The Shrewsbury and Telford Hospital NHS Trust

Women & Children's HTP Focus Group

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

Questions/Answers

Part 1	**Women & Children's Focus Group** **Team responding to public questions:** Julia Clarke – **(JC) Director of Public Participation** Tom Jones – **(TJ) HTP Implementation Team** Meinir Williams – **(MW) Associate Director for HTP** Adam Ellis-Morgan – **(AEM) Assistant Director and Technical Lead for HTP** Meinir Williams – **(MW) Associate Director for HTP** Carol McInnes – **(CM) Director of Operations for Women and Children** Vicky Shepherd – **(VS) Architect** **Q&A's Following Presentation** **Q: Will the HTP be subject to the review of capital programmes announced by the new Prime Minister? If not, will there be any alteration of the full business plan accepted by the previous government?** **A: (MW)** We're confident the full business case (FBC)has been approved, we've not been told or indicated anything to the contrary that we're part of this review. We're still holding the position that the full business case has been approved and we are progressing as per plan. **Q: Will there be a diagnostic endoscopy site in Shrewsbury or will patients from the west have to travel to PRH?** **A: (TJ)** Endoscopy will remain unchanged from the current model on both sites. **Q: It was consulted upon in public that all planned procedures would be done at PRH. Has a decision been made about planned endoscopy and emergency endoscopy that was not in the public consultation document?** **A: (MW)** Given where we are, there is still urgent activity happening at PRH, hence the Urgent Treatment Centre. We must do what's right and what's safe for the patients. Given the capacity constraints raised, if we did not deliver some capability for endoscopy on the RSH site, then PRH would be completely overwhelmed and our waiting times for patients and our potential of harm to patients would increase. We must be pragmatic in doing the right thing for patients and making sure that where we can provide capacity, then we do, as we are still delivering some urgent

	care at PRH. There isn't a clear straight line between planned care and emergency care. This is about the supporting services and providing care where we can best serve patients. **A: (JC)** It is important to remember that any consultation document will invariably be different to the final business case presented as the business case is shaped both by feedback during the consultation and ongoing engagement with communities and clinicians which is an important element of any capital project. **Action: Meinir Williams to consider producing a document which shows the changes and added benefits that HTP will deliver which were not included in the original consultation in 2018.** **Q: Regarding the midwifery led service at Princess Royal. If it becomes apparent mid delivery that consultancy or higher care is needed, what is the plan for those cases?** **As an expecting mother, I feel very anxious if PRH still has a maternity ward and what will happen if a normal labour takes a wrong turn, and the emergency c-section needs to be performed. Will an emergency C-Section be performed at PRH or will they need transport to RSH?** A: (JC) With risk assessments and clinical pathways, clinical staff will identify some potential problems during the antenatal stage. Dealing with unexpected developments during delivery does rarely happen (and in the past we have had this situation when there are mums that began their delivery at the Royal Shrewsbury Hospital in the Midwifery-led unit had to be transferred during labour to the Women's Children's Centre at the Princess Royal as Caesarean sections can only safely happen in appropriately staffed obstetric theatres on the consultant site). So, this is not a new situation and the careful assessment of the mothers throughout their pregnancy is essential. If there is something unexpected that happens, there are pathways and protocols in place to respond to that quickly. This transfer during delivery is required now if mums are having a home birth anywhere in the county and need to be transferred mid-delivery. **A: (CM)** It happens very rarely, because there's a lot of risk stratification that goes on throughout any woman's pregnancy. There's a lot of discussion and focus upon choice as well. We're very supportive of women's choices about where and how they want to give birth, so that's a fundamental element all the way through the pregnancy as well. If this is an issue that mums are particularly anxious about, they have the choice to have their labour managed entirely through the delivery unit on the consultant site. We have on occasions transferred women into the consultant unit when they chose to give birth at home - if during the labour there is an indication that more support is needed, then of course there are currently policies and processes in place to bring women into the consultant unit and that will continue in the future. I will link in with my clinical colleagues and I'll send more detail through. **Action: Carol McInnes to take questions back to the senior team to provide the group with a response that can be circulated. - COMPLETED** *[Subsequent to the meeting following discussion with clinicians the additional response was received from Mei-See Hon (Consultant Obstetrician and Clinical*

