ARCHITECTS FOR HEALTH

FINAL REPORT

HEALTH ESTATES AND FACILITIES GUIDANCE ROUND TABLE DISCUSSION

WEDNESDAY 19TH OCTOBER 2016

HOSTED BY BURO HAPPOLD, LEEDS

CHAIR: PROF. JOHN COLE

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1 Background and Introduction to the Round Table

Within the healthcare design and construction industry, in both the UK and overseas, the suite of documents known collectively as "NHS guidance" has been a source of information for many years, respected worldwide.

The guidance – principally Health Building Notes and Health Technical Memoranda (or HBNs and HTMs) – was produced under the auspices of the Department of Health (DH) and became a substantial library of vital information to all professions involved in healthcare design and construction.

In recent times and with pressure on resources, the momentum by DH to keep the suite of documents up to date has slowed: the result is increasingly out of date material which is less relevant to modern practice. DH has floated the prospect of discontinuing central guidance altogether and letting the commerciality of the market place fill the void.

Over the past couple of years, Architects for Health has become increasingly concerned about the potential for guidance to be either abandoned or, maybe worse still, handed to a commercial agency wholesale, without wide industry stakeholder support.

In this context, Architects for Health contacted almost 100 individuals from across the healthcare design and construction industry to invite them to an informal 'round table' on 19th September 2016 in Leeds.

This document records the discussions and subsequent feedback of that session and makes some recommendations for further action.

2 About Architects for Health

Architects for Health is a not for profit organisation with a membership comprising not only architects, but engineers, contractors, landscape architects, healthcare planners, interior designers and clinicians.

Architects for Health believes that the spaces of healthcare have an important effect on the well-being of patients, their friends and families, and that good design can positively influence patient outcomes.
We work to bring about well-designed and restorative health facilities, through enabling conditions for this change, both through our membership and with wider health institutions and communities.
By sharing ideas, experiences and examples, we are building knowledge networks that inform and support the future design of high-quality healthcare environments.

For more information about Architects for Health visit the website at:-
www.architectsforhealth.com

3 SUMMARY OF CONCLUSIONS

Key points assembled from the day:

- DH Guidance is referred to (HBNs and HTMs) in the NHS Constitution and is hence embedded in the strategic goals of the NHS
- The DH badge on guidance is valued the world over
- Guidance is used as a standard and basis for legal cases
- Transfer of responsibility from DH to COI and so forth has diminished "organisational memory" and historical relevance
- **The assembled attendees agreed unanimously that guidance should be continued.**
- Guidance should be supported by evidence (i.e. not be the opinion of the few)
- Post Occupancy Evaluation should be an integral part of projects and lessons fed back relentlessly into guidance (A standard POE methodology is needed)
- Inputs to guidance should reflect international practice where relevant and not be parochially wedded to UK
- Refurbishment and upgrades should have appropriate guidance
- Resources across the UK (England, Scotland, Wales and NI) could be pooled
- Integration with procurement systems is important
- ADB is integral and should be closely allied with the guidance initiative. *(Though there is an opinion that ADB should be discontinued in its present form and other data systems developed – e.g. Codebook)*
- Guidance development should link in to the Carter efficiency work
- Consensus from across the healthcare design and construction industry is vital and this round table group might be a good starting point for that.

4 RECOMMENDATIONS FOR ACTION

Recommendations derived from the Round Table:

1. That the "badge" of the Department of Health should be retained on guidance material and hence, DH should retain an overview
2. That a pan-industry stakeholder group be established to give advice and consult on future direction, content and management of guidance: and that the stakeholder group be widened across the full spectrum of interests to ensure that clinical, nursing, patient and carer interests are fully represented
3. That a small core group be established under the overview of DH, to take responsibility for a programme of work as supported by and in consort with the wider stakeholder group (see 2 above)
4. That the core group and the stakeholder group should be transparent and open in working with the wider healthcare design and construction industry
5. That guidance henceforth be predicated on robust post occupancy evaluation and evidence based outcomes: and that a standardised methodology for conducting post occupancy assessments be urgently devised and introduced
6. The future plan should be realistically costed and transparently run

