NHS England and NHS Improvement

Health Building Note 11-01: Facilities for primary and community care services

Consultation Draft

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Acknowledgements

The following individuals and organisations have contributed to the development, drafting and production of this guidance:

Names of people on the working group to be added alphabetically

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Preface

About Health Building Notes

Health Building Notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

For further information on HBNs and Health Technical Memoranda (HTMs), see 'Introduction to the technical guidance' – location and hyperlink to be added.

Note on language usage

In HTMs and HBNs, modal verbs such as "must", "should" and "may" are used to convey notions of obligation, recommendation or permission. The choice of descriptor will reflect the level of obligation needed to be compliant.

The following describes the implications and use of these modal verbs in HTMs/HBNs (readers should note that these meanings may differ from those of industry standards and legal documents):

- "Must" is used when indicating compliance with the law.
- "Should" is used to indicate a recommendation (not mandatory/obligatory), i.e. among several possibilities or methods, one is recommended as being particularly suitable – without excluding other possibilities or methods.
- "May" is used for permission, i.e. to indicate a course of action permissible within the limits of the HBN or HTM.

Typical usage examples

- "Design teams **must** have due regard to the protected characteristics as defined in the Equality Act 2010." [obligation]
- "The public zone **should** be located at the front of the building." [recommendation]
- "Where it is not necessary to access both sides of the couch, the single-sided room layout **may** be used." [permission].

Project derogations from the Technical Guidance

Healthcare facilities built for the NHS are expected to support the provision of high-quality healthcare and ensure the NHS Constitution right to a clean, safe and secure environment. It is therefore critical that they are designed and constructed to the highest and most appropriate technical standards and guidance. This applies when organisations, providers or commissioners invest in healthcare accommodation (irrespective of status, for example, integrated care system, PCN or CCG).

Statutory standards plus technical standards and guidance specific to NHS facilities:

- Health Building Notes
- Health Technical Memoranda

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- Complete list of NHS estates related guidance

The need to demonstrate a robust process for agreeing any derogation from Technical Guidance is a core component of the business case assurance process.

The starting point for all NHS healthcare projects at Project Initiation Document (PID) and/or Strategic Outline Case (SOC) stage is one of full compliance.

A schedule of derogations will be required for any project requiring external business case approval and may be requested for those that have gone through an internal approvals process.

While it is recognised that derogation is required in some cases, this should be risk assessed and documented in order that it may be considered within the appraisal and approval process.

Derogations should be properly authorised by the project's senior responsible owner and informed and supported by appropriate technical advice (irrespective of a project's internal or external approval processes).

This guidance is not mandatory unless specifically stated. However, any departures/derogations from this HBN – including the measures implemented – should provide a degree of safety that is not less than that obtained by compliance with this HBN

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Executive summary

This Health Building Note (HBN) provides best practice guidance on the planning and design of primary and community care facilities including integrated care centres, health centres and hubs. It describes:

- The range of services that may be delivered from primary and community care buildings and how they may be designed to promote and encourage integration of services.
- The process for planning and developing primary and community care facilities.
- The types of space needed to deliver these services (many of which are generic).
- The way to quantify these spaces for briefing purposes.
- The way spaces can be organised into zones to create efficient, flexible, user-friendly environments.
- The engineering requirements for these buildings.

The mix and range of services to be delivered from primary and community care buildings can change over time, particularly in response to the rapid development of digital technologies. It is therefore important for accommodation to be flexible and adaptable. This can be achieved by limiting the number of specialist spaces and delivering services from generic shared spaces wherever possible. Standardising room sizes and the position of built-in equipment will also support flexibility. These principles are central to the successful design and operation of primary and community care buildings.

Typically, a primary care centre will be approximately xxxm2 for a population of xxxx [DN: figures to be agreed]. This will depend on a number of variables including contacts per annum, opening hours, and average appointment length. A sizing guide has been developed to assist with these calculations (see Appendix 4). An exemplar schedule of accommodation is provided in Appendix 5.

Guidance on generic spaces is contained in the following publications, which should be read alongside this document:

HBN 00-02 – 'Sanitary spaces'

HBN 00-03 – 'Clinical and clinical support spaces'

HBN 00-04 – 'Circulation and communication spaces'

A number of templates and tools to assist in calculating savings, assessing room utilisation, and sizing and specifying primary care accommodation are provided in the appendices to this HBN.

A selection of case studies that provide best practice examples of the service delivery and design principles outlined in this document are contained in HBN 11-01: 'Facilities for primary and community care services, Supplement A: Case studies' (forthcoming).

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1 Introduction to Health Building Note 11-01

Strong and dynamic primary and community care services are central to plans for the future of the NHS. Changes detailed in the NHS Long-Term Plan[i] and other government legislation and guidance require greater integration of services, more use of digital technologies, and responsiveness to local health and social needs. These are described in chapter 2.

Scope

This Health Building Note (HBN) provides guidance on the planning and design of primary and community care facilities.

The principles described apply to the refurbishment and extension of existing buildings, as well as to new builds.

Typically, a primary care centre will be approximately xxxm2 for a population of xxxx [DN Figures to be agreed]. This will depend on a number of variables including contacts per annum, opening hours, and average appointment length. A sizing guide has been developed to assist with these calculations (see Appendix 4). An exemplar schedule of accommodation is provided in Appendix 5.

This guidance should be read alongside the following publications for generic rooms and spaces:

- Health Building Note 00-02: 'Sanitary spaces'[ii];
- Health Building Note 00-03: 'Clinical and clinical support spaces'[iii];
- Health Building Note 00-04: 'Circulation and communication spaces'[iv].

The need to refer to other Health Building Notes for guidance on specialist spaces will depend on the range of services to be delivered.

Note
This guidance should be navigated by using the hyper-linked hexagons which are found throughout the document. These direct users to other relevant parts of the HBN and external sources of additional information.

Exclusions

This document does not provide design guidance on general in-patient beds. This information is provided in HBN 04-01 – 'Adult in-patient facilities'[v]. Certain specialist services may also be delivered from stand-alone units in acute or community settings (for example, midwife-led birthing units, day surgery facilities). This document does not provide design guidance on such stand-alone units. A full list of guidance documents can be found on the GOV.UK website.

Guiding principles

The infrastructure implications of delivering 21st century primary and community care services can be significant. In order to provide facilities that promote coordinated and integrated services, the development of primary and community care buildings should be driven by strategic service plans and informed by wide consultation.

The principles underpinning this HBN are that primary and community care facilities should:

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- provide innovative spaces which are sensitive to local service needs as identified through development of a detailed service brief;
- be proportionate to the identified demand, referencing sizing guidance in chapter 4;
- provide flexibility and adaptability through standardisation of space where practical, as described in chapter 4;
- have careful consideration of zoning, separation, and organisation of space as detailed in chapter 6;
- offer equality of access and inclusive design which is welcoming to the community they serve;
- be simply laid out to aid patient/client journeys, minimise staff movements and allow for efficient maintenance, as detailed in chapter 7;
- be safe and secure for all users;
- be designed to deliver appropriate levels of emergency preparedness and resilience;
- support staff development and training;
- provide an attractive workplace to aid recruitment and retention;
- provide appropriate space, functionality and scope for increased digitisation and use of technology;
- embrace modern methods of construction (MMC) and innovative space solutions for example, soundproof booths or smaller rooms for on-line consultations;
- create efficient, sustainable, environmentally sympathetic spaces;
- be future proof, incorporating plans and adaptable services for future development and expansion;
- create flexibility of design for future pandemics for example, provision of additional entrances for flexibility to provide “hot zone” areas within buildings;
- offer value for money and affordable solutions as defined by the Treasury five case model.

The business case process

All schemes will need a business case to justify the need for NHS resources to be invested. The most up to date approvals process can be found on the NHS England and NHS Improvement (NHS E/I) website https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/.

Developing a business case is an iterative process. It should help all stakeholders to understand why a new or refurbished facility is required, and what health care needs of the community will be met and at what cost. It should also facilitate shared ownership for ensuring the successful delivery of a scheme, and help people feel engaged in the process of designing space in which treatment and care services will be delivered.

The precise requirements for the business case documentation will depend on NHS E/I and Primary Care Commissioning Organisations (PCCO) requirements which may vary from time to time, as well as the scale and complexity of a scheme. Appendix 1 sets out what level of information is required at each stage of the business case process and provides links to the relevant parts of this HBN.

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Emergency preparedness

The 2020 Covid-19 pandemic led to an acceleration of change in the way in which patient interactions are delivered, and lessons have been learnt about innovative primary and community healthcare systems, resilience planning, and – particularly - the use of digital technologies. In recent years there has been a blurring of the boundary between primary, community and third sector care services, and this guidance aims to facilitate this further by encouraging design which uses shared space for these services, ensures digital technologies can be fully exploited, and moves away from defining space for use only by a named user.

Because of these changes, digital pathways and telehealth rollout may result in a consolidation of the estate. However, it is not inevitable that future primary and social care buildings will reduce in size. Space requirements should be service driven. Space should be used dynamically, with different providers of care making use of space at different times of day, or space being re-designated for different services as care pathways change over time.

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2 Scope and organisation of services

This chapter sets out the national policy for primary care services, and the strategic considerations to help inform an estates strategy. It will be particularly useful for teams at the very start of a project, where service planning is key.

Primary and community care services

A wide range of services fall under the heading of primary and community care, including:

- General Medical Services (GMS);
- primary care walk-in services;
- community walk-in clinics for example, phlebotomy, Warfarin;
- minor surgery for example, cryotherapy, joint injections, electrocautery and curettage;
- sexual health and family planning;
- out of hours and 111 services;
- district nursing;
- health visiting;
- allied health services;
- third sector and voluntary organisation services;
- community mental health;
- drug and alcohol addiction services;
- community and GP pharmacy;
- community dental;
- community midwifery;
- children's services;
- social services;
- home care services;
- social prescribing;
- healthy living initiatives;
- citizens advice and debt counselling.

Some outpatient elements of traditional secondary care services can also be delivered in primary care settings. These include:

- diagnostics for example, x-ray, breast screening, MRI;
- day surgery procedures;
- audiology;
- cardiology;

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- chemotherapy;
- child development/assessment;
- Child and Adolescent Mental Health Services (CAMHS);
- diabetic care;
- asthma care;
- endoscopy;
- Ear, Nose & Throat (ENT);
- eye care;
- hypertension;
- rehabilitation and assessment services;
- renal dialysis;
- rheumatology;
- sexual and reproductive health.

Policy context

Each nation has published principles and values for their NHS services. In England this is The NHS Constitution. These principles outline NHS commitments to patients and staff, and the responsibilities that the public, patients, and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of these principles and values in their decisions and actions.

The NHS Long Term Plan[vi] set out a 10-year agenda for change across the NHS in England. It described how GP practices would be funded to work together in Primary Care Networks (PCNs), creating integrated teams alongside community health and social care staff. In addition, the NHS Long Term Plan set the expectation that digitally enabled primary and outpatient care would go mainstream across the NHS. Local NHS organisations would increasingly focus on population health and local partnerships with local authority-funded services, through new integrated care systems.

It is recognised that the infrastructure implications to deliver these changes can be significant. The document 'Primary Care Networks: Critical thinking in developing an estate strategy'[vii] identifies PCN estate to be a catalyst for changing the way services are delivered, citing evidence that buildings have an impact on staff morale, retention and patient experience.

> *"Integrated primary care providers need modern, efficient buildings, equipped with the latest technologies, to enable their practices to develop and expand patient services. They also need buildings that are reliable and well maintained with the capacity to cope with future demands."*
>
> Primary care networks: critical thinking in developing an estate strategy, P.4

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How primary and community care services differ from acute clinical services

Acute hospitals deliver specialist healthcare services to a large population. For complex procedures, it is usually more cost-effective and safer to centralise specialist staff and equipment in acute settings, which most patients access less frequently. Less complex outpatient and follow-up appointments may be delivered from primary and community care estate if it can be shown to be cost effective.

Many primary and community services can be delivered from shared generic accommodation. Such shared use of space is central to the successful design and operation of primary and community care buildings.

The range of services delivered from primary and community care buildings is likely to change more frequently than those delivered from acute hospitals (to reflect prevailing needs, policy and technology). The buildings that house them should be flexible enough to accommodate these changes.

Non-NHS community, voluntary and commercial sector services

Non-NHS community, voluntary sector and commercial spaces may be located alongside primary and community care services if their addition accords with the philosophy of care and can improve affordability. Examples may include:

- library;
- adult education;
- children's centre;
- housing office;
- benefits advice office;
- Citizens Advice Bureau;
- training kitchen (teaching cooking skills and healthy eating);
- healthy living initiatives;
- computer training rooms/learning suites;
- gym;
- crèche;
- dance studio;
- retail pharmacy;
- café.

Co-locating services may provide many benefits, including:

- focal point for the community;
- promotion of healthy lifestyles as part of an integrated health and community care policy;
- increased footfall to the building and hence activity levels;
- creation of a critical mass of linked services;

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- increased convenience for users;
- improved funding;
- improved transport links;
- reinvigoration of deprived areas;
- job creation.

Any costs associated with co-locating services should be addressed at the first stage of the business case process as detailed in the Primary Care Approvals Process considered in Appendix 1.

Case study: Integration

CHP Jean Bishop Centre, Hull?

Will be written up at next stage of the development of this HBN Brief details here with hyperlink/reference to case study supplement

Strategic considerations

The NHS strives to continuously improve the quality of patient care and health outcomes, and to deliver well-co-ordinated and joined up primary and community care. Providers are required to proactively address the changing health and social needs of society as efficiently as possible.

Buildings need to support a service model that provides greater choice, better support, and more joined-up care in the optimal care setting. In primary care this means:

- providing every patient with the right to face-to-face consultations as well as digital;
- helping patients to avoid having to attend hospitals for outpatient appointments;
- facilitating PCNs to extend the range of convenient local services, creating genuinely integrated teams of GPs, community health, voluntary sector, and social care services.

Priorities of recent policy directives include:

- improving access;
- developing neighbourhood hubs to enable more healthcare services to be provided closer to home, rather than in acute hospitals;
- providing additional clinical space to deliver primary care services to reduce unplanned admissions to hospital, and to improve seven-day access;
- increasing the capacity for training of the workforce;
- improving premises to enable a wider workforce to be employed within primary care;
- developments that bring practices and services together into a single building;
- constantly improving the utilisation of all existing NHS tenanted buildings.

Primary Care Commissioning Organisations (PCCOs) and local authorities are required, when appropriate, to pool budgets and agree an integrated spending plan for some of their central government funding, which may include initiatives such as:

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- additional nurses in community settings to provide a coordination role for patients with long-term conditions;
- GPs providing more services in care and nursing home settings;
- providing mental health professionals in a community setting;
- hosting social workers in a community setting including GP surgeries;
- helping commissioners to support local systems to ensure safe and rapid discharge of patients, particularly in response to system pressures such as peaks in seasonal influenza, emergency planning and pandemics.

Though strategy is increasingly being agreed at integrated care system level, the approval of any primary care premises developments will continue to be considered and authorised by PCCOs. Business cases for primary care estate funding must adhere to the NHS (General Medical Services – Premises Costs) Directions 2013[viii] (or its successor publication) and the local premises strategy which should be set in the context of the integrated care system estates plan.

The Premises Costs Directions and other national policy guidance requires projects to:

- support the delivery of services a contractor has agreed to provide under its NHS contract;
- provide a safe and secure environment for the delivery of those services;
- ensure sustainability of services;
- support primary care to further develop and improve;
- safeguard recruitment and retention;
- create the platform for community-based health care;
- make the most of opportunities;
- develop generalist-led, patient-centred integrated services.

Since 2013 GP practices have been required to be registered with the Care Quality Commission (CQC)[ix]. Practice facilities are one of the key standards to which GPs must demonstrate compliance across areas such as security, infection control and fire safety. Targeted inspections are carried out annually to assess compliance with these “Essential Standards”.

Integrated care systems

To improve public health services and care for patients, and to place the NHS on a more sustainable footing, national guidance calls for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes.

Integrated care systems represent a shift in how health and care systems are organised. They depend on collaboration and a focus on places and local populations as the driving forces for improvement. The objective of these systems is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care.

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PCNs operate on a neighbourhood level and have been developed through the GP contract to cover populations of approximately 30 – 50,000 patients through multi-disciplinary teams. As a result, commissioning should focus on the planning and funding of new models of integrated care.

Improving access and advancing technology and digital services

National guidance places technology at the centre of several of its commitments.

A Reform report, 'A primary care estate fit for the future'[x] published in 2020, called for further investment and a new approach to funding digital initiatives in primary care and the Naylor Review[xi] recommends that any investment should ensure that future estate is flexible and able to adapt to the new opportunities that technology brings.

Most importantly, and particularly since the 2020 Covid-19 pandemic, electronic communications between clinicians and patients have become a key way of improving access.

The digital agenda is now fundamental to modern, efficient and responsive primary care. It enables information to flow between providers within, and beyond, organisational boundaries, and between care providers and patients. Paper light accreditations, the development of electronic patient records, and electronic prescribing have all changed workflows within general practice.

Technological advances mean there are now more innovative ways patients can access health services, and that travelling to appointments should become the exception, rather than the rule, where appropriate. There is a commitment from NHSE/I that primary care providers will continue to invest in telephone/digital triage, digital consultations, telehealth, and other specialist technological and digital solutions. 'Clicks and Mortar, Technology and NHS Estate'[xii] found that the success of technology to enhance the way NHS estate is used depends on several factors including:

- Having a vision: Organisations and local systems should be clear about the changes they want to see in health and care, and the role that technology and the estate can play.
- Having integrated, flexible plans: Technology and the estate should be planned in an integrated way, recognising the influence these areas have on one another. The speed with which technology develops can make long-term planning difficult, so building flexibility into the estate is critical.
- Being staff and patient friendly: Technology can support patients to access and navigate all parts of the system in different ways. It also has the potential to improve other aspects of the patient's experience such as freedom to monitor health from home and/or improved accessibility and equality of services. Technology can also enable an estate that is staff friendly, including supporting flexible working, as digital records will allow clinicians to access patient information from different locations. However, a redesigned estate needs to provide the right environment for staff, for example, ensuring that remote working does not lead to isolation. The best way of achieving this is to involve staff and patients in the design and planning processes.
- Being smarter: Making use of a wide range of data and intelligence to improve the way estate is managed and planned. For example, technology should be used to track staff and patients across multiple sites, supporting better allocation of resources. Another example is using real-time data to understand, for example, energy consumption, and using this to inform plans.
- Being integrated: Technology can support different services to work in a more integrated way, for example, through interoperable sharing of health records.

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- Being flexible: Some technological developments have the potential to reduce the NHS estate's footprint. For example, online consultations may reduce the need for space within healthcare buildings. Space 'freed up' by technology generates an opportunity for other services to co-locate. Changes in technology in the NHS should be driven by improvements in care and patients' experience or more effective use of the estate, rather than a desire to reduce the size of the estate.
- Introducing technology to support the estate, services and staff requires formal change management to ensure users benefit from the investment and use it to the best advantage.

Moving activity from secondary care

One-stop primary care centres, which bring together general and specialist primary care services in one location, are appropriate for addressing the accommodation needs of specialists and specialist GPs. In addition, one of the benefits of integrating primary and social care is that patients can access both in one visit and gaps in their care can be eliminated.

Primary care premises should facilitate the development of a range of services that could potentially be delivered more locally and cost effectively under the new, integrated models of care.

Significant savings for commissioners and improved access for patients can be achieved by repatriating care from secondary to primary facilities. It is accepted that a growing population of older people will keep hospitals busy with a more complex case mix. Thus, the point is not to simply "shift" care from one place to another, but to recognise a greater proportion of the rising demand can be more effectively and efficiently delivered in the community, and via technology. Further information on this and a simple template to calculate savings can be found at Appendix 2.

