Patient and Public Consultation
Feedback report August 2010

Introduction

This paper provides an update on the work which has been undertaken with patients and members of the public since the last updates to Programme Board in August/ September 2009. The paper demonstrates the success of patient and public involvement within 3Ts and provides a useful design baseline benchmark from which to measure improvements in the environment at Royal Sussex County Hospital once the hospital development is complete. Programme Board is asked to note this report.

Executive summary

Patient and public consultation within 3Ts has always been a seen as extremely important. The use of the web site where minutes and papers are frequently updated, and the various events for members of the public have been a feature of the 3Ts since its inception. For instance during August/September 2008 over 50 people were consulted within four specific design workshops and one benefits criteria workshop. The data from this phase of consultation was analysed and presented to Programme Board in August 2009.

Perhaps more significantly, the suggestions made were fed back to clinical and operational leads so that they could either act on them, or explain why these suggestions could not be taken forward. Therefore the data presented below continues this process. All the suggestions contained in the appendices will be sent to identified leads, as before, together with last years' suggestions for a progress update. There is therefore a trail of accountability at a very senior level which is recognised as best practice within patient and public engagement.

The data included in this paper paints a vivid picture of the issues which are important to the members of the public who were consulted. In general there is a strong focus on disability and access, which illustrates how buildings themselves can serve to enable or disable the people who use them. The papers finishes by recommending that consultation takes place with the wider general public, if possible, so that we can ascertain whether these views are representative of our patient population in a broader sense.

Data sources

There are several different cohorts of respondents who gave information:

1. Two groups of patients or visitors who filled in the patient experience tracker (175 in total) in February and May 2010.
2. A group of patients or carers who attended the "Flagship room workshop" (17 people)
3. Focus groups which were undertaken with specific disability or other special interest groups (approximately 90 people)
4. The Patient Public Design Panel (18 people) which has been meeting monthly since January and is made up of members of the public who have been either a) patients of BSUH and/or b)have experience of design/or construction. This group also includes LINk representatives and reports to Core Team.
5. Letters and emails which were unsolicited, from members of the public who had been patients or carers (6)

In total approximately 300 people have participated by offering their views for the benefit of the design process, although there was some overlap between 2, 3, 4 and 5.

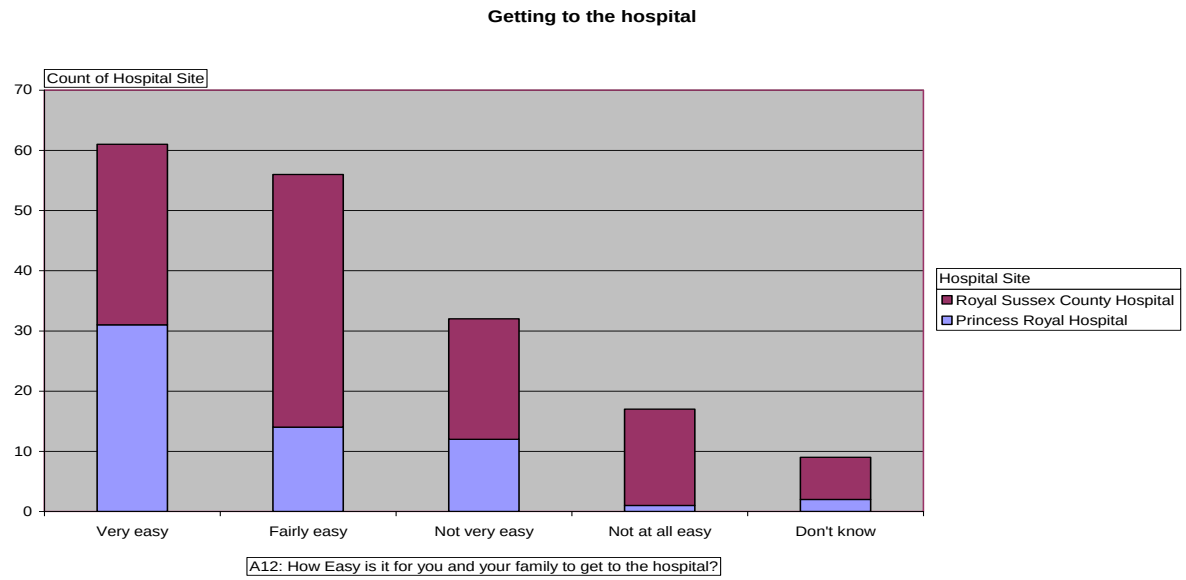
Quantitative data

The Patient Experience Team assisted patients visiting the RSCH between January and May 2010 to complete the Patient Experience trackers in two quarterly sweeps. This yielded data from 175 patients or visitors. 54% of the respondents were men and 46% female. It is also of note that 46% of respondents classed themselves as having some form of disability which affected their everyday life.

The Patient Experience Tracker asked questions specifically about way finding, and access. This was because 3Ts is working on the hypothesis that these areas will be improved through the hospital redevelopment, and we used the patient experience tracker to set the baseline. The results of these questions are show below:

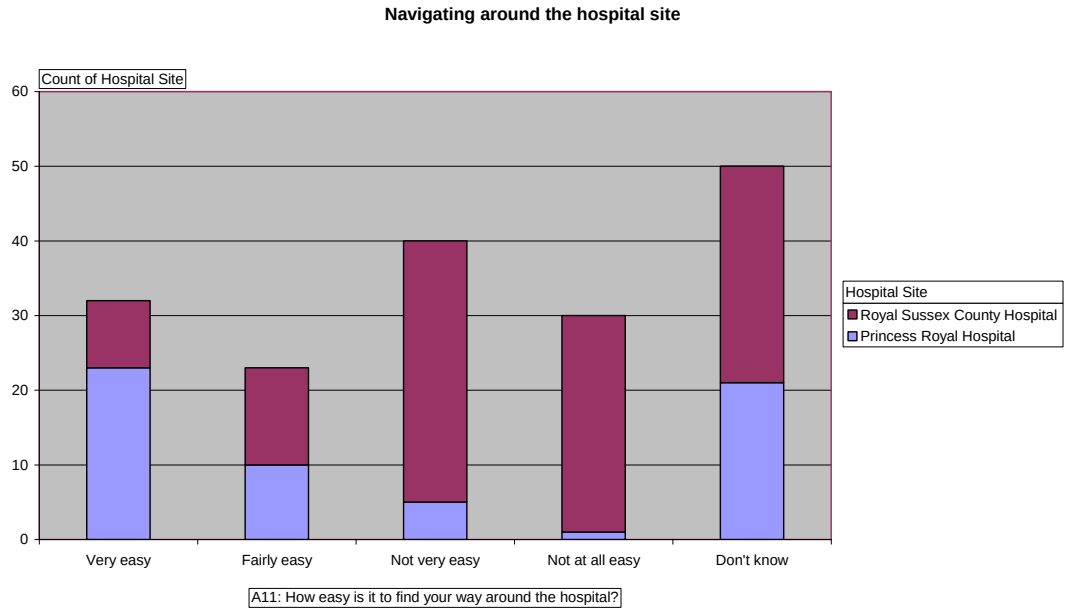
Getting to the hospital

The chart below shows that PRH compared favourably to RSCH for ease of access, although the sample size was smaller (60 compared to 115 for RSCH) with 89% saying it was easy or fairly easy at PRH and 63% saying the same for RSCH.