Recommendations derived from information and events post-Round Table including feedback from attendees and others:

7. Ownership of the Standards should be rest with the authority that commissions, sets and regulates them, i.e. central government in the guise of DH
8. The regulators need to be well informed, competent professionals who understand the standards, as well as those using them during the building process.
9. Estates-related standards and guidance should be seen as a part of the whole of the delivery of healthcare, and its regulation.
10. The range of outdated or no longer relevant guidance should be assessed
11. The purpose and structure of HBNs and HTMs should be considered
12. Emphasis should be given to the importance and benefit of POE/PPE and the need for it to be fully budgeted for in project costs
13. The structure of data management should be determined and developed to include and integrate the HBNs and HTMs whether or not the current database of ADB is continued.
14. There must be robust leadership and real understanding regarding technology, funding and the rapidly changing needs/demands from all sides, as well as a better handle on current estate conditions and cultural engagement needs.
15. That an overarching document be established to set the context and offer some parameters, such as a benchmark for populations modelling, demand by room type (e.g. CT, computerised tomography scan, per year) as an aide memoir- whether this is through PAM/Place or other groups but again should be owned by the NHS and not by proprietary companies
16. It must be acknowledged that the cost of guidance development with annual updates could save costs on capital investments.

5 RECORD OF PROCEEDINGS OF THE ROUND TABLE

The Round Table was conducted under Chatham House rules and consequently no contribution is accredited, except the remarks by the Chair and the opening presentation by Jonathan Erskine

Chair's Introductory Remarks: Prof John Cole
John Cole warmly welcomed attendees to the Round Table and hoped that the session would produce some positive outcomes.

Prof Cole began by reminding the group that the NHS Constitution includes the expectation of a clean and safe environment, utilising best practice under the rights of patients and staff, and that best practice includes Health Building Notes and Health Technical Memoranda.

Set in the context of the current climate, the Government Construction Strategy expects a 15-20% cost reduction on publicly procured projects and the utilisation of greater degrees of standardisation will contribute to this goal. In the health sector, standardisation could best be captured by appropriately crafted HBNs and HTMs.

Best practice in healthcare delivery and supportive design is constantly evolving and a dynamic means of updating and innovating is needed for guidance.

Central government procurement policy is currently not considered responsive to many pressing needs across the industry and is in some cases naïve.

The alternative view posed is that guidance is unnecessarily restrictive to freedom to design and innovate. However, without a co-ordinating focus and arguably a set of core principals, benefits from standardisation for example and lessons learned would be lost or at best poorly disseminated.

Over the past few years, the centre has tried new models for the management and development of guidance – by way of the COI and others. Currently, the core resource at DH for Estates and Facilities is much diminished and the future of guidance strategy is unknown.

The collective views of the healthcare design and construction industry might be best addressed at a high level to gain influence – to civil servants and Ministers.

In the short discussion that followed, it was noted that Post Occupancy Evaluation is seldom carried out on UK health projects. Following Prof Cole's comments on standardisation, he clarified that this would best be applied to components and layouts but not to whole buildings. It was also noted that technical (healthcare) guidance produced in the UK has an established 'market' across the world.

Jonathan Erskine, Executive Director, European Health Property Network and Research Fellow, Centre for Public Policy and Health, Durham University gave a short PowerPoint outlining initiative relating to guidance internationally.

EuHPN had conducted a survey of guidance regimes in various countries and had had 10 respondents. The methodology for the study and variety of approaches and detail of differing countries together with commentary on conclusions is given in the PowerPoint given in full later in this report.