This shift will be supported by advancing medical technology and a wider range of staffing expertise in primary care including pharmacists, social prescribers and mental health workers. Basic diagnostics (point of care testing) and interventions are increasingly the norm in modern primary care premises. Equipment is becoming smaller and more automated, which should enable increased diagnostic activity and treatment in primary care.

Promoting self-care

When patients are diagnosed with a long-term condition, effective management is essential to avoid hospital admissions wherever possible. There is an increasing emphasis on primary care to support people to self-care more day-to-day aspects of their conditions, seeking the support of healthcare professionals only for more complex elements which require clinical intervention and monitoring.

As care is increasingly seen as a partnership between the patient, healthcare professionals and other agencies, so patients are becoming better informed and better able to make choices about the treatment and management of a wider range of illnesses.

To support this, facilities for group consultations and meetings are increasingly required in primary care premises, with the opportunity to zone premises to provide flexibility for activities in the evening or at times when the rest of the building may not be open.

Workforce challenges

Primary care premises can have a significant impact on an individual practice's ability to attract and retain staff, particularly if those premises enable a practice to become a training practice. Becoming a training practice is known to improve a practice's ability to attract and retain a highly skilled

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workforce to guarantee capacity going forwards but does require high quality clinical space to be made available.

A high-quality working environment and a wide range of service provision with which to be involved can also be a major draw for new recruits in a variety of roles including those clinical roles (such as GPs and a range of specialist nurses) which are often in short supply.

An aging population

People are living longer than ever before and, as a result, the number of older people in England is growing significantly. This creates a huge challenge for the NHS. As people get older, they typically need more health and social care.

As well as the requirement for primary care facilities to be dementia friendly and accessible, there will be an increased demand for services targeted towards an older population. This increase in demand and more specialist services will place increasing pressure on primary care premises.

Greener NHS/Net Zero Carbon

The UK government has committed to reaching net zero carbon by 2050. For primary and community care facilities, this will involve a greening of NHS estates and reduction in emissions, as well as redesigning care pathways to support fewer outpatient appointments.

HTM 07-07: 'Sustainable health and social care' identifies that the success of a building's performance in terms of sustainability outcomes is dependent to a large degree on the decisions taken at the design, procurement, and construction stages of a development. It also explores the reuse of existing buildings and provides advice on possibilities for sustainable refurbishment.

The NHS Sustainable Development Unit website includes guidance to support this, including specific guidance on decarbonising NHS estate. The For a Greener NHS website has also been developed to support the NHS by sharing ideas on how to reduce the impact on public health and the environment, save money and achieve net carbon zero.

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3 Sizing a development and creating a briefing schedule

Introduction

This chapter describes the process by which the spaces in primary and community care buildings are quantified, and from that, how a briefing schedule can be generated.

This analysis can be undertaken manually, in collaboration with a healthcare planner, following the methodology set out below.

[DN: The Department of Health is currently developing an interactive online standard space scheduling system to aid this process.]

Analysis is carried out through a series of forms – provided in Appendix 4 – which should be filled in by the project team. An overview of the form structure and output is given below. Responses to the questions in the forms will drive input into a more complex database/spreadsheet.

Responses to the 'project information form' will determine the number of other forms to be completed.

Responses will lead to a basic calculation which may then be adjusted via toggle menus (for example, % support space, % utilisation, % planning/ circulation/ engineering etc) to produce a series of scenarios in a standard report format. Each scenario will include clear detail of any assumptions made. The intention would be for these reports to be in a standard suitable for inclusion in a business case.

The briefing schedule will be used to produce an informed construction cost and hence to determine whether the scheme is viable or whether basic assumptions (such as functional content, opening hours etc) will need to be adjusted to achieve affordability. It is vital that the briefing schedule is created very early in the development process to avoid abortive work being undertaken.

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Overview of form structure and output

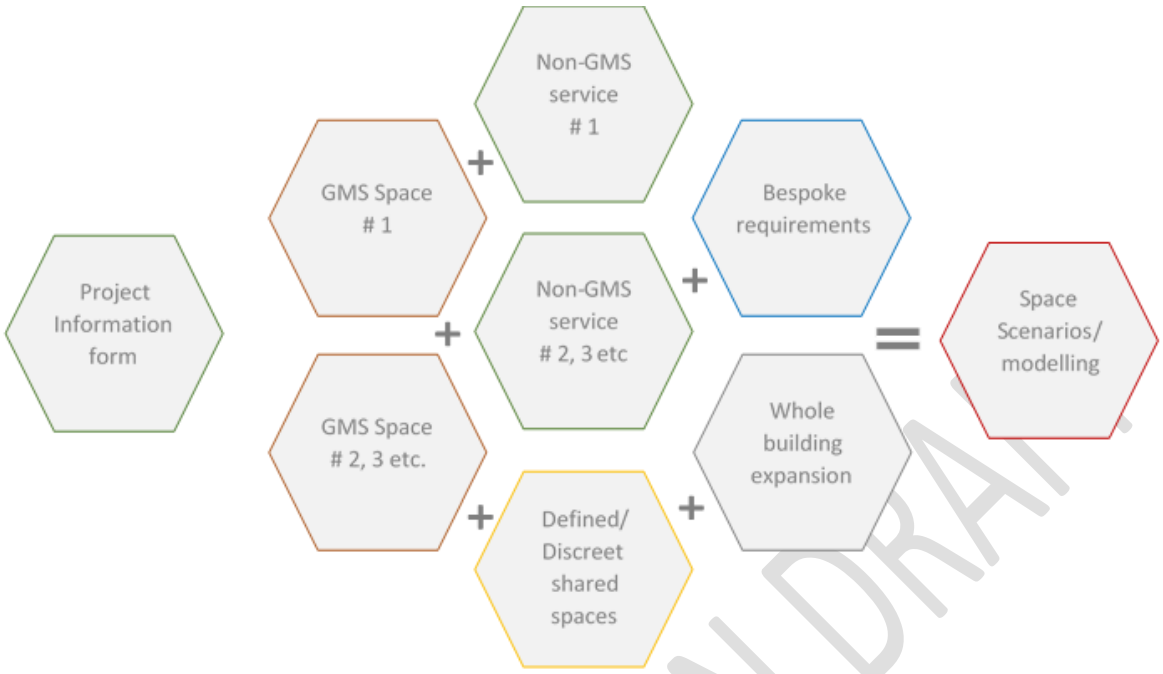

Figure 1: Space scheduler - input form structure

The above hexagons represent input forms that are provided at Appendix 4 of this document, and take the user through a series of questions that will help determine the size of the development.

Project Information Form

The project information form asks questions regarding the nature of the development (for example, new build, refurbishment etc.), the number of GMS practices to be included, and the non-GMS services which are likely to be provided.

GMS Space Form

The GMS Space form should be filled out for each GMS practice to be included in the facility, and asks questions about the population served, current and future opening times, appointment numbers and lengths, and anticipated support requirements.

Non-GMS Service Form

The non-GMS Service form should be filled out for each non-GMS service to be provided in the facility, and gives a table to be completed with proposed room sizes (both HBN standard, and non-HBN), along with number and length of appointments, and anticipated support requirements.

Defined / Discrete Shared Spaces Form and Bespoke Requirements Form

These forms provide a table to list any known accommodation requirements that sit outside of the GMS and non-GMS services, such as shared support services, amenity space etc.

Whole Building Expansion Form

This form provides a table to list any required zones for anticipated future expansion.

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Space Scenarios and Modelling Form

Having filled in the other forms the Space Scenarios and Modelling Form will provide the sizing information for the facility, with a number of changeable assumptions that will alter the figure dependent on scenario.

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4 Strategies to maximise flexibility and adaptability

This chapter provides guidance on how to ensure that there is flexibility and adaptability in the design of a new primary and social care facility.

Introduction

Because the mix and range of services to be delivered from primary and community care buildings can change over time, it is important for accommodation to be flexible and adaptable. Strategies to promote flexibility and adaptability include:

- the use of generic patient/client contact spaces wherever possible;
- limiting the number of more specialist spaces;
- standardising room sizes and position of built-in equipment;
- considering future engineering service requirements at the outset;
- having flexible and adaptable forms of construction;
- developing a modularised approach to planning and construction;
- providing space for future expansion from the outset.

Primary and community care services involve at least one or more of the following activities:

- counselling;
- consultation (both face-to-face, by telephone and video conferencing);
- examination;
- diagnostics and screening;
- treatment of disease, disorder or injury;
- minor surgery;
- physical therapy;
- speech and language therapy;
- education.

Activities will occur on a planned basis (for example, routine GP consulting or specialist outreach consulting), unplanned basis (for example urgent care or walk-in services) or a combination of the two (for example, nurse practitioner services). This affects the way services are managed, as well as the facilities required.

Most activities involve a practitioner and an individual patient/client, although certain forms of physical therapy and counselling may take place in groups.

The use of technology will underpin many of these activities, with many involving some digital, virtual and/or telemedicine element. Going forwards, the impact of this will have implications for how space is designed and used, as reported in the Kings Fund report 'Clicks and Mortar, Technology and the NHS Estate':[xiii]

Existing use of technology includes:

- multi-disciplinary virtual meetings;
- virtual consultation;

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- self check-in systems;
- Virtual Private Networks for remote working.

Generic patient/client contact spaces should be shared on a timetabled basis to maximise their use.

Treatment activity requires special consideration. Treatments given in primary and community care settings fall under a number of categories and can occur in different room types.

- Non-invasive and minimally invasive treatments: A non-invasive procedure is one that does not break the skin, for example changing a dressing. A minimally invasive procedure is one that breaks or punctures the skin, for example injections and taking blood. These may take place in a consulting/examination room, treatment room or examination/physical therapy room, depending on space requirements.
- Invasive procedures: An invasive procedure is one that cuts the superficial layers of the skin, for example removal of moles, warts or corns, biopsies or any endoscopic procedure accessing a body orifice. A local anaesthetic or sedation may be required with an invasive procedure.

Most minimally invasive procedures can take place in a generic treatment room. Procedures that generate heat (for example, ultrasound) and/or unpleasant odours (for example, tissue viability clinics) should only take place in a treatment room with mechanical ventilation.

Some invasive procedures may require all-round couch access, including access to the head of the couch.

Standardising room sizes

In order to provide the greatest flexibility when planning a primary care development, it is desirable to use standard room sizes where practicable. As described in Chapter 5, it is possible to deliver a range of clinical and non-clinical suites of varying sizes to offer greater flexibility.

Experience has shown over the years that there are a basic number of room sizes that meet most of the clinical requirements for primary care premises. These rooms are 8m2, 12m2, 16m2 and 32m2, all of which can be generated by using a 300mm planning grid.

The size (and dimensions) of the indicative room layouts should be standardised wherever possible. Although this may mean sizing up or down to some extent, it ensures rooms can be adapted for alternative use much more easily.

It should be noted that standardisation is not suitable in all cases and may not be appropriate if it becomes cost prohibitive. An example would be in a refurbishment. The important thing is that the room planning principles described later in this document are followed.

Room size/function matrix

Room functions can be categorised into four main types:

- consultation;
- treatment;
- clinical support;

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- administration.

The following diagram provides a thumbnail of how certain functions may be accommodated in the standard room sizes. Some details on individual room layouts have been omitted to ensure the clarity of the overall diagram.

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Figure 2: Room size/function matrix

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5 Zoning and clustering of services

This chapter describes how different types of accommodation might be zoned to make optimal integrated use of the primary care facility. It also provides a concept for the clustering of clinical services.

All primary and community care buildings include the following types of space:

- public spaces;
- primary and community care spaces;
- staff spaces.

These different categories of spaces should be grouped together to create separate zones within the building.

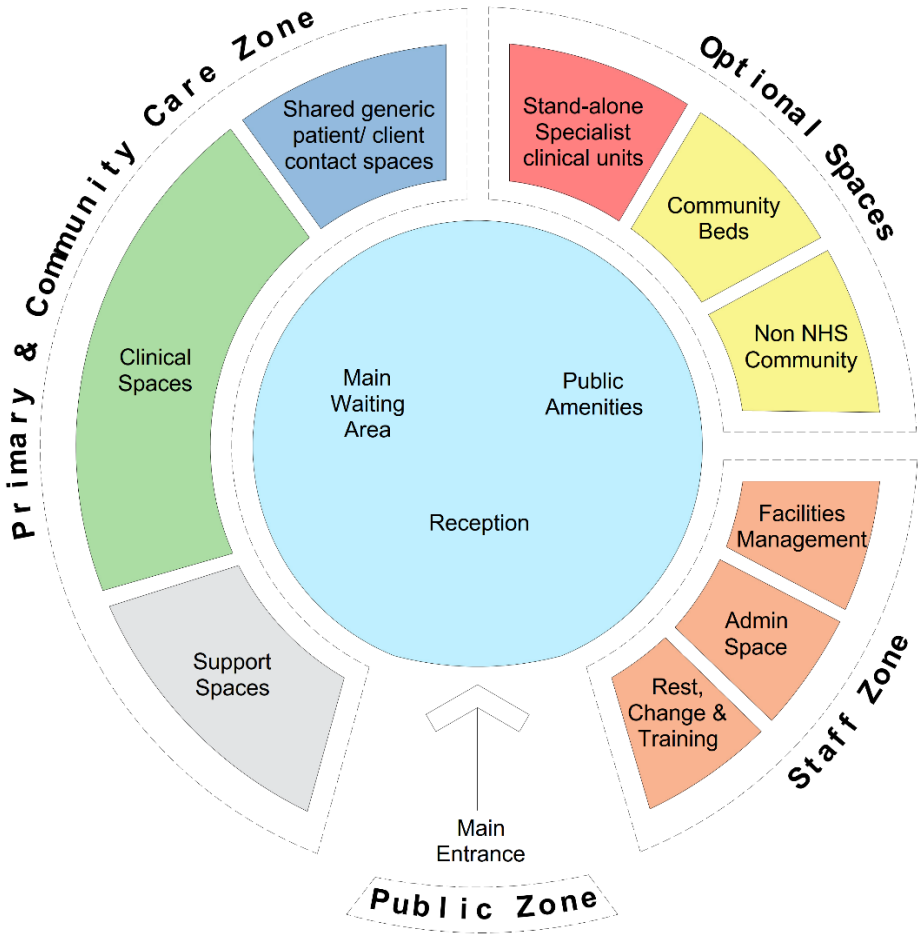

Figure 3: Zoning concept diagram

Public zone

The public zone comprises the main entrance, reception and waiting area, public WCs and health information points. It should be located at the front of the building.

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This zone should have a non-clinical character and be relevant and inviting to the community it serves.

The public zone should be:

- open and welcoming;
- visible from outside the building, to aid building legibility;
- naturally lit, with good views of external spaces.

Main entrance and reception

The main entrance point should be overseen by a desk, which is staffed whenever the building is open. This may be the main reception desk or an information point.

Situations should be avoided where visitors can access areas of the building without having passed the main reception desk.

A main reception desk is required for monitoring the waiting area and handling enquiries which cannot be dealt with electronically. The reception desk should be visible and welcoming.

Use of self check-in systems should be encouraged wherever possible and positioned in a way that invites the user to interact.

Follow-on appointments may be made either electronically or via the reception staff.

An interview room close to the main reception desk should be provided for private discussions on an unplanned basis or to accommodate patients who may need to be isolated, and so should not be blocked for sessional activity.

Waiting and patient/client information points

As waiting and patient facilities make up a large part of the public zone of the building, project teams should decide on the nature of the resulting overall space.

Where primary care and community services are provided within the same building, careful consideration should be given to the integration of waiting and public spaces.

When planning the waiting area, project teams should consider the efficiency and throughput benefits of shared waiting versus granular arrangements. The need for flexibility and adaptability is key.

The layout should be flexible enough to accommodate patient flow at peak times, and to allow children's play areas and quiet areas to be shared by different patient groups.

A range of different seating of varying heights and styles should be provided, including high-backed chairs.

Provision of desks should also be considered, to enable users to use laptops or deal with paperwork while they wait, along with free access to WiFi to allow patients to check in for their appointment online.

Wayfinding within the waiting area should be carefully considered, particularly in larger buildings. Signs are important for navigation but good use of colour, large icons, artwork and interior design can also help building users identify routes and predict destination points independently.

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Public sanitary facilities

Public sanitary facilities should be located for ease of access from public areas and be well signposted. Refer to HBN 00-02 for details on the provision of sanitary spaces.

Primary and community care zone

A primary and community care zone would normally include GPs and their staff team, NHS community providers such as health visitors, district nurses and mental health staff, and voluntary sector (third sector) organisations such as charities and those supporting people seeking welfare support and advice.

This is the zone where patients are assessed and / or treated.

Clustering of patient spaces

The clustering of patient spaces into suites is important to optimise the use of space and patient throughput.

A project decision should be made at the outset as to how the clinic rooms should be clustered. Options include, but are not limited to, the following:

- cluster by use type;
- generic clusters with shared specialist and support spaces;
- self-contained clusters.

The use of flexible standardised spaces previously described in this document allows for clusters to be reallocated at minimal expense as the use and activity of the facility evolves.

The clustering of rooms will depend on routes and reception positioning, patient call systems, storage, and shared support spaces.

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Cluster by use type

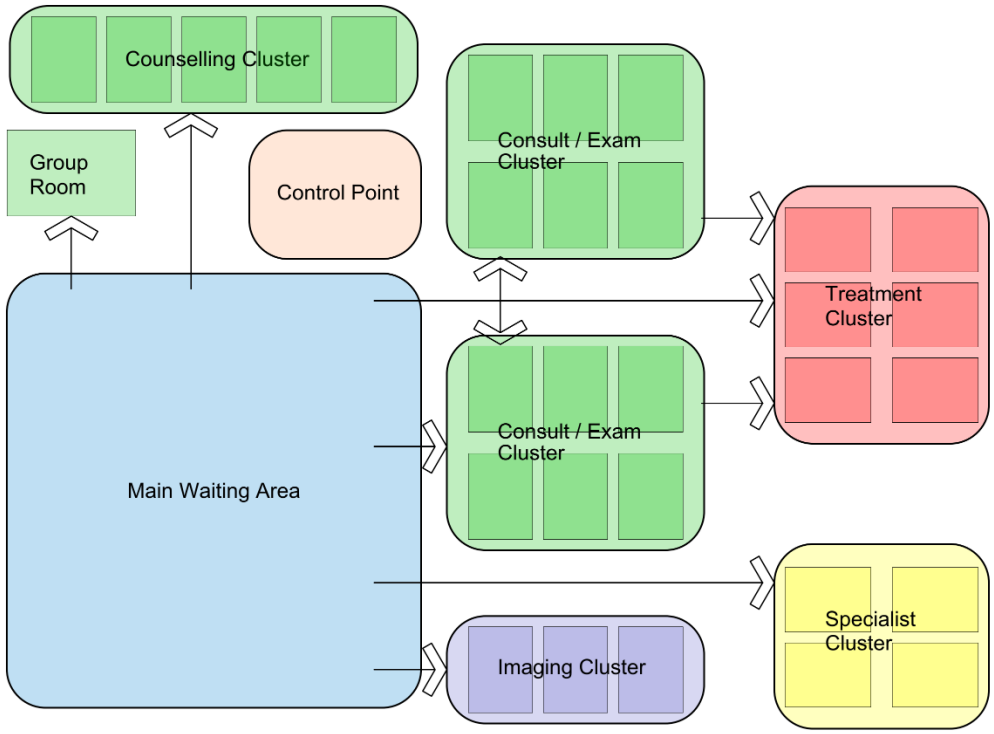

Figure 4: Cluster by use type

Clustering by type allows rooms of a similar function to be grouped together, with the patient moving to the relevant cluster as needed. This can be more efficient from a staffing perspective but involves greater patient movement.

