DELIVERING NEW
HEALTH FACILITIES

Overarching Functional Requirements Brief

Version 2.0

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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 Jersey's 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 study was the creation 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).

Using ten key clinical pathways, which have the highest demand in Jersey, a framework has been created which has tested the anticipated model of care and the NHF programme to further confirm the right services will be delivered in the right location.

The Framework incorporates the following principles:

- It is needs-based, delivering timely patient-focused interventions.
- Patient contact points are in the most appropriate and least cost setting. This can be provided at home, in the community or in a health or social care facility through either direct contact or virtually providing advice, consultations, monitoring and interventions. The Tiered Complexity definitions are provided in Table 3 below.
- Bottom-up resource model is used to reflect actual resource needed to deliver cost effective care. This includes incorporation of patient numbers, conversion rates, standards and performance indicators at each stage of the pathway provided activity-based capacity, resource, location and cost models to assess affordability, sustainability, and support delivery planning.

The Framework therefore provides a tool to confidently design services and facilities that are affordable, sustainable and meet service standards.

1.1 Demand and Capacity

Demand and capacity analysis undertaken by PwC in 2020 provided two scenarios; 1, the required amount of accommodation (Beds, operating theatres etc.) required in 2036 if the JCM was fully adopted, and 2, the same requirement if the JCM was not fully adopted.

Following a sensitivity analysis workshop with executives and clinical leadership from HCS, the capacity modelling used for the new healthcare facilities programme is derived from the 2036 scenario where the JCM is not fully adopted. This modelling scenario, moderated by the HCS leadership, has informed the development of this functional brief for the new healthcare facilities.

When considering the potential phasing of the development control plan, the capacity requirements have been reviewed to align to the date when the first buildings are programmed to open (2028). This ensures the programme will provide the right capacity at the right time, with a strategy of continued phases over time which will grow with the capacity needed up to 2036. Primarily this relates to the bed capacity, creating a scenario where the acute hospital can expand its bed base at the appropriate time and taking into consideration revised and updated capacity modelling and the benefits of any medical and technology advancement or changes to the care system in Jersey.

1.2 Clinical Service Split

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 develop and further refine the content during engagement with clinical and non-clinical teams between in 2023. It is anticipated the output of the clinical consultation is in line with individual service transformation plans, but at this point in the programme, this has not been scrutinised. Utilising the model of care and pathway analysis described above we have sought to ensure the right clinical services can be provided in the right location, providing the best service for islanders.

The objective of the clinical service split is to integrate the area (space) and staff requirements needed to support an ‘episode of care’. The planning of optimal healthcare facilities is based on the notion of ‘walls around appropriate activities and technology’. Therefore, the new healthcare facilities programme will be developed with the primary objective of supporting exemplary delivery of those activities using technology to our advantage. In order for a design to be developed, clinical service operational models must first be reviewed by the designers and developed to identify how the hospital intends to deliver the activities it will undertake.

Working closely with all the acute care clinical management teams, a high-level review has been undertaken of the current acute clinical models, potential improvements, opportunities and limitations of the Island context. Work and engagement previously undertaken for the “Our Hospital” project has not gone to waste, it has been re-checked and incorporated into this brief. The review of the operational model and potential for refinement has been considered in the context of state-of-the-art, healthcare models from around the world, but moderated to suite an island community. The influence of an integrated care approach, including other clinical services not included in the Our Hospital project, such as therapies, physiotherapy, hydrotherapy, dementia care, rehabilitation beds and step-down care, differentiates the new healthcare facilities programme from the previous Hospital Project.

This brief provides a high-level statement for the overarching principles of the New Hospital Facilities and should be read in conjunction with the functional briefs for the individual sites which provide an outline of the accommodation required and the way in which that accommodation will be arranged.

2 Anticipated flows & required adjacencies

2.1 Facility Relationships

The design objective for all sites is to integrate the area (space) and staff requirements needed to support an ‘episode of care’. This concept promotes efficient and effective flows by using multi-disciplinary clinical teams and diagnostic support to inform clinical decisions and patient streaming, reducing travel distances, aiding orientation, improving patient flow between service points and supporting the patient perception that they are in a ‘seamless campus of care’.

