Premises for Primary Care

‘Primary Health Centre: an institution equipped for services of curative and preventive medicine to be conducted by general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists’

Dawson Report 1920

Where are we now?

New ideas such as the Primary Care led NHS have put primary care services on the agenda again and GPs in the driving seat. One implication will be a need for buildings to house the expanded services.

But what is different this time round? The history of the health care provision shows that the primary care sector has emerged as the key to service delivery before. Dawson tried to introduce preventive primary care in 1920 and in the early NHS when curative care was GP work and preventive care provided by local authorities, the two activities were placed alongside in a new building type, a Health Centre. Many Health Centres were built but by the end of the 70s they were out of favour as GPs did not want to work in them. As the GPs moved out financial mechanisms were set up for them to provide their own premises under the cost rent scheme. Today the new policies of GP fundholding and the shift services out of hospitals into community settings nearer to people’s homes, is driving a significant change in primary care services and buildings.

Two strands seem to be emerging; inner cities and the rest. Outside the inner cities fund holding has taken off and GPs are expanding their premises to house many more services such as physiotherapy or complementary therapies and traditional hospital services such as outpatients and day surgery.

The other strand in the inner cities is not so promising. Here there is a heritage of the poorest quality of premises which have had the least investment over the years, combined with the greatest number of single handed GPs, who tend not to have a loud voice. Finding sites to expand premises and where GPs can group together, is much more difficult in the inner city. The location of the practice building must be immediately adjacent to the catchment population which may be only one mile across, restricting the possible choice of sites to just a few streets.

At the same time the space and environmental standards of the ‘Red Book’ are no longer adequate for 90s practice. The current emphasis is on innovative projects to house a shopping list of services, selected for each particular locality according to assessed health needs. There are a number of descriptions used for the proposed new building types; primary care resource centre, polyclinic, ambulatory care, community hospitals. Such projects can involve a range of stakeholders each with a different agenda; GPs, FHSAs, Community Trusts, private developers. The definitive models for the next tranche of health care buildings has yet to emerge from the shopping list approach. Each project has to tread its own path which allows enormous scope for innovation but is dependent on the existence of a knowledgeable client who understands the complexities of the planning and procurement process for buildings.

However a number of organisational, planning and design principles can be identified whatever the package of services.
The primary health care team may include:

- General Practitioners
- Practice Nurses
- Community Nurses
- District Nurses
- Health Visitors
- Community Midwives
- School Nurses
- Receptionists
- Practice Manager
- Clerical Staff
- Clinic Clerks
- Administrators
- Managers
- Counsellors
- Speech Therapists
- Dentists
- Podiatrists
- Physiotherapists
- Complementary Therapists
- Occupational Therapists
- Outreach Consultants
- Ophthalmologists
- Audiologists

Project briefing and designing

It is worth taking the time to develop a comprehensive brief giving special consideration to organisational, planning and design principles. It is advisable to involve all the major stakeholders and develop a measure of consensus. The following highlights some of the most important issues that need consideration. It is intended as a starting point rather than to be comprehensive.

The brief will be used by designers to inform the design process at the conceptual stage. For clients the brief offers a framework of agreed organisational principles. The brief can also be used for assessing that a design scheme has addressed these original intentions.

Organisation of patient care

Analyse functions and activities by type to establish capacity and schedule of accommodation into individual consultation, clinic and group session. This will help to highlight the need for patient call systems, relationship of waiting to clinical zones and waiting times for different activities.

Space as a resource not territory

Analyse user space requirements into functional types. Not every activity or person using the building requires a separate room. Some rooms example, GPs may carry out administrative tasks in an office rather than a consulting room.

Zoning

Separate functional zones into public, clinical and staff. Consider the hierarchy of spaces from public at the entrance to shared in the clinical areas to private for the staff. This facilitates a clear circulation pattern for people moving around the building; helps to make the building more legible to patients and visitors; affords opportunities for informal exchange amongst staff away from public areas. Being able to open and close suites of rooms may facilitate the possibility of the building being used by different users at different times. eg GP surgery on Saturdays, community groups after hours.

Tension of access, security and confidentiality

Some key requirements present conflicting demands in their physical manifestation. There is a triangular tension between confidentiality, access and security.