The EuHPN study throws up some valuable discussion points and sets out a set of potential future scenarios together with the pros and cons of differing approaches. The slide entitled "In Brief" – a simple summation of the study and relevant to the discussions at the Round Table, reads as follows:

In Brief:
... The future of the production and use of guidelines and standards for health care facilities is likely to involve:

- Some 'command and control' elements;
- Some market-based co-design;
- Multi-disciplinary research and knowledge creation;
- Much greater use of networks and risk sharing

And in the context of the study overall, the five conclusions were:

Five conclusions from the review

1. Centralised production of guidelines and standards by large public sector organisations tends to become over-prescriptive, and may stifle innovation. However, this approach ensures some equity for planners, designers and constructors.
2. Smaller public agencies have the potential to develop high quality estates strategies and guidance, but this depends on organisational stability and good leadership, along with considerable in-house expertise.
3. Third party organisations, such as R&D institutions, can probably fulfil the same role, but they also need stability and adequate resources over the long term – and a mechanism to engage with the commissioners.
4. In health systems which are becoming more 'market-like', healthcare organisations have to be willing to accept greater responsibility (and risk) for choice of which guidelines to follow.
5. Reliance on 'in-country' guidelines and standards may be coming to an end – access to international best practice and guidance is becoming easier.

Open discussion

Starting premise – that DH Guidance (HTMs, HBNs and allied documentation) is beneficial for health buildings design and is valued both in England and other countries; discussion as to the solidity of such premise.

The group responded initially to Jonathan Erskine's presentation and it was noted that where, as in the UK, responsibility for guidance has moved from DH to the COI and thence external organisations, there has been a loss of organisational memory to the detriment of continued consistency and compatibility. Over all, the strategic management of guidance must be impartial and authoritative.

A fundamental premise of guidance production is whether it is central or market led. It was noted that where courts are involved in cases involving guidance, these are considered to be a basic requirement: the endorsement of guidance by means of the DH 'badge' is considered significant by courts although there is the potential for challenge should content be demonstrably not fit for purpose e.g. out of date.

John Cole then put a key question to the group:

Is healthcare design guidance needed and does the group support its future development and continuation?

The group agreed unanimously that such guidance is needed and that the debate should move ahead as per the agenda.

The pros and cons of format and content; detail, whether generic or specific; the users of guidance; use for briefing, concept, design, detail, standardisation, finance.

At present, HBNs and HTMs are free to download from the DH section of the gov.uk website. In an earlier iteration, guidance was free to NHS users but charged for to the private sector. The various iterations of management were mentioned (COI, the KIP website, involvement with Technical Indexes) and a discussion regarding control of documents including pdf protection followed. The group noted that the cost of administration, especially with a complex charging regime, will be high.

Reference was made to the BIM4Health Group which has also been considering the interaction of guidance with its key objectives in promoting a consistent BIM approach within the NHS. BIM4Health has sought views from colleagues in the USA and there is support for guidance which is paid for.

Within the UK, some of the benefits of guidance noted were the DH endorsement, which in some quarters is seen (inappropriately) as a mandatory position. Ownership by DH is also seen as having strength in being commercially independent. Additionally, the Care Quality Commission takes DH guidance into account when conducting inspections of healthcare facilities.

The point about capturing innovation in standards was reiterated. Wider or even compulsory (if workable) Post Occupancy Evaluation was again widely supported

and suggested as an addition to the RIBA Plan of Work with an allocated fee portion.

The group considered the initial stages of a project, where the parameters and objectives are initially set. Overall, there was agreement that the 'front end' rarely allows sufficient time or resource for detailed brief creation and formulation by the client/advisory team followed by rigorous design team analysis and development, which results so often in poorly conceived schemes. It is in this climate that well researched and documented guidance based on evidential feedback would be invaluable.

Involvement and liaison with the Royal Colleges was considered to be of enormous value: it was noted that the RCN and Royal College of Emergency Medicine had been involved in developing the Repeatable Rooms initiative under P21+.

