



Historic England

Health and Welfare Buildings

Listing Selection Guide



Summary

Historic England's twenty listing selection guides help to define which historic buildings are likely to meet the relevant tests for national designation and be included on the National Heritage List for England. Listing has been in place since 1947 and operates under the Planning (Listed Buildings and Conservation Areas) Act 1990. If a building is felt to meet the necessary standards, it is added to the List. This decision is taken by the Government's Department for Digital, Culture, Media and Sport (DCMS). These selection guides were originally produced by English Heritage in 2011: slightly revised versions are now being published by its successor body, Historic England.

Each guide falls into two halves. The first defines the types of structures included in it, before going on to give a brisk overview of their characteristics and how these developed through time, with notice of the main architects and representative examples of buildings. The second half of the guide sets out the particular tests in terms of its architectural or historic interest a building has to meet if it is to be listed. A select bibliography gives suggestions for further reading.

This selection guide looks at hospitals, asylums, workhouses, almshouses and health centres. They provide strong architectural evidence of changing attitudes to the sick and destitute, and have long been some of our most functional buildings, as well as among our largest. Their design can say much about changing social attitudes and about science's impact on architecture too.

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Front cover

The former Somerset County Asylum for Insane Paupers, at South Horrington, near Wells. Designed by G G Scott

and W B Moffatt, and opened 1848. Now converted to residential use. Listed Grade II.

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Introduction

Buildings for tending to the sick and aged (and, more recently, for promoting well-being too) come in a great many shapes and sizes and vary enormously in date, from monastic infirmaries to almshouses, cottage hospitals and contemporary drop-in surgeries. They provide strong architectural evidence of changing attitudes to the sick and destitute, and have long been some of our most functional buildings, as well as among our largest. Their design can say much about changing social attitudes and about science's impact on architecture too. Hospitals display the slow embrace of the treatment of contagious and incurable diseases thanks to better nursing care

ahead of biological advances; while workhouses reveal the gradual rejection of punitive concepts regarding the 'undeserving' poor in favour of universal care. As well as this, health buildings can sometimes be fine architectural statements too.

This selection guide looks at hospitals, asylums, workhouses, almshouses and health centres. After a brief historical introduction it then provides a slightly fuller overview of the historical development of different types of health and welfare buildings, before outlining the various factors which are taken into account when considering them for designation.

1 Historical Summary

Treatment of the sick, old and infirm in the Middle Ages was largely the preserve of the church and in particular of monasteries. Evidence of a pre-Conquest leper hospital has recently been unearthed at St Mary Magdalene, Winchester, and Lanfranc's hospital at Harbledown, near Canterbury of the 1070s was perhaps the earliest Norman foundation of this kind. However, it is estimated that around 750 almshouses – specially built or converted buildings set up by pious benefactors to accommodate destitute people – still existed in 1547, after the early stages of the Reformation. Only three major medieval hospitals survived the Dissolution, all in London. St Bartholomew's and St Thomas's (re-founded in 1546 and 1551 respectively), and St Mary of Bethlehem (Bethlem, or Bedlam) for the mentally ill, the last of which had been secularised when it came under the jurisdiction of the City of London in 1346; these formed the only models for hospitals available in England until the latter part of the eighteenth century. Provision for disabled soldiers and sailors formed another strand of early hospital building. Greenwich, Chelsea, and Bethlem Hospitals in London were all masterpieces of palatial grandeur, designed by the finest architects of their day, and showed the importance of public display for these very prominent national institutions (Fig 1).

The roots of welfare architecture lie also in poor relief, and they produced far more numerous – if humbler – results. Following the Dissolution, a series of Acts (in particular the Poor Law of 1601) required individual parishes to relieve their poor and set able-bodied paupers to work in premises devoted solely to these ends. Residential workhouses for individual parishes resembled cottages or farmhouses; after the reforms of the 1782 Gilbert Act, they often became more imposing and incorporated special planning as parishes were able to group together and provide larger, shared premises for poor relief. As attitudes to paupers hardened in the early nineteenth century under the influence of utilitarian ideas, which sought to discourage idleness by making poor relief an unattractive option, so workhouse regimes became harsher with greater emphasis placed on segregation of the sexes and supervision. This approach is forever associated

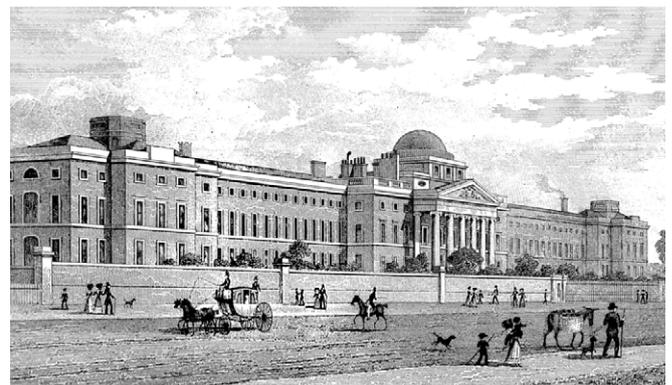


Figure 1
Bethlehem Hospital (Bedlam), London Borough of Lambeth. This was founded as a lunatic asylum in the Middle Ages. In 1815 it moved to a purpose-built accommodation in Lambeth built by James Lewis, seen here in 1828. It has since moved to Beckenham, Kent, and the building itself now forms the centrepiece of the Imperial War Museum. Listed Grade II.

with the 1834 Poor Law Amendment Act which sought to end outdoor relief, and made admission into a ‘Bastille’ a pre-requisite for assistance. However, the tradition of private charity for the deserving poor flourished alongside poor law provision and, by the eighteenth century, almshouses were powerful emblems of corporate status and private munificence and remained so well into the twentieth century.

It was not until the early eighteenth century that new ‘voluntary hospitals’ were established. These served the sick poor, and were run by boards of governors made up of local gentry; they were highly significant outlets for philanthropy, and could attain considerable visual magnificence: John Carr’s Grade I York Asylum of 1772-76 is a particularly fine example of this striking local tradition of philanthropy and a unique example of an eighteenth-century voluntary hospital dedicated to lunacy. About 250 had been established by the middle decades of the nineteenth century, and they formed the core of health care and medical innovation (through teaching hospitals) until the launch of the National Health Service in 1948. However, many other types of hospital and welfare buildings had emerged by that date, each with its own key features and dates, and these are discussed below in the section: Specific Considerations When Considering Health and Welfare Buildings for Designation.

