King's Fund cabe

King's Fund/CABE Conference

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Primary Care – Making a Better Environment for Patients and Staff

Speakers

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The Importance of Design in Delivering Healthcare

Julia Neuberger

Chief Executive, the King's Fund

I. Opening Remarks

I am delighted to see so many of you here today. This is a joint conference by the King's Fund and CABE, who we are particularly delighted to be working with in this area.

The King's Fund has been very interested in this area for a long time. Steve Gillam, Director of our Primary Care programme, has been pushing us in this direction for some time. In certain areas we are trying to broaden our approach to *Enhancing the Healing Environment*, a programme we started by giving grants to acute hospitals. We made a relatively small amount of money available alongside a training programme for nursing and estate staff, with some patient and user involvement.

The result across London has been dramatic and people have brought more resources in to make things happen. Newham General Hospital started off with one small garden and has ended up with something resembling a village green. With limited resources and some quite creative thinking, some magical things can happen.

We have just announced that we are going to roll this programme out to mental health providers this year. We may have to do it in primary care as well, whether or not we originally intended to.

We are all aware of the freedoms being accorded Primary Care Trusts (PCTs) around how they allocate their money. It will be interesting to see how much of our agenda today is linked into those freedoms – it is all very exciting.

Healthier Buildings: Designing Better Healthcare Buildings

Sunand Prasad

Commissioner, CABE

I. Good News

Some of the nicest buildings in the NHS are in primary care, unlike acute care where the idea of patient-centred healing environments is still not as rooted. In primary care buildings we have refined some really good ideas over the past 20 years, have reached a good consensus on design issues and values and have many good design examples to draw on.

II. The Challenge

We have to build on what has been achieved, but with changing procurement regimes - LIFT, design-and-build packages and PFI - we are in great danger of losing it. There is no reason why our designs cannot be delivered within PFI or PPP. However, there are barriers to overcome which will require more leadership than is being displayed at the moment.

There is quite a lot of wasted design talent; CABE, the King's Fund and others know how to use it, but there is something in the way. Officials try their best, CABE tries its best, but there is still a long way to go and a lot of leadership required from the top to break through that permafrost.

We also have to keep up with changing operational practices, technology and aspirations.

III. How?

1. Clients

a. Client-Designer Relationship

In the procurement system, there is a threat to the client-designer relationship which is at the heart of any good design. We need to protect and nurture that relationship, for example in the selection processes.

b. Intelligent Clients

We should help clients get the advice which will help them exceed expectations. The CABE Enabling Programme has made some strides and there are lessons to be learnt from that.

c. Smart Briefing

The brief is not a static item at the start of a project; it should be questioned and developed right up to the sign-off point. You must allow time to question and refine the brief while retaining the value in the new procurement processes.

d. Value Driven

We must champion integrated project processes and be value driven rather than cost driven.

2. Designers

Designers need to be more questioning, more responsive and expert – not necessarily experienced, as some of the best projects come from people who are passionate about the subject, learn quickly and are not tied down with baggage. Designers also need to be imaginative.

IV. What is Design Quality?

There is a lack of a shared language. Contractors, designers and clients often perceive design quality very differently. There has recently been an effort by the Construction Industry Council, CABE and the DTI to try to map design quality. In a parallel and overlapping process, the NHS has developed a design evaluation tool, which has been joined up with the CIC's tool and which can be found on the NHS Estates website.

There are some perennial values in the tool, as enunciated by Vitruvius: usefulness, firmness and beauty. Henry Wooten translated that as commodity, firmness and delight. The modern equivalents are functionality, build quality and impact. These are terms that can be understood across the industry and, when properly mapped in a tool, actually make a lot of sense.

V. NHS Design Evaluation Tool Kit

1. Tools

The NHS Design Evaluation tools are designed to be user-friendly, are written in plain English and can be completed in a very short time. Pilots carried out thus far show this to be the case. People welcome the tools and like the fact that something which is otherwise presented as conflicting values can be tabled at the same time and properly moderated in a cooperative fashion.

2. Functionality

It is amazing how often the importance of zoning buildings properly is overlooked. Public consultation zones and staff zones should be kept separate and interlinked very carefully.

3. Adaptability

Adaptability of layout, structure and lighting are all absolutely essential in health buildings. People are almost continuously rethinking operational practices and we must somehow allow for that. It means thinking more about the quality of spaces and adequate arrangements rather than design specifics.

4. Access

We are moving away from the idea of special provision for people with disabilities and towards the recognition of access for all.

VI. Urban and Social Integration

A major shortfall of many health buildings is their lack of attention to urban design issues. Some of the larger health buildings, including some of the integrated care centres have public rooms inside them. It is therefore essential that attention is paid, both inside and outside, to urban and social integration.

VII. Primary Care Buildings and Regeneration

Primary care buildings are playing an increasing role in regeneration. With the big investment in PCTs this will only increase in the future. We are moving away from the idea of the small doctor's surgery and are now playing a serious role in the making of the city through primary care, which is not to be overlooked.

VIII. Perennial Values

1. Landscape

Landscape is one of the most therapeutic and healing devices you can imagine in a building.

2. Internal Environment

A major lack in health buildings is the public realm, the patient experience. Toplight and large transparent spaces can lift the quality of an interior, but are missing from many health buildings at the moment.

Other perennial values include wayfinding and supervision, daylight without glare and the quality of examination, consultation and treatment rooms.

IX. Current Preoccupations

1. Healthcare Models

Healthcare models are changing and patient-focused care is being pioneered in this sector. With the coming integration of medical and social care one-stop shops will play a large part in the discussion. The great expansion in integrated teams, in professions allied to medical services (PAMS), specialist out-patient and consultation clinics, and health promotion and information are on top of the agenda at the moment.

2. Societal Changes

Staff needs are changing and people now realise that retention is a big issue. To increase productivity and morale staff need lovely environments to work in. There are new work patterns, new administrative burdens – it is extraordinary how much administrative spaces have grown in surgeries – and dual and community use of buildings.

3. Space

The key briefing and design challenge is to have sufficient and versatile space, which used to be thought of as territory and now needs to be thought of as resource.

4. The Sensory Environment

Design can heal; if we integrate art and design we effectively supplement the entire therapeutic effort. Common sense suggests that reduced stress assists recovery, calmly stimulating the senses and promoting well being, there is evidence, for example the Chelsea and Westminster study, to support this.

5. Changing Technology

The quality of space becomes even more important with technological changes. Technology is removing some of the functional requirements from space, we do not necessarily have to meet to exchange basic information; we can do that through electronic methods. We are meeting because we actually need the person in the same space, so the space must be of a high quality.

6. Finite Resources

We must focus on whole life value rather than lowest cost. We must rethink the way we set and evaluate budgets. That does not mean driving budgets ever upwards, but it does mean we must have an intelligent approach which recognises that good design can increase the resource envelope. Through design, some designers can turn £100 into £200. We have to find ways to achieve that, which will take a lot of will and leadership.

