The Shrewsbury and Telford Hospital NHS Trust

Medicine & Emergency Care and Surgery, Anaesthetics, Critical Care & Cancer HTP Focus Group

Held on Friday 8th March 2024
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

Mental Health HTP Focus Group

Team 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**
Tom Jones – **(TJ) HTP Implementation Team**
Rhianna Bennet **(RB) - HTP Project Manager**
Adam Ellis-Morgan **(AEM) - Assistant Director and Technical Lead for HTP**
Victoria Shepherdson **(VS) - Designer**
Gareth Banks **(GB) – AHR Lead Architect**
Amruta Lacy-Colson **(ALC) – Respiratory Consultant**
Ruth Smith **(RS) – Lead for Patient Experience**

Q&A's FOLLOWING PRESENTATION

Q: In the presentation you refer to a "vibrant planned care unit", what is a vibrant planned care unit?

A: (AH) – It is describing a busy a unit treating a lot of people. We're trying to make sure that people realise the planned care unit is vital for delivering care across Shropshire and that people are aware that Telford is and will be a fully functioning and busy hospital.

Q: Can you confirm that the midwife led unit will have consultant cover as and when necessary?

A: (ER) – Under HTP the consultant unit will be at the Royal Shrewsbury site. The current arrangement is that there is a midwife led unit (MLU) with the consultant unit at Telford and a MLU at Shrewsbury. Under HTP this arrangement will be reversed, so there will be a MLU alongside the consultant led unit in the new build at Shrewsbury. In Telford there will be a standalone MLU for low-risk pregnancies and this will not have consultant cover, in the same way that the current MLU at Shrewsbury does not as these are for carefully assessed low-risk pregnancies.

Q: What happens if a low-risk birth suddenly turns into a high-risk birth?

A: Under the new model the woman will be transfer from the MLU at Telford to Consultant Unit at Shrewsbury Hospital. This is common practice for MLUs, (there are other issues with MLUs that aren't currently delivering babies on site, but this is part of a separate consultation being run by the Integrated Care System). The key to this model is triaging the mother at the start of her pregnancy which the midwives are very skilled at doing, but we know that things can change and there are pathway plans in place for that. One of the drivers for these changes is to bring all the care together on one site with all specialties close by so that the consultant led unit is on the same site as the general surgeons, as there are times when the woman may need general surgery as well as maternity specialists and the clinical model ensures all specialties are now together.

Q: What percentage of the current W&C Centre at PRH will be repurposed as a respiratory diagnostic treatment centre?

A: (ALC) - There are four areas in the W&C Centre and the exact allocation is not decided, currently the neonatal unit will more likely be primarily for diagnostics – looking at sleep and ventilation medicine which is a huge growing part of our service. Underneath that the neonatal unit, there's an antenatal ward, which we anticipate will be an inpatient area and respiratory patients being looked after by respiratory consultants will stay at the Telford site. Adjacent to that currently is the post-natal ward, which we hope will be part of a small, bedded recovery area. There is the consultant led unit on the floor above which will have a lot of theatre space. All together there will be diagnostics plus a 24-hour bed base. 100% of the current neonatal unit will be for respiratory, care the antenatal ward will be an inpatient ward and there will be a mixture of inpatient and day cases in the postnatal ward. The procedure suite will have 13 rooms and two theatres which will used by medicine and our surgical colleagues therefore making more capacity in the main theatres. The Respiratory Centre will be for all patients across Telford, Shropshire and Mid-Wales

Comment: There are lots of positive features in the current designs and I also strongly recommend you have a look at the technology used at the Royal Melbourne Hospital to help people get round. There are points where visitors, patients and others can in fact get instructions and written directions to where they want to go. This will be one of the problems that we will have with this development as the existing older building isn't the easiest to navigate round. I think a lot of attention has been put into how you integrate getting people from the new extension over into the existing building, it’s really the relationship of signage to the main ward block, which will still be used.

A: (GB) - For those who are digitally literate, maybe some sort of app that could be developed. For those who are less digitally literate, we could offer some sort of paper copies, which would help better navigate, we've got some slides later that pick up on some of those themes.

Q: Is there still a place for paper maps, I personally prefer to look at a paper copy?

A: (GB) - We have the capability to do, this is something which sits outside the core funding of the project, but it may well be that when you get your appointment to visit, there's a bespoke map which tells you how to get there. It's something that we could look at developing.

A: (JC) - One of the things that we must be mindful of is the funding that is available needs to be prioritised. There are things that we must do to deliver the clinical model and building regulations. There would be some other things that are good to do, and we would like to include, and we've certainly already had offers from some of our charitable partners that they'd be happy to look at funding some of those. The technology is available to produce paper print outs in the way that you're describing, and whilst it might not be part of the core HTP funding, it would be something that could be funded using other sources.

