

ACHIEVING EXCELLENCE

DESIGN EVALUATION TOOLKIT

AEDET Refresh for NHSScotland

Instructions, scoring and guidance

Latest Drafting: 22/02/2017

AEDET Refresh

**Healthcare building design frequently involves complex concepts, which are difficult to measure and evaluate. The Achieving Excellence Design Evaluation Toolkit (AEDET) evaluates a design by posing a series of clear, non-technical statements, based on three key criteria: Functionality, Build Quality and Impact**.

This current version of AEDET, known as AEDET Refresh, represents a minor update to the AEDET Evolution, which in turn was a significant development of the original AEDET tool. It retains the same objectives and deals with similar issues, but extends these to provide for a more sustainable, health promoting and holistic approach, in line with recent NHS policy (CELs). Although it has the same objectives and deals with similar issues, it is not possible to compare scores directly between AEDET, AEDET Evolution and AEDET Refresh

The AEDET toolkit is a checklist, assisting NHS Boards and other bodies in determining and managing their design requirements from initial proposals through to post project evaluation. It should be used as a discussion agenda, a stakeholder engagement tool and a benchmarking tool for the design briefing and for reviews. AEDET forms a Key Performance Indicator (KPI) for project procurement, including in current Frameworks Scotland 2, HUB, and NPD routes. It should be used for both NHS and non-NHS funded schemes.

The use of a Design Quality Indicator Tool such as AEDET is a mandatory requirement of the NHSScotland Design Assessment Process (NDAP) under [NHS CEL 19 (2010)](http://www.sehd.scot.nhs.uk/mels/cel2010_19.pdf)  A Policy on Design Quality for NHSScotland.

THE TOOLKIT

The NHS worked closely with CABE, the CIC and Sheffield University to develop the original AEDET evaluation criteria to ensure they worked within a common industry framework. The AEDET Refresh toolkit has been updated as part of the Scottish Capital Investment Manual (SCIM) refresh 2015 to embrace current Chief Executives Letter (CELs), good practice, guidance and better define the interface with NDAP Design Statements (ds).

AEDET Refresh maintains the 3 main criteria of – **Functionality**, **Build Quality** and **Impact**; split into 10 sections. Scoring these criteria allows clients and funding bodies to assess how well a wide range of the project stakeholders have confidence in a proposed (or existing) facility performs against a series of statements defining design best practice.

The outcome is not a score, but a way of monitoring an improvement in the confidence and consensus that a range of stakeholders have that the design has/ is or will deliver. The most important records are the notes and actions from the discussions, providing design insights, lessons learned, as well as future priorities or challenges needing to be addressed.

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#  Overview

AEDET is designed as a tool for evaluating the quality of design in healthcare buildings. It delivers a profile that indicates the strengths and weaknesses of a design, or an existing building, at a particular stage/ time. It is not meant to produce a simplistic single overall score. The nature of the project and design priorities, means it may not be possible to produce a solution that would have the maximum score for all sections. Indeed it may be the case that a high score for one statement reflects a design that inevitably should be scored low on another statement. A single score would thus be misleading and uninformative.

Under the mandatory NHSScotland Design Assessment Process (NDAP) Guidance, all NHS Project Teams are required to set their AEDET target (and benchmark if the facility is existing) at Initial Agreement stage and submit this part of the IA NDAP submission prior to the Scottish Government Health and Social Care Department (SGHSCD) Capital Investment Group (CIG) meeting.

AEDET is most often used in workshops, by key project stakeholders. It is desirable that a stakeholder with experience of AEDET facilitate the group to avoid excessively lengthy debate on logistics rather than the project design. HFS may assist in sourcing an AEDET facilitator if required

AEDET is a checklist tool specifically directed towards achieving excellence in design quality, rather than ensuring compliance with legislation, regulation and guidance. High scores in AEDET do not therefore necessarily guarantee compliance. For example, sustainability and energy consumption rates of the design are only dealt with in AEDET on a cursory level. BREEAM Healthcare must be used for the evaluation of designs for environmental and energy issues. In addition the DESIGN STATEMENT required by NDAP, must describe the specific project benefits and their links to the specific environment qualities required to realise these. AEDET should not therefore be used in isolation, as a design can only be demonstrated to be successful in conjunction with the wider noted set of tools, used appropriately at key stages for each project.

Who should use AEDET Refresh?

AEDET is designed to be used by all those involved in the commissioning, production and use of healthcare facilities. In particular public and private sector commissioning clients, developers, design teams, project managers, estates/ facilities managers and design champions may find AEDET helpful. User clients such as patient, carer, visitor and partner representatives, plus members of the general public should also be able to use AEDET, with facilitation.

It is anticipated project stakeholders work together to ensure the group knows the facility/ design proposals, understands the AEDET statements and through discussion reach a wide consensus on the scores and record notes and actions.

When should AEDET Refresh be used?

* to evaluate existing buildings in order to compare them understand their strengths and weaknesses, or provide ‘benchmark’ for re-provision.
* on ‘imaginary’ facilities in order to set the ‘target’ expected from future facilities at the briefing stage
* on the proposals for new facilities in order to evaluate them, or compare designs as part of the Options Appraisal or bid evaluation process
* at various stages during the design of healthcare buildings. As the level of detail of the information available increases it may be possible to respond to more of the statements in AEDET.
* to satisfy SCIM, it is anticipated at least one AEDET (or DQI) workshop (depending on the scale and complexity of the project) should be held at the following key stages, and submitted via NDAP,

use AEDET generic question set only:

* + Initial Agreement (IA) – Target (& Benchmark) score(s)

use combination of AEDET and project specific Design Statement (DS):

* + Outline Business Case (OBC)
	+ Full Business Case (FBC), or Standard Business Case (SBC)
	+ Post Occupancy Evaluation (POE)

What is required for AEDET Refresh?

The minimum you need is the AEDET scoring layer. The guidance layer may be helpful particularly if you are using AEDET for the first time. At all later stages, the Design Statement (DS) should be used in conjunction with AEDET. With generic scoring elements cross-referenced to, or replaced by the project specific DS sections Therefore the Design Statement (DS) is also scored.

AEDET is a helpful tool to enable a group to come to a common understanding and consensus. It is helpful to have a facilitator who can moderate the group discussions, plus a scribe to record the agreed scores, notes and actions. There are two ways of doing this:

* You may try to arrive at a consensus for each AEDET / Design Statement scoring using discussion of the group as a whole.
* You may prefer first to score all the AEDET / Design Statements individually and then come together as a group to resolve differences.

In either case it is important that the facilitator should ensure that any representatives of the public or patients who may lack experience or technical knowledge are able to express their views and have them listened to. The suppliers of the proposal, i.e. contractor, or design team should not participate in the scoring, but may be present to explain the proposals in response to particular issues raised during the discussions.

