

# Enquiry by Design for Health

Design Briefing for Hospitals

*January 2008*



The Prince's Foundation  
FOR THE BUILT ENVIRONMENT

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The Prince's Foundation for the Built Environment is an educational charity which exists to improve the quality of people's lives by teaching and practising timeless and ecological ways of planning, designing and building.

We believe that if we can understand and apply time-tested principles, building once more in a sustainable way, we will reap improvements in public health, in livelier and safer streets and in a more affordable lifestyle for families and individuals. We also believe that neighbourhoods exhibiting these sustainable characteristics will increase, rather than decrease, in value over time.

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# Introduction

## Enquiry by Design for Healthcare Facilities

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### PURPOSE OF THIS DOCUMENT

**The purpose of this document is to make available the learning from three pilot Enquiry by Design (EbD) projects in order to inform and raise the quality of the Design Briefing Process for healthcare buildings in the future.**

### INTENDED AUDIENCE

The Department of Health (DH), Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs), Foundation Trusts (FTs), NHS Trusts, Design Review Panel (DRP) members, Commission for Architecture and the Built Environment (CABE), Trust technical officers, Advisors and Enablers, Statutory Planning Authorities.

### BACKGROUND

2001 saw several new design-led initiatives come to the fore: the Prime Minister's initiative on Better Public Buildings, the DH/NHS Estates initiative Better Healthcare Buildings, the creation of CABE – the Commission for Architecture and the Built Environment, the creation of CHAD – the Centre for Healthcare Architecture and Design, the OGC's – Office of Government Commerce, Achieving Excellence programme and also the inception of design reviews in the NHS.

2001 also saw the launch of a partnering agreement between The Prince's Foundation for the Built Environment and NHS Estates (continued with the Department of Health). Under this agreement a programme called 'Building a Better Patient Environment' was begun, initially supporting five Trusts – University Hospital Lewisham, North West London (BeCAD), Salford, Mid Yorkshire (Pinderfields and Pontefract), and South of Tyne and Wearside – in the development of their design vision.

The Prince's Foundation, during the period of this NHS study, was developing its pioneering Enquiry by Design (EbD) process. Since 1999, work with English Partnerships at Upton, Northampton, and on other projects across the UK has developed this collaborative design methodology.

#### Other Prince's Foundation EbDs:

- *Urban Extensions: Crewkerne (500 homes); Newquay (1,200 homes); Harlow (25,000 homes); Sherford (5,500 homes);*
- *Brownfield: Nelson (1,000 homes)*
- *Regeneration: Lincoln City Centre*

The first healthcare-focused Enquiry by Design was held at Cherry Knowle in Sunderland at the end of 2003, for one of the five original participating Trusts (South of Tyne and Wearside).

After the successful conclusion of the Cherry Knowle EbD, the Secretary of State for Health called for two further health EbDs to further test the viability and applicability of EbD in the NHS. In 2005-2006 EbDs were carried out at Sutton for the Merton, Sutton and Mid-Surrey NHS Better Healthcare Closer to Home programme, and at Alder Hey for the Royal Liverpool Children's NHS Trust.

This report summarises the lessons learnt from the three pilot EbDs, and puts forward guidance aimed at increasing public

engagement, raising design aspirations, and informing Design Frameworks for healthcare projects.

# Findings

During the course of the 'Building a Better Patient Environment' initiative with the Department of Health the Prince's Foundation made the following findings:

- a) **Strategic healthcare planning is not fully implemented in relation to physical location.** *There doesn't appear to be a clear method for the siting of hospitals in terms of physical location in relation to hospital catchment areas and population and structure densities.*
- b) **Hospital designers often lack good urban design and strategic masterplanning skills.** *It is well documented that there is a general shortage in good urban design and strategic masterplanning skills in the UK. Many hospital designers have a good understanding of how to design a hospital from the 'inside out' but not as much attention is given by both the client and the consultant, to the 'outside in' i.e. the public realm adjacent to the hospital.*
- c) **Bidders competing for the hospital cannot carry out the stakeholder consultation necessary for proper strategic masterplanning.** *It is fundamental for proper strategic masterplanning that key stakeholders in the area concerned are proactively engaged. This cannot happen in a competitive bid situation as it is not feasible to have separate consortia consulting the same stakeholders at the same time.*
- d) **Much of the design work carried out for a Public Sector Comparator is wasted.** *The design work carried out for a PSC appears to be more for costing rather than design purposes. Given that the design work often doesn't transfer directly into the final building, the precise form of architectural information needed for costing purposes appears too specific.*
- e) **Design briefing by the Public Sector for Private Sector bidders is imprecise.** *The architectural part of the hospital briefing currently comes in the form of a PSC and an accompanying outline planning application for the hospital. This information includes the detailed layout and design for the hospital worked up by consultants. This level of detail appears too specific in terms of a particular design, which will not be built, and too loose in terms of giving clear and precise instruction on the planning and site constraints.*
- f) **The stumbling block for giving precise architectural briefing appears to be that no-one wants to dampen the possibility for 'Innovation' from the private sector.** *In The Prince's Foundation's experience of design briefing for mixed-use housing developments, the private sector's largest drive in innovation is in cost saving and not design. Innovation is important but it doesn't seem that there is a clear idea from the public sector as to where this 'innovation' is best targeted*
- g) **Design review comes too late to be able to effect strategic healthcare or masterplanning issues.** *As the design review panel are only ever reacting to schemes that are already well worked up the chance for the panel's comments to effect some major issues listed above is minimal and often disruptive.*

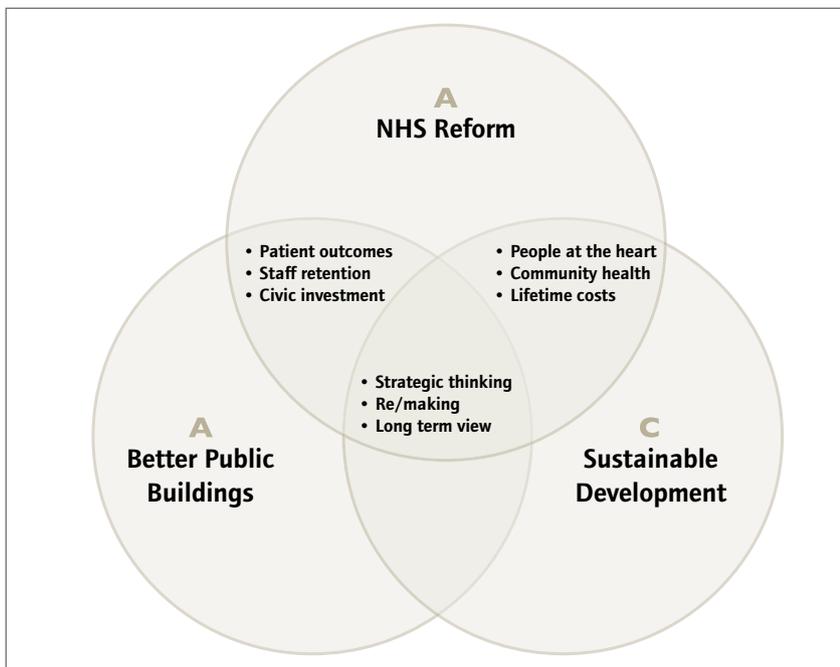
# Conclusions

## From the findings the Prince's Foundation have made the following conclusions:

- a) *The EbD process was a structure and forum that allowed the key stakeholders in a project to make carefully informed decisions about where and how to site a particular hospital in relation to its intended catchment, local population and amenity.*
- b) *It is essential when designing a hospital that the building is seen as part of a wider whole, and while the clinical model is being explored architecturally from the 'inside out', much attention should be paid simultaneously to the places around the building through masterplanning and urban design, designing from the 'outside in'. During the EbD process professionals skilled in both of these areas were working closely together to make sure both of these factors were being taken into account.*
- c) *The EbD allowed the public sector to consult and fully engage local stakeholders in helping to agree the collective vision for a particular project. This means that the wider public are only consulted by one group so it is as clear and simple as possible. This collective vision was then embodied in the design briefing for the private sector to respond to.*
- d) *During the EbD for Alder Hey two designers developed quite different hospital footprints that were capable of meeting the Trust's brief for the clinical model. These designs then informed the Design Framework document which laid out a set of clear parameters within which the private sector bidders were free to respond. This is clearly aligned to the requirements of the outline planning application which required a series of parameter plans for the building and the public realm.*
- e) *The Design Briefing documentation must be precise and parametric in order to be able to enforce the established vision for the hospital as worked up with the key stakeholders, but be flexible enough to allow for the private sector's innovation and any changing factors that may occur. This is why the design framework documentation is formatted like a design code, a method developed precisely for this condition.*
- f) *Clear feedback from private sector representation indicates that bidders would welcome clear parameters and instruction which they know have been understood by the planning authority and local stakeholders as this gives a valuable degree of certainty.*
- g) *Whilst being able to challenge these parameters if a much better solution emerges for the site, the bidders are motivated to innovate within a set of robust restrictions which are valuable given the limited amount of time that they have to design the hospital in a competitive situation. This clear brief also levels the playing field for the bidders so their competitive advantage is more likely to be positively directed on the refinement of the hospital design and logistical planning.*
- h) *Strategic design review could occur earlier in the process and be more proactive in relation to hospital strategic and masterplanning issues. This would help the Trust's work more effectively with local stakeholders in developing a collective vision for the hospital and its surroundings and lay the ground to make the route as clear as possible for the private sector in order to focus their added value in the right direction.*

# Health Agenda

## PUBLIC SERVICE MODERNISATION IN A CHANGING CLIMATE



It became clear that EbD has a positive role to play supporting these three key government drivers interested in Public service modernisation in a changing climate.

- *NHS Reform (Public Service Modernisation)*
- *Better Public Buildings*
- *Sustainable Development*

### NHS REFORM

Since taking office in 1997, the Labour government has embarked on a comprehensive reform of the national health service, underpinned by a review of spending which will see funding of the NHS increase by something like 50% to about 9.4% of GDP in 2008 (the EU average).

This is part of the comprehensive modernisation of public services.

‘Quality’ applied to NHS Reform is measured in terms of: access, effectiveness, equity, responsiveness (patient-centredness), safety and capacity.

