Using Design Guidelines for Social Infrastructure (presentation)

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Centre for Health Assets Australasia

USING DESIGN GUIDELINES FOR SOCIAL INFRASTRUCTURE

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USING DESIGN GUIDELINES FOR SOCIAL INFRASTRUCTURE

OVERVIEW OF PRESENTATION

- **CHAA and its Research**
- **Design Guidelines and 'evidence based design'**
- **Australasian HFG Project Development, Parts & Use, Review, Variations**
- **Standardisation – Why? Benefits & Lessons Learnt**
- **Benchmarking – is it possible?**
- **Conclusions**

CHAA AND ITS RESEARCH

CHAA RESEARCH PROGRAMS

1. Health facility standards and guidelines

2. Benchmarking and post occupancy evaluation

3. Capacity building/knowledge management

CHAA AND ITS RESEARCH

1.0 STANDARDS & GUIDELINES

1.1 NSW Health Facility Guidelines

- *continues* development of various NSW guidelines that continue to be translated into the Australasian project.
- *develops* HFG content for use by NSW Health Facility Briefing system

1.2 Australasian Health Facility Guidelines

- *Governance* – all States of Australia and NZ MOH
- *Issued November 2006* for 12 month period of review and commentary
- *Status depends* on jurisdictional requirements

Australasian HFG

Development Parameters include:

- Regulatory environment – mandated or advisory only
- Public and private funder requirements
- Quality/experience/availability of design consultants
- Feedback loops
- Political climate

AUSTRALASIAN HFG PARTS & USE

Website hosting ‘Australasian HFG’

- Commentary (C) – website information/introductory pages, entry point to:

Health Facility Guidelines:

Different purposes/different parts

- Guidance (G) - ‘how to do it’
- Performance requirements/ recommendations (P) – ‘what it should do’
- Advisory (A) – ‘examples of how to achieve it’