Major rationalisation and updating of antiquated and duplicated hospital stock came with the National Health Service (formed in 1948). Sir William Beveridge’s 1942 report on social services laid the foundations for a welfare state, and a 1945 proposal by Aneurin Bevan further developed the creation of a nationalised system of state health care: a hugely important step in the progress of post-war British society, which made real the wartime aspirations towards fairness, equality and compassion. The Nuffield Trust commissioned detailed studies from the architects Richard Llewelyn Davies and John Weeks, particularly of ward planning, operating-theatre design and modern services, and their recommendations inspired a new generation of hospitals. The Ministry of Health’s own Architects’ Department also experimented with new plan forms and prefabricated hospitals.

Recent investment in hospitals has been considerable, resulting in the replacement of many older buildings. The numbers of pre-1948 purpose-built hospitals still in hospital use has dwindled significantly in the past twenty years, and redevelopment of large hospital complexes has tended only to preserve the principal buildings, making the survival of ancillary buildings such as mortuaries, boiler houses and laundries increasingly rare. Overall, however, a significant part of the country’s stock of older welfare buildings including workhouses still survives, with many former hospitals and asylums finding new uses through residential conversions.

Greater detail on the history of specific building types is offered in the following section.

2 Specific Considerations

Health and welfare buildings evoke strong emotions, both positive and negative. They are places of birth and death, illness and recovery, and they can be held in high community esteem. Requests for designation are often prompted by fears of losing a prized facility. It is thus particularly important that assessment for designation is, and is seen to be, rigorous and detached, and that historical and architectural considerations alone are borne in mind.

The main outlines of the history of health and welfare buildings are relatively straightforward. Many were built with great panache using the most up-to-date architectural fashions, but within the generic building type there are large numbers of specialist institutions that have distinctive and sometimes rare features. Some of the latter may be architecturally undistinguished, and great care needs to be taken to balance the quality of the architecture of the whole with the historic significance of a particular part.

Another factor requiring comment is the issue of standardisation. Many hospitals, particularly from the 1830s onwards, were built to standard design principles. Credit will therefore be given to particularly good representative survivals of certain types as well as to examples that display particular innovation.

Alteration is inevitable in such intensively-used buildings: the survival of the essential principal elements will be a key determinant. Sometimes, isolated survivals, such as chapels, will warrant designation even when the rest of the complex has been substantially altered. Care will be

needed to define just where the special interest lies: it can be unevenly distributed across a hospital site.

Individual buildings must be assessed on their own merits. However, it is important to consider the wider context and where a building forms part of a functional group with one or more listed (or listable) structures this is likely to add to its own interest. Examples might include the janitor's house, mortuary chapel, stables or coach-house. Key considerations are the relative dates of the structures, and the degree to which they were functionally inter-dependent when in their original uses.

Some hospital or asylum landscapes will have a group value: individual buildings sometimes belong within a designed landscape in which the ensemble is of greater importance than the individual buildings. Some landscapes will deserve inclusion on the *Register of Parks and Gardens of Special Historic Interest in England* (see the selection guide on [Institutional Landscapes](#)), while other hospital complexes may deserve designation as conservation areas.

Certain overarching principles for assessing health and welfare buildings can be set out:

- All medieval hospitals and welfare buildings (including almshouses) will be eligible for designation and most dating from the sixteenth to the eighteenth centuries if they survive in anything like their original form
- Pre-1840 general hospitals, pre-1868 hospitals with pavilion plans, and workhouses prior to 1845, will be listable unless heavily altered
- Greater selection is required for later examples because of the vast increase in numbers. Architectural interest, planning, and intactness (particularly external) will be crucial considerations. Specialist hospitals (rarer outside London) developed later and may be of special interest where they deviated from normal hospital plans; relatively early dates within the overall chronology of these types will strengthen the case
- Some building types (for instance, almshouses and pre-First World War non-municipal sanatoria) were treated with particular architectural embellishment and should be assessed on their own merits, with quality of design being the most important factor
- Good modernist inter-war hospitals (which are few in number) and health centres, and those that reflect major innovations in medical practice, are eligible
- Very few post-war examples of health and welfare buildings have been designated to date, but those that display outstanding architecture and historic interest may qualify

Certain more specific principles for assessing health and welfare buildings can be set out with reference to their particular dates, characteristics, and functions, and are set out below.

2.1 Hospitals

The General Voluntary Hospital before about 1840

Many eighteenth-century hospitals started out in modified private houses and, even when specially built, to a certain extent they emulated them. This tendency towards monumental polite design is strongly felt at Guy's Hospital, London (listed Grade II*), founded in 1724 for 'the incurably ill and the hopelessly insane' and consisting of wards arranged around two courtyards (Fig 2). Hospital functions tended to be contained within a single block, although elements such as the kitchen or isolation wards were gradually removed to separate buildings. An awareness of the importance of heating and ventilation means that a greater emphasis was placed on window ventilation than would be normal in a conventional dwelling house; John Wood the younger's General Infirmary at Salisbury (Wiltshire) of 1767-71 (listed Grade II) exemplified this. From the start most had some form of board



Figure 2

Guy's Hospital, London Borough of Southwark. The main early phases of the hospital, which is arranged around inner quadrangles, are of the 1720s. This view of 1820 shows the central main entrance block by Thomas Dance, built 1728 (remodelled by Richard Jupp, 1774). The east wing was originally built by James Steere, 1738-41, and completely rebuilt in facsimile after the Second World War. The chapel and west wing of 1774-7 were also by Jupp. Listed Grade II*.



Figure 3
Royal Naval Hospital, Plymouth, Devon. The former Royal Naval Hospital was designed by Alexander Rowehead and built around 1760. The prototype

pavilion-plan hospital, with interlinked wards, corridors and service pavilions intended to combat the air-borne spread of disease. Listed Grade II.

or committee room and a chapel, endowed with particular decorative elaborateness, and these have always been particularly important parts of hospitals. James Gibbs' buildings for St Bartholomew's Hospital of the early 1730s include a spectacular great hall replete with murals by Hogarth on its staircase. General hospitals from before 1840 are normally listed if their principal elevations survive intact and their appearance has not been overwhelmed by later additions. Examples that are little extended and which retain major parts of their interiors (for instance, a fairly grand entrance hall, chapel, a panelled board room, a good chimney piece or cornicing, or medical survivals such as operating theatres) are rare, and may be eligible for listing at a higher grade. Voluntary hospitals for mental patients were built to a similar model; survival rates are very low and all would be of likely interest.

Post-1840 hospitals and the pavilion plan

General hospitals continued to multiply in the early nineteenth century, the most progressive experimenting with improved ventilation and sanitation. The mechanics of infection remained poorly understood well in to the twentieth century. 'Miasmatic' theories (the idea that disease passed through the air rather like a cloud) prevailed and ventilation remained the determining factor in hospital design until the twentieth century. This explains the popularity of the *pavilion plan* that separated functions and provided good light and ventilation to dispel foul air. Eighteenth-century in origin and influenced by French prototypes, the Royal Naval Hospital, Stonehouse, Plymouth, of 1758-62 by Alexander Rowehead (listed Grade II; Fig 3), was the first. In its fully developed form it comprised ward wings linked together at one end by corridors that

connected the pavilions (the main ward blocks) to centrally positioned service and administration buildings. Sanitary facilities were contained in towers or annexes. Many hospitals adopted combined heating and ventilation systems, notably the plenum system which brought air in at eaves level, filtered, warmed and humidified it and expelled it at a rate of ten changes a day.

