Mental Health HTP Focus Group

Held on Thursday 22nd February 2024
10:00 – 12:00hrs via MS Teams

QUESTIONS/ANSWERS

Mental Health HTP Focus Group

Team 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**
Chloe Northover – **(CN) Designer at Art In Site**
Martin Jones – **(MJ) Designer**
Maryan Davies – **(MD) Community Mental Health Transformation Lead at MPFT**

Q&A's FOLLOWING PRESENTATION

Q: In terms of managing future costs do you think there will be a massive increase in service users accessing A&E due to the improved facilities and is the system geared up to deal with that?

A: (MD - MPFT) - The plan is that as we work closer as a system the attraction of going to A&E as the first port of call will reduce as people are being supported to reach the most appropriate service at the most appropriate time as close to home as possible. This includes involving the Voluntary Community and Social Enterprise (VCSE) colleagues, so that mental health service users can access the most appropriate support services. As part of the wider transformation programme, rather than people having to jump over barriers and seek out services, and then often ending up in A&E because they have nowhere else to go, we hope to support people by them being able to access the most appropriate services more easily. It's very much work in progress and it's dependent on the collaboration of working together to try and reduce that footfall through A&E because it's not the most appropriate place, even if they have got lovely calm spaces.

A: (JC) - One of the things that came out of the autism and learning disability focus group meeting was the need for the Trust to establish a patient and carer's experience group for autism and learning disability, which is wider than HTP and is

being developed by the Patient Experience team. The wider system transformation programmes are not just about the hospital; it's about working with colleagues and communities to create care closer to home.

A: (ER) – It's about getting the balance right between the designs and the safety issues because the crisis rooms must be compliant with all the national guidance and cost as well. I don't think it is about encouraging or discouraging patients to attend ED, it's about getting them into the right place at the right time.

A: (MJ) - Most of the work that we've done so far has been on the communal spaces within the hospital. This is the first internal clinical space that we've looked at and we're looking forward to working with the clinicians because it is so important to integrate the environment with the service design and to look from the other side at what the service users themselves want and what their needs are. We are bringing all the architectural design and close up designs and then we'll be developing the designs from there. If anybody has any evidence of spaces that are designed especially for the comfort of mental health service users, we'd like to look at this as well.

Comment from focus group member: If activity does increase, it would be useful to have a service plan to manage that. The patients need these safe places, and they should be able to come if that's the only place they know where to go.

A: (JC) – We need to remember that we have got until 2026/27 for the Hospitals Transformation Programme to complete. Any changes in service levels would be for the commissioners to consider and this would be picked up in the normal way through the contract process.

Q: In the presentation there was a lot of mention of light, but there was no mention of sound. I care for two adults who are hypersensitive to sound, and I'm also quite deaf.

A: (MJ) - The idea of the sensory map is to identify calm spaces which might not be so busy/noisy as places for people to go to if they feel anxious when they're in the communal spaces of the hospital. We're also looking into the possibility of using acoustic materials which will absorb sound a little bit so that the calm spaces will be as calm as possible. There are also infection control considerations which will have to be incorporated and we will be balancing all these considerations, including costs, into our design plans.

Q: In the proposed children crisis rooms in ED could they double as Section 136 spaces (Section 136 of the Mental Health Act provides for a patient from the community to be taken to a place of safety). **Currently *Redwoods haven't really got sufficient facilities and capacity. Could this be an opportunity to create a children and young people Section 136 facility?***

A: (ER) - We don't want a Section 136 suite in the emergency department as it's the wrong place for patients. The Section 136 suite needs to be at the mental health location where there is the staff and facilities to take care of patients. There is a

	Section 136 suite at Redwoods, which is often full. When the Suite is full, then patients are brought to the emergency department. However, this is not an ideal situation, and the police must accompany the patient whilst they are in the emergency department as it is not a Section 136 “place of safety” as designated under the Act. The patients that we do see who are on a Section 136 will also have a medical issue and they come to us for their medical issue rather than their psychiatric issue. However, if the patient presents purely with a mental health issue on a Section 136 order, then the emergency department is absolutely the wrong place for them because this adds delays to their care. This is the same for adults and children. We need to get them to the right place as soon as we can, which is one of the reasons we're changing the clinical model in Shropshire with the emergency sites at Shrewsbury. It's about getting the patients to the right place as quickly as we can, so they get the care that they need sooner. Having a Section 136 suite designed into the emergency department wouldn't be the right thing to do. Having said that, the crisis rooms do need to be able to accommodate somebody on a Section 136 who needs medical care. **JC comment: Some of the language that we’ve used today, e.g. fidget rails, crisis rooms seem a bit pejorative. Gareth Banks (Regional Director at AHR, Architects) had an action from a previous meeting about the language that we use in terms of wayfinding in the new building. I'd like to include some of the information from this meeting into that action when it gets to that point. I think the language we use is very important. It needs to be intelligent and easy to understand, don’t want it to be labelling people before they've even been seen.** **ACTION: Expand action 14 from MEC & SACC meeting 5/12/23 to include consideration of condition-sensitive language.** **Comment: In children's waiting area, can we make sure that it is neutral enough to work with teenagers as well as younger children. A teenager who comes in after an overdose or something similar and being presented with ‘Nemo’ or something like that on the doors/walls of the children's room is not appropriate. Can we just make sure that it's neutral enough that it will encompass all younger people rather than their age.** **ACTION: Ensure there is age-appropriate accommodation for young people (older children) in ED paediatric waiting areas and treatment rooms.**