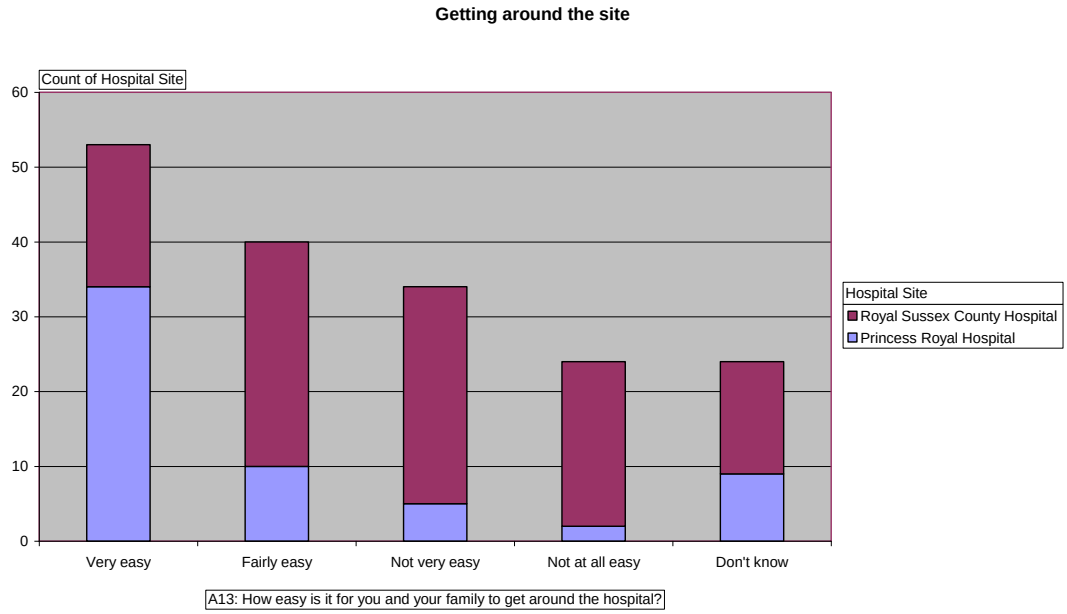
Navigating and way finding at RSCH

55% people found the RSCH site difficult to find their way around compared to only 10% saying the same at PRH:



Accessing the site itself

Finally, people were asked how they managed to manoeuvre around the site itself. Once again, 11% people at PRH found not very easy or not at all easy, compared to 44% at RSCH.



Discussion

This data contains a lot of very useful information which will be further interrogated for the purposes of benefits realisation. However, within the context of this paper, the data presented above shows conclusively that RSCH compares unfavourably with PRH for both physical access and way finding on site, although the town centre location does appear to be popular with respondents. The next section explores these issues in depth and is based on qualitative data collected within focus group settings.

Qualitative data

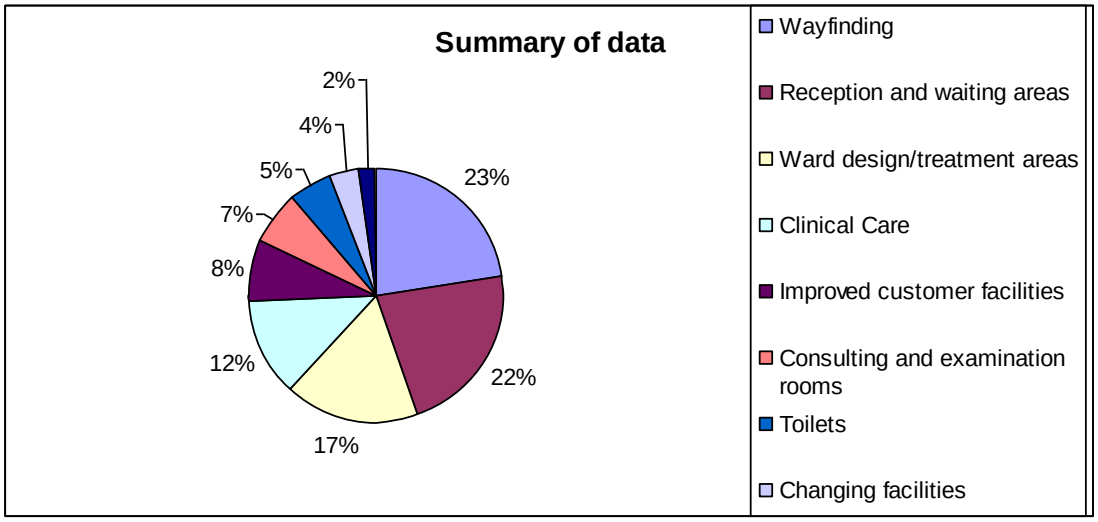
From September 2009- July 2010 a series of workshops and regular meetings were established. These aimed to gain patient/public views regarding the current environment at RSCH which is due for development and utilise these views for design purposes.

The table in **appendix one** shows those consulted. In all 11 focus groups were conducted, which were complemented by seven follow up emails and three individual interviews.

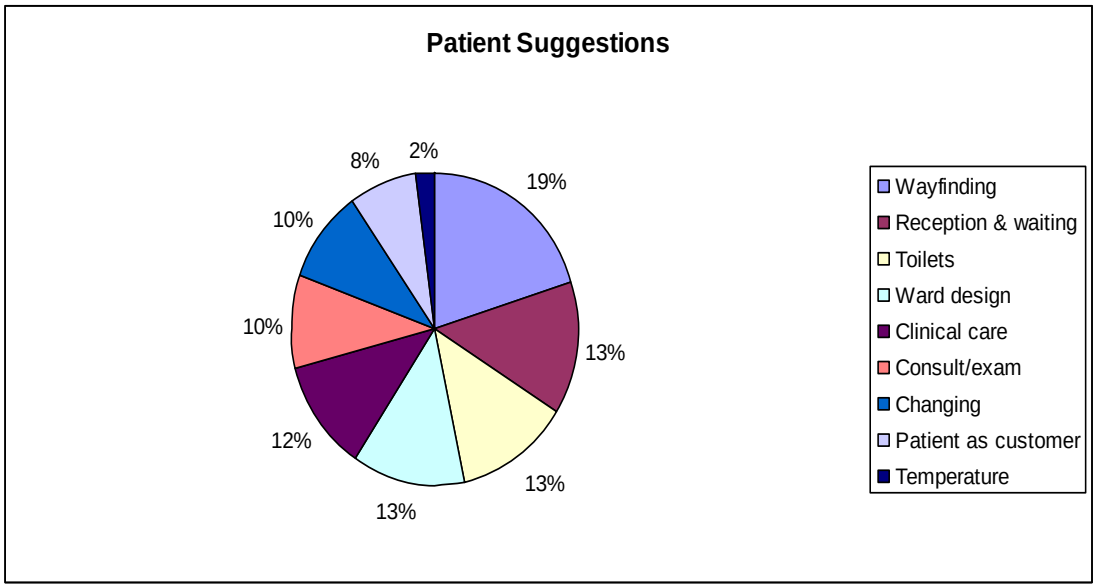
Methodology for analysis of qualitative data

The data was initially segregated into the main patient areas which were the subject of the discussions. Whilst the 3Ts design was the main focus of discussions, people often wanted to comment on the care they received, so this category was included in the initial data segregation as follows:

Patient areas and subjects discussed	
Way finding	121
Reception and waiting areas	117
Ward design/treatment areas	92
Clinical Care	66
Improved customer facilities	41
Consulting and examination rooms	37
Toilets	29
Changing facilities	21
Temperature, noise and environment	10
Total number of comments	**534**



These subject areas were then subject to a thematic content analysis based on the issues which were raised within the individual categories. This yielded valuable information on both the current facilities at the two hospitals and issues which require consideration within the design process for 3Ts. The complete lists of suggestions for improvement are summarised in **appendix two.** The suggestions below exclude duplicates and comments, so are fewer in number (103) than the total data set of comments (534).



The next section looks at these areas individually, before an analysis of the overarching themes.

Way finding

Way finding was found to be particularly difficult at RSCH and cited as a problem by 31% of those questioned. PRH, by contrast was easier for people to navigate. As expected, parking was a mentioned as particularly difficult and people found the current campus difficult for a variety of reasons, such as its slope, the numerous levels and the confusing signage.

