The Shrewsbury and Telford Hospital NHS Trust

HTP Focus Group

Held on Tuesday 2nd December 2025
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

HTP Focus Group

Team responding to public questions

Julia Clarke – **(JC) Director of Public Participation**
Adam Ellis Morgan – **(AEM) Technical Lead for HTP**
Ed Rysdale – **(ER) Emergency Medicine Consultant and Clinical Lead for HTP**
Steve Ellis – **(SE) Deputy Director of Operation Service Development Shropcom**
Sam Townsend – **(ST) Divisional Clinical Manager (Adults Community) Shropcom**
Carla Bickley – **(CB) Associate Director of Strategy & Partnership**

Q&A's FOLLOWING PRESENTATION

HTP Update:

Comment: (AEM) – Concerns were mentioned about sound proofing the rooms. We need to achieve certain decibel (dB) ratings which the ceilings will achieve, so there shouldn't be any issues regarding sound.

Q: What aspect of the room and flow design rationale reflects patients who are frail?

A: (ER) – All the room designs are up to the NHS standards. In terms of frailty, they are bigger than the current designs. In the current ward block at RSH, the bays and rooms are very small, these are much bigger, so it is easier for patients to move around and staff to provide care.

In terms of flow, we're working very closely with our Frailty and Care of Older Adult team. There will be a care of the older adult area on the ground floor of our current ward block. As part of the new build at RSH, on the acute floor we will have a frailty and SDEC (same day emergency care) area. We just finalising the exact use of this area with the Care of the Older Adult team because the number of older adults are increasing in numbers and we need to be assured that we have the right space for the numbers of patients. We have designed the new acute floor so that it is next door to the emergency department. As a large number of frailty patients come

	through the emergency department, by having the frailty ward next to the ED department this will support flow through the building. Frailty and care of the elderly also tie in with community work - frailty is very much more than just acute care, if we can get our frail patients out and home sooner, this supports their long term recovery. ***Q: It would be interesting to know the demographics of planned care patients travelling to Telford Respiratory Centre from around Shropshire, Telford and Wrekin. We need to understand the impact of elective health planned care as it is critical to helping patients as it will go into the (ICB) Integrated Care Board agenda and transport.*** **A: (ER) –** There is going to be respiratory care on both sites, but acute emergency respiratory wards will be at Shrewsbury. The planned care for sleep studies, the bronchoscopy etc will be at Telford. Some patients may need to travel further and that will be part of the (ICS) Integrated Care Systems planning, but by doing that it can be ring fenced so we can make sure it happens. People will have to travel further, but there is more guaranteed they're going to have the procedure, so therefore there's pros and cons. The ICS will have to look at it, but in terms of demographics, we've made the decision, where do we want the acute and emergency site and that's based on demographics, geography and lots of other things. We can't have one big hospital with everything together. **Comment: (JC) –** It's important to remember that the system is trying to focus on prevention, health promotion, admission avoidance, so a lot more care closer to home - virtually would be useful. The whole landscape of healthcare is changing and with the community diagnostic centres a lot of tests and scans are now done off site because treating people away from the main hospital site is the way forward. Also the HTP plan focuses on one planned site and one emergency site rather than on geography **Comment: (ER) –** The demographics for respiratory and for oncology wasn't looked at on the original part of HTP because it wasn't part of HTP. By moving Women's and Children's to RSH, the new Respiratory Centre can be provided in a fantastic clinical space. We're using it to better provide an opportunity which makes sense for the county as did the oncology and cancer unit. ***Q: The progress has been phenomenal. Is it possible in the next presentation, to see something like a milestone plan, so we could see what's already happened and what the next half year will consist of, just so we can see a visual update. You've given us all the updates of what's been done, what's in progress and what's to do, would it be possible to have one slide showing the milestones?*** **A: (JC) –** Yes, we do have a road map which isn't in this version. I think the people who have attended regularly will recognise we have had a slide which shows the different elements up to 2028, but it is not that detailed. We haven't put it in this one, but we can reintroduce it. **ACTION: Aaron Hyslop to include road map of progress and upcoming works within the presentation for the next focus group meeting.**

5 Year Community Engagement Strategy – Initial Results:

Q: Great to have key targets. What are the current stats? How did you get to these targets, do you know if they are achievable?

A: (JC) - The key targets are issued by the Department of Health. We issue our performance against them in our Performance Report, which goes to the Trust Board every two months and is available on our website. These are the targets that the government have set for all NHS Trusts.

Q: Is there any chance of an infographic that is more readable?

A: (JC) - A big thank you to Kate Ballinger who pulled the infographic together. From something even more unreadable. The presentation will be on the website, so you'll be able to open it on and zoom in on the detail.