A consulting/examination suite may comprise the following rooms:

- consulting/examination rooms for consultations and examinations. Non-invasive and minimally invasive procedures may also take place here;
- interview room(s) for discussions/counselling;
- a small store for consumables and portable equipment.

This suite would be appropriate for use by GPs, nurse practitioners, allied health professions and outreach consultants.

Consulting/examination rooms may be clustered in groups of up to eight rooms

If shared-use clean and dirty utility rooms are not available nearby, these should be provided within the suite.

Specialist consulting/examination rooms may be dispersed with generic consulting/examination rooms across a number of different suites or concentrated to form a specialist consulting/examination suite.

Treatment clusters will consist of treatment rooms for invasive procedures and procedures that produce odours, for example leg ulcer clinics. Podiatry work may take place in a treatment room

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with a podiatry couch rather than a standard couch. Treatment clusters may also contain enhanced procedures suites for minor surgical interventions.

Specialist clusters may be dedicated to diagnostic imaging, therapies, audiometry, ophthalmology, dentistry, or other specific specialist services.

A counselling cluster may contain interview rooms, group discussion / counselling rooms and storage.

Generic Clusters

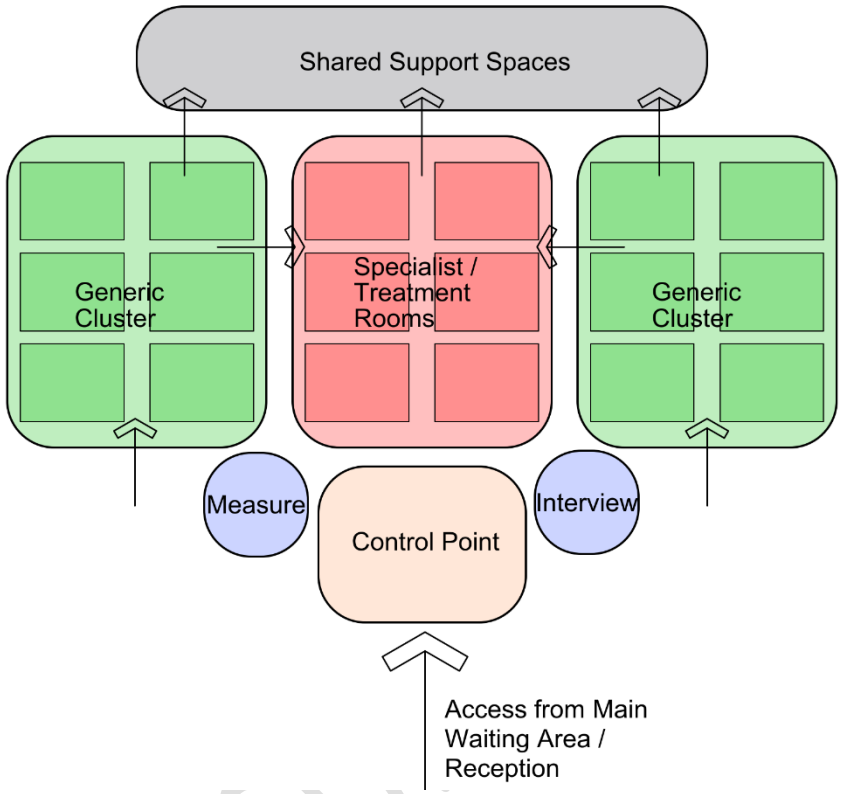

Figure 5: Generic clusters

Generic clusters will usually consist of six or eight rooms and will likely have a selection of 8m2 and 16m2 rooms that are used for consultation, consulting/examination and meetings. Two or more clusters can then have shared access to treatment and specialist rooms, and support spaces. This arrangement allows for efficiency of the shared spaces, which may have a lesser throughput than the generic rooms.

Patients may have their medical history taken and weight/height checked by a nurse prior to their consultation. This can occur in a consulting/examination room or examination/ physical therapy room. Alternatively, height and weight details self-reported by patients may be transferred electronically to the clinician prior to the patient's arrival for the consultation.

The shared specialist and treatment cluster may comprise the following rooms:

- treatment rooms for invasive procedures and procedures that produce odours, for example leg ulcer clinics. Podiatry work may take place in a treatment room with a podiatry couch rather than a standard couch;

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- Specialist consultation rooms, such as hearing test, or ENT.

The shared support spaces will include clean and dirty utilities, stores and cleaner's rooms.

Self-contained Clusters

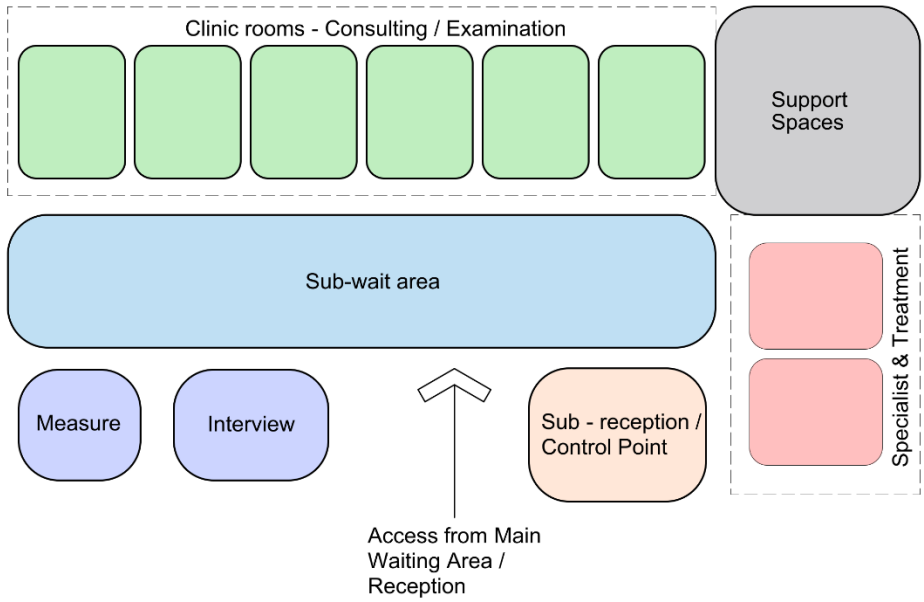

Figure 6: Self-contained clusters

Self-contained clusters provide consulting / examination spaces along with treatment rooms, specialist rooms and support spaces. This model is often used where several GPs are brought together into a single facility to allow for separate identities / working hours.

Staff zone

The staff zone should be separate from the primary and community care and public zones, possibly on a separate floor. Generally patients and visitors should not enter the staff zone.

Ideally, the staff zone should have direct access to the primary and community care zone.

The design brief should address the need for a dedicated staff entrance and car park. Staff car parks, where provided, should be well lit and observed to ensure staff safety and security.

Staff spaces include the following:

- admin spaces for practitioners and desk-based staff;
- rest rooms;
- changing areas, including shower facilities;
- training spaces (some staff training can take place in patient/client contact spaces).

Arrangement of zones relative to one another

The way in which zones are arranged relative to one another depends on the nature and scale of the building.

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In small facilities, zoning will be simple and may not be expressed in the architectural treatment of the building. In larger projects the way in which zones overlay one another will be more complex and may require architectural devices such as double-height spaces, hospital streets or external reference spaces to clarify the way in which the building is organised.

Whatever the scale of the building, the use of zones should aid wayfinding, simplify user journeys, segregate users, and demonstrate the function of the different areas within the building.

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6 Activity spaces

Room planning principles

In order to understand the minimum space requirements for clinical rooms, it is important to first understand the principles inherent in the functionality of the space.

For a basic clinical room, there will be a patient examination / treatment zone, an admin / consultation zone, and a hand washing zone:

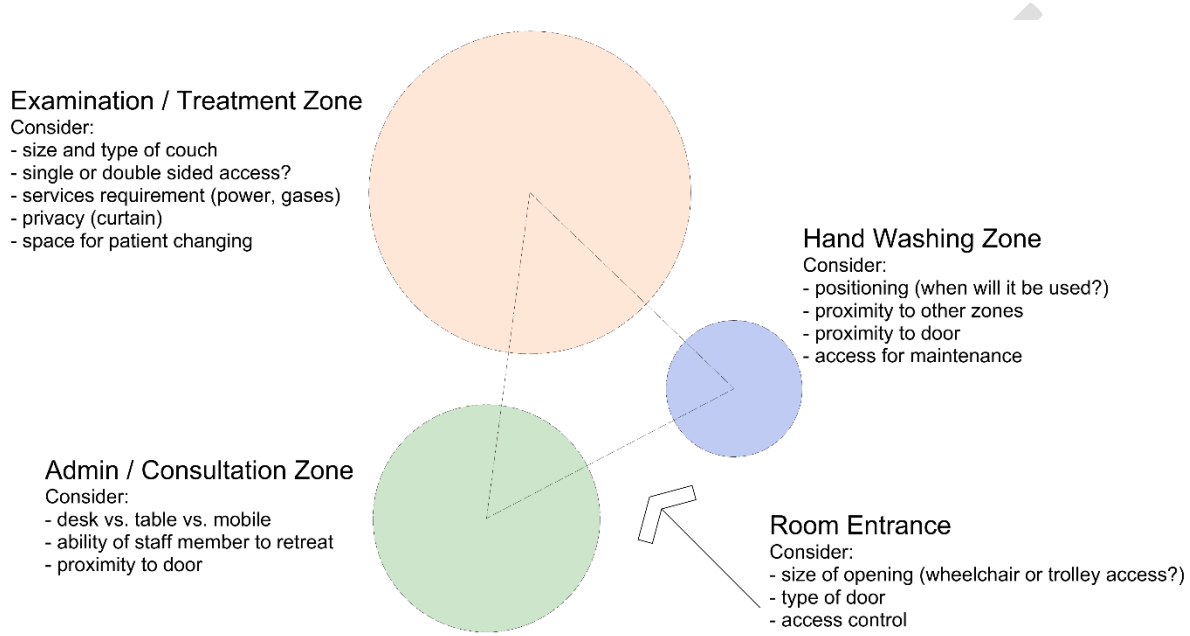

Figure 7: Activity zones

It is important these zones are arranged in a way to maximise the functionality of the space. Consideration should be given to privacy if patients need to undress. A privacy curtain around the examination / treatment zone can achieve this. There should be adequate space for the patient to dress and undress within that zone.

For the admin / consultation zone, consideration should be given to the type of furniture. A desk or workstation provides a formal arrangement, whilst a table and chairs may be preferred to offer a more discursive setting. Of paramount importance is staff wellbeing, so the ability to retreat if the patient turns hostile should be considered.

The position of the wash hand basin (WHB) is critical. The clinician should be able to easily access the WHB both before and after interacting with the patient, and also before leaving the room.

The following diagrams of the functional zones are based on the ergonomics provided in HBN 00-03, which were developed at the time in conjunction with Loughborough University.

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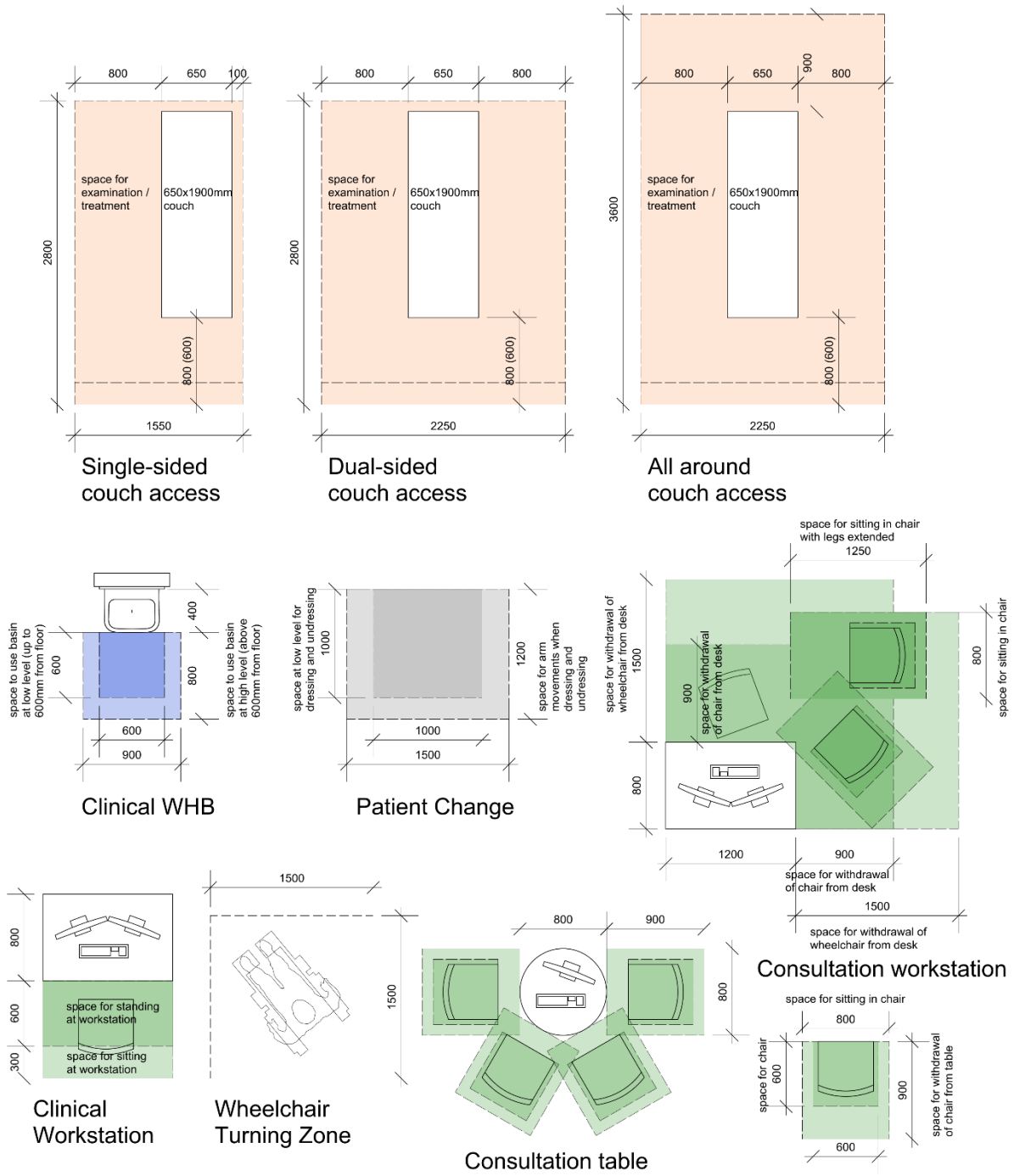

748

749 **Figure 8: Functional zones**

750 The following diagrams demonstrate how activity zones and the ergonomics around them can be
751 brought together to provide minimum sizes for a room, in this example a standard
752 consulting/examination room.

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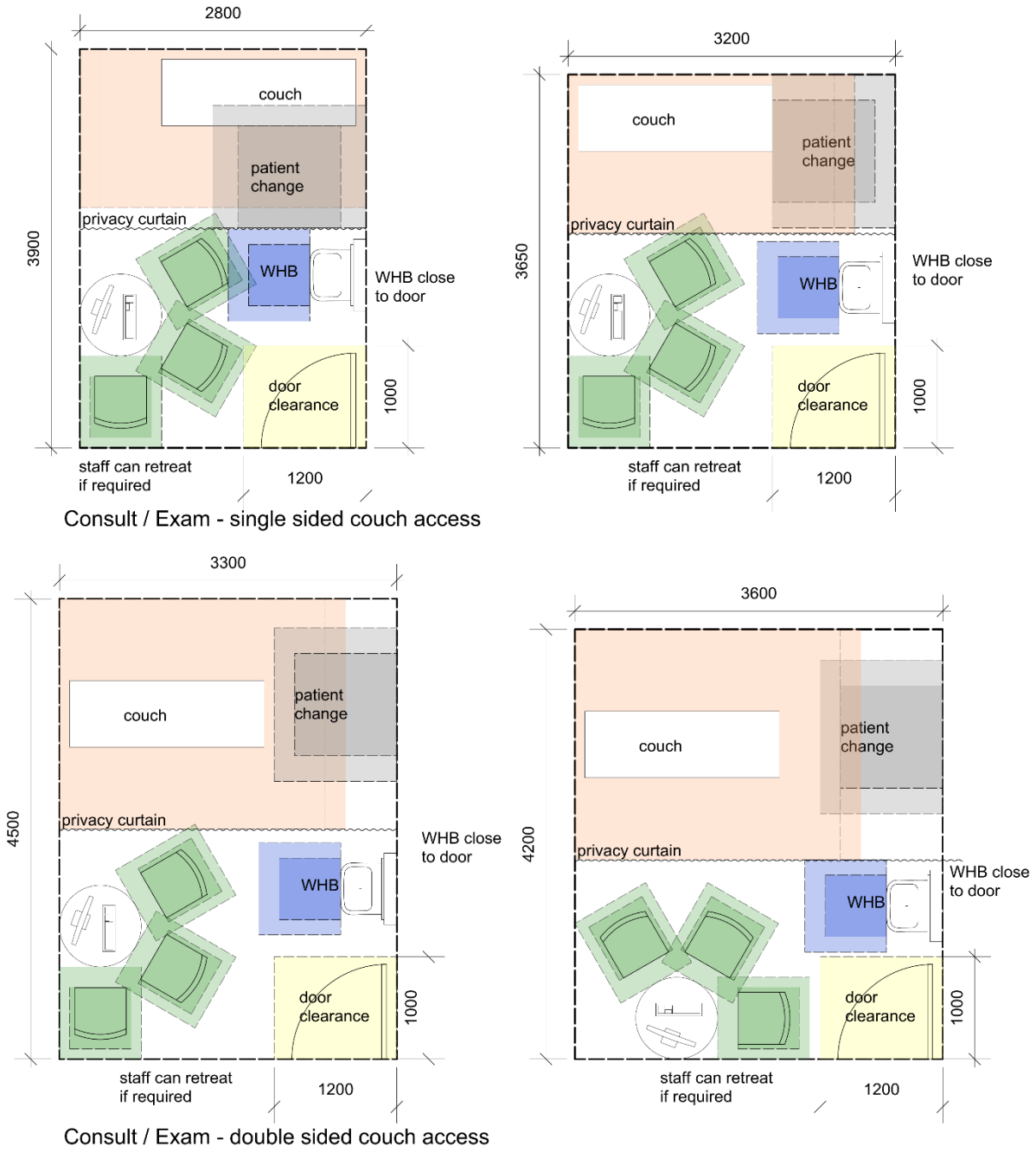

Figure 9: Combining functional zones to create room layouts

Functional content and space standards

Most of the rooms and patient spaces that are found in primary care are standard and repeatable rooms as detailed in HBN 00-01 – General spaces; 00-02 – 'Sanitary spaces'; 00-03 – 'Clinical and support spaces'; and 00-04 – 'Circulation'.

Before early design team and user group meetings but following discussion with the client during the briefing process, the healthcare planner will ideally have assembled a preliminary schedule of accommodation using standard/repeatable rooms with specialist rooms as required.

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Each schedule of accommodation will depend on different scenarios: that is, the model of care, local demographics, staffing levels, and other local provision will all impact on the final brief. Typical schedules of accommodation are provided in Appendix 5. These should be the first principles from which to design.

- The design team should use the HBN's exemplar schedule of accommodation as a baseline in order to develop a project specific schedule based on the clinical demand of individual healthcare providers.
- The healthcare organisation's user group meetings should refine and delineate requirements.

Ergonomic zones shown on the below diagrams are based on the ergonomic drawings provided within HBN 00-03, however the actual room layouts should follow the room planning principles set out in this chapter. The physical room dimensions may vary slightly to suit building type and architectural grid spacings, but the functionality should be maintained.

Main entrance, reception and waiting (public zone)

The functionality of the public zone is described in chapter 6 of this document. For detailed room layouts and design guidance, refer to HBN 00-02 and HBN 00-03.