Always make sure about the scale at which you are using AEDET. For example this could be at a whole programme; campus; facility or department scale. It is particularly important to agree this before you begin if you are working as a group. To help decide on the scale you need to look first at the level of detailed information available. If you decide to work at a smaller scale than a complete building then the NHS ADB (Activity Database) system may be helpful in deciding how to sub-divide the building. This database holds a master project, which contains information on some 30 departments and 1,500 rooms (as room data sheets).

 Instructions for AEDET Refresh use

AEDET Refresh has 3 layers:

* The scoring layer on which you score generic statements
* The guidance layer with generic descriptions of quality and best practice
* The Design Statement, mapping project specific benefits to key qualities required to realise them, using descriptions and images of success.

Different uses for AEDET Refresh

AEDET Refresh may be used in various ways, at different scales and by single or multi-disciplinary groups:

* In standalone form
* Evaluation workshops (commonest use, and preference for NDAP)
* Benchmarking uses

**In standalone form**

People and NHS organisations can use the toolkit as a standalone for various purposes. In this form it not only provides an evaluation toolkit but also serves as a standing agenda, which can inform many design based policies.

**Evaluation workshops**

Stakeholder design assessment workshops are the most common use of AEDET Refresh. These are a requirement for SCIM and submitted via NDAP.

It is important to make sure that a balanced, wide-ranging group of multi-disciplinary stakeholders are involved in the workshop. Experience to date suggests that roughly between 8 and 20 people representing the following groups should be invited to take part in an AEDET workshop, but those groups with an asterix would not usually score:

• NHS Boards

• Patient groups

• Carer / visitor groups

• NHS staff

• Board strategic management group

• Partner staff /groups

• Community groups

• Clinical user groups

• Local health partnerships

• Arts & Therapeutic environment groups

• Health Promotion groups

• Wider public representative groups

• Project Team - contractor and designers \*

• Technical Advisors - consultants and designers \*

• Health Facilities Scotland (HFS) \*

• Architecture + Design Scotland (A+DS) \*

**Benchmarking uses**

Under SCIM 2015 refresh, all NHSScotland Board’s Project Teams are required to set their AEDET target scoresheet (and benchmark scoresheet if the facility is existing) at Initial Agreement (IA) stage and submit this part of the IA NDAP submission to HFS.

This Board approved target (and benchmark) will form part of the design brief and will be used to evaluate the development of the design through the RIBA Stages. It will also be used at Post- Occupancy Evaluation (POE) to benchmark and record the final design qualities and lessons learnt to inform future projects.

At what stages should AEDET Refresh be used?

The AEDET Refresh tool has been devised to enable NHS Boards and their project teams to monitor and score a design. The toolkit should be used firstly to set the design quality benchmark at IA stage. It’s use is then mandatory as a monitor of design quality through OBC and FBC stages, before being applied in the Post- Occupancy Evaluation (POE). Thus it cannot only be used to inform the briefing process, but to assess the degree of compliance with the original brief and also to identify lessons learnt for future projects.

The criteria used in the toolkit may be adapted by Boards (through agreement with HFS) for incorporation into their specifications of design vision, philosophy and quality, which will form an important part of their briefing, whether using NHS capital funding, or a HUBHUB or NPD project.

The AEDET Refresh design evaluation process consists of the following stages:

Set and agree the timetable of milestones against which design will need to be evaluated for the particular project (refer to the NDAP Guidance which identifies the timetable for the common procurement routes);

* Assemble the data and arrange the workshop date, venue, etc, for each milestone. These dates should be set well in advance in order to ensure the attendance of all key stakeholders. They should be identified as milestones in the master programme for the project;
* Run an interactive multidisciplinary AEDET Refresh workshop
* Return the output data to the relevant benchmarking database and/ or feed into the other evaluation criteria of the business case. Submit the AEDET scoring at each stage to HFS as part of the NDAP requirements.

Comparing /selecting schemes on the basis of design

Where several design proposals are competing, the Board should use their design evaluation tools to make direct comparisons of the competing schemes. By combining the appropriate tools, the project team should make informed comparisons on the relative merits of schemes or design options, which will enable them to confidently select the design which best meets their vision and requirements. The AEDET, BREEAM Healthcare and NDAP Design Statements tools should also facilitate the identification of key issues or areas for further development by the designer, depending on the stage of procurement.

NHS Boards are strongly recommended to ensure that they have an audit trail that is fully integrated into the final selection processes that records the design evaluations of options or competing bids at key stages, e.g. HUB or NPD.

How should AEDET Refresh be used for benchmarking

It is intended that the AEDET Refresh toolkit will be used to set a project specific target score (and a benchmark score, if facilities are existing), at IA stage. Support and guidance is available from HFS and A+DS. Boards should of course seek to achieve as high a score/ consensus as practicable, for their specific project. For the target score, we anticipate at least a score 3, for each of the ten main criteria. Where scores fall below 3, Boards should actively work with their advisors/ suppliers to improve the design and raise the evaluation scores and engage in dialogue with HFS and A+DS to support optimisation.

Design evaluation workshops

The purpose of running design evaluation workshops is to ensure engagement with a wide range of stakeholders, supported by the project team and technical advisors, to allow them the opportunity to discuss the design qualities important to them, prioritise and evaluate these together, and agree ways forward.

The AEDET and NDAP Design Statement are complementary tools. The stakeholder representation should be broadly the same, and their initial workshops, followed by later evaluations of both, may run together.

An appropriately sized room should allow the display to stakeholders, of large size plans and digital presentations, plus time for set-up, if competing bids.

**Outputs from the design evaluation workshop**

The main output from the workshop should be a completed AEDET Refresh worksheet for the appropriate business case stage. This will illustrate the consensus scoring of the evaluation team, plus key notes and actions from the discussions. The list of all stakeholders scoring in the evaluation team, plus those attending the workshop but not scoring, should also be recorded.

**Information required for an AEDET Refresh evaluation workshop**

AEDET Refresh can be used at various stages in the design and use of a building, thus there will be various levels of design information that may be available at the selected evaluation stage.

NB: It is not expected that design teams produce any extra information, over and above that already in existence, for an AEDET Refresh evaluation.

**Analysing and presenting the information to the workshop**

At the main evaluation stages of a large project there will be technical reports, specifications etc, which will need to be analysed by the technical advisors. They will be seeking to test the design proposals against the output specifications set in the brief. It will therefore be necessary for the technical advisors to present the evaluation team with as much pre-analysed information as possible giving them more time to make the key judgements during the workshop.

It is suggested that the following written and graphical information is made available to the team evaluating the facility/ design.