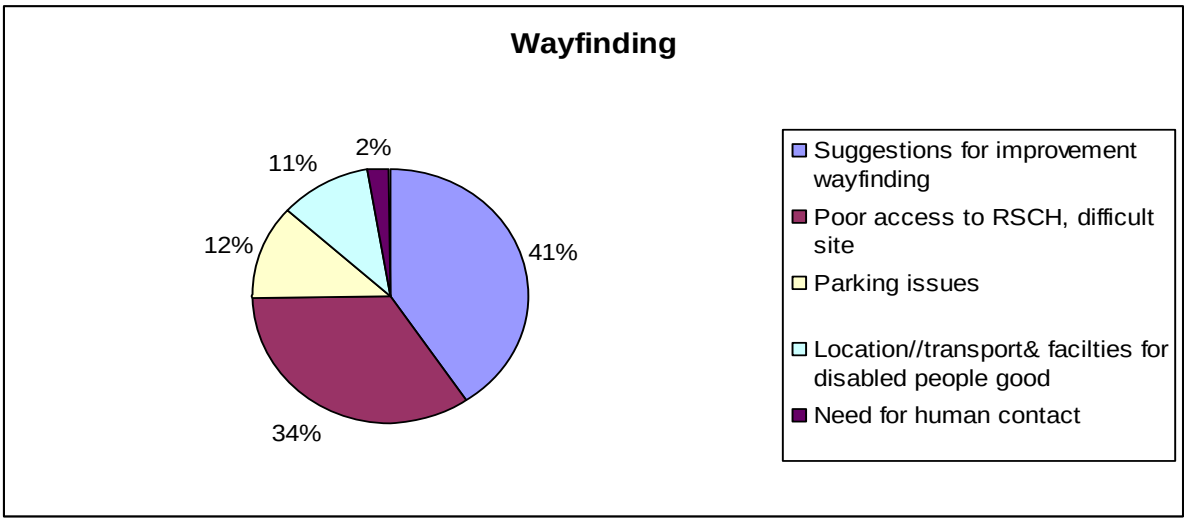
"The site is just so complicated and it is difficult to follow instructions to get to your destination. Most people can only remember 3 instructions"

- *"It's jolly good exercise!"*
- *"I used to get hopelessly lost…it's like a maze."*
- *"I didn't know where to go".*

Significantly, whilst people were enthusiastic about the benefits of information technology, several people were anxious that the advances should not take the place of human contact:

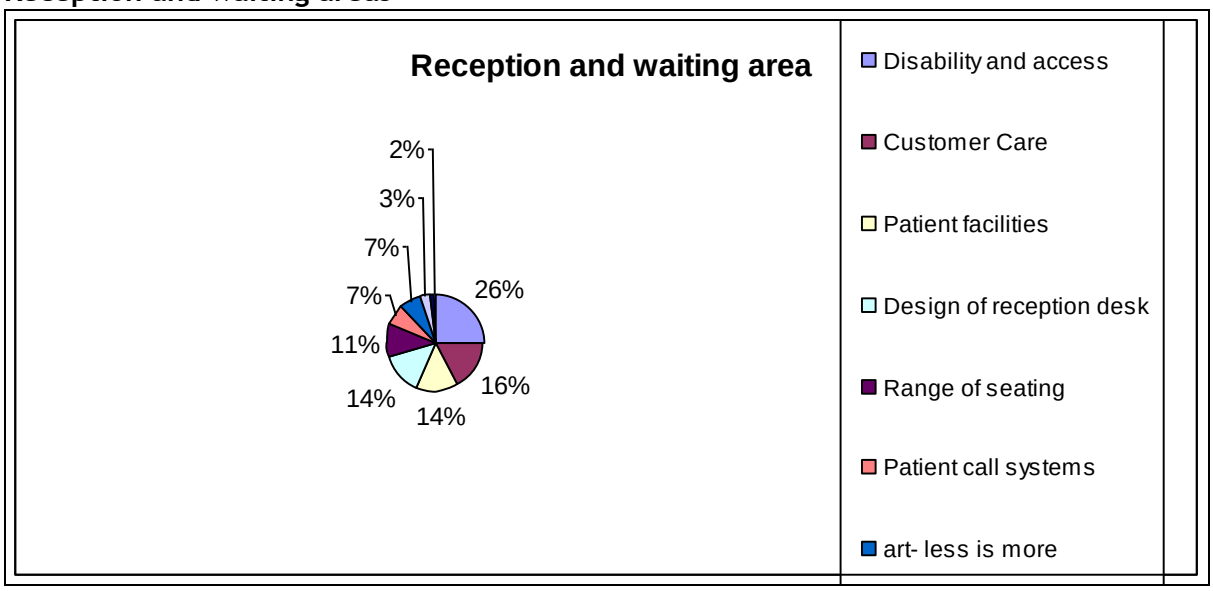
"Whatever new technology is introduced must not replace personal touch and human contact, people need options…who is going to help people start the journey?"

It was of interest that the good location of the site was mentioned 15 times (12%), as it is easy to get to by bus and is within the City.



The next main area disussed within the data was the design details of the various standard or "flagship" room areas. Those questioned had many helpful comments to make based on their experiences of using current facilities. These will be described in turn by flagship room areas:

Reception and waiting areas



As can be seen the issue of disability and inclusion was the main focus of the comments with 26% of those questioned wanting to see reception and waiting areas which were fully accessible with a range of aids for people with disabilities, such as people who were partially sighted or people with mobility problems.

In general those questioned were very keen to embrace technological improvements which would make being a patient or visitor an easier, more comfortable experience. People compared the busy environment to being in an airport or shopping centre where there are many facilities which make managing large groups of people easier. They cited examples of aids which could improve the waiting/visitor experience such as buzzers which they could take with them whilst waiting in outpatients.

"Out-patients need to be light and airy with different height chairs. I recently accompanied my wife to the breast unit in Preston Park. There the waiting area is great. It would be improved if the coffee bar opens all the time clinics are operating. Similarly, reception should be manned throughout clinics."

However, several comments about design in this area were focused on the need to minimise infection (particularly for immune compromised patients), and whether this would make acoustics for people who were hard of hearing difficult, or surfaces for people with dementia/sight loss too reflective and confusing.

"If we do get booked together to save the doctors' time can we have buzzers/ a system to let us go off around the site until we can be called as we don't like hanging around for hours, especially with the general public who might be infectious….We need smaller sub waits where we can keep away from children/people with coughs and colds."

Some comments also raised the issue of whether people should have to wait at all. However people also had a lot of contributions to make about the ambiance and environments in the waiting and reception areas. There was a clear division between people who wanted TV/music and diversion, and those who did not. One group suggested that perhaps waiting areas could be subdivided into areas with diversion and areas which were more tranquil/less stimulating. In general, comments about art were that it should be soothing, and tranquil, if present at all.

Once again, people thought volunteers and staff could help to humanise the new, technological sophisticated patient waiting experience:

"We would like to have "greeters" as well as self check-ins in reception, nice warm people."

Ward design and treatment areas

There was a range of responses about wards and treatment areas, with people very intrigued about what the provision of single rooms would mean in terms of changes to patient care. Whilst people supported the concept of single rooms because of the associated improvement in privacy and dignity, there were concerns about nursing care being adversely affected. It was interesting to note that women were more in favour of being nursed in bays of four than men.

Many people took the opportunity to describe the facilities they would like to see in treatment areas, a selection is shown below:

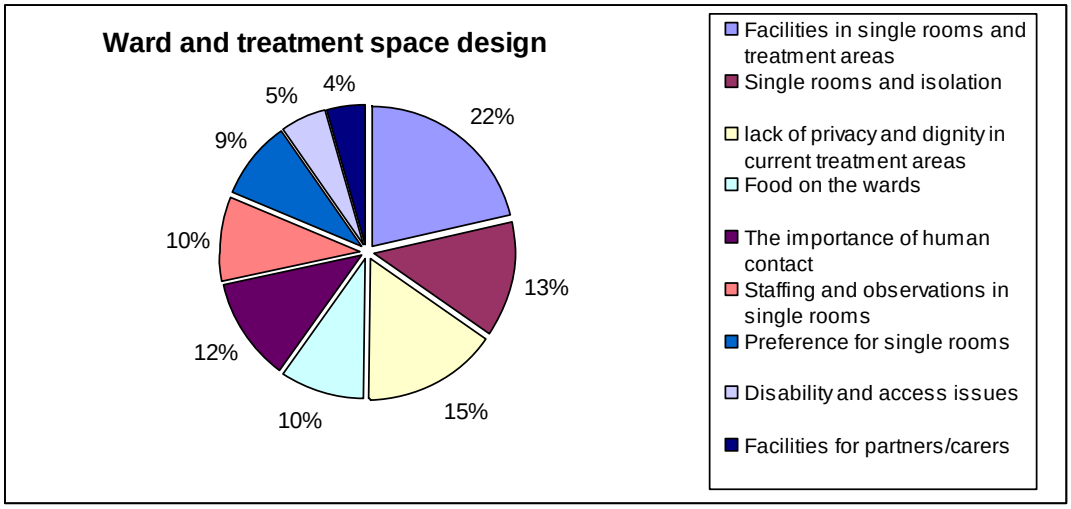
"Can we have sockets which are at waist height, and toilets you can get a drip stand into? When you are having chemo for a couple of hours you have to drink a lot of water to flush it through and then when you need to use the toilet, it can be hard to get it the drip unplugged if it's at floor level behind the chairs".

