KALEIDOSCOPE Health and Care

nuffieldtrust

Research on staff, patient and public perceptions and needs to influence the development of our hospitals

Appendices

Imperial College Healthcare NHS Trust

August 2020

About these appendices

This document provides six appendices in relation to the final report “Research on staff, patient and public perceptions and needs to influence the development of our hospitals.”

Contents

Appendix 1. Research Framework

Purpose: This research framework illustrates the structure of our approach, mapping existing and primary data collection and analysis according to the research questions which this project aims to explore, understand, and answer.

Research questions	Secondary / existing evidence	Primary data collection / Research activity
A. What do we [the Trust] already know? A.1: What has the Trust already been told as a result of previous engagement on the redevelopment of St Marys? A.2: Are there any gaps, missed opportunities, or things done less well by the Trust in the approach taken by the Trust in their prior engagement? A.3: Are there gaps in knowledge for certain groups? A.4: Would the Trust benefit from a targeted approach with certain audiences to inform any future engagement?	Friends and family feedback Complaints/Patient Advice and Liaison Service (PALS) National patient surveys National NHS staff surveys Care Quality Commission (CQC) inspection reports Patient Led Inspections of the Care Environment (PLACE) inspections Healthwatch reports Relevant existing developments eg; wayfinding programme, virtual outpatient pilot; Covid-19 reset surveys Initial research with volunteers and lay partners Big Room synthesis documents	This question is primarily informed through desktop research and refined through interviews, discussion and meetings. Redevelopment Communications Working Group meetings: • 15/06/2020 • 18/06/2020 Steering group - Meeting 1
B. What are the priorities for this redevelopment? B.1 What are the Trust's priorities for this redevelopment? B.2 What do other stakeholders see as priorities for this redevelopment?		This question is informed through desktop research, survey, interviews, discussion and meetings.

C. Covid-19 C.1 How have the changes in receiving or providing care as a result of Covid-19 made stakeholders think differently about delivering/receiving care in the future? C.2 If there have been any positive changes in care resulting from Covid-19 how might stakeholders like to see these influence the redevelopment of the hospital?	ICHT – Covid-19 Response – Survey Results BAME Health forum meeting notes Big Room synthesis pack	This question is informed through desktop research, survey, interviews, discussion and meetings.
Domain 1: Kind 1. What makes a kind hospital? 2. What can design do to make a patient feel respected in hospital? 3. What can design do to make a patient feel included in their treatment? 4. How could being treated or working at St Mary's be made kinder in the future?	Initial research data Friends and Family data for patient experience Complaints data	Three 90 minute virtual workshops to explore the priority questions put forward by the steering group Community groups Online survey to be used across key involvement groups Interviews – option of a short telephone consultation or survey follow-up call
Domain 2: Expert 1. What is expert care and treatment at St Mary's now? 2. What could expert care and treatment look like in the St Mary's of the future? 3. How could the new St Mary's help stakeholders to make the best use of your expertise? (staff and patients). 4. What features matter to stakeholders in creating a safe and professional environment? 5. What would feel out of date at the new St Mary's when it is completed in 10 years time?		Three 90 minute virtual workshops to explore the priority questions put forward by the steering group Community groups Online survey to be used across key involvement groups Interviews – option of a short telephone consultation or survey follow-up call

Domain 3: Collaborative 1. How might the redevelopment of St Marys benefit the local community? 2. How might the redevelopment best serve the multiple populations it serves? 3. How could the design support or improve informal collaboration (e.g. corridor chat and spontaneous problem solving)? 4. How important are adjacencies to other services in helping staff succeed in their work? [staff only] 5. What is the staff perspective on the value of protected space? [staff only]		Three 90 minute virtual workshops to explore the priority questions put forward by the steering group Community groups Online survey to be used across key involvement groups Interviews - option of a short telephone consultation or survey follow-up call
Domain 4: Aspirational 1. What do stakeholders experience approaching the hospital now? What would you like to see change in the future? (Surrounding environment, appearance, personal experience etc) 2. What do stakeholders experience once they are *in* the hospital; entering it, waiting, using catering and/or other facilities? What would they like to see change in the future? 3. What aspects of design contribute to a positive hospital experience? a. Appearance b. Art c. Light d. Sustainability e. Design that reflects the community served f. Design that honours the history of the institution 4. What features of St Mary's do stakeholders wish to retain and lose in the redevelopment?		Three 90 minute virtual workshops to explore the priority questions put forward by the steering group Community groups Online survey to be used across key involvement groups Interviews – option of a short telephone consultation or survey follow-up call

Appendix 2. Stakeholder Steering Group Membership

Name	Role, Group, Affiliation
Caroline Weller	Staff group chairs - Women's Network
Chloe Norton	Staff group chairs - Disability network
Daniel Marshall	Staff member
Duygu Yenidogan-Schmidt	Lay Partner and carer at St Mary's Hospital
Fiona Stubbs	Staff group chairs - LGBT+
Gabrielle Matthews	Community contact - Young people's advocate
Jane Wilmot	Disability champion, Lay Partner
Julie Fletcher	Lay Partner and volunteer
June Parker	Staff member
Kara Firth	Staff member
Karen Doherty	Staff member
Marilyn Warnick	Lay Partner
Nafsika Thalassis	BME Forum, Lay Partner
Samira Ben Omar	Community contact, Community Lives
Sarah Kinsella	Lay Partner, patient and previously involved in redevelopment
Shanaka Dias	Lay Partner and patient at St Mary's Hospital
Winsome Thomas	Staff group chairs - Nursing and Midwifery BAME Network

Appendix 3. List of community groups contacted

- Action on Disability Hammersmith and Fulham
- Action on Disability Kensington and Chelsea
- BME Health Forum
- Care Solution Bureau
- Ethiopian Women's Empowerment Group
- French African Welfare Association
- GALOP
- Healthwatch Westminster
- Imperial as One
- Imperial College Healthcare NHS Trust – Children and Young People's Group
- Imperial College Healthcare NHS Trust – Connecting Care 4 Children
- Imperial College Healthcare NHS Trust – Disability Network
- Imperial College Healthcare NHS Trust – LGBT+ Network
- Imperial College Healthcare NHS Trust – Multidisciplinary BAME Network
- Imperial College Healthcare NHS Trust – Safeguarding Team
- Imperial College Healthcare NHS Trust – Womens' Network
- Imperial College Healthcare NHS Trust – Young People's advocate
- Marylebone Bangladesh Society
- Midaye Somali Development Network
- Middle Eastern Women and Support
- Mosaic Community Trust
- MS Society West Central London Group
- One Westminster
- Paddington Development Trust
- People Arise Now
- People First
- The Advocacy Project
- WAND UK
- West London Buddhist Centre
- Young Healthwatch

Appendix 4. Semi-structured interview guide

Imperial College Healthcare NHS Trust - interview agenda

Introduction to the work

Hi my name is X and I work for Kaleidoscope Health and Care. Firstly I'd like to thank you for taking the time to talk to me today – I really appreciate it and your feedback will be very useful for this project. To get things started, I'd like to introduce you to the work we're doing on behalf of Imperial College Healthcare NHS Trust.

In 2019 Imperial College Healthcare NHS Trust launched a major programme to redevelop and refurbish its hospitals. This includes proposing to build a completely new St Mary's Hospital on the existing hospital site in Paddington.

