DELIVERING NEW
HEALTH FACILITIES

Acute Site
Functional Requirements Brief

Version 4.0

Date: January 2025

Version number	Date of change	Change Description	By whom	Authorised by
0.1	September 2023	Draft Structure and Document Initiation	GH	
1.0	September 2023	Updated Version developed as initial draft for client review	DG	KB
1.1	January 2024	Updated following Client comments from MW	DG	
2.0	February 2024	Final update following read through with HCS (SR&MW)	DG	KB
2.1	February 2024	Update to include a description of accommodation to be used by Therapies team	DG	MW
3.0	May 2024	Final agreed clean version for Director General, Medical Director and ECG sign-off	DG	MW
3.1	August 2024	Adjustment to Endoscopy and Renal, with minor adjustment to inpatient ward description to include recent clarification around use of medical beds for hyper-acute stroke and respiratory pathways. Clarification on CCU bed numbers to 15. Additional CT scanner. Draft for Review	DG	
3.2	January 2025	Minor grammatical updates	CN	
4.0	January 2025	Final Document – Signed off by ECG	DG	CN

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HCS Approval:	Signature:	Director General Health
Date of approval:		
Clinical Leadership Management Approval:	Signature:	Medical Director
Date of approval:		
Executive Client Group Approval:	Signatures:	Designation:

Contents

1 Project Summary

Over the last decade, a series of strategic and analytical documents have described the compelling need to improve the capabilities, efficiency and sustainability of Jerseys healthcare facilities to meet the range of health care needs of islanders.

This need is driven by several factors;

- An ageing population requires care associated with long term condition prevention and management which is not best served in the current facilities and care model.
- Developments in medicine and medical technology improve health treatment but require new IT, estate capabilities and adjacencies, as well as investment, to enable them to be utilised.
- An ageing estate which has surpassed its intended lifespan and presents potential safety risks whilst accumulating ever increasing backlog maintenance.
- An ageing workforce, changes in clinical skills and recruitment challenges place increasing pressure on service delivery and quality of care.

This “perfect storm” has created the imperative for the Government of Jersey to deliver a new affordable, sustainable and cost-effective care model, supported by modern health care facilities and capabilities.

The outcome of a review of the Jersey Care Model in 2020 provided recommendations for the future direction of integrated care in Jersey, additional system changes that may be required and implementation considerations.

HCS continues to develop a revised health and social care system which will be delivered around the principles of integrated care, to connect services across providers. However, this revised approach will not align with the full ambitions and connected timeline of the original Jersey Care Model.

As part of the Chief Minister’s 100-day actions, a review of the "Our Hospital Project" was undertaken in 2022. Following that review, the case for new acute healthcare facilities is still apparent, and as the age demographics change across the Island, along with the rise of new and complex co-morbidities, it is vital to develop the right facilities for the whole health system, in the right locations.

The Programme team were subsequently asked by the Council of Ministers to look at the feasibility of a multi-site option for healthcare services. This involved looking at specific locations, including a smaller facility at Overdale, the site adjacent to the General Hospital at Kensington Place, sections of the existing general hospital site as well as the ongoing use of the Enid Quenault, Health & Wellbeing Centre, and opportunities to develop facilities at a site near to the former Saint Saviours Hospital.

The multi-site review was undertaken in conjunction with a review of the anticipated future model of care which will be in place to support the people of Jersey. The outcome of this feasibility was the development of the development control plan designed to deliver services fit for the future that will include the following elements:

- The acute hospital will focus on acute treatment and pathways, ensuring emergency, diagnostic, and intervention focused services are prioritised. Critical and Specialist Care areas, including Special Care Baby Unit (SCBU) and Maternity, will be in place. The main bed base will be in the acute hospital, but ambulatory pathways will be minimised.
- The ambulatory care centre will support day procedures, outpatients and long term conditions pathways, ensuring diagnostic, ambulatory, day- case and day-intervention focused services are prioritised. It will also incorporate an Urgent Treatment Centre (UTC), hosted by HCS but connected to the Primary Care system. A proportion of future increases in ED activity can be diverted to the UTC.
- Mental Health acute services to be provided in a dedicated accommodation as part of the new healthcare facilities campus.
- Rehabilitation, step down, and dementia inpatient beds will be collocated together with physiotherapy, hydrotherapy and other therapeutic services such as dietetics and occupational therapy, to create an integrated hub for rehabilitative care outside of the acute hospital.
- Tertiary pathways will be strengthened, but we will aim to repatriate activity where possible (Bariatrics and Cancer care in particular).

This functional brief covers the acute hospital component of the new healthcare facilities programme.

2 Content

This brief reflects the clinical requirements of the acute healthcare facility and should be read in conjunction with the Functional Requirements Brief for All Sites for all general design and operational principles that will apply to all sites within the New Hospital Programme.

The starting point for the ‘Functional Content’ has been created based on the anticipated capacity required in 2036, augmented through a series of interactive clinical workshop sessions with the health and community services executive and clinical leadership teams from across the health and social care system.

This content has sought to use, where appropriate, the extensive work undertaken during the Our Hospital Project, but taking the opportunity to further develop and refine the requirements during engagement with clinical and non-clinical teams in 2023.

2.1 Clinical and non-clinical Departmental Structure.

Note: all areas shown are indicative only and do not include allowances for mechanical and electrical engineering, circulation (corridors, lifts and staircases) or outdoor spaces.

Acute Healthcare Facility

Department	Notes	Approximate size (m^2)
Public Entrance		1,258
Emergency Department	3 x Resuscitation Rooms & 16 Majors Bays	1,499
Radiology	2 x CT & MRI, 2 X-ray, 2 x Ultrasound, Fluoroscopy and Interventional Radiology	1,485
Acute Assessment Unit Beds	25 beds and 8 same day emergency care spaces	1,493
Endoscopy Unit	2 Endoscopy Rooms, 4 side rooms, 3 Pre-Procedure and 10 Recovery Bays	1,099
Inpatients	180 adult medical and surgical beds	9,709
Inpatient Wards - Private Patients	30 beds	1,632
Obstetric inpatient beds	14 beds	1,188
Maternity	6 Labour Delivery and Post-Partum Rooms and 1 Operating Theatre	1,141
Newborn Unit	9 cots	819
Paediatric Inpatients	14 beds (including 2 x Child and Adolescent Mental Health)	1,109
Critical Care Unit	15 beds	2,043
Theatre Suite	5 Operating Theatres	2,957
Pharmacy	Pharmacy split across sites	750
Equipment Library and Electronic Bio-Medical Engineering (EBME)		601
Engineering and Estates Department	On-Site base	63
Staff Rest, change and catering		1,240
Administration		510
FM Support - Non Clinical		826
Pathology		1,857
Mortuary and PM		507

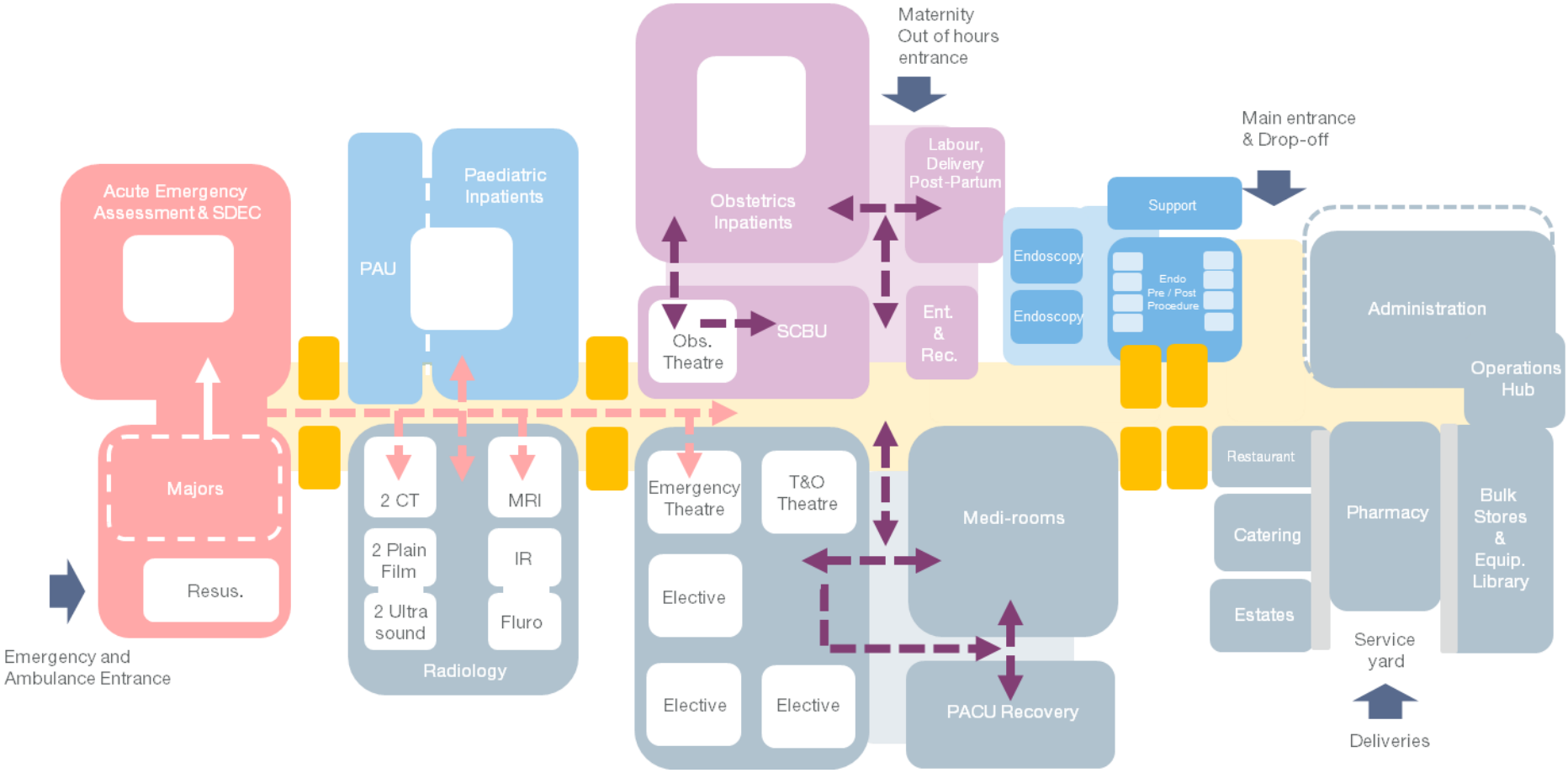
3 Anticipated flows & required adjacencies

3.1 Facility Relationships

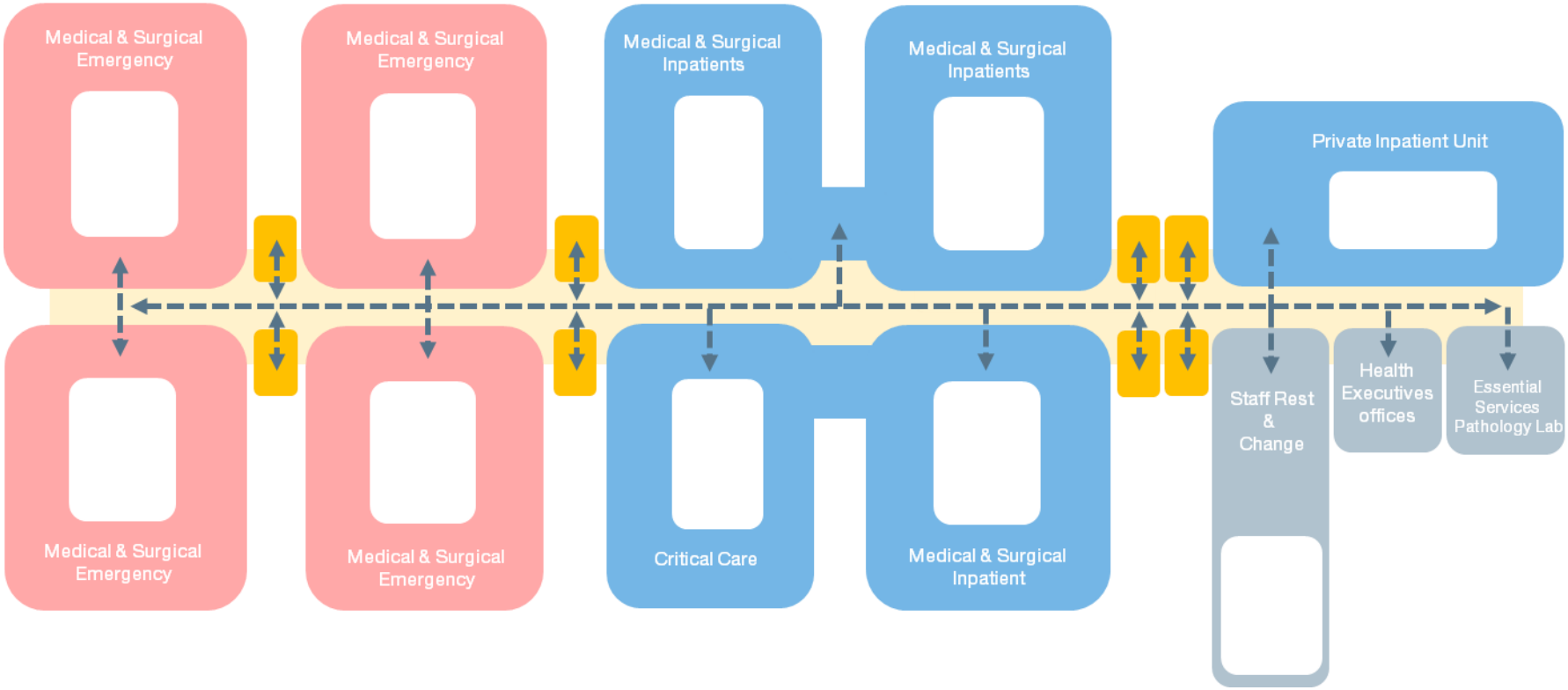
The development of the required clinical and non-clinical model and key departmental relationships, and required clinical adjacencies, are illustrated in the schematics on the following page. It is important to note this is not a design, but is to be used as an indication of the desired relationships.

