Institute of Neurological Sciences: SCIM DESIGN STATEMENT

V.8 05/07/2022

This Design Statement has been compiled to support the redevelopment of the Institute of Neurological Sciences and will act as a key briefing document. It will be used to enhance the design process and ensure project objectives are achieved.

The business objectives are:

- Improving person-centred services and patient care
- Improving clinical effectiveness and enhancing patient experience and clinical outcomes
- Improving the quality of the physical environment
- Providing flexible and adaptable facilities

The key design principles underpinning the project are:

- Provide services that will be easily and safely accessible and ensure that the new facilities reflects service user needs
- Improve clinical effectiveness by providing an environment that supports the service models, clinical effectiveness and service provision
- Provide a clinical environment which promotes the health and wellbeing of the buildings users
- To provide facilities that are efficient, sustainable and flexible to support service provision in the future

Therefore, in order to achieve these objectives, the completed development must have the attributes described below.

NB: where experiences are described below, these are expected for all people irrespective of physical, sensory or cognitive impairments.

1. AGREED NON-NEGOTIABLES FOR PATIENTS/ALL SERVICE USERS

Non-Negotiable Performance Objectives *What the design of the facility must enable (what it needs to do)*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each* *(what you expect there to be)*
1.1 SITE LAYOUT Due to the time sensitive nature of the acute care work, the facility must be well located in terms of essential adjacencies to other critical facilities / departments. It is key that specialties are co-located and/or in close proximity to allow patients' complex issues and/or unplanned emergencies to be dealt with expeditiously.	• Minimise travel distances from other critical facilities and between interdependent departments. • Level thresholds to enable smooth patient journeys. • Minimal lift transfers.

1.2 BUILDING APPROACH The routes to and from the facility must be clear, safe and intuitive to reduce stress and support patient dignity.	• Appropriate directional signage to the facility at both ends of the site and throughout the site. • There should be a defined, clear and safe pedestrian route to the main entrance for all building entrants • There must be protection for patients & visitors from emergency vehicles with clear separation between ambulance drop off points and those for cars/taxis. • Clear, identifiable and generous designated drop off points suitable for all patients. • Drop off points should be suitable for all weathers and therefore provide shelter and protection from wind and rain. • Campus car parking should be provided in close proximity (maximum of 45m, in accordance with Technical Standards) to the facility particularly for those with reduced mobility. • Routes to be well lit and observed and use landscape features to provide shelter and a soft/natural feel. • Routes to be wide enough to allow wheelchair users to pass and for families/friends to walk together and chat rather than in single file. • There should be spaces to stop and take a breather on the entrance route (seating) with shelter for protection from inclement weather. • Planting/Landscaping should be utilised to assist in wayfinding and to provide a calming environment. • External lighting should be used to provide comfort, reassurance and assist with wayfinding.  

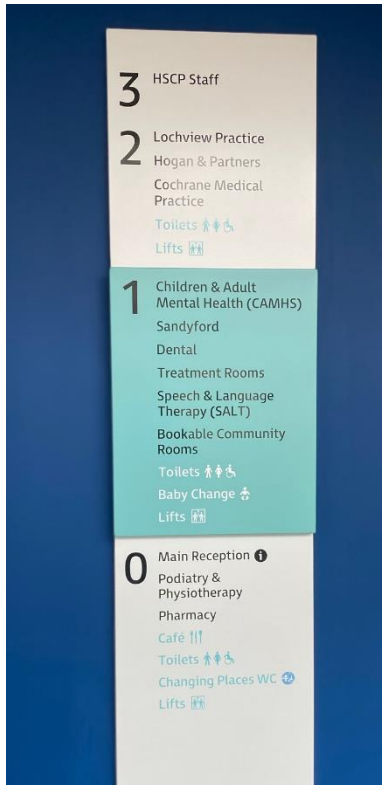
	
1.3 INITIAL IMPRESSION The facility must be identifiable so people know they are going to the right place. It needs to convey healthcare but must not look prisonlike. Instead, the initial appearance/impression must be welcoming, warm and inviting.	• Distinct visual identity on the campus. • Signage with consistent branding and colour should be clear. • Main Entrance should be clearly identifiable and visible upon approach. • Security should be a consideration but the building should not look prisonlike and should be “human” in scale and should not intimidate or impose. • Natural building materials to be utilised to soften the overall impression (timber, stone, etc). • Use of colour to assist in wayfinding which could also carry on into the building.   

