MEC & SAC HTP Focus Group

Held on Tuesday 3rd December 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) HTP Clinical Lead and EM Consultant**
Rachel Webster – **(RW) Lead Nursing Midwife for HTP**
Kate Ballinger – **(KB) Community Engagement Manager**
Hannah Morris – **(HM) Head of Public Participation**
Claire Parker – **(CP) Director of Strategy & Development, ICB**

Q&A's Following Presentation:

Q: What will the community respiratory services and long-term care look like?

A: (SPJ) – We're working very closely across the system with the community, respiratory services, virtual ward and rapid response for alternatives to patients not ending up in the ED, unless they really need to be there. We also have an outpatient antibiotic service, which bridges across primary and secondary care, which is being developed. There is also a lot of ongoing recruitment from the staffing point of view and the advantage that we have is that all these systems are either up and running or getting established now, so we can tweak those and work on the future clinical pathways to try and make things as seamless as possible between primary and secondary care.

Q: Working with the digital team to ensure joint working and shared objectives is a bland statement. When will there be interoperability of the various patient admin systems?

A: (JC) – We have Sally Orrell (Senior Communications Specialist) who comes to the quarterly Public Assurance Forum meetings to update on digital and as there is a

	lot going on across the digital offer. Sally Orrell regularly our monthly Hospital Update meeting (which all members of the public can attend). I will ask Kate to arrange an About Health Event devoted purely to digital for next year as this subject alone could fill a couple of hours. **ACTION: Kate Ballinger to organise an About Health Event on Digital for next year.** **Q: We need to be aware of the change in NHS work that the government has been discussing in digitalisation as it would be helpful to understand?** **ACTION: Kate Ballinger to liaise with Sally Orrell to include the changes in NHS work that the government have been discussing in digitalisation within brief for Hospital Update and the About Health Event.** **Q: Can we have an electronic car parking information board, so patients know how many car park spaces there are in the hospital car park?** **A: (JC) –** SaTH does not run the car park, it is an organisation called Nexus. We could certainly ask them if that is possible, it might be as they do automatic number plate recognition. **ACTION: Julia Clarke to raise the possibility of the Trust having an electronic car parking information board with Louise Kiely (Head of Facilities). [We found out following the meeting that this will be coming to SaTH in 2025/6.** **Q: The success of HTP depends on whether you can get patients out of the hospital, how will the community and social services interact?** **A: (ER) -** The Local Care Transformation Plan and the work being done in the community are ensuring that health and social care organisations are working closely together. It's about working with our commissioners to make sure that our patients are in the right place and the clinical pathways work. We are reliant on our community services delivering, both social care and Shropshire community services to make sure that patients get the right care in the right place. **Q: With the whole of the Integrated Care System (ICS) under pressure, how feasible is it that SaTH's priorities can be improved and achieved with greater funding and resources going to the other provider sectors?** **A: (ER) –** Regardless of any extra funding that SaTH gets, we need to make sure that social care, primary care and community care is robust. It can't be all at the expense of secondary care because we still need to provide a good secondary care and acute care service. It's more about how we allocate resources and those are decisions that will be made from the ICS working with all providers. One of the things we're doing with HTP in separating our planned care and our emergency care is making sure services will be a lot more streamlined and can deliver more robust critical services with less repetition and crossing between services for patients. This will then become more efficient and hopefully will bring down the hospital length of stay and make decisions easier so we can get patients home quicker, which will

have an impact on social care. Our length of stay has already come down, which is partly about numbers of beds, spaces and capacity within the hospital which HTP will help further with. HTP is aligned to the social care as well, so all the planning is entirely integrated.

A: (SPJ) - We're working in a very joined up way with the Integrated Care Board (ICB) now. When additional funding comes in from various sources, unless it's for a particular area then there will be close discussions between partners and the ICB team around the allocation of those funds to best support the community. That might be more streamlined admission avoidance teams and systems in place, or it may be towards more primary care, or even a combination of primary and secondary care. That is a conversation that's happening all the time and will continue to happen with HTP.

Q: You said you're having conversations about the cancer and the respiratory developments at PRH, which we're not in the original consultation document. Who are you having those conversations with?

A: (SPJ) – These developments were outlined in the Business Case as Phases 3 and 4 and we will be using a lot of existing estate for the respiratory centre that already exists at the PRH utilising the Women & Children centre when it moves to RSH. We have a lot of the equipment already, however there will be some additional outlay required. We will be looking to charitable sources for additional funding, which we do anyway when developing some new services. We are also putting business cases in separately to fund different areas of development that aren't covered in the £312 million for HTP. A lot of this focuses on redesign of existing pathways to be as efficient as possible and deliver the best patient experience that we possibly can and at the same time deliver a better working experience for staff. I think in the end the aim is for it to be a win-win situation. There will undoubtedly be a few teething problems along the way, so we're now working closely across all divisions and with our community teams to establish exactly the right location for all these services. A lot of that planning has now been finalised to ensure that we've got the necessary clinical adjacencies so that we can maximise efficiency of our staff working on the resources that we currently have.

