MEC & SAC HTP Focus Group

Held on Tuesday 3rd September 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:

Ed Rysdale – **(ER) HTP Clinical Lead and EM Consultant**
Hannah Morris – **(HM) Head of Public Participation**
Andrew Evans – **(AE) Centre Manager for SACC**
Lydia Hughes – **(LH) HTP Communications Manager**
Aaron Hyslop – **(AH) Engagement Facilitator for HTP**
Tom Jones – **(TJ) Implementation Lead for HTP**
Saskia Jones- Perrott – **(SJP) Divisional Medical Director**
Dianne Lloyd – **(DL) Clinical Support Services Lead for HTP**
Aruna Maharaj – **(AM) Acute Physician**
Clare Marsh – **(CM) Surgical Matron**
Paul Owens – **(PO) Centre Manager**
Wendy Southall – **(WS) HTP Implementation Lead**
Rachel Webster – **(RW) Lead Nursing Midwife for HTP**

Q&A's Following Presentation:

Q: You talk about the work that clinicians are doing to develop new pathways for services between the sites. Can you assure us that these will always involve Shropshire Community Health (Shropcom) and NHS Shropshire, Telford & Wrekin (STW) to ensure pathways are always fully integrated e.g. acute stroke and rehab?

A: (ER) - I can't say we will "always" involve, because there are some patient pathways that are purely internal, but where pathways are shared, for example with stroke, we work very closely with all our partners in the Integrated Care Systems (ICS) and the Local Care Transformation Programme. All the clinical pathways will be integrated and it's vital that we work with the community, Shropshire Community Trust (Shropcom) and primary care, because to deliver the model, we need to get patients in the right place, whether that's at home, or in the community. We can't do

	this without Shropcom and NHS Shropshire Telford & Wrekin (NHS STW). If we can get people home rather than being admitted on to a ward that is far better for the patient. The virtual wards, the hospital at home and the pathways are always linked with Shropcom and we have regular meetings with them, it is vital that we do this. **A: (SJP) -** We're doing pathway work and service development all the time and our service development and pathway work now is centred around ensuring that it's going to fit in and be fit for purpose for HTP. All specialities are working hard with clinical colleagues in Shropcom and community teams - frailty, stroke, respiratory, cardiology to name a few, because some of the success of this model relies on as many patients as possible being looked after in the community. It's better for the patient and our capacity. It's also more cost effective in the long term, it maintains patients' mobility if they're in their own home and can continue with their normal way of living. There's been a big push over the last year or two, to ensure that there's a lot of joined up working going on. It's challenging because everybody's very busy, but no pathways are being developed now without an integrated approach. **Comment: (ER) -** A 'Hot Clinic' is when somebody is seen in the emergency department or by a GP and although we don't need to bring them into hospital, they do need an urgent appointment. Previously, for example, in cardiology, if a patient had an acute chest pain, which could be unstable the wait to be seen in a normal outpatient clinic was too long, so we admitted the patient instead. Now with the development of hot clinics the patient can be seen far quicker in the next day or two, without needing a hospital admission. **Comment: (SJP) -** This week and next week we are trialling hot clinic slots in both respiratory and cardiology. We also have general medical hot clinics which are already up and running. The challenge currently is raising awareness to ensure that everybody is using these slots and booking into them. There's a two-week trial going on which we will evaluate. There's been a huge effort from colleagues to support this trial as it will be so beneficial for patients going forward. From a cardiology point of view, we are using our Same Day Emergency Care (SDEC) departments more effectively to avoid admitting a cardiology patient to hospital where it is not necessary e.g. seeing them through the "hot clinics". We are then able to bring the patient back to see the cardiologists for discussion and review. All these models are being worked up and trialled as we speak. **Q: The capacity issues have raised a few questions e.g. trying to move people back into the community at a shorter pace or time and with numerous models within the organisation testing the capacity, are they being checked in the community organisations where the patients may be supported from? Have there been extensive training programmes for staff that will eventually support the increased number of patients going back into communities sooner?** **A: (ER) -** In terms of the modelling and the training, the training for Shropcom clinicians is being done by Shropcom as the new models are developed. The modelling for our business cases was carried out alongside the ICS and they're very much a key part of any developments and they are also very committed to what they can deliver in the community as part of the Local Care Transformation Programme. The bed modelling is based on needs-based modelling of demographic growth and changes. This is why we closely link with our ICS colleagues to make sure that they