Director for Obstetrics and Kim Williams, Interim Director of Midwifery) and the SaTH Clinical Guideline covering this is also attached.
"In answer to the questions I agree with the comments provided:
There are four possible birth settings for women

- *consultant led unit,*
- *midwife led unit (MLU) alongside consultant led unit*
- *freestanding midwife led unit and*
- *homebirth.*

Currently in SaTH we offer three of these settings (no freestanding MLU) although all four settings will be offered under HTP with a freestanding MLU at Telford.

It is important that all women are continually risk assessed during their pregnancy and during labour. Part of this assessment is to consider what is an appropriate place of birth and advise accordingly. This takes place in line with national evidence-based guidelines.

Although we are not currently able to provide freestanding MLU care, it would always be the case that anyone who has additional needs identified in labour, reassessed as high risk and no longer appropriate to be receiving midwifery led care in a freestanding unit will be advised they need to be transferred by ambulance to the consultant unit. This is the same process that currently takes place for homebirths. This will be the same under the current arrangement where the consultant unit is at PRH or in the future when it is at RSH.

Q: Why is there no clinical representation at this meeting?

Unfortunately this focus group had to be rearranged at short notice, as it was due to take place in June but due to being in pre-election period it could not go ahead. We did get clinical representation for today (HTP lead W&C clinician) however, he was called to clinic this morning so had to send his apologies. The dates of our future focus groups have now been agreed until 2027 so we will ensure that there is there is clinical representation at this meeting.

Action: Carol McInnes to ensure that if the HTP Lead Clinician is unable to attend this meeting, then there should be another clinician available to attend on their behalf.

Q: Will there be a virtual ward for children and young people?

A: (CM) It's something that we are starting to look at alongside our current paediatric service. We've started to have some internal discussions about what that could look like, what that service. There are some virtual awards for children that have started to be develop across the country. We're looking to learn and see what they're doing, but it's not part of HTP.

Comment: There used to be a virtual ward at Princess Royal Hospital, Paediatric Department and I don't know why was closed. When I was there, we found it very useful, and it did have a massive impact on our average length of stay and the parents and children got great benefit from being treated at

	home. We've certainly seen that with the adult version of the virtual wards and it's good to keep people at home. **Q: Given the high volumes expected of families and children at RSH going forward, are there plans to ensure the car park is family friendly e.g. with parent child parking spaces or wider spaces to facilitate loading and unloading of children and newborns?** **A: (AEM)** At this moment in time, we've got allocated spaces across all the car parks, there are some spaces that could be facilitated for that. It's something that we will look at in the future. At this point in time, we don't have them. We do have the blue badge areas, so we have the largest spaces for accessible parking and disabled users. It will be taken on board and considered. **Action: Adam Ellis-Morgan to feedback to the designers to look at how the car park could be more family friendly e.g. with parent child parking spaces or wider spaces to facilitate loading and unloading of children and newborns.** **Q: Have the active travel and public transport feedback items been incorporated into the detail of HTP, will there be comprehensive bus services for both staff and public? Also, will the staff park and ride facility from Oxton park and ride be extended to Meole Brace Park and Ride and also North Shropshire Park and Ride?** **A: (JC)** The active travel group is being led by the Estates team because transport at both hospital sites is much wider than HTP. There is now a park and ride at Oxon, which is very well utilised. There is a park and ride service at Princess Royal now from the Telford football ground. The lead for this is Louise Kiely (Head of Facilities), We are looking at whether this service could be available to patients and visitors. The park and ride facility to be extended to Meole and North Shropshire for staff hasn't been raised as an issue by staff. **A: (AEM)** The Active Travel England specific requirements for planning permission for HTP have been incorporated into the plan, which includes the footpaths and the cycle shelters. Those have already been incorporated into the plan itself and the conditions are being discharged with the contractor and the local authority. In relation to the park and ride being extended, its possibly part of the wider parking group that Louise Kiely deals with. **A: (KB)** As a member of the Staff Travel Group who meet regularly to take feedback from what staff, there are no plans to extend the park and ride at the moment. But everything is under constant review given that we're in a very fluid situation for now and we will continue to discuss options with staff. **Q: I know staff at RSH and many of them would want to go from the Meole Park and Ride because they live on that side of town, and it would be much easier. As a visitor to the hospital, it's almost impossible to park on site. There is surely an opportunity here to quickly enlarge the park and ride for visitors. It is almost impossible to park except at certain times of the day. I can't understand why there are no plans to extend it.**

