Podcast Transcript - Exploring innovative approaches to repurposing the NHS estate, to improve health and wellbeing

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Robert Simcox

Hello and welcome to the AHR podcast where we engage in captivating conversations about the built environment and its influence on shaping a more positive future. I'm Robert Simcox, a part two architectural assistant and specialise in healthcare architecture, having worked on a number of projects across the UK.

I am particularly passionate about working with our clients to understand their unique needs and designing bespoke sustainable spaces. The NHS is responsible for around 4% of England's total carbon footprint, with 15% made up of emissions from healthcare buildings and facilities. In today's episode, we'll be discussing how we can rethink and repurpose NHS estates to improve healthcare delivery whilst mitigating their environmental impact.

I am joined today by my colleagues Victoria Shepherdson and Gareth Banks, both part of our healthcare team working from Bristol and the Shrewsbury offices. So let's begin. Welcome Vicki. Can you give us a background to your role, please?

Vicki Shepherdson

Thank you, Rob. Yes. Hello, my name is Vicki Shepherdson and I am an Associate Director at AHR in Bristol. I have been an architect in healthcare for about 25, 26 years and it is a specialism that I'm really very passionate about. I have designed buildings from very small, like breast care centres, right the way up to big PFI hospitals. These have pretty much included every single department that you can think of and every single aspect of a healthcare from small community hospitals right the way up to big acute and critical care centres. I have been witness to the very challenging and changing environment that healthcare is now facing and looking for new ways to try and solve some of these challenges.

Robert Simcox

Thank you very much. That's very interesting. So a wealth of expertise there with Vicki and welcome Gareth. Please tell us a little bit about yourself and what you're currently involved with.

Gareth Banks

Thanks Rob. So yeah, I'm Gareth Banks. I'm the head of the healthcare sector in AHR. Like Vicki, I've got over 25 years experience in healthcare design. Unlike Vicki, I've done other things than health as well. I've done education, I've done education, I've done laboratories. So maybe a slightly different perspective on how healthcare fits within a wider context of what we do as human beings and how we occupy space and new space, which is really useful, I think. And I've also worked across the world in far flung places, including Hong Kong and Abu Dhabi, which gives me another perspective in terms of how we sit within a kind of global perspective of healthcare. Thanks Rob.

Robert Simcox

Excellent. Well, thank you very much and welcome both. So I'll aim this towards Gareth in the first instance and then we can dive across to Vicki. How can the NHS repurpose their estates?

Gareth Banks

So I suppose it's set within the context of understanding kind of what works within the NHS and the estates and what doesn't work at the moment. It's quite clear that depending on your point of view, there is insufficient money to fund the way in which we deliver healthcare at the moment. And so in that context, I think it is important to look at the way in which healthcare estates respond to the changing nature. We've just gone through COVID, which fundamentally changed the relationship of people and moved it much more to a sort of a virtual environment. We're here on a podcast communicating, we're all sat in different rooms, communicating quite comfortably. So the sort of spaces that we can envisage, and particularly this is probably a more to younger population, which is less reliant upon direct face-to-face contact, is one of those areas where I think we're only just starting to scratch the surface of what that might do to the estate.

At the heart of that is the notion that the estate is probably too big and probably in the wrong place at the moment and so we need to reduce it and reposition the estate.

Robert Simcox

There's some interesting points there. So just delving a little bit into that. So Vicki, in terms of estates themselves, how can the acute and primary estate adapt to existing redundant spaces?

Vicki Shepherdson

I think some of the more successful masterplanning projects that I've worked on have really looked at the whole estate in a kind of a holistic way and they've tried to separate their estates into different zones. For example, you would have a hot zone which would have your emergency care, your critical care, your emergency theatres, your EUDs within that zone. You would then split up the other zones into kind of elective care, outpatient zones. And then somewhere in the middle, you would have your primary care, which you tend to move off site. And that's very much how we're looking to do that now.

But then also you would have your estates, departments, and your admin. And some of the best masterplans I've been involved with have been adapting those zone or strategies. And then from that strategy, you can quite easily work out which parts of those estate are then become redundant, as they don't seem to fit into any one of those categories, or they're not fit for purpose in some of those categories. By also zoning out as well, you can look at your car parking, where your emergency drop-off would be, would be around that emergency red hot zone and then around some of your kind of more elective care, you can look at more actual car parking, how people visibly get there and bus drop off and things like that.

