

Healthcare Building Forum

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*Quality out of
Control ?*

*- Let's take another (brief) look at the 'Design Quality' of our NHS
Hospitals in Scotland*

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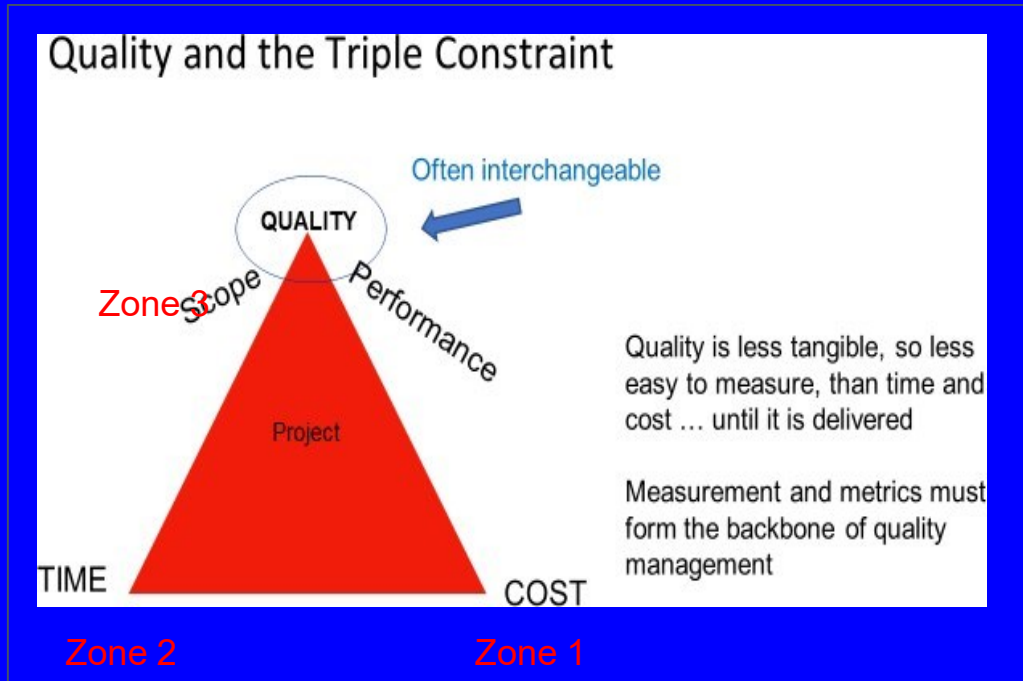
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Two questions for you.

Do we get the design quality
we deserve in our Scottish
NHS hospitals?

Do we really realise how much
poor design quality is costing
us?

Design Quality Conundrums and the Iron Triangle:



- Purpose is to enable agreement between Proj Man, Proj Sponsor and other influencing stakeholders
- Zone 1 – Cost is key. Time & Quality must give
- Zone 2 – Time deadline must be met
- Zone 3 – Requirement to be fully met

