The Shrewsbury and Telford Hospital NHS Trust

Clinical Support Services Focus Group

Held on Tuesday 15th February 2023
10:00 – 12:00hrs via MS Teams

ACTIONS

	1. Clinical Support Services ***GSm (Focus group member)*** *– Does pain management fit into this Clinical Division?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – Pain management comes under the anaesthetics umbrella, anaesthetics generally run the pain management service across the trust. This service is usually based in the community and outpatients. This should be covered in the final Planned Care focus group on 7 March, which will cover Surgery, Anaesthetics and Cancer ***JB (Focus group member)*** *– Is digital technology included in clinical support or is it separate?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – Digital technology is far greater than just HTP and its ongoing development and implementation is across the whole of the hospital. Digital is a separate workstream outside of HTP but it is integrated in what we do. The teams are working with the workstream as it covers everything that we do within the hospital. **Julia Clarke (Director of Public Participation)** – For future focus groups we can arrange a session on digital development as there is a lot going on, but it would have to be very high level. Digital has attracted a huge amount of investment to the Trust. There is a lot of work going on currently with the electronic patient record (EPR) and updating of the patient administration system. **ACTION: Sophie Stevens-Jones - to add slides on digital development in technology that are relevant each workstream to the next set of focus groups.** ***DM (Focus group member)*** *– Will the 7 day working pattern proposed lead to a considerable increase in staff needed - otherwise existing staff will need to do extra shifts and i.e., working more hours?* **Dianne Lloyd (Acting Deputy Divisional Director of Operations – Clinical Support)** – Some of our 7 day working patterns have already evolved, the staff are thinking about when the services are needed and changing their working pattern to support the 7 day working patterns, but the majority of services have required some additional investment. Clearly if we are going to support 7 day working more widely, we will need more staff to do that and that's part of having to balance the demand upon our services with the capacity we have available. For example, there is a

	pharmacy service that is only available in the morning on weekends and bank holidays, and we need to look at how we can extend that to cover the whole of the day. It's about working with all of our pharmacy team around how we can provide that and also looking at the roster and seeing where the potential gaps would be. This information is then translated into the number of additional hours we would need in addition to our current staffing to making sure we have got a robust and sustainable working pattern for pharmacy. **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – The workforce programme is integral to matching the workforce to what is required. For example, in my speciality, medicine, currently on one hospital site there is only 8am -10pm cover as we need 18-20 consultants to cover 24/7. We currently have only 8 consultants across the whole county, so we require a lot of agencies doctors to cover the rotas, and we don't have senior consultants on the floor after midnight any day of the week/weekends, so we rely on our middle grades doctors to give this (eg Specialist Registrars etc). Part of HTP is about having the right specialists for the right patients in the right place, but with our current split-site services we can't recruit the specialists that we want to recruit because our services are fragmented and split and unattractive to potential new recruits as it is not the best way of working. We have to be able to provide a full 7-day service to recruit specialists into the county. We have a workforce team as part of HTP who are working with us to produce a Workforce plan to deliver this. **ACTION: Sophie – It would be useful to have an update on the workforce position/plan for each of the clinical service areas. We will bring something on the next focus group on workforce to cover this.** ***DM (Focus group member)*** *– What is the potential timescale for the changes to reach an initial kick start. There is obviously a recruitment programme to try to increase those gaps in staff numbers. Do you have an A, B and C option if you can't reach the right number of staff? Will this be phased in because it's an ongoing problem?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – There is a distinct workforce plan as part of the business case, which is very detailed. This will involve looking at new models of care, employing new recruits, and novel ways of working for example with advanced nurse practitioners, all of which takes time. This is a programme that is already ongoing, and this will continue to be a phased approach. It will take time to train and recruit people so it is a blended approach which will happen over the next few years. It is very much modelled in o the outline business case, so we know what workforce we need to have now and in the future. **Dianne Lloyd (Acting Deputy Divisional Director of Operations – Clinical Support)** – It is fair to say that we do have areas where there are national shortages and we have had difficulty in recruiting locally. What we have been doing across CSS, is developing an extensive recruitment and retention strategy for our staff that is based on "growing our own". We have had a big expansion in our apprenticeship programmes, both pre-registration and also for post-registration so that we have a career pathway up to the advanced practice level for those who want to take on those advanced roles. We have introduced golden tickets, which are automatic job offers given to our best students so they know that SaTH would be interested in them coming and working with us in the future. We have a good track record in keeping our students who have been on placement with us as they have had a good experience working with us. There has also been a lot of success with international recruitment particularly within the therapy professions and

