The Shrewsbury and Telford Hospital NHS Trust

Medicine & Emergency Focus Group

Held on Tuesday 14th February 2023
10:00 – 12:00hrs via MS Teams

ACTIONS

	1. MEDICINE AND EMERGENCY SERVICES ***Julia Clarke (Director of Public Participation)*** *– There was an issue raised about treating a lot of people needing emergency services on the planned care site that would have had to go elsewhere. Does this link in with SDEC (Same Day Emergency Care) service that will be provided on the PRH site?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – SDEC is part of Acute Medicine and can deal with any emergency issues that can be dealt with on the same day (for patients that don't need to be admitted). This will continue to happen on both sites. Potentially more patient investigation will happen at PRH, so more patients will be treated on site and won't have to go over to RSH. The Enhanced Urgent Care Centre at PRH will be more than a GP service or a Minor Injuries Unit because there will be support from SDEC and on-site Medics – this means that advanced imaging can be done if required. SDEC is not overnight it only offers 12-hour sessions as the numbers don't warrant it operating overnight. This will help to keep more patients close to home and is a development that wasn't available when the Future Fit consultation was in progress in 2018. ***GSh (Focus group member)*** *– When the Urgent Care Centre was introduced at RSH, prior to COVID-19 it was renamed as the Urgent Treatment Centre which took a significant number of cases out of the accident & emergency department and through the Urgent Treatment Centre. Going forward what will the Centre be called, 'Urgent Care Centre' or 'Urgent Treatment' Centre, as consistency is needed?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – They are similar but slightly different, the Urgent Care Centre was a GP led service for primary care. The Urgent Treatment Centre was a combination of minor injuries as well as the primary care. The HTP team are in discussions with NHS England to agreed terminology to reduce confusion, so don't come to the wrong place. **ACTION: Meinir Jones (Interim Director for HTP) – Asked the group to think about a new name for the service, which they felt best describes what is the service provides.**

GSh (Focus group member) *– Is SDEC the same service as what we call* Ambulatory Care?

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – SDEC is the evolution of Ambulatory Care, it is much more advanced and has a lot more potential and flexibility which allows patients to be treated and discharged on the same day rather than just being an assessment route

GSm (Focus group member) *– There was a list of various medical services in the presentation e.g. cardiology, elderly, diabetes etc. Cardiology and stroke have been discussed with reference to what happens to people in Telford with those conditions, but for the other services which of those are likely to continue to be provided at Telford (excluding day case or outpatients). Will everyone in Telford need to go to Shrewsbury if they need to be admitted?*

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – All acute admissions will go to RSH. For same day emergency care and planned care admissions these will happen at PRH, where there will be inpatient beds. No acute admissions will be admitted directly to PRH as all emergency services will be at RSH.

GSm (Focus group member) *– Will the CATH (Cardiac Catheterisation) Laboratory at Telford be moving to Shrewsbury?*

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – The CATH Lab will move across to RSH with the inpatient cardiology services.

GSm (Focus group member) *– Will there be a continued Acute Medical Unit at Telford?*

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – There will be Same Day Emergency Care Unit at PRH but that will just be for patients who do not require admission (about 66% of all attendances). There will not be an Acute Medical In-patient Unit at PRH. All of it will be going over to RSH because that is where all the specialists are together. However medical inpatients could be transferred to PRH if their admission is more than 3 days.

Gordon Wood (Respiratory Consultant and Clinical lead for HTP) – It's about designing an excellent model of care, independent of geography to deliver the best care. Other hospitals have designed their care around what they have available, skill and space wise. This is an opportunity to deliver care in the best possible way and build the spaces and workforce around what is needed. The care that will be provided to RSH for acute patients will be designed specifically to provide the best care in an ideal environment.

Julia Clarke (Director of Public Participation) *– Of the patients that a currently present at A&E what percentage will still be seen at PRH?*

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – Around two thirds (66%) of patients. The vast majority of patients are not admitted.