The earliest true pavilion plan general hospitals were Blackburn, Lancashire (designed 1857, built, 1859-61, James Turnbull) and Ashton-under-Lyne, Staffordshire (1859-61, Joseph Lindley). The earliest large-scale pavilion plan general hospitals include Leeds, West Yorkshire (1864-8, George Gilbert Scott; listed Grade I; Fig 4) and Stoke-on-Trent, Staffordshire (1866-9, G B Nichols and Charles Lynam; listed Grade II), both closely modelled on the Lariboisière hospital in Paris (1846-54). The long ward ranges are sometimes

known as Nightingale wards, after Florence Nightingale (1820-1910), who on her return from the Crimean War became a prominent figure in the health reform movement and who campaigned for better hygiene and planning. Variants on the pavilion plan abounded. Early (pre-1868) pavilion hospitals are rare. A highly important act which led to the greatly increased building of hospital premises was the 1868 Metropolitan Poor Law Act, which permitted Boards of Guardians to open infirmaries as parts of workhouses, typically placed apart from the main building and often on a separate site. After 1868 the only general hospitals likely to be listable are those with novel plans (such as the cruciform University College Hospital, London 1897-1906, Alfred Waterhouse; listed Grade II, features such as circular wards (which enjoyed a brief vogue during the 1880s, as at New End Hospital, Hampstead, London; listed Grade II*) or those which have exceptionally fine



Figure 4
Leeds General Infirmary of 1864-8, by George Gilbert Scott, was one of the earliest large-scale pavilion-plan general hospitals. So palatial was its Gothic Revival

architecture that it provided the venue for the National Exhibition of Works of Art in the five months prior to its official opening in October 1868. Listed Grade I.

architectural detailing, such as Brumwell Thomas's West of England Eye Infirmary of 1898-1901 in Exeter; listed Grade II. Look out for works of art including stained glass in chapels, tile murals in children's wards (see below) and for memorials.

Hospital planning became increasingly complex as medical science advanced, with improved attention to detail such as impervious surfaces and an absence of dust-retaining ledges and shelves. Specialist rooms multiplied towards the end of the century: some were completely new in function, such as X-ray rooms (after 1895). By the late 1860s nurses' accommodation provided secure on-site accommodation, mainly to attract a higher class of women to the profession. Despite this greater complexity, which can sometimes erode earlier planned layouts, there was little significant movement away from pavilion planning before the First World War. Many hospitals grew out of workhouses: more consideration is given to this sort of building below.

From the late 1860s nurses' homes were introduced to provide secure on-site accommodation, mainly to attract a higher class of women to the profession but also to provide a quarantine environment for hospitals catering for infectious diseases. Noted architects were responsible for a number of commissions, especially in the Edwardian period, and external architectural quality will normally be the major consideration for listing. While many are institutional in nature, facades can also be proud and well-detailed, in response to the growth of nursing as a profession and the increased attention to staff comfort and welfare. Keep an eye out for lettering announcing the building's function, and consider group value with other hospital buildings nearby. Interiors were generally functional with single bedrooms above communal sitting and dining rooms, as with other women's lodgings of the period.

It was also in the late 1860s that the first ambulances appeared, at least in London. As they became more common, ambulance stations were built attached to hospitals. Invariably these were modest, freestanding structures.

The 1920s and after

Bacteriological research in the 1920s showed that infection took place by direct contact with diseased matter, and no amount of cross-ventilation would kill germs. Surgery advanced with the development of aseptic (micro-organism-free) environments and anaesthetics, and planning adapted, not least to ease the daily routines of doctors and nurses. Specialist hospital architects emerged, further encouraged by the 1929 Local Government Act which extended the role of local authorities in providing health services. In the inter-war years, hospitals were a perfect vehicle for modernist design (although they were always relatively rare). The Royal Masonic Hospital, London Borough of Hammersmith and Fulham (now the London International Hospital), 1931-3, by Sir John Burnet, Tait & Lorne; listed Grade II*, was pivotal, with its balconies, large windows and ocean-liner modernism creating a clean and up-to-the-minute image for healthcare; it was one of the first large-scale buildings of any type in the new style (Fig 5). However, neo-Georgian remained the preferred style for the first generation of municipal hospitals. Examples have to be little altered in the main elevations and have architectural coherence to warrant designation: many were fairly routine in design terms, but sometimes features such as war memorials can endow them with an extra interest. Whereas general hospitals in the inter-war period were compact, with wards, operating theatres, x-ray facilities and other technical areas concealed in single blocks that were often symmetrically composed, the post-war period separated out these elements to permit clinical areas to be changed more easily as medicine advanced. They were often single-storey blocks that contrasted with fixed ward blocks, often taller and placed centrally leading to the 'matchbox and muffin' plan. The work of Llewelyn-Davies & Weeks, consultants to the Nuffield Foundation and Powell & Moya provided the best examples of thoughtful planning and architectural elegance. Later hospitals adopted module planning systems, 'best buy' and 'nucleus'. Functionality became an architectural image in itself, and the transformation of the hospital as a building type has thus been dramatic.



Figure 5

Royal Masonic Hospital, Hammersmith, London. Founded in 1914, the Royal Masonic Hospital gained a new site and buildings in 1931-3 – one of the first hospitals fully to embody modernism. Designed by Sir John Burnet, Tait and Lorne, with sculptured concrete work by

Gilbert Bayes, the administration, ward, service and surgical blocks are built in a symmetrical yet somewhat expressionist manner derived from the Dutch architect Willem Dudok. Main block listed Grade II*.

Cottage hospitals

Cottage Hospitals emerged in the 1860s to provide hospital care for patients near their homes and family, inspired by Dr Albert Napper's foundation of Cranleigh Village Hospital in Surrey. They were very popular – there were around 300 in 1895 – and were often run on a subscription basis. Patients were expected to pay towards their care, and they were attended by their own doctor. There was no common formula. They could accommodate as few as four patients and a live-in nurse, often equipped with a small dispensary and an operating theatre. They aimed to be as homelike as possible, and were thus domestic in character, but success led to an increase in their size and the adoption of the pavilion plan. Some cottage hospitals are a feature of planned developments, notably Port Sunlight, Liverpool (1907; listed Grade II), and many were built after

1919 as war memorials. Their domestic scale lent itself to the vernacular and Queen Anne Revival and Arts and Crafts styles: many are distinguished compositions. With changes in health provision in the later twentieth century many smaller cottage hospitals became redundant or, if retained in use, were substantially extended: this has rendered many unlistable.