A: (JC) The Trust pays privately for the park and ride and it costs an substantial amount – in excess of a six figure sum annually. That is all paid for from NHS funds. To extend it to other sites would have similar cost consequences. We've issued surveys and held focus groups asking staff what they want, and this hasn't been raised as an issue.

A: (KB) The parking has been substantially easier since staff have adopted the park and ride system. There have been upwards of 180 members of staff using the park and ride every day, which then releases those spaces on site to patients and the public. There has been a far easier parking experience for patients coming onto the Royal Shrewsbury site certainly throughout June and July.

The other piece of news is that there will be a new camera system being installed across the car parks in the near future, which will then generate data of car travel around the site that will be analysed. We are planning an About Health event, on Travel, in January 2025. Louise Kiely and Shona Baugh, who lead the travel and transport group within the hospital, will be giving the presentation and they will have full details on our active travel plan, including more information on how our car parks are utilised.

Action: Kate Ballinger to put Louise Kiely's email address on the Team meeting chat. **ACTION COMPLETED**

Q: In Telford, we have lots of young families who are suffering from the cost of living and living in areas of deprivation who already struggle to get to PRH for planned care for themselves or their children. Are there plans to have some inpatient and outpatient care at PRH?

A: (TJ) Outpatients will continue to be delivered on both sites. Inpatients will move when the clinical model is inactive, probably at the end of 2027. There will be an Urgent Treatment Centre at the planned care site (PRH) and if your child needs to be admitted, they would be transferred by ambulance to the emergency care site (RSH) for that. Outpatients will continue exactly as they do.

Q: Will there be a senior registrar, consultant or senior nursing staff in paediatrics at the Urgent Care Centre? I'm mindful that unfortunately somebody may present there but will be very seriously ill.

A: (MW) Paediatrics is quite a niche specific risk that we're looking at in terms of the provision at the Urgent Care Centre. This is very important, particularly in the early days and that's what we've learned from partner organisations who have gone through this previously. It's better to have too much resource in the early days, patient safety is always most important here. What we will have, is a facility and an area that we can provide comprehensive paediatric resuscitation. We'll have a workforce who can deliver that resuscitation who are well trained and equipped. We won't have an Intensive Care Unit or a Paediatric ward that we can admit that child to. We will have emergency department staff within the Urgent Care Centre certainly for the early years until we're assured that it is being done correctly. All these safeguards are already being worked on. All of that workforce will be trained to be able to support a child in distress, should they present into the Urgent Care Centre and there will be the facilities to support this. We won't have a paediatric consultant