Increased investment in the NHS (raising to EU level of GDP) is for the delivery of more and better paid staff using new ways of working, reduced waiting time and high quality care centred on patients and improvements in local hospitals and surgeries.

This reform addresses a number of factors, not least a legacy of long term under-investment which had created a significant and mounting maintenance backlog in the building stock (feeding a vicious circle of under performance).

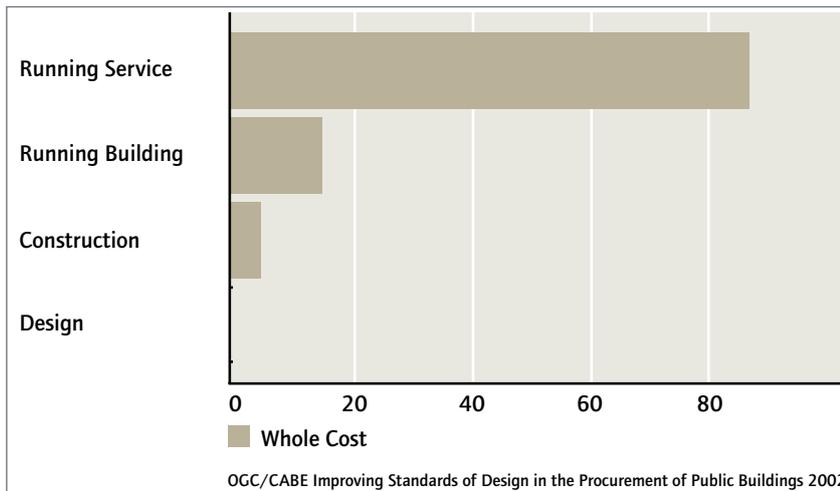
### Other drivers for change include:

- *Changing demographics*
- *Rising expectations and new medical technology*
- *Epidemiology (although circulatory diseases, including heart disease and stroke continue to be the most common cause of death in England and Wales)*
- *Personnel factors (such as the new working time directive); political factors; and the availability of information (increasing the operationalising of the choice agenda).*

“Our longer-term aim is to bring about a sustained realignment of the whole health and social care system”

[Our Health, Our Care, Our Say: A New Direction for Community Services, 2006]

## WHOLE LIFE COSTS OF HOSPITALS



The key NHS reforms affecting buildings are 100 new hospitals, 500 new one-stop Primary Care Centres and 3000 GP premises modernised by 2010.

Section 11 of the Health and Social Care Act 2001 places a duty on strategic health authorities, Primary Care Trusts and NHS trusts, to make arrangements to involve and consult patients and the public in: planning services, developing and considering proposals for changes in the way those services are provided and decisions to be made that affect how those services operate.

This new duty enables ways of working in the NHS that will strengthen accountability to local communities, and tie new healthcare developments in more closely to realising the valuable potential in local community benefits. EbD helps to extend that duty to engage the community with the design of the buildings themselves, recognising the impact on physical and social health of the built environment, directly, as well as the responsibility hospital buildings have to patients, staff, local visitors and residents alike.

Community well-being is defined as “Preventing ill-health and enabling people to play a full role in their local communities”

[Our health, our care, our say: a new direction for community services, 2006]

In order to realise the full potential of service modernisation, It has been argued

that this effort needs to be joined to other critical objectives that harness, on the one hand, the power of the built environment, and on the other the power of local communities.

### BETTER PUBLIC BUILDINGS

The Better Public Buildings Programme is the Prime Minister's initiative launched with CABE in 2000 where he asked ministers and departments across government to work towards achieving a fundamental change in the quality of building design in the public sector to bring about:

- *A step change in the quality of building design in the public sector*
- *A legacy for the future*
- *Functional buildings and civilised places with a human dimension*
- *Value for money over the long term*
- *Informing clients to help procure good public buildings*
- *Promoting civic responsibility*
- *Systematically promoting good design and community involvement*
- *Revitalising neighbourhoods and cities*
- *Transforming derelict sites and neglected buildings, reducing pressure on the countryside, uplifting and bringing hope to run-down communities*
- *Reducing crime, illness, and truancy*
- *Helping public services to perform better and aiding staff recruitment and retention*

“Promote the civic ethos which is crucial to improved built environments nation-wide”

[Anon ]

The link between the quality of public services and the quality of buildings from which those services were delivered was given official recognition by this initiative, which also recognised that individual buildings were the building blocks of neighbourhoods.

**In order to avail itself to the design skills needed to achieve the 'step change' in the quality of building design, changes in attitude and practice of commissioning were identified as:**

*A good building needs an informed client*

- *The impact of public buildings and spaces... are part of the value to the public and must be included in the overall assessment*
- *Typically the cost of design is only about 1% of the lifetime cost of a building...The million-pound mistake is made on day one, in poor briefing and design thinking.*
- *Also the link between good design and community involvement was acknowledged; promoting good design and community involvement systematically has been as important as creating functional buildings and civilised places with a human dimension.*

Good design is not a costly luxury. In fact, best practice in integrating design and construction delivers better value for money - as well as better buildings. And this is especially apparent when attention is paid to the full costs of a building over its lifetime. Improved design quality, such as better light, ventilation and views of nature can improve recovery times and even costly items such as a higher number of single bedrooms can often be paid off in terms of savings with the first year of operation (as presented by Roger Ulrich at The Prince's Foundation and King's Funds – Celebrating achievement conference in 2005.)

**Therefore in any consideration of 'value' for a hospital project, we should remember the whole cost picture:**

- *Design fees: 0.3 – 0.5%*
- *Construction: 2 – 3%*
- *Running building: 11.5 – 12.7%*
- *Running service: 85%*

[figures from OGC/CABE Improving Standards of Design in the Procurement



Photograph Alder Hey EBD

of Public Buildings, 2002 as shown in diagram on page 4]

### **Best Design Quality in Healthcare Buildings**

**In addition to delivering healthcare and balancing the books, the NHS should expect/require its healthcare buildings to:**

- *"Communicate care" (John Sorrell)*
- *Contribute positively to patient health outcomes*
- *Contribute positively to staff productivity, welfare and retention*
- *Be sustainable and energy efficient into the future*
- *Contribute to context and local social, cultural and economic activity and well being*
- *Be flexible, durable and easy to maintain into the future*

### **Building A Better Patient Environment**

The partnering agreement drawn up between The Prince's Foundation for the Built Environment and NHS Estates followed a meeting in 2001 between HRH The Prince of Wales and the then Secretary of State for Health Alan Milburn. The relationship was cemented and launched at a conference in November 2001 at which both Alan Milburn and Prince Charles spoke. The agreement became known as the Building a Better Patient Environment Programme.

**This programme has involved the following activities to date:**

- *Working with Five NHS hospital Trusts to develop their design vision (Lewisham, Pinderfields & Pontefract, Salford, Cherry Knowle, and BECaD)*
- *Participating as a member of the Design Review Panel & Steering Group*
- *Supporting the Design Champion programme (The Prince of Wales is the NHS Design Champion)*
- *Piloting Enquiry by Design with three Trusts (Cherry Knowle, Sutton, and Alder Hey)*

**A number of key factors were explored during this work, namely:**

- *Strategic and masterplanning issues (AEDET 'social and urban integration');*
- *Patient and public environments*
- *Designing for the long term*
- *Patient and public involvement in the design and planning of their neighbourhoods and public services*
- *Cross agency and inter-departmental working*
- *Loose fit hospital typologies*

The aim of the five pilot studies was to assist the NHS to raise the quality of design of healthcare premises. Essentially this was an open ended experiment, providing a resource to trusts to strengthen their attention to design quality, enabling The Prince's Foundation to provide support and



expertise in the most effective way. A similar initiative saw CABE enablers assisting other NHS trusts.

The Prince's Foundation's work with the five pilot sites highlighted that the nature of health planning is changing and the Acute/MH/Primary Care split is becoming increasingly blurred as whole health economy commissioning takes off. It is clear that there is a need for new knowledge and learning about how to do strategic estate master planning based on a whole health economy to assist SHAs and PCTs.

Thus, as the partnering relationships developed and the process of assisting and providing support to trusts became more focused, The Prince's Foundation recommended that EbD was a process that could be very useful, in bringing both health and community benefits, not only for Sunderland, the first pilot, but potentially for many other NHS Trusts as well.

### SUSTAINABLE DEVELOPMENT

**What is Sustainable Development and why does EbD contribute to Sustainable Development?**

**At the heart of Sustainable Development is the simple idea of ensuring a better quality of life for everyone, now and for the generations to come. This means meeting four objectives at the same time:**

- *Social progress which recognises the needs of everyone*
- *Effective protection of the environment*
- *Prudent use of natural resources*

- *Maintenance of high and stable levels of economic growth and employment and crucially considering the long term implications of decisions. [Quality of life counts DETR 1999]*

### SUSTAINABILITY PRINCIPLES

Sustainable systems and development tend to be typological and those where the 'parts' are considered in parallel and linked together to make a complex but robust 'whole' with built in redundancy – typically this involves linking social, environmental and economic factors together. The current climate of specialisms in both health and the built environment means that creating the appropriate forum for collaboration to create the right solution is challenging. Not only do people from different specialisms tend to speak different languages and have very different priorities, but the procurement, funding and planning processes tend to be linear and reactive which are both time consuming and very difficult to synchronise (this is important as it is often a misunderstanding that prevents collective solutions and the timing of certain decisions not being aligned).

### SUSTAINABLE COMMUNITIES

**What are sustainable communities and how does EbD contribute to sustainable communities?**

**The government publication *Securing the Future – delivering the UK Sustainable Development Strategy states (p121) that Sustainable***

### Communities should be:

- **ACTIVE, INCLUSIVE AND SAFE** – *fair, tolerant and cohesive with a strong local culture and other shared community activities*
- **WELL RUN** – *with effective and inclusive participation, representation and leadership*
- **ENVIRONMENTALLY SENSITIVE** – *providing places for people to live that are considerate of the environment*
- **WELL DESIGNED & BUILT** – *featuring a quality built and natural environment*
- **WELL CONNECTED** – *with good transport services and communication linking people to jobs, schools, health and other services*
- **THRIVING** – *with a flourishing and diverse local economy*
- **WELL SERVED** – *with public, private, community and voluntary services that are appropriate to people's needs and accessible to all*
- **FAIR FOR EVERYONE** – *including those in other communities, now and in the future.*

In short the consensus of all of these agendas and initiatives strongly suggest that a more strategic and pro-active planning of Healthcare Services is critical if they are to be integrated into the regeneration and building of sustainable communities.