	Julia Clarke (Director of Public Participation) *– Of the patients that need inpatient care and are transported to RSH how long are they likely to stay in RSH receiving their care?* **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – It depends on what care they need, if they need the Acute Specialist that takes a further few days. The idea is to put people on a planned pathway of care once the acute episode is over. If the patient needs longer, they will be taken to the PRH as the planned pathway of ongoing care. **Meinir Jones (Interim Director for HTP) –** Informed the group that frailty services will also be delivered at PRH along with the SDEC. This will provide additional support for the most vulnerable frail elderly patients who might need minor interventions/observations or blood transfusions in a short space of time to improve their condition and avoid the need to be admitted. In terms of acute episode of care this is most important when a patient first arrives at hospital and needs that specialist intervention. If within the first 72 hours the patient needs intensive input from a respiratory physician because they are acutely unwell, then they will be admitted to RSH. It's about treating the most unwell patients at RSH by the right clinician at the right time and in the right way. The patients that are not as acutely unwell can have care locally at PRH. ***DM (Focus group member)*** *– If a patient has elective surgery at the PRH and during this has an emergency, what reassurance is there that they will get access to the teams they need if the specialists are off site?* **Gordon Wood (Respiratory Consultant and Clinical lead for HTP)** – The service provided at PRH for emergencies is robust and has a mixture of specialists. The patient will have a very highly trained medical team that will include medical middle graders (Specialist Registrars) and access to medical consultants in and out of hours as you would on either site. The type of doctors that the patient will receive care from will be the same out of hours and during the day at PRH as well as RSH. There is a very clear message that there has to be access to the right skill set out of hours at PRH and this will not be compromised. There will be the same specialist registrar available with the backup of a medical emergency team which will be made up of medical juniors and registrar level doctors with access to consultants. This will give a more controlled system with all the right people in the right place. **Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP)** – If a patient requires a transfer to the emergency care site for emergency surgery or they need critical care, there will be robust pathways to do that. The team are discussing with ambulance services on how this can be done so it can be guaranteed to deliver a robust, fast, prompt transfer mechanism to get the patient to the right place if they unexpectedly need to move i.e. for critical care services. Patient safety is paramount, and it won't be compromised, if a patient needs to get to the right site there will be pathways and transport that will be set up in a timely manner. There are ongoing discussions with surgeons and medics, and we will discuss this at the Surgical, Anaesthetics & Cancer focus group in early March. Also, the teams have been speaking with Northumberland Hospital who have one central emergency care site with three or four planned care sites around it. Northumberland do a lot of operations off site with access to critical care and their clinical pathways very clear and established. This has been happening for several years now, so there have been discussions with them on working out how they have done this and learn from things that they would do differently and what works well for them.

AJ (Focus group member) *– How many Telford residents will still be able to access medical outpatient appointments locally at PRH?*

Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – The Outpatients services will continue in the same way at PRH at both sites so all patients currently seen as outpatients at PRH will continue to do so

Meinir Jones (Interim Director for HTP) – There will be additional services at PRH which will include the delivery of a medical and respiratory day unit, with more patients being treated within the local environment.
The team are also working to develop a chemotherapy day unit at PRH which will be very important for the most vulnerable patients who currently have to travel to RSH for their chemotherapy. There is a lot of work focused on what additional more complex work can be provided at PRH as well as the usual outpatient model.

ACTION: Julia Clarke asked the group to consider the list of questions below and to discuss with their organisations or families:

1. **What would good look like (for this service)?**
2. **What do you think are the biggest barriers to achieving this?**
3. **What do you think are possible solutions?**

These will be discussed as an agenda item at the next meeting

JC (Focus group member) - *Where is the arena for the patients to get involved in reducing demand at the hospital door and increase capacity by improving the outflow to discharge patients?*

Gordon Wood (Respiratory Consultant and Clinical lead for HTP) – There is an opportunity to increase earlier discharge of patients. The way to reduce a patient's stay is for them to have the right clinician and team early on, and to reduce possible de-conditioning by having the right physiotherapy, frailty and occupational teams looking after the patient. The new model will allow the patient to get the right clinician, to start care quickly, and to recover more quickly. It will also ensure the patient is placed into an environment where they can get aggressive physiotherapist, aggressive frailty support and aggressive occupational therapy to improve their clinical outcome. It's not as straight forward as how can we create more beds to get patients out of hospital? It's about the process of minimising the number of patients who need extra care once they are medically fit.

Julia Clarke ***(Director of Public Participation)*** – The ICS are holding conversations to address this some of the issues around medically fit for discharge delays and other issues and we are working with partners in the community to identify all possible solutions.

2. PRH FRONT ENTRANCE

JC (Focus group member) *– Will the avatars in the retail area be gender identifiable?*

Mark Hope (Interim Director of Estates) – No, they will just be a coloured shape.

