Strategic Estates Management

The Strategic Estates Management Advisory Platform (SEMAP) is the driving force behind strengthening the Estates Management priorities of the Institute.

NEW INITIATIVES: CONSIDERED APPROACHES

Earlier this year, the first workshop meeting of SEMAP was held in Leeds to mark the beginning of a significant new set of initiatives for IHEEM. The last two letters of the IHEEM acronym had lain dormant but, with the full support of Council and our Chief Executive, Pete Sellars, this new advisory platform was established to explore aspects of healthcare estates management.

Right: *The Strategic Estates Management Advisory Platform meeting at Brandon Medical, Leeds, 2023*

We set out an initial five key aims, and have begun to develop these through three active Working Groups:

The Big Bang of Capital Projects

Lead: Paul Holt

Developing tools and techniques for the very early stages of projects – the strategic front end.

Healthcare Planning

Lead: Suzanne MacCormick

Healthcare Planning: understanding the wide range of differing skills, exploring training and career development, and working towards professional recognition of healthcare planning.

Forum for macro estates management topics

Lead: Pete Sellars

Forum for macro estates management topics.

Current work is based around PFI hand-back and, secondly, the relationship between revenue and capital in projects.

Paul Holt, Suzanne MacCormick, and Pete Sellars, have written further about their respective working groups in the pieces below.

Two further aims

There are two further aspects of our work, which are being reviewed by the SEMAP management group:

- To derive tangible benefits for IHEEM members and also support the IHEEM business plan.
- To ensure that training offered by IHEEM is consistent with and supports the aims of the platform.

Training and Development for members – and potentially the wider EM community – is a vital part of our objectives, and we will be developing a range of tools and training as we explore relevant topics in our workstreams.

As part of an institute with a long and distinguished history, the watchword for SEMAP is 'professionalism' in all we do. As the heading above reflects, we are tackling these new initiatives with careful consideration: this is a long-term commitment, and will hopefully grow to enjoy wide recognition across the industry.

Who are the current members of SEMAP, and can I join too?

A full list of current members is available on the IHEEM website under Technical and Advisory Platforms.

SEM Advisory Platform Membership

SEMAP continues to grow and expand topics for inclusion in our agenda. We welcome new members who have a focused interest in developing the estates management debate within IHEEM. We are also registering interest for individuals wishing to join as associate members.

For more information on any of the above, contact Clair Wilkins at clair.wilkins@iheem.org.uk for further details.

Advisory Platform

'Vision - the lightbulb moment', page 26, *Creating Excellent Buildings,* CABE

Why have we chosen these initial topics?

A large part of our work looks at the very early stages of projects when experience shows that problems can quickly mount soon after the 'light bulb' moment if the full extent of what a project needs is not taken into account.

Once a new project has gone down the wrong path, even for a short period, it can be near impossible to recover.

The pie chart (right) is a stark reminder of a number of relevant but often overlooked characteristics of projects over their lifetime.

The relatively small percentage of overall cost related to 'design' includes the entire design process, including detailed and site design.

The percentage of that design component dedicated to the creative process will be comparatively tiny. The earliest elements including strategy, optioneering, and initiation – which should all happen before a brief is written and a drawing drawn - attract so small a percentage that they are invisible.

But it is in these post 'big bang' moments that the project emerges from the imagination to the page - where early errors and omissions can lead to practical failures in the long-term.

Hence the work within SEMAP to develop a professionals' toolkit which will aim to provide a range of guidance to anyone who has that lightbulb moment.

Revenue and capital *or* revenue v capital

The pie chart shows emphatically that by far the greater cost over the lifetime of a building is in the running costs – the revenue costs.