The Trust wants as many staff, patients, partners and local community members as possible to help shape the new hospitals, starting with St Mary's as the site most in need of redevelopment.

The Trust wants to know how you would like to access the new St Mary's Hospital, what it should look and feel like and to think about how we can make the new site a real asset for the community.

Interviews such as this one are part of a range of ways the Trust, supported by Kaleidoscope Health and Care, is starting this conversation.

Permissions

Now for some necessary formalities. This interview will last approximately 30 minutes. You are under no obligation to take part; you can ask me any questions you want before or throughout; you can also withdraw at any stage without giving a reason.

Your name will not be included in any publications related to this research, however we may choose to quote you directly and attribute it to 'a respondent / a participant'.

Any interview data will be kept confidential and stored securely. At the end of this piece of work all data will be deleted from our system in accordance with GDPR guidelines, and our own data protection policy.

So before we start I'll just need to check you're ok with the following:
> Do you give me permission to carry out this interview? YES/NO
> Do you give me permission to include anonymised quotes in the publication of this research report? YES/NO

Discussion guide

Firstly can you tell me who you are and why you have an interest in the redevelopment of hospitals?
Thank you for that introduction, now I'd like to explore what your relationship to Imperial College Healthcare NHS Trust (the Trust) is / has been in the past.

1) Do you know who Imperial College Healthcare NHS Trust is?
2) Which of the Trust's hospitals sites have you used in the past / currently use (provide prompts to potential sites if needed and note if they have used St Mary's)

- Charing Cross Hospital
- Hammersmith Hospital
- Queen Charlotte's and Chelsea Hospital
- St Mary's Hospital

3) Have you been involved in previous engagements with the Trust? (By which we mean have you given your time to help the Trust by offering your views or feedback on a piece of work or consultation they have undertaken)
    - IF YES: What were they?
    - IF NO: Why not? Can you think of any barriers that have prevented you from engaging with the Trust, either for you or the group you represent?

We're going to move on to your past experiences of care in hospitals, particularly thinking about the different ways a building can affect the care patients receive.

4) Think about a time you have been in hospital (in whatever role) when you have seen really exceptional care. What made that experience stand out?
5) How important do you think buildings are in helping to provide / receive exceptional care?
6) Now I'd like you to imagine a hospital which always delivers exceptional care for patients. What do its buildings look like?
7) What aspects of design do you think matter most to a positive hospital experience?
8) In your experience, how can a hospital building support how a patient feels respected?
9) How can hospital buildings support kindness in care?

Ask if participant has attended St Mary's hospital:

10) Thinking about your experience with St Mary's, what would you like to see kept as part of the hospital redevelopment?
11) Thinking about your experience with St Mary's, what would you like to see change as part of the hospital redevelopment?

Final reflections:

12) Reflecting on all our conversations today, what one piece of advice would you give to Imperial College Healthcare NHS Trust in the redevelopment of its hospitals?

AOB:

13) What further points on this topic would you like to make which you haven't had a chance to make?

Appendix 5. Methodological limitations

Our online survey had several limitations to be considered in the next phase of engagement, especially with regard to certain demographic groups. This survey was live for four weeks and we were able to promote it across a number of digital channels (Twitter, Facebook, LinkedIn), circulated through existing Trust mailing lists and the Trust Intranet, and directly promoted to 30 community groups through verbal and email communication. Nevertheless, the sample size in most demographic subgroups is too small to generalise widely or to quantitatively infer association with other variables especially when disaggregated by stakeholder group. This affects ethnicity, religion and sexuality, and to some extent age. We also obtained small numbers in the subgroups of long term conditions, which precluded analysis disaggregated to that level, although we were able to merge the data in this category to a binary variable of 'one or more long term conditions' and 'no long term conditions'. For age, in some instances we were able to collapse the two oldest age categories into one category to allow some comparison between age groups.

Our survey was designed to be as inclusive as possible, and in recognition that respondents may hold multiple identities as stakeholders. This meant that we permitted respondents to self-identify as one or more of the key stakeholder groups, which makes it difficult to quantitatively isolate true differences between the stakeholder groups. To mitigate this, we report and present most data as a proportion of the specific subcategory, and caution generalising at every subgroup level.

The limitations in the quantitative survey data are to a good degree mitigated by the mixed-methods approach where we engaged directly with various community groups and gathered data that generated rich qualitative insights at subgroup level. This qualitative analysis complements the quantitative survey data and gives more nuance and narrative examples than the survey would be able to produce alone. Surveys produce the most useful quantitative data when the sample sizes are large enough to allow differentials analysis at subgroup level, and ideally the next phase of the engagement would include a survey with a much larger sample that would be live for a longer period of time, with increased resources to permit a longer period of targeted outreach to minority groups to encourage greater survey participation. This approach may permit – if desired – analysis of association and correlation with statistical significance, to understand better trends, differences and commonalities within the data.

Limitations relating to the qualitative side of this research (participatory workshops, community outreach and interviews) relate to the nature of qualitative research. Qualitative work uses smaller samples but is more in depth, and was therefore deemed appropriate for this research which is exploratory in nature. In relation to the workshops, the number of participants who attended is a limitation that must be considered (N=37). Although these smaller numbers increased the likelihood of each participant being able to actively participate and voice their

views, a smaller number overall reduces the likelihood of these views being reflective of the Trust's stakeholders as a whole.

Similar limitations associated with the community outreach strand of this engagement include first and foremost the limited number of groups (N=7) we had the opportunity to speak to. This limitation to the research revolved around issues with recruitment for these community groups, stemming from either an absence of time for groups to participate, or a lack of resources on their side to help organise a group session, or a lack of existing meetings to participate in. Based on feedback from a limited number of community groups, these issues were exacerbated by the timing of our engagement, the majority of which was during the school summer holidays and at the end of an extended period of Covid-19 lockdown. This is likely to have impacted on the number of participants available for engagement via community groups.

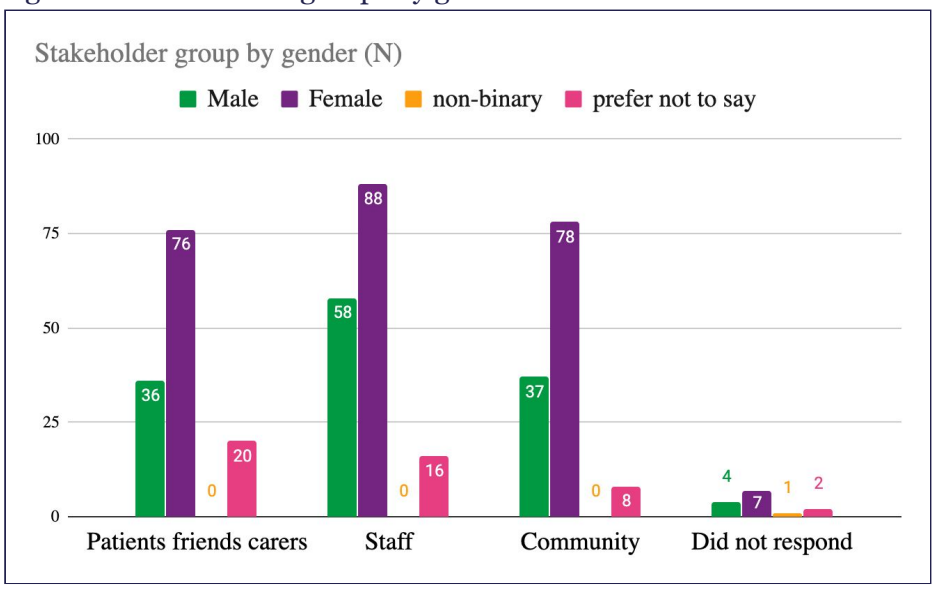
Two semi-structured interviews were conducted with respondents who were unable to participate in this engagement digitally. This small number is again reflective of a general limitation related to qualitative research, in that it is not reflective of the participating audience.