1.4 ARRIVAL The arrival experience must be welcoming, comforting and accessible to help minimise anxiety. It must offer a 'place where people are prepared to stay'.	• Wayfinding should be clear and apparent as soon as you enter the facility. • Comfortable waiting area upon entering the facility with Café facility which could be used by patients, staff and visitors. Patients can be in the facility for a long time and therefore should have the option to go and get refreshments themselves. This would give a place for longer stay residents to get away from a ward situation and have peer support conversations. From a therapy perspective destination spaces are really important and this could serve this function. It would also provide a waiting space for carers/visitors/family members to congregate and could be a central hub for building which assists with navigation and provides a clear meeting point. • Non-clinical feel with views and access to natural daylight. • Natural building materials to be utilised such as wood. • Colour schemes should enliven the spaces and feel energised. • Useable external space(s) for quiet respite and for relief should be provided immediately adjacent to enable use. • There should be covered/sheltered outside space to deal with inclement weather.    

1.5 RECEPTION

From arrival it must be clear and easy for patients to let staff know they are there and to be supported with their onward journey. Human interaction must be available to help reduce anxiety.

- Reception facilities must be immediately visible on entering the building, with options for electronic check in and face to face contact. Avoid physical barriers e.g. screening at reception area as the patient can feel isolated. Wheelchair accessible reception desk design / low level and induction loop system to be provided.
- Walk to reception from entrance doors should be within 10 metres.
- Reception area should have good interconnectivity with other admin support areas.
- Information point must be provided which can signpost to Third Sector organisations and peer support.
- Accessible toilets should be closely located to Reception area but not in full view of seating areas.
- Signage and wayfinding to be consistent and easy to understand, accommodating visually impaired/ dementia friendly design.
- Routes to onward journeys should be clear and intuitive.



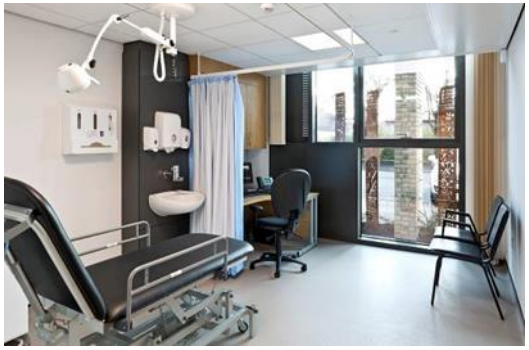
1.6 WAITING AREAS The waiting experience must help patients cope with the issues they have that day, to minimise any additional stress and promote calm.	• Waiting areas must support people with a wide range of personal/emotional needs and those with reduced mobility. • Furniture layout and seating options should be comfortable and offer a variety of sizes and groupings e.g. providing patient choices for privacy or opportunities to meet other patients/carers to offer/ receive support and kindle friendships. Some patients may wish to be alone in a busy public area so provide isolated or quieter waiting spaces. • Waiting areas should be bright with access to external views and natural daylight. • Positive visual distractions and stimulus should be provided. • 'No generic televisions in the corner of the waiting areas' • Toilets should be close by but not directly onto waiting areas for privacy and discretion. • Each sub-waiting area should have a different feel to it to provide variety and also to help with wayfinding. • Opportunities to engage with Local artists/community/patients to provide a programme of changing artwork and exhibitions. Not only would this enhance these spaces but it would offer a sense of ownership of these spaces and the facility by the patient community. • Non-clinical feel with the use of natural building materials. • Waiting areas should be digitally enabled to allow for personal choices, for users to connect to reliable WiFi and to charge any electronic devices/phones as necessary.   