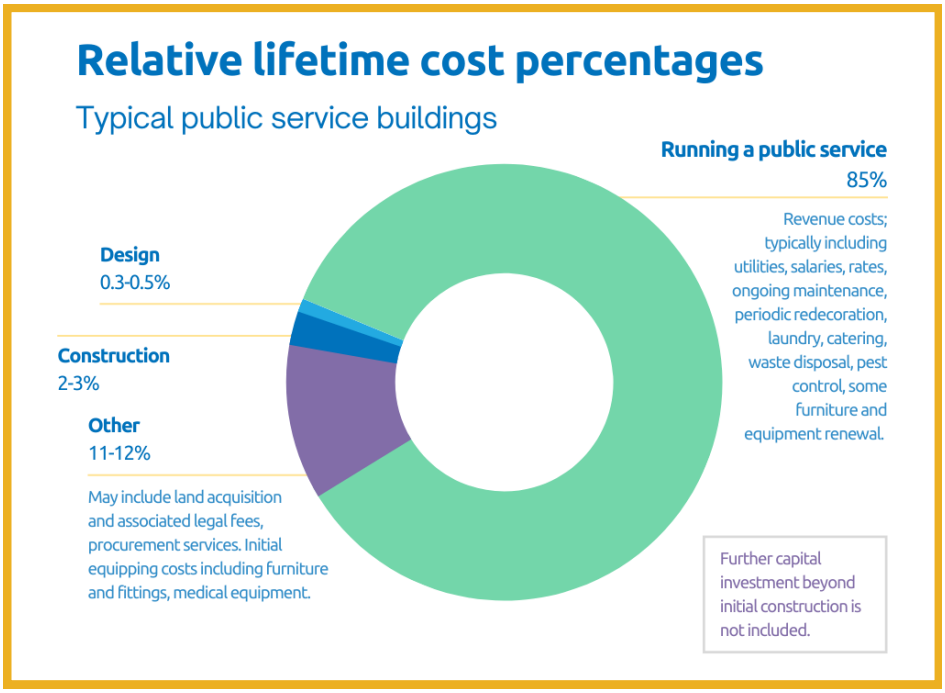
In the public sector (with some small exceptions) capital and revenue costs are kept utterly separate. It is usual within business cases to set out the revenue implications of any new capital project, but little if any work is undertaken to explore whether there might be more beneficial approaches to the watertight relationship between these two sources of cash. Small changes in concept, patient pathways, and design, can produce enormous patient and staff benefit, as well as improving efficiency and reducing revenue over a facility's lifetime: there is often little incentive to carry out option modelling based on best practice; nor is post-occupancy evaluation often conducted. Once the project ball is rolling, everything needs to be done quickly – timescales for early stages are compressed: time and capital cost become the key twin objectives.

Initial steps for any capital project

Having had the lightbulb moment, and in the initial excitement, it is all too easy to get off on the wrong foot. There will be expectations around cost and programme which, if prescribed too early, can constrain and potentially derail the proposal. There are many other possible pitfalls, and most can be avoided by seeking the right close client team members as soon as possible.

Which professionals will be best suited will depend on the specific project, but almost always, it is highly beneficial to appoint a healthcare planner to shape the proposal across a range of healthcare agendas. Equally, there is much value for larger schemes in appointing an external client advisor.

SEMAP has begun to look closely at the roles and skills available from healthcare planners, and that work is described in more detail below. We may explore the role of client advisor in further work.



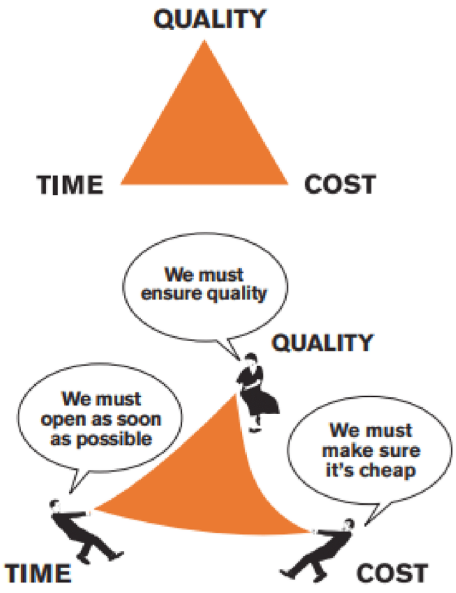
Strategic Estates Management

PFI - the end of an era

In contrast to our work on the very early stages of projects, we are also examining the implications for estates management of the end of PFI contacts, most of which run for 25 years.

The expectation for all PFI facilities is that they will have been maintained, and therefore handed back, in Condition B. For host NHS bodies, this is a real benefit, and the challenge will be to ensure that this benefit is not lost in the longer term.

There are of course many other considerations as PFI terms expire, and more detail of our work is given below.



'Time, cost, quality', page 11, *Creating Excellent Buildings,* CABE

Quality - the third key dimension

Inevitably – but not until the appropriate stage – time and cost will become the two headline metrics for capital schemes. Alongside these there should be a range of measurable health and wellbeing outcomes, established during the early work describing and then quantifying the patient/ carer/ staff and community objectives.

Across the whole of these considerations, there should be a framework setting out a comprehensive set of quality objectives. Every decision, every step, will be an influence on time and cost and also on quality. The tension between these three is often a source of difficulty, and hence defining what is meant by quality in all aspects should be established at an early stage.

Quantifying quality is not easy. But it is the one key dimension of the three that can be established by common consent of those closely involved with the scheme. These are the stakeholders, and SEMAP will be developing work to assist in identifying and engaging with stakeholders – often a difficult challenge.

