

Mind

Insights from the Dormitory Eradication Programme 2025

In October 2020 the Government announced that more than £400m would be spent over the next four years eradicating dormitory accommodation from mental health facilities across the country in an effort to improve the safety, privacy, and dignity of patients suffering with mental illness. Funding was allocated to 34 projects across all regions of England.¹

Architects for Health, in collaboration with the Design in Mental Health Network (DiMH) and Lived Experience specialist, Hannah Chamberlain, curated a workshop session on the lessons learnt from this initiative. The session featured both architects and estates professionals working on a range of schemes across the UK. A survey was shared with AfH members to widen participation.

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<https://www.gov.uk/government/news/over-400-million-pledged-to-remove-dormitories-from-mental-health-facilities>

Introducing your workshop leaders



Hannah Chamberlain is a speaker and design consultant working at the intersection of mental health, creativity and the built environment. With lived experience of bipolar disorder and a background in innovation and public engagement, she brings a distinctive, narrative-led approach to shaping spaces and design experiences that support wellbeing.

Hannah consults on award winning product designs for mental health environments, and brings her storytelling and design approach to inspire and provoke thought with professional teams and projects.



Caroline Mulholland is a Healthcare Planner with almost 25 years' experience working in and supporting the NHS; supplemented with an MSc in Planning Buildings for Health from MARU. She is a passionate advocate for creating healthcare environments that provide staff with physical surroundings that both support and enable them to deliver the best care for their patients and clients.

Caroline brings her direct delivery experience to AfH, particularly in her current position working with a major national contractor, and is keen to explore the role that architecture and construction can have in producing sustainable solutions to help address the climate emergency.

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WORKSHOP PARTICIPANTS

Caroine and Hannah were joined by:

- **Samantha Wood**, Head of Service for Mental Health Inpatients, Urgent Care and Rehabilitation, Leicestershire Partnership NHSFT
- **Geoff Neild**, Formerly, Programme Director – Making Room for Dignity, Derbyshire Healthcare NHS Foundation Trust
- **Tom Riley**, Architectural Director, Ryder Architecture
- **Robin Graham**, Director, Gilling Dod
- **Matthew Wright**, Associate, Gilling Dod

The session explored three themes through a series of case studies and group discussion. These were:

Alternative
Spaces

Markers of
Success

Need to
Knows

LEICESTERSHIRE PARTNERSHIPS NHS TRUST



Samantha Wood is Head of Service for Mental Health, Inpatients, Urgent Care and Rehabilitation in Leicestershire – it's a big portfolio and there is a big focus on inpatients. One of her first patient conversations when joining the Trust 17 years ago was with a lady who had

had a poor experience at night in a dormitory and expressed how unsafe she had felt.

The Bradgate Unit dormitory eradication project started in the middle of the pandemic – meaning co-production work that was normally embraced, was challenging and as a team, we needed to think differently.

CONTEXT

The building is an older maternity hospital, repurposed. It has, for a long time, had a negative local reputation due to the stigma associated with mental illness. Space is restricted as it is situated on the acute hospital site which makes it difficult to extend or improve outdoor space.

Because the building is landlocked – in the middle of a bigger acute site with no expansion to extension space – it meant that in order to eliminate dormitories, we needed to lose a number of beds and there was, its fair to say, some nervousness about this given the pressures facing mental health inpatients across the country. As a Trust, we are high performing in terms of not sending people out of area and this was a core principle we were committed to maintaining throughout the programme.



	Current beds	After Dormitory work	Number of beds removed/added
Ashby	21	15	-6
Asen	23	17	-6
Barnby	15	15	0
Bosworth	22	22	0
Bosworth	20	14	-6
Thornhill	18	12	-6
Waterhead	20	20	0
Welford	24	15	-9
Langley	10	28	4
Kirby	23	23	0
Scarsdale	21	26	1
Geordale	20	19	-1
Wakerley	9	9	0
TOTAL	247	218	-32

Phase 1 – Bradgate (Bosworth and Thornhill Wards)
Phase 2 – Bradgate (Ashby and Asen Wards)
Phase 3 – Evington (Coleman and Geordale Wards)
Phase 4 – Berron (Kirby and Welford Wards)

Bradgate Unit Dormitory Eradication Programme: Leicestershire Partnerships NHS Trust

The project was undertaken in four phases due to a lack of decant space (only one ward) – meaning disruption over multiple years, with work concluding in December 2024. But this phasing had benefits – there are opportunities for iterative learning.

