MEC & SAC HTP Focus Group

Held on Thursday 11th July 2024
10:00 – 12:00hrs via MS Teams

Questions/Answers

Medicine & Emergency Care and Surgery, Anaesthetics, Critical Care & Cancer (MEC & SAC) Hospital Transformation Programme (HTP) Focus Group:

SATH members of staff responding to public questions:

Julia Clarke – **(JC) Director of Public Participation**
Tom Jones – **(TJ) Implementation Lead for HTP**
Saskia Jones- Perrott – **(SJP) Divisional Medical Director**
Ed Rysdale – **(ER) Emergency Medicine Consultant and Clinical Lead for HTP**
Wendy Southall – **(WS) HTP Implementation Lead**
Adam Ellis-Morgan – **(AEM) Assistant Director and Technical Lead for HTP**
Robert Simcox – **AHR Architect**
Lydia Hughes – **(LH) HTP Communications Lead**

Q&A's Following Presentation:

Q: Healthwatch Shropshire has always expressed concerns about the stroke rehab service being based at Princess Royal Hospital (PRH) and the difficulties for people having to travel to PRH from Wales and the west of the county to visit long stay patients, especially since Ward 22 closed to rehab patients at RSH.
Can you explain how rehab services are to be provided across two sites in the new model?

A: (ER) The majority of the rehab services will be based in Telford at PRH. This means that there will be some people who will have to travel further for these services. However, this must be balanced against the advantage of having a rehab service away from the acute site (at RSH) because if you have patients being admitted as emergencies into the rehab ward, they could be admitted at all hours, from late in the evening and throughout the night, disturbing patients already asleep on the ward. However, the planned site provides a better/calmer rehab environment for patients through planned admissions. The traditional wards are all run by doctors and nurses, with rehab wards we can provide a therapy-led ward run by the different therapists who are the experts in rehab and therapy. It isn't possible to have

	everything on one site and nor would it be a better model. If you have everything on one site with one massive hospital, there will be issues of mixed emergency and planned admissions and pressures on elective beds. The clinical model of separated planned and emergency care was agreed following public consultation many years ago. The Royal Shrewsbury Hospital (RSH) site is in the middle of the geographical area that we serve which makes it more suitable as the emergency site with PRH as the planned site. There will be a small degree of rehab and frailty work at RSH, but the bulk of the long stay rehab will be at Telford. It's better for patients to be in a planned care environment to have their rehab rather than on the acute side. **Q: We still seem to have made very little progress in Shropshire in having an integrated community and hospital stroke service. There is no sign of an integrated pathway, which I find very dismaying after all this time. Also, the stroke national report does not indicate that the minor improvements that started when the stroke service was consolidated have been maintained. There are big issues about the stroke service, which I accept are not about HTP, but it is something that Healthwatch Shropshire have concerns about.** **A: (ER)** Clinicians believe that having one Emergency Department will improve stroke services because there will be one point of access for patients. At the moment with stroke services in Telford it means that if you come into Shrewsbury ED with symptoms of a stroke, you'll be seen straight away, but then there will be inherent delays in getting you to the right place (i.e. Telford) for ongoing care. In the new HTP model there will only be one ED so anyone with a possible stroke will be seen in Shrewsbury ED where all the other acute specialties will be based, including acute stroke. If a patient is in an ambulance they will be brought to Shrewsbury if they are showing stroke type symptoms. If patients do go themselves to the Urgent Treatment Centre (UTC) in Telford, they will be triaged and then transferred to Shrewsbury by ambulance in a very timely manner. In some cases, for some patients the right place might be Stoke Hospital because of the specialist interventions they can provide for some strokes. **Q: When the stroke unit moved to PRH it did provide an improved service but all on one site. We should follow up all service moves after six months or a year to check if they are successful and if they are working well.** **A: (ER)** The only services we really have now left on both sites are emergency medicine, acute medicine and critical care to some degree (the critical care service at PRH is less specialised as there's no general surgery service there. Everything else has now been specialised onto a single site because of the better outcomes and concentration of our workforce on one site to deliver the best care with our available resources. However, the way that the different consolidations have been put in place over time hasn't been pre-planned, so it's been reactive based on where we have had physical space to locate services rather than planning where the best place for patients is and where the clinical pathways should go. HTP is providing the clinical space we need to put our clinical services in the right place. We needed to bring all our clinical pathways together, so we could improve the care and outcomes for all our patients, minimise delays and maximise the deployment of our workforce. Unfortunately, this means some patients will travel further for some services, but the outcomes will be better, and healthcare is about

providing the best care we can for our patients with our available resources. That principle is key for both medicine and surgery. The HTP plans for planned surgery will be one of the biggest game changers – we have seen that over the winter and due to COVID, lots of planned surgery was cancelled because emergency and urgent care will always take priority over planned surgical admissions in terms of bed availability. By increasing our acute bed base and having ring-fenced surgical beds on our planned care site we can operate all year round without cancelling patients and the new surgical hub just opened at PRH will enable us to do that.

Q: On the website it's noted that the elective orthopaedic surgery has been put on hold at PRH due to an issue with the recovery ward. Has this now been resolved and is it back on track for orthopaedic surgery?