3.2 Whole Hospital Adjacencies and Internal flows

3.2.1 Acute Healthcare facility – Indicative Ground Floor



3.2.2 Acute Healthcare facility – Indicative Upper Floors



3.3 Access

This section sets out the access requirements specific to the acute healthcare facility. For details about general access including vehicular access and circulation,servicing and public transport access, together with communication and public spaces please refer to the overarching brief.

3.3.1 Drop off facilities

Drop-off and pick-up facilities shall be provided at the entrance to the acute healthcare facility. This shall be designed and managed to avoid congestion and a maximum wait time shall be specified and controlled by the security team. Localised parking for disabled patients, infirm patient carers and visitors, will be provided within the healthcare facility boundary.

Taxi drop-off and pick-up spaces and off-road bus stops will be identified or situated at the main entrance.

3.3.2 Patient Transport

Provision shall be made at a discreet area of each building for patient transport and non-emergency ambulances to pick-up and drop-off patients, with a provision for convenient short-term ambulance parking.

The space must be suitable for ambulances and patient transport to safely park and subsequently transfer patients under cover, utilising the vehicle tail lift system. There must be no bollards in this area and the development of a one-way system for patient transport and non-emergency ambulances only, is preferred. Immediate access to a patient transfer lounge and local patient transfer store is required.

3.3.3 Emergency Department Access

The entrance of the Emergency Department within the acute hospital building, must have capacity for at least three ambulances to draw up to the entrance at the same time. It is essential that the entrance is separate from a dedicated patient drop off area, including a separate capacity for ambulance transfers and movements. There should also be ambulance lay-over spaces for two ambulances located outside the emergency department, but away from the emergency entrance. Associated equipment and consumables storage and decontamination supplies will be located near the ambulance layover space, to support the ambulance crews.

Outside the entrance zone of the Emergency Department there should be protection from exposure to changeable weather conditions will be provided for ambulances and patients arriving by car. This area should ensure privacy and dignity for patients beingtransferred from ambulances to the ED and protect from being overlooked from other areas.

3.3.4 Parking for visitors and staff

Car park areas and/or facilities shall be integrated as part of the master plan for each facility within the acute healthcare facility and will be within 500 metres from the public entrances.

3.3.5 Staff and Public Access/Egress

There will be two distinct entrances to the acute healthcare facility: The public entrance and the Emergency Department entrance. All other department and sub-area entrances (such as inpatients, endoscopy and day of surgery pathways) will be accessed from the public entrance and concourse, therefore both entrances must be available 24/7 with the ability to control access to all sub-area entrances when required. Access to the maternity department out of hours, will need to be considered as a specific access requirement within the design solution of the building.

The mortuary facility will require a discrete public entrance with access to the relatives viewing room. A separate covered, secure and discrete access is required for ambulances and funeral director's vehicles. All areas will require access controlled access 24/7.

Due to the high volume of traffic, automatic doors are required at all these access points identified above , the design of which should take due regard to resolving the conflicting requirements of visitor and patient safety, unimpeded access and the maintenance of an appropriate environment, that is, the elimination of draughts.

Controlled access is required at all times to clinical areas. All visitor access will be via each facility main public entrance and visitors will be held in waiting areas until admitted to each area by a staff member.

The largest number of visitors will visiting patients in the inpatient wards, and therefore, good access from the car park and public entrance of each facility is an important consideration. Ward cores aim to add a further layer of control over the movement of visitors into the ward areas, by maintaining a separation of visitor reception and waiting from the clinical care areas.

Access to the main lifts and staircases will be easily identified and intuitively located from any part of the public entrance and main waiting areas. The use of colour, graphics and/or artwork in the interior design should assist and be seen as integral to the overall wayfinding strategy.

3.3.6 Private Patient Pathway

A drop-off and pick-up area and discreet pathway into the acute healthcare facility building will be provided for private or self-funding patients and visitors. The pathway will provide a discreet and segregated route to a private patients' entrance and lounge, rom here the inpatient spaces and private patient pathway to main operating theatres will be accessed. It is likely this accommodation will be efficiently organised with similar space typology, hence some aspects will be vertically adjacent to the entrance lounge (theatres/inpatient beds) requiring access to a private patient lift.

4 Clinical Services

4.1 Emergency Department and the Acute Assessment Unit (Acute Floor)

The Emergency department, by necessity, is one of the most dynamic care models in secondary care, adjusting and flexing to new innovative practices and responding to a spectrum of care episodes.

The provision of high quality emergency care is one of the tenets of any healthcare service. The current pace of change in emergency medicine is impressive and will continue to evolve, as a result of this brisk change of pace, this document will require continuous refreshment to accommodate the changes in provision of emergency medicine in the new healthcare facilities programme.

The Emergency Department (ED) as we know it is a unique venue at which patients are guaranteed access to emergency care 24/7. The ED acts as the 'Front Door' for patients of the acute hospital.

The key attributes of modern emergency medicine practices may be summarised as follows:

- Early involvement of senior emergency medicine clinicians
- Rapid access to multi-discipline experts
- Unrestricted access to imaging (Computed Tomography (CT), Ultrasound, Plain Radiography) by emergency medicine practitioners
- Expertise in relevant critical care skills in collaboration with colleagues from Anaesthesia and Critical Care
- The extended presence in the department of emergency medicine consultants providing leadership and supervision

The Emergency Department will be designed to provide immediate medical care and treatment to patients experiencing acute illnesses, injuries, or other medical emergencies. Lower category urgent care, where patients do not require an ambulance, will be provided by the Urgent Care Centre at Kensington Place. The Emergency department will incorporate:

- Resuscitation Rooms: These are for the most critical cases, such as patients in cardiac arrest or severe trauma. They are equipped with advanced life-support equipment.
- Major Care Bays: These are used for less severe emergencies, where patients receive medical assessments, examinations, and initial treatments.
- Paediatric Rooms: Designed to provide specialised care for children and infants, these rooms are equipped with child-friendly equipment and decor.
- Isolation Rooms: Isolation rooms are used for patients with contagious diseases to prevent the spread of infection.
- Vulnerable Patients Rooms: These are designed to provide a safe environment for patients experiencing mental health crises or with safeguarding requirements.

The 'Acute Floor' model, will be utilised within the Acute Hospital with the aim of broadening the 'front door'

to enable early access to senior clinical decision-makers, supporting patient safety, applying appropriate resource use, and patient flow through the acute system. A significant amount of patients assessed, diagnosed, treated then sent home with a care plan. This will reserve admission for patients that had complex diseases or need more invasive / complex treatment.

The Acute Assessment Unit (AAU) is a core component of the Acute Floor and its activities, providing evidenced based protocol-driven periods of investigations, observations and review for patients who would otherwise be admitted to general inpatient hospital beds or discharged, potentially unsafely. The AAU will form a contingent of 24 hour stay and 48 hour stay beds. The bed stock will not be interchanged between the two lengths of stay. All beds are to be used to address the inpatient exit block which can occur from emergency, however the 24 hour beds and Same Day Emergency Care (SDEC) chairs will be utilised for short stay emergency assessment, treatment and diagnostic review as well as supporting Ambulatory Emergency Care pathways where patients can be discharged and return for treatment the next day in the AAU or via “Hot Clinic” outpatient appointments in the Ambulatory Care Centre.

The unit will attend to all patients referred by their GPs, presenting with a range of conditions, particularly medical conditions which require emergency care or assessment. Telephone triage of such patients with the GP will be undertaken by a senior acute floor physician prior to admission to the AAU. The AAU will also receive patients from the ED who require observation and support, focusing on intensive short term assessment, observation or therapy of patients from ED to optimise the early treatment and discharge of selected emergency patients.

A section of the AAU will be dedicated as an Older Persons Assessment Unit (OPAU) providing a frailty pathway. Following the same protocols and approach as the main AAU, the OPAU will be staffed by a multi-disciplinary team made up of dedicated clinical specialists in elderly care. Hospital can be a challenging environment for frail older patients especially if they have dementia or a history of confusion. Once streamed into the OPAU, senior specialists in elderly care can undertake specialist assessment and review enabling the right care to be put in place as fast as possible and reduce the length of time a patient needs to stay in hospital. The aim of the unit is to formulate a care plan for the patient which takes into account all their health and social care needs not just for the medical issue which has brought them to the hospital but going forward to prevent future admission or a deterioration of any underlying conditions.

Paediatric Emergency Care should, wherever possible, be separate from the main department activity. Responsibility for the provision of care for Paediatrics should rest with the Paediatric Division and supporting teams. Certain medical paediatric patients will be streamed to the Paediatric Assessment Unit (PAU), attached to the paediatric ward. The PAU will have shared care facilities for Child and Adolescent Mental Health Services.

4.1.1 Emergency Department

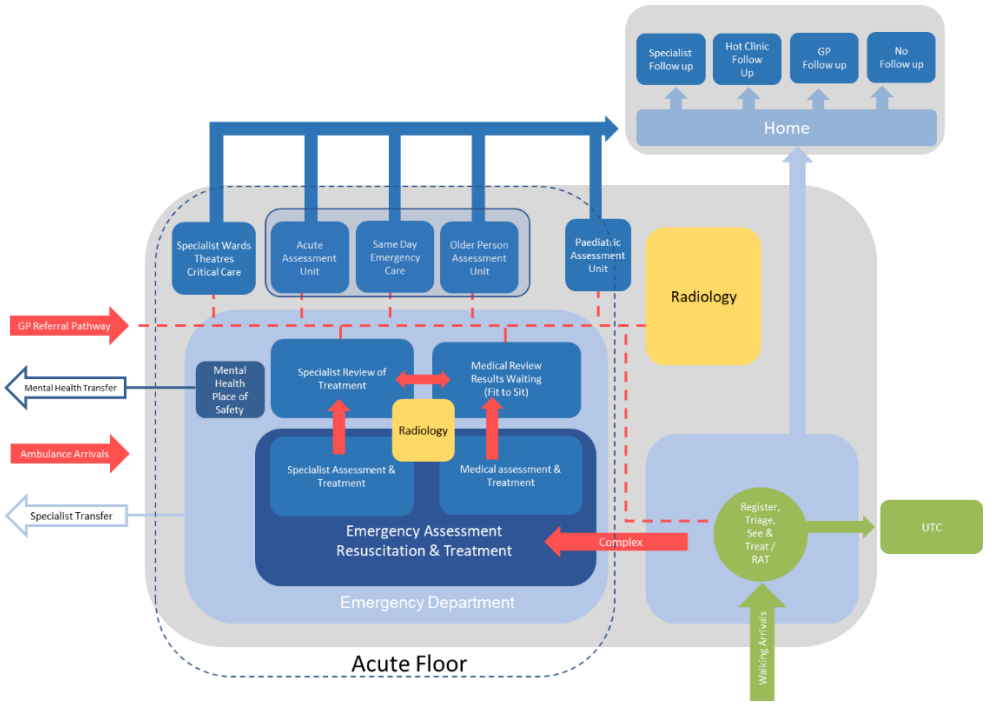
It is anticipated that patients attending the Emergency Department at the acute hospital will predominantly arrive by ambulance. Each patient will be initially assessed or treated by a consultant led team and streamed to the most appropriate location.

The planned pathway for the majority of patients arriving by foot will be to the UTC located at the ambulatory care centre. Any arrivals at the main ED, for example out of hours, may access an emergency nurse practitioner. Following rapid consultation, where necessary, patients will be streamed to the right location, where assessment diagnostic tests and treatment will be undertaken.

It is anticipated the largest volume of patients will be streamed through the UTC at the ambulatory care site. Those who have more serious conditions will be streamed to the Emergency Assessment, Resuscitation and Treatment Area.

Once seen by a clinician, certain medical patients, classified as “fit to sit” will wait in the results waiting area separate from the main treatment area within the acute floor, releasing treatment spaces for new patients. Following the receipt of the diagnostic tests, patients may be discharged or progress for further treatment and assessment.

Various grades of medical and surgical emergencies will be managed at the hospital; however, some patient pathways, such as patients requiring specialist neuro or cardiothoracic emergency attention, will be directed to specialist tertiary providers at other locations such as Southampton, Oxford and Bournemouth via the Jersey Emergency Transfer Service (JETS). This is in line with the current acute strategy and will meet the majority of the local population's emergency and trauma needs. The following diagram outlines the desired flows and adjacency for the Emergency Care, Urgent Treatment and the Acute Floor areas:



A control base within the ED will be provided and supported by an ED consultant to allow the appropriate streaming of patients referred to ED by GPs or community care providers prior to their arrival. This space will also be utilised as the command post for a major incident and as such needs to be embedded within the heart of the ED.

It is intended that all arrivals, be it by ambulance or urgent GP referral, will attend at a single entrance zone. The entrance zone will be separated by a number of physical doors, to ensure the clear separation of patients who arrive by ambulance or those who arrive by themselves.

It is essential that the entrance is adjacent to a dedicated patient drop off area, including a separate capacity for ambulance transfers and movements. It should be possible for at least three ambulances to draw up to the entrance at the same time. Ambulance lay-over spaces for two ambulances will be located outside the emergency department, but away from the emergency entrance. Associated equipment and consumables storage and decontamination supplies will be located near the ambulance layover space to support the ambulance crews. Ambulance crews will utilise the central staff hub when based at the Hospital. Car parking spaces (short-term time-limited facility) for escorts of people with mobility problems should also be provided but should not interfere with ambulance arrivals.

Outside the entrance zone, protection from exposure to the changeable weather conditions will be provided for ambulances and patients arriving by car. Secure access to the entrance zone and the department will be required at all times for patients and staff.

A reception and rapid assessment function will be located immediately adjacent to the emergency main entrance zone. The reception will support the booking in of all patients into the unit. Relatives and visitors will be directed to a local sub-wait.