P21+ (now succeeded by P22) involved 6 Principal Supply Chain Partner organisations who jointly funded the Repeatable Rooms initiative. The resultant work is available free of charge on the P21+ website for all.

However, at initial stages of schemes, there remains still considerable entrenchment of habitual behaviours. Added to this, the NHS is often firefighting to keep up with demand and immediate pressures. Furthermore, instilling best current practice can be evasive as often the wrong people are asked to make decisions quickly.

Engagement with nursing and clinical staff to establish the best model of care has to be an appropriate starting point. Involvement of staff 'on the ground' as well as senior people is equally valid. Note also that there is increasingly validity and importance in acknowledging international practice and systems.

The current systems of business cases, 'regional' planning systems and multiple levels of approvals make the initiation of projects often slow and difficult.

As a future guidance methodology emerges, it is important to incorporate clearly references to refurbishment and conversion of existing buildings, and also to be clear as to appropriate levels of derogation where space or other considerations are limiting factors. Again, studies and feedback from POE and benefits realisation are vital.

Reference was made to the Carter Review work ongoing within DH, which is reportedly working on a range of target metrics relating to clinical and non-clinical space.

Returning to initiation of projects, it was suggested that a key piece of work should be on a strategic guidance approach to ensure the high quality of project briefs.

The issue of whether guidance should be 'recommendations' or 'standards' was revisited. The idea of starting with some core and key elements, which by their nature should be unchanged, as well as setting out some mandatory minimum sizes for key spaces was debated. Reference was made to entraining European standards but caveated by the importance of an evidence base for these.

The P21+ approach to Repeatable Rooms is accompanied by a set of standard derogations for each.

There was a brief conversation around the consequences of not having guidance and the view in the room was that litigation would become more prevalent and that the 'free open' market would be unlikely to drive best practice.

Taking the above and looking to a way forward in structuring a future systematic approach to guidance development, the group agreed that there must be a broad consensus across the industry; that some dedicated resources will be needed and that this should be focused on an informed group of people mandated to proceed.

The new system must be structured to incorporate a methodology for prioritising and commissioning guidance, in accordance with the mandate from the wider industry. We noted that there will be a place for the 'mixed market' approach including public and private bodies as well as academia and significantly, clinical and nursing involvement.

Post Occupancy Evaluation was restated as a key basis for collecting evidence and learning from completed projects; and it was agreed that a standardised approach and system for POEs should be developed, with all such reports being collected and analysed centrally as a basis for further guidance development.

An associated design tool to guidance is the ADB (Activity Data Base system), which serves as a library of standard spaces and includes appropriate furniture and equipment. ADB is currently being updated and is due for release at the beginning of December 2016.

ADB clearly has much overlap with guidance and its evolution will be inextricably linked to wherever guidance goes in the future. We understand that ADB is incorporated into BIM.

Geographically, the four countries of the UK have different approaches to some aspects of healthcare projects and design but ADB appears to be consistent across all four. However, there are some subtle differences between countries and, in moving ahead with guidance development, it will be prudent to share expertise and approaches.

The group broke for lunch.
Discussion on best systems for selecting and prioritising guidance development; the practicalities of preserving and renewing DH Guidance; the commissioning of authors and technical advisors.

The afternoon session rehearsed a number of key points made during the morning session;

- The importance of guidance being accessible to all
- The pros and cons of a free service or one where a charge is made
- Whether guidance should be free to NHS staff and charged to others
- How cash would be collected and then used

- Note that a "free" offer may seem to cheapen perceived value of content
- That a DH badge is seen as vital for credibility and standing

Acknowledging the involvement of the private sector in any future initiative and the 'mixed economy', guidance might be authored in a number of ways and by a range of groups or bodies. There needs to be an informed interface with industry and client bodies at a high level to set priorities: the discussion restated the expectation that a small management group should be at the core of this new system.

