

# HEALTH BUILDING NOTE 12-01: SUPPLEMENT A

## Consulting, examination and treatment facilities Supplement A - Sexual and reproductive health clinics

2007

## ***STATUS IN WALES***

## ***APPLIES***

This document replaced HBN 12 - Out-patients  
department, Supplement 1: Genito-urinary clinic  
1990

The general principles of this document apply in Wales when followed in conjunction with relevant policy documents and regulatory requirements

The points noted on the following page should be borne in mind when applying this guidance

The following should be borne in mind when applying this guidance:

- The **Strategic Framework for Promoting Sexual Health in Wales (2000)** and the **HIV and Sexual Health Modernisation Programme (2004)** apply to Wales **and not** the *National Strategy for Sexual Health and HIV (DH, 2001)*.
- The **Sexually Transmitted Infections Directions 1991** still applies to all NHS staff in Wales **and not** the *NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000* which applies to England only.
- Much of the DH guidance for Primary and Social Care premises, referred to in this document for the commissioning of services and the provision of accommodation that is fit for purpose, is no longer relevant due to the divergence of policy direction in Wales.
- Compliance with *The Health Act 2006 Part 2: Prevention and Control of Health Care Associated Infections*, the *Code of practice relating to health care associated infections* applies only to (a) English NHS bodies other than Strategic Health Authorities; and (b) cross-border SHAs, with the Healthcare Commission being the independent watchdog for healthcare in England. In Wales, Healthcare Inspectorate Wales (HIW) undertake inspections of and investigations into the provisions of healthcare commissioned and provided by Welsh NHS bodies, and are established as the regulator of independent healthcare with full delegated authority for its regulatory decisions.
- The *National Standards, Local Action (Health and Social Care Standards and Planning Framework 2005/06-2007/08)* (DH, 2004), and the associated *Standards for Better Health*, **do not** apply in Wales.
- **HBN 14-01 Pharmacy and Radio Pharmacy Facilities** has superseded HBN 29: Accommodation for Pharmaceutical Services.
- *HBN 00-02 Sanitary spaces* and *HBN 00-03 Clinical and support spaces* will be made available as *Welsh HTMs* in due course
- The **Security Management Framework for NHS Trusts in Wales 2005** calls for NHS Trusts to have an appropriately trained Security Manager/Specialist with specific operational responsibility for Trust security matters but not necessarily having undergone Local Security Management Specialist (LSMS) training as required for the NHS in England.
- The *'Directions to NHS Bodies on Security Management Measures 2004 (Amendment) Directions 2006'* and *'A Professional Approach to Managing Security in the NHS 2003'* **do not** apply in Wales.
- With regard to Information Technology Systems, appropriate networking infrastructure to deliver clinical information is required. Consultation with local IT personnel is advisable.
- *HTM 01-01 - Decontamination of reusable medical devices* is currently being re-drafted as a Welsh HTM series.
- The NHS Wales Shared Services Partnership - Facilities Services websites should be used where KIP is referred to in order to ensure the user is aware of the status of documents in Wales.

Intranet: <http://howis.wales.nhs.uk/whe> Internet: [www.wales.nhs.uk/whe](http://www.wales.nhs.uk/whe)

## Out-patient care

# Health Building Note 12-01: Consulting, examination and treatment facilities

*Supplement A: Sexual and reproductive health clinics*



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## Out-patient care

### Health Building Note 12-01:

### Consulting, examination and treatment facilities

*Supplement A: Sexual and reproductive health clinics*



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# Executive summary

This Health Building Note gives guidance on the planning and design of a sexual and reproductive health clinic located on an acute hospital site, either as a stand-alone facility or as an adjunct to a general out-patients department (OPD).

It replaces Health Building Note 12, Supplement 1 – ‘Genito Urinary Medicine Clinics’ (NHS Estates, 1990).

It is a supplement to Health Building Note 12 – ‘Out-patients department’ (DH 2004), which provides planning and design guidance for general out-patient accommodation, and this supplement should be read in conjunction with Health Building Note 12.

Some parts of the sexual health service will be provided in the community. This guidance can be applied selectively to community-based services to ensure that appropriate accommodation is used which is fit for purpose – although reference should be made to the primary and social care website: [www.primarycarecontracting.nhs.uk/243.php](http://www.primarycarecontracting.nhs.uk/243.php).

The key changes from the previous edition of the Health Building Note are as follows:

- a sexual health clinic includes facilities for both genito-urinary medicine (GUM) services and contraceptive and sexual/reproductive healthcare, in line with the current policy for service delivery as set out in the National Strategy for Sexual Health and HIV (DH, 2001);
- a sexual health clinic is defined as a discrete functional unit. Example schedules of accommodation have been produced for separate and combined GUM and contraceptive and sexual/reproductive healthcare clinics – which include the required support spaces – rather than as additional individual clinical spaces supported by the general out-patients department;
- the use of consulting and examination (C/E) rooms and/or consulting and separate examination rooms has been clarified specifically for sexual health services;
- patient flows and activity have been evaluated across the breadth of services provided, and guidance included on activity and room use;
- example room layouts have been included for unique clinical room spaces.

## Acknowledgements

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# 1 Scope of the guidance

## Introduction

- 1.1 This Health Building Note gives guidance on the planning and design of a sexual and reproductive health clinic located on an acute hospital site, either as a stand-alone facility or as an adjunct to a general out-patients department (OPD).
- 1.2 It replaces Health Building Note 12, Supplement 1 – ‘Genito Urinary Medicine Clinics’ (NHS Estates 1990). In this edition, a sexual and reproductive health clinic is defined as a discrete functional unit, and includes facilities for both genito-urinary medicine (GUM) services and contraceptive and sexual/reproductive healthcare. This reflects the current policy for service delivery as set out in the National Strategy for Sexual Health and HIV (DH 2001).
- 1.3 It is a supplement to Health Building Note 12 – ‘Out-patients department’, which provides planning and design guidance for general out-patient accommodation, and this supplement should be read in conjunction with Health Building Note 12.
- 1.4 This Health Building Note aims to provide a pick-and-mix approach to services and facilities, rather than specific inclusions or exclusions of service provision. Specific example schedules are provided on the DH Estates and Facilities Division Knowledge and Information Portal (KIP).
- 1.5 Some parts of the sexual health service will be provided in the community. This guidance can be applied selectively to community-based services to ensure that appropriate accommodation is used which is fit for purpose – although reference should be made to the primary and social care website ([www.primarycarecontracting.nhs.uk/243.php](http://www.primarycarecontracting.nhs.uk/243.php)).

## Background

### Genito-urinary medicine, contraceptive and reproductive healthcare

- 1.6 Genito-urinary medicine is the medical specialty concerned with the screening, diagnosis and management of sexually transmitted infections (STIs) and related medical conditions, including the management of HIV and AIDS.
- 1.7 Contraceptive and reproductive healthcare is concerned with all methods of contraception and unplanned pregnancy. It may also deal with aspects of medical gynaecology, sexual dysfunction and abortion procedures.
- 1.8 Community-based contraceptive clinics are increasingly taking responsibility for providing abortion services for their district. Nearly a quarter of all pregnancies in England and Wales end in abortion. Three in ten of these women have already had one or more previous abortions (‘Abortion Statistics, England and Wales’, DH, 2005).
- 1.9 Both GUM and contraceptive and reproductive healthcare services offer health promotion/ education services for vulnerable groups and facilities for training medical and nursing staff and students.
- 1.10 The burden of STIs and unwanted pregnancies falls disproportionately on young people, and it is important that services are provided to meet the needs of this vulnerable population (‘National Strategy for Sexual Health and HIV’, DH 2001).

### Fundamental principles

- 1.11 The following are fundamental service principles:
  - the service can be attended by any person, regardless of their area of residence;
  - attendees may refer themselves;
  - prompt access is available to services;

- free treatment is normally available at the point of access;
- the service is confidential;
- on-site diagnosis of common conditions is available;
- health education/promotion is available to all attendees.

1.12 All staff involved in this service provision are subject to the NHS Trust and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000. Attendees' confidentiality must be maintained

in accordance with these and other statutory requirements, including those of the Data Protection Act (1998), and the common law.

### **Managed service networks**

1.13 The National Strategy for Sexual Health and HIV aims to develop managed service networks, allowing providers to collaborate and plan services jointly and so provide a more comprehensive service to attendees, who often have multiple sexual health needs (for example, those at risk of pregnancy are also at risk of STIs).

## 2 General service considerations

### Service provided and major functions

2.1 The main service functions of a sexual health clinic are to provide some or all of the following, depending on the clinic's size and purpose:

- a self-referral, confidential service offering a full range of services with free point-of-care treatment;
- a risk assessment of clinic attendees for STIs and contraceptive and reproductive healthcare needs;
- prevention and management of unplanned pregnancy;
- clinical examination and specimen collection, where appropriate;
- primary analysis of specimens collected;
- management and treatment of clinical conditions;
- notification of partners of infected people;
- supporting people, their partners and families;
- training and education for healthcare professionals.

### Scale of provision

2.2 When planning sexual health clinic accommodation, the most convenient measure of workload is the total number of attendances per annum. However, the nature of the service and changing patterns of care require that a number of issues be taken into account:

- a. the number and type of rooms should reflect changes in practice;
- b. the balance of consulting to examination rooms: depending on local practice, separate consulting and examination rooms, combined consulting and examination rooms, or a combination of both, may be required;



- c. the provision of satellite clinics (or level 2 services) within the community and general practice;
- d. opening times;
- e. changes in activity and workload;
- f. the provision of specialist clinics;
- g. local demography.

### Functional units

2.3 The functional unit for a sexual health clinic is the clinical room (examination, consulting and examination, or interview room – see [Appendix 2](#)). The schedules of accommodation on KIP are based on this functional unit and are broken into a number of functional groups of rooms. These are as follows:

- a. entrance facilities – with additional accommodation for stand-alone units;
- b. reception and waiting;
- c. interview and counselling;
- d. consulting and examination and treatment facilities;
- e. clinical support facilities;
- f. administration/staff support (including education/training and multidisciplinary team meetings);

- g. ancillary accommodation.

## Appointments system, reception and waiting

- 2.4 Any person attending a sexual health clinic for emergency or symptomatic reasons should be assessed on the same day, or failing that on the next occasion that the clinic is open.
- 2.5 Triage can help to identify those with most urgent need and help to ensure attendance at the clinic at an appropriate time. Consideration should be given to provision of a discrete room for the triage of attendees, in order to effectively prioritise services. Delay in attendees being seen causes undue anxiety and may lead to further spread of infection, unplanned pregnancy and to clinical complications.
- 2.6 Many clinics hold sessions after 5.00 pm, at weekends and on Bank Holidays (see [paragraph 3.14](#) on security).
- 2.7 Attendance procedures should be determined in accordance with local factors, such as clinic size, local policies and staffing levels. These may include:
- “walk-in” (non-appointment) arrangements for all attendees;
  - “walk-in” arrangements for new attendees and an appointments system for return attendees;
  - an appointments system for all attendees;
  - a separate appointments system for time-consuming specific purposes, for example vasectomy, HIV clinics, genital dermatology;
  - combinations of the above.

## Clinical management of attendees

- 2.8 Clinical management of attendees varies within the service, but may include:
- investigation, management and counselling for STIs, chronic viral infections and sexually related problems, contraceptive needs, unplanned pregnancy, human immunodeficiency virus (HIV) infection, psychosexual problems, menopause, pre-menstrual syndrome (PMS), genetic and infertility problems etc;
  - partner notification – this is an integral part of the management of all attendees diagnosed with certain STIs;

- minor clinical procedures, such as cryotherapy for genital warts, fitting and removing intra-uterine devices or systems (IUDs/IUSs) or sub-dermal contraceptive hormonal implants;
- minor operations using local anaesthetic, including genital wart ablation, vasectomy, abortion,<sup>1</sup> skin biopsy and gynaecological procedures;
- early medical abortion;<sup>1</sup>
- contraceptives and other drugs, dispensed (prescribed, issued or supplied) either in the clinic (for standard treatments), or from a nearby dispensary;
- colposcopy;
- ultrasound scanning;
- administration of nebulised pentamidine;
- complex clinical situations, including emergency life-support when required.

- 2.9 Depending on local demand, separate clinic sessions may be provided for specialist clinics (for example HIV, young people etc – see [paragraph 3.11](#)). These could replace or be additional to existing sexual health clinic sessions.

## Unplanned pregnancy counselling and abortion procedure

- 2.11 Counselling services may be provided in any appropriate clinic premises.
- 2.12 If abortion procedures are to be carried out on the premises, they must meet the requirements of section 1(B) of the Abortion Act 1967. This specifies that treatment for abortion must be carried out in hospitals vested in NHS trusts, PCTs or Foundation Trusts or approved independent-sector bases.
- 2.13 For early medical abortions, space should be provided with reclining/comfortable chairs in a non-clinical setting, with easy access to toilet facilities. Currently, attendees will stay in the clinic for 6 hours, and a consulting and examination room with clinical equipment removed may be sufficient. However, consideration should be given to the appropriate design and functionality of the consulting and examination room for other clinical uses.