	are delivering what they said they would deliver. If the community can't deliver there will be a knock-on effect on the bed capacity and SaTH and therefore, we will have the same problems as we have now which is what we're trying to address, so it's vital that we work closely with the ICS. **Q: There's a concern that whilst you're bringing things together and synchronising all your efforts in a professional way, as to whether this will be mirrored within the contracts. There are also Integrated Care Board issues and other issues for primary care delivery and the support of their staff for patients going back into the community. Has that been looked at already? If not, why not?** **A: (ER) -** The integrated work has been looked at and it is developing. I'm hopeful that the new Chair in Common (across both Shropcom and SaTH), will increase the links and joined up working between the two. An example is Nigel Lee (Chief Strategy Officer NHS STW/Director of Strategy and Partnerships SATH) who works across both the ICS and SaTH to develop strategic direction. We have a high level of collaborative working at Board level and much closer links than we've ever had before and I'm hopeful that will develop into much closer working relationships between the community and SaTH as the acute Trust. To develop the best care that we can on the acute side, we must work together with our community partners and primary care as primary care is the cornerstone of care. **Q: Now the staff are driving into Racecourse Lane, are resident's aware that traffic is now going to be coming out into that lane and how near the exit is to the main road?** **A: (LH) –** We have been physically door knocking at each house on Wellwood Close, which is about 5 or 6 semidetached houses and spoken to the residents to see if there's anything we could do to make this a better experience for them. We've taken some of their feedback on board and spoken to residents along Racecourse Lane. Staff will be coming down the strip of road in SaTH and then turning left at Racecourse Lane to join back onto Mytton Oak Road. There are bollards on the other end of Racecourse Lane, by the Oxon school. We're looking to cut back some of the hedge rows, as well as putting some double yellow parking lines to enforce car parking along there. We are aware that some staff, patient and visitors park along that Road and we're putting steps in place now so when we do launch this. it will be safe for staff and residents. The residents have been informed of all this and they are also ongoing regular drop-in sessions for residents. **Q: How many new wheelchairs will we receive and when will we get the 15 modified ones?** **A: (RW) –** I don't have an exact answer in terms of the dates expected to receive the new ones as we are subject to the manufacturer's delivery dates, nor the date we're getting the 15 modified. Both have been prioritised from a work stream perspective. I will let you know as soon as we have the dates for the 15 new wheelchairs and the 15 returned from the sick bay. There will be 30 more than we've had in operation

since the closure of the main outpatients. Sharon Stuart in the HTP team is coordinating this to expedite as much as we can.

Q: With the flow of traffic on Racecourse Lane, at home time the traffic backs up quite a bit. Bearing in mind you're going to have effectively all your traffic coming out that way, have you considered some temporary traffic lights because it could be pandemonium. I've travelled on Mytton Oak Road for the last 45 years and it's always busier than the year before. I think there will be big problems getting people out at some specific times. I think you should consider requesting temporary traffic lights there at those specific times. Also, how will the ambulances get out?

A: (ER) - For ambulances the road up to the ward block is going to be a two way, so they can come out the same way (as can cars parked in those first car parks). The buses will drop off at the ward block and then go round on a one-way system. However, it is a useful suggestion, and I will raise with Estates.

ACTION: Ed Rysdale to speak with Adam Ellis-Morgan about temporary traffic lights at RSH.

Comment: Healthwatch Shropshire visited RSH A&E recently and are pleased to have received a very positive response from SaTH on the suggestions from people we spoke to for improvements to the waiting areas within the HTP plans.

Q: Will the bed numbers once you put the extension on for the whole of the organisation, not just RSH, will they go up, down or will they stay the same?

A: (ER) – The actual physical bed numbers are staying the same based on the modelling of what we need. We are making more beds, but we are having some areas where we won't be needing to use the beds, for example the top floor of the ward block. There will be excess capacity that won't be staffed because the bed modelling is based on getting the patients cared for in the community. From the bed numbers that have been modelled with expert external companies on changing demographics, they have identified that we will need 747 acute adult beds in medicine and surgery.

