1. Title

West of Scotland Adolescent Services 24 Bed Mental Health Inpatient Ward

3rd June 2005

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2. Executive Summary

GREATER GLASGOW PRIMARY CARE NHS TRUST

ADOLESCENT PSYCHIATRIC UNIT - OUTLINE BUSINESS CASE SUBMISSION

SECTION 1: EXECUTIVE SUMMARY

2.1 Introduction

2.1.1 The purpose of this outline business case submission is to secure approval for the provision of an adolescent psychiatric unit which will serve the population of Ayrshire & Arran; Argyle and Clyde, Dumfries and Galloway, Forth Valley, Greater Glasgow, and Lanarkshire Health Boards.

2.2 Background

2.2.1 The need to develop services for adolescents is a national priority. NHS West of Scotland Health Boards' regionally agreed strategy for developing services is:

- to establish community adolescent services, with close links to the children's, social care, education, physical and mental health services and adult mental health services;
- to establish adequate in-patient facilities within the Greater Glasgow area to complete the network of adolescent psychiatry services by bridging the gap which currently exists between community based services and the interim in-patient service provided by Greater Glasgow Primary Care Division Adolescent Psychiatry Clinical Directorate.

2.2.2 The establishment of local services, in particular the provision of an adolescent psychiatric unit, will enable the flow to local services of West of Scotland Health Board patients who are currently treated outwith the west of Scotland or admitted inappropriately to adult services. The provision of an adolescent inpatient ward will be instrumental in achieving this and is necessary to secure compliance with the requirements of the Mental Health (Care and Treatment)(Scotland) Act 2003 by enabling patients to be cared for in conditions which are appropriate to their age and level of assessed need. This will minimise exposure to the risk of judicial reviews and compensation claims, and limit the need for potentially very expensive placements in private facilities to achieve compliance with the Act.

2.2.3 The proposal to establish an adolescent inpatient ward within NHSGG is fully supported by the West of Scotland Health Boards and Regional planning mechanisms, on which NHSGG has full representation, and is a key element of a plan to provide a network of adolescent psychiatry inpatient services for NHS Scotland. The scale and configuration of the adolescent ward has been worked up in close consultation with colleagues from across the West of Scotland, to determine the number and mix of places required to support the service model.

2.3 Service Model

2.3.1 The care needs of adolescents can be broadly categorised into 4 service tiers. These are: 1) assessment and treatment/onward referral, 2) specialist assessment and treatment, 3) specialist team assessment and treatment, and 4) highly specialist services for young people with very complex and refractory disorders – inpatient mental health service. To address these needs, it is necessary to ensure that there is adequate provision at each service level, and also that there is a balanced provision across all levels so that patients can move to the care package which is most appropriate to their assessed need at a particular point in time. This is achieved through a continuous process of review and assessment.

2.4 Summary of Preferred Option

2.4.1 The preferred option for developing adolescent psychiatry services to achieve the service model is to extend community services across the West of Scotland Health Board areas and provide a new adolescent inpatient ward comprising an inpatient therapeutic environment (the subject of this OBC), and to work with social services and education to establish support in inpatient and community settings (this is already developing as a separate joint work).

2.4.2 The requirement is for an Adolescent ward of 24 places, comprising 3 sub units of 8 places. Within the facility flexibility will be established for when people require care for eating disorders and those with more intensive care needs.

2.4.3 This will provide sufficient places to accommodate those patients who are currently cared for within an interim adolescent psychiatric inpatient unit which is located at Gartnavel Hospital (16 places) and other patients who are currently accommodated within mainstream adult psychiatric hospitals within the West of Scotland. It will also accommodate those West of Scotland patients who are currently placed within the private sector and bring equilibrium to the movement of West of Scotland patients into and out of the community, existing adult in-patient services and the new adolescent ward.

2.4.4 It is recognised that the transfer of patients from other settings will require to be carefully managed over a timescale of up to a year; accordingly the commissioning of the unit will be phased to accommodate this.

2.4.5 A forecast of how occupancy levels within the unit are anticipated to develop is provided within section 3.1.1 – 3.1.13 of the OBC. This shows that the adolescent psychiatry service plans to operate inpatient facilities at an occupancy level of 90% on an ongoing basis. It is envisaged that this will provide the necessary flexibility to manage peaks in demand for places as these arise.

2.5 Location of Adolescent Ward

2.5.2 The short listed options for the 24 bed in-patient ward were:-

Do nothing -	retain interim 16 bed unit in old functionally unsuitable accommodation at Gartnavel Royal.
Do minimum -	retain interim 16 bed unit in old functionally unsuitable accommodation at Gartnavel Royal and extend the building to accommodate additional bedrooms.
New Build at Gartnavel Royal -	New build of 24 beds in three sub units of 8 beds with therapeutic activity space.
New Build at Stobhill Hospital -	New build of 24 beds in three sub units of 8 beds with therapeutic activity space.

2.5.2 The planned location for the Adolescent ward is a greenfield site at Stobhill Hospital, on the basis that this provides the opportunity for maximum benefit in terms of clinical service provision, timeliness and cost.

2.6 Summary of Preferred Solution for Providing the Adolescent Ward

2.6.1 Overview

The preferred solution is for the Adolescent Ward to be provided by competitive tender to NHS Greater Glasgow under a public finance arrangement.

Under this arrangement, the successful tender (identified under OJEC procurement guidance) will provide an Adolescent facility for use by the West of Scotland NHS Boards on completion of the building.

The Adolescent Ward will comprise 24 places, all single bedrooms with ensuite facilities at ground floor level, together with day areas, therapy rooms and all other facilities consistent with the requirements incorporated within the design specified and issued by NHSGG on behalf of the West of Scotland Health Boards.

2.6.2 Timetable – Key Dates

2005

February	Approval of OBC by Health Boards
April/May	Approval of OBC by SEHD
November	Approval of FBC by Health Boards
November	Approval of FBC by SEHD

2006

March	Detailed Planning consent obtained from Glasgow City Seek tenders for work
May	Award contract
June/July	Start construction

2007

December	Construction completed, handover and operational.

2.6.3 Financial Summary

(i) The annual revenue charge which will be made by NHSGG for providing the Adolescent Inpatient Ward service is £3,530,000 (2004/05 base cost). This is affordable, being within the funding level earmarked by West of Scotland Health Boards for the project. West of Scotland Health Boards have made provision within their financial plans for capital cost associated with the Adolescent Ward (£6.9M cost base Dec 04 including optimism bias).

(ii) The economic appraisal confirms that in terms of value for money the Stobhill proposal is more advantageous than the alternative of providing the 24 bed adolescent ward service at an alternative site. This is evident from a comparison of the net present values (NPV) of the costs of the 24 bed service options:

Net Present Cost £'000	Stobhill	Gartnavel Royal	Do Minimum
Total NPC	68,330	69,990	48,350
Benefits scoring – (consensus points)	762	710	536
Cost per benefit point	89.7	98.6	90.2

Net Present Cost (NPC) is calculated by converting every payment which would be made under any option over a period of 40 years into its present day value, then aggregating these to produce a total NPC for each option.

The analysis shows that the Stobhill proposal is forecast to very significantly increase benefits and be less costly per benefit point for the increased benefits than the other 24 bed ward options over a 40 year period.

2.6.4 **Key Contractual points**

(i) The Standard OJEC Contract documentation endorsed by the Scottish Executive Health Department will be used in this publicly funded scheme.

2.7 Conclusions

(i) The provision of an Adolescent Ward within NHSGG is a national, regional and local strategic priority and is necessary to comply with the requirements of the Mental Health (Care and Treatment)(Scotland) Act 2003.

(ii) The solution proposed through use of public sector finance for the provision of an Adolescent Ward meets the requirements of West of Scotland Health Boards, is affordable and demonstrates value for money.

(iii) The solution proposed will allow West of Scotland Health Boards to establish an operational 24 bed Adolescent Ward by December 2007. The potential for securing the capital required to provide the Adolescent Ward using Private Finance Initiative within even the long term future (i.e. up to 10 years) is regarded as remote and so the publicly funded solution represents the only realistic option for providing the ward.

(iv) Full support of project from NHS or Special Health Board

The project has the full support of the West of Scotland Health Boards. This is evidenced by the West of Scotland Regional Planning Group approval for submission of the Outline Business Case and the letters confirming financial support for the project from each West of Scotland Health Board.

3. Introduction/purpose – assessment of need

3.1. Explanation of clinical need and the benefits to patients which would result from implementation of the project.

3.1.1 The proposed 24 bed ward is for patients aged between 12 – 17 from the West of Scotland Health Board areas of:-

- Argyll & Clyde Health Board
- Ayrshire & Arran Health Board
- Dumfries & Galloway Health Board
- Forth Valley Health Board
- Greater Glasgow Health Board
- Lanarkshire Health Board

3.1.2 These West of Scotland Health Board areas are characterized by high levels of deprivation. Of a population of circa 2.7 million total population more than 700,000 people live in areas with deprivation categories 6 and 7. Patients from very deprived areas are three times more likely to be admitted to hospital than those in very affluent areas.

3.1.3 Occupied bed days for admissions to the existing acute adolescent psychiatric hospital beds have increased to more than 6300 from less than 4900 between 2000 and 2004.

3.1.4 Bed occupancy range has risen to excess of 98% in the last two years.

3.1.5 A Royal College of Psychiatrists Report in 1992 referred to a total catchment population of 250,000 having between 2 – 4 beds available for children and between 4 – 6 beds available for young people up to the age of 16. Consultant Adolescent Psychiatrists have indicated that double the number of beds are required for 16 & 17 year olds. (This would equate to 12 – 18 beds per 250,000 of the population.

3.1.6 An analysis of occupied bed days for the West of Scotland Health Board areas (between 2000 to 2003) indicates a bed occupancy in excess of 98%. There have additionally been admissions to adult psychiatry services. Historical data shows that approximately half of those admitted to an adult unit stayed less than one week and although the majority of those admitted to adult psychiatry wards were age 17, a large minority was younger. It is accepted that some older adolescents who require only short term admission generally related to alcohol or substance abuse would be inappropriately managed in the proposed 24 beds. There is a requirement for increased addiction services for adolescents in the West of Scotland.

3.1.7 The small number of 17 year olds in adolescent psychiatry provision reflects historical admission criteria that hitherto restricted admissions to young people before their 16th birthday or 16 and over if still in full time secondary education. The developing service being offered to all those age 17 or under (and 12 or older) is increasingly bringing into the service appropriate 17 year olds for whom previously the adult service was all that was available. (see admission criteria in Appendix 1).

It is also recognized that a number of 17 year olds admitted to adult wards are appropriately placed in adult addiction/psychiatry services.

West of Scotland Health Board funded extra contractual referrals have also been required and an awareness of these pressures with current activity indicate an adduced additional requirement in the region of 1,500 occupied bed days.

3.1.8 The only one of many reports on adolescent psychiatry to suggest an appropriate population need for beds is the Royal College of Psychiatrists Report referred to above. This would suggest a bed complement between 40 and 65 beds for the 2.75 million population of the West of Scotland. Comparable recently commissioned Tier 4 services have provided 10 beds for a population of 1 million in South East Scotland (newly opened Young People's Unit in Edinburgh) and 12 beds for a population of 1 million in Bristol.

3.1.9 All consultant child and adolescent psychiatrists throughout the West of Scotland have anecdotally been able to recount instances of not being able to arrange admission for a young person in the West of Scotland. This is consistent with the recent Young Minds study which found "a national shortage of in-patient provision". The Scottish Needs Assessment Programme Final Report on Child and Adolescent Mental Health recommended expansion of in-patient wards for young people with mental health difficulties and stated that this was urgently needed, but didn't provide a population to bed ratio.

3.1.10 Taken together these figures suggest a range for the scale of the inpatient ward required for the West of Scotland should be between 27 and 194 beds as summarised in Table 1. These ratios exhibit a huge range of bed numbers and are based on the total population for an area. They do not take account of falling population projections or specifically reflect child/adolescent populations or take account of the developments in care.

Table 1

Patient Places – Range of Recommendations		**Equivalent for West of Scotland Health Boards (2.69 million)** [(1)]
Consultant Adolescent Psychiatry	12-18 beds per 250,000 population	129 – 193.5
Royal College of Psychiatrists	4-6 beds per 250,000 population for adolescents up to age 16	43 – 64.5
Recently Commissioned Service	10 – 12 beds per million respectively	27 – 32

The Registrar General for Scotland's mid 2000 based population projections [(1)] predict a falling birth rate to 2016 and a more than 20% fall in population from 2000 to 2016 for the existing 5 – 14 age groups summarised in Table 2 below (see also Appendix 3).

Table 2

West of Scotland Health Board % Population Change Age 5 – 14 Projection

Year	**2006**	**2011**	**2016**
A&C HB	-10.9	-21.0	-26.6
A&A HB	-10.3	-20.2	-26.5
D&G HB	-10.6	-22.7	-29.8
GG HB	-10.2	-19.9	-22.6
FV HB	-3.5	-10.9	-14.7
L'shire HB	-5.6	-13.3	-18.3
Total	-8.68	-17.91	-22.46

3.1.11 Developments in community based care have been advancing with the resourcing by Health Boards and Councils of community based specialist and generic adolescent mental health services. The experience has been an initial period of increased referral to inpatient services as community services identified unmet need. The advancing skill and experience of community service mental health professionals however has latterly seen an increasing capacity to extend the community treatment for young people with more severe mental health problems. A knock-on effect in referral to inpatient beds is anticipated over the coming decade as West of Scotland Health Boards complete the expansion of a network of more local community adolescent mental health services.

3.1.12 Taking into account the recommendations for bed ratio's per population, the current pressure on bed occupancy, the longer term reducing population and the anticipated impact of developments in care, 24 beds is anticipated as the appropriate provision.

3.1.13 The proposal is therefore for 24 beds for people aged 12 to 17 for the West of Scotland Health Board areas of Argyll & Clyde, Ayrshire & Arran, Dumfries & Galloway, Forth Valley, Greater Glasgow and Lanarkshire.

3.1.14 **Dependency**

As developments in community based care have been advancing similarly the severity of mental health problems being treated by existing inpatient wards has also advanced.

3.1.15 Over the last 15 years psychoses and eating disorders have risen to be the most frequent reasons for adolescent ward admissions.

3.1.16 An In patient Ward is required for young people who are unable to be managed in the Community. Young People aged 12 – 17 years inclusive with ICD 10 Axis 1 Disorders, which are severe and/or complex, make up the patient group that requires this specialised service.

3.1.17 Referrals are made by Community teams (referred to as Tier 3 CAMHS by S.N.A.P) for patients whose level of risk, severity of illness or complexity of presentation has made continued outpatient care untenable. The In-patient Ward will provide specialised assessment and treatment of these cases.

3.1.18 The National Inpatient Forum has stated that "All units will provide a safe and nurturing environment where young people with severe and/or complex psychiatric disorders will receive developmentally appropriate evidence-based assessment and treatment. These units would offer an integrated approach to mental and physical health difficulties, family, educational, cultural, social, interpersonal, child protection and other issues". Adolescent Psychiatry is a highly specialised discipline which requires professionals trained in providing for the needs of adolescents whose physical, neurological, psychological, cognitive, moral, social, academic et al development is progressing rapidly and where any delay will be detrimental for future functioning.

3.1.19 The assessment and treatment of adolescents requires an integrated approach to all areas of development. Psychiatric disorder robs a young person of their education; peer relationships; integration into normal family life; ability to socialise and develop peer relationships; self esteem; and ability to complete normal "maturational tasks" which are attainment of independence, establishment of sexual role / orientation; self control of aggression / opposition and achievement of self-identity. These young people require to manage difficulties rapidly and in such a way as to preserve development and enhance recovery and social and family reintegration.

3.1.20 Typical disorders requiring admission include psychotic disorder, affective disorder, eating disorder, obsessive compulsive disorder, neuropsychiatric disorders, psychosomatic disorders and disorders of development including developmental disorders. Some young people with a particularly complex presentation may require admission for clarification of diagnosis.

3.1.21 Within an adolescent unit young people benefit from integrated care provided by a multidisciplinary team. Adolescents are developmentally immature. Benefits to patients will be an added complexity for medical assessment and prescribing medication. Staff who are expert in the areas of child and adolescent psychopharmacology, family therapy and psychological therapies as well as rehabilitation. Young people will benefit from a group approach in order to preserve or promote peer group development.

Education is to be provided on site as well as access to Social work staff expert in child protection and mental health work.

3.1.22 **History of Bed Provision**

The SNAP Report (Scottish Needs Assessment Programme) states that there is a lack of specialist Child & Adolescent Mental Health Services in Scotland. The SNAP Report highlights that there has been a significant reduction of beds for adolescents across Scotland in the last ten years and under reports the case. There are currently only 35 NHS Mental Health beds in Scotland for adolescents compared with over 60 in the early 1990s.

This reduction has been unplanned and uncoordinated.

3.1.23 **Future Bed Provision**

The New Mental Health and Treatment (Scotland) Act 2003 states that Health Boards must make provision for adolescents admitted to hospital. Inherent in this is an implication that adolescents with mental disorder will be admitted to psychiatric hospitals at times. Although there may not be the need to provide specialist beds for every short term admission to hospital there is a clearly acknowledged need for adolescents to have separate provision if they require a substantial admission.

3.1.24 **Specification of Ward Environment**

For the provision of effective care the balance of care will be away from passive observation to one based on a provision of a range of therapeutic interventions. For this the following key features and benefits are required in an in-patient facility:

- Individual rooms for each patient with lockable en-suite facilities (access to en suite facilities needs to be controlled by staff for some types of patient)
- Rooms to enable group work involving small groups or families;
- Smaller ward sizes , ie. 8 beds sub areas instead of 20-30 bed wards;
- Open space for general/social interaction activities;
- Modern fit for purpose facilities on sites with general acute diagnostic services and other acute mental health facilities;
- External space (i.e. recreation/play areas).

3.1.25 Effective care management of individuals can be viewed from different perspectives:

3.1.26 Many people in acute phases of their illness can be managed at home or in well developed community adolescent services. There are times, however, when the clinical symptoms are so acute that effective care can only be provided within an in-patient environment.

3.1.27 Acute admission areas by their nature will require to care for patients with a mixture of different illnesses at different levels of severity at any given time. This can produce a very tense atmosphere sometimes referred to as a “powder keg”. This proves stressful for both patients and staff and can be mitigated if appropriate facilities are available within and out with the ward environment.

3.1.28 The ward environment must meet the need to care for young people with a range of different clinical conditions (eg. a seventeen year old young man with a paranoid psychosis and a thirteen year old young girl with an eating disorder and anxiety or depression). A combination of individual private rooms and separate rooms for group work activities will provide the facilities to manage effectively the situation outlined in the example. This environment will ensure that the person suffering from eating disorder and anxiety would have a choice of other environments to go within and out with the ward to avoid the perceived or potentially frightening behaviour of a seventeen year old young man whose condition causes disturbed behaviours. Equally, the young man with paranoia will have different environments to choose from, e.g. his own room may feel safe or he may need to be alone in a near quiet room.

It is recognized that having choices for patients that meet their clinical needs within the confines of a ward environment is very important. It is also important for young people to give staff the option of separating patients with conflicting needs so that potentially inflammable situations can be quickly calmed.

3.1.29 (a) The personal needs of an individual requiring to stay in an in-patient facility.

When an individual is admitted to an in-patient facility it can be a time of great anxiety for them that can exacerbate the problem which created the need for admission.

3.1.30 It is important, therefore, that the environment provides privacy and maintains the person's dignity. To facilitate this it is proposed that all newly built in-patient facilities have single room accommodation with en suite facilities.

3.1.31 The combination of "having your own space" and being able to access the company of others is very important to patients. The ward environment, therefore, provides both, including communal areas, where people are able to interact with each other for purposes of stimulation and social interaction. It is equally important to provide designated quiet areas (out with the patient's own single room) where patients may choose to be alone or with another person, e.g. to talk or listen to music.

3.1.32 Patients also require the opportunity to be able to get outside the ward environment to enjoy fresh air and access the garden area. Fenced (for patient privacy) outdoor areas with recreational facilities and the opportunity for fresh air and exercise are necessary.

3.1.33 Meeting the personal needs of individuals in this way will have a beneficial impact on their clinical condition.

3.1.34 (b) The needs of staff working in an in-patient facility

From a staff perspective it is necessary to have an environment that is safe and conducive to the effective delivery of therapeutic activities. The facilities described above will ensure that staff have:

- Space to manage disturbed individuals. This provides the opportunity to deliver care in a safe controlled manner that gives the patient privacy away from other patients in the ward and so maintains a level of dignity for that individual.
- Space to manage anxious or frightened individuals due to the nature of patients' illnesses, staff require options to be able to take people to areas where they can be calmed and reassured.
- Space to carry out individual, family and group therapy. If staff have access to appropriate space away from the main areas within the ward, this will allow therapeutic interventions to be carried out more effectively, ranging from active treatment to rehab processes.