Paediatric Pathways will follow a different flow, separated from the adult pathways and utilising the Paediatric Assessment Unit (PAU) which will be incorporated as part of the paediatric ward, will ideally be horizontally or vertically adjacent to the ED.

All seriously ill patients (Adult or Paeds) requiring specialist tertiary care will be stabilised and may be held in one of the resuscitation (resus) rooms (most commonly the contaminated patient room as this has the closest adjacency to the entrance) or a critical care bed until they are ready to be transferred out by aircraft. These patients may be ventilated and will have complex multi-faceted conditions.

4.2 Diagnostic Imaging

The Diagnostic Imaging facilities provided within the acute hospital facility are required to offer:

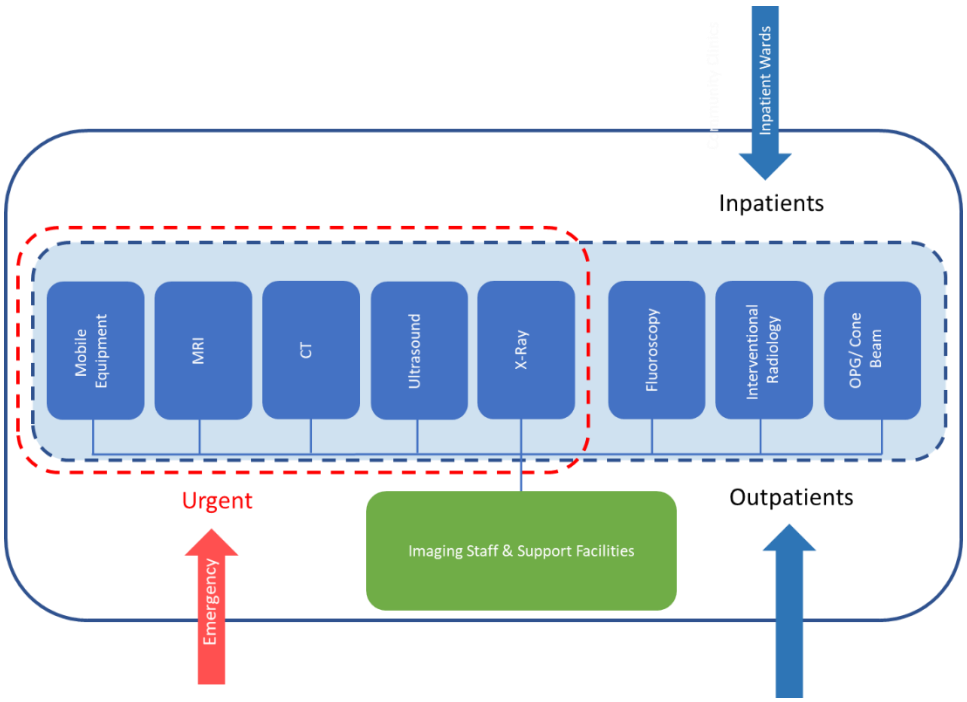
- A proven range of diagnostic facilities capable of supporting the full range of patients treated by the clinical services
- Minimal staff and patient movement to retain a compact set of functional relationships
- Seamless management of the patient journey maintaining the highest levels of patient privacy and dignity
- Ease of access from the emergency and inpatient areas

It is anticipated that the diagnostic imaging department will be at the heart of the acute hospital with rapid uninterrupted flows from the Emergency Care and the Acute Floor whilst maintaining separate Inpatient flows. Although these modalities will not have a primary function for ambulatory or outpatient services, it may be possible that occasionally these modalities could be used as a back up to the ambulatory care site, as such outpatient flows should also be considered and separated from the primary emergency and inpatient flows.

Patients should be able to transfer easily from the inpatient ward areas and emergency department for diagnostic investigations. The design of the radiology department should foster a streamlined patient flow. It is essential to separate the main patient flows by imaging modality and incorporating separate sub-waits for ambulant patients and inpatients.

The throughput of rooms is reliant upon the active management of patients from the inpatient, outpatient and emergency areas. This will be achieved by radiology staff / assistants supporting each modality and controlling the elective flow as appropriate.

The anticipated internal flows are demonstrated in the following diagram:



Careful planning will be required to ensure that the patient flows to the department from the inpatient wards, Critical Care Unit (CCU), and the ED are safe, efficient and ensure privacy and dignity during patient transfers.

There will be mobile ultrasound and digital imaging x-ray units available at the acute hospital to facilitate inpatient ward outreach service by radiographers.

4.3 Endoscopy Unit

The Endoscopy Unit in the ambulatory care centre provides an ambulant day case service, providing for a wide range of endoscopy services. Inpatient endoscopy and emergency endoscopy pathways are provided within the acute hospital facility. The service is developed in line with recommendations from the following guidance:

- Joint Advisory Group (JAG) and Global Rating Scale (GRS)
- NICE Guidance for Endoscopy
- UK Health Building Notes

The Endoscopy Unit will be a JAG accredited unit. It will provide diagnostic and treatment services in line with clear guidance and protocols for the management of most endoscopic procedures and clear pathways for predominantly elective day-case patients attending the hospital, however, an inpatient and emergency pathway will be provided. The design of the endoscopy unit will enable care that is safe, efficient, and effective by adopting the following principles:

- Flow should support the natural progression of the patient pathway, with no crossing of pre- and post-procedure patient flows (in line with JAG design and pathway guidance)
- A welcoming environment that supports a positive patient experience and incorporates calming, patient-centred design
- Patient's privacy, dignity and respect should be maintained at all times
- Two endoscopy rooms capable of supporting the specific range of endoscopic clinical procedures provided, one room will have lead lining for x-ray supported procedures.
- Patients will be segregated by gender from admission through to recovery
- Single patient spaces within recovery to provide privacy and dignity for all patients, whilst maintaining good visibility of recovering patients from the staff base
- A pleasant and safe work environment for staff, prioritising ergonomic and LEAN design principles to reduce errors and support workflow
- An environment that supports research, education and training with the infrastructure to deliver live sharing of clinical procedures
- Standardised, adaptable, and repeatable spaces which will facilitate future flexibility, expansion, and changes to clinical care

- There should be suitable facilities to accommodate patients who require independent wheelchair access.
- Noise levels should be kept to a minimum using good acoustic design to promote a calm and therapeutic environment
- Incorporating access to natural light and external views where appropriate to enhance the wellbeing of patients and staff. Care should be taken to minimise glare and ensure the privacy and dignity of patients and staff is not compromised
    - For patients, this may include waiting areas and prep/recovery spaces
    - For staff this may include staff welfare facilities and offices
- Appropriate finishes should contribute to an inviting and safe environment.
- It is recognised that the models of service delivery adopted will alter over time. It is therefore essential that the endoscopic facilities can respond to future changes in technology as well as changes in clinical service models.

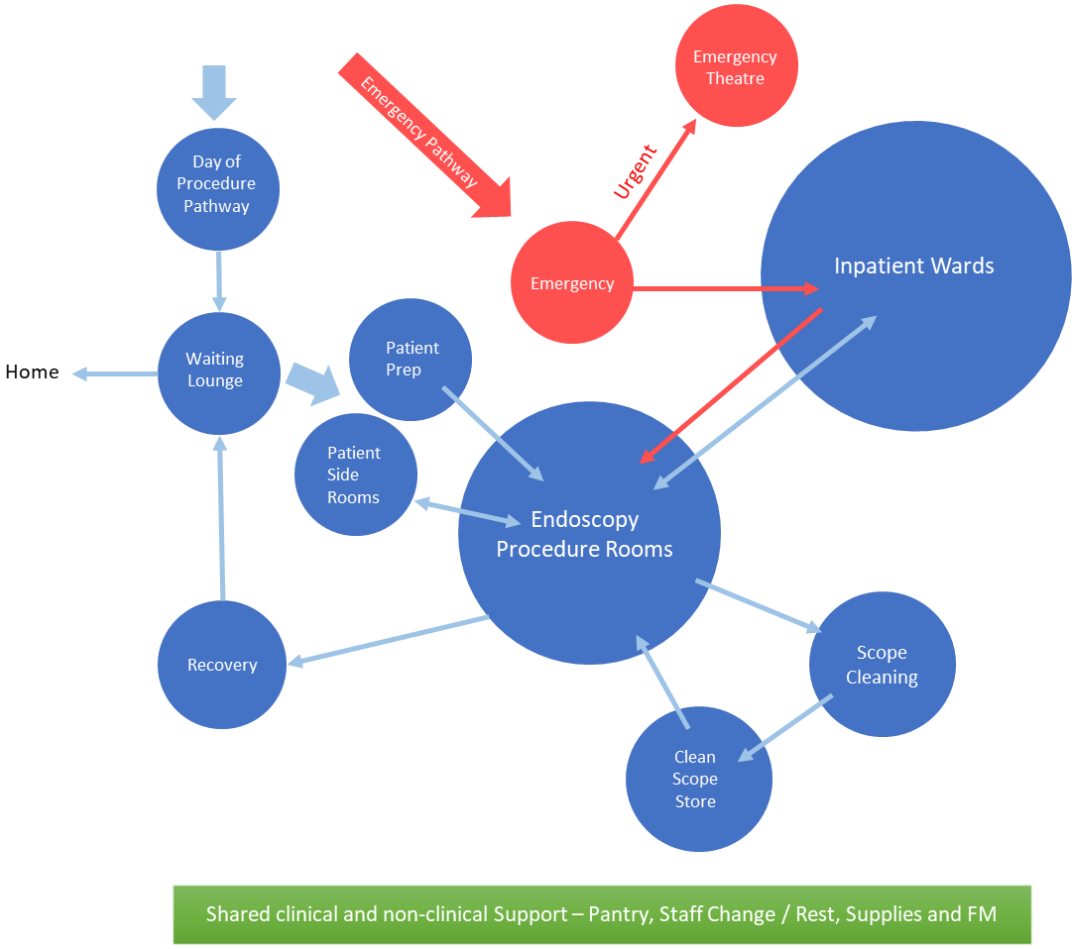
Endoscopy patients will have predominantly been pre-assessed in advance of the procedure and will subsequently arrive on a staggered basis at the endoscopy entrance and reception. A waiting area is provided for relatives and patients. The patient is then called forward into a pre-op assessment / examination room for final pre-endoscopy assessment and onward admission. Where required, patients will change within the pre-op assessment / examination area from their outdoor clothes into appropriate patient theatre gowns, if appropriate for the type of procedure. Clothing will accompany the patients in provided secure baskets, or under trolleys. Separate preparation rooms with ensuites will be provided for patients requiring enemas, patients who need to be isolated due to infection, or as a facility for private patients.

Following the procedure patients will go to the post procedure Recovery area on their recovery trolley. Once fully recovered patients will start the discharge process, change back into their clothes and then return to the waiting lounge for homeward transport.

Inpatients may also attend the unit. The flow of these patients will be kept separate from the day procedure patients. Designated inpatient bed bays are located within the suite, from which an inpatient will progress to the procedure room and the return to the inpatient ward to recover.

Patients requiring endoscopic investigation who arrive at the Emergency Department, will either be admitted to the AAU / SDEC or inpatient bed and then follow the inpatient pathway to the Endoscopy Unit. In the event of an extremely urgent emergency, the procedure will be undertaken within the Emergency Theatre within the Operating Theatre suite. Out of Hours inpatient or emergency endoscopy procedures will be undertaken in main theatres. Critical Care patients will have endoscopic procedures undertaken within the Critical Care Unit.

The following diagram outlines the anticipated construct of the Endoscopy flows.



Endoscopy staff will change into short sleeve “scrub” uniforms in the shared change facilities located within the Endoscopy suite. A supply of temporary scrub uniforms will be provided within a local store to allow staff to change during shifts if uniforms become unacceptably soiled during a shift. Staff showers are provided within the staff change area. A local staff lounge will be provided, with a central staff rest and dining facilities also provided outside the department.

Consumable sterile supplies will be provided locally within the unit, supplied from the central stores off-site. The endoscopy unit will use this store for consumables support to replenish procedure trolleys.

Further scopes will be available within the Scope Clean Room to provide for additional unplanned procedures. The Scope Clean room will be adjacent to the Endoscopy rooms.

The Endoscopy decontamination and processing area will be incorporated within the suite. Separate first stage decontamination and clean endoscope store rooms each with separate pathways, entry and exit points are required with one-way flow of equipment from dirty to the clean area / rooms. This can best be achieved by use of “pass-through” Automated Endoscope Re-processors and therefore the area should be designed around such equipment. Endoscope decontamination and washing will be undertaken to meet UK HTM and JAG accreditation.

Adequate ventilation and extraction should be provided for protection from hazardous substances. There should be two height adjustable double sinks, as well as dedicated hand washing basins within the dirty scope room. In general, it is required that goods flows are kept separate from patient flows, by use of a service corridor and dedicated vertical routes. The procedure room / or rooms will be served by respective clean and dirty hatches integrated within both the first stage decontamination and clean store.

4.4 Inpatient Ward Accommodation

The acute hospital facility will support a range of transformational change in acute healthcare provision in Jersey. The project represents an opportunity for a step change in the inpatient environment.

A ward central core will sit immediately outside of the wards and will act as the filter point for patients and their families entering the inpatient ward areas.

Accessed from the main public entrance via vertical adjacencies, the ward central core area will intuitively lead patients and visitors to the ward reception. The reception will act as an information point and ward clerking reception for the different ward areas in a clean, welcoming environment, which will set a positive, efficient and welcoming tone for patients arriving at the hospital or families visiting the ward area.

This reception area will also act as a localised security point with controlled access to the ward areas.