Comment: There is the possibility of robots to guide people around and have certain areas designated. If you're lost and you go to those areas, you tell the robot where you want to go, and the robot will then accompany you. Whether that is an architectural implication, but it does have an implication for the cost. The building itself is already difficult to navigate and when the extension is done it will be even more difficult.

A: (JC) - The key issue is using the resources we already currently have; we have over 300 volunteers and they have the interaction with patients which is what they want, and it may be that we develop a meet and greet volunteer role in the new build to support patients navigating the building.

Comment: (ALC) - For patients who have disabilities, it's about knowing which is the nearest car park to where they want to get to which is very important, especially for patients who get breathless very easily. Is there a plan or could we have a plan to ensure if you're going to have an outpatient appointment, the letter states where the nearest car park is. A lot of patients who are used to coming to one area traditionally tend to park where they are used to, but it might be on the other side of where they now need to be.

A: (JC) - That's a very good point. It's wider than HTP because it's not just going to be people coming to the building, it is something that was mentioned on the patients and carers experienced panel, possibly looking at putting in outpatient letters. There is work being undertaken outside HTP with Patient Experience and Estates looking at these issues and this could certainly be incorporated into that work.

ACTION: Lydia Hughes (HTP Communications) to liaise with HTP, Estates and Patient Experience to look at mapping car parks to patients' hospital locations.

Comment: Whilst the calm areas was suggested by a focus group for patients with autism and learning disability as being helpful for patients with neurodiversity, there was a view that from the focus group for patients living with dementia that they might feel quite enclosed and oppressed in these spaces. It's recognising that one size doesn't fit all and it's trying to make the best accommodations that we can.

	Comment: How are more comfortable seats/calm areas going to be "labelled", as I'd head straight for the green comfortable seats if I wasn't aware of their purpose. Even if I do not need them, I may be taking up a seat for somebody who does. I think everybody will feel that way. They look much more comfortable, don't like the look of the grey seats. **A:(JC)** – There is a slide which illustrates how these areas will be identified so that it's made clearer what their purpose is intended to be. **Comment:** The armrest edges look very hard, they need softening; I think a person who perhaps need a bit of rest is going to bang their arms against it. **A: (ER) –** In the department waiting room the seats must be fire and lighter proof and we need to make sure that they can't be torn apart or thrown around. In an emergency department waiting room, there are all types of patients, so the seats need to be robust enough to cope with all types of patients that come in. The Dementia Focus Group mentioned different heights and firmness of chairs are needed and this is something we will be looking at later on the project when we start to look at how rooms are kitted out. ***Q: Looking at the slide of the main entrance with the two doors headed "Main Entrance" and Emergency" if you need the urgent care but are not an "emergency", which side do you go to, Main Entrance or Emergency?*** **A: (ER) –** That's a very good point because the Urgent Care Unit is part of the footprint of the Emergency Department, it should be Emergency and Urgent Care. If you did go into the Main Entrance, it's not the end of the world because you would be re-directed into the urgent care unit on the other side, but I agree that it does need that additional signposting underneath emergency. **Action: Ensure that the Urgent Care Centre is included in the Emergency Department signposting** **Comment:** The Adelaide Hospital development was impressive, signage is on a floor-by-floor basis, using colour and pictures. For example, if you're on one floor, it has pictures of trees. If you're on the next floor, it has pictures of outback Australia. The images and the colours match each other so it reinforces and supports wayfinding. A combination of colour and pictures for coding would work well. **A: (GB) -** We are not relying on colour alone as some people are colour blind so we know we can't rely upon colour on its own. It's important we differentiate areas within the hospital to do that. **Comment:** The idea of putting a curve on the door frame or above the door frame, rather than a sharp angle is a good idea as it makes it seem softer and more welcoming rather than square. If you could use that technique throughout the building, I think that would be a very good idea. **Comment:** About the signage, if it's too high up, often people living with dementia are looking down because they're unstable on their feet and they're worried they might fall. It would be useful to have signage on the side of the door and on the arch above the door, in the green on white. It would then meet both needs.

	Comment: It would be advisable to have one type of signage in the new extension and your current signage in the rest of the hospital. It would be important for the board to consider determining its signage policy. Possibly start to introduce new signage in the old building and then move that signage into the new building. The new building will determine the signage. It will not work if there are two sets of signage within the Trust. **ACTION: Ruth Smith (SaTH Patient Experience) to discuss signage in the wayfinding exercise meetings for the Patient & Carers Experience Panel Report which then goes into the Quality & Safety Overview Committee, who then reports to the board, with a view to be taken through to Quality Operations Committee (QOC) so that it could then go on as a recommendation to the board.**