JC (Focus group member) *– What annual revenue yield will the trust enjoy from cashless retail?*

Julia Clarke *(Director of Public Participation)* – The revenue is helping to pay for the multimillion-pound new entrance and displaced admin accommodation, so it's more like paying off a mortgage. The retail offer would not be financially viable if the retail outlet was manned, although the coffee shop will be.

Mark Hope (Interim Director of Estates) - There are over 30 sites like this in the UK and the Trust believe this is a way forward with 24/7 convenience food and shopping opportunities within the hospital trust, which will be of particular interest to staff too.

GSh (Focus group member) *– Will this replace or complement League of Friends?*

Julia Clarke *(Director of Public Participation)* – There is no longer a League of Friends coffee shop at PRH due to
COVID-19 making it uncommercial. RSH have a thriving League of Friends network and at the moment there is no plan to replace the RSH League of Friends model. Currently the only way staff or visitors can get drinks at PRH is from The Apley Restaurant, Caffe Bistro in Women & Children's (both of which have limited opening hours) or through a vending machine on the main corridor.

ACTION: ALL – If you would like to be involved in meeting with the retail developers to help shape this, please contact the team on sath.engagement@nhs.net it will be passed onto Mark who will arrange a meeting separately with HTP as the funding is from a separate income stream.

3. EQUALITY HEALTH INEQUALITY IMPACT ASSESSMENTS (EHIIA)

Julia Clarke *(Director of Public Participation)* – The EqHIIAs will be shared with members of each focus group when the service leads have completed the refreshing of these. The will also be shared with the Public Assurance Forum in April and will then be reviewed at each meeting of the Focus Groups.

ACTION: To issue EqHIIAs for comment following refresh

4. TRAVEL & TRANSPORT

Julia Clarke *(Director of Public Participation)* – There is an overarching target in the NHS to meet Net Zero carbon targets set by the Government.

Meinir Jones (Interim Director for HTP) – There is a requirement within the business case for the team to deliver against the Net Zero target which also falls as a wider strategic intent of the organisation. There is a section within the business case, and I would be more than happy to pick this up and get the experts in the fields into the conversations if we need to.

Julia Clarke *(Director of Public Participation)* – Every new building which is put up by the trust must achieve excellent in the required standards which has to be at least Net Zero, it will be a very important part of the wider business case. The biggest carbon footprint that the NHS exudes is through procurement, where transport is about 15-20%.

GSm (Focus group member) *– In the analysis, is there expected to be an increase in car parking demand despite Net Zero requirements?*

Meinir Jones (Interim Director for HTP) – The team are working through this to truly understand the impact on the clinical model on what is needed around car parking, transport, administration, and back-office work and which is currently work in progress. The broad assumption is that the trust is not providing more services but services in a different way. The aspiration is to reduce travel wherever possible and to provide and support travel solutions that are user friendly as well as meeting the Net Zero carbon commitment.

ACTION: ALL – If there is anyone that is interested in joining the Travel and Transport Focus Group, please contact the team on sath.engagement@nhs.net and once the commissioned report is received, we will set up a focus group

5) FOCUS GROUP TERMS OF REFERENCE

GSm (Focus group member) *– Terms of Reference – would like the following amends made:*

- the third duty currently is to review and support the development of public engagement plans in relation of HTP and added into that, is the programme for the implementation of these. The group need to know WHEN the plans are going to be implemented.
- the fifth duty currently is to ensure the requirement of MEC (Medicine and Emergency Care) service users views are considered in the hospital's reconfiguration programme. and added into that is that the trust response to service user's views will be reported back to this group.

ACTION: Julia Clarke – These amends will be made to all of the focus groups Terms of Reference which will go to the clinical work stream and then on to the Programme Board. It was recommended that a 'you said, we did' section be incorporated into the Outline Business Case and it would be helpful to see a draft of this in the focus groups at the next meeting, recognising that it is confidential and would just be for the discussion within the focus groups.

JC (Focus group member) *– Will the ICS Joint Forward Plan succeed the NHS 10-year plan?*

Julia Clarke *(Director of Public Participation)* – This question needs to be addressed to the ICS (Integrated Care Systems) because it's their plan and they are currently consulting on this at the moment

GSm (Focus group member) *– Would like notification of future meetings for diary planning reasons.*

ACTION: to circulate dates of future meetings with draft notes/actions of meeting

Date of next meeting: Thursday 25th May 2023, 11.30-13.30pm (via MS Teams)