Enquiry by Design is a process based on collaborative strategic planning and appears to offer the perfect tool in addressing these highly complex and integrated issues.

Progress towards sustainable development cannot achieve the 'step change' of which the Prime Minister has spoken without a systematic effort to connect that agenda to the modernisation [of public services] agenda. By the same token, the modernisation process will not fulfil its potential unless implemented within a clear and coherent organising framework that can motivate professionals and the general public alike. The [Sustainable Development] Commission believes that framework can only be supplied by sustainable development.

In short, sustainable development needs better machinery, while the modernisation agenda needs a sustainable core and a bigger public purpose than can be provided solely by prevailing views of 'efficiency' and 'customer choice'. Neither programme is achieving its full potential, and we contend that neither can do so unless and until it is integrated with the other. Modernisation without sustainable development is a recipe for short-term gains but long-term waste, frustration and contradiction. Sustainable development without the leverage and resources of the modernisation agenda will remain marginal in most public services.

Sustainable Development Commission report *Sharing the Value; a sustainable approach to the modernisation agenda*, Jan 2005, p2

# What is Enquiry by Design?

The Enquiry by Design (EbD) process is a key planning tool trademarked by The Prince's Foundation, which involves stakeholders and the local community in shaping a vision for a place in an intensive design enquiry where every issue is tested by being drawn. The fundamental difference between an EbD and the conventional design/planning process is that EbDs are simultaneously interactive rather than sequentially reactive, as is usually the norm.

Enquiry by Design is a crucial element in achieving sustainable communities, delivering masterplans, campus plans and significant buildings based on enduring design principles, and developing the place-making skills of all participants in the workshop process.

## HOW DOES IT WORK IN PRACTICE?

The Enquiry by Design process brings together the key stakeholders of a proposed development to collaborate in articulating a vision for a site or place through an intensive workshop, facilitated by a multi-disciplinary design team. This will normally include local statutory agencies and authorities, landowners, local community and voluntary groups, representatives of employers, retailers and other interest groups. This is not just a means of informing the community about a planned development but actively engages them in the planning and design of their community, helping to build up the confidence and collective enthusiasm to allow the vision to be taken forward after the workshop has been completed.

Because the Enquiry by Design process relies on extremely concise and concentrated

effort over a relatively short period of time, assembling the right information is critical. The whole exercise will normally include extensive preparation and a lead-in period of five or six months to the actual workshop is usual. The list of information typically gathered prior to the workshop includes:

Technical information from the scale of the site to the regional level, and relating to relevant policy, economic, social and environmental conditions; constraints' and detailed studies of the local/historical built form and street patterns, sometimes assembled in the form of a Pattern Book. Also; local people, politics, communities, transport and movement networks, placemaking, physical resources, employment and regeneration, ecology, flora, fauna, historic buildings, archaeology and microclimate.

The number of days required for an EbD can vary, and by its very nature there can be no such thing as a 'generic EbD' since every site is different. However, it is normal for an Enquiry by Design to run for five working days and to be preceded by a number of preparatory sessions, to begin to explore key issues and to familiarise key stakeholders with the process, ahead of the main workshop.



Drawing: Relationship of five minute circles from local centres



Photograph: EbD Workshop

**The EbD workshop structure will include:**

#### **DAY ONE**

##### **Exploring Key Issues**

Technical briefings Site Tour Initial Structure Plans

#### **DAY TWO**

##### **Testing of Initial Concepts**

Multiple Masterplans Point of maximum confusion/creativity

#### **DAY THREE & FOUR**

##### **Agreement & Development of Vision**

Sign-off of Vision Consolidation of plan Specialist strategies worked up along with detailed studies

#### **DAY FIVE**

##### **Production & Final Presentation**

Resolution of any outstanding political, delivery and funding issues  
Production of final plans and drawings  
Communication to general public

The number of participants in a workshop can range from around twenty through to several hundred and this varies at different points throughout the workshop. Landowners on and around the site, local politicians, relevant council officers and local community representatives need to be involved as they are the key decision makers. Without their backing the exercise would be largely pointless. Along with the Foundation's design team these parties form the Core Team for the workshop and attend all sessions.

Representatives of any group with an interest in, and knowledge about, the site should also be involved as well as any regulatory bodies that may have an important influence over the site's development. These groups form the second tier of participants – those who can actively input technical knowledge into the evolution of the site design – and will be invited to attend a number of key sessions during the workshop.

The third tier of participants is formed of anyone with an interest in development of the particular site – typically nearby residents and people who work in the area. This group would normally attend the main presentations on the first and last day of the workshop.

#### **WHAT IS ACHIEVED?**

By the end of the fifth day of the Enquiry by Design, the product is a vision for the town or specific site which is shared by everyone who is linked to the development, including those responsible for granting the planning permission. This makes a quick delivery of the plan more achievable in a shorter time span.

# Lessons from Cherry Knowle



Cherry Knowle: Aerial view of site

## STARTING POINT

An existing mental health facility situated in large grounds of an original sanatorium. A plan stood to parcel the site, demolish the heritage building, rebuild the mental health facility as a single stand alone building, run a wide strategic road link through the middle of the site, and sell the remaining land off to a developer for housing.

## WHAT WAS ACHIEVED

- An integrated masterplan for a mixed use development, which: incorporates a new mental health facility within a new village extension; is well connected to the existing settlement and preserves existing built heritage; transforms the proposed bypass into a street with active frontages and designed-in traffic calming; meets the needs and

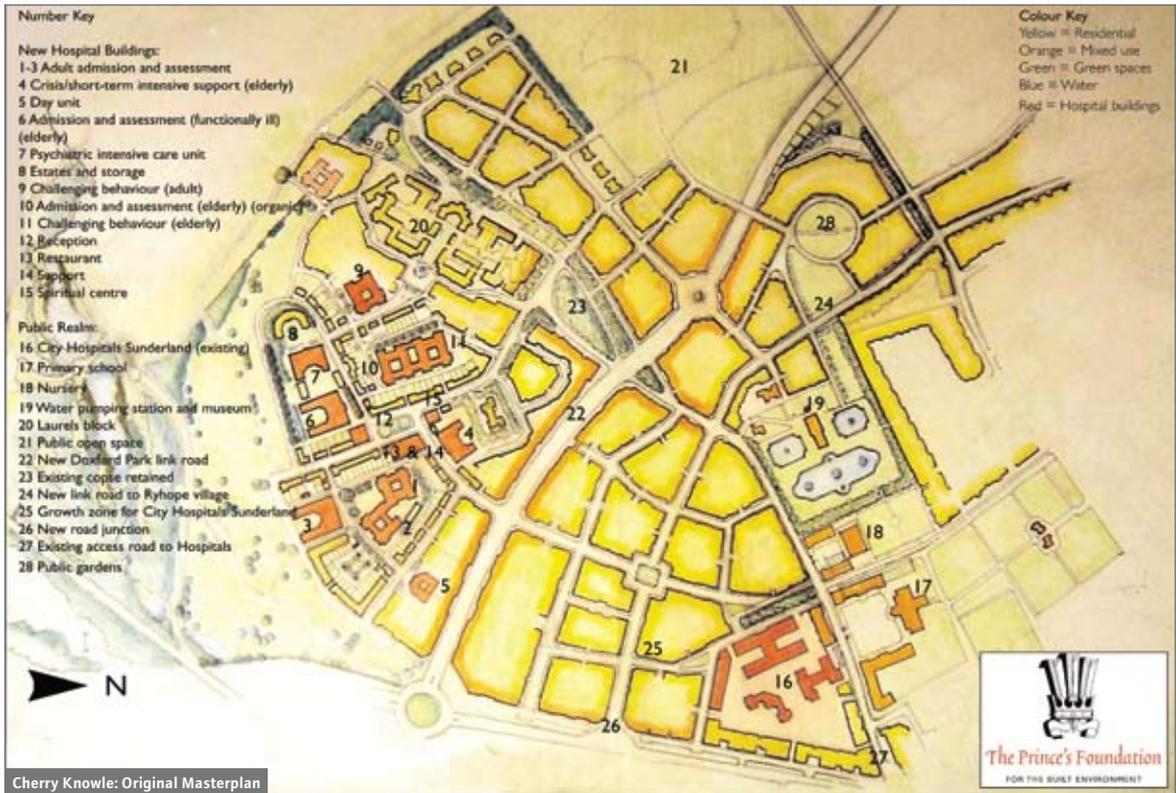
aspirations of all stakeholders – (a model for sustainable development).

- An 'integrated' and innovative new mental health facility, tested with key stakeholders, including clinicians and carers where a six stage spatial recovery strategy was developed in order that the building proactively aided the gentle recovery of patients from a private room to a public street (a new model for a non-secure mental health care facility).

## KEY LESSONS

- The level of innovation was a direct result of the EbD process; without key stakeholders being present at the time that new ideas were put forward, they would not have been able to be developed in such a comprehensive and integrated way.

- To run a five-day (single stage) EbD successfully, it is necessary to have the support and engagement of all parties. In the case of Cherry Knowle, this took six months to set up, partly because it was the first EbD pilot but also because the local authority were wary and it was difficult to get them on board due to the amount of time needed from them and the perceived potential conflict of interest.
- For connected, outside-the-box thinking to take place effectively, it helps to get people out of their normal settings and create a new creative dynamic on the site where issues are less easy to abstract.
- Healthcare investment can be used as a catalyst to leverage change and regeneration for the surrounding area and community.
- Single issues such as default highways, zonal planning and traditional healthcare models can be overcome and improved for the benefit of the end user by means of an holistic and integrated approach to design.