There was a short timeframe to perform data analysis which limited our capacity to perform an extensively in-depth analysis. We analysed 1746 qualitative excerpts mapped across all four primary data collection domains, associated with a priori and emerging themes. A wealth of quantitative data has been analysed and presented across the four closed survey questions, each disaggregated by stakeholder group, gender, sexuality, age, ethnicity, religion, and long term condition. This was a short project to produce swift insights, and more iterative and in-depth analysis of the data could be performed in the near future.

Appendix 6. Data annex

Analyses of the quantitative survey data are presented in this appendix. Table A1 on the following page describes the survey sample according to demographic and health variables. In total 145 respondents identified as female, 74 as male, one as non-binary and 28 chose not to answer the gender question. In each stakeholder group there are substantially more female than male respondents (Figure A1).

Figure A1. Stakeholder groups by gender



The majority of respondents in all stakeholder groups identified as heterosexual (71% overall) (Figure A2). Between 7% and 10% of respondents in each stakeholder group identified as Gay man (n=21 overall) and very few respondents identified as Gay woman (n=4) or Bisexual (n=4).

Figure A2. Stakeholder group by sexuality

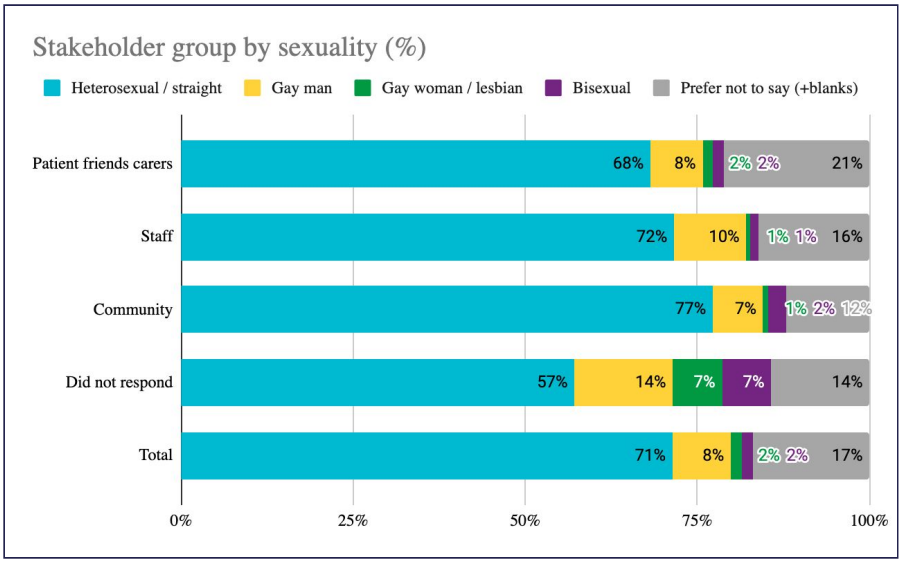
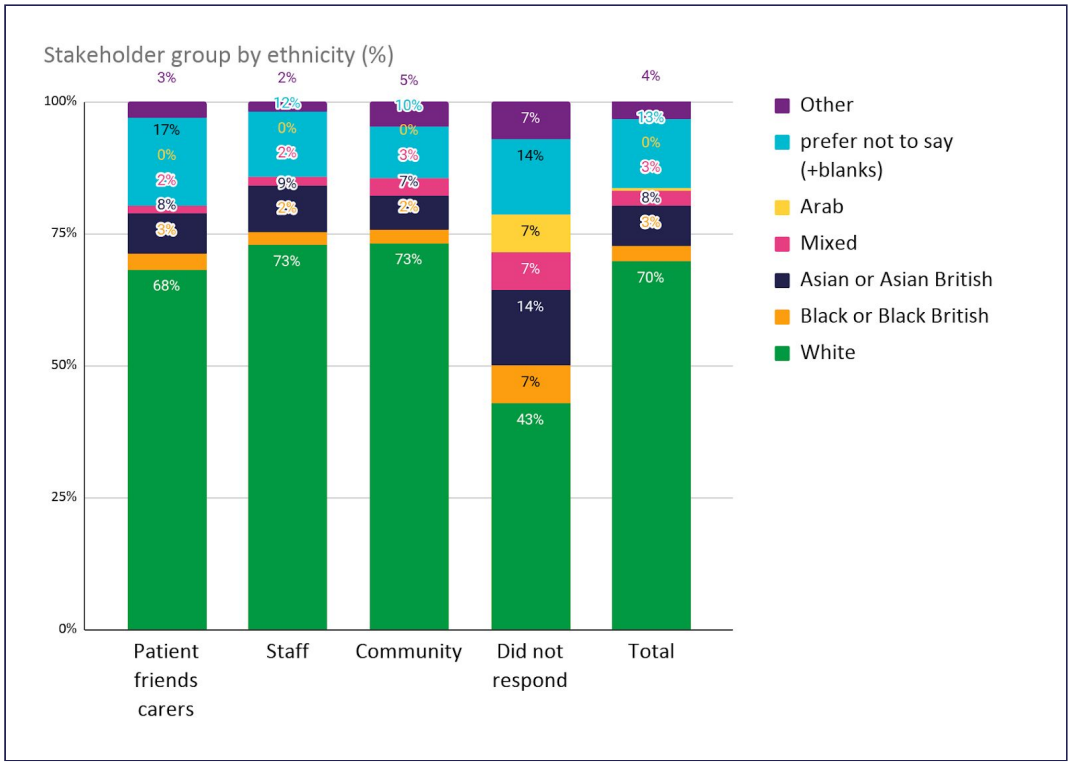