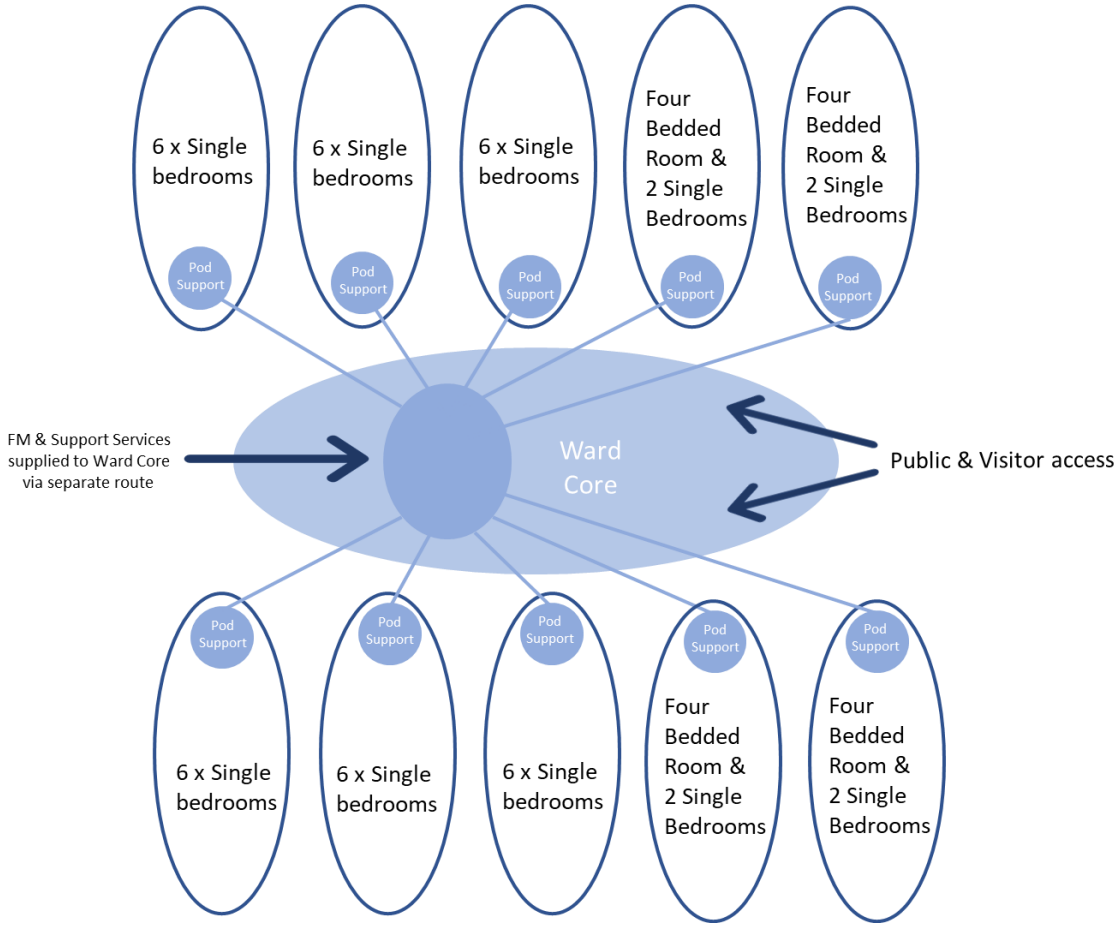
The ward central core will act as a family waiting zone and / or break out space associated with the wards. To this end appropriate waiting areas are provided along with toilet facilities.

The Inpatient Ward

The inpatient environment will provide assessment, treatment, care and recovery for patients with complex or critical needs emanating from a variety of clinical specialities. The inpatient ward concept has been developed based on the principle of a range of approximately 180 generic adult inpatient beds. This number excludes beds in the Acute Diagnostic Unit, Women's and Children's and Critical Care. The inpatient wards will be split into nursing pods of six to support the notional staff to patient ratio of 1 to 6 during the day (1 to 10 at night), but have the flexibility to be nursed in a different configuration if required. Approximately 75% of adult inpatient bedrooms will be single occupancy, the remainder will be configured in four bed bays. A proportion of single bedrooms will incorporate full coverage ceiling mounted hoists. Mobile hoists will be used in multi-bed rooms and will be stored locally within each ward.

The wards will be generic in design, but will initially be divided into separate and distinct areas which are designated for sub specialities such as Elective Surgical, Trauma, Orthopaedic and so on. Each bed space will be sufficiently sized to accommodate one patient and a relative or personal carer. A designated number of medical beds within one of the wards will be equipped with additional oxygen outlets to support a respiratory ward utilising CPAP. Four beds within a medical ward will be utilised to manage a hyper-acute stroke service. Within every ward, a number of beds will include a potable water and drain point to enable the delivery of routine renal dialysis to patients attending with other co-morbidities.

There will be one single bedroom within each 30 bed ward designated for positive lobby pressure isolation and enhanced care. These rooms will be larger than a standard bedroom and will be capable of supporting a bariatric patient, also incorporating a bariatric hoist. The bariatric patient room will require double doors and will include a dual assist WC and trolley showing capability.



Typical 30 bed ward configuration

In developing a generic facility for the management of complex or critical patients, the design must be mindful of the increasing elderly population. Therefore, at the centre of its philosophy of care delivery is consideration of the needs of all vulnerable patients including older people and those with dementia.

The facilities within this area are required to offer:

- An environment conducive to the rapid recovery of patients with complex needs
- An environment that intuitively embeds multi-disciplinary team working at its core
- Good communication regarding patient interventions
- Integration across acute and secondary care to ensure seamless management of the patient journey
- Opportunities for multi-professional skills training
- A facility which has a direct physical link to the emergency department, operating theatres, critical care unit, and diagnostic imaging thus ensuring ease of access to the clinical support areas

A number of key strategic design principles, which underpin the content of this brief:

- Resilience of the ward accommodation to be capable of flexing up or down for different clinical service profiles for short and longer term scenarios
- Adequate localised equipment storage providing clear corridors
- The provision of rooms for isolation of patients integrated into flexible spaces which support bariatric patients and also support trolley based showering facilities
- Single bedrooms will be arranged in nursing clusters or pods of four rooms to create the feel of a multi-bedded bay
- Provision of decentralised staff bases outside of each pair of bedrooms, with vision into the bedroom, for use by clinical and therapeutic staff.
- Therapy staff will play an active part in the care pathway for patients. Therapy teams and other clinical and social care teams visiting the inpatient environment, will utilise the multi-functional team room as hub / base. The multi-functional team room provides shared access to desks, computer workstations and discussion spaces, in a non-patient facing environment. It is anticipated most therapy will be undertaken within the patient rooms, however each ward core also has a rehabilitation gym to aid reablement and assessment.
- Separation of goods / facilities management (FM) flows from patient flows
- Maximisation of centralised distribution and storage facilities with appropriate top up systems to support the wards
- Ward cores providing visitor waiting, rehabilitation gym and central sterile consumable stores. One ward core will support multiple wards.

Those patients admitted via the Emergency Department (ED) will be stabilised in the ED before being admitted into the Acute Assessment Unit for zero to 48 hour stays or an inpatient ward. If the condition requires it, the patients may be transferred from Acute Floor and admitted to a specialist inpatient ward.

The design of the ward in the AAU will be identical to that of the generic inpatient wards, however it will also incorporate 8 Same Day Emergency Care spaces, which should be designed in the same formation as a four-bed bay, to provide additional flexibility and resilience in the bed base.

The main patient groups admitted to the inpatient area can be complex, and have multiple needs. A percentage of these patients will require:

- Specialist & High Dependency Care skills and knowledge
- Frequent and intensive attendance by nurses
- Frequent attendance by specialist doctors
- Acute input from therapists
- In some instances, patients with complex or specialist needs may be transferred to an off-island tertiary facility

Those patients well enough to be discharged will complete their discharge arrangements with the ward staff (medication will be dispensed either at ward level or in the discharge lounge) before proceeding to the public entrance and wait in the comfortable discharge waiting zone until their transport arrives.

The models of care will change in response to the needs of patients and their expectations, services must therefore be provided in a manner that can respond and adapt to future requirements.

4.5 Private Patient Facility

The acute hospital facility will provide a range of clinical services in line with the HCS private patients strategy, creating a new private patient offering, in a very different setting to that of the acute public hospital. Private patients will attend a dedicated private patient's department within the hospital for elective surgery and planned inpatient stays.

A dedicated and discreet entrance for private patients will be provided along with an exclusive pathway for shared specialist areas where appropriate.

A small percentage of these patients will require:

- Specialist & High Dependency Care skills and knowledge
- Frequent and intensive attendance by nurses
- Frequent attendance by specialist doctors
- Require acute input from Therapists

Inpatients and elective surgery patients will be escorted to the inpatient ward reception within the private ward. The private patient ward will be developed on the principle of 100% single bedrooms furnished and equipped to a higher specification than that of the standard inpatient bedrooms. There will be the provision of 1 room designed to include an isolation lobby suitable for the nursing of neutropenic or other conditions presenting with sepsis. The ward will be serviced by a dedicated kitchen located within the hospital itself, in accordance with appropriate fire regulations, which will provide a "chef-on-demand" service giving patients a wide range of menu choice, a daily, freshly cooked food service.

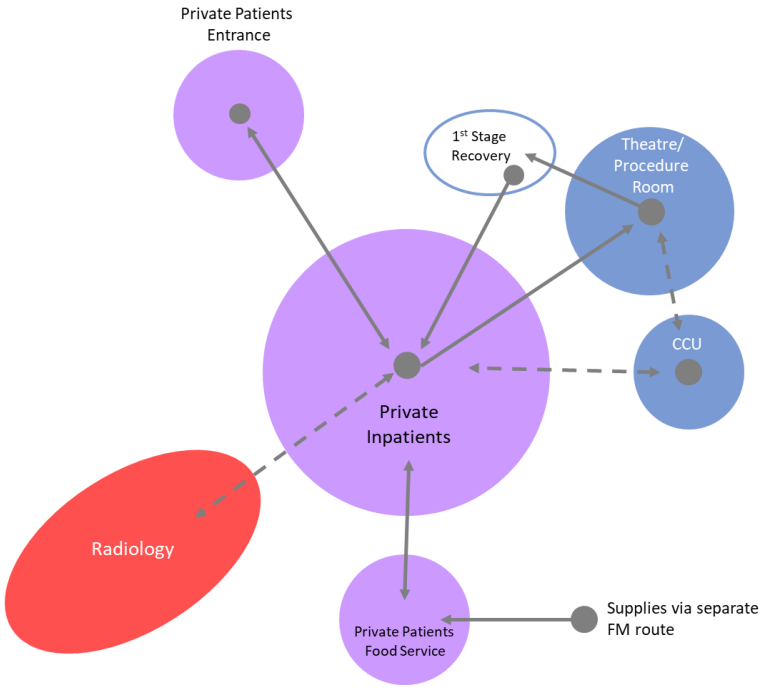
In developing a facility for the management of private patients, the design must account for the need to create a first class hotel environment, being mindful of the need to ensure a clinically functioning environment.

It must also be acknowledged that there is a requirement for clinical services to access key diagnostic and treatment facilities elsewhere on the acute hospital facility. Services will be provided in a manner that facilitates multi-disciplinary team working and encourages a personalised nursing care model. The models of care will change in response to the needs of patients and their expectations, services must therefore be provided in a manner that can respond and adapt to future requirements.

Some private patients may present at the ED and be admitted to the AAU overnight. When patients are appropriately stabilised they may be transferred direct to the private patient ward for further nursing and treatment protocols.

Private patients requiring level 2 or level 3 care will be admitted to an isolation bedroom within the Critical Care Unit (CCU). In some instances, there is the possibility of some private patients with complex or specialist needs being transferred to the UK mainland by Jersey Emergency Transfer Service (JETS). In these cases, the patient route from the emergency, private ward or CCU to the transfer point will consider the patient's

privacy and dignity. The following diagram outlines the anticipated construct of the Private Patient flows:



Private inpatients bedrooms will be provided with external views, taking advantage of the best vista that the site can offer. The rooms will be finished to a high quality, hotel standard with a domestic feel without compromising clinical and infection control standards. Each room should be provided with a private bathroom/WC with showering arrangements. When well enough to be discharged patients will complete discharge arrangements within their private room along with the dispensing and explanation of medication necessary for ongoing care.

4.6 Women's and Children's Unit

The Women's and Children's Unit will encompass the following services: Obstetrics, Maternity, Newborn Unit and Paediatrics. Paediatric outpatients and a women's health unit consisting of Gynae and Breast services will be delivered from the ambulatory care centre.

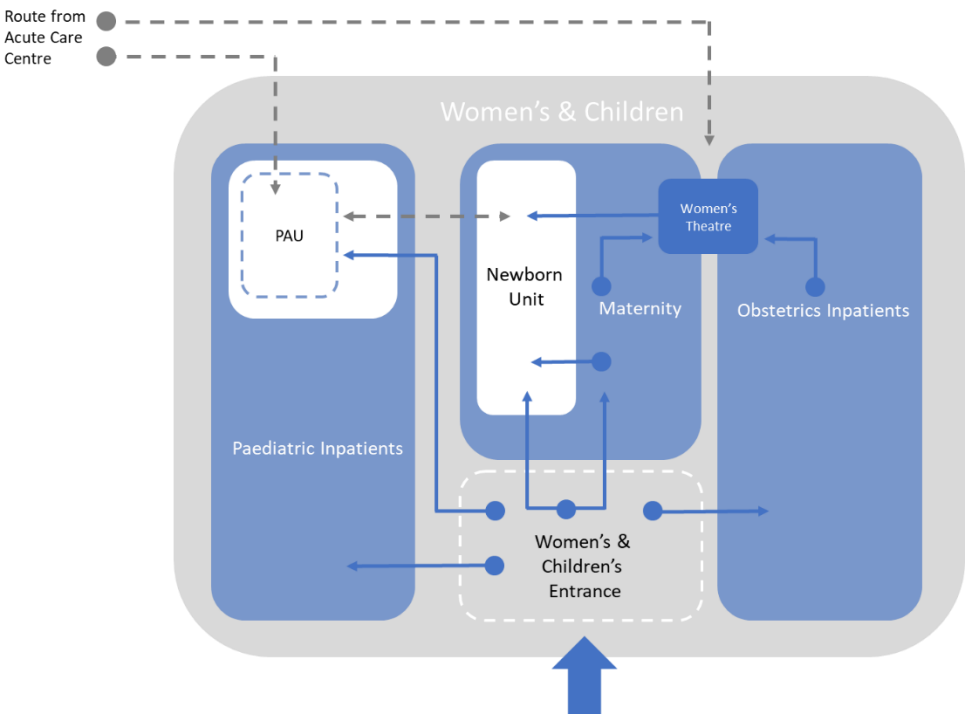
The maternity unit will encompass a consultant led Delivery Suite and a Midwife led unit. Mothers may also attend for induction, planned caesarean sections and less frequently emergency obstetrics arriving by ambulance. Expectant mothers and their partners will access the maternity unit via a dedicated access that will be provided with local short stay parking, a drop off zone and a separate area for ambulance arrivals. Inpatient wards will be located adjacent to the birthing units and will include the induction bed spaces, high dependency and ante / post-natal wards.