The core group might, it was suggested, be led by an academic institution and/or research body. We were reminded that the P21+ Repeatable Rooms initiative had subjected itself to a rigorous process involving many teams and groups in a structured way which had in itself had a quasi-research methodology.

Discussion on options for managing and developing DH Guidance on the assumption that central DH funding is not available or will be severely limited in the future; financial issues in the current economic climate; future funding dilemma.

With the premise that guidance should be "DH" badged, we considered that DH should initially be the logical host: however, it is known that many current Estates and Facilities Management functions carried out under DH will be transferring to NHS Improvement and hence NHSI might be provide longevity and a longer term authoritative host role.

The group noted that new initiatives should embrace involvement from the not-for-profit and charitable sectors. As noted earlier, there is a clear need to link this work to the Care Quality Commission and, in the light of changing care models, to bodies that commission and provide social care.

Equally valuable will be links with NICE as well as the full range of professional organisations in the field such as IHEEM, CIBSE, HeFMA, Architects for Health and IHM.

With regard to structure of guidance, one model proposed saw a range of core elements which may become mandatory: core elements must be robustly based on thorough evidence from POE or similar analyses. As new work proceeds, it will be prudent to incorporate where appropriate, international standards where they too are evidence based and reflect best practice.

Other options posed included basing guidance on ISO standards, on NBS (considered through discussion to be too narrow) and by working with NICE – although there was some uncertainty as to how that organisation might relate to Estates and FM in detail.

One vital area which the group agreed would be of value is that of establishing, at the highest level, the health and social care needs of a population using a range of readily available central data. It was acknowledged that populations vary considerably but the suggestion is that a range of key questions might give a firm basis.

The current raft of 44 STPs (Sustainability and Transformation Plans) being prepared seem to have no standardised approach which will of course make comparative evaluation difficult.

The group also endorsed the suggestion that a document setting out 'an aid to briefing' would help enormously at early stages of a project.

We heard that the current Business Case system and its approvals process is quite sophisticated and includes, as a basis, an assessment of need for the relevant population. It is understood that NHS England's Business Case guidance is due to be re-issued in 2017.

At departmental level, guidance might be subdivided into core and non-core functions but should as before in all cases be evidence based. Room sizes and their immutability prompted a wide discussion. Should a mandatory space standard be set for a given room, what scope is there then for innovation and optimisation?

The general view tended towards supporting flexibility for room uses over time and hence a suite of standardised room areas would seem to be a good basis. Loose fit seems to have been "elbowed out" in many cases in favour of economics: 'how cheap can you build it' seems to be a common theme.

In many cases, space is considered solely as a cost at project stage and much has been lost in areas such as the public realm and in staff specific spaces.

A thorough basis for whole life costing should be at the forefront of scheme design and evaluation – consideration solely of capital cost is no basis for longer-term value.

The potential for success to be measured against initial aspirations therefore is embedded – as noted above – in properly structured and managed Post Occupancy Evaluation and by closing the feedback loop.

The establishment of a consistent and well-structured POE methodology became a high priority for the group towards the end of the conversation. POE should, among other areas:

- Review procurement and briefing
- Review construction
- Review outputs including patient outcomes over a longer period

Summary and final comment from Prof John Cole

The discussion had clearly supported the continuation of a suite of guidance for healthcare facilities and also agreed that the DH badge was essential for international and domestic credibility.

Management of future guidance should be vested in a small core group, host by DH – or if appropriate, NHS Improvement, about which the group had little information.

The core group must have regard to the views and opinions of a wide range of healthcare professional and industry stakeholders and to this end, a larger group from across those stakeholders should be formed.

Post Occupancy Evaluation and the production and maintenance of evidence based research should be a core value of future guidance production.

Development of guidance including needs assessments of populations and appropriate briefing might be part of a first tranche of work for a new guidance system.

