# PRIMARY CARE BUILDINGS – GOVERNMENT POLICY, IMPLEMENTATION AND COMMUNITY INVOLVEMENT IN FACILITY PLANNING AND DESIGN

**SUSAN DEBORAH CAVANAGH, BA Hons, BSc Arch**

A thesis submitted in partial fulfilment of the
requirements of the University of North London
for the degree of Doctor of Philosophy

**JULY 1999**

# Contents


| | | *Page* |
|---|---|---|
| *List of appendices* | | *v* |
| *List of figures* | | *vi* |
| *Glossary* | | *ix* |
| *Acknowledgements* | | *xi* |
| *Abstract* | | *xii* |
| **Introduction:** | **The Study: Approach, Aims and Structure** | 1 |
| 1. | Theoretical approach | 1 |
| 2. | Aims and objectives | 11 |
| 3. | Structure of the study | 12 |
| **Chapter 1** | **Research Methodology** | 20 |
| 1.1 | Research initiation and literature survey | 20 |
| 1.2 | Interviews with health policy makers, practitioners and participants | 22 |
| 1.3 | National postal survey | 23 |
| 1.4 | Interviews with architects | 27 |
| 1.5 | Case study methodology | 30 |
| **PART I** | **A SOCIAL ANALYSIS OF PRIMARY CARE BUILDING DEVELOPMENT IN BRITAIN 1979/1997** | |
| **Chapter 2** | **The Role Of Ideas: 'Public Choice' to 'Public Health'** | 40 |
| 2.1 | Different models of health | 41 |
| 2.2 | *Public choice* and the medical model of health. | 46 |
| 2.3 | *Public health* and the social model of health. | 53 |
| 2.4 | Political approaches to inequalities in health. | 58 |
| 2.5 | Conclusion | 60 |
| **Chapter 3** | **Implementing a Primary Care-Led NHS** | 63 |
| 3.1 | The need for change. | 64 |
| 3.2 | The decentralisation process | 71 |
| 3.3 | Resources in the inner cities | 77 |
| 3.4 | Alternatives to fundholding | 79 |
| 3.5 | Conclusion | 84 |

| | | |
|---|---|---|
| **Chapter 4** | **Practitioner Stakeholders in Primary Care Facility Development** | 87 |
| 4.1 | The influence of practitioners | 87 |
| 4.2 | General Practitioners (GPs) | 89 |
| 4.3 | Community Health Service trusts | 94 |
| 4.4 | Primary Health Care Teams | 95 |
| 4.5 | Voluntary and community organisations | 98 |
| 4.6 | The promise of inter-sectoral collaboration | 99 |
| 4.7 | Conclusion | 101 |
| **Chapter 5** | **The Historical Development of Primary Care Buildings** | 103 |
| 5.1 | The development of purpose-built primary health care buildings | 104 |
| 5.2 | Early models of health centres | 106 |
| 5.3 | GP premises and NHS health centres | 112 |
| 5.4 | Alternative models of primary care buildings | 117 |
| 5.5 | Primary care building types since 1990 | 120 |
| 5.6 | Conclusion | 129 |
| **Chapter 6** | **A Critical Analysis of Standard Mechanisms for Commissioning and Designing Primary Health Care Facilities** | 130 |
| 6.1 | Commissioning and Procurement of Buildings | 130 |
| 6.1.1 | Funding GP premises | 131 |
| 6.1.2 | Funding multi-agency centres | 134 |
| 6.1.3 | Capital Investment procedures | 135 |
| 6.1.4 | The Private Finance Initiative | 136 |
| 6.2 | The Design Process | 138 |
| 6.2.1 | The project brief | 138 |
| 6.2.2 | Appointing the architect | 141 |
| 6.2.3 | The design team | 143 |
| 6.2.4 | NHS design guidance | 144 |
| 6.3 | Conclusion | 149 |
| **Chapter 7** | **The Socio/Geographic Relationship Between Primary Care and Communities** | 151 |
| 7.1 | Defining community | 152 |
| 7.2 | Geographic distribution of primary care facilities | 158 |
| 7.3 | Health professional catchment areas | 162 |
| 7.4 | Public perceptions of community and neighbourhood boundaries | 166 |
| 7.5 | Conclusion | 168 |

**PART II AN EVALUATION OF PRIMARY CARE ARCHITECTURE AND COMMUNITY INVOLVEMENT PROCESSES IN MULTI-AGENCY FACILITY PLANNING AND DESIGN SINCE 1990.**


| | | *Page* |
|---|---|---|
| **Chapter 8** | **Design Principles for Primary Care Buildings** | 170 |
| 8.1 | Design principles contributing to primary care social objectives | 171 |
| 8.2 | Design facilitation of inter-sectoral collaboration | 174 |
| 8.3 | Design facilitation of community participation | 183 |
| 8.4 | Conclusion | 198 |
| **Chapter 9** | **Community Involvement in Primary Care Facility Planning and Design** | 199 |
| 9.1 | Ideological approaches to community involvement in health service decision-making | 200 |
| 9.2 | The case for community involvement in facility planning and design | 208 |
| 9.3 | Medical and architectural professional approaches to community involvement | 215 |
| 9.4 | Responsibility for community involvement processes | 219 |
| 9.5 | Conclusion | 220 |
| **Chapter 10** | **Case Studies** | |
| 10.1 | Purfleet Primary Care Resource Centre, Essex | 222 |
| 10.2 | St. Matthews Medical and Social Centre, Leicester | 243 |
| 10.3 | Kath Locke Community Health and Resource Centre, Manchester | 264 |
| 10.4 | Neptune Health Park, Sandwell, West Midlands | 286 |
| **Chapter 11** | **Towards a Consensual Model of Primary Care** | 307 |
| **Appendices** | | A-1 |
| **Bibliography** | | A-49 |

# List of appendices


| *Appendix* | | *Page* |
|---|---|---|
| 1:1 | List of health professionals interviewed and interview frame. | A- 1 |
| 1:2 | Example of letters sent to CHCts and CHCs explaining postal survey. | A- 3 |
| 1:3 | MARU Survey of Community Involvement in Primary Health Care Building Planning and Design (postal survey 1995). | A- 4 |
| 1:4 | Summary of analysis of the postal survey. | A- 6 |
| 1:5 | Response from Sheffield CHC to postal survey. | A-12 |
| 1:6 | Interview frame for architects. | A-14 |
| 1:7 | Case study: data collection method | A-16 |
| 1:8 | Case study: background information survey. | A-19 |
| 1:9 | Case study: building quality survey | A-25 |
| 1:10 | Case study: community involvement process survey | A-28 |
| 1:11 | Case study: order of questions used in the analysis | A-32 |
| 10: 1.1 | Purfleet case study respondents | A-34 |
| 10: 1.2 | Purfleet building quality evaluation | A-36 |
| 10: 1.3 | Purfleet community involvement process evaluation | A-37 |
| 10: 2.1 | St Matthews case study respondents | A-38 |
| 10: 2.2 | St Matthews building quality evaluation | A-39 |
| 10: 2.3 | St Matthews community involvement process evaluation | A-40 |
| 10: 3.1 | Kath Locke case study respondents | A-41 |
| 10: 3.2 | Kath Locke building quality evaluation | A-43 |
| 10: 3.3 | Kath Locke community involvement process evaluation | A-44 |
| 10: 4.1 | Neptune case study respondents | A-45 |
| 10: 4.2 | Neptune building quality evaluation | A-47 |
| 10: 4.3 | Neptune community involvement process evaluation | A-48 |

# List of figures


| *Figures* | | *Page* |
|---|---|---|
| 0. 1 | Research model showing the three main units of analysis. | 11 |
| 0. 2 | Framework used to analyse primary care building development. | 14 |
| 1.1 | Community Facilities Model for Leeds. | 26 |
| 1.2 | The realistic evaluation and policy making cycle adopted from Pawson and Tilley (1997). | 36 |
| 2.1 | Socio-economic model of health adopted by Acheson (1998). | 45 |
| 2.2 | Model to describe influence of competing ideologies on the development of primary care buildings and community involvement strategies. | 59 |
| 3.1 | Financing and accountability arrangements in the new NHS. | 74 |
| 3.2 | Model to show the four levels of Primary Care Groups. | 82 |
| 5.1 | The exterior and large recreational space within The Pioneer Health Centre, Peckham, London (1935). Architect: Sir E. Owen Williams. | 107 |
| 5.2 | Finsbury Health Centre: 'Getting it across to the layman' information literature. Architect: Lubetkin. | 110 |
| 5.3 | Examples of medical centre layouts (1993). Camberwell Green Surgery, Architects: Eger Architects and De Montfort Student Health Centre, Architects: Bundey & Rogers. | 121 |
| 5.4 | Health Mall Diagram. | 125 |
| 5.5 | Nottingham Base 51: A multi-agency centre for young people. Architects: Groundworks. | 126 |
| 6.1 | Sketch design for a small health centre appropriate for rural areas. | 145 |
| 6.2 | Sketch design for a large health centre. | 146 |
| 8.1 | Flexible use of $12m^2$ rooms. Architects: MAAP. | 177 |
| 8.2 | Three Zone Model. Architects: MAAP. | 179 |
| 8.3 | Application of the Three Zone Model to a surgery at Watford. Architects: MAAP. | 179 |
| 8.4 | Plan showing separable surgeries at Rushton Street Surgery, Islington, London. Architects: Penoyre & Prasad. | 182 |

*Figures* *Page*


| | | |
|---|---|---|
| 8.5 | Section, site plan and perspective of Adelaide Road Surgery, London NW3. Showing facility built over a car park, Architects: Pentarch Ltd. | 186 |
| 8.6 | Reception area at Chiddenbrook Surgery showing open reception desk with privacy screen. Architects: Smith Roberts Associates. | 191 |
| 8.7 | Ground Floor Plan of Vauxhall Health Centre showing community resource area that can be used independently of clinical access. Architects: O'Mahony Fozard. | 197 |
| 9.1 | Model to show the variety of ways in which the public, as individual consumers and as citizens, might express views about health services. | 202 |
| 9.2 | The 'ladder of participation' devised by Shelley Arnstein. | 204 |
| 9.3 | Poster invited the local community to participate in a design session for the Zion Community Health and Resource Centre, Manchester. Architects: Triangle. | 211 |
| 10.1.1 | Purfleet Care Centre entrance. Architects: Tangram. | 222 |
| 10.1.2 | Ground floor plan. | 229 |
| 10.1.3 | Reception desk with glazed screen and entrance to minor injuries unit | 230 |
| 10.1.4 | Spiral staircase with controlled access separating agencies. | 230 |
| 10.1.5 | Curved corridor providing visual interest and privacy. | 231 |
| 10.1.6 | Pharmacy independently accessible from Centre. | 231 |
| 10.2.1 | St Matthew's Community Health and Care Centre entrance. Architects: Bundey & Rogers Architects. | 243 |
| 10.2.2 | Diagram to show building service accommodation and zoning. | 248 |
| 10.2.3 | St Matthew's floor plans. | 249 |
| 10.2.4 | Reception desk showing lower section for wheelchair users. | 250 |
| 10.2.5 | Open foyer area with café and crèche behind seating and display area. | 250 |
| 10.2.6 | Stairwell detail showing top lighting and dodecahedron form. | 251 |
| 10.2.7 | Training suite for medical students, showing opening partitions. | 251 |

***Figures*** ***Page***


| | | |
|---|---|---|
| 10.3.1 | Kath Locke entrance. Architects: Snapes Design and Build Ltd. | 264 |
| 10.3.2 | Kath Locke: ground floor plan. | 270 |
| 10.3.3 | Kath Locke: first floor plan. | 271 |
| 10.3.4 | Kath Locke: second floor plan. | 272 |
| 10.3.5 | Open ground floor reception area. | 273 |
| 10.3.6 | Café seating area. | 273 |
| 10.3.7 | Designs for new Zion Centre from community user workshop with Triangle Architects. | 274 |
| 10.3.8 | Community kitchen used as a training facility for local people. | 274 |
| 10.4.1 | Neptune Health Park: site model. Architects: Penoyre & Prasad. | 286 |
| 10.4.2 | Neptune Health Park: ground floor plan. | 293 |
| 10.4.3 | Neptune Health Park: first and second floor plans. | 294 |
| 10.4.3 | Neptune Health Park Concourse area (perspective drawing). | 295 |
| 11.1 | Factors that might contribute towards a consensual primary care system and facilities model. | 323 |

# Glossary

| | |
|---|---|
| ACHCEW | Association of Community Health Councils England and Wales |
| AHA | Area Health Authority |
| AIDS | Acquired Immune Deficiency Syndrome |
| AJ | Architects' Journal |
| BMA | British Medical Association |
| CHC | Community Health Council |
| CHS | Community Health Services |
| DoE | Department of Environment |
| DHA | District Health Authority |
| DHSS | Department of Health and Social Security |
| DoH | Department of Health |
| FHSA | Family Health Services Authority |
| GMS | General Medical Services |
| GP | General Practitioner |
| HA | Health Authority |
| HAZ | Health Action Zone |
| HBN | Health Building Note |
| HEA | Health Education Association |
| HFA | Health for All |
| HIP | Health Improvement Programme |
| HLC | Healthy Living Centre |
| HMSO | Her Majesty's Stationery Office |
| LIZ | London Implementation Zone |
| LA | Local Authority |
| MARU | Medical Architecture Research Unit |
| MPC | Medical Practitioners' Committee |
| NHS | National Health Service |
| NHSE | National Health Service Executive |
| NHSME | National Health Service Management Executive |
| OECD | Office for Economic Co-operation and Development |
| OFNS | Office for National Statistics |
| OPCS | Office of Population, Censuses and Surveys |

| | |
|---|---|
| PCG | Primary Care Group |
| PCRC | Primary Care Resource Centre |
| PFI | Private Finance Initiative |
| PHCT | Primary Health Care Team |
| RHA | Regional Health Authority |
| RAWP | Resource Allocation Working Party |
| SMR | Standard Mortality Rate |
| SO | The Stationery Office |
| UDP | Unitary Development Plan |
| WHO | World Health Organisation |

# Acknowledgements

I would like to thank everyone who in different ways has supported this investigation. First, I would like to thank those people, health professionals, architects and local residents who gave up their time voluntarily to provide the information that has formed the cornerstone of this study. Particular gratitude is due to Fay Selvan, Dr Angela Lennox, Chris Shaw, John Allen, Richard Gooden, Dave Ward and Dawn Wickham, who gave up exceptional time to answer questions and help with inquiries.

Second, I would like to thank those who have provided the wisdom, guidance and encouragement that has sustained me throughout this study. Tony Howard for his steadfast support from the beginning and Leonie Kellaher and Sue Pike for their invaluable assistance in the latter stages. Also to Jos Boys who has been inspirational since before the project began and provided theoretical and practical guidance to the last.

Finally, thanks to my family and friends whose kindness and patience has been immeasurable. Particular gratitude is due to David Snewin for his computer assistance, my parents, Peter and Elvira Richards, and my children, Hannah Walker and Gus Cavanagh, for their support and encouragement.

# Abstract

Between 1979 and 1997, British Conservative governments took the decision to shift the balance of health service delivery away from acute hospitals into an expanded network of primary care services provided from local and community based settings. This had implications for the architecture of primary care, as new and extended facilities were required. Controversially however, instead of developing a centrally planned strategy to provide an equitable distribution of resources supporting comparable services to people in all locations, government policy enabled a disparate range of primary care facilities to be built throughout the country, determined largely by the interests of individual GP practices and the particular health ideologies of district level commissioning authorities.

Against this background, this study sets out to contribute new knowledge and understanding of the development of primary care architecture in two ways. First, through conducting a social analysis of primary care buildings that explores the multiple influences of political and health ideology; implementation processes; key stakeholders; commissioning and design mechanisms; and historical and geographic contexts. Second, through developing and applying a methodology for evaluating how far design and community involvement processes in primary care building projects, built during the 1990s, have been successful in meeting the World Health Organisation's social principles for reducing inequalities in health by increasing inter-sectoral collaboration and community participation.

The findings of this cross-disciplinary study provide new insights into several areas of cultural discourse. For example, through demonstrating the impact of medical and social models of health on primary care centres; exploring political and health professional attitudes to community involvement in health facilities planning; and examining the role of architects in facilitating community involvement during the building design process. The study concludes with a discussion of some of political, organisational and architectural factors, identified during the research, that might support a more consensual approach to primary care buildings and service delivery in the future.

## Introduction

## THE STUDY: APPROACH, AIMS AND STRUCTURE

This introduction describes how the study was designed. First, it provides information relating to the theoretical base of the investigation, second, it states the aims and objectives of the research and third, it describes the structure of the dissertation.

### 1. Theoretical approach

My personal motivation for undertaking this study came from a long-standing interest in architecture as a social and political product and the desire to explore the idea of social responsibility within the architectural process.[1] Historically, the concept of socially responsible architecture has been open to numerous interpretations and controversy. An attempt at a consensual definition of socially responsible design was made in March 1993, during a two-day event organised in New York by Pratt Institute in collaboration with Architects/Designers/Planners for Social Responsibility, which included the following statement:

> *Socially responsible design celebrates social, cultural, ethnic gender and sexuality differences; is critical of existing asymmetrical social structures and relationships of power and seeks to redistribute power and resources more equitably; changes society; continually calls into question its own social, cultural and philosophical premises and, through a continuing dialectic, seeks to ensure its ends are consistent with its means, seeks in the process to develop strategies for public intervention and participatory democracy.*[2]

---

[1] This interest developed during my architectural training at the University of North London, particularly my participation in the women's architectural access course 1983/84, and my work at Women's Design Service 1986/1999.

[2] Klein, S.K. (1993) *What is Socially Responsible Design?,* catalogue of the event in New York held by Pratt Institute and Architects/Designers/Planners for Social Responsibility, March 1993, cited in Dutton, T. and Hurst Mann, L. (eds.), (1996) *Reconstructing architecture critical discourses and social practices,* Minneapolis: University of Minnesota Press, p. 18.

This definition clearly proposes that architecture should be conceived as a social process in which the designer and the public user can engage in constructing a new social vision, but it leaves many questions unanswered about the strategies that should be employed and the aesthetic and formal consequences that might result from such a process. Through this investigation into the development of primary care buildings, I have sought to examine how the practices and processes of architectural design might be used either to reinforce dominant interests or, conversely, to encourage more equitable access to resources and the democratic involvement of people from the local community. Although this study focuses specifically on primary care buildings, in developing a methodology for analysing architectural case studies I have sought to find an approach that could also be applied to other public and private building forms.

There is now a substantial body of work within architectural discourse that acknowledges the potential of architecture and urban planning as instruments for progressive social change, while recognising its more common legacy for upholding, reflecting or celebrating, dominating or ruling interests. Many architects, architectural critics and historians have been inspirational about this theme. Some examples are the work and writings of Giancarlo De Carlo (1970);[3] Lucien Kroll (1984);[4] Diane Ghirado (1991);[5] Herman Herzberger (1991);[6] Dolores Hayden (1995);[7] Mike Davies (1995).[8]

Recent architectural discourse both in the USA and in Britain has increasingly challenged the traditional depoliticised paradigms of Western architecture as either art or science. Instead it has brought to the fore the concept of architecture not merely as a physical form – an art object intended for passive contemplation, or as an awe-inspiring scientific/technological construction, but as a relation between the object (building) and its subject (user). In a collection of texts by American architectural critics,

---

[3] De Carlo, G. (1970) 'Architecture's Public' *Parametro* No 5.
[4] Kroll, L. (1984) 'Anarchitecture' in Hatch, C. (ed.), *The Scope of Social Architecture,* New York: Van Nostrand Reinhold, pp. 167-181.
[5] Ghirado, D. (1991) *Out of Site: a Social Criticism of Architecture*, Seattle, USA: Bay Press.
[6] Herzberger, H. (1991) *Lessons for Students in Architecture*, Rotterdam: Uitgeverij 010.
[7] Hayden, D. (1995) *The Power of Place*, Cambridge, Massachusetts/London: MIT Press.
[8] Davies, M. (1990) *City of Quartz*, London: Vintage.

*Reconstructing architecture: critical discourses and social practices*, Anthony Ward (1996), has described a link from William Morris, through the teachings of Hannes Meyer at the Bauhaus, into contemporary discourse, of the assertion that the production of architecture is essentially a social process.[9] Ward cites Meyer as claiming that architecture gives form and pattern to the social life of the community, 'a collective action rather than the individualistic act of an artist/ designer ...the form of the building must have a social content, otherwise it is mere decoration and formalism.'[10]

In Britain, Jonathan Hill (1998), a lecturer at the Bartlett School of Architecture, University College London, in the publication, *Occupying architecture: between the architect and the user*, has suggested that the distinction between architect and user has been artificially overstated.[11] Hill calls for a wider acknowledgement of the role of the user as 'illegal' architect, the term he uses to describe the role of non-professional architects in shaping their environment. [12] Hill argues that architects have traditionally prevented two intrusions from outsiders under the guise of protecting the public, first 'into the body of their profession' and second, 'into the body of their architecture', a position that has served to protect those in the profession, rather than the public interest.[13]

Another contributor to this publication, Jeremy Till, takes a different perspective and points out that there are dangers in universally condemning the traditional relationship between architects and community users, or making exaggerated claims for the power of 'community architecture' to reform society.[14] Till argues that architects cannot be regarded simply as an oppressive force and that many architects already include users in the design decision-making process as a standard part of their practice policy. He suggests that instead of discarding the valuable source of knowledge and experience that

---

[9] Ward, A. (1996) 'The Suppression of the Social in Design; Architecture as War,' in Dutton, T. and Hurst Mann, L. (eds.) (1996) *Reconstructing architecture critical discourses and social practices* Minneapolis: University of Minnesota Press, pp. 27-70.
[10] Meyer, H. (1938) *Education of the Architect,* lecture to San Carlos Academy, Mexico, September 30th, cited in Ward, op. cit., p. 33.
[11] Hill, J. (1998) *Occupying Architecture: between the architect and the user*, London: Routledge.
[12] Ibid., pp.136-159.
[13] Ibid., p.5.
[14] Till, 1998, 'Architecture of the Impure Community', in Hill, op. cit., pp. 62-75.

architects hold, there should be a recognised and negotiated place for the expertise of the architect within the design process.

Although Till convincingly argues against adopting overly determinist arguments of the potential of community involvement in primary care facility planning and design to transform the social condition, or having unrealistic expectations of architects becoming central advocators of social justice, a secondary motivation for my undertaking this dissertation has been to explore the possibility that if processes for community involvement in planning and designing in a local primary care facility are part of a wider political strategy to devolve decision-making they might assist in facilitating a transference of power to enable citizens to take greater control over their lives, health and local environments.

It can be argued that a primary care facility is an interactive social arena, likely to be shaped as much through use as by design. A key to designing a primary care building that facilitates productive activity must therefore lie in the architect developing an understanding of the patterns of movement and requirements of public, as well as staff users, and to be conscious of the social consequences and effects of certain of spatial arrangements and allocations. An important influence on this study relating to this issue has been the work of the urban environmentalists from London University, Bill Hillier and Julienne Hanson. They demonstrated in the publication, *The Social Logic of Space,* that the organisation of spatial categories and their distribution within buildings can operate to reinforce the status of some inhabitants (staff users) of the building over others and to control the interface between inhabitants and visitors (public users) of a building.[15] From this perspective, it would appear reasonable to argue that if a more participatory approach to facility decision-making were to be adopted, then these formal design strategies for exercising power and control over the health process need to be consciously understood by all stakeholders, including community users. Spatial organisation could then be overtly and democratically applied in accordance with the philosophies of health and culture of professional collaboration agreed for that facility,

[15] Hillier, B. and Hanson, J.(1984) *The Social Logic of Space,* Cambridge University Press, p.176-198.

instead of potentially becoming a covert system of social control. Hanson and Hillier's thesis has helped to provide a basis for understanding key differences in the main primary care building forms described in Chapter 5 of this dissertation and has aided an exploration of how different spatial arrangements can affect the principles of inter-sectoral facilitation and the interface with the local community, which is a main focus of the case studies described in Chapter 10.

As well as exploring the idea of primary care architecture as a dynamic social product and a potential contributor to social change and equality, a second theme explored in this dissertation is the attitudes of politicians and health professionals to community involvement in primary care facility decision-making processes, particularly during the planning and design stages of facility development. The relationship of communities to public institutions and professional bodies and the degree to which they should be involved in decision-making processes has become a widely debated topic not only in architecture, but also in many other fields of contemporary society. During the period under review in this investigation (1979/97), it became a key issue within health policy discourse. Latterly the discussion has focused on making a distinction between individual user involvement and public involvement in health service decision-making. For example Anna Coote, then Deputy Director of the Institute for Public Policy Research, in a lecture to the Association of Charitable Foundations in April 1997 on the theme, *User Involvement in Health Care – Where Next,* asserted:

> *Members of the public have a dual relationship with those who commission and provide services. We are both service users and citizens. In each capacity we have different interests. In the National Health Service, individuals as patients have an immediate and personal interest in the service they receive. Individuals as citizens have a broader and longer-term interest as voters, taxpayers and members of the community; they are interested in what happens not only to*

*themselves, but also to their families, neighbours and fellow citizens, both now and in the future.*[16]

Two different political approaches to health service users have surfaced in this debate. The ideology of neo-liberalism and the New Right[17], which has attempted to redefine public users, or patients, as *individual* consumers or customers, with a right to choose the type of health care they receive, and the social democratic rhetoric of the New Left, which has tended to emphasise public users either as patients or citizens with a right to a *collective* voice in determining the practices and processes of health care.[18] In other words, as Dr John Spiers, Chairman of the Patient's Association, graphically suggested from the same platform, the political dichotomy posed is whether the user of health services should be treated as 'shopper or voter'.[19]

The political and ideological divisions behind consumerist and citizenship approaches to public involvement strategies and the impact of these divisions on primary care premises is one of the major themes of this study and is a particular focus in Chapters 2, 7 and 9. The terminology connected to these arguments can be confusing. Because this study is concerned to explore the potential of the architectural process of primary care facility development to engage local people in democratic decision-making, I have chosen to focus particularly on 'community involvement' in the planning and design process. This concept implies a need for consultation with groups and representatives of the local population, and a *collective*/citizenship, rather than an *individual*/consumerist approach to involvement that the term 'user involvement' might imply. However, I would argue that to fine tune primary care services to local needs requires a recognition of the diversity, inequalities and lack of homogeneity between people, even within the same

---

[16] ACF (1997) *Association of Charitable Foundations 4th Annual Lecture on Philanthropy,* Kings Fund, 29.4.97, London: ACF, p.1. This event focused on the question of 'User Involvement in Health Care – Where Next?' Anne Coote was appointed Director of Public Health at the King's Fund in 1998.

[17] Although New Right philosophy is not recognised as a coherent doctrine or unified movement it had certain identifiable themes, such as a reduction in social reliance on the welfare state, more choice for individuals in the market and a greater role for markets generally. See Conservative Party Manifestos 1979, 1987, also Ranade (1994) pp.19-22.

[18] Labour Party (1994) p.13, para 5.2-3.

[19] Spiers' stated personal position in this lecture was 'to shift money into the pocket of the consumer'. ACF op. cit., p.13.

social groupings, such as between older people, or people from minority ethnic communities. I therefore support the argument that approaching public involvement from either an exclusively individual versus collective, or citizenship versus consumer, position is not helpful. As the architect Herman Herzberger (1991) suggested, it presents a 'false alternative', because people need systems that attend to both conditions.[20] A community centred approach to health service decision making does not have to imply that individual public user needs and choices become sacrificed for the benefit of the majority. Rather, we should ensure that the processes of community consultation and involvement are sufficiently sophisticated to include the views of unrepresented individual users and small subgroups within local populations, both as citizens and as users of the facility. However, I would claim this is a significantly different conceptual approach to primary care from one that ignores local social, cultural or ethnic groupings and inequalities and only attempts to meet health needs on an individual choice, or one-to-one professional/client basis. FAT (Fashion, Architecture Taste, 1998), a cross-disciplinary practice involved in research into art and architecture, has argued that the impact of ideological definitions of users to our everyday experiences should not be underestimated and concluded that the ideological status of the individual has a profound effect upon the way they inhabit their environment [21] This issue is discussed further in Chapters 2, 7 and 9.

The reason why the issue of professional/client relations and knowledge and decision sharing became such a common topic of cultural debate in the 1990s may have been partly due to the explosion of access to information created by computer technology, which has undermined traditional seats of knowledge. In the field of medicine for example, increasing information is available to the public on the Internet. But there had also been increasing criticism over the previous two decades, from Marxists, feminists and others, about medics defending their professional interests and excluding the public

---

[20] Herzberger, op.,cit., pp. 12-13
[21] FAT (1998) *Contaminating Contemplation*, in Hill, op. cit., p.83.

from the opportunity to make informed choices, or local communities from participating more fully in decision-making processes, either as patients or citizens.[22]

In response to these criticisms, some NHS policy-makers devised certain strategies to allow more reciprocal and open dialogues between medical professionals and patients, such as 'evidence-based' medicine.[23] Also, changes to professional training had been recommended, to support more reciprocal relationships with patients, based on the principles of 'partnerships in care'.[24] In respect to primary care facilities, a renewed interest in inter-sectoral collaboration and the development of multi-agency resource centres, where the community becomes the focus of the healing/health process, can be viewed as connected to this trend. However, the results of the national postal survey undertaken for this study, described in the following chapter (Chapter 1), indicated that during the late 1990s genuine attempts to involve local communities in the planning and design process of health facilities were largely dependent either on the chance coincidence of architects, commissioning agencies and medical professionals conceding that community involvement might be a useful or desirable element of the project, or on the voice of the local community being powerful enough to demand involvement.[25] I shall therefore argue that, if a more socially responsible approach to facility commissioning is to be taken, there needs to be a more systematic and strategic commitment by both design and medical agencies to involve community users in the planning and design of primary care facilities.[26] Otherwise public users of primary care buildings could find themselves doubly excluded from the primary care facility decision-making process, both in connection to planning the range of services to be accommodated and in the design of new buildings.

---

[22] Various critiques of the medical professional approach are provided by, Ranade, W. (1994) *A Future for the NHS: Health Care in the 1990s*, Harlow, Longman, pp. 8-21.
[23] Farrell, C. & Gilbert, H. (1996) *Debates and strategies for increasing patient involvement in health care & health services,* p. 33 London: Kings Fund.
[24] Ibid.
[25] See Chapter 1 and Appendix 1.5. Examples of both of these conditions occurring are provided in the case studies selected for this study 10.4 & 10 .3. See also DoE (1994) *Community Involvement in Planning and Development Processes*, London: HMSO, p. v. for a similar conclusion.
[26] See Chapter 9, the case studies in Chapter 10 and Chapter 11 for a development of this argument.

This dissertation will aim to illustrate that new definitions and objectives of primary care were developed in the 1980s and 1990s to address the problems of social inequalities and inefficiencies, both through developing more collaborative relationships between professional agencies involved in health service delivery and between professionals and community users. Reflecting these social ideals, the process of designing new facilities could form an integral part of this collaboration. This would require architects to play a key role in helping public and professional stakeholders to articulate their individual requirements and to work towards a compatible interactive environment

Apart from issues of social responsibility in primary care architecture and approaches to community involvement processes in facility planning and design, a third theme threading through this investigation is an exploration of how particular political ideologies and models of health have influenced government health policy. Also, how the processes of policy implementation during the 1980s and 1990s helped to shape primary care premises development. Primary care is so called because it is the first level of contact that the public has with the formal health care system and is usually accessed directly, rather than through referral from a health professional (the stage known as secondary care). However, exactly what type of primary care system should be established in Britain became a contested issue that lies at the heart of this investigation.

During the 1980s, in response to what was perceived to be a growing crisis in meeting demand for health care, the Conservative governments under the leadership of Margaret Thatcher had sought new solutions to health care provision, which culminated in policies for creating a primary care-led NHS based on political ideals of economy, efficiency and free market principles, sometimes referred to as the *public choice* approach. This led to the series of organisational changes, formalised by the *NHS and Community Care Act, 1990,* and heralding what became known as the 'NHS reforms'. During the same period an upsurge of new and challenging ideas about the direction of primary care were emanating from the World Health Organisation (WHO) following the international conference in Alma Ata, 1978.[27] These ideas were based on concepts of

[27] World Health Organisation (1978) *Alma Ata 1978 – Primary Health Care*, Geneva: WHO.

social gain through strengthening communities and reducing health inequalities. The period that has been chosen as a focus for this investigation 1979/1997 was therefore one that witnessed important developments in primary care systems and facilities both in Britain and throughout the world. The tensions and divisions resulting from competing political ideological approaches towards health systems that emerged in Britain and the effect of this on primary care facilities are a key focus of the investigation.

Inter-linked with health policies are different philosophical approaches to the concepts of health and illness. Several commentators on health policy have suggested that, historically, philosophies of health in Western Society have tended to polarise between social and medical models, stressing either the biochemical or the socio-economic determinants of ill health, for example (Ranade, 1994; Green and Thorogood, 1998). [28] [29] But in Britain, as I have already indicated, the dominance of the medical model, which had the support of successive governments since the inception of the NHS, became increasingly challenged towards the latter end of the twentieth century by alternative models. Of these alternatives, in the 1990s, the *public health* approach to primary care, based on the inter-sectoral objectives of the World Health Organisation, became the most influential.

However, alongside the medical and social models of health, which have both tended to be professionally led concepts, some postmodernist health commentators have suggested that there has also been a shift towards individuals and communities reclaiming greater control over health and illness from medical 'experts'. [30] Bury (1998) suggests this shift can be witnessed in the growing demand for self-help, complementary medicine and partnership programmes, although he was sceptical whether these elements of change would easily displace the centrality of medical science in society.[31] These issues of health and political ideology, their implications for health inequalities and their

[28] Ranade, W. (1994) *A Future for the NHS: Health Care in the 1990s,* London: Longman.
[29] Green, J., & Nicki Thorogood (1998) *Analysing Health Policy* Harlow: Addison Wesley Longman. See also Chapter 2 for more detailed definitions of social and medical models of health.
[30] Scrambler, G. and Higgs, P. (eds.) (1998) *Modernity, Medicine and Health,* London: Routledge.
[31] Bury, M. (1998) 'Postmodernity and Health', pp. 1-28, in Scrambler and Higgs, ibid.

influence on the design of primary care facilities, are developed further in Chapter 2 and form a basis of discussion throughout this dissertation.

## 2. Aims and objectives

Based on the theoretical themes outlined above, this study has two aims. First, to undertake a social analysis of primary care architecture built between 1979/1997. Second to develop a methodology of evaluating the design and community involvement processes in the new wave of primary care buildings, with reference to the social principles of primary care outlined by the World Health Organisation (Alma Ata, 1978) to which Britain was a formal signatory.[32] Throughout this research I have tried to make explicit the relationship between primary care architecture, government health policies and approaches to community involvement in facility planning and design (see Figure 0.1).

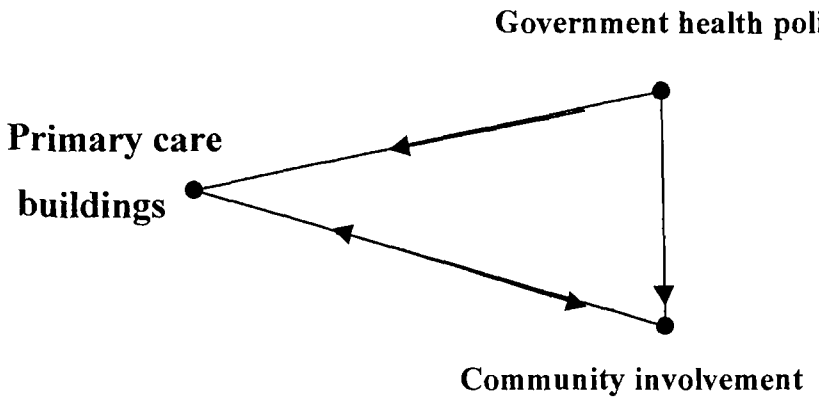



**Figure 0.1**
**Research model showing the three main units of analysis**

[32] WHO (1978), op, cit.

The specific objectives of the investigation can be summarised as:

1) To explore the political and health ideological influences behind government policies to establish a primary care-led NHS between 1979-1997 and to assess the impact of these policies and associated implementation processes on primary care building design and distribution.

2) To analyse the form of primary care architecture using a framework that considers multiple influences, including political ideology, key stakeholders and historical, economic, architectural and socio/geographic contexts.

3) To consider the interface between primary care buildings and local communities, and the arguments for and barriers preventing effective community involvement in the planning and design of primary care facilities.

4) To develop a methodology for evaluating how primary care buildings might facilitate the social objectives of increasing inter-sectoral collaboration and community participation in order to reduce health inequalities, as proposed by the World Health Organisation (Alma Ata, 1978).

5) To apply this evaluation to four case studies of multi-agency, primary care buildings, built or planned following the NHS and Community Care Act, 1990 and to specifically assess the design of the building and the community involvement process at the planning and design stages of primary care building development from the perspective of different stakeholders.

## 3. Structure of the study

In my search to identify a suitable model on which to structure a social analysis of primary care buildings. I found the methodology suggested by the feminist architectural historian and critic, Jos Boys, most useful and I have adapted this to provide a

framework for the background research and the case study evaluations in this investigation.[33]

Boys (1998) suggested that historically, architectural criticism has tended to divide into two frameworks, which are often presented as being mutually exclusive. These either present architecture as a 'product, which reflects societal structures and values', or as a 'result of a process based on the economics of development'. [34] In applying the former approach to primary care buildings, i.e. the analysis of primary care architecture as a 'product reflecting social values', it becomes relevant to understand the impact of political and health ideologies on the development of primary care buildings and to consider the ways that models of health are consciously or unconsciously reflected in architectural design. Applying the latter approach, i.e. an analysis of primary care buildings as 'the result of a process based on the economics of development', the process of implementation and financing these political decisions can be seen to be major influences on primary care facility development.

But, as Boys suggests, these two approaches alone provide insufficient analysis, because they do not engage with the specific context of architectural production and consumption, and they do not make visible the variety of positions of those involved in these processes.[35] To address these gaps, Boys proposes that two other concepts should be called to account. The first is *positionality*, which aims to make explicit the 'positions' of different players or stakeholders involved in the architectural production process. The second is the *mechanisms of translation,* or the specific processes and contexts through which the *positionalities* of key stakeholders are transformed into material form.[36]

---

[33] Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and gender', in Ainley, R. (ed.), *New Frontiers of Space Bodies and Gender*, pp. 203-217, London: Routledge.
[34] Ibid., p. 208
[35] Ibid.
[36] Ibid., pp.208-209.

In applying the concepts of *positionality* and *mechanisms of translation* to an analysis of primary care architecture I have interpreted *positionality* as exposing the relative interests and manipulations of the key stakeholders in the development, such as the commissioning agents of the building, professional staff, local communities and public users, and their manner of occupation and use of the building. *Mechanisms of translation* are interpreted as exploring how the process of architectural design and production can mediate these interests or positions. For example: through statutory commissioning procurement procedures; methods of financing primary care buildings; architectural preferences; site conditions; building and construction processes. Also, how the specific historical and geographical contexts of the project can influence architectural development. An advantage of this particular model for this investigation is that it supports a comprehensive social analysis of the influences on primary care building development, which links to exploring the role of community involvement in the planning and design process through the analysis of *positionality* or stakeholder interests and manner of occupation of the building.

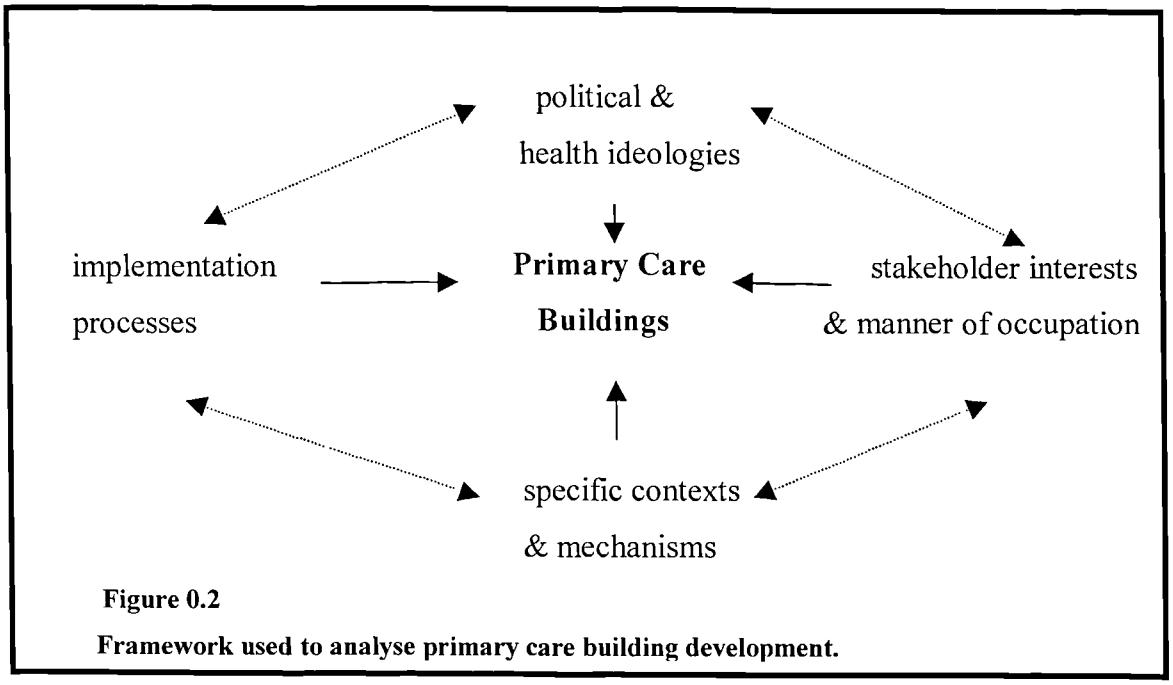



**Figure 0.2**
**Framework used to analyse primary care building development.**

**Chapter Outlines**

The organisation of the first part of this dissertation has been structured to reflect a social analysis of primary care buildings based on the framework proposed by Boys (see Figure 0.2 above). Separate chapters in this section therefore examine political and ideological influences; the impact of specific implementation processes; key stakeholder influences; historical context; architectural and financial commissioning mechanisms and regulations; and socio-geographic influences on primary care facility development.

The second part of the dissertation reports on the development of a methodology for evaluating architectural design and community involvement processes in multi-agency centres primary care commissioned after the NHS and Community Care Act, 1990, and the application of the evaluation to four case studies. The main objective of the evaluation being to assess the contribution of both the product and process of these projects to facilitating the World Health Organisation's social objectives of reducing health inequalities and increasing democratic decision-making through inter-sectoral collaboration and community participation in primary care.

*Note: Definition of terms*

Many of the key terms within this dissertation contain problems of definition and lack common consensus over meaning. For example, the concepts of 'primary care', 'health' and 'illness', 'users', 'community', 'involvement' and 'participation' are all topics of intense debate and controversy in several disciplines and have caused confusion in the development of policies and practices of primary care. Because these problems of definition are so central to the main themes and issues explored in this dissertation, they are discussed within the chapters in which they are most pivotal.

***Chapter 1*** outlines the research methodology used in this investigation. It describes the cross-disciplinary nature of the study, the initiation and development of the research and the main techniques used to gather and test information. These techniques include the initial literature survey undertaken and then updated during the study; interviews with health and design professionals, and a national postal survey to identify primary care

facilities built after the 1990 NHS and Community Care Act that had attempted to meet certain social objectives for primary care. It then describes the methodology used for the selection and evaluation of four case studies.

**Part I: A Social Analysis of Primary Care Building Development in Britain 1979-1997**

***Chapter 2*** examines the political ideologies that have been most influential in determining health policy between 1979/1997, here referred to as neo-liberalist */public choice* and social democratic/*public health* approaches. It analyses how these competing ideological positions relate to the traditional duality of 'medical' and 'social' models of health and how they have influenced forms of primary care provision in Britain. It considers how these competing approaches to health, while appearing superficially to both support a shift to primary care-led NHS, have fuelled various debates and tensions about forms of health care delivery and demonstrated key differences in approach to the fundamental issue of health inequalities.

***Chapter 3*** considers how the implementation process involved in establishing a primary care led service has influenced the pattern of primary care development. It examines how the impact of the governments' attempt to establish a primary care-led service based on a network of GP fundholding practices and a medical model of health was affected by the decentralisation of NHS management, increasing the influence of policy stakeholders at district level and resulting in diversification of primary care building forms in local areas.

***Chapter 4*** explores the power of influence of key practitioner stakeholders on primary care facility development. It considers the different cultures, relationships and structures of service providers involved in the current system of health service delivery including GPs, Community Health Service trusts, Primary Health Care Teams and voluntary organisations. It considers how the *positionalities,* or vested interests of these stakeholders have contributed to fragmentation in service delivery, and diversification in premises development. It assesses the effect of increased responsibility being

allocated to GPs within primary care and questions whether this will assist the goal of improving collaboration between professional agencies and community participation that has been the rhetorical objective of many primary care policies.

***Chapter 5*** investigates the historical development of primary care facilities. It looks particularly at how primary care buildings were influenced by different health ideologies and implementation mechanisms until 1990. It assesses the impact of the legacy of a dual system of public sector and private ownership of facilities. It then examines the development of primary care forms since the Conservative government's *NHS and Community Care Act* 1990, which introduced the major changes to the NHS leading to the NHS 'reforms'. It considers the impact on primary care architecture of the pressures to expand and update the medical/clinical services it provides, to accommodate multi-agency occupation and to become more responsive to the needs of local communities.

***Chapter 6*** considers the influence on primary care buildings of commissioning mechanisms, financial regulations and design procedures and guidance. It examines the effects of different funding mechanisms on GP premises and multi-agency facilities development. It then examines the architectural design process and central design guidance and questions the extent of their influence on the outcomes of primary care facilities. This analysis is supported by findings from focused interviews with architects with recent experience of developing primary care facilities.

***Chapter 7*** explores the interface of primary care buildings and local communities. It considers some of the different definitions of community and the difficulties this term presents in application to primary care facility planning and organisation. It examines various attempts to distribute primary care resources equitably. It considers medical professionals and the public approaches to geographic catchments and boundaries and how these can differ. It then assesses the implications for the architecture of primary care and local communities of services based on different organisational models of delivery.

**Part II: An Evaluation of Primary Care Architecture and Community Involvement Processes in Multi-Agency Facility Planning and Design since 1990.**

***Chapter 8*** is the first of two chapters in this part of the dissertation that attempts to identify factors that could be used to evaluate primary care buildings according to social objectives outlined by the World Health Organisation (1978).[37] This chapter considers how the *design of the product* of primary care architecture might facilitate inter-sectoral collaboration and community participation.[38] It first identifies design principles that medical and architectural literature indicate might be important in developing facilities in accordance with these social goals. Second, it reports how these principles have been translated into design features in recent primary care building projects, partly through information gathered in a series of focused interviews with architects of health buildings.

***Chapter 9*** focuses on the social value of community involvement within the planning and design *process* of facility development. It analyses attitudes and approaches to community involvement in health service decision making from the viewpoints of policy-makers and health practitioners. It examines possible obstructions to this process from medical and architectural professionals. The question of responsibility for management of the community consultation process is then examined. Based on interviews with health professionals, the results of the national postal survey, and evidence form the literature review, a set of items or variables is proposed that might indicate whether a community involvement process for planning and designing primary care buildings has fulfilled social objectives.

***Chapter 10*** summarises the evaluation of building quality based on social principles and the effectiveness of community involvement processes in four selected case studies of multi-agency primary care facilities. The case studies each have different ideological

[37] WHO (1978), op.cit.
[38] Ibid., Alma Ata declarations IV and VII.

bases, sources of initiation and geographic localities, but have attempted to promote multi-agency collaboration and involvement of the community in the planning and design process. It assesses how each of these models has achieved intended objectives from the viewpoint of policy (commissioning authority), practitioner (staff user) and participant (local community) representatives.

***Chapter 11*** concludes the dissertation with a summary of the main arguments and findings of the investigation and a reflection on the research process. It suggests some possible future directions for primary care facility development to reconcile existing divisions and inequalities.

This study is directed at a wide audience including health professionals, architects, and others working in the field of community and urban studies. It is guided by Pawson and Tilley's suggestion that the role of the researcher should be to feed back to the policy-maker knowledge gained by the study and thereby to feed into the wider cycle of enlightenment between the research and policy fields.[39] Through forming a fuller understanding of the determining influences on primary care buildings and focusing on innovatory examples, I am hoping the findings of this investigation will contribute towards future discourse on the subject of service delivery and facilities and the development of a more consensual model of primary care.

[39] Pawson, R. & Tilley, N. (1997) *Realistic Evaluation,* London: Sage. p.207. See also Chapter 1.

# Chapter 1
# RESEARCH METHODOLOGY

This chapter outlines the methodological approach used in the background and fieldwork stages of the research. Additional material relating to the research tools used to gather information for this investigation is provided in the appendices to this chapter (Appendix 1:1 – 1:11).

## 1.1 Research initiation and literature survey

This research project was initiated in 1993 by the Medical Architecture Research Unit (MARU) while it was based at the University of North London.[1] It was intended to respond to a resurgence of government interest and finance allocation to construct new primary care buildings following the NHS and Community Care Act, 1990. MARU wanted to explore the impact that devolving services from hospitals might have on the architecture of primary care and to determine which design features public users might consider contributed towards a good quality facility. The inception of this study coincided with a wider project on the theme of 'catchment and community' being conducted within the Faculty of Social and Environmental Studies at the University of North London and was intended to link with it. The Higher Education Funding Council Executive (HEFCE) granted funding for the project, and in January 1994 I was appointed to undertake the investigation as a research student.

It was apparent from the outset of the research that the wide range in types of primary care buildings emerging during the 1990s was a result of many types of influence. Behind the building forms lay different concepts of the meaning of a primary care-led NHS and different philosophies of health, as well as diversity caused by local circumstances and styles of architectural design. In order to explain this diversity, an

[1] MARU moved to South Bank University in 1995.

analytical approach was needed that could explore the relationships between politics, architecture, health and community (see Figure 0.1). I therefore adopted a cross-disciplinary approach and began to study relevant literature from many subject areas, including health policy, medical sociology, architectural history and sociology, and community and urban studies.

My previous working experience and knowledge had mainly related to community participatory politics and architectural and planning processes connected to urban regeneration. I soon realised that in order to comprehend the revolutionary restructuring taking place in the NHS, and its relevance to primary care facility development, I would have to learn the language and terminology of health politics and processes. I therefore attended lectures on the MA Health Buildings: Planning, Management and Design course run by MARU at University of North London (1994/5), and Primary Care Premises Forum seminars run by MARU at South Bank University (1995/1996).[2] At a later stage I also attended relevant lectures from the MA Health in the City course at the University of North London (1996/1997).

The first stage of the research involved a literary survey of medical architectural publications to trace the history of purpose-built primary care facility development. I examined key government White and Green Papers and health policy reports since the NHS was established, and particularly for the period 1979/1997. I then compared the ideology within these British government documents to those being issued by the World Health Organisation. At this time I made extensive and parallel use of the MARU and Kings Fund specialist libraries, and bookshops, particularly those at the Royal Institute of British Architects (RIBA) and the Architectural Association (AA), and the Stationery Office (previously HMSO). I also used university libraries (University of North London, London School of Economics and University of Westminster) for more general, political, sociological and cultural studies literature that reflected the climate of social change in which changes to primary care were taking place. The National

[2] These meetings were financed by the DoH Primary Care Support Force specifically to keep practice managers and other health professionals informed about the latest policy changes.

Primary Care Research Centre, a Department of Health funded initiative, based at the University of Manchester, and the Public Health Alliance, based in Birmingham, were other useful sources of information and publications. I also scanned the national and local press on a regular basis to gauge public reaction to primary care developments and in the last part of the research conducted literature searches via the internet. Although most of the historical background material was gathered in the first two years of the study, one of the most challenging and interesting elements of the research has been the need to regularly review and incorporate new ideas and arguments in response to the latest social and political developments. The most dramatic of these events being the change of government in May 1997, which necessitated a fundamental review of the research findings and a reconsideration of the political implications for the future direction of primary care.

### 1.2 Interviews with health policy-makers and practitioners

When I began this investigation in 1994, the precise impact of the NHS reforms on primary care facility development was still largely unknown and information available from literature sources was limited.[3] One of the most effective methods to gather information about contemporary developments in facility planning appeared to be to talk to health policy-makers and practitioners involved in interpreting and implementing central government strategies to extend primary care services and facilities. I therefore organised and conducted a series of semi-structured interviews with health professionals working in the health district of Camden & Islington (see Appendix 1:1 for an interview list and question frame). This health district was chosen, partly because of its connections with MARU and the Catchment and Community project at UNL and partly because it was inner London health authority within the London Implementation Zone (LIZ), where a particular focus on shifting resources to primary care had been taking

[3] For this reason in 1995 the DoE set up a Primary Care Support Force to provide guidance to professionals responsible for implementing the new policies.

place.[4] Interviews usually lasted one/two hours and were structured with reference to guidance that qualitative interviews should be open ended, neutral, sensitive and clear to the interviewee (Patton, 1987).[5] The interviews were structured flexibly around a set of predetermined questions and notes and tape recordings of the responses were made. Written summaries of the responses were written up afterwards for the purposes of comparison and analysis.

Information from these interviews provided valuable insights into the strengths and weaknesses of the government's strategy to shift services to primary care, which has usefully informed several chapters in the first section of the thesis, particularly Chapters 3 and 4. It has also helped to determine variables that could be used for the evaluation of community involvement strategies in the case studies (see below and Chapter 10).

### 1.3 National Postal Survey

In my initial literature survey I had sought basic data about primary care facilities in the UK, such as how many facilities had been commissioned since the 1990 NHS and Community Care Act, where and when they had been built and the size and services they offered. I discovered that although data and statistics relating to health, morbidity and mortality were available, there was a lack of statistics and data about primary care facilities at both international and national levels.[6] The Department of Health holds no national statistics about number, location or types of primary care buildings and can only supply lists of Community Health Service trusts and District Health Authorities, from whom information must be collected individually.[7] The gradual devolution of

[4] DoH (1992) *The Tomlinson Report*, London: HMSO indicated that London had particular disadvantages and should receive financial help to speed up improvements to primary care facilities. The LIZ was set up in response.
[5] Patton, M.Q. (1987) *How to use qualitative methods in evaluation*, London: Sage, pp-108-43
[6] Health and mortality data is available from the Office for National Statistics and the Organisation for the Economic Co-operation Development, which collects and publishes information on health care costs and financing. The WHO collects information of the health status of national populations, but there is no agency at an international level that collects data on other aspects of health care.
[7] The Department of Health Public Information Service confirmed the absence of national statistics and data about primary care facilities on 16.7.98 and by the National Primary Care Resource Centre at Manchester University.

management and facility ownership within the NHS to District Health Authority level and to individual NHS trusts had resulted in an inconsistent approach to data collection about health buildings. Information varied from informal operational information and practice inspection programmes available in some districts, to detailed audits or surveys available in others. Individual agencies and research units, such as MARU and the National Primary Care Resource Centre, had begun to collect archives and databases of selective case studies of primary care facilities, but these were connected to specific areas of research rather than being attempts at compiling systematic or comprehensive data. This made desktop evaluation and comparison of primary care facilities difficult and, as there appeared to be no other way to obtain the information, in 1995 I designed and conducted a national postal survey, based on guidance provided by Oppenheim (1992)[8], with two aims:

1. To identify multi-agency primary care facility developments in England and Wales commissioned since 1990 that had genuinely attempted to involve communities in the planning and design process.

2. To gather sufficient information about these projects to aid the selection of four case studies that would demonstrate a range of initiators, services, architectural forms and geographic locations.

The questionnaire and an explanatory letter was sent by post to 87 Community Health Service trusts (CHSts), during March 1995, and at the same time the questionnaire was distributed to all 202 Community Health Councils (CHCs) in England and Wales via the Association of Community Health Council of England and Wales's (ACHCEW) newsletter (see Appendix 1:2 & 1:3). These two agencies were selected because CHSts most often had responsibility for establishing multi-agency primary care centres, and CHCs had an interest in raising levels of community involvement and consultation.[9] As

[8] Oppenheim, A.N. (1992) *Questionnaire Design, Interviewing and Attitude Measurement*, London & New York: Pinter Publishers.
[9] See Chapter 3 and 9 for more discussion on the roles of the CHSTs and the CHCs.

the sample letter (Appendix 1:2) indicates, it was hoped that one of the eventual practical applications of the research would be to produce strategic guidance for community involvement processes in primary care facility development that could be used to inform CHSTs and CHCs about good practice. This outcome was postponed after MARUs departure to South Bank University, but remains a logical extension to the study.

The results of the postal survey were satisfactory with a 20% response rate (see Appendix 1:4 for a summary of analysis). The response indicated that only a minority of primary care projects had genuinely attempted to involve local communities in the planning and design process by using more than one or two consultation techniques. Where a level of genuine community involvement appeared to have taken place, the survey indicated two important ways the process could impact positively on the design of primary care centres. Firstly, through ensuring that an accessible and appropriate local facility for medical services was developed and secondly, by encouraging communities to play a more active role in improving the health of local people and the quality of life in their neighbourhoods.

A simple illustration of the case for involving public users in the design of facilities was received from the Chief Officer at South Durham CHC, who had been on an inspection tour of a new medical centre in the district.[10] He described the disappointing lack of patient information or health promotional literature on display for patients in the waiting areas. He also remarked that despite a presumably costly facility being developed, the lack of automatic doors into the surgery had made access difficult for disabled people and that the omission of a lift to the first floor meant that wheelchair users were unable to attend meetings or support groups held in the conference room, which had audio/visual facilities. The respondent observed, 'perhaps this may be an example of how involving the community might have resulted in some of these facilities being incorporated into the original design'. The link between community involvement

[10] MARU (1995) Survey of Community Involvement in Primary Care Building Planning and Design. Ref: CHC 66. Letter from Valerie Bryden, Chief Officer South West Durham Community Health Council.

processes and more appropriate buildings is one of the issues explored in the case studies (see Chapter 10).

Two examples of ambitious attempts to create inter-sectoral facilities and integrate social and medical facilities were received from the Chief Officer at Leeds CHC (see Figure 1.1) and from Sheffield CHC (Appendix 1:5). These projects showed proposals for the provision of a wide range of facilities, which included recreation, benefit advice, fitness and childcare services to be provided alongside more traditional medical facilities. They also included plans for extensive consultation with local people and organisations. They can now be identified as forerunners to the Health Park concept (see Neptune Health Park case study, Chapter 10) and to the Health Living Centres model, introduced by the Labour Government in 1997, and discussed more fully in Chapter 5.[11]

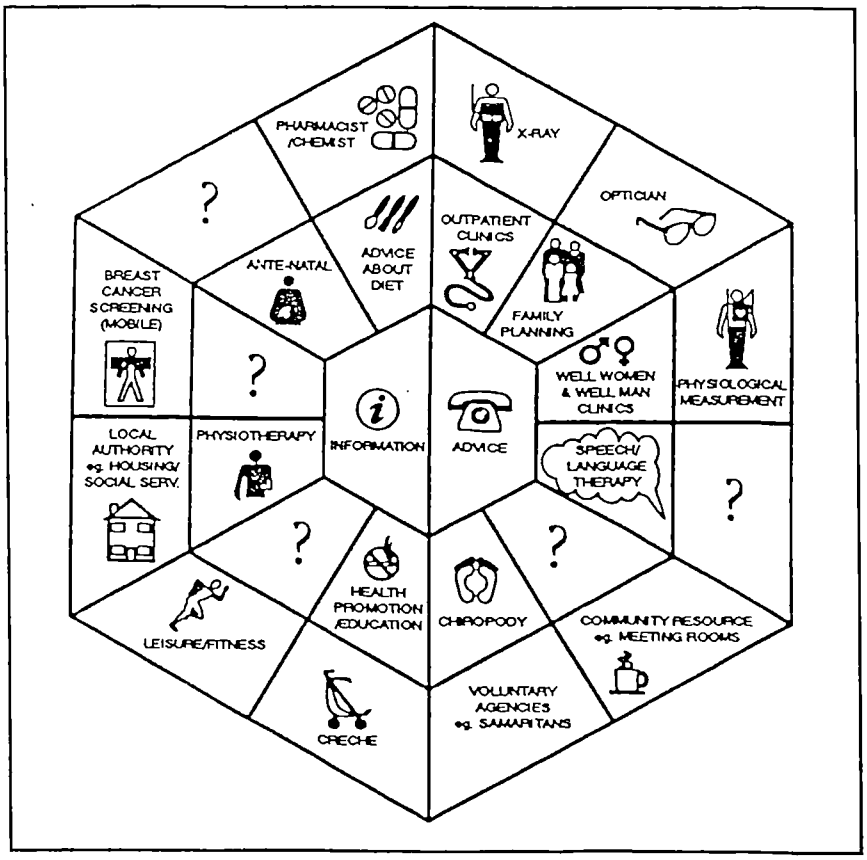



**Figure 1.1 Community Facilities Model for Leeds**

[11] DoH (1997) *Healthy Living Centres,* Letter from David Walden, Health Promotion Division, 30.12.97. London: DoH.

In the findings of this survey, the main problems encountered with community involvement processes appear to arise when the process was perceived by the public to have been tokenistic, insincere, or to have unrealistically raised community expectations about the level of influence that they could have. For example, one respondent from Manchester CHC described the community's anger at the fact that they were allowed no choice over whether or not a new facility would be built, even though a proposed new health centre meant the closure of other valued local health facilities. Experiences from community participation projects in urban regeneration schemes indicate that it is vital that commissioning agencies are honest from the outset about the extent to which the community's views can influence proposals (this issue is explored further in Chapter 9).

This postal survey was useful in providing insight into the variety and limitations of some of the primary care projects being initiated around the country and responses have been used to select variables for the evaluation of community involvement process connected with the case studies (Chapter 10). However, the information I received was limited and only represented a single viewpoint of the building and the community involvement procedure that was not necessarily shared by other stakeholders involved in the process. One of objectives for following up this survey with detailed case studies was to enable multiple perspectives of building quality and of the community involvement process to be represented in the evaluation.

### 1.4 Interviews with architects

Before commencing the case studies, I conducted a second series of focused interviews with another key professional group connected to the production of primary care facilities – the architects. One of objectives of these interviews was to assess how the shift to a primary care-led NHS had affected the briefing and commissioning process for facilities from the architects' viewpoint, in order to inform the analysis of the *mechanisms of translation* for Chapter 6.[12] The other was to discuss how design

[12] The relevance of *mechanisms of translation* is explained in the Introduction, 0.3.

philosophies might be linked to social objectives of inter-sectoral collaboration and community involvement in primary care, and to select design features that could be used as evaluation factors in the case studies.

The architectural practices selected for these interviews were chosen from London based practices that had been selected to contribute to the RIBA exhibition *Designing for Doctors,* held in 1995, This was an exhibition of contemporary surgery design organised to demonstrate the benefits of working relationships between doctors and architects.[13] The practices selected were also recommended by senior staff at MARU as having previously demonstrated high standards in the design of health building. At this time relatively few practices had experience of designing larger primary care centres, because, prior to the reorganisation of the health service, most purpose-built health centres were designed by in-house architects, employed by the NHS Estates departments. Outside NHS provision private architectural practices had tended to be used only to renovate existing health centres, or build extensions for privately owned GP premises.[14]

I interviewed architects at three practices in order to provide a range of views and to determine whether there was a consensus about design principles and features that could contribute to creating good quality primary care buildings. These architects were: Chris Shaw and Mungo Smith, Medical Architecture and Art Projects (18.2.97); Gareth Hoskins, Penoyre and Prasad (13.3.97); and Richard Barton, Avanti Architects (11.4.97). The interviews each lasted about two hours and were based on guidelines by Patton (1987) and recorded using tapes and notes.[15] The interview frame for these interviews is given in Appendix 1:6. Responses from these interviews have been used particularly to inform Chapters 6 and 8 and to determine variables for evaluating building quality in the case studies in Chapter 10.

---

[13] Monaghan, P. (1995) *Designing for Doctors*, catalogue for the RIBA exhibition, London: BMA/RIBA.
[14] The implications of this development are discussed in more detail in Chapter 6.
[15] Patton (1987), op. cit.

## 1.5 Case study methodology

The reason for including case studies in this investigation was that some of the research questions that I was seeking to answer were:

- How have political and health ideologies affected the design of primary care buildings?
- How have implementation strategies since 1990 impacted on the development of primary care facilities?
- How has the design and layout of primary care buildings facilitated the social principles on which the project is based?
- How have the community involvement processes employed during the planning and design process of primary care facilities led to an improved building and community participation?

According to Yin (1994), because these research questions focus on explanatory, *how,* questions about a contemporary phenomenon, case study methodology is particularly suitable.[16] Yin defines the case study as an empirical inquiry that 'investigates a contemporary phenomenon within real life context, especially when the boundaries between phenomenon and context are not clear.'[17] Yin's case study methodology had also been successfully applied to primary care case study investigations undertaken by the College of Health and therefore appeared to be a useful approach to adopt for this investigation.[18] The case studies are evaluated using a multi-case embedded approach in which the main unit of analysis is the *primary care facility,* and the two embedded sub-units of analysis are *building quality* and the *community involvement process.*

The aim of undertaking case studies in this investigation as stated in the introduction, was to develop a methodology for evaluating primary care building design and

[16] Yin, R.K. (1994) *Case Study Research Design and Methods*, Second Edition, London: Sage, pp 4-9.
[17] Ibid. p.13.
[18] Leonard, O., Allsop, J., Taket, A. & Wiles, R. (1997) *User Involvement in Two Primary Health Care Projects in London*, London: College of Health.

community involvement processes based on selected social objectives and from the perspective of different stakeholders. One objective was to evaluate the extent and the manner in which the design of selected buildings facilitated inter-sectoral collaboration and community involvement and whether the community involvement process used during the planning and design stages of primary care building development had been successful in contributing to a more appropriate building and community participation in the facility.

The national postal survey that I undertook in 1995 had already established that multi-agency primary care buildings planned and built since the 1990 NHS reforms were experimental and varied in both concept and content. Community involvement processes had also been inconsistent in approach and objectives. The aim of the case studies was not to seek a representative sample from which to generalise nor to develop a single blueprint for future models, it was to analyse the strengths and weaknesses of different design and community involvement process approaches in order to build up an understanding of factors that might contribute towards good practice or social responsibility in primary care facilities development.

### 1.5 Case study methodology

In selecting appropriate case studies for this evaluation exercise I sought to identify primary care projects intended for multi-agency occupation that had genuinely attempted to involve communities in the planning and design stages of development. A total population of appropriate primary care building projects was identified from the literature survey (particularly from architecture and medical periodicals), the national postal survey outlined above, and information provided by the health professionals and architects interviewed or encountered during the course of the research. Four case studies were then chosen that fulfilled the main criteria of being ideologically intended for multi-agency occupation and community involvement and also demonstrated geographical diversity, a range of initiators, services and building types. By chance the opening dates of the selected facilities occurred at intervals over the 1990s. This

provided an opportunity for identifying ideological or design progression, although there were too few examples to justify any generalisations. Another criteria for selecting the case studies was to explore innovative features that warranted investigation and evaluation for purposes of identifying good practice.

The first case study that had been purpose-built to meet the required social objectives of inter-sectoral collaboration and community participation was the **Purfleet Care Centre**, Thurrock, Essex (Chapter 10.1). This centre was opened in November 1994 and at the time was innovative in both its concept and the range of facilities it sought to provide. It was initiated by South Essex FHSA to raise the standards of primary care in a disadvantaged in a semi-rural /semi-industrial location. The original intention was to forge strong links with local community groups and voluntary organisations. A Community Access Officer (CAO) was appointed to help fulfil this task, which was a pioneering approach. This project was also selected because it was one of the first primary care centres to accommodate a minor injuries clinic among a wide range of other medical services, which was one of the mechanisms by which the government intended to scale down and devolve services from the acute sector.

The second case study selected was the **St Matthew's Community Health and Social Care Centre**, Leicester. This centre is located in a refurbished elderly peoples' home in the middle of an inner-city housing estate with an economically and socially disadvantaged local population. A Senior GP who had been working in the area initiated the project, which was supported by the local Community Health Service trust, Fosse Health. Although initiated by a GP, this project had aimed at providing a genuine partnership between many service agencies and the medical care was seen to be only a part, and not necessarily the most important part, of the services on offer. The community had been widely consulted during the facility planning process and this had resulted in several additional services being included, one of the more unusual being a community police base. Another innovative aspect of this project was the inclusion of accommodation for training doctors and other health professionals, and the employment of local residents as 'live' case studies for professionals to train in inter-agency

working. This aspect of the case study potentially had far reaching implications for changing attitudes of future health professionals towards inter-sectoral collaboration and community participation in primary care.

The third case study, **Kath Locke Community Health and Resource Centre**, Hulme, Manchester, was selected because it was a rare example of a community-led project. Although the building had originally been commissioned by the North West Regional Health Authority, it had become 'hijacked' along the way by a local voluntary agency with close links to the local community. This project was particularly important to this investigation because its objective had been to keep community control of activities and management. At the time of the site visit, no GPs were accommodated at the Centre, and only sessional and salaried GPs were planned for the future. Although the community had been consulted too late to influence the outer shell of this building they had been able to contribute to the interior design in a process facilitated by a local architectural practice that had developed specific techniques for working with public user groups.

The fourth case study, and the latest to be designed and built of this selection, was **Neptune Health Park**, Birmingham. Although professionally-led, this project was initiated by a committed partnership made up of a local voluntary agency, a local GP Practice, Sandwell Health Authority, and Sandwell Community Healthcare Trust. These agencies were all concerned to raise the quality of primary care provision in the area of Tipton, which had one of the worst health records in Britain. Considerable effort had been put into the community consultation process from the beginning and various participation groups had been organised by a specially appointed project manager with formal responsibility for the consultation process. Another reason for inclusion in this study was that it had been an architecturally designed multi-agency centre, chosen through architectural competition, which had been won by one of the architectural practices selected for interview, Penoyre and Prasad (see above). This project was therefore of interest to this investigation for three reasons. Firstly, because of the concept and spirit of collaboration across agencies in which it had been conceived,

secondly, in its commitment to and organisation of the community consultation process and thirdly, in the fusion of ideas between the commissioning team and a modernist architectural practice. Its official opening date, scheduled for June 1999, also meant that the ideology and processes adopted could be compared to the **Purfleet Care Centre,** which had opened five years earlier.

The methodology used in researching these case studies has attempted to fulfil the standard empirical research tests of construct validity and reliability. Tactics suggested by Yin to ensure rigour, are systematic and self-conscious research design, data collection, interpretation and communication.[19] The overall aim being to maintain consistency and to minimise researcher bias, influence and directiveness. In addition, following guidelines recommended by Mays and Pope (1996), I have attempted within this chapter and in associated appendices to provide a full account of the research methodology so that another researcher could follow the methods and apply them.[20] Reliability has been striven for through consistent case study protocol and the development of a case study database. I have also attempted, 'to produce a plausible and coherent explanation of the phenomenon under scrutiny' in the case study analysis (Chapter 10) and the concluding chapter.[21]

Construct validity of this research has been sought through exploring multiple sources and triangulation of evidence. The data collection was made through three main sources: project documentation analysis, focused interviews with key informants using part structured questionnaires, based on guidance from Patton (1980, 1987)[22] and Oppenheim (1992)[23], and direct observation using guidance from Judd, Smith & Kidder (1992). [24] Each case study was based on information gathered from at least three informants, using

---

[19] Yin, op. cit., p. 33.
[20] Mays, N. & Pope, C. (1996) *Qualitative Research in Health Care,* London, BMJ, p.11.
[21] Ibid.
[22] Patton (1987), op. cit. and Patton, M.Q. (1980) *Qualitative Evaluation Methods*, London: Sage.
[23] Oppenheim, A.N. (1992) Questionnaire Design, Interviewing and Attitude Measurement, London & New York: Pinter Publishers.
[24] Judd, C.M., Smith, E.R.& Kidder, L.H. (1991) *Research Methods and Social Relations,* Sixth International Edition, Florida: Holt Rhinehart and Winston, Inc.

the same framework to enable cross-case study comparisons to be made. The type of data collected from each case study in this research was descriptive, explanatory and evaluative from both a factual and an experiential or perceptive perspective. Details of the type of information sought for the main and sub-units of analysis are given in Appendix 1.7.

Focused interviews were conducted first with a main respondent from each project to obtain general background information (see Appendix 1:8). This information was checked against available documentation material and other respondents' accounts. Further interviews were then carried out with policy practitioner and participant stakeholders of the facility including a health authority or CHS trust representative, a staff use and a public user or community representative. These respondents each answered separate questionnaires about building quality and the community involvement process (Appendix 1:9, 1:10).[25]

The items used to assess building quality were selected from background research and discussions with practising architects as indicators of quality primary care buildings that would facilitate the social objectives of multi-agency occupation and an active interface with local communities (see Chapters 8 and 9 for fuller discussion of variables). The items used to evaluate community consultation process effectiveness were adapted from those recommended in the Department of the Environment's Planning Research Programme (1994) on methodologies for community involvement in planning and development processes.[26] This study was one of the most thoroughly researched and relevant studies available at the time.[27] In accordance with this methodology, ratings for questions in both surveys were graded on a simple five-point attitudinal scale of effectiveness (see Appendices 1:9, 1:10).[28] Some questions in the building quality survey, particularly those relating to inter-agency and inter-professional use, were not

[25] In some case studies the main respondent also doubled as the staff respondent.
[26] DoE (1994) *Community Involvement in Planning and Development processes,* Planning Research Programme, p.42 5.5.4, London: HMSO.
[27] DoE (1994), op. cit., p.43.
[28] Ibid., p.42, 5.5.4.

always answerable by public user respondents and the 'total score possible' was reduced accordingly for those questions. The ratings given by each respondent are shown for both surveys in the case study appendices (Appendix 10) and an overall rating is presented to allow cross-referencing on each item with other case studies.

### 1.5.3 Case study respondents

A principal intention behind the design of the case studies, in accordance with Boys's framework described in the introductory chapter, was to allow the multiple perspectives, or *positionalities,* of different stakeholders involved in the project to be made apparent and comparable within the evaluation process.[29] In this pursuit, the evaluation techniques for social programmes outlined by Pawson and Tilley (1997) have been useful.[30]

Evaluation techniques have become increasingly in focus within social research methodology. Pawson and Tilley (1997) have identified four main historical perspectives on evaluation, the *experimental*, the *pragmatic*, the *naturalistic* and the *pluralist,* all of which they perceive as having limitations.[31] Instead they have proposed using an approach for social programmes they call *realistic evaluation* and claim that the results can be used to inform developments in policy-making in order to benefit programme participants and the public. Pawson and Tilley's approach is similar to that of Boys in that they suggest that evaluation must be based on an understanding of the multiple, *contexts, mechanisms and outcomes* (CMOs) of the programme (see Figure 1.2).[32] Although Pawson and Tilley's *realistic evaluation* techniques were designed for social programmes rather than architectural case studies, application of their techniques to a social analysis of primary care buildings is easily made. In this study the wider social programme being investigated can be regarded as the primary care-led NHS.

---

[29] Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and gender', in Ainley, R. (ed.), *New Frontiers of Space Bodies and Gender,* London: Routledge, pp. 203-217.
[30] Pawson, R. & Tilley, N. (1997) *Realistic Evaluation,* London: Sage
[31] Ibid., pp. 1-30.
[32] Boys (1998), op.cit.

Primary care building projects can then be regarded either as manifestations of this wider programme, or as small scale social programmes operating at a local level. Pawson and Tilley claim that in understanding any social programme it is necessary to consider the viewpoints of three key groups of stakeholders: policy-makers, practitioners, and participants – each having a partial, but overlapping knowledge of the project (see Figure 1.2). The policy-maker having a wide social perspective but knowing little about everyday detail, the practitioner having everyday knowledge but possibly lacking the wider perspective, and the participant usually only having restricted knowledge of the project.

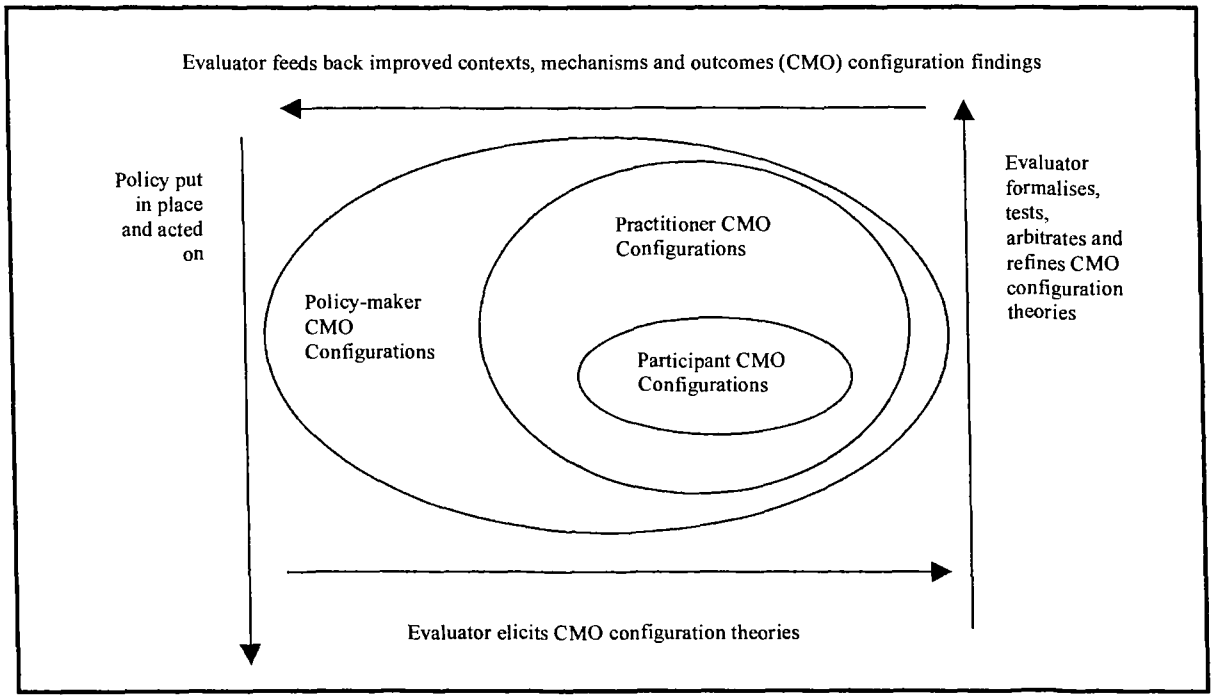



**Figure 1.2**
**The realistic evaluation and policy-making cycle adopted from Pawson and Tilley (1997)** *Realistic Evaluation,* London: Sage. p. 208.

According to Pawson and Tilley, in *realistic evaluation* the role of the researcher is to learn how the ideas of the policy-maker, practitioner and participant have constituted the programme and governed its impact. In other words, an exploration of the *positionality* of each of the key stakeholder groups is required, as Boys (1998) has also

suggested.[33] The case study methodology for this investigation, detailed in Chapter 10, has therefore been principally designed around a tripartite semi-structured interview system involving a commissioning authority (policy-maker), a staff user (practitioner) and a public user (participant) informant for each project. As is usual in qualitative studies, statistical representation was not sought, but, in selecting respondents, people in key positions to give a representative view of their stakeholder group were sought.

As it was applied in these pilot case studies, this evaluation method was only expected to provide a preliminary indication of the level and nature of consensus or dissension between stakeholder interests. However, the method was also designed to be appropriate in larger scale surveys, in which a representative number of each stakeholder group could be consulted in order to provide a statistical significant result. Any repetition of the evaluation would be unlikely to yield the same results however, because developments in time and use of the building would be likely to alter respondents' perceptions. But planned interval evaluations could be useful to see if there were any indications of improvement or deterioration in the way the facility was meeting social objectives.

### 1.5.4 Case study presentation

Information from the interviews, survey questionnaires, project documentation and direct observation for each case study was collated and organised into four main sections with sub-sections (the order of questions answered under each sub heading is given in Appendix 1:11). The sections were organised as follows:

**Section 1: Project background**

- Initiation and ideology
- Building context
- Key respondents

[33] Boys (1998), op.cit.

**Section 2: Building quality evaluation**

- Accommodation of services
- Building layout and organisation
- Design facilitation of inter-sectoral collaboration
- Design facilitation of community participation

**Section 3: Community involvement process evaluation**

- Effectiveness of community involvement process management
- Achievements of the community involvement process

**Section 4: Summary of key outcomes.**

Collation of the key informants responses was made in the main analysis (Chapter 10) in order to demonstrate consensus or dissension of stakeholders, but individual responses are held in the case study files and individual ratings to questions are given in the appendices to the case studies (Appendix 10).

### 1.5.5 Limitations of case studies and problems encountered

As I have already explained, the case studies selected had a range of completion dates from Purfleet Care Centre (November 1994) to Neptune Health Park (June 1999). The experience of undertaking these case studies has indicated that there is an optimum time for evaluating community involvement processes that is between a year and eighteen months after the building's opening date. At that point, people who had been involved in the process could usually be easily contacted and could remember events in more detail. The study of Purfleet Care Centre had proved most difficult to complete because the main community involvement process had taken place in 1992. When I started the case study in 1997 staff from the health authorities and the Community Health service trust had changed jobs and key local residents had moved. In contrast, at Neptune

Health Park, the building had not been completed at the time of the case study visit (11.97) and, although it was useful to be able to attend a user group meeting, the ultimate success of the building design could not be evaluated. Some responses to the evaluation for this study have therefore referred to anticipated results.

It has not been possible to maintain total respondent confidentiality in writing the case study reports, because it has been necessary to identify the buildings selected. Although respondents' names are withheld they may be identifiable to people connected to the project through their job titles or their role within the project. I have also included the identification and position of the respondents in the case study appendices of this dissertation, for purposes of assessment of authenticity and credibility, but would expect to withhold these in any wider publication of the research findings.

# PART I: A SOCIAL ANALYSIS OF PRIMARY CARE BUILDINGS IN BRITAIN 1979/1997

## Chapter 2

## THE ROLE OF IDEAS: 'PUBLIC CHOICE' TO 'PUBLIC HEALTH'

This chapter begins a social analysis of primary care building development, according to the framework outlined in the introduction (Figure 0.2), by tracing how particular political ideologies and models of health influenced the government to create a specific type of primary care-led health service in Britain between 1979/1997. This chapter will propose that the neo-liberal approach to health service delivery adopted by the Conservative government during the 1980s, sometimes described as the *public choice* approach, tended to support a medical model of health, rather than the more social democratically orientated strategies associated with the World Health Organisation's Primary Health Care (PHC) concept, which has become associated in Britain with the *public health* approach. [1]

This chapter will consider how these two competing ideologies, although both apparently supporting a shift to a primary care-led health service, have fundamental differences in approach that have fuelled debates and tensions connected to many of the themes of this dissertation. These include: the relationship between the state, the professions and the public; the focus on individualism versus communality; concepts of users as consumers, patients and/or citizens; and the rightful voice of the community in determining services and facilities. This chapter will also demonstrate key differences in these approaches towards the fundamental issue of health inequalities.[2] Subsequent chapters, particularly Chapters 5 and 6, will carry this analysis further by demonstrating how these competing political ideologies

[1] The NHS (Primary Care) Act 1997, which formally signaled the shift to a primary-care led system was preceded by a series of White Papers:
DoH (1996a) *Primary Care: The Future*, London: HMSO
DoH (1996b) *Primary Care the Future: Choice and Opportunity,* London: HMSO
DoH (1996c) *Primary Health Care: Delivering the Future,* (1996) London: HMSO.