So I think that's certainly one place to start. And then from that very good concept, you then start to delve a bit deeper and start to look at it in more of a kind of a granular level and actually what these buildings then can do if they are there in that position. If they don't work in that position, you make that big decision to move them out.

But part of all that, you're looking at your expansion zones as well. What is going to expand? Your hot side probably is going to expand. People are coming to hospital with more and more things. Whereas on the some outpatient, primary care things, like Gareth previously talked about, those have been done much more remotely these days. And by looking at that cold end, you can then free up some of the estate. That's certainly my experience. I don't know how you feel about that, Gareth, whether you've come across that zoning up of hospital sites.

Gareth Banks

Yes, and I think again when you look at the way in which healthcare needs to move, it's very clear if we want to really save money we need to stop people getting ill which means a much better access to primary care, much better access to diagnostics and that again at the heart of that is the notion that you don't have to give up a whole day to go and sit in a waiting room at a remote site in a hospital for

a 15 minute consultation. How can we get to the point where you might be going out for lunch and you can get that 10 minutes?

Part of that really comes back to, and again I think this is where we have to look at the opportunities that COVID has potentially given us, is there's an awful lot of vacant space now within town centres. Retail has taken a big hit which is often unfortunate for the retail sector, but from a primary care sector there are plenty of opportunities there in shopping centres and within the town centre which would not have previously been available.

So for instance I know we've done projects over in Sheffield and Leeds where we've looked at introducing sexual health clinics within shopping centres. Again that destigmatises those things, they're much more discreet, more easily done to. And again we've also had opportunities to look at kind of health centres as well in those facilities.

Robert Simcox

There are some really, really interesting points made there by both, both yourselves. And it does lead me into my next step, obviously with sustainability, being a key driver at the moment, obviously we touched on the, the, the opportunities to try and limit people getting ill by having access to primary care and so on. And then Gareth, you have then touched on, what I was going to ask next. So I'll pass it over to Vicki and it's the opportunities that we have around developing a sustainable NHS by that reuse of existing buildings. What opportunities and advantages do you see in doing that?

Vicki Shepherdson

I think if you go back to what I was talking about earlier about this outpatient zone and these consult exam room areas and then also looking at how we can use technologies these days to benefit that. I think it's about actually building what we need on the site and then also maybe not creating 15 consult exam rooms, maybe it's creating five or six pods that a consultant can go in and remote talk to someone else in their own home.

For example, that would work for the elderly population or it would perhaps work for people who can't get in, people with some autism or neurodiversity, how they don't have to then come into the hospital, which can be a very scary and terrifying ordeal for them. And I know we're certainly looking at that a lot and some of the projects they're working on. It's about perhaps using the space better. Some of this old estate that we have doesn't really work that well now for healthcare.

One example is, the project that we're working on where there needs to be a massive floor to floor zone. And then there needs to be a massive zone for the M&E to be able to get their duct working. We don't have that in our old estate. They really are very limited. So it's how we can then use that estate to its best. So maybe it is kind of more your outpatient-y materials. Maybe is more office and admin-y with these pods for the healthcare. And then maybe some of that stuff that isn't working, maybe it is knocked down or sold off and bringing more revenue into the hospital.

So I think there's some other ways that we can certainly use the advantages in technology to bring people into the hospital virtually without them having to make that ordeal or that horrific trip into the hospital. So I think that's a very sustainable way of looking at it, minimising travel, selling off the estate that's not needed, reusing what we can in an easy adaptive way. Look at the projects I've also worked on. You get so far down the line with the refurbishment and it won't work because you can't get the MRI scanner through that door or you can't get the duct working.

Why are we making those into old spaces? Why don't we create new spaces for those and push some of the other spaces, which can be adapted, the less clinically higher spaces, not your theatres, but your outpatient abdomen into some of these more older spaces. That way we're definitely reusing as much of the estate that we can. I don't know how you feel about that, Gareth and Rob?

Gareth Banks

I'm just thinking do you think there's an inertia there and a culture within NHS estates, trust estates teams of being reluctant to get rid of property?

Vicki Shepherdson

Yeah, definitely. Yeah.

Gareth Banks

I think we've all been involved in schemes where they look at the business case, the business case says it'll be more efficient if we knock this building down, create a new building, it'll be smaller, and then at the end of it they don't knock down the original building because you never know when you might need that space.

Are the incentives there to have to run a smaller estate, in the way in which trusts are remunerated and funded.

