Planned Care Focus Group

Held on Tuesday 7th March 2023
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

	1. Planned Care Services
	DM (Focus Group Member) *– About the generic 3 questions:* *1. What does good look like?* *2. What do you think are the biggest barriers to achieving this?* *3. What do you think are possible solutions?* *Whilst they are well intended, I am not sure if there is possibly something missing from the questions because they are in isolation?* **A** – I don't disagree. However, the focus groups will progress as the plans become more robust and they will develop together, so there will be more input to come from the focus groups. As the plans get more aligned, and we get more detail, the conversation will become a more engaged and two-way. We need this as the focus group could direct us to things we might not have thought about, and their purpose is all about making the services better and safer. **A** – Also we know that different people have different areas of interest. The services have currently been separated out because there is a lot of background information that comes with each one. Our intention is that we may to have an overarching meeting where it all comes together. One of the mechanisms that we will use is the About Health event, the next is on Tuesday 9th May where we will bring back all the feedback and updates from the focus groups in one meeting. There were over 100 people who attended the HTP Health event in January. In May we are hoping that we will be able to run the meeting as a live stream with questions coming into the chat on the evening as well as questions in advance. That meeting will bring everything together into one overview. As the focus groups sessions continue, we may well decide to merge the unplanned care and medicine and emergency & urgent care focus groups together, with Women & Children's staying as a separate group as its more of a discreet constituency so likely to be of interest to a more specific group. However, we will listen to what the focus group members say to us about the future shape of the groups and what they believe will work best for them, so it will absolutely be at the groups shaping. ***SS (Focus Group Member)*** *– What happens if planned care "goes wrong". I know other centres have some HDU beds on site e.g., Leicester where they have planned care at one of their hospital sites, but they will have some reserve beds there for high dependency?*

	SS (Focus Group Member) *– Also what happens if the consultant who needs to do the emergency care is in planned theatres in Telford but there's an emergency that comes into Shrewsbury?* **A** – There will be a medical emergency team at the PRH site 24 hours a day. If the patient requires critical care, they will be transferred to RSH. Patient safety is paramount, we would not be doing this if it was an unsafe service. We have also been looking at other places that do it as well e.g., Northumbria who have four-five planned care sites, they have emergency and planned care sites which are slightly different, but it works well, so we are working closely with them. We are already in discussions with our surgical, medical, and anaesthetic teams on how we do that because it's absolutely vital that it's right. **A** –HDU beds need to be staffed by critical care specialists (consultant anaesthetists) who provide the service and because we can't recruit these specialist staff, so we are unable to run two separate units, this is part of the reason why we are making the service changes in HTP. Potentially, where the critical care unit is now at PRH, we will have an extended recovery area for patients who have had their surgery and if they need extended recovery period, we will be able to facilitate this at the planned care site using the anaesthetists on site carrying out the surgical lists. It's not a HDU which would be staffed and run 24/7, but it is an extended recovery unit if the patient needs that bit longer. It will all be resolved during the detailed planning. It's a good question but we were sighted on this and will be drawing up plans and contingencies to address this. Interestingly many private hospitals who carry out surgery do not have HDU units**,** so would transfer to an NHS hospital in this situation. Our plans will be more robust and there are plans to get patients safely transferred across on the rare occasion that it is needed. We are not doing this in isolation - we are learning from other hospitals elsewhere across the country who have already put these arrangements in place. It is a well-recognised pathway of care by the NHS, and it ensures we will give the best care to our patients. **A** – It is also importance to have robust pre-operative assessments in place before the patient is admitted. The patients will be reviewed by the pre-operative assessment team which involves a nursing work up e.g., bloods, x-rays. Certain patients will also need to see a consultant anaesthetist's who will assess the patient's anaesthetic risk. When all this has been undertaken the patient will be allocated to the correct site for surgery. We already know that some patients will potentially need HDU or ITU backup following surgery, so we will have dedicated planned lists on the emergency care site for these higher-risk patients. This will ensure that there is access to critical care if there are any issues. So, a thorough pre-operative work-up is essential to treat the patient on the right site. ***SS (Focus Group Member)*** *– What would happen if a patient has a fractured neck of femur and comes into Shrewsbury as an emergency, but the hip surgeon is in Telford for planned surgery, what's the logistics that would happen in this situation?* **A** – There will always be the all-speciality surgeons on-call on the emergency site. The emergency site will always have the required consultants on-call and the Registrars will also be on site. At the moment if there is a surgical emergency at Telford and the patient is so unstable that they can't get move the patient immediately across to Shrewsbury, then the on-call surgical consultant will go across to Telford. That does create risk as the Telford theatre teams are doing far