[2] Although the subject of political ideology and community involvement is introduced here it is considered in more depth in Chapter 9.

and models of health can, as Boys (1998) has suggested, become *reflected in the architectural product* or physical form of the building.[3]

## 2.1 Different models of health

In Britain, different concepts of health have dominated policy and implementation of services and facilities at different times, and sometimes at the same time in different parts of the country. Over the last two centuries, social commentators have identified two main competing models of health. These are often referred to as the *medical model* and the *social model*, although sometimes described respectively as the 'bio-medical' model and the 'collective' model. The social scientist, Margaret Stacey (1977), has proposed three dimensions along which these models of health vary: individual or collective; functional fitness or welfare; preventative or curative.[4] The medical model is seen to emphasise the individualistic, functional fitness and curative dimensions, in which each person is regarded as consisting of a biochemical set of functions that can pathologically cause illness, and the human body is regarded as a machine that can be repaired through technological intervention by medical professionals. The medical model also gives considerable power to doctors and tends to regard the public as passive recipients of a basically scientific and technological process.[5] By contrast, the social model emphasises the collective, welfare and preventative approach to health. It seeks the causes of illnesses within the environmental, economic and social systems under which people live and tries to tackle the unhealthy component of those systems.

It has been claimed that increasing enthusiasm for the abilities of medical science to tackle ill health, based on the development of new drugs and vaccines, began to supersede the late Victorian focus on public health in Britain by the early decades of the twentieth century and

---

[3] Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and gender', in Ainley, R. (ed.), *New Frontiers of Space Bodies and Gender,* pp. 203-217, London: Routledge. See also Chapter 1.3.

[4] Stacey, M. (1977) *Concepts of Health and Illness*: a working paper on the concepts and their relevance for Research' Social Science Research Council, Health and Health Policy - Priorities for Research. SSRC.

ensured that the NHS was founded mainly on the medical model.[6] Aneurin Bevan, the founder of the NHS, had regarded health knowledge as residing with the medical 'experts' and this won doctors a privileged place in the new system that was denied to other professionals. It also resulted in the 'medicalising' of large areas of health policy and defining these as off-limits.[7] However, a growing social scepticism towards the power of medicine and medics operating alone to create health improvements from within academic and radical circles, if not necessarily a view shared by the general public, became hardened during the 1970s by some specific criticisms of the medical model from radical, feminist, Marxist and environmentalist perspectives.

Part of the radical critique originated from within medicine, particularly epidemiology, and from sociology. In 1976, Thomas McKeown wrote, *The Modern Rise of Population and the Role of Medicine,* in which he was able to give empirical support to critics of the medical model, by painstakingly applying his insights of medical and epidemiological knowledge to a historical analysis of Britain's death records since 1847.[8] Through this analysis, McKeown was able to show that the sharp decline in mortality and control of diseases in the nineteenth century, for example in levels of tuberculosis, occurred before the relevant medical innovations such as vaccinations and antibiotics. His explanation was that rising standards of living were mostly responsible for these health improvements, particularly improved diet, but that public health and hygiene measures, including better sanitation, had also contributed. Although McKeown was not disputing the usefulness of medical treatment to individual patients, his argument was that some of the claims of the medical profession in improving the health of the population were a distortion and exaggeration of the facts and that a more balanced approach to medical and social contributors to health was required. Some sociological criticism combined scepticism of medical power with a critique of professions and professionalism. Freidson (1970) had put forward ideas that the medical

---

[5] Pelletier, 1979:31.
[6] Fox, D. (1986) *Health Policies, Health Politics*, Princetown University Press.
[7] Klein, R. (1995) *The New Politics of the NHS,* Third Edition, London: Longman, p.20.
[8] McKeown, T. (1976) *The Modern Rise of Population and the Role of Medicine: Dream, Mirage or Nemesis?* Rock Carling Monograph, London: Nuffield Provincial Hospitals Trust.

profession had become part of society's sophisticated social control apparatus and argued that sequestering illness from the 'lifeworld' of the person and making it part of the 'monopoly' of the medical professions had led to a concept of the patient as a passive agent.[9] A similar idea was developed by Foucault (1976) who demonstrated how the body and illness had become open to conflicting and ever-changing interpretations of the medical expert, and conjured the image of the 'docile body' caught in the web of medical knowledge and power. [10] Ehrenreich (1979) again developed the argument by proposing that inequalities of power between patient and doctor had led to a racist, sexist, harmful and ineffective medical system.[11]

Another, particularly damning, criticism of the medical model came from Illich (1976) in his publication, *Limits to Medicine: Medical Nemesis.*[12] Illich argued that medicine is iatrogenetic at three levels: as a result of undesirable side effects in the course of clinical treatment; through the medicalisation of life that destroys people's capacity for self-care and self-responsibility and; in the mystification of medicine and illness by doctors that fosters the illusion of there being a miracle cure for every ill, if enough money was spent on them. One of the difficulties in appreciating Illich's analysis is his apparent disregard of some of the obvious benefits of medical treatment.

However, Bury (1998) has argued in defence of the medical model and medics, claiming that 'the ability of modern medicine effectively to prevent, treat and cure major diseases, especially since 1945, places it in an entirely different league to other perceptions' and that despite its 'limitations, serious errors and flaws' it '*is* the most fundamental and far reaching form of knowledge ever to have been produced with respect of the human body'.[13] The impact of the dominance of medical professionals in the NHS system and the way that this

---

[9] Freidson, E. (1970a) Professional Dominance: The Social Structure of Medical Care. New York: P Artherton.
[10] Foucualt, M. (1976) *The Birth of the Clinic,* London: Tavistock.
[11] Ehrenreich, J. (1978) *The Cultural Crisis of Modern Medicine*, New York: Monthly Review Press.
[12] Illich, I. (1976) *Limits to Medicine: Medical Nemesis.* 2nd edition, London: Marion Boyars.
[13] Bury, M. (1998) 'Postmodernity and Health' in Scambler, G. & Higgs, P. (Eds) *Modernity Medicine and Health: Medical Sociology Towards 2000,* London: Routledge, pp. 1-28. Bury was then Professor of Sociology at the University of London.

has determined the occupation of space within primary care buildings and their approach to public involvement in health decision-making are key issues that will be explored further within this dissertation.

By the late 1990s, some medical sociologists began to suggest that developments in postmodernist Western society had stimulated changes in social attitudes so that once again health, rather than illness, had become the focus of people's attentions, but that the pursuit of health had moved out of the private and into the public realm.[14] As Bury (1998) explained, society appears to have undergone a power transformation so that our 'docility in the face of monopolistic professional expertise' had shifted 'to an emphasis on active consumerism and lifestyle'.[15] Certainly publicly maintaining a healthy lifestyle, for example though participating in a sport, jogging in the park, and consuming healthy foods and organic produce appeared to have become a central part of everyday lives and media culture in Britain by the late 1990s. If this was to be a lasting social phenomenon, then designs for new health institutions, particularly at primary care level, might be expected to reflect and support these self-help preoccupations.

One of the key differences between the medical and social models approaches to health services and facilities is that, historically, it has only been through the perspective of the social model that the issue of health inequalities, within the UK population and across the world, has been comprehensively addressed. In 1980, an inquiry commissioned by the Labour government to investigate health inequalities in Britain in the 1970s, but presented to the Conservative government as *The Black Report,* had taken a social epidemiological approach to the issue. It concluded that at every stage of the life cycle there was a substantial class gradient in mortality and it recommended an extensive redistribution of national resources to counteract the effects of poverty, which it saw as being the major

[14] Foucault op. cit., p. 35 had claimed that until the nineteenth century medicine focused more on health than normality and deviance from normality, placing importance on the role of diet and regimen which involved the possibility of being one's own physician.
[15] Bury, M. (1998) op. cit., p.11.

contributor to ill health.[16] This recommendation was strongly rejected by the then Secretary of State, Patrick Jenkin, on the grounds that it would incur unacceptable levels of public expenditure. Jenkin also later denied another key finding of the report that the working class suffered poorer access to health services.[17]

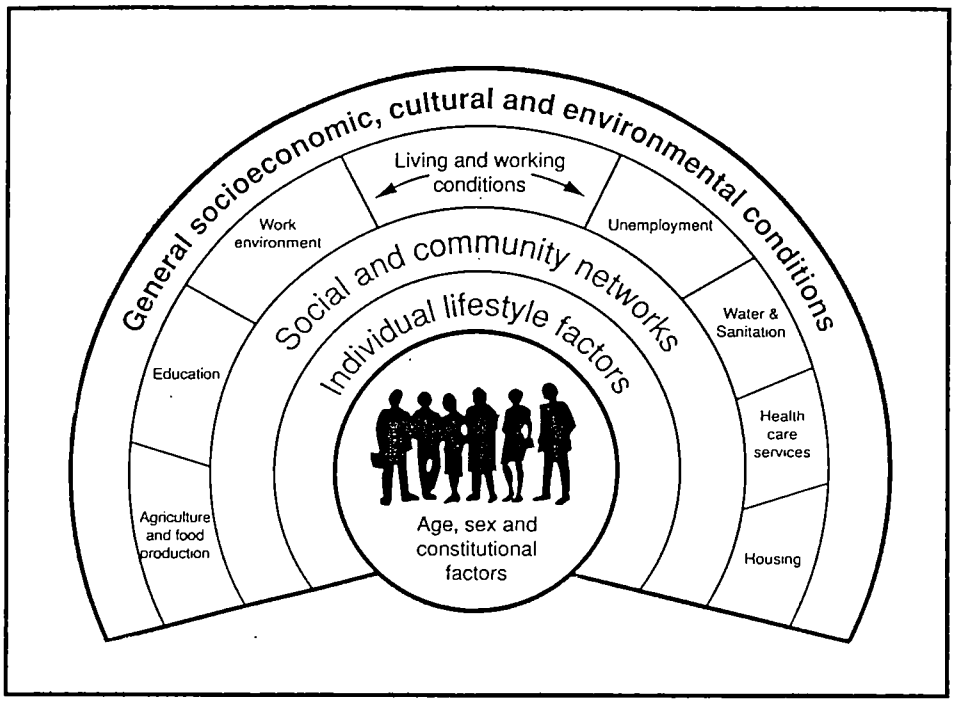



**Figure 2.1 Socioeconomic model of health adopted by Acheson (1998).**
Source: Dahlgren and Whitehead, M. (1991)

In 1986, following concerns that decentralisation of control of the NHS and other management and structural changes being proposed by the government might lead to an increase in inequalities, the Health Education Council commissioned an update of *The Black Report*, published as *The Health Divide*, which found that class inequalities in standards of health had been increasing.[18] Also during the 1980s and 1990s, some reports, discussed more fully in relation to primary care resource distribution in Chapter 3.4, focused on geographic inequalities of health between the inner cities and other regions, particularly

[16] Townsend, P & Davidson, N. (eds) (1992) 'The Black Report', *Inequalities in Health,* New Edition revised and updated, London: Penguin, pp. 331-209.
[17] Ibid. p.4.
[18] Whitehead, M. (1992) 'The Health Divide', in Townsend, & Davidson (1992), op.cit., pp.219-438.

highlighting problems of primary care resources in London, while other reports demonstrated inequalities in race, gender, and between the North and South of England. [19] The Conservative government, for reasons of political ideology, largely ignored the findings of these reports, although there were some innovative attempts to tackle them at local level. However, the issue of inequalities in health has been refocused on by the New Labour government, particularly through the commissioning of Acheson's (1998) *Independent Inquiry into Inequalities in Health.*[20] This report adopts a socio-economic model of health, recognising layers of influence, (see Figure 2.1) and proposes that all future policies, at national and local levels that are likely to have a direct or indirect effect of health should be evaluated in terms of their impact on health inequalities and be formulated so that they favour less well off people wherever possible.

## 2.2 *Public choice* and the medical model of health

During the 1980s, the Thatcher government became irrevocably converted to the idea of introducing internal market-like mechanisms and a culture of competition and individualism to the NHS. The ideas were developed by neo-liberal political theorists within the Adam Smith Institute and elsewhere as part of a wider programme for increasing efficiency and reducing public dependency on the Welfare State. Its effect was to swiftly shatter the Fabian-inspired, social democratic consensus towards the NHS that had dominated the development of health and social policy in the post-war period. It also rekindled an ideological divergence among health professionals that led to marked differences in the

---

[19] See for example:
DHSS (1981) *Primary Health Care in Inner London.* (Acheson Report), London: HMSO;
Kings Fund Commission (1992) *London Health Care 2010: Changing the future of services in the capital* London: Kings Fund;
DoH (1992) *Report of the Inquiry into London's Health Service, Medical Education and Research.* (the Tomlinson Report ), London: HMSO;
Benzeval, M. & Judge, K (1992) *The Health Status of Londoners: A comparative perspective, Working Paper No 1* Kings Fund London Acute Services Initiative, London: Kings Fund.
Benzeval, M., Judge, K, & Whitehead, M. (1995) *Tackling Inequalities in Health, an agenda for action,* London: Kings Fund.
Graham H. (1993) *When life's a drag: women, smoking and disadvantage*, London: HMSO.
Townsend, P., Phillimore, P. & Beattie A. (1988) *Inequality in the North,* London: Routledge, 1988.
[20] Acheson, D. (1998) *Independent Inquiry into Inequalities in Health*, London: SO

provision of primary care facilities around the country.

The impetus for the government to re-examine the structures of the NHS in the 1980s came mainly from the concern that there was a 'crisis of welfare', first forecast for Western Nations in 1981 by the Organisation for Economic Cooperation and Development, as a result of the rapid increase of elderly people in relation to numbers of wage earners.[21] This 'crisis' was expected to cause a gap between social expenditure and resources with serious implications for funding and over-burdening of health services. In Britain this funding crisis has been analysed in many ways, but the growing gap between the governments' budgets for the NHS and the increasing demand for acute services from the public were usually seen to be contributing factors. Funding for the acute services had been rising dramatically since the oil crisis of 1973 and there was no doubt that the economical efficiency of the NHS could be improved.

As Ranade (1994) observed, when Margaret Thatcher became Prime Minister in 1979, her negative disposition towards the welfare state and belief in private enterprise and market values made radical changes to the NHS inevitable.[22] The first significant policy departure from the centrally directed planning and management system of the NHS followed the publication of *The Griffiths Report* (1983).[23] This report was mainly aimed at health service management, of which it was highly critical. The report argued:

> *One of our most immediate observations from a business background is the lack of a clearly defined general management function throughout the NHS. By general management we mean responsibility drawn together in one person, at different levels of the organisation, for planning, implementation, and control of performance.*[24]

[21] Organisation for Economic Cooperation and Development (OECD), (1981) *The Welfare State in Crisis*, Paris: OECD.
[22] Ranade, W. (1994) *A Future for the NHS? Health Care in the 1990s*, London: Longman, pp.46-48.
[23] Griffiths, R. (1983), *NHS Management Inquiry Report*, (The Griffiths Report) London: DHSS.

The Griffiths report pushed management and management preoccupations to the core of NHS thinking and pushed aside the possibly less clearly formulated collection of ideas about services and the public good that had hitherto provided the pervading ethos within the NHS. It left the structure of the NHS unchanged, but suggested that management was ineffective at all levels.[25] This report was not targeted towards primary care, but more on devolving the management of resources from central control to acute hospitals. However, the same principle for decentralised management was subsequently applied to primary care. With hindsight Griffith's appointment was significant because it showed the Thatcher government's determination, even at that time, to model the health service and other public bodies along commercial lines. This was to lead to a fundamental change in culture, as well as structure within the NHS, and subsequently throughout the public sector.

The Secretary of State accepted the main findings of the Griffiths report and implemented changes aimed at raising standards in health care. General managers were appointed at all levels of the NHS, and senior managers were required to take responsibility for quality assurance. This was part of the move to make services more responsive to 'consumers'.[26] However, the management improvements recommended by Griffiths were insufficient to close the growing gap between government funding, the demand for services from the public, and the rising costs of running acute services. Other ideas were still being sought and began to be developed both in the UK and in the United States. In 1984, the report *Health Policy* was published by the Adam Smith Institute, which, for the Conservatives, began to fill the ideological gap.[27]

This report was one of twenty reports in the 'Omega File', a policy document produced by twenty working parties which were intended to review the extent of state intervention and explore opportunities for increasing public choice and enterprise throughout the public

[24] Ibid., p.12.
[25] Ibid.
[26] Ham (1991) pp.29-32.
[27] Adam Smith Institute (1984) *Health Policy,* Omega Report, London: Adam Smith Institute.

sector. The *Health Policy* report probably formed the most influential and comprehensive set of policy initiatives behind the Conservative government's NHS reforms. It demonstrated how capitalist politics could be injected into the NHS system and, it can be argued, there was little that appeared in Conservative health policies after this document was published that was not recommended within it.

*Public choice* was the tag given to the set of ideas outlined in *Health Policy* to bolster capitalist mechanisms by emphasising the idea that individuals could, 'maximise their own welfare given free markets and a minimum of government intervention'.[28] Although the report recognised that there would be a few 'disadvantaged people who will always need help from the rest of the community', it argued that this would be best provided through 'private markets and voluntary aid'.[29] The document argued that principles such as free services at the point of delivery, which were intended by the NHS founders to promote equality, had in reality created a situation in which the poor had become 'in competition with, and at a disadvantage to the better off' within the same system.[30] The stated aim of the 'public choice' strategy was to reduce the 'burden' of payments people need to make to support the welfare state by providing tax rebates to those who opted for private insurance.[31] It argued that:

- the welfare state was dominated by self interested groups whose advancement has been tied up to its expansion [32]
- the welfare state principle of health services being free at the point of delivery meant that they served the interests of the wealthy, who were better placed to demand them, more than the poor [33]
- free health services at the point of delivery had led to unlimited demands and this had

[28] Ibid., p.1 para 1.
[29] Ibid., p.1.
[30] Ibid., p.12.
[31] Ham, op cit., p.29, para 29.
[32] Ibid., p.5.
[33] Ibid., p.12.

inevitably led to shortages and rationing [34]

- there was no evidence that the NHS by itself has generated a great improvement in health.[35]

Although some of these criticisms of the NHS might have been shared across the political spectrum, a significant aspect of the report was its apparent contempt for the ideal of egalitarianism and its justification of 'two nation Conservatism' by claiming that the current system was failing those most in need and that there should be a return to concentrating public resources on helping the poor. The report therefore appeared to make some correlation between health and poverty, but it suggested that the alleviation of poverty could only be achieved through 'sustaining a prosperous economy, which could then afford to direct resources where they are needed'. [36] The proposed solution was to allow and encourage the better-off to buy their own health system, which would release social funds to pay for those who could not afford to pay for themselves. It is important here to note that the type of *choice* being proposed in this system was therefore only likely to be available to wealthier citizens, who could afford to 'shop around' to buy health services. The public on the lowest incomes were only to be offered a form of emergency state provision and would be unlikely to have much choice at all.

Although *choice* became a watchword of the NHS reforms, both Klein (1995) and Ham (1996) have argued that it did little to change or improve the position of service users.[37] For example, the introduction of block contracts between purchasers and providers effectively prevented money from 'following patients'– a declared aim of the strategy, so that for most patients of non-fundholding GPs the strategy resulted in less choice, because their GPs had to follow the decisions of the health authorities as to where to send paticnts, whereas before all GPs had relative freedom as to where to send patients.[38] Criticism that *public choice* was

[34] Ibid., p.9.
[35] Ibid., p.14.
[36] Ibid., p.7.
[37] See for example Ham, C. (1996) *Public Private or Community: What Next for the NHS?* London: Demos, p.19. Also, Klein (1995) op. cit., p.238.
[38] Klein (1995) op.cit.

a fictional notion also came from the Greater London Association of Community Health Councils (1989), who commented, 'the NHS Review seems to see the model patient as a person in a supermarket with time and money to spare in the health care system that wants their custom'. This report goes on to explain that the reality for many people, including older and disabled people, or those with HIV, was that they already had difficulties finding GPs prepared to take them to on their lists.[39] An increasing fear was that as budgetary constraints tightened, GP fundholders would become more discriminatory about the type of customers they wished to attract and would screen out the very old and sick

This *Health Policy* report also indicated a concern to break the power of the British Medical Association (BMA), the doctors' union, which it regarded as protecting its own interests before that of the public. It viewed the vested interest of professional groups as a major barrier to the adoption of political change. Above all, the report regarded the NHS as an expensive drain on these resources and sought alternative ways of managing the cost of the health service. It argued for a radical reorganisation of the NHS and the introduction of a market based system. To this end it suggested:

- one tier of NHS management, probably the regional health authorities, should be dissolved [40]
- contracting services out to private suppliers should be encouraged, e.g. pathology and laboratory services [41]
- there should be more GP-based care, and routine tests, such as X-rays, would best be undertaken at GP surgeries [42]
- a charging system, such as a 'medicard' (a type of credit card), should be introduced for those using health services. There would be some cost implications for those who could

[39] Greater London Association of Community Health Councils (GLACHC) (1989) *Health Service Users and the NHS Review: A Statement from Voluntary Organisations,* London: GLACHC.
[39] See for example Benezal, M. Judge, K. & Whitehead, M. (1995) *Tackling Inequalities in Health,* London: Kings Fund.
[40] Ibid., p.20.
[41] Ibid., p.20.
[42] Ibid., p.23.

afford them, but those on benefit or low incomes would be exempt. Visits to GPs could be charged on this basis, which would help to discourage trivial use [43]

- the introduction of the 'medicard' would allow universal access to private medicine if a system of recognised charges for standard treatments could be introduces. This would allow the public to top up any shortfall in state repayments themselves and this would extend public choice and reduce the strain on the NHS [44]
- cash rebates should be offered to those who have opted into private health insurance and are therefore less of a burden to the NHS [45]
- a system of universal private insurance should be reconsidered. Insurance companies would have to take on new risks unseen to avoid the problem of 'uninsurables' and the role of the government would be to underwrite the premiums of those who could not afford them.[46]

The focus of these recommendations is on increasing individual choice to medical care and reducing state dependency by moving towards the privatisation of health services and health facilities. There is also the suggestion that charges might be extended to include charges for primary care, as well as for hospital treatment.

In 1985, the political momentum for reforming the NHS moved a stage further with the publication of the paper, *Reflections on the Management of the National Health Service*, written by the American academic, Alain Enthoven, following a visit to England.[47] This paper suggested a strategy for forming a new internal market in the health service by identifying purchasers and providers within the NHS. The intention was to enable purchasers and providers to buy and sell services to each other and to the private sector. This he believed would create a more cost efficient system. His blueprint was dismissed a year later

---

[43] Ibid., p.26.
[44] Ibid., p.28.
[45] Ibid., p.29.
[46] Ibid., p.31.
[47] Enthoven, A. (1985) *Reflections on the Management of the National Health Service*, London: Nuffield Provincial Hospitals Trust.

by NHS Management as unworkable, but it had sufficiently impressed Kenneth Clark who, as health minister, was later to develop the proposals.

These ideas dominated the government's health policy thinking in the late 1980s and led to the radical reorganisation in the National Health Service between 1990/1997 that subsequently became known as the 1990 NHS reforms.[48] Through the establishment of GP fundholding and confirming the top position of GPs in the primary care hierarchy, the government's *public choice* approach led to a reinforcement of the medical model of primary care which dominated the delivery of primary health care during the 1990s (see also Chapter 3). However, this approach was seriously, if largely ineffectually, challenged by some health professionals and other sections of society during this period, who sought alternative strategies for health improvements based on a more social model.

## 2.3 *Public health* and the social model.

> *Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the country.* [49]

Running parallel to the introduction of the NHS reforms, the World Health Organisation (WHO) had been attempting to change the face of health delivery on a global scale and from a different perspective. At a conference organised by WHO and UNESCO in Alma Ata, USSR, in 1978 and attended by representatives from 134 nation states, delegates had set themselves the task of finding more cost effective and appropriate ways of improving the health of the world's population with finite resources. At this conference the global crisis in health, which was identified as the increasing failure of national systems to improve the

[48] Ham, C. (1994) *Management and Competition in the New NHS*, Oxford: Radcliffe Medical Press, p.5.
[49] World Health Organisation (1978) *Alma Ata 1978 – Primary Health Care*, Geneva: WHO, p. 34.

health of the population, was recognised as having economic causes and the key problem was considered to be inequality, both between nations and within nations.[50]

The direction adopted by the conference was a systematic and comprehensive Primary Health Care (PHC) approach to improve the world population's health by reducing inequality through reallocation and making fuller and better use of world resources. It therefore essentially adopted a political position, because it brought together issues of equity and social justice in the health system. In aiming for social equity, PHC fitted well to the Fabian socialist perspective in Britain that had influenced the founding of the NHS for a free, universal and state-provided health service, but its other principles broke away from Aneurin Bevan's rather paternalistic vision of the health service. Macdonald (1993) explained that PHC in its international context referred to 'the provision of health services that emphasise a partnership between health and other professionals and the community, as well as a system of treatment and curative care based on meeting the health needs of the majority of the population to be served'.[51] The Alma-Ata conference had insisted on the involvement of sectors such as agriculture, water and sanitation, housing, employment and education in the health improvement process. Two practical proposals aimed at reducing health inequalities and building better partnerships made at this conference, which have been adopted as key social objectives for evaluating primary care facilities in this investigation, were to increase *inter-sectoral collaboration* and *community participation* in 'planning, organisation, operation and control of primary health care.'[52]

Although the World Health Organisation's PHC system presented a radical challenge to the conventional western medical model being practised in Britain, the British government was a formal signatory of the agreement. However, in Britain and elsewhere the more revolutionary aspects of PHC soon became the focus of controversy. Macdonald (1993) described this as resulting in two versions of PHC emerging, *selective* PHC and

[50] Ibid.
[51] Macdonald, J. (1993) *Primary Health Care*, London: Earthscan, p. 9.
[52] Ibid., p.4.

*comprehensive* PHC.[53] *Selective* PHC approached the issue of health promotion by targeting selected diseases and illnesses and emphasising changes in an individual's lifestyle as the key to health improvement. This approach was regarded as a medicalisation of the original PHC message and, by some, a weaker version.

Recognition of the particular social conditions in European cities led to the WHO setting up the *Healthy Cities* project in the 1980s. This was intended to link local authorities, health agencies, the community and the private and voluntary sectors to promote a wider recognition of factors contributing to health, and create broader strategies to improve health. In the 1990s there were four designated Healthy Cities projects in the UK, officially supported by WHO.[54] The European Region of the WHO also set its own targets for health under the *Global Strategy for Health for All by the Year 2000,* which was set up to ensure implementation of the main aims of the Alma Ata conference. Despite clear differences between the PHC approach and the dominant *public choice* ideals that underlay the NHS reforms, the key PHC principles and the 38 targets of the WHO European *Health for All* strategies were independently adopted by 70 local authorities and health authorities in Britain.[55] [56]

In Britain, the only policy document that attempted to address issues of public health and contained any acknowledgement of the government's responsibility for the health of the population that went beyond the provision of a basic medical care system was the White Paper, *Health of the Nation* (1992). Klein (1995) has described this Paper as indicating a 'modulation of policy style brought about by the fall of Margaret Thatcher and John Major's succession to the premiership'.[57] The *Health of the Nation* embraced a strategy of mobilisation and urged local authorities, voluntary organisations, employers and the media to take part in a campaign for health improvements.

---

[53] Ibid., p. 72.
[54] In 1998 these were based in Camden & Islington, London and Sheffield, Liverpool, Glasgow and Belfast, but the location of these projects was under review.
[55] United Kingdom Health for All, *Network News*, Spring/Summer, 1991.
[56] WHO (1991) *Targets for Health for All*, Revised targets, Geneva: WHO Regional Office for Europe.
[57] Klein (1995), op. cit., p.210.

The *Health of the Nation* received considerable criticism particularly from the Labour Party and various left-wing organisations for failing to endorse the European targets for health and not mentioning income distribution or unemployment as contributors to ill health. [58] For example, the Radical Statistics Health Group (RSHG) argued that the main message delivered by *Health of the Nation* fell short of an acceptable national strategy for health promotion.[59] The RSHG contested that the main message in this report was for *individuals* to clean up their lifestyles and that the solution to better health lay in *individuals* taking greater responsibility for themselves and their families. They argued that this largely absolved the government of any social responsibility for improving the living conditions of sections of society, which was unacceptable, and that the *Health of the Nation* document was an attempt by the government to fit some of the concepts of PHC into the existing framework. They claimed that the *Health of the Nation* ignored three principles central to the WHO approach; the philosophy that *all* government policies should take into account their impact on the health of the population, the need to address social inequalities, and the importance of community participation.[60] They claimed that by citing only six of its 151 pages to action required outside the NHS it confused a strategy for health with a strategy for the health service. In other words this was an example of *selective* PHC, allowing a tokenistic expansion of health promotion activities, while leaving the fundamental structure of the medical model in tact.

One of the movements in Britain that actively supported and promoted the main European *Health for All by the Year 2000* (WHO) recommendations was the new public health movement.[61] The new public health movement had links back to the nineteenth century public health movement, which recognised the social, environmental and economic

---

[58] Labour Party, (1994) *Health 2000: The Health and Wealth of the Nation in the 21st Century,* London: The Labour Party, p.8, para 3.2.

[59] Radical Statistics Health Group (RSHG) (1996) 'Missing: A Strategy for the Health of the Nation', in Smith, R. (ed.) *The Health of the Nation: The BMJ View,* London: BMJ, pp.9-19.

[60] The suggestion that all government policies should address inequalities has been reiterated in the Acheson Report (1998) op., cit.

[61] In March 1999 the two wings of the new public health movement, the Association of Public Health (APH) and the Public Health Alliance (PHA), amalgamated into a single pressure group the UK Public Health Association (UKPHA).

determinants of health, but it became re-energised in the 1980s by the recommendations for Primary Health Care (PHC) developed by the World Health Organisation (WHO). Advocates of the new public health approach have not usually disclaimed the usefulness of medical science or the need for services to meet individual as well as collective needs, but have suggested that if a public health is adopted as a formal health system it could succeed in overcoming the traditional rivalry over preventative and curative approaches.[62] They tend to argue, among other things, that the formal health system in Britain should be re-orientated to give a more central role to community based services and that inequalities in health should be tackled through addressing underlying social determinants.

The *public health* approach has become a fairly dominant ideology in some areas of the country, particularly in those areas where local authorities have adopted the European *Health for All* targets, such as in Leeds, Sheffield and Birmingham. In these areas, this approach has been a major influence on radical projects for primary care facilities that are attempting to integrate medical facilities with social, leisure and advice and counselling services. The two projects from Leeds and Sheffield mentioned in Chapter 1.4 (see also Figure 1.1) and Neptune Health Park, West Midlands, one of the case studies of this research (Chapter 10.4), are examples of *Healthy Cities* inspired initiatives.

Although neither a PHC, nor *public health* approach has been officially adopted by a political party in Britain, the ideals have been associated with socialist democratic principles and appear to have obtained some support from the Labour Party during its period in opposition 1979/97 and more favourably regarded since their election to government in 1997.[63]

---

[62] See for example Taylor, P., Peckham, S., Turton, P. (1998) *A public health model of primary care – from concept to reality,* Birmingham.: PHA

[63] In 1997 the Labour government appointed Tessa Jowell as Minister of Public Health and the 1998 Green Paper, *Our Healthier Nation,* affirmed the link between health and poverty. See Chapter 11 for more discussion on this issue.

## 2.4 Political approaches to health inequalities

It is on the issue of inequalities in health that the political chasm between the approaches of *public choice* and *public health* becomes most apparent. Many would have agreed that achieving an equitable allocation of primary care resources from the 1979 situation would have been difficult. This was because despite the aims of the founders of the NHS to ensure that all necessary services were readily accessible in each area, and that care was provided on the basis of clinically defined need, rather than the ability to pay, evidence from various reports in the 1980s and 1990s into inequalities mentioned above demonstrated that this had not occurred. The geographical class divisions in Britain had ensured that residents of poor, inner city areas had rarely had access to the same quality of treatment, in the same quality of environment, as people living in more wealthy areas.

For *public choice* advocates, the principle of egalitarianism, on which the NHS was founded, was regarded as an unobtainable ideal. The Conservative governments between 1979/1997 made little pretence at seriously addressing geographic or social inequalities. For example, in November 1994, in an interview for the Guardian, Virginia Bottomley, then Secretary of State for Health, used past failures to justify continuing inequalities in the system, stating, 'I simply don't think there is evidence of a greater inequity... The history of the NHS has been one of restricted access, often on an arbitrary basis'. [64] As a consequence, under the Conservative government's NHS 'reforms' even less pressure was applied to commissioning agents to allocate primary care facilities on an equitable basis and the location and quality of new primary care facilities were mainly left for market forces and individual GP practices to determine.

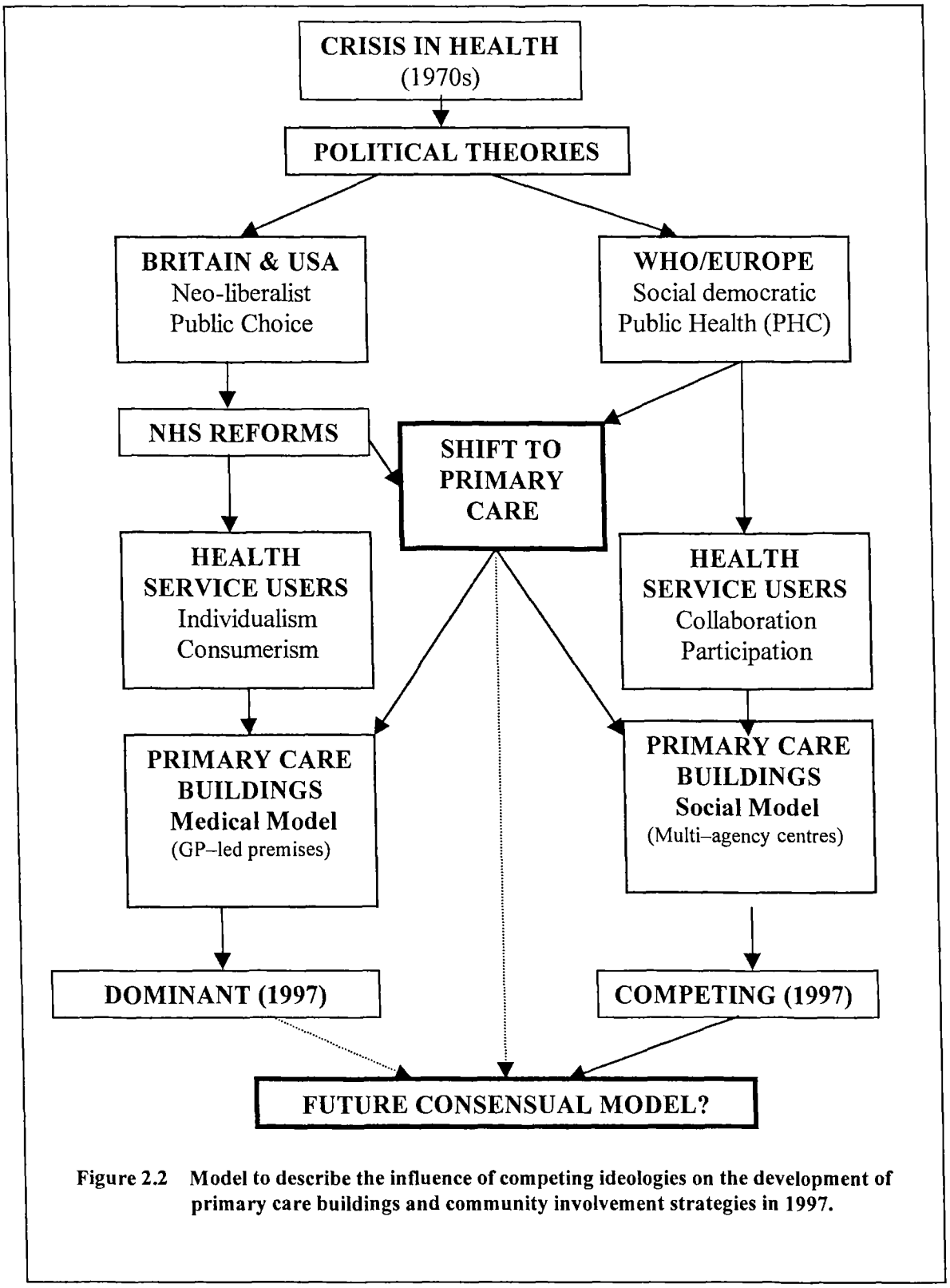



**Figure 2.2 Model to describe the influence of competing ideologies on the development of primary care buildings and community involvement strategies in 1997.**

[64] Tressider, M. (1994) *'A long drag from Golden Virginia'* the Guardian 26.11.94 p.29.

In contrast to the *public choice* perspective on health inequalities, for supporters of the new *public health* approach inequalities in income, environment, housing conditions, diet and access to good medical and community services were essential factors determining differences in the nation's health. They claimed that however difficult or idealistic achieving social equality might be it was nevertheless a political principle that should be consistently worked towards.[65] This implied that essential resources, such as primary care facilities, should be allocated in accordance to egalitarian principles. This objective was supported by the WHO report, *The Role of Health Centres in the Development of Urban Health Systems,* 1988, which described the uneven distribution of facilities and resources in urban areas as a major problem and outlined a social programme that could operate as an appropriate strategy for many disadvantaged inner-city areas of the UK. It suggested:

> *For a city to begin to tackle its health problems there must be a social contract in which the better off accept responsibility for enabling the poor to have access to essential services. A comprehensive programme of primary health care for poor urban areas would therefore include not only the provision of health services but also: creation of jobs through support for new enterprises; increased efficiency of food distribution through support for food shops and community gardens; and support for self-built housing and sanitation, as well as for public education systems and initiatives in other areas of everyday life, including energy supply and transport.*[66]

## 2.5 Conclusion

In accordance with the analytical framework outlined in Chapter 1.3, this chapter has sought to trace the dominant and main competing political ideologies that might be reflected in the form and distribution of primary care buildings. I have attempted to demonstrate how during

---

[65] See for example Macdonald (1995), op. cit, pp. 124 -140.
[66] WHO (1992) *The Role of Health Centres in the Development of Urban Health Systems,* Geneva: WHO. pp. 14-15.

the period under investigation, 1979/1997, there were in fact two sets of political ideology in Britain influencing the architectural product of primary care (see Figure 2.2 above). I argued that the main debate was over whether the neo-liberal/ *public choice,* or the social democratically inspired *public health* arguments, demonstrated the best strategies for improving the nation's health. I have attempted to demonstrate that these two approaches are based on different conceptual models of health. *Public choice* being based on an individualist, consumerist and GP-led approach to primary care, based on a *medical model* of health, whereas *public health* is based on a collective, welfare, collaborative and participative *social model* of health.

I have suggested that although superficially these ideologies both appear to support an increased role for primary care, closer examination reveals their approach to the control, management and ownership of primary care services and facilities to be significantly different. Under *public choice*, the concept of primary care is based on a medical professionally-led system, with GPs or other private financial partnerships being set up to own buildings.[67] Under *public health*, primary care is expected to establish a more social model based on equal and collaborative partnership between the various medical and social agencies, voluntary organisations and local communities and for these facilities to be mainly publicly-owned and managed.

The co-existence of these competing ideologies has important implications for creating diversity in primary care facility provision. In reality many facilities are not totally polarised but sit somewhere along the continuum between the medical and social models. However, the argument of this thesis is not that diversity, or range, in primary care facilities is necessarily bad. On the contrary, it would be difficult to argue against the concept of primary care facilities being finely tuned to meet local requirements and therefore to accept that possibility that every facility might need to be unique. The argument is that diversity within the present network of facilities is not necessarily a result of planning or responsive

[67] DoH (1997a) The New NHS: Modern, Dependable, & DoH (1998) Our Healthier Nation, London: SO.

service strategies, but has arisen through a fragmented and uncoordinated process of production that does not necessarily serve the best health interests of the local population and may increase or perpetuate existing inequalities.

The election victory in 1997 offered the Labour Party the opportunity to swing the pendulum away from the traditional, narrow medical model of health, towards a more open and collaborative model. But the signs so far are ambivalent. In forming his first government, Tony Blair appointed a Minister for Public Health, and the new policy paper *Our Healthier Nation* at least acknowledged a link between social circumstance and health that had been absent in the Conservatives *The Health of the Nation.* [68] [69] The establishment of Health Action Zones (HAZs), Health Improvement Programmes (HIPs) and Healthy Living Centres (HLCs), and the commissioning of Acheson's (1998) report into health inequalities are also encouraging signs that there may be a shift to a wider more socio-economic approach to tackling health issues.[70] However, other signals suggest there is unlikely to be a drastic swing towards a more consensual model. These include the increased power for commissioning facilities being transferred to GPs under Primary Care Groups; the continuation of publicly unaccountable Community Health Service trusts; the continuing reliance on an evaluation system based on evidence-based practice and disease specific outcomes; and the reluctance to redistribute wealth in the country through direct taxation. Some of these issues are returned to in the next chapter and later in the dissertation.

---

[68] DoH (1998) *Our Healthier Nation*, London: SO.
[69] DoH (1992) *The Health of the Nation,* London: HMSO.
[70] These concepts are outlined in DoH (1998) op cit., pp. 40 -46. Health Action Zones are intended to bring together a partnership of health organisations including primary care, with local authorities, community groups, the voluntary sector and local businesses' to tackle geographic health inequalities in the most disadvantaged areas of at least health authority size. Health Improvement Programmes are intended to use local alliances with local authorities and other agencies to set out programmes for sustained health improvements in every locality. Healthy Living Centres are discussed further in Chapter 5.5.

## Chapter 3
## IMPLEMENTING A PRIMARY CARE-LED NHS

The last chapter explored how the development of primary care facilities in the 1980s and 1990s became driven by Conservative government policies to create a primary care-led NHS based on a neo-liberal/ *public choice* approach.[1] The focus of this chapter is to examine how successful this central political strategy was in determining the subsequent pattern, distribution and type of primary care facilities at a local level and to assess the influence of policy stakeholders at the intervening level of decision-making – district health authorities and local authorities. In pursuing this objective I will seek to apply the post-structural analytical approach, suggested by Boys (1998), that the architecture of primary care since 1990 cannot be seen to simply *reflect* the dominant political health ideology, but must be seen to be partly the *outcome* of a 'dynamic, contested, complex and often contradictory process' in which stakeholder positions can have a large impact.[2] In the next chapter (Chapter 4) I will consider the influence of the second group of stakeholders, health practitioners or service providers.[3] The position of a third main group of stakeholders, public or community users or *participants*, will be discussed in Chapters 7 and 9.

In exploring the process of implementation of a neo-liberalist or public choice primary care-led strategy, and the influence of policy stakeholders at district level, this chapter will first look in more detail at the motivations of the Conservative government to increase health

---

[1] The NHS (Primary Care) Act 1997, which formally signaled the shift to a primary-care led system, was preceded by a series of White Papers:
DoH (1996a) *Primary Care: The Future*, London: HMSO;
DoH (1996b) *Primary Care the Future- Choice and Opportunity,* London: HMSO;
DoH (1996c) Primary Health Care: Delivering the Future, (1996) London: HMSO.

[2] Boys, J. (1998) *Concrete Visions: Architecture, society and the production of meaning,* unpublished PhD thesis. A similar approach to understanding the way that 'rational' policy decisions are modified by 'incremental' decision making during the implementation process has been described as 'mixed scanning' by the sociologist Etzioni. See Etzioni, A (1967) 'Mixed Scanning: a third approach to decision-making' *Public Administration Review* 27: pp.385-392.

[3] Pawson, R. & Tilley, N. (1997) *Realistic Evaluation,* London: Sage. See Chapter 1 for fuller description of Pawson and Tilley's approach to evaluating social programmes.

service provision at local and community levels and the particular form of primary care-led service that was promoted. Second, it will argue that it was partly the policy of management decentralisation after the *NHS and Community Care Act, 1990* that enabled competing ideological models at district level to effect a fragmented development of primary care facilities in some parts of Britain. Third, it will examine the consequences of the problems of providing primary care resources in the inner cities. Finally, it will consider some of the changes to the process of implementing a primary care-led service proposed by the Labour administration since 1997.

## 3.1 The need for change

Since the beginning of the NHS, there have been two main public policy-making sectors involved in implementing government health policies and facility commissioning at district level, local authorities and health authorities. This created artificial divisions between health and social services and major problems in health service delivery that have remained resilient to change. It has been a major stumbling block to increasing inter-sectoral collaboration to provide seamless care to patients, because these two sectors have different financial and management structures and cultures that make it difficult for them to co-operate in funding and occupying the buildings. Information gathered by this research indicates that although some districts have positive histories of collaborative projects, or have learnt to work together under initiatives such as *Healthy Cities* (discussed in Chapter 2), others have poor relationships that are likely to obstruct their willingness to work together. Although the New Labour government is pledged to resolve the negative aspects of this division it remains a crucial division that makes inter-sectoral collaboration unnecessarily difficult.[4]

As I have argued in Chapter 2, the apparent consensus during the 1980s to create a primary care-led NHS in fact masked fundamental political divisions about the type of system that should be established. The Conservative government's health strategies in the 1980s and

[4] The Labour Party (1998) *Labour in government: progress and plans,* London: The Labour Party p. 6.

1990s were linked to the neo-liberalist critique of the welfare state, which asserted that for economic and moral reasons the way forward was to scale down public spending and accept that the private market could and should provide some services, such as education, pensions, housing and health care.[5] It was these views that dominated the intellectual and political high ground in Britain throughout the 1980s and early 1990s.

Building on the ideas presented in the Griffiths Report (1983) and by Enthoven (1985), described in the last chapter, the first policies intended to promote a more businesslike approach to primary care were introduced by the Green Paper, *Primary Health Care: An Agenda for Discussion,* in 1986.[6] [7] This was the first comprehensive review of primary care since the origins of the NHS. The subsequent White Paper, *Promoting Better Health, 1987,* set out the government's plans for realising these recommendations.[8] Some of the government's stated objectives in these documents were to curb expenditure, to raise standards of health care, to place a greater emphasis on health promotion and disease prevention, to offer a wider range of services at the doctors surgery, and more choice and information made available to patients. Although the idea of fundholding had not yet fully crystallised in these documents, there were some specific recommendations for making improvements to GP premises. These included the introduction of financial incentives to encourage sufficient doctors in inner cities to invest in new premises and the privatisation of the General Practice Finance Corporation, which had provided government loans for GPs. The implication was to increase private capital expenditure in GP premises development.

Even at this stage there was criticism from GPs and other professional groups over the direction of these proposals for reform. Some of the specific forms of dissension included:

---

[5] See for example Ranade, W. (1994). *The Future of the NHS: Health Care in the 1990s,* Harlow: Longman, pp. 19-21.

[6] DHSS (1983) *Inquiry into NHS Management* (Griffiths Report), London: HMSO; Enthoven, A. (1985) *Reflections on the Management of the National Health Service*, London: Nuffield Provincial Hospitals Trust. See also Chapter 2.

[7] DHSS (1986), *Primary Health Care: An Agenda for Discussion*, London: HMSO.

[8] DoH (1987) *Promoting Better Health,* London: HMSO.

- the narrow definition of primary care that had been adopted [9]
- the inability of Family Practitioner Committees (FPCs) and their successors the Family Health Services Associations (FHSAs) to manage primary care [10]
- the continued fragmentation in primary care services [11]
- lack of sufficient resources to introduce the changes [12]
- problems surrounding the introduction of new contracts and incentives for primary care professionals.[13]

The Thatcher government was resolute in the face of these protestations and was determined to make changes without recourse to consultation with medical professional bodies. This only added to their unfavourable early reception.[14] The spur for the next and most decisive step in the governments reorganising the NHS system came when the impact of cumulative years of under-funding of the NHS becoming critical, particularly in the acute sector.[15] In response to these problems and the rising level of professional, political and public protests, Thatcher called for a Ministerial Review of the NHS in 1989, which led to proposals for 'a formidable programme of reform'.[16]

The 'reforms', outlined first in the White Paper *Working for Patients* (1989), were passed into legislation in the *NHS and Community Care Act, 1990* and set out the building blocks

---

[9] Marks L. (1988) *Promoting Better Health: An Analysis of the Government's Programme for Improving Health Care,* Briefing Paper No 7, London: Kings Fund.
[10] NAO (National Audit Office) (1988) *Management of Family Practitioner Services*, London: HMSO.
[11] Ibid.
[12] Audit Commission (1992) *Homeward Bound: A New Course for Community Health*, London: HMSO.
[13] General Medical Services Committee (1990) *Report to a Special Conference of Representatives of Local Medical Committees on 21st March 1990.* London: BMA. Also, Leavey, R., Wilkin, D. and Metcalf, D. (1989) 'Consumerism and General Practice' *British Medical Journal*, 298,737-9.
[14] Klein, R. (1995) *The New Politics of the NHS,* third edition, London: Longman, p.201.
[15] Surveys conducted in 1987 by the National Association of Health Authorities and in 1988 by the BMA, revealed that some authorities had begun to cancel non-urgent admissions and some health authorities were closing wards on a temporary basis and not filling staff vacancies. See for example NAHA (1987) Autumn Survey; London: NAHA; Central Committee for Hospital Medical Services (1988) *NHS Funding: The Crisis in the Acute Hospital Sector*, London: BMA.
[16] DoH (1989) *Working for Patients*, London, HMSO, p.100, para 13.1.

of a new order.[17] This Act finally introduced an internal market system into the NHS, which allowed health authorities to trade with one another, with self-governing hospitals, with NHS trusts and with the private sector.[18]

In transforming the NHS into a market economy the most important changes affecting primary care provision can be summarised as:

- the separation of purchaser and provider roles and the use of contracts or service agreements to provide links between purchasers and providers
- the creation of self-governing NHS trusts
- the gradual abolition of the Regional Health Authorities
- the transformation of district health authorities into purchasers of services
- the introduction of GP fundholding.[19]

As discussed in Chapter 2, the overall intention of the NHS reforms, in line with the recommendations in the 1984 Adam Smith Institute Omega report, *Health Policy,* was to reduce the burden of the welfare state through the gradual privatisation of the health system.[20] However, just how limited the NHS should become in offering free or subsidised services and to whom, remained an issue of debate within the Conservative Party.

The introduction of GP fundholding practices was probably the most significant and controversial change to primary care introduced by the Conservative government's reforms. It was also essential to the government's overall strategy to create a health service based on a private sector structure. Another motivating factor appeared to be that GPs' referral rate of patients to hospitals had increased, while the annual rate of GP consultations made by the

[17] Ibid

[18] The terms 'managed market', 'pseudo market', or 'quasi market' have also been used to describe this system, in order to distinguish it from a 'free market', because some controls were imposed.

[19] All these reforms are outlined in DoH (1989) *Working for Patients,* London: HMSO

[20] Adam Smith Institute (1984) *Health Policy,* Omega Report, London: Adam Smith Institute. This report is explored in detail in Chapter 2.2

public had fallen. The form of primary care service that was operating was creating an open-ended commitment of public expenditure with no way to check the number of people GPs referred to the hospital sector and no way of imposing cash limits on the amounts spent on prescribing.[21] The government became determined to gain more control over GPs' expenditure and to make them responsible for a wider range of services, including minor surgery, but in so doing they came up against the professional body guarding GPs interests, the British Medical Association (BMA).

The BMA had traditionally been a powerful force in resisting political change and they were wary that the neo-liberal policy proposals might be against their member's interest.[22] The power of the BMA had become another cause of concern to the government and they were anxious to limit its influence, but could not afford to alienate GPs. The solution, which gradually evolved during the 1980s, was the idea of GP budget holding, or fundholding as it became known.[23] GP fundholding enabled a direct funding contract to be made between the government and individual GP practices, which would be rewarded financially for their complicity in conforming to extending services and improving premises in a manner approved by central government.[24] Through the device of fundholding the government was able to remodel GP practices as a network of small businesses that could operate according to competitive market principles.

The government was anxious to speed along the process of fundholding and drove it along at a considerable pace. At first GPs purchasing powers were restricted, but the range was increased to total fundholding, enabling some GPs to purchase services wherever the best deals were on offer — including from the private sector. Their non-fundholding colleagues had no discretion and treatment for their patients was purchased on their behalf by the district health authority.

---

[21] Klein, R (1995) *The New Politics of the NHS*, third edition. London: Longman, p.164.
[22] Ham, C. (1992) *Health Policy in Britain*, third edition, Basingstoke: Macmillan, p.55.
[23] The idea of GP budget holding was introduced in DoH (1989) *Working for Patients*, London: HMSO, p. 48
[24] Ibid., p.50.

Despite being enthusiastically promoted, extended and expanded by the Conservative government during the 1990s, fundholding continued to be a controversial policy. The findings of the Institute of Public Policy Research (IPPR) report, *New Agenda for Health 1996,* confirmed that many GPs were half-hearted about fundholding and found it confused the roles of family doctor as carer and resource manager.[25] Some said that the financial incentives to encourage GPs to reclaim work from hospitals were not large enough to justify the effort, with the possible exception of minor surgery. Ranade (1994) listed five actual and potential problems with GP fundholding:

1. Increasing numbers of fundholders will lose DHAs a corresponding share of the budget, which will make it difficult to balance the needs of emergency versus elective care.
2. An increased number of semi-independent stakeholders makes planning more difficult and undermines the DHA's ability to meet Health of the Nation and Patient Charter targets and the local authority's responsibility for community care services.
3. The gains made by the first wave of freeholders may not be repeatable by all. In particular inner-city poorer practices may be further disadvantaged.
4. Fragmenting contracting by individual practices is wasteful of time and money. There is little point in developing fundholding consortia to overcome this problem when health authorities exist to do this job already and have the necessary administrative support.
5. Inequities are likely given the problems of 'cream skimming and the imprecision of allocating budgets down to practice populations.[26]

The general public's objections to the changes in health service delivery tended to focus on whether sufficient finances were available to create a transition that would be ultimately of public benefit, and whether primary care facilities could be updated and built quickly enough

[25] Institute of Public Policy Research (IPPR), (1996) *New Agenda for Health*, London: IPPR

to keep pace with hospital closures.[27] This was therefore an argument more about the manner and order in which changes were to occur than on the principle of creating a primary care-led NHS based on market structures. Also, the popular argument that fundholding created a two-tiered service was largely discredited by the Audit Commission Report, 1996.[28]

After 1990, the Conservative government maintained their commitment to strengthening and extending primary *medical* care through expanding fundholding. During November and December 1996, three White Papers were produced that were intended to consolidate the importance of primary care in the health service and to address some of the practical difficulties in the implementation of a primary care-led system that had been experienced.[29] They began to admit that there was an unfair distribution of resources across the country and a need to address the problems of premises development through more flexible arrangements. However, they confined their solutions to small adjustments in funding and resource allocation, rather than seeking any fundamental change to the system they had imposed.[30] These practical adjustments were passed into legislation through the NHS (Primary Care Bill), 1997, just before the Conservatives lost the General Election on May 1st.

Through devolving services from hospitals to primary care settings during the 1990s, the Conservative government had created the need for new and expanded primary care premises throughout the country. In the first instance they had tried to give the responsibility for the development of new premises and services to GPs, preferably as fundholders, but if not as non-fundholding, semi-independent subcontractors of the NHS, through such mechanisms

---

[26] Ranade, op. cit., p.160.
[27] Various examples of successful public protests to hospital closures were reported in an article by Wendy Moore,' Power of the People', *Guardian, Society,* 12.4.1995, pp.6-7.
[28] Audit Commission (1996) *What the doctor ordered,* London: HMSO
[29] DoH (1996a) *Primary Care: The Future*, London: HMSO;
DoH (1996b) *Primary Care the Future- Choice and Opportunity,* London: HMSO;
DoH (1996c) *Primary Health Care: Delivering the Future,* London: HMSO.
[30] DoH (1996c) op. cit., pp. 33-47.

as the Cost Rent scheme.[31] However, in some areas, particularly deprived inner city areas, where there was a deficit of GPs prepared to make an investment in premises, the government had to rely on the health authority, usually with the co-operation of the newly formed Community Health Service trusts, to take responsibility for premises development.[32] This perpetuated a dual system of primary care facility ownership, divided between premises privately owned by GPs, and those publicly owned. The historical background to this system will be explained in more detail in Chapter 5.

### 3.2 The decentralisation process.

The NHS reforms followed a programme of managerial decentralisation ostensibly to make services more locally responsive. However, decentralisation strategies do not necessarily lead to an increase in democratic decision-making, or public accountability. As Wart (1994) has pointed out, 'contrary to what is envisaged, decentralisation can actually deepen the domination of central policy'.[33] Wart suggested that it was the extent of control at sub-national level that in the end influence how far local agencies and communities could affect implementation and policy making, for example, to raise and control resources, to mobilise political support, or to attract and retain competent officials and the legal framework of rules and regulations within which local bodies work.[34] The result of the particular strategy of decentralisation of the NHS reforms on primary care facility development appears to have led to an increase in autonomy of decision-making, through the introduction of the small business model of fundholding premises and the semi independent Community Health Service trust (CHSt) facilities, and a lack of public accountability within these agencies.

As outlined above, the Conservative government was pursuing a particular agenda in its

---

[31] DoH (1996) *Primary Care: Delivering the Future*, London HMSO p.45, 6.14. See also Chapter 6, 6.1.1 for explanation of Cost Rent.
[32] See case studies in Chapter 10 for examples.
[33] Wart, G. (1994) *Health Policy an Introduction to Process and Power*, Johannesberg Witwatersrand University Press & London & New Jersey Zed Books, p.92,
[34] Ibid.

plans for creating a primary care-led health service that included neither widespread social reform, nor the redistribution of power between professional groups and the public. Instead it sought more government control over expenditure on health care and to change GPs' allegiance, from members of a professional group responsible for patients' clinical care, to that of managers of small businesses with a self-interest in maximising profits through compliance with government directives. In this the government was at least partially successful because, as Klein (1995) has observed, GPs' protestations over the reforms and objections to fundholding diminished as the financial rewards began to become apparent. In 1992 GP fundholders on average earned over £6000 extra.[35]

How then did this strategy lead to the extraordinary levels of diversification in types of primary care facilities commissioned and built during the 1990s? Why were not *all* new primary care facilities based on the model of fundholders' extending their premises to accommodate medical services devolved from hospitals? How did any models of primary care facilities based on new 'public health' or a social model of health come to be developed? The answer appears to lie at least partly with effects of the decentralised management structure of the NHS and the reduction of strategic planning. This resulted in the devolution of power from regional to district level and reduced the influence of the intervening authorities and delegating power directly to NHS hospital and CHS trusts and GP fundholders.[36]

In 1990, the government passed legislation to phase out the regional tier of management in the NHS, the Regional Health Authorities (RHAs).[37] Before RHAs were finally disbanded in 1993 and replaced by eight National Health Service Management Executive (NHSME) outposts. Their remaining strategic tasks were to carry out the government's reforms of the NHS. They therefore had to play a balancing role caught between enforcing central

[35] Holdsworth, Sir T. (1992) *Review Body on Doctors' and Dentists' Remuneration Twenty- Second Report, 1992*, London: HMSO.
[36] DoH (1989) *Working for Patients*, p.12
[37] Ibid, p.13.

directives and allowing local autonomy.[38] Responsibility for purchasing primary and secondary care services at district and local levels during the 1990s gradually came to rest with district health commissioning authorities (created through the merger of the former DHAs and Family Health Services Authorities), the CHS trusts, and GP fundholders.

The government was reluctant for the district health commissioning authorities to take the lead in establishing primary care facilities and this was only permitted if it could be demonstrated that no private finance was available. If the new DHAs were compelled to intervene to make essential primary care provision, it was only allowed to own facilities for a limited time period and then had to hand them over to GP purchasers or CHS trusts.[39] Findings from the national postal survey and interviews with health professionals conducted for this research suggest that, as a result of this policy, multi-agency centres were almost always established in deprived urban areas, where the severity of the social and health problems had encouraged health authorities and other agencies to side-step the self-interested approach of many GPs and take a broader social outlook on health improvements.

The new DHAs are accountable only to central government and not to regional authorities or local communities, which reduces their democratic accountability (see Figure 3.1), although in determining which services to purchase, they are expected to work closely with GPs, local authorities and other agencies. The post 1997 Labour government is expected to reform the health authorities' role still further, but proposals have not yet been finalised.

In the context of WHO directives, decentralisation was defined as handing down financial and managerial responsibility for health services from national and regional levels to district level. The aim was to make people accountable for what they are responsible for and to allow local people to have a greater influence on services.[40] But it has been pointed out that

---

[38] Ranade, op..cit.
[39] NHS Executive, NHS Estates. (1994/5), *London Initiative Zone Primary Care Premises Handbooks 2,* London: Crown, p 12, 3.20
[40] WHO (1978) *Alma Ata 1978: Primary Health Care,* Geneva : WHO, p.52.

there are dangers in this approach for Britain, because without appropriate safeguards, decentralisation strategies can undermine the role our particular NHS system has played in ensuring some fairness in the national distribution of resources.

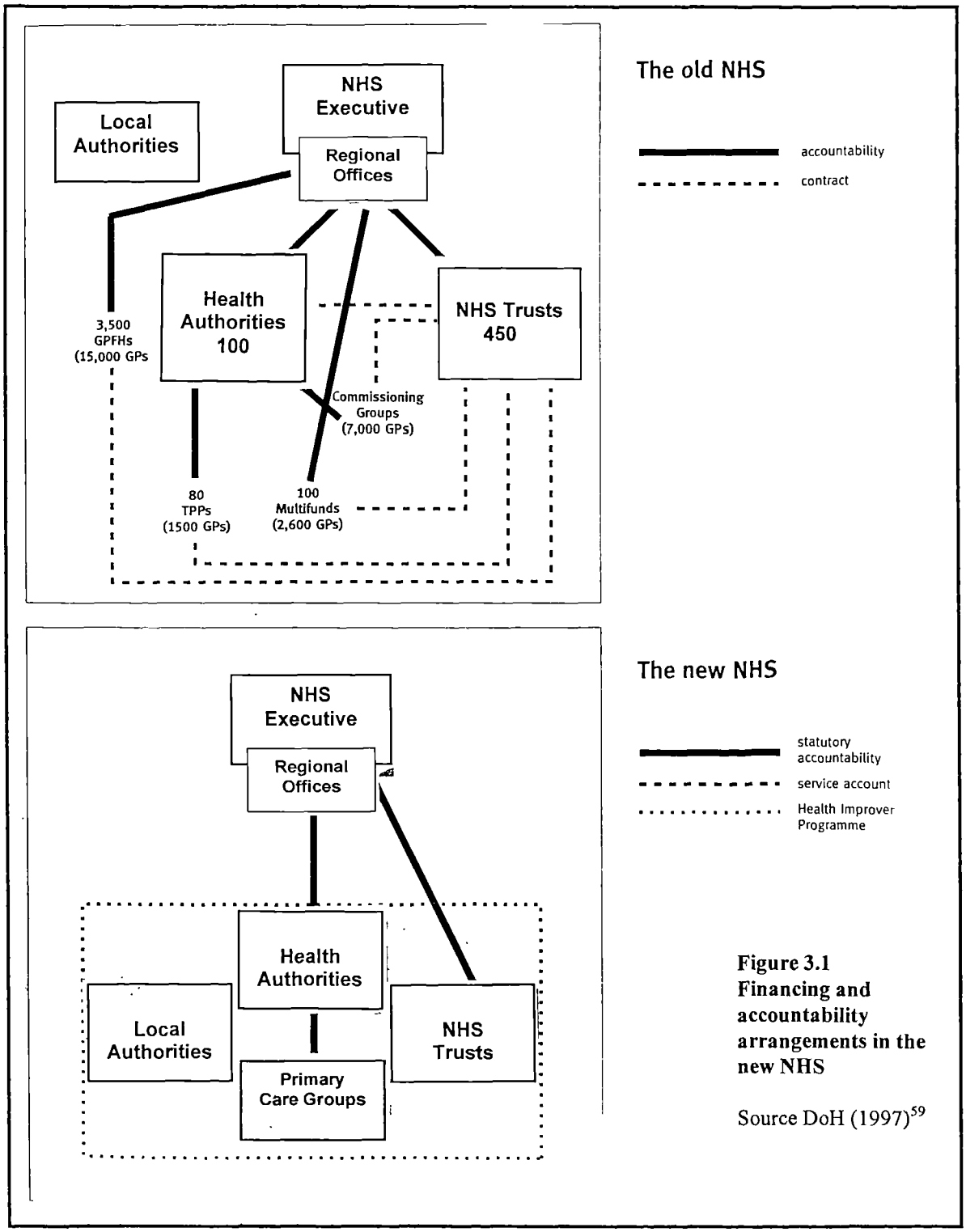



**Figure 3.1 Financing and accountability arrangements in the new NHS**

Source DoH (1997)[59]

In a lecture at the London School of Economics on 27th June 1996, the Black American Professor of Sociology, Julius Wilson, claimed that the centralised welfare state and health service in Britain had played an important role in preventing the type of ghettoising of neighbourhoods that had arisen in the USA. He described some American districts where wealthier citizens were able to secure for themselves access to privileged local facilities, which citizens in poorer areas could not afford. Wilson recommended a comprehensive welfare programme that was centrally controlled but, significantly, he argued against the interpretation that this meant that everyone should be treated the same. Instead he proposed that people should be treated differently according to circumstances within a comprehensive programme.[41] This idea is returned to in discussions about the best forms of facility distribution and service organisation in Chapter 7 and connects with the collective/individual argument discussed further in Chapters 7 & 9.

Some social commentators have suggested that the best way to ensure greater public accountability in the health service is to hand responsibility back to the local authorities. Until changes were made to the structure of the NHS in 1974, democratically elected local authorities were the direct employers and managers of many primary health services, including district nurses, health visitors and community midwives. The first major reduction of local authority power came when these services were removed from direct local authority control in 1974, but they were further eroded after the 1990 NHS reforms led to the exclusion of local authority members from the reshaped NHS trusts (see Figure 3.1). Although these changes were not effectively challenged at the time, arguments have since been made for local government to have a greater voice in local health issues.[42]

A Local Government Information Unit (LGIU,1997) discussion paper identified three concerns with NHS structures.[43] These were: the lack of public accountability within the

[41] Reported in article by Phillips, M. (1996) 'Duty is in the eye of the stakeholder', *Observer Review* 30.6.96. p. 5.
[42] Warner, N. (1994) 'Care Shared' *The Guardian,* Society, 2.11.94, p.8.
[43] Daly, G. & Davis, H. (1997) *Local Health Services: a suitable case for treatment.* Local Government Information Unit discussion paper March 1997. London. LGIU.p.1

health service; whether there should be public accountability at local as well as national level; and who should make the purchasing decisions or 'tough choices'? The paper made a strong argument as to why merely tinkering with the present arrangements was inadequate and suggested that either local authority responsibility for local health services, or directly elected health authorities was a preferable alternative, although it recognised some pitfalls and disadvantages with these proposals. Among the advantages of local authority responsibility, this paper argued that they were not only a democratically elected body, but they were also in the position to take a wider view in promoting health gain and could prioritise housing, education, child care or public transport rather than health services in order to achieve health gain.

However, as Ham (1996) has pointed out, if responsibility for commissioning health services was handed over to the democratically elected local authorities, or if separate elected health authorities were established, the need for raising the capacity for increasing resources through taxation at local level is created and, until this move is made, the responsibility is likely to remain in the hands of appointed trustees.[44] Another key point often raised is that if local authorities were to take responsibility, health budgets would need to be ring-fenced, so that money intended for health purchasing was not diverted for purposes other than health gain. It is also debated whether local authorities themselves operate on a sufficiently democratic level to ensure sufficient public representation.[45]

The difficult distinction between health and social care, particularly in respect to patient's early discharge from hospital, has continued to create confusion and dispute between health authorities and local government. This critically impacts on the implementation of primary care services and is one of the strongest arguments for establishing multi-agency centres and improving inter-sectoral collaboration. In February 1995, the Conservative government began an attempt to end the confusion through the publication of the document, *NHS*

[44] Ham, C. (1996) *Public Private or Community: What next for the NHS ?* London: Demos, p.27.
[45] Burns, D., Hambleton, P. & Hoggett, P. (1994) *The Politics of Decentralisation: Revitalising Local Democracy,* London: Macmillan

*Responsibilities for Meeting Continuing Health Care Needs.*[46] Since then, the importance of closer collaboration between hospitals, GPs and social services has led to various local initiatives producing comprehensive 'continuing care' policies and guidelines, There have also been a few examples of social services teams operating from within multi-agency primary care centres. In some areas social workers also operate from GP group practices as part of the Primary Health Care Team. But, whether or not local government increases its direct responsibility for primary care medical services in the future, it will continue to have an important influence on health areas such as safe affordable housing and environmental factors for which it has remained responsible.

### 3.3 Resources in the inner cities

The fact that there were particular problems of primary care resource allocation and distribution in London and other inner cities areas was first highlighted in the *Acheson Report,* 1981.[47] This report highlighted the central importance of developing primary care premises capable of accommodating a comprehensive GP service and to provide a range of non-GP resources within local settings. As well as improvements to GP premises it recommended the development of group practices, the amalgamation of single-handed practices, more salaried GP services, better co-ordination of agencies, improved conditions for community nurses and improved accessibility of primary care services to disadvantaged groups.

This report was followed over a decade later by *London Health Care 2010: Changing the future of services in the capital* (1992)[48] and *The Tomlinson Report* (1992)[49], which focused on the health care services provided in London, but also raised issues relevant to other

[46] DoH (1995) *NHS Responsibilities for Meeting Continuing Health Care Needs.* London: HMSO
[47] DHSS (1981) *Primary Health Care in Inner London.* (Acheson Report), London: HMSO
[48] Kings Fund Commission (1992) *London Health Care 2010: Changing the future of services in the capital* London: Kings Fund.
[49] DoH (1992) *Report of the Inquiry into London's Health Service, Medical Education and Research.* (The Tomlinson Report ), London: HMSO.

British cities. The Tomlinson Report argued that the population of London presented a range of need, unparalleled in the rest of England. It explained that the volume and density of London was higher than the rest of England, with more overcrowding and more extremes of wealth and poverty. It showed London had a higher mortality rate from AIDS and accidents and more incidents of abuse and mental illness. Compounding these difficulties, the report claimed that 46% of GP premises in the four inner London FHSA's were below minimum standards compared to an England average of 7%. It argued that the lack of availability of good quality premises in London was contributing to many GP's being unable to take on extra partners or support staff. Lack of space was also preventing health promotion, screening and minor surgery being provided and undergraduate teaching via training and practice research was made virtually impossible.[50]

The Tomlinson report recommended extra funding of 130m to upgrade GP premises, and £10m to build four new health care centres on the model of the West Lambeth Community Care Centre.[51] The report also recommended London-wide availability of expert assistance on planning, design and acquisition of premises and suggested that FHSAs should take a more pro-active role in leasing premises to GPs to meet strategic health objectives and to benefit from the reallocation of capital resources, such as sales of hospital estate. The report highlighted the difficulties and delays experienced by GPs in obtaining planning permission and recommended the introduction of premises facilitators, but this last recommendation was never implemented.[52]

One of the governments' responses to Tomlinson was the establishment of the London Implementation Zone and the administrative London Implementation Group introduced by the report *Making London Better* (1993). This gave a clear remit for premises development:

[50] Ibid., pp. 9-10.
[51] Ibid., also see Chapter 5.
[52] Ibid., pp. 9-10.

> *First we must get the basics right. Within the LIZ area we will invest in new and improved premises where they are needed. Doctors and nurses need well equipped buildings which enable them to work together to offer a wider range of services. Patients want convenient access to them. We want to see schemes which adapt premises for primary use where appropriate, and which introduce primary care facilities into shops, sports centres, schools and offices. There will be investment in the construction of primary care centres, where an expanded range of services, perhaps for patients of several practices, might be provided.*[53]

The LIG was given £175 million over a six year period to develop premises, services, education and research. These plans included proposals for the expansion or upgrading of health centres, clinics and other forms of health facilities. Part of the remit of LIZ was to speed up the procurement process of primary care facilities, but it came under criticism from some GPs 'who saw its role as being to oversee the closure of flagship hospitals rather than building up primary care'.[54] LIG was superseded in 1995 by the Primary Health Care Forum, which continued to focus on the needs of primary care within the LIZ boundaries. A significant admission in the 1996 White Paper *Primary Care: Delivering the Future* was that 'no single model of premises is likely to meet future needs in primary care.' and the acknowledgement that 'There is a significant support for some larger developments such as 'resource centres' providing a range of health and social care...'.[55]

### 3.5 Alternatives to fundholding

As I have tried to demonstrate above, and will discuss further in the next chapter, the form of primary care delivery chosen by the government, which was based mainly on fundholding, had enormous implications for the ownership, type and location of primary care facilities that were developed. This section looks briefly at some of the alternatives to fundholding

[53] DoH (1993) *Making London Better* London: HMSO.
[54] Gould, M. 'More Power ahead for London GPs' *Pulse* 24.9.94.
[55] DoH (1996c) op. cit., pp.44-5, para 6.12.

that were proposed during this period and that might influence future facilities development.

*Locality Commissioning*

The Labour Party first promoted locality commissioning as an alternative method to fundholding when it was in opposition.[56] It was proposed as a system of joint commissioning in which all family doctors would be brought together with their local health authority to become involved in decision-making on the planning and purchase of health care for patients in a given area. Since 1997, the Labour government's policy has been to prevent more GPs joining the fundholding scheme and persuade them to switch to GP commissioning teams. The plan to evolve away from fundholding can be interpreted as a move away from a self-interested *public choice* model, towards system that seeks to operate more in the public interest.

By the end of 1997 some experiments with joint commissioning, such as multi-funds (the closest operating model to locality commissioning), had already been started. [57] Some of these had already shown benefits in administration costs over fundholding, and management allowances enabled multi-funds to employ managers to negotiate contracts for hospital services according to the GPs decisions.[58] Public involvement on these early forms of locality commissioning committees was rare and even the CHCs were often not invited. As one commentator suggested, 'although locality commissioning is another product of decentralisation of health services, it is not a simple solution to complex problems'.[59]

*Primary Care Groups*

In the White Paper *The New NHS: Modern Dependable* published in December 1997, the

[56] Labour Party (1994) *Health 2000* London: Labour Party, p. 20.
[57] One example was reported in Kingston and Richmond, where 170 family doctors committed to the principle of equal access for all patients to health services had grouped together to deliver primary and secondary care to their patients and identify their social service needs. Dinsdale P. (1998) 'Pilot lights new way forward' The Guardian 4.2.98, G2 Society: p. 7.
[58] Ibid.

Labour government proposed establishing Primary Care Groups (PCGs) in all parts of the country to commission services for local patients and giving GPs and community nursing staff a leading role.[60] The stated intention was that PCGs should have control over resources, but they would have to account to health authorities as to how they would use them to improve efficiency and quality. Primary Care Groups are intended to grow out of the existing range of commissioning models and to represent, on average 100,000 people. Among their functions they are supposed to develop primary care through joint working across practices and to create better integration of primary and community health services and social services on planning and delivery.

The form of PCGs is intended to be flexible and reflect local circumstances. Initially PCGs are expected to take responsibility for commissioning and delivery of health services at any of four option levels, which start from supporting the health authority and advancing to becoming free standing bodies accountable to the health authority.[61] (see Figure 3.2). At this last stage the PCGs will become eligible for becoming a new sort of trust – a Primary Care Group trust, which the government has still to legislate for. These PCG trusts will not only be responsible for commissioning primary care, but also for providing much of it, which, to an extent will supplant the role of existing Community Health Service trusts

[59] Hudson, B. (1995) 'A little local difficulty', *Health Service Journal,* 1.6.95.
[60] DoH (1997a) *The New NHS, Modern. Dependable.* London: SO, pp. 32-35.
[61] Although ministers initially said PCGs could start at any stage, they subsequently restricted them to the first two stages in 1999-2000. See Brindle, D. (1999) 'Up for Grabs', *The Guardian,* Society, 31.3.99, pp. 2-3.

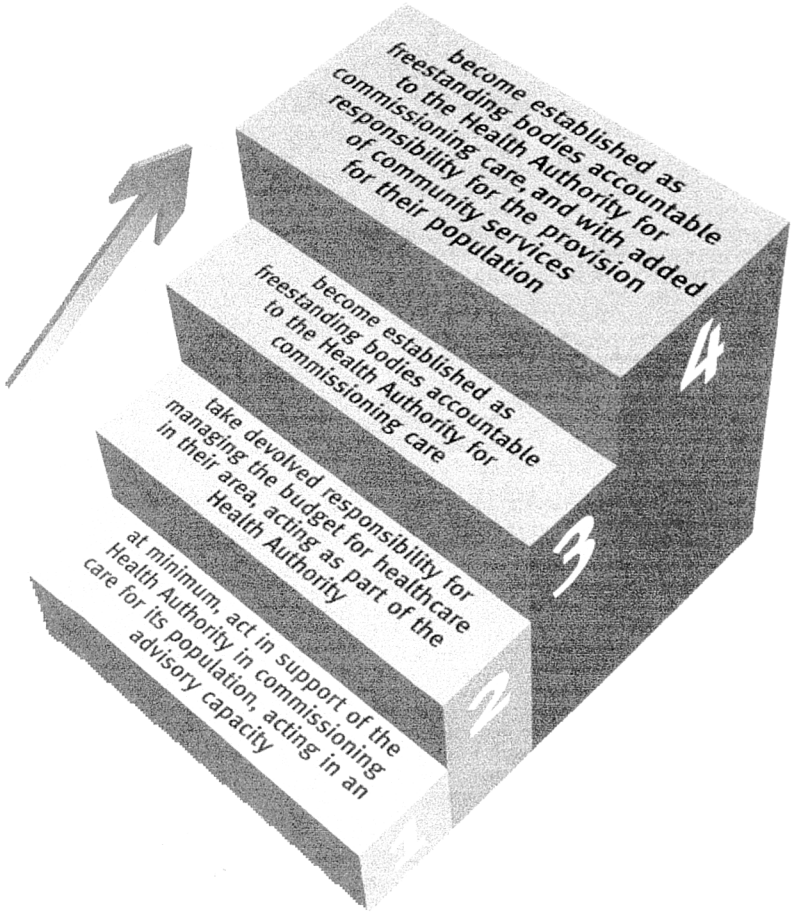



**Figure 3.2 Model to show the four levels of Primary Care Groups.** Source: DoH (1997a)[60]

On the issue of public accountability, all that the 1997 White Paper stated was that one of the core responsibilities for PCGs was to 'have clear arrangements for public involvement including open meetings'.[62] This was a disappointingly weak proposal for those seeking a system that would forge closer partnership between medical agencies and community and voluntary sectors. Despite stating that accountability agreements were to be established between PCGs and health authorities, no formal level of accountability or representation of community or voluntary sector interests, other than one lay member on the boards of the lower stages of PCGs, was demanded. The majority of seats were allocated to GPs.

Although little audible dissension greeted the arrival of this White Paper, concerns were subsequently raised about the universal willingness and appropriateness of GPs to take on

[62] DoH (1997b) *Healthy Living Centres,* Letter from David Walden, Health Promotion Division, 30.12.97. London: DoH p. 36.

this commissioning role. An article by David Brindle (1998) in *The Guardian* cited a survey which showed that 50% of 500 doctor readers of *Medeconomics* magazine (self selected) had rated the White Paper's recommendations 'poor' or 'disastrous', and one in 10 threatened to refuse to join a Primary Care Group, even though this was not an optional scheme.[63] One GP was reported as saying ' I don't know how we are going to get 100 GPs to agree how they spend money'.

Brindle (1998) reported some of the identified problems with PCGs as being: difficulties over the target population, e.g., how will these relate to perceived communities and existing health catchment areas); how doctors will play their part in PCGs without cutting time they spend with patients, inadequate management costs (£3 for each patient) and how the White Paper would integrate with the 1998 Green Paper (Our Healthier Nation) to reduce health inequalities. Brindle quoted Stephen Thornton, Chief Executive of the NHS Confederation, which represents health authorities and trusts, as being concerned that the sequential publishing of the White and Green Papers had been the wrong way round. Thornton reportedly claimed, 'if you are saying that health inequality is your number one priority then you have to acknowledge that general practice leading primary care, and primary care leading the rest of the system is not the best way to go about that... I have never met a GP whose approach, in terms of methodology and working arrangements, was based on community empowerment. They have a role to play in health improvements, but not a leadership role'.[64]

However, by March 1999 widespread concerns about the lack of accountability and inter-sectoral partnership seemed to have influenced the government. Brindle reported that the Labour government had 'risked the wrath of GPs by not extending their control of arrangements for primary care trusts.'[65] He reported that the DoH had announced that power in PCG trusts was to rest with an executive board of 11 members, with six appointed

[63] Brindle, D (1998) *Depth Charge.* The Guardian Society March 11th 1998: p. 19.
[64] Ibid
[65] Brindle, D. (1999) 'Up for Grabs', *The Guardian* , Society pp. 2-3.

by the Secretary of State. The board would comprise of a 'significant representation from general practice balanced with local nurses and other community and public health professionals'. It is too early to predict the impact of this latest shift. For example, it might mean that GPs will effectively block the development of PCGs into trusts, but it could also herald a more balanced era of control of primary care.

## 3.5 **Conclusion**

This chapter has set out to demonstrate how the contested process of implementing primary care policies helped to shape the pattern and distribution of primary care buildings during the 1990s and prevented a straightforward reflection of the Conservative government's health ideologies in the new network of facilities. The Conservatives policies towards primary care had gradually evolved during the 1980s and 1990s, but they had been modified to accommodate political and professional resistance, circumstances and new knowledge encountered during the implementation process. A national network of privately owned fundholding practices with some supporting primary care resource centres may have been the government's ideal, but a fragmented system of primary care was the result. The consequent diversity of facilities was not so much a reflection of local circumstances and need, but a reflection of the political chasm at the heart of primary care philosophy producing a system that lacked sufficient structures to ensure comparable standards of quality, or national or local accountability. Both the new authorities and the trusts created by the reforms were management, rather than representative, bodies. Primary Care Groups could also strengthen the hand of central government, because they will eventually effectively remove or diminish another tier of management from the system – the district health authority. As has been pointed out, intervening tiers of management between central government and local populations have in the past exercised significant influence over the implementation process by filtering and interpreting policies (Ham 1992). [66]

---

[66] Ham, C. (1992) *Health Policy in Britain The Politics and Organisation of the Health Service,* Third edition. London: Macmillan. p.168.