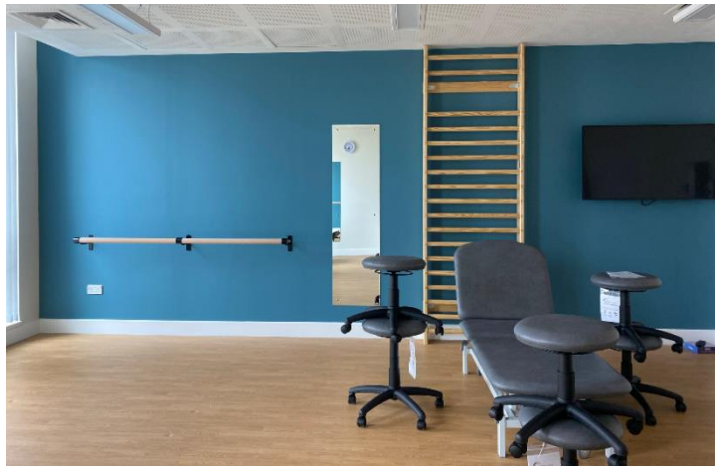
1.7 CIRCULATION Patient dignity should be a priority when moving/being moved around the facility. The circulation routes should provide views of the surrounding area and allow for the natural passing of the day to be experienced as patients move around the facility. The patient journey and transition should be reflected in the design and allow a change in mindset.	• Consideration must be given to patient flow throughout the facility and avoid the movement of patients in beds and trolleys through busy public areas. • Patient circulation routes should afford privacy and dignity. • Circulation routes should be bright with access to external views and natural daylight. • Separate inpatient lift (in particular for theatre patients) so they are not having to share with the public at vulnerable moments. • Patients should be allowed to walk to theatre if they choose to. • Temperature needs to be suitable for patients in gowns – warm and comfortable. • Wall bars should be provided to help assist with mobility and flow around the facility – not just bump rails. • Space for rest points to be provided without implications on corridor widths/circulation routes. These should be distinct spaces and not just chairs in corridors.  

1.8 CLINICAL & TREATMENT ROOMS

Must appear professional, but not intimidating. They must be designed to respect the privacy and dignity of patients. They must be flexible so that the nature of the space and equipment can be adapted to suit the patient's needs and improve patient flow.

- Spaces to be bright with access to natural daylight without compromising patient privacy.
- Flexible and adaptable spaces.
- Space to secure personal belongings.





1.9 INPATIENT AREAS Must support personal control over the environment and encourage activity, movement and enablement. They must provide positive distractions and reduce negative effects of isolation associated with single rooms, to encourage patients to be engaging socially with friends/family and other patients**.** Some patients might be in hospital for long periods of time so it is important that their environment is as bright and comfortable as possible.	• Socialisation spaces are important and should be integral to the design and layout of inpatient areas, not just a converted typical bay room or the end of a corridor. There should be 'somewhere to stop and have a conversation' and spaces for patients to come together socially if that is their preference. • Activity spaces must be provided to enable patients to maintain independence and have a cup of tea, lunch etc. • Daylight, natural ventilation and external views from lying in bed and seated without compromising visual/audio privacy. • Lighting, ventilation, temperature, IT/TV and privacy all controllable by patient. • Visual connection from room to external space and allowing unobtrusive observation from staff bases and corridors. • Bathroom designs must ensure that not all areas get wet and there is adequate provision for clothing storage whilst patients are showering. Showering facilities must be accessible for all patients with level access and suitable fittings for use standing/seated. • There should be space for people to securely store their personal belongings. • Bedroom fixtures and fittings are to be anti-ligature design. • Rooms to be digitally enabled for patient control and comfort – patients to have access to WiFi, phone charging points etc. • Links to outdoor space(s) for patients as highlighted in 1.11 below.  

1.10 OUTPATIENT AND AMBULATORY AREAS

Must be distinct from inpatient areas and ambulatory services must provide a homely and less clinical environment for patients.

- Separate entrance from inpatient areas. Outpatients and ambulatory services may have different access hours to inpatient areas therefore a separate entrance and entrance route should be considered.
- Circulation & wayfinding should be designed to minimise walking distances and avoid routes through inpatient areas.
- Open spaces for day patients to congregate and to do group activities.
    - Homely environment in day case/ambulatory facilities, waiting areas to be comfortable, making good use of art and colour on walls and furniture. Corridors and treatment rooms where possible to be inviting and not clinical.
- Outpatient and ambulatory areas should be bright with access to external views and natural daylight.
- Spaces should be flexible and adaptable to future proof in anticipation of any future change in demand/service.