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<sup>1</sup> See paragraphs 2.12 and 2.13

# 3 General functional and design considerations

## Introduction

- 3.1 Planning and design teams should refer to the following publications:
- Chapter 3 of Health Building Note 12, ‘Out-patients department’ for design guidance and information on a range of topics and environmental matters that should be taken into account when designing an out-patient clinic;
  - Health Building Notes 00-02, 00-03 and 00-04 for design guidance on general areas (that is, recurring clinical and clinical support spaces, circulation spaces and sanitary spaces).

This chapter includes general functional and design considerations to take into account when planning a sexual health clinic specifically.

## Planning and design

- 3.2 Accommodation for sexual clinics should be planned and designed to the same standard as that described in Health Building Note 12 for general out-patient purposes (see Health Building Note 12, paragraphs 3.7 and 3.11–3.41). The general atmosphere should be pleasant and friendly, to help clinic attendees and staff feel at ease. Natural lighting and ventilation should be provided where possible, and the furnishings and lighting should help to create a relaxed and comfortable environment.
- 3.3 Consideration should be given to the planning and design of facilities to ensure that attendees, particularly young people, are not discouraged from attending either because of aspects of the design or because of the location of the facility.

## Location and interdepartmental relationships

- 3.4 Sexual health clinics within hospital grounds should be situated close to, and accessed via, the main entrance. Access and circulation routes to and within the clinic should be sufficiently direct and

clearly signposted to prevent clinic attendees losing their way. See ‘Wayfinding’ (NHS Estates, 2004). However, in localities with smaller, less transient populations than an acute hospital OPD, consideration should be given to balancing the need for clear and easy access with being too visible, as this may deter some people from attending if they are concerned about confidentiality.

- 3.5 Where clinics are designed specifically for young people, consideration should be given to the location and other relationships that may encourage more young people to attend, that is:
- locating the clinic close to areas commonly used by young people (for example town centre and recreation facilities) and on easily accessible transport routes;
  - the relationship to, or inclusion of, other facilities that can support the youth culture (for example cafes/internet cafes etc).
- 3.6 Within a hospital setting, the departments that have a link with the clinic should be readily accessible from it, but project teams will need to determine how far this can be achieved. The key departmental relationships are illustrated in **Figure 1**, and the main departments concerned are:
- Pathology  
Most tests will be carried out within the clinic (see **Chapter 4** ‘Primary analysis laboratory’), and attendees will generally not be required to attend the pathology department. However, the service should be supported by a comprehensive diagnostic laboratory service and adequate transport arrangements if off-site.
  - Imaging department  
Ultrasound/imaging should be easily accessible. Radiography is required for HIV management and gynaecology, and HIV attendees may also require computed tomography (CT)/magnetic resonance imaging (MRI) scans.

c. Pharmacy

Depending on the clinic size, location and practice, common drugs required for care of attendees will be stored in, and dispensed from, the clinic. However, attendees may be required to attend the pharmacy department for some drugs (for example HIV drugs).

d. Gynaecology.

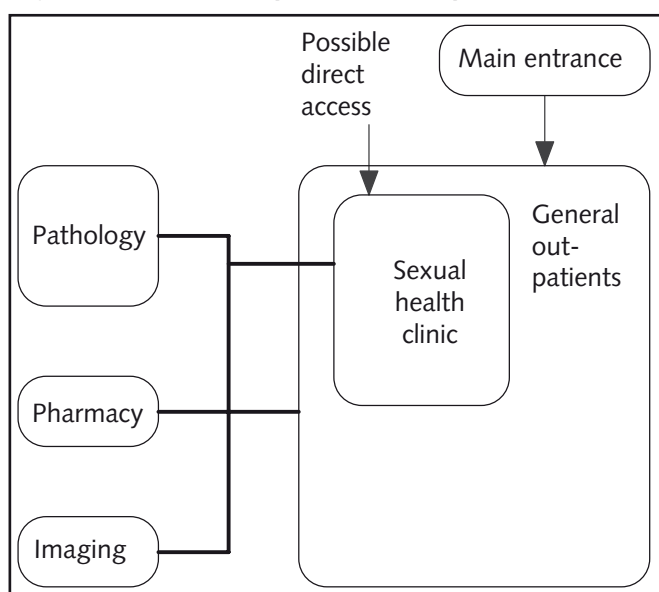
c. records;

d. supplies.

### Flexibility

3.8 The mix of attendees may vary on a daily basis, so the building should be sufficiently flexible to adapt to the requirements of both daily variations and potential future demand and changes in activity. Consideration must therefore be given to the possible requirements of specialist clinics and/or for the separation of attendees in discrete waiting areas and suites of clinical rooms. See also [paragraph 4.7b](#) (waiting spaces) and paragraphs [4.13–4.24](#) (clinical rooms).

**Figure 1 Relationships to other departments**



### Types of appointment

3.9 The needs of attendees at a general sexual health clinic may vary considerably. In evaluating the spatial requirements, consideration should also be given to the need for staff teaching and practical training. In this Health Building Note and the associated example schedules of accommodation, clinic attendees have been categorised according to type of appointment; and the attendee flow, time and space requirements have been evaluated. Reasons for attendee visits have been categorised as:

- high complexity – longer appointment time and/or involves several different rooms;
- medium complexity – average appointment time;
- low complexity – shorter attendance time and/or fewer, non-specialised rooms.

Examples of each type of appointment are listed in [Appendix 2](#), and [Figure 2](#) illustrates some notional attendee flows and room usage. For example time allocations for each category of attendee, reference should be made to [Appendix 2](#), Tables 1–4 and [Appendix 3](#), Tables 6 and 7.

## Sexual health clinic accommodation

### Core accommodation

3.7 The full range of facilities that may be required in a sexual health clinic are listed and described in [Chapter 4](#). The following spaces form the core facilities that need to be considered with regard to attendee and staff flows within the facility:

#### Patient/staff

- reception;
- waiting/sub-waiting;
- interview/counselling;
- consultation and examination;
- treatment;
- specimen toilets.

#### Staff

- primary analysis laboratory;
- utilities;

### Interview/counselling/registration

3.10 Interview/counselling may form only part of an attendee's visit or may be the sole reason for the attendance. See [paragraph 4.12](#).

### Specialist clinics

3.11 In addition to attendees presenting to general clinics, consideration should be given to the requirements of specialist clinics. Some specialist clinics may be provided on a daily basis and others



## Security

- 3.14 Assaults on hospital staff and theft of NHS property are recognised problems. As sexual health clinics may be held after 5.00 pm, when other parts of a hospital OPD or other facilities are not in use, particular consideration should be given to security. See paragraphs 5.20–5.21.

## Infection control

- 3.15 Infection control teams should be consulted from the outset of any new build or renovation project, and should remain integral planning team members throughout. In a new-build project this means that they should be members of the team that develop the business case from its inception. Detailed information about the role of the infection control team in the built environment can be found in ‘Infection control in the built environment’ (NHS Estates 2002). This document should be the first point of reference for planning teams with regard to infection control and its relation to design. A new Code of Practice entitled ‘Code of practice for the prevention and control of healthcare-associated infections 2006’ has been introduced for NHS organisations. The Code itself does not have statutory force. However, failure to comply with the Code may lead to a breach of the Health Act 2006 and, ultimately, action being taken by the Healthcare Commission.

## Decontamination

- 3.16 Decontamination is the combination of processes (including cleaning, disinfection and sterilization) used to render a re-usable item safe for further use on patients and handling by staff. The effective decontamination of re-usable surgical instruments is essential in minimising the risk of transmission of infectious agents (see Health Technical Memorandum 01-01 – ‘Decontamination of reusable medical devices’).

## Telephone services

- 3.17 Direct dialling in and out should be potentially available at all extensions in clinical spaces, subject to local control. Direct Dialling Inward should be provided to facilitate:
- people telephoning for appointments and information;
  - people telephoning for the results of their tests;
  - pre-recorded messages for out-of-hours information;
  - triage by telephone;
  - advice and counselling from health professionals.

It should include call waiting with a clear queuing system informing attendees of how long they will wait for their call to be answered.

- 3.18 Telephone conversations are best kept separate from reception activities. However, where telephones are provided in areas where conversations may be overheard, consideration should be given to their location and the detailed design of the surrounding area to improve acoustic privacy. The use of cordless telephones could be considered to enable staff to move to a more appropriate location if required.

## Patient administration systems (PAS)

- 3.19 Sexual health clinics have stand-alone PAS systems of varying complexity. This is independent of any other system in the hospital through the use of “firewalls”. A PC is required in every clinical room to track attendees through the clinic, for statutory coding, reviewing old results etc. PCs are also used by health advisers, reception, administration, and in primary analysis. Power/data trunking is recommended for flexibility in room use/layout. Consideration may be given to the use of WiFi for data access, subject to appropriate security measures.

## 4 Specific functional and design considerations

4.1 This chapter describes the full range of facilities that may be required in a sexual health clinic. The accommodation in any clinic will depend upon local service provision, activity and policy. Health Building Notes 00-02, 00-03 and 00-04 contain the specific design requirements and room layouts for standard spaces. The specific requirements for spaces in a sexual health clinic are set out below. Example schedules of accommodation are provided on KIP.

### Entrance facilities

4.2 A single access point should be provided for all attendees. In self-contained units, or any unit with direct access from the outside, an entrance lobby should be provided. For specific details of the requirements of entrance facilities, see 'Welcoming entrances and reception areas', NHS Estates 2003).

4.3 If not conveniently located elsewhere, within easy access, the following facilities should be provided in the clinic:

- a. entrance lobby;
- b. refreshment facilities;
- c. public telephones;
- d. baby changing facilities;
- e. infant feeding facilities;
- f. wheelchair parking bay.

### Reception and waiting area

#### Reception

4.4 The design of the reception area should enable clinic attendees to be received and registered in privacy. To minimise the need for verbal, and



thus audible, communication of personal details, facilities may be provided for clinic attendees to complete a pro forma in writing. See also ‘Welcoming entrances and reception areas’, NHS Estates 2003.

4.5 Consideration should be given to the first impression when entering the clinic; for example, a blank wall or a sea of faces in the waiting room could act as a barrier to attendees, particularly young people, getting to reception, and could result in their leaving before seeking help.

4.6 The location and design of the reception area should:

- a. allow reception staff to see the whole waiting area;
- b. have direct access to the health records store;
- c. have convenient access to the C/E rooms;
- d. be conveniently located for the booking of return appointments;
- e. include a next patient call system (subject to local consideration);
- f. include a facility for attendees to collect contraceptive supplies, especially condoms.

## Waiting

4.7 See Health Building Note 12 – ‘Out-patients department’ regarding the design of the clinic waiting area – facilities for sexual health clinics should be designed to the same standard and should include a separate children’s area. However, in assessing the spatial requirements for sexual health clinics, the following should also be taken into account:

- a. the provision for “walk-in” attendees in addition to those with appointments;
- b. the demographics of the local community. While the general tendency in sexual health clinics is to provide a single waiting area for all clinic attendees, certain groups/ethnic minority groups will expect/require separate male and female waiting areas;
- c. the provision of separate, or discrete, waiting areas for attendees who are particularly distressed or who are attending for some specialist clinics;

- d. the number of partners, friends, family and children attending, and the average length of stay;
- e. the provision of payphone facilities;
- f. where a clinic is specifically designed for young people, consideration should be given to appropriate interior design, use of background music and possibly internet access. If WiFi is included, this should be separate from the WiFi for clinical and administrative functions.

4.8 Provision of a television or music can be beneficial as a distraction and as an aid to acoustic privacy for discussions at reception.

## Sub-waiting

4.9 Depending on the size and design of the clinic, consideration should be given to the provision of a sub-waiting area within the consultation/examination/treatment suite. This helps attendees to feel that they are moving through the process. Sub-waits should be observable from a staffed area (for example a communications base – see [paragraph 4.26](#)).

## WCs

4.10 Separate WCs for male and female attendees should be provided near the main waiting area and should include facilities for wheelchair access.

## Interview and counselling rooms

4.11 Interview and counselling rooms should be located close to consulting and examination rooms, ensure maximum privacy and confidentiality, and have a non-clinical environment. They are required for clinic attendees, partners, families and friends, and can serve a number of purposes including:

- attendee registration.
- interview and discussion;
- counselling;
- triage.

4.12 Triage in sexual health clinics can take two main forms:

- a. **telephone triage:** the clinic may offer confidential telephone advice (for example to advise people when the appropriate time would be to attend the clinic). Consideration should be given to an appropriate location for a direct telephone line in a suitably staffed area;

- b. **triage at the clinic:** appropriate triage will help ensure that urgent cases are dealt with on the same day and, if necessary, that booked appointments are arranged for less urgent cases. Room(s) should be provided, close to reception, for the triage of attendees on arrival.