Had the Conservative government successfully managed to establish a comprehensive network of GP fundholding practices and Community Health Service and hospital trusts, this together with the dissolution of the district and regional tiers of health management could have effectively dismantled the public sector model of the NHS and replaced it with a private sector model. This did not happen. The ideal of a universal fundholding system was thwarted by its inability to make headway in the inner cities and other deprived areas, which made it necessary to establish publicly owned primary care facilities to fill the gaps.

The great disappointment for many has been that the concept of a primary care-led service offered a huge potential for providing community based facilities that could offer a wide range of support mechanisms for improving health and lessening inequalities, but that with some localised exceptions, these opportunities were missed. What seems apparent is that either solely centrally planned or locally orientated systems have drawbacks and deficiencies, and that what is needed is a system that can plan strategically at different levels to address the needs of the individual, the community, special needs groups and the nation.

The form of primary care strategy adopted by the Conservative government ultimately failed to develop a more effective system of inter-sectoral co-operation, or to create a better balance of power between and within medical teams. It also failed to harness the potential energies and enthusiasms of local communities and individuals to initiate and run their own activities for health improvements. This position has yet to be effectively reversed. The May 1997 election saw the electorate swing from supporting neo-liberal policies to more central ground policies and the extremes of a market-based primary care system appear to have been avoided at least until the next election, but by the end of 1998 there were few signs of an alternative to a GP-dominated, professionally-led service being developed in the short term.[67]

---

[67] The internal market was formally abolished in April 1999, although some argue that it will be replaced by different form of market through the PCG structure (Brindle, 1999, op.cit).

However, not all responsibility for the failure of primary care to fulfil the social aims of inter-sectoral collaboration and community involvement can be attributed to government policy and implementation processes. Some responsibility must lie with the entrenched positions, attitudes and structures within the various professional bodies involved in health delivery. The *positionality* of practitioner stakeholders and how this can impose on the spatial organisation of the architecture and manner of use of primary care facilities, particularly impacting on multi-agency occupation and the interface with local communities, is the subject of the next chapter.

# Chapter 4
# PRACTITIONER STAKEHOLDERS IN PRIMARY CARE FACILITY DEVELOPMENT 1990/1997

So far I have been arguing that the architectural product of primary care is inevitably an imperfect reflection of dominant political ideology because policy implementation is a complex, contested and interactive process that inhibits a fully predictable outcome. The last two chapters have focused on the influence of *policy* stakeholders at central and district levels. This chapter will continue to explore Boys's proposition that in order to reach a fuller understanding of the final architectural product it is necessary to understand the influence and *positionality* of all key stakeholders in the development by considering the position of *practitioner* stakeholders in primary care buildings or, to use NHS terminology – service providers.[1] The influence of private investors and developers with only a financial rather than a professional stake in primary care development will be discussed in Chapter 6 and the position of the local community or public users, who in this study represent the *participant* stakeholders, is discussed in Chapter 7 and 9.

## 4.1 The influence of practitioners

Practitioners or service providers can have a particularly powerful influence on the way that space within the building is allocated and used either through their ownership status, or in the manner of their occupation of the building. A fundamental difficulty in the practice and accommodation of primary care services has been that there is not a single set of practitioners, or service providers, but three, or sometimes four, largely separate

[1] Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and gender', in Ainley, R. (ed.), *New Frontiers of Space Bodies and Gender,* pp. 203-217, London: Routledge.

components of professionals. Services managed by the more independent sub-contracting medical practitioners of the NHS – General Practitioners (GPs), dentists, pharmacists and opticians are one set. A second set are employees of Community Health Services. A third set, who might find themselves based in primary care facilities, are those professionals responsible for social care – social workers and other health care workers employed by local authorities. A fourth set of potential practitioner stakeholders, gradually becoming integrated into primary care facilities, are voluntary and community organisations, which often offer health related counselling, advice and support services.

The semi-independent NHS sub-contracting practitioners have the option either to operate from private premises that they own or rent with the support of public money for NHS services, providing the accommodation reaches certain standards, or to lease space in shared facilities such as multi-agency centres. This immediately places those more autonomous professionals in a hierarchy with certain powers over salaried employees and with important differences of manner of employment, financial responsibility and accountability. The degree of influence held by different stakeholders, either as individual staff members or agencies, to determine the site or design of the building is therefore unequal. It will partially depend on their position in the professional hierarchy, the proportion of their financial stake in the property and on the degree of opposition encountered from other stakeholders.

Hillier and Hanson (1984) proposed in their thesis, *The Social Logic of Space,* that 'the ordering of space in buildings is in reality about the ordering of relations between people'. They argued that this usually entailed the highest status individuals either occupying the deepest space and/or controlling the circulation system and access to that space.[2] It also placed inhabitants (staff users) in a position to exercise power and control over 'visitors' (public users) through the organisation of space into discrete categories (for example, waiting rooms, consulting rooms, treatment rooms etc) and the pattern of distribution of those spaces. Boys (1998) has suggested that buildings are products of negotiation, so that, 'each building is the physical resolution of struggles over resources and meanings by all the

[2] Hillier, B. & Hanson, J. (1984) *The Social Logic of Space,* Cambridge University Press, p.2, pp.191-197.

agents in the processes of making and using.'[3]

In most instances, new primary care developments are conceived as an upgrade or extension of previous facilities, or to fill a gap in provision. The design is therefore usually based on conventional models that do not challenge established professional hierarchies or professional and community relationships. However, occasionally one person, or group of people, develops a concept of a primary care facility that requires a new order of collaboration between professionals and with the public. The difficulty facing such champion/s of a radically new type of facility is then to get all the other key stakeholders to share in this vision and help bring it to realisation. When resonance for a new vision between service agents does occur, this can also precipitate a re-examination of conventional architectural responses and result in a new and sometimes exceptional facility being developed.

Finsbury Health Centre, Islington, London, described in Chapter 5, is a historical example of synchronicity in vision between medical, architectural and social (local authority) players being achieved.[4] And, although it is too early to judge, Neptune Health Park in Sandwell, West Midlands (one of the case studies of this research) may prove to be a contemporary example of a similar resonance between architects and health professionals occurring.[5] As Hill (1998) reminds us, whether these buildings continue to play a role as an instrument of social change over time then becomes partially dependent the ethos of the project being maintained or developed through the manner of occupancy of the building.[6]

## 4.2 General Practitioners (GPs)

As I argued in the last chapter, a main objective of the Conservative governments' primary

---

[3] Boys, J. (1998) *Concrete Visions: Architecture, society and the production of meaning,* Unpublished PhD thesis, Chapter One: Introduction

[4] See Chapter 5.2

[5] See Chapter 10.4

[6] Hill, J. (1998) *Occupying Architecture: between the architect and the user.* London: Routledge.

care strategy 1979/1997 was to create a national network of GP fundholding practices throughout the country and the establishment of fundholding introduced by *Working with Patients* (1989) was one of the most significant and controversial changes to primary care introduced by the reforms.[7] [8] Through introducing fundholding one of the government's intentions was to encourage GPs to do more for themselves and to reduce demand on hospital services. However, by shifting the focus away from hospital consultants, GPs gained higher status and control within the NHS system. Also, in order to promote the fundholding system, the government gave GPs incentives to purchase, manage and develop their own premises. This placed participating GPs in an extremely powerful position to determine the location, shape and size of new primary care facilities. Through ownership and management of premises GPs strengthened their status over other health professionals, especially those employed in Primary Health Care Teams.

Fundholding was intended to be voluntary, but unsubstantiated reports claimed that health-commissioning authorities had encouraged fundholding by suggesting that assistance to develop new premises might be eased.[9] One of the approved ways that savings from fundholding budgets could be spent was to improve premises, either through structural improvements, or through improvements to furniture and fittings.[10] This raised ethical concerns that GPs could make a personal profit through their stake in the building, bought with the investment of public money, at the expense of improving patient services. [11] A principle that urgently needed safeguarding was that services should be improved before expenditure on premises became justified.

The encouragement of fundholding resulted in initiatives for new or improved premises becoming reliant on the ambitions and personal circumstances of individual practices and

---

[7] DoH (1996) *Primary Care: Delivering the Future*, London: HMSO p.45, 6.14.

[8] DoH (1989) *Working for Patients* London: HMSO

[9] Carlowe, J. (1994) 'FHSA pressure tactics over GP fundholding' *Pulse* 8.10.94, vol. 54, No.39, p.1.

[10] DoH (1993) *National Health Service Fundholding Practices Regulations*, London: HMSO, para 24.

[11] DoH (1992) The Tomlinson Report , *Report of the Inquiry into London's Health Service, Medical Education and Research,* London: HMSO, p. 10, para 33.

issues such as the potential for site development of existing premises, rather than being based on the actual needs of local communities. Consequently, some fundholding practices went a long way towards developing 'state of the art' mini-hospital type facilities, while others remained in totally inadequate premises. In terms of strategic planning fundholding was a disaster, because fundholding practices did not become evenly established throughout the country. However, it was estimated that by mid 1996 over 50% of the population were patients of a fundholding GP.

Although district health authorities were in a strategic position to ensure equitable resource allocation within the district boundaries, they could neither force GPs to buy property, nor to practice in a particular location. Away from the inner cities fundholding was more quickly established, whereas in the inner cities it was frequently resisted.[12] Some reasons for this were that GP premises in inner cities were often of poorer quality and had been badly maintained, so they required considerable financial investment to reach the required standards for GP fundholding. [13] In addition, sites in inner cities were harder to find and because the relocation of a practice had to be immediately adjacent to its catchment population, usually restricted to only a few hundred metres, this can limit choice of sites to a few streets.[14] As GPs tended to want to buy premises where property prices were most likely to rise, district health authorities were then forced to provide alternatives to GP owned and managed facilities, such as multi-agency centres, in deprived or disadvantaged areas that could not attract GPs and private investment. Another problem in the original rules governing fundholding, which was recognised in the 1996 White Paper *Primary Care: Delivering the Future,* was that fundholding may perversely have provided an incentive for some GPs to develop existing premises, when what was really required was a new building, or a move to a new site. The 1996 White Paper promised new proposals to increase flexibility for fundholders to purchase land and new buildings. It also included measures to

[12] Brindle, D (1995) 'Disillusioned GPs quit fundholding', *The Guardian,* 7.4.95.

[13] Lamb, D. (1994) *Primary Health Care Premises - Report of the Inner City GP Premises Project* Kensington & Chelsea & Westminster Health Commissioning Agency & Lambeth, Southwark and Lewisham Health Commission, p. 51.

[14] Ibid.

ensure that such developments would be linked closely to service need, as well as reflecting the circumstances of practitioners. In the event these proposals became superseded by the incoming Labour government's decision to end fundholding in April 1999.

However, despite the efforts of the Conservative government to encourage fundholding, until 1997, some of the worst primary health care premises were, and remain, occupied by single or two doctor practices. Many of these were in the inner cities and were too small to consider fundholding as an option and appear to have remained largely untouched by the NHS reforms. During 1992-1994, David Lamb, studied GP practices in the health commissioning authorities of Kensington and Chelsea, Lambeth, Southwark and Lewisham, with the aim of identifying and elucidating constraints to developing GP premises in inner cities.[15] Lamb concluded that those factors that most inhibited development included:

- GPs preference to working alone, or in partnership with a colleague or spouse
- young GPs finding it difficult to invest capital in the early stages of their career
- older GPs reluctant to invest capital in premises improvements
- the need to maintain mobility or reduce commitment due to family or career plans
- difficulties in finding alternative sites
- premises which had been improved in the past, but which had since deteriorated

Lamb pointed out that GPs had developed different values and cultures, which can be fundamental in determining attitudes to change. He identified three main orientations among GPs, which could equally apply to fundholding and non-fundholding GPs:

i) **'individual patient-focus',** which operates by reacting to patient demand and can appear introspective and isolated. It usually indicates a relatively weak conception of primary care provision as an organisational matter and focuses instead on the relationship between doctor and patient. This position often diminishes GPs

[15] Ibid.

recognition of the physical aspects of the practice premises;

ii) **'income focus',** in which maximising income is the primary concern. Various strategies are employed by GPs to achieve this. It may take the form of GPs maximising opportunities for private practice. It might be to enlarge premises to maximise development or it might be to operate a low-cost and low innovation practice with a minimum spent on premises;

iii) **'practice focus',** where the practices tend to be concerned with operational management, considerations of staff satisfaction, and interest in considering new forms of organisation and service delivery.[16]

This report largely attributed responsibility for premises development to GPs, but appears to have ignored the fact that in contrast to the funds made available to fundholding practices, few financial incentives were offered to small practices. It was therefore hard for small non-fundholding practices to make even minor improvements, such as making premises more hygienic with appropriate toilet facilities, or more comfortable for public users by providing better access or waiting facilities. The financial incentives on offer from the government were almost exclusively aimed at encouraging GPs out of single or double practices and into larger joint facilities. Where this was neither practical, nor possible, premises continued to be sub-standard and consequently, where there was little choice in an area, the public had to put up with woefully inadequate facilities.

A defence of smaller practices has been put forward by Green and Thorogood (1998), who argued against regarding single handed GPs simply as an anachronism.[17] They had found in a study using a random sample of 25 GP practices carried out in 1993 that there were some clear advantages for doctors and patients in single-handed practices such as continuity and

---

[16] Ibid., pp.39-40

[17] Green, J. and Thorogood, N. (1998) *Analysing Health Policy,* Harlow: Addison Wesley Longman. p. 98-99.

personal knowledge. They argued that support of small practices, rather than abolition, should be the aim of policy-makers. The concept of resource centres that could provide the patients of smaller GP practices with a fuller range of medical services was one of new forms of primary care facilities developed since the reforms that could be used to assist smaller practices.

### 4.3 Community Health Service trusts

The establishment of a network of NHS trusts formed another part of the Conservative government's strategy to introduce a market economy to the NHS. The White Paper, *Working for Patients* (1989) separated the roles of purchasing and providing services and this required the establishment of the new service providing bodies, NHS hospital trusts and Community Health Service trusts (CHSts).[18] The hospital trusts had responsibility for providing acute service or secondary care in hospital settings and the CHSts had responsibility for providing community and home services at primary care level, such as through district nurses and midwives. CHSts have the power to commission and own primary care buildings and together with GPs who own premises hold considerable sway over where and what type of primary care facilities get built and to an extent they can decide either to co-operate or not with district level policy-makers.

The establishment of trusts was rapid, 57 trusts were created in April 1991, but by April 1994 90% of NHS capacity was under the control of these semi-independent bodies who owned buildings and could set local pay and conditions. Trusts have to provide annual business plans outlining their proposals for service delivery and capital investment. Also, when taking the initiative to set up new facilities, such as health centres or medical care centres, CHSts usually have to come to an arrangement with a local GP practice and tensions can develop over who has overall management and control.

CHSts are not accountable to any intermediate control, but report directly to the DoH. The Conservative government tried to ensure that trusts were allowed space to make decisions

[18] DoH (1989) *Working for Patients,* London: HMSO.

on how services would be developed within the constraints of the contracts under which they operated. This freedom unleashed initiatives of enterprise, energy and efficiency in developing primary care services and facilities in some areas, and may in some instances have improved responsiveness to service users, but contentious issues about public accountability remained. CHSts have been gradually employing fewer people from local communities and are only requested to hold one public meeting a year. CHS trust boards also contain a high proportion of government appointed non-executive members, which assures adherence to central policies. In 1994 Margaret Beckett, then Shadow Health Secretary, claimed that in the NHS trusts 'only a tiny percentage of these representatives of Conservative interests have medical expertise or expertise in health service, but are there to protect Conservative Party politics'.[19] However, since their election in 1997, the Labour Party appears to have done little to make trust boards more representative, although it has claimed that it intends to.[20]

## 4.4 Primary Health Care Teams

One of driving forces behind the rise of larger health centres, and the demise of the single practitioner since the inception of the NHS, has been the encouragement of GP group practices and the establishment and extension of Primary Health Care Teams. This had a profound on the architecture of primary care as buildings, which had to expand to accommodate the growing number of professionals and support staff provided either by independent practitioners such as doctors or dentists, Community Health Service trusts or local authorities. The precise make up of Primary Health Care Teams varies from one facility to another and one way to determine what activities might be taking place in a primary care facility can be to look at the staff working in the building. Larger, more conventional primary medical care centres usually have the following core staff:

- General Practitioners (GPs)

[19] Beckett, M (1994) 'Health Service Trusts 'packed with Tories', *The Guardian*, 26.10.94, p. 4.
[20] DoH (1997) p.53, 6.39

- Practice nurses
- Community and district nurses
- Community physicians
- Administrative staff and managers

Other professional staff who might use the building in a permanent or visiting capacity are:

- Midwives
- Chiropodists
- Dentists
- Specialist consultants
- Physiotherapists
- Occupational therapists
- Opticians
- Social workers[21]
- X-ray lab technicians
- Counsellors

The establishment of health centres was intended to facilitate the activities of the Primary Health Care Team (PHCT) as the basic unit of community care, but the likelihood of the harmonious functioning of this team was always in question because of the divisions created by ownership and independence between staff, as discussed above. Views about the best method to implement primary care policies were not always shared across these groups and this has resulted in disputes and conflicts, which has created barriers to inter-agency working.[22]

[21] Usually employees of local authorities.

[22] See for example; Cumberlege, J. (1986) *Neighbourhood Nursing – A Focus for Care,* A Report of the Community Nursing Review, London: HMSO. This report suggested that community health should be run using neighbourhood rather than GP practice boundaries.

Apart from financial and organisational complications, one of the greatest sources of conflict has been the lack of coterminous catchment boundaries between community nursing staff and GPs. Until the mid 1960s, community nurses covered a set geographical area or patch and looked after people in that area irrespective of which GPs their patients attended. There was often little contact with the GPs and not much co-ordination of work. Experiments began with attachment schemes whereby nurses looked after patients on a GP list, but this never became a comprehensive system.[23] In 1986, the Cumberlege report made a renewed call for an end to the increasing use of practice nurses and for a strengthened neighbourhood nursing system to be established in every health district.[24] (This issue is discussed in more detail in Chapter 7)

Since 1997, there have been moves by the Labour government to elevate the role of nurses through creating nurse practitioner posts, but this will not shift and could even entrench the traditional professional/patient relationship by creating another tier of high status medical professionals within primary care. In my local health centre (Caversham Group Practice, Kentish Town, London) nurses now occupy similar separate consulting rooms to doctors, rather than a sharing a treatment room. This arrangement could operate against the ethos of collaborative working by isolating nurses from other members of the PHCT, unless managerial strategies, such as regular team meetings, were introduced to ensure this did not happen.

The 1990 new contract for GPs lifted the restrictions on the range of staff that could be employed directly by a GP.[25] This included a variety of health care professionals and administrative staff and managerial staff. The number of practice nurses, employed by GPs, has risen steadily over the last 15 years.[26] Some nursing and other services within PHCTs

---

[23] National Association of Health Authorities (NAHA), (1980) *NHS Handbook,* Birmingham: NAHA, Section 3.7:12

[24] Cumberlege, op. cit.

[25] DoH (1990) *Statement of Fees and Allowances for General Medical Practitioners in England and Wales,* ('Red Book'), London: HMSO.

[26] DoH (1996) *Primary Care the Future,* London: HMSO.

are now employed and managed by GPs, which is helping to reinforce GP dominance.

### 4.4 Voluntary and community organisations

Another set of potential practitioner stakeholders in primary care buildings, listed in the London Implementation Zone (LIZ) handbooks, are voluntary sector or community organisations.[27] Voluntary and community organisations are between them responsible for a wide range of advice and information services, counselling, support and self-help groups. Within the medical model of primary care provision, the valuable role played by health-related voluntary and community organisations in shoring up deficiencies in the health service, has often been given insufficient recognition or support. These organisations frequently operate from scattered and under-resourced premises and they can be keen to be re-accommodated in new community based primary care facilities if the opportunity arises. In some instances substandard accommodation has even provided a motive for voluntary organisations themselves to initiate or take an active role in the development of new primary care facilities, where they can share accommodation with other medical and social agencies (see Kath Locke case study Chapter 10.3).

Voluntary and community organisations are by definition in a good position to gauge local concerns and needs. They are also often in touch with people in marginalised sections of society, who possibly for religious or cultural reasons, are less likely to seek help from traditional medical centres. They can therefore play an important part in primary care community involvement processes to ensure that these people are included and that services and accommodation are appropriate to meet their needs. Some new primary care multi-agency primary care developments have recognised the value of these organisations in creating important links with the community and have provided them with accommodation at low rent, or the organisations themselves have received funding from local authorities or other sources to enable them to participate. One of the difficulties this sector might have in

[27] NHS Estates (1994/5) London Implementation Zone Handbooks, Bk.1, p.18: 4.5.

becoming included in multi-agency facilities is the precarious, short term nature of their funding arrangements and the potential risk this poses to a business plan. It may also inhibit them from securing appropriate allocation of accommodation.

### 4.5 The promise of inter-sectoral collaboration

The joint occupation of a primary care building by health and other agencies seeking the common objective of improving the well being of the local population should be an ideal opportunity for a fusion of medical and architectural social responsibility, but in reality collaboration between sectors and even within agencies has proved difficult to achieve. A publication issued by the Health Education Authority (1995) has argued that for healthy alliances to be effective, it is important that they are strategically based upon an agreement of principles, objectives and processes. In other words, professional rivalries have to be set aside and an altruistic common agenda agreed.[28] Professional cultural divisions and funding differences are recognised as being barriers to change by both political parties. Primary and community services are funded from several different sources. For example GPs are funded through the GMS budget and have a national contract of services with the DoH, while community health services are funded through the Community Health Services trusts (CHSts) and are a totally employed service. Funding for multi-agency capital projects can therefore be split between capital resources provided by CHSts and allocated to community units and revenue resources provided by General Medical Services. Local authority employees are paid on different pay scales and pay structures to the health authority, but they may be able to support building projects through funding sources, such as urban regeneration budgets.

Taylor, Peckham and Turton (1998) made the important point that models of delivery can also create barriers for collaboration and that the 'consequence of the small business model and the competitive element' introduced by the reforms 'is that the potential of community

[28] Funnel, R., Oldfield, K., & Speller, (1995) *Towards Healthier Alliances,* London: Health Education Authority.

involvement and collaboration between agencies is largely unrecognised or difficult to achieve for structural reasons'. [29] They have suggested that collaboration rarely happens either naturally, or as a result of exhortation, and that certain strategies need to be adopted to promote collaboration and develop a shared language and trust. These strategies might include providing professional development training to work at locality level, mobilising the consumer voice to counterbalance narrow sectional interests, developing a single organisational framework, allocating a dedicated project leader, decentralising control of resources to promote mutual dependency and a common budget.[30]

This report found that most primary care resource centres contained an extended range of community health services. Many provided accommodation for one or more GP practices and some provided a location for consultant outpatient clinics and specialised treatments. The report also found that social services, housing advice and independent advice services, were frequently based in primary care resource centres, either on a permanent or sessional basis. One of the significant findings of this study was the conclusion that GP support was crucial to the success of a resource centre. GPs can be concerned that the primary care resource centre will take away patients from their practice if only one practice is allowed to operate from within it. The researchers concluded that all GPs in the area should be involved with locality planning and that it might be more important to have GPs involved in planning primary care resource centres and commissioning services to be run within them, than to have practices based in primary care resource centres. This last point has relevance to the decision not to have a resident GP at the Kath Locke Centre (see case study 10.3.)

Another important observation made by health professionals in interviews for this research has been that some agencies might not be relevant to each other in their everyday pattern of working and that sharing staff rooms with unrelated agencies could be counter-productive if it prevented adequate communication and relationship building within agencies, for

[29] Taylor, P. Peckham, S., & Turton, P. (1998) *A public health model of primary care – from concept to reality*, Birmingham: Public Health Alliance, p. 44.
[30] Ibid., pp. 42-43.

example within primary care teams. This raises the important question of just how practical or even desirable it is to mix agencies within the same building if there is no common goal of public interest. It suggests that a multi-agency facility needs to be considered critically, rather than accepted as inevitably beneficial. It is also possible that in some instances even more rigid organisational barriers between agencies were created by the purchasing and management structures of the reforms than the barriers of distance. For example, Barton Avanti (1997) had observed at one health centre in Islington that the communicating door between the GP practice area and the CHS trust accommodation was never opened, forestalling a more integrated service to the local community.[31]

Since the reforms, the main differences in public experience of primary care from traditional models have probably occurred in deprived areas where the need for inter-sectoral and community action has been recognised and a more community orientated and partnership approach to delivering primary care has been adopted. The benefits of this approach for wider sections of the community have not yet been fully tested. However, research undertaken by the National Primary Care Research and Development Centre (NPCRDC) claims that the primary care pilots established by the NHS (Primary Care) Act, 1997, will develop new approaches to the commissioning and provision of primary care. It suggests that these will place new demands on premises, 'to accommodate professionals who have previously worked in separate locations; to house equipment and services transferred from hospital to community settings and to provide accommodation for the local voluntary and community groups...'[32] The NPCRDC suggests that these pilots will provide 'a glimpse into the future of primary and community health services'.

## 4.6 Conclusion

The strategy for primary care put forward by both political parties during the 1990s has so

---

[31] Barton, R. (1997) Recorded interview notes at Avanti Architects, 11.4.97. Barton was citing the spatial organisation at Hunter Street Health Centre, Islington,.London.

[32] Bailey, J., Glendinning, C., & Gould, H. (1997) *Better Buildings for Better Services,* National Primary Care Research and Development Centre, University of Manchester, p.1.

far been firmly based on a medical model of primary care in which GPs have been given increased responsibility for service delivery, health improvements and facility development. GP's independent contractor status has made strategic planning of primary care services difficult and created a reliance on giving GPs a financial incentive to make changes. Through giving greater power to GPs, the status of other professionals has inevitably been undermined, which is likely to be reflected in the way space is allocated within facilities.[33] The wisdom of encouraging dominance of one professional group, with a poor track record of team working, in a primary care system intended to encourage professional collaboration and partnerships between sectors has to be questioned.

Until 1999, government policy had achieved little to resolve the problems of inter-sectoral collaboration, or to shift the culture from preferring the concept of consumer choice to consumer participation. Health users could still find themselves falling down the gap between one set of service providers and another. The essential contribution of other professionals to health improvement challenges the definition of primary care as being synonymous with GPs and it remains a possible source of conflict between the two groups to the disadvantage of public users.

Clearly future health policies must not alienate GPs from the primary care system, but more structures need to be established to facilitate genuine partnerships between professionals, agencies and the community. The first Labour government policy documents and primary care service scheme pilots set up after 1997 appear to be attempting to move doctors in the direction of increased collaborative working, but even if this strategy proves successful it looks set to be a long process.[34] In the meantime, space allocation for different agencies and services within primary care facilities will depend largely on affordability and undoubtedly will be controlled by existing professional hierarchies, unless there is a will among the agencies themselves to break the mould and begin to shape a new managerial and architectural order.

---

[33] How this might occur is discussed in more detail in Chapters 5 and 8.

[34] DoH (1997a) *The New NHS: Modern, Dependable*, London: SO, and DoH (1998) *Our Healthier Nation,* London: SO.

# Chapter 5
# THE HISTORICAL DEVELOPMENT OF PRIMARY CARE BUILDINGS

One of the motivations for undertaking this investigation was to try to provide an explanation for the wide diversity of primary care buildings planned and built between 1990/1997. In my analysis so far I have sought to describe how different political ideologies and complex implementation processes have become reflected in the architectural pattern and product of primary care. I have also attempted to show how the status and conflicts of different policy and practitioner stakeholders might impact on the manner of occupancy of primary care buildings. However, with further reference to the analytical framework of this investigation and the contextual influences on primary care buildings, those facilities built after the NHS reforms were not designed and sited in a vacuum, but were influenced by historical precedents and the existing pattern of provision (see Figure 0.2).

This chapter sets out to trace the historical context of primary care buildings. It argues that, although there was an extension in range of primary care building forms connected to the NHS reforms, diversity was not a new phenomena, but that underlying differences in political ideology and ownership had always marked its development. The chapter will attempt to identify key historical facilities on the *medical/ social* model continuum outlined in Chapter 2, and attempt to illustrate how the delivery of primary care services to the public has been influenced by the dual development of public sector and GP ownership of facilities.

## 5.1 The development of purpose-built primary health care buildings

> *Health centres are here to stay and their future should be discussed on that basis. The question is no longer whether we should have health centres, but rather how to make them better, how to explore their full potential and how to help those working in them to develop better ways of caring for their*

> *patients and community. I agree with Dr Maybin when he says ' The health centre will prove to be the base from which all health care in the community will be given.*[1]
>
> J. Brotherston, Chief Medical Officer, Scottish Home and Health Department (1974).

The Conservative government's health policies of the late 1980s and 1990s, which aimed to devolve services from hospitals to create a primary care-led NHS, caused a revolution in the concept of health facility planning. Before that time NHS management had comparatively neglected primary care accommodation and the energies of medical architecture had been mainly directed at the development of hospital buildings. However, the idea that a special type of building was required to accommodate primary care services had first been suggested by the Fabians, Samuel and Beatrice Webb, in 1909.[2] The Webbs proposed the idea of 'treatment centres' that would accommodate a range of health workers and suggested that these centres should be attached to hospitals, with GPs providing links between the two types of services.[3] Their ideas were not acted upon at the time and the first serious consideration by government of the idea only came with the publication of the Dawson Report in 1920. This report argued for a network of 'primary' health centres, run by local general practitioners and linked to large, specialised and hospital based 'secondary' centres.[4]

This plan was supported between the wars by, the Medical Practitioners Union (MPU) and the Socialist Medical Association (SMA), who, among others, argued for a system of local authority owned health centres, staffed by salaried GPs, as the ideal for general practice.[5] This objective became Labour party policy in 1934, but it was not until the 1946 NHS Act

---

[1] Brotherston, J. (1974) 'Introduction', in Wise, A.R.J. (ed.) *Health Centres,* London: Health and Social Service Journal/ Hospital International, p.7.
[2] Webb, S. and Webb, B. (1909) *Royal Commission on the Poor Law and Relief of Distress*, Minority Report, London: HMSO.
[3] Ibid
[4] MoH (1920) *Interim Report on the Future provision of Medical and Allied Services,* (The Dawson Report), London: HMSO.
[5] Brookes, B. (1974) 'The Historical Perspective', in Wise, A.R.J. (ed.) *Health Centres*, Health and Social Service Journal, London: Hospital International, pp. 9-11.

that the legislation was brought in to implement the ideal, and it was clear that experiments would have to be conducted before any firm principles could be formed.[6] Although the Dawson plan was not implemented immediately, a few pioneering purpose built health centres were developed before the Second World War. These included the Peckham Health Centre, Finsbury Health Centre and Woodberry Down.[7] Each of these centres was conceived to provide broader links with public health, local social factors and health promotion ideals, than centres initiated after the NHS Act of 1946.[8]

Apart from these earlier experiments, primary care services before the Second World War were almost exclusively provided by single or two-handed doctor practices operating from residential buildings.[9] The change that took place with the introduction of a statutory requirement for health centres had profound implications not only for the architecture of primary care, but also on how health and illness was were seen. Armstrong (1985) has argued that 'if once individual GPs treated individual bodies in the domestic space of the surgery, the new health centres produced a new space between the domestic sphere of the home and that of the hospital. This new space was the 'community' coterminous with the practice population...'.[10]

The health centre inevitably created a different relationship between doctors and patients. The health centre was a separate building where the GP went out to work during defined surgery times and was on call for defined parts of a rota, rather than GPs having their working practices intimately bound up with their home life. Instead of every GP having sole responsibility for a specific number of individual's and families' welfare, responsibility for a much larger community became shared with colleagues. The clinical 'gaze' of the GP,

---

[6] Ibid., p.9.

[7] See 5.2 for more detailed descriptions of these centres.

[8] Part 111, Section 21 of the National Health Service Act 1946 gave local authorities the duty of providing equipping and staffing, but not of employing family doctors and dentists. See also 6.3.1.

[9] Maybin, R.P. (1974) 'Health Centres and the General Health Services',.in Wise, op. cit. p.22

[10] Armstrong , D. (1985) 'Space and Time in British general practice' in *Social Science and Medicine* 20: 659 –66. Cited by Green, J. and Thorogood, N. (1998) *Analysing Health*, Harlow: Addison Wesley Longman *Policy,* p. 99.

which Foucault had described, therefore shifted from a focus on the individual to an entire local population.[11] The health centre provided a new location for illness, unique to general practice. This produced new ways of understanding health and illness, and primary care and 'community' became the natural location for the new preventative approach to health prioritised by policy-makers.[12]

## 5.2 Early models of health centres

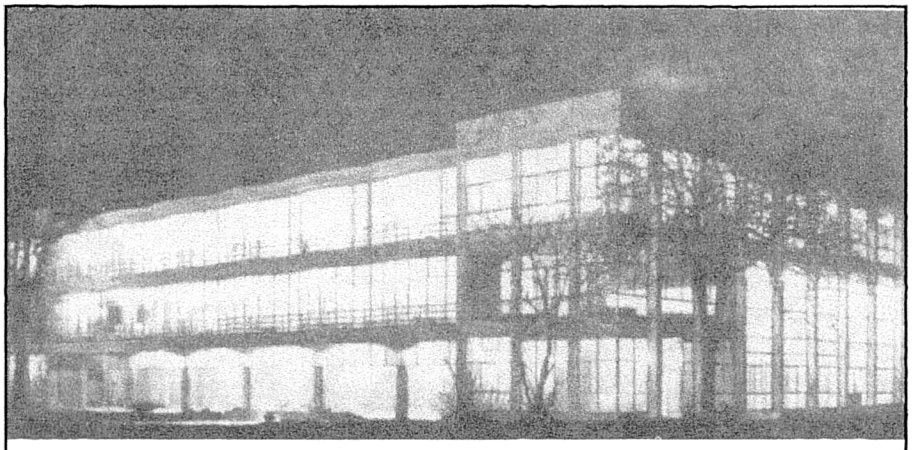
The potentially diverse range of form and social purpose for primary care developments was demonstrated in the earliest models of primary care buildings. Although not becoming blueprints for the first main wave of statutory health centres, traces of these, especially the Pioneer Health Centre, Peckham; Finsbury Health Centre and Woodberry Down Health Centre, became important influences on facilities built after the NHS reforms had brought a reassessment of the tenets of primary care. Echoes of these early models can also be found in the case studies for this investigation.[13]

The Pioneer Health Centre, built in Peckham South London in 1935, embodied a public health perspective and a holistic view of health, including dietary, social and psychological factors. It was established by a group of health professionals and privately financed and it was run primarily as a community centre with an associated medical programme.[14] Scott Williamson, one of the Centre's founders, stressed the links between health and social and environmental conditions and put forward the proposition that 'the healthy individual is the one who enjoys a buoyant and creative mutuality with his environment ....if the environment is rich in the potential for growth – physical, social, intellectual, spiritual – then the capacity of the individual for growth in mutuality or functional action is progressively stimulated'.[15]

---

[11] Foucault, M. (1973) *The Birth of the Clinic,* London: Routledge, p.xii.
[12] Green & Thorogood, op.cit.,p.100.
[13] See Chapter 10 for conceptual links between past models and case studies, e.g., Peckham/ Kath Locke; Finsbury/ St Matthews; Woodberry Down/ Purfleet.
[14] Griggs, B. (1985) 'Introduction', *The Peckham Experiment: a study of the living structure of society,* (republished edition), Edinburgh Scottish Academic Press, pp. iv-xxiii.
[15] Ibid, p.ix

The Peckham Experiment, as the project became known, was unique in that it sought to answer the question of what environmental conditions were required for the promotion of health. It was based on the tenet that health was more than the mere absence of disease and that conditions that encouraged growth and development should be established. The aim of the experiment was to compare the health of the community that used the Pioneer Health Centre to communities in similar socio-economic circumstances that did not have the



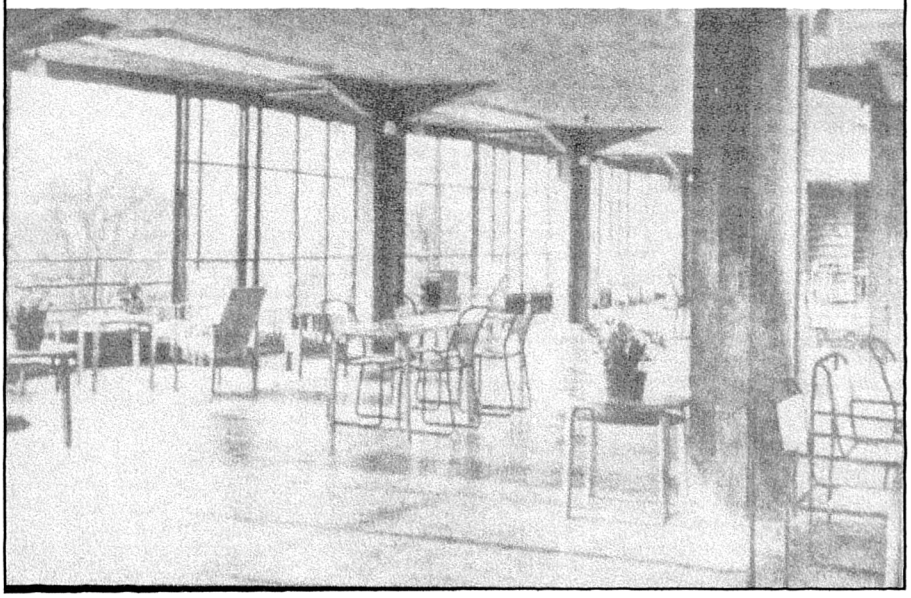


**Figure 5.1**
(Above) **The exterior of The Pioneer Health Centre, Peckham (1935).**
**(Below) The large community recreational space within**
**Architect: Sir E. Owen Williams.** Source: The Pioneer Health Centre Ltd.

support of the project. It was hoped to prove that people would thrive and suffer less illness in the right environmental conditions.[16]

The Centre was open to all families within 'pram pushing distance' on the payment of a small fee. Public users were placed centre stage, while the staff made themselves as inconspicuous as possible. The range of activities subsequently organised by the community was impressive. It included; dances, billiards, water polo, badminton, boxing, table tennis, bands and orchestras, discussion groups, concerts and plays, amateur radio, keep fit, dressmaking and cookery.[17] The design of the building was startlingly modern at the time. It was designed by an engineer, Sir E. Owen Williams, and was devoid of extraneous decorations. [18] It was built in concrete and had vast expanses of glass-walled space and an open plan interior built around a swimming pool.[19] However, the open vistas within the building were not simply a product of a fashionable architectural style. They had an essential functional purpose in enabling the health professionals to observe the local community, so that in this respect the building could be regarded as a huge laboratory for a long term, social experiment controlled by the health professionals. It is unclear how far public users understood the wider intention of the experiment, although it is claimed they understood they were under-observation.

The original Centre closed through lack of public sector support and funds in the 1950s, but some enthusiasts continued to try to keep the philosophy alive and there was a resurgence of interest in the late 1990s. The Conservative government showed some belated interest in the ideals of Peckham when the Department of Health funded research into 'community well-being' centres in 1996. This research was able to identify 300 projects conceptually

---

[16] Scott-Samuel, A. ed. (1990) *Total Participation, Total Health - Reinventing the Peckham Health Centre for the 1990's*, Edinburgh: Scottish Academic Press, p. 9.

[17] Stallibrass, A. (1989) *Being Me and Also Us - Lessons from the Peckham Experiment,* Edinburgh: Scottish Academic Press.

[18] The Pioneer Health Centre Ltd ( 1992) *Health of the Individual, of the Family of Society*, Tunbridge Wells: The Pioneer Health Centre Ltd. p5. Citing *The Architectural Review*, May 1935.

[19] Ibid

linked to the Peckham model operating throughout the country.[20] A similar concept, which specifically refers to the holistic values of the Peckham experiment as a precursor of *Health Living Centres,* has been more forcefully promoted by the Labour government since the 1997 election (see 5.5).[21] A new Centre in Peckham combining health and leisure activities opened in 1998 close to the original site and is also intended to be a 'participatory project' involving local people.[22]

Finsbury Health Centre, in Islington, North London, was built soon after The Pioneer Health Centre in Peckham, in 1938. This Centre moved closer to the NHS concept of medically orientated health centre, but it provided a much greater range of public health and health promotion services compared to later models. It had GP surgeries and recreational therapy rooms under one roof. Original facilities included 'doctors' and dentists' surgeries, a women's clinic, x-ray and tuberculosis clinics, chiropody facilities, solarium and a bacteriological laboratory, disinfecting and cleansing stations, a mortuary, and a meat room for confiscated foods... a reception flat for evacuated families, a roof terrace and a 70 seat lecture theatre'.[23] It is still considered a fine example of integrated design and health care philosophy and its partial refurbishment was carried out by Camden and Islington Health Authority in the mid 1990s and a bid for National Lottery funding had been submitted for further improvements.

The design philosophy behind Finsbury was to solve one of the central problems of health centre ambience – the reconciliation of formality with friendliness. The aim was to try to demystify medicine and demonstrate that medical science was a human science. The intention for this building was overt and it was to turn the building itself into a teaching vehicle that could transmit the message that good health was in the control of the individual.

---

[20] Gaskin, K. & Vincent, J. (1996) *Co-operating for Health,* Centre for Social Policy: Loughborough University

[21] DoH (1997b) *Healthy Living Centres,* Walden, D. Health Promotion Division, 30.12.97, London: DoH. Also see below 5.5.

[22] The new Centre is managed by the Lambeth, Southwark and Lewisham Health Commission and Southwark Leisure Services. A fuller description of this Centre is given in Gaskin & Vincent, op. cit., pp 27-28.

[23] Allan, J. (1988) *The Architectural Review*, June, 1988, p.48.

Perhaps as a consequence, the Finsbury Health Centre building has been described by John Allan, an architect with Avanti Architects, as 'good prose rather than poetry', containing a manifesto of social ideals.[24]

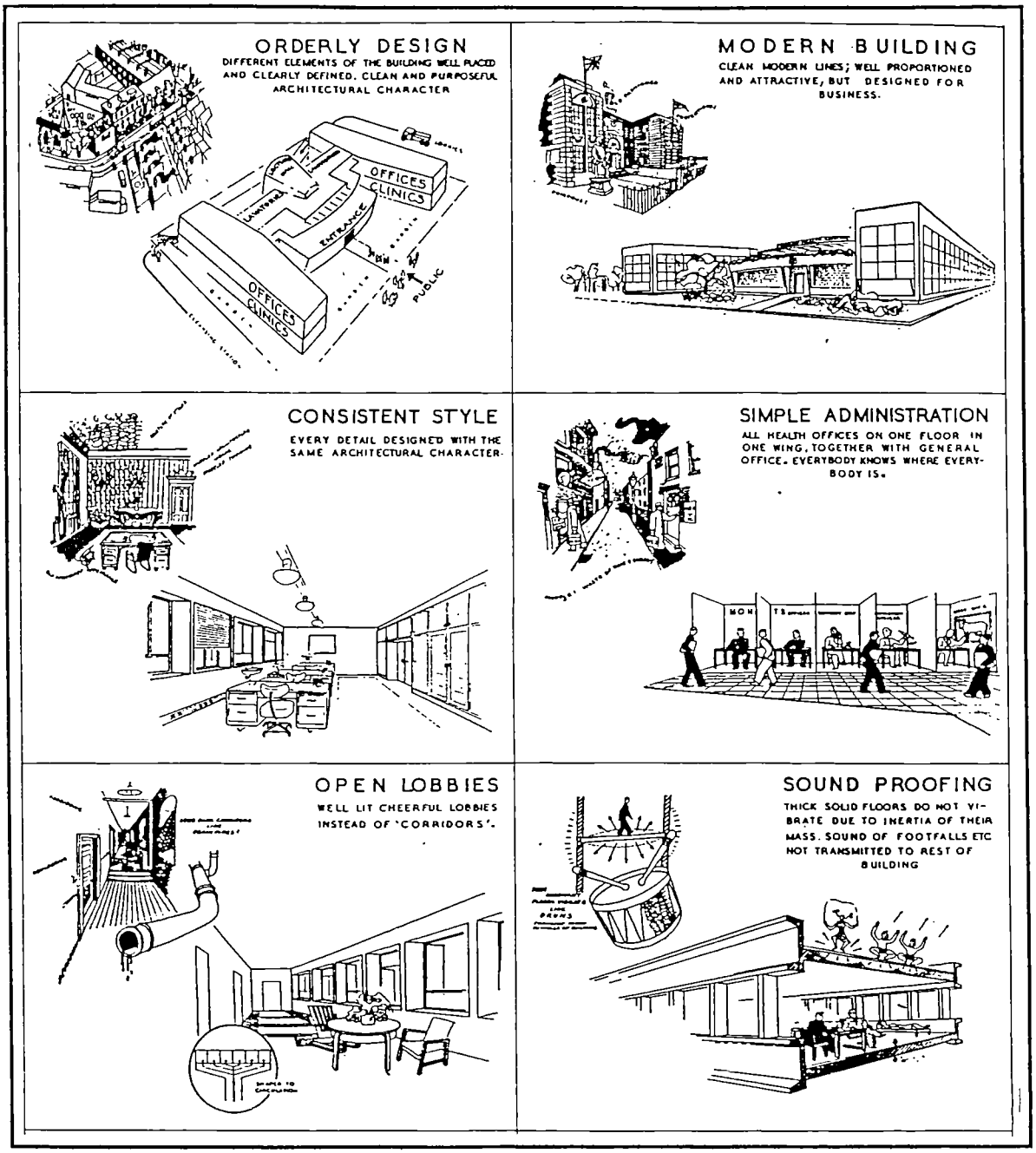



**Figure 5.2**
**Finsbury Health Centre: 'Getting it across to the layman'. Information literature, Architect: Lubetkin.**
Source: Architectural Review, June 1988, pp.49- 56.

[24] Ibid.

Allan (1988) described how the philosophy behind the Finsbury Health Centre consciously influenced his own firm's design for the Bethnal Green Health Centre built in the 1980's.

> *It seems to me that this building owes its significance and reputation to being the product of one of those rare moments of synchronicity, when under the fertile conditions of committed patronage and architectural vision, a radical social programme finds its expression in a radical design solution.* [25]

Allan's article focuses on what he terms an application of the 'principle of causality' which he says in this case related to a shared and unqualified belief in the potentiality of architecture as an agent of social improvement. He describes how in preparation for the design of this building, the appointed architectural firm Tecton, founded by Lubetkin, was initially engaged to undertake a complete social and physical survey of the borough as the first step to formulating a comprehensive and co-ordinated 'Finsbury Plan'. This was originally intended to establish a full programme of planned development, embracing housing, health care, educational and recreational amenities. This early form of needs assessment was interrupted by the outbreak of World War II, resulting in only three components of the plan, Spa Green and Priory Green housing developments and the Finsbury Health Centre being built.

Woodberry Down Health Centre, in Stoke Newington, London, was another early health centre and LCC showpiece, built just after the 1946 NHS Act, for a new estate of 20,000 people.[26] This model showed a decisive swing towards a medically orientated treatment centre. The building was planned by the London County Council before 1948 and comprised of six surgeries for GPs, two for dentists, antenatal, postnatal and child welfare clinics, a school health clinic, a child guidance clinic, an ophthalmic clinic, consulting rooms and offices for health visitors, midwives and school nurses. There was also a room for minor

---

[25] Ibid., pp.46-51.

[26] Brookes, B. (1974) 'The Historical Perspective', *Health Centres*, Health and Social Service Journal, London: Hospital International. pp 9-11.

operations and a hall for health education lectures. A day nursery was established on the same site.[27] At the time, it did not become a catalyst for the further expansion of health centres, because critics of health centres claimed it was not cost effective.[28] However, a similar model for accommodating integrated medical services was resurrected in the 1990s in the form of the primary care medical resource centre (see below Figure 5.5).[29]

These three early purpose-built primary care buildings demonstrate the openness of the health centre concept to a range of ideological and architectural approaches: i) as a social laboratory, where people are provided with an environment designed to support good health as at Peckham; ii) as an agent of social change and teaching vehicle at Finsbury and; iii) as a comprehensive medical treatment centre as at Woodberry Down.[30] The initiation of these early projects was also varied, with health professionals the major influence at Peckham, the socially minded architect the main visionary at Finsbury, and the regional government authority (the London County Council) directing proceedings at Woodberry Down. However, in each case there was a conscious, articulated attempt to reflect the purpose of the building within the architectural form and layout.

## 5.3 GP premises and NHS health centres

One of the ambitions for health centres, proposed in the 1946 NHS Act, was to correct the separation of preventative and curative medicine.[31] However, the popularity of free treatment with the public led to the curative element dominating the ethos of NHS primary care. Consequently, during the next forty years earlier inspirational experiments for promoting healthy communities, such as the Peckham experiment, or in looking at social

---

[27] MoH (1953/4), *Report for the Ministry of Health*, London: HMSO, p.91 vol. XIII.
[28] Brookes (1974), op. cit.
[29] Ibid. Other centres built on a smaller scale just after the NHS Act and regarded as equally experimental were the William Budd Centre in Bristol, a temporary centre on a new estate and the John Ryle centre in Nottingham, which was built from the conversion of two houses. The William Budd Centre is also being resurrected in the late 1990s as a Health Park (see below 5.5).
[30] This comparison is developed in the case studies/Chapter 10 and in Chapter 11.
[31] Brookes (1974), op. cit,

factors behind ill health, such as the Finsbury Health Centre, became marginalised or were abandoned.

Although a definition of a statutory health centre was given in the 1946 NHS Act, J. G. Beales, who published his legendary criticism, *Sick Health Centres and How to Make Them Better,* in 1978, reported that it was obvious during the committee stages of the Bill that nobody had much idea about exactly what sort of places health centres should be, either in terms of size, cost, administration or design.[32] Another stumbling block for the new concept was that initially the idea of working in state-run health centres was not popular with GPs, who feared that they would lose their independent status.

Brookes (1974), writing a historical perspective of health centres, explained that local authority, purpose-built health centres tended to be located on new housing estates and provided surgeries for GPs with some local authority services.[33] Brookes claimed that some GPs mistrusted health centres as a socialist conception and that at first only more socially idealistic doctors were prepared to work in them. Other concerns of GPs were that by moving to a health centre they might lose patients, or that patients would be unlikely to follow them if they subsequently chose to leave the centre. Some GPs were also worried that if the local authority charged doctors an economic rent for their use of a health centre, the cost would be too high, particularly if the doctor used the health centre as a branch surgery, but continued to maintain a privately owned surgery elsewhere.[34]

Brookes (1974) suggested that GPs misgivings about health centres, the lack of funds to set them up, difficulties in finding suitable sites and the government's desire to continue promoting group practices financed by the profession, encouraged the Ministry of Health's view that local authority owned health centres were only justified where a new community was to be provided with health services. Also Brookes argued that the speed of the

[32] Beales (1978), op. cit.
[33] Brookes (1974), op. cit.
[34] Ibid., p.10.

development of local authority health centres, during the 1950s and the early 1960s, was hampered by the range of concessions and encouragement given to GPs to help them form group practices and erect central surgery premises. This established a pattern of GP-led provision that came to dominate the system.

Consequently, by December 1965 only twenty-eight experimental statutory centres were in operation.[35] However, in 1966, local authorities in England declared their intention to build 300 centres. By June 1973 this figure had already been overtaken, 405 had been built and another 250 were planned.[36] One of the reasons for this upsurge of interest was that GPs had slowly began to see some advantages in working from health centres. These included: the use of purpose-built premises with modern facilities for team work; the relief of administrative work by paying a proportion of the cost to the local authority to pay for receptionists, telephonist and secretaries; the facilitation of post-graduate study and special interests by GPs; and participation in hospital work.[37]

It has been claimed that the duality of public sector and semi-independent, GP-owned health centres was reflected in their architectural styles. Lance Wright, writing an architectural criticism of health centres in 1980, suggested that there were two recognisable approaches to health centre design, directly attributable to the different forms of ownership.[38] One was the 'NHS approach', which took a management viewpoint of trying to solve the problem of how to get the best possible service to 'everybody' with the least expenditure of means. Wright argued that this resulted in public sector buildings that were usually anonymous, characterless environments. On arrival, patients would be sorted and posted into spaces intended to be used to their top capacity.

---

[35] Hale, N.M. (1974) 'England and Wales', p.18 in Wise, op. cit.

[36] Ibid. With the re-organisation of the NHS in April 1974 responsibility for the building and running of health centres passed from the local authorities to the new area and regional health authorities. After this statistics for the growing numbers of health centres becomes difficult to gather.

[37] Brookes (1974), op.cit.

[38] Wright, L. (1980), 'Medical Centre, Wellingborough, Northants', p. 190-191 in Stone, P. (ed.), *British Hospital and Health Care Buildings*, London: Architectural Press, pp.182/191.

Wright claimed that GP's who had expanded their practices into group practices with additional services took a different approach. The buildings provided a range of services similar to those of local authority health centres, but the layout and design of the buildings reflected the GPs desire to preserve the sanctity of the doctor/ patient relationship by providing private rooms for each GP. This created a more personalised and domestic environment.[39] But by the 1990s, such distinctions, if they were ever true, were perhaps not as obvious as they might have been previously, because many GPs appeared to have hijacked the publicly owned health centres and personalised consulting rooms with plants, pictures and other symbols of individual ownership. Moreover, by whichever route these buildings had evolved, they were invariably designed to accommodate a GP-led medical service, since the vast majority of statutory health centres had come into existence through the agreement of GPs already in practice, and often at their instigation.[40] So that the similarities tended to outweigh differences.

Hillier and Hanson's (1984) analysis of the genotype of doctors' premises describes doctors consulting rooms as usually individually dispersed units located in spaces deepest from the entrance. Visiting patients are expected to wait for administrative purposes in a shallow space at the entrance of the building. On being summonsed the patient then disappears into the deeper part of the building where the interface between the doctor/ patient takes place and the patient may not be seen again. This can be because the patient then leaves the building from a 'stage door' (a door at the back of the building), which also allows the doctor to go in and out without needing to transgress the visitors space, which, it is claimed, helps to maintain their high status as an individual professional.[41]

An important question for this study is whether the design of health centre buildings has ever proved appropriate for delivering primary care services. Beales (1978) concluded that insensitivity and attempts to over-rationalise the system had resulted in reception, waiting

[39] Ibid.
[40] Curwen, M.P (1974) 'Current Trends in Health Centre Development' , in Wise op. cit, p.13
[41] Hillier, B. & Hanson, J. (1984) *The Social Logic of Space,* Cambridge University Press, pp. 191-2.

and staff areas being shared by too many people, which had resulted in a loss of cohesion and goodwill within Primary Health Care Teams. This suggested that even the medical objectives of a health centre were not adequately accommodated by health centre design.[42] The issue of appropriate allocation of space in primary care buildings is further developed in Chapter 8.

The architectural critic, Colin Davies (1988) also condemned the health centre as 'an awkward building type: not small enough to be domestic, not big enough to gather much civic presence'. Davies argued, 'Architecturally, there might be a case for abolishing the type altogether and letting its various components find separate accommodation in adapted houses or office buildings', thereby raising similar issues about the appropriateness of integrating services indiscriminately that were discussed in the last chapter.[43] But Davies recognised that this strategy would run counter to prevalent medical wisdom to integrate services under one roof.[44]

Davies distinguished between the balance of power experienced by users of 'community' rather than 'private' health care buildings. He argued that people expected to be grateful for the care they received in a 'community' health building, whereas in a 'private' health building people were permitted to complain. He suggested that the prefix of the term 'community' to health buildings betrayed a complex network of assumptions about social responsibility. The understanding behind the concept of 'community care' was that when you fall ill the community will care for you just as parents care for their children. The social paradigm was therefore the family, and the architectural paradigm was the home, so the architectural scale for community health buildings necessarily had to be domestic. This argument is picked up again in discussing criteria for evaluating primary care buildings in Chapter 8.

---

[42] Ministry of Health (1963) *The Fieldwork of the Family Doctor*, (The Gillie Report) London: HMSO. This report placed great emphasis on the Primary Health Care Team rather than doctors working in isolation.
[43] See Chapter 4.5.
[44] Davies, C. (1988) 'East End Avanti', *The Architectural Review*, June, 1998, pp.18-26.

Davies also suggested that the method of payment for health services could crucially affect the style and ambience of facilities. In a private hospital, Davies asserted, 'community' is an irrelevant concept, because the typical private healthcare user is just another type of 'consumer' whose priority is not to be rehabilitated in the community, but simply to get back to work. The private health care user is not interested in buying 'care' only 'convenience' and subsequently private hospitals are not designed as home substitutes, but as hotels.[45] An echo of a 'customer convenience' approach to public sector primary care buildings can be seen in the fashion to call health centres 'one stop health shops' and 'health malls'. [46]

## 5.4 Alternative models of primary care buildings

Health centres and GP premises were not the only form of primary care buildings developed this century. The change in social values following World War I for improvements in health care also resulted in grants for the establishment of local authority health clinics to provide antenatal care and medical treatment. This was the beginning of a separate local authority function concentrating on preventative care, which, at the time, was not associated with the GP. During the 1960s and 1970s, health clinics were built more rapidly than more comprehensive health centres that included GPs. This was despite the fact that health centres were intended to replace the duality of GP practices and health clinics. The policy in many local authorities was for a clinic to be within pram pushing distance of any resident, and space was sought in new and existing developments to fulfil this aim. Health clinics are now usually the responsibility of Community Health Service trusts and new forms of health clinics, headed by Nurse Practitioners, have been reintroduced since the reforms. These clinics have been established as a way of relieving the strain on hospital casualty departments, however, there is some debate as to whether this type of service will offer as high a standard of medical treatment as traditional GP practices, or whether they are an

[45] Ibid.
[46] See 5.5, Multi -Agency Centres.

unacceptable method of saving money that might put patients at additional risk. Either way they remain another version of the medical model. [47]

A borderline version of primary care is intermediate care. The concept of the intermediate care centre is similar to that of the cottage hospital, which lies between a District General Hospital and a health centre. It usually offers some short stay and rehabilitation beds for non-acute cases, sometimes managed by GPs and nursing staff. Intermediate care centres also usually provide a range of day care treatments, outpatient facilities, GP and counselling services. There are often close links between intermediate care centres and neighbouring communities and local people often treasure them. Lambeth Community Care Centre was cited in the Tomlinson Report (1991) as a potential model for London Implementation Zone facilities, but the practicalities of developing a facility with GP managed beds ran into difficulties in some health districts and so far only a very few facilities based on this model have been built.[48]

Prior to the 1990s, variations to the conventional design of primary medical care facilities could be mainly found in health facilities based on the ideologies of complementary medicine and the women's health movement. The differences in modes of practice and services offered in these centres were often reflected in the building's layout and interior design. Complementary medicine centres are usually privately funded so they tend to be used by people with higher incomes, although there are a few centres that operate a sliding scale of payment, or run free NHS sessions. These centres tend to focus on individual rather than community health and therefore pose no threat to the traditional professional /client relationship. Usually they can be easily accommodated within more conventional medical

[47] Ibid

[48] DoH (1992) *Report of the Inquiry into London's Health Service, Medical Education and Research.* (The Tomlinson Report) London: HMSO. In the New Caversham Centre, a GP group practice had tried to initiate a similar facility, but health authority concerns on the revenue costs connected with a short stay facility eventually resulted in this scheme being abandoned by the NHS Executive. See NHS Estates. (1994/5), *London Initiative Zone Primary Care Premises Handbooks 1/4,* London: Crown, No 3, p.1.

practices in standard consulting or treatment rooms.[49] In centres focusing on complementary therapies, the therapeutic environment of the building is often regarded with great importance. These practices may try to reflect their emphasis on natural healing and harmony with nature by using natural materials such as wood and stone, or features such as water, fountains, and plants. For example at the Blackthorn Medical Centre, in Maidstone, GPs use a combination of conventional and complementary techniques, and patients with long-term mental or physical problems are rehabilitated through work in the greenhouses, gardens and cafe.[50]

Well-Women centres or clinics are products of the women's health movement that developed out of the women's liberation movement in the 1960's and 70's in the USA and the UK. The women's health movement began as small groups of people who formed self-help and discussion groups and some went on to open centres and clinics. They were founded on the increasing dissatisfaction among women that the majority of health care was not well acquainted with the complexity of women's complaints and circumstances. There was also criticism that women's experiences of ill health were falsely dichotomised into physical pathology and socio/economic problems as discrete elements of a woman's experience.[51] The first guidelines for Well-Women centres in the UK were drafted and adopted by the Association of Community Health Councils, England and Wales (ACHCEW) in 1981.

Well-Women centres are good examples of socially rather than medically focused facilities. They often employ lay people and volunteers to support services and seek to support to make informed health choices and take responsibility for their own health. They often see themselves as community-based and not just individual service providers, but they are often

[49] A survey undertaken by St George's Hospital medical school suggested that up to a fifth of GPs practised complementary medicines themselves, most commonly acupuncture and homeopathy, and that 93% had recommended it at some time to patients. Pulse, 17.9.94.

[50] Blackthorn Medical Centre , Maidstone, designed by Camphill Architects, is featured in Valins, M (1993) *Primary Care Centres*, London: Longman.

[51] Pearson, M, & Spencer, S. (1989), *Awareness and Use of Well Women Services in Liverpool,* (Occasional Paper No. 1), Department of General Practice, University of Liverpool.

shaped and controlled by state funding, which provides for direct services, such as counselling, family planning or drug counselling, rather than for community education, health advocacy, or other social activist projects. [52] GPs are sometimes included in the services offered, but they are usually one of the many services on offer, rather than the focus of activity. Crèches, cafes and informal meeting areas are often included in these facilities to encourage community involvement.

## 5.5 Primary care building forms since 1990

Two distinct new types of primary care facilities, influenced by the NHS reforms, had emerged by the end of 1997. In many respects these had extended the duality of the GP premises/health centre models of primary care provision established in the earlier period. One type was the new or expanded GP owned and controlled premises (usually fundholding premises), accommodating technologically sophisticated medical services such as minor injuries units, minor surgery and out-patient clinics and enlarged primary care teams. This type sometimes included complementary or other services in addition to more traditional medical services. The other type was publicly owned (usually by CHS trusts or joint funded) multi-agency centres, accommodating a mixture of social, medical, voluntary and community services. These multi-agency centres exhibited different degrees of medical or social dominance.

[52] Morgen, S. (1989) *Profiling Women's Health Centres - An evaluation of a primary health care initiative,* Discussion paper 4, Wellington: Health Services Research and Development Unit, Department of Health.

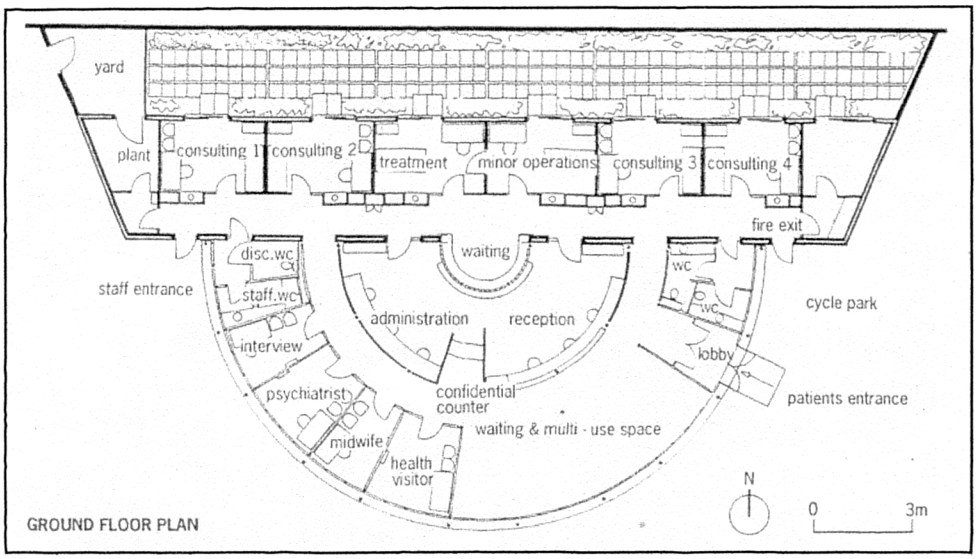
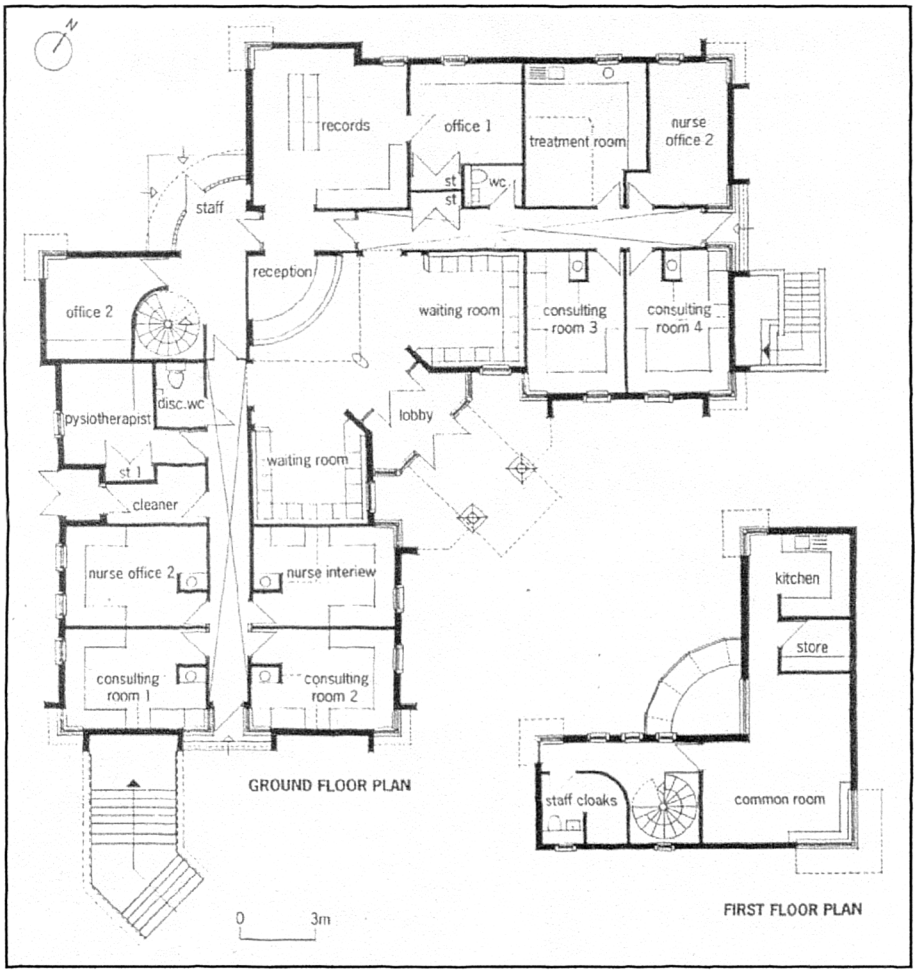



**Figure 5.3 Examples of medical centre layouts (1993). Above: Camberwell Green Surgery. Architects: Eger Architects. Below: De Montfort Student Health Centre. Architects: Bundey & Rogers** Source: Architects Journal, 24.11.93, pp.25-26



*GP- led medical centres*

One of the problems associated with this research has been the range of names given to describe buildings all offering primary care services, but differing in the range, quality, size and scale of services they offer.[53] Those primary care facilities offering mainly medical services led by GPs have tended to be called:

- General Practitioner Practices
- Health Centres
- Primary Health Care Centres
- Physicians Clinics
- Medical Office Buildings
- Doctors Offices
- Polyclinics
- Medical Centres

*to accommodate the new surgical treatment.* One of the reasons that devolution of acute services to primary care facilities has become possible is the new technology that has developed in the last two decades. Many less invasive surgical techniques are now in widespread use and are gradually being introduced into minor surgery units attached to primary care buildings, or intermediate centres (see example in Camberwell Green Surgery, Figure 5.3). New compact diagnostic equipment has also led to the development of mobile units being introduced to primary care centres and minor injury units located in primary care facilities have already replaced some accident and emergency hospital units increasing the scope of GPs. An example will be described in the Purfleet case study (Chapter 10.1). The Primary Care Act 1997, pledged support for a network of 560 'super surgeries' [54] There has also been a suggestion that there should be a pattern of primary care medical resource centres throughout the country, providing access points to town or locally based hospitals

---

[53] Valins, M. (1993) *Primary Health Care Centres.* London, Longman.

[54] Singmaster, D. (1997), 'Super-Surgeries' and the New Age of Healthcare Architecture. *Architects' Journal* 10.7.97, p.17.

serving between 20,000 and 100,000 people and linked to a small number of regional trauma centres.[55]

Pharmaceutical developments since the 1950s have also supported the shift from institutional to community care particularly for psychiatric patients and currently, new discoveries in the fields of genetics and biological sciences are expected to lead to breakthroughs in the detection and treatment of inherited and environmentally related diseases such as cystic fibrosis, heart disease, cancer and strokes. Developments in pathology will increasingly enable diagnostic kits to be made available for self-testing by GPs or nurses at health centres or at the patient's bedside, rather than in clinics or hospitals. These and other technological advances could have important implications for the pattern and design of primary care facilities in the future, however the speed of these transformations is not just dependent on the technology, but also on the resources made available to provide access to them. Eventually, technological developments may lessen the number of physical visits by the public to medical health buildings, because a certain level of consultation and diagnosis may be possible using home computers and various technological link-up and networking facilities. But there is little sign of that happening yet. On the contrary, official statistics have revealed that despite the 'care in the community' strategy, the number of home consultancies from GPs fell from 21% to 9% between 1979 -1997, suggesting that there are actually more consultancies taking place in health centres than before.[56] GP's increasing reluctance to visit people in their homes and an increase in patients' use of private transport may also account for this rise.

Since the mid-late 1990s there has been a rise in 'convenience' primary care medical centres in locations such as railway stations, shopping and business centres, catering for busy professionals. These are private organisations charging for drop-in GP services and treatments such as holiday vaccinations and diagnostic tests, but they are considered unlikely to replace the local NHS family practitioner or health centre and are expected to be used as

[55] NHS Estates. (1994/5), *London Initiative Zone Primary Care Premises Handbook 1,* London: Crown.

a supplementary service on an occasional or crisis basis.[57]

*Multi-Agency Centres*

Various types of multi-agency centres have developed since the 1990 NHS Community Care Act. This building type is of key importance to this thesis because it potentially offers an opportunity to update the ideals of the original health centre model to encourage inter-professional and inter- agency collaboration for the benefit of local communities. Facilities offering a wider range of facilities or based on social models of health are often termed:

- Health Parks
- Multi-Agency Resource Centres
- Health Malls
- Community Health and Resource Centres
- Local/Primary Health Care Resource Centres [58]

Multi-agency centres require different types of buildings and spatial arrangement to primary care buildings for GP-led facilities. One architectural feature that distinguishes this type of facility from medical treatment centres is often the conscious attempt to develop a more interactive interface with the local community through giving emphasis to an open access, 'democratic' entrance space. This sometimes includes a popular attraction such as a café, fitness or information centre. Multi-agency centres also often provide a large range of drop-in services, which require no appointment and which the public can access without encountering administrative or bureaucratic barriers, such as appointments and waiting

---

[56] Office for National Statistics(1997) *Social Trends 27*, London: SO.
[57] Butler, P. (1999) 'Ending in Tiers', *The Guardian*, Society, 27.1.99, p.37.
[58] NHS Estates (1995) *Health Building Note 36: Volume 1*. London: HMSO, p.2: 63. Here a 'local healthcare resource centre' is defined as providing services that are complementary to the primary care centre so that patients are referred on to the resource centre for treatment. This guidance refers back to the WHO publication mentioned above as a useful reference point, but it emphasizes that additional services to core medical services are there in a supporting role, rather than developing the concept that these services may have a more equal partnership status in providing health care.

rooms. These facilities are designed to attract not only people who are ill, but also people who might tend to stay away from traditional health services and facilities. They are often developed in prominent public positions such as in the town or shopping centres or at the heart of a disadvantaged residential area, and therefore can have either a commercial or social orientation.[59]

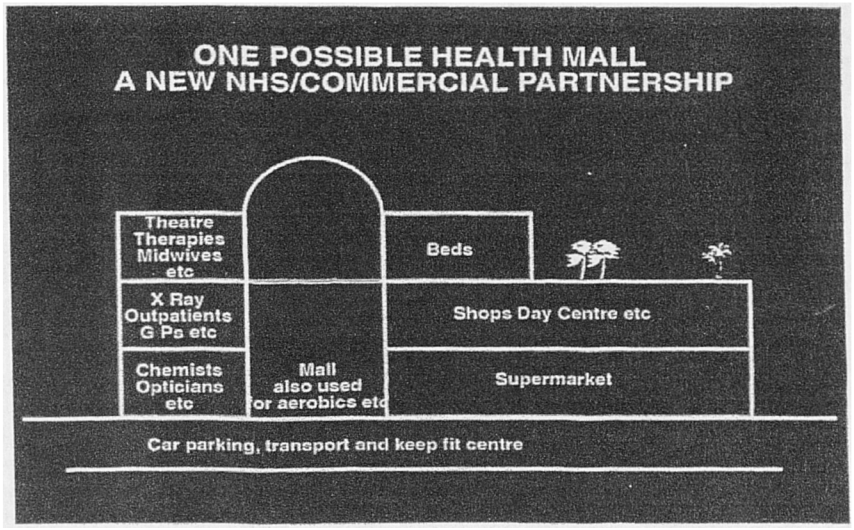



**Figure 5.4 Health Mall Diagram.** Source AMEC CASPE

For examples of a multi- agency centre building plans see Figure 5.3 below and those shown in the case studies. Examples of the wide range of services that can be found in more social/community orientation found during this investigation that have been accommodated within multi-agency centres include:

- Cafes
- Swimming pools
- Fitness and exercise centres
- Food co-operatives
- Welfare and housing benefits advice
- Stress counselling clinics

[59] AMEC-CASPE (1993) *Health Malls: an answer to inner London health needs,* preliminary report, London: AM(**1993**)[39]EC-CASPE.

- Complementary medicines and therapies
- Citizens Advice Bureaux
- Contraceptive & sex education advice
- Community action groups
- Self-help groups
- Community police facilities
- Voluntary sector agencies
- Gardening workshops
- Art and craft workshops
- Crèches
- University outposts
- Education and training centres

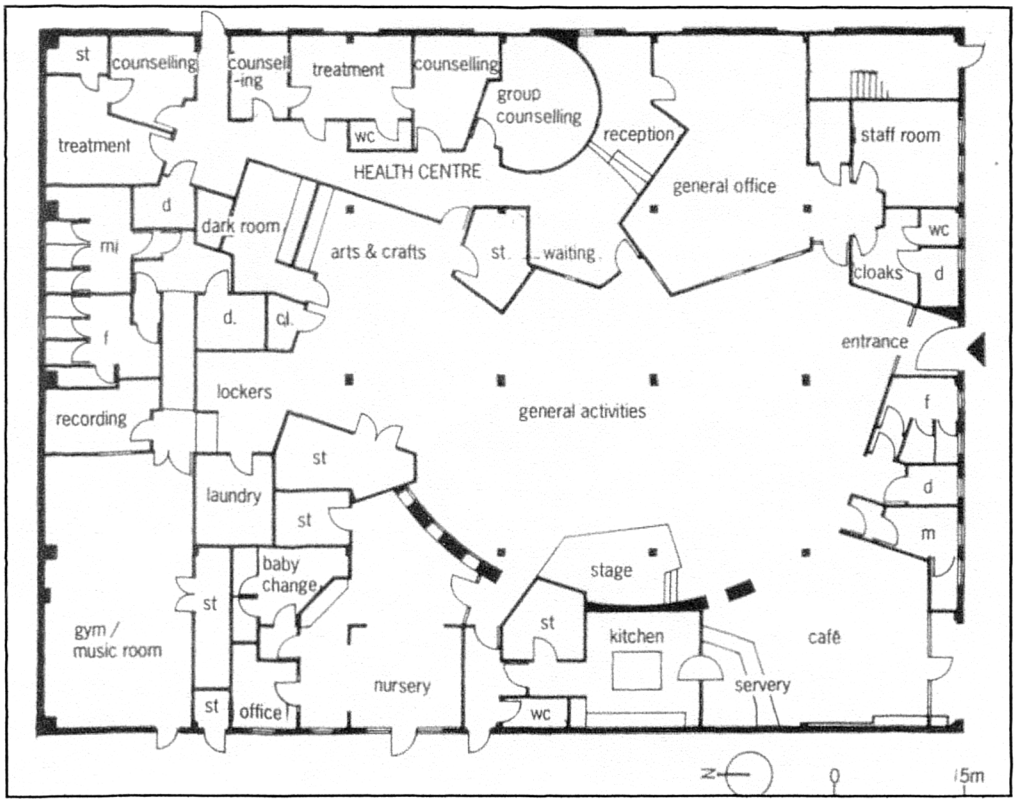



**Figure 5.5**
**A multi-agency centre in Nottingham, Base 51 (1993). The Centre is intended to provide a range of health related activities for young people.**
**Architects: Groundwork Architects ( a community architecture co-operative).**
Source: AJ. 28.4.1993, p.24.

However, as I discussed in the last chapter, inter-agency collaboration is something that different agencies need to sign up to, and is unlikely to happen through proximity alone.[60] Sometimes agencies can be grouped together for administrative convenience rather than to fulfill any aim of community health improvement. Mixing agencies of different cultures under the same roof can create problems for spatial organisation. In applying Hilllier and Hanson's spatial analysis theory to multi-agency centres, these appear to be more spatially organised like department stores than GP surgeries in terms of the desired depth of permeability of public users.[61] They are likely to have direct, or open access to more of the building, except in sections controlled by those professionals operating a one-to-one service and therefore requiring bureaucratic barriers, such as reception and waiting areas to regulate public access. Sometimes differences in the types of interface between professionals and the public have made it appear more practical to separate services in discrete buildings grouped or linked on a site as in the primary care development at Bromley-By-Bow, East London, or accommodated in discrete parts of a single building (see for example the case study, Neptune Health Park, Chapter 10.4).

A concept similar to multi-agency centres and advocating a community participative model was recommended in WHO directives in their proposals for the provision of 'reference centres' in urban areas.[62] However, Glendinning et al (1996), evaluating examples of 'primary care resource centres' as they had been developed in the North West of England between 1994/5 for the National Primary Care Research and Development Centre, reported

[60] Warbarton, A. (1995) 'Back to the Centre', *Health Service Journal,* 21·9.95, pp. 1-4.
[61] Hillier, B. & Hanson, J. (1984) op.cit. See also Chapter 4.
[62] WHO ( 1992) *The Role of Health Centres in the Development of Urban Health Systems. Report of the WHO Study Group on Primary Health Care in Urban Area* (p. 3) 'Reference health centres should carry out a range of health promotion, preventative, diagnostic, curative, and rehabilitative activities, including provision of inpatient and maternal care for patients requiring a bed for less than 24 hours. They should receive technical support from first referral hospitals and provide support and supervision to increase the quality of care at dispensaries and other health centres or sub centres. Their activities should also include social welfare, education, and environmental health. As technical and operational modules of district health systems in urban areas, reference health centres should work to develop community-based health services, responding to local health needs and taking into account social, epidemiological and environmental conditions in the populations they cover'.

that two types of resource centre had been encouraged.[63] The first provided primary care and services transplanted from the secondary sector on one site based around a GP practice, and the second provided a similar range of services in a locality setting to which surrounding GPs referred patients.[64] Both types were therefore primarily built to support medical services and plug deficiencies in existing services rather than seeking more radical approaches to primary care delivery.[65] The report found that inter-agency collaboration and community involvement in these projects disappointing. For example, only one had set up a community development worker to improve liaison and communication between the different service providers based at the resource centre. Generally they found that tight timescales had resulted in little community involvement and not enough time spent in discussing building alliances and working relationships between staff from different agencies within the new centres. They concluded that a major organisational task within a primary care resource centre development was required to get all agencies on board without the facility being dominated by one particular organisation.[66]

In December 1997, the Department of Health announced that £300 million pounds would be made available from a New Initiatives Fund, financed by the National Lottery, following Parliamentary approval in the summer of 1998.[67] Healthy Living Centres (HLCs) are presented as a completely different concept from traditional primary care centres because they are not intended to be building specific. There was no central blueprint for projects and they could be located in several buildings, use mobile facilities, or utilise existing buildings. They are intended to foster partnerships across many different organizations and groups, which together can create new ways of providing attractive facilities and services. HLCs are placed clearly in the context of the new public health strategy and are intended to be

---

[63] Glendinning, C., Bailey, J., Burkey, Y., Gosden, T., & Kirk, S. (1996), *Evaluating Resource Centres in the North West of England,* (executive summary), University of Manchester: The National Primary Care Research and Development Centre. Before its demise the NWRHA had allocated £19 million to build 17 primary care resource centres

[64] Warbarton, A. (1995), 'Back to the centre', *Health Service Journal,* 21.9.95, pp. 1-4.

[65] Glendinnig et al., (1996) op cit., p.1.

[66] Ibid.

[67] DoH (1997b), op. cit.

linked to local health targets with priority given to schemes intended to reach those people with worse than average health. Community involvement is another characteristic cited as essential for qualification for the scheme. HLCs are intended to be independent and to encourage innovative and imaginative ways of responding to local needs. [68] The intended relationship between HLCs and traditional medical services has not been made explicit, although they are not intended to replace or complete with existing statutory services or facilities. In some of the examples of Well-Being Centres, investigated by researchers at Loughborough University, on which the concept Healthy Living Centres has apparently been based, facilities were linked by a referral system to GPs, or they included community health services.[69] In other examples primary medical care was an inclusive, but not a dominating element of the facilities provided.[70]

## 5.6 Conclusion

This chapter has sought to demonstrate that historically primary care development it has always been fragmented and divided. The precise purpose of primary care buildings has been unclear and there has always been bipartite division between privately owned GP premises and publicly owned health centre facilities. By the end of the 1990s there appeared to be a recognisable trend to form more integrated services, but there was still a piecemeal rather than a strategic approach to facility commissioning. The rapid development of medical technologies and the demands for excellence in medical service delivery, coupled with demands for a broader approach to health promotion, indicate that for the foreseeable future primary care centres are likely to continue to develop in both medical and social directions within localities, either in single buildings or through linked programmes. However, in order to fulfil NHS objectives of universal access and WHO social objectives for inter-sectoral collaboration and community participation, more strategic mechanisms to ensure more equitable provision of quality and range of facilities in all areas needs to be established.

[68] Ibid.
[69] Gaskin & Vincent, (1996), op. cit.
[70] Ibid.