By physically separating care pathways in different buildings, such as the separation of inpatient care and outpatient care, or high acuity emergency care from minor injuries/urgent treatment, further aids patient flow and orientation and promotes privacy and dignity particularly in inpatient environments. These factors increase patient confidence and satisfaction, enhance clinical outcomes and create efficiencies of service delivery.

It also increases security and the control of infection, since it helps to:

- Support patients in a single area (rather than moving around the facility)
- Separates ambulant day patients from inpatients, reducing importation of infection
- Identify where patients are in their ‘care pathway’
- Control where people go
- Identify when members of the public are in areas they should not access.

The development of the required clinical and non-clinical model and key departmental relationships, and required clinical adjacencies, are illustrated in the individual site briefs.

2.2 Access

Each site will require different access arrangements, however this section sets out the overarching access and circulation principles for all sites. It includes vehicular access and circulation,servicing and public transport access, together with the entrances, communication and public spaces.

2.2.1 Access to each healthcare site and circulation

Internal site circulation routes shall be established to link external access points, car parks, the public entrances, ambulance arrivals point and facilities management service areas, supported by a clear and simple signage system. These need to be considered in the overall master planning for each site as well as traffic flow solutions, and the impact of the new developments being completed in phases.

The internal network must satisfy the requirements of the following:

- General vehicular traffic (staff, visitors and patients)
- Pedestrians and cycle routes
- Public transport and taxis
- Blue light access
- Service and delivery vehicles
- Emergency service vehicles, such as police and fire
- Major incident response

In terms of access and circulation arrangements, the design should consider:

- Design and capacity assessment of access points onto the public highway
- Design of the proposed site access security arrangements
- Plan of the proposed internal circulation roads, including details of the restrictions between theblue light ambulance routes, visitor and staff parking areas and delivery service vehicle routes
- Details of design features to achieve a five miles per hour speed limit within the healthcare facility site
- Design of fire vehicles’ access routes to building perimeters

2.2.2 Servicing and deliveries

A service and delivery strategy for the three sites will need to be developed in detail with the HCS team,who, it should be assumed for now, will be directly operating the full range of soft and hard facilities management services. The design will demonstrate service and FM routes through each facility both internally and externally.

The design will establish and develop a central location for the receipt, distribution and collection of all goods, whatever the source or destination. This facility must allow separation of ‘clean’ and ‘dirty’, as well as separate waste compound and exit.

The design concept is a requirement for (as far as is possible) clear separation of FM traffic/flows and patient visitor flows in order to meet control of infection and environmental health standards. Dedicated FM lifts for vertical movement of goods and waste are required. This will require secure access at all times.

2.3 Public Spaces

2.3.1 Concourse and waiting areas

The public entrance in each facility will provide the main public access and egress point. The entrances need to provide an environment, which makes clear its function and supports the specialities it serves with its own identity.

It is important that the entrance must be functionally suitable for purpose, makes a strong statement and provides an excellent first impression to visitors. It must be spacious, welcoming and calming in a humanscale, for those who are anxious and distressed. Wayfinding must be clear, concise and allow people to quickly identify where they should go.

The entrance, concourse and waiting area will be a key focal point for patient, visitor and family entry to each healthcare facility and will set the initial impression of the organisation, which is a vital aspect of the facility design. Considerations include:

- Art work – art work located within the front entrance should enhance the overall environment providing a positive impression of the building and organisation. It should be contextual, provide distraction to anxious patients and visitors, and be cognisant of the needs of certain groups, suchas those with dementia. A detailed Art Strategy needs to be developed
- Way-finding – this area acts as the hub for the wayfinding throughout the building and elements including flooring, pictures/paintings, signage or digital systems (IT) will be integrated into the area.The principles for wayfinding will be simple, clean and involve a multi-faceted approach utilising colour and texture. A digital strategy, utilising mobile phones, apps and other digital platforms, will support wayfinding, appointment management, patient record integration and security.