Consultation spaces

Consultation can be described as visually and aurally determining the overall condition of the patient in order to prescribe required investigation and treatment.

Virtual consultation

Virtual consultation is becoming more widely used in primary care settings and should be encouraged where possible.

The room requirements are less onerous that traditional consulting spaces, as there is no physical contact with the patient, so practices such as clinical hand washing are not required. In this respect, the virtual consultation space can resemble that of an office.

Virtual consultations may take place in 8m2 consulting rooms where a single practitioner is involved, or with several practitioners in larger generic spaces.

Consideration should be given to the use of proprietary sound-proof booths which can be installed into large open-plan areas and provide the requisite privacy.

There are also proprietary sound-proof hoods that can be installed to existing workstations.

All rooms used for virtual consultation should have appropriate sound insulation and visual screening. Where the process is likely to be prolonged, or the consultant is in the same room for a lengthy period of time, natural light and ventilation should be provided.

The space will be used by:

- a member of staff;
- potentially additional multi-disciplinary team members.

The following activities may take place:

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- The room may be used as an office space or as a counselling room for privacy purposes.
- Use of computer workstation.
- A video/voice over internet protocol (VOIP) consultation will take place between the clinician and patient and potentially additional multi-disciplinary team members.
- Separate data and voice outlets may be used where structured cabling solutions are not available.

Consulting rooms

Consulting spaces are required to provide one-to-one communication between the clinician and the patient, with space allowance for a patient escort/chaperone/ family members to be present.

The activity space described in HBN 00-03 is based on the practitioner sitting at the desk with the patient/client seated diagonally opposite. The desk should not be located between the practitioner and patient/client. The practitioner should be seated closest to the door, for ease of access in the event of an emergency or incident. Consideration should be given to providing a less hierarchical arrangement using a semi-circular or circular table with the screen viewed by practitioner and patient. This provides the patient with a choice of where to sit, and avoids individual clinicians taking over the room as their office maintaining a flexible/bookable approach.

It should be possible to rotate the computer monitor to allow the patient/client to view it.

Consulting activities can be accommodated in either 8m2 or 12m2 rooms. For further guidance and indicative layout, refer to HBN 00-03 – Figure 3, or the alternative examples below:

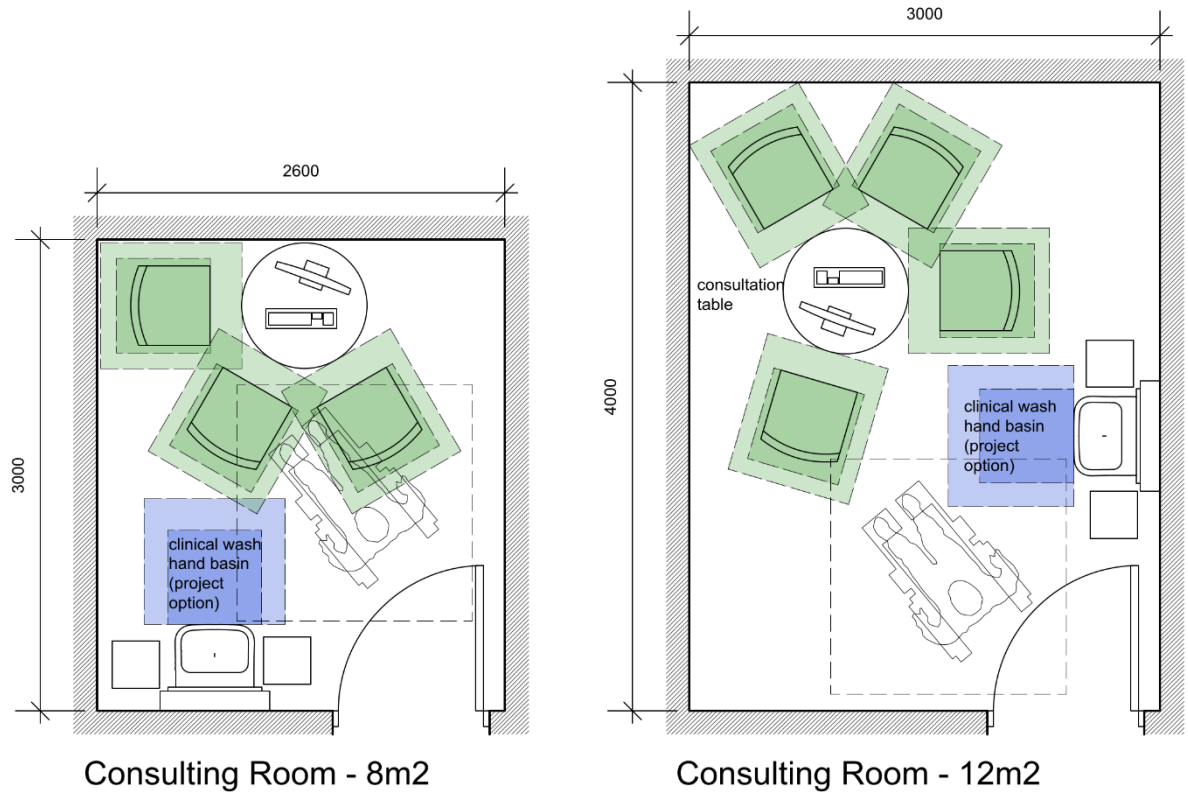

Figure 10: Consulting room indicative layouts

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Consulting/examination room

This room is intended as a flexible space for consultations and examinations for use by a wide range of specialties.

The following procedures may take place in this room:

- Non-invasive procedures i.e. procedures that do not break the skin for example, changing a dressing.
- Minimally invasive procedures i.e. procedures that break or puncture the skin for example, injections, taking blood etc.

Where it is not necessary to access both sides of the couch, the single-sided room layout may be used but to maximise flexibility and adaptability double-sided couch access is generally recommended.

Consideration should be given to whether the clinical wash hand basin is provided within or outside the curtained patient examination zone, and guidance should be sought from the local infection prevention lead. [DN: QUESTION FOR REVIEWERS - are there any strong views on this?]

For further guidance and indicative layouts, refer to HBN 00-03 – Figures 7 and 8, along with the alternative example below:

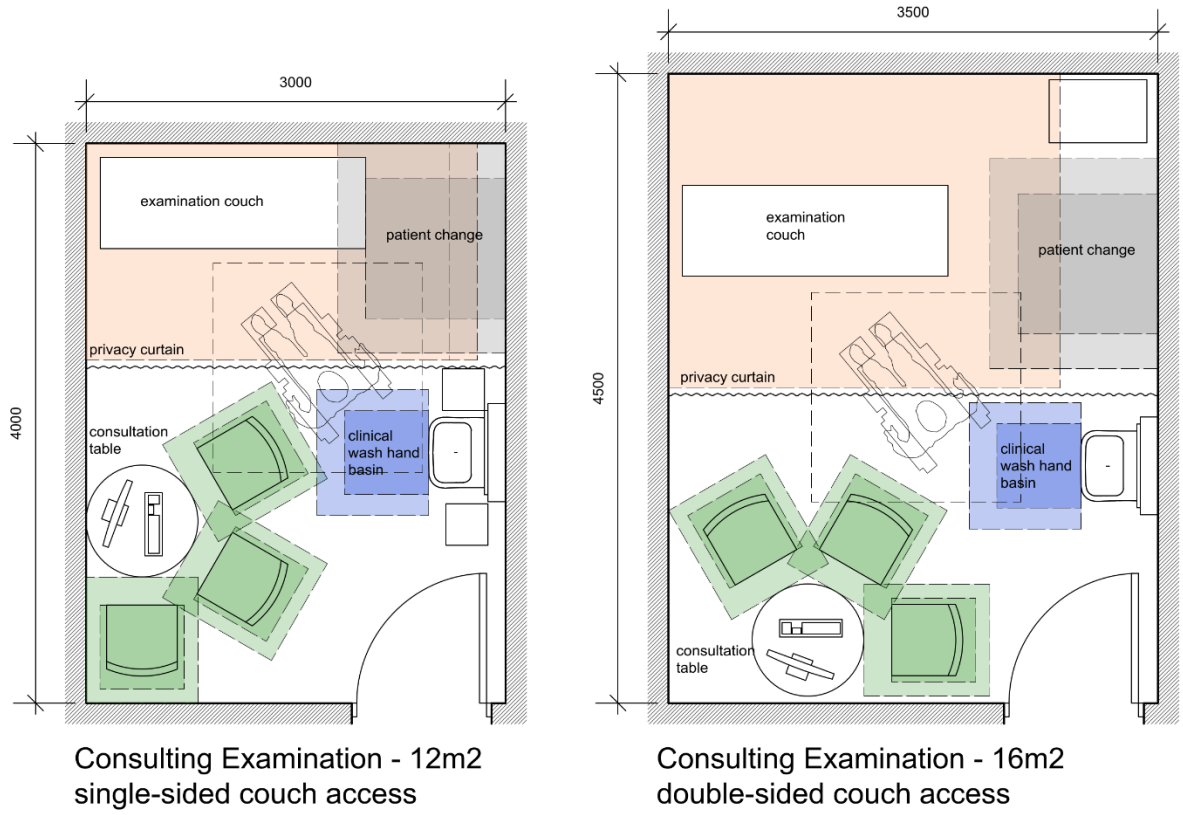

Figure 11: Consulting/examination room indicative layouts

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Interview room

Interviews and counselling can take place in 8m2 or 12m2 rooms, which should be furnished to create a non-clinical ambience. The room should have appropriate sound insulation and furnishings should be comfortable as well as practical in order to provide a viable space for open discussion.

A desk would not necessarily be provided, however, a small touchdown space for a computer workstation is advisable in the event that information needs to be researched during the course of the interview/counselling session.

Natural light and ventilation should be provided to further enhance the non-clinical ambience of the room.

The practitioner should be seated closest to the door, for ease of access in the event of an emergency or incident.

For further guidance and indicative layouts, refer to HBN 00-03 – Figures 27 and 30.

Treatment spaces

Treatment can be described as investigation and physical intervention with the general goal of mitigating and remedying the condition of the patient.

Phlebotomy room

Phlebotomy (taking blood samples) can take place in a clinical space of 8m2. A local option may be to provide two curtained spaces within a single 16m2 room. A phlebotomy chair is essential and some patients (particularly the elderly) may need privacy to divest themselves of extraneous outer clothing to provide access for the phlebotomist (especially in winter months when additional layers will be worn).

Clinical hand washing will take place between each patient but the nature of the procedure is such that all consumables can be stored on a mobile storage trolley. There will be a need for a computer workstation which can be provided on a small touchdown space or by using a hand-held tablet.

Natural light and ventilation is recommended in this room to provide distraction for the patient and a more comfortable work environment for the phlebotomist.

The space will be used by:

- the patient;
- a member of staff;
- one other, for example a family member or escort.

The following activities may take place:

- Patient may arrive on foot, in a wheelchair or with walking aids.
- Patient may divest themselves of outside clothing to allow venous access to the phlebotomist.
- Patient will be seated in a phlebotomy chair.

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- Clinical hand washing and hand sanitizer should be located close to patients and be immediately accessible to clinicians and others on entry to the activity space. Users and infection control teams should liaise and advise on the position of these units in clinical areas.
- Small items of equipment and sundries will be stored on a trolley.
- Use of mobile computer workstation.
- Separate data and voice outlets may be used where structured cabling solutions are not available.

Suggested room layout:

The recommended size for a phlebotomy room is 8m2.

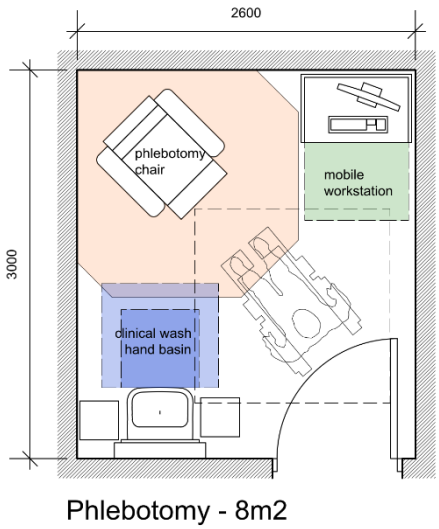

Figure 12: Phlebotomy indicative room layout

Examination/physical therapy room

An examination/physical therapy space is intended as a generic space where a variety of examinations, tests and therapies (for example physiotherapy, acupuncture and massage) may be undertaken.

The space may accommodate mobile diagnostic equipment, for example mobile ultrasound equipment.

The recommended size for this room is 12m2. For further guidance and indicative layout, refer to HBN 00-03 – Figure 20.

Treatment room

This room is intended as a flexible clinical space to be used by a wide range of specialties. The room has been sized to accommodate mobile diagnostic equipment, for example mobile ultrasound equipment.

It is assumed that sterile instruments and dressings will be held within the treatment room on an instruments/dressings trolley. The trolley may be prepared in the treatment room or an associated clean utility room.

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The recommended size for a treatment room is 16m2, as this allows for either double-sided couch access or reconfiguration to provide all-round couch access for procedures. For further guidance and indicative layouts, refer to HBN 00-03 – Figures 47, 52 and 53.

Specialist treatment – plaster room

A plaster room is used for the fitting and removal of plaster casts. The layout of the room is similar to a regular treatment room, with the addition of a plaster sink and plaster trolley.

For further guidance and indicative layout, refer to HBN 00-03 – Figure 126.

Specialist treatment – physiotherapy

Some primary care facilities may be able to provide a multiple use physiotherapy room.

Physiotherapy will require three physiotherapy couch bays, an ergometer and/or treadmill with individual cubicle spaces being curtained off, for privacy. Consideration should be given to providing a larger Bobath plinth in one of the bays.

The space will be used by:

- up to three patients;
- three members of staff;
- up to three escorts or carers.

Activities:

- Patient may arrive on foot, in a wheelchair or with walking aids.
- Patient will be positioned on a treatment couch or on a chair as appropriate.
- Clinical hand washing and hand sanitizer should be located close to patients and be immediately accessible to clinicians and others on entry to the activity space. Users and IPC teams should liaise and advise on position of these units in clinical areas.
- Small items of equipment may be used during treatment (for example, ultrasound/exercise bands/exercise balls).
- Small items of equipment and sundries will be brought in as required.
- Use of mobile computer workstation.
- Separate data and voice outlets may be used where structured cabling solutions are not available.

Suggested room layout

A standard 32m2 room will accommodate three physiotherapy bays and associated support.

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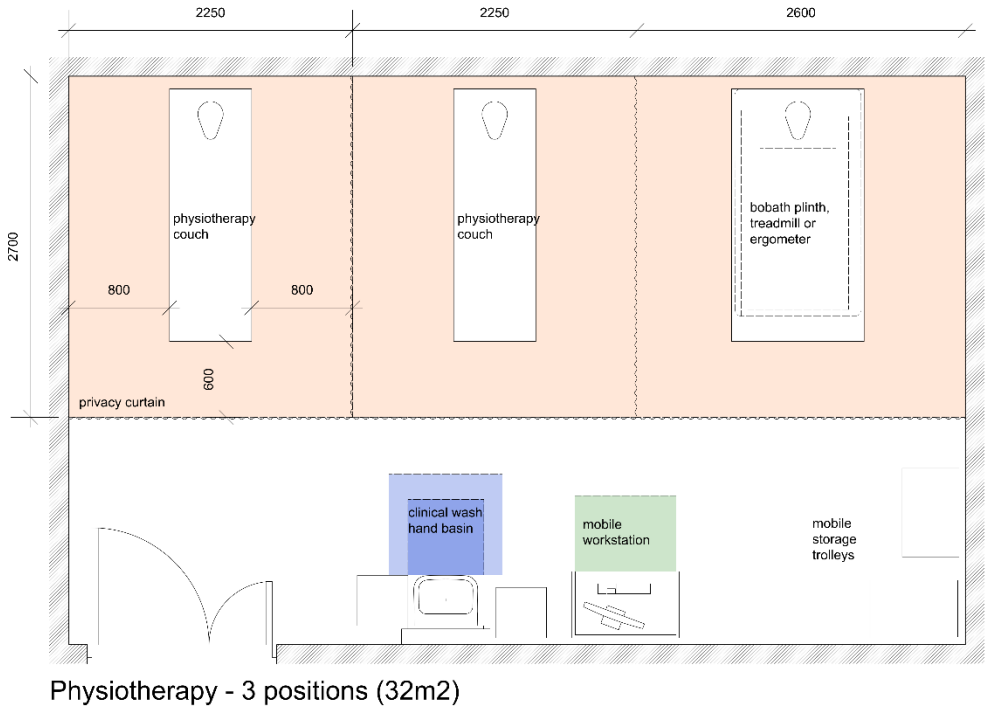

Figure 13: Physiotherapy indicative room layout

Specialist treatment – audiometry / hearing test

This room is used for testing the hearing response of the patient to a series of sounds. The interior walls of the room should be lined with sound-proof material.

Consideration may be given to using a larger standard room, with a proprietary sound-proof booth, or booths within the room.

The space will be used by:

- the patient;
- a member of staff;
- an escort or carer.

Activities:

- Patient arrives on foot, in a wheelchair, or with walking aids.
- Audiometric examination and test procedures will take place.
- Technician initiates sounds/activities from workstation.
- Clinical hand washing and hand sanitizer should be located close to patients and be immediately accessible to clinicians and others on entry to the activity space. Users and IPC teams should liaise and advise on position of these units in clinical areas. The location of this outside the booth is a project option.
- Computer workstation may be used.
- Mobile equipment may be parked and stored and/or recharged.
- Monitoring/diagnostic or therapeutic equipment may be used.
- Specialised visual aids and multi-media equipment may be used.

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- Sterile supplies and consumables may be stored.
- Separate data and voice outlets may be used where structured cabling solutions are not available.
- Room area includes room wall thickness but excludes surrounding void.
- Specialist equipment and associated services are a project team option.
- Specialist lighting equipment, communication circuits and associated services are assumed to be by a specialist manufacturer and to be defined in consultation with medical staff and audiology technicians.

Suggested room layout

An 8m2 room is recommended for audiometry / hearing test.

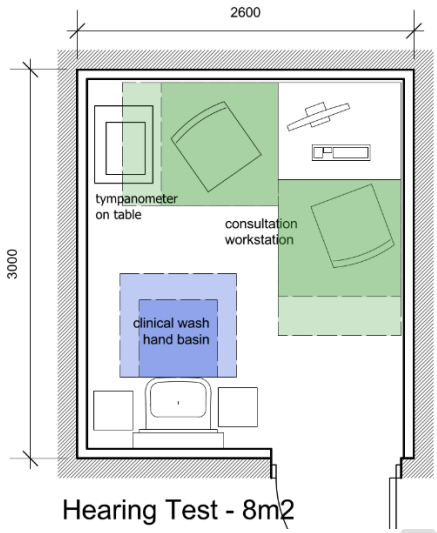

Figure 14: Hearing test indicative room layout

Specialist treatment – paediatric audiometry / hearing test

Audiometric testing in children needs to be performed in a quietly located, sound-proofed room. The room will be equipped with appropriate age group furniture, toys and playthings, and ideally should not have any external windows in order to prevent the child being distracted during the test.

A control booth should be immediately adjacent to the room with two-way intercom for communication and a one-way mirror for observation of the child throughout the test.

The space will be used by:

- the patient;
- one or two staff (plus another one or two staff in the control room);
- up to two others (escorts / parents).

Activities:

- Patient arrives on foot, in a wheelchair, or with walking aids, or requiring assistance and accompanied by parent(s)/guardian(s).
- Audiometric examination and test procedures will take place.

