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What Matters, Not What is The Matter: A Novel Approach to Empathising and Understanding the Third Space of the Healthcare Waiting Room

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This Thesis has been completed as a requirement for a postgraduate research degree of the University of Winchester

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Zara Hanna Al Shaikh

June 2002 – June 2022

UNIVERSITY OF WINCHESTER

ABSTRACT

What Matters, Not What is the Matter: A Novel Approach to Empathising and Understanding the Third Space of the Healthcare Waiting Room

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This study uniquely applied a novel design-based lens to healthcare contexts to unveil many subtleties of the patient-space milieu, furthering debate and dialogue on this important topic.

The NHS operate under complex pressures including budgetary, resourcing, global pandemics and an ever-ageing population. In response, recent governmental drives to modernise operations include the 2019 ‘Health Infrastructure Plan’ that seeks to make improvements, where the intention is to address ‘what matters to someone’ and not just ‘what’s the matter with someone’. There is a need to ensure such developments meet the stated goals of world-class facilities and well-designed spaces to speed up recovery and ensure the appropriate treatments. Outside of these pockets of innovation however, a sizeable legacy remains of outdated facilities that will continue to impact patients. Notwithstanding the intentions of the architects and service designers in the planning of health centres, the micro-level facets of the patient experience still need to be fully understood, since there lacks an emphasis on listening to the voice of the patient.

Through a deeply empathetic ‘design thinking’ lens, this research identified the multiplicity of barriers and enablers of person-centred care with hospital waiting spaces. Following a comprehensive review of literature, an initial conceptual framework was developed. This was then tested, initially via a pilot study for feasibility, before a main study conducted through a novel two-stage exploratory design. This incorporated ethnographic observation in a real NHS setting to portray situated happenings, followed by a series of semi-structured case interviews providing rich insights from the patients’ perspectives.

The results indicated important patient considerations: whilst the physical characteristics (sounds, décor, wayfinding, etc) contributed, it was revealed that ‘what mattered’ included a sense of choice, agency and dignity, and this clearly impacted well-being. As a result, an innovative theoretical framework was developed that identified the key barriers and enablers of positive patient experiences. Finally, guide for practice emerged: a discussion checklist for including multiple patient-centred considerations for future projects.

Keywords: [Patient Experience, Waiting Rooms, Spatial Design, Design Thinking, Third Space, Lived Experience]

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CHAPTER ONE – INTRODUCTION

Preface

This chapter explains the contribution, initial drivers for this study and the setting and context for this research. It locates this thesis within the field and provides an overview of the researcher's perception of the issues and topics under review. This is followed by clear explanation of the aims and objectives, key definitions, and the contribution this study makes to knowledge and practice as well as methodological rationale. The structure of this thesis is then outlined for the reader.

1.1 Contribution

This work makes four clear key contributions:

1. This study employs a novel, interdisciplinary research methodology that uniquely prioritises the voices of patients, revealing the complex and significant influence of environmental factors on their experiences;

2. By integrating two data analysis methods—Voice-Centered Relational Method and Emotion Coding—this study uncovers deeply insightful and powerful narratives of patient experiences for the first time;

3. A new theoretical framework that integrates design, spatial, and humanist perspectives opens avenues for further exploration of the key factors influencing the patient experience both in the waiting room and beyond;

4. As a significant managerial contribution, a practical guide has then been developed to help healthcare and design practitioners enhance the creation of patient spaces.

1.2 Motivations and Focus for this Work

This study was founded upon the researcher's lifetime experiences of (and obsession with) design for doing good (Liedtka, Salzman and Azer, 2017). This relates to design enabling better communications and possessing an ability to create more enjoyable and satisfying, even inspirational experiences based on user-centred approaches. At the centre of a design approach is deep empathy (Köppen & Meinel, 2015) with the customer or 'user' at the centre of the solution. However, after consideration the term 'user' is kept to a minimum within this study despite it being acceptable to some patients (Casey, 2016), as it feels somewhat impersonal, which is not in keeping with this approach.

For healthcare, the review of literature shows design thinking represents a shift from purely scientific approaches, to exploratory ways which play to the skills of creativity and visualisation (De Lille *et al.*, 2012; Kummitha, 2019; Razzouk and Shute, 2012; Sipe, 2018) and that it has potential to add great value to the healthcare experience. This is resonant as the researcher spent a large part of their career as a practising designer, grappling with open-ended, exploratory challenges and pulling on a broad repertoire of observation, visualisation and communications skills and tools to deliver innovation. For example, brand identity schemes for SMEs and freelancers, personal creative commissions (artworks, printed and digital material and even jewellery) for all types of people, and culture-change projects in the corporate sector. All of these have in common the need to listen for the problem: to see "what people do (and do not do) and to listen to what they say and do not say" (Brown and Katz, 2011, p.382); looking for clues from within the client as to how to solve it. These projects aimed to bring to life certain values and principles from the clients (akin to the NHS values which might be realised), that otherwise might have had little meaning for people in the real lived world.

In terms of space, a pertinent underpinning for this study is when the researcher owned and managed a design studio and retail/workshop space in Winchester, UK. A great deal of effort was made to create a multi-purpose spatial experience where customers could experience the brand in different and unpredictable ways. Customers were free to roam between the shop area at the front, the design studio area in the centre and the workshop/education area to the rear, and feedback frequently indicated that people just wanted to ‘be’ in the space – not always to purchase or to be educated, but just to be surrounded by interesting artifacts and stimuli. Some interesting observations and interpretations were made by the researcher concerning people experiencing spaces in their own unexpected ways (Green, 2023).

This thesis is based on a fundamental belief that noting and understanding experiences of small moments and interactions between people and spaces can help move closer to shaping innovative solutions for others that can really have meaning and resonance, and as a result, impact people more positively. This is not a hypothesis to be proved or disproved, rather it is a starting point for this exploratory research in “under-researched areas” (Stokes and Wall, 2014. p.89) that supports some of the data collection methods chosen by the researcher (see Chapter Three).

From a design perspective, successful projects are founded upon embracing the unknown, on being comfortable with complex or unmapped problems and seeing what works and being prepared to shift perspectives along the way, a concept Cross (2011, p.20) terms as “recasting of meaning”. It is this realm of working with complex ‘wicked’ problems (Brown and Wyatt, 2010, p.31) in which this study is located; in terms of shifting focus from an initial preoccupation with décor and wayfinding before the pilot study was undertaken, to listening and looking for more abstract, subtle cultural and anthropological cues from the participants in the main research phase. Above all this study is subjective; whilst intentionally conducted with as little bias as possible, the researcher has been consistently aware of the lens of design through which they see everything around them. This has been put to best use through the formation of the approach to the interviews (see Chapter Three), but particularly in relation to the chosen method for ethnographic observation (Heath *et. al.*, 2018). This research has a clear goal to ensure the peoples’ voices are heard and hence Voice-Centred Relational Analysis has been employed, involving “listening for the plot” within the data analysis (Gilligan *et. al.,* 2003 p.160).

1.2.1 The Importance of Spaces

One way of understanding patient's lived experiences, and to further the conversation on this important topic, is to consider the significance and meaning of the spaces in which these take place. The goal for the researcher here is to form a theoretical underpinning for exploring space and its meanings more broadly (as opposed to only discussing a particular hospital ward or waiting area).

Space has historically been discussed variously in academic circles as relating initially to social production (Lefebvre, 1991; Marx, 1843, 1867; Marx & Engels, 1998) as well as (political) geography (Enos, 2017; Soja, 1996), sociology (Simmel, 1958) urban power (Dahl, 1961; Harvey, 2012; Hunter 1953; Lindblom, 1977 and Polsby, 1980), power and discipline (Foucoult, 1975) and within the realms of actual space (astronomy): physics and metaphysics (Jammer, 2013). What is significant is that space has a role to play in human interactions and experiences, be it physical, virtual or imagined (see 'Third Space' below).

1.3 Definitions of Key Terms

This study focuses on uniquely applying a user-centred design lens to the patient experience and the role of space as an enabler. Naturally, these subjects are open to various interpretations, so it is important to define them for this research. The key terms defined are 'Design Thinking' and 'Third Space'. This section positions these terms for underpinning this study.

The next section explains key definitions of Design Thinking.

1.3.1 Design Thinking

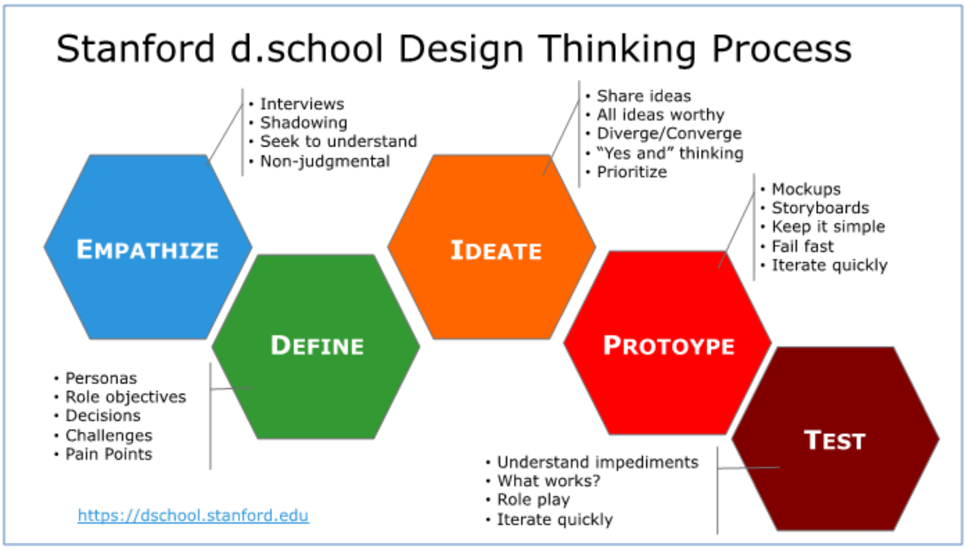
Design Thinking is essentially a way of solving problems with innovation at its heart (Brown, 2008). It is an approach not a profession (Dorst *et. al.*, 2016). It is about focusing on "questions, not answers" (Liedtka and Ogilvie, 2011, p.44). Originally the domain of corporate businesses wanting to "turn an existing situation into a preferred one" (Simon, 1969, p.111), it was adopted as having potential for service realisation and latterly for innovating in the social sector (Liedtka, Salzman and Azer, 2017).

If advances are to be made in the design of spaces for patients, it is important to recognise that design does not sit purely within the realm of designing websites and logos but should be embraced for delivering service experiences (De Lille *et. al.*, 2012). It should also come in early in the project process, rather than design historically being tagged on later (Brown, 2008). In the healthcare space, it is therefore argued here that it should therefore not be seen simply as the decoration of spaces or the placement of signage, but something evolving from the heart of user needs and emotions. Design thinking in the context of healthcare represents a shift from purely scientific approaches, to exploratory ways which play to the skills of creativity and visualisation and may add value to the patient experience (De Lille *et. al.*, 2012; Kummitha, 2019; Razzouk and Shute, 2012; Sipe, 2018).

There are many definitions of design thinking, including from key exponents such as the Stanford d.school who describe it as “a process for creative problem solving”, (Stanford d.school, 2024, Para. 1), Jeanne Liedtka who terms it as a social technology that has the potential to do for innovation exactly what TQM did for manufacturing: unleash people’s full creative energies (Liedtka, 2018), and key founder Tim Brown who coined the phrase and states that design thinking is “a discipline that uses the designer’s sensibility and methods to match people’s needs with what is technologically feasible” (Brown, 2008, p.2). Whilst the above descriptions capture the general concept, the design thinking focus for this study engages with two key perspectives:

First, the seminal design thinking framework created by the Hasso-Plattner Institute of Design at the Stanford d.school (see Figure 1.2) is suggested for this study as a methodology for attempting to empathise with the patients. It should be noted that since this is not explicitly a project to redesign a space per se (principles for enabling better experiences might be suggested, but the focus here is on giving voice to the patients and understanding their perceptions rather than creating design specifications), the first two phases of empathize and define are proposed to be adopted as the key focus for this study (see figure 1.2). For this thesis, design thinking will be termed in the lower case rather than with capital letters as this varies across narratives.

Figure 1.1 the Original Design Thinking Process (Hasso-Plattner Institute of Design at the Stanford d.school, 2005)



Second, a subset of design thinking called Experience Design is also considered when conceptualising this study. Experience design is termed by Mootee (2013) as:

> "A holistic and multidisciplinary approach to creating meaningful contexts of interaction and exchange among users and products, services, systems, and spaces. It considers the sensation of interactions with a product or service on physical and cognitive levels…. and includes the sensorial, symbolic, temporal and spatial" (p.128).

This definition aligns closely with this study in that it refers to cognitive aspects (the minds of the patients) as well as interactions, that other definitions do not. The aim is to combine these design thinking perspectives with spatial theory to test their applicability to the research aims. The following section defines the significance of the concept of 'third space' spatial theory to this study.

1.3.2 Third Space

When considering spatial aspects of this study, a key lens for this work is via Lefebvrian interpretations of Humanist Marxism (see Chapter Two) which rejects concepts of space as product or process, in favour of representational space as “lived through associations” by its users (Lefebvre, 1991. p.36). This study seeks to understand space as constructed and experienced by the users, as opposed to critiquing the pre-defined systems and infrastructures that is more typical of a structuralist Marxist approach. In other words the focus of this study concerns less how the healthcare spaces were originally planned, or how the architects or NHS management envisaged their utilisation, but on the actual day-to-day interpretations and emotions of the patients.

Following Lefebvre, the associated term ‘thirding’, a focus on ‘otherness’, was further developed by Edward Soja, a post-modern urban theorist in 1996, initially in his work on spatial geographies in the USA. Space is seen as a ‘trialectic’, both ontologically and epistemologically (see Chapter Two).

Soja (1996) described this trialectic of space as:

> “An-Other way of understanding and acting to change the spatiality of human life, a distinct mode of critical spatial awareness that is appropriate to the new scope and significance being brought about in the rebalanced trialectics of spatiality–historicality–sociality”. (p.57)

For clarity, whilst Lefebvre and Soja use both the terms ‘Thirdspace’ and ‘third space’ for these notions, this thesis uses the latter two-word description when discussing these theories.

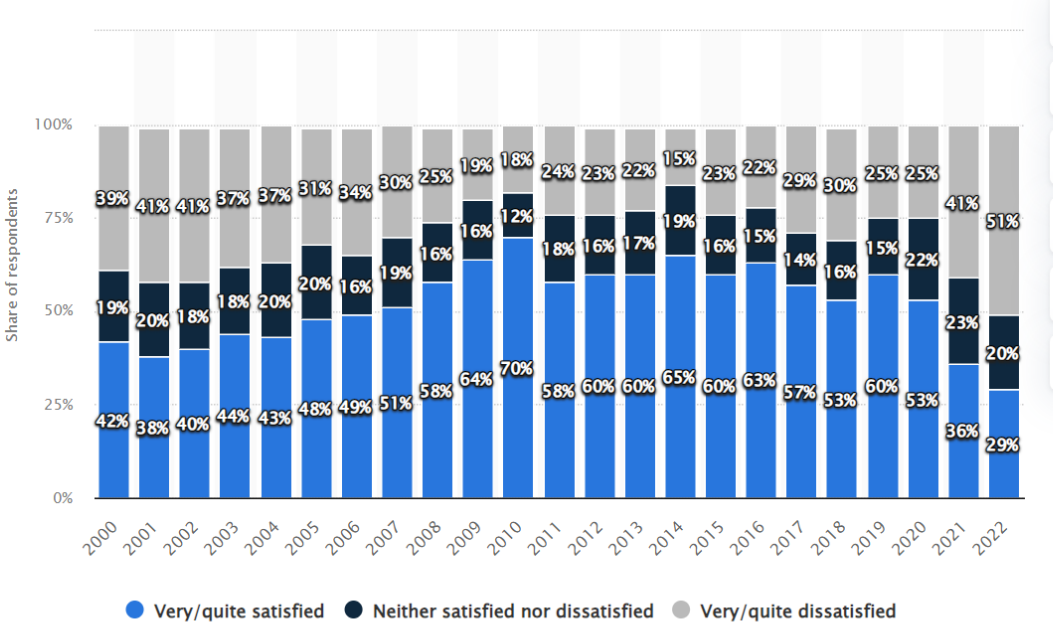
Through these two constructs of design thinking and third space, this thesis aims to discover and explore the balance between many of the practical factors that might appear significant to patients, for example effective or confusing signage, and potential broader enablers or barriers to patients having positive experiences that might be found within the third space or their lived experiences.

1.4 Healthcare as the Chosen Setting

Healthcare was chosen as the setting for this study. This came about through serendipity, as it was not within the realm of working experience for the researcher, however after being asked to visit the Royal Hampshire County Hospital Stroke ward at the outset of the study, and later, various settings at the Royal Surrey Hospitals Trust, it became evident there was a clear opportunity to contribute and to try and understand clinical spaces and the people within. Indeed, a lack of knowledge on the sector ensured the researcher came to this with an open mind throughout the study.

Other settings such as retail, education and even prisons were considered at the outset of this DBA programme and were explored in some of the early 'taught' modules, but healthcare was in effect a calling for the researcher and showed the most potential in terms of impact both socially and economically. In 2022 public satisfaction with the way the NHS is run was at a 22 year low with 51 percent of respondents being very/quite dissatisfied (Graph 1.2).

Graph 1.1. Public satisfaction with the NHS in the United Kingdom (UK) 2000-2022 (Statista.com)

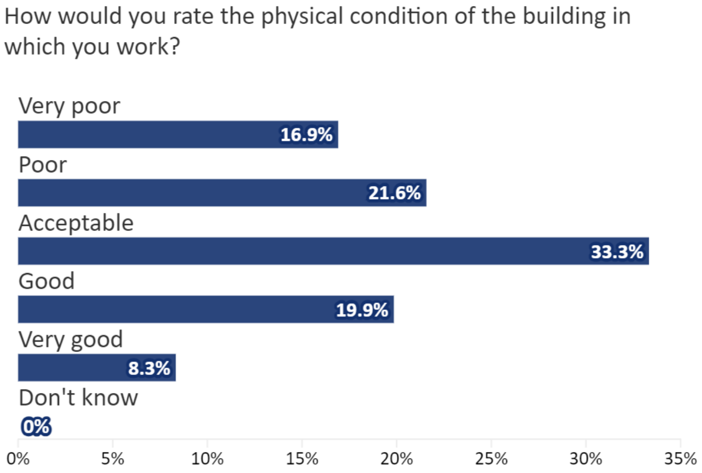


With 215 NHS trusts in the UK (Nurses.co.uk, 2022), 220 general hospitals, 49 specialist and 246 community hospitals in England alone, this represents a sizeable number of sites that more than 1.3 million people a day access (NHS England, 2023). In 2022 a British Medical Association survey (BMA, 2022) noted that many of these NHS bricks and mortar sites are in a dire state of disrepair impacting quality of life for all:

> "The quality of healthcare estates has a direct impact on the health, safety, and wellbeing of staff and patients. Healthcare facilities in poor condition present greater risk to staff and patient safety and both create and exacerbate negative working conditions." (p.7)

When surveyed by the BMA, NHS staff confirmed that the physical conditions required improvement, with 21 percent describing them as poor and only a just over third describing conditions as acceptable (Graph 1.3).

Graph 1.2 Data showing response to question on conditions of NHS buildings (BMA NHS Estates and IT survey, 2022)



Therefore in considering NHS on-site environments and experiences, it is proposed there could be many potential outlets that the outcomes of this research could reach, potentially in terms of physical environs factors and more general service conditions.

1.4.1 The NHS and Pressures

Since its inception in the United Kingdom in 1948, the National Health Service (NHS) has always been driven by enabling choice for all and a free healthcare service for patients. Whilst it remains a state-managed offering under the authority of the UK government, over time the emphasis has shifted from “social solidarity and public service” to enabling more autonomous personalised patient provision (Gorsky, 2008 p.441). In essence this means handing over the power to the patient as consumer and finding ways for them to take responsibility for their own healthcare, moving towards an ideological approach where the patient and NHS operate in a co-productive state (Coulter, 2002).

The recently updated NHS constitution (NHS, 2021) does reflect this focus on patient individuality (as opposed to purely state provision of health) and for context, the NHS values within are listed here:

Table 1.1 NHS Values (NHS, 2021)

Working together for patients	Patients come first in everything we do
1. Respect and dignity	We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits
2. Commitment to quality of care	We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience right every time
3. Compassion	We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need
4. Improving lives	We strive to improve health and wellbeing and people’s experiences of the NHS
5. Everyone counts	We maximise our resources for the benefit of the whole community, and make sure

	nobody is excluded, discriminated against or left behind

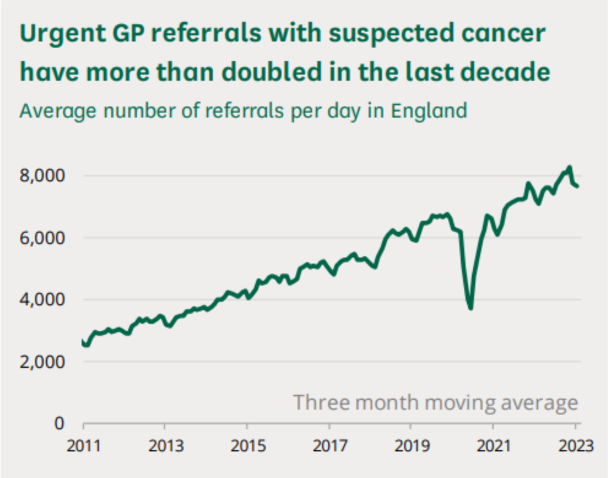
The first and fourth values are particularly pertinent to this study, where the focus is on understanding patient agency and aspirations and where aspects such as dignity and 'lived experiences' (see Definition of Key Terms below) are deconstructed (see Aims, Objectives and Approach below).

The NHS constitution also includes seven guiding principles based upon these values, and the fourth principle: "The patient will be at the heart of everything the NHS does" (NHS, 2021), supports the aforementioned goal of patients managing their own health and being able to experience tailored services based on their preferences. However, this is difficult to deliver as outlined below.

1.4.2 Addressing Pressures on Our Health System

To deliver on some of these established principles and values, the NHS Long Term Plan (2019, p.11) proposes a "new service model for the 21st century". A high priority is personalised care: "a fundamental shift in how we work alongside patients and individuals to deliver more person-centred care" noting that the importance of "what matters to someone is not just what's the matter with someone" (NHS, 2019, p.24). However, NHS healthcare settings continue to experience multiple pressures such as rapidly increasing volumes of GP referrals (for example urgent cancer referrals have almost doubled in the last decade, see Graph 1.1), cuts to financial investment, governmental, legal and ethical accountability and increasing time pressures (George *et. al.,* 2018). More recently this was also compounded by the impacts of the Covid-19 pandemic which fundamentally upended the organisation (Willan *et. al.*, 2020).

Graph 1.3. Urgent GP Cancer Referrals (Baker, 2023)



This results in priorities other than those of improving the minutiae of individual patient interactions (for example focus diverted to bringing up to 65,000 clinicians out of retirement (BBC, 2020) or postponing surgeries) and arguably an overall challenge to personalising the lived experience or prioritising service innovations. The following briefly unpacks critical factors impacting personal patient experiences.

1.4.3 The Problem of Personalisation

Whilst the main goal of healthcare and the purpose of health spaces is to promote well-being and good health (Campos Andrade *et. al.*, 2013), patient hospital experiences are diverse and subject to many influences such as lighting (Cassol *et. al.*, 2011), noise (Pattison, 1996), décor and aesthetics (Nielsen *et. al.*, 2017). Experiences also consist of varying levels of relationships and interactions constantly playing out between staff, patients and their families that concern levels of trust, intimacy, empathy (Andrade *et. al.*, 2016) and differing senses of agency and affordance from all actors in the settings (Menatti and Da Rocha, 2016). This paints a complex picture of the experience, notwithstanding the patients' specific medical treatments and conditions being endured. When this is combined with the political, financial, and other pressures mentioned above, it is understandable that what matters to a patient might be problematic to ascertain or fulfil.

At the core of this thesis is a wish to further explore the significance and inter-relationships between the above factors and to understand the lived experiences of various actors within hospital settings, with a focus on expectations and interactions with the spaces in which the patients find themselves. In essence, this is a phenomenological exploration (see Chapter Three, Research Design and Methodology) of the balance and dynamic between these elements. Unlike past studies that have reviewed the impact of specific features, for example art in the health space (Zamagni *et. al.*, 2010) or the impact of views (Ulrich, 1984), the researcher here takes a broader yet deeply empathetic approach to exploring the dynamics of the holistic patient experience, to identify emergent themes and characteristics of inter-relationships, and to reflect on the realities of the aforementioned NHS values and principles. The following section discusses this holistic experience and potential for inter-relationships in terms of the design and role of the space in which patients find themselves.

1.4.4 Research Partnership - Rationale for the Selection of the Hampshire Hospitals Foundation Trust, Hampshire, England

In order to proceed with this research and hear the voices of participants firsthand, it is important in the data gathering stages to speak with *real* patients about their experiences concerning *real* spaces. To add credibility to this study and to produce more ecologically valid data that concerns “what happens in people’s everyday lives” (Bryman and Bell, 2015. p.51), it has been decided that partnering with an NHS trust is an ambitious, yet optimum approach.

For this, it is determined that access to an NHS healthcare site which is both convenient in terms of location for the researcher, but that also concerns various forms of space in various conditions will be of benefit. Given that most hospitals have waiting areas, irrespective of clinical specialism, the study findings might therefore be widely applicable for smaller or larger NHS trusts. Since the focus of this study is the NHS, private hospitals were not considered within this scope; a comparison between these and NHS sites could, however, be a valid project following on from the conclusions of this thesis.

To source a relevant trust, initially the Royal Surrey NHS Foundation Trust responded to a request on the business networking site LinkedIn, but after an initial visit, the key contact person retired, and communications became more challenging since this project was not critical to their activities at the time. Secondly, the site under consideration was the state of the art Stokes Centre for Urology, which, as a new and modern centre, might yield results in terms of positive patient feedback, but would arguably add less value to understanding the greater number of existing older NHS centres in the UK. Some 43 percent of NHS hospitals were constructed before 1984 and are nearly 40 years old and noted as having inadequate facilities (Naylor, 2017).

Following initial meetings with the research team at the Hampshire Hospitals Foundation Trust (HHFT), it has been determined that two settings within the Royal Hampshire County Hospital, Winchester are appropriate to review, and staff there are keen to be involved. The site concerns ‘Florence Portal House’, a medium-sized, two-story building on the main hospital site (see Figure 1.1). This has been proposed by the HHFT research team due to it being an older site with a reputation for being somewhat cluttered and old-fashioned.

Florence Portal House hosts the maternity unit, breast services, neonatal unit and women’s health departments. The building opened on the 11th of January 1974 and approximately 2400 babies are born there each year (Napier, 2014). Two areas are proposed for review: the Breast Screening outpatients centre on the first floor of the building, which is purported to be of a higher standard décor-wise, and the ground floor obstetrics centre outpatients’ areas. At times patients undergoing treatment or consultations for breast conditions are also seen in this area. The key focus is the general waiting areas, public areas and possibly treatment rooms if vacant. Patients sometimes return to the waiting rooms/areas several times during one visit whilst their case progresses. Due to the choice of setting, the demographic of participants is narrowed to females, although the age might vary across the generations due to the types of condition being presented.

Figure 1.1 Exterior of Florence Portal House, The Royal Hampshire County Hospital (Author’s Own, 2023)

1.5 Aims, Objectives and Approach

Following the contextual overview, this section describes the aims and objectives for this study and explains how these are addressed within this work. This study builds on previous, primarily clinical reviews of health spaces and their impacts.

The overall research aim is to understand how patients *feel* about their time in hospital waiting rooms and what really matters to them concerning the design of spaces, in order to identify potential new conceptualisations of waiting room design. The focus is on determining and conveying emotions and the particular causal effects of diverse spatial elements.

The key research questions that this study addresses are:

1. What are patients' perceptions of hospital waiting room spaces?
2. What are the barriers and enablers of a positive patient experience in the spaces?

The research objectives are:

1. To create a conceptual framework bringing together health and design thinking domains to identify opportunities to contribute to new knowledge on the topic of patient lived experience and the role of spaces;
2. To understand patient perspectives on healthcare spaces, including how aspects of the ‘conceived space’ and the ‘perceived space’ impact their ‘lived space’;
3. To advance the understanding of ‘lived experience’ by testing the appropriateness of the framework that employs Design Thinking and Third Space principles;
4. To leverage these research insights to devise recommendations and considerations for practitioners for patient-centred and ‘lived space’ design projects.

The first objective is achieved by a thorough review of academic conversations within the literature, with the outcome being discussed in the literature review in Chapter Two and contextualised in the proposed framework at the beginning of Chapter Three. The second and third objectives are addressed through the methodology outlined in Chapter Three and the data presented in Chapter Four. Finally the discussion in Chapter 5 addresses the last objective, highlighting how these insights might inform both theory and practice moving forward.

1.6 Methodological Rationale

In order to reflect the aim of exploring concepts around lived experiences and relationships within certain settings, this work is inductive and exploratory. This engages with subjective interpretations both on the part of the researcher and the patients participating, seeking an understanding of tacit knowledge (Gephart, 2018). Therefore, the work adopts a multi-disciplinary, multi-method approach, focusing on smaller sample groups through extended, in-depth interviews and on-site ethnographic observations by the researcher to provide a greater depth of understanding (Pink, 2011).

The analysis of the data is focused on uniquely giving centre stage to the true voices and individual patient narratives, as well as acknowledging their ranges of experienced emotions. Therefore, the two methods of Voice-Centered-Relational Method (Gilligan *et. al.,* 2003) and Emotion Coding (Saldaña, 2016, p.125) are combined to this end.

The section that follows outlines the contribution of this study to various fields.

1.7 Justification of Contribution and Impact

As this study is for the qualification of a Doctorate in Business Administration, the impact of the work should focus on both academia and industry practices.

Bryman and Bell (2015) define the importance of business research as having an impact on theory, on the community of the locus of the research (in this case patients) and on practitioners (in this case clinical staff and potentially service designers, interior designers and architects). Abreu *et. al.,* (2009. p.22) also define these “modes of interaction” in three categories: people-based, problem solving, and community-based. In the context of this study people-based might include sitting on (or informing) NHS advisory boards, attending relevant conferences or engaging with health networks. Problem solving alludes to further research, prototyping (of potential new waiting rooms for example) or indeed the “setting up of physical spaces” Abreu *et. al.,* (p.23). Community-based includes more public-facing activities, which may in the context of this work, include engaging the public in the shaping of future health spaces; an approach on which this study is founded through working with patients. However, the outcomes of this work have great potential for impacting both academia and practice, as the following describes.

1.7.1 Contribution to Scholarship

In outlining what constitutes a theoretical contribution, Whetten (1989) suggests interrelationships between ideas is essential as opposed to simply rewriting existing knowledge. He also advises caution that a theoretical contribution to scholarship does not simply involve adding to a list of factors, but rather, demonstrates why and how the addition of new ideas or factors change previously accepted relationships. This study aims to explore the unique relationships between spatial trialectics and human experience, through a unique lens of design, rather than simply adding one additional stage to a current framework such as the Stanford d.school design thinking model (Stanford, 2005).

Previous academic conversations on health space factors have been centred on specific environment interventions in order to test impact on clinical recovery (Janssen *et. al.,* 2014). This study builds on research focusing on patient co-design (Donetto *et. al.*, 2021) and conversations around multiple factors or typologies impacting patient experiences (Bitner, 1992) by engaging with deep empathy for acknowledging patient interpretations, meanings and experiences. The patient voice is put front and centre of this approach which is unique in its priority over measuring more physical factors.

1.7.2 A New Model for Considering Patient Interpretations

This thesis explores how a model based on design thinking and third space principles might encapsulate the broad range of concerns and feelings that patients experience during their time in health spaces. In addition, to achieve the research aim of understanding feelings, this study reviews and builds upon existing methodologies in this field concerning how to qualitatively explore ways to prioritise the patient voice and to note how their individual words might be of significance.

For academia, it is hoped that a new framework might be developed for enabling the conceptualisation of patient spaces centred around deep empathy and addressing subtleties in patient mood, feelings and histories. This would then pave the way for research, prototyping and testing of these concepts by interventions and experiments with spaces, which this study does not proport to undertake. Finally, conducting this research from a lens of design and not health, reveals a different, novel scholarly perspective on empathising with patients and their interactions with clinical spaces.

1.7.3 Contribution to Practice

This research expects to provide practice with two key benefits: a valid and insightful collection of patient accounts and feelings on which to build a business case for change, and a defined set of principles on which to conceptualise, design, redesign and build future patient-centred public spaces (Research Objective 4). By engaging with this contribution, healthcare trusts can formulate spaces and services that will more closely meet patient needs and therefore improve patient satisfaction and well-being, as well as ensuring the patient feels recognised and included in the planning stages.

1.7.4 New Indicators and Discussion Guide for Designers and Planners

It is aimed that the knowledge created from this study might serve as a set of indicators by way of a discussion guide for healthcare organisations to both review their current spaces, whilst serving as a starting point for further development of ideas and practical solutions for creating improved environments for patients and staff. Following these indicators, based on empathy and pain points for users, in terms of applying design thinking, the more practical stages of Ideate, Prototype and Test might then be activated to take these ideas forward in a practical, physical or virtual trial environment for gaining patient feedback.

1.8 Structure of the Thesis

Following this introduction to the context for this study, in Chapter Two, a review of previously published academic and where appropriate, industry literature is presented. The aim is to identify relevant scholarly conversations in relation to the research questions of this thesis and to critically review topical themes, identifying potential gaps in the literature (Stokes and Wall, 2014). Various previous methodologies in this field will also be reviewed in relation to their applicability for this research aim.

Based upon the conclusions of this review, and in light of the research aim and objectives, Chapter Three commences with the presentation and discussion of a new theoretical framework proposed for guiding this study. This will later be reviewed for its effectiveness following the data gathering stages.

Chapter Three describes the research approach for this thesis, commencing with a description of the philosophical viewpoints adopted, before explaining the research design methodology and detailing the research methods undertaken, including ethical considerations and how the data is analysed.

This is followed by thematic presentation of the research findings in Chapter Four and then a discussion of the interpretation of these findings in relation to the literature and research objectives in Chapter Five. This chapter includes the proposal of a revised novel conceptual framework based on additional perspectives uncovered from this study. The thesis concludes with a discussion of strengths and limitations, and indications for potential further study and practitioner opportunities.

CHAPTER TWO - THE LITERATURE REVIEW

Preface

In bringing together research conversations from the diverse disciplines of health and design, and positioning these within the context of spatial, symbolic and humanist perspectives, this chapter aims to provide evidence of clear opportunities for new study to enable a deeper understanding of patient preferences.

Commencing chronologically to convey developments and context, the review then adopts a narrative approach to presenting the discussion, since narrative reviews allow for subjective interpretations by the researcher. This involves looking for "patterns and connections" (Baumeister and Leary, 1997, p.312), whereas more systematic reviews involve very specific protocols and unbiased recording of material more suited to studies in the scientific realm (Jahan *et. al.*, 2016; Stokes and Wall, 2014). In highlighting the growing debate on the topic of patient experience, the chapter groups outcomes of the readings thematically into clinical and non-clinical conversations.

Following a critical evaluation of studies concerning health spaces and their impacts, the origins and application of Design Thinking is outlined and, importantly, its significance and challenges for understanding patients is argued. Three theoretical constructs: Third Space theory, Marxist Humanism and Symbolic Interactionism are then positioned as potential foundations for this study. Bryman and Bell (2015, p.110) state that it can be "extremely problematic" in inductive research to propose theoretical constructs *prior* to data collection, since data collection unveils topics that may emerge as important and therefore generate new understanding. However, the locus of this work empathises with certain theoretical underpinnings that are purported here as key belief systems influencing this subjective study from the outset and underpinning both the pilot study and main data gathering stages, hence positioning these prior to data collection is justified. Finally, key constructs are combined into a conceptual framework that is presented at the end of this literature review and that has informed the methodology that follows this chapter.

2.1 Broad Applications of Space

Previous studies on space situate this study in that they address human needs within the physical world. Since the turn of the 21st Century, literature around experiences of space has flourished to include the aesthetics of workspaces (Schell *et. al.,* 2012; Vilnai -Yavetz *et. al.*, 2005), perceptions of interior design (Cupchik *et. al.*, 2003; Maher *et. al.*, 2017) and the role of spatial design in settings such as education (Darian-Smith and Willis, 2016; Tanner, 2013) and retail stores (Pecoraro and Uusitalo, 2014). Predominantly these studies espouse greater user participation, sense of fun or stimulation within the environs, with some applying diverse or novel theoretical models on spatial interactions. For example, Barazawa and Hanyu (2013) explore the prospect-refuge theory of landscape aesthetics (finding places to hide from enemies and places to spot them) and how this might apply to the design of interiors.

In other cases, the topic is explored from the viewpoint of psychology, where the focus is hope and positivity, such as with consideration of prison design (Haney, 2017; Jewkes, 2018) or the social status of the individual, i.e. inpatient or outpatient, where this impacts their perspectives on the importance of social versus physical factors of spaces (Andaleeb *et. al*., 2007; Campos Andrade *et. al*., 2013; Gotlieb, 2002; Pilpel, 1996; Ziaei *et. al*., 2011). More recent studies of customer spaces have tended to focus on the potential of the blend between physical and virtual spaces known as phygital and debate around how this impacts the customer journey (Batat, 2022; Hyun *et. al*., 2022; Mele and Russo-Spena, 2022). Implications for customers within the virtual reality space known as the Metaverse are also emerging in very recent research, particularly within discussion of success criteria for creating effective customer experiences (Barrera and Shah, 2023; Golf-Papez *et. al.*, 2022).

In the context of the blending of textile and spatial design practices, Fallouh (2020, p.34) terms their research as developing a “strategy to support spatial designers to undertake an interdisciplinary journey" which might be apt for this study in terms of the opportunity to potentially transform design practice through the combination of diverse disciplines and new methods of creating understanding of health spatial experiences. It is evidenced therefore, that spatial concerns touch many areas of people's lived experience and that this has traction as an on-going topic of study, however, space in relation to health has primarily been dominated by research with its origins in clinical studies as shown below.

2.2 Space in Health

2.2.1 Developments in Researching Health Environs

This section presents a critical review of scholarship concerning the significance of the healthcare space to the patient experience, commencing with a profile of the origins and development of academic conversations in this arena and then critique of the various approaches for measuring patient experience of spaces. It is important to initially convey the emergence and domination of work from a clinical perspective, as this study then raises the question as to whether approaching the topic further from a multi-disciplinary and non-clinical perspective might create new conversations.

The opportunities for creating impactful spaces that can offer support to people have been evident since ancient Greek medicine (Schweitzer *et. al.*, 2004). Artwork, for example, has been found in hospitals and clinical settings since the times of infirmaries lead by religious institutions for passing pilgrims (Pevsner, 1976). A noteworthy study marking a significant development in focusing on the immediate spaces surrounding patients was that conducted by Ulrich (1984). Ulrich positions all of his work as scientific in order to gain approval from the clinical professions (Ulrich, 2001). Approached from a clinical perspective, the longitudinal study of ward design compared patient records of recovery from cholecystectomy over a period of nine years. Clear evidence, both anecdotal and clinical, was presented of the benefits of facing a window view over patients being situated opposite a brick wall. This paved the way for further study of patient spaces and impacts, by Ulrich and others, many of which corroborated that there are benefits to considering broader factors when designing health spaces (Jasnoski Gregerson, 1995; Miles, 1994; Verderber, Grice and Gutentag, 1987). Whilst not recent, these studies are pertinent to this thesis in their acknowledgement that a range of factors might be at play simultaneously in affecting patients' perceptions.

Patient-centred research into healthcare environmental factors has gained increased traction since the 1980s, growing from analysis of primarily clinical outcomes to incorporating more emotional or sensual criterion. For example, the benefits of the arts in health gained momentum as an area of significance in the last two decades, where research unanimously sided in favour of artistic or aesthetic interventions such as the placement of paintings (Fancourt and Finn, 2019; Lankston *et. al.*, 2010; Macnaughton, 2007). Gesler introduced the idea of "Therapeutic Landscapes" in 1991, taking a geographical stance on viewing space and symbols within spaces as providing benefits for healing. Aesthetics can also be related to the humanising of spaces (Bates, 2018) or the creation of therapeutic landscapes following Gesler (Curtis *et. al.*, 2007). Perhaps not surprisingly, aesthetics is discussed less frequently within the clinical literature reviewed. The therapeutic narrative however, developed further through consideration of contexts such as natural landscapes, homeliness, and self-generated healing landscapes by patients in care homes, which were all seen as bringing tangible benefits (Williams, 1999).

Whilst significant to furthering the debate, these contributions did not sufficiently address human perceptions, and as purported by Wilson (2001), did not attend to notions of scale that he argued affect the boundaries of a space for the people within. Here these boundaries mean that a hospital only becomes a *space* because of the people that converge and create meaning within it; the lifeworld of "taken-for-granted" moments that involve having certain links to the space at particular times (Gesler, 1991, p.166). This research proposes to address the capturing and articulation of the essence of such taken-for-granted moments Gesler defines, and the methodology in Chapter Three reflects this aim.

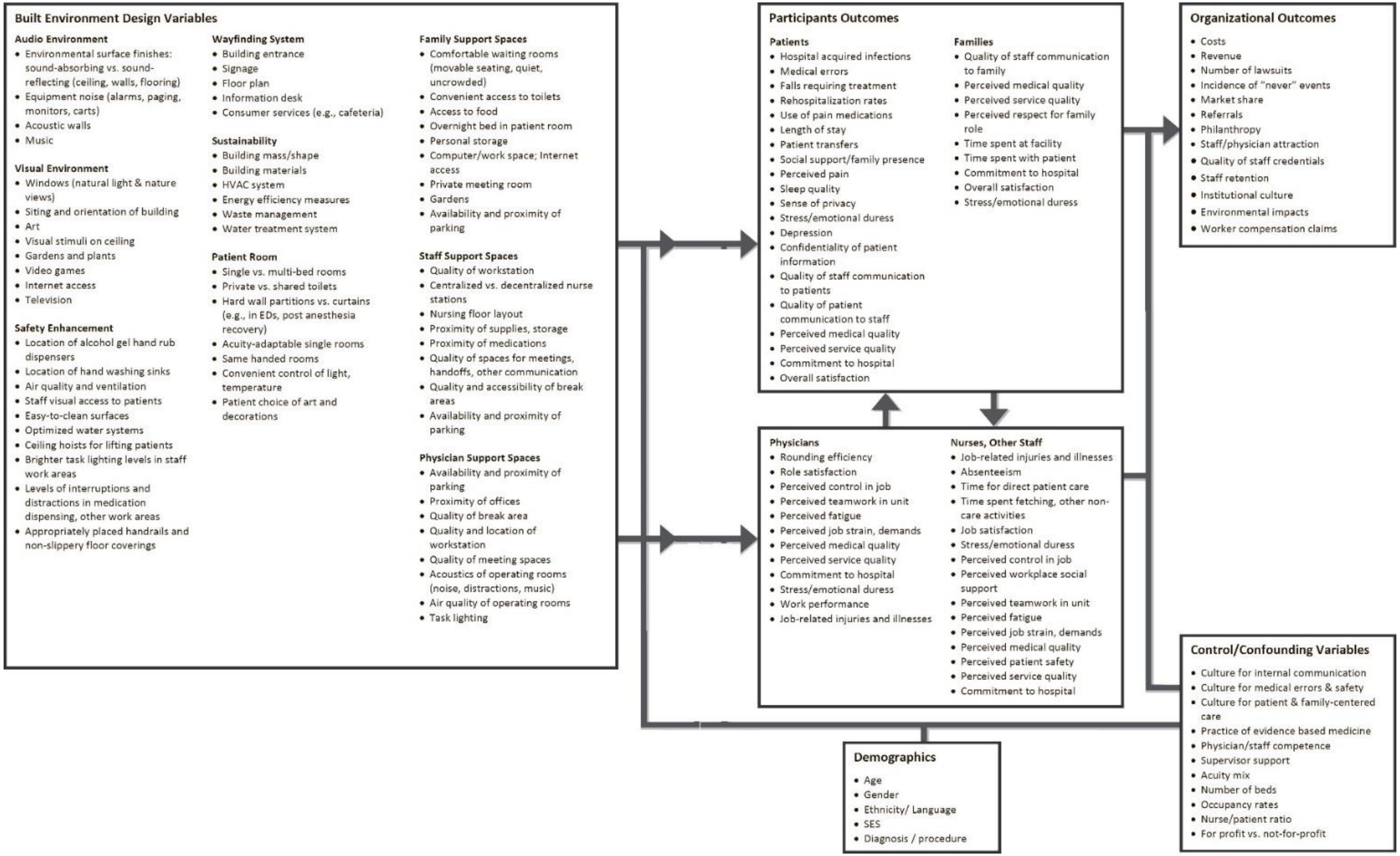
As outlined, methodologically, the practice of engaging with patient opinion by conducting individual and specific interventions has been common, such as assessing the impact of different forms of decoration before and after placement (Nanda *et. al.*, 2012; Zamagni *et. al.*, 2010), the absence and addition of Feng Shui features (Bazley *et. al.*, 2016) or the introduction of plants (Blaschke *et. al*., 2017). Yet the scope of such studies was typically restrictive, involving one factor or feature, and the analysis was usually quantitative in nature via impersonal surveys. Above all, for some time, more has needed to be done in terms of comprehending the behaviours and motivations of patients and other members within health systems (Searl, 2010).

2.2.2 Notable Clinical Studies and Conceptual Approaches

Given that healthcare, at least in its current form, cannot be separated from the physical built environment for much of its service delivery, finding ways to ensure this contributes to positive outcomes has been a key driver, to which evidence-based design (EBD), over the last 35 years approximately has contributed (Ulrich *et.al*., 2010). This developed from an approach whereby scientific knowledge, methods and data on what works, is formulated to provide guidance in health space design, yet typically this has been less effective in practice than in theory. Hamilton (2003) argues that EBD is particularly effective for healthcare, where it has garnered interested from clinicians who practice based on medical evidence to provide better patient experiences and where it also has benefits for organisational efficiency and effectiveness. Citing four levels of commitment, Hamilton's definition of EBD is also however, more theoretical than practical.

In reviewing the literature on EBD, Ulrich *et.al.'s* conceptual framework (Figure 2.1) comprises many notable attributes of health spaces that can be termed as appropriate considerations for this study and for other practitioners. The attributes of spaces listed in the first box are akin to other studies in this field, for example as highlighted in Table 2.2 below. However, Ulrich's framework fails to include patients' emotional outcomes or feelings that this thesis aims to explore in order to further understand the effects of spaces.

Figure 2.1. A Model of Participant and Organizational Outcomes of the Healthcare Built Environment (Ulrich *et.al.*, 2010)



Following Ulrich, further research developed concerning the notion of 'Enriched Environments' (EEs) for patients, focused on specific interventions and resulting clinical outcomes. EEs are termed as activations focused on cognitive or sensory stimulation which can be effective for patient recovery when combined with clinical task-based actions (Corbett *et. al., 2014;* Vive *et. al.,* 2020). For example, many studies concerned the impact of specific environmental aspects (social, physical activity, auditory) on recovery from conditions such as acute stroke (Janssen *et. al.*, 2014a; 2022; Jones *et. al.,* 2008*;* Rosbergen *et. al.*, 2017; Rosenberg, 2017; Shi *et. al.*, 2023), and brain injury (Forbes *et. al.*, 2020; Kovesdi *et. al.*, 2011). There was also a considerable amount of research concerning the importance of space for Dementia patients, where it was argued that similar additions to healthcare spaces including multisensory stimulation and home-like décor can aid patients' wellbeing (Chaudhury *et. al.*, 2018; Ferdous, 2020; O'Connor *et. al.*, 2012).

The majority of these studies, however, were scientific in nature, sometimes testing on animals, and usually focusing on medical presentation before and after a surrounding physical intervention. Systematic research from such disciplines was typically empirical, for example using behaviour mapping protocols to record the change of levels of patient activity from a physical, social and cognitive point of view (Rosenberg, 2017), or often quantitative surveys for gathering data. Whilst these works were no doubt of great clinical value, it is asserted here that they still fail to put the patient first in terms of methodologically seeking understanding of the whole picture of feelings and emotions (Centor, 2007).

More recently however, there has been an emphasis on applying a more empathetic lens to understanding patient needs. For example, there is a body of work in the context of Dementia and patient empowerment, although not specifically in the context of spaces. This aimed to gather rich data from patients through qualitative methods such as interviews or focus groups and exploring the potential of co-production (Bosco *et. al.*, 2019; Niedderer *et. al.*, 2022; Tournier *et. al.*, 2023). Despite these pockets of methodological innovation, areas such as co-design with stakeholders involve diverse forms of approach, interpretation and confusing terminologies such as participatory design, co-design, co-creation or co-production (Niedderer *et. al.*, 2022). Whilst co-design has been effective as an approach at the initial consultancy stage of projects, participation of users in the activity of the design of actual services is scarce. This is where a collaborative and iterative approach such as Design Thinking (see section 2.5.2) may facilitate continuous contribution from stakeholders past the initial feedback stage.

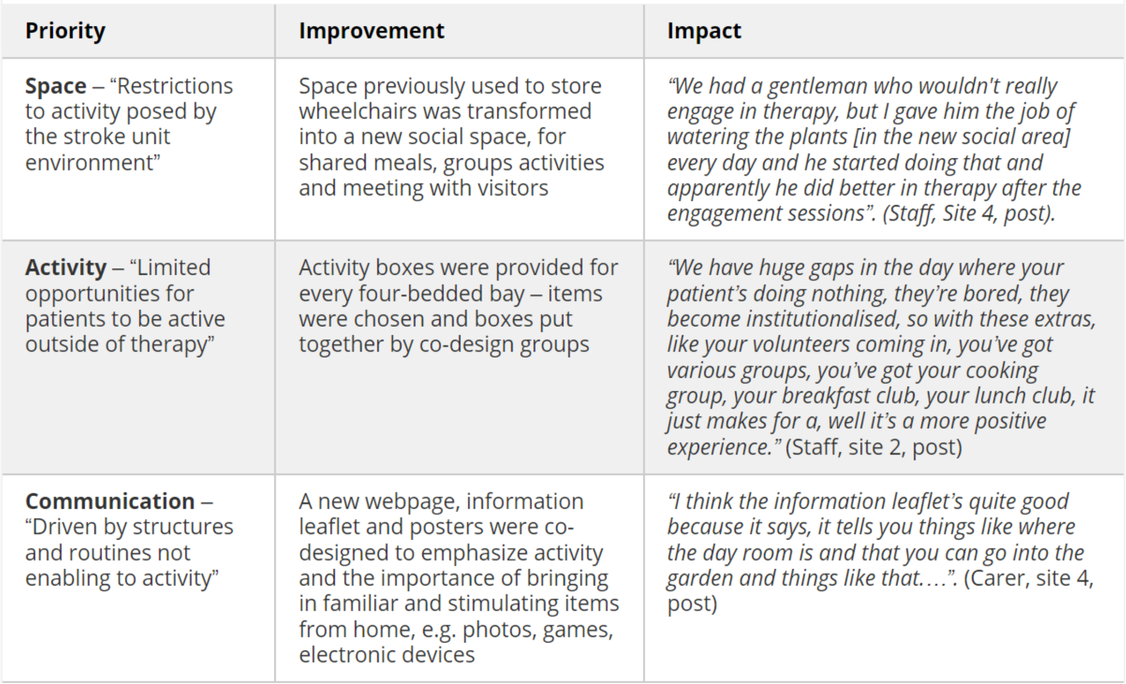
2.2.2.1 Experienced-Based Co-Design

With projects typically lasting between 6 and 12 months in duration, Experience-based Co-design (EBCD) was first implemented within the cancer service at Luton & Dunstable NHS hospital in 2004 (Donetto *et. al.*, 2014). EBCD formed to generate better healthcare through enabling patients, staff, families and others to collaborate, participate, reflect, co-design solutions and agree priorities on what to implement (Ramos *et. al.*, 2020).

Embracing EBCD, a sizeable body of work lead by Dr. Fiona Jones (Jones *et. al.*, 2008; 2016; 2020; 2021) has made significant inroads into the consideration of internal and external factors that might aid patient recovery. Such factors included décor, lighting, reduction in clutter, being active, communication and socialisation. These constitute additional elements proven worthy of consideration in any further study of health spaces since they are broader in scope than the earlier studies. Within these studies, EBCD was used widely, and being collaborative in nature, has been somewhat successful as an improvement methodology (Jones *et. al.*, 2021). Here patients and staff were able to work together to identify opportunities for change (see Table 2.1), although the bias appeared to be towards acknowledging the staff voice rather than that of the patient, despite more qualitative methodologies such as interviews being employed where the patient participated. In other words, the patient has been positioned as a recognised contributor through such methodologies, yet theirs is not the primary voice being heard.

Whilst is has been be argued that EBCD does not play a clear role in the *creative* process of shaping services (Niedderer *et. al.*, 2022), such an approach might pave the way for more rich engagement with patients or visitors in gaining feedback and defining needs. Bate and Robert (2006) expound the viewpoint that EBCD concerns more than just gathering of feedback however, and that such research initiatives should avoid becoming purely anecdotal (simply noting comments) and should be applied to creative design stages also. They favoured EBCD involving the collaborative design of services by engaging not only with needs and preferences, but the forming of total experiences using analytical frameworks.

Table 2.1 Impact of Co-designed Changes Showing Quotes from Staff (Jones *et. al.*, 2021)



Priority	Improvement	Impact
Space – "Restrictions to activity posed by the stroke unit environment"	Space previously used to store wheelchairs was transformed into a new social space, for shared meals, groups activities and meeting with visitors	*"We had a gentleman who wouldn't really engage in therapy, but I gave him the job of watering the plants [in the new social area] every day and he started doing that and apparently he did better in therapy after the engagement sessions". (Staff, Site 4, post).*
Activity – "Limited opportunities for patients to be active outside of therapy"	Activity boxes were provided for every four-bedded bay – items were chosen and boxes put together by co-design groups	*"We have huge gaps in the day where your patient's doing nothing, they're bored, they become institutionalised, so with these extras, like your volunteers coming in, you've got various groups, you've got your cooking group, your breakfast club, your lunch club, it just makes for a, well it's a more positive experience."* (Staff, site 2, post)
Communication – "Driven by structures and routines not enabling to activity"	A new webpage, information leaflet and posters were co-designed to emphasize activity and the importance of bringing in familiar and stimulating items from home, e.g. photos, games, electronic devices	*"I think the information leaflet's quite good because it says, it tells you things like where the day room is and that you can go into the garden and things like that….".* (Carer, site 4, post)

2.2.2.2 Ways of Measuring Health Spatial Factors: Frameworks and Differing Terminologies

Aside from exploratory approaches such as EE and EBCD, the key measure of patient opinion has historically been the national patient satisfaction survey which has been defined as measuring levels of care or service and strengths and weaknesses of hospitals in order to improve delivery of healthcare (Raleigh and Foot, 2010; Shirley *et. al.*, 2016). In a letter to the editor of the International Journal for Quality in Health Care, in the context of patient-reported experience measures (PREM), Bull (2021) questions whether patient satisfaction is the best measure for improving patient-focused health as this may relate more to patient expectation than actual service quality:

> "It is important to highlight the difference between 'patient satisfaction' and 'patient experience' as they are two separate (though complexly related) concepts. It could also be argued that patient-reported satisfaction measures are outdated and that PREMs are a better means of gaining insight into the aspects of healthcare that patients truly value." (p.1)

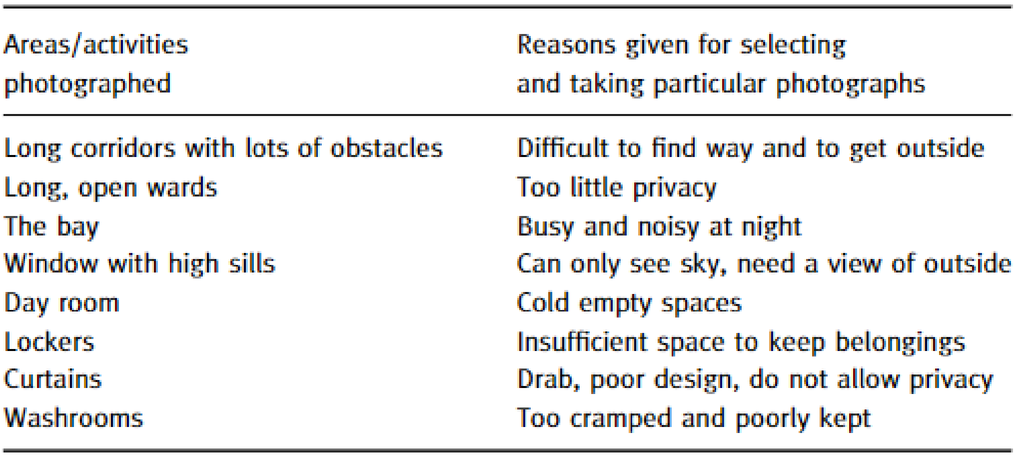
There is debate however, as to the clarity of definition and boundaries conceptually of patient experience and its congruence with "patient expectation" and "patient satisfaction"

(Bull *et. al*., 2019, p.1024). It is argued that PREMs, whilst potentially an improvement on satisfaction as a means of measuring, may be influenced by aspects outside of the health care that was experienced, and therefore might be more of a reflection of the patient's hopes and dreams or clinical outcomes as opposed to a measure of their actual health experience at that time (Manary *et. al*., 2013). Whilst it is proposed that PREMs are superior (since they seek to ask whether something was done, rather than how satisfied the patient was with what was done), they remain focused on process and are administered by surveys (Male *et. al*., 2017), which potentially misses opportunities for hearing the patients' personal views. This thesis suggests that these concepts of patient experience and satisfaction are intertwined in reality, since patients come to the waiting room with a wealth of expectations, as well as diverse experiences and outcomes of care at this stage and beyond that should not be ignored.

2.2.2.3 Patient Space Indicators

With specific reference to space, a scarcity of literature was found concerning PREM, yet some studies have proposed aligning what is measured more closely with what is important to the patient. These studies have focused on defining a set of core indicators, frameworks or measures for considering patients' issues or priorities such as the list of dislikes shown in Table 2.2 (Douglas and Douglas, 2005; Robert and Cornwell, 2013; Zhao and Mourshed, 2012). Here the term indicators can be defined as key aspects of the space that might affect patients' perceptions.

Table 2.2 List of Photographs Taken Representing Patients' 'Dislikes' (Douglas and Douglas, 2005)

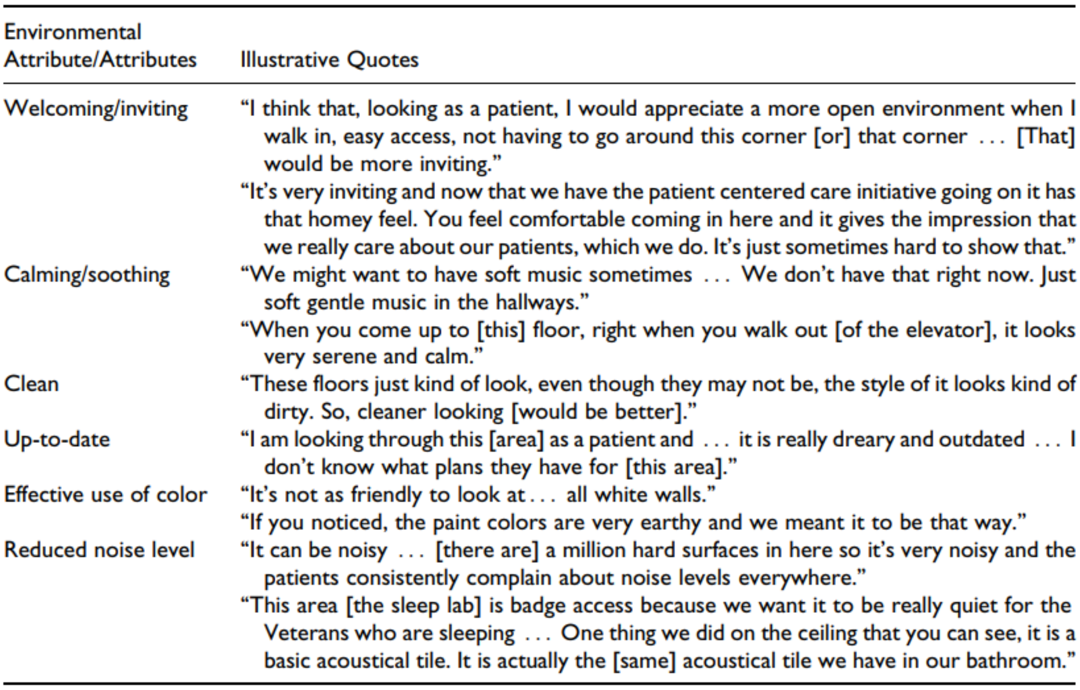


Areas/activities photographed	Reasons given for selecting and taking particular photographs
Long corridors with lots of obstacles	Difficult to find way and to get outside
Long, open wards	Too little privacy
The bay	Busy and noisy at night
Window with high sills	Can only see sky, need a view of outside
Day room	Cold empty spaces
Lockers	Insufficient space to keep belongings
Curtains	Drab, poor design, do not allow privacy
Washrooms	Too cramped and poorly kept

Due to the methodologies of these studies typically engaging with patients directly, such indicators are therefore proposed as valid and significant in framing future studies and are certainly asserted by this thesis as credible components to be considered as influencing the conceptual framework for this study. Zhao and Mourshed (2012) defined such key aspects to consider, such as seating, lighting or entertainment, as “design factors” and formed these based on conducting interviews and focus groups with patients and comparing this to extant literature in order to further shape the subsequent questionnaire.

Locatelli *et. al.* (2015) term such factors as “environmental attributes” citing examples such as “welcoming” or “soothing” (Table 2.3). However, like previous studies, the participants were clinical management, clinicians and other staff and *not* patients and so these attributes merit review before being considered as influential aspects on further patient-focused study.

Table 2.3 Environmental attributes cited by participants, (Locatelli *et. al.*, 2015, p.22)



Environmental Attribute/Attributes	Illustrative Quotes
Welcoming/inviting	“I think that, looking as a patient, I would appreciate a more open environment when I walk in, easy access, not having to go around this corner [or] that corner . . . [That] would be more inviting.” “It’s very inviting and now that we have the patient centered care initiative going on it has that homey feel. You feel comfortable coming in here and it gives the impression that we really care about our patients, which we do. It’s just sometimes hard to show that.”
Calming/soothing	“We might want to have soft music sometimes . . . We don’t have that right now. Just soft gentle music in the hallways.” “When you come up to [this] floor, right when you walk out [of the elevator], it looks very serene and calm.”
Clean	“These floors just kind of look, even though they may not be, the style of it looks kind of dirty. So, cleaner looking [would be better].”
Up-to-date	“I am looking through this [area] as a patient and . . . it is really dreary and outdated . . . I don’t know what plans they have for [this area].”
Effective use of color	“It’s not as friendly to look at . . . all white walls.” “If you noticed, the paint colors are very earthy and we meant it to be that way.”
Reduced noise level	“It can be noisy . . . [there are] a million hard surfaces in here so it’s very noisy and the patients consistently complain about noise levels everywhere.” “This area [the sleep lab] is badge access because we want it to be really quiet for the Veterans who are sleeping . . . One thing we did on the ceiling that you can see, it is a basic acoustical tile. It is actually the [same] acoustical tile we have in our bathroom.”

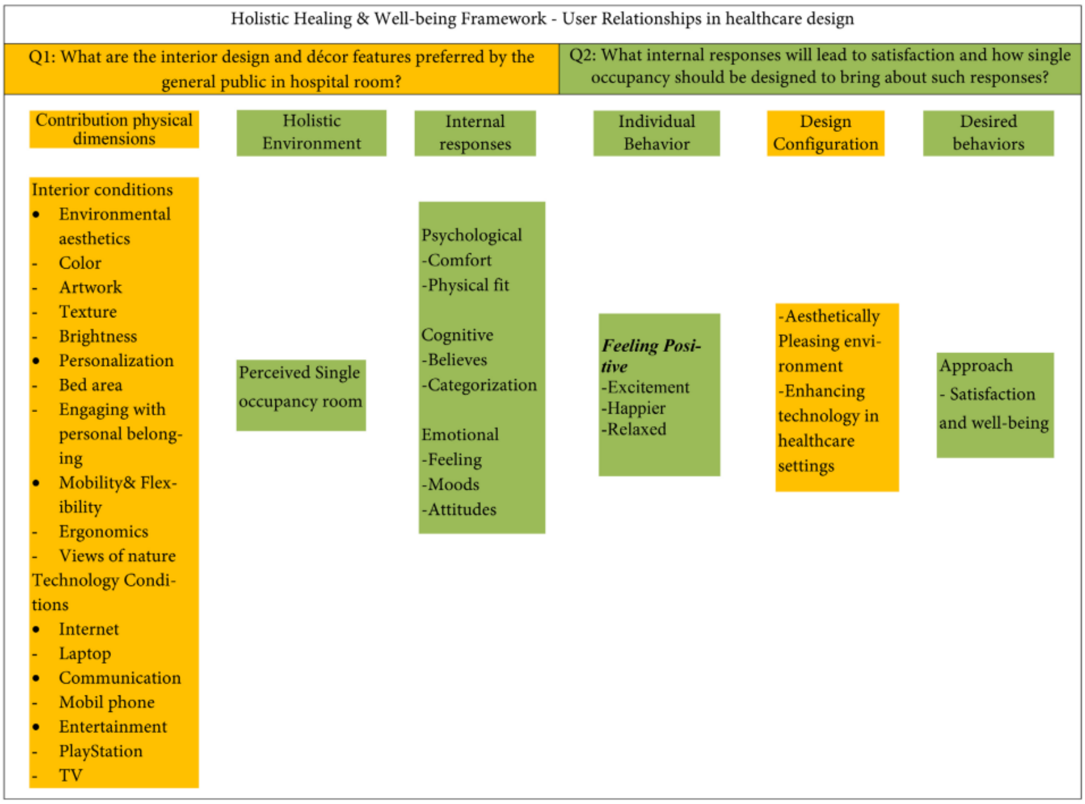
In a previous review of literature on comparisons between types of hospital departments and their effects, Eijkelenboom and Bluyssen (2019, p.96) categorised indicators into three concepts: “sensation, perception and cognition”, where patient stress was related to elements within the waiting room such as layout and decor. However, interestingly, the review also found that staff felt that attributes such as artwork and views were more critical for staff areas than for patient spaces. These terms of sensation, perception and cognition are not dissimilar to the concepts termed in Research Objective Two of conceived, perceived and lived experience (Soja, 1996). Irrespective of terminology, such works have in common the goal of identifying core aspects of the environment, and these similarly occur fairly frequently within the research and should be noted as significant.

Another relevant framework for measuring patient well-being is the Holistic Healing (HH) framework proposed by Gashoot (2022). Despite considering inpatients rather than the waiting room, the study emphasises the importance of the designer in shaping surroundings focused on patient satisfaction by comprehending theories of human behaviour. Citing the notion of “distinct distance” Gashoot describes a three-pronged set of interpersonal transactions consisting of intimate, personal, and social distances. Intimate meaning the private and immediate space around the body; interior personal comprising a space for personal conversations with family or close friends; and social as an area for more temporary contact with others. In critiquing previously significant frameworks such as Bitner’s (1992) servicescape framework as not encompassing aspects such as design configuration of spaces or technological opportunities, Gashoot then argues that four key themes influence patient satisfaction:

1. Environmental aesthetics such as wall colour and plants;
2. Personalisation concerning how the patient will respond to such aesthetics;
3. Digital technology for pleasure;
4. Mobility and flexibility in terms of navigation, spatial layout and ergonomics.

In essence, these themes can be categorised into two key areas as seen in the Holistic Healing well-being framework (Figure 2.2): ‘design and décor’ and ‘internal response’. However, this simplifies and generalises use-cases (ways of using systems to meet a specific goal for a particular user [Jacobsen and Spence, 2011]), without paying sufficient attention to the internal responses that this thesis asserts require further study.

Figure 2.2 Holistic Healing & Well-being Framework—User Relationships in Healthcare Design, (Gashoot, 2022)



Certain studies, moreover, whilst exploring a range of measures concerning space and service levels, signify a problematic juxtaposition between policy or monetary pressures and the ability to truly listen to the patients' needs and preferences (Goodrich and Cornwell, 2008; Robert and Cornwell, 2013). It can be stated that there is no one right way to define a measure of spatial factors for patients, since no one framework is conclusive and whilst there may be common factors, themes or theories occurring, the patient voice at front and centre seems rare within previous frameworks.

2.2.2.4 A Key Theme Within the Measures – Dignity and Privacy

As well as the factors and frameworks identified for patients to experience space and effectively feel enabled in different ways, the associated themes of dignity and privacy also featured quite regularly within the discourse of assessing health experiences and merit discussion within this review (Douglas and Douglas, 2005; Stephen Ekpenyong, 2021).

In the context of health, dignity is a clear concern, being a key stipulation within the UK Nursing and Midwifery Council Code of Professional Conduct, which instructs staff to take responsibility for patient dignity (Gallagher, 2004). Dignity in health has been explained variously in terms of one's inner view on one's self-worth, but also vicariously in terms of actions and behaviours by others (Gallagher, 2004). As a definition of dignity in health in this context, Mains' (1994) explanation implies a level of agency on the part of the patient that is further explored conceptually in terms of Marxist Humanism in section 2.6.2 below:

> "Dignity exists when an individual is capable of exerting control over his or her behaviour, surroundings and the way in which he or she is treated by others. He or she should be capable of understanding information and making decisions. He or she should feel comfortable with his or her physical and psychosocial status quo". (p.948)

Baillie *et. al.,* (2009) argue that dignity can be affected by both the environs and the behaviours of staff, yet debate on the surrounding environs, discussed therein in terms of lack of privacy in shared spaces, only touches on the impact of the physical space and lacked depth on this topic.

In many studies privacy was connected to respect and dignity, such as in the care home setting for older patients, (Høy *et.al.*, 2016); staff behaviours on the ward (Papoulias *et.al.*, 2014); or even concerning what was said to patients and their interpretations of communications with staff (Matiti and Trorey, 2008). This latter study is of relevance to thesis since a phenomenological hermeneutic (the "lifeworld as lived", [Laverty, 2003, p.24]) approach was taken via semi-structured interviews, whereby the goal was to understand patient meanings of how dignity was in some way compromised for them. This resulted in the provision of six factors that again might merit further review for this thesis:

1. privacy;
2. confidentiality;
3. communication and the need for information;
4. choice, control and involvement in care;
5. respect and decency;
6. forms of address

However, the limitations of applying this work to this study are that it purely considered dignity as a dimension and did not consider the impact of space on this aspect for patients.

More recent studies on dignity and privacy have focused on the ward experience (Braithwaite and Ninon, 2024; Raee *et. al.*, 2017; Reddin *et. al.*, 2019; van Belle, 2020). Whilst this is understandable since patients are residential and hence need privacy for changing, washing and sleeping for example, the waiting room merits further consideration since there is a lack of material on this topic. The main area where the waiting room featured in the context of dignity was in terms of admissions or the emergency room, but not in terms of the space specifically.

Above all, the themes of privacy and dignity were prevalent within many of the studies concerning patients and clinical spaces and arguably should be recognised and discussed in future study of patient feelings and emotions and in relation to health space interpretations. This is further discussed in the context of Marxist Humanism (see section 2.6.2).

2.3 Waiting Rooms and Their Various Features

Whilst many previous studies on patient experiences of space focused on measures relating to the hospital ward or specific clinical outcomes, there is a smaller disparate body of literature that analysed the waiting room, which is the context for this study (Arneill and Devlin, 2002; Ayas *et. al.*, 2008; Jiang *et. al.*, 2017; Juliá Nehme *et. al.*, 2021; Tsai, *et. al.*, 2007; Xuan *et. al.*, 2021). The waiting room is cited as having influence on patients and the large scale of people that have to wait for services is noted as meriting review (Juliá Nehme *et. al.*, 2021).

Generally speaking, the notion of waiting and queuing has been seen negatively, and related to feelings of being bored, confused or not being treated fairly, although conversely it has also been argued that it presents various forms of creative opportunity for users, involving waiting as 'an entrance into imaginative and experiential depth' (Bishop 2013). Here Bishop suggests that waiting, as opposed to being a notion of horizontal movement through time and space (effectively waiting for the appointment), becomes a more existential 'vertical' mode whereby different social interactions and micro cultures might be at play. He cites Gardner's (2011) work conveying how older citizens experience waiting in a bank queue as an opportunity for social interaction. Clapton (2018, p.15) however, describes the waiting room as a space that can “encourage passivity and increase anxiety and produce a retreat into, in both senses of the phrase, a patient silence”.

Waiting has even been attributed to erasing the individual identity of those waiting and turning them from person to patient (Tanner, 2002). In contrast, the waiting room experience must be acknowledged as just one part of the patient’s burdensome experience of waiting in their health journey, as articulated by Mulcahy (2021):

> “They waited in waiting rooms, in hospital beds, and at home by the phone. They waited for health care professionals to tell them what they had, where they could go, and what they could do. Often these waits were long and indefinite. Many participants described these waits as psychologically and sometimes physically detrimental”. (p.1072)

This bigger picture perspective may be pivotal for this study, in terms of not only listening for the patients’ accounts of their waiting room experience, but in recognising the context and mindset of the patients’ holistic health journey.

In health, the impact of the waiting room as a physical space is dependent on the subjective interpretation by the patient of the features within and how these fit the patient’s needs (Leather *et. al.*, 2003). These features have been variously researched and tested in different healthcare settings within the literature and have largely been muted to have beneficial outcomes when their inclusion was analysed. These included, for example, a desire for a calm environment that offered some form of nature, appropriate use of colour and facilities for children, as well as natural daylight and calm sound levels being of significance (Ayas *et. al.*, 2008; Pouyesh, *et. al.*, 2018). With reference to sound, it has been found to be both intrusive and comforting (North and Hargreaves, 1999).

2.3.1 Music

Music has been widely attributed to contributing to reduced anxiety whilst waiting, although there is a lack of research on which forms of music might be most effective (Lai and Amaladoss, 2022; Winter, *et. al.,* 1994). Despite analysing the impact of music on actual patients as subjects, including at different times of day, methods employed tended towards an intervention and then clinical or objective measurement, such as heart rate variability

(HRV), pain rating scales such as Visual Analogue Scale (VAS) (Lee *et. al.,* 2012), or in certain cases conducting questionnaires (Collins *et. al*., 2022; Spechbach, *et. al.,* 2023; Tansik and Routhieaux, 1999). Music has also been suggested as a useful distraction from hearing other noises such as doctor/patient discussions or from consciousness of waiting times (North and Hargreaves, 1999; Pfeifer and Wittmann, 2020; Ulrich, 1997). It appears an opportunity remains to discuss preferences for music type, purpose and level of volume with patients.

Whilst not considered as a form of cure for illness, colour within the waiting room and other areas was frequently cited within the research as being beneficial for patient well-being, with calm colours and lower levels of saturation being preferred (Dalke *et. al.*, 2004; 2006). However, research is somewhat inconclusive as it provides a range of results in understanding colour preferences from warm and welcoming colours such as reds and oranges to cooler calming colours such as blues and greens (Arneill and Devlin, 2003; Ayas *et. al.*, 2008; Birren, 1978; Dalke *et. al.*, 2006).

2.3.2 Lighting

Connected to colour, lighting in the waiting areas also featured widely, with preference for warmer over white lighting being evidenced; yet a desire for a mid-point of optimum brightness, and debate over when dull light is depressive or bright light is counter-productive has resulted in somewhat contradictory outcomes of various questionnaires (Huang and Chou, 2021; Zhao, and Mourshed, 2017). Natural lighting has been associated with comfort, yet colour and light should not be seen as separate elements (Balabanoff, 2017; Ismayadi *et. al.,* 2022). Given the paradoxical range of outcomes of studies concerning light and colour, further investigation of this subject, through different methodologies, might therefore be of merit.

2.3.3 The Importance of Wayfinding

Another factor that emerged frequently from the studies reviewed was that of wayfinding. Wayfinding has been well-documented as problematic in health settings; hospitals tend to be large and unfamiliar, visitors tend to be anxious on arrival and often wayfinding devices have been added over time, where the use of spaces have changed, resulting in clutter and confusion (Bubric *et. al.*, 2021; Cheng, and Perez-Kriz, 2014; Mollerup,2009). This is exacerbated in cases where patients have various levels of impairment adding to the difficulty of navigation (Jamshidi and Pati 2021).

Significantly, studies concerning wayfinding in health settings did tend to adopt more of a user-centred approach than other health space research, whereby patients were actively navigating through spaces and then asked questions about their experience. Gans (2002, p.329) argues that user-centred research into space should be primarily causal, i.e. research should focus on the way space affects social collectivities. This is supported by Thomas and Cross (2007) who suggest that organisations have a responsibility towards the social construction of places and that space and place are two different constructs. Here a space becomes a place due to the users within and the meanings they apply to it. This is the premise of this thesis in terms of the conceived versus lived experience to be addressed in Research Objective Two, Chapter One. Wayfinding then, perhaps due to the fact that all visitors will undoubtedly experience it, can be considered a key component of a user-centred approach to understanding patient-space relationships. As Rodman (1992) argued, place can be conceptually empowered to help with our comprehension of social meaning of spaces and wayfinding is possibly the most common tangible topic to consider.

2.3.4 Time and Space

When it comes to waiting rooms, time is not purely linear, but involves levels of subjectivity and is a social phenomenon (Klingemann, 2000). Whilst patient perceptions of time, and length of waiting once they found their way to the waiting room, was often embedded in the discussion of the literature, this was not seen as a key spatial concern for patients but rather something that might be an outcome of the space. Nevertheless, a range of factors have been researched in terms of the impact of these on the patients' sense of waiting. Some of these were found to be service-related aspects such as booking procedures or queue hierarchies (Naiker *et. al.*, 2018) where it is argued that operational efficiency should take priority. This was supported by Gutacker (2016) who reviewed time more broadly in terms of operation wait times, which is outside of the scope of this study but still a key factor for some patients within their health experience.

