The Shrewsbury and Telford Hospital NHS Trust

Dementia HTP Focus Group

Held on Friday 1st March 2024
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

Dementia HTP Focus Group

Members of staff responding to public questions

Julia Clarke – **(JC) Director of Public Participation**
Hannah Morris – **(HM) Head of Public Participation**
Ed Rysdale – **(ER) Emergency Medicine Consultant and Clinical Lead for HTP**
Rachel Webster - **(RW) HTP Nursing, Midwifery and AHP Lead**
Karen Breese – **(KB) Dementia Lead**
Maryan Davies – **(MD) Community Mental Health Transformation Lead at MPFT**
Chloe Northover – **(CN) Designer at Art In Site**
Martin Jones – **(MJ) Designer AHR**
Gareth Banks – **(GB) Architect AHR**

Q&A's BASED ON PRESENTATION

Q: Can you allow questions to be asked throughout the presentation as some patients could find waiting to the end of the presentation quite challenging

A: (JC) - Thank you, that's a very valid point and we will take questions after each slide of the design section and adopt this approach at future meetings.

Q: This image of corridor with grey wall and grey floor) is unhelpful as there's virtually no contrast in colour between the wall and the floor, so if you have any sort of impairment the perception of where the wall goes into the floor could be very challenging. Are these the intended colours for the new build?

A: (JC) – I agree with you - on this slide you can't see where the wall ends, and the floor begins. We will be having a focus group later in the spring with some local sight loss groups, so we'll also explore these issues with them, but in the meantime, we will make a note of that point.

A: (MJ) - That is mistake in our visualisation. The architects are very aware of the guidelines and the degree of contrast needed between different surfaces so patients can easily distinguish between the floor and the wall and doors. We will be sure not

to repeat this limited colour range in future presentations and I can confirm this would not be a colour scheme adopted in the building.

ACTION: Ensure that future presentations reflect the guidelines for contrast requirements for walls/floors etc.

Q: If people have dementia and they're in bed, how will having the proposed sensory areas in the building help them? Also, they may feel overwhelmed in some of the proposed more private "calm" spaces.

A: (JC) – The sensory map was a suggestion which came from a focus group that we held for adults with learning disability and autism. This focus group stressed the importance of having calm (retreat) spaces for some neurodiverse patients as adults/children might otherwise get very distressed when visiting hospital environments. The carers wanted to see a quiet calm space identified that they could go to. The intention was to place the sensory map in the circulation areas of the new building and ED rather than in ward areas. We understand that some patients with dementia may not wish to use these more discreet calm spaces as they may feel shut off and oppressive; but other patients may feel safe and sheltered. We understand that there is not "one size fits all" solution but we are looking at the different needs of different patient groups and how we can best meet them within the resources we have available.

Q: Some patients with an impairment may not be able to understand what the sensory map is depicting so how will having it help patients?

A: (MJ) – We will be using recognisable symbols and hopefully patients with severe impairments will be accompanied. It's also been suggested that we may add toilet location symbols to the sensory map because in the same way that people might perhaps want to sit down if there's a long distance they must travel within the building, they may also want to go to the toilet so identifying these could also be helpful in reducing anxiety for patients.

Q: Some people with dementia will struggle with the signage being too high as it currently appears on the slides. Some of the signage needs to be more at eye-level as patients with bad balance may fall if they are having to constantly look up for directions. It is recognised that people with dementia tend to look down more because they are often unsteady and unstable on their feet, so they don't tend to look up high for signage.

A: (MJ) - That's a very useful point and it is something we have heard before from other sources such as wheelchair users. However, the Stirling Group guidelines do advise placing signage higher following their research. We will make a note of your comments which I personally agree with and look to provide a combination.

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ACTION: AHR/Art In site to incorporate eye-level signage into wayfinding designs as well as signs higher up.

Q: As well as highlighting/colour-coding doors that you want people to go through have you thought about blanking out doors that you don't want people to enter - your staff will still know where they are.
If the staff-only doors are the same colour as the wall, then patients and visitors are less likely to try and go through them as they will not look so accessible.

A: (MJ) - That's a very interesting point and that is something that we did in in another hospital that we were involved with. All the doors that patients went through were dark coloured doors (with high contrast colours) and all the staff-only ones and cupboards were light-coloured like the walls. The result was that immediately when you walked into a corridor, people felt much more comfortable because the visual cues of contrasting door colour indicated that they weren't going in the wrong direction. I think that also plays into something that we think is important in wayfinding. One wayfinding approach is signage or text to support conscious decisions on direction, whereas things like colour can be used in your peripheral vision where a change of colour/tone can implicitly indicate a change.

ACTION: AHR/Art In Site to investigate the use of colour to support wayfinding.

Q: Some of the wayfinding is confusing – the tree on the left hand-side of board showing the different levels is confusing – what is it meant to signify? There doesn't seem to be any logic to its use. Also, some of the colours are not good e.g. the black print on green outpatient sign is not good. I think a lot of people would struggle to read especially people with impairments.