	radiography. When we move forward with the HTP model we will have a clearer set of services where we have trained our own staff with a far more attractive offer to make in the highly competitive recruitment market that we are in. ***DC (Focus group member)*** *– I would like clarification around what is a community diagnostic hub and what are virtual wards?* **Dianne Lloyd (Acting Deputy Divisional Director of Operations – Clinical Support)** – The community diagnostic hub is a way of expanding our diagnostic capacity and it's a national programme of work. Traditionally CT and MRI scanners were only housed in big acute hospitals, but community diagnostic hubs are bringing those scanners more locally to populations for better access and more capacity. At the moment we are working on our first one which will be situated in Telford, Hollinswood House. It will bring to the area much better access to CT and MRI scanning and were hoping that will be ready by summer/autumn this year. It's about expanding capacity but also bringing the services closer to the population. The virtual ward is a development that is being led by the community trust but essentially when our patient no longer needs to occupy an acute inpatient bed at SaTH, but they do still need an element of acute care, they can be discharged home or into a nursing home or their chosen place of residence. Our community teams will continue to support the care that the patient needs at home. It's a way of enabling patients when they are medically fit to have the care outside of a hospital environment. ***JB (Focus group member)*** *– If all trusts got together and agreed to pay locum agencies less, would it bring down agency costs?* **Julia Clarke (Director of Public Participation)** – The Trust has tried to do this through an initiative led NHS England, but it is very difficult because if you are in an emergency situation e.g. an A&E doctors calls in with last minute short-notice sickness and we don't have another doctor to cover, we can't say that we won't pay above the set price as we couldn't run the service without the medical cover, so we tend to pay what we have to rather than having to close down a service. It tends to happen in the areas that are dealing with urgent and emergency care or ITU. If there is an unexpected sickness at short notice, we will go to our framework agencies (for doctors and nurses), after trying our own in-house bank). They have the specialised agency staff, but their rates are very expensive and generally they know by the time any hospital contacts them that the staff are needed, and all other avenues have already been explored. ***GSm (Focus group member)*** *– How well are the two hospitals RSH and PRH going to be equipped with all the necessary stuff needed e.g. diagnostic equipment etc, or will there be concentration on one hospital more than the other?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – Whatever is needed to deliver the care that is required at each hospital will be there. What we don't want is to have the equipment at one site that isn't going to be used, because there are not the patients at that site who needs that investigation. I can't say that there will not be any duplication at each site, but the equipment that is at each hospital will be the right equipment and there will be specialised equipment that won't need to be at both sites.

Dianne Lloyd (Acting Deputy Divisional Director of Operations – Clinical Support) - The Pathology Centre Manager and his colleagues are working really hard at the moment at looking what is required for each of the emergency and planned care sites. There are extensive clinical workshops that are going on at the moment looking into this. Each site from a clinical support perspective will need a strong level of support, not only from staff but also from facilities and the equipment that we require which is being designed into the programme now.

GSm (Focus group member) *– In terms of pathology will there be a full path lab at both sites?*

Adrian Vreede (Pathology Centre Manager) – The answer is no, but for a very good reason. We don't have a full path lab on both sites now with having different services on different sites. Some of this is also due to the required turnaround time for some of the results from the tests. We already have different services at different sites depending on the requirements and that principle will remain without any negative impact on patients.

JB (Focus group member) *– Presumably there is a lot of clinical support staff working on both sites now, do you envisage less when this all comes into practice?*

Dianne Lloyd (Acting Deputy Divisional Director of Operations – Clinical Support) – We will need to have clinical support staff at both sites, and they will be at the right staffing level to support the specialisms that exist on both sites, and the services that exist on both sites. Our workforce plan that is being worked on at the moment describes the levels of staffing that we need. Some of those plans are based on national clinical standards, so for some services e.g. trauma, neonatal etc, there is a designated number of staff that is needed to support patients. Other services within clinical support services are not as prescriptive as that, so we are applying our knowledge and experience of what the services require to the workforce plan. Some staff do like to rotate between sites and there is a lot of flexibility in that regard. We have also started to reach out to our partners in the Community Trust, in MPFT (Midlands Partnership NHS Foundation Trust) and also at the orthopaedic hospital to look at how we can develop integrated workforce plans with them and also move our staff around flexibly along patient pathways.