- Accessibility – the entrance, concourse and waiting areas should provide for easy access to the rest of the building for any patients, staff or visitors with disability
- The control of temperature – The control of temperature throughout the seasons should provide apleasant environment and a draught lobby should aid this whilst not precluding accessibility or presenting a bottleneck.
- Waiting lounge/dining – will be themed in the manner and function of an airport lounge, with a combination of rest/dining areas which will be supported by a coffee bar with a bespoke food service and potentially themed beverage retailers
- The philosophy of the space is one that supports the patient and visitor flows into the building, but also provides a place for patients, staff and visitors to relax, socialise, wait and dine in comfortable and welcoming surroundings. There should be separate flows for public and staff, with the spacedesigned to facilitate a user experience of a break from the clinical environment.
- The concourse and waiting areas will intuitively lead patients and visitors to an enquiry point. Thesewill be designed to both act as a focal point and maintain both privacy and dignity, particularly whenpeople are expected to divulge personal or sensitive information. The facilities shall have a full range of counter heights, together with facilities to cater for people with auditory and visual impairment. Induction loops shall be provided in all receptions in addition to main control points. The optimisation of electronic and digital concepts to support patient, visitor and staff orientation and wayfinding will be developed as part of the way-finding and digital strategy.
- Appropriate waiting areas are provided along with toilet facilities. Infant feeding and changing rooms are provided for parents to discreetly nourish and nurse their babies. The area is provided with prayer rooms and support spaces
- Access to the main lifts and staircases will be easily identified and intuitively located from any partof the concourse and main waiting areas. The use of colour, signage and/graphics in the interior design should assist and be sympathetic of public wayfinding
- As the public entrance will also facilitate the main access route for staff to the central staff change, a staff route must be planned in and be easily accessible with minimal impact on the patient and visitor pathway

2.3.2 Internal Communications

All the accommodation will be linked via an internal facility network allowing for the uninterrupted movement of patients, visitors and staff between departments. The horizontal and vertical circulation routes should not form part of any departmental circulation. The design should consider the capacity of both horizontal and vertical communication routes and the influence they will have on the clinical adjacencies.

Patients are routinely transferred between clinical areas utilising a range of transport, including beds (withfull critical care accessories), trolleys and wheelchairs. The design must provide appropriate circulation routes and access routes to departments and individual rooms to maintain patient privacy and dignity at all times. Due consideration should be given to the separation of service support/FM traffic from the clinical and public flows. Multiple lifts will be required of sufficient dimensions to accommodate bed transportation.

Where doors within circulation routes are solely fire doors, then these doors shall incorporate automatic closure facilities. Where doors are required to define departments and deter inappropriate access these shall normally be in the closed position with facilities for their safe operation in allowing both patient and goods traffic.

3 Design and Operational Principles

The following section provides an overview to the draft principles of design, which the design team can use to guide the design development.

3.1 Planning Principles

3.1.1 Standardisation

The New Healthcare Facilities Programme will include a level of standardisation of rooms of comparable functionality and equipment (including safety, maintenance and training) irrespective of the proposed location. These repeatable (or 'generic') requirements are outlined later in this document, but it is expected that these generic spaces which in the main have already been developed for the previous Our Hospital Project, willbe enhanced to demonstrate wide flexibility in primary and future use.

3.1.2 Expansion, Adaptability and Flexibility

The ability to support future changes in the clinical models of care and quantum of activity is important. There is a requirement to be able to flex the capacity in the future by up to 15%. This expansion capabilitywill need to be considered in all departments over a 60-year lifecycle within the design solution. Therefore,the final design of each facility should enable a level of flexibility in terms of expansion and alternative functionality of different departments. This may be enabled through the inclusion of:

- 'Soft space' through the strategic design of ancillary and support spaces
- Identified external expansion zones,
- The consideration of a standardised space planning/ structural grid
- Maximised floor to floor height and oversized service void dimensions to enable future expansion
- Corridor ceiling void MEP routes and 25% additional MEP routing capacity
- Standardised space allowances across clinical and non-clinical spaces / rooms
- Designed in capacity for bedhead services and engineering to be added within non-clinical spacessuch as offices, for future conversion to clinical space
- Structural engineering specification to enable vertical expansion
- Commonality of ward/clinical accommodation layouts to assist with future adaptation
- Flexible/ adaptable FM methodologies for delivery, distribution and storage

- Each ward/clinical area requires isolation rooms which will also be ligature proof to allow flexible use for patients exhibiting risk of self-harm, those with physical conditions and requiring additionalsupport or secure care
- Escalation plans will include repurposing of the Private Patient facility for public patients as well as flexible utilisation of other clinical and non-clinical spaces to create clinical space.

