The Shrewsbury and Telford Hospital NHS Trust

Women & Children Focus Group

Held on Tuesday 28th February 2023
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

1. Women & Children Services

Julia Clarke *– For clarification, in the slides you talk about maternity and the paediatrics service, but don't mention gynaecology, so will gynaecology outpatients still be provided on both sites?*

A – Yes gynaecology outpatients will still be at both sites, planned gynaecology surgery will be at PRH site and emergency gynaecology surgery at RSH. Early pregnancy will be at both sites, but the Gynaecology Acute Treatment Unit (GATU) will be at RSH site.

A – All gynaecology day cases will be done at PRH and most of the planned inpatient operations will also be carried out at PRH and this will protect the bed space. If the anaesthetist or surgeon think that the patient is a high-risk patient and critical care back up is needed, then surgery will be at RSH. Clinicians estimate there will be one surgical list a month required on the RSH site for those individuals who need the backup of critical care. Very often its just a precaution rather than a necessity.

A – Most gynaecology patients who receive care will receive this in a planned way rather than as an emergency.

ACTION: Julia Clarke (Director of Public Participation) - Tom Jones (Clinical Programme Lead) to include a slide on gynaecology in the pack before it is circulated out.

AL (Focus group member) *– The Midwifery Led Units (MLU) in RSH has been closed for over 3 years for different reasons, how does this plan going forward ensure that you can keep to MLUs staying open?*

A – The MLU are dependent on midwife staffing and skill-mix. The plan is that with HTP we will continue to improve our staffing and therefore to deliver care at both sites. [The rural community MLUs are part of a wider review and not included in HTP plans] The consultant unit needs to be supported the most because it needs to function all the time for obvious reasons (as it has the highest-risk deliveries) but it's more about having the right number of staff delivering the care. What HTP is effectively doing is moving the consultant-led care from PRH to the RSH site, so there will still be risks around staffing, but we are also increasing our numbers of midwives as we go forward to try and support both of the MLUs that we have on

	the SaTH hospital sites. From an HTP point of view we are going to be delivering MLU services at both PRH and RSH sites, but this will always be staff dependant. **A** – Understand that presently from a recruitment perspective we are full staffed with no vacancies and there is still a lot of interest in working in maternity services at SATH. As HTP progresses, and we have two MLUs, SATH will become an attractive organisation to work for, so I don't think there will be the issues that there has been previously with continuous monitoring which is what we have been doing over the last 12 months. ***AL (Focus group member)*** *– The message to the public needs to be clear – are we saying there will be two MLUs – one each site??* ***Julia Clarke*** *– Do we know what the model will be under HTP, will the non-co-located MLU (PRH) be open 24/7 or only open for the same number of limited hours as community hospital MLUs?* **A** - In the current designs we retain the MLU at PRH (adjacent to the current maternity block) and in the future design at RSH there is an MLU within the footprint of the new obstetric floor. The plan is to build new facilities at RSH and develop the staffing to support the plans. **EE** – *Within the feedback can we be informed of any of the reasoning if decisions have been made and if there has been service user involvement in making that decision. From the feedback that we have received, people were incredibly nervous about going to a closed MLU out of hours. We know people have not had a choice of where they could deliver in the last 3 years as even when the RSH MLU has been open it has had very limited capacity, so caution should be exercised in using activity figures for decision-making.* **ACTION: Ed Rysdale (Emergency Medicine Consultant and Clinical Lead for HTP) – To contact the clinical lead for an update on the latest version of the final model of the two MLU's.** **RESPONSE RECEIVED FOLLOWING MEETING: HTP aims to have a consultant led unit with an MLU at RSH. PRH will have a standalone MLU. PRH MLU will remain in the same location with all the facilities that it currently has available. Both SaTH site MLUs would be open 24/7 (subject to staffing and safety considerations at the time). Both would also have birthing facilities.** **The rural MLUs are not affected by the HTP programme.** **AL** – *In the 15 steps exercise that MVP have undertaken, we get to talk to the staff and look around the maternity areas. Some of the feedback that we had from when the building moved to PRH was that the staff had a lot of input into what was needed and how the building should look, however staff felt they were not listened to, and they didn't get what they wanted, and the building was not fit for purpose. For example, there was a lack of communal area for parents in the postnatal wards. It's the design of the actual spaces that will benefit from the co-production from the very beginning. The service user input "what do you want this space to look like" and "how should it feel for you". I think that is really important so that we don't reach a point where the building is finished and it's exactly like it was in Telford. This is a real opportunity to get a purpose built building that service users will feel like it's a great place to birth in.* **A** – We are still at early stages of design around where the building is actually going and which service elements are on each floor, but as soon as we can get some architectural plans that's when we want to start sharing with our clinical teams and

	also getting service users involved as well to help shape the final design as far as is possible. We want this to be a truly collective approach to the design. **ACTION: For all from Julia Clarke (Director of Public Participation) – What are your thoughts on:** **1. What would good look like?** **2. What do you think are the biggest barriers to achieving this?** **3. What do you think are possible solutions?** We will also email you these questions for your thoughts/feedback. **2. Continued developments at the Princess Royal Hospital** No questions. **3. Looking at travel and transport** **ACTION: Kate Ballinger (Community Engagement Facilitator) to send invite for focus groups to representative of Powys Community Health Council once Andrea Blaney has confirmed who this is.** ***Julia Clarke – For clarification Is a multi-storey car park still within the plans, as it was included previosuly?*** **A –** No, depending on the outcome of the commissioned Travel & Transport report it might be explored again but at the moment all the available funding is dedicated to delivering the clinical model. **4. Equality and Health Inequality Impact Assessments** **ACTION: Julia Clarke (Director of Public Participation) noted an error on slide 23, race should be separated from religion or belief. This is a separate characteristic, Sophie Stevens-Jones (Communications and Engagement Associate) to amend before the slides are issued.** **Next Focus Group: Monday 5th June at 10am**