There is a requirement for the Newborn Unit to have an immediate adjacency to maternity and paediatrics to minimise staff movement.

The obstetric service is an integral part of the gynaecology service and deals mainly with pregnancy issues, some childbirth, post-partum period and disorders of the reproductive system. Gynaecology is a speciality that manages pathology, the female reproductive system and pelvic structures. In many circumstances the two specialties overlap, however the beds associated with inpatient Gynae pathways, will be delivered from the main adult inpatient ward areas, separate to, but with a level of adjacency to the obstetric inpatient accommodation.

The assisted reproduction unit is located within the Enid Quenault, Health & Wellbeing Centre.

The overall relationship diagram of the Women's and Children's Unit is provided in the following relationship diagram.



4.6.1 Obstetric Inpatients

The inpatient environment will provide assessment, treatment, care and recovery for patients. The inpatient ward concept has been developed based on the principle of generic inpatient beds, which are split into nursing pods of approximately 6 beds to support a 1:6 nursing ratio. Inpatient bedrooms will be all single occupancy and will be sufficiently sized to accommodate one patient and a relative or personal carer.

The obstetrics ward will support ease of staff flow, but will be physically separate and will avoid crossover of patient flows. The maternity inpatient areas will utilise midwife led discharge protocols to support efficiency within the inpatient environment. All rooms and bed bays should be sized to accommodate mothers in a hospital bed, baby in a cot, and partner staying overnight.

At least one single bedroom will be capable of supporting a bariatric patient. The bariatric patient room will require double doors and will have the inclusion of a trolley based shower ensuite with dual assist WC. For efficiency in the use of space, the bariatric rooms will be design as dual purpose with the isolation rooms. High Dependency bed spaces are included within the ward environment.

Using international best practice benchmarks as a measure, the facilities within this area are required to offer:

- An environment conducive to the rapid recovery of patients with complex needs
- An environment that intuitively embeds multi-disciplinary team working at its core
- Good communication regarding patient interventions
- Integration across acute and secondary care to ensure seamless management of the patient journey
- Opportunities for multi-professional skills training
- A facility which has a direct physical link to the CCU and Diagnostic Imaging thus ensuring ease of access to the clinical support areas.

4.6.2 Maternity

The maternity facilities will be capable of meeting the diverse needs of women and their babies. A woman who may require very different levels of input at different stages of pre-pregnancy, pregnancy, labour and post-birth, should be able to have her needs met without undue movement from one location to another. This means that appropriate care revolves around the patient rather than the patient having to move.

This model of care incorporates an obstetric Consultant Led Unit (CLU) and Midwife Led Unit (MLU) provided through a range of generic accommodation with shared support. Although collocated, the two units will have the feel of being physically separate and will operate independently of one another.

Typical birthing rooms within the midwife led unit are based on the concept that mothers will occupy them during the period of their stay - Labour-Delivery-Recovery-Post Partum (LDRP). The rooms within the CLU will in essence be identical; however, the model of care may require a mother to progress to an inpatient

space possibly via theatres. The birthing rooms are to be designed to give a homely feeling with ensuite sanitary facilities.

Delivery rooms will be provided for MLU and CLU to cover at least 1,500 births per annum. The CLU will take priority of adjacency to theatres over the MLU. Some birthing rooms will be sized and equipped to accommodate a birthing pool and at least one will be sized for multiple births. At least one room will have an enhanced specification for women who choose to pay for their care. Another room will be designated for mothers who may be delivering a still birth. This room will have a separate and discreet pathway in and out of the unit with a close adjacency to the bereavement and counselling suite and theatres.

There will be a separate pathway into the two birthing units. From a patient point of view, the two units will be completely separate, however the two units require an immediate horizontal adjacency to one another to provide the ability for a mother to be moved from the MLU to the CLU should the level of care required need to be elevated. Inpatient wards will be located adjacent to the birthing units and will include the induction bed spaces, EMC and ante / post-natal wards.

The obstetric theatre will be dedicated to maternity services and will be located within the maternity department. This will provide efficient clinical staff pathways and support spaces. It is essential that the theatres and CLU have a horizontal adjacency to one another. The elective C-section list will be delivered through this theatre, the list will be managed operationally and will not run whilst there is potential for emergency theatre use. This can be operationally managed due to the low numbers through the birthing centre.

Ante and post-natal inpatient areas will follow the same philosophy as the inpatient ward areas, in that they will be delivered through a standardised design of single patient bedrooms. The inpatient areas will utilise midwife led discharge protocols to support efficiency within the inpatient environment. All rooms and bed bays should be sized to accommodate mother in a hospital bed, baby in a cot, and partner staying overnight.

Transitional care – Babies born prematurely or needing extra care or observation can be cared for alongside their mothers on the postnatal ward as part of a virtual transitional care pathway, with care predominately given by the mother and supported by the neonatal nurses and midwives and maternity care assistants.

Readmission of infants requiring feeding support and jaundice will occur on the transitional care ward.

The patient pathway will change in response to the needs of patients and their expectations. Services must therefore be provided in a manner that can respond to future requirements, particularly with respect to the proportion of single rooms.

4.6.3 Newborn Unit

Neonatal care is the vanguard in the provision of family-centred care, which recognises the unique and individual needs of each infant and family. Family-centred care is a philosophy of care in which the pivotal role of the family is acknowledged and respected in the lives of children. Within this philosophy, families are supported in their natural care giving and decision-making roles. Parents and professionals are seen as equals in a partnership, committed to the infant and the development of optimal quality in the delivery of all levels of health care.

The service aims and objectives are related to quality & safety of care: to minimize infant morbidity, mortality and to maximise long-term health and well-being through the provision of safe, research based care, which will:

- Improve and enhance the quality of life of all neonates cared for by the Neonatal Team
- Ensure that medical and nursing staff are appropriately trained
- Ensure babies are treated in the right way and by appropriately trained staff
- Provide appropriate equipment with which to treat and monitor infants
- Promote good communications within the Neonatal Care multidisciplinary team
- Promote a professional environment that enhances family attachment
- Provide support for the families of infants in our care recognising their emotional, physical and social needs

Babies will be transferred from the delivery rooms, directly from a maternity operating theatre, maternity inpatients or transferred to the facility by ambulance. Babies may be cared for in a multi cot nursery or a single cot room. The cot accommodation will be used flexibly to accommodate babies requiring intensive care, high dependency care and special care, with sick babies who are admitted to the Intensive Care Unit (ICU) / High Dependency Unit (HDU) area being held prior to being airlifted by Jersey Emergency Transport Services (JETS) to suitable facilities on the UK mainland.

Some single bedrooms will be sized to allow a mother to sleep in a hospital bed adjacent to a special care baby or for rooms to be used for up to two special care babies, such as twins. Some babies who will benefit from transitional care supported by neonatal nursing teams will have stays within the post-natal ward with their mother. Those getting ready for home can room in with mother / parents prior to discharge. Some babies will only require admission for special care and not need to access transitional care.

For ease of nursing cot bays and single cot rooms will be monitored by de-centralised nursing zones. Hearing tests and vision testing will take place in the consultation room.

Parents need 24-hour access to all patient areas, visitors' room, interview room and milk expressing room. Mothers need to be able to visit their babies, this may be in a wheelchair of inpatient bed, adjacency with the postnatal ward is therefore desirable.

The access and security arrangements will need careful consideration as mothers and visitors will often be present at all hours. Access will be controllable whilst ensuring visitors are welcomed and feel able to arrive and leave as they wish.

Intensive Care - critically ill babies and neonates who require continuous support of organ function and continuous observation, examples being infants who require ventilation or very preterm infants with respiratory distress syndrome, prior to Jersey Emergency Transfer Service (JETS) transfer to appropriate facilities on the UK mainland.

High Dependency Care - Specialist care for babies and neonates who, though not critically ill, require continuous support and observation for neonatal conditions. Examples are preterm infants with recurrent apnoea spells, stable infants receiving nasal continuous positive airway pressure (CPAP) or those receiving parenteral nutrition.

Special Care - Continuing care for babies and neonates who require specialist support such as tube feeding or care in incubators, for example well infants who are maturing after preterm delivery or convalescing following high dependency or intensive care

Transitional Care - Care of a baby or neonate predominately given by the mother and supported by the neonatal nurses and midwives. The care of the baby or neonate requires minimal supervision and will be cared for on the post-natal ward supported by midwives for the mother, and care from the neonatal nurses for the baby.

In line with the requirements and recommendations of the UK royal colleges, international best practice benchmarks and UK NHS national service frameworks & health building notes, the clinical accommodation within this area will provide a suitable and safe environment for mothers and babies and facilities for their diagnosis, assessment, monitoring, care and treatment.

4.6.4 Paediatrics Inpatients, Emergency and PAU

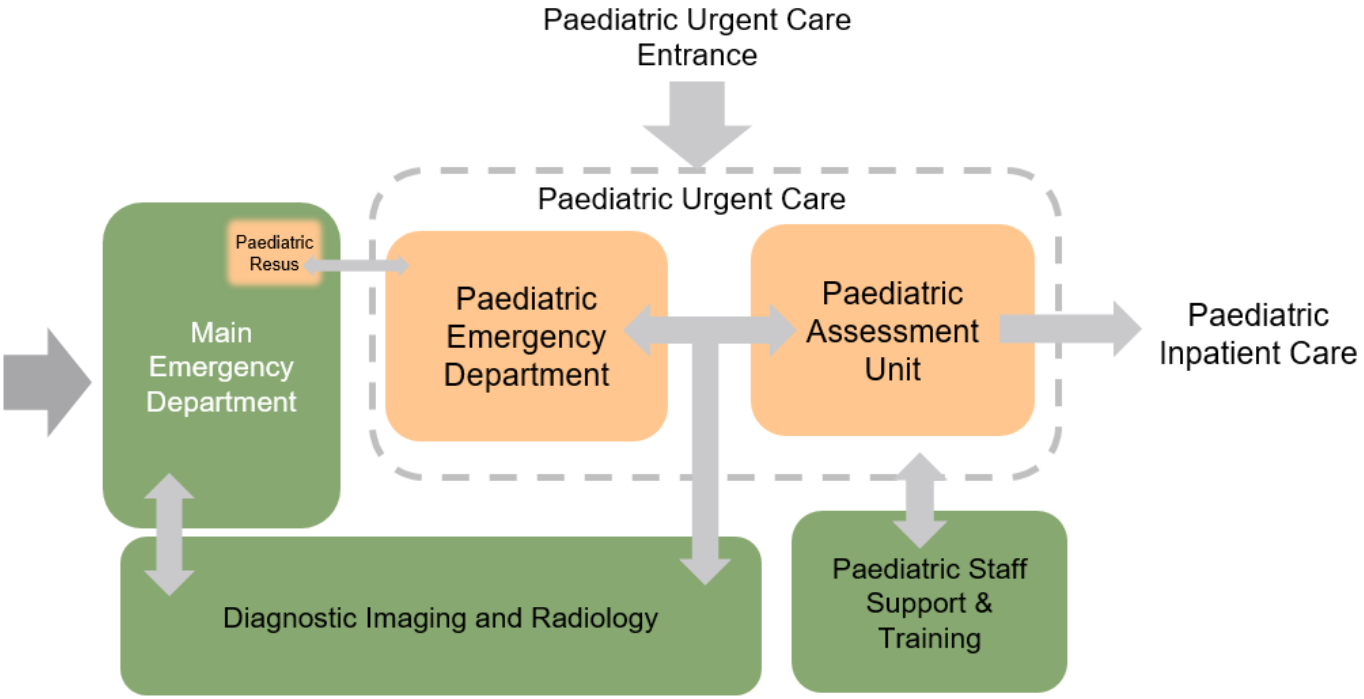
All Inpatient paediatric activity will be provided in purpose built, age related environments, where children and young people will receive high quality care delivered in the right place at the right time by skilled paediatric trained professionals.

A Paediatric Assessment Unit (PAU) will be delivered adjacent to the Paediatric ward and consists of a cohort of consult / exam rooms with ensuites.

The Paediatric inpatient ward and PAU will be co-located to minimise staff movement. Although these spaces may share support accommodation and staff, the patient flows will be kept completely separate from one another.

Those patients presenting at the ED may be treated within the ED, particularly if the patient has a trauma related condition, or may be transferred to the PAU for ongoing assessment. Patients referred to the hospital

by local GP's will be admitted to the PAU for initial assessment. Patients in ED or PAU may be admitted to an inpatient ward bed to await further diagnostic tests or surgery if required. The paediatric ED, PAU and inpatient wards will have an adjacency to one another.



The optimum design solution will accommodate a PAU within one end of the paediatric ward whilst having an adjacency with ED. In addition, the ease of movement for staff between the paediatric areas and the Newborn unit is an important consideration for the design.

On arrival at the hospital, paediatric patients booked for a 'planned elective admission' which requires an inpatient stay will report to the reception within the Women's and Children's Entrance and will then be escorted or directed (if accompanied) to the paediatric ward.