3.1.3 Site context and character

The design will be based on a robust appraisal of each site context, character and local distinctiveness. The design statement will set out how the design responds to the specifics of the site. Prime concerns will include:

- The protection or enhancement of elements contributing to character and distinctiveness
- A response to landscape character and views to and from the site
- Use of topographical features to maximise building efficiency, as well as key features such as wind protection and solar access
- A response to settlement patterns and topography
- Massing and siting patterns in the area
- A response to architectural context, materiality and scale

3.1.4 Legibility

The planning and layout of each facility within the New Healthcare Facilities Programme will be easy to understand, enabling visitors, staff and patients to find their way around with ease. Such an approach will instil a sense of ‘place’ and calm, helping people feel more comfortable and safe, thereby creating a positive image of healthcare in Jersey. The layout of each facility will include:

- A clear hierarchy of pedestrian and vehicle movement, both externally and internally
- Building location, scale, form and cross section which supports the hierarchy
- Clearly identifiable access points into the building
- Relationships to existing views and landmarks for orientation
- Distinct character areas with their own local identity
- A response to existing patterns of townscape and landscape
- New landmarks
- The use of locally distinctive materials and planting.
- Maximise the use of digital technologies, including mobile phones and apps.

3.1.5 Use of Light

The effective use of light will be an essential component of the healthcare facility design. Light shall be used both creatively within the building and externally to light the building, creating a sense of place or presence. The use of both natural daylight and artificial light shall contribute towards a high-quality environment, whilst also being efficient, thereby supporting the protection of the environment. Physiologically and psychologically it is important to admit daylight into buildings; this is particularly important within healthcare settings. It is also well known that natural light is a far more efficient (though non-uniform) source of illumination than artificial lighting, with recorded evidence-based benefits for the wellbeing of both patients and staff.

Staff shall be able to adjust lighting both for clinical work and to suit the patient's condition. The introduction of natural light into 'high-tech' areas, such as theatres, will be promoted.

Natural light shall be provided in public spaces and in occupied private and staff spaces within each building, as far as is practical. Natural and artificial light sources shall be designed to avoid glare and thermal gain. Changes in floor level will be avoided. Stairs will be well lit and abrupt changes in illumination shall be avoided, unless specified as a clinical requirement.

'Deep plan' spaces may prove necessary in certain circumstances. In such cases, the internal appearance shall be ‘relieved’ by the penetration of daylight and sunlight, from adjacent courtyards, or through roof lights and light shafts. The design will achieve high levels of natural lighting in the primary horizontal and vertical circulation routes.

3.2 Diversity, Equality and Disability

The design team will consider the diversity of the local population, which is reflected in the needs of patients, carers, staff and the public as they access services. A process of equality assessment will be applied to the design to ensure an inclusive environment that is culturally sensitive and accessible to all.

The needs of disabled people (both temporary and long-term) must be taken fully into account, including wheelchair users, frail people, those with poor mobility, those who are hearing or sight impaired, those with mental illness and the needs of children and adolescents. Requirements will be built into the design at the outset. All doors and lifts are required to be of a width and length to allow for non-standard wheelchairs and bariatric access, to improve access for those who are wheelchair users, have reduced mobility, impaired vision, etc.

It is equally important to recognise and support individuals with neurodivergent traits and those with learning difficulties, who may experience challenges related to their differences, such as difficulty with communication, social interaction, stimulation, or executive functioning. and who may benefit from spaces that enable them to be supported in their own unique way.

Provision shall enable people with disabilities full access throughout the building once they have entered through an entrance, and includes staff, as well as patient areas. Secure parking for disability vehicles shall be accounted for in the design of the facilities and provision should be made for power or battery recharge.

Wayfinding shall be accessible to all people including visually and audibly impaired patients and visitors. There shall be appropriate technologies, such as induction loops or other appropriate systems in entrance and all reception areas. Colour schemes should be thoughtfully developed (with cognisance of patients with different disabilities) so that they aid access around the healthcare facility.