**Written information**

* A brief introduction of the Board, the site and the scheme
* The previous stage’s AEDET worksheet
* The project specific NDAP Design Statement (ds)
* a ‘History in Plans’ demonstrating the original thinking, decisions and ideas from the very initial stages to the most recent stages
* Phasing of the scheme should be set out alongside a predicted or approximate time scale, with key milestone dates anticipated
* A Scheme Overview including:
	+ The size and nature of scheme (DGH/mental health/primary care)
	+ Whether the project is a complete new build or a refurbishment
	+ The nature of the site, whether it is urban, green-field etc. with a brief description of architecture, landscape character and opportunities.
	+ A description of the key service components and their inter-relationships.
	+ The departmental relationship information may be specified using diagrams. The design response to the specifications of the Board, the required capacity and adaptability for future uses / change.
	+ The Design Vision and Philosophy should be based on creating a facility that carefully balances a building that is a statement of civic pride against the need to create a welcoming environment that instils a sense of comfort and support. The expectation is that the scheme will provide a modern, quality, functional and therapeutic environment.

**Graphical information**

It is recognised that the level, detail and quality of information will vary at various design stages, but it is important that the design team presents sufficient information for the evaluation to be made. The following list suggests the design information, which will be useful for a presentation at the start of an AEDET evaluation workshop, in order to provide understanding of the proposal.

It is important that design team(s) provide clear, good quality information, which can be displayed and analysed by all participating stakeholders.

Summary list of suggested presentation information

• Location and Site plans

• Development Control Plans

• Site and Building Sections

• Landscape Appraisal - identifying key opportunities

• Existing & Proposed Floor Plans

• Existing & Proposed Elevations

• Exemplar Room Plans

This list is not exhaustive and should be added to as circumstances dictate.

AEDET scoring system

AEDET Refresh has 3 main criteria areas – **Functionality**, **Build Quality** and **Impac**t – split into 10 sections each of which will produce a score.

FUNCTIONALITY: BUILD QUALITY: IMPACT:

A- Use D- Performance G- Character and innovation

B- Access E- Engineering H- Form and materials

C- Space F- Construction I- Staff and patient environment

 J- Urban and social integration

The 10 sections summarise how well stakeholders feel a healthcare building will perform in relation to different aspects, related to generic design best practice. The sections have several statements that taken together build up a score for that section. Following IA, the project specific Design Statement allows teams to develop their own success criteria, based on their business case’s defined strategic benefits. The Design Statement clauses should be cross referenced into the relevant sections / generic statements in AEDET, and vice versa.

Other complementary tools, which are used alongside AEDET, include: Staff and Patient Environment, Section I; the more detailed ASPECT toolkit; and BREEAM Healthcare which allows a pragmatic approach, supported by HFS, to ensure the design meets NHSScotland targets on energy and the environment.

How to score AEDET refresh

The scoring and guidance layers (for each business case stage) are available as a Microsoft Excel spreadsheet. The instructions below assume the spreadsheet is being used for the AEDET design evaluation.

**Scoring statements**

You should try to respond to every statement on the scoring layer. However it is not the scores of individual statements that count, so much as the aggregated score for each section overall. The statements are primarily to break a section down into manageable and limited sets of issues that may be much easier to consider than simply trying to arrive directly at a score for the section overall.

**Scoring AEDET generic statements (g)**

Work on the scoring layer responding to the statements by giving each a score on the 6 point scoring scale.

The guidance layer gives a more detailed explanation of the generic statements and assistance, examples of good practice, on the criteria for achieving good scores. The guidance layer also helps to interpret the statements in relation to specific building types such as for example primary care or mental health.

Once you have scored each statement in a section the tool will calculate an average score for the whole section. The tool will take into account any weighting / priority you have applied to each statement..

**Scoring NDAP Design Statement (ds)**

At IA stage only the AEDET generic statements (g) are scored. After IA stage the project will have agreed specific benefits and criteria in a project Design Statement (ds). This will state how the facility will support the business case objectives through the user’s key experiences; by enabling staff in their work and personal needs; and in supporting carers and other visitors. There will also be other objectives for how the investment will have wider beneficial impacts on the community. From this stage the Design Statements (ds) where relevant, should be considered as the primary benchmark for relevant sections. However standard generic statements (g) are still required as these cover many important design qualities and performance aspects not captured in the user experiences defined within the Design Statement.

To tailor your AEDET sheet, start by assigning each ‘non negotiable’ statement in the ds to ONE of the AEDET (g) statements. Mark this as a High (2) priority weighting and use the AEDET ‘notes column’ to reference the assigned ‘non negotiable’. Score as normal in an AEDET workshop, but use the agreed Design Statement non-negotiable as the benchmark, not the guidance layer.

**Weighting**

On the scoring layer each statement may be given a weighting of High (2), Normal (1) or Zero (0). By default, the statements have a weighting of Normal (1). In a few cases a key statement may have a greater than usual importance and may be given a weighting of High (2), this will double its effect in arriving at the total score for the section.

By default, Design Statements (ds) are weighted High (2), as these directly relate to the strategic benefits agreed by stakeholders as fundamental to the success of the project. Where it is agreed a statement is not applicable to a particular project, this can be weighted as Zero (0).

Stakeholders should decide when to use these weightings, perhaps to reflect the care model. The guidance layer provides hints on weighting, and support if required, is available from HFS and A+DS.

**Using the 6 point scoring scale**

The scale is used to express a level of agreement of all stakeholders with the statement. In this case the scores should be used as follows:

• Virtually complete agreement (6)

• Strong agreement (5)

• Fair agreement (4)

• Little agreement (3)

• Hardly any agreement (2)

• Virtually no agreement (1)

The best score is 6 and the poorest score is 1. Make full use of all 6 points on the scale. Do not ‘save’ 1 for an impossibly bad, or 6 for a perfect scheme. Also a wide range of scores assists in prioritising when going forward, so be realistic.

**Unable to score**

You may find you are more confident about your scores for some sections than others. You may find some statements are difficult to respond to due either to lack of knowledge or a lack of available information. In these cases a score Zero (0) ‘unable to score’ can be used.

**Notes**

A notes section is provided on each stage’s scoring sheets. This should be used to record project specific comments and reasoning for each statement’s weighting and scoring values. The note field must be completed when a score of ‘unable to score’ is given.

**Actions**

An actions list is provided on each stage’s scoring sheets. This should be used to record key actions to take forward, and check previous actions completed

**Design Statement – alternative scoring**

An alternative option to above methodology, is to give the (g) statements, which are assigned and referenced to a specific (ds) non-negotiable, a weighting of Zero (0). Instead the stakeholders will add bespoke (ds) statements, default weighting High (2), into the relevant AEDET section, see examples in Guidance Layer. Then, in AEDET workshop simply use the 6 point scale to record the level of confidence in the delivery of each new (ds) non-negotiable statement.

Manually scoring overall sections

AEDET Refresh’s MS Excel spreadsheet automatically calculates a section average score.

To complete a paper-based scoring, the average score for all the statements under a section, is calculated as follows:

• Statements weighted Zero (0) are excluded from the calculations

• Statements weighted Normal (1) have their score added in once

• Statements weighted High (2) have their score added in twice

Divide the total section score as above, by the number of statements to give an average. To calculate the number of statements, add in 1 for every normally weighted statement and 2 for every high weighted statement. (Do not add anything for statements weighted 0).