3.1.35 Accordingly, in-patient facilities will require to be domestic in style and scale within the constraints imposed by the model of care. The environment should have the capacity to manage disturbed or violent situations.

3.1.36 The physical ward environment should provide for access to a sustained involvement in effective therapeutic interventions for patients, moving away from a custodial regime of care.

From the perspective of patient rehabilitation the ward environment needs to be able to provide privacy, quiet and space to ensure that patients are not disturbed or distressed by others on the ward.

3.1.37 This is important in view of the wide range of patient needs being cared for, which includes those who are seriously depressed or anxious and very withdrawn to those who have psychotic illnesses associated with extreme restlessness or aggressive behaviour. The ward environment will require to provide for the safety and security of both patients and staff and enable the latter to manage the environment effectively as a therapeutic unit.

3.1.38 **Benefits to patients**

The benefits to patients from the implementation of the project will be as follows:-

3.1.39 Benefits to individuals who use our service:

- Patients in crisis will be able to access a rapid response that will provide for their needs to be assessed and care to be provided in the most appropriate setting.
- Patients will be able to access services which are geographically local to their own homes.
- When patients are admitted to hospital they will be accommodated in appropriate surroundings that will meet their personal as well as their clinical needs.
- Patients will have greater privacy in these in-patient facilities. Patients will be cared for in an environment that is conducive to providing appropriate therapeutic interventions.
- The design and layout of the care environment will minimize the opportunity for self injurious behaviour by allowing for appropriate levels of observation and intervention by clinical staff.
- Community Services will be available to provide the necessary intensive support to patients following discharge.
- Delays for patients moving to the next level of healthcare will be minimized as a more appropriate balance of care will allow them to flow more smoothly through the spectrum of interagency care.
- Enhanced community services will be able to proactively follow up patients and maintain them in their community where possible, minimizing the need for hospital admission.

3.1.40 **Benefits to the population of West of Scotland**

- There will be greater equity of service provision across the Health Board areas.
  There will be a modern in-patient hospital environment that is fit for purpose. In assessing patient needs, the Primary Care Division, Adolescent Directorate, Mental Health Services had consulted with representatives of West of Scotland Health Boards' Child & Adolescent Psychiatry Services, Royal College of Psychiatrists "NICAP" study, visits to units in the UK and feedback from service users on the proposed design and incorporated their views within the statement of needs set out above. This has included regular meetings with young people's carers who have used and currently use the in-patient service from across the West of Scotland.

3.1.41 The delivery of the above benefits to patients is dependent upon joint working and implementation. Healthcare is inter-dependent for adolescents with developments in Social Care and Education. Accordingly the care pathway for the new ward will be implemented following a joint approach including for psychiatric emergency plans and issues such as risk/safety and transport for young people and families from the islands and more remote areas of the catchment area. A desk top exercise on the

relative distance to the existing in-patient site and the proposed in-patient site indicated that travel by road is negligible in distance.

3.2 Implications of not meeting the need e.g. reduced service, under capacity, inappropriate facilities, failure to meet recognised standards.

3.2.1 Without an adolescent unit young people would be admitted to inappropriate situations such as adult psychiatry, paediatric or medical beds or would be denied admission. They may be inappropriately placed in children's homes or foster care. None of these environments have the specialist trained staff to meet the needs of adolescents with psychiatric disorders. In adult facilities there are risks requiring attention to be paid to child protection. Safety cannot be guaranteed. If the existing unit is not replaced, those adolescents accessing places would be cared for in a poor quality overcrowded building with no room for day patient facilities. Failure to admit will lead to clinical deterioration or failure to progress and increasing disability and risk including suicide risk.

3.2.2 The implications of not meeting these needs can be summarised as:-

- in Adult Mental Health Wards young people's developmental needs are not designed to be met.
- in paediatric acute physical wards it is significantly more difficult to meet young people's mental health needs and
- in adult acute physical medical wards neither a young person's mental health needs nor their developmental needs are easily met.

3.2.3 The Scottish Child and Adolescent Inpatient Forum has made recommendations regarding the configuration of units. The current 16 bed unit does not meet these with the age mix in one area being too broad and the number of beds in one area too great. These recommendations have been ratified by the Inpatient Working Group of the Child Health Support Group.

3.2.4 In addition to these points, if the above needs and service objectives are not met in the way described above, this will impact on the Primary Care Division Adolescent Mental Health Service's ability to provide an appropriate balance of patient care. Rather than moving towards a community based service with a range of care options complimented by modern NHS in-patient care for those with a high dependency retention of the status quo would mean that the existing inappropriate mix and pattern of services would be maintained. This will mean that the full range of service options that could be utilized to provide appropriate care will not be made available.

3.2.5 Examples of the impact of not developing services based on assessed needs have been outlined above and additionally include:-

i. The movement of inappropriately placed patients to appropriate levels of care will not be achieved.
ii. Appropriate levels of community development and in-patient beds will not be established which will continue to skew care regime towards institutional care.
iii. In-patient settings will continue to be accessed without community triage as the resources and systems to enable this to happen will not take effect.
iv. The inappropriate mixture between community services infrastructure and in-patient facilities will continue to exist due to the absence of the capacity to meet needs that require in-patient facilities.

v. The opportunity to develop a comprehensive care pathway throughout Adolescent Mental Health Services will not be realized.

vi. Patients will be inappropriately retained in the community longer than their needs require and will be discharged to community services sooner than their needs require.

vii. In-patient care will continue to be delivered in Victorian style hospitals and not be delivered in modern facilities that support pro-active health improvements through the delivery of effective therapeutic interventions.

3.3 Services Required

3.3.1 A whole system response is required to meet mental health needs of young people across the West of Scotland which involves a range of social, educational and healthcare developments**.**

3.3.2 Services required include NHS acute in-patient care in hospitals, transitional care aimed at early rehabilitation and return to community services, community health care services that provide early assessment and early pre and post hospital discharge care and community health services that link to social work, education and other social care services when required.

3.3.3 Some of the services necessary as part of this whole system response across the West of Scotland already exist, while others require development and some required to be re-engineered. A West of Scotland planning process is already established to progress these issues.

3.3.4 **In-Patient Services**

The West of Scotland Health Boards have already commissioned to the Greater Glasgow Primary Care Adolescent Mental Health Services Clinical Directorate to provide a 16 bed in-patient facility on the Gartnavel Royal Hospital Site as an interim step towards a long term provision of 24 place in-patient service. To complete the proposed development of an in-patient ward for the West of Scotland, the Greater Glasgow Primary Care Adolescent Mental Health Services Clinical Directorate requires to develop a 24 bed in-patient ward. The ward requires to be subdivided into separate smaller 8 bedded areas to replace the existing 16 bed unit, in modern fit for purpose facilities on an acute general diagnostic hospital site.

3.3.5 The ward environment is crucial to the effective delivery of quality care by providing a facility that addresses patient's personal and clinical needs as well as the needs of staff delivering services.

3.3.6 In-patient facilities will be closely linked to the community developments to ensure good communication links and working practices in local areas are fostered to deliver seamless services so that patients can move easily through the system.

3.3.7 Future in-patient facilities will consist of admission facilities (including intensive psychiatric care) for young people in the most severe stages of their illness. Existing assets within the Gartnavel Royal Hospital Site (the lower floor of an old two storey building providing 16 beds within the same area) will need to be replaced if improved in-patient facilities are to be provided.

3.3.8 Community Services

Community Adolescent Mental Health Teams will provide the first point of entry to psychiatric services. Community services have been and continue to be developed. These services will provide rapid pick up of patients newly discharged from hospital and offer support at a vulnerable time in addition to continuing to provide a first point of contact for crisis intervention to people who might otherwise require to be admitted to hospital.

4. Background /strategic context

4.1 Description of the NHS Host Primary Care Division, West of Scotland Health Boards and catchment population for its services.

Greater Glasgow Primary Care NHS Operating Division, Adolescent Mental Health Clinical Directorate provides care and treatment to meet the in-patient healthcare needs of the West of Scotland Health Boards young people. (Argyll & Clyde Health Board, Ayrshire & Arran Health Board, Dumfries & Galloway Health Board, Forth Valley Health Board, Greater Glasgow Health Board, and Lanarkshire Health Board circa [2.7 million population]). Additionally, the Directorate provides care for young people within GGHB area a range of community settings from four geographic community adolescent mental health teams and citywide services covering people with learning disabilities, direct access care linked to schools, forensic adolescent psychiatry linked to young people's local authority provided secure accommodation and developing intensive community based care, and deliberate self harm services. The Directorate is also part of the West of Scotland planning system developing hospital ward and community services.

4.2 A key factor in the mental of young people who live within the West of Scotland Health Board catchment areas is that the West of Scotland has major concentrations of population characterized by high levels of deprivation. This is reflected in the demand for hospital admission and increased prevalence of adolescent mental health problems.

4.3 Each individual West of Scotland Health Board also committed to a review with local clinicians as to the breadth of their community adolescent mental health services with the goal of developing sufficient local community resources to support two-way reciprocal relationship with the proposed West of Scotland in-patient service.

The West of Scotland General Manager's group commissioned work to plan for future specialist addiction in-patient provision and confirmed that the provision of in-patient accommodation in modern custom built building is a high priority within an overall programme aimed at the modernization of adolescent mental health services for the West of Scotland Health Board area.

4.4 Description of the Primary Care Division Strategic Direction and Business Objectives

The Primary Care Division has developed an implementation plan that reflects a number of government policy initiatives and is inclusive of Greater Glasgow Health Board and West of Scotland health improvement priorities.

With regard to Adolescent Mental Health Services, the Primary Care Operating Division's aim is provide integrated adolescent mental health services focusing on:

- Community care;
- Developing services to meet identified gaps.

In doing so we aim to:

- Provide acute admission services in modern purpose built accommodation;
- Provide a wide arrange of therapeutic interventions in in-patient settings;
- Ensure continuity of care between in-patient and community based services and between health, social care and education services and;
- Facilitate a shift in the balance of care focused on being directed and accessed in settings most appropriate to patient needs.

4.5. The current activities of the Primary Care Operating Division and the range of quality of health care services.

Adolescent Mental Health Services

Adolescent Mental Health Services are currently provided in two main settings.

- In-patient
- Community

In-patient Services

The Primary Care Operating Division is the sole NHS provider of adolescent in-patient care within the West of Scotland area. NHS Adolescent In-patient services are currently provided from Gartnavel Royal Hospital Site. The Primary Care Operating Division is also the sole NHS provider of in-patient care for adults and older people and some specialized mental health services within the Greater Glasgow Health Board area. The range of in-patient services provided by the Operating Division is presented in the table below.

In-Patient Care	Specialist Services	Adult Services	Older People Services
	Adolescent	Acute	Acute
	Forensic	IPCU	Long Stay
	Addictions	Long Stay	
	Rehabilitation		

During 2003/04 within the Primary Care Operating Division Mental Health Services there were circa 6,000 episodes of in-patient care, almost 6,000 patient discharges from 1,100 in-patient beds.

Community Services

The Primary Care Operating Division is the sole NHS provider of the following Adolescent Mental Health Community Services:

- Community Adolescent Mental Health Teams x 4
- Direct Access
- Adolescent Mental Health Services for people with a learning disability
- Deliberate Self Harm Services
- Adolescent Eating Disorder Tertiary Service
- Adolescent Forensic Tertiary Service
- Assisted Withdrawal (substance misuse)

4.6 Assessment of the Division's current finance and cost structure

The budget and expenditure for the existing interim Adolescent inpatient services in the current year 2004/05 is £1,842,000.

Overall, the Division has a history of achieving its financial targets. This year 2004/05 sees a degree of financial uncertainty due to new pay award arrangements for medical staff and due to prescribing costs. In partnership with the Board, steps are in hand to address emerging financial pressures/trends.

4.7 Assessment of Trust resources (assets and manpower) as a current utilization service provision (including their functional suitability).

West of Scotland (Argyll & Clyde, Ayrshire & Arran, Dumfries & Galloway, Forth Valley, Greater Glasgow and Lanarkshire) Adolescent In-Patient Services are provided as shown below:

Gartnavel Royal Hospital	Adolescent In-Patient Services 16 In-Patient Beds (interim)

A snapshot of the ward accommodation provided throughout the Primary Care Operating Division is a mix of more recent accommodation but also the majority of ageing and functionally unsuitable institutional style old hospital ward wards including at Gartnavel Royal Hospital.

The Adolescent In-Patient Unit specifically is housed in the lower floor of a two storey building which is ageing and functionally unsuitable institutional style old hospital not originally designed for adolescent in-patient mental health services. The Primary Care Operating Division does not have adequate modern purpose built in-patient accommodation to enable clinicians to address a significant deficit in the quality and range of therapeutic interventions available to patients. Current ward environment does not provide sufficient space for clinicians to work with patients on an individual basis. This is attributable to the original design that was focused on simply providing ward based accommodation rather than an environment to facilitate individual treatment and therapeutic rehabilitation.

With the development of community based services, acute in-patients services have moved towards patients with more complex needs and dependencies. This has accentuated the need for individual living space for patients and for small rooms to facilitate group work with small groups of patients with similar needs.
The current configuration of accommodation acts as a barrier to the provision of appropriate packages of care by affording little opportunity for privacy of individual treatment and little opportunity for the protection of dignity.

Adolescent Mental Health In-Patient Services require to cater for the needs of a wide range of acutely ill patients with different conditions. Length of stay in mental health wards will typically be significantly longer relative to the average for adolescent surgical or adolescent medical admissions on account of the nature of these conditions, highlighting the need for single room accommodation with washing and toileting facilities. Current ward accommodation does not meet this need.

In summary the Primary Care Operating Division is unable to provide individual rooms with washing facilities for each patient, or small rooms to enable group work involving small groups or adequate open space (either internally or externally) for general/social interactive activities. The current accommodation does not meet good standards of privacy and dignity as a mixed gender ward requires young people to move through the ward to access segregated facilities.

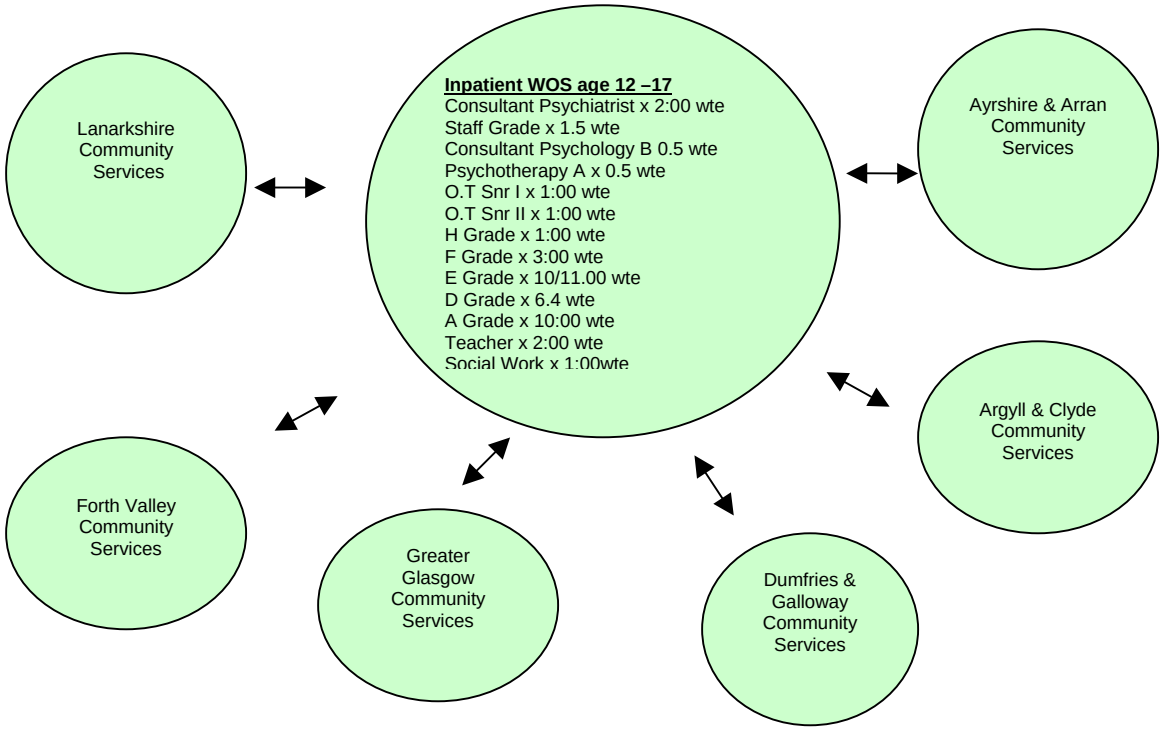
The current accommodation also doesn't provide any flexibility for staff to manage individual patients with conditions that would respond best to a degree of separation.

4.8 Human Resources

The Primary Care Operating Division is a major employer of people for mental health services directly employing over 2,500 staff.

Adolescent Mental Health In-Patient Services staff is as follows;-

Adolescent Psychiatry



The Primary Care Operating Division's Mental Health Services for adult and older people and learning disability services have carried out a programme of bed closures in recent years resulting in the closure the worst Trust in-patient accommodation in Victorian asylums in Greater Glasgow. The number of bed closures has totaled more than 1,600. This has required a reduction in the Primary Care Operating Division's hospital based workforce, which was achieved without compulsory redundancy.

With regard to the adolescent in-patient services, it is envisaged that an increase in staff numbers together with the strengthening of nursing skill mix will be required to shift the emphasis of care away from observation to the provision of a range of therapeutic interventions. Emphasis will be placed on further developing the links between in-patient and community staff, to ensure a clearly defined pathway of care for developing in-patient and community services and also enhancing existing social work and educational links.

The Division's workforce planning strategy will make provision for this through:-

- A human resource plan with related monitoring data system
- A recruitment plan and
- Learning plan

These key elements are developed further in Section 12. Personnel Issues.

4.9 Assessment of the current service performance relative to Health Boards' requirements (e.g. in the case of an acute hospital project patient activity for each of the main specialties and services a proportion of treatment conducted as day cases by specialty, average length of stay for in-patients, turnover interval by specialty and other relevant performance indicators). Also cost per case data.

Admission/occupancy levels for adolescent in-patient care are as shown in the table below:-

In-Patient Activity 2003/04

Category Description	Annual Admission	Discharges & Deaths	% Occupancy	Average Length of stay
Adolescent In-Patient	30	31	101	182

The current trends show an increase in the level of acute admissions. Admission activity has generally been increasing over the last 4 to 5 years.

Evidence suggests that acute average length of stays are higher than may ultimately be necessary as some admissions are inappropriately cared for in in-patient settings or at times discharge is delayed. There is scope to improve this by developing:-

- Links between West of Scotland In-Patient and West of Scotland Community Adolescent Services;
- Expanding the range of therapeutic interventions provided within an in-patient setting.

The enhancement of the service areas will allow more patients to be cared for in settings appropriate to their needs. The provision of new custom built in-patient accommodation allied to the introduction of additional staff with strengthened skill mix will enable the service to focus on the provision of therapeutic treatment regimes allowing patients to move more rapidly through the level of care to the level of care most appropriate to their needs.

Cost per case at the Adolescent Unit at Gartnavel Royal Hospital is £115,000 p.a. per in-patient place.

4.10 **Overview of health strategy for the area**

In September 1997 the Scottish Office issued a national framework for mental health services requiring health boards in partnership with local authorities to undertake a strategic review of mental health services and prepare a joint strategy covering a 6 year period. Since 1997 there have been a number of significant government policy initiatives which impact on the development of mental health services:-

- Designed to care;
- Aiming for excellence;
- Towards a healthier Scotland;
- Acute Services Review

The Health Advisory Service additionally produced in 1995 a thematic review entitled "Together We Stand": the commissioning, role and management of child and adolescent mental health services".

There were also a number of Scottish initiatives which have a bearing on the mental health of children and young people including:-

- For Scotland's children;
- First Minister's inaugural address declaration of a commitment to the well being to children;
- Mental health and well being support group monitoring of the 1997 framework for mental health
- Child Health Support Group "campaigning the development of child and adolescent mental health services";
- Public Health Institute of Scotland Needs Assessment Report on child and adolescent mental health May 2003 (SNAP)

A review commissioned by the West of Scotland Health Boards in response to concerns about the commissioning and provision of in-patient child & adolescent psychiatry beds concluded that there was an urgent need for a strategic approach to commissioning in-patient services, with reference to a national strategic framework for child and adolescent in-patient services. In keeping with the recommendations of this work, the West of Scotland Health Boards agreed in 2000/2001 to develop a consortium approach to commissioning in-patient adolescent mental health services in the West of Scotland.

The West of Scotland Health Boards established a steering group to plan changes to adolescent mental health services in line with the national and local policy initiatives.

Key elements of the strategy were:-

- Agree the age definition of an adolescent;
- Consider the current usage of adolescent in-patient psychiatry in the West of Scotland by Health Board area;
- Identify future provision of adolescent in-patient psychiatry;
- Undertake needs assessment for in-patient psychiatry for adolescents across the West of Scotland;
- Identify referral criteria for in-patients in the West of Scotland.