Wright/Lawlor-Wright 2018

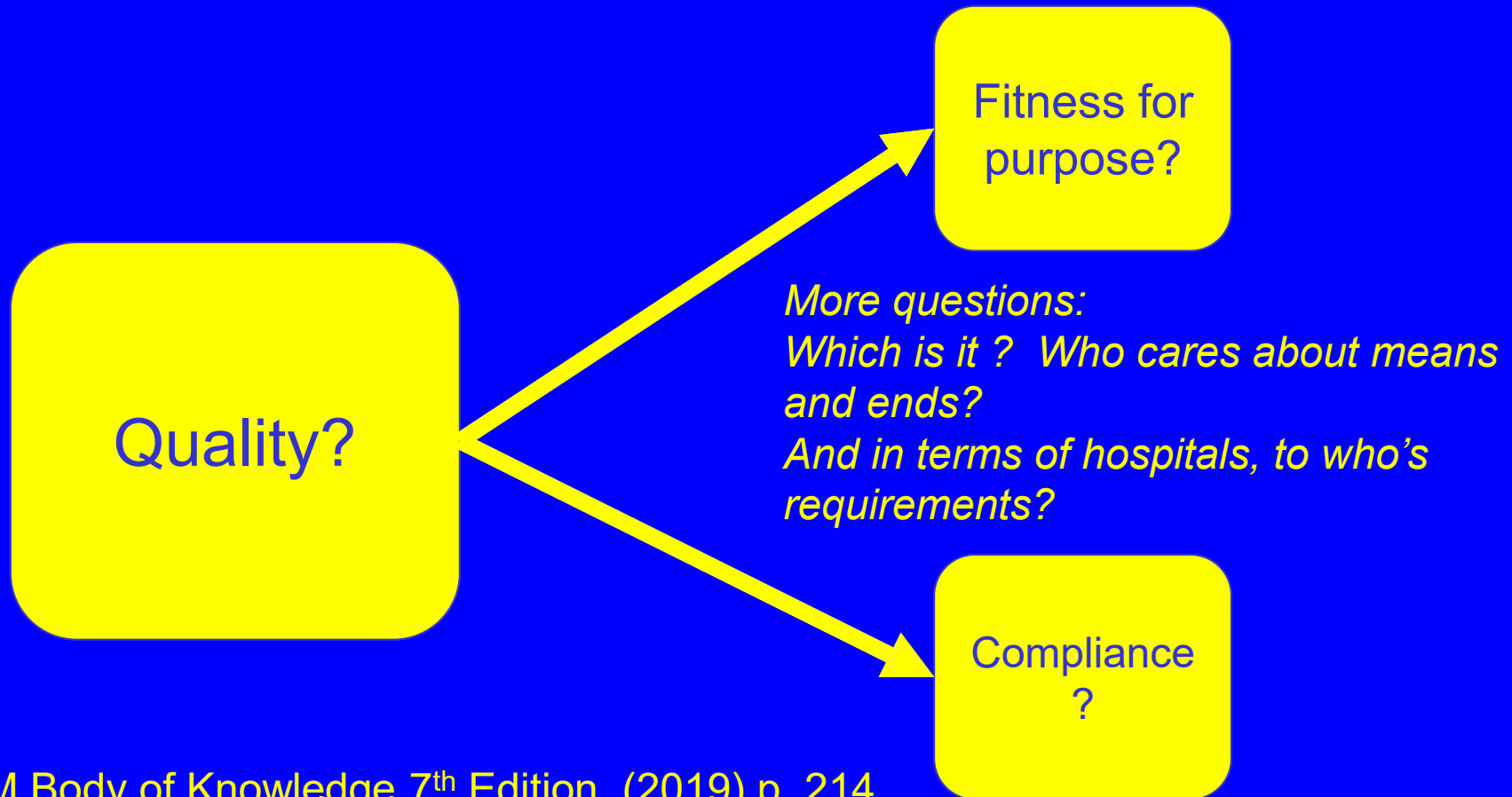
The cynical view of this model? - “a phenomenon and two best guesses”?

Design Quality Conundrums and the importance of interpretation – but from whose perspective...?