The average score is not to be used mechanistically but as a guide to suggest the overall score, using your judgement and local knowledge. A steady improvement as the project progresses through stages is indicative of quality, and increased stakeholder consensus.

AEDET outcomes

The desired outcome from AEDET is not a high or low score. The scoring only reflects the level of agreement / confidence that a range of stakeholders have in the facility or design to deliver against a generic checklist. This score will vary depending on project and the stakeholder representation. Its use is to monitor, stakeholders’ confidence in the facility or design, to deliver. Repeated use over time, will also hopefully record an upward trend, as the project develops.

The desired outcome of both AEDET and the Design Statement is is to focus stakeholder discussions. The most important records are the notes and action sections, providing stakeholder views, design insights, lessons learned, as well as future priorities or challenges needing to be addressed.

# Scoring layer

LINK TO EXCEL SPREADSHEET

# Guidance layer

FUNCTIONALITY

**The three FUNCTIONALITY sections (A, B & C) deal with all those issues to do with the primary purpose or function of the design. It deals with how well the design serves these primary purposes and the extent to which it facilitates or inhibits the activities of the people who carry out the functions inside and around the design**.

**A: USE**

**Section A is concerned with the way the design enables the users to perform their duties and operate the healthcare systems and facilities housed in the design. To get a good score under this Section the design will be highly functional and efficient, enabling people to have enough space for their activities and to move around economically and easily in a way that relates well to the policies and objective of the Board. A high scoring design is also likely to have flexibility in use**.

GENERIC STATEMENTS (g)

**A.01 The prime functional requirements of the brief are satisfied**

The whole design must meet the needs of the core purposes it serves. Clearly this is one of the most central and important considerations.

**A.02 The design facilitates the care model**

The design should express and facilitate the healthcare philosophy of the Board. Design inevitably involves trade-offs, so the relative values in terms of efficiency of healthcare delivery in the care model should be reflected here.

**A.03 Overall the design is capable of handling the projected throughput**

The sizes of spaces, circulation and access must be adequate to meet the demands made at peak times and feel comfortable throughout the operating period.

**A.04 Workflows and logistics are arranged optimally**

All the appropriate adjacencies for human circulation and the flow of facilities and services are arranged in order to minimize distances travelled and lines crossed.

**A.05 The design is sufficiently flexible to respond to clinical change and to enable expansion**

Consider using double weighting. This item may be particularly important where forecasts already suggest future expansion that is not funded as part of the current project. The design should be flexible for clinical changes where possible. The design is likely to last longer than the current models of care and patterns of treatment. Where changes or expansion can be predicted the design should show how it can be adapted to meet these. Therapeutic, technological, organizational innovations will take place and the design should be able to accommodate these without losing its coherence.

**A.06 Where possible spaces are standardized and flexible in use patterns**

Some spaces are so technically demanding that they must be very tightly designed on a functional basis. However it is highly likely that throughout the life of the design the pattern of use will change. Where possible similar kinds of spaces should be the same size and shape and be capable of changing their use as needs change. Over precise design can lead to an inflexibility that in the life of the design can cost considerably more than some small addition of initial floor area to enable future changes. It can often be the case that relatively small additions of floor space can be the most economical way of creating valuable flexibility.

**A.07 The design facilitates both security and supervision**

Consider using double weighting. This item may be particularly important if the site is in an area with historically high crime rates. The layout should include suitable supervision and control points. Entrances and departments should be designed to enable ready supervision and security. The layout should maximize passive supervision and overlooking so that all parts of the design internally and the site externally feel supervised and safe.

**A.08 The design facilitates health promotion for staff, patients and local community**

Public health promotion in the widest sense should be integral to the design. The layout, inside and out, should maximise opportunities to encourage exercise and access to outdoors, e.g. prioritising stair use, usable courtyards.

**A.09 The design is sufficiently adaptatable to inevitable change e.g. climate, technology, demographics.**

The design should reflect duties under The Climate Change (Scotland Act) 2009 to “deliver adaptation” in a sustainable way. Adaptation should include creation of a positive microclimate around building; a sustainable urban drainage system (SUDS) and increasing urban greenspace and biodiversity; promotion of green transport, and health promotion in widest sense. The design should enable aging, frail and obese patients not to feel further ‘disabled’ by the environment. Greenspace should be integral to all the above, from therapeutic views and exercise, to providing shelter and microclimates, a setting for SUDS, and biodiversity, plus reducing ‘greenhouse gases” e.g. a mature tree can save 22kg/ year of CO2.

DESIGN STATEMENT (ds)

A.1ds The design meets the objectives and benchmarks in the Design Statement in relation to building and site USE.

Design statement(s) considered under section A. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**B: ACCESS**

**Section B focuses on the way the users of the facility can come and go. It asks whether people can easily and efficiently get onto and off the site using a variety of means of transport and whether they can logically, easily and safely get into and out of the design.**

GENERIC STATEMENTS (g)

**B.01 There is good access from available public transport including any on-site roads**

Access requirements for staff, patients and visitors arriving at the design using public transport should be thought through. Any on-site roads should be adequate and sensitively designed. Road widths and turning circles should be safe and convenient. Consideration should be given to bringing public transport onto the site where possible and appropriate. Pedestrian routes from public transport points should be clear, safe and sensitively designed. Cars and other vehicles should not dominate the external public areas.

**B.02 There is adequate parking for visitors and staff cars with appropriate provision for disabled people**

In particular the design should accommodate the forecast demand in terms of staff, patients and visitors’ cars. Consideration should be given to the extra demand at major staff shift handover periods. Any points of access to the existing road system should be able to cope with peak demand. Drop off points for less able people should be provided appropriately near entrances.

**B.03 The approach and access for ambulances is appropriately provided**

Adequate segregation and demarcation of ambulance access and drop off points should be clear. Alternative routes should be considered for emergencies.

**B.04 Service vehicle circulation is good and does not inappropriately impact on the experience for service users and staff**

Attention should be given to ensure unsightly, large or noisy vehicles are kept away or shielded from pedestrian/ active travel and contemplative areas. Carefully considered integration, may add interest and normalcy. Ensure suitable surfaces, widths, bends, turning circles etc, e.g. for fire tender access.

**B.05 Pedestrian access routes are obvious, pleasant and suitable for wheelchair users and people with other disabilities / impaired sight**

The major and minor routes should be obvious with continuity of line and materials. They should be well signposted. They should be safe from vehicles and with safe crossings where they cross roads or other vehicular access. They should be free from obstacles and changes of levels. In particular isolated steps should be avoided and appropriately shallow ramps provided where changes of level are necessary.