AUSTRALASIAN HFG - STATUS OF PARTS

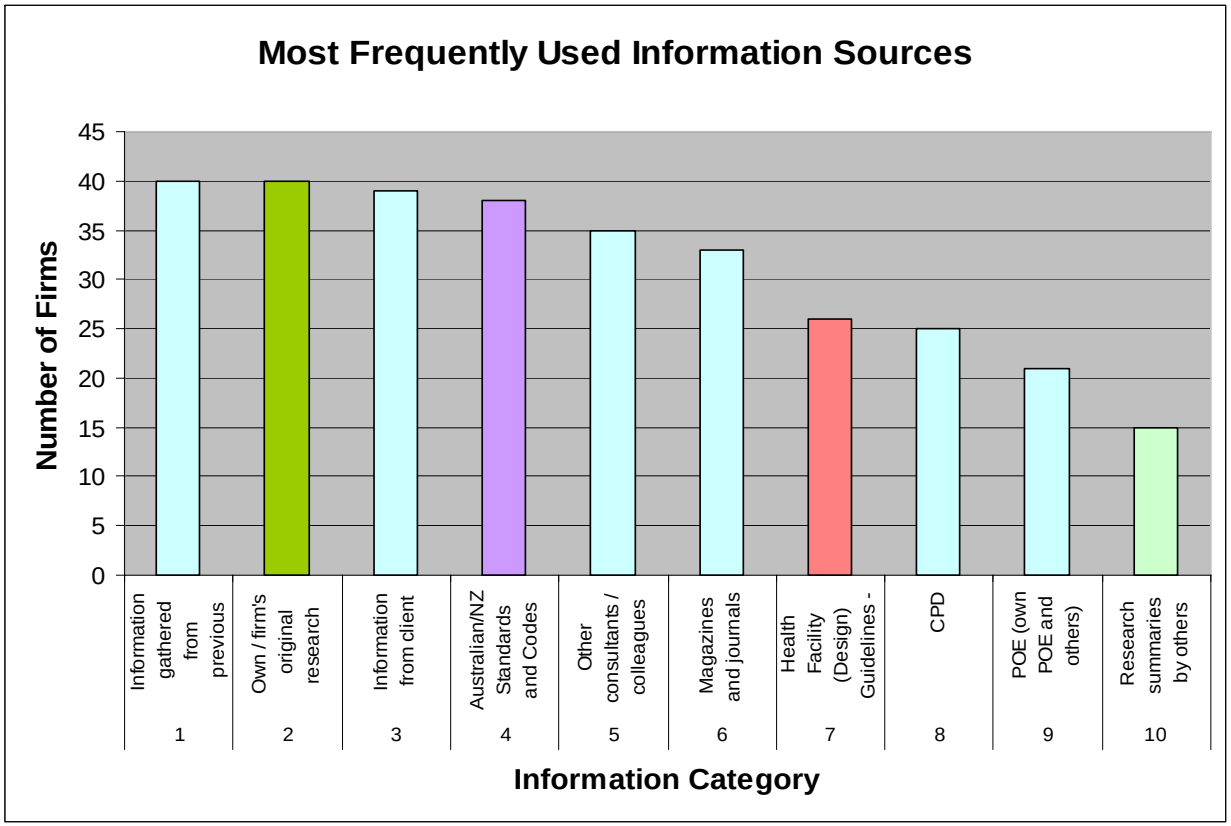
HFG Part/ component	Guidance (G) *'How to do it'*	Performance Requirements (P) *'What it should do'*	Advisory (A) *'Examples of how to achieve it'*
Status	**Not mandatory**	**May be 'mandatory' or recommended'**	**Not mandatory but may be: normative' or 'informative'**
Part A **Introduction & Instructions for Use**	How to Use the Guidelines, Outline of structure, content and purpose of each section, Terms of Reference, Tables of abbreviations, glossary, References and further Reading	Not applicable	Not applicable
Part B **Briefing and Planning**	Section 80 General Requirements (whole section) All HPU sections: -Introduction -Planning Principles	All HPU sections: -Design -Components of the unit: general provisions	Section 90 Standard Components All HPU sections: -Non Standard Components -Schedules of accommodation -Functional Relationship Diagrams -Security Issues/checklists -Other checklists (if produced) -Room Data Sheets -Room Layout Sheets
Part C **Access, Mobility, OHS and Security**	Introduction Planning	Space Standards and Dimensions Human Engineering Signage Safety and Security	Checklists
Part D **Infection Control**	General Requirements Construction and Renovation References	Building elements – hand washing Surfaces and Finishes	Checklists
Part E **Engineering Services**	Introduction (under construction)	Other Sections (under construction)	Checklists (under construction)

AUSTRALASIAN HFG DEVELOPMENT

Does classification of parts matter?