The key element of strategy is the replacement of the existing institutional in-patient accommodation with modern customized in-patient facilities as part of a network of adolescent mental health services for the West of Scotland Health Board areas.

4.11 **Assessment of any changes in pattern of services used to meet Health Board's requirements and future demand (including the rationale for any changes to the current configuration of services or estate).**

The West of Scotland Health Boards require an adolescent health service that is focused on delivering care to people where they live. Health services must meet the need for care interlocking the range of health, social and education that young people require. Community focused health services, which are linked to social care and able to provide assessment and care when required is a key element.
Where in-patient care is required, more customized hospital services linked back directly to local community services are essential.

To meet the West of Scotland Health Boards requirements, the assessment of the main changes in the pattern of services needed are :-

- Community based teams for adolescent mental health services to co-ordinate services for severely mentally ill linking into the rest of the system of care;
- A customized adolescent mental health in-patient provision;
- A dispersed model of service, with a strong local community focus in each of the West of Scotland Health Board areas;
- More specialist components of service, e.g. in-patient specialist care, focused on a West of Scotland regional basis.

By ensuring that all services are community focused, and that the means of entering and leaving hospital care is through community services, the balance of healthcare will be in the community on a local health board basis. This concentration in focus on the community will impact on the demand for acute adolescent in-patient care.

Customising in-patient care and the development of therapeutic regimes, linked back to West of Scotland Health Board community services will ultimately reduce length of stay in the NHS adolescent mental health wards.

The impact of this change in terms of the changes required to the Primary Care Operating Divisions In-Patient Estate is significant. The Adolescent In-Patient Estate has been described in Section 4.5. The main areas of impact for the current in-patient configuration are as shown below:-

Summarised Impact in current In-Patient Estate

Service	Period within which replacement regime			Replacement Required
	Long Term	Mid Term	Short Term	
Adolescent In-Patient Unit – Gartnavel Royal	X	X	√	√

√ denotes current estate configuration that will require to be changed.

It is envisaged that these services will be provided in a co-ordinated way with the replacement of mainstream acute mental health services and will be co-located with acute mainstream services on acute general diagnostic hospital sites. The strategy for the reprovision of adolescent in-patient services for the West of Scotland is being developed in keeping with these key principles.

4.12 **Rationale for Changes**

There are two main forces driving the Primary Care Operating Division to change the configuration of its in-patient services.

- Improvement in the quality of in-patient care, in terms of ward environment, staffing numbers and skills available to provide more therapeutic patient care;
- An increase in the total number of in-patient beds in support of community based services that should improve access to in-patient specialist care on an emergency basis.

Further improvements in the quality and range of community care on a local level within each West of Scotland Health Board area will increase community service links to and from in-patient care.

These issues in conjunction with recent trends in admission beds for adolescent mental health in-patients have led the West of Scotland Health Boards and the Primary Care Operating Division to conclude that there is a need for:-

- An increased provision of adolescent in-patient beds.

4.13 **Description of Primary Care Operating Division Strategy for Meeting West of Scotland Health Boards Service Requirements, including how the proposed development will meet those requirements and its impact on other Health Boards served by the Primary Care Operating Division.**

The West of Scotland Health Boards main service requirements are:-

- Improved in-patient care to deliver greater therapeutic interventions for patients;
- Increased NHS provision of in-patient beds for adolescent acute mental health care;
- Adolescent mental health acute and assessment in-patient services on general acute care and diagnostic sites;
- More comprehensive adolescent mental health services across the West of Scotland Health Board areas where gaps in provision currently exist;
- Deliver of new Mental Health Act age appropriate mental health services to meet the individual needs of young people.

The Primary Care Operating Division strategy for meeting these requirements is:-

- Modern custom built in-patient facilities to support the provision of therapeutic care;
- Improved staffing levels to give staff more time to young people on the in-patient ward;
- Training programme to enable staff to acquire (see Section 12) therapeutic skills needed;
- Replacement of dysfunctional ward accommodation/ward design that doesn't meet modern needs;
- Setting a standard of smaller in-patient bed areas for acute and assessment services (8 bedded sub sections ;
- Further develop links with West of Scotland Health Boards expanding community service;
- Strengthen links between NHS, Social Care and Education to ensure fully integrated service provision at all levels;
- Co-locate adolescent acute mental health and assessment services on site with general acute diagnostic services.

The outcome of this strategy will be:

- An improved balance of care within the West of Scotland Health Board areas focused towards local communities;
- Improved therapeutic regimes;
- Improved staffing levels;
- Improved ward based care environment fit for purpose;
- Improved flow of patients through the spectrum of care;
- Release of inappropriate ward environments that are not fit for modernized services.

Impact on other Health Boards

Each West of Scotland Health Board has planned the development of their own local Community Adolescent Mental Health Services. Improved in-patient facilities and service responses with improved links to local West of Scotland Community Services will result.

4.14 Justification of the assessment of future services and functions required by reference to Health Board requirements, projected catchment population, changes in medical technology, and other factors influencing the demand for services of the Divisions ability to meet demand

4.14.1 The care needs of adolescents are highly individualistic in nature. The West of Scotland Chief Executives/Directors of Public Health Group considered what the most appropriate model of care and service response should be adopted for the West of Scotland. In considering a model of care and model of service an assessment of what was needed took account of the following:

- The professionals view,
- Historic clinical activity
- Estimation of bed requirement
- Routinely collected data
- Benchmarks
- Demand

- Literature review
- The Multi-Centre Study (1986 – 1989)
- Contemporary views
- The Young Minds study
- The Nicaps study
- Visits to UK units to five adolescent units in Scotland and England

4.14.2 Additional and most recent, but not yet fully reported, research is the Children and Young Person's Evaluation (CHYPIE) study of eight psychiatric inpatient units for children and young people in England. This study is demonstrating the value of admission for children and young people and evidence of the outcomes arising from admission. The CHYPIE study is the most comprehensive study to date undertaken internationally of the process and outcomes of inpatient treatment for children and young people.

4.14.3 Initial indications from the CHYPIE study are that there is a real and measurable health gain from admission, with a clinically important improvement and health needs improvement across a range of domains. Examination of the process of treatment suggests that greater improvement is found:

- with longer length of stay,
- when the patient develops a therapeutic alliance with the ward staff and his/her peers,
- when the patient and family hold an optimistic view of treatment,
- when there is better pre-admission family functioning, and
- when parents have a sense of control early on in the treatment process.

4.14.4 Children and young people are noted to use a wide range of services before and after admission. At follow-up, 25% of patients had not been in receipt of any of the services recommended at discharge, with only 10% receiving full services recommended. Future intentions are to track the sample group, over a number years, and to investigate a range of components of treatment in more detail.

4.14.5 Data is not currently available on outcome comparisons between inpatient and outpatient care, and this will be an area for future research.

4.14.6 Core service expectations included a Tier 4 specialist mental health service aiming to meet the needs of severely disturbed young people would be expected to provide 24 hour psychiatric care delivered by skilled psychiatrists and mental health nurses. To assist in the tasks of assessment, diagnosis and treatment would be a multi-disciplinary team appropriately skilled and proficient in delivering evidence-based therapies.

4.14.7 Such a service would be available 7 days a week, all year round, catering for adolescents aged 12 through 17 years inclusive, with the ward capable of responding promptly to emergency and urgent admission requests.

4.14.8 Young people suffering from severe mental health disorders that seriously compromise their mental health and development, sometimes entailing risk to self and/or others, require the combination of clinical skills and environmental support and containment that only an inpatient setting can offer.

4.14.9 The assessment of what was needed also considered that the future re-provision be developed in keeping with the forward-looking vision, outlined in the HAS Together We Stand Document (1995). That proposed a Tier 4 inpatient ward function flexibly. This proposed a ward not as a rigid structure but an environment offering interlinked assessment and treatment processes with more "fluidity" at the interface between inpatient 24 hour ward based care and community based treatment.

4.14.10 This flexibility of model is to operate at the centre of a Managed Care Network (MCN) being the only Tier 4 resource offering inpatient care across the West of Scotland Health Board areas. Critical to the success of such an in-patient ward service will be the presence and professional support of colleague psychiatrists and other mental health colleagues working throughout the West of Scotland. The Child Health Support Group Inpatient Working Group has also proposed that all adolescent wards in Scotland function as an element of a Managed Clinical Network.

4.14.11 Such an approach was adopted to deliver a multi-disciplinary process that organises and integrates healthcare inputs and the process drives up the quality through reducing variations in clinical practice, supporting complex, multi-professional service delivery and reflecting evidence-based practice.

4.14.12 The West of Scotland Chief Executives/Directors of Public Health Group concluded the proposed model for the commissioning of a new Adolescent Mental Health Inpatient Ward, to provide such a flexible model of inpatient ward care was required.

4.14.13 Agreement was also reached by WoS Health Boards around commissioning the long term solution, the development of the Adolescent Inpatient Ward with an increase in bed numbers from 16 to 24. In parallel with this in-patient development at (Tier 4), work was to be undertaken to examine local community (Tier 3) services in order to ensure that these were sufficiently resourced in order to support the new model of services. This was in order to ensure adequate future provision that would support a two-way reciprocal relationship between the In-patient Ward and West of Scotland Community Services.

4.14.14 The proposed model of care recognised a strategic approach to commissioning and delivering a comprehensive adolescent mental health service using a tiered model of need and with service responses being located and organised to respond flexibly and across tiers.

The different tiers of service are summarised:

	Service Level	**Service Location**	**Brief Description of Service Activity**
Tier 1	Assessment and treatment/onward referral	Community i. Home based ii Community	Social workers, Voluntary workers, Teachers, GPs, Health Visitors – i. Mild/moderate problems ii. Health Education iii. Support

Tier 2	Specialist assessment and treatment	Community – i. Home based ii. Community	Single professional approach from a range of professionals/organisations and Direct access liaison service - More moderate problems
Tier 3	Specialist Team assessment and treatment	Community – i. Home based ii. Community	Specialist Assessment of referrals from GP's and other care providers, treatment and advice by multidisciplinary/multi-agency team, family therapy and psychotherapy
Tier 4	Highly Specialist services for young people with very complex and/refractory disorders - inpatient mental health service	Hospital based adolescent in-patient	Short and longer term stays full range of service provision available via multi-disciplinary/multi-agency team, in-patient psychiatric care and treatment and liaison

4.14.15 A balanced provision will ensure that patients are able to flow through each service element and across the interface between the service elements to the care package which is most appropriate to their needs. The model of care selected had to be able to deliver this balance of provision to ensure that the level of care provided at each element is adequate to meet the identified level of need.

4.14.16 On this basis, it follows that the alternative models of care possible are to a large extent variations on a single theme. These are described below:

Options for preferred model of care

The alternative models of care possible are described below. Each option goes some way towards filling the gap(s) in service provision identified.

Options	**Community Service**	**In-patient Resource Centre Service**
1.	No change to existing service	No change to existing service
2.	No change to existing service	Release interim ward provision and develop day programme only

3.	Enhanced development of existing health Tier 1 – 3 services (Primary Care and Community Adolescent Mental Health Teams to take account of no in-patient and no day programme	Release interim ward provision for 16 beds with therapeutic day activities.
4.	No change to existing service	Single in-patient service for the West of Scotland without a range of therapeutic day activities.
5.	No change to existing service	Return to separate in-patient with therapeutic day activities in each West of Scotland Health Board area
6.	No change to existing service	Single in-patient service for the West of Scotland with therapeutic day activities.

4.14.17 Assessment of Models of Care

In addition to the consideration given to the appropriate model of care by the West of Scotland Chief Executives/Directors of Public Health Group a professional forum event was organized that considered service requirements and produced Workshop responses in the following areas:

- What is the role and function of the ward?
- How many beds and service responses should the ward have?
- Should there be provision to maintain emergency beds, and what should be the criteria for accessing these?
- Should the unit be subdivided by age range, diagnostic group or some other criteria?
- Should there be criteria for moving from in-patient to community and vice versa? What sort of day provision should the unit provide?
- What additional support is needed to make this accessible to young people from distant parts?
- What support does the tier 4 ward require from each tier 3 service to enable the ward to function effectively?
- What level of service do tier 3 local services need from the tier 4 ward?

4.14.18 Using the report on needs assessment submitted to the West of Scotland Chief Executives/Directors of Public Health Group and the Professional Forum Event - Workshop Responses a summary comparison of derived alternative models and selection criteria with the adopted model of care is listed.

	Selection Criteria	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**	**Option 6**
1	Assessment/Treatment of young people who can't remain at home	Limited	No	No	Yes	Yes	Yes

2	Responsive to emergencies	Limited	No	No	Yes	Yes	Yes
3	Day programmes should directly link and co-ordinate with In-patient unit resources.	Yes	No	No	No	Yes	Yes
4	Gap between IP and OP needs resourced	Yes	Yes	Yes	No	Yes	Yes
5	Best use made of available adolescent psychiatry skills	Yes	No	No	No	Yes	Yes
6	More elective admissions reducing bed blockage	No	No	No	Yes	Yes	Yes
7	Rapid access/rapid response for consultation, assessment of complex cases/ provision of second opinions.	Limited	No	Yes	Yes	Yes	Yes
8	Scope for flow of patients through levels of care maximised	Limited	No	No	No	Yes	Yes
9	Affordability	Yes	Yes	Yes	Yes	No	Yes

14.15 The preferred model of care for adoption is Option 6. Option 6 best meets the derived criteria and so provides the solution which offers the potential for achieving the desired balance of care provision for adolescents.

Option 6 was the option adopted by the West of Scotland Chief Executives/Directors of Public Health Group.

The model of care has also been shared and discussed with the existing carers/parents group and is supported by existing and past young peoples carers. The design and model of care has also been discussed with the users within the existing interim ward and again has been supported by the young people who have and currently use the service.

5. Service Specification - description of services covered in the proposed project

5.1 General

The configuration of adolescent mental health services proposed for the West of Scotland Health Board includes:-

- The development of an adolescent acute in-patient facility, consisting of 24 beds with smaller sub areas of 8 beds, on a general acute diagnostic sites and the development of a robust community infrastructure in each local West of Scotland Health Board area.

The proposal to develop in-patient facilities for the West of Scotland Health Boards has taken into account the following issues:-

- Proximity to other medical diagnostic and therapeutic services;
- Places adolescent mental health hospital services in the context of general healthcare and may be de-stigmatising;
- Economies in relation to estates management issues;
- A balance between access for community served and the development of regional specialist skills and services.

The existing interim adolescent mental health in-patient ward environment for patients and staff is generally poor and does not allow for adequate space for therapeutic programmes or individual en-suite bedrooms to give patients personal space and privacy and dignity.

The ward houses patients with different mental health issues which can mean that patients with disturbing behaviour share bed areas and day living space areas and such a mix of patients may not be appropriate for the care and treatment of any of the patients. This can cause an atmosphere which can feel tense and busy when treatment is required to promote treatment and dignity for patients. The Mental Welfare Commission and the Scottish Health Advisory Service have confirmed that the adolescent in-patient ward facilities are inadequate. The adolescent mental health strategy for the West of Scotland Health Board areas promotes an acute admission ward with smaller configurations of bed numbers, ideally eight with increased nursing staff.

It is important that future acute adolescent in-patient services are provided in modern purpose built accommodation which will be flexible and deliver high quality accommodation that will promote the treatment of patients.

Detailed Description of Services

Services covered by the proposed scheme included:-

- The reprovision of adolescent acute admission beds x 24;
- Provision of a wider range of therapeutic interventions within in-patient facilities to improve clinical outcomes;
- The provision of strengthened links between adolescent in-patient services and West of Scotland's local community adolescent mental health services.

5.2 Summary of output specification for project (including desired outputs for building quality design, facilities, and services desired quality and performance standards).

The object of the project is the completion of a comprehensive service for young people with mental health problems integrated with other agencies involved in their care and treatment. The service aims to provide packages of care that are specific and proportionate to the needs of individual patients in appropriate settings as near to their home as possible and when required, in modern functional in-patient buildings that support modern health, social and educational care.

The outputs to be delivered under the Project are:

- West of Scotland Regional response in relation to population and deprivation and local need;
- Level of service provision evidence based and account taken of the NHS national provision;
- Provision of advice and support to West of Scotland local community services;
- Adequate provision of support from West of Scotland local community services;
- Scope for flow of patients through spectrum of care;
- Rapid response to demand for urgent in-patient admission and assessment (emergency admissions); this includes same or next day admission including from the Islands via flights, ferries and road transport. A brief exercise carried out using the two leading sites indicated that by road the average distances are comparable. The distances were calculated using the home address post codes of recent admissions to the interim in-patient ward to the two main sites.
- Assessment ensuring appropriate gate keeping of acute in-patients;
- Best use of specialized therapeutic intervention skills;
- Specialist clinical input due to the complexity, nature and intensity of needs;
- Customise provision of acute adolescent in-patient beds;
- Affordability.

Personal access in individual and group spaces is a key feature for modern customized in-patient accommodation. The key outputs for the project, therefore, include:-

- Service environments fit for purpose;
- Space to allow clinicians to work with patients on an individual basis;
- Space to allow patients dignity to be protected, respecting their need for privacy;
- Space for clinicians to engage effectively with small groups of patients sharing common mental health problems;
- Design assists a move in focus from observation activities toward therapeutic activities;

- Facilitate a more effective continuous transfer to community based care;
- Single gender accommodation with mixed and single gender day areas;
- Individual en-suite rooms options for each patient;
- Open space for general/social interactive activities;
- External space (i.e. recreation/garden areas);
- Two way locks which can be controlled by patients but opened by staff;
- Access by patients to their belongings and ability to return to their personal areas at will.

A summary of the outputs has been prepared and is presented in the table below:-

Output Criteria	Output	Output Measurement
West of Scotland equitable response relating to population, deprivation and local need	Enhanced Community Teams acting as the focal point at locality level for services for people with serious mental health problems	Additional investment in Community Mental Health Teams. Increase in % of acute admissions with involvement of adolescent CMHT or Social Work. A standard for more rapid pick-up of discharged patients. Protocol for next day hand over to adolescent CMHT.
Level of service provision evidence based and taking account of the NHS national provision	More specialist adolescent mental health services. Reduction in extra contractual referrals for emergency admissions.	A reduction of admission for West of Scotland ECRs. Existence of Specialist Mental Health Services for young people with eating disorders. Co-location of acute services on General Hospitals diagnostic sites.
Provision of advice and support to West of Scotland local community services.	Improved community based care for young people with mental health problems. Specialist in-patient Consultant advice for people under the care of a community team in the West of Scotland.	Agreed links to West of Scotland community team.

Output Criteria	Output	Output Measurement
Complexity nature and intensity of needs require specialist clinical input	Improved referral of patients from Primary Care Specialist care and treatment of patients in a range of appropriate settings	Reduction in inappropriate referrals from Primary Care. Strengthening and targeting the role of the community services. Development of Assertive Outreach services. Development of Partial Hospitalisation options. Development of additional drug and alcohol services. Criteria for movement of patients between core and specialist mental health services.
Best use of specialized therapeutic intervention skills	Targeted delivery of a single social and health care package to people. Improved use of staff skills.	Joint Agency Community Teams for assertive community and community based treatment and education. Reduction in use of constant observation. Joint agency protocols and criteria for accessing and different levels of social education and health care according to need.
Adequate provision of acute adolescent beds.	Prevention of delayed admission. Improved co-ordination of access to in-patient facilities.	Provision of 24 adolescent beds. Ward design sub areas of less than 10 beds. Increase in the % of patients admitted to in-patient care with involvement of Social Work or CMHT.

Output Criteria	Output	Output Measurement
Service environments fit for purpose	Modernisation of adolescent acute mental health in-patient care. Privacy and dignity for young people. Improved patient treatment.	Development of ward environments with fewer than 10 beds per cluster. Acute mental health in-patient care in new purpose built in-patient facilities located on general hospital sites. Single rooms for each patient. En suite w/c and shower options. Separate gender specific day/living area options. Separate gender specific toilet facilities. Patient accessible locks on their rooms. Individual treatment/clinic rooms. Family/Group treatment therapy rooms. Decrease in untoward incidence reporting and use of constant observation.
Assessment and triage ensuring appropriate gate keeping of acute inpatients.	Improved care pathway for patient treatment and rehabilitation.	Enhanced adolescent community health teams. Introduction of bed management system to West of Scotland adolescent service.

Output Criteria	Output	Output Measurement
Scope for flow of patients through spectrum of care.	Admission to all core levels of adolescent mental health service available to all referral sources. Patient misplacement and inappropriate re-admission avoided. Specialist adolescent mental health care services.	Reduction in inappropriate referral. Reduced re-admission rate to care services. Reduced numbers of inappropriately placed patients. Specialist mental health care service development. Protocols for patient movement between core and specialist services.

6. Project Objectives

6.1 The overall project objectives are described in Section 4.2. In summary, these are the delivery of comprehensive and equitable, needs based, adolescent mental health services.