## Consulting, examination and treatment facilities

### Consulting and examination room

- 4.13 Consulting and examination (C/E) rooms in sexual health clinics should be suitable for use by male or female clinic attendees for consultation, interview, clinical examination, collection of specimens, venepuncture, minor treatments, giving injections, dispensing drugs, colposcopy, and insertion of IUDs. C/E rooms should therefore ideally be provided with double-sided access to the couch, appropriate for male and female general and genital examination.
- 4.14 Couches for female examination may have variable geometry, facilitating internal examination. These couches should have sufficient space around them to enable the couch to be converted from a lithotomy style to flat if the attendee needs to be placed in the supine position.
- 4.15 A ceiling-mounted examination lamp, clinical washbasin, apron and glove dispenser, waste and sharps bin should be provided. Consideration may be given to providing one room with single-sided couch access and a wall-mounted examination light for some clinical procedures, particularly male examinations. Free-standing examination lights should not be the standard provision, but should be available.
- 4.16 C/E rooms offer the most flexible use of space, and they are generally used for most contraception and sexual/reproductive healthcare consultations. The following points should be considered in the design and use of C/E rooms in sexual health clinics:
  - a. space is required for equipment, and the arrangement of the C/E room should allow sufficient space for training (see [Appendix 1](#), “Example room layouts”);
  - b. one or two C/E rooms should have black-out blinds to allow them to be used for scanning and funduscopy (where blinds will be used on a routine basis, the suitability of natural ventilation should be considered);

- c. attendees may have a child (or children) with them (including a buggy);
- d. the attendee may be accompanied by an assistant/chaperone, and the healthcare professional may be accompanied by a trainee;
- e. the provision of C/E rooms in a GUM-only clinic may not be an efficient use of space, since consultation and examination are often carried out separately.

### Consulting room

- 4.17 The standard consulting room described in Health Building Note 12 – ‘Out-patients department’ is appropriate for use in sexual health clinics. There should be sufficient space for an escort, children and also a buggy/push-chair and/or wheelchair. The rooms may be used for teaching purposes, so there should also be space for an observer.

### Examination room

- 4.18 Sexual health examination rooms should be appropriate for examining either male or female





clinic attendees, and space is required for equipment. At the time of publication, a larger space is recommended than is required in general out-patient facilities. Examination rooms should ideally be provided with double-sided access to a couch appropriate for male and female general and genital examination. Couches for female examination may have variable geometry, facilitating internal examination. These couches should have sufficient space around all sides to enable the couch to be converted from a lithotomy style to flat if the attendee needs to be placed in the supine position. A ceiling-mounted examination lamp should be provided. Free-standing examination lights should also be available, and consideration should be given to providing one room with a wall-mounted examination light for some clinical procedures.

- 4.19 The use of interconnecting doors between consultation and examination rooms should be discouraged, to maintain acoustic privacy between rooms.

### Treatment room

- 4.20 A treatment room provides facilities for a range of purposes:
- general procedures during a routine clinic;
  - specific procedures, for example vasectomy, difficult IUD/implant removals/insertions, colposcopy, other gynaecological procedures, and skin biopsy.
- 4.21 See Health Building Note 00-03 for the design requirements and room layout for a standard treatment space. The specific requirements of a treatment space in a sexual health clinic are set out below.
- 4.22 Depending on clinical practice, consideration should be given to providing an exhaust system for nebulised pentamidine treatments, investigation and sample collection from attendees who may have pulmonary tuberculosis (TB). See also [paragraph 5.4](#).
- 4.23 Additional equipment in a treatment room may include diathermy, cryosurgery, a cold coagulator, a loop coagulator and a colposcope (possibly with a teaching arm or video camera/television screen). Many procedures will generate heat and odours that will need to be removed by means of appropriate mechanical ventilation.
- 4.24 Depending on local requirements, some rooms may be multi-use and may be combined treatment and examination rooms.

### Venepuncture facilities

- 4.25 This Health Building Note is based on the current practice of taking of blood specimens within the main clinical rooms. However, subject to local policy, blood specimens may be taken in separate cubicles/rooms by trained phlebotomists or nurses. Where cubicles are provided, the number of cubicles should be determined by project teams. However, one should be suitable for an attendee in a wheelchair. Each cubicle/room should be large enough to accommodate one clinic attendee on a reclining phlebotomy chair, a phlebotomist, clinical hand-washing facilities with glove dispenser, storage for sterile items, and sharps and waste bins. Space should be available for the reclining chair to be laid flat should the attendee need to be placed in a supine position.

## Clinical support facilities

### Staff communications base

4.26 The provision of a staff communications base that can supervise both clinic rooms and sub-waiting areas (if provided) will greatly improve the clinical management of a unit, and should be considered in large units. Where paper notes are used, this area also provides a secure location for the management of notes throughout the attendee's visit.

### Specimen WCs

4.27 With the increased demand for asymptomatic screening, nucleic acid amplification tests (NAATs) and pregnancy testing, most attendees will be required to provide a urine specimen. A minimum of one specimen WC per three consulting and examination or examination rooms should be provided. To reduce the traffic flow of clinic attendees and staff carrying specimens, consideration should be given to locating the WCs adjacent to the primary analysis (or dirty utility) room with direct access for specimens via a hatch. The hatch should be manufactured of easy-clean materials. Where specifically male examination rooms are provided, it should be noted that it is not considered good practice to include a urinal within the consulting and examination or examination room.

4.28 Hatches are generally not considered good practice in general out-patient facilities, where the area for testing specimens is rarely manned. However, in a sexual health clinic, the primary analysis (or dirty utility) will be staffed, and specimens will be quickly removed from the hatch and tested.

### Clean utility

4.29 A clean utility room should be located adjacent to the examination/treatment area for a working supply of clean and sterile supplies. Space is required for storage of clean supplies, laying up three to four trolleys, a clinical washbasin, and possibly a drugs fridge (if not in the pharmacy store – see also [paragraph 4.36](#)).

### Dirty utility

4.30 A dirty utility room should be located in close proximity to the examination/treatment area and, where urine is to be tested in the dirty utility, in close proximity to the specimen WC(s). Specimens may be passed through a hatch from an adjacent

specimen WC (see paragraph 4.27). Facilities are required for:

- a. the disposal of liquid waste;
- b. the cleaning of dressing trolleys and other items of equipment;
- c. the temporary holding of items requiring reprocessing or disposal prior to being placed in the disposal hold.

A combined disposal unit, with a separate worktop, and clinical hand-washing facilities are required.

4.31 Where early medical abortion procedures are carried out, consideration should be given to facilities to deal with sensitive disposal of foetal material.

### Primary analysis laboratory

4.32 Sexual health clinics providing the management of STIs should have access to a facility for specimen analysis, including microscopy. If not provided within the clinic, results should be available without undue delay. In a primary analysis laboratory, little or no highly technical equipment is required and little or no sophisticated analytical procedures are carried out. Principal activities include:

- staining and microscopy, including dark ground and teaching facilities;
- holding media in a refrigerator and specimens in an incubator, prior to transfer to the hospital laboratory;
- centrifuging specimens;
- testing urine (see also paragraph 4.30);
- reviewing products of conception.

4.33 The primary analysis laboratory should be within easy reach of all the examination rooms. It should include a sink, separate clinical hand-washing facilities, worktop, cupboards, power and data for equipment and link to IT network, two refrigerators (one for the storage of pathology test equipment, for example viral transport media, and one for the storage of pathology tests undertaken) and a centrifuge (see also paragraph 4.30 regarding urine specimen testing).

4.34 Consideration should also be given to:

- a. the detail specification of the sink, floor and worktop finish to minimise the staining of fixtures and fittings when staining slides;



- b. the ventilation specification for staining areas (extraction units);
  - c. the provision of a locked metal cabinet for storage of chemicals (COSHH Regulations 2002);
  - d. the method of fixing slides – where acetone is used, gas appliances should not be used in the same room;
  - e. the potential future space requirements of extended point-of-care (POC) testing;
  - f. the system of transfer for pathological samples to main laboratory area(s) – the clinic may need a CO<sub>2</sub> incubator to maintain samples in good condition.
- a. the provision of a worktop, cupboards, large lockable drugs cupboard (not controlled) and refrigerator;
  - b. possible provision of local, locked drug storage in the individual clinic rooms (that is, C/E or consulting rooms or at other points of medication provision);
  - c. the size of the drugs cupboard required – community facilities will require greater storage;
  - d. the preferred location within the unit for staff access;
  - e. the provision of a large area for contraceptive pills/injections and condoms;
  - f. possible storage of bulky items, that is, condoms or HIV medications, following dispensing but prior to collection;
  - g. temperature control within the storage facility being maintained within the limits defined for the product stored (see also Health Building Note 29 – ‘Facilities for medicines management’).

### Resuscitation equipment bay

4.35 A bay should be provided for resuscitation equipment and O<sub>2</sub> canisters within easy access of the C/E rooms, utility rooms and treatment rooms. Anaphylaxis packs must also be available. Project teams should consider the appropriate location within the overall storage provision for the resuscitation equipment and other specific items of mobile equipment.

### Pharmacy store

4.36 Most common drugs required for the treatment of clinic attendees will be stored in, and dispensed from, the clinic. A pharmacy store may be provided separately or included within the clean utility. Consideration should be given to:

### Records

4.37 Health records contain private and confidential information and personal details about clinic attendees and people associated with them. It is essential that health records are seen by as few staff as possible. A fundamental requirement for an integrated service will be to have integrated records,

with all staff complying with the regulations on confidentiality of STIs.

- 4.38 Until the introduction of electronic patient records (EPRs), a number of points should be noted in respect of the management of records:
- a. health records should leave the clinic only under exceptional circumstances; it is essential that accommodation is provided for them to be stored securely in the clinic, and this should be provided with direct access from the clinic reception;
  - b. the distribution of health records around the clinic, between the different health professionals, should be considered in terms of both the quantity of traffic and the security of the paper notes. Clinical notes should not be left unattended, for example on tables or racks outside of clinic rooms;
  - c. with regard to quantities of local storage and requirements for long-term storage, reference should be made to 'Records management: NHS code of practice', 5 April 2006, Annex D1: Health Records, Retention Schedule.
- 4.39 The introduction of EPRs will have a significant effect on the design, operation and management of sexual health clinics. Consideration should be given to the following issues:
- a. space will be required for computer terminals and other IT hardware in every consulting room;
  - b. IT servers may be located within clinic premises or centrally within hospitals, subject to the design of the IT services (where IT rooms are provided, consideration should be given to space required for cooling equipment);
  - c. space for notes storage will be reduced or no longer required, and a significant quantity of traffic within the unit moving records from room to room will be removed;
  - d. new procedures and policies will be required to ensure confidentiality;
  - e. how old notes are scanned or printed off, and the space implications.

## Administration/staff support

### Offices

- 4.40 Office facilities are required for medical staff, specialist/lead nurses, administration and secretarial staff, health advisers and visiting staff. Clinical administrative spaces should be provided in a flexible environment with a mixture of continuous use and hot-desk spaces. Hot desks require associated quiet and breakout spaces. See Health Building Note 00-03.
- 4.41 Electronic access to laboratory results should be available; and access to external e-mail and the Internet. A safe haven for facsimiles should be available within the clinic. Staff areas should be secure, and consideration should be given to the use of key pad/proximity sensor locks (or similar) to control access to staff areas.

### Staff changing room

- 4.42 Provision should be made for the secure lockable storage of outdoor clothing and personal items, and for the temporary storage of damp clothes.

The accommodation should comprise:

- a. full-length lockers for the storage of clothing, uniforms and personal items;
- b. space for changing, and a changing cubicle for those requiring privacy;
- c. provision for the secure storage of wet clothes;
- d. a shower;
- e. hand-wash basins;
- f. separate male and female staff WC provision, within the staff changing area and/or within the clinic space (see the Workplace (Health, Safety and Welfare) Regulations 1992).

See also Health Building Notes 00-02 and 00-03.

### Staff rest room

- 4.43 The continuous sessions often worked in a sexual health clinic do not allow the easy release of staff for refreshments in communal facilities. A room, with controlled access, should be provided where staff can sit and relax during breaks. The room should have natural daylight and semi-easy chairs, beverage-making, fridge-freezer, microwave etc, and washing-up facilities and storage for a small amount of crockery. Secure lockers (that is, lock and key) may be provided for the storage of small

items of personal belongings. Hand-washing facilities are also required. See Health Building Note 00-03 for details of the general design of staff rest facilities.

### **Seminar room**

- 4.44 A seminar room should be provided, with audiovisual equipment and lockable store cupboard(s). The seminar room may be used:
- for education purposes;
  - for multidisciplinary team meetings and case reviews;
  - as a library, with the addition of appropriate storage.

### **Photocopying facilities (including shredding)**

- 4.45 Facilities should be provided for photocopying and shredding. Depending on the quantity of copying and size of copier required, this could be provided within an administration space or in a separate space.

## **Ancillary accommodation (including storage)**

### **Storage**

- 4.46 Adequate space should be provided for the storage of equipment (for example microscopes, colposcopes, hyfrecator, scan machines and diathermy) and supplies. Actual requirements will vary depending on:
- the use of disposable or reusable supplies;
  - acute hospital or community setting and supply arrangements;
  - the need for storage of contraceptive items/ health promotion leaflets.

### **Liquid nitrogen store**

- 4.47 A liquid nitrogen store is required; this should be located to assist appropriate ventilation to the outside and access for external supplies/deliveries. The provision of supplies to the store, and for staff to top up local supplies of liquid nitrogen each morning, should be considered.

### **IT hub**

- 4.48 The departmental IT servers may be located within the main hospital servers to assist in back-up, IT maintenance and interfacing with pathology/ pharmacy/radiology IT systems without compromising confidentiality. However, consideration should be given to the provision of a local IT hub room. Ventilation and/or cooling should be provided to suit the equipment contained in the room.

### **Cleaners' room**

- 4.49 Domestic services staff provide the immediate day-to-day cleaning service from this room. It should provide storage for cleaning materials and equipment in daily use, and facilities for the various activities undertaken. Hand-washing facilities are required. See Health Building Note 00-03.

