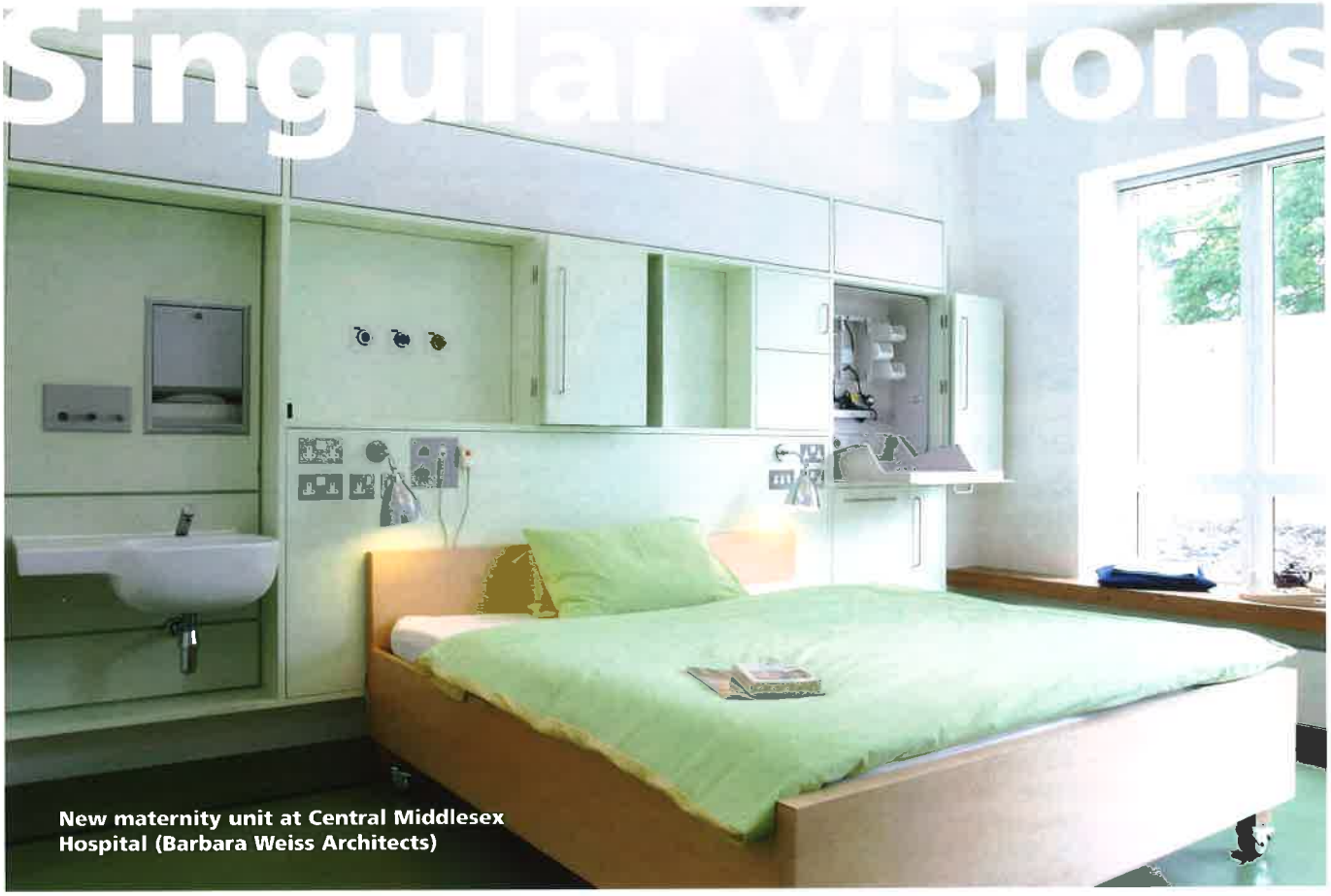
Singular visions



New maternity unit at Central Middlesex Hospital (Barbara Weiss Architects)

The recent conference held by NHS Estates featured a fascinating exchange of views on single rooms, among other key debates. James Parker reports.

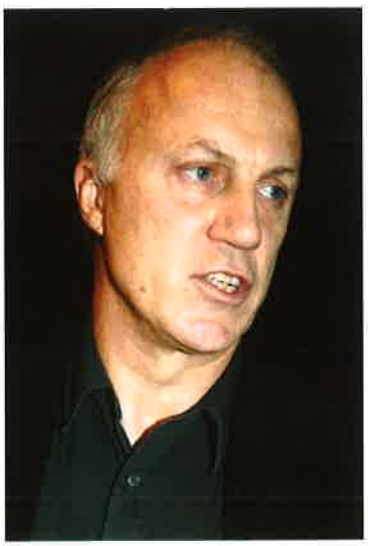
Speaking at the Transforming the Environment conference held in Harrogate last month, clinical director at NHS Estates Liz Jones told a workshop on single rooms that patients' "two main emotions" were "fear and boredom." There was certainly none of the latter in a session which heard some impassioned views from both sides of this critical debate for future health facilities.

Launching a discussion document he helped prepare with NHS Estates (*Ward layouts with single rooms and space for flexibility*), Mungo Smith from Maap Architects (pictured, right) supported the affordability case for single rooms. However he said current PFI schemes are "going nowhere," with the first 10 schemes having an average of under 25% single rooms.

The NHS Estates discussion document presents a ward model which he says costs no more to build than the current four-bed bay standard. In developing the document, Smith said in reviewing research (eg that done by bed hoist firm Arjo and other European studies), the figure of 3.6 m across each bed space "kept cropping up" with the result it was adopted by the document. He said that room lengths "was a more contentious issue." The other key principle adopted in the document was, he said, that "no one bed in a bay should be compromised by having to wait for activity to be done in any of the other three."

