NHS
The Shrewsbury and Telford Hospital
NHS Trust

SAC & MEC Focus Group

Held on Tuesday 6th June 2023
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

PART 1	**<u>Surgery, Anaesthetics & Cancer and Medicine & Emergency Care</u>** **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** Stephen McKew – **(SMc) Divisional Medical Director for Surgery, Anaesthetics and Cancer** Saskia Jones-Perrott – **(SJP) Divisional Medical Director for Medicine and Emergency** **<u>Q&A's FOLLOWING PRESENTATION</u>** ***Q: Focus group membe –*** *In concentrating on the clinical model, patients are seen as part of a process where you have patients flowing between the clinical spaces in an appropriate way to meet those clinical needs. What I would advocate is that you think about what it must be like for patients who form part of that flow going on their patient journey between those clinical spaces. I think you need to have a substantial patient and public input to help you do this.* **A: (JC) -** At present we're in discussions with the planners about the overarching design of the building. To date, we have been focusing on the clinical context and how the design meets healthcare and building standards which provide guidance around the design issues and future-proofing requirements that need to be addressed in a healthcare capital project. The next stage is about the physical environment and how we can make the process the best we can for patients and our communities by taking their views on board. ***Q: Focus group member –*** *I got the impression from an article in the local paper, the plans for seeking full planning permission were being drawn up at the moment. Is that right?* **A: (ER) –** Yes, currently we are seeking full planning permission for the new build at RSH which is in process and that's around plans for the physical building.

	Planning permission is about the layout of the clinical spaces and co-locations rather than actually down to the level of detail in each of the rooms. There is still a lot to talk about in regard of the actual design of the rooms. **A: (SMcK) -** There's two aspects to this; the physical space which is the new building, and we know which clinical services will be going into that building and this is part of the planning process but there's still lots of discussion and planning to be done around that. We know that for the best clinical outcomes for our patients we need to plan how we locate and co-locate services; this is critical to make sure that patients get the best outcome medically. For example, we know from a patient point of view it's important that we deliver cancer care closer to home and under HTP we will have day case cancer treatments at PRH as well as at RSH. From a surgical point of view, having planned surgery at PRH will protect bed space for elective procedures, such as hips and knees replacements. At the moment we are really struggling with our planned care because we can't protect our beds. With this model of care, it will really benefit our patients going forward to provide timely care. ***Q: Focus group member –*** *In regard to Future fit plans, when are we going to spend the £312million? In the interest of making it a little more seamless, what aspects of the future plan could be delivered now that maybe don't require new builds and would that help the public feel that things have moved forward a little bit and maybe there's a communication element to that?* **A: (SMcK) -** Any moves now must align with the ultimate clinical model of Future Fit, so we're already making some of those moves internally to make space trying to optimise outcomes for our patients. We need to bring some of those benefits forward by bringing clinical teams closer together which makes better outcomes for patients. If you've got well-established teams with strong clinical links, then you're much more likely to recruit more clinical staff into them to make the service more sustainable and therefore improve quality of care for patients. So yes, we're already doing a lot of that work already. **A: (S J-P) -** Any service development that we do now, we do based on where the service will be in 2026. Several years ago, we moved Stroke services to a single site at PRH and more recently inpatient cardiology to single site at PRH. These services from an acute point of view are going to move back to RSH when we deliver Future Fit. This helped us develop the clinical pathways associated with acute single site working, which has been really helpful and also helps from the point of staff retention and recruitment both from the medical, nursing, and allied health professional point of view and we're starting to see the benefits of that. We are trying very hard to move people either to or near their final destination as much as possible, so they are closer to home. So, there's a lot of work going on in the background, a lot of engagement from the technical teams at different clinical speciality level. Everybody is really excited about the changes, and it will be so good when we can actually start to see a tangible build and work that directly links to the Hospitals Transformation Programme. Hopefully that mightn't be too far in