### **Disposal hold**

- 4.50 This locked room should be provided at the entrance to the department, close to the dirty utility and accessible from the main hospital street. Collections may then be made without the need for porters to enter the main circulation space of the department. Bagged refuse and soiled linen are held here safely and securely while awaiting collection, in line with whole-hospital policy. The size of the disposal hold should be determined by the amount of refuse generated and the frequency of collection. See Health Building Note 00-03.

### **Switchroom or cupboard**

- 4.51 The departmental electrical supply will be to a switchroom or cupboard suitably identified and located within the department. The switchroom or cupboard should house the main isolators and distribution equipment. It should be designed to permit ease of operation and maintenance and be capable of being locked to prevent unauthorised interference. It may be recessed from the circulation routes to prevent open doors causing an obstruction.

# 5 Engineering services

## Introduction

- 5.1 This chapter provides general guidance on the engineering, technical and environmental aspects of healthcare building design. Specific guidance in relation to **sexual health clinics** is shown in **bold**.
- 5.2 Consultation should take place at project and design team level to ensure understanding of key issues, healthcare delivery and the appropriate standards for healthcare engineering services.
- 5.3 Designers should ensure that they read this publication as a whole, since further engineering guidance may be outlined in and cross-referenced within other sections.
- 5.4 The Health Technical Memorandum series is supported by an overarching publication, 'Policies and principles – Best practice guidance for healthcare engineering' (Health Technical Memorandum 00), which covers the following issues:
- a. overview of engineering services guidance;
  - b. statutory and legislative requirements;
  - c. professional support;
  - d. operational policy;
  - e. training and workforce development;
  - f. emergency procedures and contingency planning;
  - g. training, information and communications;
  - h. maintenance;
  - j. engineering services.
- 5.5 Guidance on specific types of engineering service can be found within the Health Technical Memorandum '0' series of documents as follows:
- a. Decontamination (Health Technical Memorandum 01);
  - b. Medical gases (Health Technical Memorandum 02);
  - c. Ventilation systems (Health Technical Memorandum 03);
  - d. Water systems (Health Technical Memorandum 04);
  - e. Fire safety (Health Technical Memorandum 05);
  - f. Electrical services (Health Technical Memorandum 06);
  - g. Environment and sustainability (Health Technical Memorandum 07);
  - h. Specialist services (Health Technical Memorandum 08);
  - j. other existing Health Technical Memorandum 2000 series guidance documents.

## Space requirements for services and plant

- 5.6 A high level of availability of engineering plant and services is critical to the ability of the facility to function safely and efficiently. It is therefore essential that the building design should incorporate adequate space for the full range of building services and the requirements for installation and maintenance of plant, ductwork, pipework and cabling.
- 5.7 Space for plant and services should provide:
- a. easy and safe means of access;
  - b. secure accommodation protected from unauthorised access;
  - c. adequate space around the plant services to permit inspection maintenance and replacement.
- 5.8 Guidance on spatial requirements for engineering plant and services is contained in Health Technical Memorandum 00. Further useful information regarding the provision of space for plant is contained in BSRIA Technical Note TN 9/92, and for building services distribution systems in BSRIA Technical Note TN 10/92.

- 5.9 With the exception of drainage and some heating pipework, engineering services should not be brought from the above-ceiling space of a floor below. Service distribution to a particular area should be contained within service spaces on that floor.
- 5.10 Plantrooms, particularly for air-conditioning and ventilation, should be located as close as possible to the areas they serve, thus minimising the amount of space necessary to accommodate large ducts.
- 5.11 Care should be taken to ensure that noise and structure-borne vibration cannot be transmitted beyond the plantroom. Further guidance on acoustics and vibration can be found in Health Technical Memorandum 08-01 – ‘Acoustics’ (in preparation; to replace Health Technical Memorandum 2045).

## Decontamination

- 5.12 Decontamination is the combination of processes (including cleaning, disinfection and sterilization) used to render a re-usable item safe for further use on attendees and handling by staff. The effective decontamination of re-usable surgical instruments is essential in minimising the risk of transmission of infectious agents. Further guidance is set out in Health Technical Memorandum 01-01 – ‘Decontamination of reusable medical devices’ (Parts A and B plus guidance for specific facilities).

## Mechanical services

### Piped medical gases

- 5.13 Piped medical gases should be designed in accordance with the requirements of Health Technical Memorandum 02-01 – ‘Medical gas pipeline systems’.

### Gases

- 5.14 **The use of natural gas for Bunsen burners should be avoided in the primary analysis laboratory, and alternative methods (for example hot plates) should be used for fixing slides. In the event that the use of natural gas is unavoidable, acetone and other flammable products should be controlled and used in a separate room.**
- 5.15 **Liquid nitrogen should be stored and decanted in an area with adequate and permanent natural ventilation.**

- 5.16 **The oxygen used for resuscitation trolleys should be stored in bottles held within a small local bottle store. Where CO<sub>2</sub> is required for laboratory incubators, this should be stored in bottles in a local bottle store shared with other gases.**
- 5.17 **If there is a requirement for medical vacuum, this would be best provided in the form of local vacuum units discharging outside.**

### Heating

- 5.18 General space heating requirements may be met by a variety of systems including radiators and radiant panels, or within the air-conditioning system. Designers should ensure that the most appropriate method is employed with regard to the healthcare environment being provided.
- 5.19 Where heat emitters are used, the surface temperature should not exceed 43°C. Exposed heating pipework, accessible to touch, should be encased and/or insulated. Further information is given in Health Guidance Note – ‘“Safe” hot water and surface temperatures’. Particular care should be taken when providing systems within mental health facilities.
- 5.20 Care should be taken to ensure that heat emitters do not adversely affect the local temperature conditions of adjacent storage and preparation areas.
- 5.21 Where used, radiators should be located under windows or against exposed walls. There should be space between the top of the radiator and the windowsill to prevent curtains reducing the output. There should be adequate space underneath to allow cleaning equipment to be used.
- 5.22 Where appropriate, heating controls should be provided to modulate heating circuit flow temperatures in accordance with external temperature. Radiators or radiant panels may also be used to offset building fabric heat losses in mechanically ventilated spaces. The system should be designed to ensure that the heating and ventilation systems operate in a coordinated manner and do not cause the space to overheat.
- 5.23 Ceiling-mounted heating panels can operate at higher surface temperatures than 43°C as long as the surface is not easily accessible. Heating panels should preferably run around the perimeter of the building. Panels should not be located over beds, patient trolley positions or in other locations where

they might radiate directly onto an **attende**e/patient or member of staff for a prolonged period.

- 5.24 Ceiling panels should be selected to aesthetically match the adjacent ceiling and should be sealed to the adjacent ceiling by means of a gasket or similar.

## Ventilation

- 5.25 Designers should undertake summertime temperature calculations to identify whether the internal temperature will rise to an unacceptable level. These calculations should take account of how both externally and internally generated heat gains may be reduced or controlled. It is important to achieve a balance between economy in capital and energy costs and creating appropriate levels of comfort through mechanical ventilation/comfort cooling. For areas where it is considered essential to install chilled ventilation systems, they should be designed in accordance with the requirements of Health Technical Memorandum 03-01 – ‘Specialised ventilation for healthcare premises’.
- 5.26 Air movement induced by mechanical ventilation should be from clean to less clean areas, where these areas can be defined. The design should allow for adequate flow of air into any spaces having only mechanical extract ventilation, via transfer grilles in doors or walls. However, such arrangements should avoid the introduction of untempered air and should not prejudice fire safety or privacy.
- 5.27 Local exhaust ventilation (LEV) will be required where exposure (by inhalation) to substances hazardous to health cannot be controlled by other means. The Health and Safety Executive publishes guidance notes, updated annually, on occupational exposure limits (Guidance Note EH40 – ‘Occupational Exposure Limits’) for the control of exposure by inhalation of substances hazardous to health. The limits specified form part of the requirements of compliance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH).
- 5.28 **Project teams should consider acoustic separation and privacy in planning these facilities. They should also investigate whether this would place restrictions on the design of areas that would otherwise be more simply ventilated. For certain rooms, mechanical ventilation may be necessary with suitable cross-talk attenuation. Similarly, for areas where distressed attendees may go, consideration should be given to means of minimising the**

**spread of noise. The use of natural ventilation should be considered in conjunction with the acoustic requirements to avoid a contradiction between compliance with overheating criteria and privacy criteria.**

- 5.29 **Mechanical ventilation will be required in the primary analysis laboratory to offset internal heat gains and to comply with COSHH Regulations for occupational exposure limits. This will include supply and balanced extract, together with proprietary ventilated workstations or fume cupboards, as appropriate, for procedures such as staining.**
- 5.30 **In treatment areas, where fumes and odours are generated, for example for diathermy, consideration should be given to the provision of local extract ventilation – preferably as an integral part of the equipment where available. The ventilation supply system should be provided with local temperature control. Consideration should be given to provision of negative pressure ventilation to a single treatment room for attendees who may be undergoing treatment for TB.**
- 5.31 Further guidance on the design of LEV systems may be found in Health Technical Memorandum 03-01.

## Hot and cold water systems

- 5.32 Hot and cold water storage and distribution systems should be designed in accordance with the requirements of Health Technical Memorandum 04-01 – ‘The control of *Legionella*, hygiene, “safe” hot water, cold water and drinking water systems’.
- 5.33 Exposed hot-water pipework, accessible to touch, should be encased or insulated. Special care should be taken when facilities are being provided for older, confused or mental health patients.
- 5.34 **Independent hot and cold water supplies are required for laboratories or dirty utility rooms where equipment or outlets are not served by a class A air break, for example laboratory taps with hose union connector.**

## Building management systems

- 5.35 All engineering plant and equipment associated with the internal environment should, where possible, be controlled, monitored and regulated by a building management system (BMS) in accordance with the provisions of Health Technical

Memorandum 08-05 – ‘Building management systems’ (in preparation; to replace Health Technical Memorandum 2005).

- 5.36 Requirements for the monitoring and control of plant and systems are also covered in the Health Technical Memorandum that relates to the particular plant or system.

### Internal drainage

- 5.37 A system of soil and waste drainage including anti-siphon and ventilation pipework should be provided in accordance with BS EN 12056.
- 5.38 Where plastic pipework materials are used, suitable intumescent collars should be fitted when breaching fire compartments, and acoustic wrapping should be applied where drainage runs above wards and other sensitive areas.
- 5.39 The gradient of branch drains should be uniform and adequate to convey the maximum discharge to the stack without blockage. Practical considerations such as available angles of bends, junctions and their assembly, as well as space constraints, will normally limit the gradient to about 1:50 (20 mm/m).
- 5.40 For larger pipes, for example 100 mm in diameter, the gradient may be less, but this will require high-quality workmanship if an adequate self-cleaning flow is to be maintained.
- 5.41 Provision for inspection, rodding and maintenance should ensure “full bore” access and be located outside user accommodation. The location of manholes within the building should be avoided.
- 5.42 To prevent the ingress of bacteria, waste outlets from distillation plant and refrigerators should be connected outside of the department, should not be directly connected to the drainage system, and should discharge via a trapped tundish or gully.
- 5.43 Drainage/waste systems from air-conditioning units should be installed to prevent Legionnaires’ disease and other bacteria back-feeding.
- 5.44 **All drainage that may be used for the passage of contaminated effluent should be clearly labelled.**
- 5.45 **At an early stage in the design process, proposals for the collection and discharge of chemical and radioactive contaminated effluent should be discussed and verified with the sewerage undertaker. Some water authorities may impose restrictions on the quantity and rate of discharge of such effluent into public sewers.**

### Acoustics

- 5.46 Consideration should be given at the earliest opportunity to the requirements for privacy and the impact of any intrusive noise that may affect the function of the healthcare facility. Guidance in relation to functional relationships is given in Health Technical Memorandum 08-01 ‘Acoustics’ (in preparation; to replace Health Technical Memorandum 2045).

### Fire safety

- 5.47 Fire safety standards in healthcare premises need to be high, owing to the vulnerability of occupants. The policy in respect of fire safety is set out in Health Technical Memorandum 05-01 – ‘Managing healthcare fire safety’. The design team should satisfy itself that the design meets the objectives of this guidance or provide a fire-engineered solution that achieves similar objectives.
- 5.48 It is important to establish during the design stage those aspects of fire strategy that may affect the planning of a project. At appropriate stages of the design process, the appropriate design team members should discuss their proposals with the relevant Building Control/Approved Inspector, and should ensure that the project team and all other planning staff are fully acquainted with the fire strategy for the design. This will include operational aspects (staff responsibilities etc), equipment provision, and building and engineering layouts.

### Fire detection and control systems

- 5.49 Fire detection, alarm and control systems are an integral part of the overall fire plan for a building. Close coordination between the architect and design engineer is essential to ensure that compartmentation, high-risk processes, dangerous goods and other fire-related risk issues are fully understood and embraced in the fire management solution.
- 5.50 For guidance see the ‘Firecode’ suite of documents (Health Technical Memorandum 05).

### Electrical services

#### General

- 5.51 Electrical installations should comply with the current edition of BS 7671 IEE Wiring Regulations together with Guidance Note 7 (Special Locations)

and Health Technical Memorandum 06-01 – ‘Electrical services supply and distribution’. See also ‘Medical Electrical Installation Guidance Notes’ (MEIGaN; MHRA).