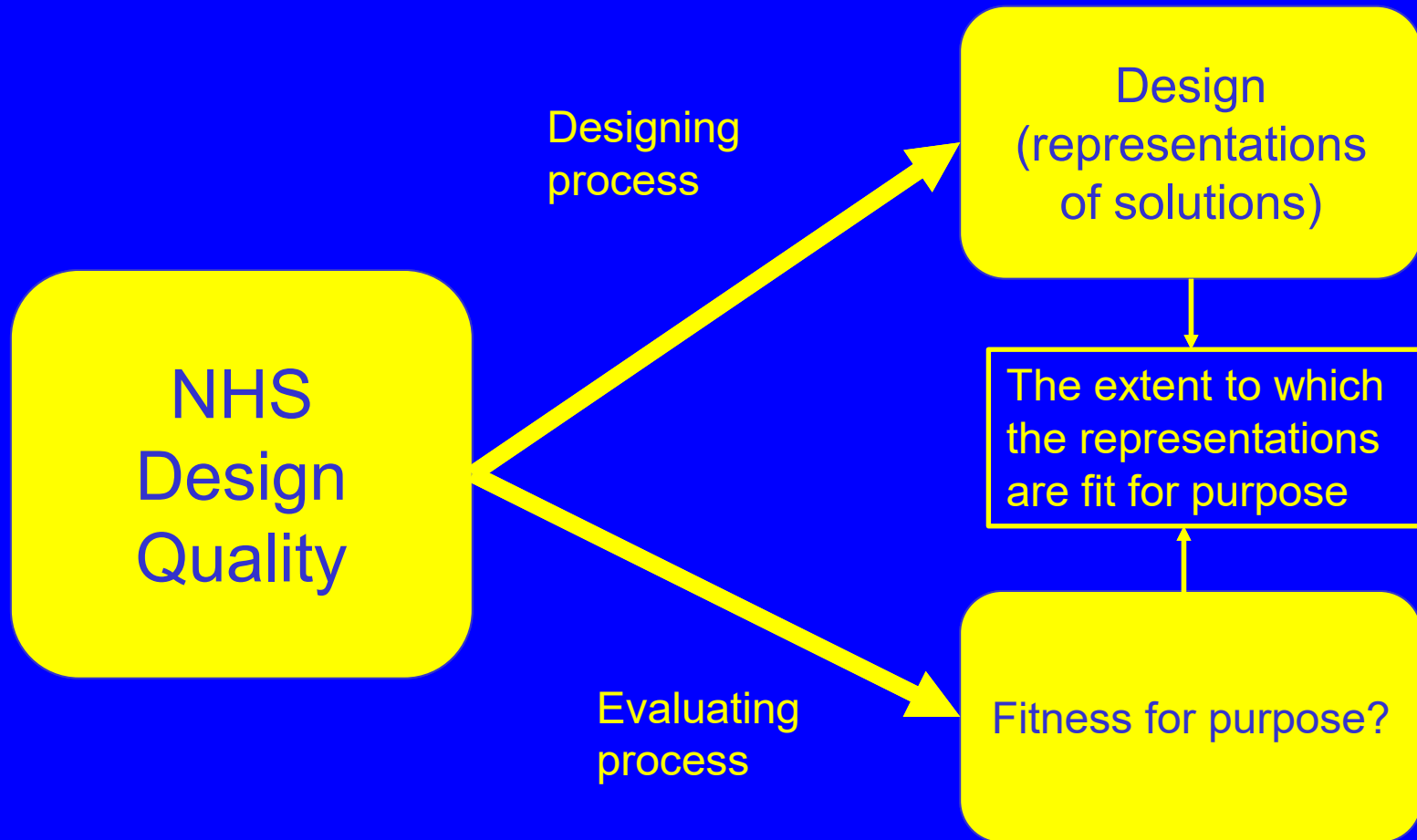


'Las Meninas', D. Velazquez, 1656

Design Quality Conundrums -fitness for purpose or compliance?- process/ (means to) or product/ (an end)? to requirements.



NHS Design Quality Conundrums – concurrent and iterative processes subject to constraints and interpretations

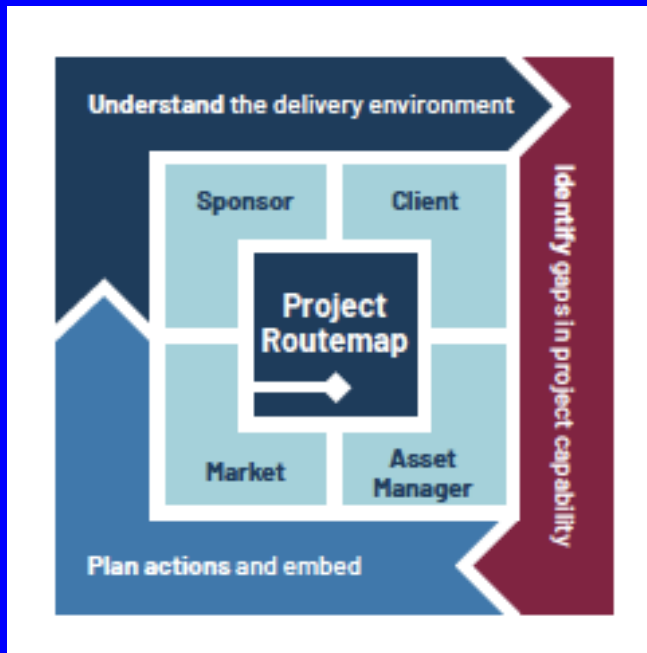


Design quality conundrums- the project environment within which the design quality sits

- Successfully designing hospitals requires an assessment of:
 - Complexity of the project work
 - The capability of the parties involved to do the work
 - The Sponsor The Asset Manager
 - The Client The market

And actions taken to subsequently align the complexity and capabilities for success –(see for example the IPA's Project Initiation Route map)

NHS Design quality conundrums – unpacking the parties and their perspectives on design quality