Q: According to the documentation, the community are expected to take off your shoulders 150 beds. On that basis would it be possible to invite Community Trust representatives to the focus group meetings so they can give their update? I'm very suspicious that they're not going to come up with the goods, because they don't have a costed plan.
We are working closely with the community as our plans are predicated on more patients being treated closer to home and we can certainly invite them to a future meeting to outline their plans,

ACTION: Hannah Morris to discuss with HTP about inviting Community Trust representatives to future focus groups.

	Q: SaTH was awarded £25million a year ago to build a new block to ease pressure on the acute wards, we're now a year on and going into the next winter and there has been no progress. Is that block going to be ready for the next winter? **A: (ER) -** This is a different contract and scheme to HTP and is a separate capital project, so I am unable to update on the timescales of this programme of work. **Q: I am confused and concerned about the Urgent Treatment Centre (UTC) at PRH and how the staffing structure will work** **A: (ER) –** The staffing structure will be by tiers rather than the actual person doing it, whether that's a Tier 3 Acute Care Practitioner (ACP) or it's a ST3, ST4 equivalent medical doctor and the level of expertise that they've got. We'll know the numbers that we need at each tier a little closer to the time. In terms of recruitment, there are more doctors currently working in the trust with that level of capacity than there are ACPs for example. It's more likely that we'll use doctors initially and then train up ACPs. We are not saying it will be X number of doctors or X number of ACPs because that will vary depending on expertise that is required. This is all being developed with the clinical teams. When we have more detail, we will bring back an update to the focus group. **ACTION: Ed Rysdale to investigate what staff grades there will be in the PRH Urgent Treatment Centre.** **Q: Will the staffing structure for the Urgent Treatment Centre at RSH be the same as at PRH?** **A: (ER) –** No, it will be different because the seniority of the staff at the UTC at Telford will need to be greater because if somebody comes into the UTC at PRH, they need to be stabilised before transfer, whereas if they come into the UTC in Shrewsbury, they've got the emergency department right next door to it. There will be senior ACPs and doctors, Tier 3, Tier 4 doctors at the UTC in Telford. That may change over time, we have got a staffing structure, it's about the skills that they've got. The ACPs are trained to a very high level. There will be GP's working there as well from the primary care point of view. We will continue working on the workforce model and ensure that it reflects latest best practice. **Comment: There needs to be a lot more clarity on the workforce model for UTC to provide general assurance so people.** **A: (ER) –** We're going to Bournemouth and Poole hospitals in the next few weeks because they're doing a very similar thing. Poole is becoming an Urgent Treatment Centre and we're going to speak to them and see what they're doing and to learn from them. We have also been to the Grange Hospital in Wales, who have a similar model although it is slightly different. The Grange has a central hospital with an Emergency Department and three UTCs elsewhere. We have also spoken to Northumbria where it is also a similar but slightly different model. In this way we can be sure we get the best of all worlds when our clinical model is implemented.

Q: You have a proposal to open 32 planned respiratory beds that will also include ambulatory care facilities for respiratory services. Has that particular development been priced into your final business case?

A: (ER) – The respiratory services is not included in the HTP £312m funding, as it was part of a new development, and not part of HTP originally. In terms of the funding, that still needs to be worked out, some of the service will be moved across to PRH. In terms of the build, there isn't a new build within the current proposal, but the HTP clinical model moves will free up space at PRH to do it so, we can use refurbished and redesigned existing space at PRH once vacated. There will be a business case put to the Board which might bring in an income, rather than a cost pressure. We are also looking at possible external sources of income to fund this.

Q: How will PRH be covered medically out of hours, will there be two rosters for the surgeons, anaesthetist and physicians, one at PRH and one over at RSH?

A: (ER) – Yes, we are looking at all parts of the staffing model. There needs to be a medical emergency response team at PRH, so as part of the plans there will be a middle tier of cover with a senior surgeon, physician and an anaesthetist at both sites. At the moment there is no surgical middle tier doctors overnight at PRH so we will be introducing a new tier of cover at PRH as part of HTP and the actual detail will be worked out in the next couple of years.