Cherry Knowle: Original Masterplan



Cherry Knowle: Revised Hospital Layout

# Lessons from Sutton

## STARTING POINT

- *The Site of the existing community hospital had been selected as the site of the proposed new Critical Care Centre, part of a major re-configuration of local services under the Better Healthcare Closer to Home programme, which planned to re-focus healthcare delivery at the Primary Care level, supported by a network of ten Local Care Centres plus one Critical Care Centre (CCH)*
- *Despite extensive consultation and selection of the Sutton site for the CCH through a rigorous formal process, considerable local political argument about the location of the CCH (Sutton or St. Helier) remained; there was also local uneasiness due to existing traffic and parking issues*
- *The Sutton site was part of a health campus including NW Mental Health Trust, Royal Marsden (Surrey branch), and the Institute of Cancer Research. Individual development plans had been halted by the local planning authority pending the formulation of a development plan for the whole campus.*

## WHAT WAS ACHIEVED

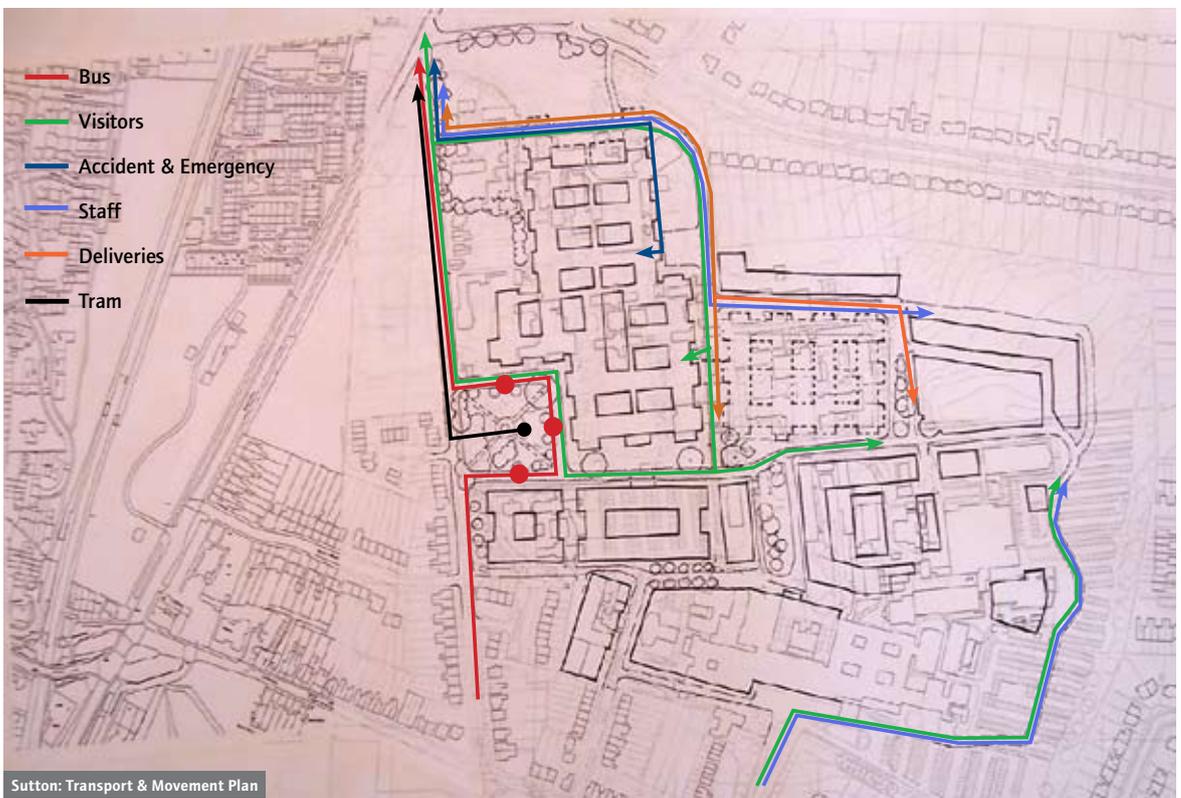
- *The EbD allowed the four health institutions to consider, develop and agree in a short space of time key principles for the development of their joint site strategy*
- *The adoption of the output of the EbD as an informal advice document by the participating local planning authority*
- *The process allowed suggestions 'from the floor' (of public meetings) to be*

*explored and incorporated because they were received at a time and into a process that was fluid and able to explore ideas holistically with the relevant technical expertise to hand*

- *The process allowed those opposed to the plans in principle to be part of the consideration of all relevant factors, and thus gain a measure of understanding.*

## KEY LESSONS

- *If political issues are unresolved when the EbD is held, the subsequent resolution of those issues can lose valuable momentum and confidence established at the EbD*
- *The proposal was robust enough to accommodate a new brief (such as an LCC instead of the CCH), demonstrating the inherent flexibility of a typological and holistic approach to urban design, campus planning and hospital building design*
- *Proximity does not ensure organisations sharing a site talk to one another. Creating a forum for common understanding is key to a successful integrated solution.*



# Lessons from Alder Hey

## STARTING POINT

The Trust's vision was to create a new specialist children's hospital within the local park to create a health park;

- *The over enthusiastic release of early concepts had backfired, stimulating fierce local opposition and city council attempts to direct the new hospital project to other sites according to their own political and regeneration agenda.*

## WHAT WAS ACHIEVED

- *A consensus about the location of the proposed new hospital and the land swap with the public park*
- *Strong local support by engagement*
- *Strong council support by demonstrating an open and robust process*
- *The assembly of parametric design briefing material to inform the Outline Planning Application which incorporated a consensus reached with all key stakeholders (including local community and local planning authority)*
- *A design framework template*

## KEY LESSONS

- *A public process such as EbD can expose hidden agendas in local 'politics' and bring credibility and objectivity to a situation that has polarised*
- *There can be professional reluctance to engage, suggesting the need for communicating the importance of attendance and expected outputs*

- *The voice of the local community is a powerful asset, but needs to be properly informed and engaged*
- *Opposition can be caused by misinformation (such as press articles, which can be problematic) and lack of engagement (an assumption that development will spoil rather than enhance)*
- *That multiple and diverse hospital designs need to be produced in the later stages of EbD in order to set the parameters which are key to a coded approach to outline planning application and design briefing.*



Alder Hey: Hospital Footprint Option A



Alder Hey: Hospital Footprint Option B

# Enquiry by Design in the NHS to Improve Design Briefing



Early group option for Sutton

Enquiry by Design can either be conducted as a single week long exercise, or as a series of shorter workshops, depending on the type and politics of a particular project. The best structure for the exercise will become clear during the scoping and preparation process. The recommendation is to break the exercise into two or three discrete parts when dealing with public buildings.

**In either case, the process has three essential stages:**

1. *Preparation (taking three to six months, depending on the complexity of the project)*
2. *Enquiry by Design Workshops (either one or a series of workshops)*
3. *Report/Design Code (publishing the agreed consensus/conclusions)*

**Potential benefits to the Health Service include:**

- *Improved strategic planning expediting outline planning and business case approval*
- *The creation of sustainable communities where healthcare facilities are integrated into local communities and networks*
- *Improved health outcomes from sustainably planned healthcare facilities*
- *Shorter project development timescales due to quicker decision making;*
- *Sustainable decisions due to fully 'bought-in', informed and educated stakeholders*

- *Corporate citizenship exercised and demonstrated*
- *Public investment leveraged for enhanced community benefits*

**Potential benefits of a Design Framework:**

- *Robust design parameters that allow for inevitable change*
- *Supports the Trust, patients and staff representatives interrogation of bidders design proposals*
- *Is less risky for the Trust and Building Consortia, and less confusing to the public, than a detailed building design which, even though 'only for illustration', can too easily give rise to very real and tangible expectations*
- *Private sector responds well to a brief with clear parameters as it shows where the fixes are. They can focus their efforts on the areas that they are best able to innovate/achieve efficiencies (i.e. the detailed building design, construction and maintenance of the building)*
- *Other stakeholders can move ahead with their own plans with the security of an agreed interim strategic framework.*
- *Whilst the suggested approach to design frameworks is new to healthcare, it has been tested extensively in relation to house building and complex urban design settings by The Prince's Foundation, demonstrating improved design quality as well as speed going through the planning process.*

- *There are a number of issues and challenges to be aware of*
- *Political resistance to a new method – e.g. from local MPs, local councillors, local authority officers, or healthcare trusts who have inherited existing processes*
- *Professional resistance to working 'in the open', for fear of limiting future opportunities*
- *Land ownership and site assembly changes (if critical stakeholders change, the process can be compromised)*
- *Timing issues – with differing timeframes amongst various stakeholders (e.g. statutory agency strategic planning), it is challenging to integrate firmly rigid procurement structures.*

EbD can develop a consensus that embraces technical requirements of a major hospital with local community sensitivities (less easily expressed in a technical output specification terms), and captures this consensus in a drawn form that can be used to directly inform as well as evaluate design proposals.

**NOTE:** The following information setting out EbD for Healthcare is not written as a guide to follow. The Prince's Foundation does offer EbD training where more detailed and structured guidance is given.

# Synopsis of Design Development

## Briefing Process for Public Healthcare Buildings/Campuses



### 1. PREPARATION

#### 1.1 Initial contact and enquiries

To build a database of three tiers of contacts – a) Core Team - the design/technical team & key stakeholder reps (20-45 people max) b) Technical Input/Staff Agencies - the wider range of stakeholders (20-45 people max) and c) all other parties and individuals with an interest in the site/project

#### 1.2 Scoping study

A select group from the core team meet to visit the site, discuss key issues and draw up critical issues and identify information needed for the EbD.

#### 1.3 Technical studies

Pull together all existing technical studies, review and brief consultants and from this prepare short synopsis for presentation at EbD. Commission any critical technical work that is needed for the EbD.

#### 1.4 Preparation of briefing report

Create a clearly written introduction to the site, the project and issues affecting the site. Create an illustrated executive summary of all the technical information so that a full constraints plan can be drawn up for the EbD.

#### 1.5 EbD logistics

Review and organise attendee list and groups, find and book suitable venues and catering for public meetings and design sessions and organise site tours.

### 2.0 ENQUIRY BY DESIGN

#### 2.1 Workshop One:

##### Site Selection and Evaluation

Any potential site or the existing/selected site are studied at a strategic level to assess their appropriateness. This is carried out using a tailored set of both qualitative and quantitative assessment criteria which

are cross referenced (Appendix 2 and 3). Some of the criteria such as movement hierarchy and location of local amenities require drawn diagrams and so this session is run as a workshop in groups in order to gain consensus. (Group C is not involved at this stage).