The service specification in Section 5, emphasises the need to provide a modern, purpose built in-patient ward. The clinical preference is for these beds to be located with general mental health in-patient facilities on general hospital diagnostic service sites. The in-patient accommodation is a key component of the model of care, and will support the delivery of effective therapeutic interventions. This service specification identifies specific needs in terms of accommodation provision:

i. individual rooms for each patient to provide privacy and dignity;
ii. small rooms to enable family and group work involving small groups;
iii. open day space for interactive/social activities;
iv. quality external space;
v. 8 bed clusters to complement the preferred model of care.

Within each West of Scotland Health Board area a comprehensive range of integrated services will be provided which will deliver seamless clinical care regimes with the regional in-patient ward.

6.2 The desired benefits of the project are detailed below:

- To provide environments which are more therapeutic as opposed to observational;
- To provide the delivery of care in more homely environments;
- To provide an environment which is less anxiety provoking;
- Access to garden area which offer a range of diversional activities;
- To provide facilities which are suitable to provide therapeutic interventions;
- To provide an environment which reduces levels of stress for staff;
- To provide facilities which have good transport links to the West of Scotland
- To provide facilities which are co-located with DGH services (medical diagnostic and therapeutic services);
- To provide a single regional specialist unit to deliver economies of scale.
- A generic design has been developed (see Appendix Two) based on these principles involving service users and input from the Carers Group.

6.3 The project objective is the reprovision of the 16 bed in-patient service currently located Gartnavel Royal Hospital based on the service requirements identified above. This is consistent with the Primary Care Operating Division property strategy. This has identified the need to close an existing accommodation site and replace this with functionally appropriate facilities which meet the requirements of modern clinical practice. The configuration of the current ward facilities prohibits the Adolescent Directorate from achieving the objectives of the project.

In addition to the constraints associated with the existing estate, there are key constraints associated with site availability, the acquisition of alternative sites and achieving planning consents.

The Gartnavel Royal Hospital site is subject to development for modernization of adult and older people mental health services and acute general hospital care. Phasing projects means that any option to progress on the Gartnavel site will be subject to access to the site in accordance with existing scheme timescales.

Another constraint to delivering the objectives will be obtaining planning consents for the new in-patient facility. As the reprovided accommodation is likely to be located on existing hospital sites, the Planning Authority is likely to require that it take a view on the overall development of the site and the impact on the local neighbourhood. Again, this may lead to some delay in achieving the project objectives.

7. Options considered

LONG LIST OF OPTIONS

The West of Scotland Health Boards were invited to nominate participants for the completion of a site benefits option appraisal, as an element of a fuller option appraisal. The nominees and report of the exercise are listed at Appendix Three.

Option		Criteria by which Option was Discounted
	Do nothing (included as a comparative)	*
1.	Do minimum – develop existing building	*
2.	Separate in-patient services in each of the Health Board Areas specific to the West of Scotland.	The six West of Scotland Health Boards have adopted a regional policy approach to commissioning relatively specialised low volume services. The volume anticipated for each individual West of Scotland Health Board is insufficient psychiatry in-patient units. Separate in-patient services in each of the six Health Board areas would not meet Health Boards policy on regional commissioning and for this reason this option was discounted.
3.	Single combined in-patient resource centre service for the West of Scotland – Stobhill	*
4.	Single combined in-patient resource centre service for the West of Scotland – Ruchill	The Ruchill site in Glasgow does not have any physical diagnostic services co-located on site. The site entrance and unused space is a steep slope which has made it unavailable for new build. The site is also located on relatively isolated, not directly accessible from main transport arteries.

Option		Criteria by which Option was Discounted
5.	Single combined in-patient resource centre service for the West of Scotland – Southern General Hospital.	The Southern General site in Glasgow does not have sufficient available acreage for the adolescent ward. The site has subsequently and additionally become subject to development and other known estate and site strategy. At the time of the workshop it was confirmed that no space was available for such a development. The site strategy has developed and incorporates new services that wouldn't see developments within a reasonable timescale (e.g. within 5 years).
6.	Single combined in-patient resource centre service for the West of Scotland – Central Belt ****	Since the option appraisal workshop exercise no sites as part of the Dumfries and Central belt options have been identified to date.
7.	Single combined in-patient resource centre service for the West of Scotland – Dumfries ****	Since the option appraisal workshop exercise no sites as part of the Dumfries and Central belt options have been identified to date.*
8.	Single combined in-patient resource centre service for the West of Scotland – Royal Hospital for Sick Children. .	The Royal Hospital for Sick Children Estates advisers confirmed for the option appraisal workshop that sufficient acreage was not available on the site. This remains the case and is anticipated that existing services could now be relocated.
9.	Single combined in-patient resource centre service for the West of Scotland – Victoria Infirmary.	The Victoria Infirmary site would not offer the support of co-located Mental Health Services and would also not offer sufficient space.

Option		Criteria by which Option was Discounted
10.	Single combined in-patient resource centre service for the West of Scotland – Woodilee.	The Woodilee site did not offer service co-location with acute mental health services or co-location with physical diagnostic services. Additionally the site was subject to a known estate/site strategy that doesn't support the siting of an adolescent unit and includes agreed closure and disposal.
11.	Single combined in-patient resource centre service for the West of Scotland - Lennox Castle.	The Lennox Castle site did not offer service co-location with with acute Mental Health Services or co-location with physical diagnostic services. Additionally the site was subject to a known estate/site strategy that doesn't support the siting of an adolescent unit and includes agreed closure and disposal.
12.	Single combined in-patient resource centre service for the West of Scotland - Gartnavel Royal	*
13.	Single combined in-patient resource centre service for the West of Scotland – Leverndale.	The Leverndale site does not offer co-location with physical diagnostic services on any level for new build and is also subject to an alternativeestate/site strategy that results in the contraction of the site and eventually transfer of acute mental health services.
14	Single combined in-patient resource centre service for the West of Scotland – Cowglen.	The Cowglen site did not offer co-location with physical diagnostic services or co-location with acute mental health services. The site has also been subject to disposal.

Option		Criteria by which Option was Discounted
15.	Single combined in-patient resource centre service for the West of Scotland – Belvidere.	The Belvidere Hospital site does not offer service co-location with acute mental health or alternative estate/site strategy including agreed disposal.
16.	Single combined in-patient resource centre service for the West of Scotland – Canniesburn.	The Canniesburn site doesn't offer co-location of acute mental health or physical diagnostic services. The site was also subject to an alternative estate/site strategy as a partnership development for long stay care. This would not offer continued NHS use or sufficient acreage.
17.	Single combined in-patient resource centre service for the West of Scotland - Broomhill and Lanfine.	The Broomhill and Lanfine site would not offer service co-location with acute mental health, the site is subject to agreed disposal and didn't offer the additional acreage required on the site.
18.	Private site.	Private land would not offer service co-location with acute mental health or physical diagnostic services. The option of a private site would have added requirement of purchase availability and cost.

Many of the sites did not meet a number of the criteria or constraints identified but once one of the criteria listed were not met not all the constraints were subsequently listed. Since the preparation for the site option appraisal workshop none of the sites that were subject to disposal have remained as options. The discounting of options on the long list remain valid following the site option appraisal to the present date.

* = shortlisted

The Do Nothing option was shortlisted to provide a baseline comparator. The Do Minimum option was also shortlisted to consider responding on the basis of a minimal approach.
**The Dumfries and Central Belt options were shortlisted, although no sites came forward as an option for consideration and they were discounted on the day of the workshop.

CRITERIA/CONSTRAINTS USED IN SHORTLISTING SITES

1. NHS and Health Board Policy on Adolescents would not be met.
2. Service integration with acute mental health.
3. Service integration with physical diagnostic services.
4. Sufficient acreage.
5. Site suitability - ie, gradients.
6. Site available within reasonable timescale.
7. Retention of existing buildings.
8. Availability of land for new build.
9. Site available for continued NHS use.
10. Site subject to agreed closure and/or disposal.
11. Site remote and difficult to access.
12. Known estate/site strategy.

Short Listed Options

Option		
	Do nothing (included as a comparative)	*
	Do minimum – develop existing old functionally unsuitable Adolescent building at Gartnavel Royal Hospital. Provide additional patient accommodation, 24 places, (with a mix of single bed and four bed dorms and limited en-suite facilities), with patient accommodation over two floors in a 16 bed and eight bed split. Access to garden area will be restricted on a steep slope on the current location. Therapeutic facilities and overnight carer's accommodation cannot be separated form sleeping accommodation which is a particular difficulty in child protection issues. In addition day and recreation space will be compromised due to restrictions of the existing building fabric. The cost of the minimum option would not provide for internal alteration with investment being targeted on refurbishing the existing layout.	
	Single combined in-patient resource centre service for the West of Scotland – Stobhill	*
	Single combined in-patient resource centre service for the West of Scotland – Central Belt **	*
	Single combined in-patient resource centre service for the West of Scotland – Dumfries **	*
	Single combined in-patient resource centre service for the West of Scotland – Gartnavel Royal	*

*** Post Option Appraisal Note

No site for the Dumfries and Central Belt options was identified or brought forward as an option for consideration and following discussion by the West of Scotland representatives these two options were discounted on the day of the workshop.

8. Exploration of PPP/PFI

8.1/8.2 The potential for procuring the project with PPP/PFI should be fully explored. Such exploration may require the carrying out of informal market sounding exercises. Where PPP/PFI is ruled out, a clear explanation of the exploratory work undertaken and the reasoning behind ruling it out must be provided.

An assessment of the PPP/PFI potential of this scheme has been carried out, as shown on Appendix 4a. On balance, it is considered that this project does not have a good potential for provision under PPP/PFI. Soundings of the market have been made, speaking to 3 bidders for health and other projects in Scotland and the rest of the UK. These soundings indicate that the scale of this project is too small to attract competitive interest. A report on these soundings is made at Appendix 4b.

The project is limited in scope for enhanced private sector innovation and cost saving, its function being simple in purpose.

There is limited scope for facilities management in a scheme of this size and the opportunity for risk transfer is scant.

Considering these points, it is concluded that this scheme is unlikely to achieve value for money if its procurement was to be pursued through PPP/PFI.

9. The Appraisal Process

9a Benefits Appraisal

9a1. Identification of non-financial benefits, an indication of when they are expected to occur, and quantification, ideally in the form of a weighting and scoring analysis

The West of Scotland Adolescent Psychiatry Reprovision Working Group established the following non-financial benefits in assessing options and desired outcomes:

- ✓ clinical effectiveness and quality
- ✓ suitability of building
- ✓ availability of facility
- ✓ accessibility
- ✓ flexibility for change and growth
- ✓ local community environment/location/amenity
- ✓ access to support

The scoring of options in accordance with these criteria is summarised below and shown in Appendix Three.

These benefits are expected to occur on operation of the new unit, staffed up to the prescribed level.

Ranking and Weighting of the Criteria

The Workshop having agreed the criteria by which to judge the short listed options were then asked to discuss and agree, with other West of Scotland representatives, ranking the criteria and subsequently to agree for each of them a weighting out of 100. The criteria were first ranked in importance from most important (clinical effectiveness and quality) to seventh most important (access to support). The first ranked criteria was given a weighting of 100. The second most important criteria was then given a weighting relative to the criteria ranked immediately above it. In this case the second ranked criteria was given a weighting of 90. This process was repeated for all the criteria in order of ranking.

The ranking and weightings that were agreed were:

	Ranking	
Rank	*Benefit Criteria*	Weight
1	Clinical effectiveness & quality	100
2	Suitability of Building	90
3	Availability - time, and technical complexity	70
4	Accessibility	70
5	Flexibility for change & growth	55
6	Local Com'ty Env'nt/Location/Amenity	45
7	Access to Support	30
		460

Site Visits

It was planned, if there was time for the Workshop representatives, to visit at least two of the sites short-listed. The constraints of time and discussion and agreement of the model of care, short listing of sites, amending and agreeing the criteria and ranking and weighting the criteria the proposed site visits were not possible. Aerial photographs of the short-listed sites were circulated and presented to provide information of the sites involved. A recent desk top exercise was carried out on the average distance to the two leading sites. This exercise used the postcode areas for recent young people admitted to the interim in-patient ward. The outcome showed that the two leading sites were equitable in distance for traveling by road.

Scoring of the Site Options

In discussion with the all the representatives a score out of 10 for each short-listed site for each of the weighted criteria was sought.

The process involved agreeing a consensus score and also took account of and recorded any more optimistic and more pessimistic views.(Full scoring is listed at Appendix Two Paper D).

The benefit criteria weighting (see Appendix Two paper D) were scaled to 100 and each of the individual scores multiplied by their individual score to produce weighted benefit scores. The results of the scoring exercise were shared with all those present at the Workshop and were as follows:

		Weighted Benefits Score
	Option	Consensus
Do Nothing	1	430
Do Minimum	2	536
Gartnavel Royal	3	710
Stobhill Hospital	4	762

The site offering the most benefits was identified as option 4 – Stobhill Hospital. The Stobhill site offers 77% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (65%) than the Do nothing Option.

Sensitivity of the Results

In order to ensure that the consensus view and results was sensitive to both optimistic views and pessimistic views from within the workshop a pessimistic and optimistic view was also recorded for each of the criteria for each of the site options. The results of these views are set out below:

		Weighted Benefits Score	
	Option	Optimistic	Pessimistic
Do Nothing	1	577	277
Do Minimum	2	680	359
Gartnavel Royal	3	793	673
Stobhill Hospital	4	825	695

The ranking of the proposed sites remained the same as the consensus view, with both the Stobhill and Gartnavel Royal sites scoring significant benefit advantages over the Do Nothing option.

Again the site offering the most benefits was identified as option 4 – Stobhill Hospital. The most optimistic view of the Do Nothing option still foresees Stobhill site offering 43% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (37%) than the Do nothing Option.

The most pessimistic view of the Do Nothing option still foresees Stobhill site offering 150% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (142%) than the Do nothing Option.

Taking account of the different views expressed on the day the ranking of the options remained consistent and therefore the consensus view can be accepted as sensitive and legitimate.

9a 2. The West of Scotland Group will evaluate the project based on the above criteria, both visiting the Ward and receiving report from the Division's General Manager – Clinical Directorates who is responsible for the service within the Division. The leading sites and the generic design have also been discussed with the existing interim wards Carers Group. The existing Gartnavel Royal site is liked by the Carers Group. The opportunities afforded by the preferred site, the speed of development that the existing estate is not thought fit for purpose by anyone including themselves and the cost issues were also recognised by carers as key factors in identifying the preferred site.

9b 1. A statement of how much the NHS Boards are prepared to spend on the services to be covered by the proposed project

The NHS Boards are prepared to spend on the project as follows :

Capital, £6600k at year 04/05 base (this cost being indexed to mid point of the building contract period and excluding optimism bias) and Revenue, £3530k at year 04/05 base.

Their shares are :

NHS Board	Share	Capital	Revenue p.a.
Greater Glasgow	59.11%	3901	2087
Argyll & Clyde	19.26%	1271	680
Dumfries & Galloway	1.94%	128	68
Ayrshire & Arran	6.08%	401	215
Lanarkshire	11.6%	766	409
Forth Valley	2.01%	133	71
Total	100.00%	6600	3530

Payment for usage of present services is based on the history of usage that each Board has made of present services in the last 3 years. Each year, this history is updated to the most recent 3 years and Boards informed of any changes in their share of costs as a result of any change in usage. This is an agreed formula for cost sharing between Boards.

It has also been agreed that the formula for revenue share will be revisited after the first year of operation for the new Ward. Boards have submitted written confirmation of their contributions and have confirmed that their 5 year revenue plans include this commitment.

9b 2. Revenue implications of the preferred option (including capital charges and the net effect on prices). This estimate should make allowances for the cost of risk and the full lifetime costs of a scheme, including provision for equipment and IM & T at the start of, and during, the project.

The revenue implications are £3,530,000 p.a. base 04/05, and are detailed in Appendix 5.

In view of the smaller-scale nature of the project, no allowance for risk is made. No significant risks, requiring quantification, are identified in this project.

9b3. Impact on the Boards' balance sheets, cash flow position and operating cost statement

The implementation of this project constitutes a minor development in the financial plans of the organisations concerned and has been allowed for in their financial planning.

9b4. Key assumptions underlying the financial appraisal and explanation of the methodology used to project income and expenditure.

The key assumptions made for the financial appraisal are :

- patient admissions and discharges remain within +/- 10% of forecast
- no major changes in services designed are anticipated
- any unforeseen changes are matched by additional revenue funding
- construction costs are contained within the funding awarded
- indexation is allowed on cost estimates, matching annual cost increases
- building is completed within the timescale planned

9b5. Full sensitivity analysis on the key assumptions behind the financial appraisal

The capital and revenue consequences of the scheme for the short-listed options are:

£'000 (Dec 04 cost base)	**Capital (incl opt. bias)**	**Revenue**
Stobhill General Hospital	6930	3530
Gartnavel Royal Hospital	7440	3604
Do Minimum	2240	2299

Do nothing	0	1842

The capital costs for the Stobhill option would require to be exceeded by more than 7% or the capital costs of the Gartnavel Royal option would require to be less by 7% for the option at Stobhill to be improved upon by the option at Gartnavel Royal.

Accepting the revenue consequences of capital costs, all other costs are expected to be the same in both high-scoring options. The remaining two options, Do Minimum or Do Nothing are inferior options included only for comparison.

A variance in capital costs of the above scale is not expected and the option at Stobhill remains financially the better option of the two options which fulfill desired outcomes.

9b 6. Explanation of how the cost of risk has been factored into the financial appraisal.

The capital cost contains a contingency sum of 2 &1/2% of all works costs, fees and equipment.

No other significant cost of risk has been identified, requiring factoring into the financial appraisal.

The project team understand that the proposed capital cost of the preferred option, Stobhill location £6,600,000 (before optimism bias) this cost being indexed to mid point of the building contract period.

9b 7. Assessment of whether there is flexibility to fund any additional revenue requirements and likely source of funding (e.g. disposal of surplus land)

There is little flexibility within the two high-scoring options for additional revenue from e.g. sale of land. Proceeds from sale of land would be of a one off nature and would not assist the revenue costs in the longer term. Any additional revenue requirements would require to be addressed by all six commissioning Boards.

9b 8. Evidence of NHS Board involvement in the development of the project (including confirmation that the scheme is affordable, complies with the Local Health Plan and will be properly managed)

Evidence of involvement is made by the paper submitted to the West of Scotland Finance Consortium and Child and Adolescent mental Health Steering Group, appointed by the West of Scotland Regional Planning Health Boards' General Managers, (see Appendix 2). Each Board has confirmed support to the sums outlined in 9b 2, above.

9c Economic Appraisal

In the process of economic appraisal, the application of optimism bias has been required and the capital costs are amended to reflect this. Details have been submitted separately to the SEHD and a summary of outcome is shown her only.

The economic values in the appraisal are drawn from :

£'000 (04/05)	**Stobhill**	**Gartnavel Royal**	**Do Minimum**	**Do Nothing**
Capital cost including optimism bias	6,930	7,440	2,240	0
Revenue cost p.a. from year 2 to year 41 (40 year life) – excluding capital charges	3,080	3,130	2,160	1,680
Assessed proceeds from sale of land	150	300	3,000	2,000

In regard to the assessed proceeds from sale of land in the case of Do Minimum and Do Nothing, these take into account the location of the present services in Henderson House, Gartnavel Royal, which occupy a prime location to the West of Gartnavel Royal Hospital West House.

This area of the hospital is planned for disposal in the long term, residential use being outlined, and the continued presence of this service here would limit significantly the proceeds from sale of West House in addition to sale of the land occupied and overlooked by Henderson House. In the case of this appraisal, these assessed values, if changed by 100% either way, do not impact the outcome of the appraisal.

Economic appraisal :

Net Present Cost £'000	Stobhill	Gartnavel Royal	Do Minimum	Do Nothing
Capital and Revenue costs over 40 years	68,180	69,690	45,350	32,720
Land opportunity cost	150	300	3,000	2,000
Total NPC	68,330	69,990	48,350	34,720
Benefits scoring – consensus points : see below	762	710	536	430
Cost per benefit point	89.7	98.6	90.2	80.7
Ranking	2	4	3	1

The outcome of this economic appraisal is that for a comparatively minor increase in cost per benefit point, (£80.7k to £89.7k), there is a very significant increase in total benefit points as a result of investing in a new build option (430 points to 762 points in the case of the Stobhill option).

In addition, the outcome of the weighted benefits scoring for all options revealed a considerable range of scores for the Do Minimum and Do Nothing options, the extremes of which were summarised as Optimistic and Pessimistic. This was to ensure that the full range of different views could also be taken into account and represented within an option appraisal exercise.

The range of costs per possible benefit point from the range Pessimistic to Optimistic Benefit points scoring are :

		Range of Costs							
		Cost £'000 per Benefit Point							
	60	70	80	90	100	110	120	130	
	Optimistic			Consensus			Pessimistic		
Stobhill									
Gartnavel									
Do Minimum									
Do Nothing									

The Do Nothing and Do Minimum options had a considerable range of scores for benefits and a view persisted that in fact the benefits from these options could be poor, as well as good, some particularly pessimistic scores arising.

