Aspects of health centre planning

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A PURPOSE designed building offering primary patient care is an attractive proposition and one which, not surprisingly, has caught the imagination of general practitioners and public alike. Several health centres have now been built and many more are in the process of being planned.

Curwen and Brookes (1969), who obtained information from the various health departments concerned, stated that some 93 health centres are now in operation in England and Wales. They also estimated that about 300 statutory health centres would be available by 1971. These would provide accommodation for one in 15 of all general practitioners. A national development of this nature requires a substantial and co-ordinated effort. Yet most of the work is being done by a multiplicity of planning teams throughout the country each working in isolation. There is little exchange of ideas or experience. Less information has come forward from the health centres already in existence than might have been expected. There are still wide gaps in our knowledge of health centre design and the best operational policies for such units have still to be described. The need for reports, however incomplete, on the problems encountered by health centre planning teams, is important. New ideas must be put forward, experience exchanged and mistakes avoided.

The need for a greater dissemination of information has been stressed by Cammock (1970) who is qualified in both medicine and architecture; Stevenson and his colleagues (1970) who reported a symposium on health centre practice; and a recent editorial article in this *Journal* (1970). As Curwen and Brookes pointed out (1969) 'The real need is to learn from the experience of others and the opportunity for this is severely limited by the lack of information'.

The writer has been a member of several health centre planning teams and has been involved in the various problems they encountered, and in the attempts to find appropriate solutions. These notes on the experience gained may prove of interest to others engaged on similar projects.

The team

It seems obvious to say that all who intend to use the centre should be represented on the planning team. It is easy, however, to overlook a potential user. For example, the local social work department, or the university if further education is to be considered. The team should meet regularly at the same place. One or two visits to existing health centres are a good investment in time. If possible, someone who has had previous health centre experience should be present at all meetings.

The stages

Planning teams go through three main stages. First, there are general discussions of need and of operational policies. These lead to a functional description of the proposed centre and to a schedule of accommodation. This latter document is simply a list of the rooms required, their proposed size, and their relationship to one another.

The architect then prepares line drawings of the unit. These are usually modified

in the light of subsequent discussion. Many doctors and nurses find it difficult to interpret plans easily so a three dimensional cardboard model may be brought into use at this point.

The final stage is concerned with the furniture and equipment of individual rooms. Lay-out drawings are placed before the team showing the position of fitments and movable items in each room. This is important as it avoids awkward arrangements which become a source of irritation later when the centre is in operation.

The architect

The architect should be brought in as soon as possible. The early meetings give him an insight into the sort of unit being considered and, more important, this stops doctors acting as designers. The users' job is to tell the architect their requirements and any special problems in as much detail as possible. It is the architect's job to design the centre based on this information. A good working relationship established at the beginning will pay dividends later when the planning problems begin to multiply.

The site

One of the most controversial points a planning team has to consider is the site of the proposed centre. There are two schools of thought in this respect. One is that the health centre should be beside the local hospital and, if possible, be physically attached to it. This creates a medical service area which allows easier patient and doctor access to hospital facilities. Further, the day-to-day contact of specialists and family doctors is good for all concerned. It has a mutually educating effect which benefits both parties and, not least, the patient.

Local hospitals, however, are not always conveniently situated. Many patients object to travelling any distance to see their doctor. A central site within easy reach of the bulk of the people to be served has much to commend it. There are several advantages. Patients can reach it easily, particularly mothers with babies and young children, and public transport is nearby. If it is beside the main shopping area, then the centre takes on a familiar and acceptable aspect which is reassuring to the patients.

The building

Many factors require to be discussed about the building itself but there are three things which are of especial importance.

First, there should be generous car parking facilities. This must be sufficient for all doctors, nurses, ancillary staff and patients concerned. A staff entrance from the car park is useful. Pedestrian access to the centre should be protected from traffic. A common drive-way with a pavement is less than satisfactory as prams and children have to be managed in safety. A pram shelter near the main door is an advantage.

Secondly, the size of the building is important. Large sprawling buildings have problems of patient flow and the reception area can become congested. Structures over one storey require a lift and many doctors are reluctant to practise from the upper floors. Centres containing 12 or more doctors, therefore, have special problems and it is often worth considering two smaller units rather than the one large centre.

Finally, the building must have a pleasing, approachable appearance. Every effort must be made to avoid an institutional look, otherwise the object of the health centre will be defeated.

Consulting rooms

There are basically two types of consulting room. The first contains the examination

area which can be curtained off to provide patient privacy. The second is a consulting room with a separate examination room which is adjacent and inter-connected.

Much can be said for both systems and each has its advocates. My own preference is for the larger single room as the patient-doctor dialogue is unbroken throughout the whole consultation. If the second design is chosen, however, the examination room should not have a door to the corridor as it may be opened in the middle of an examination. An inter-connecting door between consulting rooms is sometimes suggested. Then a suite of two or three rooms can be used as a single clinic with the doctor moving between the rooms to the patients. Some reservations have to be expressed about this system as such doors can allow noise and conversation to travel from one room to another.

The question of consulting rooms being shared by more than one doctor is often raised. This is beneficial from the economic point of view in that the room is utilized fully and the cost is shared. But it may result in a standardized room, devoid of personality, which is disliked by patients and users alike.