#### 2.2 Workshop Two:

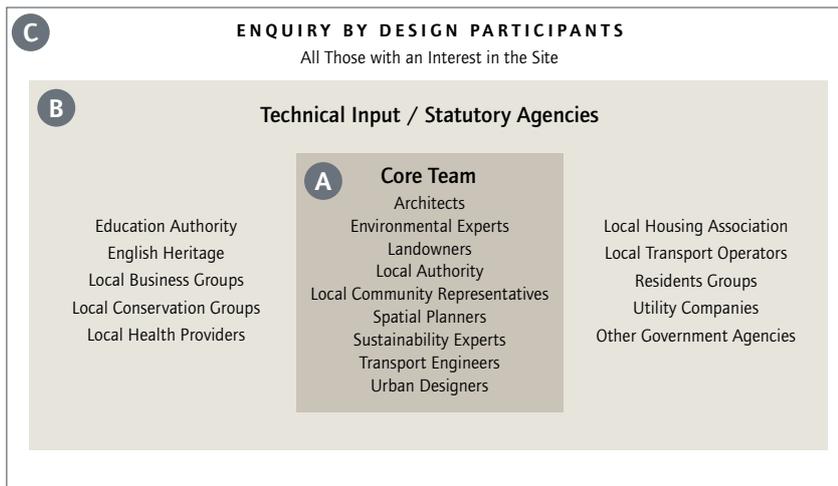
##### Site Development and Context Plan

This workshop is concerned with producing an integrated movement network and transportation/parking plan, defining site ownership boundaries/land-swap proposals/opportunities, creating preliminary phasing strategies, defining boundary treatments and set back criteria to the building as well as massing. It is very important that there is a clear and legible movement strategy combined with an indication of how the proposed buildings respond to this in terms of massing and location. At this stage the usual site analysis in terms of orientation, topography and constraints are studied; they begin to determine what the best opportunities for the siting of the building are, and critically, which general parts of the building are best suited to which location/orientation (for example at Alder Hey- main entrance off main road, main wards facing park crescent with southwesterly aspect etc.)

#### 2.3 Workshop Three:

##### Design Framework

For this workshop a more detailed clinical model and generic hospital layout needs to have been worked up. Ideally two different architects both take the draft framework from Workshop II and in multi-disciplinary groups work up a draft footprint for the



building (one working more on loose fit principles and the other driven more by clinical adjacencies). This should be worked up with accurate dimensions to ensure that vehicular turning circles, wards and corridor widths can be comfortably accommodated. These layouts are refined in discussion with key hospital staff and then the design framework is drawn up in the form of a design code with a clear vehicular movement strategy (suitable for interim adoption by the Local Authority), a clear pedestrian and cycle movement strategy, character areas and frontage standards clearly laid out with building height parameters shown on plan. This information forms the basis of the Outline Planning Application (the requirements for which are becoming more closely aligned with this approach to design).

### 3.0 REPORT

#### 3.1 Interim report

A draft report should be sent out to groups A and B within six weeks of the end of the EbD for comment. The report should outline the process that was undertaken, highlighting key decisions and record a rationale for Opinion selection. It should list the attendees and specifically when they attended. It should also list the public sessions including questions and concerns noted. This important information should be concise or contained in the appendix; the main focus of the report should be the design conclusions which should be drawn up in the proposed template outlined below.

#### 3.2 Full report published

Once feedback has been received and further technical work/checking has been carried out to ensure all parties have understood that the proposed framework is viable, the report should be published, circulated to all attendees in groups A and B and posted on a website or made available as hard copies on the site, or at an appropriate location for view by the general public.

### 4.0 IMPLEMENTATION

#### 4.1 Outline Planning Application

This should be totally consistent with The Design Framework.

#### 4.2 Public Sector Comparator

This should be based on the Design Framework template rather than a specific architectural design.

### 4.3 Design Briefing

A three stage briefing should be undertaken for bidders.

Stage 1 – talking through the design briefing material with a question and answer session.

Stage 2 – Reviewing the layout, plan and massing of the building.

Stage 3 – Reviewing the architecture and details of the building and landscape. It is also advised that the Design Review Panel visit two or more completed projects by the bidder and their design team before submission.

### 4.4 Final review

It is important that the design weighting is properly balanced to take account of the building's adaptability, repair and maintenance over 25-30 years of operation.

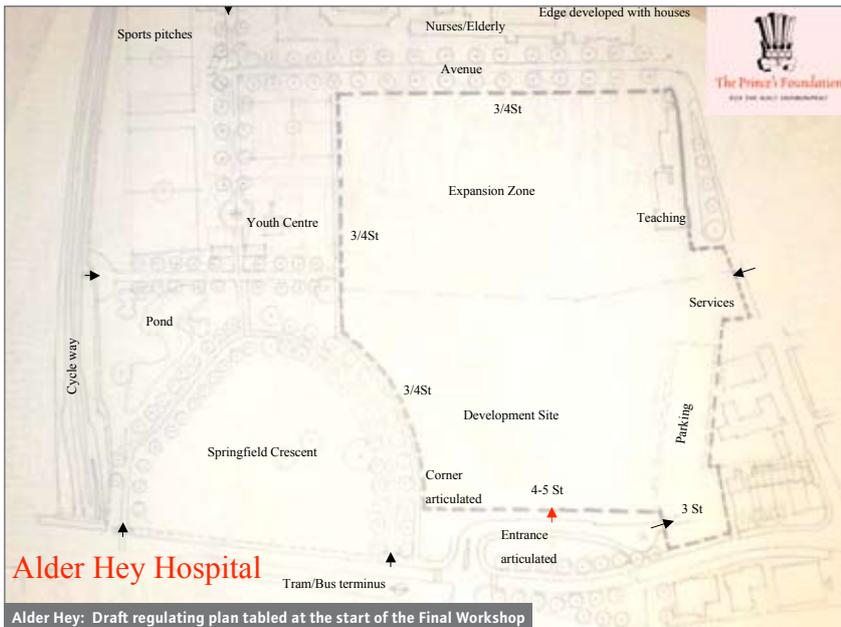
### WORKSHOP ONE

#### STRATEGIC SCALE

#### SITE SELECTION/EVALUATION

This workshop is designed to look at the bigger picture of whether such a hospital building is actually appropriate on a particular site, and if so how is it strategically located to maximise the benefits and mitigate any negative impact on the surrounding neighbourhood.





- Accessibility indices (mapping local population densities and location of health facilities).

## OUTPUT

- A preferred site that will deliver the Trust's requirements and whose selection is supported by robust planning, technical and sustainability arguments
- A basic movement strategy for the site with clear 'front door', 'back door' and traffic entry and exit locations;
- A clear and legible urban layout showing plot boundary lines and potential hospital footprint;
- A public presentation showing the site and rough footprint in order to receive and collate feedback to inform the next stage.

## STRUCTURE

This workshop starts with a series of 2-5 min stakeholder statements and a series of ten minute technical briefings on the hospital brief and design aspirations. Each of the sites or the chosen site is introduced briefly and site plans handed out with qualitative and quantitative assessment criteria attached. Groups of no more than eleven people are assigned and then the bus/coaches set off on the site tour(s) (if only one site is being analysed it is always advisable to understand at least a 1km radius from the site and so a bus tour would be followed by a walking tour in groups.)

Qualities are recorded by a small number of groups on site and quantitative criteria are completed once back in the workshop venue after the site visit/s.

Once back in the workshop venue the participants are split into groups and the site/s are analysed on site plans of the wider context area. First the orientation and site boundary is noted, next the existing primary, secondary and tertiary movement networks are drawn on the plan (in red, orange and yellow), then shops and amenities/significant buildings such as schools etc. are marked (pink and purple) and then green spaces. Once this is recorded the local centres of activity are identified and 500m radii are drawn from these centres with a dotted line and the hierarchy of centres noted from stronger centres to weaker, secondary centres. Once this information has been recorded the criteria assessment can be

systematically explored and quantified and any physical aspects which can be measured or recorded are studied through both drawing and debate.

The groups present their assessment and scores and a master score is collected with the final selection made as a result of reviewing and cross checking the two types of assessment.

## PARTICIPANTS

(in addition to Trust Hospital Representatives, their technical advisors, and EbD team): Policy and strategic officers; strategic agencies; facilitators with strategic planning and transport expertise; health planning and impact advisors; local agencies.

## INPUT

- Trust requirements: outline brief and drawn hospital footprint (however crude) and vision for hospital including the top five design essential qualities/aspirations in order of hierarchy as a reference throughout the analysis;
- All relevant ownership plans including any covenants of restrictions, mapping and topographical data of sites under review, together with all relevant local plan policies affecting the site(s)
- Movement patterns for different user groups (including patients, visitors, workforce, deliveries, blue light) traced over the relevant wider area and mapped against existing movement patterns (TA and EIA available)

## Before the Next Workshop

- Findings released into the public domain and further feedback collated;
- Further focused political and technical investigations based on site and masterplan hypothesis;
- Further technical data collation and testing based on site, movement and masterplan hypothesis;
- Formal endorsement of the site selection process where required.

## WORKSHOP TWO

### NEIGHBOURHOOD SCALE

#### STRUCTURE

Site Development Plan in Context

Evening Before Day One

This workshop starts with an evening public presentation to set out the work from the first workshop and to answer questions from the audience, gauge local concerns, and understand the positive attributes of the area.

#### Day One Morning

The morning starts with stakeholder statements and technical briefings as in Workshop 1 but tailored to the more detailed issues of placing the hospital on the site and creating a coherent and legible public space around it. Any draft/exploratory work from Workshop 1 can also be used to inform the technical briefings. After the technical briefings a site tour is undertaken in groups, the first part by coach to see the surrounding local centres

of activity and then on foot to study the site itself in more detail. Notes should be taken on plans of the site as people are walking around and discussing issues with a group leader.

### Day One Afternoon

In the afternoon the vehicular and pedestrian movement networks are examined in relation to a very basic and typological hospital footprint. Parallel groups are formed with mixed disciplines represented in each group and at the end of the day a review is held in order to agree the positive attributes of the emergent schemes. These agreed criteria are drawn up by the core team in the evening into a 'Consolidation Plan', copied and distributed first thing the next day.

### Day two

The next day groups are formed into specialisms (or related specialisms) in order to test the consolidation plan hypothesis technically. This testing is reviewed in the late morning and the plan revised accordingly in the afternoon by the core group; other specialists who are key to that process work up particular strategies in their area of expertise or undertake further analysis/testing. Although there is a limit to the amount of people who can contribute to the consolidation plan, specialists need to be 'on-hand' to answer technical questions as and when they arise.