The consensus benefit scores for these two options fall short of the benefit scores realised by the new build options at Stobhill and at Gartnavel Royal, both of which have more settled benefit scores, as well as better consensus scores.

There is a more reliable view of the benefits of the two new build options, the Stobhill option being more favourable, having more benefits for a lesser cost than the Gartnavel Royal option. A considerable effort has been made to quantify the various factors in these options but it is difficult to capture the vast qualitative improvements that the service would experience in adoption of a new build option.

9d Risks and uncertainty appraisal

In view of the small scale of this scheme, it is considered that no significant risks or uncertainties apply to the two favoured options.

For the purposes of the economic appraisal, an assessment of risks as concerns capital is shown in the optimism bias adjustments forwarded as additional information to this business case. In the favoured new build option at Stobhill site, possible site risks are identified but these will be contained within the allotted capital funding of £6,600,000 base December 04, this cost being indexed to mid point of the building contract period.

A risk to capital expenditure is the only identified risk and this will be accommodated within the capital sum. Revenue risks, if they arise, will be contained within the revenue funding set out in section 9b1.

10. Preferred Option

The preferred option is for the development of the new unit on the Stobhill General Hospital site.

Whilst both leading options deliver best outcomes in terms of the assessment criteria set out, West of Scotland Health Boards are concerned at the continuing underprovision of adolescent inpatient beds with therapeutic day activities and it is important that services are developed within the shortest practicable timeframe.

The site at Stobhill is available (2005), whereas a site at Gartnavel Royal remains subject to reprovision of all services on the Gartnavel Hospital complex, a process which will not be complete until 2007/08. It will be only after that date that a practicable site could be chosen.

For this main reason, the Boards are keen to see an early start on the scheme at the Stobhill Hospital site.

11. Risk transfer

As outlined in Section 8 (PPP/PFI) (Risks), above, the question of risk transfer does not arise in the case of this scheme.

12. PPP/PFI Legal Issues

This section does not apply.

13. Personnel Issues

The staffing profile, both present and proposed, is set out in Appendix 2.

Staff required in addition to staff presently employed for the existing service are :

Medical	0.5 wte Staff Grade
Nursing	29.05 wte Qualified
	7.0 wte Unqualified
Psychology	0.5 wte Grade B
AHP	0.4 wte Art Therapist
	0.9 wte Dietician
	0.1 wte Physiotherapist
	0.1 wte Speech Therapist
	1.0 wte Family Therapist

The Division has considerable experience and success in recruiting staff and is confident that these additional staff can be recruited.

Workforce Planning – Present and Future Staff Requirements

The Division employs 6000 staff, over 2500 (2138 wte) work in the Mental Health Division. The modernization plans for the mental health services will see the number of staff working in them increase by around 300 over the next five years. To support this the Division has a well defined Human Resources Strategy developed with full involvement of staff representatives locally through our staff partnership arrangements.

This section outlines the key components of the strategy, which will ensure the effective implantation of “Modernising Mental Health”.

Policy on Openness, Consultation and Involvement

The Trust has established a workforce planning group, which has the full involvement of staff representatives. This has produced a workforce plan that is summarised in the table below. Critical to our ability to deliver new services will be our ability to recruit and train key staff in new and existing roles.

A recruitment strategy has been developed and a small dedicated team, to implement it, is being put in place. This will involve wide advertising of vacancies through national press and professional journals, participation in careers fairs, nursing exhibitions and conferences. Improved links with colleges and universities are being made to ensure, through clinical placements, we are able to attract staff on completion of training.

Workforce planning will be developed with Glasgow City Social Work Department to ensure an integrated approach to developing services.

Education, Training and Lifelong Learning

The Trust develops a Learning Plan in partnership, in partnership with trade unions, on an annual basis linked to organizational objectives and personal development planning. In our mental health services key areas in the learning plan are core clinical training, continuous professional development and statutory training. The learning plan and its evaluation will ensure that staff have the skills, expertise and support to provide a high quality service which meets the standards set by the Clinical Standards Board for Scotland and other bodies.
The plan ensures that all staff, whether professional or support, have access to training and education opportunities. The Trust is committed to the Investors in People Standard.

Employment Practice

The Trust has a wide range of employment policies which ensure that staff are treated fairly and consistently. All policies are being reviewed to ensure they meet the Partnership Information Network (PIN) Guidelines. The Trust operates within the statutory employment framework and ensures it complies with the relevant employment legislation. The Trust has a successful track record in managing change and the Human Resources Strategy ensures that staff affected by change are supported in a planned way.

14. Timetable

The project plan is

2005

February	Approval of OBC by Health Boards
April/May	Approval of OBC by SEHD
November	Approval of FBC by Health Boards
November	Approval of FBC by SEHD

2006

March	Detailed Planning consent obtained from Glasgow City Seek tenders for work
May	Award contract
June/July	Start construction

2007

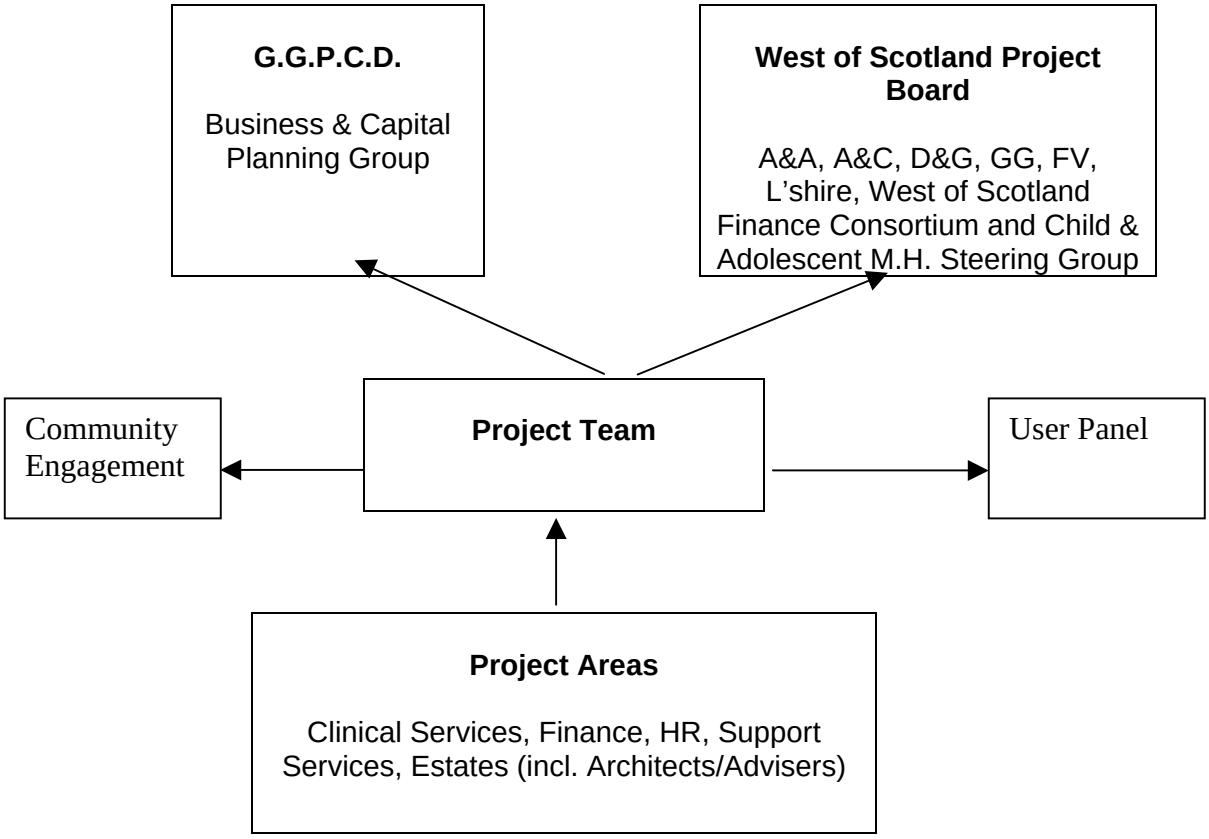
December	Construction completed, handover and operational.

15. Project Management

15.1 Description of how it is intended to manage the various phases of the project

Project Management

The proposed project management proposals are outlined below:-



Project Roles

Each of the key project roles and reporting mechanisms are outlined.

The Project Sponsor will be the W.O.S. Health Board delegates and nominated representative from the West of Scotland Finance Consortium/West of Scotland/ Child & Adolescent M.H. Steering Group. The Project Sponsor will appoint a Project Director to manage the project, facilitate and resolve difficult issues across six W.O.S.H.B.'s. The role of the Project Board will be to take responsibility for decision making, strategic vision and leadership, approve project timescale and plans, monitor and approve any changes to the programme, exercise delegated authority on behalf of the W.O.S. Health Boards to ensure the scheme framework, the clinical benefits detailed in the O.B.C., financial framework (revenue and capital) which ensures the protection and accounting positions of the six Health Boards and agreement which offers the best way for the scheme to proceed to a project conclusion.

The prime responsibility of the Project Director will be to oversee the project as a whole, including all relevant public procurements and realistic intended benefits. Specific tasks include managing stakeholders' interests in the project; providing decisions and direction on their behalf, embracing direction from the Project Board, oversee appointment of advisers and contractors to undertake the work within the project budget; act as a point of contact to all stakeholder organisations as a direct link to the Project Board.

The role of the Project Team will be to deliver the objectives set by the Project Board; give guidance to the Project Advisers at key stages in the process; direct the input through to the full business case and award of the construction contract, ensuring adequate resources are made available, review and approve the operational matters concerning operational policies; outline requirements and output specifications and outline design; take a lead responsibility for internal and external communications; monitor project costs and present summary progress reports and action on options during the project to the Project Board.

The Project Manager's role will encompass setting up the project, implementing a regime of sound project management and advising the Project Director as to progress on time, cost and quality. Specific tasks include authorise project plan, advise project management team of progress; monitor against project execution plan and ensure corrective action is taken if needed; agree project monitoring procedures and documentation and report progress the Project Director.

Project Director is the General Manager – Clinical Directorates who will oversee delivery of the project. The General Manager is educated to degree level and post-graduate diploma in Management with 19 years experience in the NHS. He has managed service development including delivery of new clinical services with related capital equipment and capital accommodation procurement.

Project Manager is the Head of Estates and the implementation of the building element of the project will be the responsibility of the Head of Estates. The Head of Estates is a qualified QS and is holder of an MBA with 12 years of experience with Glasgow University and 4 years of experience in the present organisation. He has managed a building programme in excess of £20m p.a. in the last 3 years, delivering to time and to budget in particular a £3m multi-user, award winning projects at Easterhouse, Arran Centre and Sandy Road in Glasgow. Rigorous cost control procedures are in place resulting in all capital projects being delivered within approved capital allocation.

He is supported by a qualified QS and will engage a full design team for this scheme using the OJEC procedure. There is a fully developed generic design fully involving stakeholders and clinicians which will be used by the design team. An estimate of cost of external advisers is £350,000.

Additionally, the Project Director and Project Manager will be supported by the G.G.P.C.D. Business & Capital Planning Group. This is a sub-group to the Divisional Management Team. It is chaired by the Director of Finance who carries overall responsibility for the management of capital and property matters. Its membership includes Director of Nursing and the General Manager – Clinical Directorates who are responsible for Adolescent Services in the Division. The Head of Estates and Capital Investment is also a member of the group.

APPENDIX 1

Admission and Discharge Criteria for New Adolescent Unit (updated Feb 2005 – West of Scotland Consortium)

The purpose of an Adolescent Unit is to offer in-patient assessment and management to young people with significant mental health and emotional difficulties when out-patient or day-patient care has ceased to be able to meet the needs of that young person. It must be better to admit to hospital than not to admit to hospital and an adolescent unit would not seek to replace good quality Social Work Services or fill the gap in local Child and Adolescent Mental Health Services.

Priority will be given to the Health Board areas of Greater Glasgow, Forth Valley, Argyll and Clyde, Ayrshire and Arran, Dumfries and Galloway and Lanarkshire. Consideration will be given to any young person from other areas on a case by case basis if a place is available.

The Mental Health (Care and Treatment) (Scotland) Act 2003 will come into effect in October 2005. Under Section 23 of the Act, Health Boards will have a new duty to provide appropriate services which meet the needs of any young person under the age of 18 admitted to hospital for treatment of mental disorder. It needs to be noted that whilst the Adolescent Unit will service a large proportion or this responsibility for the partner Health Boards, it will not be able, nor would it be appropriate for it, to accommodate every young person who requires admission (see below for further details). Therefore the Health Boards will have to be mindful of the need to make additional accommodations for these young people.

The age range is 12 – 17 years inclusive. Consideration will be given on a case by case basis to young people aged 11 years if they have left primary school. Young people who may become 18 in the unit will have a transfer plan negotiated with the referring team *in the months preceding their birthday.*

A Consultant Child and Adolescent Psychiatrist should make the referral when at all possible. If another team member makes the referral then the Consultant Child and Adolescent Psychiatrist must have been consulted. If a Consultant Paediatrician or other consultant wishes to refer this should be discussed with the local Child and Adolescent Psychiatry team.

Criteria for Admission

1. Where a mental disorder in a young person has led to a significant risk of suicide or significant harm may ensue if admission does not take place.

2. A young person is suffering from a severe ICD10 Axis 1 disorder (including psychotic disorder, affective disorder, eating disorder, obsessive compulsive disorder, neuropsychiatric disorders, psychosomatic disorders, and disorders of development including pervasive developmental disorders).

3. A young person's development has been disrupted by adverse experience and it is deemed that an in-patient assessment would add to the understanding in management of that case.

4. The complexity of a young person's presentation causes difficulty in reaching a diagnosis and an in-patient assessment would prove valuable.

5. Other young people may be considered where negotiation between the out-patient and in-patient consultants has led to an understanding that an in-patient assessment is required.

The needs of patients would be considered on a case by case basis but the following would make admission unlikely:

1. The level of dangerousness presented by the young person would put staff and patients at risk or the patient would require a locked environment. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

2. Drugs and/or alcohol are the sole condition causing the disturbance to the young person. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

3. The young person is affected by moderate or severe learning disability whether congenital or acquired. The staff of the current adolescent service are not trained or accredited in the management of significant learning disabilities and would not be able to meet the needs of this group of people without further training and the commissioning of extra beds. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

4. A particular mix of cases may, on occasion, preclude admission. Admitting a particular patient may cause problems for the well-being of the other patients within the adolescent unit or alternatively the other patients within the adolescent unit would cause problems for the well-being of the young person being referred.

5. The young person presents with deliberate self harm behaviours in the absence of a major psychiatric disorder of clear suicidal intent. There is evidence that this group of patients does badly if admitted to hospital and requires particular therapeutic interventions in the community.

6. The young person has an illness that is likely to require an admission of several months and is within 6 months of their 18th birthday.

Any concern for a young person, where there may be a need for admission, can be discussed with the in-patient Consultants.

Clinicians should be empowered to exercise some clinical choice when referring for admission and it may, on occasion, be more appropriate to refer to units other than the one in Glasgow when it is felt the other unit would better meet the needs of their patients.

It is proposed that the Adolescent Unit will provide consultation and advice following consultant discussion to out-patient teams throughout the West of Scotland and that second opinions would also be available to young people. It is acknowledged that the needs of young people are best met by clinicians adopting a collaborative and flexible approach to their care.

Process of referral

In order to make the most efficient use of places in the adolescent unit it would be helpful to have as much information as possible prior to or shortly after admission. The unit will supply a referral form that should be typed and posted, emailed or faxed.

Apart from the necessary clinical information and history of the referrer's involvement the following information should be included in the referral.

1. Reports from other clinicians (eg neurologists, paediatricians), social workers, educational psychologist or other professionals.
2. Results of investigations.
3. The names, addresses and telephone numbers of all workers involved in the case.
4. The names, addresses and telephone numbers of parents and carers especially in families with step parents and name changes.

The referring consultant should make an indication of the urgency of the case with the following response times being made by the adolescent unit.

Emergency – see family within 24 hours.
Urgent – see family within one week.
Planned – appointment sent within 10 days to see family within 6 weeks.

If at all possible the referrer should be present at the assessment.

Decisions about admission will be telephoned to the referring team within one working day of the assessment appointment.

During the admission there is an expectation that the referrer or a representative will attend every case review. These will normally take place every six weeks. It is also expected that a member of the referring team known to the patient will visit them periodically to maintain contact.

There must be a guaranteed place for the young person to go to for weekends and at discharge. The adolescent unit fulfils the criteria of the mental Health Act as a hospital place for detained patients.

Criteria for Discharge

1. A discharge planning meeting will take place prior to discharge whenever possible. (In cases of early discharge the meeting will be arranged as soon after discharge as possible.)

2. A planned date will be given for discharge – discharge will not be delayed because of poor resources in a community team.

3. Members of the community team will spend some time with the young person prior to discharge.

4. Before they leave the unit an outpatient appointment time will be given to the young person to be seen after discharge.

5. In exceptional circumstances discharge may be brought forwards to free up an emergency bed. Under these circumstances the family and the community team will be informed that rapid discharge may be required and there is an expectation that the outpatient team will be ready to give an early appointment.

6. Summary discharge may take place when a young person has been involved in unacceptable behaviours and the degree of their illness does not require continued admission. (Eg substance misuse, repeated absconding, aggression etc). The community team will be informed immediately. In less serious circumstances a period of time away from the unit may be recommended.

7. If a young person who is not detainable decides to discharge him or herself or the parent of a young person decides to take them home the community team will be informed immediately. Every effort will be taken to encourage them to stay or to offer a period of pass time that is negotiated with the family and community team.

8. If a young person reaches their 18th birthday in the unit the referring CAMHS team is responsible for arranging follow-up with local adult services in consultation with the adolescent unit. These arrangements should be completed at least six weeks prior to the expected discharge date. If discharge is unlikely to happen then transfer arrangements should be made so that the adult team can attend a transfer planning meeting which will takes place six weeks prior to transfer if possible. Transfer either to inpatient or outpatient services will be made at a time that is least disruptive to the patient's wellbeing

APPENDIX 2

West of Scotland Adolescent In-patient Resource Centre Site Option Benefits Appraisal

Introduction:

The West of Scotland Adolescent Commissioning Group agreed a site option benefits appraisal be carried out and each commissioning Group member was asked to nominate a representative on their behalf to take part. Nominations were also sought from the GGPCT Adolescent Directorate, finance advise, estates advise, and local mental health site management. (see attached paper A)

The format for the day was circulated in advance and followed a workshop format.

Model of Care

The Workshop attendees were asked to consider the model of care adopted by the West of Scotland Chief Executives/Directors of Public Health Group. A summary of the work previously considered by various West of Scotland Group's was also circulated (see attached paper B). The Workshop agreed that the model of care to be adopted as outlined below:

Community Service	**In-patient Resource Centre Service**
No change to existing service	Single in-patient service for the West of Scotland and development of day programme

Presentation on the proposed short list and generic design of the proposed Adolescent In-patient Resource Centre.

The long list of options were circulated with the criteria/constraints used in identifying proposed sites for short listing. The Workshop discussed proposed short listed sites from the 19 long list of sites identified. The shortlist of sites was agreed. The criteria by which a single combined in-patient resource centre service for the West of Scotland on the site of the Royal Hospital for Sick Children was discounted was confirmed as due to the lack the sufficient acreage. Sites in the Central belt and Dumfries area were initially identified for short listing. As a specific site had not been identified and brought forward for consideration they were also discounted.

Shortlist agreed by the Workshop on the day:

Do nothing (included as a comparative)
Do minimum – add on to the existing building
Single combined in-patient resource centre service for the West of Scotland – Gartnavel Royal
Single combined in-patient resource centre service for the West of Scotland - Stobhill

Criteria for Consideration of Adolescent Psychiatry In-patient Resource Centre Site

Criteria by which the workshop was to score each of the site options short-listed were circulated prior to the event. Following discussion on whether these covered the necessary areas the criteria were adapted and agreed by the Workshop. (see Paper C attached).

Ranking and Weighting of the Criteria

The Workshop having agreed the criteria by which to judge the short listed options were then asked to discuss and agree, with other West of Scotland representatives, ranking the criteria and subsequently to agree for each of them a weighting out of 100.

The ranking and weightings that were agreed were:

	Ranking	
Rank	*Benefit Criteria*	Weight
1	Clinical effectiveness & quality	100
2	Suitability of Building	90
3	Availability - time, and technical complexity	70
4	Accessibility	70
5	Flexibility for change & growth	55
6	Local Com'ty Env'nt/Location/Amenity	45
7	Access to Support	30
		460

Site Visits

It was planned, if there was time for the Workshop representatives, to visit at least two of the sites short-listed. The constraints of time and discussion and agreement of the model of care, short listing of sites, amending and agreeing the criteria and ranking and weighting the criteria the proposed site visits were not possible. Aerial photographs of the short-listed sites were circulated and presented to provide information of the sites involved.