Treatment room

Some confusion may arise over the function of the treatment room. It is designed mainly for the use of a nurse who undertakes such procedures as venesection, injections, dressings and syringing ears. Doctors may also carry out minor operations such as stitching lacerations. Urine testing is *not* carried out in this room. A treatment room has an examination couch within a curtained area and a full range of equipment including a small instrument-sterilizer. Plentiful storage space is necessary as disposable goods have to be retained here. The treatment room must have its own sub-waiting area.

Laboratory

Most health centres are planned to include a small laboratory. Its function is to allow facilities for such laboratory examinations as are appropriate to the family doctor's surgery. While they sound a good idea, laboratories in practice are grossly under-used and are often put to other purposes. Simple tests still seem to be carried out in the consulting room. Health centres are best used as collecting points for the area laboratory service and it is doubtful if a laboratory is really necessary.

Common room

A common room where everyone on the staff can go for a cup of coffee is essential. Here they can relax and enjoy a moment of well earned rest. It must be furnished in a pleasant domestic style and be large enough for the purpose. Access to a pantry containing simple cooking facilities is essential. It is not fully appreciated that in addition to this there should be a medical staff room. The large common room is inappropriate for the informal gathering of doctors. Conversations concerning patients, their treatment and their problems can only be carried out in an area of privacy and this cannot be achieved in a common room. The separation of common room from staff room is often over-looked by planning teams.

Waiting areas

Close attention must be paid to the waiting areas. The commonest planning solution is a central area over-looked by the reception point. It must not be too large or it becomes impersonal, remote and institutional. It can often be split into two sections by the reception area. Sub-waiting areas linked to the consulting suites are useful. Particular care must be taken to make waiting areas pleasant and an attractive decor and suitable furniture are important.

Patient-call systems

The ideal method of bringing the patient to the doctor has yet to be found. Patient-call systems involving lights, buzzers or both beside doctors' names in the waiting room are rarely satisfactory. They often break down, the names may not be easily read due to size or lighting conditions and some patients are easily confused. It is disheartening to see patients sitting in an otherwise attractive waiting room with their eyes glued to a board, fearful lest they miss their turn.

Loudspeaker systems are noisy, impersonal and irritating. They should be avoided. The best system is still for the receptionist to call the patient by name, and escort him or her personally to the consulting room or the sub-waiting area.

Noise

Noise must be cut to a minimum. This is avoided partly by choice of site (a quiet locality), positioning (consulting rooms away from the traffic area) and proper construction (partitions should have the sound reduction equivalent of 4.5 inch brick wall). Acoustic tiles on the corridor ceilings and other noise-producing areas are worthwhile. As much carpeting as can be afforded will also help.

Miscellaneous points

The clerical–office–receptionist staff should be grouped together so that they can assist each other and undertake each others' duties during illness and periods of leave. One should be designated senior and she should act as an office manager. A small room for this person in the office area is an advantage.

A constant complaint from existing health centres is that the record storage section is too small. Provision should be generous and if in doubt it is better to err on the side of over-provision. The type of case record to be used must be decided early. A combined record holder or a lateral filing system, for example, will require more space than that needed for the ordinary National Health Service cards.

The heating system must also be decided early and the economics of the system clearly understood. As far as possible ventilation should be natural. If mechanical ventilation is required, the rooms affected should be clearly indicated by the architect.

Toilets are usually a subject of considerable discussion. They must be suitable and sufficient and in the proper place. Those for the public should be near the waiting area or the entrance. In my opinion urinals should be avoided. One cubicle in each toilet must be large enough to accommodate a wheel chair.

Conclusion

Health centres are on the verge of a rapid expansion and more and more doctors are taking an interest in them. Planning teams are being formed in many different areas to consider the design and lay-out of individual centres. The need to exchange information and experience is of first importance and must be encouraged.

The majority of published work is connected with the function and operation of established health centres. These are valuable but few make references to planning problems or design difficulties. Exceptions to this are the papers of Beaver and Lockett (1969) who reported on the Mansfield centre; Butterfield (1968) who described the steps leading to the Thamesmead project; and Gibson (1970) who recorded his impressions after visiting a series of centres in this country.

A health centre is more than bricks and mortar. Nevertheless the structure and fabric of the building is important as are the relationships of one room to another.

A badly designed unit makes working together difficult. A well planned health centre enhances the atmosphere within which doctors and patients meet and creates a climate which furthers the end of good family medicine. It is the function of all health centre planning teams to strive for this goal.

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Well-woman clinic in general practice

During a four-year period 1,169 women attended a well-woman clinic in a group practice. Eight positive smears were detected together with one case of breast carcinoma, 94 cases of anaemia, and a number of other abnormalities. The clinic is part of a practice cervical-screening programme aimed at regular tests for women in the practice aged between 25 and 84. Patients appear to prefer attending screening clinics run by their own family doctor, and if more practices would adopt such a programme a higher proportion of the female population might be screened, and at a lower cost.

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Biochemical screening programme in general practice: A clinical follow-up

Follow-up studies on 1,041 patients who had a programme of biochemical screening by sequential multiple analyser showed that 64 results were obtained which lead to a change of diagnosis or treatment. If tests had been restricted to those indicated on clinical grounds only 15 of these results would have been obtained. Many problems in the selection, organization and analysis of these tests remain. "Such instruments may ease the physical burden of performing the analytical work and the attendant data processing operations, but the very ease with which they undertake these tasks distracts attention from fundamental questions such as whether they are performing the most appropriate range of investigations and are performing these reliably".

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