# Chapter 6
# A CRITICAL ANALYSIS OF STANDARD MECHANISMS FOR COMMISSIONING AND DESIGNING PRIMARY HEALTH CARE FACILITIES

This chapter continues a social analysis of primary care buildings, with reference to the framework outlined in the introductory chapter, by examining commissioning and design process *mechanisms,* through which certain stakeholder interests became imprinted on facility development, that were influential between 1990/1997 (see Figure 0.2). First, it will aim to demonstrate how statutory and advisory procedures and regulations governing the commissioning and procurement of NHS primary care premises have influenced the product of primary care architecture, either through facilitating, or conversely obstructing, certain types of development. Second, it will assess how far design guidance, issued by NHS Estates and other advisory agencies, has influenced the manner of occupation of practitioner stakeholders and the interface of the facility with local communities.

This research for this chapter has been informed by a series of focused interviews held with architects from three architectural practices: John Allan from Avanti; Gareth Hoskins from Penoyre and Prasad; and Chris Shaw and Mungo Smith from MAAP, who described their first–hand experiences of the impact of post-reform directives in the construction of primary care buildings.[1] Their experiences have been particularly useful in assessing the adequacy of these *mechanisms* in fulfilling government intentions and gauging the extent to which they are ignored or contested by implementing agents.

## 6.1 Commissioning and Procurement of Buildings

As previously discussed in Chapter 3, reforms to the organisational structure of the NHS in the 1990s had a profound effect on NHS Estate management. Most of the responsibility

[1] Please see Chapter 1 for explanation of the process of selecting architectural practices consulted in this study.

for property holdings was devolved from regional and district health authorities to the NHS trusts. However, at the same time special funds and flexibilities were granted to Family Health Service Authorities (FHSAs) and later, for a limited period, to the new commissioning health authorities in the London Implementation Zone (LIZ), to facilitate the shift from acute to primary care settings in London, which had been recognised to have special problems.[2] Under the LIZ flexibilities, district health authorities were allowed to have a short-term interest in some projects as a means of expediting much needed developments, and this considerably increased the number of new primary care facility development projects initiated during this period.

Another major change after 1990 was that health authorities had to submit annual primary care development plans setting out future purchasing intentions and objectives based on strategic aims agreed with the NHS Regional Office. All commissions had to be subjected to private finance procedures and full business plans submitted to the Department of Health for approval. There were other set procedures connected to planning and purchasing new or refurbished primary health care buildings, which were intended to guide primary care facility development. Some of these were statutory procedures, imposed on those with responsibility for primary care by the Department of Health; others were instigated by health authorities as recognised good practice.[3] Importantly for this investigation, different sets of procedures and regulations have governed GP premises and multi-agency centres.

### 6.1.1 Funding GP premises

*Cost Rent*

The main mechanism for doctors wanting to buy or develop their own premises has been the

[2] NHS Estates (1994/5) *London Initiative Zone Primary Care Premises Handbooks* Handbook 1. London: Crown, p.7, 1.20. See also Chapter 3.3.
[3] Ibid., p.18. 2.46-50.

Cost Rent scheme.[4] Health Building Note 46, which was intended to assist GPs and their architects to understand the problems and principles involved in building premises after 1990, defines the Cost Rent scheme simply as follows:

> *The broad intention of the scheme is to enable GPs willing to invest in new purpose built surgery premises, or their equivalent, to receive a 'rent' on a scale which in effect gives them an interest free loan on the capital borrowed for the project, if they borrow at generally prevailing rates and a return on their capital.*[5]

In cases where GP's rent their premises, they receive what amounts to direct reimbursement up to an amount that has been independently assessed for rental by the District Valuer. If GP's wish to purchase a property, or improve it, they cannot obtain direct financing from the health authority, but they are eligible for rental repayments on the basis of the assessed rental, even if as owners they do not actually pay rent. In the latter case this could mean that mortgage repayments are covered by payments from the health authority under the Cost Rent scheme, which effectively means that the public buy the property for the GPs, but have no right to a direct voice in its design or location.

The Cost Rent scheme was intended to encourage premises improvement without any increase in government borrowing, because borrowing then became the responsibility of the GP, or some other third party. The scheme makes it relatively easy for a GP to raise finance as the repayment is more or less guaranteed by the health authority, providing that the assessed rental was not in excess of the limits of the scheme. Practice premises had to be designed and built to standards approved by the health authority to qualify for Cost Rent. By 1997 these standards were generally considered too low, because they were based on

---

[4] Full details of the Cost Rent Scheme are given in the DoH (1990) *Statement of Fees and Allowances for General Medical Practitioners in England and Wales* (Red Book), London: HMSO. A variation of Cost Rent is when owner-occupiers are paid a Notional Rent, which is equal to the current market rent. Notional Rent is not cash limited and it avoids the issue of availability of resources, but it does require getting a valuation of the premises from the District Valuer.

[5] *NHS Estates (1991)* Health Building Note 46: General Medical Practice Premises for the Provision of Primary Health Care Services, London: HMSO, p.4: 1.15.

early 1960s staffing and activity levels and did not take the new demands of extended primary care services into account and valuations for new premises were frequently falling below the cost to build. Consequently suggestions were made for improving and updating Cost Rent, for example by making more room spaces in schedules for computerisation, education and training, records storage and to define layout and design principles with relation to the 'basic functional zone model' described in Health Building Note 46.[6] Another failure of Cost Rent as a commissioning mechanism, which was previously discussed in Chapter 4.3, was that it was unattractive to GPs working in the most disadvantaged social areas, because there was too high a risk involved in investing in premises, which then forced the Community Health Service trusts to step in to raise the necessary capital.

*Improvement Grants*

Another funding mechanism that was open to GPs wanting to improve premises was through improvement grants. These required GP practices to contribute some of the capital, usually between 33-66% of the actual cost of approved work, including professional; fees and statutory fees charged by the local authority.[7] For a limited period within LIZ, improvement grants up to 90% were offered.[8] Some health authorities were willing to consider an improvement grant on top of cost rent payments, which enabled practices to reach beyond the limitations of the Cost Rent standards and to make better provision for Primary Health Care Teams and other practice resources. However, the health authority contribution to the cost remained partial and improvement grants were not available for application to health centres.

These methods of encouraging and supporting GPs to be autonomous and to effectively run businesses from their own premises had a profound impact on primary care service delivery and the interface between doctors premises and local communities. There was little incentive for GPs to involve communities in any of the decision-making processes around developing

[6] Ibid., p.18: 4.18.
[7] Ibid., p.4: 1.19. Details are also given in the DoH (Red Book 1990) op. cit.

new premises, which, if acting out of self-interest, they would be likely to make to ensure the least risk and most profit to themselves. Evidence from the national s postal survey conducted for this investigation indicated that GPs tended only to consult with the public when they were concerned to boost custom and usually only in connection with waiting facilities and patient comfort.[9]

Shaw (MAAP, 1997) claimed that GPs should not be owners of practice premises, because it created conflicts of interest.[10] It made GPs over dependent on the fluctuations of the property market and GPs often relied on selling their share of the practice to finance retirement pensions. If the property market was rising, this would make it difficult for junior doctors to buy in, if it were falling they would not want to buy in. This could effectively freeze the employment structure of GPs. Shaw asserted that the use of LIZ money on individual doctors had also been a mistake, because GPS often had unstable partnerships, which split up, and caused the doctors to return to single practices, which was 'throwing money in the wrong direction'. On this point, Barton (Avanti, 1997) had also observed that moving to new premises often caused stress and controversy for GPs, which brought about partnership splits.[11] He had found that GPs in London often seemed reluctant to work in teams, but he considered this a valid position, because they may still be performing a valuable service in small practices. This confirmed Green and Thorogood's (1998) argument about the contribution of small practices cited in Chapter 4.[12]

### 6.1.2 Funding multi-agency centres

Under present regulations, multiple ownership of premises can create serious financial complications. Noble (1996) has observed that although the government's policy intentions for extending and expanding primary care was made clear, the means of procuring the

---

[8] NHS Estates (1994/5) op. cit. Handbook 2, p.12: 3.19
[9] Very few responses cited GP led premises that had involved local communities in consultation processes.
[10] Shaw, C. (1997) recorded interview notes with MAAP architects 18.2.97.
[11] Burton, R. (1997) recorded interview notes with Avanti Architects, 11.4.97.
[12] Green, J. and Thorogood, N. (1998) *Analysing Health Policy* Harlow: Addison Wesley Longman. p. 98-99.

required buildings was not.[13] Noble asserted, 'the increasing emphasis on the provision of broader, more embracing primary healthcare centres has been accompanied by the reorganisation of the NHS, which has fragmented those parts which have key roles to play in healthcare development'.[14]

Although it is possible to establish joint or charitable ownership of primary care centres, several of the architects interviewed during this research had observed there were often difficulties attached in getting multi-clients on board and committed in time to meet funding deadlines. They had observed how often simple things, such as different financial year-ends, and the lack of coterminous boundaries, made joint commissioning difficult. Ownership was most likely to fall to a CHS trust, to GP joint practices, or a third party, with others committing themselves to leasing arrangements or capital contributions. Funding was likely to come from several sources, which could include capital from trusts, or from GPs raised against guaranteed rent, but could also include urban regeneration or City Challenge grants, LIZ capital or charitable grants. Noble (1996) made the point that the question of 'who takes the risk?' was central to this process, as GPs were dealing with personal responsibilities and payments, whereas NHS employees would probably not be. GPs were therefore often reluctant to become involved in projects over which they did not have full control and would generally not put up the whole cost and responsibility for new up-sized primary health care facility themselves. The result in many areas was that no single agency had been prepared to take on the financial risks of larger projects and this had obstructed the development of quality multi-agency health centres.[15]

### 6.1.3 Capital Investment Procedures

When NHS trusts decide to spend money on new primary care facilities they are obliged to seek approval from the Treasury for any capital investment over £250,000.[16] The NHS

[13] Noble, A. (1996) 'The True Cost of Care Facilities', *Architects' Journal* 18.7.96.
[14] Ibid.
[15] Ibid.
[16] NHS Executive (1994) *Capital Investment Manual*, London: HMSO.

Estates has produced strict guidelines that must be adhered to in order to gain approval. These guidelines used to be under Capricode, but are now laid out under the Capital Investment Manual.[17] The process is linked to a business plan, which has to be submitted for approval to Regional Office, and must convince moneylenders that a proposed project is financially viable. The implementation of this system demonstrated the Conservative government's determination to run public sector services along private sector lines.

The Capital Investment Manual was designed originally for major hospital projects rather than primary care facilities. However, most extended primary care and community care projects since the 1990s have come over the £250,000 threshold limit. The scheme has come under criticism by some district commissioning authorities for being too onerous to be applied to primary health care. For some smaller projects preparing a business plan and waiting for approval can hinder innovation and can result in lost opportunities and time delays, so the practicality of this threshold is questioned. On the positive side, it can be argued that business plans do require a demonstration of need and this can lead to a sensible distribution of resources, placing an emphasis on service-led rather than capital-led planning.

### 6.1.4 The Private Finance Initiative

The Chancellor of the Exchequer launched the Private Finance Initiative (PFI), in November 1992, to promote and encourage the use of private sector expertise and capital within the public sector to transfer the risk and increase the cost effectiveness of services.[18] PFI symbolises the radical change in central government's attitude to the involvement of private finance in the provision of public services and the significant culture change within the NHS. In the field of primary care facility development it was not an overnight success and critics of the system have argued that PFI is unsuitable for smaller projects, such as health centres, because it deters projects involving shared ownership and this creates barriers to interagency collaboration.

---

[17] Ibid.

[18] The 'Private Finance Guide' is included in the NHSE (1994) *Capital Investment Manual*, NHS

NHS health authorities and trusts are required to test development proposals for implementation through PFI before approval of the full business case is given and there has to be a clear demonstration that private finance alternatives have been tested.[19] Health Building Note 36 provided some positive arguments for seeking to integrate plans for primary care centres with plans for private or local authority functions. It cited the example that in mixed use developments where the main activity is shopping, for example, an advantage might be that there was an alternative focus for local people visiting the development, which could entice people to drop in on optional health activities.[20]

In recent years, CHS trusts have been involved in various partnerships with housing associations and individual property developers to extend the variety of routes through which premises can be attained. Noble (1996) argued that the suitability of the Private Finance Initiative for providing modestly sized building developments for rental to trusts and GPs had yet to be established. Her concerns included the risk to building quality that may be incurred when the selection of architects and other design professionals was outside the control of service providers, service purchasers, staff or patients, and the pursuit of profits were allowed to compromise the interests of the public.[21] Certainly, a continued and expanded use of PFI for primary health care facilities could lead to a much bigger role for the private sector in service provision. One of the problems that had been observed by the architects interviewed was that the original private developer could sell on the property and this could cause problems for reaching agreements on leases.

Barton's (Avanti, 1997) experience was that PFI had created a money driven process, which meant that the architect had less opportunity for consultation with users.[22] He thought the process was bureaucratic and time wasting, because the architect was compelled to go through various processes, such as having to express an interest and then working up a detailed scheme, before they were told whether they had been selected. The developers

---

Executive 1994.

[19] NHS Estates (1995) *Health Building Note 36: Volume 1* London: HMSO. p.6: 1.12,

[20] Ibid., Vol. 1, p.17: 2.38

[21] Noble, op. cit.

[22] See footnote 11.

became the priority group, rather than the user client, and the process precluded the architect from having contact with the users during the early stages of the project development, because they were in competition with other practices and therefore could not reveal design ideas.

Despite the criticisms of PFI, the Conservative government remained steadfast in their support of it and the 1996 White Paper, *Primary Health Care: Delivering the Future,* continued to urge the health authorities to pursue the use of private sector investment in GP premises and health centres.[23] The first White Paper of the New Labour government (December 1997), *The New NHS, Modern: Dependable,* proposed that health service need should be the key determinant of funding major capital development but the objective was to make PFI work more efficiently, rather than to abandon the principle.[24] An alternative to PFI, which has been put forward by Ham (1996), is to encourage non-profit providers alongside public provision. NHS trusts could then eventually be returned to community and voluntary ownership.[25]

## 6.2. The design process

### 6.2.1 The project brief

In the design process one of the first mechanisms for structuring the project usually comes with the architects brief. The brief defines the clients' requirement and forms the basis for estimating costs and for the design and construction of a scheme. In 1970, Cammock and Adams, working for the Medical Architecture Research Unit (MARU) at the Polytechnic of North London (later UNL), produced a report for a briefing process containing guidelines that remained applicable and widely influential during the 1990s.[26] They emphasised that

[23] Department of Health (DoH) (1996) *Primary Health Care: Delivering the Future,* London: HMSO. p. 46: 6.14.
[24] Department of Health (DoH) (1997) *The New NHS, Modern: Dependable*, London: SO.
[25] Ham, C. (1996) *Public Private or Community: What next for the NHS?* London: Demos, p.7.
[26] Cammock, R. & Adams, S. (1970) 'A Briefing Method for Health Centres', *The Medical Officer,* issues June 12th, July 17th & August 14th.

decisions involving operational and design aspects of the building should be made jointly between the client/user and the architect. They found it regrettable that in so many planning and design situations, clients acted on behalf of unknown people, and that the main concern appeared to be to get a building constructed at minimum cost before the year's allocation had dried up. They concluded that detailed and painstaking assemblage of information, consideration of alternative policies and designs and the evaluation of effects and feedback or knowledge of results, was a rare occurrence. They stressed the importance of written operational policies for the following reasons:

1. They constitute the clients instructions to the architect explaining *what* to provide and *why*.
2. The architect can refer to them to verify functional aspects he/she is unsure about.
3. The more carefully they are construed the less likelihood there is that the client will change his mind.
4. They provide yard sticks against which proposed designs, or design options can be compared.
5. They provide the criteria for assessment for the final design in use.
6. They allow comparisons to be made between the building for which they were prepared and other buildings serving the same or similar functions.[27]

Since then, further practical guidance for health managers required to develop a brief has been issued by NHS Estates in the Health Building Note 2: *Briefing and Operational Policies* and specific advice on briefing for local health care resource centres is found in the LIZ Primary Care Handbook No 2. *Procedures, Procurement and Funding.* [28]

Barton (Avanti, 1997) claimed that since the reorganisation of the health service there was a lack of expertise at the planning level within the health authority that could ensure that the

[27] Ibid.
[28] NHS Estates (1994/5) op. cit., bk.2, pp 23/26.

briefing stage of the process was well executed.[29] Barton explained that in the past the district health authority would usually act as the client for a new health centre. The building would have been commissioned by the works department and headed by a district works officer. The architect would have discussions with the works department, who would set up a project team. This meant that there was a professional client with a body of design expertise.

Barton conceded that there had been problems with this system, in that it was bureaucratic and 'short termist', and there was a tendency for temporary, or 'Portakabin responses' to bridge gaps in services. There was also little understanding of subtleties of design, but the client had known about the processes of procurement, how buildings needed to work, and had been able to write a brief. Barton explained that the changing role of health authorities had meant that DHAs were no longer responsible for managing the provision of services and had instead become responsible for assessment of health needs and purchasing care to meet those needs. As a result, the DHAs had lost the body of knowledge connected to commissioning facilities, and outside consultants had to be brought in to advise the DHA. Unfortunately these consultants often lacked any breadth of knowledge of the locality.

Shaw (MAAP, 1997) thought that the new health commissioning authorities were best placed to provide a brief, but had found that many were unable to provide all the information required.[30] He was concerned that this often resulted in a situation in which the role of developing the brief fell back onto the architect. From a strategic perspective this was not ideal, as the architect was unlikely to have a finger on the pulse of local health requirements and could be tempted to tailor the brief to accommodate his/her design aspirations. Shaw thought that from the health-planning viewpoint another problem was that the architect was usually asked to modify existing GP premises, rather than rethink a whole concept. However, this was not necessarily the best approach, because opportunities could be missed in providing accommodation required for more long-range planning. Shaw suggested that

[29] See footnote 11.
[30] See footnote 10.

more, trained medical health planners were required within the health commissions.

### 6.2.2 Appointing the architect

Once the brief has been decided the next stage in the commissioning process is the selection and appointment of the architect. Before the reorganisation of management in the NHSS, each of the RHAs had an Estates Department with in house architects who had developed skill and expertise in commissioning and designing health buildings. Most primary health care commissions since 1990 have been given to private practices. As a result there has been a small but growing number of practices specialising in medical architecture and in developing designs for larger primary care facilities.

The DoH's (1990) *Statement of Fees and Allowances* (Red Book) requires that a registered architect should produce design proposals for developments under the Cost Rent Scheme. [31] For some of the larger commissions, architectural competitions have been used to select architects. Either open competition has been used, or a selected number of architects are invited to submit sketch plans. This process, although disliked by some architects as being time wasting and expensive, has proved to be a successful mechanism for community and public user involvement. When public users are involved in the selection procedure it can provide an opportunity for design education, whereby the public can begin to understand the complexities of balancing design options with budgetary constraints. For example, the public user team involved in the architectural selection process in the Neptune Park Health project in Sandwell expressed how it had helped them to feel involved in the decision-making of the new facility from the beginning of the project. It had also helped them to understand why some of the choices around the design of the building had been made (Chapter 10. Case Study 4).

[31] DoH (1990) Red Book 1990, op. cit.

*Consultants' fees*

Hoskins (Penoyre and Prasad, 1997) thought that ultimately the client got what they were prepared to pay for and that it was not just a question of selecting the right architect, it was necessary to pay the architect a high enough percentage fee to fully consider the users needs.[32] Hoskins asserted that there was a direct relationship between the quality of the building and the fee. If the fee was too low, for example only 6% of building costs for a modest sized building, then the architect could afford to do little more than adapt a previous scheme to a new site. The particular needs of that group of users would therefore not get a chance to be understood.

Barton's (Avanti, 1997) experience was that architects were being asked to do more and more for less money.[33] He explained that doctors were not sure of the architectural design process and expected a lot from their consultants. They needed considerable time for explaining and reassuring and fee levels were not adequate for this. Competitive fee tendering often resulted in 2 % to 3% being taken from the public consultation process, which was not a lot of money but it bought time and therefore better quality work. Other consultants that might be required in the process and might be brought in by the architect would be the quantity surveyor, the structural engineer and the building surveyor and service engineers. [34] The architects explained that it had sometimes proved difficult to secure enough money for professional fees to design a quality building. This had created pressures for architectural compromises that some practices found hard to resist, or did not have the skill to overcome.

*Building contracts*

The type of building contract the client enters into can affect the quality of the building. Barton (Avanti, 1997) thought that traditional methods of procurement had set up an

[32] Hoskins, G. (1997) recorded interview notes Penoyre and Prasad 13.3.97.
[33] See footnote 11.
[34] NHS Estates (1991), op. cit., p.41. Appendix 2: 5-8

adversarial relationship between the client, the architect and the builder, with the contractors constantly looking for ways of making more money and jumping on unforeseen costs to increase income.[35] 'Design and Build' contracts had largely overcome this problem because the client paid for a total package. This provided an incentive for the contractor to get on and get the building completed, but a new problem, of safeguarding standards of building quality could emerge, if contractors contrived to cut corners and sacrificed the quality of design for matters of expediency. However, recent experiments in managing design and build contracts, which maintained the involvement of the architects' and their design expertise, seemed to be meeting some success.

Barton (Avanti, 1997) explained that the Caversham Group Practice being built in Kentish Town, North London was a Design and Build contract.[36] The contractors were employing an architect to work up a detailed design and Avanti was checking the drawings before giving approval for the work to be carried out. The CHS trust, who were the main client, had preferred this type of contract, because they had thought it would be more certain to stay in budget as there were less opportunities for the contractor to come back for more money. On the other hand, the Caversham GPs, who were a second client, were not happy with the idea of straightforward design and build, so this arrangement was agreed as a compromise intended to protect quality. Avanti had effectively designed the building, but had not executed the working drawings. Barton explained that method of working was only one of several new forms of building contracts that appeared to be emerging that might have financial and quality advantages over previous forms of contract.

### 6.2. 3 The design team

The first stage in the briefing process according to Cammock and Adams was to assemble the user/designer planning team.[37] Subsequent NHS design guidance has been scant on

---

[35] See footnote 11.
[36] See footnote 11.
[37] Cammock, R. & Adams, S. (1970) op. cit.

recommendations to include public or community users in either user or design teams. The LIZ Primary Care Premises Handbook 2 suggests that:

> *A user team will be assembled for each project, made up of representatives of each stakeholder, and encompassing the range of disciplines contained within the centre. A wide mix of skills should be brought to the team, including medical nursing, maintenance and management. The project manager will usually attend and chair user team meetings.*[38]

Although not explicitly excluding community or public users, the inference here is that those influencing or participating in the design team would be staff users. In the next paragraph this guidance suggests, 'the design team will initially comprise the architect and quantity surveyor, and will expand to include the other professionals as the project develops'.[39] Again, there is no suggestion that the community should be represented. The decision to include public users in the design team is therefore left to the commissioning agency's discretion and the evidence of this study is that this then rarely happens. If it does occur, it is usually only as part of a project taking a public health approach to the facility development.

### 6.2.4 NHS Design Guidance

Standards of design for some aspects of primary care centres are now clearly set out in official NHS guidance, but this was not always the case. As the practice of building purpose-built primary care facilities increased during the 1960s, a flow of guidance to try to set standards of design in GP premises and health centres had begun to emanate from various sources.[40] Some local health authorities found it difficult to know which guidance to adopt

[38] NHS Estates (1994/5).op cit. Bk.2 p. 8: 2.12 /2.13.
[39] Ibid.
[40] See for example: Nottinghamshire County Council, (1966) *Health Centres*, Nottingham: Nottinghamshire County Council; British Medical Association, (1966) *Health Centres and Group Practices,* London: BMA;
National Building Agency (1966) *Design Guide for Medical Group Practice Centres.* London: College of

and asked the DHSS for official guidance. Finally, in 1970, the DHSS Welsh Office issued *Health Centres A Design Guide.*[41] The aim of this guide was firstly, to focus attention on those matters that should be considered at the briefing stage and, secondly, to offer guidance on certain design features. The guide outlined the procedures of assessing accommodation requirements for different users and included nineteen sketch plans for health centres, ranging from small centres with less than four consulting suites, to large centres with more than seven.

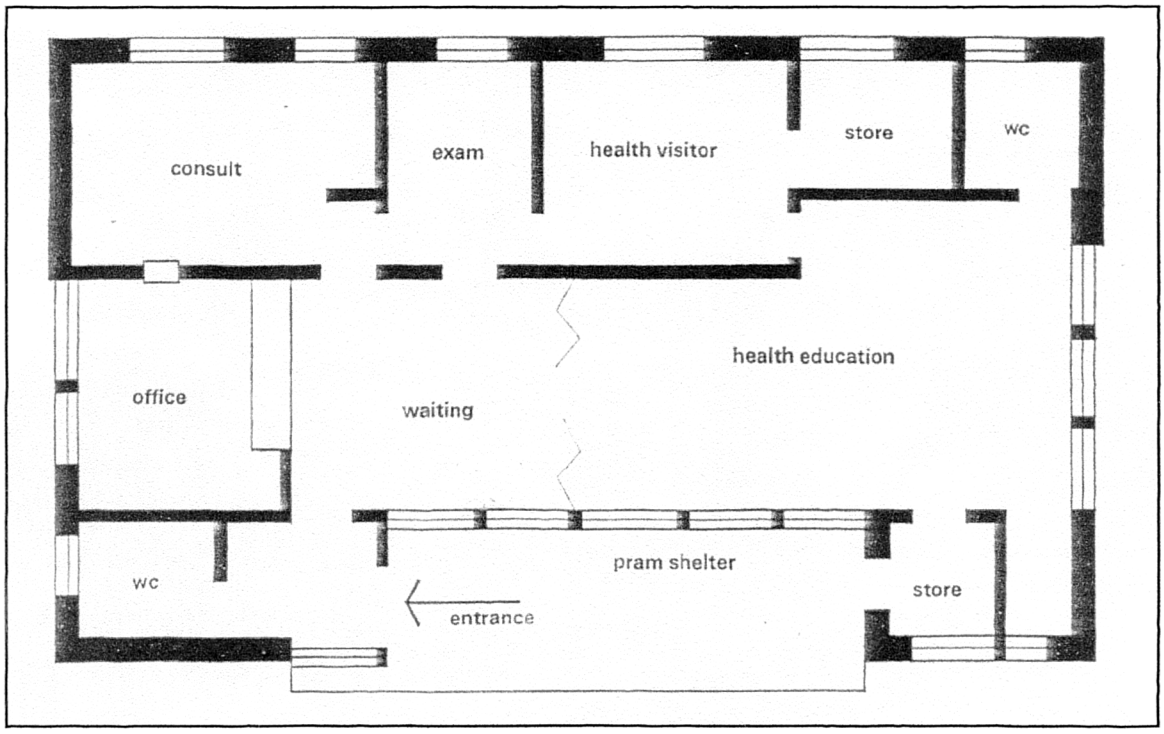



**Figure 6.1 Sketch design for a small health centre appropriate for rural areas.** Source: DHSS Welsh Office (1970).

General Practitioners;
General Practice Advisory Service (1967). *Buildings for General Medical Practice,* London: HMSO;
Medical Practitioners Union (1967) *Design for Family Doctoring,* London: Medical Practitioners Union.
[41] DHSS - Welsh Office (1970) *Health Centres - A Design Guide,* London: HMSO.


**Figure 6.2 Sketch design for a large health centre.** Source: DHSS Welsh Office (1970).

These sketches were not intended as model plans because health centre design was considered to be still evolving, as indeed it still appears to be doing. There was also no recommended optimum size for a health centre, but it was considered to be an organisational advantage if a centre could accommodate between 6-12 doctors, caring for between 15,000 and 30,000 patients. Interestingly, this guidance pointed out that if a centre was to cater for more than 25,000 patients it would become necessary to duplicate many facilities such as reception, waiting areas and treatment rooms in order for the building to avoid becoming

institutional. [42] There was already concern that a primary care facility should avoid becoming institutional by operating at a particular scale, but as these examples show the models are totally based on a GP-led, medical facility. Beattie (1974) suggested that the state of the art in design and design guidance for health centres had remained primitive as a consequence of a lack of clarity about the functions and structures of primary care facilities.[43]

In 1970 the DHSS published guidance on health centre design intended to ensure that local authorities built to an acceptable standard of accommodation and to an appropriate cost limit.[44] Cammock's (1973) criticism of this guidance was that the methodology used had based recommendations on room types and dimensions of the best available existing case studies. This meant there was no attempt to analyse user's needs, or to forecast any changes likely to result from merging previous types of accommodation. Cammock attempted to rectify this approach by analysing the functional requirements of a primary health centre and to design accommodation based on an understanding of use. Cammock's ideas on zoning are discussed further in Chapter 8.

Since the 1960s, NHS Estates, the Executive Agency of the Department of Health has been responsible for issuing most official guidance on all aspects of health estate management development and maintenance. The more recent guidance particularly relevant to designing primary health care facilities includes Health Building Notes (especially 36, 40,46,), which provide advice for project teams procuring new buildings and adapting or extending old buildings. The Health Building Note (HBN) series has been written with the intention of providing advice on the briefing and design implications of departmental policy. They are usually prepared in consultation with representatives of the NHS and appropriate professional bodies. Much of the work is now contracted out to independent agencies. For example, in 1991 the Medical Architecture Research Unit at the University of North London produced HBN 46, 'General Medical Practice Premises', which was intended to assist GPs

[42] Ibid p 6: 3.2.
[43] Beattie, A. (1974) *Alternative Strategies of Space Organisation in Health Centres,* Project No 2. Unpublished lecture notes. Postgraduate Health Facility Planning Course. MARU/UNL.
[44] DHSS (1970) op. cit.

and their architects in understanding the problems and principles involved in building new premises, or in converting or refurbishing existing premises for general practice. HBN 46 expanded on Cammock's ideas and analysed the functional requirements of primary care buildings into a 'three zone model' in which functions of the building are divided into 'public', 'clinical' or 'administrative'. The purpose of this separation is to maximise patient privacy and confidentiality, an issue that is discussed further in Chapter 8.

Following Health Building Note 46, the Medical Art and Architecture Practice (MAAP), was contracted to write Health Building Note 36 (HBN36).[45] In 1995, Volume 1 of HBN36 was published with the stated aim 'to provide guidance for the planning and design of primary health care centres and local health care resource centres in the community.[46] Volume 2, *Local Facilities in Health Care* was published in 1996 to appraise a series of case studies against the published guidance in volume 1. Another important source of guidance during the 1990s was the London Initiative Zone Primary Care Premises Handbooks, which were commissioned by NHS Estates from MARU.[47] This series offered advice on the strategic planning of local health care resource centres and, although most of the guidance was nationally applicable, there was a special reference to needs and conditions within the London Implementation Zone.

The architects interviewed for this research attributed varying levels of importance and usefulness to official design guidance. They generally appeared to refer to it and rely on it for information about more specialist areas, such as treatment rooms, or physiotherapy, and it was often used as a checklist, or for background information. However, the point was repeatedly made that this information needed to be used in conjunction with first hand observation and consultation, because each building was unique and therefore no single standard was applicable to every situation. Despite the availability of guidance, a common criticism from those architects interviewed was that some architectural practices appeared to have been more interested in putting on displays of aesthetic prowess when designing

[45] The Health Building Note series was not produced in numerical sequence.
[46] NHS Estates (1995), p.5: 1.1

primary care buildings, than considering the more mundane spatial requirements involved in health facility design. Few had bothered to make first hand observation of users activities and as a result the spaces in some health buildings looked good superficially, but were wasteful of space and had practical drawbacks for users. Another problem was that unless design guidance was understood and utilised, mistakes were unnecessarily repeated, for example through a lack of appreciation of features that respected patient confidentiality and privacy.

## 6.3 **Conclusion**

This chapter has attempted to outline and assess the impact of some of the main commissioning and design mechanisms on primary care building development since the NHS reforms. Overall mechanisms such as Cost Rent can be seen to have supported the governments' main intentions to encourage a GP dominated and privately owned primary care service, while the advancement of multi-agency centres appears to have been hindered by structures such as PFI. The emphasis on public/private partnerships appears to have resulted in missed opportunities for collaborative inter-sectoral schemes, because financial complications had led to some being abandoned, while others were compromised. It has also did nothing to encourage community involvement in the decision-making process, as demands for profitability rather than fine tuning to respond to public requirements took precedence. The 1996 White Paper, *Primary Health Care: New Directions*, went some way to sort out some of the anomalies in the original proposals, but further action to readjust the levels of risk transfer was regarded as necessary to make private finance easier to attract.[48] Since the appointment of the Labour Party to government in 1997 the ethical and financial appropriateness of private finance to be used in public service projects has been questioned once again, but by the middle of 1999 there had been no sign of this policy being reversed.

---

[47] NHS Estates (1994/5) op. cit.

[48] DoH (1996) *Primary Health Care: Delivering the Future*, London: HMSO.

Although the architects interviewed during this research acknowledged central design guidance as useful in setting standards for the design process, they also considered factors extraneous to design, such as facility and project management and adequate funding, were equally vital to the building's success. They especially regarded the loss of health authority in-house architectural expertise and the resulting insufficient briefs as operating against good facilities being built. Their identification of specific design factors that they considered might be used to evaluate facilitation of social objectives in primary care buildings is a focus of Chapter 8.

## Chapter 7
## THE SOCIO/GEOGRAPHIC INTERFACE BETWEEN PRIMARY CARE BUILDINGS AND COMMUNITIES

The framework being used for this social analysis of primary care buildings involves investigating the specific *mechanisms* and *contexts* in which the buildings are developed.[1] The previous chapter explored the impact of commissioning and design process *mechanisms* influencing building development through the implementation process of central policies and Chapter 6 explored the historical *context* of primary care building development. This last chapter of the first part of this dissertation will explore the influence of the socio/geographic *context* of primary care buildings and, referring back to the main analytical elements of the investigation, it will focus on the conceptual and organisational interface between primary care buildings and 'community'.[2] In this chapter I will propose that in part the lack of coherence and diversity that has marked primary care facility development can be traced to confusion and conflict in interpretations of 'community' and a lack of consensus over who, in what way, and which geographic areas, facilities should aim to serve.

First, this chapter will consider some of the ways that the ideas of primary care and community have been linked. It will attempt to illustrate that, although the idea of a 'community' context was central to much of the rhetoric about primary care facilities during the 1990s, in reality the use of the term 'community' in primary care rhetoric has masked a multitude of competing and conflicting political and professional interests. Second, it will outline historical attempts to distribute primary care resources equitably to communities throughout the country. Third, it will argue that for historical and political reasons, introduced in previous chapters, primary care facilities have developed two distinctive socio/geographic organisational interfaces with local communities. One of these is

---

[1] See Introduction, Figure 0.2 for a model of the analytical framework of primary care buildings.
[2] See Introduction Figure 0.1 for model of main analytical elements.

*neighbourhood-based,* and attempts to meet a range of health needs of a population within a designated immediately adjacent geographical area, the other is *practice-based*, and attempts to meet the health requirements of a restricted number of individual patients drawn from a wider geographical area. Although, these are not exclusive definitions and some facilities contain elements of both models, for example by being practice-based but operating within a restricted geographic boundary, this chapter will argue that these different organisational models can have significant implications for the planning and architecture of primary care buildings and for addressing inequalities. This is because the facilities are essentially serving different purposes, with a different balance of relationships and use of internal space by staff and providing a different interface with the local community.

## 7.1 Defining community

Health policy rhetoric during the 1980s and 1990s frequently linked the concept of 'community' with primary care services and facilities, especially in connection with strategies such as 'Community Health Services', or 'Care in the Community'. It was also suggested that facilities should be targeted to meet the needs of local communities and be accessible to those communities.[3] What was not made clear was how those communities should be identified or defined.

The concept of community has been contested in many disciplines, including anthropology, sociology, social psychology, architecture, geography and land-use planning, as well as in health policy, with little consensus so far achieved. There are many publications that explore wide ranging definitions of community that this study will not attempt to repeat, however, this proliferation itself indicates the inherent difficulty of using the term in connection with a practical issue as primary care facility planning and resource distribution.

Clarity about the catchment area and the population to be served by a facility needs to be

[3] For examples, see DHSS (1989) *Caring for People: Community Care in the Next Decade and Beyond*, London: HMSO; and DoH (1996a) *Primary Care: The Future,* London: HMSO. 6.12

sought if public users are to understand their legitimate access to facilities, and practitioners are to collaborate efficiently to provide care. Yet some social commentators have argued that the extremely subjective way the term community is used renders it almost meaningless. Among those less dismissive there is some agreement that there are at least two identifiable categories of community. One category linking people socially, through shared experience, special interests, or shared identity, as in sexuality, race, gender or disability, and the other having a spatial or geographic dimension,[4] The exact relationship between these two categories however continues to be debated, although probably most usefully some social commentators have suggested that they are not mutually exclusive but overlap, interrelate and can even complement each other.

*Neighbourhood /community*

Community sometimes appears to be used in relation to primary care services and facilities to mean something similar to 'the local neighbourhood'. Bulmer (1986) and Wilmott (1987) have both suggested that much of the confusion over the term community has developed from the common interchangeable use of the term communities with neighbourhood.[5] A study of factors in local spatial identity undertaken by Middlesex University (1994) suggested that it may be *helpful to consider* 'neighbourhood' as a social/ spatial concept, a 'place experienced from within' and 'community' as a 'network of people with a sustained recognition of voluntary common interests'. However, this report also recognises that community has a spatial aspect.[6]

Historically, many influential figures in urban planning, for example; Clarence Perry, Raymond Unwin and Charles Cooley, and Ebenezer Howard, held strong views about

---

[4] Ravetz, A. (1980) *Remaking Cities,* London: Croom Helm, p.273.

[5] Wilmott, P. (1987) *Friendship Networks and Social Support,* London: Policy Studies Institute; Bulmer, M. (1986) Neighbours: The Work of Philip Abrams Cambridge University Press 1986

[6] Middlesex University (1994), *Place and Local Identity: A Study of Factors in Local Spatial Identity* London: Planning Advisory Committee (LPAC) p. 8. S.2.3.

neighbourhood and community planning.[7] Some of these town planners believed that it was possible to create communities through appropriate planning of the built environment. Sir Patrick Abercrombie wrote in the Greater London Plan, 1944, that the 'social arguments for community planning are now fairly accepted', but his approach was essentially top-down decision-making, rather than community planning that involved the participation of local people.[8] After the war, the establishment of NHS primary care health facilities in newly planned communities was usually regarded as fundamental, and health centres and clinics were usually placed at the hub of new developments, sited alongside other public facilities, such as libraries, or shops.

More recently, the concept of top-down planning of communities has become discredited. Hillier and Hanson (1984) criticised post war planners for having social objectives but unsociable results, citing, for example, how they replaced outward looking traditional street patterns with inward facing housing estates, which ignored the fact that social identification and spatial integration often worked in contrary directions.[9] Evans (1994) has argued that in modern urban environments there was no longer such a thing as a 'local community' in any meaningful sense and that it was probably inadvisable to try to recreate it.[10] He proposed that the problem was not how to build communities, but how to encourage stable and self-regulating neighbourhoods and argued that for people to be interested in participating in local decision-making they needed to have a stake in the neighbourhood, which was either financial or social. This would suggest that effective and democratic community involvement in primary care planning and design may be dependent primarily on the extent to which all social groups in the locality can identify themselves as stakeholder citizens.

---

[7] Examples of planned communities are the Garden Cities created by Ebenezer Howard, Bourneville, created by the Cadbury family, and Port Sunlight created by the Quakers.

[8] Abercrombie, P. (1945) *Greater London Plan: 1944*, London: HMSO.

[9] Hillier, B. and Hanson, J. (1984) *The Social Logic of Space*, Cambridge University Press.

[10] Evans, B. (1994) 'Planning, sustainability and the chimera of community', *Town and Country Planning*, April, 1994, pp. 106-108.

*Locality / community*

Another term that has increasingly and often confusingly entered health policy rhetoric is *locality*, which is sometimes oversimplified to refer to the organisational structure required for an efficient service delivery. Peckham, Taylor and Turton (1998) have argued, a locality approach can 'either refer to a geographical locality that reflects real historical communities.... which makes sense to the people who live there, or it could be used as a community of interest (e.g. people with the same health problem).[11] They pointed out that this 'clearly raises questions about the appropriate focus of locality in grouping practice populations, for example in 'Multi-Funds', or 'Total Purchasing', or 'in developing geographical population bases, as in 'Locality Commissioning'.[12] A further problem with using the term 'localities' based on practice populations is that these do not necessarily correspond to people's identification with geographic areas.

*Social diversity /community*

There can be differences and conflicts of interest both within and between geographical and shared interest communities. Burns, Hambleton and Hoggett (1994) proposed that community was 'not necessarily a force for good' and that 'sometimes it could take on an extremely defensive, even selfish form and be used as a means of excluding unwanted groups'.[13] Kelly and Thorpe (1993) pointed out that the term community implied a homogeneity that belied the potential complexity and conflict within social groups.[14] They proposed, however, that people's different views could be regarded as a rich resource and presented an opportunity to embrace and work with diversity, rather than it being seen as

---

[11] Peckham, Taylor and Turton (1998), *Primary Care and Public Health Project,* Draft Summary, Public Health Alliance, p.55.

[12] Ibid., p.55. See also Chapter 4 for a explanation of these initiatives.

[13] Burns, D, Hambleton, R. & Hogett, P. (1994) *The Politics of Decentralisation* London: Macmillan, p.226.

[14] Kelly, L. and Thorpe, M. *Setting the Context: A Brief Overview of Sociological Uses of the Concept of Community,* unpublished paper for the Catchment and Community Research Unit, University of North London.

a source of conflict and exclusion. They suggested that every 'community' contained within it a variety of unequal relationships, which informed, if not always determined, individual and social experience. They claimed that every community had to be created and sustained, even those directed towards maintaining the status quo. They proposed that a useful definition reflecting this potential was that of 'community as possibility', something to be struggled for, and created from within. This concept draws on the model of radical community development originating in the work of Saul Alinsky (1971) in Chicago[15] and Paulo Friere (1976) in Latin America,[16] who both saw education as the key to the creation of communities that could then be directed towards social change. This raises the idea that will be returned to in Chapter 9 that community involvement in planning and designing primary care facilities can be regarded as an educative process that can empower local people to improve their own environment.

There has been an increasing awareness in some health districts of the need to develop strategies to ensure that minority communities and special interest groups become represented in locality purchasing consultation. It is also being recognised that proactive consultation requires a commitment from the top down and that if representatives from small and disadvantaged communities are to be involved in planning health facilities then strategies to involve them need to be culturally sensitive. Factors such as convenient time-tabling of meetings, access, transport, interpretation and reimbursing carers for child care costs, have to be considered and included in budgets.[17] Some health policy commentators have highlighted the lack of awareness that new immigrants, for example refugees from rural areas or developing countries, may have of the choices available from a European urban health system, which can be radically different from the health services they experienced before. [18] These groups may need information, translation, interpretation and advocacy

---

[15] Alinsky, S. (1971) *Rules for Radicals: a Practical Primer for Realistic Radicals,* New York: Random House

[16] Friere, P. (1976) *Education the Practice of Freedom,* London: Writers and Readers.

[17] McIver, S. (1992) *Obtaining the views of Black Users of Health Services* London: Kings Fund.

[18] For example the experiences of Vietnamese refugees from Save the Children's Deptford Vietnamese Health Project, reported by Tang, M. & Cuninghame, C. (1998) 'Ways of Saying' *Health Service Journal* 15.9.98, pp. 28-30.

before they can access resources appropriately.

*Politics /community*

Politically, the term community has been used both to invoke ideas of nostalgia and traditional conservatism and to invoke a radical vision of the future. The acceptance or not of the idea of community and support for the rights of a collective voice in decision-making at a local level has fundamental implications for politicians. As argued in Chapter 2, Conservative governments since 1979 have placed increasing focus on individual identity and individual consumer rights rather than collective rights within society. Thatcher famously denied the existence of society (the widest sense of community)[19] and under Major's government an apostrophe was carefully placed in the phrase *The Patient's Charter* to indicate a consideration for the singular patient in preference to a collective *The Patients' Charter.*[20] Other politically right-wing attitudes towards community tended towards a nostalgic recalling of the past or positing idealised forms of human interaction and connection. For example Prince Charles' plans for the model village, Poundbury, Dorchester, which were based on a nostalgic image of traditional village life and social cohesion. Such attitudes have often projected a model of responsibility in which the 'community', rather than government policy, were blamed for a breakdown in law and order e.g. the riots in Brixton (April, 1981) and at Broadwater Farm (October, 1985), but perversely rarely awarded communities with greater powers and resources for well-functioning neighbourhoods.

Traditional left-wing politics have tended to harbour concepts of communities as collectively oppressed, 'shared interest' communities, as in 'mining communities', 'the working class community', or 'global sisterhoods'. The purpose of strengthening communities in this context has been to combat the oppression rather than a bid for greater local democracy. Taking what is often described as a centre-left approach, Tony Blair is reported to have been

[19] Thatcher, M. (1987) Interview, *Women's Own,* 31.10.
[20] DoH (1992) *The Patient's Charter,* London: HMSO

influenced by the philosophy of communitarianism – the taking on of civic responsibility in exchange for opportunity.[21] One of the major exponents of communitarianism, the American, Amatai Etzioni, believes greater responsibility should be invested in communities and argues that a community, however small or large, has the right to discipline itself and to police the social behaviour of its individual members.

> *We must call for new communities, more pluralistic in form. People can and should be members of several communities at work, in the family, the neighbourhood. ... such communities are still viable but they need shoring up. That is the role of government to determine what you can and cannot localise. You nourish communities by giving them responsibilities.*[22]

Effusive rhetoric, as used in the above quotation, has been criticised for presenting homilies and confused ideas, rather than coherent policy, but it does demonstrate a supportive attitude towards community empowerment and involvement in local decision-making that should include issues, such as health services and facilities. There are also some new social movements, which appear to support the process of community involvement, perhaps without full awareness as to where it might ultimately lead politically. For example, it is argued that democracy is fundamental to the concept of *sustainability*, which is a concept gathering all party support and there have been increasing calls for bottoms-up or neighbourhood approaches to urban planning.[23]

## 7.2 Geographic distribution of primary care facilities

One of the principal objectives of the policies to strengthen primary and community care was to locate more health services, previously found in acute hospitals, in community located facilities. It was primarily argued that this would make more economical use of the limited

---

[21] See Walker, M. (1995) 'Community Spirit' reported interview in *The Guardian*, Society 13.3.95 pp. 10/11.
[22] Ibid.
[23] Evans, op. cit., p.108, and Burns, Hambleton and Hoggett, op cit, pp 81-107.

NHS budget, but it could also be commended as being more convenient for local communities by reducing travelling time for patients, carers and outreach workers.

However, unlike the District General Hospital system, which was established to serve defined areas and catchment populations, primary care facilities have never been centrally planned to relate to recognizable communities within distinct geographical areas, although some health centres were planned specifically to serve new towns or new urban housing estates and some rural areas GP practices did cover an entire territory.[24] Neither, as argued in Chapter 2, was an equitable distribution of primary care facilities ever a key objective of the Conservative governments (1979/97), which, with some limitations, had allowed market forces and GPs willingness to invest determine the pattern and distribution of facilities.[25] As a result, some local communities have developed a relatively good range of primary care facilities and services within easy distance, while others have not. In addition, as I have also argued earlier, primary care services are often run by agencies operating different catchment boundaries and with local residents, who do not necessarily share the same boundary concepts as their service providers, which causes additional inconvenience and confusion. [26] It can therefore be argued that, despite the ambitions of the NHS founders to create equitable distribution of resources and standards throughout the country, health policy-makers strategists have failed worse in developing strategies to meet this objective than similar strategies in other public sector services, such as for a network of comprehensive secondary schools.[27]

There were significant, if flawed, attempts by the Labour government during the 1970s to address the question of equity in the geographical allocation of resources from the central fund. In 1976 the Resource Allocation Working Party (RAWP), which had been appointed

---

[24] See Chapter 6 for a more comprehensive analysis of the development of the network of primary care facilities.

[25] This argument is more fully debated in Chapter 3.

[26] See Chapter 4 and Middlesex University, op.cit.

[27] Buxton, M. & Klein, R. (1978) *Allocating Health Resources,* Royal Commission on the National Health Service Research Paper no.3, London: HMSO.

by the DHSS in May 1975, proposed a formula based on population size and weighted with Standardised Mortality Ratios (SMRs), to reflect the relative need for services in different parts of the country.[28] The RAWP's proposals, however, focused only on hospital and community services, not primary care services, and only dealt with inequalities at a regional level. They were not designed to tackle inequalities within regions and were criticised among other things for being unable to tackle inequalities between social groups or between different types of resources being provided for similar services.[29]

A system developed in the 1980s to mark deprivation in the consideration of social inequalities in health, which could be applied to primary care planning, was the Jarman Indicator.[30] Under this system, the mean score for wards in England and Wales was set at zero and positive scores denoted a higher than average level of social deprivation and negative scores denoted a lower level. The Jarman measurement was also criticised for being a crude measure, as it was unable to allow for the large socio/economic differences within wards, so that health centres or GP practices may receive the same allocation for very different catchment populations. However, it was widely used as an indication of community deprivation after the new GP contract was introduced in April 1990.[31]

Accurate and appropriate demographic information and projections are vital for the successful planning of health facilities. Reliance on city-wide, or even local authority, statistical averages can hide enormous variations between different neighbourhoods. Local infra-city comparisons are needed to enable interventions to be more effectively targeted. However, the information available to district health authorities based on the national census is often inadequate, particularly about information on sub groups at neighbourhood levels. The national census is only conducted every ten years and quickly becomes inaccurate, particularly in inner city areas where the population is more mobile.

---

[28] NAHA (1980) 'Resource Allocation' *NHS Handbook 1980*, Section 2.2, Birmingham: NAHA

[29] Whitehead, M. (1992) 'The Health Divide', *Inequalities in Health,* London: Penguin, pp. 285-6.

[30] Jarman, B. (1984) 'Underprivileged Areas: Validation and Distribution of Scores' *British Medical Journal*, 289, pp.1587-92.

[31] Whitehead, M. (1992) 'The Health Divide', *Inequalities in Health,* London: Penguin pp.285-6

One factor that has made it difficult for NHS management to achieve equitable allocation of primary care resources throughout the country has been that three quarters of the General Medical Services (GMS) resources, which are not cash limited, follow GPs, who are not distributed fairly around the country. In some health authorities there are over a third more GPs per head of population than in other areas and in some parts of the country expenditure is almost two thirds higher than elsewhere.[32] The Medical Practices Committee (MPC) has traditionally been responsible for ensuring a fair distribution of doctors throughout the country, based on an expected case load of around 2000 patients per doctor. However, in reality the MPC has been more successful in preventing doctors from setting up practices, where needs were already being met, than encouraging them into less popular locations.[33] They were also unable to regulate the quality of the doctors operating in different locations. In the mid-1990s, the BMA reported difficulties in recruiting doctors, especially in the most disadvantaged inner-city areas.[34]

After 1992/3, district health authorities were allocated resources by the Department of Health according to a formula based on the size, age and health, of their resident population with an extra allowance made for the higher costs of providing services in the North and South Thames Regions. Although most of this funding took the form of block grants, some resources were set aside for spending on specific purposes, usually promoting national policies identified as priorities by Ministers. Notable examples in recent years have been the AIDS programme, services to combat drug abuse, joint finance money, and funds for developing GP practice teams and improving premises. The 1997 White Paper, *The New NHS Modern: Dependable,* produced by the Labour government, proposed a new Advisory Committee on Resource Allocation and new mechanisms to distribute NHS cash more fairly and based on need. It also included a new national formula to set shares for Primary Care

---

[32] DoH, (1996c), op. cit., p. 35: 5.10.
[33] .Ibid.
[34] Milhil, C. (1996) 'Dwindling GPs "mean crisis ahead for NHS", *The Guardian* 22.2.96 p.9.

Groups.[35] However, some more left-wing advocates will continue to argue that without major redistribution of wealth through taxation and other radical change to power structures in society, health inequities between communities will remain, even if resources are distributed more fairly.

## 7.3 Health professional catchment areas

The rational behind health catchment areas is that medical services and systems require geographic boundaries appropriate to the task they have to fulfil. In the latter part of the 19th century, the concept of the district hospital was developed to provide people in a particular area with essential institutionalised care for more common serious ailments. In the 1930s and 1940s it became clear that there were some even rarer medical conditions, which required more complex technology and specialised skills than each district hospital could provide, and the idea of regional planning for services to treat these conditions was born. The concept of health neighbourhoods is more recent and this new operational tier has become particularly important for primary care and 'care in the community' ideals. However, there has been criticism that health neighbourhoods are often created to fit the practice populations of GPs and other health professionals, rather than in accordance with neighbourhoods as understood and used by local people.[36]

People who can enrol as a NHS patient at a primary medical care facility must usually live within the catchment area of the GP or health centre. Individual GP lists are restricted to around 2000 patients and people living locally can be excluded if lists are full. Also, patients may become excluded if they subsequently move beyond the catchment boundaries. These boundaries however are rarely fixed and can increase and decrease as the popularity or capacity of that health facility changes, or as the local population fluctuates.

It can be argued that GP practice-based systems may benefit some socio/economic groups

[35] DoH (1997a) *The New NHS: Modern, Dependable*, London: SO, p.70: 9.6.
[36] Middlesex University (1994), op.cit.

more than others, which operates against providing an egalitarian service. Dr Nic Rea (1995) discovered a correlation between class and the distance from the centre that users lived.in a survey of Kentish Town Health Centre users, Rea's findings indicated that middle-class users were prepared to travel the longest distances to use the health centre, but that there was a more even distribution of class within the most immediate locality. This suggests that middle-class people are more likely to select a health facility through choice than convenience. The users from the longer distances were also most likely to attend the centre by car, so access to private transportation may also play a part in this choice.[37] Also private patients of GPs have no geographic constraints.

Another disadvantage of a practice-based system, as the Cumberlege report (1986) pointed out, is that the catchment areas of medical professionals operating from the same building can be very different.[38] GP practices do not necessarily relate to one specific local area or neighbourhood, but have lists of patients who can live miles apart and even across different health authority boundaries. Community nursing teams on the other hand are allocated to specific neighbourhoods. This has produced a mismatch in operating procedures, which causes inconvenience to users and wastes resources, particularly through professionals visiting users in their own homes. It can also facilitate against the concept of inter-professional working within primary care centres. The Cumberlege report argued vociferously for establishing a network of neighbourhood nursing services with neighbourhoods comprising of between 10,000 – 25,000 people.[39] The report also called for an end to the anomalous situation whereby '15 or 20 different general practitioners may be caring for as few as 50 households in one tower block, with the result that many different health visitors will be calling at the same location.'[40]

---

[37] Rea, N. (1995) *Use of Kentish Town Health Centre according to distance of residence from KTHC , mode of transport, reason for choosing KTHC and social class.* Unpublished survey.

[38] Cumberlege, J. (1986) *Neighbourhood Nursing- A Focus for Care, Report of the Community Nursing Review,* London: HMSO.

[39] This was based on an early yardstick for determining the catchment area for health clinics in urban areas was that they should be within 'pram pushing' or easy walking distance.

[40] Ibid., p. 14, citing Acheson Report (DHSS ,1981)

Primary care facilities that do not include independent, i.e. non-salaried, GPs can operate a neighbourhood-based system more easily. However, in multi-agency centres some services, such as counselling or health therapies may need to be available to more extensive catchment populations than those covered by neighbourhoods, in order to make a viable service provision. For example podiatry, minor injury units, or outpatients clinics, may be the headquarters for services covering a regional area. Therefore multi-agency primary care centres may need to operate at different levels, for example, as a community facility for local residents, but accessible to a wider catchment population for some services. This would still maintain an essentially geographic/locality approach to primary care delivery planning.

One of the arguments against adopting a neighbourhood-based system with coterminous boundaries for health service and local authority providers is that it would activate against individual choice and would disrupt existing arrangements. The arguments for it are to help provide 'seamless' care across service providers and to help build stronger, healthier sustainable communities, where the needs of the community, rather than the convenience of the professions, is the starting point. Here again the argument pivots around the principles of individual choice versus collective benefit. The chosen direction of the Conservative government since the reforms was decidedly towards a practice-based system to maintain the right of individual choice of GP, rather than a neighbourhood or locality-based facility that might have facilitated more co-ordinated care to members of local communities.

Some movement towards more compatible organisational polices within, if not between the NHS management structures and local authorities has begun to take place. The merger of FHSAs and District Health Authorities (DHAs) was completed in 1996. This has meant that Community Health Scrvices and GP services are now managed by a single authority. The idea of neighbourhood planning appears to have gaincd popularity in local government and has become linked with renewed interest in decentralised decision making.[41] The move towards unitary local authorities has also helped the process of integrating social services

[41] Evans, op. cit., p.108

and housing, but this has still left family doctors and social services under different management structures.

Local authorities in London and other cities are subdivided into electoral wards. Local authorities commonly talk about local communities and local neighbourhoods in ways that refer to their own geographical constructs, and they usually allocate resources according to geographic ward boundaries, rather than to smaller subdivisions, or communities as perceived by local people. The Middlesex University report (1994) recommended that local authorities should adopt a more sensitive understanding and mapping of local neighbourhoods and communities.[42] It suggested that notions about the exact nature of community can be influential in deciding how far authorities believe health facilities should be centrally and strategically planned and how much they can, or should be community-led.[43]

The report observed that town planning theorists have tended to take two main approaches towards urban analysis. One approach has been to view the city as a whole and then to consider the role of the component parts to meet the overall needs of the city. This requires the type of central strategic planning that has taken place in the construction of health service catchment areas. In practice this can mean that the needs of the individual parts are sacrificed to the good of the whole. The other approach views the city as the sum of its parts and believes it is this which gives the city its traditions, vitality, identity and strengths. Supporters of this view argue that this approach would ultimately result in a more holistic urban environment. The disadvantage can be that access to resources can also end up being unequal, for example, with minority health needs not being met because there is too little demand in smaller catchment areas. The limitations of both these approaches suggest that

---

[42] Middlesex University, op. cit., p.113

[43] Ibid., p.113-114. Recommendations included:

1. Boroughs should institute a process by which communities and neighbourhoods as perceived by residents may be identified and mapped.
2. Boroughs should set out this process within a policy context combining the mechanisms of: a) Neighbourhood based UDPs; b) A Community Development Strategy.
3. Neighbourhood definition should be regularly reviewed to ensure it remains relevant.
4. Guidelines concerning UDP preparation should be reviewed to promote a neighbourhood based approach to planning.

neither a locality nor a regional approach is adequate and that a combination is required to ensure that both local and wider range requirements are met.

The demographic argument that has been levelled against returning health commissioning to local authority control, a subject discussed previously in Chapter 3, has been that the catchment areas of local authorities are not large enough to commission acute health care, particularly in the high cost, high tech specialities, such as neurosciences, radiotherapy and cardio-thoracic surgery.[44] Any move to bring such services under local authority control is therefore likely to be resisted by the BMA, the medical Royal Colleges and many NHS managers. The pressure of technology, high unit costs and greater volume of treatments is pressurising the NHS to move towards larger purchasing authorities, serving populations on average of over 500,000, which are much larger than most local authorities.[45] However, it is still conceivable that primary care could eventually come under local authorities while acute care remained a national, centrally organised service.

In future, Primary Care Groups (PCGs), are expected to be dealing with an average population of 100,000 (i.e. ten times larger than the neighbourhoods suggested by Cumberlege), and will require the co-operation of approximately 50 GPs and between 10 /15 separate practices.[46] This will mean that PCGs will cover an area much larger than those identified by the public as within their community boundaries and will encompass disparate neighbourhoods with different health priorities. This is bound to create new conflicts of interest, but may also provide an opportunity to revisit the idea of neighbourhood facility planning.

### 7.4 Public perceptions and experience of community and neighbourhood boundaries

The public can have different perceptions of community boundaries or neighbourhoods from

[44] Warner, N. (1994) 'Care Shared', in *The Guardian*, Society, 2.11.94, p.8.
[45] Ibid.
[46] DoH (1997a) *The New NHS: Modeern, Dependable*, London: SO, p. 37 5.16

each other and from official local boundaries and medical catchment areas. People living on the boundaries of official catchments can experience particular problems and confusion. The Middlesex University study (1994) showed how borough or ward boundaries rarely conform to the diffused areas recognised by local people as being in, or out of, their neighbourhood.[47] They found that people usually perceived their local area on different levels. First, as being very localised – a few streets covering an area much smaller than wards and, second, a larger area, which may include a local shopping centre, transport station or other core facilities, but unrelated to ward boundaries or other official boundaries. The evidence showed that in public perceptions, geographic communities are as likely to be influenced by personal social factors, such as where their friends and relatives live, which group of shops they prefer, and where children are at school, as by physical features such as main roads or the distance radius from a central point.

Actual use of a local area can confound the commonsense views of professionals, who have no first-hand knowledge of the area. At a meeting in south Islington in 1995, held to discuss plans for a new health centre to replace one in Bath Street, the Camden and Islington Health Authority representative was surprised to learn from the local people that they would rather have a new centre sited across a major road, than in an industrial area adjacent to the residential area that the HA had been considering. Local people regarded the industrial area as being poorly served by public transport and unsafe and isolated at night. They did not identify it as being within their traditional community boundaries and the authorities were urged to consider a different site.[48]

Some social groups have reportedly had difficulty in accessing primary care resources or becoming included in planning health services. The homeless, travellers, sex workers and alcohol and drug addicts, may face attempted social exclusion by other community groups. An example of this occurred in King's Cross, London, when a battle was fought over the location of a clinic that the authorities wanted to establish to serve sex workers and drug

[47] Middlesex University (1994), op.cit.

[48] Interview notes Dave Lee, Chief Officer of Islington CHC. See Appendix 1.1.

addicts, who were not being adequately served by mainstream health services. Opposition was launched by some local residents and businesses, who believed that the facility would increase rather than decrease problems in the area. The health authority and others representing the special needs groups argued that those members of the community had as much right as anyone else to appropriate facilities.[49]

Perhaps unsurprisingly, some of the most ardent support for radical changes to the relationship between communities and primary care has come from individuals and organisations operating in areas of most acute social deprivation, where a radical rethink of health and social services delivery has been required. One example is the Associated Campaign for Rural England (ACRE), which has been campaigning for better community and health facilities for people in deprived rural areas. Other examples have come from local people and public health and health promotion agencies connected to urban regeneration.[50] Often the type of facility proposed is a multi-agency centre, where GPs and other health agencies are invited to participate alongside other services relating to community health.

## 7.5 Conclusion

Community is a concept that is inextricably linked to primary care services and facilities, but politicians and professionals have inadequately and contradictorily defined it and it frequently gets used interchangeably and confusingly with terms such as neighbourhood and locality. Community can have a social or geographic dimension, both of which are relevant to a social analysis of primary care buildings. As people, community members are key participant stakeholders, both in their role as potential patient/users and as citizens, but the complexity and diversity within communities needs to be recognised and addressed. This issue is returned to in Chapter 9.

---

[49] Background information about this situation can be found in: Antigha, A., (1996) *King's Cross Needs Assessment Project, The Final Report* Camden & Islington Health Authority.

[50] Gaskin, K. & Vincent, J. (1996), *Co-operating for Health,* Centre for Social Policy Loughborough University.

Geographically, primary care resources are not evenly spread among the population and this needs to be rectified to reduce health inequalities. An important question that remains is whether this is best achieved through a practice-based service, catering for individual choice from a dispersed population, or through a neighbourhood-based centre aiming to improve the health of individuals and local communities living in an adjacent geographical area. Research for this investigation has indicated that the former approach may favour more economically advantaged and mobile members of society, who have the time and transport resources to enable them to shop around and select primary care providers. Whereas the latter approach may benefit people living in more disadvantaged circumstances, where easy access is important and there is a wide range of health needs. If services are aimed at meeting both collective and individual needs, an advantage lies with a neighbourhood-based model, as long as the quality and range of services provided are universally comparable.[51]

The socio/geographic organisation of primary care facilities has important implications for the social objectives of increasing multi-sectoral collaboration and community participation, which is a focus of this study. As I argued in Chapter 4, GPs in practice-led and owned facilities are unlikely to prioritise community involvement over premises' design or services. In neighbourhood-based facilities, co-operation and collaboration between professionals and agencies should become simpler and objectives should shift from competing for customers and professional rivalry to improving the health of a given population. In the absence of the probability that a universal consensus will be reached, individual primary care projects will probably need to create their own definitions, in consultation with local people, of the precise catchment area and population to be serviced by the facility. However, in the longer term, a national strategic approach to the question of how geographic and social populations to be served by primary care facilities should be adopted, in order to reduce inequalities in access to resources.

[51] Ham (1996), op. cit.

# PART TWO: AN EVALUATION OF PRIMARY CARE ARCHITECTURE AND COMMUNITY INVOLVEMENT PROCESSES IN FACILITIES PLANNING AND DESIGN 1990/1997.

## Chapter 8
## DESIGN PRINCIPLES FOR PRIMARY CARE BUILDINGS

The first part of this study aimed to conduct a social analysis of the development of primary care buildings. I attempted to demonstrate how it has developed from the complex and interactive influences of political and health ideology, commissioning mechanisms, historical, economic, architectural and socio/geographical contexts, and key stakeholder interests. I sought to illustrate that for a variety of reasons embedded in the development process, a primary care system and network of facilities emerged that did not necessarily best serve the public interest. So the question remaining for this investigation was how might a more socially responsible primary care system be developed?

In this second part of the study I refer back to the social objectives linked to the WHO programme for Primary Health Care (PHC), described in Chapter 2. This recommended that countries should seek to reduce inequalities in health by facilitating a primary care system based on inter-sector collaboration and community participation.[1] Using these principles as a guide, I have sought to develop a methodology to evaluate how far, and in what ways, architectural design and community involvement processes facilitated these social principles in the wave of primary care buildings, built or planned following the NHS Community Care Act, 1990. I have then applied this methodology to four pilot case studies of multi-agency, primary care buildings, according to a selection process outlined in Chapter 1.

---

[1] These aims were endorsed by the WHO literature about *Health for All by the Year 2000* and also to an extent were incorporated in Conservative government policy, for example see DoH (1996) *Primary Care: Delivering the Future* London: HMSO, p.4: 1.6 & p.50: 7.6

This chapter describes how I began to develop this evaluation methodology by identifying a set of design principles that could assist in promoting the social objectives of inter-sectoral collaboration and community participation. It then describes how these principles were translated into a set of design factors that could be used as items to evaluate building quality from a social use perspective.

## 8.1 Design principles contributing to social objectives for primary care

The approach I have adopted for evaluating primary care buildings in this investigation implies a conviction that the architecture of health facilities is not neutral, but has the power to signal social values and power relationships to the community and occupants of the building through the manipulation of formal elements, such as spatial organisation or quality and choice of finishes.[2] The Italian architect Giancarlo De Carlo (1970) suggested a similar approach to evaluating buildings when he stated that one should not ask how a building was created, but 'why it was created and for whom?' De Carlo wrote:

> *A work of architecture makes no sense when disassociated from its use. The way in which it is, or could be used becomes one of the fundamental factors that contribute to the definition of quality...its meaning is entirely contingent upon its active presence, upon the system of relations it establishes with its users.*[3]

However, attempting to separate the role of design from other factors that can influence the direction and success of the facility is a complicated, if not impossible, task. As I have tried to illustrate in Chapter 6, the design intentions of a scheme can be compromised by

---

[2] There is a wide literature on architectural theory and power relations in the built environment, which could have led me to undertake a more in-depth study of the social construction of space. However, I have not pursued a detailed theoretical investigation as part of this research, because my particular interest and that of my original university research unit, MARU (see Chapter 1.1), was to conduct a pragmatic study that could yield insights with potential for practical policy intervention, and design and community involvement process application.

[3] De Carlo, G. (1970) 'Architecture's Public' *Parametro,* No 5.

mechanistic factors, such as cash limitations, site restrictions or construction, so that the subsequent failure of a facility may not necessarily be caused by the inadequate design skills of the architect. Also, the proportional contributions made by design and management factors can be difficult to identify and, as discussed in Chapter 4, a building might have been designed to facilitate inter-sectoral working with, for example, an appropriate allocation of integrated spaces, but unless there is a management policy that encourages and supports collaboration, possibly by providing time for joint working, staff still may be unable to fulfil this objective.

While acknowledging Beales's (1978) observation that much of the success of a health centre will depend on human willingness to co-operate, this chapter will seek to explore how certain design elements might facilitate the social ideals of developing inter-sectoral collaboration and links with local communities, whereas ill considered design might exacerbate tensions between staff and agencies sharing accommodation and deter community participation, resulting in a less than perfect service to the public.[4] This concept is supported by Foucault, who when asked in an interview whether architecture could in itself resolve social problems replied, 'I think that it can and does produce positive effects when the liberating intentions of the architect coincide with the real practice of people in the exercise of their freedom'.[5]

I began identifying design factors that might support social ideals in primary care architecture through a survey of NHS Estate guidance and other architectural and medical publications.[6] I then conducted a series of focused interviews during February/June 1997

---

[4] Beales, J. (1978) *Sick Health Centres and How to Make Them Better.* Tunbridge Wells: Pitman Medical Publishing Co. Ltd.

[5] Foulcault, M. (1997) ' Space Knowledge and Power' an interview conducted with Paul Rabinow, pp. 367-381 in Leach, N, (ed) *Rethinking Architecture a reader in cultural theory*, London Routledge

[6] These included *Health Building Notes 40, 46, 36*, NHS Estates (1993) *Environments for Quality Care.* London: HMSO, and the NHS Estates (1994/5) LIZ Handbooks 1-4; Scher, P. (1996) *Patient Focused Architecture for Health Care*, Manchester: Metropolitan University; Valins, M. (1993) *Primary Health Care Centres,* London: Longman.

with architects from three practices that had specialised in designing primary care buildings, MAAP; Avanti; and Penoyre and Prasad.[7] From these sources and attendance at various lectures and seminars on primary care building design organised by the Medical Architecture Research Unit at the University of North London and South Bank University 1993/96, I compiled a short list of factors that might contribute towards achieving the principles of inter-sectoral collaboration and community participation.[8] These included:

- allocation of adequate space and flexibility and economy of spaces to meet the needs of all users and services to be accommodated in the building
- facilitation of inter-professional working through appropriate spatial organisation
- facilitation of inter-agency working through appropriate spatial organisation
- facilitation of separation of agencies where appropriate through spatial organisation.

I also identified nine design factors that appeared to relate to facilitate an interactive interface with local communities. These were:

- convenient siting and location of the facility
- appropriate architectural street presence, approach and entrance
- appropriate interior aesthetics and quality of materials and finishes
- appropriate and welcoming design of reception/ waiting areas
- good access and information for public users
- provision of public facilities such as telephones, toilets, play areas etc
- security, privacy and confidentiality for all buildings users
- space planning that allows social/community activities to take place independently of medical services
- attention to issues of sustainability and ecology in the design of the building.

[7] Reasons for selecting these practices as expert respondents is described in Chapter 1.4 .
[7] Chapter 1 for more details about the research methodology used in this investigation.

This list was not intended to be exhaustive, but to represent a sufficient range of factors that could collectively indicate whether a primary care facility had been designed to fulfil the principles of inter-sectoral collaboration and community participation. The following sections provide a fuller discussion of these factors.

## 8.2 Design facilitation of inter-sectoral collaboration

There are several references in architectural guidance encouraging new primary care centres to be designed to facilitate inter-sectoral collaboration for the public benefit.[9] However, there is little practical advice on how this might be applied. A rare attempt to find a reliable tool to examine the relationship between management policies and building layouts had been made by Alan Beattie, a lecturer at MARU in 1974.[10] Beattie proposed a schematic framework for health centres that can also easily be applied to the more recent designs of multi-agency primary care buildings. He suggested three factors should be evaluated; first, 'capacity', or how well the schedule of accommodation related to the time patterns of activity in the building i.e. was there enough space? second, 'connectivity' – how well did the linkage of space relate to patterns of activity sequences? For example, was the arrangement of rooms and circulation spaces convenient and/or efficient and for whom? Thirdly, 'cardinality'– how did the sectorising or segregation of the spaces relate to the patterns of professional organisation, teamwork, etc? In other words was the building subdivided into the right kinds of categories of space? Which users benefited from those subdivisions and were any of their requirements in conflict?

Hillier and Hanson's (1984) theory of spatial organisation is useful in making the distinction between two types of control systems of inhabitants over visitors in health buildings, connected to 'local' and 'global' occupation.[11] They argued that the organisation of GP

---

[9] NHS Estates (1995) *Health Building Note 36: Volume 1* London: HMSO, p.17: 2.35-36.
[10] Beattie, A. (1974) *Alternative Strategies of Space Organisation in Health Centres,* Project No. 2, Postgraduate Health Facility Planning Course, unpublished lecture notes.
[11] Hillier, B. & Hanson, J. (1984) *The Social Logic of Space* Cambridge University Press, pp. 191-2.

premises was based on one type and that hospitals were based on the other. In GP premises, GPs, as high status professionals, occupy localised units in the deepest spaces of building, which emphasises their importance and exclusivity. The public are also allowed only controlled access to the 'global' or circulation spaces. Whereas in hospitals it is the public users who occupy wards in the deepest spaces, but the power lies with the doctors and other medical professionals, who control the circulation space and access to these units. A multi-agency centre is likely to be planned as a hybrid of both these models with some areas planned as 'democratic spaces', legitimising open access to all users, while other areas are designated territory of particular individuals or agencies.

*Allocation, flexibility and economy of space*

The allocation of sufficient and appropriate space for all agencies intending to occupy the facility is recognised by NHS Estate's guidance to be dependent on the level of involvement and negotiation with prospective participating agencies during the design process.[12] It can also be affected by the ability of those agencies to afford the resources and amount of space they require.[13] Size requirements of different agencies can change through time so that the ability for extension and expansion on the site is also an important consideration. However, as Barton (Avanti, 1997) explained, too large a site can encourage an inappropriate marriage between agencies, which can in turn lead to funding complications through incompatible financial structures (see also Chapter 4.5).[14]

In terms of the 'capacity' of specialised clinical or treatment spaces, there are only a few regulatory minimum space standards to which architects must conform. The architects interviewed cited the most critical areas in terms of space allocation to be physiotherapy, the first and second treatment rooms, and storage. However, Shaw (MAAP, 1997) argued that

---

[12] NHS Estates (HBN 36, 1995) op. cit., p.18: 2.40.
[13] See commissioning regulations described in Chapter 6.
[14] Barton, R, (1997) recorded interview notes at Avanti Architects, 11.4.97.

clients should understand that storage was expensive, costing as much as £1000m2, so its use and management had to be considered carefully.[15] LIZ Handbook 1 suggests the following reasons why a space can be ill-suited to its function:

- poor access (i.e., not wide enough for traffic flow or through other spaces)
- too much noise
- insufficient area
- wrong shape
- inadequate equipment
- insufficient heating or lighting
- insufficient storage.[16]

Flexibility has always been an objective in health centre design, but with the rapid changes in technologies, new forms of funding, and demand for multi-agency use and new services, it has become an increasingly important consideration. Barton (Avanti, 1997) pointed out that no health building ends up being used as it was originally intended and, with rapidly changing technologies, health buildings needed to be designed with more flexibility than in the past.[17] The architects described various ways in which they had tried to increase flexibility and to ensure that the potential for a building to expand or change use was planned from the beginning. These strategies included avoiding designing small rooms, because a consulting room of minimum of 12m² could equally be used as a treatment room, an interview room, or an office, and was therefore more versatile than a smaller space (see below Figure 8.1).[18] Also, they had observed that waiting rooms were often under-used and that if they could be divided from the reception area they could be used outside normal surgery hours for a variety of group or community activities.

---

[15] Shaw, C. (1997) recorded interview notes at MAAP Architects, 18.2.97.
[16] NHS Estates (1994/5) *London Initiative Zone Primary Care Premises Handbooks 1/4,* London: HMSO No 1 p.24: 5.24.
[17] See footnote 14.
[18] This concept is illustrated in MAAP (1993) 'Primary Care' *Focus 2.*

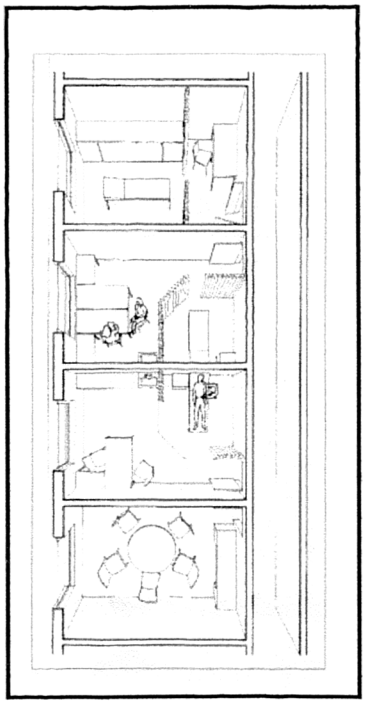


**Figure 8.1**
**Flexible use of 12 $m^2$ rooms.**

Source: MAAP (1993)[18]

The type of furniture used in a room could also determine its flexibility, for example fixed seating, or large heavy treatment couches could prevent the space being used for different purposes. Hoskins (Penoyre and Prasad, 1997) described how a primary care centre in Rushton Street, London, Islington, had been designed to allow for future fluctuations of the four GP practices occupying the centre.[19] This was achieved through a design, which enabled them to expand or decrease the number of consulting rooms available (see Figure 8.4). Barton (Avanti, 1997) considered that the impact of the Private Finance Initiative (see also Chapter 6.1.4) and the requirement of developers for buildings to consider alternative use had encouraged more flexible planning, and he claimed that in the past the design of health buildings had often been too specific and rigid.[20] He suggested that flexibility in layout could be partially achieved by designing buildings with external load bearing walls so that internal partitions could be shifted, foundations should be strong enough to support extra floors and additional space should be set aside on the site for future expansion.

---

[19] Hoskins, G. (1997) recorded interview notes at Penoyre and Prasad Architects, 13.3.97.

There seems to be no reason why health centres should not be accommodated in buildings that could be easily converted to other uses in the future, just as many health centres now occupy buildings that were once used as pubs, shops or homes. What appears to need safeguarding is over-compromising with private developers so that the building ends up having none of the special features, such as top-lighting in corridors, courtyards or gardens, which could provide a therapeutic environment for public users and a pleasant working environment for staff and public users, but has no obvious financial return. [21]

*Facilitation of inter-professional working*

Within a multi-agency facility, the separate requirements of the work-teams involved within each agency needs consideration. The case for the design of primary care facilities to aid the cohesion of Primary Health Care teams, discussed in Chapter 4, was well made by Beales (1978) and many of his observations for maintaining integrity are also applicable to other professional teams in a multi-agency centre.[22] The need for staff to have a segregated area away from the public arena to give them time to recover and prepare for further direct interaction with the public may also need to be considered.

Shaw (MAAP, 1997) described how the three-zone model developed by Cammock in the 1970s had proved a good basis for organising a health centre through providing a controlled overlap between public semi-public and professional use (see below Figure: 8.2).[23] In this model the public have full access to the public zone shared access to the clinical zone and no access to the administrative zone.

---

[20] See footnote 14.

[21] See St Matthew's case study 2, Chapter 10, for an example of primary care building built from a converted elderly people's home.

[22] Beales (1978), op.cit.

[23] See footnote 15. Also, see discussion of Ruth Cammock's design principles in Chapter 6.2.1.

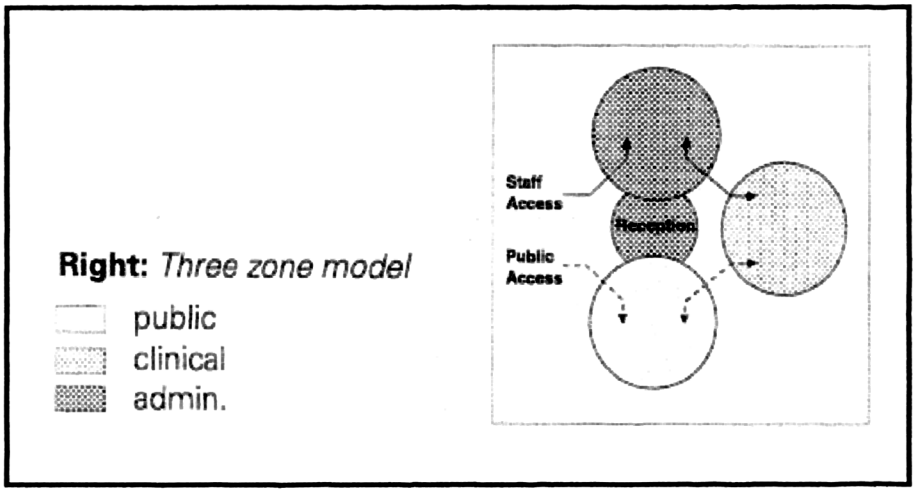
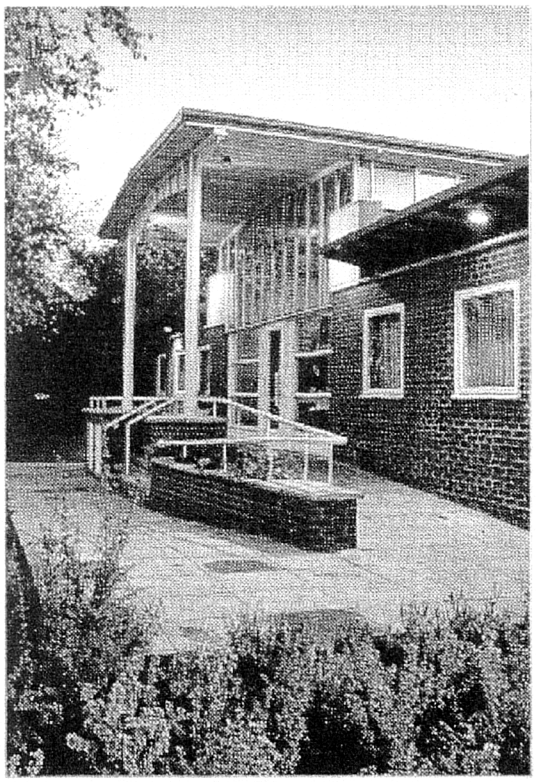
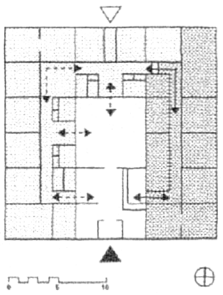



**Figure 8. 2**
**Above:Three Zone Model.** Source: MAAP (1993) [18]
**Figure 8.3**
**Below: Application of the Three Zone Model in a joint practice in Watford.**
Source: MAAP (1993) [18]



The Callowland Surgery, Watford, Herts.



Left: *Plan Diagram*
Far Left: *Main Entrance*

public
clinical
admin.

The single storey 5 GP practice at Watford illustrates clearly the zoning principles in practice. The plan is organised around the waiting room, which is naturally lit by high level windows. Privacy to the clinical areas is maximised by a corridor and a ring of service rooms separating them from the central space. Doctors and staff can move between administrative and clinical areas or out of the building without being observed by waiting patients. By the same route, distressed or critically ill patients can be escorted out of the building without passing through the public area.