Robert Simcox

A lot of that comes down to obviously the decanting of the spaces and healthcare estates, they get funds for new proposals and so on. However, there is always tends to be a backlog which needs to go somewhere. And that is usually what will infill those existing buildings and so on. And this brings back to that point that Vicki said about zoning and are those existing spaces suitable for new development, probably not because of those things touched on, such as your MEP servicing. However, the opportunities to utilise them for staff spaces, for changing facilities and so on and so forth. There is potential value in utilising those not quite up to standard spaces for such services as those. So there's definitely some merit and so on within that.

Beyond that then, in terms of the NHS sort of net zero targets, obviously when we're talking about refurbishment, there's still a drive to meet the net zero targets. What's your experience on having those refurbishments and then those refurbishments actually being upgraded to meet that set out by the net zero carbon in terms of a fabric first approach.

Gareth Banks

I think the difficulty is that when you look at the whole life carbon impact then clearly refurbishments should always be your first option. There's been a lot of carbon already invested in the structure it doesn't make sense to just discard that and then replicate that carbon investment again on new structure but I think as Vicki pointed out to the reality is a lot of these buildings just are not capable of necessarily accommodating that or it requires a much more radical intervention. So if you take the example that you gave Vicki of the floor to floor heights, I was involved in a project that was actually in Hong Kong which was turning a residential tower into laboratory space and the way we did that was that we actually knocked two floors into one to get those heights.

So you reduce the capacity and it does require significant structural intervention. But actually suddenly those 2.4 metre or 2.8 metre floor to floors are giving you 5.6 meters floor to floor and it becomes much more workable. But it does require an acknowledgement that you're going to significantly reduce the capacity of that building.

Vicki Shepherdson

It requires buy-in, doesn't it, from the whole team? And actually, at the beginning, that's the wisest move, isn't it? But like you say, there's always resonance from the estates team or from whoever, just to realize that that's actually, we're knocking out a floor. Are you crazy?

Gareth Banks

But again, when you look at the way in which it's measured, it'll be measured on the energy going forward. I don't know that there's a calculation that necessarily says if you reduce the embodied carbon by this much, that will offset. Or there'll be some financial, you know what I mean? It plays into it but it's a theoretical position rather than an actual position. That's again probably something that has to change if you want to make more of that.

Vicki Shepherdson

I think also that the problem I have, not a problem, I saw no problem with it, some of the challenges I face with it are we do such piecemeal parts of some of these big sites. We end up just refurbishing maybe one ward or two wards or three wards. And I think sometimes there needs to be this look at the site as a whole and what can we holistically do to make the whole site better. And maybe if we do two wards of that refurb, we look at the MEP for the whole block.

But then the budget goes up. So, you know, sometimes it's that initial kind of capital input for further down and then like a phased development internally how it would then work without blowing the budget, which is always kind of the problem, isn't it? We always come back to. But I think the piecemeal approach that we do sometimes does make that really quite hard to kind of achieve that net zero when we're just refurbing one ward. But, you know, these are all challenges that we love and enjoy and carry on through to the next project.

Gareth Banks

But again I suppose the context is, we've seen it with other initiatives, it's very difficult to apply large scale funding to the NHS without a really significant political will. You know, we have to be pragmatic probably for the next 10 to 15 years at least. We're going to be faced with funding which probably only provides for small-scale intervention. And again, we just have to get creative with how we do that, challenge clients and estate teams to the assumptions they're making as part of that. And indeed, in some respects, challenge clinicians. We've all been in that conversation which says, as you said at the start, we need 15 consult exam rooms. Actually do you need 15 consultancy rooms?

Vicki Shepherdson

Yeah.

Robert Simcox

I think they sort of touch on that sort of relocate the decentralisation of services and so on and not pulling them all into one space. But is there opportunity to decentralise some of those services, take them further afield offsite? And I know Vicki touched on before the opportunity for outpatients and so on and so forth. So that it maybe frees up part of that estate for reuse. And it may be that the existing healthcare estate has sufficient service spaces and so on.

Gareth Banks

So I think the key part of that, I think is looking again at, in terms of as we take spaces and clinical spaces outside of the traditional settings of acute hospitals sites, is looking at ways in which we can combine them with other community facilities to make them work. So for instance, Rob, we've got direct experience of that with the project we're doing at Cross Hands, which involves obviously not just the kind of GP's but also library and police are in there as well.

Robert Simcox

Yes, yeah so it's a collaboration isn't it of multi services all under one roof.