Table A1. Survey sample description

	Patient friends carers		Staff		Community		Did not respond		Total	
	N	%	N	%	N	%	N	%	N	%
All	132	53%	162	65%	123	50%	14	6%	248	100%
Gender										
Male	36	27%	58	36%	37	30%	4	29%	74	30%
Female	76	58%	88	54%	78	63%	7	50%	145	58%
non-binary	0	0%	0	0%	0	0%	1	7%	1	0%
prefer not to say (+blanks)	20	15%	16	10%	8	7%	2	14%	28	11%
Age categories										
16-30	11	8%	26	16%	15	12%	1	7%	32	13%
31-45	28	21%	64	40%	35	28%	5	36%	79	32%
46-60	33	25%	45	28%	34	28%	4	29%	65	26%
61-75	30	23%	9	6%	23	19%	2	14%	35	14%
76+	11	8%	4	2%	7	6%	0	0%	11	4%
prefer not to say (+blanks)	19	14%	14	9%	9	7%	2	14%	26	10%
Ethnicity										
White	90	68%	118	73%	90	73%	6	43%	173	70%
Black or Black British	4	3%	4	2%	3	2%	1	7%	7	3%
Asian or Asian British	10	8%	14	9%	8	7%	2	14%	19	8%
Mixed	2	2%	3	2%	4	3%	1	7%	7	3%
Arab	0	0%	0	0%	0	0%	1	7%	1	0%
prefer not to say (+blanks)	22	17%	20	12%	12	10%	2	14%	33	13%
Other	4	3%	3	2%	6	5%	1	7%	9	4%
MLTC										
One or more condition	63	48%	41	25%	46	37%	4	29%	82	33%
Alzheimer's disease or other cause of dementia	0	0%	0	0%	0	0%	0	0%	0	0%
Arthritis or ongoing problem with back or joints	24	18%	11	7%	17	14%	0	0%	26	10%
Autism or autism spectrum condition	0	0%	1	1%	0	0%	0	0%	1	0%
Blindness or partial sight	3	2%	0	0%	1	1%	0	0%	3	1%
A breathing condition such as asthma or COPD	14	11%	8	5%	11	9%	2	14%	16	6%
Cancer (diagnosis or treatment in the last 5 years)	2	2%	2	1%	4	3%	0	0%	4	2%
Deafness or hearing loss	7	5%	2	1%	6	5%	1	7%	9	4%
Diabetes	2	2%	2	1%	1	1%	0	0%	4	2%
A heart condition, such as angina or atrial fibrillation	5	4%	2	1%	4	3%	0	0%	5	2%
High blood pressure	17	13%	8	5%	12	10%	1	7%	20	8%
Kidney or liver disease	2	2%	1	1%	1	1%	1	7%	3	1%
A learning disability	1	1%	2	1%	2	2%	0	0%	2	1%
A mental health condition	12	9%	11	7%	10	8%	0	0%	15	6%
A neurological condition, such as epilepsy	2	2%	1	1%	1	1%	0	0%	2	1%
A stroke (which affects your day-to-day life)	1	1%	1	1%	0	0%	0	0%	1	0%
Another long-term condition or disability	19	14%	12	7%	9	7%	0	0%	22	9%
I do not have any long-term conditions	31	23%	64	40%	41	33%	3	21%	83	33%
Prefer not to say (not inc blanks)	8	6%	9	6%	8	7%	1	7%	14	6%
Other	8	6%	2	1%	6	5%	1	7%	10	4%
Sexuality										
Heterosexual / straight	90	68%	116	72%	95	77%	8	57%	177	71%
Gay man	10	8%	17	10%	9	7%	2	14%	21	8%
Gay woman / lesbian	2	2%	1	1%	1	1%	1	7%	4	2%
Bisexual	2	2%	2	1%	3	2%	1	7%	4	2%
Prefer not to say (+blanks)	28	21%	26	16%	15	12%	2	14%	42	17%
Religion										
Hindu	1	1%	2	1%	1	1%	1	7%	3	1%
Sikh	1	1%	2	1%	1	1%	1	7%	3	1%
Christian	56	42%	70	43%	50	41%	1	7%	94	38%
Buddhist	1	1%	2	1%	2	2%	0	0%	3	1%
No religion	34	26%	49	30%	41	33%	5	36%	80	32%
Muslim	2	2%	6	4%	4	3%	2	14%	9	4%
Jewish	5	4%	4	2%	3	2%	1	7%	6	2%
Prefer not to say (+blanks)	31	23%	25	15%	21	17%	3	21%	46	19%
Other	2	2%	3	2%	1	1%	0	0%	4	2%

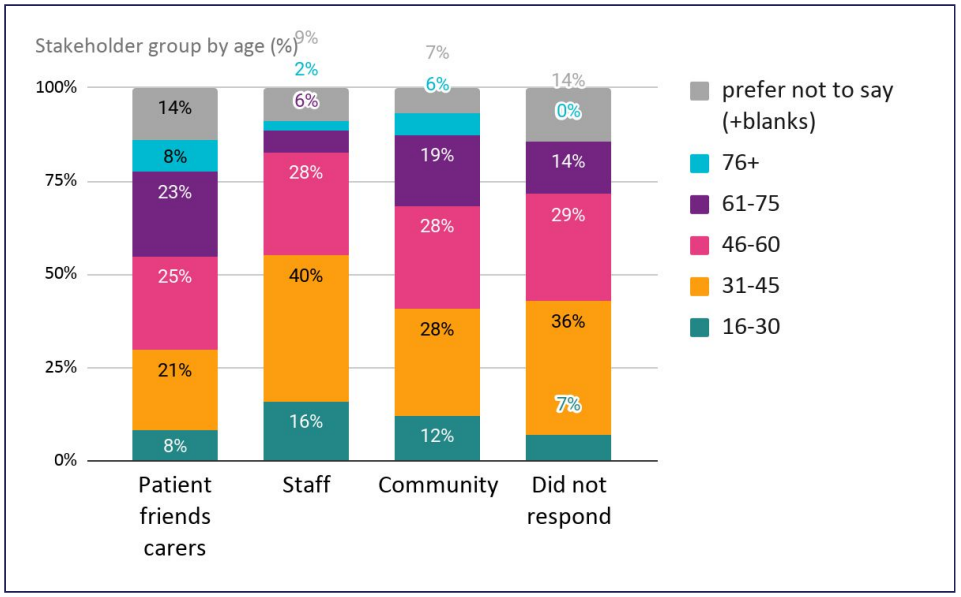
Survey respondents report a mix of ethnicities and although the sample is predominantly 'white' (70%) the spread of ethnicities are broadly similar across the stakeholder groups (Figure A3). There is a greater range of ethnicities within the group of respondents who chose not to select a stakeholder group.

Figure A3. Survey stakeholder group by ethnicity



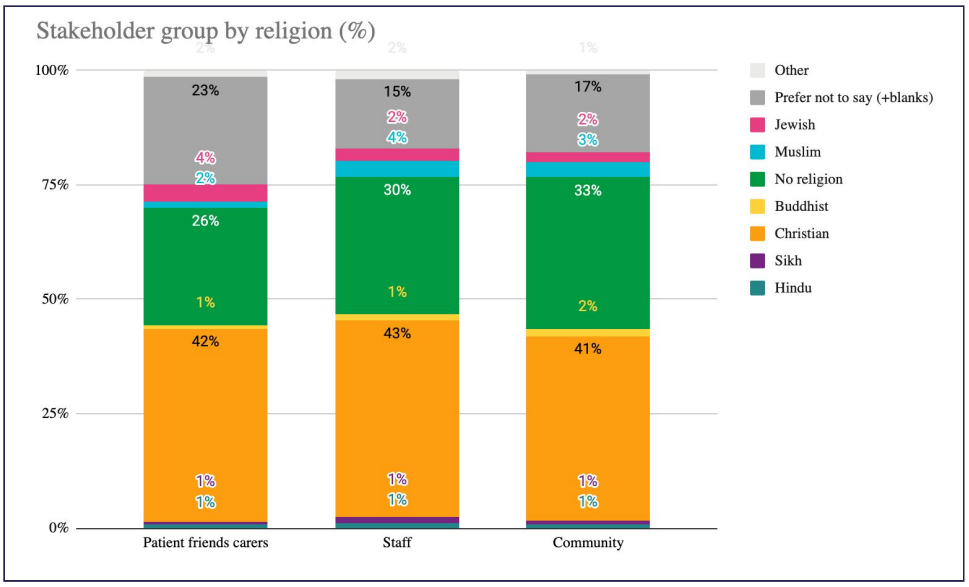
There are a range of ages in the survey sample with a similar distribution of age across the stakeholder groups, albeit with fewer over 61s and substantially more 31–45s in the staff group, which is to be expected given the working age population (Figure A).