The movement strategy, consolidation plan of the basic footprint, massing of the building and draft phasing strategy are presented to the public in an open evening session with public questions and comments recorded.

### PARTICIPANTS

(in addition to the Trust, their technical advisors, and EbD team)

- Staff, patient and carer representatives, local agencies, local community and group representatives, local business representatives, relevant local council officers in planning, education, social services, transport etc. (general public in 2 public sessions)



### INPUT

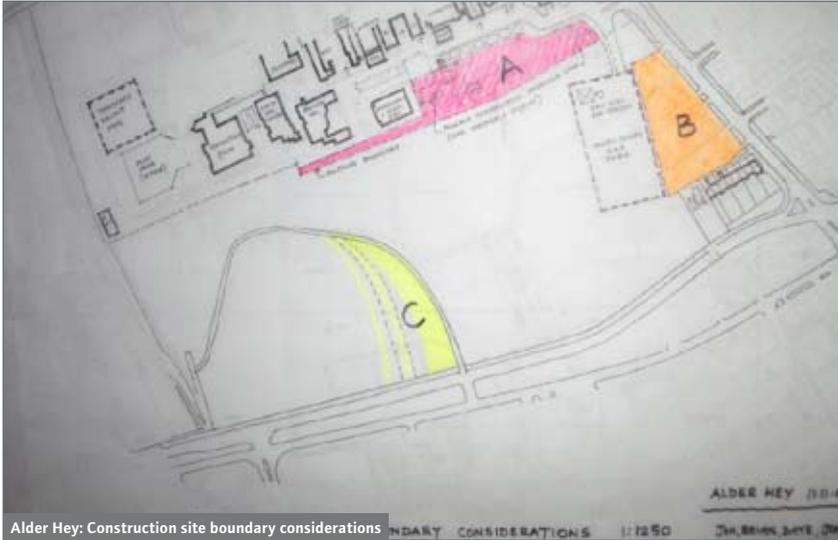
- Key technical briefing given based on hypothesis from Workshop 1
- Local movement network hypothesis refined/minimising conflict
- Strengthening local centres improving local amenities and access/local opportunities
- More detailed site and locality surveys including covenants, etc
- Planning and strategic policies affecting the site and locality
- Testing possible future change/redundancy as options
- Enhancing the public realm
- Legibility

- Civic presence

- Enclosure/space definition
- Positive open space (not left over)

### OUTPUT

- Key principles for site planning
- Placing of building on site, entrances and exits to and from site
- Principal opportunities for development on and adjacent to the site and servicing
- Land use options and phasing, refined plot boundary lines
- Potential local regeneration enhancements/opportunities.



### Before the Next Workshop

- *Technical development/exploration to test the Stage two hypothesis and bring forward technical data and knowledge to back up key parameters to be developed and agreed in the next stage;*
- *Detailed development of hospital plan by two architects exploring deliberately parametric options within constraint hypothesis produced by Workshop 2 supported by clear clinical adjacencies, phasing and flexibility options;*
- *Draft design framework.*

## WORKSHOP THREE

### SITE SCALE

#### STRUCTURE

Design Framework for Building Form, Frontages and Public Space

#### Day One Morning

This workshop starts with the technical briefings of the more detailed movement network, draft building code and the hospital layout/footprint plan which will have been coordinated prior to the workshop to make sure they are consistent together with any other detailed information that has emerged since the last workshop to inform the plan. Although the hospital layout will have been shared and informed by hospital staff, it is important to have clinical staff at this workshop to critique the proposals after they have been presented to create a better understanding of the detailed options with the Core Team. Once these briefings are complete, a movement group, public

realm group and two hospital footprint groups are formed in order to develop the overall urban and building plan further. This work continues in a more focused way with regular feedback sessions and constant dialogue to ensure everyone is kept informed of all new phases.

If a major change occurs or a creative idea emerges then it is important to have a feedback session immediately in order to understand any knock-on consequences such an idea may have; points of creative peaks or 'bifurcation' are an essential and a natural part of EbD and it the EbD leaders' role to analyse the dynamic in order to strongly steer the design solutions towards solutions that have a significant consensus while being grounded in technical achievability/reality.

#### Day One Afternoon

In the afternoon the groups present their ideas which are challenged to inform the Core Team in its production of Design Framework key diagrams in the evening.

#### Day Two

Work continues the next day in the same groups and the EbD leader focuses on the order of the final presentation which is essential in communicating the key issues of the hospital and its role in enhancing the surrounding area. It is important to refer to all the records of questions and concerns from the public sessions to make sure these have been taken on board and responded to during the process. The format and content of the presentation also needs agreeing with the key stakeholders so that they are happy

with the statements being publicly made which can be adhered to after the EbD.

#### Day Two Afternoon

In the afternoon the teams produce production drawings which are then formatted in the final presentation; all drawings are carefully documented and stored for incorporation in the final report and design framework.

#### Day two Evening

A final public meeting is held where the material is presented and again questions answered and comments/concerns recorded. It is essential that technical experts and stakeholders attend this meeting so that questions can be accurately answered and not avoided.

## PARTICIPANTS

In addition to the Trust, their technical advisors, and EbD team (as for Workshop 2)

### INPUT

- *Technical updates/briefing on all issues*
- *Presentation of two parametric hospital designs*
- *Holistic, technical and parametric planning workshop sessions*
- *One public session – to summarise conclusions, record feedback and inform the public of next steps/timelines.*

### OUTPUT

- *Codes for highways and movement patterns to, from and within the site*
- *Strategy for enhancing local networks*
- *Site development control plan, landscaping and disposal plan*
- *Principles of movements to, from and within the building*
- *Frontage Codes to define character and legibility for the building*
- *Construction Code/phasing principles*

## POST WORKSHOP

- *Publication of the EbD report*
- *Preparation of a Design Framework document*
- *Monitoring further technical work as appropriate*
- *Testing and refining Design Framework as part of preparation for Outline Planning Application*

**NOTE:** It is desirable to request information from bidders in the same format so that the design of the buildings can be easily explored like for like and not confused by diverse formatting and presentation techniques.

## DESIGN BRIEFING

It is recommended that the design briefing for the private sector occurs in three stages;

### **Stage One: Talking through the design briefing material with Q&A:**

The design framework needs to be clearly presented to show how and why decisions were taken, along with the people involved in making those decisions. Areas that must be adhered to fundamentally should also be set out in the assessment criteria and those areas where there is more room for interpretation and innovation should be identified. This clarity of briefing is usually welcomed by the private sector as it levels the playing field for bids and offers certainty. What is of critical importance with a Design Framework is that in competitive situations the level of consultation and stakeholder engagement required to create robust solutions is simply not possible for bidders – therefore their site analysis and understanding of local context and issues is superficial. It is possible at this stage of design development that some of the design parameters set out in the design framework may be challenged, or non-conforming solutions put forward for consideration by the panel. If there is a fault in the design briefing framework then all bidders are informed as to the proposed revision. Non-conforming layouts may be considered but should be presented after a conforming layout to show that the framework has been thoroughly explored first and not completely ignored.

### **Stage Two: Reviewing the layout, plan and massing of the building:**

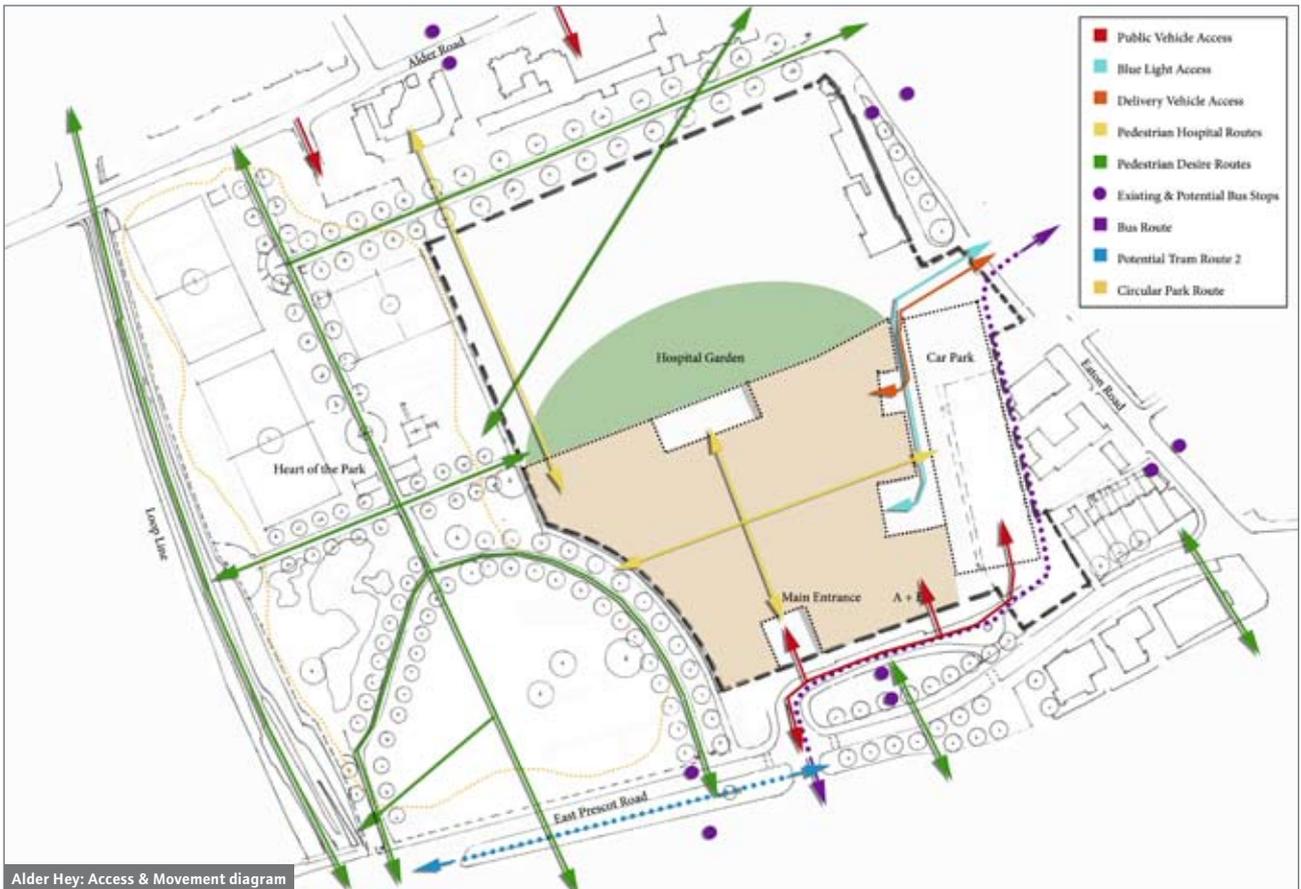
This stage assesses whether the bidder is compliant with the design framework and developing the proposal in the direction and spirit of the briefing documentation. This is critical as the creation of coherent legible and high quality public realm around hospital buildings is notoriously poor and has been identified as an area where skills are lacking within the professions. This stage requires a design guidance and capacity building role as well as a checking role. Once the principles are established

for the massing, layout and form of the building a brief discussion may be had about the proposed architecture of the building and bidders encouraged to look at good local, national or regional precedent in order to set high standards and target for the architecture.

