NHS
The Shrewsbury and
Telford Hospital
NHS Trust

Women & Children Focus Group

Held on Tuesday 5th June 2023
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

Women & Children

SATH members of staff responding to public questions

Julia Clarke – **(JC) Director of Public Participation**
Hannah Morris – **(HM) Head of Public Participation**
Ed Rysdale – **(ER) Emergency Medicine Consultant and Clinical Lead for HTP**
Julie Plant – **(JP) Divisional Director of Nursing**
Annemarie Lawrence – **(AL) Director of Midwifery**
Tom Jones – **(TJ) HTP Clinical Programme Manager**
Kate Ballinger – **(KB) Community Engagement Facilitator**
Jennifer Fullard – **(JF) Chief Communications Officer**
Rachel Webster – **(RW) HTP Nursing, Midwifery and AHP Lead**
Carol McInnes – **(CM) Divisional Director of Operations**

PART 1

Q&AS FOLLOWING PRESENTATION

Q: *There were no slides within the presentation on issues if a child was disabled. Also, the environment needs to be set out for a child who is extremely impaired. How will the model work for this group, including access issues and the physical / psychological environment?*

A: (JP) – Children, young people and parents of disabled children are at the forefront of our minds. The young people and parent engagement groups will be getting set up soon. There has been a lot of clinical engagement but next, the most important focus will be that of the young people and parents.

A: (ER) – There is a new area at the RSH Emergency Department which has a small area for children, and this has already made a massive difference to the treatment of children within the RSH site. There is also a small area for children at PRH, but it is not yet bespoke, this is being looked at. As part of this scheme there will be a new children's area designed at PRH so children will have their own specific area. The team will work with children, carers, and parents to help design the area which is what the team did at RSH.

Q: *For the Adult Learning Disability Services there is an assigned Mental Health Nurse who helps adults from their home with an ambulance trip or visit to the hospital. At the moment there is nothing for children. Until my child reaches the age of 18 years old, if my child hurts themselves, I will have a major problem in getting them to hospital.*

A: (JC) – Kate Ballinger has done some work with patients, adults, and children with learning difficulties and one of the things that we have introduced is a video virtually showing the journey inside the hospital before you have to actually make it. But we need to develop a library of journeys to cover different visits.

ACTION – Kate Ballinger to liaise with focus group member (MA - Focus group member) and Ruth Smith (Lead for Patient Experience) to discuss what the Trust can do to support Children with Learning Disabilities accessing our services.

ACTION – Julie Plant to contact questioner (MA - Focus group member) regarding involvement in the current facilities and additionally advised for reassurance, that there is now a Paediatric Mental Health Nurse employed as part of the children's unit which she will also be happy to discuss with MA.

Q: *For Inpatient postnatal stays, if you had a service user with a low-risk pregnancy who gave birth at the MLU at PRH but wanted to stay in hospital to receive support with breast feeding (as an example), would she have to be transferred with baby to RSH to be able to stay as a postnatal patient or is there still going to be some form of inpatient facility in the Wrekin MLU?*

A: (AL) – The MLU facilities at PRH will be for acute inpatient stays only. Any woman requiring a stay that's in excess of what we would deem to be acceptable post-delivery would need to be transferred over to RSH. We moved away a long time ago from having inpatient facilities in line with national practice and this is not something that is in the current staffing model.

Q: *The earlier slide mentioned the digital links, are you working with Wales for the cross boarder digital links?*

A: (AL) – We are working with the Head of Midwifery for Powys at the moment on accessing maternity records which is something that is a challenge for the team and also, we are working with the Interim Head to agree a way going forward.

ACTION – Kate Ballinger to contact the digital team to find out current position.

Q: *If a pregnant woman in Powys needs to be under the consultants at RSH, will they have their normal day to day checks done in Powys or will they need to be at RSH for that?*

A: (AL) - It depends on the individual circumstances. At the moment there are personalised care plans for all of our women, and we do have a lot of service users who meet that threshold currently. Where care can be given in the local community, that will be delivered under the Powys Community Midwives but there will be some elements of care for which that they must be seen within the inpatients or acute service setting and that will continue as planned under the model of care that we currently deliver.

Q: *What is available for Learning Disability Nurse support for children?*

A: (JP) – We are looking to recruit a Learning Disability Nurse. We have appointed a Paediatric Mental Health Nurse as part of our team. We are developing a Children & Young Peoples Participation Group and also the parent element of our PACE team.