Another Cancer patient:

"Why are we shoved out the back, almost as if we are secret? Areas have no outside views. We understand that privacy is important but we think sometimes people see cancer as something to be hidden away..... Not sure the area should look very clinical, more domestic and homely."

Another theme was that increased facilities should be made available for people with carers, such as fold down beds, or comfy chairs next to people having chemotherapy. People also made comments about inpatient food. The main thrust of these comments was that light, snacky food should be made available, as well as calorie-rich food like ice cream for people with poor appetites.

The theme of the need for the new design not to make human contact obsolete was a recurrent one.



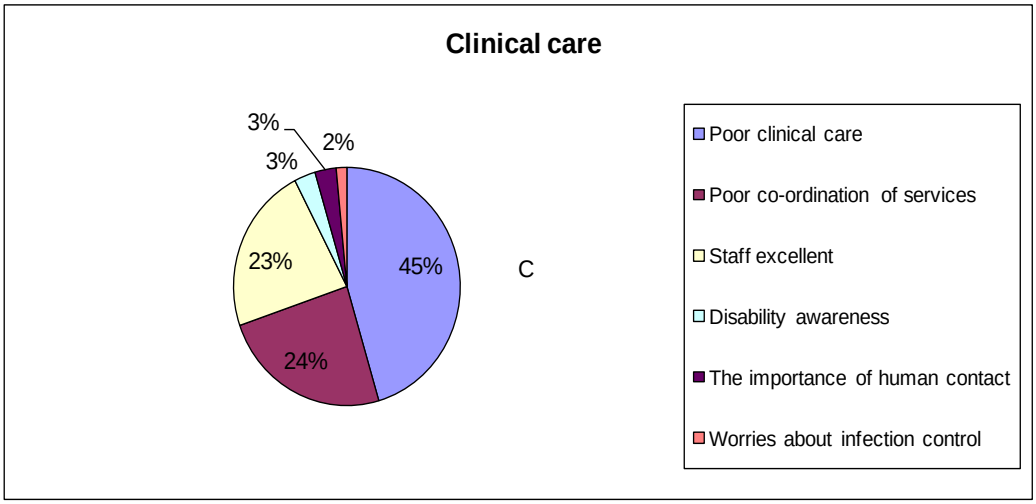
Clinical care

Whilst this was not a prompted question, it came up in every interview or focus group, so was categorised separately because those questioned used this opportunity to describe the nursing/clinical care they had received in hospital, some of which had been unsatisfactory. Others had praise for the staff. The ratio of favourable to unfavourable comments is shown below:

"Can you get someone with the right skill level to take the blood?...Several stories of nurses seeing people with tiny veins as a challenge, (!) Even though the patient knows from experience that they won't be able to find the vein unless they are a specialist phlebotomist and they will keep trying until it hurts"

Compared to:

"The staff were marvellous; the clinical care was second to none"

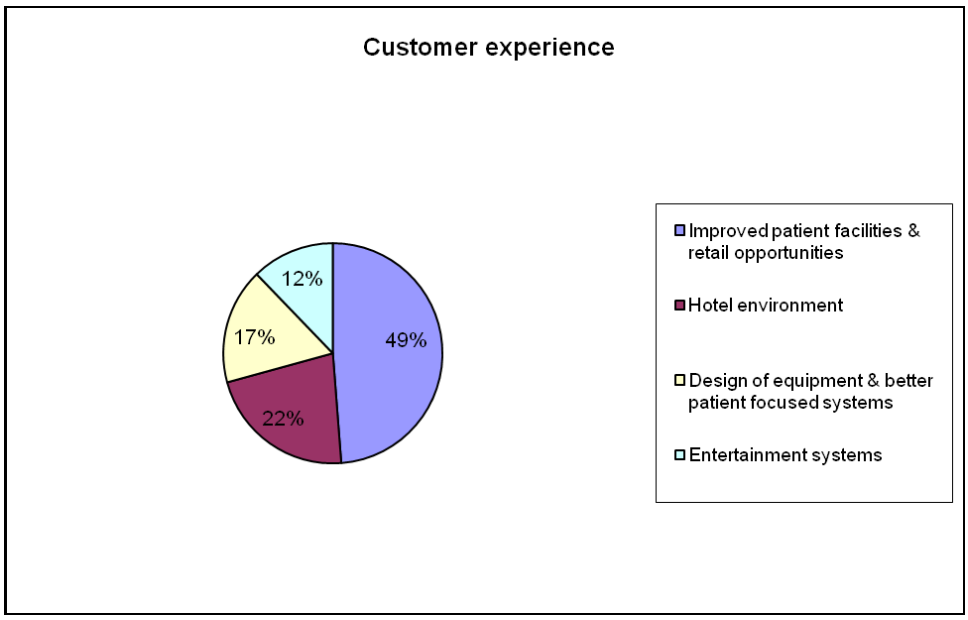


Once again, the importance of better facilities for people with disabilities and the importance of human contact arose unprompted as did the issue of infection control .One facilitator said that older people "*feared admission*" because of their worries about picking up a life-threatening infection.

Improved customer facilities

To some extent this category was implicit in many others, such as the reception and waiting areas, however it was given its own analytic category because it is considered an important area of patient feedback; as the NHS modernises and embraces the concepts of competition and choice it is moving away from the "grateful recipient" patient towards the discerning consumer. Moreover, in all the meetings with patients, this came up as consistently important. So whilst clinical skill is the most important aspect of care, improving the customer experience and making people feel valued and cared seemed to contribute to both the patient experience and the recovery process:

"There was some discussion about patient entertainment and telephone systems. The group expressed some dissatisfaction with the current arrangements in providing these services stating that the service was overpriced and difficult to use. It was suggested that as portable entertainment systems were becoming increasingly common the design should be developed with this in mind (Patients able to access Wi Fi, charging points)".



Examination and consulting rooms

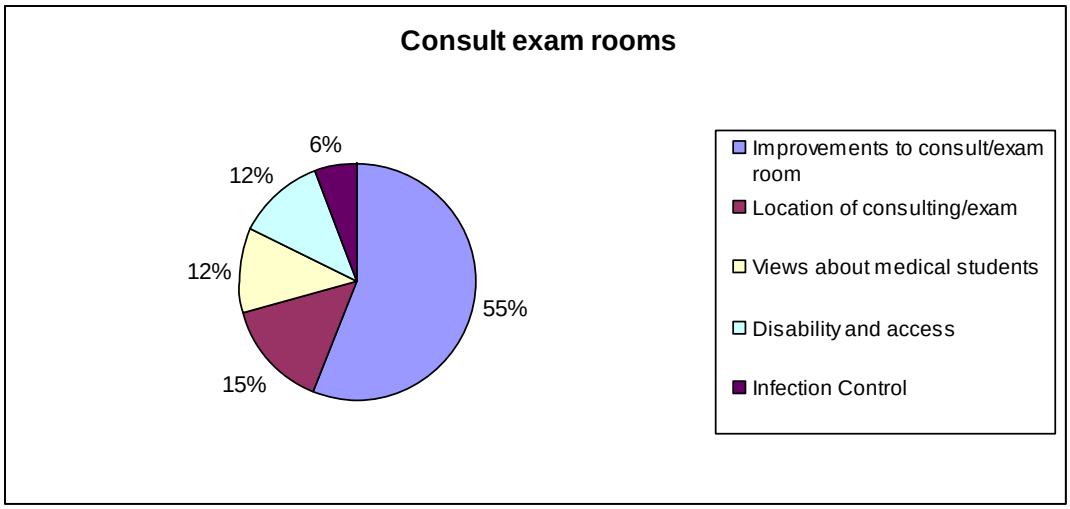
This area of feedback was mainly practical advice to the 3Ts about how the examination suites could be more user-friendly. However, there were some useful comments about the process of consultation too:

"Would like a consultation before being examined i.e. an equal exchange one -one -one, rather than a consultation when you are lying on an examination couch (!)"

And

"Should be just patient and the consultant' - Limit people coming in and out of rooms when they don't need to be there - don't make exam rooms shortcuts to other rooms".