Research showed however, that sometimes softer factors impacting perceptions of time were at play, such as the notion of being forgotten (Spechbach, *et. al.*, 2023), transparency of information whilst waiting (Xie and Or, 2017) or overall wait time in relation to the patient's sense of satisfaction (Zakare-Fagbamila, 2019). Waiting has been cited as “putting people at the mercy of another’s schedule” (Mulcahy, Parry and Glover, 2010).

In terms of the waiting room space, there is a lack of evidence of the impact of the environment on perceptions of time, however, auditory factors such as music have been shown to reduce waiting times from a patient’s view (Xuan *et. al.*, 2021). There is also some limited evidence that artistic interventions within the space can to some extents have a positive impact on “felt” (imagined) versus “clock” (actual) time (Klingemann, *et. al.*, 2000, p.85). Very little evidence seemed apparent of studies asking patients about their feelings about time and its passing in relation to the design of waiting room spaces.

2.4 Section Summary

This section has evidenced that research into relationships between spaces and users has spanned diverse forms of setting. For health it has conveyed how academic interest in understanding the effect of patient spaces has shifted from purely clinical measures and experiments to the inclusion of softer emotive concerns and interventions. Whilst a significant body of research has been conducted resulting in the emergence of common and potentially valid attributes of health spaces including sound, colour, lighting and wayfinding, methodologies have tended towards questionnaires and quantitative analysis leaving an opportunity for research to further explore emotive concerns. Waiting rooms specifically have garnered less attention than the study of the impact of inpatient ward spaces, and this also opens the door for further review.

Forms of engaging with patients such as EBCD and co-production have moved the patient narrative forward, yet it can be argued that putting the patient voice front and centre remains scarce and such models can be challenging for health staff to apply. Additionally, there is insufficient evidence of ethnographic field observation or empathetic embedding of the researcher within the settings, which would add another level of insight to potential further study.

These studies have helped to lay the foundations for this thesis in that they introduced the acknowledgement of patient preferences, their whole experience including expectations and to some extent, a recognition of a need for individualisation, yet this section highlighted the lack of more qualitative methodologies for gathering such preferences such as interviews.

Previous research has set the scene for the relevance of identifying a range of indicators or measures across a broad spectrum of the patient experience which might contribute to a wholistic understanding of patient needs. However, this might be used as a general guiderail, since to adopt a pre-determined or finite set of indicators for this study would potentially limit the value of the original data to be gathered and important factors affecting the patients in the settings within this research might therefore be missed. Psychological constructs such as dignity and privacy and notions of time have emerged as significant to the study of patient spaces and merit further review.

In conclusion, previous conversations in this field have often related to improving circumstances for one clinical condition, or forming practical or process recommendations, whereas there is a dearth of research with a clear priority of deeply understanding patient affective feelings and emotions above practical concerns.

2.5 Design and Health Research

This section discusses the role of design in health research. After portraying perspectives on design theories such as user-centred design and co-production and their application to health, conversations on the challenges of health spaces and design are also critiqued. Paying particular attention to 'design thinking', a methodology that has been gaining credibility in contemporary health service conceptualisation, and 'experience design' as a subset of design thinking, this section concludes with gaps in current literature on this topic.

2.5.1 Participatory Design Methodologies

Historically two key areas where design has been applied for health have included the architecture of health centres and hospitals, and medical innovation in clinical products and technologies (Tsekleves and Cooper, 2017). More recently design in health research has grown to address concepts of service, care and patient needs, yet with some approaches being less scientific and more iterative in nature, researchers and health practitioners have found such design-led methodologies at times uncomfortable or unfamiliar to apply (Johnson *et. al.*, 2021). Design research in health has also been cited as problematic in that it does not focus sufficiently on end-user needs, yet research by co-design or co-production methods has been muted as one way of solving this issue (Slattery *et. al.*, 2020). Here, the participation of patients and other stakeholders has been demonstrated as a beneficial aspect of service design resulting in better alignment with user needs and even cited as socially transformative in nature (Bowen *et. al*., 2013).

2.5.1.1 Co-production and Capability Sensitive Design

Co-production is often associated with designing service experiences and is effective where communities need to be recognised (Boyle and Harris, 2009). Emerging from a critique of previous public service systems, where indifference or passivity to user needs has been termed as problematic and resistance to change has been an issue, co-production has been defined as a way to engage with multiple stakeholders in a setting, encouraging their contribution, as Boyle and Harris defend:

> “The co-production critique suggests that the conscious or unconscious maintenance of service users as passive recipients is not just a waste of their skills and time; it is also the reason why systemic change doesn’t happen.” (P.11)

Co-production facilitates the sharing of knowledge between people such as patients to support each other (Boyle and Harris, 2009) and “gives responsibility back to service users” such as in the Expert Patients Programme (EPP) in the UK where patients with long-term conditions can self-manage their conditions through the establishment of a Community Interest Company (CIC), (Gov.uk, 2013). Oliver *et. al.* (2019), caution that co-production, typically being seen as wholly positive, can cause friction between various stakeholders and that the benefits and potential applications are still misunderstood, stating that motivations should therefore be clarified and potential outcomes clearly thought-through. However, in response, Williams *et. al.,* (2020) argue that the term co-production is used too broadly, that technocracy over democracy has driven research too extensively in this area and that context of the research of such projects is often overlooked; where they cite corrupting influences at play such as power systems and relational spaces. This notion of acknowledging context is topical for this thesis and merits review in order to ensure the patient situation and mindset is considered (see section 2.6.2 Marxist Humanism).

Building on the concept of design acknowledging people’s contributions, Capability Sensitive Design (CSD) (Oosterlaken, 2009), is formed from a design philosophy prioritising human capability over resource or utility, shaping what users are able to ‘do’ or ‘be’. Whilst conceived from a broader lens of design for developing communities and justice for all, Oosterlaken builds upon Sen’s (2005) argument that human rights and capability design are connected. In the context of product development Oosterlaken (2009, p.98) asserts that the “details of design” are crucial in moral terms and that these are value-laden with potential effect on privacy, autonomy, sustainability, safety, and justice. CSD, whilst still relatively new, appeals to a focus on the “existence of immense human diversity” and putting ethics above functional satisfaction. Whilst there is extremely limited evidence of research into the potential of CSD for health, Jacobs *et. al.* (2021) propose a revised framework combining Value Sensitive Design (VSD), a methodology systematically embedding values into the process (Friedman and Hendry, 2019), with Nussbaum’s (2006) ten capabilities for ensuring well-being which are:

(1) live a normal life span

(2) have good bodily health, including reproductive health

(3) experience bodily integrity, freely move around, and make reproductive choices

(4) use one’s senses and imagination, and think

(5) experience emotions and have emotional attachments

(6) exercise one’s practical reasoning in order to form a conception of the good, and critically reflect about one’s life choices

(7) establish affiliations, that is, live with others and have a social basis for self-respect

(8) live with, and express concern for, other species

(9) play, laugh, and enjoy recreational activities

(10) participate effectively in political choices, and control one’s social and physical environment, including to hold property and seek employment.

Tengland (2020 p.27) later links these capabilities with health arguing that health underpins them all but is not a capability in itself. He identifies that what a person “*is* or *does”* is a form of “functioning” that is different from the individual just knowing they may have the capability to do so.

CSD then, by paying attention to inclusivity and values, shines a light on the more emotive aspects of patient experience and the patient's sense of capability (rather than the functional success of spaces) that this thesis attempts to understand and articulate. The inclusion of functioning means that one can consider not only what the patient feels they might have been able to do, but what they actually did.

Despite various methodologies such as these for involving multiple stakeholders in projects, debate has ensued as to the benefits of incorporating public participation earlier on in the design process of health settings. Payne *et. al.* (2015) concluded their research into understanding patient needs for health spaces, by formulating an interior design brief model incorporating some 26 recommendations applying to atmosphere, points of contact, waiting and health assessment experiences (see Appendix 1). Whilst this approach engaged with patients in the initial design processes, it has been argued in a number of studies that neither patients or staff have the necessary skills or agency to determine the best form of spatial factors (Csipke *et. al.*, 2016; Payne *et. al.*, 2015; Stacey and Tether, 2015). However, it may be valid in considering the validity of some of these recommendations for future research frameworks since they emerge from a user-centred methodology.

In summary, various participative approaches to embedding patients within health design projects have been formulated and trialled in various scenarios in the last two decades, yet critique of such methodologies cautions that the process needs to be carefully considered to avoid friction between stakeholders, an over-emphasis on technology, or functional over ethical priorities.

2.5.2 Design Thinking

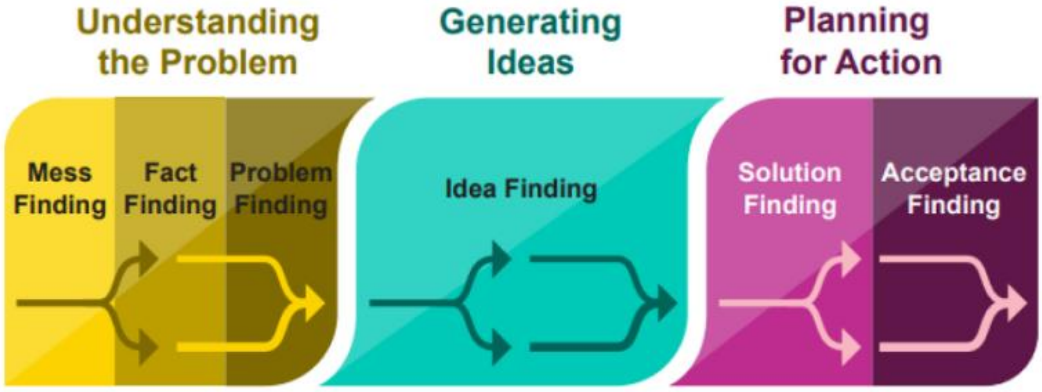
Another framework centred around user-participation is design thinking. This section concisely outlines the development of the design thinking domain and its benefits for understanding human needs. This is then brought into the context of health and the relevance and suitability of this discipline is debated. Finally, opportunities for further researching design thinking in this context are proposed, including its relevance to the research aims of this study.

2.5.2.1 Design Thinking: History and Origins

Design has been theorised widely as being about seeing and doing, with creatives acting as finders or makers, and has been described as an intersection between established knowledge and unknown concepts (Hatchuel and Weil, 2009; Owen, 2007).

Design thinking has its origins in creative approaches to problem solving, putting users at the centre of the process, and built upon the notion of brainstorming, a term coined by Osborn and shown within his original Client Problem Solving (CPS) model (Osborn, 1963), seen below following adaptation by Treffinger (1994). This three-step model of understanding the problem, generating ideas and then planning for action operates in an iterative (repetitive) way and underpins later design thinking models.

Figure 2.3 Creative Problem-Solving Model (Osborn, 1963; Treffinger *et. al.*, 1994)



Design Thinking has emerged since the late twentieth century and is essentially a way of solving problems with innovation at its heart (Brown, 2008). It has been defined as a way of being rather than purely the property of designers (Dam and Teo, 2024); it is about focusing on asking questions rather than simply seeking answers, and as articulated by Liedtka (2012):

> "Design understands that products and services are bought by human beings, not target markets segmented into demographic categories." (Para. 9)

Hence design thinking has a deep emphasis on humans first. Originally the domain of corporate businesses wanting to take problematic scenarios and seek improvements to them (Liedtka, 2018), it was adopted as having potential for service realisation and latterly for innovating in the social sector (including healthcare), where arguably it has not yet reached full potential (Liedtka, Salzman and Azer, 2017).

There are many definitions of design thinking, including from key exponents such as the Stanford d.School who explain it as method for solving problems creatively (Stanford d.school, 2022), academic and practitioner Liedtka (2018) who termed it as having the possibility to do for business and society what Total Quality Management did for manufacturing in the 1980s (Liedtka, 2018), and key founder Brown (2008) who coined the phrase and states within his blog for design consultancy IDEO that design thinking is:

> “a discipline that uses the designer’s sensibility and methods to match people’s needs with what is technologically feasible and what a viable business strategy can convert into customer value and market opportunity (para. 1)”

Most design thinking approaches have in common a five stage approach to problem solving. For example, IDEOs Five Phases of the Design Process (Figure 2.4).

Whilst the syntax varies, this typically involves an initial stage of empathising with users, followed by working to define the specific problem(s), before ideating (brainstorming) ideas for how it may be solved, then prototyping a solution through various iterations, before testing this, and if necessary repeating the latter stages. This is often done in short projects at speed (agile design sprints) to discover what works and what does not (Brown, 2008, Liedtka 2018) and then the process is repeated to shape improvements.

Figure 2.4 The Five Phases of the Design Process (IDEO, 2024)

In recent publications, the term Health Design Thinking has emerged, where the goal is to enhance human well-being through creative problem solving (Ku and Lupton, 2022). Here embedding design thinking in pharmacy redesigns, telehealth services and workshops for public health education, has shown benefits (Abookire, 2020).

2.5.2.2 Design Thinking and Health

If advances are to be made in the design of spaces for patients, it is important to recognise that design as a discipline does not sit purely within the realm of designing websites and logos but should be embraced for delivering service experiences (De Lille *et. al.*, 2012). It should also come in early in the project process, rather than design historically being tagged on later (Brown, 2008). In the healthcare environment context, this thesis asserts that design should not be seen as simply as the decoration of spaces or the placement of signage, but something evolving from the heart of user needs and emotions. Design thinking in the context of healthcare represents a shift from purely scientific approaches to exploratory ways which play to the skills of creativity and visualisation (De Lille *et. al.*, 2012; Kummitha, 2019; Razzouk and Shute, 2012; Sipe, 2018) and may therefore add value conceptualising to the patient experience.

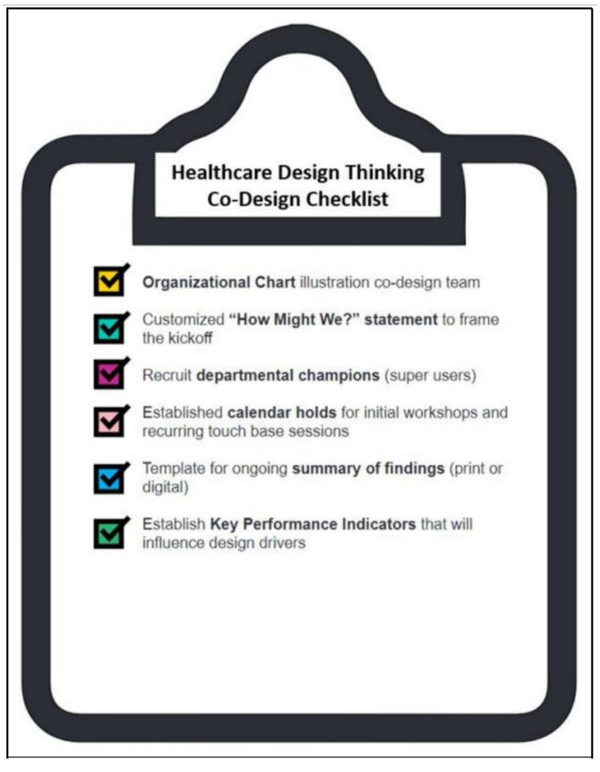
Design thinking is widely muted in academia as a solution to balancing complex or confusing “wicked” problems (Lönngren and van Poeck, 2021, p.481), yet whilst it has been utilised within various health specialisms such as oncology and radiology, these tend to be single case projects and there remains a need to focus on engaging more with end-users, particularly patients (Oliveira, *et.al.,* 2021).

Design thinking has also been discussed as a way of speeding up previously lengthy processes, sometimes spanning years, for example software or product development and implementation, although some studies suggest the effectiveness of the various stages of a design thinking process require further individual review (Altman *et. al.,* 2018; Carroll and Richardson, 2016). One area of confusion (but arguably also of freedom and flexibility) for healthcare professionals is that there is no one singular design thinking approach (Lorusso *et. al.,* 2021).

Healthcare requires constant innovation in order to best align the ever-increasing political and social demands described in Chapter One, with patient needs, yet there are only limited, easy-to-use frameworks for innovating within everyday process and organisations (Roberts *et. al.*, 2016). Increasingly complex staff collaborations sometimes known as Interprofessional Collaborations (IPC), are now required in order to deliver more integrated community-centred care, and digital technologies developed through user-centred design thinking processes have been explored as a means for enabling these, although the focus here has been on the opinions of professionals not patients (Alpay *et. al.*, 2023). Whilst end-user scenarios, such as a hip replacement requirement, have been explored through design thinking workshops, end-users were not directly involved, and therefore the health professionals assumed the voice of the patient.

Some studies do support the benefits of design thinking for health; termed as Health Care Design Thinking (HCDT), and in the context of the architecture of health settings, Lorusso *et. al.,* (2021, p.24), argue that whilst it can be “a daunting task for design teams to design effective healing spaces” in rapidly changing clinical contexts, an approach facilitating the input of multiple stakeholders is beneficial. To this end they proposed a practical framework in the form a checklist (Figure 2.5) for enabling a systematic approach to HCDT projects. However, it should be cautioned here that despite being termed as a codesign checklist, this model seems somewhat linear and process-based rather than iterative and agile/flexible.

Figure 2.5 Healthcare Design Thinking Co-design Checklist, (Lorusso *et. al.*, 2021)



Healthcare Design Thinking
Co-Design Checklist

☑ **Organizational Chart** illustration co-design team

☑ Customized **“How Might We?” statement** to frame the kickoff

☑ Recruit **departmental champions** (super users)

☑ Established **calendar holds** for initial workshops and recurring touch base sessions

☑ Template for ongoing **summary of findings** (print or digital)

☑ Establish **Key Performance Indicators** that will influence design drivers

In practice, efforts have been made within certain clinical disciplines to make design thinking easier to apply, such as the online learning platform Design Thinking for Health (n.d.) where nurses can learn to apply the model to their own challenges, or the digital course “Creative Problem Solving: Design Thinking in Health and Social Care” on the St. Georges Hospital platform (Futurelearn, n.d.). Nevertheless, despite tangible examples of design thinking product and service innovations in the health and social sector (Liedtka *et. al.*, 2017), only a smaller number of studies have turned attention to design thinking for understanding patient preferences (Park *et. al.*, 2022; Sunder *et. al.*, 2020; Uehira and Kay 2009).

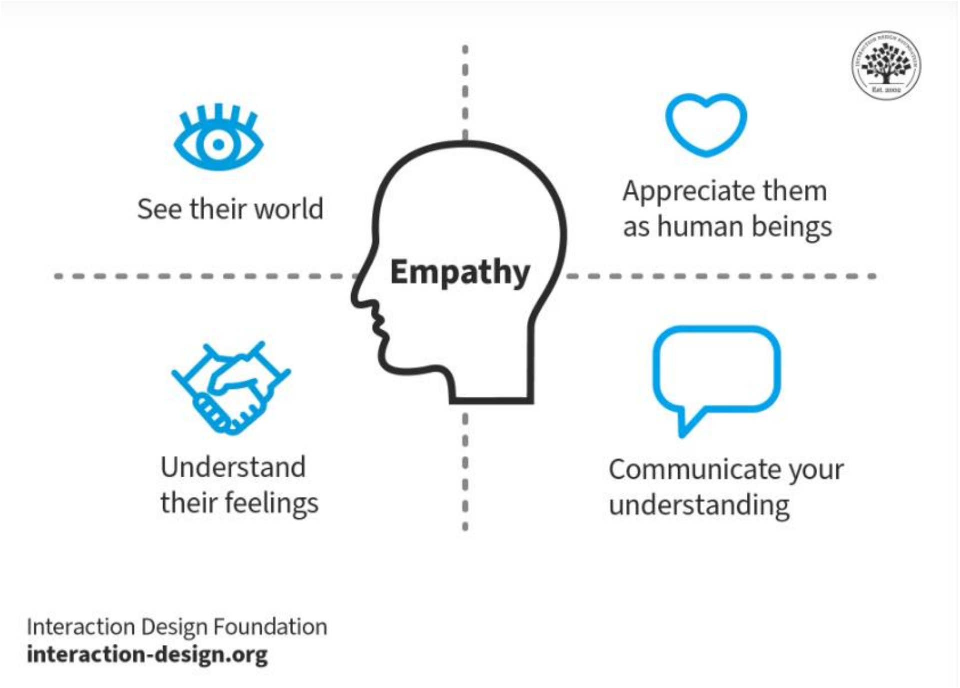
2.5.2.3 Design Thinking and This Study

The design thinking focus for this study primarily concerns two key perspectives: the Stanford d.school model and Experience Design, as these constitute key considerations of thesis: deep empathy with the end-user and an experience-focused approach.

The seminal design thinking framework created by the Hasso-Plattner Institute of Design at the Stanford d.school (see Chapter One, Figure 1.2) is adapted for this study and embedded within the conceptual framework created by the Researcher. It should be noted that since this is not explicitly a project to redesign a space per se (the focus here is on giving voice to the patients and understanding their perceptions rather than creating design specifications within the scope of this thesis), the first two phases of empathize and define have been adopted as the primary foci, with the practical stages of ideate, prototype and test suggested for later studies in practice settings.

The first phase, empathize, is the work undertaken to understand people, how they think about things, the way they operate and what has meaning for them (Hasso Plattner, n.d). Key to this stage are considerations of all perspectives of the end-users with a "compassionate eye" (IDF, 2024). This stage concerns listening to others with an open mind and see things through the user's eyes since they are the experts (IDF, 2024). Figure 2.6 shows the four dimensions of empathising according to the Interaction Design Foundation (2024). They caution that to fully empathise, researchers must put aside any bias considering the following four dimensions in relation to users: see their world, appreciate them as human beings, understand their feelings and communicate your understanding. These align well with the research aim of this study and also the chosen method of semi-structured interviews where there is space for a dialogue between researcher and user (patient).

Figure 2.6 Empathy Map (IDF, 2024)

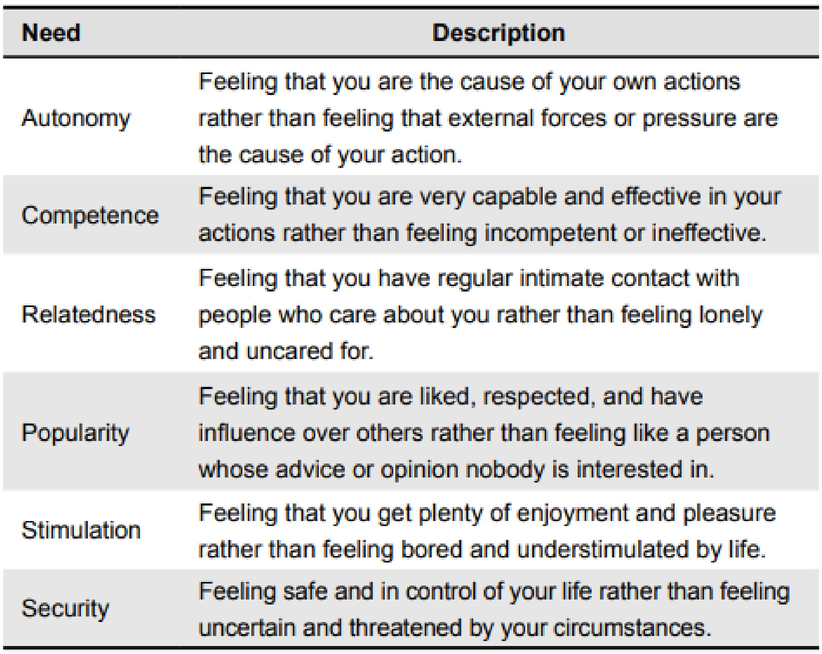


2.5.2.4 Experience Design

A subset of design thinking called Experience Design was also reviewed when conceptualising this study. Hassenzahl, (2010, p.8) described an experience as "an episode, a chunk of time that one went through, with sights and sounds, feelings and thoughts, motives and actions."

Whilst this was in the context of interactive technology, this definition is apt for this study in that patients experience certain chunks of time – particularly in the waiting room.
Building on Sheldon, Elliot, Kim, and Kasser's (2001) summary of 10 psychological needs for positive experiences, Hassenzahl *et. al*., (2010) stated that experience design concerned the pursuit of happiness and condensed this to six key needs for "positivity and happiness" to be achieved through design (Table 2.4). These were not related to health in these studies, but all appear highly appropriate for the waiting room context and patient experience more generally and could serve as useful measures when considering patient accounts of their time.

Table 2.4 Overview of a Set of Needs Suitable for Experience Design (Hazzenzahl *et. al*., 2010 p.22; Sheldon *et. al.,* 2001)



Need	Description
Autonomy	Feeling that you are the cause of your own actions rather than feeling that external forces or pressure are the cause of your action.
Competence	Feeling that you are very capable and effective in your actions rather than feeling incompetent or ineffective.
Relatedness	Feeling that you have regular intimate contact with people who care about you rather than feeling lonely and uncared for.
Popularity	Feeling that you are liked, respected, and have influence over others rather than feeling like a person whose advice or opinion nobody is interested in.
Stimulation	Feeling that you get plenty of enjoyment and pleasure rather than feeling bored and understimulated by life.
Security	Feeling safe and in control of your life rather than feeling uncertain and threatened by your circumstances.

Taking a broader view in relation to products and services, experience design is termed by Mootee (2013) as:

> “a holistic and multidisciplinary approach to creating meaningful contexts of interaction and exchange among users and products, services, systems, and spaces. It considers the sensation of interactions with a product or service on physical and cognitive levels…. and include(s) the sensorial, symbolic, temporal and spatial” (p.128)

This definition aligns closely with this study and reflects the research aims in that it refers to cognitive aspects (the minds of the patients) as well as spatial interactions, that other definitions do not address.

2.5.2.5 Challenges of Design Thinking in Health

Design thinking is largely positioned as positive within the context of health (and in the majority of design thinking-related literature), although this primarily relates to product innovation initiatives. However, it has been asserted as being nothing but a “management fad” (Nussbaum, 2011) and as being difficult to singularly conceptualise (Carlgren *et. al*., 2016a) due to multiple interpretations that it is argued hinder it being “researchable”, or applicable.

Altman *et. al.*, (2018) identified “tensions” concerning design thinking for health including: the needs of the users versus what the researchers believe to be right based on their own knowledge and experience; a reluctance for researchers to see the need for conducting the empathy user-needs phases due to literature already being in existence; and a tension between the scope of design thinking to typically hear the voice of the “outliers” in smaller samples versus typical health research focusing on large samples for generalisable findings. These are valid concerns, and the value of a design thinking approach for health should be further researched and communicated. This study is focused on such outliers with a view to results being applicable to a broader target population.

Whilst anecdotes exist of design thinking successes in industry (Carlgren *et. al*., 2016b), there remains less empirical evidence of its applicability and it has been described as difficult for managers to apply outside of product development scenarios (Liedtka, King, and Bennett, 2013). Outside the context of health, Dunne and Martin (2006) suggest that design thinking is problematic because, since the goals and aims are typically defined by project teams and not by management, the outcomes of any projects may lie outside of day to day boundaries in the workplace – in other words such innovations might upset the dominant discourse and culture within a setting. This could most certainly be the case within the NHS where there are multiple pressures affecting day to day delivery such as complex problems "arising quickly and unpredictably" that take priority (Abookire *et. al.*, 2020).

In terms of communications and buy-in within an organisation, design thinking methodologies and the resulting outcomes have also been found to be difficult to embrace by others due to their formulation around "subjective data and human-oriented values" (Carlgren *et. al*., 2016b, p.354). In terms of the NHS this may be pertinent in that this is an environment where more systematic and scientific methods have traditionally prevailed. Rylander (2009) articulates this juxtaposition as:

> "different approaches to problem solving based on fundamentally different epistemologies: a rational, analytic, or intellectual approach, versus an interpretive, emergent, and explicitly embodied approach. The problems to be addressed may be of similar, overlapping, or greatly differing character." (p.7)

2.5.3 Section Summary

This section has shown how design thinking has developed from initially being seen as an approach to solving complex or wicked business problems (Brown, 2008) to being applied to varying extents in health contexts. It has evidenced how, whilst design thinking is well-equipped in principle for addressing human needs, it can be unfamiliar for clinical professionals to navigate and that further research concerning its potential application to patient scenarios would be merited. In noting the caution that these should not be bypassed by researchers, this review suggested the adoption of the initial empathetic listening stages of the design thinking model to align with the research aims, leaving the practical stages of ideation, prototyping and testing for future studies.

2.6 Theoretical Underpinnings

2.6.1 Introduction to the Theories

This section defines and explains each of the theoretical constructs that have been considered appropriate for review in line with the aims and focus of this thesis. These theories are:

1. Marxist Humanism;
2. Spatial Trialectics and the Third Space;
3. Symbolic Interactionism.

The origins, key exponents and interpretations of these schools of thought are explained before justification as to why these are pertinent to both the study aims and objectives and the philosophical positions described in Chapter Three**.** It is important to note here that the focus is not on one theory to be proved or disproved, but rather, several different theories to be combined as guiderails for influencing the conceptual framework in Chapter Three and the resulting research design defined in Chapter Four. Being qualitative in nature, this study is typified by this ‘blurred genres’ approach (Geertz, 1983) of combining various theoretical models side by side, which is termed by Denzin and Lincoln (2005. p.14-20) as “the fifth moment of qualitative research”, a tendency that pervaded until the 1980’s.

Finally, these theories are later reformed into an initial novel framework as a foundation for the research design (Munhall & Chenail, 2008) in Chapter Three, in the framing of the data analysis in Chapter Four and considered for review and improvement in chapter Five.

2.6.2 Marxist Humanism: Origins, Schools and Perspectives

In the initial readings around the topics for this study, one of the patterns that emerged from the health space narratives concerned the notion of patients feeling powerless. There is some evidence of early literature on research into patient experiences concurring with alienation, particularly stemming from the last century (Bologh, 1981; Pulton, 1979; Seeman and Evans, 1962; Younger, 1995). Generally speaking, narratives on remoteness/alienation related to patients feeling unaware of their surroundings, unclear on what was expected of them and unsure of the systems and processes at play in the settings. For example, what was about to happen to them or where they fitted in, which paves the way for broader theoretical questions or perspectives.

The Theory of Alienation, as originally defined by Marx (1843), was a construct of a capitalist society whereby workers (not patients per se) felt insignificant, isolated and lacking in any power. They felt senses of oppression, isolation, and meaninglessness experienced as a symptom of capitalism and the industrial age. In the West, Marxism has variously been interpreted within different philosophical schools, but the alienation and consciousness narrative continued through writings influenced by Hegelian perspectives on the topic (Hegel *et. al.*, 1967, Peters *et. al.*, 2022). A range of academic lectures and studies in the mid-twentieth century comprising the French Hegel renaissance resulted in a humanist perspective on freeing humanity (Peters *et. al.*, 2022). Marxist Humanism then, emerged in the mid-twentieth century from a desire to understand what sort of society would be most favourable to human thriving (and perspectives on individual freedom) and a critical position that acknowledged that Marx had also investigated similar notions.

Whilst early definitions of humanism primarily related to the privileged and aristocracy, interpretations had in common a focus on “self-perfection, the enrichment of personality and the all-round development of the individual” (Hodges, 1965, p.177). Opinion from many philosophers over time such Aristotle, Mill, Arnold and Dewey underpinned and/or critiqued the focus of Marx’s perspective on humanism and its neglect of structures and failure to acknowledge the many facets of contemporary society. Discourse diversly comprised the relationships and dynamics of: the Bourgeois versus the proletariat; intellectual versus moral/practical virtues, liberal versus mechanical activity and dissenting voices versus authoritarian tendances (Aristotle, 1985; Dewey, 1974; Mill, 2002; Stange, 2015).

From his position that humanism overlooks the basic meaning of “being”, which he termed as "Dasein", in 1946 German philosopher Heidegger (1978) responded in his ‘Letter on Humanism’ to French philosopher Jean Beaufret’s questions (also in 1946) concerning how to restore meaning to the word “humanism”. He argued that humanism is metaphysical in that it relates to consciousness of being; of identity, time and space, over being human, and is therefore grounded in subjectivity and idealism:

> “if man is to find his way once again into the nearness of Being he must first learn to exist in the nameless. In the same way he must recognise the seductions of the public realm as well as the impotence of the private. Before he speaks man must first let himself be claimed again by Being, taking the risk that under this claim he will seldom have much to say. Only thus, will the preciousness of its essence be once more bestowed upon the word, and upon man a home for dwelling in the truth of Being.” (p.199)

In other words, he argued that humans had become obsessed with everyday superficialities and should return to a state where they are open and not labelled or categorised, without a need to conform to societal rules, which would in turn, lead to belonging and purpose.

This is in contrast to Jean-Paul Sartre’s (1946) existentialist argument that the individual shaped their existence through their free will and therefore was responsible for their own actions, where he stated that ‘existence precedes essence’; here individuals possessed responsibility for themselves but also for humanity at large (Peters *et. al.*, 2022; Sartre, 1946). Sartre rejected the notion of a fixed human nature and prioritised a focus on understanding human behaviour and individual freedom. This was in opposition to the belief that structures and systems should prevail over human agency.

Following the terms of “structure” and “social structure” being used and critiqued widely within sociology, the term “structuralism” emerged in the 1970s from French linguistic discourses (Assiter, 1984). Whilst theoretically applied to many disciplines, structuralism encompassed the idea of totalities whereby it is not component parts that are significant but the whole; put simply, a system that dominates the elements within it (Assiter, 1984). Runciman (1969) suggests a definition of the difference between structural and non-structural thinking:

> “Perhaps, however, it can be argued that 'structural' theories are distinguished from 'non-structural' in terms of their conception of societies as coherent and integrated wholes between whose components the internal interrelations are particularly strong. On this view, the rival doctrine which structuralism sets out to deny is the doctrine that institutions can be explained individually and as such in non-comparative and largely historical terms”. (p.254)

Here he argued that structural theories enabled a fuller understanding of society by considering the connectivity between institutions, thus negating individuals in this frame.

An exponent of structuralism, French Philosopher Louis Althusser situated this within Marxism by favouring social structures over individual agency. He stipulated history as purely a process without subject, and that people were purely the ‘bearers’ of structures (Perry, 2002). A critic of humanism and individuals as agents for change, Althusser purported that humanism failed to attribute the ways that social constructs and ideologies shaped humans and their day to day actions. In theorising how such ideologies are transmitted within societies, Althusser introduced and attributed Ideological State Apparatuses (ISAs) as key vehicles. ISAs included institutions such as the church and schools but arguably also hospitals (Ardhana and Wardani, 2010).

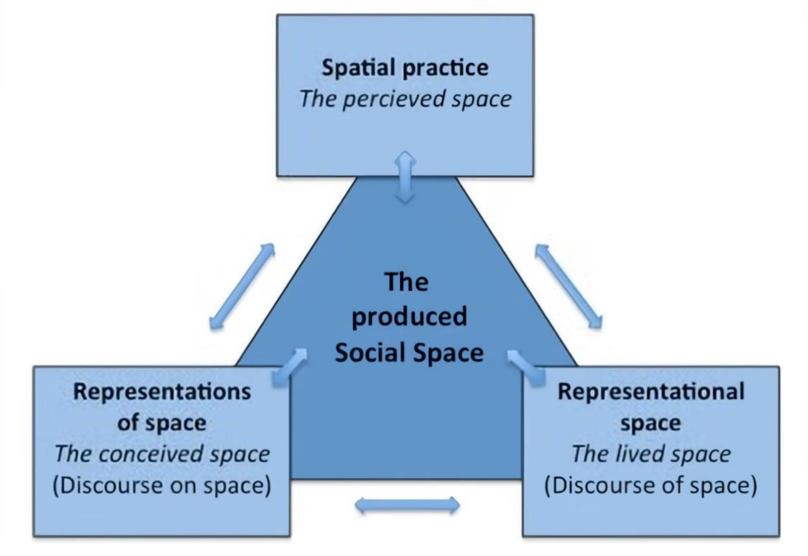
2.6.2.1 Marxist Humanism and This Study

In the 1970s, in opposition to Althusser's interpretation of Marx, which was grounded in structuralism, French philosopher Henri Lefebvre asserted that capitalist societies resulted in human alienation from each other, creating disconnection and hence he favoured individuality over societal imperatives.

2.6.3 Spatial Trialectics

Importantly, notions of space and its production became a key consideration wherein Lefebvrian interpretations of Marxist Humanism rejected concepts of space as process, in favour of representational space as "lived through associations" by its users (Lefebvre, 1991. p.36). Here humans in society and their societal interactions and modes of production produced space; space which is physical, mental and social in construction – a space of lived experience (Lefebvre, 1991). This space in turn, it was argued, moulds and recreates us. In developing his spatial triad framework (Figure 2.7), Lefebvre's intention was to facilitate engagement with spaces rather than purely consider them theoretically (Watkins, 2005). Here space became seen as "organic, fluid and alive" (Merrifield, 2000, p.211).

Figure 2.7 Spatial Triad, (Lefebvre, 1974)



Lefebvre’s Spatial triad, published in his key work “The Production of Space” (1974), breaks the interpretation of space into three component parts:

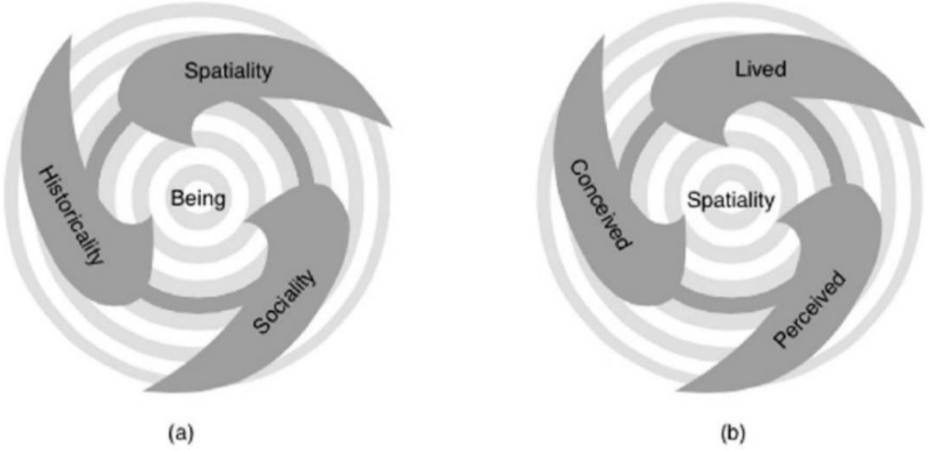
1. Perceived Space. This concerns spatial practices - how people experience and interpret physical spaces personally based on their cultural context, status and background. In the context of this study it is what happens to individuals in the waiting room and how they see it.
2. Conceived space concerns representations of space - the way the space was originally intended to be used by the planners and the ways such space might be built and populated by symbols and process based on what is deemed as appropriate by those in charge – for example the way the waiting room was designed and decorated to facilitate the needs of staff and patients.
3. Lived Space is representational space - the actual way that individuals or groups have a lived experience. This concerns behaviours, interactions and importantly the meanings assigned to these. This is not static, but a dynamic shifting space based on moments in time and space.

The spatial triad explores and articulates the various relationships between these notions of space and has been prevalent in discussion of multiple types of spaces and geographies in relation to appropriation (Lefebvre, 1974). This research seeks to understand space as constructed and experienced by the users themselves, as opposed to critiquing the pre-defined systems and infrastructures that is more typical of a structuralist Marxist approach. In other words the focus of this study is less on how the healthcare spaces were originally planned (conceived), or how the architects or NHS management envisaged their utilisation, but on the actual day-to-day interpretations and emotions of the patients (lived space). At the centre of this study is a belief that individuals, through purposive actions, here by contributing to the researcher’s collective interpretations, can change things, which is the tenet of Marxist Humanism and Lefebvrian approaches in particular.

2.6.3.1 The Importance of the Third Space

In acknowledging concepts of space and geographies and the fluid relationships between them, “Third Space” theory then seemed apt for review. Influenced by Lefebvre’s philosophies on space, the Third Space and the associated term ‘thirding’, a focus on otherness, was further developed by Edward Soja (1996) a post-modern urban theorist, initially in his work on spatial geographies in the USA (Figure 2.8). Soja, like Lefebvre, rejected the binary notions of "either /or" when theorising space, in favour of a third approach enabling a "dialectically open logic of both/and also..." (p.60). This disarmed what he termed as "permanent constructions" or a fixed, historical view of space and time (p.61). Here space was seen as a trialectic, both ontologically (how space comes into being and 'is') and epistemologically (what we claim to know about space and its meanings).

Figure 2.8 Trialectics of Being and Spatiality, Soja, 1996



trialectics (a) Ontology: 'trialectics of being'; (b) Epistemology: 'trialectics of spatiality'

Soja articulated the First space as the physical environment that is the product of planning, the Second space as how the space is conceived by the inhabitants - the social norms and expectations of how one might behave, and finally the Third Space as the way people actually live and experience the First space through the ideals of the Second space (Soja, 1996). This study considers all three facets when listening to participants and looking for enablers for positive patient experiences but pays particular attention to teasing out the diverse interpretations of the Third Space: the social or 'other' space.

Soja (1996) described this ontological and epistemological trialectic of space as:

> "An-Other way of understanding and acting to change the spatiality of human life, a distinct mode of critical spatial awareness that is appropriate to the new scope and significance being brought about in the rebalanced trialectics of spatiality–historicality–sociality" (p.10)

In the context of the study of walking a through a public park, Moles (2008) defined Third Space as enabling us to extend concepts of geographical 'imagination' where through the praxis of engaging with the space, a Third Space of creating meaning emerges. This meaning might be construed through new notions of identity, or even a Third Space where marginalised voices come to the fore. Whilst Hooks (2014) articulates this idea more politically by claiming Third Space as a space of resistance to colonisation, this study asserts that the Third Space in this context is a space of personal interpretation and experience rather than a site of political action.

In relation to the healthcare domain there is only a small amount of literature concerning Third Space, primarily in the mid-2000s. A later exception is one paper that focuses on nurses as opposed to patients (Chulach and Gagnon, 2016) which suggests an opportunity to develop new conversations and seek new interpretations of Third Space in health settings, however, there is an opportunity to research Third Space more in this context, especially concerning the waiting room where almost no studies were found. Piggot *et. al.* (2016) do briefly mention Lefebvre's notion of space in their discussion of the liminality of corridors and waiting spaces, but this is very brief and is only with respect to one concept: social space.

2.6.4 Symbolic Interactionism

Concurrent with spatial theory, this study proposes that a final important construct in relation to the research aims is that of symbolic interactionism. Despite the Third Space and symbolic interactionism stemming from different theoretical schools, they share a focus on identity and social conceptions of meaning. Both prioritise the significance of individual interactions and cultural exchange within spaces.

Symbolic Interactionism is a sociological theory that was first conceptualised (although not named as such) by George Albert Mead (1934), and later crystalised by Blumer (1969) through examining the ways humans act with things. Symbolic interactionism concerns deriving meaning from "interactions between people" (Saunders, 2019 p.141) and society and specifically the way people communicate via language and symbols. Mead focused on the significance of social interactions in growing one's own sense of identity suggesting that this was what helped form one's understanding of the outside world and themselves within. This connection to the outside world concurs with Clapton's (2018) view of the waiting room as a liminal space, where we transform from being citizens to patients-in-waiting, arguably in essence reforming our identity whilst visiting.

Emerging from the Chicago School of sociology, Mead, Blumer and others pioneered using qualitative approaches including ethnography to understand human interactions. Whilst Mead, and Symbolic interactionism are associated with the paradigm of Pragmatism, Symbolic Interactionism is known for its Interpretivist lens. Symbolic interactionism focuses on complexity, richness and multiple interpretations (Saunders, 2019. p.141). Blumer (1969) argued that symbolic interactionism was based upon three premises: firstly that humans act towards objects such as physical things (chairs, trees) and even other persons or groups/ organisations according to the meanings they have for them; secondly the meaning comes from the social interaction with other people; and thirdly, these meanings are modified through an interpretive process used by the individual. Speaking methodologically, Blumer cautioned that individual interpretations must be acknowledged over greater systemic (or structural) matters:

> “ To ignore the meaning of things toward which people act is seen as falsifying the behavior under study. To bypass the meaning in favour of factors alleged to produce the behavior is seen as a grievous neglect of the role of meaning in the formation of behavior.” (p.3)

However, further critique in the latter part of the 20th century argued that by focusing on meaning and interpretation as key tenets of symbolic interactionism, Blumer’s focus was purely subjectivist (Snow, 2001) and topics such as social structures, social organisation and cultural variation were under-researched in this context (Cohen, 1989; Fine, 1992; Hall, 1972; Huber, 1973). More recent studies on interactionism have debated notions of self and identity in what Vom Lehn *et. al.* (2021) summarise as three key developments in the theorization of identity and self:

1. The rise of digital communications meaning we are no longer always in-person but on screens, which Gottschalk terms as the “terminal self” (Gottschalk and Whitmer, 2013, p.310);

2. Notions of selfhood being outside of purely linguistic and cognitive fields, but rather emotional and non-verbal indicators and modes of communication such as in the case of animals and infants;
3. Identity as a new nexus of power or resistance in terms of self-identification, such as with race or gender.

These factors should be considered for this thesis and for further research, with the first being pertinent to any potential virtual prototyping and testing of patient spaces, the second seeking more subtle cues from participants behaviours and narratives, and the third ensuring matters of ethics and identity are both seen and heard by the researcher.

A complementary framework and methodology appropriate to symbolic interactionism, multimodality should be discussed here since it provides opportunities for understanding how individuals relate, comprehend symbols and create meaning in linguistics and social contexts, as articulated in the second development above.

2.6.4.1 Multimodal Thinking and Sensual Ethnography

Multimodality could be a useful consideration for engaging with diverse design factors and can be defined as a communication and learning paradigm to facilitate the social and semiotic changes within modern society (Bezemer and Kress, 2016). It has developed since the 1990s and is partly attributed to the rise in modes of media due to digital developments Cameron and Panović, 2017). In this theoretical model there is no primary mode of meaning making, all modes are viewed as significant. For example, Bezemer and Kress provide a simple representation of an operating theatre and the significance of all the signs including the various uniforms of staff, the room layout and actual viewpoints of the operation (Bezemer and Kress, 2016). In this theoretical frame, people use a range of semiotic resources within their environs for communicating and thus to be observed, and importantly for this thesis, a level of agency is provided to the sign-maker: the patient.

Of parallel importance is that such an approach does not privilege language (Jewitt, Bezemer and O’Halloran, 2016) which is the traditional domain of the research interview and opens the door for more wide-ranging methodological interpretation of meaning-making, which might be pertinent when understanding the needs of potential participants. An example might be an ethnographic multimodal review of the circumstances of post-stroke patients who might be variously cognitively impaired. This multimodal approach could provide opportunities for learning from various forms of patient behaviours and analysis of socio-semiotic meaning making (Hull and Nelson, 2005). Pink however (2011), is keen to caution that in terms of multimodal ethnography, it is important for this to become "*critical"* and not simply returning to a classical observational approach, but rather focus on experience through what she terms as its dual responsibility:

> "First, ethnographic research can indeed enable a greater understanding of practices, experiences and more. Second, a sensory ethnography that challenges the pre-set categories of multimodal analysis and breaks down the binaries between image and text can surely also create a self-critical and reflexive strand within multimodal analysis." (p.274)

This opens the door for new forms of ethnography whereby more sensual and subtle cues of human interaction might be noticed and noted in different forms.

2.6.4.2 Symbolic Interactionism and Health

Studies on public health via symbolic interactionism take account of subjectivity within human interactions and acknowledge that meanings are "actively interpreted, negotiated, and modified" between people and social spaces (Carter and Lamoreaux, 2023, p.624; Knyahnytska, 2014). Such spaces come with certain behavioural labels or expectations. For example, through his research into deviance and labelling theory, Becker underpinned the potential relationship between interactionism and health (Becker, 1963). Labelling theory proposed that the terms used to describe individuals affected their behaviour, particularly in relation to the negative labelling of minorities who were seen as deviant. In health terms Becker attributed the labelling of "illness" as problematic whereby clinicals were too keen to assign multiple categories of disability with zeal in relation to what makes society functional versus dysfunctional (Becker, p.7).

For this thesis it could be argued that the notion of 'patient' automatically assigns to visitors expectations and forms of role and behaviours within the waiting room, despite certain individuals coming for routine check-ups, and arguably not yet technically 'patients' at all. Goffman (1963) positions symbolic interactionism in terms of stigma, and the labelling of ailing individuals and how they manage their own social interactions (Williams, 2022). Goffman coined the term "frame analysis" whereby societal conventions or misrepresentations on the framings of certain happenings/situations lead to vulnerability for the individual, and the importance of individual inclinations and their emotional constitution towards social interactions becomes paramount here (Helle, 2019). Whilst he has been accused of not "elaborating a more explicit theory of frames" and favouring real world examples of interactions (such as 'talking' as a form of performance), Goffman does define "natural" versus "social frames", the latter concerning "guided doings" in which individual humans were in some way involved and subject to certain standards (van Dijk, 2023, p.158). In this context, "guided doings" could be analogous with the processes and rules of the hospital waiting room setting – the social frame of this thesis.

2.6.5 Section summary

This section has positioned three theoretical movements as highly significant to this study. Following concepts of alienation, identity and conditions for humans thriving being explored, a contextual definition and overview of the developments of Marxist Humanism was presented. The influence of this on Spatial Trialectics, and in particular, the theory of the Third Space was explained and positioned as relevant and applicable to this study. The three elements of thirding are proposed as being critical to exploring patients and their experiences of spaces. It was asserted that Third Space is under-researched in health contexts.

Finally, Symbolic Interactionism was discussed as a key framework for identifying meaning within many areas of social inquiry, and as a useful tool for interpreting contexts and relationships in which humans interact, including the understanding of symbols, identities, labels, frames and resulting emotions. This is therefore also pertinent for conceptualising methodologies for researching patient perceptions.

2.6.6 Relationship between the three theories

Whilst no literature was found that explicitly linked the three theories above, it is argued for the first time here that they constitute a shared interest in comprehending human agency, social structures and the multiple aspects of social interactions. This thesis takes this novel position and combines these lenses in reviewing the case of the health space and patient experience and the various dimensions therein, in order to envision a better future for patients and staff.

2.7 Conclusion to Literature Review

This literature review has considered perspectives on patient experiences from the positions of the origins of research in the area, through clinical studies, then the shift towards more user-centred methodologies and the challenges of applying design-led approaches. It then positioned three theoretical constructs as essential underpinning lenses for potential future study including this thesis.

Through the reading of both clinical and non-clinical academic papers, business reports and books, it was determined that there are many opportunities for validating spatial concerns and emotive experiences since they touch many aspects of patients' lives. It was evidenced how there are a myriad of factors at play affecting patient perceptions and that research has shifted over time to incorporate more sensual criterion. However, it was argued that 'taken for granted' moments of patients should be acknowledged through this study.

It was shown how previous research in the field has tended towards only considering a limited number of, or singular interventions into an environment to be tested with patients, and that this resulted in a somewhat binary, before-and-after approach which it was argued excluded the understanding of motivations and behaviours.

As a result of this review, it was argued that the majority of health studies of patient spaces have missed an opportunity to prioritise the voice of the patient and that more qualitative methods, adopting empathetic approaches typified by design methodologies and broader measurement frameworks, should be explored.

This review evidenced that, whilst there has been a considerable volume of health research over the past twenty years, comprising a shift from clinical outcome measures of spatial concerns to a more holistic perspective on spatial impacts, there remained a significant lack of studies prioritising the patient's personal feelings and emotions. Whilst a body of work was found that proposed various measures or indicators comprising diverse features of spaces, this tended to concern aspects of process and practical interventions rather than acknowledging and explicating more subtle emotive moments that this study asserts is lacking. Finally, this review found that whilst the focus of design for health has been a developing area of interest, especially in the areas of co-creation, there remains a lack of research applying design thinking approaches to listening for patient voices, particularly in relation to their perceptions of health waiting room spaces.

Whilst it was found that there were new frameworks created for enriching patient environs which were then tested, these were often measured in relation to physical recovery rather than human mindset. Pockets of methodological innovation were uncovered, yet the range of new participative terminologies caused confusion for practitioners. Arguments were shown for more engaging research methodologies, yet these often historically failed to put the patient first, favouring other stakeholders.

A range of measurement indicators and frameworks for gauging hospital space designs were seen as valid considerations for further study, yet these were noted as being process-based and hence missing opportunities for seeing and hearing the patient voice and the whole picture of expectation and experience. Dignity and privacy were prevalent themes and many studies found these to be meriting further research. This, in part, led to the theoretical frameworks later in the review.

Design was then reviewed in the context of health and found to be primarily applied for product innovation or architecture, but less prevalent in service or user-experience. Co-production and Capability Sensitive design did go some way to addressing this, however. This review highlighted arguments for bringing user needs in at multiple stages of the design process and how this has been lacking. Challenges of stakeholder management and technology dominance were also uncovered as topical issues in applying design to health.

Design Thinking was contextualised and shown as having potential within many research narratives, and generally seen as being a holistic device for conceptualising the patient experience around their needs. Critique of design thinking methodologies was found to be in the realm of researcher subjective bias, confusion over methods and tools, and as having less empirical evidence as beneficial for health. The juxtaposition between scientific and human-centred design methodologies was also theorised as potentially problematic.

Following this review, a resulting conceptual framework (Figure 3.1) is then proposed at the start of Chapter Three as a guiderail for shaping the methodology that follows.

CHAPTER THREE – RESEARCH DESIGN AND METHODOLOGY

Preface

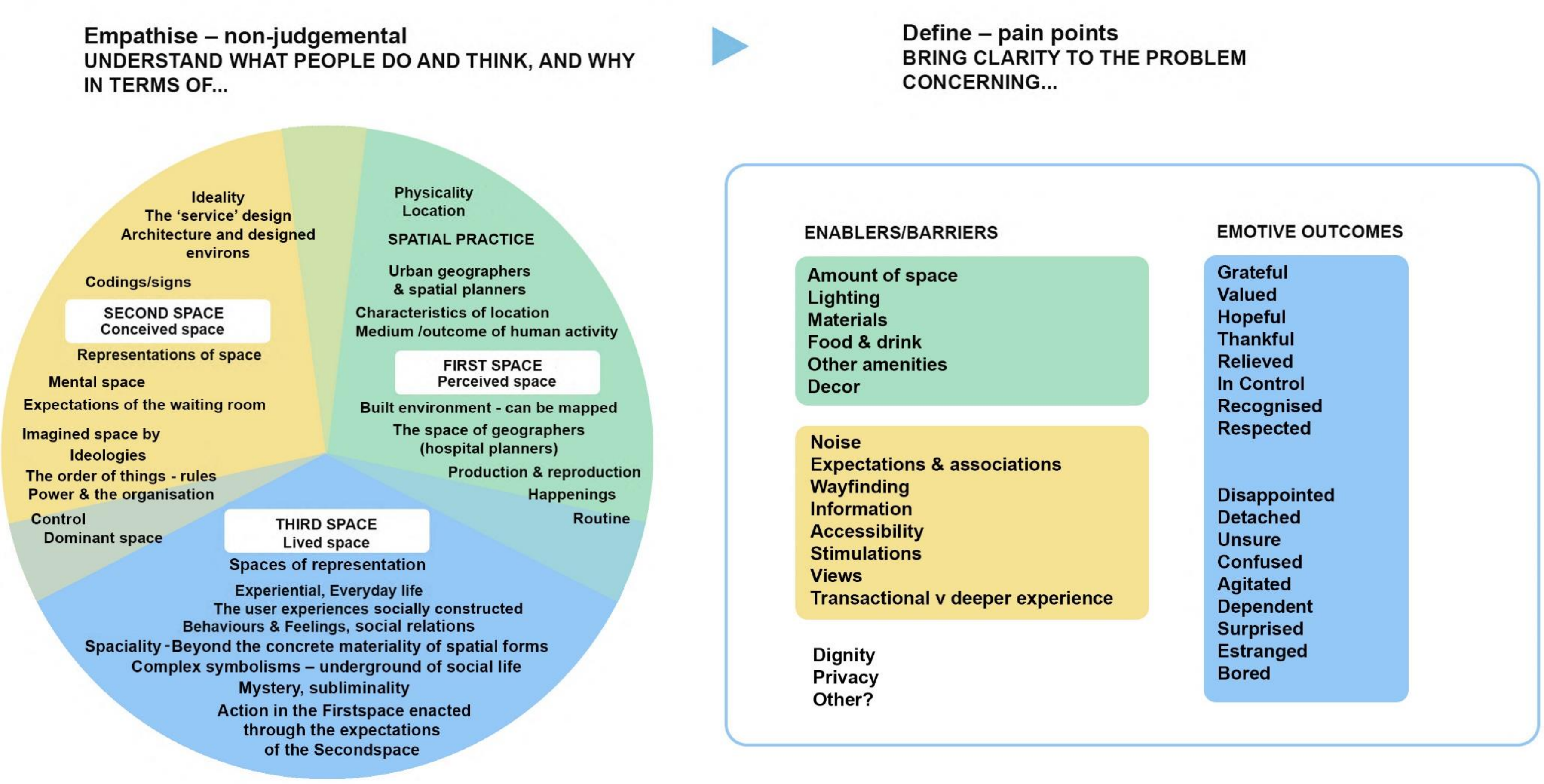
This chapter explains the research design and methodology for this study. Following the review of literature in Chapter Two, a relevant theoretical construct for framing this methodology is presented. The philosophical underpinnings and rationale for the chosen qualitative approach are then discussed. This is followed by an in-depth description of the stages of the study and justification of the methods utilised. The chapter concludes with a detailed account of the many ethical considerations, procedures followed, and authorisations required for a project of this nature.

3.1 Conceptual Framework

Conceptual frameworks are combination of ideas, assumptions and theoretical constructs that together underpin the research design, these define the key elements and “variables and presumes relationships among them” (Miles & Huberman, 1994, p.140). Considering the notion of frameworks in shaping the focus of research, Ravitch and Riggan articulate this as a “dynamic meeting place of theory and method” (2016, p.141). This research aims to explore patient perceptions of health spaces and experiences in the patients’ third space through a design, as opposed to clinical lens. As shown in Chapter Two, spatial trialectics and third space theory (Soja, 1996) are suitable underpinnings for conceptualising this study.

The following framework (Figure 3.1) is based on key literature findings to provide a model on which the research design is founded.

Figure 3.1 Author's Conceptual Framework, Adapted from Lefebvre (1991), Soja (1996), Mootee (2006) and Hasso-Plattner Institute of Design at the Stanford d.school, (2005)



This model shows how the first stages of the design thinking methodology have been adopted for this study. Due to the research aim being to understand how patients *feel* and what matters to them concerning health spaces (see Chapter One), in essence, this study critically focuses on rejecting overarching structuralism in favour of understanding individuals, agency and component parts of systems. The model utilises the first two stages of the design thinking model, Empathise and Define, but not the latter stages of Ideate, Prototype and Test, since these are outside of the scope of this work but have great potential for future study.

As evidenced, the Empathise stage concerns seeing the patients' worlds, appreciating them as human beings, understanding their feelings and communicating this understanding (IDF, n.d). Here key notions of the first, second and third spaces in the circle should be understood and interpreted within a suitable research design to capture feelings on such topics from participants. Through exploration with patients of the attributes on the right, which commonly emerged from the literature, new definitions of patient needs and views on enablers and barriers of positive experiences might be gathered and defined through this study. The outcome of the data gathering methodology outlined in below will test the validity of this model to the research aim.

3.2 Philosophical Underpinnings

It is important in research studies to acknowledge the position the investigator takes and the way they see the world; the 'worldview' (Bryman & Bell, 2015) from which the researcher's topic, aims and methods are conceptualised. Also known as a paradigm (Flick, 2023), this latter term is used below when describing the position of this study. Paradigms are fundamental to research as they inform the epistemological and ontological perspectives on which the study is based, and the strategies and methods that derive from this. As further explained below, Epistemology refers to the nature of knowledge and "how we know what we know" and the limits of knowledge, whereas Ontology concerns the "nature of being" and theories and ideas about the nature of various kinds of existence (Sanders and Wilkins, 2016, p.5.). No researcher should undertake their inquiry without being clear on the paradigm that is informing their approach (Guba & Lincoln, 1985).

3.2.1 Interpretivism

This study adopts the paradigm of Interpretivism. Interpretivist social science is a common approach within qualitative research that according to Gephart (2018):

> "seeks to understand members' tacit knowledge, shared meanings and the informal norms everyday actors use to act in the world." (p.4)

This is in contrast to positivistic approaches typified in natural sciences that can be said to lack concern for individual agency, positionality or collective common sense meanings (Cloke *et. al.,* 2014). Positivism involves the adoption of purely scientific, empirical methods in order to produce data which is not influenced by any human opinion or bias (Saunders, 2015). Aligning with positivism is the notion of objectivism whereby all judgement is removed in relation to research being undertaken. Subjectivism, on the other hand recognises the role the researcher plays in the process of data gathering and analysis and the meanings assigned to such data (Stokes and Wall, 2014). A positivist approach is rejected by this thesis due to its focus on objectivism over subjectivism and the position that opinion, beliefs and attitudes cannot be measured (Kitchin, 1999).

In contrast to the historically dominant narrative of scientific study and rational and logical inquiry of natural world phenomena, the social sciences discipline began to emerge in the nineteenth century (Comte, 2009; Durkheim, 1938). The tenet of Interpretivism being that in order to truly comprehend societies and cultures, it was necessary to interact and engage with people directly (Martineau, 1838). Importantly for this study, key notions such as sympathy and empathy were positioned as essential building blocks of understanding the world and its inhabitants.

Approaches based on 'sensemaking' within organisations (Garfinkel, 1967), purported that accounts of happenings are not independent of the structures in which they exist. This aligns with the values of this study where, notwithstanding the humanist rejection of Marxist structuralism stated earlier, patient stories are wholly acknowledged and seem somewhat shaped by the environs in which they take place. Weick (1995) further explored sensemaking within organisations by asserting that it cannot simply concern decision making but must engage with a recognition of the 'ambiguity and complexity' within organisations. This study notes and recognises such complexities within the NHS services and spaces, as outlined in

Chapter One and the setting for this study, and the multi-dimensionality of the comments patients make in their reflections echo this. Indeed, as reflected in the research design in this chapter, this is where this study differs from most in this field, as evidenced from the Literature Review in Chapter Two, since it embraces this complexity by gathering feedback on the dimensions of space, interaction and feelings simultaneously, rather than previous studies which take more of a singular approach to studying one dimension (Ander *et, al*., 2013; Mackrill, Cain and Jennings, 2013; Nielsen *et. al*., 2017; Ulrich, 1984).

As identified in the Literature Review in Chapter Two, some studies did validate how the proposed multi-dimensional approach of this thesis combining social and environmental factors can produce useful results (Andrade *et. al*., 2013; Gashoot, 2022; Menatti and Casado da Rocha, 2016). However, many of these tended methodologically toward being theoretical papers or relying on a questionnaire approach. Such self-completed questionnaires, it can be argued, were valid in that they typically enabled a large number of patients to be surveyed, without the challenges of different interviewers influencing the results, and could also be cost and time effective. In contrast, it is asserted here that such methods inhibit the ability to probe participants for further elaboration, lacking the rich insights this study seeks to obtain. There is also potentially the chance of missing data due to respondents opting out of answering certain questions (Bryman and Bell, 2015).

Under the guise of Interpretivism, Giddens (1976) developed the theory of ‘structuration’ whereby the individual is said to be both influenced by existing structure, and in activating their own agency, influence and further shape structure. In the context of this study this particular framework is rejected, since, whilst the patient accounts of their experiences will have been influenced by the NHS structure, the shaping of future structure might only come about through the power of the collective stories rather than individual action being able to ‘make a difference’ (Giddens, 1976, p.15). It could however be argued that in having their say, a level of individual agency is nevertheless activated.

By adopting an Interpretivist stance through exchanging and sharing ideas, ‘notions gradually emerge’ (Stokes, and Wall, 2014. p.139). Research objective two of this thesis is to understand patient perspectives on healthcare spaces including how aspects of the ‘conceived space’ and the ‘perceived space’ impact their ‘lived space’. Here the focus is on exploring concepts around lived experiences and relationships within certain settings, so the approach that follows is appropriate and justified, since it acknowledges subjective interpretations both on the part of the researcher and the patients participating. Here the researcher embeds themselves directly in the settings to build a rich picture of “actual occasions and situations in which products are used, services are used, services are received, and benefits are conferred” (Mariampolski, 2006, p.17).

In relation to interpretation and identifying the blurring of genre boundaries within sociological understanding, Geertz (1983 p.21) moots that it is not that there are no conventions for interpretation, but that there is a clear propensity to “accommodate a situation at once fluid, plural, uncentered and ineradicably untidy” and this is the context in which this study sits. Geertz proceeds to describe the freedom of a social sciences interpretive approach:

> “Instead they could proceed with their vocation, trying to discover order in collective life, and decide how what they were doing was connected to related enterprises” (p.21)

This research study explores this freedom, finding collective order between the NHS waiting area spaces, atmospheres and human interactions, and subjectively makes connections between them.

3.2.1.1 Interpretivism and Bias

Adopting a phenomenological approach combining interview and observation, this methodology seeks to understand how individuals interpret their lived experience: how they “perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it” (Patton, 2002, p. 115). However, within such an approach, subjective interpretations by the researcher are present, and therefore the historical assumption of neutrality might be challenged (Marshall and Rossman, 2021). Denzin and Lincoln (2005) describe this potential bias as coming from “a distinct interpretive community that configures, in its special way, the multicultural, gendered components of the research act” (Denzin & Lincoln, 2005, p. 21), in other words, the privileged position of the researcher.

Marshall and Rossman argue that canonical qualitative research genres including phenomenology, “assume that knowledge is not an objective truth but is produced through intersubjectivity" (Marshall and Rossman, 2016; 2021). Intersubjectivity involves the ways in which researchers and participants create meaning together, acknowledging that knowledge is co-constructed through social interactions, and for this reason it is important that this research recognises this and accommodates potential concerns relating to possible researcher bias with the patients.

Marshall and Rossman (2021) consider the critical perspective that as researchers, we should:

1. examine how we represent the participants and search for their counternarratives and modes of domination (Seidman, 2016) in our work;
2. scrutinize the "complex interplay of our own personal biography, power and status, interactions with participants, and the written word" (Rossman & Rallis, 2017, p. 80);
3. be vigilant about the dynamics of ethics and politics in our work

Concerning these three injunctions, this study utilises two different data analysis techniques to cross reference and thus dimmish bias, with the Voice Centred Relational method possessing a specific focus on searching for the above counternarrative in the 'listening for the plot' stage. It also allows for the personal perspective of the researcher to be noted within the analysis in the 'relational analysis/contrapuntal voices' stage, which reflects the second point concerning scrutiny above. Ethics is a key consideration in working with the NHS but with reference to data gathering the researcher steered the patients to focus on the space rather than potentially distressing or personal clinical conditions via constructing semi-structured interviews rather than unstructured.

Data was also triangulated against the observation stage by comparing themes cited as well as with the pilot study outcomes, and finally in comparison with previous studies. One shortcoming was the inability to member-check the findings with participants due to the restricted timescale and also limited participant availability, although this should be ensured within the planning of further study. Finally, the researcher was cautious not to inflict their own ideas for improved spaces from the ethnographic observation phase by ensuring that interview questions were not loaded with predefined features, attributes or ideas for spaces.

3.2.2 Inductivism

In keeping with an interpretivist perspective, this research design was conceived and shaped through the lens of inductivism. Inductivism is typified by research that utilises observational methods and small sized participant samples to aid in sense-making of certain contexts or phenomena, although the word *sample* here is not always fitting of a human-centric study such as this (Stokes & Wall, 2014; Creswell, 2013). As seen in Chapter Two, previous studies on patient environments have often been approached from a deductivist approach, where a hypothesis is stated and then proved or disproved through testing and control, or quantitative analysis has been the focus, often in a laboratory environment (Caspari *et.al.*, 2006; Janssen *et.al.,* 2014; Ulrich, 1984; Zamagni *et.al.*, 2010). This study however, concerns feelings and emotions; an inductive approach (Stokes and Wall, 2014) prioritising user-experience over measuring clinical outcome, recognising the subjectivity of the researcher and the symbolic interactionism (Saunders, 2015) between patient, elements of the environs and staff. Therefore, to produce specific hypotheses from the literature review would not be providing patients with scope to tell their stories and share the minutiae of their various experiences; for example of, lighting, noise, decor or their own personal distractions within the waiting room. Such specificity would contradict the aims of the project as stated in the study aim: to *explore* and *understand* the barriers and enablers of positive patient experiences. However, whilst this study did not aim to prove or disprove a particular theory, a provisional conceptual framework was created as a synthesis of the initial readings in order to guide the researcher and check for topics for further review after the data gathering stage.

3.2.3 Epistemological and Ontological Perspectives

A key concern for further understanding the paradigm from which a study is conceived is the Researcher's epistemological view on the world. Epistemology concerns viewpoints on the sources of knowledge; what is acceptable and how it is made (Saunders, 2015). A scientific approach to knowledge being correct or incorrect is documented as not necessarily being applicable to studying the social realm (Bryman and Bell, 2015). Instead, a recognition that knowledge is only made by certain actors in certain situations at a certain time is seen as a valid philosophy. This research is based on the epistemological view that knowledge depends on understanding details of a given context and meanings for the actors therein, and that such knowledge is made by the reflection of these parties and the subjective interpretations of the researcher (Stokes and Wall, 2014). This supports the choice of methods described below.

As previously outlined, Ontology concerns the nature of being; the researcher's perspective on what exists and what constitutes reality (Saunders, 2015). Here it is proposed that reality is only created by the experiences and relationships between patients, staff and their surroundings, at a particular time and space, so this is relativistic in nature (Stokes and Wall, 2014; Whittle and Spicer, 2008). Reality here can be described as intersubjective, where we are not actually separate entities but as Cunliffe (2016) states:

> "we are always in relation with others – with particular persons, communities, history, culture, language and so on…we are who we are because of our living and lived relationships with others" (p.742)

It is argued here that an NHS outpatient's department is such a community at that time and space, between the people present that day and the interactions and dialogues taking place within the spaces. Cunliffe's approach is pertinent for this study since it concerns being ethically reflexive and acknowledging the uniqueness of others whilst "treating others with solicitude and respect" which is the goal here (Cunliffe, 2016, p.741).

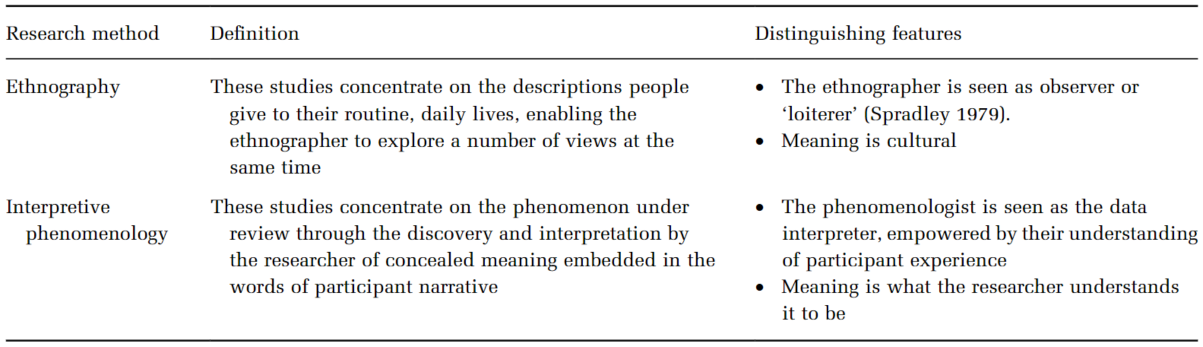
By exploring this inter-relational lived experience of patients over and above purely the design of the space or processes, the methodology that follows combines ethnography and interpretive phenomenology to create situated understandings and not finite knowledge (Hammersley and Atkinson, 2007).

3.2.4 Methodological Approach: Combining Ethnography and Interpretive Phenomenology

In order to increase the validity of the data, this study employs a combination of two research methodologies: ethnography and interpretive phenomenology. This combination most aptly reflects the aims of this study, concerning looking for meaning in narratives and behaviours whilst enabling a level of validity through triangulation of the data (Maggs-Rapport, 2000, p.219). Validity can be termed as the extent to which the goals of the researcher are achieved in the context of what they are trying to study (Collis and Hussey, 2013) or in other words, ensuring that the chosen methods produce dependable results (Stokes and Wall, 2014). Triangulating these data from a combined methodology (Maggs-Rapport, 2000. p.220) aids in ensuring credibility where possible in a subjective, interpretative study of this nature. Methodological triangulation involves seeing the relationships between data and methodology rather than simply comparing and contrasting the outcomes of two sets of data (Denzin and Lincoln, 1994).

The table below (see Table 3.1) explains the key differences in characteristics between each methodological approach. Here ethnography is defined as enabling accounts of everyday practices, with the researcher observing these and then assigning cultural interpretations. Interpretive phenomenology however, concerns looking for underlying meaning within the participants' words where the researcher is subjectively adding meaning to the data. This study adopts this order of things in constructing the research design, since both elements engage with the patient setting and the happenings within. This approach can be termed as a multi-method design where more than one approach to collecting and analysing data is implemented (Collis and Hussey, 2013).

Table 3.1 Distinguishing Features of Ethnography and Interpretive Phenomenology (Maggs-Rapport, 2000 p.220)



Research method	Definition	Distinguishing features
Ethnography	These studies concentrate on the descriptions people give to their routine, daily lives, enabling the ethnographer to explore a number of views at the same time	• The ethnographer is seen as observer or 'loiterer' (Spradley 1979). • Meaning is cultural
Interpretive phenomenology	These studies concentrate on the phenomenon under review through the discovery and interpretation by the researcher of concealed meaning embedded in the words of participant narrative	• The phenomenologist is seen as the data interpreter, empowered by their understanding of participant experience • Meaning is what the researcher understands it to be

3.3 Research Design

This project consists of a three stage method that includes an initial pilot study. These are sequential, with the ethnographic field observation stage then setting the scene for understanding general happenings and the culture of the chosen hospital space, before a series of semi-structured interviews with patients.

Table 3.2 Research Design Stages (Author's Own, 2022)

Stage	**Approach**
Pilot Study	Online semi-structured interviews

Data Gathering 1 Ethnographic Field Observation	Observational sketching /notetaking/photography at two settings
Data Gathering 2 Interpretive Phenomenology: Qualitative Interviews	In-depth semi-structured case interviews

3.4 The Pilot Study

Pilot studies are known to be beneficial for testing the effectiveness of interview questions prior to interviewing the final participants (Stokes & Wall, 2014) and for allowing other potential problems with the proposed research approach to emerge (Sanders and Wilkins, 2016). It has been argued that gathering qualitative data in pilot studies such as patient viewpoints can help provide useful insights for larger trials or studies. But according to a review of studies on PubMed (the National Library of Medicine's collection of biomedical literature) between 2013 and 2017, only 40 percent of pilot studies included qualitative data, which has in part been attributed to a lack of understanding of the value of, and guidance on how to conduct studies in this way (Baldeh *et. al.*, 2020). The pilot study here was essential for testing out the notion of being able to capture subtle feelings and emotions from patients (which is the research aim) and to reveal the kinds of data and topics that might emerge from conversations. It was an opportunity to see if patients (and their relatives) were happy to discuss such feelings and to potentially shape the content and format of the main data gathering stages to follow in the main study.

The main study involved the researcher interviewing patients and conducting observational fieldwork from a real NHS site. It was therefore very important that the methodological approach to the data gathering was proven as appropriate and valid. Here valid refers to the both the capability of the methods to address the research objectives and treating patients ethically. Whilst several attempts could be made to revisit patients, and indeed the site could, in principle, be revisited easily, the scope for acquiring data should be focused, since participants' time might be precious, or reflecting on experiences more than once might be sensitive. Site access could also be an issue for the researcher, so the more thorough the pilot study, the greater the opportunity for minimising these challenges.

The pilot study for this thesis was conducted during the lockdown stages of the Covid-19 pandemic. This meant that it was not possible to see participants in person. However this eventually proved convenient and relaxing for the participants and their relative, since they could be interviewed in the comfort of their own homes and in a space of their choice. It was also not possible to visit any healthcare sites at this time to observe and build context prior to conducting interviews, which did leave the researcher somewhat in the dark concerning the venues being discussed and highlighted the clear need for gaining such deeper insights through on-site observation in the eventual main study. Lessons learned from this pilot stage and their impact on the main study are explained in Chapter Four.

3.5 Main Study - Phase One Data Gathering: Ethnographic Observation

Ethnography is an anthropological approach to the methodical description of human behaviours, via various methods that involves description of people, interactions, and beliefs (Sanders and Wilkins, 2016) resulting in an understanding of a culture within a landscape. Marcus (1998, p.391) notes that, whilst ethnography concerns unpredicted narratives and freedom of performative actions he terms as "messy, many-'sitedness", there is a problem, in that by analytically framing that which is being observed (in this case the happenings on the hospital waiting area), such work can be restricted by these framed boundaries. But he states how the object under observation typically operates outside of the researcher's perceived analytical boundaries and it is this openness that he finds fascinating, which the participants in this study have often demonstrated when being observed. For example, whilst conducting fieldwork in one of the waiting areas, a patient fainted, and the performative aspects of the space (where to sit, how to find one's way, how to pass the time), operated outside of their immediate usual modes of operation, and the researcher's initial plan on what to observe.

Adding a layer of ethnographic field observation where the researcher is in-situ helps to build a fuller picture of the context that can later be discussed with participants, for example at interview (Atkinson *et. al.*, 2012; Hammersley and Atkinson, 1983). By engaging with immersive methods involving placing the researcher directly in the field alongside patients, more informed and vicarious experiences are explored (Denzin and Lincoln, 2008) whereby there is a need to be present to make sense of things rather than purely working with recorded data (Bryman and Bell, 2015). To align with Research Question Two, and the 'empathy' stage of the methodology; specifically in terms of exploring the 'conceived space' and the 'perceived space', it was first necessary for the researcher to visit the actual two sites being experienced; to "educate the senses, calibrate judgement and pick out objects of…inquiry" (Flick, 2023. p.288). This helped develop insights that later informed the next phase of data gathering: the semi-structured interviews.