Military hospitals

Military hospitals were often at the forefront of developments in hospital planning and design. The first army and navy hospitals – respectively Chelsea (begun 1682; listed Grade I) and Greenwich (begun 1691; listed Grade I) – accommodated retired and disabled soldiers and seamen in the grandest surroundings which sought to rival Louis XIV's Les Invalides in Paris: both were royal foundations in which compassion

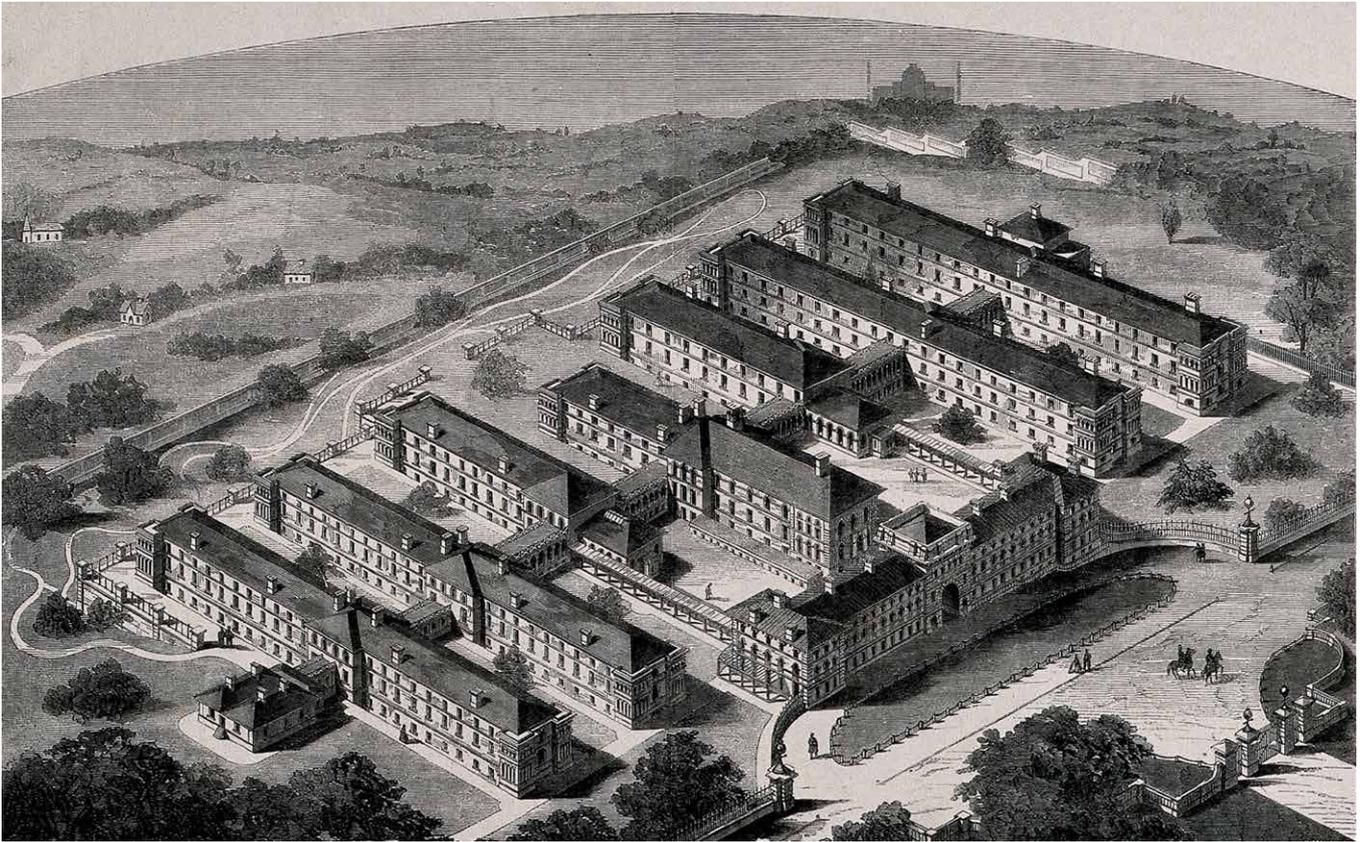


Figure 6

Royal Herbert Hospital at Woolwich, in the Royal Borough of Greenwich, London. The army's Royal Herbert Hospital of 1861-5, seen here in a contemporary engraving. Designed by Captain Galton

of the Royal Engineers, it provided a model for military and civilian hospitals alike. Listed Grade II.

for the victims of war added lustre to the House of Stuart. Military hospitals in the modern sense of the word do not appear before the eighteenth century and the Royal Navy built its first examples in the Mediterranean. In Britain, Haslar, near Gosport, Hampshire (1746-1761; listed Grade II), and Stonehouse, Plymouth (1758-62) for naval patients, were the first. It was Stonehouse that proved most influential, for Alexander Rovehead or Routhead was allowed to produce a series of detached buildings rather than a quadrangle, which enabled infections to be isolated and maximised the circulation of air. Cross-ventilated wards were established in both services by the 1820s. The army's Royal Herbert Hospital at Woolwich (1861-65; listed Grade II; Fig 6) was among the first true pavilion plan hospitals in the country and provided a model for military and civilian hospitals alike. Designed by Captain

Galton of the Royal Engineers (and Florence Nightingale's nephew), it is now flats. Aimed first at combatants suffering infectious diseases and from the eighteenth century providing separate wings for the mentally ill, military hospitals came gradually to also offer facilities for the families of servicemen. Later nineteenth-century reforms led to the construction of bespoke army medical and veterinary facilities (as on Millbank, in London, where the former Royal Army Medical College stands beside the Tate Britain) which could combine architectural presence with functional interest; the Cambridge Military Hospital in Aldershot, Hampshire (opened in 1879), is a particularly good example of this category. The Royal Air Force began to erect purpose-built hospitals between the wars: Ely, Cambridgeshire (1939-40) and Wroughton, Wiltshire (1939-42; Fig 7) were



Figure 7
Wroughton Hospital, Wiltshire. The Royal Air Force's purpose-built hospital at Wroughton of 1939-42, a striking example of the International Modern style. In the six months after D-Day almost 5,000 patients were treated there.



Figure 8
New Hospital for Women, (The Elizabeth Garrett Anderson), London Borough of Camden. The most famous of the pioneering women's hospitals, run by and for women, opened as a dispensary in 1866. The present building dates from 1889-90 and is now offices and a small museum. Listed Grade II.

striking examples in the International Modern style. Barracks generally had hospitals too.