Working with patients, trusted others and lived experience partners – to improve from phase one to phases two, three and four.

The Trust had a change in leadership during phases three and four, and with a fresh perspective, one of the challenges put forward was to be more ambitious, when previously we'd opted for more minimal improvements.

In response to this, phase four really expanded the scope of works to explore the whole environment and maximise the opportunity.

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“ Be more ambitious!

This included maximising outdoor spaces, more dignified bathrooms; more open spaces so that patients with dementia who like to pace and loop could benefit from walking loops.

What worked really well for us was having such a strong partnership approach with the architects, clinicians, people with lived experience and our estates colleagues and the outcomes speak for themselves in terms of how much these environments have improved the experience of both our patients and our staff.

LESSONS LEARNT

1. **Be More Ambitious. We could have built a new hospital. This didn't occur to us!**
2. **Be aware that mission creep occurs with an iterative process. Build in contingency for scope change – including changing opinions on the products we want to use.**
3. **Engage with the executive leadership team. Risk appetite changes over time and that means we need to think differently about what we deliver.**



The Making Room for Dignity Programme: Derbyshire Healthcare NHS Foundation Trust + Ryder Architecture

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

CONTEXT

The Making Room for Dignity Programme (MRfD) had three strategic aims:

1. Eradicating dormitories
2. Eradicating mixed age group accommodation
3. Eradicating unnecessary out of area psychiatric care

Of these three strategic aims the first two are linked to the dormitory eradication programme.

Prior to the Making Room for Dignity Programme, 118 of Derbyshire's 142 mental health beds were based in dormitory wards, with up to five service users sharing a room.

PROGRAMME

Derbyshire Healthcare NHS Foundation Trust worked with Ryder on two brand new inpatient facilities. This was done through a co-development approach to design process including, service user, clinical and medical professionals, and support services such as E&F.



Kingsfisher and Carsington Units, Kingsway Hospital Derby
Making Room for Dignity: Derbyshire Healthcare NHS FT

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The first of the new facilities is located at Kingsway Hospital in Derby and provides:

- Three 18 beds adult acute wards – a total of 54 beds
- A 14 bed PICU ward
- A Section 136 (place of safety) suite.

A second unit at Chesterfield Royal Hospital, provides:

- Three 18 beds adult acute wards – a total of 54 beds
- A Section 136 (place of safety) suite.

In addition to these two facilities, the MRfD Programme includes:

- 12 bed older adult refurb – Walton Hospital, Chesterfield
- 34 bed adult acute refurb – Radbourne Unit Derby
- 8 bed enhanced care unit – Kingsway Hospital Derby

PERSPECTIVE



For Geoff Neild, taking the role of Programme Director for the Making Room for Dignity programme was personal: a friend ended up on one of the Derbyshire wards some time before the programme started and for 10 days, his mental health was worsening, adjusting to that environment.

The programme started during Covid-19, so once again meetings and consultations were online, using Teams. Pre-evaluation was undertaken to give baseline measurements and post-evaluation is still to come and will involve a range of personnel, including clinicians, nurses, OTs, estates and facilities.



Above: Derwent Unit, Chesterfield Royal Hospital
Below: reducing the stigma of using the service by creating welcoming buildings



For Architectural Director and Healthcare Architect, Tom Riley, the headline goal was to remove dormitories, but there was an opportunity to do much more.

This included reducing stigma, so service users enter a positive place of support and recovery.

**“ Different spaces
are provided to
suit individual
user’s needs**

Collaboration is key to the process, with end user group consultation throughout the design process enabling all user needs to be addressed. This enabled us to create a variety of spaces which offer staff good visibility without compromising privacy.

Older facilities with shared bedrooms and small spaces proved challenging for patients’ recovery, as well as for staff to manage. Private bedrooms with ensembles allow users to have spaces which suit their individual needs.

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Service users have control over their own environment, with the ability to control the lighting, heating, and ventilation within their own personal space.

Different spaces are provided to suit individual users' needs and moods. These include communal lounge and activity spaces, as well as calm and quiet rooms where users can retreat for privacy and reflection.

Access to outside spaces are provided from each ward, with both therapeutic and activity spaces. On the first floor, a second garden allows access to outdoors without the need to be escorted downstairs.



Above and Below: Derwent Unit, Chesterfield Royal Hospital – Ryder Architecture and Derbyshire NHSFT



POST OCCUPANCY EVALUATION

The team are taking a data-driven approach to Post Occupancy Evaluation (PoE), particularly to see how the new facilities are impacting staff.