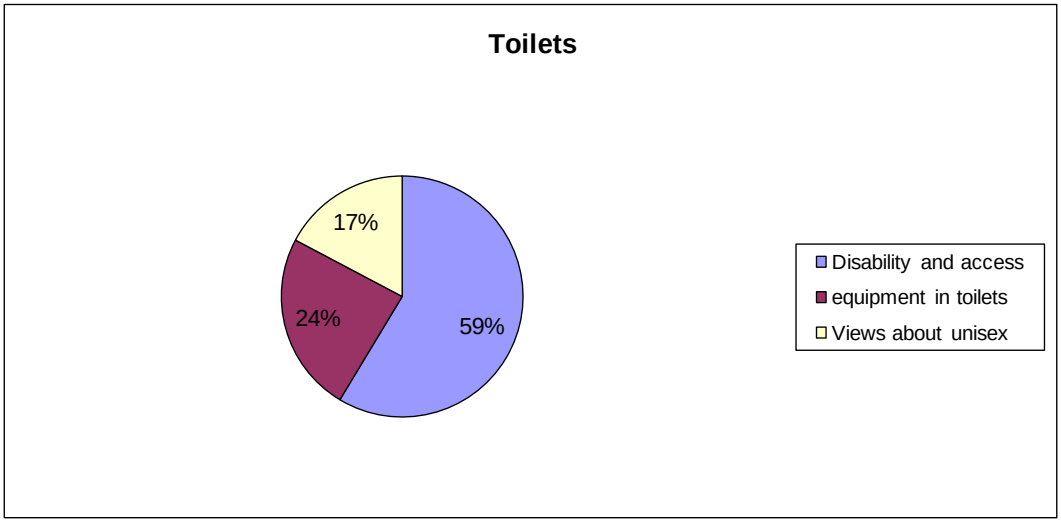
"Lose the desk - there was a fair amount of consensus that desks are a barrier to proper communication and interaction. Desks where doctors have to turn their back to you to write or type were considered just as bad… Private practice was cited as an example where there is no desk between the patient and doctor"



Toilets

Toilets were an important category for patients with disabilities. Those questioned also embraced the challenge of space utilisation and accepted the idea of changeable male/female toilets. However, there was unanimous rejection of unisex suites of toilets.

The disability issue prompted thoughtful and authentic suggestions which were born out of the lived patient experience, from areas such as the lack of shelving for stoma patients, through to the need for pedal bins which are hand operated for patients in wheelchairs who cannot used foot operated waste bins.



Changing areas

This was a narrow, specialist area for discussion which was prompted by the 3T team wanting to know how to design changing areas in the most space efficient yet patient – friendly way. The Flagship Rooms workshop ran a session specifically in this subject with 3 variants being discussed as follows:

1 Change and wait in communal area
2 change and wait in an area with other people who are also changed
3 Change and wait in a self contained cubicle.

There followed a useful discussion about the advantages and disadvantages of these variants. There was concern about the patient examination and treatment rooms being sound proofed if people were waiting next to them:

One issue mentioned was that when consulting rooms are next to busy waiting areas as it can be hard if you have had bad news to step out into the busy milieu with shops and people milling about.

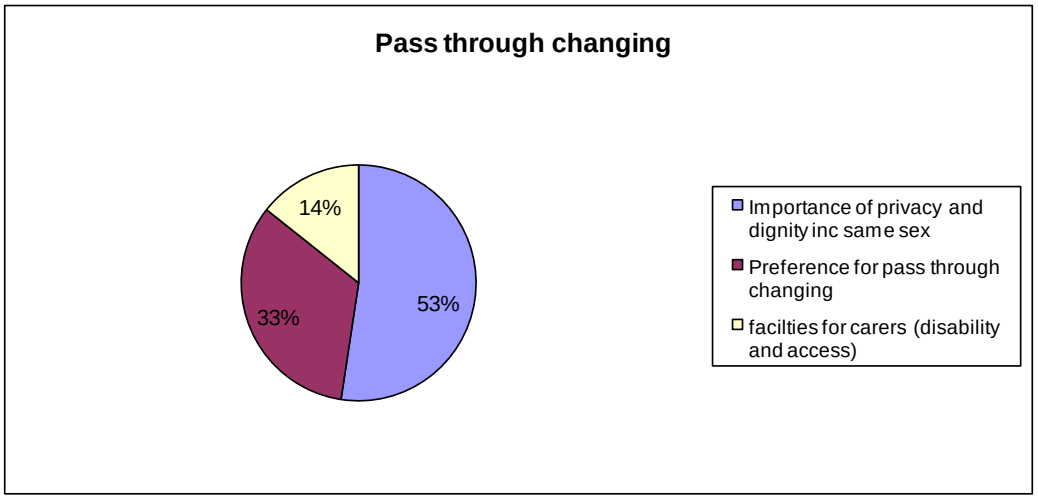
People were asked to vote on the preferred option using the diagrams and sticky labels provided. Variant 3 was narrowly the favourite. This provided useful feedback to the design team.

"Prefer to wait with other people who are changed, shouldn't have to wait with fully clothed people"

"Can we have lockers for our stuff?"

"If we have to wait once changed can you keep us informed about how long we will be waiting especially if we are going to be on our own?"

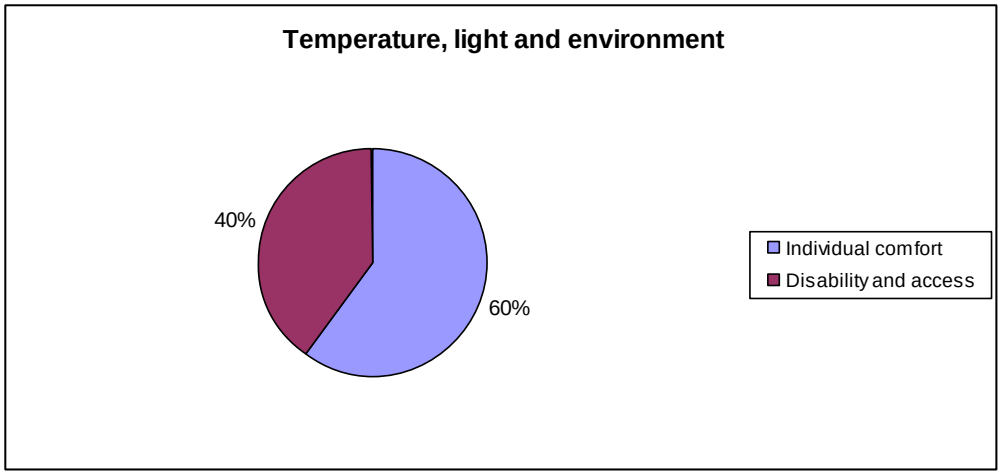
An additional issue which became apparent through feedback was the additional requirements of people with disabilities; several groups added that changing rooms should have sufficient space for people to be assisted whilst changing and for wheelchairs. Whist this requirement will have space implications; these can be mitigated by the provision of the requisite number of larger assisted change areas.



Temperature, light and the environment

This was the smallest category for analysis, but nevertheless provided some interesting insights into issues which were important for patients and their visitors. For instance single rooms were welcomed by some because they could give people the chance to alter the temperature and light to suit themselves.

The issue of disability also came through as partially sighted people favoured natural light wherever possible. There were also concerns that people with hearing loss would have difficulties if the surfaces were all reflective and non absorbent, as sound bounces off them and causes problems in crowded places. It is hoped that the design team can work out a technical solution to this problem.



