# Healthcare Infrastructure for a Web of Care

## European Health Property Network 2016 Workshop
## 23-25 November, Madrid

## Speakers and Abstracts

# Arch. Professor Simona Agger

Chair of the European Health Property network

Simona Agger is an architect and urban planner who began her career as a lecturer at the University of Venice and then at universities in the US, Canada and Europe. She has conducted studies about the challenges of Venice's urban situation for Unesco and for the Italian Research Ministry, and she has worked as an expert for the Italian Senate in the preparation of the first "special law" for Venice. In 1979 she published a major book "Urban self management – Planning for a new society" (M.E. Sharpe).

From 1998 to 2005 Simona worked as a consultant with the Company Europrogetti & Finanza, specialized in the promotion and evaluation of development projects for the Regions of the South of Italy co-financed by the European Commission and the Italian Government. In 2002 she was appointed as one of the experts for the Italian Ministry of Health's 'Evaluation of Health Investments' team for evaluation of investments programmes of the 20 Italian Regions and of the major new hospitals financed with National Government funds. Together with a subgroup of 5 other experts, she has contributed to a methodology for the ex-ante evaluation of regional health infrastructures planning, now known as 'MexA', which has been used to help Italian regions to reduce health service costs without cutting services.

At the present time Simona collaborates with the Sant'Orsola University Hospital of Bologna in the project EcoQUIP, a collaborative, pro-innovation procurement progamme which involves six hospitals in Italy, Netherlands, UK, Hungary and Poland. For the Ministry of Health she has participated in several European projects involving many EU Countries and also new member states such as Bulgaria and Slovakia. She has been project manager of an European project of the program "Community Action in the Field of Health" under the DG SANCO and at the present time she is project manager of "RES-Hospitals- towards zero carbon hospitals with Renewable Energy Systems", which involves partners from eight EU countries. She also has extensive international working experience having worked as an Architect and Planner in Algeria, Gabon and Senegal, and in the US she has been involved in research for the renewable energy with the Oakridge National Laboratory and at the present time she develops projects concerning energy saving and use of renewable sources for hospitals and health facilities.

On the EuHPN board Simona represents SIAIS, the Italian Society of Architecture and Engineering in Healthcare. Her email contact address is simona.agger@gmail.com.

*A new Urbanism for a new Web of Care*

The City on one hand, and the System of delivery of Healthcare on the other, are facing similar problems, the most acute of which are due to the increase in service demand in parallel with shrinking financial resources.

The transformation of the Hospital from silos/citadel /ivory tower to a “system of care” seems to be a winning solution in terms of reducing the burden on hospitals and guaranteeing a continuity of care from the hospital to home.

But the question then arises as to whether this ‘explosion’ of parts, and creation of new sub-infrastructures, will change the way in which the health system interacts with society and theurban environment.

The analysis of the present relation between hospital and urban society brings surprising results. The hospital and the city (management especially) ignore each other, with some important institutions looking at the health of the city as a factor that does not involve the hospital. The conclusion is that the hospital seems to be apart from the city, not a part of the city.

The analysis in the second part of the presentation focuses on the problems that are plaguing urban society, of which the health system takes charge those which concerning people when they are sick and need healthcare services. In effect it is paradoxical that the health system ignores the urban society problems. In collaborating proactively in solving or mitigating social problems, the health system would have the important result of keeping people out of its facilities. That includes obviously the large and crucial domain of prevention.

A bilateral change of attitude and culture seems almost wishful thinking. The last part of the presentation examines some of the signs indicating that it is possible.

Institutions know that change is needed, citizens are actively calling for this and it is clear that the urban environment must adapt to serve better particular groups such as the elderly, children, and people with disabilities. These factors are brought together through the work of planners who wish to reconnect Urban Planning and Public Health, to develop ‘Healthcare Urbanism’. This is the future: creating the path for an integrated, systemic vision of city and health, an urbanism that, thanks also to new technologies, will support the transformation of the present hospital-citadel into a web of care.

# Professor José Mª Ezquiaga

Dean of the Governing Board of the Institute of Architects in Madrid; President of the Architectural Foundation COAM

From the very beginning of his professional career, his work has been linked to the city and to Urban Planning. During recent years, both his academic and his professional interest have been focused on theoretical research and practical integration in projects of the different scales, the geographical and the social, that make up the territory and ultimately, the city. His projects have been the means for experimenting and researching in what refers to the process of creation of the contemporary landscape.

**Academic Studies**

José Mª Ezquiaga has a PhD in Architecture (1990); he was awarded the "Premio Extraordinario de Doctorado" (Extraordinary Prize of Doctorate) by the Technical University of Madrid (1990), he became an Architect by the "Escuela Técnica Superior de Arquitectura de Madrid" (Higher Technical School of Architecture of Madrid) (1979) and took a degree in Sociology and Political Science at the Complutense University in Madrid, (1981).

**Awards**

"European Urban and Regional Planning Award" granted by the European Council of Spatial Planners, ECTP-CEU, 2012. "Premio Nacional de Urbanismo 2005" (National Award for Urbanism 2005). "Premio de la XII Bienal Española de Arquitectura y Urbanismo 2013" (Award at the Spanish Biennial on Architecture BEAU 2013). "Premio de Investigación" de la Bienal Iberoamericana de Arquitectura y Urbanismo 2012 (Research Award at the IberoAmerican Biennial on Town Planning and Architecture BIAU 2012). "Premio Europeo Gubbio" (Gubbio European Award) granted by the "Associazione Nazionale Centri StoricoArtistici de Italia", 2006 y and Mencion de Honor (Honourable Mention) 2012. Mención de Honor en los Premios de Arquitectura Internacional 2015 (Honorable Mention in the International Architecture Awards) granted by the the Higher Council of Institutes of Architects of Spain "Premio de Urbanismo del Ayuntamiento de Madrid" (Madrid City Council Urbanism Award) 1986, 1989, 1995 and 1997; "Premio de Investigación del Ayuntamiento de Madrid" (Research Award granted by Madrid City Council) (1990), and "Premio de Urbanismo del Colegio Oficial de Arquitectos de Madrid" (Urbanism Award granted by the Official Institute of Architects in Madrid) (1986, 2011 and 2012).