The limited funding available under the Cost Rent scheme, together with a tight site dictated the simplicity of the planning of this building. The large central space and it's high roof breaks through the ring of cellular rooms to form the main entrance and canopy, providing views of the street from within the building.

Shaw explained there was a need to understand two levels of professional working, the formal and informal links, and that there was a need to provide opportunities for interaction and separation at both these levels. However, as Hanson and Hillier (1984) argued, zoning cannot just be regarded as a practical way of safeguarding privacy and security, but it can also be used to support professional hierarchies and to control public access and circulation and therefore should be consciously applied in accordance with the social philosophy of the building.[24]

*Facilitation of inter-agency working*

Inter-agency working has been one of key aspirations and objectives of the new primary care approach. For example, LIZ Handbook 1 states that 'it is essential for the robust development of local health care that the various agencies involved work with each other from the beginning' and that agencies such as the 'DHA, community trust, local authority and voluntary agencies, such as Age Concern, should be placed in a working relationship in which there is a transparency of decision making so that all agencies feel that they are party to the compromises and reconciliation that will certainly have to be made'.[25] LIZ Handbook 2 recommends that 'the philosophy of each of the stakeholders, whether trust, FHSA, or private sector, should be clearly set out' at the briefing stage and that areas of possible conflict should be resolved to facilitate integrated project policies, covering issues such as:

- philosophy of care
- environmental philosophy
- revenue assumptions
- workload
- hours of operation

[24] Hillier & Hanson (1984), op.cit.
[25] NHS Estates (1994/5), op. cit., Bk 1, p.13: 3.7.

- staff training.[26]

All these issues have implications for design and can help to determine how far to integrate or divide the space used by the different agencies. For example 'hours of operation' might have security or circulation implications within the building, requiring some parts to be locked at different times. Issues such as whether there is a common entrance and a first port of call reception for all agencies or a meeting space large enough for all agencies will need to be resolved. When working structures are in line, different agencies may be able to share floors, corridors or rooms, and therefore extend opportunities for developing closer working relationships, but this needs to occur in a manner that does not fragment the integrity of specific professional teams.

*Separation of agencies*

'Cardinality', sectorisation, or segregation, is an issue facing designers of new hybrid primary care developments, where the building is to be shared by several practices and/or other agencies, who may not necessarily want to integrate with each other, or for whom integration is not appropriate. In these instances, the architect may have to create discrete areas that allow the possibility of greater integration or change of use in the future.

This issue can be relevant to facilities accommodating more than one GP practice or PHCT. The importance of the size and integrity of the practice team was discussed in Chapter 4. Barton (Avanti, 1997) described the experience of designing a two-practice facility in Bethnal Green in the 1980s, where one of the GP practices had Asian doctors with mainly Asian patients, while the other practice dealt with other ethnic groups.[27] Both practices had sought to maintain their practices separately and had originally requested separate entrances and reception areas, but site and financial restrictions eventually led to these being provided

[26] NHS Estates (1994/5), op. cit., Bk 2, p.25: 6.20.
[27] See footnote 14.

in a single larger space, but in distinct areas. Barton considered this solution had been ultimately successful in design terms, but this incidence raises important social issues about how best to cater for cultural diversity within health buildings and yet promote integrated communities.

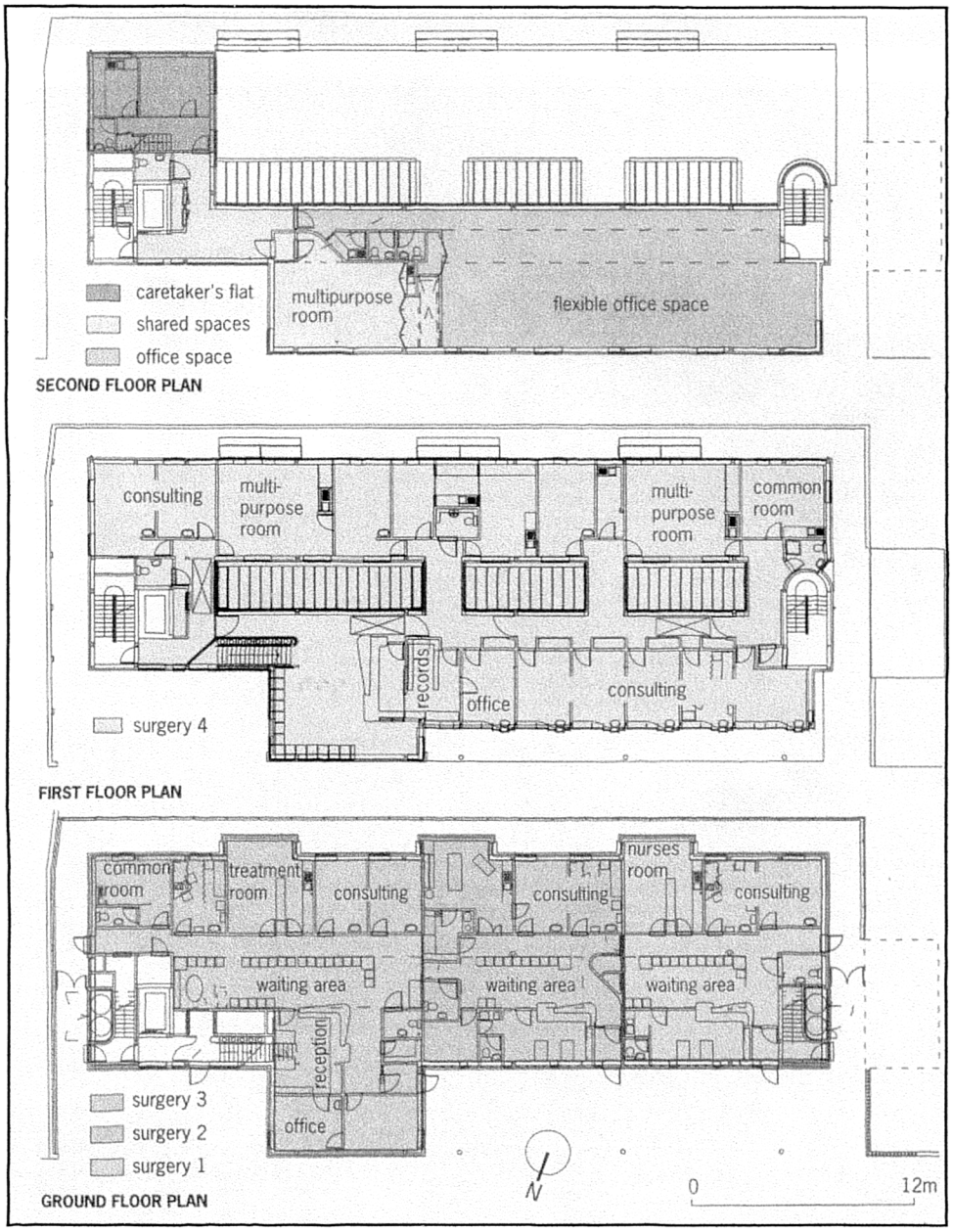



**Figure 8.4. Plans of Rushton Street Surgery showing four separate surgeries. Architect : Penoyre and Prasad.** Source: AJ. 24.4.1997, p.31.

One of the problems associated with shared use of a building is the need of certain agencies for independent access, for example a pharmacy might require access from both within a primary care facility and independent public access from the street (see the example of the pharmacy in Purfleet case study 10.1). Separate entrances can be useful in some circumstances, but they can also activate against collaborative working by increasing the isolation of agencies. Hoskins (Penoyre and Prasad, 1997) showed how the plan of the Rushton Street surgery (see above, Figure 8.4) had been designed to allow the four practices to operate independently by providing four separate entrances for the practices, but had retained the possibility of sharing some areas within the building.[28] In some primary care developments it could be more appropriate to maintain agencies in separate buildings on the same site, possibly linked by covered walkways.

## 8.3 Design facilitation of community participation

> *Involvement of people in healthcare functions – and health promotion in particular – as part of a normal healthy lifestyle may be encouraged even further if a healthcare centre or local healthcare resource centre can be organisationally integrated with a social function such as a fitness centre, recreation centre or community centre. Use of appropriate spaces may be shared. As a result space utililisation will be improved, running costs reduced and a two-way flow of information about activities facilitated.*[29]

Guidance for primary care services and facilities during the 1990s stressed the importance of increasing accessibility and attracting local people to use the facility, particularly those who might otherwise not enter a health building, or visit a GP, in order to reduce health inequalities within society. The following factors have been selected because they might influence whom, why and how often local people might attend a primary care facility. They

---

[28] See footnote 19.
[29] NHS Estates (HBN 36, 1995), op. cit p.36: 2.39

might also indicate whether the building has been consciously designed to facilitate individual public users and local communities to play an active and participative role within the facility, apart from receiving treatment from professionals, for example through the provision of space for social, community, self-help or exercise space.

*Siting and location of the facility*

The LIZ Primary Care Handbook 1, *Strategic Planning*, recommended that health centres and resource centres should be near the 'centre of gravity of the area and the population served and accessible by adequate public transport' also that the site 'needs to be of a size and shape that allows for economic building design'.[30] For purposes of flexibility, it was also recommended that the site should be large enough to enable future expansion.[31] As discussed in Chapter 7.2, uneven distribution of primary care facilities is still a problem in many localities. Some communities are well served while others have to travel considerable distances. Ideally, all geographic communities should have an easily identified primary care facility in close proximity as this is key to creating equality of access to primary care and to the concept of a primary care centre as a community resource.[32] If a primary care facility project is led by professional agencies, community involvement in the choice of site can be an important factor in encouraging a sense of community ownership and avoiding making false assumptions about geographic boundaries as perceived by local communities.[33]

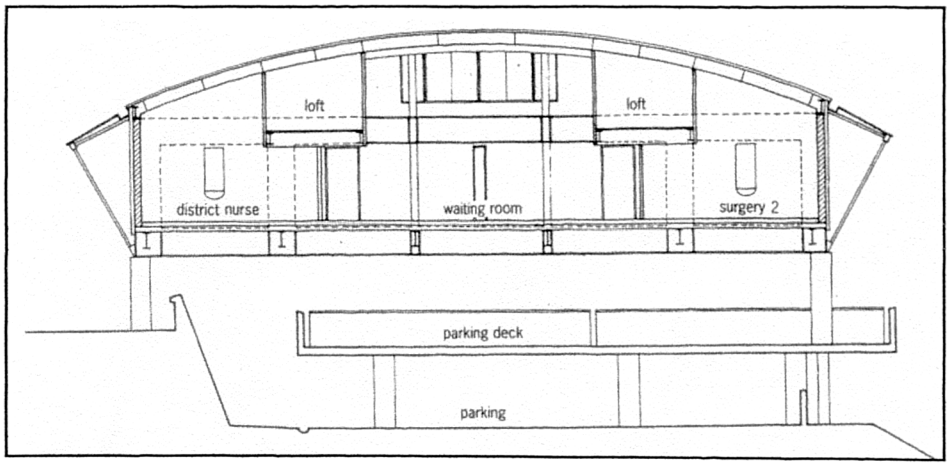
Architects are usually presented with a site and the site itself can have a great influence on the design of the facility and the interface with the local community. Shaw (MAAP, 1997) considered the appropriate siting of a primary care building was essential to the creation of a successful facility and confirmed that it should be in good population centre, with transport

[30] NHS Estates (1994/5) op cit., Bk 1, p.1: 1.22
[31] Ibid.,Bk 1, p.21: 3.5/3.13.
[32] This issue of equality and resource allocation was discussed in more detail in Chapter 4.3 and 4.4.
[33] See also Chapter 7.4.

links that are considerate of the travel times of carers and support groups.[34] The difficulty of finding suitable sites in cities was recognised as a major problem, but Shaw believed there were too many taboos regarding what was accepted as a suitable site for primary health care. Shaw argued that there was no good reason, given adequate lifts and fire escapes, why primary care should not be sited at the top of multi-storey blocks, providing that there was a ground floor receptionist. Hoskins (Penoyre and Prasad, 1997) described how they had designed a surgery on the upper floors of a building, but there had been problems with the receptionist being isolated on the ground floor.[35] Also, that a facility on an upper floor increased the level of signalling and signage necessary to announce the facility. Barton (Avanti, 1997) thought that often the solution was to look harder for appropriate buildings and that the problem was that often doctors sought accommodation in buildings unsuitable for modern NHS facilities, such as old Georgian houses, rather than in light industrial or warehouse buildings, which could be more easily converted.[36]

The architects also described some projects where restricted sites had led to innovative design solutions. For example, Penoyre and Prasad had used the opportunity to develop a narrow inner city site in South London into an interesting building. Geoff Penoyre, presenting this building to architectural students at a UNL in 1994 suggested that possibly the availability of greenfield sites in more rural and suburban areas which presented no design restrictions had led to such a plethora of bland health centre designs. Another radical solution to a site problem had been found by the architects, Pentarch Ltd, in Swiss Cottage, London, when the shortage of appropriate space had led them to design a practice over a car park accessed by a heated and lit ramp (see below, Figure 8.5).

[34] See footnote 15.
[35] See footnote 19
[36] See footnote 14.



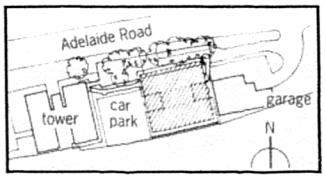
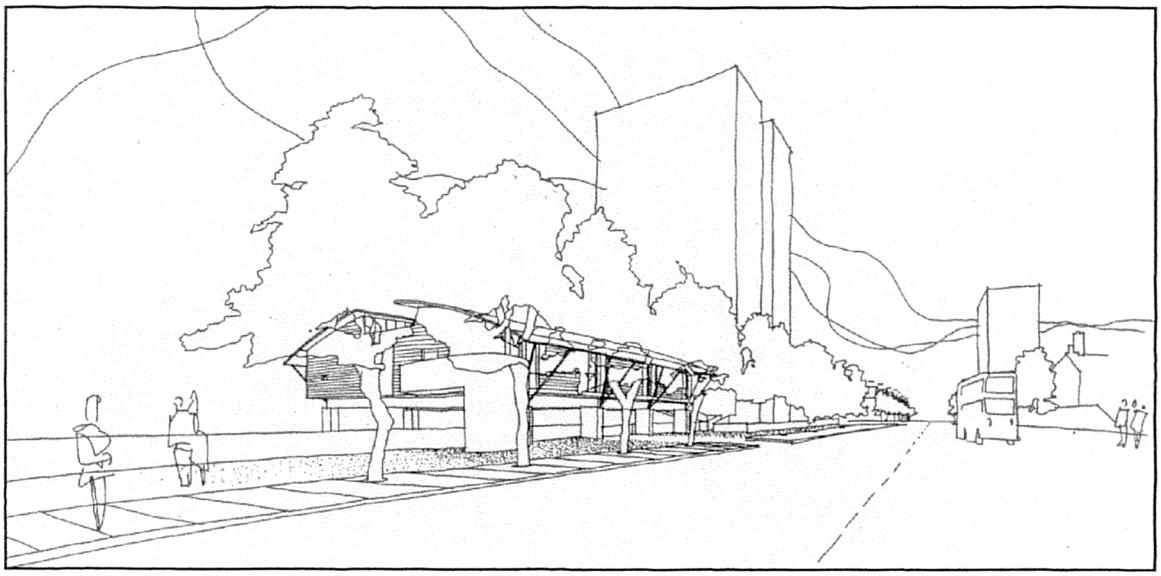




**Figure 8. 5**
**Above: section, Left: site plan. Below: perspective of Adelaide Road Surgery, London NW3. Showing facility built over a car park. Architects: Pentarch Ltd.** Source: AJ.25.11.1992 pp 35-45



*Street presence, approach, entrance*

Allan (1988) wrote that 'if the plan of a health building can be understood as a diagram of human relations, an elevation can be regarded as a public address system offering advice,

conveying intentions, reflecting priorities'.[37] He argued that 'architects and commentators should search out and explain the causal connections between building design and the social context of which it is a product'.[38] This raises questions as to whether a primary care centre should convey a domestic presence by blending in with adjacent buildings. For example by looking like another house in a residential street or another retail outlet in a shopping street, or whether it should be given elevated civic presence as a public landmark. These are clearly decisions that might be advantageous to discuss with local communities, as it will alter their visual landscape.

Shaw (MAAP, 1997) thought primary care buildings should have a strong presence and considered the design of the entrance and approach vital.[39] He explained that MAAP regarded the visibility of receptionist from street as important as they provide a human link that can be encouraging to new patients or those in distress. They have achieved this in some schemes with an open glass frontage that enables a receptionist to be visible from outside and the receptionist to see people entering. Hoskins (Penoyre and Prasad, 1997) agreed that a health centre should announce itself and explained that they usually achieved this effect by the type of materials used by the practice, which made it stand out from what was already there. He pointed out that the prominence of the health building was dependent to some extent, on its scale. In smaller projects, signage and lighting of the entrance needed more important consideration. Also, he thought clear information at the entrance about opening times and the services available was important and helped to avoid public frustration.

The architectural critic Colin Davies (1988) has provided some interesting suggestions for decoding various health centre forms and styles. Davies argued that the architecture of health buildings can mirror 'hidden assumptions about illness, disability, professional expertise, responsibility, class, community, power and freedom', so that:

---

[37] Allan, J. (1988) 'Health Centre, Bethnal Green, London'. Architects Account, *Architectural Review* Vol. CLXXXIII No 1096, June 1988.
[38] Ibid.

> *... in general terms the style of medical architecture has shifted from a celebration of the marvels of modern medicine to a tone of soothing reassurance and subtle deception.... The domestication of medical architecture – the rumpled Neo-Vernacular – arose in part due to renewed distrust of technological medicine.* [40]

*Internal aesthetics and quality of materials and finishes*

Official guidance on the environment and design of primary care buildings, including references to art, courtyards, natural and artificial lighting and finishes, is provided in HBN 36.[41] The question of whether or not a primary care building should appear institutional has been one of the key topics among architects and medical staff. The dilemma may be linked to the perceived social trend to veer away from discredited institutions, such as mental hospitals.[42] The ambience created by interior decoration can have an obvious impact on public users' experience of the building, for example, either by appearing warm and welcoming, or cold, clinical and daunting.

Smith (MAAP, 1997) suggested that rather than attempting to escape the institutional it was important to create good, comfortable institutions.[43] He argued that the public was not fooled by wallpaper and up-lighting because the signs of an institution came through signage, long corridors and the repetition of features such as lights, doors, carpets. The scale of the building made it impossible to avoid the fact that it was an institution. Smith argued that to pretend a primary care building was a house was nonsense, an insult to public intelligence and a misreading of the semiotics involved. Given the range of people and personal taste preferences involved, he thought attempts to give health centres a cosy domestic feel were likely to backfire.

---

[39] See footnote 15.
[40] Davies, C. (1988) 'Architecture of Caring / East End Avanti' *Architectural Review* Vol. CLXXXIII No 1096 pp.15/26. June 1988, p.16.
[41] NHS Estates (HBN 36, 1995) op. cit., p.23: 5.10-5.39 & p.23 5.35-39.
[42] See for example the various case studies featured in the AJ 18.7.96.
[43] Smith, M. (1997) recorded interview notes with MAAP architects, 18.2.97.

Allan (1988) argued that people who need health care also need clear, reassuring, three-dimensional structures to guide them in times of stress. In discussing the aesthetic of Finsbury Health Centre (cited in Chapter 5.2), designed by Lubetkin in the 1930s, he asserted that:

> *Democracy is not necessarily achieved by being casual or folksy, or indeed by masking the social classifications needed to achieve specific tasks. Democracy – in this as in other spheres – is surely to do with freedom of information, or architecturally speaking, about legibility of organisation, explicitness of intention, about the admission of causality.* [44]

Some designers perceive a conflict between the aesthetic requirements of a medical centre and those of a social or community centre environment. However, the concept of a public building appearing welcoming and uplifting can be equally appropriate for both medical and social aspects of a primary care facility and there seems to be many modern styles and materials that can create an ambience that is neither clinical, nor overtly domestic.[45] Another solution is to have separated, but linked, medical and community facilities that maintain different aesthetics.

Hoskins (Penoyre and Prasad, 1997) regarded texture and natural light to be important in primary care buildings and also the ability of all the building's users to see out to the world beyond the building.[46] Features used to bring light into the building included building consulting rooms around courtyards, and top lit corridors. Hoskins thought health buildings should appear well made in order to gain users' respect and to deter vandalism.[47] He found that good quality furniture was a deterrent to vandalism because the community appreciated

---

[44] Allan (1988) op. cit., p.50.
[45] An example of this approach to primary care interiors has been taken at the Shrewsbury Centre, at East Ham Memorial Hospital, where the interior is described as 'more like a theatre foyer than a health building' *Architects' Journal*, 18.7.96, p.39.
[46] See footnote 19.
[47] See footnote 19.

that anyone should care, for example, about what type of chairs they sat on. He explained that Penoyre and Prasad designed much of their own built-in furniture because this then became part of the capital building costs and did not have to be paid for by GPs. A downside of this strategy was that the furniture was then fixed and could not be rearranged easily to suit another service provider.

Shaw (MAAP, 1997) maintained that the important concept of building quality contributing directly to public health still did not appear to be understood by some authorities, or some doctors commissioning buildings.[48] He argued that it was not until the 1980s that the quality of the environment of primary care buildings became more generally recognised as an integral part of the healing process for patients, and important for the effective working of staff. Previously, most health centres had tended to be regarded simply as a shell for housing services, rather than as having an experiential influence on the occupants. He suggested that both health authorities and doctors needed better education about the relationship between health and environment in order to encourage them to invest in better quality buildings.

*Design of reception and waiting areas*

The design of the entrance and reception areas of a primary care facility can set the tone of the building and influence the first impressions of public users. The main difference in design objectives might be between those buildings attempting to create a democratic entrance and reception space – a space which every individual has as much right to occupy as any other, and a hierarchical space, in which one group perceives they are occupying a space belonging to another group or individual.The role of the receptionist and the location of a reception desk and waiting area can play a key role in determining this experience. For example, in multi-agency centres the issue of how many reception areas there should be, and whether there is a need for a central information point can have important implications for public

[48] See footnote 15.

users' impressions of the facility and on collaborative working. For example, separate receptions can create a more intimate scale for users of the service, but may reduce opportunities for informal encounters between staff from different agencies. Other factors connected to the receptionist and desk,
such as visibility, accessibility, confidentiality and security of staff, also require a considered design approach.[49]

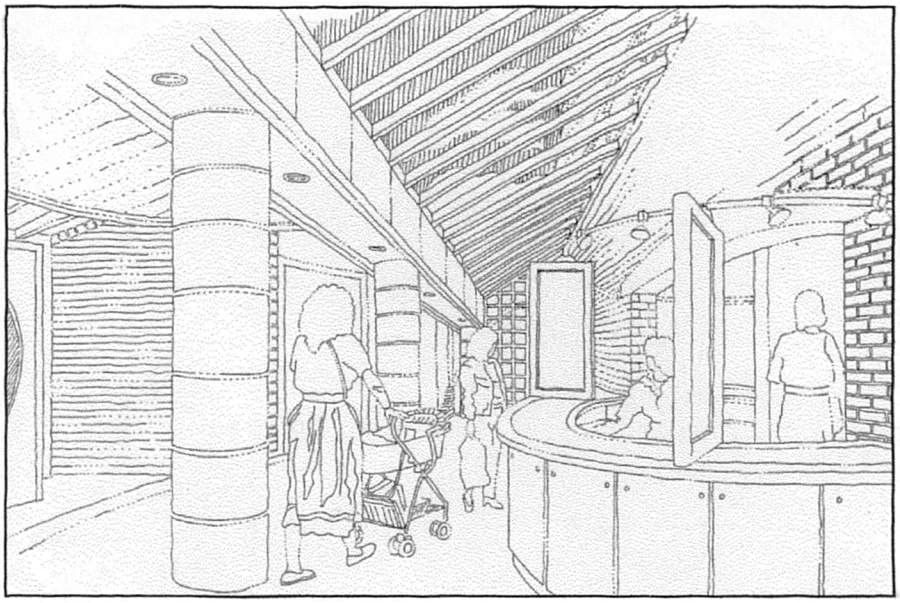


**Figure 8. 6**
**Reception area at Chiddenbrook Surgery showing open reception desk with privacy screen.**
**Architect: Smith Roberts Associates.** Source: AJ. 5.5.93. p.36.

Patients can spend more time in waiting rooms than in treatment or consulting rooms and yet this factor has not always been recognised by designers of facilities. Waiting can be stressful and having a warm comfortable ambience is critical. Shaw (MAAP, 1997) suggested that the waiting needs of certain groups needed to be considered.[50] For example, he had realised that Muslim women might be better served if an area was set aside for

[49] NHS Estates (1991) *Health Building Note 46: General medical practice premises for the provision of primary health care services.* London: HMSO, p.21, 5.7-14.
[50] See footnote 15.

women-only waiting. MAAP preferred to create waiting and circulation areas that were discrete and away from the direct visibility and audibility of the reception area.[51]

*Security, privacy and confidentiality for all building users*

Perhaps one of the great advances in the design of medical buildings in the last two decades from the public user's viewpoint has been the acceptance by both medical and design professions of the need to increase levels of privacy and confidentiality during consultations and treatment.[52] Confidentiality is particularly an issue at the reception desk and in the storage of case notes. The security of property and of staff and public from personal attack has also become of increasing concern in more recent years.

Shaw (MAAP, 1997) suggested that issues of territory were very important in primary care buildings, for example when public users were moving from private medical space or consulting rooms into public areas.[53] He therefore designed transition areas and thresholds carefully, paying specific attention to the 300mm space on either side of a door, because this allowed those entering or leaving space for making mental and physical adjustments. Other techniques allowing for moments of adjustment were curved, or staggered corridors created (see example at Purfleet, Figure 10.5). Intercommunicating doors between consulting rooms and treatment rooms were usually avoided because of the weakening of sound proofing this. Shaw described how they had been looking at some of the new sound masking technologies, which could allow private conversations to take place in crowded areas.

All the architects I interviewed had worked on various design methods to facilitate staff security. For example, the location of the reception desk was considered most important, and the point was made that the design of the desk needed to be high enough, or deep enough, to make a physical assault on a receptionist difficult, but still enable direct

[51] NHS Estates (1995)(HBN36) op. cit., p.22, 5.15-18. Some other issues relating to patient waiting are covered in HBN 46.
[52] Ibid., p.23: 3.34-3.40.
[53] See footnote 15.

communication between the receptionist and public. The traditional use of glass screens was considered distancing and unfriendly, which could escalate a patient's anxiety as well as prohibiting confidentiality. Barton (Avanti, 1997) explained that following the stabbing of a doctor by a patient at one health centre in Islington, Avanti had been asked to review staff safety at the centre.[54] In response he had been working on a consulting room layout that would allow doctors to sit to the side of patient and yet not have their backs to the door. Most of the architects suggested that technological security solutions needed to be applied sensitively. Staff training in dealing sensitively, but safely, with the public had proved effective, but the physical separation of staff from public by use of glass screens and grills had proved counter-productive by increasing public frustration (for an illustrated comparison, see the security shields at Purfleet, Figure 10.1.3 with the open desk design at Kath Locke, 10.3.3). All the architects had some experience of introducing new security technologies. These included intelligent CCTV, pinpoint alarms and intelligent direction systems, which could signal where a patient should go. Shaw (MAAP, 1997) predicted these would eventually be used in most primary care buildings, because although the systems were expensive, the buildings and equipment were expensive and required protection.[55]

*Public access*

Social attitudes towards the accessibility of buildings have been gradually changing over the last two decades. The disability campaign, which successfully focused on the access needs of wheelchair users, was joined in the 1980s and 1990s by campaigns for improvements in access from other pressure groups who pointed out that level access, wider doors and lifts were required by a range of people, such as carers with small children and pushchairs, and benefit everyone.[56] The 1995 Disability Discrimination Act has made it compulsory for all

[54] See footnote 14.
[55] See footnote 15.
[56] The work of organisations for people with disabilities, such as the Centre for Accessible Environments the Disabled Living Foundation and RADAR in the early 1980s have been followed by campaigns for improved access for carers with children, for example by the We Welcome Small Children Campaign and Women's Design Service and ParentAbility in the late 1980s and 1990s.

new buildings, to which the public has access, to provide for wheelchair accessibility. The underlying philosophy in introducing access regulations was that as far as reasonable the built environment should be made as accessible to disabled people as it is to able-bodied people. Shaw (MAAP, 1997) observed that ideally there should be neither ramp nor steps within a health centre, but, if these were unavoidable, then it was important to make features, such as ramps, an attractive part of building through using beautiful wooden hand rails.[57] Many basic access requirements for primary care buildings are covered in the Health Building Notes 46 & 36.[58]

Barton (Avanti, 1997) also placed public legibility of the building as a high priority in the design of primary care buildings so that people did not wander around lost or confused.[59] He pointed out that Avanti had achieved legibility in some designs through top-lit corridors radiating from a central point. This enabled people to find their way back to reception. Internal signage was regarded as an important indicator of the prevailing culture in primary care buildings. In some projects clients wanted to create clear signage systems, while others have attempted to avoid written signs altogether. At St Bartholomew's Medical Centre Oxford it was found that avoiding written signs had changed doctors' behaviour and encouraged them to welcome patients personally and escort them to the consulting rooms.[60]

*Public facilities and comfort*

The provision of public facilities within a primary care centre can send important signals to the local community about the ideology of the facility and the value, status and degree of ownership awarded to local people.

One way of encouraging local use and interaction is to provide a health information facility on a drop-in basis, either through an electronic information system or a staffed information

[57] See footnote 15.
[58] NHS Estates (1991), (HBN 46), op. cit., p.21.5.3/4 & p.23 5.28-29.
[59] See footnote 14.

point that does not require a prior appointment. This facility should be designed both to be visible and to allow discrete access. HBN46 also suggests a method of displaying written notices and storing leaflets that allows the reception area and waiting rooms to be kept tidy.[61]

The provision of public refreshment facilities can also send important signals to the local community about the openness of the facility and give encouragement to those people, who might not otherwise enter the building, but who might benefit from some of the activities and services, to come for the first time.[62] Refreshment areas can also provide advice and ideas about nutrition and training opportunities for local people. They also provide opportunities for informal inter-staff and staff/public user encounters. Public telephones in health centres are important to enable members of the public to relay information, explain delays or arrange transport, and these need to be located near entrances and waiting areas. Guidance on the appropriate provision of WCs for the adult public is brought up to date in HBN36, but facilities for children, especially nappy change, are not mentioned and it has been left to architects to design these important provisions.[63]

Social awareness of the needs of carers and children has also been growing in the 1990s. Provision for children has become more commonplace in waiting areas of public and commercial buildings where children are expected. Observational evidence gathered through this investigation suggests that provision for children, particularly play areas in waiting areas, has been gradually improving, but there are still few crèches attached to primary care centres. However, some multi-agency centres have experienced difficulty in funding the initial capital expenditure and revenue costs of crèches (see Neptune Health Park case study Chapter 10.4). Also, outside play areas for children rarely seem to be provided, even where there is space on the site to accommodate it.

---

[60] Westcott, P. (1991), 'Inside the Healing Dome', *The Guardian,* 19.4.91, p.31.
[61] NHS Estates (1991), (HBN 46) op. cit., p.22, 5: 19.
[62] See case studies 10.2 and 10.3.

*Independent Community Activities*

> *Emphasis on prevention implies not only passive health promotion clinics (healthy lifestyle, anti smoking) which only the well motivated may attend, but initiatives such as associating health resource facilities with social centres, so bringing such activities close to those most in need of guidance.* [64]

The NHS reforms of the 1980s and 1990s brought a new emphasis on health prevention and a renewed interest in encouraging local communities to have access to information and advice and to take part in fitness classes and organise self-help sessions. Space may need to be accessible to the community at different times to medical treatment hours and should not necessarily have to be supervised by health professionals. Hoskins (Penoyre and Prasad, 1997) described how a large meeting hall had been given a separate entrance at the health centre designed at Rushton Street Surgery, Islington, London, so that the community could use it in the evening (see Figure 8.4).[65] Hoskins had observed that there were no longer many community centres being built and had thought that these could be an important community resource as well as supplying the centre with a larger meeting space for a variety of purposes. A similar provision was made at the Vauxhall Health Centre, Liverpool, where pressure was put on the North Merseyside Community Trust to redevelop the health centre with community involvement and to allow the community independent access to the building (see below, Figure 8.7).

[64] NHS Executive, NHS Estates. (1994/5), *London Initiative Zone Primary Care Premises Handbooks 1/4,* London: Crown. Bk. 1, p.21: 5.7.
[65] See footnote 19.

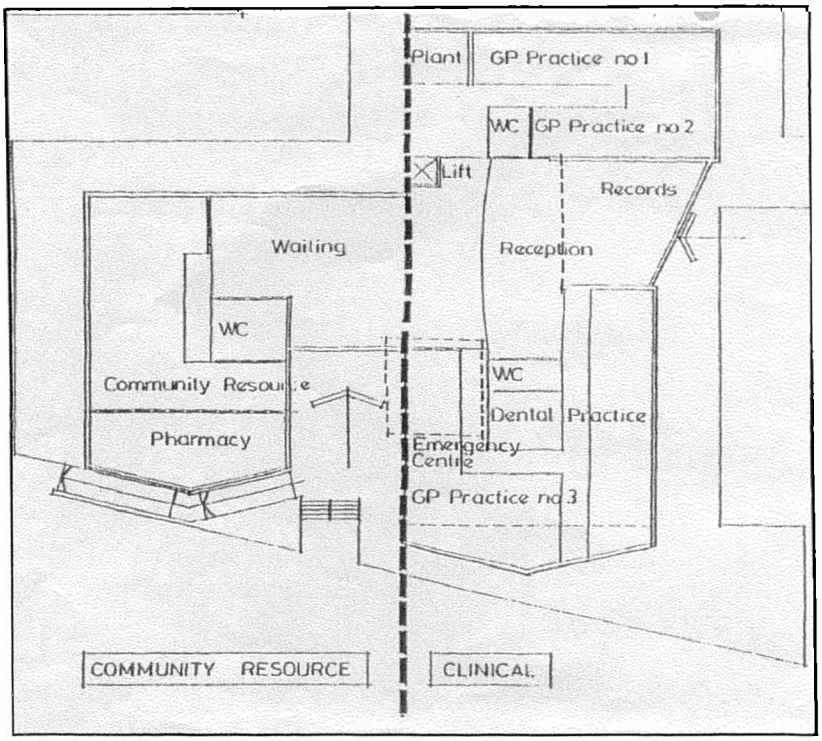



**Figure 8. 7**
**Ground Floor Plan of Vauxhall Health Centre showing community resource area that can be used independently from clinical access. Architects: O'Mahony Fozard.** Source: NHS Estates Bk 3 (1994/5)

*Sustainability and ecology*

Despite increasing social interest during the 1990s about sustainability in connection to buildings and local environments, recommendations on issues such as waste and recycling, car driving and parking are notably absent from official guidance for building development in pre-1997 directives. For example, no distinction is made between the need to provide parking space for essential staff, or public users and the need to deter unnecessary car journeys in line with general political trends for reducing the number of non-essential car journeys.[66] The architects I interviewed for this study agreed that sustainability and ecology issues were often neglected in health building development. Shaw (MAAP, 1997) regarded

[66] See for example NHS Estates (HBN 36, 1995) op. cit., p.23: 3.29/33.

low maintenance costs as an important consideration when designing health buildings and explained that MAAP had tried to achieve this primarily via energy conservation and easy maintenance systems, also some materials were also chosen with an awareness of their ecological characteristics.[67] Barton (Avanti, 1997) thought that ecological issues were important, but that because ecological solutions could contain additional initial capital expenditure which sometimes deterred their practice from offering more sustainable solutions, even though these might be recouped in the longer term from maintenance costs.[68]

Although sustainability was not an issue that could be dealt with in-depth within this dissertation, I included it as a design factor, because I wanted to assess whether any of the case studies I had selected had considered the promotion of sustainable ideals in partnership with local communities, or within the facility itself. If there was none, this could indicate that there was a need for further research and guidance about the subject.

## 8.4 Conclusion

The purpose of this chapter has been to explore design factors that could contribute towards the social principles for primary care, outlined by the World Health Organisation, of inter-sectoral collaboration and local community involvement. The objective was to consider how formal and spatial arrangements, and surface treatments, might send messages to different building users about their role and position within the facility, and signal their relationship to other building users and the local community. The design factors (listed above), explored in semi-structured interviews with selected architectural practices, are those which appear to either facilitate or prevent certain activities, or reinforce or neutralise power relationships within primary care facilities. These factors have formed the framework for the evaluation of building design in the four case studies presented in Chapter 10 (see also the building quality survey, Appendix 1:9).

---

[67] See footnote 15.
[68] See footnote 14.

## Chapter 9
## COMMUNITY INVOLVEMENT IN PRIMARY CARE FACILITY PLANNING AND DESIGN

Following the theme of the last chapter, which focused on identifying design principles connected to the social objectives of facilitating inter-sectoral collaboration and community participation in the *product* of primary care architecture, this chapter will explore how community involvement at the planning and design stages of the architectural *process* might contribute to meeting the same social objectives. This chapter will build on the discussion of definitions of community in Chapter 7 to explore how strategies to involve local communities in the planning and design stages of primary care buildings could contribute towards better buildings and social benefit, and to consider some of the obstacles that might inhibit that process.

Community involvement is an issue of debate in sociology and cultural, community and urban studies, as well as among public service providers and policy-makers. It is often discussed as a pragmatic issue and although practicalities such as time, management and issues of fair representation, are clearly important, this chapter will suggest that genuine and effective community involvement in planning and designing primary care buildings is ultimately dependent on a political willingness to extend democratic decision-making to a local level. This chapter will attempt to demonstrate that the ideological consumerist versus democratic controversy, discussed in earlier chapters, which has divided approaches to primary care service delivery, has also divided political and professional approaches to community involvement and contributed to fragmentation, inequality and missed opportunity within primary care provision.

It is not the intention of this chapter to discuss the various techniques for involving communities in health service decision-making process or planning and designing facilities.

There is already an extensive literature on the subject of community involvement techniques used in health service planning and decision-making, listed in Buckland (1993)[1] Blaxter (1995)[2] and Farrell and Gilbert (1996).[3] More specific techniques for community involvement in building design are also discussed in various publications (see for example, DoE, 1994;[4] Environment Trust, 1994;[5] Towers, 1995 [6]). Instead, this chapter will look first at the political differences between neo-liberal and social democratic approaches to community involvement in decision-making in the health service. Second, it will examine the case for extending staff and community involvement to the level of decision-making relating to planning and designing primary care facilities. Third, it will consider some of the barriers to community involvement in facility planning and design that can stem from entrenched professional attitudes and restrictions within the architectural process. Fourth, it will consider the question of who should take responsibility for the process of community involvement. Finally, it will identify commonly cited indicators of effective community involvement processes that I selected as items of measurement for the case study evaluations described in the next chapter.

## 9.1 Ideological approaches to community involvement strategies in health service decision-making.

In the introduction to this dissertation, I cited the argument between Anna Coote, and Dr John Spiers (1997) about whether health service users should be best regarded as 'shoppers' or 'voters' (also often described in health literature as 'consumerist' and 'democratic'

---

[1] Buckland, S. (1993) *Consumers and the NHS: An annotated bibliography* University of Plymouth: Social Services Research and Information Unit, Occasional Paper 1

[2] Blaxter, M. (1995) *Consumers and research in the NHS: consumer issues within the NHS*, Leeds, and Department of Health.

[3] Farrell,C. , and Gilbert,H.(1996) *Debates and strategies for increasing patient involvement in health care and health services.* London:Kings Fund.

[4] DoE (1994) *Community Involvement in Planning and Development Processes*, London: HMSO.

[5] Environment Trust (1994) *Creating Involvement* London: Environment Trust Associates and the Local Government Management Board.

[6] Towers, G. (1995) *Building Democracy: Community architecture in the inner cities*, London: UCL Press.

approaches).[7] Hirschman (1970) had previously made a similar distinction in developing the concepts of 'exit' and 'voice', as contrasting strategies for forcing bureaucracies to be responsive to external pressures, either by users taking their custom elsewhere, as in 'exit', or by expressing their dissatisfaction to the management, as in 'voice'.[8] Hirschman described this split as a fundamental schism, whereby 'exit' belongs to the realm of economics, while 'voice' is rooted in politics. The Conservative reforms of the NHS are acknowledged to be based on a culture of market competition built around the consumerist option.[9]

While these distinctions often appear to influence health policy-making strategies, they do not necessarily benefit the public, who need strategies for involvement at both collective/democratic and individual/ consumer levels. Bristol & District CHC (1995) attempted to influence their health authority to adopt a multi-leveled approach to public consultation in their 'listening to local voices' conference *Involving Local People in Health Care Purchasing* (see Figure 9.1).[10] [11] This model of public involvement follows ideas of *associationalism*, first proposed by Hirst (1994) and supported by Ham (1996), which suggest the need to strike a balance between collective and individual responsibility in health matters.[12] Ham states:

> *The importance of maintaining universality and comprehensiveness as values that should underpin the NHS suggests that collectivism should remain a guiding principle. At the same time individual responsibility must be enhanced if citizens*

---

[7] ACF (1997) *Association of Charitable Foundations 4th Annual Lecture on Philanthropy, Kings Fund 29th April 1997*, Conference Report, p.1. This event focused on the issue 'User Involvement in Health Care – Where Next'.

[2] Hirschman, A.O. (1970) *Exit, Voice and Loyalty,* Cambridge Mass: Harvard University Press.

[8] Taylor, P. Peckham, S., & Turton, P. (1998) *A public health model of primary care – from concept to reality*, Birmingham: Public Health Alliance, p. 46.

[9] NHS Management Executive (1992) *Listening to Local Voices* Leeds, Department of Health.

[10] Bristol & District Community Health Council (1995) *Involving Local People in Health Care Purchasing*, Conference Report: Bristol & District CHC, p.11.

[11] See Chapter 7, and Hirst, P. (1994) *Associative Democracy,* Polity Press: Cambridge.

Ham, C. (1996) *Public, Private or Community: What next for the NHS?*, London: Demos, pp. 46-48.

*are to have a stake in the NHS and feel a sense of commitment to fellow citizens. The reassertion of community control through an invigorated voluntary sector alongside public provision could offer real gains in avoiding the weaknesses of a for-profit culture and in reconnecting public service with those they are intended to serve.*[13]

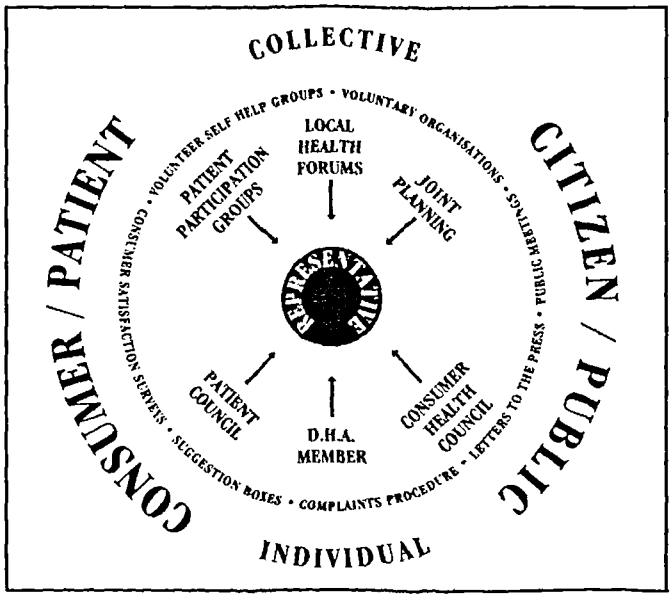



**Figure 9.1**

**Model to show the variety of ways in which the public, as individual consumers and as citizens might express views about health services.**

Source: Bristol & District CHC (1995)[10]

Within the NHS, it has been suggested that Aneurin Bevan's awe of GPs medical expertise may partly account for the lack of interest in seeking wider professional or public participation in health decision-making in the earlier years.[14] Also, that perhaps overwhelming loyalty and gratitude felt by the public towards the NHS and unflagging belief in medical science protected it for a long time from criticism, or demands for greater involvement from the public. Whether or not this was the case, some observers believed that before the 1990s, despite some serious efforts to involve communities and the public in other forms of social planning, such as urban regeneration schemes, NHS attempts at public consultation about were either non-existent, or were so token that they had stretched public

[13] Ham, C. (1996) *Public Private or Community: What next for the NHS?,* London, Demos. p.75, citing Hirst, P. (1994) *Associative Democracy,* Cambridge: Polity Press.
[14] Klein, R. (1995) *The New Politics of the NHS,* Third Edition London: Longman, pp.19-20.

credibility to an extreme. [15]

By the 1980s and 1990s, criticism about the lack of public consultation had begun to increase across the political spectrum. As I described in Chapter 2, the argument that the NHS had become unresponsive to public needs and concern is alleged to have become one of the triggers for Thatcher's 1989 ministerial review.[16] However, although the rhetoric of the subsequent reforms emphasised that there should be a new relationship between the NHS and service users and there was some encouragement for a 'listening to local voices', or a collective voice in decision-making, overall the Conservative government directed strategies on increasing patient's individual rights as consumers with initiatives such as the *Patient's Charter* and *Patient-Focused Care*.[17] [18] [19] Another strategy for increasing public user involvement favoured by the government during the 1980s and 1990s concentrated on seeking improvements in the methods of communication and amount of information available to individual users through mechanisms such as, the *Consumer Health Information Consortium* (CHIC) and *Evidence Based Patient Choice*.[20] [21]

It is frequently argued that public involvement can take place at different levels and does not necessarily mean active participation, especially if only basic information is provided or sought from users.[22] Shelley Arnstein (1969), an American sociologist, developed a 'ladder of citizen participation', which has become widely used as a means of assessment in public participation projects (see Figure 9.2).[23] Arnstein advocated that all participants in projects or initiatives should seek to be clear about the level on the ladder to which they aspire before

---

[15] Lee, D. (1995) recorded interview notes at Islington CHC, (2.3.95), see Appendix 1.1.
[16] Although this did not prevent the reforms themselves being introduced without public consultation and with little public support.
[17] NHS Management Executive (1992) *Listening to Local Voices* Leeds, Department of Health.
[18] Department of Health (1992) *The Patient's Charter*, London: Department of Health.
[19] NHS Executive (1995) *Progress with Patient- Focused Care,* London: Nuffield Institute for Health
[20] DoH (1996) *Primary Care: The Future*, London: HMSO
[21] Farrell, & Gilbert, op.cit.
[22] There is controversy and contradiction in health literature about the usage of the terms 'participation' and 'involvement'. See Farrell & Gilbert, op. cit., p. 6 for a more detailed analysis of these terms.
[23] Arnstein, S. (1969) Citizen Ladder of Participation, *Journal of the American Institute of Planners*, Vol. 35 (4) pp. 216-244.

commencing on the process of participation. She argued that there is a link between citizen participation and the redistribution of power and suggested 'there is a critical difference between going through the empty ritual of participation and having the real power needed to affect the outcome of the process'.[24] In reviewing some of the hair splitting literature that has subsequently emerged on the relative merits of 'involvement' versus 'participation', I have adopted the view that nothing useful is gained by this, but that a genuine attempt at social benefit and some transference of power to the community should be sought as part of the process. Also, Towers (1995) makes the important point that effective citizen partnership rather than control is probably the best that can be attained in public building projects, because, as I have argued in earlier chapters relating to primary care facilities, the stakeholder base is so diverse and the funding mechanisms are so complex.[25]

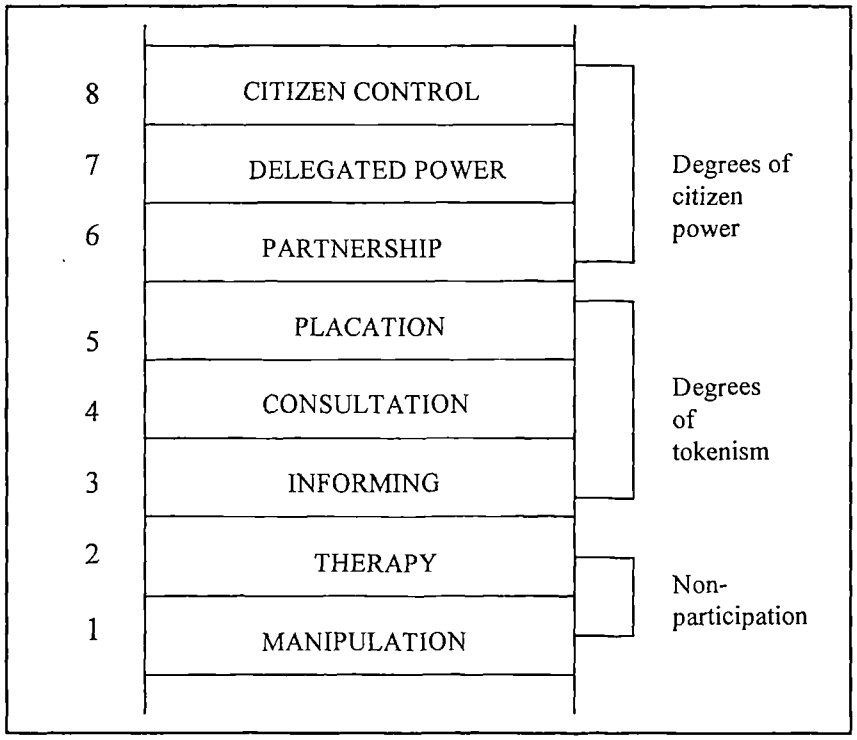



**Figure 9.2**

**The 'ladder of participation' as devised by Shelley Arnstein. (1969)**

[24] Ibid. Arnstein has been accused of implying quality judgements through using words like words like manipulative, tokenistic, or minimal, which imply an assumption that higher levels of the ladder represent better forms of participation. However, a counter argument could be made that in cases where there are many preconditions and restrictions on the type of health facility proposed, there may be good reason to limit or carefully target community involvement, so as to not raise unrealistic public expectations and waste resources. In some circumstances limited community involvement may be better than nothing, but it is imperative that limitations are honestly admitted from the start and the reasons publicly stated.

[25] Towers (1995), op. cit. pp. 157-172.

However, even achieving effective community partnership in primary care decision-making appears to have been a relatively rare occurrence. Macdonald (1995) pointed out that consumerist measures 'carefully excluded the collective dimension of participation and reduce it to the humanisation of the bureaucratic links between the individual and the system'.[26] Dave Lee, Chief Officer of Islington CHC (1995), had observed that consultation within the NHS had become devalued through the debacle of hospital closures during the early 1990s and that the public in central London had developed little trust in the sincerity of the health authorities to consult with them.[27] Also, he had noticed that most of the consultation that had taken place had been at the level of providing the community with information about decisions that had already taken place.[28] Leonard et al (1997) in an evaluation of two primary health care projects in London had also observed that the government's rhetorical emphasis on community involvement was coupled with a lack of achievement in practice.[29]

A democratic and collective approach to participation in primary care was put forward by the World Health organisation (WHO) as a fundamental part of the global strategy to reduce inequalities, in the *Health for All by the Year 2000* objectives. The strategy of Community Involvement in Health Development (CIH) was proposed not just as a programme, or a right, but as a principle for maximising people's involvement and contributing to their health care.[30] Oakley (1989) suggested this definition of CIH was both a powerful statement of intent and a political commitment:

> *Community involvement (in health development) is a process by which partnership is established between the government and local communities in the planning, implementation and utilisation of health activities in order to benefit from*

[26] Macdonald, J. (1995) *Primary Health Care*: Medicine in its Place. London: Earthscan, p. 98.
[27] Lee (1997), see footnote 15.
[28] Ibid.
[29] Leonard, O., Allsop, J., Taket, A., and Wiles, R. (1997) *User Involvement in Two Primary Health Care Projects in London,* College of Health, South Bank University, p 3.
[30] WHO (1991) *Community Involvement in Health Development: Challenging Health Services,* Report of WHO Study Group, Geneva: WHO.

*increased self-reliance and social control over the infrastructure and technology of primary health care.* [31]

Oakley argued that some form of organisation at local level was required to act as a vehicle for involvement, but acknowledged that different areas needed to decide whether existing structures were adequate or whether new structures would need to be created to enable wider representation of the community.[32] CIH did not appear to make much advancement in Britain during 1979/1997, perhaps because, as the WHO Study Group (1989) acknowledged, for community involvement to become a real force in health care planning, a political commitment and a desire to strengthen and empower communities were pre-requisite.[33] The WHO Study Group (1989) argued that many disadvantaged communities were too fractured and lacking in resources to be able to speak with a united voice and take greater control over health services and facilities. It was realised that these communities needed development to enable them to take part in the local democratic processes.[34]

Historically, governing politicians have rarely encouraged collective or community involvement in decision-making. Instead, well-organised, protesting, or demanding local communities have tended to be seen as a threat to the establishment of the day and repressed by government legislation. Some examples of repression of the collective voice that occurred during 1979/97 include the Criminal Justice Bill (1995), which legislated against public assembly; uncompromising approaches to union disputes; and the abolition of the Greater London Council (1988).

I have already argued that the changes in management structure of health authorities and abolition of Family Practitioner Committees (FPCs) brought about by the NHS reforms, increased the role of managers, eliminated the representative element and did little to

[31] Oakley, P. (1989) *Community Involvement in Health Development,* Geneva: WHO, p.13.
[32] Ibid., p.34
[33] WHO (1991) op. cit. p.29.
[34] Ibid.

improve accountability or encourage the involvement of local people in policy planning and decision-making.[35] Also, the Private Finance Initiative resulted in some decisions, which may have previously have been made in public after some discussion with users, being made in secret for reasons of commercial confidentiality.[36] The powers of the only statutory user representative organisation, the Community Health Councils (CHCs), have also been severely under-resourced and undermined since the NHS reforms.[37] For example, consultation with the CHC used to be required if there was any substantial change in the use of health buildings, but, after April 1996, CHCs were placed outside the NHS managerial chain, which effectively removed grass-roots representation at a management level.[38] In 1995, the Institute for Public Policy Research report, *Voices Off: Tackling the Democratic Deficit in Health,* suggested that CHC's remained seriously underfunded and resourced in both human and financial terms and suggested that a radical overhaul, giving CHCs clear rights, proper resources and an independent establishing authority, was required to retain credibility.[39]

The main political controversy therefore appears not to have been whether the NHS should become more responsive to communities, but rather the extent and manner in which public viewpoints should be consulted within this process, and how far the collective voice should be allowed to influence practice. Although it is acknowledged that some improvement in health professionals' attitudes towards public users may have occurred, and that greater efforts have been made to provide more information and choice of treatment, overall most literature on public accountability since the NHS reforms draws attention to the fact that the power of public users to collectively influence key decision-making within the health service

---

[35] See Chapter 3.
[36] See Chapter 6.
[37] For example the CHCs have no rights to inspect NHS trust premises or be represented on NHS trust boards. Ranade, W. (1994) *A Future for the NHS: Health Care in the 1990s, London*: Longman, p.71.
[38] When the regional authorities were dissolved in April 1996, the Secretary of State became the CHC's establishing authority.
[39] Institute for Public Policy Research (IPPR), (1995) *Voices Off: Tackling the Democratic Deficit in Health,* London: IPPR.

was largely removed from the organisation structure.[40] It is too early to tell whether the Labour government elected in 1997 will satisfactorily reverse this trend.

## 9.2 The case for and against community involvement in facility planning and design

Even if the principle of there being a collective voice in local health service decision-making is accepted, this may still fall short of being extended to the planning and design stages of local primary care building commissioning. Funding for public consultation and involvement in planning and designing primary care facilities generally has to come from health budgets, which might otherwise be spent directly on treating patients. This expenditure therefore rightly needs to be justified to commissioning health authorities, or other budget holders. This can cause difficulties because some of the potential benefits of community involvement, such as social cohesion, or less wasted resources, are qualitative and long term rather than quantitative and may be hard to evaluate. However, there are powerful arguments that point out the benefits of community involvement and illustrate how the failure to consult or involve can lead to added costs and penalties later on.[41]

Theoretically, an argument for community involvement in primary care facility planning and design can be made from a consumerist or a democratic perspective. However, essentially the consumerist argument is likely to centre on 'value for money' and ensuring responsiveness to users, whereas the democratic argument will focus on citizen's rights and community empowerment. If the commissioners of the building adopt a consumerist approach, then the amount of local community involvement sought in the more detailed stages of service delivery planning, such as planning and designing individual facilities, is

[40] This is a conclusion is drawn by Taylor, P., Peckham, S. & Turton, P. (1998) *A Public Health Model of Primary Care – From Concept to Reality,* Birmingham: Public Health Alliance, p.48.

[41] See for example RIBA Community Architecture Group (undated). *A right to participate- towards people centred development,* London: RIBA; or Church, C. (1997) 'A Right to Participate' in *Streetwise,* Issue 28, Vol 7:4. Also Towers (1995), op.cit. p.172. Social gain is becoming 'costed in' as part of the local authority Best Value contracts replacing competitive tendering.

likely to be minimal. Facility commissioners will probably accept the role of medical and design professionals as adequate assessors and advocates of the public interest. If there is any consultation during the design process, it will tend to be with staff users higher up in the hierarchy, i.e. GPs, who will not necessarily have links with the community outside their professional relationship, rather than nurses or reception staff. Staff lower in the hierarchy and local communities will tend only to be given information about decisions already made. For example, by being given leaflets explaining the changes, or by being presented with architects' drawings or models, rather than actively being expected to contribute ideas that will be acted upon.

With respect to staff users, Carpman and Myron (1993) have argued that the more powerful the individual is within the facility (in primary care facilities the most powerful will probably be the GPs), the more likely they will be to participate anyway.[42] They suggested that this may be a positive factor because these staff users can contribute useful information based on experience and their approval of the design is often required. However, they argued it was equally important to seek out the participation and expertise of less powerful user groups such as nurses, reception staff and cleaners, because these people were directly involved in day to day operations of the facility and their contributions could be crucial to the success of the project.

From an architect's perspective, as I argued in Chapter 6.2, a major concern in approaching a new primary care building project will be to satisfy the client and fulfil the brief. A key question is therefore, *who is the architect's client*? Staff from privately owned GP premises and publicly owned health facilities, now usually the property of Community Health Service trusts, are likely to give a different response. In GP premises the principal clients will usually be regarded as the GPs, both as owners and as the main staff users. Whether or not other staff users or the community are given the opportunity to participate at any level in the

[42] Carpman, J. R. & Myron, G. (1993) *Design That Cares: Planning Health Facilities for Patients and Visitors.* 2nd Edition, Chicago: AHA.

design of GP owned facilities will be dependent on the GPs attitude and the ideological culture of that particular practice. As Taylor et al (1998) have observed, the promotion of the small business model in GP practices, supported by the NHS reforms has meant that the 'potential of wider community involvement and of a collaborative approach with other agencies is largely unrecognised or difficult to achieve for structural reasons'.[43]

In publicly owned primary care facilities the extent to which all the staff and community involvement is sought, will probably be determined by the dominant ideological position of the key policy and practitioner stakeholders. In multi-agency centres all the key practitioners are likely to be represented in the planning and design process for logistic purposes, although there might still be a hierarchy operating over decision-making in accordance with the professional status, financial resources invested, or the amount of space allocated to that group. However, the level of involvement and influence allowed to the community may be more arbitrary, and the community may not be recognised as a legitimate client. But this situation is likely to be avoided if local community groups themselves are direct clients of the architect, through their occupation of space for voluntary or self-help health services. For example, at the Kath Locke Centre in Manchester, local community and public users were automatically represented within the staff user consultation process, who were in turn able to consult with their own client groups on planning and design issues.[44] This made the design consultation process directly and obviously beneficial to community groups and reduced the time and effort spent on organising special community consultation meetings.

The architect Giancarlo De Carlo (1970) has suggested that there is a fundamental difference between planning 'for' and planning 'with' users in the quality of the planning.[45] He argued that 'by "participation of the users" we do not mean that the users should work at the drawing board or that users dictate and the architects transcribe' but that

---

[43] Taylor, P., Peckham, S. & Turton, P. (1998) *A Public Health Model of Primary Care – From Concept to Reality,* Birmingham: Public Health Alliance.p.44

[44] See Chapter 10.3

[45] De Carlo, G. (1970) 'Architecture's Public' *Parametro* No 5.

'participation transforms architectural planning from the authoritarian act which it has been up to now into a process'. This process is explained as having three phases – the discovery of needs, the formulation of formal and organisational hypothesis, and use, which are correlated in a cyclical relationship'.[46]

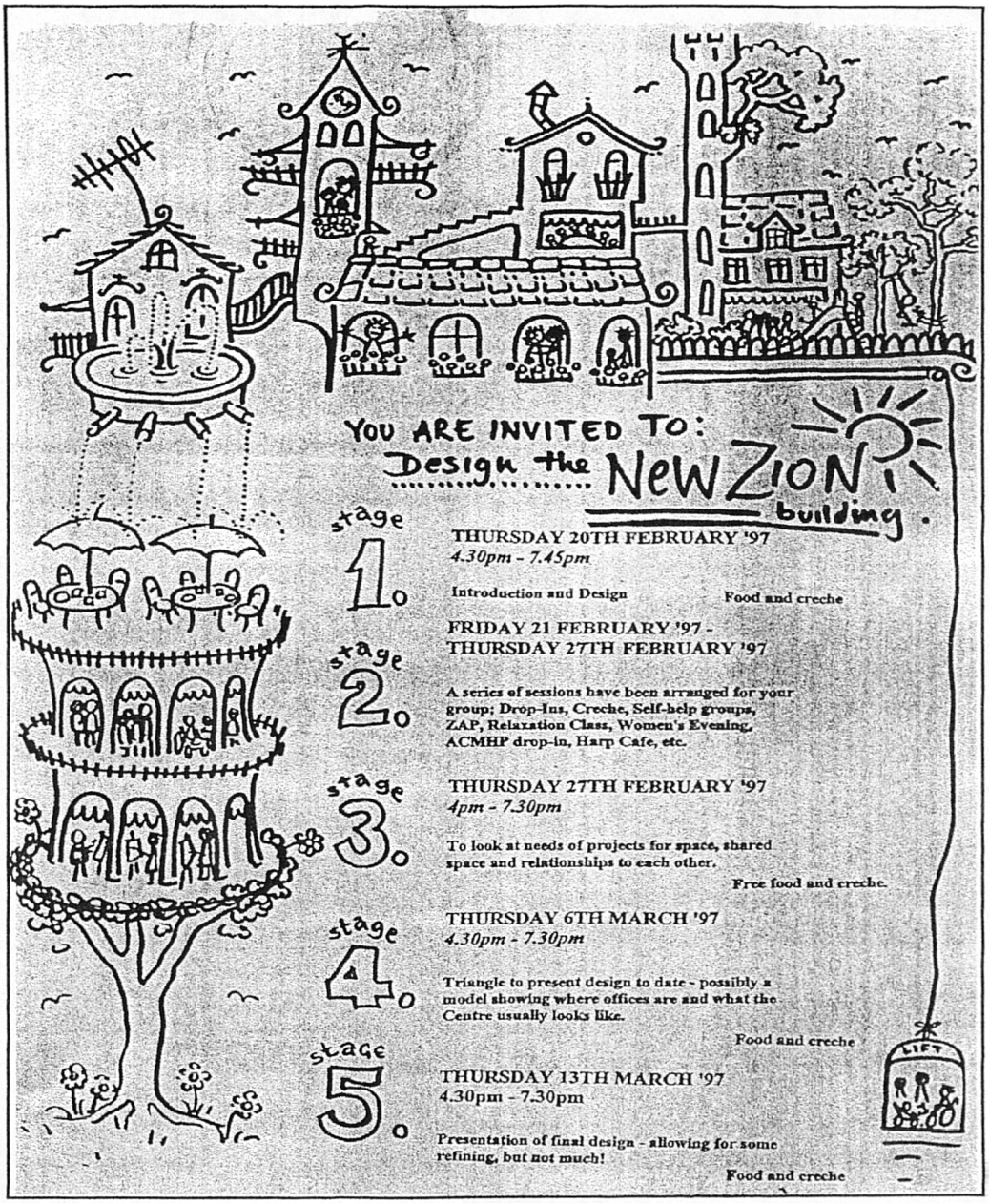



**Figure 9.2**
**Poster invited the local community to participate in a design session for the new Zion Community Health and Resource Centre, Hulme, Manchester. Architects: Triangle.**

[46] Ibid, p.212.

Over the last twenty years a variety of techniques have been developed to help demystify the design process. As Towers (1995) argued, these techniques have grown out of community action and a determination to be heard and gain greater control over their environment.[47] However, one of the most simple and useful ways for the community to be involved is through full and open discussion with the architects about design problems and solutions.

Among the architects I interviewed in connection with this research it was not hard to find support for the inclusion of staff representation in the design process of primary care facilities, but they appeared far less convinced about the usefulness of involving communities. The architects accepted that many design considerations and space allocation in primary care buildings were dependent on the joint use of space by staff, and so it was important for the architect to learn from them whether certain arrangements were acceptable and practical. Staff users also needed to understand why compromises sometimes had to be made. Shaw (MAAP 1997) suggested that better and bigger spaces could often be allocated if rooms could perform multi-functions and that economical buildings were always sought because nobody wanted to waste money on buildings that could be better spent more directly on services and health gains.[48] He suggested that staff satisfaction with the building was important, because the building needed to be perceived as a good place to work. If it was not, he alleged that it would soon become neglected, fail to attract good staff and the facility would fall into a negative spiral. Hoskins (Penoyre and Prasad, 1997) asserted that time allowed at the design stage for consultation with staff users had a direct bearing on the subsequent quality and success of the building.[49] He considered that meeting the specific requirements of the staff-client crucially informed the briefing process and that the practice adopted a consultative approach to allow 'the essential truths inherent, but not necessarily apparent in a brief to emerge in the design'.

[47] Towers (1995), op. cit., pp. 168-174
[48] Shaw, C. (1997) recorded interview notes at MAAP Architects, 18.2.97.
[49] Hoskins, G. (1997) recorded interview notes at Penoyre and Prasad Architects, 13.3.97

So although the case for staff representation and involvement in the planning and design process appeared to be acceptable to all the architects interviewed, some claimed they could see little evidence to suggest that it would help for the community to become involved in the process. This appeared to be mainly because their perception of a primary care building was that of a professionally owned and/or dominated, specialist facility, not one shared with or accountable to the community? This would therefore imply a need for the community to be more widely acknowledged as a legitimate client and that the facility should be accountable to local citizens, public users and communities, as major stakeholders.

Feedback from the national postal survey that I conducted in 1995, outlined in Chapter 1, has provided evidence that a range of both consumerist and democratic benefits could arise from involving the community in planning and designing primary care facilities. Some advantages of community involvement were cited as:

- a better targeted facility which has drawn on local knowledge to provide the required services
- a facility that is more publicly accountable and which allows the community to have a voice in the way services are delivered
- a facility that encourages the idea that the attainment and maintenance of health is best achieved through a participatory partnership between individuals, communities and professionals
- a building that has greater commitment from the community, who recognise it as a valuable resource that is welcoming and accessible to the whole community and positively contributing to the quality of local life.[50]

However, it was also clear from this survey that even when there was commitment to community involvement from those initiating the project, there could be opposition from some health professionals. A common objection to community involvement encountered was

[50] See also Appendix 1.4.

that the process was unlikely to reach the 'real' community and therefore would inevitably be unrepresentative. This issue has already been raised in Chapter 6 and will be discussed in more detail further on in this chapter, but the objection can be countered by establishing a multi-faceted participation process and by balancing even an imperfect involvement process with the gains that might be offered from even a small group of community representatives. The study by Leonard et al (1995) of user consultation strategies identified four other barriers to community involvement, which would need to be addressed. These were:

- a too limited strategy: e.g., the health authority had not identified the range of community organisations with an interest in the project
- different perspectives towards the community involvement process: e.g., GPs were cautious about the level that was desirable and the CHC wanted a more radical approach to planning the development and felt marginalised
- problems in deciding the appropriate timing of involvement. For example in the early stages the planning was vague whereas once funding and planning permission were secured changes became limited through cost and time implications
- contrasting strengths and weaknesses of the agencies acting as advocates of service users. For example, the residents association who knew locality and community well did not have expertise on the organisation of the health service. [51]

This evidence indicates that barriers to community involvement in facility planning from professionals, in both medicine and design, can be both attitudinal and structural. The next section will consider how changes to the traditional training methods and institutional structures of professional practice might help to change attitudes to community involvement.

[51] Leonard, O. Allsop, J. Taket, A. and Wiles, R. (1997) *User Involvement in Two Primary Health Care Projects in London* College of Health, South Bank University. p.36.

## 9.3 Medical and architectural professional approaches to community involvement

Farell and Gilbert (1996) have argued that a new approach to the relationship between health professionals and public clients is required in order to create a more egalitarian partnership.[52] Education and training are seen to be the main mechanisms for bringing about this change and they make three recommendations: the introduction of the principles of public involvement into professional education and training; the development of training for professionals to work with users; the development of training for lay people to work with professionals. A radical experiment to change the type of training received by GPs along these lines was been piloted in Leicester (see St Matthew's case study Chapter 10.2). Here the experience of a GP working on a deprived housing estate led her to believe that medical professionals needed more opportunities to meet clients in their home environments in order to understand the full range of health related issues facing residents. In response she set up a training centre within a primary care facility on the estate and paid local families to act as case studies for trainee doctors and other health professionals. This type of training could have a significant impact on the future attitudes of GPs, not least by impressing on them that their patients may have a valid contribution to make in finding solutions to health problems. This could become routinely extended to consultation about the type of facilities that would meet those needs. The employment of salaried GPs to follow a specific job description directed at a mission and a strategy has been suggested as another way to encourage a partnership approach to users and other health professionals.

There has also been some evidence that professionals have been willing and eager to involve communities and public users in the decision making process, but have been deterred or obstructed because they have not been provided with the resources to accomplish this. For example Taylor, Peckham and Turton (1998) found that some 'primary care professionals, especially GPs, felt that the pressures of their day-to-day workloads inhibited any wider

[52] Farrell, & Gilbert op. cit., p.31.

contact with their communities unless they were given identified time to do it.' [53]

Architectural training has also been slow to recognise the value or importance of involving communities in public building projects. Participation management has not been a standard part of architectural training, although some architectural schools are beginning to address this issue. For example there is now a Community Unit at the Manchester School of Architecture, which has been working on collaborative projects with local community groups. And, De Montfort University is developing a CUDE (Clients and Users in Design Education) course, which is intended to introduce design education degree students to client and user issues in briefing, design and presentation processes. The new commissioning and purchasing practice of 'Best Value' introduced to local government and other public bodies in 1997, whereby quality of service as well as economy becomes a required condition, may also eventually influence the health facility commissioning process and ensure that architects are adequately resourced to involve public users at the design stages of primary care.

Perhaps as a result of deficiencies in training, scepticism about the usefulness of community involvement among some of the architects I interviewed appeared deeply rooted. One of the arguments they raised against community involvement was that public aspirations for health buildings were too low, and that considerable education would be required before the community could make informed choices. An examination of schemes where communities have had the opportunity for involvement in design processes supported by architects demonstrates no justification for the view, sometimes expressed that consultation with communities will inevitably lead to bland architecture, and there are several examples of social housing schemes here and in Europe where residents have chosen radical design aesthetics. [54] Indeed, it could perhaps be more justifiably argued that there are quantities of characterless buildings being constructed, where communities have had no involvement in

---

[51] Taylor, Peckham and Turton ,op. cit.

[54] See examples cited in Herzberger, H. (1991) *Lessons for Students in Architecture*, Rotterdam: Uitgeverij 010 Kroll, L. (1984) 'Anarchitecture' in Hatch, C. (ed.), *The Scope of Social Architecture*, New York: Van Nostrand Reinhold. Towers (1995) op. cit.

the decision-making, such as some of the monotonous estates of speculative low cost private housing. So maybe it should be claimed that more design literacy is required by both the public and professionals to enable them to make informed, imaginative or adventurous choices. Among the many successful educative strategies that have been used, one idea has been for user group managers to arrange for community groups to visit similar facilities already built, another is to invite architects to present and explain the appropriateness of different designs, and yet another is to organise design workshops in which users can contribute ideas.

A fear, expressed by one of the architects, was that localised community involvement might lead to a consumer-led, rather than a needs-led facility and that the demographic needs of the wider area could then be neglected. But, as was discussed in Chapter 3, this need not happen if appropriate levels of strategic planning existed at national, regional and district levels, which would ensure a fair distribution of resources for less common ailments. Another objection raised was that health buildings were too specialised for much input to be made by the public. However, not all the architects I interviewed shared this view. Hoskins (Penoyre and Prasad, 1997) described one scheme where the GP Practice had been keen to consult with their patients and had asked the architects to provide accessible drawings, perspectives, coloured sketches and readable reports, to enable them to consult with their patients.[55] Project architects from Penoyre and Prasad had also been involved in a user forum that had been set up to discuss design issues at Neptune Health Park (see Chapter 10.4).[56] Triangle Architects, interviewed in connection to the Kath Locke case study, had also demonstrated that community could and should be involved in many of the conceptual and interior design aspects of the building. They had worked with local people to encourage them to contribute ideas for incorporating art and local craft in the design based on their local knowledge and different cultural backgrounds (see Figure 9.2)[57].

---

[55] See footnote 49.
[56] See Chapter 10.4
[53] See Chapter 10.3
[57] See Chapter 10.3

Professional scepticism has clearly not been the only barriers to architects' engagement with community involvement. There has also been a lack of resources or structures to support architects who have wanted to involve communities in the design process. This was recognised by the RIBA Community Architecture Group in their 'A Percentage for Participation' campaign during the 1990s, which had tried to encourage public and private developers to commit around 1% of development costs to public participation at the design and development stages. The architects interviewed explained that it was usually harder for them to consult with communities than with staff users and also expressed concern that they were not necessarily the best people to have this responsibility in the briefing stages. Shaw (MAAP, 1997) thought that wider public user involvement for health facility planning, particularly through the CHC, was desirable, but had not proved practical.[58] Shaw suggested that public consultation had often appeared to be hindered by the mistrust that had developed between the CHC and the commissioning authority, usually over the issue of hospital closures. The architects also pointed out that the practice of competitive tendering, discussed in Chapter 6.2.2, which health authorities and other commissioners had often been compelled to adopt, had made it hard for any architect to include public participation procedures voluntarily, because of the extra time and resources this would involve.[59] Competitive tendering had often required cutting back on time allowed for staff user consultation. So that unless it was stipulated in the brief, and funding specifically allocated for the task, it was unlikely that architects would attempt to organise any public involvement in the design process, other than that necessary to forestall local planning objections to a scheme. This usually resulted in architects being restricted in providing information about completed schemes to the public, rather than seeking their active public participation and involvement.

[58] See footnote 48.

[59] This situation might change as the result of Best Value contracts, which have been replacing CCT in local authorities and recognise the concept of social gain.

## 9.4 Responsibility for community involvement processes

Although I have been arguing for more participative relationships with communities to be fostered within professional training and the importance of community involvement in the planning and design process of facility commissioning, I am not necessarily convinced that either the commissioned architects or stakeholder medical professionals are best placed to take overall responsibility for this process.

Evidence from this investigation has suggested that the initiative for involving communities in the development of new health facilities since the reforms has been over dependent on the committed championship of certain individuals, rather than being part of properly planned and conducted process. Champions have emerged from within health authority, the medical professionals and the local community (in other words any of the key stakeholder groups). For example in the St Matthew's case study, a GP took the lead in involving local people in the decision-making for a new centre with the support of the CHS trust, but this was done in addition to a full time workload as a GP, with no extra pay (Chapter 10.2).[60] In the Kath Locke project in Manchester, community workers put in hours of unpaid time to consult with other local people.[61] This is clearly not a role that many professionals or members of the public would be prepared to, or capable of, taking on, even if they were ideologically committed.

If the principle of a systematic democratic approach to primary care facility commissioning is adopted, then the question of who should take overall responsibility for creating, conducting and coordinating a community involvement strategy and integrating representative views into a consultation process needs to be properly addressed. Managers of community involvement strategies need to be skilled researchers, community advocates, meeting facilitators, interpreters of design graphics, and project managers. One of their

[60] See Chapter 10:2
[61] See Chapter 10:3

major tasks is likely to be handling conflicting viewpoints. For example, community and other users may disagree, user groups and designers may disagree, and external constraints may make some user groups' needs impossible to meet. As a result, user group managers need mediation skills to enable them to prepare participants for the possibility that their recommendations will not always sway design decisions and to provide them with explanations as to why their recommendations were not accepted. Also, the architects selected for the project would be required to work directly with community and other user groups on the design stages of the process and they also require appropriate training and resources to enable them to do this.

However, although the literature and the original research undertaken for this investigation indicates that community involvement is a complex professional process, there is a distinct gap in official NHS guidelines and training to support this process and ensure good practice. There are increasing numbers of external consultants and individuals developing the skills and experience to undertake this task, but no centrally recognised standards. One solution adopted at Neptune Health Park was to appoint an experienced and independent project manager to be responsible for the user consultation process and developing a community involvement strategy with clear objectives.[62] This could provide a model for good practice for community involvement in larger projects that could be adopted elsewhere.

## 9.5 Conclusion

This chapter has set out to explore the case for community involvement in the planning and design of primary care development. It has sought to show how political ideology behind consumerist and democratic approaches can impact on the level and form of community involvement in decision-making sought by commissioners of new primary care facilities. It has also explored how different attitudes to community involvement could result from the development of privately owned GP premises and publicly owned primary care premises.

[62] See Chapter 10.4

It has explored some of the obstacles to community involvement that might be caused by architectural and medical professional attitudes, and the restriction of resources and structures to enable them to engage in that process. It argued that education as well as changes in the mechanisms of commissioning buildings may be required to enable architects and medical professionals to share decision-making with communities in the planning and design process. It also suggested that the management of a community involvement strategy and the brokering process between the community and the architects was a complex field that warranted proper attention and the development of a clear and comprehensive strategy.

Despite increasing public debate and the growing literature on the subject, there is still an absence of explicit criteria that can measure the success or failure of community involvement processes (Blaxter 1995).[63] From the research for this chapter I have therefore selected a set of factors as variables for measuring the effectiveness of community involvement processes in primary care facility planning and design, specifically in relation to facilitating the social objectives of inter-sectoral collaboration and community participation. These are:

- clear objectives for the community consultation process in terms of the level of power that the user would have in the decision-making process
- commitment from the commissioning agencies for the community involvement process
- a trained person appointed to take responsibility for the community involvement process
- adequate time and resources allocated to the community consultation process
- commitment from all facility users to undertake involvement in the process
- consensus about the aims and objectives of the proposed facility.

These factors have formed the items for the survey that I developed for the community involvement process survey (see Appendix 1:10). The general methodology for the case studies is described more fully in Chapter 1 and the summary reports of the case study analysis are described in the next chapter of this dissertation.

[63] Blaxter (1995), op. cit.

Chapter 10

**CASE STUDY 1**

# Purfleet Care Centre

## Purfleet Care Centre, Tank Hill Road, Purfleet, Essex, RM19 1SX

Size of building: 890m$^2$, site 3870m$^2$

Cost of building: £1.1 million

Architect: Tangram Architects Ltd

Centre opening date: November 1994

Date of site visit: 21.11.97

**Figure 10.1.1**

**Purfleet Care Centre entrance**

## 1.0 Project background

### 1.1 Initiation and ideology

This project was initiated by South Essex FHSA in recognition of the low standard of current primary care provision in the area. It was intended to provide a focal point for health care in Purfleet and to strengthen the shift from secondary to primary and community health care in the area. Capital money was provided through Regional Health Authority funding designated for deprived areas outside the London Implementation Zone (LIZ) area and from Thurrock Council.

The new facility was planned to replace the inadequate existing local GP premises and pharmacy; to provide a Centre for various other fragmented local health services; and to become a forum for local activities. The nurse-led Minor Injuries Unit was intended to replace services previously based at the Orsett A&E Department and was expected to serve a wider area than Purfleet itself. The Orsett A&E Department had been centralised at Basildon Hospital in 1990 and the loss of this facility had received considerable local opposition. The location of the facility at Purfleet was acknowledged to be largely the result of public pressure to improve health care in the local area, although it was strategically not an ideal location. The building was owned by the South Essex Health Authority and was leased to the current multi-occupants of the building.[1] A summary of objectives for developing the Centre provided by the MARU 1996 evaluation were:

- To provide a flexible environment capable of responding to changes in local needs and perception of those needs.
- To prevent admission to hospital and to support discharge from hospital through the collaboration of different agencies.
- To provide as far as possible a seamless service in the provision of local health needs and

[1] Ownership of the building was expected to be transferred to Thameside Community Healthcare Trust in 1998.

to strengthen these initiatives by joint training and information.[2]

The mission statement provided in the Centre's information leaflet and engraved on a brass plaque on the wall in the reception area reads:

> *Within this unique Centre we offer a wide range of professional and voluntary services working together, and with you, to improve your health and social well being.*[3]

### 1.1.2 Building context

Purfleet Care Centre is located in a geographically ill defined and isolated area in West Thurrock, South Essex. Purfleet was once a village and is now a part urban, part rural area with some local industry. The Thames, the M25, the A13 arterial road and the Purfleet by-pass define the area of Purfleet. The Centre is located within a residential area, among housing estates that include private, local authority and housing association provision. Local facilities, such as shops or other social and leisure amenities, are sparse.

Tangram Architects were appointed as architects and engineers to the project in 1992. The Centre is a low building of one and two storeys, set back from the main road that runs through Purfleet, Tank Hill, on a triangular site. The Centre is only just visible from the road and poorly sign-posted. The local bus service is infrequent (half hourly) and it is a ten minute walk uphill from Purfleet railway station. There is extensive car parking adjacent to the building.

The immediate area of Purfleet has a residency of approximately 2000 of whom the majority are young, single and transient. The wider locality of West Thurrock has a total population of 69,710 (Census 1991, Office of National Statistics), which has a high proportion of

---

[2] MARU (1996) *Purfleet Care Centre Evaluation*, Full Report, South Bank University, South Essex Health, Essex FHSA.

[3] Purfleet Care Centre (1997) *Purfleet Care Centre Information Leaflet*

young couples with children and single parents in the local area. There is an above average unemployment level of around 10%. The Jarman deprivation score is +26.[4] There are only a small number of people from minority ethnic groups living in the area. The largest minority groups are Vietnamese and Bosnian/Croatians and there is a Travellers community living on a site in nearby Stifford.[5]

### 1.1.3 Key respondents

The interviews and the site visit took place over four days in November and December 1997 and February and December 1998. This case study was difficult to conduct because of the time gap between the Centre opening in November 1994 and the interviews taking place. During this period there had been many staff changes and the health authority had been reorganised, which made it hard to trace people who had been involved at the initiation and early user consultation stages of the project. Due to staff changes two commissioning authority representatives were interviewed for this project.