	fewer emergency surgical operations and they don't have any inpatient surgical teams as all the inpatient surgical beds are at Shrewsbury and this is one of the clinical risks at the moment that we are trying to reduce. If all the emergencies are on one site, then the theatre teams will be an experienced with the emergency work. There will be rotas set up so that the right team are always available. We have enough consultants in all specialties to deliver planned surgery sessions on the Princess Royal site and emergency cover on the Shrewsbury site. ***GS (Focus Group Member)*** *– Is there any sense of the proportion of planned care patients which will be treated at Telford as against Shrewsbury?* **A** – There are no absolute figures, but most cases will be at the Telford site mainly because most of the planned care cases do not require critical care and in any event the vast majority of procedures are day cases. The big vascular cases (which are very complex with the risk of bleeding) and most of the complex inpatient work will be done at the Shrewsbury emergency care site. The same with the lower gastro-intestinal surgeons as most of their inpatient work will also be at the emergency site because they are complex cases that could need critical care; however, all their day case work will be at PRH site. The majority of the inpatient surgical specialties and 99% of the bariatric surgeries (weight loss) will be at the PRH site. This is very important for this group of patients because currently due to demands on inpatient beds at PRH for emergency patients we have not been able to provide bariatric surgery over the last few months/years because of COVID and winter pressures. Under HTP there will be a dedicated bariatric service at the PRH site and protected bed capacity for surgical patients as there will be no direct medical emergency inpatient admissions. ***GSm (Focus Group Member)*** *– It appears there will still be a lot of planned care taking place at RSH in the new model, will that run the risk of getting squeezed out by all emergency work (medical and surgical) coming into RSH?* **A** – There is always that risk which can never be entirely removed but the risk will be reduced, currently the planned care service at the moment still treats the patients with high grade cancers and requiring big vascular surgery. These are the life-threatening cases, and they are still taking place at Shrewsbury despite the emergency pressures because they are effectively so serious that they are the same priority as an "emergency", even though technically they are planned, but usually the surgery is planned to take place within days. There will be inpatient emergency surgical beds at the emergency site and some planned care(for high-risk surgery) surgical beds at RSH. The bed numbers are increasing at RSH, so there will be more beds available. With the changes this will give enough theatre capacity and enough surgical beds to ensure we are able to provide the care that we need to deliver. ***Julia Clarke (Director of Public Participation)*** *– So is it fair to say that what although we classify some of the most serious planned care cases under the umbrella of planned surgery, it is actually so life-threatening that it really is as urgent as emergency surgery, but we just have a day or two to bring the patient in?* **A** – Yes exactly, so for example if you have someone who has an aneurism that keeps on growing, at some point it's going to burst then that becomes an emergency, and you want to get the patient in well before the risk of that.