Assembling stakeholders to work together in agreeing the quality dimensions of the project has the benefit of providing a common framework which can be referred to and tested at stages as the scheme unfolds.

The Construction Industry Council (CIC) has developed a specific tool for this – DQI for Health (Design Quality Indicators) – now in use for over 20 years. The initial stakeholder workshop is held at pre-briefing stage – before a single line has been drawn on a drawing or any attempt has been made to assemble a brief.

Now read on...

Duncan Sissons, Paul Holt, Suzanne MacCormick and Pete Sellars explore our work more deeply below.

Paul Mercer

Chair of SEMAP

Healthcare architect, and former NHS Estates Director

This is a long-term commitment, and will hopefully grow to enjoy wide recognition across the industry.

We welcome comments and feedback

SEMAP is itself just starting out, and we would be pleased to hear from members to hear your views. We will reflect all comments in future articles in HEJ.

Please send your thoughts to Zanna Mercer: zanna.mercer@iheem.org.uk for further details.

SOME KEY ASPECTS OF SEMAP

Duncan Sissons

Vice Chair of SEMAP

Managing Director, Sissons Consult Ltd, Chartered Surveyor and Project Manager

Over recent years IHEEM has had significant success in developing the engineering profession within healthcare, creating the role of Authorising Engineer (AE), who - as an appropriately qualified engineer - has demonstrated relevant skills, competence, and experience. An AE is the only person accredited by IHEEM to provide specialist technical advice, guidance, and support to healthcare organisations to meet the regulatory and statutory requirements across a number of engineering disciplines. AEs encompass a number of engineering disciplines, and are key to providing a safe and operational healthcare estate. The AE accreditation is attained and retained by an individual rather than a company.

There is no such healthcare-specific accreditation currently for other professions involved with the design and delivery of the wider healthcare estate, yet they have the capacity to cause untold damage and cost.

IHEEM's newly created Strategic Estates Management Advisory Platform (SEMAP) brings together senior members of IHEEM and fellow professionals highly experienced in the design and management of healthcare facilities. Members are representatives from various design disciplines, including architects, civil and structural engineers, chartered surveyors, project managers, and healthcare planners.

As an example, my professional background is as a chartered surveyor with involvement in the design and delivery of healthcare projects for over 40 years, both in the UK and overseas.

The value of mentoring

A local Trust has a highly motivated surveyor currently undertaking a degree via day release, but was unable to support him in professional membership of the Royal Institution of Chartered Surveyors (RICS) as no one in the team was a Chartered Surveyor. As a member of IHEEM, I was pleased to be approached by the Trust to act as Supervisor to allow the employee to gain professional status of the RICS: this was agreed, and produced clear benefits for both parties. In doing so, the Trust retained a highly motivated and competent individual within the NHS, and enhanced the skills of the individual, who is able to provide an improved service to his employer, whilst improving his job satisfaction. I, meanwhile, was only too happy to help develop a young surveyor.

This scenario is all too common across the NHS, and talent is being lost to other sectors. Recognising this IHEEM is looking to see how to best support the training development of all estates professionals employed by Trusts. It is not the intention to usurp the role of established regulatory bodies, but rather to supplement their proven skills with continuing professional development focused within the healthcare sector.

Healthcare planning

The role of healthcare planner presents more of a challenge, as the discipline draws upon skills for individuals from many diverse backgrounds. IHEEM has created a number of workstreams, one of which is tasked with looking at the development of and how to promote healthcare planning as a recognised profession. Suzanne MacCormick gives a summary of the work of that working group below

Catch up with SEMAP at Healthcare Estates

There will be an update on all of the workstreams of SEMAP at the forthcoming IHEEM conference being held in Manchester on 10th and 11th October.

SEMAP PRESENTATION AT

HEALTCHARE ESTATES

Our presentation and panel discussion will be on Tuesday 10th October at 15.00 – see conference programme for full details.

THE BIG BANG OF CAPITAL PROJECTS

Best practice for project initiation – the strategic front end

Paul Holt
Workstream 1 Lead
Associate Director @CS2, and part-time lecturer at the University of Bolton

We have invited an eclectic mix of expertise from across the NHS 'family', including Architects, Strategic Health Project leads, and 'in-house' NHS Directors of Estates and Facilities to determine how we might define good practice in the early development of a construction project.

If we achieve our initial objective, we are then set the challenge of identifying tools and skills IHEEM can promote, supporting stakeholders in maximising their opportunity for a positive experience in the delivery of a successful project.

We launched proceedings in late July 2023 asking a simple question…….'Who is our Client?'