Paediatric surgical patients will be admitted to the paediatric ward prior to surgery and return to the ward to recover. Consideration needs to be given to the physical pathway for a child or young person to move into the Surgical Suite. It is intended that the majority of spaces within the surgical suite, such as theatres and support accommodation, will be utilised by Adult and Paediatric patients and therefore duplication is to be minimised, but separation of flows within the design is essential.

Within the acute paediatric area, the facilities to be provided include a fully comprehensive emergency and inpatient service for children suffering from medical, surgical, and orthopaedic / trauma. Some patients may require transfer via Jersey Emergency Transfer Service (JETS) to facilities on the UK mainland.

The department design will provide for consideration of the differing patient flows to ensure that the privacy, dignity and safeguarding of paediatric patients is kept separate from that of adult patients at all times.

Within the acute Paediatric Inpatient area, the facilities to be provided include a fully comprehensive inpatient service to children and young people.

The functions of the ward are:

- To provide assessment, treatment and care for Paediatric patients of any medical or surgical specialty;
- To provide a knowledge and training focus in the care of Paediatric patients.

The Inpatients area should make provision for the

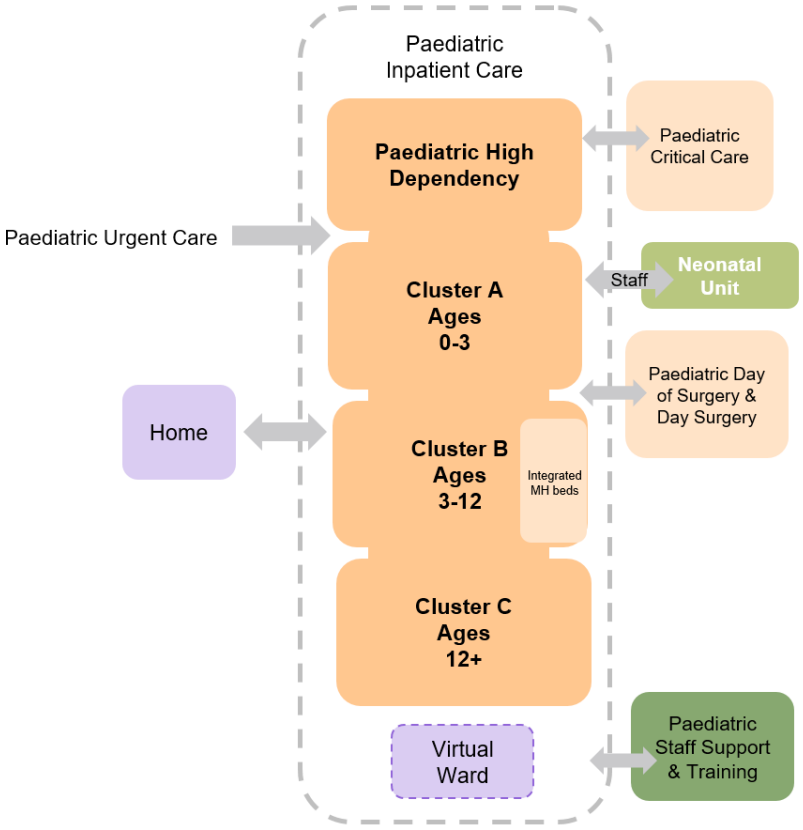
- Assessment, treatment and care for children with acute and chronic medical and surgical conditions.
- Assessment and treatment of adolescents.
- Delivery of high dependency care (level 2)
- Management and treatment of mental health and other co-morbidities

Given the wide range of age groups in the Paediatric environment, it is preferential whenever possible to consider the inpatient environment as a series of age banded clusters, where accommodation is more age specific and patients of similar ages are grouped together. Patients may, therefore fit into the following clusters:

Cluster A (age 0-3)

Cluster B (age 3 – 12)

Cluster C (age approx. 12+)



Flexibility is paramount within the unit and it must be possible to support the breakdown of age groups as well as being able to flex between clusters over time. e.g. Cluster A to flex into cluster B as required and vice versa and cluster B to flex into cluster C and vice versa as required. It must still be possible to contain children, who may be independently mobile within their designated clusters. Consideration will be given to the provision of an adolescent and young adult unit within the paediatric department that would provide age related facilities.

Consideration must be given, across the age bands but particularly in adolescents to provide an environment which can support patients with mental health and physical health illness. This may include patients who have eating disorders, self-harm or attempted suicide. Equally this can include patients who are disruptive and have challenging behaviour, as well as youth violence.

The design of the inpatient accommodation will need to take particular reference to vulnerable patients and those patients with complex mental health issues, although the accommodation itself will not be used for the medium or long term care of paediatrics presenting with mental health issues without physical comorbidities. It is equally important to recognise and support children and young people with neurodivergent traits, who may experience challenges related to their differences, such as difficulty with communication, social interaction, stimulation, or executive functioning. and whom may benefit from services and spaces that enable them to be supported in their own unique way.

The design should reference and support the hospitals safeguarding policy.

4.7 Emergency and Elective Surgery Suite

The Surgery Suite will provide interventional services for planned elective surgery (where an overnight stay is likely to be required) and emergency surgery patients. The day surgery suite will be located within the ambulatory care centre.

The Maternity theatre will be located in the Maternity Department, however a horizontal or vertical adjacency with main theatres is required. A separate pathway for private patients is required and is documented within a separate Private Patients section of this brief.

The department design will provide for consideration of the differing patient flows to ensure that the privacy, dignity and sensibilities of individual patients are preserved.

All elective patients attending the surgical suite will follow a day of surgery pathway also known as theatre direct. All elective surgical patients will undergo a pre-operative assessment at an earlier appointment.

The facilities provided within the department are required to offer:

- A range of surgical facilities capable of supporting the specific range of clinical services provided by the hospital on island
- Seamless time management of the patient journey maintaining the highest levels of patient privacy and dignity
- An environment conducive to the rapid recovery of patients with complex needs
- Good multi-disciplinary communication regarding patient interventions

It is recognised that the models of service delivery adopted will alter over time. It is therefore essential that the surgical facilities can respond to future changes in the technology as well as changes in clinical service models.

The quantum of elective and emergency operating theatres has initially been assessed as five, however two further day surgery theatres and two minor surgery theatres are provided at the ambulatory care centre as well as a separate dedicated maternity theatre. An additional minor procedure room is included within the Outpatients Department also within the ambulatory care centre.

Contingency for a shell space for future expansion will be considered and much of the soft space has been appropriately sized to allow future adaptation. A number of Operating Theatres will require to be provided with skirt-less Ultra Clean Ventilation (UCV) canopies. One theatre will be designated specifically for emergency and trauma. All theatres will have the infrastructure to support integrated theatres, laparoscopic theatres, hybrid and interventional modalities and robotics.

Anaesthetic rooms have been sized (and will contain the infrastructure) to be used as Critical Care beds in the event of winter pressures or future pandemics.

The vast majority of elective surgery patients will arrive at the Public Entrance on the day of their surgery and

will be directed to the Surgery Reception. In this area a waiting area is provided for relatives and patients. The patient is then called forward into an interview / mediroom for completion of admission documentation, final pre-operative assessment, and preparation for surgery. These patients will change within the mediroom from their outdoor clothes into appropriate patient theatre gown and remain in this room until called / collected for surgery.

Once collected for surgery, patients will be taken into the anaesthetic room. The majority of patients will walk to theatres. Those unable to do so will be taken by chair from the mediroom.

Some elective and emergency patients may arrive on a bed and once processed through the surgery control base, will be held in a bed waiting / transfer area until being transferred to theatre.

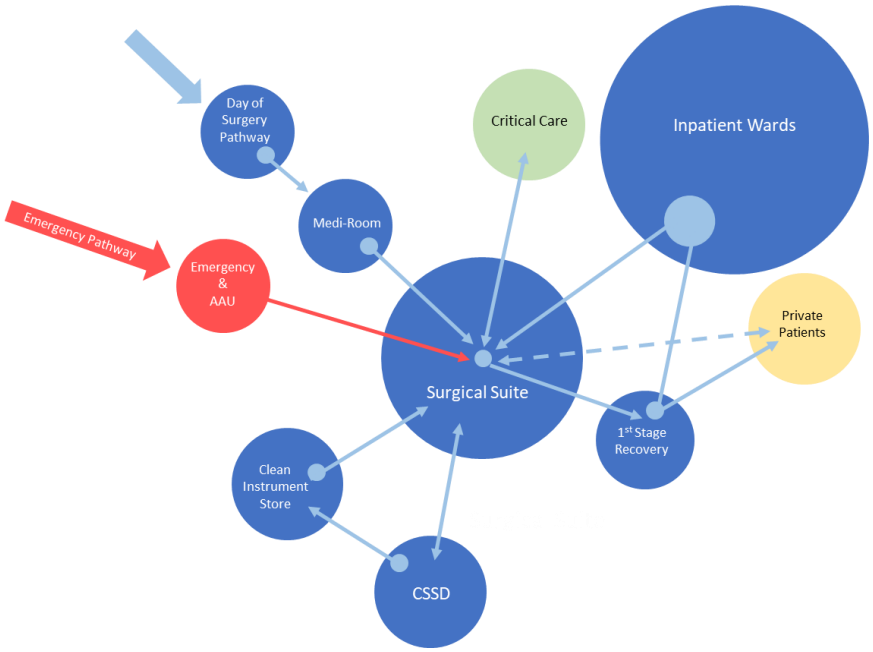
Following induction, the anaesthetised patient is moved into theatre and transferred onto the table. The patient's bed, trolley or wheelchair is then moved to the operating room exit bay and held there during the surgical procedure.

Following the procedure patients who have received a general anaesthetic will go to the post anaesthetic care unit (PACU) on their bed or theatre recovery trolley or if necessary, be transferred directly to the Critical Care Unit. Non-critical elective inpatients will remain in the PACU until recovering sufficiently before moving to their designated ward.

With consideration of privacy, dignity and gender separation, the design of the PACU bays should be such that the visibility of patient to patient should be minimised. Dedicated separate areas for paediatrics will need to be provided which minimise, or ideally eliminate, the crossing or passing of adult / gender specific patient pathways.

Two of the required recovery bays will be designed to provide patient isolation and will be provided with a gowning lobby to facilitate barrier nursing. These bays will have glazed partitions to facilitate maximum patient observation during the recovery process. One isolation recovery bay should be sized to accommodate the occasional bariatric patient. These isolation rooms are sized to support extended recovery protocols and can also be utilised as Critical Care beds in the event of winter pressures or future pandemics.

The following diagram outlines the anticipated construct of the Operating Theatre flows.



A centralised theatre changing area where theatre staff will change into short sleeve “scrub” uniforms will be located with ease of access to theatres. Staff showers are provided within the support area along with a boot/clog changing lobby as part of the footwear washing utility room. A local staff rest will be provided within the department for breaks and refreshments.

Consumable sterile supplies will be provided to the sterile consumable store within the department, supplied from the off-site central stores. Pre-packed sterile instrument trays will be delivered to the theatre sterile instrument store and / or central shared preparation area via the clean Facilities Management (FM) route in closed carts. These carts will contain the appropriate predetermined sets for the days planned procedures.

The instrument sets required for a particular surgery list will be collected from the sterile instrument store and be taken directly to the theatre suite or to the preparation room. Here the instrument sets will be prepared for each particular operation.

After each operation the used instrument sets will be taken to the connected theatre dirty utility. Here the instrument tray will be sorted to remove any disposable items and placed in a clinical waste bin. The dirty tray will then be appropriately treated (which may include the use of a water or other such spray) and placed into a dirty returns cart. The full dirty returns cart will be taken to the dirty hold and CSSD returns room for eventual return to the CSSD central collection point via the dirty FM route, for reprocessing. Generally, this will take place when the surgical list is completed, but this may also occur during or prior to the end of a surgical list.

It is required that goods flows are kept separate from patient flows, by use of a service corridor and dedicated vertical routes.

The Surgical Suite will be fully staffed during normal working hours. A designated number of Theatres will be available 24/7 to meet Emergency, Trauma and Obstetric surgical requirements.

All clinical rooms, such as the operating theatre, anaesthetic room, prep rooms, dirty utility and PACU, will be provided with “touch-screen” computer systems to minimise infection control risks.

4.8 Critical Care Unit

The intent of the Critical Care Unit (CCU) is to provide a model of service delivery, which is required to deliver safer, sustainable services and better outcomes for patients than is currently the case. The concept of flexibility in the management of critical care and the ability to step up and down between critical care levels 3 and levels 2 without moving the patient to a different room is central.

The CCU staff will support patients requiring critical care level 2 and level 3 care. The table below provides definitions for levels of critical care dependency:

Level 2	Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those ‘stepping down’ from higher levels of care
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Some of the key principles underpinning the critical care service model are:

- Integration and consolidation of critical care services that incorporates all specialties and diagnostics
- The critical care unit is an essential service for the hospital network especially for the support of complex elective surgery and the management of emergency care
- The role of the critical care unit will be consistent with the needs of the patient population as reflected in volume and complexity of demand.
- The CCU will have effective operational and functional relationships with theatres (including maternity and obstetrics), recovery, diagnostics, wards and the emergency department.
- The Level 3 and level 2 critical care will be managed as a combined “unit” with flexible functionality between level 2 & 3 and operating theatre recovery.
- For some critical care pathways, the CCU will provide level 3 care until the patient is transferred to a tertiary unit.

The service will provide multi-disciplinary care and treatment for critically ill patients from both surgical and medical specialities, including invasive monitoring and multi-organ support.

Level 2 and 3 patients may initially be cared for short periods of time during stabilisation of their condition in the theatre suite and emergency resuscitation room prior to transfer to the unit. Some patients requiring specialist intensive care will only be held in the CCU until appropriate arrangements are made by Jersey Emergency Transfer Service (JETS) to appropriate units on the UK mainland.

Patients will be supported by the CCU team when transferred to the Imaging / Radiology department whilst undergoing any imaging or interventional radiology procedures and will therefore be subject to inter-departmental transfers between CCU and Imaging / Radiology.