The goal was to observe happenings, the atmosphere, and goings on. It was decided that as well as more conventional photography and note-taking (Heath *et. al.*, 2018), observational sketching might also be a suitable method for this phase. Whilst more typically, researcher-generated photography has been seen as a key source of data for this kind of observation (Bryman and Bell, 2015, p.564), it can be argued that sketching enables an 'other' kind of data to be gathered (Heath *et. al.*, 2018). Whereas photography can only capture an immediate moment in time, sketching has the potential to embrace the researcher's choice of what to note, over a period of perhaps many moments within the one sketch. This can show the complexity with which the vitality of life might be experienced, or what Back and Puwar (2012, p.11) term as "multiple registers within which social life is realised". However, since some areas were often fairly quiet, photographic methods were usually deemed as sufficient by the researcher in terms of noting signage, mood and lighting of the spaces. 44 photographs of the environs were taken, with care not to include people. Filming was also considered but was deemed as too sensitive/invasive by the researcher for a live patient environs.

Photographs in field study are seen as valid data for ethnographic research (Thomas, 2009) and can convey a layer of depth and other elements that might be missed solely through the spoken word (Guest, Namey, & Mitchell, 2013). Saldaña (2016, p.57) believes that the most apt way for analysing photographs is holistic, whereby rather than applying specific single keywords to images, richer notes and reflections on images should be encouraged, beginning with "jottings" rather than specific codes. However, the appropriate step-by-step procedures for coding photographic data has not been well-documented (Drew and Guillemin, 2014).

The photographs here were analysed in an interpretive, subjective and flexible manner, by noting the immediate response to the subjects of the photo (not human subjects but attributes of spaces) rather than a systematic semiotic decoding of elements within the photograph, since it was the subject matter, rather than the image composition which was deemed as significant for this study.

3.5.1 Ethnographic Observation: Method

The plan was to conduct in-depth on-site observation, spending time in both waiting areas. This was planned to be ‘overt’ (Stokes and Wall, 2014), whereby the patients in the public areas might tell, if they were looking, that they were a part of the observed situation. Initially it was agreed that patients would not be actively engaged with (spoken to), but rather they would be silently observed coming and going within the spaces, and a poster (see Appendix 2) would be displayed should they wonder what was happening, feel concerned or wonder why the researcher appeared to be taking notes (Walsh, 2012). This poster was approved by the NHS Research Ethics Committee.

Different waiting room and lobby areas of Florence Portal House were visited by the researcher between during March, April and May 2023 across eight separate visits at different times of day and in different weather conditions (see Table 3.3). Average visit times were two hours in duration.

Table 3.3 List of Observational Field Visits Undertaken

Visit 1	Gynaecological outpatients waiting area – Suite 1	Cloudy yet reasonably bright weather	Medium busy – steady flow of visitors
Visit 2	Waiting area – Anthony Letchworth Ward	Interior area – no weather visible	Quiet – very few visitors
Visit 3	Gynaecological outpatients waiting area – Suite 2	Interior area – no weather visible	Quiet – few visitors but staff coming and going
Visit 4	Main entrance lobby area	Cloudy weather	Medium – steady flow of visitors
Visit 5	Breast screening clinic waiting area	Sunny weather	Quiet – very few visitors
Visit 6	Breast screening clinic waiting area	Overcast weather	Busy – room almost full
Visit 7	Breast screening clinic waiting area	Sunny weather	Medium busy – steady flow of visitors
Visit 8	Gynaecological outpatients waiting area – Suite 1	Sunny weather	Medium busy – steady flow of visitors

Walsh (2012) suggests five potential issues with 'conducting relations' in the field being observed. Table 3.4 lists these issues in the context of this study:

Table 3.4 Five Issues in Conducting Relations in the Field for this Study. Adapted from Walsh, (2012, p.254)

1. Gaining trust and managing initial responses	Patients (and staff) needing to know what the research is there for, are they clinical or something else, or are they a patient? How to explain why the researcher has sat there for so long or appears to be taking notes. The prominent placement of the poster (Figure 44) close to the researcher initially addressed this.
2. Impression management	Ensuring the researcher fits within the waiting area as a 'normal' person rather than dressed unusually or behaving in a superior manner. The researcher was casually dressed and relaxed in manner in order to blend in.
3. Awareness of the consequences of non-negotiable characteristics	Aspects such as the researcher's age and gender and how that blends in with the environs. Fortunately the researcher is of the same gender and approximate age as patient visitors to both centres, and although older than those typically in the maternity area, did not particularly stand out.
4. Dealing with marginality	How the researcher can 'live in two worlds at once'. This concerns both keeping a certain distance, whilst observing according to the study scope and embedding themselves and experiencing the environs directly. The researcher, for example, could subjectively feel tension in waiting, despite not waiting to actually be examined. This can be aligned with the *empathy* stage of design thinking (Stanford, 2005)

5. Deciding when to leave	This relates to: 1. Leaving the space on a particular day – which was essentially done when the space became empty or a focus of a particular 'foreshadowed problem' had been exhausted. 2. Leaving the space for the final time. Which was once a sense that no new ideas or material might be gained and a level of 'theoretical saturation' had been reached (Glaser and Strauss, 1967).

Over time, due to the requirement to recruit further participants for later interview, there was a greater level of dialogue with patients by the researcher - see 'sampling' below. The key aim of the field observation was to directly experience being in these spaces for various periods of time from fifteen minutes to ninety minutes per area, finding one's way, waiting, sitting, listening and feeling. Jeffry and Troman (2003) state that there is no one rule for the length of time to be spent in the field, but rather this is dependent on contingent circumstances such as researcher time/access capabilities and pressures from funders for example. Hammersley (2017) highlights how time in the field is a real pressure for research students needing to complete their studies. This project aligns with Mariampolski's view that the amount of overall time in the field varies, but typically visits spanning between two and four weeks is optimum, as is the case with this study where visits took place over three weeks.

Actions by the researcher whilst visiting included sitting in the waiting areas in various seats from various viewpoints (see Chapter Four), trying to navigate the spaces, using the facilities such as washrooms and approaching the desks.

Whilst making observations, themes and topics from the *empathy* stage of the conceptual framework in chapter two, including the third space triad were constantly referred to. These served as a checklist of prompts, sometimes known as 'foreshadowed problems' (Walsh, 2021, p.251) for the researcher to experience and to note. For example, the researcher observed the daily practices and characteristics from the 'first space', then apparent rules and supposed systems from the 'second space', before finally observing subliminal interpretations of general mood or types of behaviours as typified by the third space. No conclusions or fixed opinions were formed at this time, the aim was to generate a volume of different forms of data for later review and interpretation.

After initially entering the site, the experience of finding out where to go was recorded in note form and via a series of photographs of signage and other symbols. The various options for seating were experienced, sketched and noted. Features and offerings within the spaces were also photographed and described in written form for later review and as topics for potential use within interviews.

3.5.2 Ethnography: Analysis

According to Brewer (2000), ethnographic analysis aims to organise, interpret and add meaning to various artifacts and is explained as:

> "the process of bringing order to the data, organizing what is there into patterns, categories and descriptive units, and looking for relationships between them." (p.105)

The process for the analysing these artifacts was adapted from Mariampolski's four steps, from pure observation to "fully processed insights" (Mariampolski, 2006, p.185). Whilst this model was originally developed for the analysis of marketing data, it was deemed as apt for this study because it considers human-centred activities and behaviours which concurs with an empathetic lens adopted for this study (see Figure 3.1). These steps were interpreted and adapted for this study in Table 3.5.

Table 3.5 Adaptation of Mariampolski's Four Steps of Moving from Raw Observations to Fully Processed Insights (Mariampolski, 2006)

Compiling the data	Make certain everything is organised (sic) so that nothing important escapes attention. Compile and order the photographs, sketches and notes taken from visits to the outpatient areas.
Reviewing the data	Seek out inherent meanings, on-going process because conditions in the field may require adaptation and modification of research tactics. For example empty waiting rooms versus busier days, different weather outside impacting mood/atmosphere/light.

Decoding the data	Make sense of the visual and written record. Explain through concepts, generalisations to delineate meanings. This includes the recognition of early 'hunches' that emerge from the earliest encounters. A level of reflection and note taking after each visit to the outpatients' areas and flexibility of interpretation of patient behaviours.
Making imaginative (marketing) "leaps" on the basis of the data	Share insights to deliver full value: in this case to fully inform stage two - interviews. Produce interpretations such as the apparent importance of décor once on site.

3.5.2.1 Compiling the Data

The first phase was to review which data had been collected at the 8 separate visits, these included photographs, sketches and notes in the form of written memos. These were first grouped according to the various spaces visited; lobby, suite 1 etc.

3.5.2.2 Reviewing the Data

These data were then initially categorised within the three elements of the spatial triad from the conceptual model in Chapter Two: first space, second space and third space.

3.5.2.3 Decoding the Data

Following this, the observations and notes within the three sections were grouped into themes broadly considering the 'define' stage of the conceptual framework. The aim was to explore and define the pain points and emotions observed during the ethnographic visits by the researcher. These were then formed into a schematic diagram (see Chapter Four) where relationships between the themes and their relevance to the conceptual framework in Chapter Two were considered.

3.5.2.4 Making Imaginative Leaps

Key broader meanings and insights from the themes we then reflected upon and prioritised in order to inform discussion topics for the interview stage that followed.

3.6 Main Study - Phase Two Data Gathering: Semi-Structured Interviews

The second stage of gathering data consisted of a series of semi-structured interviews with patients from the two centres within Florence Portal House. Interviews are a well-established method for inductive research where conversations between researcher and participant(s) take place to lead to new information or knowledge (Stokes and Wall, 2014). In business research Bryman and Bell (2015, p.210) relate interviews to gaining information pertaining to “norms, beliefs or values”, but this study also gathers patient accounts of broader contexts and happenings. Enabling a broader conversation with less formality works well in the health setting since participants feel more ‘respected, listened to and involved’ (Sanders and Wilkins, 2016, p.140). Birch and Miller (2012, p.5) argue that the relationship between participant and researcher is an active exchange of ‘ideas and understanding’ that can lead to rich data in the context of a social relationship, and semi-structured interviews were chosen here to enable such exchanges that a more structured approach might have inhibited.

Semi-structured interviews employ a level of flexibility to help to establish topics of discussion and guiderails between the researcher and participant yet allow the participant space to describe broader factors or accounts in their own words (Sanders and Wilkins, 2016, Stokes and Wall, 2014). They also facilitate a checking of understanding that is not possible in a more structured interview approach (Almari, 2019).

A semi-structured approach was chosen for this study since it enabled various aspects of the patient’s individual hospital experiences to be discussed, whilst ensuring the conversations did not stray too much towards clinical treatments or other personal medical factors outside the scope of this study that might present ethical challenges concerning distress (see ethics below).

Previous studies in this area have shown how semi-structured interviews have been effective in helping understand aspects of the patient experience. For example, as demonstrated by Austin *et. al.* (2020, p.349), conducting interviews helped to convey how ‘patient-reported outcomes’ (PROS) can provide more depth of information in terms of medical and well-being outcomes. Here the semi-structured approach aided in ‘understanding the context’ and ‘diverse perspectives’ of various stakeholders.

The disadvantage of semi-structured interviews is that they can take time to gather sufficient data during the interview process or produce large amounts of ‘wordy’ or extraneous data that can be time-consuming to analyse (Sanders and Wilkins, 2016) as well as costly and labour intensive (Newcomer *et. al.*, 2015).

3.6.1 Rejection of Questionnaires

Many previous studies concerning patient environs have employed questionnaires for gathering data (Andrade, 2013; Jiang *et. al.*, 2017; Tsai *et. al.*, 2007; Xuan *et. al.*, 2021). Whilst the UK and the USA have been pioneers in implementing ‘nationally standardised surveys for measuring patients’ experiences’ (Wong *et. al*., 2020, p.12) and these may reach a larger number of participants, they do not allow for the deep ‘interpretive explanations’ of ‘actions, images, utterances’ that interviews permit (Geertz, 1983, p.22), hence observation and interviews are selected to meet the research aims and focus of this study.

3.6.2 Sampling of Participants

As previously mentioned, unlike the pilot study where convenience sampling (Stokes and Wall, 2014) resulted in a random combination of patient circumstances and settings visited, the approach for this study is to focus on two specific areas within one NHS location and therefore to explore the perceptions of patients in relation to these. These spaces were suggested by the Hampshire Hospitals NHS Foundation Trust research team as pertinent to review, because they are closely situated to each other, and one is purported to be newer and an example of better design than the other older space. These also apparently have clinical/patient connections in that they treat patients with related conditions such as breast cancer and gynaecology, although the data later challenges this assumption (see Chapter Four).

To this end, the approach to recruiting participants was initially stratified purposive sampling (Bryman and Bell, 2015), where typical persons in the area of interest are sampled. Purposive sampling involves the context of the research goals and identifying criteria for addressing these goals. This methodology evolved into somewhat of a sequential purposive sampling approach (Teddlie and Yu, 2007), where criteria for sampling were broadened as the study progressed, this is because certain other situations became significant, for example a small group of new mothers wanted to describe their experiences of the same spaces.

The principal inclusion criteria, as approved by the NHS ethics committee (see *ethics* below) for sampling were patients who:

a) attended one of the two settings at Florence Portal House

b) attended within the last three years

c) were between 18 and 80 years of age

d) possessed full cognitive capabilities (ability to recall details)

The initial exclusion criteria (patients who would not be included in the sample for this research) were:

a) patients who suffered from dementia or neurodegenerative diseases (since they would not be able to recall memories of visits)

b) those with Stroke or Mental Health conditions

c) those who had only visited once

d) those who had not stayed on-site for at least one night*

* Exclusion criteria D was later removed once it had been decided that the waiting areas and outpatients was the key study focus.

This was later followed by snowball sampling in order to recruit further participants, since the initial group were keen for their contacts to also be able to share their stories and snowball sampling is common within networks (Coleman, 1958), such as new mothers. Snowball sampling is used more frequently within qualitative research approaches and is a process whereby participants then suggest others (Bryman and Bell, 2015). One advantage of snowball sampling is the ability to both make the most of and understand the commonalities of networks (Noy, 2008).

3.6.2.1 Sampling Participants – NHS Considerations

Since this research was taking place within the partner setting (The Royal Hampshire County Hospital's Florence Portal House), many discussions took place with the NHS trust research department concerning the best way to recruit patients. It was decided that initially, patients would self-select, by picking up a specially designed leaflet (Appendix 3) that was to be placed at the reception desk of both venues and in the waiting areas. This leaflet was designed by the researcher to be eye-catching and colourful, inclusive in terms of age and ethnicity of the featured person on the flyer, to be persuasive and to provide the patient with an easy way to follow up if interested. Flyers were to be supplied and replenished as demand dictated.

So that patients might easily be able to follow up and find out more, a new email was established: yourpatientviews@winchester.ac.uk. This linked to the researcher's email inbox, who then replied with relevant information such as the patient information sheet and consent form as shown in Appendices 7 and 8.

To offer an alternative and more convenient method, a QR code was also shown on the flyer. Due to their fast connection to smart devices, QR codes are noted as a valid method for recruiting volunteers (Gu, *et. al.*, 2016). This QR code linked to a purpose-built website featuring further information about the study and a contact form (Appendix 4). This website with the URL yourpatientviews.co.uk was optimised for both laptop and mobile devices (Appendix 5), again with a view to convenience for the potential participants.

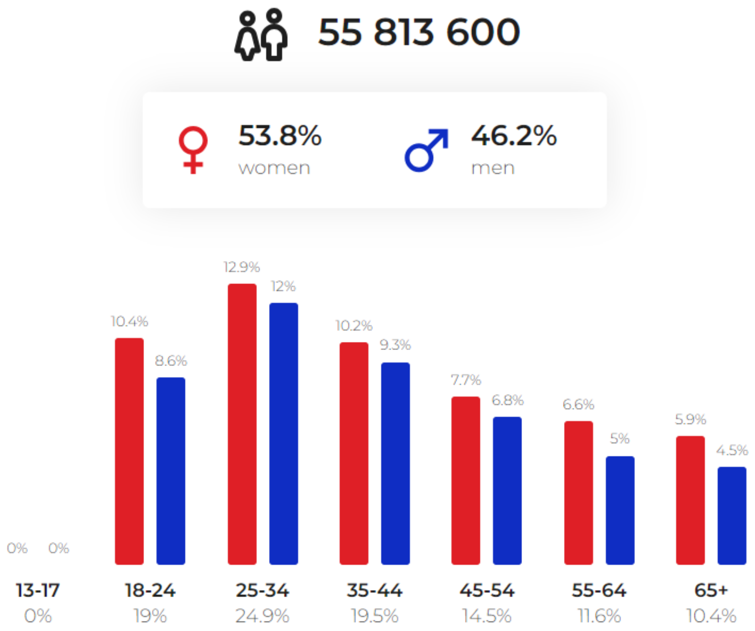
3.6.3 Potential Challenges of Recruiting Participants

Whilst the leaflets and website had been publicised and distributed in the settings, it was not possible to oversee the daily handing-out of leaflets to patients. Whilst it was noted that clinical staff had placed leaflets on the reception desks and on the tables in the waiting areas, there were many other items on display to compete with, and choosing to pick-up a leaflet was purely at the discretion of the patient, who likely was more concerned with their appointment at the time.

Due to this slow start, a discussion took place with the NHS research team and clinic staff, and it was agreed that the researcher could also speak with patients to ask if they might be interested in volunteering for interview during their observation stage in the waiting areas. A great deal of sensitivity was required here since patients were sometimes anxious about their appointments, and this method was only tried on one occasion, although two patients did come forward this way.

The remaining participants were recruited via the researcher placing a digital version of the leaflet on social media (Instagram, Facebook and LinkedIn) and a third of volunteers came forward via this route, with Facebook being the most popular. Social media has been found to be an effective route for obtaining participants for interview (Darko *et. al.*, 2022). There is a possibility however, that social media may not potentially reflect the target population for a study, since some patients might not access Facebook for example (Topolovec-Vranic and Natarajan, 2016). However, according to Napoleon.cat (2023) the amount of Facebook users in the United Kingdom has increased, with more than half being women, and more than ten percent of users being over 65 years of age (see Graph 3.1). Therefore it is possible that older generations, for example, were not excluded.

Graph 3.1 Profile of UK Facebook users in October 2023, (Napoleon.cat.com, 2023)



Following the sampling procedures outlined, recruiting participants was a lengthy and challenging process. Whilst some patients used the email address offered within the leaflet to contact the researcher and others filled in the form on the website, a greater percentage responded to word of mouth recommendations by friends of participants or via social media. After a considerable effort to reposition leaflets in the settings, to persuade hospital reception staff to mention them and also posting the opportunity on the researcher's Facebook page, it was determined that the achievement of gaining up to 20 interviews aligned well with previous studies, and in progressing through the interviews this was clearly a sensible point for saturation being reached.

3.6.4 Interview Approach and Structure

Following previous studies (Annemans *et. al.,* 2018; Black *et. al.,* 2018) and the outcomes of the pilot study, it was decided that 20 interviewees were a suitable target number for this study. Interviews were planned to last approximately 45 minutes to one hour, reflecting the lessons learned from the pilot study.

Following these lessons learned, patients were given a choice of venue for interview: either online via Microsoft Teams or in person at either the University of Winchester premises, a café, or the participant's home. Whilst some state that in-person interviews allow for a better rapport and reading of body language (Bryman, 2001) and are more naturalistic (Gillham, 2005), there is increasing argument for enabling more diversity from the point of the researcher's practice, for example their geographic location (Tucker and Parker, 2014). Oltmann (2016) proposes the following list of considerations when selecting mode of interview (Table. 3.6). Online video interviewing has become more commonplace since the Covid-19 pandemic and participants are now more accustomed to this communications method (Self, 2021).

Table 3.6 Components of the interviewer's context (Oltmann, 2016)

Time and financial costs
Geographical distribution of respondents
Sensitive or controversial topics
Technological problems
Interviewer safety
Note taking
Interaction effects
Non-verbal language and cues

Whilst in this context the geographical distribution of respondents was not significant (they were all from Hampshire in the south of England), time was more pressing for some who were attending the interview whilst on their lunch break and hence scheduling became paramount for them (Self, 2021). Technical issues or accessibility to the internet have also been cited as potentially problematic for participants with online interviewing (Maitland, 2018) and this was a further reason for this study offering choice of medium and location to participants as part of an empathetic approach. Whilst there is limited literature on the advantages or disadvantages of combining online and in-person interviewing within one study, research shows the outcome on terms of richness and length of narratives do not differ significantly (Johnson *et. al*., 2021).

Uniquely to this study (since almost all previous studies in this area have only been on the clinical site), no interviews were conducted within the hospital space due to the researcher not wishing to interview patients at the same time/location as their appointment. The researcher was wary that they might be distracted, limited for time or even taken away for clinical treatment (Annemans, 2018).

3.6.5 Interview Questions Framework

As can be seen in Appendix 6, a script of key topics was generated in order to loosely facilitate conversations around spatial and social concerns rather than experiences of clinical treatments. For example, after making the participants comfortable and confirming their consent, initial conversations centred around their feelings before and on arrival at the settings. The narrative then proceeded to discuss finding their way, impressions of various aspects of the waiting space, relationships with others and interactions within the space and finally their ideal waiting scenario.

3.7 Managing the Data

All interviews were recorded on Microsoft Teams, whether conducted in person or online. This was effective in that it automatically provided a basic transcript recording for later review. Alcock and Iphofen (2007) argue that using digital software for transcription of qualitative interviews means researchers can adopt a more reflexive approach where they are free to work without having to engage with external transcription services and remain close to the data. However, McLellan *et. al.* (2003, p.65) caution that careful decisions must be made in terms of preserving the "morphologic naturalness of transcription" where words, punctuation and everyday language should be preserved. This is particularly important for this study, where individual stories concerning feelings and emotions were told.

Once the files had been downloaded and saved, the names of participants were anonymised (see *ethics* below) and assigned a numeric code (i.e. patient1) prior to any coding and the files were secured on a password protected computer. Since all patients were of the same gender and not related to each other in any way, assigning 'intimate' personal alternative names rather than numeric codes (Edwards, 2020) was not seen as a particular contextual benefit for this study. In other words, there was not, for example, the delicacies of a parent child relationship to keep in mind when conveying the findings, where personal names may have reminded the reader of such relationships; for example 'Jayne' as mother and 'Lewis' as son.

Due to the scale of this study, a full data repository (web-based platform for storing and sharing vast amounts of research data) was not required (Antonio *et. al.*, 2020), so transcripts were backed-up onto a password secured personal external drive in the event of data loss. In accordance with the University's Research Data and Records Management Policy, research data and records should be retained for as long as they are of continuing value to the researcher and the wider research community (University of Winchester, 2018). However, the policy recognises that in many instances, researchers will resolve to retain research data and records for varying lengths of time. In this context the data will be securely stored as above for a period of two years from collection, which should be sufficient time to access this for further research or dissemination and concurs with the proposed time stated in the 'IRAS' ethics form (Appendix 11) submitted by the researcher to the NHS Research Ethics Committee (see Ethics Considerations, 3.9, below).

3.8 Analysis of Interviews: Coding Approach

Flick (2023, p.386) highlights how analysing qualitative data, whether textual or visual, enables the researcher to "make statements about implicit and explicit dimensions and structures of meaning-making" within the material. Saldaña (2024, p.87) builds upon this in acknowledging three spheres of environmental influence on individuals: 'macro' being global or national trends (herein such as pandemics and NHS pressures), 'meso' being local or community groupings (here meaning the local clinic and types of similar patient groups), and 'micro' being the "immediate sphere of influences" and social identity constructions, in this context the waiting room and the notion of 'patient' that are manifestations of the macro level (Nassauer and Legewie, 2022). For this study, bearing in mind these ideas and taking a multi-layered approach to the analysis, both in terms of types of coding and cycles of readings, ensured that the interviewees' voices and perspectives were heard and acknowledged as much as possible.

Coding in qualitative studies can be described as applying a word or brief phrase to capture the essence or meaning of an element of data; a "researcher-generated construct" that adds subjective meaning for later analysis (Saldaña, 2016, p.4). Thematic coding is prevalent in qualitative research and typically centered around several readings of data to extract basic themes, groupings of organized themes and broader global themes emerging from the readings (Braun and Clarke, 2019; Stokes and Wall, 2014). Sanders and Wilkins (2016) argue that inductive researchers can make sense of data in any ways they wish, however adding values (in this case words or typologies) via coding helps to make the data manageable. Typologies are termed as the framing of differences between people or happenings (Rivas, 2012) and involve grouping cases or subjects into types based around similar patterns (Stapley *et. al.*, 2022).

Due to this being a qualitative study, the approach to coding the interviews is eclectic; an assemblage of several coding methods which is holistic rather than prescribed (Saldaña, 2016).

For this thesis a unique combination of two affective methods is employed. These are:

1. Voice-Centered Relational Analysis (The Listening Guide)
2. Emotion Coding

These typify affective coding which considers the subjective aspects of human experiences, emotions, and conflicts by effectively labelling them (Saldaña, 2016), and therefore enable the identification of the core motives for human action and reaction.

3.8.1 Voice-Centered-Relational Analysis

In order to convey the immediacy of personal emotions and feelings and perspectives experienced by the participants, it was important to select a coding method that allowed their voices to come through. Hence the approach of the Voice-Centered-Relational Method (VCRM). This was deemed highly suitable as ”importance is placed on attending to the broader social and cultural issues that shape and constrain participants' narratives” (Hutton and Lystor, 2020, p.16). It offers a way of hearing and developing an understanding of several different layers of a person’s expressed experience as it bears on the questions posed (Gilligan *et. al.,* 2003). This ‘Listening Guide’ methodology offers a way of illuminating the complex and multilayered nature of the expression of human experience and the interplay between self and relationship, psyche and culture. As well as listening for voices, VCRM acknowledges the importance of social relationships (Jankowska, 2014). Rather than prioritising the self-sufficiency of the patient in this case, it focuses on a ‘relational ontology’ or way of being (Stokes and Wall, 2014), whereby the relations between entities (physical attributes of the space and the patients) are more fundamental than the entities themselves (Wildman, 2010). Here humans are situated within a more complex web of intimate and larger social relations (Gilligan, 1982; Jankowska, 2014; Mauthner and Doucet, 1998). VCRM acknowledges this by unveiling individual narratives in terms of relationships to others, but also here in terms of relationships to the space, whilst additionally including the researcher’s own interpretations of the narratives (Mauthner and Doucet, 1998).

Although this study combines a second coding approach of ‘emotion coding’ (see below) which involves codes and categories, VCRM steps away from this in recognising that human life is “multi-layered, contradictory” and interconnected (Josselson, 2011). This approach highlights how, unlike more common qualitative coding methods which jump to categorising and cutting up the data, the researcher should pay attention to attentively listening and not "overwriting the expressions, meanings, and resonance of their participants" (Hutton and Lystor, 2020, p.15). Since this method has its origins in giving a voice to those who may have been marginalised, originally within feminist relational psychology (Brown *et. al.*, 1991), it is fitting for the aims of thesis to give a voice where patient voices are not always heard. Whilst this study is not centered around a feminist ontology, it is pertinent that the participants were all women.

The adoption of voice-centred-relational analysis for this study utilised all four stages of analysis and interpretation of both the verbatim transcripts and listening to the original recordings on Microsoft Teams:

1. *Listening for the plot:* (listening for events and plots and generating a researcher's emotional response to these)
2. *Listening for the voice of "I"* (focusing on the individual's sense of self within the broader narrative) and creating 'I poems' (See Appendix 16)

3. *Listening for contrapuntal voices* (tuning into different aspects of the story based on the theoretical framework)

4. *Listening for broader political, social and cultural structures* (listening for clues about the culture of the hospital and the waiting room, and how these affected the patients' experiences

In the first stage of listening for the plot, several readings are initially conducted to build a picture of what is happening within the various stories being relayed. At the same time the many layers of the landscape, in this case the context of the health setting and the patients' own worlds, are attended to (Brown and Gilligan, 1992).

In the second stage of Listening for the voice of "I", the idea is for the researcher to pick up on the various subtleties and rhythms of the first-person voice and how they talk about themselves.
"I poems" (Debold, 1990) are then created from these narratives (see Appendix 16). Here every statement involving "I" is collected and placed sequentially, to create intimate, resonant poems, or as Gilligan *et. al.* (2003) describe the process:

> “Cutting the text close and focusing in on just the I pronoun, the associated verb and few other words moves this aspect of subjectivity to the foreground, providing the listener with the opportunity to attend just to the sounds, rhythms, and shifts in this person’s usages of “I” in his or her narratives.” (p.163)

In the third stage of listening for contrapuntal voices, through several more readings of the texts, different levels of the stories that resonate with the research aims and questions are identified. In this case the focus is on looking for feelings about the barriers and enablers of a positive experience for the patients. At times the patient might be heard to speak in different ‘voices’ according to what the researcher is looking out for, for example when looking for comments about the social challenges of the space versus listening for feelings about décor.

For this study, the final stage of Listening for broader political, social and cultural structures was focused primarily on how the culture of the hospital and the waiting room, and potentially the macro or micro level “spheres of environmental influence within” (Saldaña, 2024, p.86), affected the patients’ experiences. This was related back to the research questions. Reviewing broader contexts of power and politics and structures, however, could potentially merit further future research since this was not the key aim of this study.

3.8.2 Emotion Coding

To provide an even richer account of experience, a second method of analysis, ‘Emotion Coding’ (Goleman, 1995; Kahneman, 2011) was applied to the same transcripts. Emotion coding is particularly appropriate for understanding “intrapersonal and interpersonal participant experiences and actions” (Saldaña, 2016, p.125) and involves initially highlighting all emotions or feelings the subjects may have experienced (Miles, Huberman and Saldaña, 2018). Emotion coding is particularly suited to studies that involve social actions and participants’ life conditions; it recognises the subtleties and range of intensities of possible emotions (Dobbert and Kurth-Schai, 1992; Saldaña, 2016) and is therefore apt for this study focus. Here a great level of empathy was required on the part of the researcher to identify with these emotional lived-experiences and time was therefore taken to consider the most appropriate code (see the findings in Chapter Four), as led by the data rather than previous outcomes from the ethnographic stage or the literature review.

Coding typically involves ‘initial’ first cycle coding to apply many and wide-ranging keywords to notable themes or topics, also known as ‘concept coding’ (Saldaña, 2016, p.119), before more ‘focused’ second cycle coding to form “overarching ideas or propositions from the initial coding outcomes” (Lofland, 2006, p.201). After the second cycle, certain codes were altered to more accurately reflect the nature of comments made. For example, ‘invaded’ was changed to ‘vulnerable/exposed’ since most participants were referring to not wanting to being in other’s space, rather than feeling attacked. Likewise, ‘annoyed/agitated’ seemed more akin to somewhat ‘upset/unhappy’ on review. From these initial codes and themes, a review of their frequency of occurrence was undertaken, to understand the prevalence of certain issues over others. Each time a participant mentioned a particular moment or feeling that seemed to convey a distinct emotion, a code was counted. This was noted in a table before a word cloud was created for ease of viewing, this helped provide scales of barriers and enablers to consider. When a participant mentioned an idea or a wish for how they might envisage a better waiting room, this was coded as ‘wishful’ and kept separate from their critiques of the current spaces/experiences.

A further cycle of the emotion coding approach was to identify the most pertinent ‘In Vivo’ quotes from participants to build a fuller picture of these feelings and to see how these emotional experiences informed the verbal accounts that followed (Fisher, 2007). In Vivo coding concerns using actual words or phrases from the original data and is particularly suited to honouring the participants voice (Saldaña, 2016) and grasping the underlying meanings of human experience (Stringer, 2014). As mentioned previously, it was essential for this study that the voices of participants were heard directly. Finally, these codes were placed into overarching categories for presentation and review (see Chapter Four).

3.8.3 Considerations of the Chosen Coding Methods

Whilst there are many options for coding of data, both manually or electronically, it is useful to “take a pragmatic approach stance toward human inquiry” and to select the most appropriate tool for the task (Saldaña, 2011, p.177-8). Hence after consideration, the two methods above were chosen. However, whilst emotion coding is pertinent for drawing out the feelings and sentiments of participants, Hart-Johnson (2017) cautions that researchers have a moral and methodological responsibility to be conscious and emotionally aware, by ensuring that academics look past their own position; their ego and privilege and decide how much of the ‘oppressed’ participant’s experience should be acknowledged.

3.9 Ethics: Key Considerations

This section of the chapter outlines the various ethical considerations for this study. Since this research was conducted with an industry partner (the NHS) and with actual patients, it was also necessary to undergo a full ethics review by the NHS Health Research Authority Research Ethics Committee (REC) and hence the structure of this section reflects the contents of this review.

It has long been a necessity within the natural sciences to gain ethical approval for research, particularly within healthcare, where for example medicines might need to be tested on human subjects (Stokes and Wall, 2014, p.212). Qualitative research for the social sciences can be known as posing more challenges ethically due to its nature of being more open-ended, particularly with ethnography, where the research might take unpredictable paths or where phenomenological interviews might lead to revealing stories or emotions (Bryman and Bell, 2015, p.150).

3.9.1 Ethical Context

Due to this being a purely qualitative study located within an essentially natural sciences setting, there is somewhat of a dualism between the necessary confines and practices of the clinical discipline and the desired flexibility and openness of this exploratory research. In other words, accessing real participants (patients) brings with it some fairly strict deontological rules on the part of the institution which must not be broken (Stokes and Wall, 2014), and yet the tenet of the outlined research design needs to allow for a fluid and more “situation ethics” approach considering relativism of the participants’ perspectives (Goode, 1996).

3.9.2 Research Ethics Committee Approval

Whilst ethics guidelines of any University overseeing research need to be adhered to, as was the case for this study (see Appendix 9), it is also necessary to comply with codes of practice from relevant professional associations or committees (Bryman and Bell, 2015).

The Research Ethics Committee (REC) acts on behalf of the Health Research Authority (HRA) to review ethics applications for undertaking research in healthcare in the United Kingdom. This is where studies engage with human participants and typically within the NHS (HRA, 2023, [online]). Following discussions with the local NHS research team, it was agreed that a full ethics review would be required. The process involved submitting many forms and documents to the HRA in order to clarify the approach to be taken for this research and to indicate how ethical challenges would be addressed. Appendix 10 shows the various documents that were submitted. As can be seen, various proofs of indemnity and insurance were required, as well as letters from the University sponsors, CVs, risk assessments and copies of participant-facing information. A full research 'protocol' also had to be written that outlined the project proposal in a great deal of detail and accompanying schedules. However, the most detailed document was the IRAS form (see Appendix 11): a pro-forma application that covered the following topics:

1. Category of study (qualitative study only)
2. Outlines of any funding/costs
3. Site and location of study
4. Confirmation that no children would be involved and that the study was not 'intrusive'; involving adults lacking capacity to give consent
5. Details of all researchers and supervisors involved
6. Research proposal
7. Full research design and proposed methodology
8. Scientific justification for the research
9. Description of the proposed sample of participants and inclusion/exclusion criteria
10. Plan for participant recruitment and gaining of informed consent
11. Details of potential risks to participants
12. Kinds of data, expiry of data and approach to storage
13. Incentives and payments
14. Dissemination once the research was completed

Many versions of these documents were completed, edited and resubmitted in order to ensure accurate compliance with NHS protocols and processes. Some of this work was completed prior to the formal scheduled REC panel meeting to review this application, and some post-meeting. The researcher was not asked to be present at this meet and there was a long lead time for scheduling once final documents had been submitted and signed-off for submission to the committee. Examples of some of the queries raised by the committee and later addressed included:

- Clarification on how and when the healthcare team would be involved in assessing suitability of potential participants
- Changes in some terms such as ‘of sound mind’
- The ineligibility criteria of stroke, mental illness, dementia and neurodegenerative disorders be reviewed and clarified as to whether these were indications where the ability to communicate is severely affected
- Clarification on how a potential participant who did not have access to MS Teams or Zoom but was very keen to be involved, be able to take part in the study
- Explanation as to why non-English speaking participants would be excluded from taking part in the study
- Confirmation that for interviews participants would self-identify (i.e. they would see the averts in the clinic spaces and will make the decision whether to contact the researchers themselves) rather than local NHS staff actively identifying participants (i.e. the NHS staff would only place adverts in their clinical space and hand out adverts generically to those they see in clinic, rather than reviewing their records to identify specific individuals)

This work involved various signatories from the University of Winchester every time a small change was made and so became a lengthy but necessary and rigorous process. On completion of the final submission, after a period of approximately six months and interim approval status updates, a final letter of approval was received. This included dates by which the study must be complete and instructions in the event that any terms of the study might change, for example, a different location being required.

Following this approval, it was necessary to apply for a Research passport (Appendix 13), a document that included all details of sites to be accessed, ID checking and named contacts whilst on-site. Only on receipt of this document was the fieldwork able to commence.

3.10 Conclusion to Chapter

This chapter has explained the research design for this study, including the philosophical position of the researcher. This work takes the stance of inductivism, with a subjective approach to gathering data qualitatively. A two-phased approach of ethnographic field observation and semi-structured interviews was explained and justified. Following lessons learned and applied from the Pilot Study, 15 hours of on-site overt observation was undertaken. 20 semi-structured interviews were conducted with participants from the two NHS sites and affective coding practices adopted were explained and justified. Ethical considerations were discussed, primarily via detailing the application for full NHS ethics committee approval, which was awarded for this study.

The next chapter details the findings from this research design and data gathering approach.

CHAPTER FOUR – FINDINGS

Preface

In this chapter, the insights gained from the pilot study and the main data-gathering phases are summarised and interpreted in the context of the research aim to understand how patients feel and what matters to them while they are in the waiting areas. This fulfils research objective two: to understand patient perspectives on healthcare spaces, including how aspects of the 'conceived space' and the 'perceived space' impact their 'lived space'.

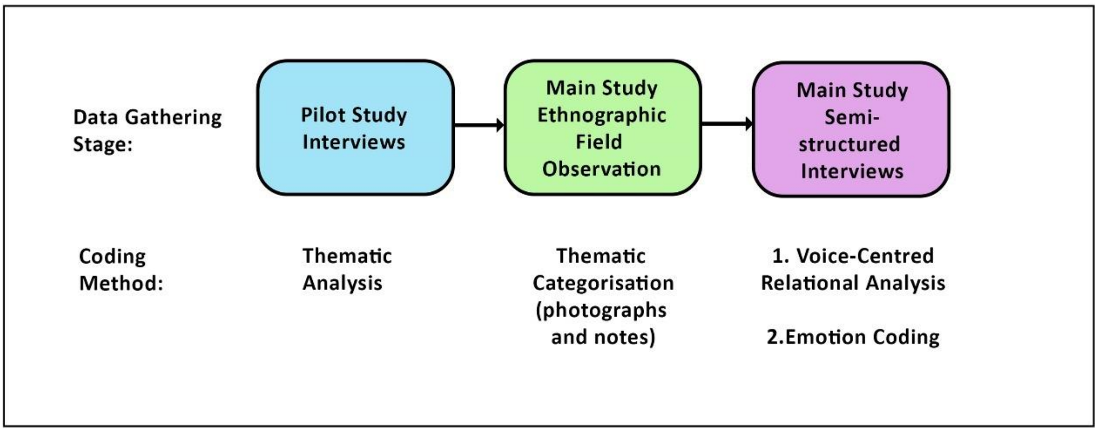
As a reminder, here are the research objectives that these findings aim to reflect:

The research objectives are:

1. To create a conceptual framework bringing together health and design thinking domains to identify opportunities to contribute to new knowledge on the topic of patient lived experience and the role of spaces;
2. To understand patient perspectives on healthcare spaces, including how aspects of the 'conceived space' and the 'perceived space' impact their 'lived space';
3. To advance the understanding of 'lived experience' by testing the appropriateness of the framework that employs Design Thinking and Third Space principles;
4. To leverage these research insights to devise recommendations and considerations for practitioners for patient-centred and 'lived space' design projects.

The outcomes from the pilot study are first presented via thematic analysis of the interviews. The two stages of the main study then follow: first, the data from the ethnographic field observation is presented through thematic categorisation, then the outcomes of the two analysis stages of the semi-structured interview data; Voice-Centred Relational Analysis and emotion coding are shown (Figure 4.1).

Figure 4.1 Schematic Showing the Analysis Stages of this Study (Author's Own, 2024)



4.1 Pilot Study

This section presents the outcomes of the analysis of the data collected from the three interviews from the pilot study stage. For reasons explained in Chapter Three, there was no field observation conducted for the pilot study. Lessons learned from this stage and how these impacted the main data gathering stages are then presented. For clarity, here is a brief profile of the patients and their accompanying relatives (terms here as 'visitors') who participated:

Table 4.1 Profile of Pilot Interview Participants. Author's Own (2020). Names Are Invented

Interview Number	Participant	Age	Gender	Patient Circumstance	Setting	Duration	Notes
1	Patient1 (Ralph)	80+	M	Several two-night visits – unplanned (first = A&E)	Winchester NHS hospital	2 nights at a time	Husband
1	Visitor1 (Caris)	80+	F				Wife
2	Patient2 (Zoe)	17	F	Long term cancer patient	Southampton and London NHS	Many nights - approx. 1 week mean	Daughter
2	Visitor2 (Kendra)	45-55	F			Sometimes stayed on ward	Mother (previously health professional)
3	Patient3 (Susan)	45-55	F	Covid-19 emergency admission	London NHS ward	8 days	n/a (also a health professional)

4.1.1 Key Themes Identified from Pilot Study

Much of the data supported the concept that the physical environment evidently impacted the patient experience and perceptions of well-being, both positively and negatively during their visits. Relationships between the various people within the hospital spaces were also significant, more so since these patients had also been inpatients. Key themes conveyed by participants were categorised as: feeling grateful; having empathy for others; feeling undervalued; experiencing disappointment; feeling detached; feeling unsure; and being agitated by the environment . The environment appeared to be the most frustrating aspect for patients and their relatives.

4.1.1.1 Feeling Grateful

The majority of the discussion appeared to reveal more challenging aspects of hospital stays. Nevertheless, there were some small moments or incidences of appreciation which might be termed as small micro-cultural practices (Lofland *et. al.*, 2006):

> “I hadn’t really taken anything with me, and I didn’t have any money and I was getting really hungry and thirsty… one of the lady in the reception - she offered to lend me money!” (Patient 1)

These moments were typified by appearing outside of normal organisational operations (a tenet of the second space), whether manifested though individuals or groups. All participants mentioned more than once the positive impact of interactions with, and warmth of the nurses during their stay:

> “The nurses, they’re very sympathetic" (Patient 2)
>
> "They're the constant” (Visitor 2)
>
> “The nurses were very attentive” (Patient 1)
>
> “I did get chatting to quite a few of the nurses, they understood me” (Patient 3)

The data revealed that it was typically people operating outside of their core roles or everyday practices who appeared to resonate most with positive patient experiences.

4.1.1.2 Having Empathy for Others

All patients/visitors noted observations about others in their hospital spaces – frequently highlighting the apparent mismatch of their neighbours to their own conditions/demographic. One aspect that was uncovered was the patients' sense of others' misfortune. This appeared to stem from patients being placed near those with more pressing medical concerns and at times this resulted in upsetting or worrying moments for our participants, but also a sense of gratitude and relief that they were not in the same predicament:

> "She was the definition of a wailing banshee - she would say 'oh my god' the whole time - it was quite upsetting" (Patient 3)
>
> "The patients were of a different type you could tell; I got the feeling some of them had cancers of various sorts - that was real stuff..." (Patient 1)

4.1.1.3 Feeling Undervalued

The most substantial portion of the data alluded to various iterations of feeling undervalued; including challenges with communication, feedback or trying to be heard. Patients cited various scenarios of having to negotiate, requesting approaches to aspects of their treatment or attempting to have a say in things:

> "I persuaded them to basically let me stay there" (Patient 3)
>
> "I said please just tell me what you're doing, and I'll be fine" (Patient 2)

In contrast to the common appreciation for the nurse, the Doctors were unanimously described as having a detrimental impact on the experience overall:

> “…the doctors - sometimes I feel like I'm not 100% heard” (Patient 2)
>
> "I wasn't treated as a person, yeah it was a condition that they were treating, yeah illness not a person" (Patient 3)

4.1.1.4 Experiencing Disappointment

Disappointment commonly manifested itself in terms of frustrations with the systems or sudden unexpected changes within the environs. Such unexpected happenings were sometimes unsettling for patients and yet seemed at times insignificant to staff. All participants commented on the unpredictability of events during their stay; this was in relation to sudden changes to occupation of neighboring beds, being moved to unknown spaces or the constant change in staff treating them which disrupted senses of continuity:

> "…they just say, ‘we've got to move you' and then you kind of go 'oh no' - you know, you've got your space... and your neighbour" (Visitor 2)

4.1.1.5 Feeling Detached

All participants recollected a level of indifference to their use of time and space during their stay which appeared to go unnoticed by staff:

> “I think I just stared into space to be honest” (Patient 3)
>
> “you’ve got to be prepared to just sit there like a lemon and wait” (Patient1)

4.1.1.6 Feeling Unsure

There were many times described when patients felt unsure, this was generally articulated as a nervousness around what might happen at any moment.

> “I just didn't know who anybody was - I wasn't really sure who was doing what” (Patient 3)
>
> “The only privacy you get is if they draw the curtains round you and they're going to do something to you” (Patient 1)
>
> "you feel like you're constantly on guard don't you, and you think ‘oh god, someone's going to walk in!’” (Visitor 2)

4.1.1.7 Agitated by the Environs

The most frequent and a theme that commonly occurred was that the surrounding environment presented challenges to the patient, with light, noise and states of disrepair being common critiques. Notions of personal space, condition and location of features/amenities, and proximity to others were often criticised:

> “It was horrendous - it was really basic because it was tatty, very small." (Visitor 2)
>
> “The water took about 15 minutes to get hot and so it wasn't a pleasant experience.” (Patient 3)
>
> “There was a little cupboard next to you for your bits and pieces, I couldn't actually get into it, the beds were too close.” (Patient 3)

The pilot study reviewed in-patients as well as outpatients, and so patient expectations depended to some extent on whether their stay was planned or unexpected, the length of time they had endured their illness or condition and previous histories. For example, Patient 3 was often frustrated with not knowing the rank or role of staff and Visitor 2 expressed frustration at the length of time things took and the lack of care with reference to tracking the administering of medicines.

Expectations concerning practical aspects of the ward space seemed low for some patients and some level of submission or acceptance was seen in terms of furniture being shabby or not accessible, water not heating, windows not opening or busy atmospheres. Paradoxically it can be argued these aspects contribute negatively to user’s well-being significantly, as light and noise were frequently cited as a frustration.

4.1.1.8 Sense of Identity, Agency and Well-being

As was also found in the literature (see Chapter Two), privacy was cited as a key contributor to patient well-being, and this was frequently challenged in these experiences cited by the participants. Patients felt that privacy mostly eluded them. They felt on edge due to the lack of privacy, which was compounded by the unpredictability and the frequent accounts of being cramped physically and invaded mentally by noise and other distractions.

In terms of patients feeling individually valued, the findings showed that patients were all looking to be heard by healthcare staff in some way and this presented a challenge. For example, several patients mentioned using persuasion to convey how they were feeling in order that they might access services, and others cited the need to have their treatment explained during the process for their own mental well-being.

In summary, choice seemed to be somewhat absent from their experience; in relation to food and drink, levels of activity or distraction to engage with or approaches to treatment. Patients were left feeling dependent and at times unseen within the system they found themselves in, arguably highlighting the importance of findings by Janssen and Rosenberg which indicated that engaging patients in sensory, cognitive, and social activities would improve their perception of recovery (Janssen *et. al*., 2010; Rosenberg, 2017).

4.1.2 Pilot Study: Methodological Lessons Learned

The pilot study revealed the following methodological factors which were then considered for the main study of the thesis:

1. Giving patients the choice as to where to be interviewed offered a good level of flexibility in order that they had freedom with the time and space to feel most comfortable. For the final study (where all Covid-19 restrictions were lifted) it was decided patients could therefore choose online or in person, and at a venue of their choice: their home, a university room or elsewhere. It is unlikely such beneficial flexibility may have been offered if the pandemic had not impacted the pilot study in this way.

2. Choosing to conduct interviews away from the healthcare space proved beneficial, since participants stated they were less focused on their clinical treatments and had space to reflect and recall certain happenings. This was continued for the final study.

3. Using Microsoft Teams to record all interviews was effective as a means of providing a convenient initial digital transcript and audio recording for sense making. Whilst video was also used during the pilot study, this added little value to the researcher in terms of looking for gestures/visual indicators and it was decided, after discussion with participants, that they were also happier and more relaxed when not on camera.

4. Four patients were interviewed in the pilot study phase. Whilst providing extensive transcripts, it was clear that more would be of benefit to provide a richer account and fifteen to twenty interviews was therefore decided as an optimum range without overwhelming this study. This concurs with previous studies in this field (Caspari *et. al.,* 2011; Chu *et. al.,* 2019; Curtis *et. al.,* 2007; Locatelli *et. al.,* 2015) where a level of saturation started to occur with key observations and similar instances occurring repeatedly (Glaser and Strauss, 1967). However, Saunders (2012) does state there are no particular rules concerning how many interviews to conduct. Bryman and Bell (2015) note that interviews and observations should be seen in terms of having meaning to the researcher only when they are combined.

5. For the pilot study patients sat with a relative who also contributed. Whilst interesting and at times useful for prompting the patient, the decision was taken not to have relatives present for this final study, since at times they distracted the patient mid-conversation and interrupted frequently. Taylor and de Vocht state that both interviewing couples and interviewing individuals come with advantages and disadvantages, since a partner can either facilitate or constrain the narrative (Taylor and de Vocht, 2011). However Zarhin, (2018) cautions that interviewing with a second participant can become a site where one silences the other. For this study, this tended complicate and confuse the resulting transcripts, with many interruptions, so only individual patients were interviewed for the final study.

6. The exploratory affective approach to coding of the data during the pilot stage revealed that both methods employed were appropriate for the research aims and the kinds of data produced. Affective coding addresses subjective acknowledgement of human experiences, conflict and emotion (Saldaña, 2016). These methods are Emotion Coding (Goleman, 1995; Kahneman, 2011) and Voice-Centered-Relational analysis (Gilligan *et. al*., 2003; Hutton and Lystor, 2020).

7. Forty-five minutes was deemed as a suitable target interview time that allowed for sufficient detailed accounts of experiences without saturating topics or repetition in the data (Saunders *et. al.*, 2018). This was especially the case since the final interviews concerned outpatients only, rather than also considering inpatients' stories, so interviews could be shorter. This is because in the pilot study with inpatients, there were more elements of the experience to discuss such as privacy in getting changed and knowing when meals were appearing, which did not occur in outpatient waiting areas.

8. The approach to sampling participants for the pilot study was purely convenience (Stokes & Wall, 2014) due to not having an NHS partner at that time and the limitations of Covid-19 meaning specific spaces could not be visited. This meant that patients for the pilot had a broad range of clinical conditions including a long-term case of Leukaemia and Covid-19. Three had stayed as inpatients, two were outpatients, and various locations were experienced, including Southampton General Hospital, Guy's and St. Thomas' Hospital in London, and The Royal Hampshire County Hospital Winchester. It was therefore difficult to compare experiences of the same space. This did however build a broad picture of emerging topics to potentially focus on for the main study (See Chapter Five: Discussion).

The sampling approach for the final study was much more specific (see section 3.6.2). Having an NHS partner with two specific locations, purposive sampling through patients self-selecting, and more similar types of patient condition being experienced, suggested that the final data to be gathered might be more valid, with trustworthiness and comparability of the data being greater (Guba and Lincoln, 1985).

9. The semi-structured interview questions used in the pilot study were formed as a result of the overall study aims and the initial literature review. Apart from questions concerning the on-ward experience which were not a part of the final study, (such as concerning overnight ward noise) these questions proved very effective in enabling patients to describe their experiences in terms of the spaces and happenings, so many were retained for the final study. The semi-structured (Sanders, 2016) approach also proved ideal in terms of enabling freedom for participants to explain their feelings and emotions as well as more descriptive accounts of décor and wayfinding, whilst not straying too much into clinical matters. This semi-structured method was also retained for the final study.

4.1.3 Section Summary

This section has presented the outcomes of the pilot study. Whilst some patient narratives concerned specific stays as inpatients, many of the themes identified also related to outpatient waiting room scenarios, for example not knowing what was going to happen next or feeling a lack of sense of privacy. Notions of identity and agency and agitation by various features of the physical environs also came through clearly and merited further exploration in the main stage of this research. Many methodological lessons were learned concerning flexibility of interview location, size and composition of the sample group, questions asked and coding approaches. Overall this study demonstrated that the methodology was effective in uncovering the minutiae of the lived experiences of patients in waiting rooms.

The following section presents the outcome of the main study, commencing with the ethnographic observation stage.

4.2 Main Study – Ethnographic Observation

The following section is presented in terms of Mariampolski's steps of moving from raw observations to fully processed insights as outlined in Chapter Three (Mariampolski, 2006). The approach to the analysis is explained here for context.

4.2.1 Compiling the Data

After initially gathering the various photographs, notes and sketches from the eight separate site observation visits, these were first grouped according to the spaces they represented: lobby area; breast screening clinic; Anthony Letchworth waiting area; obstetrics suite 1 waiting area and obstetrics suite 2 waiting area. The photographs were numbered for ease of reference (see Appendix 14).

4.2.2 Reviewing the Data

The written notes were then categorised according to the principles of the first, second and third space from the conceptual framework, as shown in Memo 1, Appendix 15. For example, the décor being tired and damaged was a characteristic of the space as typified by the Firstspace, the confusing wayfinding was a circumstance of planning typified within the Secondspace, and the sense of feeling like it was a space for staff not patients was a subliminal notion, and product of the first two spaces as experienced within the third space.

The photographs were assigned emotion codes as in Memo 2, Appendix 15. These codes were somewhat influenced by the literature and also the conceptual framework (Chapter 3) but, as noted, this was an "open" approach to coding as common with ethnography rather than a ground theory approach (Blumer 1970, p.57). Rather than purely relying on the pain points identified from the literature (Table 2.2, Chapter 2), additional new codes were also assigned to reflect insights gained from these photographs by the researcher. For ethnography, rather than "definitive" prescriptions of what to see (Blumer, 1970, p.57), the use of codes is seen more as a "sensitising" concept whereby they may be used in multiple categories as a "general sense of reference" (Flick, 2023, p.388). For clarification, the initial coding of the notes versus the photographs were treated differently due to different experiences by the researcher at the time of visits, so a flexible approach was required. The written notes concerned a mixture of reflections, feelings, visual observations, general feelings and hunches, whereas the photographs were of situations that had a more direct, focused, immediate emotional effect on the researcher at the time, and were taken simply as recording devices of those effects.

With the exception of the sketch of the chair layout in the breast screen clinic waiting area (see the digital version in Memo 4, Appendix 15) the sketches were not seen as adding a benefit and were discarded, since no people or interactions were recorded and in this instance, the photographs proved to be a more reliable and useful source.

4.2.3 Decoding the Data

These interpretations by the researcher of both the notes and photographs resulted in themes as an outcome of the observation stage, to support the aims of Research Objective 2: to understand patient perspectives on healthcare spaces in different qualities of setting and how aspects of the ‘conceived space’ and the ‘perceived space’ impact the ‘lived space’, (see Chapter One).

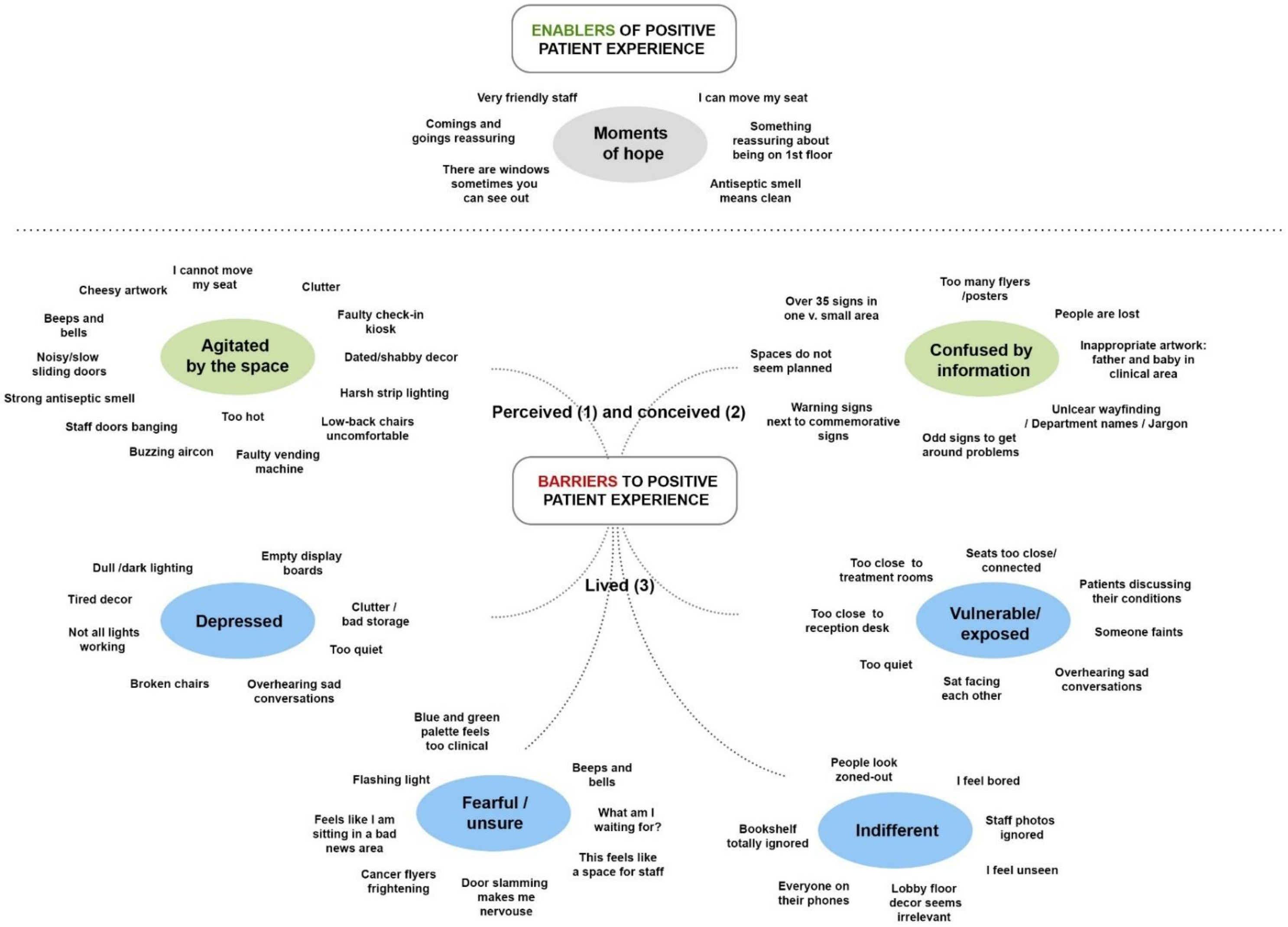
These themes were grouped into categories as shown in Figure 4.2, and as per the “sensitising” concept (Blumer, 1970, p.57), some themes appear in multiple categories. Equally, whilst some observations made could be directly attributed to notions of first, second or third space, some could not, since they were both characteristics of the space, part of the original planning, but also a subliminal emotion experienced by the observer.

Overall, the categories resulting from the observation were divided into two contexts: *enablers* of positive patient experiences and *barriers* to positive patient experiences. As can be seen in Figure 4.2, possibly because the observation was through the researcher’s subjective critical eye, there were far more barriers than enablers.

The enablers, being limited in number, were all classified in only one category termed as ‘Feeling Grateful’ and were seen as various small factors affecting the experience. These included: being able to move one’s furniture; seeing out of the window; watching comings and goings (possibly as a distraction) and concurring with the pilot study: friendly and approachable nurses.

Since there were multiple themes/factors which were experienced as barriers, these were grouped in the following categories: agitated by the space; confused by information; depressed; vulnerable/exposed; fearful/unsure and indifferent. In terms of the context of such themes within third space theory, it was difficult to purely attribute these exclusively to either first, second, or third space due to their interconnections and tendencies to occur in more than one space. As Lefebvre acknowledged, the relationships between the three spaces are neither linear nor stable but fluid and dynamic (Leckie *et.al*., 2010, p.228). However, as shown in Figure 4.2, the categories of ‘agitated by the space’ and ‘confused by information’ did lend themselves more directly to notions of perceived or conceived space, with the other categories being more emotive or personal as typified within the lived space.

Figure 4.2 Categorisation of Themes from Main Study Field Ethnographic Data Gathering Stage (Author’s Own, 2023)



These ‘barrier’ categories will now be presented in turn.

4.2.4 Agitated by the Space

What agitates one visitor might not annoy another (Douglas and Douglas, 2005), however, there were various aspects of the environment that were disturbing to the researcher. Things not functioning properly was a primary concern and very noticeable. These included an empty and disabled vending machine, which emphasised the lack of available refreshments (Figure 4.3), broken chairs (Figure 4.4), a door with no key (Figure 4.5), and a check-in kiosk that did not yet work. Having hand-written signs placed on these items only emphasised the problem. The overall effect was that nobody seemed to care.

Figure 4.3 Broken Vending Machine in the Main Lobby Area, and the Hand-Written Sign

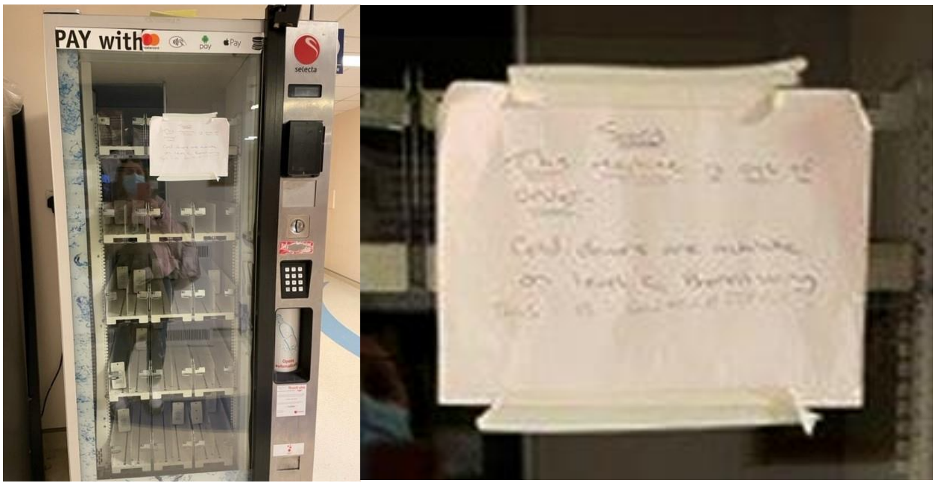


Figure 4.4 Broken Chair in the Anthony Letchworth Waiting Area

Figure 4.5 Door with No Key

Other agitating factors included noises, such as constant beeps and bells (including phones ringing), air conditioning buzzing and unusually noisy sliding doors in main reception. When in an anxious or anticipatory mood, such noises might cause distress.

When sitting for a while in a space and simply waiting, elements such as shabby décor can also become an annoyance to look at and arguably send a message of a lack of care (Figures 4.6 and 4.7).

Figure 4.6 and Figure 4.7 Scruffy Décor

4.2.5 Confused by Information

The primary issue in terms of confusion, was too much signage and other information. For example 35 different signs were counted in a small area (Figure 4.8).

Figure 4.8 Overwhelming Amount of Signs in a Small Area

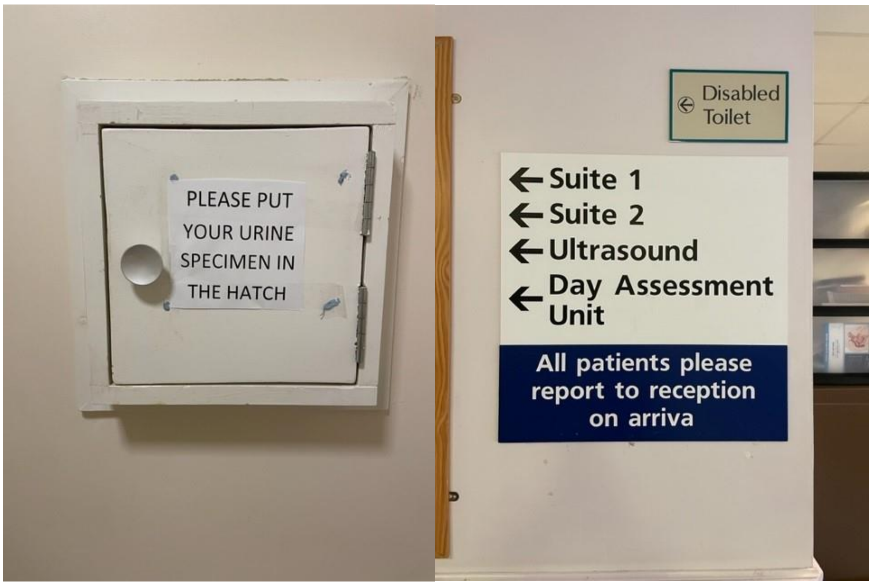
At times extra signage was improvised to get around a problem (Figure 4.9) or confusing combinations of signage were placed adjacent to each other, with instruction signs next to commemorative signs (Figure 4.10) which felt somewhat overwhelming.

Figure 4.9 Signs to Get Around Problems

Figure 4.10 Different Types of Signs Mixed Together

Despite the volume of signs, patients often were seen wandering around looking lost and consulting their phones to find where to go and some signs used somewhat abstract naming conventions or served unexpected purposes (Figure 4.11).

Figure 4.11 Unusual Signage and Unclear Naming Conventions for Outpatients



4.2.6 Depressed

Whilst depression is a clinical term relating to stress and melancholy (Paykel, 2008), here it is used to represent a miserable dull feeling caused by the environs. Unlike the patient responses in the interviews (see 4.4 below), the researcher felt agitated rather than upset (probably because they were not awaiting an examination) and hence the naming of this category differs from the interview emotion themes.

The strongest influence on this feeling of agitation appeared to be lighting. This supports the arguments in the literature that lighting is significant (Balabanoff, 2017; Huang and Chou, 2021; Ismayadi *et. al.,* 2022; Payne *et. al.,* 2015; Zhao and Mourshed, 2017). One challenge appeared to be the weather outside (and number of windows) affecting the inside light, plus the proliferation of harsh lighting in waiting areas (Figure 4.12). At times some areas were very dark and dull.

Figure 4.12 Office-Style Harsh Lighting

Another concern, whilst not critical to care received, that did have an effect on the experience of the visits was the notion of clutter or storage, with items seemingly left in unintended locations. Though it is noted that hospitals have procedures and practices to undertake, the use of space did not always seem focused on the customer and corridors or entranceways seemed to be used for storage (Figure 4.13). This again portrayed an image to some extent of internal process being more important than customers.

Figure 4.13 Storage in Unusual Locations

One of the more challenging aspects causing an unhappy experience when waiting, was that treatment rooms were often located directly adjacent to seating areas. Figure 4.14 shows the door to a room where patients were being given bad news which could be heard when waiting directly outside, with an upset patient then exiting the room where the researcher was seated, causing some concern and distress. Similar conversations could be heard in other waiting areas around the setting from other treatment rooms. Overhearing was also a feature of the findings from the pilot study.

Figure 4.14 Treatment Room Where Unfortunate Conversations Could Be Heard

4.2.7 Vulnerable/ Exposed

A sense of lack of space or invasion of personal space was experienced in different ways during the observations. At times this felt like one's own privacy was being invaded, whereas at other times the researcher was conscious of not invading other's space. Some seats were physically joined together and fixed to the ground, posing decisions as to where to sit and next to whom (Figure 4.15). In such sensitive contexts as obstetrics and breast screening, this felt inappropriate since visitors might want their own space.

Figure 4.15 Fixed Chairs in the Obstetrics Waiting Area

The overhearing of conversations, both outside of the aforementioned treatment rooms and within the waiting areas also contributed to a lack of privacy and a sense of being invaded or invading of others privacy. It felt awkward and worrying to hear patients discussing their concerns and symptoms with their relatives in the open waiting areas.

The location of the reception desk in relation to the seated waiting areas had both positive and negative connotations. It was somewhat reassuring to see and hear general comings and goings and a useful distraction, yet the constant ringing of phones, and at times, overly jovial chatter of staff became an annoyance. The ability to be able to choose the proximity to the desk in the breast screen clinic waiting area alleviated this somewhat (see Appendix 15, Memo 4).

4.2.8 Fearful/ Unsure

It was quite easy to feel fearful and unsure during the visits to waiting areas. One of the strongest causes of such feelings was the proliferation of posters featuring serious conditions such as cancer. Whilst it is noted that it may be advisable to signpost patients to such information for the purpose of prevention, it caused concern and worry when sitting in the waiting areas with little else to occupy oneself.

The use of pale blue throughout some areas as a décor colour also prompted notions and reminders of clinical things, despite a soft beige/pink also being seen in the obstetrics area – this could have been intended as a gentle reference to the pink and blue often associated with babies, although this was not noted at the time. Whilst the literature showed that blue and green are potentially viable colours for health spaces (Arneill and Devlin, 2003; Ayas *et. al.*, 2008; Birren, 1978; Dalke *et. al.*, 2006), these did feel a little too medical or even institutional for the researcher.

The addition of the aforementioned noises such as beeps and door slamming added to the sense of heath institution. At one point, what looked like an emergency light was flashing for some time in the obstetrics waiting room, which made the researcher feel somewhat alarmed (Figure 4.16).

Figure 4.16 Emergency Light

Whilst having areas that are reserved only for staff is understandable – the form or wording of signage preventing visitors from entering came across as somewhat prioritising the needs of staff rather than patient (Figure 4.17).

Figure 4.17 Staff-Only Signage

4.2.9 Indifference to the Surrounding Environs

Indifference or apathy was not something that was prevalent within the literature, however the pilot study revealed that people felt they somewhat numb or were staring into space (see 4.1.1.5 above). This notion of zoning out was certainly observed during the observation, and although it was felt inappropriate to photograph other individuals, this numbness was also experienced by the researcher personally. In essence it was very boring sitting within these spaces for more than 15 mins or so, and certainly for longer periods. Elements that had evidently been placed by hospital designers to help or alleviate such feelings did not have any effect on the observer. For example, the friendly gesture of the inclusion of staff photo boards and bookshelves (Figure 4.18) or the decoration on the lobby floor (Figure 4.19) seemed to serve little purpose to the researcher when faced with such waiting room experiences and potential worries about what was to come.

Figure 4.18 Various Interventions To Aid With The Environs

Figure 4.19 Floor Design

4.2.10 Making Imaginative “Leaps” on the Basis of the Data (Mariampolski, 2006)

According to Mariampolski (2006), this stage of analysis involves ‘sharing insights to deliver full value’. In this context, a summary will be presented from the ethnographic phase, with further discussion in Chapter 5.

Before these insights are summarised, a particular observation took place from the third visit to the breast screening clinic waiting room that is worthy of noting.

After visiting the space several times, it became evident to the researcher that the position of the seating was potentially significant to the nature of experience for the visitor. Hence, a review was completed of the different experience in sitting in each of the nine chairs in the waiting room for approximately ten minutes per seat. Appendix 15, Memo 4 shows a schematic representing each of the chairs and the other ‘items’ in the room. The notes below this identify the impact on the researcher of sitting in each (identical) chair.

Key insights from this exercise were that being too close to the reception desk or treatment rooms, and having one’s back to the window caused some minor discomfort or stress. Whereas being able to see across the room but also out of the window from the rear of the room felt more comforting. Whilst such interpretations might be subject to individual preference, this served as a useful starting point for discussions with the interviewees and provided food for thought in terms of room layouts.

4.2.11 Section Summary

Using Mariampolski’s (2006) framework as an approach, this section presented the ethnographic field data. The written notes and photographs were grouped thematically into categories representing enablers and barriers to a positive patient experience. These were presented in the context of third space notions of perceived, conceived and lived experience.

The following section presents the outcomes of the analysis of the data from the semi-structured interviews.

4.3 Main Study: Semi-Structured Interviews

The following section outlines the findings from the seventeen interviews with patients. First, the results of the Voice-Centred Relational Analysis of these data are presented, showing case descriptions and analysis of each patient in tables for context. Then the emotion coding of the same data is shown, firstly through a word cloud to convey main themes found (and more detailed table in Appendix 17) and then via explanation of each category with pertinent patient In Vivo quotations cited.

Finally this chapter is concluded with an overall summary of these findings before the discussion in the context of the research aims and the literature is presented in Chapter Five.

4.3.1 Voice-Centred Relational Analysis Findings

4.3.2 Explanation of Tables Presented

The tables that follow (Tables 4.2 – 4.18) show a summary of the analysis of this listening approach on a case by case basis. In the first column, a pertinent quote from each participant is provided for context and the format of each interview is shown.

The second column shows some background on the participants' circumstances for context. This approach also aligns with Flick's (2023) definition of coding being a multi-stage procedure where topic-based comparability between cases (interviews) is enabled, whilst "at the same time remaining open to the views" of individual participants. It was appropriate therefore to commence by providing an interpretation of each case. This is important for this study because interpreting feelings (the key research aim) involves subjectivity from the point of the researcher but also how the interviewees themselves happened to 'construct or perform identities and subjectivities' (Rapley, 2012, p.551).

The third column displays the researcher's interpretation of the 'plot', as described in Chapter Three, where the story being told by the patient is then noted (Gilligan, 2003).

This is followed with the fourth column showing an excerpt of the relevant I Poem deduced from the transcript. The full I Poems can be seen in Appendix 16. As outlined in Chapter Three, a key aspect of the relational method of analysis is to listen to the participant's first-person voice - to pick up its distinctive cadences and rhythms and to hear how this person speaks about him or herself (Gilligan *et.al.,* 2003). This stage therefore involves identifying the first person statements in the participant's stories and composing logical stanzas for review, in the order they appeared in the transcripts.

Finally, following the approach of the Listening Guide stage: Listening for Contrapuntal Voices (Gilligan, 2003), the fifth column shows this analysis by the researcher. This involved conducting several readings of the same texts whilst looking for different strands or layers of the story, in line with the research aims and following the initial plot interpretations and I Poem creation. Here there was reflection on the significance of these multiple layers to the research aim of understanding 'what matters' and the how the 'conceived space' and the 'perceived space' impact the 'lived space' (see Chapter One).

Table 4.2 Voice-Centred Relational Analysis of Patient 1

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 1 - Interviewed at University “Suffice to say I’m very self-sufficient, but other patients, annoying me… I sat there I was overhearing all sorts; you can hear everything they're saying.”	Her background is in academia: Psychology and Business. She is now in her 70s, retired, and is a savvy and smart individual who has a strong mind. She had had over 21 operations in relation to the conditions treated in this research setting, having been treated at both departments in Winchester several times. She found the process before even arriving (travel and booking) challenging and she identified inefficiencies in the system (lack of seating/’wrong’ staff treating her) as a frustration. She liked to feel responsible for calling out such issues for the benefit of others which seemed important to her self-concept and may be in part due to wisdom gained with her advanced years.	This shows how she takes responsibility for herself and others and effectively challenges the system. She speaks here in a confident manner, almost justifying her approach to things. She clearly sees herself (and others, as customers), questioning what is happening within the space. There is an element of frustration.	I just try, you know I was chatting I said I think you should go and ask I said yes I said how did you get here? I said, go and ask	It seems there was a certain level of pride at play here, almost a sense of wanting to prove they still ‘had it’ and a somewhat theoretical, intellectual way of positioning their own experience. I felt their controlled frustration was palpable, and this was channelled constructively by trying to help and support others who they perhaps saw as less fortunate or able than themselves. They were almost playing the hero despite their own clinical journey and navigation of the spaces physically and emotionally.

Table 4.3 Voice-Centred Relational Analysis of Patient 2

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 2 - Interviewed Online on Microsoft Teams “There's no one there to greet you… just take a seat and wait. We sat there by ourselves… and then I was shown into a room. Someone called me.... and it was like going for a panel interview.”	Patient 2 is a female patient who is 70 years old and likes to keep fit and active. She had visited both areas of the setting several times as an outpatient. Feeling secure and supported was important to her and she felt tense when in this setting compared to others she had experienced. Looking for reassurance and a personal touch was crucial for her being able to control her stress. Having her own identity acknowledged was also a significant need for this interviewee.	She speaks with honesty but there is quote a lot of emotion in her poem. She clearly still felt these emotions of fear and found it difficult to feel at ease. To the point of finding it hard to remain in the space, she is anxious, apprehensive and unhappy.	I sat there with my husband I just found that uncomfortable I was extremely tense I have to say I was leaving I didn't like it	This patient was very conscious of her previous experience at a supposedly more caring hospital and was therefore making comparisons and trying to match the care from the previous place where she felt they ‘had their arms wrapped around you’. She did seek this and acknowledged it when she felt cared for. However, I feel she was sensitive and lonely on her cancer journey and her surrounding lifestyle was a huge part of this picture affecting her view on her experience of the space here. Ensuring the space made her feel welcome and effectively hand-held the whole time was so important for her sense of well-being. I feel she wanted to be seen.

Table 4.4 Voice-Centred Relational Analysis of Patient 3

Patient ID	**Patient Background**	**Listening for the Plot**	**I Poem Excerpt**	**Relational Analysis - Contrapuntal Voices**
Patient 3 - Interviewed in Person at the University “They could have asked if I wanted a drink or, yeah, even point out things like toilets over there… this is the water station. Or if you're nervous: here are some magazines or even, like, a game.”	She is a female in her twenties working in marketing and communications. She only visited the setting a couple of times (although had visited the Basingstoke equivalent several times) and this was a referral. Being reassured and knowing where she was in the process (and space) was important to her. Also, small gestures such as hot drinks being available and the space being modern and having ‘distractions’ was of importance to this patient.	She speaks in a confused manner, the stopping and starting conveys just how confused she was at the time and still appears to be in this account. This feels unsure and unclear, as she was likely feeling at the time.	I wouldn't say it was very clear I could really I didn't really know I was going to I think so… I had to be like, pointed I feel like I wasn't looking	I felt this patient was brave considering they were young. She was definitely worried about the specific aspects that might add to her anxiety such as wayfinding. I felt that she is someone who would really benefit from the small additional things such as coffee. She really wanted to be distracted and I could feel she was putting a brave face on things. She made me think that the design should appeal to younger people, perhaps more reflecting their usual life where they might frequent cafes, gyms and shops.