- 5.52 Prior to final design, a full assessment should be made of the risk, function, occupation, equipment and resilience requirements for the area. This will influence the extent and location of services, the availability of alternative electrical supply distribution and the need for local standby supplies if appropriate.

### Electromagnetic compatibility

- 5.53 Care should be taken to avoid mains-borne and electrical radio frequency interference affecting diagnostic and monitoring equipment, computers or other sensitive electronic equipment. Guidance on the avoidance and abatement of electrical interference is given in Health Technical Memorandum 06-01 – ‘Electrical services supply and distribution’.

### Main intake switchgear and distribution boards

- 5.54 The main electrical supply should be part of the whole site/building network and should provide adequate capacity for both normal and all assessed business-critical needs.
- 5.55 Main intake and distribution equipment should be sited away from patient areas and areas where access would disrupt normal communication routes.
- 5.56 Careful consideration should also be given to the impact from flooding, pipework leaks and mechanical damage.

### Emergency electrical supplies

- 5.57 Emergency electrical provision should comply with the requirements of Health Technical Memorandum 06-01.

### Small power distribution systems

- 5.58 Depending upon the capacity of the emergency generator installation and risk assessment (see [paragraphs 5.44–5.46](#)), it may be appropriate to provide separate essential and non-essential small power distribution systems.
- 5.59 Adequate provision should be made in circulation areas, for example corridors and lobbies, to allow the use of domestic cleaning equipment having flexible cords up to 9 metres long.

### Lighting systems

- 5.60 Lighting services, including lighting controls, should comply with CIBSE’s ‘Code for Lighting’; Guide LG2 – ‘Hospitals and Health Care Buildings’ and Guide F – ‘Energy Efficiency in Buildings’.
- 5.61 In areas where VDUs are in use, lighting should be designed to comply with the guidance given in CIBSE Guide LG3 – ‘The Visual Environment for Display Screen Use’.
- 5.62 To achieve energy efficiency, lighting systems should be designed to:
- maximise use of natural daylight;
  - avoid unnecessarily high levels of illumination;
  - incorporate efficient luminaires, control gear and lamps;
  - incorporate effective controls.
- 5.63 Lighting and the appearance of luminaires should be coordinated with architectural design. In particular there should be collaboration to ensure that decorative finishes are compatible with the colour-rendering properties of lamps and that the spectral distribution of the light source is not adversely affected. See also ‘Lighting and colour for hospital design – a report on an NHS-funded research project’ (Dalke et al, 2004).
- 5.64 Light switches should be provided in easily accessible positions and at appropriate locations in corridors and general circulation areas. In areas with multiple luminaires, switches should permit the selection of luminaires appropriate to the area requiring illumination.
- 5.65 Where local circumstances permit, the provision of time switches or occupancy controls using infrared, acoustic or ultrasonic detectors should be encouraged. Additionally, low-energy or ultra-low-energy lighting should be considered as the primary lighting source.
- 5.66 Safety escape lighting should be provided on primary escape routes in accordance with the provisions of Health Technical Memorandum 06-01, Health Technical Memorandum 05-02 ‘Guidance in support of functional provisions for healthcare premises’ and the CIBSE Lighting Guide LG2 – ‘Hospitals and Health Care Buildings’.
- 5.67 It is essential that fluorescent lighting in all areas where medicines or containers are processed,

including stores, is derived from lamps having suitable colour-rendering characteristics.

- 5.68 **Examination lights in examination and treatment rooms should ideally be of the fixed and adjustable type in preference to mobile floor-standing units. Flexibility of use and flexibility for future changes should be considered in making a choice between wall- and ceiling-mounted types. Provision should be made, however, for the use of portable examination lights in case these are required.**
- 5.69 **Adequate external lighting should be provided for the safety of attendees and staff after dark. This is particularly important in locations, including footpaths and car parking areas, that are remote from the main hospital.**

#### Patient/staff and staff emergency call systems

- 5.70 Patient/staff and staff emergency call systems should comply with the requirements of Health Technical Memorandum 08-05 'Bedhead services' (in preparation; to replace Health Technical Memorandum 2015).
- 5.71 Patient/staff call points should be provided in all spaces where an **attendee**/patient may be left alone temporarily – for example consulting, examination and treatment rooms and WCs.
- 5.72 Staff emergency call points are for a member of staff to call for assistance from another member of staff. They should be provided in all spaces where staff consult, examine and treat **attendees**/patients. Consideration should be given to the use of technology as a deterrent or to enable a response to an incident.
- 5.73 The patient/staff and staff emergency call systems may be hard-wired or radio systems.
- 5.74 Where considered necessary, staff crash call points may be specifically provided for members of staff to call the crash team. This is not required as a standard installation, and needs to be specified for individual rooms where the **attendee** is at high risk of suffering a cardiac arrest.
- 5.75 A visual and audible indication of the operation of each system should be provided at a suitable staff base to give responding staff unambiguous identification of the call source, with a repeater unit in the staff rest room.

#### Security

- 5.76 Measures should be incorporated in the design of all NHS buildings to help protect the safety of staff, **attendees** and visitors and the security of the premises. Security systems will require a local risk assessment and crime prevention survey to be carried out for both daytime and out of hours, to include swipe cards, smart cards, CCTV and other available technological solutions. The project team should discuss security with the local police crime prevention officer and the trust's nominated local security management specialist (LSMS) at an early stage in the design process.
- 5.77 See the Directions to NHS Bodies on Security Management Measures 2004 (Amendment) Directions 2006 and 'A Professional Approach to Managing Security in the NHS' (NHS Security Management Service, 2003).
- 5.78 The local fire officer and LSMS should be consulted concurrently to avoid the possibility of the demands of security and fire safety conflicting.
- 5.79 **In view of the sensitivity of such a facility, the use and location of CCTV should be carefully considered – for example external cameras only and after-hours use only. The LSMS should be consulted on the use, selection and installation of CCTV.**

#### IT and telephone wiring systems

- 5.80 The IT and telephone infrastructure within the facility may be determined by existing systems within the building. However, where possible, a structured wiring system as described in Health Guidance Note – 'Structured cabling for IT systems' should be provided. This will permit a unified approach to the provision of cabling for:
- voice systems;
  - data systems;
  - imaging systems;
  - alarm systems.
- 5.81 While this "universal" cabling system is initially more expensive than separate voice and data systems, the long-term cost of ownership may prove beneficial.
- 5.82 In determining the nature of the IT system to be provided, it is necessary to identify:
- areas to be served;

- b. whether structured cabling will be used;
- c. what density of outlets is to be provided (not less than two per workstation);
- d. whether wiring will be on a “flood” or “as required” basis.

**5.83 This should be integrated with the main system, with a local switchboard routed through reception with Direct Dial Inward lines. The local switchboard console should be located close to reception but away from attendees and their interaction at reception to maintain confidentiality. The use of cordless phones at reception should also be considered (see paragraph 3.16).**

**5.84 There should be a link (with firewall) to the hospital’s main patient records system. For remote or stand-alone locations, a separate computer hub should be provided within the clinic. Designs should include appropriate provision with futureproofing in the size of cableways and distribution trunking for cabling systems.**

**5.85 Access to interpretation services should be considered for areas with diverse ethnic populations.**

**5.86 A message board texting system should be considered for each major reception/waiting area.**

**5.87 A designated software system should be provided to facilitate attendee bookings, recall management and automatic generation of required data sets.**

**5.88 Consideration could be given to the inclusion of a texting service to attendees’ mobile phones, subject to approval of the trust, and with appropriate safeguards to protect attendee confidentiality.**

### **Bedhead services and entertainment systems**

**5.89 Allowance should be made for the introduction of television and radio systems in waiting areas, to create a relaxing atmosphere, staff rest areas, and in locations where it would be beneficial in masking sound transfer.**

**5.90 Other services should be provided in accordance with Health Technical Memorandum 08-03 ‘Bedhead services’ (in preparation; to replace Health Technical Memorandum 2015).**

### **Pneumatic tube transport systems**

**5.91** If a new pneumatic tube system is to be installed, significant investigation needs to be undertaken to ensure that the system will meet the needs of the whole or that part of the hospital site. For further guidance on the design of pneumatic tube systems, see Health Technical Memorandum 08-02 (in preparation; to replace Health Technical Memorandum 2009).

**5.92 It is anticipated that the bulk of specimen testing will be carried out in the primary analysis laboratory. However, consideration should be given to the likely throughput of the remaining specimens to be sent to and returned from the main pathology lab in determining the need for portering versus automatic means of transfer via a pneumatic tube conveyor system.**

### **Lifts**

**5.93** Lifts may be required in order to comply with the requirements of the DDA or Part M of the Building Regulations. For further guidance on the design of lift installations, see Health Technical Memorandum 08-04 (in preparation; to replace Health Technical Memorandum 2024).

### **Controlled Drugs storage**

**5.94** Controlled drugs cupboards within wards or clinical areas should be fitted with a red lamp indicating when the cupboard is unlocked. A repeater lamp should be sited outside the doorway of the room in which the cupboard is located. If appropriate, a secondary repeater should be taken to a permanently staffed station.

**5.95** The normal power supply for each cupboard should be backed up by a small integral battery to cover the short period between mains failure and the generator becoming available.

**5.96** To assist in keeping their contents secure, controlled drugs cupboards should be fitted with a seven-lever mortice lock designed to meet BS 3621.

### **Sustainability and energy efficiency**

**5.97** The environment in which people live and work has a key influence on their health. Environmental considerations should therefore be taken into account when building or adapting facilities. The minimising of environmental impact by ensuring that energy is only used necessarily and efficiently is considered in this guidance with respect to:

- a. natural daylighting;
  - b. natural ventilation;
  - c. night set-back;
  - d. building regulations;
  - e. heat recovery;
  - f. water conservation;
  - g. minimising solar gain.
- 5.98 Efforts should be made to maximise the use of natural lighting. Passive solar design (PSD) should be employed to ensure that, as far as possible, areas such as wards, recovery units and offices are located where they can benefit from natural daylight, while other areas, for example stores, WCs and utility rooms, are located towards the core of the facility.
- 5.99 Areas where glare may be a problem, for example rooms where VDUs are routinely used, should similarly be located away from direct natural daylight.
- 5.100 Natural ventilation of rooms should be employed wherever possible and appropriate. Design should incorporate measures for minimising solar heat gains, which, if controlled, will avoid the need for mechanical ventilation. Measures to minimise the need for cooling should include locating temperature-sensitive accommodation away from south-facing fascias, shading windows, and using reflecting glass where appropriate and cost-effective.
- 5.101 Energy-using systems including heating, ventilation, cooling and lighting should be controlled to minimise consumption. Consideration may be given to utilising the thermal properties of the building when the facility is not in use, for example at night or weekends, where circumstances permit.
- 5.102 Energy recovery systems should be employed when possible, and particularly on ventilation systems.
- 5.103 For further guidance on energy efficiency, see Health Technical Memorandum 07-02 'Encode – making energy work in healthcare'.

### Commissioning and maintenance

- 5.104 It is important that, on completion of an installation and prior to hand-over, the performance of engineering services and equipment is fully commissioned to validate their function and achievement of performance.
- 5.105 The final acceptable performance details should be recorded and, together with full manufacturers' details, made available to users and the maintenance organisation before the facilities are handed over.
- 5.106 Once the facilities are operational, the overall performance should again be further performance-tested when full operational conditions are achieved. This will check that the interface between systems has not been compromised and that the systems operate to the designed criteria.
- 5.107 Risk management, operational procedures and contingency plans should be fully evaluated with staff to ensure that, in the event of an emergency, procedures can be put in place to maximise the safety of **attendees**, staff and visitors. Opportunities should be taken to practise these procedures when it is safe to do so, in order that staff remain fully conversant with what is required of them and can fully appreciate the issues involved.

# 6 Cost information

## Introduction

- 6.1 For all types of health building, it is important that building costs and revenue expenditure are best-value and consistent with acceptable standards. In applying this guidance, the need for economy should always be of prime concern. Where appropriate, space should be shared between similar activities taking place at different times. However, this solution should not be detrimental to the proper functioning of the spaces involved, nor to the needs of users.

## Departmental cost allowance guides

- 6.2 Departmental Cost Allowance Guides (DCAGs) related to this Health Building Note are officially notified in 'Quarterly Briefing', published by the Department of Health (see [www.dh.gov.uk](http://www.dh.gov.uk)). For a full listing of all DCAGs see 'Healthcare Capital Investment' on the Department of Health Estates and Facilities Knowledge and Information Portal (KIP) at <http://estatesknowledge.dh.gov.uk>.
- 6.3 For general guidance on producing business cases and ensuring robust cost information is obtained to underpin business cases, see 'How to cost a hospital' (NHS Estates 2005).
- 6.4 The attention of the project team is drawn to the Capital Investment Manual (CIM – Business Case Guide) at [www.dh.gov.uk](http://www.dh.gov.uk). This aims to reduce planning work and to encourage the production of sound business case support of both capital and revenue expenditure. Capital works estimates should be based, wherever applicable, on industry norms, such as DCAGs plus a percentage to cover on-costs.
- 6.5 The DCAGs for this Health Building Note reflect the total building, engineering and accommodation requirements that a sexual health clinic will require when incorporated into an acute general hospital where the common use of services will be available. Costs are based on a typical two-storey new-build

unit on a greenfield site with no planning constraints.

- 6.6 DCAGs are exclusive of VAT, building and planning fees and all local authority charges, and are based on a location factor of 1.00.