	the distance, and we can actually start to show our staff and the public that things really are progressing ***Q: Focus group member –*** *The £312million (which was reduced from the £500million bid to central government approximately 18 months ago), is the original costing submitted following Future Fit. It is a very large sum and most of the funding is I assume for the new build at RSH. But beyond the RSH build cost, where can we see the distribution of that £312million in terms of adequate capacity to meet demand, and also the split between hardware, buildings, equipment, and clinical provision?* **A: (ER) –** The Strategic Outline Case (SOC) that was approved in August 2022 details this. We've worked closely with colleagues to make sure that demand and capacity has been modelled based on demographic growth. We are also working very closely with the Integrated Care Service (ICS) colleagues, to make sure that what we're doing from an acute point of view ties in with the local care plan and their plans for what happens in the community because they are all tied into demand and capacity. In terms of how the £312million is being spent, this is part of the Outline Business Case which is going through the formal process of Treasury approval to make sure it is spent to deliver the clinical model that we have designed in line with the public consultation during Future Fit. In terms of the difference between the £312million and the £500million, there have been some changes there are some changes which do not detract from the clinical model that we want to deliver but make best use of existing, refurbished and improved building stock. Also the Elective Care Hub development at Telford, has now been funded separately outside the £312million. There have been other pots of money that we've received in recent years to deliver improvements ahead of time, such as the endoscopy suites on both sites which have been upgraded. The Elective Care Hub at PRH is also absolutely key to delivering the clinical model, but was funded separately and should be completed in early 2024. **A:(JC) -** The £312million delivers the clinical model, a lot of the additional funding we've received has been to deal with some of the estate issues on both sites. Separately to HTP we have received nearly £100million to support some of the estates work for example work related to estates improvements. Some buildings that may not have been part of the original scheme such as the Copthorne Building have had significant money spent on them and are now modernised. We have also received funding for a number of new wards at RSH. All of this is through separate funding, which isn't coming out of the block of capital for HTP. It's about making sure that every penny is spent as wisely as it can be. The key message for the public is that the clinical model for HTP will be delivered in full from the £312million. **A: (SJ-P) –** We want to ensure that we are delivering the best possible care in the most effective and efficient way that we can for our patients. This is our one shot at getting it right. I'm really confident that we will make excellent use of the estate that we've got on the PRH site to deliver fantastic, planned care, not only operations but also diagnostics and outpatient care. Where possible we also want

to try and avoid hospital admissions - if we can avoid admitting people to hospital, that has to be a real positive, as nobody wants to come into hospital.

We have a really good opportunity with the PRH to have a thriving hospital site. I think it's important that we build up these patient pathways and adjacencies with public and patient involvement.

Q: Focus group member – *Where will urology be, I heard it was going to be in Telford, but would it need to be in Shrewsbury as well?*

A (ER) – Under the HTP plans planned urology will be at PRH. So, if you're having a planned operation that doesn't, or is unlikely, to require critical care this would be at PRH. A lot of urology services are day case and so will be going through the day case unit at PRH. If it's a much larger, more complex urological operation with the chance of requiring intensive care, then that operation will be carried out at RSH. If somebody comes in and needs an acute admission because of a urological problem for say renal colic and renal stones or something similar, it will be an emergency admission which will be undertaken at RSH. It depends on what the clinical problem is, but if it's planned care that doesn't require or is unlikely to require critical care, then that surgery will be at PRH.

This will be the same with all the surgical specialties and we're planning to have to ring fence planned care beds at PRH so that planned operations don't get cancelled, as all the emergency admissions will be at RSH.

A: (JC) - The key difference it's going to be the type of care that you need that's going to decide which site you will go to. If it's emergency care, it will be on RSH site and if it's planned or nonlife-threatening care, it will be on the PRH site.

Q: ***Focus group member –*** Which wards at RSH will still be in use and are those the ones that the money will be spent on?

A: (SJ-P) - We have started to plan where we think different specialities are going to be on the acute site and we have done a considerable amount of work to develop our respiratory support units in our high dependency respiratory care area on the respiratory ward at RSH. We plan to use that unit going forward in the Hospitals Transformation Programme. All the work and planning we're doing now is aiming to make the existing spaces, that we will need to use, as fit for purpose as possible. We are also very aware of the need for side rooms so we're making sure when we are thinking about where different specialities are going to be, that we are utilising side rooms as effectively as possible.