Figure A4. Stakeholder group by age



Religion is generally the same across the three stakeholder groups. The most common religious affiliations are Christianity (38%), or no religion (32%) (Figure A5).

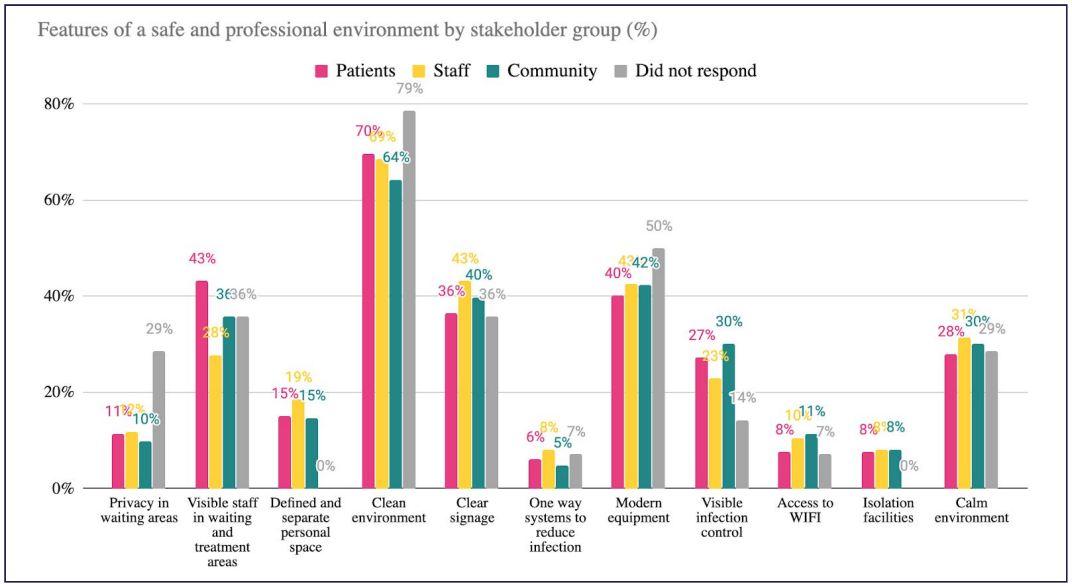
Figure A5. Stakeholder group by religion



Analysis of features of a safe and professional environment

Survey respondents were asked to select their top three design features that give confidence of a safe and professional environment. Community, staff, and patients agreed that the top features are clean environment, modern equipment, clear signage, and visible staff in waiting and treatment areas. Patients prioritised visible staff slightly more than other stakeholder groups (Figure A6).

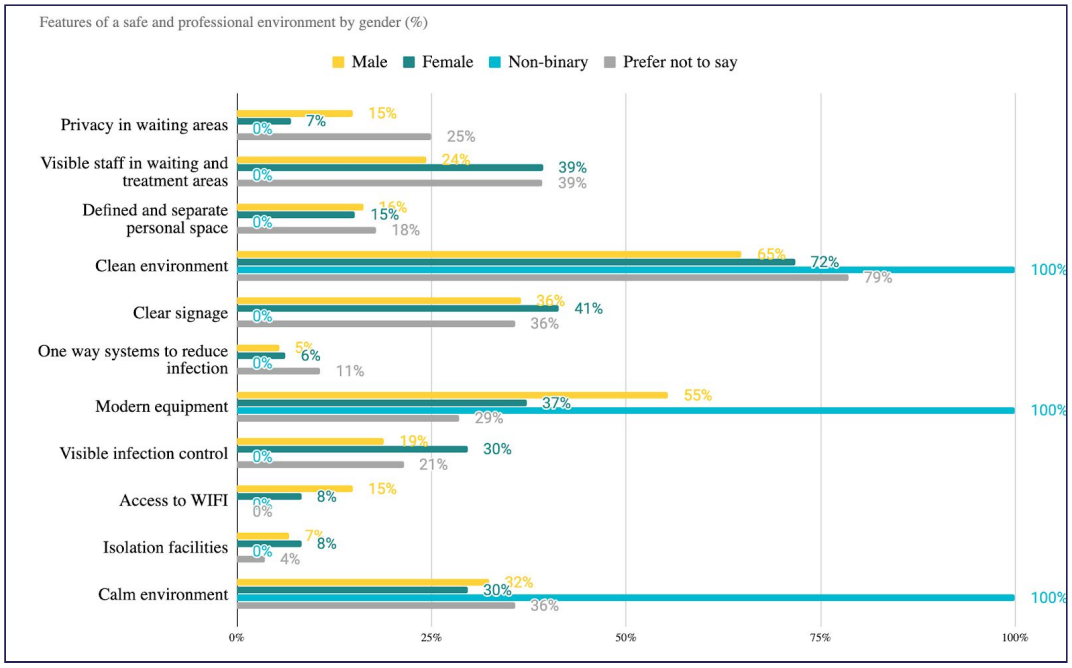
Figure A6. Features of a safe and professional environment by stakeholder group (as % of stakeholder group)



There were small differences between gender groups (Figure A7). The top choice among both male and female respondents was clean environment (M=65%; F=72%). Modern equipment was ranked second (55%) and clear signage (36%)

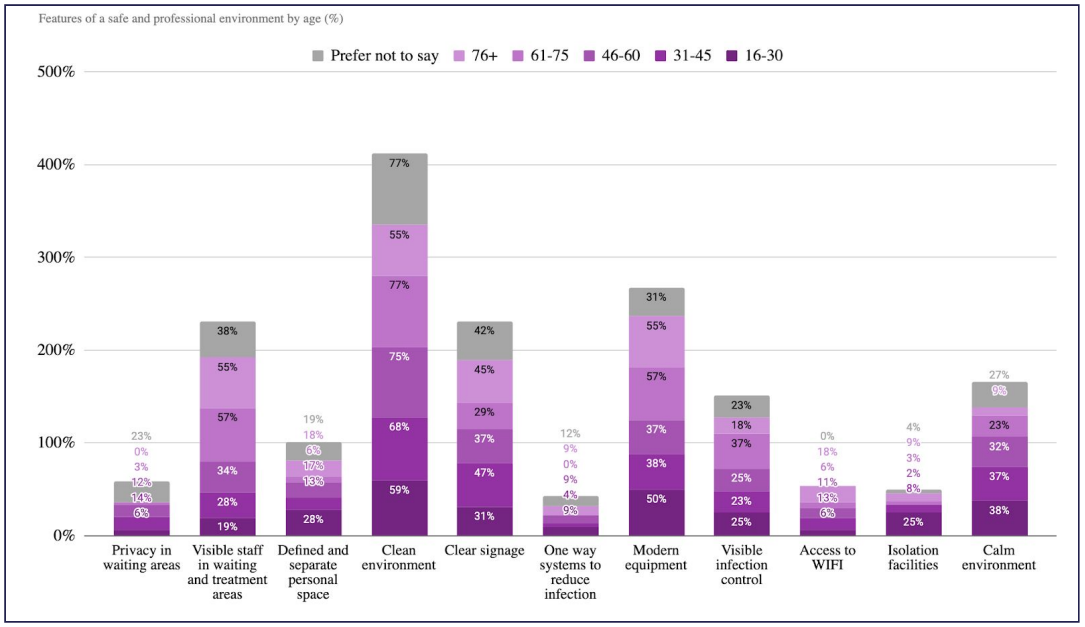
ranked third among male respondents. Among female respondents clear signage ranked second (41%) and visible staff ranked third (39% - which was selected by only 24% of male respondents). Just one respondent identified as non-binary gender.