Vicki Shepherdson

There's the Abbey area one that we did, didn’t we as well, where that was much more of a community centre. And I think, unfortunately, our generation is very different to the generation that went before us. And you see that generation used to go to the libraries and they used to make that very much going out experience, seeing each other. But it's kind of bringing that now into these community centres and mixing some of those sectors up a bit and making them more of like health and wellbeing centres.

It's got your libraries in it. It's got your community centres, like your yoga spaces, or it's got maybe an outpatient in it and a doctors in it. It's making them multifaceted so that actually they will be a success because there's so many different things into it. And I think going back to years and years and years

ago when we used to have real communities and we all looked after each other. And these centres can be the heart and the hub of that again. And I think the Abbey area one is absolutely stunning. Well, the example of what that is and what that looks like is really something that I think we could all strive for, and we could build more of those.

But it's bringing in the primary care and it's bringing in some of the acute care and it's bringing in lots of other different people and bringing them all together under this one umbrella, which can only benefit, and as Gareth said, it's making people healthier, benefit everybody, can't it? And it's destigmatising that, oh my God, I've got to get to the car park, when I get to the car park, where am I going to park, when I get to this site, where do I then go? Some people just walk to these community centres, which has to be beneficial for everybody. Hopefully.

My wish is that we create more of these as we go forward and we can build on the experience that we have so far on those and start to create more. Maybe even try and drive some of these, some of the developers and try and drive some of these forward.

Robert Simcox

Yeah, some very interesting success stories that both of you have mentioned. And they both sort of revolve around pulling these bespoke health care environments to the centre of an existing urban environment, or potentially in the example that Gareth used, the residential zones were actually built upon after the proposal for the health care centre was put forward. So that niche of making sure that these hubs are the centre and have multiple sectors within.

Gareth Banks

I don't know to what extent again planning changes are required on that. I mean again, we're acutely conscious of the shortage of housing. Some in the region of about 300,000 houses a year is what's required. But I don't know whether as part of that the ability to provide these community spaces through 106 agreements etc. are really pulled into that. Is there a quid pro quo? Because one of the difficulties you're going to have with GPs in particular is when you look at the typical GP ownership model, they will own the premises. They would probably inherited it from a senior partner 25, 30 years ago. They're paying peanuts on the rent. And then when you ask them to go into albeit purpose built significantly better facilities. The rent hikes are significant, which often would invalidate that. So I think we have to find ways of getting those subsidised rents in to allow GPs to take advantage of that, so it becomes desirable.

Vicki Shepherdson

Maybe it's providing some of those pharmacies in there to give them, you know, some of those out, you know, obviously everyone goes to the pharmacy, don't they? Usually straight after the doctor's and it's 20 miles away if you are where I live. Or maybe it's putting nurseries in some of these, you know, bringing loads of sectors together. And loads of people, maybe from my generation, which also would want to use some of these spaces. I couldn't tell you that when I went to a library, but I could tell you, you know, it was only last week I was at the doctor's surgery. I think it's about bringing all these together so they have a desirable place for some of these doctors to move to.

Maybe they can park there. No one can park at my surgery. But I think it's making them really desirable. So that they do want to move there, but you're never going to get over that, are you? That small rent that they have at the moment. But maybe selling it as somewhere where there's more throughput that people would actually want to go there.

Gareth Banks

Well, or you in effect, other people pay a slightly higher rent or I don't know. I mean, I'm just, I'm sure there are commercial ways of doing that. Or as I say, you know, if it's done as part of a housing development, the build costs, you know, don't play part of that. It just needs a bit more invention, doesn't it? And innovation in terms of the funding models for those to get it to work a bit better.

Vicki Shepherdson

You can always put a gym in there. It would be a great idea, wouldn't it? Go to your gym and then go and get your health check. And then all that time you've dropped your child off at the nursery. These are all things that would make it very appealing to many people, wouldn't it, on very different things. I'm dropping Nan off at the library. It's all sort of planning my future here. I think it's about making them very desirable and, like you say, giving them subsidised rents for having these other paying services within them.

Robert Simcox

Some good case studies that you've raised on that and some opportunities to go forward on that. In terms of the challenges then of repurposing health care facilities or other sectors into health care facilities, all these mixed use developments then.

What are the key issues or key challenges that you find or that you're finding in the current workload that you've got?

Vicki Shepherdson

I think with me it's repurposing the existing building. We get so far down the line and we find that actually it's going to cost a lot of money to refurbish that space into a high acuity, high clinical space. When actually there's a new build next to it which would probably fit that purpose and we can move some of that admin out of that space and put it in the next space which actually would suit that better, would suit more that kind of cellular division.