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- Observation of activities and responses are monitored from the control room through a one-way panel.
- Technician initiates sounds/activities from workstation.
- Clinical hand washing and hand sanitizer should be located close to patients and be immediately accessible to clinicians and others on entry to the activity space. Users and IPC teams should liaise and advise on position of these units in clinical areas. The location of this outside the booth is a project option.
- Computer workstation may be used.
- Toys, books and games are stored.
- Mobile equipment may be parked and stored and/or recharged.
- Monitoring/diagnostic or therapeutic equipment may be used.
- Specialised visual aids and multi-media equipment may be used.
- Sterile supplies and consumables may be stored.
- Separate data and voice outlets may be used where structured cabling solutions are not available.
- Room area includes room wall thickness but excludes surrounding void.
- Specialist equipment and associated services are a project team option
- Specialist lighting equipment, communication circuits and associated services are assumed to be by a specialist manufacturer and to be defined in consultation with medical staff and audiology technicians.

Control Room Activities:

- Observing activities and responses within Audiometry booth/room through a one-way panel.
- Technician initiates sounds/activities from workstation.
- Use of computer workstation for access to electronic patient records.
- Separate data and voice outlets may be used where structured cabling solutions are not available.
- Room area includes booth/room wall thickness but excludes surrounding void.
- Specialist equipment and associated services are a project team option.

Suggested room layout

A 16m2 room is recommended for paediatric audiometry, with an adjacent 8m2 control room.

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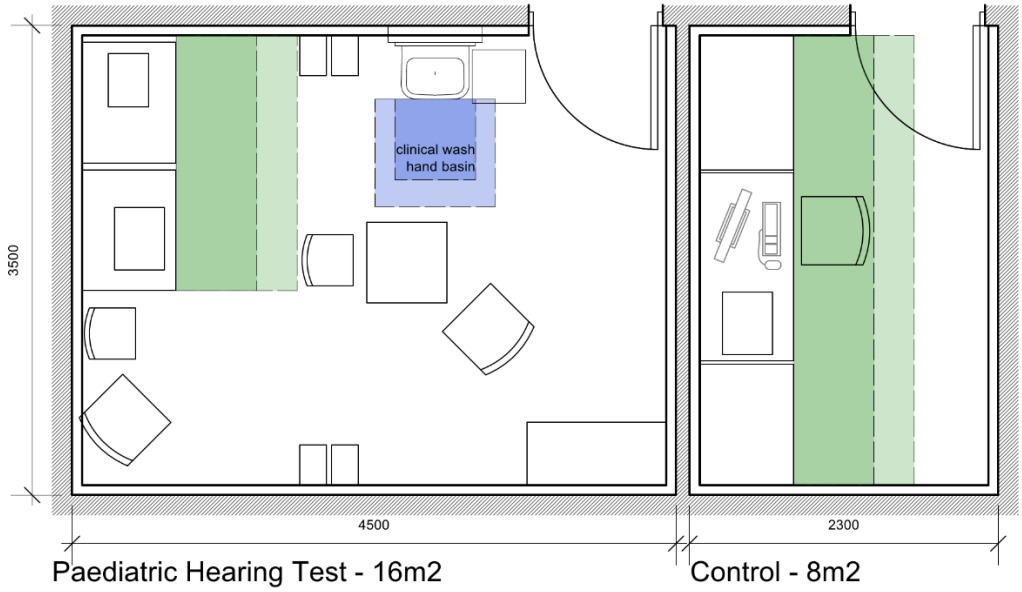

Figure 15: Hearing test indicative room layout

Specialist treatment – enhanced treatment suite

Where minor interventions are required, an enhanced treatment suite may be used.

Some enhanced procedures may be performed in treatment rooms with all-round couch access rather than operating theatres (see the British Association of Day Surgery Directory of Procedures [xiv], for a list of procedures that may be undertaken in a procedures room).

If this is the case, the following facilities may be required:

- treatment room with all-round couch access;
- changing rooms;
- recovery facilities;
- clean utility room;
- dirty utility room.

The above can all be accommodated using standard room sizes described in this document.

Requirements for recovery space (sitting and/or reclining) will depend on the types of surgery undertaken and whether patients are sedated. If only one reclining couch space is required, an examination/physical therapy room may double up for this purpose. Planning decisions should take account of patient culture and preferences in terms of privacy, modesty and same-sex accommodation.

For more guidance on invasive enhanced procedures, and indicative layout, refer to HBN 10-01 – Paragraph 3.34.

Specialist rooms and services

[DN: QUESTION FOR REVIEWERS - Should we provide room layouts and service descriptions for the following specialist services that may be provided in a primary care setting?

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- Dental & OMFS;
- Ophthalmology
- Mental Health
- Cardiac Outpatients
- ENT;
- Sexual Health
- Urology
- Breast Screening
- Chiropody & Podiatry

Are there any others? Should guidance for these services sit here? Or do they belong in their own speciality HBNs (ie. Cardiac OPD in HBN 01-01)? Alternatively, should this be provided in Outpatients HBN and referenced here?]

Group rooms

A group room is a room with minimal fittings that can be furnished in different ways for different activities, from group consultation to exercise therapies and meetings / seminars.

Chairs may be arranged in rows for seminars/conferences or around a central table for meetings.

Alternatively, mats may be brought into the room for exercise classes (for example, antenatal classes, parentcraft, yoga, pilates etc), or prayer facilities. Note that prayer and multi-faith facilities will have sensitive religious requirements.

For flexibility, an adjacent space should be provided for the storage of equipment and furniture when it is not in use within the room.

It is recommended that standard 32m2 rooms are used as group rooms, however the size may be adjusted to suit the proposed activity.

For further guidance and indicative layouts, refer to HBN 00-03 – Chapter 4.

Support spaces

Support spaces are essential ancillary accommodation, such as utilities that support the functionality of the department.

Clean utility

This room is for storing sterile supplies and consumables, excluding infusion fluids, and for storing and preparing medicines, excluding controlled drugs.

Empty supplies trolleys and dressings/instruments trolleys will be held here and restocked for distribution to clinical areas.

The recommended size for a clean utility is 8 or 12m2. For further guidance and indicative layouts, refer to HBN 00-03 – Chapter 8.

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Dirty utility

Depending on the facility's waste management policy, dirty utilities may be used for holding waste sacks prior to their removal to a disposal hold and for the disposal of small amounts of liquid human waste. Urinalysis may also take place here (using a dipstick). Small quantities of small items may be held here prior to reprocessing.

The space required for holding waste sacks will depend on the local disposal policy. As soon as sacks have been filled, to avoid cluttering and build-up of odours, they should be sealed and taken away (as soon as possible thereafter) to the associated disposal hold to await collection.

The location of dirty utility rooms should minimise travel distances for staff from patient areas to reduce the risk of spillages and cross contamination, and to increase working efficiencies.

The recommended size for a dirty utility is 8m2 or 12m2. For further guidance and indicative layouts, refer to HBN 00-03 – Chapter 8.

Cleaners room

Cleaners' rooms should provide handwashing facilities, along with storage space for both wet and dry cleaning materials.

For guidance and indicative layouts of cleaners' rooms, refer to HBN 00-03 – Chapter 9.

Disposal hold

For guidance and indicative layouts of disposal holds, refer to HBN 00-03 – Chapter 9.

Administration spaces

Offices, whether open-plan or single person, are non-clinical spaces used by staff for administration tasks, including reviewing / updating patient records and informal meetings.

For further guidance and indicative layouts, refer to HBN 00-03 – Chapters 12 and 13.

Storage

Refer to local operational policies.

Storage of equipment should not be underestimated due to the number and variety of specialties using the premises.

The storage of mobility aids and equipment such as walking frames should also be considered.

Consideration of the location, size and management of stores is important. Small stores may be located throughout the facility for holding a variety of small equipment and supplies close to the point of use. An alternative is to provide fewer larger stores, using standard rooms sizes, which may be easier to manage.

Staff welfare facilities

Staff support requirements will be project specific and based on local operational policies.

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Staff rest rooms, changing rooms and WCs should be shared by different groups of staff. Good quality environments should be provided in staff rest areas to encourage their use and the resulting interaction that occurs. For design guidance refer to HBN 00-03 – Chapter 10.

Separate male and female staff changing and showering areas should usually be provided in the staff zone.

Staff WCs and drinking water points may be distributed around the building, including within the staff zone.

For design guidance on staff changing areas and WCs refer to HBN 00-02.

[DN: QUESTION FOR REVIEWERS - should we now Post Covid19 be making reference to the ability to put on and take off PPE in separate dedicated areas? This could be rooms used for other purposes and re-functioned during an emergency measure situation?]

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7 Engineering requirements

Introduction

This chapter sets out the general engineering services recommendations for premises used for the delivery of primary and community care.

It does not provide detailed design information for individual engineering services. Reference should be made to the associated HTMs of which the designer should be familiar with.

This guidance will inform designers of the criteria and general specification needed to meet the functional requirements. Specific requirements should be formulated in discussion with both end-users, such as clinicians as well as ventilation, electrical and water safety groups and manufacturers of specialist equipment. Some issues particularly those related to pharmaceuticals or radiation may require specific and detailed discussion with the relevant licencing authority.

General

The design, specification, installation and validation of engineering services must comply with all statutory requirements and conform to the guidance contained in the relevant HTM.

The function and range of treatment and support delivered within primary and community care facilities is constantly being expanded. The design and provision of the engineering services in such premises should reflect their current and likely future requirement. The harness of engineering services should support the flexible use of the premises and have the capacity to allow trailer mounted external diagnostic or treatment units such as scanners or theatres to “plug in” to the services that they will require.

When determining the layout and capacity of the engineering services the possibility of a future extension of the premises should be considered.

The effect of a loss of an engineering service on the ability of the premises to deliver its function should be risk assessed at the design stage. Risk is addressed from the effect on the patient (clinical risk, life safety) and continuity of service (business continuity), i.e. whilst a patient may be safe the loss of a facility such as IT servers over a prolonged period may prevent or degrade the delivery of the service. In each case the ability to provide an alternative back service or the need to duplicate critical systems should be considered.

In many cases the premises will not be occupied outside of general working hours. It is also unlikely that the engineering services will be operated and maintained by dedicated “on site” staff. In most cases engineering support will be by contracted routine service visits and breakdown call out. The design of the engineering services, selection of equipment and method of monitoring its performance should reflect this reality.

Energy efficiency and sustainability

A holistic approach to the energy consumption and carbon footprint of the premises should be taken when considering the engineering services.

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In traditional design, heating, cooling, ventilation, lighting, electrical power and domestic hot water were all considered in isolation. A more integrated approach as suggested below may provide an efficient design with a lower environmental impact.

- Roof and /or facade mounted solar panels to produce electrical energy.
- A battery storage system with the facility to sell excess power to the incoming main.
- Low energy light fittings with movement or illumination level sensors.
- A heat pump (air to water, ground to water or water to water).
- A thermal store supplied by the heat pump and serving an underfloor, radiant ceiling or air handling system to provide heating or cooling to the premises.
- A calorifier fed by the heat pump with supplementary immersion heater to supply domestic hot water.
- Ventilation by natural or mixed mode methods. Powered ventilation only where required for the control of airborne infection of specialised equipment environment control.
- Incoming electrical mains to provide back up and receive excess electrical power.

Other scenarios using wind generation or exploiting local waste heat sources may be possible. As the premises in question are generally not continuously occupied, there is an opportunity to build up and store energy for use when it is occupied and reduce costs by selling the surplus.

Note that if the above approach is taken then it needs to be integrated into the architectural design process, whether a new building or refurbished premises. It may not be possible to successfully add it in later.

The engineering performance of the premises should be metered and monitored by a Building Management System (BMS) that can be remotely accessed by the “off site” contracted support.

Parts of the premises may be sub-let to outside services such as a coffee bar or commercial physiotherapy provider, the engineering inputs to these areas should be metered so that the costs can be recharged.

Internal environmental conditions

The primary objective is to maintain a comfortable environment for the patients, staff and visitors. In general areas a temperature in the range 18-22°C and humidity between 30-70%RH will be suitable. In examination and treatment rooms where patients may have to undress a temperature range of 20-23°C will be required.

Natural ventilation is preferred but where this is not possible, mixed mode ventilation i.e. air input through controlled openings with fan assist as required by the internal temperature and / or occupancy level. Where powered ventilation is required it should be justified on the basis of airborne infection risks or the requirement for stable environmental conditions for specialised diagnostic equipment. See HTM 03-01; Part A; for guidance on ventilation.

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Natural daylight but shaded from direct solar effects is preferred, supplemented by low energy fittings with illuminance level sensors in general areas. All other rooms to have low energy light fittings with occupancy sensors. In rooms with scanning equipment display monitors, it should be possible to dim the lights.

Engineering services

General considerations

Engineering plant and equipment should be located internally in dedicated plant rooms or spaces that are effectively secured from unauthorised access. Plant should only be located on a roof if it is within a lockable plant room. If the plant or equipment has to be outside to operate efficiently e.g. a chiller, it should be completely secured from access by unauthorised persons.

Sufficient space should be allowed around plant and equipment for it to be safely accessed, inspected and maintained. Provision should be made for the safe storage of spares and consumable items.

The distribution of services to final points of use should be concealed in walls, floors and above ceilings. Where this is not possible the services should be encased so as not present any ligature points and have a smooth cleanable surface.

Using ceiling voids as supply or return air paths or plenums is not permitted.

All services entering rooms potentially containing radiation must be routed through specially designed access points so that shielding is compromised as little as possible. See HBN 06-01 Facilities for diagnostic imaging and interventional radiology for details.

Devices for the control and safe isolation of engineering services should be:

- located in circulation rather than working areas;
- protected against unauthorised operation;
- clearly visible and accessible, where intended for operation by the department clinical staff.

Where engineering services penetrate the exterior or interior fabric of the building the point of entry should be sealed to prevent water penetration and uncontrolled air leakage.

Engineering services that need to be accessed for routine service and maintenance should be located in plant or staff only areas. If the access point has to be in a general area it should be via a lockable low air leakage access hatch or removable panel.

Electrical services

Electrical services should be designed in accordance with HTM 06-01 and agreed with the client's Electrical Safety Group (ESG).

The design process should consider, but not be limited to, the following:

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- normal electrical supplies and their resilience;
- emergency electrical supplies;
- electrical interference;
- uninterruptable supply units (UPS);
- isolated power supplies (IPS).

The risk having regard to the specific clinical room function should be assessed.

Designers should ensure that the electrical loads are balanced across the infra structure network and that there is sufficient capacity to meet current and potential future demands.

Provision to connect a mobile emergency generator in the event of a local mains power failure should be considered.

Lighting

The use of as much natural daylight as possible will help in creating a bright and airy feel to the space. Where natural light is not available through conventional means, consideration should be given to technologies such as artificial skylights, light pipes, etc..

Low energy artificial lighting should be provided as required. The use of illumination level and / or occupancy sensors to automatically turn down or switch off lights will reduce energy consumption.

Rooms where patients have to lay down should have light fittings that prevent them looking directly into bright light sources.

The lighting in rooms containing diagnostic imaging viewing monitors should be dimmable.

Mechanical services

Heating, cooling, ventilation and air conditioning

The heating and cooling provision in the premises should be achieved be either an underfloor system, a radiant panel ceiling or a tempered air ventilation system.

A ventilation system should be designed in accordance with HTM 03-01 and agreed with the client's ventilation safety group (VSG). The first choice should always be natural ventilation, followed by mixed mode or assisted natural ventilation, powered tempered air ventilation and finally full air conditioning.

Air conditioning should only be provided in rooms or areas that have a clinical airborne infection risk or that contain equipment that needs to be kept in stable conditions to ensure it remains in calibration. In such rooms there should be a clear indication that the ventilation is operational or not, together with a means of adjusting the temperature within the design limits.

If fan coil units are selected they should not be located above fixed equipment such as scanners and must be fully accessible for routine service and maintenance. All air connections to the fan coil unit

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should be fully ducted and the ceiling void should not be used as a plenum for either the supply or return air path.

Domestic water services

Domestic water services should be designed in accordance with HTM 04-01 and agreed with the client's Water Safety Group (WSG).

Above ground drainage

Provision for inspection, rodding and maintenance should ensure "full bore" access and be located to minimise disruption or possible contamination. Manholes should not be located within working areas.

The choice of drainage material and method of installation should be full specified and not left to the discretion of a contractor.

Medical gases

Medical gas services should be designed in accordance with HTM 02-01.

The range of gases, location and number of terminals and system capacity should relate to the clinical needs. The provision of medical gasses and design of the system should be in conjunction with the client's medical gas safety group (MGSG)

Medical gas cylinders should be located where they cannot be tampered with, vandalised or stolen.

Security

Local security policies should determine at the planning stage the level of security to be provided.

The safety and security of staff when the building is in use should be assessed and suitable provision made to mitigate the risk.

When the building is unmanned, the design features necessary to prevent unauthorised entry, vandalism and theft should be assessed. If CCTV is provided in order to help deter or identify miscreants, the cameras and their cabling should be protected to prevent vandalism or deliberate attempts to disable them.

Controlled drugs should be stored in a secure facility connected to an alarm system.

Integrated communication services

These include internal and external telephone, nurse call systems, room occupied indication, hands-free intercom systems, information and entertainment systems. The extent and specific requirement for such systems should be agreed with the client and designed in accordance with HTM 08-03.

Cabling for these systems should be protected from electromagnetic interference.

Secure Wifi for staff use and open access Wifi for patients and visitors should be provided throughout the premises.

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Closed circuit television (CCTV) may be required to monitor patients in scanning rooms.

Information technology (IT)

Designers should consult with the client's IT team to identify requirements. These are likely to include the need to access centrally held electronic records and information supporting:

- the appointment booking system;
- patient arrival sign in system;
- staff access to patient medical records;
- picture archive and communication systems (PACS);
- diagnostic information database;
- drug and medicine database;
- building management information, records and services;
- Etc.

Fire

Addressable fire detection systems should be designed in accordance with HTM 05-02 and the wider fire strategy for the premises in agreement with the Fire Officer and Local Fire Brigade.

Commissioning and validation

The engineering services should be commissioned by the contractor and their performance independently validated by the client's appointed Authorising Engineers.

Flow measurement and proportional balancing of air and water systems require adequate test facilities to be incorporated at the design stage. Guidance is contained in the appropriate HTM and Commissioning Codes published by the Chartered Institute of Building Services Engineers (CIBSE) or the Building Services Research and Information Association (BSRIA).

Where specialised medical equipment such as that used for diagnostic imaging is installed, preliminary commissioning of the equipment may need to take place prior to handover of the area that it occupies. Note that final proof of performance of such equipment can only be undertaken once all of the contractual works are complete and the building and its services have been validated and accepted by the client.

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Appendix 1: HBN guidance and the business case process

All schemes will need a business case to justify the need for NHS resources. The most up to date approvals process can be found on the NHS England and NHS Improvement website https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/.

This appendix describes the business case process and sets out the main issues to be considered by project teams at each stage, including links to the relevant parts of this HBN. The aim is to show how elements of this HBN fit into the flow, rather than to be prescriptive about the process. The business case process is illustrated at Figure 16.