Q: Focus group member – *Coming from the Welshpool area, we are concerned about the transfer times for people who have strokes, cardio, or anything similar. The proposed closure of the Welshpool Air Ambulance is an issue for us; we've been told in a number of meetings that our air ambulance service doesn't really use Shrewsbury a great deal, but I've been to Shrewsbury a few times and the Welsh Air Ambulance have been there. I'm just wondering what impact that's going to have on plans for the future in terms of dealing with people with acute*

problems, from the stroke point of view in mid Wales, bearing in mind that our ambulance response times in Wales at the moment is pretty terrible?

A: (SJ-P) - At present stroke and cardiology services are acutely delivered at PRH, whereas under HTP the acute delivery of stroke and cardiac will move back to Shrewsbury - which will provide better care for all the communities that we serve. By streamlining acute and planned care and protecting our beds we also won't have the same ambulance offload delay issues that we are currently seeing, frequently at both hospitals and hopefully that will release ambulances to be able to reach people in a more timely fashion. Our trauma patients (for example motorcyclists involved in serious accidents around Wales), will generally continue to go direct to Stoke Hospital.

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:

(SMcK - summary) - I think there's a feeling that we need to get out. We need to get into more groups, particularly the younger population. From an external point of view, I think it's refocusing and looking at some of those areas.

It's not just about what's in the future, it's about what we have done up until now and what is currently underway to make things better. Also, advertising what we've done in the hospital itself, for example when people come into the hospital, having the opportunity to read and see what it is going on.

It is important to reach out in the Telford and Wrekin area and again we came back to the business of different types of media for getting out to people, not just to groups but providing information to the general population. It needs better general engagement with the public and jumping on the back of some of the existing events that are taking place.

We talked briefly about workforce, about how we will attract workforce, from the retention and recruiting point of view this is very important. But the point that was well made was that if we get out more in terms of selling the story, this will also help with our recruitment and potentially our retention workstreams as well.

There was a point made about, the frontage of some of the hospitals and the signage. We covered work which is underway in some areas, and I think people understand and respect the fact that the clinical side of it obviously is the focus for HTP. But of course, all the cosmetic area issues as well are equally important and are being addressed as part of the delivery of the project. Communications and contact were really the main theme from this particular group.

	(Focus group member) – *The University Hospital of Dorset have 'Coming Soon Vision' on their website landing page. Do we have the same?* **ACTION - Jenny Fullard/ Comms team to update the website pages.** **(HM) –** There was a lot of discussion around ensuring the integration of the HTP programme with the wider health economy and linking in with primary and community care. Some of the advantages include looking at streamlining the services and the medical pathways. The comments include having the patient in the right place, with the right people. There was some discussion around involving the public and whether there could be representatives on the different committees. **Action: Programme Board to review suggestion of public membership on sub-committees** **LP *(Focus group member)* –** We need to keep any communication as simple as possible and make the explanations clear and precise. We've got to look at health literacy due to some of the information being too technical which we have on our website. I also think a brilliant idea is to have more flyers around the hospital so people can see all the good things that have been done. Perhaps we could look at the examples of the urgent care and the emergency care. **Action: Jenny Fullard/ Comms to review the use of flyers that update on latest developments for both sites and distribution and public events**
PART 2	***Session 2 Question and feedback*** ***Question*** • **How do you want to be involved in the HTP Programme?** • **What's working?** • **What can we improve?** **Feedback** **(HM) -** It's really important that we get out, not just representatives but our public and our patients and how we do that is a challenge. There is a lot of information going around, not all of it accurate. We talked about representation on committees and the individual's attending committees which feedback to their groups and the way that it was previously done under Future Fit, but after that it stopped. We need to make sure that we promote, and we give information. Some people felt that decisions were being made and there wasn't public involvement, so it's really important that we're communicating that information. We talked about communication, our website and our leaflets and the way we're telling information and making sure that it's accessible to people that may not be involved in health. **(JC) -** We will take these comments and suggestions to the HTP Programme board, and we will ask for a response. We will feedback to the focus groups at our next sessions as well, so that there are clear responses to the points that have been made.

	ACTION: Julia Clarke to prepare report from focus groups to HTP Programme Board **(SMcK) -** Reinforcing engagement links with regional bodies and North Powys, is similarly very much, more of the same approach