3.3 Security and Safety

Security involves the protection of all assets, not only physical assets. This is achieved through a processof deterrence, prevention and detection. Security therefore includes protection for staff, patients and visitors, equipment, premises, communications and information.

The new healthcare facilities will consider and include the appropriate security measures embedded throughout the designof the Healthcare facility, maximising the benefits of technological solutions including RFID for asset tagging, patienttagging, access control and staff security cards. Security design will reflect the requirements of local guidance.

It is intended that the security service and personnel within each facility will be primarily managed throughexisting workforce and porters. A detailed policy will be developed in order to clearly outline the intended security strategy. However, the following functions will need to be accommodated and be fully autonomousin the event of a “lock down”:

- Operational control of the security function
- Responding to planned, routine and emergency call outs
- Local monitoring of buildings via CCTV/alarm functions
- Management of deployed security personnel
- Key management.

3.3.1 CCTV

A CCTV system will be operable 24/7. Full design requirements will be identified in the security strategy,although it will require and/or provide the following:

- A server in a dedicated location
- A web-based interface
- HD capacity
- Full CCTV Camera coverage of all internal and external public areas.

3.3.2 Lighting

Lighting should be provided to all entrances, recesses, movement routes and car parks. Light fittingsshould be vandal resistant and easily maintained. Lighting should be mounted at a height that allows best spread of light, without shadows and reduces vulnerability to vandalism while being compatible with landscaping where appropriate. Light pollution levels will need to be carefully considered, particularly in relation to neighbouring buildings.

3.3.3 Entrance Doors

A vital ingredient of the overall resilience of the premises is the ability to invoke an emergency "Lock Down" to deny access to persons from outside the building. The access system will also need to be harmonised with the requirements of fire regulations.

Fire doors should be provided without external door furniture. Each fire exit must be protected by an intruder alarm, monitored by the security system.

3.3.4 Windows

Locking devices and opening restrictors shall be fitted to all ground floor and other vulnerable windows. Opening restrictors (with override capability) shall be fitted to all windows above the ground floor, in compliance with local guidelines. Ligature reduction requirements must be considered where clinically appropriate within specific elements of the New Healthcare Facilities.

3.3.5 Intruder Alarms

As a minimum, the building(s) intruder alarm(s) should be integrated with the Building Management System (BMS) and other ICT/security systems to be determined through a detailed security strategy, which needs to be developed.

3.4 Fire Precautions

A detailed Fire Strategy needs to be developed. Any departure from the aforementioned Fire Strategy must be supported by a full engineering appraisal and should not impose any operational restrictions or revenue costs upon each facility. The design solution should address the conflicting need for unimpededegress and the prevention of un-authorised access of doors, the sole purpose of which is escape in the event of fire.

A clear and compliant fire planning strategy, in synergy with the security strategy, shall be incorporated into the design which may include the following:

- Fire alarm and detection system
- Interface and isolation of plant systems
- Water supplies for the fire brigade use
- Firefighting equipment including wet and dry risers
- Firefighting stairs and lifts
- Emergency lighting
- Arson prevention
- Access for fire appliances
- Safe storage of flammable substances

3.5 Wayfinding

The design must incorporate a way-finding strategy with innovative solutions to promote efficient and appropriate wayfinding for patients and visitors. Clear signage is required throughout each site, with accountbeing taken for people who have either a physical, visual and/or hearing impairment and those with neurodivergent traits and those with a learning disability. A digital strategy utilising mobile phones, apps and other digital platforms will support wayfinding, appointment management, patient record integration and security.

3.6 Infection control

The control of infection is important in both clinical and non-clinical areas. The following aspects are described to complement existing hospital policies on infection control and where any conflict in approaches are identified then the HCS policy will take precedence:

- All areas in which clinical activity is undertaken require the provision of clinical wash hand basins (WHB), positioned at the point of care and within all utility rooms. Additional facilities are required within all patient bedrooms
- Glove and apron and alcohol gel solutions dispensers are required to be accessible within (or immediately outside) any room within the acute, rehab or ambulatory facilities, which accommodates any patient bed, trolley or reclining chair
- Alcohol gel solution dispensers are required at both entry and exit points to clinical areas i.e.: inpatients wards, outpatient clinics, but must not be included within the mental health facility.
- The new healthcare facilities will not provide either staff or patients with tablet soap (other than in an emergency), but provision must be made for it to be safely “stored” in bathrooms and shower areas to prevent accidents
- The use of hot air hand dryers will be excluded in areas other than toilets off the main public concourse
- All required consumables utilised for washing, soap, scrub, alcohol gel, drying and protective clothing will be supplied to point of use by the healthcare facility supplies team
- Floor-based facilities to be minimised in sanitary areas, to aid cleaning of floors. For example, toilets and wash hand basins mounted back to the wall
- A separate WHB is required in all areas where beverages or food are prepared, other than areas designated for “self-help” where liquid soap and paper towels can be utilised at the sink
- All catering facilities must comply with local food safety legislation and industry standards

- Combined bucket sink and hand-rinse basin assemblies (Janitorial Units) are considered appropriate in Domestic Services/Cleaner rooms with a detergent unit dosing dispenser

The use of design to assist the effective control of infection is essential. The following key points need to be considered:

- Finishes shall be of a standard that does not allow microorganisms to harbour and should allow for ease of cleaning and special considerations will be given to active surfaces and preventative design measures as part of the design process. Non-pick sealants should be used.
- Lighting shall be designed so that there are no ledges or ridges where dust can build up and then be dispersed
- Electric socket outlets shall be designed to be flush mounted or in trunking systems to prevent the build-up of dust
- Particular attention is required to the interface between adjoining finishes, for example wall and floor junctions, windowsill, wall junctions and bump protection on walls.

3.7 Information Management and Technology (IM&T)

The IM&T design will be developed by the IM&T consultants and will align to the NHF Digital Strategy. It will be required to interface with the existing hospital systems, telehealth, telemedicine and remote telemetry, and international eHealth community developments.

The data network should be resilient by design and incorporate a medical grade Wi-Fi 6+ wireless LAN throughout the building allowing for a separate wireless channel for patient access and hospital management. Full integration with a hospital-wide RFID system will be required to support real-time location tracking of assets, patient and equipment. There will be a need to ensure appropriate integration and compatibility of systems used at the Hospital.

Audio-visual links between clinical teams in each facility and across facilities will be required. Such links will be widespread throughout the new healthcare facilities and will include the operating theatres and clinical procedure rooms, as well as the inpatient and outpatient environments.

3.7.1 Telecom & Data Points & Call systems

The standard requirements for people (staff, patients and visitors) to access the IM&T facilities, both telecom and data, will be developed by the IM&T consultants.

However, the design team must consider the integration of a free-to-view patient entertainment system with a common infrastructure working in tandem with bring your own (BYO). Such devices will be multi- platform, providing inputs for connecting other devices or charging devices as well as having a platform to enable patients to make catering choices. It is anticipated that a policy of BYO device will be encouraged within the new healthcare facilities for entertainment, utilising a patient

Wi-Fi channel. Patients will be able to use their mobile phones in appropriate and permitted areas.

All healthcare services will pursue the HCS vision of a “paper light” policy, maximising the use of multi-platform access (such as electronic patient records, PACS images and logging FM faults or supplies requirements) will be managed through the clinical Wi-Fi network, utilising laptops or tablet devices.

VOIP systems linked to wireless handsets and integrated with the nurse call systems are required to support the operational nursing model. This will also allow patients to talk to staff and ward receptionists talking to nursing teams designated to an individual patient care and wider communication with other clinical and non-clinical staff allied to the patients’ care.

Wi-Fi channels for all separate clinical, maintenance, public, emergency uses are required, providing 100% coverage, internally and externally, within the new healthcare facilities campus.