It was suggested that one of the next steps in taking this whole initiative forward might be for Architects for Health to manage a wide-ranging survey to ask respondents for views on priorities for guidance development and to also identify where there is currently missing areas of guidance

6 LIST OF ATTENDEES

Prof John Cole	Chair
Carole Crane	Architects for Health
Paul Mercer	Architects for Health
Jonathan Erskine	Durham University and EuHPN
Prof Jim Chapman	Emeritus Professor Manchester University
Glynis Meredith-Windle	ArcHealth
Conor Ellis	Citrica
Sue Holding	Technical Publishing Resources
John Prendergast	Technical Publishing Resources
Sam Oliver	Codebook International
Erica Bishop	Integra/ Loughborough University
Sandra Aitcheson	Northern Ireland DH
Brendan Smyth	Northern Ireland DH
Jenny Shaw	Guys and St Thomas's NHS Trust
Keith Hayes	Graham Construction
Phil Smith	NHS England PAU Midlands
Donna Hewitt	NHS England PAU North
Mark Simpson	Sweett Group
David Kershaw	Balfour Beatty
Alan Kondys	Vinci Construction
Cliff Jones	P22 DH Lead (part-time)
Karl Redmond	BIM4Health Group
Sue Hignett	Loughborough University
Marisa Shek	Cowan Architects/ Expert Witness
Jane Ho	HKS Architects
Simon Harwood	NW London CCG
Simon Bourke	Buro Happold

7 POWERPOINT PRESENTED BY JONATHAN ERSKINE

.The complete presentation is accessible to view via the AfH website. If you want to read the whole text:-

Go to https://www.architectsforhealth.com/wp-content/uploads/2017/05/AfH-Guidance-Meeting-presentation-191016.pptx

8 FEEDBACK FROM ATTENDEES AND OTHERS

Comments post meeting were received from eight attendees and some others who were not able to come on the day. It was evident there was common opinion in many of the responses and the most significant of these have been incorporated into the text on page five above as items no. 7 – 16. The full range of the responses will be included in any future discussion.

The discussion will be conducted under Chatham House rules – anything said may be recorded in the minutes but will not be attributed: comments may exceptionally be offered 'off the record' in which case they will not be noted down.

This discussion does not aim to solve the problems surrounding the use of DH guidance in the form of HBNs, HTMs and ADB. Rather the aim is to explore the use of the guidance notes and to form an opinion on whether they will be necessary in the near and/or distant future and by whom they should be developed and financed. The meeting is informal and is not to be overly regulated so that all opinions may be heard.

10.30 Welcome and Opening Remarks – Prof John Cole

10.35 Introductions by attendees and a brief explanation of their interest in the discussion and hopes for the future.

10.45 Starting premise – that DH Guidance (HTMs, HBNs and allied documentation) is beneficial for health buildings design and is valued both in England and other countries; discussion as to the solidity of such premise.

11.45 If the meeting agrees that DH Guidance is **not** required then there will be an adjournment.

11.45 Assuming the meeting agrees DH Guidance is needed the discussion will continue – the pros and cons of format and content; detail, whether generic or specific; the users of guidance; use for briefing, concept, design, detail, standardisation, finance.

12.30 Lunch

13.30 Discussion on best systems for selecting and prioritising guidance development; the practicalities of preserving and renewing DH Guidance; the commissioning of authors and technical advisors.

14.30 Discussion on options for managing and developing DH Guidance on the assumption that central DH funding is not available or will be severely limited in the future; financial issues in the current economic climate; future funding dilemma.

15.15 Summary and final comment from Prof John Cole

15.30 Close

10 ACKNOWLEDGMENTS AND THANKS

Architects for Health and all of the attendees would like to thank warmly Prof John Cole for chairing the Round Table amid his other myriad appointments and for his thoughtful leadership on the day.

Thanks are also due with much gratitude to Simon Bourke and his team at Buro Happold in Leeds who kindly hosted the Round Table and supported the event with much care and generosity.