Table 4.5 Voice-Centred Relational Analysis of Patient 4

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 4 - Interviewed in Person in Their Home “I'm nosey. But I also like to have that sense of there's another world out there”	They are a female retired administrator retraining as a florist. As a previous cancer sufferer they had visited the setting (and others) many times as an inpatient and outpatient. Feelings of solidarity and camaraderie were important for her experience – and how the environs enabled this was seen as significant. Having views, distractions and humour were noted as key contributing factors to her sense of dignity.	Here the spoken word is almost one of acceptance and dependence. There is little questioning here, just a hesitant recollection of something being done or a notion of being processed. It almost feels foreboding.	I can't remember whether I asked I eventually I was taken through I think it was a matter of I had to I had to be taken up I was taken I remember just it was it was dark at night I remember being taken	I respected this patient enormously since they had had quite the cancer journey. I admired their pragmatism yet could see a thread of wanting privacy and also to be ‘jolted’ somewhere else in their mind, through perhaps humour or entertainment, would help them massively and I felt the space might really somehow appeal to their need for ‘personality’.

Table 4.6 Voice-Centred Relational Analysis of Patient 5

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 5 - Interviewed in Person at the University "I think if you went in, and you were distracted by something or a magazine that might be in the month you were in and not five years previous, then it might help."	They are a female primary school teacher in their late forties. They had visited both parts of the setting on several occasions by way of a referral. There was a sense of acceptance or low expectation, almost sarcasm, in this interviewee in the way they described the environs. And yet they did see factors such as music and distraction as useful in improving the experience. It seemed that they had detached themselves to some extent from the negative aspects of the environment.	There is an element of frustration and disappointment in her words. Also an acceptance about the way things are, yet a notion of being unwelcome. A level of pessimism is present.	I just think it's making them more… I mean you could go into a university [Hospitals] I think they will have that negative connotation I don't I think it's historically the way hospitals I think especially with older hospitals	This patient seemed quite heightened to particular negative aspects the environment had for them. Although I felt they seemed to somewhat successfully distance this from their own emotional distress, they could be easily pleased through certain small offerings such as coffee or décor. Whilst seeming emotionally and practically self-sufficient when in the setting, it seemed they carried with them deep concerns for family and friends and wanted pleasant distraction. I felt they almost had two layers operating at once, the practical brave layer and the worried underpinning.

Table 4.7 Voice-Centred Relational Analysis of Patient 6

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 6 - Interviewed in Their Own Home in Their Lunch Hour "The waiting room vibe: sort of old smelly books. You know, for you to buy or donate, and I appreciate some people may want to do that".	Patient 6 is an English female in her fifties who works full-time in the publishing industry. She was fairly time-poor due to her commute. She had visited the settings a few times for routine check-ups. This interviewee noted how there was a juxtaposition between the dual purpose of some areas for both maternity and breast screening and how this might be problematic for some. She was quite objective and even critical in her analysis of the scene, possibly due to her experience in being able to articulate different contexts in her day job. Observations on the passing of time tended to dominate her perspective on the space.	There is a real sense of discomfort here. She is clearly upset by what she had heard and feels almost guilty in the way she states she could not look. Her words convey both fear and frustration with things.	I think they probably need to be kept separate and kept moving I was kind of half glancing over I was dreading her coming out I was thinking I can't look at this	I almost felt a cynicism from this patient. Describing the chairs as 'legal' and the 'smelly old books' I could not detect much emotion other than disappointment. However, there were many occasions where she displayed an almost contradictory softness where she wanted to chat or socialise within the same environs.

Table 4.8 Voice-Centred Relational Analysis of Patient 7

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 7 - Interviewed in Person at a Local Café "It's sort of fine if it's your third child and you're in a proper nuclear family where everything's tickety-boo and your mental health is fine, and all your other pregnancies have gone great, and you might be in a position to look at the (pictures of babies) but how many there are in that situation? Probably hardly anyone".	Patient 7 is an English mother of one young child who is in her fifties who works in art therapy with young people and children. As an older mother she articulated her previous concerns over not being typical of the audience in the maternity area of the setting. She is an advocate of natural medicine and also an artist, so her critical eye on such a setting was fairly thorough. For her self-concept she clearly needed to be seen and reassured as an older parent atypical in the setting.	Using the present tense makes this still seem raw for her: 'I'm'. There is clearly fear and apprehension combined with hesitancy when describing how she did not feel she fitted in. There is also vulnerability and feeling exposed within these words.	I've gone in for the scans I was terrified I wouldn't get my child I'm there waiting for that scan I'm feeling like an imposter I'm feeling like I'm not a mum, it might not happen I feel like it's sort of fine if it's your third child	This patient was quick to identify aspects of the space that could be visually or aesthetically improved. I noted she was energised to see improvements and full of ideas. Yet alongside this I felt a sense of insecurity from her about not finding her fit within a system for which, on several levels, she felt, wasn't shaped around her. I found this somewhat ironic since it could be argued she is typical of local residents; in that she is white and middle-class. I was left with a sense that spaces should try harder to be explicitly inclusive and to almost celebrate this diversity of audience without showing tokenism somehow.

Table 4.9 Voice-Centred Relational Analysis of Patient 8

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 8 - Interviewed in Their Own Home in Their Lunchbreak "I'd been told what was happening there, but it was a very sort of quick… and you're feeling anxious; worried about the treatment and everything else… you feel a bit exposed and a bit like you haven't got a safe space, yeah…to go to".	She is an English civil servant and single parent in her mid-fifties who is fairly time poor, hence participating during her lunch hour. She had visited the breast-screening unit as an outpatient for a routine check-up. For this patient, reducing anxiety and staying calm were key themes for her wellbeing throughout her account of her experience.	There is an undercurrent of anxiety in these words. Whilst she says what she would like, it is clearly coming from a place of needing to be distracted and taken away from what is immediately in front of her. She arguably did not notice the elements in the room because she was in a heightened state, as the last line shows. She did not say what she was concentrating on.	I prefer to always have some sort of noise I prefer to I'd like the radio on or anything I find that even sitting in this room without any noise, it's upsetting me I mean, there was probably some tables around I didn't notice it being untidy I didn't notice it being unclean I think I was probably just concentrating	The overriding sense I got from her was indifference. She had some trouble recalling particular aspects of the space. Whilst I felt this was ok, I also thought that spaces should not leave you feeling indifferent. I felt they have a stronger role to play somehow, and her apathy agitated me in thinking they must do better.

Table 4.10 Voice-Centred Relational Analysis of Patient 9

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 9 - Interviewed in Their Own Home “If anyone comes out with bad news, they have to face everyone looking at them, which I think is awful. As a woman in my 30s when I first had breast cancer, I found it really difficult - I would sit in the waiting room and there used to be a TV in the corner of the room showing women breastfeeding…it's really insensitive.”	Patient 9 is a female in their late forties working full-time in place management. They have had multiple health issues and have therefore attended the setting many times over the years as an outpatient and inpatient. For them the subtleties of signs and symbols within their environs had great impact on their sense of privacy and levels of stress.	She is determined in these words to carve her space. There is an element of trying to convey and justify how important privacy is to her. She hints twice that this was challenged, and she feels exposed, again using the present tense so it still feels very real for her. She alludes to the seating as a key challenge, a form of contested space.	I could probably have got this wrong I've got this thing in my head that […] just all very little seats I can't remember other than… exposed I am quite a private person I am a very private person I just, you know, I keep myself to myself I'm not like that. I can, I'm very open but… I tend to, you know I wouldn't be a sharer I've gotta get through this	I could really feel the multiple clinical journeys this patient had been on. If it wasn’t for her experience in place management I felt she night have been a lot angrier about her critique of the setting. She clearly was grateful for the staff but was in parallel strongly, yet seemingly objectively, critical of the physical aspects. Keen to suggest ideas, I felt she was grateful for this opportunity to have her say.

Table 4.11 Voice-Centred Relational Analysis of Patient 10

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 10 - Interviewed Online via Microsoft Teams "There were leaflets around… I actually went to pick one up to mainly to take my mind off. Although that's ridiculous because what I picked up was obviously keeping my mind on it. As a neurodivergent person, what I find most distressing about these scenarios is not knowing the process upfront."	She is an English neuro-diverse woman who works in Higher Education in her early fifties. In this account it was important to have this divergence recognised and clarity of information and expectation seemed critical to their sense of wellbeing and 'connection with place'.	There is an element of confusion – almost dizziness here. There is hope that the leaflet may bring some clarity or distraction, but she is honest that it actually caused anxiety instead.	I still felt like the area was I thought, oh, I don't have to... I actually went to pick one up to mainly to take my mind off [what] I picked up was obviously keeping my mind on it	This was interesting because she clearly viewed her whole experience through her ADHD lens – and this manifested as a heightened sense of things and agitation. However, there was also an additional strand of dialogue due to her creative background where she possessed quite clear opinions about how things should be. I could relate to this since we share a similar background, so I was wary of not pushing the conversation towards solutions.

Table 4.12 Voice-Centred Relational Analysis of Patient 11

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 11 - Interviewed Online via Microsoft Teams "You then do have that walk… and you go down the corridor. It's kind of that's it's quite long. And it was the first time I did it. I was really walking in that corridor. I was really nervous. And you're on your own. I think if somebody walked you down saying so, this is what's going to happen, it would be more reassuring."	She is an English property developer in her mid-forties. She has visited the setting several times both as an outpatient and inpatient for various clinical reasons. For this patient, privacy and respect were key areas of concern, where she felt both personally exposed whilst being concerned for others.	There is an element of confusion – almost dizziness here. There is hope that the leaflet may bring some clarity or distraction, but she is honest that it actually caused anxiety instead.	I still felt like the area was I thought, oh, I don't have to... I actually went to pick one up to mainly to take my mind off [what] I picked up was obviously keeping my mind on it	This was interesting because she clearly viewed her whole experience through her ADHD lens – and this manifested as a heightened sense of things and agitation. However, there was also an additional strand of dialogue due to her creative background where she possessed quite clear opinions about how things should be. I could relate to this since we share a similar background, so I was wary of not pushing the conversation towards solutions.

Table 4.13 Voice-Centred Relational Analysis of Patient 12

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 12 - Interviewed Online via Microsoft Teams "When you go you are not looking forward to it… then it's empty, soulless and bland… if it's not a good experience you're more likely to miss the next one."	She is an English educator in her early sixties who has visited the setting several times for routine check-ups. Seemingly due to her design and agricultural background, this patient primarily relayed stories and critical concerns about the physical aspects of the environment and how these contributed to a negative experience for her. This was less about her own identity and more about observation and critique of the various symbolic elements that contributed to the experience.	In three short blunt lines she is clearly expressing her disappointment and disdain for the sterile atmosphere. She almost seems angry. The last line shows an element of cynicism or acceptance that she has a low expectation of the waiting room.	I, it felt clinical I cannot bare UV lights I expect it	This was an interesting dialogue, with the patient only wanting to deliver their critique of their experience in short, concise statements. I felt that there were two levels of confidence operating simultaneously here: an outer concise critique and wish list of better spatial elements, combined with a pragmatic but perhaps avoidant view of their own experience clinically, emotionally and practically.

Table 4.14 Voice-Centred Relational Analysis of Patient 13

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 13 - Interviewed Online via Microsoft Teams "Sometimes the people are lovely, and then you just go and sit down, and you're just left there not knowing where you're going... and you can look around the room waiting, everybody does that - just sit there, they took lots of the leaflets and things away and spaced the chairs out since covid. You're just sitting there doing not very much. Really not knowing what's going on."	She is an English woman in her mid-sixties working as a part-time celebrant who, having had a serious health issue, has visited the setting many times over the past ten years. For her, the environs clearly had a responsibility towards allaying fears and putting patients at ease.	There is polite criticism here. There is an appeal to a more human approach. In her words she is quietly hopeful and inclusive. There is warmth to her words.	I should say [bland] I don't I don't think it does need to be clinical I have to have intuitions I don't wish to have it I'd rather see something… I think it should be mixed because people are so so so different	I had great compassion for this lady given her health journey. She showed a great deal of consideration, almost putting others before herself; there was a wisdom about her. I felt she was very sincere and in touch with her sensitivities with the space and her emotions. She seemed like a trusted source without embellishing her stories for dramatic effect. Yet her story was peppered with direct accounts of where things confused, made her apprehensive or vulnerable, which were her main emotions.

Table 4.15 Voice-Centred Relational Analysis of Patient 14

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 14 - Interviewed Online via Microsoft Teams "And I remember thinking, I would only be here if they really thought I had cancer, because there, everything around me was talking about cancer. I think it's scary, actually, that we accept it's the way it is".	Patient 14 is a female English professional in her mid-fifties. She visited the setting several times for follow-up referrals as well as other hospital locations in Hampshire, UK. She communicated that she had had several fairly traumatic experiences with hospitals previously which shaped her perception. This seemed to help her focus on what was important to her in clinical environs, and, whilst not bitter, she seemed continuously disappointed in what she saw.	She is genuinely baffled here, as to why you would sit in such an area. There is an element of gentle anger or frustration in her words. The corridor is emotive for many.	I think it's quite a…it's an unpleasant experience [in a corridor] I don't know why they do that I don't know why you can't be in a comfortable, pleasant place	She gave a colourful and rich account of her story, brining into play her previous hospital experiences, which resulted in what seemed like a balanced view of Winchester. I felt she was wishing for more and seemed to know what would work for her. I also most felt a sadness or disappointment that things could not be designed with the care that is typical of children's wards. I felt I wanted to reassure her the world could be better.

Table 4.16 Voice-Centred Relational Analysis of Patient 15

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 15 - Interviewed in Person "It's the end of a corridor. It's like the end of something rather than the journey. Do you know what, there are waiting areas at the end of a corridor. So you feel like you're sitting in a corridor. You're sitting in a corridor. Yeah, there is no privacy in that bit."	Patient 15 was the only patient in this study who had previously had a clinical role. She is 55 year old woman who had been a patient at the setting on more than three occasions. She had quite a broad view of what worked and what did not but, possibly due to her clinical background, and her views were often balanced between practical needs and what makes for a calming space.	She is pensive here but recalls the feeling of being uncomfortable with overhearing others or with general disturbing sounds. She feels exposed and almost doesn't know how to articulate this.	I think having, yeah… I feel very vulnerable when you can hear voices I can hear what they're saying I noticed I sat there, doors banging	I liked her pragmatism and the fact she seemed able to wear multiple hats. She judged the spaces quite objectively, highlighting various disturbing or disappointing features, yet at times was wishful for a better world. I felt she was not over-emotional but wanted change.

Table 4.17 Voice-Centred Relational Analysis of Patient 16

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 16 - Interviewed Online via Microsoft Teams "It's just a bit soul destroying… mum went through the whole cancer treatment and everything many years ago and my dad, he was so done with seeing all these sorts of medical posters with advice. I think you can so easily make a waiting more room more into a sort of living room space where it's actually a pleasant space to be."	She is a 47 year old event artist who was visiting the setting during the period of these interviews and knew it fairly well. With an arts background she had an observant eye and sensitivity to visual elements. In this case the conversation tended towards imagining better things such as visions for plants and fabrics over and above the realities of what was.	Here she seems pensive and baffled as to whether more could be done. It seems a mixture of frustration with moments of hope, reflecting on whether more could be done with the space to help people navigate.	I still I still think generally I suppose they have so many signs and so many departments I do wonder sometimes I do wonder sometimes […] could they?	I felt a seriousness from this patient, probably brought out by the clinical experiences of her and her immediate family. There was a calm frustration here about various ways the space had been designed and I think this patient found it hard to disconnect these from immediately looking for solutions. I felt she wanted to fix things because she felt she could see what the problems and opportunities were.

Table 4.18 Voice-Centred Relational Analysis of Patient 17

Patient ID	Patient Background	Listening for the Plot	I Poem Excerpt	Relational Analysis - Contrapuntal Voices
Patient 17 - Interviewed in Person at the University “In that [area] space that I ended up when I was lost, yes, I felt like I'm infringing on somebody else's privacy because the consultation room was so close.”	Patient Seventeen is in her thirties and is a science professional and had visited the settings a few times. Some of her opinions were typically less emotive than other participants – taking a more balanced view to seeing the pros and cons of situations. Key elements for her appeared to be challenges with wayfinding, finding distractions whilst waiting and not infringing on others.	In this somewhat lengthy stanza, she portrays the to-ing and fro-ing of trying to find her way very clearly. There is confusion mixed with apprehension here since she is worried about missing her slot. She is effectively on the back foot before she has arrived, and her words convey this.	I did get lost then I ended up in two different places I actually found the place I saw the sign I thought I was supposed to go straight I was supposed to go up I went to the receptionist I definitely felt rushed I was lost, late I was lost	My feeling was that on one level she was frustrated with everything, the lack of certain facilities or the way things were in the spaces, and yet was happy to suggest small innovations, seemingly balancing her scientific and creative sides.

4.3.3 Voice-Centred Relational Analysis – Stage 4: Composing an Analysis (Gilligan, 2003)

The purpose of this final stage is to bring together these various readings and interpretations of the Voice-Centred Analysis approach to look for synergies between the texts and to relate these to the research questions and conceptual framework. To this end, the discussion on the meanings of these findings will be presented in Chapter Five.

4.3.4 Section Summary

This section has presented the data from the 17 interviews when analysed through a Voice-Centred Relational Analysis approach. Following multiple reviews of the transcripts, plots, I Poems and contrapuntal voices were identified and presented. This provided a different viewpoint of the meanings of the patient narratives and different insights into their feelings and emotions at their time of visiting.

4.4 Interviews: Emotion Coding Analysis Findings

Since this was an interpretive study where an open approach to the data was taken (Blumer, 1970), a second approach to interpreting these data was applied. Codes resulting from the ethnographic stage were not, however forced upon the later interview data; rather, new codes were identified based on what the narratives conveyed for the researcher; although many themes were similar to the ethnographic findings, the pilot study and also aspects of the literature.

Following multiple readings of the transcripts, and where needed, checking the videos/audio recordings for expression, the following codes were assigned based on the participants' narratives. These were based on their apparent feelings, at the careful consideration of the researcher:

1. Vulnerable/exposed
2. Confused
3. Anxious
4. Apprehensive
5. Uninspired
6. Processed
7. Disappointed
8. Unhappy/upset
9. Frustrated
10. Empathetic
11. Indifferent
12. Uncomfortable
13. Grateful
14. Unwelcomed
15. Overwhelmed
16. Pessimistic
17. Avoidance
18. Dependent
19. Satisfied
20. Bored
21. Reassured
22. Unseen
23. Wishful
24. Entertained

The word cloud in Figure 4.20 shows the relative frequency of application of these codes to the patient's narratives. Of the 24 codes emerging from the 17 interviews, the most common feeling was that of seeming 'vulnerable/exposed' with 59 cases. This was closely followed by the notion of seeming 'confused' with 56 cases, and 'anxious/stressed' with 46 cases and 'apprehensive' with 45 (see Appendix 17 for a full table of codes and frequency).

Figure 4.20 Word Cloud Showing Relative Frequency of Codes Emerging from Interview Data (Author's Own)

Following this initial coding stage, the codes were then placed within broader categories considering the conceptual framework and themes from the ethnographic stage. These categories are:

1. Feeling Grateful
2. Feeling vulnerable/exposed
3. Symbolic meanings, communication & trust
4. Patient empowerment, cultural competence & agency
5. Depressing factors
6. Commodification of health, patient autonomy
7. Apathy

The section that follows provides significant detail as to the participants' perspectives resulting from the data within these categories numbered above. Many In Vivo quotes (Saldaña, 2016) have purposefully been selected from the transcripts, to convey both the scale and range of emotions experienced and the depth of some of the feelings which can be more fully understood in this direct way. Individual patient code numbers are not shown here, since the aim was to group types of feeling together to build a composite picture per emotion.

4.4.1 Feeling Grateful

Within the interviews, there were times when participants acknowledged some of the positive enablers of their experience, including where they showed empathy for others, were grateful for certain things, or were occasionally, if somewhat rarely, satisfied, reassured or entertained.

Emotions of empathy frequently related to not knowing what other patients were experiencing and being sensitive to those feelings despite their own apprehension:

> “You don't wanna necessarily worry somebody else cause you don't know what they're in there for.” (Patient 3)

> “The radio - it didn't matter what was on it, no, you weren't even really listening to the music - it wouldn't matter. It was just something. So you felt like you could talk without disturbing somebody else. You don't know what they're going through.” (Patient 3)

> “There was a woman in there who was sobbing, very quietly with her partner. And I felt or, you know, yeah, it's so hard. But I felt that [I was far that], I would say that she obviously had had some, you know, really bad news.” (Patient 10)

At times these feelings were caused by the physical space:

> “There weren't even enough seats for everyone, so ,I, I remember giving up my chair for an elderly person and, yeah, I know.” (Patient 16)

At other times, empathy was felt for staff who were seen to be doing their best with what they had, or where patients did not want to be any trouble or bother staff by being a distraction:

> “…bless them like they've always had to [to] create little spaces for people to wait, and it's tiny and there's no space and you can just feel like they're constantly improvising to squeeze things into corners.” (Patient 16)

> “…they have to process a lot of people and you, don't want to be taking up too much of their time as well.” (Patient 8)

Other aspects of patients conveying moments of hope were when they seemed grateful. This often felt like they were grateful *despite* everything and only occasionally meant being grateful for things that were features of the spaces:

> "I thought it was quite good in the fact that they did have some second-hand books." (Patient 1)

> "I always remember, like, the radio being on in the corner which I thought was quite good cause it's kind of like a distracting sort of…" (Patient 3)

> "So actually, even though it's a bit of a crappy waiting room downstairs, I do feel safe when I'm there" (Patient 9)

Perhaps more significantly, patients were almost overwhelmingly positive and grateful for the attitudes and behaviours of nursing staff:

> "You've got to work with what you've got, and I think my experience, … I just wanna say anyway, how unbelievably caring [they are]." (Patient 16)

> "They're warm, they're really warm people. And so I do think they try and make it personal for you." (Patient 11)

The only other positive moments of feeling grateful concerned being satisfied or entertained, but such emotions seemed very scarce:

> "The chatter of the staff, but that's the bit I like. I like listening to people's lives or just yeah…" (Patient 5)

> "So I'm looking at the main corridor and I can see the reception area and see people coming and going. I'm partly nosy, so quite like to see the activity that's going on all here, even just the receptionist having just their informal chat. But at least it's like the day-to-day life." (Patient 6)

4.4.2 Feeling Vulnerable/Exposed

This category refers to patients feeling sensitive, vulnerable or exposed within the waiting room, particularly in relation to notions of privacy or boundaries, and was one of the key apparent barriers dominating the patients' accounts of their experiences. It also reflects where patients were made to feel uncomfortable in some way, either physically, personally or socially. Privacy; both feeling invaded, or conscious of infringing on others, was the concept most alluded to throughout the interviews and affected everyone interviewed.

A frequent emotion that was revealed was discomfort or distress caused by hearing private conversations between clinical staff and patients:

> "… I sat there I was overhearing all sorts; you can hear everything they're saying." (Patient 1)

> "Ah, so, and so you're hearing people in those rooms. Horrible. Yeah, I feel very vulnerable when you can hear voices. Oh, because if I can hear what they're saying, then they can hear what's going to be said to me. So it's about privacy, you know… Yes privacy." (Patient 15)

> "Once you go down, you walk through the corridors and you're sitting on little chairs outside doors, and you can hear people talking. That's what I found really really disconcerting. I could hear medical conversations about people." (Patient 11)

As well as overhearing difficult conversations, feeling challenged by physical proximity (or even personal perceptions of proximity) to others was something the patients experienced. At times this involved averting gazes or feeling watched as Patient 3 articulated:

> "…because it's where the chairs are in a room sticking together. It's really intimidating to look at somebody else who's probably going through quite a lot themselves. Like you're nervous. You don't wanna make eye contact and you don't know where to look sometimes because you don't feel like you're looking at them." (Patient 3)

She was also a little self-conscious, possibly as she was younger than most in this clinic, and felt exposed when standing up in the space:

> “Sometimes it's not nice when they come into the room and they kind of call your name out and then you kind of have to stand up in front of everyone. Like, ‘it's me now’ sort of thing. It's, yeah, like everyone's looking and watching you.” (Patient 3)

Proximity to the treatment rooms also caused concern to many patients whilst waiting; they seemed to feel more frightened by being able to see or hear the space they might next enter:

> “When I got lost, I ended up in a different waiting room which was very, very cramped and right next to the consultation room. Yeah, that felt uncomfortable because somebody was in there… I felt like I'm infringing on somebody else's privacy because the consultation room was so close.” (Patient 17)

> “And the seating area, you're quite close proximity to people because they've done it in a U-shape… And the [treatment] rooms are very close to the seating area. There's no space.” (Patient 15)

General feelings of claustrophobia were also articulated by Patient 11, in part due to the size of the space but also due to the configuration:

> “It's a lot of…It feels like it's lots of long narrow, because of the shape of the building. It feels like, long. You're going down a little corridor. You're waiting in like, little pens… I just remember thinking, I'm sitting here in a tiny little space with loads of other people, someone with their pram, somebody. And it all feels a bit cramped…and, I wouldn't say claustrophobic because that's a bit over the top, but it just feels…” (Patient 11)

4.4.3 Symbolic Meanings, Communication & Trust

This category primarily concerns patients feeling confused or lost, in part due to the role of symbolic aspects of the space, which was the second highest occurring code within the analysis. Patients were confused in terms of finding their way (with 15 patients (88%), mentioning this specifically), or in terms of generally knowing what was happening. Often this related to trying to interpret the various signs on the site, almost from the moment of arrival which added to patients' anxieties and can be seen in the many cases below:

> "So from arrival, I found it quite difficult to find initially, 'cause I don't know if, like many hospitals are like this…Luckily, there was someone or a nurse walking past, and she said that you needed to go upstairs sort of thing. But it wasn't very well signposted. I don't know if I wouldn't necessarily found it without the assistance." (Patient 3)

> "When you arrive at the building itself first it's like ohh wait, where do I go?" (Patient 16)

The lack of human greeting or some kind of reception was also noted by several patients:

> "You go in the door and you're on your own, because there's no meet or greet or reception or anybody in sight – so you walk in the door and then I was thinking , trying to look for signs, it's difficult to locate which sign you need to be looking at, they seem to just be placed randomly around the walls, there just seems to be no thought about how you might feel when you walk in the door." (Patient 7)

> "There is no, there wasn't any reception, and everything was all about…where am I going? What am I doing?" (Patient 2)

> "…when you come in the front, there's nobody there to greet you. Which I think is really quite significant, and although there are signposts everywhere, there are too many of them." (Patient 15)

The actual signs themselves, whilst present, also caused confusion:

> "Um, I can't remember what it says on there, but I actually don't know what it means – what the words mean – yes – even now I don't know!" (Patient 7)

> "What people think they've written on signposts, it's people who are working in the system that know what those signposts mean.. Yeah, but as a patient, they don't know what DAU stands for." (Patient 15)

> "I had no idea where I'm going. So when you walk in the entrance there was the signage right in front and but there's a lot of text and a lot of different clinics, and it's not necessarily clear on which level or which ones and what about the wording of those signs." (Patient 17)

Some patients commented that there were too many signs, which aligns with the observations made in the field by the researcher:

> "…the signage itself, there's a lot of it and it's not specific enough where particularly the beginning." (Patient 13)

> "I thought it would be the next door, but it was the previous door. Too much signage. Yes. Yeah, it is confusing." (Patient 17)

Generally speaking, patients seemed disorientated which added to their senses of anxiety and apprehension whilst waiting:

> "I can never understand, despite the many appointments and I went there a lot, all those times I went in there I never understood where I was supposed to be, at what time, or which waiting area." (Patient 7)

> "I didn't know, I was a bit disorientated. I've never been to the hospital before, and I met the consultant on the stairs." (Patient 9)

> "You're very lost and you don't know, you know which department you're going to." (Patient 13)

Aside from being lost, confusion also arose from feeling unclear or somewhat phased about how things worked or what was supposed to happen. Patients discussed how if there was a process or plan of what typically happens when at an appointment, it was not made clear to them, and as a result they felt completely baffled at times:

> "…so you've got multiple situations where, and I've felt, you know, if you're nervous, it's not going in, it's not going in and that's when you're like what did they say? you completely feel lost." (Patient 15)
>
> "My recollection of the whole experience is you sit on very soulless blue chairs outside various rooms, wondering what the hell is going on." (Patient 13)
>
> "I wasn't sure why I'm waiting here" (Patient 3)

4.4.4 Patient Empowerment, Cultural Competence & Agency

Many of the feelings in this category concerned feeling anxious in the setting. This was in part related to arriving with preconceptions, worrying about the order of things, or what was about to happen to them, or seeing off-putting information resulting in lacking a sense of power or agency. This manifested in terms of feeling apprehensive, which every interviewee alluded to. This also related to feeling unwelcome or overwhelmed by the environment as well as feeling dependent or unseen whilst waiting.

88% of patients experienced feelings of feeing generally anxious about hospitals, arrival or the overall idea of things:

> "I don't wanna be a patient. Nobody wants to be patient." (Patient 16)
>
> "I just found that uncomfortable, I was extremely tense. I have to say." (Patient 2)
>
> "…it's very sterile and very intimidating actually. And I think if you're anxious about anything…" (Patient 6)
>
> "…even when you've been going for, you know, quite a long time… every time you go, you're quite nervous." (Patient 13)

Patients also mentioned how they were worried more broadly about many other things including the potential outcome of any tests; in essence they were arriving with many worries on their minds:

> “When you're arriving you're not taking it in, … no because you're so preoccupied you've got all the other things you're worried about.” (Patient 13)

> “I mean, hospitals are horrible, you know. I don't enjoy going into hospital because it will trigger emotions. And if you're going for a test, you know that the result of that test could change your life.” (Patient 14)

> “It's not just cancer. It's, you know, there are other things going on in people's lives and you know, you're stressed about a number of issues, and you know, obviously you're worried about your house and the future, and that's all playing on your mind. So you are tense.” (Patient 2)

The quiet atmosphere in the waiting room also contributed to senses of anxiety and general nervous mood:

> “Yeah I remember it being very light and very calm and quiet there weren’t very many people around, in fact sometimes slightly eerie..you can’t see anybody..” (Patient 7)

> “But you know, when it's so quiet and nobody's talking, you walk into a room and you're clearly… most people are tense going there.” (Patient 16)

Other patients understandably had very intense concerns about a potential diagnosis and felt distress from the surrounding clinical posters/leaflets:

> “ I also always remember all the leaflets on the walls which I found kind of quite overwhelming because it was all like scary signs of different symptoms and illnesses and cancers, and when you're in that point of time where you're getting something checked, you don't necessarily want to be reminded of it.” (Patient 3)

> “It needs colour, and say, less brochures and information staring at you ‘cause it only makes you panic. Exactly. Actually, I think it only makes you think. Ohh, that's me. Don't know. That's me. And it might not be you exactly. They should give out the information when it's relevant, if it's relevant to you or when it's relevant to you and be scared to be discussed an individual basis.” (Patient 4)

> “Put it this way, I looked at it and thought….I couldn't think of anything I didn't want to read any of that, and I had my book and so I knew second time round to take something like that. No, I didn't want any of that at all. No!” (Patient 11)

General heightened emotions around waiting and worrying about being in the right location to be seen, or correct stage within the process were common:

> “You need the process, and you need to know am I in the right place? Have they forgotten me? You know is, is this, is this right? Should I? Because me. I'm. I'm in my panic thinking I've got it wrong.” (Patient 10)

> “And so I suppose when you see that ohh….they came after me. I mean, it's probably just because they're seeing different doctors or nurses or whatever, but it you still come to your own conclusions, don't you?” (Patient 6)

> “It’s like that thing of moving down the line to the end thing that you’re nervous about, so when you’re in the main ‘pen’ and it’s alright and we’re all ok together, then they single out – ‘it’s you’” (Patient 7)

Time pressures and not being late was a concern for many participants, especially knowing if they had or had not missed their appointment:

> “And I think that can kind of adds to stress. Yeah, the emotion. You don't wanna be late. You gonna miss your appointment. You know, they're under pressure as well sort of thing.” (Patient3)

> “But it was a very sort of quick, quick, like, just gonna sit here and sister or so and so will come and see you next. And you're feeling anxious.” (Patient 8)

> “I definitely felt rushed because I was by that time I was lost, late and because I was lost. . I didn't want to be too late so that I didn’t miss my slot and I'm not actually seen.” (Patient 17)

Another very closely linked concept to patients feeling generally anxious, was the notion of feeling apprehensive about what was to come. Initially this seemed to relate to general apprehensions of what was about to happen, or not knowing how things worked within the setting:

> “What I find most distressing about these scenarios is not knowing the process upfront.” (Patient 10)

> “Your mind is flitting between what's gonna happen. What's gonna happen to me and you’re alert. Ohh. Well, look at that article. Ohh. No, I'm still anxious. I still anxious. Don't know what's happening on my way to going…. When am I going to be seen? who's gonna say so?” (Patient 4)

> “And I suppose it's just the unknown. You don't know what's coming. You're going into an area and language, probably, that's not every day.” (Patient 6)

In some cases anxiety related directly to worrying about the outcome of test results:

> “It's a survival thing as well… you just go into that thing of right.. I've gotta get through this. And this is not a nice thing to have to wait for. Bad news, good news. Whatever. You’re just waiting.” (Patient 9)

> “Distressing, you know, because you're. Yeah. You're about to find out if you've got cancer.” (Patient 14)

> “It's nerve wracking, 'cause you're waiting for somebody to say it's OK.” (Patient 11)

At other times, patients were specifically feeling apprehensive about not being missed out:

> “You almost panicked when someone leaves because you feel like you're gonna lose your spot or you're gonna get called and missed. So I almost felt like I had to stay there because they're obviously, they're under pressure.” (Patient 3)

> “I think there's just people coming and going and you're waiting. You're sort of constantly not sure if it's you. Yeah. You're waiting to see if there's somebody, they're waiting for you and people say hello to you.” (Patient 8)

Feeling anxious or self-conscious in the space and trying to work out how or where to sit/walk/stand became an issue for some patients:

> “You're alert because you're kind of quite heightened… and can you sit here? And then you're like, oh, should I be sitting here?” (Patient 11)

> “It's just, you know, chairs - going take one and what is quite difficult I think is on sort of an emotional level as well. Then you're going to take a seat.
> Do you sit next to someone? Do you sit away from them and then people come in for different things and you wonder where they are in their journey?” (Patient 13)

> “You then do have that walk. You know the walk from there and you go down the corridor. It's kind of that's it's quite long. And I was the first time I did it. I was really walking on that corridor. I was really nervous.” (patient 11)

Feeling unwelcomed by the space also came across from some interviewees where they were hoping for some kind of personal greeting:

> “I remember the reception, which is all behind glass, isn't it? And I find that a little bit austere, but obviously I appreciate why.” (Patient 8)

> "When you come in the front, there's nobody there to greet you. Which I think is really quite significant and although there are signposts everywhere, there are too many of them." (Patient 15)

This notion of feeling unwelcome appeared to have been exacerbated by the décor:

> "Not welcoming, I think it's quite cold. I literally I think it's all like, it's, it's either like blues or whites or it's cold. It doesn't feel warm." (Patient 11)

> "The whole, the whole thing, it either feels very barren and sanitary or it feels quite depressing. Soulless." (Patient 14)

A smaller number of patients mentioned examples of feeling dependent or unseen in the spaces as summarised clearly by Patient 7:

> "It's like this lottery – you walk in, and you hope you're gonna get someone who's on it. You need to be 'seen' you need to feel seen… and you need to be seen by someone who knows how to help you and what to do… you feel like the system there is not working and so, the 'end user interface' is impossible for them to achieve." (Patient 7)

Another aspect of patient empowerment related to the apparent perceived lack of individual power or autonomy, a sense of feeling dependent or inferior:

> "And then I was shown into a room. Someone called me, shown into a room. And it was like going for a panel interview." (patient 2)
>
> "It's almost like a power thing. They have the central station, you know." (Patient 3)
>
> "...and just, my head down waiting for a lady to come and take me away." (Patient 14)

4.4.5 Depressing Factors

Whilst a generic term – this category reflects a general notion of doom and gloom conveyed by elements within the spaces including factors such as furnishings or lighting or wear and tear. It reflected patients' disappointment, lack of inspiration and at times, upset or frustration with things. A general pessimism and acceptance that nothing might change also seemed present. Whilst not necessarily having high expectations, 76% of patients seemed somewhat resigned and disappointed in things, initially with the seeming lack of care towards planning the space:

> “It almost looked like it was like a pop-up unit if that makes sense? Like, it was just thrown together and that this was the space they were using. And that was the sort of thing. They'd thrown chairs into this waiting space and that was kind of how they were operating.” (Patient 3)

> “Yeah, there was a lack of design. So how do you say just one word? Lack of design? So yeah, a lack of a lack of interest really. Because of course the I get the whole patient care is the patient care. So how would anybody have enough time to do any of the extra stuff that's seen as just superfluous and peripheral?” (Patient 10)

> “We'll just hang a generic flower picture, but it's, it's so generic and not actually, you know, ‘we're not gonna rock the boat’ and they keep it so, so mundane. And so again, there's no real thought has gone into it. It's like, oh, here's a picture. Hang it up.” (Patient 16)

The lack of extra small touches (in part a legacy of Covid-19 changes) was noted by some patients as significant:

> “I noticed even when I went even with Covid done, that they've moved away the actual extras…. yeah, all the extras. What a shame it... it is a shame because it reminds you you're in a hospital. Reminds you of the stark environment that you're in, your illness, stark - the whole thing.” (Patient 4)

A general low and negative feeling about the spaces was also articulated by several patients, this clearly had an impact on their mood:

> “But it's, it's just, so it is a bit soul destroying.” (patient 16)
>
> “I do think it's a quite, you know, because I've been in there a lot. But you know more than other people, I do think it's quite depressing... It's a very depressing kind of area.” (Patient 11)

Some patients almost turned to cynicism in their observations:

> "It's mad, isn't it when you actually think about it, why are these hospitals so horrendous? I bet you men design them, that's why." (Patient 14)

> "And yeah, I think we just need to be a little bit braver, you know, with our spaces and [and] this whole idea of not wanting to offend people, it's like, well, you're actually offending people all the time, yeah.." (Patient 16)

At times patients seemed actually unhappy or upset by circumstances in the spaces. The causes were largely similar to those causing frustration, so these emotions have been grouped. At other times they just conveyed a sense of being generally uninspired. Some patients commented with frustration on the inappropriateness of the décor to their clinical circumstances:

> "There are three waiting areas, and there's one that's very...blues it's all painted blue. Lots of pictures of newborn babies on the wall and people are going in with problems. Yeah, they're all. They're being completely fake. And it's blue – a rubbish colour, negative, cold on welcoming…" (Patient 4)

> "It is inappropriate to have pictures of babies – it should be muted – not in-your-face stuff… and definitely not anything representational." (Patient 7)

> "You've got a window and it's got those horrible blinds. Yeah, vertical Venetians. There's a tiny little window, so there's hardly any air in there. There's no view." (Patient 9)

Others were generally agitated by the spaces, facilities or activities within:

> "I wouldn't even call it a waiting area. Actually I've been. I've waited in the corridor. I mean it's, I mean, it's a bit shit, really, you know… sorry." (Patient 9)

> "I don't want to see that! – medical info!" (Patient 12)

At times the patients became quite passionate about their feelings and frustration could be felt:

> “It's hard to know where the waiting area stops and starts because it's like plopped in the middle of all the doors. The doors slamming.” (Patient 11)
>
> “It's not rocket science to make improvements. It doesn't have to be so clinical. There's really no reason.” (Patient 16)

Noise and light were also causes of annoyance and anxiety for many:

> “In terms of volume I'm thinking [of the] that silence that is almost deafening!” (Patient 5)

> “I cannot bare UV lights, I’m sensitive to light - but I expect it.” (Patient 12)

> “People washing their hands, you can hear bins closing because of Clinical waste. It goes in bins and stuff like that, and they're not all soft closing, so they bash down.” (Patient 15)

The seating layouts and availability caused particular upset for some participants:

> “I'm not going to say nice things about that... the chair arrangements are always in couples, and someone would put their bag on, you know, and they spread themselves out, don't they?” (Patient 9)

> “And then there weren't even enough seats. And there's just… this doesn't have to be that way!” (Patient 16)

> “Because even that it's like, why? So the seats are all the way around the room, so it's quite a big space. Why in a circular…? It feels less hospital, [and then if it] why all that space and then you're just sort of staring at each other as well because you're sitting in a circle and because they keep spaces between the seats?” (Patient 15)

The final emotion within the ‘depressing factors’ category concerned patients seeming uninspired by what they saw or experienced, these quotes were coded specifically when patients showed this emotion of feeling uninspired or flat, and this was surprisingly common:

> “…. it's dark. It's on the ground floor and it's rather boring areas.” (Patient 1)

> “It, it was quite bland. Um, if I remember. OK, nothing particularly stood out. I don't think they had a television. I'm not sure if they did. I'm not sure.” (Patient 2)

Small touches were seen as potential solutions to this feeling uninspired or flat:

> “If you went in and you were distracted by something or a magazine that might be in the month you were in and not five years previous, then it might help, but I think the sort of pictures that are framed, they're all very dated and muted. They're not vibrant colours….” (Patient 4)

> “And even if there was just a coffee machine and you, you know, or a filter coffee or something that you could…just something. But I think the whole colour and environment just makes you think you are waiting in those sorts of horrible plastic chairs.” (Patient 5)

The condition of features or out-dated aspects disturbed some patients and they found this off-putting or uninspiring:

> “The chairs were a bit tatty. Almost. Yeah, like the environment. It looked very well worn.” (Patient 3)

> “It just it gives me kind of waiting room vibes - sort of old smelly books.” (Patient 6)

> “It looks/ feels very 1980s, you know that, you know that kind… the patterns of that pine and those colours, yeah, just it feels very.. I think they're bright blue those chairs.” (Patient 9)

> “Maybe a bit more modern? You know, they're all so 1970s, aren't they 80s? Yeah.” (Patient 14)

Blandness – particularly in relation to palettes, was mentioned often:

> “And so, yeah, and the room, everything there’s beige and uninviting.” (Patient 15)
>
> “It’s empty, soulless, bland, all pastels.” (Patient 12)
>
> “ I thought that you go upstairs and it’s that awful pinky laminate, pine stuff” (Patient 11)

Homeliness was seen both positively and negatively within the narratives:

> “It's just a bit soul destroying… mum went through the whole cancer treatment and everything many years ago and my dad, he was so done with seeing all these sorts of medical posters with advice. I think you can so easily make a waiting more room more into a sort of living room space where it's actually a pleasant space to be.” (Patient 16)

> “I mean, it does feel thinking about it a little bit like an old people's home, you know, like you’re old people are like sitting around.” (Patient 10)

4.4.6 Commodification of Health; Patient Autonomy

A most significant outcome of the interviews was that many patients conveyed the notion of being ‘processed’ within the system and feeling like a nameless consumer, since so many of them alluded to this. This was highlighted by 12 of the 17 patients. A by-product of this seemed to be the need for being distracted or occupied in some way to evade such feelings.

The following quotes reflect notions of being processed or helpless within the system or space. Several patients initially alluded to feeling moved around the physical space without any agency or understanding. It is notable how patients use terms such as being ‘moved’ or ‘put’, being ‘instructed’ or ‘sent’ around the setting:

> *“*OK, sometimes *I was instructed* to wait in the corridor at the end.” (Patient 3)
>
> “You’re just waiting for somebody to *come and drag you* in for the test.” (Patient 13)
>
> “So *I was moved*, and I was sat down in the corridor.” (Patient 11)

Patients also felt conflicted about being moved back to the same space to wait again:

> “You're always getting back to that same starting place, so that was problematic.” (Patient 6)

> “And you come back, and you do feel that you're starting at zero again, something there. Isn't there something there about being put in a corridor is not the next stage ideally, as it would be better to put in a separate room or something? I think in a separate room.” (Patient 8)

> “And when they came back to get you the second time, when you sat there, you’ve gone, and you come back, and you been asked to wait again.” (Patient 17)

Patients were reading into potential meanings of where they had been sat which caused concern for them as articulated here:

> “I've been moved down to those chairs at the end, what does that mean for me? And you almost need to know the sense of why you're sitting in that area and not that area and yeah.” (Patient 10)

At other times the significance of initially being given a form to fill in on a clipboard appeared to feel like being processed for some patients:

> “I think it was kind of like a [very just like] system, like here’s a clipboard, go and sit down, and you're kind of in a queue [that] aren't you. It's not that I felt unwelcome, it, it's just, I suppose they're used to it every day.” (Patient 3)

> “Initially they give you a clipboard to fill in some details and even that feels…you know, it's a million questions to answer like, where your life, um and then you are taken quite quickly…” (Patient 6)

Other more general emotions of patients feeling processed were conveyed through impersonal feelings or sensing they were simply part of a bigger system, although nearly all patients did empathise with the pressures on the NHS:

> “They are following such a process. And I suppose they have to be equal to everyone that's going through sort of thing.” (Patient 3)

> “And because they must do it with so many patients every single day.” (Patient 6)

> “You feel like they really care for you and but in every other sense you are just a number, aren't you?” (Patient 16)

> “As you move through the process, just a bit like you're being a number because they, you know, I understand, it's their job and they do a lot of it, and they have to process a lot of people and you don't want to be taking up too much of their time as well.” (Patient 8)

Acceptance of being in a process was clear for some and a general numbness or dependency:

> “You’re in a holding pattern, there aren't you. That's all you do.” (Patient 3)

> “Because you just, you’re just being processed. You just accept whatever you see is there.” (Patient 4)

One way patients appeared to try and regain a sense of autonomy, was through distraction, and their comments showed various factors of the space which helped or hindered this. Some aspects of the space were noted as helping:

> “Minutes can feel like an hour for sure. Yeah. And it's nice to have distractions like, you know, a magazine or...” (Patient 9)

> “The comings and goings, I suppose, distracted me in the reception. There were quite a number of people coming and going.” (Patient 10)

Interventions for distraction initiated by the staff were not always seen positively:

> "I think it, distraction is the main thing that, like, I was going back to the leaflets or the posters on the board, that's not necessarily the structure you want, that just caused more concern." (Patient 3)

> "And no, it gives you a better ambiance, doesn't it? Reduces your stress levels. If you've got nice music on, but as you said, what one person's nice music is another person's fingers down the blackboard." (Patient 15)

> "You don't need to be reminded of why you're there." (Patient 16)

4.4.7 Apathy

A significant portion of interviewees, over 70%, felt passive to many aspects on the environs or distanced from things. This seemed notable in terms of indifference; this indifference was expressed in their words and tone, hinting at a lack of user-centred design. Aspects such as bookshelves were not always received as perhaps intended:

> "The bookshelf. Do I care?" (Patient 10)

> "They don't want to read a book when they're sitting there, and they don't wanna be thinking about taking a book home. No. Well, I, I wouldn't. I wouldn't if I was going to take a book, I'd take my own book." (Patient 5)

Indifference to leaflets and flyers weas articulated many times as per these examples:

> "They're just sitting there, and they will read loads and loads of different things. They're just staring." (Patient 15)

> "Again, there were flyers in different spots. I mean, I think to some extent … feeling indifferent about that particular space. Which is not really what, what is wanted, but you know, feeling indifferent". (Patient 17)

> "You know, the information, previously it was sort of like something that I just noticed out of interest, but I didn't look in any depth to it." (Patient 2)

Overall, a general lack of impact of the space was noted:

> "It was quite bland…OK, nothing particularly stood out. I don't think they had a television. I'm not sure if they did. I'm not sure." (Patient 2)

> "There was nothing. Very light and plain. Yeah, probably cream walls or…. and clinical again. I didn't notice it being unclean or anything like that, so there was nothing bad. I think I was probably just concentrating on, yeah, maybe in the remaining calm, basically." (Patient 8)

4.4.8 Section Summary

This section has presented many pertinent quotes from the participants' interviews, grouped within categories comprising one 'enabler' and six 'barrier' themes of patient experience, as influenced by the literature, the conceptual framework and observations from the ethnographic stage. This was following multiple readings of the transcripts and the application of 24 initial primary codes. It has shown how feeling vulnerable, confused and/or anxious were the most frequent apparent emotive outcomes. By the inclusion of In Vivo accounts of their moments in the setting, the complexities of individual experiences of the waiting room, as well as similarities between feelings are brought to the fore. Here, the unique individual voice and its layers of (sometimes contradictory) expression, and how the patient speaks about themselves, is recognised. The interplay of relationships between the patient, the researcher and cultural contexts of the space have been explored.

4.5 Conclusion to Chapter

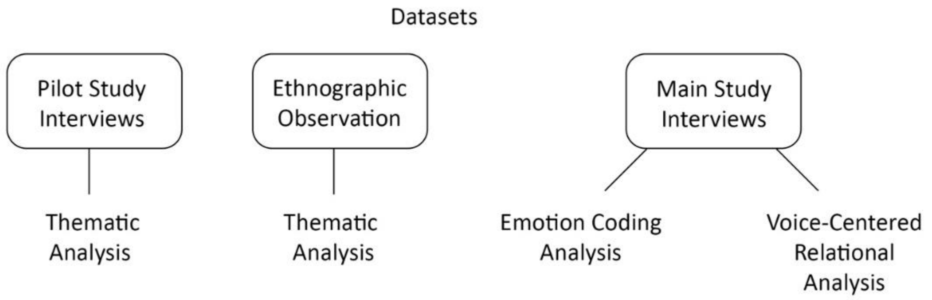
This chapter has presented the findings from all data gathering stages; the pilot study, the ethnographic field observation and semi-structured interviews. The aim was to present the findings and review them in the context of the suitability of the conceptual framework derived from the literature review in Chapter Two.

Many codes were applied to these various data, via a "sensitising" approach where multiple codes might overlap (Blumer, 1995). These were then grouped into broader categories, again driven by the various forms of data (photographs, field notes, interview transcripts) and on reflection of the conceptual framework. The additional analysis of Voice-Centred Relational coding added further depth to the interview interpretations by seeking to prioritise the patients' individual voices and emotions and the interpretations of these by the researcher.

4.5.1 Connections Between the Data

Before proceeding in Chapter Five to discuss these findings and their relation to scholarship, to the research questions, and the suitability of the conceptual framework, it is appropriate here to summarise the connections between the data. Three groups of data, resulting in four sets of analyses have been presented here: pilot interviews data, ethnographic observation data and main interviews data; the latter being analysed with two separate methods (see Figure 4.21).

Figure 4.21 Forms of Data Produced from this Study (Author's Own)



Looking for patterns between these four sets of analysis; effectively triangulating the findings 'at the level of the data sets' rather than individual cases (since the field observation stage did not focus on individuals), helps to present a more synthesised summary of outcomes for later discussion and can strengthen the foundation of this qualitative research (Flick, 2023). In essence the patterns of each analysis can be compared for similarities and differences, and it can be asked whether there are similar barriers or enablers noted within the observations and the interviews, or whether there are differences of patterns between the emotion-coded and voice-centred analyses for example.

Whilst Flick (2023) cautions that convergent results (where the data outcomes are very similar) might mean that one data-gathering method only might have been sufficient after all, Denzin & Lincoln (2000) see triangulation as ‘extending the possibilities of knowledge production’ rather than purely confirming results, and hence insights go past what might occur from one single approach.

4.5.2 Convergent Themes

In reviewing all the data, whilst naming conventions might differ slightly (lead by the sensitive coding of individual texts/types of data), there were several key notions that emerged clearly throughout. Experiencing moments of feeling grateful, being confused, feeling vulnerable/exposed, feeling detached or indifferent, being upset, and feeling disappointed or depressed were emotions dominant within all data sets. Across the data, similar circumstances tended to lead to such emotions; for example, the exemplary care from health staff (primarily nurses) was almost entirely cited as a positive. Linked to this, empathy for others was quite frequent and not anticipated within the conceptual framework in Chapter 2. Feeling exposed or vulnerable also came through very clearly at all research stages, even from the field observation where the researcher was not technically a patient waiting to be seen. Here it was frequently the physical space, layouts or proximity to things or to other people that caused a high level of concern for almost all.

Confusion was a dominant feeling across the main data gathering stage, although this was most evident from the interviews and typically was in relation to signs and symbols. At times however, more cognitive notions of knowing where one was within a system or process were evidenced as very confusing, and the quotes from participants highlight this clearly.

Perhaps understandably for a clinical setting, anxiety and apprehension were common outcomes of all interviews, but at quite a significant scale, and this was somewhat complex since the data showed it came from multiple causes. For example, the patients’ previous circumstances or medical histories, disconcerting features of the physical space (noises, or cancer posters for example), worrying about test results, being unsure of how things worked, experiencing 'sterile' spaces or generally feeling nervous about the idea of a hospital were all highly emotive aspects for interviewees.

Frustration, and to some extent feeling upset came through most clearly from the interviews and was especially clear within the In Vivo quotes by patients. They did not hold back in expressing such frustrations and at times these still seemed raw/present for them, as the I Poems served to concisely demonstrate.

Indifference was an emotion that occurred perhaps more than the researcher was expecting and became a notable concept that was not considered within the conceptual framework; arguably since it is not something designed in the planning of spaces, or part of the daily production of space and yet it was very prevalent in the lived space of the patient (see Chapters 2 and 5). Arguably difficult to physically demonstrate, this nevertheless was very common in the patients' accounts of their experiences and was caused at times by physical aspects of the space such as plain or tired décor, low expectations of the NHS, but also interestingly, general pessimism about things.

As discussed in the next chapter, a somewhat less expected finding from this study was the extent to which patients felt processed/unseen. This was, perhaps understandably less notable within the field observation data, where the researcher did not personally experience a whole 'customer journey' through the space, such as being called in for an examination, and hence did not join in with the whole process. But for the patients, particularly in the main interviews, the data evidenced how these emotions of being in a bigger, somewhat cold system had an impact on them. This also links to notions of autonomy, agency and identity that did not feature in the original conceptual framework, and that are discussed further in relation to the literature in the chapter that follows.

Similar to these concepts of feeling empowered or seen, privacy was clearly a key theme from all data sets but particularly within the interviews where this was articulated from several perspectives where spatial, social, cognitive and physical elements were at play, and feelings about privacy varied greatly.

4.5.3 Divergent Themes

There are few concepts or emotions that did not occur across all the data.

The notion of confusion was less prevalent from the pilot study narratives; this may have been because the patients in the pilot study were all discussing different settings where they were inpatients, and hence wayfinding and systems and processes may have differed to the self-sufficiency of the waiting room, or at times the setting may have for example, had superior wayfinding.

The field observation indicated less of an emphasis on being upset, again likely due to the fact that the researcher was not attending for a real appointment – although agitation by elements of the space (lighting, broken chairs, overhearing things) was a factor that closely aligned with the interview data and something that the researcher and patients were all sensitive to.

In conclusion, with the exception of notions of autonomy, agency and identity, the data clearly shows confluence between key emotions experienced by patients, that these were of great importance or significance to them and that the spaces had a key causal role to play.

Chapter Five discusses the significance of these new findings in the context of the research aims, how these contribute to current knowledge on this topic and the validity of the original conceptual framework proposed in Chapter Two. It indicates synergies with, and contrasts to recent scholarly narratives on the topic of patient waiting rooms and where further opportunities arise for new study and practice.

CHAPTER FIVE – DISCUSSION AND CONCLUSION

Preface

The purpose of this chapter is to provide comment and evaluation of the findings within the context of prior research in the field, the overall research aims (Geng and Wharton, 2016), and to demonstrate the original contribution and significance of this work.

Commencing with a brief overview of the findings presented in Chapter Four, these insights are then related to the research question before discussion of how they contribute to further knowledge and understanding within the field. There is then discussion of the originality and impact of this work, including a review of the applicability of the conceptual framework that was initially formulated to underpin this research. In highlighting key contributions to scholarship and new knowledge that has been generated, a revised conceptual framework for further research is then proposed.

In keeping with the professional doctoral emphasis of this research, the academic contribution is followed by the presentation of a prototype of a unique ‘Health Space Design Playbook’. Conceptualised from the findings of this study, this could be used within industry by practitioners as a point of reference and discussion.

5.1 Unique Contributions to Knowledge

Aside from the specific insights discussed in 5.5 below, this study has three major contributions to make to scholarship:

1. By prioritising articulating the voices and emotions of patients, a novel, rich and comprehensive picture is painted of the waiting room experience;

2. Exploring the waiting room through a combination of spatiality and design thinking-based empathy proves to be an effective way of more deeply understanding the complexity of patients’ relationships with the spaces;

3. Whilst previously established ‘hard’ factors (Ulrich, 2001), such as light, noise or décor have been shown to impact perceptions of quality, this thesis has revealed how the patient experience of the waiting room is more far complex and subtle than previously theorised. It additionally aggregates notions of individual agency and autonomy, vulnerability, symbolic interpretations and uncertainty.

5.2 Research Aims and Key Findings

From a subjective, interpretivist position and through a user-centred lens, this study aimed to explore and understand patients’ first-hand perceptions of hospital spaces with specific emphasis on the barriers and enablers of a positive experience in the health waiting room. The key aim was to focus on how patients *feel* and what holistically mattered to them concerning the waiting environs; as opposed to reviewing clinical outcomes based on individual interventions or purely analysing physical factors.

Through the creation of a bespoke conceptual framework bringing together health and design thinking domains to serve as a guiderail for the study (see Chapter Two), the objective of this thesis was to understand patient perspectives by uniquely listening for how aspects of spatiality manifest in the patients’ emotions. This novel approach was influenced by theories of spatial geographies and trialectics as espoused by Soja (1996) and more general notions on the production of space by Lefebvre (1991). Adopting the first two phases of a design thinking methodology (Brown 2008; Leidtka, 2018) ensured the approaches of initially seeking empathy and then defining barriers and enablers were adopted. The goal was then to advance the understanding of ‘lived experience’ by evaluating the appropriateness of this conceptual framework.

Following a pilot data gathering stage to evaluate methodological feasibility with 5 participants, further stages of ethnographic field observation in a real hospital waiting room and 17 in-depth semi-structured interviews were conducted with patients from the same setting and resulted in “thick descriptions” of their cases (Geertz, 1973). Material generated included photographs, notes, sketches, and lengthy interview transcripts. This resulted in four analysed datasets as outlined in Chapter Four.

5.3 Key Outcomes

Before discussing specific insights gained, there are three fundamental panoptic themes that this thesis asserts are of particular significance in light of the literature and the data.

5.3.1 Dignity, Agency and the Marxist Humanist Lens

Notions of dignity are challenging for patients and enabling individual agency should be further prioritised. As explained in Chapter Two, dignity relates to senses of agency and as Mains (1994) articulates from a nursing viewpoint, concerns when an individual can exert control over their own behaviour, surroundings or treatment and can understand information and make decisions. Critically, the findings of this thesis bring these notions very much to the fore, but in terms of this *not* being achieved. Whilst Mains expands the definition by stating that one “should feel comfortable with his or her physical and psychosocial status quo” the patient’s narratives however, conveyed that these diverse constituents of dignity were problematic for them since they did not feel they could exert control or feel comfortable with the status-quo. These tenets, as purported by Mains and challenged by the patients’ narratives, align with a Lefebvrian interpretation of Marxist Humanism (1991) where concepts of structure and space as process are rejected as problematic in favour of focusing on individuals and their agency. In highlighting these challenges for patients, this thesis asserts that such Marxist Humanist interpretation of agency and dignity is a valid conceptualisation for understanding the complexity of people’s lived experience in this field.

5.3.2 The Multiplicity of Waiting

The waiting room experience should be considered concurrently from multiple perspectives. The context situated by Bishop (2013) where waiting becomes a mode whereby “different social interactions and micro cultures are at play” was also reflected copiously within the data. From an architectural viewpoint, Bishop highlights the paradox of waiting and its related spaces being restrictive and controlling, whilst in parallel offering new opportunities for novel forms of social and physical interactions.

The data certainly reflected this, even within individual cases, where at times a patient felt both disempowered, yet experiencing new situations of opportunity such as when helping others. This presented a complex and multi-faceted picture of the patient journey which at times was challenging to deconstruct and interpret due to this dualism. However, this supports the inter-disciplinary nature of this study, which is in opposition to previous works that tended to consider the impact of singular physical environmental attributes or social factors. Supporting this outcome, as Gashoot (2022) outlines, a user's perception of the environment is affected by sociological needs, psychological state, and individual differences. The patient waiting room concept involves many typologies, the exploration and analysis of which requires a multi-layered and flexible theoretical framework and one which is arguably more comprehensive than that which was initially proposed in Chapter Two.

5.3.3 Notions of Security and Symbolic Meaning

As evidenced in Chapter Four (4.4.3), approaching and being in the waiting room space is omnipresent with emotions of confusion and uncertainty. These themes fit with the dimension of "security" from Hazzenzahl *et.al*'s (2013, p.22) stipulation of needs for experience design. This is termed as the need for "feeling safe and in control of your life rather than feeling uncertain and threatened by your circumstances". This was a trend that underpinned much of the data; a seeming undercurrent of a sense of anxiety or insecurity for all. For example, patients felt uncertain about where they were going, what was happening, threatened by potentially losing their space in presupposed (non-physical) queues, and/or lacking control of the various physical features and social interactions therein. Many of these feelings emerged from signs and other symbolic aspects of the space causing confusion and a questioning of their literal and signified meanings. This was disconcerting for patients, affecting their interpretations of physical elements, and even relations with other people, which at times overwhelmed them. This builds a case for further reflecting on the topic through symbolic interactionism and in particular Blumer's (1969) assertion that meaning must not be overlooked in favour of factors (examples here being signs, seating, information, rules) that simply produce behaviour. In other words, by considering symbolic interactionist perspectives, this thesis strikes a balance between acknowledging such factors and prioritising the understanding of deeper meanings for patients, which other studies do not address.

5.6 Summary of Insights

Considering the primary research data, new insights are summarised in Table 5.1 below. This shows the most common themes, grouped into the categories identified from the main interviews and then given a strength of occurrence of feeling according to the researcher’s subjective interpretation of all data. This concurs with the word cloud shown in Chapter Four (Figure 4.20) but provides context here. It is concluded that feeling vulnerable or exposed, confused, anxious, stressed and apprehensive were the most common emotions. The factors causing these feelings will now be discussed further in the context of the research objectives and extant literature in the section that follows.

Table 5.1 Summary of all findings, grouped into categories and strength of feeling applied

Summary category	Key feelings or emotions	Strength of emotion	Key Causes identified	Pertinent quotation
Feeling vulnerable/exposed	Vulnerable Exposed	Very High Very High	Seating – too close, who sits where? Overhearing/overheard Too quiet Too close to treatment rooms/desk	*"And the seating area, you're quite close proximity to people because they've done it in a U-shape... And the [treatment] rooms are very close to the seating area. There's no space."*
Symbolic meanings, communication & trust	Confused	Very High	Arrival difficulties/unwelcome Too much or confusing signage Not knowing what is about to happen	*"What people think they've written on signposts, it's people who are working in the system that know what those signposts mean.. Yeah, but as a patient, they don't know what DAU stands for."*
Patient empowerment, cultural competence & agency	Anxious Stressed Apprehensive Unseen Unwelcome	Very High Very High Very High High High	Previous illnesses/experiences Late/lost/in right place? Clinical décor/ barren Clinical posters and flyers Noises in the space Impending diagnosis Missing their slot The unknown No welcome	*"Put it this way, I looked at it and thought....I couldn't think of anything I didn't want to read any of that, and I had my book and so I knew second time round to take something like that. No, I didn't want any of that at all. No!"*
Depressing factors	Unhappy Upset Frustrated Disappointed Pessimistic	Medium/High Medium/High Medium/High Medium Medium	Mixed types of purpose of space Noise, light, seating Décor/old/inappropriate/dull/dingy Being put in corridor Lack of design or facilities/extras Low expectations of nice design	*"If you choose the right colour furniture, so choose colour but not just, you know, the standard sort of green that they go for, whatever it is...especially in a waiting area, there's, there's no reason, umm, to not have, you know, what you, what people would have at home."*
Commodification of health, patient autonomy	Processed Dependent	Medium/High Medium/High	Being moved about aimlessly Waiting not knowing 'Cold' form filling (handed clipboards)	*"I've been moved down to those chairs at the end, what does that mean for me? And you almost need to know the sense of why you're sitting in that area and not that area and yeah."*
Apathy	Indifferent	Medium	Bland décor Out of date magazines	*"I mean, I can't recall anything of note other than lots of leaflets. Yeah. And posters."*
Feeling Grateful	Grateful Satisfied	Medium/High Low	Staff care, staff gestures Generally low expectation, feeling zoned out, relief Some wishes articulated	*"You've got to work with what you've got, and I think my experience, ... I just wanna say anyway, how unbelievably caring [they are]."*

5.5 Discussion of New Insights

5.5.1 Feeling Vulnerable/exposed

Feeling comfortable with one's boundaries, the gaze of others and not hearing conversations between others are all critical to patient well-being in the waiting room. As outlined in Chapter Four, this category refers to where patients felt vulnerable in the setting, wherein challenges in terms of self-perceived boundaries of occupation were experienced. In other words, they felt very worried about proximity to others. This concerned both imagined notions of individual space and its delineation, or physical invasion of their own, or another's space through either being too close or overhearing private conversations.

One aspect of such delineation of one's own space to which many participants alluded, concerns the emotive aspects of seating. This study asserts that patients are impacted quite profoundly, not simply by the size or number of seats (Zhao and Mourshed, 2017), but also deciding where to sit. From the data, this element seems loaded with potential challenges to one's identity in terms of how comfortable one feels (both physically and emotionally) or indeed how invaded or exposed. The nature of seating being restrictive in fixed lines is a finding which concurs with previous research (Ulrich, 2001), was mentioned by some participants and was also an observation from the fieldwork where it felt challenging. The opposite effect of seats being too far apart, in some cases a legacy of Covid social distancing, was noted by several patients as making them uncomfortable and was also found within the researcher's analysis of seat locations to have considerable impact on experience (see Appendix 15, Memo 4). The patients also mentioned the notion of seat location or style making them feel more or less exposed (too much space for example), which links with the idea of avoiding 'confrontational' chairs as highlighted by Payne *et.al.* (2015) and uncomfortable seats leading to negativity (Campos Andrade *et.al.,* 2013).

One of Payne *et. al.*'s 26 design recommendations for healthcare and wellbeing centres, suggests allowing for "an expansive view from the seats where possible to allow 'people watching' of non-private activities" (Payne *et. al*., 2015, p.274). This resonated with about half of the participants of this study who felt this was of benefit, yet the notion of 'non-private' activities such as watching those walking by, was still articulated in these findings as potentially problematic and therefore careful consideration of what constitutes "non-private" activities should be taken. The findings were inconclusive on such aspects of watching others, including the reception desk comings and goings, which some felt was comforting whilst others did not.

Also from Payne *et.al.'s* 26 recommendations, item A3: "provide auditory privacy in health assessment areas" (Payne *et. al.*, 2015, p.270), hints at the need for sensitivity around exposure of patients. As evidenced in the previous chapter, overhearing conversations was clearly problematic, affecting senses of privacy and causing concern about other patients in the spaces. As with dignity, privacy has many facets within waiting spaces; protecting your own privacy, as the findings support, is particularly pertinent when waiting to be screened for personal matters such as those of the gynaecological clinic. These outcomes align with Matiti and Trorey's, (2008) perspective that privacy is one of the six key elements of dignity, here concerning what was said to patients and their interpretations of communications with staff. In this context of the overhearing of conversations, many of the patients in this study cited such dialogues as leading to feelings of vulnerability.

This thesis argues that it is the details of design which result in situations such as patient privacy being compromised. This aligns with Oosterlaken's (2009) argument for capability design, since such details are value-laden with potential effect on privacy, and therefore ethics should be put before function when considering design. In this context such details might be the proximity of treatment rooms to waiting areas, open doors or thin walls, which were cited as problematic by patients due to hearing unwanted dialogues.

5.5.2 Symbolic Meanings, Communication and Trust

Clear signage, feeling welcome and knowing what is going on are critical components of patients waiting experiences. Signs, as key components of communication within waiting spaces, were prevalent within the literature as being precarious (Bubric *et. al.*, 2021; Cheng and Pérez -Kriz, 2014) and the data universally supported this, with all patients telling stories of confusion with wayfinding. Though it is therefore not surprising to see this topic occurring within the patients' stories, the prevalence of this within their accounts, and the level of feeling of disorientation, literally and psychologically, was significant. The puzzling approach of 'the more signs the better' as inferred by the

Researcher from the field observation stage, was pivotal in causing confusion for patients within the findings. This reflects Mollerup's (2009) position that despite built environs initially being planned well, additions and changes over time were accountable for such notions of confusion in relation to wayfinding. This is important, because based on the data, this study asserts that arrival is a key component of the patient's conceptualisation of their experience and sets the tone for their state of mind for the rest of their visit. This aligns with Locatelli *et. al.'s* (2015) point that a significant "environmental attribute" (p.22) is that of "welcoming/inviting", whereby they illustrate that a more "open" environment when walking in would be more inviting. "Open" can be interpreted in diverse ways, but these data indicate this would mean minimal amounts of signage with clear and simple language and a friendly human greeting.

Other symbolic aspects such as clutter, disrepair, and overwhelming amounts of disparate forms of information were reported as cumulatively leading to a state of distress and reinforced anxieties for patients when waiting. This thesis assets that, every broken, dull or dishevelled aspect sends a message of lack of care that the patients relate to their expectations of treatment. This connection was made by some interviewees. This aligns directly with Arneill and Devlin's (2002) study where photographs of dull areas elicited speculation that the care about to be received would be equally disappointing.

5.5.3 Patient Empowerment, Cultural Competence and Agency

This study asserts that patients make strong and diverse connections between what is outside and what is inside; in terms of weather and its impact on light, arrival stresses (parking or wayfinding for example) or past clinical experiences. These concepts require acknowledgement within hospital design. This connection to the outside world reflects Clapton's view of the waiting room as a liminal space between the outside world and the inside "encounter" where anxiety can be increased (Clapton, 2018, p.13). Few studies allude to this, however. Findings here also connect to the bigger picture presented by Mulcahy (2010) where multiple waiting scenarios such as waiting by the phone, waiting for results or waiting for their turn, are seen as valid. This thesis concurs with such broader notions of the patient journey since these were also troubling for the participants in this study. Patients bring these emotions and memories with them to the waiting room, and therefore opportunities emerge within the space to potentially acknowledge and allay such patient anxieties. It is argued here that space, rather than purely human behaviour, has the capability to affect such outcomes.

Whilst this study is not the first to note this, the stories told here give emphasis to the disquiet concerning clinical information overload, or what Clapton (2018, p.12) terms as “white noise”. Almost all participants in this study described feeling apprehensive after seeing off-putting clinical information, on posters or on flyers, to a greater extent than has been noted in previous research. In some patients this also created a feeling of lack of choice over what was immediately confronting them. Clapton (2018) also sighted posters as causing agitation for patients, although within this study the level of apprehension caused by such features and the highly emotive accounts of this amounted to them being a considerable challenge to senses of well-being. This links with the notion of affordance: patients being able to potentially control the variables of what is experienced within the environment, for example being able to switch a lamp on or off (Devlin *et.al.,* 2023). Addressing such opportunities would be contingent on options being clearly presented or offered to individual patients, and therefore a challenge to what Altman terms as unwritten rules of behaviour or “scripts” of spaces (Devlin *et.al.,* p.49). Patients in this study indicated choice over attributes of the space and some sense of control over them would be of benefit, although which particular attributes and how this would work in practice would need to be prototyped and tested.

5.5.4 Depressing factors

This thesis shows that emotions run high in a clinical setting, even within the outpatient setting of the waiting room. Patients are effectively in a heightened state of sensitivity and can be upset, frustrated or depressed by attributes that might not usually cause such concern. This may in part be due to expectations around coming to an appointment, but also the feeling of passiveness of waiting (Devlin *et.al.,* 2023), the aforementioned lack of affordance or unsettling confusion. It is asserted here that this paper exemplifies the depth of emotions more distinctly and vividly than any previous studies.

Many of the design or sensory attributes of waiting rooms (colour, light, noise, views) that have been found within much of the previous literature to be significant enablers or barriers were also evident here and attributed as largely problematic by patients in this study. Chapter Four shows the many examples described by participants, and the literature review in Chapter Two demonstrates how commonly such attributes have been noted as significant factors within previous research (Arneill and Devlin, 2003; Ayas *et. al.*, 2008; Birren, 1978; Dalke *et. al.*, 2006; Huang and Chou, 2021; North and Hargreaves, 1999; Pfeifer and Wittmann, 2020; Ulrich, 1997; Zhao, and Mourshed, 2017) although scarcely based on patients' spoken accounts such as within this approach. However, whilst leading to a range of emotions spanning the categories of the findings in this study, the primary emotive outcomes here are frustration, disappointment or even unhappiness. Pertinent examples are discussed in the following paragraph in relation to other research.

Taken-for-granted happenings related to staff going about their daily business such as: doors closing noisily; repeated beeping sounds not being addressed; assumptions that patients know what is happening, or the approach of displaying prolific amounts of information (clinical or otherwise) are clearly distressing for patients. Unlike this study where the effect of such activities on the patient has been evidenced as cumulative, within other literature these have not been found as connected with each other. Individual happenings within, or attributes of spaces have generally been discussed. For example, Locatelli's (2015) account of levels of noise reflecting off hard surfaces resulting in multiple patient complaints. One of these attributes, a most emotive topic within the interviews and dominant within health space literature, with a confusing range of positions adopted, is colour. Whilst Gashoot (2022) leverages science to suggest the brain finds that blues, greens and cool colours create illusions of calm, happiness and relaxation, the majority of patients in this study found they symbolised medical or clinical ideas that put them on alert and were unwelcome. Fresher, lighter colours were a theme throughout these data seen positively, unsurprisingly perhaps as opposed to dull colours, yet there is ambiguity within the responses that is reflected in the range of positions on this topic spanning the literature. Whilst this thesis clearly illustrates colour is important for patients, and points towards blues and greens causing anxiety, further research of this concept is required to clarify best practice as this remains inconclusive.

Another emotive factor, as established within the literature review and assorted studies, is light. Similar to colour, patients conveyed contradictory opinions, with bright, natural light being preferred, but not too bright and certainly not white, fluorescent strip lighting often seen in large offices. Patients interviewed also often looked up, citing the impact of ceilings, this was rarely discussed within the literature. Many patients empathised that clinicians may need bright lighting for working, but simply could not comprehend or fathom how this might translate to the waiting area. Frustration was seen here and was the same with other factors (for example furnishings, décor and layout) where a lack of apparent recognition of the difference between clinical and waiting areas was baffling for patients. The patients' preference for natural light aligns with Gashoot's (2022) position that this helps with healing and that daylight is preferred. This study aligns with various previous research which suggest a preference for warmer over white lighting, yet also reflects the discourse and debate on what constitutes optimum brightness (Huang and Chou, 2021; Zhao and Mourshed, 2017). It is suggested here that more clarity might be provided on such topics via further research conducted through a design thinking approach; specifically via the later stages of prototyping and testing, that are outside the scope of this study. It can be argued that the patient perspectives in Chapter Four on lighting, colour and other tangible attributes do reinforce and further exemplify the issues but are inconclusive as to suggesting precise preferences or requirements.

Finally, a notable finding that was not evident within the literature, is that patients are extremely sensitive to clinical activities in their space if in conflict with their own health circumstances, especially when the décor emphasises this, such as inappropriate artwork. For example, patients attending for a gynaecological problem, perhaps relating to infertility or leading to hysterectomy, were very disturbed by being in the vicinity of hopeful-looking pregnant women, sometimes with young children in tow, coming and going for scans. Outdated artwork showing happy babies was described as offensive to some. This was also cited in terms of breast cancer-related consultations taking place in the same area as maternity/post-natal checks, where breast-feeding information was displayed. Some patients felt this was highly insensitive. It is noted however, that this may be unique to this particular setting, although similar conflict (but between different health conditions) may exist elsewhere.

5.5.5 Commodification of health, patient autonomy

This thesis asserts the space has potential to play a pivotal role in reducing the emotions of feeling processed or invisible in the system. As Chapter Four demonstrates, there were a range of dynamics at play, including social factors or interactions, but also the way potentially helpful information about the patient's journey was absent. Many patients felt frustratingly dependent and deprived of the how and why of the way things worked. Not feeling 'seen' and losing identity was a significant issue for many, where despite unanimously complimenting staff, patients felt like a token number in the space whilst waiting. This concurs with Tanner (2002) articulating how waiting has been attributed to erasing individual identities - turning them from person to patient. Related to issues of process and waiting are the concepts of time and passivity, a complex and subtle relationship where multiple factors are at play. For example this is reflected Spechbach, *et. al.'s* (2023) notions of being forgotten, Xie and Or's (2017) relationships with the transparency of information, or Zakare-Fagbamila's (2019) discussion on wait times in relation to satisfaction. This thesis asserts that waiting not only puts patients "at the mercy of another's schedule" (Mulcahy, Parry and Glover, 2010, p.1063) in terms of time, but in other ways. Indeed waiting time itself was not seen as critical in these findings, but feelings of aimlessness, invisibility and dependence were sizeable outcomes that the waiting space should be able to assist with diminishing. As found in this study, waiting and queuing have been described negatively, related to boredom, confusion or unfair treatment (Arneill and Devlin, 2002; Ayas *et. al.*, 2008; Jiang *et. al.*, 2017; Tsai, *et. al.*, 2007; Xuan *et. al.*, 2021). Particular to this setting, since this was not articulated in the literature, returning to the same waiting area repeatedly causes distress both for the patient returning and others watching and wondering why.

Related to notions of commodification, this thesis asserts there is a paradox between being cared-for and effectively being left to one's own devices. Findings show that patients felt as if they were in a self-service environment which seemed to contradict sharply with their expectations of being cared for in a health setting. Small but notable examples from this study include the moment of arrival (lack of greeting of any kind), being handed a clipboard to self-fill, and having to find out oneself the location of amenities such as bathrooms. These examples correspond to three of Matiti and Trorey's (2008) six components of dignity, specifically:

3. communication and the need for information;

4. choice, control and involvement in care;
6. forms of address.