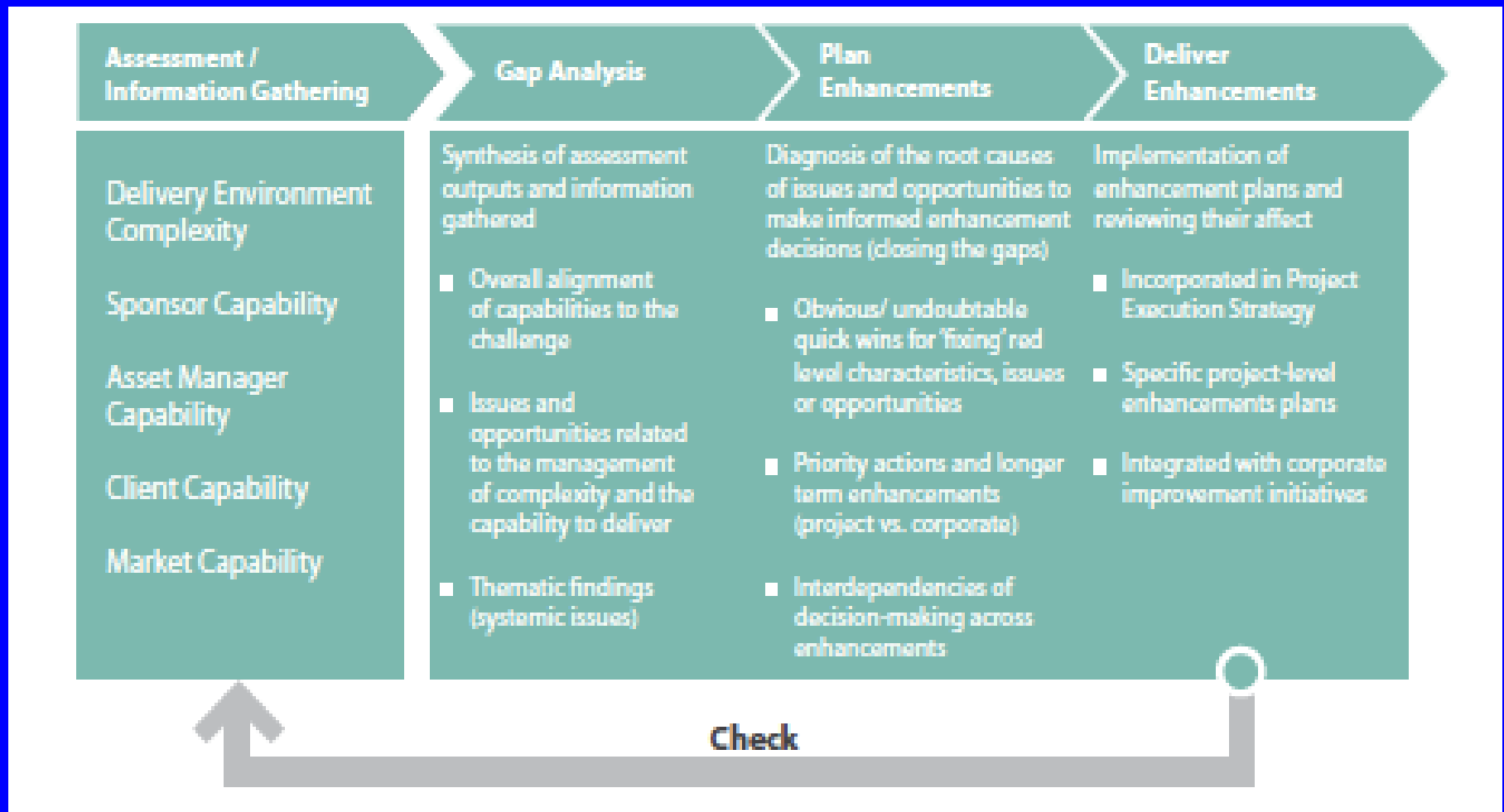


- Sponsor – Government (as now devolved for the NHS in Wales and Scotland) – Design quality policy...
- Client – NHS Trusts and Boards – mandated policy; standards; legislation
- Market : Contractors, Designer, funders - Experience, knowledge, skill, competitive tension driving interpretation and innovation (e.g., use of digital, MMC, AI, TQM)
- Asset Managers – Operational phase: NHS Trusts and Government Agencies plus private sector asset managers (e.g., PPP)

Extract from latest
Infrastructure and Projects
Authority's Route map 18.2
February 2022

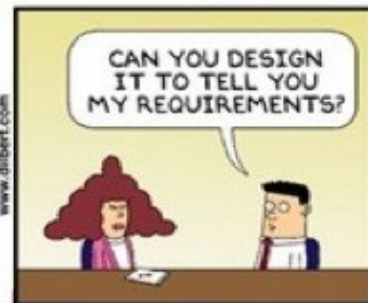
A typical NHS Hospital

Design quality conundrums- aligning for success the project environment within which the design quality sits



Touted as 'best practice' but question: Does it happen all the time in the NHS ?

What really goes on and is it really any surprise?