**B.06 Outdoor spaces wherever appropriate are useable, with safe lighting indicating paths, ramps, steps and fire egress.**

The inclusion of useable outdoor spaces is particularly beneficial to health and wellbeing. Provision of safe, therapeutic outdoor space, should be integral for all public health facilities. The natural environment provides opportunities to make social contact and enhance community cohesion. Greenery in even tiny urban spaces can be utilized effectively to gain positive health promotion results. Safe lighting is a Health & Safety and DDA legislative requirement.

**B.07 Active travel is encouraged and connections to local green routes and spaces enhanced**

Green Travel Plans and Health Promotion are linked priorities for long term sustainability of any project. The design should identify early on, opportunities to enable and enhance active travel and connect to wider green infrastructure networks. This may identify works beyond the immediate project boundaries. Appropriate time will be required for any grant or joint funding arrangements.

**B.08 Car parks should not visually dominate entrances and green routes**

The landscape or Art & Environment strategy should integrate the car parking into a holistic design to which balances delivery on a range of benefits. These may include SUDS or Biodiversity duties as well as promotion of active travel. On site, improved safety, pleasant setting and priority for pedestrians and cyclists, should reduce the dominance and reliance on motorised transport.

DESIGN STATEMENT (ds)

B.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to services ACCESS by the community.

Design statement(s) considered under section B. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**C: SPACE**

**Section C concentrates on the amount of space in the design in relation to its purpose. It asks if this space is well located and efficient and whether people can move around in it efficiently and with dignity.**

GENERIC STATEMENTS (g)

**C.01 The design achieves appropriate space standards**

In addition to the technical spaces, all general spaces must be adequate to meet normal demand comfortably and peak demand at least adequately. In particular entrance areas should be uncluttered and spacious as must all circulation and social spaces. Provision for special areas for children should be considered. Space for external franchises and other add-ons should be thought about. The design must clearly follow and at least satisfy all the minimum requirements of the relevant NHS Guidance. A good design strategy will have listed all the relevant specific notes and shown how the design meets these as opposed to making general statements.

**C.02 The ratio of usable space to the total area is good**

The net to gross ratios should be calculated and show high figures. Where possible, spaces should be capable of being shared to maximise utilisation. The design strategy and the brief should see space as a resource not personal territory. Dual use of circulation space should be exploited where this can be effective, for example to create informal social and gathering spaces. The overall proportion of exclusively to circulation space should be minimised.

**C.03 The circulation distances travelled by staff, patients and visitors are minimised by the layout**

Consider using double weighting. This item may be particularly important where emergency treatments are common. It is also likely to be particularly important for those groups of staff who need to move around as a normal part of their job. Clinical adjacencies as determined by the care model are minimised. Patients and visitors are faced with journeys that are as logical and short as possible.

**C.04 Any necessary isolation and segregation of spaces is achieved**

Any required clinical isolation should be achieved. In addition inherently noisy areas should be kept away from quiet ones. Similarly inherently messy or unpleasant visual areas should be isolated. Inappropriate adjacencies that might offend sensibilities should be avoided. The design should naturally isolate and screen areas which patients and visitors may not wish to see.

**C.05 The design maximises opportunities for space to encourage informal social interaction & wellbeing**

The design should reflect and provide this. Areas where the boundaries between genders may need to change in use should be clearly identified and solutions for providing this made apparent.

**C.06 There is adequate storage space**

It is very easy to underestimate the amount of storage space required. This frequently leads to other major failures in the use of designs. Common results are to see materials stored in public areas causing restrictions, adding to safety risks and giving a sense of clutter. Sustainable storage needs to be as close as practicable to actual use. The design should avoid creating core storage spaces which can easily be eliminated. Storage may be required at several stages in the various supply / use / disposal systems.

**C.07 The grounds maximise potential for informal and formal therapeutic activities**

Greenspaces are proven to support tackling a range of health and social problems - obesity, cardiovascular disease, mental ill health, anti- social behaviour and health inequalities. Health facilities should lead the way in using greenspace (existing and new) for therapeutic activities, including occupational therapy and green healthcare prescribing.

**C.08 The design maximise benefits of internal/ external spaces working together**

The outside spaces should support the work of the NHS staff inside, and provide direct benefits to patients, staff, visitors and local community. A master plan approach, highlighting external design potential early in the project development, should support the grounds and building design to be coherent, mutually supportive and deliver the widest benefits. Working with voluntary sector and community groups can maximize these opportunities.

DESIGN STATEMENT (ds)

C.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to how service users relate to SPACEs inside and out.

Design statement(s) considered under section C. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points, is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

BUILD QUALITY

**The three BUILD QUALITY sections (D, E & F) deal with the physical components of the design. This is where the more technical and engineering aspects of the design are evaluated. It asks whether the facility is, or is likely to be, robustly built, reliable, easy to maintain and operate, long lasting and sustainable. It also relates to the process of construction, and to what extent disruption and risks to healthcare services are minimised.**

**D: PERFORMANCE**

**Section E relates to the technical performance of the facility across its whole lifetime. It asks whether the physical components of the design are high quality, fit for purpose and sustainable. However how well the design functions for human use is in sections A-C.**

GENERIC STATEMENTS (g)

**D.01 The facility is easy to operate**

 The general organization of the design both inside and outside enables the management of the facility including grounds, over its life cycle, from construction, operation and replacement/ demolition to be as straightforward and sustainable as possible. This should include a strategy for appropriate adaption, refurbishment and /or expansion in the future.

**D.02 The facility is easy to clean and maintain**

The design’s physical details and the materials make it easy to clean and maintain. Surfaces should have finishes that enable simple and quick methods of cleaning especially those that require to be clean for clinical reasons. Access to windows for cleaning both externally and internally should be as easy and sustainable as possible. Maintenance access and replacement of key elements, from plant, to planting is easy and sustainable. This may require the provision of safe access routes, cradles, platforms etc.

**D.03 The facility has appropriately durable finishes and components**

The materials both externally and internally should be able to last for their predicted lifespans. Key element lifespans should be as long as practicable, and where shorter than the predicted lifespan of the overall facility, then D.02 & F.04 become particularly important.

**D.04 The facility will weather and age well**

The design should be able to age gracefully. The nature of the facility, choice of materials, and detailing of junctions all affect this. As do the ease of maintenance/ replacement access. Some materials such as masonry can look better as they get older, whereas some may quickly look dirty and uncared for. Carefully considered, robustly detailed junctions between materials are needed, as these can rapidly deteriorate, especially in exposed elevations.

**D.05 Access to daylight, views of nature and outdoor space are robustly detailed**

Good details should ensure the investment in greenery, windows etc, achieve their potential, e.g. solar film will not diminish light quality, courtyard are usable, their floors receive daylight.

**D.06 The design maximises the opportunities for sustainability**

The design requires to implement a range of mandatory duties, from biodiversity to waste reduction, green transport to SUDS. This ultimately requires facilities through their whole life cycle to be sustainable and practicable, particularly to reduce long-term energy and carbon use.