Julia Clarke (Director of Public Participation) *– If anyone has any questions for Ed Rysdale, Dianne Lloyd or Adrian please contact myself, Kate Ballinger or Hannah Morris hannah.morris39@nhs.net / kate.ballinger@nhs.net / julia.clarke7@nhs.net*

2. Continued developments at the PRH

Julia Clarke (Director of Public Participation) *– We are intending on setting up a separate focus group, and if you interested in getting involved in the development of the new front entrance to PRH then please email: sath.engagement@nhs.net*

SS (Focus group member) *– Great idea regarding the contactless shop, but some people only like to use cash.*

Julia Clarke (Director of Public Participation) – There will be a manned coffee outlet (probably from 8am to 8pm) where people can change their cash into pre-paid cards so they can use the tap and go offer. At the moment there is nothing for staff and visitors in the PRH main entrance (the League of Friends closed their shop because of the low footfall so this will transform the front entrance at PRH.

JB (Focus group member) *– When do we envisage this new retail opportunity to be available?*

Mark Hope (Interim Director of Estates) – It should be around late summer early Autumn by the time it's been fitted out. Within the coffee shop there will be a whole range of convenience foods as well, so if people prefer to shop through that route they can (obviously Costa will only be available during opening hours). At other times the 24/7 idea is really the real push for the convenience store. They will use your purchasing habits to then restock those stores, this will be good for those who need to visit the hospital regularly and also for the staff.

3. Looking at travel and transport

Julia Clarke (Director of Public Participation) *– If you are interested in being part of this focus group, please register on sath.engagement@nhs.net making sure that you confirm which focus group you would like to attend.*

4. What is an EqHIIA?

SS (Focus group member) *– I'm assuming all of this will apply to the workforce plans as well. One of the comments from the previous sessions was that we are finding it difficult to recruit into our area for many different reasons. Whether it is due to the lack of diversity within the Shropshire area as a general consensus, has this been a challenge in terms of some of the people wanting to work here because diversity is not always represented?*

Julia Clarke (Director of Public Participation) – That's a very good point and part of the Public Participation team members - Kate Ballinger and Michael Crawshaw's role is to go out to seldom heard communities, because it's important that we go to them rather than they come to us. Safeguards are in place around workforce, but they are different safeguards around equal opportunity and fairness, but they are there, overseen by our Workforce team. We have very robust rules and processes around recruitment to ensure that we are not discriminatory. If you look at our community and diversity statistics, our workforce is much richer in terms of diversity statistics than the community population statistics. Many of our professional specialities we would not be able provide care if we didn't not have that diversity of staff. Our EQHIIA is very specific to our patients and communities and the remit does not cover workforce for this document

Kate Ballinger (Community Engagement Facilitator) – We have inclusion networks within the trust now, staff disability, staff pride and a staff race & equality network. Within that there is also a menopause network for women of a certain age, and we are also looking at introducing a pastoral, spiritual and religious network as well. We want to make sure we have support for all our staff. We are the largest employer in Shropshire, with over 6,500 staff working in our hospitals. We want our

	staff to have a good experience working with us. There is an EDI (Equality, Diversity and Inclusion) team working within the trust which heads up these staff networks to make the offer better for staff who might be feeling vulnerable because they feel different. If you know of anyone that you think would benefit, please let us know at *sath.engagement@nhs.net* **5. We would like your thoughts on:** • **What would good look like?** • **What do you think are the biggest barriers to achieving this?** • **What do you think are possible solutions?** ***Julia Clarke (Director of Public Participation)*** *- We will email you questions for your thoughts/feedback. We are also very happy to come out and speak to any groups/organisations to get their views* **Next Clinical Support Services Focus Group meeting:** **Thursday 21st September 2023, 11.00-13.30**