NHS Design quality conundrums- compare the 'reality' of designing hospitals compared to other things

[1]

➤ Designing NHS hospitals is:-

- Complex and complicated; Is not (contrary to some beliefs) 'largely objective' in nature. The typology is large and mixed
- Subject to Value for Money, scrutiny and accountability
- Happens, typically, 'once in a life-time', meaning, in practice:
 - Coping with a mandated (policy) environment but with typically inexperienced stakeholders (*I don't know if you don't*)...
 - Lack of specific knowledge - from status quo and for the future

NHS Design quality conundrums- compare the 'reality' of designing hospitals compared to other things

[2]

➤ Designing NHS hospitals is:-

- A process that is notoriously messy, iterative, and subject to numerous standards & constraints (views, audits, legislation)
- Difficult to prototype – lack of performance testing/PoE nascent
- Sits + competing value regimes – NZC; Social Value; COVID
- Competing int. priorities - Business as Usual v. Project Work
- Subject to numerous externalities – 'prisoners of urgency' not least 'political pressure', risks; planning issues; audits...
- Unlike manufacturing or typical private sector projects

Enter current (extant) Policy on Design Quality for NHS Scotland (2010 rev)

- CEL 19 (2010) (45 pages) is the current mandatory policy
 - Genesis:
 - This policy was developed in Scotland following a coordinated tripartite approach between SGHD, Health Facilities Scotland and A+D Scotland to *‘assist health boards to increase their capacity to raise the design quality of healthcare building projects’* via numerous means.
 - *Note Well: When introduced, (2010) there was a significant pipeline of NHS projects in the UK and to its credit, the policy raised the profile and status of the importance of design quality*

However this is 2022, and “CEL 19 (2010) is now embarrassingly out of date and is no longer fully fit for purpose”

This is a serious problem and requires urgent attention!

Why is this the case ?

In defending this provocation, I will refer to 3 recent examples of design award-winning* UK hospitals

➤ The Elmview and Muirview Units, (NHS Fife)

- <https://www.ads.org.uk/stratheden-hospital-elmview-and-muirview-wards/>

➤ The 'Garden Hospital' (NHS Dumfries and Galloway)

<https://www.architectsjournal.co.uk/buildings/dumfries-and-galloway-royal-infirmary-the-uks-first-garden-hospital>

<https://www.ryderarchitecture.com/project/dumfries-and-galloway-royal-infirmary/>

➤ Cancer Centre at Guy's Hospital (London)

- <https://www.rsh-p.com/projects/health-and-science/cancer-centre-at-guys-hospital/>

**Including peer reviewed, independently and industry recognised national and international awards*

Reasons why CEL 19 (2010) requires urgent reform [1]

- Processes, standards, procurement and technology have significantly moved on since 2010. CEL 19 does not address or refer to this. Its out of step and date.
- Published research, based on practice, convincingly challenges the singular theoretical basis of CEL 19. Its not fully fit for purpose.
- Lack of evidence to show that the policy has actually been implemented fully in practice.
- Little peer-reviewed evidence to show that CEL 19 has worked. Lack of empirical research undertaken or even currently being sponsored by SGHD.

Reasons why CEL 19 (2010) requires urgent reform [2]

- Key Risks that arise from this lack of reform include:
 - Risk 1. Without reform, there is the risk of 'ossifying bureaucracy' setting in and lack of innovation
 - Risk 2. Without reform, the potential to make significant capital savings will continue to be lost
 - Risk 3. Not clear if SGHD, HFS or A+D Scotland are doing anything soon about these reforms – where is the leadership for updating and reform?

Answers to the questions.

Q1. Do we get the design quality we deserve in our hospitals?

My answer: No.

Q2. Do we really realise how much poor design quality is costing us?

My answer: No.

Summary

- The the 'worlds' of quality, design, design quality and evaluating design quality NHS hospitals are, compared to other sectors a 'special case'
- Policies that mandate the improvement of design quality of hospitals are:
 - Important and worthy – they save time and money and improve well-being and therapeutic benefits to patients, staff and visitors
 - Need to be regularly updated and be in 'lock-step' with changes in technology and research

Conclusions and Recommendations

- The current NHS Scotland policy (CEL 19 (2010) is in urgent need of reform and updating
- Such reforms should include renewed SGHD sponsorship of research and creation of a specific community of practice within the sector for improving the evaluation of design quality that reaches out to Scottish professional, university and industry bodies and groups

Thank you for time.

(A full version of this presentation and its argument is available upon request)



➤ Your questions please.

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