Q: Patients who are being transferred to RSH, will they be accompanied by a doctor in the back of the ambulance, or will it just be a paramedic?

A: (ER) – It depends on what the transfer is needed for. At the moment the vast majority of our transfers generally don't have a doctor going with them unless it's needed, even if they're going to the Royal Stoke University Hospital. However, if it's a critical care transfer and the patient needs an anaesthetist to accompany them to maintain their airway, then absolutely they'll have a doctor with them, as happens currently. If the patient has infusions running, they will need to have a nurse with them alongside the paramedic and that will happen, so it'll be on a case-by-case basis. If in a clinical case and they need a nurse or a doctor to go with them, then absolutely that will happen.

Comment: At least one hoarding design panel should be devoted to health promotion. You have a responsibility to promote good health, and you've got a lot of space there, and that space will be used for probably three or four years so there should be some health promotion information there. Also, because you've got nothing to spare from your £312mit might be worth buying a digital panel that can give different messages. It won't be cheap, but it would be good for you to be able to change the message, especially if there are any delays etc.

ACTION: Lydia Hughes to investigate panels that give different updated messages for health promotion and to look at the option of a digital panel.

Comment: I was led to believe that the boardings going along the main road as you come in where the site build is, it's going to be more photographs rather than words

	of the actual building. As you walked along one end to the other, you were walking and looking at what the building would be like when finished. **ACTION: Lydia Hughes confirmed there will be photographs of the finished building on the boardings along RSH building.** ## Q&A's After the Meeting: **Q: One of the issues I didn't pick up in earlier focus groups or through looking at the architect's layouts is how the acute medical floor is to be divided up between specialties?** **ACTION: HTP to feedback how the acute medical floor is to be divided up between specialties.** **Q: I have had concerns about stroke services throughout my 10 years at HWS, and I would like to understand how many beds will be ring-fenced for the hyper-acute/acute stroke service. e.g. was this number of beds calculated from the demographic data on the future probable incidence of stroke? How is the rest of acute medicine organised? e.g. are there separate areas for cardiology etc?** **ACTION: HTP to feedback how many beds will be ring-fenced in the hyper-acute/acute stroke service. e.g. was this number of beds calculated from the demographic data on the future probable incidence of stroke? How is the rest of acute medicine organised? e.g. are there separate areas for cardiology etc?** **A: (HTP) –** Initial bed modelling for RSH and PRH was based on general demographic effect rather than disease specific effect, but specialities were involved in this analysis and the current planned allocation for RSH acute/hyperacute stroke beds is the same as the current provision at PRH with the addition of a co-located gym. The stroke rehab beds will remain at PRH. However, there is opportunity to expand physically with the space that is available at the RSH site (although clearly there will be workforce implications that would need to be factored in) and the clinical team will continue to work through the practical operational model, which will of course be informed by any activity change over the next 3 ½ years. For acute admitting medical specialities at RSH there will be an acute floor in the new build for acute medicine. This will be separate from the acute floor for Cardiology, Gastroenterology, Respiratory Medicine, Stroke, Care of the Elderly, General Medicine and Renal medicine. The exact locations of all the speciality areas will be confirmed through the space allocation process which is ongoing. When we have more detail, we will be able to share and will bring the detail back though the quarterly focus groups and About Health events over the next few years as plans are developed. **Q: What will be the overall capacity of the children's ward, when it moves to RSH and will it stay the same, will it be smaller or bigger?**

	A: (HTP) - The capacity is relatively like the current bed base at PRH however, there are some slight changes. In addition to the current bed capacity of the children's ward, there will be an additional 4 beds specifically for adolescents aged 16-18 and the Children's Assessment Unit (CAU) will increase capacity from 8 to 10 beds. The children's day surgery unit at RSH will be co-located on the unit and will have its own bed capacity (currently they use beds on the children's ward). Please note that the children's day surgery unit (8 beds) will be utilised for procedures, surgery and could be used as additional inpatient capacity when there is a surge in demand.

.