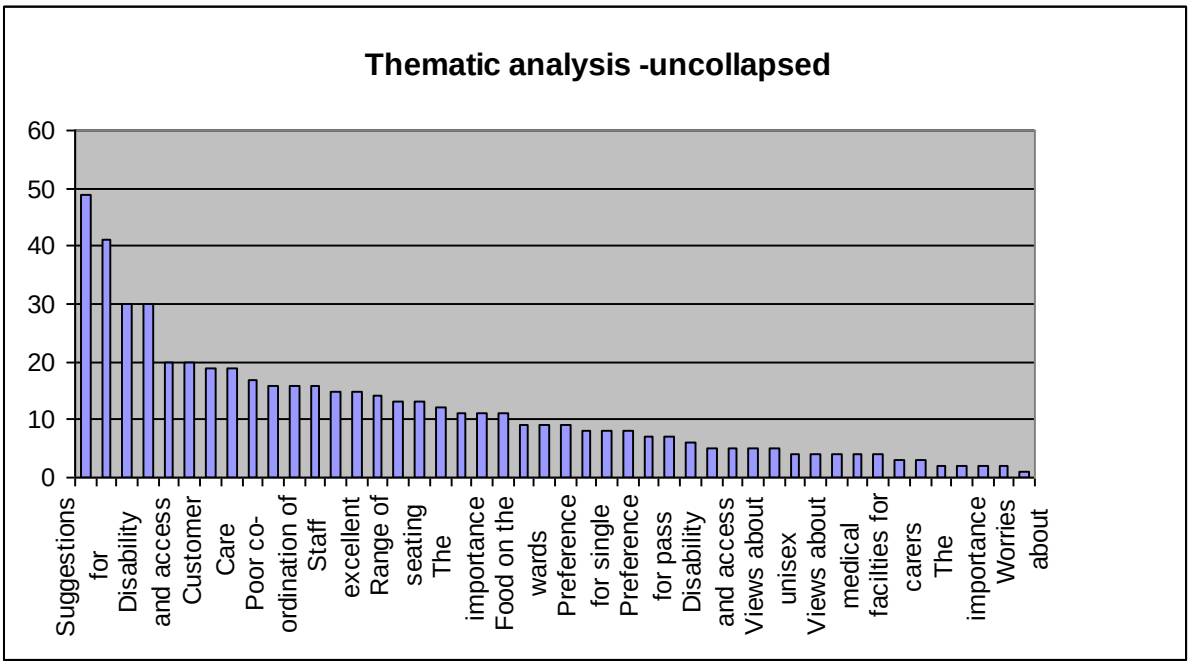
Discussion

The analysis so far has concentrated on specific design issues which arose from the initial categorisation. This was undertaken by examining the question areas within the initial questionnaire, i.e. people gave answers to the questions they were asked. Thus far the only unprompted responses were around the areas of clinical care, and improving the patient as consumer experience as, regardless if the questions asked, people wanted to discuss this.

However, several themes came through many of the design categories and were thus "grounded" in the data. It was thought of interest to examine the data set in its entirety to see how important they were. Therefore the thematic analysis was applied to the total data set, and the results are as follows:

Theme	Number of times
Suggestions for improvement wayfinding	49
Poor access to RSCH	41
Poor clinical care	30
Disability and access	30
Facilities in single rooms and treatment areas	20
Improved patient facilities & retail opportunities	20
Customer Care	19
Improvements to consult/exam room	19
Disability and access inc parking	17
Poor co-ordination of services	16
Patient facilities	16
Design of reception desk	16
Staff excellent	15
Parking issues	15
lack of privacy and dignity in current treatment areas	14
Range of seating	13
Location//transport & facilities for disabled people good	13
Single rooms and isolation	12
The importance of human contact	11
The importance of human contact	11
Importance of privacy and dignity inc same sex	11
Food on the wards	9
Staffing and observations in single rooms	9
Hotel environment	9
Preference for single rooms	8
Patient call systems	8

art- less is more	8
Preference for pass through changing	7
equipment in toilets	7
Individual comfort	6
Disability and access issues	5
Location of consulting/exam	5
Entertainment systems	5
Views about unisex	5
Facilities for partners/carers	4
IT & innovation	4
Views about medical students	4
Disability and access	4
Disability and access	4
faculties for carers (disability and access)	3
Need for human contact	3
Disability awareness	2
The importance of human contact	2
Infection Control	2
Infection Control	2
Worries about infection control	1
Total	**534**

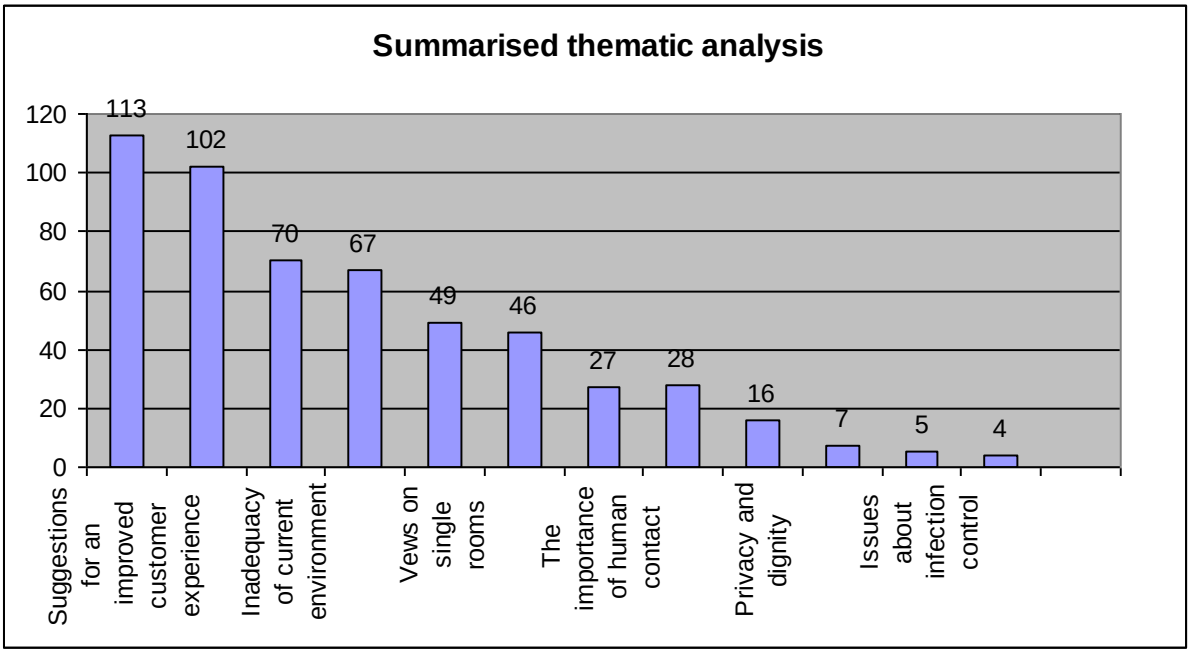


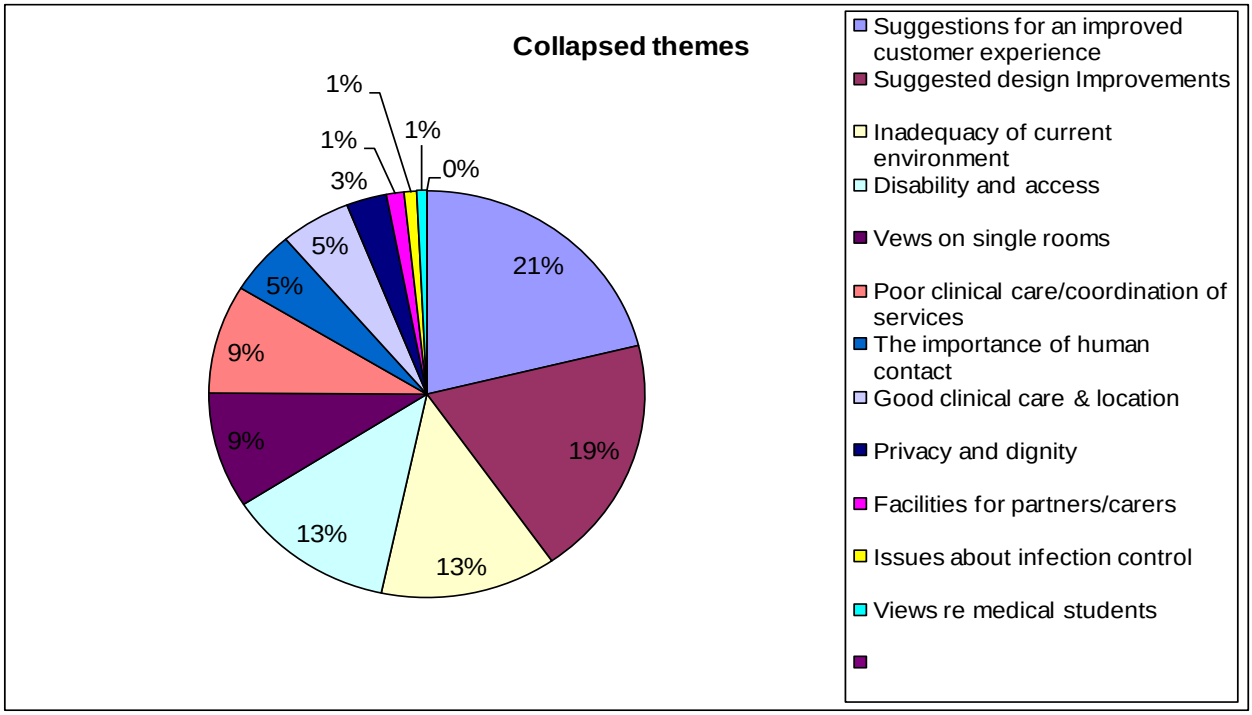
This did not seem very meaningful and was very repetitious. However it did allow issues which were important to patients to emerge such as the following:

- Disability and access
- Facilities for partners/carers
- Infection control
- The importance of human contact

Therefore it felt appropriate to collapse the categories and summarise the thematic areas into more manageable categories as follows:

Collapsed Themes	Number of times
Suggestions for an improved customer experience	113
Suggested design Improvements	102
Inadequacy of current environment	70
Disability and access	67
Views on single rooms	49
Poor clinical care/coordination of services	46
The importance of human contact	27
Good clinical care & location	28
Privacy and dignity	16
Facilities for partners/carers	7
Issues about infection control	5
Views re medical students	4
Total	**534**

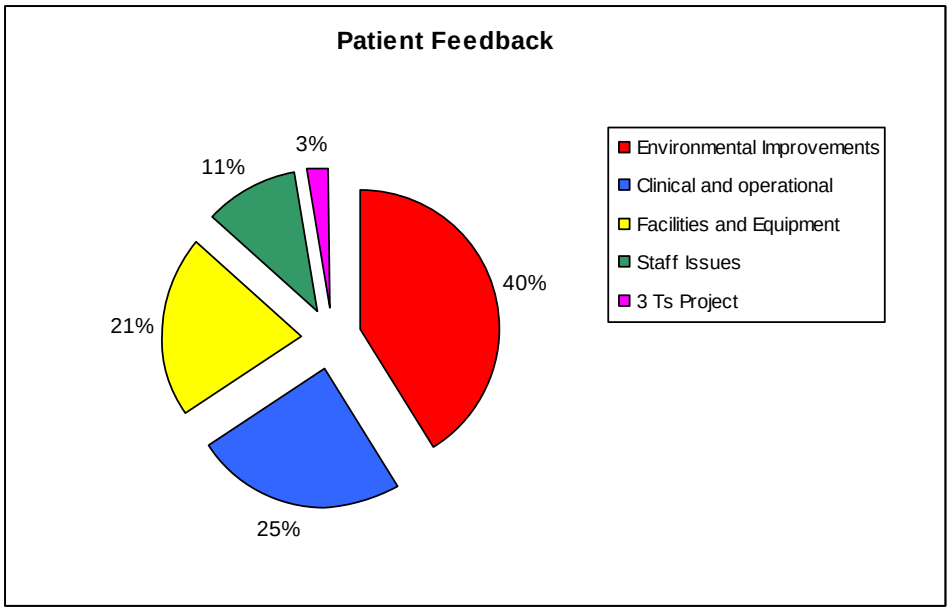




Thus, leaving aside the "promoted" responses such as design improvements, it can be seen that patients/carers are asking us to design a facility which is allows them to be treated with increased privacy and dignity and which is essentially a caring, modern and therapeutic environment as well as a clinically excellent one.

Comparison with 2008-2009 data

This compares well with the data which was collected over the previous two years which was previously presented to the Programme Board. As would be expected, there was some overlap in the membership of those consulted from a LINk perspective, but the more recent exercise contains a much larger sample (from circa 50 people to -circa 125 excluding people consulted via the questionnaire).
Whilst the previous categorisation was analysed differently, the largest categories were broadly equivalent although design improvements are a larger category than clinical/staff issues in the current year than during the previous data collection exercise. This should be seen as a natural development as many of those consulted are now more fully engaged in the design process than the previous year when they used the opportunity give their views about their previous experiences in hospital. Thus the comparison demonstrates the consistency of patient/public concerns over time in the types of issues raised.



Conclusion

This analysis has shown that patients and their carers/visitors are willing to engage in a debate about the way the hospital should be designed. Their views are an additional, rich source of data which can be included within the design information, as it has generated some insights which are only possible when someone has actually been a patient; that is feeling vulnerable, anxious, in unfamiliar surroundings and with additional requirements because of their illness or disability. In this sense the design should facilitate and enable the patient to "get past" the disability and confidently navigate throughout the hospital in order to access the services which they require. This is where hospitals differ from other public buildings; they are used by a larger proportion of sick people and their significant others, who may themselves be feeling stressed and anxious. It is therefore welcome that BSUH has this additional resource to draw on, both for the current design and during the remainder of the design process which will continue to provide an important window into the patient experience, once people have had the chance to process their experience and draw on it for the benefit of others. Comments in **appendix two** will now be forwarded onto the responsible leads for action and response. These leads are also being asked to update their responses to last year's paper.

Further work

The data presented above is to be complemented by a web-based questionnaire which will be on the BSUH web site which has been designed for anyone to use, but it is hoped that patients or members of the public who do not find it easy to attend meetings or visit the hospital in person may find it a helpful feedback mechanism. In this sense BSUH will attempt to reach people who represent other sections of the community as well as those with a long term disability.[1]

Anna Barnes
5th August 2010
With grateful thanks to Mariusz Pryzbytek who assisted with the data categorisation and segmentation.

[1] This report was presented to the Patient and Public Design Panel on the 30th September 2010. I was asked to re-emphasis the importance of infection control in the new design, as it was felt this had been a greater concern than would appear from this analysis.

Appendix one

Data source	Event	Date
Email	Email about Reception from Nicola Fieldhouse	Jun-10
Email	Email from Enid Ball re: changing areas	May-10
Email	Rosemary Rimmer-Clay - Email. Re:Feedback from Patients	15th July 2010
Email	Email from Stewart Boyling - Comments on Flagship Rooms	15th July 2010
Email	Patient Suggestions Cherry Mayers.	15th July 2010
Email	Volunteers' feedback	May-09
Email	Ward suggestions From Norman Webster	May-10
Focus group	Bishop Hannington Memorial Meeting	Jan-10
Focus group	CHD Patient Group Meeting	Monday 14th December 2009 17:00 to 18:30
Focus group	Focus group and semi structured interview questions: Cardiac Group	15th July 2010
Focus group	Focus group at Leach Court: Deaf/Blind social group	18th June
Focus group	Focus group with cancer patients	24th April 2010
Focus group	Notes of Inaugural meeting of the Patient and Public Design Panel Held in the Audrey Emerton Building	25th February 2010 5.15pm-6.45pm
Focus group	Notes of the 3rd meeting of the Patient and Public Design Panel Held in the Lecture Theatre Sussex House	28th April 2010 5.15pm-6.45pm
Focus group	Notes of the 4th meeting of the Patient and Public Design Panel Held in the Royal Alexandra Children's Hospital	27th May 2010 5.15pm-6.45pm
Focus group	A Summary Record of Workshop at St Dunstan's	3rd March 2010
Focus group	Volunteers Focus Group	20/05/2010
Focus group	Write up of focus group with ward volunteers	5th May 2010
Focus group	Focus group with Brighton and Hove Federation of Disabled People	13th July 2010
Individual Interview	Focus group and semi structured interview questions Deaf and blind participant	15th July 2010
Individual Interview	Flagship Room Design Focus Group - The Brighthelm Centre	17th June 2010
Individual Interview	Flagship Room Design Focus Group - The Brighthelm Centre	Thursday 17th June 2010 9:00am to 12:30am
Letter	Letter re glass lift From: Groves, Nick Sent: 24 March 2010 18:05 To: 'bridge.64@ntlworld.com' Subject: RSCH 3Ts Build: Glass Lifts?	24/03/2010 00:00

Appendix two

	Way finding
1	Can we have tactile footpaths so we know we are in a passage way
2	Use technology – audible announcements for location
3	Intranet map
4	Services at PRH: buses don't run after a certain time of night
5	The current situation – issues highlighted include the distance between buildings and slopes up the hill. A suggestion was made that a bus could go up to the top of the hill and there could be a travelator to help move people around the site. It was commented that A&E was a long distance from the front entrance. Signage is a problem and one can get lost in the current building.
6	How about some lines on the ground to guide you to your department
7	Parking no problem in disabled bays. Need more bays.
8	Multiple lifts Colour coding
9	Use of art landmark pieces for signposting
10	Multi lingual signs or assistants
11	Signs which are diagrammatic
12	I would welcome a glass lift to get to different levels as I have a phobia using enclosed lifts
13	less floors the better for wheelchair users and possibly more ramps please
14	40 X works well but needs to be more frequent and is sometimes late
15	Buses should also have announcements (like London buses) as for less mobile people, by the time they realise they have to get up they have missed their stop
16	voice activated signs
17	Avoid bits of paper all over the walls – they are confusing to those people who are sight impaired – have a no notice zone, keep walls simple and bright
18	Rooms numbered in sequence is also helpful
19	Audio guides as in museums were universally agreed as a good idea with the proviso that people with visual impairment rely on their hearing a lot and therefore the earphones must be designed with this in mind i.e earphones go behind one ear
20	No security at all, taken guards away from Millennium