**Academic Posts**

Tenured Professor in the Urbanism Department at the "Escuela Técnica Superior de Arquitectura de Madrid" (Higher Technical School of Architecture of Madrid) since 1995, with 4 recognized periods of 6 years of outstanding research work. He's been a Guest Lecturer at the Universities of: Technical University of Torino, Rome (La Sapienza), "Instituto Universitario di Architettura di Venezia" (University Institute of Architecture in Venice), TU Delft, Dortmund, Oxford Brooks, Oporto, Lisbon, Tongji of Shanghai, Rochester Institute of Technology in Dubai,

UNAM Mexico, Brasilia, "Nacional de Colombia" (National in Colombia) Bogotá and Medellin, Los Andes and "Pontificia Universdad Javeriana" (the Javerian Pontificia University) in Bogota, UBA Buenos Aires, La Plata, Montevideo, Panamá, Piura of Lima, San Ignacio de Loyola University of Lima (Peru), Católica de Chile (Catholic University of Chile), Concepción (Chile) and San Sebastián of Puerto Montt (Chile). Faculty Associate in the Lincoln Institute of Land Policy (Cambridge, USA). He has collaborated in numerous Masters Degrees and Postgraduate Courses, including the Master of Science Programme in Architecture given by Politecnico de Milano; the Urban and Regional Planning Master Degree given by Technical University of Madrid UPM; the Territory and Urban Policy Master Degree given by Carlos III in Madrid, the Urban Projecting Master Degree given by Catalonia Polytechnic University UPC ; the Master in City Science given by Technical University of Madrid UPM and the Urban Design Master Degree given by Colombia National University. He's published more than one hundred and fifty essays and research studies in books and specialized magazines in the United States, Germany, Great Britain, France, Italy, Holland, Switzerland, Spain and Latin America.

**Experience in Public Administration and Management**

He has held a number of urban responsibility positions in both a Local and a Regional Administrations in Madrid: Head of the Planning Department at the "Gerencia Municipal de Urbanismo" (Urbanism Municipal Agency) in Madrid (1985-88), General Director of Urbanism for the Madrid Region (1988-91) General Director of Urban Planning and Concertation for the Madrid Region (1991-95). At present, he is Founder and Principal at "Ezquiaga Arquitectura Sociedad y Territorio". (Ezquiaga Architecture, Society and Territory).

**Professional experience in Spain**

Director of the Plan Insular de Menorca (Premio Nacional de Urbanismo 2005 (Menorca Island Land-use Plan (National Award for Urbanism 2005)) and Premio Europeo Gubbio 2006(Gubbio European Award)); of the Proyecto Estratégico Madrid Centro (Premio Europeo de Urbanismo 2012, Premio de Investigación Aplicada BIAU 2012 y Premio COAM 2012) (Strategic Project for Madrid's City Centre (European Urban and Regional Planning Award 2012, Research Award at the IberoAmerican Biennial on Town Planning and Architecture BIAU 2012 and COAM Award 2012), Bases del Plan Regional de Estrategia Territorial de Madrid (Premio de Urbanismo de Madrid 1995) (Basis for the Regional Plan and Spatial Strategy for Madrid (Madrid City Council Urbanism Award 1995)). As well as this, he is the Author and Director of the Regional Plans of, Lanzarote, Gernika, Durango, East of Almeria, the Built-up Urban Areas of the city of Huelva, the Metropolitan Area of Murcia, Leon, Avila, "International Tajo", Alqueva Reservoir, the Gata Mountain Range and the Pasiego Region, the Master Plans of: Cordoba, Burgos, Guadalajara, Logroño, Segovia, Talavera de la Reina, Puertollano, Parla, Elda, Ciutadella de Menorca and the Cultural Heritage Management Plan of Siguenza. Author y Director of Urban Projects such as: the Castellana Extension, the remodeling of the military installations of Campamento in Madrid, the Madrid Green Rail Corridor, North Alcorcon (Madrid), the linear park along the Manzanares and the residential areas that have come through thanks to public initiatives like Valdebernardo (Madrid), Fuentelucha (Alcobendas, Madrid) or El Bojar (Cantabria). In architecture, the Social Housing Projects for one hundred and sixty homes, carried out in collaboration with the Colombian architect Rogelio Salmona and fifty homes in collaboration with architect Giancarlo Mazzanti (2012) both for the City Council Land and Housing Department (2007), those are most relevant to mention.

**International Professional experience**

Advisor in the European Committee for the "Terra" Programme, he has participated as an expert on "URBAL" Programmes, and the V Framework Program for Research and Technology Development and Interreg III-C South Zone. He has been an International Advisor in the development of the "Ley de Ordenamiento Territorial" (Colombian Territorial Legislation) and the Master Plans of the cities of Bogotá and Medellin (2006). He has also been a Consultant for the IDB InterAmerican Development Bank for the development of the Territorial Strategy of the Metropolitan Region of Buenos Aires (2006-07), the Sustainable Urban Development Project: Best International Practices and Relevant Experiences for Brazil (2011). Institutional Strengthening in Territorial Planning and Urban Management in Nicaragua (2013). Expert for the CAF LatinAmerican Development Bank in charge of the report titled "Infraestructura para el Desarrollo: Urbanización e Infraestructura" (2012) (Infrastructure to enable Development: Town Planning and infrastructure, 2012) Director of the Plan de Gestión del Patrimonio UNESCO (UNESCO Cultural Heritage Management Plan) in Panama (2012). nternacional Expert for the Plan de Revitalización del Centro de Bogotá (Bogota Historic District Revitalization Plan) Instituto Distrital de Patrimonio Cultural (2015) Director of the research: Lessons learned in 20 cities in Latin America and the Caribbean: Emerging and Sustainable Cities Initiative (ESCI), Inter-American Development Bank IDB (2015)

Institutional responsibilities Dean of the Governing Board of the Institute of Architects in Madrid (2015- ). President of the Architectural Foundation COAM (2015- ). He was part of the National Urbanism Experts Commission created by the Ministry of Public Works, Transport and Environment in 1995. He was also a member of the Urbanism Advisory Board of the Madrid City Council (2005-07). Member of the EUROPAN Spain Scientific Committee in 2010-2011.

## Dr Elke Jabukowski

Health Policy Consultant, WHO European Regional Office

Dr Elke Jakubowski works as a Senior Advisor on Health Systems and Policies for the WHO Regional Office in Europe. She is a medical doctor with a master degree in health policy. Her particular interest lies in improving decision-making for better health and wellbeing through system thinking. Most of her career has been at international European level, working with the World Health Organization, the European Parliament, and as an independent consultant. She has advised governments in more than 30 European countries on health and health system issues. Being from Germany, she has also gained experience at political level in Hamburg which helped her to better understand the political determinants of health. Next to her work on advising governments on strengthening health systems, Elke has published in various journals and for some book publishers and holds a continuous academic affiliation with the epidemiology and health system

department of the Hannover Medical School in Germany where she is leading a European health system module.

