Medicine</li> <li>• Respiratory Medicine (including bronchoscopy)</li> <li>• Medical Gastroenterology</li> <li>• Urgent GI endoscopy (Upper and Lower)</li> <li>• Cardiology (non-invasive)</li> <li>• General (Adult) Surgery</li> <li>• Gynaecology</li> <li>• Trauma</li> <li>• Orthopaedics</li> <li>• Urology</li> <li>• ENT</li> <li>• Critical Care (adult): Level 2 and 3</li> <li>• General Anaesthetics</li> <li>• X-ray and Diagnostic Ultrasound</li> <li>• CT Scan</li> <li>• MRI Scan</li> <li>• Urgent Diagnostic Haematology and Bio-chemistry</li> <li>• Clinical Microbiology/Infection Service</li> <li>• Occupational Therapy</li> <li>• Physiotherapy</li> <li>• Acute Mental Health Services (Liaison Psychiatry)</li> </ul> | <ul style="list-style-type: none"> <li>• Diabetes and Endocrinology</li> <li>• Rheumatology</li> <li>• Dermatology</li> <li>• Acute Oncology</li> <li>• Palliative Care</li> <li>• Neurology</li> <li>• Nephrology</li> <li>• Maxillo-Facial Surgery</li> <li>• Plastic Surgery</li> <li>• Burns</li> <li>• Interventional Radiology</li> <li>• Speech and Language</li> <li>• Dietetics</li> </ul> |

### **East Cheshire NHS Trust**

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SK10 3BL

**Tel:** 01625 421000

**Website:** [www.eastcheshire.nhs.uk](http://www.eastcheshire.nhs.uk)

### **Stockport NHS Foundation Trust**

Stepping Hill Hospital  
Poplar Grove,  
Stockport  
SK2 7JE

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**Website:** [www.stockport.nhs.uk](http://www.stockport.nhs.uk)



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