Shropshire Community Trust: Community Transformation:

Q: I have long had concerns that there are very few integrated care pathways, i.e. from acute through recovery and rehabilitation, and then living with a condition in Shropshire, Telford and Wrekin for long term conditions such as Stroke, Coronary Heart Disease, Diabetes, Parkinson's, etc. I know there has been involvement of clinicians from both ShropCom and SaTH in working up some of the HTP pathways, but no one has answered my question about how patients have been engaged in developing these. I was involved with the (MSK) Musculoskeletal Programme Board as a patient rep and found they were very receptive to my contributions. I was impressed with the development of my Recovery Self-Management App and working together with leisure services from physical exercise, etc. How do you involve patients in the development of these pathways?

A: (ST) - I think particularly around the integrated neighbourhood teams, what we have acknowledged is as we start to develop them, we absolutely need to bring patients in and understand from them what they need and how they want it to be delivered. The formalising of it and getting the message out there about it, we still need to do that bit. In terms of specific pathways across clinical conditions, I think as we move into the group model, we will find those conversations are much more joined together. It's a working progress, but patients and people who've had that lived experience are the best people to guide us in how to do it.

A: (SE) - It's important around negotiating the pathway because that's what I would want. My family member needs medical care regularly at the moment and I need to help them negotiate some of those pathways. We want to make sure that it is much clearer and more straightforward, so that the patients who are at the centre are aware of what s happening and what their plan of care is.

A: (CB) – As part of the Enabled Health Framework there are six components. There is a lot of work and momentum in there, whereby we are working with our (PCNs) Primary Care Networks and GPs individually and particularly focusing on long term conditions within the neighbourhood framework. We are assessing the

	population of health management data of all the clinical needs of those locations, and we are looking at the access and the populations. Most of our GP practises are using something called risk stratification, which is identifying the patients that may have a higher risk of need and care. There is about 50 per practice at the moment that they are specifically targeting to help identify and learn to put in appropriate pathways, communication, support groups and all the other services that we need to manage their conditions with a view for the good practise to be rolled out wider across our patches. **Comment: (CB) –** The work around MSK has made a huge difference and there have been some good lessons learnt, such as the use of the leisure centres and the digital app is fabulous. ***Q: Prior to COVID, my husband's podiatry appointments were always in Wem, now we find that we need to come to Shrewsbury. Is there any possibility that you might relocate the podiatry services? If not there needs to be a plan to consider this problem.*** **A: (SE) –** A few weeks ago and I was at a workshop led by Cornwall Isles of Scilly, talking about neighbourhood hubs. They run half a day at a village hall locally to do some of the neighbourhood work. From that knowledge it would be useful to take services out to where people live. We shouldn't be afraid of doing stuff at small locations such as village halls and community centres, rather than expecting everything to go on in a health building. **ACTION: Steve Ellis to liaise with the podiatry team to find out if there is a possibility to relocate closer to Wem or to the more rural areas.** ***Comment: You're talking about having partnerships and wider engagement with people who have long term conditions. It seems to me that when it comes to cancer care, you hear about Macmillan and services like this, but when it comes to the Stroke Association which does a huge amount of work, it doesn't seem to be mentioned. A while back when I was doing some work at Keele University the only local support group I could find was in Market Drayton. I feel there's an opportunity to highlight to people the contribution that comes from these specialised charities.*** **A: (SE) -** I agree. I think they have a huge opportunity and this is why I talk about The Mind Association as well. There are lots of those areas that we can utilise and it's about making sure we're open to those. **A: (ST) -** I completely agree, there's so much more support out there that as a Community Trust and NHS workers we could tap and pull into, but I think we've been blinkered sometimes about getting on with what our bit of it is. The shift into neighbourhood and doing things with our partners is very much about being out there and seeing how we can all work together and not just do our own little bit because that's what can get disjointed for people. **A: (JC) –** The Engagement team do go out to events put on by the voluntary sector and act as a gateway signpost. That's something that we could look at working closely in terms of engagement and awareness raising in the future.

Comment: Following on from access to services, there's sometimes a need for mobile services, is that a possibility?

A: (SE): I agree, I covered the vaccination service through the early days from 2020 onwards and we had a mobile vaccination bus that did some of that work. From some of the stuff we do around well-being, I know the local authority get out to do prevention work on that same bus, as it belongs to the local authority. They go out to places like cattle markets and into rural communities. I think there's more that could be done with that, it depends on the service we're offering, but certainly prevention, vaccination, all that sort of stuff we could do. I think there's an opportunity there.

Comment: Maybe podiatry could be done in that way?