All bed spaces will be generically equipped with the same infrastructure including monitoring and life support systems, regardless of care level or clinical pathway. This will enable optimal flexibility of beds and will enable provision for patients with varying degrees of illness during times of peak demand. However, media dialysis panels will only be supplied to the isolation bedrooms.

All patients require a bed space which is large enough to permit all clinical interventions and accommodate multi-parameter monitoring, mobile fluoroscopic imaging, life support systems and a clinical hand wash basin. Additional to this an area for a staff zone is required in each patient bedroom for note taking / documentation and 1:1 observation of the patient.

The unit's complement of beds will be split into nursing pods and will include within that complement negative and positive pressure isolation facilities.

Each pod will incorporate single and twin bedrooms with full wall width glass screen doors which can be opened completely to create a bay style space or be closed to create a room. The glass screen doors will need to be capable of only opening a small distance when required for staff access whilst a patient is receiving treatment or personal care. The glass screens will need to be capable of providing switchable privacy or observation depending on patient need. Solid walls between bedrooms will also be provided with large windows between bedrooms to support visual communication between staff members. These windows will also require to be capable of providing both privacy and observation depending on patient need. The isolation rooms will be provided with a gowning / transfer lobby to allow for barrier nursing and provide isolation to protect immune-suppressed patients and the unit from risk of any air borne infections.

The unit should be designed to allow a nursing team to manage both single and twin bedrooms, subject to the requirement for flexibility i.e. the need for 1:1 or 1:2 nursing care. The design of the unit will facilitate gender separation and maintain privacy and dignity of patients without compromising the flexible use of space.

The requirement for the provision of single and twin bedrooms must be balanced against the need to maximise visibility of all patients.

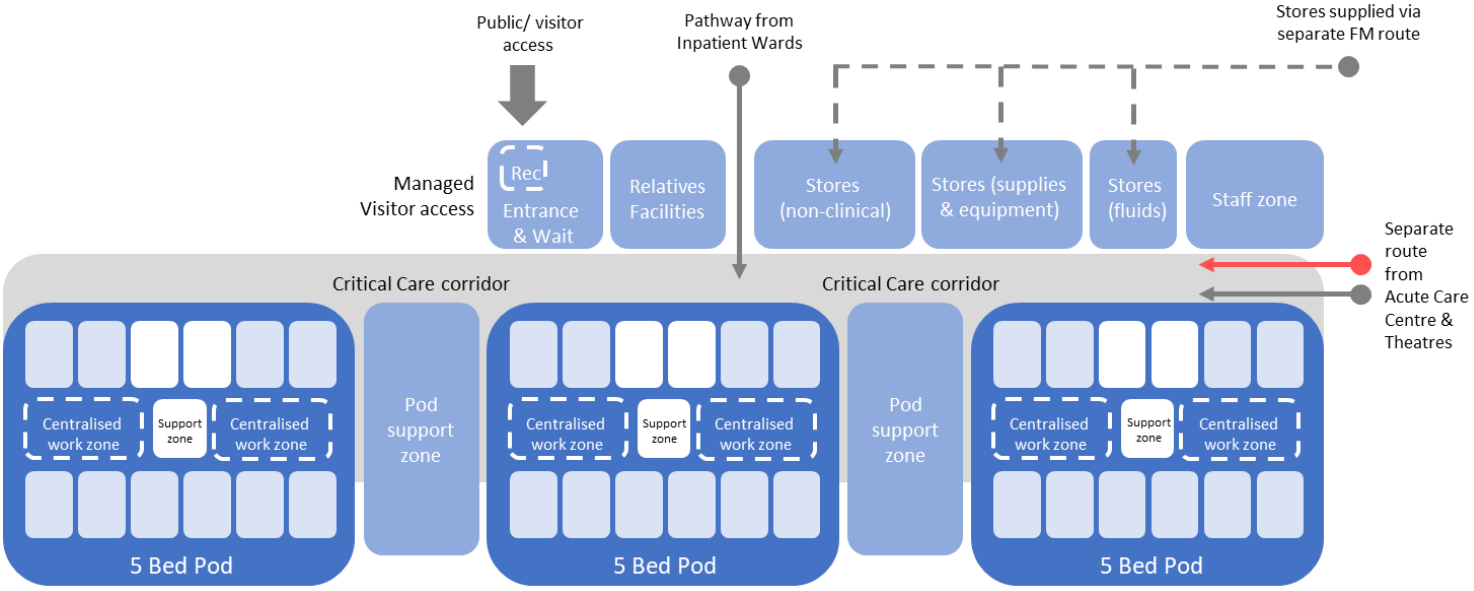
Each nursing pod will include a central work area, stat lab, utilities and a number of de-centralised nursing zones providing rapid supply of consumables. This central support zone will afford clinical teams with the shortest possible journey between spaces and where possible be of low level design to provide an open plan work space which can support ease of staff communication and support, ultimately supporting increased patient safety.

A central telemetry monitoring station is required for consultants to actively review live telemetry of patients within the unit and crucially in bed spaces elsewhere within the hospital. The station will provide full telemetry review, PACS, Radiology Information System (RIS) and Electronic Patient Records (EPR), enabling a senior clinician to monitor and manage patients who may be on the cusp of admittance to CCU, but who can be remotely monitored within enhanced care spaces within standard acute inpatient wards.

Each nursing pod support will require immediate access to clean supplies, which can be held at the de-centralised nursing stations, and dirty utility areas. Shared support with provision for adjacent storage for IV fluids, linen and equipment with the aim of minimising travel distances whilst maximises the benefits of shared facilities.

Although patients to be cared for in this area are critically ill there is a requirement to maximise the availability of natural day light as many will remain in the unit for significant periods of time and appropriately located windows are important in terms of meeting their psychological needs and that of the staff.

The unit must be designed to support all specialties, with no physical barriers to delineate and establish boundaries between specialties. The following diagram outlines the desired flows and adjacency:



4.9 Pharmacy

The Pharmacy service within the acute hospital facility will be a hi-tech robotic and electronic service integrated within the clinical departments, to support the delivery of a high quality patient-focused service to all acute patients in Jersey.

The service will be responsible for the management and dispensing of pharmaceutical products to patients in all clinical areas including dispensing for individual patients and supplying stocks of medicinal products to local automated dispensing cabinets within wards and other clinical departments. The pharmacy will be split across multiple sites to help meet the needs of the ambulatory and outpatient centre as well as the acute hospital facility, mental health and rehab and step down. The ambulatory site will provide a patient facing dispensary.

The pharmacy service for the acute hospital facility will receive all pharmacy bulk supply deliveries at an off-site storage location to provide resilience to the department. Supplies will then be moved to the acute hospital pharmacy goods-in when required. The pharmacy will be located adjacent to the FM delivery area to minimise the distance for transfer of pharmaceutical items. The security of this area must be compliant with regulatory requirements on the safe and secure storage of pharmaceuticals. On delivery to the hospital the items will be moved to a bulk storage area with capacity to store at least 10 pallets of bulk items. All pharmacy items will require signing for by a member of the pharmacy staff at the goods receipt area. A lockable (digilock) temperature controlled secure store room will be required at the goods in area for deliveries which are made out of hours.

Adjacent to the bulk store deliveries will be logged, held, broken down into smaller supply packs and be

delivered to the appropriate pharmacy storage points or to further distribution points via conveyor belt (linked to the pharmacy dispensary), or loaded into a hopper for placement in the pharmacy robot.

The dispensary area will have a robot which will incorporate approximately 6 ward box filling stations. Walk in fridge and freezer rooms need to be available within the central storage area to allow for the storage of temperature sensitive supplies. The dispensing functions for the inpatient pharmacy will be a staff only area supported by a reception, wait and “out of hours” cupboard, lockable pigeon holes will hold dispensed pharmacy supplies for specific clinical areas until they are picked up from the pharmacy area. There is a requirement for a separate controlled drugs room, with block construction and alarm system. Within the main dispensary there needs to be a small extemporaneous preparation area.

The inpatient pharmacy service will be based on the principle (wherever possible) of original pack supply labelled ready for stay / transfer / discharge. It is proposed that the patient’s own medications will be held in a lockable medication cabinet provided within the patient bedside lockers. An automated pharmacy system (such as Omnicell, Pyxsis or equivalent) will be incorporated into the dispensing process for all clinical areas, providing electronic automation of stock control and dispensing / distribution, replacing traditional medicines cupboards. Ward medication stocks will be kept to a minimum, allowing a holding capacity of 96hrs for defined patient medications and operating a “just in time” top up service.

Within the surgical suite, local medications and controlled drug holding will be required within anaesthetic rooms. These drugs will be dispensed from the automated dispensing units and recorded as issued to specific local controlled drug cabinets. Volatile anaesthetic agents will be issued to anaesthetic rooms as usage requires.

The service model is centred upon proactive involvement of the pharmacist in the care of the patient which will necessitate significant input from the pharmacy team within the patient areas including the critical care unit (CCU) and inpatient wards. To enable this approach a pharmacy base will be required within ward core areas. To support rapid discharge or transfer of patients, it is envisaged that the pharmacist will have already dispensed the majority of To Take Out (TTO) drugs within the patient medication locker, however it is accepted that further medication may need to be dispensed at the point of discharge, which will be managed by a pharmacist from the pharmacy base within the ward core.

The pharmacists will provide advice and information to patients, medical, nursing and other professional staff to ensure the safe and appropriate selection, use and administration of medicines. A key principal of this operating model is that a pharmacist will be accessible to potential admissions from the emergency department and emergency admissions as required.

The Aseptic preparation of pharmaceuticals will be undertaken within the ambulatory care centre pharmacy department which will ideally have an adjacency to the chemotherapy unit for staff flows.

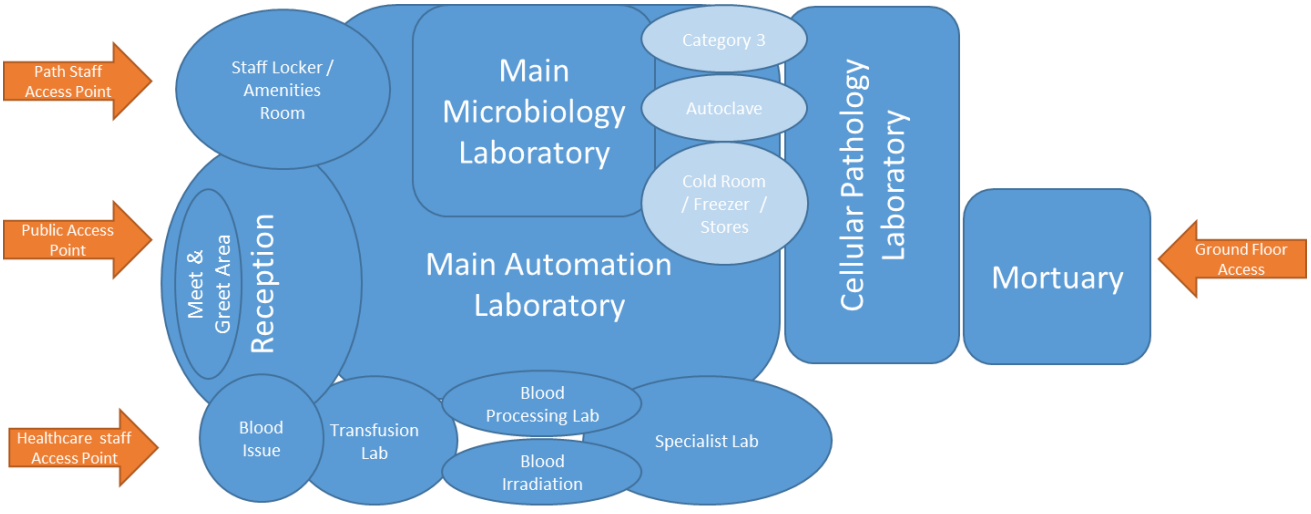
4.10 Pathology and Mortuary

The Pathology service will represent a central managed standalone facility with clinical blood sciences (biochemistry, haematology (including blood transfusion) immunology), microbiology (including virology) and cellular pathology disciplines. Pathology is configured into separate disciplines with little overlap, but has a multidisciplinary service for out of hours working.

The Pathology Service also acts as a blood transfusion centre managing the Islands donation service, and provision of blood for transfusion to patients at the healthcare facility. Blood collection is proposed to take place within the ambulatory care centre.

There are close working relationships between the transfusion laboratory and the emergency department (ED), acute assessment unit (AAU), theatres, inpatient wards and the maternity & gynaecology services and between the mortuary and histology laboratory. Phlebotomy services are currently managed outside the Pathology service.

The andrology laboratory, which will include a small cryogenic facility will be staffed by visiting pathology staff, but this will be developed outside of the acute facility.



Main Pathology Block Adjacencies

The Main Pathology facility including; diagnostic laboratories for specific disciplines (blood transfusion, haematology, biochemistry, microbiolofgy (including virology) and cellular pathology, reporting, administrative and common rooms can be located into a single site.

The Pathology service will be located as part of the acute healthcare facility for safe and secure transfer of specimens to the laboratories in both routine and urgent situations. The key services that require pathology services 24/7 365 days a year are; ED, theatres, AAU, inpatients and maternity.

A protocol for the safe and secure transfer of specimens to the laboratories from the ambulatory centre will be developed, with samples arriving at the pathology reception.

If the pathology department is located over more than one floor then a lift of minimal dimensions must be accessible to allow for the provision of large laboratory equipment and supplies. The size should be at least equivalent to that of a ‘bed lift’.

The department front end transition area should allow them to change to laboratory coats prior to entering the laboratory areas.

In the main pathology area a specimen reception should be at the front of the department for easy access by couriers, sample transfer service and healthcare staff and have close adjacency to the main laboratory dirty areas. The specimen reception may include the pneumatic tube point for the department depending on the buildings adjacency to the other healthcare facilities. There should be a reception area where visitors are able to wait.