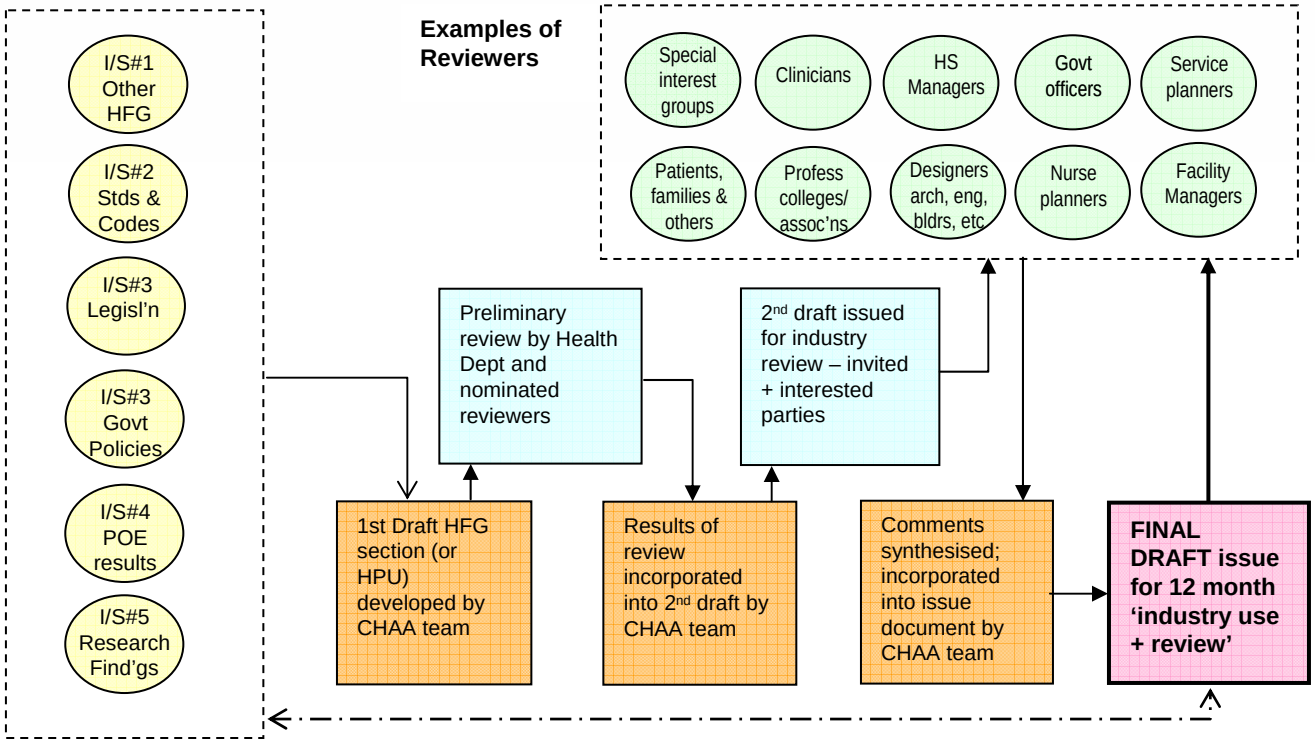
- Some jurisdictions wish to mandate all or part of the guidelines e.g. private hospital regulation
- Implications for the language used – BCA, Standards/Codes, Natspec examples.
- Categorisation allows legislation to refer to only