3.7.2 IM&T Data Infrastructure

The project will incorporate two linked, but physically separate, main IM&T equipment rooms at each site to provide a resilient solution for the new healthcare facilities. Offsite data centres will be used for the majority of data storage and will be connected to each of the site’s main equipment rooms by fibre optic network cables. IM&T equipment rooms will be secure controlled environments and designed in line with the agreed IM&T strategy and appropriate standards. The area must have restricted access and suitable access control. There will be a requirement for fixed and wireless telecommunications service providers to provide services enabling wide area communications for access to the internet and enabling in-building cellular 4G and 5G network services. The location of the IM&T equipment rooms needs to be designed to accommodate standards compliant Structured Cabling System (SCS). The SCS will be designed to a maximum compliant distance (based on the cable type) from the terminating point within a cabinet to the terminating point at the device end. All IM&T main equipment rooms and Sub-equipment rooms (MERs, SERs) must have autonomous command and control in the event of a “lock down”. Direct internet and data links with appropriate firewalls are required. There will be a requirement for a high-performance Wi-Fi network to enable staff, patients and visitors to access IM&T services and the public internet. The IM&T data network will need to be designed to offer high performance and be resilient and secured from cyber threats. The IM&T network will be expected to enable digital workflows and smart building functionality.

3.7.3 Patient Entertainment

As described in 3.7.1 a free access patient entertainment system will be made available to each inpatient bedroom. The system will provide a range of TV and radio channels, as well as internet connections. Such a device will be multi-platform, providing inputs for connecting other devices or charging devices, as well as having a platform to enable patients to make catering choices. It is also anticipated that a policy of bring your own device, will be encouraged within the New Healthcare Facilities for entertainment, gaming and utilising the patient Wi-Fi channel. Patients will be able to use their mobile phones in appropriate and permitted areas.

3.7.4 Electronic Patient Records (EPR)

The new healthcare facilities will adopt a paper light approach to working, with electronic patient health records (EPR) being available at all clinical workstations as well as through the clinical Wi-Fi network utilising laptops or tablet devices. The system will be required to interface with the existing Hospital and clinical service systems, telehealth, telemedicine and remote telemetry links with hospital partners in the UK and any future digital programmes. All new facilities will have appropriate provision of a robust network capability with easy access to PCs within all clinic treatment, consulting rooms, wards, doctor and specialist's work areas and patient rooms.

3.7.5 Pneumatic Tube Stations

Pneumatic Tube Stations will be provided within the acute hospital facility only. These, will be contained within secure locations and required to link all departments, including the Essential Services Pathology (specimen reception) and Pharmacy (main dispensary area). Within the clinical areas, pneumatic tube stations will be located within a dedicated pneumatic tube bay to facilitate ease of use for pathology and pharmacy requirements. The Pneumatic Tube must have sufficient bore to allow medicines to be sent, and fully secured at ward end.

3.8 Manual Handling

Safe and efficient handling of patients and goods at all times will be ensured through the provision of appropriate aids, vehicles and space. Staff will receive full and appropriate training, in accordance with HCS manual handling polices.

3.8.1 Patient Handling – General

Each clinical service may be required to assist patients in moving or transferring, and the provision and the use of hoists, is an integral component of any clinical activity.

All areas for patient use should conform with the policy for patient handling. This will include adequate turning circles to accommodate wheelchairs and wheeled commodes. In all areas where there is a possibility to transfer a patient laterally from a stretcher, table or trolley, adequate space should be made available to facilitate such a transfer.

A proportion of inpatient bedrooms will be provided with full room coverage ceiling-mounted hoists. Where used, ceiling mounted hoists should be recessed/flush mountedwithin the ceiling grid and provide full room coverage. Handling of patients deemed to be bariatric will be in accordance with the hospital polices for patient handling.

3.8.2 Sanitary facilities

In addition to the facilities described within individual departments, public toilet provision is required within the entrances and all public support areas. The public toilet provision will include single sex areas utilising cubicles and includes disability facilities and baby feeding/changing facilities in strategic locations. In addition, toilet provision for independent disabled users must be readily available on each level. Provision for ‘changing places’ facilities will be included in the main entrance accommodation of each facility.

3.9 Patient discharge

Defined processes will support efficient and effective discharge of patients. The aim is to ensure that the clinical teams work in an integrated way to support a single instance of discharge. Key to this approach isthe presence of a Clinical Prescriber during the clinical discharge of a patient. The Clinical Prescriber will deliver their service from mobile dispensing trolleys, enabling the patient to receive their “to take out” (TTO)drugs at the same time as the clinical discharge.

3.10 Patient confidentiality

All staff have a duty of care to ensure patient confidentiality at all times. This includes the appropriate sharing of information with other staff and access to patients' clinical data (paper or computer based). The design will ensure facilities are designed to promote confidentially.