All laboratories should be designed to at least Containment Level 2. The laboratory space should be large, open plan with support rooms off a central area including cold rooms, CAT3 suite, PCR lab and slide storage. There will be a main analyser area which will need a water supply and drainage.

There is a requirement for temperature monitoring and alarm systems for all fridges and freezers and for some ambient storage linked to the Building Management System (BMS) and the switchboard 24/7. There should be, within the laboratory, a separate partitioned area to facilitate administrative work without leaving the laboratory.

The department will have an autoclave and wash up room with agar plate storage adjoining the wash up room. The Public Health (Water) service will be located in the microbiology lab.

Administrative and clerical support will be provided within the department. Where possible offices which are integral to the laboratory can have glazed partitioned walls so as to allow borrowed light and also visibility of the laboratory area.

There should ideally be a split between administrative and reporting functions within ‘clean’ areas where no clinical waste is generated and laboratories and investigative rooms within ‘dirty’ areas which do generate clinical waste.

Where possible the College of American Pathologists guidance should be adopted for clean and dirty space, such that staff enter the pathology area from the healthcare facility into a change / locker room in which they put on their laboratory coats and pass through an internal door into the laboratory area. It could be that the staff locker room, showers and WC are all located in such a space.

The laboratory can be future proofed to some extent by the provision of large laboratory spaces with utilities and services, and the use of modular or mobile benching with cupboard and drawer space. There should be sufficient storage and archive areas within the overall pathology footprint.

The nature of progression in pathology, the changing technology and introduction of new tests can present operational challenges to space configurations and working practices, which at any one time cannot be fully predicted or planned for. Suitable infrastructure will need to be in place to allow for these changes

The evolving services, expertise and experience of staff, demand that any new design should provide maximum flexibility for future use to accommodate such changes, without the need for major refurbishment. The laboratory spaces should maximise the use of natural light.

In any future service model the development of point of care testing facilities is set to increase. Dependant on the nature and repertoire of services required, most of the analysers and associated equipment can be trolley mounted or fit onto a single worktop. The equipment is largely mobile / portable but will require the provision of power and network ports.

The future requirements of pathology are also largely dependent on the development of clinical services across the new healthcare facilities. The functional brief makes provision for current and known future requirements. The new laboratory design needs to be able to accommodate changes to future practice and increased workload.

The histopathology lab will require down draft cutting benches and height adjustable benching. The samples and formalin will be stored in large ventilated cabinet within the lab. The lab area must be closely temperature controlled and should not have air vents directly over cut up benches. Consultant histopathologist reporting rooms should be adjacent to the histopathology laboratory and their secretarial support. These consulting rooms must have natural light. Histopathology should have close adjacency to the mortuary. Other consultant rooms and medical secretary offices should have close proximity to pathology as they are an integral part of the diagnostic / reporting process.

The mortuary must be located with the main pathology building with a ground floor covered, secure and discrete access for funeral director’s vehicles and ambulances. This space can also be utilised for emergency body storage, if required and should have the appropriate services available to enable this. The bier room must have good adjacency to the body storage area. The entrance for the viewing area needs to be located away from clinical and FM areas. The interior design should be sensitive to the needs of bereaved relatives visiting the facility. Décor that promotes a comfortable and relaxed atmosphere would be appropriate. Natural light should be incorporated wherever possible with access to an outside garden.

The main mortuary entrance should be directly adjacent to the body handling area (which will have an H frame ceiling hoist) and 30 body fridges, including 10 bariatric spaces and a number that can be used as freezers and paediatric storage fridges. A number of the fridges must be capable of being sealed in the case of a criminal investigation. The fridges will be double sided so there is access from the PM room too. An interlocking lobby for staff is required for access to the PM room and must have a boot disinfecting tray. In the PM area two PM tables will be provided. This area should have a central floor drain so that it can be fully washed down.

The PM room should have as much natural light as possible. Adjacent to the PM room there should be a small dirty linen space and instrument washer. A viewing area should overlook the PM tables and cut up bench and have a fully sealed glass screen with small pass through hatch. The viewing area to be fully DDA compliant. A staff support area should include office space, staff room and change facilities.

5 Non Clinical Support Services

5.1 Central Staff Zone

The Central Staff Zone in the acute facility will be a key area for staff to rest, dine, change and meet within the new healthcare facilities programme. The concept will include; dining area, changing areas, rest areas and on-call rooms. Accessed from the public entrance via vertical adjacencies, the central staff zone will have a welcoming feel embedded into the interior design and furnishings, in the style of a business class lounge. Dining may be supported by a healthcare facility run concession style catering service in the same style as the main public catering area. It is intended that certain areas of the lounge will support informal working and meetings. There will be a cluster of interview rooms and seminar rooms nearby for meetings and discussions away from clinical departments.

A separate quiet room is provided incorporating recliner chairs for staff rest or relaxation. The room maybe used by staff having a short break or who have finished a shift, but are due to return to work in a matter of hours.

Changing facilities are located in the zone for male and female staff. These will be supported by WC's (including accessible facilities) and showers.

Where uniform is required to be worn, all staff will change on site at the start and end of their shift. Walking out of healthcare facility grounds in uniform is to be discouraged and the decision is driven by control of infection.

A supply of disposable scrubs will be provided within departments for staff whose uniforms become heavily soiled. These will be available to enable the staff member to change locally and then progress to the central change area to shower if required.

The design intent is to deliver the rest and dining areas for staff in one area, with the changing area centrally located.

5.2 Stores & Supplies

The new healthcare facility programme will apply a lean supplies system utilising “just in time” replenishment of consumables, durables, and general supplies within embedded and localised mobile storage areas.

The aim of this approach is to use appropriate, skilled staff to manage the stores and supplies process, leaving nursing staff free to focus on care services. Stores, catering and FM flows will be segregated from the patient and visitor flows. This approach will be embedded through intelligent design approaches.

In developing both the clinical requirements brief and the schedule of accommodation, the strategy has assumed a ‘top up’ system with good management and associated storage. Bulk storage will not be provided at a local level and all such support will come from either an off-site central storage facility or a managed service contract. Both would support a just in time strategic approach to stock whether equipment, consumable or sterile supplies. Good and resilient service access routes for supplies are required.

Incoming stores will be delivered to a dedicated goods in/out receiving area within each facility where they will be distributed to the appropriate department within the healthcare facility via a discrete FM supplies route.

Most stores will be distributed on a topping-up basis; and stores will require ‘picking trolleys’ and topping up trolleys to be available. Porters or Supply team will need to monitor and control stockholding levels in all departments, but as confidence in the topping-up system increases, so stock levels can reduce.

72 hours of consumables stock will be held at ward level within the sterile consumables satellite store where this will be managed by an automated supply chain system. Replenishment will be managed by the supply team directly from the receiving store under either a managed service contract or similar arrangement.

The stores need robust security, pest control and fire alarm systems, and arrangements for out of hours access.

5.3 Central Sterile Stores Department

All surgical instrument sterilisation will take place at the central sterile stores facility at Five Oaks.

The theatre sterile instrument boxes and single wrapped surgical instruments sets will be taken via the clean FM supplies route to the theatre where all surgical procedure sets will be held in the sterile instrument store using a closed carts system. These carts will contain the appropriate predetermined sets for the days planned procedures and will be held in the sterile instrument store until they are needed within the preparation rooms in the theatre suites. Further emergency procedure trays and single wrapped instruments will also be held in the sterile instrument store. It will need to be of a size that sets are separated from supplementary instruments and sets are not stacked.

Both the sterile store and sterile instrument store would require access from both the clean supplies route and from within the theatre suite, to reduce the ingress of stores and people within the theatre environment.

All instrument, sterile consumables and equipment stores will be a controlled environment (temperature, humidity and light levels (no direct sun))

After each operation the used instrument sets will be taken to the connected theatre dirty utility. It is here the instrument tray will be sorted to remove any disposable items and placed in a clinical waste bin. The dirty tray will then be appropriately treated (which will include the use of a water spray) and placed in sealed caskets in a dirty returns cart. The full dirty returns cart will be taken to the dirty hold room for eventual return to the CSSD central collection point via the dirty FM route, for reprocessing. Generally, this will take place when the surgical list is completed, but this may also occur during or prior to the end of a surgical list. It is required that goods flows are kept as separate as possible from patient flows, by use of a service corridor and dedicated vertical routes.

5.4 Equipment

Within the acute facility, a small storage provision will be provided on a departmental basis for the local shared storage of equipment. These areas shall provide secure storage with appropriate facilities for the charging of electrical equipment.

In addition, the operational assumption is that the acute healthcare facility will include the provision of an equipment library for the storage of patient related items not in constant use. This would be serviced by Electro-Bio Medical Engineering (EBME) and would include cleaning and disinfection of such items of equipment.

The acute healthcare facility will include a workshop for the disinfection and repair of smaller medical equipment and the commissioning of new assets. The facility will require medical gases, compressed air and distilled water.

Secure storage facilities shall be provided for holding equipment such as mobile imaging equipment and wheelchairs in close proximity to the clinical areas they serve. The radiology strategy assumes that ultrasound and mobile x-ray units will be securely stored at the central ward core and within local equipment stores where required. The parking of equipment and trolleys within circulation areas and spaces is considered wholly inappropriate.

Hydrogen Peroxide Vapour (HPV) decontamination equipment will be utilised for room and equipment decontamination. This equipment and a decontamination cabin, will be located within the support services area (equipment library / bed decontamination).

5.5 Linen & Laundry

Linen and Laundry washing services will continue to be provided off-site. Within the acute healthcare facility the collation and distribution will be managed from the Laundry store and Linen exchange areas.

Linen will be segregated into used, soiled and infected linen categories at the point of use and appropriately bagged prior to transfer to the linen exchange area via Dirty FM routes. After external processing, all clean items are returned to the healthcare facility laundry store where they will then be decanted to the point of use via the clean FM routes.

The outline strategy is that the acute healthcare facility will use an RFID system that automatically tracks and manages laundry activity for linen. The RFID technology will read RFID tags attached to linen, allowing it to be automatically identified, counted and tracked. The system also facilitates sorting and validates pick-ups and deliveries at receiving locations.

Scrubs and uniforms will be included within the acute healthcare facility laundry system through the use of scrub dispensing units in all staff changing areas.

5.6 Kitchens & Dining

The majority of the food service will be cooked off-site. However onsite catering will be provided to the café, dining and staff areas restaurant areas within each facility. The off-site supply will provide daily provisions to wards, beverage points and staff rest areas. This detailed strategy will be developed by a specialist catering consultant, but it is expected that menu choices will be automated via the patient entertainment system and/or internal ICT networks. A meal production area will be provided within the catering area, where specific patient meals are organised and distributed to the correct ward / patient area.

The catering service for the private inpatient environment will be via an on-site fresh-cook “chef-on-demand” service giving patients a wide range of menu choice of a daily, freshly cooked food service at set meal times.

A concession style café / coffee shop will be provided in the public dining area in the main entrance of most facilities. Where possible, this area will provide a 24-hour service through a limited fresh cook service. Food service will be distributed to each required location plus provide pre-prepared supplies to the café, staff beverage area and meeting rooms when required.

A central washing up service will be provided, however, each ward pantry and all beverage points will retain a small quantity of cutlery, glassware & china for local use and wash-up.

A detailed catering strategy will be developed.

5.7 Portering Services

The new healthcare facility programme will be supported by a multi-skilled portering service. This will be controlled from a “Front of House” hub which includes a dispatch point and a wheelchair store. It is anticipated that, in the future, portering services for the operating theatres will be provided by HCA’s.

Porters will play a central role in the use of electronic stock replenishment systems, delivery of supplies and returns via trolley based systems. As such they will need to be provided with access to computers or tablets to facilitate their role.

The portering service will adopt modern communications and location technology to assist in their rapid and efficient deployment.

5.8 Cleaning & Housekeeping

The quality of both patient and staff experience, and the control of infection is largely determined by the quality of cleaning services provided.

Cleaners Rooms will be provided to meet the needs of each service and rigorous training and supervision arrangements will be implemented. Some cleaning (concourses and public areas) may take place at night by Night Cleaning Teams. However, it will be necessary to ensure equipment does not disturb patient rest and sleep.

The Housekeeping Department will issue cleaning materials and protective clothing as required from a central storage area to local departmental cleaner’s rooms as needed across all new health facilities. Detergent unit dosing systems will be provided within each cleaner’s cupboard. The cleaning regime will utilise microfibre cleaning utensils, cloths and mop heads. All microfibre items will be decontaminated, cleaned and reissued from the central domestic services / housekeeping area. Floor cleaning machines which require repair, will be transferred to the FM workshop for their immediate repair.

5.9 Waste

Waste segregation at all departments and levels is a key requirement for the acute healthcare facility. Hazardous, healthcare risk waste, special healthcare risk waste, non-risk waste recyclable and miscellaneous waste storage, collection and transfer arrangements must not be evident in public areas.

The design will demonstrate the separation of departmental storage / integration of collection systems into the mechanical handling facilities and use central collections where practical.

The design should consider that waste management is a critical issue for a health facility. Waste is closely linked to the risk of infection, and personal injury to waste management operatives and other staff and therefore the design will ensure, where practical, that these risks are minimised.

Waste disposal hold areas shall not be visible to visitors, patients or staff from normally accessible areas. Refuse collection facilities shall be located such that they do not cause nuisance and offence to staff, visitors, patients and adjacent properties. The external sharps bin compound will need to be monitored by CCTV linked to switchboard and security.

Waste collection and transfer routes in the building shall be discreet, or separate from those routes used by the public and visitors.

Recycling will be promoted at department, ward and whole healthcare facility level.

An external bin compound with waste segregation will be required at the site.

6 Schedule of Accommodation (SOA)

The Schedule of accommodation provides departmental summaries which have been produced at a room by room level to underpin the functional brief. The schedules provide a net area for each room and gross area for each department. The overall communication, interdepartmental circulation and engineering allowances (horizontal and vertical circulation, principle services and satellite plant rooms etc.) are shown at the bottom. The SOA is provided in a separate version controlled spreadsheet.