the parts that can or will be mandatory
- Otherwise the guidelines are ‘recommended’ practice only (default position).

HEALTHCARE DESIGNERS SURVEY RESULTS
INFORMATION SOURCES USED



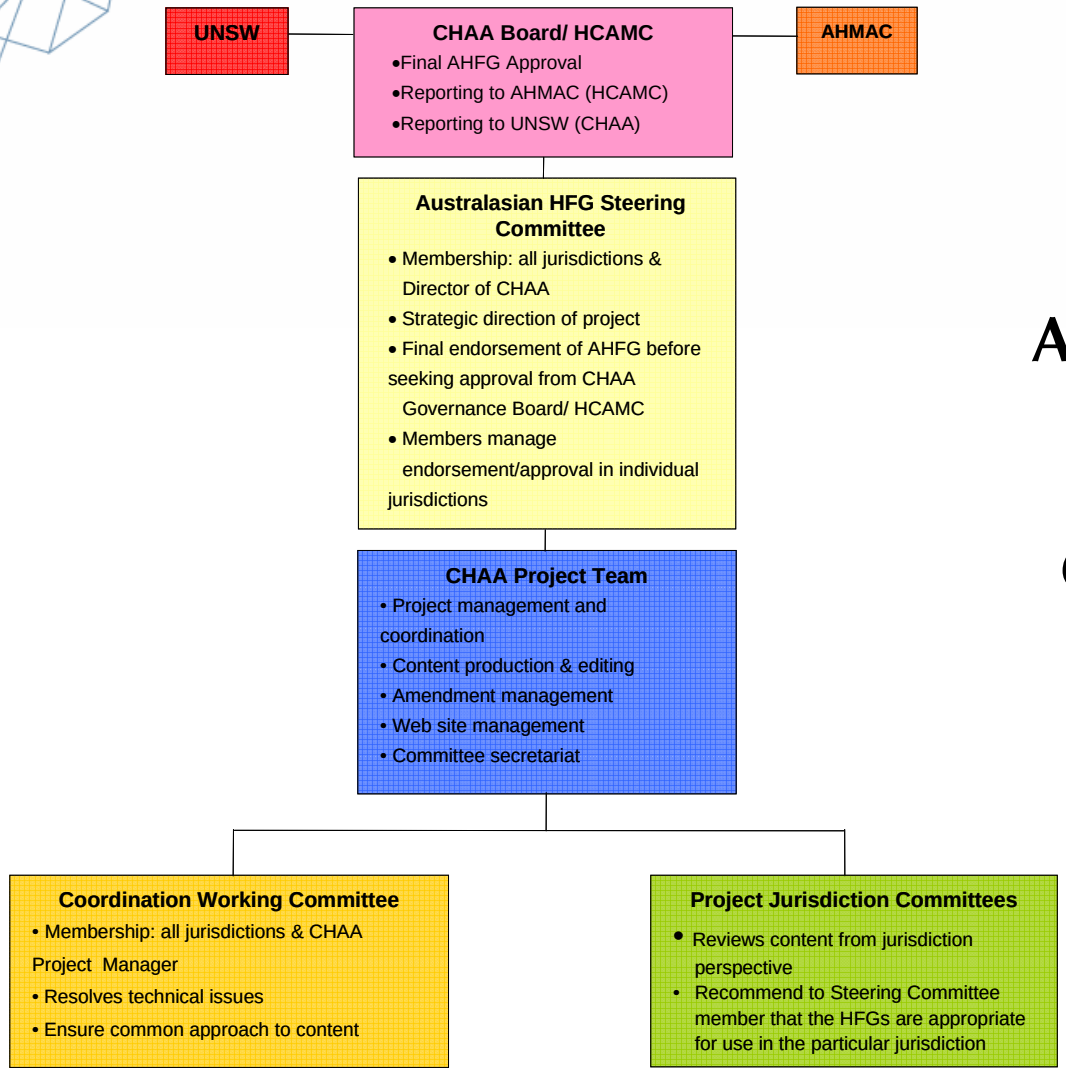
RAIA-UNSW Healthcare Designers Survey, 2006