Only fragments survive of the temporary hatted hospitals set up during the First World War. Many large houses were also used for medical care (like Cobham Hall, Kent; listed Grade I) and this can add an extra layer of interest to them. This also applies to numerous temporary ward buildings erected before and during the Second World War. Often bleakly utilitarian, in their construction and planning, they are nonetheless becoming rarer all the time and do bear witness to an epoch of global conflict and high casualties in an age of total war. Few military hospitals of architectural merit were erected after 1945.

The specialist hospital

This was largely a nineteenth-century phenomenon to care for cases excluded from most general voluntary hospitals, and there were many different types. Most began in converted houses but from about 1850 purpose-built hospitals began to be built. The key areas of interest in the design of larger examples are the ways in which mainstream general hospital planning was adapted to meet the

demands of each specialism. London had the greatest concentration and variety of specialist institutions, such as the small St Mark's Hospital, London Borough of Islington, built in 1853 for the treatment of fistula (Grade II) but relatively few survived competition from teaching hospitals that began to create their own specialist departments, a position exacerbated by the rationalisation of services after 1948.

Maternity hospitals

Early examples were similar to general hospitals. The earliest English example, in Westminster, dated from 1765-67. Alarming high mortality rates from childbed fever (higher than in other hospitals) closed many of them down. One of the first designed to combat infection was the new Liverpool Lying-in Hospital (1884, E H Banner), which provided single rooms in 'cottages' placed on either side of the central administrative building. By the 1920s and 1930s maternity wards became increasingly common in general and cottage hospitals, and after the Maternity and Child Welfare Act of 1918, municipal maternity hospitals, homes and clinics were established that attempted to put patients at ease in small rooms rather than large wards.

Women's hospitals

These appeared in the 1840s and there were twelve by 1871. Most adopted pavilion planning principles. The New Hospital for Women, London Borough of Camden (listed Grade II; Fig 8) founded in London by Elizabeth Garrett Anderson (1836-1917), the first woman to qualify as a doctor in England, was the most famous, and trained women doctors to work overseas – notably in India. From the 1870s general hospitals began to set up gynaecological wards and specialist departments. By the 1930s the desire for separate women's hospitals was in decline.

Children's hospitals

Separate children's hospitals came relatively late. Great Ormond Street hospital in London (founded 1852, built 1872-7 by E M Barry on the pavilion principle; parts listed Grade II*) was the first in England and by the late 1880s there were 38 in Britain. A special feature of children's hospitals, and specialist children's wards in general hospitals, from around 1900, is their decoration with tile murals depicting appropriate subjects like nursery rhymes. Many were produced by Doulton of Lambeth or Carter and Co of Poole, and where these survive, they may be a deciding factor in a listing assessment. Children's hospitals tended to have large ward kitchens for heating milk, and large out-patients' departments, sometimes with a pram-store and ramps for ease of access.

Orthopaedic hospitals

The Orthopaedic hospital movement is an early twentieth-century phenomenon. One of the main causes of deformity being TB, orthopaedic hospitals often resemble sanatoria. Many were ephemeral hutted establishments and have left few listable remains.

Eye hospitals

The main spur to the establishment of eye hospitals was the need to treat soldiers returning from Egypt and India with eye diseases that began to spread to the civilian population. This led to the foundation of London's Moorfields Hospital (1804-5) and fifteen eye hospitals had been established in England by 1840. Only one was purpose-built: the Ophthalmia Hospital near Regent's Park, London (1818, John Nash;



Figure 9

Buxton Hospital, Derbyshire. Built as a stables and exercise yard for horses in 1785-90 to a design by John Carr, this was converted to a hospital in 1859 by Henry Currey. In 1881-2 Robert Ripon Duke covered the exercise yard with a huge glass dome and made other additions. Listed Grade II*.

demolished), an exceptional building, prefiguring elements of pavilion planning and featuring a very early form of artificial heating and ventilation. Purpose-built eye hospitals appeared in most major cities in the later nineteenth century and featured elements to cater for blind or partially-sighted patients, for instance, carefully regulated lighting, coloured window glass, and carefully considered circulation systems. Their relatively small scale encouraged architectural decoration, for example at the 'U'-planned Royal Eye Hospital of 1884-6 by Pennington and Brigden in Manchester (Grade II).

Mineral water and sea-bathing hospitals

Hospitals for the treatment of diseases such as rheumatism and arthritis were established in spa towns. The Bath Mineral Water Hospital of 1738-42 (by John Wood) was an early philanthropic institution that sought to offer the city's renowned therapeutic facilities to a wider social range of patient. Other examples were provided with baths and douches along with exercise yards, that at Buxton (Derbyshire; listed Grade II*) being a domed structure of monumental proportions (added 1881-2 to a re-used riding school; Fig 9). Sea-bathing cures became popular in the

eighteenth century. The first purpose-built sea-bathing hospital was erected at Margate, Kent (1796, Rev John Pridden; listed Grade II) to ease the tubercular complaints of the London poor by exposing them to fresh sea air and sea water. Its small wards had access to open colonnades on to which beds could be wheeled. Sea bathing was also a popular treatment at seaside convalescent homes.

Cancer hospitals and hospitals for incurables

Most general hospitals excluded cancer or incurable cases and Britain's (indeed, the world's) first cancer hospital opened in 1852 in a rented house in London's Fulham Road (later called the Royal Marsden Hospital, with bespoke premises dating from 1859-60). Until the late nineteenth century cancer hospitals could offer little by way of treatment, but the discovery of X-rays, radioactivity and radium revolutionised treatment, and more radical surgery was developed. Separate 'incurables' hospitals began to appear in the mid-nineteenth century, flourishing in the 1880s and 1890s. Many were established in large houses, offering a comfortable domestic environment – the fundamental principle in terminal care – and reflected in the architecture of purpose-built examples which anticipated today's hospice movement: one such complex was the Border Counties Home for Incurables, designed by G D Oliver in Carlisle in 1884. Large day rooms, a small private chapel and a garden became important design elements, as seen at the Royal Hospital and Home for Incurables in Wandsworth, built in 1864 by WP Griffith and listed Grade II.