Which a lot of these older spaces do, they don't tend to be the free spans, they tend to have lots of low bearing walls. And it's about thinking a bit outside the box. And maybe we don't use that space for a wall, but we use maybe the other space for a wall and put their admin and stores in this one. I think that's where I've come across that we get so far down and then we need three escape stairs. There's no way that's going to get three escape stairs in that because you've got patients in it. So that becomes hard and then you add more and more money to it and then it becomes unfeasible.

So I think that's a challenge that I face where it's not really going to work from day one. And we try and make it work. Where actually we just need to think about it a bit more holistically. Maybe the two buildings are adjacent to each other. How could they work together? A lot of times you're putting offices in, like lots of big clinical spaces where actually they would suit better going somewhere maybe a bit more adjacent in an existing building and use, you know, the technologies that we have available to connect into the other one.

Gareth Banks

I think you're right. The key elements of that is decanting. So again, if you're looking to repurpose existing clinical space, for the duration of the work, you've got to move people out potentially into temporary accommodation, which is very expensive. On the other hand, if you go for something like administrative space, that's much cheaper to provide. So for instance, at Telford Hospital, we've just converted the first floor of one of their admin blocks into three new elective theatres. Fortunately, it was done on the nucleus template. So to some degree, the architects had envisaged that degree of flexibility. But certainly, it's some portacabins within the hospital grounds for the duration of the work to allow the admin staff to move out.

That was tied in, I think, with new entrance and admin accommodation which is attractive from a retail perspective works well for and again it's cheap to provide from an office type accommodation but that's created the right space and the right proximity to the existing theatres and make a massive difference to that.

Vicki Shepherdson

We could only benefit the staff, can't we? If they've got all their clinical facilities all close together, if they can work much easier within that area. Surely if all your spaces are in one and you're not walking

down one, but now more massive corridor to get to somewhere else, past a plethora of admin spaces, that's only going to be benefit to the staff, isn't it? So yeah.

Gareth Banks

Maybe this isn't really relevant but I'm just thinking if, as we're doing new hospitals and I suppose at some point we will be delivering new hospitals in whichever form but creating those kind of soft spaces whether it's initially through welfare or whatever which means that if you want to expand you're not having to knock down clinical accommodation, it's a pretty sound strategy to adopt, isn't it?

Vicki Shepherdson

Yeah, definitely.

Robert Simcox

I suppose there's an ever-changing brief as well that the clients drive which obviously doesn't give you that when you've got the robust or the rigor of an existing building to work within. Having a flexible brief or the opportunity to house a flexible ever-changing brief can bring with it its own complexities. You've got a finite amount of space that you have to work within.

How we do repurpose those spaces and everything with a changing brief. In terms of when we're talking about refurbishments. When we look at that, obviously it involves works to adjacent spaces and existing services and so on. So how have you found the disruption to neighbouring services and how have you dealt with that, when having to interact with that sort of environment?

Gareth Banks

I think as a design team, we're a bit limited in what we can do. I think ultimately it's probably down to the level of communication with the contractor that they need to be able to speak to. And I suppose to some degree the estate's team, they need to forewarn people what's likely to happen, what the impacts are, and then keep them informed.

Vicki Shepherdson

Yeah, it's always communication, yeah.

Gareth Banks

I know on a previous podcast we had a with the Swansea Bay, they were talking about, you know, even just bringing tea cakes and things in the evening, just softens that role. You know, the reality is clinical staff are very resilient, as we've shown time and time again, professional, adaptable but they need a little bit of notice before they need they can exercise those skills and I think that's that's probably the thing that you really need to get right.

Vicki Shepherdson

I think one of the most, I've done quite a lot of emergency care refurbishments and obviously they don't shut at any point, but they obviously are expanding and expanding because more and more services are then coming within the ED department. Obviously, as we all know, ED departments are getting busier and busier. And the job that I worked on was creating another ward space within that.

And there was a great site person. And literally, every beginning on a Monday, he would be going around and he would collect all the people from the surrounding areas and sit down with them and tell them what's happening. And they'll be saying, okay, it's going to be really noisy on Monday, Tuesday, Wednesday. It's going to be really pants. It's going to be awful and terrible, but we will finish on Thursday and Friday. So actually, the people put up with it because they knew it wasn't going to go on for two weeks. They knew it was going to be three days. So actually, they could stomach that because they moved patients, which would obviously would not be able to tolerate that to the other side. Do you know what I mean?