Scoring of the Site Options

In discussion with the all the representatives a score out of 10 for each short-listed site for each of the weighted criteria was sought. The process involved agreeing a consensus score and also took account of and recorded any more optimistic and more pessimistic views.(Full scoring is listed at Paper D).

The benefit criteria weighting (see paper D) were scaled to 100 and each of the individual scores multiplied by their individual score to produce weighted benefit scores.

The results of the scoring exercise were shared with all those present at the Workshop and were as follows:

	Option	Weighted Benefits Score Consensus
Do Nothing	1	430
Do Minimum	2	536
Gartnavel Royal	3	710
Stobhill Hospital	4	762

The site offering the most benefits was identified as option 4 – Stobhill Hospital. The Stobhill site offers 77% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (65%) than the Do nothing Option.

Sensitivity of the Results

In order to ensure that the consensus view and results was sensitive to both optimistic views and pessimistic views from within the workshop a pessimistic and optimistic view was also recorded for each of the criteria for each of the site options. The results of these views are set out below:

		Weighted Benefits Score	
	Option	Optimistic	Pessimistic
Do Nothing	1	577	277
Do Minimum	2	680	359
Gartnavel Royal	3	793	673
Stobhill Hospital	4	825	695

The ranking of the proposed sites remained the same as the consensus view, with both the Stobhill and Gartnavel Royal sites scoring significant benefit advantages over the Do Nothing option.

Again the site offering the most benefits was identified as option 4 – Stobhill Hospital. The most optimistic view of the Do Nothing option still foresees Stobhill site offering 43% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (37%) than the Do nothing Option.

The most pessimistic view of the Do Nothing option still foresees Stobhill site offering 150% more benefits than the Do Nothing Option. The second highest scoring option, Gartnavel Royal site, also offers significantly more benefits (142%) than the Do nothing Option.

Taking account of the different views expressed on the day the ranking of the options remained consistent and therefore the consensus view can be accepted as sensitive and legitimate.

These scores are all represented in graphical form (see Paper E)

The Site Benefits Option Appraisal will be put forward to form an element of the full option appraisal process to be carried out as part of the Business Care process.

Paper A

Workshop Nominations

West of Scotland Health Boards:

Elaine Corcoran, Renfrewshire PCT
Jamie Redfern, Yorkhill NHS Trust
Lynn Cuddiley – representing Jennifer Milligan, - Dumfries & Galloway HB
Joe McGhee, Forth Valley HB
Stuart Telfer, Ayrshire & Arran HB *(was unable to attend on the day)*
Kathryn Thomson – representing Stephen MacLeod, GGHB
Charles Clark, Lanarkshire HB
Clare Sinclair Lanarkshire HB
Louise Wiesar, Lanarkshire HB

Adolescent Directorate:

Heather Gardiner, GGPCT – Adolescent Directorate
Anne Marie Discombe, GGPCT - Adolescent Directorate
Sarah McGuffog, GGPCT - Adolescent Directorate
John Marshall, GGPCT - Adolescent Directorate
Julie Metcalfe, GGPCT - Adolescent Directorate
Mary Hattie, GGPCT - Adolescent Directorate

Estates/Finance/Support Service/Mental Health Services

Anthony Curran, GGPCT – Strategic Estates
Donald Thomson, GGPCT - Finance
David Pace, GGPCT – Support Services
Clive Travers, GGPCT – Sector General Manager (inc.MH services on Gartnavel Royal site)
Calum MacLeod, GGPCT - Sector General Manager (inc.MH services on Stobhill Hospital site)

Facilitator

David Harley, GGPCT –General Manager Clinical Directorates

Paper B

Site Option Appraisal

West of Scotland Adolescent In-patient Resource Centre 30th January 2004

Model of Care & Evaluation of Service Model Options

The care needs of adolescents are highly individualistic in nature. The West of Scotland Chief Executives/Directors of Public Health Group considered what the most appropriate model of care and service response should be adopted for the West of Scotland. In considering a model of care and model of service an assessment of what was needed took account of the following:

- The professionals view,
- Historic clinical activity
- Estimation of bed requirement
- Routinely collected data
- Benchmarks
- Demand
- Literature review
- The Multi-Centre Study (1986 – 1989)
- Contemporary views
- The Young Minds study
- The Nicaps study
- Visits to UK units to five adolescent units in Scotland and England

Core service expectations included a Tier 4 specialist mental health service aiming to meet the needs of severely disturbed young people would be expected to provide 24 hour psychiatric care delivered by skilled psychiatrists and mental health nurses. To assist in the tasks of assessment, diagnosis and treatment would be a multi-disciplinary team appropriately skilled and proficient in delivering evidence-based therapies.

Such a service would be available 7 days a week, all year round, catering for adolescents aged 12 through 17 years inclusive, with the Unit capable of responding promptly to emergency and urgent admission requests. Young people suffering from severe mental health disorders that seriously compromise their mental health and development, sometimes entailing risk to self and/or others, require the combination of clinical skills and environmental support and containment that only an inpatient setting can offer.

The assessment of what was needed also considered that the future re-provision be developed in keeping with the forward-looking vision, outlined in the HAS Together We Stand Document (1995). That proposed a Tier 4 unit function as a “mental health resource centre”. This proposed a unit not as a rigid structure but an environment offering interlinked assessment and treatment processes with more “fluidity” at the IP / DP interface and similarly at the DP / OP boundary.

The Resource Centre model is to operate at the centre of a Managed Care Network (MCN) being the only Tier 4 resource offering inpatient care across the West of Scotland Health Board areas. Critical to the success of the Centre will be the presence and professional support of colleague psychiatrists and other mental health colleagues working throughout the West of Scotland.

Such an approach was adopted to deliver a multi-disciplinary process that organises and integrates healthcare inputs and the process drives up the quality through reducing variations in clinical practice, supporting complex, multi-professional service delivery and reflecting evidence-based practice.

The West of Scotland Chief Executives/Directors of Public Health Group concluded the proposed model for the commissioning of a new Adolescent Mental Health Resource Centre, to provide inpatient and day patient care was required.

Agreement was also reached by WoS Health Boards around commissioning the long term solution, the development of the Adolescent Resource Centre with an increase in bed numbers from 16 to 24 and an expanded day programme. In parallel with this development at Tier 4, work was to be undertaken to examine local Tier 3 services in order to ensure that these were sufficiently resourced in order to support the new model of services. This was in order to ensure adequate future provision that would support a two-way reciprocal relationship with the In-patient Resource Centre.

The proposed model of care recognised a strategic approach to commissioning and delivering a comprehensive adolescent mental health service using a tiered model. The different tiers of service are summarised:

	Service Level	**Service Location**	**Brief Description of Service Activity**
Tier 1	Assessment and treatment/onward referral	Community Home based Community	Social workers, Voluntary workers, Teachers, GPs, Health Visitors – iv. Mild/moderate problems v. Health Education vi. Support
Tier 2	Specialist assessment and treatment	Community – iii. Home based iv. Community	Single professional approach from a range of professionals/organisations and Direct access liaison service - more moderate problems
Tier 3	Specialist Team assessment and treatment	Community – iii. Home based iv. Community	Specialist Assessment of referrals from GP's and other care providers, treatment and advice by multidisciplinary/multi-agency team, family therapy and psychotherapy
Tier 4	Highly Specialist services for young people with very complex and/refractory disorders and inpatient mental health service	Hospital based adolescent in-patient Centre Care	Short and longer term stays full range of service provision available via multi-disciplinary/multi-agency team, in-patient psychiatric care and treatment and liaison

The provision of an effective service for adolescents demands that a comprehensive approach is adopted to ensure a balanced provision of care packages across all the service levels identified above. A balanced provision will ensure that patients are able to flow through each service element and across the interface between the service elements to the care package which is most appropriate to their needs. The model of care selected had to be able to deliver this balance of provision to ensure that the level of care provided at each element is adequate to meet the identified level of need.

On this basis, it follows that the alternative models of care possible are to a large extent variations on a single theme. These are described below:

Options for preferred model of care

The alternative models of care possible are described below. Each option goes some way towards filling the gap(s) in service provision identified.

Options	Community Service	In-patient Resource Centre Service
1.	No change to existing service	No change to existing service
2.	No change to existing service	Release interim ward provision and develop day programme only
3.	Enhanced development of existing health Tier 1 – 3 services (Primary Care and Community Adolescent Mental Health Teams to take account of no in-patient and no day programme	Release interim ward provision for 16 beds with therapeutic day activities
4.	No change to existing service	Single in-patient service for the West of Scotland with a range of therapeutic day activities.
5.	No change to existing service	Return to separate in-patient with a range of therapeutic day activities in each West of Scotland Health Board area
6	No change to existing service	Single in-patient service for the West of Scotland with a range of therapeutic day activities.

Assessment of Models of Care

In addition to the consideration given to the appropriate model of care by the West of Scotland Chief Executives/Directors of Public Health Group a professional forum event was organized that considered service requirements and produced Workshop responses in the following areas:

- What is the role and function of the unit?
- How many beds/day programmes/day places should the unit have?
- Should there be provision to maintain emergency beds, and what should be the criteria for accessing these?
- Should the unit be subdivided by age range, diagnostic group or some other criteria?
- Should there be criteria for moving from in-patient to day-patient status and vice versa?

- What sort of day provision should the unit provide?
- What additional support is needed to make this accessible to young people from distant parts?
- What support does the tier 4 unit require from each tier 3 service to enable the unit to function effectively?
- What level of service do tier 3 local services need from the tier 4 unit?

Using the report on needs assessment submitted to the West of Scotland Chief Executives/Directors of Public Health Group and the Professional Forum Event -Workshop Responses a summary comparison of derived alternative models and selection criteria with the adopted model of care is listed.

	Selection Criteria	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**	**Option 6**
1.	Assessment/Treatment of young people who can't remain at home	Limited	No	No	Yes	Yes	Yes
2.	Responsive to emergencies	Limited	No	No	Yes	Yes	Yes
3.	Day programmes should directly link and co-ordinate with In-patient unit resources.	Yes	No	No	No	Yes	Yes
4.	Gap between IP and OP needs resourced	Yes	Yes	Yes	No	Yes	Yes
5.	Best use made of available adolescent psychiatry skills	Yes	No	No	No	Yes	Yes
6.	More elective admissions reducing bed blockage	No	No	No	Yes	Yes	Yes
7.	Rapid access/rapid response for consultation, assessment of complex cases/ provision of second opinions.	Limited	No	Yes	Yes	Yes	Yes
8.	Scope for flow of patients through levels of care maximised	Limited	No	No	No	Yes	Yes
9.	Affordability	Yes	Yes	Yes	Yes	No	Yes

The preferred model of care for adoption is Option 6. This meets the derived criteria and so provides the solution which offers the potential for achieving the desired balance of care provision for adolescents.

This was the option adopted by the West of Scotland Chief Executives/Directors of Public Health Group.

Paper C

Workshop Agreed Criteria

1.	Accessibility Service requires to be accessible to main centres of population (Glasgow, Paisley, Stirling, Hamilton, Motherwell, Dumfries, Ayr/Kilmarnock) by Public or Private transport and for staff.
2.	Clinical Effectiveness and Quality • The optimum size of a generic unit will provide care in small sub-groupings of beds. • Positive well being of patients • Less self harm & harm to others • Ability to achieve clinical standards • Shorter lengths of stay in hospital and longer in the community • Improved stability in the patient environment • Multi-disciplinary team approach • Good staff/patient relationships
3.	Suitability of Building The physical environment is an important quality issue for patients. Ideally, it should make a positive contribution to the healing process. The proposed development should deliver significant benefits in terms of: • The visual and aural environment (both within and outside of the buildings) and the thermal environment (within the buildings). • Space for therapies • Space for Education • Ground floor access • Space for recreational activities
4.	Access to Support Co-location with acute psychiatric services providing immediate access to additional medical, nursing and other clinical staff, in addition alternative accommodation. Co-located with acute physical diagnostic services. Access to academic and teaching department's.
5.	Availability – time, and technical complexity The service is a priority for development and therefore options that deliver the service quickly will offer significant benefits. Options should be examined in terms of the availability of the site/buildings, the degree to which technical problems and complexities have to be overcome and the likely differences in timescales required to complete the facility.
6.	Flexibility for Growth and Change Needs of services change over time. Options should be examined in terms of the degree to which they can deliver benefits such as: • The ability of the site/building to accommodate limited expansion • The flexibility and ease with which the buildings can be changed to meet service needs • The potential for alternative uses for the building/site in the future
7.	Local CommuntiyEnvironment/Location/Amenity Access and quality of local rehab/community amenities inc. local shops, and social facilities.

Paper D

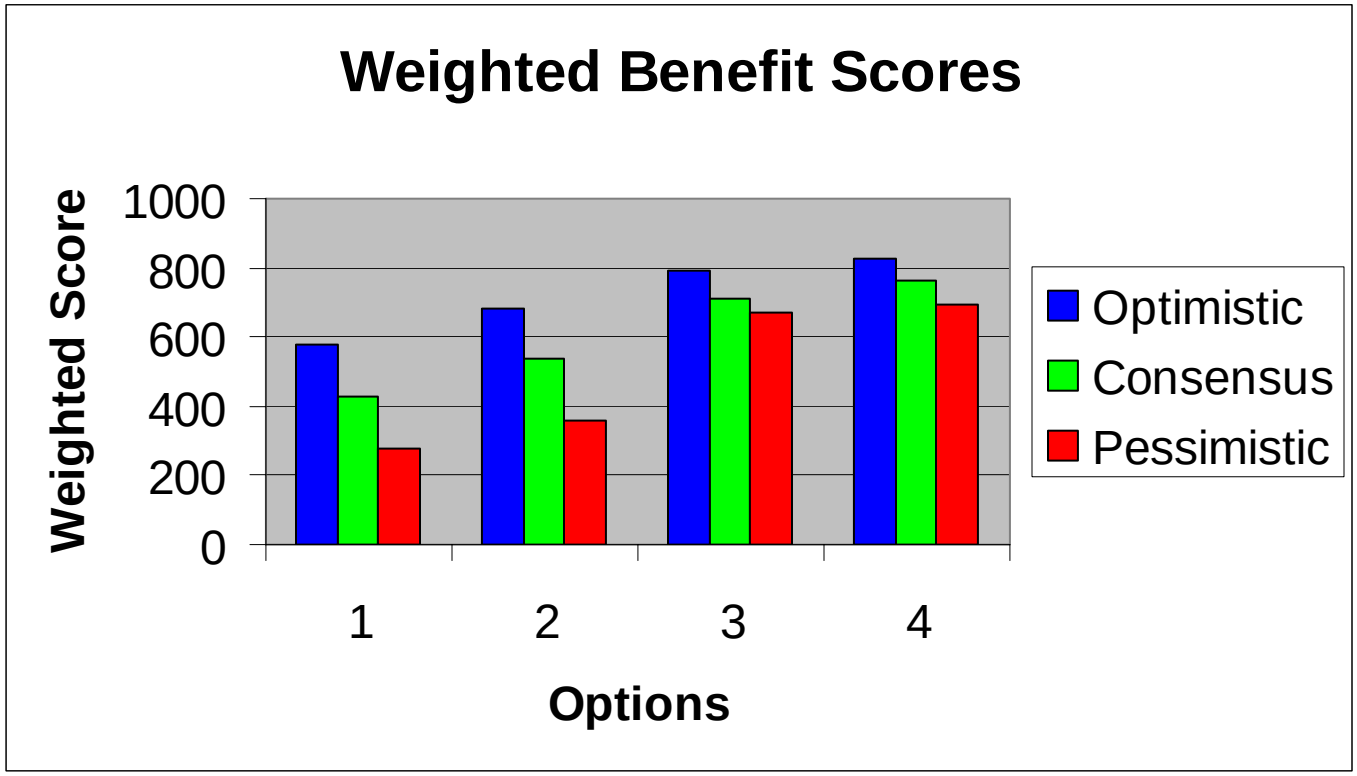
Workshop scores out of 10 for each option for each benefit criteria and the scaled weightings. Each score was multiplied by the scaled weighting.

Scoring of Options	Option 1 Do nothing			Option 2 Do minimum			Option 3 Gartnavel Royal			Option 4 Stobhill		
Benefit Criteria	Consensus	optimistic	pessimistic	consensus	optimistic	pessimistic	Consensus	optimistic	pessimistic	consensus	optimistic	pessimistic
Clinical effectiveness & quality	2	5	2	5	7	3	9	10	9	9	10	9
Suitability of Building	1	3	0	5	7	3	9	9	9	9	9	9
Availability - time, and technical complexity	6	6	4	5	6	2	5	5	3	8	8	6
Accessibility	9	9	5	8	9	6	7	9	7	6	7	5
Flexibility for change & growth	1	4	1	2	3	1	4	5	4	8	8	7
Local Com'ty Env'nt/Location/Amenity	9	9	6	7	9	7	7	9	7	5	7	4
Access to Support	6	7	4	6	6	5	6	6	5	5	6	5
	34	43	22	38	47	27	47	53	44	50	55	45

weighted scores		
	wtd	scaled wt
Clinical effectiveness & quality	100	21.73913043
Suitability of Building	90	19.56521739
Availability - time, and technical complexity	70	15.2173913
Accessibility	70	15.2173913
Flexibility for change & growth	55	11.95652174
Local Com'ty Env'nt/Location/Amenity	45	9.782608696
Access to Support	30	6.52173913
	460	100

Paper D

	Weighted Benefits Score		
Option	Optimistic	Consensus	Pessimistic
1	577	430	277
2	680	536	359
3	793	710	673
4	825	762	695

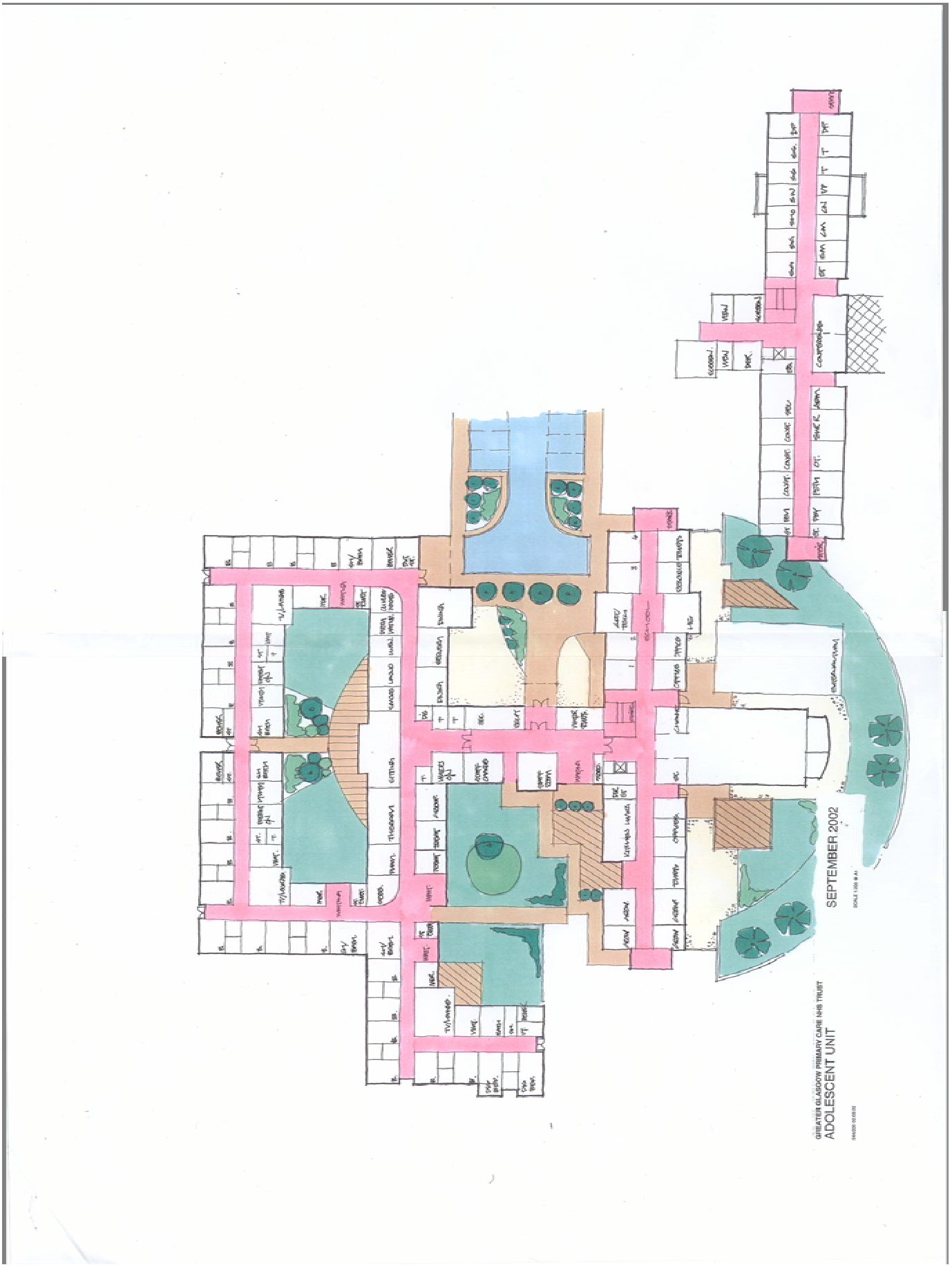


LONG LIST OF OPTIONS

Option		Criteria by which Option was Discounted
1.	Do nothing (included as a comparative)	*
2.	Do minimum – develop existing building	*
3.	Separate in-patient services in each of the Health Board Areas specific to the West of Scotland	1
4.	Single combined in-patient resource centre service for the West of Scotland – Stobhill	*
5.	Single combined in-patient resource centre service for the West of Scotland – Ruchill	3/5/8/11
6.	Single combined in-patient resource centre service for the West of Scotland – Southern General Hospital	4
7.	Single combined in-patient resource centre service for the West of Scotland – Central Belt **	*
8.	Single combined in-patient resource centre service for the West of Scotland – Dumfries **	*
9.	Single combined in-patient resource centre service for the West of Scotland – Royal Hospital for Sick Children	4/9
10.	Single combined in-patient resource centre service for the West of Scotland – Victoria Infirmary	2/4
11.	Single combined in-patient resource centre service for the West of Scotland – Woodilee	2/3/10/12
12.	Single combined in-patient resource centre service for the West of Scotland - Lennox Castle	2/3/10/12
13.	Single combined in-patient resource centre service for the West of Scotland - Gartnavel Royal	*
14.	Single combined in-patient resource centre service for the West of Scotland – Leverndale	3/8/12
15.	Single combined in-patient resource centre service for the West of Scotland – Cowglen	2/3
16.	Single combined in-patient resource centre service for the West of Scotland – Belvidere	2/3/10/12
17.	Single combined in-patient resource centre service for the West of Scotland - Canniesburn	2/9/4/3/12
18.	Single combined in-patient resource centre service for the West of Scotland - Broomhill and Lanfine	2/4/10
19.	Private site	2/3

* = shortlisted

The Do Nothing option was short listed to provide a baseline comparator. The Do Minimum option was also short listed to consider responding on the basis of a minimal approach.
**The Dumfries and Central Belt options have been short listed for the present, although no site has to date come forward as an option for consideration and they may be discounted on the day of the workshop.