21	Colour zoning for wards

	Reception & Waiting
1	Booking in stations /pods would be esp. useful for BSL/SSE users, for example they can then check in whilst waiting for interpreters, often questions asked at this point are basic and probably would be to Confirm name, address and GP, DOB, clear well structured English may be suitable with yes no options, with good readability and clear options.
2	Vibrating pagers, as an option. This can also alert deaf person to an emergency/fire alarm.. as well as providing privacy and reducing anxiety of missing be called in busy waiting rooms
3	Blind/VI People and who use services frequently will often orientate them selves around furniture, so it is not always a good idea to move furniture/seating location.
4	Background Music
5	Placement of reception areas/desks, together with colour contrasted orientation/location/tactile pathway clues, ideally desks/reception areas could be situated immediately ahead of the front door, with clear signage.
6	Hearing Loop Systems should be permanently fitted in reception areas, and all key rooms.
7	Out-patients need light and airy with different height chairs
8	Need a separate place for buggies and wheelchairs, not across the seating isles.
9	Suggested seats in corridors to help people traverse the site, so they could have a rest on the journey..
10	I asked a question about Art and was told that geometric patters were not to be used as these could trigger epilepsy.
11	Good reading material is very important
12	Customer Care – the biggest issue is training staff in customer care
13	Acoustic ceiling for reception so can hear what people are saying
14	Re: Volunteers--- Requirements: **small office** for hanging coats, make cup of tea (have to make their own) keep belonging safely.-**better desk** (all sit in a row '' influx)-**some permanent staff** – lack of continuity, leaves lots of rubish behind desk – need sufficient storage, not little bits of paper stuck to the wall – need someone to take responsibility-people hand in equipment when should be taking back to dept. (volunteers end up taking them back to dept, e.g. crutches, zimmers)

	Toilets
1	Unisex toilets disliked
2	There should be enough toilets throughout the hospital
3	Two stoma patients mentioned the need to have shelves in toilets so that they did not have to place things on the floor
4	hooks for walking sticks
5	cleaners should not leave cleaning fluids in toilets or bathrooms and that they should be regularly cleaned of bodily fluids
6	the chairs in the waiting areas would have been better with arms for people with mobility problems
7	Use contrast on background tiles to differentiate where the loo is, where the sink is etc
8	Automatic flush is good
9	They asked whether there will be toilets, baby change (not just in the women's toilet) and seating in the main reception area
10	Pedel bins which can be operated by hand for people in wheelchairs
11	Can bathrooms/shower rooms be equipped with bidets ?
12	Could we design and patent a high bidet and earn some money?
13	Can bathrooms/shower rooms be equipped with a) grab rails and b) sufficient hooks , shelves or chairs on which to put towels, wash bags and clothes?

	Ward Design
1	No mixed-sex bays
2	Day case for oncology - prefer single rooms with bed. This allows for better comfort and quiet.
3	When having treatment, often do not feel like holding conversations. A comfy chair would allow partner / friend to to use computer for work, as often there for longish time
4	Can we have sockets which are at waist height, and toilets you can get a drip stand into?
5	Areas have no outside views. We understand that privacy is important but we think sometimes people see cancer as something to be hidden away
6	Bed bound patients are given a commode but no means of hand washing. Would it be possible to supply hand cleaning gel dispensers on the bedside lockers of bed bound patients.
7	Keep the fridge stocked up with healthy choices Ice cream very good when your tastes are shot through chemo, and you are losing weight A la carte ordering much preferred to set meal times Light, tasty snack meals , crackers, cheese fruit Small, medium or large portions should be available.
8	View from bed versus view from staff – layout shown does not make it possible to see the door, and therefore staff, and the view from the window
9	ordering meals on touch screen rather than on paper
10	There was agreement that touchdown bases (i.e. small worktop areas distributed throughout the ward) were a good idea to ensure nurses spend more time with patients.
11	Rather than curtains or blinds which require regular cleaning I think venetian blinds enclosed in the double glazing, might be preferable. Perhaps if they were coloured it would reduce their impersonal / clinical appearance.
12	The comfortable chair placed next to each bed ought to be covered with a wipe able waterproof covering rather than ordinary fabric which is easily soiled and can look very grubby within a short time
13	Would it be feasible to fit an intercom to the nurse call system e.g.. if a patient were to ring for a bedpan the caregiver could communicate with the patient and could go to the patient fully equipped rather than having to go to the patient, ascertain the need, go away and get whatever is needed then go back to the patient.

	Clinical Care
1	People not introducing themselves
2	Nursing stations on wards – a few people felt that these were just used as areas to chat and were noisy and busy, and wondered whether there was some rules that meant they had to be in the middle of the ward
3	When you buzz a nurse and there is a delay in them coming then want to know the reason for this
4	“Give staff their own space to chat so they don’t do it in front of patients”
5	Make information available across the departments Stop admin staff loosing files.
6	Can you get someone with the right skill level to take the blood? Several stories of nurses seeing people with tiny veins as a challenge, (!) even though the patient knows from experience that they won’t be able to find the vein unless they are a specialist phlebotomist and they will keep trying until it hurts.
7	Nurses’ station too busy, too chatty. Keep away from the beds
8	could the evening drink trolley include glasses and small bowls for those patients who wanted to clean their teeth?
9	Top things we should leave behind or fix• Staff training and awareness re visual impairment.
10	No help to eat meals
11	No coordination on arranging discharge.
12	Services poor at weekends.

	Changing
4	Not using curtains on changing cubicles because material does not protect auditory privacy, is not solid so is not something you can hold onto, people with visual impairment often need something to hold onto to balance.
5	Bell/alert would be good – not as in an emergency but if something happens or you need someone and need to call them discreetly
6	Mechanism of letting people know how long they are waiting so they don't feel as if they have been forgotten
7	There must be hoist facilities
8	Rails you can hold onto whilst getting changed
9	Enough room for a carer if you need assistance.
10	Concern about the patient examination and treatment rooms being sound proofed if people were waiting next to them

	Examination and Consultation Rooms
1	Toilets outside consulting areas and you get locked out (Preston Park) and can't get back through the key pad door.
2	There needs to be enough room round the couch to accommodate the doctor and carer
3	Medical students should sit in line of sight of the patient so they can see what they are doing (not behind their back)
4	Need to prevent staff coming into the room and interrupting the consultation (very intrusive and off-putting)
5	Good to be able to show results etc on the PC screen
6	Air conditioning would be good
7	(Walking on) cold floors – under floor heating?
8	Anatomy etc diagrams hidden behind closing whiteboard so that you can write/draw on the closed side
9	Ventilation that means doors don't need to be opened or fans used
10	Lose the desk – there was a fair amount of consensus that desks are a barrier to proper communication and interaction. Desks where doctors have to turn their back to you to write or type were considered just as bad

	Patient as consumer
1	Electronic patient records
2	Couldn't the design be even more curved, and more organic, and a lot less like something made out of lego? .
3	There should be drinking fountains and a space for nursing mothers
4	Don't use corridors as waiting areas
5	The use of pagers at the Marsden was given as an example of making waiting less inconvenient, so that people can go and have coffee then be buzzed when it is nearly time for their appointment.
6	WH Smith charges higher prices in the shop than it does on the high street, ie. comparable with airports.
7	Design of packaging. As the National Health Service presumably wields immense power on the pharmaceutical industry, would it be possible to insist on certain specifications for packaging? Many individually packed tablets are difficult to access for patients with limited manual dexterity.. Child- proof screw top bottles of tablets are unfortunately also patient proof. I have seen elderly patients who live alone asking the pharmacist to unscrew the tops of bottles when they collect their prescriptions. How about asking Universities to get their Design/Pharmacy students to design packaging following your specifications? Small competition for this and the bidet as incentive?
8	It was suggested that as portable entertainment systems were becoming increasingly common the design should be developed with this in mind (Patients able to access Wi Fi, charging points).

	Temperature and Noise
1	"Lighting needs improvement". One person with visual impairment and a neurological disorder explained that too bright light can trigger epilepsy.