Working with the Trust we will compare new and old facilities – in terms of length of stay, recovery pathways, recurrence of incidence, staff and user wellbeing.

LESSONS LEARNT

1. There are far wider benefits than just removing dormitories – providing light and space and free access to garden spaces;
2. Consider therapeutic spaces beyond the bedrooms;
3. Don't underestimate the importance of sleep: it's the cheapest thing the NHS can do to improve health outcomes.



Above: Modern facilities and an abundance of space allows service users to select a space that suits their need and mood.
Left: Shared facilities and access to outdoor space for all.

SUSSEX PARTNERSHIP NHS FOUNDATION TRUST + BLACK COUNTRY NHS FOUNDATION TRUST



Robin Graham, Director at Gilling Dod Architects has personally been involved in five dormitory eradication schemes since the government announced funding and Gilling Dod as a practice, has been involved in an even larger number of projects across the country.

Combe Valley Hospital in Bexhill (Sussex) will provide 54 individual beds across three wards for older adults and functional mental health.

Edward Street Hospital comprises a 15 bed dementia ward and a 15 bed functional older adult ward, stacked on top of each other. Both wards here are mixed gender: the design has to accommodate a plan that could flex the number of each gender at anyone time.

Both wards in this scheme are for a mixed gender user group. The design had to accommodate a plan that could flex the number of each gender at anyone



Above: Edward Street Hospital, West Bromwich – Black Country NHS Trust

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Above, Dorothy Pattison Hospital, Walsall – Black Country Healthcare NHS Trust

Dorothy Pattison Hospital was also designed and built for the same trust. It was designed for the same user groups and had the same gender split requirement.

Bedrooms were located in a horseshoe arrangement around a central courtyard. These were grouped in clusters of two or three beds with control doors. This allowed for gender split flexibility in those multiples.

Each cluster of two or three beds had its own seating area. This resting space encouraged interactions with staff and was also used by staff whilst on one to one night-time observations.



Above: Courtyard at Dorothy Pattison Hospital, Walsall – Black Country Healthcare NHS Trust

One of the core benefits in eradicating dormitories is to enable better sleep. It is probably the most cost-effective self medication we can provide.



Above: Edward Street Hospital dormitories prior to demolition Below: New single bed rooms at Edward St.



Bedrooms form roughly 70% of the new building footprint. and are therefore very important spaces.

“ In the future, could wearable technology help personalise care to suit individual user’s needs? ”

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As Associate, Matthew Wright explains, 'balancing loneliness with security and privacy is key. Anecdotal evidence suggests lower rates of self-harm when spaces are shared: service users are less likely to do self-harm in front of others.'

Covid-19 pushed us towards single beds, but on the acute side, further anecdotal evidence suggests we are seeing better turnaround (improvement) in patients in dormitories rather than single beds.

POST OCCUPANCY EVALUATION

We've already talked about a data driven approach. A slightly different slant might be towards wearable technology.

Using common machine-learning technology applied over time, we should be able to intelligently teach the building / room thermostat what the thermal sweet spot is for each occupant in each bedroom. Similarly, harmful LED light could be filtered to emit colours less harmful to sleep in the evenings.

LESSONS LEARNT

The programme has had far wider benefits beyond simply eradicating dormitories. It also has enabled us to address a wide range of existing problems across the NHS's mental health hospital estate – for example:

1. **Get the basics right – provide light and space;**
2. **Provide free and level access to nature and quality garden spaces;**
3. **Create a safe environment for service users that is homely, welcoming, and uplifting.**

OBSERVATIONS

Across the entire programme, bedroom design varies extensively. While most roughly following the principles of the repeatable room, there is a broad range of bedroom quality – for example window size, extent of furniture provision, interior design, added value elements. This is the result of project value engineering and an individual Trust's approach to and perception of risk, rather than their selection of architect/design team.



Above: Dorothy Pattison Hospital, Walsall – Black Country Healthcare NHS Trust

Attitude to risk has a big impact on ward design generally. In some instances, taking a risk-averse approach has meant removing any hint of perceived risk, sometimes at the expense of positive service user experience. This is an ongoing challenge and has become more notable post-Covid-19 with higher acuties.

The eradicating dormitories programme has been instrumental in creating a new generation of high quality mental health hospitals. With outdated and not-fit-for-purpose facilities still forming the majoring of the NHS mental health estate, what should the next big mental health hospital building programme focus on?