Questions and Answers

Sam Crowe, Primary Care Report Magazine

You mentioned the need to safeguard design values within the changing procurement process. Could you elaborate further on the dangers?

Sunand Prasad

Unless design is championed throughout the process and time given to ensure the required dialogue occurs between designers, clients and contractors – I would not distinguish design as separate from the overall delivery mechanism – we will not get the design we want. Selection processes need to be value-based and quality driven, not cost-based. That is a very difficult thing to do, as ultimately people work to value for budget, not value for money.

If we carry forward the idea that only those who have done it before are capable of doing it again we will never tap the talent out there. Selection processes are militating against inclusion of people who have not done this before. In addition, by ignoring these areas in schools of architecture the architectural profession has shot itself in the foot. One way to get inclusion is for clients to ask for it.

Mohammad Asar, Battle McCarthy Engineers

Your presentation seemed to concentrate on architects and those who will deliver. Another critical issue to address is the expectations of visitors. The television programme 'UK's Worst' deals directly with people's shattered expectations. What are your thoughts on that?

Sunand Prasad

The idea of showing both good and bad examples is absolutely essential. There is a legacy of sub-standard buildings in Primary Care and we are still, tragically, constructing buildings in PFI that are not buildings to be proud of in the future – not because PFI is unable to deliver those buildings, but because we have not figured out how to deliver them. It requires enormous effort.

In changing some deeply embedded cultures, unless there is a really big push from the top we will not make the difference. We think it can be done and are incredibly grateful for the way this Government has championed design, but it really needs to be sustained.

Dr Karen Jochelson, Research Officer, Public Health Programme, King's Fund

I am delighted that you identified sustainability as a chief concern for architects and designers. I would urge you not to leave sustainability as an environmental issue – it also has a direct impact on health. You spoke about the healing environment and the aesthetic impacts, but equally the design and the types of materials used in the building have a local, national and international impact on health. Given that we are building buildings for health, we need to think more broadly about the consequences of those decisions.

Sunand Prasad

I completely agree. The focus on social, economic and environmental sustainability, and to think of the experience of people is absolutely correct. Other sectors are doing slightly better than health in this area. Wessex Water's operations headquarters is an excellent example of a beautiful environment which sustains the people within it as well as the world. It might cost a little more money, but it will be more than repaid in a very short time.

Government Investment and Policy Trends in Primary Healthcare and their potential to release Innovation

Lord Hunt

Ministerial Design Champion, Department of Health

I. Design Champion

If you look at what the NHS has done over the last 30-40 years in terms of design the picture is pretty depressing. It is striking how unambitious the health service has been in the quality of the design of what it produces. I accept that there are big challenges in turning this around quickly, but we are beginning to see some very fine examples.

One depressing element of my job is opening hospitals where people are proud of what they have done, but where the design is terribly unambitious. Some of those projects have been funded through our own capital programme as often as through PFI, so we should forget the PFI aspect. The question is how we commission good design in everything we do.

II. King's Fund

We are on the cusp of a huge development in our capital, and we very much need to get the design right. The King's Fund has always had a very strong commitment to a healing environment and we have worked with them on that. The work done by the King's Fund over the years has shown that good design has a very significant impact on the quality of the healing environment for both patients and staff. That must be a theme in everything we seek to do going forward.

III. CABE

CABE has been tasked by the Prime Minister to ensure our public building programme is designed to a standard which will create symbols of civic pride in our communities.

IV. Public Building Renaissance

It has been very interesting to see what has happened in Birmingham over the last 100-150 years. It was at the vanguard of municipal pride in the Victorian era and some of the buildings from that era are buildings we can be very proud of. The tragedy for Birmingham was that the next great

building expansion was in the 1960s and there were a lot of mistakes in terms of what was taken down and what was put up.

We are now seeing a vast improvement in what is being designed and built. The City Council deserves a great deal of credit in recognising that great buildings have an enormous impact on the success of the whole community. I want the health service to recognise they are not just building a facility to treat patients; it is part of the local environment and economy. When it is engaged in either refurbishing old or building new buildings, it is part of the renaissance we want to see in our public buildings.

V. Opportunities

I am particularly going to work with two trusts in central Manchester and central Birmingham, where they are at the start of the process of building two huge new teaching hospitals. I am absolutely determined that those two buildings are seen as flagships for the 21st century and that the design is of the first order.

It will cost money, but trusts must be ambitious in what they seek to do. That is how I see my role as design champion: adding bite to the work CABE, the King's Fund and NHS Estates are doing. I want to get the message across to the NHS that what we are doing has a big impact not only on healthcare and the way patients are treated, but also on local communities. We have a fantastic chance to get some wonderful new buildings up and running, with the NHS leading rather than following other parts of the public sector.

I believe we can do it; there is already evidence in the NHS of some wonderful buildings. Some wonderful buildings have been created for people to be treated in and to work in.

VI. Design Champions

We are launching a number of initiatives around today's conference. I would emphasise two things in this. Firstly, we do need to take advantage of our initiative with CABE, which has an excellent track record and can be of enormous help to the NHS. I will have a close dialogue with CABE to ensure we implement the lessons learned from previous problems. Secondly, we are requiring trust boards to nominate a non-executive director to raise and keep raising the issue of design.

This can lead to a stupid situation where you appoint non-executives to be champions, but their effort dissipates and does not provide the impetus you require. However, there is a very good reason for championing design. We have some very high calibre people amongst our non-executives who can add value to this process. Their job is to be a nuisance, to ensure design is as important a part of the process as any other consideration. In a sense, this non-executive director is there to try to ensure that design is not squeezed out as the project progresses.

Last week I met with Sheila Jones, the design champion on the central Manchester trust board, who is very capable and determined. I have encouraged her to tour the country and look at examples of good hospitals and new hospitals being built or just completed, so she can come back and ensure design gets its rightful place throughout the building process. We will ensure every trust has a design champion and then I would like to see NHS Estates working with CABE to develop a programme to work with these people. Those committed to making this happen will find that these people will be very good advocates and champions, and I would encourage you to work with them as much as possible.

VII. Foundation Trusts

After the budget was announced, Alan Milburn talked about the next steps in the implementation of the NHS Plan, including Foundation Trusts. We want to move the Department out of micromanagement of health service. With an independent inspectorate and national standards, we can free up the service much more than we have ever done before. Our key idea is to create Foundation Trusts, which will give trusts much more local ownership and freedom to develop services in the way they are best able.

Giving Foundation Trusts much more freedom in terms of borrowing would create the conditions to allow us to focus on design, particularly if we can also change the governance so that they are seen as community-owned organisations rather than creatures of the Department of Health (DoH). The link between community ownership and good design is absolutely clear and that is something we need to give some impetus to as we develop Foundation Trusts.

Questions and Answers

James Parker, Editor, HD Magazine

Is the target of 500 one-stop shops misguided, as the crucial factor is taking the time to inject design quality? Should you be rethinking that at this point?

Lord Hunt

I do not deal with primary care in the Department, so I cannot give you a definitive view in relation to the targets. I hope you are wrong, because it is very important that we maintain the momentum in achieving the changeover in primary care. I would want to see design as a very important component of improving primary care.