Figure A7. Features of a safe and professional environment, by gender (as % of gender category)



There is some consistency among age groups regarding features of a safe and professional environment (Figure A8). Clean environment ranks first among all age groups. However, older age groups are more likely to prefer visible staff in waiting areas and less likely to prefer a calm environment than younger groups.

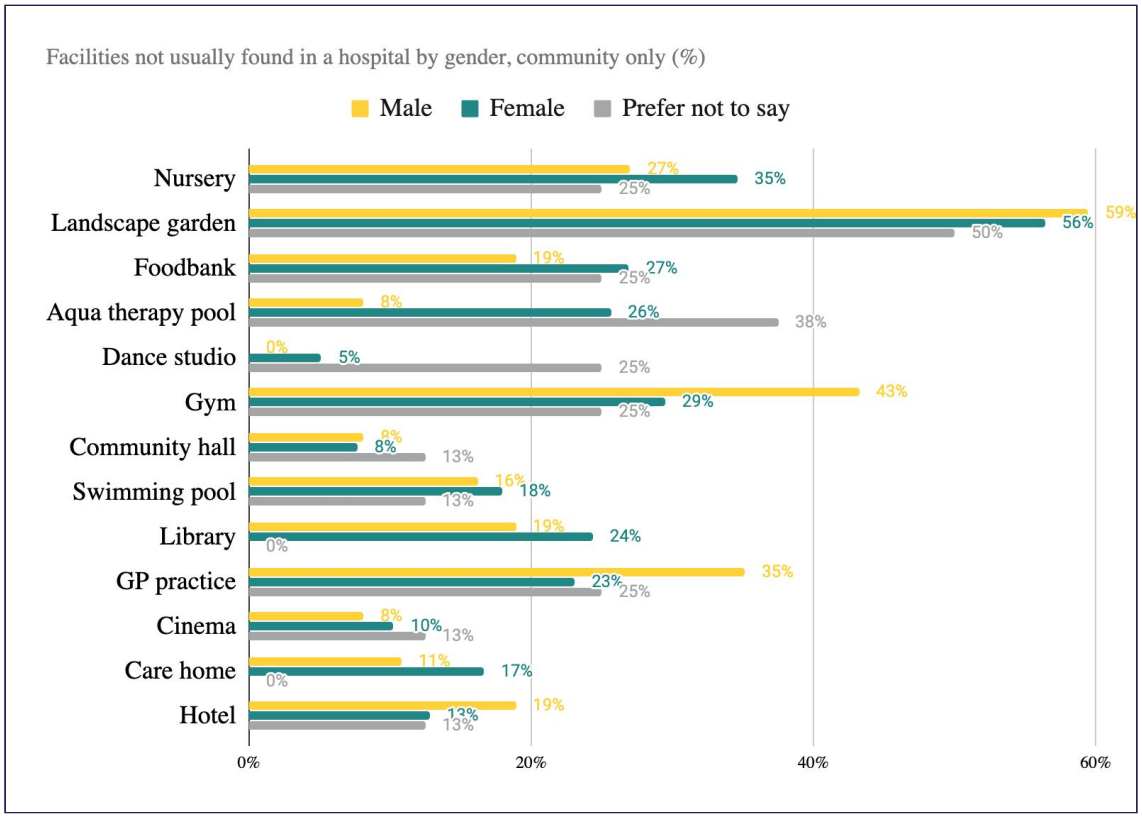
Figure A8. Features of a safe and professional environment by age (as % of age group)



Analysis of facilities not normally found in hospitals (community only)

Community members were surveyed on their top three preferred facilities that would not normally be found in a hospital setting (Figure A9). The most popular choice was a landscaped garden (57%), followed by gym (33%), nursery (32%) and GP (27%). Yet the choices differed slightly by gender[1]. Both men and women equally preferred the landscaped garden, but women slightly preferred a foodbank and aqua therapy pool over the GP practice. A higher proportion of men chose the gym than women (M=43%; F=29%), and vice versa for the nursery (M=35%; F=27%).

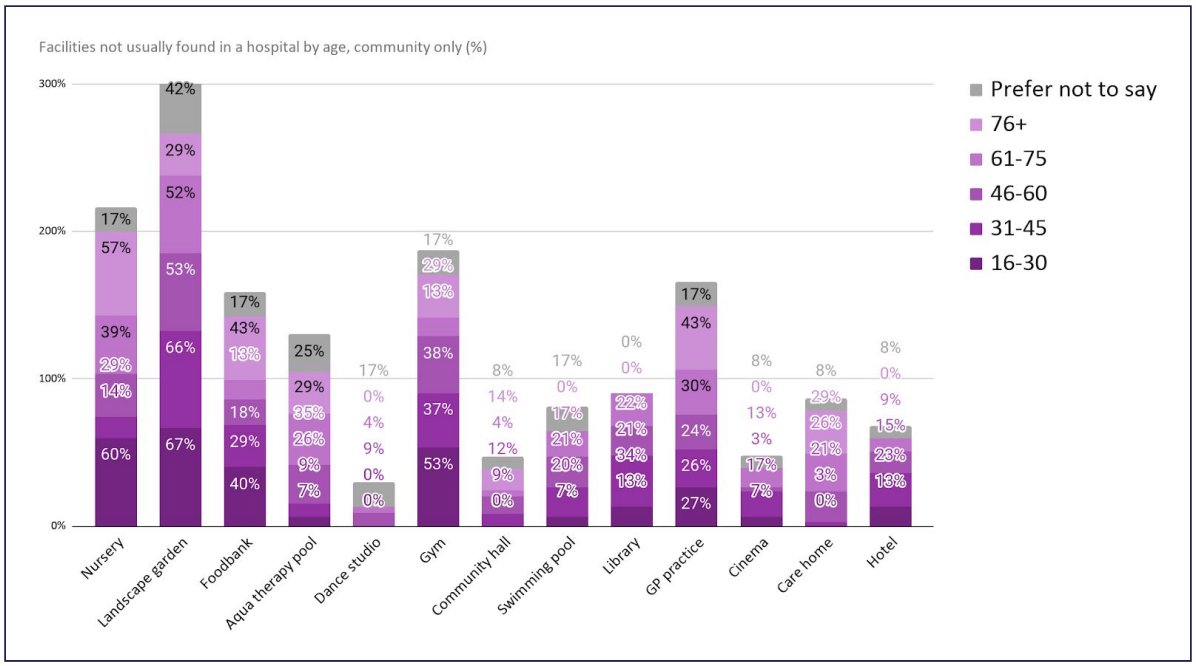
Figure A9. Preferred hospital facilities by gender (community only) (as % of gender category)



There are differences by age, although small numbers of respondents in the top age group for stakeholders identifying as community members (N=7) (Figure A10).

[1] 'Non-binary gender' was available as a selection option, however no respondents used this gender option and completed the questions for Community members.