Whilst Matiti and Trorey (p.2709) suggest these expectations should be matched with “relevant nursing activities”, this thesis argues these should be also be supported and enabled by the design of the space and artifacts within.

5.5.6 Apathy

According to these outcomes, the concept of apathy and indifference should be considered in reviews of patient waiting room experiences. Apathy can be difficult to sense within narratives but can be identified through interpretative methodologies where codes are applied to qualitative data such as interviews (Baber *et.al.,* 2021). This was not a key thread found within the literature although notions of passivity, boredom or indifference did occur (Spechbach *et.al.,* 2023; Ulrich, 2001). From the results of this study, apathy is interpreted as being indifferent to one’s surroundings, which in turn is described as related to having low expectations of what the NHS is able to offer. The patient narratives hint at a kind of general submissive acceptance of the way things are, in parallel with an empathy for other priorities such as prioritising budgets and resources on immediate patient care rather than space. Feelings that things had not actually been designed at all, or that no consideration appeared to have been made of design choices and their impacts, was exemplified by patients in terms of descriptions of generic, beige, plain or bland décor. Patients often connected such feelings with staring into space or just trying not to think about things. This study found that offerings on the part of the clinic, such as magazines or books to help with this were overlooked, in part due to not being up-to-date or relevant to the audience. Such factors of “dreary and outdated” were also identified in the study by Locatelli (2015, p.22) where “up-to-date” was one of the key environmental attributes identified as a requirement through noting comments from patient walk-throughs within American health care centres.

One potential solution to apathy: creating distraction, emerged both from the literature and these findings where music, television screens, books, magazines, talking with others and artwork were all mentioned as having potential (Arneill and Devlin, 2002; Ulrich *et.al.*, 2002, Zamagni *et.al*., 2010). Music has been related to consciousness of waiting times

(North and Hargreaves, 1999; Pfeifer and Wittmann, 2020; Ulrich, 1999). However the desire for music or televisions provoked a mixture of strong reactions, both for and against in this study and merits further testing. Almost all patients were oblivious to libraries that had been placed in the waiting areas, preferring to bring their own books, and yet stated they found it hard to concentrate anyway. Artwork was subject to many opinions in terms of abstract versus figurative, nature versus other subjects, and choice of artwork has also been cited within previous literature as a benefit (Lankston *et.al.*, 2010). Whilst Ulrich (2001) states that abstract art elicited negative comments and disturbed patients, these findings contradicted this as several patients in this study favoured abstract over figurative art. Gashoot (2022) identified how art depicting rivers or water scenes evoked joy, although this study did not reveal this, however this may be because patients were not exposed to these scenes when visiting. The overall consensus here was that art was very welcome, on condition that it was in some way interchangeable, perhaps digitally, the latter point being exclusive to this study and reflecting the nature of repeat visits that many patients had experienced.

5.5.7 Feeling Grateful

As seen above, artwork and other creative interventions are seen as potentially positive contributors to the waiting room experience. For this study, a greater number of barriers to positivity than enablers were cited by patients, but this can be understood on the context of patients reflecting on the own experiences. However, as seen in Chapter Four and within some elements of the literature, the behaviours of care staff have an impact on opinions about the waiting room experience. As noted in the patient quotations, the care by staff in this setting was universally appreciated, especially when they went the extra mile to build a personal relationship. However, other attributes were mentioned by patients in this study as desirable factors, which many patients became quite vocal about when interviewed. These included softer factors such as interior elements to create more homely-like environs, a concept mentioned by several patients. Examples include the desire for cushions, rugs and softer furnishings and even plants, although patients recognised this presented potential challenges in cleaning. Plastic plants were universally hated in these patient stories. Other studies have also highlighted that home-like décor can aid well-being (Chaudhury *et. al.*, 2018; Ferdous, 2020; O'Connor *et. al.*, 2012), although historically this has been the preserve of consideration for settings such as dementia homes. This thesis asserts it is time to focus on such elements for the waiting room and evaluate their validity moving forward.

5.5.8 Section Summary

In conclusion, whilst patients have different clinical situations, histories and circumstances, in this study, they experienced remarkably similar emotions and feelings in the waiting room. These emotions run deep and are not forgotten. Similar feeling and emotions also emerged from other settings and scenarios when listening for the patient voice as evidenced from the pilot study.

5.6 Evaluation of the Conceptual Framework

This section reviews the effectiveness of the conceptual framework originally proposed in Chapter Three in light of the research aims and objectives and the resulting findings in Chapter Four.

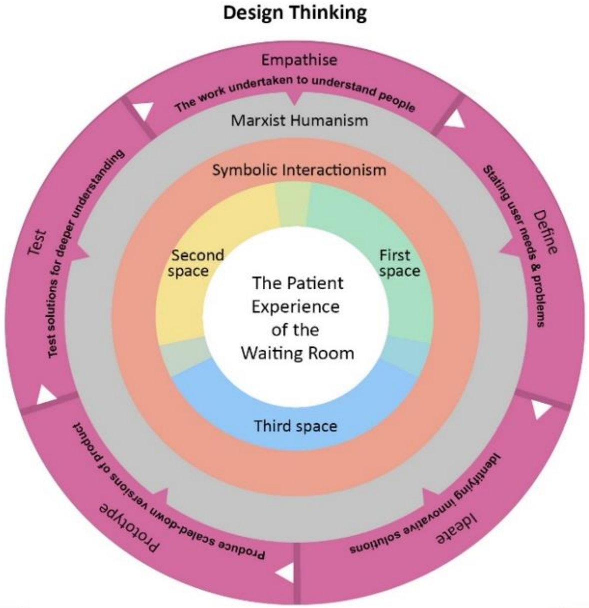
Following a comprehensive review of literature, the conceptual framework (See Chapter Three, Figure 3.1) was initially formed combining theoretical approaches from the worlds of design and spatial theory, reflecting a ‘blurred genres’ approach (Geertz, 1983) as a foundation for the research design. The effectiveness of this framework is now discussed in relation to the results of the data analysis.

As has been evidenced in Chapter Four, the field observation and patients’ narratives revealed different attributes and features of the patient waiting room experience, from physical features to more conceptual interpretations such as finding one’s way. The empathetic stage of non-judgemental data gathering, realised through the topics shown in the circle in relation to the trialectics of space, proved as a highly appropriate starting point for conversations. Notably, patients often volunteered stories loosely around the topics listed without being prompted, and these topics broadly reflect the scope of the majority of the resulting transcripts as well as the observations made by the researcher.

The enablers/barriers listed in the green and yellow boxes originated from the literature around the subject and were all identified as contributing attributes to greater or lesser extents by patients from the interviews. Although patients scarcely explicitly mentioned the words ‘dignity’ or ‘privacy’ their accounts reflected these concepts and constituted significant components of their overall lived experience. Defining these attributes in terms of engendering a range of positive, or more often negative feelings, or what design thinking sometimes terms as pain points (D.school, 2024) for patients as shown in the blue box, was therefore a suitable approach. The data reflected such emotions, albeit lacking certain new insights.

However, whilst overall fitting for consideration of these core elements, this model was lacking in certain perspectives and outcomes that became of significance when reviewing the data. Therefore a revised model is proposed for further framing research in this area and includes more layers or lenses through which to consider patient feelings and real experiences of waiting rooms. Figure 5.1 shows a revision proposed to the original framework in respect of the findings of this study.

Figure 5.1 Author's Revised Conceptual Framework, Adapted from Lefebvre (1991), Soja (1996), Mootee (2006) and Hasso-Plattner Institute of Design at the Stanford d.school, (2005), and in Reflection of Study Findings



Symbolic Interactionism

Hybrid, fluid & contested nature of spaces
Diverse cultural, social, influences shaping space
Liminal experiences & transformative encounters
Vulnerability, & resilience
Cultural competence
Accommodating diverse identities, beliefs & practices

Identity
Social conceptions of meaning
Cultural exchange within spaces
The ways humans act with things
The meaning of interactions

Complexity, richness and multiple interpretations
Meaning as modified through an interpretive process used by the individual
The "terminal self" - digital
Notions of selfhood being emotional
Identity as a new nexus of power or resistance

Marxist Humanism

Commodification of healthcare
Access, quality, & patient autonomy
Enable individual agency, empowerment

Social inequalities, access & equity
Human thriving
Individual freedom
Individual agency
Space as lived through associations
Societal interactions producing space
How space moulds and recreates us
Space as organic, fluid and alive

Dignity and privacy within spaces
Feeling seen
Knowing how things work
Feeling welcomed
Level of feeling processed
Modes of address
Choice

Spacial Trialectics

First space

PERCEIVED SPACE
SPATIAL PRACTICE

Urban geographers & spatial planner's space
Physicality and characteristics
Medium of human activity
Built environs - can be mapped
Production & reproduction
Happenings

Amount of space
Lighting
Physical signs
Seating
Materials
Food & drink
Other amenities

Third space

LIVED SPACE
SPACES OF REPRESENTATION

Experiential, everyday life
User experiences
Socially constructed
Behaviours & feelings
Social relations
Spatiality - beyond the concrete materiality of spatial forms
Complex symbolisms - underground of social life
Mystery, subliminality
Action in the first space enacted through the expectations of the second space

Emotive outcomes:

Vulnerable/exposed, Confused, Anxious/stressed, Apprehensive, Uninspired, Processed, Disappointed, Empathetic, Unhappy/upset, Frustrated, Indifferent, Grateful, Uncomfortable, Unwelcomed, Overwhelmed, Pessimistic, Avoidance/distractionDependent, Satisfied, Bored, Unseen, Reassured, Entertained

Second space

CONCEIVED SPACE
REPRESENTATIONS OF SPACE

Idealogies / ideality
The service design
The designed environs
Codings & signs
Aesthetics
Decor & artwork
Mental space
Expectations
Imagined space
The order of things
Rules (unspoken)
Power & the organisation
Control
Dominant space

Noise
Expectations & associations
Wayfinding
Information
Symbols & semiotics
Stimulations & distractions
Views
Transactional versus other experiences

5.6.1 Revised Conceptual Framework

As has been stated in this thesis, viewing experiences of waiting spaces through the user-centred methodology of design thinking, and via an epistemology based upon spatiality, deeper insights of the impacts of the attributes of spaces and emotive outcomes can be uncovered. It is not proposed that there is a revision to the spatial trialectics model (Soja, 1996) since the three forms of perceived, conceived and lived space are apt and comprehensive. However, this study informs that as well as approaching the study of spatial experiences through the above frames, additional humanist philosophical perspectives help to add meaning, provide depth and build connections when interpreting the qualitative data. Effectively this model represents a ‘zooming out’ from the previous framework (and other studies) to encapsulate broader viewpoints.

Rather than a prescriptive flowchart of sequential processes, the revised model presents a circular, fluid way of approaching such study. At the core is the aim of understanding the patient experience through the various dynamics of the spatial triad. These are detailed within the model in terms of concepts to note and related potential enablers and barriers to review. Importantly, the model proposes that all of these attributes are analysed though humanist lenses. As shown on the model, reflecting on these via Symbolic Interactionist and Marxist Humanist subjectivities enables a level of depth to the outcomes that this thesis argues other studies have overlooked. Whilst physical attributes might vary across sites of study, these lenses, adopted through a user-centred design methodology should further the capability of acknowledging deep emotions and underlying meanings.

5.7 Implications for Practice: The Health Space Design Playbook

The Health Space Design Playbook presented in Appendix 18 is a prototype booklet that has been developed by the researcher to encapsulate knowledge gained from this study. Informed by the new insights from this research, this guide will prove invaluable for professionals from multiple disciplines who might be updating older waiting rooms or formulating new health spaces. It might also be of use for other health areas, such as primary care settings, or indeed other forms of waiting room outside of the domain of health, such as transport. It is designed to be used as a flexible conversation prompt when considering various elements of waiting rooms and includes many points raised by these patients as key attributes for review.

There are many ways this book might be utilised or disseminated: for example, initially it might be presented in its prototype form to the research team and staff at HHFT for review and discussion in order to share findings and identify any potential small edits for ensuring the greatest impact. It might then be presented at various forums such as health conferences and symposiums to gather feedback and interest and guidance as to possible routes for further dissemination. Aligning with various health trusts for publication could be a viable option, or alternatively identifying one or two initial partners who are developing new spaces could be a valid first step in gaining feedback on the booklet and testing the value of topics suggested for discussion. Health organisations such as Health Innovation Wessex (2024) might also be valid organisations to approach with this material since they focus on best practice for driving innovation in health. Another option might be broader publication, perhaps via The Department of Health and Social Care or another UK health institution. An alternative route could be to collaborate with architects and designers who specialise in health space design. A series of meetings could be set up, with the booklet forming a kind of agenda of discussion points before ideally forming some prototype development projects accommodating these considerations.

5.8 Strengths and Limitations and Future Research

Like any study, this research design has strengths and limitations.

Working alongside the NHS and having access to ‘real’ patients has provided this work with authenticity, an ethical foundation and evidence of a tangible review of current circumstances. Having a clear goal of focusing on feelings through an empathetic methodology has resulted in a vivid and emotive case for balancing practical and personal motivations and needs. Adopting a designer’s user-centred, rather than clinical stance on the study has resulted in a subjective yet sensitive understanding of factors over and above the medical status of patients.

However, in terms of limitations, to ensure this work was capable of being delivered, this research was based upon one NHS setting in the south of England rather than a range of settings such as, for example, an inner-city trust. Whilst data presented clearly portrays common opinions from this sample of patients across diverse age groups, and the aim was for in-depth, “thick descriptions” (Geertz, 1973), this was a breast screening and gynaecological setting and hence all patients were female, with 16 of these being white British women and 1 white European, so a greater diversity of participants could be achieved.

Despite being seen as a valid number for qualitative study (Annemans *et. al.,* 2018;, the sample size of 17 patients could be extended to a larger number of patients such as 50 or more, across several different settings in the United Kingdom for comparison. Broadening the reach to other, perhaps less affluent or ethnically diverse areas would also provide further data and might provide different considerations to add to this knowledge, which is critical to ensure a valid and inclusive perspective forms the resulting practitioner playbook. Adding further types of clinics to the review could also result in further viewpoints on waiting spaces, for example by gathering data from prostate clinics, which are focused on males as opposed to females. Comparisons could also be made between different parts of the country. As Chapter One indicates, 21 percent of staff describe their settings as poor, and only a just over third describe conditions as acceptable (Chapter One, Graph 1.3) so there may be multiple areas further study might consider.

In choosing to prioritise the patient voice, this study has not gathered data from hospital trust staff, administrative personnel or clinicians. Whilst this has been an approach in various previous studies, this could now work as a methodology in this context for further sense-checking the patient data or conducting discussions with staff, through an action research approach (Stringer, 2014) to move towards recommendations for making improvements. To broaden the scope of this work, a much larger-scale study could be undertaken, possibly utilising national data more fully via a survey, and through gathering both qualitative and quantitative data to demonstrate the scale of the issues. This could be delivered online via snowball sampling (Stokes and Wall, 2014) and organic media (Vora, 2023) whereby the survey would be reached via posts on multiple social media channels. Data gathered might then include quantitative information concerning the number of patients feeling a certain way and helping to define scale in terms of frequency of feelings as well as possibly and understanding of differences of opinion across demographics and locations. A greater understanding of the volume of waiting areas and their conditions could also be of benefit to inform further studies.

A specific goal to understand the difference between older and new waiting areas could merit further review; whilst it is feasible that newer centres may present less challenges for patients, other factors might reveal themselves. Linked to this, a comparative study could be made between private and NHS waiting areas.

Slightly diversifying from this thesis, another logical step might be to conduct more of a psychological study into the patients’ frame of mind in relation to the waiting room, since much of the data alluded to cognitive challenges for patients concerning choosing where to sit, feeling seen and notions of their identity whilst in the spaces.

Design thinking was seen as a strong guiding methodology for unveiling the depth of patient feelings and the key principles of being empathetic, and defining pain points were always kept in mind by the researcher. However, due to its theoretical emphasis and focus on the first stages of listening rather than redesigning, this approach did not fully exploit the full range and power of the design thinking methodology. This was beneficial in that this study continuously kept focus on prioritising feelings, rather than be tempted to design anything new, but also meant that the practical aspects of such a methodology, such as iterating (brainstorming new features) were not yet applied. In this vein, it might be valid to continue this research via working with interior design or architecture professionals to understand waiting room challenges from their perspectives in the spirit of knowledge exchange in light of this new data. One approach that could be highly effective, in partnership with NHS trusts and third-party spatial designers/architects, is the concept of prototyping a waiting room based on the outcomes of this study.

Prototyping is the next logical step in the design thinking methodology (Brown, 2008), as explained in Chapter Two. This might be done either digitally through leveraging virtual reality technology, where it is relatively easy to change spatial features, or physically in a real space which might have a greater direct physical impact on the participants, for example when reviewing signage or amount of space. This could be a two-phased approach with initial virtual spaces to test and try various iterations, which is another common design thinking approach, before creating a physical space which could be used over a period of time for further data gathering opportunities and exploring softer issues such as textures and furnishings.

5.9 Conclusion to Chapter

This chapter has presented a discussion of the findings from this study in the context of the research aims and objectives and extant literature. Connections and concurrences were identified between this study outcomes and previous studies, particularly in terms of the range of attributes that were notable components of the patients' experiences. Three unique contributions to scholarship were suggested as a result of this work, including how a more comprehensive picture is painted of patients' experiences through articulating their voices, how applying design and spatial lenses helps to more deeply uncover the complexity of patient-space relationships, and that the waiting room lived experience should acknowledge hard factors but prioritise the understanding of vulnerabilities, uncertainty and subliminal impressions as key emotive concepts within the third space.

5.10 Conclusion to Thesis

Through a novel combination of spatial and design lenses on the field of health, this study aimed to understand how patients *feel* about their time in hospital waiting rooms and what really matters to them concerning the design of spaces. The focus was on determining and conveying the participants' emotions and the particular effects caused by diverse spatial elements. This differed from previous studies which primarily focused on individual interventions, clinical outcomes or other quantitative measures as evidenced in the review of literature. With an underpinning of these novel lenses, and building upon humanist spatial theory, an initial conceptual framework, as stated in Research Objective One, was developed to guide this study and to address the aims and objectives.

The first research question: ‘what are patients’ perceptions of hospital waiting room spaces?’, was addressed by the gathering of data through in-depth interviews with a total of 20 patients who provided rich and detailed accounts of their experiences and opinions.

Through a unique methodological approach combining an initial pilot study to test methodological effectiveness, a stage of ethnographic field observation in an NHS setting, and a series of interviews with patients from the same setting, an insightful qualitative dataset was produced. These data were analysed through an exclusive two-pronged method of combining Voice-Centred Relational analysis and Emotion coding. Thematic analysis of the Researcher’s field notes and memos further corroborated these findings.

The data clearly answered the second research question: ‘what are the barriers and enablers of a positive patient experience in the spaces?’, since a multitude of factors became evident. Some of these factors reflected previous narratives on the topic, such as concerns over noise, lighting and décor, however, emotions such as feeling vulnerable, confused or processed, very much came to the fore, providing new insights and knowledge. This evidenced a greater need for understanding the complexity of relationships between patients and waiting spaces and the impact of the ‘conceived space’ and the ‘perceived space’ on the ‘lived space’ as expressed in Research Objective Two.

In light of these findings, and Research Objective Three: ‘to test the appropriateness of the original conceptual framework’, a revised framework was then presented that incorporates acknowledging these more subtle humanist philosophical perspectives to add meaning, provide depth and build connections. Effectively this model represents a ‘zooming out’ from the previous framework (and other studies) to encapsulate broader viewpoints.

Following this unique contribution, opportunities for further research were identified including pursing the further design thinking stages of prototyping and testing. To this end, and in order to address Research Objective Four: ‘to leverage these research insights to devise recommendations and considerations for practitioners for patient-centred design projects’, a new Health Space Design Playbook was created for supporting designers, architects and planners.

Above all, this research provokes deeper discussion about the subtleties of patient-space relationships and the need for a more human-centred approach to research that puts the patient voice and feelings at the fore.

Key Contributions

In summary, this work makes four clear key contributions:

5. This study employs a novel, interdisciplinary research methodology that uniquely prioritises the voices of patients, revealing the complex and significant influence of environmental factors on their experiences;

6. By integrating two data analysis methods—Voice-Centered Relational Method and Emotion Coding—this study uncovers deeply insightful and powerful narratives of patient experiences for the first time;

7. A new theoretical framework that integrates design, spatial, and humanist perspectives opens avenues for further exploration of the key factors influencing the patient experience both in the waiting room and beyond;

8. As a significant managerial contribution, a practical guide has then been developed to help healthcare and design practitioners enhance the creation of patient spaces.

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Appendices

Appendix 1. The 26 Design recommendations for healthcare and wellbeing centres (Payne *et. al.,* 2015).

Atmosphere design recommendations

A1. Maximise natural lighting and use artificial lights carefully.
A2. Include lighting positioned at a low-level to help the visually impaired (Dalke *et al*., 2004).
A3. Manage sound levels so that a quiet, peaceful centre is created by: : considering the room acoustics (arrangement of physical structures and materials), : considering the position of each functional area, : exercise caution in adding unrelated sound sources (e.g. television or music), : provide auditory privacy in health assessment areas.
A4. Soft, comfortable, informal, furnishings with a variety of ergonomic seating styles are recommended rather than confrontational, formal chairs and desks.
A5. Add plants if hospital regulations permit.
A6. Use tonal colours to provide contrast for those with impaired vision (Dalke *et al*., 2004)
A7. Avoid strong colours which can be over stimulating for those with mental health problems (Phiri, 2006).

Initial points of contact design recommendations

IC1. Suitable doors and sufficient space to enable easy access for wheelchairs and pushchairs.
IC2. Provide a visible reception, located a short distance from the entrance.
IC3. Provide a visible and clear queuing system that communicates waiting times and is visible from the reception and waiting areas.
IC4. Furnishings should encourage patient-staff interactions to occur at eye level.

Waiting experience design recommendations

WE1. Ensure waiting times are less than 30 minutes..
WE2. Provide a comfortable and relaxing waiting area, possibly through the provision of refreshment facilities and a children’s play area where necessary.
WE3. Clearly display waiting times by the entrance and waiting areas.
WE4. Present different types of wellbeing information in different areas to avoid a cluttered and complex looking environment.

WE5. Provide choice by including a number of small separate waiting areas.
WE6. Avoid including unrelated distraction activities such as music and televisions.
WE7. Allow an expansive view from the seats where possible to allow 'people watching' of non-private activities (e.g. of those walking by rather than those being assessed).

Health assessment design recommendations

HA1. At least, but preferably more than, one private consultation room is necessary. (This will also vary depending on expected visitor capacity of a service.)
HA2. Incorporate a number of assessment areas with different levels of privacy.
HA3. Consider auditory and visual privacy, through adequate sound proofing including non-reflective and soft surfaces.
HA4. Position computers to ensure privacy.
HA5. Make practical health assessment equipment a visible, attractive feature if alternatives also exist in a private location and are clearly communicated and freely available.
HA6. Use technology to attract people to healthcare and wellbeing centres, but provisions for those less confident with technology is also necessary.
HA7. Hygiene facilities are necessary including sinks.
HA8. Discuss the location of storage facilities with health professionals

Appendix 2. Researcher Observation Poster (Author’s Own, 2023)

UNIVERSITY OF
WINCHESTER

RESEARCH
OBSERVATION

This is Sarah Green.

As part of her PHD research into patient experiences she needs to observe the use of this space for a short time.

No identifiable information about you will be collected.

For further details you can email:

Yourpatientviews@winchester.ac.uk

IRAS Project ID 315883

Appendix 3. Patient recruitment flyer distributed in waiting areas (Author's own, 2022)

NHS
Hampshire Hospitals
NHS Foundation Trust

UNIVERSITY OF
WINCHESTER

Can you share your feelings about the healthcare spaces you experienced?

Photo: Batel Studio

A new research study would like to understand how you feel about the spaces you visit here, and the impact of these on your experience.

We would love to interview you!

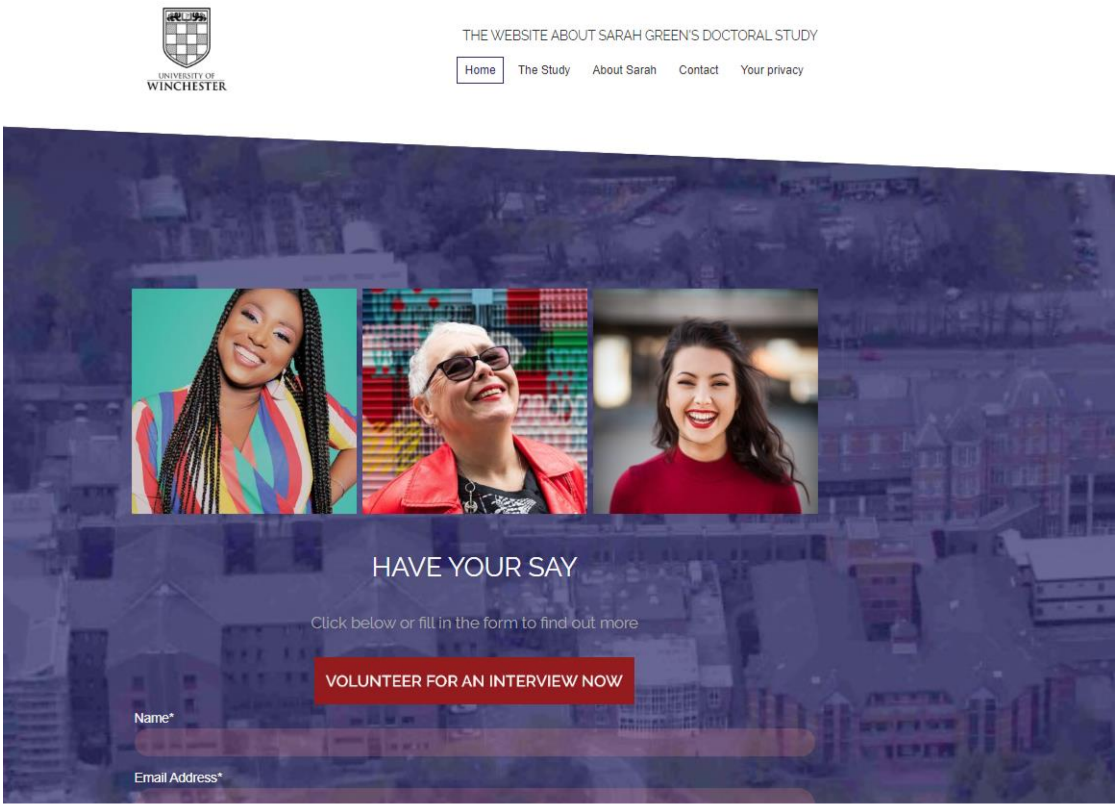
As part of her PHD study, University of Winchester researcher Sarah Green is exploring your views on how healthcare environments make you feel.

This research will be invaluable in making future recommendations on the design of patient spaces.

Please volunteer for a confidential short online interview.

For more information email: yourpatientviews@winchester.ac.uk

Appendix 4. Screens From the Custom-made Website for this Study, (Author's own 2022)



HAVE YOUR SAY

Click below or fill in the form to find out more

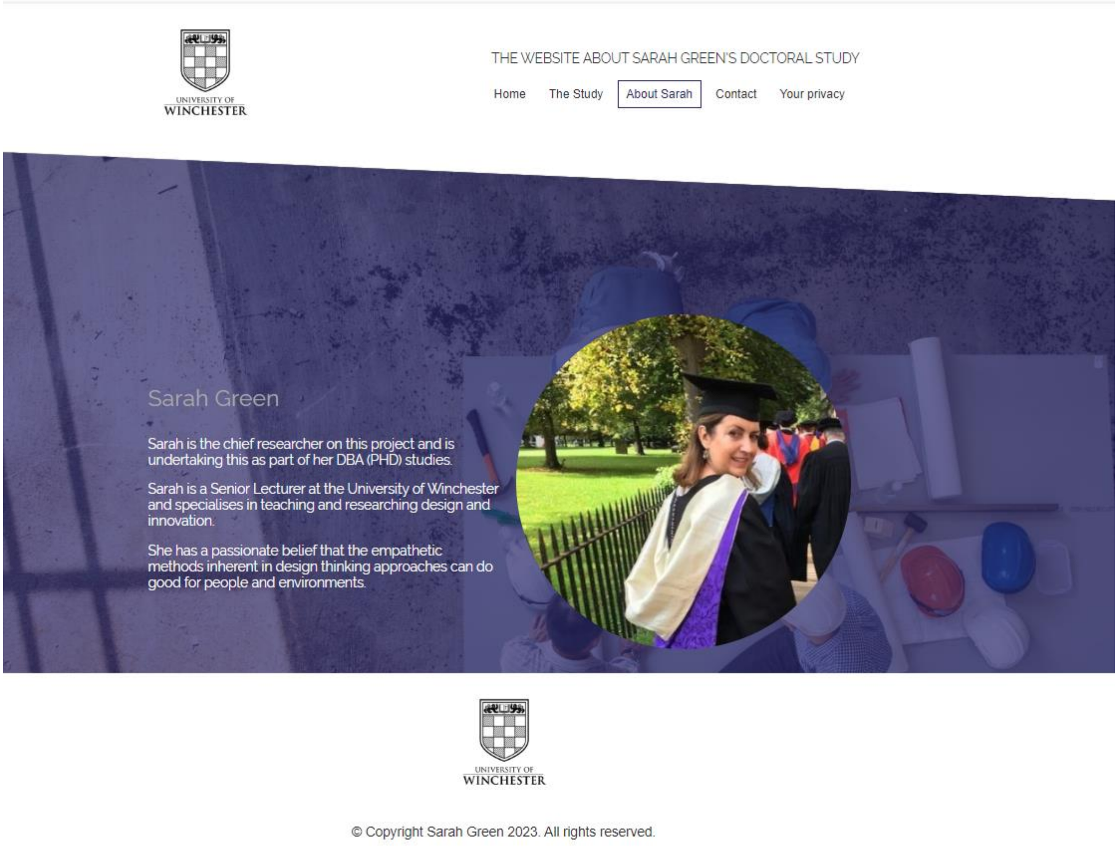
About the study

We'd like to invite you to take part in our research study. Joining the study is entirely up to you. Before you decide we would like you to understand why the research is being done and what it would involve for you. After emailing us, one of our team will go through an information sheet with you, to help you decide whether or not you wish to take part.

This study is being undertaken as a part of an educational qualification for a Doctorate in Business Administration (DBA) which is similar to a PHD.

You will be invited to take part in an interview with the researcher - typically this is no more than 45 minutes, and online. The researcher will provide questions/topics about the environment and then you will be encouraged to talk about these. The researcher may suggest further discussion topics as and when necessary, but these will not be clinical issues.

The information sheet and consent forms will explain everything and you will not be identifiable after your interview.



THE WEBSITE ABOUT SARAH GREEN'S DOCTORAL STUDY

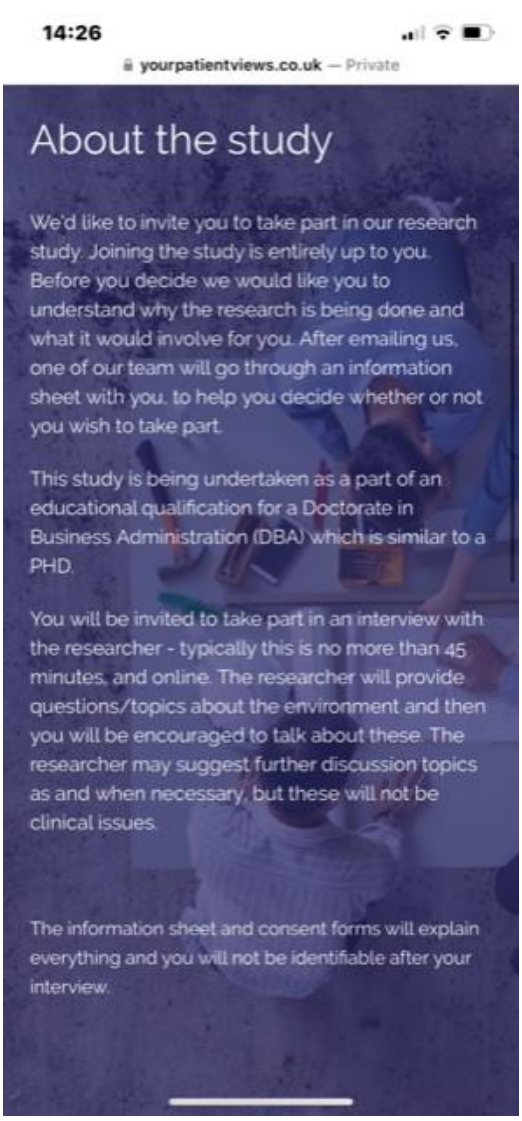
Sarah Green

Sarah is the chief researcher on this project and is undertaking this as part of her DBA (PHD) studies.

Sarah is a Senior Lecturer at the University of Winchester and specialises in teaching and researching design and innovation.

She has a passionate belief that the empathetic methods inherent in design thinking approaches can do good for people and environments.

Appendix 5. Screens From the Custom-made Mobile Website for this Study, (Author's own 2022)



About the study

We'd like to invite you to take part in our research study. Joining the study is entirely up to you. Before you decide we would like you to understand why the research is being done and what it would involve for you. After emailing us, one of our team will go through an information sheet with you, to help you decide whether or not you wish to take part.

This study is being undertaken as a part of an educational qualification for a Doctorate in Business Administration (DBA) which is similar to a PHD.

You will be invited to take part in an interview with the researcher - typically this is no more than 45 minutes, and online. The researcher will provide questions/topics about the environment and then you will be encouraged to talk about these. The researcher may suggest further discussion topics as and when necessary, but these will not be clinical issues.

The information sheet and consent forms will explain everything and you will not be identifiable after your interview.

Appendix 6. General Script for Interviews (Author's own 2021)

Interview commences – scene setter:

As you may know, the focus of this pilot project is to explore the details of your feelings and recollections about your hospital experience in terms of you being within the space.

I am interested in understanding all sorts of details so may ask you to try and recall those as best you can. Naturally some of these may have faded over time, but equally, as some memories of your treatment may have been processed, perhaps you may find space now to remember some of the other aspects of your visit. Finally, you may think of things I am not asking you about which would be invaluable.

So, let's start with any thoughts or memories you may have about your arrival on scene…

Remembering the first few moments. Are there impressions **you recall on arriving** (perhaps when waiting, finding your way or on registering)? - what were you feeling?

Prompts:

- So, do you recall particular things about the atmosphere? Immediate environment?
- Ok so let's talk more about *waiting.* What do you think/see/feel?
  - Anything you recall visually about the place?
  - Your sense of time?
  - Your fundamental needs and then other needs?
    - Seating/food/bathrooms

Can we discuss your seating (if applicable – if not, then the treatment space)– firstly when you arrived and then later…

Let's chat about your initial perceptions of the space you sat in.

Can you describe your memories or experiences of things at first?

Starting with noise, light, how busy it was?
Use some describer words for me?

- The things *provided for you* in your space?
- The things *you may have liked* in your space?
- Finding your way?
- Options for eating/drinking /selection/treats)?
- Your sense of privacy?
- Comfort?
- Décor?
- Views?
- Space to move?

- Boredom?
- Sense of time?

Did your opinions or experiences of any of this change if visiting more than once?

Now let's think about the rest of the public spaces… What were your views on the various spaces available to you as patient?

- Where you were able to go? Or felt able to go?
- How the space was used?
- Where visitors could access extra things (books etc)?
- The areas where the medical staff were based?
- 'No go' zones?

In what ways might *others* there (staff/other patients/other visitors) have 'known' anything about you?

- Your preferences, tastes, needs or even your 'style' if you like?
- How important did you feel this was to you? At the time? And Now?
- Is there anything that might have made a difference here?

Did you feel able to 'personalise' your space? Would you have wanted? In what ways may it have helped?

What about non-medical things that may have helped you? Let's explore the things you did or saw to pass the time.

a. Tell me if you were offered things to pass the time or make things more pleasant, or for other reasons?
b. To what extent did you feel able to bring things in, say from home, to use to make your visit better and why/how was this important to you?
c. Which things would you say made the greatest difference to your experience?
d. Was 'distraction' a useful thing for you? Would it have been?
e. Was it important to you to feel 'at home'?

Let's talk about people.

f. Did you want to interact with others or perhaps keep yourself to yourself?
g. Did you feel you were particularly listened to?
h. How would you describe the kinds of relationships you had with medical staff or others?
i. Could you be yourself?

- j. Was there anyone there you had a particularly good relationship with? Why was this?
- k. What would have made things better concerning people?

What would your dream waiting room look and feel like and why?

Appendix 7. Patient Information Document

THE UNIVERSITY OF WINCHESTER

Patient Information Sheet

You are invited to volunteer to take part in the following research entitled:

Empathising and ideating patient experiences: a novel approach to understanding diverse perspectives on 21st century healthcare environs

We'd like to invite you to take part in our research study. Joining the study is entirely up to you. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through this information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. We'd suggest this should take about 15 minutes. Please feel free to talk to others about the study if you wish.
The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.
Then we give you more detailed information about the conduct of the study.

Researcher name: Sarah Green, University of Winchester.

This study is being undertaken as a part of an educational qualification for a Doctorate in Business Administration (DBA) which is similar to a PHD.

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to consent before the study commences.

What is the research about?

The focus of this project is to explore your feelings and recollections about your time in a Hampshire hospital. We are interested in understanding your experiences of the physical space you were in (for example the immediate area where your bed was and/or the general treatment/waiting space), anything you recall about the atmosphere (for example noise, light) and how you felt about finding your way around or knowing what was happening. You might call this the 'lived experience' of your time there. Importantly the research is interested to explore other aspects you may feel were significant to your stay not mentioned above. *Whilst your medical condition and treatment was/is extremely important, the focus of this study is the other aspects of your stay and not the clinical treatments.*

Why are you being asked to take part?

Because you stayed in or visited a Hampshire Hospital, you are over the age of 18 and can recall the experience. Taking part is entirely voluntary.

What will you have to do if you take part?

You will be invited to take part in an interview with the researcher. The researcher will provide questions/topics about the environment and then you will be encouraged to talk about these. The researcher may suggest further discussion topics as and when necessary, but these will not be clinical issues. The meeting will last 45 minutes maximum and is at a time and place to suit you. This would ideally be online (via MS Teams or Zoom) but in-person in a public place if you prefer. The interview will be recorded (video if online or audio only if in person).

Following your participation and your consent, you may be contacted again within a one-year period should the research project require clarification of something you mentioned about your experience.

What are the benefits of taking part?

This is a unique study that hopes to explore and reveal many considerations of the design of patient experiences. These findings will potentially inform new developments of healthcare spaces and the expectation is that they will contribute positively to improving the design and resulting patient experience of such spaces in the future. In taking part you will have a chance to tell your story, to have your say and help shape these developments. You may also find it a benefit to reflect on your experiences more broadly in a friendly approachable context.

How will the data be used?

These data will be used to inform the above study and will be analysed and compared with other respondents' data. It may also be used anonymously for academic knowledge exchange (e.g. in academic journals, book chapters, seminars and conferences). The interviews will be recorded purely for the researcher's reference. After the data has been transcribed the recordings of meetings will remain on the researchers PC only until the PHD is complete - approximately July 2024. This PC will be locked with a password and therefore only for access by the researcher for the purposes of analysis during the study.

At the end of the study the recordings will be deleted. The transcribed data (notes) from the recordings will be kept for a period of up to two years from July 2024 for the researcher to refer to for further analysis should it be required by the researcher. Any quotations used in the write-up of the study will be anonymised and therefore will not be identifiable.

You will be able to read the transcriptions and resulting thesis should it be of interest, and you can request this at the time of interview.

Are there any risks involved?

In taking part there is no risk greater than those risks faced in everyday life. You may find yourself talking about an emotive subject and you may therefore cease the interview if needed.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your name and contact details including:

- Name
- Email address
- Phone Number
- Dates and venue of hospital visits

People will use this information to do the research and to ensure the researcher can contact you during this process.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from: www.hra.nhs.uk/patientdataandresearch
- by sending an email to: Yourpatientviews@winchester.ac.uk
- or by emailing Stephen Dowell, University Data Protection Officer, University of Winchester: stephen.dowell@winchester.ac.uk

What happens if I change my mind?

You have the right to withdraw at any time without your legal rights being affected. There is no penalty for withdrawing and there will be no ill feeling. You do not have to answer any question that you feel you don't want to. Should you withdraw and wish for your data to be withdrawn also, the appropriate measures will be taken to ensure this.

What if something goes wrong?

As this is purely a conversation about your views on the space, it is highly unlikely anything can go wrong. However, as above, you have the right to withdraw at any time.

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions by emailing: Yourpatientviews@winchester.ac.uk.

If you remain unhappy and wish to complain formally, you can do this by contacting The University of Winchester Complaints team. Details can be obtained by emailing: research.complaints@winchester.ac.uk.

Who has approved this study?

This study has been reviewed and approved by both the University of Winchester Postgraduate Research Ethics Committee and the NHS **North East - Tyne & Wear South Research Ethics Committee.**

Where can I get more information?

If you would like to ask any questions about this research, please get in touch with Sarah Green. Her contact details are below.

Yourpatientviews@winchester.ac.uk

Please direct any written enquiries to:

Sarah Green

Room UWBS105 Faculty of Business and Digital Technologies.

University of Winchester | Romsey Road | Winchester| SO22 5HT

Appendix 8. Patient Consent Form

THE UNIVERSITY OF
WINCHESTER

IRAS ID: 315883

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project:

Empathising and ideating patient experiences: a novel approach to understanding diverse perspectives on 21st century healthcare environs

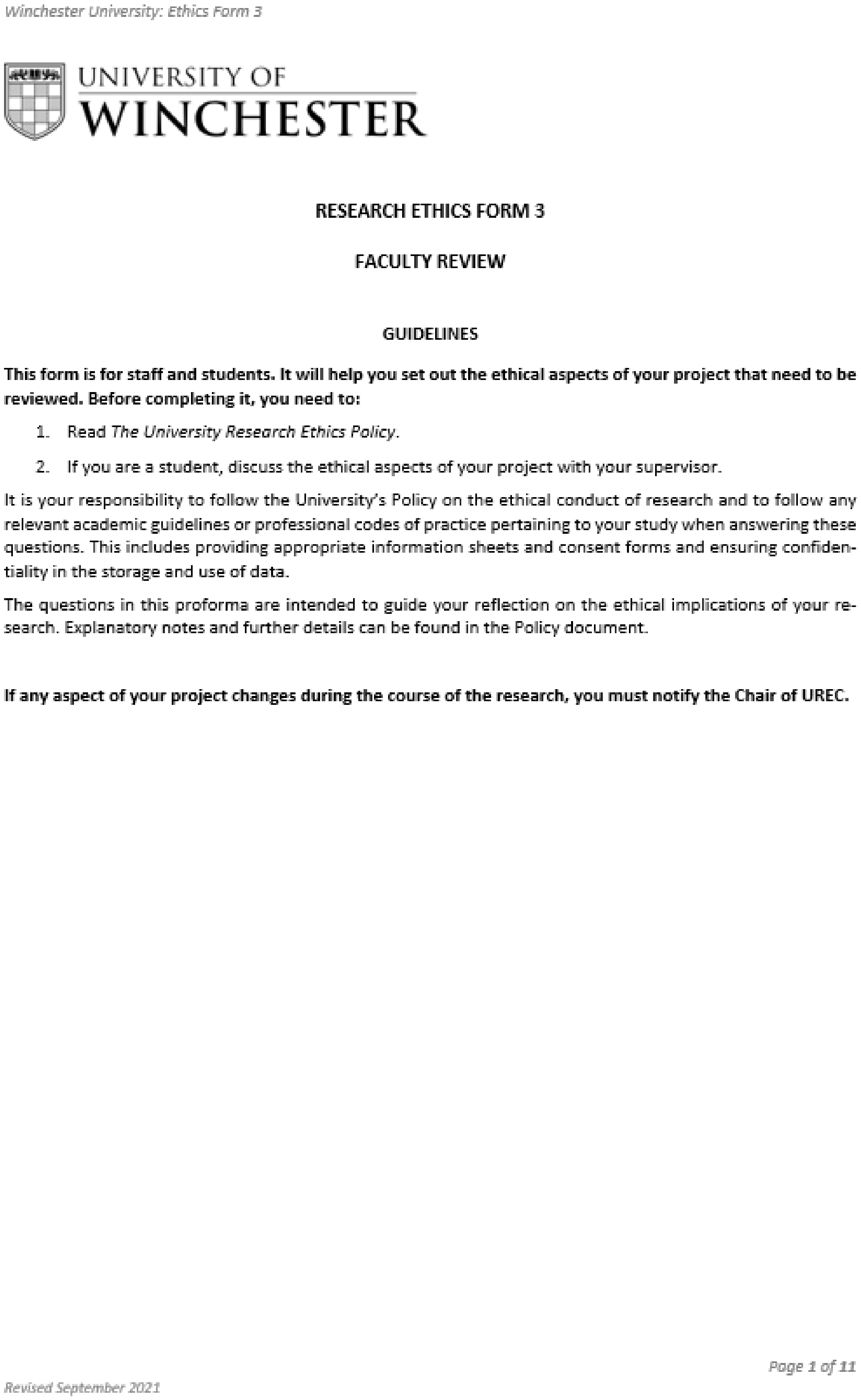
Name of Researcher: **Sarah Green**

Please initial box

1. I confirm that I have read the information sheet dated 26/11/22 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I agree to take part in the above study. ☐

________________________		
Name of Participant	Date	Signature
________________________	________________________	________
Name of Person seeking consent	Date	Signature

Appendix 9. University Ethics Form



Winchester University: Ethics Form 3

UNIVERSITY OF WINCHESTER

RESEARCH ETHICS FORM 3

FACULTY REVIEW

GUIDELINES

This form is for staff and students. It will help you set out the ethical aspects of your project that need to be reviewed. Before completing it, you need to:

1. Read *The University Research Ethics Policy*.
2. If you are a student, discuss the ethical aspects of your project with your supervisor.

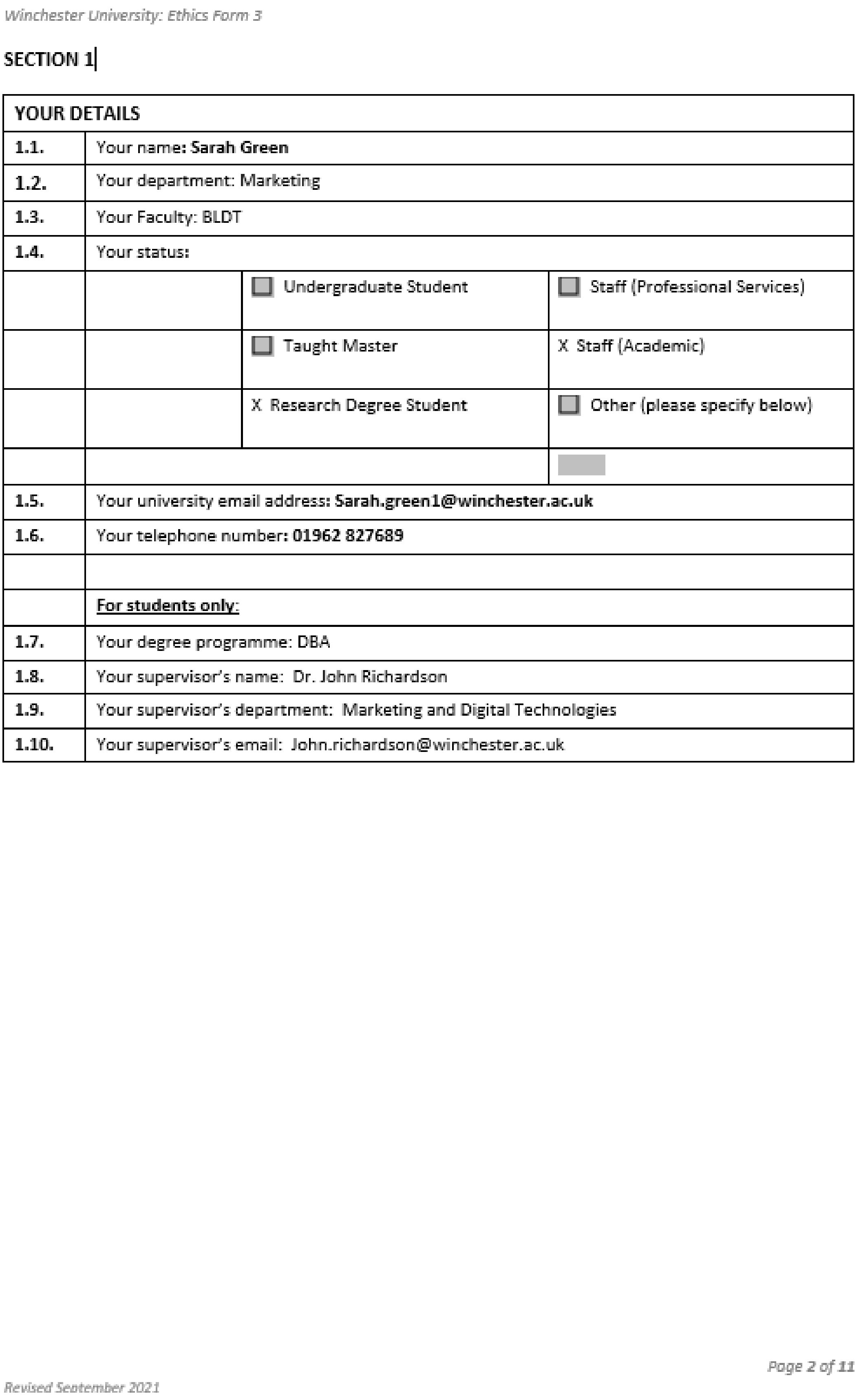
It is your responsibility to follow the University's Policy on the ethical conduct of research and to follow any relevant academic guidelines or professional codes of practice pertaining to your study when answering these questions. This includes providing appropriate information sheets and consent forms and ensuring confidentiality in the storage and use of data.

The questions in this proforma are intended to guide your reflection on the ethical implications of your research. Explanatory notes and further details can be found in the Policy document.

If any aspect of your project changes during the course of the research, you must notify the Chair of UREC.

Page 1 of 11

Revised September 2021



Winchester University: Ethics Form 3

SECTION 1

YOUR DETAILS			
1.1.	Your name: **Sarah Green**		
1.2.	Your department: Marketing		
1.3.	Your Faculty: BLDT		
1.4.	Your status:		
		☐ Undergraduate Student	☐ Staff (Professional Services)
		☐ Taught Master	X Staff (Academic)
		X Research Degree Student	☐ Other (please specify below)
1.5.	Your university email address: **Sarah.green1@winchester.ac.uk**		
1.6.	Your telephone number: **01962 827689**		
	<u>**For students only**</u>:		
1.7.	Your degree programme: DBA		
1.8.	Your supervisor's name: Dr. John Richardson		
1.9.	Your supervisor's department: Marketing and Digital Technologies		
1.10.	Your supervisor's email: John.richardson@winchester.ac.uk		

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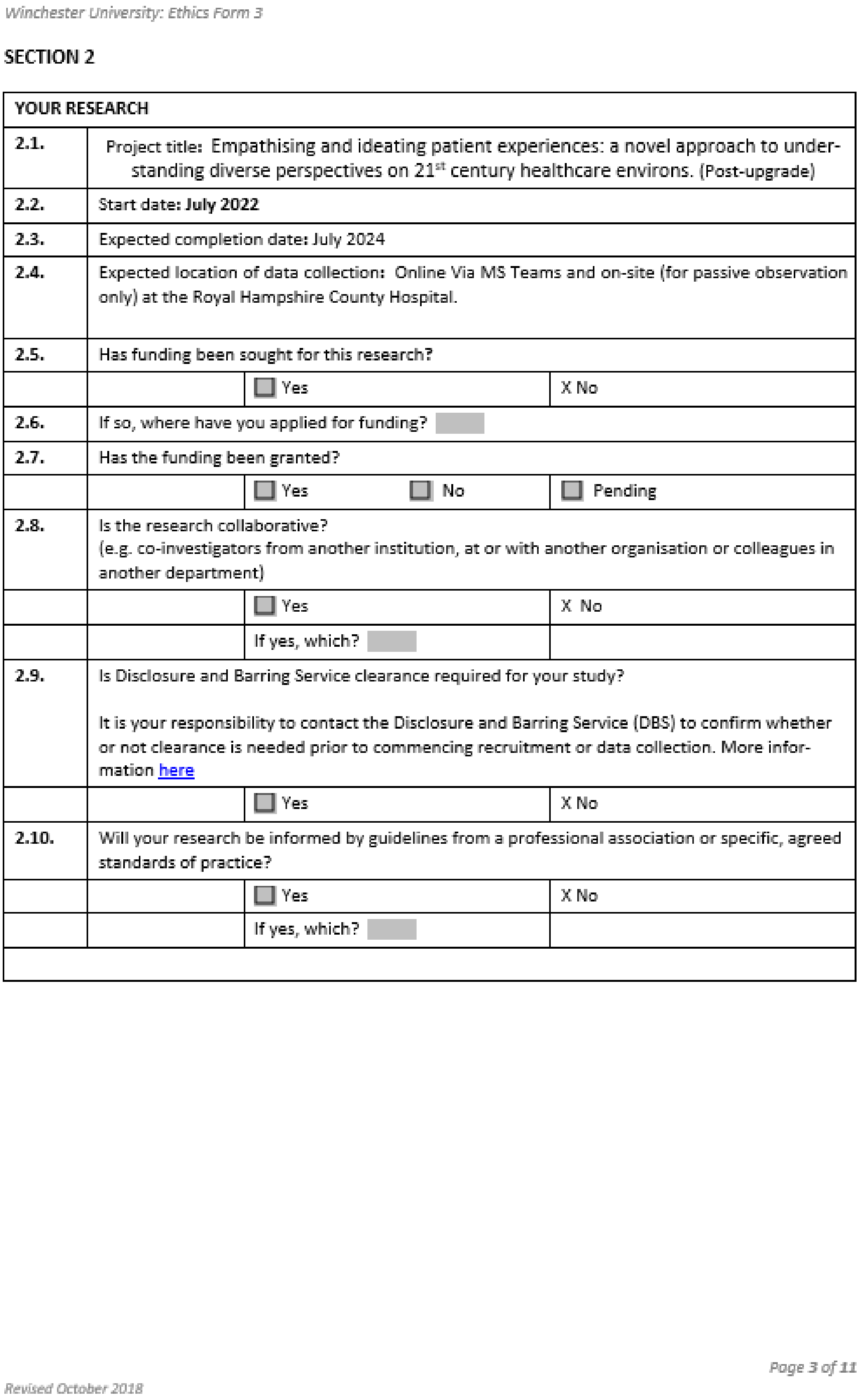
Revised September 2021



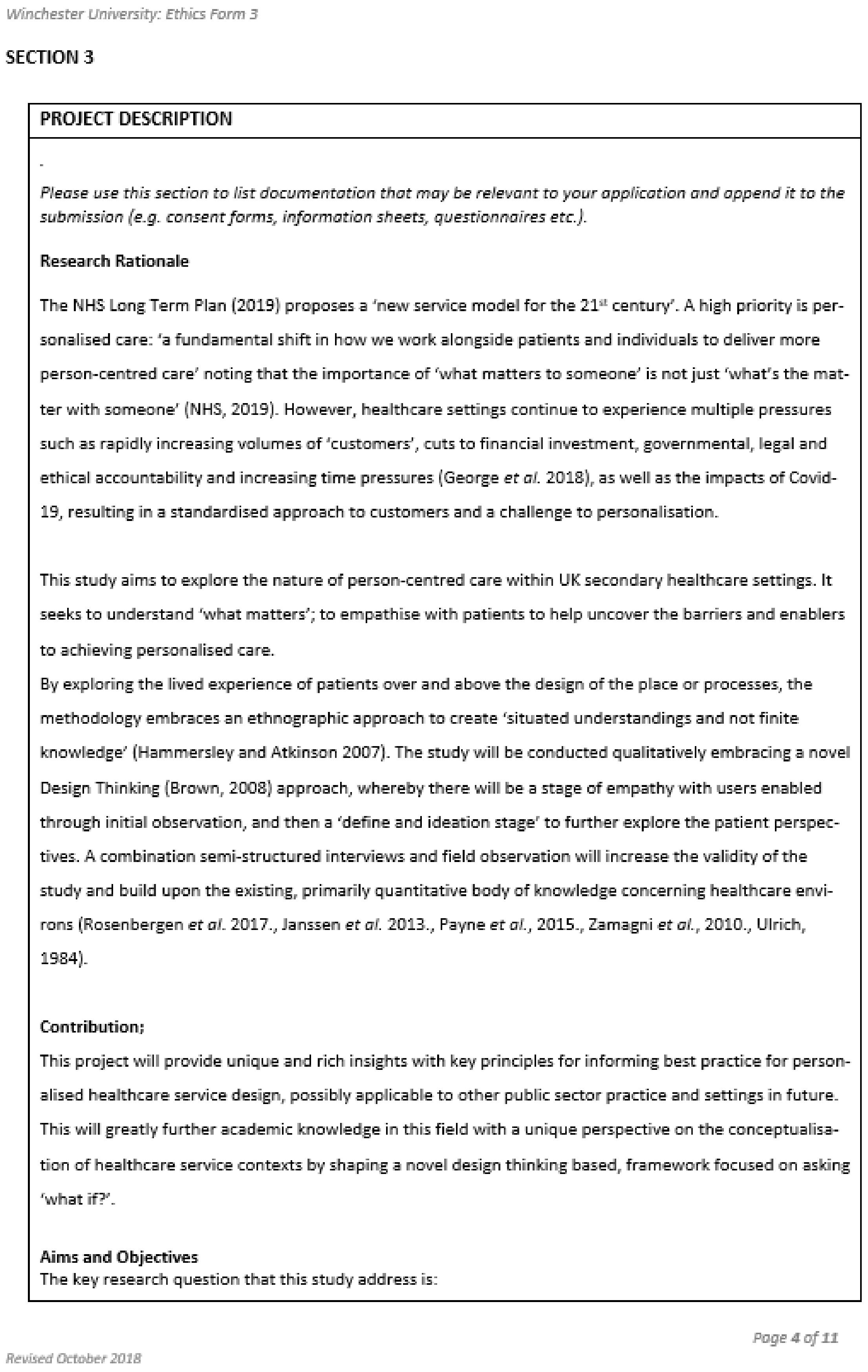
Winchester University: Ethics Form 3

SECTION 2

YOUR RESEARCH			
2.1.	Project title: Empathising and ideating patient experiences: a novel approach to understanding diverse perspectives on 21st century healthcare environs. (Post-upgrade)		
2.2.	Start date: **July 2022**		
2.3.	Expected completion date: July 2024		
2.4.	Expected location of data collection: Online Via MS Teams and on-site (for passive observation only) at the Royal Hampshire County Hospital.		
2.5.	Has funding been sought for this research?		
		☐ Yes	X No
2.6.	If so, where have you applied for funding?		
2.7.	Has the funding been granted?		
		☐ Yes ☐ No	☐ Pending
2.8.	Is the research collaborative? (e.g. co-investigators from another institution, at or with another organisation or colleagues in another department)		
		☐ Yes	X No
		If yes, which?	
2.9.	Is Disclosure and Barring Service clearance required for your study? It is your responsibility to contact the Disclosure and Barring Service (DBS) to confirm whether or not clearance is needed prior to commencing recruitment or data collection. More information here		
		☐ Yes	X No
2.10.	Will your research be informed by guidelines from a professional association or specific, agreed standards of practice?		
		☐ Yes	X No
		If yes, which?	

Page 3 of 11

Revised October 2018



Winchester University: Ethics Form 3

SECTION 3

PROJECT DESCRIPTION

Please use this section to list documentation that may be relevant to your application and append it to the submission (e.g. consent forms, information sheets, questionnaires etc.).

Research Rationale

The NHS Long Term Plan (2019) proposes a 'new service model for the 21st century'. A high priority is personalised care: 'a fundamental shift in how we work alongside patients and individuals to deliver more person-centred care' noting that the importance of 'what matters to someone' is not just 'what's the matter with someone' (NHS, 2019). However, healthcare settings continue to experience multiple pressures such as rapidly increasing volumes of 'customers', cuts to financial investment, governmental, legal and ethical accountability and increasing time pressures (George *et al.* 2018), as well as the impacts of Covid-19, resulting in a standardised approach to customers and a challenge to personalisation.

This study aims to explore the nature of person-centred care within UK secondary healthcare settings. It seeks to understand 'what matters'; to empathise with patients to help uncover the barriers and enablers to achieving personalised care.

By exploring the lived experience of patients over and above the design of the place or processes, the methodology embraces an ethnographic approach to create 'situated understandings and not finite knowledge' (Hammersley and Atkinson 2007). The study will be conducted qualitatively embracing a novel Design Thinking (Brown, 2008) approach, whereby there will be a stage of empathy with users enabled through initial observation, and then a 'define and ideation stage' to further explore the patient perspectives. A combination semi-structured interviews and field observation will increase the validity of the study and build upon the existing, primarily quantitative body of knowledge concerning healthcare environs (Rosenbergen *et al.* 2017., Janssen *et al.* 2013., Payne *et al.*, 2015., Zamagni *et al.*, 2010., Ulrich, 1984).

Contribution;

This project will provide unique and rich insights with key principles for informing best practice for personalised healthcare service design, possibly applicable to other public sector practice and settings in future. This will greatly further academic knowledge in this field with a unique perspective on the conceptualisation of healthcare service contexts by shaping a novel design thinking based, framework focused on asking 'what if?'.

Aims and Objectives

The key research question that this study address is:

Page 4 of 11

Revised October 2018

“What are patients’ perceptions of hospital spaces in Hampshire, UK, what are the barriers and enablers of positive patient experiences and what is the role of the ‘lived space’ in shaping person-centred care?”

The research objectives are therefore to:

1. critically analyse existing literature bringing together health and design thinking domains to identify opportunities to contribute to new knowledge on the topic of patient lived experience and the role of space therein;

2. understand patient perspectives on healthcare spaces in different qualities of setting (old and new) including how aspects of the ‘conceived space’ and the ‘perceived space’ impact their ‘lived space’;

3. advance the understanding of ‘lived spaces’ by the development of a novel framework that employs Design Thinking and Third Space principles;

4. leverage these research insights to devise recommendations for practitioners of patient-centered and ‘lived space’ design projects.

Methods

It has been valuable, through the literature review to date, to understand potential affinities in the findings and to review these across settings and patient conditions. However, the weakness of these studies has been a lack of focus on the patients’ general feelings, hopes and fears of their experience This study will be based upon a relativist ontology where reality is only created by the experiences and relationships between patients, visitors and staff at that time and place (Whittle, 2008).

This initial two stage method will consist of empirical enquiry where primary data is collected (Hammond and Wellington, 2013). This will be conducted through a sequential qualitative data gathering approach consisting of 1) ethnographic observation, 2) case-study interviews . There is potential for a third stage which would seek new ethics review.

1. Ethnographic observation.

Building upon the pilot study, and to further set the scene and provide context for this study, the initial phase will consist of in-situ passive observation of patient spaces by the researcher within two NHS Hampshire settings (Winchester and Basingstoke). This would either be within the main welcome/waiting areas (for ease of access and observations of initial wayfinding/onboarding) and/or on-ward if access is permitted. The aim *is not to interview participants at this stage* but just to note the various comings and goings over a period of up to two hours. This will be done through note-taking, photography or sketching but the aim is for the researcher to immerse themselves passively within the environs and make observations on the happenings and atmosphere. This will take place in the summer/autumn of 2022.

2. Qualitative Interviews - newer setting and older setting.

This phase will consider patient (and staff) experiences of a newer setting (Candover Clinic) followed by an older setting (Winchester RHCH). This phase will consider subjective reflections of the patients, as well as possible staff involved in the conceptualisation and delivery of the service and space, and therefore will provide an in-depth understanding on the issues and opportunities faced (Stokes and Wall, 2014). Topics will be informed by the themes from stage one as well as the literature review (see questions below).
The aim is to understand the challenges and opportunities for enriching patient visits, what patients might hope to experience during their care within healthcare spaces, and the current status quo in terms of how each space impacts patient's lived experiences. It is planned that these interviews (up to 10 in relation to each setting) may take place outside of the setting (eg. Via Teams/Zoom at the patient's home) as the focus is not on their condition (which they may be preoccupied with onsite) but on their reflections of their general experience. Any staff interviews would take place at the time and location of their preference. It is expected these would be between 45 minutes to one hour duration.

Following discussion with Hampshire Hospitals NHS Foundation Trust (HHFT), these participants will be recruited voluntarily (flyers will be available in the settings for them to come forward and contact the researcher). The research team at HHFT felt this was the most suitable method of recruiting participants given that no medical issues will be researched. An information sheet will be provided.

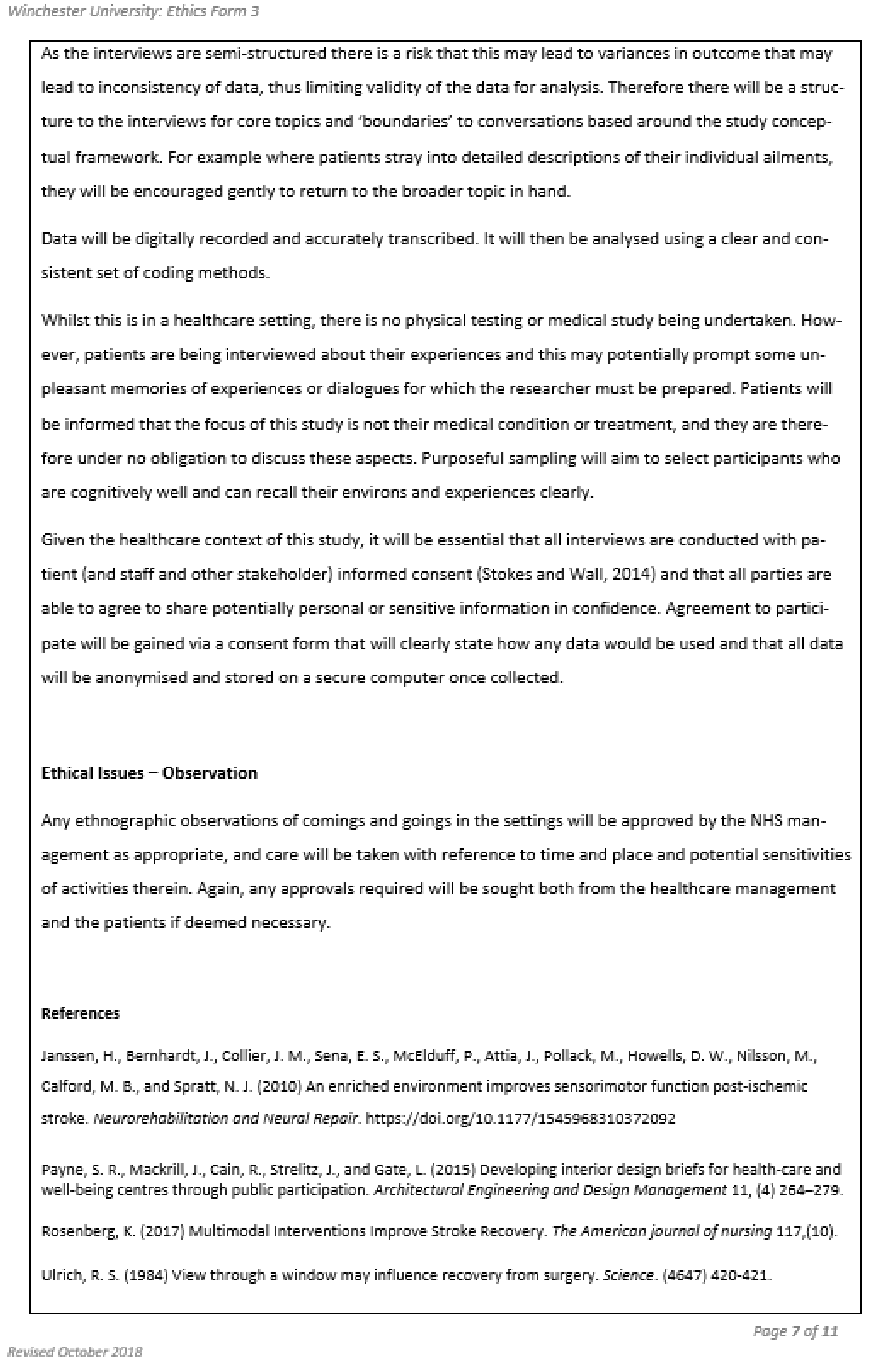
The intention is that groups would be regular outpatients and with potentially similar conditions where they have had to visit the setting more than once. As with the pilot study, open-ended questions will be posed concerning views on the immediate space, feelings on arrival and wayfinding etc. Clinical questions *will not* be asked.

3. Phase three - Prototype and ideation.

NOTE.
The third phase is under discussion following feedback from the recent successful upgrade viva.
It is not currently a requirement for ethical approval and may not go ahead. If this phase is to proceed, new ethical approval would be sought.

Data Analysis

Ethical Issues - Interviews



As the interviews are semi-structured there is a risk that this may lead to variances in outcome that may lead to inconsistency of data, thus limiting validity of the data for analysis. Therefore there will be a structure to the interviews for core topics and ‘boundaries’ to conversations based around the study conceptual framework. For example where patients stray into detailed descriptions of their individual ailments, they will be encouraged gently to return to the broader topic in hand.

Data will be digitally recorded and accurately transcribed. It will then be analysed using a clear and consistent set of coding methods.

Whilst this is in a healthcare setting, there is no physical testing or medical study being undertaken. However, patients are being interviewed about their experiences and this may potentially prompt some unpleasant memories of experiences or dialogues for which the researcher must be prepared. Patients will be informed that the focus of this study is not their medical condition or treatment, and they are therefore under no obligation to discuss these aspects. Purposeful sampling will aim to select participants who are cognitively well and can recall their environs and experiences clearly.

Given the healthcare context of this study, it will be essential that all interviews are conducted with patient (and staff and other stakeholder) informed consent (Stokes and Wall, 2014) and that all parties are able to agree to share potentially personal or sensitive information in confidence. Agreement to participate will be gained via a consent form that will clearly state how any data would be used and that all data will be anonymised and stored on a secure computer once collected.

Ethical Issues – Observation

Any ethnographic observations of comings and goings in the settings will be approved by the NHS management as appropriate, and care will be taken with reference to time and place and potential sensitivities of activities therein. Again, any approvals required will be sought both from the healthcare management and the patients if deemed necessary.

References

Janssen, H., Bernhardt, J., Collier, J. M., Sena, E. S., McElduff, P., Attia, J., Pollack, M., Howells, D. W., Nilsson, M., Calford, M. B., and Spratt, N. J. (2010) An enriched environment improves sensorimotor function post-ischemic stroke. *Neurorehabilitation and Neural Repair*. https://doi.org/10.1177/1545968310372092

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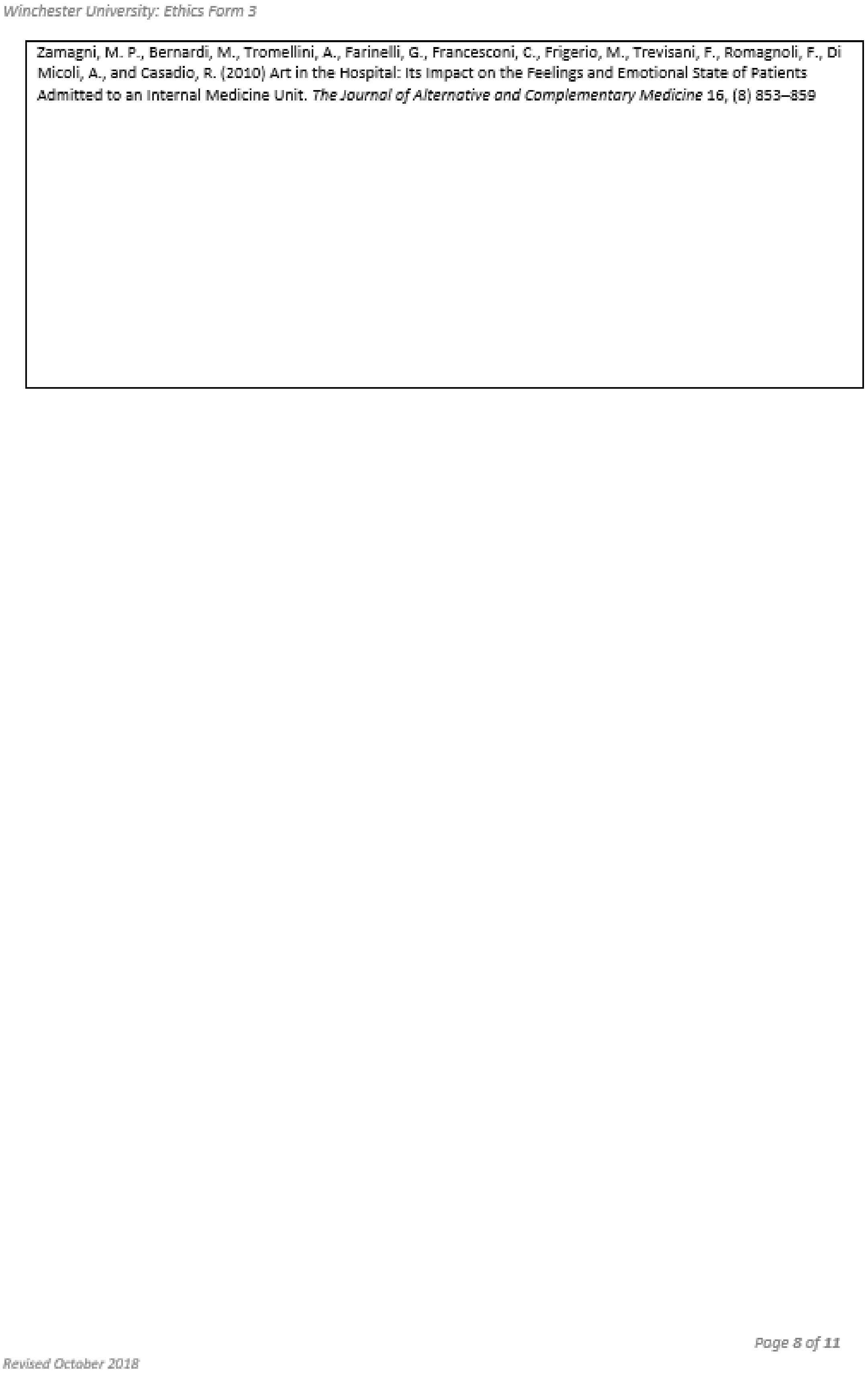
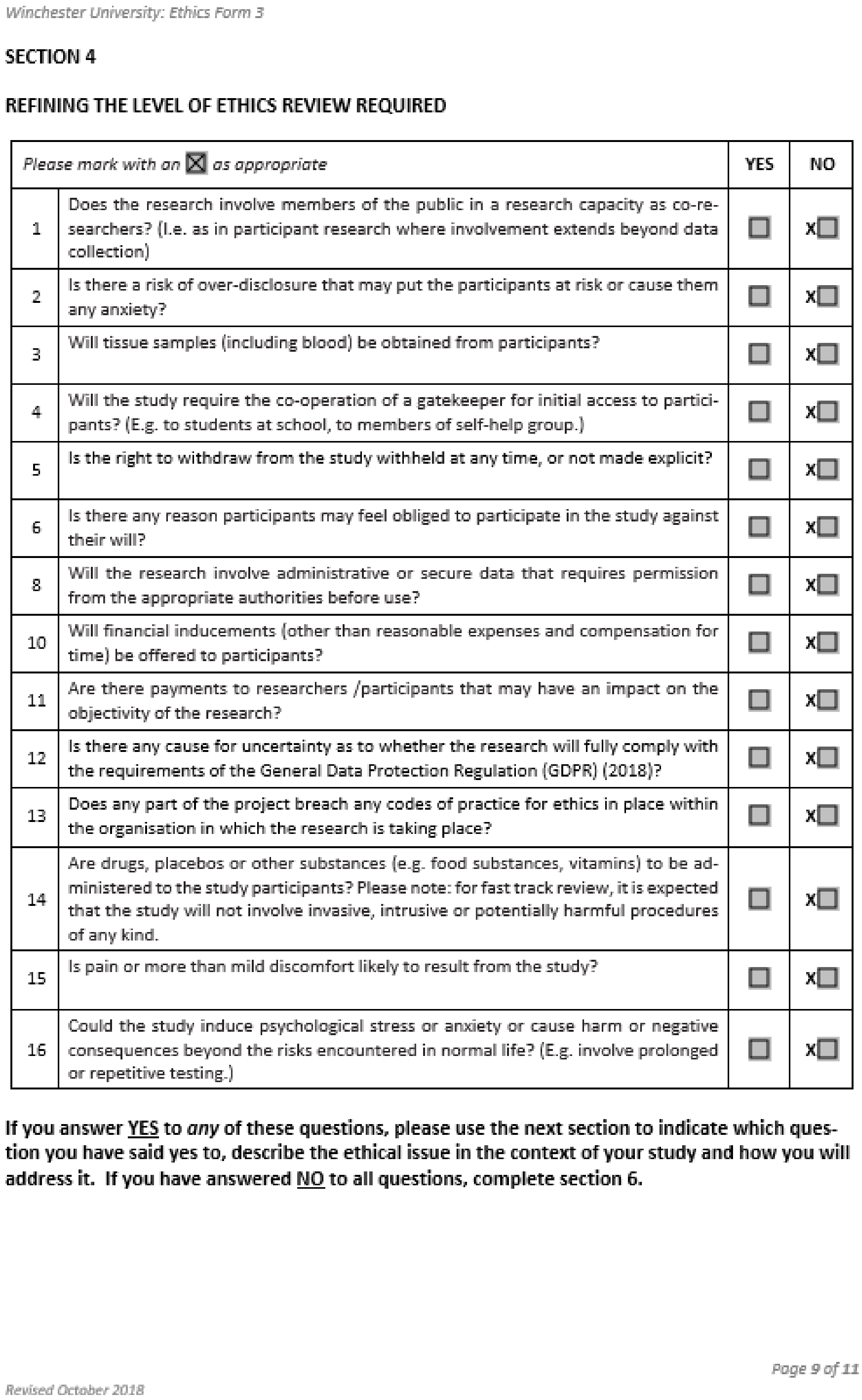
Rosenberg, K. (2017) Multimodal Interventions Improve Stroke Recovery. *The American journal of nursing* 117,(10).