I can see the importance of the LIFT process in Birmingham, where a lot of single-handed GP practices are in premises which are simply not up to the job. There are clearly some big issues around how you can move to a position, particularly in the inner cities, to get the required quality

of building. There is always a tension between good design and other pressures on the system, but we do need to ensure we keep the momentum on that.

Rosella Starick, Chelsea and Westminster Hospital

Which parameters are you following to evaluate 'ambitious' design?

Lord Hunt

We have developed a process of making fitness-for-purpose assessments of new capital projects, in which design is a significant component part – 35% – of the evaluation. That is the main process by which we make judgements about design. We have a process whereby the issue of design is fully considered in signing off new projects. If we have concerns, we have the mobility to go back to the individual trust and express them. There may be a second question around the effectiveness of expressing these concerns, but we do have a process in place to deal with it.

Sir Stuart Lipton, Chairman, CABE

I welcome your comments; the agenda you laid out is splendid. We propose that every project should have an audit before it starts. Only last Friday the major contractors group confirmed their willingness to support good design. We have the information to implement a simple audit using the skills of local people, practitioners and designers; we just need to implement it.

Lord Hunt

I am very open to suggestions and ideas from the NHS, designers, architects and builders about how we can properly monitor and get this fully ingrained in the system. I am hoping to meet with CABE shortly to pick up and champion some of these ideas. I am not someone who often sings the praises of non-executives in the NHS, because they have often been ineffectual. However, I do think that having someone on the Board who will make it their business to ensure design is given its rightful place will be important, provided we can ensure they understand the possibilities.

The NHS has produced some good examples, but we have not got them across to many of the people in the health service. I want to get the excellence of what is happening in a number of places through to as many of our people possible. If we do that others will desire the same excellence for their own buildings, which would generate the momentum we need.

Ian Inshaw, Chairman, Northeast Oxfordshire PCT

With the formation of the our new strategic health authority, the new chief executive has made the announcement that we are to merge and that he considers mergers as the best way forward. This is disrupting the whole process. We have GP clinicians engaged in delivering specialist

services in primary care, which is taking 1,200 patients away from the much-pressed John Radcliffe Hospital.

As a result of this announcement, those GPs are beginning to disengage. Frankly, it does not help us in delivering primary care or in developing these community hospitals, which I believe will be the forefront of primary care development.

Lord Hunt

I cannot comment on the specifics, as I do not know the local circumstances, but I can comment on PCT development. In dealing with the Eastern region, I have picked up concerns that once the new strategic health authority is in place, the first thing they will want to do is tackle PCT mergers. The last thing the health service needs is another wholesale restructuring. There may be exceptional local circumstances that warrant a PCT merger, but the clear message from ministers is that we are not into another round of major restructuring.

There are issues around management capacity if you are a small trust, but there are also very imaginative ways of dealing with them. In public health we have already said you will have public health networks in order to deal with specialties that an individual PCT would not be able to employ.

Robert McMahon, Chief Executive, Leicester City West PCT

It is a very exciting time for primary care; we have a primary care-led health service and there is likely to be significant investment in primary care facilities. I welcome many of the good messages we have heard about the design of buildings, which will be integral to communities, but we must not forget that first and foremost those buildings must be based on robust service design. In addition, the service models we design today are unlikely to be valid in ten years time, since the face of health care is changing so much. The buildings must also be adaptable in the future.

Lord Hunt

That is a very important point and in some of the new buildings I have seen that has clearly been an important consideration. One advantage of the present building programme is that building whole hospitals rather than the ghastly 50-year phased-in process, gives us a sporting chance that the staff involved in the discussions around the new building will actually be working there. The more you are able to involve users, the better. Having enough flexibility to meet the changing needs of healthcare is equally important.

Primary Care Facilities: the Practitioner's View

Dr Roy MacGregor

General Practitioner, James Wigg Practice, Kentish Town Health Centre

I. Bringing Design Awareness to the Primary Care Team

1. The Boiler House Legacy

In 1983, Terence Conran arranged for Stephen Bailey to put on an exhibition at the V&A, at that time called the Boiler House, on taste. It was an opportunity to look at simple design objects, from kettles to cola bottles, and the importance of spaces. At the time we were looking at a project to improve our own building. The project to date has had a very long gestation period, which has been a benefit in terms of design.

We have all shared and exposed each other to the process and it has often been thought provoking. There have also been a number of projects going on within our primary care team towards the delivery of an integrated care centre.

2. Kentish Town Health Centre

When our centre was built, it was an award-winning building with a clever design, taking up a small area of the site and was one of the first local authority-built health centres. Camden has an interesting mix of patients, with a lot of political refugees and asylum seekers, the highest teenage pregnancy rate in the UK and the highest mental health admission rate in the UK.

II. Project Context

1. Funding

The Healthy Living Centre initiative is one of the funding streams which allowed us to proceed with the project. We have secured £700,000 of lottery funds to put a healthy living initiative within the new integrated care centre. This building will improve access, service a cluster of practices, and bring secondary care out of hospitals.

2. Our Practice

There are a lot of associated projects happening in primary care at any one time; it is not all about buildings. One thing we have had to deal with is the huge size of our practice: 13 doctors and a very large team looking after more than 14,000 patients.

3. Concurrent Connected Projects

We have a full-time IT manager to help us become a paperless practice. We have succeeded in moving from note keeping to being entirely paperless, which has allowed us to move our medical records off-site. We also have projects around booking appointments, interfacing and PDAs for collecting data, which allow access to the same recordkeeping and avoids the patient having to repeat their story.

III. What will we have?

Camden is one of the first care trusts in the UK where health is working alongside the local authority. We will have out-patients, digital X-ray facilities and possibly a mammography screening centre based in the new care centre. Palliative care, dealing with the terminally ill, will have their main resource centre with us. There is also a new older person rehab team called 'Reach', a very sensible development in that it allows people to put off their admissions to hospital by having intensive care in the home, or to come home more rapidly because of the available support.

Our out-of-hours doctors' co-op will be based with us, as will the community mental health team and the Children's Community Nursing Team, which looks after children on ventilators at home, gives intravenous infusions at home and keeps children out of the wards. It has a very significant effect on the configuration of paediatric services locally. We will also have traditional PCT services such as dentistry and podiatry.

IV. Partnership Working

1. Partnerships

We have established this momentum through partnership working. We have done a lot of work with the Architecture Foundation, MARU, Paintings in Hospitals, RIBA and the DoH. We have also done some workshops with Sparknow, an outside facilitating company.

We had a furniture design residency with us from the Architecture Foundation who made us look at spaces in new ways, produced some very novel solutions and stimulated a lot of debate and discussion.

V. Stakeholder Events

Stakeholder Events were held to link up all of the different teams: palliative care, children's nurses and so on. Using funding from our PCT, we got them together and had a real hands-on event where people talked and thought about how they would like to work in a new integrated care centre.