Hyper-linked hexagons (with tools such as a space calculator) which are used throughout this appendix can be accessed from the NHSI website at http://www.XXXX

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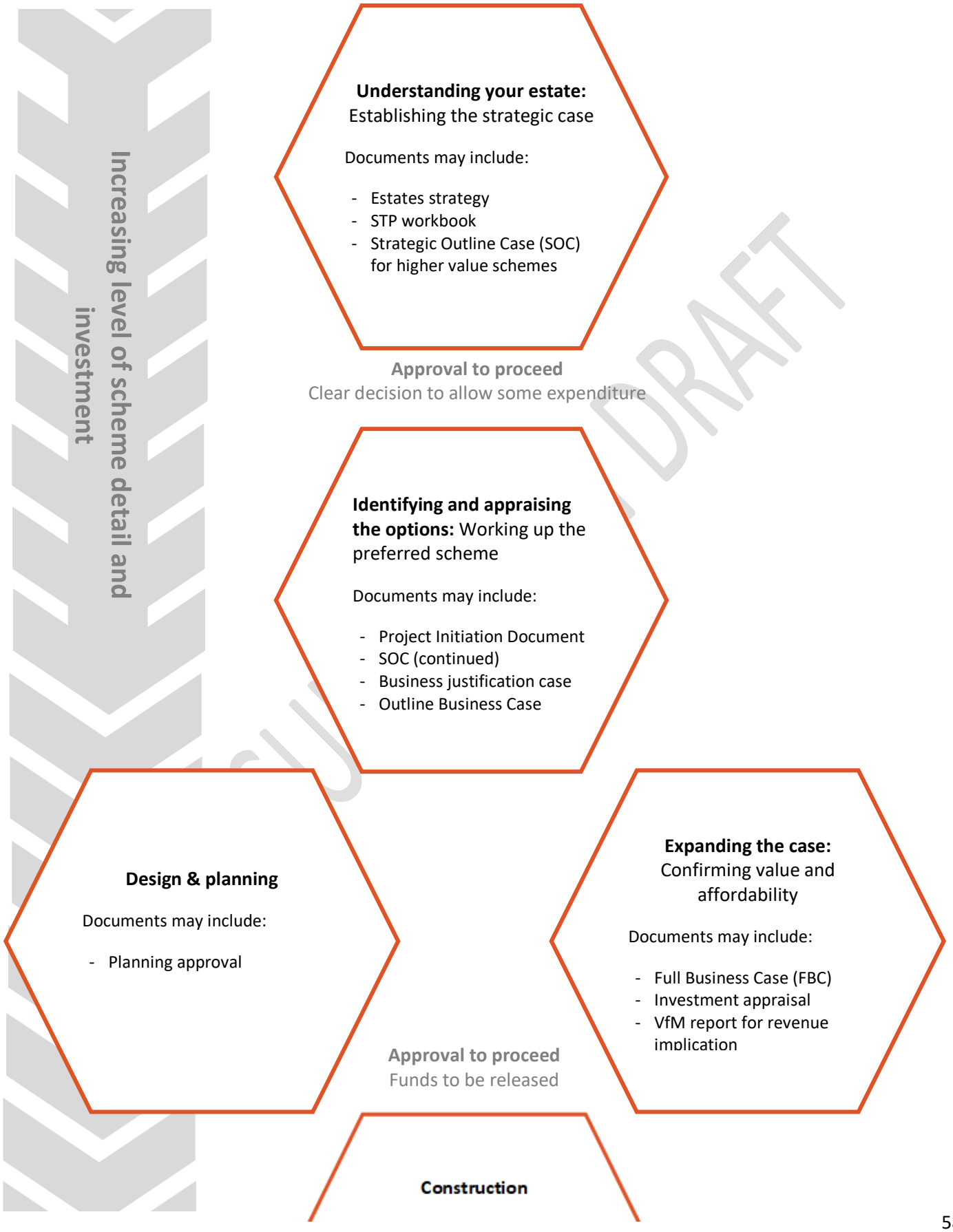
Figure 16: Approvals flow diagram



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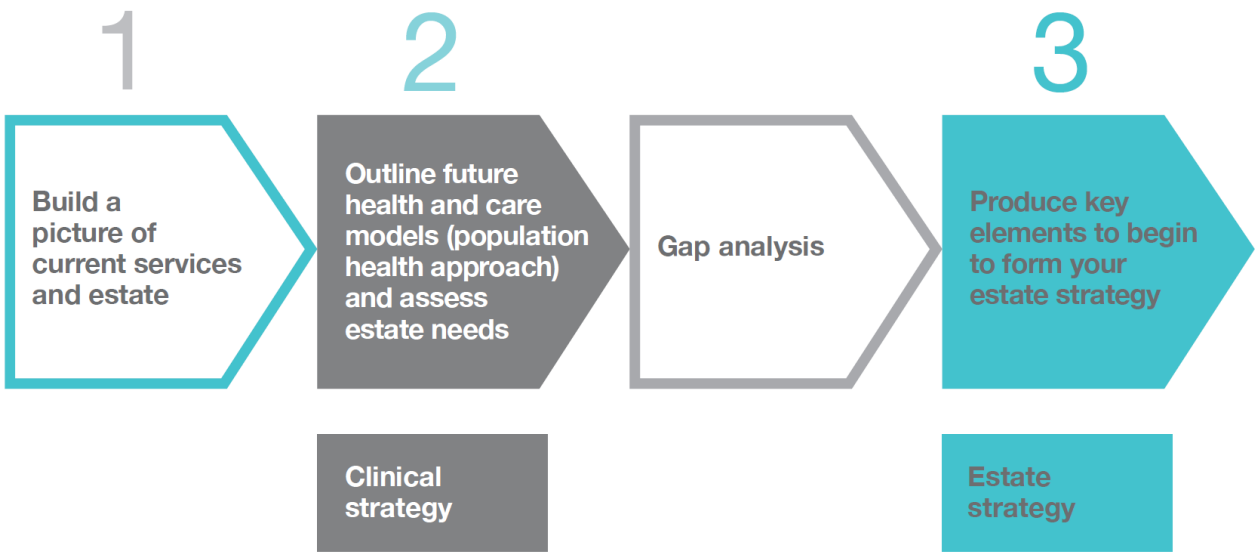
Understanding your estate: Establishing the strategic case

The ultimate objective of modern primary and community care facilities is that they support and enhance the provision of high-quality, integrated health and care services. Useful background documents to be aware of with respect to this are The General Practice Premises Policy Review[xv], and the Naylor Review[xvi], as these identify some of the issues effecting the NHS estate.

NHSE/I regularly collate information on leases, utilisation, available space, and condition and this should be made available through the Strategic Health Asset Planning and Evaluation (SHAPE)[xvii] platform to inform strategic planning.

Primary Care Commissioning Organisations and care providers should work collaboratively to develop a clear picture of their estate in their local area. In the document Primary care networks: critical thinking in developing an estate strategy[xviii], a three-step approach (Figure 17) to help networks embark on estate discussions and development of an estate strategy is recommended.

Figure 17: Three-step approach to developing a PCN estates strategy



Primary care networks: critical thinking in developing an estate strategy, P4

An estate strategy will provide the rationale for recommendations, and planning tools such as SHAPE[xix] can be used to support the planning of services and assets. Additionally, it is important to understand at an individual building level, the current room usage of an existing primary care facility. This can be easily achieved through a room utilisation audit using a basic template as seen below.

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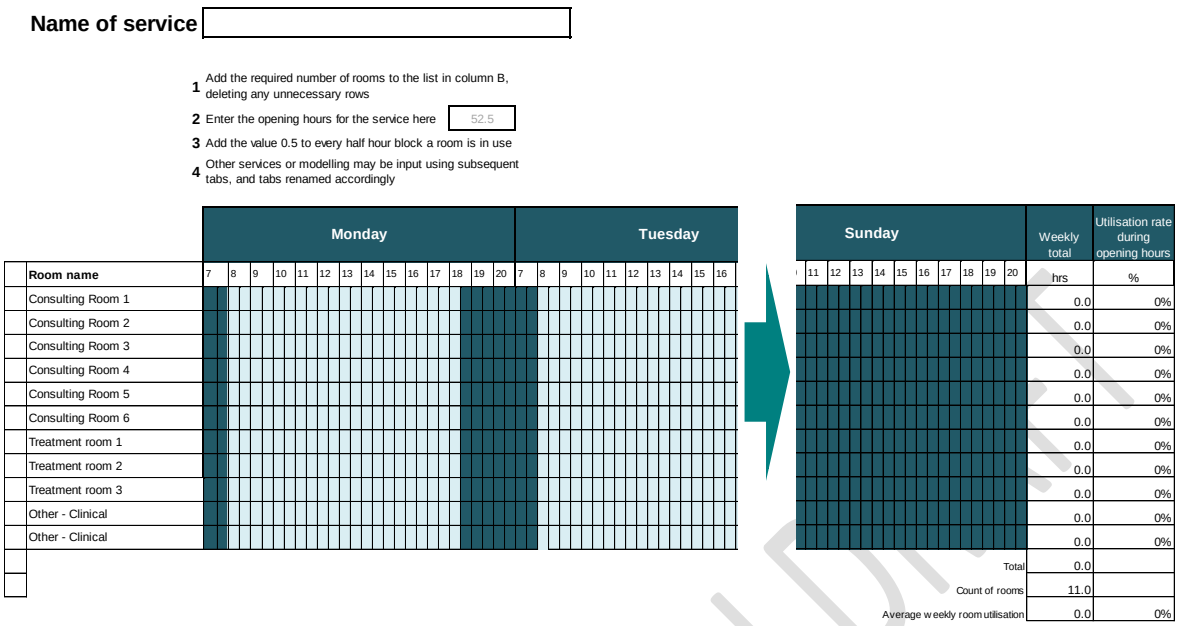
Figure 18: Room utilisation template



An electronic version of this is available at the NHSE/I portal.

[DN: Link included here temporarily]

Room utilisation template.xls

Case study

Work needs assessment @ Lennard Road, Croydon

Stages:

- Determine the spatial requirements of the tenants
- Review occupancy arrangements
- Assess business needs – engage with stakeholders
- Assess workplace utilisation – OccupEye, benefits but limitations
- Develop workplace solutions – help to deliver agile work programme, culture change
- Report on findings

Objective:

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Deliver more efficient and higher-quality estate which meets the operating needs of the occupants and delivers the CHCP partnerships objectives.

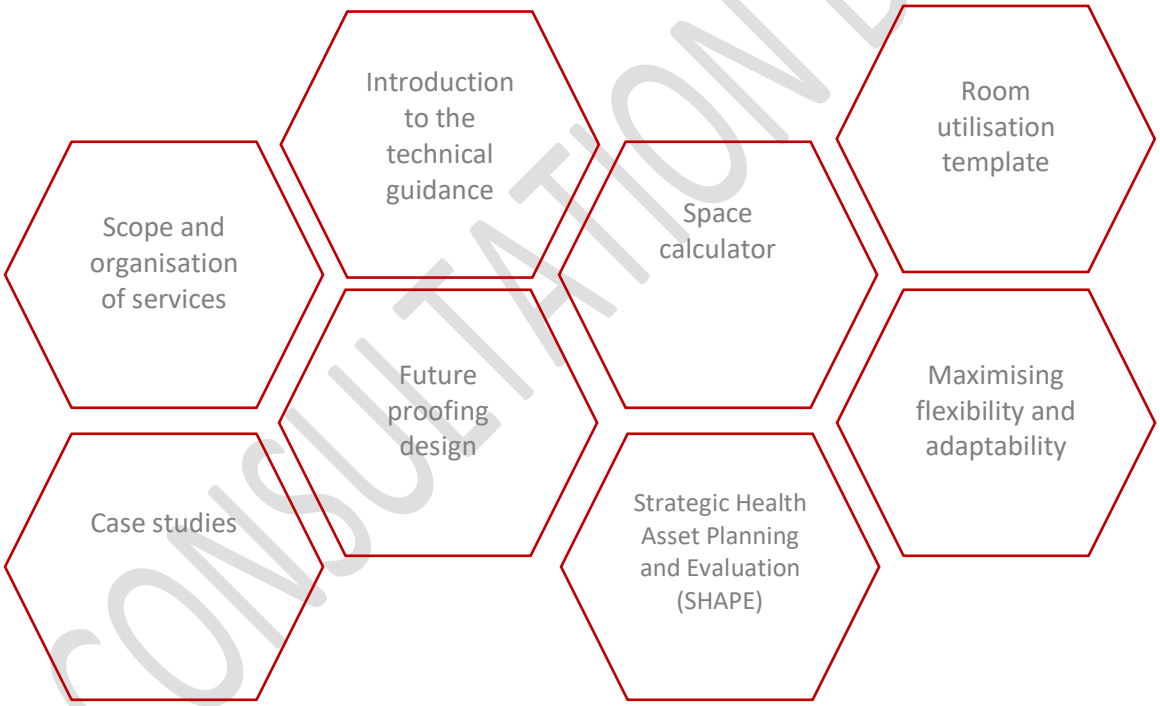
Further details are available at case studies supplement A.

Funding

Most community and primary care facilities will be funded through capital investment from government resources or third-party developers. Revenue costs for GMS facilities can be funded via the NHS (General Medical Services – Premises Costs) Directions 2013[xx], through reimbursement of rent. Any case for funding will be required to include a clear breakdown of funding streams as well as the value of any loans or grants involved.

Approval of revenue funding will have different requirements to capital funded schemes. Separate provision for testing the Value for Money (VfM) of the rental tone will not usually be required beyond a DV's (or other independent valuer's) report.

Establishing the strategic case: HBN Tools and guidance



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Establishing the strategic case: Wider reading and supporting documents

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Identifying and appraising the options: Working up the preferred scheme

Space requirements for integrated and/or co-located services should be determined through discussion and collaboration with relevant providers and other stakeholders at an early stage of any development.

This stage will involve the establishment of a professional team to support the business case and premises development through to completion.

At this stage, a team of stakeholders including patients, PCCO and provider/contractor representatives, a healthcare planner, District Valuer and project architect. Consultation with other potential providers including third sector and voluntary organisations, and existing clinical and non-clinical staff to collate their input on proposals should also be carried out. This can be achieved to great effect through existing GP practice patient participation groups, as well as questionnaires, public meetings, and structured interviews.

Potential stakeholders should be treated as development partners or tenants. Such a partnership approach will provide benefits including:

- A strategic approach to service development and integration.
- Improved collaboration on the development of space and design solutions which promote integrated methods of working and improved patient flows.
- Engagement of the partners in health equity audits and health impact assessments.
- Sharing of data and expertise.

Consideration of at least the following issues will be necessary at this early stage:

- Will voluntary sector users be charged for using the space, and if so, is this at a commercial rate or a nominal one, with the balance being borne by other stakeholders?
- To what extent should co-located services be self-contained or integrated?
- How should they be branded? As part of the overall building, or should they express their own identity, separate from that of the NHS?
- Can staff share rest, changing and administration facilities?
- How long will each lease or licence be needed on the space? What alternative uses could this space have in the future?
- What future expansion space and/or flexibility is needed?
- How will engineering services in the building need to be organised? Will there be separate metering and billing?
- How will the IT be networked in the building (for example shared hub room)?
- How can the building be designed to allow operation of different parts of the building at different times, particularly during times of national emergencies such as a future pandemic? Further guidance is available in HBN 00-07 Planning for a resilient healthcare estate.
- How can the different design, construction, and operational standards for healthcare delivery aspects of the building be communicated in the client's brief?

Service brief

It is important at an early stage to focus on the key information required to test the feasibility of a proposal and any proposed new ways of working, as follows:

- The functional content of the scheme: A simple statement identifying the vision for the service and listing the range and scope of services to be delivered.
- New models of care, including a description of service standards and how they will be organised and measured.
- Identification of stakeholders.
- Current and anticipated population and health needs.
- Anticipated activity levels.
- Operational assumptions such as opening hours, average duration of appointments, target utilisation etc.
- Workforce capacity, identifying required whole time equivalent (WTE) staff working in various settings.

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This information will be brought together for each potential service in the form of a service brief [DN: Template to be developed as part of web resource to ensure it can be updated as required]. This is a date-tracked document that will require formal sign-off before it is used to generate a briefing schedule. It will be an iterative document, being updated and modified as more detailed information appears and as stakeholder commitment is confirmed.

Briefing schedule

Once a strategic plan and service brief have been prepared, a briefing schedule can be generated, as detailed in Chapter 5. This will set out the requirements for the premises solution and predict, within acceptable bounds of accuracy, the likely size of any new development.

The schedule should be created early in the development to avoid any abortive work.

Identifying a preferred option

In conjunction with other information, the briefing schedule will enable a range of potential physical solutions to be identified and evaluated:

- Against the strategic objectives identified.
- In terms of site fit and local authority planning policy: Advising on the approximate area of the building, which in conjunction with a high-level knowledge of local planning policy objectives (relating to use, siting, massing, access, sustainability, landscape etc.) can be used to decide on likely numbers of floors, orientation and the ability to provide on-site parking etc.
- To test potential to deliver appropriate design standards: Any preliminary building solution that appears as part of testing for site-fit can be evaluated against high level strategic and functional design issues (for example, inclusive design and sustainability criteria) to establish whether the potential site is likely to have the characteristics to deliver a scheme that meets acceptable design and organisational standards.
- For affordability and value for money: The approximate capital and/or revenue cost implications of any development can be established from the briefing schedule. This, combined with the staffing numbers from the service brief and information about the likely development stakeholders, can be used to establish options for the scheme's procurement, affordability, and value for money.

These options should then be tested qualitatively as part of a desktop options appraisal early in the scheme development. This will test the preferred/viable options against strategic requirements and the service brief.

Once funding has been approved in principle, it will be important to expand the desktop appraisal to test the decision-making process through detailed appraisal with stakeholders.

Scoring criteria and its weighting will be agreed and applied to each option. Compliance with this HBN will be an important criterion to consider. [DN: Include an example option appraisal on HBN web portal]

Compliance with statutory requirements

Any preferred option(s) must also provide assurance of compliance with:

- HBN11-01 ☐

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- All relevant HBNs and HTMs ☐
- Equalities Duty ☐
- Infection control requirements ☐
- Greener NHS and Net Zero ☐
- NHS wayfinding guidance ☐
- Firecode compliance[xxi] ☐

Further details of compliance will be required later in the business case process.

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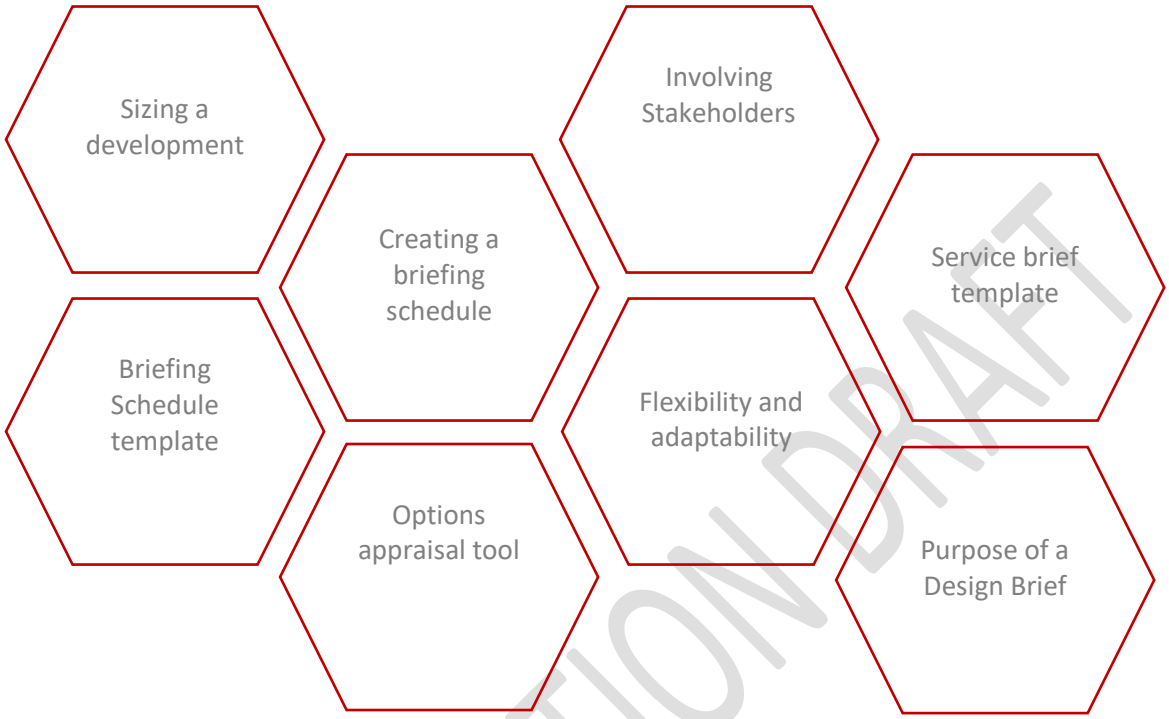
Identifying and appraising the options: HBN Tools and guidance

[NB: To be hyperlinked to relevant sections and web resource]



Identifying and appraising the options: Wider reading and supporting documents

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Expanding the case: Confirming an affordable and value for money scheme

Approval to proceed to Full Business Case (FBC) will mean a project team can be reasonably confident that funding will follow and so can invest further resources at risk in more detailed planning, design, and consultation as part of an FBC.