Q: I have a friend, in her 90's who was a qualified nurse. She was having a district nurse attend her home two days a week, suddenly she was told they could no longer come and was informed to get to her doctors' surgery. She hasn't seen a doctor for months. She doesn't want to trouble anybody, but she is in enormous pain. How can she somehow get linked into having reinstated treatment she desperately needs?

A: (ST) - She should contact the (PALS) Patient Advice and Liaison Service, which will get her to the right people and team:
Shropcom email address is: shropcom.customerservices@nhs.net

A: (JC) - For any issue with any NHS organisation, (PALS) Patient Advice and Liaison Service is the place to go. They are there to help sort out problems, and concerns.

Q: I noticed in the Shropshire Star that we have been identified as a pilot neighbourhood area. What is the pilot site, who put us forward for the pilot site, what was the documentation and is there any cash with it and where is the centre for the development?

A: (SE) – There was something called the National Neighbourhood Health Implementation Programme (NNHIP) a new initiative by NHS England and the Department of Health to shift care into communities, focusing on preventative, integrated and accessible health services in deprived areas to tackle health inequalities. In Shropshire, Telford and Wrekin there are two places. One is Shropshire, one is Telford and Wrekin. Both places bid and it was led by the local authorities, with support from across the NHS colleagues, Shropshire was successful in winning the bid. It does come with a national neighbourhood coach who's someone from the local authority leading the work across the whole of Shropshire. There are 18 leaders from across the system. That is me, Carla Bickley as Chair, Steve McKew from acute and people from the local authorities, Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) in Oswestry, the five PCNs across Shropshire and from the voluntary sector. We're working together now and starting that process. Theres a lot of work going on in the background to develop those pilots.

	A: (CB) - There's almost two elements of the neighbourhood health work. There is the shift that we were doing as a system in terms of wanting to improve GP access, wanting to improve our pathways, long-term conditions such as diabetes, all the enablers for the Urgent and Emergency Care Transformation Programme and the Planned Care Programme. At which time the 10-year plan kicked in with the three shifts. We now have the National Neighbourhood Health Implementation Programme, we are one of many in the country, for the first wave, which is specifically looking to address areas and improvements predominantly pertaining to long term conditions, although there are specific areas and illnesses that we will progress based on need. In terms of who put this forward, it was a system led by the (ICB) Integrated Care Board whilst engaging with all partners, PCNs, all our providers, the voluntary sector and local authority colleagues who had all signed up. As a result, they allocated individuals to support, and they were given the authorisation to continue this work. There have been two or three workshops set up nationally where they share good practise, lots of structural things and different pathways for us to start to look at. We have a coach that's designated to us for two days a week, a lady called Emma Pyra who works at the ICB and Naomi Roach, who works for the local authority. We are in the process of working with all our PCNs to look at their local information, intelligence and data that they've got on the needs of their communities to further enhance and develop pathways. Likely within the next week, there is a new Neighbourhood Framework which we will look to embed and work towards. There are various elements in the neighbourhood programme that we will be working on, which is the population health, access to GP surgeries, pathways and urgent and emergency care, which are the services we spoke about for maintaining patients at home rather than admission to hospital. Also discharges, making sure that they have got the appropriate care and support in place for discharges and a whole host of other things. ***Comment: I do have a great problem with this concept of neighbourhood, when I read national documents, a neighbourhood is defined as a community of around 30 to 50,000 people. Which is somewhat different from your message. I'm very concerned and there's a lot of confusion about what neighbourhood is or what it isn't and what the expectation should be. I'm quite sure lots of ordinary citizens have no idea what the concept is and what the consequences are.*** **A: (SE) –** We're quite early in the stage of developing this. We have SaTH colleagues, the Community Trust, PCNs and local authority colleagues across the spectrum. I don't disagree that we need to make sure we get the right message out to our patients and citizens. We are working on outcomes, that's the key, but I think it's how we share that which is important. As plans are being made, we need to start involving the community as feedback is important. More detail needs to be given on the programme as it is key to our success as a system in providing healthcare going forward. ***Comment: It would be helpful for some approach be made to the Joint Health Overview and Scrutiny Committee to do a presentation on the Neighbourhood Programme. I can't express how complex I see it all being. If I'm confused, lots***

	of other people are going to be confused. We need to get the confusion out the way. ***Comment: Everybody is doing lots of things and everybody's fairly at the limit of what they can do as well. This is part of the problem. I do think better use could be made of public platforms, by that I mean radio, newspapers, libraries, centres, anywhere where there's large numbers of the community present where you could have a survey, possibly written that could be in an envelope and posted. It could be tried in a small way and from that you might also get some expert patient volunteers. They're the people who have repeated entries into A&E or to the GP and the people who are desperate to receive some care in their own home and can't. So, I think better use of public platforms.***