### **Stage Three: Reviewing the architecture and details of the building and landscape:**

This more detailed analysis of the building becomes more personalised and so having a design tool like Audit is important to make sure that guidance is given objectively and not subjectively. However, if a clear vision or design aspiration has been set out by the Trust then this should be vigorously perused. Again non conforming designs may be considered after perusing and presenting conforming options.

Note: Importantly, the use of parametric information as set in the design framework allows a Trust to distinguish between elements of the brief that are 'musts', from elements that are 'illustrative' (not intended to constrict bidders' proposals). An exemplar design solution which is a complete building design will tend to confuse these two.



Alder Hey: Access & Movement diagram

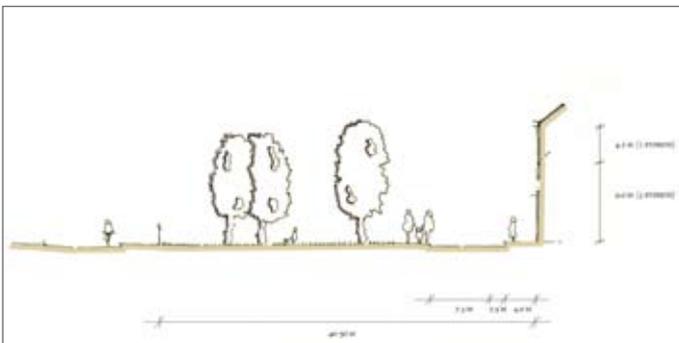


Alder Hey: Green space strategy diagram



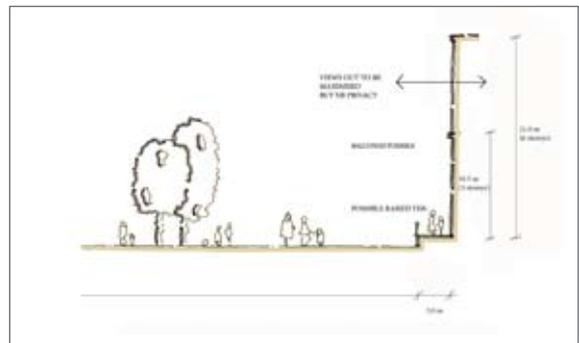
# Alder Hey

## Frontage Conditions—Sections



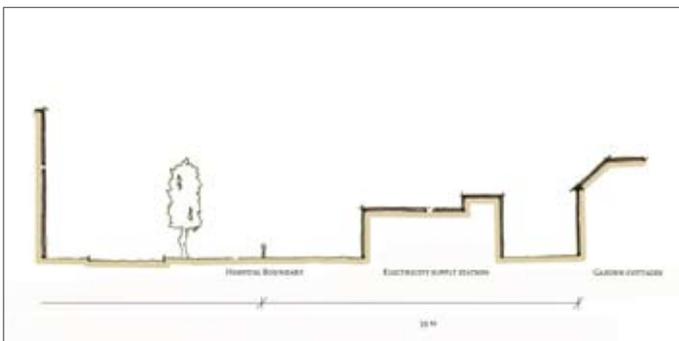
**Section 1: Main entrance front** (East Prescott Road and hospital interface)

The main public hospital entrance, providing efficient and convenient access, a sense of welcome and comfort, and a suitable civic presence and pride (this is an important building, doing important work). The layout on plan will also need to accommodate access and highways requirements.



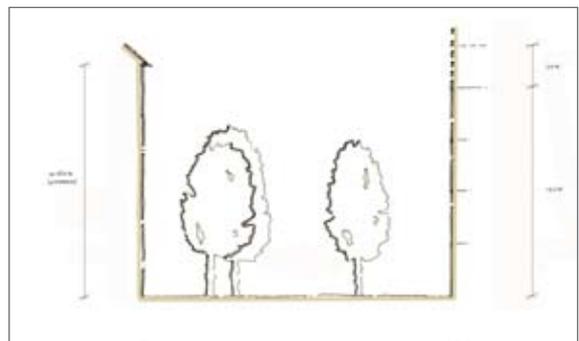
**Section 2: Hospital to public park**

Together with the main hospital frontage, this is the critical elevation, which should respond to the formality of the historic country park, providing positive enclosure to it. Views out to the park from staff and especially ward areas should be maximised, and balconies encouraged, without compromise to issues of privacy and dignity. A raised terrace overlooking the park would be possible.



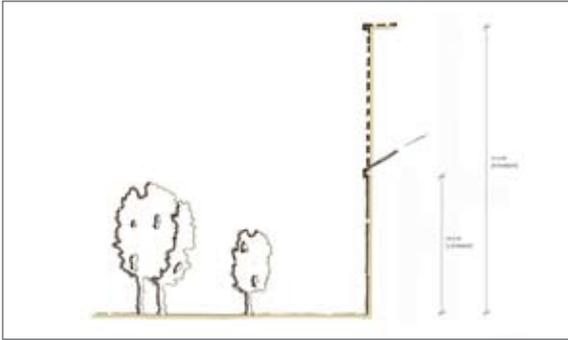
**Section 4: Car park to cottages**

The carpark is to be designed with regard to the impact on the adjoining cottages and service buildings. Suitable planting and screening are likely to be critical.



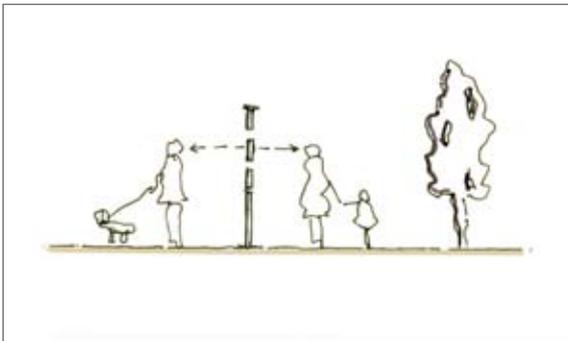
**Section 3: Car park to hospital**

The area between the hospital and carpark should not be 'left over' space, but positively designed. Any working areas that overlook the space should have a positive view of landscaping.



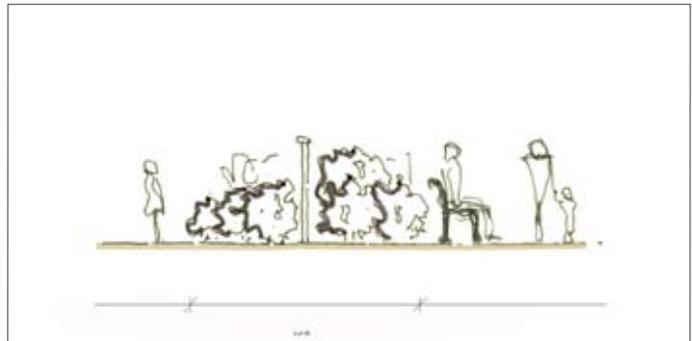
**Section 5: Hospital to health garden**

The design and scale of and access to the external area should be suitable for the purpose of using the area as a therapeutic garden for children. It should also provide a refuge for parents and carers, as well as staff. Covered walkways and pavilions should be incorporated alongside landscape features for play and entertainment. In places a more domestic scale would be appropriate.



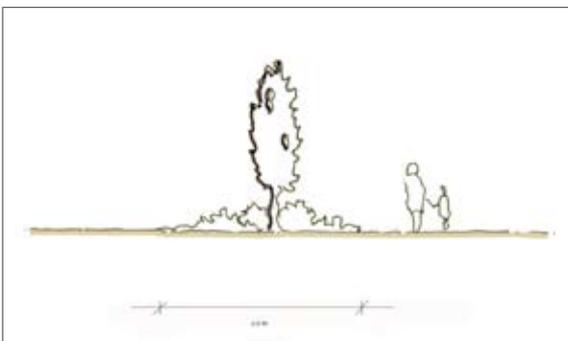
**Section 7: Health garden to public park**

2 m secure boundary - visually transparent, railings/ wall + railing combinations; gated access.



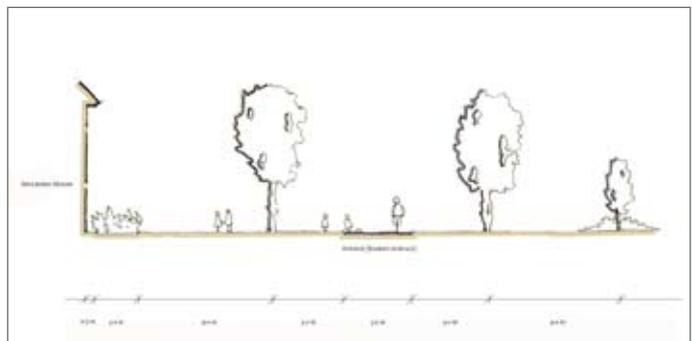
**Section 6: Health garden internal areas**

In order to separate those areas within the hospital external area that are to be used exclusively by patients, carers and staff, and areas to which the general public may gain access at certain times, a 2 m privacy and security screen - (wall and/or planting; gated access) - should be created.



**Section 8: Health garden to Mulberry avenue**

2 m secure boundary with planting + small trees; gated access.