ACTION – Julie Plant (Divisional Director of Nursing) to contact focus group members (JS and MA) to discuss the development of a children and young people participation group and also the parent element of the Post-Acute Care Enablement (PACE) team.

ACTION – Kate Ballinger to introduce JS and MA to Ruth Smith (Head of Patient Experience) as one of her big focuses is around children and young people with learning disabilities.

Q: *I've asked several times by pregnant ladies why they now have to go to Shrewsbury, which is around 30 miles away and why there is not going to be a Maternity Unit anywhere near where they are (Telford)?*

A: (AL) - Just like at the moment there are antenatal services in the Royal Shrewsbury Hospital and Princess Royal Hospital. When the Consultant Unit moves to the Royal Shrewsbury Hospital, we will still provide antenatal clinic services at the Princess Royal Hospital So, this element will not change - we have antenatal services in both hospitals and that will continue. If a woman needs to birth in the consultant led unit, then of course that consultant led birth experience will be on the Shrewsbury site, but in terms of accessing services from a day-to-day antenatal clinic perspective, the service will continue as they are currently provided.

Q: *If some women decide to go to Wolverhampton, how does that work? Does Shropshire then have to pay Wolverhampton for the services. What's the impact on the Shropshire Health Services?*

A: (ER) – Currently patients can choose where they get their care. If the Consultant Unit is at the PRH site, then women around Oswestry may choose to go to Wrexham and the same for women in mid Wales. Although some women in the east Telford area may go to Wolverhampton when the Consultant Unit moves to the Royal Shrewsbury Hospital, some other women in mid-Wales may choose not to go to Wrexham, so it's difficult to predict. As discussed at the public consultation in 2018, we will have an emergency care site and a planned care site. After looking at our populations, in terms of where the emergency site would be, the Royal Shrewsbury site was deemed to be the best location in terms of the emergencies that we treat. So yes, some patients will have to travel slightly further, but the care they get will be better and safer because they'll have all specialties together. Having surgery linked up with maternity and gynaecology is really important. So, women will still receive all their antenatal care at their local hospital in the overwhelming majority of cases because those services are still going to be on both sites.

In terms of the finance, none of this model is a financially driven model. It is about the clinically safest and best model for all of our patients.

***Q:** My concern is for women who have to travel a far distance to the hospital to give birth or parents of children that have been admitted to the children's area. Will they have beds or places made available for the parents to stay? This causes big problems, especially with the financial crisis at the moment. I'm asking for this issue to be taken into consideration.*

A: (JP) – We are really mindful of the need for accommodation for new mums with babies on the neonatal unit and also the parents or carers of our children on our paediatric ward. In the plans we have looked at additional rooms on the neonatal unit and also, we have beds for parents on our neonatal unit at present. Additionally, all of our bed spaces on paediatrics have now got a fold down bed for parents and we involved parents in the testing of these.

***Q:** With Powys midwives, we know that there is an issue in that not everything comes back when our babies are born in Shropshire. We might be informed that the baby has been born but quite we're not. The new mums don't come home with a book, which we were told was going to be looked into. My daughter not long ago had a baby over in Shropshire and she came home with a piece of paper with everything written on it. I brought this up previously about four years earlier. This is very disappointing.*

A: (AL) – I am in talks with the Interim Head of Midwifery at Powys and we're discussing exactly that. Obviously, there are some access issues because we use Badgernet here (digital records) and Powys don't, but from a GP perspective, the information is reaching the GP and we just need to continue to work with our system partners to look at how we can improve the information that women actually take home.

PART 2

BREAKOUT SESSIONS
Session 1 Questions and feedback
Questions

- **What is the impact on your communities?**
  - **Advantages**
  - **Disadvantages**
- **How do we manage this together?**
- **How can we support/engage families/carers?**

Feedback:

(Public member) I think the advantages of the model outweigh any of the criticisms.

(Public member) For Powys residents the advantage is to have the Emergency Centre and the Women & Children's Centre nearer to us.

(Public member) Travelling time is a disadvantage for Telford parents, even if parents are taking their own children, it's a long journey. It's about 27 miles from here to Shrewsbury. Also being able to visit if they have to stay in for any length of time. I appreciate you saying there may be some beds for people to stay over, but I have had children in Birmingham Children's Hospital and it's a real tie. If you've got other children, it's really difficult because you've got young children at home and a partner that works. Having to travel that distance by public transport means some parents probably can't go very often. It's a real disadvantage, unless we could do something which I suggested years ago where we provided transport direct from hospital to hospital, for parents to pay for so if they could get to Telford, they could use a bus that went directly to the hospital or vice versa.