Ulrich, R. S. (1984) View through a window may influence recovery from surgery. *Science*. (4647) 420-421.



Zamagni, M. P., Bernardi, M., Tromellini, A., Farinelli, G., Francesconi, C., Frigerio, M., Trevisani, F., Romagnoli, F., Di Micoli, A., and Casadio, R. (2010) Art in the Hospital: Its Impact on the Feelings and Emotional State of Patients Admitted to an Internal Medicine Unit. *The Journal of Alternative and Complementary Medicine* 16, (8) 853–859



SECTION 4

REFINING THE LEVEL OF ETHICS REVIEW REQUIRED

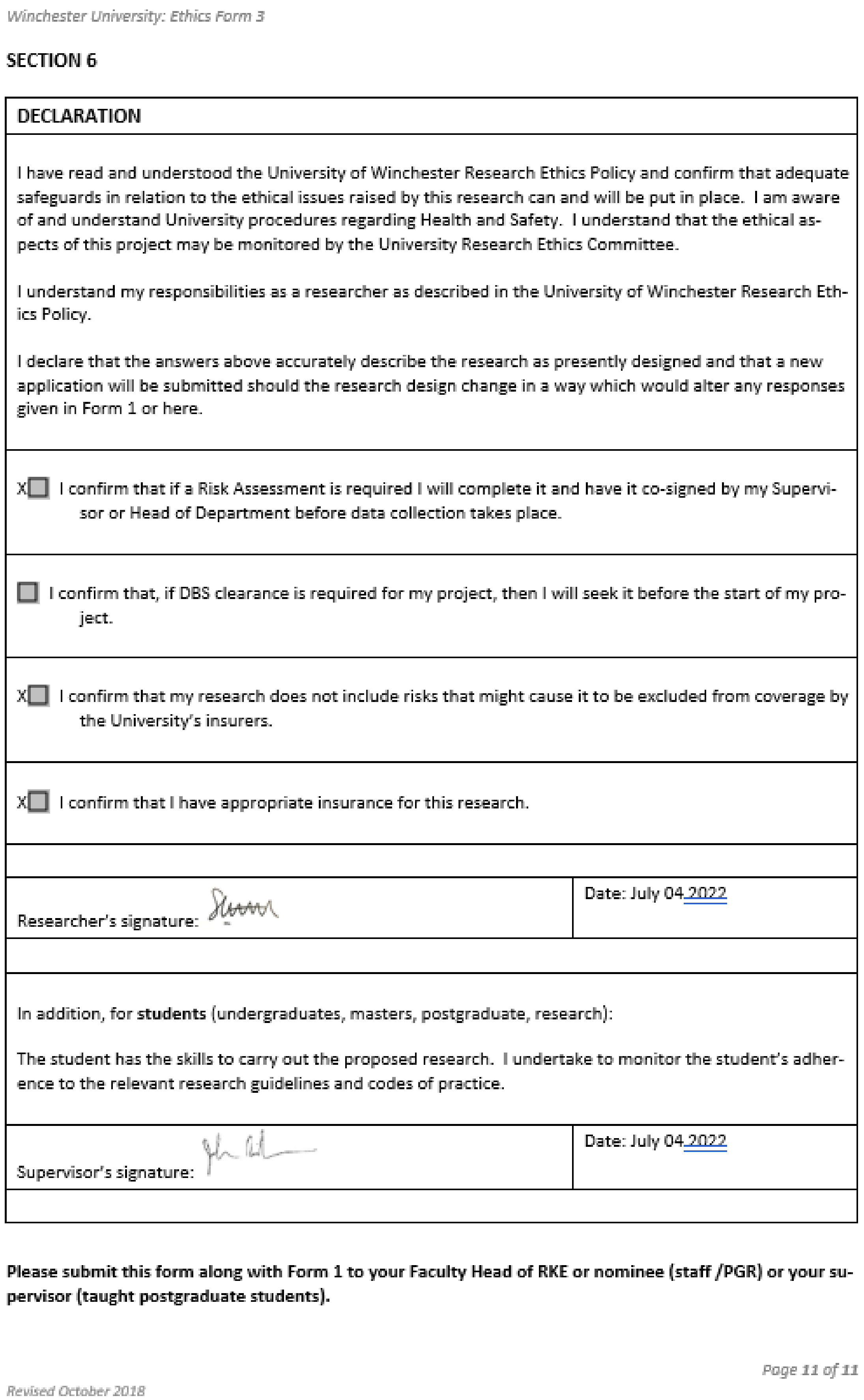
Please mark with an ☒ as appropriate		YES	NO
1	Does the research involve members of the public in a research capacity as co-researchers? (I.e. as in participant research where involvement extends beyond data collection)	☐	x☐
2	Is there a risk of over-disclosure that may put the participants at risk or cause them any anxiety?	☐	x☐
3	Will tissue samples (including blood) be obtained from participants?	☐	x☐
4	Will the study require the co-operation of a gatekeeper for initial access to participants? (E.g. to students at school, to members of self-help group.)	☐	x☐
5	Is the right to withdraw from the study withheld at any time, or not made explicit?	☐	x☐
6	Is there any reason participants may feel obliged to participate in the study against their will?	☐	x☐
8	Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?	☐	x☐
10	Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	x☐
11	Are there payments to researchers /participants that may have an impact on the objectivity of the research?	☐	x☐
12	Is there any cause for uncertainty as to whether the research will fully comply with the requirements of the General Data Protection Regulation (GDPR) (2018)?	☐	x☐
13	Does any part of the project breach any codes of practice for ethics in place within the organisation in which the research is taking place?	☐	x☐
14	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants? Please note: for fast track review, it is expected that the study will not involve invasive, intrusive or potentially harmful procedures of any kind.	☐	x☐
15	Is pain or more than mild discomfort likely to result from the study?	☐	x☐
16	Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life? (E.g. involve prolonged or repetitive testing.)	☐	x☐

If you answer YES to *any* of these questions, please use the next section to indicate which question you have said yes to, describe the ethical issue in the context of your study and how you will address it. If you have answered NO to all questions, complete section 6.

SECTION 5

ADDITIONAL INFORMATION AND AMENDMENTS

Use this space to address ethical issues highlighted by the checklist in section 4, or to amend an original submission.



Winchester University: Ethics Form 3

SECTION 6

DECLARATION

I have read and understood the University of Winchester Research Ethics Policy and confirm that adequate safeguards in relation to the ethical issues raised by this research can and will be put in place. I am aware of and understand University procedures regarding Health and Safety. I understand that the ethical aspects of this project may be monitored by the University Research Ethics Committee.

I understand my responsibilities as a researcher as described in the University of Winchester Research Ethics Policy.

I declare that the answers above accurately describe the research as presently designed and that a new application will be submitted should the research design change in a way which would alter any responses given in Form 1 or here.

X☐ I confirm that if a Risk Assessment is required I will complete it and have it co-signed by my Supervisor or Head of Department before data collection takes place.

☐ I confirm that, if DBS clearance is required for my project, then I will seek it before the start of my project.

X☐ I confirm that my research does not include risks that might cause it to be excluded from coverage by the University's insurers.

X☐ I confirm that I have appropriate insurance for this research.

Researcher's signature:	Date: July 04 2022

In addition, for **students** (undergraduates, masters, postgraduate, research):

The student has the skills to carry out the proposed research. I undertake to monitor the student's adherence to the relevant research guidelines and codes of practice.

Supervisor's signature:	Date: July 04 2022

Please submit this form along with Form 1 to your Faculty Head of RKE or nominee (staff /PGR) or your supervisor (taught postgraduate students).

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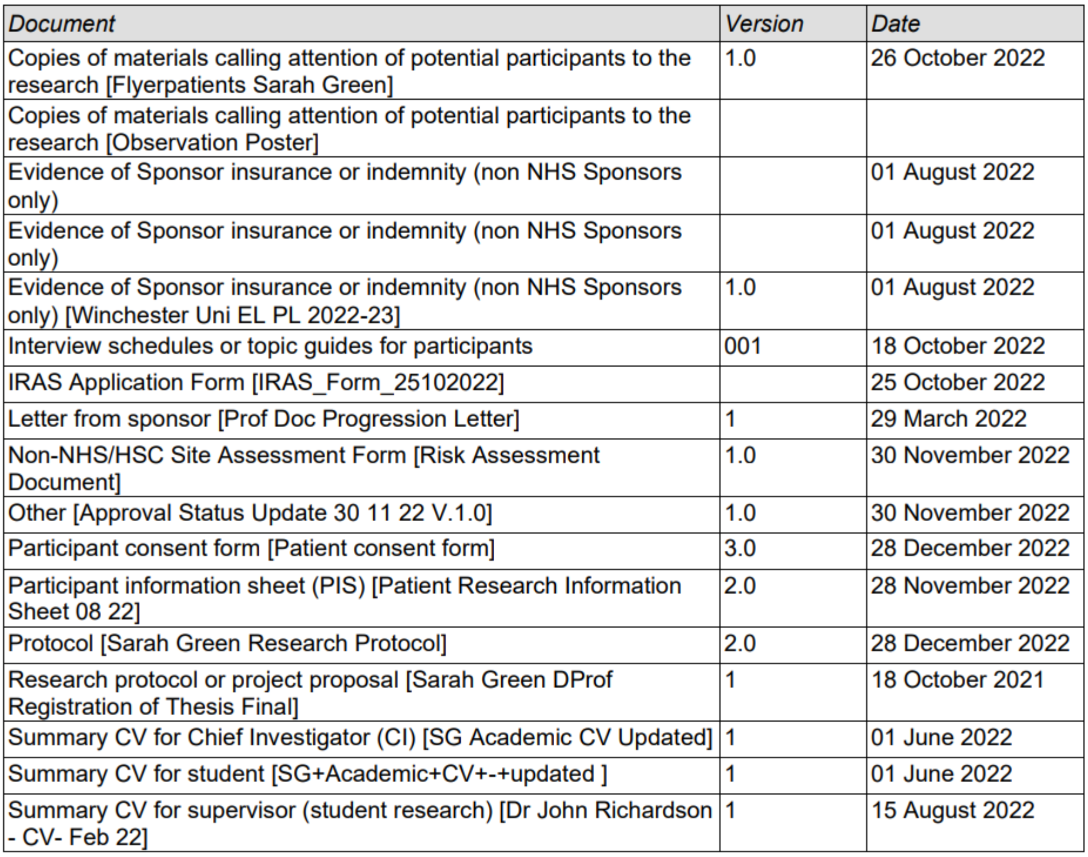
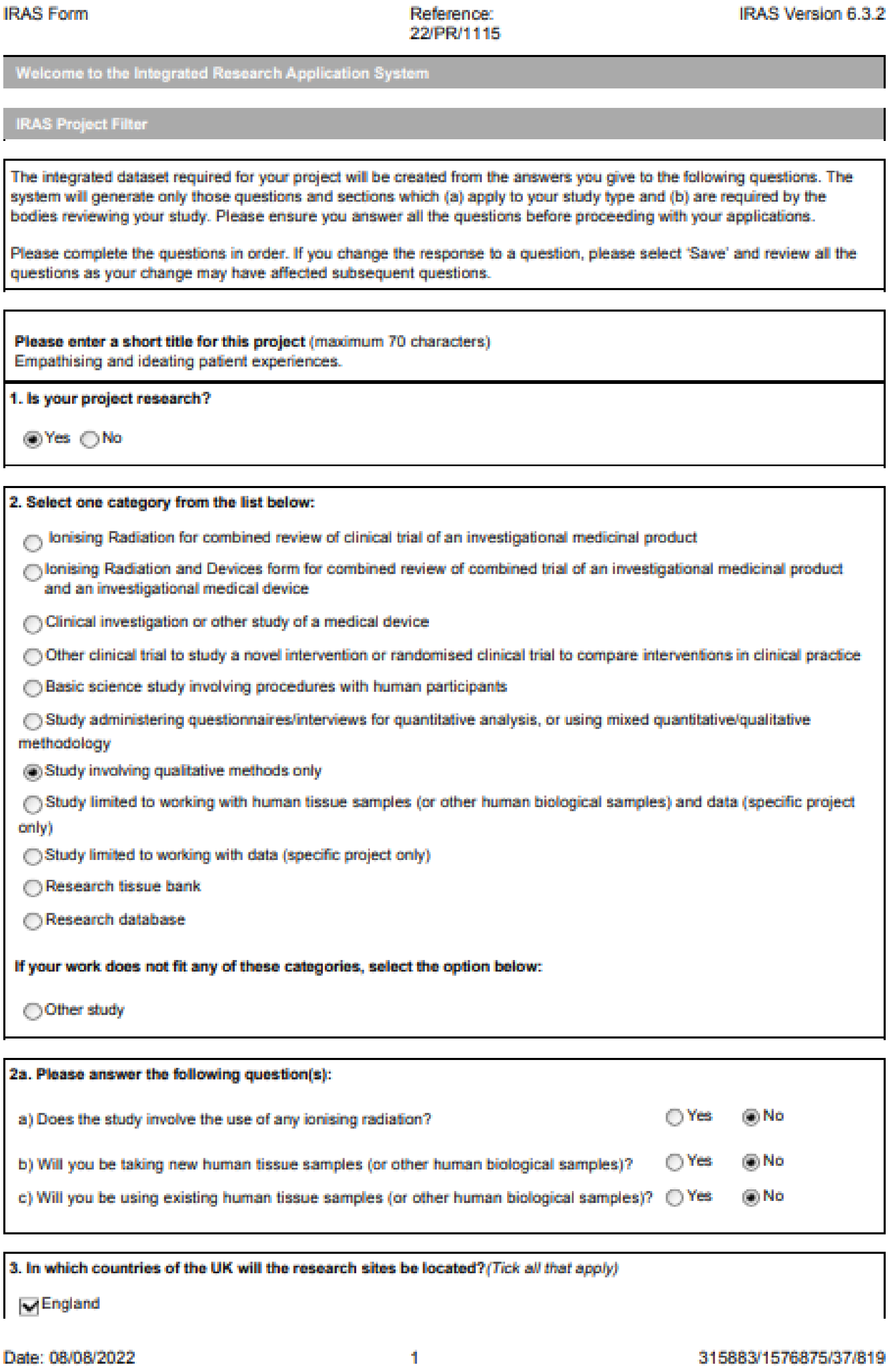
Revised October 2018

Appendix 10. List of Documents Submitted to IRAS



Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Flyerpatients Sarah Green]	1.0	26 October 2022
Copies of materials calling attention of potential participants to the research [Observation Poster]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 August 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 August 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Winchester Uni EL PL 2022-23]	1.0	01 August 2022
Interview schedules or topic guides for participants	001	18 October 2022
IRAS Application Form [IRAS_Form_25102022]		25 October 2022
Letter from sponsor [Prof Doc Progression Letter]	1	29 March 2022
Non-NHS/HSC Site Assessment Form [Risk Assessment Document]	1.0	30 November 2022
Other [Approval Status Update 30 11 22 V.1.0]	1.0	30 November 2022
Participant consent form [Patient consent form]	3.0	28 December 2022
Participant information sheet (PIS) [Patient Research Information Sheet 08 22]	2.0	28 November 2022
Protocol [Sarah Green Research Protocol]	2.0	28 December 2022
Research protocol or project proposal [Sarah Green DProf Registration of Thesis Final]	1	18 October 2021
Summary CV for Chief Investigator (CI) [SG Academic CV Updated]	1	01 June 2022
Summary CV for student [SG+Academic+CV+-+updated]	1	01 June 2022
Summary CV for supervisor (student research) [Dr John Richardson - CV- Feb 22]	1	15 August 2022

Appendix 11. IRAS Form Submitted for NHS Ethics Approval



IRAS Form | Reference: 22/PR/1115 | IRAS Version 6.3.2

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Empathising and ideating patient experiences.

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

- ○ Ionising Radiation for combined review of clinical trial of an investigational medicinal product
- ○ Ionising Radiation and Devices form for combined review of combined trial of an investigational medicinal product and an investigational medical device
- ○ Clinical investigation or other study of a medical device
- ○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ○ Basic science study involving procedures with human participants
- ○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ● Study involving qualitative methods only
- ○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ○ Study limited to working with data (specific project only)
- ○ Research tissue bank
- ○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

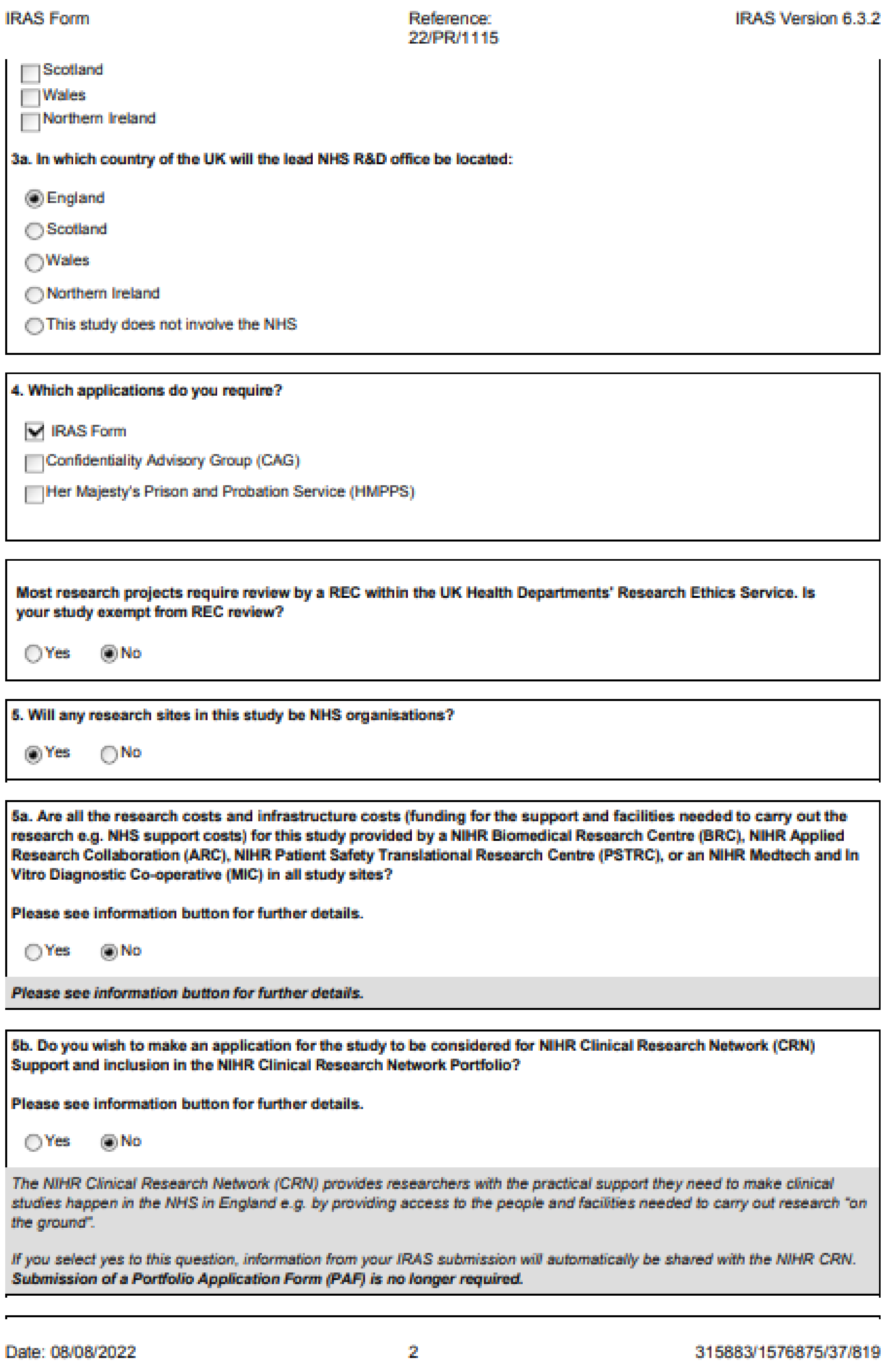
2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England

Date: 08/08/2022 1 315883/1576875/37/819



☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes ● No

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.

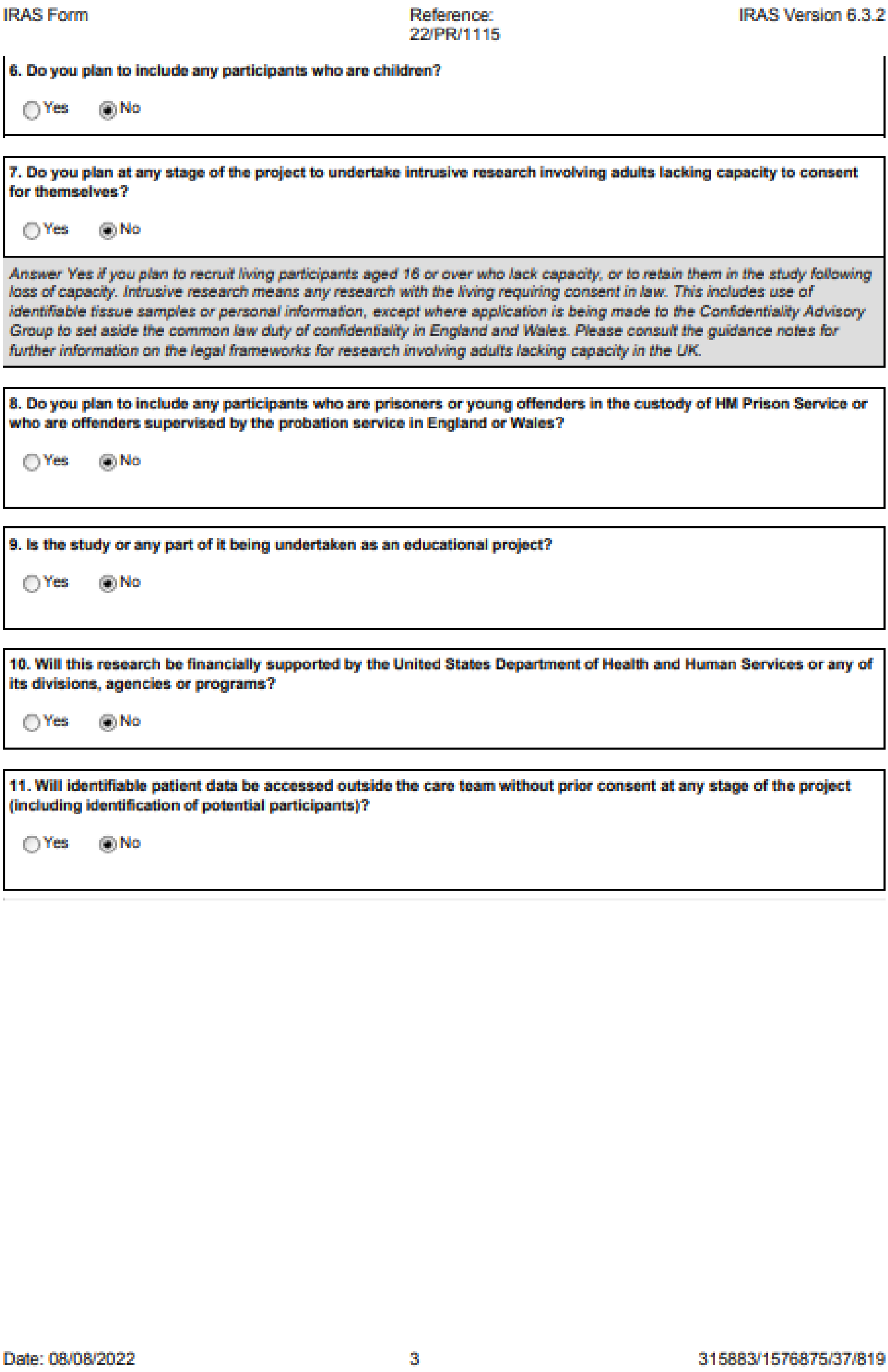
5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***



IRAS Form | Reference: 22/PR/1115 | IRAS Version 6.3.2

6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

○ Yes ● No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

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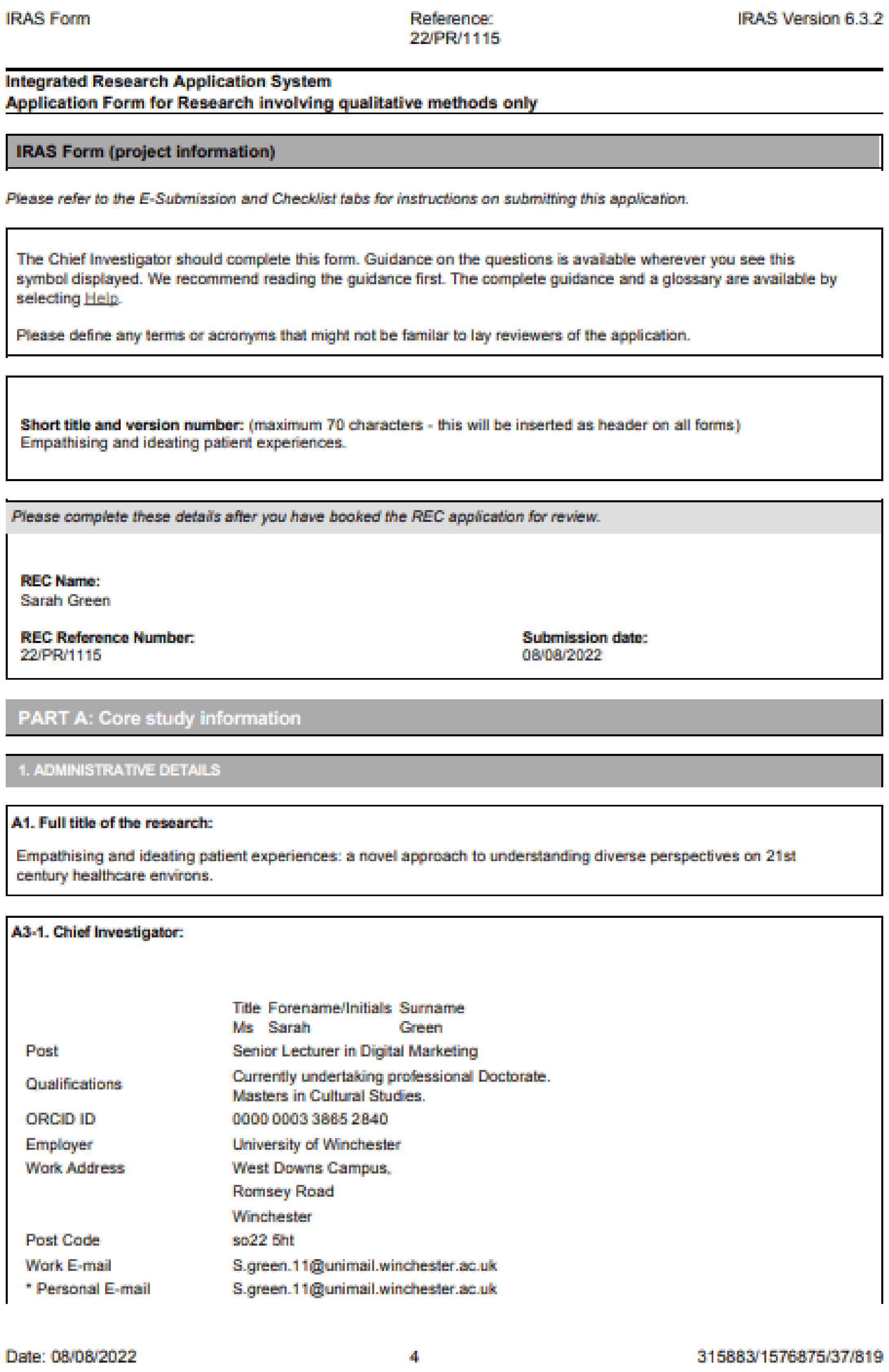


Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Empathising and ideating patient experiences.

Please complete these details after you have booked the REC application for review.

REC Name:
Sarah Green

REC Reference Number:
22/PR/1115

Submission date:
08/08/2022

PART A: Core study information

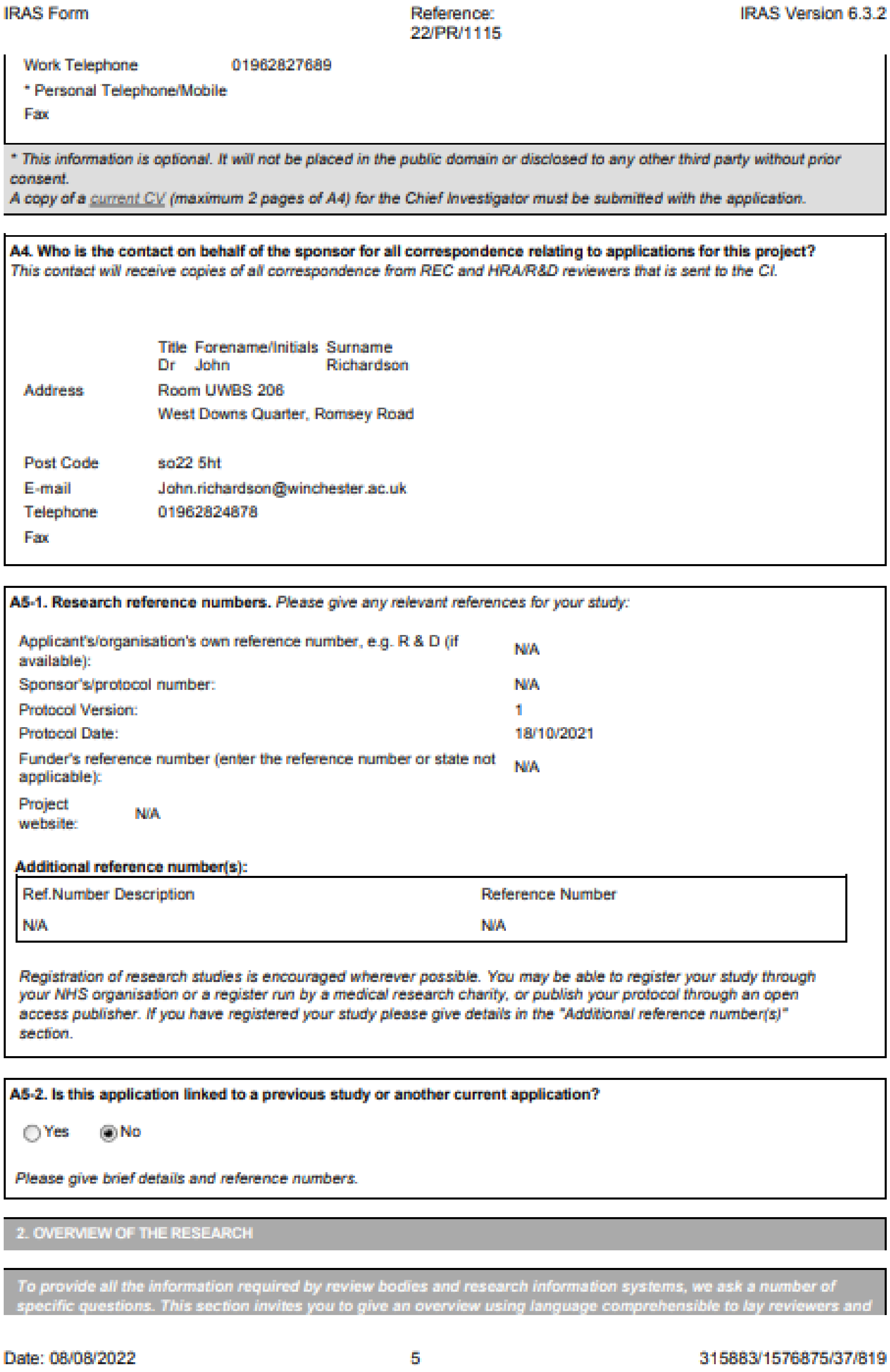
1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Empathising and ideating patient experiences: a novel approach to understanding diverse perspectives on 21st century healthcare environs.

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Ms	Sarah	Green
Post	Senior Lecturer in Digital Marketing		
Qualifications	Currently undertaking professional Doctorate. Masters in Cultural Studies.		
ORCID ID	0000 0003 3865 2840		
Employer	University of Winchester		
Work Address	West Downs Campus, Romsey Road Winchester		
Post Code	so22 5ht		
Work E-mail	S.green.11@unimail.winchester.ac.uk		
* Personal E-mail	S.green.11@unimail.winchester.ac.uk		



IRAS Form | Reference: 22/PR/1115 | IRAS Version 6.3.2

Work Telephone	01962827689
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Dr	John	Richardson

Address: Room UWBS 206
West Downs Quarter, Romsey Road

Post Code: so22 5ht
E-mail: John.richardson@winchester.ac.uk
Telephone: 01962824878
Fax:

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	1
Protocol Date:	18/10/2021
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number
N/A	N/A

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and

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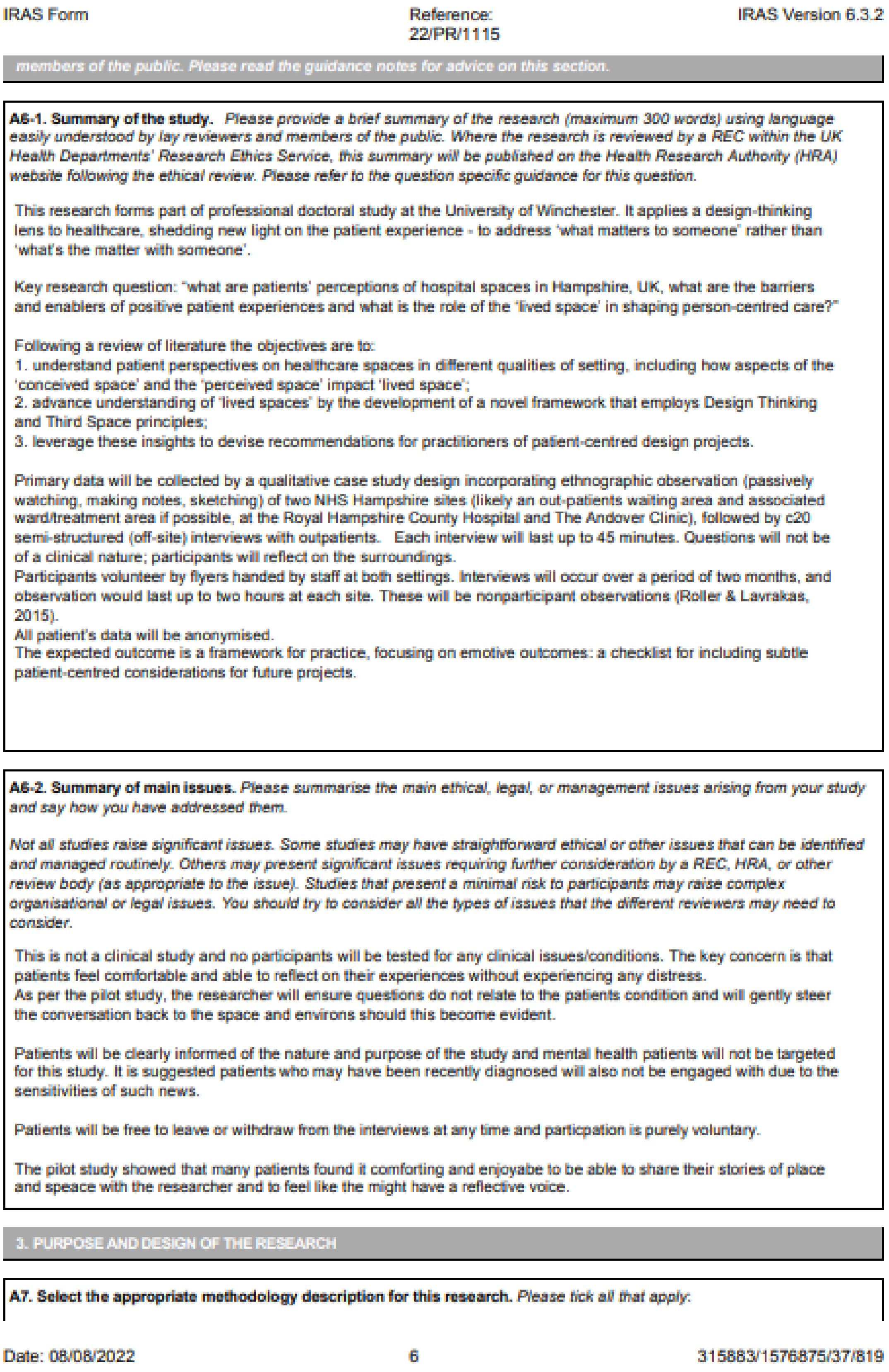


members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This research forms part of professional doctoral study at the University of Winchester. It applies a design-thinking lens to healthcare, shedding new light on the patient experience - to address 'what matters to someone' rather than 'what's the matter with someone'.

Key research question: "what are patients' perceptions of hospital spaces in Hampshire, UK, what are the barriers and enablers of positive patient experiences and what is the role of the 'lived space' in shaping person-centred care?"

Following a review of literature the objectives are to:
1. understand patient perspectives on healthcare spaces in different qualities of setting, including how aspects of the 'conceived space' and the 'perceived space' impact 'lived space';
2. advance understanding of 'lived spaces' by the development of a novel framework that employs Design Thinking and Third Space principles;
3. leverage these insights to devise recommendations for practitioners of patient-centred design projects.

Primary data will be collected by a qualitative case study design incorporating ethnographic observation (passively watching, making notes, sketching) of two NHS Hampshire sites (likely an out-patients waiting area and associated ward/treatment area if possible, at the Royal Hampshire County Hospital and The Andover Clinic), followed by c20 semi-structured (off-site) interviews with outpatients. Each interview will last up to 45 minutes. Questions will not be of a clinical nature; participants will reflect on the surroundings.
Participants volunteer by flyers handed by staff at both settings. Interviews will occur over a period of two months, and observation would last up to two hours at each site. These will be nonparticipant observations (Roller & Lavrakas, 2015).
All patient's data will be anonymised.
The expected outcome is a framework for practice, focusing on emotive outcomes: a checklist for including subtle patient-centred considerations for future projects.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

This is not a clinical study and no participants will be tested for any clinical issues/conditions. The key concern is that patients feel comfortable and able to reflect on their experiences without experiencing any distress.
As per the pilot study, the researcher will ensure questions do not relate to the patients condition and will gently steer the conversation back to the space and environs should this become evident.

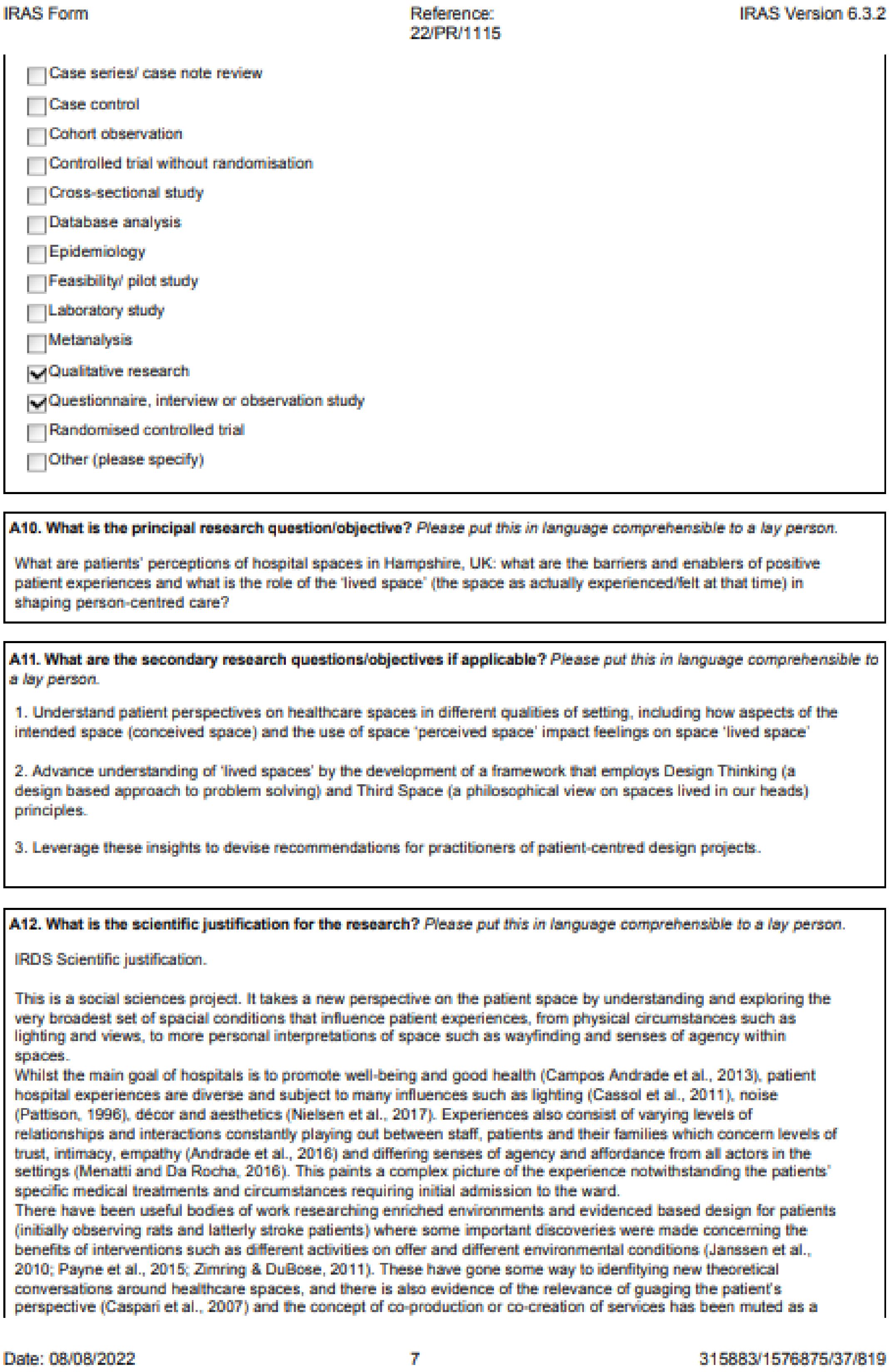
Patients will be clearly informed of the nature and purpose of the study and mental health patients will not be targeted for this study. It is suggested patients who may have been recently diagnosed will also not be engaged with due to the sensitivities of such news.

Patients will be free to leave or withdraw from the interviews at any time and particpation is purely voluntary.

The pilot study showed that many patients found it comforting and enjoyabe to be able to share their stories of place and speace with the researcher and to feel like the might have a reflective voice.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*



☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation
☐ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study
☐ Laboratory study
☐ Metanalysis
☑ Qualitative research
☑ Questionnaire, interview or observation study
☐ Randomised controlled trial
☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What are patients' perceptions of hospital spaces in Hampshire, UK: what are the barriers and enablers of positive patient experiences and what is the role of the 'lived space' (the space as actually experienced/felt at that time) in shaping person-centred care?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

1. Understand patient perspectives on healthcare spaces in different qualities of setting, including how aspects of the intended space (conceived space) and the use of space 'perceived space' impact feelings on space 'lived space'

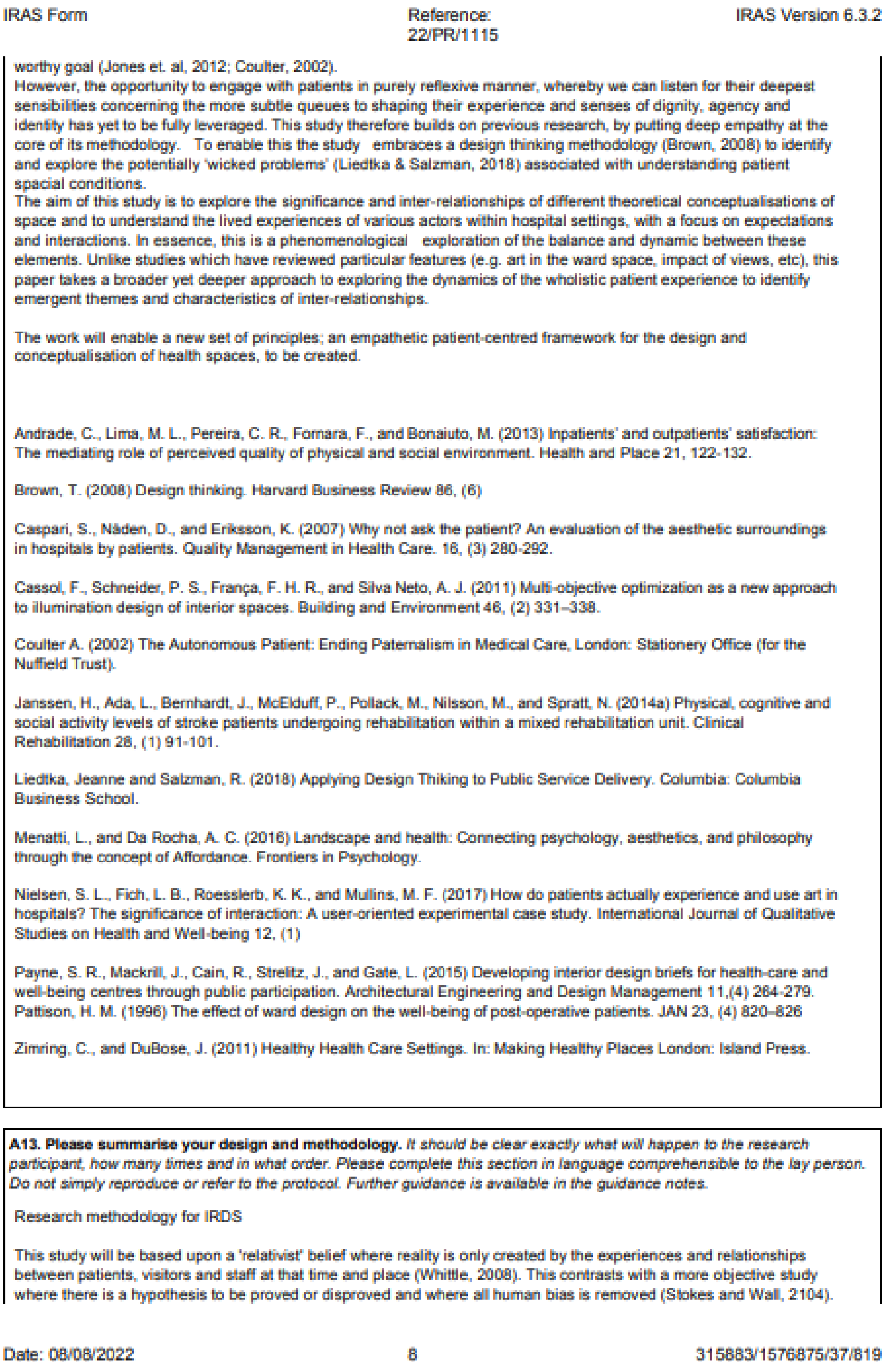
2. Advance understanding of 'lived spaces' by the development of a framework that employs Design Thinking (a design based approach to problem solving) and Third Space (a philosophical view on spaces lived in our heads) principles.

3. Leverage these insights to devise recommendations for practitioners of patient-centred design projects.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

IRDS Scientific justification.

This is a social sciences project. It takes a new perspective on the patient space by understanding and exploring the very broadest set of spacial conditions that influence patient experiences, from physical circumstances such as lighting and views, to more personal interpretations of space such as wayfinding and senses of agency within spaces.
Whilst the main goal of hospitals is to promote well-being and good health (Campos Andrade et al., 2013), patient hospital experiences are diverse and subject to many influences such as lighting (Cassol et al., 2011), noise (Pattison, 1996), décor and aesthetics (Nielsen et al., 2017). Experiences also consist of varying levels of relationships and interactions constantly playing out between staff, patients and their families which concern levels of trust, intimacy, empathy (Andrade et al., 2016) and differing senses of agency and affordance from all actors in the settings (Menatti and Da Rocha, 2016). This paints a complex picture of the experience notwithstanding the patients' specific medical treatments and circumstances requiring initial admission to the ward.
There have been useful bodies of work researching enriched environments and evidenced based design for patients (initially observing rats and latterly stroke patients) where some important discoveries were made concerning the benefits of interventions such as different activities on offer and different environmental conditions (Janssen et al., 2010; Payne et al., 2015; Zimring & DuBose, 2011). These have gone some way to idenfitying new theoretical conversations around healthcare spaces, and there is also evidence of the relevance of guaging the patient's perspective (Caspari et al., 2007) and the concept of co-production or co-creation of services has been muted as a



worthy goal (Jones et. al, 2012; Coulter, 2002).
However, the opportunity to engage with patients in purely reflexive manner, whereby we can listen for their deepest sensibilities concerning the more subtle queues to shaping their experience and senses of dignity, agency and identity has yet to be fully leveraged. This study therefore builds on previous research, by putting deep empathy at the core of its methodology. To enable this the study embraces a design thinking methodology (Brown, 2008) to identify and explore the potentially 'wicked problems' (Liedtka & Salzman, 2018) associated with understanding patient spacial conditions.
The aim of this study is to explore the significance and inter-relationships of different theoretical conceptualisations of space and to understand the lived experiences of various actors within hospital settings, with a focus on expectations and interactions. In essence, this is a phenomenological exploration of the balance and dynamic between these elements. Unlike studies which have reviewed particular features (e.g. art in the ward space, impact of views, etc), this paper takes a broader yet deeper approach to exploring the dynamics of the wholistic patient experience to identify emergent themes and characteristics of inter-relationships.

The work will enable a new set of principles; an empathetic patient-centred framework for the design and conceptualisation of health spaces, to be created.

Andrade, C., Lima, M. L., Pereira, C. R., Fornara, F., and Bonaiuto, M. (2013) Inpatients' and outpatients' satisfaction: The mediating role of perceived quality of physical and social environment. Health and Place 21, 122-132.

Brown, T. (2008) Design thinking. Harvard Business Review 86, (6)

Caspari, S., Nåden, D., and Eriksson, K. (2007) Why not ask the patient? An evaluation of the aesthetic surroundings in hospitals by patients. Quality Management in Health Care. 16, (3) 280-292.

Cassol, F., Schneider, P. S., França, F. H. R., and Silva Neto, A. J. (2011) Multi-objective optimization as a new approach to illumination design of interior spaces. Building and Environment 46, (2) 331–338.

Coulter A. (2002) The Autonomous Patient: Ending Paternalism in Medical Care, London: Stationery Office (for the Nuffield Trust).

Janssen, H., Ada, L., Bernhardt, J., McElduff, P., Pollack, M., Nilsson, M., and Spratt, N. (2014a) Physical, cognitive and social activity levels of stroke patients undergoing rehabilitation within a mixed rehabilitation unit. Clinical Rehabilitation 28, (1) 91-101.

Liedtka, Jeanne and Salzman, R. (2018) Applying Design Thiking to Public Service Delivery. Columbia: Columbia Business School.

Menatti, L., and Da Rocha, A. C. (2016) Landscape and health: Connecting psychology, aesthetics, and philosophy through the concept of Affordance. Frontiers in Psychology.

Nielsen, S. L., Fich, L. B., Roesslerb, K. K., and Mullins, M. F. (2017) How do patients actually experience and use art in hospitals? The significance of interaction: A user-oriented experimental case study. International Journal of Qualitative Studies on Health and Well-being 12, (1)

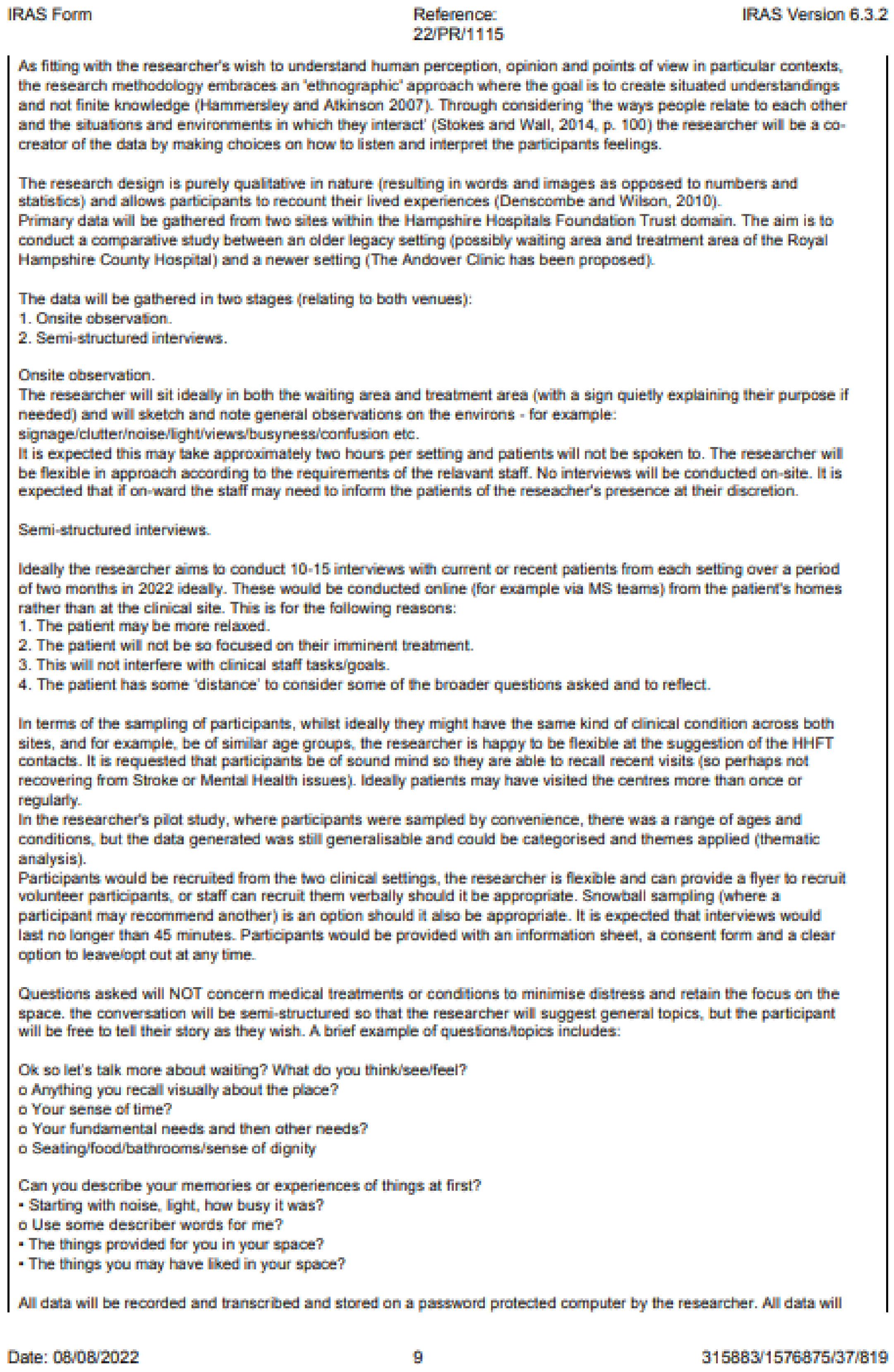
Payne, S. R., Mackrill, J., Cain, R., Strelitz, J., and Gate, L. (2015) Developing interior design briefs for health-care and well-being centres through public participation. Architectural Engineering and Design Management 11,(4) 264-279.
Pattison, H. M. (1996) The effect of ward design on the well-being of post-operative patients. JAN 23, (4) 820–826

Zimring, C., and DuBose, J. (2011) Healthy Health Care Settings. In: Making Healthy Places London: Island Press.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Research methodology for IRDS

This study will be based upon a 'relativist' belief where reality is only created by the experiences and relationships between patients, visitors and staff at that time and place (Whittle, 2008). This contrasts with a more objective study where there is a hypothesis to be proved or disproved and where all human bias is removed (Stokes and Wall, 2104).



As fitting with the researcher's wish to understand human perception, opinion and points of view in particular contexts, the research methodology embraces an 'ethnographic' approach where the goal is to create situated understandings and not finite knowledge (Hammersley and Atkinson 2007). Through considering 'the ways people relate to each other and the situations and environments in which they interact' (Stokes and Wall, 2014, p. 100) the researcher will be a co-creator of the data by making choices on how to listen and interpret the participants feelings.

The research design is purely qualitative in nature (resulting in words and images as opposed to numbers and statistics) and allows participants to recount their lived experiences (Denscombe and Wilson, 2010).
Primary data will be gathered from two sites within the Hampshire Hospitals Foundation Trust domain. The aim is to conduct a comparative study between an older legacy setting (possibly waiting area and treatment area of the Royal Hampshire County Hospital) and a newer setting (The Andover Clinic has been proposed).

The data will be gathered in two stages (relating to both venues):
1. Onsite observation.
2. Semi-structured interviews.

Onsite observation.
The researcher will sit ideally in both the waiting area and treatment area (with a sign quietly explaining their purpose if needed) and will sketch and note general observations on the environs - for example: signage/clutter/noise/light/views/busyness/confusion etc.
It is expected this may take approximately two hours per setting and patients will not be spoken to. The researcher will be flexible in approach according to the requirements of the relavant staff. No interviews will be conducted on-site. It is expected that if on-ward the staff may need to inform the patients of the reseacher's presence at their discretion.

Semi-structured interviews.

Ideally the researcher aims to conduct 10-15 interviews with current or recent patients from each setting over a period of two months in 2022 ideally. These would be conducted online (for example via MS teams) from the patient's homes rather than at the clinical site. This is for the following reasons:
1. The patient may be more relaxed.
2. The patient will not be so focused on their imminent treatment.
3. This will not interfere with clinical staff tasks/goals.
4. The patient has some 'distance' to consider some of the broader questions asked and to reflect.

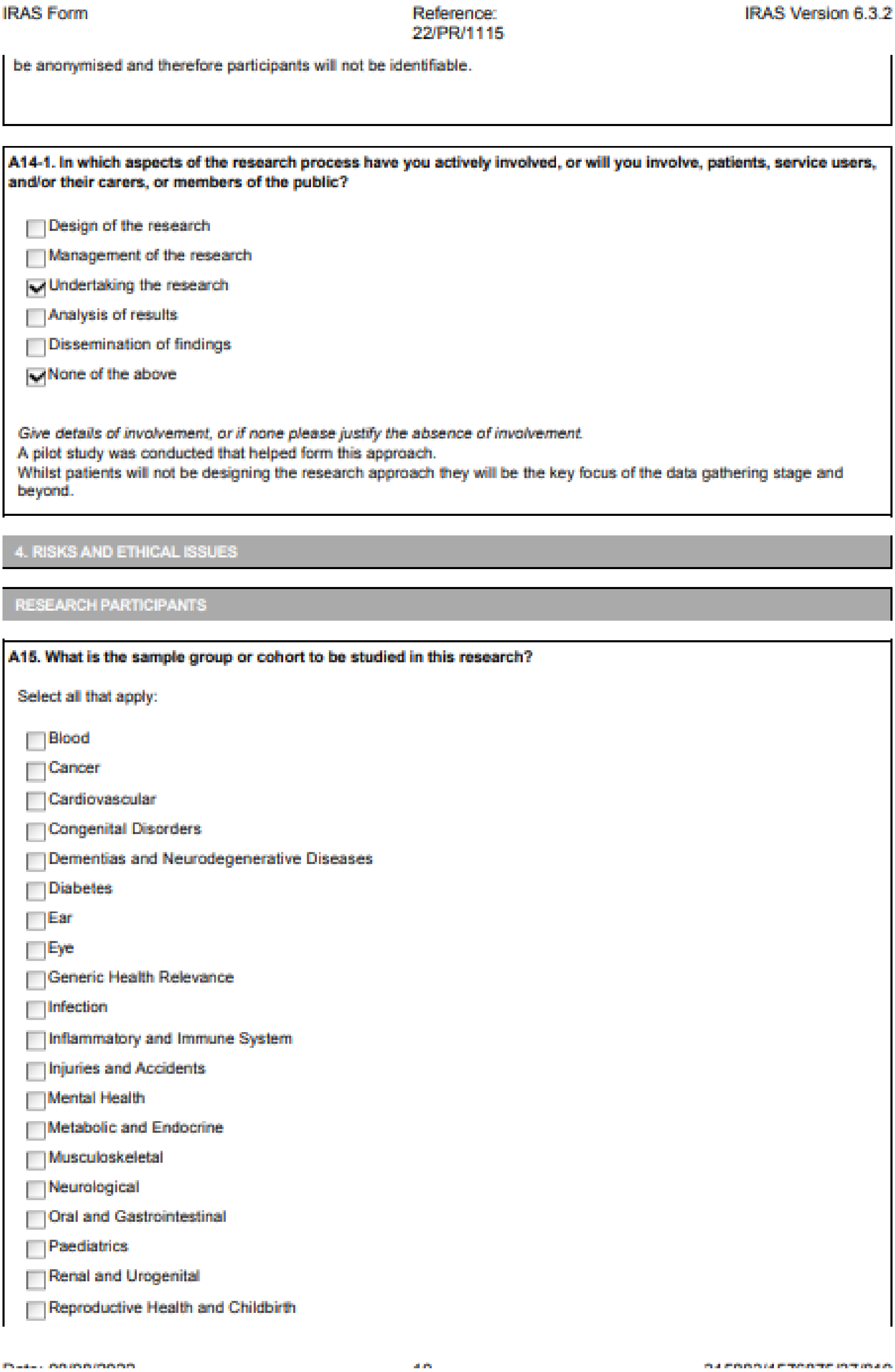
In terms of the sampling of participants, whilst ideally they might have the same kind of clinical condition across both sites, and for example, be of similar age groups, the researcher is happy to be flexible at the suggestion of the HHFT contacts. It is requested that participants be of sound mind so they are able to recall recent visits (so perhaps not recovering from Stroke or Mental Health issues). Ideally patients may have visited the centres more than once or regularly.
In the researcher's pilot study, where participants were sampled by convenience, there was a range of ages and conditions, but the data generated was still generalisable and could be categorised and themes applied (thematic analysis).
Participants would be recruited from the two clinical settings, the researcher is flexible and can provide a flyer to recruit volunteer participants, or staff can recruit them verbally should it be appropriate. Snowball sampling (where a participant may recommend another) is an option should it also be appropriate. It is expected that interviews would last no longer than 45 minutes. Participants would be provided with an information sheet, a consent form and a clear option to leave/opt out at any time.

Questions asked will NOT concern medical treatments or conditions to minimise distress and retain the focus on the space. the conversation will be semi-structured so that the researcher will suggest general topics, but the participant will be free to tell their story as they wish. A brief example of questions/topics includes:

Ok so let's talk more about waiting? What do you think/see/feel?
o Anything you recall visually about the place?
o Your sense of time?
o Your fundamental needs and then other needs?
o Seating/food/bathrooms/sense of dignity

Can you describe your memories or experiences of things at first?
- Starting with noise, light, how busy it was?
o Use some describer words for me?
- The things provided for you in your space?
- The things you may have liked in your space?

All data will be recorded and transcribed and stored on a password protected computer by the researcher. All data will



be anonymised and therefore participants will not be identifiable.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☐ Design of the research
☐ Management of the research
☑ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
A pilot study was conducted that helped form this approach.
Whilst patients will not be designing the research approach they will be the key focus of the data gathering stage and beyond.

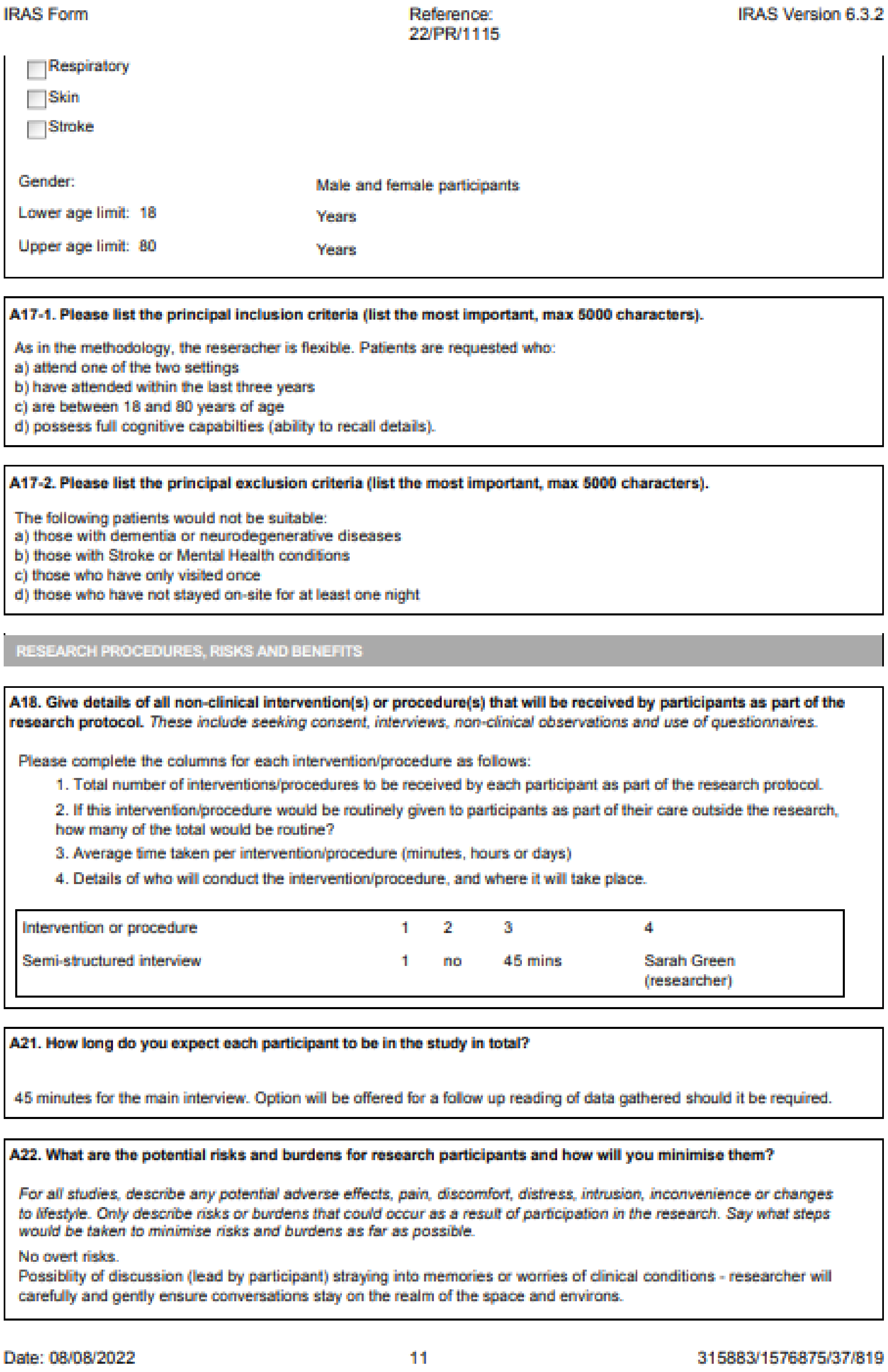
4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System
☐ Injuries and Accidents
☐ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☐ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth



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☐ Respiratory
☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 80	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

As in the methodology, the reseracher is flexible. Patients are requested who:
a) attend one of the two settings
b) have attended within the last three years
c) are between 18 and 80 years of age
d) possess full cognitive capabilties (ability to recall details).

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

The following patients would not be suitable:
a) those with dementia or neurodegenerative diseases
b) those with Stroke or Mental Health conditions
c) those who have only visited once
d) those who have not stayed on-site for at least one night

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Semi-structured interview	1	no	45 mins	Sarah Green (researcher)

A21. How long do you expect each participant to be in the study in total?

45 minutes for the main interview. Option will be offered for a follow up reading of data gathered should it be required.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

No overt risks.
Possiblity of discussion (lead by participant) straying into memories or worries of clinical conditions - researcher will carefully and gently ensure conversations stay on the realm of the space and environs.

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A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

○ Yes ● No

A24. What is the potential for benefit to research participants?

The participant may enjoy or feel some sense of being listened to by being able to tell their story and share their views. The outcomes of the study could result in some of the recommendations being implemented - thus creating improvements to the space and ther experiences of it.

A26. What are the potential risks for the researchers themselves? *(if any)*

None expected

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Initially the expecation was that participants would be sourced by the direct care team.
Further to discussions it was suggested that the researcher might create a flyer from which patients may volunteer.
The researcher is flexible but does require the HHFT team to suggest two settings and therefore examples of groups of patients who might be a good fit.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

● Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

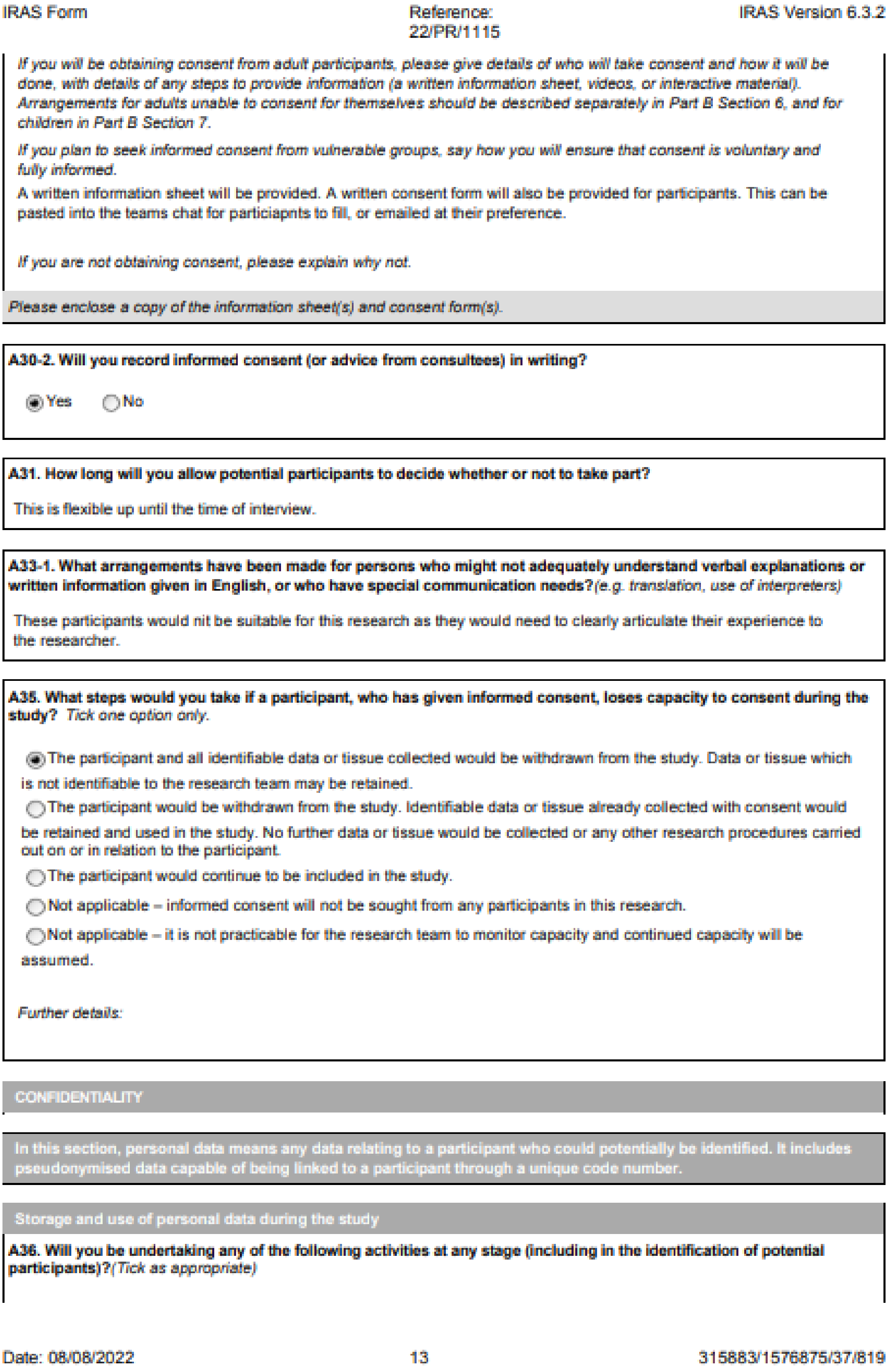
This is at the discretion of the HHFT reserach team but it is expected that, if required, they may either place these in a waiting area or hand them to patients.
The leaflet has not been created yet as may not be required. The reseracher will take the HHFT team's lead on this.

A29. How and by whom will potential participants first be approached?

By members of staff at the two settings tbc.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No



If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

A written information sheet will be provided. A written consent form will also be provided for participants. This can be pasted into the teams chat for particiapnts to fill, or emailed at their preference.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

This is flexible up until the time of interview.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

These participants would nit be suitable for this research as they would need to clearly articulate their experience to the researcher.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

● The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

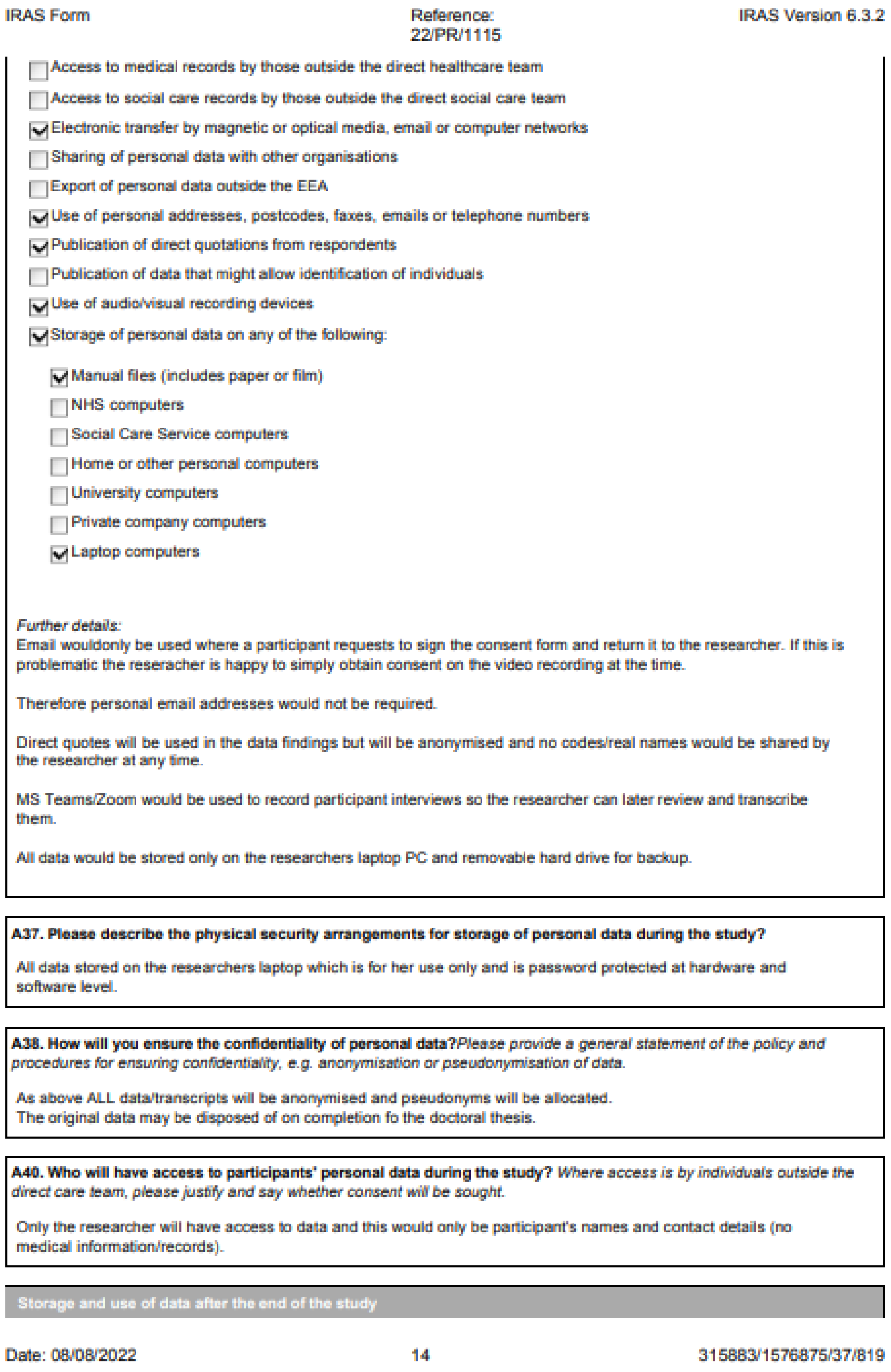
Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*



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☐ Access to medical records by those outside the direct healthcare team
☐ Access to social care records by those outside the direct social care team
☑ Electronic transfer by magnetic or optical media, email or computer networks
☐ Sharing of personal data with other organisations
☐ Export of personal data outside the EEA
☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:

  ☑ Manual files (includes paper or film)
  ☐ NHS computers
  ☐ Social Care Service computers
  ☐ Home or other personal computers
  ☐ University computers
  ☐ Private company computers
  ☑ Laptop computers

Further details:
Email wouldonly be used where a participant requests to sign the consent form and return it to the researcher. If this is problematic the reseracher is happy to simply obtain consent on the video recording at the time.

Therefore personal email addresses would not be required.

Direct quotes will be used in the data findings but will be anonymised and no codes/real names would be shared by the researcher at any time.

MS Teams/Zoom would be used to record participant interviews so the researcher can later review and transcribe them.

All data would be stored only on the researchers laptop PC and removable hard drive for backup.

A37. Please describe the physical security arrangements for storage of personal data during the study?

All data stored on the researchers laptop which is for her use only and is password protected at hardware and software level.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

As above ALL data/transcripts will be anonymised and pseudonyms will be allocated.
The original data may be disposed of on completion fo the doctoral thesis.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the researcher will have access to data and this would only be participant's names and contact details (no medical information/records).