*Thinking big: how to be part of transforming care.*

Health systems across Europe continually mutate in response to various environmental pressures such as through demographic and epidemiological changes, scientific and technological breakthroughs, evolution in the understanding of roles and responsibilities of different actors in health care, and innovations altering clinical practice. In addition, transformational agendas are becoming increasingly intertwined across governments, the economy, service sectors, civil society and people within countries and internationally. Thus, decision making in health care is becoming bewildering complex.

It is against this background that the WHO Regional Office for Europe has launched an initiative to support decision makers by providing an impartial environment, helping them to think through and capitalize on insights from other countries and decision making colleagues on how they have moved forward in leading health system transformation.

The presentation will look at the question of how much we can influence the evolution of care, how we can identify drivers for change and how we can overcome barriers hindering transformation. To provide some practical illustrations, we will report from selective case experience of some countries in adopting transformative agendas and will look at how they have strategized and maneuvered to implement, secure and sustain transformative health system change.

Finally, we hope to discuss with the audience the implications of the dynamics of large scale transformative change on options for adapting planning, design and re-engeneering of health care facilities. Finally, we hope to discuss with the audience the implications of the dynamics of large scale transformative change on options for adapting planning, design and re-engeneering of health care facilities.

## Dr Antonio Duran

Director, ALLDMHEALTH, Seville, Spain

Through more than 20 years of work, Dr Antonio Duran has achieved a broad professional record as International Consultant collaborating with many international organizations. He has especially extended working relationships with the World Health Organization and the World Bank and has also worked for the European Union, and International Development Bank, the UK Department for International Development, and others.

Dr. Duran has gained particular expertise in working in and leading health system reform projects. His experience in most Eastern European and Former Soviet Union Countries has provided him with particularly deep knowledge of Transition Countries. He has also worked in Asia (Bahrain, China, India, Maldives and Nepal) and Latin America (Bahamas, Brazil, Dominican Republic and Panama).

Antonio Duran acts as CEO at AllDMhealth, a private consultancy company in the fields of Health Policies and Systems. He regularly collaborates and holds an honorary appointment as Technical Adviser for the European Observatory on Health Systems and Policies in Brussels. Dr. Duran is also visiting Lecturer at the Andalusian School of Public Health, in Granada, Spain, where he teaches Health Systems and International Health Policies, a regular lecturer on the same topics for the Management Centre in Innsbruck, Austria, as well as a frequent speaker at national and international fora. He has a broad range of publications on the above areas, the latest ones being a book on "Governing Public Hospitals".

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*Changing models of care in Spain in the context of European health system development*

In an environment of "awareness of the desirability of higher efficiency in resource use" (although Spanish health indicators were good and hospital outputs comparable to those in neighborhood countries) social changes in the 1980s in Spain:

1. Generated consensus around the need to adjust hospital management. There was also a functional needs analysis re: possible basket of services, spaces and endowments;
2. Triggered an analysis by several Regional Health Services of different organizational and legal modalities and a negotiation exploring the economic impact of the decision to create a new health facility with the corresponding Regional Ministry of Finance;
3. "Justified" negotiations with the Regional Ministry of Finance, which were completed, remarkably, without involvement of Regional Parliament or the like.
4. The efforts were aimed at newly-built regional or even local hospitals with few hundred beds hospitals and a cautious objective of not forcing unmanageable changes (unions wanted to maintain the quasi civil servant existing status of the affected personnel).

The process had common features plus specificities in the preferences of Regional Governments' policy makers. After some adjustments, four offshoots of increased hospital autonomy were promoted, with an implicit agreement of future cross-fertilization:

- Consorcios, used since the 1980s, as legal entities resulted from merging resources from more than one public authority plus sometimes private non-profit entities whose staff were not statutory employees -i.e. not civil servants; managers typically had some autonomy to decide on the basket of services to offer.

- Empresas Públicas Sanitarias, "Public Healthcare Companies" were introduced in 1992, owned by the public sector but subject to private law in matters not governed by specific legislation, or by the founding statutes; non-statutory staff instead of civil servants (and clinicians under a performance-related payment scheme, as opposed to under a salary).

- Fundaciones, promoted in 1994, were non-profit entities under private law, with a founding capital and public, private or mixed participation explicitly created to meet any particular social need and autonomy to choose where to invest and whether to rent or buy equipment; staffed with non-statutory health care professionals.

- Concesiones Administrativas, launched in 1999, were a joint-venture between private health insurers, health groups, building societies, or banks receiving the tender to build and manage a hospital. in contrasts with the Private Finance Initiative, PFI model in England, clinical and non-clinical services were included, usually with non-statutory staff; in Alzira, the statutory staff was given a choice on whether or not to convert to non-statutory status.

Key lessons: (i) there were no insurmountable difficulties to work in the new environment; (ii) efficiency and responsiveness improvements depended on the abilities of board members and senior managers, and the nature and pace of change varied according to individual management capacity; (iii) most new hospitals in Spain are in fact being built on the foundations of arrangements newly learnt (this indirect fertilization of the entire Spanish hospital system more than justifies the innovation carried out).

On the minus side, (i) the goal of extra autonomy has been deteriorated due to poorly explaining results and low accountability; (ii) a few politicians unaware of the complexities involved in active, intelligent commissioning for changing provider behavior can damage years of effort; (iii) the tipping point at which regional governments begin to regret having granted more autonomy and to reassert their central authority may be lower due to financial stress and other competing political priorities.

Overall, even if the new models have lost shine with the crisis, reform programs evaluation should understand that bringing about change takes time (health systems have very deep roots in each society!).

## Dr Dorjan Marušič

Tetras, Slovenia

*Making healthcare accessible across borders: the AdriHealthMob project*

EU directive enables free flow of patients among member countries, where they should receive safe and quality health care. Member states should facilitate cooperation in cross-border healthcare provision at regional and local level. Cross-border collaboration offers the potential to improve the performance of health systems at local, regional and national level, improving access and sharing experiences. However, there are many challenges, such as legal, cultural and contextual factors, to use and successfully implement offered and available potentials. Problem with information and communication technology are often mentioned in combination with cross border health care. It is a question

whether issues like level of digitalization, interoperability of information systems and e-health technologies and similar can be actually defined as problems. The technology is there and exists; it has been used in many other areas of our life, like banking. The background reasons why such technology is not sufficiently used in health care, are a consequence of legal, financial and organizational questions. AdriHealthMob project is a successful example of cross border cooperation at a wider scale to to promote cooperation in IPA region. Health Platform is presented as a way to continue cross border cooperation at a higher level and has potential to help assuring quality and safe health care for the EU citizens in the future.

## Dr Luigi Bertinato*

Local Health Authority N.20, Veneto Region, Italy

*Cross-border health care in Europe: challenge and opportunity for promoting new models of care*

More than a decade ago, there was little discussion of the issue of patient mobility at a European level. The Treaty of Maastricht made clear that health systems were a matter for national governments.