Account will be taken of:

- Acoustic room requirements in clinical and non-clinical areas. Where clinical areas include curtained cubicles, separate interview/counselling and consult/exam rooms will be available for confidential/sensitive conversations
- Window glazing on the ground floor, where patients are likely to be partially dressed during examination
- Discrete areas in reception/waiting space, where sensitive/personal information can be exchanged without being overheard.

3.11 Staff Welfare

3.11.1 Staff rest

HCS leadership will encourage staff to move away from their immediate work area whilst taking breaks and to make use of the central staff zones. The staff zone will be strategically located close to relevant clinical areas to maintain close adjacencies to reduce staff travel time. Most clinical areas, including wards, critical care and theatres will incorporate staff rooms. However, staff will be encouraged to consume meals within the central staff zones. Areas for quiet rest and work will be included in this area, along with a number of on-call rooms. The staff will have access to a kitchen and catered facility in each building.

3.11.2 Staff changing

All staff will change into/out of uniform on site in the dedicated area. Staff changing is to be provided as acentral area within each facility, adjacent to the main staff zone and readily accessible from the Public Entrance and all departments.

The number of lockers, within the central change, will require validation by the staffing and shift modelling.Small cube lockers will be available within all clinical areas for staff personal belongings, however changingin clinical areas will not be allowed (other than in an emergency). Departments where scrubs will be worn will have localised changing areas to support infection control requirements.

Staff shower areas will be integrated into the staff changing areas, which will be designated by gender, including gender neutral provision.

3.11.3 Staff toilets

Separate staff toilets are to be provided, both centrally and within departmental areas to serve an identifiedclinical and administrative section. Separate male and female assigned staff toilets must be provided.

3.11.4 Staff catering

The central staff zone within each facility will provide the healthcare staff with an area for staff to prepare their own meals. Smalldepartmental beverage points are provided within ward areas for ad-hoc beverages. It is envisaged that staff will have the use of a 24-hour access to hot food. This will form part of the catering strategy which needs to be developed.

3.12 Office accommodation

Management, administration and clinical staff will require accommodation to support efficient and effectivework practice. Within a central administration area, office accommodation will be provided in line with the Government of Jersey office strategy, providing administrative areas for consultants and hospital clinical leadership, supported by zoned facilities for medical secretarial staff. Certain departments, such as Endoscopy, Radiology and CCU, will incorporate office accommodation within the clinical department.

Seminar/meeting rooms will be centralised within the central administration area, the central staff zones, knowledge and research areas and within reach of certain clinical departments. All will be available for useby a departmental/central booking system. Certain designated seminar areas, outside of the knowledge and training area, will be equipped to provide low fidelity simulation for clinical training.

3.13 Public art

Each new health facility will incorporate the provision of pieces of art to create and promote a healing environment. The design solution should be culturally sensitive and make provision for appropriate lighting in all public areas and selected clinical areas. The use of themed wall murals is encouraged. Provision of art works should also be considered for areas of public access and areas of visual amenity.

3.14 Multi-faith facilities for reflection and prayer

Facilities will be provided for patients, visitors and staff to receive spiritual support whilst at each new health facility. Provision will be made for:

- Multi-faith space for reflection
- Washing prior to prayer
- Storage
- Multi-faith administrative space and counselling

3.15 Health retail and third-party retail

Where possible, an area near the main entrance of each facility will be provided for retail space. Certain spaces may be managed by the hospital or voluntary organisations. However, third-party providers may also be invited to take up part of the retail or coffee shop space.

4 Repeatable Rooms

The design will apply the adoption of a repeatable room methodology to enable people (patients, staff, andvisitors) to hold a familiarity of spaces wherever they are in the building and to capitalise on some measure of standardisation. This involves identifying repeatable room types, whose content and design occurs in multiple instances across the programme. These spaces have, in the main, already been designed and agreed with the clinical teams for the Our Hospital Project. The intention is to keep the valuable work undertaken with clinical teams and re-use this on a template basis, showing both primary function and that of potential future flexible use, with that template then being applied across the new healthcare facilities programme.

The ability to support future changes in the clinical models of care and quantum of activity is important, hence the building has been briefed to be capable of increasing or to flex capacity as well as to adjust clinical space in ways we do not yet know.