After 90 minutes of detailed, heterogeneous discourse reflecting over 300 years of combined history, knowledge, and expertise, it became evident (and probably not surprisingly) that we all had differing views on 'Who is the Client'.

This discovery very quickly then helped the panel to recognise that there is no single one solution to the concept of 'Best Practice.' We accepted that every party/group involved in the development of a project will look through their 'professional lens' – reflective of our own behaviours and personal interpretations of a simple question.

Unknown Unknowns

If we accept people apply 'what they know,' we then might argue that project attendees apply their conscious or unconscious bias, and with that an unintended application of Donald Rumsfeld's 'Unknown Unknowns' (Feb 2002). A further delve into Rumsfeld's view on the Iraqi War leads to the 'Johari Window' – a model designed to help people better understand their relationship with themselves and others.

Whilst we don't intend to dive into management psychology and personal behaviours, we started to advance an emerging theme that we may need to develop individual toolkits to help different audience members understand the purpose of the brief.

As Group Chair I asked my colleagues why we build NHS accommodation - my rationale (personal bias) being that construction is an output of the conversation on the needs of the patient/clinical journey. How often have we sat in meetings applying a 'construction mindset' (further bias), making the construction process the purpose/focal point?

To any construction professional reading this article, ask yourself how many times you mention the patient, and by association their visitors and staff in the brief? That might give you a sense of whether you see the build project as an 'output' or the 'raison d'etre' for the project.

Reinventing the wheel?

As we started to define the emerging themes, it was evident that the fundamental principles of managing an embryonic brief don't change. We reflected on the multiple areas of good practice developed over several decades, conscious that we did not want to, or indeed need to, reinvent the wheel.

At this stage we recognised:

- The transient nature and understanding of a broad audience/stakeholders, maybe operating at a strategic level (Trust Board) technical level (IHEEM members), clinical level – both strategic and delivery, as professional consultants, as contractors, or as public representatives.
- How we include 'minority views' (i.e. dissenting or alternative opinions), and subsequently how to ensure that stakeholders are given appropriate voice.
- The forever changing clinical environment/need.
- The funding challenges and the ongoing deteriorating estate.
- The conflict between central policy control, operational realities of project delivery, and the perception of design change through derogations et al.
- The changing motivations, capacity, and capabilities of all involved.
- An opportunity to review how international best practice can positively influence design development and 'front end planning' focused on:
  - Who to involve.
  - What processes should be undertaken.
  - How to think about prioritising and weighing different professional inputs.

Working Groups

Next steps for WG1

Moving forward, our next step is to start to determine the tools and skills IHEEM can promote for clients and others faced with, maybe, their first experience of working on a major capital project delivered through:

- Seminars
- Online sessions
- Written articles
- Connecting into an international perspective/supply change
- Workshops for a wide range of external healthcare stakeholders, as well as IHEEM members

Suzanne MacCormick
Workstream 3 Lead
Director, Spencer Harrison Ltd, Healthcare and Management Consultants

Developing a framework for the profession

HEALTHCARE PLANNING

Despite its long history, there is still a certain amount of mystery that surrounds healthcare planning – both what it is, and indeed what it does.

The World Health Organization (WHO) has a 140-word, four-point definition that includes generic descriptions of project management and policy frameworks, but fails to clarify the real scope, complexity, and genuine value, that healthcare planning brings to healthcare estates design. There is also no recognised accreditation or defined skillset for the profession, nor a global definition of what a healthcare planner is.

The complexities

Healthcare planning comprises a plethora of skills, techniques, and capabilities, that underpin the delivery of excellence in clinical design. Starting long before any decision to build or remodel space is made, it asks the existential questions to define the current situation and understand what lies beneath the presenting problems. It then considers the end-game and what is needed to resolve those problems for the immediate, middle, and long term.

It includes:

- **Situational analysis** - digging beneath the presenting issues to understand the problems and their cause
- **Strategic and operational planning** – to understand future clinical aspirations and ensure delivery of global best practice
- **Population health needs assessment** – including epidemiology, capacity and demand analysis, and quantitative modelling
- **Service model development** – to facilitate an understanding of what service components, assets, and other resources, are necessary to create and deliver the service
- **Functional assessment** – ensuring a detailed understanding of process and functions across the seven flows of healthcare
- **Space, infrastructure, utilisation, and facility planning** – defining the optimum space requirements for a compliant design wrapped around excellence in clinical delivery
- **Simulation modelling** – to test scenarios of flows, functions, and human factors, to inform the solutions
- **Digital design** – ensuring that digital components facilitate delivery of the functional requirements

Pursuance of excellence

Whilst buildings often cause restrictions to services and users, a new building will not resolve constraints unless it is designed around the flows of the service and its logistics. When form follows function, building design facilitates delivery of service and clinical excellence. Healthcare planning is the academic and practical underpinning that ensures the raison d'être of healthcare buildings is paramount - it's the discipline that ensures that the exam question is interrogated, understood, and then answered, in the most exemplary manner.