It's just kind of forewarning them what's coming. And, you know, as we all know, if it's something drilling all day and all night, it's going to get on top of you because you also don't know when it's going to end. But if you are told it's going to end on a Wednesday, you can kind of stomach it, I think. So, and like I said, the staff are amazing, you know, people working in that environment anyway. From what I found, the communication is the key. Telling them what's going on. And it's going to be rubbish, but at the end of the day, you're going to have an amazing facility that we're all going to be super proud of.

And also, you know, getting them to put the site gloves and the site hats on and walking them around the site as well and saying, look, it's growing, it's going to be really good. This is going to be your staff rest area. This is going to be where you're going to see patients.

I think there is that kind of communication. And as I got in a kind of expanding on what Gareth said, that is the key to kind of making it a successful project, bringing them along on the journey with you.

Robert Simcox

Have you found then that when a contractor is bought on board relatively early in the design process, have those jobs tend to have gone a little bit smoother and run a little better than those when contractors are bought on late on and their involvement is more of a, this is what you're getting design and build this. Have either of you got any experience or?

Gareth Banks

I think there's still a little bit of suspicion in the relationship between client and contractor. I think if we talk a lot about collaboration, I think if it is genuinely collaborative and each party trusts each other, I think that's what you need. So if you bring the contractor on and accept his suggestions as to how to make life easier and that's not just about how he makes more profit. That is more useful. And I think by the same token, if the contractor accepts that the client has a great deal of difficulty confirming decisions and sticking to decisions because as you said before Rob, you know, stuff changes, you know, on a daily basis. I think it's the attitude which it brings, I think. I think there's definitely benefits, I would definitely say should bring them on earlier but there's no point just doing it for the sake of doing it, it's not a panacea, it requires investment and trust to make it work in that context.

Vicki Shepherdson

And I think it's like you say, bringing them into some of the user group meetings and understanding why we have designed where we have designed it. It's not an architectural whim a lot of the time. It's actually to fulfil a need that that person needs within that space. They need that clinical washroom basin to be there, they need that window. I think it's them understanding the nature of the design, how we've got to there. And those have been some of the more successful projects where they have come into the user group meetings and they've sat there and they've listened to the days, what a day a nurse or a doctor was involved in and how they use those spaces. Those have been by far the easiest and the smoothest ones. And it's not just been all the architects doing that. Well, no, we haven't. We've done it because the doctor or the nurse or whoever, the manager wanted it like that. And that's why we've done it. And then nine times out of ten, the penny drops and they go, oh yeah. And they're like, yeah, that's why we've done it. So those have definitely been some of the better projects, but it can't be a token gesture. You have to be in it. And sometimes that can be a bit tricky.

Gareth Banks

The opportunities are enormous. I mean, we've done projects involved in one down in Cardiff, which is looking at a Grade II listed building that's slowly declining. If we're successfully getting the funding from the Welsh government, that will generate a brand new health and wellbeing centre, which brings that building back to life.

From a sustainability point of view, it means that we're really, again, repaying the investment of carbon there. And we're placing the health facilities right at the heart of the community and really making it work but we have to have that vision and not just kind of go for the easy option which is to throw up another another building or

Vicki Shepherdson

Yeah.

Robert Simcox

It’s quite interesting job that one because it's got a history of being a hospital. So to retain that use as healthcare and those sorts of facilities is great for that community because there's a legacy and a history that's maintained then and that will pull that historic identity and maintain that which is quite quite key I think in creating an identity of a space, especially when over a period of time.

Gareth Banks

You have to be careful. That's not putting operating theatre into it and stuff. It's using spaces. As you said, Vicki, a lot of health care that we traditionally think of requires high degrees of servicing. But actually, consult exam rooms, it's just an office with a sink, really, isn't it? Yeah. So.

Vicki Shepherdson

No, they don't, do they? Or I just say, yeah, or it's a hotel room. That's all it is. It doesn't need to be anything else. And I, you know, I do fight, hand up a level, whatever the phrase is, to kind of make them, no, no, no, they don't need, they're not cutting someone open in this space. You're just saying hello to someone and looking at their knee or looking or pressing in their stomach. It can be a hotel room. There's no reason why it can't be a hotel room. There literally is no requirement.

And actually, putting your patient at ease so they can feel they can talk to you is nine tenths out of the problem. Amount of times I walk in a doctor's surgery, it's pastel pink and I sit in a plastic chair. It's just phenomenal. Whereas if I walked into a really nice, and it doesn't cost the money to paint the wall lovely or use a different furnishing. Some of this healthcare kind of stuff is really expensive. There's no reason why it can't be a plasterboard ceiling. Some of this stuff is, we're paying over and above because the word clinicals in it.