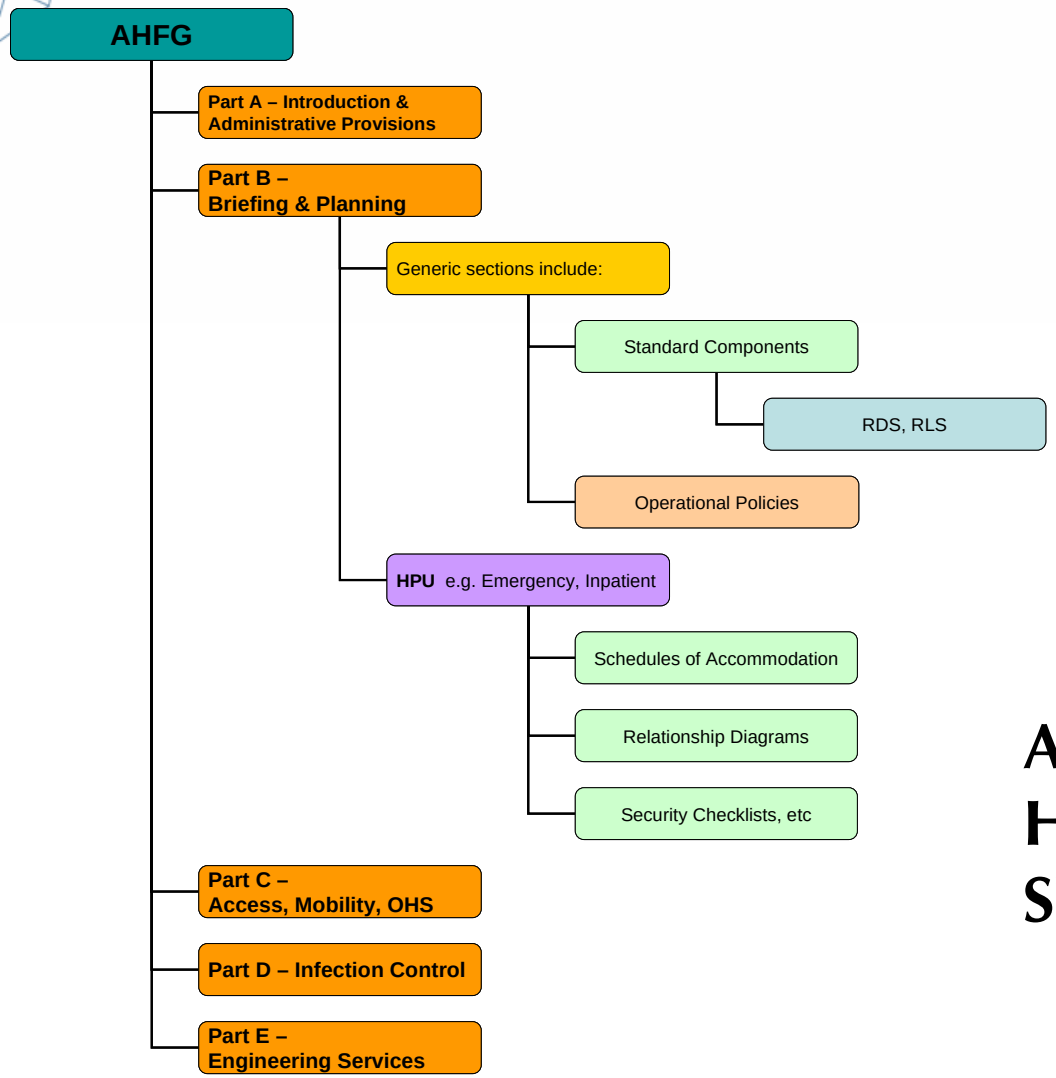
AUSTRALASIAN HFG – DEVELOPMENT PROCESS



Australasian HFG Development Process

AUSTRALASIAN HFG PROJECT STRUCTURE & GOVERNANCE





AUSTRALASIAN HFG STRUCTURE

AUSTRALASIAN HFG FEATURES

- Web access
- Minimal costs to use
- Links to NSW Health Facility Briefing System
- Generic parts that cover all health facilities – std comps, RDS, RLS (PDF format)
- Specific parts for specific hospital units HPU (health planning units) or departments

AUSTRALASIAN HFG REVIEW

Review Process:

- Regular review of all sections – 'sunset dates'
- Standardised commentary form – track comments received/processing/audit trail
- Input from Variation process – Aust/State
- Input from Benchmarking & POE projects
- Input from all CHAA research ie the 'evidence base' – healthcare designers' survey, HAI project, culture and health, etc
- Process of continuous improvement

AUSTRALASIAN HFG DEVELOPMENT

Variations to Guidelines:

- HFG content – handled at Aus/NZ level (CHAA)
- Particular project/State/jurisdiction based variations – handled at State/jurisdiction level
- Suggested criteria for variations (NSW trialling)
  - **Safety** of patients, staff, community
  - **Quality of service delivery**
  - **Quality of facility design** (eg may improve flexibility of use/'future proof'/streamline construction of this facility)
  - **Direct financial benefit** (must be quantifiable)
    - Capital cost
    - Operational cost

A STANDARDISED APPROACH TO HEALTH FACILITY DESIGN

Why do it?

- Body of knowledge can be used on more than one project, available to every project team
- Communicate acceptable/recommended standards to support healthcare delivery
- Purpose of HFG is briefing not prescriptive design
- Some evidence that standard layouts reduce clinical errors in practice

STANDARDISED APPROACH TO HEALTH FACILITY DESIGN

Key Benefits include

- Reduced debate over repeatable elements
- Design process focuses on project specific elements
- Reduced number of design variations
- Consistent quality between projects
- Consultation/user groups more effective
- Assist in meeting minimum legal obligations – standards, codes, etc

STANDARDISED APPROACH TO HEALTH FACILITY DESIGN

Lessons Learnt

- 'Evidence base' required & continuously developed & improved
- Briefing 'starting point', not a design substitute – let designers do their jobs!
- Must be translatable to 'real' space
- Must allow/support > one operational model
- Anticipate the future
- Never finished!