11 GLOSSARY

ADB	Activity Data Base A computer package to assist healthcare planners, architects, and teams involved in the briefing, design and equipping of healthcare environments. The package contains detailed data drawn directly from the Departments Health Building Notes (HBNs) as well as Health Technical Memoranda (HTM) publications.
AfH	Architects for Health – open to all professional of many disciplines interested in the design, construction and management of healthcare buildings
AMRC	Academy of Medical Royal Colleges - Royal Colleges comprise: - General Practitioners, Anaesthetists, Paediatrics and Child Health, Midwives, Radiologists, Ophthalmologists, Obstetricians and Gynaecologists, Psychiatrists
BIM4Health	Building Information Modelling for the NHS
Carter	The Carter Review - A review of operational productivity and performance in English NHS acute hospitals
CHP	Community Health Partnerships
CIBSE	Chartered Institution of Building Services Engineers
COI	Central Office of Information
CQC	Care Quality Commission – The independent regulator of health and social care in England
DH	Department of Health
DQI	Design Quality Indicator – The standard of design quality required on a project as defined by the client (with expert, professional assistance)
EPP	Efficiency and Productivity Programme – review of how NHS Trusts can reduce unwarranted variation in productivity and efficiency across every area of a hospital
EuHPN	European Health Property Network – effective investment in and management of health property throughout EU
GSL	Government Soft Landings – to champion better outcomes for built assets during the design and construction stages powered by a Building Information Model (BIM) to ensure that value is achieved in the operational lifecycle of an asset.
HefmA	Health Estates and Facilities Management Association
HBN	Health Building Note Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. They provide information to support the briefing and design processes for individual projects in the NHS building programme. They are used by the whole design team, clients and clinical and non-clinical users, contractors and suppliers
HTM	Health Technical Memoranda This series brings together all documents relating to Health technical memoranda which deal with decontamination, waste management, heating and ventilation, electrical, acoustics, lifts, fixtures and fittings and all other aspects of hospital building services etc. They are used by the design team, especially the services engineers and referenced by hospital facilities management teams.
IHEEM	Institute of Healthcare Engineering and Estate Management

IHM	Institute of Healthcare Management
ISO	International Organisation for Standardisation
KIP	Knowledge and Information Portal – online version of DH Guidance information. Now no longer available
NICE	National Institute for Health and Care Excellence – Improving health and social care through evidence based guidance
NHSI	NHS Improvement - Better healthcare, transformed care delivery and sustainable finances
NBS	National Building Specification for the UK
P21+	NHS Procurement Framework - addresses the principles of effective collaboration between the Department of Health, NHS and construction supply chains whilst addressing the process of delivering further cost efficiency savings for the NHS.
P22	ProCure22 (P22) is a Construction Procurement Framework administrated by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England.
PAM	Dept. of Health Premises Assurance Model - an NHS organisations annual self-assessment of its governance and assurance for non-clinical services
PAU	Project Appraisal Unit – NHS England
PCR	Post Contract Review - review of the management of contracts
PLACE	Dept. of Health Patient Led Assessment of the Care Environment - an NHS organisations annual self-assessment of its soft FM and infection control standards conducted by a stakeholder group comprising patients, carers and staff)
POE	Post Occupancy Evaluation - systematic evaluation of opinion about buildings in use, from the perspective of the people who use them. It assesses how well buildings match users' needs, and identifies ways to improve building design, performance and fitness for purpose.
PPE	Post Project Evaluation – a record of what went well, what could be improved and what lessons have been learned following completion of a project
RCN	Royal College of Nursing
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
RIBA	Royal Institute of British Architects
SCP	Supportive Care Pathway – an end-of-life care pathway that is used to ensure that anyone with an advanced life-limiting illness receives the best possible care
STP	Sustainability and Transformation Plans - 44 areas in England covering all of England charged to develop proposals and make improvements to health and care.