A good healthcare planner is the conduit that brings together capital and estates, strategic and operational, and clinical requirements and aspirations, to ensure a clinically led design that is future-proofed.

SEMAP

IHEEM Healthcare Planning sub-group

The IHEEM Healthcare Planning sub-group comprises nine highly experienced successful healthcare professionals from the wide range of design disciplines (including healthcare planning) who proffer well over 300 years of combined experience. It has been established to debunk the mystery, offer clarity about what healthcare planning is, and establish and agree the core competencies, standards, and measurable skills that it comprises. Overall, its intent is to ensure a legacy of competent healthcare planners who will form an integral part of a design team to ensure every healthcare capital project facilitates delivery of clinical excellence, optimum user experience, and improved clinical outcomes.

Progress

At our inaugural meeting in July we defined healthcare planning in terms that capture the breadth and depth of the discipline, but that can be understood easily by the lay person despite its complexity (Figure 1).

We summarised the core components of the discipline as:

- Strategic healthcare (the why and where)
- Operational and clinical planning (the what and who)
- Space and facility planning (how and where)

It's clear that while these three components each have their unique focus, there is also a wide overlap of shared approaches and tasks, and the skills and competencies, needed to deliver the functions of each component (Figure2).

In our subsequent workshops we've begun to detail the tasks and approach that comprise each element of these three components, and flesh out the skills and competencies required across the healthcare planning landscape.

We've also settled on a module-based approach that recognises existing courses and accreditation that already exist. This will allow a "pick and choose menu" of modules that gives the learner the freedom to tailor the course to their particular needs and interests, but avoid unnecessary duplication.

Overall, we want to ensure both clarity and rigour, and provide fit-for-purpose accreditation that recognises the complexity of healthcare planning and the myriad of tasks it comprises (figure 2).

We've already begun to populate each section with the glut of policy and guidance documents that govern so much of the health and social care backdrop – not just as a citation, but to offer genuine direction and shortcuts through the abundance of sources and maze of regulations.

The way forward

It's early days – and this is the mere groundwork that will underpin the development of a course and accreditation that offer genuine value to the discipline. Of course, we are aware of the huge task ahead of us. But, with the foundations laid, our combined skills, breadth of expertise, and shared passion to deliver our objectives are all fuelling the process. We are excited about the road ahead, and about helping to shape the healthcare planners of the future which, in turn, will support the development of healing environments that facilitate delivery of clinical excellence and improved outcomes.

Figure 1 - Basic healthcare planning components

Figure 2 - Healthcare planning definition

Working Groups

Pete Sellars
Workstream 4 Lead
Chief Executive Officer, and Past President, IHEEM

Research and review topics currently in the spotlight

ESTATES MANAGEMENT MACRO FORUM

This workstream forum brings together practitioners, academics, and innovative industry professionals, to address headline poignant topics in estates management today. Following the highly successful and widely accredited earlier work exploring a common language for acuity, the group is setting out to develop practitioners' guidance for two key areas of relevance to EM developments.

PFI hand-back

Across the NHS, many PFI projects are reaching the end of their contract period, and the processes relating to the hand-back from external PFI companies to host NHS bodies presents many complex challenges.

Just as the initial implementation of PFI was an uncharted process, so the hand-back of those schemes is something of an enigma at present.

The work of the group will seek to explore all aspects of PFI hand-back, with the goal of supporting estates colleagues across the NHS. IHEEM is developing a "paper to digital" governance toolkit which will dovetail into the Premises Assurance Model (PAM), and will deliver the practitioners' guidance needed in all aspects of the process.

The key to success is managed transition and a willingness by all parties to collaboratively develop solutions which work for all involved. On the day the PFI contract ends, there should be no 'cliff edge': preparation and modelling of every aspect of the estate affected by hand-back is essential, with a recommendation by IPA and others that preparation begins up to 7 years before the expiry date, supported by IPA health checks.

The NHS is not alone. Many other public services have extant PFI contracts, and there is some initial guidance published by the Infrastructure and Projects Authority in several linked documents under the heading 'Preparing for PFI contract expiry'. Some of these documents are nearly a year old, and it is the intention of this SEM working group to produce guidance for current circumstances.