This situation has changed, in many ways after the approval of the EU directive on cross-border health care and patient mobility. The extent of mobility within Europe has increased markedly. Many people from northern Europe have decided to spend their retirement years in the warmer climates in the south. The growth of budget airlines mean that many people whose parents might never have travelled beyond the nearest large city may take several short breaks each year in a different part of Europe. These same airlines allow a growing number of people to commute weekly between a home in one part of Europe and work in another. This new European generation, accustomed to crossing frontiers with ease and enabled to purchase goods and services from any part of the European Union, is less likely to accept constraints on where it can obtain health care.

The continuing imbalance between supply and demand in Europe's health systems, it may be that there is scope for greater mobility that would benefit both patents and health care providers within Europe. The EU health care systems are now facing the need to harmonize their model of care in order to find common answers to the EU citizens health need and in particular : rights and duties of mobile patients; sharing spare capacity and trans-national care; health professionals new skills; European centres of reference; health technology assessment; health systems information strategy; motivation for and scope of cross-border care; data protection; e-health; improving integration of health objectives into all European policies and activities; establishing a mechanism to support cooperation on health services and medical care; developing a shared European vision for health systems; and responding to enlargement through investment in health and health infrastructure. Some relevant examples will be presented during the workshop.

*Member of the EU expert panel on"cross-border care".

# Candace Imison

Director of Policy, Nuffield Trust, UK

Candace Imison is the Director of Policy at the Nuffield Trust. She joined the Nuffield Trust in 2014 with a remit to develop a work programme on new models of care, including technology and workforce. She is the lead author of "Delivering the Benefits of Digital Healthcare", a recent report on exploiting the benefits of new technology.

Candace was previously Deputy Director of Policy at The King's Fund, where she researched and published on a wide range of topics, including future health care trends, service reconfiguration, workforce planning, polyclinics, community health services and referral management. Candace has extensive senior management experience in the NHS, including at board level for providers and commissioners. She was also a Director of Strategy for a large acute trust and Director of Commissioning for a large health authority. Candace worked on strategy and policy at the Department of Health between 2000 and 2006, including working on the Wanless Review, the White Paper "Our Health, Our Care, Our Say" and "Keeping the NHS Local", setting out policy for the reconfiguration of hospital services. She is currently a non-executive director of a large NHS foundation trust.

Candace holds a Master's degree in health economics and health policy from the University of Birmingham and a degree in natural sciences from the University of Cambridge.

*Creating a Web of Care: why and how?*

Hospitals are part of an interconnected web of care stretching from the patient's home to the most specialist tertiary-level service. Clinical networks and new technologies offer opportunities to strengthen that web and deliver more co-ordinated care, but those planning services need to look across that web to ensure the most efficient distribution of services, to remove duplication, and to ensure that patients receive the right care, in the right location, at the right time.

This talk will explore the major drivers of health and social care of the future. It will look at how demand is changing and how health and social care need to respond to that changing demand. It will look at how technology is transforming care delivery, shifting from a model based on isolated providers delivering episodes of care to a population based approach supported by a wider "web of care".

# Steven P Bannister B.Sc (Hons) MCIOB, FIHEEM, MAPM ,MASHE

Managing Director, Northumbria Healthcare Facilities Management Ltd, UK

Steven Bannister is Managing Director of Northumbria Healthcare Facilities Management Ltd as part of a dual role also encompassing Director of Estates and Facilities at the Trust, since April 2012. In addition, he recently relinquished his interim role as Director of Estates at North Cumbria University Hospitals.

Prior to his appointment at Northumbria, he held similar roles at Newcastle University Hospitals NHS Foundation Trust, and Calderdale and Huddersfield NHS Trust.

Steven holds several professional memberships including Chartered Builder and Fellow status, in addition to his B.Sc. (Hons) in Building Surveying and Estate management.

*The NHS Five Year Forward View and how the Estate can act as an enabler*

The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff. But some challenges remain. The quality of care that people receive can vary; preventable illness is common; and growing demands on the NHS means there is financial pressure on local organisations. The needs and expectations of the public are also changing. We are living longer, but we often require different, more complex care. New treatment options are emerging, and we rightly expect better care closer to home.
There is broad agreement that, in order to create a better future for the NHS, we need to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

The Five Year Forward View brings together this agreement in a vision for the NHS. It highlights three areas where there are growing gaps between where we are now and where we need to be in 2020/21. These gaps are:

- the health and wellbeing of the population
- the quality of care that is provided
- and finance and efficiency of NHS services.

The Five Year Forward View is a vision where patients are in control of consistently high-quality care that meets their needs – regardless of where they live. It is a vision where everyone takes prevention and healthy living seriously – helping to reduce the damage caused by unhealthy lifestyles. And it is a vision where everyone with a stake in health and care comes together to find ways to reduce inefficiency.

It is an ambitious vision, but there is widespread agreement among those working in the NHS, clinicians and people who use services that it can be achieved. The growing gaps in the quality

of care, our health and wellbeing and NHS finances can be shrunk over the next five years by collectively adapting what we do, how we think, and how we act in order, to meet the principles of these huge change programmes, the asset base, property portfolio and estates strategies must embody those new demands and reflect them.

The following presentation entitled 'The NHS Five Year Forward View and how the Estate can act as an enabler' tries to describe what one such locality in the north east of England is trying to achieve and how that change may be reflected in the asset base and estate it occupies.

## José María Hurtado de Mendoza

Estudio Entresitio, Madrid, Spain

**estudio.entresitio** is a partnership formed by María and José María Hurtado de Mendoza and Cesar Jiménez de Tejada.

After graduating, Jose Maria worked for 4 years on Rafael Moneo's office involved in the Gregorio Marañón Children's Hospital and the enlargement of the Prado Museum, and after winning a scholarship at the Spanish Academy in Rome joined the office in 2003.

They have won several competitions that allowed them to build a number of projects during the decade 2000-2010, amongst which health care centers and social housing dwellings are the main topics.

Their work has been widely published, including Architectural Record, AV, Bauvelt, Detail, Mark Magazine, Space, AIT, Speech, The Plan, etc. being selected as "Design Vanguard" by Architectural Record in 2007. It has also been shown in several international exhibitions such as the Venice Biennale in 2000, 2006 and 2008, Spanish Biennials of 2009 and 2011, Iberoamerican Biennials of 2006 and 2010, or Young Architects of Spain (JAE/YAS).