Figure A10. Facilities not usually found in a hospital by age (community only) (as % of age group)



We collapsed age into two age groups (61 and over, and 60 and under) and removed those who did not state their age, which allowed a more meaningful comparison between age groups (Table A2). Over 61s rank: #1 Landscape garden (47%), #2 Nursery (43%), and joint #3 GP practice (33%) and aqua therapy pool (33%) as highest priorities. Under 61s rank #1 Landscape garden (61%), #2 Gym (40%), #3 Nursery (29%) and #4 Foodbank (26%) as highest priorities.

Table A2. Facilities not usually found in a hospital by age group (community only)

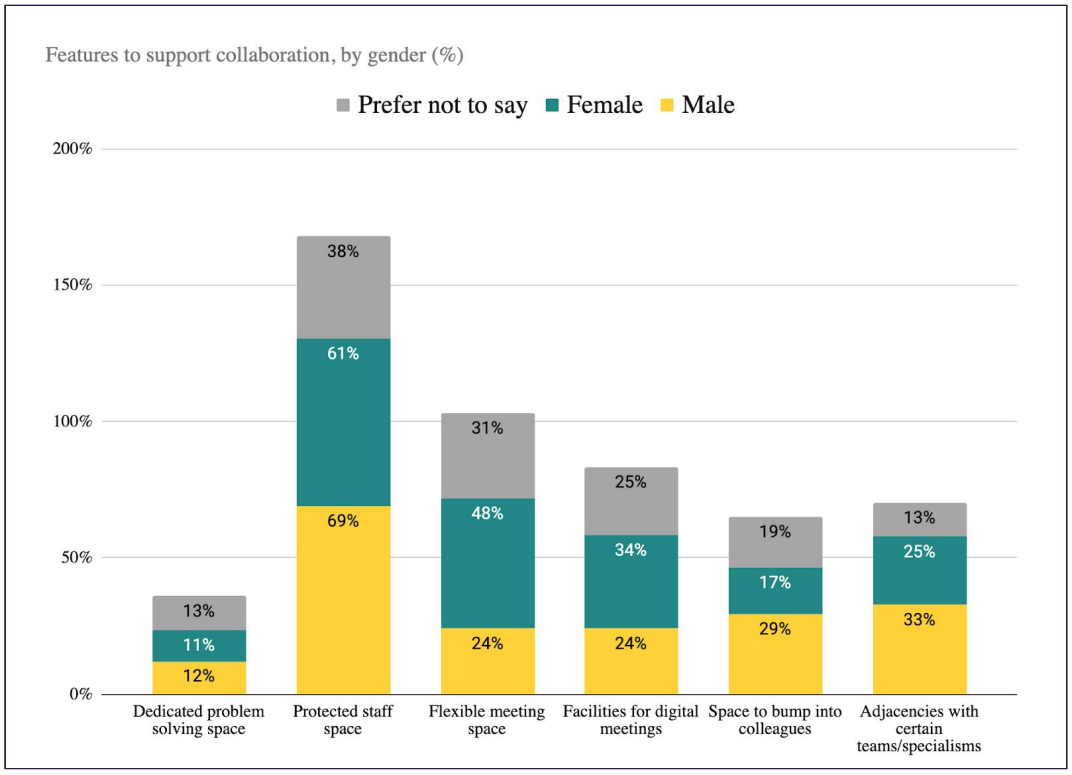
Response	61-60		61 and over		Total
Nursery	24	29%	13	43%	37
Landscape garden	51	61%	14	47%	65
Foodbank	22	26%	6	20%	28
Aqua therapy pool	13	15%	10	33%	23
Dance studio	3	4%	1	3%	4
Gym	34	40%	5	17%	39
Community hall	7	8%	2	7%	9
Swimming pool	15	18%	4	13%	19
Library	21	25%	5	17%	26
GP practice	21	25%	10	33%	31
Cinema	8	10%	3	10%	11
Care home	8	10%	8	27%	16
Hotel	15	18%	2	7%	17

Analysis of features that support informal collaboration (staff only)

Staff were surveyed on their top two preferences for hospital design features that could support or improve collaboration (Figure A11). Protected staff space is the top priority (62%), followed by flexible meeting space (38%), facilities for digital meetings (30%) and adjacencies with certain teams (27%).

There are differences by gender: male staff rank adjacencies second priority and space to bump into colleagues third priority.[2] Female staff rank flexible meeting space second and facilities for digital meetings third. Adjacencies and space to bump into colleagues is a lower priority for female staff than for male staff.

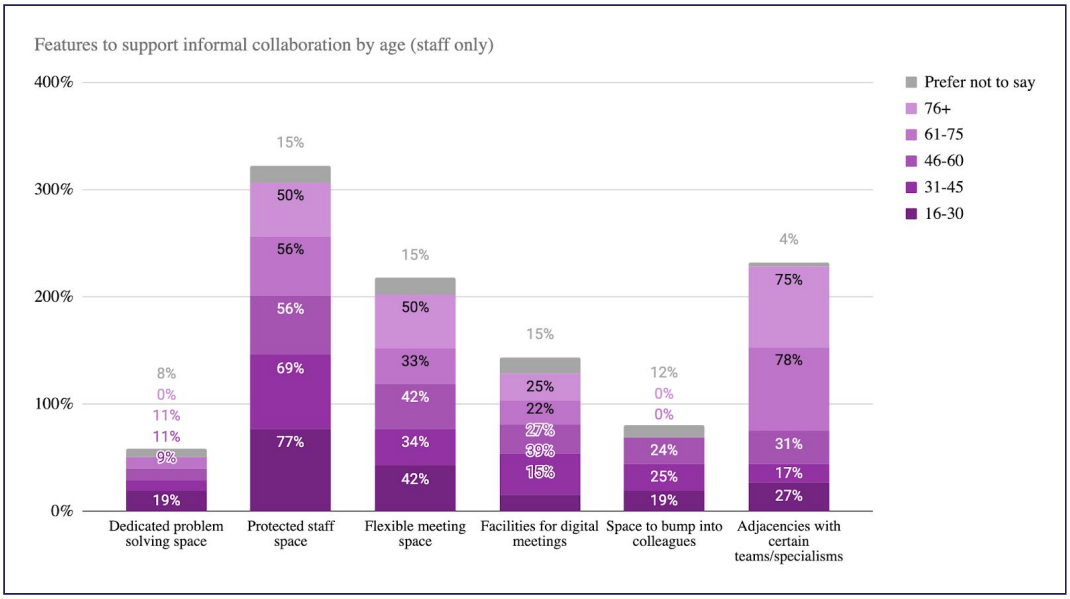
Figure A11. Design features to support collaboration by gender (staff only) (as % of gender category)



Staff over 60 are more likely to prioritise adjacencies with certain teams or specialisms over other options for supporting informal collaboration, although the actual numbers of respondents in these two age groups are small (61–75 N=18; 76+ N=8) (Figure A12).

[2] 'Non-binary gender' was available as a selection option, however no respondents that completed the questions for Staff members chose this gender option.

Figure A12. Design features to support collaboration by age, staff only (as % of age group)



By collapsing the top two age groups and removing those who did not state their age, we can make a more meaningful comparison between staff aged above and under 61 years (Table A3). Protected staff space remains the top priority for those aged 16–60 (66%), whereas adjacencies are highest priority for those 61 years and above (77%).

