Healthcare and Architecture: Northern Ireland’s Legacy
With increased self-governance and control over investment in Northern Ireland since the start of devolution in 1998, greater jurisdiction over the provision of health care services has allowed for a significant increase in the capital investment and diversity of services provided through the Department of Health, Social Services and Public Safety (DHSSPSNI). This publication of case studies takes a snapshot of the state of capital investment in healthcare facilities across Northern Ireland, their architecture and an increasing attention to quality and flexibility in design over the decade since 2002.

Under the current Health and Social Care model, Northern Ireland is served by four area Health and Social Services (HSS) Boards and nineteen HSS Trusts, which oversee Acute Hospitals Trusts, Acute and Community Trusts, and Community Trusts. Within this system there are increasing levels of facility from local health centres and community health centres to local hospitals, acute hospitals and regional centres. Over the past decade the Northern Ireland Assembly and the DHSSPS have made substantial architectural and infrastructure investments in all of these geographic and service areas; from regional hospital projects to more decentralised facilities such as Community Treatment and Care Centres (CTCCs) and Wellbeing Centres.

Projects completed in this time include extensive renovations and new services or patient facilities at the Mater Infirmorium, the City, and the Royal Victoria Hospital in Belfast, a new south ward and specialist services block at Altnagelvin Area Hospital, a new critical care block and maternity block at the Ulster Hospital, new wards
at Antrim Area Hospital and a new neurology ward at Musgrave Park Hospital. New hospitals have been provided at Downe and Enniskillen. More local facilities include new psychiatric units at Craigavon Area Hospital and Gransha Hospital, new day centres to address needs for learning disability in Newry and Lisburn, and new children’s homes in Omagh and Newry. In Belfast alone, over the past decade, there have been seven new CCTCs completed around the city, mainly integrated into existing urban areas. Upcoming projects include a new radiotherapy unit at Altnagelvin, major replacement phases of the Ulster Hospital, new theatres at Craigavon Area Hospital, new A&E wards at Antrim Area Hospital, new health and care centres at Ballymena, Banbridge and Lisburn, and a new Omagh Hospital.

To address the future provision of health care buildings, according to the current under-secretary for the Department of Health Estates Investment Group, John Cole, requires careful consideration of budget allocations, procurement methods and quality of design. Evaluating the quality of health care in the UK is typically based on differing metrics that focus on ‘key domains’ related to quantitative aspects of care provision: effectiveness, access and timeliness, capacity, safety, patient centredness and equity (Leatherman and Sutherland cited in Sutherland and Coyle 2009, 16-17). In addition to these factors, Cole argues for recognition of the ‘contribution that the creation of healing environments (through high-quality architectural design) can make to improving patients’ experiences and outcomes’.

Seen in the wider historical context since the end of the 19th century, Northern Ireland has a diverse legacy of quality health care facilities, some of which were pioneers in terms of technology, hygiene and construction, like the 1903 air-condition system at Belfast’s Royal Victoria Hospital, or strong Victorian-era examples, like the John Lanyon designed buildings at Holywell Hospital, Antrim. In the more than one-hundred years since these notable buildings were completed however, chronic underinvestment, and changes to health delivery and in medical practice meant that these facilities no longer ‘reflect modern-day care and the standards that we [sic] should be giving people in line with current departmental policies’.
Current levels of investment, according to DHSSPS of approximately £200 million per annum over the last five years, £1.8 billion capital need over the next four years, are double those of a decade ago and more still than comparable levels in the period from the 1960s to 1990s when most of the current health care development in Northern Ireland was completed. Despite higher levels of recent investment however, many facilities are still over fifty to more than one hundred years old, and are at the end of their useful life as healthcare facilities without major upgrades or replacement that are estimated would cost approximately £5 billion.

Government, Health Estates, local Trusts and their design and development teams now face a challenge to balance the needs of modern service standards, and sustainable buildings in the long-term against a deficit of public funds available to meet the full capital investment needs in the short to medium term. Increasingly the provision of new facilities at all levels involves greater collaboration among practices in Northern Ireland working alongside other architects and multi-disciplinary design and construction teams from the UK and Ireland –with local architecture practices taking the design lead more often. Financial support is shared by public and private sources but private-led procurement in the form of Private Finance Initiatives (PFI) and Public-Private Partnering (PPP) have been more prevalent with larger projects while Performance Related Partnering (PRP) or other types of ‘third-party development’ arrangements are becoming the preferred approach for medium and smaller facilities. Private investment and charges require careful consideration to balance value for money with quality of architecture or landscape environments, service delivery and lifetime facilities management costs.

Keeping in mind the relatively small percentage of initial building cost versus lifetime expenditure for health care facilities, and the increasing recognition of the positive relationship between better quality healthcare environments and patient health, not to mention the wellbeing of medical staff working in these facilities, another future challenge will be to collectively safeguard against over-tightening capital building budgets and reducing space or quality
standards. With such an ambitious level of completed projects in Northern Ireland already, many of which have won awards in the UK and Ireland as well as garnering significant recognition further afield in Europe, this publication provides only a small selection of case studies, but they can hopefully act as a timely benchmark and catalyst for discussions going forward.

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REFERENCES