Q: Given that obesity is a very expensive, mostly preventable growing problem, what food strategy is there for Shropshire and are there any plans to ban ultra processed food on NHS premises?

A: (CP) - Both councils have weight management strategies that have been approved by their Health and Wellbeing Boards. I don't know if there's anything specifically in that. Certainly, we have put in our response to 'Change NHS' that we do need support from government around some of the decisions that they make. We know that there's a push for removing or changing tobacco control legislation, whether they've got in mind to do anything about ultra processed foods. I think there's a bit of an argument and debate about what ultra processed foods are. It's worth having a look at the weight management strategies as they are interesting reads, and we do get involved in those conversations. Weight management goes from the prevention of lower tier access and then includes tier 3 and tier 4 obesity management as well. There are a lot of new drugs that are coming online that

support weight management, but we want to stop people getting overweight in the first place.
We are working closely with the local authorities about weight management. It's going to be hugely important in the diabetic pathway. As far as what's in the minds of national government, I don't know.

ACTION: Julia Clarke to contact Weight Management leads in the Local Authorities and flag these issues raised.

Q: I'm delighted to hear of local services being tailored to local needs, but there's also a need for the clinical pathways to be designed so that they are providing the same standard of care and access to facilities across the whole patch. How far do you feel that we're getting towards those integrated pathways?

A: (CP) - We are improving in some areas, but I think we've not gone far enough. We've decided to take a few areas at a time, our three priorities are diabetes, which is going to take three years to properly embed rather than try to change things in six months. Diabetes is our first, then cardiovascular disease (CVD) which will incorporate stroke. Prevention hypertension at CVD prevention is also on the list and frailty. These are not quick pieces of work, but we are taking an integrated programme approach with the diabetes work. We want to make sure that prevention is bolted on to the front of some of these because the most cost-effective way to stop people needing complex rehab is to prevent them having a stroke in the first place. The whole pathway has got to be looked at. I think with the stroke pathway there have been slight improvements but it's not going to happen in six months and it's not fully integrated. It's on our priority list next and we are taking a very different approach. We are looking at an outcome-based approach to commissioning so that it allows our providers to come together and deliver what's best. It will also give a bit more flexibility around things like business cases and service specifications, so it's a new way of working that we have been trying out over the last 12-18 months. It's positive for patients and it's not felt this collaborative for a long time. GP practises, pharmacists, voluntary sector organisations are all on side. This closer collaboration of the Hospital Transformation Programme and bringing those models together with the local care work and we have all started to have these conversations in one place.

ACTION: Kate Ballinger to contact Claire Parker around attending the Diabetes About Health Events being arranged at SaTH in 2025.

Comment: I have looked at some of the weight management strategies and there's little about food in there. If you are not sure what is ultra processed, what about excessive sugar. I've had some correspondence with Costa Coffee, and they seem to have absolutely no idea what excessive sugar in cakes is. You would think a large organisation should be able to develop cakes with a lot less sugar than 30%.
I have suggested that they become part of the solution rather than the problem.

Q: When will we see the results of the neighbourhood approach in terms of reduced demand on A&E?

	A (CP): We're starting to track that data now with some of the work that we're doing. I think the difficulty is that you'll always fill a bed, but what we're trying to do through bringing HTP and the local care programmes together is, using the data to track the impact that schemes are having on the hospital in general, including access, length of stay etc. If you have any ideas, that would be helpful, because I can feed them into those discussions. We are starting to see some of the benefits now but it's difficult to isolate which programme is having that benefit. **Q: Each month I look at the A&E production figures and they've gone up over the past few years by around 7-8% between 2020 and now. Does that sound right?** **A: (ER) –** There was an increase but it's difficult to say exactly because 2020 was a bad year due to COVID, as the numbers went down massively. I think this year it's pretty much plateaued on last year in terms of admissions. ED attendances have plateaued, but delays have not. It's complex and, there's some effect happening on those that are attending, but our long waits are still there. **A(CP) -** The challenge is if we start to look at the integrated pathway work and the specifics again, we need to get more into prevention mode, so looking at the data, for example how many people with diabetes end up in A&E because they're having a hyperglycaemic attack and can we reduce those attendances by improving diabetic control. These are the sort of outcomes that we need to look at as we move into the clinical pathway work. **Q: I'm interested in how you see the rural community hospitals in Shropshire, in relation to the main hospitals and any other major secondary provider?** **A: (CP) -** I think they're going to be integral to the neighbourhood work that we do. I think we can utilise them much better for access to services. From a personal perspective, I went to Whitchurch to the Minor Injury Unit, when I broke my leg, to avoid going into Shrewsbury A&E. I think there's more that we can do. We're trying to offer more out at Bishop's Castle Hospital that's different to the bed base that we've got in there. We're looking at the community services in Ludlow and what we can deliver. There's so much more that we can utilise for those communities, we're trying to plan our services and the neighbourhoods working around some of our sites and the rural sites. We can certainly minimise the amount of travel and keep stuff local where we can. **Comment:** If the overall integrated plan for ICB involves all agents working together, flow has a possibility of working for patients, but they must work together, it can't be isolated projects. Things like social prescribing, there is some data and it's been going on for a long time. **Q: Is there some reduction in social prescribing and working to capacity recently in Shropshire?** **A: (CP) -** Certainly not from a funding perspective. I would have to check with Shropshire Council because they employ for us, but certainly the funding is still there