	on site, but I would hope as years go by that we can have urgent treatment paediatric trained advanced practitioners/nurses, but the specialist paediatric input will be at RSH. **Comment: I think you do need to consider connecting the Urgent Treatment Centre at PRH with the A&E centre at Shrewsbury using video conferencing so that the consultant paediatrician can be present very quickly. Have you got that in your plans?** **A: (MW)** Yes, we have bespoke rooms designed for exactly that purpose, so what we'll have is a virtual emergency department capability at the Urgent Treatment Centre. We're matching the workforce to best meet the presentation of those patients coming through the doors. Most of the patients don't need an accident and emergency consultant, they need more of a generalist within illnesses as opposed to accident and emergency. That's the principle that we're taking here on matching the workforce for the Urgent Treatment Care across in PRH to be able to sustain 65% of the current presentation that comes through that door which will still be able to safely be managed at PRH to minimise the flow. It's not in anybody's interest to downgrade or to change the PRH site so it creates more pressure on RSH. The model for the Urgent Treatment Centre across PRH is being designed to best meet the presentation of the patients that are currently attending there and that's including the children. **Comment: There is also the possibility specifically for children that a connection to Birmingham Children's Hospital could be provided to bring the specialist expertise of Birmingham Children's Hospital to be brought to PRH or RSH using video. I think that is a major story that needs to be put into the public domain as this would start to look like advanced medicine.** **Action: Meinir Williams to investigate the Birmingham Children's Hospital expertise to be brought to PRH or RSH using video.** **Q: It was said that full inpatient care would move over to RSH in 2027, is it inpatient care that is currently remaining at PRH until that point?** **A: (JC)** Yes. **Q: At Telford you said there's going to be no consultant paediatrician available. We support quite a lot of families with complex children and complex needs, and I personally have one myself. If a family was to present a child that was too complex for the team at that point, would they automatically be sent to Shrewsbury, because complex children can get ill very quickly, and you would want to go to the closest hospital possible. In our case, we've been to Shropdoc, for example, and then they've said, "It's just a viral infection". I go to A&E, 2 hours later the child needs oxygen. How would that be managed?** **A: (MW)** It's difficult discussing individual specific cases, but our clinicians are extremely good at assessing and understanding what the risk is of the individual. There will be a rapid transfer system staffed with the ability to secure the transport,

	to take the patients across, to RSH should it need to. Around care planning, there will be children known to the service with complex needs and will have a care plan in place. It might be in these cases that they would direct you to RSH, because that would always be the safest thing. The other thing that we are looking to develop are, there are examples nationally around Urgent Treatment Centre by appointment, so we are looking at using 111, so if your child is poorly, instead of putting your child in the car and heading off, you would pick up the phone to a service and we would be directing you through that triage process to the most appropriate department, unit or service. We're learning a lot from Gwent Hospital around patient flow and the emergency care by appointment type approach. **Q: Would children who have open access to the clinicians at Telford already, if they required urgent help and open access, would that be moved to Shrewsbury as well?** **A: (CM)** Yes of course, we're keen not to undo anything that's working well, but also to look at the opportunity that this gives us to articulate as well about the potential that we've got and to make sure that we're exploring all those options as well. There is real opportunity for us to do more of this work. We do have a patient group that we are establishing, and I think you would be a great addition to those discussions that we're having because that's the work we're doing today. **Q: Is there a guarantee in place at the separate children's emergency area and will it be complete and open at RSH before the move from PRH?** **A: (MW)** Yes, the emergency department teams are working incredibly hard now to put that separation in under the current estate that they have. It's not easy because they're not purpose built, it's a challenge for HTP that the emergency department teams are currently facing and trying to resolve. **Q: How do people walk and cycle through the RSH site from North to South and from East to West?** **A: (AEM)** It's a discussion outside of HTP, it's not something that HTP will consider. We're on a split site, there's no practical way of going from East to West. You will need to go around the periphery, there's no cut through the hospital site because of the changing levels. **Action: Kate Ballinger to pick up on the comment with the Travel and Transport group on facilitating the routes around the hospital so that they're available for cyclists and pedestrians.** **Comment: Because the site is on different levels, I think the key would be to have enough cycle shelters for bicycles strategically in place.** **A: (JC)** We had a big drive to put in additional bike shelters for both staff and visitors. Not many visitors come on their bikes, only people that are local staff. We do have quite an active travel group and as part of the latest developments we've improved shower facilities for staff. If staff are cycling there is access to showers, there is a lot of work going on under our sustainability.

Q: Will the parking spaces be increased after construction has finished and will more disabled and accessible parking become available?

A: (AEM) We're working on the final car parking numbers now through the Travel and Transport group.

Comment: In the documentation it points out that ultimately there be 108 more parking spaces than there are now.