1.11 SUPPORT SPACES The facility must provide spaces for patient activities, both internally and externally, which can be used for therapeutic purposes, 'incidental rehabilitation' and respite.	• Provide areas people can use to aid mobility and walking. • Circulation spaces to be used creatively for activities and rehabilitation without adverse implications on patient flow and wayfinding. • Garden spaces to be provided for respite and to be accessible to all including patients in beds. There must be spaces for tables and wheelchairs. • There must be sheltered external spaces that people can use in inclement weather. • Utilise outdoor spaces for therapeutic activities – such as gardening etc. • Outdoor spaces should replicate range of outdoor obstacles to practice mobility – slopes, hills, ramps etc. • Horatio's Garden for Spinal Injuries is a 'paradise for patients' and should be used as a precedent. • There must be comfortable spaces for quiet reflection.    

2. **AGREED NON NEGOTIABLES FOR STAFF**

2.1 ACCESSIBILITY Staff must be able to access the facility in a safe and convenient manner during daylight and darkness. They must also be encouraged to use green travel options.	• Pedestrian and cycle access routes from local roads, public transport and parking areas to be safe, accessible, clear and well lit. • Safe crossing points at vehicular routes. • Reliable vehicular parking for staff working late at night/early morning within reasonable distance of facility entrance. • Staff vehicular parking should have direct access/short routes to facility and be well lit. • 50 Electric vehicle charging points within 200m of building entry points. • Secure cycle store with charging point for electric cycles. Associated washing/changing area and facilities to be provided *(refer also to 2.2 below).* • Staff only entrance which should be located away from Main (public) Entrance to avoid confusion.    

2.2 WELLBEING The facility must provide for the human needs of staff, both in terms of immediate needs for sustenance and in promoting personal health and wellbeing.	• A mix of dedicated Staff spaces for personal downtime and social gatherings. Comfortable spaces away from patients and relatives where staff can discuss their day in confidence and privacy without being overheard. Spaces for impromptu conversations and informal communications. They must be attractive to encourage use, with good daylight, interesting views and a range of seating areas, some more social and some to allow quiet time. • Theatre staff are unable to leave the facility whilst on shift therefore Rest & Relaxation Hubs should be co-located to Theatre spaces. It is important these have access to natural daylight and external views given the amount of time staff spend in spaces without this. • Kitchen area(s) required with places to store and prep food to allow staff to prepare meals on site and come together socially. • Flexible changing facilities that allow for personal privacy and are designed to respect gender sensitivities. • Shower facilities and space for staff to dry clothing to encourage green travel options. • Space for staff to store personal belongings (access to lockers for staff members). • Easy to access outside space (not at entrance area) for staff get a breath of fresh air away from public spaces which provides contrast to working environment. Could be Rooftop terrace to ensure Staff privacy. • Overnight accommodation must be provided for on call staff groups.  

	
2.3 WORKING RELATIONSHIPS The layout of the facility must be designed to aid interdisciplinary working, encourage staff interactions and communication, and to support learning.	• There must be suitable dedicated flexible training spaces which are large enough for team training and simulation which should be readily accessible by staff. • There must be a large lecture theatre with smaller associated seminar/meeting rooms. • Opportunities for staff from all disciplines/departments to meet informally during the course of the working day. • Flexible 'Break Out' spaces to facilitate impromptu 1:1's or small groups to have conversations in privacy without being overheard.  

2.4 NON-CLINICAL WORKING AREAS Must not feel segregated and must offer a range of environments to suit different tasks.	• Office environments to have access to natural daylight & external views. • Flexible and agile workspaces to allow for personal preference in working environment such as spaces for quiet working, spaces away from the main working area for 1 on 1 chats/meetings and space for sensitive calls. • Should feel attractive and inviting - not clinical and sterile. • Office spaces for some clinical environments e.g. Theatres must be “close by & at hand” to allow easy access.  

2.5 FACILITIES MANAGEMENT The management and transfer of materials and waste, and the maintenance of the facility must not impact the nature of patient areas or staff rest areas.	• Consideration must be given to all internal finishes from a cleaning and maintenance perspective. • Facility to be easy to clean and service without impacting on patient areas, or staff rest areas, visually or with noise. • Material flows should be separated from public flows. • Sufficient goods distributed storage (Corridors should not be used for storage). • Secure waste holds to be located in close proximity to each ward area. • Goods delivery areas including storage facilities for clinical departments to be accessible without implications on Patients. • Plant areas should be accessible without impacting on function of facility. • Vehicle service routes to be placed away from public and clinical areas to minimise noise impact and disruption. (Deliveries can arrive during the night so this needs to be taken into consideration). • Secure Service Yard sufficiently sized with no unauthorised access.  