because it comes through the primary care network, Direct Enhanced Service (DES).

ACTION: Claire Parker to contact Shropshire Council to see if the funding is still in place and whether has there been a reduction in social prescribing.

Comment: In Oswestry it's quite difficult for patients who have multiple problems as people must travel quite far for appointments with a cost to get to that hospital, around 40 miles away. In the case of elderly people, it's so difficult to get extra care.

A: (JC) - Rural life has many advantages, but sometimes the rurality is an issue. Help can be given if you clinically need transport or if you need financial support on income grounds. You can be reimbursed if you meet the criteria, but the criteria is set out nationally.

A: (ER) - At the start of the public consultation back in 208 we recognised that some people may need to travel further to access services. The reality is there aren't enough patients in Shropshire and Mid-Wales to have two fully functioning large acute district hospitals. There aren't enough patients to keep the skill set for surgeons at both sites. By bringing medicine and surgery together we can provide a better service from an acute point of view. We understand that patients from Oswestry and Mid-Wales will have to travel a little further for planned care, but the care they'll get will be more robust and there will be less cancellations, as we're having to cancel patients for planned care because of the emergency care pressures. It does create some added trouble, but there's no simple way to do this. We want to provide the best care that we can.

Q: Patients are upset because they can't get an appointment with their GP. How much pressure is there on the urgent care system? Also, why isn't the ICB spending more on general practises? I've seen people who need dressings done, having come out from the hospital and their GP practice are telling them to go to A&E when there are no appointments, which is crazy. Why can't patients see a district nurse?

A: (CP) - Yes, it is difficult to access general practice. Demand has gone up and the workforce of general practice has gone down. Additional roles have increased, but our headcount of GPs has gone down. The demand went up over COVID by about 35%. It's still running at about 11% increase in demand. Some of that is created by the waiting lists as people sit on long waiting lists which is creating additional demand on GP practices. The other issue is that the General Medical Services contract is a core contract, and it doesn't cover things like wound dressings, ECGs (electrocardiograms) and echocardiograms. That is something that we are working on with general practice and how we can get better coverage for those kinds of services to commission them properly. That sits as part of the diabetes work and the cardiovascular work because we recognise it is an issue.
Unfortunately, all the general practices and the ICB can't put additional resource into it because it's done nationally through the GMS (General Medical Services) contract. We can commission the locally commissioned services, which we do, but that's our only opportunity to do that. It's all passed through payment directly from government

	for the GP contracts and they're all independent businesses, all 51 practices across Shropshire, Telford & Wrekin. We work with them closely and we're looking at things like telephone access as there's been a 2-year recovery plan on GP access to phones and trying to improve that system. The next 12 months is working with individual practices to hopefully improve that access. **Q: I thought the last tranche of money that went into GP practices was for other practitioners and not GPs?** **A: (CP) –** This government have highlighted investment within primary care. They're a national consultation now and the ICB as an organisation will be putting in a response. I suspect overwhelmingly the issue of GP availability is going to come from the members of the public, so it will be interesting to see how the government responds to that. Their plan is to have their 10-year plan ready for May next year. If you have a view, then I would encourage you to go on to the website: https://change.nhs.uk **A: (CP) -** The additional roles funding that's supported the wider range of professionals that work in GP practice has been changed. Previously you could not employ a GP through that funding, it was restricted. Now practices can utilise that funding if they want to employ a GP rather than a nurse associate. There's a bit more flexibility around it. **Comment:** A member of Shropshire Community Health NHS Trust should attend future focus groups. **ACTION: Julia Clarke to liaise with Shropshire Community Health NHS Trust to arrange for a colleague to attend future focus group meetings.**