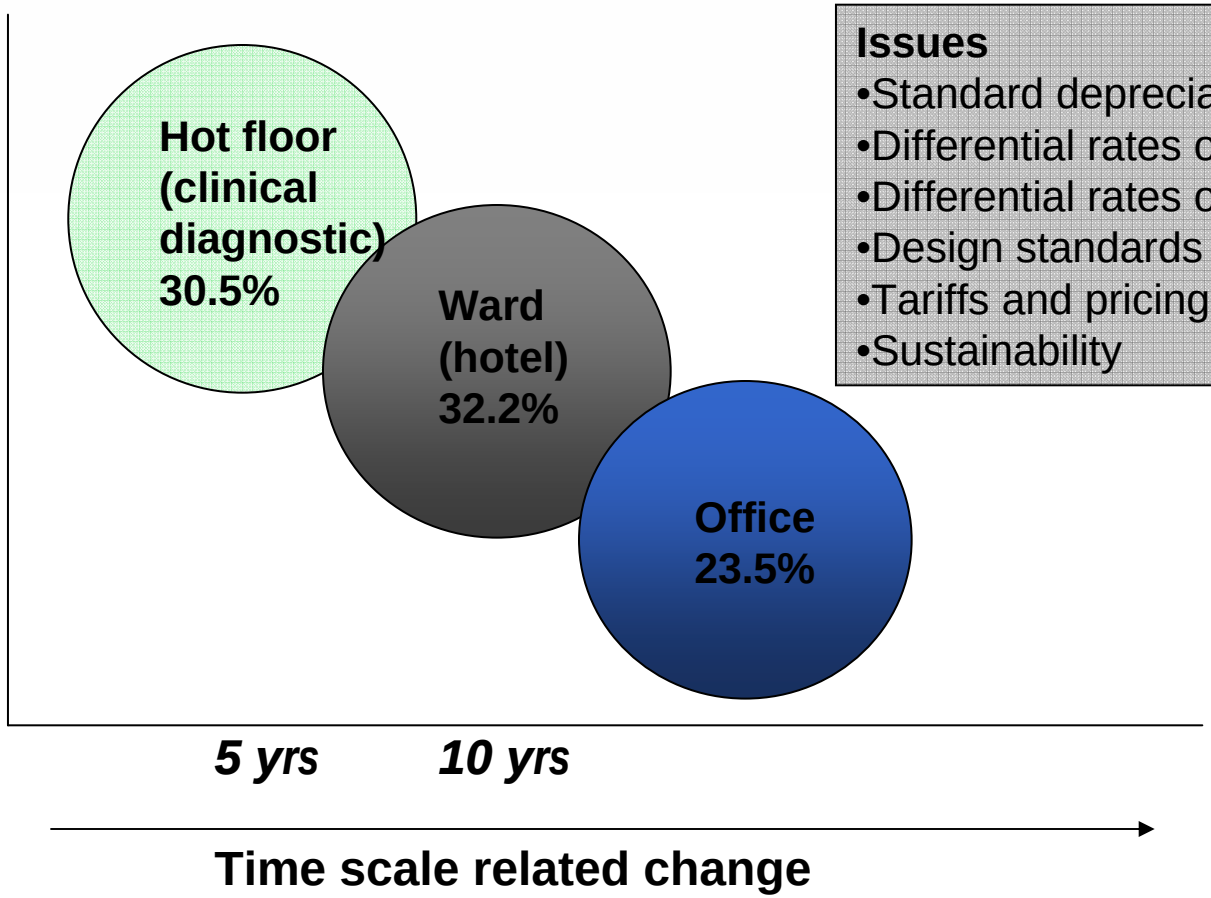
BENCHMARKING HEALTH PROJECTS

Issues

- Very difficult to develop and use appropriate benchmarks
- Requires more robust project evaluation
- Data collected not consistent
- Does not always support innovation
- Cost-benefit analysis for departures (from guidelines or benchmarks) that may lead to innovation
- Should be a source of evidence for health projects to ensure consistency & value
- Support the delivery of better health care – or no point!

BENCHMARKING HEALTH PROJECTS

Whole life value - understanding the cost profile



Issues
- Standard depreciation (25 + yrs)
- Differential rates of decay
- Differential rates of replacement
- Design standards
- Tariffs and pricing
- Sustainability

Technology can account for up to 60% of capital cost

EuHPN, 2006

BENCHMARKING HEALTH PROJECTS

• Towards improved capital effectiveness

From lifecycle cost efficiency
to Lifecycle economic value and sustainability

Integrated capital and revenue budgeting

Work process systemisation

Adaptable - 'good' design - capital models

EuHPN, 2006

UNSW fbe

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AUSTRALASIAN HFG IMPLEMENTATION

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