Storage and use of data after the end of the study

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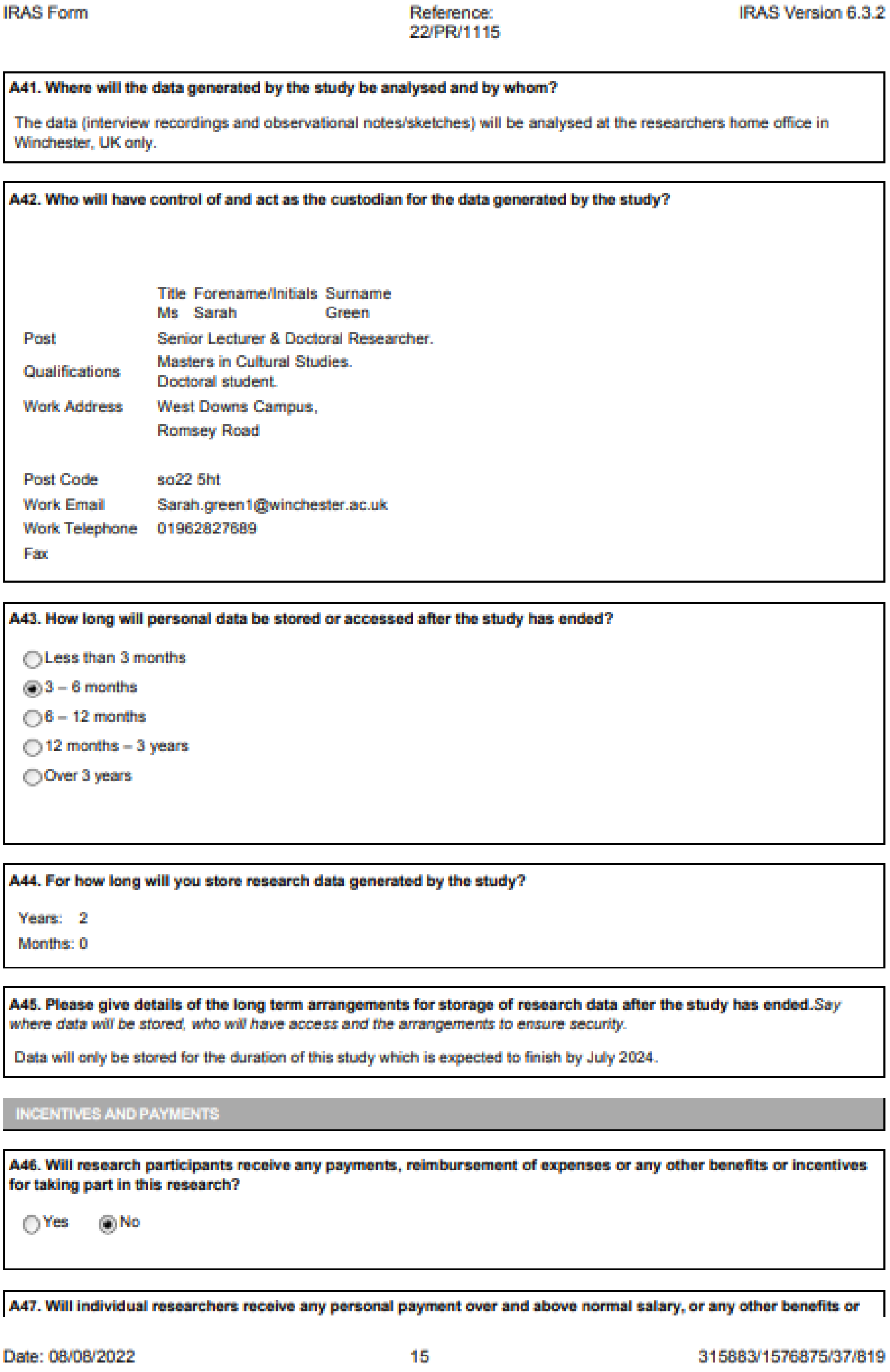


A41. Where will the data generated by the study be analysed and by whom?

The data (interview recordings and observational notes/sketches) will be analysed at the researchers home office in Winchester, UK only.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title Forename/Initials Surname Ms Sarah Green
Post	Senior Lecturer & Doctoral Researcher.
Qualifications	Masters in Cultural Studies. Doctoral student.
Work Address	West Downs Campus, Romsey Road
Post Code	so22 5ht
Work Email	Sarah.green1@winchester.ac.uk
Work Telephone	01962827689
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

○ Less than 3 months
● 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 2
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

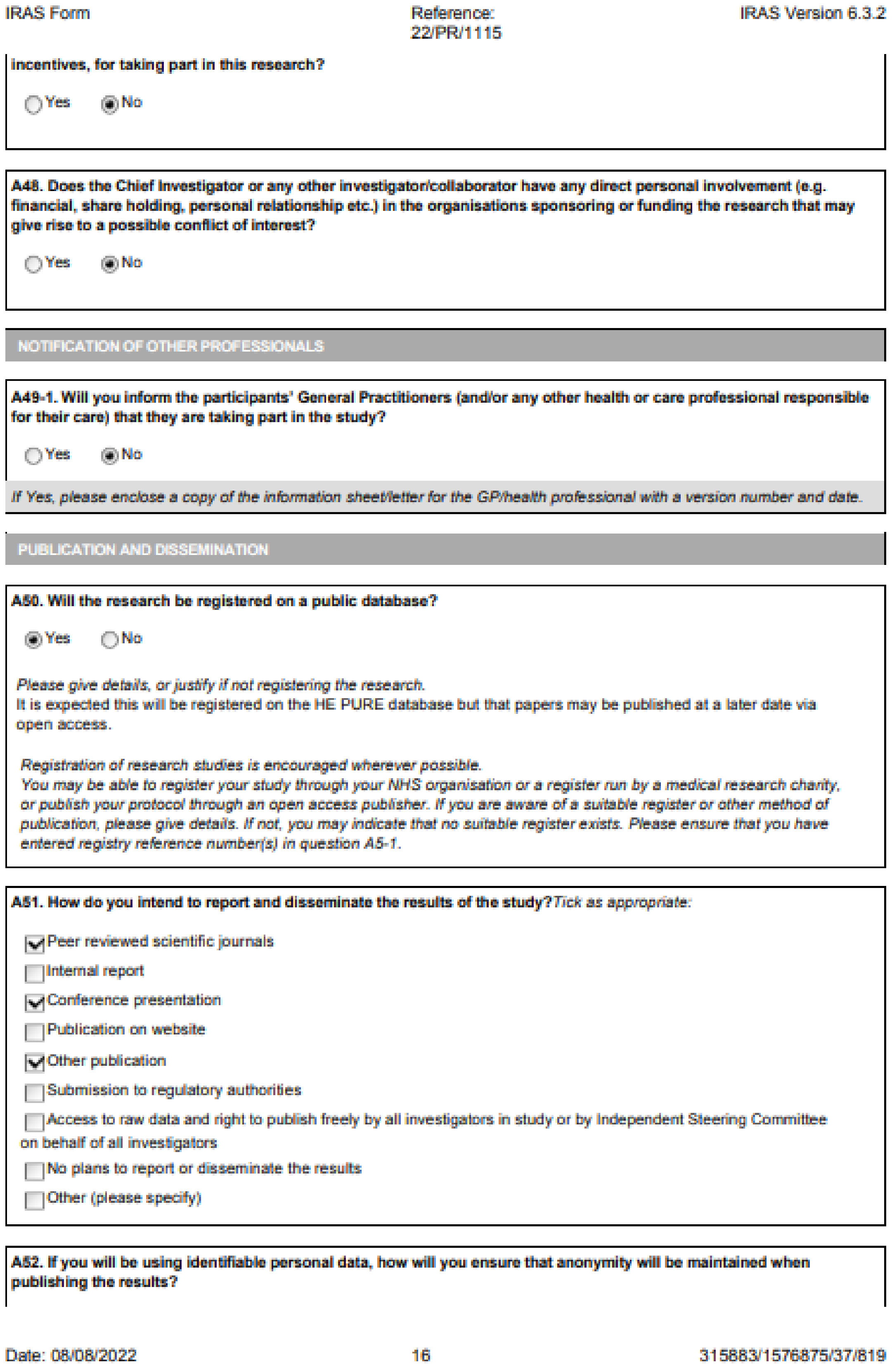
Data will only be stored for the duration of this study which is expected to finish by July 2024.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ● No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or



incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

● Yes ○ No

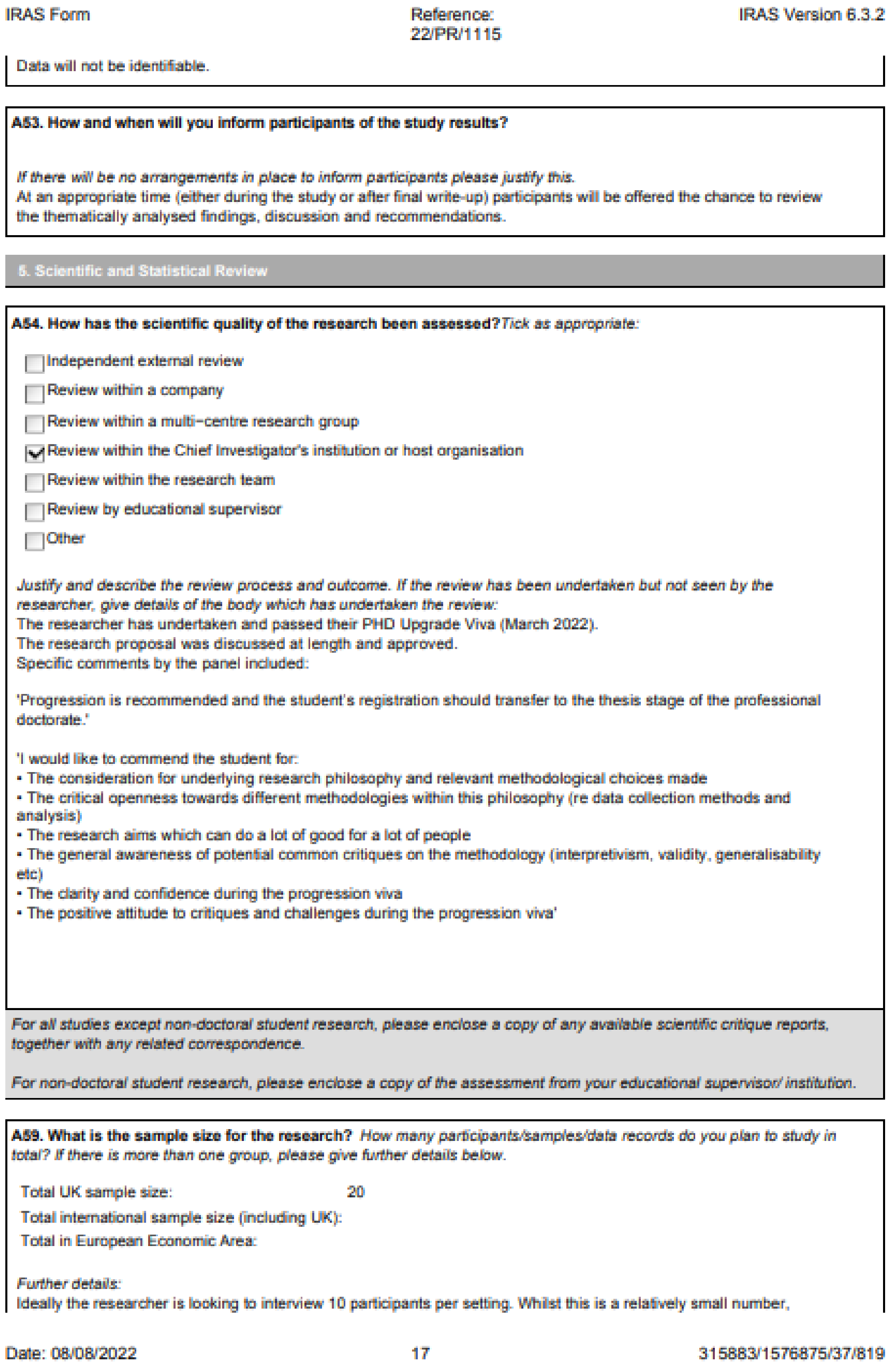
Please give details, or justify if not registering the research.
It is expected this will be registered on the HE PURE database but that papers may be published at a later date via open access.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☐ Internal report
☑ Conference presentation
☐ Publication on website
☑ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?



Data will not be identifiable.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
At an appropriate time (either during the study or after final write-up) participants will be offered the chance to review the thematically analysed findings, discussion and recommendations.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☑ Review within the Chief Investigator's institution or host organisation
☐ Review within the research team
☐ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The researcher has undertaken and passed their PHD Upgrade Viva (March 2022).
The research proposal was discussed at length and approved.
Specific comments by the panel included:

'Progression is recommended and the student's registration should transfer to the thesis stage of the professional doctorate.'

'I would like to commend the student for:
- The consideration for underlying research philosophy and relevant methodological choices made
- The critical openness towards different methodologies within this philosophy (re data collection methods and analysis)
- The research aims which can do a lot of good for a lot of people
- The general awareness of potential common critiques on the methodology (interpretivism, validity, generalisability etc)
- The clarity and confidence during the progression viva
- The positive attitude to critiques and challenges during the progression viva'

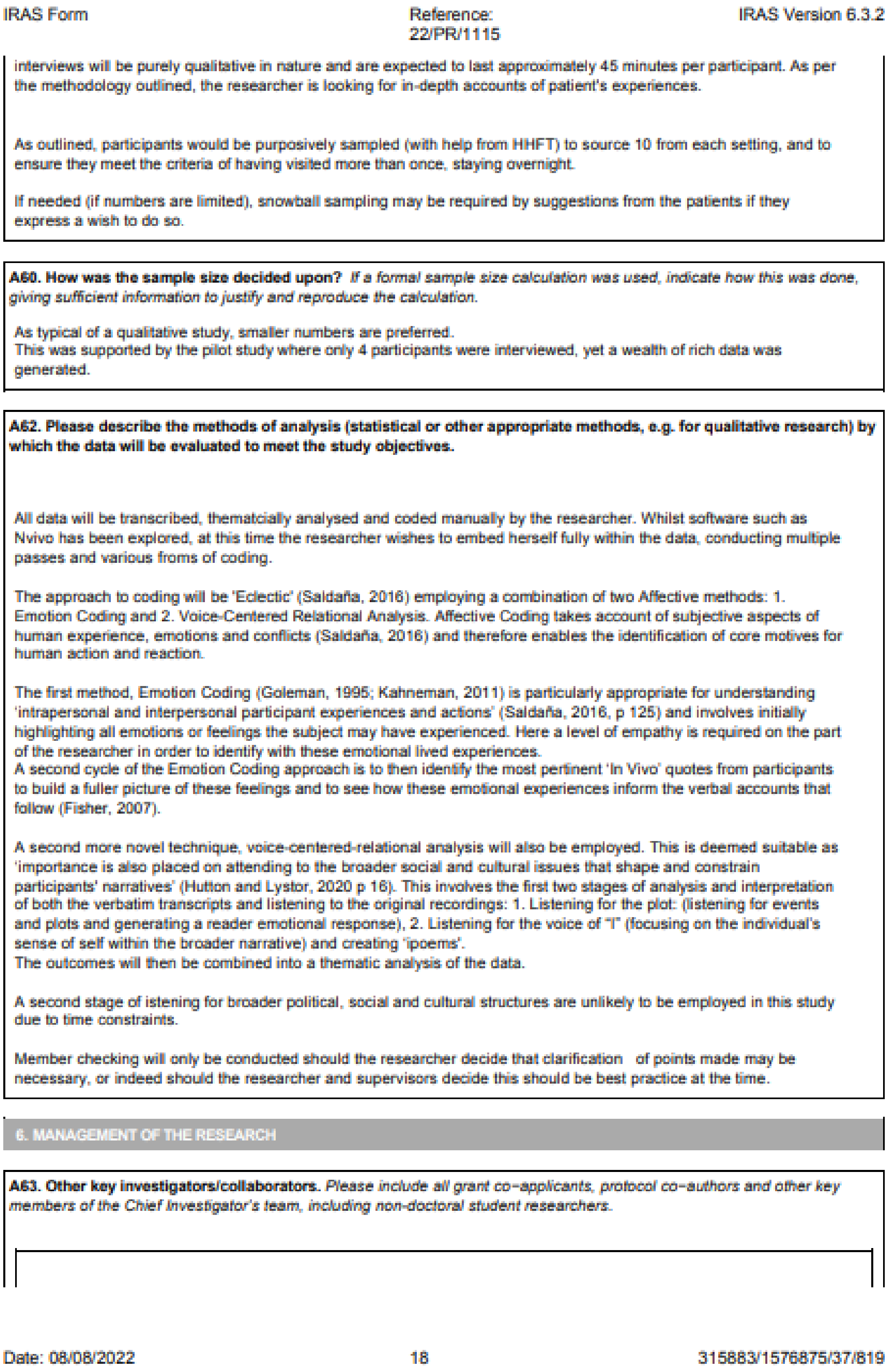
For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	20
Total international sample size (including UK):	
Total in European Economic Area:	

Further details:
Ideally the researcher is looking to interview 10 participants per setting. Whilst this is a relatively small number,



interviews will be purely qualitative in nature and are expected to last approximately 45 minutes per participant. As per the methodology outlined, the researcher is looking for in-depth accounts of patient's experiences.

As outlined, participants would be purposively sampled (with help from HHFT) to source 10 from each setting, and to ensure they meet the criteria of having visited more than once, staying overnight.

If needed (if numbers are limited), snowball sampling may be required by suggestions from the patients if they express a wish to do so.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

As typical of a qualitative study, smaller numbers are preferred.
This was supported by the pilot study where only 4 participants were interviewed, yet a wealth of rich data was generated.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

All data will be transcribed, thematcially analysed and coded manually by the researcher. Whilst software such as Nvivo has been explored, at this time the researcher wishes to embed herself fully within the data, conducting multiple passes and various froms of coding.

The approach to coding will be 'Eclectic' (Saldaña, 2016) employing a combination of two Affective methods: 1. Emotion Coding and 2. Voice-Centered Relational Analysis. Affective Coding takes account of subjective aspects of human experience, emotions and conflicts (Saldaña, 2016) and therefore enables the identification of core motives for human action and reaction.

The first method, Emotion Coding (Goleman, 1995; Kahneman, 2011) is particularly appropriate for understanding 'intrapersonal and interpersonal participant experiences and actions' (Saldaña, 2016, p 125) and involves initially highlighting all emotions or feelings the subject may have experienced. Here a level of empathy is required on the part of the researcher in order to identify with these emotional lived experiences.
A second cycle of the Emotion Coding approach is to then identify the most pertinent 'In Vivo' quotes from participants to build a fuller picture of these feelings and to see how these emotional experiences inform the verbal accounts that follow (Fisher, 2007).

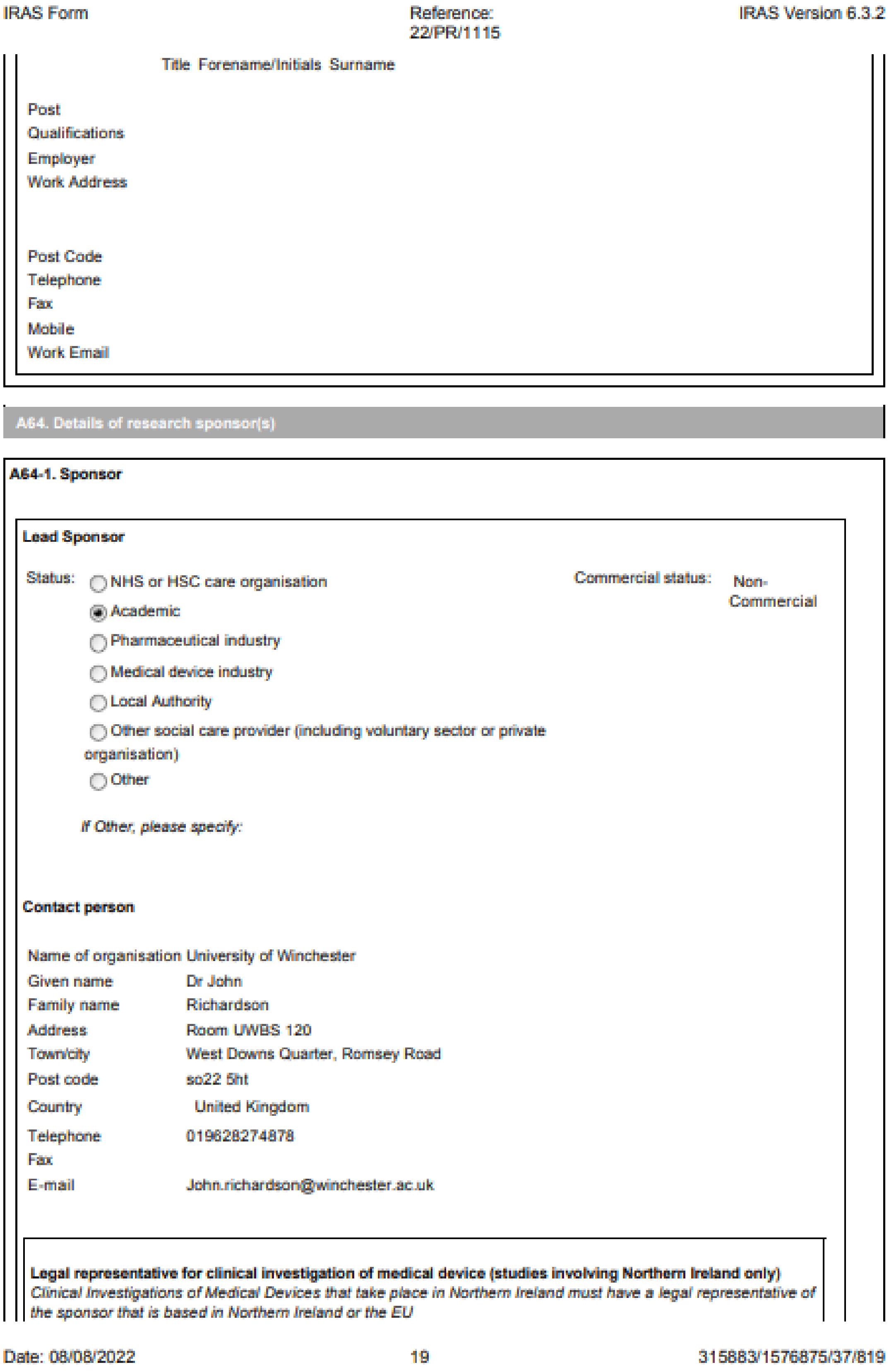
A second more novel technique, voice-centered-relational analysis will also be employed. This is deemed suitable as 'importance is also placed on attending to the broader social and cultural issues that shape and constrain participants' narratives' (Hutton and Lystor, 2020 p 16). This involves the first two stages of analysis and interpretation of both the verbatim transcripts and listening to the original recordings: 1. Listening for the plot: (listening for events and plots and generating a reader emotional response), 2. Listening for the voice of "I" (focusing on the individual's sense of self within the broader narrative) and creating 'ipoems'.
The outcomes will then be combined into a thematic analysis of the data.

A second stage of istening for broader political, social and cultural structures are unlikely to be employed in this study due to time constraints.

Member checking will only be conducted should the researcher decide that clarification of points made may be necessary, or indeed should the researcher and supervisors decide this should be best practice at the time.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*



Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

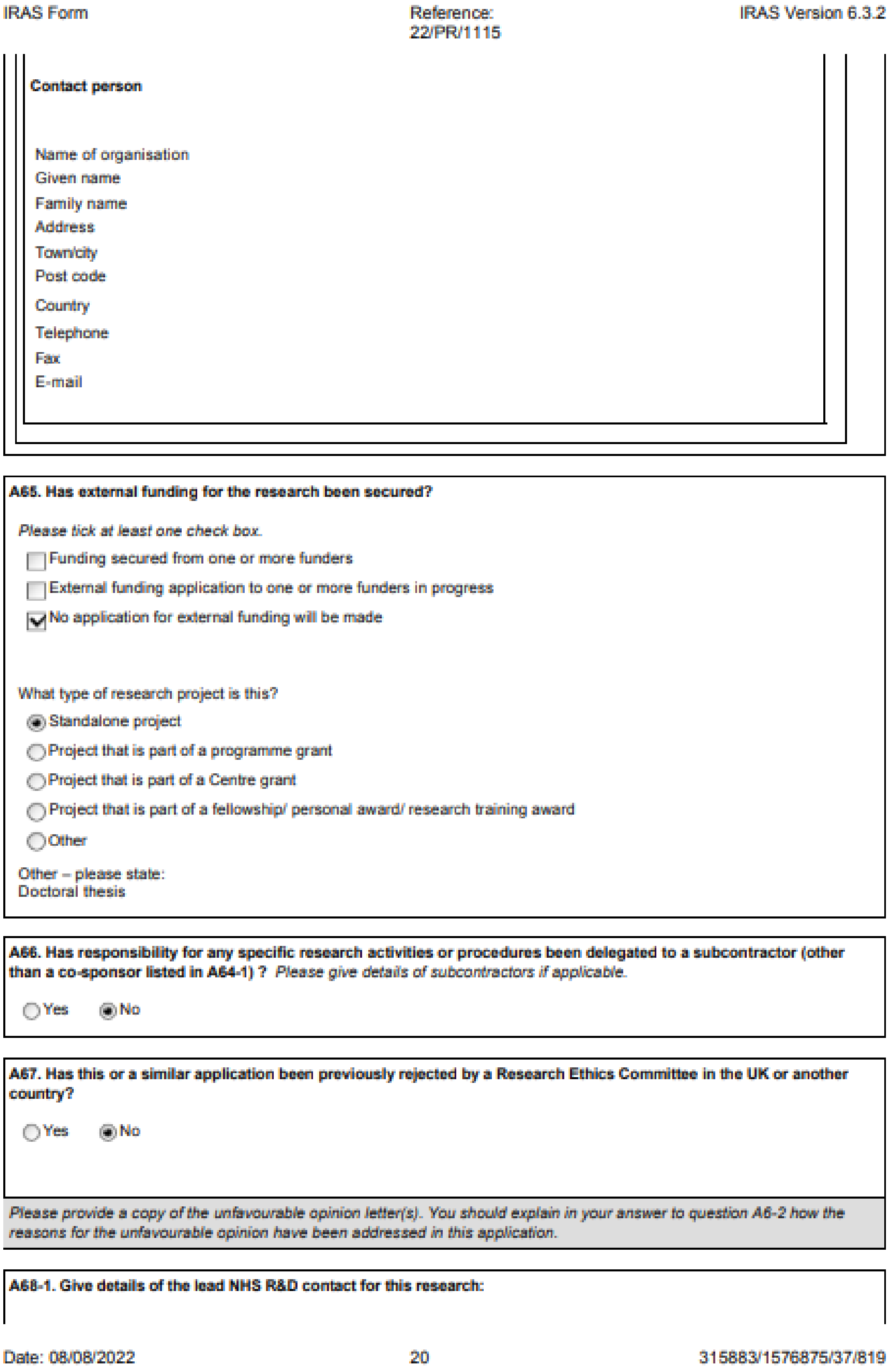
If Other, please specify:

Commercial status: Non-Commercial

Contact person

Name of organisation University of Winchester
Given name Dr John
Family name Richardson
Address Room UWBS 120
Town/city West Downs Quarter, Romsey Road
Post code so22 5ht
Country United Kingdom
Telephone 019628274878
Fax
E-mail John.richardson@winchester.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU



Contact person

Name of organisation
Given name
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

● Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:
Doctoral thesis

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

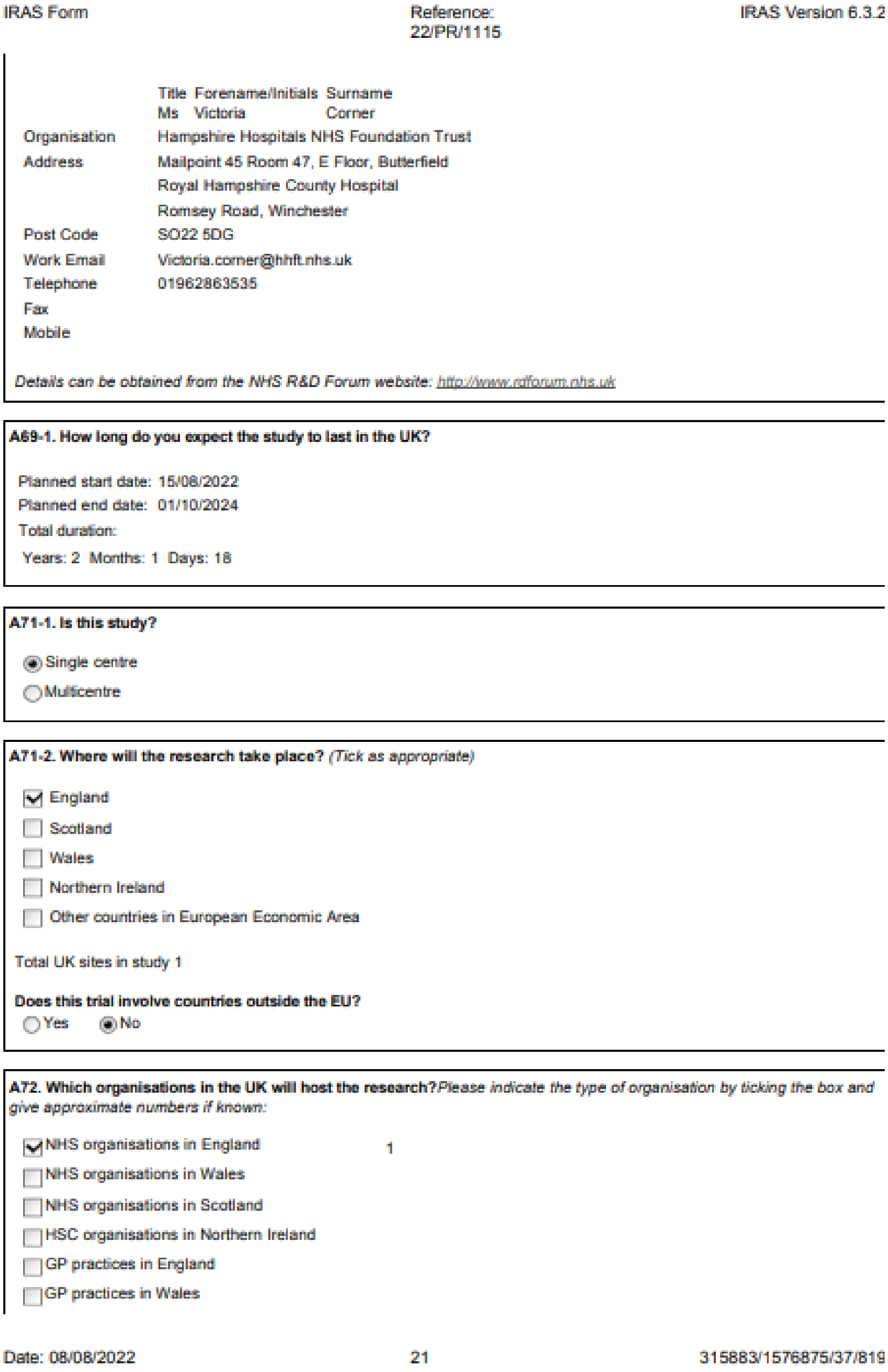
○ Yes ● No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:



Title	Forename/Initials	Surname
Ms	Victoria	Corner

Organisation Hampshire Hospitals NHS Foundation Trust
Address Mailpoint 45 Room 47, E Floor, Butterfield
Royal Hampshire County Hospital
Romsey Road, Winchester
Post Code SO22 5DG
Work Email Victoria.corner@hhft.nhs.uk
Telephone 01962863535
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 15/08/2022
Planned end date: 01/10/2024
Total duration:
Years: 2 Months: 1 Days: 18

A71-1. Is this study?

● Single centre
○ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

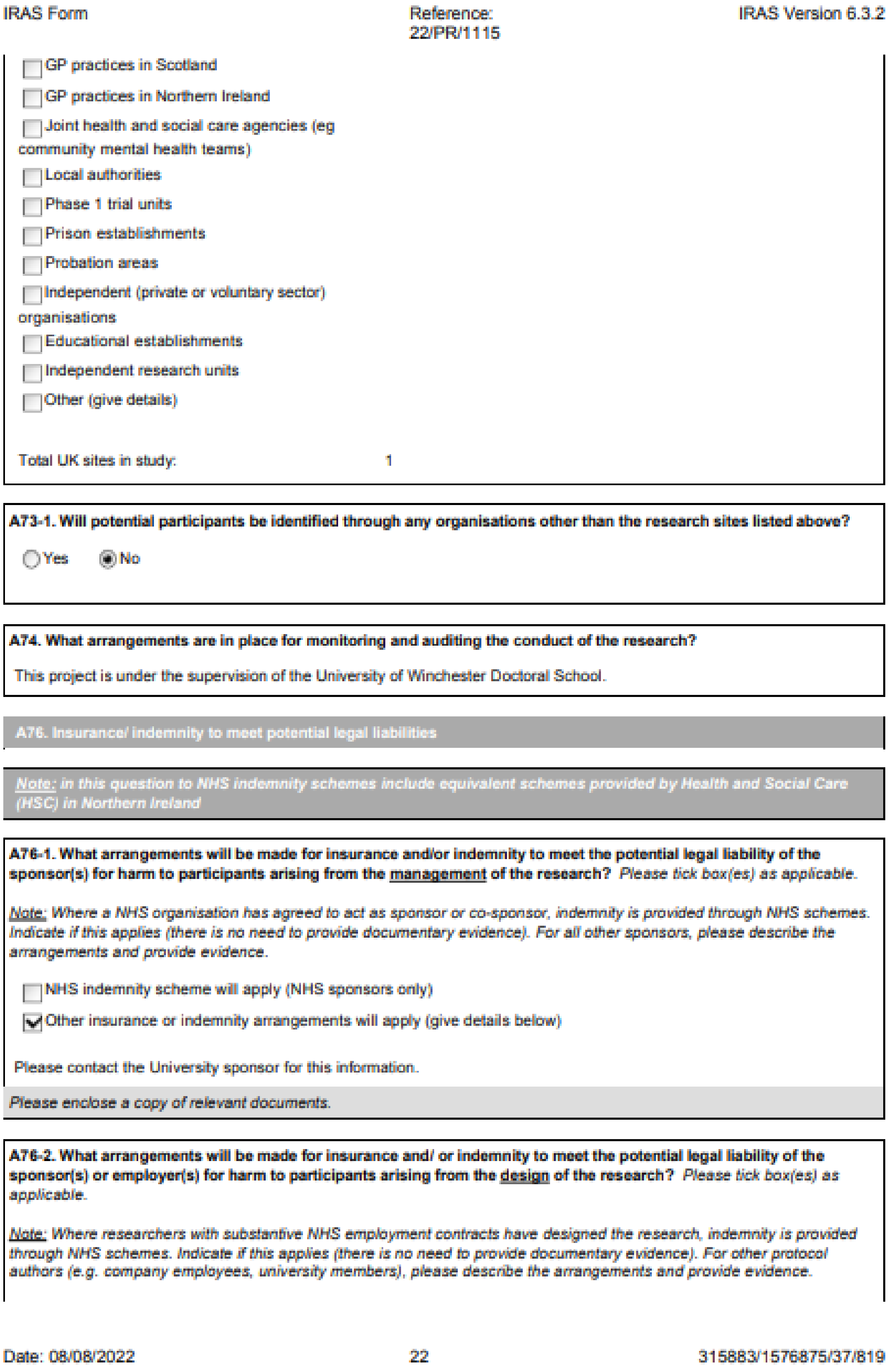
☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?
○ Yes ● No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	1
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	



☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Joint health and social care agencies (eg community mental health teams)
☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent (private or voluntary sector) organisations
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ● No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

This project is under the supervision of the University of Winchester Doctoral School.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

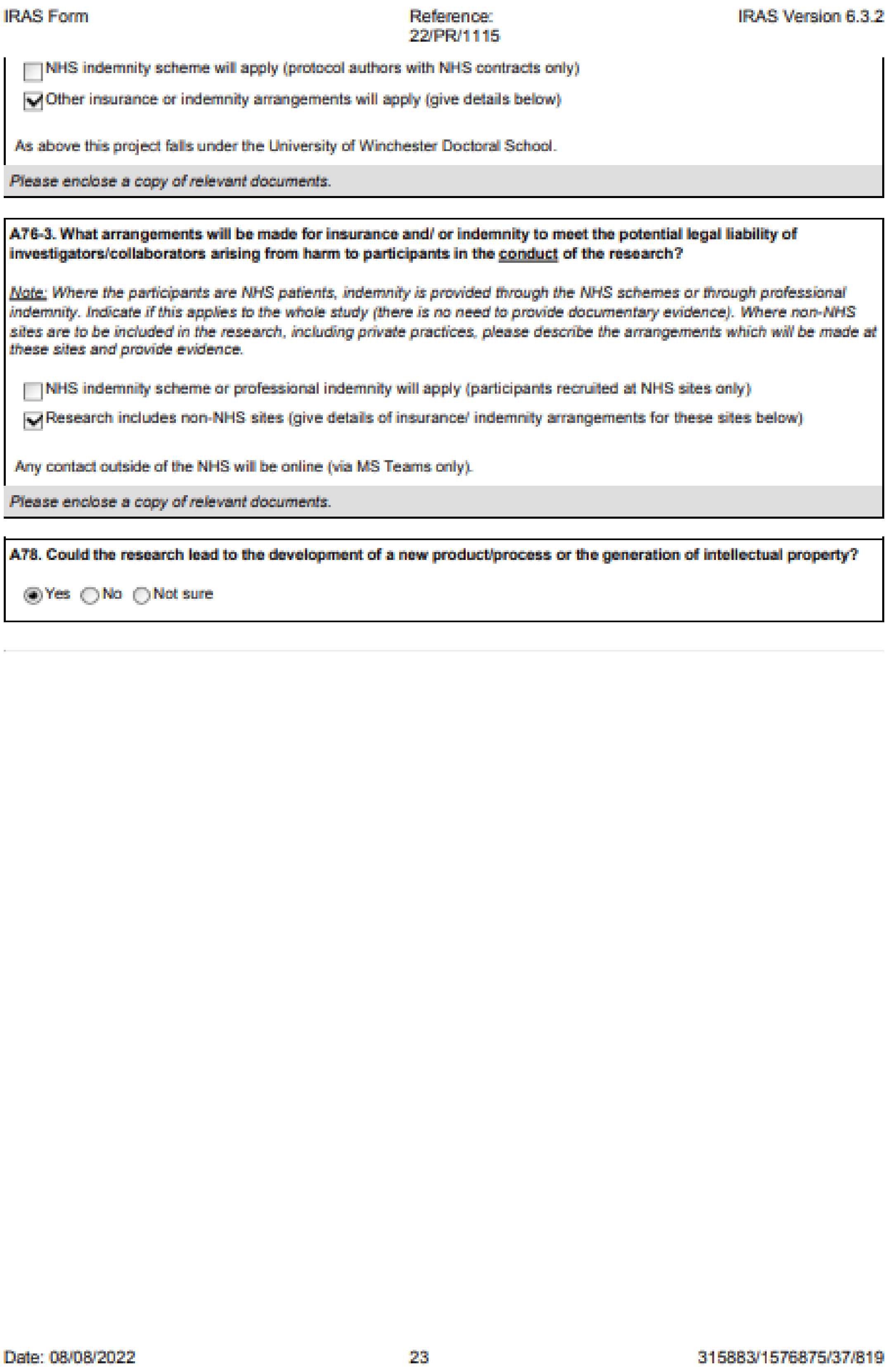
☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Please contact the University sponsor for this information.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.



☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

As above this project falls under the University of Winchester Doctoral School.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

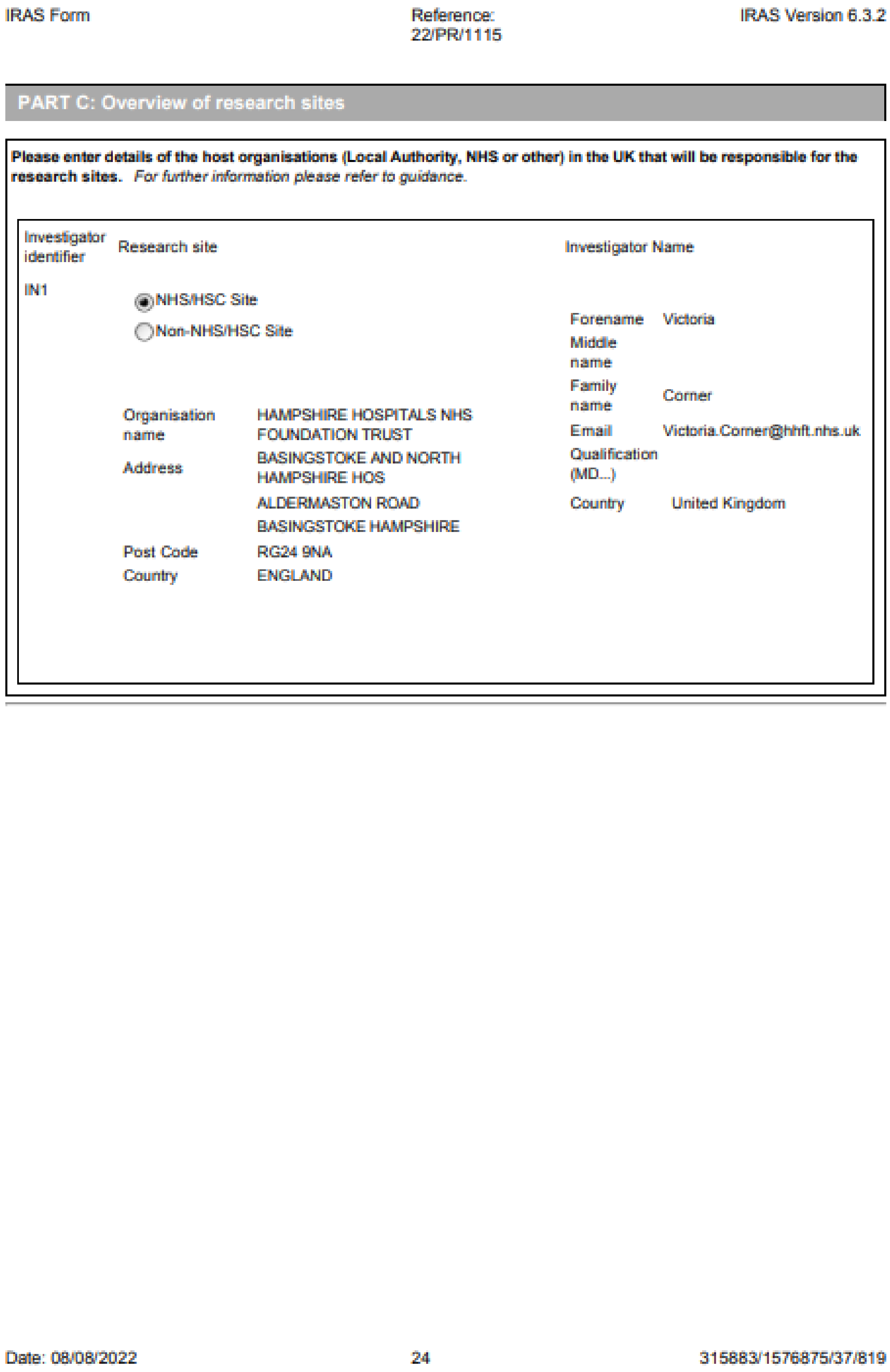
☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Any contact outside of the NHS will be online (via MS Teams only).

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

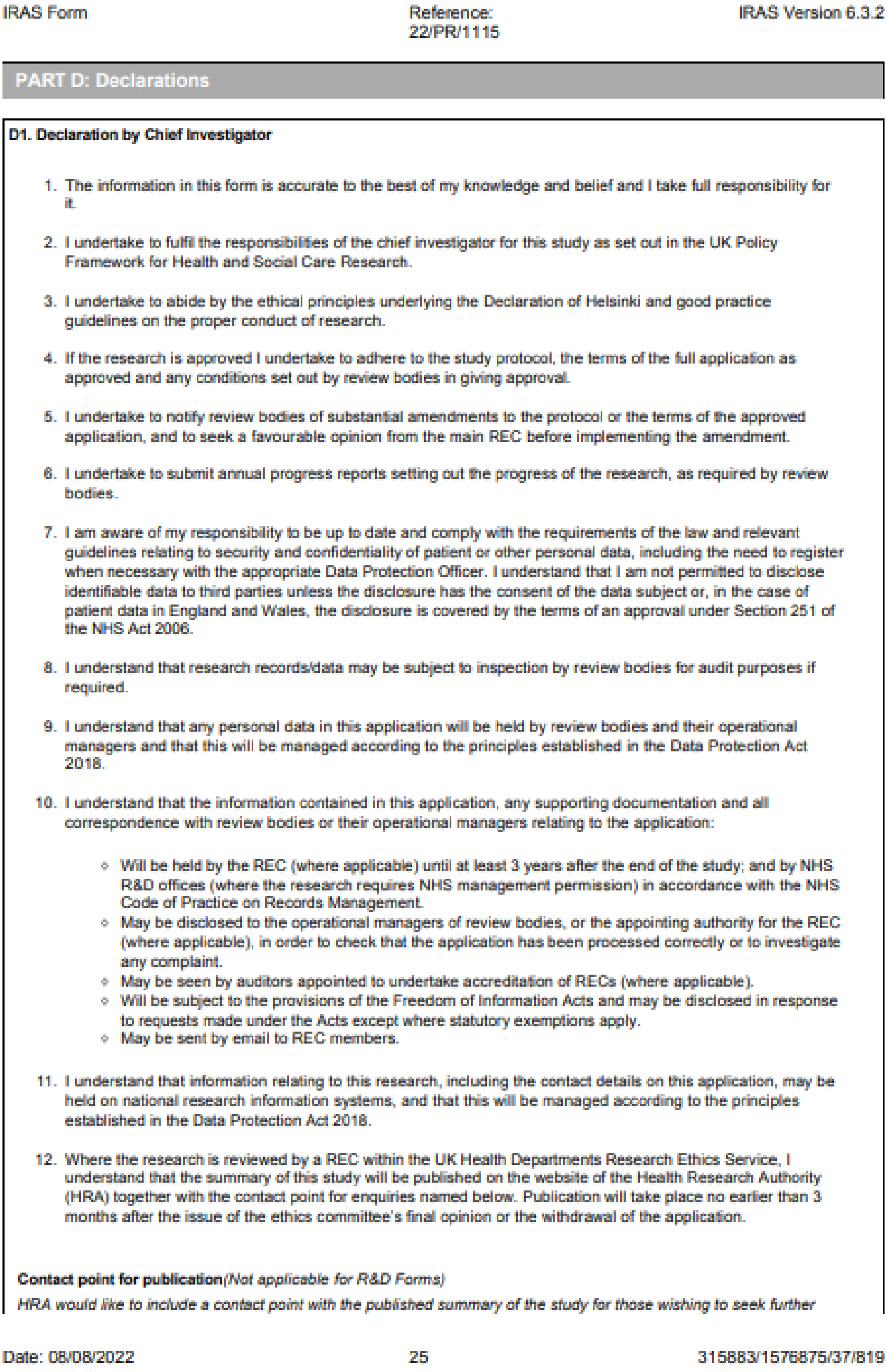
● Yes ○ No ○ Not sure



PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	● NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST Address: BASINGSTOKE AND NORTH HAMPSHIRE HOS ALDERMASTON ROAD BASINGSTOKE HAMPSHIRE Post Code: RG24 9NA Country: ENGLAND	Forename: Victoria Middle name: Family name: Corner Email: Victoria.Corner@hhft.nhs.uk Qualification (MD...): Country: United Kingdom



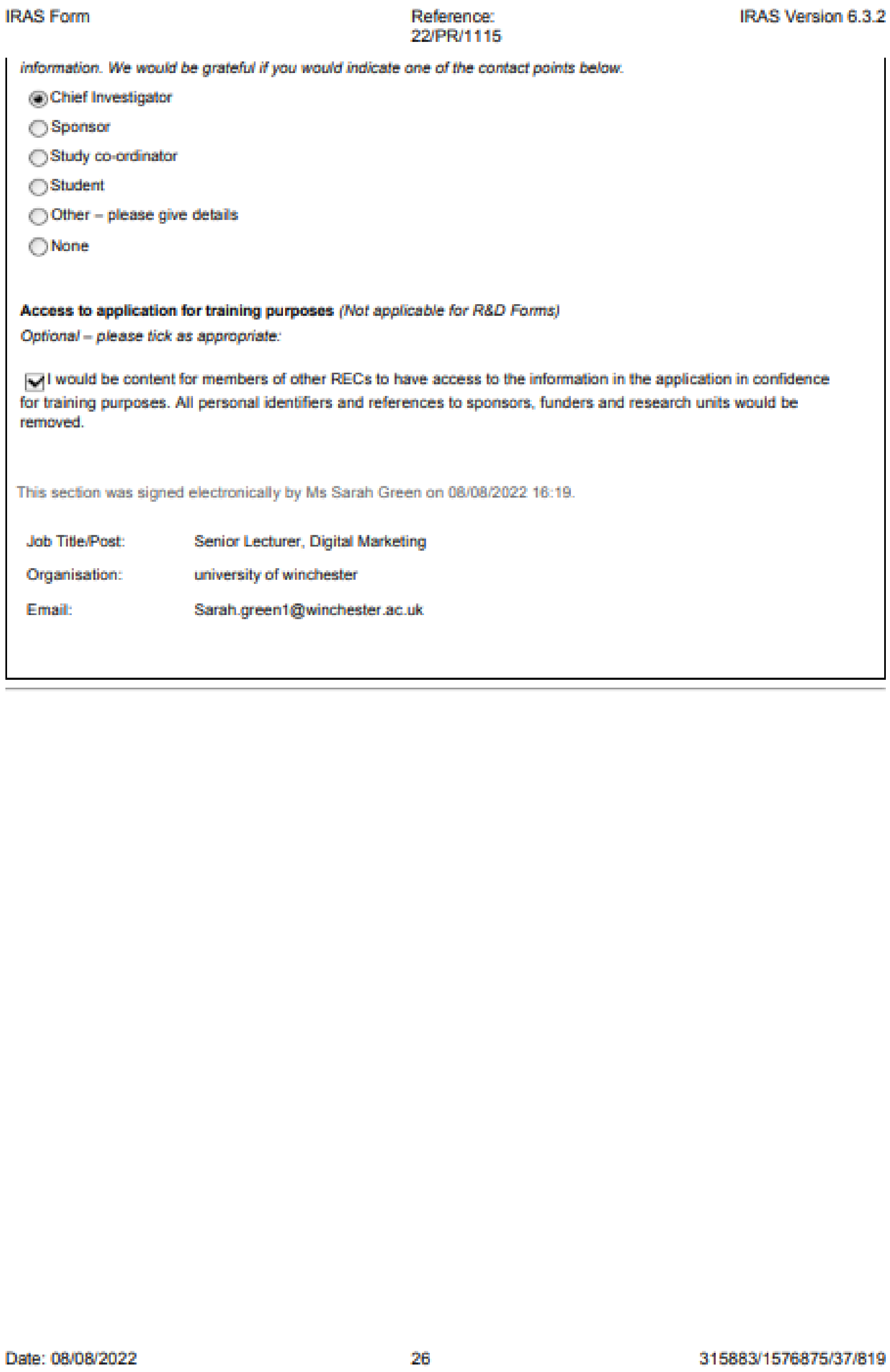
PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further



IRAS Form | Reference: 22/PR/1115 | IRAS Version 6.3.2

information. We would be grateful if you would indicate one of the contact points below.

● Chief Investigator
○ Sponsor
○ Study co-ordinator
○ Student
○ Other – please give details
○ None

Access to application for training purposes *(Not applicable for R&D Forms)*

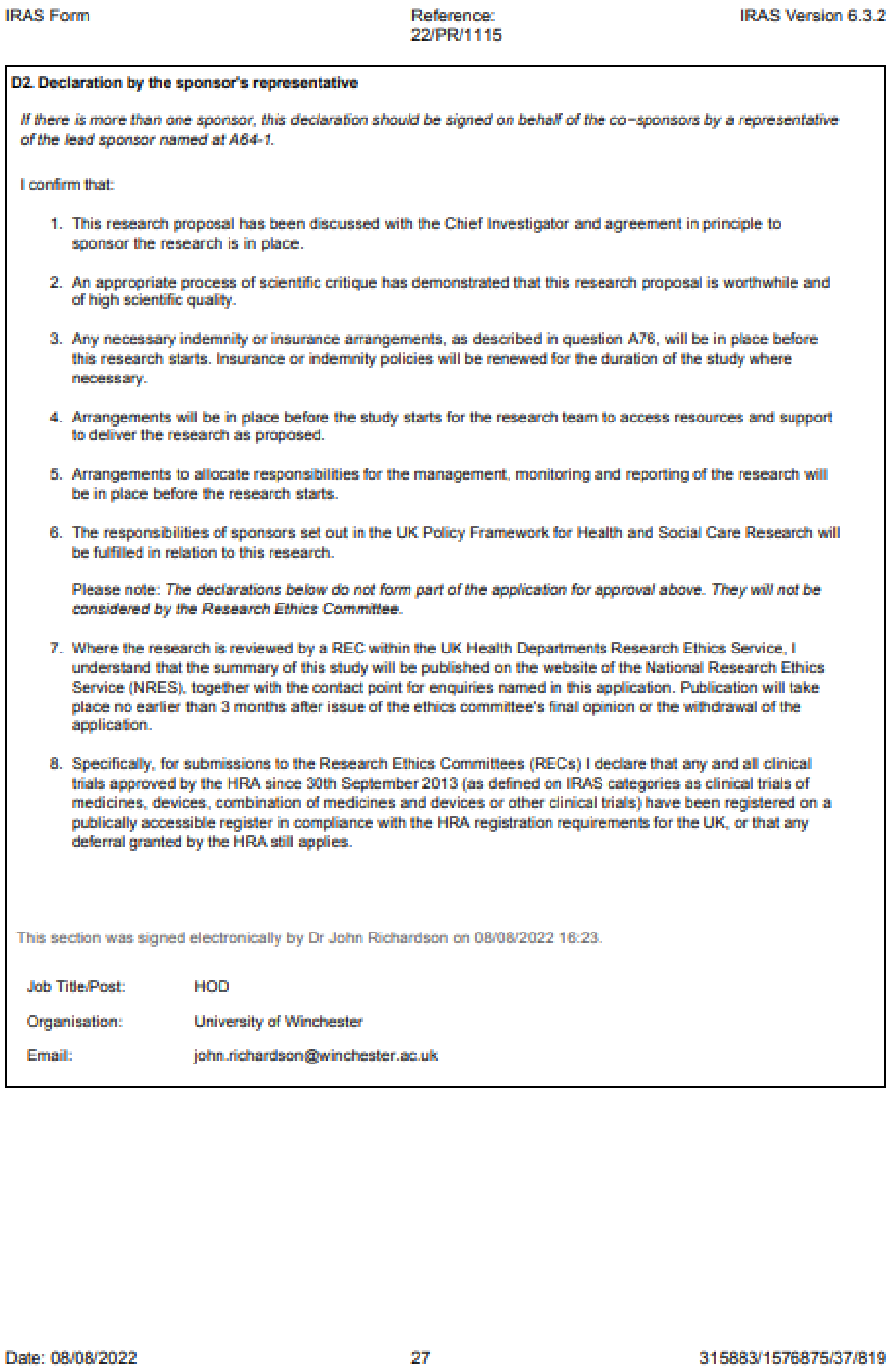
Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Ms Sarah Green on 08/08/2022 16:19.

Job Title/Post: Senior Lecturer, Digital Marketing
Organisation: university of winchester
Email: Sarah.green1@winchester.ac.uk

Date: 08/08/2022 | 26 | 315883/1576875/37/819



IRAS Form

Reference:
22/PR/1115

IRAS Version 6.3.2

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

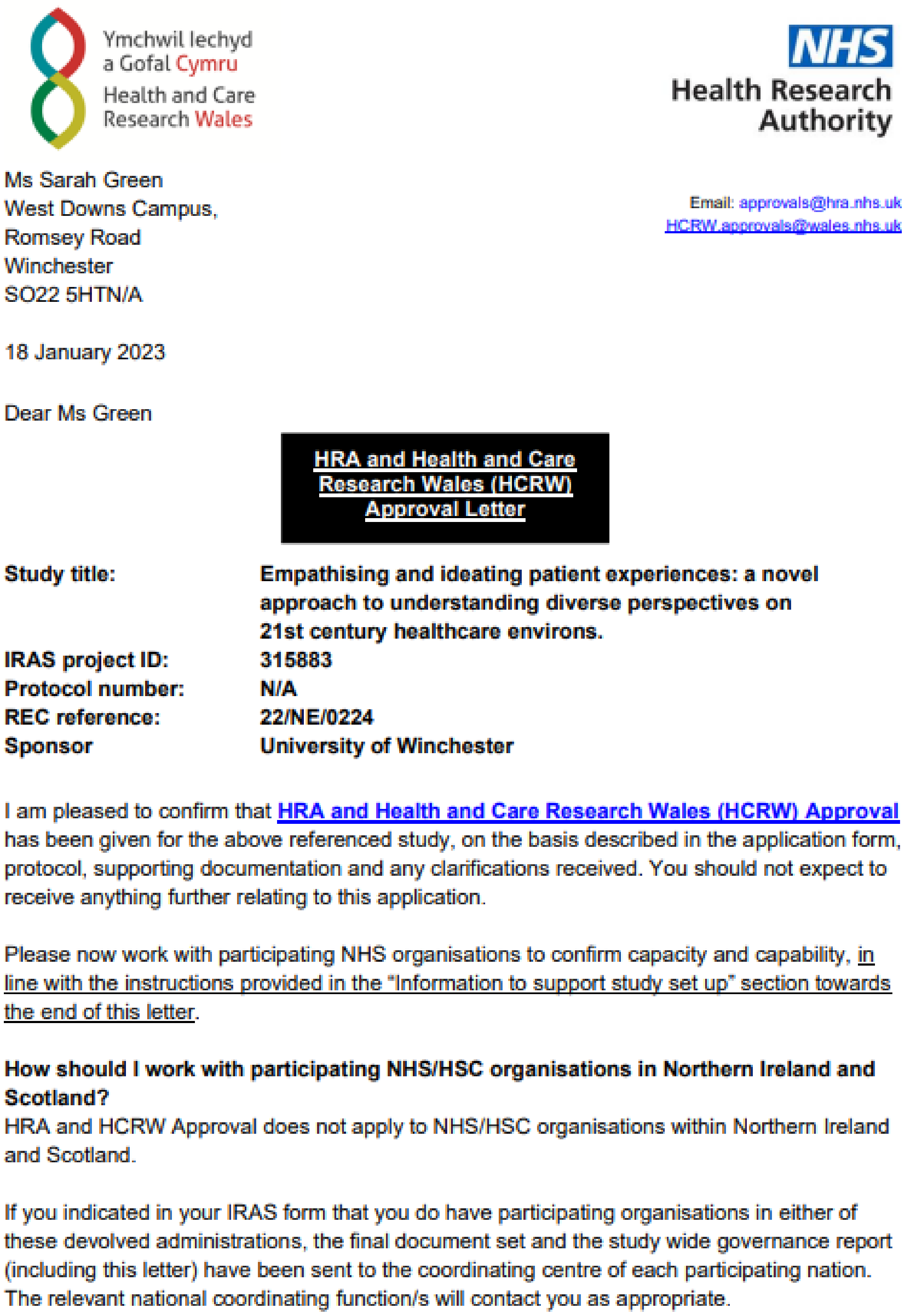
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by Dr John Richardson on 08/08/2022 16:23.

Job Title/Post:	HOD
Organisation:	University of Winchester
Email:	john.richardson@winchester.ac.uk

Date: 08/08/2022 27 315883/1576875/37/819

Appendix 12. Letter of Approval from REC



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Ms Sarah Green
West Downs Campus,
Romsey Road
Winchester
SO22 5HTN/A

18 January 2023

Dear Ms Green

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Empathising and ideating patient experiences: a novel approach to understanding diverse perspectives on 21st century healthcare environs.**
IRAS project ID:	**315883**
Protocol number:	**N/A**
REC reference:	**22/NE/0224**
Sponsor	**University of Winchester**

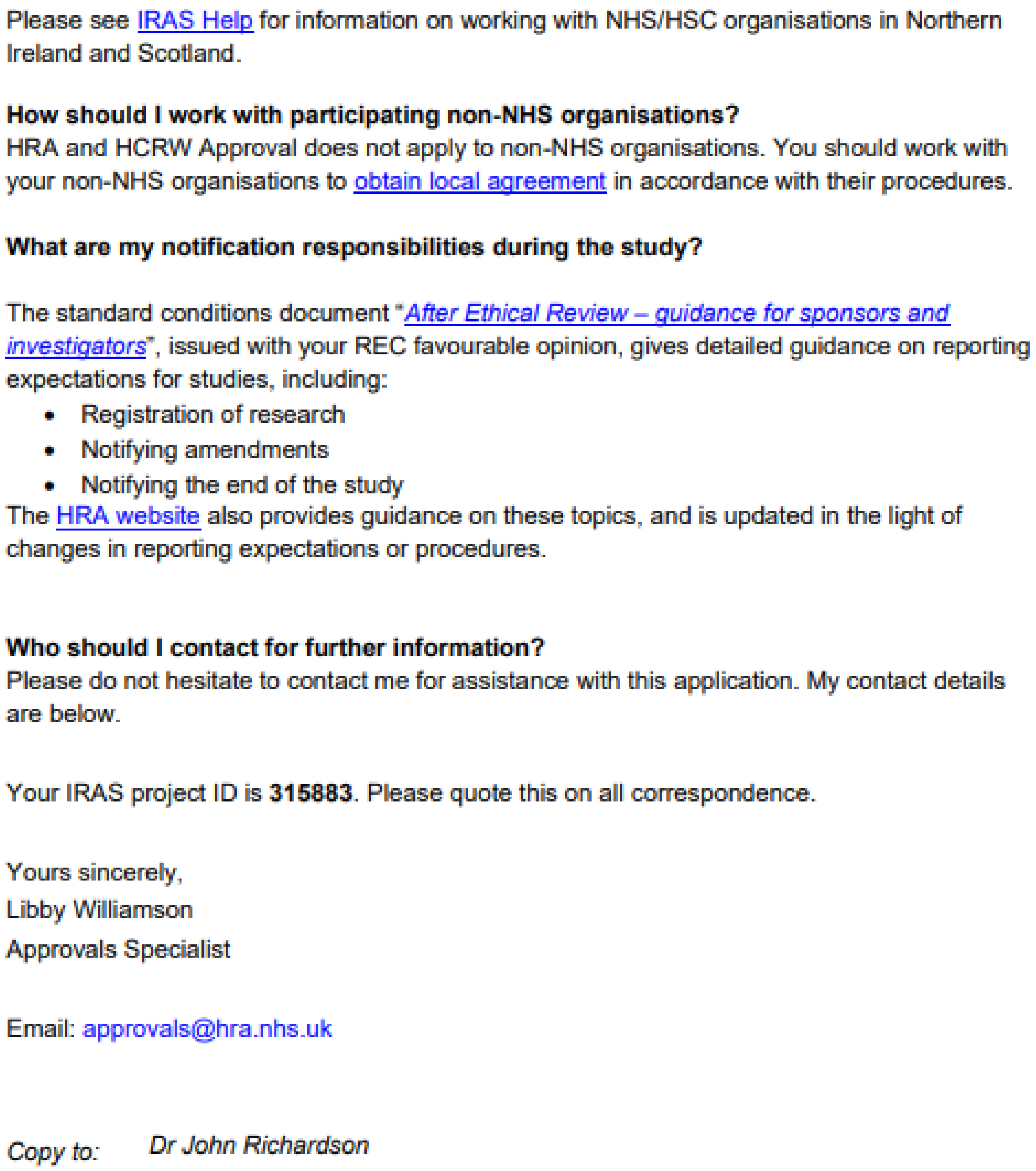
I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.



Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **315883**. Please quote this on all correspondence.

Yours sincerely,
Libby Williamson
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Dr John Richardson*

Appendix 13. Letter of Access – Research Passport

Hampshire Hospitals NHS
NHS Foundation Trust

Basingstoke and North Hampshire Hospital
Aldermaston Road
Basingstoke
Hampshire
RG24 9NA

Sarah Green

21-Feb-2023

Dear Sarah Green

Letter of access for research

This letter is to confirm that we are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer, and to confirm your right of access to conduct research through Hampshire Hospitals NHS Foundation Trust, the purpose and terms and conditions which are detailed below. Your employer is responsible for ensuring all necessary checks have been carried out.

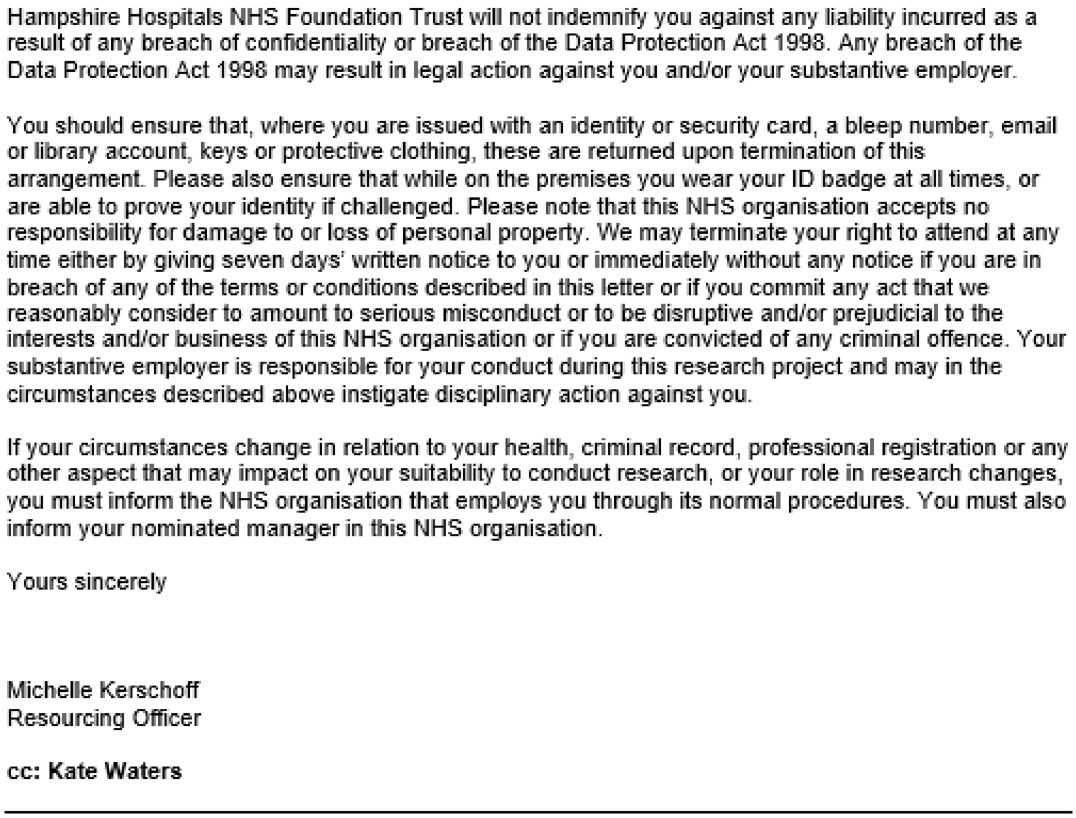
This right of access commences on **01-Feb-2023** and ends on **31-Jan-2024** unless terminated earlier in accordance with the clauses below. You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to Hampshire Hospitals NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee. While undertaking research through Hampshire Hospitals NHS Foundation Trust you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager **Kate Waters** in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third-party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings. You must act in accordance with Hampshire Hospitals NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Hampshire Hospitals NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation, and to take reasonable care for the health and safety of your self and others while on Hampshire Hospitals NHS Foundation Trust premises.

Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times. You are required to ensure that all information regarding patients or staff remains secure and **strictly confidential** at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence, and such disclosures may lead to prosecution.



Hampshire Hospitals NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property. We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Michelle Kerschoff
Resourcing Officer

cc: Kate Waters

Appendix 14. Thumbnails of Photographs Taken with Code Numbers Assigned


G01


G02


G03


G04


G05


G06


G07


G08


G09


G10


G11


G12


G13

G14


G15


G16

C02

C03

C04

C05

L01

L02

L03

L05

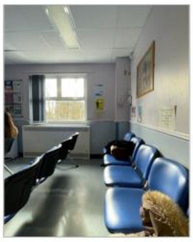
L06

L07

S01

S02

S03



S04

S05

S06

S201

S202

S203

S205

S206

S207

S208

S209

Appendix 15. Memos from Ethnographic Observation

Memo 1. Summary of written notes (with some photographs) from all visits, structured within third space model.

First space

Perceived – spatial practice – mental - embraces production and reproduction: Characteristics of location – medium and outcome of human activity – routines – description.

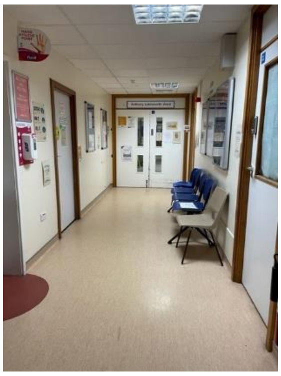
- The seats feel close together – fixed (obstetrics)

- Noone looks at all the brochures/flyers on the wall in the rack (obstetrics)

- Its dark and dull in here (obstetrics)
- The décor is tired and damaged (obstetrics)
- Staff use first names that seems nice (obstetrics)
- The view from the side window is pleasant (obstetrics) – why don't the chairs face that way?
- There is a constant buzz of aircon its annoying (obstetrics)
- There is no music (obstetrics)
- A woman faints (obstetrics)
- The staff are friendly (obstetrics)
- Only some lights work (obstetrics)
- There is a flashing light alarm (obstetrics)
- A patient said she was thirsty as staff walked by with their coffee (obstetrics)

- The vending machine did not work (lobby)

- The waiting space is simply a few seats in a corridor immediately outside treatment rooms – there is a lot of coming and going (Letchworth)



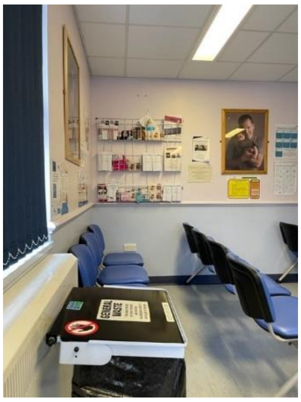
- Some chairs are broken with a warning not to use them ((Letchworth)

- 'Sue' is very nice when she greets people (obstetrics 2)
- The chair backs are low and uncomfortable (obstetrics 2)
- Some display boards are notably empty (obstetrics 2)
- People enter – look v confused and then check their phones for where they are supposed to be (lobby)
- The wood must have been intentional to feel calmer (Breast screen clinic)
- It is too warm (breast screen clinic)
- The chairs seem new (breast screen clinic)
- There are several windows and some chairs face them (breast screen clinic)
- All the lights are on – it is very bright in here (breast screen clinic)
- The staff are exceptional – friendly and informal (breast screen clinic)
- Half the people are on their phones (breast screen clinic)
- Patients can be heard quietly discussing their conditions with their relative (breast screen clinic)
- Those staring into space look more worried (breast screen clinic)
- A patient is becoming distressed/crying (breast screen clinic)

Second space

Representations of space - conceived – historicality – physical. Planners and architects. Control – codings – signs – dominant space – regulatory – rules – materiality – objectivity – built environment.

- Posters are randomly displayed – a pregnant woman next to how to hold a baby (obstetrics)
- Staff are constantly going in and out of doors - it is their space not ours (obstetrics)
- The office strip lighting is practical yet harsh (obstetrics)



- The cancer flyers are scary (obstetrics).
- The wayfinding is unclear and the use of which space for which purpose is unclear. (obstetrics)
- There is clutter (obstetrics)
- There is a digital check-in kiosk, but it was not working (lobby)
- There are over 35 small signs in the small waiting area (Letchworth)

- These spaces do not feel planned at all (obstetrics)
- Why are these called suite 1 and 2 – it confuses me (obstetrics)
- The staff photo board is there – no one looks (obstetrics 2)
- Why is it called Anthony Letchworth?
- Someone put floor décor there, but no one is looking (lobby)

- Antiseptic is a result of cleaning processes (breast screen clinic)
- The signage is quite minimal here (breast screen clinic)
- The seats are comfortable and individual rather than fixed which feels nice (breast screen clinic)
- This feels deliberately spacious (breast screen clinic)
- 9 chairs have been placed in this large room (breast screen clinic)
- Maybe the signage should be zoned in some way (colour coded?) (breast screen clinic)
- Beige blinds seem better than blue
- When does/should the radio go on? It is not on (breast screen clinic)
- This space feels like it had a really important part to play in my experience (breast screen clinic)
- People appear to be waiting in in two-three repeated episodes – and more chairs are needed now (breast screen clinic)

Third space

Spaces of representation - lived – social – spatiality - (neither physical nor mental) complex symbolisms – underground of social life.

- At 1/3 full it already feels cramped (obstetrics)
- Everyone is on their phones – seemingly oblivious to the walls around them (obstetrics)
- How must it feel to see a ‘how to hold a baby poster’ when you are here for a pregnancy problem? (obstetrics) They are ‘cheesy’, and naive

- It feels annoying that the posters on the wall are all wonky (obstetrics)
- I feel bored, annoyed by the clutter, agitated by the clinical posters (obstetrics)
- The door slams make me nervous (obstetrics)
- However – the comings and goings feel like progress (obstetrics)
- The staff on reception seem ‘inappropriately’ happy (obstetrics)
- Are patients just sitting with their worries? – not doing much with little to inspire (obstetrics)
- There is a strong sense of waiting – but for what? Not knowing. (obstetrics)
- People are huffing. (obstetrics)
- The flashing light is alarming! (obstetrics)

- It is disturbing hearing conversations in the treatment rooms ((Letchworth)
- Having only three chairs to wait makes me feel lonely – is it only me today? (Letchworth)

- This feels like it is a place for staff not patients (Letchworth)

Please do NOT LOCK this cupboard - it only contains linen and we have no key for the door - thank you G.O.P.

- I feel like I am sitting in a bad news area – why is this not somewhere private? A woman is crying.
- It feels slightly odd having elements from 'home' here – books, radio – small pictures - I ignore them (obstetrics 2)

- The sliding doors are constant and slow and loud (lobby)

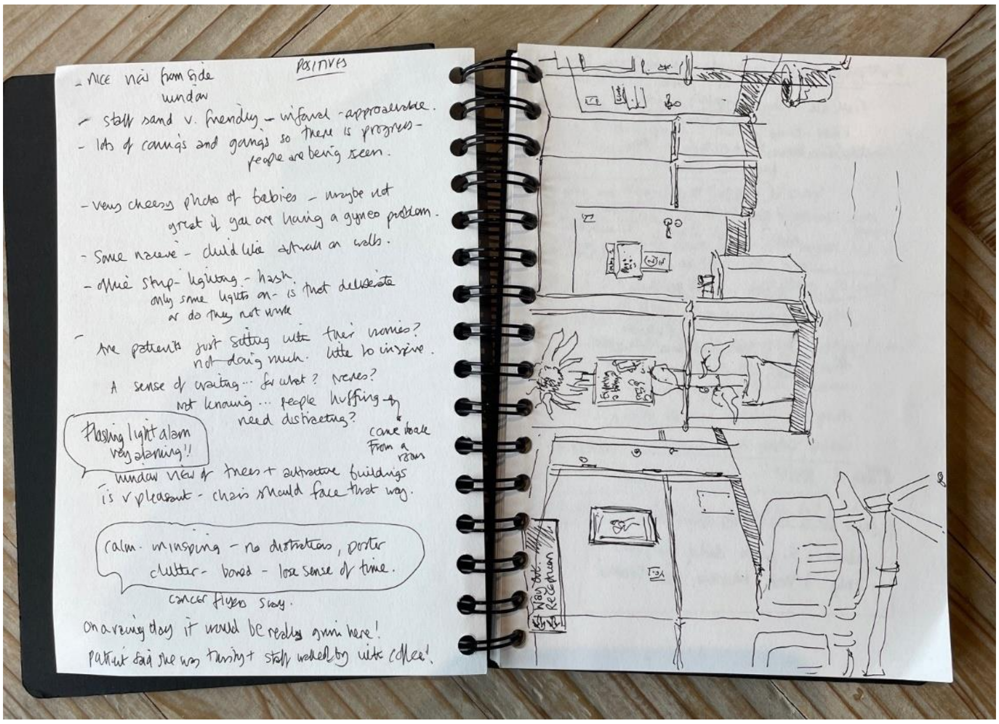
- The lift squeaks loudly its annoying (lobby)
- This is not a welcoming space (lobby) – do people remember the names of where they are supposed to go?
- The antiseptic smell is both reassuring and scary (breast screen clinic)
- The views from the window are uninspirational but bright today (breast screen clinic)
- Several patients seemed confused as they had come to the wrong department (breast screen clinic)
- The room feels a bit large/exposed for the amount if chairs in it (breast screen clinic)
- There is something reassuring about being on the first floor (breast screen clinic)
- If I'm here for a routine scan the cancer signs feel very alarming
- The blues and greens feel clinical (breast screen clinic)
- The treatment rooms are out of view, so I feel calmer (breast screen clinic)
- It feels comforting that there are general comings and goings outside (breast screen clinic)
- The beeps and bells seem alarming – event the telephone (breast screen clinic)
- I want to hold the other women's hands (breast screen clinic)
- There is no music, and it feels a bit too silent in here (breast screen clinic)
- Plants are needed (breast screen clinic)
- Those with relatives look happier than those alone Plants are needed (breast screen clinic)
- Plants are needed (breast screen clinic)
- No-one looks at the bookshelf- ever! (breast screen clinic) nor the leaflets
- It is too quiet in this room (breast screen clinic)
- There is a gentle but annoying high-pitched sound (breast screen clinic)
- Some people look as if they have 'zoned out' (Obstetrics)

Memo 2. Table of emotion codes interpreted from photographic material gathered during field observation

Emotion/feeling	Subject	Photo ID.
Confusing	Multiple types of signage together – warnings next to commemorative. Jargon/ similar names.	G06. C02. C3. G12. G14.
Dehumanising	One of many sitting in connected chairs like a production line	S03. S04.
Institutionalised	The standard blinds and harsh office style lighting. Thoughtless display of multiple brochures in old fashioned holder. Broken chairs. Very dull entrance.	S01. S02. S05. L07. G15. G16.
Fragile/unnerving	Photos of babies in obstetrics clinic where patients might sometimes have serious problems with pregnancy. Many clinical flyers.	S01. S05.
Alarming	Many clinical flyers.	S05.
Dull/uninspired/indifferent	Dull lighting and clutter	C01.
Foreboding/frightening/unsure	Dull soulless corridors with closed doors Lift very functional / dated	C04. L05. G08.
Unwelcoming	Forbidding signage. ‘Back stairs’ feeling Storage in public areas. Dull entrance.	C05. L03. L01. G01. G13. G15. G16. G4. G12.