	GSm (Focus Group Member) *– Have you got any plans for improving or changing the pain management service at the hospitals?* **A** – The pain services in the hospital are run by the anaesthetic team and pain nurses which is a commissioned service. The inpatient pain service is a 7-day service, and they facilitate pain reviews and patient control (when the patient is controlling their own pain relief) on the inpatient wards which is an acute pain service run and commissioned by the hospital. The chronic pain service is not run by the hospital but by the community trust. So, there are two different pain services, the hospital run the acute pain service for the inpatients which will stay as it is, but the chronic pain service is still with the community trust, which is separate from the palliative care team, which is more specific and a very essential care and different from the pain service. **ACTION: Julia asked for Slide 10 which refers to the pain management system to be made clearer on this point** ***GS (Focus Group Member)*** *– You said palliative care was separate from pain management, but it doesn't seem to be that separate?* **A** – They are very integrated but there are two separate teams. Palliative care is more than pain management, it's about the whole pathway covering end-of-life care which can last for weeks and months or longer. The Palliative care team and end of life care team are now integrated to try to provide a more joined-up pathway to patients and families. The palliative care team also works hand in hand with the hospice team, so it's a wider scope than the chronic pain management team has - it's a specialist service in its own right and it is a vital service. ***GSm (Focus Group Member)*** *– Will both pain services be available at PRH and RSH?* **A** – There is no change with the acute pain service or palliative care service under HTP - they will still be available at both sites, and the chronic pain service will continue to be run by the community. ***DM (Focus Group Member)*** *– Have the group had the opportunities to give the individual focus presentations to key figures and scrutiny groups within the local authority areas?* **A** – We have spoken to some of the groups, there was a recent meeting with some of the members of the Joint Overview and Scrutiny Committee led by Nigel Lee, the Senior Responsible Officer and the very first focus group (Medicine and Emergency & Urgent Care) had a member of the Joint Health Overview and Scrutiny Committee who observed the meeting and reported back to them. Every Borough and County councillor in the county and Mid-Wales and all the Town, Parish and Community Councils are now Community members and we keep them updated through our monthly "Getting Involved" newsletter email which has an update on HTP so that they are hearing it directly through ourselves rather than through third parties. GSm has also very kindly invited the team to the Shawbirch Patient Group on Thursday, and we will be pulling together all the four presentations into one overarching presentation to present to them and then to publish on our website, so all the information is in one place. We go out to external meetings to invite participants to the clinical focus groups where we can have more detailed conversations about the clinical services as we go forward. We will also be sending

	out a SurveyMonkey questionnaire with these slides and your questions/answers, which will ask you how you would like to see the format for the future focus groups. These will also be published on our website. After listening to today's meeting there is a strong argument for bringing together the Medicine & Emergency Care and the Planned Care focus groups, so when you do the survey, this may be something that you would want to suggest if you think this might be a better use of your time to merge these groups. **A** - The monthly Get Involved update is sent out to nearly 4000 members and updates on HTP and includes the offer to come out and talk to external groups because we think this is the best way of reaching as many interested people as we can. We also attend meetings of other groups and seldom hear communities and will be taking information on HTP and how to get involved or find out more. Any support that this group can give to promote the About Health event in May would be very much appreciated - there was positive feedback after the January About Health event with particular comments focusing on the advantage of the clinicians having the opportunity to talk through the clinical model without interruptions and to then take questions from everybody that was interested so a lot of common themes were covered. Both the presentations and the video, plus all the questions/ answers received have now been published on our website. HTP Focus Groups Updates - SaTH ***SS (Focus Group Member)*** *- How can we reach the younger population as well; we need to reach a lot more people?* **A** – One of the other areas covered by the Public Participation Service is our Volunteers Team – so as well as community engagement we also hold regular Young People Academies. There was a young people's Academy which went ahead a couple of weeks ago with 42 young people who attended from all over the county. We encourage them to sign up to become community members and there have already been a couple of signups from that and we are contacting the rest of the group too. The Volunteer and Community Engagement team do a lot of engagement work with the local colleges, there have been conversations with Telford College, and we attend the College induction events across Shropshire and Telford & Wrekin. We are also building up links with Colleges in Oswestry where we have just been to a Career's Fair. There is also the Young Volunteer's Scheme and half of all our current volunteers are under the age of 25. The team went to the Patient Group in Market Drayton and made a link with The Marches School, and they have offered to get a few young people to attend one of our next focus groups. But this is always work in progress so any other suggestions would be gratefully received **Next Focus Group: Tuesday 6th June 2023 at 10.00am**