Isolation hospitals

'Pest houses' to isolate those with a communicable disease are known from the later Middle Ages, and a statute of 1665 sought to ensure their provision by parishes. Various examples are listed, both of purpose-built structures and of houses taken over for this function. Smallpox was a particular problem, and in London purpose-built smallpox hospitals were provided from 1746 onwards. The earliest purpose-built isolation hospital for cases other than smallpox was the Liverpool Fever Hospital

(1801). This had small wards intended to reduce cross infection arranged on either side of an axial corridor. 'Houses of Recovery', as they were called, were established between 1802 and 1804 in London, Manchester and Newcastle upon Tyne. They increased greatly in number after the Metropolitan Asylums Board was set up (for London) in 1867 and the Public Health Act of 1875 (for the rest of the country). The Isolation Hospitals Act (1893) enabled County Councils either to provide isolation hospitals or compel local authorities within the county to do so. From the early 1890s to 1914 some 300 local authority isolation hospitals were built. Hospitals were large, dominated by parallel rows of detached ward blocks linked by a covered way, in an extreme form of the pavilion plan that even provided distinctive ventilated basements to allow the free movement of air beneath the wards. Nurses were kept in isolation on the site, there were special ambulance stations and large buildings at the entrance marked the divide between public and contagious areas. Municipal isolation hospitals were established from the late 1870s to model plans produced by the Local Government Board. Their rural counterparts were smaller, and often attractively laid out with detached villas. Isolation blocks of cubicles began to appear in 1906 to cope with the rise in number of notifiable diseases. The success of antibiotics in the treatment of infectious diseases from the 1940s led to the rapid decline of isolation hospitals. Many were put to new uses or abandoned altogether.

Sanatoria

These are among the most distinctive hospitals, and can attain great architectural distinction. Private sanatoria became increasingly common from the late nineteenth century. Tuberculosis, one of the great killers of the nineteenth century, was not identified as a specific disease until the 1820s and there was no effective cure until the discovery of the antibiotic streptomycin in 1943. The first purpose-built hospital for consumption in Britain was the Brompton Hospital, Royal Borough of Kensington and Chelsea, London (1844 -54, F J Francis; listed Grade II; and chapel 1849-50, E B Lamb; listed

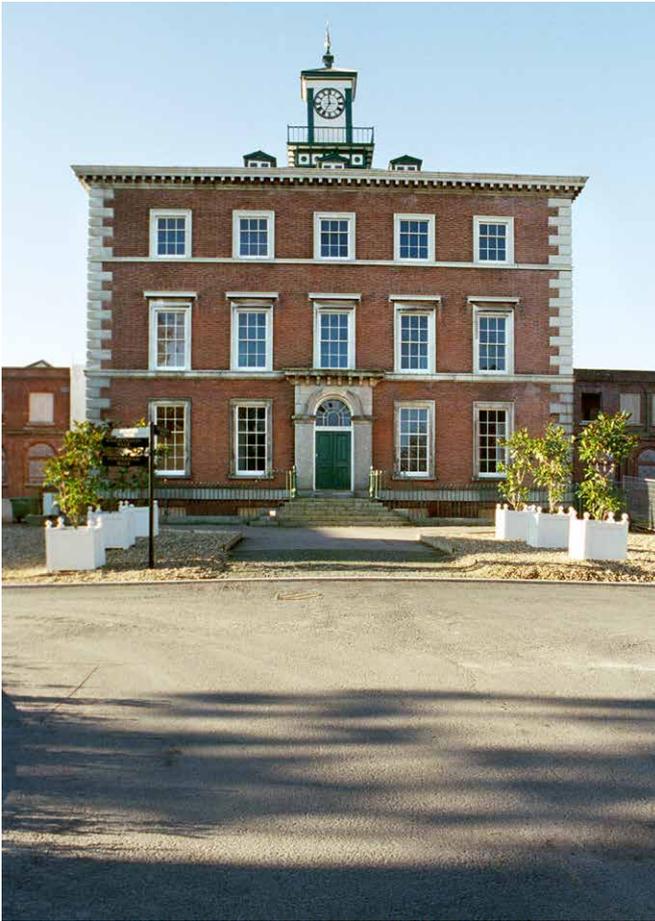


Figure 10
Exe Vale Hospital, Exminster. Built as the Devon County Pauper Lunatic Asylum in 1842-5 by Charles Fowler, its modified radial plan combining easy supervision with reasonably-spaced wards. Around were exercise yards and gardens. Listed Grade II*.

Grade II*) which comprised a series of small wards with up to eight beds opening off a wide corridor that doubled as a day room.

Following the work of Hermann Brehmer in Silesia in the 1860s and Dr Edward Livingstone Trudeau between 1872 and 1885 in the United States, patients increasingly followed a regime of living and sleeping as much in the open-air as possible. A landscaped setting became an important design element, ideally with beneficial scented pines. Between 1891 and 1911 over fifty sanatoria were built in England and Wales, many of architectural distinction. Features to look out for include butterfly plans, sometimes around a central conservatory and open verandas (frequently now glazed in). Sanatoria were built in large

numbers by local authorities after the 1921 Public Health (Tuberculosis) Act. By this date X-rays and surgery formed part of the treatment. Many county sanatoria were very plain – often single-storey with a south-facing veranda – and some adopted a style of minimal modernism. As well as dedicated sanatoria, TB wards and dispensaries were often added to workhouse infirmaries, which were also provided with revolving shelters and graded walks in landscaped grounds.

Asylums

Mental illness was for centuries regarded as a spiritual affliction rather than a medical one capable of treatment. Early secular responses were as much about the containment of patients as cure. London's Bethlem or Bedlam Hospital (rebuilt 1675-8, by Robert Hooke; demolished) was the earliest, and grandest, hospital for the mentally ill. Of the handful of eighteenth-century asylums, most used or resembled country houses both inside and out. A desire for more humane treatment (pioneered by the Quakers at The Retreat, Heslington Road, York of 1792; listed Grade II) led to the Asylums Act of 1808. Supervision was an important factor, which made radial plans a preferred approach, as for prisons: the former Devon County Asylum at Exminster (Charles Fowler, 1842-45; listed Grade II*; Fig 10) embodies the approach. Purpose-built private asylums were once common but are now very rare: Brislington House, outside Bristol (1804-6; listed Grade II), is a notable survival, with deliberately laid-out grounds which were also intended to comfort the patients. Asylums from before 1845, private or pauper, are not numerous and are generally architecturally distinguished; they should be carefully considered together with their grounds, which can have landscape interest.

Between 1808 and 1845 thirteen county pauper asylums were established, plus six that were for both private and pauper patients. The Lunatic Asylums Act of 1845 made the erection of a pauper lunatic asylum compulsory in each county, and 50 pauper asylums were added between then and 1888, some by counties and some by boroughs. All asylums were required to have chapels. A few asylums included detached



Figure 11
Claybury Asylum, Woodford Bridge, Essex, 1888-90, and the major work of the specialist asylum architect, G T Hine. This was the first to use successfully the

echelon plan, on which all later asylums were based. Listed Grade II.

houses or villas for recovering patients, but these generally proved too expensive. The 'corridor plan' with a large ward and day room, combined with some small secure rooms was generally adopted and remained standard. Early examples could be grouped into radial and double-cross plans as at Bodmin, Cornwall of 1818 by John Foulston and Grade II*. The Retreat at York established the model for placing the asylum on a hill outside the town with fine views, placing as many wards as possible facing south. As asylums grew larger they were built in the countryside but with good rail links, and an extended 'U' or 'H' plan became common, with those most able to enjoy the view placed in the centre. A third generation of asylums followed the creation of county councils in 1888. Most of these were built on an echelon plan and this (as elaborated at Claybury Asylum, Chigwell, Essex, by G T Hine of Nottingham, 1888-90; listed Grade II; Fig 11) became the standard model. In all asylums the different classes of patients were housed in pavilions, simulating domestic villas, arranged off a single-storey corridor, but in an echelon plan they were laid out in a V or arrow head shape so more could all enjoy a south elevation or fine view.