## On-costs

- 6.7 An allowance for on-costs (such as communication space, external works, external engineering services and abnormals) should be added to the DCAGs. Abnormals will largely be determined by site characteristics (such as an inner-city location or poor ground conditions) and by the condition or type of any building to be refurbished.
- 6.8 Project teams should assess all likely on-cost implications of individual sites and schemes at the earliest opportunity.

## Locational factors

- 6.9 Locational factor adjustments should be applied to works costs (that is, DCAGs plus established on-costs) to take account of local market conditions. For further information, see 'Quarterly Briefing' ([www.dh.gov.uk](http://www.dh.gov.uk)).

## Schedules of accommodation

- 6.10 The schedules on KIP show example notional whole department accommodation. The examples are not to be taken as ideal provision for any particular project.
- 6.11 Each example has been divided into functional groups of rooms as defined in [paragraph 2.3](#).
- 6.12 The schedules of accommodation may be updated from time to time. For the latest version see the schedule of accommodation database on KIP (<http://estatesknowledge.dh.gov.uk>).

## Dimensions and areas

- 6.13 The critical dimensions of an area are determined by the spatial requirements of any activities to be

carried out within it. Studies to establish dimensional requirements, in the form of critical dimensions, appear as diagrams in [Appendix 1](#) of this document and in Health Building Note 40 – ‘Common activity spaces’.

- 6.14 Planning teams should have data available at the earliest stages of a project to enable the approximate assessment of sizes involved. Areas used for the purpose of establishing cost allowances are listed in the schedules of accommodation at the end of this chapter. These areas do not represent recommended sizes, and should not be regarded as specific individual entitlements.
- 6.15 The efficient planning of a building may necessitate a variation to the areas given. For example, in the refurbishment/conversion of older property:
- rooms tend to be larger than the areas given;
  - some rooms may be too small or in the wrong location for efficient use;
  - circulation space tends to form a larger than normal proportion of the total area.

## Circulation

- 6.16 All internal corridors, small vertical ducts, spaces occupied by partitions/walls and other space for circulation are costed in the DCAGs. Provision is also made for a 5% planning zone and 3% allowance for engineering.
- 6.17 Circulation figures included in the DCAGs are those anticipated for new-build facilities. Where constraints are encountered, for example in refurbishment/conversion of older types of property, this figure may increase.

## Communications

- 6.18 Hospital “streets”, staircases and lifts (linking spaces) are not included in the DCAGs. Costs related to these elements, along with a suitable space allowance, should be made in the on-costs.

## Land costs

- 6.19 DCAGs are exclusive of all land costs and associated fees. However, costs associated with land costs should be included in business case submissions (as detailed in ‘CIM’), and may therefore have an important impact on the overall cost viability of a scheme.

## Engineering services

- 6.20 The following engineering services are included in the cost allowances (see [Chapter 5](#) and Activity DataBase for further information). Primary engineering services are assumed to be conveniently available at the boundary of the department.

### Mechanical services

- a. Heating: low-pressure hot water system.
- b. Ventilation: mechanical supply and extract to all clinical areas and areas requiring extract owing to type of room, that is, internal waiting areas, WCs etc. Ventilation plant, for example air-handling units/extract fans, is not included in the cost allowance.
- c. A share of the ventilation plant and central refrigeration is included in the cost allowance.
- d. Cold water service: centrally supplied to service points including drinking water. Storage tanks are excluded. An independent supply is required for the lab.
- e. Hot water service: supplied from a central system; storage and generator are excluded. An independent supply is required for the lab.

### Electrical services

- a. Departmental distribution switchboard.
- b. General lighting as required by tasks.
- c. Examination lighting (examination lamps).
- c. Fluorescent, safety and emergency luminaires, as appropriate.
- d. Socket-outlets and other power outlets for fixed and portable equipment.
- e. Supplementary equipotential earth bonding connections.
- f. Standby and safety installations from the main hospital supplies.
- g. Patient/staff and staff/staff call systems;
- h. Fire and security alarm systems.
- j. Impulse or battery-operated clocks.
- k. “Next patient” call system.
- m. Staff location extension to the hospital system.
- n. Telephone internal cabling distribution and outlets. Hand-sets excluded.

- o. Data wireways only included.
- p. UPS supplies and equipment.
- q. TV/radio wireways only.
- r. Power and data trunking is recommended for flexibility in all clinical and administrative areas.

### **Equipment (group 1)**

- Lockable drugs cupboard.

# Appendix 1 – Example room layouts

## Introduction

### Room layouts

The example room layouts included within this Health Building Note have been prepared following visits to sites in England and detailed discussion between the working group and clinicians. They are intended to illustrate

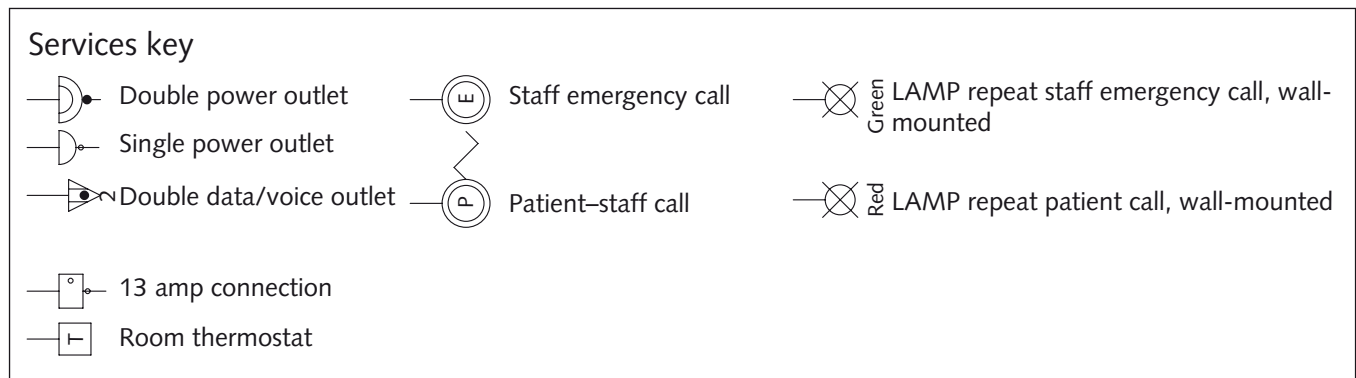
example functional space, based on good practice, and to highlight design issues for project teams to consider.

All dimensions are in millimetres.

### Engineering services

All engineering services in the room layouts are illustrated according to the key in Figure A1.

**Figure A1 Engineering services key**



## 1. Examination room – double-sided couch access

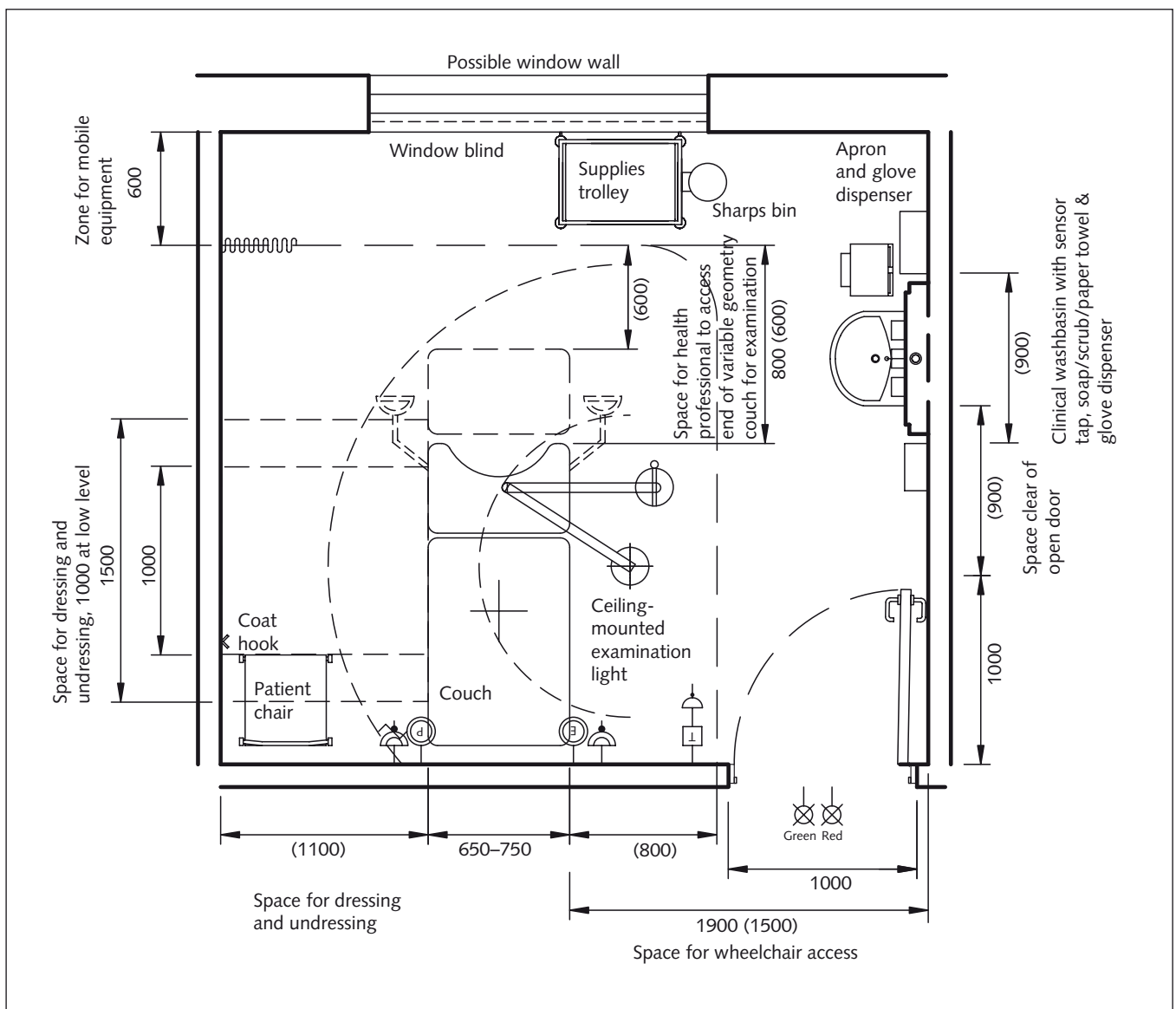
### Activities

- Examination of patient by healthcare professional plus assistant with patient's escort present.
- Minimal changing by patient at couch side, that is, patient will only expose the body part that needs to be examined.
- Holding supplies trolley for storage of sterile supplies and consumables.
- Clinical hand-washing with apron and glove dispenser.
- Training.

### Notes

- Patient–staff call is a project option.
- The general examination couch illustrated in the example layouts for this Health Building Note is 1900 mm in length. Where a different sized couch (that is, commonly 1800–2100 mm) is used, the room size should be considered to ensure adequate working area.
- The couch should ideally be appropriate for male and female general and genital examination. Couches for female examination may have variable geometry, facilitating internal examination. These couches should have sufficient space around all sides to enable them to be converted from a lithotomy style to flat if the attendee needs to be placed in the supine position.

Figure A2 Examination room – double-sided couch access



## 2. Examination room – single-sided couch access

### Activities

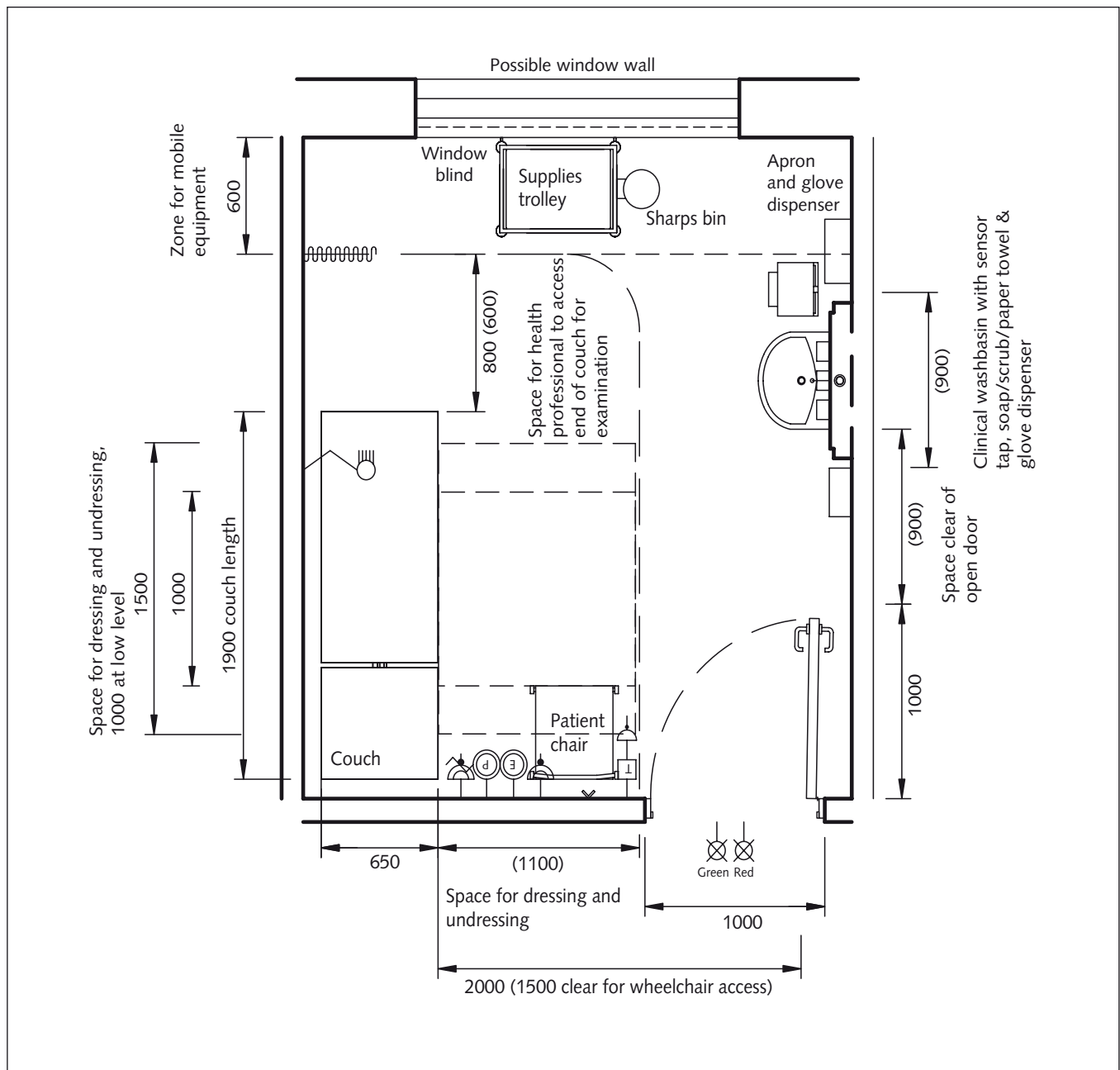
- Examination of patient by healthcare professional plus assistant with patient’s escort present.
- Minimal changing by patient at couch side, that is, patient will only expose the body part that needs to be examined.
- Holding supplies trolley for storage of sterile supplies and consumables.