Users have been very involved since the beginning of this process. Two years ago we conducted an extensive survey into what users would like to see in the building. More recently, we have attended and collected views at Caversham Neighbourhood project work and open days, which has been an important and very successful source of information.

Everybody attending stakeholder events, including users, had to do some preparatory work. They had to appoint design champions from within their own service and complete some homework, which involved making postcards of workspaces and how to improve them. The events led to fantastic communication between the teams, gave us all a sense of ownership and everyone felt involved in the evolution of our new centre.

VI. Good Design

1. Delivering Good Design

We found that having the vision and drive to create something different is important in delivering good design, as is resourcing – which should not be a problem in the NHS, but the difficulty is in accessing resources. A major problem for LIFT, PUK and partnerships for health is that we have not thought about how, when you are batching premises in a LIFT process, you can deliver six new primary care centres without increasing resources on the frontlines.

You cannot have estates departments and facilities departments – who are currently overwhelmed with the number of initiatives and money thrown at them to do initiatives – without having more people on the ground. We must campaign for the next wave of LIFTs to be more adequately funded in terms of people in estates departments and PCTs. I believe partnership working is the key to delivering success.

2. Procuring Good Design

a. LIFT

I think LIFT is capable of procuring good design if adequately thought through and resourced. I do believe that batching schemes are a reasonable way forward. Five hundred one-stop shops is an extremely ambitious target, which I think is possible to deliver. It is an exciting initiative and there is momentum behind it, so we should all take advantage of it to achieve primary care change.

b. RIBA

The RIBA process may not be exportable everywhere. We had a long gap between the completion of our outlying business case and the LIFT process starting, which we have taken advantage of to use the RIBA process. Our architect's brief will obviously be very important in achieving a satisfactory output specification and clarity about function is most important. I like the architect's expression 'form following function within budget', but we must strive for value for money. Even if sustainability issues are more expensive we must include them.

VII. Camden Design Initiative

Camden has a new Director of Planning with huge ambition and Camden has won the 2002 Council of the Year award. There are good things happening and I believe there is a bright future here. Camden's Design Initiative is a partnership between the Architecture Foundation, the Bartlett School of Architecture and the Greater London Association. The initiative is designed around trying to repeat what Camden managed 20-30 years ago in producing some very interesting buildings.

VIII. Selecting Architects

1. New Architects

Apart from the RIBA process, the Architecture Foundation has produced two books which have been a useful resource in inviting people to participate in the competition. I hope we can make an opening for up-and-coming ideas.

2. RIBA Process

The Official Journal of the European Community (OJEC) is a daily publication for contracts of a certain size. We have been astounded by the level of interest from the OJEC; we have now had 175 enquiries and 80 expressions of interest. Twelve people will be interviewed in mid-May and four of those selected to try to provide a winning solution, which will then be offered to three potential LIFT partners during the ITN stage of negotiations.

IX. Evaluating Design

Specifications and what you say in the OJEC are both important. We will be developing our very own evaluation toolkit which will be used by a very inclusive assessment panel, a jury of members which will include centre users. We will also employ consultant advice and assistance, and are using the DoH document, *Achieving Excellence Design Evaluation Toolkit.*

X. Conclusions

Twenty years on from the Boiler House experience, we will have a new building. I believe we are in a very exciting present and will have an even more exciting future.

Questions and Answers

Martin Shirley, Director, MSSI

The relationship between client and architect is of great value and needs to be nurtured from the beginning. I would suggest to all clients that if they begin their process without their architect they will miss out on a great part of the dialogue open to them. It can be a very binding thing and very worthwhile in the long term.

Dr Roy MacGregor

I completely concur. We have been through several processes on the existing site to try to achieve a solution, two of which have involved detailed sketches with our architects. The relationship has been instrumental in allowing us to inform our brief, but it is a pity that in normal NHS procurement routes this is not a dialogue that starts at a very early stage.

Khurijan Mohammed, General Practitioner, Greenwich

In terms of the design of your future integrated healthcare centre, have you concentrated as a commission on care pathways at a primary care level? In terms of care management of patients, we have seen rationing and waiting as the same thing for far too long. It is not the same thing.

How are you going to be able to deliver better primary care services as a GP and how is that going to be linked to the resources we are going to have in primary care, if not ring-fenced within these unified budgets? How will that affect your patient outcomes?

Dr Roy MacGregor

That is an excellent question. My answer is that we have done quite a lot of work around care pathways and have even approached the King's Fund to do a piece of audit work around our existing practice and the future practice. One of my partners works for the PCT and is developing a lot of work around this.

A specific example of a changed outcome is in our relationship with the local Citizens' Advice Bureau. I believe the primary care team does not involve clinicians very much; baby massage, welfare advice, social workers and health visitors are just as important in the baby clinic as

doctors. A local study has shown that every £10,000 put into providing welfare advice delivers a change in the economy of £100,000 of increased income. We can achieve that kind of change in the local economy by delivering different and wider services.

Stuart Hodgkinson, Director, Latham Architects

I was interested to hear that you had users on the evaluation team. What was the extent to which you had them involved in the briefing process? Is it important to involve them in the brief or is it a case of the architect and doctor knows best?

Dr Roy MacGregor

We have involved users in the briefing process and in the pre-briefing process. They have been involved in making clear how the current centre is dysfunctional and how it can be made more functional. It as been very enlightening having them on board; we have some very active non-executive members within the health centre.

Delivering Design Quality

Chair: Sir Stuart Lipton

Chairman, Commission for Architecture and the Built Environment

I. Introduction

We take a holistic view of architecture and the environment. We are passionate about architecture, public room and public space; at the same time we are very committed to looking at buildings in their entirety, at whole life values, social values and patient values. I am delighted to be working with the King's Fund, who are experts in this field.

II. Our Role

CABE's central message is very simple: we are here to help and to listen. We want participation and engagement, but we are very small. We will grow to 40 people this year, so we cannot tackle every project. However, we will give clues on projects which we are not involved in. We try to be selective and look for important projects, small or large. It is very difficult to define that importance; it is a project-by-project analysis.

III. Design Champions

Government is being very kind to us and the speech by Lord Hunt this morning was very encouraging. Lord Hunt is one of eight ministers who are design champions under the chairmanship of Lord Falconer. We meet every quarter and are tasked with improving the quality of buildings in the built environment. We are making progress – not quite as fast as I would like – but progress nonetheless.

IV. Commitment to Health

We have a deep commitment to health. To us, the essential ingredients are that buildings must be uplifting, efficient and effective. Health costs are approximately 80% personnel and buildings are 4%-5%, so if a new building increases output and patient flow, you effectively have a free building. For those in the construction and design industries that is a pretty effective marketing tool.

This is a huge programme, we would encourage you to do your best, but the system is still in the growing stage. We have a lot of expertise in the field, but it is probably not available to every

trust. CABE feels that every trust should have the opportunity of a learning experience and an understanding of how the experience works in a fairly detailed form.

CABE will be involved in some of the projects with Peter Wearmouth, in establishing the needs for and explaining the nuances of deep plan buildings and natural light. It is very important that we use the skills you all possess. A great deal of knowledge is available, but is it available in the right place?