A: (TJ) The elective surgical hub provides day surgery procedures, but many elective Orthopaedic procedures require a stay on an inpatient ward, and there are plans in place to protect an inpatient ward at PRH for elective orthopaedics in the very near future. Hip replacements are done in main theatres with laminar air flow. The problem at PRH has been compounded by the fact that the elective capacity inpatient ward has been used for emergency medical patients, but plan is in place to resolve this.

Q: What priority is there for single sex facilities, particularly lavatories and washing areas? What provisions for single sex wards have been made for those in HTP?

A: (AEM) We do have a dedicated Changing Places facility on the ground floor for profoundly disabled patients. We also have disabled patient toilets throughout a central core within the building which are on each floor.

A: (RS) In terms of toilet provision, we have anticipated some new legislation which is expected to come out later this year and have ensured that all WC's across the building are provided in single rooms that can be used by both males and females. We have a number of WC's that are centrally located within the core of the new building on each floor and some which are located just off the corridor from the café in the main entrance.

Q: Can GP surgeries be provided with posters and social media communications for our social media sites and waiting room message screens so we can help pass that flow of information through to patients (particularly here at Mytton Oak Surgery where there will be a significant local impact on patients?)

A: (LH) This is something that we can arrange. I will liaise with Rick Mills (Mytton Oak Surgery) who has kindly offered to pass information on to the Digital Transformation Lead within the Primary Care Networks who can make sure that the information is disseminated through to the practices to update the practice screen for the public to view.

ACTION: Lydia Hughes (HTP Comms lead) to liaise with Rick Mills to provide content for GP surgery health screens

	Q: Is it possible to put information about HTP within local newspapers, as not everyone is on social media? **ACTION: (LH) To investigate getting information put into the local newspapers.** **Q: The mapping and colour schemes were discussed in concept last December, are they now near sign off?** **A: (JC)** The mapping and colour schemes were indicative for discussions and decisions on colour schemes, furniture types, signage and other internal decisions will be considered at dedicated workshops to look at those issues but we're still a little way from having to make those decisions, but we will begin the work on that in good time. It was noted that the normal convention for ED signage was white text on a red background and the current images showed a reverse approach (red text on white background) which was inconsistent with NHS colour schemes. **Action: AHR to ensure signs in ED would be white on a red background.** **Q: In terms of future focus groups, will discussions on interiors, wi-fi and other things be later this year or into next year as we're still very much at the conceptual stage. I did notice on some of the slides it said that even when we have designed the wayfinding approach that the plan is for a focus group to look at a sample in situ to make sure that they do work before it is all rolled out. Is that still the plan?** **A: (JF)** Yes, based on comments from a previous focus group it was agreed that this approach would be taken to ensure that signage and wayfinding etc is clear, especially for things like symbols and lettering. This is an important part of the process to include as we go forward. **Q: There seems to be an emphasis on providing a calm environment, but I am a little concerned about the lack of contrast in colours particularly for people with visual impairments so they can more easily read notices. I'm a little concerned that there is a tension between keeping things calm for certain patient groups and the amount of contrast you need for other groups. Will you be holding some focus groups to sort through those issues?** **Q: During the course of the whole thing this morning there is obviously a very clear definition in your minds about the difference between emergency care and urgent care and yet the one sign that you chose to display is emergency and urgent care underneath, so how will patients be directed to the different areas?** **A: (ER)** At the urgent and emergency care at the Royal Shrewsbury site, for the walk-ins it will be for the same entrance, that's why it's one sign outside. Once the patients are inside, they will be triaged and directed to either emergency care or urgent care (as they are at the moment). The majority of patients will be triaged to urgent care, but if you do need emergency care it is initially through the same entrance. The ambulance entrance is different, it will say 'Emergency Ambulance

	Only', The Urgent Treatment Centre at Shrewsbury will be within the same footprint as the Emergency Department and patients will be triaged to the correct place. **Q: If I came in with a pain in my neck and I go to emergency and through to emergency and urgent care, how will I get triaged?** **A: (ER)** Everyone will get triaged in the same way. If you're at Telford and you went into the Urgent Treatment Centre, but it was decided that you needed to be seen by the emergency team, ambulance transport arrangements would be made to get you over to Shrewsbury to the Emergency Department. This is part of the clinical pathway work, so the triage will be the same and then you'll be directed. For example, if you went to Telford with chest pains having a suspected heart attack, transport could be arranged to take you directly to Stoke Hospital. **Q: Why do we need to have the word 'Emergency' at the Royal Shrewsbury site?** **A: (ER)** If people think they have an emergency, there needs to be signage, so they know they're going to the emergency department. If for example they think they might be having a heart attack they will want to go to the emergency department and not to urgent care. At Telford, there won't be the emergency centre there but there will be an Urgent Treatment Centre, so we want to signpost people to the right place first time. **A: (JC)** At the moment the public don't need to understand the difference between the two services, but as the HTP model becomes established and once the building is in place the difference will be much clearer. We're currently in a transition stage, but from the beginning we need to be very clear otherwise there is a danger that some people do not realise the distinction between emergency care and urgent care