Well, actually, this isn't clinical. It's just a room where you're talking to someone. So, yeah, and so, you know, old buildings are great for some of those kind of more community outpatient services.

Robert Simcox

So when out of both of your experience, when do you find it more expensive to convert an existing building as opposed to building new? What would be the key factors you would look for in an existing building, for instance?

Gareth Banks

I think it's always going to be cheaper to convert. But the relative cost savings against the sacrifices that you make in doing that often make it unpalatable. You're not saving half the cost. You may be saving, you know, 20% of the cost or something. It's where I think it's really difficult. So I think something like Cardiff project is a really good example where there's real benefit to that. And to some degree that the health board is on a bound to protect that building. So they have to invest that money. I think it becomes a little bit more difficult in a asbestos ridden 70s block that is in the wrong place on the site and actually just needs to be knocked down. I mean sometimes knocking it down is the right answer, but I think it shouldn't be the default answer I think is what we're really saying.

Vicki Shepherdson

I think it's about us as architects challenging them as well and saying, are you really, you know, is this building the right building for this? Why are we choosing this building? Why are we choosing this location? Could this not be put somewhere better? I think it's around, we are architects, we know our buildings, we know how they work. Some of the other people that design the briefs or put the

allocation to where that building is, don't know buildings as well as we do. So I think sometimes it's about really challenging the need for that building to have that function in it and is that the right one?

And access is key. How are we getting patients in? How are we getting patients out? How are we getting MEP in? How are we getting MEP out? Basic stuff that you need to do from day one and fire. Fire and access are the two ones that cause the biggest headaches for me personally in reusing the existing building because a lot of the time it's getting an inpatient person in a bed from one area to another area.

It's not acceptable to take them outside. You can't do that. Especially some of the places I've worked, you can't do that. And you can't get them to put in an ambulance to patrol them around the site to go somewhere else. So access, I think, is key access. And then, you know, and then once you've got that and fire, it becomes a bit more palatable. But I think it's challenging the brief and making sure it is in the right place and it's the right thing. And then it's looking at the building itself. How are we getting the people in? How many people out on all those kinds of things? I think.

If you get those two things kind of working together initially, I think you're then on for a bit more of a success. Rather than going, oh, this won't work now, we can't get the patients in, how are we going to get the beds in? They won't fit through the doors. Well that's kind of key, isn't it?

Robert Simcox

When then, throw this on its head, when's it better to build new?

Gareth Banks

when you've got an asbestos riddled, leaky roofed, cellular, cellular, with no lifts.

Vicki Shepherdson

You have to go about three flights of steps to get to it. It was so much structure.

When you're putting in a highly serviced building, you can't. I mean, Gareth was very lucky with that. With an operating theatre, you need three metres minimum ceiling to floor to get your hoods in, to get your operating lights in. It's a minimum. MRI buildings, it's really hard to put that into an existing building with a Faraday cage, quenching pipes or how you get the MRI into the building. You know, you've got to reinforce the floor to get it where it is. You've got to put a concrete pad in. Those diagnostic operating theatres and critical care. That's another really hard one, isn't it, Gareth?

Gareth Banks

I think the reality is you can probably do anything you want. It just costs so much money that's not actually creating space. It's just creating an environment that is usable. And I think that's where you really have to think about, is this really the best use of that money? And I think, as you said before, it may well be that you might need a new operating theatre.

But the way to create that operating theatre is to build a new operating theatre and move office space out or something like that as opposed to going well that's where we have to put it because that space is available. I mean we haven't been even touched on kind of masterplanning and hospital development plans you know they don't seem to be to feature too much in a lot of estates thinking.

Vicki Shepherdson

Yeah, but that goes back to the zoning, doesn't it? It goes back to the zoning we were talking about. Let's put all your theatres together. Move your changing out. Move your changing out so there's a direct link, but put it somewhere else. As long as you've got a clean corridor and a dirty in and a clean out, that's fine. But I think it's like you said earlier, Robert, about moving some of those kind of softer spaces and the admin-y and the thing you're about and putting them together. But that creates its own challenges and putting an operating theatre next to an assistant operating theatre and it's all going live. But anyway, yeah.

Robert Simcox

I've got one final query before wrapping up. What are the challenges around working with community partners when adapting spaces and collating services?