V. Partnership with NHS Estates

We have a wonderful relationship with Peter Wearmouth, Chief Executive of NHS Estates and that relationship is borne out by a new funding partnership. Peter is giving us some money, which makes him a good partner for us, since we are rather starved of funds. This partnership will allow us to work on design quality across the whole NHS programme. We want to develop great healthcare facilities of which we can all be proud.

Procuring Design Quality in Primary Healthcare: Working with LIFT

Peter Wearmouth

Chief Executive, NHS Estates

I. Introduction

My Minister was here this morning outlining the Government's commitment to investing in healthcare. With that comes investment in healthcare buildings. I will go into more detail in terms of what we are trying to do. We do appreciate that the challenges are immense; can the NHS and the construction industry cope?

II. Design in Healthcare

1. Scope of the Challenge

Not since the 18th century has there been such an impetus for investment in healthcare buildings. Within ten years we will have replaced or refurbished 25% of our healthcare buildings. We have 24 million square metres of building space, of which six million will need to be replaced or refurbished within ten years. The challenge for the construction industry is immense.

2. Pride

Our buildings are a physical manifestation of the healthcare delivered within them. Looking at various buildings you have an immediate sense of what is taking place inside. If our buildings are not clean and functional, if local people are not proud of the buildings in which healthcare is delivered, they will not be proud of the NHS. We have gradually seen a significant investment programme brought about by that fact and the views of the NHS and clinicians as well.

3. Healing Environment

There is now a greater acknowledgement of the role of design and how it sits alongside the science of medicine. There is a more sophisticated understanding in architecture about the interaction between people and space. I feel there is a research base which should point the way to us building a healing environment built-for-purpose for the 21st century.

4. Procurement

We do focus on functionality and minimising costs, but we need to get the basics right. The construction delivers a product to the NHS – a healthcare building – which provides a physical environment in which to deliver healthcare services.

5. Lifecycle

The procurement of the product is only one element of the lifecycle of any building. We need to not only look at getting best value in procurement; we have to look at planning, design, procurement and disposal. We must look at the whole lifecycle, or else get bogged down with procurement routes and value for money. At the end of the day we are delivering products in which patients see three things: doctors, nurses and buildings. Without any of those three, the other two cannot function. The development of a sound investment in healthcare buildings is that important to the NHS.

III. Targets

The NHS is embarking on its largest investment programme. We have already refurbished or rebuilt 1,000 GP premises, but we are not doing so well with one-stop shops. We have built around 70 or 80 one-stop shops according to the definition within the NHS plan.

A new document was published with the budget called 'Developing the NHS Plan – the Next Stages'. We have the introduction of Foundation Trusts, which have the ability to enter joint ventures; I believe PCTs can enter joint ventures. Do you need an NHS LIFT? You might, but PCTs now have the legal power to do an NHS LIFT themselves if they wish. They will also have the legal power to enter into more working relationships with the private sector.

In terms of Primary Care, I believe we are witnessing the contribution and advances of engineering and science in moving the treatment and care of patients from acute settings in hospital to community settings, for example diagnostic, treatment and more out-patient services. Equipment is getting smaller and we are getting less invasive in the way we treat people, so they can go home sooner or be dealt with as day cases.

There will be an extended role for private finance, but it is not the procurement route that is important; it is the product. PFI, joint ventures, PPP and public procured schemes are just procurement routes. We have to start with a good brief, an informed client with advisers to ensure they can inform that process. If they get a poor outcome, it is no use blaming PFI, PPP or NHS LIFT; it is down to yourselves or your colleagues to ensure these are delivered. It is down to the private sector to deliver on the clients brief. That is very simplistic, but this is how it is supposed to be all about in theory.

IV. Healthcare Spending

As a percentage of GDP, health spending settlement is approximately 7.5%. That is the argument my department used to get the cash we did. It will rise to 10.6% by 2022, rising rapidly over the next five years. More doctors and nurses require more building capacity. To provide the world class healthcare system that UK citizens want, it has to increase its building capacity. For every £1 spent on healthcare, 20p goes into providing the built environment.

V. Achieving Excellence in Healthcare Design

We continue to implement our design programme *Achieving Excellence in Healthcare Design*, which we put together with CABE and other colleagues. Lord Hunt is very committed to delivering the design agenda within the NHS and is personally mentoring four schemes.

VI. Healthcare Architecture

Design and thinking surrounding healthcare architecture needs to be reinvigorated. We are still designing and building buildings that look the same as they did 30-40 years ago. We still have waiting rooms and consulting rooms, but society has changed. We have consumerism and increasing demands from the patient. Patients now understand what they want and are no longer submissive, but we build architecture that is submissive.

Perhaps we need to look differently at healthcare architecture and develop a balance between the delivery of clinical care and efficiency. We need to learn from the best in other industries in designing our built environments before we even come into contact with clinicians.

VII. Stakeholders

There are many stakeholders involved in delivering the built environment, including patients and citizens, doctors and nurses, other health professionals, the major contractors group, the King's Fund and others. We also have partners at the Commission for Architecture and the Built Environment. Our framework should have been launched today by Lord Hunt.

If fully supported, CABE and ourselves can make a worthwhile contribution to design at the outset of a project, but it also needs to be considered as the whole project develops. We need to create buildings for patients, staff and citizens. A lot of issues the issues I have had with the closure of hospitals, they have not been about what happens inside them, but about the hospital as an institution.

VIII. Ownership

When somebody proposes to build a new hospital, there is immediately a campaign to save the old one. The old hospital has ownership; a lot of life experience has taken place in that hospital. When we build a new hospital, we might consult the public, but they do not have ownership of it.

We somehow have to get that ownership, but at the same time the NHS must refurbish its assets. Some assets have worn out and we have to change them. If we are going to regenerate and change, we need to determine the best way to involve local communities in our healthcare buildings. We need your help in this; it cannot be done from the centre. We set the targets and have secured the money to allow us to modernise the NHS, but you are the ones who must deliver. We must work together.

IX. Building Notes

One example of NHS Estates work is the production of hospital building notes. We are just altering hospital building note 36 for primary healthcare premises, this is being undertaken by the Medical, Architecture and Research Unit with NHS Estates. It will incorporate the latest design thinking around primary care property and premises. The document will highlight the importance of producing a clear design brief at the outset, to ensure the client gets what they want. It will also tell clients what not to do, or else they may not get what they want.

X. Design Vision

We have set a new design vision at NHS Estates with ministers. To deliver the vision, each element of our vision will have mandatory standards attached to introduce into the NHS. We are not going to tell you how to design your buildings, but we do want mandatory standards. For example, over the last three years we have seen a decrease in building size to deliver healthcare. The occupants do not like it and it goes against what we see in society; buildings are increasing in size, not decreasing.

That is being driven by the cost envelope set within the scheme. I accept that everybody wants to build the best possible building they can, but we will be setting standards and determining what PCTs will get to build. In terms of the approval process of the strategic health authority or the Department – or even the NHS Trust – we expect all schemes to be costed at that level.