3. AGREED NON-NEGOTIABLES FOR VISITORS (FAMILY/FRIENDS/CARERS)

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each*
3.1 ACCESSIBILITY The routes to and from the facility must be clear, safe and intuitive for visitor access as well as helping to reduce stress when visiting family/friends etc.	Benchmarks for Visitors should be indistinguishable from those for Patients identified in in 1.2 & 1.3 above. In addition, the facility must also provide: • Information about what other facilities are available on the wider hospital site for use of visitors is to be displayed digitally or via assessible fixtures located on and routes to and from the INS facility. Information to include key site amenities such as retail, catering, active and public transport, greenspace, walking routes, art & sanctuary, changing places.
3.2 AVAILABILITY The facility must provide support for visitors who are travelling far and those who need to be with patients out of hours.	• Single patient bedrooms should be designed to allow relatives to stay overnight within them, but some separate overnight accommodation should be provided away from patient areas. • These relatives rooms must be of a specification 'like a small hotel room' with access to daylight, external views, en-suite facilities and tea & coffee making facilities. • Breakout and Rest Spaces must be available for visitors coming to see long term patients. These should feel 'homely' and non-clinical. • Consideration should be given to routes visitors will take to wards out of hours. Avoid going through services/areas that close down out of hours.

	   
3.3 WELFARE & WELLBEING The facility must be welcoming, comforting and accessible for visitors. It must provide for the human needs of the visitor and support their wellbeing.	Benchmarks for Visitors should be indistinguishable from those for Patients identified in in 1.4, 1.5 & 1.6 above. In addition, the facility must also provide; Within the INS Facility (ies): • Flexible space for use by 3rd Sector organisations to provide information and offer support for family, friends and carers. Preferably located near Reception so it is visible and accessible upon arrival.

	• Suitable toilet facilities for use by visitors near ward areas. It is not acceptable for visitors to have to go back to the entrance/reception area in order to go to the toilet. • Baby change facilities. • Changing Places facility • Visitors should have access to WiFi, phone charging points etc. • Access to green spaces for walks and to allow visitors 'a breath of fresh air'.  

4. ALIGNMENT OF INVESTMENT WITH POLICY

Non-Negotiable Performance Objectives *What the design of the facility must enable*	**Benchmarks** *The physical characteristics expected and/or some views of what success might look like for each*
4.1 The design of the facility must contribute to the wider regeneration of the area in terms of townscape.	• The facility/facilities should be sympathetic to the urban townscape surrounding campus and enhance the local area/campus. • The facilities should well located to be easily accessible by all modes of public and private travel.
4.2 The facility should be designed to be sustainable in its development, use, adaptation and decommissioning.	• The design of the building will achieve the aims set out in the policy statement: A Policy for NHS Scotland on the Climate Emergency and Sustainable Development – DL (2021) 38. • The building will be designed to achieve Net Zero Carbon objectives in operation through design of building fabric (airtightness), and renewable energy sources wherever possible. • The building will be designed to optimise energy performance using climate projections to 2050. • Emissions will be minimised during construction. • The building design will support all focus areas of the NHS Climate Change and Sustainability Strategy 2020-2025 • Sustainability to be achieved through linking into active travel networks, provision of bicycle storage and changing facility, EV charging points. • The project team will refer to guidance **Sustainable Design and Construction (SDaC) Guide (SHTN 02-01)** and demonstrate application and compliance with this guide. • Sustainability reviews will be carried out at key design stages and reviewed by INS Redevelopment MEP & Sustainability Group. • Early NDAP, SDaC & KSAR reviews will allow a pragmatic approach to ensure sustainable principles are applied holistically. • This will include identifying specific SDaC targets and total energy kW/m2 target. • NHSScotland Soft landings (SL) Guidance, Equality benchmarks and Digital Strategy policies are to be utilised by the project team.
4.3 Future service change/expansion.	• The Site is to be large enough to meet the HCP future model design in addition to planning for future changes to services and technology. • The Building design and construction must enable adaptation & flexibility and future expansion, e.g. ‘repeatable rooms & standard components’; ‘loose fit’; modular grid; ‘soft spaces’; climate change; all electric energy source. • Safety, Accessibility & Equality will be at the foundation of our design and operations.

	• The facility/facilities must be located and designed that they may be realigned to meet changes in service. • The design adopted will maximise the ease of maintenance and alteration and minimise disruption toclinical services. • The facility/facilities, should be adaptable for modern and future technologies to allow services to advance throughout their lifetime.