DESIGN STATEMENT (ds)

**D.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to service and building PERFORMANCE**

Design statement(s) considered under section D. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**E: ENGINEERING**

**Section E is concerned with the design of engineering systems as opposed to the main architectural features. It asks whether the engineering systems are, or are likely to be, of high quality and fit for purpose, reliable, easy to maintain and operate, and sustainable.**

GENERIC STATEMENTS (g)

**E.01 The engineering systems are well designed, flexible and effective**

Engineering systems should be effective and flexible. Local controls should be provided for use by staff and patients. Engineering systems should operate quietly and respond rapidly. These systems should operate satisfactorily through all seasons of the year and be capable of adapting to reconfiguring of the design in future.

**E.02 The engineering systems exploit any benefits from standardization and prefabrication where relevant**

Standardisation is not sought in its own right, but may be beneficial during construction, maintenance and replacement across a facility life cycle. Unnecessary variation can be expensive. Again prefabrication is not sought in itself, but may offer value for money and may help to ensure easier and speedier construction which may cause less disruption and risks to essential services on site, provide consistency, and sustainable, easier maintenance.

**E.03 The engineering systems are energy efficient**

The engineering systems should be designed to be efficient and economic in use and to meet or exceed all statutory and mandatory NHS targets.

**E.04 There are emergency backup systems that are designed to minimize disruption**

The design should meet the emergency backup requirements of the project and the clinical requirements of the brief. In particular coverage should be considered for medical gases, emergency generators, batteries, nurse call systems, heating, theatre and other lighting, hot water, cold water storage, IT and telephones. This backup extent should be sustainable.

**E.05 During construction disruption to essential healthcare services is minimised**

The continuity of essential services in healthcare is vital. It is necessary using SHFN 30 and HAI Scribe to ensure risks due to the design or construction proposals are identified and minimized throughout the life cycle of the procurement process from briefing to operation. Modifications to both the design and the construction should be considered. Temporary relocation of healthcare or other services may also be necessary to ensure public safety.

**E.06 During maintenance/ replacement disruption to essential services is minimised**

Similar to E.05, the design requires to minimise the potential disruption and risk to healthcare services in the future maintenance and replacement of elements throughout the facility’s life cycle. Key element lifespans should be as long as practicable, and where shorter than the predicted lifespan of the overall facility, then D.02 is particularly important

**E.07 The design and layout contributes to efficient zoning and energy use reduction**

The design layout and controls should enable efficient zoning and energy use reduction, throughout the life cycle of the facility. This should include hours of operation and similar environmental conditions being grouped together. A project specific judgement should be made as to extent of back-up depending on the kind of facility, based on sustainability, modelling and data, not generic, blanket % ‘rules of thumb’.

**F: CONSTRUCTION**

**Section F is concerned with the technical issues of actually constructing the design and with the performance of the main components. A design that scores well under this Section is likely to be constructed as quickly, easily with the lowest risks practicable, given the circumstances of the site; and to offer a robust, sustainable and easily maintained solution**.

GENERIC STATEMENTS (g)

**F.01 If phased construction is necessary the various stages are well organised**

Consider using double weighting. This item may be particularly important if it is necessary to phase the project either for financial reasons or to keep existing services operating while the construction is in progress. If the project needs to be built in phases this is made as easy as possible by the design. In gaining access to future phases, disruption and risks to healthcare services and neighbours should be minimised. Ideally each phase should be self-contained. Any future demolition should be clearly thought through. However as the construction phase is a very short part of the total life cycle of the facility, it is often undesirable to allow the phasing itself to dominate the final design.

**F.02 Temporary construction work is minimised**

In order to satisfy the needs of phasing it may be necessary to construct some facilities which will then later be demolished or removed. This is obviously additional expenditure for which there is no long term benefit and yet further short term potential disruption and risks. This should be minimised, especially for essential healthcare services. However, as with F.01 the final design is the key consideration, its benefits may outweigh a short term decant.

**F.03 The impact of the construction process on healthcare services is minimised**

Ideally the site works should be laid out so that contractor’s areas are entirely separate from continuing healthcare operations. This may not always be possible but overlaps should be avoided if possible or identified and minimised where not. Crossing points where contractors’ site traffic routes may affect other traffic and pedestrians should be minimised.

**F.04 The building and grounds can be readily maintained**

Components in the construction should be designed to require minimal maintenance. The lifecycles of components should be known and thought through. Access to components that will need maintenance or replacement is both easy and sustainable. In particular access to items which need attention is available without disrupting the operations of patients and staff.

**F.05 The construction is robust**

Workmanship and junctions between materials and components should be well detailed, with sufficient strength and integrity for their functions and locations.

**F.06 The construction allows easy access to engineering systems for maintenance, replacement and expansion**

The design of the construction should be integrated with the design of the engineering systems. Access to engineering components that will need maintenance or replacement is easy and sustainable. In particular access to items which will need attention is available without disrupting the operations of patients and staff. Some items require more attention than others and disruption should be minimised by designing access routes, hatches and removal panels etc to enable this, e.g. en-suite WC cisterns maintained from corridor.

**F.07 The construction exploits any benefits from standardization and prefabrication where relevant**

Standardisation is not sought in its own right, but may be beneficial during construction, maintenance and replacement across a facility life cycle. Unnecessary variation can be expensive. Again prefabrication is not sought in itself, but may offer value for money and may help to ensure easier and speedier construction which may cause less disruption and risks to essential services on site, provide consistency, and sustainable, easier maintenance.

**F.08 The construction maximises opportunities for sustainability**

The build should implement the mandatory duties that range from biodiversity to waste reduction, green transport to energy and carbon reduction. This ultimately requires construction evidence of resource efficiency, e.g. WRAP toolkit, but most importantly across whole life cycle, demonstration of decision making achieving sustainable ‘excellence’.

**F.09 The construction contributes to being a ‘good neighbour’**

The contractor and client requires to work together to benefit the whole local community. This should include use of Good Corporate Citizenship Assessment Model (GCCAM) and Considerate Contractors Scheme, but also wider local health and sustainability promotion.

**F.10 The construction minimises HAI risks**

Team work between the contractor, designers, NHS users and NHS estates is necessary to ensure the Healthcare Acquired Infection risks are identified, monitored and reduced, particularly for to the public and vulnerable patients. Use of HAI Scribe and SHFN 30 will support this elimination, reduction and monitoring, throughout the facility’s life cycle.

IMPACT

**The four IMPACT sections (G, H, I, & J) deal with the extent to which the design creates a sense of place and contributes positively to both the setting and lives of those who use the facility and the local community who are its neighbours**.

**G: CHARACTER AND INNOVATION**

**Section G deals with the overall feeling of the design. It asks whether the building and grounds have clarity of design intention and whether this is appropriate to its purpose and setting. A design that scores well under this section is likely to work holistically, to lift the spirits and to be seen as an exemplar of good architecture and place-making**.