The main respondent, who provided background information for this project was the Purfleet Centre Care Co-ordinator. She was employed by Thameside Community Services Trust and according to a job description given in the MARU Report (1996) was responsible for 'development of protocols, identifying health care needs, liaison with the community and voluntary organisations and anything that contributes to the creation of an integrated local health service.'[6] This respondent had only been in post since September 1995 and was therefore unable to provide detailed information about procedures and processes prior to that date.

As with the other case studies the building quality evaluation survey and the community process evaluation survey were conducted by a staff user, a public user and a commissioning

[4] See Chapter 7.2 for explanation of Jarman Indicators
[5] MARU, (1996) op. cit.
[6] Ibid., p.22.

agent respondent. For confidentiality reasons identification details are provided in Appendix 10:1.1 and evaluation ratings are provided in Appendix 10:1.2 and 10:1.3. The following is a summary of the main points raised by all of these respondents and information gathered through direct observation and project documentation.

*Project documentation and other references*

An extensive evaluation of the Purfleet Centre had been commissioned by Essex FHSA, in 1996, to examine whether the objectives of the Centre had been achieved and a contribution made to the shift from secondary to primary care. This was carried out by MARU who produced a full report in 1996 that made extensive recommendations, both about management structures and alterations to the layout and design.

MARU (1995) *Purfleet Care Centre*, Case Study LIG Handbook NHS Estates.
MARU (1996) *Purfleet Care Centre Evaluation*, Full Report, South Bank University, South Essex Health, Essex FHSA.
*Purfleet Care Centre Information Leaflet* (1997).
*South Essex Health Authority Annual Public Health Report 1996/1997,* SEHA. NHS.

## 1.2. Building quality evaluation

### 1.2.1. Accommodation of services

Purfleet services are divided into three wings and most services have their own discrete areas that can be divided off, although some waiting areas are shared. The public services are mainly located on the ground floor and the first floor rooms are used mainly for administration, outreach staff office bases, a staff meeting room and recreation facilities.

**Medical Services**

GP Surgery

Minor Injuries Unit

Pharmacy

Opticians

Podiatry

Dentist

Physiotherapy

Speech therapy

Blood testing

Baby Clinics

Health Visitor and Nursery Nurse

Community Psychiatric Nurse

District Nurse

School Nurse

**Community Services**

Social Work Service

Parent and Toddler Group

Women's Group

DIAL: Disability Information Advice Line

Drug and Alcohol Service

Family Planning

Benefit Help Desk

Community Mothers Scheme

One of the services offered at Purfleet of particular interest to this study is the Minor Injuries Unit. Traditionally in the NHS, minor injuries treatment was only available in secondary facilities usually within the Accident and Emergency departments and this had become one of the services that the Conservative government had wanted to devolve to primary care as part of the NHS reforms. The Minor Injuries Clinic at Purfleet is run by Thameside NHS Trust and was estimated by MARU (1996) to be treating 8500 people annually, who would otherwise have had to be treated at an Accident and Emergency

hospital department.[7] The Unit has its own designated waiting and reception areas, although patients for other treatment services sometimes shared these.

Another interesting service accommodated at Purfleet is the pharmacy, which has been designed to be part of the Centre with internal access, but which can also operate independently as a local shop with direct access from the car park (see Figure 10.1. 4). This provides a convenience to the public users of the GP surgery and creates a useful retail facility that attracts a wider user group to visit the Centre.

[7] MARU (1996), op.cit.

## 1.2.2 Building layout and organisation

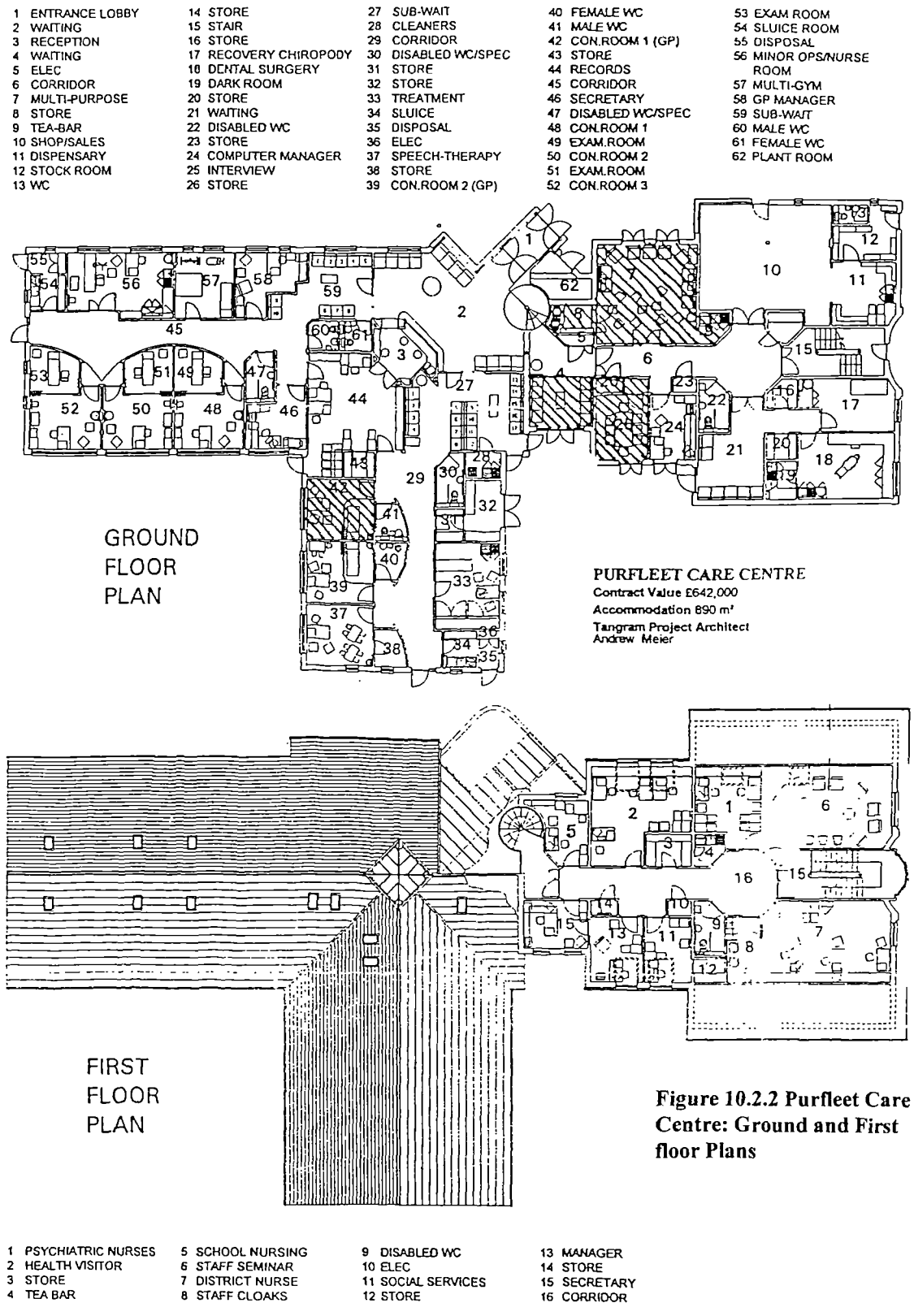



**Figure 10.2.2 Purfleet Care Centre: Ground and First floor Plans**


**Figure 10.1.3 Reception desk with glazed screen and entrance to minor injury unit.**

**Figure 10.1.4 Spiral staircase with controlled access separating agencies.**

**Figure 10.1.5**
(Left)

**Detail of curved corridor providing visual interest and privacy.**

**Figure 10.1.6**
(Below)

**Attached pharmacy independently accessible from outside.**

### 1.2.3 Design facilitation of inter-sectoral collaboration

*Space allocation, integration and separation*

The staff user respondent explained that staff working in agencies located in different sections of the building had experienced variations in the degree to which the design supported collaborative working. Staff working on the second floor could feel left out of the main activity in the Centre because the public were not expected to come to the second floor and not many staff working on this floor were in at the same time. The spiral staircase was regarded as an awkward design feature adding to the psychological isolation of staff on the upper floor. For those staff working on the ground floor of the building there were more opportunities to meet and communicate, but this was dependent on whether they were able to leave their posts.

All the respondents perceived inter-agency collaboration to be more of a management than a design issue within the facility. Some agencies had found it difficult to make time to meet and deliberate efforts had been made to encourage agencies to communicate more regularly. These had included holding coffee mornings and arranging sessions at a hotel to improve communication and the development of co-operative working. Most staff used the first floor seminar room for lunch breaks. However the siting of the pharmacy and dentist away from the centre of the building and the location of some staff on the first floor were perceived to be drawbacks to informal communication. The public user respondent had found the Centre intolerant of outside agencies attempting to use the building and because no specific space had been allocated for social and community use, it had been difficult for some groups to arrange to meet there. He reported that originally there had been no separated zone for staff envisaged for the upper floor and that the community was to have access to both floors particularly as the meeting room was on the upper floor.

The design of the building was regarded as capable of allowing separation of services and sections if and when required. The public user respondent had the impression that security

features within the building sometimes created unnecessary barriers between staff and for community users.

### 1.2.4 Design facilitation of community participation

*Siting, approach, entrance, reception and ambience*

All the respondents regarded the Centre as being in a good position for the residents of Purfleet, because it was on the main road and in the middle of the residential community. It was also located on neutral ground between two estates where there had been some tension between residents. The Centre was also next to the local Primary School, which made it convenient for local parents. However, it was acknowledged by the commissioning authority respondents that the services provided in the Centre had different catchments and that by being on the edge of Thurrock, with the Thames as a barrier on one side, made it a less than convenient location for the wider population. It was also isolated, because of poor transport and pedestrian links. This isolation was believed to be contributing to a lower use of the Centre than its potential warranted. Patients from the wider Thurrock area, who wished to use the Minor Injuries Unit but were without access to private transport, were particularly adversely affected.

General satisfaction was expressed by respondents with the design of the entrance to the building, which had an attractive glazed porch and atrium area (see Figures 10.1.1 &10.1.4), but the approach from the road was thought to be obscure and not adequately sign posted.[8] There was a high standard of internal finishes in the building. Staff users appreciated the solid wood doors, light fitments and quality flooring. The building appeared to be well maintained and looked clean and attractive after three years. Care was clearly being taken to keep up the appearance of the building. For example, in the community room, where the upholstery of the easy chairs had been marking the paintwork, wooden panels had been put

[8] MARU (1996), op cit. This report had recommended a new sign from the road and a sign to mark the entrance to the Centre, but these had not been provided at the date of the site visit in December 1997.

around the walls at an appropriate height to prevent this re-occurring. However, the public user reported that many local people had found that there was over concern with the appearance of the Centre and that it felt too clinical. He claimed that while it was important to maintain standards, it was also necessary to ensure that people felt welcome and, for example, should be allowed to put up notices and posters in the entrance area.

The Centre had one central reception area and several sub-waiting areas for the different service providers. The concept was for all visitors and staff to pass through a central reception and then to disperse to the different service areas, the exception to this being visits to the pharmacy, which had its own entrance from the car park. The main reception desk was screened from the public by a glass partition (see Figure 10.1.3). The staff respondent, who worked in reception was satisfied with this arrangement and thought it necessary to provide adequate security for staff. The public user respondent was unhappy with the design of the reception and thought that the glass screen and the uniforms worn by the reception staff made the Centre feel unwelcoming. He did not accept that there was justification in the use of glass security screens and had found the use of uniforms by the receptionists, some of whom were local people, to be incongruous and unfriendly.

The staff respondent explained that receptionists were supposed to perform two duties: firstly, as Community Access Officers they were the first port of call for all visitors to the Centre who required information and directions to the appropriate services and; secondly as receptionists for the GPs. The combination of these functions at one desk was not considered ideal and a separate open table in the entrance area for the Community Access Officer would have been a preferred. The high amount of glazing in the entrance/ reception area and in the dentists' reception made it uncomfortably hot in summer.

*Security and confidentiality*

Security for both staff and public was generally regarded as high. CCTV was not used either inside or outside the building. Panic buttons were supplied and swipe cards were used to access rooms. The Minor Injuries Unit stayed open until 10pm and other sections of the

building were locked once those services had closed. There were procedures operating that ensured staff did not work alone in the building.

Although the conditions for confidentiality were perceived to be generally good (for example there was adequate soundproofing in the wall density), the main respondent did not consider public confidentiality had been adequately addressed in the waiting area of the Minor Injuries Unit. Here, the reception desk, at which patients were expected to provide personal details to the nurse, was too close and exposed to others in the waiting area. The dual-purpose reception desk in the entrance area and the lack of a confidential office for the CAO were other concerns mentioned. The public user pointed out that people attending the drugs and alcohol clinic might not want to ask the way to this through a glass partition. However, the separation of the entrance / central reception area from the waiting areas meant that there were less likely to be people to overhear conversations at the reception desk.

*Accessibility, public facilities and comfort*

The building has a level entrance, wide doors, no level changes on the ground floor, fully accessible toilets on both floors and a stair lift on the back staircase. No visual aids have been included in the building, but both receptionists have trained in using sign language. An information library of leaflets on health related issues was available in the entrance hall and information on a wide range of health and local issues was provided by the CAO in her role as 'first port of call'. The public user was critical of the lack of a lift to the upper floor as this prevented easy access to many people with mobility difficulties.

There was no permanent crèche, although play areas had been provided in the GP and Minor Injuries waiting areas and in some of the treatment rooms. Crèche facilities on an occasional basis could be arranged through the CAO. Toilets were of high standard and included nappy-change facilities. There were no public refreshment facilities available, except from the pharmacy where soft drinks could be purchased. Hot drinks were offered to the public by staff in circumstances of need. The public user reported that the community had been

denied the opportunity of putting up their own information leaflets and posters.

*Independent community use*

There was a policy to hire rooms to the community for a range of purposes, but the appropriateness of use was vetted. Charges for services to the public could not be made and this inhibited the use of facilities to complementary medicine and alternative therapists. It was expected that rooms hired for business purposes would be at a full rate, but that charges for rooms for other purposes were flexible and discretionary. The public user respondent was extremely critical of the way access to community and voluntary groups had been handled and felt that the design frustrated this from occurring. He explained that there was no discrete area in the Centre that could be used by the community and keys were not available to community workers or voluntary agencies not resident in the building. Consequently, groups that would have liked to meet at the Centre had been discouraged and given up.

*Sustainability and ecology*

None of the respondents were aware of any conscious attempts at ecological design within the facility, apart from the under floor heating system which was considered economical and that the building was well insulated. There was some concern about overheating in the building in the summer and lack of control over opening windows on the ground floor for security reasons. There did not appear to be any other particular attention paid to issues of ecology or sustainability in the Centre and the heavy reliance on car use for many public and staff users of the Centre was a negative point.

## 1.3 Community involvement process evaluation

### 1.3.1 Effective process management

*Clear objectives*

The commissioning authority representatives explained that there had been an intention at

the beginning of the project to involve the community in the development of this project, but that this had become fragmented. The first part of the process took place during the period to assess service need. At this time the District Health Authority was seeking to improve primary care development in the area and meetings with various agencies and community representatives were undertaken to elicit views. The South East Essex FHSA had been responsible for the consultation process and set up a steering group of representatives and a project manager to oversee the process. There had then been a gap while the building was designed and built in which only the service providers were consulted and then public users became involved again when the facility was opened and this was being sustained through the role of the Community Access Officer.

The Community Health Council's (CHC) response to my original survey reported their understanding of the project's objectives to be, 'to access and deliver health packages suitable to the area and users'.[9] Although the staff user had not been around at the developmental stage, she believed that the purpose of the user involvement process had been to create a good community facility. There had been very little in the area before and nowhere that had served as a focus for the community. The public user thought that the original discussions for a wider concept of primary care that would include community and social facilities had not materialised. He also thought that there had never been any real intention to consult with the local community, only with professional health agencies and representatives from the local church and school.

*Time allowed*

The commissioning authority thought that there had been no particular pressure on the time allocated for consultation and that various presentations had been made to the CHC. In addition, joint planning teams had been involved in the project.

[9] MARU (1995) *Survey of Community Involvement in Primary Care Building Planning and Design*, reference CHC12, question 6.

*Successful management and commitment to the consultation process*

The survey response from the CHC had rated the procedures used to involve community groups as 'very successful'. Methods reported were: notification of proposal to the CHC; public meetings; survey of local users' opinions; and involvement on the project team.[10] The commissioning authority representative explained that there had been good attendance at early consultation meetings, but that there had also been considerable scepticism from the public that the Centre would be built at all. There had also been concern that the new facility would not adequately replace the loss of services being closed at local hospitals. It had been hard for local people to balance these two developments. He thought that the facility had been partially built in response to high public demand and expectation and may not have been located at Purfleet if this had not been the case.

The public user agreed that the need for medical services in the area had been high and that the health authority had done a good job in bringing together the medical professionals into the consultation process through a series of seminar/discussion sessions. However he thought that there had been far less attention paid to involving the community and that they had been mainly invited to presentations of decisions that had already been made. He believed that this was partly due to a lack of understanding and awareness by the health authority of involvement strategies and politics at that time, but considered that the staff consultation was a considerable advance on previous consultation practices.

The establishment of the post of the Community Access Officer (CAO) had been recognised by the planning team as important to keeping the community involved and services relevant to local people. However, the staff respondent believed that confusion over the roles of receptionist and the CAO had led to the underdevelopment of that role. Also, an ongoing user forum that had been recommended in the MARU 1996 report had still not been established by December 1997.[11] The staff user expressed the view that the members of the community wanted to be involved, but did not want to attend formal meetings. She

[10] MARU (1995), *Survey of Community Involvement in Primary Care Building Planning and Design*, reference CHC12, question 7.

therefore went into the community as the Community Access Officer, or they came to the Centre to express their views. The Community Access Officer had therefore become the main medium through which the community were consulted.

*Consensus reached*

The commissioning authority representatives expressed the view that in the end those agencies that had become involved in the project were those who genuinely wanted to see the proposed developments realised. Among those staff users who had been consulted about their requirements in the planning and design stage a high consensus was achieved in the final design of the building. But there had undoubtedly been conflicts and disagreements about the project, which had to be worked through. One of the issues of contention had been over the exact siting of the project. Because it was sited across the road from one of the residential estates, there was concern that the facility would be cut off by fast moving traffic and that it would be dangerous for local residents to reach. The public user thought that there was a high level of consensus achieved by the multi-agencies involved. For example Thurrock Council had donated the land to the project. But he thought that the community and social aspirations for the Centre had been overlooked.

### 1.3.2 Achievements of the community involvement process

*Improved access*

The commissioning agencies believed that opportunities had been given for the community to give views about siting and accessibility of the facility and information provision became one of the key objectives and objectives of the Centre. The staff user considered that despite some compromise (such as with the siting, see above), access to the building was one hundred per cent better than in previous facilities. There were wide circulation spaces and level access on the ground floor. She also made the point that the Community Access Officer was in reality a local information officer post, enabling help and advice to be given to people on a whole range of issues and saving GPs time.

---

[11] MARU (1996) op. cit., p.69.

It was generally agreed that geographically the Centre was accessible to Purfleet residents as it was on their doorstep, but that it was not well located for the wider area. The public user representative thought that the facility was convenient rather than accessible to the local community in that it was not a community focused facility, but controlled by health professionals. He thought that although the previous facilities, some in pre-fabricated temporary buildings, had been far from ideal they had been user friendly and had made local people feel comfortable.

*Additional community activities and community ownership*

Through the creation of the Community Access Officer posts, unique in the area, a range of community activities such as the mum's group, Baby Talk, women's groups, relaxation classes, parent and toddler group, MIND and drug and alcohol advice unit, slimmers' clubs and counselling groups had been set up. The involvement of the voluntary sector, such as MIND, in running sessions was also a result of the community involvement process. However, the public user respondent had been disappointed in the lack of encouragement to independent community groups from the area and felt there had been a lack of trust and willingness to share control with local people. The commissioning authority representative cited evidence of community ownership to be in the high take-up of services from the local area. Many people had transferred to the Purfleet GP Practice and the dentist and pharmacist had both established successful services.

*Process objectives met*

The commissioning authority representatives believed that the consultation process had met its original objectives, although they admitted that these had been loose to start with. They claimed that the greatest achievement of the project was probably the transition from a low to high standard of primary medical care in the area. The greatest disappointment had been the loss of some of the voluntary services through lack of adequate funding. The public user respondent agreed that the process had met its objectives in terms of providing a good range of medical services, but was disappointed that the building had not become appropriate for community use.

**1.4 Summary of key outcomes**

Purfleet was one of the earliest examples of a multi-agency centre in Britain to open following the NHS 1990 reforms. It was innovative in concept and in the range of facilities it sought to provide, which included a Minor Injuries Unit and the Community Information Service as well as a broad range of voluntary and community organisation activities. However, despite the establishment of the Community Access Officer with responsibilities for developing links with the community, the Centre predominantly offers medical services, and many of the voluntary services that had originally been expected to share the facility either did not move in, or had dropped out. It would therefore appear that although the building layout provides the potential for a more integrated facility, the GPs dominant managerial position within the Centre has obstructed the development of more equal partnerships with other service providers and the local community.

The building design is of general high quality, with some attractive architectural features such as the atrium entrance and the curved corridors (see Figure 10.1.5). Generally the accommodation for the various medical services seems to have been accurately predicted, but there was an insufficient allocation of space provided in the original design for community or social purposes. However, there does appear to be scope within the site to enable the facility to grow and respond to community demands, if managerial will and financial resources were sufficiently forthcoming. The atmosphere within the facility was quite formal, an effect caused partly by the screened reception area and the dominant location of the Minor Injuries Unit and GP surgery. However, some minor adjustments to the design recommended by the staff respondents to improve the interface with the community could easily be carried out and it is hard to see the justification for this not being done. For example, the social/community facilities could be given a higher profile by the inclusion of a separate first port of call desk in the entrance area.

The facility also appeared under-utilised. The local community is readily identifiable and closer links with the local schools, the church and residents committees could easily be

encouraged through more open or drop-in facilities, such as a café. The facility could also be given a higher profile by better signage and possibly an improvement in the local bus service, which would encourage users from a wider area. Pedestrian walkways and crossings could also be improved.

The creation of the Community Access Officer post has clearly been one of the most innovative features of this project. It has enabled consultation with users to become part of an ongoing process, but as a newly developed post it needs to be monitored and be flexible enough to respond to the needs of the community. Care also needs to be taken that these posts are not subsumed by other more traditional receptionist duties. The CAOs also appear to have become professionally isolated as there were no other people locally in similar jobs and their training needs greater consideration. More independent use and participation in the Centre by outside community and voluntary agencies need to be encouraged.

It is perhaps significant of a lack of managerial responsiveness in this Centre that so many of the adjustments recommended by the independent MARU study of 1996 had still not been implemented by the end 1997, possibly preventing the potential of this facility and greater public use to be realised. Unfortunately the current locality manager was unavailable for interview and so the reasons for this were unknown. The former health authority area manager claimed that he had been committed to carry out most of the recommendations in the report, but that the change to his position and responsibilities within the health service had prevented him carrying this through.

Chapter 10

**CASE STUDY 2**

# St Matthew's Community Health and Social Care Centre

## Prince Philip House, Malabar Road, Leicester

Size of building: 1190 $m^2$

Cost of building: £1.5 million

Architect: Bundey and Rodgers

Centre opening date: July 1996

Date of site visit: 26.9.97

---

**Figure 10.2.1 St Matthew's Community Health and Care Centre entrance.**

## 2.1 Project background

### 2.1.1 Initiation and ideology

This project was initiated and its momentum sustained during the development stages largely through the commitment and work of the Senior GP at the St Matthew's Medical Practice. This GP explained that she had started working in the area in 1988 and had been shocked by the high levels of deprivation experienced by her patients. She had found local residents articulate and clear about their needs, but powerless to change the circumstances of their lives. She also found that there were many health and social services operating in the area, but that they were not integrating their strategies to deal with people's problems. She realised that there were many contributing factors to community well-being and this inspired her to help create both a physical environment and a strategy for bringing about local health improvements, which echoed some of the objectives of the Peckham Experiment.[1]

This GP can be regarded as following a tradition set by other 'champion' GPs, who have been determined to follow through a social vision by changing the face of health care. But the project still could not have been realised without support from other stakeholders. In the early stages the GP reported that she had received invaluable support from Fosse Health (NHS) Trust, and in particular from the Locality Manager for the trust, who had commissioned a local health needs assessment. This assessment had reinforced the necessity for change and the St Matthew's Community Health and Social Care Centre had been launched as a partnership project, between Fosse Health (NHS) Trust and The Senior GP Practice Partner and the local community. It had aimed at developing a genuine multi-agency approach to service provision that would give local residents the opportunity for greater input. Both the Senior GP Practice Partner and the former Chief Executive of the Fosse Health Trust stressed the importance they placed on the close partnership they had formed and the high degree of co-operation of other key people to being able to realise the project so successfully. The project had developed a mission statement:

> *To develop a centre which will lead and work with Statutory and Voluntary organisations to promote and improve the health, educational and welfare needs of the St Matthew's community, facilitating residents to play an active role in developing and sustaining local services. The objectives extend beyond service delivery and community involvement. The provision of a multi-agency teaching experience for professionals is maximising the potential of the project.*[2]

Fosse Health (NHS) Trust had been a major funder of the project, contributing £1 million pounds to its development. Other charitable and statutory sources had raised a further £700,000. The project was also partly supported by the Single Regeneration Budget (SRB) fund, which committed £11,750,000 to stimulate economic development and employment prospects in the area and to tackle issues of crime and safety. The SRB also funded the Drug and Alcohol Project and the Mediation Project at the Centre.[3]

One of the more unusual features of this project was the inclusion of a police base within the Centre, which according to the CA representative, the vast majority of residents had been very determined to include. However, perhaps the most radical and long-sighted provision was the Leicester University training outpost, currently run by the Senior GP and Director of Community Health Care Studies, which was accommodated in the second floor training suite. This facility was intended to educate the next generation of GPs and other medical professionals in an inter-agency approach. The Senior GP explained that the objective was to ensure that those professionals likely to work with local communities in the future would have greater appreciation of how different agencies could work together to improve the quality of life for local residents. Providing training within the Centre enabled students to work with local residents on the Estate as case studies (apparently the residents involved are paid for their time), and this provided students with direct experience of working in a multi-agency setting.

---

[1] See Chapter 5.2 for a more detailed description of the Peckham Experiment.
[2] Lennox, A. (1997) *Summary of the St Matthew's Project, Leicester, May 1997*, St Matthew's Medical Centre, Prince Philip House
[3] Ibid.

### 2.1.2 Building context

St Matthew's Community Health and Social Care Centre (CHSCC) is located on the edge of an inner city estate, set back on a slip road from Humberstone Road, which is a main road leading to the city centre, approximately ten minutes walk away. The site of the new St Matthew's CHSCC is adjacent to the original Medical Centre on the edge of the St Matthew's Estate, which had accommodated a three person GP practice. This facility had become too small and new premises were sought. First the vacant chapel building opposite was considered then, when the adjacent elderly peoples home became available, this site became the preferred option even though the building was bigger and more services than originally planned were required to fill the space.

The St Matthew's housing estate, within which the Centre is located, was rated by a CACI national survey based on household earnings as the second most poverty stricken estate in the UK (CACI 9/96). 85% of the local residents were on Housing Benefit, three times the city's average, and the estate had a Jarman rating of 64.[4] The population was concentrated at the age range extremes, with a high proportion of under-fives and elderly people. There were a high number of single parents on the Estate. 14% of residents were Asian, and 8% were of mixed race. This was not a particularly high proportion of minority ethnic groups compared to neighbouring catchments, partly because of the high proportion of white British elderly living on the estate. A high proportion of local residents were ex-offenders. The Senior GP considered the huge health problems of the area to be inextricably linked with problems of housing, social disadvantage, unemployment and poor life style. She explained there had also been a high incidence of racial harassment and domestic violence on the Estate.

St Matthew's CHSCC is accommodated in a refurbished elderly people's home. There had been an attempt to consider a new build on the site, but this had proved to increase the cost prohibitively. The building consists of three linked, twelve sided drums (dodecahedrons).

The drums have concrete frame with cavity brickwork in situ concrete floors, concrete beams and roof. The architect of the project explained that the external fabric of the building was virtually untouched by the redevelopment with the exception of the installation new high-insulation windows and the removal of asbestos panels. Internally many of the internal walls were demolished and repositioned, new toilets were added to the ground floor link sections and storerooms were built in the central sections of the two outer drums. All main service utilities were replaced.

### 2.1.3 Key respondents

The Senior GP Practice Partner and Director of Community Health Care Studies of St Matthew's Medical Centre, provided background information about this project. This respondent was also the staff user respondent for this project. As with the other case studies the building quality evaluation survey and the community involvement evaluation survey were conducted by a staff user, a public user and a commissioning agent respondent based on questions outlined in Appendix 1:11. For purposes of confidentiality identification details about the respondents are withheld in the case study reports but, for assessment purposes, are provided in Appendix 10:2.1. Evaluation ratings of different items are provided in Appendices 10:2.2 and 10:2.3. The following is a summary of the main points raised by all of these respondents and information gathered through direct observation, project documentation and a meeting with the architects, Bundey and Rogers.

*Project documentation and other references*

Lennox, A. (1997) Summary *of the St Matthew's Project, Leicester,* May 1997, St Matthew's Medical Centre, Prince Philip House.

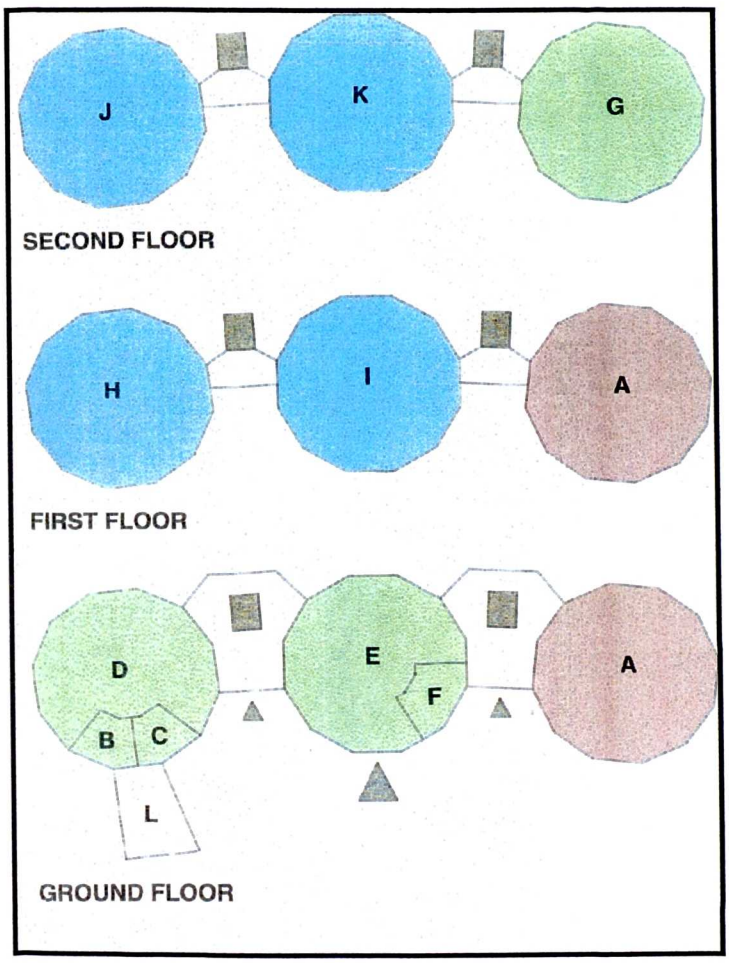
NHS Estates (1995) *Health Building Note 36: Volume 2.* London: HMSO, Case Study.

The Health Authority is funding a two-year evaluation of this project.

[4] Ibid. See Chapter 7.2 for an explanation of Jarman Indicators.

## 2. 2 Building quality evaluation

### 2.2.1 Accommodation of services



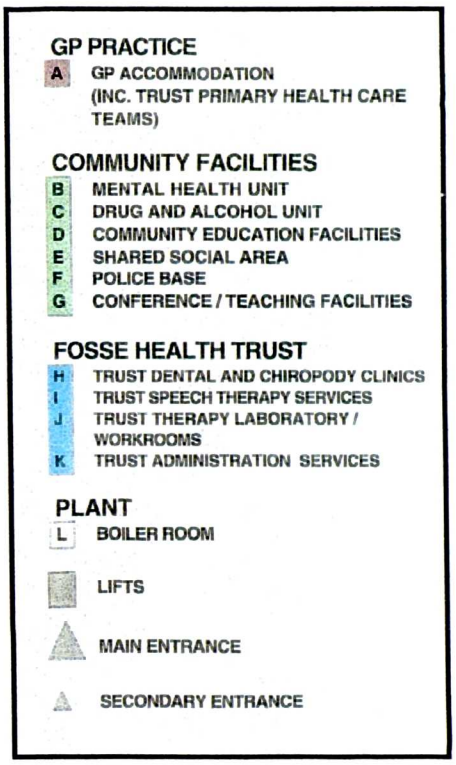




**Figure 10.2.2**
**Diagram to show building service accommodation and zoning.**

Architects: Bundey & Rogers

### 2.2.2 Building layout and organisation

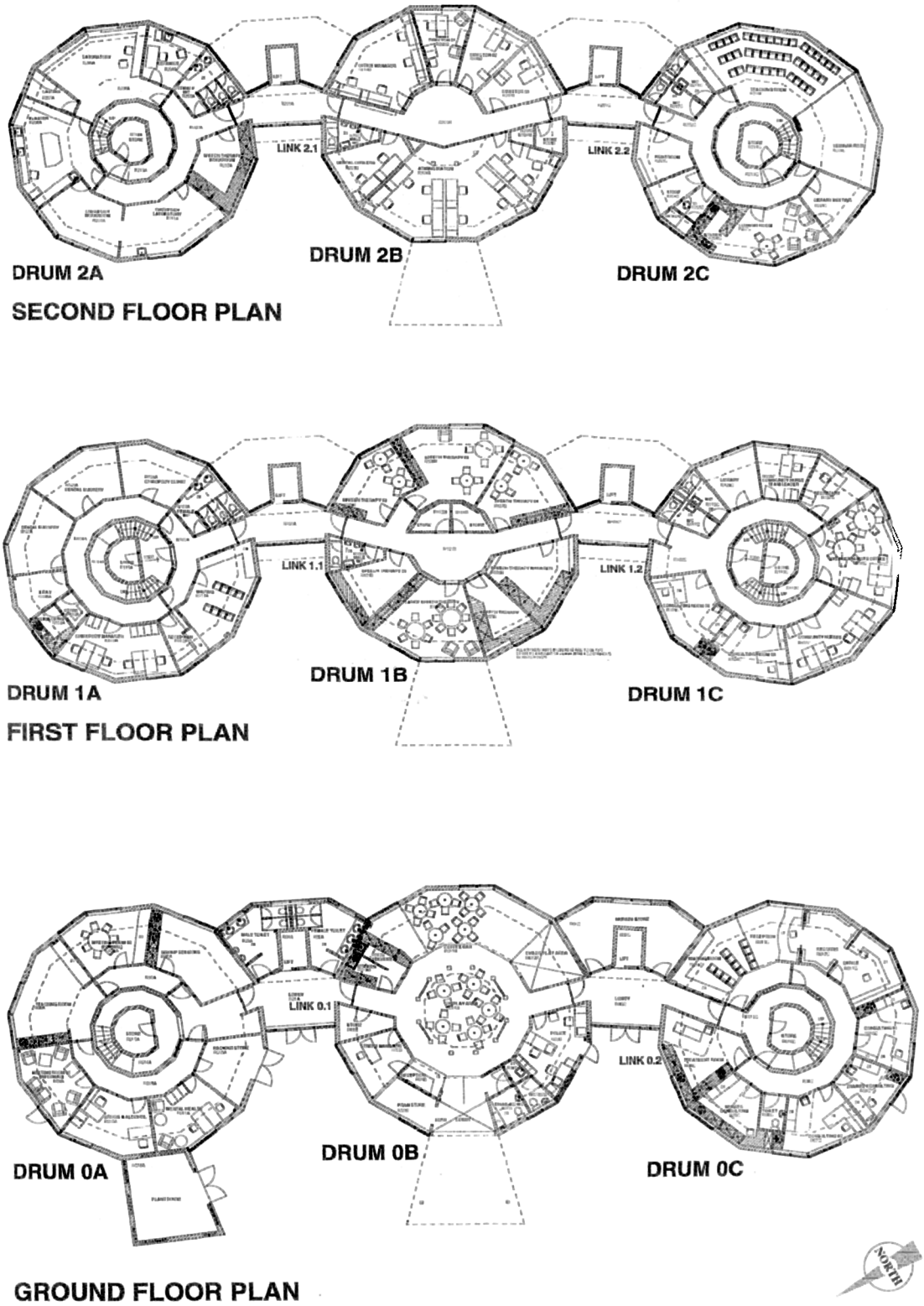



**Figure 10.2.3 St Matthew's Floor Plans**

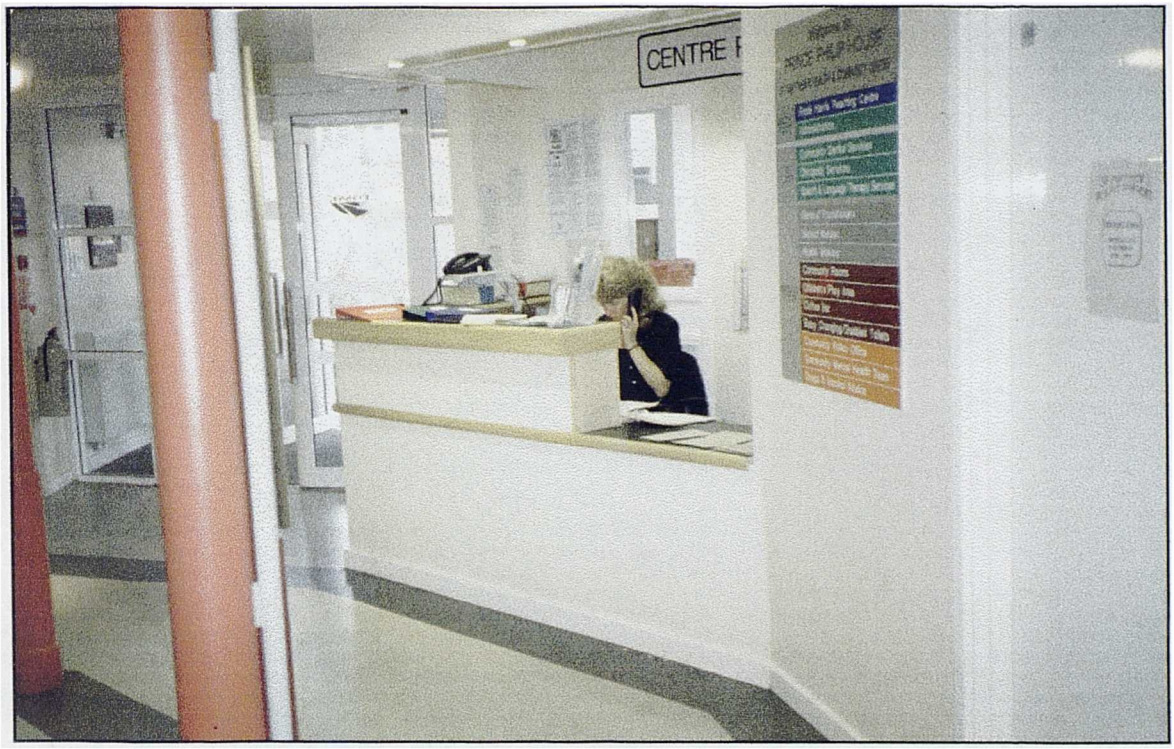



**Figure 10.2.4. Reception desk showing lower section for wheelchair users.**


**Figure 10.2.5 Open foyer area with café and crèche behind seating and display area.**

**Figure 10.2.6**
(Left)
**Stairwell detail showing top lighting and dodecahedron form.**

**Figure 10.2.7**
(Below)
**Training suite for medical students on second floor showing opening partitions between room sections.**

### 2.2.3 Design facilitation of inter-sectoral collaboration

*Space allocation, integration and separation*

Although the three-drum structure of this building suggests a vertical orientation, the allocation of space to service providers has been planned horizontally. The aim has been to keep the majority of general public activity at the ground and first floor levels and locate the more private staff areas such as the administrative offices, laboratory facilities and teaching facilities on the second floor. Flexibility in the size and use of rooms has been achieved through the provision of movable partitions between some sections and through extending sections into and out of the centre space (see Figure 10.2.7).

The concept of inter-professional and inter-sectoral working has been a central ethos of the project and respondents perceived the extent to which this has been achieved as a triumph of vision and management, rather than architecture. Concurrence with the ethos of inter-agency working has been a condition of entry for service providers, and mechanisms for more closely linked work were being slowly introduced. However, as one respondent pointed out, not all of the services provided in the building are exclusively for the St Matthew's Estate as some services are headquarters for the whole district, catchment areas therefore vary between service providers. However respondents suggested that the kudos of being the district centre of some services has had the effect of raising the professional tone of the building, which has been welcomed by the community as a positive benefit as putting St Matthew's on the map. Even more importantly for promoting the concept of inter-agency working, the training suite on the second floor is a facility dedicated to the long-term investment in inter-agency working, providing essential experience to medical and other health professionals in working with disadvantaged families in a collaborative manner.

No obvious barriers in the building design had been reported as deterring communication between the fourteen agencies already working in the building and some of the administrative staff from different agencies worked together in the same office. The cellular structure of the building allowed sections to be closed or opened as required. The police

base on the ground floor had a separate external entrance which enabled it to be accessible at weekends or in the evenings and the vertical drums could be divided up by locking inter-connecting doors as required.

### 2.2.4 Design facilitation of community participation

*Siting, approach, entrance, reception and ambience*

The siting was considered convenient both for residents of the St Matthew's Estate and for those visiting from neighbouring catchment areas with good bus links to the centre of Leicester and other areas. The respondents generally regarded the street presence and entrance as being easily visible and the only criticisms were that when the pathway from the estate shops had been resurfaced with block work it was not extended to the centre. This would have created a more distinctive visual link from the shops. The Methodist chapel was also regarded as tending to distract the eye from the Centre's entrance. There was not much external space attached to the Centre and the local authority had recently provided extra car parking for the Centre on adjacent land. There had so far been no discussion about possible alternative uses for the original small car park, which could be used as a garden, or outdoor play area. The staff respondent thought that staff and users would resist any loss of car parking space.

The interior of the building appeared to be bright, warm and friendly without being overly domestic in appearance. Interest and unusualness was created by the way that spaces radiated out from the middle of the drums, which created a quirkiness in the shapes of the rooms and circulation spaces, compared to the squares rectangles and long straight corridors that feature in many health centre buildings. There was also considerable natural light from the abundant windows in the rooms and roof lights illuminating the top stairwells (*see Figure* 10.2.6). Satisfaction was expressed, by all the respondents, about the general high standard of appearance in the building, which had been open a year. The lack of obvious wear and tear appeared to reflect well on both the quality of materials used and the respect shown to the building by the users, which indicates a senses of ownership. The only noticeable

problem was the rising of some of the vinyl floor covering in the foyer area, which appeared to worsen in wet weather.

The walls were plain and light cream in colour, but the columns in the display area of the foyer were painted red which had helped to enliven this space. The absence of art work or other types of decoration was explained as being mainly due to lack of money and not wanting to spend to much on decoration the first time around on a new build project. The commissioning authority representative explained that although there had been an original idea for art and design students from De Montfort University to carry out a project in the building, it had later been thought more appropriate to allow more time for the local community to think about how it should be decorated. They could then decide who they would like to carry out the work once they had had a chance to get to know the building.

The main foyer/reception area was on the ground floor of the central drum with a reception desk by the entrance (see Figure 10.2.4) There was also a separate waiting and reception area for the GP practice and another on the first floor for the clinical services. The staff respondent regarded the separate reception/waiting areas as important, because they signalled to users that the GP and other medical services were only part of the services on offer in the building. This had however created the problem that children waiting for some of the services provided on the second floor did not have easy access to the play area in the main foyer and they got bored. A different calling system was being considered, whereby the main waiting for parents and children for the services located on the first floor could be in the main foyer space.

*Security and confidentiality*

Despite being in a disadvantaged area with a high local crime rate, there was a high level of satisfaction from staff and public users about the building security system. Magnetic swipe cards and identity badges were used to enter most rooms, and staff were vigilant about challenging people who appeared to be in the wrong parts of the building. There were also panic buttons in most rooms, but there was no CCTV system inside the building, although

there was one outside. It is possible that the permanent police presence in the building may be having a deterrent effect on criminal behaviour within the building and there had so far been no serious thefts or violent incidences.

The building had adequate sound insulation between rooms and the only criticism connected to privacy and confidentiality in the building was about some of the seating in the GP waiting room being too close to the reception desk, so that conversations could be easily overheard. Staff had however received several complaints from the public about the difficulty involved in negotiating the doors along the corridors, because they were heavy. The architect responded to this criticism by saying that the situation was caused by the conflict between the fire regulations and the needs of people with mobility problems. He suggested that a solution would be magnetic closers, which could be easily fitted, but might be costly. This solution was going to be pursued by the Senior GP.

*Accessibility, public facilities and comfort*

There was a general high level of satisfaction with public access to the building, including from the public user, who had brought several users in wheelchairs to visit the Centre. The only difficulty she had encountered was when she had been using a side entrance at the weekend and the person she was accompanying had tripped over a low wall. The commissioning authority representative thought that colour coding should have been used in the decor to limit problems with orientation for users of the building. There were however some minor criticisms of other public facilities. More signage was said to be required in the building as some public users regarded it as a maze and they became disorientated and lost. In the main foyer some of the notices and the information leaflets did not get seen because they were on the back of display screens that were not visible from the entrance, so people going straight to the stairs, lifts or GP surgery or other services missed them (see Figure 10.2.5). It was suggested some of the more important notices should be located on the corridor walls or in the sub-waiting areas. There was only one play area for young children in the main foyer to the building. Smaller play-stations at the sub-waiting areas needed to be considered, or a different calling system adopted. There was a coffee bar, but it was not

considered to be visible from the entrance and this prevented some people from knowing it was there. Also it was dependent on volunteers to run it so people could not rely on it. Additional facilities were required on the ground floor for staff to make tea. There was also a kitchen/common room on the third floor for staff lunches.

*Independent community use*

Several rooms that had been designated for use by the community could accommodate various activities, including established services such as the Tenant's Association. The design also included a large public meeting area in the central foyer, separate from the doctor's reception and waiting area and with an integral coffee shop and play area. Some activities had not been started because there was no community development worker in post and it was role of this person to encourage and organise more community activities within the building.

*Sustainability and ecology*

There appeared to have been no specific attempt to address issues of ecology and sustainability in the building design, although an efficient and cost efficient heating system had been installed that was linked to the centralised system for the estate. Asbestos had been removed during the refurbishment. Mechanical ventilation and double-glazing had been installed on the road side of the building to cut noise and air pollution. Also, safe waste disposal facilities and procedures had been incorporated.

## 2.3 Community involvement process evaluation

### 2.3.1 Effectiveness of the process management

*Clear objectives*

From the staff user and the commissioning authority respondent's perspective, the aims of the community involvement process were: to develop the right type of environment for inter-agency services; provide a multi-agency training unit with the local community; involve

people on the estate in determining the content of services that should be provided, be involved in the design work for the building and in the modifications and changes that had to be made. The public user was not certain that local people understood the details of what was required, but thought they had generally believed that the service providers wanted to know what local residents wanted.

*Time allowed*

To the question as to whether sufficient time had been allocated to the community involvement process, respondents gave very different answers. The public user thought there had been plenty of time for the consultation process. The commissioning authority respondent also thought there had been enough time allowed for consultation and made the point that it could always be argued that there was insufficient time and that it would never be possible to consult the whole population. He suggested that democracy was 'a flawed process that in reality enabled only limited representation' and that the best that could happen was to engage a number of local people in the project and hope that this would provide a 'finger on the pulse' of the community.

The difference in perception on this issue appeared to stem from the fact that existing staff, such as the Senior GP, had taken unpaid time to conduct the community involvement process. The process had therefore been dependent on her personal commitment to the task, rather than being planned and paid for as an essential job. The problem therefore may have been the lack of resources and recognition of importance of user participation, rather than the time allocated to the process. The responses indicated that better guidance was needed about the strategies and resources required for involvement.

*Successful management and commitment to the consultation process*

The staff user respondent, the Senior GP, had had a lot of responsibility for the consultation process and had been given no protected time to do the work and had done it in her own time. A resident from the Tenants' Association had also played an important role and the Senior GP was also greatly helped in the early stages by the Locality Manager and the

Project Manager from Fosse Health NHS Trust. The Locality Manager had been responsible for getting funding for a health visitor to conduct research into local needs and the Project Manager had liased between user groups and the architects. The management process of consultation had clearly been regarded by respondents as successful despite the fact that there may have been too much reliance on the Senior GP's determination and personal commitment to the process.

The staff user asserted that the health authority was very committed to the project, but had no mechanisms set up to support it. The health authority had constantly bent rules to enable the project to proceed. She considered that a similar project would now be far easier to undertake, because the mechanisms were there and a precedent had been set and she believed that the trust had been far more instrumental than the health authority in enabling the project to be realised. The other respondents confirmed that the health authority had visited, taken part in meetings and public discussions, supported the project by approving the business case and by being flexible about the way money was allocated to the project. They had also put in some money and given personal encouragement to the initiators of the project. So, although the health authority had not been as directly involved in setting up the project as the trust, their support of the project had been vital and they had been prepared to take the risk of setting up a new concept in primary care delivery.

The respondents reported that there had been a lot of local enthusiasm for the project and a willingness to contribute. The staff user had observed that some people had had difficulty in reading or writing, but had made verbal suggestions. The public user explained 'we tried to think of ideas and I wrote things down that the people I cared for said. They were pleased to be involved and asked for their opinions.' She also explained that the community wanted to be involved and would have been angry if they had been left out. The local people I met seemed very involved with the project, although they expressed concern that not enough local people knew what it was offering.

*Consensus reached*

The staff user respondent thought that there had not been much conflict about the idea of the new Centre, because the necessity for the old medical centre to close had provided an urgent need to build new facilities that were more convenient and of better quality. The main public concern had been the loss of the elderly people's home. The commissioning agent respondent thought that considerable consensus about the project had been reached mainly because it had been hard not to be inspired by the Senior GP and Locality Manager's vision for the project.

### 2.3.2 Achievements of the community involvement process

*Improved access*

A focus of the public consultation had been around the design of the entrance and this had been one of the conditions of charity money. The community had asked for the coffee bar, somewhere for children to play and good access. The staff user claimed that had the local community not shown so much enthusiasm, the Centre might have been located away from the Estate.

*Additional community activities and community ownership*

The coffee bar was clearly one of the most valued features by public users. It was acknowledged to have a valuable role not just for convenience and a socialising opportunity, but in helping to draw in local people and allowing them to find out about services on offer. It was unfortunate that this importance was not being acknowledged through designated staff funding. At the time of the site visit the coffee bar was dependent on the goodwill of one volunteer who only opened it for certain periods. A more regular arrangement could have ensured continuity and provided a service local people could rely on.

The respondents had observed that the public consultation process had provided publicity for and about the local community. This had encouraged specific services to be drawn to the area that may not have otherwise become involved. St Matthew's had become part of

Leicester's Urban Programme and the Drug and Alcohol Unit and Mediation Services run by the voluntary sector had become brought into the project. The police base was another community facility directly requested by the community. This had made the Trust's Project Manager realise that the vast majority of the local residents wanted a peaceable and safe life and that the local community had been most alarmed when another local police base was closed.

Over one hundred residents had been involved in the design process for the Centre which, the respondents claimed, had given the community a vital sense of ownership. The staff user claimed there was still a lot more to do and that another two years were required to build up the interaction with the community. An outreach community development worker was being appointed to forward this action. However, residents had already undertaken a number of roles within the St Matthew's project including running the coffee shop, sitting on the management committee of Prince Philip House and becoming involved in a number of multi-agency initiatives, such as the St Matthew's Parenting Project and the Employment Initiative.

The public user thought that some local people still did not know that the Centre was there for them and believed they had to be registered with a doctor to come in, but that people who had been involved in the consultation process had enjoyed participating. She thought it had good effect on the community, as people had not felt they were being left out from the decision-making. The commissioning authority respondent had observed that some individuals and local agencies, such as the church and local schools had wanted to become part of the project because they had seen it had a real chance to make a difference to health in the area. A local headmaster had come on to the management committee of the project's charitable trust.

*Process objectives met*

The respondents appeared to agree that the project had developed objectives as it went along and that the original objectives had not been particularly high. These had initially been

to provide a better environment for staff to work in. However, the concept had expanded with the process of consultation with the community. The staff user claimed that she had learnt a huge amount through undertaking this process. At the beginning there had not seemed to be a great deal of political support for this type of project, because the links between poverty and ill health were not being officially recognised. But she thought that this had all changed with the new (Labour) government and that the project was now getting a lot of attention. It had become a model for a health centre in which medical treatment is regarded as only one aspect of what is needed. There was going to be a two-year qualitative evaluation study of action research to determine the impact of the project on the well being of the local population.

The public user thought the main achievement of the project was better access and a good grouping of services. The only disappointment she had noted locally was the loss of the old people's home that had been on the site. The commissioning agent thought that the project had changed the way the trust approached primary care projects. It had recognised the importance of mission statements that clearly lay out the intention of the project and the facility and then to make sure that the project upheld those values. He asserted that in St Matthew's a medium had been created that was being looked after by people within the community, because it had the potential to bring what was needed to that community and that it has started to develop self-confidence and empowerment within the community.

### 2.4 Summary of key outcomes

One of the objectives of this project was 'to develop a centre, which would lead and work with statutory and voluntary organisations to promote and improve the health, educational and welfare needs of the St Matthew's community'.[5] The observational evidence a year after opening was that this objective has begun to be realised. The contribution of medical treatment and services was regarded as only a part, and not necessarily the most important part, of the project and a good mix of services were being accommodated.

The training facility to promote multi-agency working has the potential to make an extremely important contribution to the development of more integrated community-orientated primary health care services. If the project is successful, it will demonstrate how a primary health care facility can provide an education and training base for professionals, where the community becomes the instructor. This ought then to be considered as a model for other primary care resource centres to help break down professional barriers.

This had been a fundamentally professionally-led project and the further objective to facilitate 'residents to play an active role in developing and sustaining local services', had not been fully achieved. In seeking community involvement in the development of the project, the Senior GP had acknowledged that the community were articulate and resourceful, but that local talents were often wasted and that certain structures were required to enable them to participate and keep them participating, in the project. Expectations for future participation of the community in the Centre appeared to be reliant on the skill of the incoming community worker to build up confidence with local people to become actively involved in running their own services. This worker would clearly need the continuing support of the medical staff to accomplish this task.

This Centre had been conceived as a co-ordinating point for the project, rather than the focus of the project itself. This was an important objective and should keep the work of the Centre focusing outwards, rather than inwards because the building was perceived as a means, rather than an end in itself. This concept appears to have close links to the idea for Healthy Living Centres and may well prove an important forerunner for future primary care facilities.

The project has benefited by having the involvement of all the main service providers and the community from the start, which has enabled a high level of satisfaction and pride in the building to be reported. The project and the Centre clearly have the potential to create a

[5] Ibid.

more interactive partnership with the local community, and it appears to have the support of managers for it to move in that direction, but it will require a determined strategic shift to take place. Architecturally, there appeared to be no reason why this should not become a more community managed facility, although the central foyer area, the café and the community rooms needed to be reorganised and better publicised to attract local residents.

Chapter 10

**CASE STUDY 3**

# Kath Locke Community Health and Resource Centre

## 123 Moss Lane East, Hulme, Manchester

Size of building: 2,500 $m^2$.

Cost of building: £2 million, plus £500,000 setting up costs.

Architect: Snapes Design and Build Ltd.

Triangle Architects (special consultants).

Centre opening date: November 1996

Date of site visit: 24.7.97

**Figure 10.3.1 Kath Locke Community Health and Resource Centre**

## 3.1 Project Background

### 3.1.1 Initiation and ideology

Kath Locke CHRC had been conceived as a new primary health care resource centres planned for Manchester by the North West Regional Health Authority just before it was disbanded. It was one of the last primary care buildings to be built before the Private Finance Initiative was introduced and was therefore financed entirely by public money. It became the first primary health care resource centre nationally to be managed by a voluntary agency.

The local community had been hostile to the idea of the new facility at first because they thought that it was being imposed on them without sufficient consultation. They were also concerned that it might threaten existing services and facilities, such as the nearby Zion Community Health and Resource Centre, which was located in adapted and overcrowded church buildings. However after a while, the community users and managers of the Zion CHRC, began to consider the possibility of bidding for the management of the new Centre to enable a development and expansion of services. Following discussion with local residents and voluntary service providers they presented a bid to Manchester Health Authority in November 1995. The philosophy for the Centre as written in this bid was:

- To respect the needs of service users regardless of life-styles or choices made by them.
- To develop existing and new services in partnership with statutory organisations, in order to develop health services
- To work in a way which empowers local people rather than 'treats' them.

These aims show a clear intention to move beyond the proposals of the government's White Paper, *Health of the Nation* (1992), which was criticised by the Director of the Kath Locke CHCRC as overemphasising the need for the public to alter their lifestyles and placing too much blame for ill health on individual lifestyle choices. In contrast, the aim at Kath Locke was for staff to work with the community to improve their well being, rather than merely

provide services for them.

Although the first attempt by the management of the Zion Community Health and Resource Centre (CHRC) to persuade Manchester Health Authority to allow them to manage the new facility was unsuccessful, a second bid made in partnership with the North British Housing Association (NBHA), a local housing association, succeeded. NBHA were considered to have the necessary administrative and financial expertise to manage the fabric and maintenance of the building. Subsequently, the health authority also agreed to develop new premises for the Zion Community Health and Resource Centre (due to open in 1999) and that both the Kath Locke Centre and the Zion Centre should be managed under an umbrella body called the Community Health and Resource Centre Ltd (CHRC).

The Kath Locke Centre was named by the Management Committee after a local Black woman and community activist, who had worked dedicatedly for many years to improve health services to local people in the area. This choice of name was intentionally symbolic as it was hoped to signal to local people that the Centre belonged to them.

### 3.1.2 Building context

The Kath Locke Community Health and Resource Centre (KLCHRC)) is located in the Hulme area of Manchester. The surrounding neighbourhoods, Hulme and Moss Side, are racially mixed and economically disadvantaged localities of inner Manchester. The 1991 census had recorded a 35% ethnic minority population. African-Caribbean was the largest ethnic minority group and Chinese, Somali, Asian and Irish communities were among the others. Approximately 75% of local people were receiving housing benefit.

The Centre Manager of Kath Locke explained that Hulme had undergone many changes in its urban landscape following an extensive regeneration programme in the 1980s and 1990s. This had upgraded the quality of housing and community facilities in the area. Moss Side has had less money spent on it and was still regarded as a seriously deprived area. One of

the major problems was the lack of local food shops and supermarkets in the area, which impacted on the diet and health of the community. However, during the process of regeneration in Hulme, the local community had begun to be active in decision-making processes on planning, health and social issues. Local people had also built up a strong network of self-help and voluntary agencies on a range of health related issues, including an African-Caribbean Mental Health Project, a Drug Advice and Support and a Parent and Infant Support Project. Therefore, when the opportunity for a new health centre in the area was proposed, the community had been in a good position to become involved in its development.

The building occupies a prominent corner site between Moss Lane East and Princess Road. A bus route passes the building that runs into the city centre, but services are poor to other parts of the city and to adjacent neighbourhoods. The building has a steel-framed construction with a traditional tiled and pitched roof. The exterior has two, principal three storey brick elevations, which form an oblique gable end. There is a feature tower and a two-storey recessed feature with cylindrical columns incorporated on the principal elevation. There is a car park for staff and disabled users to the rear of the building and two wheelchair accessible entrances, one from the car park and one from Moss Lane East.

### 3.1.3 Key respondents

The Centre Manager for Kath Locke CHRC, who had been in post since the building opened in November 1996, provided background information for this project. The Director of the Community Health and Resource Centres Ltd. and the Locality Manager of Hulme and Moss Side gave information about the period prior to 1996. As with the other case studies the building quality evaluation survey and the community process evaluation survey were conducted by a staff user, a public user and a commissioning agent respondent. To provide confidentiality, identification details are provided in Appendix 10:3.1 and evaluation ratings are provided in Appendix 10:3.2 and 10:3.3. The following is a summary of the main points raised by all of these respondents and information gathered through direct

observation and project documentation.

*Project Documentation*

Zion Community Health and Resource Centre (1995) *New Horizons, Tender Bid from Zion Community Health and Resource Centre for Management of Primary Care Resource Centre, Moss Lane West, Manchester,* November 1995.

Kath Locke CHRC (1997) *Drop-In Services,* Centre Information Leaflet.

Triangle Architects (1997) *Zion Two, Community Health and Resource Centre and associated housing development.* Design Complementary to Accompany Planning Application.

## 3. 2 Building quality evaluation

### 3.2.1 Accommodation of services

Kath Locke Community Health and Resource Centre opened in November 1996, but was not running a full range of services at the time of the case study visit in July 1997. The services operating were a mixture of statutory medical, voluntary and self-help services. Additional services, such as a crèche and a diabetic clinic, were planned to start in the forthcoming months. There was no resident GP, as it was thought that this might change the emphasis of the Centre from a community resource to a professionally dominated medical centre. Also there had been significant opposition to the Centre from GPs initially as they thought it might threaten their practices. Since the Centre had been opened there had been eleven inquiries from medical practices wishing to relocate, but it had been decided to appoint a GP/s to run sessions rather than have a permanent GP practice on the site. Among the services being offered at Kath Locke was a particularly high number of drop in services giving local people instant access, including:

Dental services

Asian Women's information and advice

Debt counselling consumer rights and legal and housing advice

Stress counselling

Massage service

Advice and support for the blind and partially sighted

Family planning

Sexual assault advice and support

Methadone prescribing programme

Other services requiring appointments were:

African and Caribbean Mental Health Project

Audiology

Chiropody

Creative Support

Community Mental Health Nursing Services

Social Services Mental Health Team

Community Dietician

Midwifery Services

Sensory Integration Project

Orthoptics

Physiotherapy

District Nurses

Sickle Cell and Thalassaemia service

As well as the regular organised services, rooms could be booked on a temporary, or one-off basis by community groups, whose aims fit the ethos of the Centre. Charges for rooms were made at the discretion of the management committee.

### 3.2.2 Building layout and organisation

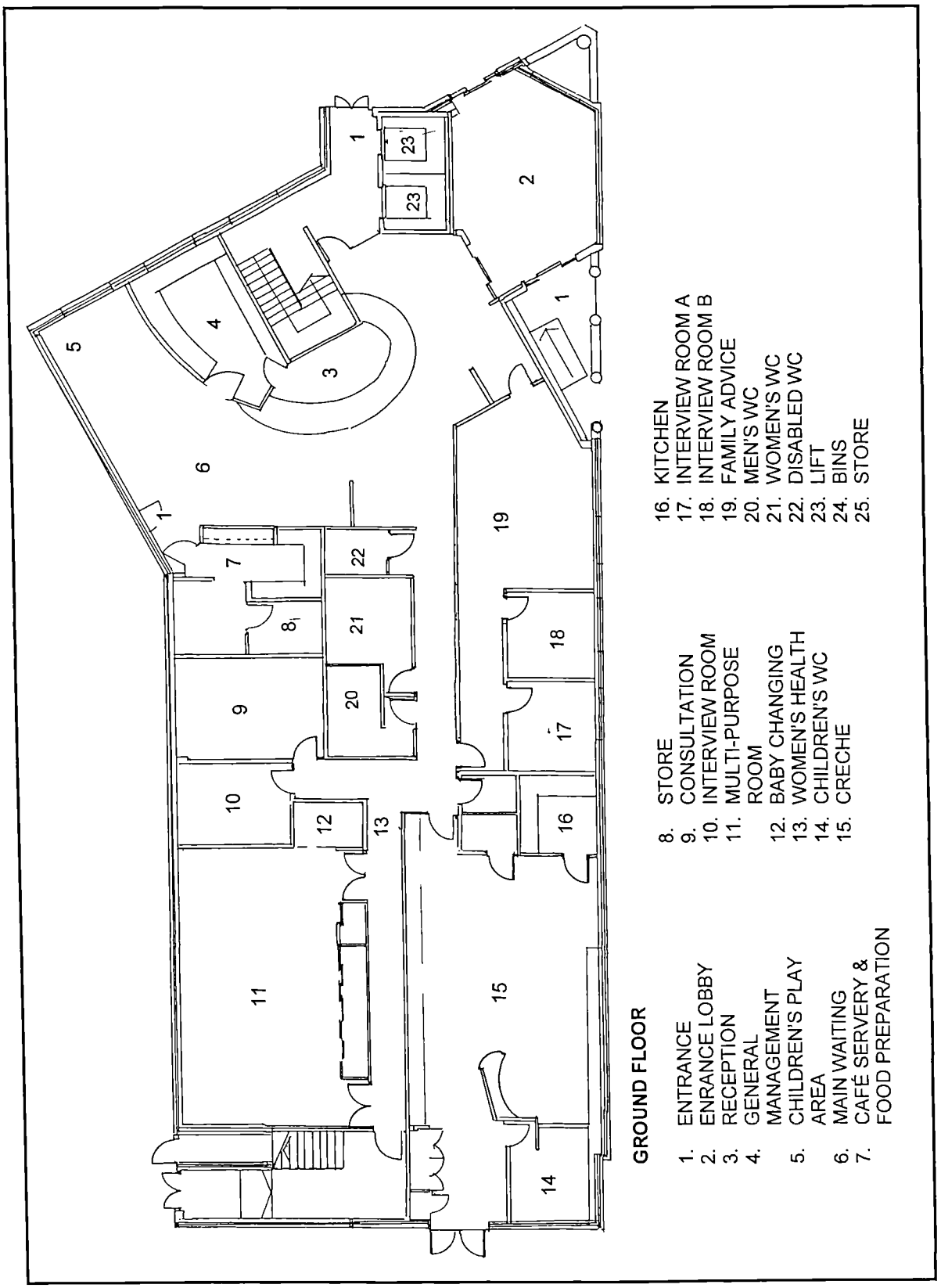



**Figure 10.3.2 Kath Locke: Ground Floor Plan** Architects: Snapes Design and Build

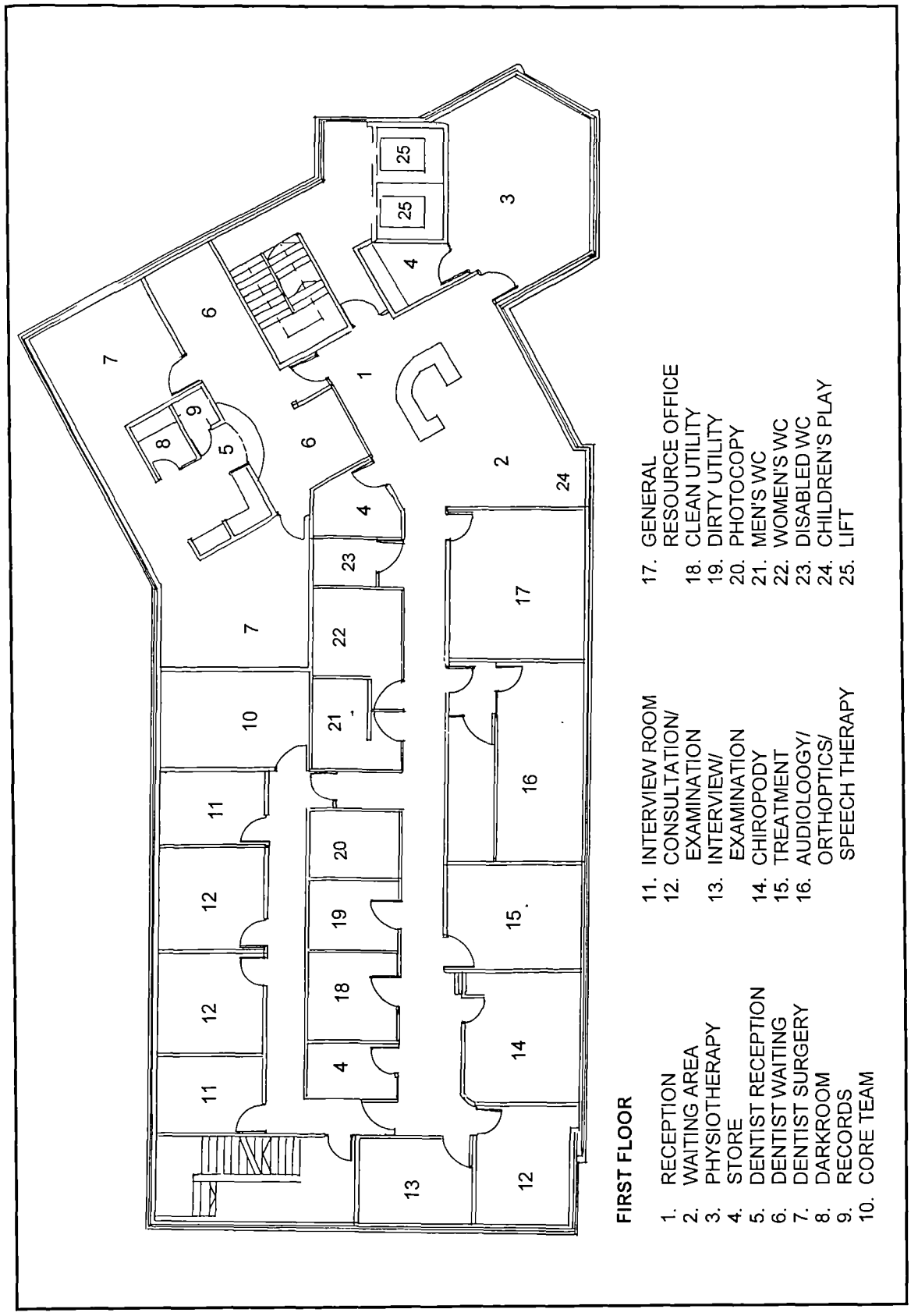



**Figure 10.3.2 Kath Locke: First Floor Plan** Architects: Snapes Design and Build

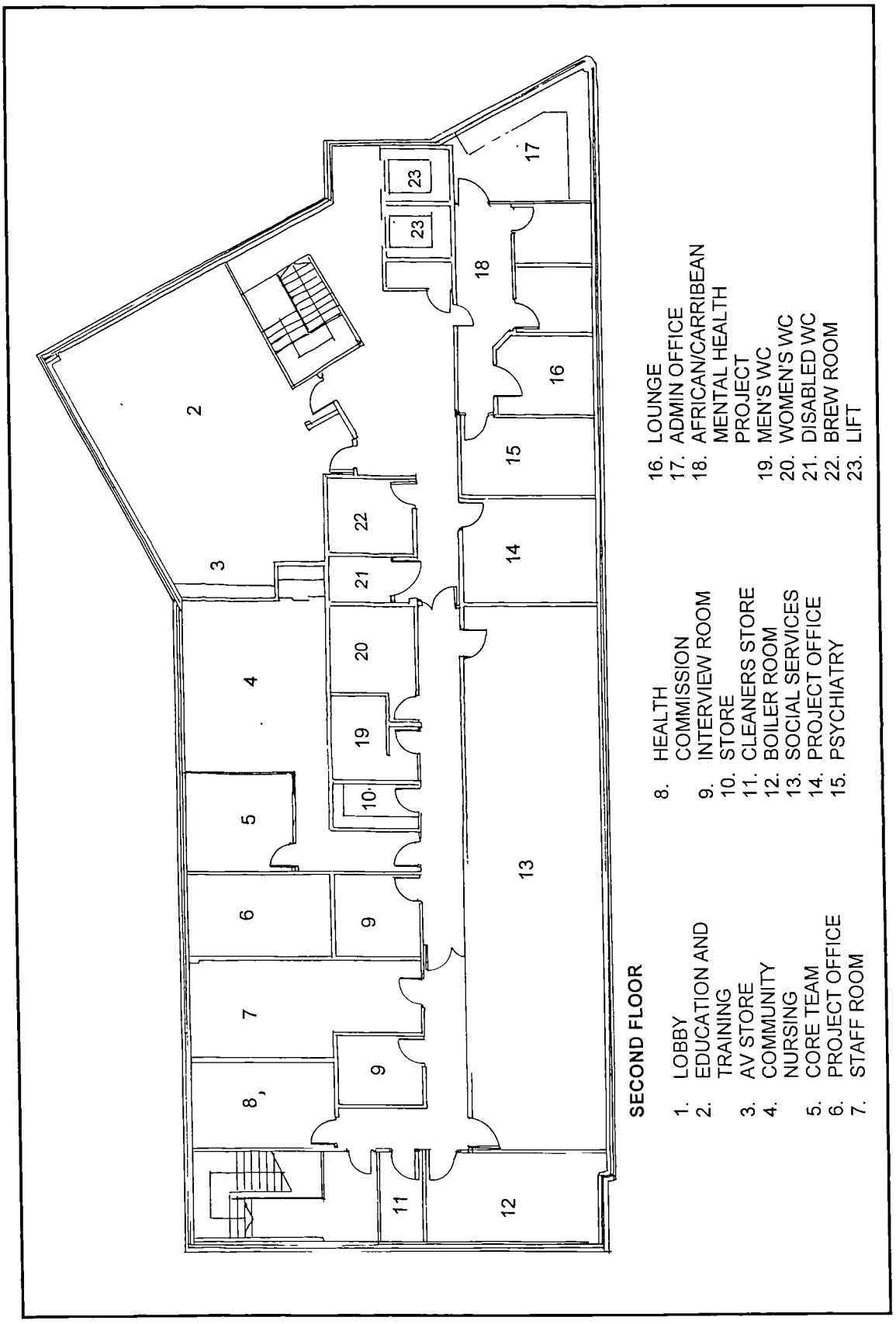



**Figure 10.3.2 Kath Locke: Second Floor Plan** Architects: Snapes Design and Build


**Figure 10.3.5 Open ground floor reception area**

**Figure 10.3.6 Café seating area**

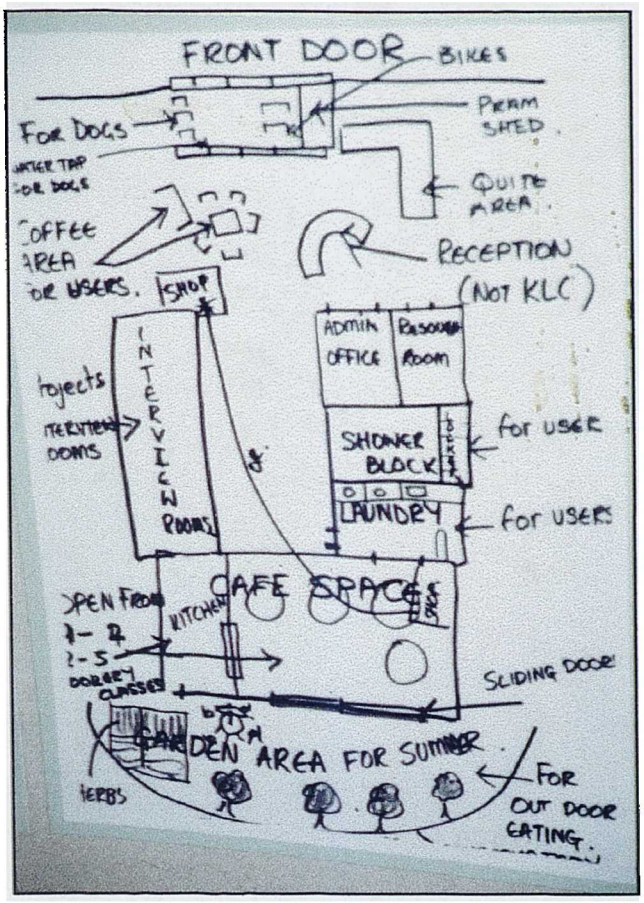
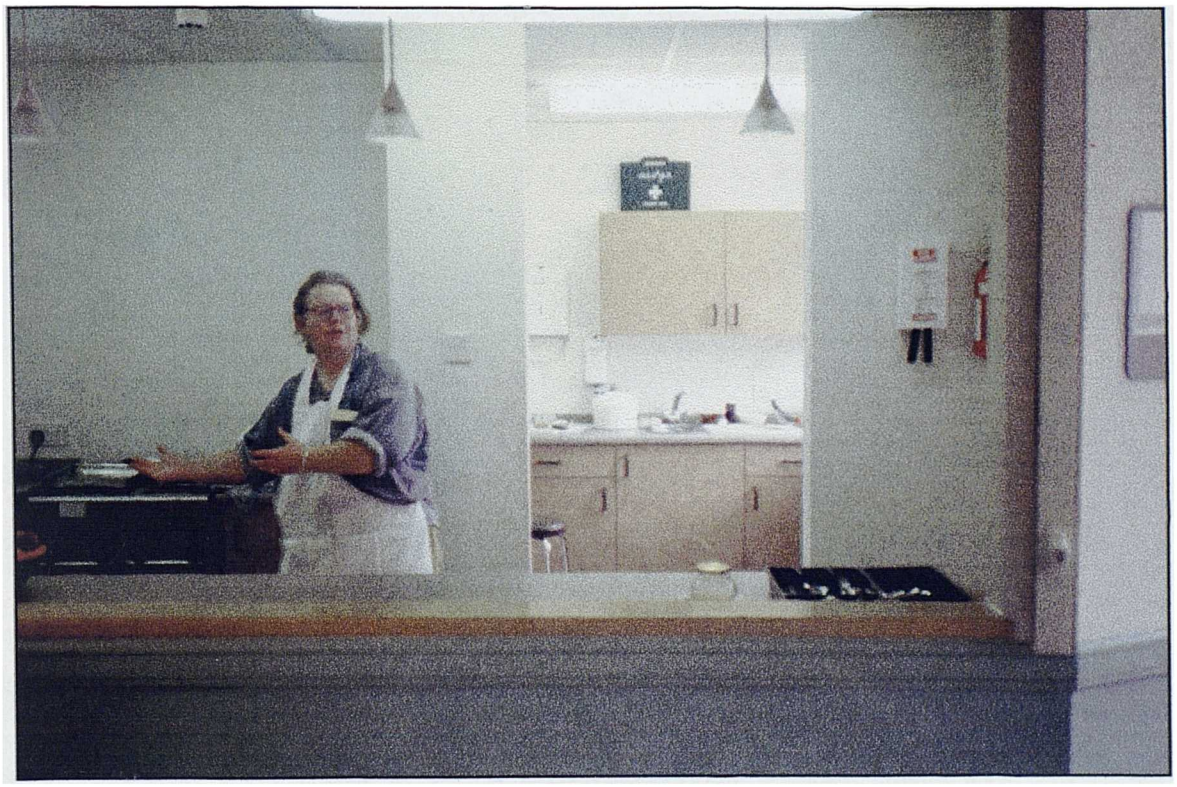



**Figure 10.3.7**
(Left)
**Designs for new Zion centre from community user workshop with Triangle Architects.**

**Figure 10.3.8**
(Below)
**Community kitchen used as a training facility for local people.**



### 3.2.3 Design facilitation of inter-sectoral collaboration

*Space allocation, collaboration and separation*

The Kath Locke Community Health and Resource Centre was regarded by respondents as having a strong commitment to the ethos of co-operative working and the building was generally regarded by staff users as being conducive to enabling staff to work well together and being a pleasant environment to work in. But the staff respondents admitted that they found it difficult not to compare the new Centre with the poor standard of previous accommodation that they had worked in previously, and that this made it hard for them to criticise the building. Staff who spent most time in the building gave space allocation, flexibility and economy the lowest rating. Problems identified were:

- too many small rooms and not enough opportunity to join spaces up
- not enough outside space had been allocated to the crèche and the siting of the playground between the road and dustbins was poor and potentially hazardous
- too many staff parking spaces had been allocated, which dominated the outside area
- not enough space had been allocated to some services, while others had too much and this was difficult to retract from staff without objections being raised
- not enough seating space had been allocated for the cafe and an outside seating/garden area would have been welcomed
- no space had been allowed for creative workshops where people could make a mess;
- larger meeting spaces were required
- too many narrow, long straight corridors
- the Audiology room had been placed on the noisier (traffic) side of the building resulting in noise distraction
- large items of furniture or equipment, such as clinical couches, restricted room use for other purposes
- the kitchen design had been allocated too much storage space and not enough space for food preparation, especially because this facility was intended to be used for training

purposes.

Particular design barriers to inter-agency working were identified as being the long corridors and lack of visual links between agencies and the general lack of storage space which made sharing spaces less convenient. The community café and main waiting area was regarded as a good place to meet people from other agencies informally (see Figure 10.3.6). Some of the agencies had originally requested more separation from each other, such as the Afro-Caribbean Mental Health agency and the Social Work agency and dividing doors had been provided, but in practice these had never been closed or locked. The location of the drug clinic close to the crèche area and the risk of drugs being taken in the adjoining toilet had also created problems.

### 3.2.4 Design facilitation of community participation

*Siting, approach, entrance, reception and ambience*

The siting of the building was considered appropriate for local people by all the respondents because it was on the borders of two local communities, Hulme and Moss Side, and could therefore serve both. However, some people living on the furthest Moss Side borders had complained that they were too far from the Centre. The solution appeared to be either to provide more convenient public transport links for those living on the furthest borders of the catchment area, or for additional facilities to be built within a smaller radius of those border areas. The Centre has high visibility from the street and was located on a main road, but it was considered under-used. The staff believed this was connected with the need to publicise the Centre better and to educate the community about what services it could offer them, than it was about the location or physical presence of the building. For example the dentist services appeared to be under-used, because they were not allowed to advertise, nor were the visiting school dentists allowed to recommend the service to the public, even though the facilities were undoubtedly more modern than many other local services. Sometimes visiting members of the public had been disappointed not to find a GP in residence at the Centre, but the numbers of public users was slowly increasing.

The staff users were critical about some of the materials and finishes in the building. By the time the Zion CHRC had control of the management at Kath Locke many important decisions about the building had already been made. The general layout had been decided and many of the fittings such as the door handles had been ordered. When the Zion CHRC took over the management they commissioned Triangle Architects to work with them to try to change the ambience of the building through the internal decorations. They wanted to shift the style of the building away from having a clinical atmosphere to being a more welcoming, community style of building. The design of the open reception desk was crucial to this decision (see Figure 10.3.5).