This statement was developed through the engagement of the following stakeholders:

Patient reps:

Caroline Sincock, Neurology Voices, Chair

Laura Brock, Neurology Voices, Representative

Service reps:

Craig Broadfoot, General Manager, Neurosciences, OMFS* and Spinal Injuries

Lisa Dorrian, Clinical Services Manager, Surgical Services

Marie Austin, Lead Nurse, Medical Services

Laura McConnell, Senior Charge Nurse, Neurosurgery (representing Lead Nurse, Surgical Services)

Jacquie Pursey, Site Superintendent Radiographer, Diagnostics

Debbie Clark, Lead Radiographer, Neuroradiology

Donna Bisland, AHP** Team Lead, Neurorehabilitation

Alison Cassidy, AHP Team Lead, INS

Bryan Dawson, Lead Clinician, Neuroanaesthesia

Saif Razvi, Lead Clinician, Neurology

Teng Cheng Khoo, Consultant in Rehabilitation Medicine

Elaine Kennedy, Senior Charge Nurse, Outpatient Department

Sharon Johnston, Deputy Site Facilities Manager, Facilities

Pam Philp, Peri-operative Department Co-ordinator, INS Theatres

Planning Reps:

Daniel Kieran, Corporate Planning Officer, Corporate Planning Team

Jill Cram, Corporate Planning Officer, Corporate Planning Team

Jordan Livingstone, Corporate Planning Officer, Corporate Planning Team

Project Team:

Susan Walker, General Manager, Regional Services

Craig Dunn, Project Manager, Capital Planning

Marjorie Johns, Planning Manager, Regional Services

Thomas Mills, Project Manager, Capital Planning

Susan Smith, Project Support, Regional Services

5. SELF ASSESSMENT PROCESS

Decision Point	Authority of decision	Additional skills or otherperspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation
Site selection	Decision by Capital Project Board	Comment to be sought from NDAP to inform and support Capital Project Board's decision.	Utilising AEDET, SDaC, KSAR and NDAP design statement to determine if the criteria are being met. Risk/benefit analysis considering the capability of sites to deliver a development which meets the above stated criteria	Site feasibility. Local Authority plan.
Completion of brief	Decision of Capital Project Board withadvice from the Project Team	Patients/Patient representatives, clinical and non-clinical service/building users, staff and Project Team.	The above design statement will be included within the brief	Benchmark against best practice statement and completed brief
Selection of Delivery/Design Team	Project Team	Design Advisor external to Project Team, Architecture and Design Scotland (A&DS)	Design statement will be added to the project brief and assessed against AEDET.	Design statement is a key document in the development of the project.

Decision Point	Authority of decision	Additional skills or otherperspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation
Selection of early design concept from options developed	Decision of Capital Project Board withadvice from Project Team	External technical advisor. NDAP	Assessment of early options, Utilising AEDET, SDaC, KSAR and NDAP design statement to determine if the criteria are being met and to assess the likelihood of options delivering a facility which demonstrates the objectives of the design statement.	Sketch proposals developed to with sufficient detail distinguish main use types – circulation, outpatient areas, ward areas, theatres, ICU, offices, staff facilities, etc.
Approval of design proposals to be submitted for planning authority approval	Decision of Capital Project Board with advice from Project Team	Internal and external stakeholder engagement process. Technical advisor. NDAP	Formal option appraisal to assess the likelihood of options delivering a facility which demonstrates compliance with the above criteria	Review against design statement and approved service models.
Approval of detailed design proposals to allow construction	Decision of Capital Project Board with advice from Project Team	Design Advisor NDAP	Assessment of early options using AEDET, SDaC, KSAR and NDAP design statement to to evaluate and review with reference to agreed Design Statement objectives	Review against design statement and approved service models.

Decision Point	Authority of decision	Additional skills or otherperspectives	How the above criteria will be considered at this stage and/or valued in the decision	Information needed to allow evaluation
Post Project Evaluation	Decision of Capital Project Board withadvice from Project Team	Independent analysis by technical advisers/service providers.	Assessment of completed development against the objectives set out in the design statement and final AEDET SDaC and KSAR review.	Review against design statement and HCP service models. Conduct patient/relative and staff satisfaction survey within 2 years of occupancy.