Main constructed projects have been recognized with prizes and honor mentions in more than 28 awards; 10th and 11th Spanish Biennial, 7th BIAU (Iberoamerican Biennial of Architecture and Urbanism), Barbara Cappochin Biennale, Madrid's city Architectural Prize, and ENOR, BigMat, ATEG, NAN, VMZinc, AIT Magazine, Asprima, Archdaily "building of the year", 2 Honor Awards in the 4th Boston Society of Architects' (BSA) 2014 Design Awards. 1st COAM 2014 Prize and WAN "House of the Year" 2014 Award.

Lately they have been awarded 3rd Prize, New Cinema and Digital Culture Center, Bogotá, Colombia. 3rd Prize, New Maternelle, Licee Francois, Madrid, and 1st. Prize, National Museum of Memory, Bogotá, Colombia. July 2015 (with MGP arquitectura y urbanismo), currently under development.

***3 x 1***

*= Municipal healthcare centres San Blas+Usera+Villaverde. Madrid, Spain. The story of why we have built the same building three times …*

Do you remember that Bill Murray's movie from the nineties called "groundhog day"? In the film, each day was the same day and from 7am it started all over again, one time after another.

Going seriously, it has been crazy at times but mostly rewarding to have the chance of building three times the exact floor plan. It all started with an unusual competition for doing two centres for the same client (Madrid's city council), with the same budget and the same functional program but only two different sites. Sites were in both cases quite irrelevant environments with anonymous social housing surroundings.

Our answer to those initial conditions was to work with the idea of a "placeless building". A great sense of formal+functional+conceptual autonomy was required to allow the building develop no matter where.

To emphasize the spatial value of the interior, we resorted to the LeCorbusierian idea of "reconciliation of opposites". The hermetic and heavy image of the exterior precedes the open and light space of the interior.

The program for the healthcare centre is implemented extensively on a single ground floor. The different rooms of the program are organized on a loose irregular orthogonal grid, where thirteen patios are arranged in a zigzag pattern between the public and private rooms along three parallel (non)-corridors. There is a non stop visual continuity across interiors and courtyards that provides space enlargement.

In opposition to this light system, split up by the patios, the solid and heavy façade is conceived as a continuous windowless mass. The absence of hollows in the vertical walls of the exterior enclosure causes the relationship between the interior and exterior of the building to occur vertically, almost with the sky above. The glass panels do not define patios, but hollows in the horizontal façade of the exterior shell of the building, creating a vertical relationship that allows an isotropic interior space to be generated. The transparency and mirroring qualities of the glass creates multiple visions by reflected symmetry.

The corridor vanishes, it ceases to exist as the traditional linear connecting structure, because the alternating arrangement of the empty spaces and public areas allows a weak relationship to exist between the "x" and "y" coordinates of space.

# Anne Øster Hjortshøj

Executive Officer, Department of Quality and Development, Zealand Region, Denmark


*Helbredsprofilen.dk – The Health Profile.dk*
*How short films on life with chronic conditions support a more coherent web of care*

Helbredsprofilen.dk (The Health Profile) is a webpage designed for patient with chronic conditions and their relatives. The webpage consists of more than 600 films (1-3 minutes each) where professionals, patients, and relatives share information. The content is defined by patients and relatives, and secondly by professionals in a workshop where the facilitator ask questions like:

"What would you have liked to know if you were diagnosed today?"
"How do you cope with living with your illness?"
"What is important to know for patients in various stages for the illness?"

Helbredsprofilen.dk supplements and replaces oral and written information. It addresses several problems in modern health care:

- 25 % of the adult population in the Zealand Region have low literacy and find it difficult to read most patient information
- Health professionals have limited time available for questions
- Most patients need information repeatedly to fully understand, reflect, and act accordingly – especially in a situation of crisis
- Many patients have nowhere to turn with many of the questions related to having a chronic condition (e.g. emotional reaction; the ability to return to work; the constraint on the family).

Helbredsprofilen.dk is developed in cooperation between the regional hospitals, the primary health care in the municipalities, and general practitioners. The webpage follows all cross sector clinical standard and agreements on coherent treatment. By putting the patient need for useful, understandable, and coherent information first, the webpage supports a coherent web of care for patients.

The webpage is available on http://www.helbredsprofilen.dk (choose preferred language in upper right corner).

## Alistair Rose

Project Director, Lancashire Care NHS Foundation Trust, UK

*The Harbour Project, UK: new environments and approaches to mental health care and dementia*

The Harbour is a recently completed 154 bed mental health inpatient facility in Blackpool, Lancashire. It includes residential accommodation for the different mental health specialisms of Functional Acute, Advanced Care, Dementia, and Psychiatric Intensive Care. The Harbour was conceived as one of four new inpatient facilities in Lancashire to replace dated existing accommodation, the design and configuration of the existing accommodation was holding back the development of a modern mental health inpatient service.

The Harbour was planned and delivered with significant involvement of service users and clinical / medical staff. Time was taken at the outset to determine the new service models, then the staffing required for these new service models, and lastly the design of the accommodation needed to provide this service.

Through the planning stages an opportunity was taken to relocate these mental health inpatient services to a new site to allow the service to deliver optimal accommodation to allow clinical, medical, and support staff to have the greatest amount of time for service user care. The Harbour is a landmark building at the approach to Blackpool and allows a confident statement about the importance the NHS places on good mental healthcare.

The presentation will outline the approach taken to the siting of the Harbour, the importance of early and continuous engagement with service users and staff in the planning and design stages, and how this involvement has led to the completed facility. Key findings of the Post Project Evaluation taking place in early November 2016 will be discussed, highlighting the differences between the aspirations of planned project and the use of the completed facility a year after opening.

## Fred Bisschop

Partner, nCZB, Netherlands

Fred Bisschop is a Dutch health economist who has been working in various functions related to building activities in health care. He is no stranger to the EuHPN as in his previous functions both for Bouwcollege and TNO he was present at a number of EuHPN meetings.

When decision making about investments was still done by the Minister of health care he was co-author of many reports about investment projects. Later he began to publish about the changes that were needed when competition was

introduced in health care – for example a joint report with the Dutch banking association about the financial position of Dutch hospitals and possible solutions. He also developed instruments that could lead to better investment plans like the Life Cycle Costing (LCC) approach. He has worked as a consultant on a large number of business cases for hospitals that were trying to finance their investment plans.

In 2013 Fred started, together with his two partners Leo Mimpen and Theo Staats, a consultancy network called nCZB. They continue to work in the tradition of the former Bouwcollege and Dutch Centre for Health Care and Architecture by looking at investment plans in a multidisciplinary and independent way. They have a permanent supporting role for CZ, one of the largest Dutch health insurers. They also have the mission to keep on publishing about subjects which are of general interest. Last year they published about the key figures to be used when making investment plan based on the former building guidelines.