We do not want ideas of saving £5 million through innovative design; we want buildings which are fit-for-purpose. Whether it is PFI, PPP or public procure schemes, it still costs the same in the private sector. If it is costing less, I want to know why. If we have a cost envelope, we want to get the right quality into it. We have set departmental standards and will give the cash upfront to deliver it, so it is down to local innovation to come up with the design – within the framework that has been set.

XI. Civic Pride

One issue around primary care premises is stimulating civic pride. In some instances a healthcare building is a focal point for the local community and we should seek to ensure that building earns the respect and enhances the loyalty of the community. It creates a good first impression, introduces feel-good factors and adds value to the patient experience.

XII. The Right Product

If you get the right product, it should not be negotiable. If we are going to buy a product, we all need to ensure we buy a product which is fit-for-purpose. NHS Estates remit is that, if we require, we can examine all designs and we have put a stop to some schemes because of poor design. We are not there to do that, and we do praise good design when we see it. I have worked with CABE on some of their reviews of major schemes and found it extremely interesting. It is stimulating to realise the breadth of experience within CABE to come forward with the comments they had.

XIII. Achieving Excellence Design Evaluation Toolkit

In the design evaluation toolkit there are simple non-technical questions around functionality, impact and build. The CIC are also doing a toolkit and I was concerned that their toolkit, although generic, does not touch on the cultures of the health service and the construction industry. These are two different cultures, and to bring them together is very difficult. One is about delivering a healthcare service and dealing with people, the other is about building buildings and getting a bottom line. We have to bridge the two cultures and this particular toolkit is one way to look together at whether we are getting good quality design.

XIV. Primary Care Design Issues

1. Identifying Needs

How can PCTs and users ensure a good design brief? The first prerequisite is identifying what you need. I believe everybody needs professional help in delivering a specialist function, for instance from an architect or an engineer. You know what you want, the role of the designer is to interpret that vision into a concept and assign a cost.

2. Developing a Vision

CABE have introduced an enabling service to support clients. They have a number of schemes to assist NHS clients in developing their ideas into a concept. We have a database of facilities which

you can visit and set benchmarks against. There is also guidance available on design and procurement.

3. NHS LIFT

NHS LIFT aims to provide local expertise in support of the delivery of the built environment. The NHS still needs to be an informed client, but we do need help and support – hence NHS LIFT. There are other procurement routes in delivering a primary care premises, such as third party developers, public procured schemes, independent procurement, joint ventures with PCTs and NHS LIFT. There is a whole range of procurement solutions available.

XV. Holistic Approach

You have to know what you want, put it in a brief, and ensure you can bridge the gap between the construction industry, the architect and yourself to come up with a finished product you want.

XVI. Private Sector

There has to be partnerships between the public and private sector, who have always been in the forefront in delivering healthcare buildings. Over 82% of buildings in primary care are privately procured at the moment.

XVII. NHS Estates

1. Primary Care Estate

The capital value of the primary care estate is about £2.7 billion. We are going to invest at least another £1 billion over the next three years and likely another £3 billion for the three years after that.

2. Acute Care Estate

The acute care estate is worth £23 billion, but it would cost £76 billion to replace. It is a rather large estate and we have significant investment sums to deliver.

XVIII. Challenges

Can the British construction industry rise to the challenge? They tell me they can. Can the architectural profession and the practices who understand health rise to the challenge? If we cannot, what are we going to do about it? We have massive investment programmes in health,

education and transport coming through. If we cannot seek help here, we will have to seek help overseas – we are going to build them.

XIX. Design Issues

1. Innovation

Architecture should push the boundaries of innovation. Healthcare buildings are a focal point and if we do not push innovation we will not get innovation in architecture. The capital costs are only a small amount of the whole life cost of the operation of the building. Relative to personnel costs, capital costs are only 10% of the total cost, but it has a major impact on what happens within the building.

2. Privacy and Dignity

The North Croydon Medical Centre becomes more private as you move up through the floors of the building, relating to the clinical interventions you are going to receive. If you go to the top floor of the building be prepared for some pain.

3. Natural Light and Ventilation

We are seeing an increase in deep plan buildings in hospital architecture, looking at floor-to-roof costs. A balance must be struck between natural and artificial environments and we must ensure we deal with the harsh environment deep plan buildings can bring.

4. Wayfinding

Healthcare buildings in primary care are going to increase in size, not decrease, and if anybody goes into a deep plan building without good wayfinding they will quickly become lost.

5. Circulation

The Wembley Centre for Health and Care is at the heart of healthcare within Wembley. It acts as the pivotal hub for healthcare services, links other health and social care activities together and is a visual reference point for members of the public.

6. Summary

All of these schemes have been nominated by clients, scored highly by patients and staff and received praise from the community they serve. That is our ultimate goal in the NHS.

XX. Delivery

We need local ownership of these projects. The role of the Department is to set policy, issue guidance and hold the system to account. Delivery is down to you, because that is what you said you wanted. We will get the money, set the framework and manage performance, but it is down to local PCTs to deliver. We do not have a centralised approach to managing things.

Questions and Answers

Keith Cox, Director, Capita Architecture

You asked whether the industry was ready to respond to the demands placed by the investment to be made and which has already been made. My concern is around the amount of money wasted in the prolongation of the tendering process. Is there a way of speeding up that process?

Peter Wearmouth

There has been a change in the private finance arrangements within PFI. We have reduced the number of bidders, so on a small scheme we would only go out to three organisations instead of six and then down to one straight away. NHS Estates launched its partnering programme in the Northwest and Midlands where we are looking at a partner arrangement with five building consortia to deliver £300 million worth of schemes. That arrangement goes through one OJEC process and we then have partners who build for us according to a schedule of rates.

We are also looking at batching our major capital schemes to reduce the procurement process. We had a very bespoke process for procuring healthcare buildings. The idea behind NHS LIFT is to secure a procurement partner and let them deal with those issues on a long-term partnership arrangement.

We are out to OJEC on three LIFTs and have our first partnering programme underway. I would challenge the industry to show me any other government department who is doing better than health; I will go and have a look. We are interested in anything in the private sector that would benefit us.

Mohammed Asar, Architect

You began by talking about whole lifecycle costing. John Rouse gave a lecture which outlined a fantastic ratio which illustrates this. He calls it the 1:5:200 ratio: 1 is the capital cost of the building, 5 is the lifetime cost of the building and 200 is the value of the money it makes with the people. It really drums home the essential nature of the quality of the building being

fundamentally important, so people do not take days off sick and they want to go into work. Your emphasis on doctors, nurses and buildings should be commended.

Dr Roy MacGreggor

I am impressed with your designation to local people to come up with innovation to drive this forward and to do the delivery. We are all in favour of that, but would you agree that within LIFT there is a problem about resourcing people in estates teams and on the ground to do this. You cannot deliver six new primary care schemes into an estates department which is already overworked. What are you doing to cascade the money down to people on the ground to facilitate this innovation?