Triangle Architects advised them to change the original specification for carpet on all floors throughout the building and to have a vinyl flooring, in all the common areas leaving carpet only in the office areas. The architects had incorporated designs in the flooring, which had been created at a workshop with users. This helped to personalise and enliven the spaces. The vinyl flooring had worked well and maintained its appearance, whereas the carpeting was looking worn less than a year after the Centre had opened, and the staff now wished they had specified vinyl throughout. Other techniques to create a more friendly atmosphere in the building were: the provision of dado rails in the corridors, with toning colours above and below; feature walls with wall paper; curtains in some rooms; uplighting; art by a local artist on the walls; tea, coffee and snacks available from the cafe in the reception area and background music on the radio. It was thought that more art would help to break the monotony of some of the corridors.

*Security and confidentiality*

A serious design fault that had been experienced in the building was inadequate soundproofing in the Audiology room and throughout the building. There had been a dispute with the builders over liability for this. Ventilation was another serious problem in the building. It had tended to overheat and did not have sufficient cross ventilation. Other irritations had been the inappropriate design of the door handles, which were difficult for some people to grip.

After winning the bid for managing the Kath Locke Centre, Zion CHRC had the design of the reception area altered to meet requirements for a more informal and welcoming arrangement. They had a low wide curved reception desk designed as the main feature of the entrance area. There was general satisfaction with the reception in use, although one of the problems identified was the lack of an opening section in the desk. As a result, if one of the receptionists needed to comfort a member of the public, or escort them somewhere, they had to go through the door in a back office to access the public area and lost visual contact. A gateway from the reception desk into the reception area would have been preferred.

All the respondents regarded security within the building as high without being obtrusive. The receptionists controlled access to the upper floors by an automatic entry system. Internal doors were kept locked. There were no CCTV cameras inside the building, although there were some on the outside. Receptionists worked in twos and threes and could give each other support if necessary. There were panic buttons in every room and staff were given training on their use and other aspects of security and ways of communicating with the public. The depth of the reception desk created a separation from the public that was not unfriendly. A good balance therefore appeared to have been reached in the design between protecting the staff and creating a welcoming environment.

*Accessibility, public facilities and comfort*

The building had two entrances, a lift and is fully wheelchair accessible. There were tactile direction signs and other signage uses contrasting letters to make them more easily readable and there was an induction loop system. The provision of two entrances was criticised by some of the respondents because this had resulted in wheelchair users arriving by car using the back door, while other service users used the front entrance. A single entrance for all public users would have been preferred and this would have improved the building's security. Resiting the entrance at the corner of the building could have enabled this. The long corridors may also have caused problems for some users with mobility problems.

Health and service information was provided to visitors by a touch sensitive machine. There was an information/display board with leaflets in the reception area. There was a large crèche with an outside area that was about to be run by a local childcare organisation. This was due to open in September 1997. There was a high standard of toilet provision, disability toilets and baby change facilities throughout the building. There was a community cafe next to the ground floor reception, which was run by local people. The current staff criticised the layout of the kitchen area as having not provided enough preparation space, but too large a food storage area. It had been hoped to use the kitchen as a training ground for local people to gain employment, so a generous amount of space to prepare food and for circulation was important.

*Independent community use*

There was a clear commitment from the managers of this project to encourage the community to take the initiative in running services and creating support groups. It was possible for members of the local community to book rooms at the Centre for various activities. While conducting the site visit I witnessed two groups coming in to book sessions, for a one-off event and a regular group session. However, the respondents expressed some concern about the size and types of rooms available for public users, particularly the lack of a large meeting space or workshop area suitable for art and creative activities. The high rating given by respondents for this variable may therefore reflect the high level of commitment to independent community use, rather than the suitability of the accommodation (see Appendix 10:3.2).

*Sustainability and ecology*

Respondents' awareness and rating of issues of ecology and sustainability were low and there was no evidence that any particular attention had been paid to these issues in the design. Although many of the individual variables on building quality were given a high rating in this survey, two of the respondents had reservations about the overall quality. The main deficiencies were cited as the inadequate size of the building to accommodate all the activities they would have liked to run and there were important drawbacks in the building's

ventilation and soundproofing systems. One respondent believed that the design and build construction method and the lack of community involvement and control of the design process from the beginning had resulted in a less than perfect tuning of accommodation to need. Respondents' judgement of the building was also affected by their awareness of the low standard of other health buildings in the area. All the respondents expressed satisfaction that they had managed to achieve more of a community atmosphere at Kath Locke than at other resource centres in the area, which they claimed appeared more clinical.

The managers of this project thought they had been fortunate in finding an architectural firm that was both committed and had the skills to facilitate community involvement in the interior design planning process (see Figure 10.3.7 for ideas from one participation workshop). The skills and confidence gained by the community in undertaking this process are now being built upon in the planning and designing of a new Zion Centre, which was due to open in 1999. There still appeared to be some practical improvements that could be made relatively easily, such as resiting and landscaping the outside play area for the crèche, the enlargement of the cafe seating area and a rethink on the car park space to create more garden areas. Inherent problems with ventilation and soundproofing appeared to be more fundamental, and more costly and difficult to solve.

## 3. 3 Community involvement process evaluation

### 3.3.1 Effective process management

*Clear objectives*

The extent of influence of the community consultation process over the design of the building had been limited by the fact that the outer shell of the building and some of the inner layout had been determined before the local community became involved, i.e. before the November 1995 bid was accepted. The main aim therefore had been damage limitation and to try to change the emphasis within the Centre away from a medical centre to community-oriented drop-in facility. Once the community had made the decision to put in their own bid for managing the Centre they understood why they were involved and what

they wanted to achieve.

*Time allowed*

The staff user representative did not consider that enough time had been allocated for consultation. This was because the community did not become properly consulted in a way that they could change things until after November 1995 and by then many decisions had been taken. Also, the period of consultation between deciding to bid for management of the Centre and the bid submission date was only eight weeks. The public user respondent suggested that although there had not appeared to be enough time, in retrospect this may have helped to sharpen their minds and kept them involved. She suggested that they had to pull out all the stops to meet deadlines and that if there had been more time people may have lost interest. The commissioning authority respondent thought there had been enough time but that it was not always been well used.

The dissension over this issue possibly indicates that it is not just the length of time provided that is important, but the way in which time is used. On one level there might never seem to be enough time for a consultation process, but this can have a galvanising effect if the community can rise to the challenge, and is given adequate support to meet deadlines. This can require people to make some personal sacrifices to influence the outcome of the project. If there is insufficient interest, a longer time scale may be required to ensure that representations of all user views are obtained.

*Successful management and commitment to the consultation process*

The Director of CHRC Ltd. explained that she had become responsible for the consultation process, but she had underestimated the level of conflict there would be between meeting the needs of those who would continue to be accommodated in the old building and those who would be located in the new building. She explained that she had learned not to try to put off conflict debates, but to try to work through them to a resolution. The public user agreed that the Director of CHRC Ltd had final responsibility, but had considered the Locality Manager collectively responsible for the consultation process. She thought that the

process had been successful, but very painful and that some risks had been taken, such as the decision to change of name of the Centre to ground it in a community ethos, which the health authority could have rejected. The commissioning authority respondent thought that as Locality Manager he had been responsible for the process from the health authority position and felt that this had only been partially successful.

The staff user thought that commitment from the health authority had varied during different stages of the consultation process. The public user thought that the health authority had been willing to involve the community in the project development process, which had been partially shown by the appointment of the Locality Manager from within the voluntary sector. But there was also a sense that the health authority was wary of upsetting the community, because it had a powerful voice. At first many people had been sceptical about the benefit of community involvement and thought that the health authority had little understanding of the community's needs, but they had became involved despite this. The commissioning agent respondent thought that Manchester Health Authority has demonstrated considerable commitment to community involvement without necessarily knowing how to do it. One way they had shown this commitment had been by restructuring the area into six localities, which each had a manager responsible for gaining the views of local people.

Both the staff users and the community had shown a high level of commitment to the process, but this had meant considerable hard work, particularly for the staff. The community had showed its commitment by attending meetings and writing letters to MPs and the press.The public user explained that the community was very committed to putting in the bid and had taken part in presenting it themselves. She recalled a considerable emotion, discussion and debate about many of the issues that the new Centre raised, but that because it represented a new vision for the area this had meant that the time it took had ceased to be an issue and meetings had been generally well attended.

*Consensus reached*

There was agreement that consensus for this project had been hard won and that there had been considerable concern over protecting existing services at the Zion Centre, but that there had been a determination to make the best of any compromises.

### 3.3.2 Achievements of the community involvement process

*Improved access*

Respondents reported that consultation with the community had resulted in improvements to the information available to visitors and had ensured level access, disabled parking and easy level changes. Local people had been asked their opinion about how the Centre should appear and features had been sought to change the atmosphere from clinical to welcoming. Public user facilities were good and included a crèche, a café and high standards in the toilet and baby change facilities. The cafe, a more spacious reception space, the crèche and the women's evening were all achieved as a result of the consultation process.

*Additional community activities and sense of community ownership*

It was evident that the building provided a high level of community facilities, which had been an integral part of the project's objectives. Respondents explained that the consultation process had ensured that 50% of the accommodation was used for community facilities, including art and therapeutic groups.

*Process objectives met*

The staff respondent claimed that one of the greatest achievements of the consultation process had been to bring the social work team to accept the more informal atmosphere of the building, as they had been used to a more fortress like environment. The more informal arrangements in the building therefore seemed to have begun to bridge the cultures of statutory and voluntarily run services. The consultation process was seen to have been essential to get everyone to support the Centre. The community would have demanded inclusion, because they already had a history and culture of involvement in local issues but

the consultation process also appears to have resulted in fundamental changes within the health authority. The Centre is providing much needed service to many different sections of the community including the Black community, lesbians, gay men and disabled people. With slightly better funding staff respondents believed the Centre could maximise its considerable potential.

### 3.4 Summary of key outcomes

Kath Locke CHRC is a courageous, pioneering venture resulting from the vision and determination of the local community and community leaders to keep control of the services provided to them. The ideology behind this project appears to have come from community and voluntary sector belief that the community itself, even in a very disadvantaged area, could provide the solutions to many of its own problems, if it was given the resources to do so. The health authority demonstrated vision, trust and courage in backing this venture. The decision not to have a permanent GP practice on site has had a major impact on the type of service and approach being offered by this facility , which has important implications for the design of a primary health care facility. It potentially frees primary care facilities from the dangers of an over-clinical or professionally dominated ambience, and shifts the balance of services towards the social side of the spectrum. However, it also avoids some of the issues of inter-sectoral collaboration, rather than tackling them. In so doing it preserves divisions between medical and social solutions to health problems, which need resolution.

The influence of a health philosophy to create closer links with the community has been made evident in the interior arrangements. The entrance and reception have been made as open, informal and welcoming as possible and rooms are readily available for community use. The overall design of the building might have been even more imaginative and appropriate if the community had been involved in it from the beginning. The community were fortunate in finding an architectural practice skilled and committed to involving communities in the design process. Experiences gained through this process were already having a longer term benefit as the community was involved in the development of a new

Zion CHRC, and the community had been able to influence this project from its inception.

There seemed to have been a lack of clarity over who should have been responsible for the community involvement process and, as the Director of CHRC Ltd pointed out, certain skills required to resolve conflicts had to be learnt as they went along. The role of managing the process appears to have been extremely demanding, and over-reliant on the good will and dedication of the individual involved. Her experience would appear to support one of the arguments of this thesis, that the person undertaking this role should have proper training, planning and support.

The community involvement process for this facility appears to have involved the community in great determination to gain local trust and overcome technical obstacles in their claim for management rights. It had been a big step for them to take and they had become justly proud of their achievements. They had continued to take an active role in managing the building. The success of the process had been largely due to the well-established and organised community structures that had previously been built up in Hulme. The community had already become actively involved in running a wide-ranging network of services that had reached many sections of the local community. These established community structures had enabled their involvement to be activated more quickly and easily. Success was also due to the dedication of key players to push the process along. All the key respondents for this case study expressed a high degree of personal commitment and were particularly concerned with making the project viable and relevant to local needs. A high proportion of staff lived in the community and had established links with local people, which had clearly facilitated the process.

Community involvement in the design process became a critical part of the preparation for sharing the building as the various agencies learnt from each other how they operated. The process also allowed sections of the community to take over discrete areas of the building, such as in the African Caribbean mental health suite, without dominating the Centre and excluding other sections of the community.

Chapter 10

**CASE STUDY 4**

# Neptune Health Park

## Address: Owen Street, Tipton, Sandwell, W. Midlands

Size of building: 2300m$^2$

Cost of building: £2,167, 000

Architect: Penoyre and Prasad Architects

Centre opening date: June 1999.

Date of site visit: 3.12.97

---

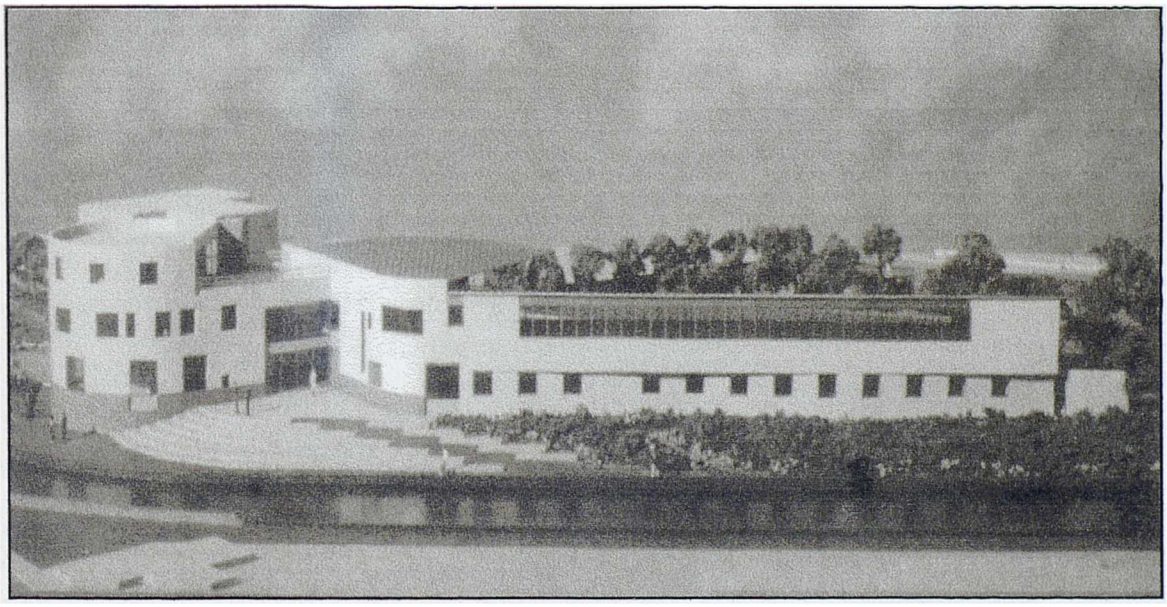


**Figure 10. 4.1 Neptune Health Park: Site Model**

## 4.0 Project background

### 4.1 Initiation and ideology

The concept for Neptune Health Park grew from an idea proposed by Murray Hall, a local voluntary body and independent community trust, for a health bureau that could provide information, advice and counselling to the local community. This idea was extended into a proposal for a wider facility through other health related developments in the area. These included the determination of doctors in the Black Country Family Practice to improve their premises and provide a better quality of service to their patients, and the determination of Sandwell Community Healthcare NHS Trust and Sandwell Health Authority to ensure they were meeting the needs of residents and reducing inequalities in the Tipton area. The project had also received support and co-operation from Sandwell Social Services, which had been working increasingly closely with Sandwell Health Authority, Sandwell Metropolitan Borough Council and Tipton Challenge.

The capital cost of Neptune was approximately £3.4 million, which covered land purchase, works, fees, furnishing and equipment. Most of this money was provided by the DoH to Sandwell Healthcare NHS Trust and was not subject to private finance initiative (PFI) conditions, although a full business case had been submitted and approved. On completion, the building and land was to be owned by Sandwell Healthcare Trust and the private practitioners (based on commercial rents) and the development was intended to keep within existing revenue costs.[1]

The scheme received £500,000 from the Tipton Challenge Partnership, which had won a City Challenge bid in 1992 and had been seeking ways to regenerate Tipton. This donation was intended to specifically benefit Murray Hall Community Trust. Other regeneration projects, close to the Health Park and linked with an 'urban village' concept being promoted

[1] Sandwell Healthcare NHS Trust (1997b) *Neptune Health Park Information Pack.*
Sandwell Health Authority (1997) *Working Together for Sandwell's Health.*

by Tipton Challenge Partnership, were the development of a new shopping centre, a library and a market square. The local swimming baths were also being refurbished.

There have been many claims made for the philosophy behind Neptune Health Park. The February 1997 News Bulletin, produced by Sandwell Healthcare Trust to keep everyone informed of the progress of the project, describes the 'Spirit of Neptune' as follows:

> *Neptune is more than a building. It starts from the premise that health is influenced by many factors and all agencies and services impact on peoples' health. To improve health we need to work more closely together... The services developed will be highly flexible; multi agency with shared resources, policies and development. We call this the 'spirit of Neptune' - not just a collection of isolated services, but real partnerships to meet the needs of patients and users.*

The four main aims of Neptune are given as:

- To develop more integrated working between agencies, within agencies and between workers in Tipton.
- To increase local access to a number of services in one place.
- To create flexible primary care services.
- To increase local ownership and involvement in health.[2]

Structures have been set up to manage the project until the building completion, which include a project board, an executive team, a project manager, a project team, a commissioning team, and an external evaluator from the University of Central England. The management structure for Neptune after the building is operational had still to be decided and it was understood that the management would fall into two arenas; management of the

---

[2] Sandwell Healthcare NHS Trust (1997a) *Neptune News Bulletin*. February 1997.

facility and management and development of the concept or 'Spirit of Neptune'.[3]

The project had the backing of Sandwell Health Authority, which had become inspired by the WHO *Health for All* in the late 1980s and had set about developing a Healthy Sandwell 2000 Charter with 38 targets to be achieved. The Sandwell Charter had therefore predated the *Health of the Nation* (1992) strategy and covered a wider spectrum of health determinants.[4] Sandwell Health Authority was therefore predisposed to be supportive of the type of multi-agency development that Neptune Health Park proposed.

### 4.1.2 Building context

Neptune Health Park is located in the centre of Tipton, one of six Black Country towns in the industrial heart of the West Midlands and inside Sandwell Metropolitan Borough. The building occupies a 5-acre canal side site, just off Owen Street and the main shopping centre of Tipton. Tipton has one of the worst health records in the UK, with a death rate around 25% higher than the national average and twice the usual number of still births.[5] The population of North Sandwell of which Tipton is part is 75,420. Tipton itself has around 27,500 residents. The town of Tipton represents two of the six electoral wards of North Sandwell to be served by Neptune. The population in the wider area had been in decline, but in Tipton it was perceived to be steadying. There is approximately a 10% Black and minority ethnic population, mainly Asian, with smaller representation from African Caribbean and Chinese communities. Also, there is a high elderly population and a large number of single parents in the locality.[6] The Project Manager explained that local residents identified highly with the town of Tipton. They do not see Tipton as part of Birmingham despite its proximity and some residents, mostly elderly, have not even visited Birmingham and rarely travelled to neighbouring towns.

---

[3] Sandwell Healthcare NHS Trust (1997b) op.cit.
[4] Sandwell Health Authority (1997) *Working Together for Sandwell's Health.*
[5] Since the case study was completed Sandwell MBC has been rated as the seventh poorest local authority in England and Wales in the 1998 index of local deprivation places and has been included in the first wave of Health Action Zones.
[6] Sandwell Healthcare NHS Trust (1997a) op.cit.

The local GPs had already formed their own locality group and met regularly to review practice. This group had been accepted as a Locality Commissioning pilot, although it was expected to be one of the smallest in the country, as the average population size for locality commissioning groups was expected to be between 100,000/150, 000.

The contract for the design of the Health Park was won through architectural competition. Staff and public user representatives were on the commissioning panel. In choosing Penoyre and Prasad, the commissioning panel opted for an uncompromisingly modernist design by a well respected architectural practice, experienced in designing health buildings (see chapters 9/10). The building has been designed as a structure and form, which will follow the line of the canal curve. It is intended to be a prominent building with a three-storey round end section and a longer, one and two-storey section. Finding a site for the project was not as difficult as it may have been in other parts of the country because there is a large amount of derelict land in Tipton, but this site was regarded by respondents as being in a optimum location.

### 4.1.3 Key respondents

The interviews and site visit took place in December 1997. The main respondent was the Project Manager of Neptune Health Park, who had been employed by Sandwell Healthcare NHS Trust since July 1996. As with the other case studies the building quality evaluation survey and the community process evaluation survey were conducted by a staff user, a public user and a commissioning agent respondent. For confidentiality reasons identification details are provided in Appendix 10:4.1 and evaluation ratings are provided in Appendix 10: 4.2 and 10:4.3. The following is a summary of the main points raised by all of these respondents and information gathered through direct observation and project documentation.

*Project documentation and other references*

Murray Hall Community Trust (1997) *Annual report 1996/1997*

Tipton Challenge Partnership (1996). *Health in the Heart of the Urban Community: Neptune Heath Park Project.*

Sandwell Healthcare NHS Trust (1997a) *Neptune News Bulletin.* February 1997.

Sandwell Healthcare NHS Trust (1997b) *Neptune Health Park Information Pack.*

Sandwell Health Authority (1997) *Working Together for Sandwell's Health.*

Wickham, D. (1996) *Worker Consultation Report.*

Wickham, D. (1996) *User Consultation Report.*

## 4.2 Building Quality Evaluation

### 4.2. 1 Accommodation of services

Neptune has been designed as a 'one stop shop facility' with open access, 'where people can enjoy a cup of tea, walk around the garden or by the canal, get information, take part in an exercise class or see a health worker'.[7] It is intended to be a community health resource for everyone in the north Sandwell area. Some services, such as the café and information centre, were to be immediately accessible to all, while others, such as radiography or physiotherapy, would need referral from GPs. The Black Country Family Practice would only be accessible to registered patients of the practice.

Services were to be provided in two wings of the building, which vary in height between one and three stories (see plans). The open access entrance area, which was to accommodate the café information and retail facilities, separates the two wings, which roughly divide the medical services from the voluntary services. Services planned to be accommodated in the facility in December 1997 were:

---

[7] Sandwell Healthcare NHS Trust (1997a) op.cit.

**Medical Services**

Outpatient services including x ray, blood testing,

Outpatients clinics e.g. gynaecology, cancer and heart disease.

Minor surgery

Primary care surgery

Black Country GP Family Practice

Physiotherapy

Chiropody

Audiology

Community Nurses

Pharmacy

Optician

**Community facilities**

Two multi-use rooms for community use

Base for voluntary sector organisations, such as Sandwell Advocacy.

Citizens Advice Bureau

Sandwell Advocacy

'Healthy Options Café'

Crèche

Garden

Public health information centre.

### 4.2.2 Building layout and organisation

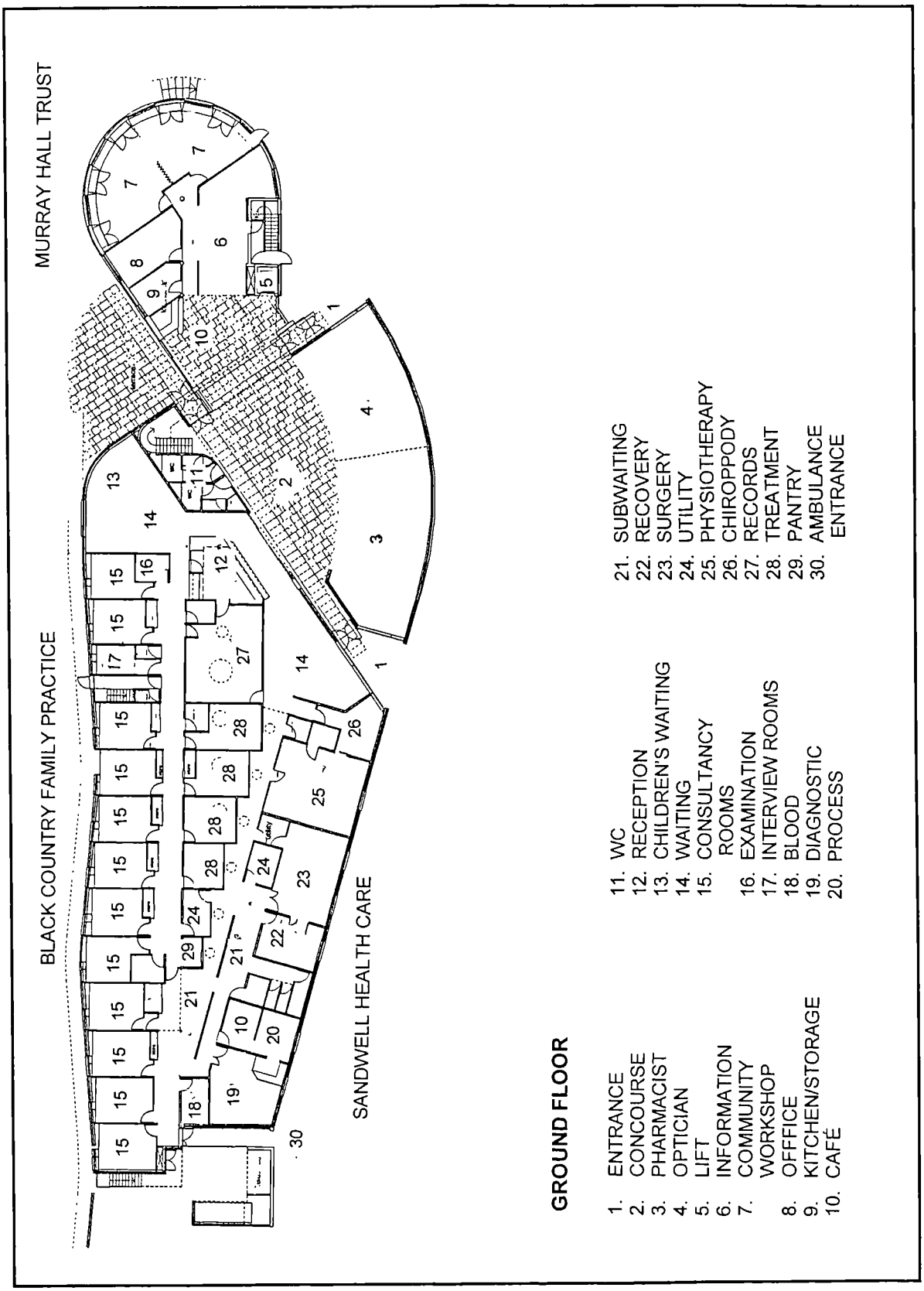



**Figure 10.4.2 Neptune Health Park: Ground Floor Plan.** Architects: Penoyre & Prasad

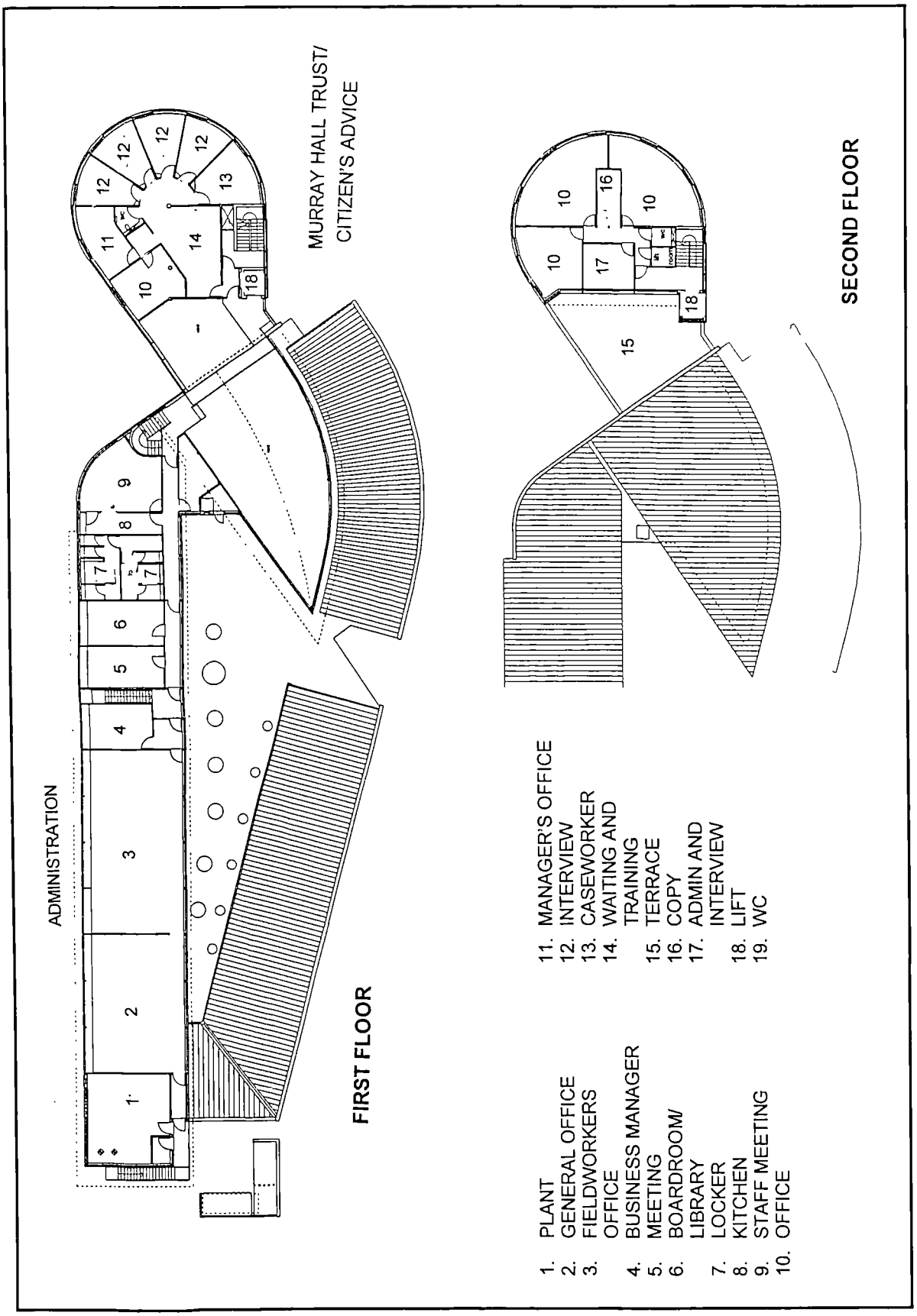



**Figure 10.4.3 Neptune Health Park: First and Second Floor Plans** Architects: Penoyre & Prasad

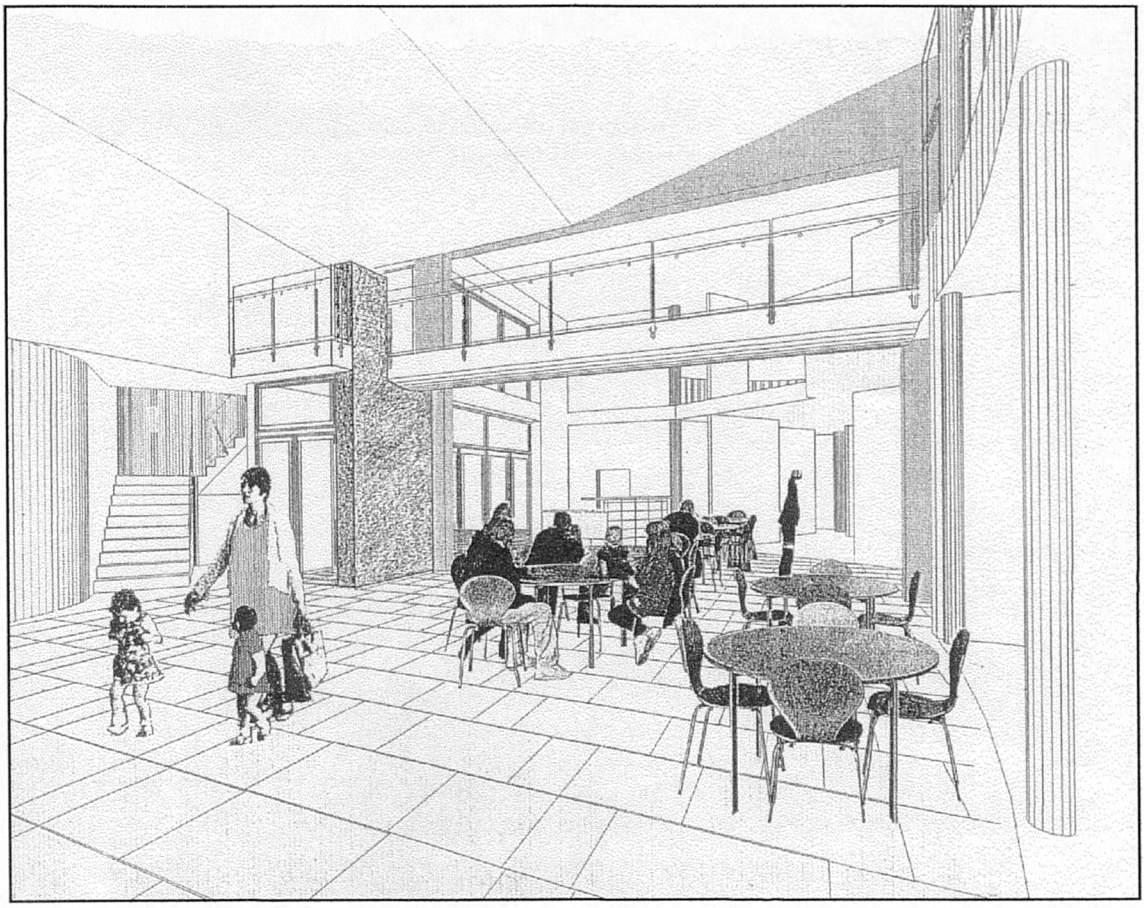


**Figure 10.4.4 Neptune Health Park: concourse area (perspective drawing).**
Architects: Penoyre & Prasad

### 4.2.3 Design facilitation of inter-sectoral collaboration

*Space allocation, integration and separation*

Facilitation of inter-professional and inter-agency working had been one of the main objectives of the project and was one of the key principles around which the building had been designed. Although it was believed by all respondents that adequate attention had been paid to this factor, the final proof would not be available until the facility had been operating for some time. The building had been designed to allow a co-operative working structure, but it has also been arranged in discrete areas so that these could operate separately if required. Requests for separate staff entrances from some agencies and other unnecessary divisions had already been rejected as being against the ethos of the project. It was recognised that projects would be one way of demonstrating joint working and two projects had already been initiated that were regarded as part of the Neptune concept.[8]

### 4.2.4 Design facilitation of community participation

*Siting, approach, entrance, reception, ambience*

Neptune Health Park was perceived to be in a convenient location for local residents, on an attractive site, close to the town centre and on the edge of the canal. One concern expressed was that insufficient bus routes passed the site and there had been discussions with the transport authority, which is a private company; to have some buses re-routed. Local residents wanted to encourage greater use of public transport, because only 42% of Tipton residents are car owners, but there is still heavy pollution in the area due to the volume of cars passing through. A case was being made to Sandwell local authority for a subsidy for extra bus routes. Some local people had also wanted a separate footbridge across the canal to the Health Park, but this facility would have cost £400,000 and was abandoned.

[8] These were: ALADIN (A Local Advancing Development in Nursing), an action research project involving the Black Country Family Practice and Sandwell Healthcare NHS Trust to structure and prepare the nursing team at the practice to support and deliver and commission health care in response to local and national need; and Case Management, a joint working pattern established between Black Country Family Practice, Sandwell Healthcare NHS Trust and Social Services around admission and discharge of patients.

There had been much discussion about the exact position of the entrance and, as importantly, what part of the reception area that the entrance should open in to. The user forum's perception was the entrance doors should not directly face the GP reception desk, because this might communicate the impression that the facility was just a GP surgery and not that it had many different types of service open to the public. This difficulty appeared to have been overcome in later designs. The public user group expressed confidence that the reception areas would be far better than the arrangements at other facilities in the area. There had been concern that there might not be a clear focus point for those entering for the first time and it had been suggested that an information and welcome point should be clearly visible from the entrance. There was a general expectation from both staff and public users that the building would be safe to work in and visit, and that an adequate security system would be installed. But there were concerns about how the building would be protected from vandalism and theft, particularly because it was on an exposed waterside site. There were ongoing discussions about how a 24-hour manned service might be provided on the site. One suggestion had been the inclusion of an ambulance station in the grounds, but this had not yet been agreed.

The public user respondent expressed disappointment that some of the finishes that had been discussed and presented at the competition stage of the project, such as the grass roof, had been abandoned for being too costly as the project progressed. The public user group claimed that they understood that compromises had had to be made for financial reasons, but still expected the building would look attractive and would be a credit to Tipton. The group were being consulted and informed about decisions for finishes. They were also able to make their own suggestions via the user group meetings about using local craftsmen for some of the furnishings and fittings, such as the garden furniture. Also, to bring in local artists and to display features of local interest, such as a mural, which might show scenes of Tipton's past.

*Security and confidentiality*

It was thought that the question of confidentiality of staff and users had been thought through and addressed.

*Accessibility, public facilities and comfort*

The building was designed to be wheelchair accessible throughout; other aids to people with sensory disabilities, such as colour coding, were being discussed with various disability agencies that would be involved in the service provision at Neptune. It was difficult for respondents to assess user comfort before the building was operational but a crèche and small outside and inside play area had been planned. However, there had been difficulties in financing the crèche facility that remained unresolved.

*Independent community use*

The building had been designed so that the community could rent out rooms for various activities and the central entrance area was designed as an open community facility that was independent of any specific service provider. Concerns over the possibilities of vandalism were unresolved and doubts were expressed about the adaptability of the building in the long term and how easy it would be to extend the building if necessary.

*Sustainability and ecology*

There was agreement among the public user group that ecological and sustainable factors, such as energy conservation, should have been more evident. Budgetary restraints were cited as a cause for some of the ecological ideas, such as the grass roof being dropped, but there was concern that these omissions might lead to higher maintenance costs in the long term. There was mixed response to the question of overall building quality. There was a high expectation that the building would be the best community facility in the area, but disappointment was expressed that the building had not been designed to a higher specification in terms of finishes. The public users also expressed the view that more could have been done to involve public art and local craftsmanship. Other ideas mentioned were the need to link the building with local history and the heritage of the area and make more

of the water frontage.

## 4.3 Community involvement process evaluation

### 4.3.1 Effectiveness of process management

*Clear objectives*

Respondents explained that the objectives of the project and the community involvement process had not been clear from the beginning, but had evolved as the project developed. The public user respondent thought that the various parties involved had different objectives, but had personally hoped that the process would allow local people to become more involved in their own development and in the decision-making programme for the project. He thought there had been a genuine attempt to involve local residents and patients of the Black Country GP practice. The commissioning agent respondent asserted that the objectives had become clear after the initial ideas for the project were formed, then the community had been informed and structures set up to ensure their involvement. He perceived the ethos for community involvement to be well established in the health authority.

*Time allowed*

The public user considered that there had been plenty of time allocated for consultation once the objectives of the project had been become established. The aim of involving the community in the project development had been there from the outset and so generally the time allowed was adequate. The staff user respondent considered that there had been plenty of time overall, but that certain stages had been rushed. Once the architectural competition was decided and the building work had begun there had occasionally been a conflict between deadlines for construction within a fixed time scale and the wish to consult more widely.

*Successful management and commitment to the community consultation process*

It was agreed among all the respondents that the Project Manager had had the most individual responsibility for community consultation process, but she had only been in post since July 1996. Before this, Murray Hall had played an important role in ensuring the community would have a voice in the process. Neptune Steering Group had also been responsible for the community consultation process. The staff user respondent thought that some aspects of the consultation process had been satisfactory, but more could have been done to involve non-represented public users and individuals.

The appointment of the Project Manager appears to have been crucial in sustaining the community consultation process and her background in health promotion and commissioning and experience of developing multi-agency working and in community development techniques shaped her approach to the process. The user consultation methods she adopted included a consultation on the competition plans, which was carried out with 62 workers and 46 members of the public, chosen at random. She also produced a range of information materials on the project; convened the six weekly user group meeting, which had assisted with arranging and publicising a publicity road-show and had enabled feed-back of local opinion and information as well as providing a consultation platform for planning and design issues.

The staff user respondent claimed that the health authority had shown more commitment to the community consultation process than the trust, who had less experience of the process and had become used to dealing with the public as consumers rather than as citizens. The public user respondent expressed the view that the health authority had been three steps removed from the process and he would have liked to have seen greater representation at public meetings. The commissioning agent respondent asserted that Sandwell Health Authority was committed to collaborative working with the public and believed that this was the way forward to changing attitudes and practices in the professions and to providing seamless care to the community. He believed that the health authority had been instrumental

in providing background strategies and literature to support working with local communities on health related initiatives. The public users however, who had been less aware of the 'behind the scenes' activities, clearly would have appreciated more visible representation at public meetings, and this would also have helped the health authority to appear to be more publicly accountable.

The staff user respondent claimed that there had been a level of involvement from the community in the consultation process through the community structures in Tipton, which had gone beyond information giving. However, he was aware that the community committees that had been involved had usually been dominated by white, working class males and that there were still some sections of the community, such as children, who had not been involved in the process. The public user respondent had been disappointed by the lack of response from local people, and believed that there was still a 'them and us' mentality about involving themselves in projects planned by the authorities. The commissioning agent reported that he believed that community commitment had been high, but admitted he had not been that close to it.

*Consensus achieved*

The staff user claimed that there had been many heated debates about the project, but that these had been healthy. The respondents agreed that the architectural competition had created a good focal point for establishing shared objectives of the facility. There had been a significant consensus that the Health Park should look like a community building and not a mini hospital. The public user group expressed the opinion that they had not had much connection with other groups who have been involved in the decision making processes, such as the staff users and had felt a bit isolated. Nevertheless they believed that that there was consensus about the direction the project was heading. The lack of communication between groups in the process was acknowledged by the Project Manager to be a shortcoming in the process so far, which she planned to improve.

### 4.3.2 Achievements of the community involvement process.

*Improved access*

The staff user respondent proposed that perhaps the most important physical achievement of the community involvement process was greater accessibility and that the building was designed to be fully wheelchair accessible. Other local groups such as the Deaf Forum, Disability Access, local advocacy scheme and various health support groups had given advice on other issues related to accessibility. Much discussion had taken place about access issues including how the car parking should be organised and who should have priority. One of the services that it was hoped the Health Park would provide was youth counselling and a concern was that by attempting to make the building appear open and public, this might not offer enough discretion for young people seeking privacy. It had been agreed that outreach workers would be employed to offset any problems caused by this. What was clear from these observations was that some of the more controversial or contested issues about the design had been publicly debated and the conflicting arguments understood if not agreed by the participants in that debate.

Respondents explained that the issue of access had emerged through the staff and public user architectural competition consultation survey. There had been concerns expressed about the long corridors shown in part of the design as being inconvenient for people with mobility problems, which had become modified in later designs. Also, many of the suggestions to improve access, such as siting of toilets, footpaths through the car park, and the juxtaposition of services within the building to decrease distances that people might have to walk, had been responded to and altered by the architects wherever possible. The project architect also expressed his appreciation of the feedback from the community consultation process and claimed that receiving users' suggestions could only help to improve the design of primary care buildings.

*Additional community activities and sense of community ownership*

The main respondent explained that there were going to be community rooms available for

activities and short term projects. There would be a notional charge for hiring this space and the public user respondents considered that having so many facilities available to the community under one roof would be a godsend. The authorities had listened to the community viewpoint and had provided the facilities that they had suggested, wherever it had been possible. The commissioning agent representative explained that the building had been initiated from the idea of an information bureau, which was a community resource and the concept of it being a community building had remained prevalent.

The public user explained that this was the first experience that many people have ever had with planning a new health facility and that they had been able to be involved from the beginning, which had helped them feel connected to the project. He claimed the consultation process had given Tipton pride of ownership in a quality facility and that it had listened to local viewpoints. He suggested that the greatest achievements of the process had been the sense of community ownership that had been engendered and the gain of a facility in which so many services had level access and were under one roof. The disappointments had been the reduction in budgets for some parts of the design that had meant that less attention had been paid to details than there might have been.

*Process objectives met*

The staff user respondent considered that the community involvement process had been good for the professionals involved and that some of the service stakeholders had had to change their positions to co-operate with other agencies. But he perceived the process had only been of partial benefit to the community, because it had not reached some sections. However, he claimed that the community involvement exercise had resulted in a greater sense of local ownership in the facility and that people had been reporting their enthusiasm for the project to Murray Hall.

The commissioning agent respondent considered that the consultation process had been successful in its own right and had been important as a pilot experiment for future projects. Eventually he thought it might change service delivery by breaking down barriers between

agencies and this would allow a comprehensive service to be available to the public, which no single agency could have achieved. He claimed that the process had increased the commitment of voluntary health promotion agencies and had already encouraged local businesses to improve their recycling procedures.

The selection of the architect with community representation was considered by all respondents to have been a very important achievement of the project. The greatest disappointments had been issues over transport and car parking, where staff needs had taken precedence over public needs. Also, that finance for the crèche had not yet been found as no agency was prepared to take responsibility for the running costs.

*Consensus reached*

The reforming philosophy of Sandwell Health Authority, which is committed to an integrated and multi-agency approach to health improvement, and to building genuine partnerships with the local communities has greatly influenced the concept of Neptune Health Park. The project was consciously intended to be a vehicle for social change and improvement and appears to have received high consensus in this conception with all the agencies involved. A statement from Murray Hall Community Trust asserted:

> *Neptune is about more than relocating services under one roof. It will allow users to have a greater sense of control about what is happening to them, Offering a wider choice to the customer will in turn produce a better user outcome.*[9]

## 4.3 Summary of key outcomes

The decision to appoint a modernist architectural practice demonstrated courage and confidence on behalf of the main stakeholders to create a vanguard facility in terms of

[9] Sandwell Health Authority (1997) op.cit.., p.9.

design, as well as in its mix of statutory, voluntary and community services. The commissioned architectural practice, Penoyre and Prasad, had demonstrated a commitment to quality health buildings in past projects and in interviews undertaken during this project clearly concurred with the philosophy that the building itself had a part to play in the healing and caring objectives. The involvement of the community into the design aspects from the beginning of the project, particularly through their inclusion on the architectural selection panel, had a significant impact on public users' sense of control over the project. It also introduced an educational element enabling them to understand different design approaches and the choices that became necessary for financial reasons. So that although architectural competitions are not always popular with architectural practices, because they can consume considerable amounts of unpaid time, they can become a valued part of the community involvement process.

This was a professionally led community involvement, process, but it appears to have genuinely tried to involve the local community in the decision-making programme. The strategy to appoint a Project Manager with specific responsibility to help establish and co-ordinate the consultation process was a notable feature of this project. It allowed a properly structured process to take place without relying too heavily on the goodwill of individuals. It therefore avoided the ad hoc approach to public consultation has undermined other processes. The public users' perception was that there had not been a clear objective from the beginning for the community involvement process and that objectives had evolved with the process, but in this project this could be interpreted as positive strategy, indicating that the community had been allowed to influence the decision-making and agenda setting from the beginning, rather than because it was a poorly planned process.

Potential public users of this facility appear to have been offered a range of opportunities to become involved in the planning and design process, but had not always taken these up. The public user respondents blamed this on community apathy and 'too much whinging', whereas the health professionals blamed inadequate processes and structures that had prevented some sections of the community from becoming involved. One of the problems

was perceived to be the City Challenge process that had preceded it, which had involved considerable public consultation and had caused community fatigue. Also, some of the structures and community forums that could have been used to get feedback from the public had been disbanded before the consultation over Neptune began, making the process more difficult. Nevertheless, although flawed, the consultation process adopted at Neptune was the most strategically well planned of the case study projects.

## Chapter 11
## TOWARDS A CONSENSUAL MODEL OF PRIMARY CARE

In accordance with the aims, objectives and theoretical themes outlined in the introduction, this investigation set out first, to undertake a social analysis of primary care buildings through an examination of multiple influences on their development; second, to evaluate the extent to which the product and processes of primary care architecture have begun to facilitate the social principles of equity, inter-sectoral collaboration and community participation, as proposed by the WHO (1978).[1] This latter objective involved conducting a set of case studies of primary care facilities built after the 1990 NHS and Community Care Act, which had formalised the shift to a primary care-led NHS. In this final chapter I will attempt to summarise the key findings of both parts of the investigation, reflect on the research process, and set out some ideas for halting the fragmentation of provision and organisation that appears to be undermining the primary care system.

The first part of this investigation sought to demonstrate that the architecture of primary care was both a product and an outcome of a socially dynamic process reflecting political health ideology, implementation processes, stakeholder interests and the mechanisms and contexts of architectural production. The analysis was structured using a framework developed by Boys (1998).[2] Chapter 2 attempted to demonstrate how competing political approaches to developing a primary care-led NHS during the 1980s and 1990s had led to extreme diversity in the pattern and design of primary care facilities. It argued that this had produced a primary care system that was not necessarily in the public interest, nor forwarded the principle of providing equitable access to services. It described how the neo-liberalist approach to primary care adopted by the Conservative governments 1979 –1997, and founded on the principle of reducing the 'burden' of the Welfare State to the tax payer,

[1] World Health Organisation (1978) *Alma Ata, 1978: Primary Health Care,* Geneva: WHO. See also Chapter 2.3
[2] See Introduction, Figure 0.2 and the research methodology outlined in Chapter 1.

had adopted a *public choice,* or individualistic/consumer, approach to public users of the health service. The Conservative government's preferred strategy had been to provide primary care through the development of a network of GP-led, medically orientated facilities, based on a small business model that was reliant on market forces. This approach was widely criticised for largely ignoring social determinants of health and failing to tackle health inequalities convincingly. It had resulted in a primary care-led system in which GP fundholders became major beneficiaries. Among other inducements, GP fundholders were encouraged by public financial subsidies to make individual profit from premises investment, rather than the government directing resources to those people most in need of health improvements.

This chapter suggested that the main challenge to the type of primary care led-system proposed by central government during this period had come from advocates of the new *public health* model. The main principles of this model were based on the collective/social democratic ideals of equity, inter-sectoral collaboration and community participation agreed by the British government at the Primary Health Care conference organised by the World Health Organisation at Alma Ata in 1978.[3] It was observed that primary care facilities founded on this model had tended to be orientated towards the community, rather than towards individual patients. They often incorporated a range of service agencies to address environmental and social, as well as medical contributors to health. It proposed that these facilities might be regarded as moving towards a more integrated and socially principled model of health care. However, the national survey conducted as part of the research in 1995 indicated that only a very small number of this type of primary care facility in the country had been built. Those that had been built were usually sited in socially and economically disadvantaged areas that were unlikely to attract GP fundholding practices – the Conservative government's preferred form of primary care facility.[4]

---

[3] WHO (1978) op. cit.

[4] See Appendix 1:4 . Through this survey approximately 6 multi-agency primary care facility projects, built since 1990 were identified that had also made a genuine attempt to involve communities by using 4 or more consultation techniques and were mostly in socially and economically disadvantaged city locations.

Chapter 3 focused on the implementation processes connected to the Conservative government's primary care strategy from during the 1980s and 1990s. It sought to demonstrate how the *public choice* model of primary care, whereby facilities had been left to develop in accordance with market forces, had failed to provide adequate distribution of resources. It suggested that this failure, together with the managerial decentralisation brought in by the Conservative's NHS organisational reforms, had given rise to the challenge of an alternative 'public health' model emerging in some socially and economically disadvantaged parts of the country. The absence of a national strategic planning policy during this period had therefore compounded the existing uneven and unequal pattern of primary care provision, by enabling local policy-maker stakeholders, such as the health authorities or NHS trusts, to establish facilities according to different ideological principles in different parts of the country.

Chapter 4 focused on the concept of *positionality* proposed by Boys (1998), which was interpreted as relating to the way in which different stakeholder interests in primary care architecture became embodied both in the building design and use.[5] This chapter particularly considered the influence of different groups of health practitioners on primary care building development. The main argument was that the manner of ownership and occupation of primary care facilities by primary care service providers has played a key role in determining the allocation and accessibility of the accommodation. It referred to Hanson and Hillier's thesis that spatial arrangements enabled the balance of power and control between staff inhabitants and public visitors to be adjusted.[6] So that in theory, for example in a GP-led facility, the power and control of the GPs becomes reinforced through their occupation and dominance of primary units and their control of the circulation system, through secondary level staff (such as receptionists). By contrast, in a multi-agency/collaborative model the control and power of the facility should be more equally shared by participating agencies.

---

[5] Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and Gender', in Ainley, R. (ed.), *New Frontiers of Space Bodies and Gender,* pp. 203-217, London: Longman. Also see Pawson, R. & Tilley, N. (1997) *Realistic Evaluation,* London: Sage and Chapter 1.5.3 for discussion on stakeholders.

[6] Hillier, B. and Hanson, J. (1984) *The Social Logic of Space*, Cambridge University Press.

However, I also tried to demonstrate that currently in multi-agency centres, crucial differences between agencies, particularly between local authorities and health authorities, in terms of status, culture and organisation, can militate against co-operative partnerships and collaborative working.

Chapter 5 examined the historical development of purpose-built primary care centres and sought to demonstrate how the main forms of primary care provision that emerged after the Conservative's NHS reforms, GP-owned and publicly-owned multi-agency centres, were a perpetuation of a bipartite system that had existed since the beginning of the NHS. It proposed that this had resulted in two identifiable styles of primary care architecture. The distinction not usually recognisable in the external aesthetic, apart from in a few notable exceptions such as Finsbury Health Centre and Neptune Health Park, because most buildings tended to follow the neo-vernacular style, but often apparent in the internal spatial organisation and public interface. For example, through multi-agency centres often having 'democratic' entrance areas (welcoming everyone without appointments being required) and weaker barriers to the circulatory system within the building, allowing the public direct access to many services without having to pass through intermediate holding or screening systems.

Chapter 6 sought to demonstrate that the mechanisms for commissioning and financing new primary care buildings set up by the Conservative government had been more favourable to single-agency, or GP-led facilities, than multi-agency occupation. It attempted to demonstrate how mechanisms such as the public finance initiative (PFI) and competitive tendering, together with the different financial structures of key stakeholders, discussed in Chapter 4, could inhibit the successful development of multi-agency primary care facilities.

The last chapter of this first part of the dissertation, Chapter 7, examined the interface between primary care facilities and local communities and catchment areas. It argued that another major barrier to inter-sectoral collaboration, and therefore to equitable and accessible health care, had been created through incompatible socio/geographic

organisational systems. GPs have usually operated a practice-based system providing for patients on a self-selected list, who can reside across a wide area. In contrast, Community Health Service trust and local authority employees, such as health visitors, community nurses and social workers tend to use a patch or neighbourhood-based system, working with patients living within a specific catchment area. It suggested that this had created an anomalous situation that did not appear to be in the public interest and concluded that a neighbourhood-based system appeared to address the principles of equity, collaboration and participation, which this investigation has focused on, more appropriately. However, it acknowledged that this issue was linked to the collective/democratic versus individual/consumer dichotomy in approaches to public users of the health service, discussed in earlier chapters, and was dependent on a supportive political ideological strategy.

In the second part of the dissertation, the focus shifted from seeking to analyse the social influences on primary care buildings to a consideration of how the product and processes of primary care architecture could themselves exercise a social influence on local communities. The first chapter of this second part, Chapter 8, focused on identifying design variables that might contribute to the social objectives of increasing inter-sectoral collaboration and community participation to help reduce health inequalities in the local community. Research for this chapter revealed that most private architectural practices in the early 1990s had had little opportunity to design larger, multi-agency primary care facilities. This was because prior to the Conservative's NHS 1990 organisational reforms, which disbanded them, in-house health authority architectural departments had usually developed this type of facility. However, a set of potential contributory design principles that might support multi-agency occupation and community participation and could be used in the case study evaluations were explored through an examination of the design guidance literature and through interviews with three architectural practices, who had specialised in designing primary care facilities. Design features identified included space allocation and organisation, siting, ambience, public facilities and independent community access. These were converted into items for evaluating the case studies.

Chapter 9 explored the potential of community involvement processes in planning and designing facilities to contribute towards the social ideals of equity, multi-agency collaboration and local community participation. Research for this chapter drew on different sources of information to establish a set of variables to indicate an effective community involvement process. This chapter examined the politically conflicting attitudes to community involvement in the decision-making process, which seemed to polarise around the consumer versus citizen models of involvement. It cited research that indicated the overall effect of the 1990 NHS reforms had been to repress both the collective voice and public accountability in health service decision-making. It suggested that there appeared to be potential social benefits from undertaking a community involvement process, but that various political and professional barriers needed to be overcome. In particular, responsibility for community involvement needed to be recognised as a process that required adequate resources, and needed to be skilfully negotiated, possibly by an independent trained professional.

The four case studies that formed the major part of the field investigation for this study, described in Chapter 10, were selected to demonstrate how far and in what ways inter-sectoral collaboration and community participation had been facilitated through the building design and community involvement process, in a range of multi-agency facilities built since the reforms of 1990. The case studies provided a considerable amount of information relating to architectural processes and production of primary care buildings. For this thesis the data has been collated mainly to illustrate issues relating to the main arguments of this thesis, but it has potential for further analysis as will be discussed later in this chapter.

In terms of providing a wide range of services and facilitating inter-sectoral collaboration, these case studies exhibited different positions on the medical/social model axis. For example, although the Purfleet Primary Care Resource Centre had been pioneering in its original objective of providing a wide range of services, an entrenchment of professional attitudes from some of the medical staff had prevented it from shifting away from a dominant medical orientation. It had continued to operate as a GP-led facility rather than

seeking a more equal partnership with other agencies. The central location of its minor injuries unit had reinforced the medical ambience. The separation of some of the agencies by a spiral staircase to the upper floor of the building also appeared to have isolated some staff and hindered inter-agency working. On the positive side the siting and design of the pharmacy to provide access externally and internally from the main facility had created advantages for the community and the pharmaceutical business. This device of dual access could have been used to create other more social/health-related services on the site, such as a community café, an advice centre, or a fitness centre, which could have complemented the medical services.

St Matthew's Medical and Social Centre was another professionally-led facility, but here more effort appeared to have gone into balancing the GP position within the facility with other medical, social and community services. The presence of the community police office in the entrance area indicated a broader approach to meeting local health requirements, which had apparently been welcomed by the local community. However, this study had not been able to investigate any potential conflicts of use caused through having the police in close proximity to health and social services. The training centre accommodated on the top floor to train health professionals in inter-agency working, is a pioneering development in the promotion of collaborative working. If this pilot is successful and similar training centres are established in other primary care facilities throughout the country, it could have an enormous impact in quickly shifting staff attitudes and manner of working with local communities. At Kath Locke Community Health and Resource Centre, the social/community orientation of services was the most developed of the case studies, but there had been no attempt to integrate GP facilities. This might suggest that an optimum balance of medical and social services had not been reached, although there appeared to be scope within the building design to achieve this. At Neptune Health Park, the different agencies that were to occupy the facility had been working to develop a strategy for inter-sectoral collaboration before the building opened. At the time of the case study it was too early to tell how well the design would facilitate this in practice, and some fears had been expressed that the separate wings of the building might activate against ideal levels of collaboration.

With reference to building design facilitating community participation, in all the case studies significant efforts had been made, even if they had fallen short of exemplary practice. Purfleet had appointed two Community Access Officers, which was an innovative step, but the people in these posts did not appear to have been given sufficient support, either in terms of accommodation and location within the building, or through training. This was militating against them liaising more effectively with the public. Also, insufficient space appeared to have been allocated for the community to use for independent activities. This was perceived by the local community representative to be seriously undermining the involvement of local people in the Centre. Although this was regarded by respondents as more a management than a building design problem, the design could have allocated space for community use that could be accessed externally, as well internally, as had been provided for the pharmacy (see above). The design of the reception space could also have been made to appear more welcoming. At Kath Locke, Neptune and St Matthew's, the open, rather than screened reception desk, and the café space in the entrance areas provided a welcome to the community that was lacking at Purfleet. The use of local artists, free advice desks, community notice-boards, and the provision of prominent children's play areas and crèches were other design features provided in some of these Centres to facilitate interaction and involvement with the local community. Case study respondents regarded these features as useful in attracting members of the community, who might be reluctant or fearful to approach services that could help them to improve their health. Respondents also confirmed that the convenient siting of the facility, adequate signage and the importance of close public transport links were vital to encourage maximum use.

The community involvement processes undertaken in all the case studies were well intentioned, if ultimately flawed. At Neptune a specific person had been appointed to plan and carry out the task and this appeared to have added considerable range and depth of the consultation process. In the other projects the job had been undertaken by one of the key stakeholders, with little or no experience. Community involvement had only taken place during the design as well as the planning stages at Kath Locke and at Neptune. Importantly, in both of these Centres the process had been facilitated by the appointment of architectural

practices committed to, and experienced in, community consultation. At Kath Locke, the staff and community had only been involved in designing the internal furnishings and fittings, but this had greatly helped to improve the ambience of the facility and shift the emphasis away from a medical to a more community-orientated facility. Another clear advantage for the consultation process identified at Kath Locke was the high percentage of accommodation that had been allocated to community and voluntary sector organisations. This enabled easier consultation with some sections of the community, such as the Afro-Caribbean community and Asian women, on the design of Centre and helped to legitimise the community as one of the architect's clients from the outset. At Neptune the planned involvement of the community in the briefing process and choice of architect, right through to selecting the colour scheme, provided the best example from the case studies of a thorough community involvement process. Although this process had admitted weaknesses in linking staff and community user groups, and in reaching all sections of the community, indicating that specific training for community involvement facilitators is required. With regards to support from key policy-makers, a simple lesson that could be learned from the St Matthew's case study was that however much the health authority had supported the community consultation process behind the scenes, if they did not appear at meetings with the public, they did not receive any credit.

These studies, and particularly the findings of the case studies, have produced a large volume of information that could be further analysed for particular audiences as extensions to this PhD research. For example, a more detailed exploration of the historical development of the architectural plan and space organisation of primary care buildings could be made. This could examine how the growing complexity of the primary care concept, the divisions in health ideology and varying attitudes to public/professional relationships have been reflected in the spatial layout of primary care buildings. This could be of interest to architects of health buildings and facility planners. Also, guidance could be produced to inform architects of those design features that might encourage inter-sectoral collaboration and community participation. This could include a more in-depth study of how far the physical integration or separation of spaces used by different sectors in multi-agency

facilities might aid or hinder the collaboration process. For example, from these case studies the community health services and the GP and social facilities appear to have been more consciously integrated in the St Matthew's and Kath Locke buildings, than at Purfleet or Neptune, where they had been separated into different wings and levels. Specific recommendations for community involvement processes in planning and designing primary care buildings could also be developed that would be useful to Community Health Councils and commissioning bodies in guiding future projects. Another study might explore the potential of primary care centres to encourage local sustainability initiatives through using ecologically considerate materials, systems and policies and to promote an example of a 'healthy' building. According to evidence from this research, so far sustainability initiatives appear to have been largely ignored in primary care facility planning and design.

Reflecting back on the progression of this research project, one of the most interesting aspects has been noting how evidence supporting the principles of community involvement and a more consensual and collaborative model of primary care in Britain, has lain against the shifting sands of political/social ideology. When I commenced this research in January 1994, the political climate was moving determinedly towards increasing the piecemeal privatisation of primary care management and delivery of services. Therefore, at this time, the concept of a strategically planned, consensual model of primary care, uniting medical and social approaches, which I found myself increasingly supporting as being in the greater public interest, fell against the dominant trend. Since the May 1997 election, the general political rhetoric, particularly in connection to social exclusion polices, appears to have been moving closer towards a concept of strengthening neighbourhoods through partnership projects, joint sector working and involvement of communities.[7] What appears to be undermining this strategy is adequate co-ordination of these new initiatives to ensure, for example, that health zones, education zones, and employment zones really do work together to turn around the most deprived areas. So that within the context of a wider social rhetoric, the role of primary care and primary care facilities still seems to be ill defined. Nevertheless,

---

[7] DETR (1998) *Breaking Down the Barriers,* Report of the Social Exclusion Unit, London: SO

as a result of the marked shift in social policy since 1997, this thesis is likely to emerge in a more receptive climate to its main recommendations than could have been envisaged at the outset of the investigation.

I would argue that the methodological and analytical framework used in this investigation enabled me to conduct a comprehensive social analysis of the architectural development of primary care buildings, although this was necessarily limited in scope through being a PhD study rather than a wider research programme. The combination of Boys's (1998) analytical framework for understanding architectural development based on multiple influences, together with Pawson and Tilley's (1997) methodological techniques for evaluating social programs (particularly their emphasis on multi-stakeholder perspectives), and Hanson and Hilliers' (1984) thesis for analysing spatial organisation within buildings, has proved to be an effective basis for making explicit the multiple social influences on primary care buildings in recent history. [8] [9] [10] A similar methodology could almost certainly be applied to other building forms. The methodology designed to conduct the pilot case study evaluations. and outlined in Chapter 2, has also proved effective in enabling sufficient evidence to be gathered to demonstrate that design and consultation processes involved in the development of primary care architecture can potentially facilitate social objectives for primary care. In arguing this case it must be noted that the scale of this investigation was limited and hence the reliability and generalisability of the information obtained. However, as this study acknowledged in Chapter 9, representation is an inherent problem in all user research and the methodological problems encountered in this research can be understood to reflect in microcosm 'real world' problems of developing effective user or community participation.

In these case studies, the volume of evidence gained from the evaluation surveys was restricted to a few selected informants at a particular stage of the development of the facility. As noted in Chapter 4, there are likely to be considerable differences in status and

[8] Boys (1998) op. cit.
[9] Pawson, R. & Tilley, N (1997) op. cit.
[10] Hanson & Hillier (1984) op. cit.

manner of occupation of buildings between health professionals and with other staff working in a primary care building, such as reception staff or cleaners. The opinions provided by the single staff respondent in the case studies are therefore unlikely to reflect the views of all staff working in the building. Similarly, a single public user respondent cannot possibly represent the different viewpoints of local community members. An issue, which needs to be addressed in a wider study, is that the views expressed by experienced community activists (such as those who participated in the case studies) are likely to be significantly different to opinions of users often left out of mainstream consultation processes. Examples of frequently marginalised users being homeless, frail or disabled people, and people from minority ethnic communities (differences within communities were discussed in Chapters 7 and 9). Key policy makers can also differ dramatically in their viewpoint of the project's processes and practices and, as this is likely to be a relatively small but powerful influential group, ideally it would be useful to include more of them in the evaluation process. As the experience at Purfleet demonstrated, staff changes at higher managerial levels can affect the way that support to certain policies and practices is given.

Working within the limitations of a small scale PhD study, I have aimed to develop a framework that might be used on a larger scale with a more representative sample of respondents, if sufficient resources were available. The questionnaires and scoring process were therefore used here as a pilot to test the evaluation mechanisms, rather than for conclusive analytical purposes. If larger numbers of respondents were involved, then the usefulness of obtaining total scores for comparative and analytical purposes becomes more apparent. Nevertheless, obtaining the different perspectives and scores from even this limited number of representatives of key stakeholder groups has proved to be of value in gaining first insights into the social effectiveness and impact of the projects. It has also provided a relatively simple way to identify potential limitations or conflicts in the design and the community involvement strategies. I am reasonably confident that, with minor adaptations, the evaluation techniques developed for this investigation could be extended to involve more representative numbers of stakeholders, which would enable a more comprehensive evaluation. It could also be used to evaluate projects at intervals to see if agreed social

objectives were becoming more, or less, successfully met.

As with other research projects involving recent history or contemporary studies, the methodology used in this study was influenced by the circumstances that prevailed during the initiation and early development stages. As explained in Chapter 1.1, this research was partially initiated by the Medical Architecture Research Unit at the University of North London (MARU) to clarify uncertainties about the direction new policies and practices engendered by the Conservative government's NHS reforms were leading. If an investigation into primary care buildings were to start in the year 2000, the methodology chosen would undoubtedly reflect the developments that took place in the 1990s. For example, as previously mentioned, at the start of this study in 1994 very few private architectural practices had experienced designing larger primary care building developments. Therefore, at that time, the most practical methodology to gain advice and information about the influences of spatial organisation and other design features was to interview a small panel of experts with the relevant experience. However, by the end of the decade many more multi-agency primary care buildings had been built and the numbers of architectural practices that could be consulted had significantly increased. This could have allowed a wider survey. The case study selection could also have been made from a larger total population. The other major difference has been the changed political context in which primary care developments are taking place under New Labour, which has altered the expected direction of resources and initiatives.

From the evidence of this investigation I would conclude that primary care facilities based on a multi-agency, neighbourhood model do offer greater potential for facilitating the social objectives of equity, inter-sectoral collaboration and community involvement, than the GP-led medical practice model. However, the findings of the case studies indicate that there are still many shortfalls to overcome in both the product and processes of primary care architectural development. Overall, this investigation has demonstrated that, at the end of the 20$^{th}$ century, primary care facilities are fundamentally divided in ideology, form and organisational approach and that a further shift in strategy will be needed in the 21$^{st}$ century

to create a consensual, pluralistic, but socially responsible, primary system. A principal objective of which should be to provide a more logical, egalitarian and comprehensive service to members of the public, wherever they live, than the present fragmented system allows. This requires a planned diversity of facilities to complement existing provision and meet public needs, rather than the unplanned, fragmented system which currently prevails, and which is over-dependent on the self-interest of individuals or professional groups.

The introduction to this thesis described the starting point for this thesis, illustrated in Figure 0.1 (page 11), to explore relationships between the arenas of primary care buildings, government health policy and community involvement. Based on the findings of this research, a reworked diagram is presented in Figure 11.1 (p.323) to illustrate the complexity of factors that need to be considered in creating a network of primary care buildings designed to facilitate the WHO principles of equity, inter-sectoral collaboration and community involvement. In this diagram *Primary Care Buildings* are located at the interstices of the spheres of influence of *Government Policy* (based on a principle of promoting social equity), a *Primary Care System* (based on the principles of inter-sectoral collaboration), and *Community* (developed from the principle of involvement in local decision-making). The diagram shows four sets of pre-conditional factors, identified from the background and field research for this project: *political policy*, *community sector*, *health sector* and *architectural practice*, which need to be synchronised to achieve this objective. Three of these sets of conditional factors are largely dependent on the collaboration of the main stakeholder groups, policy-makers (central government/health authorities), practitioners (health sector professionals) and participants (community users). The third is the temporal support required from architectural practices during the facility design process, but which can have a lasting influence on the facility. These factors are described below and summarised in the boxes shown in Figure 11.1.

**Political policy:**

- There needs to be a clear political commitment from central government to create a primary care-led system, based on WHO/PHC principles and leading to a consensual

model that encompasses medical, social and environmental elements.

- National, regional and local strategies need to be developed to improve health, reduce inequalities and ensure quality and accessible services are available to all.
- A commitment to reducing health inequalities needs to be included in all social policies.
- Central government and health authorities need to be committed to devolve certain powers to local level and to resource structures and mechanisms to enable full community involvement.
- Central government needs to ensure that sufficient resources are available to implement a network of facilities based on the consensual model.
- The financial mechanisms made available for new facilities must place public good before profitability.
- Central government needs to end the damaging divisions caused by health services split between local authorities and health authorities and to establish a more pragmatic joined-up body.

**Health sector:**

- Health professionals need to develop commitment and mechanisms to facilitate inter-sectoral and inter-professional working.
- Health professionals including GPs need to be trained to work democratically and collaboratively.
- A comprehensive network of neighbourhood-based, rather than practice-based, facilities needs to be developed.
- Facility-based mechanisms (for example joint projects) need to be set up to ensure ongoing communication and co-operation across agencies.
- The financial, organisational and mechanisms of different agencies involved in primary care need to become more compatible.
- All service agencies should be accountable to the public.
- There needs to be an end to over-dominance of GP's within the primary care system and the establishment of a professional culture of shared responsibility for the collective and

individual well being of local communities.

**Community:**

- All sections of the local community need to be empowered to take an active role in local decision-making.
- Adequate levels of community development, supportive organisational structures and ongoing community needs assessment should be provided on a neighbourhood basis.
- Public perceptions of geographic boundaries and identities need to be understood by service providers.
- Trained independent community involvement officers should assist the public to participate at different levels and stages of health service decision-making, including at the design as well as the planning stages of new facilities.
- Community access officers should be employed within multi-agency primary care facilities to ensure ongoing community involvement.

**Architectural practice:**

- A practice of architecture needs to be developed that acknowledges and supports the principle of community involvement in the design process, and recognises the community as a legitimate client.
- Architectural students and existing practitioners should be trained in community involvement techniques.
- Commissioning structures and briefing processes, including financial/tendering mechanisms, are required that both support and insist on appropriate consultation with the community.
- A development of knowledge and expertise on how design factors can facilitate collaborative inter-sectoral working and community participation in primary care facilities.
- A synchronicity of social vision with commissioning agents/other main stakeholders is required.

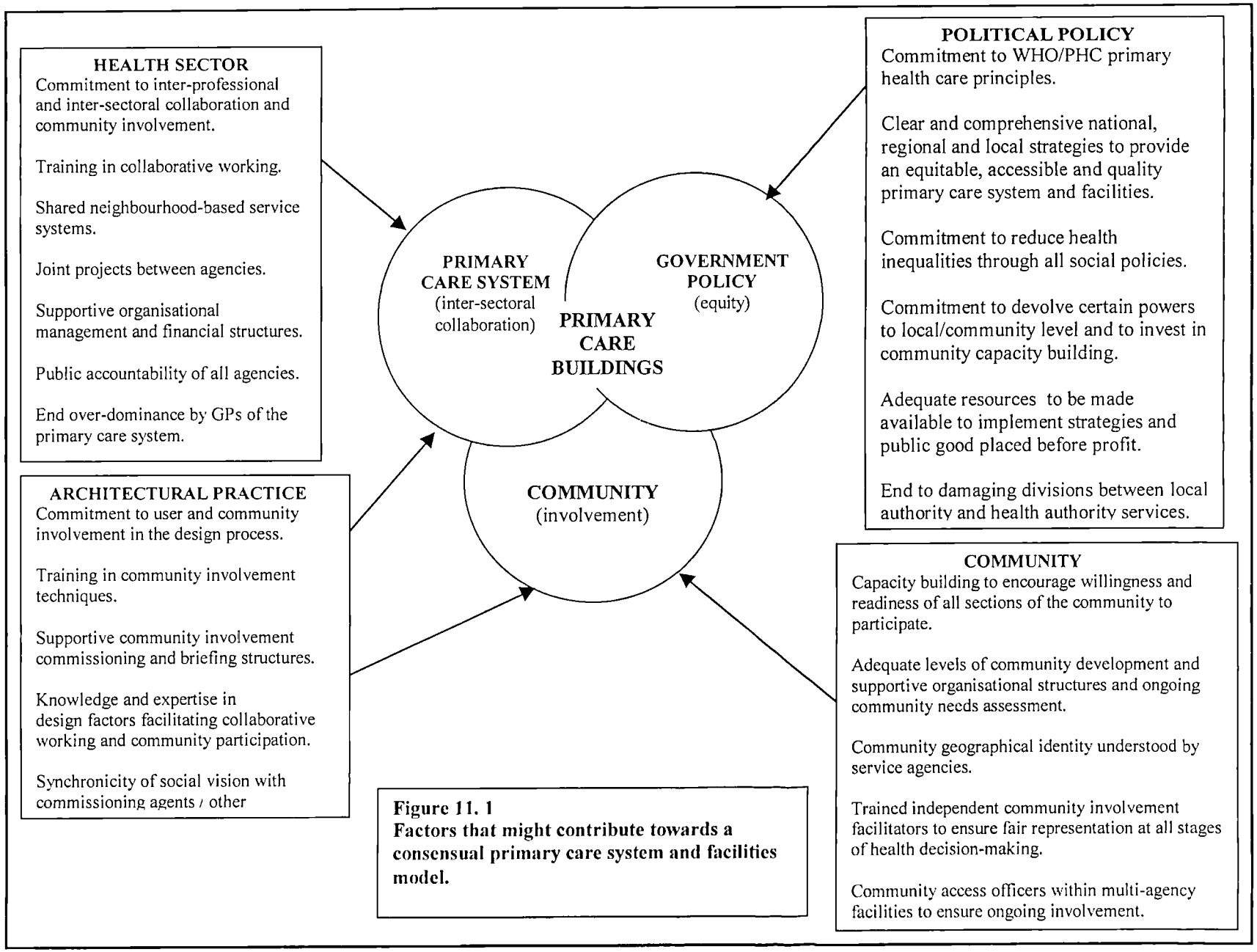



**Figure 11. 1**
**Factors that might contribute towards a consensual primary care system and facilities model.**

There is not space within this dissertation to attempt developing a detailed concept of how a consensual model of a primary care facility might operate. This should by definition be determined with full reference to public consultation and debate. But for the sake of speculation, features from existing medical and social models that appear to be highly valued by the public and might be included are:

- A facility that preserves the potential for personal and individual relationships to develop between the public and GPs and other health professionals.
- The availability of the latest technology for medical treatment and diagnosis.
- Access to a wide range of services that might contribute to better health.
- A spatial organisation system that supports the co-operation of all professionals and agencies operating within the facility in maximising the good health of public users individually and collectively.
- A resource that is flexible enough to enable various self-help and community health-related initiatives to be easily accommodated.
- A facility that provides a meeting place to consider the wider health needs of the community from medical, social and environmental viewpoints.
- A building whose location and visual impact reflects the role which the primary care facility plays in the life and the health of the community.

The case studies included in this investigation demonstrate some, but not all, of these features. The architectural model for multi-agency working needs further development and refinement, and fundamental changes are required within the organisational and managerial structures in primary care to support professional collaboration. Existing primary care buildings obviously cannot be altered overnight to reflect new ideologies, and in switching to a consensual model of primary care most of the initial changes might have to be managerial and organisational rather than physical.

It may not be necessary for all services connected to primary care need to be accommodated in one building, although this could lessen the chances of some people, who had maybe

originally come to a primary care facility for recreational purposes, accessing health information or resources. It may also lessen the chances or speed at which different agencies learn from and adapt to each other's service practices and policies. So proximity has distinct advantages, but there is no reason why a combination of health and recreational facilities should not be linked together on a site, or within a neighbourhood range.[11] What appears vital is that there should be a co-ordinated approach to primary care provision, so that physically or geographically separated facilities are recognisable, to both the public and practitioners, as a network designed to facilitate improvements in the community's health. As long as each new health and social facility is clearly linked into the consensual strategy, they can be designed to meet individual locality requirements of content, context and form, and to complement existing provision.

So what possibility might there be of a consensual primary care model being adopted? On one level there is justification for pessimism. Apart from the formidable difficulties of obtaining a political mandate for the consensual model and developing clear central policies, implementation mechanisms, and a universal network of neighbourhood-based facilities, objections would almost certainly come from GPs, who would undoubtedly lose power. Privately owned practice-based GP facilities would need to be gradually phased out and replaced by publicly owned neighbourhood-based facilities, where GPs would become salaried employees of the NHS, although financial incentives for special services or responsibilities might still be made available. Re-orientating the mind-sets of GPs to comply with a consensual model would obviously be no small undertaking and would require time and retraining.

Government health policies to set up Primary Care Groups, which began to be implemented in April 1999, are set to eventually make primary care facilities the responsibility of Primary Care Group (PCG) trusts.[12] There remain questions over how PCG trusts will commission

[11] An example of this type of facility has already been developed in Bromley-By-Bow in east London.
[12] See DoH (1997) *The New NHS: Modern, Dependable,* London: SO and Chapter 3.5 on Primary Care Groups.

new facilities and the impact this will have on the health of local communities. One possibility is that the forces of economy will put pressure on GPs to become accommodated in larger, multi-agency units. It remains to be seen how enthusiastic GPs will be about integrating medical services with more socially or community orientated services, such as those proposed for Healthy Living Centres.[13] Although PCG trusts may prove to be an appropriate level at which to plan a strategy for a consensual model system, this level of planning will need to be complemented by appropriate national, regional and neighbourhood strategies. These structures have not so far been clarified. Power within the trusts will have to be prevented from being over-dominated by medics, and public representation and accountability will need to be assured.[14]

Although the financial implications of the shift to a consensual model of primary care would have to be calculated, the initial capital costs may be able to be partly offset by the sale of acute sector buildings. In the longer term all primary care property would become publicly owned and, if properly managed and made accountable to local communities, should eventually save public money. If private finance continues to be used to construct health buildings then it will be important to safeguard the long-term interests of the public and to ensure that private finance rules are not be allowed to become barriers to the development of essential new facilities. Perhaps significantly, none of the multi-agency centres in the case studies had been financed through PFI and several commissioning agencies, interviewed during this research, expressed concern that funding multi-agency projects under the current PFI arrangements would be difficult. However, by the end of 1999, the Labour government had shown no sign of nationalising primary care facilities and had only talked of amending PFI conditions.

However, at certain levels signs of progress towards a consensual model can be perceived. Some social commentators have claimed that the election of a Labour government in 1997

---

[13] DoH (1997b) *Healthy Living Centres,* letter from David Walden, D. Health Promotion Division, 30.12.97, DoH. Healthy Living Centres are also discussed in more detail in Chapter 5.
[14] Brindle, D. (1999) 'Up for Grabs', *The Guardian*, Society, pp. 2-3.

heralded a curb on society's descent into blinkered individualism and personal greed. They suggest that there is growing public and government recognition that maintaining good health cannot just be regarded as the responsibility of an individual, but that individuals need the support of living in a healthy local community. In addition to seeking the expansion of medical services at primary care level, the Labour government's first White and Green Papers on health after 1997, alongside the 1998 Acheson report on health inequalities, and reports from the Social Exclusion Unit, have begun to acknowledge and address ways that social, economic and environmental factors can impact on people's health.[15] [16] [17] [18] These papers do encourage greater collaboration between agencies and promote a concept of galvanising and co-ordinating energies of individuals, professionals and communities within local neighbourhoods to improve opportunities for good health. Also, crises in global economies in the late 1990s may have dented confidence in market forces to guarantee social prosperity, which might allow a re-examination of the importance of investing in public welfare systems and public architecture for the long-term benefit of society.

Finally, focusing again on the design stages of the primary care facility commissioning process, architects could support a shift to a consensual model by aspiring to the highest standards of building quality, sustainability and participation in meeting local health needs. Architects' training should ensure that students are aware of the social influences and contributions of buildings and that they understand the potential value and techniques of community involvement. Under a consensual primary care system, the community formally becomes one of the architect's main clients. A legitimate part of the role of the architect therefore becomes to use her/his professional skills and knowledge to extract essential ideas from the community for improving their own health through the new facility provision and to transform their vision into reality through a carefully negotiated and participative process.