GREATER GLASGOW PRIMARY CARE NHS TRUST
ADOLESCENT UNIT
SEPTEMBER 2002

CRITERIA/CONSTRAINTS USED IN SHORT LISTING SITES

1. NHS and Health Board Policy on Adolescents would not be met.
2. Service integration with acute mental health.
3. Service integration with physical diagnostic services.
4. Sufficient acreage.
5. Site suitability - ie, gradients.
6. Site available within reasonable timescale.
7. Retention of existing buildings.
8. Availability of land for newbuild.
9. Site available for continued NHS use.
10. Site subject to agreed closure and/or disposal.
11. Site remote and difficult to access.
12. Known estate/site strategy.

APPENDIX 3

Table 1 Projected population by council and health board area (persons)

Area	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Area
	100.00%	99.88%	99.75%	99.63%	99.52%	99.40%	99.28%	99.16%	99.04%	98.91%	98.79%	98.67%	98.55%	98.42%	98.29%	98.16%	98.03%	
SCOTLAND	5114600	5108670	5101713	5095694	5089837	5083861	5077784	5071608	5065351	5059066	5052798	5046519	5040210	5033810	5027316	5020680	5013831	SCOTLAND
Health board areas																		Health board are
Argyll & Clyde	423500	421817	420163	418568	416958	415356	413727	412104	410453	408792	407130	405468	403782	402104	400420	398711	396963	Argyll & Clyde
Ayrshire & Arran	373400	372261	371056	369950	368845	367698	366527	365326	364114	362885	361633	360368	359087	357787	356457	355098	353720	Ayrshire & Arrar
Borders	106900	107038	107095	107105	107096	107069	107019	106947	106862	106770	106659	106544	106410	106267	106126	105968	105806	Borders
Dumfries & Galloway	145800	144973	144278	143768	143239	142682	142097	141483	140845	140191	139520	138837	138143	137431	136702	135971	135214	Dumfries & Gallo
Fife	350400	350847	350954	350853	350760	350643	350508	350351	350174	349985	349800	349600	349385	349161	348930	348683	348415	Fife
Forth Valley	278000	278629	279156	279709	280260	280793	281318	281826	282327	282837	283333	283831	284340	284856	285359	285872	286376	Forth Valley
Grampian	523400	521429	519688	518342	516945	515456	513901	512276	510585	508845	507091	505282	503445	501570	499659	497712	495746	Grampian
Greater Glasgow	904400	902377	900156	898121	896337	894747	893334	892076	890997	890043	889223	888520	887921	887368	886908	886485	886086	Greater Glasgow
Highland	208600	208610	208480	208275	208037	207744	207407	207035	206633	206188	205732	205250	204755	204228	203678	203092	202490	Highland
Lanarkshire	562000	561900	561666	561540	561386	561190	560941	560640	560274	559879	559421	558939	558407	557834	557215	556551	555836	Lanarkshire
Lothian	783600	787343	790484	793327	796281	799280	802350	805476	808642	811865	815132	818455	821835	825242	828662	832115	835588	Lothian
Orkney	19480	19391	19290	19186	19083	18972	18855	18727	18598	18475	18348	18210	18075	17940	17790	17644	17480	Orkney
Shetland	22440	22188	22068	22037	22001	21969	21938	21904	21876	21840	21810	21771	21739	21704	21671	21637	21600	Shetland
Tayside	385500	383021	380651	378647	376607	374529	372406	370255	368070	365866	363650	361423	359167	356909	354643	352363	350065	Tayside
Western Isles	27180	26846	26528	26266	26002	25733	25456	25182	24901	24605	24316	24021	23719	23409	23096	22778	22446	Western Isles
	100.00%	99.81%	99.60%	99.43%	99.25%	99.08%	98.91%	98.75%	98.58%	98.42%	98.26%	98.10%	97.94%	97.78%	97.62%	97.45%	97.29%	
	2687100	2681957	2676475	2671656	2667025	2662466	2657944	2653455	2649010	2644627	2640260	2635963	2631680	2627380	2623061	2618688	2614195	

Table 4 Projected births by council and health board area (persons)

Area	2000 -2001	2001 -2002	2002 -2003	2003 -2004	2004 -2005	2005 -2006	2006 -2007	2007 -2008	2008 -2009	2009 -2010	2010 -2011	2011 -2012	2012 -2013	2013 -2014	2014 -2015	2015 -2016	Area
SCOTLAND	52721	52058	52087	51887	51462	51100	50791	50558	50426	50369	50344	50330	50324	50326	50320	50274	SCOTLAND
Health board areas																	Health board areas
Argyll & Clyde	4334	4254	4236	4191	4137	4085	4048	4005	3981	3967	3954	3938	3938	3926	3921	3904	Argyll & Clyde
Ayrshire & Arran	3659	3593	3576	3552	3501	3460	3427	3399	3381	3357	3343	3337	3318	3309	3299	3280	Ayrshire & Arran
Borders	1006	983	978	960	946	926	904	889	882	869	864	857	856	857	852	853	Borders
Dumfries & Galloway	1370	1333	1316	1298	1272	1251	1231	1213	1202	1191	1185	1181	1175	1168	1168	1160	Dumfries & Gallow
Fife	3484	3446	3447	3439	3408	3385	3365	3352	3347	3343	3347	3346	3350	3354	3356	3351	Fife
Forth Valley	2875	2845	2856	2851	2836	2822	2809	2809	2817	2829	2834	2842	2855	2867	2875	2891	Forth Valley
Grampian	5422	5307	5264	5215	5142	5075	5014	4966	4933	4906	4896	4892	4880	4871	4866	4856	Grampian
Greater Glasgow	9539	9492	9563	9584	9573	9573	9580	9612	9629	9663	9695	9714	9737	9743	9749	9736	Greater Glasgow
Highland	2161	2119	2104	2076	2040	2003	1976	1951	1931	1918	1909	1902	1895	1892	1883	1876	Highland
Lanarkshire	6104	6037	6036	6015	5959	5914	5861	5821	5795	5767	5750	5734	5718	5709	5691	5683	Lanarkshire
Lothian	8276	8277	8379	8437	8454	8487	8521	8548	8589	8647	8692	8743	8783	8826	8876	8922	Lothian
Orkney	178	171	172	167	168	165	156	159	155	151	148	147	145	144	142	137	Orkney
Shetland	253	246	241	240	235	237	236	237	234	241	241	238	241	241	242	243	Shetland
Tayside	3820	3722	3694	3640	3578	3510	3462	3404	3367	3339	3311	3292	3271	3263	3252	3241	Tayside
Western Isles	240	233	225	222	213	207	201	193	183	181	175	167	162	156	148	141	Western Isles
	100.00%	98.83%	98.93%	98.60%	97.84%	97.22%	96.68%	96.33%	96.14%	96.03%	95.98%	95.93%	95.91%	95.84%	95.77%	95.60%	
	27881	27554	27583	27491	27278	27105	26956	26859	26805	26774	26761	26746	26741	26722	26703	26654	

Table 3 Projected percentage changes in population from base year, by broad age group; council and health board areas

(percentages)

Area	All ages			0-4			5-14			15-29			30-44			45-59			60-74			75 & over			Area
	2006	2011	2016	2006	2011	2016	2006	2011	2016	2006	2011	2016	2006	2011	2016	2006	2011	2016	2006	2011	2016	2006	2011	2016	
SCOTLAND	-0.7	-1.3	-2.0	-10.9	-13.0	-13.3	-8.3	-17.3	-22.1	-1.2	-0.3	-4.2	-5.7	-15.4	-22.2	9.8	15.5	20.6	2.0	11.7	18.3	5.9	11.3	18.0	SCOTLAND
Health board areas																									Health board areas
Argyll & Clyde	-2.3	-4.3	-6.3	-13.0	-16.9	-18.2	-10.3	-20.2	-26.5	-1.5	-1.6	-7.1	-9.3	-21.5	-29.2	8.6	13.0	15.9	1.8	10.2	14.4	4.3	9.7	17.1	Argyll & Clyde
Ayrshire & Arran	-1.8	-3.5	-5.3	-12.1	-15.9	-17.6	-10.9	-21.0	-26.6	-2.2	-2.3	-8.5	-8.0	-19.7	-26.7	6.4	8.9	10.4	4.4	14.4	19.8	6.9	13.6	22.0	Ayrshire & Arran
Borders	0.1	-0.3	-1.0	-14.0	-20.6	-23.0	-4.0	-13.6	-21.7	-4.7	-0.5	-1.8	-7.5	-22.0	-32.7	9.7	13.6	17.3	6.7	21.5	30.5	7.2	12.4	21.0	Borders
Dumfries & Galloway	-2.5	-4.8	-7.3	-15.3	-21.1	-23.2	-10.6	-22.7	-29.8	-4.0	-2.2	-9.0	-12.5	-28.4	-37.6	4.6	6.3	5.4	5.2	15.1	20.3	12.7	20.6	30.7	Dumfries & Galloway
Fife	0.0	-0.2	-0.6	-10.5	-12.4	-12.4	-9.4	-18.1	-22.5	0.9	1.9	-2.7	-6.8	-16.9	-23.3	9.7	13.6	17.9	6.2	20.3	28.8	6.9	12.6	20.2	Fife
Forth Valley	1.2	2.1	3.0	-9.7	-10.3	-8.8	-3.5	-10.9	-14.7	0.8	4.2	3.2	-3.8	-12.5	-17.8	8.4	14.0	20.8	6.0	18.1	23.5	7.5	15.6	26.0	Forth Valley
Grampian	-1.8	-3.5	-5.3	-12.9	-17.2	-18.4	-9.7	-20.5	-27.0	-2.3	-1.1	-5.7	-11.0	-23.9	-32.7	10.7	12.9	13.5	3.9	18.3	29.1	10.1	18.1	26.2	Grampian
Greater Glasgow	-1.2	-1.8	-2.0	-9.6	-8.8	-7.8	-10.2	-19.9	-22.6	0.1	0.3	-4.4	-2.9	-10.1	-15.4	13.2	25.1	35.0	-5.8	-3.3	1.6	-2.4	-1.9	-1.1	Greater Glasgow
Highland	-0.6	-1.6	-2.9	-13.4	-18.8	-20.7	-7.4	-17.2	-24.2	-2.7	-2.9	-8.1	-9.6	-22.0	-29.8	8.1	10.5	10.6	8.2	23.2	32.8	12.1	21.8	34.4	Highland
Lanarkshire	-0.2	-0.5	-1.1	-10.2	-13.0	-14.3	-5.6	-13.3	-18.3	-3.3	-3.7	-7.2	-4.7	-13.7	-21.1	9.8	17.2	23.6	3.5	11.8	18.1	11.4	21.8	32.9	Lanarkshire
Lothian	2.4	4.4	6.6	-6.7	-4.4	-1.8	-4.7	-10.9	-12.1	1.2	3.8	3.4	1.7	-2.9	-7.5	12.3	21.3	33.1	1.1	12.4	20.4	5.2	9.0	13.8	Lothian
Orkney	-3.2	-6.5	-10.3	-17.9	-25.5	-30.6	-16.3	-29.3	-37.8	-5.9	-9.6	-20.9	-9.9	-25.6	-36.1	5.0	7.7	6.9	9.7	22.4	29.2	7.4	14.0	25.8	Orkney
Shetland	-2.2	-3.0	-3.7	-9.7	-10.4	-9.2	-12.5	-23.0	-25.3	1.1	4.6	1.2	-10.2	-20.1	-27.7	3.4	4.3	5.0	13.3	31.5	41.5	3.1	6.9	16.3	Shetland
Tayside	-3.4	-6.2	-9.2	-14.7	-20.6	-23.2	-9.5	-20.1	-27.9	-4.5	-4.0	-9.4	-10.9	-25.5	-34.7	6.6	7.5	7.8	-0.1	8.8	13.2	6.1	10.3	15.0	Tayside
Western Isles	-6.3	-11.6	-17.4	-18.6	-30.3	-41.5	-16.7	-27.2	-37.4	-14.4	-25.4	-35.7	-10.0	-25.4	-41.3	2.0	0.7	-0.2	4.7	15.4	18.9	-0.4	1.7	9.2	Western Isles

This booklet summarises the Registrar General for Scotland's mid-2000 based population projections for the council and health board areas of Scotland. The projections have been controlled to the mid-2000 based national population projections for Scotland prepared by the Government Actuary's Department (GAD) in consultation with, and at the request of, the Registrar General. A reference volume about the projections for the four countries of the United Kingdom will be published later in 2002 (ONS Series PP2 no 23). This volume will contain details of the methodology and underlying assumptions used in producing the national projections.

Table 2 Projected population, by sex and broad age group; council and health board areas															
Age			2000			2006				2011				2016	
group		Persons	Males	Females		Persons	Males	Females		Persons	Males	Females	Persons	Males	Females
									Argyll & Clyde						
All Ages		423.5	205.4	218.1		413.727	201.448	212.279		405.468	197.926	207.542	396.963	194.05	202.913
0-4		23.97	12.312	11.658		20.855	10.711	10.144		19.925	10.234	9.691	19.6	10.07	9.53
5-14		54.952	28.365	26.587		49.307	25.37	23.937		43.836	22.702	21.134	40.414	20.907	19.507
15-29		76.997	40.028	36.969		75.869	39.72	36.149		75.764	39.572	36.192	71.528	37.605	33.923
30-44		98.039	48.17	49.869		88.898	43.92	44.978		76.984	38.385	38.599	69.452	35.028	34.424
45-59		80.62	39.462	41.158		87.548	42.578	44.97		91.137	44.263	46.874	93.437	45.093	48.344
60-74		60.19	27.121	33.069		61.269	28.24	33.029		66.302	30.858	35.444	68.884	32.269	36.615
75 & over		28.732	9.942	18.79		29.981	10.909	19.072		31.52	11.912	19.608	33.648	13.078	20.57
									Ayrshire & Arran						
All Ages		373.4	179.86	193.54		366.527	177.614	188.913		360.368	175.314	185.054	353.72	172.51	181.21
0-4		20.302	10.415	9.887		17.838	9.179	8.659		17.083	8.797	8.286	16.726	8.615	8.111
5-14		48.464	24.733	23.731		43.167	22.141	21.026		38.284	19.75	18.534	35.561	18.355	17.206
15-29		66.786	34.261	32.525		65.33	33.745	31.585		65.266	33.782	31.484	61.104	31.891	29.213
30-44		82.454	40.131	42.323		75.836	37.208	38.628		66.171	32.832	33.339	60.45	30.467	29.983
45-59		73.171	35.571	37.6		77.832	37.717	40.115		79.718	38.555	41.163	80.807	38.984	41.823
60-74		54.927	25.132	29.795		57.337	26.724	30.613		62.829	29.427	33.402	65.781	30.755	35.026
75 & over		27.296	9.617	17.679		29.187	10.9	18.287		31.017	12.171	18.846	33.291	13.443	19.848
									Forth Valley						
All Ages		278	134.901	143.099		281.318	137.209	144.109		283.831	138.876	144.955	286.376	140.394	145.982
0-4		16.003	8.218	7.785		14.452	7.426	7.026		14.351	7.368	6.983	14.594	7.496	7.098
5-14		35.254	17.992	17.262		34.037	17.457	16.58		31.427	16.338	15.089	30.074	15.631	14.443
15-29		52.603	26.47	26.133		53.037	26.822	26.215		54.808	27.571	27.237	54.271	27.554	26.717
30-44		64.507	32.028	32.479		62.025	30.789	31.236		56.446	28.065	28.381	53.021	26.413	26.608
45-59		53.516	26.17	27.346		58.011	28.43	29.581		60.995	30.051	30.944	64.663	31.796	32.867
60-74		37.855	17.513	20.342		40.127	18.832	21.295		44.702	21.041	23.661	46.746	22.025	24.721
75 & over		18.262	6.51	11.752		19.629	7.453	12.176		21.102	8.442	12.66	23.007	9.479	13.528
									Dumfries & Galloway						
All Ages		145.8	70.785	75.015		142.097	69.224	72.873		138.837	67.764	71.073	135.214	66.038	69.176
0-4		7.702	3.935	3.767		6.523	3.342	3.181		6.078	3.114	2.964	5.912	3.029	2.883
5-14		18.257	9.326	8.931		16.322	8.346	7.976		14.117	7.278	6.839	12.809	6.627	6.182
15-29		22.154	11.373	10.781		21.274	11.053	10.221		21.663	11.348	10.315	20.165	10.616	9.549
30-44		31.067	15.238	15.829		27.171	13.277	13.894		22.236	10.764	11.472	19.371	9.399	9.972
45-59		29.973	14.706	15.267		31.349	15.386	15.963		31.873	15.517	16.356	31.604	15.328	16.276
60-74		24.424	11.586	12.838		25.682	12.301	13.381		28.123	13.592	14.531	29.376	14.151	15.225
75 & over		12.223	4.621	7.602		13.776	5.519	8.257		14.747	6.151	8.596	15.977	6.888	9.089

Table 2 cont/

Table 2 (Continued) Projected population, by sex and broad age group; council and health board areas

Age group	2000 Persons	2000 Males	2000 Females	2006 Persons	2006 Males	2006 Females	2011 Persons	2011 Males	2011 Females	2016 Persons	2016 Males	2016 Females
						Greater Glasgow						
All Ages	904.4	434.131	470.269	893.334	430.575	462.759	888.52	429.381	459.139	886.086	428.778	457.308
0-4	51.034	26.276	24.758	46.141	23.634	22.507	46.554	23.843	22.711	47.076	24.111	22.965
5-14	112.812	57.585	55.227	101.301	51.985	49.316	90.39	46.4	43.99	87.273	44.698	42.575
15-29	193.65	95.679	97.971	193.931	94.463	99.468	194.273	94.82	99.453	185.128	90.494	94.634
30-44	219.742	109.712	110.03	213.291	107.419	105.872	197.594	98.854	98.74	185.806	91.815	93.991
45-59	149.799	73.145	76.654	169.639	83.096	86.543	187.345	92.083	95.262	202.266	100.118	102.148
60-74	118.24	52.258	65.982	111.351	50.204	61.147	114.374	52.58	61.794	120.082	55.775	64.307
75 & over	59.123	19.476	39.647	57.68	19.774	37.906	57.99	20.801	37.189	58.455	21.767	36.688
						Lanarkshire						
All Ages	562	273.537	288.463	560.941	274.106	286.835	558.939	273.875	285.064	555.836	272.852	282.984
0-4	33.498	17.171	16.327	30.097	15.413	14.684	29.156	14.939	14.217	28.712	14.709	14.003
5-14	73.782	37.885	35.897	69.623	35.708	33.915	63.989	32.733	31.256	60.26	30.839	29.421
15-29	109.975	56.024	53.951	106.358	54.454	51.904	105.876	54.159	51.717	102.02	52.267	49.753
30-44	134.562	67.011	67.551	128.205	64.13	64.075	116.172	58.624	57.548	106.205	53.685	52.52
45-59	104.153	50.665	53.488	114.406	56.045	58.361	122.038	60.047	61.991	128.761	63.832	64.929
60-74	74.577	33.852	40.725	77.213	35.542	41.671	83.406	38.772	44.634	88.084	41.136	46.948
75 & over	31.453	10.929	20.524	35.039	12.814	22.225	38.302	14.601	23.701	41.794	16.384	25.41

		2006	2011	2016
Total	343521			
A&C	54952	-10.9	-21.0	-26.6
A&A	48464	-10.3	-20.2	-26.5
D&G	18257	-10.6	-22.7	-29.8
GG	112812	-10.2	-19.9	-22.6
FV	35254	-3.5	-10.9	-14.7
L'shire	73782	-5.6	-13.3	-18.3

2006	2011	2016	
313714	281993	266380	
8.68%	17.91%	22.46%	drop
48946	43409	40322	
43485	38660	35642	
16322	14117	12809	
101301	90390	87273	
34037	31427	30074	
69623	63989	60260	

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APPENDIX 4a

West of Scotland Adolescent Services Inpatient Ward

Exploration of PPP/PFI : Market Soundings

1. In exploration of PPP/PFI, the market was sounded for possible interest in this project. Telephone contact was made with 3 private sector parties which have active interest in PPP/PFI developments and the background to this project was explained to them, describing its nature, size, scope and timing.