## Dr Mateusz Lichon and Dr Marcin Kautsch

Krakow University, Poland

Marcin Kautsch is a lecturer and researcher at the Institute of Public Health, Jagiellonian University Medical College. He is also the project coordinator (Poland) of the project co-funded by European Commission: "EcoQUIP – Improving the efficiency, quality and sustainability of healthcare through innovation procurement" and "EPP-eHealth – Transforming the Market for E-Health Solutions".

In the past Marcin participated as a lecturer, a project author and a project leader in many training, research and consultancy programmes (international and national) including, among others: the Harvard & Jagiellonian Consortium for Health, a joint venture between Harvard and Jagiellonian universities, the LCB Healthcare project, dealing with innovative procurement, the Leonardo da Vinci DELTAH Project (Developing European Leadership Through Action-learning in Healthcare), "RES-Hospitals: Towards zero carbon hospitals with renewable energy systems", ENERGY-4-HEALTH", the "LEPHIE: Leaders for European Public Health project", led by the Maastricht University and other all-Poland projects financed by the World Bank, TEMPUS, PHARE, USAID and the European Commission. He was the representative on Poland in the COST Action IS0903 "Enhancing the Role of Medicine in the Management of European Health Systems – Implications for Control, Innovation and User Voice" and the co-chair in the VOICE Working Group of that action. He has extensive research experience and is an editor and author of healthcare management books. Apart from his academic career, he also works as a consultant for a number of health care units and local authorities in the field of public health and health care management.

Mateusz Lichoń is assistant to projects co-funded by European Commission aimed at increasing efficiency in healthcare by innovative solutions in Poland: EPP (e-health solutions), EcoQUIP (innovative procurement) and RES Hospitals (renewable energy solutions). He is a PhD student and a teaching assistant at Jagiellonian University. He is also a publicist to nationwide newspaper 'Ogólnopolski Przegląd Medyczny' (National Medical Review).

Mateusz has worked in various international organizations including American Institute For Foreign Study, European Health Management Association and European Parliament. He is a former action member and Early Career Researcher in COST Action IS0903 'Enhancing the Role of Medicine in the Management of European Health Systems – Implications for Control, Innovation and User Voice'.

He earned a Master's Degree in Political Science and Social Science at Jagiellonian University. He is also an alumnus of ICPSR Programme in Quantitative Methods of Social Research at University of Michigan, Leaders for European Public Health Programme at Maastricht University and Sustainability Leadership for the Health Care Sector Programme at University of Cambridge.

*Possible e-health contribution to the web of care*

Web of care and more personalized health services can benefit from the development of e-health solutions, that could lead to efficiently distributed and decentralized health care. Both, European Union and many Member States recognize the importance of e-health. Still, its development faces a number of challenges and its implementation remains uneven among various European countries. Additionally, the ultimate aim of usage of such solutions can vary due to cultural differences and various understanding of the role of patients in health care, that again corresponds with the level of patient empowerment or self-management that should be attributed to them.

This presentation will describe barriers and opportunities of the development of e-health from a perspective of stakeholders from three European countries: Denmark, Poland and Spain. It will also showcase various approach to the critical needs of contemporary health care (e.g. patient empowerment) and the level of belief that e-health solutions could help in meeting them.
Presentation is based on quantitative study conducted on a sample of 321 stakeholders representing health care sector from various European countries. The study was conducted as a part of EPP-eHealth project, cofounded by European Commission and executed by a consortium that includes partners from Denmark, Poland, Spain and the UK.

## Roger Pernas Vallès

CEO, CASA Solo Arquitectos SLP

Roger Pernas Vallès, CEO of CASA Solo Arquitectos SLP, has worked extensively in the healthcare field in Spain, Tunisia, Cameroun, Bolivia and Luxembourg, since the mid-1990s. During that time he has undertaken a very broad range of projects, encompassing new builds, extensions and refurbishments at every scale, and including health facilities for general hospital services, elderly care, maternity, rehabilitation, neonatology and many other specialties. He recently collaborated with Robin Guenther and Gail Vittori, in their book 'Sustainable Healthcare Architecture' to contribute a case study chapter on the Santa Lucia University General Hospital.

*Designing for environmentally sustainable healthcare: the case of the Santa Lucia University General Hospital*

"With the vision that 'good architecture is self-sustainable', Santa Lucia is a compelling, integrated, futuristic hospital. Emphasizing quality and effectiveness of patient care, prevention and health promotion, Santa Lucia blends a humanistic design with a complement of climatic design and renewable energy strategies including natural ventilation and extensive daylight. The water reuse and efficiency strategies employed at Santa Lucia offer a roadmap for an integrated approach to water demand reduction and harvesting of on-site resources to offset reliance on municipally treated potable water."
*Sustainable Healthcare Architecture (2nd Edition). Robin Guenther and Gail Vittori (eds). Wiley. 2013.*

## Sara Sanson

Strategic Management department of the 'A.S.S. n.1 "Triestina", Trieste, Italy

Sara Sanson is a manager in the Public Relations Office of the Strategic Management department of the healthcare organisation 'A.S.S. n.1 "Triestina" in Trieste, Italy. Her background is in healthcare management, quality, training and research methods, and in addition she has a Masters degree in Analysis and Management of Communications. She has played a central role in the recent integration of two healthcare organisations in the Trieste region, as well as the SmartCare project.

*SmartCare Project and Friuli Venezia Giulia deployment site*

From http://pilotsmartcare.eu/project/project-overview.html:

SmartCare aims to define a common set of standard functional specifications for an open ICT platform enabling the delivery of integrated care to older European citizens. A total of 23

regions and their key stakeholders will define a comprehensive set of integration building blocks around the challenges of data-sharing, coordination and communication.

Ten regions will then pilot integrated health & social services to combat a range of threats to independent living commonly faced by older people while the other will prepare for early adoption. In a rigorous evaluation approach, the pilot will produce and document much needed evidence on the impact of integrated care, developing a common framework suitable for other regions in Europe. Guidelines and specifications for procuring, organising and implementing the service building blocks will be produced. The organisational and legal ramifications of integrated care will be analysed to support long term sustainability and upscaling of the services.

SmartCare services will provide full support to cooperative delivery of care, integrated with self-care and across organisational silos, including essential coordination tools such as shared data access, care pathway design and execution as well as real time communication support to care teams and multi-organisation access to home platforms. The services build on advanced ICT already deployed in the pilot regions including high penetrations of telecare and telemonitoring home platforms. System integration will be based, whenever possible, on open standards and multivendor interoperability will be strongly encouraged. The common services will allow efficient cooperative care delivery and empower all older people according to their mental faculties to take part in effective management of their health, wellness, and chronic conditions and maintain their independence despite increasing frailty.