This stage will involve a professional team as above, with the addition of any newly confirmed contractors/tenants/services, landlord(s) and the developer.

To ensure a suitable solution is agreed, consultation on plans should be conducted with a wide range of stakeholders including:

- a working group of staff and patients (potentially via a Patient Participation Group);
- the wider patient population and local community;
- other local providers of health and social care;
- local elected representatives such as councillors and the MP;
- Health and Wellbeing Boards;
- Local Overview and Scrutiny Committees.

Contractors and construction professionals will also be involved. Once plans are agreed, the construction contract will be put out to tender to confirm actual costings compared to affordability assumptions made earlier in the process.

Planning and Highways departments will continue to be consulted on plans. A letter of support should have been sought prior to progression of the preferred option through the FBC process.

This stage of the process should:

- provide a narrative and justification for how and why the proposed scheme has been selected;
- detail how the scheme best meets the needs of the population and service brief;
- confirm that the scheme is affordable and offers value for money.

Adherence to the technical guidance provided in this HBN should be referenced.

An FBC should clearly identify funding source(s) and conclude with a recommendation for funding to be released. This may be subject to final planning approvals depending on the scale of the scheme.

Preferred options: Working up the detail

A detailed design brief/briefing schedule and specification will be agreed, including a schedule of accommodation (SOA) [NB: SOA template to be developed as part of space calculator and/or web resource] based on HBN sizing guidance and standardised room sizes and layout.

The brief will include reference to:

- access and inclusive design;
- patient and community consultation;

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- innovation to meet local need;
- innovative use of limited space;
- integrated working;
- futureproofing;
- IM&T;
- sustainability and For a Greener NHS;
- service resilience and business continuity;
- BREEAM requirements.

Based on the SOA and zoning guidance, designs will be worked up for the proposed projects between the architects, providers, developers, and PCCO/commissioners, in liaison with other building users. 1:50 scale drawings must be included within the FBC.

Depending upon the procurement route, this will be the time to put the project out to tender or provide details of the proposed tendering arrangements for construction

The Treasury's five case model

The precise requirements of this process should be proportionate to the scope and scale of the project being considered. Business cases should provide appropriate levels of information depending on the quantum of investment involved and whether it is predominantly an NHS capital or revenue project, the latter of which is frequently led by a third-party developer who will carry the majority of the investment risk. A small project is defined as under £1 million in capital value, a medium project is £1 - £3 million, and large greater than £3 million[xxii]. However, these figures are subject to change so should be checked with your PCCO at the time of preparing an FBC. The amount of detail provided within a business case should be proportionate to the size of scheme.

The five case model process provides quantitative and qualitative data that allows proposals to be broadly viewed from five interdependent dimensions. These provide the agreed standards for business case approvals, as set out in the NHS Executive Capital Investment Manual and The Green Book: Central Government Guidance on Appraisal and Evaluation.

Lease

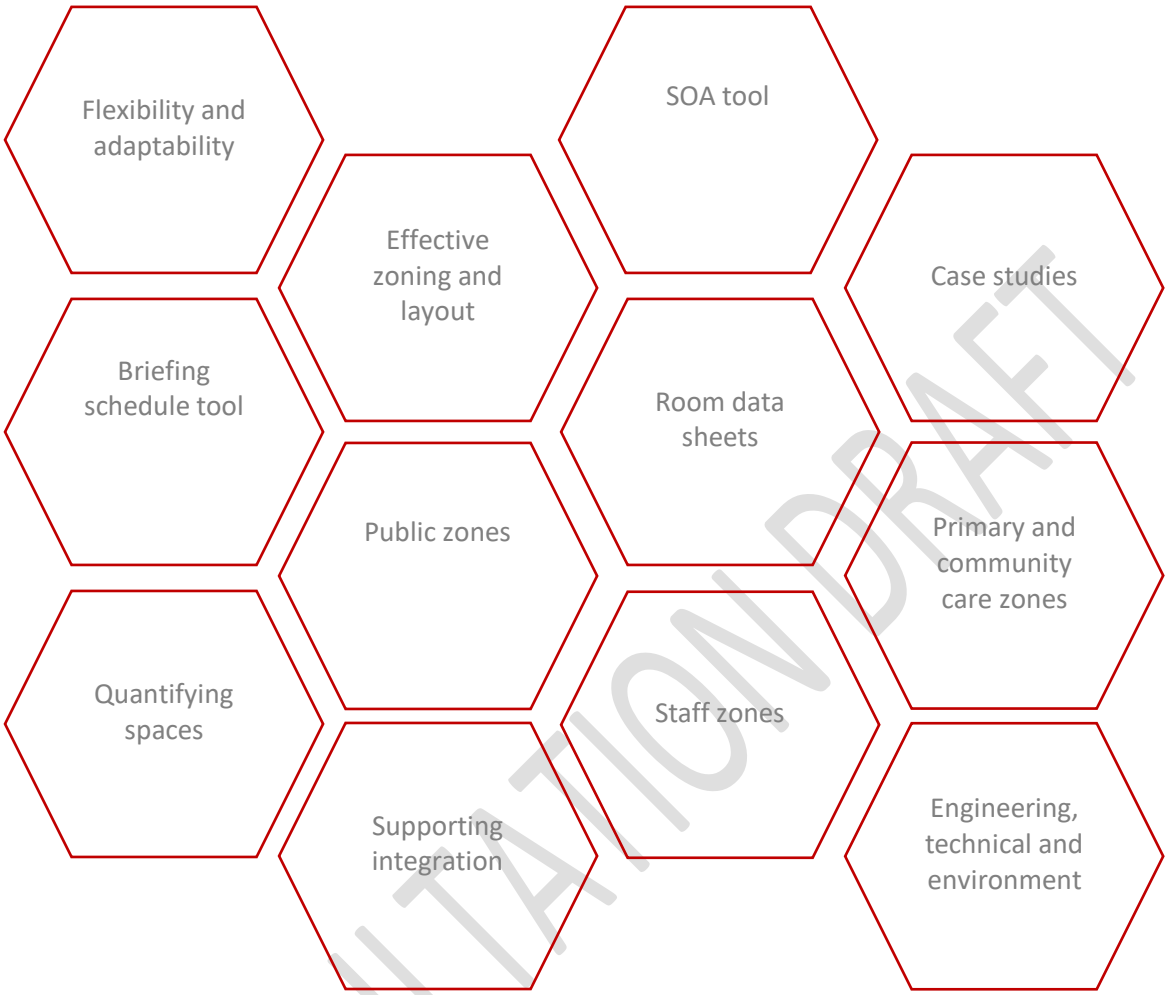
Having provided agreed Heads of Terms and near-final lease documentation within the FBC submission, relevant parties should provide assurance of their intention to enter an NHS compliant lease for a period recommended by the District Valuer.

The BMA has developed a template lease for GP premises which is available on their website. It is important to note that the agreed lease is a template only. All GP practices should seek their own legal and professional advice to ensure that the terms are right for them. The template lease will be different if you are taking a lease for a whole building. The core principles still apply.

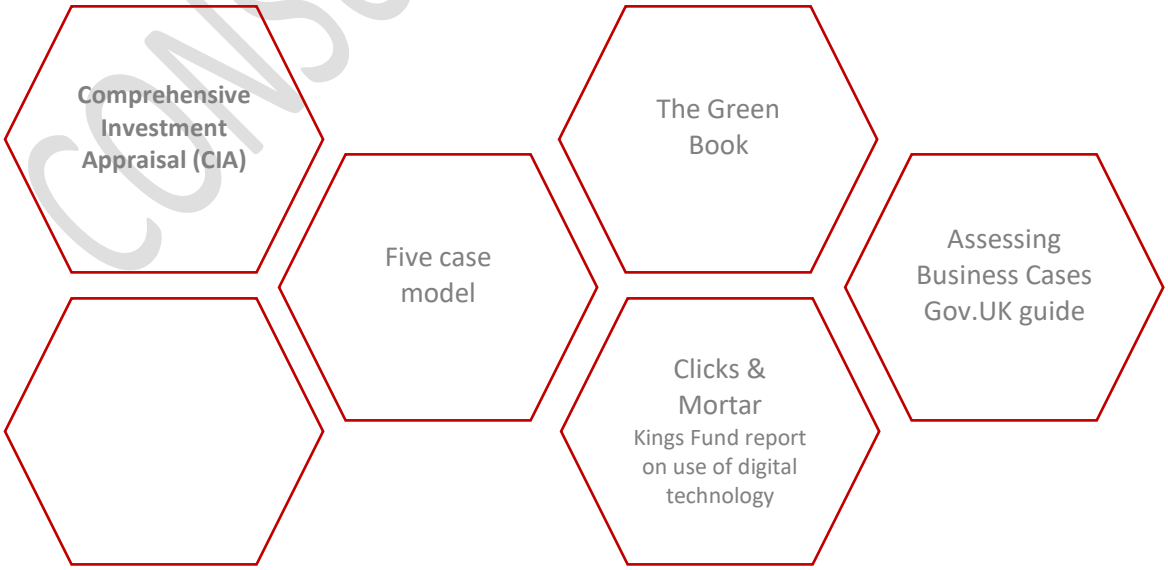
CONSULTATION DRAFT

Approval in principle and FBC: Tools and guidance

[NB: To be hyperlinked to relevant sections once document combined]



Approval in principle and FBC: Wider reading and supporting documents



CONSULTATION DRAFT

Design and planning

The design and planning stage is likely to involve PCCOs and integrated care organisations, developers, landlord(s), architects, engineers, planning and highways departments, construction professionals and contractors in close liaison with prospective tenants.

It will involve developing the final working drawings and gaining planning permission. A briefing paper may be submitted to the PCCO to provide details of the final design, detailed timescale and delivery/mobilisation plan, an updated risk registers and recommendation to proceed to construction.

Design considerations

The design of most spaces within primary and community care buildings will be driven mainly by functional considerations. In the public zone and the external expression of the building, however, there are opportunities to create special places through the careful use of scale, materials, colour, signage, sound, scents, and lighting.

HBN 00-01 provides general design guidance in respect of these. Although mainly applicable to adult acute in-patient healthcare facilities, it recommends many principles that are relevant in a primary care environment.

The following sections expand on HBN 00-01 to provide more specific primary and community care guidance.

Consultation on design

The lead architect should lead on consultation during the design process. This will be an iterative process in which plans are discussed collaboratively with those who will be using the space in the first instance, as well the project management team. Consultation with patients is also recommended through engagement meetings, social media, questionnaires, and publication of designs on organisation websites, and in public waiting areas.

IM&T and digital innovations

Digital innovation is changing the way services are being delivered, and this will have an impact on how space is designed and used. For more details see chapter 4.

For a greener NHS and net zero carbon

See greener NHS section in chapter 2.

Accessibility and inclusive design

Inclusive design aims to remove the barriers that create undue effort and separation. It enables everyone to participate equally, confidently and independently in everyday activities[xxiii].

Good design should reflect the diversity of people who use it and not impose barriers of any kind. Design which promotes equality, dignity and respect is one of the fundamental standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, tested through CQC assessment. This includes ensuring people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous and independent. To achieve this, design teams must have due regard to the protected characteristics as defined in the Equality Act 2010.

CONSULTATION DRAFT

Meeting access needs should be an integral part of what primary and community care facilities do every day. Detailed guidance on accessibility may also be found within the Building Regulations 2013 and Approved Document M. Access to and use of buildings, Volume 2 – Buildings other than dwellings.

Wayfinding is also a crucial element of inclusive design which is covered in 'Wayfinding' (NHS Estates 2005) and Health Building Note 00-04 – 'Circulation and communication spaces'.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15

Care Quality Commission (CQC) requirements for primary care are set out in Regulation 15 – Premises and Equipment, and compliance will form part of the CQC's assessment of any new CQC registration application.

The CQC requirements are, for premises to be:

(a) clean
(b) secure
(c) suitable for the purpose for which they are being used
(d) properly used
(e) properly maintained, and
(f) appropriately located for the purpose for which they are being used.

Guidance on criteria and compliance standards can be found on the CQC website.
Further guidance on the above may be found in HBN 00-09: Infection control in the built environment. Infection control teams should be consulted from the outset of any project and should form part of the planning team.

With regards to security, all schemes should be considered against the criteria set down by the Secure by Design initiative which covers the public realm in and around the building. Larger schemes will require a formal application and sign-off of achievement.

Emergency preparedness

See emergency preparedness section in the Introduction.

Art and integrated design

Art within primary and community care sites should work with the building and landscape design to create a positive therapeutic environment and support wayfinding.

A 2019 World Health Organisation (WHO) report (The role of the arts in improving health and well-being in the WHO European Region) identified a major role for the arts in the prevention of ill health, promotion of health, and the management and treatment of disease. It found that the beneficial impact of the arts could be furthered through supporting collaboration and stronger pathways between the arts, health, and social care.

On larger projects it may be beneficial to appoint an arts co-ordinator at an early stage to ensure that a comprehensive arts strategy is established, and that artwork is properly integrated into the building fabric and wayfinding strategy.

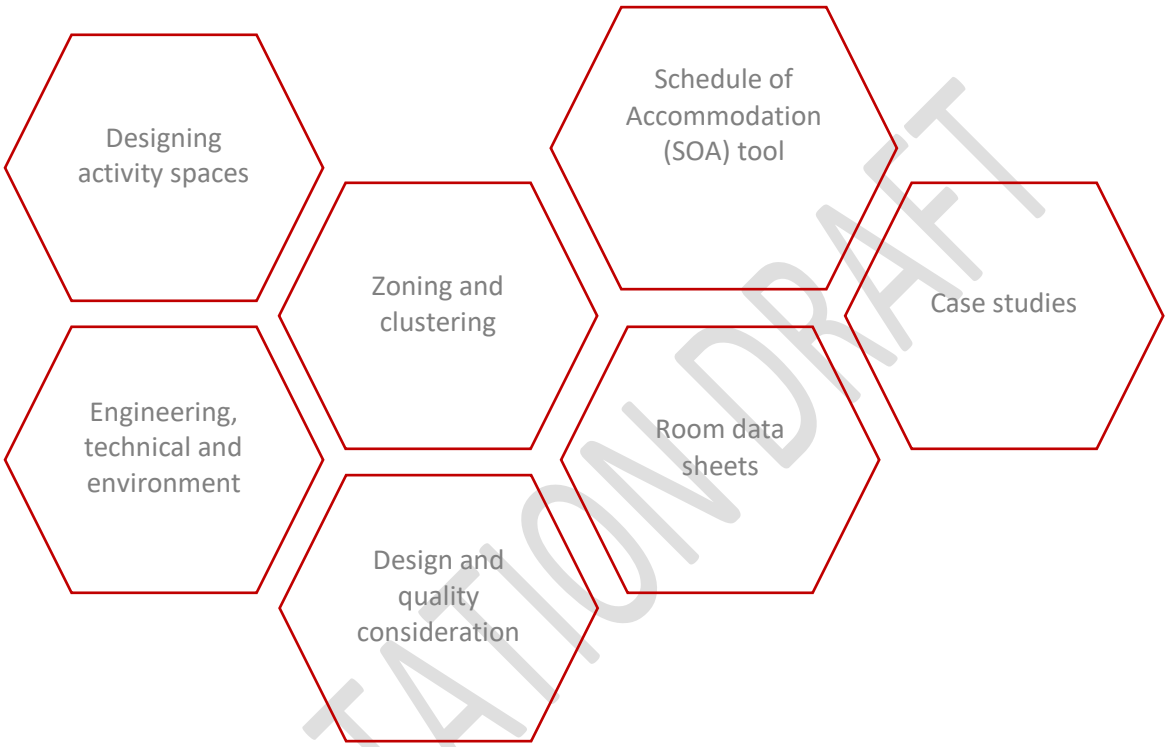
The possibility of involving the local community in the production of artwork should be explored. The Arts Council provides guidance and routes to funding for projects which promote arts and culture.

CONSULTATION DRAFT

NHS identity

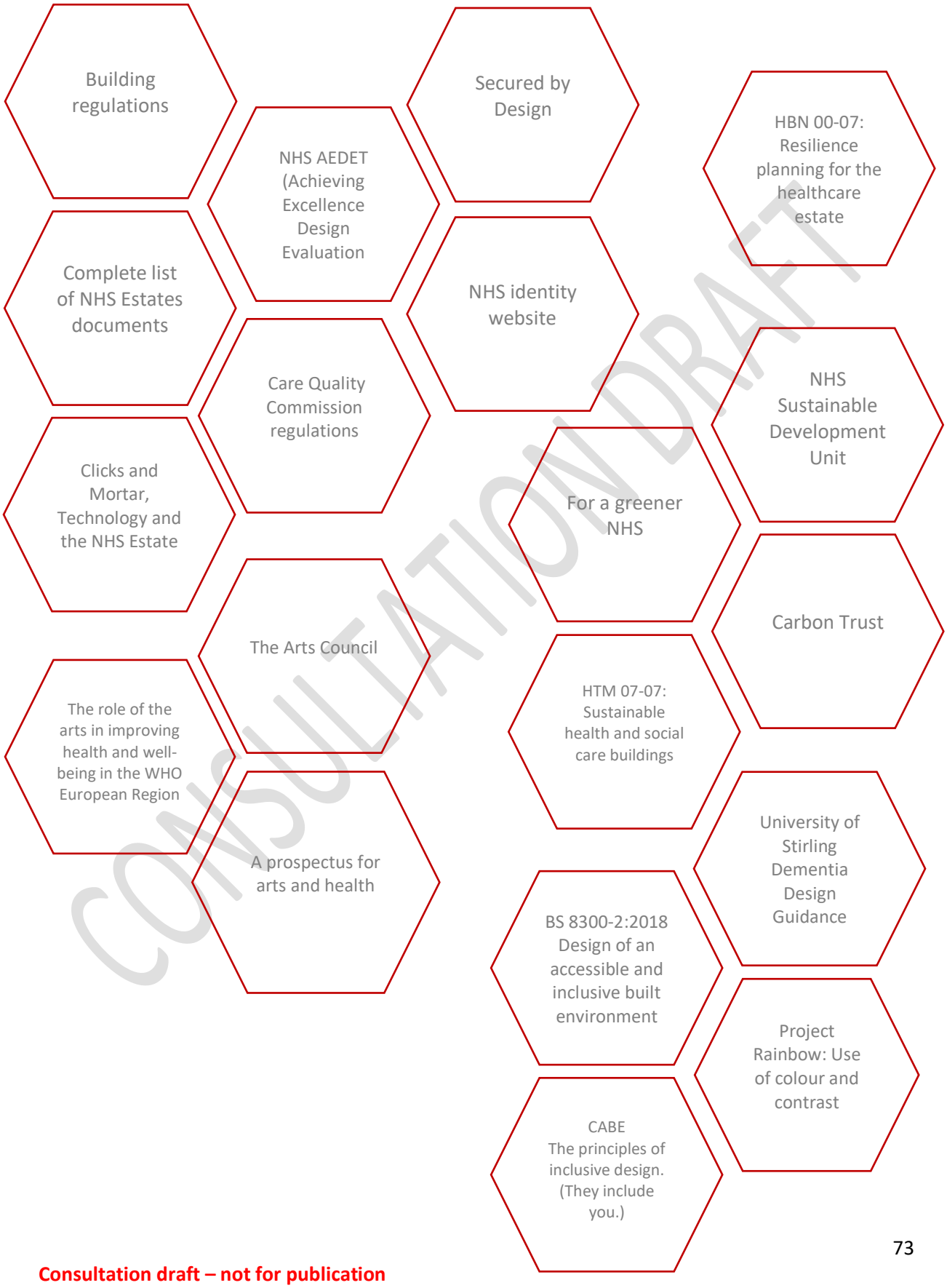
All users of the NHS Identity have a responsibility to protect it. Information and identity guides on NHS branding can be found on the NHS identity website. Final decisions on branding should be made locally, in conjunction with all project stakeholders including NHS and non-NHS organisations.