Together with the ancillary buildings – administration block, kitchens and recreation hall, medical superintendent's or deputy's house, chapels, laundry and workshops (work was an integral part of the therapy), boiler house and chimneys, and sometimes farms and railway stations – these huge institutions formed impressive and coherent ensembles that need to be assessed for listing in the round, especially if the landscapes (which may be candidates for registration) survive in anything like their original layout; conservation area designation can be appropriate too. Later asylums break down the institutional quality of Hine's prototype by dividing them into smaller units, a counter-trend that is worthy of note.

The earliest (that is, 1850s and 1860s) hospitals for the mentally handicapped are of special interest. These were privately funded, there being little provision within the Lunacy Acts for the mentally handicapped. Modelled on private houses, they emphasised training and entertainment and were equipped with workshops and sometimes theatres. Colonies, first established for epileptics, emerged in the late nineteenth century (Chalfont



Figure 12

Finsbury Health Centre, London Borough of Islington. Lubetkin and Tecton's health centre of 1935-8, Finsbury's 'megaphone for health', had doctors'

consultation rooms, a dental surgery, a solarium, lecture hall, disinfection centre and an attractive waiting area. Listed Grade I.

St Peter, Buckinghamshire, 1884 (listed Grade II), funded by Passmore Edwards was the earliest and influenced later developments, not least the major building programme of the 1920s (following the 1913 Mental Deficiency Act which required local authorities to accommodate the mentally handicapped). Characteristically plain, stripped neo-Georgian in style, these buildings need to be assessed on architectural grounds as well as in the context of the associated landscaping which can sometimes increase their interest.

Convalescent homes

Convalescent homes emerged in the mid nineteenth century when it was recognised that the chances of patients recovering from illness or surgery were compromised if they had to return from specialist facilities to home where conditions were often overcrowded and insanitary and diet poor. Early plans mirrored general pavilion hospital (and occasionally butterfly) designs, perhaps with a dining hall and day rooms in addition. The ideal of a group of villas was adopted by the Metropolitan Asylums Board at Winchmore Hill in the London Borough of Enfield but generally proved too

expensive. Most convalescent homes of the later nineteenth century were located in the countryside or by the sea and often resembled country houses or hotels: light and air, as well as rest and good food, were assigned particular importance as means to recovery.

Health centres

Concern about the general health of the population around 1900 culminated in the formation of the National Association for the Prevention of Infant Mortality in 1912, while the Maternity and Child Welfare Act of 1918 was the foundation of today's child welfare services. The responsibilities placed by that Act on local authorities for mother, baby and child welfare created an enormous expansion in the provision of such services during the 1920s and 1930s, providing an embryonic national health service to a significant part of the population. For a number of years the major work of these Infant Welfare Centres was advice on feeding, general management and hygiene. This resulted in a gradual improvement in standards of child care and a steady decline in infant mortality.

The 1946 National Health Services Act made it a duty of health authorities to build health centres, with powers to purchase land, so that ‘all the skills and services which patients need, outside of hospitals, could be brought under one roof.’ This was a very important step towards a new emphasis on preventative care. In practice, however, few of architectural interest were built. The best examples pre-date the NHS, notably Finsbury’s, in London (1935-8, by Lubetkin and Tecton, listed Grade I), an outstanding design with a bright enticing entrance – called ‘a megaphone for health’ – with doctors’ consultation rooms, a dental surgery, a solarium, lecture hall and disinfection centre (Fig 12). It is the outstanding example of the type and became the model for the post-war nationwide system of comprehensive healthcare, although its high architectural standard was seldom reached. Early built responses to the creation in 1948 of the National Health Service will now have historical claims to interest, uniquely the Grade II example at the Woodberry Down estate, 1948-52, London Borough of Hackney, but architectural interest will still be a vital consideration in determining listability. Somewhat analogous to these are purpose-built doctor’s surgeries: fairly large detached houses with surgeries, waiting rooms and other features incorporated into their planning. These begin to emerge as a distinct house type in the mid-nineteenth century. Only with government investment in the 1960s were purpose-built clinics for group practices built in numbers.

Perhaps specific to London are the purpose-built flats and consulting suites built in the inter-war period in Harley Street.

2.2 Welfare buildings

Almshouses

These represent a valuable link between medieval and modern approaches to welfare provision. St Cross Hospital, Winchester (refounded in 1443, and still flourishing; listed Grade I), embodies the collegiate approach of individual units around shared facilities that continues down to this day. The combination of private and

municipal charity means that some towns have several almshouses, some – as in the case of Banbury (Oxfordshire; listed Grade II) – growing out of medieval charitable institutions which survived the Reformation. Larger almshouse complexes are distinctive both in plan form and architectural detail, with prominently placed chapels serving to project the piety of their benefactors and the sanctity of charity; secular status was also confirmed through heraldry, sculpture and inscriptions. Accommodation for residents was frequently set to the side or rear and resembled a cloister or college quadrangle, with similar emphases on formality. Worcester’s Berkeley’s Hospital of 1703 (listed Grade I; Fig 13) exemplifies the category, and must stand for many other foundations. The almshouse tradition remained strong throughout the nineteenth and into the twentieth century, although most foundations were of simple rows of single-storey dwellings. Where there is good design quality, frequently in a revivalist manner, and the building is not too damaged by alteration, they will be eligible for designation. Their traditionalism is part of their appeal, so architectural conservatism is to be expected; it is the quality of design and execution which will determine listing.



Figure 13 Berkeley’s Hospital, Worcester. An almshouse endowed by Robert Berkeley of Spetchley in 1692 for twelve poor men. Two-storey ranges for chaplain and warden front a courtyard with six single-storey almshouses to either side; a chapel of 1703 stands at the far end. Listed Grade I.