A: (MJ) – The tree on the left-hand side of the Level wayfinding board has been incorporated as it makes the sign more eye catching and using artwork is a way of conveying meaning without words. The idea of a tree is that the roots and trunk represent the lower levels of the building with the branches and top representing the higher levels. In other words, it's something that's unique to that space in the building so that the space has an identity. One of the things that we've heard from people is that if a hospital looks the same all over, this can make someone quite anxious. Also, people feel they must read all the signs to know where they are and as we know, reading lots of signage causes cognitive overload. The tree was a simple and instantly recognisable symbol which also brough a sense of nature into an otherwise sterile, clinical environment. However, I think we may need to review the signs because I think people feel that the tree artwork is too close to the information, and perhaps needs to be more separated from the signage.

A: (GB) - The advantage of the tree logo is that it gives you some sense of how far up the building you are. However, I suppose for it to make sense, it needs to be in locations where you can see the full height of the tree so somewhere like the central core of the building, where you've either gone up the stairs or you're getting out of a lift as opposed to appearing isolated deep within the floor. It's serving a very specific purpose, but I take your point around whether there is some iconography that we can use to help give a little bit more context and logic.

Comment: I would love to see a theme of trees with greenery all over the place in the building with different pictures of trees in different places. That would give you

	the theme of something natural, which is good for people but at the same time as maybe helping to define one area from another. **Comment:** What I would find helpful is if there are four floors as shown as an example on the wall sign on the slide, would be to have each floor linked to a different colour, and in the lift have the numbers the same colour that used for the floor and the way-finding sign. This would make it a lot easier to understand where you're going and if you have the wall the same colour facing you when you get out of the lift it confirms you're in the right place. **ACTION: AHR/Art In Site to review proposed (tree) artwork accompanying current signage and the use of colour-coded floors/lifts**. **Comment:** you will be aware that people with dementia need to be able to see a clock wherever they're sitting, and if the clock also identifies where they are (e.g. Emergency Dept, Royal Shrewsbury Hospital) that would be helpful if someone is confused - people would know where they are as well as what time it was. **A: (MJ) -** We're looking for design principles, so for instance, the principle of associating a clock with some information, even if it's only the name of the ward that you're in, is very useful for us because it means that it's something that we can repeat and build on through the hospital. **ACTION: AHR/Art In Site to plan in "named" clocks with location as well as time throughout.** **A: (JC) –** There is going to be further discussion about what we call departments/rooms. Clearly the clinicians will come up with what they would like to call areas, but then need to talk to service users and get their views so that the function of an area is easily understood. **A: (GB) –** It will probably take a lot of time to agree on the final department. We know what we must do, and we will be starting it in the very near future. This is a pre-existing action being monitored through the quarterly Medicine & Emergency Care and Surgery, Anaesthetics, Critical Care & Cancer focus group (meeting next on 8th March) **Comment:** There needs to be a variety of chairs and seating areas with different heights, or at least normal, low and high, because older, frail people may not be able to get out of lower seating and might not be able to get into it easily either. The seating in some of the slides doesn't look as though it's got much support behind the person. **ACTION: AHR/Art In Site to consider range of seating available (heights/support etc) at a later stage.** **Comment:** The slide shows toilet doors in yellow, I think it needs to be a sharper yellow, a lighter yellow – the colour on the slides looks more like faded wood. Also

	on the actual toilet doors, the male and female signage is too small and would not be visible from the end of a corridor. They need to have signs at 90-degree angles above the doors so they would be visible from a distance and would not be damaged by porter's transport cages. **ACTION: AHR/Art In Site to review signage and colour scheme for toilet doors.** **Comment:** In terms of labelling for wayfinding, it would be worth having a look at the Robert Jones and Agnes Hunt Hospital (RJAH) system of numbers. It is quite a convenient method, and it allows you to be able to change things quite easily on a big chart. **ACTION: AHR/Art In Site to review RJAH (Oswestry) hospital number methodology.** **Q: Is it possible to see the floor plans to make sure the arrangements in individual rooms/areas have considered the patients perspective?** **A (JC):** There have been Public Assurance Forum representatives at all the clinical workstream 1:50 clinical design meetings and floor plans are available at the quarterly Women & Children's (W&C) focus group and the Medicine & Emergency Care and Surgery, Anaesthetics, Critical Care & Cancer (MEC&SACC) focus group – these are held on MS Teams and also face to face in the SECC where the plans are available on request. **A (GB):** All the building floor plans can be developed in 3D. I know traditional floor plans can be difficult for people to interpret but we can produce 3D views which make it much easier to visualise, so if there are specific things that anybody would like to see, we'd be happy to generate those views in 3D, so you can see exactly what the patient's experience would be. **Action: Gareth Bank to produce 3D designs of each department for the June focus groups for Women & Children's and MEC & SACC.**