Q: The issue is at both hospitals. The disabled parking spaces aren't necessarily all accessible. You've got young children who have had to walk on the road with parents pushing their wheelchairs because there's nowhere to park, and that's at any time of the day. There are parents who have gone at 8:00am and still can't get a parking space for their children in wheelchairs and then you've got to consider the parents safety of lifting those wheelchairs out of those cars and it is not an easy process. Will there be more spaces because currently you can't get a parking space and it's not safe?

Action: Adam Ellis-Morgan to investigate disabled parking spaces and spaces for families.

Action: Kate Ballinger to pick up the issue around accessible parking at PRH through the travel and transport group as this is not a specific HTP issue.

Q: Will there be different signs to clearly indicate staff and patient parking?

A: (AEM) It is there at this moment in time, there is the blue and the grey signs that you can clearly see. There is a larger wayfinding strategy that's being produced for the final estates, so it may be that the colours will be incorporated into the final estate plan, but we're not there yet within the design. Before we finalise the designs, we will be taking those to public groups to get their feedback.

Q: To whom is the six figure Sum for park and ride paid to?

A: (JC) The Local Authority tendered for the contract and the provider is Arriva

Q: What discussion is to take place with regards to accessing different routes for care e.g. 111 minor injuries and GP. Having had the unfortunate need to experience paediatric care recently, the level of information around options for next step care is shocking with basic questions being unable to be answered, they often simply refer to distance as opposed to level of care.

A: (JC) We will link you with Carol McInnes due to that being about ongoing working and improving the experience on the service as this is not linked to HTP.

Action: If people want to get involved with the focus group or want to contact Carol directly: carol.mcinnes1@nhs.net or text on 07511 163882.

Q: Will there be an Intensive Treatment Unit standard ambulance that will be able to transfer both adult, child and critically ill patients between sites?

	A: We're working again with the Grange Hospital in Gwent, Newport and learning from what they did when they moved their emergency services and created Urgent Treatment Centre's within their Hub and Spoke Model. Initially they commissioned a dedicated ambulance to be parked outside the Grange for 12 months. However they only used it once in the 12 months that it was sat there. They decommissioned that provision and there hasn't been any issues since. West Midlands Ambulance Service are incredibly pressured currently with availability and response times because our systems are overburdened. The answer is yes, there will be an emergency transfer capability. How that's going to be commissioned is a question that we're currently working through. **Q: How many toilets for disabled people will they be?** **A: (VS)** We do have disabled toilets on every single floor of the new building, and they all comply with the new building regulations. You can be reassured there will be public access to a disabled toilet on every single floor and within the departments for staff, patients and visitors. There will also be a Changing Places facility for adults with disability in the new main entrance (there is currently no such provision at RSH) **Q: How many inter transfers will occur between the Urgent Treatment Centre at PRH coming inbound to this (RSH)site? I calculated 20,007, which is 65%.** **A: (MW)** Those numbers may well be right if we did nothing to change the pathways or the systems that we're currently working. If we did nothing and just allowed access the way that it's happening now, then that may well be true. The principles that we're working to is to make sure that the patient gets to the right place the first time, which is why we're looking at pre direction - urgent care by appointment and working with the ambulance services to make sure that all those life and limb threatening patients go directly to the right place the first time, using learning from elsewhere who have gone through these processes, and having a comprehensive communications campaign that gives the public information of where best to access their care. There is a fundamental difference between patients who would be transferring from the Urgent Treatment Centre in Telford to RSH than patients accessing the right service in the right place the first time. Those numbers that you've predicated that statement on are correct. We are saying that 35% of current attendances at PRH will need to receive their care at RSH, because those are the patients that fall within the life and limb threatening and needing acute medical interventional specialist backup from all those specialist services sitting behind an emergency department. That doesn't equate that we would be physically seeing those patients at Telford and then moving them across. In terms of the hospital transfers, our anticipation is if we get it right, the inter hospital transfers will be minimal because our pathways will be designed to make sure that the patient gets to the right clinician in the right place at the right time. We want to make sure that those pathways provide the best possible care and outcomes for our patients. Once we know the quantum and the impact that those pathways will have, positively and negatively, then we can look at what the expected inter hospital transfers will be. Our aspiration should be that there are very few patient transfers, because patients will be at the right site from the outset.