Progressing through design and planning: HBN Tools and guidance



CONSULTATION DRAFT

Progressing through design and planning: Wider reading and supporting document



CONSULTATION DRAFT

Construction

This stage of the process is likely to involve a team including PCCOs and integrated care organisations, developers, landlord(s), architects, engineers and planning and highways departments in close liaison with prospective tenants.

Project management and mobilisation team meetings will be scheduled regularly to monitor progress against expected timescales and budgets.

Reference to this HBN will be minimal by this stage unless there are changes to the design which would require further approvals.

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Appendix 2: Delivering outpatient activities in primary care settings

The areas in Table 1 should be considered as indicative of the clinical services and/or follow up appointments that can be delivered in primary care when suitable primary care facilities are available. This list of services cannot be prescriptive as commissioning arrangements are dynamic with, for example, block contracts being replaced, more tariff prices being unbundled, and clinical pathways updated.

Services would be delivered by consultants visiting a practice on a sessional basis to undertake outpatient appointments.

By completing the current hospital tariff and activity column (A) and proposing the future primary care cost and activity figures (B), a potential saving column (C) can be calculated

Table 1: Example outpatient activities which may be brought into general practice

	A	B	C (= A - B)
Treatment function name	Estimated cost of activity based on hospital tariff (£)	Estimated cost of activity based on primary care costs (£)	Potential saving (£)
Trauma & Orthopaedic follow-up			
General Surgery follow-up			
Urology follow-up			
Pain Management			
Neurology			
ENT			
Cardiology			
Paediatrics			
Colorectal			
Ophthalmology			
Gastroenterology			
Diabetic Medicine			
Dermatology			
Gynaecology			
Respiratory Medicine			
Rheumatology			
Vascular surgery			
Total			

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Examples of other activities that can be brought into a GP facility to generate savings from tariff prices can be seen in Table 2.

Table 2: Additional activities

NHS Health Checks
Telemedicine facilities
Improved minor surgery, including Carpal Tunnel Injections
Minor Injuries
Long term contraceptive services
Psychological therapies/counselling
Foot care Adviser for Diabetic patients
Fast Track Occupational Therapy
Physiotherapy treatment services
Midwife/Health visitor activities
Diagnostic Services
Frail & elderly Substance Misuse and Shared Care

Other services which extended facilities will be able to provide which are likely to yield less direct savings include:

- obesity and healthy living clinics;
- centre of excellence for care of older patients;
- memory clinics;
- stretch and strength classes.

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Appendix 3: Primary and community care room directory

The directory below matches services to room type based on an understanding of the activities involved. [Table still under review.]

Primary and community care service activity	Minimum recommended room type		
	Generic room (possibly with some specialist equipment or minor modifications)	Specialist room	HBN reference
Acupuncture	Examination/therapy room*		HBN 00-03
Aromatherapy	Examination/therapy room*		HBN 00-03
Arts and craft therapy	Group room		HBN 00-03
Baby clinic	Large group room		HBN 00-03
Benefits advice consultation	Interview room		HBN 00-03
CAMHS interview and counselling (individual)	Interview room		HBN 00-03
Chemotherapy treatment	Examination/therapy room*		HBN 00-03
Chiropody/podiatry	Treatment room		HBN 00-03
Citizens advice bureaux consultation	Interview room		HBN 00-03
Consultation and examination	C/E room		HBN 00-03
Continence consultation and treatment	Treatment room		HBN 00-03
Contraceptive advice and dispensing	C/E room		HBN 00-03

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Contraceptive advice and fitting	Treatment room		HBN 00-03
Dental recovery	Sitting recovery area or reclining recovery room		HBN 00-03
Dental surgery		Dental treatment room	Not yet available [DN: QUESTION FOR REVIEWERS - This is still not available – could we assume all around access consult/exam room 00-03?]
Diabetes consultation and treatment	C/E room		HBN 00-03
Dietetics consultation (group)	Group room		HBN 00-03
Dietetics consultation (individual)	Interview room		HBN 00-03
Discussion group (up to 8 people)	Group room		HBN 00-03
District nurse treatment	Treatment room		HBN 00-03
ECG	Examination/therapy room*		HBN 00-03
Echocardography	Treatment room		HBN 00-03
ENT consultation (high volume)		ENT C/E room	HBN 12-01C
ENT consultation (low volume)	C/E room		HBN 00-03
Family planning	C/E room		HBN 00-03
Foot health	Treatment room		HBN 00-03
Free movement exercise (with mats/handheld equipment)	Large group room		HBN 00-03

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Surgical consultation and examination	C/E room		HBN 00-03
GP consultation and examination	C/E room		HBN 00-03
GP training (consultation and examination)	C/E room		HBN 00-03
Group activity (up to 8 people)	Group room		HBN 00-03
Health visitor consultation and treatment	C/E room or treatment room**		HBN 00-03
Hearing testing, adult		Adult hearing test room	HBN 12-01C [DN: It looks like this should have been HBN12:3 supplement 3: ENT and audiology clinics, hearing aid centre but this has been archived – any up to date ref?]
Hearing testing, child		Paediatric hearing test room	HBN 12-01C [DN: ENT/audiology question as above]
Housing advice consultation	Interview room		HBN 00-03
Immunisation	C/E room		HBN 00-03
Inoculation	C/E room		HBN 00-03
Leg ulcer treatment	Treatment room		HBN 00-03
Marriage guidance consultation	Interview room		HBN 00-03
Massage	Examination/therapy room*		HBN 00-03
Mental health interview & counselling (individual)	Interview room		HBN 00-03

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Midwife consultation	C/E room		HBN 00-03
Musculoskeletal/rehab physiotherapy (individual)	Examination/therapy room*		HBN 00-03
Musculoskeletal/rehab physiotherapy (large equipment)	Large group room		HBN 00-03
Music therapy	Group room		HBN 00-03
Near patient testing (blood gas, etc)	Near patient testing room		HBN 00-03
Nurse practitioner consultation and treatment	C/E room or treatment room**		HBN 00-03
Ophthalmology consultation and examination (high volume)		Ophthalmology C/E room	HBN 12-01D [DN: It looks like this should have been HBN12:4 supplement 4: Ophthalmology, but this has been archived – any up to date ref?]
Ophthalmology consultation and examination (low volume)	C/E room		HBN 00-03
Outpatient consulting and examination	C/E room		HBN 00-03
Pharmaceutical consultation	Interview room or C/E room		HBN 00-03
Phlebotomy	Examination/therapy room*		HBN 00-03
Physical measurement room	Examination/therapy room*		HBN 00-03
Physiotherapy specialist treatment (wax, splint, ice)		Splint room	Not yet available [DN: Still not available. Can

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			we make any other assumptions here?]
Physiotherapy treatment (individual)	Examination/therapy room*		HBN 00-03
Plaster treatments (fitting and removing)		Plaster room	HBN 00-03
Practice nurse consultation and examination	C/E room		HBN 00-03
Practice nurse treatment	Treatment room		HBN 00-03
Preparation for parenthood classes	Large group room (minimum 40 sq m)		HBN 00-03
Rehabilitation therapy (individual)	Examination/therapy room*		HBN 00-03
Remembrance group discussion up to 8 [DN: What is this?]	Group room		HBN 00-03
School nurse consultation and treatment	C/E room or treatment room**		HBN 00-03
Sexual health consultation and examination	C/E room		HBN 00-03
Sexual health treatment	Treatment room		HBN 00-03
Smoking cessation group, up to 8	Group room		HBN 00-03
Social work interview and counselling session	Interview room		HBN 00-03
Specialist nurse consultation and examination	C/E room		HBN 00-03
Speech and language consultation (group)	Group room		HBN 00-03

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Speech and language consultation (individual)	Interview room		HBN 00-03
Spirometry	Examination/therapy room*		
Stroke club	Large group room		HBN 00-03
Toenail clipping service	Treatment room		HBN 00-03
Ultrasound investigation	Treatment room		HBN 00-03
Urgent care assessment	C/E room		HBN 00-03
Urgent care assessment and treatment	C/E room or treatment room**		HBN 00-03
Venepuncture (see phlebotomy)			HBN 00-03
X-rays		X-ray room	HBN06-01

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Appendix 4: Sizing a development

HBN assumptions/benchmarks for GMS space

Benchmark	Assumption	Commentary
Opening hours	52.5 core GMS Plus, Enhanced Service hours of extended opening	
Weeks per year	50.4 weeks	52 weeks less 8 Bank Holiday days
List size	Weighted	[DN: QUESTION FOR REVIEWERS - Use of weighted list has been questioned, but there are strong arguments for keeping to weighted list as these numbers are based on health needs which in turn effect service needs. By only using raw list size, much of the additional needs due to deprivation levels will be lost. Consultation rates are only one small element of how much space is needed. We would welcome any thoughts on this.]
Number of contacts per year	5.4 appointments per patient per year	Based on most recently published (2008) National Qresearch data. Rates are likely to have increased since 2008, and best practice would be to analyse service specific consultation rates based on previous 12 months of clinical system GMS appointment data
Consult/treatment room ratio	Consult 7:3 treatment	Changed to a ratio (Previous version assumed 100% consulting plus 20% treatment) as it is of the total number of GMS appointments provided (i.e. 100%) [DN: QUESTION FOR REVIEWERS - In the original HBN calculation, we calculate the treatment and consulting rooms separately based on a ratio and round both up, rather than calculating total and then splitting based on the ratio (which would reduce rounding error?). I suspect this is due to varying appointment durations, but there are other ways around that which lead to a smaller rounding error – this requires further discussion. Thoughts?]

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Average appointment length	**Consult:** 15-minute **Treatment:** 20-minute	No change from previous HBN assumption. There may be an argument for the consult time to be increased due to more easily resolved cases being increasingly seen using phone/digital/triage and face-to-face appointments seeing a higher proportion of complex cases with co-morbidities etc. [DN: QUESTION FOR REVIEWERS - How we treat telephone/digital consultations is still to be agreed. It would be possible, for example, to split these out and treat them separately where providers choose to calculate their service specific consultation rates – However, this could be seen as a disincentive for digital-first if providers knew their space allowances would be reduced? The calculation is likely to require some level of flexibility around the amount of space needed for these types of consultation based on locally agreed service models. We would welcome thoughts and opinions on this]
% room utilisation	60%	It has been suggested that the current 60% utilisation assumption is set too low, leading to over-specified schemes. [DN: QUESTION FOR REVIEWERS - We know that at circa 80% services start to struggle with logistics and room bookings, and that cleaning requirements are likely to increase as a result of COVID. Is 60% realistic, or does this require further debate?]
% support accommodation	64% total support space 36% total clinical space	Based on previous HBN allowances (per calculation in PAU space estimator) [DN: are these still appropriate?]

CONSULTATION DRAFT

As described in the HBN, space will be calculated by adding up the list of required room sizes (both functional and support spaces) to provide the Net Departmental Area (NDA). Departmental uplift percentages are then added to the NDA to allow for Planning (wall thicknesses etc.), Engineering (switch rooms, pipe boxings etc) and Circulation (corridors). The percentage assumptions are detailed below

Departmental uplift percentage assumptions

Benchmark	Departmental Uplift (%)
Planning	6
Engineering	4
Circulation	30

This provides the Gross Departmental Area (GDA). This is repeated for each department, or discreet service.

Finally, whole building uplift percentages are added to the total GDA, to allow for Communication (whole building circulation, such as lift cores and corridors between departments), Plant and Waste Management.

Whole building uplift percentage assumptions

Benchmark	Whole building uplift (%)
Circulation	15
Plant	15
Waste Management	5

The resulting figure is the Gross Internal Area (GIA).

As the design progresses, the percentages are replaced by as designed floor areas.

The below input forms take the user through a series of questions that will ultimately drive an Excel spreadsheet to help determine the size of the development in the early stages of project development (PID/OBC).

It is possible to adjust most elements of the calculation to meet local needs. Justification for deviation will be required to support the calculation ensure transparency.

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Project Information: Input form

Name of development/project

- Text input

How would your proposed development best be described:

- ☐ Refurbishment
- ☐ Extension and minor refurbishment
- ☐ Extension and major refurbishment
- ☐ New build

Response may drive some input around limitations/assumptions where refurb

How many GMS providers are likely to be included in the space (response will drive the creation of as many separate input forms as required for calculation)?

Number of practices: Number of practices

Which of the following (non-GMS) primary and community services are likely to be provide from the space?

- ☐ Practice based pharmacists and community pharmacists
- ☐ Outpatient services
- ☐ Community services
- ☐ Health visitors
- ☐ District nurses
- ☐ Midwives
- ☐ School nurses
- ☐ Social workers
- ☐ Home care advisors
- ☐ Generic support workers
- ☐ Allied health professionals
- ☐ Third sector
- ☐ Mental healthcare providers
- ☐ General, personal and community dentists
- ☐ Other non-GMS services: state #1
- ☐ Other non-GMS services: state #2
- ☐ Other non-GMS services: state #3

Bespoke space

- ☐ Library
- ☐ School
- ☐ Café
- ☐ Other: state #1
- ☐ Other: state #2
- ☐ Other: state #3

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GMS space: Input form (s)

A GMS input form will be provided for each GMS service reported in the Project Information Form

Name of GMS/GP practice: Click or tap here to enter text.

Population

Current weighted list size: Click or tap here to enter text.

Is this likely to change significantly in new premises?

Choose an item.

If so, how is it expected to change? Click or tap here to enter text.

Opening times

GMS funded opening hours per week

Current opening times

Day	Open hr : min	Close hr : min	Hr : Min
Example	*8 : 00*	*18: 30*	*10:30*

Monday	**08:00**	**18:30**	**10:30**
Tuesday	**08:00**	**18:30**	**10:30**
Wednesday	**08:00**	**18:30**	**10:30**
Thursday	**08:00**	**18:30**	**10:30**
Friday	**08:00**	**18:30**	**10:30**
Saturday	**00:00**	**00:00**	**00:00**
Sunday	**00:00**	**00:00**	**00:00**
TOTAL HOURS PER WEEK			**52**

Are these expected to change in new premises? If so, how many hours will be provided? [DN: Calculation should reflect that only part of building may be open during extended hours]

Choose an item.

CONSULTATION DRAFT

Future opening times

Day	Open hr : min	Close hr : min	Hr : Min
Example	*8 : 00*	*18: 30*	*10:30*

Monday	**08:00**	**18:30**	**10:30**
Tuesday	**08:00**	**18:30**	**10:30**
Wednesday	**08:00**	**18:30**	**10:30**
Thursday	**08:00**	**18:30**	**10:30**
Friday	**08:00**	**18:30**	**10:30**
Saturday	**00:00**	**00:00**	**00:00**
Sunday	**00:00**	**00:00**	**00:00**
TOTAL HOURS PER WEEK			**52**

How many weeks per year is the practice open?

- ☐ HBN default 50.4 weeks
- ☐ Other: Provide justification for deviation/assumptions

Appointments

Average number of contacts per patient per year?

- ☐ XX.XX visits per patient per year
- ☐ Not known, but I'd like to calculate this (Link to calculator widget – with question – would you like to calculate ratio by consulting/treatment/telephone/digital?)
- ☐ Not known, but I'd like to continue using the HBN benchmark of 5.4

Average consultation/treatment time:

Consulting/Examination rooms:

- ☐ Input local value: XX minutes
  Provide justification and/or link to calculator widget above
- ☐ Use HBN benchmark (15 mins)

Treatment room:

- ☐ Input local value: XX minutes
  Provide justification and/or link to calculator widget above
- ☐ Use HBN benchmark (20 mins) [DN: How should we treat phone/digital here?]

Proportion split between consulting/treatment/telephone/digital room use:

- ☐ Sliding scale consult/treatment out of 100
- ☐ Use HBN benchmarks/default (70:30)

Support and allowances

Target room utilisation

CONSULTATION DRAFT

- ☐ Locally agreed value: XX%
  Provide details of logic/agreement
- ☐ Use HBN benchmark (60%)

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Non-GMS service: Input form(s)

Name of service: Click or tap here to enter text.

Input method

- ☐ Input space requirements manually
- ☐ Calculate requirements based on HBN standards

Input space requirements manually

HBN standard room sizes

Primary and community care service activity	Generic room and size	Size (m2)	No. required	Specific support requirements?	Notes/ assumptions
Use definitions from HBN (inc. HBN00-03) in drop down – see table 1 in chapter 4 which needs updating? Would need 'other' option	Auto-fill based on selection in column 1	Auto-fill based on selection in column 1 but enable edit (only with justification para)	Drop down	Auto-fill standards from HBNs?	

Non-HBN-standard room sizes

Primary and community care service activity	Room requirements	Size (m2)	No. required	Specific support requirements?	Notes/ assumptions
Free-text					

CONSULTATION DRAFT

Consultation draft – not for publication

Calculate requirements based on HBN standards

Expected number of appointments per week requiring a drop-down menu with HBN standard rooms**:** XXX

Average appointment length: XX minutes

Service operates XX **weeks per year**

HBN standard room sizes:

Clinician/ service	HBN room definition (size)	Specific support requirement	Number of appointments per week	Av. Duration of service/ appointment	Hours of service provision/week	Free text/ assumptions/ comments
		e.g. clean/dirty utility			Data validation – number between 0 and 168 hours	
Expand as needed						

Non-HBN-standard room sizes

Primary and community care service activity	Room requirements	Size (m2)	No. required	Specific support requirements?	Notes/ assumptions
Free-text					

Support and allowances

Target room utilisation

CONSULTATION DRAFT

- ☐ Locally agreed value: XX%
  Provide details of logic/agreement
- ☐ Use HBN benchmark (60%)

Defined/discreet shared spaces: Input form

Detail	Space requirement (m2)	Support requirement	Detail/justification
e.g. shared staff room, training space etc….		Could drop down with utility/specimen WC etc?	

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Bespoke requirements: Input form

NB: HBN 00-01 relates to primary and community care space. Bespoke requirements are included for context. Calculations should be undertaken separately.

Detail	Space requirement (m2)	Detail/justification
e.g. Library, Café, School etc		

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Whole building expansion

Expansion space/zone (m2)	Description or space	Detail of need/timescales	Funding arrangements
	e.g. roof void above reception or extension space to East of waiting room.		

Engineering allowances for expansion/future development	Justification/assumptions	Detail of need/timescales	Funding arrangements

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Consultation draft – not for publication

HBN Space requirement scenarios

[DN: QUESTION FOR REVIEWERS - Reports should have the functionality to define certain assumptions and toggle between scenarios. This may be achieved through a page to set assumptions and then 'print/download/save' button for selected options to include a 'summary' of assumptions and table with the associated space requirements. Please offer any thoughts/opinions on what variables and level of detail might be included for modelling and options appraisal]

CONSULTATION DRAFT

Appendix 5: Schedules of accommodation

[DN: In preparation]

CONSULTATION DRAFT

Appendix 6: Room data sheets

[DN: In preparation]

CONSULTATION DRAFT

References

[i] [i]The NHS Long Term Plan; available from: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

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