(Public member) There does need to be some kind of accommodation or some kind of facilities and also the travel.

Q: (HM) – Travel is coming up quite a bit in the conversations we're having. How do you think we can manage this together? It has been suggested hospital transport, what other solutions do you think there are?

(Public member) I don't think we've got that answer yet, because this has been under discussion for a long time, public transport is not good, and I think things have got worse with the financial crisis.

Q: (Public member) *Any possibility of being able to have something funded that runs along the same sort of lines as the voluntary car service where you have drivers who use their own car, who are happy to take patients, relatives for appointments or to visit. They could just pay a small amount towards the cost. I think Shropshire Council reimburse the travelling expenses for the drivers. Is that something that hospitals could sort out between them?*

A: (TJ) - I think that's outside the remit of the NHS, but in previous discussions and during the Future Fit days, we did have a travel and transport group. We also have a travel and transport strategy which our colleagues in Estates are developing. The true issue is that we don't have any control over the private sector of transport companies, and we do lobby them to try and get better access to the sites from the railway stations whilst trying to influence their bus routes. Going back to the earlier (SP - *Focus group member)* suggestion, the charitable and voluntary sector have been involved in discussions before, so I think going forward in the next three years we try to involve them again.

A: (RW) - Part of the solution relies on also working differently in the sense of reducing the times that people actually need to access or have treatment at the acute site with a lot more where possible, the care and interventions being delivered closer to home. So that's the other side of the clinical model that is inextricably linked in reducing the need.

A: (JC) - There is going to be a travel and transport group set up later in the year because we know that when you get here, finding somewhere to park is another big issue. So, there are a number of options that are being explored and I know we are working with the local authorities as well to look at the art of the possible. That is something that there will be more detail on, but it will be, later in the year after the summer.

(Public member) When we're talking about Community transport, certainly in Powys, the Community transport schemes have lost lots of volunteers, so they really are struggling to get volunteer drivers. At the moment I think maybe when the travel and transport group does restart, there needs to be engagement with those community transport schemes to see if there's any way that they can encourage new drivers to come on. With the care closer to home, I know that is something that Powys Health Board is also working on, and I believe that they are working with SaTH and possibly the HTP team too.

	(TJ) - In the separation of patient care flows (emergency and planned), it will involve greater travel distances to the planned care site for some patients, but at least your surgery will be protected. At the moment we are cancelling a lot of activity, especially in the winter months. So that's another definite advantage of this clinical model, not letting our patients down by cancelling their surgery. ***Session 2 Question and feedback*** ***Question*** • **How can we support and engaging families and carer groups?** **(Public member)** The people you need to speak to are the ones that you can't really get access to very easily for whatever reason. There are family centres within the county, where I think under 5-year-olds go to, possibly you could engage with them. I think some of those disadvantaged groups go to those meetings quite often. Possibly talking to The Women's Institute, places where there are going to be mostly lots of women, perhaps as a way to get into talk to local parish councils and town councils to spread the word. I think things are there, but people don't know how to contact them. **(JF) –** Some of the areas that we thought we needed to work together on were looking at how people are supported to get to hospital, the careful planning that needs to be in place particularly for patients that may have more complex needs. The importance of communications as there was a feeling that information is fragmented at the moment. How do we join up those different services to improve communications? There is a need to work within communities, as we get closer to this and the implementation, helping people to understand where to go for information, where to go for the care, they need and working with communities to do that. There was an interesting point about empowering GPs with the information that they need to help people and to help advise people where to go. **(ER) -** I have had a number of sessions with local GP's about HTP and I will continue to do so through the GP board. The difficulty with GPs is they are a very disparate group, so it all depends on whether they attend the GP board or when they come. The other issue with GPs is that they are all effectively self-employed practices, it's whether they have the time to go to the meetings. So yes, they do know about our plans, and we are feeding through to the ICS and the primary care networks. **(Public member)** Perhaps if we go to the GP office manager, then it's down to them to relay it to the GP. We will then have a specific person to contact. **(KB) -** I am working with the Integrated Care Board leads for primary care. I have talked to their workforce lead and their education lead. We will be going to an Integrated Care Board GP Forum to talk to them about receiving the Getting Involved community updates. Every time we go out, Mike Crawshaw (Public Participation Engagement Facilitator) and I, Kate Ballinger (Community Engagement Facilitator) make a point of trying to identify GP practice emails and also their Patient Participation Groups, which can be challenging in terms of finding the right people. But we're working with the Integrated Care Board, Telford

Patients First and Shropshire Patient Group to try and make this as wide reaching as it possibly can be.