As all 42 ICBs develop their Estates Infrastructure Strategies there is an urgent need to produce robust commercial handover plans from both the ICB and LIFT perspectives.

The scope of this work extends into all of IHEEM's professional groupings, and involves colleagues from all the Institute's Technical and Advisory Platforms.

Capital and revenue or capital v revenue

The watertight separation of capital and revenue allocations and budgets for public sector bodies, including the NHS, has patently not served well over the years.

The workstream will take a fresh and whole-system view of financing healthcare facilities from cradle to grave and – most importantly – challenge economic appraisals of business cases so that capital and revenue are evaluated as complementary and interrelated.

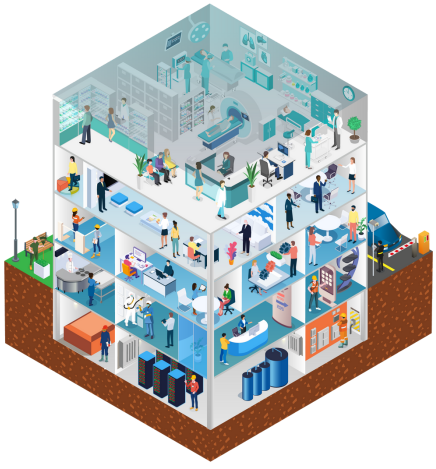
Crucially, the assessment of projects should include, at its core, the aspiration to improve health outcomes and patient care.

Colleagues will recognise the relentless downward pressure on capital project costs to achieve the 'allocated capital budget', often set far too early and without full project information, let alone a brief. (See also the work of Workstream 1 noted above). As a scheme gets some tangible form, then follows the development of its 'revenue consequences', as if revenue is very much a secondary aspect of the project.

The workstream hopes to develop some new thinking around project costing and the application of this to current 'whole system' redesign being evaluated by Integrated Care Boards to support the required move to primary and social care defined by the AfH as the "shift closer to home".

It is hoped that this work might be rolled out to assist ICBs as they prepare their development proposals.

> ***The group is setting out to develop practitioners' guidance for two key areas of relevance to EM developments.***



SEMAP final thoughts

CHALLENGING INGRAINED ATTITUDES

Paul Holt

Workstream 1 Lead
Associate Director @CS2, and part-time lecturer at the University of Bolton

Let me start with an observation as I reflect on the current debate on recruiting staff into the NHS Estates Function.

The definition of insanity is doing the same thing over and over again and expecting a different result.
- Einstein et al

Sitting outside the NHS Family gives me a unique perspective on what we might do - having honed an NHS career over nearly 30 years, culminating in the position of Director of Estates and Facilities in both the Acute and Mental Health world. My observations from the IHEEM 2023 recruitment discourse led me to the Einstein comment, as conversations reflected meetings I attended from circa 10 years ago……..ageing staff, poor pay, lack of opportunity – unable to recruit.

Equally, the current challenge is further complicated as employment trends remain uncertain, and hiring increasingly competitive, as companies compete in a smaller new talent pool.

Increasingly, more people are seeking flexible opportunities – whether that is working from home, expecting a shorter working week, or not having 'the same passion for the job' as their predecessors. Exacerbating the problem is a whole sector of the employment market having never returned after COVID – arguably the very expertise that NHS colleagues seek.

As a final observation, and depending on where you sit in terms of the age, your attitude to work (as a baby boomer) will be diametrically opposite to that of the later generations, and specifically Generation Z. Whilst I won't get into the rights and wrongs of what we should expect from work…as a baby boomer myself, I often wonder whether we can learn from Generation Z in striking a true more manageable 'work/life balance'.

Growing new leaders

So, how do we move forward to prevent the employment risk of 'falling over the assumed cliff edge'? The obvious is to rethink the 'insanity' conundrum and set out a new path of employment growth from within the internal NHS market. Are we really saying that across a workforce often in their multiple hundreds, colleagues don't have the next set of frontline and strategic leaders? Most of the NHS E & F leaders I know started on the front line – in my case as a 'time-served' plumber. What did I do and what help did I get to become a Director of Estates and Facilities? What do our staff want? Whilst it is easy to ask questions, one area of new learning is the application of the modern apprenticeship model of training, and with it a fundamental shift in the way our staff can grow.

Apprenticeship Degree

My personal experience is to help deliver the fully funded IWFM accredited Apprenticeship Degree at the University of Bolton. We expose an eclectic mix of technically qualified students across all ages and accountabilities to the whole array of knowledge requirements an EFM leader would require – giving them a confidence to not only improve in their current role, but also to expand and develop new ambitions. Adapting the NHS Personal Development Plan model may well close the gap between employer need and employee desire, in essence…… Doing something deliberately different to that done before and delivering outstanding results.