GENERIC STATEMENTS (g)

**G.01 There are clear ideas behind the design of the building and grounds**

The building and grounds design should embody a clear and coherent vision, confidently communicating its function and aspirations through its various physical elements.

**G.02 The building and grounds are interesting to look at and move around in**

The design should have sufficient variety to create interest both in terms of the overall form and massing externally and the internal and external places created for people to feel comfortable in. But without losing the clear vision (see G.01) or becoming confusing.

**G.03 The building, grounds and arts design contribute to the local setting**

The design should be sensitive to the community and location it sits in, urban, suburban or rural. Appropriate in scale, form, materials and colour palate, the grounds and art in particular should benefit facility users and local community, with places of therapeutic value.

**G.04 The design appropriately expresses the values of the NHS**

Primarily a healthcare facility should be about the people who it is there to care for. A civic presence may be appropriate, but an institutional or corporate image is unlikely to be. The overall design should lift the spirits of those who work and are being treated in it as well as those who visit or reside nearby. It should communicate a strong positive image of the NHS.

**G.05 The project is likely to influence future healthcare designs**

The design should use and express current best practice in terms of form and technology. The design should clearly reflect new and appropriate models of healthcare provision. It should be a design that clients, designers etc. wish to visit when working on future projects.

**G.06 The design provides a clear strategy for future adaptation and expansion**

The design should incorporate zones for change and growth, to deal with inevitable future changes in healthcare models and technology. See also A.09 drivers for change.

**G.07 The building, grounds and art integrate to create sustainable therapeutic places**

The Art and Therapeutic Environment strategy should be integral to the design, both inside and out. There should be a creative and positive benefits for the whole community.

DESIGN STATEMENT (ds)

**G.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to CHARACTER and INNOVATION**

Design statement(s) considered under section G. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**H: FORM AND MATERIALS**

**Section H deals with the nature of the design in terms of its overall form and materials. It is primarily concerned with how the design presents itself to the outside world in terms of its appearance and organisation. Although it deals with the materials from which the building and grounds are constructed it is not concerned with these in a technical sense but rather the way they will appear and feel throughout the life of the facility.**

GENERIC STATEMENTS (g)

**H.01 The design has a human scale and feels welcoming**

However large or small the design it should appear welcoming to staff, patients and visitors. The scale should be appropriate to a caring image. Scale is the result not just of the size of the project, but of the way certain features are expressed. Windows, floor to floor heights, doors and entrances all contribute to the potential for views in and out of the facility.

**H.02 The design contributes to the local microclimate, maximising sunlight and shelter from prevailing winds**

The design is well orientated on the site to maximise its potential. In particular the building and grounds should be designed to capture sunlight appropriately. It should shelter people approaching it from the prevailing winds and poor weather. The design should also maximise the health promotional potential, embracing views of greenery and access to the landscape from both users and local community, and from within or outwith the site.

**H.03 Entrances are obvious and logical, in relation to likely points of arrival on site**

Consider using double weighting. This item may be particularly important where there are likely to be large numbers of visitors on a daily basis, where there are many new or stressed users, where there may be more than one entrance or where there may be several routes onto the site. The form of the design should invite approach and entry and make the places where the public enter apparent, even without signs. The design should respond to the major expected points of arrival. The entrances should be obvious from these angles.

**H.04 The external materials and detailing appear to be of high quality**

Materials should be chosen to enhance the design as a whole. The form and materials should be well detailed. The design of the building and grounds should be as one, and these should combine to age gracefully rather than show unsightly staining or weathering.

**H.05 The external colours and textures seem appropriate and attractive**

Colours and textures should articulate and enrich the design’s form and enhance its setting. As with interior colour schemes what feels appropriate will, to some extent, depend on the type of facility and style. However exterior colours and textures should also be chosen to relate positively to adjacent architecture, landscape, climate and other aspects of the setting.

**H.06 The design maximises the site opportunities and enhances a sense of place**

The building and landscape design should sit well on the site and enhance the overall setting. This may include using the topography to reduce the impact of the building scale, or terrace landscaping enabling disability access. It should also include enhancing site ecology and biodiversity, using existing key features, e.g. mature woodland or waterways; or new features e.g. SUDS pond, sedum roof. The facility should promote health both to its users and the wider community, all should be encouraged to use the grounds to their potential, e.g. for walking, cycling, social or growing spaces.

DESIGN STATEMENT (ds)

**H.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to FORM and MATERIALS**

Design statement(s) considered under section H. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**I: STAFF AND PATIENT ENVIRONMENT**

**Section I deals with how well an environment complies with best practice as indicated by the research evidence. The statements correspond to the sections in ASPECT (A Staff Patient Environment Calibration Tool).**

GENERIC STATEMENTS (g)

**I.01 The design respects the dignity of patients and allows for appropriate levels of privacy and company**

Consider using double weighting. This item may be particularly important for space where patients spend significant amounts of time, or where sensitive consultations, treatments or discussions may take place. Both company and privacy are highly valued by patients and staff and the design should facilitate both. The spaces where patients are likely to be for lengthy periods should provide places where they can have both visual and acoustic privacy. Patients should be able to have private conversations and to be alone if they wish. However, it should also be easy for patients to find company and be with others. Patients’ dignity should be respected by the design. When being treated or examined they must be shielded from the gaze of others and should not be overheard. Toilets and bathrooms should be nearby but located discretely without being in full view of others.

**I.02 The design maximises opportunities for daylight/ views of greenery or natural landscape**

Consider using double weighting. This item may be particularly important for space where patients and/or staff spend significant amounts of time. Rooms where patients or staff spend long periods should have windows which afford high quality daylight and views, particularly to greenery and across natural landscape. Patients should be able to see green plants, ground and the sky. Trees reflecting seasonal changes, reinforce our connection with the world. This is particularly important where patients may be in bed for long periods or having to wait. Where patients may be concerned or under stress the view should be calming. The restorative effects of daylight and natural views are well proven.

**I.03 The design maximises opportunities for access to usable outdoor space**

Patients should be able to go outside easily and have access to well landscaped gardens and green infrastructure. Both staff and patients should be able to see nature especially greenery/ green vegetation. This might be in the form of interior planting or external gardens. Restorative green spaces and infrastructure are shown to be helpful to those recovering from short term treatments, to comfort visitors and provide respite for harried staff. Being able to walk or sit in such places can reduce blood pressure, relieve stress, encourage healing and restore hope/ wellbeing, providing proven benefits for local community as well as facility users. Health promotion opportunities should be maximised where practicable.

**I.04 There are high levels both of comfort and control of comfort**

Consider using double weighting. This item may be particularly important for space where patients and/or staff spend significant amounts of time. Patients and staff should be comfortable. The temperature should be comfortable all year round and be capable of easy local control. Patients and staff should be able to exclude sunlight and darken spaces when patients wish to sleep. Artificial light should be easily controllable offering patterns suitable for day and night and for winter and summer. Patients and staff should be able to open windows and doors easily for fresh air. The places where staff work or patients spend time should be quiet and free from unwanted levels of operational or background noise. Stress and heart rates have been proved to rise in noisy healthcare facilities, yet research shows rising noise levels in hospitals, wards and in critical care units in particular.