Lazy/neglectful/agitating	Half-hearted displays of décor. Odd signs to get around problems. Broken vending.	S201. S202. S209.S206. S207. G13. G10. G7. S203. L02. L01. G02.

Memo 3. Image of typical page of researcher's observation notebook



POSITIVES

- nice view from side window
- staff said v. friendly – informal – approachable.
- lots of comings and goings so there is progress – people are being seen.
- Very cheesy photo of babies – maybe not great if you are having a gyneo problem.
- Some naive – child like artwork on walls.
- office strip-lighting – harsh. only some lights on – is that deliberate or do they not work
- Are patients just sitting with their worries? not doing much. little to inspire.

A sense of waiting… for what? news? not knowing… people huffing – they need distracting?

came back from a room

Flashing light alarm very alarming!!

- window view of trees + attractive buildings is v pleasant – chairs should face that way.

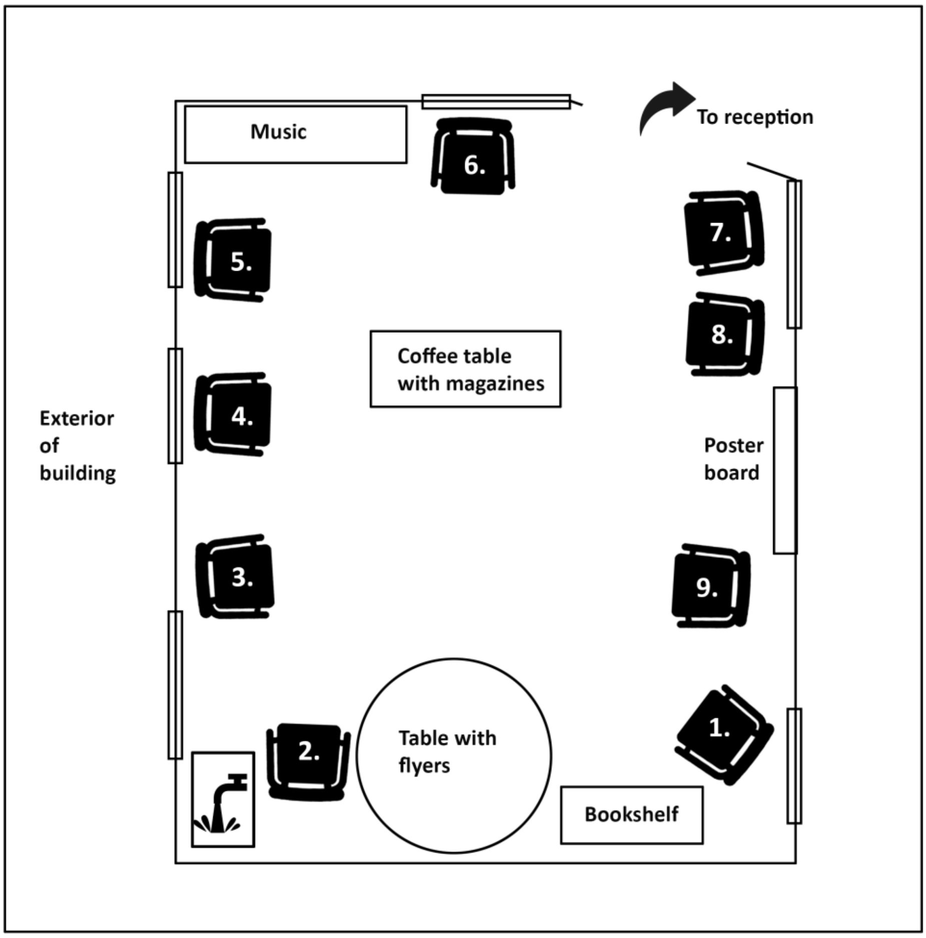
calm. uninspiring – no distractions, poster clutter – bored – lose sense of time.

cancer flyers scary.

On a rainy day it would be really grim here!

Patient said she was thirsty + staff walked by with coffee!

Memo 4. Summary of sketched layout and key notes concerning chair positions within the Breast Screening Clinic space.



Chair 1

Can see all three windows. This feels like a safe corner. It’s cosy. I can see staff coming in and can access the table.

Chair 2

I can see all the activities at the reception desk. It feels more hectic. I can see everyone who leaves and enters – I am more self-conscious.

Chair 3

I cannot see the windows. I am facing many cancer posters. I can see the reception desk.

Chair 4

I cannot see the windows. I can see the treatment corridor. This feels more clinical.

Chair 5

I cannot see the windows. I can see the treatment corridor. This also feels clinical, and I can hear and see the reception desk.

Chair 6

I face other patients – I feel I am at the head of the room. I feel a little uncomfortable/exposed – a bit like a class teacher. I can see the windows, but my main focus is on the other 8 chairs. I can also see the whole of the treatment corridor. This feels like quite a vulnerable position.

Chair 7

I can see the windows and have my back to the treatment area, which feels good. However, I feel a little close to the noise of reception.

Chair 8

I can also see the windows and have my back to the treatment area, which feels good. I can now see the ugly buildings out of the window.

Chair 9

I can see the windows, which feels good. I am less close to reception which is slightly better.

Conclusion – Seats 1 then 9 then 2 are the best positions for me.

Appendix 16. I Poems from Voice-Centred Relational Analysis

I Poem Patient 1

I was there
I had that procedure
I tend not to park
I try and get the bus

I'm quite fortunate
I've got good hearing
I had to say it was them

I went
I also had a mammogram
I had lumps
I'd been referred

I didn't know what was going to happen
I sat there

I thought it was quite good - second-hand books
I went and bought
I mean, it was going to charity
I thought, well

I thought this is silly
I thought, they should say
I eventually saw someone
I think she may have been the sister
I said to her
I said, but there's all those people sitting in the waiting room

I sat
I also sat
I mean, you don't see, you don't see a doctor
I would have liked some feedback
I would have liked some information

I think
I was concerned about it
I recently lost a very good friend
I was a bit twitchy
I would think

I don't
I mean anybody's looked at every bit me
I was a bit disconcerted
I understand they've done additional training
I didn't think you had a lot of privacy

I'm fairly stable

I mean
I used to see this all the time
I used to have to say to solicitors don't use that speak
I mean I’m; you know..

I was a little bit early
I logged in quarter of an hour before
I was supposed to be in forwarded from the GP
I thought, hang on a minute

I was sitting there

I explained to five other people

I think
I don't know
I'm thinking the last time
I have had many procedures there
I don't like to be cold
I like to be quite warm
I was cold
I'm not a shrinking Violet

I'm alright myself
I’m very self-sufficient
I was taking a book with me
I'm not doing that, you know
I think it's as you get older
I mean I have acute hearing
I was overhearing all sorts

I just try, you know
I was chatting
I said I think you should go and ask
I said yes
I said how did you get here?
I said, go and ask

I will chat to other people
I'm interested in other people
I'll talk to them
I think as you get older, you start to get more impatient

I think they said what's the problem?
I identified the area

I said no

I said yes

I did feel listened to

I think it should be signposted

I think

I've walked in there and thought, where do I go?

I Poem patient 2

I like to keep fit as much as I can

I remember 40 thinking. Ohh, that's it

I mean, my daughter's 42

I look at her and…

I went to the Florence unit

I've been to both

I can. I can quite vividly

I walked in

I didn't know the place

I didn't think it was well sign-posted

I was totally confused

I just thought, well…

I had difficulty in finding someone

I sat there with my husband

I just found that uncomfortable

I was extremely tense

I have to say

I was leaving

I didn't like it

I was me and not a number

I wasn't a patient - I was a person

I wouldn't ever

I think you're feeling

I was shown into a room
I was really upset about everything
I think
I found it really hard transferring

I was diagnosed….
I rented out my house
I'd nowhere to live
I don't
I didn't know
I mean, we're talking about a matter of weeks
I was out there

I came back
I have my nephew's bedroom
I went and stayed with other people
I came back to here
I was able to get my house back
I just
I thought there's no way
I can say to her
I want you out

I had that appointment
I've worked with the public
I think
I think
I went behind a screen
I said I'm sorry
I just got so upset

I think - coldness in that interview room

I mean
I think
I also had
I don't think they were aware of it
I had an emergency operation
I had to register with again with the GP
I said, sorry to interrupt you

I would be normally be…
I've never been really
I've never had any other illnesses
I've always been fit and healthy

I really thought it was bizarre having breast cancer and maternity together
I just thought that was odd

I think - the seating arrangements
I'm, by that time
I had

I've gone through the chemotherapy
I just noticed out of interest
I didn't look in any depth to it
I think if I've gone along
I think there was information around there
I didn't find
I found that was, you know, adequate

I mean to be quite honest,
I've been diagnosed
I'm just amazed about the number of women
I know of now
I couldn't believe it

I don't think they had a television
I'm not sure if they did
I'm not sure

I've seen different things
I just think
I've broken my wrist
I always used to have pains
I didn't even think

I think it
I think on initial meeting
I wonder
I think it's wild
I think it's well, you know

I attended alone
I was away
I did come with my husband
I was going through all my treatment
I went in with him

I didn't have the full picture
I particularly wanted someone

I first started

I had someone there with me

I thought it was surreal

I think

I think you know, having a good space and comfortable seats

I think is important

I know

I Poem patient 3

I found it quite difficult to find
I don't know if
I think that can kind of adds to stress.
I don't know
I think you would just had to kind of look around

I don't know
I wouldn't necessarily find it
I could remember
I mean Florence Portal house

I wouldn't say it was very clear
I could really
I didn't really know
I was going to
I think so…
I had to be like, pointed
I feel like
I wasn't looking

I did
I think it was kind of like a system
I suppose they're used to it
I was early
I was probably one of the first

I brought my mum
I can remember
I can remember
I think there was like leaflets
I always remember, the radio

I thought was quite good

I always remember
I found kind of quite overwhelming (leaflets)

I'm always advocating awareness
I guess something distracting
I don't know what
I don't know
I just wouldn't want something

I don't know, tips on how to be healthier
I have found
I found quite intimidating
I was saying

I remember just like leaflets of like alcohol consumption
I can actually
I remember those two windows at the side
I remember it being quite cloudy
I remember like the Lino had been [like] worn out

I think it would
I feel like there's things that they could implement

I think you almost feel like you can't leave
I almost felt like
I had to stay there
I waited for about 20 minutes
I had an appointment
I came back out to the…
I was seen again

I remember there might have been a few magazines,
I don't
I just remember maybe
I don't know - leaflets everywhere. Yeah.

I wasn't always necessarily sent back
I was instructed to wait in the corridor at the end
I don't know
I felt a bit overwhelmed

I had been through
I say I'm nervous and worried.
I've been through
I hadn't been through it in Winchester
I wasn't really sure
I hadn't been here before
I wasn't sure why I'm waiting here
I'm not sure why it's taking so long

I'm gonna
I shouldn't say
I suppose
I said before
I suppose they have to be equal

I would say just like that, keep the chat going

I like to be offered coffee
I don't even think there was a water machine there
I didn't see it when I was there
I would like they could ask if your parent or your partner could come in
I don't know if they necessarily ask
I had to ask them

I suppose
I wasn't staying
I think
I wanted a drink

I think it’s distraction
I was going back to [that] the leaflets

I would say
I feel like there could have been improvements in the environment
I don't know, two and two [chairs]
I feel like they could have

I do
I feel like
I really was more so in Winchester.
I'd never been introduced to, like, this genetic information
I could process it.
I'd worries about tablets I had, they kind of answered

I understand that they are under a lot of pressure
I didn't feel like they were rushed

I think it was quite funny.
I'd had, yeah, I'd seen
I was in Winchester
I can show you mine
I was worried about it

I remember it was quiet
I would say it was a bit too quiet
I suppose
I think

I was saying the radio wasn't on

I always remember the footsteps

I've got it

I feel like the environment was totally different from the treatment rooms

I feel like it was a bit more lighter in the treatment rooms

I know they don't have the time

I just remember, there might have been two or three, just big windows. And they looked out onto nothing.

I feel like that could make it really nice [plants] if they were, like, set next to it around the window

I Poem patient 4

I, my mum and my sister were around
I, my feelings were different
I’ve got to go on this journey with a partner
I suppose also

I mean, obviously there was waiting
I don't think
I don't think we waited that long
I was then taken up to the ward
I was then taken up

I didn't know how to sit on the chair
I mean, that's…

I can't remember whether I asked
I eventually I was taken through
I think it was a matter of
I had to
I had to be taken up
I was taken
I remember just it was it was dark at night
I remember being taken

I suppose I was
I was taken to Florence portal
I was actually
I was eventually put
I was going along corridors
I didn’t really know where
I don't think there's any internal system
I mean, there were different cases

I was very, very lucky
I just think Florence Portal House is exceptional
I also like to have that sense of there's another world out there
I think that that element of camaraderie…
I've been through it before
I think people will interact as much as they want to

I think you don't want it to be too sterile
I noticed
I went even with covid done, they've moved away the actual extras
I mean, even if it were plastic plant, yeah
I think I think colour.
I think it only makes you think
I think they rely on donations

I'm still anxious
I'm still anxious

I mean it depends on that type of hospital
I mean they could
I'm not sure if it's quite…
I don't know what it's like now

I sat for a long time
I mean animals
I don't know. I don't know
I felt years darker down there
I just
I just remember it being…it's cold cause it's blue paint again

I think from memory
I went there for meeting

I took my daughter in there

I mean obviously when you go into actually have your chemo it's different

I remember

I Poem patient 5

I can totally relate
I mean
I know they're not there to be entertaining
I think if you...
I think the sort of pictures that are framed, they're all very dated and muted

(Thankfully) I wasn't
I think sitting there
I think if you overanalyse…
I can quite easily do
I think it's anxiety

I tend to move forward and think everything
I went down to the room
I was then yeah
I don't have a mask

I suppose
I think the whole colour and environment…
I think
I think it's just too quiet
I think you hear everything because of that

I've always got the radio on
I like
I like listening to people's lives

I imagine it's very generic for all
I mean
I think the last time
I said

I was scared to come back
I don't
I mean it's not there
I mean it's a hospital
I think there's always
I would imagine clinical facts

I don't like birds
I don't like cats
I think for me that would be absolutely fine
I wouldn't watch on a day-to-day basis
I think if you're making something more of a home environment
I think bringing it down specific colour, probably very much goes with people's own tastes

I felt it was very dismissive
I was left feeling like you've just taken up an hour
I think that can make people nervous to go back
I said, I was unsure this time
I'm going to get it checked again

I know that you're on their books
I can shortcut through
I need to, you know, touch wood
I won't

I just think it's making them more
I mean you could go into a university
[Hospitals] I think they will have that negative connotation
I don't
I think it's historically the way hospitals
I think especially with older hospitals
I think sometimes you can see

I Poem patient 6

I think in terms of arriving
I think when you get up
I think if you're anxious about anything..

I think you obviously, as a hospital
I think all the sort of…
I kind of knew my way

I appreciate some people may want
I did sit there for an hour just looking around
I suppose it's just the unknown

I think initially they give you a clipboard
I can't remember the second time
I think you do that
I can’t remember

I did
I sat with my back against the windows
I'm looking at the main corridor
I can see the reception area
I'm partly nosy

I suppose if anything
I was outside for about half an hour
I don't really like, silence
I felt they didn't really talk to each other
I didn't..

I suppose even if it was different furniture
I just think that those sort of high up..
I mean
I don't know you're at the doctors..

I know I'm asking for a lot of things
I think it
I think. I think it's just too quiet

I would say so, for someone like me
I think chatting and distraction
I'm always happy to talk
[Yeah] I've got one

I then found this other lump
I was like, thinking right
I felt, was more compassionate

I mean
I have literally picked up something before
I think if you're making something more of a home environment
I suppose when you see that
I mean, it's probably just because
I kind of thought realistically I'm probably OK

I think they probably need to be kept separate and kept moving
I was kind of half glancing over
I was dreading her coming out
I was thinking
I can't look at this

I think, you know, being able to hear
I think there are several cases when you are sat in silence
I can guarantee you that at any breast screening centre

I would argue for a few weeks before… It's building up
I think the environment has a role to play in that

I Poem patient 7

I was thinking , trying to look for signs
I knew it was upstairs
I may even have been several years before
I went upstairs and then I'm looking again
I seem to
I'm always looking for the standard thing
I can't remember what it says on there
I actually don't know what it means
I don't know!

I remember it being very light
I was only very slightly nervous
I'm aways in a rush
I think I sat on a chair
I think it increases any anxiety because there's no distractions
I think it heightened it at that point
I was massively fearful/unsure

I see a pale blue
I identify it as a calm colour
I wasn't really thinking about their
I was thinking about my own home
I'd say some low comfortable furnishings
I mean when I'm at home
I always put on work from home music
I just ask my Alexa

I really hate that – having screens
I really really hate it

I was doing more IVF
I needed the

I wanted the NHS to do it
I was really hopeful

I can never understand
I went there a lot
I went in there
I never understood where I was supposed to be
I feel invisible…

[what] I feel comes across
I don't think this is
I mean when you try to fix anything
I know it needs to be done
I'm not saying it can't be done
I'm just saying that's why it's so hard

[What] I like to call messy ceilings
I mean right inside that section

I've gone in for the scans
I was terrified I wouldn't get my child
I'm there waiting for that scan
I'm feeling like an imposter
I'm feeling like
I'm not a mum, it might not happen
I feel like it's sort of fine if it's your third child

I Poem Patient 8

I think
I'm pretty sure it was upstairs
I don't remember it being wooden
I knew about it beforehand
I did walk
I can't really remember very much
I was thinking about was that ohh the last time
I was here
I had, I had my daughter basically

I was just wondering where I needed to go
I don't remember asking anybody
I think I must have
I think I pretty much went straight in there
I found out where I needed to go
I think was upstairs
I would have gone up the stairs and avoided going in a lift
I remember that

I remember where the waiting room was
I think it was. It was starting to be quite a hot day
I was there with my own to start with
I think another couple of people might have turned up
I seem to remember there was a man and a woman
I was not on my own

I remember there's no magazines or anything
I probably thought ohh we're not allowed to have any magazines anymore.
I think with what I was going in for, is all a bit scary really
I think I prefer and some leaflets

I wasn't there very long

I sat pretty much opposite
I sat with my back to the window
I was trying to make it as cool as possible
I can't remember the way

I think you can see the receptionists
[why am] I waiting so long?

I prefer to always have some sort of noise
I prefer to
I'd like the radio on or anything
I find that even sitting in this room without any noise, it's upsetting me
I mean, there was probably some tables around
I didn't notice it being untidy
I didn't notice it being unclean
I think I was probably just concentrating

I think there's just people coming and going and you're waiting
I was getting quite anxious by this point
I thought it was gonna happen next
I understand, it's their job
I think where I was sat
I was facing down the
I might think they're chairs at the end
I was waiting next to a room
[where]I ended up going into
I think, next

I don't really know why you're not put back in the waiting room

I might be misremembering
I think that all hospitals are green and blue
I think it's green colour. It's generic anyway

I think I'd been told what was happening there
I think you probably feel a bit exposed
I think it was... there was nothing. Very light and plain.

I think you're sitting on, it might have been standard hospital chairs
I think it's those sorts of plastic bucket type chairs
I don't know whether it would be possible to have, you know sofas with low tables
I think that's the same magazines. It's always…

I don't think
I mean if it if it had audio something
I can't remember WIFI
I've never seem to be able to have

I'd never really object to that [music]
I really don't like artificial plants
I suppose it's better than nothing at all
I don't know if they can have [greenery]
I know you probably couldn't have rugs

I don't retain information
I'm not sure
I don't
I've got to think

[Upstairs] it was bright on its plus points
I mean, it was just a bit sterile
I'd just like
I'd like all rooms to have outside windows
I just know it's not possible

I Poem Patient 9

I was six months
I didn't know
I was a bit disorientated
I've never been to the hospital
I met the consultant on the stairs
I didn't know where to go

I had scanned
I went [first time] very crowded
I'm talking about the scans
I'm not talking about …
I have been to the breast [clinic]

[they have to face everyone looking at them, which] I think is awful
I found when I went there
I found that really quite difficult
I found it really difficult
I sat in the waiting room
I mean, so that's not very nice

I'm not going to say nice things about that
I think we've been in there before

I mean, I think the parking got a bit better now
I sort of feel that there's no…

I used to call it appointment phobia

I'm deaf, and I've been able to hear their conversations!
I mean is that fair to say when you're arriving.. Not knowing
I would say that my experience there is definitely a bit of anxiety
I don't know if that is because of the waiting area

I have had
I’d say I generally have a bit of anxiety really going
I suppose so
I would say about Florence Portal is the care
I have had there, generally speaking […] very good

I actually, even though it's a bit of a crappy waiting room downstairs
I do feel safe when I'm there
I haven't…
It could not have been any better
I don't feel like that when again I went
I would have been there in February
I'm in and I'm out really quickly, you know
I'm just trying to get out again
I'd say the staffing there a pretty good waiting area is poor
I mean, it's not perfect [care]
I know that

I do remember a picture of Monet
I remember concentrating on that a lot
I don't remember […] There's no music
I find music very calming
I would...
I'd say, and it's a distraction as well
I don't recall it being
I've never recalled it

I mean, there's no décor, is there?
I mean I'm never gonna read that magazine unless I go into a hostel
I wasn't sure
I was pregnant
I'm very familiar with a very different experience

It's very quiet. Yeah
I think it's a good thing

It's a very serious kind of space
I don't know
I remember the reception
I find that a little bit austere
I appreciate why
I can't recall anything of note other than lots of leaflets
I remembered being quite spread apart
I've been in that room a fair amount
I don't like that because you can't talk to your partner

I don't remember any colour
I don't remember

I do like the quietness, but it's a bit too quiet
I think when I was there, there was no water
I'm pretty sure it's pine [furniture]
I think they're bright blue those chairs
I think I've seen the pink ones somewhere else

I wouldn't even call it a waiting area
I've been
I've waited in the corridor
I mean, it's a bit shit, really

I could probably have got this wrong
I've got this thing in my head that […] just all very little seats
I can't remember other than… exposed
I am quite a private person
I am a very private person

I just, you know, I keep myself to myself
I'm not like that.
I can, I'm very open but…
I tend to, you know
I wouldn't be a sharer
I've gotta get through this

I would say they're all very… […] sterile

It's a place of curiosity [imaginary waiting room]
I think that there are some women who have small children
I want it […] everybody wants bright, fresh light rather than dim

I never have overhead lights on now, unless I'm working on something
I think it's the tone
I remember being on the children's

I think they've been up there once before
I don't know whether or…
I do actually
I think you can't do that downstairs - you've got these young mums and then you've got women who
are desperate

I don't know
I always felt that the space is negative, Florence portal because there's no green space
I've sat downstairs
I've seen [is] those doors slamming open, shut, open shut
I found it quite difficult to cope with

I don't like seeing people coming in and out of rooms
I think that it's a bit of an invasion of privacy
I'm not sure what you could do
I don't like hearing the nurses talking about someone
I cannot.

I've said this before is that there's no dignity

I think they're just dealing with a high volume

I noticed one thing that made me feel slightly uncomfortable

I just thought I should level with you on a round table

I didn't like that

I mean, it was a practical thing as in the room is tiny

I don't think I've been in that one

I've been in the one in the canteen

I been in that building

I've been to all of them as a different kind of patient

I've been there to find out whether or not I was having a miscarriage

I was in there - they had these little rooms

I remember the [I know the] kindness of people there

I felt every emotion in that building at some point

[Why do they have the breast care downstairs…a very good question, which] I would be asking

I think when someone might be having a real problem

I mean the ones about breastfeeding

I wanna .. I always think ohh

I want to be by the window. Yeah

I've seen some women in the late 80s … tends to be focused on the older

I had two small children

I like to

I have to

I took him to a hearing test once

I Poem Patient 10

I mean it could
I had to end up going on to ward
I wasn't kept in
I should have actually stayed for a few hours
I didn't because it felt all very relaxed

I was there
I went to the
I was told to go walk into the...

I don't know
I was directed left to another reception
I'd been there
I was told to go to the edge
I'm like, OK, well, what, what, what?
I chilled out. Walked down. Found my way

I got into that reception
I was greeted very nicely and told to wait
I was greeted by somebody
I sat for a while
I don't know
I was looking around
I felt

I went. I went left
I didn't feel cold
I think there was some artwork on the wall

I can't exactly remember
I did feel quite relaxed
I went on the instructions
I just went with that
I didn't look at any signage
I just kind of kept that in my head
I sort of went

I mean there was definitely some leaflets
I can't remember what those were
I didn't pay too much attention
I think it sort of felt like colourful artwork [on the wall]
I can't remember exactly

[comings and goings] I suppose, distracted me in the reception
I'm in their call
I don't know how to get rid of that
I'm in
I'm in their conversation no matter what

I don't know if her title would be a nurse
I can tell you straight away. It feels cold
I don't know it just because it's so big
I suppose
I mean
I actually went with my husband
I thought, well, if it's bad news
I need somebody with me

I've got enough going on

I didn't need an extra layer

I was with him

I still felt like the area was
I thought, oh,
I don't have to...
I actually went to pick one up to mainly to take my mind off
[what] I picked up was obviously keeping my mind on it

I think it's interesting
I went in there with without any kind of understanding
I can't remember exactly the leaflet
I thought OK that that looks interesting
I should know

I think that there was a big range
I suppose
I picked one up
I wanted to distract myself

I didn't particularly want to have a conversation
I must have been there about 10 minutes

I wasn't about to have a conversation with him
I don't know if that's a divergent thing
I do like my privacy
I suppose

I'd love that

I find most distressing [not knowing]

I moved from the reception area

I will be doing this

I should have had to do it

I had a very nurse who was chatty

I think that had she not been talking to me

I'm going to do this, this

I didn't really know what had happened to me until afterwards

I think the fact they've got to move you two different spaces is also challenging for them

I deemed it as a major procedure

I feel like I've got PTSD

I don't

I honestly don't think that's an overreaction

I've just had a major procedure

I'm not one for hanging around

I can sense things

I felt I outstayed my welcome in that particular space

I'm literally in shock and that's

I think another challenge

I've been and I've gone

I've had my procedure

I don't know if there's anything there

I needed to go and lie down

I go in there

I said, oh, it's a bit

I don't really want to mess your bed up

I'm, you know

I'm sure you've got enough
I'll just sit on the chair
I know they needed to tell me

[Am] I in the right place?
I'm in my panic thinking
I've got it wrong
I was you know struggling over the years

I suppose that the nurse
I was moved […] taken, you know, taken from that situation to another
I've drank my tea!

[the pain] I'm getting now is quite horrific.
I go and see somebody?
I'm trying to give you a context
[Where am] I in the process?
]Should] I go home yet?
I phoned him
I said, can you please pick me up

I really like [you know] very calming.
I think would suit most people
I personally like it, you know, a low level jazz
I think that would set a nice cosy sort of scene
I love art and I love any kind of…

I was walking into the hospital
I'm like, oh, that's interesting [art]
I was like, oh,

I haven't got time to do that
I'll you know
I'll think about it another time

I love bright, bright colours
I suppose you can look at the psychology
I mean, isn't green supposed to be a really, really calming colour?
I think there's other psychological stuff around colour

I think the challenge with furniture […] will be a cost
I get all of that
I've had accidents
I just feel […] it's just not inviting in in the slightest, is it?
I understand the whole sitting upright
I get the whole disability focus

I think no, it's a disaster for the environment. Anything plastic
I don't know, local universities, art schools
I think it feels like there was something tapestry
I can't
I don't know
I can't remember

I do think greenery for me anything tree-wise
I remember the bookshelf
I think
I mean
I love books
I didn't know
I didn't have the time

I looked at the leaflet instead.

I did notice

I do recall that you can swap books or whatever

I don't feel like there there's a need for TV

I don't like about TVs is they can be a distraction for me

I'm like, oh, God, get me out of here now

I think

I like

I definitely like to feel connected to a place that I go

I connect with the place

I think I would

I would prefer those sorts of environments for me to feel at home

I Poem Patient 11

I've had different experiences
I can talk about all
I think
I hadn't actually thought about it
I read your thing

I've been up
I could
I was in
I had a partial
I had a hysterectomy
I was in and out
I had obviously an overnight stay

I'm lucky
(best thing) I've ever done
I read your thing
I went, oh, yeah

I mean, yeah
I did. I mean
I suppose you don't
I wasn't going to talk about the ops stuff
I can talk about
I kind of

I knew
I was going to meet either consultants
I do think it's a quite
I've been in there a lot
I do think it's quite depressing...

I mean, lucky
I live nearby
I could
I was able to walk
I don't know

I was just thinking, it's such an important part
I've always just thought
I don't know […] it feels like a school

I think it's a different experience when you go up
I know it's laminated wood

I was doing the gynae
I found really, really disconcerting
I could hear medical conversations
I was sitting outside thinking this is really private
I can tell you
I found really strange
I could literally hear somebody
I've had this picture
I was expecting
I went, oh

I do think the waiting room [upstairs]
I, each time
I've taken my book

I've always been by myself
I've been in there
I literally was sitting in this really small space

I just felt, you know
I was thinking
I'm OK because my mindset knows
I'm to have
I just felt it was a bit
I thought
I was…
I always remember
I always remember thinking
I'm glad
I'm someone who's kind of really sure
I'm not gonna have any more
I just found that a bit…. you needed to be somewhere more private

I can't probably digress
I just digressed

I think you're not sitting
I suppose
I've just felt
I've have always

I remember thinking, oh
I've been in the hospital
I think you could make it softer

I mean, it's all like pinky, isn't it

I think that's really important. You can look out
I felt each time
I went in
I was really nervous
I haven't been before

I didn't know what to expect
I was
I was quite anxious
I went in for the first time

I thought
I know
I'll take my book
I'll sit
I'll read
I knew that was there

I've always sat in the same place
I've gone back
I've sat looking out
I've always sat

I mean, it does feel […] like you’re old people
I think it's good
I don't
I don't make eye contact
I don't want to
I didn't want to have a conversation
I went
I felt or, you know, yeah
I felt
I was far enough away
I wasn't
I knew
I wasn't in her space

I would say that
I felt that maybe she should

I never had bad news
[if] I had bad news,
I want to be sitting in that room?

I did
I ended up in lots of different places
I ended up
I had to have a little biopsy
I was moved
I was sat down in the corridor
I knew they told me
I knew
I was there
I knew, I knew
I wouldn't
I was gonna see the consultant
I went
I'm not going into that room
I sort of
I knew
I knew
I don't. It felt different

I was sitting outside
I could hear
I could hear two
I literally heard
I had mine
I heard every single word

I didn't [say]
I should
I

I should have
I remember
I hope when she's talking to me, there's no one outside

I do think […] it's really private
I didn't tell
I remember
I’ve got a hospital appointment

I like it. 'cause it's spacious

I was really walking
I was really nervous
I think if somebody walked you down

I think
I think the staff
I've had there
I met, there are probably the kindest
I've come across
I've had, you know
I said thank you

I can't
I do remember thinking
I can't remember

I put it this way
I looked at it
I couldn't think of anything
I didn't want to read any of that
I had my book
I knew second time

I didn't want any of that at all
I think, yeah
I
I remember looking
I don't want to look at that

[When] I was pregnant
I probably would have
I might look at that

I think there was
I think there were some […] books or magazines
I think
I remember[…] there's a table
I remember thinking, why is that table there?

I mean, it's not great views
I like the fact it was light
I like
I hate
I hate seeing corridors
I like seeing natural light

I always sat
I could look out
I would never sit with my back
I like looking out at life

I don't know
I was sitting
I was sitting where I was

I think

I had brought
I had water
I think I had water in the corridor

I always thought
I remember maybe 10-15 minutes
I remember thinking
I'm starting to read now

I think
I like
I prefer it
I wouldn't want a TV
I wouldn't want that
I've sat in A&Es when they've had that
I don't know

I think I would want calm
I mean
I would
I'd like some candles

I'd like […] Radio 2 on
I don't think
I'd want that [music]
I think no
I'd like it quiet

I think
[If short time] I was in there
[if] I had ended up being in there for an hour
I would like
I always think […] not too sterile

I think
I think there were some books or magazines

I think
I like light
I think sort of bright
I don’t like the strip lights
I wouldn't want to say

I just think
I think […] a comfy
I don't know
I wouldn't want to relax
I don't know
I would feel
I'd like to, kind of want to sit up

I would imagine
I've always tried
I don't get them these days

I love
I always have fresh flowers
I think if you had fresh flowers

I would like it to be like white
I don't know
I would, you know, like some Hockney prints

I can't

In my head
I imagine. It's like, really awful. Waterfalls or landscapes?
I don't know it's
I wouldn't want any of that
I'd like
I know what I like
I would love […] something colourful

I think that's…
I just think they show that somebody thought about
I think […] means someone's thought

I've not got one.
I know
I went to friends recently [tv]
I think that would be
I just think that's [a] nice

I do think they [..] try and make it personal for you
I think […] different to the staff that are in the, you know, the gynae
I think it's quite cold
I literally
I think it's all like […] It doesn't feel warm

I just remember
I'm sitting here in a tiny little space
I thought that you go upstairs […] different to downstairs
I definitely felt
I know it has to be

I just
I've been at Southampton
I just feel that it's just more […] open

[Should] I be sitting here?

I'm next to a really pregnant woman

I'm about to have a scan

I'm having […]parts

I'm having removed

I Poem Patient 12

I, it felt clinical
I cannot bare UV lights
I expect it

I think it's not inviting – needs artwork and colour
I think it's empty, soulless, bland
I wouldn't have looked out of window
I don't want to see that – medical info

I like big plants – real
I don't like bland artwork
I'd like white walls - clean and bright

I hate that grey/pink colour, awful
I cannot bare UV lights
I'm sensitive to light
I expect it
I feel the doormat – needs a statement
I want a sanctuary, [to] leave it all behind me

I Poem Patient 13

I've been there a few times
I went for assessment
I've been part of a trial

I think it's very funny
I have got a friend
I don't like getting this.
I'm like walking everywhere, right?
I'm trying to find the stairs
I mean, I don't
I don't know, actually
I bet the signage itself, there's a lot of it

I don't know why
I first went
I like being on time
I mean
I know younger people also go

I think at the beginning
I remember
I was diagnosed
I don't know what questions
I don't know
I didn't
I believe that's changed
I've been hearing

I think that's not […] you don't get to
I suppose when you first go
I went to this little smoking area

And I went in the building
I think as you go

I don't think any of Florence Portal
I don't know Florence Portal
I don't know who they are

I don't know why that [carpet] is so
[Am] I at the right place or not?
I think is on sort of an emotional level [choosing a chair]
[Am] I in the good news area?
I find
I think there's soulless blue

I suppose you are on alert
I think there’s something wrong with you [if you’re not scared]
I know a few people
I think you need better basic information

I haven't noticed it
I haven't noticed it
I mean
I think there […] used to be a few magazines on the table
I'm not sure they're there

I first went
I don't tend to pick anything up
I tend to look at posters
I think there's some water
I don't think coffee and tea

I've never heard anybody

I find it quite intrusive
I'm sorry to tell you that no […] it doesn't get easier each time
I think

I think sometimes there's [music]
I think it varies

I should say [bland]
I don't
I don't think it does need to be clinical
I have to have intuitions
I don't wish to have it
I'd rather see something…
I think it should be mixed because people are so so so different

I think it's very difficult to make it like a spa
I mean, you could […] have some headphones

I think there's an issue with NHS Blue and NHS Greens

I'm not sure if you're a wheelchair user, actually
I was there and they had to kind of move the chair around
I think it is first impressions because that's what sticks

I Poem Patient 14

I have been more than once
I think so
I got the letter
I think
I was about 49
I had my first
I think since
I've been back once

I vaguely remember
I have to say
I get rid of the stuff
I would say

I would say
I find Winchester [quite a pleasure
I think Winchester
I think the signing […] quite good
I think you always feel a little bit lost
I think the staff are generally very welcoming
I don't remember feeling […] distressed

I think it's relative
I mean, hospitals are horrible, you know

I don't enjoy going into hospital
I was seventeen
I had kidney failure
I don't go to

I'm probably quite easily pleased
I can't remember
I don't think it's a very welcoming
I mean I've
I wouldn't say it's like
I'm actually…
I think that, you know, the walls are dull

I do remember
I think it might have been when I had the lump
I had to go back
I would say […] very barren and sanitary … it feels quite depressing

I would say about 10 minutes
I'm just wanting to say green chairs
I've got OK: there we go

I think it was over the summer
I don't recall blinds
I would say a lot of artificial light
I don't remember […] nice sunny, natural light

I don't recall [water]
I don't remember
I mean, you're not gonna sit and read a book
I would be on my phone probably
I would have gone alone

I'm not
I mean, I work in sales, right
I'm quite antisocial in a situation like that
[it's not a place] I particularly want to be

I mean, if there was a young mum with a kid
I might chat
I wouldn't be rude
I basically want to get over and done with

I've gone from mammograms
I don't remember hearing
I mean, you can hear hustle and bustle
I suppose, but it's quite disconnected

I think it's quite a…it's an unpleasant experience [in a corridor]
I don't know why they do that
I don't know why you can't be in a comfortable, pleasant place

I would have probably tried to […] my head down waiting for a lady
I was like
I'm going to the nut house

I'd say, […] too much nurse caring can also make you feel like ….
I'm, this is quite serious
It's such a personal experience
I think if it's your first
I think
I've had three mammograms […] it's a completely different experience, yeah

I'm trying to drag myself back
I've been
I can't think […] it was a sort of corner area. Really miserable
I just sat there thinking, oh my God

I remember thinking
I would only be here if they really thought
I had cancer

I mean, if
I think about … Sarum Rd Hospital
I think just warm
I mean
I'm not a designer at all, but
I mean maybe Blues and greens, but cozy
I don't think it's the colour per se.
I mean, people say like greys are cool colours

I mean the navy and pink!
I don’t know
[What] I quite like is when you walk through the horrible long corridor [artwork]

I think a bit like
I don't know
I mean, it's never gonna be like, lovely, right?
I think, like the dentist
I go to […] there's like little sofas

I think [artwork on the wall] just generic nice pictures [could be cities could be nature]
I think anything that makes it feel a bit more homely
I mean, nice
I'm sure there are specific plants that you get that would just give a nice vibe
I think soft furnishings rather than plastic chairs stuck together
It's probably not very hygienic
I think as long as you have a..
I mean not gonna be there for hours
I don't think you need to go too fancy
I think a coffee machine
I, for me, rolling television maybe I'd watch that
I think probably maybe just having music is enough

I would compare it to the way they tend to do children's wards
I bet you men design them, that's why
I mean flooring
I'm guessing it doesn't have to be cold

I think just, just imagine a comfortable café
I would pop into for a nice cup of tea

I've never
I think I have an assumption that hospitals are pretty cold
I'm being devil's advocate
It's like, I guess the reality is…

I Poem Patient 15

I am […] there's nobody there to greet you
I think… really quite significant
I asked if it was working
I love the floor

I think it could be quite confusing
I did. OK.
I think having, yeah…
I feel very vulnerable when you can hear voices
I can hear what they're saying
I noticed
I sat there, doors banging

I don't normally go […] very often
I think
I've only been in those rooms maybe once

I think people look at them
I would say more people will read notices when they're bored
I think it's important to be on the wall

I don't know, too much information
I wouldn't even say it's subdued because subdued is nice lighting
I will probably go on my phone
I like people watching

I love the hospital environment
I've always loved it
I still love watching people
I love psychology and
I'm thinking

I like watching things like that

I'd like to see daylight
I'd like so, therefore, a window
I'd like to see plants
I, I'd like to see comfortable chairs
I think some nice background music
I wouldn't want is […] they're all around the outside of the walls [chairs]
I see it from that point of view.
I also see it from friendly inviting
I don't have plant ideas

I love colour
I love bright colours
I don't really like the pale greys and the cappuccino colours
I just don't like that

I'm very blue person, so turquoise
I think it'd be too bright for a hospital
I would have them really, really bright

I like outdoor [images]

I'll tell you what's really good
I, had [the] MRI scans
I'm petrified, of course
I had to put my head in first
I absolutely freaked out
I had to go away
[they put a window in the ceiling, not real]
I was, there you go
[And] I'm going

I don't mean air conditioned air

I mean air

I Poem Patient 16

I'm there now
I've never been an inpatient
I mean
I know if you know it's quite difficult […] finding your way
I suppose when you arrive […] it's like ohh wait, where do I go?

I find that in hospitals always
I was I
was in
I was there yesterday […] it's like oh my God

I find that the actual the whole uh department
I say, reasonably modern
I would say better

I know there are signs, but it's still
I don't know
I suppose when it used to be, there was a little shop
I've been so many times
I know my way around

I still
I still think generally
I suppose they have so many signs and so many departments
I do wonder sometimes
I do wonder sometimes […] could they?

I mean, whereas some areas of the hospital
I thought with…
I call it the best cleaning whatever
I say well designed you know

I know the other parts of the hospital so well and they are not

I do think now of course the layout could be different

I remember once waiting there for about 50 minutes
I'm not blaming anyone
I know this was also still maybe partly leftover from COVID
I remember giving up my chair for an elderly person and, yeah,
I know

I just remember thinking cause it's quite a big waiting room
I think you can so easily make a waiting more room more into a sort of living room space
I'm just generalizing here
I know cushions aren't… are not…
It's not good example
It's not very hygienic, but you know

I know exactly
I suppose most people are on their phones
I think the network isn't very good

I also just, […] it's the minute you sit in one of those hospital chairs, it feels very medical and institutional, doesn't it?

I did go to the private clinic
I had to have an MRI
I was impressed with the furniture there
I know that the furniture is very expensive

I don't know, they're still doing it, but they did that for COVID
I don't know who came up with that idea, but it doesn't have to be
I think yeah

I don't wanna be a patient. Nobody wants to be patient

I think they've got [light and colours]

[if] I remember correctly

I should know

I should have paid more attention

I think it's the chairs

I know there's some of those chairs are sort of high back and others are just the smaller standard

I know the colours in there all quite light

I know, for instance that this was blue colours

I say

I've been going in a lot for our children and for myself lately

I'm going to all the different [areas]

I, you know, the children’s ward is always the one that gets the most attention

I think what they do almost in most hospitals[…], ohh well, well, we've got room for a picture here

I just like … windows […] it creates another dimension

I think with pictures

I personally think with pictures you can't go wrong with nature

I suppose, white is OK you because then you can just hang things and also you can rotate things

I know they take up more space [sofas]

I would have little coffee tables, you know?

I think you, you […] invite people to have more conversation

I would even

I ended up spending from 8:30 till 12:00

I knew it was probably gonna take longer

I brought his tablet

I was looking for charging points. Nowhere

I'm not one of those mums

I just thought, no, this is gonna take a while

I have spent, been hours in waiting rooms

I wanna make you good use of my time

I wanna be able

I need to call a client

I can't remember

I think wasn't it on once with classical music

I always think you can't really go wrong with very gentle classical music

I think they should just try it

I actually think most people would prefer that over the silence

I'll just, just wait here until the next person comes

I think none of it is ideal, is it?

I think my experience,

I just wanna say anyway, how unbelievably caring

I feel like crying

I never thought

I take their time

[Thank God] I don't have toddlers anymore

I, maybe they don't get many children there

I'm gonna leave my child at home […] from time to time, people who have to bring a child with them

[if] I had, like a tiny little, you know, those kitchens, though, those little play kitchens

I know it's a nightmare for maybe for tidying up

I don't know about hygiene

I don't know how they, but it's just like, forget about all that
I might be completely wrong

I find [tv screens] really annoying personally
I know it's handy because they can put all sorts of information on there
I'm personally not a fan

I think you know
I like what have I seen lately
I saw brilliant thing at a hotel […] it was digital art […] tiger slightly moving

I don't know
I suppose it never gets done, does it?
I think it's more how they care for you, isn't it?

I know it's like, oh, well, who's gonna water them?
It's just, I know, I know

I can't help but walk into space
I always think what would I do to make this more appealing and?
I think we just need to be a little bit more brave
I know that they couldn't probably go for that, but why not?

I Poem Patient 17

I did get lost then
I ended up in two different places
I actually found the place
I saw the sign
I thought I was supposed to go straight
I was supposed to go up
I went to the receptionist
I definitely felt rushed
I was lost, late
I was lost

I guess it was more recently refurbished

I got lost, I ended up in a different waiting room
I'm checking in
I spent most of the time in the waiting room
I don't know
I remember that there was one large table […] a lot of empty space

I actually thought that probably one of the patients that are waiting would turn it on [radio]
I think switched on [would make a difference]
I was pretty sure that there would be some water
I think a lot of people didn't notice
I was the only one that actually used it

I was next to the flyer stand and facing the windows
I was actually surprised to find one in Polish and Ukrainian
I'm in those waiting rooms
I took a couple

I think about 10 to 20 minutes at a time
I've already waited…

I did not notice any toilets
I was going to the consultation room
I had no idea that there are any

I didn't see any windows
I didn't have access to it to a window
I think so
I like
I like to look outside
I guess it just gives me a sense of larger space

I had [apart from] in the consultation room
I did feel private
I had the scan it was pulled [curtain]
I could not see them

I felt like I'm infringing on somebody else's privacy
I felt uncomfortable
I didn't feel like
I should hear those [conversations]

I remember the very large poster
I think so […] as if it was one of those made for like a large bus stop or something
I'm not sure I could say anything

I think maybe some neutral pictures

I think it depends on the plants
I like to think that if they are very colourful
I think I would

I did fill in the form at the very beginning
I was also asked about my employment

I always got confused coming back down
I was fine going up
I could never find the stairs
I could never find the stairs

I mean
I've been there before
I watched videos recorded because it was still covid times
I knew where to go

I was going to a different clinic
I had no idea where I'm going
I'm trying not to say anything
I was going to the breast clinic

I didn't even get my letter
I had only the phone call
I couldn't really remember exactly
I ended up with the breast nurse
I think so - she straight away checked
I'm there or not
I haven't even sat down

I can't remember there was actual TV going
I think not
I think there were just some short clips made by NHS
I don't know
I'm not sure how it might feel
I think to some extent people have been feeling indifferent about that particular space

I don't mind interacting with others
I usually don't initiate it
I never know what kind of situation

I think
I noticed that
I didn't always understand what she was saying
I could definitely express myself
I was in the consultation room - the nurse, we did have a little chat

I was staying in the in the post Natal ward

I immediately thought about the type of light [ideal]
I've been warm, light and warm colours
I don't know why
I’m immediately thinking about. Blue
I would say there wouldn't be too many open spaces
I would add something in the middle
I would not necessarily want to sit very close

I remember game when I was a kid
I was young and we all sat in a circle
I felt that when I went into that waiting room
I would say some soft furnishing
I think it depends if people are on their own
I do remember that it was quite bright
I didn't want to be too late
I didn’t miss your slot.. [so] I'm not actually seen

I think
I will even add snacks to it […] the machine […] was broken

I thought it would be the next door, but it was the previous door
I came for the antenatal ward
I was staying overnight
I had no idea where to find a nurse
and I really need the [toilet]
I have no idea where to go

Appendix 17. Table of Initial Emotion Codes Assigned to Interview Data

CODE	NATURE OF THE EMOTION	TOTAL MENTIONS	# OF 17 PARTICIPANTS MENTIONING	BROADER CATEGORY
Vulnerable/exposed	Feeling too close to others, overhearing conversations, cramped areas, awkward or difficult silences	59	12	CONTESTED NATURE OF SPACE & DIVERSE IDENTITIES
Confused	Wayfinding issues: lost. What was happening?	56	15	SYMBOLIC MEANINGS, COMMUNICATION, TRUST
Anxious/stressed	Arriving worried, missing their slot, late. Previous circumstances affecting things.	46	15	PATIENT EMPOWERMENT, CULTURAL COMPETENCE, AGENCY
Apprehensive	Nervous of what was to come/results/outcomes/tests	45	16	PATIENT EMPOWERMENT, CULTURAL COMPETENCE, AGENCY.
Uninspired	Dull environs, shabby,	42	16	DEPRESSED
Processed	Being 'put' somewhere. Feeling next in line. Not feeling human.	32	12	COMMODIFICATION OF HEALTH, PATIENT AUTONOMY
Disappointed	Showing regret about things, sad things weren't better	28	13	DEPRESSED
Empathetic	Considering spaces for others, other's emotions, needs and circumstances	27	9	MOMENTS OF HOPE
Unhappy/upset	Annoyed by things, upset by things, cross	26	11	DEPRESSED
Frustrated	As above but frustrated rather than upset	26	9	DEPRESSED
Indifferent	Not noticing, or noticing but apathetic	18	12	APATHY
Grateful	Thankful for small things	16	9	MOMENTS OF HOPE
Uncomfortable	Either physical (chairs) or emotional linked to privacy	15	8	CONTESTED NATURE OF SPACE & DIVERSE IDENTITIES
Unwelcomed	Not feeling seen – particularly on arrival	14	8	PATIENT EMPOWERMENT

				CULTURAL COMPETENCE, AGENCY.
Overwhelmed		8	5	PATIENT EMPOWERMENT, CULTURAL COMPETENCE, AGENCY.
Pessimistic	Not hopeful/ accepting of low quality	7	2	DEPRESSED
Avoidance/distraction	Needing to be occupied, taking one's mind off things	6	6	COMMODIFICATION OF HEALTH, PATIENT AUTONOMY
Dependent	Waiting to be told / moved	6	5	PATIENT EMPOWERMENT, CULTURAL COMPETENCE, AGENCY.
Satisfied	Generally ok with something	5	3	MOMENTS OF HOPE
Bored	Apathetic, uninspired	4	3	DEPRESSED
Unseen	Not feeling seen – particularly on arrival	3	2	PATIENT EMPOWERMENT, CULTURAL COMPETENCE, AGENCY.
Reassured	Comforted (usually by people)	3	5	MOMENTS OF HOPE
Entertained	Distracted or amused	2	2	MOMENTS OF HOPE

Appendix 18. The Health Space Design Playbook (Author's Own)

The Health Space Design Playbook

Prompts to Put the Patient First

A User-Centred Discussion Framework for the Creation of Positive Patient Spaces

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The Health Space Design Playbook

All images: photographed by Sarah Green
Cover and book design: Sarah Green

Contents

Foreword

This guide came about through serendipity.

I was studying on one course whilst thinking about another: my Professional Doctorate. I had just started and was exploring ideas for my research topic. I knew I wanted it to be about spaces in some way, and design in another.

And then the lightbulb moment.

A fellow student on the course asked if I'd go and take a look at the hospital she worked in as a part-time clinician. We all know the pressures on our public health systems, but there was so much to see; so many things that I felt could be tweaked or improved.

Six years and 80,000 words later and I know so much more about patients and their feelings about spaces now. This guide shares just a little bit of this new knowledge in the hope that it might help practitioners make a difference to a patient's day and their lived experience of the waiting room.

Sarah Green

Welcome to The Health Space Design Playbook!

This guide is designed to help you when considering the design and use of patient waiting rooms or other public health spaces, whether old or new.

It is based on some extensive research that was undertaken in Hampshire, UK into patient feelings about health spaces and what matters to them.

In gratitude to all the patients who gave their time and such honest accounts of their experiences.

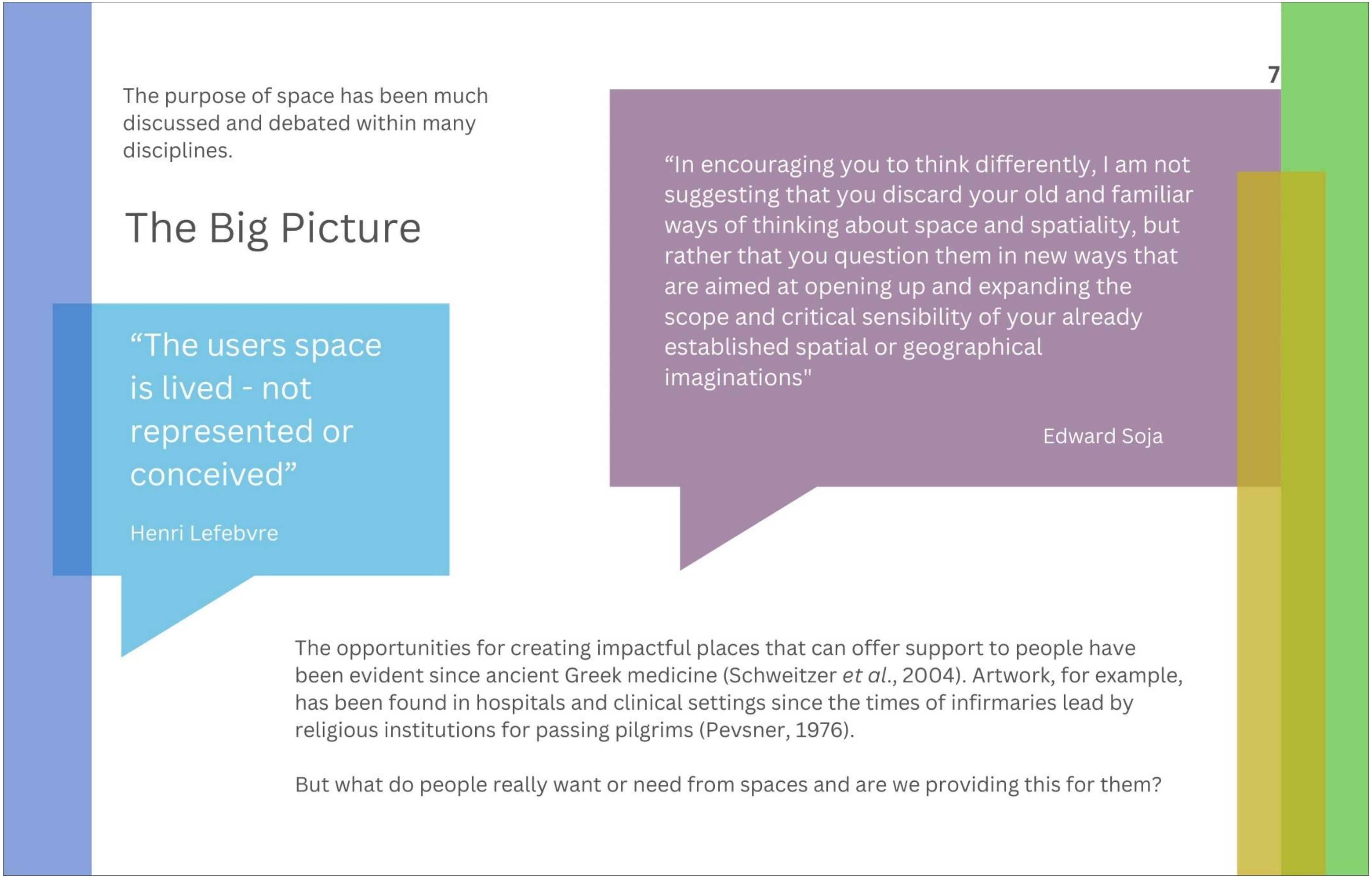
How to Use This Guide

The pages that follow pose some questions and discussion points about various aspects of waiting room spaces and beyond.

While it would likely be a worthwhile exercise to review them all, perhaps discussing with key stakeholders, they can also be used independently of each other.

These are designed as starting points for conversations around your particular setting, and so rather than being prescriptive, they simply signpost issues that occurred from the research that may merit fresh perspective or new kinds of dialogues and innovations in your settings.

Enjoy the journey!



The purpose of space has been much discussed and debated within many disciplines.

The Big Picture

> “The users space is lived - not represented or conceived”
>
> Henri Lefebvre

> “In encouraging you to think differently, I am not suggesting that you discard your old and familiar ways of thinking about space and spatiality, but rather that you question them in new ways that are aimed at opening up and expanding the scope and critical sensibility of your already established spatial or geographical imaginations"
>
> Edward Soja

The opportunities for creating impactful places that can offer support to people have been evident since ancient Greek medicine (Schweitzer *et al*., 2004). Artwork, for example, has been found in hospitals and clinical settings since the times of infirmaries lead by religious institutions for passing pilgrims (Pevsner, 1976).

But what do people really want or need from spaces and are we providing this for them?

What Matters:
Why Ask the Patients?

To deliver on some of their established principles and values, the NHS (2019) proposed a new service model for the 21st century. A high priority is personalisation: a shift in working alongside patients and individuals to deliver more ‘person-centred care’, noting that the importance of ‘what matters to someone’ is not just ‘what’s the matter with someone’.

However, healthcare settings continue to experience multiple pressures including the legacy of the Covid-19 pandemic (Willan *et. al*, 2020).

Against this backdrop there is a complex picture of the patient experience which is diverse and subject to many influences such as lighting (Cassol *et al*., 2011), noise (Pattison, 1996), décor and aesthetics (Nielsen *et al*., 2017).

Also at play are various types of relationships and interactions between staff, patients and their families and the space, involving levels of trust, intimacy and empathy (Andrade *et al*., 2016).

A study was undertaken in Hampshire, UK to start to explore these dynamics, by putting the patient’s voice front and centre and asking them what really mattered and how they felt - in this case in the waiting room.

What’s Behind the Approach?

Underpinning this discussion framework are the results of this research. Many common themes emerged from the data; these are highlighted for you to review and discuss in the pages that follow.

Calming Anxieties

Many factors were at play which increased feelings of apprehension whilst waiting

Who’s Space is it Anyway?

Protecting privacy and respecting others in spaces was a strong thread within the data

The Big Questions

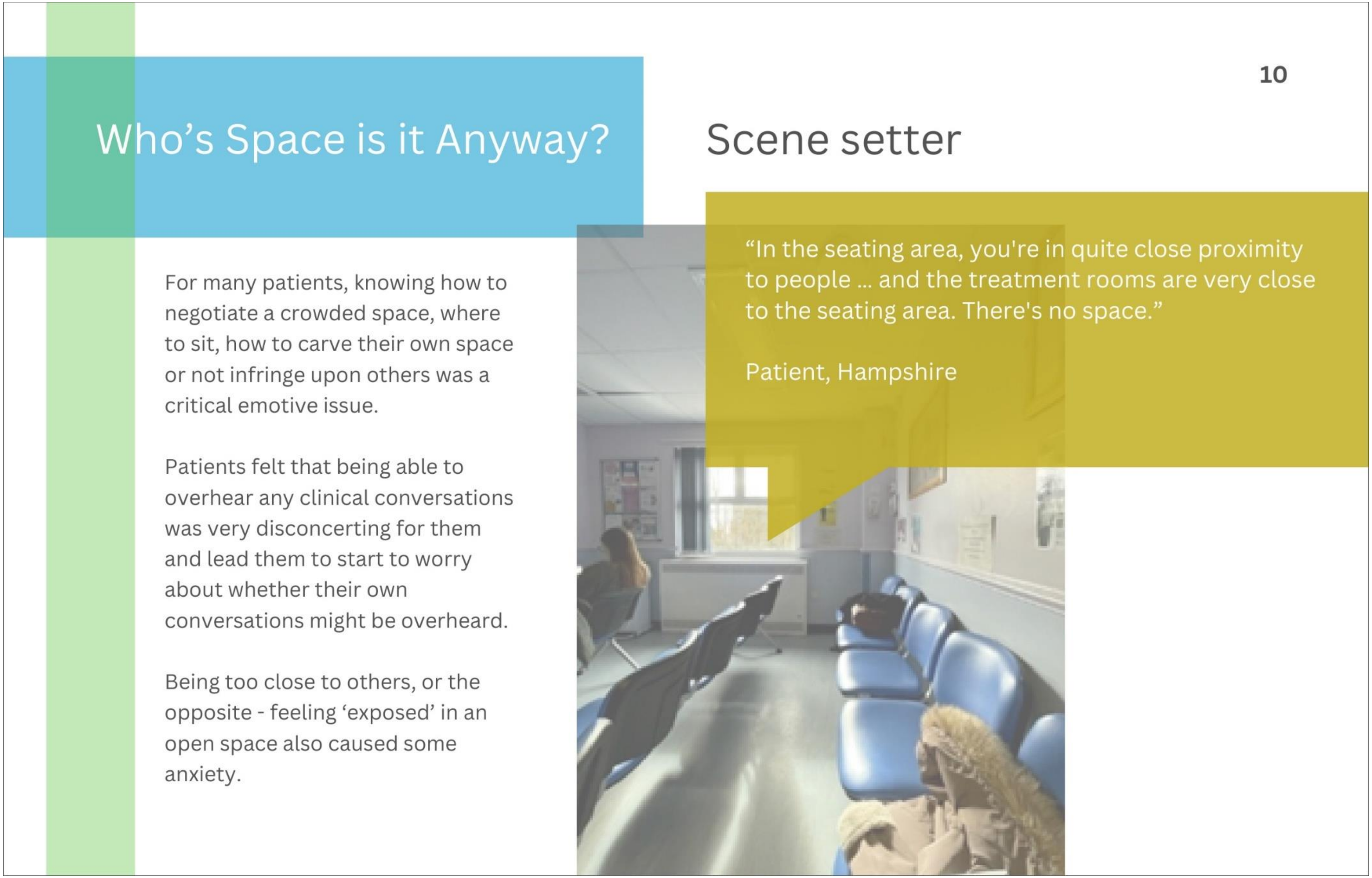
And of course aspects such as light, sound, decor and other features all had a big impact on patients

Communication and Trust

Hospital spaces proved to be confusing, especially when patients were in a heightened state of alert

Moments of Hope

Aside from complimenting the general care of staff, patients were quite vocal on things they hoped for from a better waiting experience



Who’s Space is it Anyway?

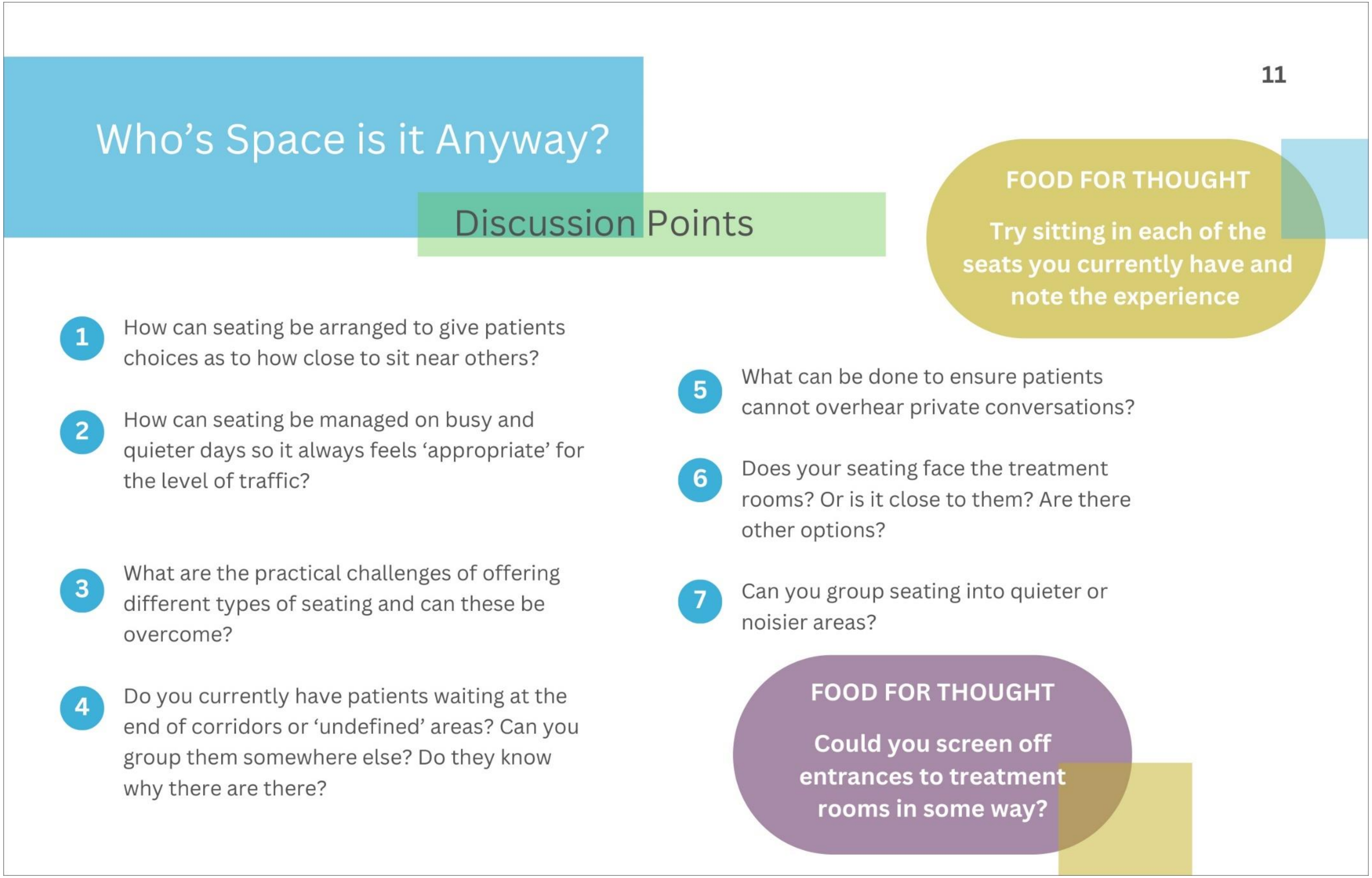
Scene setter

For many patients, knowing how to negotiate a crowded space, where to sit, how to carve their own space or not infringe upon others was a critical emotive issue.

Patients felt that being able to overhear any clinical conversations was very disconcerting for them and lead them to start to worry about whether their own conversations might be overheard.

Being too close to others, or the opposite - feeling ‘exposed’ in an open space also caused some anxiety.

> “In the seating area, you're in quite close proximity to people ... and the treatment rooms are very close to the seating area. There's no space.”
>
> Patient, Hampshire



Who’s Space is it Anyway?

Discussion Points

1. How can seating be arranged to give patients choices as to how close to sit near others?
2. How can seating be managed on busy and quieter days so it always feels ‘appropriate’ for the level of traffic?
3. What are the practical challenges of offering different types of seating and can these be overcome?
4. Do you currently have patients waiting at the end of corridors or ‘undefined’ areas? Can you group them somewhere else? Do they know why there are there?
5. What can be done to ensure patients cannot overhear private conversations?
6. Does your seating face the treatment rooms? Or is it close to them? Are there other options?
7. Can you group seating into quieter or noisier areas?

FOOD FOR THOUGHT

Try sitting in each of the seats you currently have and note the experience

FOOD FOR THOUGHT

Could you screen off entrances to treatment rooms in some way?

Communication and Trust

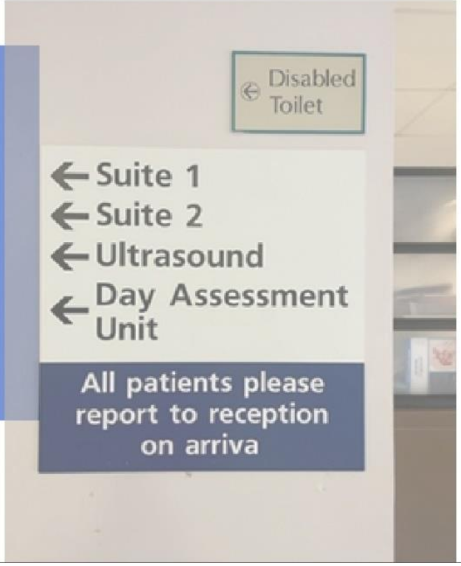
Scene setter

Not feeling truly welcomed had a big impact on many patient’s visits. They were often feeling lost on arrival and seeking a human to speak with.

Being confused by too many signs with technical jargon, and trying to remember their instructions was also a problem for many.

Not having an idea of what was going to happen to them during their visit (aside from clinical outcomes) was very disconcerting for patients.

> “...when you come in the front, there's nobody there to greet you. Which I think is really quite significant, and although there are signposts everywhere, there are too many of them.”
>
> Patient, Hampshire



Communication and Trust

Discussion Points

FOOD FOR THOUGHT

Try arriving at your setting and noting how this might feel for a new patient

1. How are your patients greeted on immediate arrival? - is there a human? Is it warm and helpful and inviting?
2. What could the space do to immediately allay their fears in the first moments of arrival?
3. Do your signs use clinical jargon? Is this truly necessary - could you say blood tests instead of phlebotomy for example?
4. Can you group signs into types? i.e. wayfinding, health and safety, commemorative.
5. Can you solve the problems in other ways that some signs have been created to cover up?
6. What could you hand patients to help them understand ‘the way things work around here’?
7. Could you work with volunteers to ‘hold the patient’s hand’ durng their visit?

FOOD FOR THOUGHT

Try to have as fewer signs as possible and use colour coding or symbols

Calming anxieties

Scene setter

Many of the feelings in this category concerned feeling anxious in the setting. This was in part related to arriving with preconceptions, worrying about what was about to happen to them, or seeing off-putting or frightening medical information. This manifested in terms of feeling apprehensive, which every patient described.

Patients also talked about not feeling 'seen' when they were in the waiting toom.

88% of patients experienced feelings of feeing generally anxious about hospitals.

"...it's very sterile and very intimidating actually, and I think if you're anxious about anything..."

"...even when you've been going for quite a long time... every time you go, you're quite nervous."

Patients, Hampshire

Calming anxieties

Discussion Points

FOOD FOR THOUGHT

Who could you partner with to offer calming aspects ? eg. garden centre or local charity/school

1. How can you strike a balance between clinical necessity and homely comforts?
2. Can medical posters, flyers and other materials be handed out only as appropriate or situated within other areas such as treatment rooms?
3. What can softer elements can you introduce to add calm to the environs?
4. Can you change the palette of your decor away from default blues and greens to something warmer? Patients liked the idea of fresh white but with pops of colour for example
5. Are there any ways you can add elements of personalisation so your patients feel more 'seen'? For example letting them choose or control certain aspects of the environment such as artwork or choice of music.
6. What can you do to give them a sense of where they are in the 'queue' - a digital board with a chosen pass-name? Regular personal updates from a staff member/volunteer?
7. How can you label the various waiting areas so patients know they are in the right place and feel grounded?
8. What can you offer as pastimes for positive distraction that patient's would really value?

The Big Questions

Common features of spaces

Scene setter

The research confirmed that the various attributes of spaces including factors such as furnishing, lighting, colour, décor and general wear and tear really affected patients’ sense of well-being. This caused at a minimum a lack of inspiration or passivity about spaces, but at times, even upset or frustration with things.

Whilst not necessarily having high expectations, 76% of the patients studied seemed somewhat resigned and disappointed in the way spaces had been put together.

> “I don't remember any colour. It's all very insipid, isn't it?
> You know, we have the word bland today. ”
>
> Patient, Hampshire

The Big Questions

Discussion Points

FOOD FOR THOUGHT

Could you partner with a local studio or university?
Could patients submit artwork?

Light and Sound

1. Can you move away from ceiling lighting and offer different forms of low lighting?
2. Can you move elements within the space to make the most of any natural light? For example turn chairs towards windows?
3. Can you offer music (patients preferred classical or general ambient) at a low level but perhaps that they can customise?
   Can you review your area to eliminate disturbing noises such as bin lids banging or doors slamming?

Colour and Artwork

4. Can you review wall colours and materials to move away from default blues and greens? Can you offer a more sophisticated palette?
5. What artwork do you currently have on your walls? Does this reflect modern life in any way or is it very Can you change or rotate the showing of these somehow?

Features and Furnishings

6. Are elements within your space looking very tired and lacking in care? What can be done?
7. Can a greater range of furnishings be offered? Do you give patients choice?
8. Are patients wanting to work, rest, watch or talk? How can the features help with this?
9. What is the easiest way to offer refreshments?

Moments of Hope

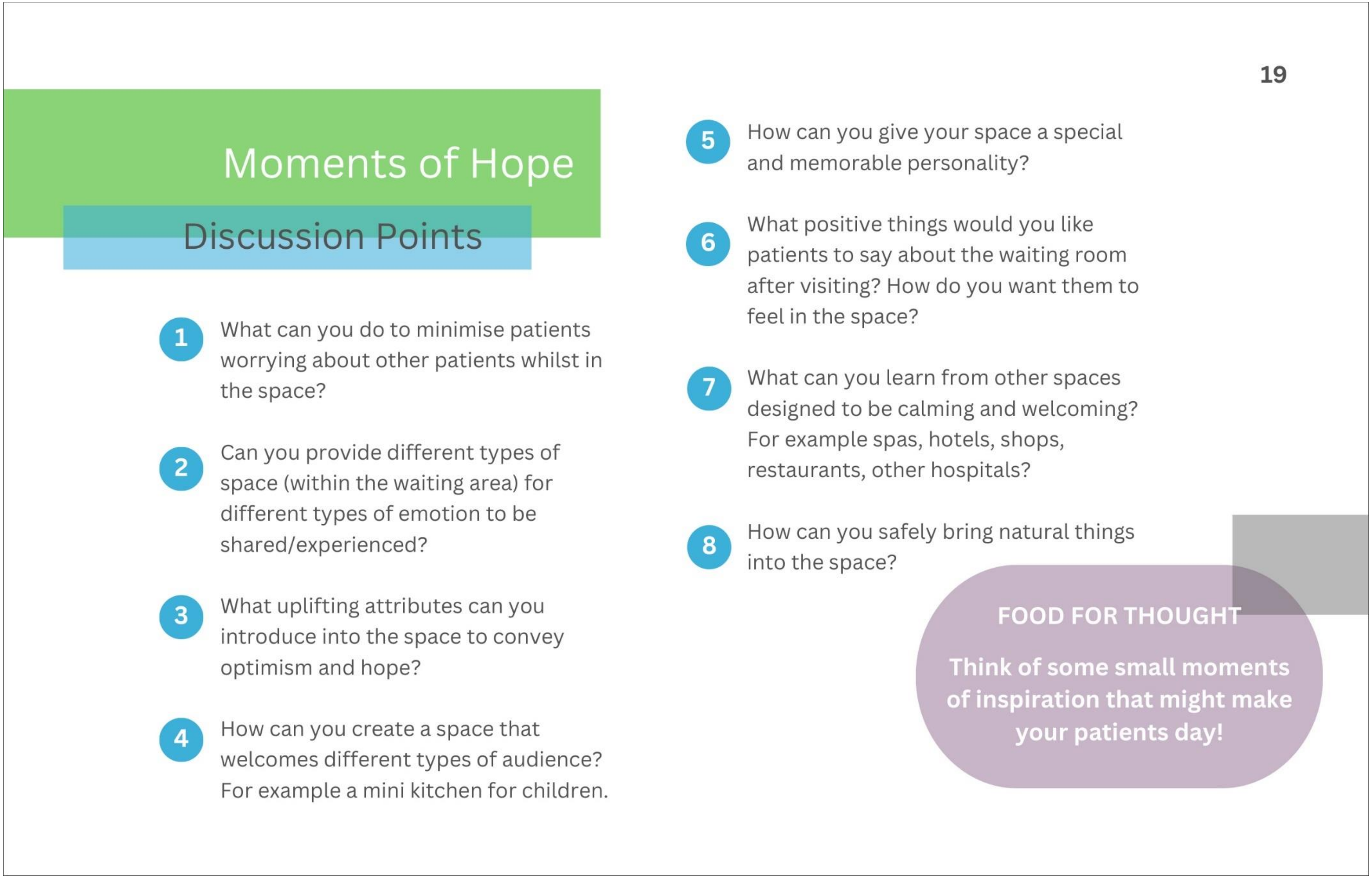
Scene setter

Aside from complimenting the general care of staff, patients were quite vocal on things they hoped for from a better waiting experience.

Whilst opinions varied, there were many common elements that were envisioned by the patients when asked what would make a great space for them.

For example, they were grateful when the radio was on as it relieved awkward silences and overhearing of others.

> " I like the fact it was light, and you could see daylight."
>
> "The chatter of the staff, that's the bit I like. I like listening to people's lives."
>
> Patient, Hampshire



Moments of Hope

Discussion Points

1. What can you do to minimise patients worrying about other patients whilst in the space?
2. Can you provide different types of space (within the waiting area) for different types of emotion to be shared/experienced?
3. What uplifting attributes can you introduce into the space to convey optimism and hope?
4. How can you create a space that welcomes different types of audience? For example a mini kitchen for children.
5. How can you give your space a special and memorable personality?
6. What positive things would you like patients to say about the waiting room after visiting? How do you want them to feel in the space?
7. What can you learn from other spaces designed to be calming and welcoming? For example spas, hotels, shops, restaurants, other hospitals?
8. How can you safely bring natural things into the space?

FOOD FOR THOUGHT

Think of some small moments of inspiration that might make your patients day!

Next steps

This booklet has presented some key considerations that may merit discussion and experimentation in order to improve the patient waiting room experience.

Here are three things you could do next:

1. Create a small working taskforce to review how things today are using these considerations as a measure.
2. Trial one or two very small tweaks to the space - focusing on what can easily, cheaply and quickly have most impact.
3. Talk to your patients!

A word on Design Thinking

Design Thinking is a way of solving complex or unpredictable problems by focusing on putting oneself in the user's shoes - known as 'use cases' (Brown, 2008). It was used in approaching the research that underpins this guide and comprises the following steps you might wish to review for any projects you might undertake:

1. EMPATHISE: non-judgemental, seek to understand users, see their world and note it
2. DEFINE: create profiles of users (personas) and consider their challenges and pain points
3. IDEATE: open minds, share ideas, dismiss nothing, make priorities
4. PROTOTYPE: rapidly create mock-ups or small interventions. Iterate and fail fast
5. TEST: understand what works, role play, keep testing and trying out scenarios

The Health Space Design Playbook

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