Location within the practice catchment area for patients, ease of transport and walking are important considerations in choosing the site. Mobility access to and around the building is essential. Consider the special needs of people with sensory impairments. People may be
Organisational, Planning and Design Principles

(temporarily disabled and may need to be accompanied from car to clinic.

Devise planning relationships to take account of patient confidentiality. It is important that conversations in clinical rooms cannot be inadvertently overheard. Avoid waiting areas immediately outside clinical rooms.

Whilst offering a welcoming arrival to patients at reception it is important to provide adequate security for staff at the desk. The ability to step away from the counter, inhibit physical attack and call for help are reassuring to staff. Privacy for sensitive conversations at the desk and the ability to take telephone calls in privacy are also essential.

Security for records away from public areas is essential. The overall security is important for buildings which can be targeted because they contain both drugs and electronic equipment.

Response to change

Consider the potential to change or expand the building in future. Explore the use of rooms for several functions by designing, for example, to a universal space standard, by providing accessible storage. Design to accommodate as yet undefined needs.

Consider the possibility of using this building for another function in future.

Communications

Provide adequate systems for expansion of telecommunications systems including fax, phone, computer, diagnostic linkups by fibre optics and modem. For the next decade it is likely that computerised patient record systems, smart cards, image transfer to hospital for screening will develop alongside manual and paper systems. Ensure the potential to alter and extend these systems without major disruption to people and building fabric.

Sustainability

Evaluate the impact on revenue and environmental costs in relation to energy efficiency, maintenance of materials and finishes, use of ‘green’ components.

A sense of place

Consider the environmental needs for special care groups such as children and older people. A sense of welcome, place and tranquility are appropriate design intentions which can be enhanced, for example, by the imaginative use of natural light, local control of temperature, comfortable places to sit.

Analyse the site to enhance its specific qualities such as orientation, views, access and context. Exploit the individual circumstances to develop a special and appropriate building which is both adaptable and robust.

Primary health care activities may include:

- Consulting/Examination
- Nurse Treatment
- Minor Surgery
- Minor Injuries
- Pathology
- Pharmacy
- Interview
- Specialist Clinics
- Group Meetings
- Physiotherapy
- Speech therapy
- Occupational Therapy
- Complementary Therapy
- Dentistry
- Podiatry
- Reception
- Record storage
- Waiting
- Children’s Waiting
- Office
- Office Base
- Seminar
- Library
- Staff Amenities
MARU on Primary Care

Recently MARU has prepared a briefing guide, Primary Health Care Premises: a resource, which is conceived as a tool to support those developing premises for primary care. This sets out a route map to the planning process, the principles of a project brief, and an introduction to designing and evaluation study. The main focus of the document is a briefing tool for developing a project brief and appraising a design scheme.

MARU has had a continuing interest in the planning and design of primary care premises. During the 1970s Ruth Cammock directed a programme of work including her seminal Health Centres Handbook and her work on Reception, Waiting and Patient call. She championed the patient as the service user in her work on Confidentiality. Her team also looked more deeply at the utilisation of examination and treatment rooms. This work could relevantly be repeated for today's circumstances.

During the 1980s MARU ran The Inner London GP Premises Advisory Service for the DHSS which gave advice to individual GPs on their particular premises problems and facilitated premises development. The HBN 46 was prepared in the unit at this time. Future plans are to develop a series of distance learning materials on the issues around premises improvement, extension and rebuild for GPs and their Practice Managers.

MARU

MARU is an integrated research and postgraduate teaching unit which offers consultancy and access to a specialist library collection. Our philosophy is to take a multi-disciplinary analytical approach to studying the match between health care services and buildings. We keep abreast of current changes in health service delivery patterns and new technologies and in particular consider strategies for building implementation, bringing together current thinking and lessons from history. Our research and consultancy activity creates a framework for developmental postgraduate study at Masters, Research Degree and CPD levels.

Selected references


LIG Primary Care Handbooks: No 1 Strategic Planning, No 2 Procedures, Procurement and Funding, No 3 Case Studies, No 4 Planning and Design Information. London Implementation Group (LIG). NHS Estates 1994.