- Clinical hand-washing with apron and glove dispenser.
- Training.

### Notes

- Patient–staff call is a project option.
- The general examination couch illustrated in the example layouts for this Health Building Note is 1900 mm in length. Where a different sized couch (that is, commonly 1800–2100 mm) is used, the room size should be considered to ensure adequate working area.

Figure A3 Examination room – single-sided couch access



### 3. Consulting and examination room – double-sided couch access, single door

#### Principles

- Separate zones for consulting and examination, including clinical hand-washing.

#### Activities

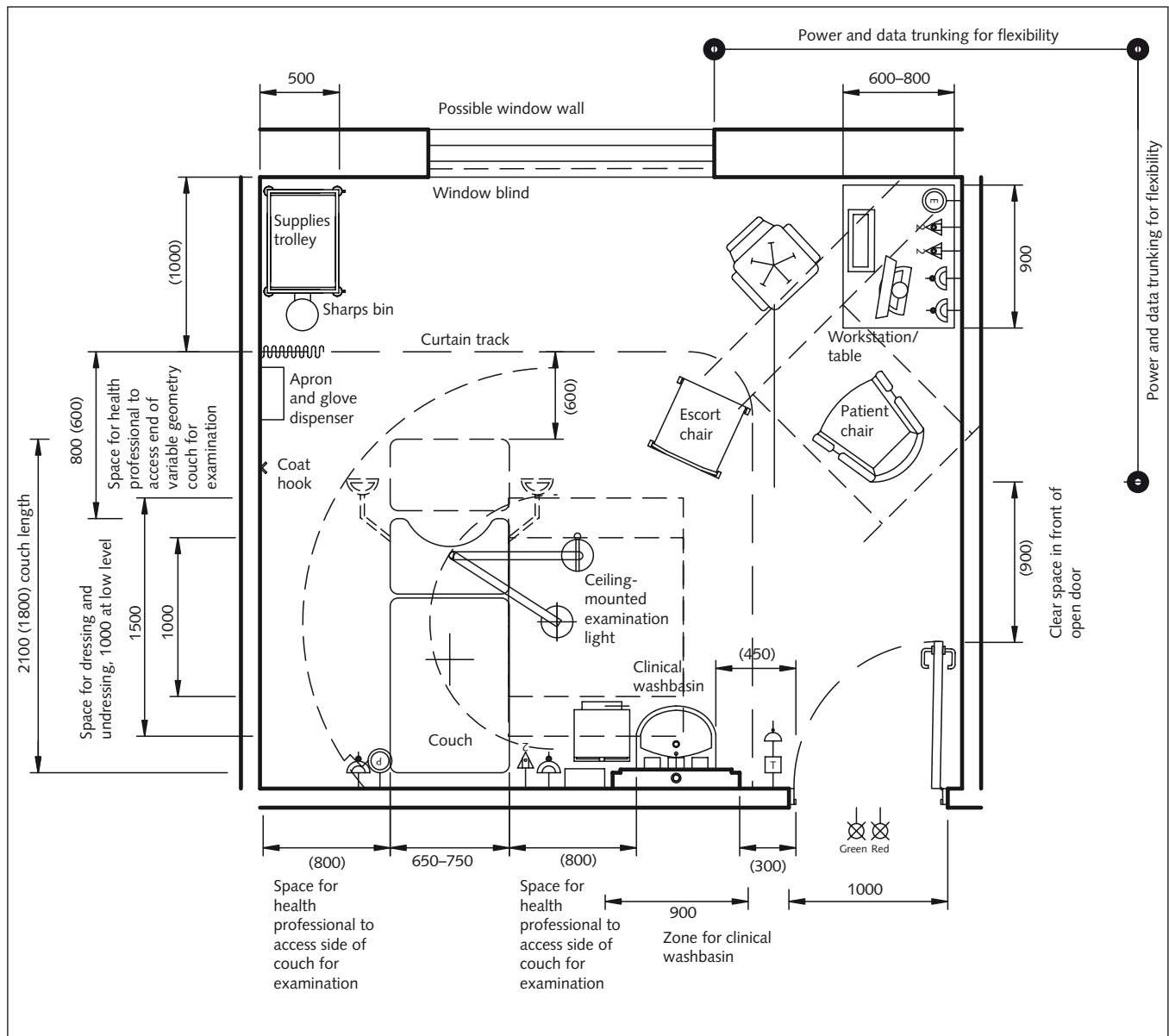
- Interview patient in privacy/confidence.
- Examination of patient by healthcare professional plus assistant with patient's escort present.
- Collection of specimens.
- Venepuncture.
- Minor treatments, giving injections, dispensing drugs, colposcopy and insertion of IUDs.
- Minimal changing by patient at couch side, that is, patient will only expose the body part that needs to be examined.
- Holding supplies trolley for storage of sterile supplies and consumables.
- Clinical hand-washing with apron and glove dispenser.

- Training.
- Accessing EPRs – computer workstation/table required.

#### Notes

- The general examination couch illustrated in the example layouts for this Health Building Note is 1900 mm in length. Where a different sized couch (that is, commonly 1800–2100 mm) is used, the room size should be considered to ensure adequate working area.
- Patient–staff call is a project option.
- When seated at the workstation, the healthcare professional should be positioned comfortably to acknowledge a visitor on entry and should not be silhouetted against the window during interview.
- The couch should ideally be appropriate for male and female general and genital examination. Couches for female examination may have variable geometry, facilitating internal examination. These couches should have sufficient space around all sides to enable them to be converted from a lithotomy style to flat if the attendee needs to be placed in the supine position.

Figure A4 Consulting and examination room – double-sided couch access, single door



## 4. Consulting and examination room – double-sided couch access, door and half

### Principles

- Separate zones for consulting and examination including clinical hand-washing.
- This optional layout includes bed/trolley access where it may be required for transfer of the attendee/patient.

### Activities

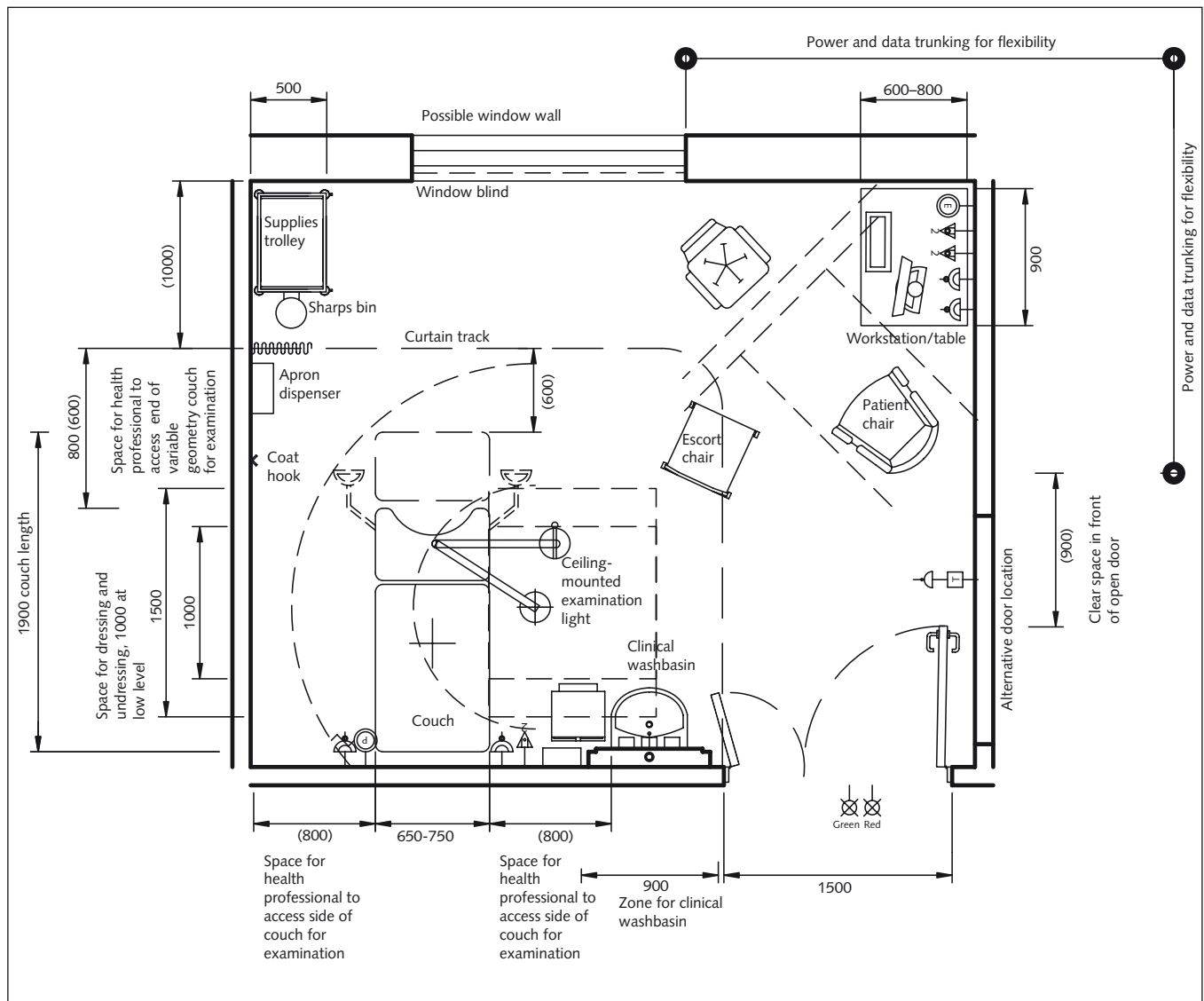
- Interview patient in privacy/confidence.
- Examination of patient by healthcare professional plus assistant with patient's escort present.
- Collection of specimens.
- Venepuncture.
- Minor treatments, giving injections, dispensing drugs, colposcopy and insertion of IUDs.
- Minimal changing by patient at couch side, that is, patient will only expose the body part that needs to be examined.
- Holding supplies trolley for storage of sterile supplies and consumables.
- Clinical hand-washing with apron and glove dispenser.

- Accessing EPRs – computer workstation/table required.
- Training.

### Notes

- This optional layout includes bed/trolley access where it may be required for transfer of the attendee/patient.
- The general examination couch illustrated in the example layouts for this Health Building Note is 1900 mm in length. Where a different sized couch (that is, commonly 1800–2100 mm) is used, the room size should be considered to ensure adequate working area.
- Patient–staff call is a project option.
- When seated at the workstation, the healthcare professional should be positioned comfortably to acknowledge a visitor on entry and should not be silhouetted against the window during interview.
- The couch should ideally be appropriate for male and female general and genital examination. Couches for female examination may have variable geometry, facilitating internal examination. These couches should have sufficient space around all sides to enable the couch to be converted from a lithotomy style to flat if the attendee needs to be placed in the supine position.