Join the discussion

SEMAP provides opportunities to network, learn, and share experiences and knowledge. Find out more at iheem.org.uk

Estates and Facilities

SPOTLIGHT ON

CLAIRE HENNESSY

Claire Hennessy FIHEEM is Director of Estates and Facilities with Birmingham Community Healthcare NHS Trust. From a young age she built extensive Lego block estates with her brother, thriving in science classes at school, while a family friend who worked as an aircraft mechanic also inspired Claire to go into engineering. She went on to train with the Royal Navy as one of the first female Weapons Engineering Mechanics at 17, starting her career with the NHS four years later as an apprentice electrician with Hammersmith Hospital.

An illustrious NHS career has seen Claire progress through Craftsperson status, into estates management and directorship. Her engineering background has been invaluable throughout, with her roles requiring broader skillsets as she has progressed, including budgetary, people management, contract, and soft facilities management services oversight. Central to her development in these areas has been the support and freedom offered by senior leaders and mentors to train and hone new skills in each post, which she has carried forwards and further built on in each new role.

Claire's appreciation of people development and knowledge-sharing extends beyond her professional life, as she has recently made a return to the military as a volunteer approved instructor, training cadets across a broad range of key skills. 'It is a fantastic youth organisation that is really inclusive and supports young people to develop key skills that will help them through life, making learning fun and inspirational,' she says.

Throughout her career, at the heart of Claire's drive to deliver exceptional estates management is provision of the best possible environment and facilities to support high quality care and treatment to patients. 'When you work in this environment and witness people at their most vulnerable, the empathy you feel is overwhelming.'

Her commitment to professional standards and patient care is evidenced by the myriad awards she has won throughout her career. Accolades include Junior Engineer of the Year with the Central London Maintenance Association at the start of her career, with her team most recently winning the IHEEM's Estates and Facilities Team of the Year, Sustainable Achievement award, and Champion of Champions.

The latter was awarded to Stephen Hinckes, nominated by Claire for his positive leadership, career guidance, and mentorship, to junior E&F team members. The recognition of her team's commitment to nurturing professional development neatly comes full circle from the support that Claire has also benefitted from throughout her career. It demonstrates that at its most effective, such a culture cascades from the top tiers of leadership, ensuring its longevity, impact, and sustainability.

Get in touch

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Knowledge Partner

TAHPI
A to Z of Health Planning

In 2020 IHEEM explored the possibility of introducing a short training program in "Health Facility Planning". For this initiative IHEEM partnered with TAHPI, a multinational company with deep experience in all aspects of Health Planning, including training courses for professionals in the field.

Healthcare covers services, facilities, and people. It is a field which involves participants from different educational and professional backgrounds - ranging from Clinical, Architecture, and Engineering, to Administration, Management, and Maintenance.

The development and management of a healthcare estate requires all these professionals, with their respective skills and contributions towards a common goal - being healthcare services. On a daily basis, they need to interact with one another and coordinate their activities. In other words, an estate is an ecosystem of healthcare with dynamic relationships and (hopefully) equilibrium between the different activities. In this context a few questions arise:

- How do the individuals know their role within the greater ecosystem?
- How can they effectively perform their roles by knowing the broader objectives?
- How can they communicate with colleagues from vastly different professional backgrounds?
- What standards, guidelines, or examples, can they use to respond to the issues at hand?

In practice, most of the individuals learn the interactions within the system through the work itself. This can be challenging, and takes time to absorb. Also, it tends to reinforce existing practices, which may or may not be optimal, efficient, or best practice. If all that is available is learning within the limited surrounds of one's own colleagues, the personnel involved are likely to have a limited view of the larger ecosystem of healthcare. Many may fall into an opinion silo (or group think), forming opinions from a limited angle of their own profession. Therefore, despite the commitment to the common goals, improvement tends to be slow, and the path uncertain.

For true collaboration between colleagues, communication through a common foundation is essential. Otherwise, each person will be speaking the language of their own profession, typically from the angle of their own experience elsewhere. Furthermore, it cannot be assumed that such experience has been based on the best examples to be followed in the future.

The IHEEM-TAHPI courses were structured to address these issues. Recently, thanks to the Pandemic, the courses were taken online, resulting in greater participation by all relevant professionals from around the world. Each session typically has 5 to 7 participants from the healthcare estates in the UK.