2. The contacts were made with Balfour Beatty Construction, Robertson Projects and Dawn Construction. In each case, they declined interest on the grounds that they were heavily engaged on a number of projects already and the project was not of a scale to engage their interest.

3. This outcome is consistent with a presentation by Paul Brewer of PricewaterhouseCoopers to the Scottish Executive Health Department's PPP/PFI & Capital Network Meeting of 16th May 2001 at which he stated that the market found PPP/PFI less suitable for small schemes of less that £10m due to excessive set up costs.

APPENDIX 4b

WEST OF SCOTLAND ADOLESCENT INPATIENT WARD
FACTORS IN ASSESSING PPP/PFI POTENTIAL

Factor	Yes	No
Strategy		
The service strategy underpinning the project is clear and has been agreed with "internal" stakeholders	√	
The service strategy and any associated change programme is acceptable to the local community	√	
The service is required now	√	
There will be a continuing need for the service	√	
The service could be provided by a private sector partner without detriment to the future operation of the organization	√	
The health body can clearly see benefits in partnership working		√
Content		
The service required is clear and can be defined in specific terms	√	
It can be described and measured in an output specification	√	
The health body seeks a service and not simply an asset		√
The project is of a kind that has previously provided suitable for PPP/PFI		√
The project is of a frequently offered or repetitive nature		√
There is scope for private sector innovation and cost saving		√
Risk		
There is a realistic opportunity to transfer public sector risk		√
The risks to be transferred are of a kind that a private sector partner can accept and manage	√	
There is scope to find alternative uses for any assets remaining at the end of the proposed period of contract	√	
The nature of the opportunity will offer an incentive to the private sector to perform effectively		√
Financial factors		
The project is affordable against revenue projections	√	
Any estimated unitary charge is also affordable		√
The estimated unitary charge offers potential value for money against the public sector comparator		√
Off balance-sheet treatment has been achieved for similar projects	√	
Timescales and term		
The contract proposed has a forecast term suited to the service and to whole lift costing	√	
The target date for service start can be met by a PPP/PFI procurement timetable		√
Marketability		
Projects like the one proposed have already attracted PPP/PFI market interest		√
The project is likely to offer a commercial return to the private sector		√
The income stream supporting the project is well covenanted	√	
The market is likely to be receptive to the opportunity		√
There are sufficient players in the market to offer effective competition		√
The project could be linked with another opportunity to enhance marketability		√
Project management arrangements		
The health body has defined its project management team	√	
The health body has identified sufficient financial resources to support the project	√	
The health body has agreed arrangements for involving all appropriate stakeholders during the procurement process	√	

West of Scotland Adolescent Mental Health Services Consortium **APPENDIX 5**

		Projected costs 04/05 16 bed interin unit		Incremental Development Costs		Total cost after Development 24 Bed Inpatient Unit	
Salaries	Scale	**WTE**	**FYE £000's**	**WTE**	**FYE £000's**	**WTE**	**FYE £000's**
Medical							
Consultant	Top	2.0	191	0	0	2.0	191
Staff Grade	Top	1.5	88	0.5	30	2.0	118
	Total Medical	3.5	279	0.5	30	4.0	309
Nursing							
Trained	Top I	1.0	42	0.00	0	1.0	42
	H Top	1.0	38	0.00	0	1.0	38
	G Top	1.0	38	2.00	76	3.0	114
	F Top	2.0	68	1.00	34	3.0	102
	E Top	11.2	353	6.55	206	17.8	559
	D Top	6.0	154	19.50	501	25.5	655
		22.2	693	29.05	817	51.3	1,510
Untrained	TA p	10.0	168	7.00	118	17.0	286
	Total Nursing	32.2	861	36.05	934.942	68.3	1,796
AHP's							
Psychology	Gr B sp. 45	0.5	30	0.5	30	1.0	60
	Gr A sp.35-37	1.0	44	0	0	1.0	44
Psychotherapist	Gr A sp.36	0.5	21	0	0	0.5	21
Occ. Therapy							
Snr I	Mid	1.0	31	0	0	1.0	31
Snr II	Mid	1.0	26	0	0	1.0	26
Art Therapist				0.4	11	0.4	11
Dramatherapy	External	0.4	13	0	0	0.4	13
Family Therapist				1	48	1.0	48
Dietetics	Mid	0.6	21	0.9	32	1.5	53
Physiotherapy	Snr I Mid	0.1	4	0.1	4	0.2	8
Speech Therapy	Gr 2 sp 26	0.1	2	0.1	2	0.2	4
	Total AHP's	5.2	192	3	127	8.2	319
A & C							
Grade 4	Mid	1.0	18	0	0	1.0	18
Grade 3	Mid	2.0	31	0	0	2.0	31
		3.0	49	0	0	3.0	49
Directorate Management		0.5	25	0	0	0.5	25
	Total Salaries	**44.4**	**1,406**	39.55	1091.942	84.0	2,498
Supplies							
Equipment			7		8		15
Pharmacy			20		10		30
PAM's equipment			1		5		6
Catering			39		21		60
Laundry			2		4		6
Uniforms/Bedding			2		2		4
Domestic			45		12		57
General Services			2		2		4
Travel			14		10		24
Training			16		14		30
Stationery/Postage			5		5		10
Portering/Transport			4		2		6
Sub-total Direct Supplies			157		95		252
Accommodation (total cost £737k including capital charges at £450k (£6.6m build cost assumption))			236		501		737
Total Direct Supplies & Accommodation			**393**		596		989
Sub-total Salaries & Supplies			1,799				
Personnel, Payroll, Hospital Mgt, Finance			43		0		43
TOTAL RECURRING COSTS			**1,842**		1688		3,530

Appendix 6a

WoS ADOLESCENT OBC STOBHILL OPTION

Optimism Bias - Upper Bound Calculation for Build

Lowest % Upper Bound	13%
Mid %	40%
Upper %	80%
Actual % Upper Bound for this project	18%

	£'000
Capital cost of this option	6600
Upper bound optimism bias factor = 18%	
Mitigated, as attached by 73%	
Apply optimism bias factor 18% x 27%	
= 5%	330

Build complexity

Choose 1 category		X		
Length of Build	< 2 years	x	0.50%	0.50%
	2 to 4 years		2.00%	0
	Over 4 years		5.00%	0
Choose 1 category				
Number of phases	1 or 2 Phases	x	0.50%	0.50%
	3 or 4 Phases		2.00%	0
	More than 4 Phases		5.00%	0
Choose 1 Category				
Number of sites involved (i.e. before and after change)	Single site*	x	2.00%	2.00%
	2 Site		2.00%	0
	More than 2 site		5.00%	0

* Single site means new build is on same site as existing facilities

Location

Choose 1 Category				
New site - Green field	New build		3%	0
New site - Brown Field	New Build		8%	0
Existing site	New Build	x	5%	5.00%
	or			
Existing site	Less than 15% refurb		6%	0
Existing site	15% - 50% refurb		10%	0
Existing site	Over 50% refurb		16%	0

8.00%

Scope of scheme

Choose 1 category		X		
Facilities Management	Hard FM only or no FM	x	0.00%	0.00%
	Hard and soft FM		2.00%	
				0
Choose 1 category				
Equipment	Group 1 &2 only	x	0.50%	0.50%
	major Medical equipment		1.50%	0
	All equipment included		5.00%	0
Choose 1 category				
IT	No IT implications	x	0.00%	0.00%
	Infrastructure		1.50%	0
	Infrastructure & systems		5.00%	0
Choose more than 1 category if applicable				
External Stakeholders	1 or 2 local NHS organisations		1.00%	0
	3 or more NHS organisations	x	4.00%	4.00%
	Universities/Private/Voluntary sector/Local government		8.00%	0

Service changes - relates to service delivery e.g NSFs

Choose 1 category				
Stable environment, i.e. no change to service		x	5%	5.00%
Identified changes not quantified			10%	0
Longer time frame service changes			20%	0

Gateway

Choose 1 category				
RPA Score	Low	x	0%	0.00%
	Medium		2%	0
	High		5%	0

9.50%

Scheme name: WoS ADOLESCENT OBC STOBHILL OPTION Appendix 6b

Contributory Factor to Upper Bound	% Factor Contributes	% Factor Contributes after mitigation	Explanation for rate of mitigation
Progress with Planning Approval	4	2	The Stobhill site is an existing NHS site with a masterplan showing how parts of the site are intended to be used in the long term future. The part of the site on which it is intended to build the new facility has no alternative NHS uses assigned to it and it is considered that detailed planning will not be obstructed. Detailed planning consent is outstanding.
Other Regulatory	4	4	The only regulatory factor identified is the possible requirement of Scottish Water to attend to drainage from the site. Allow no mitigation meantime.
Depth of surveying of site/ground information	3	2	The history of the site is known and whilst site surveys remain to be carried out, there is no evidence to suggest problems with this site. The Board constructed a £5m 66 bed mental health unit adjacent to the proposed site 6 years ago of a single storey construction and no adverse ground conditions were found then.
Detail of design	4	2	The design has been arrived at following a detailed review of service objectives and output requirements that arise from these objectives. These are set out in Sections 5 and 6 of the Business Case. The design has been tested against examples of small units elsewhere in the U.K. and a design output arrived at following this stage. Further, the design has been shared with stakeholders of the project and has been found to reflect their aspirations.
Innovative project/design (i.e. has this type of project/design been undertaken before)	3	0	There is nothing innovative about the design and the Board has considerable experience of single storey construction of which one case is cited above..
Design complexity	4	0	There is no complexity about the design.
Likely variations from Standard Contract	2	1	No variations to standard contract are required. None are anticipated.
Design Team capabilities	3	1	A design team will be appointed using the OJEC procedure and they will be appointed on the basis of experience and skills. Criteria for selection will include experience, references, detailed interview and demonstration of understanding of the project output objectives. The stakeholders and Board professional estate staff will be involved in the assessment of choice.
Contractors' capabilities (excluding design team covered above)	2	1	A contractor will be selected who can demonstrate successful experience on a project of this scale and type. Tenders will be assessed by the project stakeholders, the professional advisors for the project and by the internal professional staff. The assessment will entail examination of experience, history of building and record of building to design, timetable and cost. Acknowledging that contractor problems are not unusual, despite all these steps, partial mitigation, only, is made at this stage.
Contractor Involvement	2	0	The contractor will be fully briefed as to requirements and will be invited to suggest any improvements that may be offered, subject to strict fulfilment of the project brief.
Client capability and capacity (NB do not double count with design team capabilities)	6	0	The client has considerable experience in building and design.
Robustness of Output Specification	25	4	The output specification is robust. It is for a building only. No services are included. Nevertheless, acknowledgement is made of the early stage of this project and complete mitigation of this issue is not allowed for.
Involvement of Stakeholders, including Public and Patient Involvement	5	2	There has been very considerable input of the service users to this project. Patients, their carers/parents and a range of community interests have been contacted and their views sought on the proposals, across the West of Scotland. Support is widespread for the new ward and service to the West of Scotland. In addition to meetings with users and carers a public involvement exercise was undertaken between February and April 2005 and the output is attached as Appendix 6c.
Agreement to output specification by stakeholders	5	3	Stakeholders have approved the design but allowance is made for a degree of optimism bias at the further involvement by stakeholders in detailed design at the next stage.
New service or traditional	3	0	This project represents enhancement of existing services.
Local community consent	3	0	Consultation with the local community has revealed no local objection to the scheme.
Stable policy environment	20	5	The policy environment is stable. Regardless, it is considered prudent to allow an optimism bias at this point, given the unknowability of future demands of the service.
Likely competition in the market for the project	2	0	There is likely to be good competition for a build of this size. A number of builders are available for construction in the Greater Glasgow area.
TOTAL	100	27	

Note: Across all contributory factors, mitigation would be expected to be greater the greater the extent of risk quantification and risk management.

Appendix 6c

Date 22nd April 2005
Our ref DH/LW
Direct Line 0141 211 0662
Fax 0141 211 0245
Email David.Harley@gartnavel.glacomen.scot.nhs.uk

Dear

When I originally wrote out to everybody I said I would be writing again to update you all on progress.

This letter is to update you about the responses we have received.

We received eight responses and they covered the following points:-

- Everybody who was able to respond welcomes the move to significantly improve provision for young people in the West of Scotland moving from the existing 16 in-patient beds to 24 beds.

- Having taken into account the known demand for additional in-patient care and the projected population for the West of Scotland along with National Reports/recommendations and our clinician's views, we concluded that increasing the number of beds was required.

- We had mixed views from those that were able to respond concerning the generic design that we circulated. The views included making sure we had provision for an overnight stay for carers/parents, to the layout being more conducive to modern day health care, and also that the design was very institutionalised.

- Up to now we have only been able to prepare a "generic" design. We need to do this so we could work out how much a new building for 24 young people would cost. For the next stage of the design we will appoint architects and then prepare a final design. We will ensure that our most experienced clinicians are fully involved in this process and also ensure that we seek more input from those who expressed opinions about the generic design layout.

- Clarification was sought on if the in-patient beds would deal with patients who specifically had an eating disorder and those young people who currently were required to be admitted to adult intensive psychiatric care unit beds.

- Our design thinking is deliberately based around three sub units of eight beds. Our clinical teams have considered that this will be flexible enough to deal with young people who have an eating disorder when they need in-patient care and also flexible

enough within a sub unit to deal with the young people who would require intensive in-patient services.

- We had mixed views from those that were able to respond concerning the accessibility of the site, the convenience of hotels and guest houses around Gartnavel as well as places to visit nearby, even where this would delay having the new ward.

- Up to now nobody has disagreed that what we really want is lots of space in a purpose built ward, built to the highest possible clinical standards and that is also homely, and we would like it now. Of the eight responses we received two specifically stated that they would prefer Gartnavel for a variety of reasons, one reason given by both was certainly for location. One response specifically stated that the ward quality of service was more important than location within Glasgow. Another response specifically felt there would be more space at Gartnavel if the Health Board had not decided to sell off part of the land at Gartnavel.

- Obviously everyone would like the proposed new ward to be nearer to where they live. Overall, it is not specifically better in terms of average mileage for all admissions in either proposed location. We do not believe by starting on the final design now that we would be compromising the design and quality of the ward if the location was Stobhill. Two areas for health care development over and above the planned developments on the Gartnavel site still remain. Only one of these areas has been recognised as needed as an option for mental health in-patient services for young people. There is still an additional piece of land at Gartnavel but none of these pieces of land will now become available until 2008 and a new in-patient ward for young people on the Gartnavel site couldn't be completed before 2010. Along with the delay the land available is also a different and narrower shape and this would have an impact on the design that won't be a factor at Stobhill.

- Among the concerns from those who were able to respond were whether people in the Stobhill area might complain about a new mental health ward in the hospital grounds that Stobhill includes plans for an open/out-patient drug and alcohol ward and that a hospice exists adjacent to the Stobhill option site.

- We have communicated with the communities living around Stobhill for a number of months about the potential for a new mental health ward for young people on the hospital site and have not been notified of any concerns. We do not believe that an open drug and alcohol ward will adversely affect the young people attending for in-patient services. Our current ward at Gartnavel Royal has been adjacent to an in-patient ward for people with an addiction for many years.

- The plans for replacement adult mental health services at Gartnavel also include a new ward for adults with addictions and this has not and continues not to be a difference between the two locations. The proximity of the site option at Stobhill to the existing hospice is also not considered to be a clinical concern. There are also plans for the existing hospice to move further into the Stobhill site nearer to the ACAD (Ambulatory Care and Diagnostic Centre site).

- The Gartnavel site has an acute hospital on site for blood tests, renal ultrasound and ECG for patients who become extremely unwell.

- The future plans for Stobhill include an ACAD (Ambulatory Care and Diagnostic Centre). This is a unit that will have testing facilities such as blood tests, renal ultrasound and ECG. The current Stobhill Hospital also currently has testing services for blood tests, ultrasound and ECG.

During this process of asking people for their views, a number of issues have been raised in relation to the availability and proximity of other health services. The availability and proximity of health services have been considered and as shown in relation to the summary of these points and responses above we believe don't alter the overall consideration of the relative merits of the two main sites to date.

The strongest opinions seem to be expressed about the location of the new ward due to the transport links and the local area in terms of local amenities and feel of the local area. Obviously the distance travelled does depend on where you live. In my previous letter I did refer to a brief exercise on average distance by road from the home addresses of young people admitted in the course of last year and the difference was negligible. The train station for Hyndland is nearer than the train station to Stobhill (Stobhill nearest railway station is 0.9 miles away). Shops and coffee houses are available at Byres Road, Glasgow, just over one mile on foot from Gartnavel and the Triangle at Bishopbriggs just over one mile from Stobhill. The new ward will also carry out escorted trips using public and our own transport and both locations are connected by bus routes to these areas. Whilst some people felt safer in the Gartnavel area, we also do not believe Bishopbriggs is an inherently unsafe area.

This does not, of course, diminish the strongly held opinions of individuals who feel Gartnavel would be a preferable site. However, taking account of all of the different and sometimes opposite responses received (and each point has been listed separately and attached for information) our Outline Business Case has been submitted with Stobhill as an overall preferred option.

We did undertake to submit the views and opinions we received for consideration and we have also done this.

Finally, once we know if the Outline Business Case has been approved or not we will then follow up the interest that has been expressed in being involved in the final design of the ward.

I hope that my contacting you has felt to be a helpful and useful exercise, irrespective of whether you feel disappointed or pleased with the outcome to date.

For my part, I would like to sincerely thank you for your time and input and all the responses I received.

Yours sincerely

David Harley
General Manager – Clinical Directorates

Argyle and Clyde Health Council

Lanarkshire Health Council

Ayrshire & Arran Health Council

Forth Valley Health Council

Dumfries & Galloway Health Council

Greater Glasgow Health Council

Stepping Stones Organisation

Mental Health Network

Mental Health Forum, Wise Group

Dumbarton & District Mental Health Forum

West Dumbartonshire Carers Forum

Mental Health Who Cares

Mental Welfare Commission

Glasgow Association of Mental Health

Scottish Association for Mental Health

Kenmore/Vesalius Street Tenants Association
Sandyhills Residents Association
Old Balornock Tenants Association
Nevis & Campsie Tenants & Residents Association
Bluevale/Whitevale Tenants Association
Armadale Residents Association
Ladywell & High Tenants Association
Royston Square Tenants & Residents Association
Sandyhills High Flats Tenants Association
Easterhill Place Tenants Association
Mid Balornock Tenants & Residents Association
Wellpark/Broompark Residents Association
Bridgeton High Rise Flats Tenants Assocation
Glasgow Cross Tenants & Residents Association
Townhead Tenants Association
Antonine Housing Co-operative
Greens Tenants Residents Association
Harestanes Community Association
Baldernock Community Council
Bishopbriggs Community Council
Campsie Community Council
Kirkintilloch Community Council
Lenzie Community Council
Milton of Campsie Community Council
Torrance Community Council
Twechar Community Council
Waterside Community Council
Baillieston Community Council
Balgrayhill Community Council
Calton Bridgeton Community Council
Carmyle Community Council
Dennistoun Community Council
Gartcraig Community Council
Germiston Community Council
Merchant City Community Council
Milton Community Council
Molendinar Community Council
Mount Vernon Community Council
Parkhouse Community Council
Possilpark Community Council
Ruchill Community Council
Sprinboig Community Council
Springburn Community Council
Swinton Community Council
Townhead Community Council
Wallacewell Community Council
Wellhouse Community Council
Woodlands and Park Community Council
26 Members of the Scottish Parliament covering West of Scotland Constituencies