(Public member) I think the problem with the patient groups at the moment is that we've felt for some time that we weren't valuable anymore. Several years ago, we were involved with everything that was happening at the beginning and we were properly involved, so we had our input at the beginning and a lot of the patient groups now have folded because they don't feel that they're needed anymore. There is no contact until we're at the stage where all you seem to want now is for us to agree with what you've decided. So, I think there might be some work around getting patient groups back interested to start at the beginning with whatever you're working on at the time.

Session2 Questions and feedback
Question 2

- **How do you want to be involved in the HTP Programme?**
- **What's working?**
- **What can we improve?**

(Public member) We had a lady at the CCG who was responsible for the patient groups, Karen, and she kept us informed right from the beginning. And when you were starting something for example in maternity, right at the very beginning, you asked for patient participation in that. People were selected from the practices wherever. So, they went to the first meeting, and they helped inform what you were going to include in the process. Whereas now, from what I'm told by other groups, that's not happening it's a long way along before we have any input into it.

A: (CM) - When I was working in Shropshire CCG, I worked with Karen. It was a role that was employed by the Shropshire CCG Board, and it was very much focused around and linking in with primary care in terms of patient representation. Karen moved into a different role some years ago and I don't think those roles have been replaced in the new ICS structure, but it is slightly outside of our control, but this can be fed back to the ICS.

ACTION – Hannah Morris to feedback to the ICS around this issue

Q: (Public member) From *the evening Community Cascade meetings, what sort of response are you getting from those? Do you feel that those are working? And also, I know that you are communicating with town and community councils in Wales and the parish councils in Shropshire. Do you feel that those are working?*

A: (HM) - I think whenever you're doing involvement, not one approach meets everybody's need and I think there is something around face-to-face contact. You might go out to a lot of events and those are really important and it's something that we haven't been able to do over COVID. I think the Community Cascade, the daytime one goes out to more people than the evening Cascade, but again just having a variety of different options available to meet different people's needs, but also going out to groups and they're having that face-to-face contact I think is really important as well.

(JC) - At the end of the presentation from today, the final slide showed that there's lots of ways that people can get involved, and we've got a number of parish councils that we are going to talk to about HTP, because parish councils with their constituents and community councils is a very good way of cascading information. Mike Crawshaw and Kate Ballinger go to lots of public events, and clearly different people want different things. There's lots of different things that we try, some are more successful than others. We rely on The Public Assurance Forum which has membership from the two senior Patient Groups (Shropshire Patient Group and Telford First). We also have the Voluntary Community Sector Assembly and PAVO, which is the Powys Voluntary Organisation and the Chief Officer's Group COG, which is the Telford & Wrekin equivalent. They have literally thousands of members, and they cascade things through their newsletters, so we're reaching as wide as we can. We will go anywhere where people will want to listen to us.

(JF) – We need to make sure we are involving lots of different groups, going out into the communities, and really just helping to raise awareness and understand any issues that they may have. There has been lots of really good ideas about different places that we could go with a lot of commentary around communication is key and I think there was just a feeling that we need to just keep on. We need to be sharing information as it becomes available and just make sure we're drip feeding that information. What was really reassuring to hear is there's lots of groups out there that are really keen to have that information in to help us to be able to share this and also get the feedback from those groups to bring them back into these forums. We need to be clearer about what each of the focus groups will cover and also about our naming. So, for example, tomorrow morning we've got the Medicine & Emergency and the Planned Care side of things. And there was just a comment that people might not understand that A&E is part of Medicine & Emergency Care. So, if there's a way when we're promoting these that we just help explain what medicine and emergency means and the types of services that will be exploring.

(JC) – There is another About Health event on the 25th July. The information about that and the focus groups is all we will send you round this presentation, if you click in the links, hopefully that will be able to update a bit more about the planning permission situation by then. We will give you a heads up on that if and when we get any communication. We want to come to any groups or organisations that you belong to and whether it's about HTP or anything, we're very happy to come. If you e-mail sath.engagement@nhs.net we will come out to your environment and talk to you and your meetings / groups about what is going on so that we can get your views. It's really important that we do that as well as telling you what's happening with us. We need to know your views on what's important to you and how we can make the new delivery of HTP the best possible services we can have.