Peter Wearmouth

If we go back 10-12 years, we would have had 1,500 people who dealt with procurement of major capital schemes. Local responsibility was to deliver frontline services. With the gradual reduction in capital investment we saw the removal of that infrastructure to deliver capital schemes within the NHS.

These people did not design the buildings, but they did facilitate the design, understood the healthcare processes, assisted in developing the frontline and developing briefs. We have to somehow rebuild that skill and look at how we can work together. I am not saying we have to rebuild these people within the NHS. The skills are out there, we need to ensure we have the capacity within the industry to provide the skills to the NHS. We have to determine if these are NHS skills or skills we would source in a partnership.

In the first LIFTs to be agreed we have put in investment to procure project directors and project leads. You do get support from NHS Estates in preparing your SSDP plans and for partnerships for health in the actual OJEC process. The money given out is all given to the frontlines, who decide how to procure the resource to deliver new buildings. We do not keep money back at the centre to do this.

As we move out, and this will increase rapidly, we have to understand which skills are required. It is a partnership between industry and the NHS; I do not want to put them back in NHS Estates because we quickly lose our skill base. I write policy, I do not build buildings. I need people who are going to interface with the NHS who have the skills to deliver the solutions.

Stephen Langford, Director of Service Transformation, NELHA

Within the next 10 years most of Northeast London will look like a building site, as most of the hospitals are being redeveloped in the first wave of LIFT. I performance manage the acute trusts

which are all going through the PFI process at the moment. I would be interested to hear how you think the new consumerism standards might impact on some of those projects?

Peter Wearmouth

The consumerism standards were set by NHS Estates in response to a perceived reduction in the quality of the built environment which we needed to put back in order to deliver a more modern healing environment for the 21st century. We reviewed with patients, users, clinicians, medics and the industry the additional resource we need to put in to capital schemes to ensure modernisation.

When you go on holiday, would you want to share one room with four strangers? There are a whole range of issues around privacy and dignity we need to address in the NHS to modernise our healthcare settings. It is not about how healthcare people work; it is about how we are more civilised within the NHS and treat people more humanely.

On top of that we now have the Wanless review, which stipulates that our buildings are not being designed for the 21st century. We must correct that and this was part of the proposals we put forward. Business cases are not approved unless they have consumerist standards within them.

We cannot hold up a building programme because we invent something halfway through, so we must be pragmatic about this. The Department has set the standards and if NHS Trusts cannot design to those standards tell us your design solution and we will consider it.

Sir Stuart Lipton

The overall message is that we have to do this together; listening and learning. There is still a long way to go, but it is a great opportunity. It must be you driving the excellence to turn the dream into reality. When are we going to see professionals and construction companies drop out? When are they going to start refusing the tender? I hear of a lot of groans and moans, but I do not hear of a lot of people refusing tenders.

Report back from workshops

Sunand Prasad

CABE Commissioner

I. LIFT

There is a mythical animal called LIFT, which we all recognise and are prepared to welcome. However, we do not know much about it and its keepers do not know much more than we do. Its keepers are working hard at identifying all the parts of it and it will come together. It took quite a long time to get PFI relatively understood and underway as well. We are presumably all here because we want to make things happen – so we will make it happen.

II. Change

Another recurrent theme in the workshops was the difficulty in keeping up with change and the role of competition. People are concerned about a possible role for design competitions and whether we are going to repeat the wastefulness of tendering.

III. Capacity

Is there the capacity in the industry amongst designers to provide the healthcare buildings to the standards we are looking for and to support clients? Is there capacity in the whole LIFT initiative? We are assured there are enabling funds and the GP resources initiative, which are there to support and facilitate this process. For example, in one workshop we were advised that these funds will help unlock land ownership issues and that mixed-use development is to be encouraged. If local GPs form partnerships to share land then that is going to be welcomed and used. The coming of age of primary care is in becoming part of the regeneration of cities and the making of communities.

IV. Knowledge Management

Knowledge management and exchange is essential in developing this expertise, particularly the willingness to look at international examples and set very high benchmarks. At the same time there is an idea that to have a clear threshold is important – perhaps using the Achieving Excellence in Design Evaluation Toolkit to at least prevent the worst. That may seem like a lowly objective, but perhaps that is not such a bad thing; Government initiatives are about raising the

average. The toolkit is not suddenly going to produce geniuses where they did not previously exist. However, it will make general standards better and will increase transparency.

V. Keep it Simple

There was a plea to keep it simple; one fiddler out of tune can ruin the product of an entire orchestra. With that Zen thought I am delighted to introduce the czar of primary care, Dr David Colin-Thomé.

Where Now – What is the Future for the Delivery of Primary Healthcare in England?

David Colin-Thomé

National Director for Primary Care, Department of Health

I. A New Primary Care

1. New Public Management

The new public management is a key issue. We had a neo-Stalinist type of management in the health service where the tier above told you what to do and expected you to perform. Unless we develop a much more two-way type of management in the health service we will struggle with delivering targets and improving the lot of our patients. This will have to manifest itself in these new animals, not just LIFT but also PCTs.

2. PCTs

PCTs are now going to be the key people in the health service. We are told that by 2004, they will have at least 75% of the NHS money – which is true – but in fact they will have 100% of the local NHS money. The other 25% is kept nationally for big capital projects and so on. PCTs will be the funders of the local health service.

3. Devolution

One if the issues for PCTs is devolution, one of Mr Blair's four principles for the public sector. When Wales and Scotland were being devolved I went to an academic meeting where it was said that in devolving to an organisation 'they' become the new centralists. There is a real issue of PCTs not taking on that mantle. Their relationship with the primary care team is going to be quite crucial.

4. Accountability

Primary care teams will have to be far more accountable to their patient population – a test of the new style of approach. Even if you have a magic organisation called a Foundation Trust the funding will still come from PCTs – they will not have carte blanche to do what they wish unless it is relevant to the local community.

5. Examples

We have run pilot programmes to make information software available in waiting rooms. The software even allows patients to have a go at differential diagnosis of their problem and patients began to book time to go on the computer. Another example is a DoH funded initiative where you had 50,000 homes linked to digital TV on which you could get health information and book directly with your practice. You could also have a nurse consultation while sitting at home.

6. Exclusion Gap

I suspect these sorts of approaches are going to be growth areas. I worry that as people become more information literate the exclusion gap is going to get broader. Perhaps primary care premises could be a resource for people to gain access to software and to guide people through its use.

II. General Practice

The British GP model of local primary care teams delivering services to a local population is here to stay for the time being. The new 'GP contract', which will go out for approval starting in June, is beginning to model new approaches. It will be much more practice-based and quality driven and will encourage an expanded range of services.

III. Fresh Challenges

As the world gets more complex, people live longer and have more multiple illnesses, primary care has to be able to look after people across a broad range of conditions, rather than going off to several specialists and having their care fragmented. In many ways their role will become much more focused. The evidence suggests that a first-contact primary care system produces better health outcomes than one which is secondary care orientated. It is also more cost-effective.