Smith also mentioned that his firm's recent Kidderminster Treatment Centre (see *HD*, January 2005) was a successful attempt to build single rooms to both HBN and 'Consumerism' space standards, although it is not a standard acute facility. On affordability of single rooms, he said the believed savings from higher bed occupancy rates were "not yet proven." Smith also presented the idea of a "universal room" which could have either six-bed, four-bed or single room

"It does not take a great drop in bed numbers to make the move from four-bed bays to single stack up" – Mungo Smith



"There are a relatively small number of patients who say they don't want to be on their own" – Liz Jones, NHS Estates

conformations. He admitted that the NHS is "relying on people to present [research] in a concise form that trusts have time to read."Architect Mike Nightingale contributed the thought that the centre needed to drive change in this area: "Briefs don't change until the centre grabs hold of it and says 'we want 100% single rooms and we can afford it because here's the evidence it costs less over 60 years'." The debate's chair, NHS Estates' Jonathan Millman however countered that the guidance HBN 4 (1997) proposed 50% single rooms and "PFI is not adhering to that." While the clinical aspects of reducing bed numbers by using different care models was discussed, most of the debate focused around dealing with the situation as it currently is. Mungo Smith said: "It does not take a great drop in bed numbers to make the move from 4-bed bays to single stack up."

Liz Jones presented market research undertaken on behalf of NHS Estates of 1000 members of the public who had not necessarily had experience of healthcare facilities. The poll revealed that 52% of the sample wanted to stay in a single room, and 37% would prefer to be in a shared space. However some delegates expressed the view what those with no experience of staying in an NHS facility could not provide valuable data. Roger Ulrich of Texas A&M University challenged the figures: "They are correct in some ways and misleading in others – nothing like policy should be based on them." He said researchers in the US have been collating data since 1980 on "millions" of patients in the US, and these have to date shown that 93% prefer single rooms. While there could be cultural differences at play here (eg, as one questioner said, "currently single rooms are isolation rooms in the UK,), Ulrich asserted that "European data is almost identical to the US on a room-mate being a source of stress [to patients]". Ulrich admitted that there is a "substantial minority" of patients in the UK that prefer multi-bed wards, but that "almost 100% of them have no experience of single rooms, therefore it is not a fair comparison."

Another questioner from the floor, an NHS nurse, said that statistics needed to incorporate the fact that 20% of single beds tended to be allocated to HDU areas, which she said were "very demanding on staff." She added that research in Canada had found that children desired to be in multi-bedded bays. However, a matron present went as far to say that "It's not about patient choice."

Liz Jones in her presentation attacked a perceived resistance to change on the part of nurses: "Nurses sometimes find it difficult to imagine alternatives. They are worried about observation [eg when moving over to single room plans] but then find it's fine." However this was out of kilter with the rest of her talk, in which she defended multi-bed spaces. Jones focused heavily on the 'human' side of the argument, however she was faced with a barrage of arguments for single rooms, which she countered with answers ranging from: "We will need more staff" to "There are things we can do on improving patient privacy." An A&E nurse later commented that "a lot of the time we are trying to shoehorn processes into a building [rather than design around future processes]."

Jones rather confusingly said that the "fear and boredom" which plagued patients could be reduced by contact with others, yet "this was not an argument against single rooms." She also held that (from the 1000 person sample survey) women preferred multi-bed bays, while men under 45 preferred single rooms. Jones concluded by saying that the NHS has to have some flexibility "for the relatively small number of patients who say they don,t want to be on their own."

One of the more revealing facts of a very interesting session was relayed to *HD* regarding a major London PFI scheme yet to get off the drawing board. The trust behind the scheme in question was currently looking at 3.2 m per bed space (below current 'Consumerism' guidance) however some involved are pushing for an increase to 3.6 m with 50% single rooms to meet HBN 4 requirements. However a sobering thought is that this 3.6 m would, it is believed, mean an increase of £15m to the capital cost. It will remain to be seen whether the possible reductions in bed numbers and higher occupancy from single rooms will be able to be proved, to persuade the PFI industry that such increases are worthwhile. The discussion document and events such as this will feed into the preparation of the updated HBN 4 – expected to be published later this year.

In other key sessions at the conference, Roger Ulrich presented a wide range of results from research into patient outcomes with reference to the healing environment. US architect Kirk Hamilton spelled out the practical meaning of "evidence-based design" and presented a range of very corporate-looking yet luxurious American hospital interiors, some of which resembled images from hotel brochures. However the Kern Critical Care Unit (at Legacy Good Samaritan Hospital, Oregon), although seen previously in his presentations, was again a revelation. It features intensive care rooms with windows surrounding the patient, overlooking beautiful scenery, and Hamilton said he believed that CCU patients were even taken out onto the sunny balconies on occasion.

Hamilton encouraged architects to share information, because they "live in the past, and think that to share information gives ground to their competitors." He added: "We should go for being the first to write about it," and closed with a challenging proposition: "If evidence exists, then architects responsible for facilities have the same level of responsibility to use it as they do to include fire doors." Chair of the event (and chair of NHS Estates) Bill Murray closed the event with a positive indication that the future incarnation of NHS Estates will be the ideal locus for collating usable research. "The new NHS Estates will be charged with the task of pulling together this evidence," he said, adding: "it will also pull together the institutions, internationally." This gave some sort of hope that current central moves would follow his assertion that: "If you're not going on best evidence then you're not doing the job." HD