Figure A5 Consulting and examination room – double-sided access to couch, door and half



## 5. Primary analysis laboratory

### Activities

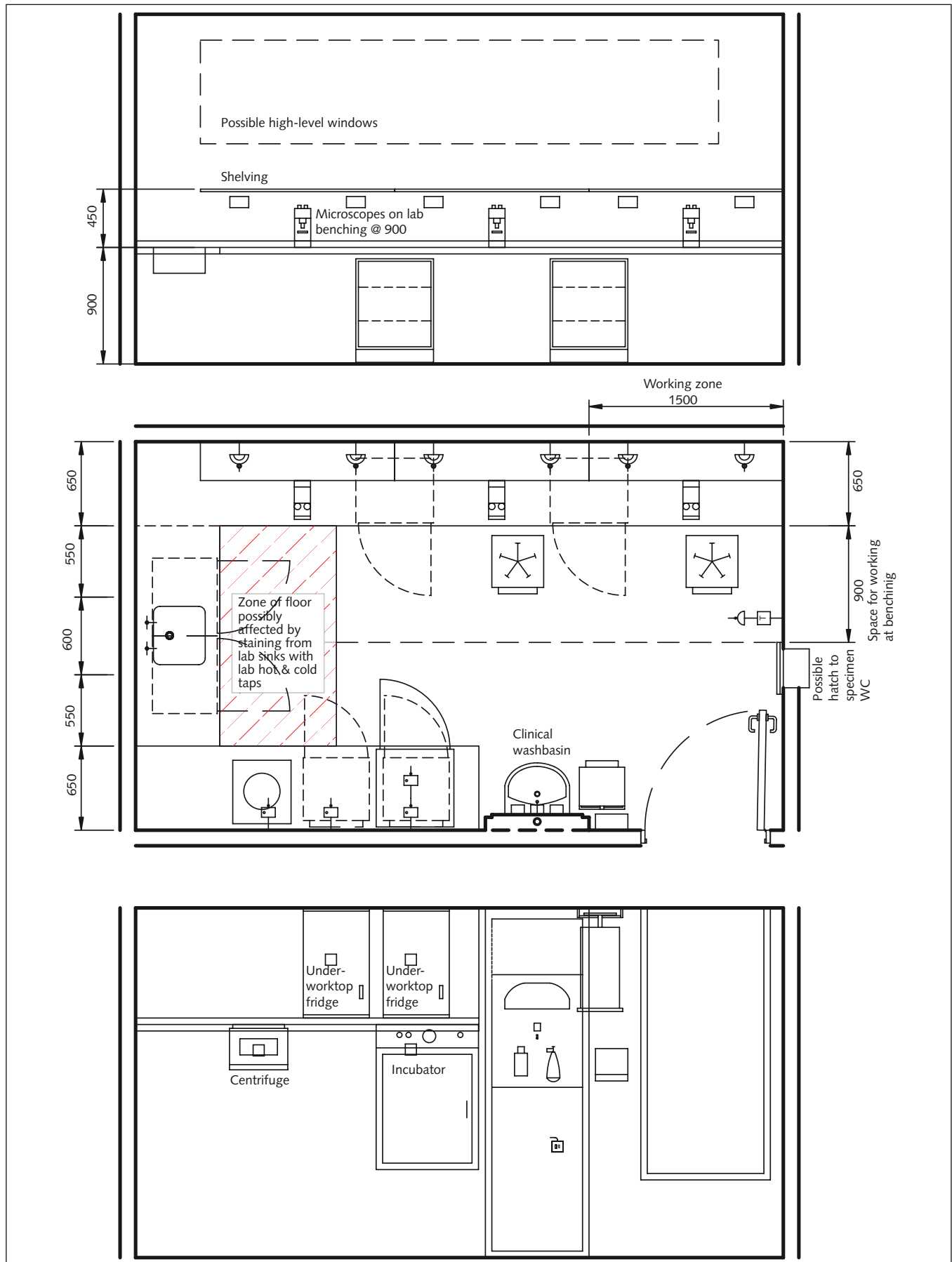
- Specimen analysis – staining and microscopy, including dark ground condenser and teaching attachments.
- Holding media in a refrigerator and specimens in an incubator, prior to transfer to the hospital laboratory.
- Centrifuging specimens (depending on local logistics/ the time before samples get to the main lab).
- Testing urine (see also [paragraph 4.30](#)).
- Reviewing products of conception.

### Notes

- Storage under worktop may be mobile.

- Consideration should be given to:
  - a. the detail specification of the sink, floor and worktop finish to minimise the staining of fixtures and fittings when staining slides;
  - b. ventilation specification for staining areas (extraction units);
  - c. provision of a locked metal cabinet for storage of chemicals (COSHH);
  - d. the method of fixing slides – where acetone is used, gas appliances should not be used in the same room;
  - e. the potential future space requirements of extended POC testing;
  - f. the system of transfer for pathological samples to main laboratory area(s) – may need CO<sub>2</sub> incubator in the clinic to maintain the samples in good condition.

Figure A6 Primary analysis laboratory



# Appendix 2 – Activity calculations and sizing

This appendix provides guidance on the sizing of sexual health clinics. It illustrates the requirements for each service, and example schedules of accommodation are included in [Chapter 6](#). The data used is for illustrative purposes only. Project teams should substitute local data.

**Note:** This document is focused entirely on clinical room(s) requirements and does not attempt to address staffing resources.

## General assumptions

There are many different operational policies and practices in sexual health clinics. In order to accommodate the range of clinical management strategies, this Health Building Note makes assumptions about common **generic practices** in order to define space needs.

- Every clinic attendee reports to reception.
- Time is taken to register attendees, check details and prepare notes.
- Attendees are interviewed in either a separate interview or a combined interview/examination suite.
- Most attendees will visit reception on their way out either to make a follow-up appointment or to collect supplies.
- Triageing attendees may lead to additional requirements for interview rooms.
- The inclusion of trainee healthcare professionals working within the clinic will increase room numbers required, as they will see their own clients, but under supervision.
- The time requirements on a room used for clinical examination should incorporate room preparation, (un)dressing, specimen preparation, issuing of drugs and phlebotomy/scanning.
- Nurses, health advisers (HAs) and counsellors may have their own case load and so will need their own rooms.

- Some attendees may need pre-test counselling (PTC) rather than simple pre-test discussions (that is, for HIV testing) before/after clinical examination.
- Most GUM attendees have microscopy irrespective of symptomatology.
- Phlebotomy has not been identified as a separate room/space requirement.
- IUD, implant, abortion and vasectomy attendees will have counselling pre-procedure – not necessarily on the same day.

## Factors that impact on room usage

- In most general clinics, it is very difficult to assign a clinical suite for a particular purpose because the requirements are unclear before the attendee arrives.
- Frequently, additional unpredicted complications arise during history-taking, for example an attendee may feel unwell following a procedure and need to recover, and so may “block” a room.
- All rooms need preparation before and after a clinic.
- Clinicians need time to process and reconcile clinical specimens and complete notes at the end of a session.
- Different staff groups have different sessional times.

## Types of appointment

See [paragraph 3.9](#).

### High-complexity appointment

These include:

- new or return high-risk attendees;
- new or return attendees with an STI identified;
- complex contraceptive cases;
- management of complex presenting infections, for example hepatitis/syphilis; unplanned pregnancy counselling/post-abortion follow-up;
- management of attendees with pelvic pain and/or gynaecological problems;

- sexual assault;
- male and female sterilization.

### Medium-complexity appointment

These include:

- IUD/implant/contraceptive diaphragm;
- asymptomatic, low-risk attendee including blood-borne infection screening;
- new contraceptive consultation.

### Low-complexity appointment

These include:

- chlamydia screening;
- ongoing treatment, for example wart clinic;
- STI counselling;
- return contraceptive consultation;
- cytology;
- wart management.

### Specialist clinics

These include:

- HIV;
- menopause/PMS;
- genital dermatology;
- vasectomy;
- colposcopy;
- early medical abortion;
- sexual dysfunction.

## Room usage

This Health Building Note attempts to group the presentations of clinic attendees into categories to determine space needs, irrespective of the clinic booking system (see [paragraph 3.9](#)). In order to assess the room usage requirements, an assessment has been made of the average time taken for individual attendees, within the defined categories, and the resultant possible activity per room evaluated based on a 3.5-hour clinic session.

Table 1 illustrates the notional timescales that were developed. An example breakdown of some of these figures is further clarified in [Tables 6 and 7](#).

**Table 1 Average number of appointments per clinic session, based on a 3.5-hour session**

Appointment type	Time per attendee (min)	Potential appointments per session (per clinical room)
High-complexity	30 minutes	7
Medium-complexity	20 minutes	10
Low-complexity	10 minutes	21
Specialist clinic	30 minutes	7
Interview/counselling	13 minutes	16

## General clinical room requirements

In order to assess the actual likely general clinical room requirements of varying clinics, the average case mix (attendee mix) of a 3.5-hour (210-minute) session has been considered. The average number of attendees per clinic/room session shown in [Tables 2–4](#) has been assumed for the purposes of the calculation within this Health Building Note.

**Table 2 Sexual health: example average case mix per clinician or room per session**

Appointment type	%	Time per attendee (min)	Average time per attendee
High complexity	50.00	30.00	15.00
Medium complexity	20.00	20.00	4.00
Low complexity	30.00	10.00	3.00
<b>Total average time per attendee</b>			22.00
<b>Average no of attendees per room per session (rounded)</b>			<b>10.00</b>

**Table 3 GUM: example average case mix per clinician or room per session**

Appointment type	%	Time per attendee (min)	Average time per attendee
High complexity	75.00	30.00	22.50
Medium complexity	12.50	20.00	2.50
Low complexity	12.50	10.00	1.25
<b>Total average time per attendee</b>			26.25
<b>Average no of attendees per room per session (rounded)</b>			<b>8.00</b>

**Table 4 Contraceptive and reproductive health: example average case mix per clinician or room per session**

Appointment type	%	Time per attendee (min)	Average time per attendee
High complexity	25.00	30.00	7.50
Medium complexity	25.00	20.00	5.00
Low complexity	50.00	10.00	5.00
<b>Total average time per attendee</b>			17.50
<b>Average no of attendees per room per session (rounded)</b>			<b>12.00</b>

The following methodology has been used to calculate the number of required clinical rooms:

$$\text{The total number of attendees per session (E)} = \frac{A}{(C \times D)}$$

$$\text{The number of required clinical rooms per session/suite (F)} = \frac{E}{B}$$

Where:

A = Total attendances per annum (current or projected)

B = Average number of attendees per room/suite per session

C = Working weeks in year

D = Number of clinic sessions per week

E = Total number of attendees per session

F = Number of clinical rooms required

**Table 5 Calculation of clinical room requirements**

Example activity (from **Tables 2–4**)

		Sexual health (50–50 split)	Sexual health (50–50 split)	GUM	Contraceptive and reproductive healthcare
A	Total attendances per annum (current or projected)	15,000	30,000	10,000	10,000
B	Average number of attendees per session	10	10	8	12
C	Working weeks in year	48	48	48	48
D	Number of clinic sessions per week	7	7	7	7

## Calculation

Step-by-step calculations are shown at items E to F below:

		Sexual health (50–50 split)	Sexual health (50–50 split)	GUM	Contraceptive and reproductive healthcare
E	Number of attendees per session (= A/(C × D))	45.0	89.0	30.0	30.0
F	Number of clinical rooms (= E/B) required in real terms	4.46	8.93	3.72	2.48
		<b>5 rooms</b>	<b>9 rooms</b>	<b>4 rooms</b>	<b>3 rooms</b>

### Notes:

1. Depending on local policy, a clinical room is a consulting room, an examination room or a consulting and examination room.
2. Coincident requirements for specialist clinics/treatment rooms would be additional to the general clinic requirements.
3. Treatment rooms should be provided additionally on the basis of 1 per 2–4 clinical rooms.
4. Interview/counselling rooms should be provided on the basis of 1 per 2 clinical rooms.

## Appendix 3 – Detail of activity times

The following tables provide example detail time and room use breakdowns that have been developed and used in the overall activity/room use calculations in [Appendix 2](#).

**Table 6 Detail breakdown of times for high room-complexity GUM appointment**

ACTIVITY	ROOM RESOURCE	NOTIONAL TIME (min)		
		Clinical rooms	Interview and counselling rooms	Waiting
Report to reception	Reception			
Waiting	Waiting room			Up to 15
Clinician consultation	Consulting room or consulting and examination room	10		
Referred to HA/nurse	Waiting room			Up to 15
Pre-treatment counselling	Interview and counselling room		10	
Wait for examination	Waiting room			Up to 15
Clinical examination	Examination room or consulting and examination room	15		
Wait for results	Waiting room			Up to 15
	Laboratory			(15 while waiting)
Discuss results	Consulting room or consulting and examination room	5		
Referred to HA	Waiting room			Up to 15
Partner notification	Interview and counselling room		10	
Appt for results/TOC	Reception			
<b>TOTAL</b>		<b>30</b>	<b>20</b>	<b>Up to 75</b>

**Table 7 Detail breakdown of times for high room-complexity contraceptive and reproductive healthcare appointment**

ACTIVITY	ROOM RESOURCE	NOTIONAL TIME (min)		
		Clinical rooms	Interview and counselling rooms	Waiting
Report to reception	Reception			
Waiting	Waiting room			Up to 15
Clinician consultation	Consulting room or consulting and examination room	5		
Wait for treatment	Waiting room			Up to 15
Clinical treatment	Treatment	20		
Discuss treatment	Consulting room or consulting and examination room	5		
Waiting	Waiting room			Up to 15
Collect supplies etc.	Reception			
<b>TOTAL</b>		<b>30</b>		<b>Up to 45</b>

**Note:** For details of a study regarding the time it takes to undertake an IUD fitting, see *Journal of Family Planning and Reproductive Health Care*, Vol 32, No 3, July 2006, pp 171–172.

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