Workhouses and workhouse infirmaries

Few early purpose-built workhouses survive, one of the best examples being the cloth manufactory (now the museum) at Newbury, Berkshire, 1626-2 (listed Grade I). Larger numbers of residential workhouses survive from the eighteenth century: most are listed. The deterrent approach was embodied in two workhouses erected outside Southwell, (Nottinghamshire); one (1808; listed Grade II; Fig 14) built for the parish, the other (1824; listed Grade II*) for 49 neighbouring parishes. The latter provided the model for the hundreds of new workhouses erected throughout the country after the Poor Law Amendment Act (1834); it is now opened by the National Trust. This legislation required parishes to form 'unions' for the sake of economy, each with its own workhouse. Four model plans were produced by the specialist workhouse architect Sampson Kempthorne. The guiding design principle – the panopticon, a radial plan, with wings emanating from a central hub – facilitated both surveillance and the segregation of paupers by age and sex. There were local variants but the commonest form was the 'square' or cruciform plan, but others adopted the 'hexagon' or 'Y'-shaped plan. An austere classical style was



Figure 14
Southwell workhouse, Southwell, Nottinghamshire. Southwell's workhouse of 1808 was designed, like that in Dickens's *Oliver Twist*, to deter idleness and intemperance. About 1839 it was converted to a Baptist chapel with attached manse. Listed Grade II.

favoured for cheapness, while several unions opted for an Old English or Elizabethan one, reminiscent of almshouses and thus alluding to a very different tradition of philanthropic care. Around 320 workhouses were built between 1834 and 1841, and many of the better preserved examples are listed. Later plans evolved. The 150 or so workhouses erected between 1840 and 1870 mostly comprised three parallel ranges: an entrance range, the main building and an infirmary. By 1870, this poorly-ventilated corridor plan was losing favour, and separate-block schemes, designed on pavilion principles, were adopted although this did not take root in the south of the country (outside London).

The most significant additions to workhouses were infirmaries, casual wards and chapels (see above). After a series of scandals, the Metropolitan Poor Act of 1867 encouraged London authorities to establish large pavilion plan infirmaries on separate sites from their workhouses. Provincial authorities shortly followed suit a year later. Separate-site hospitals were huge, accommodating large numbers of chronic cases (mainly the aged and infirm), and with substantial maternity wards, since workhouses were often the only option for unmarried mothers. More enlightened unions also built schools in an effort to distance children from the contaminating influence of adult paupers.

Old Poor Law workhouses (pre-1834) and the first generation of New Poor Law workhouses (1834-41) are likely to be listed. Corridor-plan (typically of 1840-70) and pavilion-plan (about 1870-1914) workhouses need to meet more rigorous criteria, especially regarding their architectural quality, the degree of survival and group value with related structures. Infirmary buildings from before 1867 are rare and will warrant serious consideration for listing. Those built after 1870 should be tested according to more stringent criteria, focusing on architectural quality, the completeness of the ensemble and innovative or important planning. Unusual features such as ambulance stations and casual wards are worth seeking out.

Dispensaries

Early dispensaries were philanthropic foundations, erected to provide medical advice and medicines; some later became voluntary general hospitals, for instance, George Wightwick's public dispensary of 1835 in Plymouth. Local authorities were establishing dispensaries from the late nineteenth century. For listing, architecture and external elaboration will be important considerations, as will degree of survival and date.

Children's homes

Examples that pre-date 1800 are rare. Outstanding among them was the Foundling Hospital, London (1742-52; demolished). Throughout the nineteenth century, many children continued to live in workhouses, alongside adult paupers. Until the 1870s, the most difficult pauper children attended industrial or 'barrack' schools; a largely

intact example is to be found outside Leeds, at Adel, built from 1857 for the Leeds Society for the Reformation of Juvenile Offenders (listed Grade II). Between the 1870s and 1890s schools were built on workhouse sites. Discredited by the 1890s although not universally rejected, few industrial or workhouse schools survive today. An alternative for problem pauper children was the cottage home, where children lived in family groups, introduced from France and perhaps first adopted in Britain at the Princess Mary's Village Homes at Addlestone, Surrey, in 1871 (demolished). In the 1870s Dr Thomas Barnardo adopted the cottage home system on a vast scale, beginning in 1876 with the Girls' Village Home in Barkingside, Essex (much listed Grade II; Fig 15). The success of Barnardo's, and other charitable cottage home villages, encouraged poor law authorities to adopt the model, which consisted of a number of



Figure 15

Barnardo's Girls' Village Home, Barkingside, Essex. Dr Barnardo began building a 'Village Home' for destitute girls in 1876, a series of cottages under the care of 'mothers' arranged around a green.

The cottages were similar in elevation to a plan by Henry Roberts for Prince Albert's Model dwellings shown at the Great Exhibition in 1851. Extensively listed at Grade II.

detached or semi-detached ‘cottages’ set around a green or village street, each under the care of a house-mother. The ‘scattered-home’ system that gained favour after 1900 and which marked the beginning of ‘care in the community’, reduced the need for special institutions and very few were erected after 1918. Not many examples of industrial or cottage homes survive today with their interiors intact. Some have panache, and interiors may in rare instances preserve features such as moralising inscriptions in dining rooms; cottage homes may have overall planning interest that lends itself to other designations.

Other buildings associated with health and welfare

This short guide cannot possibly explore all the many ways and institutions through which assistance has been provided to the needy

over half a millennium and more: orphanages, homes for the blind, and the deaf and dumb, for inebriates, and the many halls and other buildings provided by bodies such as the Salvation Army (founded 1865; see Oakley 2011 in the Bibliography below) have all played their part: the list is a long one. To give but one last example; soup kitchens. One of the most memorable of these is the Soup Kitchen for the Jewish Poor, Brune Street, Spitalfields, (London Borough of Tower Hamlets), of 1902 (listed Grade II; Fig 16). That said, the principles and guidance which are set out above for other building types will have general applicability in listing assessments.



Figure 16
Soup Kitchen for the Jewish Poor, Brune Street, Spitalfields, London Borough of Tower Hamlets. Designed by Lewis Solomon and built in 1902. The cornice is inscribed ‘Way Out/Soup Kitchen/5662. 1902/

For the Jewish Poor/Way In’. Inside the plan of the soup kitchen is largely unaltered and includes the ‘Queuing room’, with original white tiled walls, committee room and kitchen. Listed Grade II.

2.3 Extent of listing

Amendment to the Planning (Listed Buildings and Conservation Areas) Act 1990 provides two potential ways to be more precise about what is listed.

The empowerments, found in section 1 (5A) (a) and (b) of the 1990 Act, allow the List entry to say definitively whether attached or curtilage structures are protected; and/or to exclude from the listing specified objects fixed to the building, features or parts of the structure. These changes do not apply retrospectively, but New listings and substantial amendments from 2013 will provide this clarification when appropriate.

Clarification on the extent of listing for older lists may be obtained through the Local Planning Authority or through the Historic England's Enhanced Advisory Service, see www.HistoricEngland.org.uk/EAS.

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The Workhouse <http://www.workhouses.org.uk/>

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