## Inés Fábregas

Business Development Manager, PMMT Forward Thinking Healthcare Architecture, Spain

*Clear Code Method: maximizing the accessibility of healthcare facilities*

To achieve real inclusive healthcare facilities it is important to understand what Universal Accessibility means, why is it necessary and what are the values and benefits that visitors and staff will achieve with it. Universal Accessibility ensures equal conditions for everyone and helps build a society where no one is discriminated against, regardless of their abilities.

Nowadays, 15% of world's population have some kind of disability. Furthermore, 25% of people in the world has some kind of limitation in the use of the physical environment. Therefore, 40% of the world's population is disabled or has some kind of limitation in the use of the physical environment. By the other hand, studies reveal that 46% of disabled people are over 60 years old and, at present, there are around 900 million people aged 60 or older, but it is estimated that in 2050 this number will have increased to 2.000 million.

In recent years, our world has become a little bit more conscious about Universal Accessibility. Promoting various rules and regulations. However, the necessary knowledge to implement real Universal Accessibility is dispersed and segmented, making it difficult to have a global vision. To

guarantee inclusive healthcare architecture, it is necessary to have a tool that organises all the existing information, allowing us to measure the effectiveness of any action executed.

Clear Code is a method developed by PMMT, for the objective analysis and the optimized implementation of Universal Accessibility. The method takes into account the needs of all the possible disabilities and limitations in relation to architectural space. To do so, all the diseases recognised by the OMS were classified, forming 13 different groups, and the different actions to be implemented for each group were identified. After the results of a CLEAR CODE analysis, it is possible to measure with objectivity the level of Universal Accessibility, and to provide those solutions that will guarantee inclusiveness in a more effective way.

## Jonathan Erskine

Executive Director, EuHPN; Research Fellow, Centre for Public Policy and Health, Durham University, UK

Jonathan has worked in health policy research for the past twelve years at Durham University, where his research interests are in large-scale change in health systems, the links between healthcare reconfiguration and the built environment, quality improvement methods and integrated care. As Executive Director of the European Health Property Network he is actively involved in ensuring that EuHPN meets its mission as a knowledge hub for organisations interested in planning, designing, building and financing all kinds of health facilities.

*The Vanguard Experiment: large-scale change in the English NHS*

The English NHS is undergoing another wave of major reform and reconfiguration. This time, however, these changes are not mandated by legislation, but by policy directives from national bodies such as NHS England and NHS Improvement. The focus is very firmly in achieving a step-change in integration of care, across secondary, primary, community and social care, with the aims of matching patient and citizen need with the available resources, and making full use of emerging technologies.

The 'Vanguards' are the vehicles for what is known as the New Care Models programme, which in turn is the means adopted to enact the ambitions of the 'Five Year Forward View'. In essence, the Vanguards are collaborative groups of local healthcare commissioning and provider organisations, which have been assigned some resources to try out different forms of integrated care. They have been described as an attempt to 'rebuild the airplane while it is flying', and that seems quite an accurate view! Whether the Vanguards will succeed or not is open to question, but the really interesting element is trying to understand the factors that may enable or hinder their success, and then applying those lessons to later reforms.

# Pentti Itkonen, PhD

CEO, South Karelia Social and Healthcare District, Finland

Pentti Itkonen leads a community wide integrated organization that includes acute care, primary care, social services and services for elderly people. The budget is 460 million euros and the number of workers is 4500.

He is the former development manager in the Ministry of Social Affairs and Health in Finland and he was responsible for the structural and managerial changes at national level following the interaction of ICT in social and healthcare organizations. Before that he was the director of North Karelia Hospital District being responsible for the specialized health care in the region.

Pentti Itkonen received his degrees from the University of Tampere and the University of Kuopio in Finland and he has written several articles on structural changes in social and healthcare.

*A new model of emergency care in Finland- what happens to the buildings?*

The main purpose of this presentation is to describe those actions which are the most important to decentralize hospitals and provide more “out – of – hospital” services. This is due the fact that during recent years we have seen a plethora of new management approaches for improving organizational performance: total quality management, flat organizations, empowerment, continuous improvement, reengineering, kaizen, team building, and so on. So far all these approaches in social and healthcare have very often only meant providing great volumes, measuring and prizing single products, supervising of contracts, controlling and calculating budgets and adding regulation. In spite of that the costs continue to rise at an unsustainable rate in all countries.

In response to the failure of traditional methods for controlling only costs the experience in EKSOTE (The South Karelia Social and Healthcare District in Finland) is improving value by evaluating well-defined patient outcomes against treatment costs. In practice this means for example to invest more in home rehabilitation to keep patients in good condition and then have less service needs in other parts of the pathway. The other example is to invest in new kind of emergency care model to avoid patient transportation to emergency room services.

The measurement is possible to implement especially in Finland and in EKSOTE because every Finnish resident has a personal identity code. This means that the measuring system has unique personal identifiers to link multiple sources of data- such as episodes of care, visits to doctor or expert nurse, visits to emergency room services, labor input and compensation that currently exists in multiple databases. The possibility of linking the various data sets in this fashion has the potential for creating a holistic view of outcomes and system costs, both direct and indirect, across the entire care-delivery pathway.

All this also have a huge impact on hospital design and institutional care in primary care wards and care homes. When we started our integrated organization in 2010 we had 1800 institutional beds in the region. Now we have 1350 beds. In the beginning we also had 90.000 m2 different kind of facilities and now we have 60.000m2. Also in the new facilities of the acute hospital we have space for digital medical services. This means that we are facing a very challenging period of time in planning social- and healthcare premises.

## Gunvor Øfsti

Special Advisor, South Eastern Norway Regional Health Authority, Norway

*The patient's health service - how to further develop the health service to the best for the patient?*

Health care in Norway is organized into two different management levels. Specialist health service is managed and funded directly by the State, and the municipalities are frame funded and have responsibility for all other health service.

National government introduced The Coordination reform in 2012 and adresses three major challenges:

- Patients needs for coordinated services
- Limiting and preventing disease
- Population development and the changing range of illnesses among the population

Goals are to be realized through several instruments: legal, economic, professional and organizational.

The Coordination reform is a reform of direction. The focus is on health promotion, better interaction between specialist health care and primary care and moving responsibilities, tasks and money to the municipalities.

A unanimous Storting (Parliament) is behind the goals of The Coordination Reform. In the period after 2012, there have been several white Papers from the Parliament and other national documents who maintains the challenges and the goals for health services development. Last year the government introdused a special plan for developing the specialist health care; “national health- and hospital plan”.

There are a lot of factors affecting the health care development: Professional development, technological development, demographic development, internationalization, change in the disease picture, change in patient role, policy and political areas, economic conditions and the organization of the services.

The lecture will draw lines between the different national guiding principles and the various factors that influence the development.