**I.05 The design is clearly understandable and wayfinding is intuitive**

Consider using double weighting. This item may be particularly important for large or complex designs or collections of buildings. The whole facility should be easily understandable allowing for easy way-finding. The entrance should be obvious from arrival on site, and the way out should also be clear. There should be a logical hierarchy of spaces in the design with varying scales appropriately indicating the public and private domain, both internally and externally. It should be clear which are staff only areas and patients and visitors should easily be able to tell where to find a member of staff. Different parts of the design should have different characters in order to avoid an overall feeling of being nowhere. Distinctive landmarks, familiar artefacts from the past, self-contained looping paths are techniques for maximizing legibility and orientation both inside and outside the building.

**I.06 The interior of the facility is attractive in appearance**

The interior should feel light and airy. Spaces where patients spend significant amounts of time should be made as homely as possible. There should be daylight and views of greenery, and a stimulating variety of appropriate colours and textures. The interior should look tidy and well cared for as well as clean. Ceilings should look interesting, especially where patients are likely to be on beds or trolley for any length of time. Patients should be able to store and display personal items.

**I.07 There are good bath/ toilet and other facilities for patients**

Bath and toilet facilities are known to be important to patients. Ideally there should be a choice of bath or shower. Well designed signage, tonal contrast, non-slip flooring, seats, handrails and shelves within easy reach, enable patients not to feel ‘disabled’ by the design. Places for socialization, religious observance and live performances are also important. Having the option of a relative/friend being able to stay overnight very close by, can make a big difference to patients. In their own spaces, patients should have access to a range of suitable furniture including comfortable seating and a table. Patients who are able should have places to go and facilities to use, from tea making, to vending machines and gardens.

**I.08 There are good facilities for staff, including convenient places to work and relax without being on demand**

Support facilities particularly impact on staff. It may be very important to be able to change into working clothes, to shower and to store clothes and belongings safely. Staff need to be able to get away from demand sometimes when working in order to concentrate, and also when taking a break. Respite space should be provided nearby, with access to facilities, from IT, to tea-making, vending, views and gardens. Shared work and social spaces encourage team building and integration. Retail facilities nearby are also important to staff.

**I.09 There are good opportunities for staff, patients and visitors to use outdoors to recuperate and relax**

The use of outdoor space has proven health and wellbeing benefits. Where possible waiting and respite facilities should have direct access to suitable outside waiting and respite space.

DESIGN STATEMENT (ds)

**I.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to STAFF AND PATIENT ENVIRONMENT**

Design statement(s) considered under section I. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

**J: URBAN AND SOCIAL INTEGRATION**

**Section J deals with the way the design relates to its surroundings. It asks whether the design plays a positive role in the neighbourhood whether that is urban, suburban or rural. A facility that scores well under this section enhances its setting rather than detracts from it.**

GENERIC STATEMENTS (g)

**J.01 The height, volume and skyline of the design relate well to its setting**

Consider using double weighting. This item may be particularly important where the design is in either a tight urban environment or a very rural environment. The profile and skyline of the design as it is approached should fit in well with the local neighbourhood.

**J.02 The facility contributes positively to its locality**

The locality should be enhanced by the addition of the facility. This might be through the way it opens up vistas, closes and contains urban space, or perhaps provides a landmark or useable greenspace. The design should be sensitive to its setting, whether urban or rural, sit comfortably within it, and the interior and exterior should be cohesive/ mutually beneficial.

**J.03 The hard and soft landscape contribute positively to the locality**

The hard and soft landscape around the facility should be therapeutic in their qualities. They must be designed to last, to minimize maintenance, and add to sustainability, from improved air quality, micro-climate, SUDS, green travel, biodiversity and health promotion. The spaces around the facility should be green, pleasant and promote community and pedestrian links. The design should feel as if it ‘belongs’ to this place, optimising local features & topography.

**J.04 The design is sensitive to neighbours and passers-by**

Consider using double weighting. This item may be particularly important where the facility is largely in the public domain for example in a town and many people may be passing by or through the site on a daily basis. The design should be a ‘good neighbour’. Those approaching the design or passing by should feel safe and connected to it. Neighbours may see the design every day and should benefit as well as occasional users.

DESIGN STATEMENT (ds)

**J.ds01 The design meets the objectives and benchmarks in the Design Statement in relation to how the development fits in / improves the setting**

Design statement(s) considered under section J. to be referenced in the Notes. These are ones that best relate to the generic guidance above. Scoring should consider if the design, in relation to these points , is answering the requirements in the left hand column of the Design Statement to produce an environment with the qualities noted in the right hand column of the Design Statement.

# References

Scottish Government guidance

**Scottish Capital Investment Manual (SCIM)**  <http://www.scim.scot.nhs.uk/>

**SCIM guidance: NHSScotland Design Assessment Process (NDAP)** [www.scim.scot.nhs.uk/Support/SCIM\_DA\_BC.doc](http://www.scim.scot.nhs.uk/Support/SCIM_DA_BC.doc)

**Scottish Government policy for NHSScotland, including, but not limited to, the following NHSScotland Chief Executive Letters (CELs) :**

**NHS CEL 19 (2010)** A Policy on Design Quality for NHSScotland [www.sehd.scot.nhs.uk/mels/cel2010\_19.pdf](http://www.sehd.scot.nhs.uk/mels/cel2010_19.pdf)

**NHS CEL 01 (2012)** Addendum: Health Promoting Health Service [www.sehd.scot.nhs.uk/mels/CEL2012\_01add.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_01add.pdf)

**NHS CEL 02 (2012**) A policy on sustainable development for NHSScotland [www.sehd.scot.nhs.uk/mels/CEL2012\_02.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2012_02.pdf)

**NHS CEL14 (2010)** Sustainable development: Good Corporate Citizenship Assessment Model for NHSScotland [www.sehd.scot.nhs.uk/mels/CEL2010\_14.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2010_14.pdf)

**NHS References**

**HBN 00-01** Core elements: General design guidance for healthcare buildings [www.hfs.scot.nhs.uk/publications/1413797038-HBN\_00-01%20General%20design%20guidance%20for%20healthcare%20buildings\_cover.pdf](http://www.hfs.scot.nhs.uk/publications/1413797038-HBN_00-01%20General%20design%20guidance%20for%20healthcare%20buildings_cover.pdf)

**AEDET** Achieving Excellence Design Evaluation Toolkit (5 parts) NHSWales [www.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=7615](http://www.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=7615)

**Design Quality Indicator (DQI)** Construction Industry Council (CIC) [www.dqi.org.uk](http://www.dqi.org.uk/)