**Section 13: Public access avenue along retained Mulberry house**

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# Appendix & References

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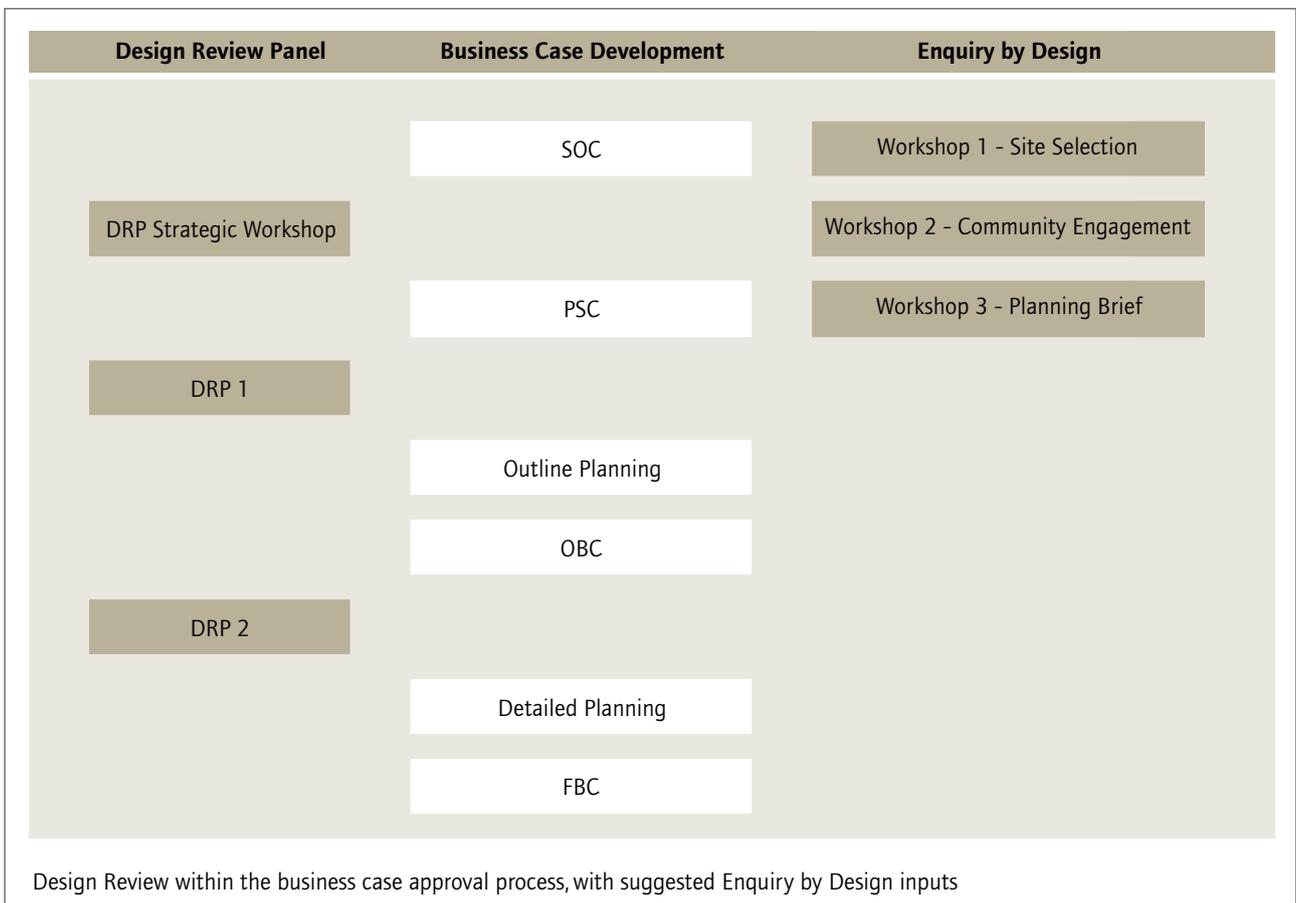
## GREAT BRITAIN GUIDES

- a. *The Prince's Foundation for the Built Environment* <http://www.princes-foundation.org>
- b. *Department of Health* <http://www.dh.gov.uk>
- c. *Cherry Knowle EbD report and DVD available from The Prince's Foundation*
- d. *Sutton EbD report available from The Prince's Foundation*
- e. *Alder Hey report available from The Prince's Foundation*  
*Items c, d and e are also available from the Department of Health's website:*  
<http://www.dh.gov.uk/en/policyandguidance/organisationpolicy/estatesandfacilitiesmanagement/index.htm>
- f. *Securing the future - delivering UK sustainable development strategy (2005)*  
<http://www.sustainable-development.gov.uk/publications/uk-strategy/index.htm>
- g. *Strengthening accountability – involving patients and the public (2003)*  
[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4008005&chk=rVmyFE](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008005&chk=rVmyFE)
- h. *Department of Health: Sustainable development action plan (2006)*  
<http://www.dh.gov.uk/assetRoot/04/13/22/23/04132223.pdf>
- i. *Sustainable Development Commission: Sharing the value – a sustainable approach to the modernisation agenda (2005)*  
<http://www.sd-commission.org.uk/publications.php?id=190>
- j. *Department of Health white paper: Our health, our care, our say: a new direction for community services (2006)*  
[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4127453&chk=NXIecj](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj)
- k. *Department of Health white paper: Our health, our care, our community: Investing in the future of community hospitals and services (July 2006)*  
[http://www.dh.gov.uk/assetRoot/04/13/69/32/04136932.pdf](http://www.dh.gov.uk/assetRoot/04/13/69/32/04136932/04136932.pdf)

## INTERNATIONAL GUIDES

- l. *The Neighbourhood Charrette Handbook* <http://louisville.edu/org/sun/planning/char.html>
- m. *Western Australia Planning Commission - The Enquiry by Design Handbook A Preparation Manual*  
<http://www.wapc.wa.gov.au/Publications/28.aspx>
- n. *Smartcode* [http://www.dpz.com/pdf/3000-SmartCode\\_v8.0%20combined.pdf](http://www.dpz.com/pdf/3000-SmartCode_v8.0%20combined.pdf) (Caution: 53 MB PDF file)
- o. *Participatory Methods Toolkit – A Practitioner's Manual* [http://www.viwta.be/files/30890\\_ToolkitENGdef.pdf](http://www.viwta.be/files/30890_ToolkitENGdef.pdf)

**APPENDIX 1: ALDER HEY PROPOSED EBD SEQUENCE**



## APPENDIX 2: ALDER HEY OUTCOME OF DAY ONE

### OUTCOME OF DAY 1

The groups were asked to rank the sites based on their evaluations, which are recorded below:

Group/Site	Estuary	Widnes	Thingwall	Stanley	Alder Hey
Planning	4	1	3	5	2
Design Group 1	5	3	4	2	1
Movement	5	2	3	4	1
Design Group 2	5	1	3	4	1
Position overall	5	2	3	4	1

### OUTCOME OF DAY 2

The group agreed that the fifth ranking site would be eliminated from the final scoring, which is recorded below (unweighted scores in brackets):

Group/Site	Widnes	Thingwall	Stanley	Alder Hey
Movement	76	80	75	111
	(31)	(31)	(30)	(40)
Design (averaged groups) 2	148	169	157	176
	(50)	(52)	(48)	(48)
Planning	60	70	84	68
	(25)	(27)	(32)	(26)
Total	284	319	316	355
	(106)	(110)	(110)	(124)
Position overall	4	2	3	1
	(4)	(=2)	(=2)	(1)

### CONCLUSION OF SITE SELECTION WORKSHOP

Through a robust process of qualitative and quantitative evaluation, five short listed sites were investigated over the course of the two day workshop. The investigation involved a visit to all sites followed by a series of design exercises carried out in groups. Two of the groups focused on the ability of the site to support the delivery of the Trust's design and clinical vision. The other two groups considered transport and deliverability questions.

**The final conclusion of the workshop was recorded in the following agreed statement:**

The best site for the new children's hospital is the Alde Hey/Springfield Park site.

No other site is able to deliver the Trust's vision for health.

The Wilmere Lane site looked to be the easiest to deliver.

**APPENDIX 3: ALDER HEY: SITE ASSESSMENT CRITERIA**

Site Assessment Criteria	Score (0-5)	Weight	Total (possible)
<b>Procedural (Planning considerations)</b>			
Receptiveness of local authority to a hospital on the site?		2	10
Consistent with planning policy?		2	10
Is the site not in the Green Belt (or a major existing developed site)?		4	20
Is the site within a Regeneration Area?		2	10
Is the site Brownfield?		4	20
Would there be support from the local population and wider health economy?		2	10
Do existing land uses need to be relocated?		2	10
Is the site affected by Listed Building/Conservation Area designation?		2	10
			0
<b>Geographical (location/accessibility)</b>			0
Is the site well located in terms of other NHS facilities?		2	10
Is the site well located in relation to need within the region?		4	20
Does the site have good access to motorway/trunk road network?		4	20
Does the site have good access to public transport?		4	20
Are there opportunities to improve public transport?		2	10
Is the site conveniently accessible on foot/by bicycle?		4	20
			0
<b>Infrastructure</b>			0
Is any major road building required or any access difficulties envisaged?		2	10
Is a significant demolition required?		1	5
Will it be possible to connect main services easily?		2	10
Are there any other infrastructure/regeneration benefits?		1	5
			0
<b>Design Concept</b>			0
Is the site capable of supporting the Trust's vision for health?		4	20
Level access to principle uses (e.g. clinics, wards and outside space)?		4	20
How appropriate would a hospital be in this setting?		4	20
Is there opportunity to enhance the public realm?		2	10
Does the site relate well to any surrounding natural environment?		2	10
			0
<b>Topographical</b>			0
Is the site reasonably level?		4	20
Are adjoining activities compatible with a hospital?		2	10
Is there any contamination on site?		2	10
Would the site be capable of taking development up to 4 storeys?		4	20
Is the site crossed by overhead power lines or other major constraints?		2	10
			0
<b>Operational</b>			0
Is the site appropriate size? (min. 12ha max 18ha)		4	20
Is the site appropriate shape?		4	20
Would there be any security issues related to this site? (e.g. overlooking)		2	10
Does the site adjoin an existing NHS estate/other NHS facilities?		2	10
Is there scope for future expansion and flexibility?		4	20
<b>TOTAL</b>			<b>460</b>

*Should you require any further information regarding any aspects of this report please note the following contacts:*

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