People often associate the health service with the hospital. In fact, GPs and our teams see over one million patients every working day. It is a significant contact point and the most popular part of the health service. A lot of that is based on localness; small practices are more popular with patients than larger practices. The GP factory model is not popular with patients.

IV. Primary Care

1. What Patients Value – Range of Services

Patients value a range of onsite services. Now that we have a PCT they could at least provide a range of services for a group of practices, rather than each practice having to have everything on one site. There is a whole hub-and-spoke opportunity, but still relatively local. When the

Peckham health centre was set up back in the 1930s the definition of who would use it was 'pram-pushing range.' We will need to ensure localness and some practices could be the hub if other GPs could get over the tribal issues.

2. Rapid Access

Some of the Government's biggest areas are in emergency care and access. The access targets for GP have met universal acclaim as a wonderful way forward, but it is very difficult to get better access. It is not only about money; it is also about reorganising how we care. NHS Direct, working with out-of-hours GP co-operatives, have demonstrated a dramatic fall in GP workload. With an array of premises – walk-in centres, NHS Direct and out-of-hours – you can begin to construct something locally.

V. Pharmacists

The great untapped resource is the community pharmacist. If we are looking at new build, perhaps pharmacists should be far more integrated into the primary care provider service in the future. At the moment they are basically trained as scientists – who finish up having to also be shopkeepers. We should really be tapping into their clinical knowledge and expand the range of services they perform. It will be a test to link that into a local primary care setting, but they are a great untapped resource – all 20,000 of them – that we need to better integrate into the health service as we move forward.

VI. Primary Care Issues

1. Better Coordination

If we could better coordinate care then patient care could be much better delivered in community settings. In our practice we found that by systematically offering care for patients with existing heart disease we dropped the mortality rate by over 40%. Systematic care with modern drugs can make a big difference to patients' lives.

2. Case Management

Another issue is the case management approach, where you pick on people who have the more extreme end of disease and provide much more intensive support for them. Not only do you get better outcomes in terms of quality of life, you save millions in bed usage because patients did not need to be admitted as often and were far less likely to have lengthy stays.

3. Community Perspective

There are massive opportunities to begin to redesign a lot of what we do. The other connection is the great unfulfilled potential in looking at a community perspective as well as at one-on-one care. That could be done at a local level as well as by a PCT.

4. PHCT and Public Health

The Royal College of Radiologists reckon that at least 20% of all X-rays carried out in the UK are clinically unnecessary. There is a real issue around not subjecting patients to unnecessary interventions which are potentially dangerous if they are not clinically appropriate.

5. Intermediate Care

As the funder of the health service, the PCT might want to make some radical assumptions about the use of the hospital. The first consideration would be the future of standalone out-patient departments. As a concept a lot of the first contact and follow-ups are now passed their sell-by dates in that different models of care are emerging. For instance, direct booking for surgery would save a lot of time.

6. Day Surgery

The whole concept of the out-patient department needs to be redesigned or expanded into using it as a diagnostic and treatment centre. Another big issue is the concept of day case surgery. Many hospitals in the country are well off the pace of achieving the 85% that clinicians say can be achieved.

7. Hospital Care

Hospital services are still necessary, but it is not necessary to be stuck in a hospital. That has implications for district general hospitals, which are expensive at the low tech end and not round-the-clock enough for really high tech end. How we work in district general hospitals will be far more in ambulatory care settings, planned elective surgery and so forth, with far more care, follow-up and preventive work done elsewhere.

There needs to be a whole redesigning of the hospital and primary care settings, both in the organisation and in our mindset. There has been a rigid division between primary and secondary care for too long. Once a patient is referred on you need to see yourself as a resource to care for patients. That is where Government policy is taking us, but it has important implications for the future of buildings and the use of buildings.

VII. National Services Frameworks

National Service Frameworks pick on certain diseases or groups of patients with illnesses and try to define a set of good practice and key targets around clinical care. It gives us an opportunity to make a difference to our patients and gives us a framework to say that if the system has to develop and include social care, can we use the National Service Framework as an organisational development tool to improve care, remove rigid barriers and utilise the most appropriate person and location. That has implications on the way we design our estates as well as in the way we work.

VIII. Healthcare in Context

The health service is relatively marginal for the improvement of a country's health. The health service should not try to run the world, but need to examine how our work fits into the wider public health agenda. At a very local level, welfare benefits could be available at local GP practices. At a much larger level the Government Office for London explored the idea of whether we could use local labour schemes to improve local economies through new buildings. There is a wonderful opportunity to have better healthcare facilities, but also to bring more wealth and regeneration into local communities. Much of this work will have to be the responsibility of PCTs, who will have to be supportive of the GP model and begin to address the wider strategic issues around the use of hospitals and the public health agenda.

IX. Summary

The work you have done today around the health gained from premises is absolutely crucial, as is the linking of IT in this. We need to have a LIFT for IT to bring central procurement but local development. All of this is pointless unless we have modelled better care for our patients, both in the health service and in the public health agenda.

Questions and Answers

Participant 1

What does your ideal urban primary care centre look like?

David Colin-Thomé

It varies. The first contact GP, depending on space and availability, may be not far removed from what you see as a better built and better organised general practice. In many areas that is the model, rather than the all-singing, all-dancing factories. Localness will be a key issue. Some practices will have larger premises where they can do some of this wider range of work, or you

may have to have standalone diagnostic treatment centres. I think it will vary depending on availability of space and so on. I like the fact that LIFT forces local health systems to have a proper premises linked to patients needs. There is no one model, but localness will remain a big issue.

Participant I

Some people do not know exactly what is expected in the LIFT bidding process. Has the work been done in terms of defining that?

David Colin-Thomé

GPs are the most equitably distributed service in this country and LIFT was an attempt to get better premises, this is one way of delivering better services. The system needs to have a defined plan initially and I commissioned the work of assessing the suitability of general practice premises. We need to prioritise and have a proper strategy with coherent planning. We need to work our way through the most problematic areas. LIFT also takes some of the economic pressure off GPs because they do not have to fund everything themselves.

I hope it does not degenerate into just a building programme. It begins to say: have a strategy linked to the service, tackle the bad areas first and do not get locked into one model of ownership of premises, which GPs have done in the past.

Participant II

I was really intrigued by what you said about the preference of clients for the single-handed local GP. Government policy seems diametrically opposed to the preference of small practice.

David Colin-Thomé

There is no Government policy to get rid of small practices. There was a bit of a wobble after Dr Shipman about the single-handed practice, but the new GP contract is a quality-based approach. It has about 30%-50% of the cash based on quality markers. Small practices do suffer from a lack of range of services, which is where PCTs can fit in.

A lot of big practices are unpopular because they are impersonal. An issue for big practices is how to personalise their services. There is no government policy against that at all, but as things percolate through the system you may get different messages. In the Department of Health exciting new ways of working, such as health action zones are meant to empower and bring about innovation, as they percolate through the system they become more bureaucratic and less useful.

Sunand Prasad

Thank you very much David for your fantastic conclusion and thank you all very much for coming.