80% of survey respondents felt single bedrooms had the most positive impact for service users

of survey respondents said access to outdoors and staff spaces outside clinical areas had the most positive impact for staff

40%



Survey Responses

TIPS FOR A SUCCESSFUL TRANSITION

1. Good briefing, listened, challenged, applied our understanding and initiative;
2. Completing on time. Lots and lots of service user engagement;
3. Collaboration and co-design;
4. Staff, service user and carer engagement. Employing a Change and Transformation PM;
5. Provide control over heating/lighting/ventilation within individual bedrooms. Provide a variety of spaces for individual needs, from social spaces to quiet private spaces, as well as access to outside for all.

WHAT IF ANYTHING, WOULD YOU CHANGE FOR SERVICE USERS?

1. More activity spaces, more open plan, some details;
2. Autonomy over internal bedroom environment temperature;
3. More facilities close to the unit i.e. cafe. More control over their environment;
4. Reduce the number of bedrooms per ward from 18 to either 15, or ideally, 12.

WHAT IF ANYTHING, WOULD YOU CHANGE FOR STAFF?

- Better place to do admin, staff rest more easier to access;
- Reduce the number of beds per ward;
- Undertake a review of the blind spots created by the castellated door locations of the P22 repeatable rooms.

“A room may be comfortable, but therapy fails if the spaces beyond it lack variation in size, function, and degree of publicness. Too many facilities have successfully eradicated the dreaded dormitories, only to trap service users within environments where circulation spaces are too narrow, too dark, too busy, and too institutional.

SURVEY RESPONDENT



Opinion

There is no doubt that the Dormitory Eradication programme provided a significant investment in the physical environment for mental health services, and the benefits of this investment for both staff and service users will be felt for many years to come.



“ Good mental health facilities need to transition from being a building to being a service.

SURVEY RESPONDENT

This provides a unique opportunity to assess the role of the built environment in providing safe, therapeutic spaces, to learn lessons, and to share them across architectural, design, and clinical communities.

Designing for Dignity: Lessons from Therapeutic Environments

Creating therapeutic spaces in healthcare settings – especially mental health facilities – requires more than just meeting regulatory standards. It demands a deep understanding of how environment influences wellbeing, safety, and recovery. Recent reflections from practice offer valuable lessons on how to design spaces that are not only safe and compliant but also healing and empowering.

Flow, Function, and Feeling

One of the most critical design elements is the flow of social spaces. These areas must encourage natural movement and interaction without overwhelming users. Open-plan dining areas, for example, have proven effective

as multi-purpose spaces that are freely accessible and foster community. Similarly, window seats – a simple, cost-effective addition – can offer comfort and a sense of connection to the outside world. But not all patients thrive in social environments.

This insight has led to a push for larger bedrooms that include day spaces, allowing individuals to retreat without feeling isolated. The Finnish model, which incorporates single and family rooms for users needing support, is a compelling example of how design can accommodate diverse needs.

Safety and Sleep

Safety is paramount, but it must be balanced with dignity and therapeutic value. Traditional seclusion rooms are being replaced with positive de-escalation spaces, such as rooms with boxing sets, which encourage active engagement rather than punishment. This shift reflects a broader understanding that hyperactivity should not be mistaken for misbehaviour—design and staff training must work hand in hand.

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Sleep quality is another vital factor. Thoughtful choices in room colours can positively impact rest, while noise management is essential—complete silence can be unsettling for some patients. Creating a calm, sensory-friendly environment supports better sleep and overall wellbeing.

Technology and Operations

There's growing interest in integrating technology, such as smart keys for rooms, to enhance autonomy and streamline operations. However, these innovations must be supported by adequate staffing to ensure they're effective and safe.

Measuring Success

Post-Occupancy Evaluation (PoE) is key to understanding the impact of design. Both quantitative and qualitative data are needed to assess outcomes like aggression levels, length of stay, and patient satisfaction. For instance, on Thornton Ward, male patients showed higher aggression levels, but design changes led to no increase in incidents and a reduced length of stay—a powerful marker of success.

Engagement and Inclusion

Designing therapeutic spaces isn't just about architecture, it's about people. Stakeholder engagement, including patients and the wider community, ensures that spaces reflect real needs and preferences. This collaborative approach helps create environments that are not only safe and compliant but also inclusive, dignified, and healing.

On behalf of Architects for Health I would like to sincerely thank everyone who participated in the workshop and data gathering, and I look forward to further conversations on this topic.

Caroline Mulholland



Image: Chesterfield Royal Hospital, Ryder Architecture and Derbyshire NHSFT