Gareth Banks

Community partners. I'm trying to think what you what you mean by community partners.

Vicki Shepherdson

Two different doctor surgeries, two different doctorate surgeries. Yeah.

Robert Simcox

So I suppose in essence, stakeholders, isn't it? Having a multitude of stakeholders, how you manage and mitigate the adverse opinions from each, how you negotiate space. Obviously there is a finite amount of space available.

Gareth Banks

Right.

I suppose you need to try and find compatible partners, don't you? That's probably the trick.

Vicki Shepherdson

Yeah, taking cakes to meetings as well, taking cakes to meetings and biscuits. Get everybody off on the right foot. Have some cake.

Gareth Banks

I think if everybody wants to be there at 9 o 'clock and leave at 5, that's a different proposition from partners who some of them might want to be there at 6 and leave at 3 and others who want to be there from 2 and work till 8 in the evening. And I think that's probably the way to do it. It's almost like marriage counselling, isn't it? There's got to be something there for it to work. Like you say, if it's two people who just hate each other, there's nothing we can design that will really get that to work.

Vicki Shepherdson

And it's really hard doing it in silos. I've worked on projects where I've got a doctor's surgery coming in and then an outpatient clinic. And they wanted to create their own empires and their own environments and they were constantly pulling apart and the building was getting bigger and bigger. They both had their own staff rest, they both had the same reception. And actually it was really hard, but getting the two in the same room and saying, look guys, this building ain't going ahead because we can't put you both in there at the moment. We haven't got the space.

How about you have one reception desk, you have one end and you have the other? And actually when they start talking to each other, rather than using us as kind of a battering ram, it then starts to work. But that's really hard to get them into the same space to talk about it. And actually, there's lots of Chinese whispers that go on between them before you get them into the one space. And then that becomes, you know, you do have to take a lot of cake to get that to work and promises of cake and bacon sandwiches to kind of get them there.

But those have been the ones that have worked out better when they can actually see why the other person wants that space and why the other person wants that space. And then they can eventually try and work it out together. Otherwise, if they're in silos, the building doubles in size and everybody wants to be on the ground floor. So it becomes this like grand bungalow that's not going to work. So that's my experience is eventually trying to get them together and then be the mediator between them.

Robert Simcox

Yeah, I suppose it's again, it's about getting everybody around the table early doors to understand, to take them on that journey as to say, look, this is, this is the opportunity that we're presenting you. This is what, what we want at the end of the day. And it's about understanding their needs, their aspirations. And then it's about, I suppose, that's what we're good at is, is designing buildings around them, for them to make sure that they use, to make sure that if certain stakeholders require certain opening hours about positioning them right in the building so that they get that opportunity. So the architecture works around that. So the patient flows, the movement flows and everything follows suit from that. And it's about, like you said, get them around the table, have those discussions, bring tea and cake and make sure everybody gets what they want in the end of the day.

Vicki Shepherdson

I think it's sometimes about reminding them because you know you get your head down don't you? Why they're here. We're here to provide service to patients and to people and remind them and I know the project that we're working on in Shrewsbury we have a lot of focus groups, don't we Gareth, and actually listening to what actually they want from a hospital and the patients want from a hospital not just what the clinicians want which you know don't get me wrong that's very very important but the end of the day it's a service industry that we have to provide to the to the patients and listening to them a lot of the time and reminding people why you are here and what you are doing.

We are that person in the middle trying to help the clinicians, we're trying to help the patients and sometimes it's reminding them that these are people that you're dealing with because I think day to day you have to forget they're people because of the nature of their job but it's just reminding them these are actually mums and dads and people that you are looking after here.

And I think that can be a great kind of like catalyst for them to be working together. So Bob or wherever isn't going from one side of the hospital and then to the other side of the hospital and then to the other side of the hospital, Bob just wants to come to one place in the building because Bob's hip doesn't work. It's sometimes reminding them that what you are doing and why you are here, which sounds a bit obvious, but I think sometimes these people are so busy and they're so passionate about what they do, it gets a bit lost, I think. That's certainly been my experience, anyway.

Robert Simcox

So some really interesting points there and I'd like to thank you both. That brings us to the end of today's episode of the AHR podcast. A big thank you to Vicki and Gareth Banks for joining us and sharing your experiences.

We hope that our listeners have enjoyed this episode. You can find all podcast episodes on our website or you can subscribe via your preferred podcast platform. Thank you very much for listening, and we look forward to you joining us again next time.