---

[15] DoH (1997a) *The New NHS: Modern, Dependable,* London: SO.
[14]DoH (1998) *Our Healthier Nation*, London: SO.
[15] Acheson, D. (1998) Independent Inquiry into Inequalities in Health, London: SO.
[16] DETR (1998) *Breaking Down the Barriers,* Report of the Social Exclusion Unit, London: SO

The implementation of a consensual model of primary care therefore may still be some way off, but I hope this research has demonstrated that many of the key concepts and structures that might support it already exist. A determined political strategy and professional willingness to increase inter-sectoral co-operation and facilitate community participation could make it a reality.

**Appendix 1:1 List of health professionals interviewed and interview frame.**

---

***List of interviewees:***

George Moorcroft, Practice Manager, Kentish Town Health Centre (23.6.94).

Peter Waugh, Director of Services Development, Camden & Islington FHSA (10.11.94).

Catherine Pallister, Strategic Planning Officer, Camden and Islington FHSA (27.1.95).

Geoffrey Ellam, Chief Officer, Bloomsbury CHC (27.1.95).

Ruth Stern, Co-ordinator, Camden Healthy Cities (16.2.95).

Dave Lee, Chief Officer, Islington CHC (2.3.95).

Belinda Pratten, Researcher, Kings Cross Needs Assessment (2.3.95).

Sarah Timms, Services Manager, Camden Community Health Services Trust (17. 3. 95).

Linda Saltwell, Project Worker, Kings Cross Needs Assessment (6.4.95).

Kate Jones, Co-ordinator, Community Action Group (CAG), Camden & Islington Health Authority (16.6.96).

Roselyn Wilkinson, Information Officer, Association of Community Health Councils in England and Wales (ACHCEW), (18.9. 96).

***Interview questions***
(taped face-to-face interviews 1994/1996).

1) What have been the main advantages and disadvantages of the NHS reforms to primary care in Camden and Islington?

a) advantages
b) disadvantages

2) How have the NHS reforms specifically affected the development of primary care buildings?

3) How adequate has funding for the reforms been?

4) In what ways has funding affected the projects you have been involved in?

5) How equitable is the current distribution of facilities throughout the borough?

6) Do you think any communities are being particularly under-resourced?

7) How good are communication and co-operation between service providers?

8) What new developments and inter-sectoral projects are planned for primary care buildings?

9) How far are communities and public users participating in consultation and decision making about the role of primary health services and buildings?

10) Do you know of any examples of good practice in community participation in the health district?

11) What type of community involvement process might be useful in any project you are involved in?

12) What changes would most improve the health of the population?

13) What changes do you see as occurring in the type of primary care facilities available in:

a) 10 years

b) 25 years

**Appendix 1:2 National postal survey sample letter sent to Community Health Councils and Community Health Service trusts.**

---

Address

March 1995

Dear

**COMMUNITY INVOLVEMENT IN PLANNING PRIMARY HEALTH CARE BUILDINGS**

I am writing to request your co-operation in collecting information for a research project, which aims to produce strategic guidance for community and user consultation and participation in planning and designing primary health care facilities.

The Medical Architecture Research Unit (MARU) is currently researching the future development of primary health care buildings. One of its initial findings has been that there is a lack of any acceptable procedure for consultation and participation of communities and users in planning new primary health care facilities. MARU therefore intends to develop and publish, in consultation with CHSt's, CHCs and other agencies, guidelines for community involvement.

The first stage in this research is to identify primary health care building commissions, which have seriously attempted to involve communities and users in the planning process, regardless of whether the results have been successful.

If you can identify a community involvement project for primary health care facilities, which has taken place in the last five years within your area, I would be grateful if you would complete the attached brief questionnaire and return it to me at MARU.

Many thanks for your support.

Yours sincerely

Sue Cavanagh
Research Fellow

Appendix 1:3 National postal survey questionnaire (March 1995).

## MARU SURVEY OF COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE BUILDING PLANNING AND DESIGN.

**Please provide information about any new, or renovated primary health care building in your locality, which has seriously attempted to involve communities and service users in the planning and design process during the last five years.**

**If you cannot identify an appropriate project please tick this box ❑, complete respondent details at the end of the questionnaire and return the form. Please photocopy this form if you can identify more than one project.**

**Name of primary health care building**

.....

**Address**

.....

.....

.....

**Best person to contact for more details about this project:**
**Name and position** .....
**Tel:** .....

**1. Building Type** (please cross box)

GP Premises ❑
Health Centre ❑
Health Clinic ❑
Other please state.....

**2. Who initiated the plan for building or renovating this facility?**

Family Health Service Authority ❑
District Health Authority ❑
Community Health Services Trust ❑
Community Health Council ❑
GPs ❑
Community group ❑

Other please state .....

**3. Which agency has taken the main responsibility for community involvement?**

.....

**4. Which methods of community consultation/participation were used?**

Notification of proposal to CHC/Health Forums ❑
Public meeting/s ❑
Survey of local/ user opinion ❑
Public exhibition of proposed scheme ❑
Involvement in briefing procedure ❑
Involvement on project team ❑

Other please state .....
.....

**5. When did community involvement in the planning/design process take place?**
**1990 ❑ 1991 ❑ 1992 ❑ 1993 ❑ 1994 ❑ 1995 ❑ Ongoing ❑**

**6. What do you think was the main purpose of involving the community in the process?**

.....

**7. How successful was the procedure to involve community groups from the viewpoint of the CHSt/Community Health Council?**

very successful ❑
quite successful ❑
uncertain ❑
not very successful ❑
a failure ❑
too early to tell ❑

**8. Please comment briefly on the merits and achievements of the community involvement process:**

**9. Name and position of respondent** .....
**Address**.....

**Tel:**.....

**Thank you for your support.**

Please return this form to:
**Sue Cavanagh**
**Research Fellow**
**50 Swains Lane**
**London N6 6QR**
**TEL/FAX (manual) 0171 485 1513**

**Appendix 1:4 Summary of analysis of the national postal survey.**

---

## MARU SURVEY OF COMMUNITY INVOLVEMENT IN PRIMARY CARE BUILDING AND DESIGN

### 1. Survey design

A pilot questionnaire was first sent to ten named Chief Executives of Community Health trusts. Three completed pilot questionnaires were returned, and minor adjustments were then made to the final questionnaire. The final questionnaire (Appendix 1:3) was then sent with an accompanying letter (Appendix 1:2) explaining the project to the remaining 87 named Chief Executives of Community Health Services trusts in England. It was also distributed, with an accompanying letter, as part of a regular mailing of the Association of Community Health Councils in England and Wales (ACHCEW) to the Chief Officers of the 202 local Community Health Councils.

In order to distinguish between different types of non-response, the questionnaire was prefaced with a request for respondents to tick a box, and return the questionnaire if they did not think there was an appropriate example of a project involving communities in their area. If a project could be identified, the name and address of the centre was requested as well as the name and phone number of a contact, who could supply further information about the project if the project was selected as a case study.

In addition to buildings identified by the questionnaire, further information was sought about buildings identified through other surveys undertaken at MARU, and from articles in the medical and architectural press that suggested there had been a high level of community involvement. The final selection of case studies was made from all identified projects, according to whether they met a range of pre-selected criteria that allow a range of types of facility and local settings to be included.

### 2. Research questions

The central research questions that the survey addressed were:

1. Which projects during the last five years have attempted to involve communities or users in the planning and design stages of primary health care buildings?
2. What type of buildings was involved?
3 what consultation procedures were used in the planning process?
4. Who has taken the lead for initiating projects?
5. Who has taken responsibility for the consultation process?
6 What was the main objective of the consultation process?
7. How satisfactory has the consultation been from the viewpoint of the different agents and user groups involved?
8. What factors have contributed to the success or failure of the consultation process?

## 3. Response rate

From the total mail-out of 305 questionnaires, 61 (20%) questionnaires or letters were returned

Of the 97 questionnaires sent to the Community Health Service trusts, 22 were returned (22.7%). 15 named projects in their area, and 7 indicated they were unable to identify an appropriate project.

Of the 208 questionnaires sent to the Community Health Councils, 39 were returned (18.7%). 18 identified primary health care buildings that have had community involvement and 21 were unable to identify an appropriate project.

### Conclusion

A total of 33 projects were identified by the respondents as having had a serious attempt to involve users in the planning and design stages. The slightly higher proportional response rate from the CHS trusts may be the result of the more personalised form of approach. However the trusts seemed to be more prepared to respond if they thought they had a positive project (2:1). The CHCs responded more equally whether they had a positive project or not.

## 4. Responses to questions

### Building Location

Out of the total of 33 locations cited, projects involving community participation were mainly identified in larger towns and cities, including 4 in the London Implementation Zone, 2 in Outer London, 3 in Liverpool, and 2 in Manchester.

### Question 1. Building Type

There were 11 different primary health care building types identified by the survey, these were described as follows:

| | |
|---|---|
| 1 | Community Facilities Model |
| 3 | Community Hospitals |
| 4 | GP Premises (3 with additional facilities) |
| 1 | Hamlet (Community Health Clinic, Outpatients Outreach and Community Services). |
| 14 | Health Centres (3 with additional facilities) |
| 1 | Holistic Health Centre |
| 3 | Health Clinics |
| 1 | Intermediate Care Centre |
| 1 | Multi-Agency Centre |
| 3 | Resource Centres |

1 Resource Centre for Elderly People

**Question 2. Who initiated the plan for building or renovating this facility?**

14 projects were initiated by the Community Health Services trusts.
1 project was initiated by the community
1 project was initiated by GPs
2 projects were initiated by the FHSA
2 projects were initiated by the District Health Authority
1 project was initiated by the Regional Health Authority
1 project was initiated by a combination of GPs and community workers
9 were joint initiatives by various combinations of the above organisations
2 were incomplete

**Question 3. Which agency has taken main responsibility for community involvement?**

In the majority of cases the same organisation or combination of organisations which initiated the project took responsibility for involving the community. Three organisations used outside consultants. In the three projects initiated by either the DHA or the RHA, responsibility for community involvement had been taken over. In two cases by the local Community Health Service trust and in one case by the health commission. In one project the CHC said they had been the main agent responsible and in another project the CHC said they had had taken joint responsibility for community involvement.

**Question 4. Which methods of community consultation/participation were used?**

Respondents were asked to tick any of six community consultation techniques that had been used in the project. These techniques had been identified through prior discussions with health agents as being those most commonly employed. A seventh category allowed additional techniques to be identified.

The purpose of this question was to ascertain the extent and range of techniques used to involve communities in the decision-making process. The question was designed to help filter out projects that had only minimal, or token levels of community involvement There are minimum statutory requirements in the planning regulations which require a local community to be informed of new buildings. As I was seeking to identify projects which went beyond mere information giving and were genuinely prepared to listen to and act on recommendations from arising from community consultation, I was particularly interested in schemes which had involved surveys and involvement in briefing procedures and on the project team.
The techniques were coded as follows:

Code 1 Notification of proposal to CHC/ Health Forum
Code 2 Public meetings/s
Code 3 Survey of local/user opinion

Code 4 Public exhibition of proposed scheme
Code 5 Involvement in briefing procedure
Code 6 Involvement on project team
Code 7 Other

Of the 30 schemes which had completed this section
10 schemes had used all 6 of the named techniques.
2 used 5
6 used 4
4 used 3
3 used 2 "
5 used 1 (these were all Code 1 or 2 indicating minimum involvement or incomplete consultation procedures).

6 respondents supplied information about additional techniques that they had used. These were:

Setting up focus groups
Establishing a community health forum to consider services
Consultation with local GPs
Routine contacts with local councillors
Consultation papers
Meetings with specific local groups – examples given were: Residents Associations, Historic Society, League of Friends, Mental Health directorate, and Social Services.

**Question 5: When did community involvement in the planning/design process take place.**

In order to be able to trace people who had been involved in the consultation process and who would remember sufficient detail I had decided to restrict the survey to projects that had been initiated or completed within the five years from 1990 -1995. Of the identified projects

18 projects were ongoing
15 projects were complete

**Question 6: What do you think was the main purpose of involving the community in the process** (30 responses).

Most of the responses from both the CHC's and the CHS trusts cited positive reasons for the consultation process, e.g. to encourage a better facility. A few cynical, critical or ambivalent responses to this question were received from the CHCs, where the respondent believed that the purpose for consultation had been tokenistic, rather than a genuine attempt at community involvement. Some respondents cited more than one purpose for the process.

**Positive purposes**

7 to encourage community ownership and use of the facility.
1 to further democracy
3 to obtain views and preferences of the community in the planning of the facility
3 to get support for the concept and maintain public relations
1 to communicate objectives
2 to resolve potential problems early on
4 to ensure appropriate services were identified and reflected local needs
1 to ensure the service was robust and survived
1 to ensure rationalisation of location for the service was reasonable
1 to match design and location to future demand as defined by public users
4 to ensure the building will meet needs and is user friendly and accessible

1 to benefit the people who work in it

**Less positive or ambivalent responses**

1 damage limitation
1 to appear to do so
1 to tell us what was going to happen
1 to inform local residents and overcome planning objections in a conservation area
1 part of the patient-focused process
1 to gain community funding

**Question 7: How successful was the procedure to involve community groups from the viewpoint of the Community Trust/Community Health Council?**

In this question the variables were coded as follows:

| | | Total Response Rate | CHC | CHST |
|---|---|---|---|---|
| Code 1 | very successful | 9 | 5 | 4 |
| Code 2 | quite successful | 17 | 7 | 10 |
| Code 3 | uncertain | 1 | | 1 |
| Code 4 | not very successful | 1 | 1 | |
| Code 5 | a failure | 1 | 1 | |
| Code 6 | too early to tell | 3 | 3 | |
| | | **32** | **17** | **15** |

This response indicated that the majority of respondents (66%) considered the procedures employed had been either quite successful, or very successful from their viewpoint. However specific reservations and concerns about the process in the final question often tempered their judgement.

In seven cases, where projects were ongoing, final judgements could not be made. And only two thought the consultation had been a total failure. One of these was the only GP initiated project cited and the respondent thought that the intention was not genuine consultation but to tell the community what they were planning to do. The other project

considered a failure that was initiated by the RHA in which the CHC was critical of the short consultation paper and the short time scale allowed for feedback.

**Question 8: Please comment briefly on the merits and achievements of the community involvement process.**

**Summary of perceived gains**

- well-used comfortable accommodation which provides services for people with disabilities
- probable reduction in vandalism through sense of ownership
- reduction in anxiety of local population about the new development. (The
- exercise proved valuable despite fears that objections might endanger the plan).
- early acceptance of the project.
- sense of community ownership.
- smooth progression through planning process
- eagerness by the community to understand the need for change
- a high level of community support for the project and a greater acceptance of services that might otherwise have raised public concern. i.e. psychiatric services.
- ability to improve the design of the facility to local groups satisfaction
- showing up gaps in the consultation strategy that could be rectified in future projects
- improvement in relationships generally between the CHS trusts and the community.
- helping to establish a local identity
- improvement of local access to services
- helping to remove obstacles that disadvantage people in receiving the healthcare they need.
- helping to provide local facilities that reduce the requirement for people to travel long distances for treatment

**Summary of concerns**

- communities were being asked to compromise too much, or not listened to enough
- time scales for consultation were too short
- community representatives may be reluctant to sit on steering groups with 'health professionals'. A "users only" group may need to be established to put forward their views.

## Appendix 1: 5 Response from Sheffield CHC to national postal survey.

***THE UPPERTHORPE COMMUNITY PROJECT -A "PECKHAM STYLE" COMMUNITY PROJECT IN SHEFFIELD***

**Background**

In 1990 four separate departments of the City Council submitted bids for Urban Programme to improve and develop facilities in the Upperthorpe area. The buildings were in poor condition and their usage had been greatly restricted leaving only the Swimming Pool and Library services. The Health Authorities became involved and following a review of community needs the agencies began to consider how best the complex of buildings might be utilised to improve the quality of life and health of local people by developing community facilities.

The "Upperthorpe Project" was placed within the 1992 City Challenge bid. At this point there was clear recognition of the opportunities presented by the Peckham model and Trustees of Pioneer Health Centres were invited to meet members of the group and advise on progress with the Project. Financial support was sought from partner organisations including Sheffield Health Authority, the Sports Council and Sheffield College.

The City Challenge bid was unsuccessful but the Project Group continued to meet, maintaining a shared vision of a community resource which would promote health and well-being for all members of the local community and increase opportunities for education, recreation and leisure.

**Recent achievements**

In 1993 the Project became more formally linked with the North West Inner City Action Plan (NWICAP), a significant housing refurbishment programme affecting approximately 60% of the public sector housing in the area.

Non-recurrent funding was made available to repair some of the buildings and refurbish the Laundry building to provide a Day Centre for services managed by the Family & Community Services department of the local authority. Monies have also been allocated towards the cost of installing a lift to access the upper floors of the linked buildings.

At the same time, the NWICAP area was put forward as the City's priority area for Single Regeneration budget and this [successful] bid includes further development of the Upperthorpe Project. The Project Group have used this process to review progress and activity to date and clarify our **aims and objectives** as follows.

***What is the Uppertharpe Project?***

A centre for well-being, an holistic project for health, education and recreation.
The project has core activities.

- library and information service

- swimming pool
- advice service
- day centre

plus space for extending service to provide:
- primary health care outreach/health promoting activity
- one-stop informational support service
- social space including a cafe
- leisure activities
- education and training

**Next steps**

A smaller, task-oriented Project Management Group has now been formed to take forward the action plan for the project and develop a business plan.

In additional to our success in obtaining SRB money the Project has been included in the URBAN (Eurofunding) bid.

These financial resources will enable further refurbishment of the buildings and we will be appointing a full-time Project Co-ordinator to support the Management Group and seek further partnership funding.

We plan to develop closer links with members of the local community, building on consultation meetings held earlier in the year.

**Opportunities for developing primary health care services within the Upperthorpe Project**

The appointment of the Health Authorities' locality Health Development Worker in the area has provided an opportunity to look more closely at the health needs of the local community and the services currently provided. This has led to health partners working together to clarify their understanding of the role of community development in the provision of health services and the implications for contracting.

At the present time, the local community are served by a number of general practitioners outside the area and the health authority are seeking to support the development of a new health centre in close proximity to the Upperthorpe Project.

It is envisaged that the facilities available within the Project will provide opportunities for primary health care workers to work more flexibly with groups and individuals within the community setting, promoting positive health and wellbeing across all ages and sections of the community.

Ref: JS/UPPBR2 DOC – 07/12/94

## Appendix 1.6 Interview frame for architects

Architect Practice Survey: Design Philosophies for Primary Care Buildings

Architectural Practice:

Address:
Phone: Fax:

Respondent:

Date:

### DESIGN QUALITY FACTORS

1. Do you think that primary care buildings require a different design approach to other types of small public buildings?

2. Do you think that there is a set of design principles that need to be taken into account in order to create a good primary care building, if so what are these factors?

3. Does your practice have an explicit design philosophy for primary care buildings, if so, which principles is this based on?

4. How do you think a primary care building should relate to its surroundings, i.e., its street presence and how would you translate this concept through design features?

5. How does your practice approach the issue of aesthetics in health buildings? In what ways is this made manifest, i.e., through common features, materials, architectural detail, entrance style?

6. What techniques do you use to address issues of current and future flexibility?

7. What zoning system do you adopt for interior layouts and what purpose does this serve?

8. Apart from the regulatory requirements for space allocation, is there any additional space you would wish to allocate for a particular purpose?

9. What design features might you use to increase staff and public security?

10. Which design features might you adopt to improve patient privacy and confidentiality?

11. What provision do you think is important to encourage and facilitate public access and comfort?

12. How do you address issues of sustainability and ecology in the design of primary care buildings and how would this impact on users experience?

13. How, and in what forms, would you regard community involvement as useful and important in the planning and design process?

14. Are there any other factors that you think could underlie successful primary care building?

---

**BARRIERS TO SUCCESS**

15. In your experience which non-architectural factors have hindered the successful development of a primary care building?

16. Have you experienced any of the following:

a) conflicts of interest/culture by the buildings users
b) problems with levels of funding
c) problems with sources of funding
d) problems with planning regulations
e) difficulties with building contracts
f) problems with project management
g) problems with design consultants' fees
h) problems with facilities management
i) community/user involvement in the commissioning and briefing process
j) changes in social demography that have affected buildings use
k) other problems?

17. Could you identify the main effects of the NHS reforms on the architecture of primary care buildings?

18. How do you predict the architecture of primary care buildings might develop in the future?

## Appendix 1:7 Case study: data collection method

### 1. Data collection for the main unit of analysis: the primary care facility.

*Descriptive information sought:*
- Projects' size
- Cost
- Ownership/tenure
- Building consultants
- Building management
- Building time-scale
- Location and catchment area
- Project's philosophy and objectives

*Explanatory information sought:*
1) Who initiated the project and why? (Health policy/ideology)
2) Who has taken responsibility for commissioning and developing the project?
3) Who has taken responsibility for conducting the user involvement process?

*Evaluative information sought:*
How successfully does the centre meet the requirements of building users, including those of staff, patients and local communities and what role has user involvement in the planning and design process played in the development of the facility?

*Data Collection method:*
Face-to-face focused interviews with key informants, documentation analysis, direct observation and survey questionnaire. Summary of data collected from evaluation surveys used in sub-units of analysis (see below).

### 2. Data collection for sub-unit of analysis 1: building quality

*Descriptive information sought:*
- Siting
- Street presence approach and entrance
- Building materials and finishes, internal and external
- Space allocation for all main service functions
- Numbers of professional staff and other staff employed on site
- Agencies accommodated on site.
- Flexibility and economy of space
- Staff and public safety and security systems.
- Public accessibility
- Public facilities and comfort
- Community resources.
- Sustainability and ecology

*Explanatory information sought:*

1) How does the design facilitate i) inter-professional working, ii) inter-agency working?
2) How does the design accommodate the needs of public users in terms of access, comfort, and privacy?
3) What type of interface does the facility provide with the local community?

*Evaluative information sought:*
1) How successful is the building design and quality from the viewpoint of a staff user, public user and commissioning agent.
2) How well does the design facilitate inter-agency collaboration and create an active interface with the local community.

*Data collection method:*
Documentation analysis included the study of architectural plans, diagrams, schedules of accommodation, project archives, previous studies, building evaluation surveys, drawings, photographs. Other methods included direct observation, photographic surveys and focused interviews with key informants using the 'building quality evaluation survey' (Appendix 1:9).

### 3. Data collection for sub unit of analysis 2: the community involvement process

There is now an extensive literature on the subject of community involvement and consultation techniques in health policy decision making which explore ways of involving public users and suggest factors that might contribute towards genuine community involvement, but much less on methods of involvement specifically on health facility planning and design. At the time of commencing the fieldwork for this investigation, the Department of the Environment (1992) had commissioned the most recent and thorough study into the approaches, effectiveness and principles for involving communities in planning and development projects. [1] Although this research was undertaken using case studies from urban regeneration projects it seemed appropriate for adaptation to an evaluation of community involvement in primary care facility planning and design. This methodological structure, together with feedback from the MARU national postal survey (1995) and interviews with health professionals described above, formed the framework for the evaluation of the community involvement process in the interviews with the key respondents.

The final set of variables selected to indicate effective management of the community involvement process were:

- Having clear objectives for the community involvement process in terms of the level of power that the community would have in the decision-making process.

[1] DoE (1994) *Community Involvement in Planning and Development Processes,* Planning Research Programme, London: HMSO. This study was carried out by BDOR Ltd, Bristol, Newcastle Architecture Workshop and The Planning Co-operative, Birmingham under the auspices of a steering group that included representatives from the Royal Town Planning Institute and the Royal Institute of British Architects.

- Adequate time and resources allocated to the community involvement process.
- Someone with clear responsibility for project
- Commitment from the commissioning agencies to the community involvement process
- Commitment from the community to be involved in the process
- The achievement of consensus about the facility by agencies and user groups.

Physical and attitudinal indicators of process achievements were also sought and these were selected as:

- Improved access in terms of physical access, clear information about services, level access, disabled parking, easy level changes and patient comfort.
- Additional community facilities arising from the user involvement process.
- A sense of community ownership that can increase use of the facility and deter vandalism.
- The attainment of involvement process objectives.

These variables were translated into questions for the purpose of evaluation and the resulting semi-structured survey was used with key respondents in face to face interviews (see Appendix 1:10). The respondents were also asked to give a factor rating on the same five point attitudinal scale used in the building quality survey evaluation and the results of these are given in the case study appendices.

*Descriptive information sought:*
- Who was responsible for the process?
- Which users were involved?
- What methods of consultation/participation were used?
- Chronology of community involvement
- Why was community involvement included in the project development?
- How were public users involved in the process?
- How were the staff users of the building involved in the process?

*Evaluative information sought:*
- To what extent was the community involved in the process?
- How well did the process work from the viewpoint of the staff user, health authority and public user?

*Data collection method:*
Data collection methods included: documentation analysis; attendance at a user group meeting; focus interviews with key respondents using the community involvement process evaluation survey (Appendix 1:10).

## Appendix 1:8 Case study: background information questionnaire

**PRIMARY HEALTH CARE CENTRE BUILDINGS**
**PROJECT BACKGROUND DETAILS**

**Main Respondent's Name:**

**Position:**

**Address:**

**Phone:**
**Fax:**

**Date of consultation:**

---

**PROJECT**

**1.** Building name:

**2.** Address:

**3.** Client:

**Contacts**

**4.** Health District:

Health Authority contact:

**5.** User contact:

Address

Tel:

CHC:

CHC contact:
Tel:
Fax:

**6.** Staff user contact:

**7.** Architect

Name:

Address:

Tel:
Fax:

| | | |
|---|---|---|
| Schedule of accommodation | YES ❑ | NO ❑ |
| Plans available | YES ❑ | NO ❑ |
| Photographs | YES ❑ | NO ❑ |

Other buillding consultants:

Main contractor:

Type of contract:

Was local labour been used in building YES ❑ NO ❑

**BUILDING DETAILS**

**8.** Health building type:

**9.** Building start date:
Completion date:

**10.** Cost of building/floor area:
Funding/capital:
Funding reimbursement:

**11.** **Tenure**
Building owned by:
Practice tenure:

**Site/location**

**12.** Site/ location:

Inner /urban / suburban/rural :

**13.** Building aesthetic:
**14.** Building size $m^2$ :
Storeys:

**15.** Additional land:.

**16. Community profile**

Catchment area/size:

Ethnic profile:

Income: low ❑ middle ❑ mix ❑

Local Authority:

Coterminous boundaries:

**17. Reason for Project /Philosophy of Care**

**SERVICES DETAILS**

**18. Staff**
Number of GPs

PHCT YES ❑ NO ❑

Total number of medical staff
admin & other

**19. Main medical services**

**20. Community services**

**COMMUNITY INVOLVEMENT PROCESS**

**21. At which stages of the planning and design process has there been community involvement?**

**Planning:**

| | |
|---|---|
| Needs assessment | ❑ |
| Project inception | ❑ |
| Feasability | ❑ |
| Service planning | ❑ |
| Site procurement | ❑ |

**Design**:

| | |
|---|---|
| Briefiing architect | ❑ |
| Selection of architect | ❑ |
| Sketch design development | ❑ |
| Selection of contractors | ❑ |
| Project team | ❑ |
| Selection of finishes | ❑ |

Other community involvement please state:

**Cost of community involvement if known:**

**Chronology of community involvement:**

| Date | Type of involvement |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**22. Which users have been involved in the consultation?**

CHC ❑
Special needs groups ❑
Medical staff ❑
Other staff ❑
Local residents ❑
Local groups ❑
Individuals ❑
patients of existing practices/ health centres in the area ❑

Other please state:

**23. What consultation methods have been used**

**DETAILS**

Rapid Appraisal ❑
Local group meetings ❑
Community planning weekends ❑
Public survey ❑
Public meetings ❑
Patient survey ❑
Public exhibition ❑
Vox pops ❑
Research ❑
User working group ❑

**Other please state**:

**24. Has there been any attempt to evaluate the success of the building?**

YES ❑ NO ❑

Methods used:

Results if known:

**25. Has there been any attempt to measure user satisfaction with the building?**

YES ❑ NO ❑

Methods used:

Results if known:

**26. Further contacts**

**BARRIERS TO SUCCESS**

**Have any of the following factors adversely affected the buildings success?**

1. **Project management**

   YES - NO -

   Comment

2. **Conflicts of interest/culture by the buildings users**

   YES - NO -

   Comment

3. **Levels of funding**

   Comment

   YES - NO -

4. **Sources of funding**

   YES - NO -

   Comment

5. **Planning regulations**

   YES - NO -

   Comment

6. **Building contracts - the effects of design and build**

   YES - NO -

   Comment

7. **Are there any other factors that have been a barrier to the building's success?**

## Appendix 1:9 Case study: building quality questionnaire.

**PRIMARY HEALTH CARE BUILDINGS**
**BUILDING QUALITY EVALUATION SURVEY**

**Respondent's Name** .....

**Position**.....

**Address**.....

.....

**Phone:**
**Fax:**

**Date of consultation:**

**Case study**.....

BUILDING DESIGN QUALITY

1 **How satisfied are you with the building's siting /location?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

2. **How satisfied are you with the building's street presence approach and entrance?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

3. **How satisfied are you with the quality of the building materials and finishes?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①
Don't know - Comment

4. **How satisfied are you with the design of the reception/waiting areas?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**5. How satisfied are you with the allocation of space for service functions and the flexibility and economy of spaces?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**6. Does the building layout facilitate inter-professional working?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**7. Does the design of the building facilitate inter-agency working?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**8. Does the design of the building allow for separation of agencies where appropriate?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**9. Does the building provide sufficient public and staff security?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**10. Does the building enable sufficient public and staff confidentiality?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**11. How do you rate the buildings accessibility?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**12. How do you rate public facilities/ refreshments/toilets/baby change/comfort in the building?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**13. Does the building enable independent community activity?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**13. Does the building design consider eclological and sustainable issues?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**15. How do you rate the building's quality overall?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

Don't know - Comment

**16. What specific improvements would you like to make to the building?**

**Appendix 1:10 Case study: community involvement process questionnaire.**

---

**PRIMARY HEALTH CARE BUILDINGS**
**COMMUNITY INVOLVEMENT PROCESS EVALUATION SURVEY**

---

**Respondent's Name**.....

**Position**.....

**Address**.....

.....

**Phone:**
**Fax:**

**Date of consultation:**

**Case Study**.....

---

**THE COMMUNITY INVOLVEMENT MANAGEMENT PROCESS**

**Role in process**

What has been the nature of your involvement in the consultation process?

**Time of involvement**

Which **period** (months and years) were you involved in the community consultation process?

**1. Did the consultation process have clear objectives?**

**Yes** ⑤ **No** **0**

**What were these:**

**2. Time Allowed**

Was sufficient **time** allowed to enable an effective community consultation process to take place?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

3. **Who was responsible for the management of the community/ public/user consultation process?**

.....

**Has this management been undertaken successfully?**

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

4. **Health Authorities' Commitment**
How do you rate the Health Authority or commissioning agent's commitment to community involvement, and how have they shown/or not shown commitment?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

5. **Community Commitment**
How high do you rate community commitment to the consultation process and how have they shown/not shown commitment?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

6. **Consensus Achieved**
How much consensus has been achieved between agents involved in the involvement process?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**ACHIEVEMENTS OF THE COMMUNITY INVOLVEMENT PROCESS**

**7. Improved Access**

Has the process resulted in a building which is more accessible or convenient to the public?

In what ways was accessibility improved

- better information
- level access
- disabled parking
- easy level changes

other please state:

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**8. Additional Community Facilities**

Has the consultation process resulted in any community facilities or other services which would not have been provided otherwise?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**9. Community Ownership**

Has the process resulted in a greater sense of community ownership in the facility than there would have been otherwise?

If yes, is there any evidence for this?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**10. Achieve objectives**

How well has the process met its objectives?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**11. Good Process**
Overall how worthwhile do you consider the community involvement process has been?

**RATING** V.High ⑤ High ④ In Between ③ Poor ② V. Poor ①

**Comment:**

**12. Greatest achievement of process?**
What do you consider has been the greatest achievement of the community Involvement process?

.....

**14. Greatest disappointment of process?**
What do you consider has been the greatest disappointment of the Community involvement process?

.....

**15. Additional information**

## Appendix 1:11 Case study: order of survey questions used in the analysis

**Building Design Quality Evaluation**

**1.0 Design facilitation of inter-sectoral collaboration**

*Space allocation, integration and separation*

1.1 How satisfied are you with the allocation of space for service functions and the flexibility and economy of spaces?
1.2 Does the building layout facilitate inter-professional working?
1.3 Does the design of the building facilitate inter-agency working?
1.4. Does the design of the building allow for separation of agencies where appropriate?

**2.0 Design facilitation of community participation**

*Siting, approach, entrance, reception and ambience*

2.1 How satisfied are you with the building's siting /location?
2.2 How satisfied are you with the building's street presence approach and entrance?
2.3 How satisfied are you with the design of the reception/waiting areas?
2.4 How satisfied are you with the building's ambience and quality of materials and finishes?

*Security and confidentiality*

2.5 Does the building provide sufficient public and staff security?
2.6 Does the building enable sufficient public and staff confidentiality?

*Accessibility, public facilities and comfort*

2.7 How do you rate the building's accessibility?
2.8 How do you rate public facilities/refreshments/toilets/baby change/comfort in the building?

*Independent community use*

2.9 Does the building design allow independent community activity?

*Sustainability and ecology*

2.10 Does the building design consider ecological and sustainable issues?

**Community Involvement Process Evaluation**

## 3.0 Effectiveness of the community involvement process management

*Clear objectives*

3.1 Did the community involvement process have clear objectives?

*Time allowed*

3.2 Was sufficient time allowed to enable an effective community involvement process to take place?

*Successful management and commitment to the community consultation process*

3.3 Who was responsible for the management of the community/public user involvement process?

3.4 Has this management been undertaken successfully?

3.4.1 How do you rate the commissioning authority's commitment to the community involvement process and how have they shown/not shown commitment?

3.6 How do you rate community commitment to the process and how have they shown/not shown commitment?

*Consensus reached*

3.7 How much consensus was reached between agents who participated in the involvement process?

## 4.0 Achievements of the community involvement process

*Improved access*

4.1 Has the process resulted in a building that is more accessible, or convenient to the public?

4.2 Has the user involvement process resulted in community facilities or other services, which would not have been provided otherwise?

*Additional community activities and community ownership*

4.3 Has the process resulted in a greater sense of community ownership than there would have been otherwise?

*Process objectives met*

4.4 How well has the community involvement process met its objectives?

## Appendix 10: 1.1 Purfleet case study respondents.

The interviews and site visit for this case study took place over four days in November/ December 1997 and February and December 1998.

**Main project contact:**

Marylyn Stephens, Purfleet Centre Care Co-ordinator, employed by Thameside Community Services Trust.

**Key respondents:**

**Public User (PU)**

Ted Welsh, Community Worker, employed by Thurrock Family Service Unit located on the local Garrison housing estate.

This respondent was a local community worker based at the Thurrock Family Services Unit on the nearby Garrison Estate. He had worked in the area for eleven years and had been involved in the consultation process to plan of the Centre. He was not a personal user of the Centre, but had attended the Centre as a community worker for meetings and had knowledge of local opinion and perceptions of the Centre.

**Staff User (SU)**

Michelle Smith, Community Access Officer (SU), employed by the GP Practice. This respondent was one of the two Community Access Officers (CAOs). This respondent had not been involved in the early stages of the community consultation process, as she had joined the staff a month before the Centre opened. Her appreciation of the process had come from witnessing the results of the community consultation process in the way that the community used the Centre. The CAOs were also involved with the ongoing process of community consultation because her post had been specifically designed to maintain links with the local community and to help keep services linked to their needs. The GPs employed the CAOs.

**Commissioning Authority Representatives (CAs)**

Richard Drinkall, former Director of Service Development at South Essex FHSA. Current Chief Co-ordinator for South Essex Health Authority (CA)

Jack Hawthorne, former Area Manager for the FHSA with responsibilities to develop primary care in the South West Essex area from 1990, at time of interview. Locality Manager for South Essex Health Authority.

Two commissioning authority representatives were interviewed for this project. The first was the former Director of Service development at South Essex FHSA and currently Chief Co-ordinator Health Authority (CA). This respondent had overseen the final stages of construction and the opening months. He had not been involved in the community consultation processes to develop the brief and there had not been a community consultation process active during the planning and design process that he could recall. The second commissioning authority representative was the former Area Manager for the South East Essex FHSA who had had the role of developing primary care in Thurrock from 1990 to1996. This respondent had played a key part in initiating the Purfleet project and had been responsible for setting up some of the original meetings with key stakeholders, including local community representatives, and in developing the brief for the final project.

**Other informants:**

Colin Townsend, Purfleet Care Centre Manager.

## Appendix 10: 1.2 Purfleet building quality evaluation

| **Building Design Quality Evaluation** |
|---|
| **CASE STUDY:** Purfleet Care Centre |
| **DATE:** 21.11.97. |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Facilitation of inter-sectoral collaboration** | Staff User | Pub/ User | Commissioning Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Space allocation flexibility /economy | 5 | 2 | 4 | 15 | 11 |
| 2. Facilitate inter-professional working | 4 | 2 | 4 | 15 | 10 |
| 3. Facilitate inter-agency working | 4 | 2 | 4 | 15 | 10 |
| 4. Separation of agencies | 4 | 4 | 4 | 15 | 12 |
| **Facilitiation of community participation** | | | | | |
| 5. Appropriate siting | 3 | 4 | 4 | 15 | 11 |
| 6. Street presence | 4 | 3 | 4 | 15 | 11 |
| 7. Ambience/materials and finishes | 5 | 4 | 5 | 15 | 14 |
| 8. Reception and waiting | 4 | 2 | 5 | 15 | 11 |
| 9. Staff /public security | 4 | 4 | 4 | 15 | 12 |
| 10. Staff/public confidentiality | 3 | 2 | 4 | 15 | 9 |
| 11. Accessibility | 5 | 2 | 4 | 15 | 11 |
| 12. Public facilities/comfort | 3 | 2 | 4 | 15 | 9 |
| 13 Independent community activity | 4 | 1 | 4 | 15 | 9 |
| 14. Ecology and sustainability | 3 | d.k | 4 | 15 | 7 |
| 15. Overall quality | 4 | 3 | 4 | 15 | 11 |

## Appendix 10:1.3 Purfleet community involvement process evaluation

| **Community Involvement Process Evaluation** |
|---|
| **CASE STUDY:** Purfleet Care Centre |
| **DATE:** 21.11.97 |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Effectiveness of process management** | Staff User | Pub/ User | Commissioning Authority | Total Possible | Total obtained |
|---|---|---|---|---|---|
| 1. Clear objectives | 4 | 2 | 2 | 15 | 8 |
| 2.Time allowed | d.k. | 3 | 4 | 10 | 7 |
| 3.Process management | 4 | 4 | 4 | 15 | 12 |
| 4.CA commitment | 4 | 2 | 4 | 15 | 10 |
| 5. Community commitment | 4 | 3 | 3 | 15 | 10 |
| 6. Consensus reached | 4 | 4 | 4 | 15 | 12 |
| **Achievements of process** | | | | | |
| 7. Improved access | 5 | 4 | 4 | 15 | 13 |
| 8. Add community resources | 5 | 2 | 3 | 15 | 10 |
| 9.Community ownership | 4 | 2 | 4 | 15 | 10 |
| 10. Achieve objectives | 4 | 3 | 4 | 15 | 11 |
| 11. Overall good process | 5 | 4 | 4 | 15 | 13 |

**Appendix 10: 2.1 St. Matthews case study respondents.**

---

The interviews and survey for this case study took place over two days in September / November 1997.

**Main project contact:**

Dr Angela Lennox, Senior Partner, St Matthews Medical Centre and Director of Community Health Care Studies. Involved in the planning and setting up of the Centre.

**Key respondents:**

**Staff User (SU)**

Dr Angela Lennox, Senior Partner in the GP Practice at St Matthews Medical Centre.

**Public User (PU)**

Susan Earls, local resident and care worker, who uses the Centre regularly, both personally and in the role of a volunteer carer, accompanying frail older people on the Estate to use services at the Centre.

**Commissioning Authority Representative (CA)**

Roger Bettles, former Chief Executive Fosse Health (NHS) Trust. Fosse Health provided funding for this project and was an active partner in its initiation.

**Other informants:**

Arthur Warrington, former Project Manager, Fosse Health (NHS) Trust (Estates Department).

Vivien Blackburn, GP Practice Secretary.

Tony Rogers, Project Architect for Bundey and Rogers, Architects.

## Appendix 10: 2.2 St Matthews building quality evaluation

| **Building Quality Evaluation** |
|---|
| **CASE STUDY:** St Matthews Community Health and Social Care Centre |
| **DATE:** 27.6.97. |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Facilitation of inter-sectoral collaboration** | Staff User | Pub/ User | Commissioning Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Space allocation flexibility /economy | 5 | 5 | 5 | 15 | 15 |
| 2. Facilitate inter-professional working | 5 | d.k. | 4 | 10 | 9 |
| 3. Facilitate inter-agency working | 5 | d.k. | 5 | 10 | 10 |
| 4. Separation of agencies | 5 | d.k. | 5 | 10 | 10 |
| **Facilitiation of community participation** | | | | | |
| 5. Appropriate siting | 5 | 5 | 5 | 15 | 15 |
| 6. Street presence | 4 | 5 | 4 | 15 | 13 |
| 7. Ambience/materials and finishes | 5 | 4 | 5 | 15 | 14 |
| 8. Reception and waiting | 5 | 4 | 5 | 15 | 14 |
| 9. Staff /public security | 4 | 5 | 5 | 15 | 14 |
| 10. Staff/public confidentiality | 4 | 5 | 5 | 15 | 14 |
| 11. Accessibility | 2 | 5 | 3 | 15 | 10 |
| 12. Public facilities/comfort | 4 | 5 | 4 | 15 | 13 |
| 13 Independent community activity | 5 | 5 | 4 | 15 | 14 |
| 14. Ecology and sustainability | 3 | d.k | 2 | 15 | 5 |
| 15. Overall quality | 5 | 5 | 4 | 15 | 14 |

## Appendix 10: 2.3 St Matthews community involvement process evaluation.

| **Community Involvement Process Evaluation** |
|---|
| **CASE STUDY:** St Matthews Community Health and Social Care Centre |
| **DATE:** 27.6.97 |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Effectiveness of process management** | Staff User | Pub/ User | Health Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Clear objectives | 4 | 4 | 4 | 15 | 12 |
| 2.Time allowed | 1 | 5 | 4 | 15 | 10 |
| 3.Process management | 5 | 5 | 4 | 15 | 14 |
| 4.CA commitment | 5 | 4 | 4 | 15 | 13 |
| 5. Community commitment | 5 | 4 | 4 | 15 | 13 |
| 6. Consensus reached | 4 | 4 | 4 | 15 | 12 |
| **Achievements of process** | | | | | |
| 7. Improved Access | 5 | 4 | 4 | 15 | 13 |
| 8. Additional community resources | 5 | 5 | 4 | 15 | 14 |
| 9.Community ownership | 4 | 3 | 4 | 15 | 11 |
| 10. Achieve objectives | 4 | 4 | 5 | 15 | 13 |
| 11. Overall good process | 5 | 4 | 5 | 15 | 14 |

## Appendix 10:3.1 Kath Locke case study respondents.

The interviews and site visit for this case study took place over two days 24/25th July 1997.

**Main project contact:**

Dawn Rivers, Centre Manager for Kath Locke CHRC, employed since the building opened in November 1996 and responsible for co-ordinating activities at the centre. Fay Selvan and Ian Mello-Baron (see below) also supplied background information on developments prior to 1996.

**Key respondents**

**Staff User (SU)** (Building survey only)

Dawn Rivers, Kath Locke CHRC Manager (see above).

**Staff User (SU)** (Community Involvement Process survey only)

Fay Selvan, Director of Community Health and Resource Centre Ltd (Managing Agents for Kath Locke CHRC). As Director of the Zion Centre, Fay Selvan had led the community involvement process from September 1995 / November 1996. She had been especially responsible for consulting with the voluntary sector services that were to be accommodated in the new centre. She had an office at Kath Locke and was therefore also a staff user of the building.

**Public User (PU)**

Mary Murphy, a local resident, a Councillor for Hulme, and a Centre user. Mary Murphy was involved in the consultation process since 1993 (inception of the PHCRC proposal) first as an objector to the planned PHCRC and then as an active participant in the 1995 ZCHRC bid. Mary Murphy had originally been a social worker who had often referred clients to the Zion Centre for women's aid and drug referral. She had been an active user member of the community during the consultation period and had helped

She had been a member of the Zion Management Committee for three years.

**Commissioning Authority Representative (CA)**

Ian Mello-Baron had been Chair of the Afro-Caribbean Mental Health Project, which had operated at the Zion Centre, before being appointed by Manchester Health Authority as Locality Manager for the Hulme/Moss Side area in 1993. As well as having played an active role in developing the community involvement process, he had an office in the Kath Locke Centre and therefore had experience as a staff user of the building.

**Other informants:**

Dave Ward, Consultant Architect, Triangle Architects Ltd.

## Appendix 10:3.2 Kath Locke building quality evaluation.

| **Building Design Quality Evaluation** |
|---|
| **CASE STUDY:** Kath Locke Community Health and Resource Centre |
| **DATE:** 27.7.97. |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Facilitation of inter-sectoral collaboration** | Staff User | Pub/ User | Commissioning Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Space allocation flexibility /economy | 3 | 4 | 3 | 15 | 10 |
| 2. Facilitate inter-professional working | 4 | d.k. | 4 | 10 | 8 |
| 3. Facilitate inter-agency working | 4 | d.k. | 2 | 10 | 6 |
| 4. Separation of agencies | 4 | d.k. | 2 | 10 | 6 |
| **Facilitiation of community participation** | | | | | |
| 5. Appropriate siting | 5 | 4 | 4 | 15 | 13 |
| 6. Street presence | 4 | 4 | 2 | 15 | 10 |
| 7. Ambience/materials and finishes | 4 | 4 | 2 | 15 | 10 |
| 8. Reception and waiting | 4 | 4 | 4 | 15 | 12 |
| 9. Staff /public security | 4 | 4 | 4 | 15 | 12 |
| 10. Staff/public confidentiality | 4 | 4 | 2 | 15 | 10 |
| 11. Accessibility | 4 | 4 | 3 | 15 | 10 |
| 12. Public facilities/comfort | 4 | 3 | 4 | 15 | 10 |
| 13 Independent community activity | 4 | 5 | 4 | 15 | 13 |
| 14. Ecology and sustainability | 3 | d.k | d.k | 15 | 3 |
| 15. Overall quality | 3 | 4 | 3 | 15 | 8 |

## Appendix 10: 3.3 Kath Locke community involvement process evalauation

| **Community Involvement Process Evaluation** |
|---|
| **CASE STUDY:** Kath Locke Community Health and Resource Centre |
| **DATE:** 27.7.97 |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Effectiveness of process management** | Staff User | Pub/ User | Commissioning Authority | Total Possible | Total obtained |
|---|---|---|---|---|---|
| 1. Clear objectives | 4 | 4 | 2 | 15 | 10 |
| 2.Time allowed | 2 | 4 | 3 | 15 | 9 |
| 3.Process management | 3 | 5 | 3 | 15 | 11 |
| 4.CA commitment | 3 | 3 | 5 | 15 | 14 |
| 5. Community commitment | 4 | 5 | 5 | 15 | 14 |
| 6. Consensus reached | 4 | 4 | 3 | 15 | 11 |
| **Achievements of process** | | | | | |
| 7. Improved access | 5 | 5 | 5 | 15 | 15 |
| 8. Add community resources | 4 | 5 | 5 | 15 | 14 |
| 9.Community ownership | 4 | 5 | 5 | 15 | 14 |
| 10. Achieve objectives | 4 | 5 | 4 | 15 | 13 |
| 11. Overall good process | 5 | 5 | 5 | 15 | 15 |

## Appendix 10:4.1 Neptune case study respondents.

The interviews and site visit for this case study took place in December 1997.

**Main project contact**:

Dawn Wickham, Project Manager of Neptune Health Park since July 1996, employed by Sandwell Healthcare NHS Trust.

**Key respondents**:

**Staff User (SU)**

Malcolm Bailey, Project Manager, Murray Hall Community Trust. This respondent was the Project Manager of the Murray Hall Community Trust, a voluntary organisation that will be based in Neptune. He had been involved in the project since its inception and had also acted as an advocate for community involvement in the project's development. He regularly attended Neptune Staff User Group meetings.

**Public User (PU)**

Richard Marsden, local resident and user of Blackstock Practice. This respondent was a local resident and user of the Blackstock Practice and was Chair of Murray Hall Community Trust. He regularly attended Neptune User Group meetings

**Commissioning Authority Representative (CA):**

Neil Lockwood, Chief Executive Sandwell Health Authority. Since 1992, he had been mainly involved in helping to develop the concept of Neptune, rather than having more practical involvement. He had been consulted over the building design, but had not played an active role in the community involvement process, although he had supported it in principle.

**Other informants:**

Joan Lovell: Local resident and user of Blackstock Practice.

Paul Perkins: Local resident and user of Blackstock Practice.

Richard Gooden: Project Architect, Penoyre and Prasad.

## Appendix 10:4.2 Neptune building quality evaluation.

| **Building Design Quality Evaluation** |
|---|
| **CASE STUDY:** Neptune Health Park |
| **DATE:** 3.12.97 |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Facilitation of inter-sectoral collaboration** | Staff User | Pub/ User | Commissioning Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Space allocation flexibility /economy | 4 | d.k. | 4 | 10 | 8 |
| 2. Facilitate inter-professional working | 4 | 5 | 5 | 15 | 14 |
| 3. Facilitate inter-agency working | 4 | 5 | 5 | 15 | 14 |
| 4. Separation of agencies | 5 | 5. | 5 | 15 | 15 |
| **Facilitiation of community participation** | | | | | |
| 5. Appropriate siting | 4 | 4 | 5 | 15 | 13 |
| 6. Street presence | 4 | 4 | 5 | 15 | 13 |
| 7. Ambience/materials and finishes | 3 | 4 | d.k. | 10 | 7 |
| 8. Reception and waiting | 3 | 5 | 5 | 15 | 13 |
| 9. Staff /public security | 3 | 4 | 4 | 15 | 11 |
| 10. Staff/public confidentiality | 4 | 5 | 5 | 15 | 14 |
| 11. Accessibility | 4 | 5 | 5 | 15 | 14 |
| 12. Public facilities/comfort | 4 | 5 | 5 | 15 | 14 |
| 13 Independent community activity | 4 | 5 | 5 | 15 | 14 |
| 14. Ecology and sustainability | 2 | 3 | 3 | 15 | 8 |
| 15. Overall quality | 3 | 5 | 4 | 15 | 13 |

## Appendix 10: 4.3 Neptune community involvement process evaluation.

| **Community Involvement Process Evaluation** |
|---|
| **CASE STUDY:** Neptune Health Park |
| **DATE:** 3.12.97 |
| **Score: very high ⑤ high ④ in between ③ poor ② very poor ① don't know (d.k.) = 0** |

| **Effectiveness of process management** | Staff User | Pub/ User | Commissioning Authority | Total possible | Total obtained |
|---|---|---|---|---|---|
| 1. Clear objectives | 2 | 2 | 4 | 15 | 8 |
| 2.Time allowed | 4 | 5 | 5 | 15 | 14 |
| 3.Process management | 3 | 5 | 4 | 15 | 12 |
| 4.CA commitment | 5 | 3 | 5 | 15 | 13 |
| 5. Community commitment | 3 | 2 | 4 | 15 | 9 |
| 6. Consensus reached | 4 | 4 | 5 | 15 | 13 |
| **Achievements of process** | | | | | |
| 7. Improved access | 4 | 5 | 4 | 15 | 13 |
| 8. Add community resources | 4 | 5 | 5 | 15 | 14 |
| 9.Community ownership | 5 | 5 | 4 | 15 | 14 |
| 10. Achieve objectives | 4 | 5 | 55 | 15 | 14 |
| 11. Overall good process | 4 | 5 | 5 | 15 | 14 |

## Bibliography

Acheson, D. (1998) *Independent Inquiry into Inequalities in Health,* Report, London: S.O.

Adam Smith Institute (1994) *Health Policy*, Omega Report. London: Adam Smith Institute.

Adams, L. (1996) 'The role of Health Authorities in the promotion of health', in Scriven, A. & Orme, J. (eds.) *Health Promotion: Professional Perspectives,* pp. 36-43, London: Macmillan Press Ltd.

Alinsky, S. (1971) *Rules for Radicals: a Practical Primer for Realistic Radicals,* New York: Random House.

Allan, J. (1988) 'Health Centre, Bethnal Green, London', Architects Account, Avanti Architects, *Architectural Review,* Vol. CLXXXIII No 1096, June 1988.

Allsop, J. (1995) *Health Policy and the NHS: Towards 2000*, 2nd Edition, London: Longman.

AMEC-CASPE, (1993) *Health Malls: An answer to inner London health needs,* preliminary report, London: AMEC -CASPE.

Antigha, A. (1996) *Kings Cross Health Needs Assessment Project,* Final Report (September 1996), Camden & Islington Health Authority.

Arnstein, S. (1969) 'Citizen Ladder of Participation', *Journal of the American Institute of Planners*, Vol. 35(4), pp 216-244.

Atkinson, D. (1994) *The Common Sense of Community,* DEMOS.

Audit Commission (1991) *Report and Accounts,* London: HMSO.

Audit Commission (1996) *What the Doctor ordered,* London: HMSO.

Baggott, R. (1994) *Health and Health Care in Britain,* London: Macmillan Press Ltd.

Bailey, J., Glendinning, C. & Gould, H.(1997) *Better Buildings for Better Services,* University of Manchester.

Baker, G. and Bevan, J. (1973) *A Bibliography on Health Centres in the United Kingdom,* London: Update Publications Ltd.

Barker J. (1995) *Local NHS healthcare purchasing and prioritising from the perspective of Bromley residents- a qualitative study.* Paper 1: March 1995, Department of Public Health Development Series, Bromley Health.

Barton, R. (1992) *Building for Health - A Premises Manual for General Practice,* London: North West Thames Regional Health Authority.

Barton, R. (1997) recorded interview notes with Avanti Architects Ltd ,11.4.97.

Beales J.G. (1978) *Sick Health Centres – and How to Make Them Better,* London: Pitman Medical.

Beattie, A. (1974) *Alternative Strategies of Space Organisation in Health Centres* Project No.2, unpublished lecture notes, Postgraduate Health Facility Planning Course, MARU.

Beckett, M (1994) 'Health Service Trusts packed with Tories', *The Guardian*, 26.10.94, p. 4.

Beer, S.H. (1969) *Modern British Politics*, 2nd Edition, London: Faber

Benzeval, M, Judge, K. & Whitehead, M. (1995) *Tackling Inequalities in Health: An Agenda for Action,* London; Kings Fund.

Blaxter, M. (1995) *Consumers and research in the NHS: Consumer issues within the NHS*, Leeds, Department of Health.

Boyle, D. ed. (1990) *Community Planning and Building: a guide for people on creating their own environment.* London: London Voluntary Services Council, Planning Aid for London.

Boys, J. (1998) 'Beyond Maps and Metaphors? Rethinking the relationships between architecture and gender', in Ainley, R. (ed.) *New Frontiers of Space Bodies and Gender,* pp. 203-217, London: Routledge.

Brindle, D. & White, M. (1997) 'Biased' NHS Trust purge puts Dobson in Firing Line', *The Guardian,* 10.11.97: p.2.

Brindle, D. (1998) 'Depth Charge', *The Guardian*, Society 11.3.98, p. 19.

Bristol & District CHC (1995) *Listening to Local Voices – Involving People in Health Care Purchasing,* Conference Report. Bristol & District CHC.

British Medical Association (BMA), (1966) *Health Centres and Group Practices,* London: BMA.

British Medical Association (BMA), (1966) *Health Centres and Group Practices,* London BMA.

Brookes, B. (1974) 'The Historical Perspective', *Health Centres*, Health and Social Service Journal, London: Hospital International.

Brotherston, J. (1974) 'Introduction', in Wise, A.R.J.(ed.) *Health Centres,* London: Health and Social Service Journal/ Hospital International.

Brunt, G. (1992) *Health Centres, Towards an Evaluation Methodology,* PhD thesis, Kings Fund Library.

Burns, D, Hambleton, R. & Hogett, P. (1994) *The Politics of Decentralisation,* London: Macmillan.

Cammock R. (1973) *Health Centres Handbook,* London: MARU.

Cammock, R & Adams, (1970) 'A Briefing Method for Health Centres', *The Medical Officer,* issues June 12th, July 17th & August 14th 1970.

Cammock, R. (1971) *Building Evaluation Methods - Health Centres,* London: MARU

Cammock, R. (1972) *Some Aspects of Provision for Reception, Waiting and Patient Call in a Selected Group of Large Health Centres,* London: MARU.

Cammock, R. (1973) *Health Centres Handbook,* London: MARU.

Cammock, R. (1975) 'Confidentiality in Health Centres and Group Practices: The Implications for Design'. *Journal for Architectural Research,* 4(1): February 1975, pp. 5-17.

Cammock, R. (1977) *Utilisation of Consulting Suites in Health Centres,* London: MARU.

Cammock, R. (1981) *Primary Health Care Buildings: Briefing Design Guide for Architects and their Clients,* London: The Architectural Press.

Carpman, J. R. & Myron, G. (1993) *Design That Cares: Planning Health Facilities for Patients and Visitors,* 2nd Edition, Chicago: American Hospital Publishing Inc.

Church, C. (1997) 'A Right to Participate' *Streetwise,* 28, pp.13-15

College of Health (1994) *Consumer Audit Guidelines,* London: College of Health.

Cumberlege, J. (1986) *Neighbourhood Nursing – A Focus for Care,* A report of the Community Nursing Review, London: HMSO.

Curwen, M.P. & Brookes, B. (1973) *British Health Centres Directory,* London: Kings Fund Centre.

Curwen, M.P. (1974) 'Current Trends in Health Centre Development' in *Health Centres,* Health and Social Service Journal, London: Hospital International, pp. 12-13.

Dahl, R. (1961) *Who Governs?* Yale University Press.

Dahlgren, G. & Whitehead, M. (1991) *Policies and Strategies to Promote Social Equity in Health,* Stockholm Institute of Future Studies.

Daly, G. & Davis, H. (1997) *Local Health Services: a suitable case for treatment.* Local Government Information Unit discussion paper, March 1997. London: LGIU.

Davies, C. (1988) 'East End Avanti', *The Architectural Review,* June, 1998, pp.18-26.

Davies, M. (1990) *City of Quartz,* London: Vintage.

De Carlo, G. (1970) 'Architecture's Public', *Parametro* No 5.

Department of the Environment (DoE), (1994) *Community Involvement in Planning and Development Processes,* London, HMSO.

Department of Environment, Transport and the Regions (DETR), (1998) *Breaking Down the Barriers,* Report of the Social Exclusion Unit. London: SO

Department of Health (DoH), (1986) *Primary Health Care: An Agenda for Discussion,* London: HMSO.

Department of Health (DoH), (1987) *Promoting Better Health,* London: HMSO.

Department of Health (DoH), (1989) *Working for Patients,* London: HMSO.

Department of Health (DoH), (1990) *Statement of Fees and Allowances for General Medical Practitioners in England and Wales,* ('Red Book'), London: HMSO.

Department of Health (DoH), (1992) *The Health of the Nation,* London: HMSO.

Department of Health (DoH), (1992) *Report of the Inquiry into London's Health Service, Medical Education and Research,* (The Tomlinson Report), London: HMSO

Department of Health (DoH), (1992) *The Patients Charter*, London: DoH.

Department of Health (DoH), (1993) *Making London Better*, Manchester Health Publications Unit.

Department of Health (DoH), (1996a) *Primary Care: The Future*, London: HMSO.

Department of Health (DoH), (1996b) *Primary Care the Future- Choice and Opportunity,* London: HMSO.

Department of Health (DoH), (1996c) *Primary Health Care: Delivering the Future,* London: HMSO.

Department of Health (DoH), (1997a) *The New NHS, Modern: Dependable*, London: SO.

Department of Health (DoH), (1997b) *Healthy Living Centres,* Letter from David Walden, Health Promotion Division, 30.12.97, London: DoH.

Department of Health (DoH), (1998) *Our Healthier Nation*, London: SO

Department of Public Health (DPH) (1993). *Population Health Needs Assessment, Camden and Islington, January 1993.* Bloomsbury and Islington and Hampstead HA and Camden and Islington FHSA /H.A, London: Department of Public Health.

Department of Health and Social Security (DHSS), Welsh Office (1970) *Health Centres - A Design Guide,* London: HMSO.

Department of Health and Social Security (DHSS), (1981) *Primary Health Care in Inner London*, (Acheson Report), London: HMSO.

Department of Health and Social Security (DHSS), (1983) *Inquiry into NHS Management* (Griffiths Report), London: HMSO.

Department of Health and Social Security (DHSS), (1986) *Primary Health Care - An Agenda for Discussion,* London: HMSO.

Department of Health and Social Security (DHSS), (1987) *Promoting Better Health - The Government's Programme for Improving Primary Health Care,* London: HMSO.

Department of Health and Social Security (DHSS), (1989) *Caring for People in the Next Decade and Beyond* London: HMSO.

Department of Health and Social Security (DHSS), (1989) *Working for Patients,* London: HMSO.

Department of Health and Social Security (DHSS), Welsh Office (1970). *Health Centres - A Design Guide.* HMSO.

Devlin B. (1996) 'Don't turn back the clock' *The Guardian,* Society, 3.7.96, pp. 6-7.

Dickson. (1996) 'Blood sweat and tiers', *The Guardian,* Society, 11.89.96, pp. 2-3.

Dinsdale P. (1998) 'Pilot lights new way forward', *The Guardian*, Society, 4.2.98, p.7.

Dorrell S. (1996) *A Service with Ambitions: The Record of the NHS,* Report of a speech at a National Association of Health Authorities and Trusts (NAHAT) Symposium, 14.11.96. London: NAHAT .

Duggan, M. (1995) *Primary Health Care: A Prognosis,* London: IPPR.

Duncan, P. & Halsall, B. (1993) *Building Homes People Want: a guide to tenant involvement in the design and development of housing association homes,* London: National Federation of Housing Associations.

Dutton, T. & Hurst Mann, L. (1996) *Reconstructing Architecture: critical discourses and social practices.* Minneapolis, University of Minnesota Press.

Easton, D. (1953) *The Political System*, Knopf.

Ehrenreich, J. (1978) *The Cultural Crisis of Modern Medicine*, New York: Monthly Review Press.

Enthoven, A. (1985) *Reflections on the Management of the National Health Service*, London: Nuffield Provincial Hospitals Trust.

Environment Trust Associates (ETA)/ Local Government Management Board (LGMB), (1994) *Creating Involvement - a handbook of tools and techniques for effective community involvement,* London: ETA/LGMB.

Evans, B. (1994) 'Planning, sustainability and the chimera of community', *Town and Country Planning,* April, 1994, pp.100-108.

Fabre, J. (1996) Letter from Professor from Institute of Child Health, UCL, London, to *The Guardian,* 7.12.96, p. 22.

Farrell, C. & Gilbert, H. (1996) *Debates and strategies for increasing patient involvement in health care & health services,* London: Kings Fund.

Foster, A. (1992) 'Integrating Primary and Secondary Care: Today's and Tomorrow's Priorities' *Primary Health Care Management*, 2(5), February 1992, pp.2-3.

Foucault, M. (1973) *The Birth of the Clinic,* (1997 edition) London: Routledge.

Fox, D. (1986) *Health Policies, Health Politics*, Princetown University Press.

Freidson, (1970) *Professional Dominance: The Social Structure of Medical Care,* New York: P Atherton.

Friere, P. (1976) *Education the Practice of Freedom,* London: Writers and Readers.

Funnel, R. Oldfield, K. & Spcller,V. (1995) *Towards Healthier Alliances*, London: Health Education Authority.

Gaskin, K. & Vincent, J. (1996) *Co-operating for Health,* Centre for Social Policy Loughborough University.

General Practice Advisory Service, (1967) *Buildings for General Medical Practice,* London: HMSO.

Ghirado, D. (1991) *Out of Site: a Social Criticism of Architecture,* Seattle: Bay Press.

Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy,* Oxford, Polity Press.

Glendinning, C., Bailey, J., Burkey, Y., Gosden, T.,& Kirk, S. (1996) *Evaluating Resource Centres in the North West of England,* (executive summary), University of Manchester: The National Primary Care Research and Development Centre.

Glennerster et al (1992) *A foothold for fundholding*, London: Kings Fund.

Gordon, G. (1993) 'Setting out the ground rules for a GP's practice brief', *Architects Journal* 7.4.93.

Gould, M. (1994) 'GP's health centre innovation a winner', *Pulse*, 22.10.94, p. 31.

Greater London Association of Community Health Councils (GLACE) (1989) *Health Service Users and the NHS Review: A Statement from Voluntary Organisations,* London: GLACE.

Green, J. and Thorogood, N. (1998) *Analysing Health Policy,* Harlow: Addison Wesley Longman.

Griggs, B. (1985) 'Introduction', *The Peckham Experiment: a study of the living structure of society*, (republished edition), pp. iv-xxiii. Edinburgh Scottish Academic Press.

Ham, C. (1991) *The New National Health Service*, Oxford: Radcliffe Medical Press.

Ham, C. (1992) *Health Policy in Britain the Politics and Organisation of the Health Service,* Third Edition, Basingstoke: Macmillan.

Ham, C. (1994) *Management and Competition in the New NHS*, London: NAHAT.

Ham, C. (1996) *Public Private or Community: What next for the NHS?* London: Demos.

Hayden, D. (1995) *The Power of Place*, Cambridge Massachusetts/London: MIT Press.

Henderson, G. and Tarpey, M. (1990) *Assessing the Lambeth Community Care Centre,* London: LCCC.

Hendessi, M. (1994) *Getting Better All the Time? A report of a project on user and carer involvement in the NHS,* London: London Health Alliance.

Herzberger, H. (1991) *Lessons for Students in Architecture*, Rotterdam: Uitgeverij 010.

Higgs, R. (1985) *Example of Intermediate Care: The New Lambeth Community Care Centre,* British Medical Journal, 291: pp. 1395-97.

Hill, J. (1998) *Occupying Architecture: between the architect and the user*, London: Routledge.

Hillier, B. and Hanson, J. (1984) *The Social Logic of Space*, Cambridge University Press.

Holliday, I. (1992) *The NHS Transformed*, Manchester: Baseline Book Company.

Hope, C.A. (1974) 'Health Centre Planning' *Health Centres,* Wise, A.R.J. (ed), London: Health and Social Service Journal/ Hospital International.

Hoskins, (1997) recorded interview notes at Penoyre and Prasad Architects,13.3.97.

Hudson, B (1995) 'A little local difficulty', *Health Service Journal*, 1 June 1995.

Hughes, J. and Gordon, P. (1992) *An optimal balance?* London: The Kings Fund London Initiative.

Illich, I. (1976) *Limits to Medicine: Medical Nemesis*, 2nd Edition, London: Marion Boyars.

Institute of Public Policy Research (IPPR), (1996) *New Agenda for Health*, London: IPPR.

Ivory, J. et al. (1980) *Health Centres - Does Small Mean Success?,* Health and Social Service Journal, pp. 1564-65, 5.12.80.

Jarman, B. (1984) 'Under privileged Areas: Validation and Distribution of Scores' *British Medical Journal*, 289, pp.1587-92.

Jones J. (1994) 'Kill or Cure Time for the NHS', *The Observer* 13.2. 94. p.4.

Judd, C.M., Smith, E.R.& Kidder, L.H. (1991) *Research Methods and Social Relations,* Sixth International Edition, Florida: Holt Rhinehart and Winston, Inc.

Kapiro, A. (1979) *Primary Health Care in Europe*, Regional Office for Europe, Copenhagen: WHO.

Keen, J. et al. (1987) *Briefing Guide for General Practice Premises,* London: MARU.

Kelly, L. and Thorpe, M. *Setting the Context: A Brief Overview of Sociological uses of the Concept of Community,* Unpublished paper, Catchment and Community Research Unit, University of North London.

King Edward's Hospital Fund for London.(1966) *Health Centres,* conference paper, King Edward's Hospital Fund for London, November 1966.

Klein, R. (1995) *The Politics of the NHS*, third edition, London: Longman.

Kroll, L. (1984) 'Anarchitecture' in Hatch, C. (ed.) *The Scope of Social Architecture,* New York: Van Nostrand Reinhold.

Labour Party (1994) *Health 2000: The health and wealth of the nation in the 21st century* London: The Labour Party.

Labour Party (1997) *New Labour because Britain deserves better,* Election Manifesto: London: The Labour Party.

Labour Party (1998) *Labour in Government Progress and Plans,* 24.11.98. London: The Labour Party.

Lamb, D. (1994) *Primary Health Care: Premises Report on the Inner City GP Premises Project 1992-1994,* Kensington & Chelsea and Westminster Health Commissioning Agency/Lambeth, Southwark and Lewisham Health Commission.

Law, J. (1986) 'Care Centres are a Base for GPs', *Madeconomics*, April 1986, pp.59-69.

Lawson, N. (1992) *The View from Number 11. Memoirs of a Tory Radical,* London: Bantam Press.

Leach, N. (ed.) (1997) *Rethinking Architecture: a reader in cultural theory,* London: Routledge.

Leonard, O., Allsop, J., Taket, A. & Wiles, R. (1997) *User Involvement in Two Primary Health Care Projects in London*, London: College of Health.

Local Government Training Board (1992) *Citizens and Local Democracy - Empowerment: a theme for the 90s*, London: Local Government Management Board.

Lubbock, J. et. al. (1985) 'A Patient Revolution - Special Report on Lambeth Community Care Centre', *Architects' Journal*, 182 (42) pp. 60-103.

MacDonald, J.(1993) *Primary Health Care, Medicine in its Place,* London: Earthscan Publishing Ltd.

Maybin, R.P. (1974) 'Health Centres and the General Health Services', *Health Centres,* Wise, A.R.J. (ed), London: Health and Social Service Journal/ Hospital International.

Mays, N. & Pope, C. (1996) *Qualitative Research in Health Care*, London: BMJ.

McIver, S. (1992) *Obtaining the views of Black Users of Health Services,* London: Kings Fund.

McKeown, S. & Keen, Justin. (1987) *The impact of information technology on the design of future health buildings,* final report, London: MARU.

McKeown, T. (1976) *The Modern Rise of Population and the Role of Medicine: Dream, Mirage or Nemesis?* Rock Carling Monograph, London: Nuffield Provincial Hospitals Trust.

Medical Architecture Research Unit (MARU), (1968) *Working in Health Centres,* symposium report, London: MARU.

Medical Architecture Research Unit (MARU), (1978) *Accommodation Standards for Medical Buildings - Volume 1: Dispensaries, Clinics and Health Centres,* London: MARU.

Medical Practitioners Union (MPU), (1967) *Design for Family Doctoring,* London: Medical Practitioners Union.

Middlcmas, K. (1979) *Politics in Industrial Society,* London: Andre Deutsch.

Middlesex University (1994) *Place and Local Identity: A Study of Factors in Local Spatial Identity,* London: London Planning Advisory Committee (LPAC).

Milhil, C. (1996) 'Health in Question', *The Guardian*, 18.10.96, p. 4.

Millar,B. (1992) 'A PATCH work cover for health', *Doctor* 26.3.92 p 40-41.

Ministry of Health (MoH), (1920) *Interim Report on the Future Provision of Medical and Allied Services,* (The Dawson Report), London: HMSO.

Ministry of Health (MoH), (1953/4) *Report for the Ministry of Health*, vol. XIII, London: HMSO.

Ministry of Health (MoH), (1962) *A Hospital Plan for England and Wales,* London: HMSO.

Ministry of Health (MoH), (1963a) *Health and Welfare: The Development of Community Care Plans for the Health and Welfare Services of the Local Authorities in England and Wales,* London: HMSO.

Ministry of Health (MoH), (1963b) *The Field Work of the Family Doctor*, (The Gillie Report) London: HMSO.

Monaghan, P. (1995) *Designing for Doctors*, catalogue for the RIBA exhibition, London: BMA/RIBA.

Moore, W. (1996) 'Return of the Soundbite King', *The Guardian,* 6.3.96, p. 9.

Morgen, S. (1989) *Profiling Women's Health Centres - An evaluation of a primary health care initiative,* (discussion paper 4), Wellington: Health Services Research and Development \Unit Department of Health.

National Association of Health Authorities (NAHA), (1980) *NHS Handbook* Birmingham: NAHA.

National Association of Health Authorities and Trusts (NAHAT), (1987) *Autumn Survey 1987,* London: NAHAT.

National Association of Health Authorities and Trusts (NAHAT), (1993*) Reinventing Healthcare towards a new model*, London: NAHAT.

National Building Agency (1966) *Design* Guide *for Medical Group Practice Centres,* London: College of General Practitioners.

Navarro, V. (1986) *Crisis in Health and Medicine,* London: Tavistock.

NHS Estates (1991) *Health Building Note 46: General medical practice premises for the provision of primary health care services,* London: HMSO.

NHS Estates (1994) *Environments for Quality Care: Health Buildings in the Community.* London: HMSO.

NHS Estates (1994/5) *London Initiative Zone Primary Care Premises Handbooks 1/4.* London: Crown.

NHS Estates (1995) *Health Building Note 36: Volume 1 & 2.* London: HMSO.

NHS Estates (1995) *Health Building Note 40: Common Activity Spaces. Volumes 1, 2, 3, 4,* London: HMSO.

NHS Estates (1996) *An Exemplar Estate Strategy,* London: HMSO.

NHS Executive (1994) *Health Buildings in the Community,* London: HMSO.

NHS Executive(1994) *Capital Investment Manual,* London: HMSO.

NHS Management Executive (1992) *Listening to Local Voices,* Leeds: Department of Health.

NHS Management Executive (1992) *Local Voices: the views of local people in purchasing for health,* NHSME, London: HMSO.

Nazroo, J.Y. (1997) *The Health of Britains Ethnic Minorities,* London: Policy Studies Institute.

Noble, A. (1989) *Information Sheet 1: Notes on the Acquisition and Improvement of Practice Premises.* London: MARU.

Noble, A. (1989) *Information Sheet 2: Evaluating Designs for GP Premises,* London: MARU.

Noble, A. (1996) 'The True Cost of Care Facilities', *Architects Journal,* 18.7.96.

Nottinghamshire County Council (1995) *Health Centres,* Nottingham: Nottinghamshire County Council.

O'Keefe, E.Otteweil & Wall, A. (1992) *Community Health: Issues in Management,* Sunderland Tyne and Wear: Business Education Publishers Limited.

Oakley, P.(1989) *Community Involvement in Health Development,* Geneva: WHO.

Ong, Bie Nio (1996) *Rapid Appraisal and Health Policy,* London: Chapman and Hall.

Oppenheim, A.N. (1992) *Questionnaire Design, Interviewing and Attitude Measurement,* London & New York: Pinter Publishers.

Patton, M.Q. (1980) *Qualitative Evaluation Methods,* London: Sage.

Patton, M.Q. (1987) *How to use qualitative methods in evaluation,* London: Sage.

Pawson, R. & Tilley, N. (1997) *Realistic Evaluation,* London: Sage.

Pearson, M, & Spencer, S. (1989) *Awareness and Use of Well Women Services in Liverpool,* Occasional Paper No. 1, Department of General Practice, University of Liverpool.

Peckham, S. Taylor, P. and Turton, P (1998) *Primary Care and Public Health Project Part Two,* Draft Summary, January 1998, Birmingham: Public Health Alliance.

Phillips, M. (1996) 'Duty is in the eye of the stakeholder', *Observer Review,* 30.6.96. p. 5.

Radical Statistics Health Group (RSHG), (1991) 'Missing: A Strategy for the Health of the Nation', in Smith, R. (ed.) *The Health of the Nation: The BMJ View,* London: BMJ.

Ranade, W. (1994) *A Future for the NHS? Health Care in the 1990s*, London: Longman.

Richardson J.J. and Jordan A.G. (1979) *Governing under Pressure*, London: Martin Robertson

Scambler, G. & Higgs, P. (eds.) (1998) *Modernity Medicine and Health: Medical Sociology Towards 2000,* London: Routledge.

Scher, P. (1992) *Environmental Design Quality in Health Care*, Manchester: Arts for Health.

Scher, P. (1996) *Patient Focused Architecture for Health Care*, Manchester: Metropolitan University.

Scott-Samuel, A. (1997) 'Sweeping Changes', *The Guardian,* Society, 7.16.97, p. 9.

Scott-Samuel, A. (ed.) (1990), *Total Participation, Total Health - Reinventing the Peckham Health Centre for the 1990's*, Edinburgh: Scottish Academic Press.

Scottish Home and Health Department (1973), *Health Centres in Scotland*, London: HMSO.

Scriven, A. and Orme, J.(ed.) (1996). *Health Promotion: Professional Perspectives,* London: Macmillan Press.

Shaw, C. (1997) recorded interview notes with MAAP architects, 18.2.97.

Silver, R. (1993) 'Getting the Treatment', *Design*, issue 533, May 1993, pp. 21-24.

Silverstone, R. (1980) *Doctor's Attitudes to Health Centres,* London: The City University Business School and Gresham College.

Singmaster, D. (1997), 'Super-Surgeries' and the New Age of Healthcare Architecture'. *Architects' Journal*, 10.7.97, p.17.

Smallridge, A. (1994) 'A Safe and Accessible Surgery', Building study, *Architects' Journal,* 23.3.94, pp. 31-39.

Smith, M.(1997) recorded interview notes with MAAP architects, 18.2.97.

Smithies, J. & Webster, G. (1998) *Community Involvement in Health: from Passive Recipients to Active Participants,* Aldershot: Ashgate.

Southern Community Health Research Unit (SCHR)(1990) *Planning Healthy Communities - A Guide to doing Community Needs Assessment,* Adelaide: Southern Community Health Research Unit.

Stacey, M. (1977) *Concepts of Health and Illness*: a working paper on the concepts and their relevance for research, in Social Science Research Council, *Health and Health Policy - Priorities for Research,* London: SSRC.

Stallibrass, A. (1989) *Being Me and Also Us - Lessons from the Peckham Experiment,* Edinburgh: Scottish Academic Press.

Stone, P. (ed.), (1980) *British Hospitals and Health Care Buildings - Design and Appraisals,* London: Architectural Press.

Tang, M. & Cuninghame, C. (1998) 'Ways of Saying', *Health Service Journal,* 15.9.98.

Taylor, A. (1992) 'GPs Built Model Care Centre,' *General Practitioner,* November, p. 54.

Taylor, D and Bloor, K. (1994) *Health Care, Health Promotion and the Future General Practice,* London: Nuffield Provincial Hospitals Trust, RSM Press.

Taylor, D. (1991) *Developing Primary Care: Opportunities for the 1990's* (King's Fund Institute Research Report 10). London: King's Fund and The Nuffield Provincial Hospitals' Trust.

Taylor, P., Peckham, S. & Turton, P. (1998) *A Public Health Model of Primary Care: From Concept to Reality,* Birmingham: Public Health Alliance.

Tempest, J. (1996) *The Planning System and the National Health Service,* in Greed, C. (ed.) *Implementing Town Planning,* Harlow: Longman, pp. 164/180.

Thatcher, M. (1987) Interview, *Women's Own,* 31.10.87.

The Pioneer Health Centre Ltd (1992) *Health of the Individual, The Family and Society,* Tunbridge Wells: The Pioneer Health Centre Ltd.

Torimo, E. (1991) *Towards a Health District: Organising and Managing District Health Systems Based on Primary Health Care,* Geneva: WHO.

Towers, G. (1995) *Building Democracy: Community Architecture in the inner cities,* London: UCL Press.

Townsend, P. & Davidson, N. (1982) 'The Black Report,' *Inequalities in Health,* New Edition, revised and updated 1990, London: Penguin.

Tressider, M. (1994) 'A long drag from Golden Virginia', *The Guardian,* 26.11.94, p.29.

Valins, M. (1993) *Primary Health Care Centres,* London: Longman.

Valins, M. & Salter, D. (1996) *Future Care: New Directions in Planning Health and Care Environments,* Oxford: Blackwell Science.

Warbarton, A. (1995) 'Back to the centre', *Health Service Journal,* 21.9.95, pp. 1-4.

Warner, N. (1994) 'Care Shared' *The Guardian,* Society, p.8.

Wart, G. (1994) *Health Policy an Introduction to Process and Power,* London & New Jersey: Zed Press.

Webb, S. and Webb, B. (1909) *Royal Commission on the Poor Law and Relief of Distress,* Minority Report, London: HMSO.

Weeks, J. (1991) 'Treating Health Care Buildings', *Building,* (supplement), 256 (7683), February 1991, pp. 8-29.

Westcott, P. (1991) 'Inside the Healing Dome' *The Guardian,* 19.4.1991, p.31.

Whitehead, M. (1992) 'The Health Divide', in *Inequalities in Health,* London: Penguin.

World Health Organisation (WHO), (1978) *Alma-Ata 1978 Primary Health Care,* Geneva: WHO.

World Health Organisation (WHO), (1981) *Global Strategy for Health for All by the Year 2000,* 'Health for All' Series No 3, Geneva: WHO.

World Health Organisation (WHO), (1981) *Plan of Action for Implementing the Global Strategy for Health for All and Index to the 'Health for All' Series 1-7,* Geneva: WHO.

World Health Organisation (WHO), (1982) *Primary Health Care: from theory to action.* Report on a WHO symposium, Regional Office for Europe, Copenhagen: WHO.

World Health Organisation (WHO), (1985) *Targets for Health For All,* Regional Office for Europe, Copenhagen: WHO.

World Health Organisation (WHO), (1992) *The Role of Health Centres in the Development of Urban Health Systems,* Geneva: WHO.

Wilce, G. (1988) *A Place Like Home - A Radical Experiment in Health Care,* London: Bedford Square Press.

Williams, S (1994) 'Community Orientated Primary Care: From Concept to Reality', *Primary Care Management,* pp. 3/6, Vol. 4, Number 8, London: Longman.

Willmott, P. (1987) *Friendship Networks and Social Support,* London: Policy Studies Institute.

Willmott, P. (1989) *Community Initiatives: Patterns and Prospects,* London: Policy Studies Institute.

Winn, E. & King, C. (1987) *Breaking New Ground - Report at King's Fund Conference on the Lambeth Community Care Centre,* London: King's Fund.

Wise, A.R.J. (ed.), (1974) *Health Centres,* London: Health Service Journal/ Hospital International.

Women's Design Service (1992) *Antenatal Waiting Areas,* London: WDS

World Health Organisation (WHO), (1992) *The Role of Health Centres in the Development of Urban Health Systems,* (report of the WHO Study Group on Primary Health Care in Urban Areas), Geneva: WHO.

Wright, L. (1980) 'Medical Centre, Wellingborough, Northants', in Stone, P. (ed.), *British Hospital and Health Care Buildings,* pp.182/191, London: Architectural Press.

Yin, R.K. (1994) *Case Study Research Design and Methods,* Second Edition, London: Sage.