# Gunn Håberget

Hospitalplanner, Norwegian Hospital Construction Agency


*Planning the patient's health service – A case study from Helgeland, Norway*

The Norwegian Coordination Reform (2012) was followed by the National Health and Hospital Plan in 2016. This plan underscores even more the need for collaboration between hospital specialist health services and municipal primary health care.

The National Health and Hospital Plan defines three types of hospitals and mandates local health trusts to collaborate with municipalities to establish local medical centers with joint healthcare service. This provides a way to achieve the objectives stated by the Norwegian Parliamentary Resolution entitled 'Safe hospitals and better health care wherever you live':

- Patient oriented health care – in which patients take an active part in their treatment and in the development of the health care system
- Appropriate number of employees with appropriate qualifications – utilizing their time and resources effectively for the best interest of the patient
- Hospitals with a clear division of labor, organized in mutually interactive and supportive teams
- Renew, simplify, improve and digitalize health care
- A health care system governed by the overriding goal of high quality and safe care
- Strengthen prehospital acute and emergency services outside hospitals

The Regional Health Authorities are instructed to initiate a process to define future structures for each hospital in the respective region with respect to local requirements and conditions, within the framework of the Parliamentary Resolution.
Norway is a geographically elongated country with one of the longest and most rugged coastlines in the world, and scattered settlements. Some regions have greater challenges than others due to for example harsh weather conditions, bad roads, declining populations, and difficulties in recruiting health personnel.

This lecture is a case study on how the Coordination Reform (2012) and the National Health and Hospital Plan affect planning of hospital structure in the district of Helgeland, North Norway. Helgeland has a population of less than 80 000 inhabitants in an area of 17936 square kilometers. It contains 4 towns, 3 of which have hospitals. The local government of Helgeland is currently investigating several options for combining one or more hospitals with one or more local medical centers.

# Liesbeth van Heel

Programme Secretary, Erasmus MC, Netherlands

Liesbeth van Heel (1964) was trained in Facility Management and Business Economics before joining Erasmus MC as a management trainee. Since the late '90 she has been involved in the Erasmus MC redevelopment project as project secretary, and manager within the directorate of Corporate Real Estate. She has gained expert knowledge on the cutting edge of developing a good new university hospital and an innovative, sound and robust new building. Recently she focusses on a safe transition to the new facility, but is still involved in national and international orientation and knowledge sharing. She is also responsible for PR on the Erasmus MC project.

*Building a knowledge sharing network to deliver the evidence needed to transform care*

When we started our project (with the motto: thinking differently, working differently and building differently, thus transforming the way in which care would be delivered in our new hospital building in 15 years' time) we were hungry for the knowledge out there – visiting conferences and other projects for reference, finding literature, asking experts to gather expertise on specialist subjects; because we wanted to be a good, knowledgeable and responsible client for architects and engineers and owner of the new hospital building. Our efforts were compressed in a few guiding principles for the design, which have been used to steer and guard the design through the years. We did engage in some research of our own and invested in a team of experts within the hospital to help translate between hospital staff and the design team. Our approach and philosophy behind the building was already of interest to other hospitals and design teams (even before the first brick was laid, so to speak), and it was noted that Erasmus MC tried to integrate 3 approaches in the Dutch Hospital of the Future examples: sustainability, flexibility and process redesign (of course adding healing environment in the mix). In visiting other projects in this phase, we sharpened our ideas about design solutions (roughly from 2000 to 2010).

In the years 2010-2015 we actively, maybe on the wave of evidence-based design, helped develop new knowledge in the field, during a research collaboration between TNO/DuCHA and Erasmus MC. We used the existing hospital as a lab to try out some interventions and new approaches (e.g. for procurement). I have presented some of the results at recent EuHPN workshops. Also, we took it upon us to look for evidence that our design effort and emphasis did indeed work out as we hoped, hence the Post-Occupancy Evaluation (POE) study, that we presented in the workshop of 2014. This also shows that in this period we became aware of the EuHPN-network as a way of sharing knowledge and picking up ideas and contacts elsewhere in Europe. More visits from other countries and projects were the result. Within Erasmus MC (and for myself) the focus shifted from the building design to the process design and the transition phase toward the new building. This made us look again in our (during the years widening) network for hospitals undertaking that effort, with major changes (e.g. single patient rooms) before us. What lessons could we learn from others, and what lessons did we learn ourselves because of the phased realisation of our project (also looking at the process management of the

redevelopment project over the years). We invited an international audience in 2014, when we shared the hand-over from the building design to the process design (and architectural lead for the project within EGM architects), with a guest lecture from EBD-guru Kirk Hamilton. Following developments in our own country, but also in (Nothern) Europe through my hospitals' membership of EuHPN, I became aware of some trends (e.g. the PFI efforts in the UK, the consortia building for the regional clients in Scandinavia), and wondered about structures and results and the role of the client/owner in all this.

Both as a personal voyage, but also as part of the team of experts that have guided and guarded Erasmus MC's new building project so far (and now has to stand down and let go of its baby/child and let the end users take charge), I wonder what to do next. Who could benefit from our expertise and how could we go about sharing it. This has been an is a 'once in a lifetime' opportunity, as it often is for other hospitals big or small. We have looked around for other individuals (experienced project managers, researchers) to see how we can, alongside the more commercial industry and the knowledge institutions in the Netherlands, add value and speed to the spreading of innovation, solutions for sustainability & futureproof design and responsible ownership. Maybe the way these three circles meet and interact within the EuHPN is an example of what can be done to accelerate the needed care transformation for Future Hospitals. Maybe hospitals themselves are important 'hubs' in the network of knowledge on health infrastructure.

## Antonio Ocaña

Partner, AIDHOS Architects

*Two different approaches in PPP projects: Puerta de Hierro Hospital and Royal Liverpool University Hospital*

Different ways to undertake the construction of new healthcare infrastructures affect, in a decisive way, the final result. This presentation will analyse two different hospital projects, similar in size, goals and management model (PPP Public Private Partnership) developed in two different countries. These two cases are "Puerta de Hierro" in Majadahonda (2008) and the Royal Liverpool University Hospital in the UK (under construction). Our company was involved in both processes, and the aim of this talk is to analyse the difference model of competition (Tender vs Competitive Dialogue), and as result of that, the different aspects of the development in schedule, organization, teams, efforts, costs, etc. In order to think about new models of care (the 'web of care'), we should ask if these enormous efforts to develop new infrastructures, during a long period of time, are adequate or not to face new challenges for new ways of care, and how these possibilities of management, treatment and diagnostics have been incorporated in the life of hospitals.

Finally, we'll have a short look at the architectural organisation of "Puerta de Hierro" Hospital in order to understand better the visit to this hospital.