The feedback through personal testimonials has revealed the value of a formalised training programme that puts all the elements of Health Facility Planning into a systematic framework. In order to achieve this, the courses start from the definition of Health Planning: "Planning for Health of People". From this simple proposition, the course unfolds and covers all the steps that require consideration and participation of the different professions. These are covered in 17 discrete sessions over 9 days. The main subjects are:

- Introduction to Health Service Planning (Demand, Supply, Gap)
- Standards and Guidelines
- Project Briefing
- Functional Relations
- Masterplanning
- Health Facility Design & Modular Design
- Design requirements of 5 Functional Units (Inpatients, Surgery, ICU, Emergency and Medical Imaging)
- Consultation and Approvals
- Project Coordination and Integration

Within this framework, many other aspects of health planning are covered, such as medical equipment, models of care, and unified terminology. There is an element of un-learning involved, clearing out wrong perceptions, accumulated from the dark daysof the past but persisting today.

Over 15 years of these courses has indicated many benefits:

- Interaction with colleagues from around the world, opening eyes to different ways of practice
- Understanding that for many requirements, better examples are available and can be learned
- Sources of information including a substantial number of templates that can be immediately adopted and used

The courses encourage the participants not to focus solely on their current profession or daily tasks, but on their long-term careers and the need to understand a little about every other profession that is involved in healthcare. Similarly, they are encouraged to look at examples of good practice and design solutions from around the world, even those under different regulations and standards.

These tend to open eyes to alternative possibilities, and may even influence the next generation of standards and guidelines in the UK. As a shortcut to this objective, the participants are taught how to read and - when appropriate - how to use the International Health Facility Guidelines (iHFG) and automated software for creating competent design briefs and equipment lists based on guidelines.

Aladin Niazmand, Director of TAHPI

Upcoming training

TAHPI offers an extensive programme of healthcare planning training courses.

Discounts are available to all IHEEM members.

For further information on upcoming dates, see our Training Dates section, go to our website, or contact office@iheem.org.uk

For true collaboration between colleagues, communication through a common foundation is essential.

TRAINING AND DEVELOPMENT

TAHPI
A to Z of Health Planning

Aladin Niazmand

Managing Director, TAHPI

Aladin Niazmand is a Director of TAHPI, an international firm specialising in Health and Aged Care. TAHPI is headquartered in Australia, with regional offices from Sydney to London. Aladin has 35 years of experience in health planning, including responsibility for over 350 health and aged care projects in 20 countries.

Aladin is responsible for the research and publication of the International Health Facility Guidelines (IHFG), as well as country-specific Guidelines for eight health authorities.

Aladin is the Development Director of the HFBS suite of web-based health planning applications used by thousands of consultants worldwide. The HFBS modules include health service planning, supply, demand, gap and forecasting, as well as briefing and medical equipment specifications.

Aladin is a champion of modular design and construction specifically for healthcare projects, having completed many such projects - from networks of primary care centres to six-storey specialised hospitals.

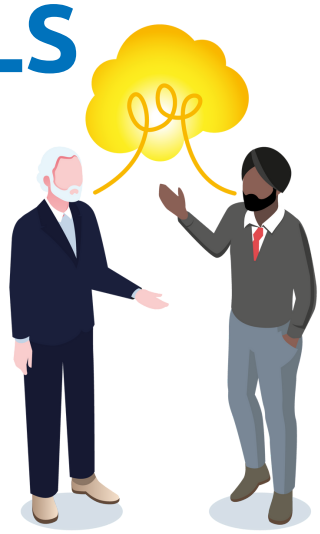
He has been a speaker at more than 30 international health conferences, and regularly gives CPD-approved master classes in health facility planning, health service planning, and hospital commissioning.

TESTIMONIALS

A few testimonials from the professionals from Healthcare Estates are quoted below, which are self-explanatory:

"It's an excellent course, a must for anyone that's interested in facilities development in the future."

"I think it's a much needed course to take when looking to undertake a hospital redevelopment programme."



Head of Estates Projects, UK

"It's been an absolute pleasure to meet everybody from all around the world and … what a packed course it's been. I personally feel as if I've done a university module in a very short period of time and the information that's been shared…. I think this course should be mandatory for a lot of designers that are working in any sort of healthcare …. it would be my view that even some of the basics are not widely understood by people who are working in the industry. Thanks very much … It's been a very enjoyable nine days."

Head of Capital Projects, UK

"It's been great to learn so much international best practice for me because I think in the NHS in the UK sometimes we're very focused on ourselves sort of internally, so it's been great to learn what the rest of the world is converging on in terms of healthcare … planning and design it's going to be. The course will be really useful for the projects I'm currently working on, and some of the areas we've looked in detail the last few days … the course overall has been a really great experience to take part in and meet everybody and many thanks …. for sharing [this] extensive knowledge."