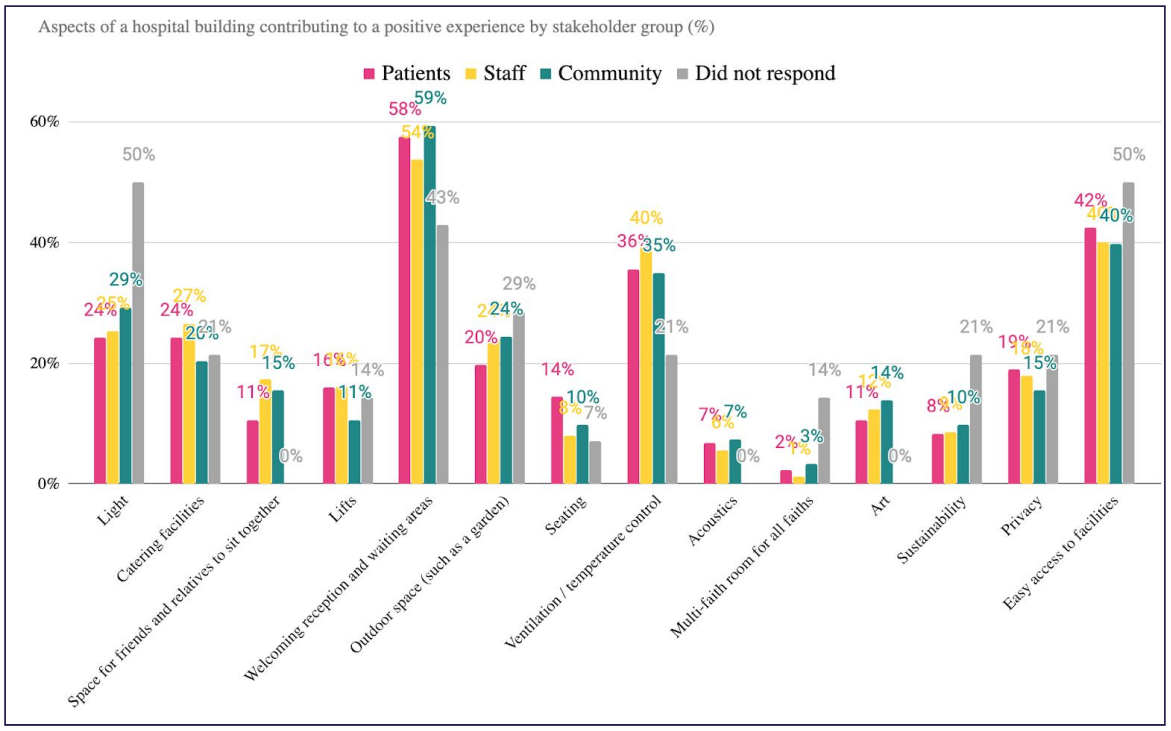
Table A3. Design features that support informal collaboration (staff only)

Response	16-60		61 and over		Total
Dedicated problem solving space	16	12%	1	8%	17
Protected staff space	89	66%	7	54%	96
Flexible meeting space	52	39%	5	38%	57
Facilities for digital meetings	41	30%	3	23%	44
Space to bump into colleagues	32	24%	0	0%	32
Adjacencies with certain teams/ specialisms	32	24%	10	77%	42

Analysis of design aspects contributing to a positive hospital experience

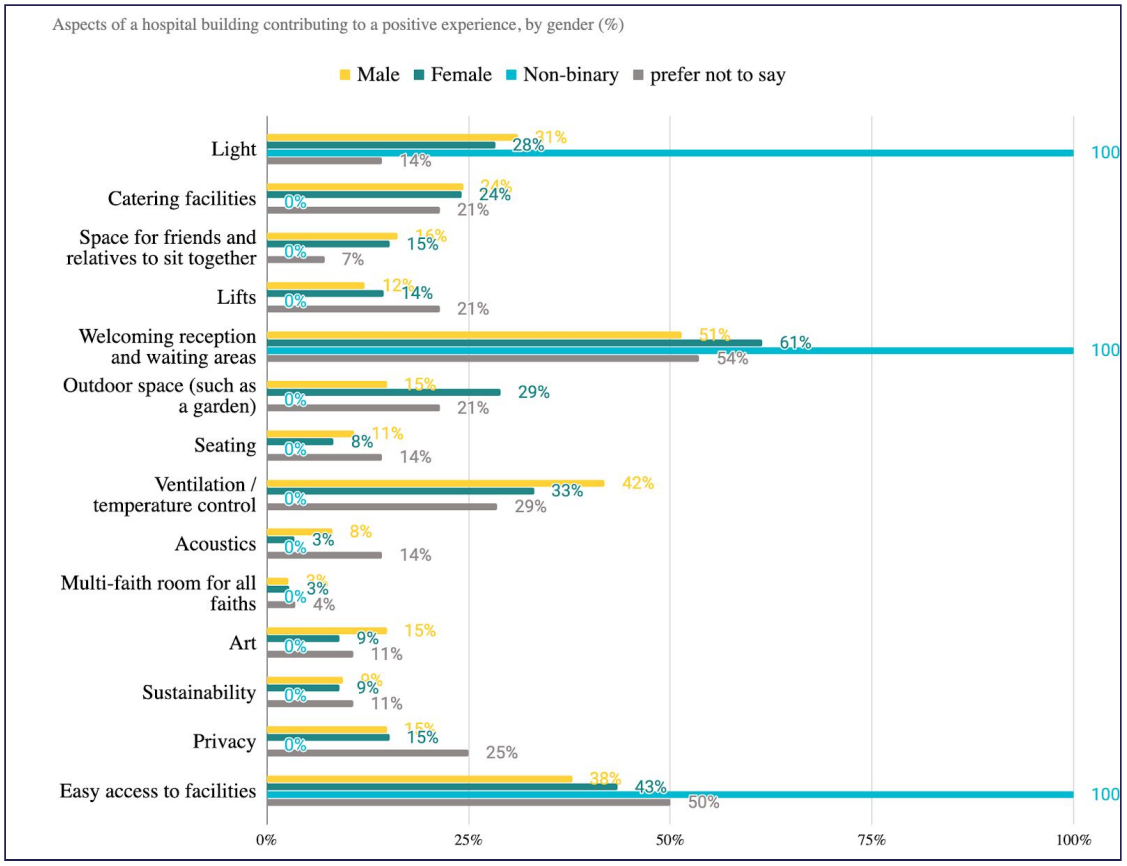
Respondents were asked to choose their top three features of a hospital building that contribute to a positive hospital experience (Figure A13). Welcoming reception and waiting areas were the top choice among all stakeholder groups, followed by easy access to facilities as second choice, and ventilation and temperature control as third choice. Light, catering and outdoor space all ranked similarly across the stakeholder groups as the fourth, fifth and sixth priorities.

Figure A13. Aspects of a hospital building contributing to a positive experience, by stakeholder group (as % of stakeholder group)



There is a degree of consistency among gender groups (Figure A14). The top choice among both male and female respondents is a welcoming reception and waiting areas. Ventilation is ranked second and easy to access facilities ranked third among male respondents. Among female respondents these two aspects are ranked third and second respectively. There is just one respondent identifying as non-binary gender.

Figure A14. Aspects of a hospital building contributing to a positive experience, by gender (as % of gender category)



There is consistency among age groups regarding design aspects that contribute to a positive hospital experience (Figure A15).

Figure A15. Aspects of a hospital building contributing to a positive experience, by age (as % of age group)